The impact of the parenting training ‘We are Parents’ on positive parenting in Ethiopia

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Abstract

There is a lack of evidence for the effectiveness of parenting programs in developing countries, where difficulties like poverty and stress may lead to poor parenting. A mixed method design was used to study the impact of the parenting training ‘We are Parents’, on positive parenting practices, including affection, responsiveness and stimulation. Pre- and post-test data of 31 parents with children not older than 18 years, was obtained using a questionnaire (quantitative), and interviews (qualitative) were conducted with 10 parents after the training. Results show that parents significantly increased their positive parenting practices, as higher outcomes are found between pre-test and post-test data for positive parenting as a whole, and each of the components affection, responsiveness and stimulation. Interviews support the increase in positive parenting. Parents report that they have learned different things, and made changes in their parenting practices, with regard to affection, responsiveness and stimulation. The current study contributes to the evidence of effective parenting programs in developing countries, and offers meaningful applications for further research in this field. Furthermore, this study shows the potential for promoting positive parenting in developing countries by the use of parenting programs, like ‘We are Parents’, for both fathers and mothers.

Keywords: parenting training, positive parenting, developing countries, Ethiopia

Samenvatting

Er is een gebrek aan de bewezen effectiviteit van ouderprogramma’s in ontwikkelingslanden, waar moeilijkheden zoals armoede en stress oorzaken zijn voor een slechte opvoeding. Met gebruik van een mixed-methods design is onderzocht of de oudertraining ‘We are Parents’ een effect heeft op de positieve opvoedingspraktijken van ouders en elementen van positief opvoeden: affectie, responsiviteit en stimulatie. Voor en na de training, is een vragenlijst (kwantitatief) afgenomen bij 31 ouders met kinderen tot en met 18 jaar. Daarnaast zijn er na afloop van de training interviews (kwalitatief) afgenomen bij 10 van deze ouders. Resultaten tonen aan dat de opvoeding van ouders significant positiever is dan voor de training, met een hogere mate van affectie, responsiviteit en stimulatie. Interviews bekrachtigen deze bevindingen: ouders rapporteren leeropbrengsten en positieve veranderingen in hun gedrag, met betrekking tot affectie, responsiviteit en stimulatie. Het huidige onderzoek draagt bij aan de bewezen effectiviteit van ouderprogramma’s in ontwikkelingslanden en biedt interessante aanbevelingen voor toekomstig onderzoek. Daarnaast toont dit onderzoek de potentie om positieve opvoedingspraktijken in ontwikkelingslanden te bevorderen met behulp van ouderinterventies, zoals ‘We are Parents’, voor zowel vaders als moeders.

Sleutelwoorden: oudertraining, positieve opvoeding, ontwikkelingslanden, Ethiopië

The impact of the parenting training ‘We are Parents’ on positive parenting in Ethiopia

Deficient care is one of the reasons that an estimated 200 million children under the age of five fail to reach their potential in cognitive and social development (Grantham-McGregor et al., 2007). This means that there is a discrepancy between the current developmental levels of these children and the levels they would achieve in a nurturing environment. Parenting, particularly in poor environments, can be difficult for a number of reasons: stress, illness, lack of awareness for the need of loving care and poverty (World Health Organization, in Eshel, Daelmans, Cabral de Mello & Martines, 2006). Such reasons may cause poor parenting, which affects the development of children. The highest percentage of disadvantaged children live in the Sub-Saharan African countries, where many children are exposed to poverty, malnutrition, poor health and a non-stimulating home environment (Grantham-McGregor et al., 2007). So, there is an urgent need to provide support to caregivers of children in many African countries (Evans, Mantola & Neyko, 2008), which is also recognized by the World Health Organization, who made a call for interventions in these countries (Mejia, Calam & Sanders, 2012).

Parenting programs have shown to be effective in improving parental care and across a range of parental and child outcomes (Knerr, Gardner & Cluver, 2013; Mejia et al., 2012). However, effectiveness was shown in high-income countries; research on the effectiveness of such parenting programs in developing countries remains limited (Eshel et al., 2006; Mejia et al., 2012). Although awareness of child development is increasing in developing countries, only a few systematic evaluations of child development programs have been conducted in developing countries (Engle et al., 2007). Moreover, parenting programs focus primarily on preventing physical and neuro-cognitive difficulties, instead of preventing emotional and behavioral difficulties (Mejia et al., 2012). No systematic reviews on parenting interventions aimed at improving parenting skills and parent-child relationships in low-and middle income countries were found (Knerr et al., 2013). This study, therefore, focuses on the impact of the parenting training ‘We are Parents’ on positive parenting in Ethiopia, as this parenting program aims at providing parenting skills for parents in developing countries.

Positive parenting and the consequences on child development

Positive parenting has many benefits for children, as the way parents raise their children has a major impact on child development. Positive parenting can be defined as caregiving wherein parents show affection, responsiveness, and stimulate their children (NICHD Early Child Care Research Network, 1996). With positive parenting, parents can fulfill the responsibility of raising their children and always consider what is best for them, as

written in article 18 of the Convention on the Rights of the Child (UNICEF, 1989).

Components of positive parenting (affection, responsiveness and stimulation) affect the development of a child. Positive parenting includes activities that engage children in interpersonal interactions (Bornstein & Putnick, 2012). Openness, listening and emotional closeness makes children feel valued, accepted and approved of (Bornstein & Putnick, 2012). Also, inadequate stimulation and interactions can affect the development of a child by disrupting basic neural circuitry (Engle et al., 2007). So, affection, which can be defined as engagement and stimulation of the child, and positive parent-child communication, influences the development of the child. Furthermore, parental warmth and love increase the quality of parent-child relationships and their communication (Cherie & Berhanie, 2015). In addition, responsiveness, defined as the prompt, suspended and appropriate interaction with a child, provides better cognitive and psychosocial development (Eshel et al., 2006). Responsiveness is a causative factor in enhancing a child's wellbeing too (Eshel et al., 2006). Stimulation, which includes increasingly complex developmentally appropriate interactions, matched to the emerging abilities of the child between caregivers and children, that enhance child development (Engle et al., 2007), also has an influence on child-development. It was found that, just as parental warmth and love, parental support increases the quality of parent-child relationships and their communication (Cherie & Berhanie, 2015). Furthermore, positive parenting can be a protective factor in the growing up of children. For example, it can protect children against risky sexual behavior (Cherie & Berhanie, 2015). Considering the fact that positive parenting has many benefits for the development of children, a call was made to increase positive parenting practices in low- and middle- income countries (Chang, Park, Singh & Sung, 2009; Knerr et al., 2013).

