Nurture First

The State of Home-Based Childcare in Kenya

Findings from Kisumu, Murang'a and Mombasa Counties.

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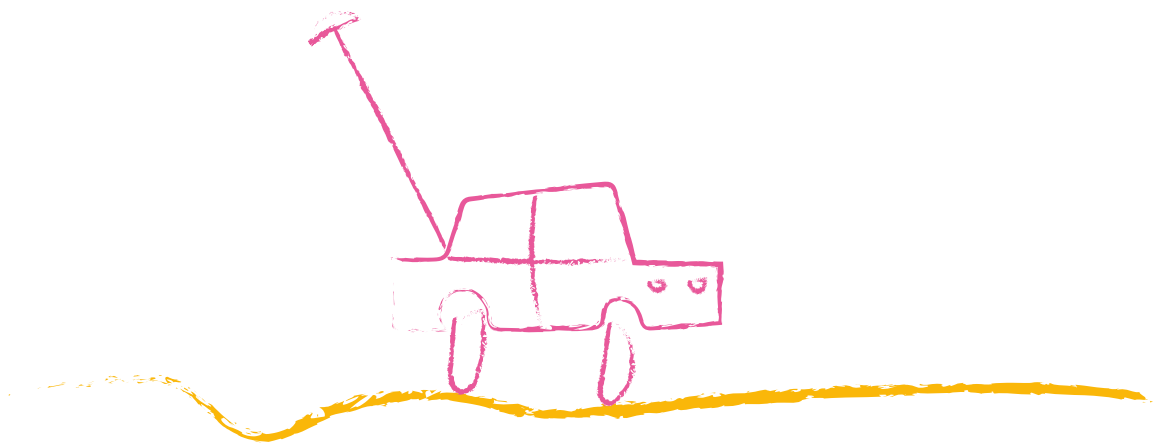

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Glossary

Community
Refers to the group of people served by the HBCC, including the children, their families, and the broader network of individuals who interact with, and support the childcare environment.

Community-Based Organizations (CBO)
Are locally formed, nonprofit groups that operate within a specific community to address its unique needs and priorities. They are typically driven by community members, focused on grassroots development, and dedicated to improving well-being through services, advocacy, and capacity-building initiatives tailored to local challenges and opportunities.

Early Childhood Care and Education (ECCE)
Encompasses any setting that offers learning and caregiving services for children from birth until they reach compulsory primary school age.

Early Childhood Development (ECD)
Refers to the holistic development of children from zero to eight years, encompassing health, nutrition, care, protection, early learning and psychosocial well-being.

Early Childhood Development Education (ECDE)
Refers to the education-focused component of ECD, referring mainly to pre-primary education for children aged four to five years.

Home-Based Childcare (HBCC)
Refers to paid or unpaid, non-parental childcare that takes place in the home of the childcare Provider, typically involving children from more than one family, as opposed to care provided in a purpose-built or multi-purpose centre. This definition does not include nannies, babysitters or relatives who provide care in the child's own home.

Nurturing Care Framework
A comprehensive, evidence-based approach launched by the World Health Organisation (WHO), UNICEF and the World Bank Group in 2018. The framework guides policies and services to support parents and caregivers in providing the care infants and young children need to survive, thrive, and reach their full potential. It serves as a coordinated roadmap for action, to ensure every child receives the strongest possible start in life.

Providers
Those offering HBCC to their community. We use Providers with a capital P throughout the document to reference those offering childcare in home-based settings.

Quality Improvement Roadmap (QIRM)
A program that supports HBCC Providers to meet minimum quality standards, allowing for self-paced progression towards basic and ideal standards. The program includes in-person training, monthly community-led mentorship, and SMS and voice support. It is designed to be scalable in diverse settings.

Executive Summary

The first five years of life are a critical period for children's brain and physical development, yet millions of young children globally lack access to quality childcare. In Kenya, Home-Based Childcare (HBCC) - care provided by non-familial caregivers in their own homes - has emerged as a vital, prevalent, community-embedded solution for infants and toddlers, particularly in low-income households.

Thousands of predominantly female Providers deliver daily nurturing care that enables parents to work and fills the gap for children aged 0–3. These are children who are not reached by other Early Childhood Care and Education (ECCE) systems. This makes **HBCC a core social and economic infrastructure** that underpins household livelihoods and local economies, while shaping children's long-term prospects.

However, HBCC remains largely invisible in data and policy , receives no public financing, and relies on small, irregular contributions from families. Against this backdrop, NurtureFirst and partners undertook an HBCC mapping in Murang'a, Kisumu, and Mombasa, **reaching 5,350 Providers caring for 21,784 children**.

This report presents the first systematic picture of Kenya's HBCC landscape. This mapping report seeks to be a *practical tool for policymakers*, implementers, and funders to align programmes and financing with Providers' and families' needs, *strengthen the quality and recognition of HBCC*, and *inform coordinated, equitable investment in childcare systems*.

5,350 Providers caring for 21,784 children.

Average Provider: Child Ratio *1:3*

Key Insights & Relevance for Policy & Programming

Insights		Implications
HBCC a critical, neglected pillar	1	**Ecosystem-wide efforts needed**
HBCC is a critical pillar of the care system, underpinning the social and economic functioning of society. It is prevalent across rural-urban divides. It is powered mainly by women, serving economically-vulnerable communities, yet, it is disconnected from supportive services - offered by community, public and private sectors - that could enhance quality childcare.		Data generated collectively and made accessible to stakeholders - implementers and government - enables more responsive and coordinated service delivery and policy reform for lasting impact. Alliance-building around HBCC is essential to secure formal recognition of Providers, given HBCC's role in supporting livelihoods, enabling women's economic participation, and improving child development outcomes
HBCC can serve as primary services delivery channel for ages 1-3	2	**HBCC should be integrated as core ECD infrastructure.**
HBCC Providers care for children as young as a few weeks old, with those aged 1–3 in a particularly vulnerable blind spot: they have aged out of the most intensive infant health contacts but are not yet benefiting from pre-primary–embedded health, nutrition, and early learning services.		HBCC settings already reach a large share of this age group every day, offering a powerful, under-used platform to extend essential early childhood development support - including early identification of health and development conditions - directly to these children. This underscores the need to formally recognise and invest in HBCC as a core delivery channel rather than a peripheral or informal add-on.
HBCC can support early learning in addition to safety	3	**Recognise HBCC Providers as early educators**
HBCC Providers primarily see their role as safeguarding children's survival and wellbeing . However, low Provider to child ratios (1:3) and strong demand for training (90%), presents a strong opportunity to enhance early learning, responsive caregiving, and positive child development outcomes		Policy and programmes should intentionally reframe HBCC Providers as early educators , not just caregivers, and invest in practical training and tools that build on existing low Provider-child ratios to strengthen early learning, responsive caregiving, and positive child development outcomes.

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Insights

HBCC Providers offer trusted childcare that low-income families would otherwise lack.

HBCC providers serve, and are among, the most socioeconomically vulnerable. They provide families with extremely limited resources, an accessible and trusted option for care and early learning closer to home. This is an option that they would otherwise not have.

HBCC is under-resourced

Providers show strong commitment, and basic caregiving strengths, but operate in structurally constrained, under-resourced environments — with limited space, weak WASH, few materials, minimal nutrition support, and no clear standards or pathways for professional development.

HBCC is community-driven childcare

Personal passion for childcare and responding to community needs are the most commonly cited motivations for starting HBCC services, yet the sector struggles to reflect this social and deeply embedded community practice in policy and programming.

Implications

4 Support HBCC as an equity pathway - prioritizing the most vulnerable children and Providers.

HBCC should be formally recognized and prioritized as a strategy to increase equity and transform the educational and livelihood potential for children of all backgrounds, particularly those who are socio-economically vulnerable

5 Integrated quality improvement results in out-sized impact.

Governments and partners should invest in an integrated quality improvement package that combines clear national HBCC standards, practical training and coaching, supportive (non-punitive) supervision, with targeted investments in infrastructure, WASH, play and learning materials, and nutrition support .

6 Affirm Providers as strong community pillars delivering an essential public service

Recognising and affirming HBCC providers as culturally resonant caregivers and frontline ECD workers is essential for elevating their work in ways that feel authentic to them. Adopting a rigid entrepreneurship framing may undermine Providers' motivations and connection to the role.

Insights

HBCC is unsustainable

HBCC Providers serve, and are among, the most socio - economically vulnerable. They provide families with extremely limited resources, an accessible and trusted option for care and early learning closer to home. This is an option that they would otherwise not have.

Providers are isolated

HBCC Providers themselves are deeply isolated yet thousands express a strong desire to connect, revealing a major unmet need for peer learning and support, and collective voice.

Implications

7 Public financing is necessary

HBCC must be treated as a public good rather than a self-funded micro-enterprise, with predictable public financing to cover the true costs of quality care. This should exist alongside - and not be eclipsed by - direct interventions that strengthen Providers' financial stability through financial literacy, shared resource models, and linkages to existing programs.

8 Networks will elevate care

Investing in Provider networks is essential to ensure the authenticity, integrity, and sustainability of HBCC reform: they are the only real engine of lasting political reform. In addition, strong provider-led networks surface immediate needs and connect HBCC Providers to relevant services, strengthening their emotional and financial resilience.

Recommendations

1. Recognition

Establish HBCC as a formal, valued component of Kenya's ECD system and critical social and economic infrastructure

2. Quality & Capacity

Equip Providers to deliver optimal Nurturing Care through quality interactions and stimulating environments

3. Connection & Collective Organisation

Strengthen Provider-led networks and associations to drive and sustain policy change, and access to services

4. Financial Sustainability & Affordability

Build an equitable funding ecosystem for HBCC with government public investment as the foundation

Introduction

Background

The first five years of life represent the most rapid period of brain and broader physical development, shaping children's health, learning, and lifelong wellbeing.

During this foundational window, nurturing care, safety, responsive interactions, nutrition, and early learning opportunities are essential.

Yet, with an increase in women participating in the workforce, traditional support systems shift, and families increasingly depend on childcare arrangements outside the home.

Globally, it is estimated that 40% of all children (nearly 350 million) need childcare but do not have access to it (Devercelli and Beaton-Day, 2020).

Home-based childcare (HBCC), a form of childcare that is offered by a non-familial provider in their home, is an extremely popular and prevalent form of childcare worldwide (Samman & Lombardi, 2019) particularly in low-income households, because it is accessible, community-embedded, and culturally aligned with family needs (Kaneko, M. et al 2020).

Across Kenya, thousands of Providers, mostly women, provide daily nurturing care in HBCC settings, forming a vital but historically invisible pillar of early childhood development.

These Providers enable parental employment, meet essential caregiving needs for children ages zero to three, and sustain the well-being of families whose infants and toddlers fall outside the formal Early Childhood Care and Education (ECCE) system.

Despite their contribution, HBCC Providers have long operated with limited recognition, almost no public financing, and minimal access to training or support services.

Systemic Gaps

Investment in Early Childhood Care and Education (ECCE) is characterised by a significant policy paradox: while investments yield high societal returns (WHO, 2018), the sector remains profoundly undersupported domestically and globally.

A major driver of this under-investment is **the absence of reliable and representative data** on the scale, quality, and users of home-based childcare, reflecting the lack of an evidence base to advocate for increased public and philanthropic investment.

With respect to financing for ECCE, this challenge is acutely felt in Sub-Saharan Africa, where governments typically allocate a median of 2% or less of their education budgets (Harris et al., 2024) to ECCE.

In 2021/2022, Kenya reported public spending of KSh 10.2 billion on ECDE (Kenya Education Sector Report, 2024) - ~1.8% of its total education budget - a figure far below the 10% minimum benchmark urged by the 2022 Tashkent Declaration (UNESCO, 2022).

Our own analysis of 2023/24 ECDE spending among County Governments revealed that spending was entirely concentrated on pre-primary education or formal ECDE centres - for children aged four to five - with only four counties referencing “childcare facilities” as distinct programs.

Global aid mirrors this domestic skew, with only about 2% of international education aid targeting the sector and negligible amounts reaching HBCC specifically (Putcha, et. al., 2016).

The persistent absence of dedicated financing for HBCC means that Providers must stretch very limited resources, relying almost entirely on small, irregular contributions from families to sustain services. Yet there is very little information about who these families are, the conditions under which they use HBCC, or the pressures they face.

Without predictable funding for training, materials, safe spaces, and supervision, quality improvements remain ad hoc and uneven, resulting to wide gaps in the safety, nurturing care, and early learning opportunities available to young children.

HBCC already reaches thousands of children each day, functioning as a frontline care system that warrants immediate investment to ensure all children between zero to three years access quality, nurturing, developmentally appropriate care.

Such investment is critical to unlocking child development outcomes with long-term implications for cognitive and socio-emotional development, learning outcomes, and future productivity.

Strengthening HBCC is also central to fulfilling Kenya's obligations under the African Charter on the Rights and Welfare of the Child—including the rights to survival, development, education, and protection—for the 4.2 million children aged zero to three (African Union, 1990; KNBS, 2019).

At the same time, targeted investment in HBCC advances Sustainable Development Goal (SDG) Target 4.2 on quality early childhood care and SDG Target 5.4 on recognising and valuing unpaid care work, thereby linking child development outcomes with women's economic empowerment (Government of Kenya, 2024; WHO et al., 2018; UN, 2015).

NurtureFirst exists to catalyse collective action and government leadership to deliver an early childhood and care system that gives every child a strong start, enables both HBCC Providers and families to work with dignity, and drives inclusive economic growth.

As a foundational step towards this, a dedicated effort to map HBCC was undertaken to generate credible evidence on the scale, distribution, and characteristics, and to make visible the Providers who have long been operating beyond the reach of formal systems.

Strengthening HBCC is also central to fulfilling Kenya's obligations under the African Charter on the Rights and Welfare of the Child.

Why this mapping?

This HBCC Mapping Report offers, for the first time, an analysis of Kenya's HBCC landscape in three counties: Murang'a, Kisumu, and Mombasa; and reached **5,350 Providers** that collectively care for **21,784 children**. We purposively selected Murang'a, Kisumu, and Mombasa to capture varied demographic and economic contexts and examine how HBCC supports families across different settings.

This report reveals the scale of provision, the socio-economic profile of Providers, the daily realities of caregiving, and the structural barriers affecting quality and sustainability of HBCC. Consequently, it highlights both HBCC Providers' commitments to quality childcare and the significant challenges they face. The report also provides a holistic profile of children and the families who depend on HBCC.

This mapping has already catalysed action. Using data from this mapping exercise, County Governments, community-based organisations, and NurtureFirst have co-designed local interventions to support improved quality childcare delivery, supported Providers to establish networks, developed minimum quality guidelines, and advanced policy recognition across multiple counties.

Together, these partnerships are laying the foundation for coordinated, equitable, and evidence-driven investment in HBCC ecosystems.

Murang'a, Kisumu, & Mombasa Counties.

Kenya Country Overview

Under Kenya's devolved system, the Constitution (Fourth Schedule, Part 2) assigns County Governments, the responsibility for pre-primary education and childcare facilities.

The December 2024 delineation of functions (Gazette Notice No. 16483) further clarifies that the National Government develops national policy, norms and standards for childcare facilities, and County Governments are responsible for enacting corresponding county legislation, establishing, registering and managing facilities, and enforcing quality standards.

Executive Order No. 1 of 2025 subsequently confirms that the State Department for Children Services as the lead national entity for childcare implementation, within this shared framework. The framework also underscores the need for resource sharing and community participation to support effective implementation at county level.

