



WOMEN EDUCATIONAL RESEARCHERS OF KENYA
Linking Research to Advocacy and Action



Endline Study on Let's Play, Spaces for Kids to be Kids, Samburu and Isiolo Counties LRFP No.: 2019-9153564

FINAL REPORT



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List of abbreviations and acronyms

ASAL: Arid and Semi-Arid Lands

CBC: Competence Based Curriculum

CEC: Chief Executive Committee

CHWs: Community Health Workers

CHVs: Community Health Volunteers

ECD: Early Childhood Development

FBO: Faith-Based Organization

GAM: Global Acute Malnutrition

KDHS: Kenya Demographic Health Survey

KNESSP: Kenya National Education Sector Strategic Plan

KNUT: Kenya National Union of Teachers

KPI: Key Performance Indicators

MCAs: Member of County Assembly

NGO: Non-Governmental Organization

ODK: Open Data Kit

PHN: Public Health Nutritionist

SAM: Severe Acute Malnutrition

SDG: Sustainable Development Goals

UNICEF: United Nations Children's Fund

WERK: Women Educational Researchers of Kenya

MoE: Ministry of Education

MoH: Ministry of Health

NACOSTI: National Commission for Science, Technology, and Innovation

RA: Research Assistant

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EXECUTIVE SUMMARY

The endline assessment was conducted in the two counties of Isiolo and Samburu (refer to maps in the appendices) in July – August 2020, with sampling based on their respective sub-counties. This study had been scheduled to take place earlier but due to COVID 19 pandemic, it was rescheduled. The specific objectives of the assessment were to document achievements on coordination and management of integrated ECD; as the changes in caregiving practices by caregivers; assess the improvements on health, nutrition, education, and child protection services; document any barriers and enablers and make recommendations that can strengthen community-based integrated ECD at county levels. These objectives guided the research questions.

The study approach was across-sectional mixed-method approach. The targeted sample was from communities that the baseline was conducted since the project implementation adopted a whole community approach to integrated ECD services. A total sample size of 766 parents with at least one child who is under 5 years was targeted and a total of 745 parents were reached. Data collection was undertaken by physically visiting the households but ensuring the health protocols are observed, the ECD centres were visited to observe the facilities and talk to the headteacher and ECD teachers that were mobilized prior to the exercise. The health centres were also visited and the community health volunteers interviewed. The county government staff, and project staff were also interviewed.

The findings indicate that there is a slight difference in the characteristics of the caregivers at baseline and endline but not to invalidate the findings. On the coordination and management of integrated ECD services, it was noted that due to the project's efforts, the coordination and management of the project that was dormant is now efficient; the ministry of health has better-coordinated activities with the ministry of education and other relevant ministries, and there are more play and learning materials in ECD centres.

On improved and responsive caregiving practices for children under 5, the assessment found that there are improved child caregiving practices for newborns with better feeding practices, better knowledge on immunization, and less ignorance on the importance of birth registration.

On improved integrated ECD services, findings on nutrition indicate that there is an increased intake of water, proteins, and vitamins compared to baseline. On health, the majority of the caregivers know the main sign of a sick child (fever) but few recognize the sign of blood in the stool; more households are treating (purifying) their water for cooking and drinking compared to baseline. On early learning, there is over two times the proportions of homes that were stimulating under 5s through different activities compared to baseline with different family members taking up different roles; the assessment confirmed availability of materials in ECD centres even though disproportionately across the two counties (more in Isiolo). On the other hand, child protection, it was noted that ECD centres are disproportionately secure with those from Samburu noted as more secure than those from Isiolo.

The critical enablers for the integrated ECD include proper and effective coordination of the existing structures and systems, the commitment of the county governments and the line ministries/departments, and the willingness of the communities to participate and support the ECD systems.

The assessment recommends the partner organisations and county governments to continue supporting the structures (such as Technical Working Group, advisory committees) to facilitate the coordination of the integrated ECD services; The county governments to scale up the project with support from the partners and the MoH and MoE to continue working together in integrating child caregiving services and through the Community Health Volunteers.

1.0 Background to The IKEA/UNICEF Project

1.1 Introduction

Early years are critical for child survival, growth, and development yet one out of three under 5 years of age children are not achieving their development potential. In fragile contexts, this ratio is even worse. Moreover, many children do not receive adequate nutrition, healthcare, and opportunities required to reach their full potential because of their families' income status, geographic location, ethnicity, disability, or socio-cultural issues. Education seeks to provide a solution to societal problems. In Kenya, under the new structure of education, basic education is organized into three levels: Early years' education, Middle school, and Senior School. Early years education includes 2 years of pre-primary education for children aged 4 to 5 years (Sessional paper No 1 2019). According to UNICEF's baseline report, a quarter of children in Kenya are stunted and only 68 percent are fully vaccinated while over 6,000 new HIV infections are realized in children every year (UNICEF Baseline report, 2017-2018). Additionally, Arid and Semi-Arid Lands (ASAL) face the unique challenges of disparities in the provision and accessibility of basic services that compromise the provision of quality ECD services. Notably, Isiolo and Samburu counties are particularly vulnerable to adverse environmental and weather conditions that result in recurrent and severe droughts and sometimes flooding. Children from these two pastoralists' counties suffer from malnutrition. The proportion of stunted children was 30% in Samburu and 18% in Isiolo as of 2014. (KDHS, 2014).

The Sustainable Development Goals (SDGs) seek to address young children's development, seeing it as key to the transformation that the world seeks to achieve by 2030. Embedded in the SDGs on hunger, health, education, and justice are issues of malnutrition, child mortality, early learning, and violence. The agenda for improving early childhood development is entrenched in these goals. The SDG goal 4 target 2 on early childhood development (ECD) and universal pre-primary education emphasizes that countries should ensure all girls and boys have access to quality, free and compulsory early childhood and pre-primary education delivered by well-trained educators by 2030. In line with this, UNICEF continues the implementation of its Strategic Plan in Isiolo and Samburu Counties as stipulated in the respective County Development Plans (CDPs) 2018-2022. The endline study is therefore to assess the changes made against the objectives of the baseline and generate evidence for future programming of integrated ECD.

In Kenya, under the fourth schedule of the constitution (2010), ECD is devolved and therefore the 47 counties are mandated to budget for and implement ECD programmes independently. This means the respective county governments have the responsibility to deliver quality ECD services. The national government intervenes when necessary, for instance, to ensure the terms of service of the ECD teachers are harmonized. The management and coordination of ECD programmes in Kenya by the Ministry of Education (MoE) is under the directorate of basic education is at the national level.

The National Centre for Early Childhood Education (NACECE) is responsible for curriculum and resource materials development and training of professional support for early years' learners.

Section 26 of the Basic Education Act stipulates the role of the county governments which includes the provision of funds for infrastructural developments and training of teachers for early years' education (Basic Education Act 2013). This, therefore, means that it is the responsibility of the County governments to provide childcare facilities. In terms of the political context of this study, Samburu County has realized increased enrolment of pre-primary school learners from a total of 20,420 in the year 2013 to 42,938 in 2019 (Samburu County Integrated Development Plan (CIDP) 2018-2022). This notable increase can be attributed to investments by the county government in education and specifically the early years learning stage. In Isiolo, pre-primary school enrolment increased from 8645 in 2016 to 16295 in 2019, a notable increase from the previous years. Other interventions that have contributed to increased enrolment include the introduction of school feeding programs and reintroduction of mid-morning snack (porridge) and lunch (Isiolo County Integrated Development Plan CIDP 2018-2022).

1.2 Key Policies Relevant to the Endline Study

The Kenya National Education Sector Plan (KNESSP) outlines the commitment of the government of Kenya to ensuring that no child is left behind in terms of access to education. Articles 43 (f) and 53 (1) (b) of the Kenya Constitution provides for the right to education and the right to free and compulsory basic education, respectively. The Basic Education Act (2013) guarantees the right of every child to free and compulsory basic education. The government is also committed to implementing international and regional obligations related to education, such as Sustainable Development Goals (SDGs), Continental Education Strategy for Africa (CESA) among others. In this regard, MoE is committed to providing and promoting competence-based and equitable learner-centered education, training, and research for sustainable development. Therefore, the Government of Kenya (GoK) continues to invest heavily in the education sector, committing about 5.4% of the Gross Domestic Product (GDP) to the sector.

The introduction of the Competency-Based Curriculum (CBC) is designed to ensure that at the end of each learning cycle every learner will be competent in 7 core competency areas namely: Critical Thinking and Problem Solving; Imagination and Creativity; Citizenship; Learning to Learn; Self Efficacy and Digital Literacy. By the end of early years education, the learner should be able to: demonstrate basic literacy and numeracy skills for learning; communicate appropriately using verbal and/or non-verbal modes in a variety of contexts; demonstrate appropriate etiquette in social relationships; apply creativity and critical thinking skills in problem-solving; explore the immediate environment for learning and enjoyment; practice hygiene, nutrition, sanitation, safety skills to promote health and wellbeing; demonstrate the acquisition of emotional, physical, spiritual, aesthetic and moral development for a balanced living; demonstrate an appreciation of the country's rich and diverse cultural heritage for harmonious co-existence and apply digital literacy skills for learning and enjoyment (KICD, 2017).

