SOCIAL PROTECTION & JOBS

DISCUSSION PAPER

No. 2214 | DECEMBER 2022

Childcare Arrangements for Low-Income Families: Evidence from Low- and Middle-Income Countries

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Project 41595

Childcare Arrangements for Low-Income Families: Evidence from Low- and Middle-Income Countries

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Abstract

This study reviews options of childcare and early learning arrangements in developing countries, focusing on innovative options for public and nonstate provision that fit the needs and constraints of low-income families. It discusses both home-based care (provided in a home setting) and center-based care (nurseries, crèches, daycares or sometimes preschools) through various country examples and four in-depth case studies (from Colombia, Kenya, India, and Liberia). This comparative analysis shows that a wide range of provision models are leveraged to meet the demand for childcare in low- and middle-income countries and that intentional policy initiatives can promote positive social norms towards early childhood services and women's economic empowerment. Yet, benefits to children and families depend on the quality of services and the wider enabling environment thy operate in.

JEL Codes

I25. Education and Economic Development
J13. Fertility • Family Planning • Child Care • Children • Youth
J16. Economics of Gender • Non-labor Discrimination
J24. Human Capital • Skills • Occupational Choice • Labor Productivity

Key words

Childcare, early learning, preschool, early childhood education, early childhood development, home-based, center-based, women's economic empowerment, women's labor participation, human capital, low- and middle-income countries

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Acknowledgements

This note is a joint product of the Social Protection and Jobs and the Education Global Practices at the World Bank. The report was written by Alisa Currimjee (Consultant), Jem Heinzel-Nelson Alvarenga Lima (Consultant) and Sara Troiano (Senior Social Protection Economist). It was prepared under the guidance of Frances Beaton-Day (Consultant), Amanda Devercelli (Senior Education Specialist), and Ella Humphry (Education Specialist). The team is grateful to Marina Bassi (Senior Economist), Lucia Nhampossa (Senior Education Specialist), and Federica Ricaldi (Senior Economist) for their contributions.

Finally, we would like to acknowledge the financial support from the Early Learning Partnership Mutli-Donor Trust Fund, which funded this study.

Data for the note was collected in the period of June 2020 to June 2021.

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ABBREVIATIONS

ECD	Early childhood development
ECE	Early childhood education
EPAG	Economic Empowerment for Adolescent Girls
GDP	Gross domestic product
HCB	Hogares Comunitario de Bienestar (Community Welfare homes)
ICBF	Instituto Colombiano de Bienestar Familiar (Colombian Institute of Family Welfare)
ICDS	Integrated Child Development Services
INR	Indian rupee
LMIC	Low- and middle-income country
NCS	National Créche Scheme
NGO	Nongovernmental organization
SD	Standard deviation
SEWA	Self-Employed Women's Association

EXECUTIVE SUMMARY

This study reviews childcare options in developing countries, focusing on availability of innovative options that complement public early childhood development (ECD) centers and fit the constraints that low- and middle-income countries (LMICs) face. It analyzes the approaches to implementation and reported benefits of different types of childcare arrangements, particularly those oriented toward low-income families. Although not exhaustive, it was designed to be a reference for practitioners interested in mapping and exploring different types of childcare services, designing tailor-made solutions, and identifying potential partners for knowledge exchange on childcare.

The review discusses home- and center- (nurseries, crèches, daycares, preschools) based care and uses case studies to illustrate various models and present evidence on their outcomes, implementation challenges, and strengths and weaknesses. Although approaches vary greatly to fit the constraints and objectives in each context, this study identifies some common trends to inform the policy discussion on childcare.

Providing quality childcare and early learning opportunities to vulnerable populations is a cost-effective way to boost a country's human capital and productivity. The evidence presented in this report confirms that cost-effective childcare models exist that deliver quality childcare services to low-income families. These childcare services increase children's cognitive and socioemotional skills, mothers' participation in the labor market and productivity, siblings' attendance in school, and household income and welfare, and these benefits are greatest for the most vulnerable families. For instance, the studies reviewed found that access to childcare services has greatly increased employment of mothers—ranging from 10 percent to 45 percent higher than control groups studied.

A wide range of service provision models are helping meet demand for childcare in LMICs. Different models fit multiple contexts, demands, and constraints. Nongovernmental organizations (NGOs), civil society organizations, private sector organizations, and cooperatives are increasingly emerging as key stakeholders to fill gaps in public provision of childcare, with innovative alternative solutions to public ECD centers and arrangements targeting low-income families. The most vulnerable people can be reached most effectively when

governments support investment and coordination. Examples of successful partnerships established between government and various stakeholders in Colombia, India, and Liberia stand out as promising practices offering a mix of robust enforcement of quality standards, stable financing, and flexible implementation arrangements.

Quality assurance is a challenge in many LMICs. Lack of quality standards was reported in several case studies. Even where standards exist, many countries lack effective mechanisms for their roll-out, monitoring, and enforcement. Low-quality childcare deserves particular policy attention because it can have adverse ECD effects on children and discourage parents from seeking childcare. The review describes several complementary initiatives that can be undertaken to increase quality, including by increasing professionalization of the childcare workforce (Colombia, Ecuador, Liberia); signaling quality through certifications (Kenya); and strengthening monitoring through institutions (Mozambique, Ecuador), parental engagement (India), or networks of support (Kenya).

Effective childcare requires supporting the childcare workforce. Availability of qualified staff is a key challenge to providing quality childcare services. Many countries and programs, such as large-scale home-based government-supported registered childcare programs in Mexico or Colombia, have shown that it is possible to pursue the dual objective of providing childcare and training a skilled childcare workforce. Elevating the status and competences of the childcare workforce—through relevant, continuous training; proper salaries; and societal recognition—is critical to promoting quality services.

Social norms regarding childcare provision and use and women's labor participation can be changed over time through intentional policy initiatives. As shown in the example of privately run, NGO-supported childcare centers in Kenya, once programs are in place, the benefits become evident to the community and can garner widespread support, especially when advocacy targeting key stakeholders accompanies them.

More-robust and -comprehensive monitoring and evaluation is needed to increase buy-in on the childcare agenda and increase efficiency of ongoing programs. Although this study summarizes significant evidence supporting investment in childcare, it also identifies some important knowledge gaps. Rigorous evaluation and qualitative evidence of development benefits related to childcare are scarce. This review includes examples, for instance in the Liberia case study, of how to set up a rigorous research plan to support program design, implementation, and evaluation.

1. INTRODUCTION

Investment in affordable, quality childcare[1] has a strong economic rationale, with potential to secure a "triple dividend": developing young children, empowering women and facilitating their labor market participation, and fostering economic growth by increasing business profitability and improving the socioeconomic condition of communities (Figure 1). In a virtuous cycle, affordable, quality childcare can help businesses profit from greater workforce stability, skills, and productivity. Those gains, in turn, enhance families' income and savings, enabling them to invest in their children's human capital accumulation.[2]

FIGURE 1. BENEFITS OF CHILDCARE

Source: Devercelli and Beaton-Day 2020.

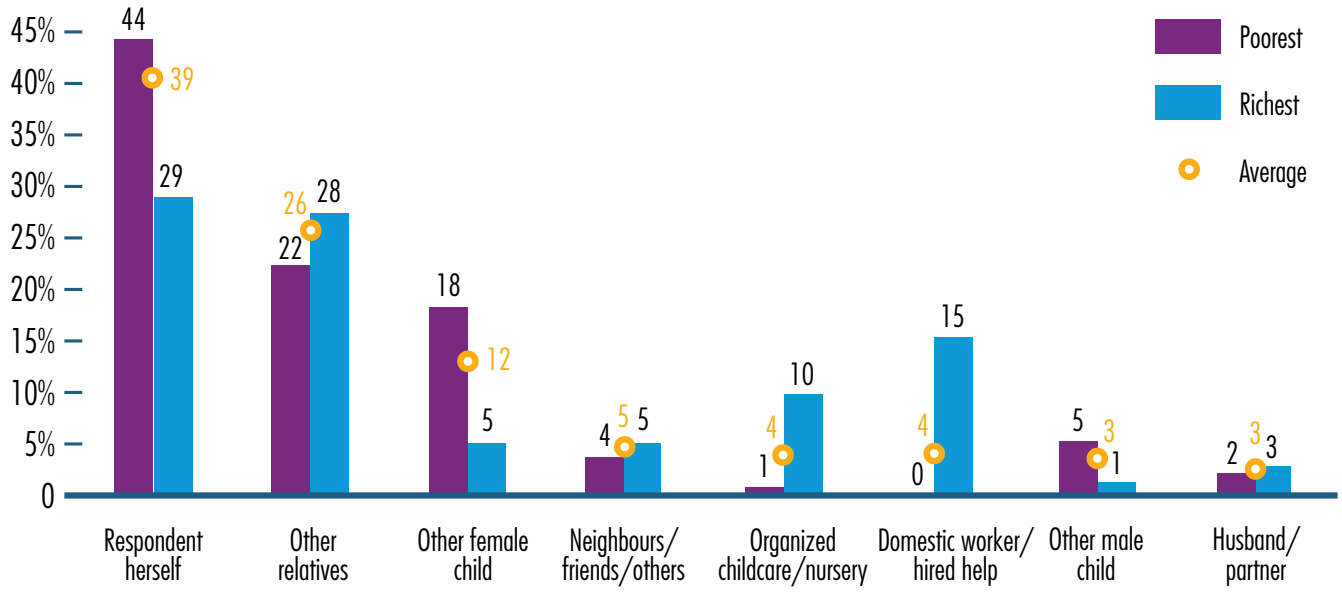
1 Broadly defined, the term childcare includes all types of education and care provided for young children. The term is also used more specifically for supplemental care of children from birth to age 6 (in some cases 8) by persons other than primary caregivers.

2 For more information on benefits of childcare, see Devercelli and Beaton-Day (2020), Diaz and Rodriguez-Chamussy (2016), and UNICEF (2019a).

Demand for childcare services is growing globally, as women increasingly enter and stay in the workforce and their role as primary caregivers evolves, but millions of working parents, particularly in low- and middle-income countries (LMICs), do not have access to viable childcare options beyond extended family support. Vulnerable populations typically live and work in areas underserved in terms of social services, including childcare. Existing options are often not aligned with parents' needs, values, income status, and work hours. The low earnings and vulnerable working conditions in many LMICs make it difficult for workers to afford care services, especially formal ones. Additionally, traditional roles along restrictive gender norms that women occupy as primary caregivers in many societies may deter the use of childcare.

For LMICs, data on childcare provision, quality, and cost (out of pocket incurred by families and public financing) are extremely limited. Available data indicate a dramatic lack of access to childcare, particularly low-cost options (Hein and Cassirer 2010; IFC 2017; Samman, Presler-Marshall, and Jones 2016). From a sample of 31 developing countries, on average only 4 percent of employed women, and fewer than 1 percent of the poorest women, use some form of organized childcare (UN Women 2015) (Figure 2). The childcare challenge is particularly acute for families with children younger than 3 (ILO 2018).

FIGURE 2. CHILDCARE ARRANGEMENTS FOR EMPLOYED WOMEN WITH CHILDREN YOUNGER THAN 6



Source: UN Women 2015.
Note: Unweighted averages based on surveys conducted in 31 developing countries between 1995 and 2022.

To inform the policy discussion on how to increase access to quality childcare, this review presents examples of international childcare options in developing countries. In particular, it focuses on availability of options that complement public early childhood development (ECD) services and fit the constraints (e.g., low population density, low-income families, little margin for profits) found in many LMICs. If they meet quality standards, these types of arrangements can offer promising options for closing the childcare gap for vulnerable families while supporting child development.

The international literature on implementation and benefits of different types of childcare arrangements, particularly those oriented toward low-income families is scarce, but learning from existing experiences can be useful to summarize preliminary conclusions, build advocacy around successful models, and identify remaining knowledge gaps. Although not exhaustive, this review is designed to be a reference for practitioners interested in exploring various childcare arrangements, developing innovative solutions, and identifying potential partners for knowledge exchange on childcare.

II. CHILDCARE OPTIONS

The primary objective of childcare is to care for and support child development while parents are at work. Childcare services should provide a nurturing, safe environment for infants and toddlers, with access to adequate nutrition, a safe space, and stimulating materials and opportunities to learn and play. Ideally, childcare centers operate for a full day, to align with parents' working hours.

This review focuses on childcare services targeting children up to age 6, the typical age at which they begin primary education.[3] We categorize childcare and early-education services for children into two broad groups:

i. **Home-based care** refers to childcare provided in a home setting. Home-based care can consist of care that someone provides in the child's own home—such as a nanny, au pair, or domestic worker—or care provided for a group of children in a caregiver's home. Home-based services may be preferred because of the lack of supply or limited affordability of center-based daycare,

3 Services for children aged 0 to 3 are often provided separately from services for children aged 4 to 6, which frequently takes the form of preschool education. Preschools may help prepare children for primary education but might offer only a partial childcare solution in that, in many countries, they operate for only a half day.

as well as individual preferences and cultural norms. Vulnerable workers with low, irregular earnings may not be able to afford to hire a nanny or domestic worker to care for their children (Alfers 2016; UNICEF 2016). In some cases, families may use a relative or someone close to the family in exchange for low wages or room and board. Low-income families often receive childcare services from a neighbor or community member in the neighbor's or community member's home.

ii. **Center-based care** refers to nurseries, crèches, and daycares. Preschools can also serve as center-based childcare, although their primary focus is on preparing children for primary school by supporting their cognitive, socioemotional, and physical development (while continuing to provide quality care). A variety of actors operate these facilities, including government, workers' organizations, nongovernmental organizations (NGOs), community- and faith-based organizations, private providers, and employers. They are situated in a range of contexts, including informal settlements, rural communities, and on or near worksites.

Home- and center-based care may be government registered or licensed and regulated based on national standards of early childhood care and education.[4]

Recognizing the gap in access to childcare for low- and middle-income families and the profound benefits that childcare can provide, various actors in LMICs are designing innovative programs that support high-quality childcare, including for the most vulnerable populations. Table 1 summarizes the various types of childcare, and the following section provides in-depth descriptions of each type, along with examples from LMICs.

4 Improvised and unremunerated family arrangements, such as taking the child to work or leaving the child with a sibling or other relative, is a third form of childcare but one that can have important negative consequences for families. The 2015 UN Women survey shows that the most common form of childcare for working women with the lowest incomes is to care for their children while they work. In a survey of low-income countries, 46 percent of children younger than 5 were left alone or in the care of a sibling younger than 10 for at least 1 hour in any given week (Samman, Presler-Marshall, and Jones 2016). Not only can this limit the child's development, but it also results in women having extremely limited options for employment and in older children—often girls—not being able to attend school (Alfers 2016; Samman, Presler-Marshall, and Jones 2016). As such, this third form of childcare is not considered in this review.