Positive parenting interventions in developing countries

The urgent need to improve positive parenting practices in developing countries was recognized by a range of program developers, since several parenting programs were designed and introduced, related to positive parenting in developing countries. Available studies on these parenting programs showed positive outcomes, since these programs were effective in increasing positive parenting behaviors. It was found that interventions in developing countries have been modestly effective in enhancing maternal responsiveness, which lead to better child health and development, especially for children at risk (Eshel et al., 2006). The Mediation Intervention for Sensitizing Caregivers (MISC), which was designed to improve the quality of early-adult child interactions, was found to be effective in enhancing maternal responsiveness. This intervention seems to have positive and long lasting effects on mother-

child interaction and consequently promoted socio-emotional and academic performance of children (Klein & Rey, 2004). The MISC showed that after a year of intervention, mothers were more sensitive, responsive and optimistic than mothers in the comparison group (Klein & Rey, 2004). The intervention also affected the parent-child interactions, which included less harsh commands and fewer orders (Klein & Rey, 2004). In addition, an effect on the mother-child interaction was found in the study on the impact of the STAR (Stop, Think, Ask, Respond) intervention, wherein mothers who completed the training showed significant decreases in the use of verbal punishments (Nicholson et al., 1999). Furthermore, A positive impact on the quality of the mother-infant relations was found in an intervention South Africa, which wanted to improve the relationship between mothers and infants. Mothers were significantly more sensitive after the intervention and had a higher score on secure infant attachments (Cooper et al., 2009).

Another effects were found with the Head Start parent program, which targets the increase of parental involvement and parental skills so parents can better stimulate their children. The study on the effect of this program revealed that participants of parental support groups were found to have higher levels of parental stimulation and lower levels of parental intrusiveness (Chang et al., 2009). Furthermore, the in Jordan nationally implemented Better Parenting Programme (BPP), which targets enhancing parental knowledge, attitudes and behaviors related to caregiving of young children, shows an effect. After the program, participants increased their positive discipline methods, played more with their children and increased in explaining reasons to the child (Al-Hassan & Lansford, 2011). Furthermore, the SCORE’s Parenting Skills Training, which was given with the purpose of improving parental behavior in Uganda, showed that parents who attended the program significantly improved their positive parenting behaviors (Schneider et al., 2015).

These effective parenting programs were found to have similarities in their design and approach, which may have been key factors in their success. Most programs were given by trained people of whom most were already involved in the community where the training was given, for example social workers or teachers (Al-Hassan & Lansford, 2011; Cooper et al., 2009; Klein & Rey, 2004; Nicholson, Brenner & Fox, 1999; Schneider, Agaba, Lowicki-Zucca & Larok, 2015). The intervention in South Africa used home visits (Cooper et al., 2009), other programs offered parenting classes and group sessions as intervention (Al-Hassan & Lansford, 2011; Chang et al., 2009; Nicholson et al., 1999; Schneider et al., 2015). The MISC intervention combined these parenting classes with home visits (Klein & Rey, 2004).

The Better Parenting Program in Jordan, the MISC intervention in Ethiopia, and the Head Start Program, had taken the culture and context of the place where the training was offered in consideration within the design of their program (Al-Hassan & Lansford, 2011; Chang et al., 2009; Klein & Rey, 2004). For example, the Better Parenting Program was designed with a holistic perspective on children's growth and development. It was taken into account that children grow up within the context of a family, community and nation (Al-Hassan & Lansford, 2011). Furthermore, the South Africa program, the MISC intervention, and SCORE's Parenting Skills program used different materials (e.g. video, quizzes, workbooks) and (inter)active teaching methods, like role-plays, homework, and discussions, instead of just giving information (Klein & Rey, 2004; Nicholson et al., 1999; Schneider et al., 2015).

Most parenting programs only included mothers (Chang et al., 2009; Cooper et al., 2009; Klein & Rey, 2004; Nicholson et al., 1999). The Better Parenting Program and the SCORE's Parenting Skills program included both fathers and mothers, but the majority was still women (94% and 76,6%). Furthermore, almost all interventions focused on parents of young children (infants, toddlers or children up to 5 years) (Al-Hassan & Lansford, 2011; Chang et al., 2009; Cooper et al., 2009; Klein & Rey, 2004; Nicholson et al., 1999). Only the SCORE's Parenting Skill program was found to improve parenting skills for parents of children up to the age of 18 (Schneider et al., 2015).

Effectiveness of positive parenting interventions

Programs may not be effective in developing countries for several reasons. The problem of poor child development can only change when a substantial effort is made to design appropriate integrated programs (Grantham-McGregor et al., 2007), which means that programs need to be tailored to the specific context where they will be implemented. Furthermore, programs need to be designed to be effective in this specific context. Parents differ in their way of caregiving, because of different intuitions and different acquired knowledge about parenting (Bomstein & Putnick, 2012), especially in low-income countries, where there is a large diversity. Traditional beliefs about child development may largely dictate childcare in those countries (Aboud & Alemu, 1995). Parenting style also differs (Woolfolk, 2013). Some cultures ask for strict parenting caused by living in a dangerous neighborhood, while raising children in other cultures is more focused on learning to respect one and other. Therefore, there is not a training that fits every community within a country, unlike in high-income countries (Mejia et al., 2012). Moreover, ideas about parenting and childhood are mostly defined by Western countries (Ambert, 1994). Thus, to provide support

and make a change in the behavior of people, it is important to understand their needs, build upon helpful traditional practices and give new knowledge in a participatory way (Evans et al., 2008). Programs must be adjusted to the specific context in which they are implemented. Acceptability and fit to a specific cultural context, increases the probability of successful outcomes (Mejia et al., 2012).

Caregiving in Ethiopia and the parenting program ‘We are Parents’

The lack of effective parenting interventions in developing countries was confirmed in a search for effective parenting interventions in Ethiopia. Although early interventions for psychosocial development of children were initiated in Ethiopia in 1989 (Klein & Rey, 2004), only few effective parenting programs were found. Ethiopia is one of the Sub-Saharan African countries where many children are exposed to poor parenting, as it seems that most children perceive their parents to be neglectful (Tsemrekal, 2013). Although mothers are the major source of communication for children, there is very little communication between mother and child (Aboud & Alemu, 1995). Infants are not seen as a partner in the interaction with adults (Klein & Rey, 2004). The main role of the mother is to feed and clean their child and not lose sight of it; very few mothers see psychological development of their child, and providing stimulation, as their role (Aboud & Alemu, 1995). Logically, encouraging a child is rare (Klein & Rey, 2004). The way parents raise their children, is significantly related to achievement and authoritative parenting, which includes high levels of parental warmth and control (Woolfolk, 2013), may provide better cognitive strategies for children (Tsemrekal, 2013). Therefore, it seems very beneficial to improve positive parenting in Ethiopia by the use of a parenting program.

Help a Child (Red een Kind), a Dutch based organization that wants to improve the welfare of children and strengthen communities in underdeveloped areas, designed the parenting training ‘We are Parents’ to improve parenting skills for mothers and fathers of children from birth to the age of 18, so parents can provide adequate and relevant support for their children. A manual was written, which included seven sessions about (a) what is a parent, (b) the childhood of the parents and the childhood of their children, (c) the needs of a child, (d) parental behavior, (e) other influences on a child, (f) protection of children, and (g) making a plan for the future. Since the organization wants to introduce the parenting training to different African countries, the manual was designed as a framework that needs to be complemented and finalized by local professionals. In this way, each training can be tailored to the specific cultural context of the place where the training will be given. In addition, the training was designed to be given in an participatory way by local workers.

A six week pilot was done in March and April 2016, in Ethiopia. The pilot was carried out on behalf of Help a Child, in collaboration with Ethiopian Kale Heywet Church (EKHC) Kuriftu Center, as a Master internship project. The parenting training was adjusted to the socio-cultural context of Ethiopia, since the manual was based on key informant interviews and focus group sessions that were conducted in the target area. The intervention team consisted of four employees of EKHC Kuriftu Center, who delivered the parenting training: one manager, one health officer and two social workers who were familiar with the community. Seven sessions of three hours took place twice a week. The intervention team was prepared to deliver the parenting training during a Training to Trainers (TOT), which was given by Help a Child. In this training, the 'trainers', or facilitators, were trained for three days about how to facilitate the training and to improve their own facilitating skills. The TOT was also given to make the facilitators familiar with the goal and content of the training.