Purpose of this Mapping Report

This Mapping Report responds to a critical system need by establishing a clear evidence base on HBCC to inform coordinated action.

It provides insight into who delivers childcare in communities, the enabling environment required for quality care, and the key intervention points that must be prioritised for Kenya to achieve real and equitable progress on early childhood care.

It is designed as a *practival decision-informing tool* for policymakers, implementers within and beyond the early childhood development sector, and funders working to strengthen childcare systems in Kenya.

Readers can use this report to:

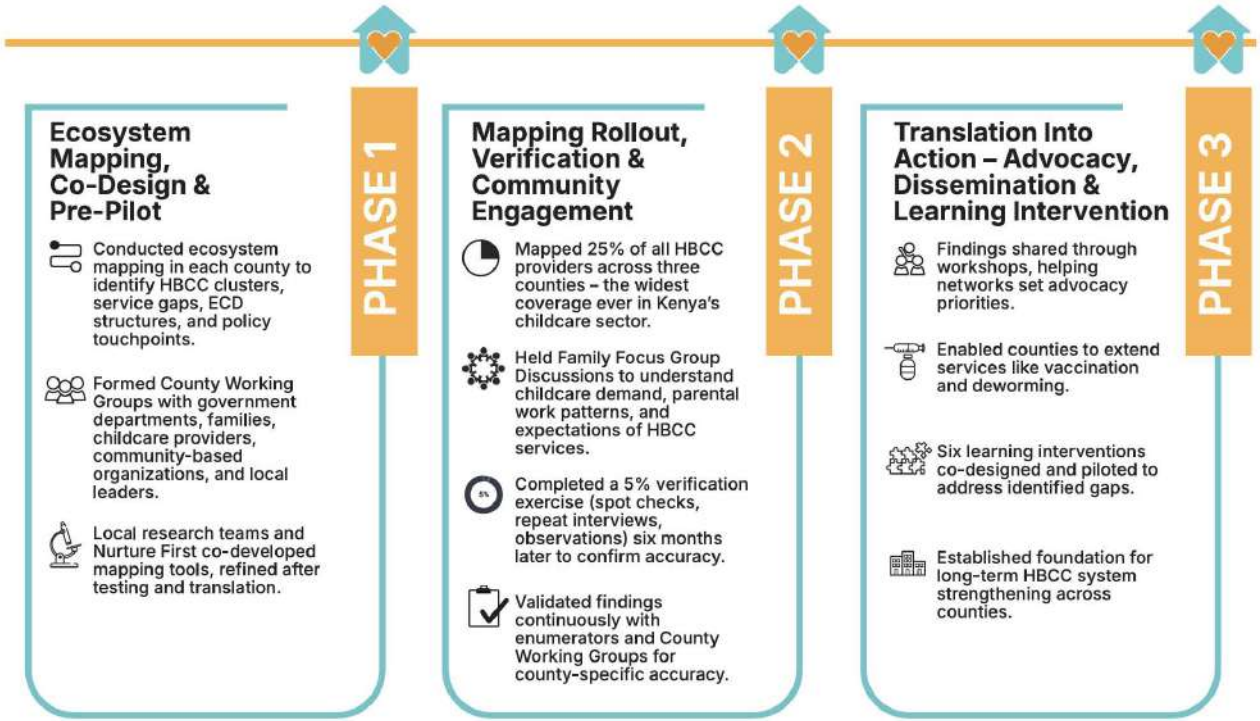
1. Understand the HBCC landscape : children cared for, Provider prevalence, operations, needs and barriers to quality service delivery

2. Identify opportunities to align programming, services and financing with HBCC Providers' needs

3. Strengthen advocacy for recognition of HBCC in National and County policy frameworks

The Process

The HBCC Mapping initiative was designed to *generate baseline evidence* needed to inform responsive, community-led support systems for the HBCC sector.



Mapping the HBCC Workforce: A Collective, Multi-phase process

Ecosystem Mapping and Collaborative Co-Design (months 1-3)

Phase 1

The first phase focused on understanding the existing childcare environment and creating a community-owned mapping strategy responsive to local needs.

To achieve this, in each County, an **ecosystem mapping process**[1] was carried out to identify key players and structures related to early childhood development, including services offered and relevant policies or regulations.

A crucial step was **establishing local collaboratives** in each county, known as **County Working Groups (CWGs)**. They played a vital role in providing contextual guidance, technical supervision, supporting community integration, and helping select the research teams.

They brought together a diverse range of Early Childhood Development stakeholders:

1. Governmen t representatives from national and county-level departments (Education, Health, Gender and Social Services)
2. Local and inter national civil society organisations delivering support services locally
3. Community members including local childcare providers, families (and non-parental headed households), community-based organisations (CBOs), and local leaders.

Local research teams and NurtureFirst led the technical mapping design which entailed:

- Determination of the **appropriate sample size** (approximately **25%** of the estimated HBCC provider population).
- Co-development of the **mapping tools**, along with tool testing and translation.
- **Methodology refinement** to determine effective methods for identifying “active HBCC Providers” through verifiable criteria
- **Data verification**: comprising spot checks, repeat interviews, and physical observations; and planning for a **verification exercise** that was conducted later on in the project.

1 https://nurturefirst.org/kenya-hbcc-systems-map/

HBCC Provider Mapping and Verification (months 4–8)

Phase 2

The mapping initiative began in Mombasa County to allow for learning and adaptation before expanding to other counties. Community participation was embedded throughout both the mapping and verification phases.

Mapping involved deploying validated tools to achieve broad coverage and capture a holistic, accurate view of the home-based childcare sector, resulting in:

- **Scale and representation**
  The mapping achieved a representative sample of 25% of the estimated HBCC providers in each county, using a comprehensive, 109-item structured questionnaire administered via KoboCollect.

  Data collection involved in-home visits by trained enumerators, requiring approximately 40-60 minutes per Provider to cover demographics, qualifications, perceived challenges, and quality of care.

  Crucially, the credibility of Provider self-reports was enhanced through triangulation, complementing the quantitative survey data with systematic observations using a standardized 30-item physical environment checklist.

- **Contextual validation**
  Continuous, real-time validation happened through ongoing dialogue with enumerators and Community Working Groups (CWGs) during data collection.

  This helped the team quickly identify where the tool needed to be adapted for the local context, allowing for swift context-specific adjustments to be made.

- **Complementary demand-side insights**
  Focus group discussions (FGDs) with families captured crucial demand-side insights (parental work patterns and HBCC service delivery expectations)

Data fidelity through verification: six months after the initial mapping, we conducted a **5% verification exercise** (involving spot checks, repeat interviews, and physical observations). This step confirmed the existence, active **status, and reported characteristics** of mapped HBCC Providers, significantly strengthening **data accuracy**.

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Dissemination, Advocacy & Learning Interventions ongoing

Phase 3

The primary goal of this phase was to move findings into the public sphere and directly influence programming and policy.

- **Dissemination and validation**

  Key findings were shared and validated through targeted sector convenings at global, national and county levels", ensuring alignment and ownership among all stakeholders, contributing towards validation, and promoting data accuracy.

- **Direct advocacy**

  Local HBCC providers networks used the findings to define and shape their advocacy priorities , transforming data into a unified voice for change.

- **Service extension**

  Local non-state actors were able to extend and tailor services and programs based on the specific gaps identified by the mapping exercise. County departments began extending critical health services, such as vaccination and deworming , directly to the children cared for by mapped HBCC Providers.

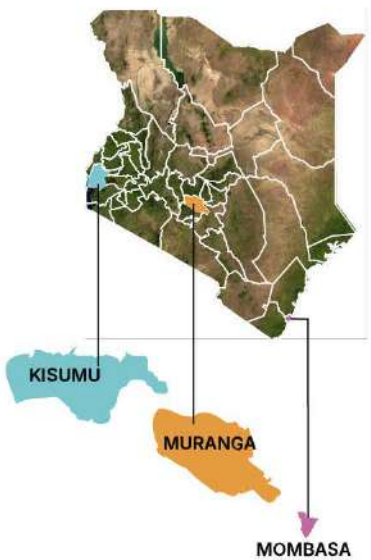
- **Learning and innovation**

  NurtureFirst, along with local partners and community-based organisations co-designed and are currently piloting six specific **"learning interventions"** to address the operational, quality, or structural gaps identified during the in-depth mapping study.

This deliberately inclusive mapping process is informed by our belief that to strengthen local HBCC ecosystems, robust and actionable evidence is most effectively generated with communities, rather than solely about them.

We see sustained, community-led evidence processes as a core system need. To this end, we share tools, data and learning transparently so Providers, County Governments and sector partners can use the evidence to design responsive policies and programs for young children and their Providers.

Findings



1,798 Providers
6,221 Children

1,268 Providers
6,756 Children

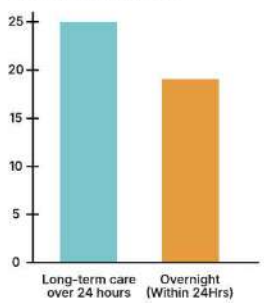
2,284 Providers
8,672 Children

Provider Profile

- 44 Average Age
- 19.8% Smart phone Access
- 40% Membership in social groups
- 14% Connected to other HBCC Providers
- 74% Providers without Secondary school completion Certificate
- 7% Providers who have formal ECD Training
- 9 Average number of Hrs HBCC Providers operate
- 75% HBCC Providers operating for >5 years

Care Hours

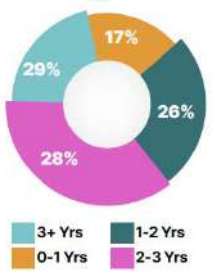
Provider offerings: Longterm care and Nightcare



Children in HBCC

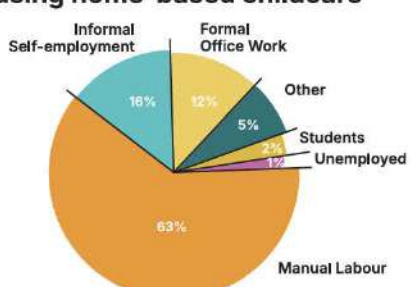
Ages of children in HBCC

Provider:Child Ratio 1:3



Nutrition

Primary Occupations of Parents using home-based childcare



Hours of Care

Average daily hours spent in HBCC

Fees & Payments

Providers Charging Fees 49%

Collected Consistently 51%

Kshs. 100

Average fee per child per day

12

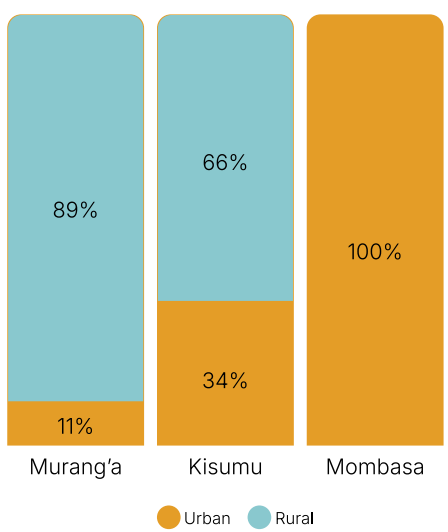
Key Insight 1

HBCC is a critical care system for families across demographic divides in Kenya and can be the foundational delivery system for services across Counties

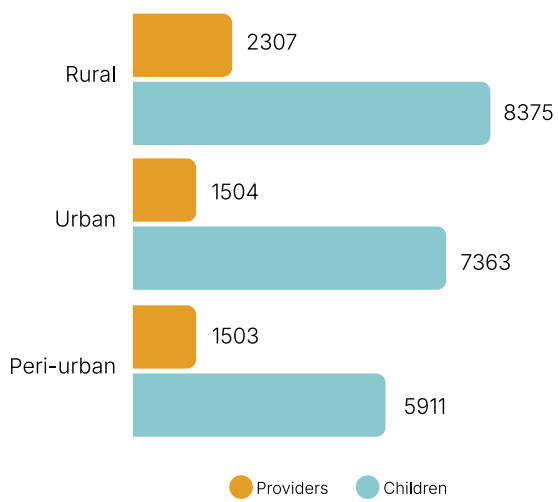
HBCC is a culturally resonant, community-driven, and organically scaled childcare solution widespread across Murang'a, Kisumu, and Mombasa counties, filling a critical gap where formal early learning and childcare services are inaccessible, unaffordable, or entirely absent.

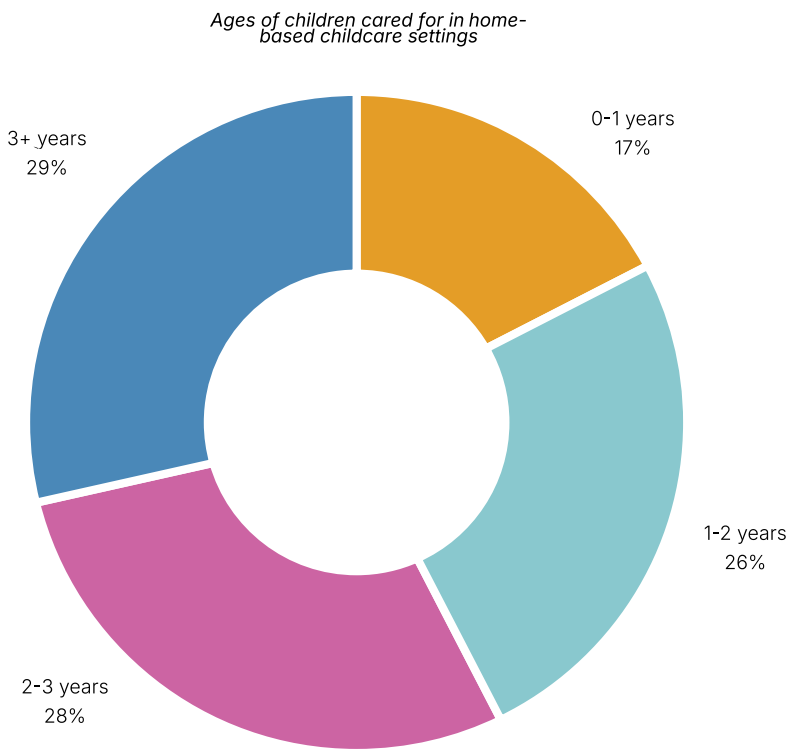
Despite substantial differences in population distribution and levels of urbanisation - 61% of Kisumu's population is rural, only 11% of Murang'a's population resides in urban areas, and Mombasa is predominantly urban - HBCC Providers are present in significant numbers in all three counties, this indicates strong cultural and community demand for HBCC across both rural and urban contexts.

Providers who operate in rural or urban settings across counties



Number of Providers compared to number of children by level of urbanization





Across the mapped HBCC settings, a total of **21,784 children** are cared for. The age distribution shows that care is heavily concentrated in the earliest years, with 17% aged 0–1, 26% aged 1–2, 28% aged 2–3, and 29% aged 3 years and above.

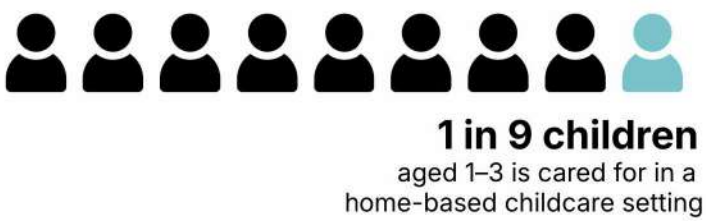
Overall, **more than two-thirds of children in HBCCs are under three years**, highlighting the central role of HBCC in providing care during the most developmentally sensitive period prior to entry into formal ECDE.

