WORLD BANK GROUP

Parenting Programs to Promote the Nurturing Care of Children:

Essential Considerations

Acknowledgments

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Executive Summary

This document provides comprehensive guidelines for designing, implementing, and evaluating effective and scalable parenting programs—including by examining their costs—particularly in low- and middle-income countries. It emphasizes the critical role of nurturing care in child development, outlines the essential considerations for designing and implementing these programs to enhance caregiver-child interactions and improve child outcomes, and highlights the need for context-specific, integrated approaches to maximize program impact and sustainability.

Main messages

1. The foundational importance of nurturing care and parenting programs

Nurturing care, encompassing good health, nutrition, protection, early learning, and responsive caregiving, is fundamental for a child's cognitive, motor, language, and social-emotional development. Approximately 75% of children under five in low- and middle-income countries do not receive minimally adequate nurturing care. Parenting programs are defined as interventions aimed at enhancing caregivers' knowledge, attitudes, and practices to support their children's development. These programs focus on various areas, including health, nutrition, and responsive caregiving. Parenting programs are a key strategy to address this gap, promoting positive parenting practices and child development outcomes. These programs are not limited to cognitive development but encompass multiple areas of child development and can positively impact caregivers' well-being, violence prevention, and economic trajectories. Numerous studies and systematic reviews demonstrate the effectiveness of parenting programs in improving child development outcomes. Key impacts include enhanced caregiver-child interactions, better health and nutritional status, and improved cognitive and emotional development. Effective parenting programs share common content and delivery approaches, which can be tailored to meet the needs of families. These programs can be delivered through various formats, including home visits, group sessions, and digital platforms, to reach a broader audience.

2. Key considerations for effective implementation and scalability

Successful parenting programs require careful attention to design, training, supervision, and system readiness, including the following essential considerations:

Situational assessment: A thorough intersectoral assessment of demand, supply capacity, and the broader implementation ecosystem is crucial before designing a parenting program. This involves engaging stakeholders across health, nutrition, social protection, and education (among others), as well as community leaders, to understand cultural nuances and existing infrastructure and for identifying barriers and enablers for implementation.

Evidence-informed theory of change: Programs must have a clear, evidence-informed theory of change with measurable indicators, developed collaboratively with multiple stakeholders. This framework should consider caregivers' capacities, emotions, skills, and behaviors, alongside child outcomes.

Delivery platform and approach: integration into existing service platforms (e.g., health, education, social protection) is vital for sustainability and scalability. Programs can either implement existing, proven designs (e.g., Reach Up and Learn) or adapt core components ("active ingredients") to the local context, ensuring alignment with local workflows and capacity.

Target population and prevention level: Clearly defining the target population (including fathers and other caregivers) and the level of intervention (universal, selective, or targeted) is essential, considering varying parenting needs across child developmental stages.

Content and messaging: Content should be comprehensive, focusing on early stimulation, responsive caregiving, positive discipline, nutrition, and health promotion. Messaging should be clear, culturally relevant, and leverage behavioral science principles to encourage sustainable behavior change. Programs must be agreeable to stakeholders and families to ensure participation.

Dosage and modality: The duration and intensity of the program (dosage) and delivery format (e.g., home visits, group sessions, digital platforms) significantly influence effectiveness and are critical for success. Programs should be delivered in formats that fit the community's needs. While weekly sessions are common, higher dosages and booster sessions may be needed to sustain effects.

Facilitator selection, training, and support: The quality of facilitators is paramount. Whether trained professionals or paraprofessionals, they require adequate training, ongoing support, and quality assurance to build trust and effectively deliver the program.

Monitoring and evaluation: A robust M&E plan with pre- and post-test measurements, and ideally a control group, is necessary to assess outcomes and adapt the program. Measurement tools should be feasible, reliable, and valid within the specific context.

3. Understanding and leveraging costing data for informed decision-making

A significant barrier to scaling parenting programs is the lack of reliable costing data. The guidelines highlight the importance of systematic cost data collection and analysis, and include an application of this using tools like the Brookings Childhood Cost Calculator (C3). Key insights from country-level case studies (Uganda, Nigeria, Panama, The Philippines, The Gambia, Peru) reveal:

Cost variability: Program costs vary widely based on factors such as location (rural vs. urban), program scale (pilot vs. scale-up), and delivery modality (group sessions vs. hybrid with home visits).

Cost drivers: Direct costs, particularly labor, often constitute the majority of expenses. Program evaluation can also be a significant cost, especially in pilot phases.

Cost-effectiveness: Scaled-up group sessions tend to be the most cost-effective on a cost per beneficiary basis, while pilot hybrid programs generally incur higher per-beneficiary costs.

Strategic investment: Robust cost analyses are crucial for governments and organizations to make informed decisions about feasibility, resource allocation, and sustainability, enabling the design and implementation of cost-effective and impactful parenting programs.

Overall, this guidance note serves as a practical guide for policymakers, program designers, implementers and practitioners looking to enhance the quality and impact of parenting interventions globally. It emphasizes that successful parenting programs are not one-size-fits-all. They require tailored approaches, integration into existing systems, strong implementation structures, and cost-informed planning to ensure they are effective, equitable, and sustainable in promoting nurturing care and human capital development. Well-designed parenting programs can be a cost-effective way to significantly enhance early childhood development and strengthen families.

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Glossary

Attachment

An emotional bond that connects a child to their caregiver, typically formed in early infancy.

Secure attachment

One of many forms of attachments and contributes to emotional regulation, resilience, and social competence.

Caregivers

A person responsible for the daily care and support of a child. Includes mothers, fathers, other family members like grandparents, or non-relatives who are directly responsible for the child at home or outside the home. Caregivers can be paid (e.g., teachers, childcare providers, and paraprofessionals, or unpaid (e.g., parents).

Cognitive skills

Refer to an array of skills including (among others) literacy, abstract thinking, self-reflection, attention shifting (e.g., the ability to shift back and forth between multiple tasks), and memory.

Early Childhood Development

Period from birth until the transition into primary school (typically from 0–5 years of age) characterized by rapid physical, motor, cognitive, language, and social-emotional development.

Early learning

A component within Early Childhood Development which focuses specifically on the development of skills and knowledge through play, exploration, communication and daily interactions with caregivers. It emphasizes learning experiences that prepare children for school and lifelong learning.

Early psychosocial stimulation

Supportive interactions between a child and caregiver (e.g., talking, playing, singing, and reading) that foster a child's cognitive, language, social, and emotional development. It strengthens brain development by providing enriching experiences and nurturing relationships, especially during the first years of life when the brain is most responsive. These activities are often part of broader interventions that support caregiver mental health and promote positive parenting.

Harsh parenting

Parenting practices characterized by high levels of control, coercion, punitive behaviors, and negative emotional tone. This may include verbal aggression, psychological manipulation, and physical punishment.

Nurturing care

Includes guaranteeing children's good health and nutrition, protection from violence and other threats, exposure to early learning opportunities (e.g., play), and interactions that are emotionally supportive and responsive to children's needs.

Nurturing Care Framework

A roadmap for action that promotes the conditions children need to thrive, including good health, adequate nutrition, security and safety, responsive caregiving, and opportunities for early learning. It emphasizes the importance of supporting families and communities, especially during the first 1,000 days of a child's life.

Minimally adequate nurturing care

Refers to the basic level of care that meets a young child's essential needs for health, nutrition, safety and security, early learning, and responsive caregiving. Children who do not receive this level of care are at an increased risk of poor developmental outcomes and not reaching their full potential.

Motor skills

Set of skills including fine motor skills that involve the use of small muscles (e.g., object manipulation or drawing) and gross motor skills, which involve large muscle movements (e.g., walking or running).

Parenting programs

Interventions, activities, or services aimed at caregivers to strengthen their knowledge, attitudes, behaviors, and practices for supporting their relationships, interactions, children's development, and their own caregiver well-being.

Physical punishment

Any punishment in which physical force is used and intended to cause some degree of pain or discomfort, however light. It includes punishments such as spanking, hitting children with objects, and other forms of physical aggression.

Positive discipline

Non-violent discipline that fosters children's development, learning, and emotional well-being through guidance, communication, and reinforcement of positive behaviors.

Responsive caregiving or responsivity

The ability of caregivers to be in tune with their child's emotional state, to be able to identify and understand their child's signals, and subsequently to respond in a developmentally appropriate way and in a timely fashion. For the purposes of this guidance note we will be using the term responsive caregiving.

Shared book reading

When a caregiver reads to children in an interactive way which leads to enhancing children's language, cognitive, and early literacy development through conversation, questioning, and turn-taking.

Social-emotional skills

Includes children's emotional and behavioral self-regulation, emotional knowledge, and social competence. Children's ability to navigate their emotions, to identify others' emotional states and to get along with peers and adults.

Stimulation

Cognitively and social-emotionally enriching activities that parents and other caregivers engage in with children in or around the home, including playing, singing, telling stories, and reading, among others.

Introduction

Children's exposure to nurturing care from parents and other adult caregivers serves as the foundation for developing cognitive, motor, language, and social-emotional skills. These skills are crucial predictors of lifelong learning, health, and economic success. Yet, globally approximately 75% of children under the age of 5 (almost 200 million children) in low- and middle-income countries do not receive minimally adequate nurturing care, putting them at risk of not reaching their developmental potential.

Parenting programs have been identified as a key strategy to promote the nurturing care of children and children's cognitive, motor, language, and social-emotional development (see Blackhaus et al. 2023 & Jeong et al. 2021). This includes interventions that focus on caregiver-child interactions, shared book reading, and other forms of early psychosocial stimulation, and those that focus on violence prevention, positive discipline, and supports for parental mental health. Given their potential effectiveness, it is essential to understand how to design and implement parenting programs to improve human capital development and support the next generation.

A recent review examined ten parenting-focused projects and found that while small-scale interventions—often led by research teams—demonstrated positive impacts on child development, similar success was not consistently observed when programs were implemented at scale through government platforms. The review pointed to lower intensity, reduced frequency of sessions, and competing demands on frontline workers as key challenges that may undermine effectiveness in scaled-up settings.

These findings underscore critical gaps in implementation that can dilute program impact. They reinforce a key insight from the implementation science literature: **implementation quality is the critical driver of program success.** Integrating parenting programs into existing platforms remains a practical and scalable approach, but it requires careful attention to design, training, supervision, and system readiness.

> **Part 1** of this document provides an overview of what parenting interventions are, the different modalities often used in delivering such interventions and a summary of the evidence on their effectiveness for policymakers.
>
> **Part 2** presents a set of essential considerations that policymakers, program designers, and World Bank task teams should take into account in developing high-quality, scalable and effective parenting programs.
>
> **Part 3** addresses a critical and often overlooked consideration: the cost of parenting interventions. It outlines existing tools to estimate the cost of parenting programs and presents country-level costing data generated using one of these tools.

Together, the insights presented in this document aim to guide policymakers and task teams as they assess the feasibility, affordability, and cost-effectiveness of interventions in their specific contexts.

Part 1: Understanding Parenting Programs

What are parenting programs?

Parenting programs are interventions, activities, or services aimed at parents and other adult caregivers to strengthen their knowledge, attitudes, behaviors, and practices for supporting their relationships and interactions with their child, as well as their children's development and caregiver well-being. This includes the child's needs related to safety, health, nutrition, early learning, and healthy attachment with their caregivers. These programs are directed at children and caregivers, who are often parents, but may also include guardians, grandparents, extended family members, and anyone who serves as a child's caregiver. Parenting programs focus on developing skills and not simply providing information. The content of parenting programs often includes components of early childhood education (e.g., early stimulation), health, nutrition (e.g., breastfeeding and feeding practices), responsive caregiving (e.g., supporting caregiver sensitivity, responsivity, and the formation of secure attachments), and social protection (e.g., violence prevention). A common misconception is that parenting programs only aim at stimulating children's cognitive development. In reality, child development is composed of multiple areas (i.e. physical, cognitive and social-emotional development), so parenting programs require perspectives and contents from multiple disciplines to positively impact child health and developmental outcomes.

Box 1. Parenting, relationships, and interactions are the building blocks for lifelong development and well-being

Science has shown that nurturing care—including health, nutrition, protection, early learning, and especially responsive caregiving—is essential for human development across the life course. In childhood, the most critical relationships and interactions are often those with parents and other adult caregivers. These relationships provide the foundation for nurturing care and enable the child to receive critical inputs through meaningful interactions. Responsive caregiving—such as "serve and return" exchanges where adults notice, interpret, and respond to a child's signals—together with protection from violence and opportunities for early learning, builds the basis for lifelong outcomes in learning, physical and mental health, social-emotional development, and economic well-being.

Ethnographic and psychological evidence shows that families, parenting, relationships, and interactions may look different across settings due to variation in social norms, socialization goals, values, and attitudes. Despite evidence on variability in family composition and parenting, there is growing evidence from cross-cultural studies (e.g., the Multiple Indicators Cluster Survey or the Parenting Across Cultures project) on how nurturing care is universally important for young children's development. For example, mothers', fathers', and/or other caregivers' engagement in stimulation activities—such as playing, reading, singing songs, and telling stories—is associated with positive child development outcomes across countries. Similarly, harsh parenting by any household member, including physical punishment, has been shown to increase the risk for detrimental developmental, health, and behavioral outcomes across cultures and countries, even those where physical punishment is socially acceptable, normative, or legal.

