In Search of Sustainable Childcare Models in Sub-Saharan Africa: Lessons on Implementation and Support

Prepared for Catholic Relief Services

Shawnee Cummings
Master of Public Policy Candidate
Sanford School of Public Policy
Duke University

April 2025

Faculty Advisor: Shelley Liu, Ph.D.

Table of Contents

Table of Figures

Acronyms

APHRC: African Population Health Research Center

BAM: Brigadieres Assistantes Maternelles

CARE: Cooperative for Assistance and Relief Everywhere International

CBCC: Community-Based Childcare Center

CBO: Community-Based Organization

CFA: West African CFA Franc

COFE: Child-Optimized Financial Education

CREDI: Short Form Caregiver Reported Early Development Instrument

CRS: Catholic Relief Services

DRC: Democratic Republic of Congo

ECC: Early Childhood Care

ECD: Early Childhood Development

ELP: Early Learning Partnership

GDP: Gross Domestic Product

GIL: Gender Innovation Lab

GNI: Gross National Income

IPA: Innovations for Poverty Action

LMIC: Low- and Middle-Income Countries

MELQO: Short-Form Measuring Early Learning Quality and Outcomes

NGO: Non-Governmental Organization

REPAFE: Réseau Provincial des Associations des Femmes pour la Promotion de l'Education

RUTF: Ready-to-use Therapeutic Food

SILC: Savings and Internal Lending Communities

UNICEF: United Nations Children's Fund

USD: United States Dollar

VHW: Village Health Worker

WASH: Water, Sanitation, and Hygiene

WB: World Bank

WFP: World Food Programme

Introduction

Access to quality, affordable childcare services is a problem that plagues all societies, but especially in communities with low resources and/or the absence of a childcare market. Ensuring sustainability of services, usage, and quality is difficult to balance while also meeting the needs of the poorest populations in Sub-Saharan Africa. In examining some innovative approaches to childcare, one can learn the strengths and weaknesses of the different models while also documenting lessons on how to best support childcare providers in resource-constrained environments. Building the evidence base on childcare in Sub-Saharan Africa and finding viable policy solutions will help address the heavy care work burdens on women that limit their economic participation and productivity, enhance providers' abilities to offer quality, affordable care to families across Africa, and facilitate children's growth and development in early childhood development (ECD) and nutrition, while also providing safe environments for children to learn.

Through the exploration of four case studies, this brief will show that no childcare model is one-size-fits-all, but that certain models may be more versatile, cost effective, or may work well in specific environments. Each model has a constant tension between quality and profitability, and to promote both aspects, the recommendations include advocacy for an inclusive and flexible regulatory framework, advocacy for ministry ownership, leveraging existing resources through partnerships with local and provincial governments, continued investment in training, and collaboration with livelihoods programs to explore how the programs can complement one another, among others.

Policy Question

On behalf of Catholic Relief Services (CRS), this report addresses the following policy question: "How can CRS support women daycare providers in Sub-Saharan Africa to implement a sustainable business model in low resource environments?" The policy implications generated by this question are vital for how CRS conducts its operations in Africa and how CRS can make the most impact through its interventions, for women's economic participation, children's development, and childcare providers and entrepreneurs in sustaining their businesses.

By examining different daycare business models in low resource environments of Sub-Saharan Africa, the analysis identifies opportunities and gaps that CRS can use to better support women daycare providers and the children being cared for. Taking this approach into account, a more targeted policy question is, "How can CRS utilize lessons learned from different childcare business models in low resource environments of Sub-Saharan Africa to better support women daycare providers in sustaining their businesses and expanding access to affordable, quality childcare?" In the context of this question, working definitions are established for "support," "daycare," "sustainable," and "low resource environments."

"Support" will refer to the activities, trainings, and/or support that CRS can provide to daycare providers; one of CRS' current projects provides support to daycare providers by conducting trainings on ECD, child protection and safeguarding, quality improvement of daycare services, budgeting, marketing, and business forecasting; providing small grants to buy supplies and/or upgrade facilities; and assisting daycare providers in establishing low time commitment side businesses to provide an additional cash stream for their daycare services (i.e. small scale

agricultural production, raising chickens). Solutions presented for this question will take "support" to include activities or actions similar in cost, scale, and feasibility.

The term "day care" in this context is interchangeable with "childcare" and "early childcare" (ECC) and refers to services that are provided to supervise children, age 6 or under, and simultaneously ensure that ECD, child protection, and nutritional needs are met. Daycare services and centers are diverse and can range in size, setting, funding source, and business model, and part of this research will identify the best way to support providers given different models.

"Sustainable" in the context of this research question will refer to a daycare business that provides enough revenue to provide a living wage to the daycare owner and employees (if applicable), while being offered at a cost that is accessible to families, without compromising quality. Put similarly, the daycare business would be viable within communities, in that the daycare provider is motivated to offer their services and parents are able to access those services. Additionally, it is important to note that a model may present an opportunity for long-term sustainability but may still require subsidies or grant funding for start-up costs and the first few years of operation.

Lastly, "low resource environments" include countries that fall within the World Bank's criteria for low-income countries, which is a gross national income (GNI) per capita of USD 1,145 or less in 2023.[1] Low resource can also refer to low income/low wage and rural environments, where resources may be scarce, but the entire country may not be categorized as low-income; while in theory and largely in practice, a middle-income country differs in terms of state resources, increased capacity, and ability to regulate and enforce standards, this report will demonstrate that that is not always the case and that low-income environments in middle-income countries, such as Kenya's informal settlements, can sometimes simulate low resource environments. Though the two environments are not the same, the similarities may still allow us to learn from childcare models and implementation in middle-income countries. Rural environments are also pertinent to the policy question because nearly half of the total population of low and middle-income countries live in rural areas and in the "poorest countries," it rises to 67%.[2]

Landscape Analysis and Literature Review

Childcare in Low and Middle-Income Countries (LMIC)

Women are often tasked with unpaid care work for their families and further, women spend three times as much time on unpaid care work than men.[3] For many women, childcare responsibilities can inhibit their ability to obtain steady employment, especially if they do not have family to help provide childcare. And for women who are working a wage-earning job, they often have a "double burden," where they are responsible for both their wage-earning job, as well as taking care of children and the home as a second job.[4] Even more dire, recent research suggests that women in rural agricultural communities can be tasked with a "triple burden," in which they are expected to have a wage-earning job to purchase basic necessities, to care for children and the home, and to tend to their agricultural farms to maintain stable food production for their family.[5] Access to daycare in low-income countries can address at least the childcare component.

Where childcare markets exist in low-income countries, childcare is usually offered by the private sector.[6] Experts and those that work in this sector often see childcare as a "public good" that should be "provided by the state," but even though this is the ideal, one must "look to other market actors to fill the gap" until that ideal is realized by low-income countries.[7]

Daycare services are offered in a few forms: home-based care, center-based care, and family or other informal arrangements.[8] Home-based daycare services are services typically offered in a home setting but can be offered in either the child's home or the home of a caregiver, where caregivers often care for multiple children.[9] Home-based care is often less expensive to provide, earns less than center-based childcare, may be able to operate unregistered, and may not be held to the same standards as formal childcare centers.[10] Center-based daycare services refer to nurseries, daycare/childcare centers, crèches, and preschools, which can be operated by "government, workers' organizations, nongovernmental organizations (NGOs), community- and faith-based organizations, private providers, and employers."[11] Center-based care is often more expensive to provide given the added costs of the center itself, earns more than home-based childcare, must be registered in most cases, and is expected to adhere to ECD standards and regulations in order to operate.[12] Outside of both of these forms are informal arrangements with friends, family members, and neighbors and this type of care may be compensated or uncompensated.[13]

It is nearly impossible to determine the proportion of daycares that are home-based v. center-based, let alone informal arrangements, as this would require data collection on the care arrangements of households in LMIC, which is largely unavailable. Even with the data, the estimates would remain incomplete, as there are many home-based childcare providers that operate unregistered due to contexts involving over- or under-regulation, implying that even the recorded counts may be underestimating the number of home-based childcare providers.

Increasing access to child care options in LMIC can directly contribute to the "triple social and economic dividend," that involves improving ECD outcomes, increasing women's participation in the work force, and supporting economic growth.[14] The policy question examines all three of the triple dividends, in which the provision of daycare can improve ECD, child protection, and nutrition for children; improve business model sustainability for women-owned daycare providers, thereby increasing their labor force participation and the participation of mothers; and contribute to the economy and childcare market. In addition to providing the opportunity for mothers to participate in the labor force, childcare may also diversify employment options available; for example, if a mother has consistent childcare, she may be able to take on more stable employment, jobs in the formal sector, and opportunities that would not have been an option if she had to bring her child with her.

Cost Burdens and Other Barriers Associated with Child Care Access in LMIC

Shifting our attention to low resource environments, daycare services can allow mothers to join and/or return to the work force, but the need for these services remains largely unsatisfied due to concerns about inconsistent quality of care across providers and the cost burden for individuals already living at subsistence level.[15] ECC providers in Africa almost entirely operate in the private sector, even in urban slums, and multiple studies have indicated that "high costs of ECC prohibit many mothers from using these services."[16] A randomized controlled trial was conducted in one of Kenya's slums and the cost of childcare services in the area of the study was approximately USD 5 per month[17]; the authors' findings revealed very high demand for childcare services, especially for younger children, that "uptake among mothers who were given subsidized daycare was 42.9% higher" than the control group, and that mothers offered subsidized childcare were 17.3% more likely to be employed than mothers not offered vouchers.[18] In addition, the subsidized

access "increased women's employment by 20 percentage points amongst those who used the service and women were able to work fewer hours of paid work without any loss of earnings."[19]

While cost is the predominant barrier to access in low resource environments, other barriers to childcare are in abundance and can include distance of daycare facilities from home or work, gender norms, operating hours that "do not accommodate long or irregular workdays," and concerns over quality that may lead to barriers in trust.[20] The proximity of childcare is a key component to determining access and this holds true particularly for rural communities, where there may not be childcare services or family within a reasonable distance.[21] Gender norms impact how women are traditionally perceived as caregivers, the level to which society accepts the idea of women in the workforce, including both mothers and childcare providers, and whether there is an openness to other people providing childcare, as opposed to only the mother or family members.[22] Operating hours of daycare centers will limit who is able to utilize the services largely based on their employment schedule, which makes barriers increasingly difficult to overcome for workers in the informal sector, where hours don't always follow a traditional 9am-5pm schedule.[23] Lastly, mothers will have barriers related to trust, as they will need to feel comfortable knowing that "their children are receiving loving care in a stimulating environment."[24]

Aatif Somji, an author of a couple briefs referenced in this paper, outlined some of the constraints to developing childcare markets in one of his briefs and many of which came up consistently in this report[25]:

Demand Side Constraints:
- Willingness to pay
- Quality and safety concerns
- Distance from home or workplace
- Operating hours

Supply Side Constraints:
- Attendance fluctuations create inconsistent income and difficulty planning
- Seasonality of enrollment
- Issues with collecting payments from parents on time

Support-related Constraints:
- Lack of trained providers or training opportunities
- Availability of infrastructure
- Access to finance

Market Constraints:
- Government Regulation and standards
- Lack of clear mandate for childcare in government
- Social and/or gender norms impacting whether there is supply or demand for childcare

Source: (Somji, 2020)

Existing Research on Day Care in LMICs

Research has shown consistently that there is a "positive association between the percentage of children enrolled in pre-primary education," which include ECD centers, and "the percentage of children developmentally on track."[26] In addition to being developmentally on track, the benefits of ECD have shown to have lifelong benefits that include higher achievement in school and improved quality of life later in life.[27] As noted by the Cooperative for Assistance and Relief Everywhere (CARE) International, "investing in early childhood development is critical to breaking the cycle of poverty and inequality, particularly among the most vulnerable populations"[28]; CARE also notes that not addressing early deficiencies in childhood development, nutrition, and well-being can result in lifelong deficiencies.[29] Concerningly, 53% of children in

LMIC live in "learning poverty," defined as "being under able to read and understand a simple story by the end of primary school" and this figure is as high as 80% in some of the poorest countries.[30] Experts in the field state that learning poverty has its roots in the earliest years of a child's life and that quality childcare informed by ECD strategies during these years can yield lifelong benefits.[31]

There is also evidence from LMICs that details how childcare provides necessary protection for children while parents are working, or where parents have typically tried to multi-task, as well as improved nutrition outcomes.[32] In a case examined in this paper, as well as some examples from Asia, there is reduced incidence of fatal accidents, exposure to hazardous worksites, and reduced incidence of children wandering off and getting lost.[33] As for nutrition, emerging evidence across LMICs demonstrates inconclusive findings, but there are some studies that find children who attend childcare centers experienced increased dietary diversity, increased percentage of daily nutrition requirements consumed, and reduced incidence of malnutrition.[34]

The research on daycare service provision and interventions typically splits between women's empowerment/labor force participation and early childhood development, limiting the amount of research that focuses on both children and women benefiting from the same intervention.[35] Notably, there is an even larger gap when looking at daycare providers themselves, with Kabay et. al. (2024) identifying only one study that includes outcomes for providers.[36] Service provider outcomes are a gap in the research and an area for exploration in this analysis of how to best support childcare providers.

Government investment in childcare can be difficult to obtain, especially in low-income countries where there are not many resources and there are competing demands for limited resources. In addition to few resources, governments are not incentivized to invest in childcare due to it being a long-term investment that does not see tangible returns for decades and the incompatibility of such a long-term investment with the time horizons of election cycles. Some upper-middle-income countries, such as South Africa, have implemented policies that provide government subsidies to increase affordability of childcare services[37]; however, South Africa's subsidy program has numerous issues including its application process, lack of capacity to fully serve the eligible population, and the subsidy itself being inadequate to increase affordability.[38]

Government support is critical to further investment in daycare services, scale up the provision of daycare, and to maintain access to childcare for vulnerable populations, as there is an incentive for private providers to serve less vulnerable populations to maximize profits.[39] Although, South Africa is not a comparable environment to the resource constrained environments analyzed herein, it is an example to look to as countries develop their childcare markets. In addition to, or as a step prior to, government funding, research also shows that public-private partnerships with multiple stakeholders have shown strong potential for expansion of services.[40]

Methodology

With every childcare model, there is a constant tradeoff between the profitability of the model, cost to users, availability of services, and quality of the care provided. While clearly difficult to achieve, the goal is to make quality childcare services that incorporate ECD, child protection, and nutrition available and accessible at a cost that users can afford and in a way that maximizes profitability for service providers so that businesses can sustain themselves. To attempt to achieve

all of the aforementioned aspects, there are a diversity of business models that operate in this space, each with its own tradeoffs. No certain model works best, as daycare services are often context-specific and not one-size-fits-all. While the number of models that exist is beyond the scope of this report, it will highlight a few of the innovative and successful models that are emerging as possible solutions to high demand in Sub-Saharan Africa, including traditional community-based centers, mobile crèches, social franchises, and private provision with NGO support. All of the models being examined can incorporate partnerships and government assistance, but do not require government involvement to operate.

In approaching the policy question, "How can CRS utilize lessons learned from different childcare business models in low resource environments of Sub-Saharan Africa to better support women daycare providers in sustaining their businesses and expanding access to affordable, quality childcare?," an analysis of four case studies was conducted and informed through two methods: (1) document analysis of reports, working papers, studies, news articles, and blogs issued by NGOs, donors, researchers, and academics, followed by (2) semi-structured interviews and surveys with individuals and childcare centers, who work and/or research in this field.

This report features four different childcare models in LMICs of Sub-Saharan Africa, outcomes associated with each daycare model, and ways to support each model in a resource-scarce environment. The information highlighted in each case study is the business model and outcomes of interest that have critical implications including: location (urban, rural, peri-urban), target age group, regulatory barriers, ways to support the model and/or providers using the model, perceived or realized improvements in child protection, ECD, and nutrition, challenges faced by providers in low resource environments, and sustainability of each model.

Case Studies

I chose four case studies which together reflect a diversity of community-based childcare business models, urban/rural environments, and target populations: the traditional community-based model, the mobile crèche model, the social franchise model, and private provision with NGO support. Each case study will be presented with an exemplary case, or two, to explore in detail.

Models	1. Traditional CB Case	2. Mobile Crèche Case	3. Social Franchise Model	4. Private Provision + NGO Support Case
Locations	Rural, Democratic Republic of Congo	Peri-urban and urban, Burkina Faso	Urban and peri-urban, expanding to rural, Kenya	Urban, Maseru and Leribe districts Lesotho
Age Group	2-6 years old	0-5 years old	6 mos.-5 years old	0-4 years old

Table 1: Case Studies

The first business model, a traditional community-based model, involves caregivers from the community and a village committee comprised of parents and community members that oversees the childcare center. Partnerships with government or NGOs are possible to obtain additional support or layer service provision. Community based models are rising in popularity in Sub-Saharan Africa and centers are funded by the community, sometimes with support offered by the government and/or an NGO.[41] Community-based models have also shown to be successful in rural areas, where there is high demand for childcare services given that many people do not have support from family members or caregivers nearby.[42] The technical support provided by

governments or NGOs can include coordination, quality supervision, infrastructure investment, implementation, design, monitoring, and co-management.[43]

The second business model is a mobile crèche, which is often in partnership with a government or an employer. Women that work on construction or public works sites, usually as part of safety net programs, are often paid low wages and the location of their job changes frequently, presenting barriers to finding childcare near their work.[44] Without childcare, mothers also risk either leaving their child unattended or bringing their children to potentially hazardous work sites.[45] Mobile crèches respond to this need, as they offer a pop-up daycare service that moves *with* the work site.[46] The entity that implements the model provides safe infrastructure and childcare workers[47]; governments and/or employers may make contributions to operating costs, but funding can also be obtained through philanthropic funds.[48]

The third is a social franchise model, which resembles that of a commercial franchising model, and seeks to replicate and scale up socially driven models and/or programs.[49] The social franchise model is characterized by an organization (hub) that provides services to childcare providers (spokes) in exchange for a small fee to help providers improve the quality of their centers.[50] After completing trainings and a mentorship period, childcare centers that meet the franchise's quality standards are then able to use the organization's branding to signify quality of services. Social franchises provide additional support beyond training and ongoing support, which can include toys, learning materials, access to finance for infrastructure improvements, and more. One main drawback is that it is unclear how well a social franchise model can operate in rural areas with lower population density that limits ability to scale up.

The fourth business model is private, center-based care with NGO support. Private, center-based providers are either individuals or companies that provide childcare services to children in a center, as opposed to someone's home. Private provision is a standard business model and center-based care is not uncommon. But given the role of an NGO providing support, this model directly responds to the overarching policy question being examined in this brief. This model is a similar to a social franchise in that many of the levers of support are the same, but it can be distinguished by the lack of branding passed onto providers, the provider (childcare provider) and assisting entity (NGO) are separate and not part of one business, and NGO support, both financial and technical, is typically time-limited by projectized funding.

Document Analysis and Semi-Structured Interviews

Given the wealth of information published on daycare service provision, a lot of information has already been gathered in reports and existing research; although, most of the information available focuses on child-centered outcomes or women's empowerment outcomes, as it pertains to mothers who can enter the workforce once they obtain daycare services. Using document analysis, information was gathered about each case and gaps in the compiled information were identified and used to generate additional interview questions for each case. By finding all publicly available information, it prevented the interviews from being duplicative of past interviews or information that could be found elsewhere so that interviews were focused only on missing information and/or unanswered questions. The documents analyzed for each case are documented in Appendix A.

The second method used to inform the selected cases was semi-structured interviews, and surveys. About three people were interviewed for each case, with the exception of Case IV: Private Provision, as well as some subject matter experts, resulting in a total of eleven interviews and two

surveys.[i] A list of interviewees and survey respondents is available in Appendix B. In the interviews with subject matter experts, the aim was to gather information that would inform the broader research on daycare services in low resource environments and how to best support a business model that ensures child protection, nutrition, and ECD needs are met. Individuals that worked on specific projects and/or conducted impact evaluations of projects that used each business model were interviewed to better inform the research on the inner workings of NGO/donor support and how different entities have supported daycare service providers. Lastly, an attempt was made to interview daycare service providers, as they would be able to provide personal experience, but unfortunately, no direct contact was made with any providers; although, many of the interviewees conducted qualitative interviews and interacted with providers directly. Interview questions for each interviewee are listed in Appendix C. Through these interviews, the aim was to fill the gaps that were identified after analyzing documents and existing literature for each respective model.

To analyze the interviews conducted, NVivo, a qualitative software, was used. The interview transcripts were coded to help identify themes, supplement the case studies with quotes, and fill gaps where documents and literature are lacking. An inductive approach was employed in the thematic analysis to see what insights or themes emerge from the interviews. A thematic analysis approach was chosen because it is flexible and prioritizes what can be learned from interviewees' responses. The five themes are identified in the following list and explored further in the "Thematic Findings Across Cases" section to follow:

- There is a lack of resources for stakeholders involved in the provision of childcare services, including but not limited to, providers, parents, NGOs, donors, and governments.
- There is a consistent lack of ownership of childcare (primarily ages 0-3) by government ministries across contexts. Without one ministry who has the mandate, it results in fragmented processes, a lack of consistent funding, and often, an absence of regulation.
- Regulation can both help and harm childcare providers, as it can act as a catalyst for growth or a detriment to childcare. Over- and under-regulation can impact the policy landscape, the services that providers can offer, availability of childcare, and quality of care provided.
- The skills that providers gain through training and their experience as caregivers to children are not recognized or acknowledged by society, the government, or any authoritative body, reinforcing the undervaluation of care work.
- Community and parent buy-in are critical to the community-based models examined in this paper, as it shows consistent investment in childcare *with* providers and builds relationships that strengthen the quality of care provided to children both at home and childcare centers.

Using multiple qualitative methods was the most appropriate way to answer the policy question because one method cannot fill the gaps in the way this question necessitates. There is a lack of publicly available quantitative data on daycare services in low-income countries, limiting the ability to run any kind of quantitative analysis. There is abundant research on the provision of daycare services in middle-income countries, and some in low-income countries, that can be

[i] For organizations located in Africa, the option of a survey or a virtual interview was offered, with the intent of being cognizant of their time, organizational capacity, and language barriers. The organizations opted for a survey so that they could provide thoughtful responses at their convenience. Survey questions are also included Appendix C, alongside interview questions. The limitation of this option is that respondents may give shorter responses than they would if speaking in an interview.

obtained from analyzing documents; although, speaking with experts, organizations, and providers will provide supplemental information on both low resource environments, lessons learned from projects in LMICs, and provider perspectives. Each model generated insights for daycare providers in low resource environments. Each model's strengths and weaknesses were further assessed to help determine how those insights could be translated across contexts.

Findings

Thematic Findings Across Cases

A Lack of Resources for Providers and Other Involved Stakeholders

A common theme across interviewees and when discussing relevant stakeholders in the provision of childcare was a lack of resources, primarily financial. Starting with providers, operating in a resource-constrained environment raises many issues and is inherently interconnected with parents also having limited resources. For example, interviewees noted that one of the biggest challenges for providers is the lack of consistent income, either due to attendance fluctuations, parents' inability to pay, or difficulty enforcing payment of fees.[51] Attendance fluctuations can be related to parents' inability to pay or inability to use services consistently, but the fluctuations were also mentioned in terms of the "seasonality" of childcare. Dr. Anne Fitzpatrick, interviewed in connection with Case III: Social Franchise Model, and Aatif Somji, a Senior Researcher for ODI Global, both noted that there will be seasons when attendance drops and particularly, when school for older children is out of session.[52] This fluctuation can be attributed to older children being responsible for watching the younger children, as opposed to the mother having to pay for childcare.