HBCC is closing the ECD service gap for children aged 1-3

Data from the counties confirms that the largest share of HBCC-enrolled children are aged one to three, making up 50–75% of children cared for in HBCC settings. This cohort is largely overlooked by both Education and Health Systems, falling between formal ECCE provision that targets children aged 4-5 years on one side, and structured contacts with the Health System which focus on postnatal, infancy visits, and immunization for children under one year of age.

In Murang'a County, there are 43,551 children aged 1–3 years (KNBS, 2019). Our representative sample of HBCC Providers - a fraction of those believed to be operating in the county - were already caring for approximately 4,700 of these children.

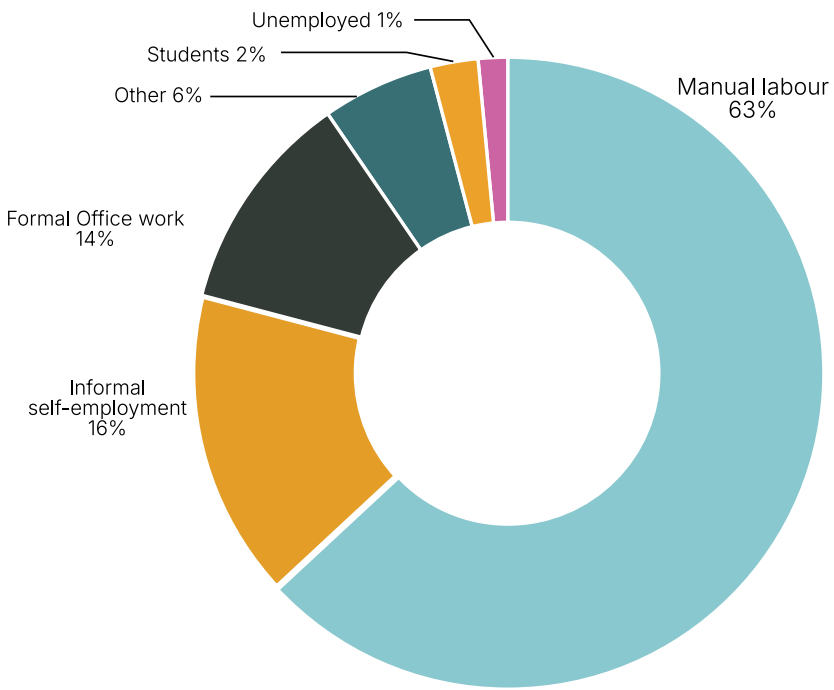
In other words, this small slice of Providers provides early childhood care to roughly one in every nine children. Similar proportions are found in Mombasa and Kisumu County.



Who HBCC Serves: Families supported by a vital and accessible childcare solution

The distribution of HBCC mirrors the economic rhythms of Kenyan communities and is shaped by the livelihoods of the families who use them, primarily low-income households engaged in informal or economically precarious work.

Primary occupations of parents using home-based care



The distribution of HBCC mirrors the economic rhythms of Kenyan communities and is shaped by the livelihoods of the families who use them, **primarily low-income households engaged in informal or economically precarious work**.

In the **rural areas** of Murang'a and Kisumu, women's engagement in agriculture, casual labour, and small-scale trading creates unpredictable workdays that require flexible childcare.

In **urban** and **peri-urban areas** (Mombasa, Kisumu city wards) informal-sector work is dominant and is characterised by long, non-standard day and night working hours, and non-salaried and unpredictable wage arrangements.

Formal childcare is either unavailable or incompatible with these sorts of working arrangements, making demand for HBCC equally high across all these settings.

HBCC is also a **critical enabler for young mothers**, allowing them to pursue higher education through accessible and affordable childcare.

Scarcity of Alternatives

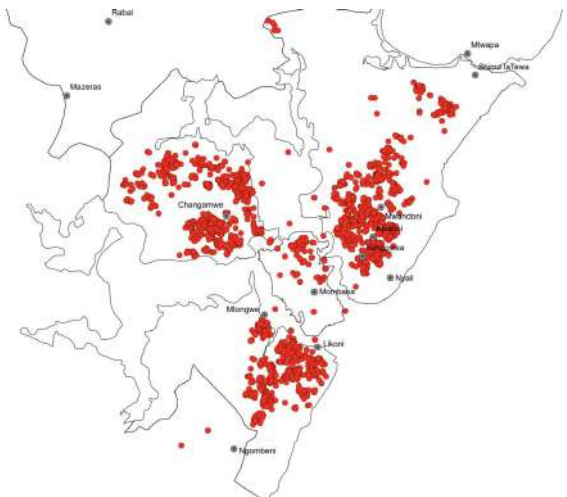
47% of enumerators encountered other early childhood development services during the mapping. Where alternatives do exist, they are mainly centre-based Early Childhood Development facilities nested within primary schools, private childcare centres, or religious institutions that typically serve higher income families. All these options rarely serve children under four years, are often scarce and widely dispersed, and often operate within set, standard hours.

Unequal Distribution: Some families are doubly disadvantaged

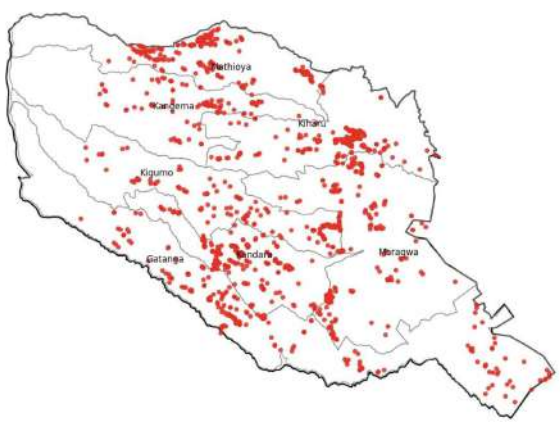
HBCC prevalence varies significantly across sub-counties. In several areas, the limited supply of both formal ECDE centres and HBCC Providers highlights a clear opportunity to expand HBCC, both in quality and scale, to better meet family needs and strengthen equitable access to Early Childhood Care and Education, and parental labour opportunities.

Sampled HBCC Locations in Kisumu, Murang'a and Mombasa Counties

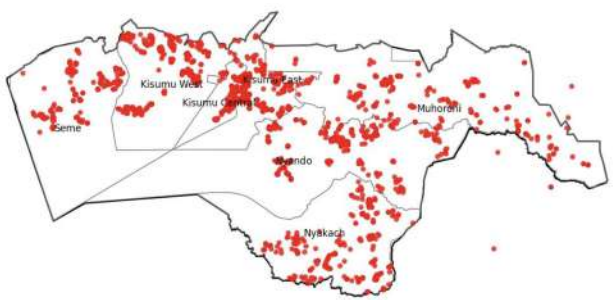
Sampled HBCC Locations in Mombasa County



Sampled HBCC Locations in Murang'a County



Sampled HBCC Locations in Kisumu County



Provider Motivations: A workforce built on a culture of care, necessity, and community demand

The motivations driving HBCC Providers are diverse, however, consistent themes emerge between Counties. Across the counties, **requests from neighbours** was the most commonly cited motivation for Providers to start their work.

In Murang'a a further 26% were motivated to begin offering childcare services out of a **personal passion for childcare**. In Mombasa (28%) shared that **economic necessity** was their top reason for running a HBCC.

Meanwhile in Kisumu, though 25% of the Providers referenced their **personal passion for childcare** as their main reason for running a HBCC; family needs, caring for relatives or responding to a crisis situation, play a much larger role in initiating HBCC services in Kisumu (12%) compared to Mombasa (5%) or Murang'a (4%).

Relatedly, Kisumu County has the highest rate of Providers who do not regularly charge for their services (77%), followed by Murang'a (26%) and Mombasa (9%), reflecting a strong ethos of care and communal responsibility.

Providers Vulnerability: A workforce characterised by social-economic vulnerabilities

HBCC Providers operate under severe socio-economic constraints, facing financial instability, lack of formal recognition, housing insecurity, and professional isolation all while shouldering critical responsibility for children's safety and wellbeing without adequate support, training, or compensation.

Lack of Formal Recognition Prevents Access to Support and Benefits: The HBCC sector operates overwhelmingly in the informal economy, with 99% of providers reporting no formal registration status. This lack of formal recognition prevents providers from accessing government support, training, formal employment benefits, and financing opportunities. It also creates constant uncertainty about their business's legal standing.

Personal circumstances compound Provider vulnerability

Providers are sometimes the only bread-winner for their household: 38% are single, separated, or widowed women, and 46% come from female-headed households. Sometimes HBCCs operate from Providers' homes and 39% of Providers report "balancing childcare responsibilities with other household duties" as one of their biggest challenges.

This emotional and physical toll represents a psychosocial vulnerability.

Financial instability and low earnings create a fragile HBCC ecosystem

HBCC Providers face significant financial instability due to low, irregular income and a lack of formal benefits. Their primary source of income comes from contributions paid by parents, and based on what is affordable rather than the true cost of childcare delivery.

Further nearly half of all providers (49%) report unreliable income or difficulty collecting payments from parents as one of their biggest challenges.

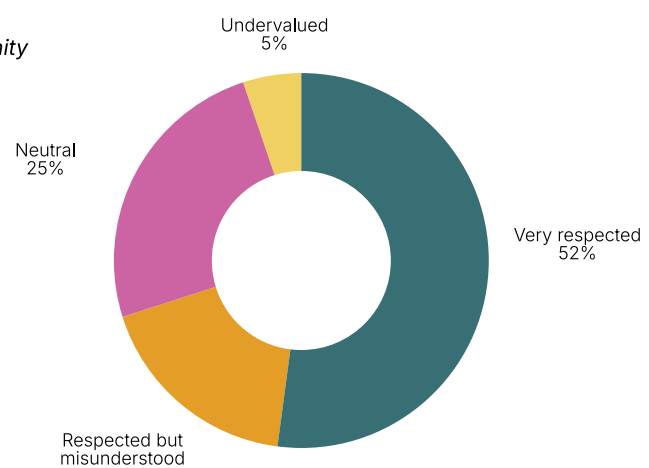
How providers are perceived in the community

Despite these compounding socio-economic challenges, **Providers feel valued** , with 70% reporting that they feel respected in their communities, including 52% who feel very respected.

This level of social trust is a major asset: it affirms that families recognise the vital role Providers play in keeping children safe, nurtured, and cared for so parents can work.

High job satisfaction levels reinforce this strength: **75% in** Kisumu, 77% in Mombasa, and 86% in Murang'a are satisfied or very satisfied with this work choice, demonstrating personal fulfillment even in the face of financial and operational constraints.

How Providers think the community perceives their work



Key takeaways

- Across Kenya's diverse settings, HBCC is a critical foundational early childcare system that emerged organically to solve a local childcare shortage. It is vital social and economic infrastructure that helps the most economically vulnerable families to remain economically active by offering flexible care that allows them - especially women - to work and earn a living.

- HBCC is filling a cr itical gap in Early Childhood Development services for children ages one to three who most often fall into a blind spot : they have aged out of the most intensive infant health contacts but are still too young to benefit from pre-primary-based health and early learning services. As a result, they are largely invisible to both the Health and Education Systems, despite this being a critical window for brain development, nutrition, and protection.

- HBCC Providers find satisfaction in their work and feel seen and valued by families and the local community , underscoring the sector's strong social roots and its role as an organic, community-responsive solution whose deep community ownership is a key driver of long-term sustainability.

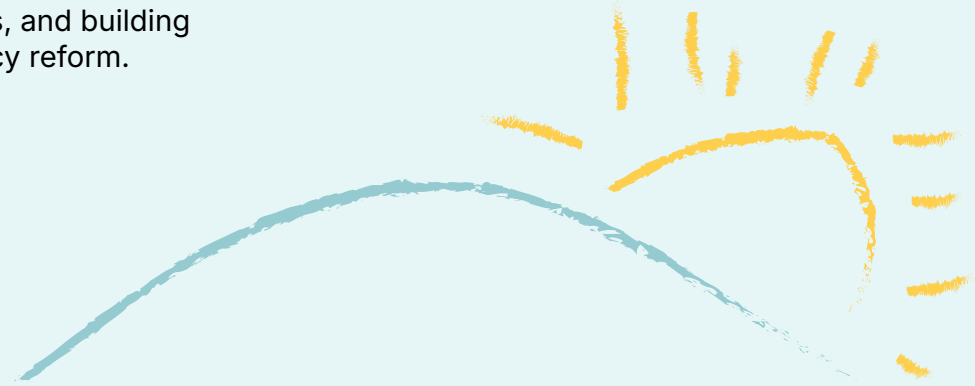
- HBCC Providers are among the most socio-economically vulnerable actors in their communities, despite bearing immense responsibility for the early development of Kenya's future human capital. This stark mismatch underscores an urgent imperative for formal recognition and support through policy inclusion, dedicated financing, and coordinated, multi-sectoral system planning.

Key implications

Recognising HBCC as critical economic and social infrastructure, NurtureFirst is working to strengthen both the visibility, professionalization, and long-term sustainability of the sector.

The goal is to shift public perceptions to fully acknowledge HBCC Providers as frontline early childhood caregivers whose work directly contributes to early childhood development, women's economic empowerment, and long-term social and emotional wellbeing - all key contributors to Kenya's current and future economic prosperity.

We believe that the most effective and sustainable solutions are rooted in affected communities. As such, our approach is centred on creating and supporting local Community Platforms, and building alliances to advance national, regional and global policy reform.



Key Insight 2

HBCC Providers should be recognized and proactively integrated into availabe systems to bridge the service access gap and improve quality

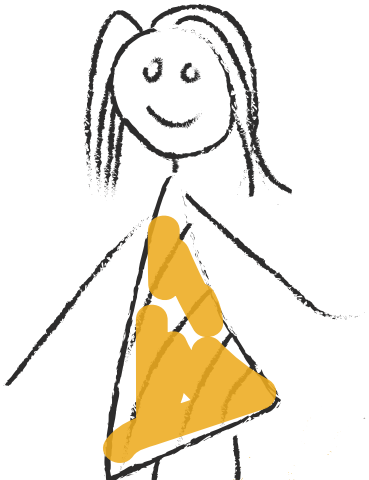
A vital public workforce operating without public and civil society support

The mapping reveals a striking gap between HBCC Providers on the one hand, and the government and NGO systems designed to support Early Childhood Development on the other.

During the ecosystem mapping phase, local county working groups identified over 146 unique services - provided by Commercial, Government and Non-Government Actors - that could support Providers' wellbeing and improve delivery capability.

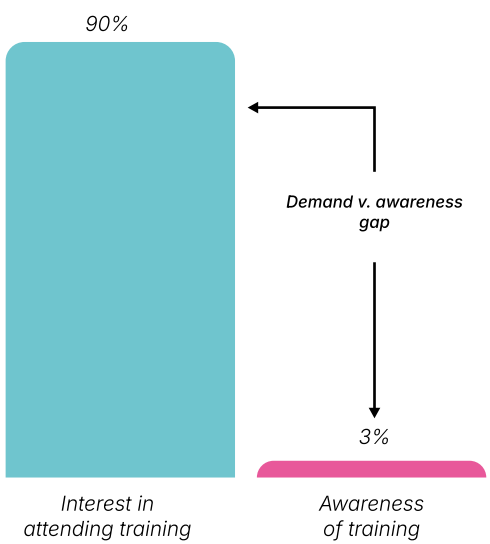
However, only 3% of Providers are aware of Government support programmes, and a similar number are aware of NGO initiatives. Providers' lack of awareness also signals a systemic breakdown: services may exist, but they are not reaching the Providers who support hundreds of thousands of the country's youngest children.