TABLE 1. TYPES OF CHILDCARE SERVICES

TYPE OF CHILDCARE PROVISION	REGISTERED[A]	DESCRIPTION	TYPICAL FINANCING MODALITY	EXAMPLES
HOME-BASED CHILDCARE				
HOME-BASED CHILDCARE SERVICE	No	Childcare provided for group of children in caregiver's home	• User fees • In-kind transfers	South Africa
HOME-BASED CHILDCARE SERVICE	Yes	Childcare provided for group of children in caregiver's home	• User fees • Public subsidies	Mexico Colombia Rwanda
CENTER-BASED CHILDCARE				
PUBLIC CENTERS	Yes	Publicly managed childcare services	• User fees • Public funding (national or local government) • Social insurance (social security contributions) • Donor funding	Ecuador Brazil Bolivia
PRIVATELY RUN CENTERS (FOR PROFIT AND NONPROFIT)	Yes and no	Privately managed preschools and childcare services ranging from high end to low cost	• User fees • Donor funding • Public subsidies • In-kind transfers	Kenya South Africa
COMMUNITY AND NGO-RUN CENTERS	Yes and no	Community-managed, usually with NGO or government support	• User fees • In-kind transfers • Public subsidies • Donor funding	Mozambique India
COOPERATIVE CENTERS	Yes	Focus on parental ownership and contributions	• User fees • In-kind transfers • Membership dues • Cooperative profits • Public subsidies • Donor funding	Guatemala India
ON-SITE CHILDCARE AND MOBILE CRÈCHES	Yes and no	Childcare provided at parent's worksite	• User fees • Public subsidies • Donor funding • Social insurance • Corporate profits	India Burkina Faso Liberia
EMPLOYER-SUPPORTED CENTERS	Yes	Various models, including onsite childcare (established or contracted)	• User fees • Corporate profits • Public subsidies • Social insurance	Kenya

Source: Devercelli and Beaton-Day 2021; ILO and WIEGO n.d.

Note: NGO, nongovernmental organization.

a. Registered refers to services and centers that are formally registered with the government and are expected to adhere to ECD standards and requirements.

HOME-BASED CHILDCARE

Unregistered home-based childcare

Unregistered home-based childcare consists of an informal childcare business in the provider's home. In some contexts, a group of women (or families) who work in the same sector or area will pool resources to pay for a neighbor or community member to care for children. User fees for this type of childcare are usually very low, which makes it popular in low-income settings. The quality of unregistered home-based childcare services varies because they are unregulated, which means that there are no basic training, infrastructure, or amenity requirements. Most examples observed provided generally low quality of services, suggesting that, in countries where there is a lack of or ineffective regulation and quality assurance systems, projects should support these parts of the enabling environment.

EXAMPLE OF UNREGISTERED HOME-BASED CHILDCARE: **SOUTH AFRICA**			
Population:	57.78 million	**Net enrollment in childcare / early learning (ages 4–5):**	85%
GDP per capita:	USD 6,374	**Female labor force participation rate:**	50%
Income level:	Upper middle	**Share of informal jobs (15-64):**	51%
Program name:	[Home-based childcare]		
Year established:	2011		
Context:	Urban areas, low-income neighborhoods, and informal settlements in Durban		
Target group:	Children younger than 3		
Main features: In South Africa, institutional care for children younger than 3 is only provided privately. Because of cost barriers, informal workers often leave their children with neighbors who provide childcare services out of their own home. In Durban, South Africa, a group of female trash collectors pool their resources together to pay an older couple in their neighborhood to care for 10 to 15 children in their home.			
Fees: There is a fee for the service, but families often pay using in-kind contributions or other nonmonetary forms of payment because of their volatile, low earnings. Although South Africa has a subsidy model for nonprofit providers, it is applicable only to registered providers, and registration barriers are high.			
Quality observations: Providers are all informal workers and have no formal training or qualifications to be registered childcare workers. The state does not regulate these types of centers. Because these types of daycares are located in low-income areas, they lack basic amenities; for example, dirt roads turn to mud in the rain, which limits access to the facility.			
Results: There is no published evidence on benefits. Although this service may be valuable in underserved communities, particularly for women who cannot afford center-based childcare, poor quality may limit ECD outcomes and make it difficult for families to trust and use these services.			

Source: Alfers 2016; ILO and WIEGO n.d.

Registered home-based childcare

Registered home-based childcare services are registered with the government and expected to adhere to infrastructure criteria, health and safety standards, child-adult ratios, caregiver qualifications and accreditations, and other requirements. In many LMICs, there are barriers to micro and small firms registering as formal businesses and adhering to requirements and standards—especially those related to infrastructure—increases operational and set-up costs, which may result in higher fees. In some countries, governments offer subsidies to families for registered home-based childcare or to individuals who establish registered home-based childcare services to support profitability (OECD 2017).

EXAMPLE OF REGISTERED HOME-BASED CHILDCARE: **MEXICO**

Population:	126.2 million	**Net enrollment in childcare / early learning (ages 3-5):**	83%
GDP per capita:	USD 9,673	**Female labor force participation rate:**	44%
Income level:	Upper middle	**Share of informal jobs (15–64):**	69%
Program name:	*Estancias Infantiles para Apoyar a Madres Trabajadoras* (Daycare Support for Working Mothers)		
Year established:	2007–2019		
Context:	Urban and low-income areas		
Target group:	Children younger than 3		

Main features: Mexico's *Estancias Infantiles para Apoyar a Madres Trabajadoras* was established in 2007 with the goal of increasing women's labor force participation. Until 2019, it provided subsidized childcare services for low-income mothers (and single fathers) who were working, looking for work, or studying.

The government offered subsidies to women or community groups who wanted to establish registered home-based childcare services. The subsidy covered costs related to converting an adequate space within their home, buying educational and learning materials, paying for insurance, and other costs. To ensure that the program met parents' needs, centers were required to operate for a minimum of 8 hours per day, 5 days per week.

Fees: The government paid up to 90 percent of the monthly fee for childcare services directly to the childcare worker, and parents and guardians paid the remaining share.

Quality observations: Providers were required to register their business and adhere to staff training, accreditation, and other standards that the government set. To qualify for the subsidy, providers had to complete secondary education, receive national accreditation as childcare providers, and pass a psychological test. Programs could care for a maximum of 60 children and had to maintain a children-staff ratio of no more than 8:1. Despite these measures, the program received criticism over perceived low quality.

Results: The program provided significant benefits to mothers in terms of employment and income. Mothers benefitting from the program were 18 percent more likely to be employed and worked 6 more hours per week. A 2010 study found that households saw a 28 percent increase in income after joining the program. Benefits were particularly strong for women who were not working before joining the program. The program also enabled rapid expansion of a trained childcare professional workforce, with almost 3,500 caregivers receiving a childcare certificate within 2 years.

Source: CONEVAL 2019; Gerhard and Staab 2010; Hunt and Samman 2016; ILO and WIEGO n.d.; Mexico and SEDESOL 2017; Samman, Presler-Marshall, and Jones 2016.

EXAMPLE OF REGISTERED HOME-BASED CHILDCARE: **COLOMBIA**			
Population:	49.65 million	**Net enrollment in childcare / early learning (ages 3-5):**	84%
GDP per capita:	USD 6,668	**Female labor force participation rate:**	57%
Income level:	Upper middle	**Share of informal jobs (15-64):**	38%
Program name:	*Hogares Comunitarios de Bienestar (HCB; Community Welfare Homes)*		
Year established:	1986		
Context:	Rural and urban nationwide, except for the departments of Amazonas and Guainia		
Target group:	Children aged 6 months to 5 years from vulnerable families		

Main features: HCB is a home-based childcare program registered with the government of Colombia. Childcare providers (*madres comunitarias* or community mothers) deliver services that include supplementary nutrition and psychosocial stimulation. HCB is one of the largest programs in Latin America, with more than 65,000 registered home-based centers and more than 1 million children enrolled.

Fees: Funding is provided through a mix of public financing and parental fees, with parents paying monthly fees of less than 25 percent of the daily national minimum wage.

Quality observations: Early studies of the program in the 1990s found that care providers had, on average, low education and inadequate training, which affected the quality of ECD services. Since then, quality and student outcomes have increased because the *Instituto Colombiano de Bienestar Familiar* has offered early childhood care and education training in partnership with the National Learning Agency as part of the formal vocational education system. Student-teacher ratios are limited to 14:1 for children aged 18 months to 5 years, 2:1 for children aged 3 to 6 months, and 1:1 for children with disabilities.

Results: An impact evaluation of the program found positive effects on cognitive and socioemotional development of children exposed to the HCB program for more than 15 months. Increases in cognitive test scores ranged from 4 percent to 5.4 percent and were close to 8 percent for socioemotional development scores. The benefit-cost ratio was estimated to be in the range of 1.4 or 2.7 (depending on the discount rate). Access to HCB services increased the probability of female employment from 12 percent to 37 percent and increased the number of hours worked by an average of 75 hours a month.

Source: Bernal 2015; Bernal and Fernandez 2013; Diaz and Rodriguez-Chamussy 2016.

For further information, see the related Case Study in Annex A.

EXAMPLE OF NGO-RUN HOME-BASED CHILDCARE: **RWANDA**

Population:	12.3 million	**Net enrollment in childcare / early learning (ages 3-5):**	23%
GDP per capita:	USD 773	**Female labor force participation rate:**	84%
Income level:	Low		

Program name:	CARE International's ECD
Year established:	2010
Context:	Rural (districts of Kamonyi, Musanze, and Nyamagabe)
Target group:	Children aged 18 months to 3 years

Main features: The NGO CARE International helps mothers form daycare groups. The mothers work in pairs to provide at-home daycare services for other women in the community in a room in the home of one of the group members renovated for proper sanitary conditions, with handwashing and toilet facilities. The NGO partners with community health workers to monitor children's health and nutrition. Parents—usually mothers—develop a rotating schedule in which each parent oversees services one morning per week. Each ECD site serves 10 to 12 children, who typically attend 5 days per week for 4 to 5 hours in the morning.

Fees: Parents pay a small weekly fee to cover recurring costs such as porridge and soap and fixed costs such as benches and mats.

Quality observations: CARE International provides ECD training and guidance to parents.

Results: Although no rigorous evaluation has been conducted to estimate causal impact, several quantitative and qualitative studies have reported interesting results. A quantitative study from 2013 suggested that children who attended achieved significantly higher grades than peers at the end of grade one. Qualitative data reported that children attending had better behavior, better understanding of proper use of materials, and more appropriate interactions with teachers than their peers. Parents—mostly mothers—attending focus group discussions noted economic benefits because they had more time to dedicate to productive activities. A 2015 quantitative study found significant differences in child survival rates and child health indicators between the intervention and comparison communities but no difference in ECD outcomes.

Source: CARE 2013; Clinton 2013; Lavin et al. 2015.

CENTER-BASED CHILDCARE

Public centers

Public childcare centers and pre-primary schools vary in their cost to families, from free or heavily subsidized to costing as much as nonpublic options. Although provision of public pre-primary education is increasing globally, few countries (especially LMICs) provide much public childcare. Although several LMIC governments are working to expand public childcare, this requires significant financial and human resources, implementation capacity, and political commitment, which may mean that large-scale coverage of public childcare centers is not always feasible and realistic in the short or medium term.

Some governments engage in public-private partnerships and support services that nonstate actors including individuals, NGOs, community groups, and faith-based organizations manage, providing public resources to cover some or all of the operating costs. Requirements for these public-private partnerships vary from country to country and can include targeting vulnerable populations, meeting quality standards, following a particular curriculum, providing food, and training practitioners. Implementing public childcare through various providers requires a clear, comprehensive implementation structure. Lack of government regulation and monitoring may create challenges, including lack of quality, low staff-child ratios, and overall lack of childcare worker ECD capacity and knowledge.

EXAMPLE OF PUBLIC CENTER-BASED CHILDCARE: **BRAZIL**			
Population:	209.5 million	**Net enrollment in childcare / early learning (ages 4-5):**	92%
GDP per capita:	USD 8,921	**Female labor force participation rate:**	54%
Income level:	Upper middle	**Share of informal jobs (15-64):**	22%
Program name:	*Crèches* and *Pré-escolas*		
Year established:	1970s		
Context:	Urban and rural, provided in most municipalities		
Target group (age range of children):	Early childcare in Brazil is divided into two stages: children younger than 3 attend daycare, called crèches, and 4- and 5-year-olds attend preschool. Preschool is part of the formal public education system, and all children in Brazil are required to attend 2 years of preschool.		
Main features: There are two types of early childhood centers (including crèches and preschools): the government owns and operates "direct" centers, and private institutions operate "indirect" centers that the government funds. Both follow the government's regulations and enrollment system.			
Fees: Free.			

Quality observations: Perceived quality of crèches is generally low, especially in rural areas, where centers are less likely to be staffed with qualified teachers or equipped with proper support materials. The average student:teacher ratio is approximately 26:1.

Results: Evaluations found that use of public center–based care increased the probability of maternal employment by 44 percent, with mothers more likely to work full time and to work in the formal sector (Sanfelice 2019). Impact on maternal employment was larger when provision of childcare was low before the intervention. Household incomes increased 16 percent.

Source: Attanasio et al. 2017; Sanfelice 2019; UNICEF 2019b.

EXAMPLE OF PUBLIC CENTER-BASED CHILDCARE: **ECUADOR**

Population:	17.08 million	**Net enrollment in childcare / early learning (ages 3-5):**	66%
GDP per capita:	USD 6,345	**Female labor force participation rate:**	55%
Income level:	Upper middle	**Share of informal jobs (15-64):**	42%
Program name:	*Centros Infantiles del Buen Vivir* (Good Living Children's Centers)		
Year established:	2007		
Context:	Urban and rural nationwide		
Target group (age range of children):	Originally 6 months to 5 years; since a 2012 reform, the program accepts children aged 6 weeks to 3 years. The program mainly targets low-income families.		

Main features: *Centros Infantiles del Buen Vivir* are the primary providers of public childcare services in Ecuador, serving children throughout the country. Most centers operate under third-party agreements with local governments, community organizations, foundations, churches, and other providers, who receive public funds to cover operating costs. Centers were originally under the Institute for Children and Families and later incorporated into the Ministry of Social and Economic Inclusion.

Fees: Free.

Quality observations: Early quality assessments (2012) showed significant gaps in quality, with few centers meeting acceptable standards. Upon receiving these findings, the government undertook reforms to improve service quality, including hiring and training additional teachers and assistants and workforce professionalization (childcare workers now earn at least minimum wage and are covered under social security), inspecting centers and closing those that fail to meet standards, and transferring over-age children to early childhood education services. A later evaluation (2015) found significant improvements, although there was still room for improvement.

Results: No published results available.

Source: Araujo et al. 2015.

Privately run center-based childcare

Low-cost, for-profit providers are one of the greatest nonstate sources of childcare and preschool, especially in low-income urban areas. They typically consist of single providers and operate like small businesses or chains, charging varying fees to parents. They can be formal and registered within a public-private partnership or legal but not formally registered with the government. When not registered, they are less accountable to national regulations and quality standards, which can affect quality. Informal centers also have more agency in the programs they follow, giving them, for instance, the freedom to use a language of instruction different from that of formal public providers, sometimes making them more attractive to targeted pools of families.

EXAMPLE OF UNREGISTERED FOR-PROFIT CHILDCARE: **KENYA**			
Population:	51.39 million	**Net enrollment in childcare / early learning (ages 3-5):**	N/d
GDP per capita:	USD 1,711	**Gross enrollment in childcare / early learning (ages 3-5):**	6%
Income level:	Lower middle	**Female labor force participation rate:**	72%
Program name:	*Kidogo*		
Year established:	2014		
Context:	Urban and peri-urban (on the outskirts of Nairobi)		
Target group:	Children aged 6 months to 6 years		
Main features: Kidogo is a social enterprise that works to increase access to quality, affordable early childhood education (ECE) in East Africa. It uses a social franchising approach to give female Kenyan entrepreneurs (mamapreneurs) tools to create or expand their own childcare micro-businesses. Centers operate 8 or more hours during the working day. These centers remain unregistered because the national quality assurance system for daycare is limited, and centers must go through the same expensive registration processes that commercial businesses do to register.			
Fees: Approximately USD 1 per day.			
Quality observations: Kidogo provides training and mentoring for mamapreneurs on ECE and health and nutrition to improve the quality of care provided to young children. It also provides participants with a starter kit with key resources for their centers, along with ongoing quality assurance.			
Results: The program supports approximately 541 mamapreneurs caring for more than 10,700 children.			