Dr. Beam, who was interviewed in relation with Case III: Social Franchise Model, also laid out the challenges related to variable income when stating:

> "The biggest challenge you have, I think, is that you can't charge very much money because people can't afford it, and they can't pay you in advance. They can't pay you a week at a time. They can't pay you a month at a time, and it's unlikely that they have enough stability in their lives to use services in a very regular way…And so what that means is that your income is super variable and also often quite low, which means that if you want to provide anything else for the children, like you have a lot of uncertainty there, and there's just not a lot of money you can bring in in order to like support the children…So I think that's a really big challenge, and because of the sort of like community social contract…These are children you're caring for and you do it because you probably like them, and they're your neighbors, etc. There's not a great way to enforce the types of contracts in a way that would be more like you have to pay for this. I need this so I can run my business so I can afford to buy clean water, so I can afford to feed them good food, etc. So, I see that as a big challenge. but I think ultimately, there's just they're trying to run something with basically very, very little income that's highly variable."[53]

Mr. Somji also explored variable income and the implications for planning when stating, "so in some cases they'll have planned, maybe food and stuff. So, it's hard to plan how many to cook for or to get food for" and when planning does not align with actual attendance, "then it goes to waste,

and you're losing that money as possible profit."[54] Also highlighted by Mr. Somji was the social contract when he stated:

> "And it's not like, you know…Okay, you don't pay. You can't come. You know the child cannot go there. It's more like a community, right? So people will say, look, I can't pay today, but can I pay you next week or the week after, and no one will say no, so they won't turn away the child…But then, obviously, that's a cost that's borne by the childcare provider with no guarantee of when it will come back."[55]

Looking on to parents, depending on the location, there may be extremely inconsistent employment opportunities for parents that impact their income, ability to use childcare, and ability to pay fees consistently and timely. Similar to the way it affects providers, lack of consistent employment makes it difficult for parents to plan their income and subsequent usage of childcare services, and the lack of consistency may also result in a seasonality of childcare usage that is different from whether school is in session. For example, with Case II: Mobile Crèche Model, the underlying public works project resulted in a seasonality of childcare usage, as the crèches had a significant drop in demand after the public works project concluded.[56]

Next, even the NGOs and Donors that are funding the projects are struggling with a lack of resources, that has in the case studies:

- Limited the type of childcare model that could be used.[57]
- Excluded partners unwilling to work on light touch models.[58]
- Excluded certain project components or measures (i.e., nutrition).[59]
- Required additional funding requests.[60]

Lastly, governments also have a lack of, and in some cases also a misallocation of, resources. Mr. Somji specifically noted two persistent issues in the underfunding of childcare:

> "Two things: one, very resource-constrained environment, but also number two, I think it's a long-term investment. It's a really long-term investment actually. So, it's not like you pay the money, and you reap the reward immediately. It's like you pay the money, and in 20, 30, 40 years' time, you're reaping the benefits of it…In those contexts, I think there's less of an incentive to then invest that money for a really long, far term gain when maybe there are a lot of short-term needs…And also, you know, focusing on constituencies, reelection, those kinds of things."[61]

And while a strong case for childcare and its long-term benefits has been made to governments repeatedly, there is still a lack of funding allocated to childcare. In some cases, the lack of funding may be attributable to corruption and the underfunding of a vast majority of government sectors, or in other cases, it could be due to a lack of ownership of childcare among ministries.

Which Ministry Owns the Issue of Childcare?

The next common finding across cases was that ECD is not within any ministry's mandate and the lack of ownership results in early childcare being underfunded, reliant on cross-collaboration among ministries, and subject to fragmentation. All the case studies had fragmented systems in which childcare initiatives were a collaboration among the Ministry of Education, Ministry of Women/Gender, Ministry of Social Services, Ministry of Health, and numerous others.

As explained by Mr. Somji:

> "And when it comes to ECD, like early childhood, it kind of spans different government departments. So unlike, let's say, maybe more like school where it's sort of the Ministry of Education. ECD oftentimes falls under education, health, there might be a department of families, or women and children…So it kind of goes across a bunch of different ministries without a single one being the lead agency…it kind of almost falls through the cracks in some instances. So, I think that's also something that should be thought about from a policy perspective is, what is that entry point? And is there a way to make it a bit more efficient?"[62]

And this is not to say that the ministry with the mandate should not consult other sectors, make linkages across programs, or collaborate when beneficial; however, leaving childcare to exist without any one ministry being responsible continues to allow it to slip through the cracks or be easily left behind.

Ensuring one ministry is in charge of the childcare mandate was a specific effort in Case IV: Private Provision, but now that the mandate is under one ministry, there has been a realization that there needs to be continued advocacy to ensure that one ministry takes the appropriate actions to promote the availability of quality childcare.[63] Therefore, while efforts should be made to assign the childcare mandate to a specific ministry to improve funding opportunities, streamline decision making, and increase efficiency, it is clear that the work to advocate for childcare providers' interests, accessible ECD regulations, and the investment in childcare by governments does not stop at ministry ownership and will require ongoing work to see substantial change. Makhotso Moeletsi, interviewed in relation to Case IV: Private Provision, noted issues related to the underfunding of childcare, now that the Ministry of Education and Training has taken over the childcare mandate:

> "Another thing, though, is the resources challenges and this has happened for decades. You know, the budget for ECD is under 0.5 [percent of GDP] …very low. And that's another challenge, irrespective of the awareness being created, advocacy done by different people, we have some resources being added, but this is also a challenge. They even mentioned that human resources will also be a challenge, because it would be that we need people who specialize to our skills."[64]

Therefore, while ministry ownership is a great starting point for improving the childcare landscape, it is far from the overarching goal and will require consistent, long-term work with government, including advocating for funding increases.

Regulation as Both a Benefit and a Hindrance to Childcare Sectors

In navigating the four cases, it became clear that regulation itself is a double-edged sword. A lack of regulation can sometimes be advantageous in the short-term by allowing informal childcare models to operate where they would not normally meet childcare standards. In the same context, if regulation is too heavy-handed, it may make it too difficult for a childcare market to form or it may exclude successful, informal models. For example, Dr. Koussoube, who was interviewed in relation to Case II: Mobile Crèche Model, stated:

> "And it's not just like in Burkina. Other contexts, so in Benin, for instance, where I'm working on another like childcare project, so they do have a legal provision and rules around childcare that are really strong. So normally, this type of project where you are having like childcare in a tent somewhere like wouldn't work if you follow the legislation. But in this type of program, because you're like working as part of a World Bank program funded by the government…So if you were going to do like a childcare center like this like outside of this program, it wouldn't be possible, because of the legal provision and everything."[65]

Elise Williams, an ECD consultant who works with an international financial institution[ii], stated that, " the danger here is making regulations or certifications unattainable for a lot of these providers who might not have the right infrastructure or capacity to meet them."[66]

Regulation is necessary in the long-term, as it creates minimum standards to protect children and foster safe childcare environments. An absence of regulation in the long-term can result in a childcare sector comprised of low-quality care, limited opportunity to formalize, and that may end up harming children more than helping them. To address both the need for minimum safety standards and a flexible, inclusive system that uplifts, rather than excludes, providers, multiple interviewees discussed an approach involving "tiered standards."[67] Ms. Williams noted that it would help create a progressive system with essential minimum standards on one end and more advanced criteria on the other to promote continuous improvement that allows providers with less resources to continue operating as they work toward achieving greater quality over time.[68] Mr. Somji also explored this idea when stating:

> "There should really be regulation to ensure that quality is there, whether it's about health and safety, whether it's about the ratios of caregivers or those kind of things…Obviously, on the one hand, that's important. On the other hand…let's take the social franchising model. These are all informal childcare providers…so to expect them to reach a standard which is, let's say, impossibly high, and to enforce it and shut them down if they don't do that will also be counterproductive to the goal. So, I think it's more like, I don't know what each country would be doing, but broadly, I would say, it's like having a goal to aim towards long-term. But then, in the meantime, making small steps to progress and trying to incentivize providers to do that rather than punishing them for not reaching this lofty goal, which really isn't attainable in the short term anyways."[69]

A Lack of Recognition for Providers' Skillsets

Providers are integral to society in that they provide valuable work and care for children in one of the most impactful times of their lives. Unfortunately, childcare and care work remains undervalued, along with providers' skills that they obtain from training and put into practice through their roles as caregivers. Dr. Ajayi, interviewed in connection with Case II: Mobile Crèche model, stated that this was not only a transfer of skill for the providers themselves but that it was then passed on to parents and had a reverberating effect that "cascaded" to the community.[70]

[ii] Interviewee requested a pseudonym and for her organization not to be disclosed.

Ms. Williams highlighted when discussing recognition of providers' skills that training to build a skillset "doesn't require long initial training programs, especially where needs are immediate and workforce supply is limited, as long as practitioners continue to receive support over time. So yes, formalizing, licensing, certifying, but then, also, looking at what's the most important part of this – making sure that the services are meeting the needs of children and families, and improving continuously."[71] And so while providers will not be recognized with a degree for such a short training, there still could be an additional mechanism to identify providers that have completed certain trainings.

Dr. Friedson-Ridenour, interviewed in relation to Case II: Mobile Crèche model, stated the following regarding providers skill sets:

> "I think in environments where there's no training in early childhood at all, at least some basic training is really valuable, right? I think the fact that these providers were given at least some basic skills does a couple of things. One, I think it's super important for their care of children. And two, I think it elevates their confidence and their ability as professionals in this space, right? So, I think that there's the challenge and the very real perception that those that provide education at lower levels, even kindergarten, first grade, second grade, are less professionals than those that provide junior high school or high school education, right? And so, there's this kind of hierarchy among childcare providers and professionals. And of course, those that are providing crèche childcare are like the lowest of the low in terms of prestige. And so, I think anything that increases their skills, visibly provides them with certificates or some kind of like recognition of their skill is really important to them as being like professionals in this space. And that's something that NGOs can often provide and making sure that that, of course, is tailored appropriately to the environment."[72]

Ms. Moeletsi even stated that, "And in this cohort, right now you won't believe, we have a teacher, a professional teacher who has a daycare center. I won't say retired, but resigned, due to challenges at home … That's what she did and established a daycare center. This person did home economics, and at some point, also nutrition…Then she was like, you know, what you're providing is not a refresher. It's more like training me to know this, because I was not even doing this…And even the way they do their work, you see that real trainings were helpful, and this is the feedback that we also get."[73]

Across contexts, it is evident that the trainings held for providers are impactful, educational, and make a big difference in the care provided. However, because of the undervaluation of care work, a couple of interviewees noted that it can create interesting dynamics related to payment for childcare. Dr. Beam stated in relation to the work performed by providers:

> "On the one hand, people will say like, Oh, it's undervalued. They're often underpaid. They're not making a lot of money, etc. But, on the other hand, it's valued as like care work, right? Like they're providing care for people's children. And so, as a result, the idea of making money off of that, like they're doing it because you have to right, you have to be able to cover your expenses, and you have to eat if you want to provide daycare, but, the idea of a profitable business doesn't sit always super well with people, which is a challenge."[74]

The founder of Kidogo, Sabrina Habib, also addresses the interesting dynamics when stating that it is critical for caregivers to see themselves as entrepreneurs, "due to the nature of their businesses, with childcare being a traditionally undervalued economic activity, perceived as a woman's responsibility for which no compensation is due."[75]

Community and Parental Investment is Integral to the Success of Community-Based Childcare

Parents and community members' support and buy-in is necessary for childcare center success, especially when income in resource-constrained environments has a high opportunity cost. Dr. Fitzpatrick stated that, "no matter what, the local community matters right? You always want to be doing something that's valued by the local community, and it has to be approved of by the elders and have demand from the parents to have any impact at all right…But I think everything always starts with the community."[76]

Dr. Ajayi also highlighted that community can play a role where the government may be unable or unwilling to provide funding by stating that, "it doesn't have to be government, it could be – there are places that have community funds that are within the community, having people pool together their resources."[77] While this was not the case for the model that Dr. Ajayi was interviewed for, Case IV: Private Provision demonstrates the importance of community funds. In Case IV, Catholic Relief Services helped establish Savings and Internal Lending Communities (SILC) to help assist providers in gaining access to finance and parents in building savings to pay their childcare fees. Not only do SILC groups help communities with finance and savings, but they also build resilience among community members, providers, and parents.

Multiple interviewees also stressed the importance of community ownership, both for empowerment of providers and for sustainability of the model long term. As stated by Dr. Koussoube, "Obviously, you want the community to be also involved, to have ownership of the project and be able to kind of talk about their needs because the whole goal is not to impose something, but kind of like understand their needs before, and that also serves for the ownership …and the sustainability."[78]

Dr. Friedson-Ridenour highlighted an interesting finding related to parental financial investment in the mobile crèche model when detailing how typically with household finances in Burkina Faso, there is:

> "like kind of the normative distribution of responsibilities in the house where men pay for schooling for older kids, right, from primary school on up to like middle school. But it was unclear to us who was responsible for paying for a crèche, because that's kind of often the domain of women to take care of young children. And it seemed to vary across households, how involved men were in the payment of these crèche fees, and at least to some extent, men that were more invested and helped cover those costs, it seems to offset the financial burden that women may have faced if they were responsible alone. So, I think that that is a potential factor is like the household investment versus the woman's responsibility for payment."[79]

Several interviewees highlighted the importance of meeting parents where they are at and trying to eliminate barriers to childcare by ensuring centers are located near parents' homes and places of work, ensuring the hours work well for the target population, and layering services to support parents and children with centralized service provision at childcare centers.[80] Ms. Williams further

stated that invested parents, with the right knowledge, can also serve as a form of quality assurance and an accountability mechanism for providers.[81]

Lastly, parent buy-in is critical in terms of the opportunities that parents can gain from having consistent childcare available. For example, Dr. Friedson-Ridenour also highlighted how, "a woman talked about how she is really grateful for the crèche because it has allowed her to continue to work as a secretary because she couldn't bring her kid to work. So, women definitely benefit if they're able to consistently use them by changing or taking on more stable employment."[82]

Case I: Community-Based Model

Model and Case: The traditional community-based model is a daycare model that involves daycare providers from the local community, often uses community-donated or provided resources, and often has a committee or council comprised of parents and community members that oversees decisions concerning the childcare center. This model tends to be low cost, given that much of the needed resources are made available by the community. Community-based models also offer opportunities for greater community investment and engagement, as parents and community members have a voice through childcare center committees. This model's exemplary case was a component of a World Bank (WB) project in rural Democratic Republic of Congo (DRC), for which an impact evaluation was conducted by the WB's Gender Innovation Lab (GIL).[83] The DRC community-based model described is informed both through the documents analyzed in Appendix A and interviews with Dr. Aletheia Donald and Dr. Julia Vaillant, both WB Senior Economists at GIL and Co-Principal Investigators of the project.

The community-based daycare model in DRC came to fruition as part of a larger World Bank-sponsored project that was focused on agriculture after a GIL study revealed the disproportionate amount of care work that women are responsible for in this resource-constrained environment.[84] The research on disproportionate care burdens for women in DRC's rural agriculture sector spurred the pilot of community-based childcare, as more than 60% of surveyed individuals "reported being likely to leave their children in childcare if it was available."[85] After the daycare component of the WB project was implemented, GIL found that 73% of households that were provided access to childcare used it.[86]

For GIL's evaluation, "villages were eligible to participate if (i) the community agreed to participate in proposed childcare pilot, (ii) the community was willing to make a suitable building available to host the childcare center for the duration of the project and free of cost, and (iii) the community was accessible by motorbike for most of the year."[87] The sample was determined by the project's implementing partner, Réseau Provincial des Associations des Femmes pour la Promotion de l'Education (REPAFE), and the final sample included 55 randomly selected treatment villages out of 110 eligible villages in the Kongo Central province.[88] And within the 55 treatment villages, a total of 67 centers were opened – as villages with more than 14 eligible children required more than one center.[89]

Treatment villages would receive childcare centers for children aged 2-6 for about 12 months and the effects on women and children were also examined 5-19 months after project end.[90] For the duration of the project, children were able to attend the center 6 hours a day, 5 days a week and treatment centers were provided support.[91] Caregivers were selected by the women who would be using the center and community members, often based on their character, availability for the program duration, and ability to read/write.[92]

Regulatory and Legislative Environment: The project followed national guidelines that set the child-to-caregiver ratio at 14:1.[93] Dr. Donald highlighted that a 14:1 child-to-caregiver ratio is "way higher than a lot of other places" and that this added to the model's cost effectiveness.[94] Aside from the ratio, and the caregiver's use of curriculum informed by national standards and ECD best practices, the DRC lacks substantive regulation or standards for childcare centers, caregivers, safety, and other critical elements. To compensate for the lack of regulation, the Ministry of Education was involved in the project from the beginning so that they were aware of the project details, could assure quality, and conduct spot checks.[95]

Dr. Vaillant also pointed out that, "to scale it up and do this more formally…it may not be possible to have such an informal model because basically [it] wouldn't be up to standards"[96]; she further stated that "what we think we are demonstrating is, even if you have a pretty informal model, the kids still benefit from it, and the parents still benefit from it."[97] As a point of clarification, there is a distinction between formality and quality of a model and this is not to say that standards should not be pursued, just that a quality model can be implemented in a regulation-scarce environment successfully, while benefiting children, parents, and caregivers.

REPAFE added in their survey responses that they did not encounter any community-level barriers because the childcare centers were only operating in villages where the community was accepting of the project, nor any regulatory barriers, as the local and national education authorities were consistently involved in the project "at all levels."[98]

Support Provided: The WB contracted with Save the Children to create a context-specific two-week training and Save the Children also directly trained the "focal points," which were supervisors from REPAFE.[99] The focal points then trained the caregivers for treatment villages.[100] Dr. Vaillant stated that this cascade training model "seems to have worked" and Dr. Donald added that it also seems to have been a "meaningful training," as caregivers' scores on the post-training assessment were correlated with whether the center stayed open a year and a half later.[101]

In addition to the training, centers and caregivers were provided with an empty building to use free of charge for the duration of the project (from the community), and basic equipment, such as first aid kits, toys, and mats.[102] Caregivers were paid through the project, as opposed to by parents.[103] The children were also provided with lunches that were co-funded by parents and the project, in an effort to get parents to feel like they were also invested, however co-funding was not enforced and children of parents that did not pay were still fed.[104]

ECD, Child Protection, and Nutrition Outcomes: To measure ECD, children under 4 years old were measured using "Short Form Caregiver Reported Early Development Instrument (CREDI) to parents," which generates a score of children's overall developmental status based on age and milestones.[105] Children over 4 years old were evaluated using a "short-form of the Measuring Early Learning Quality and Outcomes (MELQO)," which is comprised of questions regarding "expressive language, oral comprehension, and empathy."[106] Children under 4 measured as having increased their CREDI score, with an increase of 7 percent in their summary score, however, there was not significant change in MELQO score for children over 4.[107] Dr. Vaillant also mentioned that parents stated in qualitative interviews that they noticed behavioral improvements in their children, such as being "more independent, less needy, and so it made their lives easier, even after the daycare at the end of the day."[108]

While not a specific measure or outcome in the impact evaluation, improvements in child protection were observed. In order to choose a suitable location for childcare, it had to be "protected from the elements and from wild animals," which is greater than the alternative of mothers taking their children to the agricultural fields where they work and multi-task.[109] Dr. Vaillant stated that while the children were at the daycare center, they were in "an enclosed space, as compared to an open field" with someone who's "exclusively looking after the kids."[110] Dr. Vaillant also mentioned that before the project, some mothers did "say like the kids when it rains they get wet, they get sick, they get cold."[111]

Unfortunately, nutrition outcomes were not measured, as Dr. Donald mentioned that anthropometrics would be expensive within the context of their project, and the project budget was low. Dr. Donald pointed out that what the children were eating was not too different from what was being consumed at home. At one point, Dr. Donald stated that they were thinking of incorporating Plumpy'Nut, a ready-to-use therapeutic food (RUTF) used to treat severe acute malnutrition, but that the RUTF producer was not operating in the area served by the project.[112]

Model Sustainability: From the start, this model was "childcare provider-centered" and everything else was built around that – which becomes very clear when looking at the model's sustainability.[113] One year after project end, 15 centers out of 67 were still operating, meaning that after the project ended, these populations "organized themselves independently" of the WB and now "compensate the childcare provider to keep the place going."[114] For the centers that continued to stay open, the following correlates were identified[115]:

1. If the mothers really liked, trusted, and thought the childcare provider was skilled, it correlated significantly with the center staying in operation.
2. If the provider left, the mothers found it difficult to select another provider because they selected someone they trusted, and that initial provider is the one who received the training from REPAFE's focal point. Therefore, having a provider that stays was correlated with centers staying in operation.
3. Centers with a higher number of village committee members also correlated with the center staying in operation.

Considering the correlates outlined above, one can infer that trust, skill, and consistency of the caregiver is critical to the centers staying in operation, as well as community investment in the childcare center through the village committee.

Fast forward to April 2025, only one childcare center is still in operation, located in Vunda, DRC.[116] In a survey administered to REPAFE, they noted that the center serves 10 children, but that it had to reduce the number of days in operation (3 days per week) in order to self-fund.[117] Dr. Donald also mentioned that for a while after the project, some villages engaged in informal arrangements, where "women would work in the fields of the childcare center manager in exchange for her taking care of the kids if they couldn't pay."[118] Dr. Donald further stated, "So I don't think we know 100% why, in some villages, they were able to circumvent like the financial constraints by adopting these like informal payment arrangements and in some villages, they were not."[119]

Cost effectiveness of the model showed promise, as the cost of the caregiver salary, equipment, and lunches per center was approximately USD 144 per month.[120] The average center had approximately 9 children, making the cost about USD 16 per child per month.[121] For the duration

of the project, the childcare services were free to households, and household gained approximately USD 38 per month in household income due to increases in agricultural yields, less multi-tasking required without children present in the fields with them, and increases in economic activity attributed to husbands.[122] For centers that sustained the model after project end and would have had to charge parents for services (assuming the average USD 16 per child per month), households using the center would then see a net gain of USD 22 in household income.