Among the very small group of Providers who reported accessing government services, 83% report visits from Community Health Promoters , indicating a strong existing touchpoint with the County Departments of Health. Providers most frequently reported exposure to vaccination and deworming campaigns, Vitamin A supplementation, growth monitoring and development checks.



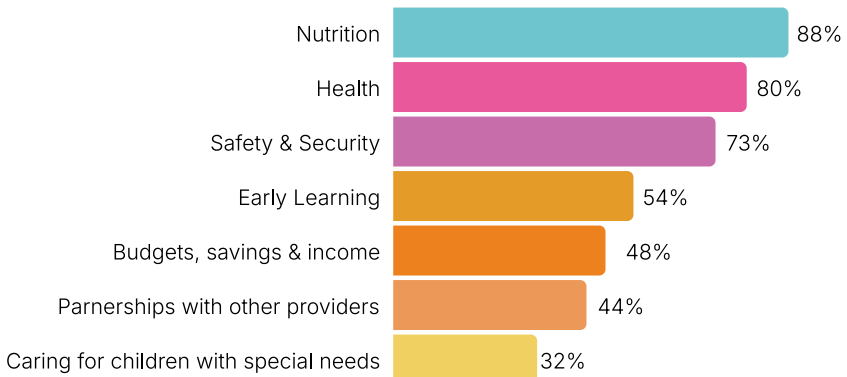
Yet this engagement with the health system is only at the most basic, outreach-driven level, typically when health workers conduct broad community campaigns. This indicates that Providers are visible to the government and NGOs as households, but invisible as essential Early Childhood Care service Providers.

Training demand vs awareness



Weighted Kenya average

Types of training that most interest providers



Significant access–demand gap

Despite the low levels of service and training access, Providers express a clear and consistent desire for training: **90% of Providers want to be trained in ECD-related topics.** However, only 3% are aware of any available training opportunities, a gap that presents a clear opportunity to strengthen childcare delivery and early childhood outcomes.

Fragmented services for Children with Special Needs

Across the three counties, the mapping exercise identified 372 children with special needs, representing approximately 1.5–2% of all children enrolled in the HBCC settings we surveyed.

The most frequently reported challenges were physical and mobility-related difficulties (22%), followed by developmental and cognitive disabilities (10%), and speech or hearing impairments (9%). However, over half of all reported disability descriptions (54%) were vague or nonspecific.

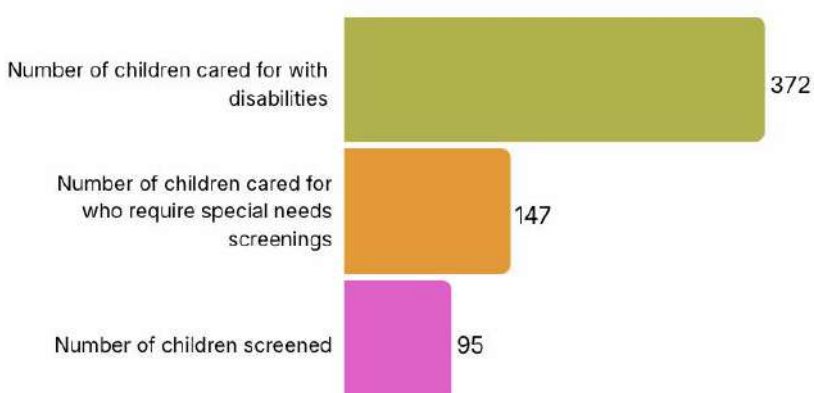
Screening and referral services (defined as standardized developmental checks conducted by trained healthcare workers to assess motor, language, cognitive and other developmental aspects) remain inconsistent and insufficient. Nearly 50% of Providers caring for children with special needs reported that the children in their care required screening and referral services, but were yet to receive the necessary support.

This gap points to missed opportunities for early screening, identification, timely intervention, and appropriate support. With adequate training and structured support, HBCC Providers can serve as a critical frontline extension of early identification and referral systems for children with developmental delays and disabilities .

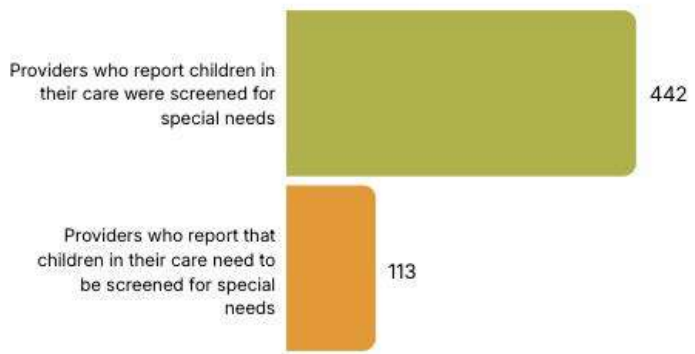
Targeting of special needs screening varies substantially across HBCC settings

Notably, three times as many Providers report that children in their care have been scr eened (450) as compared to those who report actually caring for children with special needs (113), suggesting that screening and referral support is unevenly distributed and not systematically targeted to settings where children with additional needs are present.

Number of children with disabilities, in need of screen, or previously screened, as reported by Providers



Number of Providers who report children were screened compared to number of providers who children need to be screened for special needs



Key child development lever

Diagnosis of delays, regressions, or disabilities requires specialised, technical knowledge. Early detection allows children to access appropriate interventions and support at a stage when their brains are most responsive to change, improving long-term developmental, educational, and social outcomes.

With appropriate training and support, HBCC Providers can play a critical role in identifying early signs of developmental or other challenges, and referring parents to the relevant services for follow-up support.

Formal HBCC registration pathways are nonexistent leaving Providers largely invisible

Only **1% of HBCC Providers** (71 out of 5,350) reported to be formally registered with County Governments despite collectively caring for close to 22,000 children.

This extremely low registration rate underscores a major policy gap: HBCC Providers are performing an essential public function but remain unseen by county and national systems, highlighting a missed opportunity to provide oversight and support to providers.

Policy analysis conducted alongside this mapping exercise revealed the absence of a national policy and regulatory framework for childcare. At the county-level, where licensing and registration frameworks are domesticated, HBCC has not been defined as a distinct mode of childcare delivery. As such, no formal recognition or registration pathways exist for HBCC that reflect its distinct form.

Key takeaways

- Over 95% of HBCC Providers are disconnected from formal systems and continue to deliver care without access to updated guidance on delivering optimal nurturing care. With 91% of Providers having no formal ECD training, there is an economic, social and moral imperative to recognise and support their role as early childhood practitioners.

- The extremely low formal registration rate (1%) points to the absence of an appropriate registration and licensing framework for HBCC. This contributes to a gap in quality data on provision, and presents a significant barrier to public and private investments in the HBCC sector. Such a framework should be non-punitive, and position the government as an enabler - not just an enforcer.

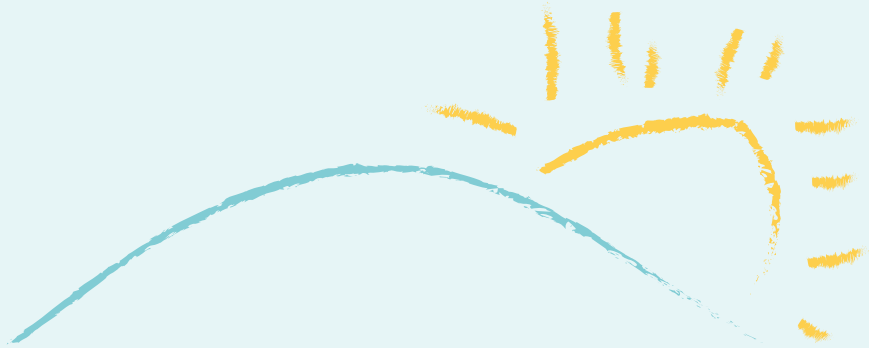
- While the mechanisms for identifying and supporting children with developmental needs appear to exist, they are fragmented and unevenly accessible, contributing to Children with Special Needs in HBCC settings being under-identified and inconsistently supported. HBCC Providers can play a critical role in supporting early identification and referral.

- Despite being disconnected and without formal training, over 90% of Providers express a strong desire to learn and attend training, creating a significant opportunity to improve quality and enable improved child development and growth outcomes.

Key implications

With only 1% of Providers registered and 95% lacking access to support services, children remain disconnected from critical health, education, and social protection systems. NurtureFirst strengthens local ecosystems by mapping and generating evidence to drive recognition, and institutionalizing platforms that connect Providers with essential government and local NGO services. Our strategy combines these direct “last-mile” linkages between Providers and the local products and services they require, with structured quality improvement training and mentorship .

Through these complementary approaches, we are modeling a more coherent and responsive HBCC system, while advocating collectively - alongside other actors and Providers network - for more accessible ECD services and clearer referral pathways.



Key Insight 3

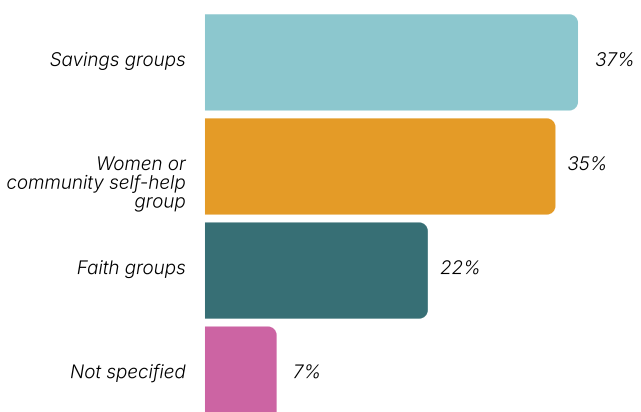
Networks are a key platform for learning and support among HBCC Providers

Social groups are a common feature of many African communities, functioning as informal institutions for mutual support, information sharing, and collective problem-solving.

Across the counties, **two in five Providers report belonging to at least one social group**. The most common group memberships are economic or savings groups and faith-based groups. 60% of Providers are not in any social group.

Group Membership Among HBCC Providers

Group affiliations of Providers who report any type of group membership



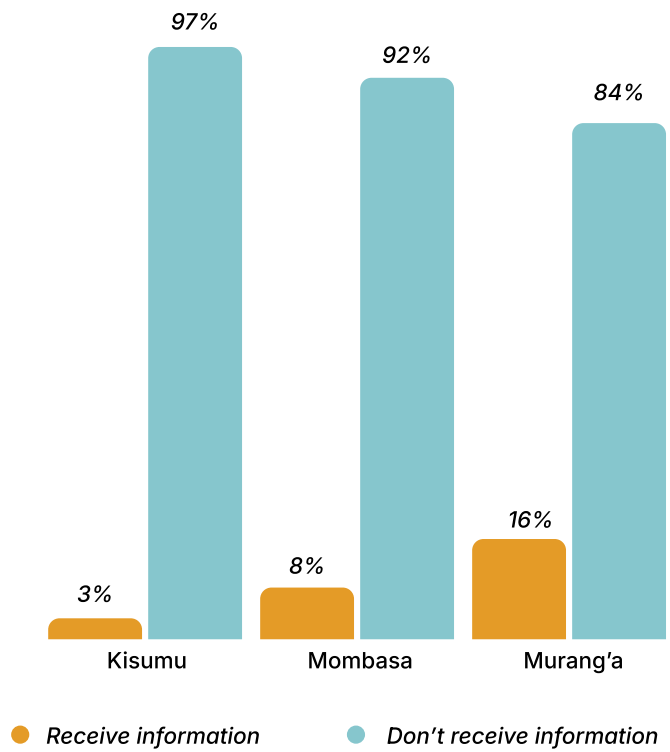
Providers are embedded in wider networks but weakly connected to one another

Only **13%** (720) of Providers across the three counties reported being connected to other Providers in the community, leaving the majority without structured avenues for childcare-related knowledge-sharing, peer support, and collective problem-solving.

78% of HBCC Providers also receive no information to support their work, highlighting an urgent need to build strong Provider networks that enable peer learning, shared problem-solving and solidarity.

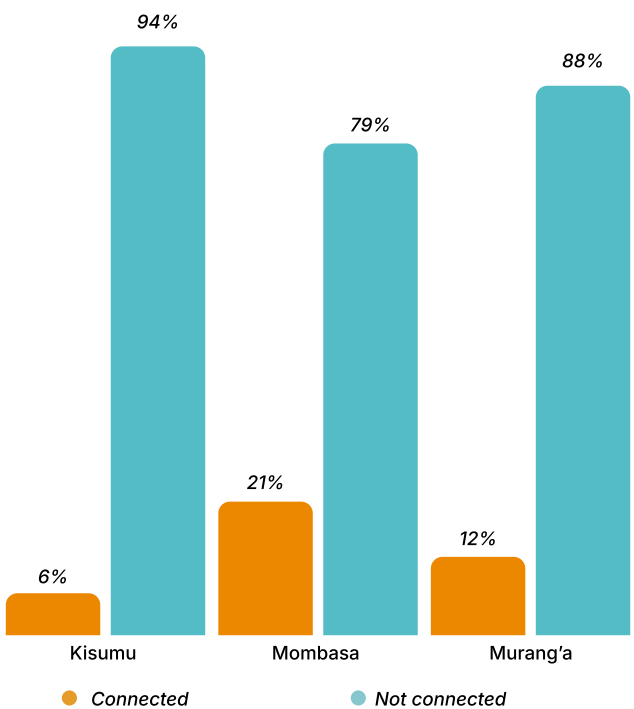
Where Providers do receive guidance, it is overwhelmingly rooted in their immediate social environment - coming from parents, neighbours, community members, and Community Health Promoters - highlighting how embedded HBCC Providers are within local community networks.

Providers who receive information about childcare by county

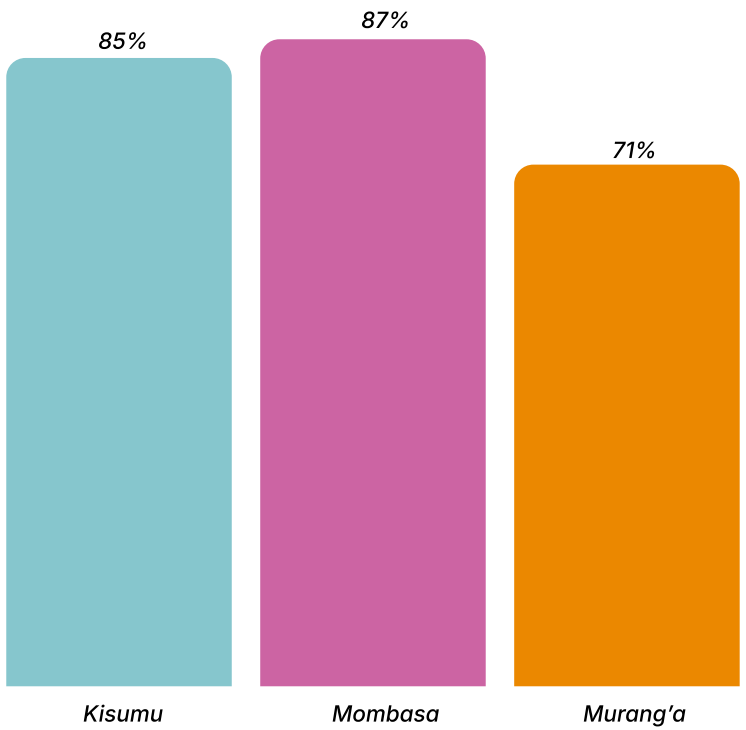


The desire for connection is extremely high. Across the counties, 83% (3,857) of Providers reported they would like to be part of a network with other HBCC Providers reported wanting to join a network of HBCC Providers.

