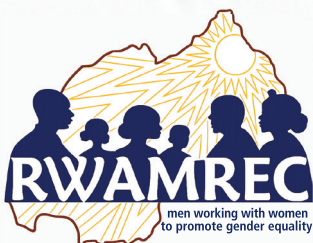
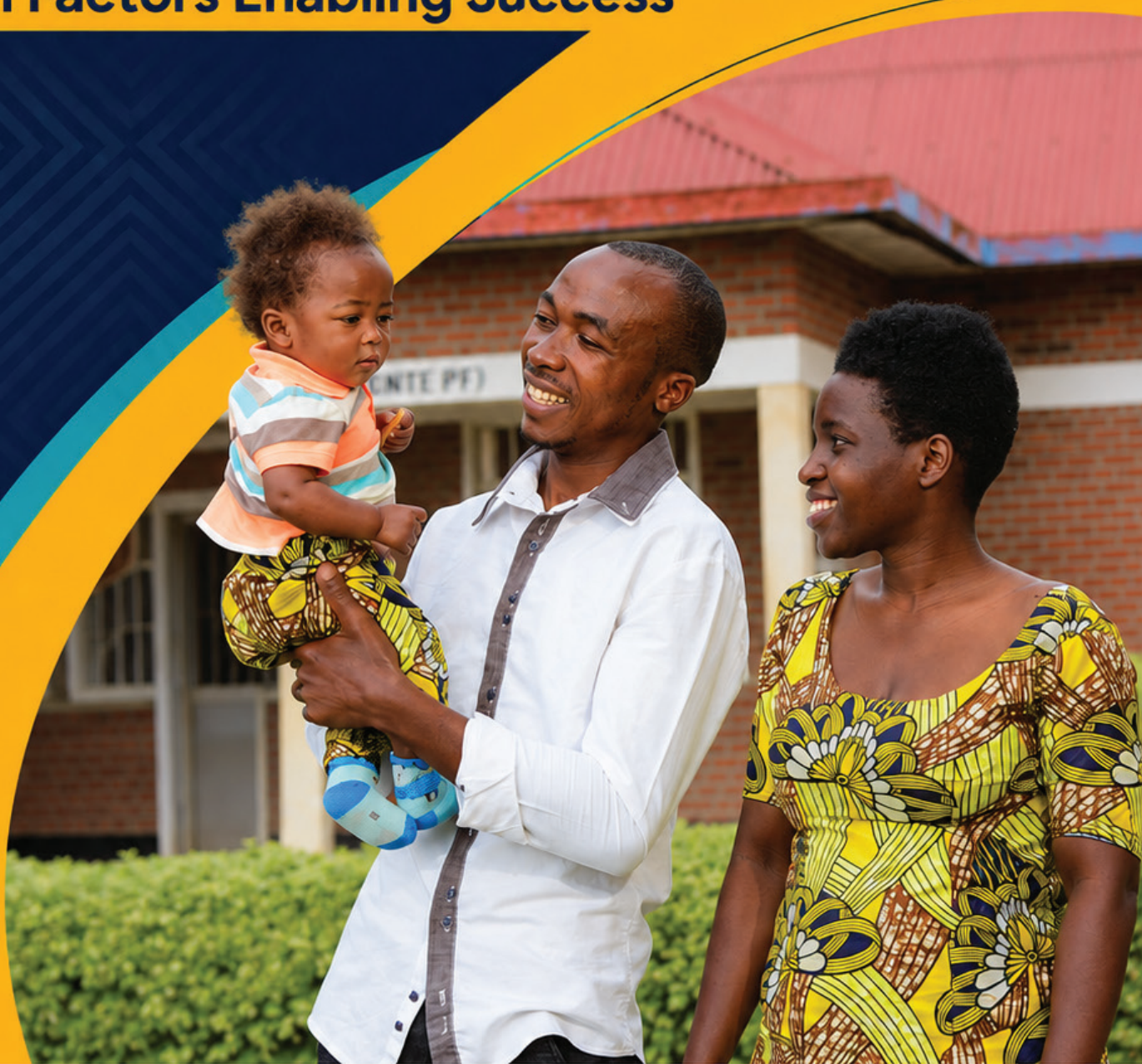


Scaling Bandebereho through the Rwandan Health System:

Ten Factors Enabling Success



IDRC • CRDI

Canada



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Photo: Perttu Saralampi for RWAMREC

1

Introduction

More evidence exists than ever about what works to tackle major health and social challenges, but most non-profits struggle to translate that evidence into programs that scale beyond small pilots. Partnering with government is seen as one of the most promising ways to scale effective programs. Public systems and infrastructure offer unparalleled reach that can be leveraged to deliver programs within existing services. Yet, there is no single roadmap to guide organizations on how to do this well. Documenting the wins, challenges, and setbacks of organizations that have scaled with government is one way to make that process more visible and to support others trying to do the same.

