What Works in ECD?  
A CEI Case Study of Five Innovative Programs in Kenya

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CEI ‘What Works’ in ECD is structured in two parts: Landscaping and Case Study. *Landscaping* is conducted in consultation with relevant education practitioners and stakeholders in Kenya. It provides an overview of the political framework, implementation in the non-state sector and challenges with areas for innovation as identified by CEI. The *Case Studies* highlight innovative ECD programs that are demonstrating results in Kenya and provide promising models that address the key thematic challenges identified. With site visits conducted, attention is paid towards specific approaches or model components that drive impact in ECD and can be shared as best practice of what works in the sector, providing justification for potential scale up or replication in Kenya and beyond.

CEI has interviewed 20 leading ECD program implementers in Kenya to understand core components of their programs and create a program profile, which is shared on the CEI platform (www.educationinnovations.org). This research includes asking questions to understand the challenges that programs face in the sector and the needs that implementers identify. This information is subsequently analysed for trends across the ECD sector.

CEI connected 50 leading ECD stakeholders including donors, implementers, educationalists and policy makers in an ECD Thematic Forum in Nairobi in August 2014. The convening shared best practice from existing models, posed solutions to common challenges faced by implementers and explored how different stakeholders can best work together within the ECD ecosystem. Challenges and solutions arising from the forum were subsequently analysed alongside qualitative data from in-depth one-on-one follow up meetings with stakeholders across the spectrum of implementers, funders, policymakers and researchers.

Following the landscaping, a case study design was chosen to probe more deeply and analyse specific ECD programs in Kenya. CEI identified 5 innovative ECD programs profiled on the CEI platform. Programs were chosen based on how they addressed the key thematic challenges and how they represented different geographical regions in Kenya. The five programs are: APDK – Star of Hope Day Care Centre, Kidogo – ECD, MEDA – Early Childhood Development Program, PATH – Integrated Early Childhood Development, and Nairobi Parenting Clinic – The Incredible Years Parent Training Program.

CEI conducted a one-day site visit at each project during April and May 2015. Two CEI team members conducted the qualitative study, which included observation, interviews and focus groups. CEI interviewed project implementers and held focus group sessions with project stakeholders (parents, government officials, community leaders). The exploratory study aimed to document and analyse evidence of innovation, stakeholder engagement, impact, scale and financials in each program and the data arising from three angles; observation, interview and focus group was triangulated. Each of the 5 case studies are presented separately; it was not intended that they would be compared, as they are delivering interventions in unique areas. Finally lessons learned across the case studies are shared and recommendations made for potential scale up of innovative interventions in ECD.
The Ministry of Education, Science and Technology (MoEST) holds responsibility for all education with regard to policy and development of curriculum and it has provided policy guidelines on ECD. The ECD curriculum, teacher training syllabus and learning materials are developed by the Kenya Institute of Curriculum Development (KICD) in collaboration with the National Centre for Early Childhood Education (NACECE). Co-ordination of ECD has been devolved to county level, in particular the District Centre for Early Childhood Education (DICECE) holds responsibility. County governments are semi-autonomous units of governance which receive 15% of the national budget and have the power to raise revenue using various methods. This presents an opportunity for creative ways of financing ECD programs within counties.

Though official government policies exist on ECD it would appear the sector is highly fragmented, with different providers operating independent of the MoEST and DICECE. Reasons for this include the significant gap between national and county government capacity levels, and insufficient efforts to enforce the existing policies amongst providers. Vision 2030 states a specific ECD strategy to integrate 2 years of free early childhood into primary education. This acknowledgement in government strategy may serve to tighten the delivery of pre-primary (age 4-6) however this is yet to be stipulated in a formal policy position. With ECD valued and advocated in a comprehensive government policy, it may encourage society to value these crucial early years in learning.

Fueled by new research on neuroscience and economic data, ECD is gaining global attention. This is reinforced by Human Rights, Social Development and Human Capital approaches manifested in international frameworks such as Convention on the Rights of the Child, MDGs and EFA which act as powerful agents of change. At the same time, funding into the ECD sector from non-state actors has increased. For example, in the last 6 months LEGO Foundation, Ashoka and IDEO have released challenge funds with focus on ECD. However, long-term funding still remains a constraint for many ECD programs in Kenya.

ECD services in Kenya are mainly provided by private entrepreneurs, social enterprises, communities and NGOs. Nonstate interventions include: delivering services directly to children, educating and supporting parents, and developing capacities of caregivers, health workers and teachers. These are not always distinct, some programs incorporate all services, however quality varies. Home-based and community based ECD programs (often located in rural areas) tend not to employ accredited teachers, instead the primary caregivers are grandparents, mamas and siblings. Programs which are center based can be broadly categorised into the following groups:

- Pre-unit attached to primary schools (serving ages 4-6)
- Kindergartens (mostly managed by entrepreneurs in more affluent areas, serving ages 4-6)
- Kindergartens (mostly managed by entrepreneurs in more affluent areas, serving ages 4-6)
- ECDE Centres/ Nurseries (managed by private entrepreneurs, NGOs, communities serving ages 4-6)
- Baby Day Care Centers (usually in low-income informal settlements serving ages 0-6)

The vast majority of ECD programs in Kenya cater for children aged 3-6 years. Significant focus is given to school readiness and thus in many instances a formal structure is adopted with rote learning and exams and limited focus on “learning through play”. As a nation Kenya has made major advancements in ECD around school readiness and compares favorably to its African neighbours. There remains urgent need to create equitable ECD provision in Kenya, in particular improving quality ECD for the poorest, the marginalized, those with special educational needs, those in rural areas and the age bracket 0-3 as they begin their critical stage of development.

Quality provision in education is highly sought yet its definition is highly contested. The following 5 factors are commonly identified as important in determining a quality ECD program. Each indicator is analysed here alongside a few current challenges as identified by ECD implementers in Kenya.

ECD is cross-cutting, and programs often involve health, education, child welfare and protection and in some cases economic wellbeing of parents is incorporated through microfinance and income generating activities or adult learning. Integrated programs whilst being desirable are not the most common approach. In many cases programs aimed at 0-3 years are predominantly health based whilst those aged at 3-6 have roots in education. This programmatic practice is reflective of the disjoint at policy level where health and education ministries are yet to cohesively deliver ECD. CEI is currently collaborating with CHMI to help bridge this gap and share learning across both sectors.

Research and evidence of what works in ECD is increasing however it is often drawn exclusively from a Western world context, especially in relation to neuro-science. There is need or increased evidence of what works in local contexts. For this CEI is well placed to conduct evaluations of innovations, and host impact reports on the online platform to share evidence of best practice and foster knowledge sharing amongst stakeholders in Kenya.