Opportunities for Support or Innovation: Based on the correlate related to providers leaving, Dr. Donald stated that for a longer-term project, a critical element of support would be "more continuous training," so that "if someone leaves, identifying a replacement or like helping train the replacement."[123]

In addition to more continuous training, Dr. Donald also mentioned that for a longer-term project, financing, supervision, support, nutrition, and increasing effectiveness of the model are areas for support that could have a substantial impact. She further suggested that even finding different stakeholders to "donate Plumpy'Nut, or whatever, to boost the nutrition outcomes of kids" or "you can layer - you can use the center theoretically as a vehicle for other service provision, even like health for mothers."[124]

Challenges: The two primary challenges noted for this model were funding constraints for the overall intervention, therefore requiring an inexpensive, "light touch" childcare model, and trouble finding an implementing partner, largely due to the "light touch" model.[125] With the funding constraints, Dr. Donald and Dr. Vaillant stated that they would need a low cost model, as they would be unable to build any infrastructure or buildings.[126]

As for implementing partners, Dr. Vaillant noted, "UNICEF didn't really want to work with us because we wanted to do a more like light touch model, not the full scale, build a daycare center …like they wanted something to be more developed, and we wanted something more scalable, more light touch. And so we had to do it ourselves, essentially, so we found the NGO that had experience in the education sector in that region."[127]

Other Findings*:* Building off the triple dividend discussed earlier in this paper, the DRC community-based model seems to offer the added benefit of a fourth dividend. To the surprise of Dr. Donald and Dr. Vaillant, husbands also benefited from this model.[128] The husbands in households that utilized the childcare centers were "10.4 percentage points more likely to participate in commercial farming, and 5.2 percentage points more likely to work in entrepreneurship (non-agricultural self-employment)."[129] Husbands even benefitted when gender attitudes and how housework is shared in the household did not change.[130]

Also an interesting and unexpected finding, was the extremely high demand that pre-dated the start of the childcare intervention.[131] The target communities for the childcare intervention included households that "had no previous experience with institutional childcare arrangements" and are "commonly not perceived as good targets for promoting childcare access, since it is assumed that women bear minimal costs from carrying children with them to the field and that it is easy for women to find childcare arrangements when they are embedded in family networks."[132] The demand sustained after project end, but the specific reasons as to why are unknown (e.g. quality of the centers, protection and safety, increased household earnings, etc.). Dr. Vaillant stated that 5 years ago or even 2 years ago, "nobody believed that rural childcare worked, was desired, or had any kind of impact on rural women's welfare" and that because of this, "we're at the very beginning

of generating this evidence."[133] Dr. Donald added that, "when we were setting up this project, it was like we heard so much negativity from all quarters – like why are you even doing this? Social norms make it so that nobody will want to attend. And we were hearing from the women that they wanted this."[134]

Additional Case: After reading a brief on community-based childcare centers (CBCC) in Malawi and attempting to reach out to the author, she recommended speaking with the CBCCs directly.[135] Contact was made directly with Nachikodowa Community-Based Organization (CBO) in Malawi to gain an additional perspective on CBCCs from the organization level, as opposed to the high-level, WB view. The Malawi CBCC model described is informed both through the documents provided by Nachikodowa CBO listed in Appendix A and survey responses from Peter Nkhoma on behalf of Nachikodowa CBO.

Nachikodowa CBO has 16 childcare centers under the organization and each center has a "management committee" that is comprised of "parents from the community."[136] When asked why they chose this model, Mr. Nkhoma responded that it was chosen "for sustainability, because the community has ownership of it" and also pointed out that it is cheaper for the caregivers and the committee to come from the same community.[137] Parents are currently expected to pay a fee to caregivers totaling USD 0.29 per child per month.[138] As far as the provision of food, Mr. Nkhoma stated that, "parents are committed to going to CBCCs and cook in shifts for the children, as well as making food contributions towards porridge...All the food contributions come from the parents themselves and other well-wishers from the community."[139]

Mr. Nkhoma acknowledged that their main issue concerning ECD standards is having access to them, but he noted that they are working with the Social Welfare Office, who is responsible for the necessary standards. He also noted that ECD standards and particularly the child-to-caregiver ratio are making it harder to operate because for their center, "the caregiver role is voluntary, so there is low turn up of caregivers."[140]

Nachikodowa CBCCs receive support from Firelight Foundation, who also published the brief about CBCCs in Malawi, in the form of grants. The grants are used to implement ECD activities, such as trainings and awareness campaigns for caregivers and the community, help construct CBCC shelters, and "provide soft loans to parents," among other activities.[141] Nachikodowa also receives support from the Ministry of Gender, Children, and Social Welfare's Social Welfare Department, who provides tablets and solar panels to CBCCs.[142] ActionAid, an NGO, also provides tablets and helps construct shelters for other CBCCs in the area.[143]

Mr. Nkhoma mentioned that the children that go to CBCCs have shown improvement intellectually, as reported by parents and primary school teachers.[144] At Nachikodowa, they have also revamped other "child protection mechanisms" like having a suggestion box at every CBCC, creating a child protection committee, designating a child protection focal person, and holding community police forums.[145] By instituting these types of safeguards, Mr. Nkhoma stated that there are "minimal cases of child abuse."[146] As for nutrition, there has been increases and improvements in nutrition and decreases in malnutrition levels compared to children in previous years.[147]

The biggest challenges to sustainability have been "parents failing to contribute enough food for the learning term," losing caregivers "looking for other green pastures because parents don't pay" the monthly amount in full, and outstanding issues because the CBCCs "need more resources that the community cannot afford," like for construction, "things like cement, nails, and timber."[148] To

address food challenges, a meeting with the village chiefs resulted in "CBCC farms provided by chiefs so that parents" could "grow food for the CBCC, and also we asked well-wishers to help with food."[149] To reduce turnover, the CBCCs engaged the committee and leaders to try and find ways to "motivate caregivers so that the retention rate will be high," like paying more money towards the CBCCs and reducing other village contributions, and considering CBCCs a "priority in government/other donations."[150] The CBCCs have also tried to help parents by offering soft loans, helping "caregivers to run small scale businesses," and giving goats "to be passed on among parents and CBCC caregivers."[151] Lastly, Mr. Nkhoma describes relying heavily on well-wishers, Members of Parliament, and the Ward Councilor (akin to a mayor) to try to fill resource gaps.[152]

When asked about opportunities for support, Mr. Nkhoma echoed some of the examples provided and added a few of his own when stating that any of the following resources would have been helpful to their CBCCs:

- ECD training for caregivers
- small loans for renovations (to caregivers and CBCC management committee)
- childcare center equipment
- business training, such as budgeting or marketing to run small businesses
- training for CBCC management committee on their role
- training on making play materials using locally available resources for sustainability
- constructing CBCC standard shelters

Lastly, Mr. Nkhoma provided raw data on their CBCC enrollment, committees, and gender disaggregation. An analysis of that data is shown in Appendix D. Notably, 13 out of 16 CBCCs have a majority of girls enrolled, and 12 out of 16 have village committees comprised of 50% or more women. Also of note was the wide variation in terms of child-to-caregiver ratio, ranging from 10:1 on the low end to 29:1 on the high end.

Case II: Mobile Crèche Model

Model and Case: The mobile crèche model is a long-standing model pioneered in India and popularized in Africa in Burkina Faso within the scope of a World Bank-sponsored project. The mobile crèche model is designed to be a mobile childcare center that can change location based on the location of the parents' work sites. The childcare sites are often in large tents, empty buildings made available by local government, or safe outdoor spaces with protection from sun, weather, and potential accidents.[153] This model, similar to Case I, tends to be low cost, given that some of the resources are donated. The exemplary case for this model is the Burkina Faso WB project, which was originally a safety net program to support youth unemployment, in which participants worked on public works sites across the capital and surrounding peri-urban areas.[154] GIL also conducted an evaluation on the pilot and found that 25% of eligible women (safety net project participants) utilize the childcare centers, which equates to tripling the use of childcare centers.[155] And in their follow-up 14 months later, effects were persistent with "higher rates of childcare usage over the past 24 hours" relative to the baseline, suggesting "initial exposure to the childcare centers generates lasting demand."[156]

The Burkina mobile crèche model described is informed both through the documents analyzed in Appendix A and interviews with: Dr. Kehinde Ajayi, a Senior Fellow at the Center for Global

Development and Director of the program on Gender Equality and Inclusion, and formerly an Economist at the WB; Dr. Estelle Koussoubé, a WB Senior Economist; and Dr. Sophia Friedson-Ridenour, a WB Social Scientist. All three interviewees have worked or currently work in the WB GIL and on the Burkina mobile crèche model.

When the project began, mothers who were participants in the projects were bringing their children with them to the public works projects, which were often hazardous.[157] Project participants that were mothers did not disclose during eligibility determinations for the project that they had children and did not have childcare, as they knew it would disqualify them and eliminate the opportunity to work for needed income.[158] After the project started and when children were seen at the public works sites, the WB decided to pilot the mobile crèche childcare model, which would create mobile childcare that moved when the sites moved.[159] The mobile crèche model also alleviated some trust barriers, as mothers knew their children were nearby to check on, and the proximity also allowed mothers to breastfeed.[160]

The WB GIL used a randomized controlled trial to "estimate the causal effects of childcare" and identified 36 public works sites that had the "potential to host a childcare center."[161] Out of the 36 sites, 18 were randomly selected for treatment and the remaining 18 were the control group.[162] Childcare was offered for ages 0-6, which is much more comprehensive than what is traditionally available.[163] Childcare offered is usually for ages 3-5, while ages 0-3 are rare, and most childcare options are often private provision and concentrated in urban areas.[164]

Eligibility conditions for participants in the labor-intensive public works project, which ended up including both the parents who used the childcare services and the caregivers who watched the children in the childcare centers were: "i) being a Burkina Faso citizen; ii) out of school or never enrolled in school; iii) not a former beneficiary of the project; and iv) aged 16 to 35."[165] Eligible participants were then selected from a lottery system.[166] Public works projects included the "construction of bridges and rural roads, the maintenance of urban roads, and administrative spaces, and reforestation."[167] Public works assignments began in July 2019 and participants worked approximately "8am to 2pm Monday to Saturday and received CFA 37,000 a month (approximately USD 63 at the time of the study, roughly the minimum wage in Burkina Faso), for the 6 months of project participation."[168] Centers were required to be open for the same schedule, but in practice, often opened up as early as 6am.[169] Caregivers were determined by either pregnancy status or on a volunteer basis, but received the same compensation as the public works participants.[170]

Regulatory and Legislative Environment: Burkina Faso has a framework for "integrated early childhood development across the Education, Health, Nutrition, Social Protection, Child Protection, Water, Sanitation and Hygiene sectors" for "basic education, including preschool education, and a national parental education program."[171] However, while these regulations are on the books, a lot "remains to be done especially in terms of funding mobilization," as well as implementation, monitoring, and quality assurance.[172] In 2016, 0.02% of Burkina's public expenditures were allocated for preschool education.[173]

Dr. Ajayi stated with regard to the model that "calling it mobile…allowed the care to be provided temporarily by these public works participants" because for "fixed structure… there's a bunch of credentialing criteria in order to be able to provide care at a childcare center."[174] This was a concern for the long run in terms of sustainability, as Dr. Ajayi noted, "if these childcare centers did stay

around for a long time, at some point they would have to be recognized as, you know, traditional childcare centers."[175] Further, the caregivers would not be able to serve as caregivers in the long run because they wouldn't meet the standards, such as having a formal degree.[176] As a larger issue, Dr. Ajayi mentioned that there aren't many public or private childcare centers, because with high standards "the cost is higher and it's harder to staff."[177] Here, along with Case I, the lack of regulation and/or its enforcement actually fell in favor of the project for its duration, but may compromise the long term viability of the centers if they are unable to meet government standards.

For this project, Burkina's standards required a child-to-caregiver ratio of 5:1, which is quite low.[178] The reason for a 5:1 ratio was because the project served ages 0 to 6 and the ratio for ages 0-2 is much lower than the ratio for 3–5-year-olds, so that ended up requiring a lower overall ratio.[179] Dr. Ajayi also added that "very few childcare interventions focus on 0 to 2 year olds" because "it is more expensive" and impacts the overall cost effectiveness.[180] Serving the 0-2 age range was absolutely critical for the project, as "almost 60% of women in our sample had at least one child aged between 0 to 2."[181] While maximum capacity for each center was 50 children, in the interview with Dr. Friedson-Ridenour, she stated that the ratio "varied substantially between sites," with some having 20-50 children and others having over 100, demonstrating the lack of enforcement of standards.[182]

For this project, GIL involved government ministries from the beginning of the project, including the Ministry of Education, Ministry of Health, Ministry of Women's Affairs, Ministry of Social Services, and Ministry of Petite Enfance, which is for pre-school, but separate from education, according to Dr. Koussoube.[183] Dr. Koussoube also stated, "I think that made really a difference in terms of the support that the providers like receive also, obviously for the sustainability of this type of project, having ministries involved from the beginning is something that is great."[184]

Support Provided: Each of the sites' childcare centers had 7-10 public works participants who were provided a 3-day training to become caregivers for the children (referred to as BAMs, given the French translation of "brigadieres assistantes maternelles").[185] The training was provided by the Ministry of Education and the Ministry of Social Services, and supervisors would also provide "ongoing support and supervision" by checking on the centers and answering questions.[186] A training on cooking/nutrition was also provided to the caregivers since they would be providing food for the children.

Dr. Ajayi noted that this model was "heavily subsidized" and that there was a lot of support, both financial and in terms of government involvement and supervision.[187] Crèche sites received "donations from UNICEF of some of the tents and some of the equipment for kids" and many of the toys were made using "household items that could be recycled into toys" and using "existing resources to create toys and games and learning materials instead of buying things."[188] The "Ministry of Health and local health centers sent health specialists to check vaccination records and set up appointments for further care," adding layered service provision."[189]

Like Case I, parents were asked to "provide a nominal contribution of approximately USD 6 per month," as children received two nutritious meals per day.[190] It was on a voluntary basis, not enforced, and children of parents that didn't pay still received meals.[191] Parents also received information on childcare and nutrition from the "national program for parental education."[192]

ECD, Child Protection, and Nutrition Outcomes: For ECD outcomes, Burkina's mobile crèche model saw an "improvement in both gross and fine motor scores for children" in the full sample

and the subset of children under 2.[193] There were also positive coefficients for children's language scores in both groups, but these findings were not statistically significant.[194] In qualitative work performed after project end, Dr. Friedson-Ridenour also stated that parents mentioned their children "were more enlightened, they were able to speak better, have better social skills, were more respectful,…they were learning and singing, and all these things in daycare."[195] Dr. Friedson-Ridenour also mentioned "all of these positive child development things absolutely were not happening when they were cared for in home environments or with family members, or in these alternative care situations."[196]

Child protection at a basic level was met through the mobile crèche model, in that it was a safe space for children away from weather, hazardous work sites, and potential accidents. Parents really valued the child protection aspects of the Burkina model, as discussed by Dr. Friedson when she stated:

> "Women really highlighted how safe these crèches were…they talked about feeling almost like at ease and relaxed because they knew their kids were safe. They knew where they were. They knew that they were being watched, that they were being attended to, you know, that if they went to the bathroom, that they would be cleaned, that they would have something to eat and that they wouldn't be wandering around…That was the biggest thing that like our children are safe and we trust that they're okay versus even leaving a child with a grandparent or a neighbor. They just never felt at ease with the idea that their children were well attended to. And they gave lots of examples of bad things that had happened. And so I think like the child protection side of it is super important, both in terms of the childcare spaces being safe and also the alternative being unsafe."[197]

Dr. Friedson-Ridenour further detailed "the real dangers of not having access" to childcare when stating:

> "in the absence of childcare, women talked a lot about how dangerous it was for children. So the dangers of bringing a child to a workplace or even the dangers of watching a child at home while working. You know, in these informal settlements, people often live in compound houses together, and it's very hard to keep kids contained and gates closed when you're also trying to multi-task working. And they talked about kids wandering out and getting lost. In rainy seasons, they have these shallows – there's like these deep holes that fill with water. They talked about kids drowning when they're not like closely watched."[198]

The parents also talked about nutrition and how their kids "got food" and that "was a real benefit for them."[199] Dr. Ajayi mentioned that for the project, "we weren't able to do anything like anthropometrics," noting that a "big challenge with COVID was that we weren't able to directly assess the kids."[200]

Model Sustainability: After the public works project ended, the childcare centers stayed in operation and caregivers were paid the same salary for every month of operation after the public works project ended.[201] At this stage, the centers were open to the general public, open for a full day, as opposed to 6am/8am to 2pm, and childcare had a cost to parents.[202] Childcare cost was a sliding scale model that charged approximately CFA 6000, or USD 9.52, for non-project participants/general public and CFA 1500, or USD 2.38, for those that were previously a project

participant.[203] Since the public works project targeted the poorest population in the area, the subsidization was also aimed to help the same population and facilitate continued usage of the childcare services.

While the centers stayed open, they were no longer "mobile" as they did not have a public works site to follow and program participants (parents) were "no longer guaranteed employment through the public works program."[204] Dr. Ajayi pointed out that "the types of employment opportunities available for women" who participated in the project "were really sporadic, so unpredictable and typically low paying" and so, "very few of them were able to afford…to put their kids in the childcare centers once the public works ended because they didn't have a guaranteed income source."[205] Due to these reasons, after the public works program ended, demand dropped significantly.[206]

Dr. Ajayi and Dr. Koussoube published a supplemental brief on the correlates for households that continued to use the childcare centers after project end. They found:

1. Increased usage for households with higher wealth.
2. Increased usage for mothers with more formal education.
3. Decreased usage for mothers who had any form of childcare support available.
4. The biggest predictor of using one of the mobile crèches was whether the mother was a caregiver at the crèche.[207]

Caregivers being the most consistent users of the crèches indicates how critical location is for users of childcare, indicating that continued usage occurs when work and childcare are collocated or located nearby.[208] While not examined in this paper, these findings have big implications for both employer-supported childcare models, where work and childcare are collocated, and for livelihoods programming, where programs implemented *with* childcare models can increase usage.

Monthly operating costs for each center were approximately USD 16.6 per child when "used at the full capacity of 50 children per center."[209] The estimated treatment on the treated (TOT) effect on participants' monthly earnings with an increase of USD 23 for the full sample and USD 25 for the subset of women with a child under 2.[210] However, there was substantial variation across centers, whether below, at, or over capacity; the average crèche had 33 children, resulting in operating costs per child being USD 25.2.[211] The relatively high cost per child can be attributed to the Burkina crèche model catering to children under 3, lowering the child-to-caregiver ratio, and decreasing cost effectiveness.[212] The lower cost effectiveness attributed to the younger children served by the childcare program is apparent when compared to community-based preschools in Mozambique.[213] In the comparison program, the preschools only served ages 3-5, and had a child-to-caregiver ratio of 15:1, resulting in a cost of USD 3.09 per child per month.[214] The care provided in the comparison case was also of good quality, as children increased their child development scores by 0.33 standard deviations[215]; Dr. Ajayi and Dr. Koussoube further state that these results imply that the Mozambique model was "three times as cost effective" as the Burkina model.[216]

Opportunities for Support or Innovation: Because this model did really well when parents had guaranteed employment/income, one way to support providers using the mobile crèche model would be to partner the mobile crèche model in tandem with work-based safety net programs, or other sites where the model makes sense, such as "as agriculture projects, refugee camps and outdoor work sites in general."[217] The WB has continued to do this, as was the case for a safety net program in Ethiopia, however the program was suspended due to conflict.[218] If replicated, it

would be critical to make sure there is some mapping of participants' households as part of the project so that when handing over the project, it will eliminate one of the challenges discussed in the following section, location of the crèche once it was no longer "mobile."

Another form of support could be in the form of procuring a space for continued usage after project end. Dr. Ajayi stated:

> "the big challenges are finding additional sources of support, so that families don't have to cover the full cost of care…When this did happen, and it worked well, were when the local municipalities either offered continued space, that they that could be used as a childcare center or offered to cover the cost of the caregivers or paying their salaries. Sometimes they offered to provide some support for the food, for the snacks that were given to the kids."[219]

This quote highlights the opportunity to support providers through in-kind donations, in addition to financial support. In-kind donations allow providers to minimize costs and minimized costs may allow the center to sustain itself, acquire savings, and become more resilient to cash flow inconsistencies. Dr. Friedson-Ridenour also mentions in-kind donations as an opportunity for support when stating, "you can imagine a situation where the government provides the physical space in an already available building, and then the NGO or the private entity isn't paying rent. That's a huge benefit in an urban setting, not to be paying rent on a building."[220]

Dr. Ajayi highlighted training as this project's most vital form of support by stating:

> "Yeah, I think the training is huge because it is like a transfer of a skill that the caregivers can use in this context, or if they want to go provide care in their homes in a different space… I think the skills are useful. And it also provides a way for them to transfer it to other people in the community because that was the plan – that these caregivers who are running the childcare centers offered sessions for parents as well. And kind of cascaded the knowledge – the same curricula – they had gone through and shared those insights, not just on stimulation with kids, but things like nutrition and the importance of vaccination and that type of thing. So yeah, training people in the community to run the centers, but then also to share that with other people in the community, I think is a big one."[221]

Dr. Friedson-Ridenour also emphasized training when explaining that not only is it critical when caring for children, but that it also elevates the confidence of the caregivers as professionals.[222]

Dr. Ajayi also mentioned that the complementary nature of the public works project provided participants/parents with training on job searching and entrepreneurship, which is valuable in helping participants think about how they can use the money from the safety net program.[223]

Lastly, Dr. Friedson-Ridenour mentioned that NGOs could have a role in "linking" or brokering relationships for childcare centers with governments or even employers – to promote employer-supported childcare – to create relationships that are "mutually beneficial."[224]

Challenges: Through Dr. Friedson-Ridenour's qualitative work with her WB colleague, Dr. Rachel Pierotti, they find that after the public works project ended, the project participants really valued the childcare services and that the demand for the centers still existed, but that there were challenges that caused usage to drop dramatically.[225]

Dr. Friedson-Ridenour mentioned one of the largest challenges was finding a sustainable funding model, as even the heavy subsidization kept the crèches out of reach for the poorest populations served by the project. The unsubsidized rate was half or less of the rate of other crèches in the area, which were 2 to 5 times more expensive, and the project participant rate was "a fraction of the cost."[226] Dr. Friedson-Ridenour explained that for the extreme poor, still the subsidized rate was "too much" and that even though the development community would likely consider the rate "affordable" for users, "it just wasn't for the extremely poor."[227] She further noted that the sustainability of funding for this model is not a "settled issue," because at the time of the qualitative work, the crèches were struggling, and for the "poorest of the poor to have access, it has to be virtually free, which these weren't."[228]

The next challenge was location. After the public works project ended, former project participants may not be traveling to the same part of town, but more critical was that once the crèches were no longer mobile, the locations of the stationary crèches were decided based on "accessible, available spaces rather than maybe the ideal location for recipients."[229] Therefore, locations close to prior project participants were not the primary concern, especially given that the crèches would also be serving the general public.[230]

Additional challenges included mismatched crèche operating hours with the work hours for individuals working in the informal sector, perceptions that childcare centers funded by user fees are just out of reach for the poor, and that while "not unique to Burkina," the "inconsistent payment sometimes of their salaries" that "are not high to start with…is very common across school settings, even in government-run schools."[231]

Other Findings: Again, similar to Case I, the interviewees encountered negative discourse, where people questioned why there needed to be childcare in low-income settings and believed misconceptions, such as that the poor relied on their social networks or relatives for childcare and that there was not demand in these settings. Dr. Ajayi mentioned that often the participants were nuclear families removed from the social and familial networks in urban areas.[232] Another misconception noted by Dr. Ajayi and Dr. Friedson-Ridenour was that women don't want childcare or that there are norms against letting other people watch over your kids, but they both noted that from their findings, this simply isn't true as long as the children are well cared for.[233] The data supports high demand for childcare in this case.[234]

While this model has encountered challenges, it has rapidly spread in many countries across Africa. Cameroon, Madagascar, Ethiopia, and DRC, among others, have either implemented or are planning to implement the mobile crèche model in their respective countries.[235] Looking at expansion critically, one important finding noted by Dr. Ajayi was that for the crèches implemented with public works projects, the regularity at which the public works projects operate will have implications for the regularity at which the childcare center operates and for the consistency in income for both groups.[236] For example, Dr. Ajayi noted that other public works project only operated one day a week, resulting in the same for the childcare center, and that it resulted in daycare providers having an inconsistency in their work schedule and income.[237]

Case III: Social Franchise Model

Model and Case: The social franchise model, and two social franchises in particular, have made a huge impact in revolutionizing childcare in Kenya. This model, unlike the first 2 cases, seeks out existing daycare providers to provide them with the resources to increase quality and once they

complete the training and meet the organization's quality standards, they can use the organization's name as a "signal of quality" to users.[238] The resources for the providers include ECD training, nutrition training, business training, small loans and/or grants, teaching materials, toys/equipment, food, access to communities of practice, ongoing mentorship and support, and access to an app that allows providers to track attendance and income.[239]

Prior to the social franchises in Nairobi, childcare centers in the informal settlements were described as often being "a dark 10 foot by 10 foot corrugated metal shack, smelling of urine and feces and absent of the usual joyful noise of a group of children" or as a large room with 2 dozen babies lying on the concrete and all awake, but silent.[240] Both social franchises formed in response to the substantial need for quality improvements and franchisees are either self-scouted, identified by community health workers, or referrals from existing franchisees.[241] While Kenya is a lower middle-income country and would not typically be considered low resource, the exemplary cases' target populations are in the settlements, or slums, of Nairobi and constitute a low resource target population.[242] Notably, over 60% of Nairobi's urban population resides in the informal settlements and often, the childcare provided is substandard, unregulated, and provided by women who "have not had any formal training in childcare."[243]

The need for quality improvement led to the formation of the exemplary cases, Kidogo and Tiny Totos, both social franchises started in 2014 in the settlements of Nairobi and currently expanding in the East Africa region. They share many commonalities and so they will be examined side-by-side, as opposed to sequentially. The social franchise model described is informed both through the documents analyzed in Appendix A and interviews with: Dr. Anne Fitzpatrick, an Associate Professor of Development Economics, and Dr. Emily Beam, an Associate Professor of Economics at University of Vermont, and Patricia Mwangi, Assistant to the CEO of Tiny Totos.