This brief traces the journey of the Bandedereho (“role model”) program from pilot project to routine delivery within the Rwandan health system. It reflects over a decade of work by the Rwanda Men’s Resource Center (RWAMREC) and Equimundo, in partnership with the Rwandan government. Today, community health workers deliver Bandedereho in three districts, reaching over 95,000 men and women, with expansion underway in a fourth. Drawing on the perspectives of staff from both organizations, this brief examines the key factors that enabled RWAMREC and Equimundo to partner with government and scale the program. We hope these insights can support other organizations on a similar path to scale — whether they’re just starting out or well on their way.

2

Bandebereho Journey to Scale

This section summarizes the Bandebereho program's journey from pilot to scale-up with government. Although four distinct phases are described, the journey to scale was not a continuous, linear, or even easy process. It took several years to move from the pilot to rigorous evidence of effectiveness, to eventually working with government to scale. There were moments characterized by intense acceleration, as key events unlocked buy-in or funding, and others where momentum and funding waned despite strong commitment and intentions. Each stage of the journey generated key learning on how to scale with government that may be useful to other organizations interested in doing the same.

Bandebereho adaptation and pilot (2013-2015)

The Bandebereho program uses fatherhood as an entry-point to work with men to build caring and non-violent relationships with their partners and children. The program promotes men's engagement in reproductive, maternal, newborn, and child health (RMNCH), caregiving, and violence prevention. Fathers of young children and expectant fathers are invited to weekly small group sessions in their communities, ten of which are designed for couples. The participatory curriculum includes 15 (pilot) to 17 (scale up) sessions with experiential activities and group discussion. The program takes a gender-transformative approach – intentionally challenging the inequitable gender norms and power dynamics that limit men's engagement and perpetuate violence. The theory of change proposes that creating a safe space allows men and their partners to reflect on the costs of rigid gender norms, and to learn and practice healthy relationship skills. This can lead to positive changes across a range of behaviors.

Bandebereho was adapted from the *Program P*¹ manual to suit the Rwandan context, as part of the three-year MenCare+ program². In 2013 RWAMREC and Equimundo (Promundo-US at the time) spent six months adapting the program through formative research in four communities, preliminary adaptation, and pre-testing the curriculum with couples. Feedback from staff and participants in the pre-test led to revisions to ensure the curriculum responded to the needs and lived realities of couples in the community. Staff from the Rwanda Biomedical Center, the implementing arm of the Ministry of Health, also reviewed the revised curriculum and provided input to ensure alignment with government policies.

The curriculum was piloted in 16 communities across four districts between 2014 and 2015. Peer facilitators, who were primarily fathers who participated in pre-test, were trained to deliver the 15-session curriculum in their communities. Over 3,500 parents participated in the program over this two-year period, with high rates of attendance: men attended 94% of sessions and women attended 85% of couple sessions. The gender-transformative approach was highly appreciated by community leaders and participating families.

In 2015, a randomized controlled trial was launched to evaluate the program's effectiveness. Data were collected from about 1,200 couples, divided between Bandebereho participants and a control group, at baseline and then again 9 months later, as the project was ending. The preliminary data showed promising impacts on participating couples immediately after participation.

Evidence generation and pathway to scale (2016-2018)

Following the pilot there was a two-year period where there was no dedicated funding to support Bandebereho implementation. Many RWAMREC staff involved in the pilot

¹ Promundo, CulturaSalud, and REDMAS. *Program P: A Manual for Engaging Men in Fatherhood, Caregiving, Maternal and Child Health*. Rio de Janeiro, Brazil and Washington, D.C. USA: Promundo; 2013. Available from: www.men-care.org/resources/program-p/.

² The MenCare+ project, led by Rutgers in collaboration with Equimundo, aimed to engage men in sexual and reproductive health in Brazil, Indonesia, Rwanda, and South Africa.

moved on to new positions or organizations. There was funding to support continued research on the program's effectiveness and to disseminate findings. Follow-up data were collected from couples enrolled in the RCT to assess impact in late 2016, a little over a year after they completed the program. The findings demonstrated that compared to the control group Bandedereho participants reported improvements in: maternal health-seeking, family planning uptake, men's participation in childcare and household tasks, and in women's participation in household decision-making. They also reported substantial reductions in women's experience of intimate partner violence and in parents' use of violence against children.