In line with the CBC learning outcomes, UNICEF's endline study on Let's Play, Spaces for Kids to be Kids, in Samburu and Isiolo counties serves as a point of reference for information and learning on the progress of ECD in the two counties. It has set a benchmark on how to design an integrated

approach to ECD services that should guide the Ministry of Education National Pre-Primary Education Policy, Nurturing Care for Early Childhood Development framework, and other relevant policies.

The following Theory of Change (ToC) was developed as a guide to the IKEA/UNICEF study as shown in Figure 1.

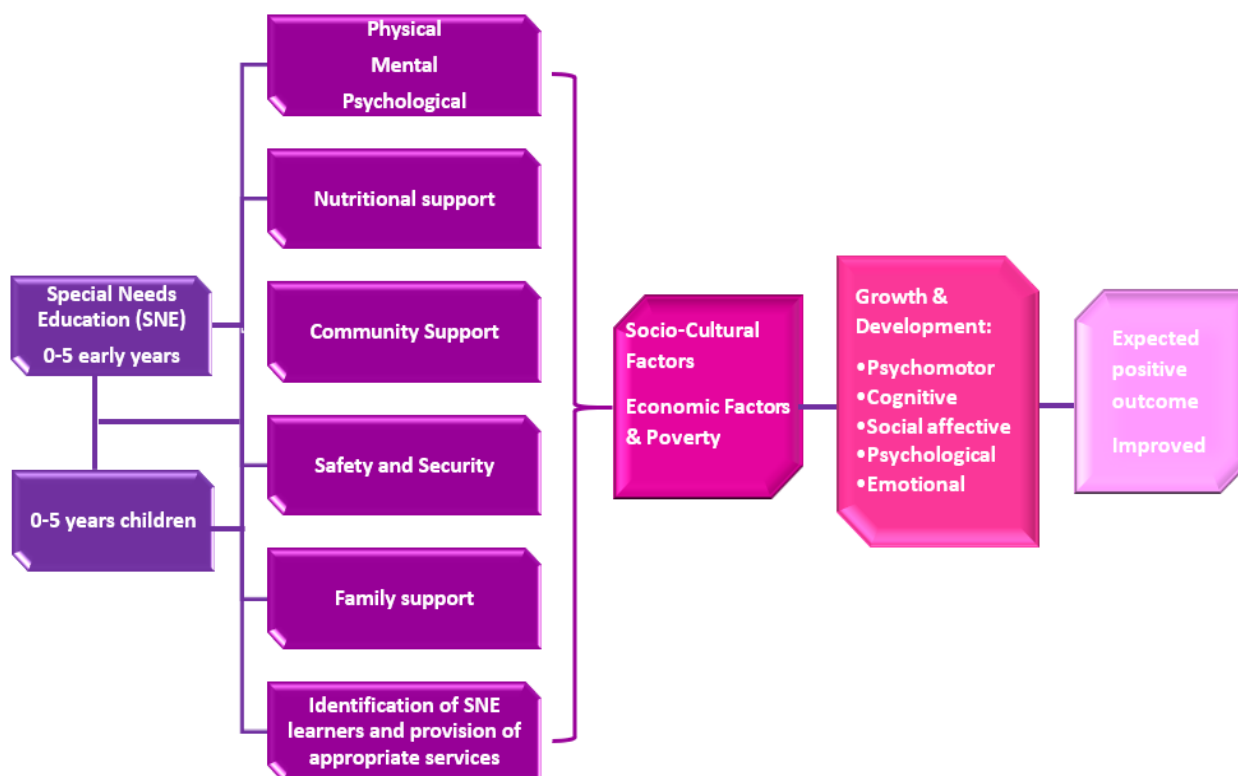


Fig. 1: Theory of Change

As indicated in the schematic presentation of the theory of change, several factors contribute to growth and development during the early years of ages 0 to 5. UNICEF’s global report on early childhood development shows that the period from conception to the start of the school provides an opportunity to shape the development of a child’s brain (Britto, 2017). During this period, a child acquires essential physical, motor, cognitive, social, emotional, and language skills which allows them to think, solve problems and communicate.

For this to be achieved, 0 to 5-year-old children require proper nutrition (balanced diets), physical, mental and psychological support, family and community support, security, and safety. This support should be provided by parents/caregivers/guardians and sometimes grandparents, health service providers, and teachers. The interplay of the independent and dependent variables as well as the intervening variables such social-cultural and economic factors, as presented in the conceptual framework, show that the health and nutrition status of a child at the formative stage is a significant determinant of the child's holistic development and their

learning ability. It is at this stage that the brain develops rapidly and therefore appropriate care must be provided. Lack of proper care may lead to negative outcomes. For instance, lack of a balanced diet, proper nutrition, and lack of play spaces may lead to stagnation of growth and development. The theory of change affirms that learning occurs when a child has a relatively permanent change in behavior, cognition, brain function, abilities, or knowledge as a result of experiences. Playspaces are vital because learning is shaped by the learners' experiences which are caused by external stimuli that are perceived by senses and communicated to the brain for processing. Negative experiences, therefore, slow down the formations of neural connections in a baby's brain and this impacts a child's ability to grow and learn.

1.3 Rationale

In 2017, a baseline study was conducted on three specific outcomes namely: mechanisms and structures established to coordinate mainstreaming of ECD at various levels; implementing and integrating care for child development model in health facilities; access to quality ECD services.

Outcome 1: Improved coordination and management of ECD at national and county levels.

The indicators were: mechanisms and structures established to coordinate mainstreaming of ECD at various levels; health facilities implementing and integrating care for child development model with KPI; access to quality ECD services. The findings on outcome one showed that the ECD coordination and management structures in Samburu County were almost similar to Isiolo County. There was no integrated coordination of ECD services, therefore much of the work was done through MoE at the county level. However, the counties had a functional inter-ministerial steering committee and a TWG to strengthen ECD operations.

Notably, in both counties, 91% of child caregivers were biological mothers to the children who participated in the study. Ninety-five percent of the biological mothers of these children resided in their household and in about half (51.6%) of the sampled households there were two primary caregivers, most of whom included a biological father. Further, there was a lack of harmonization on various models of the ECD programmes and adequate coordination, linkage, and collaboration among stakeholders delivering integrated ECD services. Weak structures of management that closes gaps in the transition of ECD management from the national government to county government were also identified.

Outcome 2: Responsive Caregiving Practices for Under 5 years.

The majority of the primary caregivers in both counties had been trained in exclusive breastfeeding (Samburu County, 47.4%; Isiolo County, 58%). More mothers in Isiolo County had been trained on immunization, complementary feeding, growth monitoring, and deworming; as compared to Samburu County. However, overall, 43.9% of the primary caregivers had no training in improved child-rearing practices (48.7% in Samburu County; 37.5% in Isiolo County).

Outcome 3: Access to Quality ECD Services by Young Children (0 to 5 years).

The findings further show that the preference for exclusive breastfeeding for children ages 0 – 5 months is higher in poor/ poorest quintile households than in the wealthy / wealthiest quintile households. Further, only half of the total sampled children aged 6 – 23 months (50.4%) had received the measles vaccine (Isiolo County, 58.7%; Samburu County, 44.3%). In Samburu County, it was established that only about 1 in every 10 households with a child aged below 5 years (9.8%) had some indoor play space/library in the living rooms; as compared to 30.1% reported in Isiolo County. The overall teacher-child ratio in the two counties was 1:50. In Samburu County, the ratio was 1:60 while for Isiolo County was 1:40.

After conducting the baseline in 2017, UNICEF Kenya, through funding support from IKEA Foundation supported Isiolo and Samburu counties to model community based ECD services through the “Let’s Play” Good Cause Campaign, Space for Kids to be Kids project. The project was implemented between 2017-2019 in partnership with Samburu County Government, World Vision Kenya, Child Fund Kenya, Isiolo County Government, and Life Skills Promoters. Its overall objective was to strengthen community based integrated ECD.

Overall this endline assessment was to support the IKEA/UNICEF project to generate and document evidence of the growth of the integrated ECD services due to the project activities. Also, the assessment results were to inform on the future similar programmes by documenting lessons learned including the project score on relevance, efficiency, effectiveness, impact, and sustainability. The findings and recommendations are expected to inform the education sector on the planning, coordination, and implementation of integrated ECD services.

1.4 Overall Endline Assessment Objective

The purpose of the endline study was to assess the changes made overtime against the objectives and baseline findings and to generate evidence for future programming of integrated ECD.