Dr. Fitzpatrick and Dr. Beam specialize in rigorous causal evaluations and large-scale randomized controlled trials; they are currently conducting an evaluation of Kidogo's model with Innovations for Poverty Action (IPA). For their evaluation of Kidogo, they are going to perform a clustered randomized controlled trial of 51 communities in 11 different counties. Providers are eligible as long as they care for at least 5 children under the age of 3 and charge a fee for at least some of the children.[244] Midline data will be collected June 2025 and endline data June 2026.

Providers for both franchises serve children ages 6 months to 5 years. Franchises often have community partners to help identify existing informal daycare centers (center-based, home-based, or school-based) that would be good candidates for becoming franchisees. After eligibility is determined, daycare service providers can opt into the improvement program offered by the franchise, which includes a training or "bootcamp," a probationary period, the opportunity to become a franchisee if quality standards are met, and ongoing monitoring and support to the franchisee. These improvements are critical, as "children aged 0-5 in low-income settlements suffer from inadequate access to clean water, electricity, and health facilities, as well as poor nutrition, education, and sanitation services."[245]

Regulatory and Legislative Environment: Childcare in Kenya is largely unregulated, as "county governments lack a legal and policy framework within with to provide adequate support to ECD services for children aged three and under."[246] Additionally, "there are no government agencies or private sector associations focused on the regulation or improvement of informal care centers" and "no social protection schemes cover childcare and childcare workers, creating a risk for businesses

that operate in the sector."[247] For any legal childcare businesses, they have to operate under a business license, as opposed to a childcare license, making licensing a very expensive process, and resulting in many providers operating informally.[248]

Because of high licensing costs and a lack of government infrastructure, Dr. Fitzpatrick highlighted how informal childcare businesses in Kenya "operate in this really gray area legally, and so, they are not really allowed to come out and advertise, they're not really allowed to operate freely, and they're doing incredibly important work in the communities."[249] She added, "if they are too public and too open about their profession, the Government will shut them down" and that "the government will come in and do raids and shut down the entire market, which doesn't actually solve the problem."[250] After the government shuts down informal childcare centers, it just "kind of makes everybody stop providing childcare for some amount of time" before resuming operations.[251] In the context of Dr. Fitzpatrick and Dr. Beam's evaluation, she noted that the government has shut down childcare businesses in whole areas, which has been challenging at times for their research.[252] Dr. Fitzpatrick did add that the government is expanding access to ECE, as public preschools are growing and there is kindergarten, but that "it's expensive to do properly" and there's a "dearth of regulation."[253]

With the lack of regulation, there is no standard child-to-caregiver ratio for ages 0-3, and when exploring two informal settlements in Nairobi, the Africa Population and Health Research Center (APHRC) found ratios ranging from 8:1 to 32:1.[254] APHRC also found that majority of center- and school-based providers received some ECD training, while only 20% of home-based providers received ECD training.[255]

Support Provided: Tiny Totos provides a 1-week (5-day) training to daycare providers on ECD strategies for play-based learning, teaching methods, health/nutrition, and other critical ECD components.[256] After the training, providers are subject to a 6-month probationary period where indicators related to safety/safeguarding, ECD, nutrition, technology, and business operations are tracked monthly before the center can be a confirmed partner.[257] Centers that meet Tiny Totos' quality standards at the end of the probationary period then have the opportunity to become a franchisee.[258]

Tiny Totos' business/entrepreneurial training is offered separately and covers components of business management, such as proper price setting for services, cash flow management, reinvesting, tracking financials and food sales, and diversification of services.[259] For example, some providers have diversified their services to include offering diapers, meals, and taking children for vaccinations or a haircut.[260]

Tiny Totos buys food and supplies, such as aprons and first-aid kits, in bulk and then resells it to providers at a heavily subsidized rate.[261] One example is the porridge that Tiny Totos sells to providers that is corn and soy-based, fortified, very nutritious, and fast and easy to make – and this porridge is now being offered to parents for purchase as well.[262] Most recently, providers can now obtain additional services, including clean cook stoves and water filters.[263] For a small fee, providers can also visit Tiny Totos centers to make toys from reusable materials and create charts/posters to hang in their centers.[264] Support is also offered to providers in the form of small loans/access to capital, as it gives providers funding to make infrastructure improvements, obtain a product loan, like a smartphone to track their business, or expand their center.[265]

Kidogo, on the other hand, has 3 full days of up-front training and then spreads the remaining trainings and coaching visits out over the course of a 3 month accelerator (formerly 6 months).[266] The trainings similarly cover topics like ECD, safety and health, business training, bookkeeping and creating teaching and learning materials, and the 3 month accelerator cost is approximately USD 5 per provider.[267] During this period, providers also receive bi-weekly coaching visits from Kidogo staff to provide guidance over the course of the program.[268] At the end of the program, centers that meet Kidogo's standards are invited to become franchisees and receive a "starter kit," (valued at USD 350) that consists of facility renovation, a hand washing station, first aid kit, learning materials and resources, branding materials, and access to Kidogo's app.[269]

Kidogo also partners with community health volunteers in conducting growth monitoring, monitoring overall health and nutrition levels, and referring malnourished children to health services so that a health professional can recommend a course of action.[270]

When discussing Kidogo's food provision, Dr. Beam stated, "food seems to be a really big part of the daycare story. When we were visiting different centers, one of the principals remarked that on the day that Kidogo, at one point they were providing eggs, on egg day, attendance shot up because parents wanted their kids to get that source of protein."[271] Both franchises provide workshops to parents on nutrition and, Tiny Totos even has an in-house nutritionist to promote a nutritious diet to providers and parents.[272]

Both franchises value peer-learning groups, or communities of practice, where providers meet to talk about their successes and challenges so that providers can learn from one another. Peer-learning can also motivate providers to improve their businesses when they see others' success, evidence of improvement over time, and can offer that evidence to parents. Importantly, Kidogo's community of practice fosters accountability, belonging, and leads to higher retention rates.[273]

Both franchises also prioritize ongoing monitoring and support for their franchisees. For Kidogo, franchisees receive mentorship, coaching, and quality assurance services and providers pay USD 5-15 for this ongoing support.[274] However, this monthly fee is not strictly enforced and "only approximately half of providers pay their monthly fees on time."[275]

As Tiny Totos has scaled up, they have had to reduce the number of support visits to daycares and make the visits more meaningful by helping with the app and finance, ensuring safeguards are maintained, and monitoring the growth and overall health of the children.[276] Tiny Totos conducts both scheduled visits and spot checks, and staff members that conduct the visits rotate on assignment to ensure visits are objective and biases do not influence whether a center meets the quality standards.[277] There are tier 1 and tier 2 daycares at Tiny Totos, of which tier 1 are the model daycares that meet all quality standards and tier 2 are daycares that are working to meet the standards but aren't quite there yet.[278] If the quality of a tier 1 daycare falls, they are immediately demoted to tier 2 until they can consistently meet the standards again.[279]

A different form of ongoing support provided by Tiny Totos is support for parent meetings, which are similar to the American concept of holding an "open house" or "back to school night."[280] For parent meetings, providers invite the parents to the daycare center so that parents can visit, see the space their child will be in, meet the provider, and then often a Tiny Totos representative is present to help explain concepts or answer questions.[281]

Kidogo and Tiny Totos each have their own apps for their providers, and they serve multiple purposes. First, they offer a way for providers to track their business, attendance, and cash flow.[282] Second, it allows the larger organizations to retain that data on attendance and profitability, and to combine it with their data gathered in the field to create a more complete and comprehensive assessment of each center and the health of the greater network of centers.[283]

ECD, Child Protection, and Nutrition Outcomes: When asked about the top three things they liked about their daycare (a Tiny Totos center), parents named childcare quality, safety, and health/nutrition as the top reasons for attending their center.[284] At Tiny Totos, ECD outcomes are demonstrated in terms of children's conduct, temperament, leadership, and willingness to help.[285] In addition, when looking at CREDI scores, 80% of children were considered "developmentally on track" at baseline (23% of which were above average and 32% were at-risk), while 83% were developmentally on track after 12 months at a Tiny Totos center (40% of which were above average and 19% were at-risk).[286] And as of 2024, 85% of Tiny Totos kids were developmentally on track.[287] Over 80% or higher of parents surveyed by Tiny Totos have noticed high improvements in cognitive skills, language development, mood, social skills, and motor developments.[288]

Approximately 80% of children in Kidogo childcare centers are considered "developmentally on track," and in an evaluation conducted by Aga Khan foundation, Kidogo kids scored higher than their peers, "including a 9% differential in executive function and a 44% differential in emotional regulation."[289]

Regarding child protection outcomes, Dr. Fitzpatrick noted that "people definitely reported concerns in terms of like safety and child development about leaving their children with relatives."[290] Additionally, there have been drastic improvements in child protection outcomes in terms of health, safety, and exposure to sanitary environments relative to the example provided in the beginning of this case, noting a dark room with unsanitary conditions.

Looking to the impact on nutrition, Tiny Totos noted a 23% decrease in the number of children referred to local health authorities for malnutrition.[291] And Kidogo's overall health and nutrition interventions have led to a 41% reduction in stunting.[292] Tiny Totos helped providers diversify their services to sell food and now 88% of their providers do.[293]

An incredible outcome for nutrition was demonstrated through Kidogo's egg program, in which "the biggest impact was seen amongst children aged 0-2, as the enterprise found a 56% reduction in stunting and a 51% reduction in wasting over a 9-month period as a direct result of Kidogo's egg nutrition intervention."[294] Children aged 0-3 receive 2 eggs per week at Kidogo centers.[295] This program was originally piloted in 2019 and then formally implemented in 2021 due to it being a "simple, easily accessible, and cost effective way to increase protein intake."[296]

Model Sustainability: Kidogo describes its structure as a hub-and-spoke model, in which Kidogo's Centers of Excellence are the hubs that demonstrate best practices and host training, while the independent daycare providers are the spokes.[297] All of the spokes in Kidogo's case are self-sufficient businesses and are capable of operating independent of the hubs; the hubs are not self-funding, in that in 2022, 96% of their funding was obtained through philanthropic grants and the remaining 4% of funding was comprised of the fees paid to the hub by franchisees.[298] For Tiny Totos, nearly 100% of their hubs' funding was grant-based in 2022, but by diversifying to sell advisory/technical services and products in 2023, they have reduced their grant funding to 87% and maintained at 87% in 2024.[299]

While both Tiny Totos and Kidogo, as organizations, started out small, they have both grown physically and financially over the last 10 years. Tiny Totos grew its organizational network of providers by 130% in 2023, while costs only grew 54%.[300] Tiny Totos credits their ability to expand to operational and cost efficiencies through the use of technology platforms, and their app in particular[301]; these efficiencies reduced Tiny Toto's gross costs by 29% per child and 42% per daycare, "while not hiring any new field staff."[302] Similarly, Kidogo's revenue in 2015 after its first year was only USD 82,550 with 37,051 in expenses, while in 2023, its revenue was USD 5,569,247 with 3,063,456 in expenses.[303] For the organizations to provide services to providers, there is usually a higher cost up front per provider due to the initial investment in training and supplies that is almost entirely covered by the organization, but after the first couple months, costs decrease to approximately USD 10-15, which is theoretically covered by the franchisee fees.[304]

Kidogo's childcare centers cost less than USD 1 per day per child to parents.[305] Even still, providers that joined Kidogo saw their revenue increase by 53-197%, with home-based daycare centers seeing the largest revenue increases[306]; the increases were attributed to better financial tracking, increased enrollment, and improvements in collections.[307] In addition to increased profitability, Kidogo has a franchisee retention rate of 90%.[308]

In 2023, 90% of Tiny Totos centers were profitable for providers and 88% of centers in 2024.[309] Average childcare revenue per Tiny Totos center is approximately USD 103 per month, but there are seemingly ebbs and flows related to the holidays, whether school is in session for older kids, etc.[310] Average revenue from selling meals per Tiny Totos center per month is an additional USD 28, following a similar ebb and flow pattern to childcare revenues.[311] Tiny Totos saw a network attrition rate of 5% in 2023.[312]

Both Kidogo and Tiny Totos have rapidly expanded their organizational footprints in the last 10 years. Tiny Totos expanded to Ethiopia last year, is testing its model in Uganda and Rwanda, and has an arrangement with Tanzania to use its app.[313] Within Kenya, Tiny Totos expanded beyond Nairobi to other cities in peri-urban and more rural areas across 6 different counties.[314] The use of technology has been critical to Tiny Totos' expansion, particularly WhatsApp and their Mtoto app, which allows providers to track attendance and business performance, access e-learning modules, confirm trainings, report issues, and follow announcements and events.[315] Tech has further allowed Tiny Totos to become data driven by highlighting trends, identifying challenges across locations, and allowing the opportunity to more specifically target their interventions.[316]

Kidogo has also expanded to 12 counties across Kenya, is engaging in government partnerships, partnering with vocational schools in Kenya, partnering with a bakery in Rwanda for employer-supported childcare, working in Rwanda to open a Center of Excellence, providing services to World Vision in Ethiopia, and advised the WB on replicating Kidogo's model in the Republic of Congo.[317] Also of importance, Kidogo has "partnered with companies in East Africa to provide on-site or near-site childcare for employees in factories, offices, and plantations."[318]

Part of Dr. Fitzpatrick and Dr. Beam's evaluation of Kidogo will include identifying correlates for successful daycare providers that have been able to sustain their business and their first comprehensive follow-up will be in summer 2025.[319] Tiny Totos noted that the providers and centers who received referrals, had high parental engagement levels, completed business training, invested in their centers with small loans, and consistently met quality standards were the centers that have been able to sustain their businesses consistently over time.[320]

Opportunities for Support or Innovation: In 2023, Tiny Totos providers identified the forms of support they appreciate the most as: 77% identified ECD training/Early Learning Programme, 70% nutrition training, and 66% business training.[321] In 2024, those three forms of support were reaffirmed in the same order by the Kenya centers, while Ethiopia's centers valued being part of a network, educational training, and nutritional support the most.[322] Continuous training and professional development for providers is critical in maintaining high quality standards and a real opportunity for continued support to providers.

For the social franchise model, Dr. Beam noted that a critical opportunity for support is through "external support" and funding.[323] She further noted that Kidogo has really benefited from external support to run their program, but of equal importance, it has allowed Kidogo to be able "to do these sort of iterations."[324] She further noted that this could be in the form of formal research questions and causal evaluations, or as simple as A/B testing to "to just see what works."[325]

Building off of Kidogo's egg program that yielded substantial nutrition outcomes for children, Dr. Beam also mentioned that food provision is another opportunity for support, whether it is "helping develop more effective nutrition programs, whether that's either like literally providing some nutrition or working with providers to be like 'here's a low cost way you can improve.'"[326] Providers may also be able to charge a little bit more if it is a "high protein, nutritious snack," as it "would be really useful, and it's also highly demanded by parents."[327] Additionally, if Kidogo's egg program is any indication, it could also result in more consistent attendance at the childcare center in an effort by parents to supplement their children's nutrition.

Similar to the other models explored thus far, an opportunity for support mentioned by Dr. Fitzpatrick was a "way to liaise with the policymakers, to allow for a more formal childcare system to operate."[328] Kidogo has been talking with the First Lady of Kenya and some policymakers "about trying to give childcare a space of its own in the legal framework."[329] Kidogo has greatly impacted childcare in Kenya, and it took almost 10 years to really get policymakers' attention, so for social franchises in more nascent stages, helping bridge these gaps with government is a huge opportunity for NGO support.

Lastly, several different people mentioned in the interviews conducted for this brief that yes, the social franchise model is great, but that it is only feasible in large population centers with the ability to scale up. This idea doesn't necessarily need to be the case but may certainly be the reality depending on the operating environment. Tiny Totos and Kidogo have already expanded to counties outside of Nairobi, and Tiny Totos has expanded to rural areas by using technology to reach populations further away and eLearning will be coming in 2025 to make learning material more accessible.[330] When asked about how this model could be adapted to more rural environments, Elise Williams, an ECD consultant who works with an international financial institution, suggested leveraging other services, programs, or interventions already reaching children and their families in these areas. These entry points could include primary schools, health centers, parenting programs, community spaces, public works programs, etc. Even if these programs lack in infrastructure, they can still offer networks or gathering points to raise awareness and engage families.[331]

With the promise of technology and by leveraging existing infrastructure, rural environments may be more of a space for innovation. It is not implied that a model should be forced to work where it

doesn't, especially given the variety of models available, but the potential for adapting the social franchise model to rural environments does not seem too far in the future.

Most importantly, further clarification is required in this debate, as a clear definition of "rural" is needed to determine how it is being defined and to ensure all are talking about the same type of environment when assessing the social franchise business model's viability. A standardized measure of rurality would provide both context and vital information in terms of market size. In some rural areas, formal childcare may not exist – as in the DRC community-based model. If a social franchise could be adapted to rural environments and wanted to move into areas with nonexistent childcare supply, the hub would likely have to take on much more of a "recruiter" role to find people who want to start childcare businesses, and this component would likely increase costs for the hub. It would also change the model from how Kidogo and Tiny Totos utilize it, in that it would no longer be focused on quality improvement of microbusinesses, but also now on the establishment of microbusinesses.

Challenges: One of the main issues facing informal childcare providers and the social franchise model in Nairobi was previously discussed in the section on the regulatory and legislative environment. With the government raiding and shutting down childcare centers in the informal settlements, where over 60% of Nairobi's urban population lives, income streams are disrupted for providers and the parents of children that attend the childcare centers, as they no longer have childcare, and childcare options become sparse, especially if the raids shut down centers in an entire area.[332] As a further detriment, regulatory agencies in Africa can be rent-seeking and in this case, may attempt to extract bribes from daycare providers. While Kidogo acknowledges on their website that they do not pay bribes or tolerate corruption, it must be acknowledged that corruption will be a challenge to overcome with both shutdowns and regulation.[333]

Overcrowding of children is another issue seen in some daycares, as Dr. Beam visited a school-based daycare in Nairobi and stated:

> "it was a school that had a daycare and they were operating like in a very large room, but there were so many children with respect to the room, that as a child, you would have a seat at the table where you could sit, and you could do your work, and all this sort of stuff, but there really wasn't any more room than that for you, so like you couldn't really go sit on the floor and go do something else. When the children were napping, they napped in their seats. They just sat and put their heads down. They had lunch there. They did everything there because that was how much room they had. Like that limited a lot of what you could do."[334]

A significant challenge that persists under the social franchise model, and largely childcare models as a whole, is that, as stated by Aatif Somji, who studied Kidogo in his own brief "So there's an incentive from a business perspective, as a business owner, to get as many children as possible, without increasing the number of caregivers. That ratio goes up, and the quality of care probably goes down. So there's something there that I think still maybe needs to be addressed obviously, from a social franchising perspective, you could say."[335] There is a lot of tension between quality and profitability, and once minimum quality levels are achieved, "subsidies are needed to drive down caregiver to child ratios and provide higher quality care."[336]

Other challenges that the social franchise model faces are sustaining financing for the hubs, integrating courses/training into its app, and working within gender norms.[337] With few funders at

the intersection of gender and ECD, grant funding is limited, and financing in the development sphere is changing quickly.[338] While Tiny Totos is preparing to launch their integrated eLearning on their app, Kidogo is also working on integrating theirs, generating big implications for rural settings in the region.[339] Lastly, gender norms are tough to navigate and Kidogo's founder, Sabrina Habib, has been open with their experience, noting:

> "We do have issues with husbands, sometimes—husbands who see their wives run these thriving businesses from something very small and want to get involved or want to take the money. We're having to develop a new strategy to engage husbands on why this is great. I think we've also had issues with husbands who find that their wives are working too much now and are not home in time to make dinner. So again, kind of dealing with some of these challenges that come with having women that are so confident and empowered. We've had a few mamapreneurs who were in really abusive relationships and were able to detach from their husbands because they have the economic independence now to do so."[340]

One challenge the social franchise model may encounter in different environments was raised by Dr. Ajayi, when discussing the Mobile Crèche case study, when she noted that:

> "In cases like in Kibera, where Kidogo is operating, where you have an urban center that's close to economic opportunities and there's a lot of employment options for women that will give them substantial income, then it does make sense where it is viable to have a childcare center where you're paying money to drop off your kids, and you're able to cover that cost with the income that you're getting. But in a lot of settings and, in the Burkina Faso setting where we did [the mobile crèche model], the types of employment opportunities available for women were really sporadic, so unpredictable and typically low paying, and so very few women from low income households, the type of women who were eligible to participate in the program, very few of them were able to afford or chose to put their kids in the childcare centers once the public works ended because they didn't have a guaranteed income source."[341]

This comment raises an important concern, as it isn't yet known if the social franchise model will be able to operate in areas where people do not have access to consistent employment opportunities or have inconsistent income streams. Inconsistent income makes it difficult to pay for childcare, and while the cost of childcare services was considered low for Nairobi (less than USD 1 per day), this price would most certainly be out of reach in Burkina Faso, where even USD 3 per *month* was out of reach for the poor.

Other Findings: In March of 2025, Tiny Totos released their 2024 Annual Report and some necessary additions are that Tiny Totos spotlighted their child protection measures by stating that they have "secured mental health consultancy support for mothers and managers experiencing extreme stress," have a "partnership and monthly retainer with a local counseling firm able to help deal with complex issues of child abuse and neglect," and that they "work with social workers, health centers, and the police to report cases of abuse or suspected abuse." [342]

Another finding emerged during the interview with Patricia Mwangi of Tiny Totos when she talked about how they have leveraged the use of WhatsApp because it is used for everything.[343] She jokingly referenced that if it's someone's birthday you have a WhatsApp group, a baby shower…

a WhatsApp Group, and a WhatsApp group for just about anything else.[344] She further stated that providers have been using WhatsApp groups for their communities of practice and then Tiny Totos has their own WhatsApp groups as well.[345] In their 2024 Annual Report, Tiny Totos reports that 78% of providers use the Tiny Totos' WhatsApp groups and 95% of providers receive texts from Tiny Totos.[346] Tiny Totos has found a way to leverage not only their own product, the Mtoto app, that is directly related to their business, but has also found ways to leverage technology using existing platforms to support daycare providers.