In 2017, RWAMREC and Equimundo disseminated the robust evidence of the program's effectiveness to high-level policymakers, to district authorities and participating communities, and to the media. The findings generated strong government interest to expand the program and scale its impact. The Minister of Health at the time established a multisectoral technical advisory group to assess opportunities to deliver Bandedereho through government structures. The health system was identified as a potential pathway for scale-up and RWAMREC and Equimundo, in collaboration with the government, spent the next year seeking funding opportunities to support the scale-up.

Transition-to-scale in the health system (2019-2022)

RWAMREC, Equimundo and the Rwanda Biomedical Center began adapting Bandedereho for health system delivery in 2019, with funding from a patchwork of donors. A decision was made to test the feasibility of community health workers delivering the program as part of their routine work, focusing on one district first. The gender-transformative curriculum, the core component of the program, was maintained but strengthened to emphasize men's participation in unpaid care work – an area for strengthening identified by the program's

evaluation. RWAMREC, with support from RBC, trained district authorities, health system managers, supervisors of community health workers in Musanze district on gender and men's engagement. This training was designed to build buy-in and the capacity to support program implementation. One community health worker per village (432) then received similar training before being trained on how to facilitate the Bandedereho curriculum. Community health workers began implementing Bandedereho sessions with couples in early 2020. However implementation was disrupted for six months due to the Covid-19 pandemic.

Once implementation restarted, community health workers demonstrated they were capable of implementing Bandedereho with a high degree of quality. Over 19,300 parents participated in the program across four cycles, with relatively high attendance despite the pandemic. On average, men attended 75% of sessions and fewer than 8% dropped out. Women attended 72% of couple sessions. Parents continued to attend at relatively high rates despite the removal of financial incentives, which were provided during the pilot. Numerous opportunities to further adapt the program to support health system integration were also identified. However, funding for implementation ended in early 2022, though some transition funding helped to retain key RWAMREC staff and a presence in the district.

Additional evidence on the program's effectiveness was also generated during this period. In 2021, a six-year follow-up with couples from the pilot was done to assess the longer-term impacts of the program. The RCT found that many original outcomes, including reduced intimate partner violence, were sustained after six years. New impacts were also shown on outcomes not previously measured, including improvements in parents' mental health and child behavior.³ A phone survey during the pandemic also found that Bandedereho couples

³ Doyle K, Levitov RG, Barker G, Bastian GG, Bingenheimer JB, Kazimbaya S, Nzabonimpa A, Pulerwitz J, Sayinzoga F, Sharma V, Shattuck D. Gender-transformative Bandedereho couples' intervention to promote male engagement in reproductive and maternal health and violence prevention in Rwanda: Findings from a randomized controlled trial. PLoS One. 2018 Apr 4;13(4):e0192756.

were more likely than control families to report supportive couple and family relations during the lockdown. This new evidence of long-term effectiveness increased government demand for expansion to new districts and supported fundraising efforts to make that a reality.

Expanded scale-up in new districts (2023-2026)

Beginning in early 2023, the scale-up expanded to two more districts in the Northern Province, while implementation continued in Musanze. This new phase focused on further adapting and testing the program for integration in the health system, with the aim of optimizing it for nationwide scale-up. In Burera district, two models for training community health workers were tested and evaluated, and new supervision and monitoring structures assessed. Learning in Burera informed changes that were then tested as the program expanded to Gakenke district in 2024. During this phase, responsibility for leading program training, supervision, and monitoring was increasingly shifted from RWAMREC to the health system.

More than 1,000 community health workers were trained to deliver Bandebereho in Burera and Gakenke districts and successfully reached 46,800 parents. Similar attendance rates to the transition-to-scale phase were observed, but dropout rates were lower (less than 5%). An additional 25,400 parents were also reached by ongoing implementation in Musanze district, where improvements in attendance and dropout rates were seen. This occurred after remuneration for community health workers delivering the program (in all districts) was introduced and community leaders were more deeply engaged in program implementation.

An important step in the scale-up was the formalization of defined roles and responsibilities for RWAMREC and the government in the scale-up. The government also integrated five new indicators to measure men's engagement in health services in the national health information management system

(HMIS). RWAMREC developed the indicators in collaboration with RBC and the Ministry of Health to help capture the facility-level impacts of the program on men's engagement. The three districts where Bandebereho was operating provided important testing ground for these new indicators. Health workers and data managers in these districts were trained on how to gather, report, and analyze the data.