Source: Beaton-Day and Devercelli 2018; Kidogo 2019.

For further information, see the related Case Study in Annex A.

EXAMPLE OF GOVERNMENT-SUBSIDIZED NOT-FOR-PROFIT CHILDCARE: **SOUTH AFRICA**			
Population:	57.78 million	**Net enrollment in childcare / early learning (ages 4-5):**	85%
GDP per capita:	USD 6,374	**Female labor force participation rate:**	50%
Income level:	Upper middle	**Share of informal jobs (15-64):**	51%
Program name:	Government subsidies for ECD centers		
Year established:	Before 2003		
Context:	National		
Target group:	Children younger than 6, focusing on low-income families		
Main features: Most ECE in South Africa, especially for younger children, is provided through the nonstate sector. The government ECD subsidy program allows registered, not-for-profit providers to apply for subsidies of 17 rand (USD 1) per child per day. Providers must generally demonstrate that a child is eligible through an income means test, although this may not be necessary in some poverty-declared areas. The subsidy must be used 40 percent for nutrition, 40 percent for educator and practitioner salaries, and 20 percent for equipment.			
Fees: Subsidy is estimated to cover less than half the cost, with parents covering the rest.			
Quality observations: Limited quality assurance system beyond compliance with registration (and renewals every 5 years) and little information collected on quality.			
Results: The subsidy reached more than 600,000 children in 2019/20. It is important for increasing the affordability of services, but the subsidy reaches only a small percentage of eligible children, and there are various challenges with applying for, claiming, and using the subsidy, which restricts its effectiveness. These include a challenging application process, insufficient budget to reach all eligible children, inadequate subsidy amount, onerous reporting, unpredictable funding (based on attendance making centers financially vulnerable given fixed costs), and challenges with the prescribed ratio because it is misaligned with center operating costs.			

Source: Ilifa Labantwana 2021.

NGO- or community-run center-based childcare

In many LMICs, NGO- or community-run center-based childcare services have become a popular model for reaching low-income households, but the degree of government engagement in financing and regulating these childcare services varies considerably across countries, affecting availability, accessibility, and quality. These types of services often require that parents pay a fee, although fees are usually low.

EXAMPLE OF GOVERNMENT-SUPPORTED, COMMUNITY-RUN CHILDCARE: **MOZAMBIQUE**			
Population:	30.37 million	**Net enrollment in childcare / early learning (ages 3-5):**	2%
GDP per capita:	USD 499	**Female labor force participation rate:**	78%
Income level:	Low	**Share of informal jobs (15-64):**	75%
Program name:	*Desenvolvimento Integral da Criança em Idade Pré-escolar* (Holistic Development of Children of Preschool Age)		
Year established:	2012		
Context:	Rural, in about 350 rural communities across five provinces		
Target group:	Children aged 4 to 5		
Main features: The *Desenvolvimento Integral da Criança em Idade Pré-escolar* program, piloted from 2012 through 2019, financed construction of community-based preschools (*escolinhas*). With financial and technical assistance from the World Bank, the Ministry of Education and Human Development competitively contracted third-party providers to provide a range of services at the community level, including community mobilization, *escolinha* facility construction, teacher training (facilitators), and ECD service provision. Services were available 3 hours per day, 5 days per week.			
Fees: According to project implementation requirements, families were expected to contribute to the functioning of the *escolinhas* through financial support, in-kind support (e.g., providing food or water), or services (e.g., cleaning). As of 2019, 66 percent of caregivers did not pay fees or make in-kind contributions. Only 8 percent reported paying fees, and 23 percent reported providing regular in-kind contributions. More than 60 percent of caregivers supported the *escolinhas* with services such as overall maintenance and cleaning.			
Quality observations: Application of Measuring Early Learning and Quality Outcomes (a classroom observation tool) exposed major problems related to poor use of learning materials, lack of required pre- and in-service teacher training, and almost no use of a curriculum to guide learning. Assessment of service quality resulted in overall low scores on pedagogy in almost all subject areas.			
Results: An impact evaluation of the program is underway. A previous 2-year pilot of a similar model that Save the Children implemented in Mozambique demonstrated significant benefits for children and family members. In particular, children aged 3 to 5 who participated in the Save the Children community-based ECD intervention were 24 percent more likely to enroll in primary school at the optimal age of 6 and were better prepared to learn, performing significantly better on measures of cognitive, fine motor, and socioemotional development than children in a control group. Parents of participating children also benefited, showing better parenting behaviors, including spending more time playing with their children and believing less in physical punishment. Finally, important positive spill-over effects were observed in other family members. Older siblings were more likely to be enrolled in school, and caregivers were 26 percent more likely to have worked in the 30 days before interview, with the largest benefits for mothers, probably because siblings and caregivers spent less time caring for young children at home.			

Source: Heinzel-Nelson Alvarenga Lima and Barros Martins 2019; Martinez, Naudeau, and Pereira 2012.

EXAMPLE OF GOVERNMENT-SUPPORTED, COMMUNITY-RUN CHILDCARE: **INDIA**			
Population:	1.35 billion	**Net enrollment in childcare / early learning (ages 3-5):**	73%
GDP per capita:	USD 2,010	**Female labor force participation rate:**	20%
Income level:	Lower middle		
Program name:	Integrated Child Development Services (ICDS), or *anganwadi* centers		
Year established:	1975		
Context:	Urban and rural, with every community of 400 to 800 people with at least one center		
Target group:	Children aged 3 to 6, mainly from vulnerable groups		
Main features: ICDS is the world's largest integrated ECD program. A network of more than 1.3 million anganwadi centers across every region in India offers ICDS services, providing nonformal preschool education to children aged 3 to 6. The centers operate only 3 hours per day. As of 2013, about 35 million had benefited from ICDS preschool services through its wide range of health, nutrition, social protection, and early learning services. Although it is supported by funds from the central and state governments, ICDS is organized through community-based centers through paid "volunteers," which enables the centers to bypass government regulations and hire personal at below-market pay.			
Fees: Free.			
Quality observations: Because of its large size and fast expansion, the ICDS scheme suffers from low-quality ECD and poor infrastructure. As the number of anganwadi centers has grown, there have been difficulties in hiring and retaining teachers because they are underpaid, undertrained, and overworked. *Anganwadi* workers are not formally recognized as civil servants and do not have access to the same benefits. Absenteeism and teacher drop-out rates are high, and workers have staged large-scale protests across India.			
Results: Despite the program's large scope and budget (USD 2.31 billion in fiscal 2019), no robust impact evaluation of the program has been conducted, although independent small -scale studies have found that children who attended *anganwadi* centers perform better than peers who did not on various ECD outcome indicators. A recent ICDS mission framework has indicated that a small percentage of *anganwadi* centers could be extended into *anganwadi* centers-cum-crèches to provide daycare facilities for children from the age of 6 months.			

Source: Samman, Presler-Marshall, and Jones 2016; Timsit 2019.

Childcare cooperatives

Cooperative-run childcare centers are emerging around the world as an alternative to private for-profit and NGO- or community-run centers by promoting ownership and participation of childcare workers and users (ILO and WIEGO 2018). Types of services provided through childcare cooperatives vary based on local context and care needs of their members. Cooperatives have a diverse range of stakeholders, including care providers, families, governments, and community agents. In the formal and informal economies, workers' organizations can mobilize cooperatives to provide childcare services for members.

EXAMPLE OF CHILDCARE COOPERATIVE: **GUATEMALA**			
Population:	17.25 million	**Net enrollment in childcare / early learning (ages 3-5):**	47%
GDP per capita:	USD 4,549	**Female labor force participation rate:**	40%
Income level:	Upper middle		
Program name:	*Unidas para Vivir Mejor* (Cooperative Children's Center)		
Year established:	1994		
Context:	Urban, inlow-income neighborhoods of Villa Neuva, Guatemala		
Target group:	Children aged 45 days to 5 years from families with parents working in the area		
Main features: *Unidas para Vivir Mejor* was founded in 1989 as a handicraft cooperative run by women in low-income neighborhoods in Guatemala. The cooperative has expanded production of handicrafts to fund social programs to support women's economic empowerment, including community childcare. Centers are open from 7 am to 5 pm to coincide with parent's working hours.			
Fees: About USD 22 per month, per child. Worker-members pay a reduced monthly fee of USD 15. Fees contribute to center activities and nutritious meals, complemented by proceeds from the handmade fair-trade crafts department. Children from the lowest-income households are exempt from fees when other funds from private donors and foundations are available.			
Quality observations: Worker-members manage the center, and many staff members are also members. Staff are trained in the Montessori approach and in early stimulation and nutrition. The Montessori teachers receive on-going assistance, training, and material donations from Montessori-trained volunteers.			
Results: No published results available.			

Source: ILO and WIEGO 2018; UPAVIM n.d.

EXAMPLE OF CHILDCARE COOPERATIVE: **INDIA**			
Population:	1.35 billion	**Net enrollment in childcare / early learning (ages 3-5):**	73%
GDP per capita:	USD 2,010	**Female labor force participation rate:**	20%
Income level:	Lower middle		
Program name:	*Self-Employed Women's Association (SEWA) Sangini Child Care Workers' Cooperative*		
Year established:	1986		
Context:	Urban (Ahmedabad, Gujarat)		
Target group:	SEWA members' children aged 0 to 6		
Main features: SEWA is a trade union representing self-employed women in the informal economy such as agricultural workers, domestic workers, street vendors, and waste pickers. The union help members obtain social protection, including income, food security, and establishment of childcare centers. There are 13 centers across the city of Ahmedabad caring for 350 to 400 children. The centers are open from 9 am to 5 pm to coincide with parents' working hours. The cooperative is part of a broader workers' movement through SEWA linked to the national Forum for Crèches and Child Care, which brings together more than 500 children's, women's, and workers' rights organizations calling for quality public childcare services.			

Fees: The childcare centers depend largely on financial support from SEWA ventures, private donations, and local government. Parents pay a monthly fee of 175 rupees (USD 2.5) per month that covers about 10 to 15 percent of the centers' monthly running costs (~20,000-25,000 rupees, USD 271-400). Because most parents who work in the informal economy have low earnings, they are unable to pay higher fees.
Quality observations: Each center accepts a maximum of 15 children per facilitator, who provide basic education and social skills, adequate nutrition, and basic health services. Shareholder facilitators and parents elect a board every 3 to 5 years that provides quality assurance. Childcare workers, selected from the community and cooperative members, receive training from SEWA before starting work and every 3 months. An in-house capacity-building team focuses on facilitator skills. As a result, childcare workers are seen as leaders in their communities, given their knowledge of children's health, nutrition, social development, and early education.
Results: Sixty-four percent of working mothers who used the centers said that they were able to increase their number of working days and income as a result of the increased working time available and reduced childcare burden. Childcare centers were also perceived as helping build trust and solidarity among SEWA members and commitment to the trade union and the cooperative model. The cooperative has become an important part of the social fabric of these dense urban communities, opening avenues for engagement with local and national government.

Source: ILO and WIEGO 2018; Moussié 2016.

For further information, see the related Case Study in Annex A.

On-site childcare and mobile crèches

Because many caregivers bring young children to work because of lack of other childcare arrangements, on-site childcare arrangements have begun to emerge in some countries. One type of on-site childcare is the mobile crèche. Originally started in India, the mobile crèche system is formalized mobile childcare that follows women as they move between work sites. This is particularly relevant for migrant, agricultural, public works, and construction workers. NGOs commonly support mobile childcare, supplying materials and training to caregivers. The childcare is often established in an empty building that the local authority offers or in tents or outdoors under a tree. The government usually has some role in regulating the programs and ensuring that employers contribute to funding.

EXAMPLE OF MOBILE CRÈCHE: **INDIA**			
Population:	1.35 billion	**Net enrollment in childcare / early learning (ages 3-5):**	73%
GDP per capita:	USD 2,0010	**Female labor force participation rate:**	20%
Income level:	Lower middle		
Program name:	*NGO Mobile Crèches*		
Year established:	1969		
Context:	Urban, serving migrant women working at urban construction sites		
Target group:	Children younger than 3 (crèches) and aged 3 to 5 (*balwadi*)		
Main features: Before mobile crèches were established, many women brought their children with them to sometimes dangerous work sites or left them without adult supervision. Mobile crèches support childcare centers through direct delivery of childcare services, establishment of a center and eventual takeover and supervision by the construction company, and NGO identification and training on childcare service provision (most centers). The mobile crèche day care model is an 8-hour program that operates 6 days per week.			
Fees: No fees charged to users. Mobile crèches have different funding models, and employers are responsible for a percentage of or total funding.			
Quality observations: Mobile crèche interventions include protection and care, nutrition, health and hygiene, education, and community awareness. To sustain benefits of the intervention, childcare workers enlist support from parents, the community, employers, and local and state agencies.			
Results: As of 2018, mobile crèches had reached almost 11,000 children through 72 urban locations, with 62 at construction sites in Ahmedabad, Bangalore, Chandigarh, Delhi National Capitol Region, and Mohali and 10 centers in poor settlements in Delhi. The program included strong advocacy, which helped build public support for passing the 1996 law making crèches mandatory at worksites employing more than 50 women.			

Source: Samman, Presler-Marshall, and Jones 2016; Mobile Crèches 2018.

EXAMPLE OF MOBILE CRÈCHE: **BURKINA FASO**

Population:	19.75 million	**Net enrollment in childcare / early learning (ages 3-5):**	5%
GDP per capita:	USD 715	**Female labor force participation rate:**	58%
Income level:	Low	**Share of informal jobs (15-64):**	55%

Program name:	Burkina Faso's Mobile Crèche Scheme under the World Bank Youth Employment and Skills Development Project
Year established:	2016
Context:	Peri-urban, with the program pilot implemented in Manga
Target group:	Children younger than 6

Main features: The mobile crèche scheme was piloted in Burkina Faso as part of a project to support skills development and employment for vulnerable youth, mostly women, through temporary public work opportunities. Motivation for the pilot came from the observation that many female workers were forced to bring young children to work sites because of lack of other childcare arrangements. The government developed a standardized list of materials (all weather resistant) and a stimulation program based on the national preschool curriculum, adapted for younger children. The mobile crèches offer parent education, health services, and vaccines for children, with opportunities for mothers to breastfeed. In addition to providing childcare services, they create a new public works stream for the caregivers. This service follows the women as they move from worksite to worksite because each work placement is around 6 months. The mobile crèches take place under a tree or in an empty building offered by a local authority; the United Nations Children's Fund has donated large weather-resistant tents.

Fees: Although the program receives public funding through a World Bank project, mothers contribute a modest monthly fee (approximately USD 6), which is held in a collective mobile pay account and used to buy food for the children.

Quality observations: The Ministry of Education trains childcare assistants, who receive the same wages as other workers at the site. An ongoing training and support system compensates for the initial low caregiver education. Provided by a local, government-employed early childhood specialist, training focuses on caregiving techniques and content.