Case IV: Private, Center-Based Care with NGO Support

Model and Case: The fourth model is private, center-based childcare supported by an NGO. NGO support to private childcare providers, as previously mentioned, can be similar to a social franchise because many of the forms of support are the same. This model is distinguishable by the lack of branding passed onto providers, the provider (childcare provider) and assisting entity (NGO) are separate businesses, and NGO support is typically time limited due to projectized funding. For this model, an NGO also supports existing daycare providers to improve the quality of their services, rather than recruiting individuals to become daycare providers. Providers with this model can be either home-based or center-based, but in the exemplary case for this model, there was a push for providers to have a separate space for childcare provision, external to the home. The exemplary case is Catholic Relief Services' (CRS) project in Lesotho that supports existing childcare providers to increase quality, with the project entitled 'Catalyzing Quality Sustainable and Replicable Daycare Services in Lesotho.' This model's exemplary case currently operates in the "Maputsoe and Thetsane industrial settlements in the Leribe and Maseru districts" of Lesotho.[347] The private, center-based model with NGO support is informed both through internal documents provided by CRS and an in-depth interview with Makhotso Moeletsi, the Project Manager.

The CRS project began as a 3-year project to "transform the quality of care at 30 daycare centers…resulting in improved nutrition, health, and developmental outcomes for children 0-4 years through an affordable and replicable model of quality daycare services."[348] There are numerous components to the project, including infrastructure improvements, training on ECD, nutrition, and hygiene, linking daycares with village health workers (VHW) to layer health and nutrition services, developing a sustainable business model that provides affordable services to parents and a living wage for the provider, establishing Savings and Internal Lending Communities (SILC) to help support parents and providers, advocating for government adoption of childcare center guidelines, ensuring centers' compliance with guidelines, and promoting government support of daycare centers through engagement and advocacy with the Lesotho Government.[349] CRS' 3-year project is in its 2nd year, and is currently supporting 20 day care centers.[350] In each year of the project, CRS supports a "cohort" of 10 day care centers, and while the original intention was to stop support to each cohort at the end of their respective year, the project has not followed that path due to the earlier cohorts needing ongoing support from CRS.[351] Ms. Moeletsi stated that:

> "The initial plan was that we're going to support the 1st cohort of 10 daycare centers, 5 coming from one area 5 coming from another area. Well, after the 12-month period, we should be comfortable to say we did support these people, and they should be able to continue. Then, that was more like our sustainability approach, like we'll provide that support only for the 1st year and going forward we won't. But when we got into implementation and seeing how people are doing, the differences in terms of how they adapt, just receive content in a different way…we

> find that some of the people need that continued support closely…because people are different. We picked that this is not going to work…we have to change. We are forced by the situation. So, what are we going to do? Then, we're like, okay, we are going to ensure that these people are still getting support, but because we don't have the resources, it is not going to be something that we do in an intensive way. It will still be like reducing, like the 1st year you were getting 100% support from CRS and us being available all the time, monitoring. But then going forward, we were like, we'll still be there, but we have to reduce the frequency…So we're still continuing, but not heavily."[352]

The first two cohorts of providers were selected by CRS based on certain criteria, but with the third cohort, CRS collaborated with health centers by "requesting them to identify existing daycare centers and share their details with CRS for selection based on established criteria."[353] All health centers submitted their lists, which are being utilized in the selection of the third cohort this year.[354]

Regulatory and Legislative Environment: Prior to the start of the project, childcare (ages 0-3), similar to the other 3 cases, was overseen by multiple different ministries within the Government of Lesotho.[355] Namely, this project involves the Ministry of Education and Training, Ministry of Health, Ministry of Agriculture, Food Security, and Nutrition, and Ministry of Gender, Youth, and Social Development.[356] Also prior to the project, there were no ECD standards or existing regulations for childcare centers to abide by.[357]

As part of the support offered by this project, CRS advocated to the government on behalf of providers to have one ministry take ownership of childcare for purposes of regulation, oversight, and developing ECD standards.[358] CRS also advocated for the singular ministry, the Ministry of Education and Training, to issue ECD standards and quality guidelines for day care centers to abide by, as the lack of regulation prior to the project resulted in significant variation across childcare centers in terms of formality and quality.[359]

Support Provided: CRS holds various training sessions for day care providers and assistants that focus on day care center activities, nutrition, food preservation, hygiene, sanitation, health and safety, creating safe indoor/outdoor environments free from hazardous objects, making play and learning materials out of reuseable materials, and business training (business model, marketing, development plan).[360] One additional training aimed to foster, "inclusive environments for all children" by focusing on raising awareness of disabilities including "physical, hearing, visual, intellectual, learning difficulties, health, and behavioral challenges"[361]; the training also made providers "aware of the importance and way to support children with special needs daily," as parents often face challenges related to stigma and discrimination when attempting to find childcare arrangements for their children with disabilities.[362] The trainings vary in length based on the content, for example the training on ECD and childcare is a 4-day training, while the business training is a 1.5-day training.[363] For at least the ECD and childcare training, pre-training and post-training assessments are administered to "ensure that people were able to even comprehend or understand the contents of the training."[364] Makhotso Moeletsi, the project manager, stated that before even beginning the training process, she conducts learning needs assessments to identify each participant's gaps in knowledge and whether they have "been exposed to this content" so that she can tailor the training content to focus on knowledge gaps.[365]

Once the content is tailored, the pre-training assessment is administered, followed by the training, and then the post-training assessment. Pre-training assessment scores ranged from 23% to 83% and post-training scores ranging from 61% to 88%.[366] When getting the day care providers' feedback during stakeholder meetings, providers further demonstrated increased knowledge related to disability screening and discussed transformed day care center environments that are inclusive to all children.[367]

A priority of the project was to layer service provision and CRS does this by promoting collaboration between village healthcare workers (VHW) and day care providers.[368] There are 10 VHWs who provide monthly, ongoing growth monitoring and immunization services for the children at the centers, and both providers and parents have expressed that they appreciate the health services provided to the children.[369] Parents noted that they "do not have to miss work for children to get their required vaccines and/or monthly growth monitoring."[370] Healthcare services are provided to the children free of cost – but the VHWs do receive some support from the project.[371] For example, VHWs usually provide services to the community out of their household, but CRS recognized that this structure would require each parent to take their child to the home of the VHW for growth monitoring services and that that requirement would be incompatible with most parents' work schedules[372]; therefore, CRS proposed that each VHW be assigned a childcare center to visit monthly, rather than each parent needing to take their child individually.[373] To help support the VHW with a change in their normal operations, CRS conducts regular stakeholder consultations and provides a stipend to the VHWs since they now have to travel out in the field, buy lunch, and pay for transport to the childcare centers.[374]

To improve nutrition, the project identified stakeholders, conducted training on child nutrition and feeding practices, constructed gardens for vegetable production, conducted training on water, sanitation, and hygiene (WASH) and smart agriculture practices, and established linkages between childcare providers and key ministries to ensure access to food provided by the World Food Programme (WFP) and the Ministry of Education.[375] The project also helps teach providers how to feed the children and what to feed the children by conducting trainings on a quarterly basis, and working with the ministries that oversee food security and nutrition to develop a feeding menu that meets children's nutritional needs.[376] Partnering with the relevant ministries helps ensure the project is not implementing a costly model that the ministries will be unable to sustain after the CRS project ends.[377]

Infrastructure improvements were conducted with day care providers, although to varying degrees depending on providers' starting points. For providers that were providing childcare services out of their home, CRS constructed childcare centers, and for providers that already had centers, CRS would either improve the infrastructure, add an additional room, or improve the outdoor space so that children had a place to play outside.[378] The infrastructure improvements helped bring centers up to the standards that are soon to be implemented by the government, and quality improvements have increased enrollment in the centers.[379] In addition to the project support, providers even had family members assist with the semi-skilled labor needed for the construction or improvements to the centers to help minimize costs.[380] Improvements also included flooring, painting, art, and kitchen renovations, and ensuring there are ramps at the center so that they are accessible for children with disabilities.[381]

Another component of the project is Savings and Internal Lending Communities (SILC), which is a "savings-led microfinance approach that provides a safe place for poor households to save and

borrow to increase their income."[382] SILC helps "protect members' limited resources by shifting their money from poorly protected informal locations (e.g., under the mattress) to investments in group members' businesses," which provides "a positive return (dividend) on their savings."[383] In the context of this project, SILC has been used to help parents have access to cash to pay fees on time, and helped day care providers use their savings to improve their day care center buildings, as a complement to the funding they receive for infrastructure improvements.[384] Combined, the SILC groups have saved approximately USD 33,500. Eventually, these groups will reach the "share out period" where everyone gets paid what they contributed plus their respective dividends and then a new cycle of lending and sharing will start.[385] As it pertains to childcare provision specifically, there has been "a significant reduction in delayed fee payments compared to the project baseline" for those that have participated in SILC.[386] Support networks have also formed to encourage fee payments, as parents now send messages and reminders to each other regarding payment due dates in WhatsApp groups in an effort to decrease the financial stress on providers.[387]

The project has also changed its support structure for providers to increase the overall support available given that project staff are not always available.[388] For the second cohort, two mentors are located in each of the project's two districts, and the mentors were identified as leaders from the first cohort.[389] The project encourages providers to meet with mentors on a quarterly basis so that mentors can assess if knowledge gaps have been filled and whether providers are demonstrating understanding and making necessary changes.[390] Mentors also provide trainings in the local community, distribute information related to ministry food deliveries, and sometimes even monitor the other centers.[391]

ECD, Child Protection, and Nutrition Outcomes: Parents have provided positive feedback on ECD outcomes, for example, one parent with a child that was unable to sit or move their body, provided feedback and appreciation for the care and feeding of their child whose mobility has now improved.[392] Providers have also "transformed the environment" in their centers "to cater for all children irrespective of physical status"[393] And lastly, when checking in on providers, they have been adhering to the child-to-caregiver ratio described in the proposed childcare guidelines being pursued with government.[394]

Child Protection for the childcare centers in Lesotho was a big concern before the project, as Ms. Moeletsi stated that she no longer sees "children dying in daycare centers due to poor nutrition," which is a testament to the nutrition outcomes as well. Ms. Moeletsi recounted that before the CRS project, "providers used to leave children in the households and go out, run the errands, leaving them there, sometimes tied them with the rope on the bed, and leave them" and that there was "emotional abuse…an environment that's very unhelpful." Ms. Moeletsi added, "we're not seeing that happening because we created awareness."[395]

Ms. Moeletsi has also conducted training on how to store toxic substances away from children and even brought the police and fire department to conduct trainings so that providers know what to do in case of emergencies.[396] Other improvements in child protection include improvement in the language used in the presence of children, safeguarding of heaters, eliminating any conditions or practices that could create a negative or abusive environment for the children, conducting police clearances for all childcare providers, and ongoing monitoring and cataloging of children's conditions or accidents that occur.[397] Lastly, the project has a group of identified assistants to help when providers need to hire someone to watch the children while they attend a training or just need additional help at their center[398]; this helps avoid exposing the children to "a number of people."[399]

Nutrition outcomes were very positive, as the project has seen a decrease in child mortality due to malnutrition and related illnesses relative to the number of cases observed prior to the project.[400] Out of all of the childcare centers supported by the project, none have reported any deaths related to safety or malnutrition throughout the life of the project.[401] And out of 27 children that were identified as underweight, 20 have improved to normal weight with proper feeding.[402]

To further support nutrition efforts, gardens were constructed for vegetable production so that the vegetables could be used in the food provided to the children by caregivers[403]; and due to high vegetable production, childcare providers were able to supply parents with produce for use at home and sell extra produce to meet the children's other needs and inject capital into their businesses.[404]

Model Sustainability: The centers that have sustained their services the best have been the centers with the most resources prior to the project and the centers with high enrollment providing a substantial base of resources.[405] Centers that have also participated in SILC have seen progress, in that it offers access to finance to supplement the resources that the project can provide.[406]

Interestingly, the centers in the Leribe district have done better than the centers in the Maseru district, even across the cohorts. Ms. Moeletsi said that while they do not know why Leribe has seen such success, but that she thinks "it is communication. They are able to communicate, to meet, to support one another," while in Maseru, the providers are trying to communicate, but it has not come as easily.[407] Ms. Moeletsi also noted that it could just be the composition of the daycare providers by stating,

> "Maybe the composition of the daycare center providers. Maybe some are good at motivating others, even sometimes good at sharing even the resources, because that's what is happening there. So, I believe there's a difference even when you get in those areas, you'll see that when you say produce vegetables, [Maseru] will have one plot. [Leribe] will be having 3. When you say start constructing, [Leribe] will be like sharing the resources. If, for instance, CRS bought the nails – No, don't buy the nails because I already have them. We're going to share them…I tried as much as possible to do that in [Maseru], but Leribe is doing well."[408]

Over time, the clientele for the childcare centers diversified, but the quality improvements have not pushed out the poor, as the providers were advised that they shouldn't increase their prices due to an increase in quality of services alone.[409] Ms. Moeletsi highlighted that there is a diverse composition of children in the childcare centers, listing children of military, police, teachers, nurses, and petrol attendants, as well as a mixture of children from different income classes.[410]

Another aspect of sustainability that fared well in this case was parental involvement, as CRS "tried as much as possible also to ensure that the parents can visit the daycare centers, participate, support" the centers and their children.[411] As of October 2024, enrollment was at 498 children across 20 childcare centers (cohorts 1 and 2) and training has been administered to over 350 parents of children that attend the centers.[412] Parents have also supported each other in ensuring payments to providers are made on time and that fellow parents attend SILC meetings.[413] Ms. Moeletsi also noted that when there are good relationships with parents, they may be more willing to comply with fee payments and may be more willing to try to understand the reasoning behind fee increases when they happen.[414]

A major sustainability initiative in this project was to create linkages with government ministries so that after project end, the Government of Lesotho, and more specifically the Ministry of Education and Training, would take over the role of training, childcare oversight, regulation, and all other aspects falling in the childcare realm.[415] These linkages are exemplified in the connection made between providers and the Ministry of Health in working with VHWs, the Ministry of Education and the Ministry of Agriculture, Food Security and Nutrition in coordinating food deliveries and creating a comprehensive approach to improving nutrition outcomes.

However, one concern mentioned by Ms. Moeletsi was in relation to a review meeting with government officials to find out how they are preparing for project end, how they plan to sustain the work, and what they find difficult/easy to continue with.[416] According to Ms. Moeletsi, the government officials in the review meeting stated that the way in which CRS provided trainings is different than how the government would and that the CRS trainings are organized, follow a specific schedule, are held on a quarterly basis.[417] Ms. Moeletsi also recalled the officials recognizing CRS's "resources to put these people together outside" and ability to "train them without any challenges," while they did not see themselves as having the resources to do so.[418]

Opportunities for Support or Innovation: Continued advocacy for childcare providers with the Government of Lesotho is a major opportunity for support, as Ms. Moeletsi stated that "yes, were giving this mandate" to the Ministry of Education and Training, but there is no way real enforcement mechanism for providers to ensure that the ministry carries out the agreed upon actions, aside from cabinet oversight.[419] The government funding for ECD is also extremely low while there is also a need to expand the early childhood care involvement unit. On the date of the interview, Ms. Moeletsi noted, "even today, we don't have the standards for childcare, we don't have legislation within the Ministry of Education and Training to support what we are doing… there's still a gap."[420] The project will still need "advocacy for policy," which presents an opportunity for CRS to either do so themselves through project end, and/or find a way to create a unified voice or platform for providers to continue advocacy beyond project end.[421]

Ms. Moeletsi explained that a major gap and opportunity for support is to have training manuals that cater to different literacy levels, by including more pictures and less words, as some of the providers are illiterate and some do not read much.[422] She also noted that the providers who struggle with literacy will be able to understand pictures better and form different meanings than with words.[423] Another opportunity for support also relates to training materials, as Ms. Moeletsi notes that having "some materials that are very short or very small written in the local language" would be helpful so that they don't find themselves having to translate everything.[424]

Challenges: Ms. Moeletsi noted that there was substantial variation across centers in terms of infrastructure, resources, and the respective starting points of childcare centers selected for the project:

> "It could be I have 5 children, while another has 10 children. It means that the income is now different in terms of resources. So, this shows that this person with better income will be able to even do things in a faster way. And sometimes someone may have a child who is able to support financially…while some do not. I remember a case that we're having currently of a daycare center provider living in a shack, as a household. A shack is not even insulated, leaking, and also, smoking after the children, using the very same house, having a very low number of children

> - all those things that are happening, and does not even have support from anybody. So, all these people, they're not able to implement everything at the same time, and they're in different states, some daycare centers have 3 rooms, some 2, some 1, some, you see, were now establishing. Some were operating in the household…and we have to find means of getting them out…So we have to standardize with whatever resources that we're having. Hence, at the end of the day, you'll see that they are at different levels…Even when you look at them, the way they're operating, even when you get in their environment, you'll see that."[425]

There was also significant variation across the cohorts in terms of how quickly providers implemented changes using the resources from the project.[426] For example, the 2nd cohort exhibited a "slowness to construct and renovate buildings due to limited resources besides those that are provided by the project," which delayed the timeline for implementation of improvements, and ended up affecting the training timeline.[427] The 2nd cohort was unable to finish the full scope of the ECD training content and will have to join the same training with the 3rd cohort.[428]

Another challenge that arose later in the project was that there was support provided to the first cohort, including creating outdoor play spaces and installing toilets and cabinets for some, and when you look to cohorts 2 and 3, Ms. Moletsi noted that "they are not in the same position and we have to dig deeper into the pocket, like you need to take out money and do this because there's no more uniformity in these daycare centers."[429] The project did not necessarily account for each cohort being at vastly different starting places and as a result, has requested and received additional funding from CRS to ensure cohorts 2 and 3 get as much support as can be offered within the budget.[430] Ms. Moeletsi still does not think that the additional funding will get cohorts 2 and 3 to the same place as cohort 1, but they are still trying to find ways to help them in any way they can "to close the gap."[431] For example, the first cohort was able to build cabinets and other equipment, and the CRS office in Lesotho is getting rid of some furniture, including cabinets and desks, so those furniture pieces will be donated to cohorts 2 and 3.[432]

Other concerns about limited resources arose when utilizing the services of the village healthcare workers (VHW). As mentioned earlier, CRS provides a stipend for transport to the childcare centers and lunch for the VHWs, but this has become a bigger expense because support to the first cohort never completely stopped.[433] Ms. Moeletsi added that they couldn't stop certain services, like health services, as you cannot say you provided "enough" health services[434]; so now the VHWs attend to more centers and service provision can take more than one day.[435]

An interesting challenge that is seemingly unique to this case is that many of the providers are elderly, around 60 to 70 years old, and younger childcare providers are rare.[436] It is a challenge because older providers do not want to stop providing care, but it is also difficult for them to sit through long trainings, pay attention, and be active enough to play with the children.[437] CRS project staff have tried to have older providers identify one of their adult children who could possibly attend the training and pass on the information to the provider, but it remains a challenge for the project.[438] Early on, there was also some resistance by the older providers to hire any other people to help them and the child-to-caregiver ratios were too high, ranging from 10:1 to 15:1.[439] Ms. Moeletsi said the project aimed to, "make them aware that they need to have assistant day care center providers…as you have 6 children or more, you need to have someone who is assisting." The willingness to hire people has shifted, but it can still be a challenge to pay another person with variable cash flow.[440]

Other Findings: Fluctuations in attendance at daycare centers also cause surges and rushes for VHWs, Ms. Moeletsi noted that this is still better than the VHWs' alternative, which are empty promises from the government to pay them for their services.[441] The government has pledged to pay VHWs but has not fulfilled or sustained that promise.[442] Payments come occasionally when the government has extra funds, but CRS has been able to consistently provide support to VHWs for their services.[443] And while resources for the project are limited, CRS was able to increase the stipend as the number of childcare centers increased for VHWs so that they are compensated based on their time spent.[444]

The CRS project in Lesotho has also been very diligent about consulting, following up with, and incorporating feedback from stakeholders.[445] Ms. Moeletsi explained that stakeholder interviews are "important for us to build on existing experience of people who have been there, and also to learn from them what works and what does not work for some of the things that we brought into this project."[446] Two stakeholder meetings in mid-2024 involved 35 representatives among the key stakeholder groups.[447] These meeting have yielded significant outcomes to the project, such as a strengthened referral systems between day care providers, VHWs, and nurses which has ensured timely health services are provided to children that attend daycare centers.[448] Stakeholder meetings also are the reason behind community health centers helping select the 3rd cohort of daycare providers.[449]

Table 2: Findings Across Case Studies

Model	1. Traditional CB Case	2. Mobile Crèche Case	3. Social Franchise Case	4. Private Provision + NGO Support Case
Location	**Rural, Democratic Republic of Congo**	**Peri-Urban/Urban, Burkina Faso**	**Urban/Peri-urban, expanding to rural, Kenya**	**Urban, Maseru and Leribe districts, Lesotho**
Age Group	**2-6 years old**	**0-5 years old**	**6 mos.-5 years old**	**0-4 years old**
Opportunities for Support	• Continuous training • Nutrition support • Ongoing support and supervision • Layered service provision	• Continuous training • Use in tandem with livelihoods projects • In-kind contributions • Brokering relationships	• Continuous training • External funding to allow test interventions • Food provision • Liaison with policymakers	• More accessible training materials (literacy and language barriers) • Continued advocacy with the Government
ECD Outcomes	• Age 0-4: increased CREDI score 7% • Age 4+: No significant changes in MELQO score • "More independent and less needy"	• Improved gross and fine motor scores • "enlightened" and improvements were not seen in previous care arrangements	• 80%+ of kids "on track developmentally" • Kidogo: 9% differential in executive function, 44% differential in emotional regulation relative to peers	• Parents provided positive ECD feedback • Transformed center environments to cater to all children • Adherence to child-to-caregiver ratio
Nutrition Outcome	• Not measured • Tried to partner with Plumpy'Nut but they didn't serve the area	• Not measured, but parents recognized children were fed and that it was a benefit	• Tiny Totos: 23% decrease in referrals for malnutrition • Kidogo: 41% reduction in stunting	• Decrease in child mortality • 20 of 27 underweight children have improved to normal weight
Child Protection Outcomes	• Improved. Before the project, when it rained, kids would get wet, cold, and sick • Center was safe space away from weather and animals	• Prior to the project, parents brought children to work sites • Provided a safe space away from weather, work sites, and accidents	• Parents had safety and child development concerns when leaving children with relatives • After the franchises, centers were no longer unsafe and unsanitary	• No longer children dying due to malnutrition • Police clearances for all providers • Prior to the project, providers left children at home to run errands
Main Challenges	• Funding constraints required a light-touch model • Difficult to find a project partner	• Subsidies were not enough for the poor • Distance • Hours did not align with informal sector	• Lack of regulation • Raids and Shutdowns • Gender norms • Overcrowding • Quality v. Profitability	• Lack of regulation • Need for ongoing support • Variation in resources • Age of providers
Regulatory Environment and Legislation	• Ratio: 14:1 • May not meet standards due to informality	• Ratio: 5:1 • "mobile" and the temp. nature of project does not require crèches to meet standards	• No ratio. In practice, 8:1 to 32:1 • Needs policy/regulatory framework	• No ratio yet. 6:1 encouraged for project. • Working with government to pass standards/framework
Sustainability	• Correlates: (1) mothers trusted the skills of caregiver, (2) caregivers that stay long term, (3) high number of village committee members • HH income increased by $38 per mo. and average cost of childcare was $16 per child per mo.	• Despite subsidies, demand still dropped • Correlates: (1) higher wealth HHs, (2) more educated HHs, (3) mothers w/o other care options, (4) being a caregiver at the crèche • Income increased by $23-25 per mo. and average cost was $25 per child per mo.	• Hubs are grant-funded, and spokes self-sustain • Still low costs to parents • Both cases have expanded in Kenya and to other countries • Providers are profitable • High retention rates	• Variation in success of childcare centers in different project areas • Communication and pooling resources • Creating linkages with government to promote sustainability after project end • Cultivating strong parent relationships

Conclusion and Policy Recommendations

The four models presented in this brief, while all community-based variations, faced both similar and unique challenges. In concluding the analyses of the cases, there are some clear challenges that need to be addressed, as well as places for innovation, opportunity, and impact on the childcare landscape. The crux of this paper, childcare models that juggle a tradeoff between quality and profitability, remains unchanged and was reaffirmed numerous times through the findings. Looking forward to how lessons learned can be used as opportunities to improve the provision of childcare, the following section contains policy recommendations for Catholic Relief Services.

