Web Appendix Table D: Saving Brains responsive care and early learning (RCEL) Transition-to-Scale projects: Summary of challenges and course correction

Project Name	Transition to scale of an integrated program of nutritional care and psychosocial stimulation to improve malnourished children's development	An integrated intervention targeted at deprived pre-school children in rural areas	Home visiting programs to improve early child development and maternal mental health	Saving Brains, Changing Mindsets
HUMAN RESOURCES: CHALLENGES AND COURSE CORRECTION				
Interaction with existing services	Integration and coordination with health services in rural Bangladesh.	Competition from a new government-run parenting program, ICBF.	Integration into existing family health strategy home-visits increased visit frequency but reduced number of families visited. Local workers demanded financial incentives to deliver new project and prioritized pre-existing activities.	Issues encountered were gaining confidence and trust of construction companies, quality assurance of individual NGOs, securing adequate infrastructure, particularly as a decline in the construction industry slowed project progress
Adaptation for implementation	-	Shift required from didactic learning to 'demonstration and practice' method of learning. Supervision forms were adapted to type of data collected.	Busy schedule of Community Health Workers (CHWs) meant missed appointments were not rescheduled. Child Development Agents (CDAs) more frequently rescheduled visits. Supervision was jeopardised by existing heavy workloads and required intervention by project coordinator.	During scale-up, the focus remained on strengthening supervision quality of partner NGOs.
Training time commitment	Training schedule difficulty for government clinic workers was mitigated by split of training schedules to maintain clinic duty cover.	Long training time commitment was mitigated by incentivisation.	-	-
Staff recruitment / remuneration / retention	Salaried government workers expected incentivisation for additional work and some refused to conduct sessions; this was mitigated by motivational meetings and supervision.	Attrition of workers was mitigated through fast-track training programme. Workers in one affluent town did not value RCEL project, and tasks were unfamiliar to these workers (<3% of sample).	Difficulty in identifying CHWs to deliver intervention in addition to existing routine. High turnover of CHWs considering intervention too time consuming.	Difficulties in identifying sufficiently qualified workers, but not overqualified and viewed RCEL as 'beneath their station'. Initial high attrition rates as workers apprehensive about working with children <3 yrs. Changes made to training modules and selection criteria.
Supervision	-	Reticence from providers unfamiliar with close coaching was mitigated by promoting positive tutoring relationships. Implications and impacts from rurality of workers on supervision.	Supervision not considered a priority by supervisor priority requiring project coordinator to intervene, holding meetings with CDAs and performing supervised visits.	-
CONTENT: CHALLENGES AND COURSE CORRECTION				
Adaptation for implementation	Minor adaptations to Reach-up for the pair study and major adaptation for the group study. Adapted for use in community clinics instead of homes and to be used for fortnightly visits instead of weekly in both studies.	Simplification of curricula language to facilitate provider use. Reluctance to lend toys/materials led to introduction of toy library. Wide developmental age range in groups led to adaptation with more baby-friendly routines and sub-groups by age.	Reach-Up was adapted for twice monthly visits instead of the original weekly visit. Mothers did not like the toy's original appearance which they considered poor. Toy was redesigned to be more appealing.	During scale-up in other regions of India e.g. Bangalore, training module was contextualized, and nutrition menu adapted to the local context.
Materials	Complaints regarding quality of toys (parents) led to extended provider training to facilitate more 'fun' interactive	Initial reluctance for recyclable toy materials but toy-making workshops changed perceptions. Toy library	Materials required cultural adaptation. Adaptation guide needed to be clear regarding exactly what could be adapted	Materials were translated for regions requiring the desired learning materials.

	sessions and directions for making new toys.	developed to promote unrestricted use which was appreciated by caregivers.	and what concepts had to be maintained to guarantee fidelity.	
Recipient attendance, retention & incentivisation	Attendance challenges included distance to clinic, late start to sessions, and expectation of nutritional supplement. More timely attendance and stricter time-keeping encouraged. Incentivisation included oil supplementation distribution & caregiver motivational meetings.	High value of project nutritional package incentivised attendance. Tutors and providers supported problem-solving to overcome barriers to attendance (i.e. long distances, travel costs, job responsibilities etc.). Encouraging positive social interactions meant beneficiaries more motivated.	Beneficiaries had no other incentives but the program itself. The major cause of attrition was mobile populations due to rental accommodation. Mothers enjoyed and wanted to complete the programme.	-
References	(1-3)	(1, 4)	(1, 4)	(1, 5)

CDA=Child development agent, CHW=Community health worker, RCEL=Responsive caregiving and early learning

References

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