Current study

This study will focus on the impact of 'We are Parents' on positive parenting in Ethiopia. The study will examine if 'We are Parents' improves the skills of parents, and if therefore it might be beneficial to implement the training program to more African countries. In addition, the current study will contribute to the existing evidence about the effectiveness of parenting programs in developing countries, and to the improvement of positive parenting practices in low- and middle- income countries. Including both fathers and mothers with children up to the age of 18 in the current study is unique, since earlier studies only, or mainly, included mothers.

The current study will examine the following question: "What is the impact of the parenting training 'We are Parents' on positive parental behaviors of parents in middle Ethiopia?". In order to examine the effects of 'We are Parents' on positive parenting, the impact of the training will be examined on three components of positive parenting: affection, responsiveness and stimulation.

Methods

Sample

Forty participants from the Ethiopian communities Godeti, Mika, Worku, Gandagorbe, Babogaya and Kebele Nine, were selected for the study, by four social workers of EKHC. Social workers contacted the participants through church, through other EKHC projects (e.g. income generating groups), or by using their own network (some social workers live in the same community as the participants). Participants from Gandagorbe were selected with the guidance of a social animator. Twenty participants from the urban villages, and 20

participants from the rural villages, were selected. Participants needed to be parent of a child between the age of 0 and 18 years old. The social workers invited parents by asking if they were willing to participate in the training. To create a diverse group of participants, both literate and illiterate participants were included in the study. It was tried to select an equal number of men and women.

Prior to the first training session, two information meetings were held at the training locations; at Kuriftu Center for urban villagers and at Babogaya School for rural villagers. Participants were orally informed about the study. In total, 37 participants attended the training, including 16 participants from urban areas and 21 participants from rural areas. For the study, 31 participants were selected based on their presence during the pre-test intervention, which included 13 men and 18 women between 29 and 63 years old, with an average age of 41.16 (*SD* = 7.95). Men had an average age of 46.92 (*SD* = 7.41, range = 29) and women an average age of 37 (*SD* = 5.38, range = 17). Some participants estimated their age, since they did not know their date of birth. The average number of children per parent was 3.13 (*SD* = 1.36), with a minimum of one child and a maximum of six children. The marital status of the participants was married for 87.1% (*n* = 27), divorced for 3.2% (*n* = 1) and widow(er) for 9.7% (*n* = 3). Of the participants, 29% had no education (*n* = 9). The highest education level was grade 1- 4 for 6.5% of the participants (*n* = 2), grade 5-8 for 29% (*n* = 9), grade 9-10 for 19.4% (*n* = 6) and grade 11-12 for 6.5% (*n* = 2). 9.7% of the participants had another form of education, such as basic adult education (*n* = 3). Nineteen participants were literate, and 12 participants were illiterate. Participants were separated into two groups for the intervention, based on their place of residence. One intervention group consisted of 13 urban villagers, including six men and seven women, with an average (approximate) age of 40.38 (*SD* = 5.91, range = 19). The group had three illiterate participants. The other intervention group existed of 18 rural villagers, including seven men and 11 women, with an average (approximate) age of 41.72 (*SD* = 9.27, range = 34). This group had nine illiterate participants.

Design and procedure

A mixed methods design was used to study the impact of the parenting training ‘We are Parents’ on positive parenting. Parents filled in a quantitative questionnaire before and after the parenting training. In addition, random selected parents participated in interviews (qualitative). Parents were asked if they agreed to be included in the study, since using informed consent is not common practice in the context. All parents gave their permission.

The study was conducted by interns of Help a Child in Bishoftu, Debre Zeit, in collaboration with EKHC Kuriftu center. During pre-test and post-test, employees of EKHC Kuriftu center were appointed to assist participants by reading the questionnaire to illiterate participants. These employees were social workers, managers or drivers of EKHC Kuriftu center, who were literate and therefore able to read the questionnaire for the participants. The trainers (or facilitators of the training) were present during the pre-test and post-test, but assisted only during the pre-test, in order to avoid socially desirable responses from the participants at the post-test.

Quantitative measurements

Data was collected by using a quantitative questionnaire (see Appendix A for the complete questionnaire), designed by Lieselot Roelandts and Maud Weerden on behalf of Help a Child. The questionnaire was based on the content of the parenting training 'We are Parents'. Items about parental behavior were based on the 'Parent Behavior Survey', which was used during the impact evaluation of the SCORE's Parenting Skills Training on caregiver knowledge, behavior and child wellbeing (Schneider et al., 2015). Items were adapted to the socio-cultural context of Ethiopia and verified by the Utrecht University, Help a Child and EKHC Kuriftu center. The questionnaire consisted of 61 self-rating items, dealing with parent behavior, skills and knowledge. Items 1 to 27 were general questions and filled in by each participant. Two items were only filled in if the participant had a partner (item 2 and item 9). Item 7 and item 16 were only filled in if the participant had a daughter. Items 28 to 36 were only filled in if the participant had a child between the age of 0 to 6, items 37 to 48 if the participant had a child between the age of 7 to 13, and item 49 to 61 if the participants had a child between the age of 14 to 18. Eight domains of parenting were supposed to be assessed: child development (14 items), parents relationship (2 items), parent-child relationship (12 items), parental competence/confidence (3 items), controlling behavior (13 items), health/care/hygiene/nutrition (6 items), alcohol (2 items), and child protection (6 items). Appendix B shows the questions per domain. The internal reliability of the questionnaire was good, as shown by the Cronbach alphas calculated for each domain at pre-test and post-test, ranging from .60 to .94, except for parents relationship during pre-test ($\alpha = .54$) and parental competence/confidence during post-test ($\alpha = .46$).

Since the questionnaire was used for the first time, a pilot was conducted in one of the communities, Gandagorbe, to monitor the usability of the questionnaire and suitability within the Ethiopian context. A convenience sample of five volunteers was used. Volunteers were selected based on their willingness and sufficient similarity to the participants. The first

version of the questionnaire used a 5-point scale with 1 (*never),* 2 (*rare),* 3 *(sometimes),* 4 *(often),* and 5 *(always)* to score the items. However, the pilot uncovered a lack of variance in the participants' answers, which were very high. The lack of variance made it difficult to measure improvements of parental behaviors, since the outcomes on the post-test could not be reported much higher than the high pre-test outcomes. Therefore, the response scale was changed into a 10-point scale with 1 (*never)* and 10 *(always).* Due to the lack of time, there was no pilot with the final questionnaire to check the suitability of the scale in the Ethiopian context. The questionnaire was developed in English and translated into the Ethiopian national language, Amharic, by a native Amharic speaker.

To measure the impact of the training on positive parenting, several items were used to compute scores on the three dimensions of positive parenting: affection, responsiveness and stimulation. For each dimension, variables were created by computing scores for items relating to the dimension (Cronbach's $\alpha > .70$).