Evidence and learning on scale-up generated during this phase – including on impact, cost, and cost-effectiveness – fed into the development of a national scale-up strategy. The strategy was developed through a consultative process and outlines the vision and process for expansion to all 30 districts. Government endorsement of the strategy is expected in late 2026. During the development of this brief, Bandebereho expanded to a fourth district in the Northern Province, Rulindo.



BANDEBEREHO JOURNEY TO SCALE

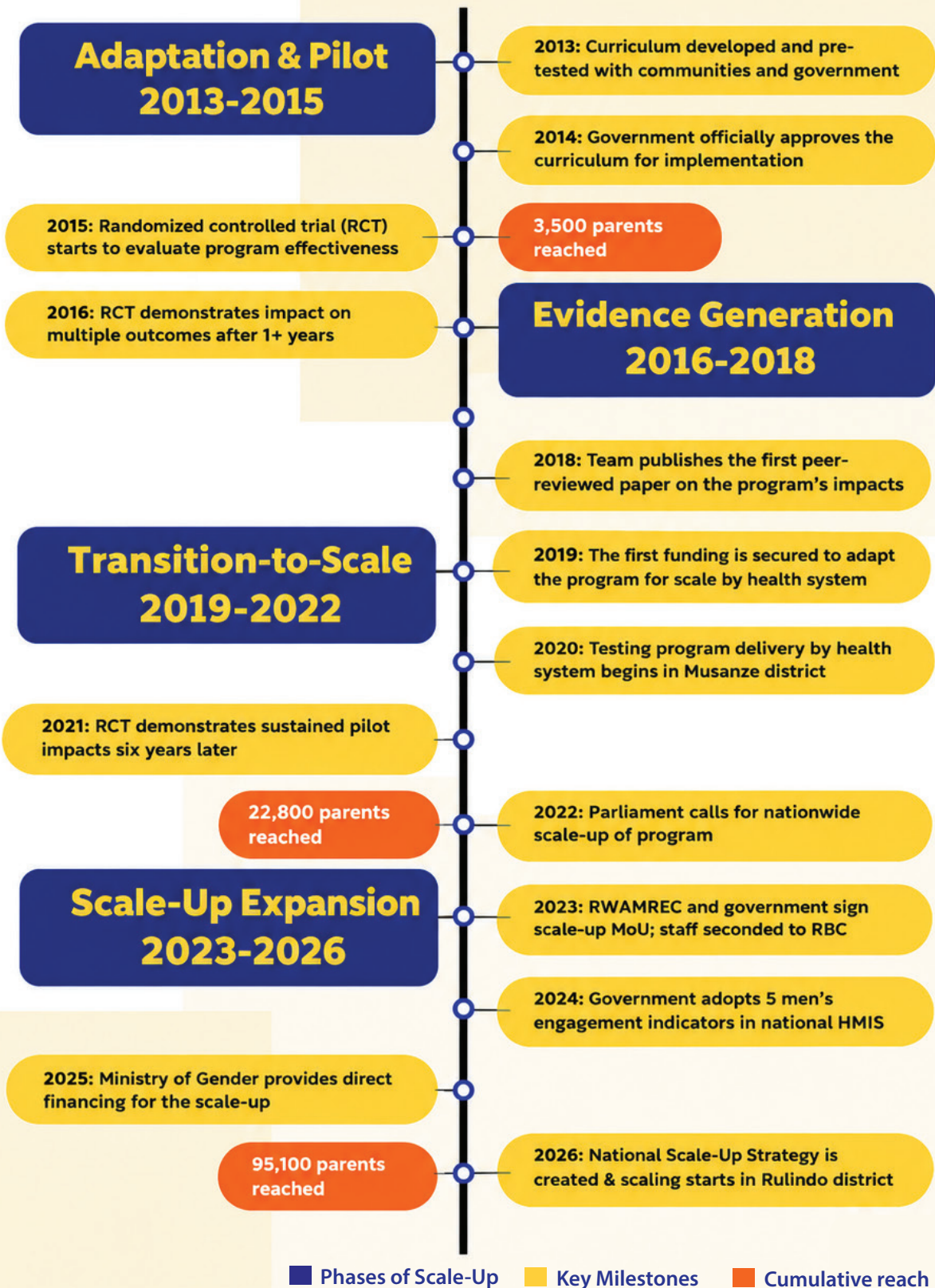




Photo: Perttu Saralampi for RWAMREC

3

Key Factors that Enabled Scale-Up with Government

“The more we scale, the more we adapt, the more we learn.”
– *RWAMREC staff member*

This section outlines 10 factors that RWAMREC and Equimundo staff involved in the program identified as enabling Bandebereho to shift from an NGO-driven pilot to government scale-up through the health system. Guidance for other organizations on how to put these insights into practice are provided at the end of the document (see Box 2).