Local cultural traditions in child-rearing form an integral component when designing ECD programs. Successful programs are designed with the community and implemented to involve key community stakeholders such as children, parents, caregivers, community health workers, community leaders (religious, cultural, political) and encourage their feedback and input throughout. Challenges arise firstly where communities do not see the importance of ECD and secondly where different methodologies are introduced which diverge from cultural norms or expectations for a learning environment, for example positive discipline or learning through play. In these instances implementers seek support from other stakeholders to create a holistic approach advocating for the importance of ECD and the value of different learning methodologies in the early years.

There has been a steady increase in ECD training and ECD Teacher Training Centres with the support of government and private institutions. In most ECD institutions teachers hold secondary school certificate and a certificate/diploma in ECD. In spite of this there are a significant proportion of untrained teachers practicing ECD and
there is no organised training for caregivers of children under 3. Retention rates are very low in this profession. With very low salaries, the ECD profession is often seen as a stepping stone to another career thus creating high turnover of teachers and constant need to train with few experts in the profession. A robust framework is needed at policy level which incorporates pay scale, job security and professional development. Others and fathers should be included in discourse around caregivers. Innovative ways of incorporating parental engagement and parent training is needed in ECD programs.

It is the mandate of DICECE to quality assure ECD services by inspecting private and public institutions; infrastructure, teaching learning materials, and curriculum and pedagogies are evaluated. Inspection is intermittent and in instances where institutions do not meet standards there is a lack of capacity to address inadequacies and bring about improvement. Strengthening the MoEST operational structure including linkages between central and county government bodies would strengthen quality assurance.

Monitoring of child development varies greatly between institutions with some ECD centres showing no evaluation of learning and development. There is need to strengthen the curriculum with new assessment of learning focused on developmental stages and competencies away from exam based expectations. With this there is need to build capacity of caregivers to identify, teach and assess learning through play and competencies.

- Pre-unit attached to primary schools (serving ages 4-6)
- Caregiver professional development
- Facilitating learning through play with low/no cost resources
- Assessing learning based on developmental milestones
- ECD services for children aged 0-3 with a strong developmental/learning component
- Providing a free ECD service for the most needy
- Integrated ECD programs
- Motivating ECD teachers to stay in the profession
- Community advocacy on the importance of ECD.
Kidogo is a hybrid social enterprise established in January 2014. Kidogo’s mission is ‘to improve access to high-quality, affordable early childhood care and education to transform the trajectory of families living in poverty’. Kidogo has a growing team of local and international specialists and a board of advisors.

Kidogo recognises that working parents in Kenya’s informal settlements have few good options for child care. Children are left home alone, with an older sibling or in a baby day care, and the latter often has substandard infrastructure and resources and inadequate or no care and stimulation. Kidogo’s goal is to improve upon the limited access to quality early childhood care in informal settlements by providing a new model for delivering sustainable and scalable care to pre-school children. Kidogo adopt a ‘hub’ and ‘spoke’ business model. This consists of model ECD centres, ‘hubs’, which act as best practice in the informal settlement for quality ECD provision. To date two hub centres have been established in Kibera and Kangemi, both within Nairobi County. A holistic child care service is offered for children aged 6 months to 6 years with a child-friendly environment, trained and certified ECD caregivers, nutritious meals, parental engagement and a customised ECDE curriculum. The ECDE curriculum is based on the Kenyan national curriculum but draws learning from theories and best practice across the globe with a local contextualised application. The curriculum emphasises learning through play, problem-solving, and social-emotional learning. The second component of Kidogo’s model is the ‘spoke’. Kidogo’s micro-franchising ‘spokes’ support local parents to run their own local baby-care centres by providing a business-in-a-box. This includes relevant training, mentorship, access to learning materials and business skills through the Kidogo network that help them grow their small businesses and thrive economically, thus reaching more children with quality ECD provision.

- Financially sustainable
- Scalable model
- Provides holistic ECD to children in informal settlements aged 6 months to 6 years
- Provides teacher training, professional development and motivation
- Incorporates learning through play

To date, there is no proven, financially sustainable child-care model in Sub-Saharan Africa’s informal settlements. Kidogo combines the sustainability of early childhood development ‘hubs’ with the scalability of micro-franchised ‘spokes’. The business is designed to achieve breakeven, which means it does not have to rely on external donors. To date one of the hub centres has achieved breakeven within the first month of opening.

Alongside sustainability, scalability is pivotal to Kidogo and makes the program innovative amongst other ECD providers in the region. CEI has identified a number of successful ECD centres in Kenya, however these are mostly one-off innovations, providing high quality ECD services but restricted to a pocket of society. In a country with vast number of children in need of quality ECD, designing for scale is critical. During a CEI interview with a community elder, she confirmed that a challenge in the informal settlement is the incredible number of families living in poverty who cannot even afford the fees at Kidogo’s hub centre. To her, the solution for reaching more children is training and improving the services that are currently offered by mamas. This reinforced the need for the ‘spoke’ model.

CEI observed a successful integration of low cost and high quality at Kidogo ECD centres. This can be challenging to achieve and Kidogo are still to prove this at scale across the spokes, which launch June 2015. During CEI interviews with parents it was evident that the price point was affordable to many and they were happy to pay for quality teaching, a safe environment and nutritious meals in particular. Kidogo’s strong emphasis on recruiting quality teachers, providing on-going development and motivation to teachers is key to them delivering high quality ECD. CEI observed a vibrant classroom where the teacher engaged children in active learning and children were confident and enjoying their learning. This has been achieved at a low cost to beneficiaries by offering teacher salaries that are fair but not overly exceeding market average and equipping classrooms with locally available resources and play materials. Kidogo noted that achieving high quality at a low cost is a challenge; recruiting and retaining teachers of the right calibre is not easy and there is a common expectation amongst parents for a free service. However, it was apparent to CEI that by proving quality, parents were willing to pay the fees and what is more they feel they are receiving value for money. This serves as a lesson learned to other ECD providers in informal settlements.

- Work collaboratively with county government

During its short implementation period, Kidogo has engaged in discussions with the County Government, including Nairobi, Kisumu and Mombasa where it has shared best practice and lessons learned.
from Kidogo ECD centres. CEI has noted that the model is especially interesting to county governments, who have the mandate to build and set up ECD centres in their respective counties. Collaborating with local government officials in Kibera and Kangemi is recommended to build presence and understanding in the community – both strengthening understanding of community needs and sharing understanding of the Kidogo model of best practice.

Additionally Kidogo is working with the County Government and other stakeholders in developing a National Policy regarding the rapidly increasing baby-care sector. Currently there is no structure around quality standards, registration mandate or monitoring guidelines for operating a baby-care facility. Therefore in collaboration they are setting a framework to ensure wide-scale baby-care quality improvements.