Affection. Affection, defined as engagement and stimulation of the child, and positive parent-child communication, was assessed by the following items: (a) I give an explanation when I forbid or order my child something, (b) I listen to my child's opinions and ideas, (c) I joke and play with my child, (d) I give praise to my child when it does something good and (e) I encourage my child to share his/her feelings and opinions with me ($\alpha = .77$ at pre-test and $\alpha = .81$ at post-test). The first three items were asked for each age category. Some parents have children of different ages, therefore, the scores they gave for each age category were averaged for each parent. The item related to praise was a general question and asked to each participant. The last item was supposed to be asked within each age category, but it was asked as a general question, for the age category 0 to 6, and for the age category 7 to 13. Therefore, only the general score was used, which was filled in by each participant.

Responsiveness. Three items were used to measure responsiveness, also known as the prompt, contingent and appropriate interaction with a child ($\alpha = .75$ at pre-test and $\alpha = .84$ at post-test). Parents were asked if they give attention to their child when the child asks for it, if they give advice when the child needs it, and if they make time free to talk with their child. The items were general questions and asked to each participant.

Stimulation. Five items were used to measure stimulation, defined as the increasingly complex developmentally appropriate interactions, matched to the emerging abilities of the child, between caregivers and children, that enhance child development (Engle et al., 2007) ($\alpha = .74$ at pre-test, and $\alpha = .70$ at post-test). Parents were asked if they stimulate their child to go to school, if they stimulate/encourage their child to learn something new, if they advise their

child about peer relationships, if they teach/advise their child to protect itself from sexual and physical abuse and if parents teach/advise their daughter to protect herself from abduction. The first item was asked for the age categories 7 to 13 and 14 to 18. If parents had children of different ages, the scores for both categories were averaged for each parent. The other items were asked as a general question, but the item if parents teach/advise their daughter to protect herself from abduction, was only filled in by participants who had a daughter.

Qualitative measurement

Data was collected using interviews. The interviews were conducted after the training was completed. Within each intervention group, five participants were randomly selected. In the urban intervention group, three men and two women were selected and interviewed individually. Because of the short time available, a group interview was held in the rural intervention group, with four men and one woman.

The interviews were held by the interns of Help a Child. The manager of EKHC served as interpreter during the individual interviews, and an Ethiopian employee of Help a Child served as interpreter during the group interview. The answers of the participants were translated from Amharic to English after an answer was given; there was no immediate and literal translation of each word or sentence. Participants were asked if they had learned something from the training, and if anything has changed because of the training. Lastly, they were asked if they wanted to add something to the interview. During the individual interviews, a record was made and the translated Amharic answers of the participants were transcribed. During the group interview, only notes of the translated Amharic answers were made. The components of positive parenting (affection, responsiveness and stimulation), and the related quantitative questions, were used to measure the impact of the training on positive parenting.

Analysis plan

To measure the impact of the parenting training 'We are Parents' on positive parenting, IBM SPSS Statistics 22 (BM Corp, 2013) was used to analyze all quantitative data. Pre- and post-test scores for the variables *affection*, *responsiveness* and *stimulation* were computed and compared using a paired samples T-test. The t-test was analyzed for the parents as a group (n = 31), and for fathers (n = 13) and mothers (n = 18) separately.

Qualitative data was analyzed to examine whether participants mention something they have learned or whether they mention any changes, related to affection, responsiveness and stimulation. First, answers of the participants were structured in the categories (a) learned: answers in which parents reported that they have learned something of the training, and (b)

changed: answers in which parents reported that something had changed after the training. Afterwards, it was analyzed within each category, if answers of the parents were related to affection, responsiveness and stimulation. If answers of the parents corresponded with the definition of a concept, or with the quantitative questions which were related to each concept, it was used as a result.

Results

Descriptive statistics

Variables. Outcomes for the variables *affection*, *responsiveness* and *stimulation*, were measured. The descriptive statistics for all variables are presented in Table 1. Prior to conducting the T-test, normality of difference scores between pre-test and post-test needed to be checked for each variable. The Kolmogorov-Smirnov test of Normality was used to check the normality and showed normal distributions for the difference variables *affection* ($D(31) = .20$, $p > .05$) and *stimulation* ($D(31) = .20$, $p > .05$). The test indicates a deviation from normality for the variable *responsiveness* ($D(31) = .01$, $p < .05$).

Normality of pre-test and post-test data of each variable was checked using Kolmogorov Smirnov test of Normality too. All variables were found to have a normal distribution during pre-test (non-significant with $p = <.05$), and the variables *affection* and *stimulation* were found to have a normal distribution during post-test. The test indicates a deviation from normality on the variable *responsiveness* ($D(31) = .001$, $p < .05$) during post-test. Prior to conducting the T-test for fathers and mother separately, the normality of scores of fathers on all variables, and scores of mother on all variables, was checked using Kolmogorov Smirnov test of Normality. The variables *affection* and *stimulation* were found to have a normal distribution during pre-test and post-test for fathers, but a deviation from normality on the variable *responsiveness* was found ($D(13) = .046$, $p < .05$). For mothers, the variables *responsiveness* and *stimulation* were normal distributed, but *affection* was found to have deviation from normality during posttest ($D(18) = .023$, $p < .05$).

Table 1

Statistics for all main variables (N=31)

	r						*M*		*SD*	
	Pre-test			Post-test						
	1	2	3	1	2	3	Pre	Post	Pre	Post
1. Affection	-			-			7.16	8.11	1.79	1.53
2. Respons	.82	-		.79	-		7.11	8.04	1.94	1.87
3. Stimul	.62	.70	-	.79	.53	-	7.84	8.43	1.75	1.27

Note. All correlations significant at 0.01 level (2-tailed). Respons = Responsiveness. Stimul = Stimulation, Pre = Pre-test, and Post = Post-test.

Statistical analysis

Paired samples T-test. Outcomes were significant at $p < 0.05$ for parents as a group, and a moderate effect size ($d = 0.4 - 0.6$) was found for positive parenting and each variable. Outcomes for mothers were not significant ($p = > .05$). For fathers, outcomes were significant at $p < 0.05$ for positive parenting as a whole, and for the variables *affection* and *responsiveness.* Results of the paired samples T-test are presented in Table 2.

Table 2

Paired Samples T-test

Difference between pre-test and post-test		*M*	*SD*	95% CI	*t*	*df*	*p*
Positive parenting	All parents	-0.83	1.61	[-1.42, -0.24]	-2.97**	30	.01
	Mothers	-0.73	1.93	[-1.69, -0.22]	-1.62	17	.13
	Fathers	-0.95	1.07	[-1.60, -0,31]	-3.21**	12	.01
Affection	All parents	-0.95	1.94	[-1.66, -0.24]	-2.91*	30	.01
	Mothers	-0.66	2.30	[-1.80, -0.48]	-1,23	17	.24
	Fathers	-1.35	1.29	[-2.13, -0.57]	-3.77**	12	.00
Responsiveness	All parents	-0.94	1.91	[-1.63, -0.24]	-2.73*	30	.01
	Mothers	-0.89	2.25	[-2.01, -1.67]	-1.67	17	.11
	Fathers	-1.00	1.37	[-1.83, -1.74]	-2.64*	12	.02
Stimulation	All parents	-0.59	1.57	[-1.17, -0.02]	-2.11*	30	.04
	Mothers	-0.65	1.83	[-1.56, -0.26]	-1.50	17	.15
	Fathers	-0.52	1.18	[-1.23, -0.20]	-.158	12	.14

Note. *p <.05 (2-tailed). **p <.01 (2-tailed).