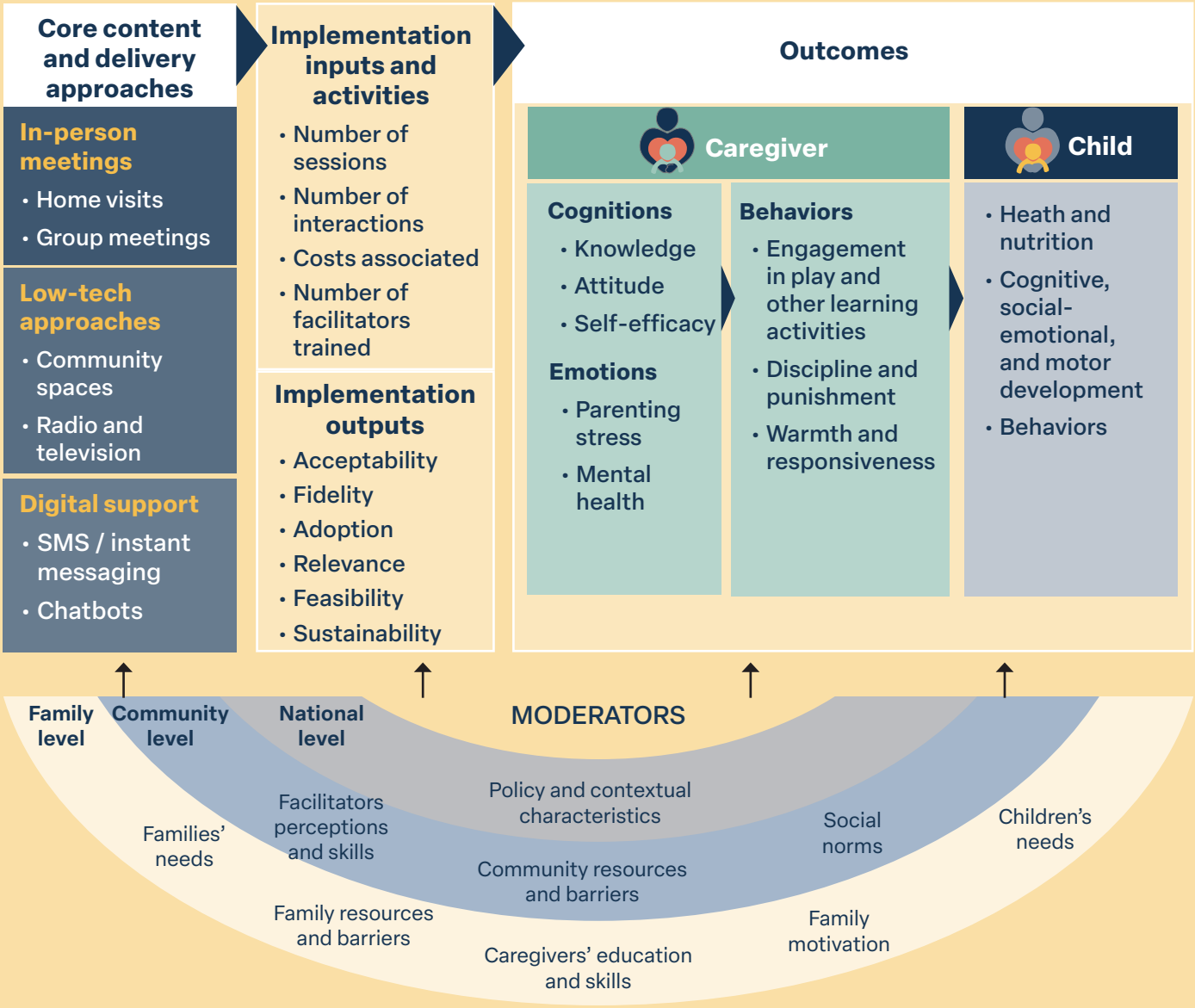
Global evidence also shows that country-level improvements in nurturing care, including positive parenting, are associated with improvements in child development across countries. Therefore, investing in strategies that promote positive parenting, relationships, and interaction can have lasting positive effects on both individual and societal outcomes.

How do parenting programs work?

While each parenting program has a specific theory of change, evidence-informed parenting programs tend to share a common set of contents and delivery approaches that have been shown to be effective in achieving impacts for caregivers and children (see Figure 1).

Parenting programs can support the objectives of multiple sectors. These programs can benefit not only children but also caregivers' physical and mental health, nutrition, cognitive development and learning, social-emotional development, the prevention of violence, and economic trajectories, among other outcomes. Therefore, parenting programs can positively impact outcomes valued in different sectors, including the nutrition, health, education, and

Figure 1. Theory of change of a parenting program



social protection sectors. Even programs with a strong focus on a specific child outcome (e.g., stimulation for children's cognitive development) have been effective in promoting other outcomes (e.g., mental health of caregivers), therefore demonstrating the potential effects of parenting programs in multiple family and child outcomes.

The core components of parenting programs can be, and have been, delivered through different platforms. Parenting programs can be delivered as stand-alone programs or integrated into an existing service platform, including health and social services, educational institutions, child protection systems, or other civil society platforms. The choice of implementation approach should be made according to the specific needs of families, as well as the resources and infrastructure available.

Parenting programs can be delivered in different formats. In-person approaches are often delivered through home visits or group meetings. Existing evidence indicates both approaches can be effective. Some components of parenting programs, such as knowledge of child development, can also be delivered virtually through mass media (e.g., radio, television, social media), or other digital approaches that leverage newer technologies (e.g., chatbots), which can reach parents at scale. Table 1 provides examples of common delivery approaches used to deliver parenting programs.

Table 2 provides examples of common types of programs that a parenting component can be incorporated into. In the Caribbean, health center waiting rooms served as venues for parenting education sessions to enhance caregiver knowledge. In Pakistan, a national community health program incorporated parenting support and in Bangladesh nutrition programs combined parenting education with growth monitoring services. Mexico's Prospera program, a conditional cash transfer initiative, included parenting workshops to encourage child health and education. Jamaica's school-based parenting program actively involved parents in improving positive parenting and early childhood development. In India, a participatory women's group provided a platform for enhancing child well-being.

Table 1. Common delivery approaches for implementing parenting programs

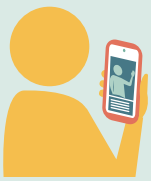
Home Visits:	
	Home visits are the most common format of program delivery, and they are usually performed by frontline workers, such as community health workers or social workers. During such visits, three types of inputs related to parenting can be delivered: knowledge, parenting techniques, and assessment of the family's needs and situation. The knowledge is passed to caregivers through clear and culturally adequate messages on how children develop, what their main needs are, and the importance of cultivating healthy environments for and relationship with the child. Then, the visitor can also demonstrate techniques on how to achieve these results, e.g., on breastfeeding and child stimulation, as well as on how the caregiver can train their awareness and responses to the children's signals, supporting a secure attachment to the child. Home visitors often leave play materials in the home or demonstrate activities that can be done with available objects in the home or without any objects at all. Finally, given consent, the visitor can observe and ask questions to assess the family's needs, as well as identify signals of heightened vulnerabilities such as food insecurity or domestic violence. This information can then be used to refer families to supportive public services, when parenting programs coordinate with local platforms. This approach also allows access to hard-to-reach families in rural areas, or those with low mobility, who do not access other services. Such visits are usually made weekly or biweekly and sometimes are also coupled with the delivery of health or nutrition services.
Group Sessions:	
	Group sessions deliver knowledge and techniques to caregivers and children in convenient locations within the community, such as primary care centers and schools. While this format is not ideal to assess individual family's needs, it has the advantage of providing peer support and reinforcement of positive social norms around parenting. Trained community health workers, community volunteers, or paraprofessionals lead these groups, demonstrating activities, supporting caregivers as they practice the skills, answering questions, and leading discussions with participants. Group sessions can also be used to deliver health and nutrition information to families, connecting them with multiple public services.
Mass Media:	
	Radio, television, newspapers, social media, and other mass communication channels can be leveraged to reach large audiences of caregivers with consistent messaging at low cost. These approaches are effective for promoting positive parenting practices—such as early stimulation, positive discipline, and child nutrition—especially in settings with limited access to in-person services.
Digital and Mobile Technology:	
	Newer technologies—such as mobile text messaging, WhatsApp, chatbots, and interactive digital platforms—offer scalable ways to provide tailored, age-specific parenting guidance. These tools can deliver just-in-time support and reminders, adapt content based on child development stages, and increase engagement through personalization and interactivity. These technologies are particularly valuable in settings where face-to-face contact is limited, such as during public health crises or in remote areas, and they support continuous, flexible delivery of parenting programs. WhatsApp and similar messaging apps allow for two-way communication, fostering engagement and enabling caregivers to ask questions or receive personalized feedback. Chatbots can simulate conversational support, making guidance accessible 24/7 and reducing the need for direct human involvement. Digital platforms can also incorporate multimedia content such as videos, audio clips, and interactive activities to enhance learning and retention. While these platforms should not entirely replace face-to-face interaction, they can boost the impact of parenting programs and extend their reach in a cost-effective manner.

Table 2. Programs where parenting components are commonly added

Health Center Waiting Room:	
	Waiting rooms in health clinics can be conveniently used to provide caregivers with information on child development, model good parenting behavior, organize activities for children, provide play toys and books, and so on. This delivery platform is a good way to reach mothers already attending their routine health visits with their children, especially when health professionals can assess the child's specific needs and communicate with the parenting program for further follow-up. However, this format might miss those who do not regularly access the healthcare system, and often are the most disenfranchised.
Community Health Programs:	
	In low-income settings, community health programs are often the best way to reach caregivers of young children. Such programs are usually implemented through frontline workers that can deliver messages to caregivers to promote early stimulation at child health checkups, growth monitoring sessions, or community events. Both home visits and group sessions often utilize community health workers, as they are typically well-known and trusted in the communities they work in.
Nutrition Programs:	
	Parenting programs can be delivered together with nutrition programs to individual families or groups and in different locations, such as health or community centers. Nutrition programs are particularly well suited to deliver knowledge on child development and parenting techniques to caregivers of young children since they usually focus on children under two, when rapid brain development is happening and the quality of inputs received by the child is especially important for their long-term wellbeing. Nutrition programs frequently promote breastfeeding and responsive feeding, which are good ways to also support warm and positive relationships between caregivers and children.
Cash Transfer Programs:	
	Cash transfer programs have expanded rapidly in all parts of the world and can be used to provide caregivers with information on nutrition, health, and early stimulation at cash delivery points or at regular gatherings for beneficiaries. This approach is particularly relevant for low- and middle-income countries, where existing early stimulation interventions may be limited and where targeted cash transfers provide a primary (and sometimes the only) vehicle for reaching vulnerable households. Cash transfer programs may also support caregivers' financial autonomy, which can help families secure stable resources for children in the long term.
School-Based Programs:	
	Schools are a powerful way to support families with young children—not only through group-based sessions, such as parent-teacher meetings and school gatherings, but also through home-based outreach. Parenting programs delivered through schools can help caregivers learn about early learning, good nutrition, health, safety, and emotional support. These sessions can benefit not only children in preschool but also their younger siblings. When schools provide parenting support, it helps parents feel more confident, builds stronger connections between home and school, and creates a shared space where families can learn and connect.
Women's Participatory Action and Learning Groups or Microfinance Groups:	
	Parenting support can be built into women's learning or savings groups to help mothers support their children's development. With the help of a trained guide, women come together to talk about parenting, health, nutrition, hygiene, early learning, and mental well-being. They share challenges and find local solutions together. These groups not only strengthen parenting but also build women's confidence, knowledge, and decision-making power. When women are supported and empowered, they are better able to care for their children.

The effectiveness of parenting programs can be measured and monitored through quantitative and qualitative approaches. However, when interpreting results, it is important to understand the potential factors influencing the programs' performance. Several contextual factors can limit the impact of parenting programs such as quality of implementation, cultural relevance, low uptake, or challenges in sustaining program delivery long enough to make a meaningful impact in children's development (see Figure 1 — "Moderators").

What is the evidence on the effectiveness of parenting programs in promoting positive parenting and child development?

There is growing high-quality evidence from systematic reviews and meta-analyses (see Blackhaus et al. 2023; Jeong et al. 2021), randomized trials, and other quasi-experimental and observational designs on the effectiveness of parenting programs and interventions. For instance, evidence from the meta-analyses and randomized trials from Colombia, Iran, Jamaica, Liberia, Peru, Rwanda, South Africa, Thailand, and The Philippines, among other settings, indicate that parenting programs tend to have the below impacts on child outcomes and on adult caregiver outcomes (most evidence is for mothers, specifically):

Figure 2. Effectiveness of parenting programs

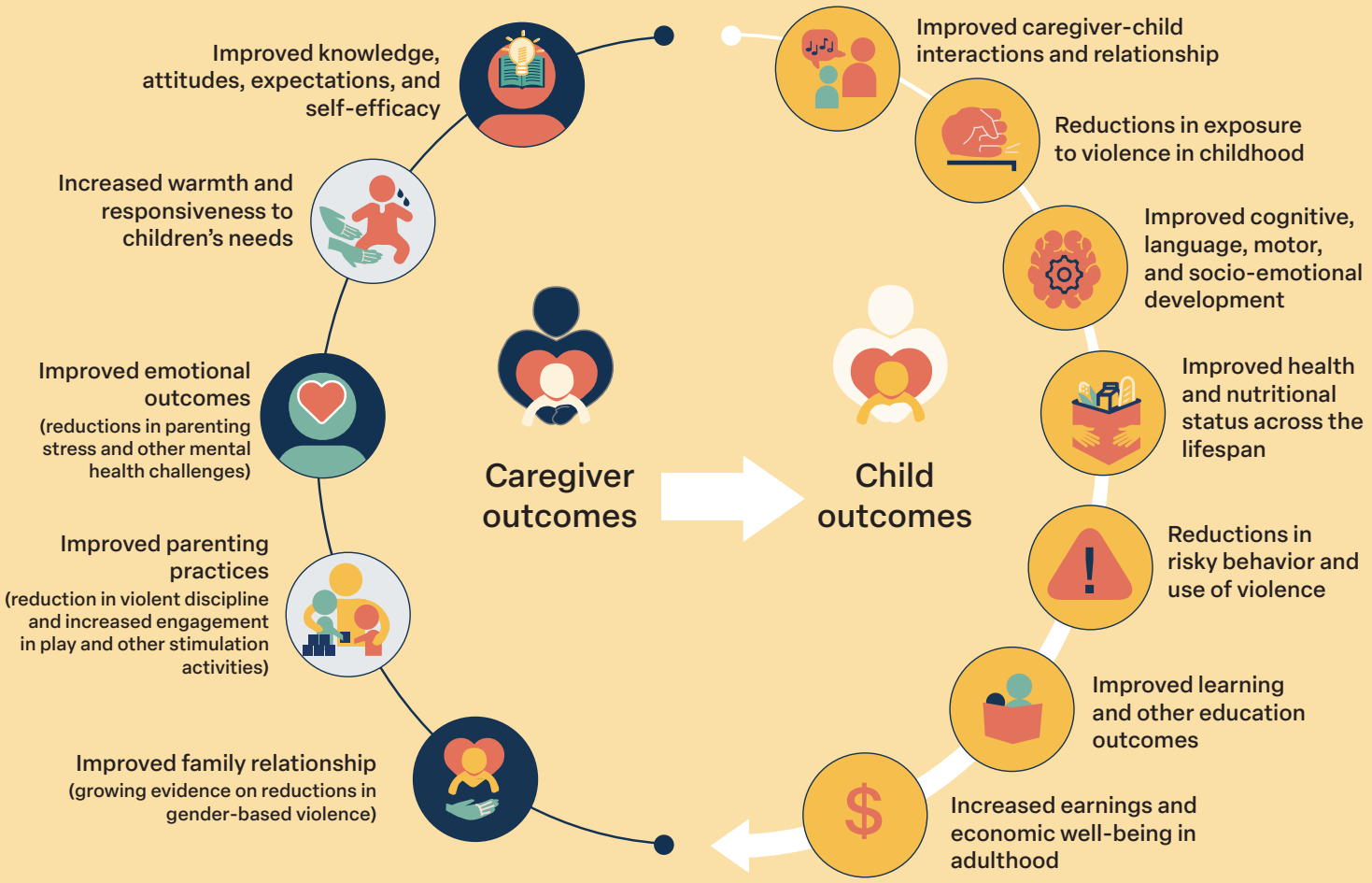


Table 3 presents illustrative examples of parenting programs implemented in different regions of the world and provides a summary of their implementation characteristics and impact.