- Advocacy on ECD amongst parents/caregivers
- Regular feedback collected from parents/caregivers

From the outset, Kidogo sought to actively engage the community in understanding the importance of ECD and supporting them to see value in non-traditional styles in ECD, such as learning through play and socio-emotional development. Kidogo conducted a marketing campaign in the community prior to opening to share these values and bring families to the Kidogo centre. Kidogo continues to engage openly with parents through an open door policy for one-on-one meetings, termly parent forums to address any issues, parent feedback and the new establishment of a parent teacher association at each site led by nominated parent representatives. Kidogo noted that it has received great input from fathers as well as mothers in the community. Through CEI’s focus group interview with parents it was clear that they valued ECD learning for their children and in particular they discussed the value of learning through play and social growth such as playing with others, speaking well and washing hands. However, it was not evident that parents reinforce this development at home, especially during the holidays. Kidogo noted that this is something they seek to strengthen to ensure a holistic approach to their children’s development. Notably this involves engaging the community beyond parents as grandparents, older siblings, and neighbours also play a role as caregivers. Kidogo’s micro-franchising spoke model has the ability to reach more of this demographic.

The impact evaluation began in April 2015 and results will be shared upon completion in October 2016.

Ongoing monitoring is completed on a daily and termly basis at each centre. In particular child enrolment, attendance and development are measured alongside parental feedback. Using operational and financial metrics, the Kidogo team is tracking the cost-effectiveness and potential for scale of their “hub & spoke” model. Specifically, the focus is placed on the ability of individual centres to reach operational sustainability (breakeven) and be easily replicable across communities.

Qualitative Child Development Impact
A few case studies shed light on the child development impact Kidogo has, before the release of their impact evaluation data.

In Kangemi, Kidogo received a child of nearly 3 years who did not speak and could not balance. Within the first month of joining Kidogo, he started to mutter simple words and run with other kids. Today he is one of the lowest children, speaking his mind at any opportunity. He runs with other children, and no longer falls each time he tries. His mother is thrilled with the progress and states, “I can’t believe this is my child!”

In Kibera, Kidogo has received two twin girls who are 18-months old, but are the size and weight of six-month olds. They had previously been residing in a local baby-care with no food or stimulation. When they first arrived in Kibera they were withdrawn, quiet, disengaged, non-vocal and had very poor eating habits. Within a few weeks of Kidogo care, they began to smile, laugh and play – improving their language, motor skills and cognitive development, in addition to immensely improved physical health and growth.

These two cases are only a few that represent qualitatively the impact Kidogo has on child development, even in their earliest stage of implementation.

Kidogo is currently conducting an 18-month Impact Evaluation. The evaluation is focused on 2 key metrics:

1) Child Development & Readiness to Learn. This takes into account each child’s holistic development, including physical, cognitive, psycho-motor, language and socio-emotional outcomes to ensure children are adequately developing and learning at each stage in life. Using local development assessment tools (Protocol for Child Monitoring), Kidogo is implementing a case control study with baseline, mid-point and end-point assessment tools.

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<table>
<thead>
<tr>
<th>Key</th>
<th>Value</th>
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<tbody>
<tr>
<td>Number of centres</td>
<td>105</td>
</tr>
<tr>
<td>Number of teachers</td>
<td>8</td>
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<tr>
<td>Parental satisfaction measured on a likert scale in 6 key areas: Teachers, materials, care, environment, education, nutrition.</td>
<td></td>
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<tr>
<td>‘Overall Satisfaction’. Kibera Centre = 38% Very Good, 62% Good; Kangemi centre = 43% Very Good, 46% Good</td>
<td></td>
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<tr>
<td>Kidogo Parents rated the teachers and environment highly (74.1% Very Good and 63% Very Good, respectively). Kangemi parents rated materials and teachers highly (67.9% Very Good and 60.7% Very Good, respectively). In terms of the quality of child care, 100% of Kibera parents ranked it as Very Good (55.6%) or Good (44.4%), with 82.1% rating quality of care Very Good or Good in Kangemi.</td>
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</tbody>
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During the CEI focus group in Kangemi, parents reinforced the high satisfaction with the quality of service at Kidogo. Notably amongst citing the high quality environment, teachers and nutrition as reasons for sending their children to Kidogo, two parents noted that one of the reasons for choosing Kidogo was the ‘mzungu’ leadership (as it would help their children...
Kidogo’s challenge lies in achieving the dual goals of generating positive social impact for the poorest families in Kenya while at the same time making enough financial revenue and profit to fuel their aggressive growth plans. Whilst the centres themselves can reach break-even and become self-sustaining, additional revenue is required for growth. As such Kidogo is considering income-generating lines which will fund its growth strategy, for example a teacher training college, retail, publishing and consulting.

An elegant combination of ECD expertise and business acumen has enabled Kidogo to launch an ECD model which looks promising to provide much needed sustainable and scalable quality ECD provision in informal settlements. A critical point now for Kidogo is achieving the same quality in its micro-franchising ‘spokes’. Evidence from CEI observations has shown that caregivers require regular professional development and engagement in order to excel and stay committed long term. Micro-franchising is naturally a high-touch endeavour and thus will be important to create momentum and peer-learning within the community to support caregivers and maintain high quality in the long term. Fostering the growth of mamapreneurs into leaders who are able to identify the business and ECD needs of their day cares will be critical to its success.

Kidogo’s financial outcomes are as follows:

**Financials**

- **Annual Operating Budget**: is 175,000 USD
- **Beneficiaries pay KES 1,500 per month at the Kibera centre and KES 1,800 per month at the Kangemi centre.**

Kidogo's growth and scale are driven by its financial model, which allows it to systematically collect and analyse data on its operations. This helps Kidogo to identify trends and make informed decisions about how to best use its resources.

Kidogo opened its first ECD centre in Kibera in September 2014. In January 2015, Kidogo opened a second ECD centre in Kangemi, also within Nairobi County. With these two ‘hub’ models established Kidogo is now focused on the ‘spokes’. In June 2015 Kidogo is officially launching its micro-franchising program, the ‘spokes’. The program seeks to work with enterprising women in the local community – “mamapreneurs” to start, or grow their baby care centres into a higher quality childcare “spokes” that become part of the Kidogo network. Franchising is seen to be pivotal at Kidogo in order to achieve scale and reach the number of families needed to make a real impact. Under the franchising program, Kidogo would charge mamapreneurs for a “business-in-a-box” which would include: training, learning materials and ongoing monitoring and business support for franchisees. Starting the needs assessment process in February, Kidogo worked with IDEO.org, engaging human centred design principles to discover the most viable and effective interventions in supporting community baby cares, and prototyping viable models. Therefore, in launching this month, Kidogo has a strong foundation of ideas and strategies to pilot.
Malindi Education Development Association (MEDA) is a community-based organization operating in Malindi, Kenya, established in 1997 to promote education of children, youth, and adults. The organization is governed by a board of trustees and a management committee that comprises community stakeholders.

