



Designing, implementing, evaluating, and scaling up parenting interventions

A handbook for decision-makers
and implementers



World Health
Organization

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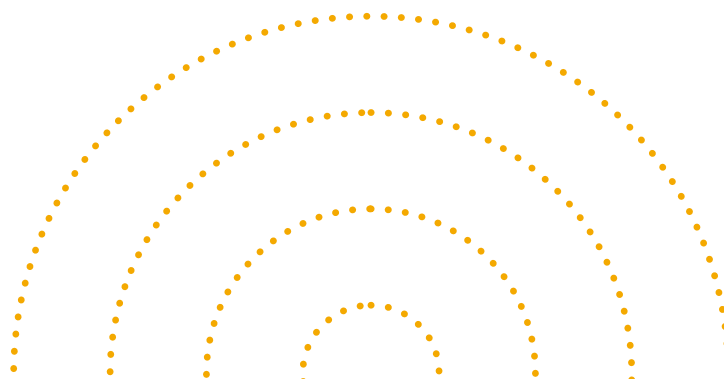
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Executive Summary

This handbook provides comprehensive advice for policy-makers, practitioners, and stakeholders involved in the development, implementation, and monitoring of evidence-based parenting interventions. It offers a practical, step-by-step approach to selecting, designing, evaluating, implementing, monitoring, and scaling up parenting interventions in different contexts, and by referencing relevant research and offering templates and other resources to support implementation, it acts as a bridge between the evidence for parenting interventions, and practice.

Why are parenting interventions important?

A parenting intervention is a set of structured activities to help parents/caregivers improve parent-child interactions and the overall quality of parenting that a child receives. These interventions focus on strengthening skills and behaviours to improve the way that parents/caregivers relate to their child, as well as parental knowledge, attitudes, beliefs, and feelings. Throughout this handbook the term “parent/caregiver” is used to refer to mothers, fathers, and other caregivers or guardians who are responsible for the care of a child, including grandparents, other relatives, or non-biologically related carers. It does not refer to other adults who may be responsible for the care of a child outside the context of a home environment, such as teachers or medical personnel, although carers in institutional homes may be included.

The three-phase structure of this handbook comprises six actionable steps and multiple sub-steps to guide the process of creating effective and sustainable parenting interventions (see Box 1 for a checklist).



Phase 1: Groundwork for implementation

The first phase emphasizes the foundational steps required before implementing evidence-based parenting interventions. It begins with effective stakeholder engagement, guiding decision-makers in identifying, involving, and building networks with relevant stakeholders. A focus on co-designing interventions with local stakeholders, including parents and children, ensures cultural adaptation, promoting intervention ownership and effectiveness. Special attention is given to marginalized groups, ensuring inclusivity and tailored approaches for families with children who have disabilities.

To choose the right intervention, decision-makers are guided through the process of gathering and synthesizing information about the problem, existing efforts, and the focus population. A robust understanding of the community’s needs, feasibility, and existing evidence drives the process of selecting or developing a theory of change and identifying key intervention components. This phase culminates in matching objectives, intervention components, and target populations for a coherent approach.



Phase 2: Intervention implementation

Phase 2 concerns the practicalities of delivering evidence-based parenting interventions. It addresses approaches to identifying participating families and engagement strategies, leveraging existing platforms, and enhancing accessibility. The handbook provides guidance on determining suitable delivery platforms, formats, intensity, and length, aligning these choices with the intervention’s theory of change and the context’s resources. Planning for implementation requires clarifying minimum requirements, human resource planning, training, and operational planning.



Phase 3: Learning and sustaining

The final phase focuses on sustaining interventions and on equipping users to assess readiness for scaling up, adopting, and eventually sustaining interventions. The handbook provides guidance on engaging stakeholders, establishing partnerships, ensuring quality assurance, and integrating systems for long-term success. This phase emphasizes data-driven decision-making, using routine monitoring and evaluation and impact evaluations to oversee and assess implementation and measure impact and cost-effectiveness. Disseminating evidence and sharing learning is emphasized as essential for ongoing improvement and informed decision-making.

Conclusion

This handbook equips stakeholders with the knowledge and tools to develop, implement, and sustain effective, evidence-based parenting interventions. By following the outlined phases and steps, users can address child maltreatment, improve family well-being, and contribute to healthier communities. This comprehensive handbook empowers users to create impactful parenting interventions and lays the foundation for better futures for families and children worldwide.



Box 1. Checklist for users



Phase 1: Groundwork for implementation

Step 1: Engage and collaborate with stakeholders

Create a stakeholder engagement plan

- ✓ Conduct a stakeholder mapping
- ✓ Budget for engagement activities
- ✓ Generate commitment
- ✓ Build constituencies that leverage existing networks
- ✓ Align timelines for engagement, resources, and advocacy

Work with local populations to design and adapt interventions

- ✓ Select an adaptation framework
- ✓ Involve stakeholders at all stages of design and implementation

Consider potential impact on marginalized groups

- ✓ Consider the specific needs of families with disabilities

Step 2: Choose an intervention

Gather and synthesize information

- ✓ Bring together existing sources of information
- ✓ Map existing efforts: who is doing what, where, when, for whom, and why?

Select and understand needs of target population

- ✓ Conduct a needs assessment
- ✓ Understand the barriers and enabling factors

Develop a theory of change

- ✓ Define the problem that the parenting intervention aims to address, and the target population
- ✓ Determine the overarching goals of the parenting intervention
- ✓ Consider the factors that cause and perpetuate the problem
- ✓ Identify pathways to change based on the established theoretical frameworks and empirical evidence

Identify key intervention components

- ✓ Consider different content needs for different developmental stages
- ✓ Consider different content needs for different contexts
- ✓ Promote gender-transformative parenting throughout the intervention

Match objectives, intervention components, and target populations

- ✓ Identify existing intervention materials and guidance



Phase 2: Intervention implementation

Step 3: Deliver the intervention

Identify participating families and engagement strategies

- ✓ Identify the level of participation: universal, selective, or indicated
- ✓ Determine strategies to recruit and engage participants
- ✓ Encourage stakeholders to raise awareness, refer participants, and provide support to them
- ✓ Make intervention activities accessible for participants
- ✓ Get feedback from stakeholders on barriers to access and how to address them

Determine intervention delivery platforms, methods, and frequency

- ✓ Work with community-led groups or CSOs
- ✓ Utilize formal service delivery systems
- ✓ Align with the intervention's theory of change
- ✓ Assess available resources, in line with the selected delivery platform
- ✓ Determine what is feasible and acceptable in the context

Step 4: Strengthen systems for implementation

Clarify minimum standards to start implementation

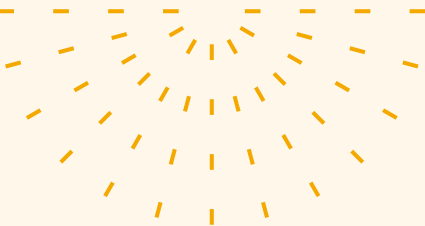
- ✓ Identify the activities required
- ✓ Determine the essential inputs required to carry out the activities
- ✓ Specify the outputs
- ✓ Develop a clear and explicit road map

Human resource planning, training, and support

- ✓ Select context-appropriate facilitators
- ✓ Consider how to compensate and retain facilitators
- ✓ Establish sustainable training mechanisms
- ✓ Provide ongoing supervision and support to facilitators

Operational planning, financing, and oversight

- ✓ Develop (or use existing) implementation guides that outline required resources
- ✓ Include monitoring and evaluation activities
- ✓ Ensure continuity of services through properly resourced referral systems





Phase 3: Learning and sustainability

Step 5: Establish readiness for scaling up the intervention

Launch phase

- ✓ Establish a clear intervention objective
- ✓ Ensure there is a robust evidence base
- ✓ Assess scalability
- ✓ Plan for scale-up
- ✓ Engage stakeholders
- ✓ Adapt the intervention as needed
- ✓ Pilot-test the intervention

Adoption phase

- ✓ Establish advocacy and political partnerships
- ✓ Obtain national stakeholder involvement
- ✓ Establish collaborative and intersectoral partnerships
- ✓ Identify intervention champions
- ✓ Provide training and capacity building

Scaling up phase

- ✓ Establish quality assurance
- ✓ Collect data and evaluate
- ✓ Harness technology and innovation
- ✓ Expand gradually

Sustaining phase

- ✓ Secure funding for sustainability
- ✓ Institutionalize and integrate systems
- ✓ Course-correct and continually improve
- ✓ Expand delivery to new contexts
- ✓ Identify economies of scale

Step 6: Evaluate and learn from the intervention

Develop a monitoring and evaluation framework

- ✓ Consider the objectives of the intervention
- ✓ Select and measure indicators based on the intervention theory of change and logic model
- ✓ Refer to existing indicator guidance for the specific objectives and outcomes of your intervention components

Develop an operational plan for data collection

- ✓ Determine what existing sources of data can be used
- ✓ Strengthen and combine efforts for training, reporting, and supervision processes
- ✓ Gather quantitative and qualitative data on feedback about implementation and intervention processes
- ✓ Consider scale and usability when designing monitoring and evaluation systems

Analyse and disseminate

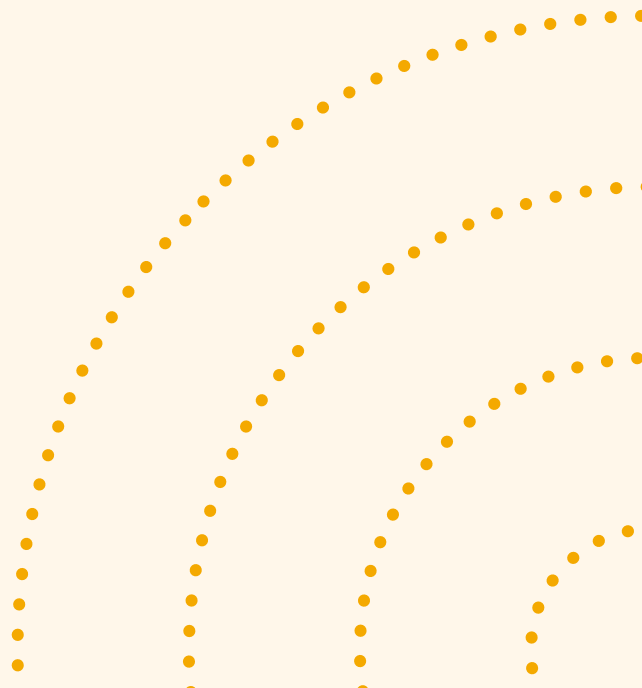
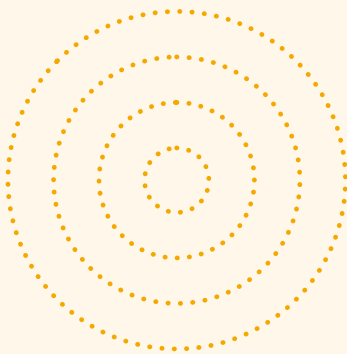
- ✓ Analyse and share learning, conclusions, and implications regularly

Plan for evaluation

- ✓ Conduct an evaluability assessment before planning an impact evaluation

Ensure safe and ethical data collection on children and adolescents

- ✓ Adhere to ethical guidelines and national laws and protocols for any data collection activities



Overview

Purpose of this handbook

This handbook offers a practical, step-by-step approach to selecting, designing, evaluating, implementing, monitoring, and scaling up parenting interventions in different contexts. It was developed through a multi-phased, consultative process designed to consolidate best practices and lessons learned in the field of parenting interventions (see Annex 2: Methods used to develop the handbook). It acts as a practical companion to the recent [WHO guidelines on parenting interventions to prevent maltreatment and enhance parent-child relationships with children aged 0–17 years \(I\)](#). And by referencing relevant research and offering templates and other resources that can support implementation, it serves as a bridge between the evidence for parenting interventions, and practice.

The handbook is intended for a range of audiences involved in developing parenting interventions – from local and national government policy-makers, heads of department for civil society organizations (CSOs) and development agencies, to programme or service managers, and other practitioners. The handbook is not intended for training facilitators.

What this handbook contains

With these audiences in mind, the handbook is structured around three key phases and six main steps in the development and implementation of an intervention.

Phase 1: Groundwork for implementation

1. Engaging and collaborating with stakeholders
2. Choosing an intervention

Phase 2: Intervention implementation

3. Delivering the intervention
4. Strengthening systems for implementation

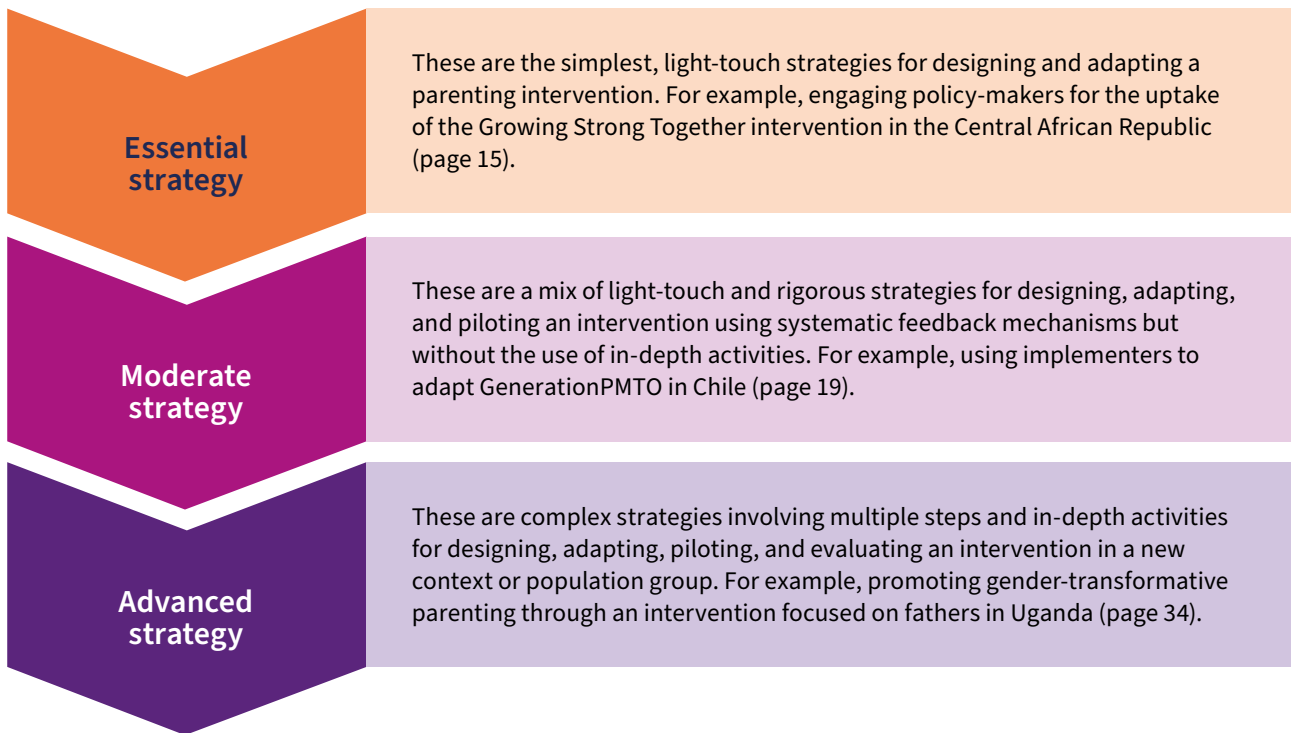
Phase 3: Learning and sustaining

5. Evaluating and learning from the intervention
6. Establishing readiness for scaling up interventions

The key steps in each phase can be approached in several ways depending on available time, financial and human resources, and the political and civil context. In Phase 1 of the handbook, each step is presented as part of a continuum of design and implementation strategies – from the simplest “essential strategies” to more intensive and rigorous “advanced strategies” – to help decision-makers select the most appropriate strategy for their situation (Fig. 1).



Figure 1. Continuum of implementation strategies in this guide

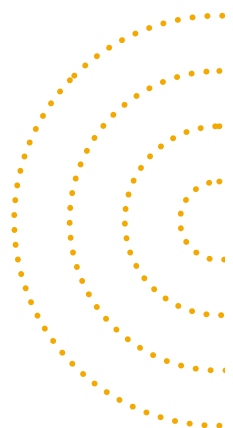


► **Essential strategies** are the lightest-touch strategies, or the minimal requirements for designing or adapting a parenting intervention. These models prioritize linguistic and cultural relevance but do not include rigorous formative research or pilot studies. Such strategies may be designed to adapt an existing intervention or change the delivery mechanism in a minor way to fit the local context.

► **Moderate strategies** are a mix of light-touch and rigorous approaches for designing an intervention in situations where decision-makers may not have the time or resources to conduct in-depth activities. These approaches might start with small pilot studies or the translation of materials in order to assess context-relevance and add context-specific content as necessary. Design and adaptation are typically informed by different sources of systematically collected feedback (e.g. a technical or local advisory board, feedback from intervention participants and staff, etc.).

► **Advanced strategies** are rigorous approaches to designing, adapting, piloting, and evaluating an intervention in a new context or population group. Advanced strategies have three key characteristics: 1) a pre-implementation formative phase to collect data on the life experiences, needs, and cultural context of the population group; 2) the inclusion of context-specific sessions, where needed, informed by formative research or piloting; and 3) adaptation of intervention content in response to the piloting and evaluation. While advanced strategies are ideal for collaboration, cultural adaptation, and evaluation, they may not be appropriate or feasible in all situations.

To support decision-making, this handbook features case studies highlighting how **essential**, **moderate**, and **advanced** strategies have been used by practitioners in different contexts. Examples are colour-coded to support easy identification of the preferred strategy.



Why evidence-based parenting interventions?

An estimated 50% of children aged 2–17 years are exposed to some form of child maltreatment every year (2, 3), making it a global health problem. Child maltreatment manifests as different types of abuse (physical, emotional, and sexual) and neglect. All forms of maltreatment may simultaneously affect the same child (4, 5).

Child maltreatment is most frequently perpetrated at home by parents and caregivers, although children may also experience it elsewhere, such as in schools and in the community. Addressing child maltreatment should be a high priority for all countries, considering its long-lasting negative consequences. Longitudinal and epidemiological data indicate that child maltreatment raises the risk of mental health, emotional, and behavioural problems for young people, including anxiety and depression. Violence during childhood also raises the risk of youth engaging in a range of high-risk behaviours such as alcohol and drug abuse, unprotected sex, self-harm, violence towards others, committing crimes, and dropping out of school. Some of these high-risk behaviours can lead to disability or death (4, 5). These consequences endure throughout a child's life, with long-term adverse effects on their health, development and learning outcomes. Children and adolescents who experience child maltreatment are also more likely to perpetrate violence against their own children or become survivors or perpetrators of intimate partner violence and other forms of interpersonal violence as adults (6–9).

In addition to the direct impact of child maltreatment throughout the life course, the economic cost of child maltreatment is daunting. For the year 2017, estimated total annual costs attributable to child abuse, maltreatment, and neglect were US\$ 581 billion in Europe and US\$ 748 billion in North America. In East Asia and the Pacific, the economic costs of violence against children ranged between 1.4% and 2.5% of the region's annual GDP (2). Despite the severity of the problem, evidence shows that parenting interventions can prevent and reduce child maltreatment and also enhance positive, nurturing parenting and improve children's social-emotional development and behavioural outcomes (10–11).

Parenting and its influences

Parenting is a core human process that helps ensure the physical, emotional, financial, and psychological well-being of children and youth. Through positive parenting, humans experience love and protection; learn to live in a world where rules and routines must be followed; strengthen the necessary skills to be social beings; and become productive citizens. Even though parenting experiences are not the only determinants of the lives of individuals, they have a critical impact on overall development (12).

Parenting should always be understood within the contexts and cultures in which families live (13). These include environmental factors, such as humanitarian crises, economic trends, community violence, access to services, and local policies or laws; family factors, such

as displacement, poverty, household size, presence of multiple caregivers, and cultural values; parent factors, such as education, employment, marital status, mental health, and personal experience; and child factors, such as disability, behaviour, age, and gender. For example, the parenting practices of forcibly displaced parents who lack identity documentation will be impacted by the stresses associated with work exploitation or lack of access to basic services such as health coverage. Families impacted by community violence may use parenting practices characterized by stringent monitoring and supervision. Families struggling with inadequate housing, nutrition, and income may experience significant adverse impacts on their daily parenting routines. At the same time, parenting is a vital resource for helping children thrive in the face of adverse environments – a resource that can be strengthened and supported through parenting interventions.

What is a parenting intervention?

The World Health Organization (WHO) defines a parenting intervention as a set of activities or services directed at parents/caregivers, with the objective of “improving parent–child interactions and the overall quality of parenting that a child receives”. Parenting interventions together present a social behaviour change strategy that operates at community (group of parents) and family level (14). They focus on parents/caregivers strengthening their skills and behaviours to improve the way they relate to their child, although interventions may also address parental knowledge, attitudes, beliefs, and feelings (1). Evidence-based parenting interventions are often grounded in the following psychological theories:

- Attachment theory suggests that the quality of a child's early interactions with their primary caregiver determines their attachment style. If the caregiver is consistently responsive to the child's needs and provides a secure and nurturing environment, the child is more likely to develop a secure attachment style. This attachment style allows the child to feel safe and supported in the world. However, if the caregiver is inconsistent or unresponsive, the child may develop an insecure attachment style, which can cause anxiety, mistrust, and difficulties forming relationships in the future (15).
- Social learning theory holds that children's behaviour is shaped by their real-life experiences, through which they learn by observation and imitation, and from the social or material benefits they may reap from different behaviours. For children, primary sources of these experiences are the family and parents/caregivers, who shape children's behaviour through these responsive processes. Coercion theory extends social learning theory by incorporating a cycle of coercive parent-child interaction where both parties resort to negative behaviours to gain control over each other. This creates an escalating cycle of conflict that can become a habitual way of interacting for both the parent and child over time, helping to perpetuate child behavioural problems and parental stress (16, 17).

Parenting interventions may also draw on other theoretical frameworks depending on their specific content or theory of change – e.g. interventions to support parents/caregivers of adolescents experiencing conflict-related psychological distress may use behaviour change theory or social cognitive behavioural therapy (such as the Early Adolescent Skills for Emotions (EASE) intervention (18) or the Teaching Recovery Techniques + Parenting intervention (19) for Syrian refugees in Jordan and Lebanon). More recently, evidence-based parenting interventions have begun to include components that encompass power and gender-transformative approaches based upon feminist theories on family violence (20). These include the Safe at Home intervention (21) in Democratic Republic of the Congo, which involves specific sessions on gender and power within the home (22) (page 28), and the REAL Fathers intervention which specifically engages men and concepts of masculinity (23, 24) (page 34).

Decades of research across the world have resulted in the development of evidence-based parenting interventions that are effective in helping parents/caregivers strengthen parenting skills that enhance children's development, mental health and overall well-being (25–27). By improving positive parenting and reducing harsh parenting, they are effective for preventing and reducing violence against children.

Why are parenting interventions important?

Parenting interventions are important because they support parents/caregivers to build and strengthen the knowledge, skills, and relationships necessary to respond to the demands and responsibilities associated with raising children and youth (12, 28). In the early years, responsive parenting offers children a nurturing and secure base for exploring the world. At all developmental stages, responsive parenting helps children learn that they are listened to, and that pro-social behaviours are rewarded with expressions of encouragement, praise, and love. Likewise, nurturing care and positive discipline can prevent and redirect children's negative behaviours by communicating clear expectations, providing mild and safe consequences, and facilitating learning experiences for children while enhancing the parent-child relationship. As children become adolescents, positive parenting can help youth achieve critical developmental tasks, such as developing adequate social skills, becoming self-sufficient, being accountable for their own decisions, learning how to maintain various types of relationships, avoiding or reducing risky behaviours, and establishing boundaries to protect themselves and others (12, 28).

As adults, new parents/caregivers will often refer to their experiences of parenting during their own childhood as they discover their own identities as parents/caregivers. For this reason, parenting is multigenerational in nature (29, 30). However, it is important to highlight that even if adults were exposed to harsh or abusive parenting in childhood, they can always modify the parenting legacies they received. Adults who have experienced abuse can transform those painful experiences into loving and

nurturing parenting experiences with their own children. Thus, regardless of difficult backgrounds, parenting can be geared towards human connection, emotional intimacy, and love (29, 30).

Furthermore, evidence shows that effective parenting interventions positively impact multiple aspects of family life, such as family cohesion, intimate partner relationships, caregivers' stress and mental health, and the overall quality of parent-child relationships (10). Longitudinal research also indicates that parenting interventions may be associated with increased parent/caregiver income due to fewer family conflicts resulting in enhanced ability to engage in productive activities (10, 12, 28, 29).

Why should countries scale up evidence-based parenting interventions?

In 1959, the UN General Assembly adopted the Declaration of the Rights of the Child, which defines children's rights to protection, education, health care, shelter, and nutrition. In 1989, the Convention of the Rights of the Child was widely ratified, showing a clear commitment among nations to advance children's rights. Specifically, the convention stated that nations should prioritize initiatives aimed at providing nurturing and safe living environments for children, without exposure to any form of violence (31). These were not ideals or aspirations, but stated human rights adopted by countries across the world. Nevertheless, elevated levels of violence against children globally reveal that the reality of children's rights does not match these stated ideals. While most countries have at least one national action plan to prevent violence against children, these efforts are not translated into concrete actions, with only one-fifth of countries monitoring or reporting their progress on prevention efforts (2).

In addition to being a proven means to help parents/caregivers enhance their positive parenting skills, improve child development, and reduce child maltreatment (32), evidence-based parenting interventions also have the potential to help countries and communities protect children's rights and achieve broader outcomes linked to the Sustainable Development Goals (SDGs) (Box 2) (33). Parenting interventions are directly relevant to several SDG targets, most notably: Target 16.2 "End abuse, exploitation, trafficking and all forms of violence against children and torture of children"; Target 4.2 "Provide access to quality early childhood development and care"; Target 5.2 "Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation"; and Target 16.1 "Significantly reduce all forms of violence and related death rates everywhere". Research shows that positive parenting and parental monitoring and supervision can be "development accelerators" or protective factors, meaning they have been linked to lower experiences of multiple types of violence, including sexual abuse and transactional sexual exploitation (34). Governments can use such solutions to impact multiple childhood violence targets simultaneously

The sustained delivery of parenting interventions can also contribute indirectly towards several other SDG goals related to reducing preventable diseases, improving mental health, and reducing inequalities (Table 1) (35). Caregiver praise has been found to be a valuable primary development accelerator, contributing to substantial reductions in suicidal thoughts, improved pro-social behaviour, fewer peer problems, and less substance abuse (36, 37). Nevertheless, despite their positive impacts, the dissemination of evidence-based parenting interventions continues to be limited across the world, and is particularly scarce in low- and middle-income countries (2, 38).