1.4.1 Specific Objectives

The specific objectives of the study were:

- i. To document achievements made towards coordination and management of integrated ECD.
- ii. To assess whether the parents/caregivers/guardians with children 0-5 years (including health care providers) have improved knowledge on caregiving practices such as feeding, hand washing, child stimulation, and communication.
- iii. To assess improvements on ECD indicators for health and nutrition, education, child protection, and WASH in the target age group since the baseline study was conducted in 2017.
- iv. To document the barriers and enablers to achieving the project outcomes.
- v. To document lessons and recommendations from the project that strengthen community-based integrated ECD at county levels.

1.4.2 Research Questions

The research questions that guided the endline assessment to respond to the five assessment objectives were:

- i. What are the achievements made towards coordination and the management of integrated ECD?
- ii. Has the knowledge on child-caring practices such as feeding, hand washing, child stimulation, and communication improved among parents/caregivers/guardians with children 0-5 years (including health care providers)?
- iii. Has there been any improvements in the project's ECD indicators for health and nutrition, education, child protection, and WASH in the target age group since the baseline study was conducted?
- iv. What are the barriers and enablers to achieving the project outcomes?
- v. What lessons and recommendations from the project are meant to strengthen community based integrated ECD at county levels?

1.5 Significance of the Endline Assessment Findings

The endline study findings were crucial in the realization of UNICEF's Strategic Plan, CPD 2014-2018, Rolling Work Plan (RWP) and UN Development Assistance Framework (UNDAP) 2017-2018. The IKEA/UNICEF project findings responded to target: Output 7.2 on innovative models for health behavior and optimal health service delivery; Output 8.2 on community-based nutrition services and behavior change strategies in the most deprived countries, selected urban settlements and refugee settings to improve maternal and newborn nutrition by 2018; Output 11.1 on the capacity to develop, strengthen and implement innovative community based scalable ECD models within the CFS frameworks in selected county governments and partners by 2018. At the county level, the IKEA/UNICEF project findings on how to run integrated ECD services inform the planning, coordination, and implementation of ECD at county levels, particularly how to engage the county governments in the management of integrated ECD services as a focal coordination point. The success story of multi-sectoral collaboration in the delivery of ECD services and in identifying the existing gaps and shortfalls and linking the county governments to the households offers the government and citizens another avenue for a partnership which generally improves service delivery. The integrated ECD services is an innovative model that led to replicable results and therefore one that ought to inform future ECD programming and contribute to the growing body of knowledge around ECD.

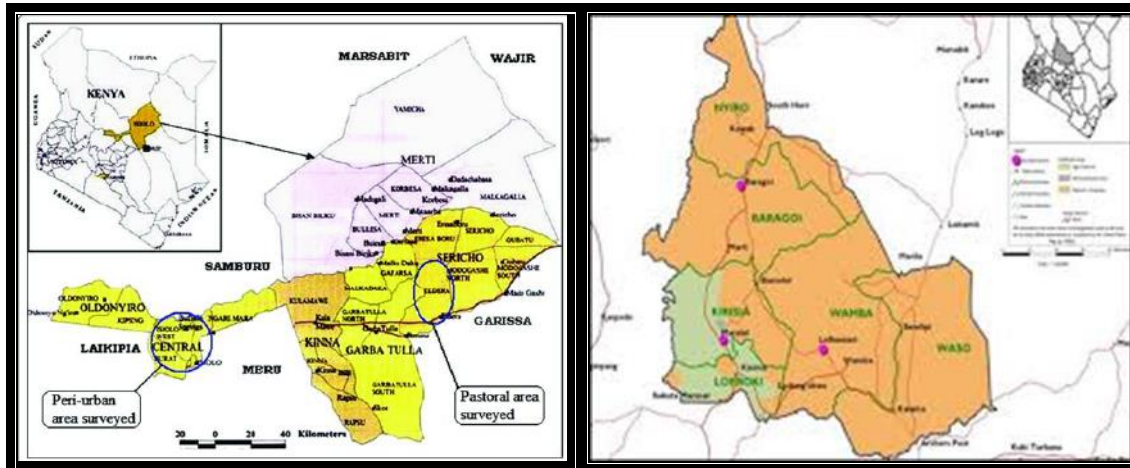
1.6 The Scope of the Endline Assessment

The endline study was conducted in the two counties of Isiolo and Samburu (refer to maps in the appendices), with sampling based on their respective sub-counties. In Isiolo County the study focused on the following sub-counties: *Isiolo, Garbatulla, and Merti* while in Samburu the focus was on *Samburu West, Samburu East, and Samburu North* sub-counties. This mirrored the baseline study to allow for comparability of the findings that emerged. The overall goal of the endline assessment was to document the changes made in line with the objectives and baseline

findings and to generate evidence for future programming of integrated ECD services. The assessment had a mix of the stand-alone ECD centres, privately owned ones and ECD Centres attached to public schools, based on the provision of integrated ECD Services in relation to the national standards such as health, nutrition, child protection/birth registration, wash facilities and play spaces. It also included health facilities providing ECD services such as functional play spaces for use by children when mothers/caregivers/guardians make clinical visits to these facilities.

Map of Isiolo County

Map of Samburu County



2.0 Review of Related Literature

The endline study literature review provides an overview of the global situation in relation to the provision of integrated ECD services. It then describes the situation in Kenya as far as the provision of ECD services is concerned. Finally, the end-line study context for the target counties namely Isiolo and Samburu is discussed. The essence is reviewing literature in this study is to provide an understanding of the current situation in terms of the provision of integrated ECD services.

2.1 Background of ECD in Kenya

Globally, in the poorest countries, there is a significant risk that children do not survive to their fifth birthday and when they do there is a further risk of not enrolling in school let alone completing the full education cycle. By the age of 18 years, the lasting effects of poor health and nutrition in childhood manifest, limiting physical and cognitive abilities (Kraay, 2018). Children have rights that are often overlooked and it is in this regard that the United Nations policies reiterate the need for early childhood institutions, policymakers, and educators to promote and implement children’s rights (Theobald, 2019). Early childhood is a time of rapid development during which the foundations for communication, connection, and identity are built and children’s experiences are developed and shaped by various factors some of which are cultural

beliefs, family backgrounds, and societal factors (United Nations, 2006). Research has established that from an early age, children are acutely sensitive to their surroundings and they respond to others' emotions and behaviors as they build their own identity in multiple ways. The family,, plays a critical role at the formative stage. (Theobald, 2019).

Starting to breastfeed at birth, within the first hour and exclusive breastfeeding for the first six months provides babies with the best nutrition possible. It also establishes a bond between mother and child at this formative stage when the right nourishment, responsive stimulation is required for healthy brain development. This means that health and nutrition during the 'early moments' are critical for providing a foundation for a child's brain and body. The early years begin with the health and nutrition of the expectant mother. Additionally, no child should experience violence, abuse, and neglect nor be exposed to the hazards of pollution or trauma caused by natural disasters. This not only protects them from bodily harm but also ensures proper brain development. Establishing conducive, loving, and caring environments creates a protective buffer for children to survive and thrive. Stimulation during the early moments of a child's life is of paramount importance. Parents/ caregivers/guardians play a critical role in this regard. Talking, playing, reading and singing are crucial activities that express love. It is for this reason that the IKEA project focused on these critical components of child development. According to IKEA (2018), grandparents to play a vital role in bringing up children in Isiolo County, as was revealed by UNICEF's outreach to families' programme whose purpose was to ensure that all caregivers acquire positive parenting practices. Furthermore, findings by IKEA showed that there's nothing more contagious than the giggles and laughter of young children, and that play is essential for stimulating children's brain development and can have a lasting impact on their ability to thrive later in life. Sadly, many children in the arid and semi-arid regions of Kenya don't have access to places to play. Stimulating the neural connections builds a foundation for brain development and hence the child's future. (Britto, 2017). This study, therefore, conforms to these requirements and further seeks to provide additional information for development and wellbeing.

The Government of Kenya considers early years' education a crucial foundation stage for, character formation and lifelong learning. This is in line with SDG 4, Target 2 which obligates states to ensure that all children access quality early years' education. Early years of quality education provides opportunities for children to enhance their cognitive, social, moral, spiritual, emotional, and physical development. Similarly, SDG 4 calls for the building and upgrading of safe education facilities, gender-sensitive, non-violent, and of an inclusive nature. Furthermore, Kenya also adopted Agenda 2063, which is about "*The Africa we want*". This agenda requires all states to expand universal access to quality ECD. Moreover, the health and nutrition status are a significant determinant of the child's holistic development and learning ability, hence early childhood has been identified as a period when the brain develops rapidly and therefore appropriate health, nutrition, early education, and care must be provided to ensure a better and healthy future for the child. Such holistic approaches which integrate adequate nutrition, good health care, early stimulation, early learning, communication and security, physical, mental, and social-emotional dimension are recognized as constituting the foundation of proper growth and

development of children.