The Early Childhood Development Program (ECDP) aims to eradicate illiteracy by holistically supporting ECD centres in Malindi for children aged 3-8. The centres may be private or public and provide education integrated within the Islamic Madrasa system, thus incorporating local culture. ECDP supports teachers and caregivers at the centres by providing opportunities for certified training in topics including education, health, mentorship, and pedagogy. ECDP also supports broader ECD stakeholders associated with the centres (parent, caregivers, government officials) by facilitating forums and groups for stakeholders to collaborate and share best practice in context-specific learning, teaching, and learning through play; such forums also provide opportunity for advocacy on ECD. A third area of implementation is the ECDP resource centre and playgrounds that are owned by ECDP (the latter being an income-generating activity) and offer additional child development support to ECD centres and families in Malindi.

- Professional development for ECD teachers
- Student resource centre
- Learning through play
- Provides teacher training, professional development and motivation
- Community advocacy on the importance of ECD

In addition to creating a community that contributes to the development of ECD, MEDA established ECD Teacher Associations in 2006 to strengthen provision in ECD centres. As the program visited different villages in Malindi, it supported the start-up of associations to make it easier to build the capacity of ECD teachers on a larger scale. Now, the four regional Teacher Associations may advocate sector issues, offer peer-to-peer learning, and on occasion receive professional training from an external expert. This innovation is critical as there is often limited professional development support from government or other providers specific to ECD teachers, which can lead to lack of motivation or poor retention of teachers. CEI noted that this approach is particularly innovative in the field of ECD, as there are very few peer learning networks for ECD teachers, which span an entire county. The associations now operate independently with support when required, meeting 2-3 times per term.

The student resource centre offers a haven where children can come to complete their homework, receive support on areas of learning difficulty, read, and play. The centre is open throughout the week and also offers guidance to teachers and caregivers on how to develop learning materials, how to identify learning difficulties in children and how to support them. Situated at the resource centre is the playground open to the public at a fee. This is not only an income-generating activity for the program but reiterates and reinforces its messaging on the importance of learning through play delivered to the teachers while also engaging the community.

- Delivering intervention within government structures and systems
- Working collaboratively with local government officials

To enhance the development of ECD across Malindi, MEDA regularly shares information and partners with government officials in Malindi through community sensitization, capacity building for teachers, and working groups. This was especially relevant in the first few years of the program.

- Advocacy on ECD in the community
- Communities demonstrate involvement beyond the project activities
- Community committees established to promote best practice in ECD

Community participation and ownership is central to ECDP; the initial two years after launching were dedicated solely to community sensitization on the importance of ECD and to promoting the MEDA ECDP model to cultivate community ownership beyond its beneficiaries. MEDA continues to prioritize community engagement in ECD and has established Area Advisory Councils, which focus on key themes in ECD and are led by the community. During council meetings community members discuss key issues and challenges in ECD specific to the region. Together they identify solutions to the challenges and share best practice. This creates community ownership over children’s wellbeing in the region. During the CEI focus group
consisting of parents, community leaders, teachers, and the local education officer, it was noted that community meetings provided the opportunity to air grievances, share ideas and news, as well as disseminate information. The Area Advisory Councils also create a mechanism that further engages the community to raise funds for the ECD program.

Impact
The quantitative data above has been documented as ECDP offers support to centres and to teachers in the region. The following qualitative data were collated from beneficiaries to monitor the impact of the program on the community.

- Student and teacher attendance, retention, and increased enrollment. Attendance at supported centres is monitored through the attendance registers. Enrollment enquiries are also recorded and shared with ECDP thrice a term.

- Teacher performance post training. Through interviews and assessments at the supported centres, ECDP can monitor the success of the teacher training. The Teacher Associations also offer an opportunity to assess the impact of the teacher training and identify areas requiring improvement.

- Learning environment and resources: ECDP visits centres bi-annually to observe the learning environments to assess whether they are child friendly. This informs the level of support they may need in developing learning materials, tools to measure outcomes, and play toys.

- Parent/community engagement. To monitor parental and community engagement, ECDP relies on the Area Advisory Council meetings held quarterly, the fundraising events, and community meetings to document the levels of engagement. At the centres, a book recording contributions and results of parent meetings aids ECDP to monitor impact.

Growth and scale
- Open a disability rehabilitation centre
- Develop resources for sale as an income-generating activity
- Improve playgrounds to increase income

Since MEDA was founded as an organization aiming to improve literacy and spearhead ECD in Malindi, it has grown to support 200 ECD centres, established Teacher Associations, which have been replicated by others in nearby Kilifi town, in five zones, and opened the only public playground in the region. Through funding, the program plans to continue with its activities as well as open a rehabilitation and ECD centre for children with physical disabilities, particularly cerebral palsy, as this is an area that has been disregarded. It also plans to use its skills in developing learning and play materials as a source of income to subsidize its activities by selling them to clients. Though MEDA has playgrounds in the centres that are accessible to

870
5 E cent s
Supported schools/centres in the four zones since inception

500
Med in Malindi and Maga
Edward Godstone

58,920
Approximate number of learners served since 2005
335
Teachers trained since 2005

A CEI Case Study of Five Innovative Programs in Kenya
the community, through a benefactor it was able to open a bigger public playground where children pay KSH 50 for 25 minutes of play, generating further income. By improving the playground it will be able to accommodate more children, generating greater income.

**Finance**

| Not for profit | Annual Operating budget is approximately US$1.5 million across 3 countries. |
| Funded by Conrad N. Hilton Foundation | Free service to beneficiaries – CHVs, caregivers and children. |
| Income generating activities including an annual fundraiser, fees from training departments (ECD, computer, and secretarial), renting out events equipment, and playground |

MEDA has developed a robust and holistic methodology in its approach to supporting both private and public ECD centres in Malindi. With vast experience and support from the community, it has been able to offer support and improvement to ECD provision across the county. Aspects of MEDA have been adopted in other towns in the county such as the Teacher Associations in Kilifi. There is opportunity to replicate other components of the model in neighbouring counties. These counties would benefit from the ECDP approach as they have similar cultures, making adaptation easier. ECDP supports ECD centres where Madrasa was already integrated into the curriculum; therefore the community members were engaged in learning at the ECD level, making it easier to support an existing framework. This would make scale in the region low cost and therefore attractive to county governments. CEI noted that organizations such as KCDF highlighted ECDP as a model program to learn from and recommended partnership with Mombasa County. In order to achieve this, ECDP would benefit from an impact evaluation. Current limited resources have meant that the impact of the ECD Village Committees and Teacher Associations has not yet been evaluated. Whist qualitative evidence in the CEI focus groups points to these groups enhancing ECD provision, an impact study would add testament to this. Building up the MEDA team with more ECDP program employees would enable ongoing monitoring and evaluation. This is an area that will be addressed in time as MEDA secures funding.
APDK is a non-governmental organisation established in Kenya in 1958 to enable persons with disability to overcome their physical limitations and empower them economically and socially to become self-reliant and fully integrated members of their communities. Working closely with the Ministry of Medical Services, APDK has a countrywide network of 9 branches, most of which are located within the government’s provincial or district hospitals. To meet its objective, APDK offers its services through the Community Based Rehabilitation (CBR) Matrix that consists of health, education, livelihood, social, and empowerment pillars. The Star of Hope Day Care Centre program is implemented under the education pillar.