Box 2. Why should countries scale up evidence-based parenting interventions?

The scaling up of evidence-based parenting interventions should be a top priority for every country. First, these interventions are an effective approach to help countries advance children's rights, and thereby abide by international human rights declarations and SDG commitments. Second, parenting interventions are an evidence-based means of promoting the safe and healthy development of children, and the emotional well-being of parents/caregivers and families. Finally, investment in parenting interventions constitutes a sound economic approach for governments.

Table 1. How parenting interventions contribute to the sustainable development goals

Recommendation	Target group
16.2 End abuse, exploitation, trafficking and all forms of violence against and torture of children.	Parenting interventions reduce harsh parenting and child maltreatment.
16.1 Significantly reduce all forms of violence and related death rates everywhere.	Parenting interventions reduce harsh parenting and child maltreatment.
5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation.	Parenting interventions reduce harsh parenting and child maltreatment.
4.2 By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education.	Parenting interventions have positive effects on child development and parent-child relationships.
1.3 Implement nationally appropriate social protection systems and measures for all, including floors, and by 2030 achieve substantial coverage of the poor and the vulnerable.	Parenting interventions can be delivered by social protection systems and reach the most vulnerable families.
3.2 By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least 12 per 1000 live births and under-5 mortality to at least as low as 25 per 1000 live births.	Milder forms of maltreatment can be precursors to severe forms of abuse that may result in death. Parenting interventions can reduce harsh parenting and maltreatment.



Table 1 (continued). How parenting interventions contribute to the sustainable development goals

Recommendation	Target group
<p>3.4 By 2030, reduce by one third premature mortality from noncommunicable diseases through prevention and treatment and promote mental health and well-being.</p>	<p>Parenting interventions reduce the risk for child maltreatment, a known risk factor for noncommunicable diseases.</p> <p>Parenting interventions can improve child and parent mental health.</p>
<p>10.3 Ensure equal opportunity and reduce inequalities of outcome, including by eliminating discriminatory laws, policies and practices and promoting appropriate legislation, policies, and action in this regard.</p>	<p>Parenting interventions are unlikely to widen social inequalities and instead – by targeting families and children most in need – have the potential to contribute to reduced inequalities of outcome.</p>

Using evidence to design parenting interventions

Attention to rigorous scientific evidence is essential to successful and effective implementation of parenting interventions. Evidence reveals which interventions are beneficial, and without it, there is a risk of implementing interventions with no benefits, thereby wasting resources and potentially causing harm to populations. Based on these considerations, choosing parenting interventions that have moderate- to high-quality evidence of effectiveness is immensely important for governments and institutions tasked with providing citizens with initiatives that will benefit families (39).

In the hierarchy of evidence, systematic reviews and meta-analyses of randomized trials of interventions provide the best overview of available evidence for specific parenting intervention(s) in relation to their effectiveness on a range of designated outcomes. Next, randomized controlled trials (RCTs) compare changes in outcomes among two equivalent groups: one group receiving the intervention and one group not receiving the intervention.

This comparison group allows RCTs to have high validity, meaning that there is great confidence that the changes in outcomes that result from the intervention itself, rather than other external factors that may influence both groups (Fig. 2) (39). RCTs can also be used to understand which intervention components are most important. Where RCTs are not possible, other types of studies have been used to examine the likely influence of an intervention on participant outcomes, such as cohort studies (following participants over time); case control studies (where a group that has an outcome is compared to a group that does not have the outcome); and case studies (in-depth documentation or record of a particular case over time). However, without randomized comparison of groups, confidence in the causal role of the intervention is reduced. Evidence on interventions can be quantitative (counts, percentages, or other numerical data) or qualitative (written or oral data that provide understanding of an individual or group's reality).

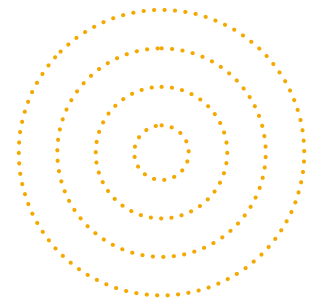
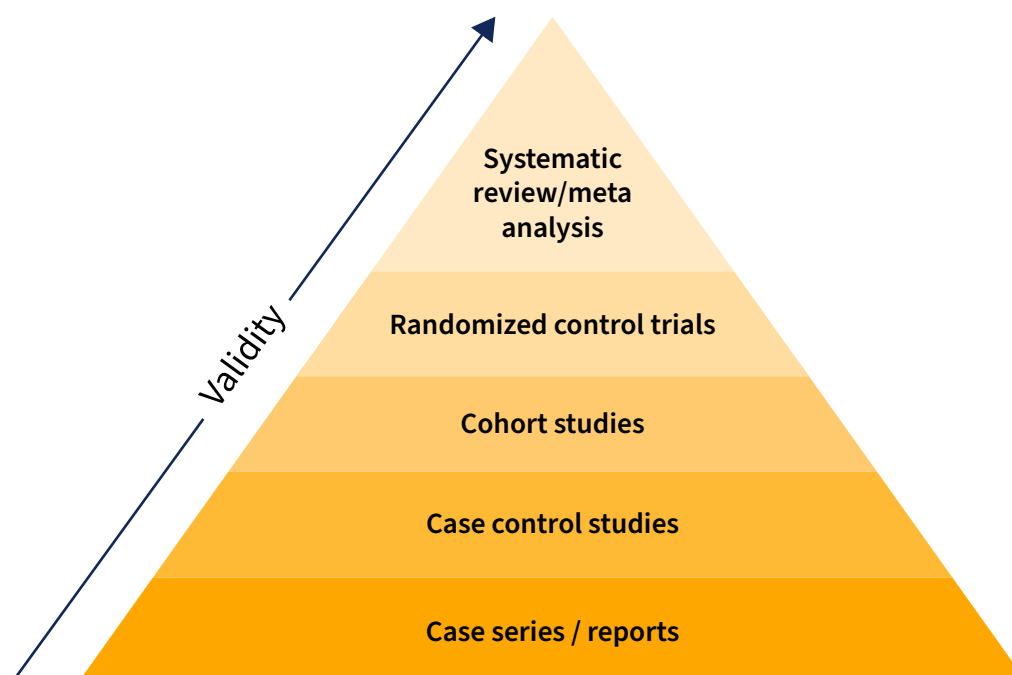


Figure 2. Traditional evidence hierarchy for questions related to effectiveness



Source: (39)

Evidence-based parenting interventions are those supported by evidence from high-quality RCTs that show beneficial effects and no harmful effects on relevant outcomes (Box 3). For decision-makers, relevant outcomes are those that are important to the target population and the goals of the planned intervention, such as the age group of the children and their needs. This is a key definition to keep in mind when selecting a parenting intervention.

However, funding and disseminating parenting interventions that are supported by high-quality evidence can often be challenging because of resource constraints (38). For example, training to become a certified facilitator of well-established parenting interventions is usually a lengthy process that can exceed budgets and timeframes and lead local government to choose interventions that lack sufficient evidence of effectiveness but are easy to implement and have large-scale reach. This carries the risk of implementing interventions that may fail to benefit parents/caregivers and children – or at worst cause harm – and potentially waste communities' efforts and government resources. For this reason, research about what works to prevent and reduce child maltreatment and improve other outcomes for children is only one type of evidence that decision-makers may wish to investigate. Equally important are wider questions about the proposed intervention, such as its overall cost and cost effectiveness, feasibility and acceptability within the local context; implementation fidelity and quality; and equity of access and outcomes. These types of evidence still require continuous collection of quantitative and qualitative data. More on different strategies for monitoring and evaluating parenting interventions can be found in Phase 3, Step 5.

There are numerous high-quality RCTs evaluating parenting interventions from every region of the world and the findings of these studies are summarized for

decision-makers in the systematic reviews that underpin the [WHO guidelines on parenting interventions to prevent maltreatment and enhance parent-child relationships with children aged 0–17 years](#) that inform this handbook (Box 4) (1, 10, 11)). The reviews show that similar interventions can be effective across a wide range of contexts and cultures, which can give decision-makers confidence about the generalizability and relevance of these findings to their contexts (40). Details on the recommendations and the evidence that informed them can be found in the guidelines and supporting documents available online (see Table 2).

Box 3. What is an evidence-based intervention?

An evidence-based intervention is one that has been tested in a rigorous study that statistically demonstrates changes in the parenting practices of parents/caregivers, and – where appropriate – shows that these practices are associated with positive behavioural or mental health changes for members of the intervention target group.

While practice-based interventions rooted in the experiences and reflections of parents/caregivers and practitioners on child-rearing strategies can also be beneficial, these forms of evidence are insufficient to make an intervention “evidence-based”, and further investment in generating evidence on these interventions is needed.

Table 2. Evidence informing each recommendation in the who guidelines on parenting interventions to prevent maltreatment and enhance parent-child relationships with children aged 0–17 years

Recommendation	Target group	Effectiveness evidence	INTEGRATE evidence
1	Parents and caregivers of children aged 2–17 years living in low- and middle-income countries (LMICs)	Effectiveness review for LMICs (131 randomized controlled trials)	<ul style="list-style-type: none"> • Qualitative perception review (217 studies) • Human rights review (17 studies)
2	Parents and caregivers of children aged 2–10 years, globally	Global effectiveness review (278 randomized controlled trials)	<ul style="list-style-type: none"> • Review of within-trial moderators (eight studies) • Review of economic studies (eight reviews / seven studies)
3	Parents and caregivers of adolescents aged 10–17 years living in LMICs	Effectiveness reviews for adolescents in LMICs (30 randomized controlled trials)	<ul style="list-style-type: none"> • Evidence gap map review (76 reviews) • Implementation review
4	Parents and caregivers of children aged 0–17 years living in humanitarian settings in LMICs	Humanitarian effectiveness review for LMICs (18 randomized controlled trials)	<ul style="list-style-type: none"> • INTEGRATE evidence was largely indirect (drawing on high-income countries or general evidence from LMICs) for recommendations 1, 3, 4, 5
5	Parents and caregivers of children aged 0–3 years, globally	<p>Reviews published for early childhood development (ECD) guidelines (41)</p> <p>Updated early childhood development review</p>	



Box 4. Global evidence on parenting interventions: a snapshot

For the *WHO guidelines on parenting interventions to prevent maltreatment and enhance parent–child relationships with children aged 0–17 years* (1), two main systematic reviews, two systematic sub-reviews, and one narrative review were conducted (10). The first review focused on parenting interventions in low- and middle-income countries (LMICs) for parents of children aged 2–17 years. The second review examined the effectiveness globally of the most widely distributed parenting interventions focused on children aged 2–10 years. The team conducted two sub-reviews of the main LMIC review, focusing on parenting interventions: 1) for parents of adolescents aged 10–17 years; and 2) delivered in humanitarian settings in LMICs. Finally, the team conducted a narrative review on parenting interventions in the first 3 years of life.

These systematic reviews found a total of 435 RCTs from 65 countries that showed that parenting interventions improve a range of parent, child and family outcomes. These interventions reduce negative parenting behaviours, including maltreatment, and improve positive and nurturing parenting across all contexts and types of interventions examined. Most of the reviews also found that parenting interventions reduce parent depression and child behaviour problems.

There was very little evidence of differential effects on different subgroups of families across all reviews – effects of parenting interventions did not vary according to country poverty level, the sex of the child, parent education level, family poverty, or child age. There was some evidence of differential effect by ethnicity in the global review, whereby trials that included mostly ethnic minority families showed smaller improvements in negative parenting and child behaviour problems compared to mostly ethnic majority families. Additionally, trials that focused on children with higher levels of behaviour problems showed stronger effects on improving behaviour problems and positive parenting.

Although most trials were conducted in high-income countries, the evidence base from LMICs was substantial: 131 trials from all regions of the world were included in the LMIC review, and 26 further LMIC trials in the early childhood development and humanitarian review.

Adapting parenting interventions to context and culture

Most evidence-based parenting interventions were originally developed in high-income countries and tested with ethnic majority populations, reflecting where resources for development, implementation, and evaluation of interventions have historically been concentrated (10, 42). However there are notable exceptions, such as [Familias Unidas](#), an evidence-based parenting intervention originally developed with Latino and Latina populations residing in Miami (43), and adapted for communities in Latin America and the Caribbean. Another example, [Parenting for Lifelong Health \(PLH\)](#), is a suite of affordable, not-for-profit and open access parenting interventions originally developed and tested with Xhosa families living in the Western and Eastern Cape provinces of South Africa and widely disseminated in low- and middle-income countries (44).

Since the 1990s, “cultural adaptation” has rapidly expanded in the field of parenting intervention research. Cultural adaptation refers to “the systematic modification of an evidence-based intervention protocol to consider language, culture, and context in such a way that is compatible with the client’s cultural patterns, meaning, and values”. (45)

Thus, a culturally adapted parenting intervention is a version of a parenting intervention originally developed and tested for one population that has been adapted to a new population to ensure contextual and cultural fit. Studies that summarize results from multiple adaptation investigations indicate that culturally adapted interventions can be more effective than non-adapted ones (40). Even if resources for adapting interventions are limited, a few well-targeted adaptations can have significant and positive impacts on parenting and child outcomes.

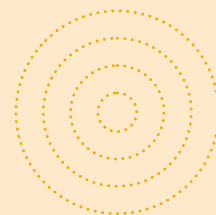
Cultural adaptation is essential because the dissemination of non-adapted interventions can be ineffective or harmful if the parenting principles and practices they contain are not contextually or culturally relevant to the population. This handbook provides guidance on how decision-makers can engage stakeholders and approach collaboration and consultation throughout their initiatives to promote inclusive and appropriate practices.



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Phase 1.

Groundwork for implementation



Step 1: Engaging and collaborating with stakeholders

Step 1.1: Identify participating families and engagement strategies

- ✓ Identify the level of participation: universal, selective, or indicated
- ✓ Determine strategies to recruit and engage participants
- ✓ Encourage stakeholders to raise awareness, refer participants, and provide support to them
- ✓ Make intervention activities accessible for participants
- ✓ Get feedback from stakeholders on barriers to access and how to address them

Step 1.2: Determine intervention delivery platforms, methods, and frequency

- ✓ Work with community-led groups or CSOs
- ✓ Use formal service delivery systems
- ✓ Align with the intervention's theory of change
- ✓ Assess available resources, in line with the selected delivery platform

Step 1 outlines which stakeholders to engage and how, and presents examples of how to work with stakeholders in line with the continuum of implementation strategies in the Overview section.

Stakeholders are any individual or group that has an interest in an initiative, including those who are targeted by the intervention or policy directly, or involved in its development or delivery (including children and adolescents); broader community members; local and national authorities; and CSOs. Several different types of stakeholder can be engaged throughout the development, implementation, evaluation, and scale-up of a parenting intervention (Box 5). The involvement of stakeholders is crucial to ensuring the feasibility and acceptability of complex interventions such as parenting interventions (46). Support from relevant actors can secure commitments to, and allocate adequate financial and human resources for, the implementation and scale-up. This is particularly true for interventions and services that will be implemented at a national level, since these depend on the strength of existing systems and

coordination mechanisms within government sectors (47). However, even for simple and low-resource approaches to intervention development, engaging and consulting stakeholders is necessary to ensure adequate resourcing and sustainability.

1.1. Create a stakeholder engagement plan

Engaging stakeholders from the outset can help to build a constituency, legitimize change, realign and mobilize resources, and help achieve intervention sustainability (48).

Who should be engaged?

At a minimum, parenting interventions engage parents/caregivers as the target population and direct participants, and sometimes children and other family members (essential strategy). Other stakeholders directly involved in the intervention, such as providers and facilitators, can also be engaged to gather additional input at all stages of intervention development, implementation, and uptake (moderate strategy). Wider stakeholders at the community or national level who are not directly involved in the intervention but who might be invested in its success could also be engaged (advanced strategy).

✓ Conduct a stakeholder mapping

Deciding on who to engage should start by mapping all potential supporters and opponents, along with their interests, resources, and willingness to be involved. Using a tool to map stakeholders according to their relative influence and interest can be useful – e.g. the [MSI Scaling Up](#) stakeholder analysis tool is helpful to identify key stakeholders and their interests, positions, and resources relevant to scaling up an intervention (48). Using the stakeholder mapping, select which stakeholders to engage, and develop strategies for legitimation and advocacy specific to each actor. Deciding who to engage will depend on the time and resources available.

An essential strategy for stakeholder mapping involves conducting community sensitization or information sessions to generate interest and recruit participant parents/caregivers. In addition to participating in intervention activities, parents/caregivers (as well as older children and adolescents, Box 6) might also be engaged during or after an intervention through satisfaction surveys or informal feedback discussions.

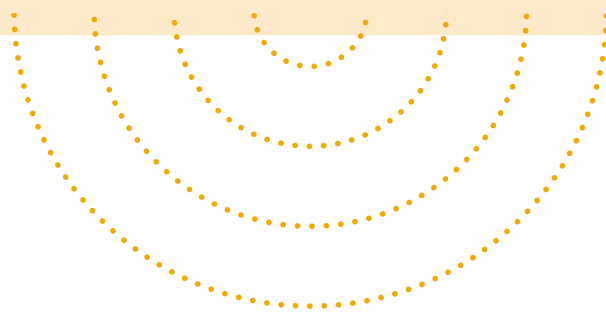
A moderate strategy for stakeholder mapping could be to consult implementation staff on the relevant local and regional stakeholders who are necessary to engage from their perspectives. For example, through consultation with implementation managers, key actors and ministries could be identified and points of contact established based on their existing networks.

An advanced strategy could involve cross-sector engagement to gain support and finances for implementation. The health and nutrition, social welfare, and education sectors are often involved in the design, delivery, and monitoring of parenting interventions. Collaboration with other sectors is also recommended

depending on the components of a specific intervention. Adequate referral to response and support services may require engaging the justice or security sectors. For interventions aiming to change social norms and values, ministries for gender, women, and child development could be crucial to involve, as they can lead policy change, ensure implementation, and advocate for cross-sector financing and support (47). The nutrition sector frequently serves as the delivery platform and can even take the lead in implementing parenting interventions. It may also be strategic to involve ministries of finance at an early stage to make sure parenting interventions can be adequately resourced and prioritized in annual budgets.

Box 5. Types of stakeholders to engage in parenting intervention initiatives

- **Parent/caregiver:** An adult responsible for the daily care and support of a child, including biological or adopted parents; aunts, uncles, grandparents, or other kin; and others who are directly responsible for the child at home.
- **Children:** Anyone under the age of 18 years.
- **Other family members:** Other individuals within a household or community who are present in the child's life and have a close relationship with the child and family.
- **Implementation managers:** Individuals who oversee implementation of the intervention, account for resources, build capacity, and solve problems.
- **Frontline service providers:** Facilitators, counsellors, health providers, and other individuals who work directly with participants and community members.
- **Community leaders:** Individuals widely perceived to represent or hold a formal or informal gatekeeping position for the community or a part of the community.
- **Policy-makers:** Individuals responsible for drafting, enacting, and implementing plans of action, laws, and policies, including but not limited to:
 - state/provincial and national-level legislative bodies;
 - local government and municipal authorities;
 - ministries for gender, women, and child development;
 - ministries for health and nutrition;
 - ministries of finance, labour, and economic development;
 - interior and planning ministries.
- **Social care systems:** All public, private, and voluntary entities that contribute to the delivery of social work, personal care, protection or social support services to children or adults in need.
- **Health care systems:** All public, private, and voluntary entities that contribute to the delivery of health care and medicine.
- **Educational systems:** Authorities responsible for education in a particular geographic area; school leaders and teachers.
- **Researchers:** Individuals or teams who contribute to the planning, implementing, and analysis of research to learn about a context, problem, or intervention.



Box 6. Working with children and adolescents

Engaging older children and adolescents as stakeholders in the intervention design and evaluation process is important given the high prevalence of maltreatment globally, its consequences on the health and well-being of children and adolescents, and the disempowerment that can result from their exposure (48). The voices of youth exposed to child maltreatment are often absent from programme and research priorities, which can lead to a discrepancy between research and interventions that are relevant to youth and those that are pursued by the practitioner community (49). The engagement of children and adolescents in intervention development and research can improve the design and delivery of interventions and services that are intended to support them, and therefore should be prioritized. In addition, youth participation has been found to have significant benefits for children and adolescents, including improvements in social-emotional learning, skill acquisition, interpersonal relationships, and self-efficacy (50). This is particularly critical for those youth who have experienced systemic violence and discrimination, whose voices have the potential to influence policy and practice (48).

However, involving children and adolescents as stakeholders raises safeguarding risks, and it is therefore essential to put in place procedures to mitigate the potential for harm. Similarly, it is important that youth are engaged in activities in a meaningful and empowering way, and not in a manner that tokenizes them or that further entrenches harmful power dynamics – for example, holding youth-only activities or establishing a youth

advisory group where children and adolescents can be engaged as stakeholders without being subjected to unequal power dynamics or social norms. Personnel working with children and adolescents (including decision-makers, providers, facilitators, researchers, etc.) should receive training on working with children and child safeguarding, including local and national laws for reporting of child safety concerns and referral procedures for counselling and other services (51).

Decision-makers seeking to involve children and adolescents in design and evaluation activities should consult the most recent guidance on the safeguarding of children, such as:

- Ethical Research Involving Children (ERIC) evidence informed ethics guidance for research involving children and young people (52, 53)
- Minimum Standards for Child Protection in Humanitarian Action (54)
- UNICEF Guidelines on Adolescent Participation and Civic Engagement (55)
- UNICEF resources on child safeguarding in coordination of the Global Education Cluster and other Clusters and Areas of Responsibility (for NGOs) (56)
- IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings (57).

How should stakeholders be engaged?

Engaging stakeholders involves: 1) budgeting for engagement activities; 2) generating commitment; and 3) building constituencies. The [MSI Scaling Up](#) toolkit suggests many evidence-based ways to do this (48), while the main components of a multisectoral stakeholder engagement plan can be found in Box 7 (adapted from the *WHO INSPIRE Handbook*) (47).

✓ Budget for engagement activities

Costs associated with stakeholder engagement might include:

- staff time for leadership of coordination efforts;
- staff time for participation in coordination;
- costs associated with planning, communication, and meetings;
- costs for data collection and analysis.

Stakeholder activities such as convening in-person meetings with community members are advised, but may not be possible if there are insufficient resources for organizing events and compensating participants. While some of these additional costs may be difficult to justify in resource-poor contexts, opportunities for cost savings should also be considered, as strong stakeholder engagement strategies can help to avoid duplication of sector-specific activities and provide opportunities for pooling and mobilizing resources. For example, while conducting cross-sectoral meetings might have cost implications, they could help identify existing structures where activities are already being conducted with parents/caregivers that could be used for mobilization, such as local offices within the health sector using community health volunteers to work with parents as part of nutrition programming.

Box 7. Main components of a multi-sectoral stakeholder engagement plan

- Clearly defined roles, responsibilities, and core capacities of the sectors, organizations, and individuals involved.
- A designated coordinating body, with enough influence and resources to make decisions, implement action steps, and hold coordinating agencies accountable.
- Mechanisms to encourage and incentivize collaboration, such as:
 - designating senior-level focal points within each sector, ministry, or other body;
 - articulating common goals and commitment to implementing the same strategies;
 - mapping existing efforts, roles, and responsibilities to assess and address barriers and gaps;
 - sharing information through regular meetings, workshops, webinars, etc.;
- adding time-bound indicators to measure collaboration and data-collection efforts;
- developing violence-prevention expertise that survives funding or political cycles within ministries and institutions. This includes cultivating constituencies (groups with a special focus) rather than individual “champions”.
- Resources available for coordination. Sometimes sectors with larger budgets can contribute to the cost of coordination or participation for other entities. For example, it may be feasible to provide grants or stipends for NGOs or other agencies to participate in collaboration efforts.
- Stakeholder mapping (for example using the [MSI Scaling Up](#) toolkit).
- Timeline of stakeholder activities that aligns with implementation timelines and key advocacy opportunities.

Source: adapted from (47)

✓ **Generate commitment**

Generating commitment involves securing the endorsement of local administrators and national government policy-makers to scale up interventions or roll them out at national level. Through stakeholder mapping, “champions” – or effective leaders – who have the credibility and influence to transform processes can be identified at multiple levels, and the willingness to use their political or social capital to support the intervention (48). Through these champions, legitimation, or placing the need for change high on the agenda of decision-makers, can be achieved. These champions should be explicitly mentioned in stakeholder engagement plans and can even be brought in to review them. Commitment can also be formalized through local and national action plans that are signed off by relevant policy-makers and ministries. While these may take time to develop, they can provide a structure that is less dependent on the ongoing support of key champions who are essential during early stages of intervention adoption.

✓ **Build constituencies that leverage existing networks**

The stakeholder mapping can help identify and mobilize constituencies or coalitions of stakeholders who can more effectively advocate for the adoption and implementation of needed changes (48). An efficient way to do this is to align parenting intervention scale-up efforts with pre-existing coordination mechanisms, strategies, or national plans. This can be done within government or national coordinating mechanisms that already have a mandate for developing, coordinating, and building the national and local infrastructure needed to implement a parenting intervention.

Where activities occur outside government – with nongovernmental organizations (NGOs) or CSOs – coordinating mechanisms such as the [Global Protection Cluster](#) in humanitarian settings have existing mandates for mobilizing resources and actors to reduce child maltreatment. Other existing mechanisms could include work to prevent and reduce different types of violence and maltreatment, such as female genital mutilation and/or cutting; child and forced marriage; and gender-based violence, as well as health interventions and immunization campaigns such as HIV/AIDS or child nutrition initiatives (47). By aligning intervention scale-up efforts with these existing strategies, stakeholder engagement and scale-up activities could occur within a ministry or mechanism explicitly designated to coordinate a multisectoral taskforce, reducing the replication of efforts and competition for resources.