Results: Following the success of three pilot projects, Burkina Faso has replicated this initiative in 18 communes. An impact evaluation of the Burkina Faso mobile crèche scheme conducted in 2021 shows somewhat promising results. Twenty-five percent of women who were offered childcare services used them, suggesting an unmet need. Furthermore, women who had childcare services at their worksite saw improvements in employment outcomes, psychological well-being, and financial resilience and savings. For instance, there was a 13 percent increase in women's likelihood of having saved money in the past year and a 25 percent increase in their reported capacity to mobilize funds in an emergency, although effects on women's involvement in decision making and on gender attitudes were limited. The impact evaluation found that attending childcare improved children's gross and fine motor skills but not language scores.

Source: Ajayi, Dao, and Koussoube 2022; CFI.co 2019; Haddock, Raza, and Palmisano 2019; World Bank 2021.

EXAMPLE OF ON-SITE CHILDCARE: **LIBERIA**			
Population:	4.82 million	**Net enrollment in childcare / early learning (ages 3-5):**	59%
GDP per capita:	USD 677	**Female labor force participation rate:**	72%
Income level:	Low	**Ratio of female to male labor force participation rate:**	89%
Program name:	Economic Empowerment of Adolescent Girls and Young Women (EPAG) Project		
Year established:	2010		
Context:	Urban and peri-urban, implemented in Greater Monrovia		
Target group:	Children younger than 6		
Main features: The World Bank EPAG project was launched in 2008 to increase employment and income for Liberian women aged 16 to 24. The program provides vocational training through a business development skills track and a job skills track, along with job placement to facilitate transition to work. To increase young mothers' participation, the project introduced on-site childcare. Designated childcare rooms were located near training classrooms to accommodate breastfeeding mothers. NGO-provided childcare services had to adhere to government childcare guidelines and quality standards. In 2016, the program piloted a new training stream focused on training childcare and early learning practitioners.			
Fees: Free.			
Quality observations: Childcare guidelines for care services and basic quality standards were defined based on consultations with specialized NGOs and project beneficiaries. The project also developed terms of reference for childcare providers, with specific requirements on minimum training. EPAG's quality monitors make routine, unannounced visits to ensure that service providers are adhering to quality standards.			
Results: In focus group discussions, program participants reported appreciation for childcare services. Among the main benefits cited, the centers were found to enable trainees to concentrate on lessons without distractions. The childcare services, along with transport stipends and food, also reduced absenteeism and drop-out rates, helping maintain a 90 percent program attendance rate. Ninety percent of participants in the childcare training stream found employment.			

Source: Haddock, Raza, and Palmisano 2019.

For further information, see the related Case Study in Annex A.

Employer-provided childcare

A growing body of research shows that investing in childcare services for employees reduces absenteeism, decreases turnover, and increases employee productivity, which is good for business. Employer-supported childcare complements parental leave and benefits and supports workers with young children. Employers and businesses directly support and fund this type of childcare, which offers practical childcare solutions to workers, allowing mothers to continue breastfeeding while at work, and ensures a safe, nurturing environment for children.

Examples of this type of childcare are more commonly found in the formal economy and in high-income countries. The reach of employer-provided childcare is limited in low-income countries, where women's paid work opportunities are predominantly informal. For more information on employer-supported childcare, the International Finance Corporation–led Global Tackling Childcare Working Group has developed resources to support employers' implementation of childcare solutions to benefit working parents and their children (IFC 2017; 2019).

EXAMPLE OF EMPLOYER-SUPPORTED CHILDCARE: **KENYA**

Population:	51.39 million	**Net enrollment in childcare / early learning (ages 3-5):**	N/d
GDP per capita:	USD 1,711	**Gross enrollment in childcare / early learning (ages 3-5):**	76%
Income level:	Lower middle	**Female labor force participation rate:**	72%

Program name: Safaricom
Year established: 2010
Context: Urban
Target group: Employees' children aged 3 months to 7 years

Main features: Safaricom is a telecommunications company operating in Kenya with more than 5,000 employees, of whom 51 percent are women. In 2010, to respond to absenteeism and lateness related to childcare arrangements, Safaricom decided to offer on-site childcare with centers operated by an external private childcare provider. Safaricom's two on-site crèches are located in Nairobi: one at its call center and another at one of three headquarters sites. Older children who need less supervision can use the company's resource center, office space, or computer stations. The call center crèche is open from 6:30 am to 6 pm, 7 days per week, including holidays. It has one room for all children, with a separate sleeping room and kitchen and an outdoor play area. Access to a doctor is provided separately for all staff and for children using the crèche. At the headquarters' site, crèche hours are 7:30 am to 5:30 pm on weekdays. It also has one room for all children, with separate changing facilities and a food preparation room.

Fees: Free.

Quality: To ensure quality, Safaricom outsourced childcare operations to Children's World, an independent, qualified, private provider of crèche, play, and childcare services, under the overall management of Safaricom's Health, Safety, and Wellness Team (part of the Human Resources Division). Parents are welcome to give feedback about crèche services. Over time, this has included suggestions to have more-structured activities for children; to increase provision for children aged 3 and older, including more educational activities; and for childcare providers to receive first-aid training.

Results: The company benefitted from a decrease in staff absenteeism and management time taken to rearrange schedules at its call center. Staff at the call center and headquarters offices report that having crèche facilities on-site increases productivity because they feel more settled, can concentrate better, and are more focused on tasks. Parents value the chance to visit their children during the workday. Safaricom is operating a new program called Safaricom Connect, a return-to-paid-employment program for women who have been out of employment for 1 to 10 years. The company is considering partnerships with other daycare providers in other regions to reach all staff.

Source: IFC 2017.

BOX 1. STIMULATING SUPPLY OF CHILDCARE SERVICES

To increase the supply of childcare and complementary services offered in public centers, several governments and other stakeholders have implemented programs that provide funds or training for workers to establish their own childcare services. Incorporating childcare into skills training and public works programs is a cost-effective approach for governments to take to address multiple challenges with a single investment by promoting employment opportunities (usually targeting women), increasing the supply of childcare, and improving ECD outcomes for children.

South Africa's Expanded Public Works Program (2004-2014) is one of the only programs that made a large-scale attempt to consider childcare a public program. The program not only focused on typical labor-intensive public works—such as building and maintaining roads, dams, or housing projects—but also included ECD services work and training. This new approach sought to expand women's access to employment. Beneficiaries were hired at a minimum wage and provided services for their communities while receiving training and accreditation. The South African government reported that, as of 2015, nearly 20,000 home-based care practitioners were deployed and trained, and almost 185,000 children were receiving care from providers trained through the program. The childcare portion of the program had mixed results, largely because of lack of work opportunities for beneficiaries after the training. Although the program trained existing and new ECD workers and childcare providers, it was criticized for providing few to no actual work opportunities and overall lack of support for beneficiaries once they were qualified and the training period was finished (Antonopoulos and Kim 2011; Parenzee and Budlender 2016; Samman, Presler-Marshall, and Jones 2016).

III. CONCLUSIONS

This review describes a variety of childcare arrangements that LMICs are implementing. Although approaches vary greatly to fit context, constraints, and objectives, it is possible to identify some cross-cutting trends, common challenges, and promising features. This section discusses some of the key conclusions from the review, as well as areas for further research.

Providing affordable, quality childcare services to vulnerable populations is possible and cost effective

The evidence presented in this report confirms that there are alternatives to standard publicly provided center-based services, including some that are cost effective in delivering quality childcare services to low-income families. Although rigorous evidence of outcomes and impact is scarce, studies have confirmed that these innovative childcare arrangements can increase children's cognitive and socioemotional skills (Colombia, Mozambique, Rwanda), mother's participation in the labor market and productivity (Burkina Faso, Colombia, Mexico, India, Mozambique), siblings' attendance in school (India, Mozambique), and household income and welfare (India, Mexico). Benefits tend to be greater for the most vulnerable families with the least access to childcare before interventions. Investment costs associated with these childcare services tend to be low (overall and per pupil), especially when compared with other levels of education or remedial policies in later life-cycle stages.

Everyone has a role to play

A wide range of service provision models are helping meet demand for childcare in LMICs. These models represent different solutions that fit multiple contexts, demands, and constraints. NGOs, civil society organizations, private sector organizations, and cooperatives are increasingly emerging to fill gaps in public provision of childcare, with innovative, tailor-made solutions targeting low-income families. In the efforts described, these stakeholders tend to pay attention to affordability, flexibility, and monitoring and evaluation.

Reaching the most vulnerable people at scale is most effective when governments support investment and coordination (see Box 1 for an example from South Africa).[5] The examples suggest that, without government support, initiatives targeting the poorest populations are unable to grow or must shift their focus toward less-vulnerable populations to increase the pool of clients and be financially sustainable. Conversely, the cases of public-private partnerships presented in this review confirm that a combination of stakeholders (public, private, NGOs, civil society organizations) in various roles (financing, implementation, coordination) offers more potential to expand these models. Governments also play a crucial role in setting quality standards, ensuring that they are enforced, and establishing an affordable registration system to encourage childcare providers to join the formal sector and the standards system. Examples of successful partnerships established between the government and stakeholders in Colombia, India, and Liberia stand out as a promising practice offering a favorable mix of robust enforcement of quality standards, stable financing, and flexible implementation arrangements.

Quality is critical to reap the benefits of investment

Low-quality childcare programs can limit child development and may discourage parents from seeking childcare altogether, but quality assurance is a serious challenge in many LMICs. Lack of quality standards was reported in several case studies. Although some have developed standards for preschool services, most do not have national standards for services targeting children younger than 3. Even if there are quality standards, many countries lack effective mechanisms for their introduction, monitoring, and enforcement. The challenge of low-quality childcare deserves particular policy attention because it can have adverse ECD effects and may discourage parents from seeking childcare. This review describes several complementary initiatives that can be implemented to improve quality, including increasing professionalization of the childcare workforce (Colombia, Ecuador, Liberia); signaling quality through certifications (Kenya); and strengthening monitoring through institutions (Mozambique, Ecuador), parental engagement (India), or support networks (Kenya).

Effective childcare requires strengthening the childcare workforce

Availability of qualified staff is a key challenge to providing quality childcare services. Some countries and programs, such as the large-scale, home-based, registered childcare programs in Colombia and Mexico, are paying special attention to the childcare workforce, with positive benefits for the overall quality of the programs. In some cases, strengthening the childcare workforce has been formally

5 Some policy options for government investment reviewed in this study include public services financed and delivered by public entities; public services supported by government and delivered by nonstate entities; nonstate services supported by government through subsidies or other inputs; public financial support, such as conditional cash transfers, paid directly to families; and policies to mandate employer-supported childcare.

recognized as a program objective. In Liberia, technical childcare skills training for young women was provided in on-site crèches for young mothers—in a virtuous cycle of strengthening services for young women looking for employment and their children. In some countries, such as Burkina Faso, public works programs offer mobile crèche services, training and short-term public employment as childcare staff, or both. The Kenyan micro-entrepreneurship example illustrates a different model for how to increase the supply of and demand for childcare services simultaneously. Irrespective of the model, elevating the status and competence of the childcare workforce—through relevant and continuous training, proper salary, and societal recognition—is crucial to providing quality services.

Norms on childcare can shift

Many of the examples discussed in this review are from contexts with strong social norms and preferences about childcare and women's labor market participation, yet the case studies confirm that norms and demand for childcare services can shift. Once programs are established, the benefits become evident to the community and can garner widespread support. Ad hoc accompanying advocacy targeting key stakeholders can also promote widespread acceptance. In Kenya, for instance, parents once cited location and affordability as the most important factors when considering enrolling a child in daycare, but their priorities shifted after exposure to the Kidogo program to include caregiving skills, play-based activities, nutrition, and safety. Even where women's participation in labor markets is low and there are clear gender norms on employment (Brazil, Colombia, Mexico), access to childcare services has greatly increased employment of mothers, ranging from 10 percent to 45 percent higher than control groups studied.

More-robust, -comprehensive monitoring and evaluation is needed

This report offers examples of how childcare services have been created or adapted for vulnerable families in LMICs, but it also highlights some important knowledge gaps. Rigorous evaluation of these programs is scarce, and qualitative evidence is rarely collected in a structured, longitudinal way to determine trends in perceptions over time. Key information on implementation, such as cost or implementation challenges, is not readily available, including for established, publicly funded programs (e.g., the Integrated Child Development Services program in India), yet as highlighted in the case studies for Colombia and Mexico, periodic program evaluation is essential to adjust program design and increase program efficiency and effectiveness. Overall, a more-comprehensive, -robust effort to monitor and evaluate programs would help build the case for expanding childcare solutions.

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ANNEX A. IN-DEPTH CASE STUDIES

This Annex comprises short implementation reviews of selected programs that are promising childcare options for families in low- and middle-income countries (LMICs). The case studies include four models:

- Government-financed, registered, home-based childcare services (Colombia)
- Low-cost private childcare services targeting low-income households (Kenya)
- Cooperative childcare centers (India)
- Government-financed on-site childcare centers (Liberia)

Several factors were considered when selecting these models. Models that appeared promising in terms of scalability and replicability in other LMICs while ensuring some quality standards and accessibility to low-income populations were prioritized. The implementation review then focused on models that appeared less often in existing literature; for instance, although data are available on public childcare centers and those run by nongovernmental organizations (NGOs), information on other forms of childcare arrangements is limited. We aimed to fill this gap by summarizing the information available on these models, with a focus on implementation constraints and potential. Table A.1 compares some key operational dimensions of the case studies.

TABLE A.1. MAIN FEATURES OF SELECTED CASE STUDIES

		HOGARES COMUNITARIOS DE BIENESTAR (COLOMBIA)	KIDOGO (KENYA)	SEWA COOPERATIVE CENTERS (INDIA)	EPAG CHILDCARE (LIBERIA)
PROGRAM OVERVIEW	Type of service	Registered (home or center based)	For-profit (center based)	Cooperative (center based)	On site (center based)
	Main beneficiaries	Children from vulnerable backgrounds (aged 0-5)	Children of Nairobi's informal settlements (aged 0-5)	Children of SEWA cooperative members (aged 0-5)	Children of EPAG trainees (aged 0-5)
	Number of childcare and early childhood education centers	53,000	45	13 urban; 20 rural	19
STAKEHOLDERS	Childcare operator(s)	Parents	Individuals (mamapreneurs)	Cooperative members	Third-party NGOs
	Government entities involved	Instituto Colombiano de *Bienestar Familiar* (Colombian Institute for Family Welfare)	None	Integrated Child Development Services (Ministry of Health and family Welfare); National Crèche Scheme (Ministry of Women and Child Development)	Ministry of Gender, Children, and Social Protection
COSTS	Financing source	Payroll taxes, community contributions, parent fees	Parent fees, grants, donations	Parent fees, SEWA Cooperative (shares), local donations, public subsidies	Public finances through donor support
	Cost center establishment or upgrade (average) (USD)	Information not available	350 for franchising upgrade	~400	17,500 across program (~920 per center)
	Cost per child per month (average) (USD)	Information not available	~6-7	~11	4
	Parent fees per month (USD)	~6	~18	~1-2	0
WORKFORCE	Staff selection criteria	Community member demonstrating solidarity and civic values	Completed mamapreneur training, proposed center meets Kidogo's quality standards	Community member with positive attitude toward handling young children	Background or minimum training in first aid or nursing aid
	Pre-service training	Professional-technical program on ECD	Kidogo's mamapreneur training (18 days over 6 months)	Brief training by SEWA Academy	National ECD training or EPAG program's ECD track in later stages of program (6 months)
	In-service training	Professional–technical program on ECD	Community of practice	Skills upgrading every 3 months	N/A
	Salary per month (USD)	~342	~180	~125 (minimum wage)	75
QUALITY	Standards or curriculum	Curricular Bases for Early and Preschool Education	The Kidogo Way (aligned with the Nurturing Care Framework)	No information available	EPAG childcare guidelines
	Monitoring mechanism		Kidogo's franchising coordinators	SEWA Academy, National Crèche Scheme, Integrated Child Development Services	Third-party NGOs and government

Note: ECD, early childhood development; EPAG, economic empowerment for adolescent girls; NGO, nongovernmental organization; SEWA, Self-Employed Women's Association.