Percentage of providers who are connected to each other by county



Percentage of unconnected Providers who want to be connected, by county



Key takeaways

- HBCC Providers operate without the support of a Community of Practice, with only 13% of providers connected to one another. Three out of every four Providers report not receiving any information regarding their work. This isolation prevents the powerful multiplier effect of peer-to-peer learning and prevents Providers to amplifying their own voices and collectively advocating for the support they need.

- The desire for connection among Providers is exceptionally strong, with 3,857 providers across the three counties explicitly wanting to join an HBCC-focused network. This significant number points to a substantial, unmet need for collaboration and community.

Key implications

The acute isolation of the HBCC workforce, coupled with their strong desire to connect, presents a significant opportunity. Organised networks can play a critical governance role, serving as platforms for peer accountability, self-regulation, and the gradual adoption of shared quality standards .

They offer the government a more structured counterpart for dialogue, coordination, and oversight, making it easier to channel training, resources, and supervision in ways that systematically improve quality.

NurtureFirst directly addresses HBCC Provider fragmentation by supporting Providers to establish and manage their own networks, believing that Provider networks, conceived as Communities of Practice and Belonging , are a pathway for scaling and sustaining HBCC support programs.

Recently established networks are drafting and presenting memoranda to County Governments, contributing to budget and planning processes, offering vital psychosocial support and a sense of solidarity, and functioning as a critical “last-mile” mechanism that links Providers to health, nutrition, social protection, and early learning services.

Key Insight 4

Targeted approaches support Providers to improve quality and outcomes across nurturing care domains

Quality childcare plays a critical role in safeguarding children and nurturing their development, complementing the role played by primary caregivers at home in ensuring children receive the five key components of the Nurturing Care Framework: good health, adequate nutrition, responsive caregiving, opportunities for Early Learning, and Safety and Security (WHO, 2018).

The Nurturing Care Framework is a roadmap for action, to help children survive and thrive to transform health and human potential. This framework exists alongside other guidelines and implementation tools to support the nurturing care agenda.

This section examines both structural and process quality in HBCC settings. Drawing on HBCC Provider feedback alongside systematic observations by trained enumerators, it offers a rich, triangulated view of quality "on the ground," capturing both what Providers say they do, and what is actually happening in practice.

These findings highlight specific, actionable gaps where relatively modest investments - such as clearer and context-specific standards, practical guidance, supportive supervision, and low-cost materials - could translate into substantial improvements in children's safety, learning, and overall well-being.

Quality in childcare is commonly understood along two interrelated dimensions: structural and process. Structural quality refers to the physical environment and foundational features of a childcare setting, while process quality relates to the day-to-day experiences children have in that setting, shaped largely by their interactions with, and the competencies of, caregivers (OECD, 2018). Together, these dimensions capture how the nurturing care framework is put into practice in childcare settings.

How did we define quality?

The definition of quality for Home-Based Childcare (HBCC) was developed through a triangulated, multi-level framework that grounded global evidence and benchmarks in local realities, preferences, and priorities. This process integrated three critical perspectives:

1. **Parental preference**

   Quality was initially informed by the voice of the HBCC service users. Focused Group Discussions (FGDs) were conducted with parents to elicit their definitions of quality, preferences, and selection criteria for childcare services.

2. **Local expertise and contextualization**

   In 2023, the County Government of Mombasa established a Technical Working Group to define Minimum Quality Standards, adapting existing public health, education, and social protection standards used in institutional settings.

   The resulting standards - developed through a deeply consultative 12 month process involving Nurturing Care Framework (NCF) domain experts and HBCC immersion for TWG members - were enriched through County Working Group discussions across all the Counties[3].

3. **Global benchmarking**

   To provide external rigor and ensure alignment with evidence-based practice, quality standards were validated against international guidelines and standards: The Nurturing Care for Early Childhood Development (WHO et al., 2018), UNICEF's Programme Guidance for Early Childhood Development (UNICEF, 2017), OECD (Organisation for Economic Co-operation and Development) Starting Strong Series (OECD, 2021), and World Bank Guidance Note: Essential Elements of Quality in Childcare Settings[4] (Kelly & Beaton-Day, 2025).

This synthesis formed the foundational definition of quality used for the mapping, and informed the subsequent development of the NurtureFirst Quality Improvement Roadmaps (QIRM) to support HBCC Providers meet minimum, basic and best practice Minimum Quality Standards.

3 NurtureFirst is working with the County Government of Mombasa to pilot these standards, align them to national standards - currently in development - and embed them in non-punitive registration and licensing frameworks.
4 NurtureFirst reviewed and contributed to an early draft of this publication.

Structural Quality

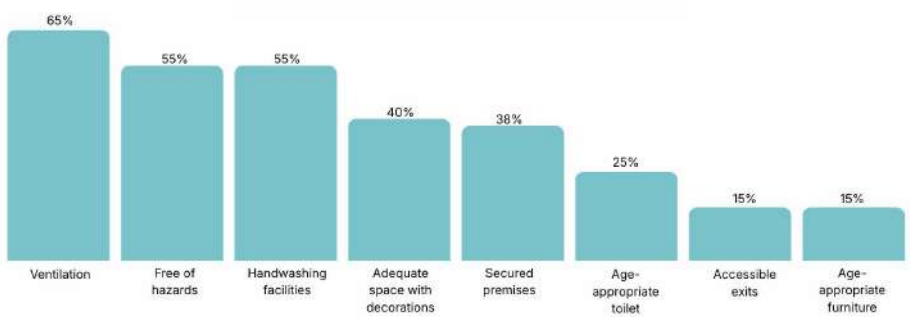
Physical Environment: Multiple constraints and structural gaps

Observations across the country reveal that, while many spaces meet some minimum conditions - such as secure premises, basic cleanliness, and adequate light and ventilation in approximately two-thirds of facilities - significant gaps remain:

- **Ventilation**: Ventilation is largely **adequate**, with **65%** of homes rated as “well ventilated” or “very well ventilated,” and only a small minority **(8%)** reported as poorly ventilated due to missing or blocked windows.
- **Floor Condition: 55%** of homes use **durable, hard surfaces** (mostly bare concrete), but **one in five homes (21%)** still rely on unhygienic, non-durable surfaces like earth or mud.
- **Sanitation:** The sanitation standards are markedly low heightening the risk of waterborne and hygiene-related diseases among young children: facilities are dominated by **pit latrines (58%)** and a high prevalence of shared access (for example, nearly half of all flush toilets are shared); critically, **unimproved and hazardous methods** (like bucket latrines and open defecation) exist in 7% of HBCCs

- **Space:** 60% of settings are overcrowded
- **Securing a nd fencing:** a smaller 38% are fenced, and just 15% have accessible fire exits—an important concern given periodic fire incidents in informal settlements.
- **Child-sized fur niture:** is available in fewer than 15% of HBCCs

Percent of providers who meet physical environment standards



These conditions reflect low-income, informal housing realities, economic constraints, and the absence of guiding HBCC standards in Kenya.

- One in three Providers operate from rented homes , often in informal settlements or low-income areas where they have limited control over structural improveements such as lighting, ventilation, sanitation, or flooring.
- Providers who own their homes tend to have longer residence histories , but are still constrained by the cost of renovations, landlord approvals, or limited access to financing for upgrades.
- Numerous Providers have lived in the same housing units for 3–5 years , and HBCC emerged organically within the space available, not as a purpose-built facility.
- Kenya currently has no national standards governing infrastructure for childcare services, whether home-based or centre-based, meaning HBCC Providers have no formal guidance on required space, ventilation, sanitation, or safety measures[5].

Taken together, the findings show that while physical and infrastructure limitations are significant, they arise from systemic constraints, not providers' lack of care or willingness.

Availability of materials

Play materials - which include basic and pretend play and exploration materials, early books, picture materials and everyday objects - are a core ingredient of early stimulation, giving young children opportunities to explore, imagine, and practise emerging skills. Yet 70% of HBCC Providers report that they do not have adequate resources for the children in their care and identify this as their single biggest challenge.

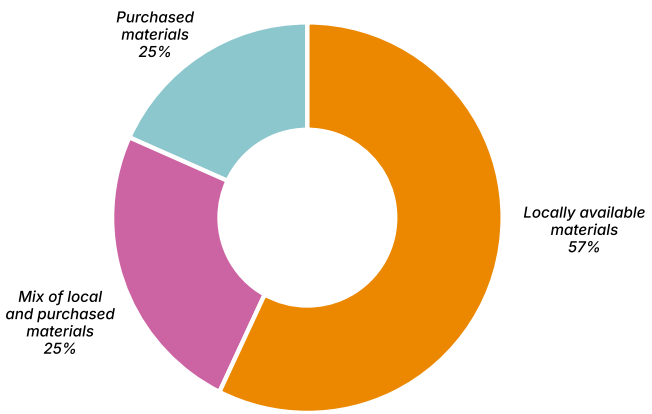
This constraint not only limits the variety of learning experiences, but also places an emotional burden on Providers who might be aware of what children need but lack the means to consistently provide it - especially in low-income settings where parents are unable to supply materials themselves.

> 70% of HBCC Providers feel that they do not h ave adequate access to resources for their children, and cite this as their most significant challenge.

Among those with access to materials, 57% of Providers rely on locally available items such as sticks, leaves, and mud; 18% use purchased toys; and 25% use a mix of both.

5 Efforts are underway from the State Department of Children Services to develop national childcare standards. Mombasa County has developed HBCC-specific minimum quality guidelines that are being piloted before adoption into licensing and regulation frameworks.

Types of materials Providers use when playing with children



Books are an important tool for building children's vocabulary, imagination, attention, and early concepts. Children aged 0–3 explore books with their bodies and senses: looking, listening, touching, and pointing. They provide an accessible means to promote school readiness and reduce early learning inequalities in low-resource settings. **However, only 18% of providers report having books**.

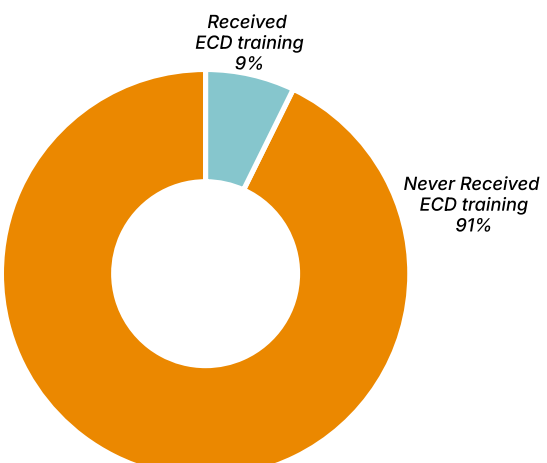
"Only 18% of Providers report having books."

Minimal formal ECD training and professional development opportunities

Most Providers (93%) have never received formal ECD training leading to ECDE-accredited certificates or other recognised credentials. Among those who are trained, the pattern is highly fragmented - a mix of ECDE certificates, and short courses on childcare, nutrition, or Maternal and Child Health.

Providers' expertise is grounded mainly in lived experiences and community practices. With targeted and structured HBCC-relevant training and supervision, this existing base of practical knowledge can be rapidly strengthened, enhancing the overall competency and status of this workforce.

Percentage of Providers who report ever receiving Early Childhood Education (ECD) Training



Similarly, trainings on financial literacy, which could significantly bolster Providers' ability to provide childcare, are effectively nonexistent - only 1% of Providers report having received this type of support before.

Despite operating in physically constrained environments, and with extremely limited formal training, many HBCC Providers still manage to meet basic safety and hygiene thresholds, drawing creatively on locally available items to support children's early learning.

A demographic in need of flexible support pathways

The predominantly female (98%) HBCC workforce ranges from 16 to 85 years, with an average age of 44. This wide age distribution demonstrates that the HBCC sector is a critical source of income and activity for women across all life stages.

This demographic reality requires support systems and formalization pathways that are flexible enough to accommodate the needs of both younger and older Providers within the informal economy; and should leverage their two main information lifelines: Community Volunteers - including Community Health Promoters (56%) - and mobile phones (49%).

Process Quality

Observed care-giving routines are strongly oriented toward meeting young children's basic physical needs (nutrition, hygiene, and protection). This indicates that Providers are reliably attending to **survival and health needs**, a basic threshold of quality.

Caregiving routines reported per county

Further, Providers' confidence levels in understanding and responding to various children's cues indicate that they are generally able to respond to children's cues in a timely and sensitive manner.

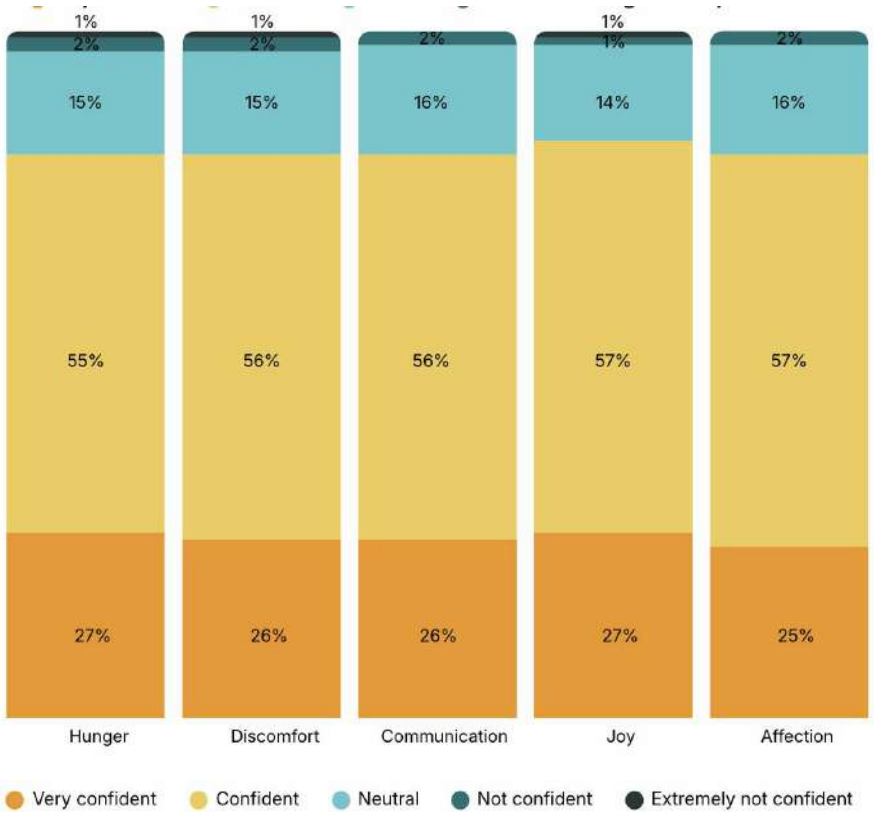
For every category, from basic needs (hunger) to emotional expressions (affection), over 80% of respondents feel confident or very confident.

Early learning that supports cognitive, socio-emotional and motor development

In practice, Providers already deliver some foundational stimulation - mainly play, singing, and counting - which is developmentally appropriate and highly beneficial for infants and toddlers, fostering essential motor skills, emotional security, and language rhythm.