Table 3. Illustrative examples of parenting programs implemented around the globe

Country/ Intervention	Target group and scale	Platform/ delivery setting and workforce	Dosage	Selected contents	Selected delivery strategies	Main impacts
EAST ASIA AND PACIFIC						
THE PHILIPPINES Masayang Pamilya Para Sa Batang Pilipino	60 adult caregivers of children aged 2–6 years	Embedded within a conditional cash transfer, delivered in community centers	• 12 bi-weekly sessions, 2 hours each • 5 SMS messages • One 10-minute telephone consultation	• Conflict solving skills • Child-led play • Preventing child behavior problems • Household rules and routines	• Group discussion • Role-play • Modeling • Use of illustrated stories	• Reduced child maltreatment (d=-0.50) and emotional abuse (d=-0.59) • No detectable effects for an index of positive parenting nor positive attitudes towards physical punishment
CHINA Integrated Parenting Program	222 caregiver-child (6–18 months old) dyads in 21 villages	Home visits by community health workers	• Bi-weekly home visits for one year	• Training on interactive activities • Information on child health and nutrition	• Coaching • Delivery of information	• Increased child cognitive development (d=0.24) • Reduced diarrheal illness (8.1 percentage points) • No detectable effects for health or nutrition outcomes
EUROPE AND CENTRAL ASIA						
LITHUANIA Video-Feedback Intervention	55 mothers of children aged 6 months	Psychologists with master's degree implemented the sessions	• Five (5) home visits, monthly, 90 minutes each	• Promotion of play • Sensitiveness and responsiveness	• Videotaping • Providing personal video-feedback	• Improved mothers' sensitive responsiveness (d=0.78)
WALES Incredible Years Toddler	60 caregivers of children younger than 2 years	Health visitors and childcare practitioners	• 12 weekly group meeting sessions, each about 2 hours	• Praise and rewards • Managing child behavior problems • Promotion of play	• Videotaping • Group discussions • Role-play	• Improvements in caregivers' mental health (d=0.37) • No detectable effects on child development, home environment, or child behavior, (d=0.37) use of praise (d=0.70)
NORTH AMERICA						
USA Healthy Families Massachusetts	517 first-time adolescent parents (younger than 21 years)	Home visits by trained professionals	• Biweekly prenatal visits, and weekly meetings for at least for 6 months	• Childcare • Relationship • Effective parenting skills	• Coaching • Counseling	• Reduction in parenting stress (d=0.25), less reported difficulties with children (d=0.22), and reductions in risky behaviors like substance use (d=OR=0.59)

Country/ Intervention	Target group and scale	Platform/ delivery setting and workforce	Dosage	Selected contents	Selected delivery strategies	Main impacts
LATIN AMERICA AND CARIBBEAN						
JAMAICA Irie Homes Toolbox	115 caregivers of children younger than five	Preschool teachers	• 8 weekly 90-minute group meetings	• Praising • Managing child behavior problems • Managing emotions • Child-led play • Promotion of academic skills	• Modeling • Practice of behaviors • Role-play • Group support	• Reductions in harsh parenting (d=-0.29) and increases in parental involvement (d=0.30) • Improvements in child behavior as reported by parents (d=006-0.21) but not as reported by teachers
CHILE Nadie es Perfecto	Implemented at scale; used a representative sample—2,916 caregivers and 3,597 children aged 0–5 years	Professional staff working in local health centers (e.g., nurses, psychologists)	• 6 to 8 weekly group meetings, 2 hours each	• Promotion of play and stimulation • Managing child behavior problem • Improving parental self-esteem	• Group discussion • Parents can choose the topics to discuss in each session • Provision of written materials	• Increased child vocabulary and social-emotional development (d=0.1) • Positive impacts on an index of parental behaviors and beliefs (d=0.09)
PERU Cuna Más	Implemented at scale; evaluation comprised 67,000 children aged 0–36 months old	Paraprofessionals with limited education	• Weekly 1-hour home visits	• Child-led play • Promotion of play and stimulation • Use of low-cost homemade toys	• Demonstrations • Practice and feedback • Encouragement	• After two years, increased child development scores (d=0.10), caregiver stimulation (d=0.09), and reduced physical punishment (d=-0.2) • No detectable effects on an index of positive parenting or availability of play materials in the home
BRAZIL ACT: Raising Safe Kids	245 (3.1-years-old on average) from the 2015 Pelotas Birth Cohort Study	Facilitators were staff from the Pelotas' health and education sectors who had at least a graduate degree	• Nine group-based, two-hour weekly sessions	• Child development • Strategies for behavioral regulation • Problem-solving techniques	• Training with interactive activities • Slides • Videos	• No effect of ACT on the primary outcome of child aggression (d=0.11), but ACT reduced harsh parenting (d=-0.23) • No impacts on other parenting, child development, or stress outcomes
SOUTH ASIA						
INDIA Adaptation of Reach up and Play	209 caregivers of children 10–20 months in 27 slums	Embedded within existing child development services; home visits by local community workers	• 18 months of weekly 1-hour home visits	• Maternal-child interactions • Promotion of play and stimulation • Use of low-cost homemade toys	• Demonstrations • Practice and feedback • Encouragement	• Improvements in cognitive development (d=0.35), n receptive language (d=0.22), expressive language (0.190 and fine motor (d=0.11) development
PAKISTAN Adaptation of Care for Child Development	657 mother–infant dyads, younger than 2 years	Embedded within the Lady Health Worker Program; community health workers delivered group meetings/home visits	• Monthly home visits and community meetings	• Promotion of play and stimulation • Help caregivers observe and respond to their child's signals	• Demonstrations • Practice and feedback • Encouragement	• Improvements in mother-child interactions (d=0.9), knowledge and practices (d=0.7).

Country/ Intervention	Target group and scale	Platform/ delivery setting and workforce	Dosage	Selected contents	Selected delivery strategies	Main impacts
MIDDLE EAST AND NORTH AFRICA						
LEBANON Ahlan Simsim Families	1,015 5–6-year-olds and their caregivers, Syrian and Lebanese families in communities with scarce early childhood education services	Teachers with at least one year of early childhood education experience	• Remote component: 11-weeks, 32 WhatsApp calls, 35-40 minutes each, and messages • In person: 11 sessions, 25–30 minutes once a week	• Positive relationships • Early learning • Safety and security	• WhatsApp calls and groups • Provision of learning materials • Coaching	• Improved child development (d=0.26 to 0.45) and interactions with children (d=0.40 to 0.52) • No detectable effects on parenting stress
IRAN SOS! Help for Parents	108 mothers of children aged 2–6 years	Trained physician	• Two, 2-hour sessions, one per week	• Parenting skills • Managing child behavior problems	• Discussions with trained physicians • Video clips • Role-play	• Pre- post-improvements in parenting behaviors • Reductions in harsh parenting (d=0.5)
SUB-SAHARAN AFRICA						
RWANDA Sugira Muryango	541 families with children aged 6–36 months	Embedded within the social protection system; delivered by local community facilitators	• 12 weekly home visits, each of 60 minutes. • Additional booster sessions 3 and 6 months after finishing the implementation	• Parent self-care and stress management • Conflict solving skills • Nutrition • Promotion of play and stimulation	• Coaching • Live feedback • Psychoeducation	• Improvement in motor skills (d=0.16), and personal-social development (d-0.09), as well as father engagement (OR=1.59) • Decreased harsh parenting (IRR=0.74) and intimate partner violence (IRR=0.62). • No detectable effects on child growth outcomes
SOUTH AFRICA Parenting for Lifelong Health for Young Children	148 caregivers of children (2–9 years old) with clinical levels of conduct problems	Paraprofessional community members. Community meetings	• 12 bi-weekly sessions, 2 hours each	• Conflict solving skills • Child-led play • Preventing child behavior problems • Household rules and routines • Praise	• Group discussion • Role-play • Modeling • Use of illustrated stories	• Improvements in positive parenting (39%), positive child behavior (11%) • Reductions in caregiver depression (20%)

Notes:

Cohen's d is a measure of effect size that shows the standardized difference between two means. It helps you understand how big the impact of an intervention is. A d of 0.2 is considered small, 0.5 medium, and 0.8 large.

The odds ratio (OR) compares the odds of an outcome occurring in one group to the odds in another. An OR of 1 means no difference, greater than 1 means higher odds in the treatment group, and less than 1 means lower odds.

The incidence rate ratio (IRR) compares the rate at which events happen in two groups over time. It's used when outcomes are counted over a period. An IRR of 1 means equal rates, more than 1 indicates higher rates in the exposed group.

Parenting programs that have been shown to be effective in randomized trials tend to include contents on:

- The promotion of quality one-on-one time and caregivers' engagement in play and other stimulation activities
- The promotion of non-violent discipline (e.g., praise, rule-setting)
- The promotion of positive health and nutrition behaviors
- Self-care and emotional regulation techniques
- Conflict solving skills
- Parenting that promotes gender equality.

Similarly, these programs tend to include delivery approaches aimed at promoting caregivers' capabilities, including (among others):

- Demonstrations and modeling of behaviors
- Joint problem solving
- Positive feedback and peer and facilitator support
- Role-playing, practice, and rehearsal of behaviors
- Setting parenting goals and homework

The choice of implementation approach should be made according to the specific needs of families, as well as the resources and infrastructure available. Box 2 below describes the case of a parenting program tailored to internally displaced and conflict-affected populations.

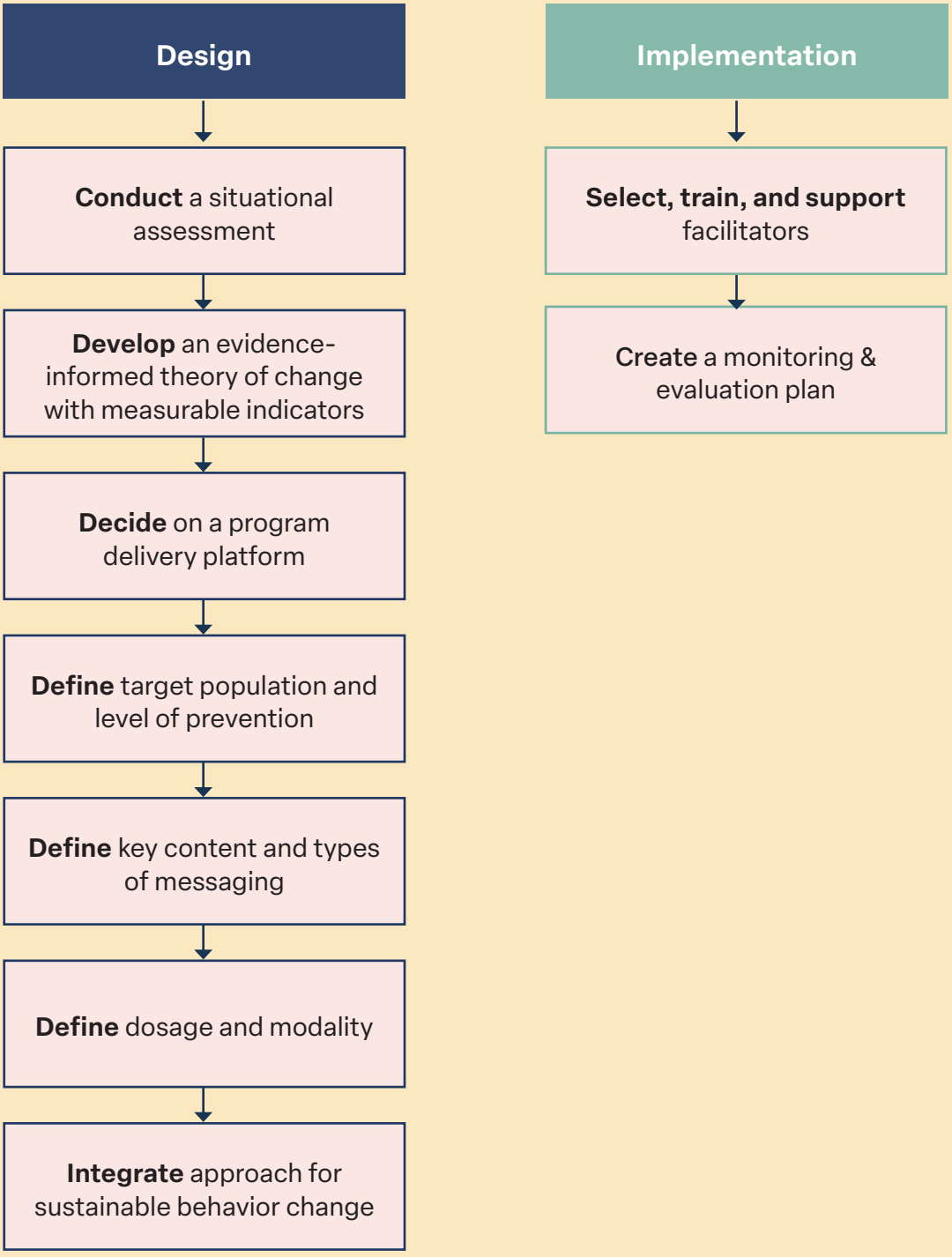
Box 2. Parenting programs for internally displaced and conflict-affected populations

Families living in Fragile and Conflict Affected (FCV) settings face considerable adversity that threatens their wellbeing, parenting, and child development. Moreover, teams working on these settings may face additional barriers to the implementation and evaluation of parenting programs. These settings offer considerable challenges but also important opportunities to promote the nurturing care of children. For example, ongoing conflict can limit access to certain areas, making it difficult to follow up with families or collect data on home environments. Social divisions between neighbourhoods can also prevent group-based sessions from bringing together caregivers across communities. These complex challenges, however, also present important opportunities to promote nurturing care for children in high-risk settings.