While it cannot be said that one model is best, they all succeed in certain areas and struggle in others. More importantly they all have a constant struggle between the cost to users, profitability to the provider, and quality of service provision. All the aspects of the models should be carefully considered before implementation and a thorough diagnosis phase should be conducted to see what already exists, what the community wants or doesn't want, what existing infrastructure or services can be leveraged, and what is the most promising and impactful access point for CRS to support childcare providers.

Policy Recommendations to Catholic Relief Services

1. **Work with national governments to advocate for a regulatory system, similar to the "tiered regulations" discussed in the Thematic Findings section, that recognizes variation and multiple levels of quality, creates an enabling environment for providers, and helps uplift providers offering lower-quality care.**
    a. Within a regulatory system that allows for variation, there still must be a bare minimum level of quality that centers must meet to ensure children are safe and protected. The minimum level will likely look different depending on context, as seen with child-to-caregiver ratios, but safety should be top of mind when cultivating the low standard. Certain standards will be universal regardless of context, like children not being left alone, storing hazardous chemicals away from children, and making sure that centers have clean and sanitary environments.
    b. Instead of excluding or punishing providers offering lower-quality services or who do not have specific infrastructure, the regulatory system should offer clear, actionable steps and support to providers that want to improve the quality of their care. The actionable steps will be subject to each individual regulatory system and the resources of governments but should include training, a pathway to improvement, motivating providers to take steps toward higher quality care where possible, and making the standards themselves accessible to childcare providers. Although repeated failures to meet minimum standards should be flagged and in cases of repeated inaction, providers must not be allowed to operate.
    c. Because this type of system will require substantial monitoring, rent seeking and corruption of officials will be a significant threat to good policy, as they may try to elicit bribes when monitoring childcare centers or find other avenues for corruption.
2. **Work with provincial or local governments to leverage existing resources that can ease burdens on providers and create partnerships with government to ensure long-term sustainability.**

   a. Creating partnerships with local and provincial governments can help providers obtain in kind donations, technical support, or establish partnerships that can ensure sustainability beyond the scope of the project. Public-private partnerships are particularly powerful, in that they can strengthen service provision, build relationships, and allow for collaboration, even if not purely financial in nature.
   b. Working with local governments may also help CRS leverage existing infrastructure (i.e. buildings) that the government may be able to loan to the project, high-traffic locations in more rural areas for purposes of establishing childcare (i.e. a health clinic or school), and existing services to make them more centralized for mothers and children using childcare centers (i.e. health monitoring in partnership with the Ministry of Health).

3. **Advocate for one ministry to take ownership of the childcare mandate within the national government.**
   a. Ownership by a dedicated ministry will better ensure coherent, comprehensive funding and policy development and will streamline efforts to improve childcare within a country. The designated ministry will differ across countries based on context and should still consult other sectors where practicable.
4. **Continue and maintain investment in good quality, contextually relevant training for providers and pursue a path/partnership with government to formally recognize the skills of childcare providers and centers that meet certain quality standards.**
   a. Training should be provided, even if brief, to all providers and comprised of content on ECD, nutrition, child protection, inclusive education, and environments for children with disabilities, health, business management, and making play materials out of reusable materials. Other topics may be warranted based on context. Training materials should cater to varying levels of literacy and have translations in local languages where possible. Government involvement should be fostered to build relationships with key stakeholders, cultivate opportunities for layering of service provision, and ensure long-term sustainability.
   b. Training that specifically focuses on ensuring accessibility for children with disabilities is notably uncommon, aside from in Case IV: Private Provision, and should be prioritized to help overcome stigma and discrimination in communities and to help ensure that services are available and accessible for all children.
   c. CRS should work with the government to come up with a way to formally recognize the skills providers obtain through training and centers that meet certain quality standards, whether through a certification system, labeling, or accreditation. Licensing may also be a great next step for governments that have more resources or are seeking more formality in the provision of childcare services.
5. **Encourage collaboration between childcare and livelihoods programs to explore how these sectors can support and complement one another to increase sustainability.**
   a. Arguably one of the most important recommendations, testing collaboration between these sectors will have substantial implications for projects moving forward and a critical opportunity to address the models' economic sustainability given the fundamental nature of paying for childcare services.
   b. CRS has direct control over this policy recommendation and will not have to depend on any external stakeholders for implementation.

   c. Further collaboration could be explored in combination with CRS' Child-Optimized Financial Education (COFE) program, in which CRS provides training to members of SILC groups using "a unique financial education curriculum that supports parents and other caregivers to plan for and meet the basic needs of all children in their care."[450] Caregivers that participated in SILC groups including COFE, "resulted in greater caregiver payment of children's required school expenses compared to participation in savings groups only."[451]

6. **As a minimum standard, all childcare centers should have consistent and predictable food provision for children.**
   a. The way in which centers obtain food will be different, even project to project, for example, the food donations from the Ministry and vegetable gardens in the private provision case, and wholesale from Tiny Totos' hubs in the social franchise case. And it does not need to be an expensive program, because even simple interventions, like Kidogo's egg program, had significant positive effects.
   b. Partnerships should be made with ready-to-use therapeutic food (RUTF) manufacturers, such as Plumpy'Nut, to ensure that providers have a supply on hand for severe malnutrition cases.
7. **Encourage the formation of trade associations to help form relationships, provide opportunities for collaboration and cost-sharing among providers, and advocate for providers as a unified front.**
   a. With the existence of a trade association for childcare providers, the association would be able to maintain the advocacy and work being conducted by Ms. Moeletsi in Case IV: Private Provision. After ministry ownership, the association could pursue the continued advocacy. An association could also be a unified voice for providers if there is rent seeking behavior, corruption, or abuse of power.
   b. In high competition environments, trade associations may not be feasible.
8. **Continue to advocate for (a) funding from donors to promote stronger investment that will expand the sector and increase access to childcare, and (b) awareness of the importance of childcare and the challenges to ensuring affordable access to quality care.**
   a. As evidence and the generation of impactful findings builds in the coming years, CRS must continue to advocate for funding related to ECD and childcare to encourage greater investment by donors in the long-term future of children and communities across Sub-Saharan Africa.
   b. Raising awareness of the importance of ensuring affordable access to childcare and the challenges that impede access to services is critical to gain support and traction with communities and governments. As childcare and barriers to access become bigger priorities for communities and communities make demands of their governments, governments will face increasing pressure to respond with services, subsidies, partnerships, or other actions to help support their constituencies.

Decision-Making Matrix
*No model is one-size-fits-all so this matrix should be used as a discussion starter to assess the local context, not as the answer.
*Low and High Budget are general terms and specific to the organization
*No existing childcare refers to supply of childcare, meaning no childcare providers in the area.

Table 3: Decision Matrix

	Low Budget	**High Budget**
No Child-care	**Low Budget x No Childcare** Projects with low budgets that are operating in areas with no existing childcare market could substantially benefit from the effective, yet low-cost aspects of the **traditional community-based model**, but viability is dependent on the regulatory environment and whether it allows informal models to exist. Could also work if subsidized for users: **Mobile Crèche, Private Provision** **Considerations:** subsidies available, regulatory environment, CRS' willingness to recruit providers	**High Budget x No Childcare** A high-budget project in an area without childcare provision presents two routes that could be taken, (a) CRS could either take a low-cost model, like the traditional **community-based model or the mobile crèche model** and implement it at a much larger scale than that of a low budget project, or (b) CRS could establish comprehensive childcare centers on a smaller scale, similar to the **private provision model**, but also requiring recruitment of providers. **Considerations**: level of involvement desired, project duration, CRS' willingness to recruit providers, demand for childcare, regulatory environment
Child-care	**Low Budget x Childcare** In contexts with established childcare providers, CRS can act as a "hub" to support pre-existing "spokes" using the **social franchise model**. This model eliminates most, if not all, of the need for infrastructure, which reduces cost, and allows CRS to provide targeted support that is tailored to the environment. Could also work: **Traditional Community-Based Model** **Considerations:** demand for childcare, whether existing providers require quality improvements, regulatory environment	**High Budget x Childcare** A high-budget project in an area with childcare provision has two options, (a) CRS could either take a low-cost model, like the traditional **community-based model or the mobile crèche model** and implement it at a much larger scale than that of a low budget project, (b) act as a "hub" to help improve quality of existing childcare centers, similar to both the **private provision model and social franchise models,** and depending on the desired level of involvement, this could be small or large scale. **Considerations:** demand for childcare, whether existing providers require quality improvements, regulatory environment

Appendix A: Documents Analyzed to Inform Interview Questions

Traditional Community-Based Model

Cassidy, Rachel, Roxane Zighed, and Cansu Birce Gokalp. 2023. "Designing and Implementing Low-Cost Childcare Solutions: Lessons from the Africa Gender Innovation Lab." Washington, DC: World Bank. https://doi.org/10.1596/40824.

Donald, Aletheia, Francisco Campos, Julia Vaillant, and Maria Emilia Cucagna. 2018. "Investing in Childcare for Women's Economic Empowerment." World Bank, Washington, DC. https://doi.org/10.1596/30273.

Donald, Aletheia, Sara Lowes, and Julia Vaillant. 2024a. "Experimental Evidence on Rural Childcare Provision," March.

Donald, Aletheia, Sara Lowes, and Julia Vaillant. 2024b. "Experimental Evidence on Rural Childcare Provision," July.

Donald, Aletheia, Julia Vaillant, Francisco Campos, and Maria Emilia Cucagna. 2018. "Caring about Carework." World Bank, Washington, DC. https://doi.org/10.1596/30118.

Fernandez Gorostidi, Irene, Sara Troiano, and Adaorie Felicia Osademey Udechukwu. 2024. "The Catalyst to Unleash Women's Economic Potential in Africa - Childcare." World Bank Blogs. August 2024. https://blogs.worldbank.org/en/nasikiliza/catalyst-to-unleash-womens-economic-potential-africa-childcare-afe-0824.

Nachikodowa CBO Community Based Childcare Centers (CBCC) Data

Neuman, Michelle J., Christin McConnell, and Foster Kholowa. 2014. "From Early Childhood Development Policy to Sustainability: The Fragility of Community-Based Childcare Services in Malawi." *International Journal of Early Childhood* 46 (1): 81–99. https://doi.org/10.1007/s13158-014-0101-1.

Shallwani, Sadaf, Amina Abubakar, and Moses K Nyongesa. n.d. "The Quality of Learning and Care at Community-Based Early Childhood Development Centers in Malawi."

"Supporting True Community-Driven Early Childhood Systems for Sustainable Early Childhood Outcomes." n.d. Firelight Foundation. Accessed December 29, 2024. https://www.firelightfoundation.org/supporting-true-communitydriven-early-childhood-systems-for-sustainable-early-childhood-outcomes.

"The Need to Invest in Community Based Childcare Centres | UNICEF Malawi." n.d. Accessed December 1, 2024. https://www.unicef.org/malawi/stories/need-invest-community-based-childcare-centres.

Mobile Crèche Model

Ajayi, Kehinde, Aziz Dao, and Estelle Koussoubé. 2022. "The Effects of Childcare on Women and Children: Evidence from a Randomized Evaluation in Burkina Faso," November. https://www.cgdev.org/publication/effects-childcare-women-and-children-evidence-randomized-evaluation-burkina-faso.

Ajayi, Kehinde F, Aziz Dao, and Estelle Koussoubé. n.d. "The Effects of Childcare on Women and Children: Evidence from a Randomized Evaluation in Burkina Faso - Policy Brief."

Ajayi, Kehinde, Estelle Koussoubé, Aziz Dao, and P. Rita Nikiema. 2024. "Who Uses Childcare Centers? Evidence From Burkina Faso." https://doi.org/10.1257/pandp.20241013.

Cassidy, Rachel, Roxane Zighed, and Cansu Birce Gokalp. 2023. "Designing and Implementing Low-Cost Childcare Solutions: Lessons from the Africa Gender Innovation Lab." Washington, DC: World Bank. https://doi.org/10.1596/40824.

Currimjee, Alisa, Jem Heinzel-Nelson Alvarenga Lima, and Sara Troiano. 2022. "Childcare Arrangements for Low-Income Families: Evidence from Low and Middle-Income Countries." World Bank, Washington, DC. https://doi.org/10.1596/39717.

Jolk, Rebekka Grun von. 2019. "World Bank on Social Protection in Africa: Burkina Faso Mobile Childcare Scheme Could Transform Public Works." *CFI.Co* (blog). January 23, 2019. https://cfi.co/africa/2019/01/world-bank-on-social-protection-in-africa-burkina-faso-mobile-childcare-scheme-could-transform-public-works/.

The Borgen Project. 2021. "Mobile Childcare in Burkina Faso." BORGEN. May 13, 2021. https://www.borgenmagazine.com/mobile-childcare/.

World Bank. 2021. "Enabling Women to Work and Their Children to Blossom: The Double Success Story of Mobile Childcare in Burkina Faso." World Bank. March 2021. https://www.worldbank.org/en/news/feature/2021/03/08/enabling-women-to-work-and-their-children-to-blossom-the-double-success-story-of-mobile-childcare-units-in-burkina-faso.

World Bank and Umbrella Facility for Gender Equity. 2020. "Results Series: Childcare Goes Mobile in Burkina Faso." https://documents1.worldbank.org/curated/en/121511593447275110/pdf/Childcare-Goes-Mobile-in-Burkina-Faso.pdf.

Social Franchise Model

Aga Khan Foundation, Kidogo, The Aga Khan University, and Daraja Civic Initiatives Forum. 2021. "Building a Brighter Future for Vulnerable Children: An Early Childhood Development (ECD) Policy Brief." https://www.akfusa.org/wp-content/uploads/BBF-Policy-Brief.pdf.

APHRC. 2022. "Early Childhood Care and Development in Rural and Urban Settings in Kenya." African Population and Health Research Center. February 2022. https://aphrc.org/wp-content/uploads/2022/03/Policy-Brief-Early-Childhood-Care-and-Development-in-Rural-and-Urban-Settings-In-Kenya.pdf.

Cartier Philanthropy. 2024. "What 'Entrepreneurship' Means for the Poor." December 2024. https://www.cartierphilanthropy.org/news/what-entrepreneurship-means-for-the-poor.

Currimjee, Alisa, Jem Heinzel-Nelson Alvarenga Lima, and Sara Troiano. 2022. "Childcare Arrangements for Low-Income Families: Evidence from Low and Middle-Income Countries." World Bank, Washington, DC. https://doi.org/10.1596/39717.

Devercelli, Amanda E., and Frances Beaton-Day. 2020. Better Jobs and Brighter Futures: Investing in Childcare to Build Human Capital. World Bank. https://doi.org/10.1596/35062.

Fernandez Gorostidi, Irene, Sara Troiano, and Adaorie Felicia Osademey Udechukwu. 2024. "The Catalyst to Unleash Women's Economic Potential in Africa - Childcare." World Bank Blogs. August 2024. https://blogs.worldbank.org/en/nasikiliza/catalyst-to-unleash-womens-economic-potential-africa-childcare-afe-0824.

Fitzpatrick, Anne, Emily Beam, and Maira Reimao. 2024. "Improving Childcare Quality Through Social Franchising." SSRN Scholarly Paper. Rochester, NY: Social Science Research Network. https://doi.org/10.2139/ssrn.5037817.

Grantham, Kate, and Aatif Somji. 2022. "Childcare Solutions for Women Micro and Small Enterprises." Donor Committee for Enterprise Development.

Habib, Afzal. 2020. "Child Nutrition at Kidogo." Kidogo: Unlocking Potential Through Quality Childcare. May 4, 2020. https://www.kidogo.co/post/child-nutrition-at-kidogo.

Howard, Jill, Fiona Wilson, and E. Hachemi Aliouche. 2020. "Kidogo: Addressing the Childcare Needs of Low-Income Families in East Africa." https://doi.org/10.34051/p/2021.9.

"Impact - Kidogo." n.d. Kidogo: Unlocking Potential Through Quality Childcare. Accessed January 11, 2025. https://www.kidogo.co/impact.

Kidogo. 2018. "Kidogo 2018 Annual Report." 2018. https://issuu.com/kidogo_ecd/docs/kidogo_2018_annual_report_-_final_m.

Kidogo. 2022. "Kidogo Presentation." November 2022. https://africa.unwomen.org/sites/default/files/2022-11/Nov%203%20-%20Kidogo%20-%20Presentation.pdf.

"Kidogo." n.d. Rights CoLab. Accessed March 5, 2025. https://rightscolab.org/case_study/kidogo/.

"Kidogo - Quality Child Care through Social Franchising." n.d. MIT SOLVE. Accessed January 12, 2025. https://solve.mit.edu/challenges/the-care-economy/solutions/59010/application.

Nallari, Anupama. 2021. "Four Innovative Approaches to Childcare in Informal Settlements." *Cities4Children* (blog). 2021. https://cities4children.org/blog/four-innovative-approaches-to-childcare-in-informal-settlements/.

Osman, Botul. 2022. "Home-Based Childcare Centers Plug a Gap in Nairobi Informal Settlements." APHRC (blog). October 5, 2022. https://aphrc.org/blogarticle/home-based-child-care-centers-plug-a-childcare-gap-in-nairobi-informal-settlements/.

"Our Work - Kidogo." n.d. Kidogo: Unlocking Potential Through Quality Childcare. Accessed October 4, 2024. https://www.kidogo.co/our-work.

Republic of Kenya. 2017. "The Kenya Integrated Early Childhood Development Policy Framework." March 2017. https://platform.who.int/docs/default-source/mca-documents/policy-documents/policy/ken-ch-50-01-policy-2017-eng-iecd-policy-framework.pdf.

Spring Impact and Echidna Giving. 2020. "Support Programs for Home-Based Child Care: A Global Study." 2020. https://www.springimpact.org/wp-content/uploads/2021/04/Support-Programs-for-HBCC-A-Global-Study_Full-Report.pdf.

Teti, Claudia. 2024. "The Hidden Economics of Remarkable Women (HERO)." Foreign Policy (blog). November 26, 2024. https://foreignpolicy.com/podcasts/hidden-economics-of-remarkable-women-hero/.

The Care Economy Knowledge Hub. 2022. "Kidogo - Brief." https://www.the-care-economy-knowledge-hub.org/wp-content/uploads/2023/06/49-Africa-Kidogo-V2.pdf.

The Care Economy Knowledge Hub. n.d. "Kidogo." Care Economy (blog). Accessed March 4, 2025. https://www.the-care-economy-knowledge-hub.org/listing/kidogo/.

Tiny Totos. 2024. "Tiny Totos' 2023 Annual Report." Tiny Totos. April 5, 2024. https://www.tinytotos.com/post/tinytotos2023annualreport.

UN-Habitat. 2023. "Kenya Country Brief." https://unhabitat.org/sites/default/files/2023/07/kenya_country_brief_final_en.pdf.

WBG VC Stream, dir. 2021. Better Jobs and Brighter Futures: Investing in Childcare to Build Human Capital. https://www.youtube.com/watch?v=dYj7Pwea8mg.

Private, Center-Based Model with NGO Support

Catholic Relief Services. 2022. “COFE: Child-Optimized Financial Education A Mutli-Sectoral Approach That Support Vulnerable Families to Thrive.”

Catholic Relief Services. 2024. “Catalyzing Quality Sustainable and Replicable Daycare Services in Lesotho - Global Education Fund Progress Report.”

Catholic Relief Services, and Makhotso Moeletsi. 2024. “Sustaining Quality Childcare and Early Childhood Development Services in the Industrial Areas of Lesotho - CIES Presentation Miami 2024.” March.

“Savings-Led Microfinance.” n.d. Text. CRS. Accessed March 23, 2025. https://www.crs.org/our-work-overseas/program-areas/savings-led-microfinance.

Appendix B: Interviewees and Survey Respondents

Interviewee/Survey Respondent	Organization	Model
1. Dr. Aletheia Donald	World Bank, Africa Gender Innovation Lab	Traditional (DRC)
2. Dr. Julia Vaillant	World Bank, Africa Gender Innovation Lab	Traditional (DRC)
3. Marcelline Kibungi	Réseau Provincial des Associations des Femmes pour la Promotion de l'Education (REPAFE)	Traditional (DRC)**
4. Peter Nkhoma	Nachikodowa CBO*	Traditional (Malawi)**
5. Dr. Estelle Koussoube	World Bank, Africa Gender Innovation Lab	Mobile Crèche (Burkina Faso)
6. Dr. Kehinde Ajayi	Center for Global Development	Mobile Crèche (Burkina Faso)
7. Dr. Sophia Friedson-Ridenour	World Bank, Africa Gender Innovation Lab	Mobile Crèche (Burkina Faso)
8. Dr. Emily Beam	University of Vermont	Social Franchise (Kenya)
9. Dr. Anne Fitzpatrick	Ohio State University	Social Franchise (Kenya)
10. Patricia Mwangi	Tiny Totos	Social Franchise (Kenya)
11. Makhotso Moeletsi	Catholic Relief Services	Private, Center-Based w/NGO Support
12. Aatif Somji	ODI Global	N/A
13. Elise Williams***	International Financial Institution***	N/A

* CBO = Community-based organization

** = Took a survey, as opposed to participating in an interview.

***** = Interviewee requested a pseudonym and for her organization not to be disclosed.**

Appendix C: Interview Questions

Traditional Community-Based Model Questions
Interviewees: Dr. Aletheia Donald and Dr. Julia Vaillant

1. Why was this specific community-based model chosen for this project?
2. Would a different business model have worked in this environment?
3. How did the day care centers that continued operating after the project end sustain the model and/or their funding?
4. Given that REPAFE administered the childcare intervention, did they also administer the in-depth ECD training for the caregiver?
5. Was this intervention effective enough to scale up? What challenges would that present?
6. What specific legislation, legal barriers, regulations, or policies did you have to navigate in this environment and context? Safety standards for childcare, ECD standards, standards for childcare workers. (i.e., national guidelines allow a maximum of 14 children per caregiver)
7. What sustainable business models have you seen in the provision of day care services in low- or middle-income countries?
8. Have you seen certain business models operate more effectively in low resource/low wage/low income/rural environments than others?
9. What are the most effective ways that you or another organization have supported female day care service providers?
10. What elements of your support have day care service providers found to be the most helpful? Were you able to survey day care service providers?
11. Did you observe the provision of day care services in DRC being correlated with increased nutrition? ECD outcomes? Child protection? If so, do you have any data that shows that?
12. What unique challenges were present for day care service providers in very low resource environments such as rural DRC? What can be done to overcome these challenges?
13. What can different stakeholders do to help support the provision of day care services? (government, donors, NGOs) How about specifically with the community-based model?
14. Can you share any datasets or documents from the childcare intervention? (funding, enrollment, ECD indicators, etc.)
15. Can you put me in contact with anyone in country (REPAFE) and any day care providers/women involved in the community-based model?