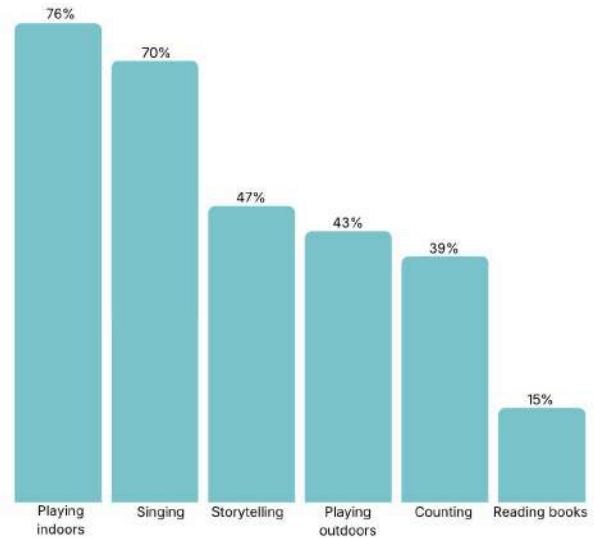
However, the extremely low rate (15%) of Providers incorporating storytelling or shared book reading - important for language development and early literacy - is notable. This pattern reveals that while early learning is happening, it is narrow in focus.

Providers' confidence levels in understanding and responding to various cues

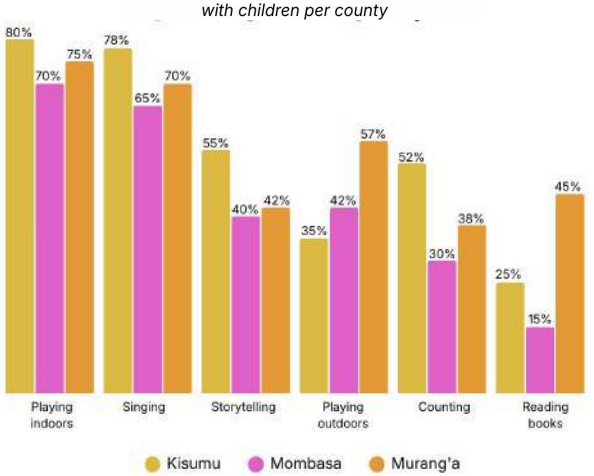


Key Insight 4

Types of activities providers report doing with children



Types of activities providers report doing with children per county



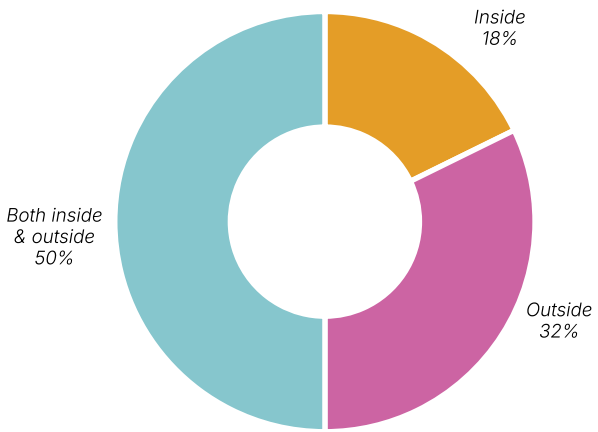
Lower demand for early learning training

Providers primarily see their role as safeguarding children's survival and wellbeing: they overwhelmingly prioritise training in nutrition (88%), health (80%), and safety (73%), while just over half (54%) express interest in early learning. This suggests that play-based and stimulation-focused caregiving are not yet widely understood as being part of their remit, even though Providers are, in effect, very early educators. There is therefore a critical opportunity to sensitise Providers that early learning is not an "optional extra" but a core dimension of quality care, and offer targeted support to optimise children's development during these foundational years.

Age-appropriate play-based activities

The importance of child-led and adult-supported play experiences form the core of early learning, supporting brain development, attachment, language, and socio-emotional skills. Indoor play (such as responsive interactions, songs, stories, and simple object exploration) and outdoor play (which adds unique benefits through movement, sensory stimulation, and exposure to varied environments) provide opportunities for young children to build the cognitive, physical, and relational foundations they need to thrive. **Across the counties,50% of Providers reported that children spend most of their playing in both indoor and outdoor spaces**.

Where children spend most of their time playing

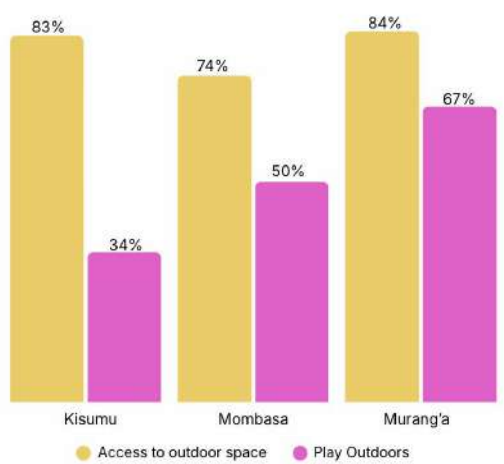


Whether indoor or outdoor, HBCC settings are lively, play-rich environments where children's play is **dominated by gross motor activities** comprising ball games (29%) and running, jumping, hide-and-seek, and chase games (28%). 25% of children engage in improvised play with toys and objects. Forms of play that are strongly linked to early cognitive, language, and socio-emotional development - such as singing and storytelling - and roleplaying, are less reported at 16% and 2% respectively.

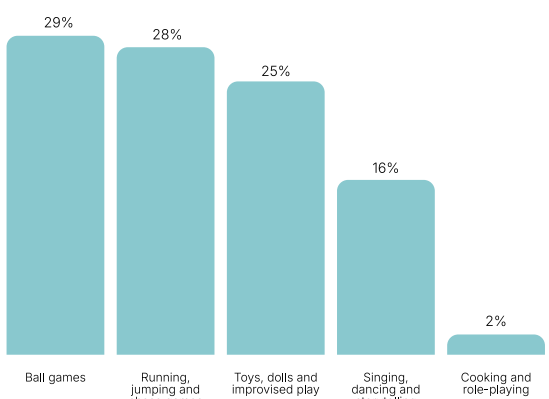
Access to safe outdoors spaces

Across all three counties, most HBCC settings have access to outdoor areas where the sky is visible. These outdoor spaces not only support physical development but contribute to better mental wellbeing and healthy vitamin D levels. The actual use for children's play varies widely, suggesting additional constraints - especially safety concerns - limit how often these spaces are used.

Providers' outdoor access and children's outdoor play frequency by county

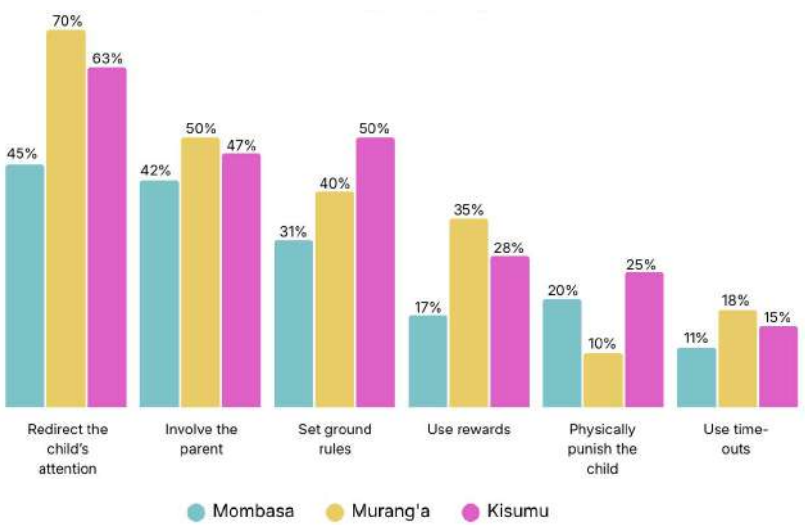


Types of games children typically play, as reported by Providers



Positive Discipline

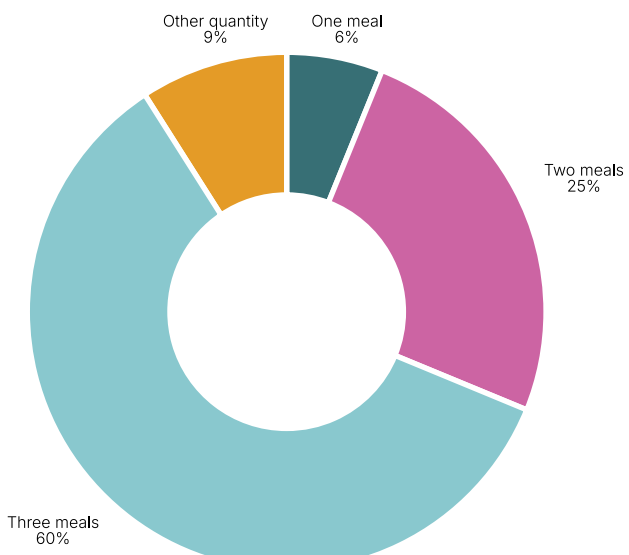
Behaviour management plays a vital role in early childhood development, supporting children to build emotional regulation and social skills. Many Providers already use approaches such as verbal guidance, redirection, and separation to manage behaviour. There is a strong opportunity to further strengthen the use of positive, developmentally appropriate strategies that nurture children's social and emotional growth.



Nutrition

Nutrition is a critical determinant of physical development including brain development in the early years. Across the Counties, 78% of HBCC Providers report that they provide meals for children in their care, and in 91-98% of cases, Providers themselves are responsible for preparing and cooking. Murang'a County is a notable outlier, with only 18% of Providers indicating that they prepare meals on site, underscoring county-level variation in how children's nutritional needs are met within HBCC settings.

Meals per day provided per child in HBCC



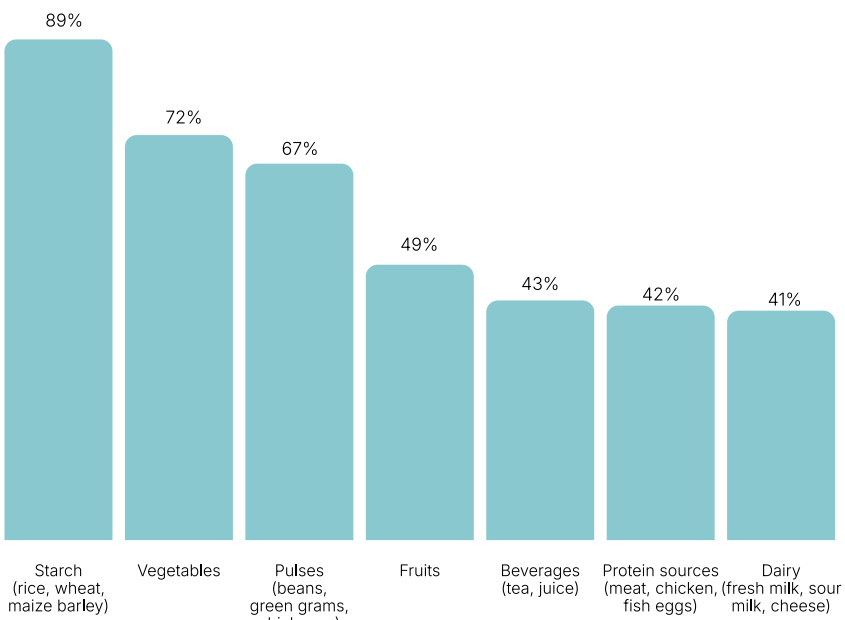
Most HBCC Providers supply multiple meals per day, with 60% providing three meals and 27% providing two. In practical terms, an estimated 10,701 (49%) children receive the bulk of their daily food intake in HBCC settings, making Providers pivotal gatekeepers of children's nutrition, health, and early brain development.

Limited dietary diversity: The three most commonly offered food groups are starches (89%), vegetables (72%), and pulses (67%). By contrast, only two in five providers report serving animal-source protein or dairy.

Such meals meet basic energy needs but provide insufficient variety of nutrients required to support optimal growth, brain development, and immune function in children aged 0–3 years.

Kisumu and Murang'a emerge as notable outliers, with 62% of providers in Kisumu reporting higher than average (42%) provision of animal-source protein (predominantly fish and meat) and 62% of providers in Murang'a reporting provision of dairy (primarily milk).

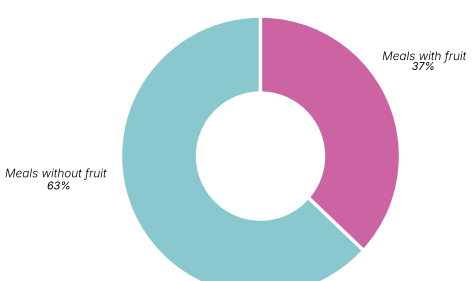
Percent of Providers who report giving children different types of food and beverages



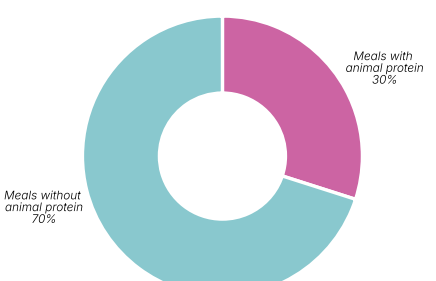
The dominant starches offered are rice, ugali (a firm cooked porridge made of maize flour, a common staple food in Kenya), and potatoes. Commonly reported vegetables include amaranth, kales, collard greens, spinach, and cabbage, while pulses are primarily represented by beans and green grams. Only 37% of Providers offer fruit to children in their care.

Providers report that food is one of their two largest expenses—nearly 90% of providers in Mombasa and Kisumu report food (88-90%) is their highest expense. For Providers in Murang'a, 76% of Providers report that water and rent are their highest expenses, followed by food.

Percentage of Providers who feed children fruit as part of the meals provided



Percentage of Providers who feed children animal protein as part of the meals provided



A harsh yet common reality is that high prices make nutritious diets increasingly unaffordable for the majority of Kenyan households. Recent analyses of the Kenyan food system show that although diverse and healthy foods are available, income poverty and rising food costs mean 74% of the population cannot afford sufficiently nutritious and varied diets, with affordability —rather than access—acting as a primary barrier to dietary diversity (de Jong et al., 2024, UNICEF, 2025)[6].

Whether brought from home or by the Provider, children consume largely the same foods: The foods offered by Providers broadly mirror those provided by parents with minor exceptions: parents provide porridge and tea substantially more frequently (~30-40%). This suggests that many households are not consuming diverse diets at home - whether due to cost, limited knowledge, or other constraints.

Provider-parent interactions

Focus Group Discussions revealed that in most cases, there is no clear agreement or contract governing the relationship between Providers and parents. Instead, key issues - such as how fees are set and adjusted, pick-up and drop-off times, and who is responsible for providing food - are handled through ongoing, ad hoc negotiation.

This lack of clarity leads to misunderstandings and inconsistent expectations, and places additional emotional strain on Providers. Establishing simple, shared agreements on roles and responsibilities creates a clearer framework for collaboration, enabling Providers to put in place predictable systems and processes that are understood and respected by all parties.

6 While our study did not directly ask Providers why they do not offer more diverse diets, Providers' reported expenses alongside wider evidence on food systems, strongly suggests that cost, rather than physical access, is a central barrier.

Key takeaways

- HBCC environments are often physically constrained and under-resourced due to systemic limits rather than Provider neglect or unwillingness . This strong foundation of Provider commitment and ingenuity, must be matched with clear national standards, and targeted investments in infrastructure and materials, to allow Providers to offer safer, more stimulating spaces for young children.

- Low Child-Provider r atios amongst the vast majority of Providers presents an exciting opportunity to strengthen process quality , and improve early learning and responsive caregiving outcomes. With targeted training, coaching, and simple tools, Providers can quickly build the skills needed to engage more confidently and meaningfully with each child - arguably the most important lever for improving child outcomes.

- HBCC Providers ar e a predominantly older, female workforce ranging across all adult ages with varying levels of capability ; efforts to support them must comprise flexible and age-responsive pathways that also consider their existing information lifelines: Community Volunteers and mobile phones.