CASE STUDY 1

HOGARES COMUNITARIOS DE BIENESTAR, COLOMBIA

Country context

Colombia has a long history of public investment in early childhood development (ECD). The *Instituto Colombiano de Bienestar Familiar* (ICBF, Colombian Institute for Family Welfare), a government entity founded in 1968 in response to problems affecting Colombian society, has long supported young children's nutrition and protection. Colombia also has a strong early learning system, with the first public preschools established in the 1960s, the first national preschool curriculum disseminated in the 1980s, and early education levels established in the 1990s (Yoshikawa and Kabay 2015).[6]

In the 2000s, Colombia strengthened intersectoral coordination to support ECD. In 2006, the *Codigo por Infancia y Adolescencia* established central and local mesas de infancia y adolescencia (intersectoral committees responsible for children and families). This was strengthened in 2011 by establishment of the *Comisión Intersectorial para la Primera Infancia* (Intersectoral Commission for Early Childhood), which assembles representatives of the ICBF, Ministry of Health and Social Protection, Ministry of Education, Ministry of Culture, National Department of Planning, and Department of Social Prosperity, which reports to the First Lady. The *Comisión Intersectorial para la Primera Infancia* developed an integrative early childhood policy called *De Cero a Siempre* (From Zero to Always) to define a comprehensive framework for coordination of services tied to ECD: childcare, early education, nutrition, health, and protection of rights. In 2016, the *De Cero a Siempre* strategy was adopted into law (Andrew et al. 2018; Cárdenas and Cadena 2020).

In the past decade, the proportion of children enrolled in pre-primary education (typically aged 3 to 6) in Colombia increased significantly, from about 51 percent in 2011 to 82 percent in 2019 (UIS n.d.). About 80 percent of these enrollments are in public preschools. Although data for younger children are less available, it is estimated that about one-third of Colombian children younger than 3 were enrolled in early childhood care and education in 2017, a proportion similar to the Organization for Economic Cooperation and Development average (OECD 2019). The female labor force participation rate is 57 percent, and 38 percent of jobs are in the informal sector (UIS n.d.).

As of 2013, approximately 42 percent of Colombian children were attending home-based or community-operated early learning centers (Andrew et al. 2018). The following sections describe this modality, which the ICBF offers as part of the *Hogares Comunitarios de Bienestar* (HCBs, Community Welfare Homes) program.

Overview

HCBs are nonparental family units that provide childcare for vulnerable populations and promote women's labor force participation. Their approach is grounded in promoting decentralized community empowerment and women's labor participation and leadership. They were

6 Pre-jardin for 4-year-olds, jardin for 5-year-olds, and transición (to primary school) for 6-year-olds.

established in the 1970s as a way to improve children's nutrition and social protection in areas lacking basic services. Soon, the HCBs' educational role was recognized, and they were prioritized in the government's national strategy to foster social equity. They now observe the technical orientations of the *De Cero a Siempre* policy to support holistic development of young children (ICBF n.d.a). The HCB is now one of the largest programs in Latin America, serving more than 1 million children (Diaz and Rodriguez-Chamussy 2016).

Community members, known as *madres comunitarias* (community mothers) or *padres comunitarios* (community fathers), henceforth referred to as community parents, who have the attitude, aptitude, and time to care for a group of at-risk children, run the HBCs. They typically have a high school degree, and all are required to attend a 40-hour pre-service training. Each community parent serves up to 15 children aged 6 months to 6 years, providing them with 50 percent to 70 percent of their daily nutritional needs and promoting their health and their physical, social, and cognitive development.

The HCB, which comprises all home-based childcare and early learning services specific to children younger than 5, includes several models.[7] The two main ones are **family HCB** (home-based childcare), in which a community parent opens a space in their home to care for 12 to 14 children aged 6 months to 5 years, and **group HCB** (center-based community childcare), in which two to seven family HCBs operate within the same physical space within the community, typically involving the support of mayors' offices and other public and private entities (ICBF n.d.a).[8]

Program origins and implementation

In 1974, the government established a scheme whereby employers had to contribute a small percentage of payroll to help ICBF provide childcare for children younger than 7. Through its *centros comunitarios para la infancia* (community centers for children) and *centros de atención integral al preescolar* (comprehensive care centers for preschool), later called *hogares infantiles* (children's homes), the ICBF spent the next decade refining its services to reach Colombia's vulnerable children, providing them with supplementary food, nutritional control, social protection, and early learning opportunities, but these centers achieved limited coverage, especially among the most disadvantaged children (Castillo Cardona, Ortiz Pinilla, and González Rossetti 1993).

In 1986, a new childcare and preschool system was launched through the HCBs. Inspired by smaller-scale programs in neighboring countries such as Ecuador and Venezuela, HCBs target families employed in the informal sector by offering home-based childcare. As mentioned, its approach is grounded in promoting decentralized community empowerment and women's labor participation and leadership (Castillo Cardona, Ortiz Pinilla, and González Rossetti 1993).

Funding

Funding is a mix of public funding and parent fees. A government-established scheme whereby employers had to contribute 2 percent of their payroll initially funded the ICBF (Castillo Cardona, Ortiz Pinilla, and González Rossetti 1993). When introduced in the 1980s, the HCB program was widely popular and reached 122,000 children during the first year. This rapid expansion led the government to increase

7 Complementary educational and training programs for pregnant women and parents to learn how to care for and stimulate their children holistically are provided in association.

8 Basic care units may be offered in association with childcare arrangements; fixed and itinerant basic care units support children younger than 2, pregnant women, and breastfeeding children younger than 6 months through group meetings and individual home meetings. If a Family HCB or Group HCB is accompanied by an interdisciplinary team (e.g., anthropologists, social science professionals) that performs on-site monitoring and supports development of intentional interactions, it is referred to as a qualified or integral HCB.

employers' financial contributions from 2 to 3 percent of payroll, with the extra 1 percent earmarked for childcare services (Bernal 2012).[9] The ICBF now receives most of its funding from taxes, notably the income tax for equality, which is a national levy on employer profits. Its budget had grown to about 0.63 percent of gross domestic product (GDP) in 2019 (Cárdenas and Cadena 2020).[10] It is estimated that families using HCB services pay a monthly fee of about USD 6.30, or typically 22 percent of average household per capita income, although there is a cap on parent fees (Diaz and Chamussy 2016). Communities also contribute to HCBs through volunteer labor, infrastructure, and nonmonetary contributions (Castillo Cardona, Ortiz Pinilla, and González Rossetti 1993).[11]

Quality observations

Nutrition guidelines: The program has established a set of nutritional standards according to the characteristics of the population under care, the types of services offered, and international nutritional intake parameters. The program is designed to supply children with 70 percent of daily energy and nutrient requirements, ensuring that they receive the necessary calories, protein, fat, carbohydrates, vitamins, and minerals to promote proper body functioning and healthy growth (Feed 2016).

Curriculum: HCBs' activities revolve around free play and personal care, with little time spent on more-structured learning such storytelling, reading, number games, and letter and color identification (Bernal 2012). The curriculum is in line with the 2017 Ministry of National Education's Curricular Bases for Early and Preschool Education, which integrates developmental areas into a holistic framework including communication, body awareness, social-emotional confidence, executive functioning, and creativity. It deviates from a more-academic "school readiness" approach by focusing less on literacy and numeracy skills. In selected cases the ICBF applies a local modality in which curricular guidelines are adapted to the local sociocultural context (UNICEF 2020).

Workforce qualifications: Community parents must meet various requirements to open a home-based HCB. They must have resided in their community of operation for at least 1 year, have completed secondary school, be aged 20 to 45, and have adequate medical certifications, and each member of their household must have a clean judicial record. They must also meet qualitative requirements such as being recognized by the community for their solidarity and civic values and pledging their commitment and time to provide care in a written letter (ICBF n.d.a).

Workforce training: In the early stages of program implementation, community parents had, on average, low education levels and inadequate training in childcare (Bernal 2012). A 2009 evaluation found that more than three-quarters of community parents had only completed secondary education, and all respondents scored less than 60 percent on the Knowledge of Infant Development Inventory, a 58-item test of knowledge of childcare and parenting practices, health and safety, and child development processes. These findings motivated the ICBF, in partnership with the National Learning Agency, to develop a professional-technical degree in ECD and care for community parents (Bernal 2012), which costs approximately USD 650 per person and offers a professional-technical degree upon completion of three academic semesters during which community parents learn about and practice ECD science, cognitive and socioemotional growth, health and nutrition, and response to sudden illness and accidents. Participation is free for caregivers because the National Learning Agency pays for it, but caregivers must incur all costs related to transportation, materials, and uniforms, estimated at USD 223 per academic semester

9 The results achieved helped the ICBF gain political support and economic stability, also through support of international development organizations. In addition to its central operations, it has regional offices in Colombia's 33 departmental and provincial capitals, supporting a unique national to local structure within the government.

10 Colombia also makes subsidies available for center-based childcare providers, such as those provided through aeioTU, a social enterprise that constructs and operates early childhood development centers for children aged 0 to 5.

11 There are limited records of such contributions, and it is difficult to weight them alongside other sources. A United Nations Children's Fund study from the early 1990s estimated them at about USD 14 per child per month.

(Bernal 2012). Results of this training were promising, with the ICBF recording improvements in implementation of learning activities, use of pedagogical resources, and caregiver-parent interactions. These changes also improved children's health and learning outcomes, especially those younger than 3 (Bernal 2012). All community parents must participate in basic pre-service training and qualification that the ICBF provides in partnership with local universities and other entities (e.g., foundations) specializing in ECD (ICBF n.d.b).

Workforce remuneration and benefits: During the first few decades of the HCB, community parents (mostly women) did not have employment contracts, earned salaries well below minimum wage, and had no social security, but since 2014, they have been considered formal workers, earning minimum wage and qualifying for social benefits. It is estimated that community parents earn approximately USD 342 per month, which is about 28 percent of the average monthly wage in Colombia's public sector (Diaz and Chamussy 2016). The annual cost of this change in contractual arrangement (for more than 50,000 community parents) was close to 0.05 percent of GDP per year (Cárdenas and Cadena 2020).

Parent engagement: Community parents organize bimonthly meetings with parents during which they cover topics such as nutrition, health, parenting, and domestic violence. Community parents select topics based on needs detected in interactions between children, parents, and the community and suggestions stemming from ICBF guidelines (Bernal 2012).

Quality assurance: The *Comisión Intersectorial de la Primera Infancia* developed quality standards for early learning in Colombia and established them as part of the *De Cero a Siempre* policy. This commission assembles representatives of the ICBF, Ministry of Health and Social Protection, Ministry of Education, Ministry of Culture, National Department of Planning, and Department of Social Prosperity, and reports to the First Lady. The six main components of care targeted by the quality standards are family, community, and networks; health and nutrition; pedagogical process; human talent; educational and protective environment; and administrative and management processes (ICBF n.d.b).

Outcomes

Enrollment: By 2018, the IBCF was serving about 1.9 million children in Colombia. It is estimated that, of the more than 53,000 community parents, approximately 43,000 provide home-based childcare, and 10,000 provide center-based childcare (Cárdenas and Cadena 2020).

Child development outcomes: Over the decades, many studies have assessed the impacts of the HCB program on children's development outcomes.

- On health and nutrition, findings include a decrease in the prevalence of diarrhea and acute respiratory infections and a 0.45–standard deviation (SD) increase in height, although some studies found a limited impact on weight (Attanasio and Vera-Hernandez 2004; Leroy, Gadsden, and Guijarro 2011).
- On cognitive development, findings include a 0.15-SD increase in scores on a parental assessment of cognitive development after at least 15 months of exposure for children aged 3 to 4 and a 0.30-SD increase for children aged 4 to 5, a 0.14-SD increase in verbal reasoning from the Woodcock-Munoz Language Survey for children aged 3 to 4 and a 0.20-SD increase for children aged 4 to 5, and a 0.24-SD increase in mathematics scores (Bernal and Fernandez 2013). It was estimated that fifth-grade students who had attended HCBs had 14.5–percentage point higher total test scores (Bernal et al. 2009).

- On socioemotional skills, findings are more varied. Play interaction skills improved by 0.12 to 0.3 SDs after 15 months of exposure, but this extended exposure time also seemed to worsen aggressive behaviors, with a negative effect of 0.17 SDs on disruptive play (Bernal and Fernandez 2013). These findings align with the broader literature on socioemotional skills. Childcare settings can offer opportunities to develop social skills but can also engender aggressive behavior when children compete for resources and attention (Bernal and Fernandez 2013).

Women's economic empowerment: In terms of female empowerment and labor force participation, a study in 2004 found that sending children to HBC increased the probability of mothers' employment by about 25 percentage points and increased their number of hours worked (Attanasio and Vera-Hernández 2004; Leroy, Gadsden, and Guijarro 2011). The workplace benefits seem to be higher for women from disadvantaged families.

Key takeaways

Strengths

- **Positive cost-benefit analysis:** Overall, the HCB is popular as an easy-to-implement, low-cost intervention, with limited initial investment in infrastructure and an estimated cost-benefit ratio of 1.4 or 2.7, depending on discount rates related to parents' wages (Bernal and Fernandez 2013).
- **Equitable approach:** The HCB program targets vulnerable populations and has deliberate strategies for rural areas. It also limits the financial burden on parents by capping fees at 25 percent of their income.
- **Institutional support and investment:** Since its creation, the ICBF and its services have had support from all levels of administration, which results in strong financing mechanisms that ensure sustained investment.
- **Intersectoral integration:** Thanks to the intersectoral coordination that the *De Cero a Siempre* policy and its Intersectoral Commission have enabled, the ICBF was able to adopt a comprehensive approach to program structure and implementation. With HCB, this is highlighted in the systematic inclusion of nutrition standards and use of interdisciplinary professional teams to support community parents.
- **Parental choice and influence promoted by decentralized structure and community empowerment:** Communities are empowered to help community parents deliver contextualized services. The ICBF has regional and local offices across the country, which provides autonomy to communities to adapt services and standards.
- **Broad package of support, including training, rather than just financial contributions:** The basic preservice training provided to all HCB providers helps ensure a minimum level of quality and removes a common barrier around a lack of training services that nonstate sector providers face in other countries when establishing services. Since 2014, community parents have been considered formal workers, earning minimum wage and qualifying for social benefits.
- **Coexistence of several modalities:** As the variety of services associated with the HCB program and the other childcare intervention models the ICBF supports indicate, Colombia is strong in promoting services tailored to the needs of its population. This variation and experimentation are useful for recommending and implementing adequate solutions in different contexts.