Childcare is characterized by having well-qualified, well-paid, stable staff, low child-adult ratios, and efficient management; and offering a program that covers all aspects of child development (physical, motor, emotional, social, language, and cognitive development). Further, early years' education is considered a very essential level of education that prepares early years' learners for achieving Universal Primary Education and the SDGs. Ensuring access to quality ECD is a key strategy for improving learning and education outcomes as well as the efficiency of education systems (UNICEF, 2018). Consequently, one of the three outcome areas of the Innocenti programme 2018-2021 is to undertake research on critical issues for child rights and wellbeing (UNICEF, 2018).

Arid and Semi-Arid Lands (ASAL) face the unique challenges of disparities in the provision and accessibility of basic services that compromise the provision of quality ECD services. Notably, Isiolo and Samburu counties are particularly vulnerable to adverse environmental and weather conditions that result in recurrent and severe droughts/flooding. Children from these two pastoralists' counties suffer particularly from high incidences of malnutrition. According to KDHS (2014), the proportion of stunted children in Samburu is 30% and 18% in Isiolo (KDHS- 2014). Moreover, in both counties, 91% of child caregivers were biological mothers to the children who participated in the study. Ninety-five percent of the biological mothers of these children resided in their household and in about half (51.6%) of the sampled households there were two primary caregivers, most of whom included a biological father.

To enhance early childhood experience and enable children from marginalized communities to develop holistically, UNICEF Kenya, through funding support from IKEA Foundation has been supporting Isiolo and Samburu Counties to model community-based Early Childhood Development (ECD) services through the "Let's Play Good Cause Campaign, Space for Kids to be Kids" project. The project is being implemented in partnership with Samburu County Government, World Vision, Child Fund Kenya, Isiolo County Government, and Life Skills Promoters, with the overall objective to strengthen community-based integrated ECD. The endline study findings, therefore, sought to enable the realization of UNICEF's Strategic Plan, CPD 2014-2018, Rolling Work Plan (RWP), and UN Development Assistance Framework (UNDAP) 2017-2018. It targeted: Output 7.2 on innovative models for health behavior and optimal health service delivery; Output 8.2 on community-based nutrition services and behavior change strategies in the most deprived countries, selected urban settlements and refugee settings to improve maternal and newborn nutrition by 2018; Output 11.1 on ensuring capacity to develop, strengthen and implement innovative community based scalable ECD models within the CFS frameworks in selected county governments and partners by 2018. (UNICEF Baseline report, 2017).

2.2 Status of ECD in Isiolo and Samburu Counties

Research on ECD points to the need for an ecological, life-course approach to the provision of ECD that addresses the child in the context of family, and the family in the context of community. Ultimately, improving children's health and well-being involves effective professional services that are developmentally appropriate and support and strengthen resiliency and reciprocity for young children and their families through positive social connections and actions that go much beyond discrete, individual service provision. Respective governments have obligations in terms of service provision and adequate resource mobilization. It is evident from the county integrated development plan that in Isiolo and Samburu counties there are intervening variables such as poverty, insecurity, socio-cultural beliefs, socio-economic factors that may hinder the realization of the growth and development and learning progression of the 0 to 5-year old's.

The Isiolo County Integrated SMART Survey Report of 2017 established global acute malnutrition (GAM) prevalence of 18.2 % and severe acute malnutrition (SAM) prevalence of 3.3%. The current GAM rates indicate a critical situation compared to the previous year during the same period, with a significant difference (Isiolo County SMART Survey Report, 2017). According to Isiolo County Integrated Development Plan -2018-2022, there are 160 ECDE centres out of which 42 are privately owned. In 2017 total enrolment was at 16,295 with 9,102 being boys and 7,193 girls. The teacher-pupil ratio in the ECD centres is 1:87 which is far above the optimal of 1:40. This means that there is a shortage of teachers. The population of the under five years' age group is estimated at 25,662 and 90 percent of them are expected to be in school. Inadequate ECDE facilities are one of the reasons why children who are of school-going age are still at home. Poverty, drought, and the nomadic way of life further complicate this situation. (Isiolo County Integrated Development Plan -2018-2022). The IKEA project responded to the dire need for rapid infrastructure development, skilled teachers, play equipment and materials, and enhanced nutrition.

The Samburu County Integrated SMART survey of 2017 revealed that the Global Acute Malnutrition had gone up from 14.5% to 18.3% in 2017. The SAM had also gone up from 2.4% to 3.8 %. In the same year. Samburu County registered a stunting rate of 34.0 %, severe stunting of 10.6%, and underweight of 34.3% indicating a need for immediate action to respond to this issue (Samburu County Integrated SMART Survey, 2017). Further, information from Samburu and Isiolo Integrated County plans to show the availability of play spaces for early years' learners at 94.8% and 67.6% for Samburu and Isiolo Counties respectively. In Samburu 280 ECDE classrooms, 70 sanitary blocks, were constructed using ward development funds, and 200 ECDE centers were provided with tanks. According to The Samburu County Second County Integrated Development Plan 2018-2022, the total number of ECDE centres in the county is at 529 with a total enrolment of 42,938, 24180 boys and 18,758 girls. As of the year 2017, there were 470 teachers and this translates to a teacher/pupil ratio of 1:91. The county government recognizes to need for allocation of more resources towards the improvement of ECDE services especially in rural areas

to ensure that all the children under-five are enrolled in school and that there are sufficient teachers. (Samburu County Second County Integrated Development Plan 2018-2022)

2.3 Coordination and Management of Integrated ECD in Kenya

It is evident that devolving authority for ECDE provision to the counties has brought opportunities, as well as challenges. Coordination and management of ECDE between the central government and the counties are not clear. The central government retains authority for ECDE in terms of policy, standards, curriculum, and assessment. Counties on the other hand are responsible for implementing policies, developing programs, training personnel, and providing infrastructure. In some cases, however, the legal lines of authority are unclear. For instance, the authority to hire ECDE teachers has been a source of dispute. (World Bank, policy brief document on ELP, 2016).

The IKEA project, therefore, focused on the improvement of coordination and management of ECD at national and county levels. The indicators were: mechanisms and structures established to coordinate mainstreaming of ECDE at various levels; health facilities implementing and integrating care for child development model with KPI; access to quality ECD services. The project's baseline findings showed that ECDE coordination and management structures in both Samburu and Isiolo Counties were dysfunctional (UNICEF Baseline Survey, 2017). There was no integrated coordination of ECD services, therefore the implementation of the ECDE activities was being done by officials from the MoE at the county level. However, the inter-ministerial steering committee and a Technical Working Group (TWG) to strengthen ECD operations were in place. Further, there was a lack of harmonization on various models of the ECD programmes and adequate coordination, linkages, and collaborations among stakeholders delivering integrated ECD services. Weak structures of management that closes gaps in the transition of ECD management from the national government to county government were also identified.

2.4 Devolution and Financing of ECD in Kenya

There has been a focus on early years' education policies and care across the developed world and particularly in Europe. The UK has realized a raft of policy changes alongside increased investment. Despite this, there are major issues related to the levels of government funding and the regulatory context. Further, the divergences between the providers financing for early years' education in terms of their own objectives and the underlying values. These factors continue to influence the delivery of universal provision of high-quality early years education and care. (West, Roberts & Noden, 2010).

In Kenya, according to a World Bank policy brief on the costs, constraints, and opportunities of scaling up preschool in Kenya, the responsibility for ECDE provision was devolved to the counties without adequate financial resources. In fact, no specific budget allocation from the central government is given to counties to provide ECDE services (World Bank, policy brief document on ELP, 2016). The document further outlines the ECDE costs as follows: investment/Capital costs;

renovation and maintenance of existing building and infrastructure; ECDE center construction; learning and play equipment (indoor and outdoor); information and communications technology (ICT); furniture and equipment; toilet construction and renovation recurrent costs; salaries for teachers and teacher assistants; in-service training; teaching and learning materials (curriculum materials, stationery, pens, books, chalk, plasticine/clay, teaching aids and tools, etc.); supervision and quality assurance staff; support staff (e.g. cooks, security); meals for feeding program; utilities and operation. This is consistent with the IKEA project’s overall objective to strengthen community-based integrated ECD (World Bank, policy brief document on ELP, 2016) It is in this regard that to enhance early childhood experiences and enable children from marginalized communities such as Isiolo and Samburu counties to develop holistically, UNICEF Kenya, through funding support from IKEA Foundation supported community-based ECD services through the “Let’s Play” Good Cause Campaign, Space for Kids to be Kids project. The project was implemented in partnership with Samburu County Government, World Vision Kenya, Child Fund Kenya, Isiolo County Government, and Life Skills Promoters.

3.0 METHODOLOGY

This section details the endline study design, sampling framework, quality assurance, data entry, and analysis including ethical protocols that guided the study processes. The endline assessment employed a descriptive research design combining both quantitative and qualitative data in a complementary way to respond to the endline study objectives. The methodology was designed to assess the relationship between the various variables described in the conceptual framework and how they related to the development of holistic children.