- Half of all children mapped r eceive the bulk of their daily food intake in HBCC settings , and are exposed to a limited range of food groups that closely mirrors their nutrition intake at home. Given the critical role nutrition plays in brain development, Providers are shouldering immense responsibility without support . A systemic and local solution is needed to identify and address the specific constraints to age-appropriate, quality nutrition, while simultaneously equipping Providers with practical guidance and support on affordable, nutritious feeding practices.

Key implications

Strengthening Providers' knowledge and practices present one of the most effective and scalable pathways to improved early childhood development outcomes. With partners, NurtureFirst is piloting "Quality Improvement Roadmaps" (QIRM), consisting of training curricula and a community-led mentorship program that supports HBCC providers to meet basic quality standards across all nurturing care domains.

Our goal is to open-source the QIRM to allow actors to scale effective quality improvement support to all Providers who require it. To realise this scale of impact, the QIRM will be aligned to national childcare standards, and supported by enhanced non-punitive county monitoring and supportive supervision.

Physical and material investment are also critically important, as we explore further in *Key Insight 5*. In parallel, childcare stakeholders must also help address the broader systemic constraints shaping HBCC - such as informal urban housing, inadequate WASH infrastructure, and limited access to affordable, nutritious food - to create enabling environments where quality can be achieved and sustained.

Key Insight 5

Financial and in-Kind investments in HBCC are critical for attainment of quality and equitable childcare

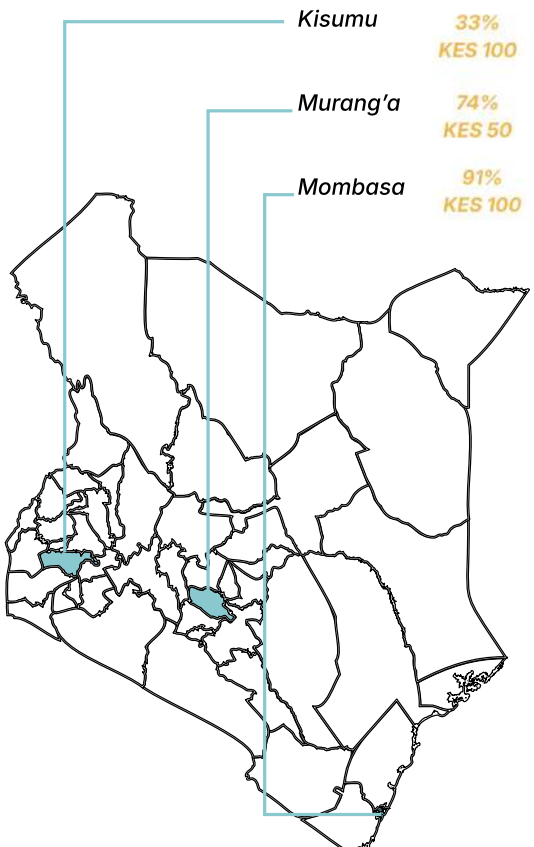
HBCC Payments: Cash, Kind, and Care over Fees

Fee structures and forms of payment vary widely across HBCC settings, and not all Providers charge for their services. Where payments are made, they are accepted in both cash and in-kind contributions, The proportion of HBCC Providers who report charging fees varies markedly by county: 33% in Kisumu, compared with 74% in Murang'a and 91% in Mombasa.

Parental Payments are irregular or incomplete
Between one third and half of all Providers consistently reported that parents do not pay fees on time, skip payments entirely during difficult months, pay below agreed-upon amounts, or only when able. Mombasa exhibits the highest payment instability, with nearly half of providers (49%) reporting that parents do not consistently pay.

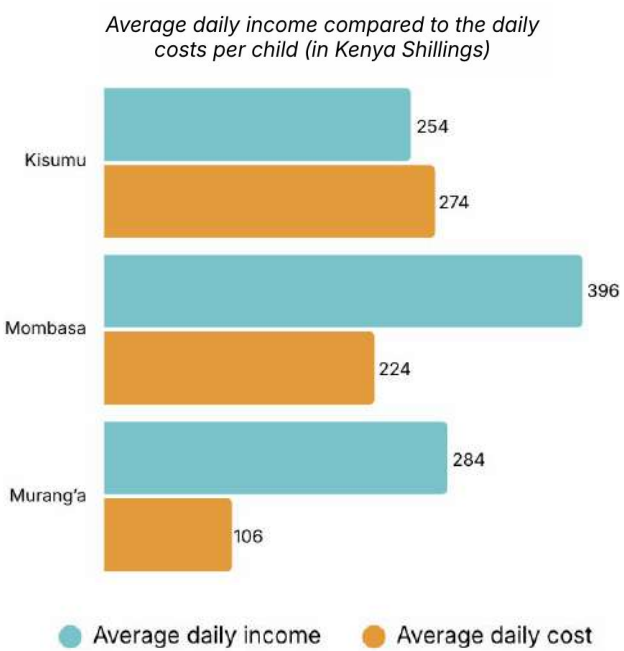
Taking previous findings into consideration, these patterns suggest that HBCC is shaped by social obligation, reciprocity, and community norms around care, and not driven solely by income-generation motives.

Percentage who charge,and amount charged (daily popular rate)



Providers operate on non-existent or fragile margins

Across all three counties, Providers consistently reported income levels that barely cover - and in some instances fall short - of their operational expenses. The quantitative comparison of *daily income and expenditure* illustrates this strain clearly:



Income is directly proportional to the number of the children

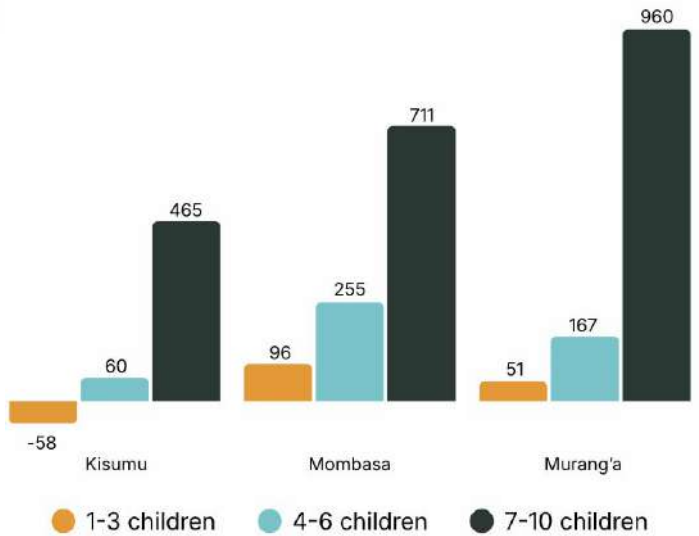
With only minor variations, all counties display a similar pattern, earnings closely track the number of children cared for, with the smallest HBCCs operating on the thinnest margins.

Providers caring for 1–3 children report the lowest daily income (overall KES 195 income against KES 163 spend), with Kisumu Providers even running a deficit (KES 160 income vs KES 218 spend). Providers in Mombasa and Murang'a earn only modest surpluses.

For Providers with 4–6 children, income rises but margins remain very thin and income stability is low (overall KES 430 vs KES 245), leaving limited room for savings or reinvestment. Only Providers with 7 or more children report clearly higher earnings (overall KES 1,680 vs KES 897 spend). This indicates that financial viability depends heavily on the number of children cared for, and the size of the HBCC operation.

Largely due to space constraints and fluctuations in demand, 87% of Providers care for fewer than seven children effectively capping their potential income. While a small minority care for ten or more children, they still do not see proportional increases in income because family contributions remain extremely low.

Average daily income compared to the daily costs per child (in Kenya Shillings)



Only **17%** *keep any financial records.*

It is likely that Providers are not reporting all expenses, indicating a strong need for financial literacy training and support

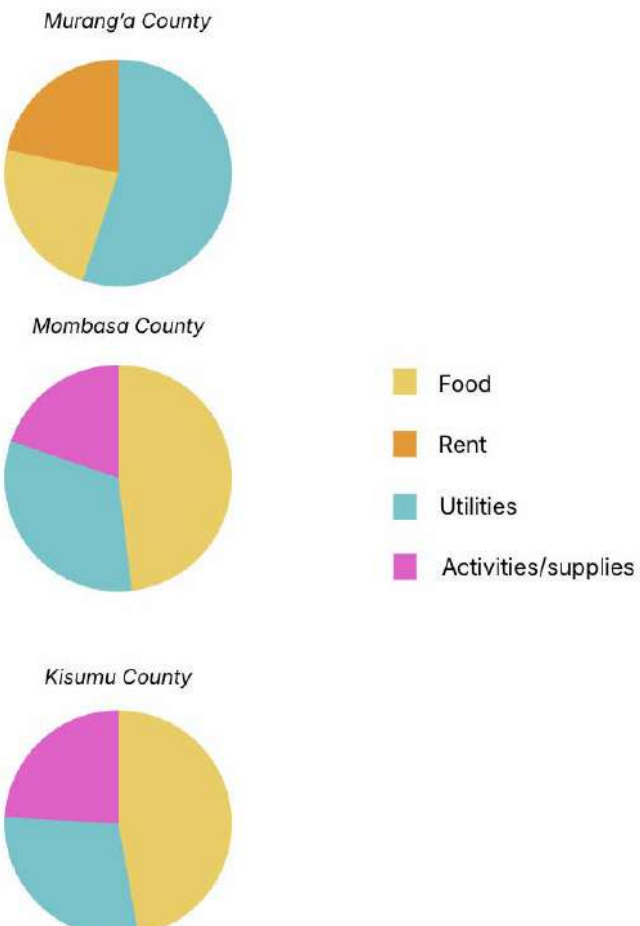
In a sector that is overwhelmingly female - where two in five Providers are single, separated or widowed - and with limited employment options, HBCC currently offers income, autonomy, and community contribution.

However, without training and financial support, it traps women in extremely low-paid, high-responsibility, high-burnout roles.

A "children's ayah" provides a useful benchmark for non-skilled childcare work, with a basic minimum daily wage of KES 775 (Republic of Kenya, 2024), yet only HBCC Providers in Mombasa and Murang'a caring for more than six children earn amounts that come close to this level - underscoring how far most HBCC incomes fall below the lowest formal wage reference point.

Strengthening HBCC financing and skills development must therefore be treated as a core women's economic and justice priority, demanding deliberate policy action, targeted subsidies, and integration into wider livelihoods and social protection programmes.

Top three items providers spend most of their money on in their HBCC



Cost drivers

All Providers indicated that food is among their top two highest monthly expenses , with Mombasa (~88%) and Kisumu (~90%) reporting it as their top cost driver.

While essential, this spending on food crowds out investments in other drivers of nurturing care: spending on Activities/Supplies consistently ranked lower - 36% in Mombasa and 46% in Kisumu.

The exception is Murang'a, where Utilities (Water/ Electricity) (~75%) surpassed food (~68%) as the most frequently cited major expense. Across all counties, Rent/ Lease remains the lowest primary expense, cited by only 11% of Kisumu Providers, and rising to 30% in Murang'a.

Providers predominantly rely on the small cash or in-kind contributions received from families to cover their costs. However, half of all Providers report that parents experience difficulty paying them .

How Providers arrive at their fees

Across all three counties, Providers determine what to charge based on parental affordability and mutual agreement, against a backdrop of widespread economic hardship.

Fee Determination Method	Percentage of Reasons Mentioning Theme [7]
Agreement / Negotiation	23%
Parental Affordability	22%
Cost / Expenses / Economy	8%
Area Rate / Standard Fee	2%

The single most frequent factor determining the fee is Agreement/Negotiation with Parents (23%). This theme shows that Providers rarely impose a fixed price. Instead, the final fee is the result of dialogue, bargaining, or a mutual consensus on what is “manageable” for both parties.

This negotiation is, however, severely limited by the equally dominant factor of parental affordability (22%). The fee reflects what families can bear, not what it actually costs to deliver quality childcare, which is far less commonly reported (8%).

This low frequency confirms that Providers are largely unable to pass on their operational costs (e.g., rising food prices, utilities). In many ways, the fee that is paid is more a token contribution or minimal stipend for basic supplies.

49% of Providers report that Parents are not able to consistently pay them.

7 Since many Providers cite multiple reasons (e.g., both “Agreement” and “Affordability”), the percentages below are not mutually exclusive and represent the proportion of all unique reasons that mention a particular theme.

The payment preferences of HBCC Providers reveal distinct county patterns: the daily rate remains the most popular choice across Counties - 81%, 62%, and 59% in Muran'ga, Kisumu and Mombasa respectively.

Other options, such as hourly, weekly, monthly, and morning/ afternoon rates, are marginal in comparison, with the exception of Mombasa, where more Providers (29%) report that parents prefer monthly rates.

Providers Regularly Use Their Own Resources to meet operational costs

54% of Providers reported supplementing their HBCC operations with personal savings, primarily to purchase food, pay rent, buy cleaning supplies, and meet emergency needs.

Lastly, the mapping data revealed that most Providers operate for 3-5 years, strongly signalling HBCCs struggle to survive on family contributions alone . This underscores an urgent imperative for governments to invest decisively in stabilising and strengthening the sector.

Quotes from providers

> *I calculated my expenses, but parents cannot afford more, so I had to reduce the fee.*

> *If I charge higher, I will lose parents. Most of them are casual workers who earn very little.*

Key takeaways

- There is a deep structural tension within the HBCC sector: Providers deliver an essential commun ity and public service, yet operate almost entirely at their own financial risk with minimal government or NGO investment or support.
- HBCC runs on fina ncially fragile, unpredictable, and largely unsustainable models . The sector is underfunded even for current quality levels and far from what quality childcare actually would cost to deliver. Upgrading meals, play and learning materials, and ongoing Provider training and mentorship would require system-level public and private investment.
- Financial lit eracy is a critical tool for Providers self-reliance and financial wellbeing , and should be made accessible to all Providers. However even with this knowledge, HBCC is untenable as a business for the vast majority of Providers.

Key implications

Local childcare systems need to find ways to make HBCC delivery more financially sustainable for Providers and and parents who rely on them, without imposing a rigid entrepreneurial framework onto a sector rooted in communal care and social support.

This requires action at multiple levels. At the system level, efforts should focus on defining and costing what quality childcare entails and ensuring that public financing structures reflect childcare's role as an essential social service and economic infrastructure rather than an informal enterprise or self-funded activity.

At the Provider level, strengthening HBCC services involves expanding access to practical supports such as financial literacy, tools for managing irregular income, and inclusive financial resources that enable more stable and higher-quality care.

Together, these interventions contribute to an enabling environment for safe, reliable, and equitable childcare provision.

Recommendations

The mapping reveals both the scale and the systemic importance of HBCC in Kenya.

To unlock its full potential as a driver of **Early Childhood Development, school readiness, long-term human capital growth, and women's economic empowerment**, Kenya should adopt a coherent, multi-level strategy centred on four core pillars: Recognition, **Quality & Capacity, Connection, and Financial Sustainability** supported by essential cross-cutting actions in **data, policy, and public advocacy**.

1 Recognition: Establish HBCC as a formal, valued component of Kenya's ECD system

Why this matters

Recognising Providers means recognising children's right to nurturing care and equitable early learning

Key Actions

- **Develop a national and county recognition pathway for HBCC Providers**, including a tiered registration and licensing framework
- **Recognise HBCC as essential to Kenya's human capital goals**, including in national development plans, including and proceeding Vision 2030, and County Integrated Development Plans (CIDPs)
- **Clarify roles across Health, Education, Social Protection, and Labour**, enabling HBCC to be supported as an integrated caregiving service.
- **Create county-level HBCC Provider registers** to support planning, service delivery, and referral systems

2. Quality & Capacity: Equip Providers to deliver optimal Nurturing Care

Why this matters

Quality interactions and stimulating environments are the strongest predictors of *child development outcomes* .