An example of a parenting program implemented in an FCV setting is Semillas de Apego, a community-based psychosocial program in Colombia that promotes the mental health of mothers, fathers, and other caregivers, as well as early child development. The program aims to break the intergenerational transmission of poverty and trauma derived from armed conflict, displacement, forced migration, and other adverse environments that have affected more than one million children aged 0 to 5 in Colombia. Delivered over 15 weekly group sessions, Semillas de Apego provides tools designed to: (1) process life experiences and recognize children's emotions; (2) understand child development, the effects of adversity on children, and ways to foster secure attachment bonds; and (3) build parenting teams that foster healthy relationships and stimulating care within families.

Between 2014 and 2023, the program has been implemented in different phases to analyze its appropriateness, acceptability, impact, and potential scalability. An impact evaluation of the program was conducted in Tumaco between 2018 and 2019, one of the municipalities most affected by violence in Colombia. A total of 1,370 mothers, fathers, and caregivers of children aged 0 to 5 years participated in the evaluation. The program demonstrated a positive and statistically significant impact in five dimensions: caregiver mental health, quality and style of child-caregiver relationship, child mental health, and early child development. The program is an opportunity for children and families affected by conflict and forced migration to lead healthy and thriving lives.

Part 2: Guidelines for implementation, scalability, and effectiveness



Research offers important lessons on how to implement parenting programs effectively across different settings. Parenting programs have proven effective across a range of settings, including high-income countries, low- and middle-income countries, and Fragile and Conflict Affected (FCV) contexts. Factors such as how often families participate, how long the program lasts, and how well it fits with family needs can influence how effective it is.

In short, the way a parenting program is delivered plays a crucial role in its long-term success. A review by Bower et al. (2020) identified several key factors that support program sustainability, including strong organizational capacity, thoughtful planning, reliable funding, and effective partnerships. Just as important is ensuring that the program aligns well with existing local systems and day-to-day operations. The review also emphasized the value of building staff skills. Notably, the quality of the relationship between the home visitor and caregiver stands out as a major factor influencing parent engagement—underscoring the importance of having well-trained, consistent, and trusted frontline workers who can build strong connections with families over time.

Below are some key characteristics of successful program implementation.

Table 4. Key implementation characteristics of parenting programs and interventions

Characteristic	Definition
Dosage	Frequency, intensity (e.g., duration of home visits or group sessions), and overall duration of program participation
Modality	Format of the delivery (e.g., in-person, group, virtual), including location, approach, platform.
Acceptability	Program is agreeable or satisfactory to policymakers, facilitators, families, and other actors
Adoption	Intention, decision, or action to implement or participate in the parenting program
Appropriateness and relevance	Fit or compatibility of the program with a specific culture, social norm, existing service infrastructure, unmet need, policy priority, or social objective
Feasibility	Degree to which the parenting program can be implemented in the specific setting
Fidelity	Extent to which the parenting program is implemented as planned or expected
Integration	Extent to which the parenting program is embedded into the existing service infrastructure or integrates with existing programs or services
Sustainability	Refers to how much a parenting program can be sustained over time

Design

Conduct a situational assessment

The first step in designing a parenting intervention is to conduct a situational assessment to understand demand, supply capacity and the broader implementation ecosystem. What makes this type of assessment unique is the intersectoral nature of parenting programs. National ECD strategies and action plans, many of which have been recently developed, can provide valuable insights into government priorities and planned investments. However, because parenting is influenced by multiple aspects of family life and child development, it is important to engage actors across sectors—including health and nutrition, social protection, education, and financial services. Policymakers, facilitators, and NGOs from each of these areas can help identify how their existing systems and points of contact with families might contribute to the program's success. Sectoral strategies in health, education, and social protection also offer important context for understanding the enabling environment. Early engagement with community leaders, sociologists, and anthropologists can help surface cultural entry points, social norms, and context-specific barriers or enablers that may not be captured through formal documents alone. This multidimensional approach helps ensure that the assessment is not only comprehensive but also contextually grounded.

A key part of this assessment is to look at each platform's capacity to integrate and deliver parenting content as part of their routine activities. This step is essential not only for identifying service gaps, but for designing a program that is aligned with existing structures and more likely to be sustained over time. A strong example of this approach is Chile Crece Contigo, a national early childhood support system that coordinates parenting and child development services across multiple sectors, including health, education, and social protection. Rather than creating a new program from scratch, Chile's strategy embedded parenting support into routine services already reaching families, helping ensure scale, sustainability, and equity in access.

To inform this process, it is useful to review available data from population and household surveys, such as the Multiple Indicator Cluster Survey (MICS), Demographic and Health Surveys (DHS), and Violence Against Children Surveys (VACS), as well as country-level World Bank documents like the Human Capital Review. Literature reviews can help map the current landscape—highlighting existing parenting programs, available evaluations, and potential delivery platforms.

Once initial needs are identified and existing programming is understood, it is important to speak directly with key actors. Interviews and focus groups with policymakers, frontline workers, and caregivers can provide valuable insight into system capacity, service gaps, social norms, and families' beliefs and needs. Reviewing past situational assessments in early childhood development—such as those conducted in Bangladesh—can offer useful guidance for structuring this process.

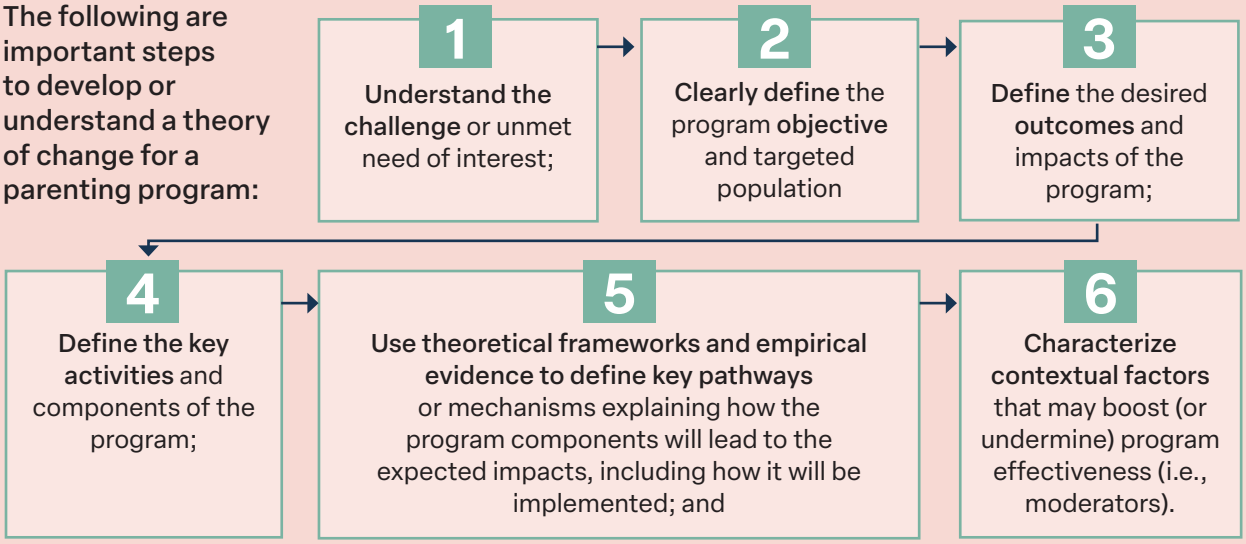
It is also important to consider how political and institutional sustainability can be built early in the process, particularly when programs are intended for government handover. This includes engaging influential champions, aligning with national priorities, and strengthening political will through evidence of effectiveness, ongoing dialogue with policymakers, and early involvement of key institutions.

Develop an evidence-informed theory of change with measurable indicators

Country teams should have a clear understanding of the program goals, as well as how to achieve and measure them. A critical step is to develop a clear, evidence-informed theory of change that identifies activities, outputs, outcomes, and impacts of programs, along with measurable indicators to monitor and evaluate progress. A theory of change can facilitate articulation between key stakeholders, planning, and evaluation. Therefore, it is important that multiple stakeholders participate in designing and agree on the theory of change to ensure a common understanding of the activities and objectives of the program.

Box 3. Steps to develop a theory of change

The following are important steps to develop or understand a theory of change for a parenting program:



Parenting programs' theories of change should consider caregivers' cognitions, emotions, skills, and behaviors, in addition to child outcomes. For example, caregivers' knowledge and attitudes (cognitions), stress and mental health (emotions), self-regulation (skills), and engagement with children (behaviors). Theoretical perspectives from ecological and systems theories, social learning theory, attachment theory, and capabilities of neuroscience-informed perspectives may be helpful to outline the potential mechanisms and moderators of the theory of change of parenting programs.

While the theory of change provides a structured starting point, it is not fixed. It should be viewed as a living framework that evolves throughout the design, piloting, and implementation process. As new insights emerge, the theory of change should be revisited and refined.

Decide on a program delivery platform

When planning to implement a parenting program, country teams should engage in dialogue with key sectors supporting early childhood development—such as health, nutrition, social protection, and education—and assess which delivery platforms are best positioned to support parenting interventions. The choice of implementation approach should be made according to the specific needs of families, as well as the resources and infrastructure available.

Parenting programs have successfully been integrated into the health, education, nutrition, and social protection sectors promoting sustainability and effectiveness. But integration means more than just linking with existing institutions. It also requires aligning the program with the daily routines of frontline workers, who are often already managing many responsibilities. Parenting activities can be added to home visits for child health check-ups, nutrition support, or school meetings. This makes it easier for workers to deliver the program consistently, using tools and approaches they are already trained in.

This kind of integration also brings important benefits for families. Parenting programs can act as an early point of contact in a broader chain of care—helping identify health, developmental, or social concerns early on and linking families to services they may not know about or otherwise access. When frontline workers already know the community and have relationships with caregivers, families are more likely to attend sessions and apply what they learn. Delivering programs through trusted platforms also helps identify families who are not yet registered in the system, creating a path for them to receive services and for governments to gather better data for planning and investment.

Together, these strategies make parenting programs more practical to implement, more relevant to families' lives, and more impactful—both for children's development and for building stronger, more inclusive service systems.

Define target population and level of prevention

Clearly defining the target population is an important step in designing an effective parenting program. Interventions should specify not only who the caregivers are, but also the age range of the children the program aims to support. Parenting needs and strategies vary significantly depending on the developmental stage of the child. For example, interventions targeting caregivers of children aged 0–36 months often focus on responsive caregiving, early stimulation, and health/nutrition, while those for children aged 3–5 years may address school readiness, emotional regulation, and positive discipline.

Parenting programs can and should benefit all caregivers and their children, not just mothers. Given that parenting programs seek to benefit caregivers' cognitions (e.g., knowledge, attitudes, beliefs, expectations), emotions (e.g., self-regulation, mental health), and behaviors to support children's healthy development, these programs can target multiple caregivers who spend time with and care for children, including mothers, fathers, grandparents, and other adult caregivers. Indeed, while fathers remain overlooked in parenting programs, a recent review that included 33 studies (15 from Sub-Saharan Africa, 6 from South East Asia, 5 from Europe and Central Asia, 3 from Latin America & Caribbean, 3 from East Asia and Pacific, and 1 from Middle East and North Africa) indicated that father-inclusive parenting programs can improve child, paternal, maternal, and couple outcomes, showing the importance of gender inclusivity in parenting programming (see also this review on how parenting programs can simultaneously reduce violence against children and intimate partner violence).

Parenting programs and interventions can vary in their intervention score according to whether the targeting is universal, selective, or indicated:

1. **Universal programs** are aimed at all parents or caregivers with no specific selection characteristics or criteria. An example could be a digital program offered to all city residents.
2. **Selective programs** are aimed at parents or caregivers that are exposed to risk factors for maladaptive outcomes, for example those living in extreme poverty or living in conflict areas.
3. **Indicated programs** are more intensive interventions aimed at caregivers who are referred to services due to experiencing high risk for poor outcomes, including for example caregivers who use violence within the home or with children with behavioral problems.

The availability of resources (funding, training, inputs) and demand (prevention or treatment) should be considered when choosing between universal, selective and indicated programs.

Define key content and types of messaging

Designing the content and messaging of a parenting program is central to achieving meaningful and lasting improvements in caregiver practices and child development outcomes. Effective programs are grounded in the nurturing care framework, which emphasizes five interrelated components: good health, adequate nutrition, responsive caregiving, security and safety, and opportunities for early learning. Parenting program content typically focuses on key areas such as early stimulation, responsive caregiving, positive discipline, nutrition, and health promotion, all aligned with the NCF pillars. The messaging approach should be clear, culturally relevant, and actionable, using principles from behavioral science to encourage sustainable behavior change—for example, by reinforcing positive habits, addressing barriers, and leveraging caregivers' motivations. Based on these considerations, countries and program designers generally have two main options to consider:

1. **Implementing an existing program design**

   Several parenting programs have demonstrated strong adaptability across diverse cultural and geographic contexts. For example, Reach Up and Learn, originally developed in Jamaica, has been effectively adapted in over 20 countries, including Bangladesh and Brazil. Similarly, Care for Child Development (CCD) has been widely used in over 40 countries as a flexible module integrated into existing health and nutrition services. Parenting for Lifelong Health (PLH) provides open-access programs for different age groups and has been adapted in over 35 countries including the Philippines.

   General Advantages: Programs that have been tested in multiple settings allow for comparison of results across countries. They often provide a clear structure, established materials anchored in global evidence, and documented outcomes. Many programs offer resources that are already translated across multiple languages and have been adapted to various contexts. Some are open-source and available at no cost.

   General Challenges: Adapting programs to the local language and culture may require time and expertise. Some programs involve licensing requirements or fees for materials and training. In addition, certain models may assume a certain level of infrastructure or workforce capacity that may not be present.

2. **Adapting core components from existing programs**

   A second option is to identify the core components, or "active ingredients," of proven parenting programs and adapt them to the local context. These components refer to the key content and delivery methods that have been shown to drive impact—such as positive reinforcement, early learning through play, and home visits. Country teams can access well-established resources to explore options of different program designs.

   Rather than using one program in full, this approach draws from the best available evidence across multiple sources to build a more context-appropriate intervention. It allows for greater flexibility and relevance, especially when local systems cannot fully support a high-cost or heavily licensed program.

   This option should always be informed by the system's ability to support training, supervision, staffing, and delivery capacity. Choosing a high-quality program that the local system cannot sustain often leads to poor implementation or abandonment over time.

   Recommended steps in using a core components approach include:

   - Reviewing evidence from existing parenting programs, including curricula, systematic reviews, and meta-analyses;
   - Piloting and testing adapted content with local families and frontline workers;
   - Running a small-scale feasibility study to assess delivery and outcomes.