3.1 Endline Study Approach and Methodology

The endline assessment was cross-sectional but adopting a mixed-method approach. This was necessary for two reasons; first, it allowed the use of both quantitative and qualitative methods in the collection of relevant data, and secondly, allowed comparison of the emerging findings both at outcome and output indicator levels with the baseline values respectively. This was necessary to respond to the key questions on relevance, effectiveness, efficiency, impact, and sustainability of the project from baseline to endline.

3.2 Data Collection Strategy

The rigorous process of data collection started with the development of relevant research tools. For triangulation, both qualitative and quantitative data were developed and validated. Data was gathered in multiple stages and the same procedure followed in both locations (Isiolo and Samburu counties). Table 2 summarizes the data collection strategies that was employed in the endline assessment.

Table 1: Endline Study Strategy and Tools

Questions	Specific Questions	Tools	Analysis
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To what extent was the project successfully designed and implemented?	How did the project design involve key stakeholders (community members, pupils, teachers, etc.)	Survey KIIs Guidelines	Stata/SPSS
	To what extent was the project implementation design followed?	KIIs Guidelines Survey	Stata/SPSS, NVIVO/MaxQDA
How has the project complied with the major needs and interests of the target groups and the national context?	How did the project identify the relevant target group? To what extent did the project ensure the needs of the target group were met?	KIIs Guidelines, FGDs, observation	Stata or SPSS NVIVO or MaxQDA
How well were the activities converted into outputs?	To what extent was the quality of the outcomes achieved?	Observation Survey	NVIVO or MaxQDA
What worked and what did not work?	To what extent did any unexpected results contribute to the current delivery of the project's purpose?	Survey, FGDs	Stata/SPSS, NVIVO/MaxQDA
How has the current delivery of the project's purpose contributed to the overall goal of the project? (Input and output impact).	Is there a difference in ECD integration approaches to stakeholder engagement, and is one more effective than another?	KIIs Guidelines Survey FGDs	Stata/SPSS, NVIVO/MaxQDA
To what extent has the project put in place strategies or mechanisms that will ensure that benefits or interventions continue after the project life? .	How is the flow of benefits for beneficiaries and for ECD? What is the level of ownership by stakeholders and beneficiaries? Will the beneficiaries of the project be able to adapt and ensure continuity of the project? To what extent have the project's activities been integrated into local institutional structures? What is the level of outcomes? 1-3?	KIIs Guidelines FGDs observation	Stata/SPSS, NVIVO/MaxQDA
What challenges were faced during the implementation of the project? What can others learn from this project?	What challenges were experienced during the implementation of the project? How did these challenges influence/interfere with the project's progress and success? How were the challenges managed to allow for successful completion of the project? What are the key learning areas for future related projects?	KIIs FGDs	Stata/SPSS, NVIVO/MaxQDA

3.3 Target population

The study targeted 59,233 children of age category 0-5 years, 364,579 caregivers, 868 teachers, 736 CHVs, and 239 head-teachers in Isiolo and Samburu counties. In arriving at sample sizes of the various categories of the informants, the endline assessment utilized a mixture of sampling strategies. For instance, purposive sampling was used to select key informants that provided firsthand information on the status of ECDE in the two counties. These were the government officials at national and county levels, the IKEA project team, and implementing partners. The sample size for 0-5 years' children and caregivers/households was determined using Krejcie-Morgan's formulae for determining sample size (The table is provided as annex 1). These were larger samples and Krejcie-Morgan Table outlines formulae of determining sample size for such a large population at a confidence level of 95 percent and a margin of error of 5 percent (Krejcie & Morgan, 1970). For teachers and CHWs/CHVs, the study assessment sampled 10 percent of the population giving a sample of 30 and 57 teachers in Isiolo and Samburu counties respectively while 33 and 42 CHVs in Isiolo and Samburu respectively. For the health facility, the assessment sampled 15 and 23 health facilities in Isiolo and Samburu counties representing 30% of the total target population.

The target population versus the sample size used in the endline assessment including the justification for the samples was as shown in Table xx.

Table 2: Target Population Versus Sample Size

Type of Respondent	Population			Sample Size			Justification
	Isiolo	Samburu	Total	Isiolo	Samburu	Total	
Children	16,295	42,938	59,233	378	381	759	Krejcie & Morgan Table
Caregiver/Parent	143,294	221,285	364,579	383	383	766	Krejcie & Morgan Table
Head teacher	45	194	239	30	30	60	IKEA Project schools
Teacher	300	568	868	30	57	87	10% of the target population
CHV	322	414	736	33	42	75	10% of the target population
ECD Walkabout	45	194	239	30	30	63	IKEA Project schools
Health Center Walkabout	50	75	125	15	23	38	30% of the health facilities

Source for Target Population: Departments of Education & Health (Isiolo & Samburu Counties); EMIS, 2014; and KNBS, 2017; Kenya Master Health Facility List (2017) <http://kmhfl.health.go.ke>

In addition, the study also targeted government officials at national and county levels from MoE and MOH. At the county level, there were the CECs, County ECD directors, county directors of education, sub-county directors of education, sub-county ECD coordinators, health and nutrition officers, project implementers, and UNICEF project team.

In summary, the endline assessment involved a total of 1,677 respondents whose categories are

as outline in Table 3.

Table 3: Category and Number of Respondents

No.	Category of Informant	No
1	Children	687
2	Caregivers/Parent	745
3	Headteachers	59
4	Teachers	94
5	Community Health Workers	59
6	Health Centre Managers	4
7	County ECD Directors	2
8	Sun County Director of Education	3
9	ECD Ward Coordinators	6
10	Ministry of Health Officials	5
11	UNICEF Project Team	1
12	Nutrition Officers	3
13	Implementing Partners	6
14	Agriculture Officers	3
	Total	1677

The response rate for the various categories of respondents was high with over 90% adequate to give a true reflection of the views of the target population.

Table 4: Sample Size per County

	Targeted			Achieved			% Achieved		
	Isiolo	Samburu	Total	Isiolo	Samburu	Total	Isiolo	Samburu	Total
Children	378	381	759	346	341	687	91.5%	89.5%	90.5%
Caregiver	383	383	768	370	375	745	96%	98%	97%
Head Teachers	30	30	60	31	28	59	103%	85%	98.3%
Teachers	30	57	87	56	38	94	93%	58%	108%
CHV	33	42	59	35	24	59	100%	100%	100%
ECD Walkabout	30	30	60	29	33	62	97%	100%	103%
Health Center Walkabout	15	23	38	12	13	25	80%	56.5%	65.8%

3.4 Recruitment of Research Assistants

a) Recruitment Process: The study developed a criterion that was used to identify and recruit Research Assistants (RAs). The criterion took into consideration; the qualifications of the RAs, the knowledge level of the study sites by RAs particularly the ECDE centres, their research experience

including use of virtual data collection platforms, gender, and availability during the data collection period. Based on this criterion, 15 RAs were recruited, 10 females and 5 males. In terms of study sites, eight (8) were in Samburu (3 females and 5 male) and 7 were in Isiolo, all female. The use of locals ensured that only local RAs familiar with the study sites and able to fluently communicate in their local languages were contracted. WERK had a strong presence in Isiolo and Samburu counties, implementing similar projects that require the use of virtual data collection methods and therefore used the existing linkages to recruit 15 RAs with adequate knowledge in the use of tablets in data collection.

b) Training of the Research Assistants: The endline assessment conducted a four (4) day online training of the recruited 15 RAs facilitated by four trainers. There was an online data training manual that was developed to guide the training process attached as Annex 1. Among the sessions that were conducted was the use of the mobile application (ODK) in data collection and submission techniques which was expected to increase the response rate. Tips on field entry were integrated into the program to enhance the capacity of RAs to introduce the assessment process properly and minimize the chances of informants refusing to participate.

Since the study was conducted during the time of the COVID-19 pandemic, RAs were reminded to strictly adhere to the government's health safety requirements which included washing of hands/ sanitizing, wearing masks-respiratory hygiene, and cough etiquette, and social distancing. Besides the MoH protocols, RAs were trained on COVID-19 prevention and use of the protective materials to protect themselves during fieldwork and also guide the various respondents on the same. The RAs were provided with the various protective materials required by the RAs and respondents during data collection. The protective materials ranged from masks, gloves, sanitizers including measures of observing social distancing and curfews put in the place by MoH towards curbing the pandemic.

c) Pre-testing of the Tools: Training of RAs also involved pre-testing of the research instruments. Given that training was virtual, pre-testing was incorporated into training in such a way that after covering a specific tool(s), RAs were allowed to pre-test. A few ECD centers and their surrounding households and health facilities in Isiolo and Samburu counties nearest to the RAs were used for pre-testing. After pre-testing, the data was uploaded and trainers used the submitted data to conduct a plenary session with the RAs to review the process including making readjustments where necessary to the research instruments and guiding the RAs on how to navigate the noted challenges. This ensured that the research instruments were sharpened and ambiguous questions adjusted or dropped altogether.