Key Actions

- **Develop a national HBCC Minimum Quality Standards Framework** - and adopt a non-punitive monitoring and support system
- **Create County-level funds to support Providers improve structural quality** - such as books, materials and toys, carpets and rugs etc.
- **Develop systems that make learning continuous,** to improve children's developmental trajectories
- **Roll out accessible HBCC training modules to improve practices and promote standards** attainment - on responsive caregiving, play-based learning, nutrition, child protection, and health referral pathways, that recognise the inherent knowledge and experience of Providers. Leverage **flexible, low-literacy and multilingual training approaches and toolkits that leverage locally available resources and play**, recognising that 98% of providers are women, many juggling care and economic responsibilities.

3. Connection & Collective Organisation: Strengthen networks, systems linkages, and support structures

Why this matters

HBCC providers operate in isolation, with limited access to supervision, professional networks, or referral systems. *Yet networked Providers learn faster, access more support, and deliver better-quality care* .

Key Actions

- **Support the establishment of County and National HBCC networks** - recognise these platforms as key constituents in policy and planning decisions, and encourage self-regulation through network-led quality charters, peer accountability mechanisms, and community feedback systems.
- **Recognise and leverage networks as delivery channels** - using them to coordinate and cascade Provider training, distribute learning and play materials, and facilitate early identification, referral, and follow-up for children with developmental delays or special needs.

4. Financial Sustainability & Affordability: Build an equitable funding ecosystem for HBCC with government public investment as the foundation

Why this matters

Financial sustainability is ultimately about ensuring *children access consistent, quality care*. Providers cannot provide quality childcare without financial and material support. With low, irregular parental fees and high food costs, Providers subsidise childcare with their own labour and income, threatening both quality and continuity and placing the responsibility for this public good on Providers.

Key Actions

- **Allocate a minimum HBCC budget line within county ECD programs based on population of children aged 0-3 years** - to create a predictable and sustainable financing base for HBCC
- **Integrate HBCC into the routine outreach and service delivery of existing public systems to increase access** to support and reduce costs, including the Community Health System, public nutrition programmes, and ECDE supervision.
- **Develop and implement frameworks to attract complementary partners from the private sector and philanthropy** - such as co-financing arrangements, social investment windows, or matched funding mechanisms - to mobilise additional resources while aligning partners to government priorities, and quality and equity standards.
- **Provide in-kind support food, play kits, safety materials, mats, and hygiene packs** to reduce the cost burden on Providers while raising minimum standards for health, safety, nutrition, and early learning.

Appendix

A. Abridged Methodology

1. Sampling Strategy

The baseline mapping adopted a multi-stage sampling strategy to ensure broad representation across rural, peri-urban, and urban settings.

Three counties—Murang'a, Kisumu, and Mombasa—were purposively selected to reflect diverse demographic, economic, and childcare landscapes. Within each county, wards and sub-counties were sampled proportionate to population density, the prevalence of informal childcare, and the presence of existing community structures.

The sample reached 5,350 HBCC Providers, collectively supporting 21,529 children. Both registered and unregistered providers were included to capture the full spectrum of informal childcare provision.

2. Provider Identification & Selection

Providers were identified through a combination of:

- **Community Health Promoters (CHPs)** and local administrative structures
- **Snowballing and neighbour referrals**, reflecting how childcare information flows in communities
- **On-the-ground mapping**, where enumerators moved household-to-household to verify active caregiving sites
- **Market area scanning** in high-density urban clusters

Eligibility criteria included:

- ✓ Currently caring for at least one child aged 0–5 in their home
- ✓ Primary caregiver responsible for daily routines, feeding, safety, and learning activities
- ✓ Operating consistently (not casual or one-off babysitting)

This approach ensured inclusion of both established and newer providers, capturing Kenya's rapidly growing HBCC landscape.

3. Data Collection Methods

This study adopted a convergent mixed methods design, integrating both quantitative and qualitative research methods to provide a comprehensive and nuanced understanding of the challenges and opportunities encountered by HBCC providers.

The study used the following tools:

- **Structured digital surveys** administered by trained enumerators
- **Household-level child counts** verified on-site
- **Observation checklists** assessing play areas, sanitation, lighting, furniture, and safety
- **Open-ended questions** on motivations, childcare charges set-up,challenges, nutrition practices, training needs, and caregiver routines
- **Provider diaries and narrative prompts** in select sites
- **County-level availability scans** for other childcare services

Data was collected using **mobile tablets**, with daily reviews for completeness and quality control.

Verification Exercise - What Changed?

During the verification phase, selected Providers were *revisited to validate child numbers, routines, and physical environments.*

This process led to:

- *Removal of duplicate entries*
- *Correction of inflated child counts in a few clusters*
- *Updating Provider statuses (active vs temporarily closed)*
- *Refinement of location coordinates*
- *Stronger alignment between observed environments and survey responses*

These adjustments strengthened the accuracy and credibility of the final dataset.

4. Limitations

While robust, the study had limitations:

- **Self-reported financial and nutrition data** may include recall or social desirability bias.
- **Lack of administrative data** (e.g., registration records, licence lists) limited the ability to validate Provider status independently.
- **Absence of certain variables** (e.g., formal "training desire" field or special needs screening records) restricted deeper analysis.
- **Operational invisibility** of HBCC meant some Providers may have been missed, particularly in hard-to-reach rural areas or high-density informal settlements.
- **Observation constraints**: Short visits may not fully capture caregiver–child interaction quality.

5. Ethical Considerations

The mapping adhered to ethical standards for child-related research:

- **Informed con sent** obtained from all Providers, with clear explanation of purpose, use of data, and confidentiality measures.
- **Voluntar y participation** with the option to withdraw at any time.
- **No identifying information** of children was collected.
- **Safeguardin g protocols** were followed, including referral pathways for any concerns encountered during fieldwork.
- Enumerators were trained **in child protection principles, respectful engagement, and data privacy**.

Because regulatory frameworks are absent, this study drew on international best practices to interpret quality indicators. These included guidelines on:

- **Overcrowding** → assessed using child-to-space ratios from WHO/ UNICEF early learning environment standards
- **Adequate light and ventilation** → presence of windows, airflow, and natural light requirements
- **Sanitation adequacy** → safe toilets, handwashing, child-accessible hygiene
- **Developmentally appropriate furniture** → availability of child-sized seating, feeding stations, and learning surfaces

B. Justifications for 25% Sample

The 25% sample size was determined to be the minimal acceptable threshold necessary to achieve a desired level of statistical precision for key variables, such as **"perceived quality of care."**

Assumption 1: Homogeneity of the Population.

It was assumed that the characteristics of HBCC Providers (e.g., qualifications, challenges, quality ratings) within a given county are sufficiently similar that a 25% random sample can reliably represent the overall provider population. If the population were highly diverse, a larger percentage would be required.

Assumption 2: Resource Constraints (Time and Budget) .

The most pragmatic assumption is that the 25% target represents the maximum number of Providers that could be feasibly reached, consented, and surveyed within the project's defined timeline and budget. A 109-item questionnaire taking 40–60 minutes is resource-intensive, making a comprehensive census impractical.

Assumption 3: Complete and Accurate Sampling Frame.

The justification rests on the assumption that the list used to identify HBCC Providers (the sampling frame) is accurate and comprehensive. If the true number of Providers is significantly higher than estimated, the actual coverage may be less than 25%.

Assumption 4: High Response Rate.

It is assumed that the research team could achieve a high cooperation/response rate (e.g.80-90%) among the 25% of providers selected for the sample. Reaching this target is critical, as a low response rate would threaten the representativeness of the final data set.

Assumption 5: Detecting Meaningful Effects.

The 25% sample size is large enough to ensure the study is adequately powered to detect what is defined as a meaningful or important effect size (e.g., a 10% difference in self-reported quality scores) between different groups or in relation to a benchmark.

Methodology Summary: Estimating HBCC Providers

Estimate the number of Home-Based Child Care (HBCC) Providers in Mombasa, Murang'a, and Kisumu counties using CIDP demographic data and defined utilization and Provider-capacity assumptions.

1.Data Inputs

- Primary source: Latest County Integrated Development Plans (CIDPs).
- Child population inputs:
  - *Where available:* Count of children under 5 used directly.
  - *Where only broader categories exist* (e.g., under 15): Proportional allocation applied to estimate 0–3 population.

2.Deriving the 0–3 Population

- CIDPs generally provide aggregated age bands; disaggregation required.
- Assumption: Even age distribution within reported categories.
- Output: Approximate number of children aged 0–3 in each county.

3. Estimating HBCC Utilization

- Utilization assumption: 60–80% of children aged 0–3 are cared for through HBCC arrangements.
- Method:
  - Lower bound = 0–3 population × 60%
  - Upper bound = 0–3 population × 80%
- Output: Range of children expected to be in HBCC care.

4.Calculating the Number of Providers

- Provider capacity assumption: Each HBCC Provider cares for 8 children.
- Method:
  - Providers (lower bound) = (HBCC children @ 60%) ÷ 8
  - Providers (upper bound) = (HBCC children @ 80%) ÷ 8
- Output: Range of HBCC Providers per county.

5. Output & Use Cases

- Final estimates include:
  - Estimated children in HBCC (60–80%)
  - Corresponding Provider counts (8 children per Provider)
- Application: Supports sampling frames.

Kisumu HBCC Providers Estimation		
Utilization Scenario	Children in HBCC	Providers
60%	51,000	6,375
80%	68,000	8,500

- Kisumu 25% Sampling Target: 1,594–2,125
- Actual Number of Providers Mapped: 1,798

Muranga HBCC Providers Estimation		
Utilization Scenario	Children in HBCC	Providers
60%	31,800	3,975
80%	42,400	5,300

- Muranga 25% sampling target:994 -1,325
- Actual Number of Providers Mapped:1,268

Mombasa HBCC Providers Estimation		
Utilization Scenario	Children in HBCC	Providers
60%	69,600	8,700
80%	92,800	11,600

- Mombasa 25% sampling target:2,175 – 2,900
- Actual Number of Providers Mapped:2,284

References

Brooks, A., Brazys, S., Boroffice, F., & Mainali, A.(2024) . Childcare and early childhood development expenditures in Africa: Comparative policy insights for advancing women's economic empowerment. Center for Global Development. https://www.cgdev.org/publication/childcare-and-early-childhood-development-expenditures-africa-comparative-policy

de Jong, M. V., et al.(2024) . An overview of the Kenyan food system: Outcomes, drivers and activities. Foresight4Food / Wageningen University & Research. https://foresight4food.net/wp-content/uploads/2024/05/Final-Kenya-FS-map-for-lay-out_V2.pdf

Devercelli, A. E., & Beaton-Day, F.(2020) . Better jobs and brighter futures: Investing in childcare to build human capital. Washington, DC: World Bank. https://openknowledge.worldbank.org/handle/10986/35062

Harris, K., Ajayi, K., & Mainali, A.(2024) . Childcare and early childhood development expenditures in Africa: Comparative policy insights for advancing women's economic empowerment. Center for Global Development. https://ideas.repec.org/p/cgd/ppaper/349.html

Intergovernmental Relations Technical Committee.(2024) . Gazette Notice No. 16483 (16 December 2024). https://www.igrtc.go.ke/sites/default/files/2025-11/Gazette%20Notices%20Vol.%20CXXVI%E2%80%94No.%20219%20of%2016th%20December%202024%20Delineation%20of%20the%20National%20and%20County%20Governments%20Functions..pdf

Kaneko, M., Lombardi, J., & Weisz, A.(2020) . Support programs for home-based child care: A global study. Spring Impact. https://www.springimpact.org/2020/10/support-programs-for-hbcc/

Kelly, M., & Beaton-Day, F.(2025) . Guidance note: Essential elements of quality in childcare settings. Washington, DC: World Bank. https://doi.org/10.1596/43106. License: CC BY-NC 3.0 IGO.

Kenya National Bureau of Statistics.(2024) . Economic survey 2024. Nairobi: KNBS. https://www.knbs.or.ke/reports/2024-economic-survey/

OECD.(2018). Engaging young children: Lessons from research about quality in early childhood education and care. Paris: OECD Publishing. https://www.oecd.org/content/dam/oecd/en/publications/reports/2018/03/engaging-young-children_g1g8b70c/9789264085145-en.pdf

Organisation for Economic Co-operation and Development (OECD). (2021). Starting strong VI: Supporting meaningful interactions in early childhood education and care. Paris: OECD Publishing. https://www.oecd.org/en/publications/2021/06/starting-strong-vi_0a304435.html

Organization of African Unity. (1990) . African Charter on the Rights and Welfare of the Child (OAU Doc. CAB/LEG/24.9/49). Addis Ababa: OAU. https://www.refworld.org/docid/3ae6b38c18.html

Republic of Kenya. (2024). The Regulation of Wages (General) (Amendment) Order, 2024 (Legal Notice No. 164, Kenya Gazette Supplement No. 186). Nairobi, Kenya: Government Printer. https://labour.go.ke/sites/default/files/2025-01/Regulation%20of%20Wages%20%28General%29%20%28Amendment%29%20Order%202024%20full.pdf

Republic of Kenya. (2024). Third voluntary national review on the implementation of the Sustainable Development Goals. Nairobi: Government of the Republic of Kenya. https://www.planning.go.ke/the-3rd-2024-voluntary-national-review-reportvnr-on-sdgs/

Samman, E., & Lombardi, J. (2019) . Childcare and working families: New opportunity or missing link? UNICEF Early Childhood Development. https://www.unicef.org/documents/childcare-and-working-families-new-opportunity-or-missing-link

UNESCO. (2022). Tashkent declaration and commitments to action for transforming early childhood care and education. World Conference on Early Childhood Care and Education, Tashkent, Uzbekistan, 14–16 November 2022. Paris: United Nations Educational, Scientific and Cultural Organization. https://www.unesco.org/sites/default/files/medias/fichiers/2022/11/tashkent-declaration-ecce-2022.pdf

United Nations.(2015) . Transforming our world: The 2030 agenda for sustainable development (A/RES/70/1). New York: United Nations. https://sdgs.un.org/2030agenda

United Nations Children's Fund (UNICEF). (2017) . Programme guidance for early childhood development. New York: UNICEF. https://www.unicef.org/media/107616/file/UNICEF-Programme-%20Guidance-for-Early-Childhood-Development-2017.pdf

United Nations Children's Fund (UNICEF). (2023) . Analysis of food systems for children in Kenya. Nairobi: UNICEF Kenya. https://www.unicef.org/kenya/reports/analysis-food-systems-children-kenya

World Health Organization, United Nations Children's Fund, & World Bank Group. (2018) . Nurturing care for early childhood development: A framework for helping children survive and thrive to transform health and human potential. Geneva: World Health Organization. https://www.who.int/publications/i/item/9789241514064

World Health Organization, United Nations Children's Fund, & World Bank Group. (2018) . Nurturing care for early childhood development: A framework for helping children survive and thrive to transform health and human potential. Geneva: World Health Organization. https://www.who.int/teams/maternal-newborn-child-adolescent-health-and-ageing/child-health/nurturing-care

Alice Opany, HBCC Provider (R) with Cynthia Irene Mire, Parent (L).

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Nurture First

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Findings from Kisumu, Murang'a and Mombasa counties

Scan the QR code to access the Nuture First HBCC Database