Réseau Provincial des Associations des Femmes pour la Promotion de l'Education (REPAFE) Questions
Respondent: Marcelline Kibungi

1. Why do you think the community-based model worked so well for this project?
2. Could a different childcare business model operate in this environment?
3. Have you been able to continue working with any of the community-based day care centers that continued operating after the project end?
    a. Have they been able to sustain the model and/or find a way of self-funding?
    b. Have you seen any of the community-based models expand?
    c. What challenges are there to expanding?

4. Were there any legal barriers, regulations, or policies you had to navigate in this environment and context? Safety standards for childcare, ECD standards, standards for caregivers. (i.e., national guidelines allow 14 children per caregiver)
5. Have you seen other day care business models in the rural/urban communities of DRC?
    a. Did certain day care business models operate more effectively in low resource/low income/rural environments than others?
6. In what ways have you, or similar organizations, been able to support female day care service providers (in this project or others)? What was most effective?
7. Have any caregivers or parents given you any feedback on aspects that they found to be helpful?
    a. Were you able to survey any caregivers?
8. Aside from ECD outcomes measured by the World Bank, did you find that day care services were correlated with increased nutrition? ECD outcomes? Child protection?
    a. If so, do you have any data that shows that?
9. What unique challenges were present for day care service providers in very low resource environments such as rural DRC? What can be done to overcome these challenges?
10. What can different stakeholders do to help support the provision of day care services? (government, donors, NGOs) How about specifically with the community-based model?
11. Can you share any datasets or documents from the childcare intervention? (funding, enrollment, ECD indicators, etc.)
12. Can you put me in contact with any caregivers or women involved in the community-based model?

Malawi CBO Survey Questions
Respondents: Nachikodowa CBO

1. Name of your CBO
2. Why did you choose a community-based model to provide childcare?
3. Why has this model worked well for your center, and do you think a different childcare business model could be as effective?
4. Can you explain your childcare business model and its structure? (examples: Is there a committee or council that oversees the childcare center or its decisions? How is the childcare center funded? (charging parents, grant funding, etc.) Are lunches provided and if so, how are they funded? Any other information critical to how the center operates?)
5. Imagine you are back where you were when you started the childcare center. What support would have been most helpful to you from an NGO? (examples: ECD training for caregivers, training certifications, small loans for renovations, childcare center equipment, business training such as budgeting or marketing, etc.) (Please feel free to list any ideas you may have)
6. In your experience, have you seen childcare services increase or improve outcomes of children's nutrition? early childhood development? child protection? If so, how?
7. Are there any organizations, businesses, or NGOs that currently provide support to you or have in the past? If so, what organization, what type of support was provided (financial/grant, training, equipment, etc.), and what support, if any, was the most helpful?
8. What unique challenges do you face in a low resource/low-income environment? What was helpful in overcoming these challenges? (example: a unique challenge may be

parents' inability to pay and a way to overcome it could be to make informal payment arrangements by trading goods or services)
9. Have you seen other childcare business models operate in rural or urban communities of Malawi? If so, please provide details.
10. Have you seen certain childcare business models operate more effectively in low resource/low-income environments than others? If so, please provide details.
11. Are there specific regulations, legislation, or policies you had to navigate in Malawi? (example: a child-to-caregiver ratio, ECD standards, safety standards, etc.) If so, did the regulations or policies make it harder to open or operate your childcare center? How?
12. What can different stakeholders do to help support community-based childcare models? (government, donors, NGOs, communities)
13. Do you have any data or documents related to your childcare center that you can share? Data and documents could be related to the center, outcomes, enrollment, funding, etc. If you answer yes, I will follow up with you via email.
14. If you have email addresses for any **other CBO's** that would be willing to answer this survey, please list them here.
15. If you have email addresses for any **caregivers** that would be willing to answer a survey, please list them here.
16. May I quote you in my final report provided to CRS?

Mobile Crèche Childcare Model Questions
Interviewees: Dr. Kehinde Ajayi and Dr. Estelle Koussoube

1. Aside from mobility, were there any other reasons this model was chosen for this project? Were other models considered?
2. What aspects make this a "community-based" model? Was there a committee to oversee the centers or did it have community resources/involvement?
3. As it pertains to the training of caregivers, were there any trust issues that arose from mothers feeling distrust toward someone else caring for their children?
4. Do you know if any of the crèches continued operating after the endline survey?
    a. Have they been able to financially sustain the model?
    b. Alternatively, since many of the public works participants were able to save money because of the project, do you know of any women that then used it to open their own childcare businesses?
5. Exposure to childcare generated lasting demand, even after the public works project ended. Were there any correlates for the women or HHs that continued to use childcare?
6. Were there any challenges encountered as you scaled up within Burkina Faso? Or, to your knowledge, the mobile crèche model in other countries (Cameroon, Madagascar, Ethiopia)? Or, to your knowledge, across industries (agriculture projects, refugee camps, outdoor work sites)?
7. What unique challenges were present for day care service providers in very low resource environments such as Burkina Faso, and especially in rural areas? What can be done to overcome these challenges?
8. What specific legislation, legal barriers, regulations, or policies did you have to navigate in this environment and context? Safety standards for childcare, ECD standards, standards for childcare workers.

9. Have you seen certain business models operate more effectively in low resource/low wage/low income/rural environments than others?
10. What are the most effective ways that an NGO or another organization can support childcare providers? What about women entrepreneurs that start their own childcare business?
11. What elements of your support have day care service providers found to be the most helpful? (ECD training, nutrition/cooking training, equipment, etc.) Were you able to survey day care service providers?
12. Did you observe the provision of day care services in Burkina Faso being correlated with increased nutrition? ECD outcomes? Child protection? If so, do you have any data that shows that?
13. What can different stakeholders do to help support the mobile crèche model? (government, donors, NGOs)
14. Are you able to share any datasets, interviews, or documents from the childcare intervention? (funding, enrollment, ECD indicators, interviews with caregivers, etc.)
15. Can you put me in contact with anyone in country and any day care providers/women involved in the mobile crèche model?
16. Did you notice over time, whether the clientele using the daycare services changed, or did it stay essentially the same due to the nature of the RCT? If it changed, how and why did it change? (Notes persistent increase in take up).

Mobile Crèche Childcare Model Questions (Qualitative Research)
Interviewees: Dr. Sophia Friedson Ridenour

1. Do you know to what extent the crèches are still operating, if any still are?
    a. Have they been able to financially sustain the model?
2. In your qualitative research, have you found any explanations as to why certain women or HHs continued to use childcare while others did not?
3. Did you notice over time, whether the clientele using the daycare services changed, or did it stay essentially the same? If it changed, how and why did it change?
4. Were there any challenges encountered as the project was implemented Burkina Faso?
    a. Or, to your knowledge, the mobile crèche models in other countries (Cameroon, Madagascar, Ethiopia)?
    b. Or, to your knowledge, across industries (agriculture projects, refugee camps, outdoor work sites)?
5. What unique challenges are present for day care service providers in very low resource environments such as Burkina Faso? What can be done to overcome these challenges?
6. Did any of the providers mention regulations, or policies in this environment and context? Safety standards, ECD standards, child to caregiver ratio.
7. What are the most effective ways that an NGO or another organization can support childcare providers? Were you able to survey day care providers on this?
8. What elements of support have day care providers found to be the most helpful? (ECD training, nutrition/cooking training, equipment, teaching materials, etc.) Were you able to survey day care providers on this?
9. Did providers observe the provision of day care services in Burkina Faso being correlated with increased nutrition? ECD outcomes? Child protection? If so, do you have any data that shows that?

10. What role do different stakeholders have in helping support the mobile crèche model? (government, donors, NGOs)
11. Are you able to share any data, interviews, or documents from your qualitative research?

Social Franchise Model Questions
Interviewees: Dr. Emily Beam and Dr. Anne Fitzpatrick

1. Why was the social franchise model chosen for this study? Were other models considered, and would they be as effective?
2. Who is your implementing partner? Kidogo, Tiny Totos, or another organization?
3. The intervention is being applied to home-based, center-based, and school-based childcare services, correct?
4. During the 3-month mentorship period, the day care operators are operating their services during this time, correct?
5. As it pertains to the training of caregivers, have you seen training/certification increase trust of parents who are concerned about others caring for their children?
6. Do you have any research from your implementing partner on the correlates for day care entrepreneurs that have continued to operate their childcare business over time?
7. Were there any challenges encountered as you started implementing this study? Or, to your knowledge, the scaling of the model as implemented by the partner organization?
8. Many point out that a social franchise model will not work in less-populated/more rural areas due to the inability to scale up – how do you respond to this? Are there adjustments that could be made to use the social franchise model in more rural environments?
9. What unique challenges are present for day care service providers in very low resource environments such as Kenya's settlements, and especially in more rural areas? What can be done to overcome these challenges?
10. What specific legislation, legal barriers, regulations, or policies did you have to navigate in this environment and context? Safety standards for childcare, ECD standards, standards for childcare workers.
11. Have you seen certain business models operate more effectively in low resource/low wage/low income/rural environments than others?
12. What are the most effective ways that an NGO or another organization can support childcare providers?
13. Do you have any survey data on what elements of support day care service providers find to be the most helpful? (ECD training, business trainings, teaching materials, capital improvement grants, equipment, etc.) Have you been able to survey day care service providers on this?
14. Have you observed the provision of day care services in Kenya being correlated with increased nutrition? ECD outcomes? Child protection? If so, do you have any data that shows that?
15. What can different stakeholders do to help support the social franchise model? (government, donors, NGOs, communities)
16. Are you able to share any datasets, interviews, or documents from the intervention? (funding, enrollment, ECD indicators, interviews with caregivers, etc.)
17. Can you put me in contact with anyone involved in the intervention, the implementing organization, and any day care providers/women involved in the social franchise model?

Social Franchise Model Questions (abbreviated questions, but more in-depth discussion)
Interviewee: Patricia Mwangi

1. How has the use of technology increased the reach of Tiny Totos? Have you been able to support day care providers that are further away?
2. Do you have any research/data on the correlates for day care providers that have been able to sustain their childcare business over time?
3. In your experience, what elements of support day care service providers find to be the most helpful? (ECD training, business training, teaching materials, small loans, equipment, etc.) Are you able to share the survey data that informed this question in your 2023 annual report?

Questions for Aatif Somji

1. What successful business models have you seen in the provision of day care services in low- or middle-income countries?
    a. Have you seen certain day care business models operate more effectively in low resource environments than others?
    b. What about rural environments?
2. What unique challenges are present for day care service providers in low resource environments? What can be done to overcome these challenges?
3. What are the biggest challenges to scaling up childcare in Sub-Saharan Africa? What can be done to overcome these challenges?
4. Many point out that a social franchise model will not work in less populated/more rural areas due to the inability to scale up. Do you think adjustments could be made to adapt the social franchise model to more rural environments?
5. Have you seen the provision of childcare being correlated with increased nutrition? ECD? Child protection?
6. What specific types of legislation, regulations, or policies are critical to promote the provision of childcare services in low and middle-income countries? (Safety standards for childcare, ECD standards, standards for childcare workers, etc.)
7. In your experience, what have you seen as the most effective ways that an NGO could support day care service providers in low resource environments? (ECD training, nutrition training, equipment, business training, small grants etc.)
    a. How can other stakeholders support childcare providers? (government, donors, communities)
    b. What types of support are most critical to help day care service providers scale their business while maintaining quality and making a profit?
8. How can we incentivize local/provincial/national government investment or partnerships to help ease cost burdens on low-income populations?
9. What demand-side interventions have you seen promote or increase uptake of childcare usage?

Questions for Elise Williams

1. What successful and adaptable business models have you seen in the provision of day care services in LMIC? Are there any that seem to hold across contexts?

   a. Have you seen certain day care business models operate more effectively in low resource environments than others? What about rural environments?
2. What unique challenges are present for day care service providers in low resource environments? What can be done to overcome these challenges?
3. What are the biggest challenges encountered when attempting to scale up childcare in Sub-Saharan Africa? What can be done to overcome these challenges?
4. Many point out that a social franchise model, such as Kidogo, will not work in less populated/more rural areas due to the inability to scale up. Do you think adjustments could be made to adapt the social franchise model to more rural environments?
5. Have you seen the provision of childcare correlated with increased nutrition? ECD? child protection/overall safety?
6. What specific types of legislation, regulations, or policies are critical to promote the provision of childcare services in low and middle-income countries? (Safety standards for childcare, ECD standards, standards for childcare workers, etc.)
7. In your experience, what have you seen as the most effective ways that an NGO can provide support to day care service providers in low resource environments? (ECD training, nutrition training, equipment, business training, small grants, provision of food for meals, technical assistance, etc.)
   a. What role can other stakeholders take on to support childcare providers? (government, donors, communities)
   b. What types of support are the most critical to help day care service providers maintain quality services and make a profit?
8. How can we incentivize local/provincial/national government investment or partnerships to help ease cost burdens on low-income populations?
9. How can we encourage increased/more robust monitoring and enforcement of childcare quality standards?

Appendix D: Analysis of Nachikodowa CBO CBCCs

Nachikodowa CBO CBCC Number	Number of Caregivers	Total Enrollment	% girls	Child-to-Caregiver Ratio	Total committee members	% women on committee
1	1	15	73%	15:1	10	70%
2	3	30	60%	10:1	10	40%
3	2	24	67%	12:1	10	50%
4	2	23	74%	12:1	10	60%
5	2	20	45%	10:1	10	70%
6	1	29	76%	29:1	10	80%
7	1	29	55%	29:1	10	50%
8	1	21	67%	21:1	10	60%
9	2	21	62%	11:1	10	50%
10	2	26	54%	13:1	10	40%
11	2	25	60%	13:1	10	40%
12	1	24	38%	24:1	10	30%
13	1	25	72%	25:1	10	60%
14	1	18	33%	18:1	11	55%
15	1	18	67%	18:1	10	60%
16	1	20	65%	20:1	10	60%
	* CM = CBCC Committee Members					
	* CG = Caregiver					

Bibliography

Aga Khan Foundation, Kidogo, The Aga Khan University, and Daraja Civic Initiatives Forum. 2021. "Building a Brighter Future for Vulnerable Children: An Early Childhood Development (ECD) Policy Brief." https://www.akfusa.org/wp-content/uploads/BBF-Policy-Brief.pdf.

Ajayi, Kehinde, Aziz Dao, and Estelle Koussoubé. 2022. "The Effects of Childcare on Women and Children: Evidence from a Randomized Evaluation in Burkina Faso," November. https://www.cgdev.org/publication/effects-childcare-women-and-children-evidence-randomized-evaluation-burkina-faso.

Ajayi, Kehinde, Estelle Koussoubé, Aziz Dao, and P. Rita Nikiema. 2024. "Who Uses Childcare Centers? Evidence From Burkina Faso." https://doi.org/10.1257/pandp.20241013.

APHRC. 2022. "Early Childhood Care and Development in Rural and Urban Settings in Kenya." African Population and Health Research Center. February 2022. https://aphrc.org/wp-content/uploads/2022/03/Policy-Brief-Early-Childhood-Care-and-Development-in-Rural-and-Urban-Settings-In-Kenya.pdf.

CARE and Covance Charitable Foundation. 2020. "A Model Beginning: CARE's Early Childhood Development for Rwanda's Most Vulnerable Children." CARE. https://www.care.org/wp-content/uploads/2020/06/CH-2010-A-Model-Beginning.pdf.

Cartier Philanthropy. 2024. "What 'Entrepreneurship' Means for the Poor." December 2024. https://www.cartierphilanthropy.org/news/what-entrepreneurship-means-for-the-poor.

Cassidy, Rachel, Roxane Zighed, and Cansu Birce Gokalp. 2023. "Designing and Implementing Low-Cost Childcare Solutions: Lessons from the Africa Gender Innovation Lab." Washington, DC: World Bank. https://doi.org/10.1596/40824.

Catholic Relief Services. 2022. "COFE: Child-Optimized Financial Education A Mutli-Sectoral Approach That Support Vulnerable Families to Thrive."

———. 2024. "Catalyzing Quality Sustainable and Replicable Daycare Services in Lesotho - Global Education Fund Progress Report."

Catholic Relief Services, and Makhotso Moeletsi. 2024. "Sustaining Quality Childcare and Early Childhood Development Services in the Industrial Areas of Lesotho - CIES Presentation Miami 2024." March.

Clark, Shelley, Caroline Kabiru, Sonia Laszlo, and Stella Muthuri. 2017. "Can Subsidized Early Child Care Promote Women's Employment? Evidence from Kenya." The GrOW Research Series. https://idl-bnc-idrc.dspacedirect.org/server/api/core/bitstreams/e16e3646-0a27-48df-aca1-4631f6279ce9/content.

Clark, Shelley, Sonia Laszlo, Caroline Kabiru, and Stella Muthuri. 2017. "Can Subsidized Early Child Care Promote Women's Employment?: Evidence from a Slum Settlement in Africa." Institute for the Study of International Development. May 2017. https://grow.research.mcgill.ca/publications/working-papers/gwp-2017-05.pdf.

Currimjee, Alisa, Jem Heinzel-Nelson Alvarenga Lima, and Sara Troiano. 2022. "Childcare Arrangements for Low-Income Families: Evidence from Low and Middle-Income Countries." World Bank, Washington, DC. https://doi.org/10.1596/39717.

Devercelli, Amanda E., and Frances Beaton-Day. 2020. *Better Jobs and Brighter Futures: Investing in Childcare to Build Human Capital*. World Bank. https://doi.org/10.1596/35062.

Donald, Aletheia, Francisco Campos, Julia Vaillant, and Maria Emilia Cucagna. 2018. “Investing in Childcare for Women’s Economic Empowerment.” World Bank, Washington, DC. https://doi.org/10.1596/30273.

Donald, Aletheia, Sara Lowes, and Julia Vaillant. 2024. “Experimental Evidence on Rural Childcare Provision,” March.

Donald, Aletheia, Julia Vaillant, Francisco Campos, and Maria Emilia Cucagna. 2018. “Caring about Carework.” World Bank, Washington, DC. https://doi.org/10.1596/30118.

Fernandez Gorostidi, Irene, Sara Troiano, and Adaorie Felicia Osademey Udechukwu. 2024. “The Catalyst to Unleash Women’s Economic Potential in Africa - Childcare.” World Bank Blogs. August 2024. https://blogs.worldbank.org/en/nasikiliza/catalyst-to-unleash-womens-economic-potential-africa-childcare-afe-0824.

Fitzpatrick, Anne, Emily Beam, and Maira Reimao. 2024. “Improving Childcare Quality Through Social Franchising.” SSRN Scholarly Paper. Rochester, NY: Social Science Research Network. https://doi.org/10.2139/ssrn.5037817.

Grantham, Kate, and Aatif Somji. n.d. “Childcare Solutions for Women Micro and Small Enterprises.”

Habib, Afzal. 2020. “Child Nutrition at Kidogo.” Kidogo: Unlocking Potential Through Quality Childcare. May 4, 2020. https://www.kidogo.co/post/child-nutrition-at-kidogo.

Howard, Jill, Fiona Wilson, and E. Hachemi Aliouche. 2020. “Kidogo: Addressing the Childcare Needs of Low-Income Families in East Africa.” https://doi.org/10.34051/p/2021.9.

“Impact - Kidogo.” n.d. Kidogo: Unlocking Potential Through Quality Childcare. Accessed January 11, 2025. https://www.kidogo.co/impact.

Kabay, Sarah, Brianda Romero Castelán, and Rebecca Smith. 2024. “A Multigenerational Perspective on Childcare: A Review of Rigorous Research in Low- and Middle- Income Countries,” June.

Kidogo. 2018. “Kidogo 2018 Annual Report.” 2018. https://issuu.com/kidogo_ecd/docs/kidogo_2018_annual_report_-_final_m.

———. 2022. “Kidogo Presentation.” November 2022. https://africa.unwomen.org/sites/default/files/2022-11/Nov%203%20-%20Kidogo%20-%20Presentation.pdf.

“———.” n.d. Rights CoLab. Accessed March 5, 2025. https://rightscolab.org/case_study/kidogo/.

Malou, Elizabeth Nyibol. 2024. “The Triple Burden: Women Selling Their Labour in South Sudan.” Rift Valley Institute; Cross Border Conflict. https://riftvalley.net/wp-content/uploads/2024/07/The-Triple-Burden_FINAL.pdf.

Moussie, Rachel. 2020. “Quality Childcare Services for Workers in the Informal Economy.” WIEGO; ILO. https://www.wiego.org/publications/quality-childcare-services-workers-informal-economy.

Moussié, Rachel. 2021. “Childcare Services in Cities: Challenges and Emerging Solutions for Women Informal Workers and Their Children.” https://doi.org/10.1177/0956247820987096.

Roberts, Andrea Suozzo, Alec Glassford, Ash Ngu, Brandon. 2013. “Kidogo Early Years Inc - Nonprofit Explorer.” ProPublica. May 9, 2013. https://projects.propublica.org/nonprofits/organizations/472471232.

S. Cummings Interview Dr. Anne Fitzpatrick. 2025.

S. Cummings Interview with Aatif Somji. 2025.

S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant. 2024.
S. Cummings Interview with Dr. Emily Beam. 2025.
S. Cummings Interview with Dr. Estelle Koussoube. 2025.
S. Cummings Interview with Dr. Kehinde Ajayi. 2025.
S. Cummings Interview with Dr. Sophia Friedson-Ridenour. 2025.
S. Cummings Interview with Elise Williams. 2025.
S. Cummings Interview with Mme Makhotso Moeletsi. 2025.
S. Cummings Interview with Patricia Mwangi of Tiny Totos. 2025.
S. Cummings Survey Responses form Nachikodowa Community-Based Organization. 2025.
S. Cummings Survey Responses received from REPAFE. 2025.
"Savings-Led Microfinance." n.d. Text. CRS. Accessed March 23, 2025. https://www.crs.org/our-work-overseas/program-areas/savings-led-microfinance.
Shallwani, Sadaf, Amina Abubakar, and Moses K Nyongesa. n.d. "The Quality of Learning and Care at Community-Based Early Childhood Development Centers in Malawi."
Somji, Aatif. 2020. "Child's Play: The Case for Developing Childcare Services to Boost Women's Economic Empowerment." International Labour Organization. https://www.ilo.org/sites/default/files/wcmsp5/groups/public/%40ed_emp/%40emp_ent/%40ifp_seed/documents/publication/wcms_752814.pdf.
Spring Impact and Echidna Giving. 2020. "Support Programs for Home-Based Child Care: A Global Study." 2020. https://www.springimpact.org/wp-content/uploads/2021/04/Support-Programs-for-HBCC-A-Global-Study_Full-Report.pdf.
Teti, Claudia. 2024. "The Hidden Economics of Remarkable Women (HERO)." *Foreign Policy* (blog). November 26, 2024. https://foreignpolicy.com/podcasts/hidden-economics-of-remarkable-women-hero/.
The Care Economy Knowledge Hub. 2022. "Kidogo - Brief." https://www.the-care-economy-knowledge-hub.org/wp-content/uploads/2023/06/49-Africa-Kidogo-V2.pdf.
———. n.d. "Kidogo." *Care Economy* (blog). Accessed March 4, 2025. https://www.the-care-economy-knowledge-hub.org/listing/kidogo/.
Tiny Totos. 2024a. "Tiny Totos 2023 Annual Report." Tiny Totos. April 5, 2024. https://www.tinytotos.com/post/tinytotos2023annualreport.
———. 2024b. "Tiny Totos 2024 Annual Report." Tiny Totos. 2024. https://www.tinytotos.com/post/tiny-totos-is-pleased-to-launch-our-2024-annual-report.
UN-Habitat. 2023. "Kenya Country Brief." https://unhabitat.org/sites/default/files/2023/07/kenya_country_brief_final_en.pdf.
Women in Informal Employment Globalizing and Organizing. 2024. "Child Care in Markets." WIEGO. https://www.wiego.org/sites/default/files/resources/file/child-care-in-markets.pdf.
World Bank. 2019. "Ending Learning Poverty: What Will It Take?" https://openknowledge.worldbank.org/entities/publication/af5e123e-27e9-5d15-b534-ec22ebe42d96.
———. 2021. "Enabling Women to Work and Their Children to Blossom: The Double Success Story of Mobile Childcare in Burkina Faso." World Bank. March 2021. https://www.worldbank.org/en/news/feature/2021/03/08/enabling-women-to-work-and-their-children-to-blossom-the-double-success-story-of-mobile-childcare-units-in-burkina-faso.