Where these constituencies do not already exist, decision-makers could consider establishing a task force with an influential representative from each sector or implementation location dedicated to initiating the scale-up of parenting interventions as part of their own implementation or stakeholder engagement plans.

For instance, in the example given in the moderate strategy in Box 8, when the Parenting for Lifelong Health for Young Children intervention was adapted for scale-up within the health system in Thailand, an expert group was convened to guide its adaptation and implementation (49–51). In addition to supporting the roll-out and sustainability of the intervention, creating a taskforce or working group could also help to align and mobilize resources and build long-term constituencies for parenting initiatives in the context or country.

► Moderate strategy

Box 8. Engaging experts for the adaptation of the Parenting for Lifelong Health for Young Children intervention, Thailand

At the outset of their rigorous adaptation process to integrate a parenting intervention into the public sector, UNICEF Thailand conducted stakeholder mapping to identify existing policies, interventions, and information sources on parenting education and skills-building across the country. The mapping identified that the public health system was the most strategic sector for scaling up parenting interventions on a national level. The mapping was followed by a rigorous cultural and contextual adaptation process and formative evaluation. The evaluation used mixed methods, including quantitative caregiver data from a survey, plus qualitative data from individual and group interviews with caregivers and intervention facilitators.

Qualitative methods were used to examine the cultural and contextual relevance of the key intervention themes, process, structure, schedule, and logistics, and to identify potential barriers and opportunities for scaling up the intervention.

Individual interviews were conducted with 20 professionals and academics, while focus group discussions were held with a Parenting Experts Working Group. The six parenting experts included Thai psychologists, academics, researchers who had conducted evaluations of parenting interventions, and parenting professionals. They met five times through the course of the project, advising on adaptation and other implementation aspects.

This testing and fine-tuning of the intervention was conducted in parallel with capacity building in the public health sector to support intervention implementation and sustainability. Development and testing took place in one pilot province, prior to scaling up in other provinces in the region.

When should stakeholders be engaged?

After deciding how to engage stakeholders, the next consideration is when identified stakeholders should be engaged. Ideally stakeholder engagement planning should occur at the earliest stages of intervention design, alongside of planning for scale-up (47, 52). Particularly in situations involving national or government strategies, building commitment for the intervention from the outset can raise awareness among all stakeholders around the magnitude and consequences of child maltreatment and catalyse national and regional movements to address it (1). Failure to engage stakeholders from the outset can diminish the success of an intervention and its sustainability, as without sufficient consultation before intervention roll-out, the necessary actors or participants may not be “ready” (53).

✓ **Align timelines for engagement, resources, and advocacy**

In contexts with limited time and resources, linking opportunities for engagement with existing implementation timelines, national or international mechanisms, or advocacy campaigns can bolster interest from champions or constituencies. National mechanisms are forums that periodically convene representatives of relevant sectors to discuss the latest available data on violence against children with a view to identifying emerging problems and risk factors for timely action. For example, national assessments of existing policies, services, infrastructure, and levels of violence (through surveys such as the Violence against Children and Youth

Survey (VACS)) (58) can be a powerful tool for raising awareness of child maltreatment and informing resource allocation and coordination of inputs and activities with stakeholders.

International mechanisms or advocacy campaigns can be mutually beneficial opportunities to convene representatives of national ministries who are dedicated to initiating interventions and sustaining momentum (47). These include forums or partnerships where countries or regions come together to explore the most effective strategies for ending child maltreatment. For example, in the essential strategy in Box 9, the roll-out of the Growing Strong Together intervention in the Central African Republic developed by the International Rescue Committee for families experiencing armed recruitment (59) benefited from the engagement of the Minister of Gender Promotion, Protection of Women, Family and Children. This long-term approach demonstrates the need to develop timelines and links as part of the stakeholder engagement plan, indicating precisely when each activity will be implemented and by whom (47).



► Essential strategy

Box 9. Engaging policy-makers for the uptake of Growing Strong Together, Central African Republic

In the Central African Republic, the International Rescue Committee first communicated with the office of the Minister of Gender Promotion, Protection of Women, Family and Children during the start-up of the project to develop Growing Strong Together, a parenting intervention that aims to support families in conflict-affected communities experiencing recruitment of children to armed groups. Through group-based and family visit sessions with parenting groups, the intervention strengthens caregivers' skills and knowledge to protect children, adolescents, and young persons (aged 8–21 years) from recruitment, and promote their reintegration following association with armed forces or armed groups.

The Minister spoke about the intervention at a highly publicized event organized for the International

Day against the Use of Child Soldiers. Key to this engagement strategy was involving the ministry in the development and piloting of the intervention from its inception, at which time she committed to supporting future dissemination efforts. Its dissemination during an international day relating to the goals of the intervention also raised awareness among other actors who might be interested in funding or implementing such interventions. This strategy not only ensured the support of the ministry for the scale-up of the intervention, but also strengthened the ministry's larger efforts to advocate for increased commitment and resources to support families with children recruited by armed forces and armed groups. The intervention is now being scaled up through the country's Child Protection Interagency Group.

1.2 Work with local populations to design and adapt interventions

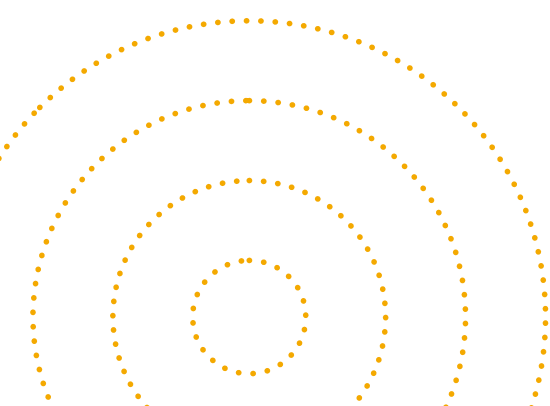
Top-down approaches to implementing parenting interventions in new contexts may risk overlooking key contextual and cultural issues that are relevant to intervention beneficiaries. Identifying locally developed interventions already being used and/or developing or adapting interventions with local stakeholders can help to prevent the dissemination of contextually inappropriate approaches (60, 61). **Co-designing**, or collaboratively designing parenting initiatives with community leaders and decision-makers, and co-developing problem-solving strategies, is one approach to addressing barriers to implementation and adoption by communities and organizations (60, 62). Alternatively, **co-adaptation** refers to engaging in collaborative work to modify existing parenting interventions and involves decision-makers and developers consulting target populations to ensure that intervention content and methods of delivery are contextually and culturally relevant (60, 61).

Box 10. Common types of adaptation for parenting interventions

When adapting existing interventions, there are typically two types of adaptation: surface-level and deep-structure (47).

Surface-level adaptation refers to interventions that require minimal adaptations to ensure a contextual and cultural fit with target populations – e.g. translating intervention materials into local languages or changing visual depictions or other illustrative examples of parent-child interactions to fit local cultural contexts.

Deep-structure adaptation refers to modifications that involve detailed evaluation of intervention content and delivery procedures to ensure contextual and cultural relevance. As such, deep-structure adaptations can involve changing some of the core components of original interventions, adding components that are highly relevant to target populations, or a combination of these strategies (47).



How are co-designing and co-adapting done?

Co-design and co-adaptation require defining short- and long-term goals that fit the contextual and cultural realities of target populations, with local leaders involved as key decision-makers (see Box 10 for types of adaptation).

✓ Select an adaptation framework

To adapt an intervention for a given context, it is important to follow a well-defined adaptation framework. For example, one of the most widely disseminated adaptation frameworks is the Ecological Validity Model (EVM) (45, 63). Under the EVM framework, adapters must ensure that adaptations are conducted on the following eight dimensions of adaptation:

1. **Language**, or using the language of target populations.
2. **Persons**, or ensuring that the agents delivering interventions constitute a good ethno-cultural fit with target populations.
3. **Metaphors**, which involves using culturally relevant symbols and concepts.
4. **Content**, ensuring that the knowledge communicated in interventions is culturally relevant.

5. **Concepts**, ensuring the theories and assumptions informing interventions are culturally relevant.
6. **Goals**, which consist of contextually and culturally relevant intervention objectives.
7. **Methods**, ensuring the intervention delivery approach is culturally relevant.
8. **Context**, considering the target populations' greater economic, social, and political environments.

The following case studies in Chile, China, Kenya, and the United States of America (USA) illustrate the continuum of practices for designing and adapting parenting interventions in various contexts to ensure appropriate collaborative efforts.

An advanced strategy to co-design and co-adapt is illustrated by the deep-structure adaptation of Parenting for Lifelong Health for Young Children for street-connected mothers (*Malezi Bora na Maisha Mazuri: "Good Parenting for a Good Life"*) in Eldoret, Kenya. Using a multi-phase, community-based participatory action research method, this initiative had two aims for its adaptation: 1) to specifically engage young people in street situations – a group socially stigmatized in addition to being at high risk of physical and sexual violence; and 2) to ensure the intervention's relevance for both mothers *and* fathers in this target population (Box 11).

► Advanced strategy

Box 11. Engaging street-connected communities for the adaptation of Malezi Bora, Kenya

The Malezi Bora project is a participatory action research project to adapt, implement, and evaluate an evidence-based parenting intervention for parents in street situations in Kenya.

To explore content and delivery considerations for engaging male caregivers in the intervention, a Parent Advisory Group of 10 mothers and fathers in street situations guided the development and refinement of the research questions and data collection tools; co-analysed the data using arts-based and participatory approaches; co-created an emerging theory of change; and planned for and participated in research dissemination. Engagement also included a community-building day where the Parent Advisory Group and other members of the street community were invited for a day of team-building activities to build trust.

The project was guided by a Steering Committee composed of representatives of local community-based organisations (CBOs) supporting the street community, and researchers and practitioners based at local, national, and international academic and non-profit organizations.

More than half of the data collection team had lived experience on the streets, with two being past participants of the Malezi Bora intervention; others had a long history of working with the street community in a practitioner capacity via various CBOs, and with whom the street community shared a deep sense of trust. All received in-depth research training, as well as an equal opportunity to engage in different research activities (e.g. participant mobilization, interviewing, notetaking, presentations, etc.) to gain a wide range of research skills in preparation for future employment opportunities.

No major decisions about the research were made without endorsement by the Parent Advisory Group, the Steering Committee, and advice from the data collection team.

The project culminated in a knowledge-sharing event, where stakeholders working with the street community across different sectors (e.g. CBOs, government, academia, and the street community) gathered for a participatory workshop to explore how the findings can inform further adaptations to the programme, as well as other collective approaches to support parents in street situations in Kenya.

► **Advanced strategy**

Box 12. Cultural adaptation of GenerationPMTO, USA

The multi-step process started with the adaptation of GenerationPMTO for Latino and Latina immigrant populations in Utah, USA. This process consisted of adaptations focused exclusively on the core parenting components of the GenerationPMTO intervention. All adaptations were implemented by addressing the eight dimensions of the EVM framework. The adapted intervention was renamed by parents as: “CAPAS: *Criando con Amor, Promoviendo Armonía y Superación*” (Raising Children with Love, Promoting Harmony, and Self-Improvement).

In a subsequent study, researchers established a collaboration with community leaders keen to offer a parenting intervention that addresses parenting issues and supports families with immigration-related challenges such as discrimination and familial bicultural stressors (e.g. USA-born children refusing to speak Spanish).

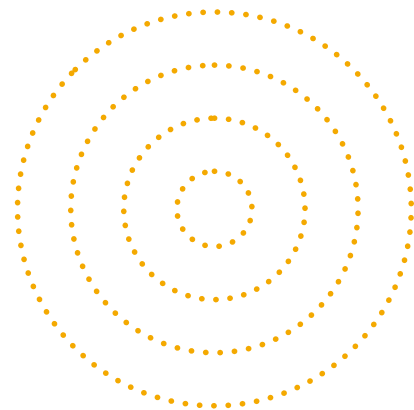
To determine the impact of adding components focused on immigration-related challenges and biculturalism, a differential cultural adaptation design was implemented. Investigators compared a version of the CAPAS intervention exclusively focused on parent training components (CAPAS-Original) against a “CAPAS-Enhanced”

intervention in which parenting intervention components were complemented by sessions focused on strategies to help parents cope with immigration-related challenges. The new content was informed by a qualitative study previously conducted with families in the target population. These families provided detailed reports describing immigration-related challenges commonly experienced by Latino and Latina immigrants in the area, as well as cultural issues of relevance to them, including the desire to become bicultural families.

Researchers found that both adapted interventions (i.e., CAPAS and CAPAS-Enhanced) significantly improved parenting practices for caregivers. However, the reduction of child mental health problems in families that participated in the CAPAS-Enhanced intervention was statistically higher than families exposed to CAPAS-Original. These findings provided empirical evidence indicating that including components to help Latino and Latina families cope with immigration-related stressors such as discrimination, as well as giving families tools to promote biculturalism within the family, were associated with the largest intervention benefits for children’s mental health.

In line with the continuum of implementation practices, the adaptation process can range from multiple advanced phases to simpler essential or moderate adaptations. The examples below illustrate two different strategies for adapting the evidence-based parenting intervention [GenerationPMTO](#) (64). In the advanced strategy with CAPAS-Enhanced, researchers adapted this intervention for first-generation Latino and Latina immigrant parents/caregivers in the USA (14, 65, 66). The process was guided by the community leaders’ request to offer an adapted intervention that could help parents/caregivers not only strengthen their parenting skills but also build skills and resources for coping with immigration-related stressors and biculturalism challenges (Box 12).

In other contexts, the adaptation process has followed a more straightforward process, building on knowledge gained in previous adaptations – for example, the moderate strategy of GenerationPMTO in the Chilean context (Box 13). Specifically, the San Carlos de Maipo Foundation funded an adaptation of GenerationPMTO for families in Santiago, Chile (67–69), informed by the EVM cultural adaptation framework (63).



► Moderate strategy

Box 13. Using implementers to adapt GenerationPMTO, Chile

This initiative professionally translated the original English-language based group version of GenerationPMTO (i.e., Parenting Through Change). The translated materials were compared to the Spanish manuals used in previous adaptations of GenerationPMTO (for Mexican-origin immigrants in the USA and Mexican nationals in Mexico City) to verify their accuracy. Finally, two bilingual certified trainers completed a thorough revision of the Spanish version of the parent materials to ensure their cultural relevance and linguistic appropriateness for the Chilean context.

Once the manual was adapted, Chilean implementers trained in GenerationPMTO evaluated the contextual

and cultural relevance of the adaptations when delivered to 24 Chilean families. According to qualitative findings, caregivers indicated high satisfaction with all components of the adapted intervention and offered additional recommendations to refine it further. Caregivers' feedback was incorporated into a final adapted version that was pilot tested with 281 Chilean caregivers. According to initial findings, participants were highly satisfied with the contextual and cultural relevance of the intervention. In addition, the intervention led to positive changes in parenting skills and children's mental health.

A third example is an essential strategy surface adaptation of the Triple P intervention (70) in China, Hong Kong Special Administrative Region (Hong Kong SAR). This was conducted by providers with high cultural competency who made minor adaptations to the intervention during implementation given its high relevancy to the new context (Box 14) (12, 71).

What resources are needed to adapt an intervention and promote ownership?

Engaging stakeholders and using collaborative design and adaptation approaches throughout each stage of an intervention can contribute to sustainability. Ideally, initiatives should lead to parenting interventions being "owned" by local communities or authorities, a process known in the implementation science field as "full transfer". In Uganda, the co-design of Parenting for Respectability and the co-adaptation of Parenting for Lifelong Health for Teens (Box 15) both involved a variety of stakeholders in their development and roll-out, contributing to their uptake and sustainability over time. This process is essential to ensure the grounding of interventions in line with local communities' existing resources.

✓ **Involve stakeholders at all stages of design and implementation**

To achieve this, it is crucial to involve stakeholders in more than just co-design and co-adaptation. Their engagement should also extend to various stages of the intervention, including assessing community needs, matching evidence-based interventions with targeted populations, and evaluating, sustaining, and scaling up parenting initiatives (explored in later sections of this handbook).

► Essential strategy

Box 14. Adapting Triple P during implementation with experienced providers, China, Hong Kong SAR

The adaptation of Triple P in China, Hong Kong SAR is an example of surface adaptation to a new context. For this adaptation of Triple P, the researchers and intervention providers were skilled local psychologists experienced in parent and family work. They were trained by international trainers from Australia in the Triple P group-based parenting intervention (Primary care Triple P). Apart from translation into Cantonese, the team made minor adaptations for urban low-income Chinese families. For example, families commented that they did not feel it was culturally appropriate to praise their children, so different forms of wording to encourage and reward children were developed that were more comfortable for the families. The providers felt that very few adaptations were needed, likely because of the cultural and professional competence of the local psychologists, but also potentially because many of the goals and concepts of many parenting interventions appear to resonate with families from a range of cultures.



► **Advanced strategy**

Box 15. Co-designing versus co-adapting parenting interventions: implementing Parenting for Respectability (PfR) and Parenting for Lifelong Health, Uganda

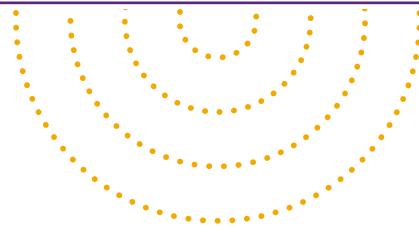
Two examples from Uganda demonstrate possible advanced approaches to co-design or co-adaptation. Parenting for Respectability (PfR) is an evidence-based parenting intervention co-designed through a research collaboration in Uganda. It comprises 16-sessions, 10 of which are delivered to single sex groups, and six to mixed sex groups, facilitated by a trained peer facilitator. The intervention deliberately emphasizes recruitment of fathers and parental couples, as well as mothers. Weekly sessions last about 2 hours. The intervention builds on parents' concerns to enhance the respectability of their family and aims to reduce four factors associated with child maltreatment and gender-based violence: poor attachment and parental bonding; inequitable gendered socialization; harsh parenting; and intimate partner conflict and disrespect. Intervention design followed the 6SQuID model of intervention development and multisectoral advice.

The intervention was designed to be evidence-based and have a clear theory of change, which incorporated three specific theories: attachment theory; the concept that positive behavioural control develops emotional control; and social learning theory. The first version was developed from 2013 to 2014, with input from an Advisory Committee recruited early in 2014, comprising professionals with expertise in GBV from NGOs, the Ministry of Gender, Labour and Social Development, and Makerere University.

The intervention then underwent a formative evaluation in three stages from 2014 to 2016, in two communities with six groups and 138 participants. Predictors of poor parenting and GBV were confirmed, and the formative evaluation led to several modifications, including a reduction from 21 to 16 sessions.

Local leaders provided guidance on the suitability of existing structures and groups for delivery, including making adjustments to address potentially exclusionary group dynamics. The team's co-design approach followed participatory engagement principles, and ongoing efforts to scale up PfR in Kenya and Tanzania involves multiple levels of co-adaptations of sessions, materials, mobilization strategies and delivery strategies.

In contrast, the Parenting for Lifelong Health for Teens intervention was co-adapted from South Africa to the Ugandan cultural context as part of the USAID PEPFAR-funded DREAMS Initiative, through a collaboration between the Bantwana Initiative and Clowns Without Borders South Africa. After an expert review by Ugandan partners, the intervention materials were translated into local languages with role plays and other activities adapted for communities in western Uganda. Responding to input from community-based implementing and participating families, the original 14-session programme was included as part of an integrated package of services along with school-based interventions for teachers and administrators, economic strengthening activities for caregivers, grassroots football activities for children, and village child-care case management facilities. The adapted intervention maintained five core sessions with an additional session focusing on a topic selected by community members. The weekly delivery was also adjusted to daily or monthly sessions depending on how the programme was integrated with other services. The community-level intervention has been scaled up to reach approximately 60 000 families across 29 districts.



► Moderate strategy

Box 16. Site-specific adaptation of the Growing Strong Together intervention, northern Nigeria

Learning obtained during training for, and pilot implementation of, Growing Strong Together – an intervention developed by the International Rescue Committee for families experiencing armed recruitment – was crucial for adapting and finalizing the parenting intervention curriculum and package of supporting resources. Through piloting, the project team was able to understand how the curriculum worked in different settings and then adjust for safe delivery. For example, while caregivers of children formerly recruited and children at risk (not formerly recruited) were able to mix in the parenting groups in Democratic Republic of the Congo and Central African Republic, in one site in Nigeria these groups had to be separated into two different groups of parenting sessions to reduce stigma and discomfort for participants and ensure safe delivery of the curriculum. Similarly, in some sites across countries, men and women were separated into different participant groups, whereas in others they were able to mix.

The project teams documented these challenges resulting from context-specific dynamics in gender, age, and ethnic and community groups that arose throughout piloting to incorporate them into revisions of the final curriculum, and include them as practical examples of adaptations for contextualization. Using these examples, further considerations were added throughout the curriculum and highlighted as points for contextualization depending on the specific scenario in each implementation site. These considerations will help to ensure the safe delivery of the curriculum while achieving the goal of guiding parents as they support their children to prevent recruitment and facilitate their reintegration.

1.3 Consider potential impact on marginalized groups

Potential adverse effects caused by an intervention or stakeholder engagement process must always be considered. Some contexts might have complex political or civil situations that require sensitive identification and involvement of marginalized groups or minoritized populations.

For example, fragile settings cover a range of situations including armed conflicts, humanitarian crises, and protracted emergencies. It can be challenging to reach families living in such settings since they may be dispersed or undocumented, and in some low-resource and fragile settings, formal health, social welfare, and other service delivery systems may be degraded or destroyed. Similarly, while engaging stakeholders can minimize “top down” approaches to selecting and implementing parenting interventions, it is also crucial to consider which groups are easier to engage, which groups are harder to engage, and what implications this may have for decision-making (e.g. adolescent parents/caregivers, single parents/caregivers, employed parents/caregivers, or other groups who less often participate in parenting interventions). In some cases, identification of hard-to-reach groups to encourage their participation can even put them at heightened risk of violence or retaliation. In these situations, alternative mechanisms may be required to identify participants and deliver interventions.

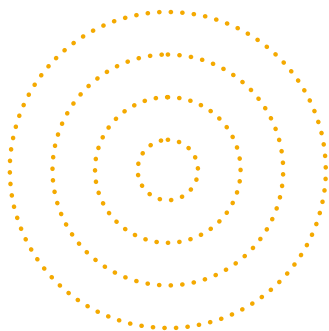
A study exploring ways to include LGBTQI+ families in research and interventions on violence prevention in humanitarian contexts found that past efforts to directly target these groups have put them at risk of harm (72). Respondents revealed that when well-meaning providers seek out LGBTQI+ participants for interventions, their identification through research and interventions has led to harmful retaliation. Similarly, a feasibility study on the adaptation of the Growing Strong Together intervention in three different conflict contexts in northern Nigeria found that the delivery approach had to be altered by site when adapted and piloted to be safe for all participants (59) (see Box 16). This careful adaptation process required substantial engagement to gather feedback from participants and implementers.

Engaging only individuals from or representatives of ethnic or religious majority populations or other groups with unequal concentrations of power can result in intervention strategies that overlook key contextual and cultural issues. This can also create barriers to transformational change or put marginalized populations at risk of harm. Therefore, stakeholder engagement processes should consider which individuals and institutions benefit from the current status quo or whose principles may be at odds with social norms transformation (73).

✓ **Consider the specific needs of families with disabilities**

Another group that might require specific consideration for inclusion in parenting interventions are families with a person with a disability. This encompasses both families of children with disabilities and families of parents/caregivers with disabilities. Children with disabilities are almost twice as likely to experience violence compared to peers that are not disabled (74). Parents/caregivers of children with disabilities encounter greater difficulties in attending to their children's specific needs, which leads to higher levels of parental stress and health issues (75). Furthermore, the long-standing stigma and discrimination that exists in some cultures in relation to disability exacerbate the social isolation experienced by families of children with disabilities (76). These adversities accumulate to increase the risk of child maltreatment and diminish children's learning opportunities, perpetuating a cycle of poor development.

Parenting interventions can be beneficial for families of children with disabilities. These interventions can take various forms, such as non-disability-specific, evidence-based parenting interventions, interventions adapted from evidence-based parenting interventions, or evidence-based parenting interventions specifically designed for the population living with disability (77). Evidence indicates that for families of children with disabilities, they are effective in reducing child behavioural problems (78–81), enhancing parent-child relationships (79), promoting positive parenting practices (78, 80), reducing parental stress (82), and improving parental self-efficacy (81, 83). However, the existing evidence primarily comes from a few high-income countries, with limited research on interventions in low- and middle-income countries (79).



There are two main approaches to providing appropriate parenting support to parents/caregivers of children with disabilities:

- ✓ **Disability-inclusive design** ensures that the parenting intervention is designed to be universal and open to families with or without disabilities. In this case, it is important to design and deliver the intervention with sensitivity towards families with disabilities. For example, using appropriate language, ensuring equal access to the intervention, making necessary physical accommodations, and fostering a non-stigmatizing environment to encourage participation.
- ✓ **Disability-specific design** involves the provision of parenting interventions exclusively for families with disabilities. For example, the Incredible Years Preschool Basic Programme was adapted and delivered exclusively for families of preschool children with developmental delay and disability in China, Hong Kong SAR. A small RCT evaluating the intervention's effects demonstrated positive impacts on parent-child interaction, parental stress, and child behavioural adjustment (84). Another example is the [WHO Caregiver Skills Training Programme for Families of Children with Developmental Delays or Disabilities](#), highlighted in Box 17 (82, 84–89).

An ideal approach to supporting families of disabled children is to use a twin-track method (89) whereby the needs of families of children with developmental delays and disabilities are not only included in parenting interventions across sectors and in universal support, but are also offered targeted support through specialized services and interventions (90). This method aims to improve the accessibility of general parenting support to families with disabilities while also providing tailored support to address their unique needs. However, the advanced strategy of using a twin-track method requires more resources and funding than applying the two approaches separately. To implement this method in a way that is sensitive to user needs, it is important to collaborate closely with families living with disability, their support networks, and representative organizations.

Inclusive strategies should also be developed to improve the accessibility of parenting support for parents/caregivers with disabilities. This can involve using alternative formats such as braille, large print, or audio recordings for those with sensory impairments. Additionally, parenting interventions designed specifically for parents/caregivers with intellectual disabilities, such as interventions using simplified materials and visual aids, have shown promise in improving child care, child safety, parent-child interaction, parental emotional well-being, and social support, as indicated by emerging evidence from a few high-income countries (91, 92).