FACTOR 1

Equitable, Long-Term Partnership Between RWAMREC and Equimundo



The long-term collaboration between RWAMREC and Equimundo was critical to the early success of Bandebereho and its later scale-up. The two organizations, which share common goals of engaging men in caregiving and gender equality, had already partnered on research and programming in Rwanda. Familiarity with each other's work enabled the two organizations to work closely on the Bandebereho adaptation and pilot, which was strengthened by embedding a full-time Equimundo staff member within RWAMREC. After the positive results of the pilot, this strong working relationship made it possible for the two



organizations to agree on a common vision for scale and to fundraise to achieve it.

Maintaining a strong partnership based on trust and shared values was facilitated by a willingness to have open dialogue and examine the power dynamics inherent in North-South partnerships. Established trust helped both organizations to navigate difficult moments, complex donor relationships, and the political dimensions of working with government. Respect for each organization's unique strengths and expertise proved crucial as the program scaled, including as organizational roles shifted. Where Equimundo initially held grants and subgranted to RWAMREC, this relationship was eventually reversed – a positive shift that reflects the strength of the partnership and RWAMREC's leadership on the program.

FACTOR 2

Demonstrated Alignment with Rwanda's Health and Gender Policies



Demonstrating how the Bandedereho program aligned with Rwanda's existing health and gender policies was central to securing government support for the pilot and its scale-up. RWAMREC and Equimundo actively framed the program within Rwanda's strong political and legal framework to advance gender equality, violence prevention, and RMNCH. This framework includes policies that explicitly acknowledge inequitable gender norms and engaging men as part of the solution. This made it possible to present Bandedereho as a direct response to the



government's own priorities, not as an externally driven initiative and supported meaningful government buy-in at all stages.

Critically, Rwanda has an enabling policy environment for promoting gender equality and engaging men and boys, which are not present in all contexts. As a result, the government welcomed an initiative focused on increasing men's engagement in health, caregiving, and gender equality, and there was little resistance to the program's core goals or approach. Crucially there has been sustained high-level political support for investing in approaches that engage men, including in sharing unpaid care work and preventing violence. The program's growing influence is now evident in national policies where Bandebereho is identified as an effective approach, such as the National Transformative Strategy: Engaging Men and Boys for Gender Equality Promotion.

FACTOR 3

Early and Sustained Collaboration with Government



Close collaboration with government from the very start of the Bandebereho program was critical in creating the conditions for scaling through the health system. Given the program's focus on engaging men in RMNCH, the Rwanda Biomedical Center (RBC) was a core partner from the outset. RWAMREC required official approval of the Bandebereho curriculum, posters, and messaging from RBC prior to implementation. RWAMREC and Equimundo



chose to go beyond these requirements and actively involved staff from RBC's Maternal, Child, and Community Health Division in all aspects of the pilot. RBC staff contributed content to ensure the curriculum aligned with government priorities, participated in its pre-testing and in training facilitators, and were key partners in the randomized controlled trial assessing program effectiveness.

The early involvement of RBC had important consequences for scale-up, even though it was not initially done with scale in mind. RBC staff developed firsthand knowledge of the program and became Bandebereho advocates. They were also uniquely positioned to identify potential pathways for scale through the health system and to build the institutional support needed to make that happen. Partnership with RBC was further strengthened during scale-up because of RWAMREC's flexibility and willingness to adapt to suit government timelines. RWAMREC staff also worked with RBC and district government to find ways the program could advance health system priorities or address challenges, most notably during the pandemic. This built further trust and a sense of true partnership. At the same time, RBC's involvement demonstrated government ownership to district authorities and health workers involved in the scale-up.

Of course, there have been challenges, including high turnover among government staff and leaders. Early in the scale-up, momentum slowed when high-level champions left and relationships had to be rebuilt from scratch. As a response, RWAMREC began to more deliberately cultivate relationships with institutions – working with technical staff within and across departments, not just individual champions. A full-time RWAMREC staff member



has been seconded to RBC to support the scale-up since 2023. Beginning in 2026, RWAMREC staff supporting districts to scale have been embedded in district hospitals. A Memorandum of Understanding (MOU) between RWAMREC and RBC, and a separate one with the Ministry of Health, define their respective roles and responsibilities for the Bandebereho scale-up. These elements provide a stable foundation for continued collaboration despite changes in staff or high-level leaders.