3.5 Data Collection Process

After training, the RAs were divided into two teams; the Samburu team comprising of 8 RAs and two researchers, and the Isiolo team consisting of 7RAs and two researchers for data collection and supervision of the process respectively. The RAs were required to collect the necessary research tools which included a fully charged tablet and research permit. Before commencing the data collection exercise the RAs first paid a courtesy call to the county offices where they explained the purpose of the endline assessment and sought permission to conduct the study. In each of the teams, there was a county coordinator whose role was to coordinate the data collection process among the RAs and reported to the researchers.

Each of the RAs was assigned a specific number of caregivers that were to be visited by making earlier bookings. They also visited the health facilities and conducted interviews with the health facility manager to establish the availability and functionality of play facilities, equipment, and materials for 0-5 years old. Also, they were to carry out a walkabout both at the ECD and health facility. At the ECD center, the RAs interviewed the head-teacher to collect the school data and also interviewed two ECDE teachers.

3.6 Data Analysis and Management

a) Data Cleaning: The study collected both quantitative and qualitative data. After data collection, the quantitative and qualitative data underwent different processes for cleaning. For quantitative data, the SPSS output was checked from accurate entries and completeness of the submitted files. Those that did not have over a third of the questions responded to were removed from the data set. For the qualitative data, the collected data was transcribed. This was carefully done combining data collected through note-taking and electronically by use of recorders to ensure that the sentiments from the informants were captured as correctly as possible. This was done by the researchers and preliminary analysis conducted that allowed accurate cleaning of the files that were emerging. It was the clean quantitative data and qualitative data that was fed into SPSS and N-VIVO for the generation of tables and narratives respectively to support responding to the set endline assessment objectives.

b) Data Analysis: The research team used a non-crossover approach in analyzing the quantitative and qualitative data collected. This approach allowed the team to give equal weighting to both the qualitative and quantitative data (Onwuegbuzie, & Combs, 2010).

Quantitative Data: Data was disaggregated, summarized, and described using descriptive techniques such as means, standard deviations, frequencies, and percentages. The variables and codes from the closed-ended sections were keyed into the SPSS software, a statistical computer program, and analysis conducted to ensure the data meets all relevant statistical assumptions. A

descriptive analysis was carried out for all survey tools utilizing appropriate descriptive measures based on the type of variables, categorical versus continuous. Additionally, group comparisons and cross-tabulations were performed to incorporate all the study variables.

Qualitative data: The N-VIVO software was used to support the analysis of qualitative data. Thereafter, relevant themes were developed along with the emerging themes and discussed results in relation to the objectives. The team ensured that the coding and the interpretations made from codes were “data-driven” and constructed from the “raw information” available in the transcribed responses to the endline study questions. Qualitative data analysis ensured a comparison of the data from various sources to create a trustworthy account of the impact of the interventions. The data derived from the KIIs, mapping exercises, and walkabout were coded, transcribed, and analyzed by assigning summative short phrases, words, or portions of the scripts (Miles & Huberman, 1994). The codes were then categorized into groups describing a similar phenomenon. This regrouping consolidated the meanings and provided the needed explanations to respond to endline assessment objectives. The categories were then synthesized into themes and used to develop narratives which were used to triangulate, expand, and in some cases, clarify the findings from the quantitative data.

3.7 Limitation of Endline Assessment

The endline assessment faced a number of limitations and challenges during pre-fieldwork, fieldwork, and post-field work as shown in Table 5.

Table 5: Limitations and Mitigation of Endline Assessment

NO	LIMITATION	MITIGATION
1	Limited access to children aged 0-5 years	We intentionally examined children participation at the household level and during health facilities visit
2	The inability of RAs to directly conduct classroom observations to find out the extent of use of child-friendly pedagogical methodologies due to COVID 19 pandemic	We integrated child-friendly teaching methodologies and other aspects that were to be observed into the teacher questionnaire and head-teachers for self -reporting.
3	Inability to have senior researchers supervise data collection physically	The hiring of county coordinators to supervise the process and having the senior researchers remotely available for consultation, check and support data collection period
4	Managing COVID-19 pandemic	Provision of protective materials required by the RAs and respondents during data collection and going through the MoH protocols.

5	Virtual Data collection Errors	Selection of RAs with previous experience in virtual data collection A rigorous 3-day virtual training on virtual data collection Adoption of ODK that allowed tracking of time taken on each question. Use of experienced researchers to conduct qualitative interviews and to generate transcripts
6	Accessing busy caregivers in the two counties	Encouraged making earlier appointments and rescheduling of interviews and /call-backs

3.8 Quality Assurance

Quality assurance was a critical component of this project. There was a quality assurance committee that was constituted to oversee the endline assessment process. The committee carried out internal assessments of the endline process and the output quality. The committee put in place data validation processes such as pre-testing and the necessary adjustments of tools before actual data collection. Furthermore, the selection process of the RAs was done professionally leading to the recruitment of competent individuals. The online data collection training of the recruited RAs enhanced the capacity of the RAs their roles.

During the data collection process, the fieldwork coordinators had specified roles to supervise the process. There were transcription procedures that were developed and guided the collection of qualitative data. This was done by researchers who were required to conduct preliminary analysis and help clean the qualitative data before it was subjected to N-VIVO for the generation of reports. To achieve this, in addition to note-taking, tape recorders were used during the key informant interviews. The assessment also put in place clear reporting structures which ensured challenges experienced were mitigated as promptly as possible.

3.9 Ethical Consideration

The endline assessment observed the highest standards of ethics during the endline study process. Informed consent was sought from all respondents before the commencement of the data collection process. Parents/guardians/caregivers and teachers were requested to give written consent for the participation of children under their care. A consent form was prepared in line with WERK’s Child Protection and Safeguarding Policies and UNICEF’s procedure for ethical standards in research, evaluation, data collection, and analysis (UNICEF, 2015). Using the UNICEF’s guidelines, consent was sought at two levels when engaging children, the parent/guardian/caregiver and also assent from the child. A child’s refusal to participate or continue in the research was respected.

Even after agreeing to participate in the study, they were informed about their freedom to withdraw their consent at any stage of the interview process without having to explain. Anonymity and confidentiality were also observed in all the project activities. Accordingly, pseudonyms were used for schools and individuals to conceal their actual identities. Where a photo was taken or used, the study obtained consent from the informants. WERK's ethical guidelines sought to protect the confidentiality of those participating in the study and ensure data obtained is used only for the intended purpose.

3.10 Ethical Clearance

The endline study assessment adhered to NACOSTI's requirements that all research projects that involve human beings as research participants should satisfy the ethical standards for research as provided for in the Guidelines for Ethical Conduct of Biomedical Research involving Human Subjects in Kenya (2004) and any other applicable internationally recognized ethics guidance documents. To adhere to these requirements, the study processed got a permit from the National Commission of Science, Technology, and Innovation (NACOSTI), and an ethical clearance certificate approval.

4.0 FINDINGS

4.1 Characteristics of the Endline Assessment Sample

This section outlines the general characteristics of the households by reporting on the profiles of the project beneficiaries. The general profiles are compared to the baseline characteristics to establish if the sample at baseline and the one at endline are similar to allow comparability of the sample used at the baseline and endline. Endline assessment data was collected from 745 households (Isiolo County 370 and Samburu county 375). A total of 687 children aged 5 years and below from the 745 households were also covered.

Household Characteristics: The IKEA Project sought to document the household characteristics of the targeted children aged 0-5 years, their caregivers, ECD centres, and health facilities. The household characteristics of the sampled caregivers were as shown in Table 6.

Table 6: Caregivers Household Characteristics

		Baseline			Endline			Change from BL		
		Isiolo	Samburu	Total	Isiolo	Samburu	Total	Isiolo	Samburu	Total
Gender of the Head of the household	Male-headed	87.9% (356)	79.1% (359)	83.2% (715)	82.1% (284)	75.1% (256)	78.6% (540)	-5.8%	-4.0%	-4.6%
	Female-headed	12.1% (46)	20.9% (95)	16.8% (144)	17.9% (62)	24.9% (85)	21.4% (147)	5.8%	4.0%	4.6%
Average age of the Head of the Household	Females	37.28 (356)	37.27 (359)	37.28 (715)	39.18 (284)	42.23 (256)	40.63 (540)	1.9	5.0	3.4
	Males	37.29 (49)	32.03 (95)	33.82 (144)	35.02 (62)	34.27 (85)	34.59 (147)	-2.3	2.2	0.8
	Total	37.28 (405)	36.17 (454)	36.7 (859)	38.44 (346)	40.25 (341)	39.34 (687)	1.2	4.1	2.6
Religion of the respondent	Christian	34.1% (138)	94.7% (430)	66.1% (568)	44.2% (153)	76.2% (260)	60.1% (143)	10.1%	-18.5%	-6.0%
	Islam	65.9% (267)	1.1% (5)	31.7% (272)	55.8% (193)	0.6% (2)	28.4% (195)	-10.1%	-0.5%	-3.3%
	Traditional		2.2% (10)	1.2% (10)		23.2% (79)	11.5% (79)	0.0%	21.0%	10.3%
	Others		2% (9)	1% (9)				0.0%	-2.0%	-1.0%
Highest Level of the head of the household	No formal education	31.9% (129)	50.2% (228)	41.6% (357)	38.4% (133)	58.1% (198)	48.2% (331)	6.6%	7.8%	6.6%
	Primary school	34.3% (139)	29.7% (135)	31.9% (274)	36.4% (126)	19.6% (67)	28.1% (193)	2.1%	-10.1%	-3.8%
	Secondary school	27.2% ()	15.6% ()	21.1% ()	19.1% ()	9.7% ()	14.4% (99)	-8.1%	-6.0%	-6.7%
	Tertiary College/college	5.4% ()	4% ()	4.7% ()	3.8% ()	10.3% ()	7% (48)	-1.7%	6.3%	2.3%
	University Degree	1.2% ()	0.4% ()	0.8% ()	2.3% ()	1.8% ()	2% (14)	1.1%	1.3%	1.2%
	Refused					0.6% ()	0.3% (2)	0.0%	0.6%	0.3%