► Advanced strategy**Box 17. The WHO Caregiver Skills Training Programme for Families of Children with Developmental Delays or Disabilities**

The WHO Caregiver Skills Training Programme for Families of Children with Developmental Delays or Disabilities ([WHO CST](#)) is specifically designed for caregivers of children aged 2–9 years with developmental delays or disabilities. Its aim is to equip caregivers with the necessary skills to promote child development, with a particular focus on social communication, adaptive skills, and behavioural adjustment. In addition to this, the intervention is designed to improve the emotional well-being of caregivers and enhance family functioning, while also promoting social inclusion and community participation.

The intervention comprises five core components – joint engagement, spoken and nonverbal communication, behaviour management, daily living skills, and caregiver well-being – and uses both group and individual approaches.

Optional modules are available for children who have minimal spontaneous spoken language or comorbid conditions. While the modules are delivered in parent groups, tailored support is offered through goal-setting activities, one-on-one in-vivo coaching, and three complementary home visits.

The WHO CST is currently being adapted and tested in all WHO regions, and initial results indicate a strong need for the intervention. There is also evidence of good intervention feasibility and promise in promoting parent-child interaction, child communication, parental self-efficacy, and parental stress reduction. Additionally, a [self-learning version of the intervention](#) is available online, although further evaluation is required to understand its effects.



Step 2: Choosing an intervention

Step 2.1: Gather and synthesize information

- ✓ Bring together existing sources of information
- ✓ Map existing efforts: who is doing what, where, when, for whom, and why?

Step 2.2: Select and understand needs of target population

- ✓ Conduct a needs assessment
- ✓ Understand the barriers and enabling factors

Step 2.3: Develop a theory of change

- ✓ Define the problem that the parenting intervention aims to address, and the target population
- ✓ Determine the overarching goals of the parenting intervention
- ✓ Consider the factors that cause and perpetuate the problem
- ✓ Identify pathways to change based on the established theoretical frameworks and empirical evidence

Step 2.4: Identify key intervention components

- ✓ Consider different content needs for different developmental stages
- ✓ Consider different content needs for different contexts
- ✓ Promote gender-transformative parenting throughout the intervention

Step 2.5: Match objectives, intervention components, and target populations

- ✓ Identify existing intervention materials and guidance

Once stakeholders are engaged, the next step is to select the intervention. If there is already a clear goal and set of target outcomes for the intervention, then matching these goals and objectives to a theory of change and adapting it based on existing evidence may be relatively simple. However, if the best intervention components for the target population are still being determined, then evidence on the context in question may need to be gathered and synthesized.

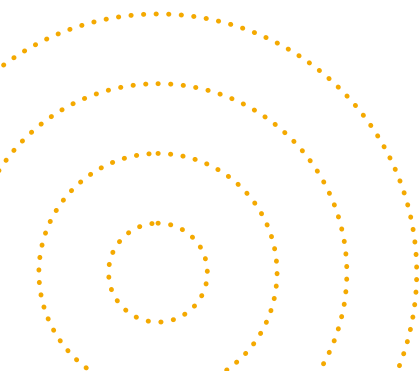
The following sections outline how to bring together information on needs, the objectives and theory of change of the intervention, and core intervention components to match an intervention to the target population.

2.1 Gather and synthesize information

To choose an intervention, decision-makers need to understand the scope of the issue they are seeking to address and who it affects most. Decision-makers may wish to address issues such as child development, family violence, mental health, or risky behaviour. Using violence prevention as an example, decision-makers would need to answer the following questions to identify evidence and select context-relevant interventions :

- What forms of violence affect children in the population?
- Where, when, and to whom does this violence occur?
- What risk factors contribute to a higher or lower risk of child maltreatment?

In addition to understanding the problem, decision-makers will also need to know what structures and actors are already working on this issue within their context – e.g. any legal, policy, or programmatic efforts that are in place to address child maltreatment.



What is the scope of the problem, who does it affect most, and why?

✓ **Compile existing sources of information**

The first step is to gather and synthesize data from different sources. As described in the next section, conducting a community needs assessment might be an ideal way to gather information in some contexts, but in other circumstances there may not be sufficient time or resources to take this in-depth route. A community-based approach may also be less feasible for national-level interventions where decision-makers are scaling up parenting interventions through the government. In these cases, existing assessments can help to understand the evidence within the context, such as VACS or Demographic and Health Surveys (DHS). Nonetheless, it is advised that even national-level interventions consider the needs and concerns of communities to assure adequate adoption and engagement at community level.

What legal, policy, and planning efforts currently address the problem?

The aims and objectives of an intervention should align with elements of any national or local action plans, including selecting goals, objectives, and targets, so that they can be endorsed by key stakeholders (see [Phase 1, Step 1](#), on stakeholder engagement).

Convening stakeholder groups and task forces can be a collaborative way for decision-makers to gather and synthesize evidence – for example by bringing together assessment data from different ministries or NGOs to get a full picture of the main forms and risk factors of child maltreatment, or by mapping existing evidence-based interventions or approaches already in use, their cost, and successful strategies for scaling up.

✓ **Map existing efforts: who is doing what, where, when, for whom, and why**

Several tools exist to help decision-makers bring together evidence and information from different sources. For example, the WHO-INTEGRATE Framework brings together evidence from across different sources for decision-making (93) and underpins the review of evidence that informs the WHO guidelines on parenting interventions to prevent maltreatment and enhance parent-child relationships with children aged 0–17 years (11). WHO's *INSPIRE: seven strategies for ending violence against children* handbook (47) offers guidance on how to work with multiple sectors that may sometimes have divergent goals through a series of simple steps, starting with having a thorough understanding of existing evidence. These and other frameworks can be helpful during advisory group meetings or stakeholder discussions in order to map existing efforts.

2.2 Select and understand needs of target population

Once the scope of the problem is clear, decision-makers should consider the prevention level (see [Step 2, Table 6](#)) of the intervention and the appropriate entry point – for example, a government ministry may decide to implement a parenting intervention to reduce levels of violence across all or part of their country. Alternatively, a municipality or NGO may plan for implementation in specific communities or localities for a selective intervention with an at-risk population.

At which level will the intervention be planned and implemented?

If intervening within a specific locality or region, assessing community or population needs is the basis for establishing strong collaborations and for effective co-adaptation. First, it is essential that proposed parenting initiatives respond to the expressed needs of target populations and are not imposed on communities. In addition, understanding the needs of a community or population is essential to decide how interventions should address contextual and cultural issues associated with such needs.

✓ **Conduct a needs assessment**

There are wide differences across communities, and as such there is no single way to assess community needs. In some contexts, a brief needs assessment (essential strategy) may be the ideal method based on the local context faced by service providers and other stakeholders. These assessments can be implemented relatively swiftly and take various forms, ranging from analysing existing health or social service databases or evaluating epidemiological indicators that indicate the need for implementing specific parenting initiatives (94, 95).

An advanced strategy might be to conduct a thorough needs assessment of target populations. These are particularly strong methods, as members of communities will express their goals for specific parenting interventions. For example, the development of the Parenting for Lifelong Health, CAPAS-Enhanced, and Growing Strong Together interventions included formative qualitative phases in which parents/caregivers from focus communities described the contextual challenges and opportunities associated with living in their communities, the cultural values and traditions they considered essential to their childrearing efforts, and their most pressing day-to-day parenting needs. These formative phases were helpful for the development of all three interventions as content and delivery approaches were fully informed by parents/caregivers' feedback (96, 97).

► Advanced strategy

Box 18. Conducting a community needs assessment and matching evidence-based knowledge with identified needs

Community needs assessments are a more in-depth method that requires considering additional questions:

- What aligns with the values, beliefs, and practices of the community?
- What methods are considered respectful by the local community?

From a collaborative design perspective, a community may express the need to have parenting interventions in accessible settings such as community centres, churches, and schools. Thus, the intervention-testing process must focus on evaluating the feasibility of implementation across the proposed settings. With regard to co-adaptation, an immediate need expressed by parents/caregivers is often the urgency to address child problematic behaviours by focusing on limit-setting, parenting skills, and discipline. However, a key principle across evidence-based parenting interventions is to first improve the parent-child emotional relationship and only when such a relationship has been improved it is appropriate to focus on discipline (81). Thus, families' expressed needs must fit with what research indicates constitute best practices in parenting interventions.

As a general principle, it is essential to encourage community leaders to define the priorities for their context and establish a needs assessment that is feasible, relevant to local leaders or structures, and aligns with the priorities of the target population (Box 18).

✓ Understand barriers and enabling factors

In addition to assessing community needs, decision-makers should consider how aspects of the context might influence how an intervention is implemented. The WHO-INTEGRATE Framework outlines criteria for integrating effectiveness evidence and other important factors to make decisions in a systematic way [93]. These criteria include:

- balance of benefits and harms;
- human rights and sociocultural acceptability;
- health equity, equality, and non-discrimination;
- societal implications;
- financial and economic considerations;
- feasibility and health system considerations.

Where possible, it is beneficial to gather information on existing services and whether they reach all children and families who may need them, regardless of age, sex, gender identity, language, religion, disability, and economic status. This information can be used to prioritize the highest-risk groups and fill existing gaps in service provision (47).

2.3 Develop a theory of change

The next step is to establish objectives and identify or develop an intervention theory of change, which can help determine how a parenting intervention will lead to positive outcomes for a target population. A well-articulated theory of change is important for effective intervention planning and evaluation, as it identifies and defines the underlying causal mechanisms of the parenting intervention and provides a clear framework for monitoring and evaluating intervention effectiveness.

What is the overall objective of the intervention and how will it be achieved?

An intervention's theory of change can be based on context and needs assessments, and empirical evidence and established theories, including attachment theory and social learning theory, as discussed in the [Overview section](#). As an essential strategy, decision-makers may wish to adopt an existing evidence-based intervention, making only surface-level adaptations, and thus incorporate its theory of change rather than develop their own. As part of this step, it is advisable that a stakeholder or expert group reviews the existing theory of change to check its applicability to existing goals and contexts.

In contrast, an advanced strategy would involve four steps in creating an intervention theory of change tailored to the current need and context (98). Ideally, this theory of change would be developed and refined through continuous consultation and feedback from stakeholders ([Phase 1, Step 1](#)) and routine programme monitoring and evaluation (M&E) ([Phase 3, Step 5](#)).

✓ Step 1: Define the problem that the parenting intervention aims to address, and the target population

Decision-makers should base this on the information gathered through existing data or a needs assessment, such as the high prevalence rate of child maltreatment in the local context. The population can be all families in the region, families who are deemed to be at higher risk of maltreatment due to complex needs, or others (refer to [Phase 2, Step 3](#) for deciding who to support).



✓ **Step 2: Determine the overarching goals of the parenting intervention**

Decision-makers should ensure that the goals are specific, measurable, and attainable. For example, in response to high rates of child maltreatment, the goal may be to decrease its prevalence.

✓ **Step 3: Consider the factors that cause and perpetuate the problem**

This requires drawing on evidence about risk and protective factors for the problem. For instance, research has found that parents/caregivers who make internal and stable negative attributions about their children's challenging behaviours and have higher than normal expectations of their children are more likely to use violent disciplinary practices (these are risk factors) (99, 100). Conversely, children with a secure attachment style are less likely to develop behavioural problems (this is a protective factor) (101–103).

✓ **Step 4: Identify pathways to change based on established theoretical frameworks and empirical evidence**

This involves exploring whether the risk factors are amenable to change and the protective factors can be enhanced.

For instance, the intervention may target negative parental attitudes and expectations by providing information about child developmental stages and behaviours, and support parents/caregivers in fostering positive parent-child relationships and strengthening attachment bonds to prevent child behavioural problems.

After completing these four steps, decision-makers may want to create a simplified theory of change for the parenting intervention. A visualization of this might look like the essential strategy example in Fig. 3.

A theory of change for a parenting intervention is much more complex than a simple diagram can depict and will likely include many additional components. For example, Fig. 4 illustrates the theory of change of the [Safe at Home intervention](#), which was developed by the International Rescue Committee in North Kivu, Democratic Republic of the Congo, for use in conflict settings to address co-occurring intimate partner violence and child maltreatment. This advanced strategy sets out how change happens – from initial changes in knowledge, skills, attitudes, and environment, which lead to changes in behaviour, and which eventually help improve gender equity and security of the home environment for women and children.

Fig. 3. Example of a basic intervention theory of change (essential strategy)

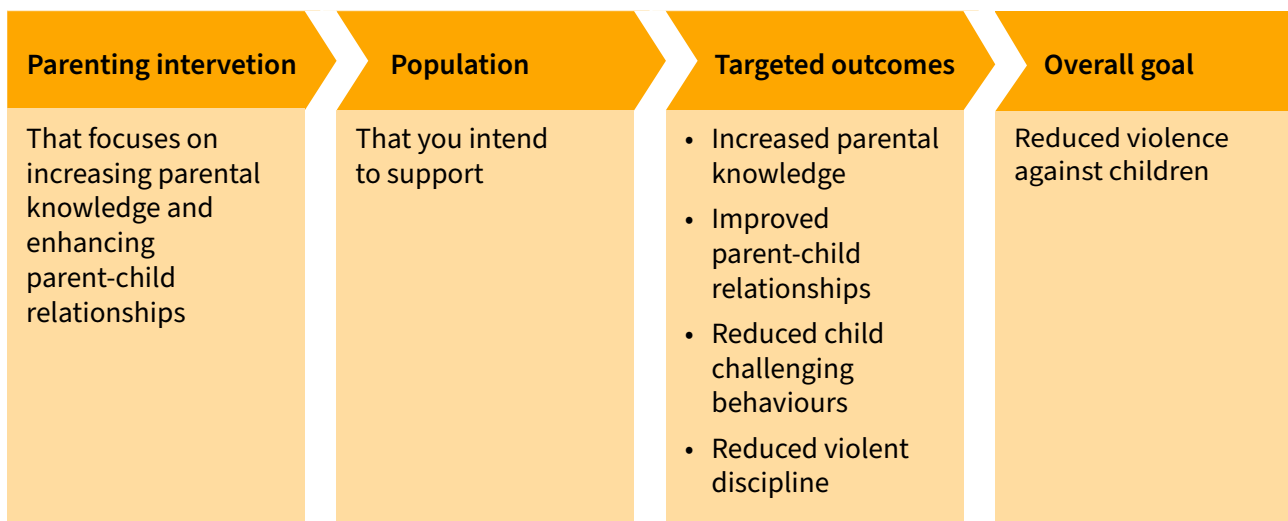


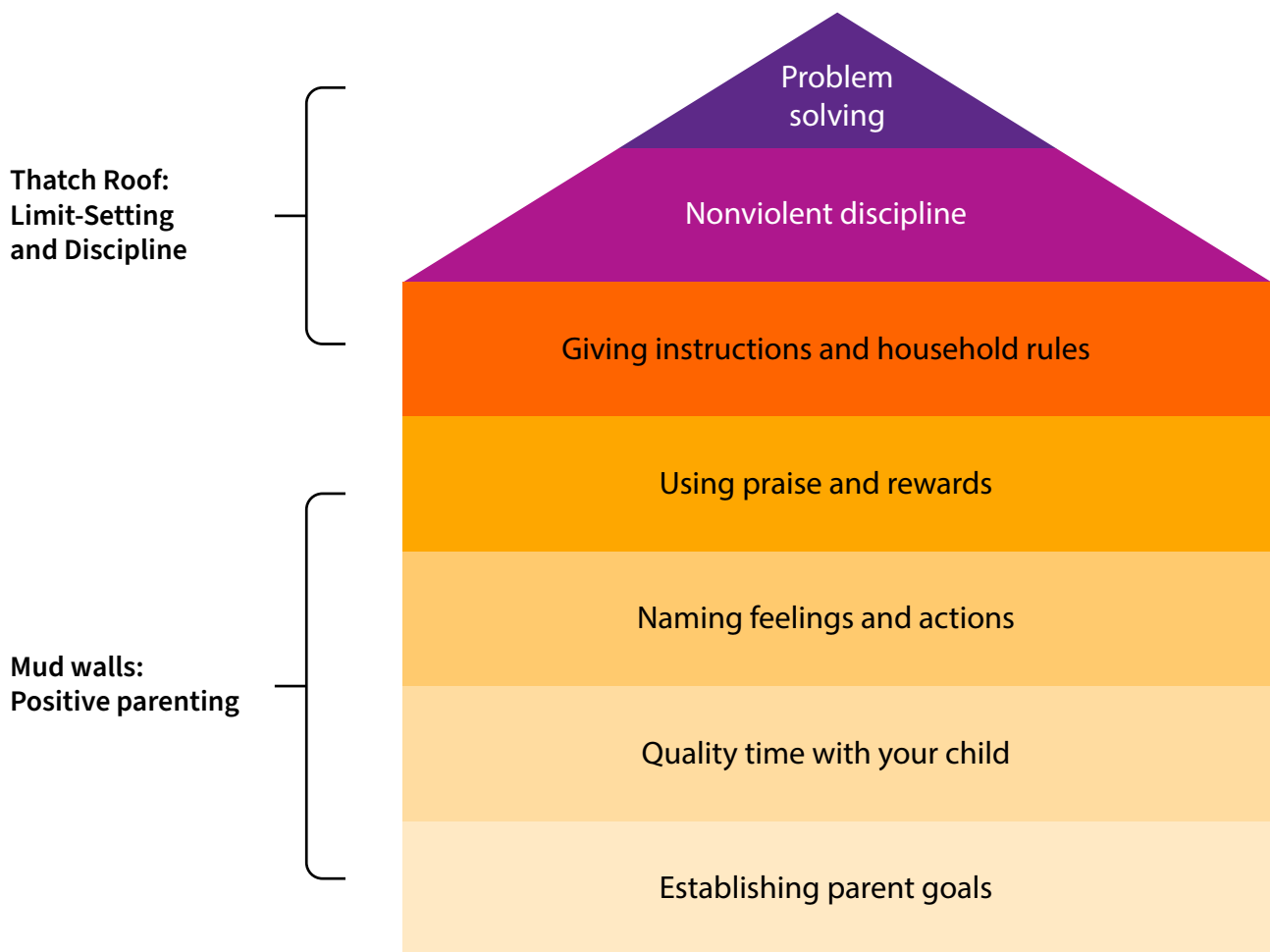
Fig. 4. Example of an advanced strategy to create a theory of change: safe at home intervention



Abbreviation key: IPV – intimate partner violence

Source: Reproduced from International Rescue Committee (IRC) Safe at Home. Module 1, Introduction to Safe at Home (21), with kind permission from the IRC. IRC notes that Safe at Home should always be implemented in settings where services to which victims/survivors of child maltreatment and gender-based violence can be referred for care.

Fig. 5. Example of an accessible theory of change model for facilitators and parents/caregivers



Source: Reproduced from Parenting for Lifelong Health for young children – facilitator manual (104), with kind permission from Parenting for Lifelong Health.

Sometimes a theory of change model for a parenting intervention can be presented in a format that is easy for both facilitators and participants to interact with and understand. For example, the Parenting for Lifelong Health interventions (104) use a House of Support model to illustrate the two-stage approach to behaviour management training developed by Hanf (105) that underpins many social learning-based parenting interventions (Fig. 5). The House of Support is introduced to participants at the beginning of the intervention using the metaphor, “If the foundation of the house is strong, the roof will be easier to maintain.” This helps facilitators and parents/caregivers understand how focusing on positive parenting skills that improve parent-child relationships (e.g. one-on-one time with your child, naming feelings and actions, using praise and rewards, etc.) can reduce negative child behaviours, which will in turn make discipline less necessary. This is an important step prior to learning nonviolent strategies (e.g. redirecting, ignoring negative attention-seeking and demanding behaviours, using appropriate consequences, and involving children in resolving conflicts). While this model is simplified, it is an effective tool for use in discussions about the intervention objectives with participants.

2.4 Identify intervention components

The central idea behind parenting interventions is that improving parenting behaviours can have a positive impact on children and adolescents. Regardless of whether the goal is to address child maltreatment, behavioural problems, or promote child development, the main focus is always on improving parenting practices. This results in a central question for decision-makers: what intervention content is essential in parenting interventions?

What components are essential in parenting interventions?

The [Overview](#) section introduced how practical parenting interventions for parents/caregivers draw on social learning and attachment theory. For example, social learning theory informs the use of proactive parenting strategies and nonviolent disciplinary techniques, which can reduce parent-child conflict and child problem behaviour (105).

Likewise, attachment theory guides the creation of techniques aimed at strengthening parent-child bonds through positive interactions and parental responsiveness and sensitivity.

In addition to modifying parenting behaviours, parenting interventions may involve psycho-education to help parents/caregivers understand child development and the significance of positive parent-child interactions, alongside content aimed at cultivating child socioemotional and cognitive skills or improving parents/caregivers' own well-being. Research has demonstrated that the quality of parenting is strongly linked to parental well-being, with caregiver mental health issues being a predictor of dysfunctional parenting practices (106). This underscores the importance of promoting the health and emotional well-being of parents/caregivers, which is increasingly recognized globally (107). Evidence from WHO's parenting guidelines shows that participating in an

evidence-based parenting intervention enhances mental health, and that these interventions reduce parent/caregiver symptoms of depression and anxiety.

Table 3 provides an overview of the essential components typically included in evidence-based parenting interventions (105, 108–111). It is worth noting that the number of techniques taught or sessions included in a parenting intervention do not necessarily correspond to effectiveness (112). Decisions regarding content to be included should be based on strong evidence, the needs assessment, and theory of change.

While there is no established standard for the sequencing of sessions in parenting interventions, research evidence recommends starting with building positive parent-child relationships and cultivating child skills before moving on to disciplinary procedures, such as proactive parenting and nonviolent discipline (105).

Table 3. Essential components of evidence-based parenting interventions

Schemes	Components/ techniques	Explanations during early and middle childhood (0 to 10 years)	Explanations during adolescence (11 to 19 years)
Psycho-education Strategies to teach concepts and provide information about parenting and child development to parents/caregivers and children	Knowledge of child and adolescent development	Learning about typical child physical, cognitive and emotional development, behaviours, and needs	Learning about puberty, sexual development sexual and reproductive health and risk-taking. Communication and understanding about ongoing developmental changes and communicating about future life decisions
	Knowledge of parent-child/ adolescent interactions	Understanding the coercive parent-child interaction cycle and the importance of positive parent-child interactions	Creating an atmosphere of mutual trust, honesty and respect. Creating a culture of open communication (e.g. at family mealtimes)

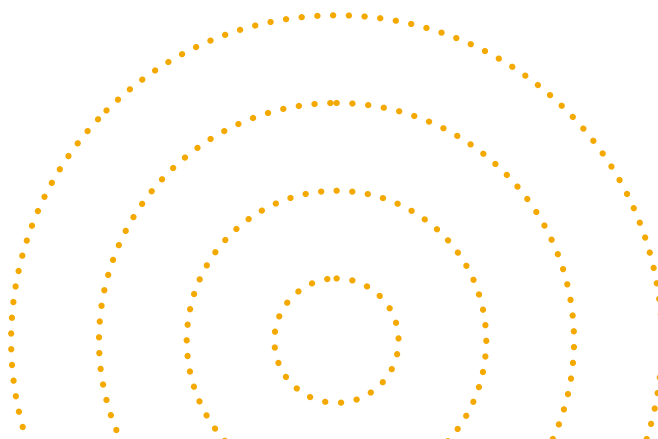


Table 3 (continued). Essential components of evidence-based parenting interventions

Schemes	Components/ techniques	Explanations during early and middle childhood (0 to 10 years)	Explanations during adolescence (11 to 19 years)
Relationship building Strategies to build and strengthen positive, nurturing, responsive relationships between parents/caregivers and children	Quality time together	Spending time with the child e.g. through child-led play or engaging children in interactive household chores	Enhancing a reciprocal and responsive relationship, including spending time with each other, quality time and allowing for growing independence
	Active listening	Paying full attention to what the child is conveying, and providing verbal and nonverbal feedback to show that they are heard	Demonstrating interest and showing the adolescent that they are respected, and that their thoughts and feelings are valid and worthwhile. Being fully present in the conversation, not interrupting, listening mindfully and asking thoughtful questions
	Empathy building (getting to know the child and understanding how they feel)	Understanding the child or adolescent's perspective and how they perceive the world, bonding with them to support them with friendship conflicts, school pressure etc. Helping them develop empathy and coping skills to help navigate their unique set of stressors. Allowing age-appropriate independence and assertiveness	
Positive reinforcement Strategies for parents/caregivers to reinforce positive, desirable behaviours in children	Praise (verbally praising the child when they show a positive behaviour)	Verbally praising the child or adolescent when they show positive behaviour, giving encouragement and taking an interest. Praising openness when the child or adolescent admits bad behaviour	
	Reward	Offering the child tangible (e.g. a toy) or intangible (e.g. a kiss) rewards when they exhibit positive behaviour	
Proactive parenting Preventive strategies for parents/caregivers, e.g. to employ distraction, or communicate boundaries and consequences for crossing them to empower children	Positive and direct command	Giving the child positive (e.g. use "do" rather than "don't"), simple, clear, and age-appropriate instructions using a calm and non-imperious voice	Talking about solutions and focusing on possibilities
	Household rules	Letting the child know what behaviours are expected and why	Rules about communication and behaviour are age-appropriate and agreed with the adolescent
	Routines	Creating and practicing daily routines with the child to create a sense of security	Preventing conflict by keeping rules and limits consistent
	Monitoring and supervision	Knowing and supervising what the child does with whom	Active awareness and some control of whereabouts, activities and friendships

Table 3 (continued). Essential components of evidence-based parenting interventions

Schemes	Components/ techniques	Explanations during early and middle childhood (0 to 10 years)	Explanations during adolescence (11 to 19 years)
Nonviolent discipline Strategies to respectfully and safely address a child's resistance, lack of cooperation, problem behaviour and to support appropriate behaviour	Time-out	Removing children from where the negative behaviour occurs and not offering them any attention, interaction, or fun things (use with caution)	Age-appropriate consequences for not meeting agreed expectations for communication and behaviour
	Ignore	Ignoring negative behaviours (e.g. attention-seeking or demanding) by not talking about it and pretending not to see it	
	Redirect	Redirecting the child's attention from negative behaviour to another activity (e.g. positive behaviour) to prevent the negative behaviour from occurring	
	Consequences	Letting the child know or experience the natural consequences of a negative behaviour (e.g. "if you jump in the puddle, your feet will be cold and wet"), or setting a realistic logical consequence for a negative behaviour (e.g. "if you play on the tablet for more than an hour today, you cannot hang out with your friends tomorrow")	
Child and adolescent social-emotional learning A process of acquiring social and emotional values, attitudes, competencies, knowledge, and skills for children and adolescents		Developing the child's physical, cognitive, and linguistic development	Strengthening abstract, reasoning, and logical thinking
		Teaching the child to recognize, describe, and handle different emotions	Coaching emotion-regulation skills, such as accepting or managing negative feelings
		Teaching the child how to interact with others	Emerging engagement in decision-making, problem-solving and coping strategies, in line with capacity
		Teaching the child how to deal with daily problems	
Caregiver well-being Strategies to support parent/caregiver emotional well-being and mental health, which enable them to provide responsive caregiving	Emotional regulation	Helping the caregiver understand and regulate their own negative emotions (e.g. anger, stress, depression, or anxiety)	
	Problem-solving skills	Helping the caregiver develop strategies (e.g. shared decision-making and effective communication) to cope with daily challenges, such as family conflicts	
	Mental health	Referrals to mental health services, as needed	
	Intimate partner relationships	Supporting positive intimate partner relationships between caregivers, such as sharing responsibilities, open communication, and conflict resolution	

✓ Consider different content needs for different developmental stages

Parenting intervention components should be tailored to reflect and respond to the specific needs of children at different stages of development (113). For infants and toddlers, emphasis should be on understanding and supporting children through developmental milestones, establishing secure attachment, and providing nurturing care, which includes responsive caregiving, good health, adequate nutrition, a safe and secure environment, and opportunities for early learning (114). For young children aged 2–10 years, parenting interventions informed by social learning theory that combine nurturing, responsive parenting with proactive and nonviolent practices to support positive child behaviour and development are most suitable (1). Adolescence is characterized by increased conflict with parents/caregivers and more risk-taking behaviours, making effective communication, better decision-making (e.g. around safe sex, substance use), and improving mental health critical components of parenting interventions for parents/caregivers of adolescents (1, 115). Moreover, the use of each technique should be tailored to match the child's age, as the way to spend quality time and set household rules with a 6-year-old is different for a 15-year-old (Box 19 highlights Familias Unidas, an intervention that addresses risky behaviours among adolescents that was recently evaluated in Chile (116) and Ecuador (117)). Nevertheless, it is essential that interventions have flexibility built into them, as even among teenagers, families will have different needs related to the specific age of each child and other contextual factors and preferences. Hence, many interventions avoid “scripting” parenting strategies for parents/caregivers but instead guide parents/caregivers to generate their own solutions based on learning about parenting principles, and problem-solving around how these might best translate to their own situation.