Interviews’ analyses

Interviews showed that parents learned several things from the training in relation to components of positive parenting: affection, responsiveness and stimulation. Furthermore, the parents reported changes in their parental behavior, which became more positive. This was shown in the story of one mother:

“My daughter wants to go live with her aunt, I tried to discourage her. I asked myself how I could do it without offending or forcing her. I took her to a shop to buy her clothes. These little gestures can make children listen if you have a good relationship with them. It is important to show love instead of punishing, since this will not work. My daughter came back to live with me” (woman).

Affection. Parents reported that they have learned from the training how to engage and stimulate their child, and how to communicate in a positive way with their child (parental affection). Four parents reported that they have learned how to discuss with their child, for example: “How children can raise their ideas, their issues, their feelings, their different attitudes” (woman). Furthermore, parents learned how they can create room for children to be

more active and participatory in discussions. This is explained by several parents who told that they involved their children in discussions after the training. For example: “Previously, there was no discussion time with our kids, but now we are discussing every issue openly, very transparently without any restrictions or limitations” (man), and: “My kids are very happy and sociable and communicant and (. . .) to express their issues and ideas with transparent manner, without any fear of things” (woman). Parents improved the communication between themselves and their children; improvements were mentioned by 90% of the participants. For example, one father said that families come together more often, to discuss and raise different issues. Another father said that the communication between his children became “very positive, smart and loved based”, and that he, after the training, gives more space for his kids to raise different ideas and issues.

In addition, the quality of the communication changed, as was shown in an interview with a mother who told that she used to be tough and highly aggressive. She used to talk in a high pitched voice, which made her children very nervous. Now, after the training, she is very calm and she shares her idea in a better way: “Now the communication with my kids is in a very humble and honest way”. Moreover, 30% of the parents told that, before the training, they ordered and commanded everything from their child, and gave restrictions or threatened with punishments. After the training, these parents reported a change: they are discussing now, in a more loving way, and there is more participation (helping each other). “Before I beat and punished my children hard. Now, I discuss more with them and have dialogues with them” (man). Another parent illustrates the impact of the parenting training: “Before, my children were disorganized and sloppy. Now, through discussion, I managed to make them more organized. My children listen to me. I have a better relationship with them and there is more friendly interaction between me and them” (woman). These results showed that parents increased their affection.

Responsiveness. Participants acquired more knowledge in relation to responsiveness, and changes, with regard to responsiveness, occurred after the training. Parents reported that they have learned that they have the responsibility to fulfill the needs of their children. One mother explained: “I understand the role of father and mothers: both should give more attention to children and are responsible for the health, education, and balanced food of the children”. Parents told that there was no space and time for children before the training. For example, one mother said that her only concern used to be her job, not her kids. After the training, she told: “I am very drastically changed. . . . We are raising everything a lot in the family”. Other results of the training were reported by two mothers who told: “The training

made me pay more attention to my child”, and “. . . currently I show some love. Highly love, that means when I am baking injera (Ethiopian dish), they are coming to the kitchen and they are following what I am doing. When they are going to school, they kiss me”. Furthermore, parents responded better to the needs of their children than before the training. This was explained by a father who told that, before the training, he gave his children all kinds of job, but now, after the training, he gives them jobs that are acceptable for their age and body size. So, responding better to the abilities of his child. Another parent reported that he tries to find out what his child need, too. Interviews showed that parents became more responsive toward their children than before the training.

Stimulation. During the interviews, parents reported that they have learned several things in relation to stimulation. Thirty percent of the parents reported that they have learned how to take care of their children, which includes being involved with their school. One mother said: “I only have one child of eight years old. I know the importance for example school attendance, studying, playing and food”. Also, parents learned how to stimulate their children. One father learned “How to consult children”, and a mother reported: “I have now insight in how children can solve problems, like peer pressure. I want to help children by preventing bad practices and keep them safe”. Furthermore, parents learned about the importance of stimulating their child: “I should be more involved with children and create a good environment for them” (woman), and “It is always good to be actively engaged with children and help them with their problems” (woman). In addition, one mother reported that she had learned that it is better to advice your child and discuss with them in order to correct behaviors, instead of shouting bad words to them.

Although parents report about what they have learned in relation to stimulation, only one actual change in relation towards the support of children was mentioned during the interviews: one father told that he, and also his wife who did not attend the training, first ordered their children to do things, but now act as a role model. This means that he and his wife first show how children can do things, so their children can learn from this and copy what they are doing: “Families are helping them together”. Interviews showed that parents gained more knowledge, became more aware of the importance of stimulation, and that behaviors have changed.

Discussion

This study was carried out to study the impact of the parenting training ‘We are Parents’ on positive parenting practices in Debre Zeit, Ethiopia. Results from a sample of 31 parents with children up to the age of 18 years old, show an impact on positive parental

behaviors. Results indicate that ‘We are Parents’ had a positive impact on positive parenting of participants, including affection, responsiveness and stimulation. Results show that parents increased their affection towards their children: after the training parents were more likely to engage and stimulate their child, and have more positive communication between parent-child. In the interviews, participants mention that they discuss more with their child than before the training, and that the interaction is more friendly than before. Improvements on parental responsiveness were found too, which indicates that parents are likely to give more attention to their child if asked, give advice when their child needs it, and make more time free to talk with their child than before the training. Furthermore, parents reported that they stimulate their children more than before the training, which means that they after the training became more likely to stimulate their child to go to school and learn something new, advise their child about peer relationships and teach or advise their child to protect itself from abuse and abduction.

Changes in the parental behaviors are likely to be a result of the training, since outcomes are supported by the fact that several meta-analyses and available evaluations show the effectiveness of parenting programs across a range of parenting outcomes and positive long-term outcomes (Chang et al., 2009; Eshel et al., 2006; Evans et al., 2008; Klein & Rey, 2004; Mejia et al., 2012; Nicholson et al, 1999;). For example, results are consistent with earlier studies that showed that parenting interventions, in both developed and developing countries, can improve parental responsiveness (Eshel et al., 2006; Klein & Rey, 2004). Results are also supported by the finding that parents increased their levels of cognitive stimulation and supportiveness after participating in parental support groups (Chang et al., 2009). Furthermore, there is evidence that under similar circumstances, changes in parenting behaviors are possible as it was shown that mothers in low-income countries, with the stress of poverty, were able to make positive changes in their parenting behavior (Nicholson et al., 1999). Therefore, it can be considered that changes in the parental behaviors were probably a result of the training.

Results indicate that changes in parental behaviors are different for fathers and mothers. Due to the small sample size, it cannot be concluded that the training had more impact for mothers than fathers, but results indicate that the training especially may had an impact on positive parenting practices of fathers, since the outcomes on positive parenting were not as big for mothers. The difference between outcomes for mothers and fathers might be a result of the large gap between what women and men know concerning childrearing, and the larger involvement of women in childrearing (Evans et al., 2008). To fill this gap, a call

was made to include fathers in parenting programs in developing countries. Results of the current study show the potential for including men in parenting program in developing countries. However, to change the parental behavior of fathers, and men’s traditional role in childrearing, the wider society needs to change and support the new roles of men (Evans et al., 2008). Therefore, including both fathers and mothers in the current training may have been a key element in the change of the parenting behaviors. On the other side, including both fathers and mothers may have been the key element of the smaller impact for mothers too, since including only mothers in parenting programs was found to be effective (Chang et al., 2009; Cooper, et al., 2009; Klein & Rey, 2004; Nicholson, et al., 1999). It is possible that mothers feel more freely to speak without the presence of men, but the difference between men and women may also be caused by the large gap. Fathers were likely to have fewer knowledge and skills before the training. Therefore, they might have been able to learn and to adapt more.