The Centre offers access to affordable, quality, and relevant education to children with disabilities in and around Mukuru slums. The children range from the age of 3 to 9 years. Some of the disabilities that the children have include cerebral palsy; mental health issues; visual impairment and hearing impairment. Through the school, children with disabilities get preparatory school skills. It offers a holistic curriculum that includes imparting of self-care skills, early childhood education (ECE), nurturing the development of social skills and interaction, as well as psycho-social support and counselling for parents and caregivers. When the children are ready, they are taken to the Ministry of Education Science and Technology’s (MoEST) Educational Assessment Resource Centre to be assessed for appropriate placement in government schools. The school is run by an ECD and special education specialist engaged by APDK. The specialist combines the government-approved ECD curriculum as well as the special education curriculum. The school has a capacity for 20 children. The specialist has trained caregivers (often mothers of the children enrolled in the Centre or alumni children) who help out in the daily care of the children. The parents are also involved in fundraising — this mainly involves soliciting food and other school material donations from corporate organizations. Additionally, parents donate about 120 shillings every week toward the purchase of food for the children when they can. APDK has also engaged an occupational therapist to assist at the Centre.

CEI identified this program as innovative amongst other ECD programs in the region because it offers inclusive ECD for children in one of the poorest and disadvantaged areas in the country. The program also adopted an approach that promotes awareness creation on disability and the need for ECD, destigmatising disability in the community and at the same time helping the community to understand the benefits of enrolling children with disabilities in an ECD Centre. This is critical as children with disabilities have often been overlooked in the education system, and engaging them at a young age is key.

To implement this model, APDK first conducted a baseline survey that led to the establishment of a Comprehensive Community Based Rehabilitation Program (CCBR). Through the program, APDK is not only offering ECD and rehabilitation services to children with disabilities but also advocates and promotes the rights, inclusion, and participation of persons with disabilities and their families in the community. CEI identifies community acceptability and involvement to be a critical component for implementing a quality ECD program. This is a strength of this program and has contributed towards a mind-shift in the community on the importance of ECD and inclusivity of children with disabilities.

- Provides inclusive ECD to children with disability between the ages of 3 and 9 and one of the lowest-income areas in the country
- Provides home-based rehabilitation and caregiver counselling to children aged 0-3
- Provides children with assistive devices at either no cost or a heavily subsidized cost
- Promotes parental engagement through use of parents as caregivers at the Centre
- Extensive community advocacy conducted on the importance of ECD for children with disability

The program is well networked with both local and national government structures. From the onset, collaboration with the local government administration helped APDK secure the space for the Centre at a local public primary school next to the chief’s office. The program has established a Special Needs Unit (SNU) in the local public primary school. The program advises on how to run the SNU, and program representatives sit in government committees on Special Needs Education. The program is also working with existing government structures in order to realise the program goals. For instance, children go to the MoEST Educational Assessment Centre for assessment before their requisite placement. The children from the school also transition to other government facilities once they graduate from the Star of Hope Day Care Centre. In a CEI interview, the area chief noted that the program is very much in line with government priorities and respective government line ministries have always been briefed and involved in the program interventions in the community.

- Advocacy on inclusive ECD and child rights in the community
- Communities demonstrate involvement beyond the project activities
The project started with the sensitization of the community on the importance of equal rights for children with disability. This was done through reaching out to community leaders, parents, and caregivers. The project also engages the community through provision of home-based rehabilitation services and counselling to parents and caregivers of children with disability. As testimony to the programs engagement in the community, parents and caregivers present during the CEI focus group said they had been referred to the Centre by general community members. The program has also established a community of parents of children with disability who support one another. Additionally, community advocacy by APDK has led to members proactively reporting children with disabilities to the local authorities who then refer the children to the Centre for the necessary support.

APDK records the children’s developmental milestones beginning from when they get to the Centre in order to track development and ascertain whether the children are ready to transition into mainstream schools. Once they have transitioned into mainstream schools APDK continues to follow up through verbal interviews with new teachers and parents to see how the children are progressing. Sometimes an APDK social worker will visit the children’s new schools if they are nearby. This was confirmed by the parents CEI spoke with, one of whom had a daughter who had attended the Centre several years ago.

Qualitative data is collected through observations and documentation on a regular basis.

- Ability to reach the poor.
  - APDK’s enrollment assessment tool is used to capture the social-economic status of the family therefore ensuring that only the very needy children are admitted into the program.
- Increased enrollment.
  - Student attendance and teacher attendance are measured through a register kept at the Centre as well as through observation. Registration is done on a daily basis.
- Standardized assessment.
  - APDK has a tool used to assess children before they join the Centre. Variables recorded in the tool include: child’s name, age, sex, residence, date of assessment, diagnosis of disability, family social history, medical history, ability to perform activities of daily living, gross motor skills, sensory motor skills, developmental milestone assessment and perception.
  - Children are also taken to the Government Assessment Centre to measure their readiness for transitioning into the next level—either mainstream school, or special needs school.
  - During the CEI focus group, parents reported that there has been improved quality of life for their children with disabilities after joining the program.

APDK’s exit as projected in the next 2 years will leave a huge gap in service if not well managed. As is the case in many other extremely low-income areas in Nairobi and around the country, there is severely inadequate provision of ECD services to children with disability. APDK will need to intensify its engagement with government in order to get ECD centres catering to children with disabilities established by government in local public primary schools in order to fill the gap. CEI identifies this as a critical need nationwide. Devolution of the ECD functions presents an incredible opportunity for APDK to promote the establishment of ECD centres for children with disabilities in the counties as County Governments are currently building ECD centres in their jurisdictions. This could ensure massive and rapid scale up of the program. To anchor its advocacy strategy, APDK would benefit from conducting a form of census for the children with disabilities in all counties. This could be a powerful tool to use in convincing policymakers and funders on the need for ECD centres for children with disabilities. Alongside this need for advocacy for the establishment of teacher training centres for ECD teachers of children with disabilities. This is a gap as currently there are no public institutions that specialise in training these teachers.
Integrating Early Childhood Development (I-ECD) was a short term project implemented by PATH from 2012 – 2014 in Kenya and Mozambique; for purposes of this case study, we will focus on PATH’s I-ECD work in Kenya only.