"World Bank Country and Lending Groups – World Bank Data Help Desk." n.d. Accessed October 14, 2024. https://datahelpdesk.worldbank.org/knowledgebase/articles/906519-world-bank-country-and-lending-groups.

World Bank and Umbrella Facility for Gender Equity. 2020. "Results Series: Childcare Goes Mobile in Burkina Faso." https://documents1.worldbank.org/curated/en/121511593447275110/pdf/Childcare-Goes-Mobile-in-Burkina-Faso.pdf.

Endnotes

[1] ("World Bank Country and Lending Groups – World Bank Data Help Desk," n.d.)
[2] (Grantham and Somji 2022)
[3] (Women in Informal Employment Globalizing and Organizing 2024; Moussie 2020)
[4] (Malou 2024)
[5] (Malou 2024)
[6] (Clark, Laszlo, et al. 2017)
[7] (Somji 2020)
[8] (Devercelli and Beaton-Day 2020)
[9] (Currimjee, Lima, and Troiano 2022)
[10] (Moussié 2021; Spring Impact and Echidna Giving 2020; Devercelli and Beaton-Day 2020)
[11] (Currimjee, Lima, and Troiano 2022)
[12] (Spring Impact and Echidna Giving 2020; Moussié 2021; Devercelli and Beaton-Day 2020)
[13] (Devercelli and Beaton-Day 2020)
[14] (Kabay, Castelán, and Smith 2024)
[15] (Clark, Laszlo, et al. 2017)
[16] (Clark, Laszlo, et al. 2017)
[17] (Clark, Laszlo, et al. 2017)
[18] (Clark, Laszlo, et al. 2017)
[19] (Clark, Kabiru, et al. 2017; Somji 2020)
[20] (Grantham and Somji, n.d.)
[21] (Fernandez Gorostidi, Troiano, and Felicia Osademey Udechukwu 2024)
[22] (Grantham and Somji 2022)
[23] (Grantham and Somji, n.d.; Women in Informal Employment Globalizing and Organizing 2024)
[24] (Women in Informal Employment Globalizing and Organizing 2024)
[25] (Somji 2020)
[26] (Grantham and Somji, n.d.)
[27] (Grantham and Somji, n.d.)
[28] (CARE and Covance Charitable Foundation 2020)
[29] (CARE and Covance Charitable Foundation 2020)
[30] (World Bank 2019; Devercelli and Beaton-Day 2020)
[31] (Devercelli and Beaton-Day 2020)
[32] (Devercelli and Beaton-Day 2020)
[33] (S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025; Devercelli and Beaton-Day 2020)
[34] (Devercelli and Beaton-Day 2020)
[35] (Kabay, Castelán, and Smith 2024)
[36] (Kabay, Castelán, and Smith 2024; Ajayi, Dao, and Koussoubé 2022)
[37] (Currimjee, Lima, and Troiano 2022)
[38] (Currimjee, Lima, and Troiano 2022)
[39] (Currimjee, Lima, and Troiano 2022)

[40] (Currimjee, Lima, and Troiano 2022)
[41] (Ajayi, Dao, and Koussoubé 2022)
[42] (Fernandez Gorostidi, Troiano, and Felicia Osademey Udechukwu 2024)
[43] (Fernandez Gorostidi, Troiano, and Felicia Osademey Udechukwu 2024)
[44] (Grantham and Somji 2022)
[45] (Grantham and Somji 2022)
[46] (Grantham and Somji 2022)
[47] (Grantham and Somji 2022)
[48] (Grantham and Somji 2022)
[49] (Grantham and Somji, n.d.)
[50] (Grantham and Somji 2022)
[51] (S. Cummings Interview with Dr. Emily Beam 2025; S. Cummings Interview with Aatif Somji 2025; S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[52] (S. Cummings Interview Dr. Anne Fitzpatrick 2025; S. Cummings Interview with Aatif Somji 2025)
[53] (S. Cummings Interview with Dr. Emily Beam 2025)
[54] (S. Cummings Interview with Aatif Somji 2025)
[55] (S. Cummings Interview with Aatif Somji 2025)
[56] (S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[57] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[58] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[59] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024; S. Cummings Interview with Dr. Kehinde Ajayi 2025)
[60] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[61] (S. Cummings Interview with Aatif Somji 2025)
[62] (S. Cummings Interview with Aatif Somji 2025)
[63] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[64] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[65] (S. Cummings Interview with Dr. Estelle Koussoube 2025)
[66] (S. Cummings Interview with Elise Williams 2025)
[67] (S. Cummings Interview with Elise Williams 2025)
[68] (S. Cummings Interview with Elise Williams 2025)
[69] (S. Cummings Interview with Aatif Somji 2025)
[70] (S. Cummings Interview with Dr. Kehinde Ajayi 2025)
[71] (S. Cummings Interview with Elise Williams 2025)
[72] (S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[73] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[74] (S. Cummings Interview with Dr. Emily Beam 2025)
[75] (Cartier Philanthropy 2024)
[76] (S. Cummings Interview Dr. Anne Fitzpatrick 2025)
[77] (S. Cummings Interview with Dr. Kehinde Ajayi 2025)
[78] (S. Cummings Interview with Dr. Estelle Koussoube 2025)
[79] (S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[80] (S. Cummings Interview with Dr. Kehinde Ajayi 2025; S. Cummings Interview with Dr. Estelle Koussoube 2025; S. Cummings Interview with Elise Williams 2025)
[81] (S. Cummings Interview with Elise Williams 2025)
[82] (S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[83] (Donald, Lowes, and Vaillant 2024)
[84] (Donald, Vaillant, et al. 2018)
[85] (Donald, Campos, et al. 2018)
[86] (Donald, Lowes, and Vaillant 2024)
[87] (Donald, Lowes, and Vaillant 2024)
[88] (Donald, Lowes, and Vaillant 2024)
[89] (Donald, Lowes, and Vaillant 2024)
[90] (Donald, Lowes, and Vaillant 2024)
[91] (Donald, Lowes, and Vaillant 2024)

[92] (Donald, Lowes, and Vaillant 2024)
[93] (Donald, Lowes, and Vaillant 2024)
[94] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[95] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[96] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[97] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[98] (S. Cummings Survey Responses received from REPAFE 2025)
[99] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[100] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[101] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[102] (Donald, Lowes, and Vaillant 2024)
[103] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[104] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[105] (Donald, Lowes, and Vaillant 2024)
[106] (Donald, Lowes, and Vaillant 2024)
[107] (Donald, Lowes, and Vaillant 2024)
[108] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[109] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[110] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[111] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[112] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[113] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[114] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[115] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[116] (S. Cummings Survey Responses received from REPAFE 2025)
[117] (S. Cummings Survey Responses received from REPAFE 2025)
[118] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[119] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[120] (Donald, Lowes, and Vaillant 2024)
[121] (Donald, Lowes, and Vaillant 2024)
[122] (Donald, Lowes, and Vaillant 2024)
[123] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[124] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[125] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[126] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[127] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[128] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[129] (Donald, Lowes, and Vaillant 2024)
[130] (Donald, Lowes, and Vaillant 2024)
[131] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[132] (Donald, Lowes, and Vaillant 2024)
[133] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[134] (S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[135] (Shallwani, Abubakar, and Nyongesa, n.d.)
[136] (S. Cummings Survey Responses form Nachikodowa Community-Based Organization 2025)
[137] (S. Cummings Survey Responses form Nachikodowa Community-Based Organization 2025)
[138] (S. Cummings Survey Responses form Nachikodowa Community-Based Organization 2025)
[139] (S. Cummings Survey Responses form Nachikodowa Community-Based Organization 2025)
[140] (S. Cummings Survey Responses form Nachikodowa Community-Based Organization 2025)
[141] (S. Cummings Survey Responses form Nachikodowa Community-Based Organization 2025)
[142] (S. Cummings Survey Responses form Nachikodowa Community-Based Organization 2025)
[143] (S. Cummings Survey Responses form Nachikodowa Community-Based Organization 2025)
[144] (S. Cummings Survey Responses form Nachikodowa Community-Based Organization 2025)
[145] (S. Cummings Survey Responses form Nachikodowa Community-Based Organization 2025)
[146] (S. Cummings Survey Responses form Nachikodowa Community-Based Organization 2025)

[147] (S. Cummings Survey Responses form Nachikodowa Community-Based Organization 2025)
[148] (S. Cummings Survey Responses form Nachikodowa Community-Based Organization 2025)
[149] (S. Cummings Survey Responses form Nachikodowa Community-Based Organization 2025)
[150] (S. Cummings Survey Responses form Nachikodowa Community-Based Organization 2025)
[151] (S. Cummings Survey Responses form Nachikodowa Community-Based Organization 2025)
[152] (S. Cummings Survey Responses form Nachikodowa Community-Based Organization 2025)
[153] (Ajayi, Dao, and Koussoubé 2022)
[154] (Ajayi, Dao, and Koussoubé 2022; S. Cummings Interview with Dr. Kehinde Ajayi 2025; S. Cummings Interview with Dr. Estelle Koussoube 2025)
[155] (Ajayi, Dao, and Koussoubé 2022)
[156] (Ajayi, Dao, and Koussoubé 2022)
[157] (Ajayi, Dao, and Koussoubé 2022)
[158] (World Bank 2021)
[159] (Ajayi, Dao, and Koussoubé 2022)
[160] (World Bank 2021)
[161] (Ajayi, Dao, and Koussoubé 2022)
[162] (Ajayi, Dao, and Koussoubé 2022)
[163] (Ajayi, Dao, and Koussoubé 2022)
[164] (Ajayi, Dao, and Koussoubé 2022)
[165] (Ajayi, Dao, and Koussoubé 2022)
[166] (Ajayi, Dao, and Koussoubé 2022)
[167] (Ajayi, Dao, and Koussoubé 2022)
[168] (Ajayi, Dao, and Koussoubé 2022)
[169] (Ajayi, Dao, and Koussoubé 2022)
[170] (Ajayi, Dao, and Koussoubé 2022)
[171] (Ajayi, Dao, and Koussoubé 2022)
[172] (Ajayi, Dao, and Koussoubé 2022; S. Cummings Interview with Dr. Kehinde Ajayi 2025)
[173] (Ajayi, Dao, and Koussoubé 2022)
[174] (S. Cummings Interview with Dr. Kehinde Ajayi 2025)
[175] (Ajayi, Dao, and Koussoubé 2022)
[176] (S. Cummings Interview with Dr. Kehinde Ajayi 2025)
[177] (S. Cummings Interview with Dr. Kehinde Ajayi 2025)
[178] (Ajayi, Dao, and Koussoubé 2022)
[179] (S. Cummings Interview with Dr. Kehinde Ajayi 2025)
[180] (S. Cummings Interview with Dr. Kehinde Ajayi 2025)
[181] (Ajayi, Dao, and Koussoubé 2022)
[182] (S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[183] (S. Cummings Interview with Dr. Estelle Koussoube 2025)
[184] (S. Cummings Interview with Dr. Estelle Koussoube 2025)
[185] (Ajayi, Dao, and Koussoubé 2022)
[186] (S. Cummings Interview with Dr. Kehinde Ajayi 2025)
[187] (S. Cummings Interview with Dr. Kehinde Ajayi 2025)
[188] (S. Cummings Interview with Dr. Kehinde Ajayi 2025)
[189] (World Bank and Umbrella Facility for Gender Equity 2020)
[190] (Ajayi, Dao, and Koussoubé 2022)
[191] (Ajayi, Dao, and Koussoubé 2022)
[192] (Ajayi, Dao, and Koussoubé 2022)
[193] (Ajayi, Dao, and Koussoubé 2022)
[194] (Ajayi, Dao, and Koussoubé 2022)
[195] (S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[196] (S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[197] (S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[198] (S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[199] (S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[200] (S. Cummings Interview with Dr. Kehinde Ajayi 2025)

[201] (Ajayi, Dao, and Koussoubé 2022)
[202] (Ajayi, Dao, and Koussoubé 2022; S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[203] (S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[204] (Ajayi, Dao, and Koussoubé 2022)
[205] (S. Cummings Interview with Dr. Kehinde Ajayi 2025)
[206] (S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[207] (Ajayi et al. 2024)
[208] (Ajayi et al. 2024; S. Cummings Interview with Dr. Kehinde Ajayi 2025; S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[209] (Ajayi, Dao, and Koussoubé 2022)
[210] (Ajayi, Dao, and Koussoubé 2022)
[211] (Ajayi, Dao, and Koussoubé 2022)
[212] (Ajayi, Dao, and Koussoubé 2022)
[213] (Ajayi, Dao, and Koussoubé 2022)
[214] (Ajayi, Dao, and Koussoubé 2022)
[215] (Ajayi, Dao, and Koussoubé 2022)
[216] (Ajayi, Dao, and Koussoubé 2022)
[217] (World Bank and Umbrella Facility for Gender Equity 2020)
[218] (Cassidy, Zighed, and Gokalp 2023)
[219] (S. Cummings Interview with Dr. Kehinde Ajayi 2025)
[220] (S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[221] (S. Cummings Interview with Dr. Kehinde Ajayi 2025)
[222] (S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[223] (S. Cummings Interview with Dr. Kehinde Ajayi 2025)
[224] (S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[225] (S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[226] (S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[227] (S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[228] (S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[229] (S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[230] (S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[231] (S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[232] (S. Cummings Interview with Dr. Kehinde Ajayi 2025)
[233] (S. Cummings Interview with Dr. Kehinde Ajayi 2025; S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025)
[234] (S. Cummings Interview with Dr. Kehinde Ajayi 2025; S. Cummings Interview with Dr. Sophia Friedson-Ridenour 2025; S. Cummings Interview with Dr. Aletheia Donald and Dr. Julia Vaillant 2024)
[235] (World Bank 2021; World Bank and Umbrella Facility for Gender Equity 2020)
[236] (S. Cummings Interview with Dr. Kehinde Ajayi 2025)
[237] (S. Cummings Interview with Dr. Kehinde Ajayi 2025)
[238] (Somji 2020)
[239] (Howard, Wilson, and Aliouche 2020; Kidogo 2022; The Care Economy Knowledge Hub 2022)
[240] (Howard, Wilson, and Aliouche 2020; Kidogo 2018)
[241] (Tiny Totos 2024b; Fitzpatrick, Beam, and Reimao 2024; The Care Economy Knowledge Hub 2022)
[242] (Howard, Wilson, and Aliouche 2020)
[243] (UN-Habitat 2023)
[244] (Fitzpatrick, Beam, and Reimao 2024)
[245] (The Care Economy Knowledge Hub 2022)
[246] (Aga Khan Foundation et al. 2021)
[247] (The Care Economy Knowledge Hub 2022)
[248] (S. Cummings Interview Dr. Anne Fitzpatrick 2025)
[249] (S. Cummings Interview Dr. Anne Fitzpatrick 2025)
[250] (S. Cummings Interview Dr. Anne Fitzpatrick 2025)
[251] (S. Cummings Interview Dr. Anne Fitzpatrick 2025)
[252] (S. Cummings Interview Dr. Anne Fitzpatrick 2025)

[253] (S. Cummings Interview Dr. Anne Fitzpatrick 2025)
[254] (APHRC 2022)
[255] (APHRC 2022)
[256] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025)
[257] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025; Tiny Totos 2024b)
[258] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025)
[259] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025)
[260] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025)
[261] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025)
[262] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025)
[263] (Tiny Totos 2024b)
[264] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025)
[265] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025)
[266] (Grantham and Somji, n.d.; Currimjee, Lima, and Troiano 2022; The Care Economy Knowledge Hub 2022)
[267] (The Care Economy Knowledge Hub 2022)
[268] (The Care Economy Knowledge Hub 2022)
[269] (The Care Economy Knowledge Hub 2022)
[270] (Habib 2020)
[271] (S. Cummings Interview with Dr. Emily Beam 2025)
[272] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025; The Care Economy Knowledge Hub 2022)
[273] (Howard, Wilson, and Aliouche 2020)
[274] (The Care Economy Knowledge Hub 2022)
[275] (Fitzpatrick, Beam, and Reimao 2024)
[276] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025)
[277] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025)
[278] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025)
[279] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025)
[280] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025)
[281] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025)
[282] (Grantham and Somji, n.d.)
[283] (Tiny Totos 2024a)
[284] (Tiny Totos 2024a)
[285] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025)
[286] (Tiny Totos 2024a)
[287] (Tiny Totos 2024b)
[288] (Tiny Totos 2024b)
[289] (Kidogo 2022)
[290] (S. Cummings Interview Dr. Anne Fitzpatrick 2025)
[291] (Tiny Totos 2024a)
[292] (The Care Economy Knowledge Hub, n.d.)
[293] (Tiny Totos 2024b)
[294] (The Care Economy Knowledge Hub 2022)
[295] (The Care Economy Knowledge Hub 2022)
[296] (The Care Economy Knowledge Hub 2022)
[297] (Howard, Wilson, and Aliouche 2020)
[298] (The Care Economy Knowledge Hub 2022)
[299] (Tiny Totos 2024a; 2024b)
[300] (Tiny Totos 2024a)
[301] (Tiny Totos 2024a)
[302] (Tiny Totos 2024a)
[303] (Roberts 2013)
[304] (Spring Impact and Echidna Giving 2020)
[305] (Howard, Wilson, and Aliouche 2020)
[306] (The Care Economy Knowledge Hub 2022)
[307] (The Care Economy Knowledge Hub 2022)

[308] (The Care Economy Knowledge Hub 2022)
[309] (Tiny Totos 2024a; 2024b)
[310] (Tiny Totos 2024a)
[311] (Tiny Totos 2024a)
[312] (Tiny Totos 2024a)
[313] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025)
[314] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025; Tiny Totos 2024b)
[315] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025)
[316] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025)
[317] (The Care Economy Knowledge Hub 2022; "Impact - Kidogo," n.d.)
[318] ("Kidogo," n.d.)
[319] (S. Cummings Interview Dr. Anne Fitzpatrick 2025; S. Cummings Interview with Dr. Emily Beam 2025)
[320] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025)
[321] (Tiny Totos 2024a)
[322] (Tiny Totos 2024b)
[323] (S. Cummings Interview with Dr. Emily Beam 2025)
[324] (S. Cummings Interview with Dr. Emily Beam 2025)
[325] (S. Cummings Interview with Dr. Emily Beam 2025)
[326] (S. Cummings Interview with Dr. Emily Beam 2025)
[327] (S. Cummings Interview with Dr. Emily Beam 2025)
[328] (S. Cummings Interview Dr. Anne Fitzpatrick 2025)
[329] (S. Cummings Interview Dr. Anne Fitzpatrick 2025)
[330] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025; Tiny Totos 2024b)
[331] (S. Cummings Interview with Elise Williams 2025)
[332] (UN-Habitat 2023)
[333] ("About Us - Kidogo," n.d.)
[334] (S. Cummings Interview with Dr. Emily Beam 2025)
[335] (S. Cummings Interview with Aatif Somji 2025)
[336] (Spring Impact and Echidna Giving 2020)
[337] (The Care Economy Knowledge Hub 2022)
[338] (The Care Economy Knowledge Hub 2022)
[339] (Tiny Totos 2024b; The Care Economy Knowledge Hub 2022)
[340] (Teti 2024)
[341] (S. Cummings Interview with Dr. Kehinde Ajayi 2025)
[342] (Tiny Totos 2024b)
[343] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025)
[344] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025)
[345] (S. Cummings Interview with Patricia Mwangi of Tiny Totos 2025)
[346] (Tiny Totos 2024b)
[347] (Catholic Relief Services 2024)
[348] (Catholic Relief Services 2024)
[349] (Catholic Relief Services 2024)
[350] (Catholic Relief Services 2024)
[351] (Catholic Relief Services 2024)
[352] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[353] (Catholic Relief Services 2024)
[354] (Catholic Relief Services 2024)
[355] (Catholic Relief Services 2024)
[356] (Catholic Relief Services 2024)
[357] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[358] (Catholic Relief Services 2024)
[359] (Catholic Relief Services 2024)
[360] (Catholic Relief Services 2024; S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[361] (Catholic Relief Services 2024)
[362] (Catholic Relief Services 2024)

[363] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[364] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[365] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[366] (Catholic Relief Services 2024)
[367] (Catholic Relief Services 2024)
[368] (Catholic Relief Services 2024)
[369] (Catholic Relief Services 2024)
[370] (Catholic Relief Services 2024)
[371] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[372] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[373] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[374] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[375] (Catholic Relief Services 2024; S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[376] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[377] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[378] (Catholic Relief Services 2024)
[379] (Catholic Relief Services 2024)
[380] (Catholic Relief Services 2024)
[381] (Catholic Relief Services 2024)
[382] ("Savings-Led Microfinance," n.d.)
[383] ("Savings-Led Microfinance," n.d.)
[384] (Catholic Relief Services 2024)
[385] (Catholic Relief Services 2024)
[386] (Catholic Relief Services 2024)
[387] (Catholic Relief Services 2024)
[388] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[389] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[390] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[391] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[392] (Catholic Relief Services 2024)
[393] (Catholic Relief Services 2024)
[394] (Catholic Relief Services and Moeletsi 2024)
[395] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[396] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[397] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[398] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[399] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[400] (Catholic Relief Services 2024)
[401] (Catholic Relief Services 2024)
[402] (Catholic Relief Services 2024)
[403] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[404] (Catholic Relief Services 2024)
[405] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[406] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[407] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[408] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[409] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[410] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[411] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[412] (Catholic Relief Services 2024)
[413] (S. Cummings Interview with Mme Makhotso Moeletsi 2025; Catholic Relief Services 2024)
[414] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[415] (Catholic Relief Services 2024; S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[416] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[417] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)

[418] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[419] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[420] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[421] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[422] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[423] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[424] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[425] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[426] (Catholic Relief Services 2024)
[427] (Catholic Relief Services 2024)
[428] (Catholic Relief Services 2024)
[429] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[430] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[431] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[432] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[433] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[434] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[435] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[436] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[437] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[438] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[439] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[440] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[441] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[442] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[443] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[444] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[445] (S. Cummings Interview with Mme Makhotso Moeletsi 2025; Catholic Relief Services 2024)
[446] (S. Cummings Interview with Mme Makhotso Moeletsi 2025)
[447] (Catholic Relief Services 2024)
[448] (Catholic Relief Services 2024)
[449] (Catholic Relief Services 2024)
[450] (Catholic Relief Services 2022)
[451] (Catholic Relief Services 2022)