► Moderate strategy

Box 19. Preventing high-risk behaviours among adolescents in Latin America

Familias Unidas is an evidence-based substance use and sexual-risk behaviour preventive intervention for families of Hispanic youth, developed by the University of Miami. It has been widely implemented in Latin America and the Caribbean, and recently evaluated in Chile and Ecuador.

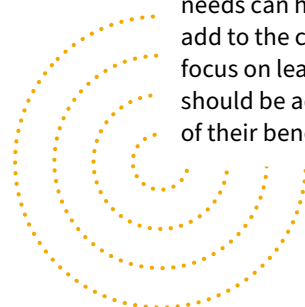
Familias Unidas was first tested using an RCT in Chile between 2016 and 2019 with 240 families and has since become public policy in the country. Findings confirmed that the intervention, which focuses on improving parenting skills such as effective behaviour management, effective communication, and parental involvement, can have a short- to medium-term impact (between 24 and 36 months after the intervention)

on risky behaviours among adolescents, such as substance use and sexually risky behaviours.

However, a recent study looked at the effects of Familias Unidas (n=129) over time compared to community practice (n=110) in Ecuador. Results showed that while the Familias Unidas intervention did have a positive impact on family functioning, it did not directly impact adolescent conduct problems when outcomes were assessed at a six-month follow-up with participants. Therefore, the intervention's effect on adolescent behaviours needs to be tested through further studies.

✓ Consider different content needs for different contexts

Depending on the needs and theory of change, parenting interventions may incorporate additional content to address age- or context-specific challenges. For instance, the Parenting for Lifelong Health intervention for parents and adolescents includes budgeting sessions to improve financial literacy and stability for families (118, 119). The Incredible Years School Age Basic parenting intervention offers parents/caregivers advice on how to partner with teachers to collaboratively foster children's learning skills and promote academic success (120). It should be noted however, that adding additional sessions on broader needs can have drawbacks as well as benefits as they may add to the cost of the intervention and may decrease the focus on learning parenting skills. Thus, additional topics should be added only with careful thought and evaluation of their benefits.



✓ Promote gender-transformative parenting throughout the intervention

Parenting interventions also provide crucial opportunities to address gender-based violence and reduce exposure to gender-specific risk factors for violence, such as maternal burnout resulting from sole child care responsibility, which increases the risk of child maltreatment. Children learn discriminatory gender norms from parents and caregivers, through their language (e.g. telling girls to “stop being bossy” or to “act like a lady”) and their actions (e.g. assigning only mothers to child care and household chores). To prevent negative gender stereotypes continuing into the next generation, it is important to integrate gender-transformative parenting into all intervention components (121, 122).

This extends beyond engaging male parents/caregivers in child care and involves increasing awareness of gender stereotypes, addressing harmful gender norms and attitudes, and promoting positive gender norms throughout the intervention. For instance, equitable distribution of resources and opportunities for children of all genders can be encouraged, such as allocating equal play time to boys and girls and avoiding associating certain activities with a specific gender. For parents/caregivers of adolescents, an intervention might offer guidance on discouraging stigmatization around puberty and discussing gender equity and sexual identity with their child. Moreover, it is critical to highlight the evidence that shows fathers’ involvement directly benefits children (123, 124) and to support male participation in caregiving. This presents an opportunity to encourage balanced sharing of caregiving responsibilities and to model gender-equitable behaviours at home. [The REAL Fathers Initiative](#) is an example of an evidence-based parenting intervention that promotes gender-transformative parenting (125) (Box 20).

► Advanced strategy

Box 20. Promoting gender-transformative parenting in Uganda

The Responsible, Engaged, and Loving (REAL) Fathers Initiative aims to reduce violence against children, and intimate partner violence, and is designed for young men aged 16–25 years who are transitioning to fatherhood. The intervention focuses on promoting equitable gender norms, positive couple relationships, and nonviolent and positive parenting practices for fathers. Respected men in the community are identified and trained as mentors who provide group sessions and home visits to young fathers. In addition, monthly broad-based campaigns are conducted to reinforce key messages and create a supportive environment for positive gender norms.

[REAL Fathers](#) has been developed, piloted, and scaled-up in Uganda since 2013 and is currently being adapted in India. Evidence from Uganda indicates that the intervention is effective in reducing violence against women and children (125).

How should a parenting intervention be facilitated?

Effective parenting interventions focus on behaviour change rather than only providing parents with information. At the essential/minimum level, parents/caregivers should be provided with ample opportunities to practice and reflect on these skills, supported by trained facilitators who deliver the intervention (110). Depending on available resources, parenting interventions can also use a variety of delivery techniques that combine didactic and interactive approaches to assist parents/caregivers in reinforcing skills and information. Some common delivery techniques are listed in Table 4.

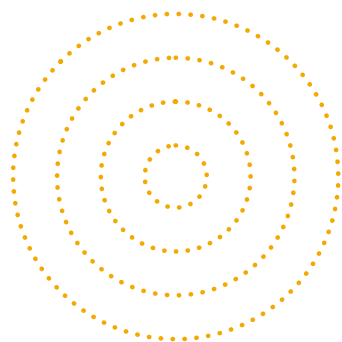


Table 4. Types of facilitation techniques for parenting interventions

Facilitation techniques	Explanations
Setting goals	Facilitators explain the session's purpose and work with parents/caregivers to establish their objectives
Didactic teaching	Facilitators explain intervention content to parents/caregivers
Observing and reflecting	Facilitators observe and discuss parent-child interactions (e.g. based on video or on direct observation if children are present)
Modelling	Facilitators demonstrate the application of parenting skills
Practicing or role-playing	Parents/caregivers practice skills with their child (if present) during the session or role-play with a facilitator, another caregiver, or an inanimate object
In-vivo feedback	Facilitators offer feedback immediately after parents/caregivers' practice or role-play
Home practice	Parents/caregivers practice skills at home, sometimes with provided handouts or devices to record progress and reflections
Group discussion	Parents/caregivers share and discuss challenges and coping strategies
User-friendly materials	Parents/caregivers receive easy-to-understand intervention materials such as posters and cards

2.5 Match objectives, intervention components, and target populations

Determining what components are best for the target population requires matching the goals of the initiative with intervention components or theories of change that have been tested in similar contexts, ideally while also considering the needs of target communities.



What interventions exist from similar contexts that could be adapted?

✓ Identify existing intervention materials and guidance

After choosing a strategy that matches the aims of the initiative and existing evidence, decision-makers can identify intervention materials and guidance relevant to their context.

Depending on the context, there are typically two ways to do this:

- A systematic mapping and appraisal of interventions (where time and resources allow, Box 21).
- Sourcing original materials, guidance, and evidence directly from intervention developers or implementers and using the tools specifically designed for the intervention.

Through the mapping and appraisal of evidence-based interventions, decision-makers can begin to identify the core components of their intervention. Mismatches between the original intervention model and the context in which it will be rolled out can also be identified and categorized, including what adaptations might be needed.

► Moderate strategy

Box 21. Convening a task force to establish national parenting guidelines in Kenya

The Kenyan government undertook a process to develop the National Parenting Programme, which consists of guidelines, an intervention manual, and population-level messaging as part of a larger initiative to reduce child maltreatment during COVID-19. To develop the intervention curriculum, the Kenyan government held a workshop in 2021 with support from UNICEF, the Global Partnership to End Violence against Children (End Violence), and other partners. At the workshop, organizations providing parenting interventions nationally were invited to submit their intervention materials and present their work for consideration.

The workshop enabled the government to understand which actors were working in parenting nationally and to identify evidence-based interventions on which to base the national programme. After the presentations and a desk review of interventions, the Kenyan Department of Social Development evaluated possible interventions based on two main criteria: an intervention with 1) a rigorous evidence base and 2) that could be implemented through government-linked community structures. After deliberation with the nationally representative Technical Working Group, the ICS Skilful Parenting curriculum was selected as the basis for what would become the National Parenting Programme Manual.

Mapping parenting interventions with a representative advisory group in Uganda

The Ugandan Ministry of Gender, Labour, and Social Development (MGLSD) started the initiative to develop a Ugandan National Parenting Programme in 2019, funded by the Oak Foundation, UNICEF, and End Violence. As part of this initiative, the MGLSD and the Child Health Development Centre (CHDC) in the College of Health Sciences at Makerere University established the Parenting Agenda Initiative, a three-tiered structure of over 70 organizations including government ministries and CSOs. The first activity of the Parenting Agenda Initiative was to conduct a comprehensive mapping of national parenting interventions. The mapping comprised a desk review and survey to identify existing parenting interventions, their origin, location, services, effectiveness, and providers.

Based on the findings of the mapping report, the Parenting Agenda Initiative determined the need for National Parenting Standards to establish the guidance required for an intervention to be effectively implemented. This would include minimum standards for a parenting intervention and provide a regulation and quality control framework for interventions that were already operating. In addition, the mapping report revealed the need for an evidence-informed manual on how to implement parenting programmes, resulting in the subsequent development and testing of the National Parenting Programme Manual.

How to match evidence-based interventions with context and needs

Light-touch, essential strategies for parenting interventions might include skill-building techniques based on attachment and social learning theories, allowing flexibility to customize the content based on child age, participant preferences, and contextual factors, as well as avoiding “scripting”. Where a moderate strategy is used, parenting interventions may integrate skill-building with the acquisition of information, attitude change, enhancement of child skills, and promotion of caregiver well-being. However, it is again important to note that simply adding more parenting components to an intervention does not guarantee greater effectiveness.

A more advanced strategy might consider rolling out multiple interventions as part of a system of delivery. Parenting is influenced by various factors, such as parental poor mental health, family poverty, intimate partner violence, and harmful gender norms (100, 126–132). On the other hand, family-friendly policies, accessible services, and community cohesiveness can help prevent child maltreatment (133–136). Some interventions are designed to tackle multiple issues simultaneously. For example, the Safe at Home intervention (pages 28 and 48) aims to address both intimate partner violence and violence against children. While it may not always be feasible to tackle multiple factors within a single parenting intervention, it is possible to coordinate with other services to enhance the intervention’s impact.

In any matching process, essential intervention components should be retained as much as possible (47). This process is called preserving fidelity, which means implementing the intervention with all the components and characteristics that made it successful in the first place, such as the theory of change, core contents, learning methods, and the means of delivery. However, decision-makers will need to balance preserving fidelity with the adaptations necessary to match the priorities, needs, and expectations in the context of where the intervention will be implemented.

[Phase 1, Step 1.2](#) provides an overview of different types of cultural adaptation, including surface-level and deep-structure adaptation. Some adaptations will have a bigger influence on the fidelity of the intervention than others. Acceptable versus risky adaptations include those in Table 5 (as outlined in WHO's *INSPIRE Handbook: action for implementing the seven strategies for ending violence against children* (47)).

Interventions may differ depending on the evidence from each context and how it matches the needs of the target population. While substantially changing the intervention from location to location may compromise effectiveness, some flexibility may be needed to ensure that intervention

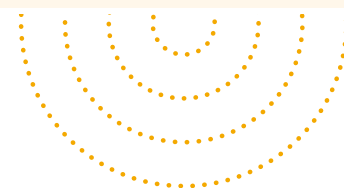
components are feasible to implement. In large countries, the intervention design should be flexible enough to be decentralized at regional, county, and village levels so that they can be appropriate for implementers and participants and reach all individuals who need them (47). Allowing an intervention to be adapted to be more culturally relevant and feasible to local contexts may also be essential to its scale-up.

The CAPAS-Enhanced intervention ([Phase 1, Step 1.2](#)) represents an advanced strategy to incorporate the community's expressed needs. This field example demonstrates the need to adapt the intervention to take account of the cultural and immigration-related challenges expressed by parents/caregivers in the qualitative study. To this end, adapters incorporated sessions focused on discussing immigration-related stressors, such as the ways in which parenting practices were negatively impacted by racial discrimination, work exploitation, and social isolation. Parents/caregivers also expressed how cultural values highlighting the importance of family and respect for others helped to buffer them against such immigration-related stressors. Sessions on promoting cultural strengths were therefore added into the curriculum.

Table 5. Acceptable and risky adaptations

Acceptable adaptations	Risky and generally unacceptable adaptations
<ul style="list-style-type: none"> • Translating materials into local languages and refining vocabulary accordingly • Using culturally relevant images in manuals to increase ethno-cultural matching (e.g. parents resembling the target population) • Using cultural references, including images and graphics, to increase resemblance to local people, places, and customs • Changing aspects of activities such as physical contact to correspond with local norms • Making references to expectations of interactions according to local norms and expectations (e.g. physical contact). Adding local and culturally focused evidence-based content to increase the relevance and appeal to participants • Adapting methods to deliver information according participants' literacy or access to technology 	<ul style="list-style-type: none"> • Reducing without appropriate justification the length of time for which participants are involved in the intervention (e.g. the number or length of sessions) • Eliminating key messages, constructs, or skills that must be learned • Removing topics that account for the effectiveness of interventions • Altering the theoretical approach without justification • Trying to implement the intervention with inadequately trained staff or volunteers • Using fewer than the recommended number of staff

Source: (47)





Cape Town, 2012 © WHO/Alexandra Swanepoel

Phase 2.

Intervention implementation



Step 3: Delivering the intervention

Step 3.1: Identify participating families and engagement strategies

- ✓ Identify the level of participation: universal, selective, or indicated
- ✓ Determine strategies to recruit and engage participants
- ✓ Encourage stakeholders to raise awareness, refer participants, and provide support to them
- ✓ Make intervention activities accessible for participants
- ✓ Get feedback from stakeholders on barriers to access and how to address them

Step 3.2: Determine intervention delivery platforms, methods, and frequency

- ✓ Work with community-led groups or CSOs
- ✓ Use formal service delivery systems
- ✓ Align with the intervention's theory of change
- ✓ Assess available resources, in line with the selected delivery platform

3.1 Identify participating families and engagement strategies

Parenting interventions are typically delivered at one of three different prevention levels: universal, selective, or indicated (Table 6). Ideally, parenting interventions are offered at a universal level, as they have many benefits for a wide range of children and parents/caregivers when delivered across different services (including health, education, social welfare), and through civil society channels. However, a particular intervention package may be more beneficial if delivered only to the families and communities who need it the most. These could include (among other specific groups) parents/caregivers who use violence to discipline their children; families with adolescents who are joining gangs; families living in humanitarian settings; or families living in poverty (10). It may also be possible to design an intervention that is adaptable across universal, selective, and indicative levels so that parents/caregivers receive more intensive components where and when necessary. For example, a study in Michigan, USA, gave parents/caregivers the choice between three different formats of the GenerationPMTO intervention and found improved child hyperactivity/inattention outcomes as a result of the different available models (137).



Table 6. Levels of prevention for parenting interventions

	Prevention level	Example
Universal interventions	Beneficial for all families with no specific characteristics	All families within a school are eligible to participate in the intervention
Didactic teaching	Beneficial for parents/caregivers or families “at risk” for higher levels of maltreatment or worse consequences because of their complex needs, such as being in poverty, being forced migrants, or being HIV-positive	Migrant families living in an informal shelter Child is at risk of recruitment by an armed group Children and families in a community with high levels of deprivation and poverty
Indicated interventions	Beneficial to parents/caregivers or children who are referred for services or identified for additional support, for example because they currently use violence within their home or are experiencing difficulties with child behaviour	Parent with a mental health condition Adolescent in contact with the juvenile justice system Child with marked behaviour problems

✓ **Identify the level of participation: universal, selective, or indicated**

The following questions can help to decide who to include in the intervention (138):

- What group of parents/caregivers and/or children should be involved in the intervention activities? Will it be universal, selective or indicated?
- Will the intervention be delivered to parents/caregivers only, or will children also be involved?
- Should male parents/caregivers or other household members participate?

✓ **Determine strategies to recruit and engage participants**

Once the level of participation is decided, determine which population will participate in the intervention and how to recruit them by identifying what will make potential parents/carers want to participate.

Strategies to recruit and engage participants

Common motivating factors for participation are the timing of the intervention activities, buy-in from the community and family, and a sense of commitment and readiness for change (138). Addressing the following considerations can help successfully recruit and retain parents/caregivers:

- Identify what recruitment strategies are likely to work best, and in what format (e.g. face-to-face, posters, radio, or a combination).
- Decide if different recruitment strategies are needed for male and female parents/caregivers.
- Identify potential referral pathways for parents/caregivers (e.g. workplaces, schools, clinics, faith-based organizations, etc.).
- Find out the most convenient time and place for the intervention to take place, and consider if it could be held in a venue where parents/caregivers already gather for other purposes (Box 22).



Box 22. Locating interventions where parents/caregivers already gather

One strategy to improve intervention accessibility is to hold activities where parents/caregivers already gather. Examples of this approach across different settings include the following.

Tanzanian NGO [Investing in Children and Their Societies](#) (ICS-SP) delivered parenting interventions to parents attending an existing farmers' group. These groups typically discussed farming methods and supplied low-cost seeds to farmers. Embedding the group-based parenting intervention Skilful Parenting in these groups was found to be acceptable to parents, effective in an RCT, and successful at engaging a much higher proportion of men than other parenting interventions.

And as part of the government-run Conditional Cash Transfer system in the Philippines, parents attend a fortnightly parent group at a centre and thereby qualify for the cash transfer. Parenting for Lifelong Health for Young Children was embedded in this system, with parents attending a 12-session fortnightly intervention. It was found to be acceptable to parents, and effective in an RCT. Parenting interventions have also been implemented and evaluated in other frequented locations, for example, the Happy Families initiative in churches in Kenya and Triple P in the workplace in Australia.

Box 23. Raising community awareness of parenting support in Touwsrante, South Africa

The Institute for Security Studies (ISS) and the Seven Passes Initiative undertook a violence prevention project using a [whole-community parenting strategy](#) in Touwsrante, a low-income rural township in South Africa. The whole-community strategy involved a combination of group-based parenting interventions in community venues and working with the community to identify the best ways to spread parenting messages to families throughout the township. Parents generated ideas for publicizing the parenting strategy, such as displaying parenting messages and logos at the local clinic, on notice boards and windows, and through song.

A steering committee was established to guide community members interested in participating in parenting-change processes. Parenting messages were further refined by the community, for example a logo depicting children being held aloft by the community with the slogan “working together for a better community” was created. This was reproduced as a sticker and as design on T-shirts that included parenting slogans “I am a positive father”, “I am a positive mother” and “Working together for positive parenting”. The parenting songs were set to music, recorded at a studio, and sung at community meetings and on local radio.

✓ **Encourage stakeholders to raise awareness, refer participants, and provide support to them**

One approach for generating demand is to leverage partnerships with stakeholders to raise awareness, refer families using services in other sectors, and provide holistic support for families. Local ministry officials and CSOs who are already conducting activities with the target populations are a useful entry point for creating interest among potential participants or directly referring parents/caregivers to the intervention. For example, an intervention at the selective prevention level for parents/caregivers of young children aged 0–3 years could work with the health sector to identify and recruit mothers receiving antenatal care in health clinics. Interest in the intervention could also be generated through broader community engagement activities including media or information campaigns, and community mobilization (139) (Box 23).

Enhancing accessibility for participants

Interventions must be accessible for participating families – especially those living in poverty or with complex needs who may be deterred by factors such as transport costs, lack of child-care support, taking time off work, and health challenges (11).

✓ **Make intervention activities accessible for participants**

Help ensure interventions are accessible to families most in need through, for example:

- offering material support to allow parents/caregivers to participate (e.g. providing meals, food coupons, or payment for transport costs, and choosing accessible locations and timing);
- making sure the venue and timing for in-person group sessions are accessible (e.g. distance from participants' homes, disability-inclusive venues, consideration for working parents/caregivers, and running intervention activities in the daytime if the venue may be unsafe at night);

- improving outreach through digital or hybrid interventions (see next section, “Determining delivery platforms, methods, and frequency”);
- providing additional intervention components for vulnerable or age-specific populations (e.g. trauma-sensitive elements for displaced populations, or resources for parents/caregivers to talk about alcohol and drug use or sexual exploitation for adolescent-focused interventions) (93, 138).

✓ **Get feedback from stakeholders on barriers to access and how to address them**

During the planning phase it may be helpful to discuss potential accessibility concerns with stakeholders across different sectors, and regardless of the level of intervention (universal, selected, indicated). This may involve strategies that enhance access for all (e.g. providing a meal), or strategies that selectively help the most disadvantaged families (e.g. child care for lone parents/caregivers, or transport for those who need it). As described in [Phase 1, Step 1.3](#), dedicated outreach and planning for parents/caregivers and children who are part of marginalized groups or minoritized populations are also necessary to ensure equal access to, and participation in, the intervention.

3.2 Determine delivery platforms, methods, and frequency

The next step is defining the delivery platform, format, and frequency/length of the intervention components. When deciding how a parenting intervention will be implemented, the following questions should be considered.

What existing accessible and trusted platforms can be used?

Choosing the right delivery platform for an intervention can help increase reach and sustainability, be it a CSO, CBO, or an existing formal service delivery system such as educational institutions, social protection systems, and health systems. Considerations on what platform to use include whether the platform:

- is ready to integrate the intervention without disrupting its existing services, including staffing, resources, and capacity;
- demonstrates strong leadership and commitment to providing parenting support;
- links parenting interventions to additional services for vulnerable families;
- has the potential to minimize the stigmatization of beneficiaries.

✓ **Work with community-led groups or CSOs**

CSOs that might deliver parenting interventions include community-based organisations, faith-based organizations, youth and family groups, women’s rights groups, or village associations, among others. These groups and organizations often have well-established relationships with local families, good knowledge of local cultures and contexts, and experience in working with community leadership. When using community-led groups or CSOs as the delivery platform for parenting interventions, it can be helpful to partner with government actors who can enhance the capacity of these organizations and provide oversight and guidance to align the parenting services with policy frameworks and national standards.

✓ **Utilize formal service delivery systems**

Decision-makers can also deliver parenting interventions through existing service provision systems, such as health facilities, educational institutions, and social welfare or social protection mechanisms (Box 24). Leveraging existing accepted and trusted service platforms that are accessible to the target population contributes to sustainability, local ownership, and stakeholder buy-in. It can also enhance the likelihood of institutionalization ([Phase 2, Step 3](#)) or the packaging of multiple interventions to form a system of delivery.

What delivery methods are most feasible and context-appropriate?

Delivery methods are the ways in which parenting sessions are conducted (including the structure of the group), and they should align with the intervention’s theory of change; have access to available resources (including human resources, venues or physical spaces, and materials); and be culturally appropriate. Delivery methods for parenting interventions include the following:

Face-to-face, facilitated interventions that are led by a person or group of people who provide guidance or instruction throughout intervention activities. These in-person interventions can take place in various settings, such as schools, clinics, community centres, or through home visits. Face-to-face, facilitated interventions have the best evidence of effectiveness, with 77 systematic reviews demonstrating impact across multiple outcomes (10).