At the onset, PATH conducted a situational analysis in 2012 to investigate community understanding and practices related to ECD. The analysis found that the community definition of ECD did not necessarily include children 0-3 years and tended to be education-focused, with less importance given to a child’s holistic needs: health, nutrition, care, and stimulation. In particular, play was viewed as a waste of time and there was poor perception of children’s rights. The community held a negative attitude towards ECD centres and ECD teachers.

PATH implemented I-ECD to improve community understanding and practices of integrated ECD. I-ECD achieved this by integrating ECD into maternal and child health services already being delivered by community-based organisations (CBOs) and government institutions. The project used the Essential Package as its main vehicle for building capacity of community health volunteers (CHVs) and their supervisors in integrated ECD. The Essential Package is a comprehensive set of tools developed by a consortium led by Save the Children, which provides guidance, training and activities for children aged 0-5 years and their caregivers on care and stimulation, health, nutrition, and child-protection. Prior to implementation, PATH adapted the Essential Package through rigorous formative assessments.

PATH’s integrated ECD model has three main outcomes: supporting the creation of an enabling environment for integrating ECD into services reaching young children; capacity-building of service providers; and generating and documenting evidence on the impact of ECD integration. Thus, the short-term project provided valuable lessons learned and insights into what works in integrated ECD, thereby informing phase II - Scaling up Early Childhood Development (S-ECD), which is being implemented from 2014 to 2017.

ECD provides an innovative approach using the existing government touch-points to reach children aged 0-5 years and their caregivers with age-appropriate care and stimulation interventions. Using the health sector as an entry point is especially powerful, as this sector has the capacity to consistently reach every child during the first three years of life. I-ECD uses existing structures and builds capacity of health service providers, ECD teachers, and CBOs to integrate counselling and demonstrations around care and stimulation, nutrition, learning through play, development of simple toys, telling stories to children, and integrating child protection into their normal service delivery. PATH works hand-in-hand with government to demonstrate impact of this project and explore ways to make the underlying systems and policies more reflective of the importance of integrated ECD. CEI identified this program as innovative amongst other ECD programs in the region because it offers an integrated ECD intervention for children aged 0-3 years, before they enroll in an ECD program delivered through an educational institution. Children 0-3 years are reached through home visits by CHVs who are already implementing the MOH’s Community Health Strategy. As this approach is integrated into existing government structures, it has potential to be scaled up in a sustainable manner and reach all children, including the most vulnerable.

PATH is an international non-profit organisation specialising in global health. For over 40 years, PATH has been a pioneer in translating bold ideas into breakthrough health solutions, with a focus on child survival, maternal and reproductive health, and infectious diseases. With headquarters in Seattle, PATH has a large county-based program in Kenya with nearly 150 staff.
Evidence from the program to date has shown that even after PATH has completed activities, stakeholders continue to take ownership of the integrated approach and the implementation of holistic ECD services. The component of play is effective as caregivers make their own no-cost play materials such as a clay car or musical instrument from a bottle and engage with children to learn through play. This is transformative, as in many households play was previously discouraged. In addition, children were kept aside, rather than being encouraged to actively engage with their caregivers, especially male caregivers.

- Contributing to policy reform
- Delivering intervention within government structures and systems

The program is integrated into existing government structures. MOH CHVs integrate components of ECD into their routine household visits within their area of operation and are monitored by their usual supervisors—i.e., the CHEWs (Community Health Extension Workers). The I-ECD program used a training of trainer methodology to first train CHEWs, who in turn trained the CHVs that they normally train and supervise. When the project ended in 2014, the activities continued within the MOH structure. Of note: when CEI met with a CHEW who had been trained by I-ECD, he stated that for the intervention to continue and be scaled up, it ultimately needs to be written into government policy with an associated budget. Until ECD integration is normalised, there will be some CHVs who show resistance to integrating ECD into their household visits, especially as they are volunteers who may have an aversion to additional workload. However, this needs to be reinforced for future scale-up of the program. Following the end of the project, PATH is meeting and discussing with government to discuss ways to strengthen the enabling environment for integrating ECD. Lessons learned from the program have already been shared with government stakeholders at the national and county levels.

- Advocacy on integrated ECD in communities
- Communities demonstrate involvement beyond the project activities

Project activities incorporated sensitisation amongst community members on integrated ECD, primarily through use of CBOs. Activities included: parenting education through religious institutions, sensitising school management teams on the importance of ECD, and facilitating quarterly fun days for children. Beyond the project activities, CEI saw evidence of community ownership and improved practice:

- CHV home visits continue to incorporate aspects of ECD, even after the formal end of the program.
- Community members have embraced learning through play and have continued to develop home-made toys. One caregiver, whose house the CEI team visited during its trip, has independently established a play centre that he has opened to other children in the neighbourhood.
- CHVs have become role models in their own families by sharing integrated ECD messages in their households.
- A Father-to-Father support group has been independently established in one community to continue advocacy and practices around integrated ECD.

Through routine monthly monitoring, quantitative data was collected on number of practitioners trained, community members trained/reached, and children impacted through the intervention:

- **Number of practitioners trained in Essential Package**
  - 60 ECD teachers on child-centred age-appropriate learning methodologies, 43 ECD teachers trained on conducting health and nutrition assessments.
  - Number of religious institutions targeted with parenting messages
  - 499 caregivers trained, community members reached: 540 (Kenya, Siaya County)

Qualitative data was collected through an endline assessment that was conducted between May and August 2014. The assessment made use of focus group discussions, interviews, and observations to determine acceptability and feasibility of the I-ECD model. Endline assessment findings were shared in a stakeholder forum in 2014. The evaluation report will be made available to stakeholders upon request.

- Change in attitudes of caregivers.
  - Through interviews and focus group discussions, caregivers, community opinion leaders, CHVs, CHEWs, government officers, and ECD teachers demonstrate: (1) appreciation of the importance of stimulation and play as essential components of children’s overall health and well-being; (2) understanding of ECD practices as they relate to the youngest children 0-3 years before they enter pre-primary education centres; (3) understanding of how children’s play materials can be made using local resources.

CEI saw evidence to support this finding, including coming across a group of CHVs who had set up an income-generating activity to provide funds to continue making low-cost toys. CEI met two caregivers who had both been making toys at home out of the clay found in the yard. One caregiver had opened up a “play centre” for local children to come and play with the homemade toys. The CHEW and CHVs reported that they observed greater interaction between parents and children and that there was greater appreciation of the role of play as critical to child development and well-being.

- Experiences with the Essential Package.
  - Initial training methodology and integration into government health system structures was praised by users. Visual guides and associated key messages were considered helpful to CHVs. For improvement, CHVs requested refresher training.
CEI saw evidence to support this finding when meeting the CHVs who had continued using the Essential Package resources even after the i-ECD program had formally concluded. CHVs made reference to the value of the Essential Package as a job aid that made their work easier. They noted that parents on occasions asked them to leave the tool behind so they could independently read more of the information contained in the package.