Regardless of whether the approach includes implementing an existing program design or adapting core components from existing programs, it is important to consider how the target population or level of prevention can be modified without compromising outcomes. This requires identifying and preserving the program's core components—the essential elements that drive its effectiveness—while adapting surface-level features to fit the new context (e.g., language, format, examples). Modifications should be based on a strong theoretical or empirical rationale, and the new population should share similar risk factors or contextual characteristics with the original group. Adaptation for different target populations should follow a structured process, be pilot-tested, and include ongoing monitoring to ensure fidelity and effectiveness are maintained.

Additionally, piloting is particularly important. A pilot allows for testing feasibility, acceptability, and fidelity, while providing early indicators of impact. It also helps identify potential barriers and necessary refinements before committing to full-scale implementation.

Define dosage and modality

The dosage describes the duration and intensity of a given parenting program. This includes the number of visits or meetings, length of the program, frequency of sessions, and total number of contact hours. The type of delivery modality often varies greatly, from individual home or clinic visits to community-based group sessions, to hybrid-delivery modalities using in-person sessions and complementary digital supports.

Quality of delivery sessions is key, but a sufficient quantity is a precondition to achieving successful lasting results. Weekly sessions are the most used frequency. Piloting the program is useful to assess whether the frequency is sufficient. While there is no conclusive evidence on

the optimal number of visits or meetings to maximize the impact of parenting programs, recent evidence shows that the effects of these programs tend to dissipate in time, dissipating in about two years after concluding implementation (seen (see Backhaus et al. 2023 & Jeong et al. 2021). Therefore, it is probable that more is better, and higher dosage can facilitate sustaining effects. To achieve a higher dosage, it is possible to increase the number of visits and group meetings, but also to include additional booster sessions after concluding implementation through an addition visit or meeting, or using other modality such as SMSs, WhatsApp messages, or chatbots.

The ideal dosage for a given intervention should be decided based on the community or country-specific needs. For example, interventions that promote responsive caregiving can be integrated into existing clinic visits that children are already receiving. As such, teams should review the relevant literature on existing parenting programs in their context and ensure that they review similar interventions in other contexts, paying attention to the dosage delivered and the outcomes observed. Relevant literature will vary based on the context, but recent reviews of parenting programs (see Blackhaus et al. 2023 & Jeong et al. 2021) are a good place to start.

Integrate approach for sustainable behavior change

When working on the theory of change, developers need to define the essential program contents and approach that are expected to lead to impacts on caregivers and children.

Parenting programs are social interventions designed to support parents by offering knowledge, practical tools, and connections to broader community and multisectoral services. **A key step toward achieving sustainable improvements in parenting—and, in turn, in child development—is encouraging positive shifts in parenting behaviors.** Insights from behavioral science can play a valuable role in understanding what motivates behavior change and how to design programs that effectively support and sustain those changes over time.

Parenting is a demanding task, and parents and other adult caregivers need **cognitive (e.g., knowledge, planning skills, self-efficacy) and emotional resources and capabilities (e.g., self-regulation and coping skills) to achieve their parenting goals and be responsive and sensitive to their children's needs.**[1] Growing evidence indicates that structural inequities, racism, oppression, discrimination, and other contextual adversity (e.g., extreme poverty and violence) can undermine the key cognitive and emotional capabilities that caregivers require to provide nurturing care.

Within this context, behavioral science and existing evidence clearly demonstrate that providing information only is not enough to support parents and caregivers, particularly those facing adversity. Therefore, effective parenting programs tend to promote:

1. Relevant skills for parenting, including knowledge, self-confidence, positive attitudes and expectation, empathy, conflict solving skills, and self-regulation,
2. Motivation and self-efficacy/confidence, and
3. Opportunities for parents to practice and develop positive behaviors (*see above key delivery strategies identified in the literature*).

1 Cuartas & Rey-Guerra 2020; Bornstein 2015.

Implementation

Select, train, and support facilitators

One of the most important components in implementing a parenting program is the selection, training, and ongoing support of facilitators. Depending on the program's design and intensity, facilitators may include trained professionals—such as nurses, psychologists, pediatricians, early childhood educators—or community-based personnel, such as community health workers, local leaders, or experienced parent peers. While it may be ideal in some cases to involve highly qualified professionals, evidence shows that paraprofessionals can deliver high-quality interventions when provided with adequate training and supportive supervision.

Importantly, the perspectives and comfort of parents should guide facilitator selection. **Parents are more likely to engage and apply recommendations when they trust and feel respected by the facilitator.** In many primary health care settings, community health workers are already skilled in conducting home visits and supporting child development and may have prior training in monitoring developmental milestones. These existing strengths can be leveraged—either by involving them directly in program delivery or by drawing on their knowledge to provide support, referrals, or supervision within the local implementation model.

Table 5 provides examples of different facilitators employed in various parenting programs, the intervention content, and the delivery setting. As demonstrated, the type of facilitator often depends on the delivery setting and intervention goal (such as nutrition and responsive caregiving).

Table 5. Examples of parenting programs by facilitator

Facilitator	Country	Intervention Content	Delivery Setting
Trained local health worker	Bangladesh	Early stimulation and nutrition counseling & material distribution	Health center & home
	Nepal	Maternal mental health & infant nutrition counseling	Community meetings
Community workers	Jamaica	Early stimulation counseling & nutritional counseling	Home
	Madagascar	Nutrition counseling & supplements	Home
Teachers	Malawi	UNICEF Play & Learn curriculum	Childcare center

Note: All the parenting programs listed are supported by the Strategic Impact Evaluation Fund (SIEF)

It is also important to conduct quality assurance during the training and supervision process of facilitators to understand the implementation characteristics that often determine program success. Some questions that should be asked internally during training include:

1. Is the training resulting in improvements in facilitator knowledge?
2. How frequently are the facilitators contacting the parents?
   a. If less than intended, why?
3. How long do these sessions last and what content is covered in the sessions?
4. What are the facilitators' perceptions of these sessions?
5. Do facilitators feel parents understand the information being taught?
6. How often are facilitators being supervised?
7. How do facilitators and supervisors feel about the supervision structure?
8. What are the parents' perceptions of these sessions?
9. Do parents and facilitators have any suggestions for program improvement?
10. Is the facilitation and supervision structure sustainable?
11. How long does the program last?

Create a monitoring & evaluation plan

Central to implementing a parenting program is the flexibility and adaptation that are necessary to be built into the program itself. Qualitative and quantitative checks throughout the intervention process, which can be built into the theory of change itself, should be utilized for quality assurance and fidelity purposes in terms of the intervention itself, and to adapt the program as necessary.

The final step is to create a monitoring and evaluation plan to collect and leverage user feedback and measure outcomes. Ideally, this monitoring and evaluation plan should include pre-test and post-test measurements, and a control group with baseline equivalence. If a control group is not feasible, pre-test and post-test measurements should still be prioritized, and implementation characteristics should always be captured, as described above.

The selection of the measures should align with the program's agenda and aims. There are three core principles that should aid in selecting a measurement tool: feasibility, reliability, and validity.

- **Feasibility** describes how easy the tool is to be used. That is, do the facilitators understand how to use the tool? Do they feel that the way the tool measures caregiver and child behavior is an accurate depiction of their actual behavior? Is the amount of time it takes to use the tool feasible within the data collection period? Are there any costs associated with the tool?

- **Reliability** describes how consistently a tool measures a given construct. There are two main types of reliability that are often used, inter-rater reliability and test-retest reliability.
  - » Inter-rater reliability describes how similar two independent raters scores are when using the same tool to observe the same phenomenon. This can be captured by having a small percent of total observations captured by two raters instead of one in order to ensure that the tool is being applied correctly across raters
  - » Test-retest reliability describes how consistent scores from the same tool are over time when administered to the same individuals by the same facilitator. This can be captured by having a small percent of individuals observed using the same tool at two periods of time (e.g., 1 or 2 weeks apart)
- **Validity** describes if a tool measures what it is supposed to. For example, does a measure of child development truly capture the essence of child development in a given context. There are a variety of different types of validity (e.g., concurrent, criterion, predictive), and the type of validity that is of interest will likely vary based on the construct and context.

It should be noted that reliability and validity are context specific. What this means is that even if a tool is found to be feasible, reliable, and valid in one country, or even in a given city within the same country, that does not mean that the tool will be reliable and valid in a different country or city within the same country. Therefore, it is often recommended to select a tool that has been previously validated in the country where the intervention is being conducted, but to make sure the necessary adaptations and psychometric tests are conducted to ensure the tool is feasible, reliable, and valid within the specific sample you are working with within the intervention country. As such, this World Bank document, provides a framework for the why, who, what, and how questions that must be considered prior to selecting tools for measuring ECD outcomes.

There are several excellent resources that can be utilized to help select a tool (see Table 6). Parenting programs often aim to improve some aspects of the nurturing care framework (i.e., health, nutrition, safety and security, responsive caregiving or early learning). As such, a scoping review published in 2022 provides a summary of the existing tools used to measure aspects of the nurturing care framework in LMICs. However, it should be noted that the psychometric properties and theoretical relevance of these tools were not evaluated in the scoping review itself. Another systematic review, published in 2024, focuses specifically on tools that measure caregiver-child interactions in LMICs. Similar to the NCF scoping review, it does not evaluate the psychometric quality of the tools, but it provides an overview of each tool by country for task teams interested in which tools have been applied in their country of interest, and it provides a risk of bias summary for each tool included. Lastly, it is often the interest of parenting programs to quantify child development in some way. As such, it is recommended that task teams utilize the World Bank Resource: Measuring Child Development: A Toolkit for Doing it Right. This resource, published in 2017, provides an overview of existing measurement tools in the field of ECD and includes a measurement inventory for task teams to filter by the goals of their specific program. However, since 2017, a variety of new tools have been developed, so task teams should contact experts in the field and their own country partners when selecting a tool to measure child development.

Table 6. Resources to help identify measurement tools for monitoring and evaluation of parenting programs

Resource	Description
Scoping review of measurement tools and indicators for assessing nurturing care used in LMICs	Tables 3-7 provide an overview of all existing tools that have been used, how frequently they're used, how they're scored, the age range, and a brief description of each tool.
Systematic review of caregiver-child interaction	Table 1 provides an overview of the tools, the country of origin, LMIC country it was used in, age range, setting (i.e., free interaction at home, semi-structured interaction), modality, scoring system, dimensions of interaction, and how frequently they've been used. Table 2 provides more information about the practical feasibility of each tool including the time taken, stimulus required, assessors required, cost, special equipment needed, training required, and post assessment requirements.
Toolkit for Measuring Early Childhood Development in Low and Middle-Income Countries	Toolkit with corresponding ECD measurement inventory repository that allows task teams to filter by age, domain of ECD, modality of assessment, goal of assessment (i.e., screener, ability test, population-level measure), origin, number of countries it is applied and used in, training required, minimal time, and accessibility/cost.

If an intervention aims to improve parent-child interactions by promoting responsive caregiving and providing micronutrient supplementation, intermediate and implementation outcomes (such as the percentage of micronutrients being distributed) and long-term outcomes (such as levels of responsive caregiving and child development) should be measured at multiple time points. Qualitative data can also be instrumental at all time points as it can aid in understanding bottlenecks in the adaptation and implementation process (such as parents' understanding of the importance of the program as well as their understanding of their own behavior change).

Part 3: Understanding the Cost of Parenting Programs: Tools and Country-Level Insights

The lack of costing data on parenting programs leaves implementers unable to assess the feasibility of a parenting program in their context. Recent evidence finds that only fifteen percent of parenting programs report any costing data. Among the parenting programs that report cost, the incremental cost-effectiveness ratios are estimated to range from US$29 to US$5,063 per standard deviation increase in child development outcomes, leaving governments unable to estimate the cost to implement or scale up a given intervention.

Despite growing evidence of the benefits of parenting programs, a lack of reliable costing data continues to hinder informed decision-making and scale-up efforts. Most parenting interventions do not report cost information, making it difficult for governments and implementing partners to assess affordability and sustainability. Few examples include the case of PADIN in Brazil, Msingi Bora in Kenya, and a Reach-Up and Learn adaptation in India. Capturing accurate cost data is essential not only for understanding how much programs cost, but also for determining what drives those costs, how resources are allocated across components, and where efficiencies can be gained. Without this information, it is challenging to compare delivery models, estimate the financial requirements of scaling, or advocate for integration into national budgets.

Many implementers find it challenging to collect cost data in a systematic and practical manner. The World Bank's technical note, Capturing Cost Data, provides clear guidance tailored to those managing or delivering parenting programs. It emphasizes that costing is a comprehensive investigative process requiring the triangulation of budgets, monitoring data, interviews, and direct observations throughout the program cycle. While budgets and financial records form the foundation of cost data, these sources must be disaggregated by specific inputs—including the quantities and unit prices—and adjusted to reflect the portion attributable to the intervention itself. Ideally, cost data is captured in real time during program implementation, as retrospective collection at project close risks inaccuracies and missing information.

Building on these foundational data collection principles, a range of costing tools have been developed to support implementers and policymakers in estimating and analyzing the costs of parenting programs. This section introduces costing tools developed by UNICEF, the ILO, and the Brookings Institution. We further demonstrate the application of the Brookings Childhood Cost Calculator (C3) to generate detailed, context-specific cost estimates. This section illustrates how costs vary and identifies key cost drivers that influence the feasibility of parenting programs.

Costing tools

There are three primary costing tools that were developed for the purposes of understanding the cost of Early Child Development interventions: The ILO's Care Policy Investment Simulator, UNICEF's Early Childhood Education (ECE) Accelerator Simulation Model and the Brookings Childhood Cost Calculator. Although these are not the only costing tools that exist within the field of ECD, these are the most widely used for ECD-specific costing.

The ILO's Care Policy Investment Simulator was developed to be used to build an investment case for integrated and transformative care policy packages, including early childhood care and education services (ECCE), based on care needs and existing policy gaps. By providing both the investment requirements and the benefits that these investments generate in terms of return on investment, job creation and reduction of gender inequalities in employment, this Simulator is a powerful advocacy tool to place this topic in national agendas and convince governments to act.

UNICEF's ECE Accelerator Simulation Model was created to develop scenarios for better planning and financing of ECE services. The focus of UNICEF's model is on early childhood education and focuses on costing and policy analysis.

The Brookings Childhood Cost Calculator (C3) is an online, publicly accessible costing tool for a range of ECD and education interventions. The tool allows for cost data to be entered into a guided survey form, and can provide a range of calculations, estimates and simulated costs. It includes different cost classifications such as cost categories, resource types, investment versus recurrent costs, imputed (donated) resource costs, and functionalities such as currency conversions and amortization.