FACTOR 4

Rigorous Evidence of Impact across Multiple Outcomes



Generating a robust evidence base was central to moving from pilot to scale-up. The RCT of the pilot provided tangible evidence that Bandebereho contributes to multiple national policy goals – including maternal and reproductive health outcomes, reducing intimate partner violence and violence against children, and improving parenting practices. Crucially, government staff were involved as co-investigators generating this evidence and as authors on publications. This helped consolidate government support and demand for scale-up. After the RCT findings were presented to the former Minister of Health in 2017, she established a technical advisory group to review potential pathways to scale through government.

Rigorous evidence of impact was and continues to be critical to securing donor funding for scale-up. The investment case was further strengthened with the evidence demonstrating



that program impacts lasted well beyond the pilot. The RCT data, combined with capacity building of the health system, made it clear to national and district officials that Bandebereho helps them to achieve their goals and performance indicators. Bandebereho came to be seen as an effective, homegrown solution to achieving national goals. This strong ownership and long-term evidence of effectiveness helped to galvanize additional donors to support the scale-up.

The evidence generated from the pilot was also critical in making informed decisions about how to adapt the program for scale without compromising its effectiveness. The evaluation identified several key mechanisms of change and helped to clarify its essential or core components.⁴ RWAMREC and Equimundo were able to draw on this evidence to push back against suggestions that a shorter curriculum would be faster and less costly to deliver at scale. By arguing that shortening the program would undermine fidelity and therefore impact, they were able to gain government and donor buy-in to maintain the program's core components at scale.

FACTOR 5

Multi-Sectoral Government Engagement in Scaling



Bandebereho's focus on engaging men in health, gender equality, child development, and violence prevention meant that multiple government institutions had a stake in the program. The decision was made to bring other

⁴ Levto RG, Doyle K, Bingenheimer JB, Lahiri S, Kazimbaya S, Karamage E, Sayinzoga F, Mutoni M, Rubayita CH, Barker G. Improved Relationship Quality, Equitable Gender Attitudes, and Reduced Alcohol Abuse as Key Mechanisms to Reduce Intimate Partner Violence in the Bandebereho Couples' Randomized Trial in Rwanda. *Prev Sci.* 2022;23(8):1495-1506.



government institutions on board when the Bandedereho Scale-up Technical Advisory Group was established. The advisory group is chaired by the Director of RBC's Maternal, Child, and Community Health Division and includes representatives from the Ministry of Gender and Family Promotion, Ministry of Health, and National Child Development Agency. This ensures that institutions whose mandates align closely with Bandedereho's outcomes have a formal seat at the table and strengthens government ownership. The diverse expertise these individuals bring with regard to health, gender, violence, and early child development also benefits the program.

Technical advisory group members have been crucial in promoting buy-in and ownership within their respective institutions. The advisory group meets quarterly to share progress, review learning from implementation and research, assess alignment with Government policies and priorities, and advise on the scale-up. The multisectoral nature of the group enables it to see potential linkages between Bandedereho and other government programs. This includes ways to link facilitators and participants to other community structures, or to integrate aspects of men's engagement in other government initiatives. The advisory group members oversaw the development of the national scale-up strategy to expand Bandedereho to all 30 districts. Their participation and validation of the strategy by this multisectoral group may help solidify its formal adoption by government.



FACTOR 6

A Well-Chosen Pathway to Scale



A clearly defined and strategically chosen pathway to scale was critical for moving from pilot to scale-up. The health system was chosen by the advisory group after systematically assessing a range of government and community structures through which to potentially scale. The health system emerged as the most feasible and sustainable pathway for several reasons: community health workers provide an existing nationwide platform, the health system is relatively well-resourced, and it has functional reporting structures from local to national level. At the district level, district health units work alongside district hospitals to support health centers to provide health services, guided by RBC at the national level. These existing structures provide the necessary architecture to implement, monitor, and report on the program at scale.