- Measurement: Capacity of ECD implementers (as a proxy for quality of ECD services)
  PATH observed improved resources and child-friendly environments including presence of talking walls in ECD centres. Development of materials for play and learning using local materials were observed in ECD centres and households. There was increased enrolment in many ECD centres, but irregularities in payment of fees and lack of understanding among caregivers about importance of ECD centres still exist. Increased knowledge and improved communication skills of CHVs and more holistic CHV home visits were observed.

CEI saw evidence to support these findings during its visit. Both CHVs and the CHEW made reference to their improved knowledge on integrated ECD, especially around nutrition, child protection, and learning through play. They reported feeling more capacitated and having the ability to identify poor development more quickly, as well as identifying any cases of abuse. CHVs reported that they are now known as “community doctors” and felt that their status in the community had been elevated due to their improved knowledge and skills.

- PATH is currently working with the MoH at national and county levels and with nongovernmental stakeholders such as UNICEF to systematically integrate ECD into facility- and community-based health services. Key to the process is building an enabling environment for integration of ECD into health service delivery guidelines, tools, and training and supervision processes.

- PATH is adapting and validating a counselling package based on the UNICEF/World Health Organization module on Care for Child Development. Health facility service providers and CHVs will be trained in this package and the entire process will be integrated into existing MOH planning, training, and supervision structures.

- This current phase of implementation will be an at-scale pilot, starting with 16 health facilities and their linked community units in Siaya County. Further scale-up will be informed by the results of this first round of implementation.

- PATH is also documenting and disseminating program results more rigorously, in order to drive ECD-friendly policies and promote greater investment in ECD integration—both nationally and globally.

- Concurrently, similar work is taking place in Mozambique and South Africa.

- Landscaping activities for ECD integration into the health system will commence in 2015 in additional countries.
I-ECD marked the launch of PATH’s integrated ECD work. The program was launched in 2 countries, with activities in a third country (South Africa) integrated into a larger maternal and child health systems strengthening project funded by BHP Billiton Sustainable Communities. I-ECD endline assessment results revealed a high degree of acceptability among key service providers, implementers and beneficiaries, as well as feasibility of the concept of integrating ECD into existing services. PATH’s current phase of integrated ECD work builds upon I-ECD and features a more streamlined model of ECD integration using touch points within government health service delivery in both health facility and community settings. PATH has also made an informed decision to focus specifically on children aged 0-3 and their caregivers, given the lack of programs targeting children in this age group and the high returns on investment associated with working with the youngest children. PATH is developing a range of strategic partnerships for introduction of this work in new geographies and seeking to strengthen the evidence base around this new approach. PATH is concurrently working with the MoH at national and county levels and with nongovernmental stakeholders such as UNICEF to adapt and validate training and counselling materials and the overall approach in Kenya as part of piloting at scale in western Kenya. PATH is seeking new funding and implementation, research, and advocacy partners for work to be carried out in sub-Saharan Africa as part of its larger regional/global integrated ECD scale-up strategy.

CEI identifies this program with potential to scale across Kenya and other countries. Evidence from the program to date has shown that even after conclusion of program activities by PATH, stakeholders continue to take ownership for the integrated approach and sustain the implementation of holistic ECDs. This is partly due to the fact that the PATH ECD model is integrated into existing structures—primarily, government health systems. Notably, this also means that the key to scalability also lies in strengthening and working within government systems. Replication of PATH’s integrated ECD model is most feasible in countries where government CHVs conduct regular household visits, as household visits serve as additional touch-points for ECD integration beyond the obvious health facility touch-points. For sustainability, the government CHVs should ideally be in long-term positions and remunerated/recognised for their work. While PATH has successfully motivated volunteers, this will need to be addressed over the long-term and at scale.

Financials

CEI visited the implementers and beneficiaries in Kenya after the I-ECD program had come to an end. It was a testament to the success of the program that core elements of the project were continuing in communities despite the exit of PATH. The concept of integrated ECD was clearly understood and practiced by CHEWs and CHVs, who expressed taking greater pride in their work as a result of the addition of the ECD component to home visits. There was evidence at the household level of families making low-cost play materials and a stronger understanding of all aspects of ECD among caregivers. The project model integrates its interventions into government planning, implementation, and supervision systems, which allows for greater prospect of scale-up and sustainability. In order to build a more convincing case for scale-up of the program in new regions, CEI recommends assessing child development outcomes after the intervention. (This was not feasible in a short-term project but should be included in future scale-up.) Such an evaluation is essential to understand the impact of the integrated ECD approach upon the child. A second consideration is maintaining the motivation of CHVs as they take on a broader work plan, noting that they are volunteers. This project successfully upskilled and raised the profile of CHVs which motivated them to undertake the integrated ECD. Achieving this at scale can bring more challenges and will need to be planned alongside national and subnational government stakeholders.
The topics target the parents and caregivers of newborns through teens, with some programs specifically designed for parents only. Noted benefits of the program for the beneficiary include reductions in parental stress, child aggression and disruptive behaviour, parental reliance on corporal punishment, and use of criticism, as well as increases in pro-social behaviour, confidence in parenting, and use of praise.

For sustainability, parents are given handouts for reference at home and form support groups amongst the alumni while the clinic holds online chat sessions to support clients at no cost.

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**Innovation**

- Parental and caregiver support, training, and development
- Focus on socio-behavioural development
- Comprehensive coverage, from newborn to teen

Nairobi Parenting Clinic Ltd is a Nairobi-based company registered under the Companies Act (Cap 486) on 10th December, 2010. Its mission is to promote the psychological wellbeing of individuals and families by providing scientifically proven preventive treatment and health care services. Nairobi Parenting Clinic Limited is managed by a board of directors and a chief executive officer while services are provided by professionals including psychiatrists and psychologists.

The Incredible Years Parent Training Program delivered by Nairobi Parenting Clinic is a series of interlocking, evidence-based programs for parents, children, and teachers, supported by over 30 years of research. The goal is to prevent and treat young children’s behavioural problems and promote their social, emotional, and academic competence. The programs, developed in 1984 in USA, are used worldwide in schools and mental health centers and have been shown to work across cultures and socioeconomic groups.

The program is delivered in two ways: one-on-one training at the clinic’s premises for an average of twelve lessons costing KSH 3000 per session or large group sessions costing KSH 500 per person.