Table 7 illustrates a comparative summary of the Brookings C3, ILO Care policy Investment Simulator, and UNICEF ECE Accelerator Simulation Model across their purpose, area of focus, users, costing method, type of analysis and cases for use. Overall, the ILO tool is more suitable for policies (e.g., parental leave), while the Brookings tool is geared towards parenting programs.

The Brookings C3 tool can be used to gain a comprehensive understanding of program costs, including total program cost, cost per beneficiary, and detailed cost distributions. C3 enables analysis across multiple dimensions. For the purposes of our analysis and based on the availability of costing data, we focus on cost classifications, cost categories, and resource types. Figure 2 outlines the key cost categories within each dimension, providing a structured framework for assessing cost distributions. The first level is cost classification: overhead costs and direct costs. The second level is the cost categories. Within overhead costs, cost categories include Program Design, Indirect Program Management, Program Evaluation, Other Overhead Costs. Within direct costs, cost categories include Training, Direct Delivery, Direct Program Management, Transfers to Individuals or Families, Other Direct Costs. The third level is resource types which include Labor; Building, Land, and Infrastructure; Materials, Supplies, and Equipment; Travel, Accommodation, and Transportation; Facilities Rental; Other Resources.

Table 7. Comparison of early childhood costing tools

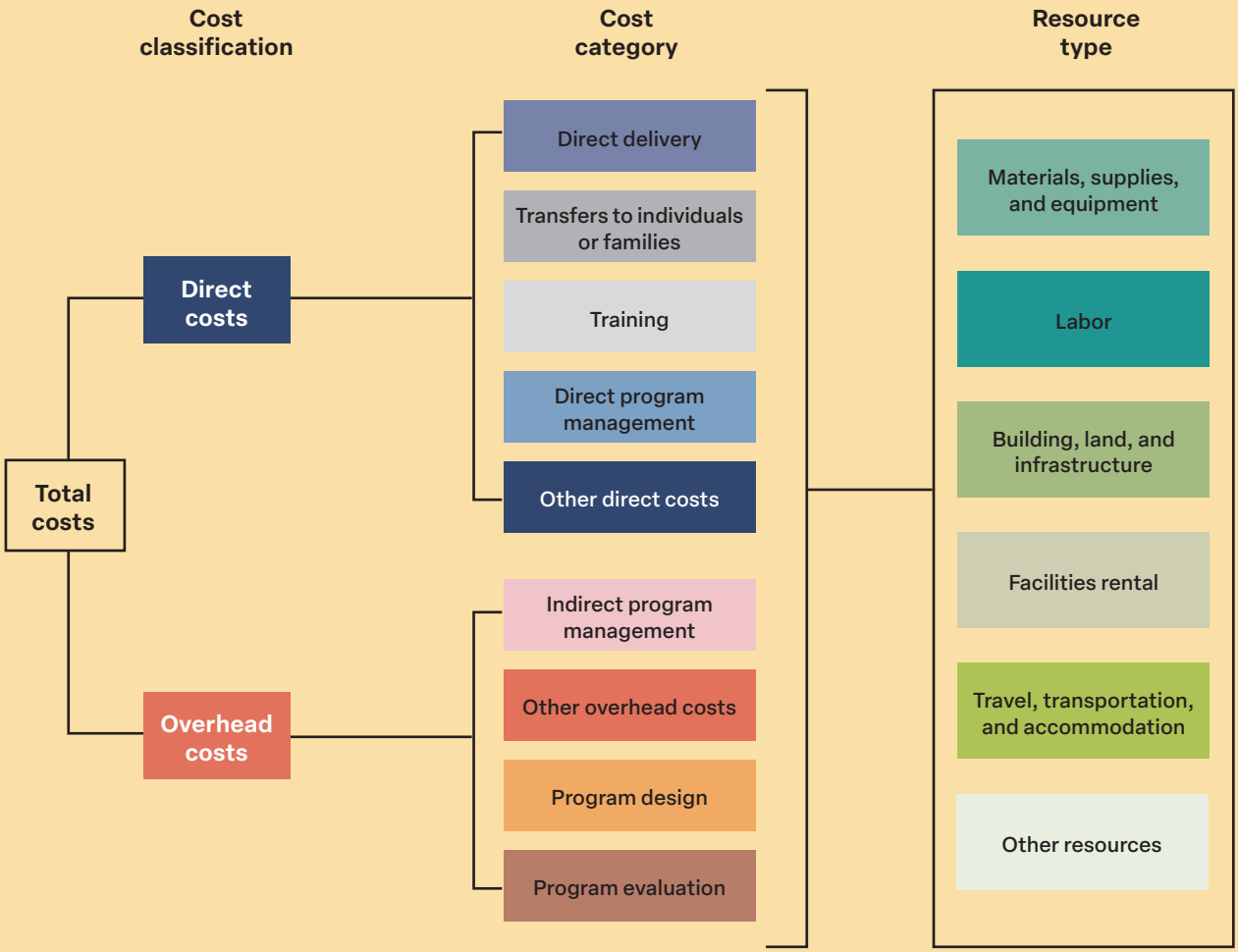
	Brookings Childhood Cost Calculator (C3)	ILO Care policy Investment Simulator	UNICEF ECE Accelerator Simulation Model
Purpose	To facilitate costing of past, current or future (potential) programs to determine cost per beneficiary and total (resources needed), compare costs between initiatives, understand cost distribution, and costs of scaling	To present how to close care policy gaps through investments in country- specific gender-transformative care policy packages and assess the multiple benefits of investing in the care economy.	To develop scenarios for better planning and financing of ECE service delivery through evidence-based decision-making and exploring their relative feasibility, scalability, and sustainability.
Area of focus	All intervention areas with a focus on children (education, health, nutrition, social protection, water & sanitation, governance)	Parental leave, breastfeeding breaks, childcare and long-term care services with quality care jobs	Early childhood education
Users	Governments, international organizations, policymakers, funders/donors, researchers, implementing organization staff, and other stakeholders		
Costing method	Micro-costing/Ingredients-based costing	Macro-simulation based on input-output and SAM data and 180 other variables embedded in the tool	Micro-costing and macro-costing
Type of analysis	Descriptive and prescriptive	Descriptive and prescriptive	Prospective
Used for	Cost economy and cost efficiency analysis: Planning, budgeting, scaling	Cost-effective and cost-benefit analysis subject to availability of additional data.	Cost-benefit analysis for planning, budgeting and policy and legal reforms
How to use the tool	Users access the online tool through a cost-free registration process. After selecting from a set of sectors and intervention types which are used to differentiate cost calculations, users enter data into an online guided survey form distinguishing between cost categories, resource types, investment versus recurrent costs, and imputed (donated) resource costs. The tool includes built-in functionalities such as currency conversions and amortization. Guidance provided in the online tool as well as in a user guide. Additional support available	Users access the online tool through a cost-free registration process. After selecting one or more countries, they can set policy parameters for one or each of the 4 care policies, choose the projection year and run the results which include: investment requirements (available in national currency, USD and %GDP), job generation (by direct, indirect and induced jobs, disaggregated by gender and formality) effects on employment ratios of women, gender earnings gaps and ROI. Guidance to be provided in a tutorial video in the online tool and user manual. Additional support to ILO Constituents and partners on an ad-hoc basis and through ILO-ITC global and regional training programs on the care economy	Users download the tool from the ECE Accelerator website. This is a freely downloadable tool accompanied by a detailed user guide. Users input data into the 'inputs' sheet within the template, followed by entering policy decisions into the 'policy decisions' sheet. The tool automatically populates all other sheets using pre-added formulae. The results are shown in the form of required human resources, infrastructure and financial resources. Various costing scenarios are also provided in the model to pick from.

Source: Authors

The designers of The Brookings C3 tool intended for the following questions to be answered by various users:

1. What resources are needed to deliver an intervention?
2. Is the project feasible within a given budget? (Cost-feasibility Analysis)
3. What are the cost implications of a programmatic change, such as in dosage?
4. What would be the cost of scaling up a program or intervention?
5. How do the costs of intervention A compare to those of intervention B?
6. What are the cost drivers of this intervention?
7. What is the cost per beneficiary of an intervention or program?
8. How are costs distributed across cost categories for this intervention or program?
9. How are the costs distributed across resource categories for this intervention or program?
10. How are the costs distributed between one-time costs and recurring costs?

Figure 2. Categories within the Brookings Childhood Cost Calculator



Case study: Applying the C3 tool to a parenting program in Uganda

To demonstrate how to complete a costing analysis using the C3 tool, we will use a parenting program in Uganda as a case study. This pilot program delivers group sessions to caregivers with children under 6 years and is designed to support caregivers during climate-related stress (see Box 4). Costing data was compiled using project budgets, and interviews with project staff to accurately categorize costs, providing estimates of both financial and economic costs.

Box 4. Uganda—Pilot program to support parenting during climate-stress

Program description:

In Uganda, the parenting program delivers group sessions that promote positive parenting and play-based approaches. With a localized focus, the program integrates climate stress reduction, resilience-building techniques, and community-based resources to better support caregivers in the region. Beneficiaries include caregivers with children under six years old, who receive training through physical manuals, text messaging, and video-based resources to reinforce key parenting practices.

This program is considered a pilot given its limited scale and scope—it reached approximately 250 caregivers with children under age six. The specific geographic coverage and duration were limited, consistent with a pilot-phase intervention.

Total cost of program:	Total cost per caregiver per year:
$104,428.16	$417.71

Cost classification

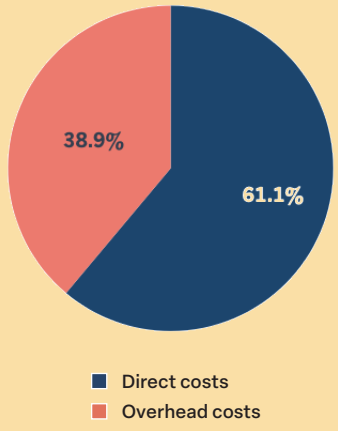
Costs are divided into two main categories in the C3:

- **Direct costs** refer to the expenses directly tied to administering an intervention.
- **Overhead costs** refer to the broader costs of designing, administering, or evaluating the programs that are not specifically tied to day-to-day service delivery.

Costs by classification in Uganda

In the case of Uganda, direct costs account for 61.1% of total expenses, while overhead costs account for 38.9% (see figure 3).

Figure 3. Costs by cost classification



Cost categories

Within the Direct Cost Classification of the C3 tool, Cost Categories include:

- **Training:** Costs associated with delivering training to those who provide direct services to beneficiaries (e.g., teachers or parents). This does not include program staff training costs, which fall under direct or indirect program management.
- **Direct delivery:** Costs associated with providing services or instruction directly. This includes salaries for teachers, center workers, or home visitors, as well as the cost of classroom materials, medications, or nutritional supplements.
- **Direct program management:** Costs linked to managing the program itself (excluding broader administrative allocations covered under indirect program management or general operations).
- **Transfers to individuals/families:** Cash, scholarships, in-kind support, or any other disbursements provided directly to households.
- **Other direct costs:** Any necessary costs that do not fit into the above categories but are essential to implementation.

Within the Overhead Cost Classification of the C3 Cost Calculator, Cost Categories include:

- **Program design:** Costs incurred prior to official implementation, including feasibility studies, proposal development, and contracting.
- **Indirect program management (Administration):** Indirect administrative and departmental overhead (e.g., electricity, water, rent). Centralized services such as human resources, legal, or procurement that are allocated as a percentage of personnel or program costs. Program-specific administrative costs (e.g., dedicated telephone lines, postage, printing).
- **Program evaluation:** Costs for formal internal or external evaluations, including baseline/endline studies, enumerator training, and evaluation reports. (Ongoing program monitoring is considered a direct program management cost.)
- **Other overhead costs:** Any overhead expenses not covered above but required for program execution.

Costs by categories in Uganda

In Uganda, Figure 4 shows direct costs broken down by cost categories. Direct Program Management accounts for 36.4%, Direct Delivery for 31.8%, and Training for 22.7%. Both Transfers to Individuals or Families and other Direct Costs each account for 4.6%.

In Uganda, Figure 5 shows overhead costs broken down by cost categories. Program Evaluation, which includes baseline and endline evaluations, accounts for 85.7%. Program Design and Indirect Program Management each account for 7.1%.

In Figure 6, we merge the direct and overhead cost categories to show their share of total expenses in Uganda. The largest single category is Program Evaluation (33.3%), which includes baseline and endline studies. This is followed by Direct Program Management (22.2%), Direct Delivery (19.4%), and Training (13.9%). Each of the following category's accounts for 2.8% of total costs: Indirect Program Management, Transfers to Individuals/Families, Program Design, and Other Direct Costs.

Figure 4. Direct costs by cost category

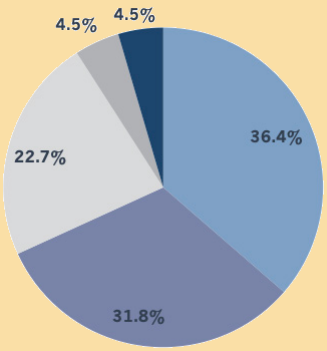


Figure 5. Overhead costs by cost category

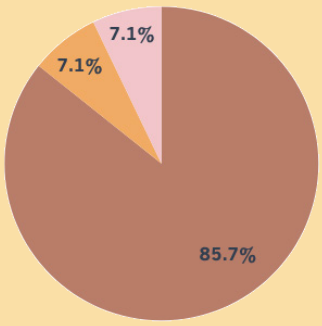
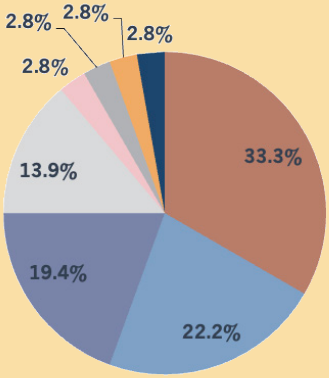
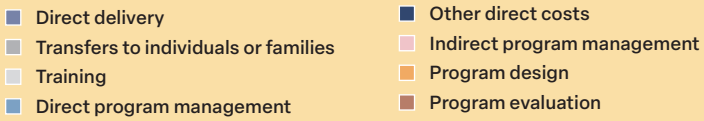


Figure 6. Total costs by cost category





Resource types

To examine how funds are being allocated and spent within the cost categories, each entry in the cost calculator is associated with a resource type. Each cost entry in the C3 Cost Calculator is associated with one of six primary resource types:

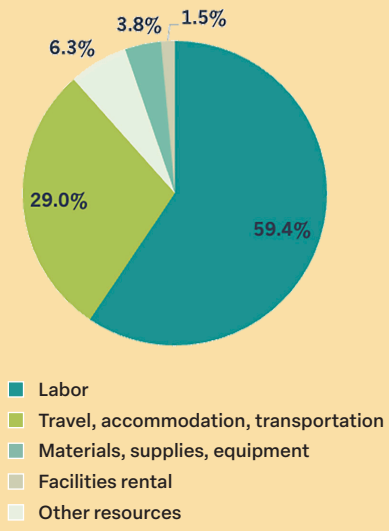
1. Labor
2. Building, Land, Infrastructure
3. Materials, Supplies, Equipment
4. Travel, Accommodation & Transportation
5. Facilities Rental
6. Other (for any expenses that do not fit the main resource types)

Labor costs are distinct from facilities rental, where the program does not own the infrastructure but pays rental or usage fees. Travel, accommodation, and transportation encompass fuel, vehicle rentals, tickets, and per diems.