The households were predominantly male-headed (78.6%) than were female heads of the households (21.4%). There were more male-headed families in Isiolo County (82.1%) than Samburu (75.1%). This trend established at endline assessment mirrors what was reported at the baseline although overall figures show that female-headed households have improved from 16.8% at baseline to 21.4% at endline. The average age of the household heads was 40 years (females had 41 while the male was 35). The average for the baseline was 37 years.

Most of the household heads were Christians (60.1%), followed by Muslims (28.4%) and traditional (11.5%). The religion of the respondents had remained the same from baseline to endline. At baseline, 66.1% were Christians, 31.7% were Muslims and only 1.2% subscribed to traditional beliefs.

The education levels in the two counties remained low. At the endline, 48.2% compared to 41.6% at baseline had no formal education while 31.9% at baseline and 28.1% at endline had primary school education.

Household Composition and Size: The average size of the sampled households in Isiolo and Samburu counties was 6 persons, and this was no different from baseline as shown in Table 7.

Table 7: Average Household Size

	Baseline			Endline		
	Isiolo	Samburu	Total	Isiolo	Samburu	Total
women aged 50 years and older	.37	.26	.31	.12	.13	.12
men aged 50 years and older	.26	.18	.22	.13	.14	.14
women aged 15 – 49 years	1.24	1.12	1.18	1.26	1.10	1.18
men aged 15 – 49 years	1.14	.95	1.04	1.15	.96	1.06
girls aged 6 -14 years	.80	.81	.81	.92	.79	.86
boys aged 6 – 14 years	.76	.76	.76	.82	.76	.79
girls aged 3 – 5 years	.32	.24	.28	.52	.58	.55
boys aged 3 – 5 years	.32	.23	.27	.49	.56	.53
girls aged 0 – 2 years	.39	.37	.38	.27	.27	.27
boys aged 0–2 years	.41	.38	.40	.32	.33	.32
Household Members	6.01	5.3	5.64	5.99	5.64	5.82

The endline assessment breakdown of under 5s children was as shown in Table 8.

Table 8: Age Breakdown in completed Years children, 0-5

Age (Years)	Baseline	Endline
Under 1 Year	24%	13%
1	18%	16%
2	22%	20%
3	20%	17%
4	15%	17%
5		17%
Gender		

<i>Age (Years)</i>	<i>Baseline</i>	<i>Endline</i>
<i>Male</i>	52%	51%
<i>Female</i>	48%	49%

The above table indicates that the majority of the under 5s children sampled were of age 2 years (20%) followed by age 5 (18%). Although there was an almost equal distribution of all age categories with the least representation being under 1 year (13%) and year 1 (16%). The gender distribution of the under 5s children was similar as baseline with male (baseline-52%, endline-51%) and female (baseline-48%, endline-49%).

Mode of Child Delivery: The number of deliveries in health facilities in Samburu and Isiolo counties increased between baseline to endline as shown in Table 9.

Table 9: Mode of Child Delivery

	Isiolo		Samburu		Total	
	Baseline	Endline	Baseline	Endline	Baseline	Endline
Health facility	69.9%	70.8%	50.1%	63.3%	60.2%	67.1%
Home by Nurse	0.3%	4.0%	0.5%	0.6%	0.4%	2.3%
Home by TBA	21.5%	24.6%	19.0%	12.3%	20.3%	18.5%
Home without assistance	3.3%	0.6%	19.6%	23.8%	11.2%	12.1%

There is a culture of taking children born out of the hospital for a medical check-up in the two counties. However, the time taken was varying as shown in Table 10.

Table 10: Time taken to take child born out of the hospital for medical check-up

	Isiolo		Samburu		Total	
	Baseline	Endline	Baseline	Endline	Baseline	Endline
Immediately within 24 hours	43.3%	39.6%	33.8%	36.8%	37.1%	38.1%
Within first 2 weeks	39.2%	39.6%	44.0%	35.2%	42.3%	37.2%
Between 2 weeks and 1 month	6.7%	19.8%	14.7%	13.6%	11.9%	16.4%
After 1 month	5.8%	0.0%	4.0%	13.6%	4.6%	7.5%
Child not taken	5.0%	1.0%	3.6%	0.8%	4.1%	0.9%
N	120	101	225	125	345	226

The endline assessment findings revealed a slight increase (1%) in the number of new birth that are taken immediately for a health check-up when born at home from baseline (37.1%) to endline (38.1%). When disaggregated by counties, Samburu county recorded a higher increase in the number of births at home taken for health check-up within 24 hours from 22.8% at baseline to 36.8% at endline.

Proportion of Children Living with Disabilities: At endline 1.1% of the under 5s in the two counties were reported to be living with some form of disability. This was a decrease from the baseline value of 1.6%. In terms of County, Samburu County reported that 2.1% of the under 5s at endline were living with disabilities.

		Baseline			Endline		
		Isiolo	Samburu	Total	Isiolo	Samburu	Total
Does the child have some form of disability?	Yes	1.2%	2.0%	1.60%	0.0%	2.10%	1.1%
	No	98.8%	98.0%	98.40%	100.0%	97.9%	98.9%

People living with the Children: At endline assessment, most children (96.3%) were living either with their both parents (59.1%) or one of their parents (37.2%).

Table 11: The Caregivers that live with the child

	Baseline			Endline		
	Isiolo	Samburu	Total	Isiolo	Samburu	Total
Biological	47.7%	40.1%	43.7%	31.6%	40.3%	36.0%
Biological father	0.2%	1.5%	0.9%	1.6%	0.8%	1.2%
Both biological parents	45.7%	55.7%	51.0%	64.9%	53.3%	59.1%
Guardian / Other caregiver	6.4%	2.6%	4.4%	1.9%	5.6%	3.8%

4.2: Endline Study Outcome Level Findings

4.2.1 Outcome 1: Improved coordination and management of ECD at national and county levels
Outcome 1 sought to assess mechanisms and structures established and mainstreamed to coordinate ECD at various levels in the study counties.

The key findings:

- The previously dormant structures for delivering integrated ECD services are now active.
- The health services departments are now working closely with other ECD service providers.
- The ECD centres have now play materials/facilities in addition to extra learning materials.

There were three indicators namely: mechanisms and structures established to coordinate mainstreaming of ECD at various levels; health facilities implementing and integrating care for child development model with Key Performance Indicators (KPI); and access to quality ECD services.

The findings on outcome one at baseline showed that the ECD coordination and management structures in Samburu County were almost similar to Isiolo County. There was no integrated coordination of ECD services with much of the work done through MoE at the county level. Samburu county had a functional Inter-Ministerial Steering Committee and a Technical Working Group (TWG) meant to address ECD services in the country and to strengthen ECD operations. However, the county did not have a policy guiding the delivery of ECD but had expanded partnership with the communities through the inclusion of area advisory committees. Further, there were systems of quality assurance for ECE in the program delivery incorporated in the ECE delivery structure.

Further, the baseline findings indicated that there were no systems or institutional structures for integrated ECD services in Isiolo County. Service delivery was scattered along with different line ministries and county government functions with no central coordination agency. Lack of an integrated policy framework addressing comprehensive ECD services was also revealed. In addition, there was no functional multi-sectoral steering committee or TWG looking at comprehensive ECD services at the county. It is important to note that the Basic Education Act of 2013, stipulates that ECD services are devolved to the county government and hence it is the responsibility of each of the forty-seven (47) counties to provide ECD services.

The endline assessment study findings of the key informants conducted in 2020 show that great improvements have been achieved through the implementation of IKEA/UNICEF let's play spaces for kids to be kids. The project activated the structures and systems that were already existing and operationalized them and allowing for implementation. There were improvements in the coordination and management of ECD systems and structures in equal measure based on key informants' opinions in both Isiolo and Samburu counties. A summary of the indicators of outcome 1 was as outlined in Table 12.