Box 24. Formal service settings to link with parenting interventions

Common service settings in which parenting interventions can be embedded include:

- **Health and nutrition facilities:** Early childhood parenting interventions can be delivered through health and nutrition centres by using routine health check-ups as the entry point, with community health/nutrition workers serving as facilitators. These health platforms offer the added advantage of identifying developmental delays and disabilities, thereby promoting inclusivity in parenting support. Adolescent-focused parenting interventions can be integrated into existing HIV-prevention programmes.
- **Educational settings:** Early childhood interventions can be embedded in existing early childhood development services, while schools can serve as a platform for delivering parenting interventions to caregivers of adolescents. Delivering parenting interventions in schools promotes an intergenerational approach, where parents/caregivers and children attend sessions together, thereby offering facilitators the chance to provide hands-on experience and demonstrate effective ways to interact with children in real-life situations.
- **Social and child protection systems:** Parenting interventions are often delivered through child protection systems as part of the violence prevention and treatment services for families at elevated risk of child maltreatment, or where violence against children has occurred. Social protection systems are also commonly used to identify and reach families in selective parenting interventions designed for “at-risk” families with complex needs. These interventions may be combined with household economic strengthening services to enhance intervention outcomes (e.g. parenting interventions are often linked to cash transfer programmes, either as an optional service or as a condition for receiving cash payments).

Digital and remote interventions enable parenting support to be provided in settings that may not have sufficient resources for face-to-face interventions, or in locations that are inaccessible to facilitators, e.g. humanitarian or conflict settings or hard-to-reach rural locations (COVID-19 accelerated this trend).

Digital parenting interventions leverage technology to provide support to parents/caregivers remotely and typically use apps, chatbots, online chat groups, and web-based delivery methods. They can increase the uptake of services and reach populations previously underrepresented in parenting interventions, such as families in remote areas. Digital interventions can also help overcome the challenges faced by in-person interventions, such as delivery costs and sometimes demand for trained personnel, and may also increase participant engagement (e.g. as in the case of the eHealth Familias Unidas intervention) (140) (Box 25).

That said, the digitalization of parenting interventions is still a relatively new field, and as most evidence on digital parenting interventions comes from high-income countries, it is unclear to what extent digitalization can benefit families in low-resource settings or where access might be limited, such as in humanitarian contexts. More evidence is needed to compare the effectiveness of digital-only interventions to in-person delivery in different settings, and other delivery models that combine in-person and digital components.

Local adaptation of evidence-based digital interventions is therefore critical to ensure that they are suitable for families with lower levels of literacy, and limited access to the Internet and personal phones.

Strategies to ensure inclusivity and equity in digital parenting interventions, such as user-friendly digital platforms or providing data-cost assistance to support families facing systemic barriers to participation, are important to include. Other remote delivery modes that do not require access to technology or technical literacy – such as radio, television, or other community- and mass-communication methods – should also be considered.

Hybrid interventions combine multiple delivery methods to meet communities’ needs, leveraging their respective benefits and potentially mitigating any limitations – e.g. supplementing weekly group parenting sessions with individual home visits can help address more complex child behavioural issues. And integrating digital parenting interventions with offline, in-person services can foster stronger relationships between facilitators and participants, while also providing personalized support to help families address their individual challenges. For example, Mothers2Mothers in Mpumalanga, South Africa, delivered a combination of remote and in-person sessions for the PLH for Teens intervention (Box 26). A quasi-experimental study showed that this hybrid delivery approach was equally effective as the traditional in-person version of PLH for Teens (141, 142).

Box 25. Digital versus face-to-face delivery: the eHealth Familias Unidas intervention

Familias Unidas is a family-based intervention that aims to reduce substance use and other health risk behaviours among Hispanic adolescents while improving parenting and family functioning. In an adaptation of the intervention in Miami-Dade County Public Schools in Florida, USA, the intervention was delivered through the Internet (eHealth) to overcome logistical barriers to participation. Youth showing problem behaviours and their caregivers were recruited for the intervention through schools. The eHealth intervention included eight online pre-recorded parent group sessions consisting of discussion by a group of parents, a telenovela (a television soap opera), and applied interactive exercises, as well as four live, facilitator-led family sessions delivered through interactive, web-based video conferencing software.

A study evaluating the eHealth intervention examined participation through Internet-based delivery and found that participation in the eHealth intervention was comparable to – and in some cases even higher than – participation in other face-to-face Familias Unidas interventions. This may be due to the flexibility of the digital programme and the added support provided through regular human interaction in the interactive family sessions. Participation in the eHealth intervention was even higher for parents who were less integrated into their residential communities, demonstrating its inclusiveness and relevance for parents/caregivers adapting to life in the USA.

Each delivery method can be group-based or single-family-based, or a combination of these.

Group-based sessions take place in a centre and can be offered at all levels – universal (offered to all families, regardless of whether they are at risk of violence); selectively (to families at high risk); and indicated (for families experiencing more severe problems of violence or behavioural problems). Group sessions are practical because they allow facilitators to reach many families at once; create social support; enable fruitful discussion and problem solving; and help to establish group norms that promote positive attitudes toward parenting. When organizing group sessions for parenting interventions it is important to consider logistical factors such as the location and timing of the sessions, providing snacks and child-care services, and reimbursing transport costs for families who live far away.

Individual-based parenting interventions are delivered to one family, couple, or parent, working with a facilitator or counsellor. This can take place in a centre or clinic, or through home visits, which may be helpful in reducing logistical barriers to participants. By being delivered at home, interventions have the potential to include both parents/caregivers and children and adolescents, and to reach other family members. Individual or single-family approaches allow facilitators to customize the intervention to meet the unique needs of each family. These interventions can offer more intensive parenting support to families with higher levels of violence or social or behavioural factors, so may be well-suited to families at the indicated prevention level. These families are likely to require more skilled staff, and costs tend to be higher than for group-based programmes. When conducting home visits, it is essential that facilitators are well-trained in providing family-based services and that they respect local cultural norms regarding service providers visiting private spaces. This includes being aware of any cultural beliefs that may impact the family's willingness to receive

visitors in their home and taking steps to create a safe, comfortable, and confidential environment for everyone involved.

How long should a parenting intervention be?

There are three dimensions to the length or intensity of parenting interventions:

- Session frequency: how often sessions are held.
- Session duration: the length of each session.
- Intervention length: how long the whole intervention lasts.

As with delivery mode, intervention length should be determined by the intervention's theory of change, available resources, and local culture and circumstances. There must be sufficient intensity of intervention content to ensure that the positive effects of the intervention can be transferred from parents/caregivers to their children (in general, higher intensity or longer length interventions may lead to better results). Fidelity to the original evidence-based intervention is key – e.g. if an intervention is proven to be effective with 12 sessions, it may not have the same effect if reduced to three sessions. For this reason, length may differ significantly depending on the intervention's theories or techniques, proposed pathways of change, and the target population's needs (or level of prevention).

✓ Align with the intervention's theory of change

For example, universal parenting interventions that focus on increasing awareness and basic knowledge of parenting typically require lower intensity than those aimed at changing parent/caregiver behaviours among at-risk families.

Box 26. Digital intervention delivery of Parenting for Lifelong Health (PLH)

The intervention developed by PLH has been adapted into three digital versions: ParentChat, ParentText, and ParentApp.

- **ParentChat** is delivered by facilitators who moderate online group chat sessions on messaging platforms (such as WhatsApp) and send daily messages to support engagement. The intervention includes text/audio messages, video messages, illustrated comics, and home activity assignments that caregivers can do with their children.
- **ParentText** is an automated chatbot powered by RapidPro, a free and open-source software that serves low-income communities without smartphone access. It can be delivered via SMS or messaging platforms such as Telegram and WhatsApp. Caregivers receive scheduled text messages that include texts, comics, audio

messages, and videos on parenting knowledge and skills. Additionally, on-demand content and weekly assessments are provided to track and promote behavioural changes.

- **ParentApp** is an offline app version of the PLH interventions, developed for use in areas with limited Internet access. It provides interactive weekly parenting workshops and gamified features to promote engagement, such as scheduled messages of praise and reminders, and earning Parent Points by undertaking self-care and positive parenting.

ParentChat and ParentText are currently being adapted and tested in Africa, the Americas, South-East Asia, and the Western Pacific. Meanwhile, ParentApp is currently being tested in Africa.

Broad-based interventions that use TV, radio, social media, or posters to promote positive parenting at the population-level are less intensive but can reach many families and are particularly useful for creating a supportive social environment for positive parenting. On the other hand, interventions that aim to change daily parenting practices require higher intensity, because parents/caregivers need enough time to strengthen, practice and apply techniques, and reflect on what they have learned. In some cases, follow-ups and booster sessions are also provided to address any issues and reinforce key messages.

✓ **Assess available resources, in line with the selected delivery platform**

The resources available for a parenting intervention are crucial in determining the appropriate intensity. This partially depends on the delivery platform selected, as the number and workload of staff can impact the intensity or length of the intervention. If resources are limited, the intervention may need to have fewer and shorter sessions, focusing on the most important intervention components. However, if there are fewer resource constraints, the intervention can be delivered with greater intensity, offering more content and opportunities to reinforce positive parenting practices.

✓ **Determine what is feasible and acceptable in the context**

Establishing the appropriate intensity of parenting interventions also requires considering local culture and circumstances, in particular participant availability. For instance, for working parents/caregivers, offering sessions on weekends may enhance engagement.

Interventions designed for families in rural areas may need to reduce intensity during harvest seasons when parents/caregivers are occupied with farming.

Parenting interventions delivered in humanitarian contexts or for parents/caregivers of left-behind children may require a lighter intensity due to constant relocations and multiple crises that make it difficult for families to commit to longer and more frequent sessions. This may also require efforts to maintain intervention fidelity ([Phase 1, Step 2.5](#)).

It is important to keep in mind that while higher intensity may lead to better outcomes, a balance must be struck between evidence on sufficient intensity to achieve intervention goals and overwhelming facilitators or participants with too much information, thereby increasing costs and diminishing effectiveness. The process of co-design and co-adaptation ([Phase 1, Step 1.2](#)) will help identify the most appropriate and feasible length.

One potential solution is to have a core universal parenting package based on common parenting components and then include additional components that are “optional” based on context and the participants. This approach was successfully implemented in the Naungan Kasih parenting intervention in Malaysia. The intervention was locally adapted to consist of six mandatory modules for all families, while offering four optional modules on topics such as sexual and reproductive health, digital parenting, disabilities, and child protection. This flexible approach allows for customized participant learning and intervention delivery, making it well-suited for scaling up (142). The Naungan Kasih intervention is currently being adapted into a hybrid-digital parenting package that can be delivered via in-person, remote, and digital formats in the rural pre-school system in Malaysia (143).

Step 4: Strengthening systems for implementation

Step 4.1: Clarify minimum resources to start implementation

- ✓ Identify the activities required
- ✓ Determine the essential inputs necessary to carry out the activities
- ✓ Specify the outputs
- ✓ Develop a clear and explicit road map

Step 4.2: Human resource planning, training, and support

- ✓ Select context-appropriate facilitators
- ✓ Consider how to compensate and retain facilitators
- ✓ Establish sustainable training mechanisms
- ✓ Provide ongoing supervision and support to facilitators

Step 4.3: Operational planning, financing, and oversight

- ✓ Develop (or use existing) implementation guides that outline required resources
- ✓ Include monitoring and evaluation (M&E) activities
- ✓ Ensure continuity of services through properly resourced referral systems



4.1 Clarify minimum resources to start implementation

Intervention implementation requires that at least the minimum resource requirements are in place.

What inputs are needed for the expected outputs?

[Phase 1, Step 2.3](#) presented the concept of, and steps to develop, a theory of change that illustrates how a parenting intervention is expected to bring about change in a specific context. Phase 2, Step 4.1 introduces another tool related to the theory of change: the logic model.

A **logic model** is a visual representation of the inputs, activities, and outputs needed to achieve desired outcomes and goals. The logic model helps clarify what the intervention will entail and what resources are required. The theory of change and the logic model are complementary tools that can be used together to enhance intervention planning, implementation, and evaluation.

Logic models come in different forms and levels of detail. The following steps can help implementers understand the essential and minimum requirements to deliver the parenting intervention. For optimal results, all stakeholders should play a part in developing the logic model (98).

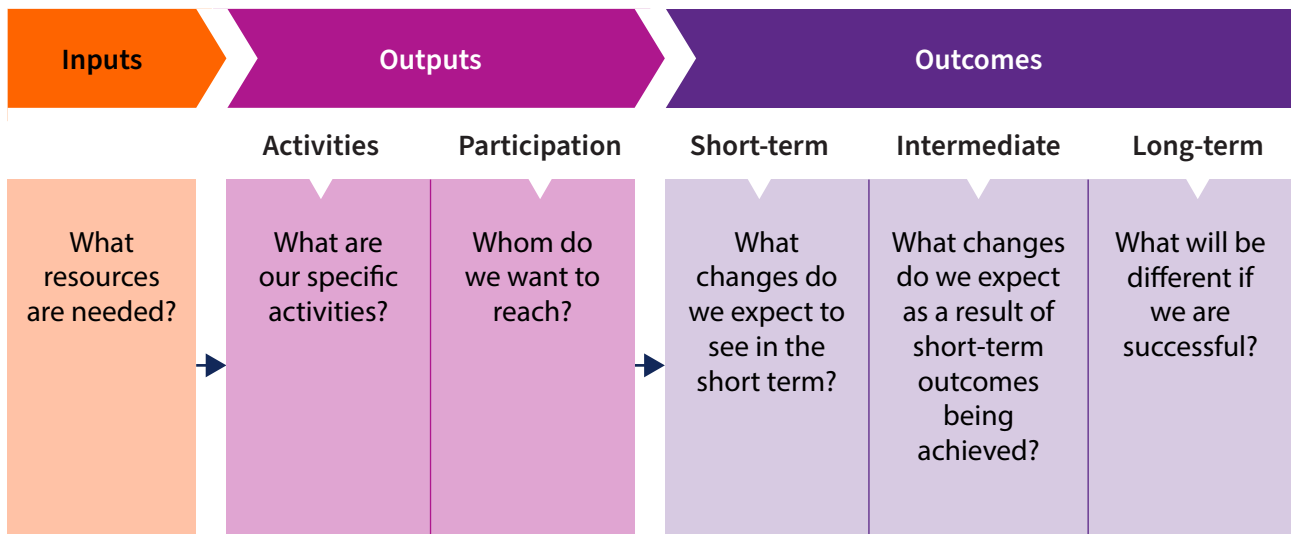
✓ Identify the activities required

This includes the intervention's content and the number of sessions necessary to achieve the outcomes and goals outlined in the theory of change, based on evidence of what works.

✓ Determine the essential inputs required to carry out the activities

This includes funding, intervention materials, human resources, and venues.

Fig. 6. Example of a simple logic model



✓ Specify the outputs

These are measurable services or “products” that result from the activities, such as the numbers of facilitators trained and participants who complete the intervention.

The level of detail required for a logic model will vary depending on the complexity and scope of the intervention. For example, a simple, essential version of a logic model for a parenting intervention can highlight the inputs, outputs, and outcomes of an intervention (see Fig. 6). An example of a more complex, moderate version of a logic model is the Safe at Home intervention, which includes the inputs, activities, and outputs necessary to achieve the desired short- and long-term outcomes (see Fig. 7).

In a more advanced strategy, it may also be necessary to include additional elements such as contextual factors or external influences (e.g. political and economic conditions) to fully capture the intervention’s implementation context. It is worth noting that regular monitoring and evaluation of the intervention may lead to adjustments or revisions of the logic model over time.

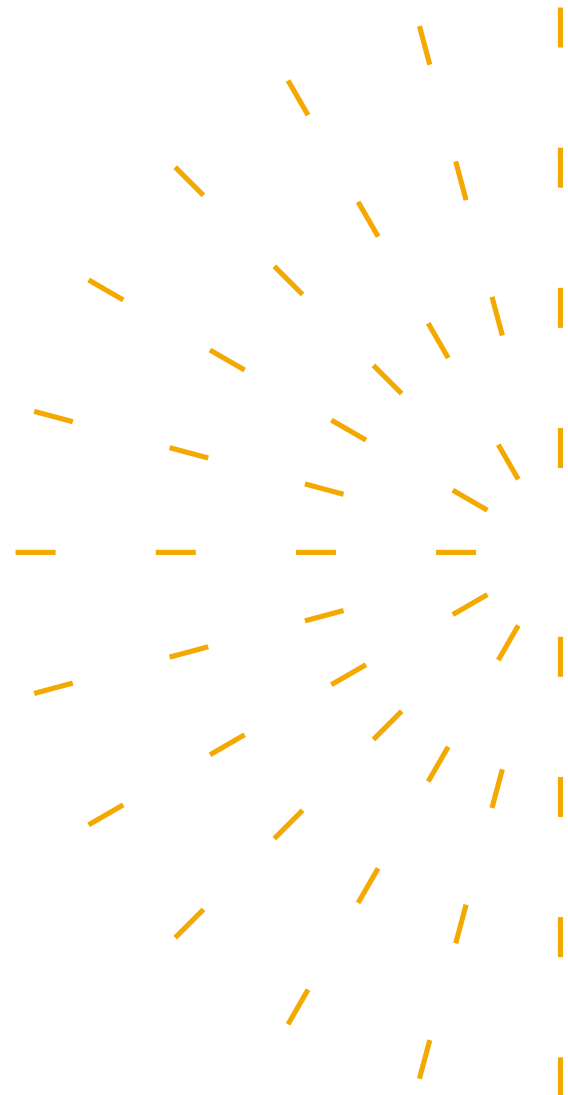


Fig. 7. Example of a complex logic model with inputs, activities, and outputs for prevention and response (safe at home intervention)



Source: Reproduced from International Rescue Committee (IRC) Safe at Home. Module 1, Introduction to Safe at Home (21), with kind permission from the IRC. IRC notes that Safe at Home should always be implemented in settings where services to which victims/survivors of child maltreatment and gender-based violence can be referred for care.

4.2 Human resource planning, training, and support

Evidence shows that identifying, training, and supporting the staff needed for intervention delivery are key factors for successful implementation (1).

What human resources are needed and what is available?

Two types of staff are needed for successful intervention implementation (Table 7):

- **Implementation staff** skilled in intervention delivery (e.g. recruiters, providers, facilitators, trainers, and supervisors), who in most instances are employed by the implementing organization or agency.
- **Management and coordination staff** (e.g. the intervention adaptation team, coordination and management team, and administration team).

How are facilitators selected and what level of training is required?

✓ Select context-appropriate facilitators

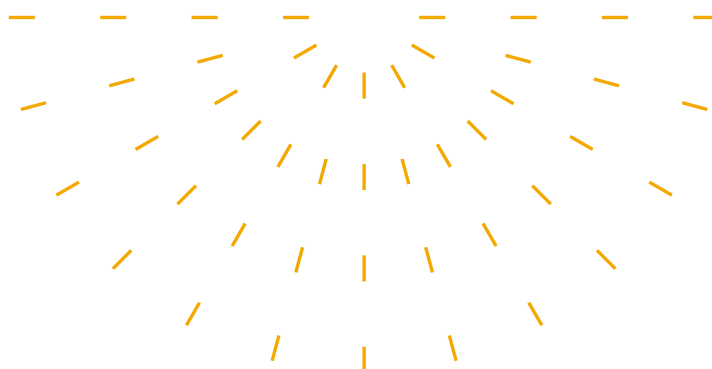
Parenting interventions can be delivered by:

- professionals (e.g. nurses or psychologists);
- semi- or para-professionals (e.g. community health or social development workers);
- lay workers (e.g. trusted community members with basic literacy skills and strong social commitment) (11).

In most countries, widespread implementation of a community-based parenting intervention relies on para-professionals or lay workers who have specific training and support (Box 27). This approach can also be the most cost-effective. However, for families with very high levels of need, it is more appropriate to have professional staff experienced in working with such families.

Table 7. Types of staff involved in implementation

Phase	Implementing personnel	Management and coordination team
Pre-implementation and capacity-building phase	Participant recruitment team in targeted communities Recruitment and training of trainers and facilitators, supervisors or coaches	Adaptation team: translator and other stakeholders responsible for the adaptation of materials and technical support Coordination and management team: to decide on the implementing organization and the participant recruitment strategy
Implementation phase	Facilitators Supervisors or coaches	Administrative and management staff: booking venues and services, budget management, technical support
Monitoring and evaluation	M&E staff	Data collectors for the pre-post questionnaire/interviews to measure parenting intervention impact



Box 27. Using para-professionals for home visits: Programa Cresça Com Seu Filho, Brazil

In Brazil, under the Programa Cresça Com Seu Filho (PCCSF) home visiting intervention in Fortaleza, home visits are conducted by community public health workers with a workload of 40 hours a week who are assigned a small geographical area. These community health workers are trained to deliver home visits while being supervised weekly by a qualified nurse.

Supervision involves weekly group meetings between the community health workers and the nurse supervisor to review the past week's home visits. Supervising nurses use a field diary to guide supervision and register quality data using a standardized checklist.

Box 28. Challenges with facilitator retention, Peru and Uganda

Challenges with facilitator retention in Peru

Cuna Más is a large-scale early childhood development intervention in Peru that operates a home visiting service in rural areas. In 2015 it was reaching over 93 000 children aged 0–36 months. As part of this public, fully subsidized intervention, trained community members were delivering one-hour weekly home visits. While regional staff and community actors perceived the intervention's compensation to be attractive on first joining it, the long hours, significant travel, challenging contexts, and job insecurity started to detract from this initial appeal. Consequently, challenges with facilitator motivation and retention were reported as a key barrier to sustained scale-up.

Motivators and challenges with facilitator retention in Uganda

Critical to success of the Uganda Parenting for Respectability Programme are the peer facilitators who deliver the intervention. Research with these facilitators found that while they were motivated by their own personal transformation and improved relationships between parents and children and between spouses, self-doubt, competing obligations, and inadequate remuneration hindered their performance. Refresher training and money for transport and a family meal reduced these challenges. Other motivating factors were the community changes resulting from their engagement with participants; supervision and mentoring; and inspiring, clear intervention content.

Integrating interventions into existing public services offers advantages such as using existing networks, organizational capacity, and available (professional or semi-professional staff) (47) who add the task of delivering the parenting intervention to their routine schedule. The drawbacks of this can include insufficient time and support for staff in their new role, thereby compromising delivery of either the new intervention or their core services (138). To maintain quality delivery and avoid overburdening staff, it is important that public service professionals are freed from other duties so they have time to deliver the interventions and are given management support for these new tasks (144).

Facilitators can also be either paid staff or volunteers. Relying on volunteers to facilitate the parenting intervention may carry risks, as their commitment and professional qualifications may be lower, and there is little rigorous evidence that parenting interventions are effective when run in this way. In the long term, cost-reducing strategies of having staff deliver interventions as part of their normal duties, or hiring volunteers, can sometimes hinder sustainability when going to scale.

What is needed to retain and sustain human resources and facilitation?

✓ Consider how to compensate and retain facilitators

The quality delivery and fidelity that are essential to implementing evidence-based parenting interventions can be difficult to achieve if they are delivered by overburdened staff or volunteers, and Box 28 highlights how facilitator retention can be a significant barrier to scale-up of parenting interventions (145–147). Thus, it is important to plan for potential staff burnout and turnover when selecting and recruiting organizations and facilitators. Ways to retain and sustain facilitators include:

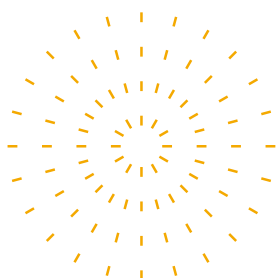
- ensuring sufficient skills training for facilitators;
- providing appropriate skilled supervision from staff with strong experience of, and enthusiasm for, the intervention;
- guaranteeing facilitators' salaries or other benefits (11).

✓ **Establish sustainable training mechanisms**

Once facilitators have been identified they must be trained to deliver the intervention as intended. While the content of training may vary depending on resources and context, it frequently involves instruction from professionally qualified trainers and coaches, covering at least the following two aspects: 1) intervention theories, objectives, components, and content (i.e., what to deliver); and 2) delivery mechanisms (i.e., how to deliver).

Active learning techniques can also be used, including practicing the delivery of key activities in the parenting intervention; role-playing as facilitators, parents, and/or children; and watching and discussing video recordings of specific sessions (11). At the end of the training, successful facilitators typically receive a certificate for participating in the training workshop, but not certification as facilitators, which usually requires a qualified assessment of intervention delivery. Facilitator training usually takes between three and five full days, though sometimes facilitators also require top-up or booster training either midway through intervention delivery or after the first round of intervention delivery to address areas that need strengthening. Recently, in the context of the COVID-19 pandemic, there has been a shift towards remote and hybrid training and supervision of intervention facilitators (1), but little is known about whether these methods are as effective as in-person training. It is often recommended that facilitators complete the parenting intervention first, either as part of a training workshop or as participants themselves (148).

It is important to consider the training regime when planning to scale-up a parenting intervention regionally or nationally. Scale-up often involves a train-the-trainer method, or cascade training, which consists of training some people to become facilitators who deliver the intervention, while others are trained to become trainers, supervisors, or coaches (1). Cascade training usually requires successive rounds of intervention delivery where a first generation of facilitators become supervisors or coaches of a second generation of facilitators, and then trainers during the third generation. This way, a sustainable training mechanism is established to build independent local capacity to train and supervise (see Box 29 for an example) (149).



Box 29. Train-the-trainer approach, Honduras

[Miles de Manos](#) (MdM) was recently established as part of the “Escuela de Padres” (School for Parents) framework, which is compulsory for families with students in most of the 23 000 public schools in Honduras. As such, MdM is now considered a permanent strategy to prevent school-based violence, with its own programmatic and budgetary resources, along with the necessary technical support and monitoring. [MdM in Honduras](#) is delivered by a variety of trained and supervised personnel (e.g. teachers, community health workers, other school-based staff, and volunteers). Prospective facilitators undergo a train-the-trainer programme that usually lasts five days. The first phase of training focuses on learning the theoretical foundations of MdM, its theory of change, facilitation techniques, and measurement instruments, for which a set of MdM manuals is provided to each trainee. The second phase of training comprises practicing the facilitation of the MdM modules and receiving feedback on techniques, appropriate use of materials, sequencing of activities, and preparation for activities. It also covers how to conduct peer and facilitator observations and feedback sessions, and complete associated paperwork.

✓ **Provide ongoing supervision and support to facilitators**

Providing training to facilitators prior to intervention delivery is not enough to ensure high-quality delivery (138). Once the delivery of the parenting intervention has started, ongoing facilitator supervision and coaching is essential. The highest standard of supervision usually involves group sessions with a trained coach using video feedback to help facilitators build skills and solve challenges encountered while delivering the intervention. However, this approach is very resource and time intensive and thus is not feasible in many contexts. Alternative forms of supervision can include in-person group-supervision sessions with facilitators reporting challenges (instead of using video feedback), live observations of facilitators delivering sessions, or on-demand, one-to-one phone calls or online support at the request of the facilitator (138, 150, 151).