Costs by resource type in Uganda

In Uganda, Figure 7 illustrates how costs are distributed across the resource types. In Uganda, Labor makes up 59.4% of total costs. Travel, Accommodation, & Transportation is 29.0% of costs. Other accounts for 6.3%. Materials, Supplies, & Equipment make up 3.8%. Facilities Rental is 1.5%.

Figure 7. Costs by resource type



Factors influencing the cost of parenting programs

Parenting program costs vary widely due to numerous factors, including program priorities, available resources, and regional contexts. Regional cost differences are evident in labor costs, income levels, and overall economic conditions. To explore this variability, we analyzed six countries, including an intervention in Uganda which was used as a case study above. All six countries include: Uganda (AFR), Nigeria (AFR), Panama (LAC), The Philippines (EAP), The Gambia (AFR), Peru (LAC). All six countries, with the exception of Peru, received grants from the Early Learning Partnership Multi-Donor Trust Fund under the Parenting and Caregiving funding round. In order to understand the costs related to these programs, we classified all six countries into three dimensions:

1. **Location:** Rural or urban.
2. **Program scale:** Pilot or scale-up.
3. **Delivery modality:** Group sessions or a hybrid-delivery modality (group sessions + home visits).

Implementing a parenting program in both rural and urban settings presents distinct cost considerations. However, rural areas often have higher implementation costs due to the need to reach widely diverse populations, requiring additional travel, logistical coordination, and staffing. Furthermore, marginalized communities (e.g., Indigenous Peoples) living in remote locations may require additional costs for cultural adaptations (e.g., translating materials to specific dialects).

Additionally, the costs and logistics of implementing a parenting program depend on whether it is a pilot or a full-scale rollout. Pilots generally require intensive monitoring, adaptive learning, and a higher per-beneficiary cost due to limited economies of scale. They often involve smaller sample sizes, which means fixed costs—such as training facilitators, developing materials, and setting up monitoring systems—are distributed across fewer beneficiaries. In contrast, scaling up a program can reduce per-beneficiary costs by leveraging existing infrastructure, streamlining processes, and benefiting from efficiencies in procurement and training. However, expansion efforts require additional investments in quality control, capacity building, and system integration to ensure fidelity and effectiveness at a larger scale.

The choice of delivery modality—whether through group sessions alone or a hybrid-delivery modality which includes home visits— also impacts program costs and outreach. Group sessions are often more cost-effective, allowing facilitators to engage multiple families at once, optimizing resources such as venue costs and facilitator time. However, a hybrid-delivery modality that combines group sessions with home visits can enhance effectiveness, particularly for vulnerable families who may require personalized support. This approach increases costs due to home visits requiring additional travel, individualized engagement, and the need for more trained staff. In remote or marginalized communities, home visits can be essential but logistically complex, requiring careful planning to ensure cost-efficiency while maintaining program impact.

Table 8 illustrates examples of parenting programs implemented in different countries and provides a summary of program factors and associated costs. In most cases, direct costs made up the majority of total program expenses and labor was the largest resource type. Detailed cost estimates for each program below can be found in Annex 1.

Table 8. Program factors, total cost, cost per beneficiary, and cost breakdown by country

Country	Target group	Location	Program scale	Delivery modality	Total costs ($)	Total cost per beneficiary ($)	Total direct costs (%)	Total indirect costs (%)	Largest resource type (%)
Uganda	250 caregivers with children under 6	Rural + urban	Pilot	Group sessions	$104,428.16	$417.71	61.1%	38.9%	Labor (59.4%)
Nigeria	400 young girls and women	Rural + urban	Pilot	Group sessions + home visits	$232,427.53	$581.07	56%	44%	Travel, Accommodation, Transportation (35.6%)
Panama	1,200 caregivers from Indigenous communities with children between 6 and 36 months	Rural	Pilot	Group sessions + home visits	$1,490,572.00	$1,242.14	57.9%	42.1%	Labor (57.9%)
The Philippines	300,000 caregivers from low-income households with children under 18; enrolled in Pantawid Pamilyang Pilipino Program (4Ps)	Rural + urban	Scale-up	Group sessions	$3,506,584.50	$11.69	96.3%	3.7%	Labor (84%)
The Gambia	7,096 caregivers with children under 3; beneficiaries of The Nafa Programme	Rural	Scale-up	Group sessions + home visits	$692,909.79	$97.65	63.1%	36.9%	Labor (34.4%)
Peru	277,283 families with children aged 0 to 36 months	Rural	Scale-up	Group sessions + home visits	$158,924,298.86	$573.15	79%	21%	Materials, Supplies, Equipment (32.6%)

Note: The number of beneficiaries and associated costs are subject to change upon completion of interventions.

Costing analysis insights

Below is an overview of the parenting programs featured in Figure 9 (see below), which compares their delivery strategies (group sessions vs. hybrid) and scale (pilot vs. scale-up) in terms of overall costs. The analysis shows that scaled-up group sessions tend to be the most cost-effective, while pilot hybrid programs generally incur higher costs.

Panama — Cuidarte (Pilot, hybrid modality)

Cuidarte tested a combination of group sessions and home visits to support early childhood development among Indigenous Peoples (IPs) with children aged 6–36 months. Caregivers participated in weekly family visits and quarterly group sessions, used videos and materials on positive parenting, and received low-cost, high-impact toys to reinforce key developmental practices.

Nigeria — AGILE (Pilot, hybrid modality)

The AGILE program traditionally focuses on women's and girls' literacy centers and schools. A pilot parenting component was added, comprising group sessions twice a week and bi-weekly home visits based on the Nurturing Care Framework. Beneficiaries include girls and children enrolled in AGILE, with a focus on promoting positive parenting messages.

Peru — Cuna Más (Scale-up, hybrid modality)

Cuna Más has scaled up to reach over 277,000 families, delivering early childhood interventions that include both weekly home visits and monthly group sessions. This hybrid model targets families with children aged 0–36 months and pregnant women in rural areas, aiming to reinforce developmental messages through regular in-person support.

The Gambia — Playful, Positive Parenting in the Nafa Programme (Scale-up, hybrid modality)

Part of the Gambia RISE Project, the Nafa Programme integrates cash transfers with Social and Behavioral Change Communication (SBCC). In its expanded phase, it has added a playful, positive parenting component consisting of bi-weekly group sessions and monthly home visits for families already enrolled in the Nafa Programme. The goal is to build essential parenting skills that enhance early childhood development.

Uganda — Supporting Parenting During Climate Stress (Pilot, group sessions)

This pilot parenting program focuses on group sessions aimed at promoting positive parenting and play-based approaches in regions affected by climate stress. The intervention integrates resilience-building techniques, climate-stress reduction strategies, and local community resources to help families cope. Beneficiaries include caregivers with children under six years old, who receive training through physical manuals, text messages, and video-based resources to reinforce key parenting practices in challenging environmental conditions.

The Philippines — Parenting Mental Health in 4Ps (Scale-up, group sessions)

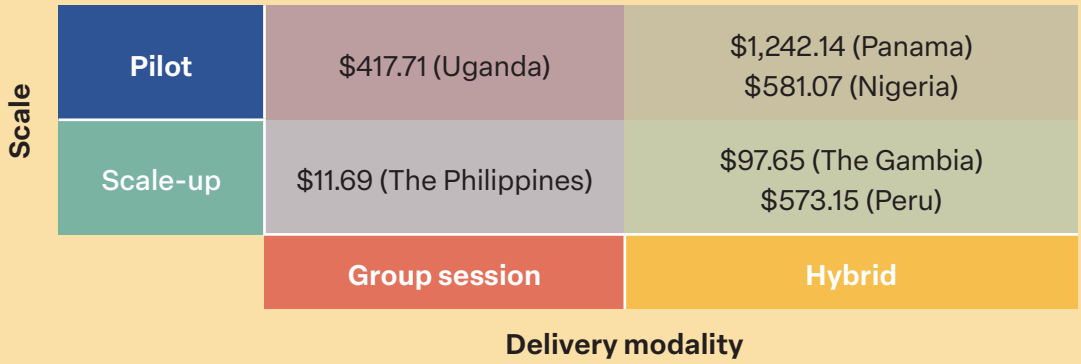
The 4Ps recently added a parenting mental health component, delivered mainly through monthly group sessions. A new mental health app has also been introduced to support social

workers during these sessions. The primary beneficiaries are parents and caregivers in low-income households, targeting approximately 300,000 individuals. Indirect beneficiaries include children aged 0–18 and pregnant mothers within these households.

Taken together, these examples highlight how programs vary in delivery modality, target populations, and scale, both of which are important factors that influence cost. As illustrated in Figure 9, group sessions at scale are generally more cost-effective, while pilot-phase hybrid-delivery modalities (combining group sessions and home visits) tend to have higher costs per beneficiary.

These categories are meant to provide a preliminary framework for comparison but should be interpreted with caution due to contextual differences and the limited number of countries included.

Figure 8. Cost per beneficiary across delivery modality and scale



Costing analyses play a crucial role in enabling governments, organizations, and policymakers to make informed decisions about the feasibility and scalability of parenting programs. The lack of comprehensive costing data has been a significant barrier to assessing the true financial requirements of parenting programs, leading to uncertainty about resource allocation and sustainability. By leveraging existing costing tools such as the Brookings C3, stakeholders can gain a clearer understanding of cost structures, cost drivers, and potential efficiencies.

The variability in costs across regions, program scales, and delivery strategies underscores the importance of context-specific budgeting. Rural programs often require additional resources for outreach and adaptation, while urban programs may face higher labor and operational costs. Similarly, scaling up a program can reduce per-beneficiary costs through economies of scale, but ensuring quality at scale requires strategic investments. Delivery strategies also influence cost-effectiveness, with group-based interventions generally being more economical than hybrid-delivery modality that include home visits. Ultimately, investing in robust cost analyses enhances the ability to design and implement parenting programs that are both cost-effective and impactful.

Conclusion

Parenting programs are a critical investment to promote early childhood development, strengthen families, and build human capital. When designed and implemented thoughtfully, these programs can improve caregiver well-being, strengthen parent-child relationships, and support children's health, learning, and emotional development.

As countries consider adopting these programs, two foundational principles should guide implementation: first, integration into existing local delivery platforms such as health, nutrition, or social protection services; and second, adaptation to the cultural context and specific needs of families to ensure relevance, uptake, and sustained impact.

This guidance note highlights that successful parenting programs are not one-size-fits-all. Rather, they must be tailored to local realities, integrated into existing service delivery systems, and supported by strong implementation structures—including trained and trusted facilitators, adequate dosage, meaningful community engagement, and cost-informed planning to ensure feasibility and sustainability. Drawing from global evidence and lessons learned, the note offers practical steps teams to design, adapt, implement, and evaluate parenting interventions that are effective, equitable, and sustainable.

By leveraging existing platforms, aligning with caregiver needs, adapting to the cultural context, embedding programs into local systems, and grounding efforts in cost-informed planning, countries can deliver parenting support at scale—reaching families with the tools and encouragement they need to help children thrive.

Annex 1. Costing Analysis by Country

Case 1: Panama—Cuidarte (pilot, hybrid modality)

Program description:

In Panama, Cuidarte was a pilot parenting program that combined group sessions and home visits (hybrid-delivery modality) to support early childhood development. The program targeted caregivers who lived in rural areas, identified as Indigenous Peoples (IPs), and had children between 6 and 36 months old. Using a structured ECD curriculum, Cuidarte facilitated weekly family visits and quarterly group sessions where caregivers engaged with videos and other materials on positive parenting techniques. Additionally, the program provided low-cost, high-impact toys to support caregiver-child interactions and reinforce key developmental practices.

Total cost of program:	Total cost per caregiver per year:
$1,490,572.00	$1,242.14

Direct costs constitute 56.0% of the total costs whereas overhead costs account for 44.0% of total costs.

The largest cost category, 32.7%, is allocated to Program Design, followed by Training at 23.9%. Additional cost categories include Direct Program Management (17.4%), Other Direct Costs (13.6%), Other Overhead Costs (10.8%), Direct Delivery (1.2%) and Indirect Program Management (0.4%).

Figure A1.1. Costs by cost classification

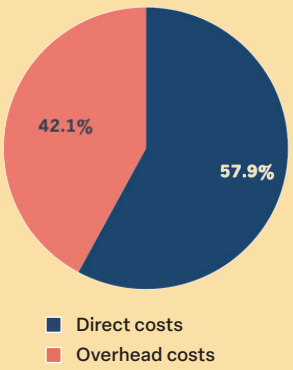


Figure A1.2. Costs by cost category

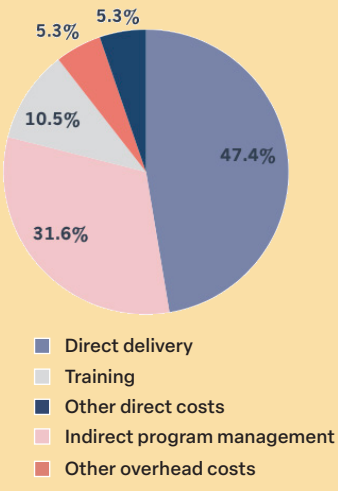
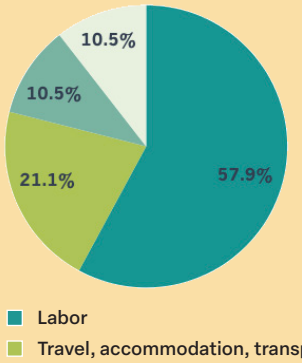


Figure A1.3. Costs by resource type



Case 2: Nigeria—AGILE (pilot, hybrid modality)

Program description:

In Nigeria, AGILE is a large-scale program that establishes mass literacy centers and schools for women and young girls. As part of a pilot initiative, the program is integrating a parenting component into its existing structure. Beneficiaries include girls and children enrolled in AGILE, with parenting group sessions twice a week and bi-weekly home visits designed around the Nurturing Care Framework to promote messages around parenting.