Including both fathers and mothers may have attributed to the change in parental behaviors, but several other factors may have attributed too. ‘We are Parents’ was adapted to the cultural context of the parents, which increased the probability of successful outcomes (Mejia et al., 2012). New practices are more likely to make sense and take hold when they are built upon the traditional practices (Evans et al., 2008). Therefore, selecting local workers to give the training might have been a reason of success too. Another explanation might be the participatory method of the training: when new knowledge is introduced in the context of dialog, sharing and brainstorming and in a participatory way, knowledge is more meaningful and changes in the actual behavior of people are more likely than when information is just given (Evans et al., 2008). The mentioned factors are likely to have contributed to the change in the parental behavior, since these factors were also found in the design of several successful parenting programs, that have shown to be effective in developing countries (Al-Hassan & Lansford, 2011; Chang et al., 2009; Cooper et al., 2009; Klein & Rey, 2004; Nicholson et al., 1999; Schneider et al., 2015).

The change in parental behavior may also be attributed by factors relating to the content of the training. It was found that poor parenting in Ethiopia occurs often: there is a lack of mother-child communication, children are often discouraged, and psychological child development and stimulation of a child is not recognized as a task of parents (Aboud & Alemu, 1995; Klein & Rey, 2004; Tsemrekal, 2013). These issues were addressed during the training, since several domains related to parenting were assed. This created awareness and provided good knowledge as parents reported that they acquired knowledge and understood

their roles better. Moreover, the parenting training was likely to affect the beliefs of the parents about the children’s needs and parenting. Although ‘We are Parents’ was adapted to the cultural context, Western ideas about child rearing might still be interwoven in the training. However, in developing countries, child care is largely inspired by traditional beliefs about child development and the roles of a parent (Aboud & Alemu, 1995). So, these Western ideas may have led to new insights and therefore changes in parental behaviors.

Some limitations of the current study could be mentioned. First, the quantitative instrument had some limitations. A self-rating scale was used to measure changes in parental behavior. Triangulation or using a control group, was not possible due to the lack of time and the lack of available resources (for example money). Therefore, the reliability is low, and social desirability in the answers of parents cannot be excluded. Furthermore, illiterate parents were assisted by employees of EKHC Kuriftu center when they filled in the questionnaire, which may have led to desirable answers. Although they were instructed to only read the questionnaire, they may have had an influence (for example, steered parent in a direction). However, the mixed method design showed similar results that indicate the increase of positive parenting, including all components. Interviews support the results that were measured with the questionnaire. Other limitations were caused by a language barrier. Local Amharic speakers served as interpreters during the interviews. Since there was no direct translation, the possibility that the interpretations were those of the interpreters, and influences on the answers cannot be ruled out. Besides, the level of English was moderate. The questionnaire was translated to the local language, Amharic, which could have led to some difference in the content of the questionnaire. However, several Amharic speakers served as interpreter and reported similar outcomes. Therefore, it is not expected this had a large impact on the results. Final limitations were related to the data. There were deviations of normality for some variables. Furthermore, the effect size was shown to be moderate. Due to all limitations, no final conclusions were draw, and was it only considered that changes in the parental behaviors were a result of the training.

The current study gives some meaningful insights that can be taken into account in further research. It would be interesting to further investigate the differences in the outcomes for fathers and mothers in order to increase the effectiveness of parenting programs. Parenting programs in developing countries could include both fathers and mothers when this increase the outcomes on positive parenting, but focus on fathers and mothers separately when this affects the impact in a negative way. Furthermore, the current study focused on the outcomes in parental behaviors, but there was no direct measure of changes in *practical* parental

behaviors since only self-reports were used. Therefore, it can be recommended to collect additional data (e.g. observations), to study the impact of the training on *practical* parental behaviors. Moreover, in order to have a complete evaluation, it would be interesting to investigate if the ‘We are Parents’ program has an impact on the wellbeing of children. Evaluations should include the measurement of child outcomes, and child effects need to be considered (Mejia et al., 2012). Although the current study did not focus on child outcomes, outcomes for children can be expected since children will experience fewer problems when parents change problematic parenting practices (Sanders et al., 2002). However, to determine this, further research is necessary. In addition, longitudinal research might be helpful to get insight in the long-term effects of the training, for both parental behavior and child outcomes. Using a control group would add more value to the longitudinal research, since this shows if changes in parental behaviors and child outcomes can be attributed to the training.

Over all, this study shows a significant impact of ‘We are Parents’ on positive parenting. Parents reported more positive parental behavior in both the questionnaire and interviews. ‘We are Parents’ is, therefore, likely to increase affection, responsiveness and stimulation of parents towards their children. The study provides meaningful insights and shows potential for ‘We are Parents’ and promoting positive parenting in developing countries for parents of children up to the age of 18 years old. Furthermore, potential for including fathers in parenting programs was shown too. The current study contributes to the existing evidence about the effectiveness of parenting interventions in developing countries, and it also shows that parenting interventions in developing countries are meaningful and important to discourage disadvantaged care of children.

References

Aboud, F.E. & Alemu, T. (1995). Nutrition, maternal responsiveness and mental development of Ethiopian children. *Elsevier Science, 41*(5), pp. 725-732. doi:10.1016/0277-9536(94)00377-6

Ambert, A. (1994). An international perspective on parenting: social change and social constructs. *Journal Of Marriage And Family, 56*(3), pp. 529-543. doi: 10.2307/352865

Bornstein, M.H. & Putnick, D.L. (2012). Cognitive and socioemotional caregiving in developing countries. *Child Development, 83*(1), pp. 46-61. doi: 10.1111/j.1467-8624.2011.01673.x

Chang, M., Park, B., Singh, K. & Sung, Y.Y. (2009). Parental involvement, parenting behaviors, and children’s cognitive development in low-income and minority families. *Journal Of Research In Childhood Education, 28*(3), pp. 309-324. doi: 10.1080/ 02568540909594663 2009

Cherie, A. & Berhanie Y. (2015). Assessment of parenting practices and styles and adolescent sexual behavior among high school adolescents in Addis Ababa, Ethiopia. *Journal of AIDS and Clinical Reserach, 6*(2), pp. 424. doi:10.4172/2155- 6113.1000424

Cooper, P.J., Tomlinson, M., Swartz, L., Landman, M., Molteno, C., Stein, A., McPherson & Murray, L. (2009). Improving quality of mother-infant relationship and infant attachment in socioeconomically deprived community in South Africa: randomized controlled trial. *BMJ(338),* pp. 974-981. doi: 10.1136/bmj.b974

Eshel, N., Daelmans, B., Cabral de Mello, M. & Martines, J. (2006). Responsive parenting: interventions and outcomes. *Bulletin Of The World Health Organization, 84*, pp. 992-999.

