Unpacking the Process of Scaling Up Parenting Programs in Four Countries

AN IMPLEMENTATION RESEARCH STUDY

Photo: UNICEF/Zambia

What do we mean by scale up?

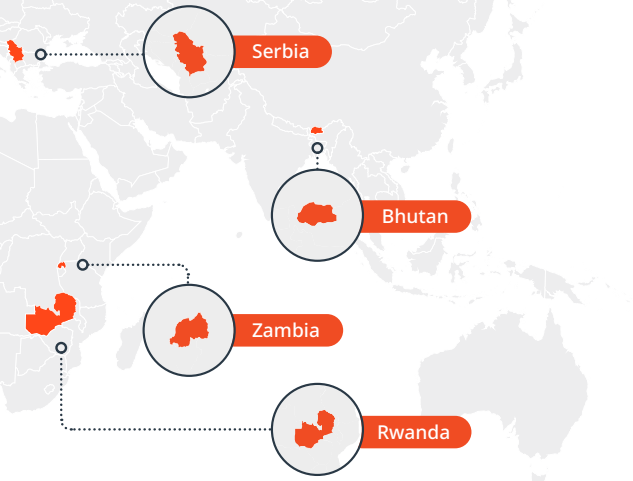
Scaling up is defined as deliberate efforts to increase the impact of successfully tested health innovations to benefit more people and foster lasting policy and program development.

The ExpandNet framework addresses both horizontal (geographic reach) and vertical (sustainable integration within a health system) scaling in addition to the Innovation's design features which indirectly influence scale.

The ExpandNet Framework

Horizontal scaling involves **expanding the program's geographic reach** and increasing community engagement. Processes include advocating to increase demand in communities, providing outreach in remote areas to enhance equity, adapting to new communities, and training sufficient numbers of providers.

Vertical scaling efforts **integrate the program into government systems** (e.g., health) by including program delivery in their information system, institutionalizing workforce training, and ensuring stakeholder engagement in decision making. Activities are required to sustain political will, build capacity, develop policy and support the program financially.



Design features of the program, including the curriculum, dosage, and mode of delivery, determine its effectiveness in improving parent and child outcomes. They may also enable or hinder efforts to scale the program.

The Playful Parenting implementation research is a five-year research award studying four parenting programs implemented from 2020 to 2024 in Bhutan, Rwanda, Serbia, and Zambia. Data were collected annually via surveys, direct observations and assessments, focus group discussions, and interviews conducted by FHI 360 along with local co-investigators and data collection firms.

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Key Findings

1 HOW DID DESIGN FEATURES CONTRIBUTE TO SCALING?

The design features of the parenting programs, such as the **curriculum**, **behavior change techniques**, and dosage, were found to be important enablers of horizontal scale. A curriculum and modality that was aligned with the needs of the community and the capacity of providers was more likely to expand. However, **these features could also hinder horizontal scale**, for example if the workforce required extensive training and if home visits were time-consuming.

2 WHAT IMPLEMENTATION PROCESSES WERE USED TO EXPAND HORIZONTAL REACH?

Horizontal scale was influenced by **training & retention of workforce, delivery modality**, and **community mobilization**

- Enablers included the workforce's satisfaction with the program and the structured manuals provided for delivery, along with group delivery.
- Barriers included the workforce feeling overworked or insufficiently incentivized, and the need for more advocacy to encourage demand.

3 WHAT PROCESSES WERE USED TO SCALE VERTICALLY FROM COMMUNITY TO GOVERNMENT?

Vertical scale, or **integration within the health system**, was found to be more challenging.

- Enablers included the political will and support from government stakeholders, as well as the integration of the program into existing health systems.
- Barriers included the lack of supervision and monitoring of the workforce, the need for more multisectoral collaboration, and the challenge of sustaining the program financially

The Programs

Design features	Bhutan	Rwanda	Serbia	Zambia
Resource Team	Save the Children	Boston College	UNICEF	UNICEF
Program (curriculum)	Prescription to Play (C4CD+)	Sugira Muryango	Playful Parenting	Care for Child Healthy Growth & Development
Behavior change techniques	Visual material, demonstration, coaching	Demonstration, coaching	Demonstration, coaching	Visual material, practice
Provider of service	Health assistant	IZU (friend of families)	Community nurse	Community-based volunteer
Professional status	Professional	Volunteer	Professional	Volunteer
Provider manual	Yes, session-specific activities	Yes, session-specific activities	Yes, Guidelines	7 counselling cards

Dosage, frequency	Bhutan	Rwanda	Serbia	Zambia
Mode of delivery	Group	Home visit	Home visit	Home, Added Group
Frequency	Monthly	Weekly	Irregular, mainly with newborn	1 to 3 months apart during infancy
Number of contacts	12, reduced to 9	12	7	7, reduced to 4
Pilot conducted	Yes	Yes	No	No

Indicators of Scale

From the findings, we derived **eight indicators** to reflect successful achievement of scale among these four parenting programs, four indicators of horizontal scale and four indicators of vertical scale. In-depth interviews with a few key stakeholders in each country provided descriptors reflecting the level of scale achieved across our eight indicators. All programs experienced notable achievements and grappled with challenges in their journeys to scale.

HORIZONTAL SCALE

DEMAND Indicator

Evidence through attendance and advocacy that families want the program.

Bhutan — "We are still trying to figure out the best ways to address [low] attendance. We've made it compulsory for health workers to report and include attendance as a performance indicator in their work plans."

REACH Indicator

Continuous expansion to new districts and to all eligible families.

Serbia — "It is clear that we have reached the target population that we wanted to reach. Through intermunicipal cooperation, smaller communities can unite and act together, to map out resources."

EQUITY Indicator

All eligible families, particularly vulnerable ones, have access.

Rwanda — "Families have been helped, especially vulnerable families."

WORKFORCE Indicator

A sufficient number of providers are being trained and supervised.

Zambia — "Supportive supervision comes only once in a while; the finances are not enough. Peer supervision won't work because you cannot supervise someone at the same level."

Photo: Save the Children

VERTICAL SCALE

MULTISECTORALITY Indicator

Stakeholders from many organizations and ministries are engaged.

Serbia — "We need formal agreements so that institutions can recognize each other and offer mutual support. If local actors aren't involved in policy-making, a lot of well-written strategies end up being impossible to implement."

ADOPTED Indicator

Government is willing and able to adopt and implement the program.

Bhutan — "The MoH adopted the program; it is managed by the Department of Non-Communicable Diseases."

POLICY, BUDGET Indicator

Government has solidified the program with policy and finances.

Zambia — "The program is embedded in policy documents in the National Health Strategic Plan 2022-2026. It has got strategic actions and also the targets that we have set for this year. The budget shows commitment... but there are so many competing priorities."

INTEGRATED IN SYSTEM Indicator

Workforce is integrated into the health system and its information management.

Rwanda — "Still, we have enormous capacity and logistics gaps. The project removed their staff at the district, sector and cell level."

Conclusion

The findings emphasize the importance of intervention design features and workforce contributions to **horizontal scaling**. **Vertical scaling** depends on political will, government capacity, policy development, and financial support. Advocacy and continuous evidence of effectiveness are essential for sustaining programs.

Scaling parenting programs for ECD in LMICs both **horizontally** and **vertically** requires a comprehensive approach that addresses **demand, reach, equity, workforce** retention, as well as prioritizes **multisectorality, adoption, policy/budget** commitments, and **integration in the system.**

Photo: UNICEF/Serbia

Photo: RPCA, Boston College

QUESTIONS?

Reach out to research_eval@fhi360.org for more information.