Challenges

- **Heterogeneity in implementation:** Along with being a strength, heterogeneity in local support and quality can also be a challenge. First, because the ICBF gives agency to department governors and mayors, lack of buy-in can greatly limit implementation of childcare services. Second, planning, budgeting, and implementation responsibilities require considerable decentralized capacity building, which can be challenging given the diversity of the country.
- **Data systems and quality monitoring:** There is variation between sectors and geographical areas in how data are collected and linked to practice and implementation. Furthermore, quality assurance is organized at the municipal level, which makes consistent monitoring difficult. Recent efforts have been made to strengthen links between national standards and quality of local implementation.

CASE STUDY 2

KIDOGO, KENYA

Country context

Preschool for children aged 4 to 5 is part of the national free and universal basic education system in Kenya (Republic of Kenya 2018b). Preschool enrollment has increased in the past decade, reaching a net enrollment rate of 77 percent in 2018 (Republic of Kenya 2018a), but access is not equitably distributed across regions and remains low in Kenya's arid and semi-arid areas, with net enrollment rates as low as 18 percent in rural Mandera County (Republic of Kenya 2018a). There are national standards for governance, financing, access, quality, and equity of the pre-primary system, but public provision of preschool is decentralized, and county governments are responsible for formulating and implementing local policies to expand services and manage workforce supply (Republic of Kenya 2018b).

Provision and regulation of childcare services are less prevalent, with no national legal or institutional framework targeting early learning and care for children younger than pre-primary school age.[12] There is no public childcare for children younger than 3. Their mothers and family members (e.g., older siblings pulled out of school), or domestic workers in high-income families, care for most Kenyan children. More-formal childcare services, typically located in urban areas, charge tuition, which is expensive for low-income families (Habib 2019).

There are lower-cost options, such as the nearly 3,000 daycares in the slum areas of Nairobi (where 60 percent of the Nairobi population lives), but these are often poor quality. Many centers are small, unsanitary, and overcrowded, with one woman caring for close to 25 children in a 10- by 10-foot space. Women running these childcare centers live in deep poverty and tend to enroll more children than they can care for to increase revenue. More than half of children in Nairobi's informal settlements suffer from stunted development due to chronic malnutrition, and most are not ready for primary school. As a result, mothers are often absent from work because they must care for sick children, keeping them from thriving economically (Habib 2019; Howard, Wilson, and Aliouche 2020).

Overview

Kidogo is a nonprofit social enterprise established in 2014[13] [14] designed to increase access to affordable, quality childcare in low-income areas by training and supporting female entrepreneurship in this sector. The specific target is to deliver quality childcare at a low price (USD 0.50–1.00 per day, or less than 20 percent of local household income), using a sustainable, expandable model. Kidogo's model focuses on specific benefits: providing children with holistic, quality ECD services during their first 5 years of life, providing affordable

12 There are decentralized policies such as the Nairobi City County Child Care Facilities Act 2017, but they are limited in scope and adoption.

13 Kidogo was first established as a for-profit business because registering nonprofit organizations typically takes 2 years in Kenya. Soon after, the company was set up as a 501(c)(3) in the United States—a nonprofit organization recognized as being tax exempt by virtue of its charitable programs.

14 Information without references was obtained from interviews with Kidogo co-founder and Chief Exploration Officer Sabrina Habib and Grant and Development Manager Alex Dye.

childcare to working mothers in urban slums so that they can pursue more and better employment, and supporting female entrepreneurs to run thriving childcare micro-businesses (Kidogo n.d.).

Kidogo follows a "hub and spoke" social franchise model to operate high-quality, affordable play-based ECD centers in Kenya's urban slums. Community hubs, or centers of excellence, are ECD centers Kidogo designed and established with children in mind, providing safe, stimulating environments. These hubs serve as best-practice models and training centers to support local women, called "mamapreneurs," to start or expand their own childcare centers (spokes) (Kidogo n.d.; 2020).[15]

Through its expansion, Kidogo has become an advocate for provision of quality childcare for low-income families. It is a founding member of the Kenya Early Childhood Development Network, established in 2015 to promote, support, and sustain an enabling ECD environment in Kenya (ECD Network for Kenya n.d.). Kidogo has participated in local policy dialogues, contributing to development of multiple legislative documents such as the Nairobi City County Child Care Facilities Act 2017 and the County Early Childhood Education Bill 2018 (Kidogo n.d.). Kidogo has also partnered with institutions such as the Aga Khan University Institute for Human Development and the African Population Health Research Centre to contribute to the evidence base on the impact of early childhood interventions. The World Bank featured Kidogo in its white paper on childcare (Devercelli and Beaton-Day 2020), and Kidogo sits on the International Finance Corporation's global advisory team for employer-supported childcare to advocate for the early years and contribute to the evidence base.[16]

Kidogo aims to convert 15 percent of the existing 3,000 childcare centers in the Nairobi area into franchisees, creating competitive pressure on surrounding providers to improve quality while maintaining similar fees. It is also considering testing the model in other East African countries (Kidogo 2020).

Program origins and implementation

Implementation of two pilot program centers started in 2015, followed by a phased expansion to 492 centers in 2021.

Kidogo's main model consists of recruiting existing childcare providers and increasing their capacity through training and mentorship. Kidogo recruits its mamapreneurs by mapping existing daycares and running workshops with support from communities. After opting into the program, mamapreneurs receive training on ECD and entrepreneurship basics in an initial 3-month quality-improvement program. During this time, Kidogo works with the childcare operators to help them achieve Kidogo quality standards. For those who do, Kidogo helps convert them to franchisees, enabling them to use Kidogo branding and receive access to the mamapreneur app, and provides additional support, including monthly learning materials. Mamapreneurs join a community of practice with other franchisees, facilitated through monthly meetings. Kidogo provides ongoing quality assurance, mentorship, and coaching to help mamapreneurs work through challenges and improve the quality of the services that they provide. Kidogo provides opportunities for long-time mamapreneurs to expand their operations by adding classes or becoming multi-unit franchisees, that is, owning multiple centers in the same area (Habib 2019; Howard, Wilson, and Aliouche 2020; Kidogo 2020).[17]

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15 The model design responds to three key findings of Kidogo's country-specific analytical work in preparation of the program: providers' lack of a vision of what quality childcare looks like, parents' and providers' lack of awareness of the importance of ECD, and limited trust in non-local interventions.

16 Kidogo has partnered with multiple nonstate stakeholders to expand its reach by including childcare services in broader programs. For instance, a partnership with CleanStart ensures that children imprisoned with their mothers have access to stimulating, quality childcare. Kidogo has initiated partnerships with local vocational training centers to provide childcare services to young mothers attending these centers.

17 In 2019, Kidogo experimented with a different path-to-ownership model that established new childcare centers and hired caregivers who would eventually take over ownership of the center. Although this model gave Kidogo more leeway to select and renovate facilities and identify young professionals to then set up and operate a childcare center in them, it was 3 to 4 times as expensive, and it took some time for new centers to earn community trust. The Kidogo team addressed these challenges but ultimately decided that the path-to-ownership route was not the most sustainable or efficient expansion method (Kidogo 2020).

Mamapreneurs operate several types of childcare centers:

- **Home based:** Mamapreneurs run daycares out of their own homes, which are generally corrugated metal shacks furnished only with a bed, where they care for eight to 10 children. Their revenues are lower because they care for fewer children, but their costs are also lower because they do not have to pay extra rent.
- **Center based:** Mamapreneurs run their businesses from a rented space. In most cases, this is still a 10- by 10-foot corrugated metal shack, but lack of personal belongings leaves space for 12 to 18 children.
- **School based:** Mamapreneurs run their daycare as part of a larger primary school and can accommodate more than 30 children. In most cases, the mamapreneur handles administrative aspects and hires a caregiver to look after the children (Kidogo 2020).

Funding

Ninety-two percent of social enterprises' resources are donor provided through sustained philanthropy. Costs of the social enterprise include salaries, identifying and recruiting mamapreneurs (USD 3.50 per mamapreneur), training mamapreneurs (about USD 50 per mamapreneur per month for 3 months), upgrading and branding franchisee (about USD 350 per center), continuous quality assurance, food (i.e., egg) supplementation, organizing communities of practice, and ongoing support (includes mentorship, coaching, support to field implementation, and monitoring, at about USD 22 per center per month). The remaining 8 percent comes from revenues from franchisees,[18] which cover most costs associated with Kidogo's franchising officers, who provide ongoing training and mentorship (Kidogo 2020).

Kidogo intends for each center to be financially sustainable (including mamapreneurs' earnings) through parent fees, which are approximately USD 19 per child per month, which is affordable for most families and allows centers to generate a small profit. It is estimated that mamapreneurs earn about USD 172 to USD 188 per month. Table 3 shows a high-level breakdown of center operating costs and revenues. In the case of the two centers of excellence (best practice centers representing the organization's ideal quality standards), parent fees are the same but are complemented with grant funding to ensure lower child: adult ratios (Kidogo 2020).

TABLE 3. BREAKDOWN OF COSTS AND REVENUES FOR MAMAPRENEURS

COSTS	
SET-UP COSTS (E.G., INFRASTRUCTURE, RENOVATIONS, BRANDING)	~USD 350 (provided by Kidogo)
ONGOING OPERATING COSTS[a]	~USD 3-4 per child per month
FEES TO PARTICIPATE IN KIDOGO PROGRAM	~USD 3 one-time application fee ~USD 10 per month for 3 months for quality-improvement program ~USD 10 per month franchise fee
REVENUES	
MONTHLY REVENUE PER CHILD (PARENT FEES)	~USD 18.5
NET MONTHLY REVENUES OF MAMAPRENEURS (PROFITS)	~USD 180

a. For an average of 15 children per center.

18 These revenues include a one-time program application fee (~USD 2), a monthly quality improvement program fee (~USD 5 for 3 months), and monthly franchisee fees (~USD 10).

Quality observations

Because there are no government regulations for childcare serving children younger than 3, Kidogo developed its own set of quality standards, called "The Kidogo Way." This holistic approach to ECD aligns with the national competency-based curriculum and with international agencies' recommendations (including the World Health Organization, United Nations Children's Fund, World Bank). The Kidogo Way outlines six building blocks to promote center success: a safe, stimulating environment; responsive, nurturing caregivers; play-based activities; comprehensive health, nutrition, water, sanitation, and hygiene programs; a parental outreach strategy to ensure continuity of learning and development at home; and sound business and administration practices (Howard, Wilson, and Aliouche 2020, Kidogo n.d.).

All mamapreneurs are trained according to The Kidogo Way and must meet the standards for each of its elements before becoming a Kidogo franchisee. Initially, the training program took 18 months to complete, but it was condensed to 9 months in 2018 and 6 months in 2019 and is now a 3-month program that includes 3 full days of up-front training followed by weekly in-service mentorship. Kidogo has recorded a 100 percent completion rate of its mamapreneur training, with 80 percent achieving its quality standards and converting to franchisees (Kidogo n.d.).

During the training program, the Kidogo community of practice helps mamapreneurs through monthly peer-to-peer mentorship. Each cohort of eight to 12 mamapreneurs elects a leader and a secretary to guide rotational meetings at each of their centers. A Kidogo staff member accompanies the group as an observer and coach. At meetings, mamapreneurs discuss common challenges, how to improve centers, and communal welfare. They also typically make teaching and learning materials for the host. According to a Kidogo report (n.d.), these communities of practice help foster mamapreneurs' sense of ownership and self-reliance and recruit or refer new childcare operators to join the program. It also reduces competitiveness between mamapreneurs by encouraging positive peer pressure and collegiality.

Centers of excellence and franchisees welcome children aged 6 months to 5 years and are open on weekdays from 6 am to 6 pm to accommodate mothers' work schedules. Daily schedules follow a play-based curriculum that engages children using age-appropriate, culturally relevant, affordable learning materials. Upon completing the initial quality-improvement program, mamapreneurs are given a starter kit that includes a manual for good-quality operations and access to the mamapreneur app, a phone-based application that helps them track attendance and payments (Kidogo 2021). One of the most important factors in ensuring quality, according to Kidogo's founders, is a center's child: caregiver ratio. In 2019, Kidogo's ratio was 12 to 15 children to one caregiver in all franchisees (and 8 to 1 in centers of excellences), less than half seen in typical daycare centers (25:1).

Kidogo-trained franchising officers who live in the community visit mamapreneurs to provide on-site assistance, mentorship, coaching, and continuous quality assurance. They help mamapreneurs work through challenges and conduct a quality check each school term. Kidogo's monitoring and evaluation team conducts periodic quality assessments and customer satisfaction surveys at the end of each term. From this data, they hold a net promoter score of 68, which is extremely good based on industry standards (Kidogo n.d.). They also collect qualitative feedback from parents and mamapreneurs.

Outcomes

As of 2021, Kidogo's 75 staff members were supporting 492 mamapreneurs in 19 informal settlements in six counties (Kajiado, Kiambu, Kisumu, Machakos, Mombasa, Nairobi, Nakuru). Of these 492 mamapreneurs, about 46 percent are school based, 33 percent are home based, 17 percent are center based, and 4 percent are church based. Kidogo has become the largest childcare provider in Kenya, reaching more 9,511 children younger than 5 (Kidogo 2021).

Evaluations showed that Kidogo kids outperformed a control group in all areas of development; most notably, they scored 7 to 10 percent higher on executive function and 41 to 48 percent higher on emotional regulation (Kidogo 2021). The program reduced child wasting and stunting rates by 29 percent. Kidogo graduates are all performing in the top 5 percent of their primary school classes (Kidogo 2021).

Several rounds of qualitative research conducted in 2014, 2015, and 2019 with more than 2,000 parents showed that the program is also associated with changes in the childcare ecosystem. These studies showed that exposure to Kidogo's childcare shifted parent demand for ECD. In earlier rounds, parents listed affordability, distance from home, and safety as the key factors they considered when enrolling a child in a daycare, but in 2019, parents at Kidogo listed physical environment (cleanliness, safety and security, child play space), caregiving skills, diet and nutrition, and play-based activities as the top factors. The 2019 review also suggests that parent engagement increased significantly, with more parents wanting to be more involved in their children's school activities and have a say in operation of school programs. Mamapreneurs report increases in knowledge of ECD and caregiving, financial literacy and autonomy, relationships with parents, scale of services, and self-confidence (Kidogo n.d.; 2021).

Key takeaways

Strengths

- **Financial sustainability of centers:** Centers are financially independent from Kidogo, their "parent" social enterprise, which favors expandability and sustainability of the model.
- **Change in local norms, demand for childcare, and quality standards:** The program changed local perceptions of benefits of childcare services for mothers, children, and childcare providers. Strong advocacy to support a more favorable institutional environment for the sector accompanied program implementation.
- **Holistic approach:** The Kidogo Way takes an integrative approach to child development by not only providing early learning opportunities, but also promoting child health, nourishment, and safety to give children a fair start to life.

Challenges

- **Costs of service provision to families:** The quality standards that Kidogo sets and the guidelines on maximum student: teacher ratio require that mamapreneurs set fees that are affordable for the working poor, but for families with limited to no income, these remain out of reach. Financial support from the government targeting the lowest-income families would increase coverage among the most vulnerable without compromising quality.
- **Lack of registration system for childcare centers:** There is no national or county-specific system to register childcare centers. The alternative for mamapreneurs is to register these centers as microbusinesses, but the licensing process is costly compared with volume of revenue. Many thus operate without such licenses.
- **Urban model:** Kidogo was designed for urban, densely populated settings where it is difficult for women to bring their young children to their workplace or find family members to look after them, but only a fraction of Kenya's counties is urban. Applying this model to rural settings may require adjustments to address challenges such as lower density and lack of infrastructure.