The government agreed to commit the human resources needed to deliver the program, including community health workers, their supervisors, and other district and health officials. Facilitators are core to the success of the program. When community health workers were identified as a pathway to scale, RWAMREC and Equimundo felt they could feasibly facilitate the program. This was because community health workers had an existing mandate to promote RMNCH, were trusted individuals embedded in local communities, and had similar backgrounds to the peer facilitators who delivered the Bandedereho pilot. However, it was clear that intensive training would be required to enable them to effectively



deliver the participatory sessions on gender, power, and violence. Thus, a core focus of the scale-up has been on how to provide community health workers with the right level of training and support to deliver the program confidently and consistently as part of their routine work.⁵

FACTOR 7

A Slow and Steady Approach to Adaptation for Scale



RWAMREC, Equimundo, and RBC made a deliberate choice to take a gradual approach to scale, rather than moving directly into widespread expansion. This decision was made to ensure program fidelity and implementation quality could be maintained beyond the pilot – essential if the program was to continue to achieve impact. The evidence was used to build consensus on the rationale for this slower, more deliberate approach among the technical advisory group members. This was invaluable when government partners or donors pressed for faster expansion and pushback was needed.

The phased approach to scale began by first adapting the program for delivery by community health workers and testing the feasibility in a single district. Responsibility for program delivery was given to the health system, but RWAMREC retained leadership over training and in supervising and monitoring implementation.

⁵ Doyle K, Bhatnagar I, Karamage E, Tuyisingize JP, Muhimpundu C, Nyiransabimana AMY, Cyiza FR, Rutayisire F, Ngayaboshya S and Mavhu W (2025) Equipping community health workers in Rwanda to deliver a gender transformative parenting program to prevent violence against women and children at scale. *Front. Reprod. Health* 7:1602136. doi: 10.3389/frph.2025.1602136.



Investing time in this transition phase allowed RWAMREC to develop a deeper understanding of how the health system functioned in practice. This made it easier to identify ways to integrate Bandedereho within its existing structures and processes. It also enabled the health system to develop an understanding of how to deliver a gender-transformative program (see box 1). Crucial learning was generated on how to adapt the program for scale, including how to improve the training of community health workers and program supervision and monitoring.

The next phase of scaling further tested and refined the model and sought to increase efficiency and government ownership, while reducing cost. This phased approach also allowed RWAMREC to gradually build capacity and shift responsibility for Bandedereho training, implementation, supervision, and monitoring to the health system. This process of iterative testing and refinement across three districts helped optimize the model for replication in new districts and the design of the national scale-up strategy.



Photo: Courtesy of RWAMREC

BOX 1

SCALING WITH GOVERNMENT AS A MUTUAL LEARNING PROCESS

The deliberately gradual approach to adapting Bandebereho for delivery through the health system created the time and space needed for mutual learning, which proved to be one of its most important benefits.

For RWAMREC staff, it meant getting to know the health system from the inside: building relationships with district-level health managers, understanding how community health workers operate within and are accountable to the health system. This ensured that all activities aligned with existing structures and protocols. It was a new experience for many staff, even those with prior health-system experience. As one Bandebereho staff member reflected during the transition-to-scale phase:

“Before this stage, one of the strengths is to know the health system – how it works, because if you don’t know how it is constructed and how it works, you can make a big mistake.”

At the same time, health system partners, including RBC staff and district-level health managers and supervisors, gained a deeper understanding of Bandebereho and the value of a gender-transformative approach. Over time, they came to see how addressing gender inequalities and engaging men in reproductive, maternal, newborn and child health could directly support their work and contribute to key health indicators. As one health system staff member described:

“At the beginning, we didn’t understand how to link gender issues with health issues, but with experience and the outcomes we saw – like the accompaniment of men to ANC – the links became more clear.”

This mutual learning process helped ensure that Bandebereho became seen as part of the health system, not as an external program being delivered through it.

FACTOR 8

Implementation Research Embedded at Every Stage



Implementation research was embedded at every stage of the scale-up. Equimundo led the research, in consultation with RWAMREC and RBC, to understand implementation in practice and identify opportunities for improvement or adaptation. A core focus was on assessing and improving quality and fidelity. At the start of the scale-up, no existing tools were found that suitably captured implementation adherence to Bandebereho's core components and principles. Together RWAMREC and Equimundo defined a set of indicators that reflected the program's gender-transformative approach and developed tools that could easily measure these at scale, which were refined over time.

At each phase of scale-up, a research agenda was developed to gather information needed to progress to the next level of scale-up. Quantitative and qualitative data were collected to assess feasibility, optimization and replicability, and to understand how the scale-up could better meet the needs of those delivering it. Learning was made available to RWAMREC and the government to inform operational decisions in real time. This rapid feedback loop meant adaptations could be tested and refined continuously, to address obstacles and support better integration, as the program expanded across districts. Reflection meetings were also held with RWAMREC staff quarterly to create space to reflect on achievements, surface challenges, and identify emerging opportunities.