Total cost of program:	Total cost per caregiver per year:
$232,427.53	$581.07

Direct costs constitute 56.0% of the total costs whereas overhead costs account for 44.0% of total costs.

The largest cost category, 32.7%, is allocated to Program Design, followed by Training at 23.9%. Additional cost categories include Direct Program Management (17.4%), Other Direct Costs (13.6%), Other Overhead Costs (10.8%), Direct Delivery (1.2%) and Indirect Program Management (0.4%).

Most costs are attributed to Travel, Accommodation, & Transportation (35.5%) and Labor (35.3%). Facilities Rental accounts for 11.7% whereas Materials, Supplies, & Equipment account for 8.5% and Other Costs account for 8.9% of total costs.

Figure A2.1. Costs by cost classification

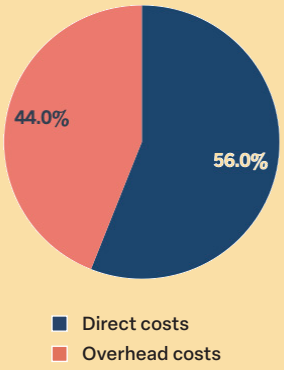


Figure A2.2. Costs by cost category

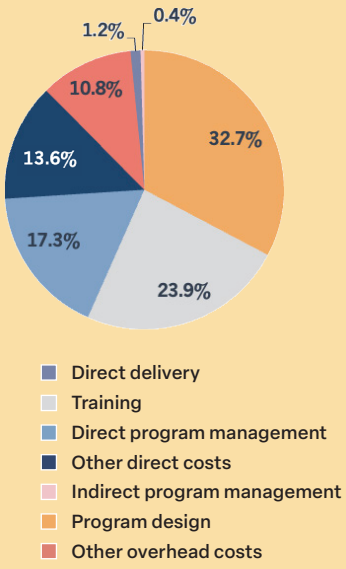
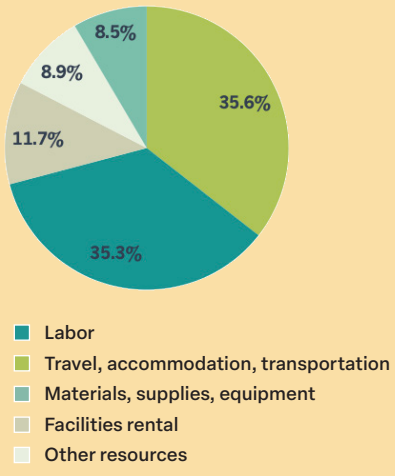


Figure A2.3. Costs by resource type



Case 3: Peru—Cuna Más (scale-up, hybrid modality)

Program description:

In Peru, the Cuna Más parenting program was scaled-up to reach 277,283 families in total. The parenting program focused on weekly home visits, but also comprised of monthly group sessions to support in delivery of ECD messages (hybrid- delivery modality). Program beneficiaries include families with children aged 0 to 36 months and pregnant women living in rural areas.

Total cost of program:	Total cost per caregiver per year:
$158,924,298.86	$573.15

Direct costs constitute 79.0% of the total costs whereas overhead costs account for 21.0% of total costs.

The largest cost category, 31.9%, is allocated to Training, which is followed by Direct Program Management (19.6%). Additional cost categories include Direct Delivery (14.5%), Transfers to Individuals or Families (8.7%), Indirect Program Management (8.0%). Program Evaluation, Program Design, Other Direct Dosts, and Other Overhead Costs each account for 4.4% of the total costs.

Most costs are attributed to Materials, Supplies, & Equipment (32.6%). Travel, Accommodation, & Transportation accounts for 22.5% of costs, followed by Labor at 18.1%. Additional costs include Other Costs (17.3%), Buildings, Land, & Infrastructure (5.1%), and Facilities Rental (4.4%).

Figure A3.1. Costs by cost classification

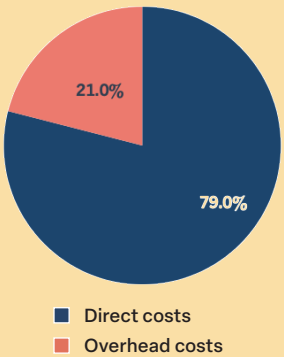


Figure A3.2. Costs by cost category

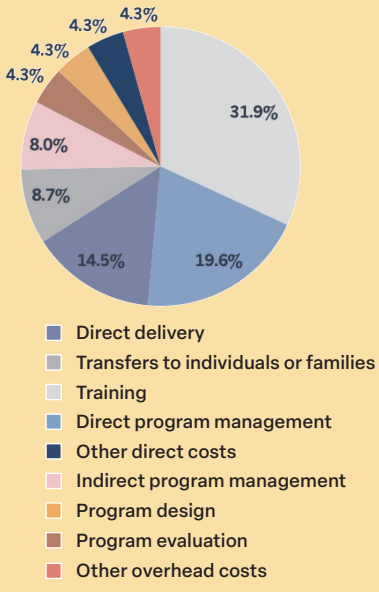
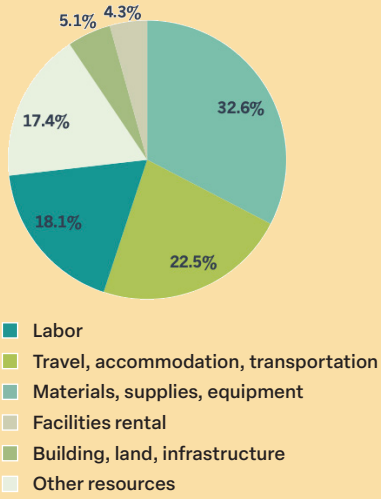


Figure A3.3. Costs by resource type



Case 4: The Gambia—Playful, Positive Parenting in the Nafa Programme (scale-up, hybrid modality)

Program description:

In The Gambia, the Nafa Programme under the Gambia RISE Project integrates cash transfers and Social and Behavioral Change Communication (SBCC) to support vulnerable families. As part of its expansion, the program is scaling up a parenting component that includes bi-weekly group sessions and monthly home visits within the existing Nafa infrastructure. This initiative targets caregivers of children aged 0 to 36 months who are already beneficiaries of the Nafa Programme, equipping them with essential parenting skills to enhance early childhood development.

Total cost of program:	Total cost per caregiver per year:
$692,909.79	$97.65

Direct costs constitute 63.1% of the total costs whereas overhead costs account for 36.9% of total costs.

The largest cost category, 32.8%, is allocated to Training, which is followed by Program Design (21.3%) and Direct Delivery (13.9%). Direct Program Management, Program Evaluation, Transfers to Individuals or Families each account for 5.7% of total costs. Indirect Program Management, Other Direct Costs, and Other Overhead Costs each account for 4.9% of the total costs.

Most costs are attributed to Labor (34.4%), followed by Travel, Accommodation, & Transportation. (29.5%), Other costs (13.9%), Materials, Supplies, & Equipment (9.0%), Facilities Rental (7.4%), and Buildings, Land, & Infrastructure (5.7%).

Figure A4.1. Costs by cost classification

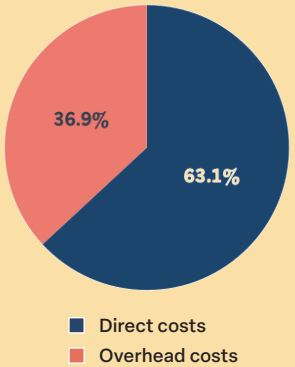


Figure A4.2. Costs by cost category

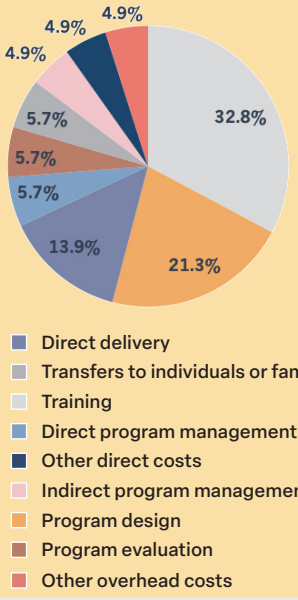
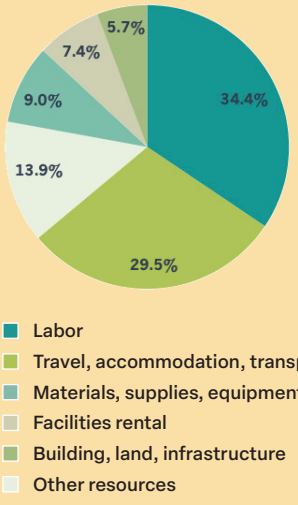


Figure A4.3. Costs by resource type



Case 5: The Philippines—Parenting Mental Health in 4Ps (scale-up, group sessions)

Program description:

In The Philippines, a parenting mental health component, consisting of monthly group sessions, is being integrated into the existing national 4Ps program. This includes the creation of a mental health app which serves as a resource for social workers delivering the parenting group sessions. This initiative targets household with children aged 0 to 18 years and pregnant mothers who are already beneficiaries of the 4Ps, which targets low-income households. The program aims to reach at least 300,000 caregivers in low-income households by the end of 2025.

Total cost of program:	Total cost per caregiver per year:
$3,506,584.50	$11.69

Direct costs constitute 96.3% of the total costs whereas overhead costs account for 3.7% of total costs. Overhead costs are significantly lower than direct costs as the parenting program is integrating into an existing scaled-up program.

The largest cost category, 80.3%, is allocated to Direct Delivery. Additional cost categories include Direct Program Management (8.7%), Training (7.3%), Program Design (3.2%), Program Evaluation (0.3% and Indirect Program Management (0.3%).

Most costs are attributed to Labor (84.1%). Materials, Supplies, & Equipment account for 7.7% and Travel, Accommodation, & Transportation account for 7.5%. Facilities Rental and Other Costs account for 0.5% and 0.3%, respectively.

Figure A5.1. Costs by cost classification

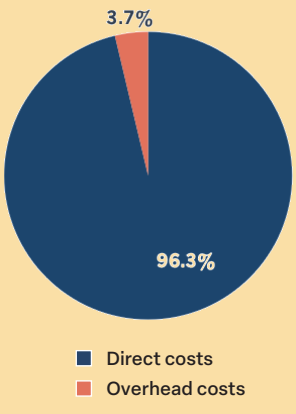


Figure A5.2. Costs by cost category

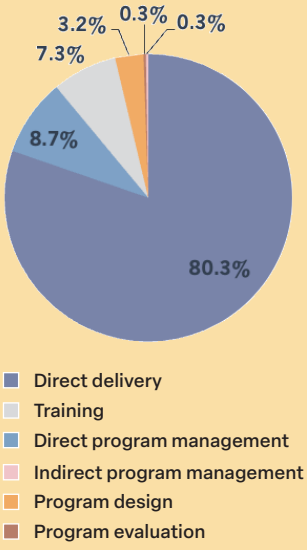
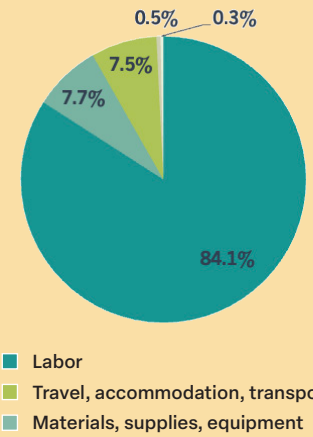


Figure A5.3. Costs by resource type



Case 6: Uganda—Supporting parenting during climate stress (Pilot, group sessions)

Program description:

In Uganda, the pilot parenting program focuses on group sessions aimed at promoting positive parenting and play-based approaches in regions affected by climate stress. The intervention integrates resilience-building techniques, climate-stress reduction strategies, and local community resources to help families cope. Beneficiaries include caregivers with children under six years old, who receive training through physical manuals, text messages, and video-based resources to reinforce key parenting practices in challenging environmental conditions.

Total cost of program:	Total cost per caregiver per year:
$104,428.16	$417.71

In the case of Uganda, direct costs account for 61.1% of total expenses, while overhead costs account for 38.9%.

The largest category is Program Evaluation (33.3%), which includes baseline and endline studies. This is followed by Direct Program Management (22.2%), Direct Delivery (19.4%), and Training (13.9%). Each of the following category's accounts for 2.8% of total costs: Indirect Program Management, Transfers to Individuals/Families, Program Design, and Other Direct Costs.

Labor makes up 59.4% of total costs. Travel, Accommodation, & Transportation is 29.0% of costs. Other accounts for 6.3%. Materials, Supplies, & Equipment make up 3.8%. Facilities Rental is 1.5%.

Figure A6.1. Costs by cost classification

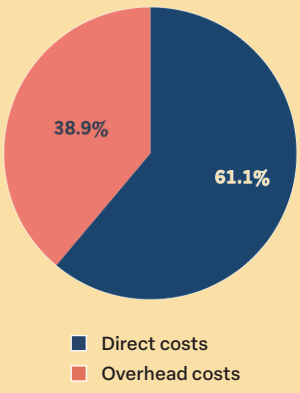


Figure A6.2. Costs by cost category

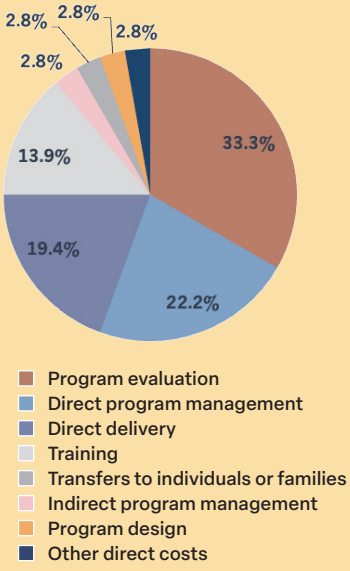
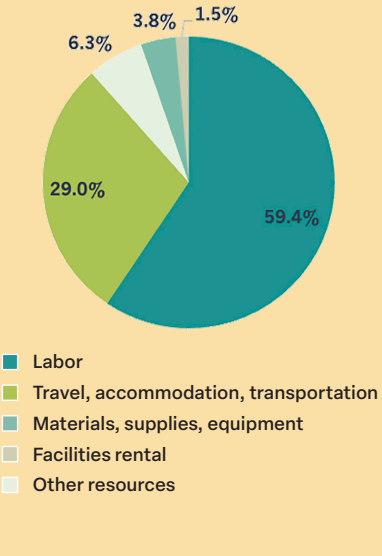


Figure A6.3. Costs by resource type

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