CASE STUDY 3

SELF-EMPLOYED WOMEN'S ASSOCIATION, INDIA

Country context

In 2019, India's National Education Policy mandated free compulsory education for all children aged 3 to 16. Although most of the education system falls under the purview of the Ministry of Education, early childhood care and education comes under the Ministry of Women and Child Development (Ministry of Human Resource Development 2019).

Integrated Child Development Services (ICDS) is the main government institution managing public provision of early childhood education (ECE). Since its launch in 1975, the ICDS has grown to become one of the world's largest integrated family and community welfare schemes. As of 2015, the ICDS was operating more than 1.3 million public anganwadi centers, mainly in rural areas, and reaching more than 85 million pregnant women, lactating mothers, and children younger than 6. Anganwadi centers provide a package of six services: supplementary nutrition, non-formal preschool education, immunization, health examinations, nutrition and health education, and referral services. Preschool education at anganwadi centers targets children aged 3 to 6 (Ministry of Women and Child Development n.d.; 2013).[19]

There is no legal framework regulating the childcare sector for children younger than 3, but the National Crèche Scheme (NCS)[20] is an important national program for young children. Launched in 2006, it is designed to empower women, especially from low-income backgrounds, by providing childcare services. Since 2017, the salient features of the NCS have resembled those of the ICDS in that it provides day care facilities for children aged 6 months to 6 years, supplementary nutrition, growth monitoring, health examinations, and immunization.[21] Crèches are set up in partnership with an NGO, with the government contributing 90 percent of the operating costs and the NGO contributing the remaining 10 percent. As of 2020, there were 6,453 functional NCS crèches across the country, a drastic decrease from almost 20,000 in 2013/14, partly because of the shift in responsibility for implementation and one-third of NCS's funding from the central government to state governments, starting in 2017 (Ministry of Women and Child Development 2020).

The next few sections describe childcare and early education services that local cooperatives in the state of Gujarat offer. These programs include childcare centers for infants and children younger than 6 and complement NCS local childcare services.

19 Despite three of four National Education Policy modalities targeting strengthening of ICDS, data indicate increasing enrollment rates across private providers. There are disparities in enrollment trends and learning outcomes according to state, family income, and gender. Children enrolled in free anganwadis tend to have poorer performance than counterparts in private preschools.

20 Previously known as Rajiv Gandhi National Crèche Scheme.

21 NCS crèches charge small monthly fees per child based on family income, ranging from 20 to 200 rupees (about USD 0.30 to 2.80).

Program origins and implementation

The Self-Employed Women's Association (SEWA)[22] represents close to 2 million female workers in the informal economy across 13 states. In response to union members' demands and recognition that working women needed a safe place to leave their children, SEWA started establishing childcare centers in the 1980s, which resulted in two new branches of the association: the Sangini Child Care Workers' Cooperative and the Shaishav Mandali (Alfers 2016; Bernard van Leer Foundation 2011; ILO 2018; ILO and WIEGO n.d.; Moussié 2016).

In the early 1980s, a few SEWA members volunteered to look after other members' children in their homes for a small fee. By 1984, these services had grown, and SEWA was running 20 childcare centers (Moussié 2016). In 1986, the program was formalized as Shri Sangini Mahila Balsewa Sahkari Mandli Ltd. (Sangini Child Care Workers' Cooperative, henceforth referred to as the Sangini Cooperative) in Ahmedabad.[23] SEWA subsequently expanded childcare services to more rural districts of Gujarat,[24] registering a second childcare cooperative in 1995 under the name of Shri Shaishav Balsewa Mahila Sahakari Mandali Ltd., or Shaishav Mandali (Chigateri 2013; ILO 2018; Shri Shaishav Mahila Bal Sewa Co-operative Ltd. n.d.).[25]

In both childcare cooperatives, members elect governing boards every 3 to 5 years. Members highlight this democratic process as a key factor in preserving high quality standards and trust in the system. The boards meet monthly to plan and manage activities, address problems that arise during parent-teacher meetings, estimate and set fees, and ensure adherence to financial regulations (ILO and WIEGO n.d.).

SEWA also plays an important advocacy role. It is a founding member of the Forum for Crèches and Child Care, a national civil society network that unites more than 500 children's, women's, and workers' rights organizations and whose purpose is to monitor and hold the Indian government accountable for providing quality childcare. This platform promotes the cooperative-run childcare model and calls for broader state support of childcare provision and improvements to the ICDS model. SEWA and the Forum for Crèches and Child Care have also joined a global campaign supported by Women in Informal Employment: Globalizing and Organizing on quality public childcare for all workers with the aim of supporting alliances and raising visibility of female workers' childcare needs (ILO and WIEGO 2018).

Funding

The average cost of establishing a childcare center is Indian rupees (INR) 25,000 (about USD 400), which includes initial community consultations and purchase of necessary resources such as educational materials, toys, and cradles. Each center's running cost is INR 20,000 to 25,000 (USD 275-400) per month. This includes the salary of two caregivers (or balsevikas), rent, supplies such as food and medicine, and supervision and administration costs (ILO and WIEGO n.d.; 2018). The average expense per child, per month is INR 800 (about USD 11) (ILO 2018).

22 SEWA was established in 1972 in response to a call from female workers in the city of Ahmedabad to organize themselves to ensure work and social security for its members. SEWA includes four main occupational groups: manual labor (including agricultural labor), construction workers, and cleaners; street vendors selling fruit, vegetables, and kitchenware; home-based workers such as embroidery workers and agarbatti (incense stick) makers; and small-scale producers such as craft workers, salt makers, and gum collectors (Bernard van Leer Foundation 2011).

23 Members applied to the Registrar of Cooperatives to establish a new childcare cooperative in 1984. It took nearly 2 years of bureaucratic negotiations to achieve approval because there were questions regarding the "product" that the cooperative was offering, the qualifications of the centers' caregivers, and the cooperative's financial viability (Chigateri 2013).

24 Most women in these areas worked in tobacco fields and factories.

25 Soon after launch, the Sangini Cooperative began partnering with the ICDS, which covered childcare centers operated by third parties who adhered to ICDS guidelines. Even though caregivers hired at SEWA-run centers had not passed school-leaving exams and thus did not qualify to run ICDS centers, the quality of their services was sufficient to sustain this partnership. Cooperative members who wanted to become childcare teachers or helpers were given access to specialized training. The number of centers that SEWA cooperatives ran for the ICDS grew from about 45 in 1989 to 185 in 2006, serving approximately 5,000 children across five districts. The ICDS and SEWA models diverged on a number of aspects, including operating hours. Typical ICDS center opening hours (typically 9 am to 3 pm) were inadequate for women who worked long hours. In 1993, SEWA began offering full-day (8 am-6 pm) services, funding extra working hours with donations from cooperative members and other donors. Eventually, differences in models and standards ended this partnership, with SEWA scaling down to run 33 centers in Gurajat for children younger than 6 (Chigateri 2013, ILO 2018, Shri Shaishav Mahila Bal Sewa Co-operative Ltd. n.d.).

Parents are expected to pay a nominal monthly fee of about INR 175 (USD 2.50) in urban areas and INR 65 (USD 1) in rural areas. SEWA's childcare cooperatives rely on several sources of funds, including contributions from the SEWA cooperative, direct member contributions, donations, and public subsidies provided under the NCS (ILO and WIEGO n.d.; Moussié 2016).

Quality observations

The Sangini and Shaishav cooperatives provide an integrated approach to childcare by catering to children's educational, nutritional, and health needs. Each center operates full days (9 am or 10 am to 5 pm) to accommodate mothers' working hours and welcome a maximum of 30 children younger than 6. Children's healthy growth is promoted through balanced, nutritious diets and doctor visits for regular examinations. Children with special needs are given extra care and, if needed, referred to other relevant services. How women interact with the centers varies according to their location and profession. For instance, street vendors usually leave children for a full day, whereas agricultural workers who may work near the center can visit during the day to breastfeed. In either case, caregivers hold monthly meetings with parents to discuss children's progress and provide information on childrearing. Although the caregiver role is typically assigned to mothers in these communities, the Sangini Cooperative encourages fathers' involvement by holding quarterly meetings with them (ILO 2018; Moussié 2016).[26]

Childcare cooperative workers (balsevikas) are SEWA members chosen from the community. They are recruited primarily based on their perceived positive attitude toward young children and their ability to multi-task; no specific education certification is required (although each center has at least one educated staff member). Balsevikas undergo brief training at the SEWA Academy, the association's training and capacity-building institution, before taking up their responsibilities. There is subsequent in-service training and skills upgrading every 3 months. Although balsevikas do not earn more than minimum wage, they report high job satisfaction as respected leaders in the community given their knowledge about children's health, nutrition, social development, and early education. They also benefit from other SEWA-run cooperatives, such as a bank, a health insurance scheme, and community healthcare worker service. Most childcare workers have maintained their jobs for more than 15 years (ILO 2018; ILO and WIEGO n.d.; 2018; Moussié 2016).

Quality assurance of childcare centers operates at several levels. The balsevikas are responsible for various center tasks and enjoy a fair degree of autonomy. Cooperative trainers and supervisors are not separate cadres, and monitoring visits focus on assisting workers by providing practical training. Partnerships with the NCS provide an additional quality assurance layer, and every crèche must be inspected at least once every 2 years (ILO and WIEGO 2018; Moussié 2016).[27]

Outcomes

SEWA members report significant benefits of childcare services in terms of work patterns, peace of mind, and awareness about child development. Sixty-four percent of SEWA mothers accessing SEWA childcare services report more working days, compared with 13 percent (Moussié 2016) of mothers who sent their children to ICDS centers with limited operating hours. A recent study found that women with access to full-time childcare services increased earnings by 104 percent, from an average of INR 1,300 to more than INR 2,700 (USD 18-37) per month (ILO 2018).

26 In addition to services for children, Sangini cooperative childcare centers have a close relationship with SEWA's health cooperative and with local health care workers and urban health care centers in their areas. As such, they are a public service access point for SEWA members for vaccinations, primary health care, and advice on various health-related concerns. They help organize community health camps, counseling sessions, exhibitions, and awareness-raising sessions on a wide range of topics, including maternal health, nutrition, noncommunicable diseases, eating habits, and government programs that women could access.

27 These inspections may be conducted at various levels, including community, district, and central, as well as by independent monitoring agencies and through mobile or web-based monitoring.

A 2015 Women in Informal Employment: Globalizing and Organizing–SEWA study found that women with children enrolled in the cooperative's centers felt more confident about the safety and well-being of their children and were better able to focus on work. They also trusted the centers to impart good values, behavior, and basic education to their children, which they had neither the time nor energy to do themselves (ILO 2018). This is partly attributable to the fact that balsevikas are from the community they serve and thus have a deep understanding of the children's socioeconomic and cultural contexts. Finally, SEWA parents demonstrate greater awareness of and interest in childcare activities and in the health and development of their children than counterparts whose children attend government centers.

Benefits from childcare spread to the family and community at large. First, children attending cooperative centers perform better than peers once they begin primary school, outperforming children who attended ICDS centers and those who did not attend any preschool childcare (Sharma, Raman, and Dhawan 2013). Second, older siblings, particularly girls, are released from childcare responsibilities and can focus on their own education. In India, it is common for older daughters of informal sector workers to stay home to care for younger siblings instead of going to school (Sharma et al. 2013). Third, women's increased mobility and earnings correlated with greater harmony among family members. Finally, women feeling that the community is caring for their children builds trust, solidarity, and commitment among SEWA members (Sharma, Raman, and Dhawan 2013). The Sangini cooperatives, in particular, play a pivotal role in the social fabric of Ahmedabad's dense urban communities and opens avenues for engaging with local and national government (ILO and WIEGO 2018).

Key takeaways

Strengths

- **Partnerships with government for expansion and sustainability:** The cooperative centers greatly benefit from NCS subsidies, which increase their financial sustainability.
- **Parental engagement through the cooperative governance structure:** To establish cooperatives, parents must sign up as shareholders and hold cooperative governance positions. They are thus deeply involved in cooperative operations and hold staff members accountable to quality standards.

Challenges

- **Lack of space and infrastructure:** This constraint is severe in Ahmedabad's urban slums and greatly restricts center activities, such as outdoor games and cooking. In Shaishav Mandali's more rural areas, centers must accommodate as many as 50 children, although infrastructure is limited to a room in the panchayat (village council) building or local schools. Costs of building new infrastructure are high.
- **Financial sustainability of centers:** The cost of running SEWA childcare centers is considerably greater than parent contributions, yet low incomes prevent families from spending more on childcare. Financial sustainability is thus difficult to achieve.
- **Competition with other service providers for qualified staff:** Although balsevikas are proud of working with SEWA cooperatives, ICDS-hired caregivers and teachers receive higher pay and greater benefits. Hence, many trained teachers, especially in rural areas, prefer to work for ICDS centers.

CASE STUDY 4

ECONOMIC EMPOWER OF ADOLESCENT GIRLS AND YOUNG WOMEN PROJECT, LIBERIA

Country context

ECE for children aged 3 to 5 in Liberia is recognized as a category of school in the education system, but it is neither compulsory nor free. It falls under the purview of the Ministry of Education, and public and nonstate actors provide it. The four main types of preschool are Ministry of Education–operated government schools across districts and counties (about half of all ECE), secular entity–operated private schools, faith-based organization mission schools, and community-based schools (Oyatoye 2018).

In 2017, ECE had a gross enrollment rate of 125 percent and a net enrollment of 59 percent, suggesting that more than half of children enrolled in ECE are over-age (UIS n.d.). Parents have limited awareness of the need for early learning, and preschool tuition fees limit access for the poorest families. Limited numbers of teachers and training them are the main obstacles related to providing quality ECE services; approximately half of ECE teachers have not received ECE-specific training (Kosaraju and Nambwira 2015; Oyatoye 2018).

Early childhood care and education services for children aged 6 months to 3 years are not included in Liberia's legislation. There is no law or policy or any large-scale public program promoting access to subsidized childcare for working women. All childcare options for children aged 0 to 3 are thus privately provided.

The main goal of the Economic Empower of Adolescent Girls and Young Women (EPAG) pilot program, launched in Liberia in March 2010,[28] [29] is to provide young women and adolescent girls with a package of skills training and complementary services to facilitate transition to employment. The program, which the Ministry of Gender, Children, and Social Protection leads, targets young women aged 16 to 27 with basic literacy and numeracy skills who are not enrolled in school within several months before program initiation and reside in one of the target urban communities in and around Monrovia, Liberia's capital (Adoho et al 2014; Kosaraju and Nambwira 2015).[30]

Participants underwent 6 months of classroom-based training, followed by a 6-month practical placement to support them in their transition to employment. Upon recruitment, participants were assigned to one of two tracks. The Job Skills track provided training in hospitality, professional cleaning and waste management, office and computer skills, professional house and office painting, security guard services, and professional driving. Toward the end of the program, an ECD training track was piloted after a market assessment identified strong

28 Information without references was obtained from World Bank EPAG consultant Frances Beaton-Day.

29 The EPAG is part of a larger adolescent girls initiative that the World Bank administers with support from the Nike Foundation and the governments of Australia, Denmark, Norway, Sweden, and the United Kingdom. The Liberia pilot has served as a model for seven subsequent pilot projects in Afghanistan, Haiti, Jordan, Lao People's Democratic Republic, Nepal, Rwanda, and South Sudan (Adoho et al 2014).