Evans, J. L., Matola, C. E., & Neyko, J. P. T. (2008). Parenting challenges for the changing African family. In M. Garcia, A. Pence, & J. L. Evans (Eds.), Africa´s future, Africa´s challenge. Early childhood care and development in Sub-Saharan Africa (pp. 265-284). Washington: The World Bank.

Grantham-McGregor, S., Cheung, Y.B., Cueto, S., Glewwe, P., Richter, L., Strupp, B. & the International Child Development Steering Group (2007). Developmental potential in the first 5 years for children in developing countries. *The Lancet, 369*, pp. 60-70. doi:10.1016/S0140-6736(07)60032-4

BM Corp (2013). IBM SPSS Statistics for Windows, Version 22.0. Armonk, NY: IBM Corp.

Klein, P.S. & Rey, H. (2004). Interaction-oriented early intervention in Ethiopia. The MISC approach. *Infants And Young Children, 17(*4). pp. 340-354.

Knerr, W., Gardner, F., & Cluver, L. (2013). Improving positive parenting skills and reducing harsh and abusive parenting in low-and middle-income countries: a systematic review. *Prevention Research, 14,* pp. 352-363. doi 10.1007/s11121-012-0314-1

Mejia, A., Calam, R. & Sanders, M.R. (2012). A review of parenting programs in developing countries: opportunities and challenges for preventing emotional and behavioral difficulties in children. *Clinical Child and Family Psychology Review (15),* pp. 163-175.doi 10.1007/s10567-012-0116-9

NICHD Early Child Care Research Network. (1996). Characteristics of infant child care: factors contributing to positive caregiving. *Early Childhood Research Quarterly(11),* pp. 269-306.

Nicholson, B., Brenner, V. & Fox, R. (1999). A community-based parenting program with mothers of young children. *Families In Society, 80*(3), pp. 247-253. doi 10.1606/1044-3894.678

Sanders, M.R., Turner, K.M.T. & Markie-Dadds, C. (2002). The development and dissemination of the Triple P – Positive Parenting Program: a multilevel evidence-based system of parenting and family support. *Prevention Science, 3*(3), pp. 173-189. doi 1389-4986/02/0900-0173/1

Schneider, O., Agaba, A.B., Lowicki-Zucca, M. & Larok, R. (2015). Impact Evaluation Of SCORE's Parenting Skills Training On Caregiver Knowlegde, Caregiver Behavior, and Child Wellbeing. Kampala, Uganda: SCORE Project.

Tsemrekal, T.M. (2013). The relationship between parenting style, self-regulated learning and academic achievement in selected primary schools in Ethiopia. (master's thesis). Retrieved from http://uir.unisa.ac.za/bitstream/handle/10500/13182/thesis_tigist%20merha%20tsemrekal.pdf?sequence=1

UNICEF. (1989). *Convention on the rights of the child.* Retrieved from http://digitalcommons.ilr.cornell.edu.proxy.library.uu.nl/cgi/viewcontent.cgi?article=1007&context=child

Woolfolk, A. (2013). *Educational Psychology*. *Pearson international edition.* (12th ed.). Pearson Education Limited.

A. Questionnaire 'We are Parents'

Questionnaire *We are parents*

Instructions
This questionnaire contains questions about your parenting practices. The first part needs to be filled in by a facilitator, who will write down the information about your children between the ages 0-18.

Child	Gender		Age	Child	Gender		Age	Child	Gender		Age
1	O	Boy	…….	4	O	Boy	…….	7	O	Boy	…….
	O	Girl			O	Girl			O	Girl	
2	O	Boy	…….	5	O	Boy	…….	8	O	Boy	…….
	O	Girl			O	Girl			O	Girl	
3	O	Boy	…….	6	O	Boy	…….	9	O	Boy	…….
	O	Girl			O	Girl			O	Girl	

Personal information
Please fill in your personal information.

Name: …….

(Approximate) age: …….

Job(s): …….

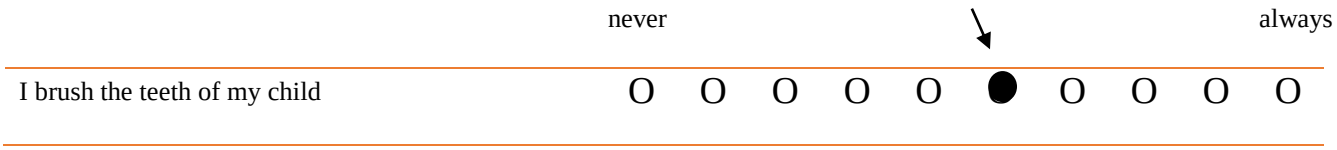
Gender:
O Male
O Female

Marital status:
O Single Parent
O Married
O Divorced
O Widow(er)
O Other: …….....

Level of education:
O None
O Grade 1-4
O Grade 5-8
O Grade 9-10
O Technical and Vocational Education and Training (TVET)
O Colleges of Teacher Training (CTT)
O Grade 11-12
O University
O Other: …….....

Instructions

There is a scale between never and always. Please, color one circle per question on the place which suits your answer the best. It could look like the following example:



General questions

Please, fill in the following questions. Answer these questions with all your children in mind.
*Only fill in this question if you have a partner. **Only fill in this question if you have a daughter.

	never									always
1. I stimulate/encourage my child to learn new things	O	O	O	O	O	O	O	O	O	O
2. *I discuss it with my partner before I make a decision about the child	O	O	O	O	O	O	O	O	O	O
3. I have the feeling I am a good parent	O	O	O	O	O	O	O	O	O	O
4. I use physical punishments (such as slapping, beating, or hitting) on my child	O	O	O	O	O	O	O	O	O	O
5. I make sure my child is clean	O	O	O	O	O	O	O	O	O	O
6. I feel like I have a good relationship with my child	O	O	O	O	O	O	O	O	O	O
7. **I teach/advise my daughter to protect herself from abduction	O	O	O	O	O	O	O	O	O	O
8. I give praise when my child does something good	O	O	O	O	O	O	O	O	O	O
9. *I get enough support from my partner (husband/wife)	O	O	O	O	O	O	O	O	O	O
10. I feel like I have enough knowledge to be a good parent	O	O	O	O	O	O	O	O	O	O
11. I face problems which are caused by the use of alcohol by myself (or my partner)	O	O	O	O	O	O	O	O	O	O
12. I provide food for my child at least 3 times a day	O	O	O	O	O	O	O	O	O	O

General questions (2)

Please, fill in the following questions. Answer these questions with all your children in mind.

	never									always
13. I take or send my child to a health professional or institution when (s)he is sick	O	O	O	O	O	O	O	O	O	O
14. I teach/advise my child to protect him/herself from sexual and physical abuse	O	O	O	O	O	O	O	O	O	O
15. I make time to talk with my child	O	O	O	O	O	O	O	O	O	O
16. **I protect my daughter from abduction	O	O	O	O	O	O	O	O	O	O
17. I vaccinate my child	O	O	O	O	O	O	O	O	O	O
18. I make sure the clothes of my child are clean	O	O	O	O	O	O	O	O	O	O
19. I am aware of the harmful sides of traditional practices (FGM, abortion, …)	O	O	O	O	O	O	O	O	O	O
20. I give attention to my child when (s)he asks for my attention	O	O	O	O	O	O	O	O	O	O
21. I protect my child from sexual and physical abuse	O	O	O	O	O	O	O	O	O	O
22. I give my child advice when (s)he needs it	O	O	O	O	O	O	O	O	O	O
23. I give my child varied/balanced nutrition	O	O	O	O	O	O	O	O	O	O
24. I encourage my child to share his/her feelings and opinions with me	O	O	O	O	O	O	O	O	O	O
25. I yell or shout at my child	O	O	O	O	O	O	O	O	O	O
26. I feel confident in my role as a parent	O	O	O	O	O	O	O	O	O	O
27. I advise my child on his/her peer relationships	O	O	O	O	O	O	O	O	O	O