Implementation research was complemented by cost analysis and cost-effectiveness studies, which explored efficiencies gained across districts, and provided evidence to support government and donor investment decisions. Lighter-weight evaluation methods were also used to measure changes among Bandebereho participants at each phase of scale-up, building on the robust evidence of impact already established during the pilot.

FACTOR 9

Layered, Flexible, and Selective Funding



Raising the funds necessary to support scale-up required a creative and selective fundraising strategy. Evidence of impact across multiple domains — including gender equality, violence prevention, and early childhood development — allowed the partners to seek funding from a range of donors rather than relying on a single funding stream. This generated the resources needed to complement the government's considerable in-kind contribution and make district-by-district expansion possible. However, this layered funding model came with real administrative demands: each donor brought its own restrictions, timelines, and reporting requirements, meaning the program had to be managed as a series of parallel projects with different milestones and deliverables.

Flexible, unrestricted funding from several foundations played a crucial role alongside project grants. These funds created space



for careful planning at key moments and bridged the gaps between funding cycles in the multi-phase scale-up. For example, a foundation provided transition funding that enabled RWAMREC to retain key staff between the transition-to-scale and the expansion to new districts. This preserved institutional knowledge and enabled continuity in the partnership with government. Such funding has also supported the development of the national scale-up strategy and high-level advocacy efforts, which helped secure direct government funding.

Equally important was taking a disciplined approach to which funding opportunities to pursue. Having a clear, government-supported plan for scale gave RWAMREC and Equimundo a strong foundation from which to engage donors. This enabled them to advocate for the existing vision rather than adapting it to fit donor priorities or calls for proposals. The long-term partnership between the two organizations, and their shared commitment to protecting the program's integrity, gave them the confidence to be selective. It made it possible to resist pressure to make changes that would have compromised the program's design or direction. It also enabled them to hold firm when donor expectations diverged from their vision for scale.



Photo: Perttu Saralampi for RWAMREC

FACTOR 10

Committed Staff and Institutional Knowledge



The scale-up of Bandebereho would not have been possible without the deeply committed staff at RWAMREC and Equimundo, and in government, who have supported the program across its different phases. Some staff have been involved since the beginning, carrying with them critical institutional knowledge about the key decisions made, lessons learned, and adaptations tested at each stage. They understand not just what the program looks like today, but why it looks that way. The team has also grown alongside the program, with newer staff contributing fresh perspectives and building their own expertise. Together, they have overseen the adaptation and scaling of the program across three districts and are uniquely capable of identifying what works, what needs refining, and where there are opportunities for more efficient or impactful ways of working.

Delivering Bandebereho at scale is considerably more complex than the pilot. It requires working closely with the health system, managing activities across local, district, and national levels, navigating relationships with multiple government institutions, and managing differing donor requirements—all while operating under significant pressure to succeed. This demands strong organizational capacity, careful coordination, and staff who can hold both the detail and the bigger picture at once. What sustains this commitment is a shared vision and a deep belief in the program's impact. Despite the heavy workload, the team is motivated by the tangible changes they witness in the lives of men, women, and families in the communities where Bandebereho is being implemented.

BOX 2

PUTTING THESE INSIGHTS INTO PRACTICE — GUIDANCE FOR OTHER ORGANIZATIONS

Drawing on Bandebereho's experience, organizations pursuing a similar path with government may want to:

- 1 Invest in an equitable, long-term partner relationship, and be ready to revisit how roles and leadership are shared as that partnership matures.
- 2 Frame the program in terms of existing government priorities and policies, rather than presenting it as an externally driven initiative.
- 3 Build relationships with the implementing government body from the earliest stages, and involve their staff as genuine collaborators.
- 4 Generate rigorous evidence of impact, with government staff involved as co-investigators and co-authors, not just recipients of the findings.
- 5 Where more than one government institution has a stake in the program, bring them together early and give them a formal, ongoing role rather than working with a single department alone.
- 6 Choose a pathway to scale deliberately, based on existing government capacity, reach, and infrastructure, rather than the easiest available option.
- 7 Resist pressure to expand faster than fidelity allows; use evidence to build consensus on a deliberate pace before momentum builds for rapid scale.
- 8 Embed implementation research throughout the scale-up, so adaptations can be tested and refined in real time.
- 9 Pursue a layered funding strategy that combines project grants with flexible, unrestricted funding, and be selective about which donor priorities to take on.
- 10 Protect institutional knowledge by retaining experienced staff wherever possible, and create space for newer staff to build expertise alongside them.

Above all, treat scale-up as a long-term, mutual learning process between your organization and government — not a one-time handover.