30 Subsequent cohorts of EPAG training would gradually extend to more-rural areas.

demand.[31] All participants also received entrepreneurship and life skills training. Business Development Services training taught young women how to identify micro-enterprise opportunities based on assessment of market needs and how to manage and expand any existing businesses they had. This track's curriculum included entrepreneurship principles, market analysis, business management, customer service, money management, and record-keeping (Adoho et al 2014; Beaton-Day and Devercelli 2018; Kosaraju and Nambwira 2015).

Overview

Overall, the initiative integrated ECD elements into the program in three ways: childcare was provided for children of trainees, with a focus on quality to try to improve child development outcomes; ECD training was included to train women as caregivers, ECD teacher aides, and center operators and link them to meaningful employment opportunities to increase the quality of Liberia's ECD workforce; and good parenting practices were promoted through life skills training. The following sections provide an overview of EPAG childcare provided to participants to facilitate participation and the ECD training track to build the ECD workforce.

The Liberian Ministry of Gender, Children, and Social Protection selected four NGOs in a competitive bidding process to implement the program's training tracks. These service providers were responsible for developing training curricula, identifying training venues, helping mobilize the nine target communities, and participating in recruiting training participants (Adoho et al 2014).

The EPAG program ran from 2010 to 2017, and the ECD training track held two more rounds until 2019. It reached 4,880 adolescent girls and young women (World Bank 2021).

Program origin and implementation

Childcare to facilitate participation: Before the launch of the EPAG program, a situation assessment indicated that lack of childcare was preventing young women from participating in labor market and skills training projects. EPAG was therefore designed to include childcare services to support women's enrollment, retention, and completion of training. Although this component was originally intended to serve as childcare rather than pre-school or formal early childhood care and education, it evolved to support child development and learning more intentionally. In Round 1, nearly 70 percent of EPAG trainees had one or more children, and this percentage increased in subsequent rounds as EPAG expanded to more rural areas (Adoho et al 2014; Beaton-Day and Devercelli 2018).

In the early implementation stages, service providers could choose from among four types of childcare: direct delivery by service providers, community-based informal arrangements, a voucher system for private services, and market-based centers (when training was conducted in such settings). Round 1 showed that uptake of childcare services was higher when service providers opted for direct delivery, so subsequent rounds adopted this option. By EPAG Round 3, all 12 training sites provided childcare services for up to two children younger than 5 per trainee (Beaton-Day and Devercelli 2018; Kosaraju and Nambwira 2015).

Integrating an ECD training track: In a dual strategy of providing employment opportunities to girls and improving the quality of childcare services at on-site centers, in 2016, the EPAG program introduced ECD practitioner training as a Job Skills training track.[32] The Children Assistant Program, a competitively selected NGO, administered, designed, and monitored this track in collaboration with the

31 Trainees were not entirely content with the vocations in which the EPAG program was training them and expressed a desire to use these new jobs as steppingstones to other professions, even if they needed to invest in more formal education. Professions cited included medicine, business, nursing, and politics.

32 A market assessment indicated demand for qualified ECD practitioners and confirmed that an ECD training track would offer meaningful employment opportunities.

Ministry of Education. The track consisted of classroom-based training for 3 months followed by a 3-month internship. Some ECD training graduates found work with the on-site centers.

Although a business plan competition for opening an ECD center was conducted in the first three rounds, there was limited support to help graduates with follow through. In a study conducted in 2018, 92 percent of graduates expressed interest in opening their own centers, but 65 percent were not sure how to proceed. Hence, in addition to classroom-based and practical training, an ECD entrepreneurship program will be piloted in the fourth round whereby 10 winners of the business plan competition will receive funding and support to open their own ECD centers to serve vulnerable children across Liberia. This package will include training, coaching, mentorship, and an initial grant of about USD 4,000 to support the first year of set-up and ongoing costs.[33]

Funding

Childcare to facilitate participation: The total cost of childcare services during a 4-month training period was approximately USD 17,500 across all training providers. The per-child cost was USD 17.50 for a training period, or USD 4.38 per month. These costs included the caregiver's stipend of a minimum of USD 75 per month for part-time work; rent for the childcare venue; and supplies such as snacks, mattresses, blankets, towels, toys, and first aid kits. These costs were budgeted directly into contracts with third-party training providers, who were responsible for managing center-level expenditures (Haddock, Raza, and Palmisano 2019). The cost per trainee of the ECD training track was USD 1,700, including all services to support participation (e.g., childcare, stipends), which is comparable with those of other vocational training tracks.

Quality Observations

Childcare to facilitate participation: During the preparation stage, the project team consulted with child development NGOs and project beneficiaries (young women) to develop childcare guidelines to define the package of care services and establish basic quality standards.[34] Childcare centers were established on NGOs' premises in rooms near training classrooms to accommodate lactating mothers yet separate from training activities. According to the EPAG childcare guidelines, childcare centers were to have, at a minimum:

- First aid kit, with pain killers, antiseptic and bandages, sponges
- Sanitation facilities, allowing for infant bathing and diaper changing
- Feeding support, child caregivers assist children in eating food that mothers supplied
- Protective confinement, to ensure that children (especially toddlers) are within a secured space
- Basic classroom equipment, including clean mattresses, blankets, towels, a few toys, and minimum snacks (Kosaraju and Nambwira 2015)

In 2014, a World Bank study reported that service providers had a relatively uniform understanding of EPAG expectations for childcare service implementation, but onsite observations showed that several requirements in the EPAG childcare guidelines were not being implemented

33 In the long term, the team is exploring partnering with microfinance institutions to support program graduates with more-sustainable financing.

34 Guidelines were documented in the project operations manual and integrated into training provider contracts.

as intended. The average caregiver-child ratio of two to three staff members per 15 to 25 children per center was low, and most sites were equipped with water and sanitation facilities but with inconsistent water supply and limited options for bathing children. Some sites did not have first aid equipment. Some mothers failed to pack meals for their children or gave them unhealthy or stale snacks, and rooms were typically too small for productive play or comfortable seating, with most having no safe outdoor space. The study recommended improvements to EPAG's childcare services, creating a new set of guidelines accompanying the ongoing ECD training track that began in 2016 (Kosaraju and Nambwira 2015).

The initial EPAG childcare guidelines proposed good practices for caregiving. A clearly defined term of reference was developed for recruiting and hiring child caregivers. First, child caregivers were required to have a background or minimum training in first aid or nursing aid. Second, at least two child caregivers were to be assigned to each center. Third, all child caregivers would receive a minimum salary of USD 75 per month for part-time work. Finding candidates with the necessary profiles and qualifications was difficult in initial rounds, and the EPAG program did not offer any additional training, but graduates of the program were recruited in later rounds offering ECD training, which increased service quality (Kosaraju and Nambwira 2015).

Third-party training providers were responsible for ensuring childcare quality. Along with reporting on all project activities and outputs, the EPAG monitoring plan required NGOs to track childcare use. Quality monitors made routine, unannounced visits to verify reports and ensure NGO compliance with all obligations, including following the EPAG childcare guidelines. The Ministry of Gender, Children, and Social Protection also played an important role in quality assurance, employing a team of quality monitors to oversee service delivery at EPAG sites. Although their main responsibility was to monitor EPAG classroom training, they also inspected sanitation, attendance, number of caregivers at each center, and conditions in the children's rooms such as presence of mattresses and toys (Kosaraju and Nambwira 2015).

Integrating an ECD training track: In the first round of the pilot (2016/17), the ECD training track consisted of classroom-based training and an internship for teacher's aides and caregivers. During the first 3 months of the program, trainees followed program curricula with input from Ministry of Education master trainers. The teacher's aide curriculum focused on childcare center business management, and the caregiver track focused on child development and education, as well as safety, health, diet, first aid, and assisting with teacher activities. Both tracks provided basic training in business skills and preparation for self-employment or work-readiness and life skills, with training materials drawn from the broader EPAG program. Trainees ended the program with a 3-month internship. During the second round (2018), the ECD certificate was aligned with the Ministry of Education's national ECD training pathways so that trainees would graduate with the officially recognized ECD Skills-based Training and Education Program qualification. All trainees followed the teacher assistant specialization track because the exclusive caregiver track was more limiting (Beaton-Day and Devercelli 2018; Kosaraju and Nambwira 2015; World Bank 2018).

The internship component is essential in building trainees' skills and confidence and providing them with valuable opportunities to put theory into practice. Some placements can serve as a path to employment. Trainees are placed in local ECD institutions or preschools for 3 months, where they work for a monthly stipend as teacher's aides Monday through Thursday and attend refresher trainings on Fridays. Trainees' placement responsibilities include supporting head teachers in designing, planning, and conducting classroom activities; establishing learning centers in schools; helping monitor children; and providing individual support to children based on need. The ECD institution monitors trainees, and training NGO and EPAG teams visit placement centers weekly. This partnership also benefits ECD institutions, which upgrade conventional teaching by using play-based early childhood activities learned from trainees. In 2017/18, placed schoolteachers were also invited for multiple-day NGO trainings to improve their teaching practices and extend program benefits. An entrepreneurship component was planned to launch in 2022 as an additional professional development opportunity for graduates, who will receive financial and technical assistance to establish good-quality, financially sustainable centers. The new ECD centers will have an element of common branding, will

be held accountable to program quality standards, and will benefit from a strong community of practice and peer support (Beaton-Day and Devercelli 2018; Kosaraju and Nambwira 2015; World Bank 2018).[35]

Outcomes

At the end of 2014, a World Bank impact evaluation of pilot Rounds 1 and 2 found that 2,408 trainees (97 percent) completed classroom training, resulting in a 47 percent increase in employment among participants and an 80 percent increase in average weekly earnings. It found that economic benefits were sustained more than a year after pilot completion, placing EPAG among the most successful youth skills development projects evaluated to date. The EPAG program also empowered the young women by increasing their self-confidence and social skills and inspiring them to pursue more-ambitious careers (Beaton-Day and Devercelli 2018; World Bank 2018).

In Round 3, the program was found to achieve 100 percent completion rates. Although the employment rate was slightly lower in Round 3 (85 percent, versus 90 percent in previous rounds), it increased by 41 percentage points for program trainees, compared with 3 percentage points for women in a control group (World Bank 2021).

The ECD training track (introduced in Round 4 in 2016) led to a 90 percent employment rate, although in the pilot round, only 54 percent were in ECD-specific employment. The percentage in ECD employment increased significantly in 2018 and 2019. Program graduates also had higher income than at baseline, which—paired with the program's financial management component—increased savings and financial stability. Preliminary results of an ongoing randomized, controlled trial have indicated that, in all domains of the Teach ECE classroom observation tool, teachers who participated in the EPAG ECD training track had better performance than peers in the control group. Table A.1 provides an overview of the program's outcomes for the EPAG ECD training track over the three cohorts.

TABLE A.1. OVERVIEW OF ECONOMIC EMPOWERMENT FOR ADOLESCENT GIRLS' EARLY CHILDHOOD DEVELOPMENT TRAINING TRACK OUTCOMES (2016–2019)

INDICATOR	PILOT ROUND 1 (2016–17)	ROUND 2 (2017–18)	ROUND 3 (2018–19)[A]
NUMBER OF TRAINEES	60	60	90
COMPLETION RATE (%)	93	98	100
PERCENTAGE OF GRADUATES EMPLOYED	90 (vs. 31 at baseline)	90 (vs. 30 at baseline)	85 (vs. 44 at baseline)
PERCENTAGE OF EMPLOYED GRADUATES WORKING IN EARLY CHILDHOOD DEVELOPMENT	54	87	93
PERCENTAGE OF EMPLOYED GRADUATES WORKING IN FORMAL SECTOR	No data	89 (vs. 24 at baseline)	83 (vs. 22 at baseline)
PERCENTAGE INCREASE IN AVERAGE WEEKLY INCOME	No data	65	74
PERCENTAGE OF WOMEN WITH SAVINGS	Graduates reported increases in savings	92 (vs. 20 at baseline)	99 (vs. 39 at baseline)
PERCENTAGE INCREASE IN SAVINGS AMOUNT		140	400

Source: World Bank 2021.

a. Randomized controlled trial ongoing. Results are from midline data collection. Endline data collection (fourth quarter 2021) will include assessment of child outcomes and teaching quality.

35 Other similar initiatives such as Kidogo in Kenya and SmartStart in South Africa inspired Design of his phase of the program.

Evaluations also found increases in women's empowerment and agency. In the pilot ECD training round (2016), graduates reported greater self-esteem, emotional empowerment, self-discipline, and optimism about the future. In Rounds 2 and 3 (2018 and 2019), evaluations included additional questions about women's emotional health. Round 2 found considerable decreases in prevalence of depression, which access to meaningful economic opportunity and ability to provide for one's children, as well as the informal counselling trainees received, can explain. Participants also reported less finance-related anxiety and less reliance on others for money. In Round 3, although women were more confident in professional and financial aspects, emotional health seemed to have worsened for women in the control and treatment groups (World Bank 2021).[36]

Key takeaways

Strengths

- **Self-reinforcing interventions targeting demand for and supply of childcare services:** The design of the EPAG program increased demand for childcare through life-skills training through awareness raising; provided on-site childcare services with quality standards, shaping current and future expectations about minimum quality of services; and trained young women to increase the supply of qualified childcare workforce. In upcoming rounds, the EPAG program will further strengthen the local supply of childcare services by supporting female entrepreneurship. The integrated, holistic program design allows for operational synergies and cross-learning across different arms.
- **Early childcare needs assessment:** The vulnerability assessment conducted before EPAG program launch identified childcare services as a key incentive for training attendance and completion.
- **Efforts to measure benefits:** Regular gathering of quantitative and qualitative data is key for continuous learning and adjusting. The EPAG team and feedback from mothers were used to assess childcare services, while impact evaluations were used to assess ECD training.
- **Continuous service improvement:** Throughout the lifespan of the EPAG project, there were conscious efforts to use data and feedback to improve service quality.

Challenges

- **Difficulty recruiting qualified caregivers for childcare services in early rounds**: Training providers reported difficulty finding caregivers with necessary qualifications and experience. Limited abilities of caregivers limited the scope of services in initial rounds to that of "babysitting."
- **Missed opportunity to focus on child outcomes as part of the childcare service:** The initial purpose for providing childcare services was to support mothers and ensure their attendance. Improving ECD outcomes assessing children's growth and learning received limited attention.

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36 Round 4 is designed to evaluate the ECD entrepreneurship program, with a focus on center quality, child development outcomes (using Measuring Early Learning Quality and Outcomes (MELQO) tools and comparing with non-EPAG provision), financial sustainability of the center, women's income, qualitative assessments on level of support, and capacity of the central host organization.

- **Complexities in institutional arrangements and expanding the ECD training track:** The EPAG program had strong support from the Ministry of Education and Ministry of Gender, Children, and Social Protection, but given the program's dual purpose of serving ECD and women's empowerment, these interviews highlighted unclear institutional arrangements for a pathway for expansion.

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ABSTRACT

This study reviews options of childcare and early learning arrangements in developing countries, focusing on innovative options for public and nonstate provision that fit the needs and constraints of low-income families. It discusses both home-based care (provided in a home setting) and center-based care (nurseries, crèches, daycares or sometimes preschools) through various country examples and four in-depth case studies (from Colombia, Kenya, India, and Liberia). This comparative analysis shows that a wide range of provision models are leveraged to meet the demand for childcare in low- and middle-income countries and that intentional policy initiatives can promote positive social norms towards early childhood services and women's economic empowerment. Yet, benefits to children and families depend on the quality of services and the wider enabling environment thy operate in.

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