Factors that need to be considered from the start when establishing a reasonable and feasible amount of supervision include:

- facilitators’ pre-existing capacities;
- facilitators’ pre-service training; and
- project costs and budget availability.

4.3 Operational planning, financing, and oversight

Operational planning requires consideration of the costs of each aspect of an intervention and whether decision-makers and implementers have sufficient funds. The cost element will be important when choosing the type and frequency of the parenting intervention; the target population and attendees; and the implementation strategy (150). Considering costs from the beginning of the process allows an informed decision on the potential sustainability of the intervention. Thus, estimating costs

should be a key component of the decision-making and implementation cycle (47).

Regardless of the chosen delivery method, successful implementation requires the implementing organization or agency to have sufficient human and financial resources to support capacity building, sustainability, quality delivery, and ongoing monitoring and evaluation (151). Although implementation costs will vary according to context, some foreseen costs can be identified for different delivery methods, participants, and frequencies – the main ones being for materials (see Box 30), intervention delivery costs, implementation costs, M&E costs, and referral-system-related costs.

Box 30. Training materials and guidance: examples from different contexts

All materials and videos needed for delivery of the Familias Fuertes parenting intervention are included in the facilitator package, which is handed to facilitators in a small briefcase. The materials are provided by the Pan-American Health Organization (PAHO) at no cost once the country has committed and has a plan to implement the intervention. The materials include:

- [Manual Familias Fuertes. Recursos para el facilitador \(Facilitator Resources\)](#)
- [Manual Familias Fuertes. Guía para el facilitador \(Facilitator Guide\)](#)

Similarly, the Parenting for Lifelong Health Programme Materials include facilitator manuals, parent handbooks, and implementation guides. The manuals and handbooks are open-source and freely available and use low-cost, culturally tailored comic stories to generate discussion between parents about different parenting styles. They are simple to adapt for a new setting.

The [Growing Strong Together](#) intervention by the International Rescue Committee also uses manuals for implementers and facilitators, with implementation guidance for decision-makers, and a shorter “Constant Companion” guide for facilitators that is easy to print or download (including in places with limited Internet availability). The full resource pack is available online in English, French, and Arabic and includes the following components:

- Desk review of evidence
- Intervention curriculum
- Constant companion: facilitator’s guide
- Family visits guide
- Facilitator training
- Monitoring, evaluation and learning framework and tools

What are the material and intervention costs?

Many evidence-based parenting interventions have text-based and sometimes audio-visual materials to guide session delivery. Text-based materials include toolkits, guides, manuals, or curricula, which include the theory of change, a breakdown of session content and timing, exercises, and key learning messages from each session. Some parenting interventions have guides for facilitators only, while others also have guides for parents/caregivers and intervention coordinators. These guides also need adaptation for local contexts, which may include translation, customizing graphics and illustrations, surface-level adaptation of the curriculum, and consideration of facilitator and participant literacy levels. Sufficient time and resources also need to be allocated for the adaptation process, which will require the set-up of an adaptation team and consultations with community stakeholders (see more in [Phase 1, Step 2.5](#)).

Once the materials have been adapted, they will likely need to be printed or disseminated digitally as PDFs, in preparation for the sessions. Some interventions have audio-visual materials showing real-life examples of interactions between parents/caregivers and children, which may need to be re-made to match local language and context. However, audio-visual materials may be too costly for roll out in low-resource settings, in terms of equipment, power supply, and costs of making adaptations.



Hence, illustrated vignettes or role-plays are sometimes used instead. Where this is done, consultation with intervention developers is advisable to maintain fidelity.

What are the implementation costs?

Implementation costs include those for training sessions and intervention sessions with families (e.g. costs for hiring appropriate venues; transport; materials for trainers, facilitators and parents/caregivers; communication with families via calls and SMS; and refreshments for family groups).

✓ **Develop (or use existing) implementation guides that outline required resources**

Ideally, organizations that have developed evidence-based parenting interventions should have an implementation guide that can help translation and replication of successful implementation across contexts. These guides generally include a list of needed resources, a timeline, and proposed budget allocation, as well as additional potential costs to improve participation in some low-income contexts (such as meals, transport, and child care). Implementation guides can also include considerations for infrastructure and the use of technology, and suggest back-up plans for unreliable equipment or infrastructure. Thus, these guides and the available intervention manuals should allow flexibility without compromising the core elements of the intervention (Box 31).

✓ **Include M&E activities**

M&E costs also need to be budgeted for from the outset. Generally, M&E involves the systematic assessment of implementation and outcomes, which requires M&E staff and data collectors' working time. The sophistication of M&E tools used will depend on available resources.

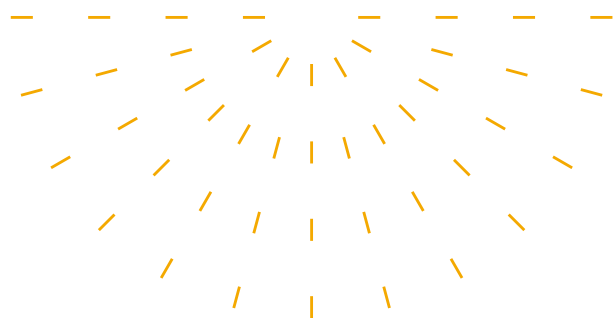
Many intervention developers include a set of monitoring tools in their implementation package. For example, the Parenting for Lifelong Health interventions have a set of open access tools from which implementers can choose materials to suit their needs. Data collection instruments need to be simple, user-friendly and compatible with existing systems (152). More on different M&E methods can be found in [Phase 3, Step 5](#).

✓ **Ensure continuity between services through properly resourced referral systems**

Establishing referral systems and communication between entities delivering the parenting intervention and other service providers (e.g. communication costs, accompanying families to specific services, stakeholder networking efforts via meetings etc.) is fundamental. These systems should be considered when budgeting and programming. In particular it is important to clarify which services the parenting intervention will refer participants to, when these referrals will take place, and how referral will be done.

Box 31. Implementation guides and tools: online resources for implementing Parenting for Lifelong Health

Parenting for Lifelong Health has developed [implementation guides](#) for service providers that are available electronically. These guides form part of a comprehensive toolkit alongside the intervention and monitoring and evaluation. The aim of these guides is to provide a step-by-step overview for coordinating preparation, implementation, and organizational learning, and include financial information on the resources that may be required for delivery. In addition, the Deutsche Gesellschaft für Internationale Zusammenarbeit GmbH and The Institute for Security Studies (ISS), with the input of PLH providers, have developed [a costing guide](#) to be used by government departments, NGOs, funders and other partners when developing plans and budgets for scaling up parenting intervention delivery. Between 2020 and 2021 these organizations offered a series of budget training workshops to different stakeholders in South Africa to help them understand how government budget processes work. A costing model was also developed during these workshops to be used for budget proposals for new and existing interventions contributing to the prevention of violence.





Mandaluyong City, 2017, 2017 © WHO/Yoshi Shimizu

Phase 3.

Learning and sustaining



Step 5: Evaluating and learning from the intervention

Step 5.1: Develop a monitoring and evaluation framework

- ✓ Consider the objectives of the intervention
- ✓ Select and measure indicators based on the intervention's theory of change and logic model
- ✓ Refer to existing indicator guidance for the specific objectives and outcomes of your intervention components

Step 5.2: Develop an operational plan for data collection

- ✓ Determine what existing sources of data can be used
- ✓ Strengthen and combine efforts for training, reporting, and supervision processes
- ✓ Gather quantitative and qualitative data on feedback about implementation and intervention processes
- ✓ Consider scale and usability when designing M&E systems

Step 5.3: Analyse and disseminate

- ✓ Analyse and share learning, conclusions, and implications regularly

Step 5.4: Plan for evaluation

- ✓ Conduct an evaluability assessment before planning an impact evaluation

Step 5.5: Ensure safe and ethical data collection on children and adolescents

- ✓ Adhere to ethical guidelines and national laws and protocols for data collection activities

M&E systems are essential for tracking whether interventions are being implemented as designed and having the intended impact, while also assessing unintended harms (see Table 8 for basic M&E characteristics). By systematically collecting, analysing, and sharing relevant, comparable, and accurate data on process, implementation, outcomes, and impact, decision-makers can improve accountability, understand delivery and allocation of resources, reflect and learn from outcomes, and share lessons learned with stakeholders.

This helps to contribute to the broader evidence base on the impact of parenting interventions (47, 90, 138). M&E systems can also provide useful information for scaling and sustaining parenting interventions (138).

At a minimum, implementation should include mechanisms to facilitate monitoring the parenting intervention through routine data collection and analysis as an essential strategy (1). Monitoring follows the progress of planned activities, identifies problems and potential harms, and provides feedback to managers and staff to identify and solve problems before they cause delays. Data from monitoring activities should be processed and analysed promptly and results shared with those in a position to take corrective action (1, 47). Evaluation of an intervention is an advanced strategy that often involves a standalone study conducted by a research partner. Guidance on when to conduct an evaluation can be found in the subsection below.

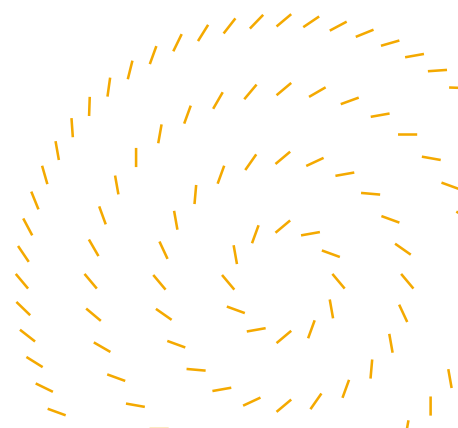


Table 8. Basic characteristics of monitoring, evaluation, and impact evaluation

Monitoring	Evaluation	Impact evaluation
<ul style="list-style-type: none"> • Periodic, using data that is routinely gathered or readily attainable • Focused on activity inputs and outputs of whether and how activities are being carried out as planned • Assumes appropriateness of objectives, activities, and indicators • Usually quantitative • Cannot assess impact by itself 	<ul style="list-style-type: none"> • Conducted often but not as part of routine data collection • Goes beyond outputs to assess intervention outcomes • Can address “how” and “why” questions • Can identify intended and unintended effects • Can use mixed-methods data from different sources • Can assess change in outcomes but cannot always determine impact 	<ul style="list-style-type: none"> • A specific form of evaluation that can assess impact and determine if it was generated by the intervention • Infrequent and generally conducted as a separate research study • Can address “how” and “why” questions (i.e. mediators and moderators) • Can be used to assess the theory of change of an intervention and answer other questions about intended and unintended effects

Source: (152)

Designing and implementing effective M&E systems for parenting interventions requires detailed planning (138). Step 5 provides a brief overview of the sub-steps required and examples of the continuum of learning practices that decision-makers can use to monitor and evaluate their interventions. Substantial external guidance exists on selecting indicators and different methods to use, depending on the target questions, the context, and available resourcing. A list of recommended resources can be found in the section on selecting indicators.

For multicomponent or cross-sectoral parenting interventions, global guidance such as UNICEF’s *INSPIRE indicator guidance and results framework* (153) and WHO’s *INSPIRE Handbook for implementation* (47, pages 272–282) provide a standardized framework through which higher-level outcomes (e.g. the percentage of children aged 1–17 years that experienced physical punishment and/or psychological aggression by caregivers in the past month) are tracked globally and can be useful for considering possible outcomes across different domains (47, 153).

5.1 Develop a monitoring and evaluation framework

Consider the following when developing an M&E framework:

Which outcomes will be the focus of the M&E plan?

✓ Consider the objectives of the intervention

To determine what information M&E activities should collect it is necessary to consider the intervention objectives. The target outcomes and indicators in an M&E framework should align directly with the intervention’s theory of change and logic model to track resources, activities, and short- and long-term outcomes (138). Systematic information on the delivery mechanisms and settings should also be documented to allow for intervention- and context-specific learning.

What indicators can be used to test if the intervention is achieving its objectives?

✓ Select and track changes over time using indicators based on the intervention’s theory of change and logic model

A parenting intervention M&E framework should include indicators related to implementation and impacts, and must cover: inputs (resources and activities); outputs (expected products or results of an intervention); and short- and long-term outcomes (154). The framework should include outcomes for both parents/caregivers and children, and consider gender, age, and other demographic differences.

One example of a basic M&E framework is the Monitoring and Evaluation Framework for Early Childhood Development in Ethiopia. This was developed by Ethiopia’s Ministry of Health for a national-level ECD intervention targeting maternal and child health, parenting, and child development (155) (Box 32).

► Essential strategy

Box 32. monitoring and evaluating early childhood development strategies, Ethiopia

As part of the Government of Ethiopia's commitment to implementing its nurturing care framework (which included revising its ECD and Education Policy and developing a health sector national ECD strategy), it developed a national ECD M&E framework, complete with indicators on inputs/process, outputs, outcomes, and impact, as set out below.

Input/process	Output	Outcome	Impact
<ul style="list-style-type: none"> • Advocacies • Annual plan preparation • ECD activities incorporated into woreda based plans/reviews • Trainings/post training follow-ups • Job aid/material distribution to facilities and households • TV, radio spots produced • ECD interventions integrated to the routine MCH services • Nutritional supplement for pregnant women 	<ul style="list-style-type: none"> • Day care centers started with tailored ECD Services • Health facilities establish child friendly corners • Children screened for developmental status • Care givers counseled on early stimulation and responsive care • Pregnant and lactating mothers screened for mental illnesses • Access to play based early learning and Pre-primary education • Children provided with toys and books at home • Mothers received care to prevent anemia 	<ul style="list-style-type: none"> • Four ANC visits • Early PNC • Skilled birth attendance • Full immunization of children • Children received deworming/Vitamin A supplementation • Children exclusively breastfed for 6 months • Children received stimulation and responsive care • Positive disciplining • Parents practice responsive caregiving • Children with low birth weight • Children participate in organized early learning/pre-primary education • Anemia during pregnancy 	<ul style="list-style-type: none"> • Under-5 children developmentally on track in health, learning and psychological well-being • Neonatal mortality rate reduction • Under-5 mortality rate reduction • Stunting Reduction

Source: Reproduced from Monitoring and evaluation framework for early childhood development in Ethiopia (155), with kind permission from the Ministry of Health, Government of Ethiopia.

Abbreviation key: ECD – early childhood development; MCH – maternal and child health; ANC – antenatal care; PNC – postnatal care.

To ensure that the M&E framework can be followed by implementers across sites and eventually scaled up, the framework should specify detailed information on the indicators in the logic model, such as the definition for each indicator, indicator targets, and how the data will be collected (see Phase 2, Step 4 for more on logic models). All M&E indicators should be time-bound, age-specific, and disaggregated by sex; age group (e.g. 0–2 years, under 5 years, 2–10 years, 11–14 years, and 15–17 years); disability level or functional difficulties; and other demographic characteristics that might influence access to parenting interventions or potential harms such as vulnerability to child maltreatment (47).

✓ Refer to existing indicator guidance for specific objectives and outcomes of your intervention components

While some indicators may be specific to the exact context or intervention, many indicators have been developed that relate to the diverse outcomes of parenting interventions. Using standardized indicators helps enable comparison across interventions, sites, countries, and regions. The SDGs, WHO's *INSPIRE: seven strategies for ending violence against children*, Child Protection Minimum Standards, Nurturing Care Framework, and other UNICEF and WHO frameworks have developed detailed and clear guidance on indicators for specific

outcomes relating to children and parenting, including measures, suggested targets, and notes on how each indicator can be collected (47, 138, 150, 156, 157). Examples of indicators across outcome domains and at different indicator levels are given in Table 9, and relevant indicator

frameworks are listed at the end of this subsection. Decision-makers should ensure that the data collection tools selected will measure the desired outcome; are appropriate for the target population and context; and are gender- and age-sensitive (150).

Table 9. Example indicators for monitoring parenting interventions

Domain	Components/ techniques	Explanations during early and middle childhood (0 to 10 years)	Explanations during adolescence (11 to 19 years)	Impact
Child protection and psychosocial support	Number and % of child safeguarding focal points at the agency level trained to respond to child safeguarding cases	Number and % of service providers who report increased confidence in responding to the mental health and psychosocial needs of children and caregivers as a result of programme interventions	% of female and male caregivers identified as needing focused parenting support who report an improvement in their mental health and psychosocial well-being at programme completion	% of female and male children age 6–17 years who report a reduction in moderate and/or severe symptoms of depression in the past 2 weeks
Early childhood development	Number of radio segments produced	Number of children aged under 5 years provided with toys and books at home	% of children aged under 5 years in intervention that received stimulation and responsive care	% of children aged under 5 years who are developmentally on track in health, learning, and psychosocial well-being
Relationship building	Number of facilitators trained to deliver the teenage intervention	Number and % of female and male adolescents aged 13–17 years who participated in the family group discussion sessions	% of female and male adolescents aged 13–17 years who report that their caregivers understood their problems and worries most of the time, or always, during the past 30 days	% difference in parent-child relationship quality as reported by female and male caregivers and female and male adolescents aged 13–17 in the intervention compared to the control group
Child maltreatment	Number and % of families who attended at least 70% of group sessions	Number and % of first-time female and male caregivers that received parenting support in past 6 months	% of caregivers who agree that physical punishment of children is necessary for child-rearing at programme completion	% change in female and male children aged 1–17 years who experienced any physical punishment and/or psychological aggression by caregivers in the past month

Relevant indicator frameworks with detailed guidance include:

- [INSPIRE Handbook, Annex A and Indicator Guidance and Results Framework](#) (47, 153)
- [The Nurturing Care Framework: Indicators for Measuring Responsive Care and Early Learning Activities](#) (114)
- [Sustainable Development Goals Global Indicators Related to Children](#) (156)
- [Reporting Guidelines for Implementation Research on Nurturing Care Interventions Designed to Promote Early Childhood Development](#) (157)
- [UNICEF Strategic Plan 2018–2021 Goal Area 3, “Every Child is Protected from Violence and Exploitation”:](#) [Indicator Manual](#) (158)

5.2 Develop an operational plan for data collection

How will information be effectively and accurately gathered?

✓ **Determine what existing sources of data can be used**

Data on inputs and outputs can be collected through routine monitoring and reporting systems. Routine monitoring systems include case management systems that collate data from different sectors to track clients and referral pathways; service data on human resources, training, and systems strengthening; data on service usage, attendance, or retention; and some outcome data such as child and caregiver behavioural outcomes within the intervention period.

Outcome data can sometimes be collected through routine monitoring but is most often collected through separate evaluations conducted by research partners or evaluation consultants. Evaluations can take 3 years or more from design to completion, depending on the length of an intervention and available resources. System-specific outcome reporting such as UNICEF’s strategic monitoring questions (SMQs), rapid assessment modules (RAMs), and country office annual reports and situational analyses can also be used to calculate outcome indicators (90, 158).

Impact indicators might be measured every 5–10 years through standalone research evaluations or through national population-based surveys that provide reliable standards for measuring variables, identifying vulnerable groups, and measuring progress. This can include surveys such as the VACS, DHS, Global school-based student health survey (GSHS), and the Youth Risk Behavior Surveillance System (YRBSS), among others. It is worth noting that these evaluations do not provide in-depth information about specific interventions or policies.

Who will collect, examine, and distribute data, and what are their training and ongoing support needs?

✓ **Strengthen and combine efforts for training, reporting, and supervision processes**

Data collection requires substantial human resources. Collection and analysis of M&E data must happen regularly and rapidly to inform real-time improvements to the intervention package. Decision-makers should identify responsible people or agencies to collect data and select appropriate timeframes in which this should occur (138). Oversight and M&E mechanisms should work closely to share data, enable adaptive learning, make course corrections, continuously improve implementation, and contribute to the broader evidence base. This is especially important when collaborating across multiple sectors and/or partners (151).

Which data collection tool(s) will be used?

When selecting data collection tools for M&E, decision-makers should consider if the tool(s) can:

- measure specified indicators;
- provide information that is quantitative, qualitative, or both;
- be made context-relevant and useful by being available in appropriate languages or formats.

✓ **Gather quantitative and qualitative data on feedback about implementation and intervention processes**

Qualitative data collection tools include interviews with participants; focus groups with stakeholders; and qualitative observational tools. Quantitative tools include surveys and questionnaires with parents/caregivers and/or children; facilitator observation forms; participant observation forms; and service data, such as the number and characteristics of parents/caregivers receiving an intervention in the past month (138).

While M&E frameworks and indicators are typically quantitative, triangulating quantitative results with qualitative tools can reveal information on barriers, unexpected benefits or harms, and successes in the words of both participants and providers. For example, in the pilot study for the Safe at Home intervention by the International Rescue Committee, qualitative results from Myanmar and Democratic Republic of the Congo revealed some barriers to participation and relevance of the intervention content for families with parents/caregivers and children with disabilities (159).



Is the data collection process easy to use and suitable for use at scale?

✓ Consider scale and usability when designing M&E systems

As scale-up of evidence-based parenting interventions continues to evolve, these interventions must continue to demonstrate impact on outcomes at scale when delivered through different methods, e.g. digital, hybrid, or remote. Building user-friendly, integrated, and scalable M&E systems is necessary to measure and ensure quality of delivery and impact at scale.

5.3 Analyse and disseminate findings

Sharing findings and evidence generated by M&E activities is essential to learn from and improve parenting interventions. To support learning, data should be processed and analyzed promptly and results shared with decision-makers for corrective action to solve problems and prevent delays (1). Evidence should be disseminated at all levels of intervention implementation, including the community level, so that facilitators and participants are involved in the process.

✓ Analyse and share learning, conclusions, and implications regularly

Triangulating data from different stakeholders at different prevention levels – e.g. bringing together findings from data collected at the national and local authority levels – can strengthen conclusions about what works to improve outcomes for children and parents/caregivers. M&E plans can be a collaborative tool to use with stakeholders from the outset of an initiative to build a common understanding of the intervention goals and how success will be measured. Decision-makers can also use M&E findings to raise awareness, engage stakeholders, and advocate for additional funding and support.

5.4 Plan for evaluation

While routine M&E systems can provide valuable information and gather feedback on intervention processes and outcome indicators, the simple analyses typically conducted for these indicators cannot reveal an intervention's impact. To accurately measure intervention impact, more complex and rigorous systems of collecting, analysing, and comparing outcome data are needed.

Evaluating the implementation and impact of an intervention can provide valuable information on whether and how it is working, helping decision-makers to avoid wasting scarce resources, and maximize the impact of their initiatives (51). However, while it is appealing for decision-makers to be able to say that their intervention resulted in an improvement in child and caregiver outcomes or reduced child maltreatment, the research methods required to draw this conclusion are an advanced strategy and can be complex and resource-intensive. Some questions to consider before conducting an intervention evaluation are:

- Who will conduct the evaluation and with what resources?
- Have there already been pilot studies or previous evaluations of the intervention in the same or other contexts that can be used to inform an evaluation design?
- What are the feasibility and safety considerations to consider when conducting an evaluation, such as the ability to randomize intervention participants or intervention sites?
- What are the barriers to conducting evaluations in the local context?



Table 10. Types of assessments to evaluate parenting interventions

Evaluation type	Purpose
Formative evaluation	Evaluates the needs or problem situation, often prior to initial development of the intervention. Sometimes referred to as a needs assessment, this strategy can be moderate or advanced depending on the methods used, and frequently identifies ways in which needs, barriers, or challenges faced by parents/caregivers, children, service providers, and other stakeholders can be addressed.
Process evaluation	Assesses whether intervention activities have been implemented as intended and resulted in specific outputs. This moderate strategy requires more time and resources than routine monitoring as it involves systematic data collection specifically for the purpose of examining intervention implementation processes and quality of delivery. For example, assessing the quality of caregiver training through a post-training survey; measuring client satisfaction in a post-intervention interview; or examining intervention uptake or reach through comparing attendance and organizational data about the number of sessions delivered and participants in each session.
Implementation evaluation	Systematically assesses efforts to implement and promote the uptake of parenting interventions (160). Through the operationalization of implementation science frameworks, this advanced strategy examines how and why evidence-based parenting interventions succeed or fail during implementation. For example, implementation studies examine the feasibility and acceptability of interventions when adapted to a new context, or how to deliver an intervention to reach more people in low-resource settings (51). More implementation studies are needed to explore the best approaches for taking parenting interventions to scale through government or public services, such as integrating with health or education systems or using digital and hybrid interventions (11, 42).
Impact evaluation	Examines the effect of an intervention for different populations and levels of prevention. Also called an effectiveness study or randomized controlled trial (RCT), this advanced strategy provides decision-makers with critical information on whether interventions are having their intended impact (47). Using rigorous methodological techniques such as randomized allocation to intervention and control groups (one group receives the intervention and one does not), impact evaluations provide the highest degree of control over an evaluation by accounting for possible external influences that may affect those receiving an intervention. This type of study design can enable decision-makers to attribute changes in outcomes to a specific intervention or even a specific intervention component.
Cost-effectiveness evaluation	This advanced strategy helps decision-makers estimate the total funds required for an intervention, comparing the cost and effect of different packages of interventions, and assessing the efficiency of resources for the delivery of each intervention component (47). Evaluation of an intervention should examine effectiveness and cost-effectiveness for different populations and levels of prevention (1).

Impact evaluations can be complex, expensive, and ethically challenging to conduct in low-resource or fragile settings, but they are not the only method for examining the effect of an intervention. **Quasi-experimental** and **non-experimental** research designs incorporating quantitative and qualitative primary data collection methods and routine data can also be used to explore – with caution – the possible impact of an intervention.

And despite the benefits of impact evaluations, not all interventions are ready or appropriate to be evaluated for their effectiveness. Therefore, decision-makers should conduct an “evaluability assessment” prior to planning.

✓ **Conduct an “evaluability assessment” before planning an impact evaluation**

Insufficient human and financial resources, challenges in accessing hard-to-reach populations, and disruptions to research and intervention activities impede impact evaluations in many settings, limiting the conclusions that can be drawn from these studies.