Nairobi Parenting Clinic is the only program of its kind in the country implementing the Incredible Years Program focusing on training parents and other caregivers on how to positively change the social behaviour of children subsequently resulting in an improvement in their academic and social performance.
The program delivers practical skills and strategies for caregivers including parents, nannies, grandparents, and early childhood education teachers raising children from birth through teen years. CEI has identified a high need for parental engagement and training in the region; whilst many programs may include components of this, NPC is innovative in that it is the only program profiled on CEI Kenya that specializes purely in comprehensive parental training on learning and behavioural issues.

**Stakeholder Engagement**

**Government**

Engage with County Government

Nairobi Parenting Clinic was included as an education stakeholder involved in the development of the Nairobi County Strategic Plan for the period 2015-2025.

**Community**

Advocacy on parenting in communities

Holistic approach to parenting; engaging nannies, teachers, guardians, caregivers

From the outset, the program was designed to benefit and upskill the whole community of caregivers. NPC recognizes that parenting is not simply the role of biological parents and that many other caregivers are involved. Thus the program is delivered to teachers, grandparents, nannies/house helps as well as parents/guardians. Through the CEI interview with a kindergarten where the program is delivered, it was noted that this approach has been effective at bridging provisions across institutions; for example aligning school and home for a unified approach to care for the child.

Nairobi Parenting Clinic actively engages in forums beyond its scope of work in order to share knowledge and advocacy on parenting issues. NPC has been involved in media campaigns discussing various aspects of parenting and education policies; through a blog and other social media avenues NPC continually educates the society on matters regarding parenting.

CEI noted that parents receiving the training invited friends and family to subsequent sessions and arranged private family sessions.

**Engage with County Government**

In 2011 when Nairobi Parenting Clinic was registered and began operating, the training was carried out at the clinic for small client groups of up to twelve individuals by three trainers. The program has currently trained 1,860 caregivers at the clinic in schools and churches.

The program aims to secure funding to allow it to scale nationwide and offer the training to low-income communities at no cost. The clinic has been carrying out a pilot for this in Kibera’s Trinity Church Arch Bishop Nzimbi Academy, which can then inform future research. Funding will also subsidize the cost of hiring trained professionals to conduct the trainings across the country and offer support in a model that will see a select number of parents receive skills as master trainers.

The support that is offered at Nairobi Parenting Clinic is extremely crucial in offering caregivers professional advice on child development and interactions. Discussion with beneficiaries confirmed that this model is novel and integral to child development, parental engagement, and teacher training. In order to scale and offer the program both nationwide and to low-income communities, NPC will strive to secure funding as well as continue to charge a fee to paying clients. Consequently through more robust M&E to monitor areas such as academic performance and post-program assessments, NPC will be able to better demonstrate its impact. Aside from funding and M&E, partnerships and sensitization within the community will also be crucial to nationwide scaling to create awareness on the impact of the program and create channels to deliver interventions.

**Impact**

Following each training session, NPC collects qualitative data from the beneficiaries through feedback and evaluations forms. NPC also observes participants after the training to evaluate their understanding of the concepts taught. Through the evaluation form, the program measures the following outcomes, both of which were rated at 99%:

- Beneficiary satisfaction and perceived effectiveness of the training
- Training program’s value for money as perceived by the beneficiary

Through an interview with a beneficiary, CEI observed that parents are more confident with their parenting and are learning to reinforce learning from school at home as well as incorporating play as a developmental tool. This has had a positive effect on parental learning with the school as well as with children who are more confident and expressive. CEI also noted a high level of paternal involvement as emphasis is placed on this in the program.
Following the Landscaping and Case Studies, CEI drew the following lessons learned and recommendations for stakeholders in the ECD sector in Kenya and worldwide.

- It became necessary to consider the meaning of innovation; for CEI this is purposefully broad. Innovation does not have to pertain to a novel idea but can be an improvement in the delivery, adaptation to a new location, improved sustainability, or scaling of a model. The ECD sector in Kenya is ripe for this form of innovation.

- Key areas for innovation in ECD in Kenya:
  - Caregiver engagement and training.
  - Assessing learning based on developmental milestones.
  - ECD services for children aged 0-3 with a strong developmental component.
  - Motivating ECD teachers to stay in the profession and providing opportunities for progression with professional development.

- Many communities hold limited regard for ECD and do not prioritise aspects such as nutrition, care and stimulation, and learning through play. There is need to advocate within communities and build understanding from the outset of the benefits of a holistic approach to ECD as well as sharing simple methods and tools to support children’s development in the home.

- It is important to consider and engage all caregivers i.e. nannies, grandparents, neighbours, and teachers who act in loco parentis and influence a child’s development.

- Understanding the local and cultural context is critical. Integrating with culturally important education models (e.g. Madrasa Schools, Mama Baby Daycares) can align with caregivers’ existing values, norms, and expectations for their children.

- Programs that have embedded themselves within the community and have community ownership have been successful at growing sustainably as the community contribute to fundraising, in-kind donations, volunteering and will take responsibility in advocating for the program.

- The devolvement of ECD to County Government provides a timely opportunity for non-state actors to engage in policy and demonstrate learnings on what is working in their programs, as County Governments seek to improve ECD in their county in some cases with limited prior knowledge or understanding in the sector and need for input from other stakeholders.

- Qualitative studies, conducted by many ECD programs, provide useful evidence of child development; for example quotes reflecting how happy a child is or how they have increased in confidence at home. Since learning and development are complex to measure, this qualitative evidence is essential to capture within the whole impact of the program.

- The national curriculum and associated assessment frameworks in Kenya are rudimental and focus heavily on repetitive learning and academics. Whilst localised tools exist (e.g. Kilifi Developmental Index) there is need for improved access to these tools for implementers and training on their usage.

- There is need for greater resources and expertise to be allocated to impact evaluation in ECD. Whilst programs monitor pupil progress, very few evaluate the impact of the program holistically on the child, and fewer still are able to conduct long-term studies. There is opportunity for funders and researchers to collaborate with implementers and conduct studies that can give robust feedback on what works in ECD.

- Disseminating results is key to success, yet not always managed effectively. Considering how to best communicate results with beneficiaries and other stakeholders is essential both for transparency and for demonstrating impact, which could lead to additional support and scale up.

- Leveraging existing systems and structures has proven effective for sustainability and growth of programs. This may be innovating within government schools or ECD centres or health system touch-points.

- In a social enterprise model, planning to scale from the outset is key. Understanding price points to generate an income that is both market value for the user but allows the program to be self-sustaining is key to growth.

### Finance

- Engaging caregivers has proven to be an important aspect of financing. This may be charging an affordable fee to users or engaging caregivers in fundraising or offering their time and expertise to the program.

- Whilst an increasing number of funding opportunities arise in ECD, organizations that succeed in gaining funds have an astute understanding of the funding landscape and understand which type of funding opportunity to seize for the stage of their program. There is need for better understanding of the funding landscape in ECD, as this will allow implementers to target time and efforts to funding opportunities suitable to their program and growth stage.