A: Early childhood, age 0-6

Answer these questions **only** with your child(ren) from the age of 0-6 in mind.

	never									always
28. I give an explanation when I forbid or order my child something	O	O	O	O	O	O	O	O	O	O
29. I have enough knowlegde to fulfill the needs of my child	O	O	O	O	O	O	O	O	O	O
30. I know where my child is when (s)he is not at home	O	O	O	O	O	O	O	O	O	O
31. I manage to change bad behavior of my child into good behavior	O	O	O	O	O	O	O	O	O	O
32. I joke and play with my child	O	O	O	O	O	O	O	O	O	O
33. I manage to make my child listen to me	O	O	O	O	O	O	O	O	O	O
34. I encourage my child to share his/her feelings and opinions with me	O	O	O	O	O	O	O	O	O	O
35. I listen to my child’s opinions and ideas	O	O	O	O	O	O	O	O	O	O
36. I have enough knowledge about the development of my child	O	O	O	O	O	O	O	O	O	O

B: Childhood, age 7-13

Answer these questions **only** with your child(ren) from the age of 7-13 in mind.

	never									always
37. I manage to change bad behavior of my child into good behavior	O	O	O	O	O	O	O	O	O	O
38. I give an explanation when I forbid or order my child something	O	O	O	O	O	O	O	O	O	O
39. I manage to make my child listen to me	O	O	O	O	O	O	O	O	O	O
40. I listen to my child's opinions and ideas	O	O	O	O	O	O	O	O	O	O
41. I have enough knowledge about the development of my child	O	O	O	O	O	O	O	O	O	O
42. I face problems which are caused by the use of alcohol by my child	O	O	O	O	O	O	O	O	O	O
43. I stimulate my child to go to school	O	O	O	O	O	O	O	O	O	O
44. I encourage my child to share his/her feelings and opinions with me	O	O	O	O	O	O	O	O	O	O
45. I know where my child is when (s)he is not at home	O	O	O	O	O	O	O	O	O	O
46. I have enough knowledge to fulfill the needs of my child	O	O	O	O	O	O	O	O	O	O
47. I talk with my child about family planning methods	O	O	O	O	O	O	O	O	O	O
48. I joke and play with my child	O	O	O	O	O	O	O	O	O	O

C: Adolescence, age 14-18

Answer these questions **only** with your child(ren) from the age of 14-18 in mind.

	never									always
49. I know where my child is when (s)he is not at home	O	O	O	O	O	O	O	O	O	O
50. I have enough knowledge to fulfill the needs of my child	O	O	O	O	O	O	O	O	O	O
51. I stimulate my child to go to school	O	O	O	O	O	O	O	O	O	O
52. I manage to make my child listen to me	O	O	O	O	O	O	O	O	O	O
53. I manage to change bad behavior of my child into good behavior	O	O	O	O	O	O	O	O	O	O
54. I listen to my child's opinions and ideas	O	O	O	O	O	O	O	O	O	O
55. I have enough knowledge about the development of my child	O	O	O	O	O	O	O	O	O	O
56. I talk with my child about family planning methods	O	O	O	O	O	O	O	O	O	O
57. I give an explanation when I forbid or order my child something	O	O	O	O	O	O	O	O	O	O
58. I face problems which are caused by the use of alcohol by my child	O	O	O	O	O	O	O	O	O	O
59. I joke and play with my child	O	O	O	O	O	O	O	O	O	O
60. I talk with my child about the relationship (s)he has with the opposite sex	O	O	O	O	O	O	O	O	O	O
61. I talk with my child about his/her future plans	O	O	O	O	O	O	O	O	O	O

Instructions for the facilitator

Before the questionnaire starts, participants should know that it is important that they answer honestly. The goal of this test is not to judge their practices, but to exam what can be learned in the training. Make sure the participants do not communicate with each other when they are filling in the questionnaire. When you have to assist a participant, please only use the example provided in the questionnaire. Do not use a question from the questionnaire as an example and do not give additional information.

Follow the next steps when using this questionnaire:

- Fill in the information about the children of the participant on page 1.
- Make sure all pages you will give to the participant stay together. This can be done by using staples or by assigning a number to each participant and writing this number on each of their pages.
- Give the participant page 1-3 and the questions related to the children’s ages. It is possible parents have to fill in more than one part when their children are in different age categories.
    - If they have children in the age category of 0-6, let them fill in part A.
    - If they have children in the age category of 7-13, let them (also) fill in part B.
    - If they have children in the age category of 14-18, let them (also) fill in part C.
- When the participant has finished, please check if all questions are answered and if each question has only one answer. Remember, the questions with */** are only filled in when relevant.
- Thank the participant and ask him/her to leave the room/space, without talking to the remaining participants who are filling in the questionnaire.

B. Questions per domain

Child development

B. I stimulate/encourage my child to learn something new
C. I give my child advise when (s)he needs it
D. I give an explanation when I forbid or order my child something
E. I have enough knowledge to fulfill the needs of my child
F. I have enough knowledge about the development of my child
G. I stimulate my child to go to school
H. I talk with my child about family planning methods
I. I talk with my child about his/her future plans

Parents relationship

- I discuss with my partner before I make a decision about the child
- I get enough support from my partner (husband/wife)

Parent-child relationship

- I feel like I have a good relationship with my child
- I make time free to talk with my child
- I give attention to my child when (s)he asks for my attention
- I encourage my child to share his/her feelings and opinions with me
- I joke and play with my child
- I listen to my child’s opinions and ideas

Competence/confidence

- I have the feeling I am a good parent
- I feel like I have enough knowledge to be a good parent
- I feel confident in my role as a parent

Controlling behavior

- I use physical punishments (such as slapping, beating, or hitting) on my child
- I give praise when my child does something good
- I yell or shout at my child
- I know where my child is when (s)he is not at home
- I manage to change bad behavior of my child into good behavior
- I manage to make my child listen to me
- I advice my child about his/her peer relationships

Health, care, hygiene and nutrition

- I make sure my child is clean
- I provide food for my child at least 3 times a day
- I take or send my child to a health professional or institution when (s)he is sick
- I vaccinate my child
- I make sure the clothes of my child is clean
- I give my child varied/balanced nutrition

Alcohol

- I face problems which are caused by the use of alcohol by myself (or my partner)
- I face problems which are caused by the use of alcohol by my child

Child protection

- I protect my child from sexual and physical abuse
- I teach/advise my child to protect him/herself from sexual and physical abuse
- I am aware of the harmful sides of traditional practices (FGM, …)
- I protect my daughter from abduction
- I teach/advise my daughter to protect herself from abduction
- I talk with my child about the relationship (s)he has with the opposite sex