Nevertheless, there are numerous examples of successful rigorous evaluations in difficult contexts. The evaluation of the Building Happy Families intervention in a region of Thailand bordering Myanmar employed a cluster-RCT to examine the impact of the intervention among parents/caregivers (161). Similarly, the Safe at Home intervention in North Kivu, Democratic Republic of the Congo was evaluated using a pilot RCT trial (22).

For high-risk and fragile settings such as conflicts and humanitarian crises, decision-makers should consult guidelines specifically for evaluative research within those contexts and conduct an evaluability assessment before undergoing an impact evaluation, given its significant ethical and resource implications (162).

Finally, it is important to remember that the complexities of influencing behavioural and social norms outcomes at scale require different considerations to those which apply to smaller pilot studies and experimental trials. Diverse evaluation methods should therefore be employed to respond to these complexities and to adequately test whether interventions that worked well under pilot conditions worked well when scaled up (73). For example, before scaling up the Msingi Bora early childhood development intervention in rural Kenya, a research partner conducted a complex, multi-arm study to test the cost-effectiveness of two different models of delivering the intervention: a group-based model versus a mixed model combining group sessions with personalized home visits. The results of the intervention can be used by decision-makers to determine which mode of delivery is most feasible when scaling up the intervention (163).

✓ **Adhere to ethical guidelines and national laws and protocols for any data collection activities**

All quantitative and qualitative data collection procedures should adhere to ethical principles for any M&E activities, ensuring that:

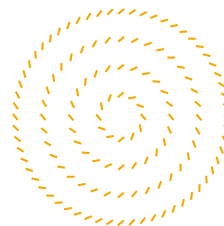
- the rights of participants are respected and protected;
- participation in M&E is voluntary and not a pre-requisite to participate in an intervention;
- the overall benefits of data collection outweigh potential risks;
- participants are selected fairly; and
- all activities uphold the “do no harm” principle.

All M&E activities with children should follow best practice from ethical guidelines on collecting data with children (164–166). At minimum, the requirements set out in the UN Convention on the Rights of the Child (31), and the Child Protection Minimum Standards (156) relating to the collection, storage, and reporting of data on children and child protection issues should be followed, as well as any relevant national and regional laws and policies.

5.5 Ensure safe and ethical data collection

Before conducting data collection activities with children or adolescents, ensure that these activities pose no potential harms for children or adolescents; follow the same protocols and procedures for data collection, storage, and use as for child protection interventions; and are in line with national and regional child protection protocols and standards.

Given that many parenting interventions involve sensitive content such as mental health, child maltreatment, and other types of family violence, maintaining confidentiality is critical for any M&E activity, no matter the type of data or indicators. Community feedback boxes or phone or SMS systems where target populations can retain anonymity and confidentiality while sharing feedback should be considered for M&E purposes. Where respondents are being asked about personal experiences in any monitoring or evaluation activities, mechanisms for anonymizing data should be in place.



Step 6: Establishing readiness for scaling up interventions

Step 6.1: Launch phase

- ✓ Establish a clear intervention objective
- ✓ Ensure there is a robust evidence base
- ✓ Assess scalability
- ✓ Plan for scale up
- ✓ Engage stakeholders
- ✓ Adapt the intervention as needed
- ✓ Pilot-test the intervention

Step 6.2: Adoption phase

- ✓ Establish advocacy and political partnerships
- ✓ Obtain national stakeholder involvement
- ✓ Establish collaborative and intersectoral partnerships
- ✓ Identify programme champions
- ✓ Provide training and capacity building

Step 6.3: Scaling phase

- ✓ Establish quality assurance
- ✓ Collect data and evaluate
- ✓ Harness technology and innovation
- ✓ Expand gradually

Step 6.4: Sustaining phase

- ✓ Secure funding for sustainability
- ✓ Institutionalize and integrate systems
- ✓ Course-correct and continually improve
- ✓ Expand delivery to new contexts
- ✓ Identify economies of scale

It is important to “begin with the end in mind” if an intervention is to be sustainable and have a long-term impact (11, 151). This means stakeholders should consider the scale and sustainability of an intervention from the start. ExpandNet defines scale-up as “deliberate efforts to increase the impact of successfully tested health innovations to benefit more people and to foster policy and intervention development on a lasting basis” (151).

Three key questions to consider from the outset are:

- Is the intervention ready to be scaled up?
- How will the intervention be adopted?
- How will the intervention be scaled up?
- How will the intervention be sustained?

There are multiple pathways by which interventions can proceed to scale. However, two scaling up pathways have proven to be most impactful and sustainable: vertical scale-up or institutionalization; and horizontal scale-up or expansion and replication.

Vertical scale-up requires integrating activities into policies, laws, government or organizational budgets, strategies, and institutional structures such as health-care systems and training centres (167, 168) (see Box 33 for an example).

Horizontal scale-up refers to the effective expansion of an activity to more locations or reaching additional populations. This involves training more people to provide the intervention and implementing strategies to reach a more significant portion of the population (151). In situations where commitment is limited, beginning with a modest level of horizontal scaling up may be more practical (169, 170) (see Box 34 for an example).



Box 33. Vertical scale-up of a parenting intervention, the Philippines

Masayang Pamilya (also called MaPa, meaning “Happy Family”) is a parent-support intervention developed through a multisectoral collaboration with Parenting for Lifelong Health Philippines to prevent child maltreatment and other forms of violence against children in Filipino families. In collaboration with the Philippine Department of Social Welfare and Development, the Council for the Welfare of Children, local and international scientists, and child and family practitioners and service providers (and with funding from UNICEF Philippines and the UBS Optimus Foundation), the project has been developing and testing the implementation of a locally adapted parent-support intervention through the national Conditional Cash Transfer (CCT) system.

An initial RCT conducted in low-income urban areas with families receiving cash transfers showed significant and sustained reduced risk for child maltreatment when compared to the control group that underwent the usual “Family Development Sessions”.

In 2020–2021 Parenting for Lifelong Health Philippines adapted MaPa core parenting themes and skills for online/digital delivery as part of the COVID-19 Playful Parenting Emergency Response. The MaPa Parenting Tipsheets were translated to 12 major Philippine languages and disseminated widely, reaching an estimated 300 000 service providers and family caregivers. MaPa webinars and radio segments conducted with partner stakeholders reached over 25 000 participants and viewers. In 2022, MaPa core messages were integrated into the national CCT programme via the online Family Development Sessions system and delivered via various platforms to 4 million Filipino households.

Box 34. Horizontal scale-up of home-visits to promote early childhood development, Rwanda

Sugira Muryango (meaning “Strengthen the Family”) stems from the Family Strengthening Intervention for Families/Children Affected by HIV/AIDS in Rwanda, and has transformed to engage fathers, reduce violence, and strengthen families overall. Through an initiative to horizontally scale-up the intervention, the Government of Rwanda aimed to reach nearly 10 000 of the most vulnerable households across three districts by the end of 2023.

Sugira Muryango is a home visiting intervention that uses active coaching to build parent capabilities and increase responsive parenting by both mothers and fathers to promote early childhood development and prevent violence. It targets families in extreme poverty with young children aged 0–36 months. An RCT of the intervention demonstrated that families who received the intervention in combination with a government-provided social protection programme practice more responsive, positive caregiving, and show improved nutrition, care seeking, hygiene, and father involvement compared to control families receiving usual care.

To achieve successful and sustained intervention scale-up, it is crucial to focus on both vertical and horizontal approaches (Fig. 8 illustrates the interdependence of these two types of scaling up). For example, In Thailand, Parenting for Lifelong Health for young children is starting to be scaled up horizontally in the primary health care system, expanding from one pilot province to multiple provinces in the North-East region, and vertical scaling up is underway by embedding the training of facilitators in the curriculum for the regional nursing college (151).

Scale-up of an intervention involves four main stages: launch, adoption, scaling, and sustaining. Each stage is explained in detail in Section 6.1, along with considerations for each step of the process (these considerations do not have to be applied in chronological order, nor are they exhaustive). A list of questions to consider at each stage is provided in Box 35.

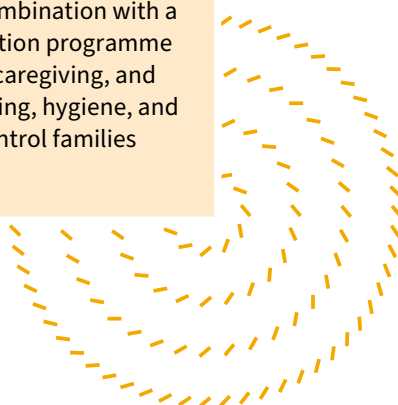
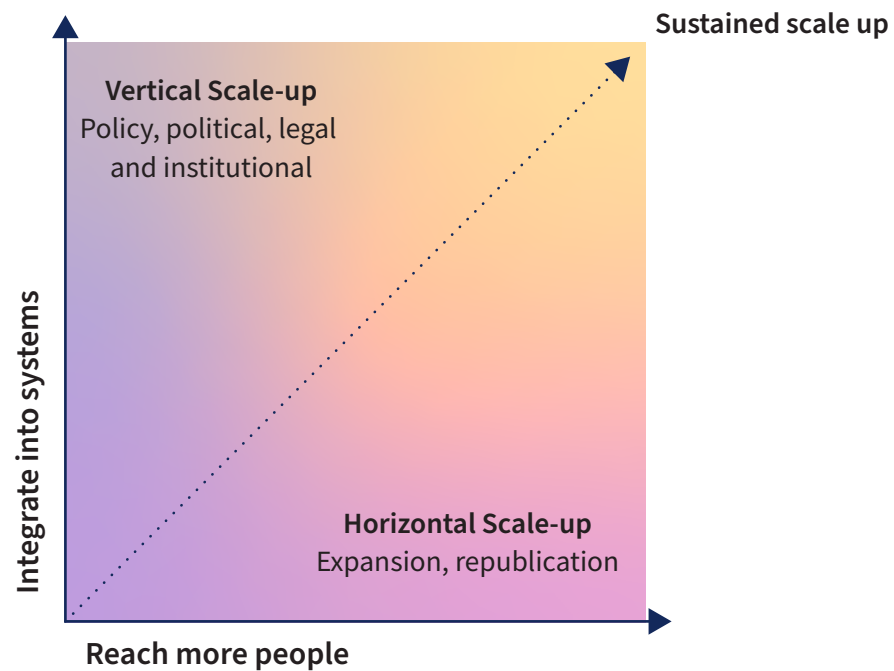


Fig. 8. Vertical and horizontal scale-up



Source: (151)

Box 35. Important questions to ask about scaling up at each phase

1. Launch

- What are the unmet needs you are going to meet?
- Who are the beneficiaries you are going to serve?
- What is the strategy for making the intervention work at scale?

2. Adoption

- What new resources, skills and policy changes are needed?
- What will it take to convince users and decision-makers?
- What organizational changes are necessary?
- How are you mobilizing the necessary support?

3. Scaling up

- What is the replication and expansion strategy and how is it being financed?
- Is the quality and fidelity of the intervention being maintained at scale?

4. Sustaining

- Are you using available information to make course corrections and maintain support?
- How are you ensuring the intervention continues to be effective at scale?
- What political, personal, or other informal channels and relationships can convince new areas (regions, districts, municipalities etc.) to introduce the intervention?
- Are economies of scale possible?

Source: (48)

6.1 Launch phase

The launch phase is the beginning of the overall scaling up process, and during this phase, efforts focus on defining a clear scaling strategy. Many of these steps overlap with the steps outlined in [Phase 1: Groundwork for implementation](#), but are applied to the specific goal of scaling up the intervention.

✓ **Establish a clear intervention objective**

Have a clear understanding of the objectives and goals of the intervention, including the specific outcomes to be achieved and the target population. Choose a parenting intervention whose targeting, and delivery modes align with local readiness for its implementation and organizational priorities.

✓ **Ensure there is a robust evidence base**

Ensure a strong evidence-base and sufficient materials and documentation for adapting the intervention to the local context (11). The evidence should be supported by rigorous research studies demonstrating the intervention's effectiveness in preventing maltreatment and improving parent-child relationships.

✓ **Assess scalability**

Many tools, such as MSI's Scalability Assessment Checklist or Real-time Scaling Labs (RTSL) (48), can help assess how relatively complex or easy the scale-up process will be, and identify ways to improve the intervention's scalability.

✓ **Plan for scale-up**

Develop a detailed scale-up plan that includes a clear description of proposed actions, timelines, roles, responsibilities, resources, and performance indicators for monitoring progress (48).

✓ **Engage stakeholders**

Engage key stakeholders, policy-makers, researchers, community organizations and parents from the early stages of intervention development. This collaboration will foster a sense of ownership and increase the likelihood of success. See [Phase 1, Step 1.1](#) on creating a stakeholder engagement plan.

✓ **Adapt the intervention as needed**

Support intervention co-designs and adaptations to ensure cultural sensitivity and relevance for the target population. See [Phase 1, Step 1.2](#) for more on co-design and co-adaptation, and [Phase 1, Step 2.5](#) for more on matching interventions with the target population.

✓ **Pilot-test the intervention**

Conduct a small-scale pilot test to assess the feasibility, acceptability, and effectiveness of the chosen intervention and use findings to inform any necessary modifications before scaling up.

6.2 Adoption phase

The adoption phase is a critical stage that aims to expand ownership of the intervention by encouraging its uptake and implementation by new organizations in a sustainable and scalable way. This requires careful consideration of existing procedures and norms within adopting organizations while allowing for the necessary modifications to make the intervention usable and ready for delivery to the target audience (11, 151).

✓ **Establish advocacy and political partnerships**

Prioritize advocacy efforts by allocating adequate time and resources for advocacy activities to secure support and long-term funding from potential donors and government organizations before implementing parenting interventions in a new context (e.g. incorporating parenting interventions into national, regional, or district-level budgets). Concurrently, establish long-term strategies resilient to political changes for sustained impact see Box 36 for an example.

✓ **Obtain national stakeholder involvement**

Establish a national committee or task force to promote political commitment to parenting interventions.

✓ **Establish collaborative and intersectoral partnerships**

Foster collaborative partnerships among diverse sectors to strengthen the support and effectiveness of the intervention. Encourage intersectoral collaborations to leverage expertise, resources, and knowledge-sharing for sustainable implementation of parenting interventions.

✓ **Identify intervention champions**

Identify and engage influential champions in communities and delivery organizations who can actively advocate for and support implementation efforts (e.g. experts on the topic with national recognition or government members with considerable influence who feel strongly about the issue).

✓ **Provide training and capacity building**

Allocate resources for comprehensive training and capacity building for intervention facilitators to ensure fidelity of the intervention model and the delivery of high-quality services to maximize impact. See [Phase 2, Step 4.2](#) for more on training requirements and strategies.



Box 36. Sustaining a parenting intervention through government structures, Chile

The evidence-based parenting intervention [Nadie es Perfecto](#) (“Nobody’s Perfect”) has been successfully adapted, implemented and disseminated in Chile since 2009. Nadie es Perfecto was developed in Canada in the early 1980s by the Public Health Agency of Canada and focuses on parents/caregivers of children from birth to the age of 5 years. The intervention’s effectiveness was tested in a nationwide evaluation study in 2009, which showed that it was effective in promoting key changes in parenting behaviours and child well-being outcomes.

In 2009 Nadie es Perfecto was incorporated into the programme offering of “Chile Crece Contigo” (a comprehensive, intersectoral, and multicomponent policy to help all children reach their full potential for development, regardless of their socioeconomic status). Chile Crece Contigo is itself embedded in a legal framework that ensures the continuity of intersectoral programme activities, supported by key government agencies, and its programme offerings are protected by law against budget fluctuations and government transitions.

Key features of the programme include its low-cost, non-proprietary nature, feasibility for large-scale implementation, and continuous support from developers for a full transfer process, which was initiated in 2009 with the adaptation of the intervention, followed by continuous trainings of multiple generations of facilitators and supervisors. Chile Crece Contigo is now seen as a model programme in Latin America.

6.3 Scaling up phase

Scaling refers to the significant expansion of the intervention’s reach and impact. This phase requires careful planning, resource allocation, coordination, and consistent M&E.

✓ **Establish quality assurance**

Implement mechanisms for ongoing quality assurance, including fidelity monitoring, regular supervision, and feedback loops to ensure consistent delivery of the intervention. Allocate resources for facilitators’ continuous training and professional development. Develop comprehensive intervention manuals and accompanying materials that provide clear guidelines and instructions for implementing the intervention to ensure effective facilitation and delivery. Facilitate the sharing of best practices and lessons learned among implementing sites to promote consistent implementation (11).

✓ **Collect data and evaluate**

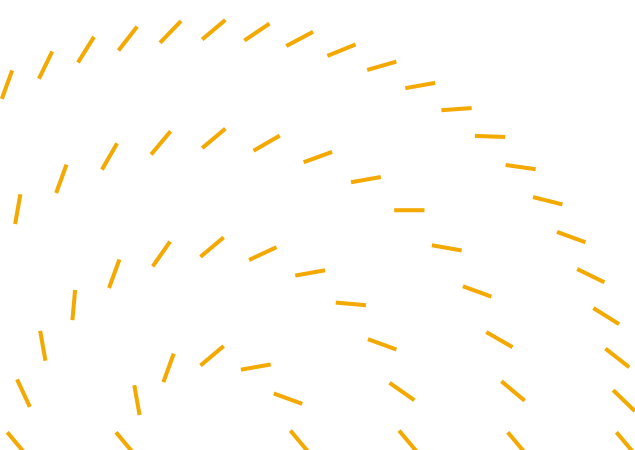
Establish a robust data collection system to monitor intervention implementation and collect outcome data. Use standardized assessment tools and evaluation frameworks to enable comparison and benchmarking across different sites. Use existing monitoring systems if embedded in public services or establish new referral systems to other services where needed (12).

✓ **Harness technology and innovation**

Explore and adopt innovative strategies to enhance the reach, accessibility, and cost-effectiveness of the parenting intervention. See [Phase 2, Step 3.2](#) for more on different delivery methods, including digital delivery.

✓ **Expand gradually**

Expand the intervention gradually in phases to establish lasting institutional capacity. Resist pressure for “explosive” scaling up, as it can lead to the loss of essential intervention characteristics and hinder progress (151). However, if sufficient resources are available or the innovation requires minimal changes in organizational practices and culture, a faster implementation strategy may be considered.



6.4 Sustaining phase

During the sustaining phase, the focus is on ensuring the long-term sustainability and institutionalization of the intervention in existing systems. This involves consolidating progress made during the initial scaling-up process and integrating the parenting intervention into policies, intervention guidelines, national budgets, and other aspects of the existing systems (171).

✓ **Secure funding for sustainability**

Explore funding sources, including government grants, private foundations, and public-private partnerships. See Box 37 for an example. Develop a sustainability plan that outlines strategies to ensure the intervention's long-term viability beyond the initial funding period (172). Phase 2, Step 4.3 provides further insight into operational planning and costs related to implementation.

✓ **Institutionalize and integrate systems**

Consider embedding the parenting intervention and ongoing M&E in existing health or social service systems to enhance sustainability and align the intervention with relevant policies and regulations (173).

✓ **Course-correct and continually improve**

Encourage implementing organizations to use adaptive management techniques by regularly collecting real-time data and information to identify areas for improvement and facilitate intervention modifications (151). Share this learning with the national coordination mechanism and other stakeholders to improve future scale-up efforts and advocate for the intervention.

✓ **Expand delivery to new contexts**

Follow established guidelines, such as the ADAPT guidance, when adapting the parenting intervention for new settings (11, 173). Regularly conduct environmental assessments to understand and track changes that may impact the scaling-up process (151).

✓ **Identify economies of scale**

Gain an understanding of the costs involved in scaling up the parenting intervention (151) and identify opportunities for cost savings through economies of scale. An example of this would be to expand the intervention to geographical regions with similar cultures and languages, leading to efficiency gains and cost savings. Explore collaborations with similar initiatives or share resources across local jurisdictions to reduce costs in the long run.

Box 37. Sustaining and scaling up interventions through public-private partnerships, Jordan, Syria and Lebanon

[Reach Up and Learn](#) is an evidence-based home visiting intervention that started in Jamaica and has since been adapted to support parents/caregivers of children aged 0–3 years in 18 countries. The International Rescue Committee adapted this model in crisis settings as part of its [Ahlan Simsim programme](#), the largest early childhood intervention in humanitarian response.

Ahlan Simsim is a partnership between the International Rescue Committee and Sesame Workshop to enhance early childhood development and learning among children affected by conflict and crisis in the Middle East. The initiative was launched with the support of the MacArthur Foundation, and additional support from the LEGO Foundation. Sesame Workshop is a non-profit organization funded through a public-private partnership with financial contributions from a number of public, government, foundation, and for-profit entities.

Reach Up and Learn trains refugee and host community workers to conduct regular visits to caregivers of young children, during which they model nurturing care, provide supportive encouragement, and lend a much-needed listening ear to parents/caregivers. As part of the intervention, the community workers demonstrate simple, homemade toys and play-based activities using context-appropriate books, puzzles, handmade toys, dolls, and local songs. The intervention is now being scaled to reach even more children and caregivers via the Ahlan Simsim programme using an audio-based intervention. The remote adaptation was made in response to the COVID-19 pandemic. An [evaluation](#) of the intervention found improvements in parent/caregiver mental health.



Conclusion

This handbook serves as a comprehensive guide for designing, implementing, evaluating, and scaling up evidence-based parenting interventions. Through a spectrum of activities to undertake groundwork for implementation, thoughtful intervention selection, and robust delivery strategies, decision-makers can effectively engage with local populations and design and adapt interventions for diverse contexts and cultures.

By focusing on strengthening implementation systems and fostering sustainability, this handbook equips practitioners with the tools needed to establish readiness for scaling up interventions and ensuring their long-term impact. Furthermore, it emphasizes the critical role of evaluation and continuous learning in refining interventions and maximizing their effectiveness. Ultimately, by adhering to the steps outlined in this handbook, decision-makers can produce parenting interventions that contribute to the well-being of families, promoting positive and lasting outcomes for communities globally.



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Annex 1: Declarations of Interest

All members of the team that drafted the handbook provided a Declaration of Interest.

Declared interests of the team members are summarized in the table below.

Table 7. Types of staff involved in implementation

Phase	Implementing personnel	Management and coordination team
Blackwell	Alexandra Oxford University, United Kingdom	Employment and consultancies with the International Rescue Committee, Parenting for Lifelong Health, and the Prevention Collaborative.
Fang	Zuyi Beijing Normal University, China	No interests declared.
Gardner	Frances Oxford University, United Kingdom	Co-developer of Parenting for Lifelong Health, a WHO/UNICEF non-commercial, open access parenting programme. Employment with Oxford University and Wolfson College, Oxford.
Lachman	Jamie Oxford University, United Kingdom	Chief Executive Officer of Parenting for Lifelong Health. Employment with Oxford University Department of Social Policy and Intervention.
Parra-Cardona,	Ruben University of Texas at Austin, United States of America	No interests declared.
Siu	Godfrey Makerere University, Uganda	No interests declared.
Thakur	Saara Oxford University, United Kingdom	Employment with Parenting for Lifelong Health and Oxford University Department of Social Policy and Intervention.

Annex 2: Methods used to develop the handbook

The development of the handbook followed a rigorous and multi-phased process designed to consolidate best practices and lessons learned in the field of parenting interventions. The process began with an extensive review of the most current and comprehensive evidence on parenting interventions, as synthesized in a systematic review conducted by WHO. This review informed the WHO guidelines on parenting interventions aimed at preventing maltreatment and enhancing parent-child relationships for children aged 0-17 years.

Phase 1: Desk research

Building on the WHO guidelines and results of the systematic review, the first phase involved identifying existing guidelines and evidence on parenting interventions to establish a foundational understanding of effective practices. A desk review was carried out to identify additional guidance and literature on parenting interventions from a global perspective. Key documents and literature identified during this phase are referenced throughout the handbook to provide evidence-based recommendations.

Phase 2: Chapter development and internal review

Each chapter of the handbook was developed by a team member with specialized expertise in the relevant topic area. Draft chapters were then subjected to a thorough internal review process to ensure cohesion and consistency across the entire handbook. This review process involved iterative feedback and revisions, guided by the overarching structure and objectives of the handbook.

Phase 3: Consultation with parenting specialists

To ensure the handbook's applicability across diverse contexts, the team consulted with parenting specialists to identify critical considerations for designing, implementing, evaluating, and scaling up parenting interventions. This consultation process involved multiple rounds of internal review and feedback from both PLH and WHO. The proposed structure, draft chapters, and final content were reviewed and revised to ensure relevance and comprehensiveness.

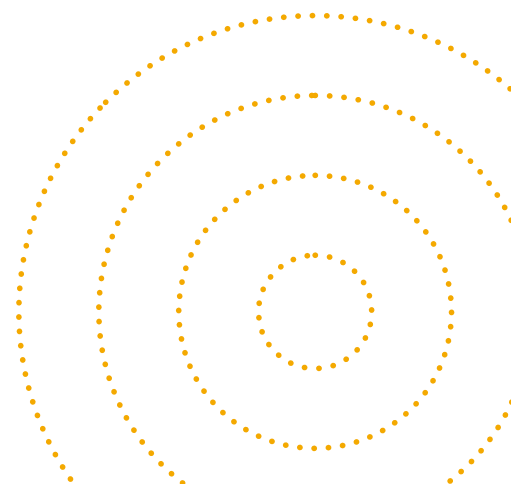
Phase 4: Field example collection and classification

Practical application of best practices was demonstrated through the inclusion of field examples. These are based on both the lessons learned during the systematic review and practice-based experience in designing and implementing parenting interventions. The team collected these field examples from real-world settings during the consultation process, as well as those identified through the authors' own experiences in designing and implementing parenting interventions. The field examples were then categorized along a spectrum of activities to illustrate the practical implications of the recommendations provided.

Phase 5: Peer review and finalization

The final phase involved an extensive peer review process. An internal group of reviewers within WHO and an external group of experts, provided critical feedback on the draft handbook. This feedback was incorporated into the final version to enhance the accuracy, clarity, and applicability of the handbook.

This multi-phased methodological approach ensured that the handbook is grounded in the latest evidence and best practices in the field of parenting interventions. By integrating existing evidence and guidance, expert consultations, field examples, and peer reviews, the handbook provides an evidence-informed, practical guide for designing, implementing, and scaling effective parenting interventions across various contexts and populations.



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