Table 12: Comparison of Baseline and Endline Findings and the Implications of the findings in Samburu and Isiolo

Indicators	Baseline assessment	Endline Assessment
Mechanisms and structures established to coordinate mainstreaming of ECD at various levels	No integrated coordination of ECD services irrespective of where some systems existed	<p>Coordination has generally improved:</p> <p>Systems are put in place to strengthen the coordination of ECD services. For instance, through the project, TWG, advisory committees, and steering committees were created and strengthened where they existed. They brought together various stakeholders through meetings where ECD services were discussed and communicated accordingly</p>
Health facilities implementing and integrating care for child development model with KPI	MoH and MoE were working separately	<p>Ministry of Health is more engaged in the stimulation of children through the provision of play materials at the health facilities and MoE closely worked with MoH through CHW who regularly visited schools.</p> <p>The Project activated the multi-sectoral approach to ECD issues which has improved coordination meetings held at sub-county, county, and national levels including with partners</p>
Access to quality ECD services	The study ECD and health centres lacked play materials	<p>UNICEF project changed the ECD participation trajectory which has improved the enrollment numbers in the study ECD centers.</p> <p>The number of ECD centres has doubled in the study counties some of which had none.</p> <p>Improved parent participation and responsiveness in terms of attending meetings geared towards improving children's learning</p> <p>The community now is taking ownership and sustainability the ECD centers for better learning of children</p> <p>Enrollment increased as well as attendance whose improvement was attributed to the provision of meals/food at school and play materials.</p>

The CHVs responses indicated that formerly ministry department of health was never engaged with the department of education as concerns ECD services but the implementation of the UNICEF Let's play project has created more awareness on the importance of various departments working together to improve the quality of education and development of children. The health care workers now know the importance of integrating ECD services at different levels and facilities. The CHVs revealed that there was good coordination between the department of health and the department of education since the implementation of the project.

Head Teacher (Isiolo-Garbatula), "coordination was done through meetings, we were called for meetings in Isiolo by the ministry of education, those life skill people, they coordinated the training of teachers on teaching and developing learning materials and also when we came back to school, we involved the parents and learners too at the same time we invited public health people to our school to talk to them on health issues, that is how coordination with the health people and the ministry was done"

When CHVs were asked to rate their participation in coordination and management meetings and forums with preference to ECD services among other activities, the findings outlined in Figure 1 below show relatively above-average community and stakeholder engagement to strengthen caregiver skills with Isiolo county indicating more engagement of CHVs compared to Samburu.

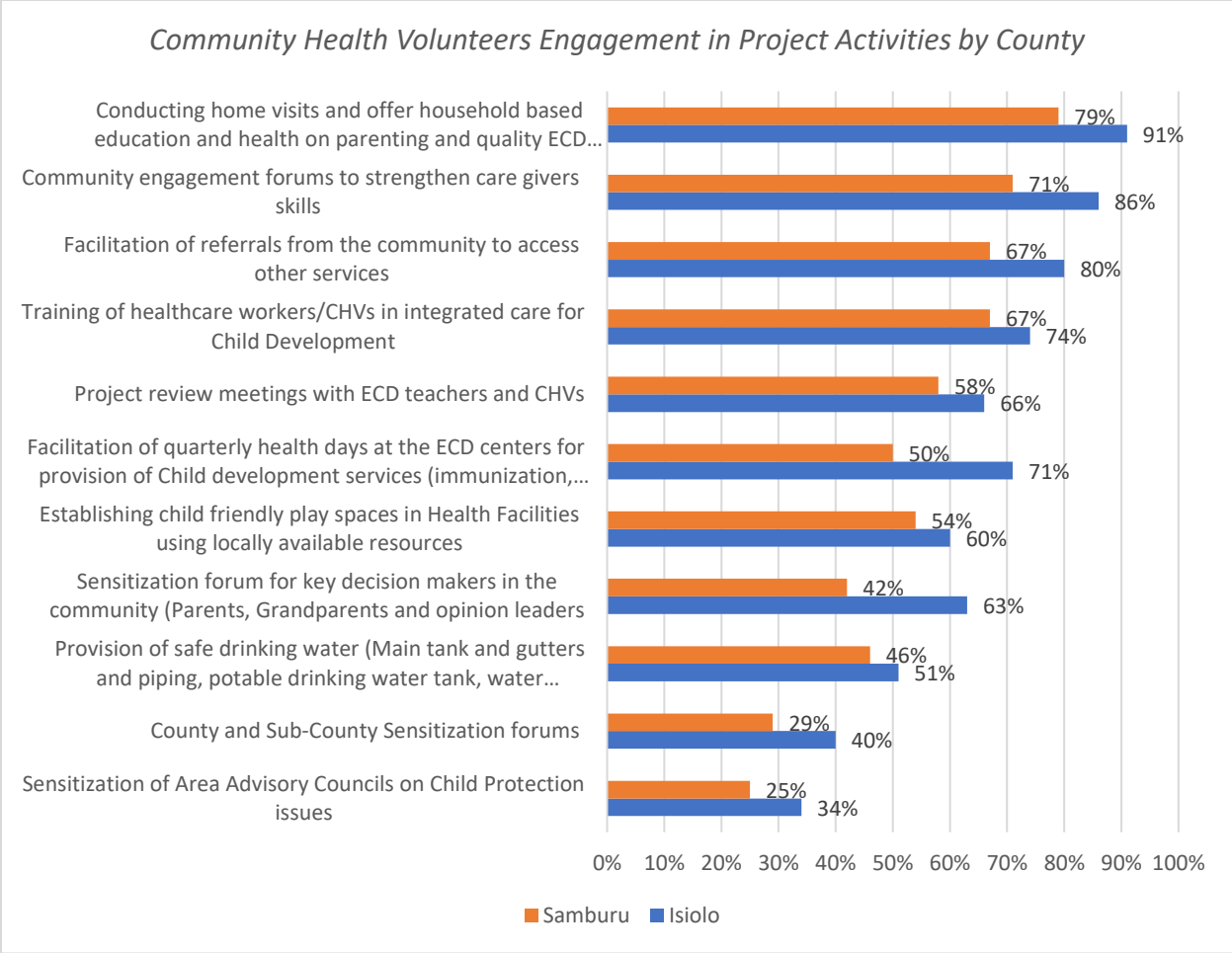


Figure 1: Participation in meetings/forums as a CHW/CHV during the UNICEF project

Other forms of participation such as project review meetings, sub-county sensitization forums, health days, among others show high attendance cumulatively of about 70% for both Isiolo and Samburu. However, conducting home visits to offer household home-based education and health on parenting topped the list on the participation of 85% for both Isiolo and Samburu. More women than men participated in ECD integrated meetings. The presence of the advisory council in sensitization on child protection issues rated a low of 30% probably because it was a high-level working group for the project with a small membership and so participation was limited. This could have been due to the fact that the project targeted 0-5years children who at this age are closer to their mothers than fathers. Relatively active were fathers, with more than half participated in the meetings and forums. The forgoing findings is a confirmation of key informants' views that coordination and management of integrated ECD improved and hence necessitated active involvement by stakeholders in matters and issues on care giving and child welfare implemented by the IKEA/Unicef project.

The project was recognized for enhancing good working relationship, specifically between health officers, workers and parents/caregivers and ECD teachers which was viewed to be helping the child to learn better. There was a consensus that the child is supported by teachers when at school and while at home the parents enhance what is learnt in school and at the health facility, the same support is provided to the children. A sub-county nurse in Merti, Isiolo county said *“Watoto wakikuja kwa shule (when they come to school), watakuwa sawa (they will be okay), wakienda hospitali, watapata (when they visit hospitals the find) the same learning, the same treatment... that amepata kwa shule, na nyumbani pia (that they get in school and at home)”*. Additionally, county governments of Isiolo and Samburu were doing their best to improve their systems, to support the children’s education and wellbeing.

The status of the ECD centers was said to have greatly improved for example the learning environment for the children with those play materials and equipment, with the appropriate age furniture was seen to be a real motivation to the children, teachers, and community. Learning in such an environment was said to be more involving and interesting. Key informant interviews also revealed that the provision of both indoor and outdoor play materials motivated and excited the children greatly and they said *“children would long for the break where they would go and swing and slide and when the ECD kits would be brought out, you would feel the excitement of the kids to play with the blocks, the crayons, plasticine to model, that joy and excitement from the children and these materials making them look forward to learning and to coming to ECD centers was fulfilling”* .

The project strengthened activities of the technical working groups that were existing at the county level and promoted knowledge sharing amongst different ECD stakeholders as well as improvement of provision of birth certificates. In this way, the coordination and management of ECD services in the study counties by the IKEA/UNICEF project, continue to help children be able to access other services including being included in the National Education and Management Information System (NEMIS), and for the school to receive capitation.

In terms of this project financing, the release of cash and supplies were timely and was done in accordance with the terms of the program document, and implementation rate. Implementing partners including the county government commended UNICEF for ensuring that resources required for the implementation of the project were availed, timely to facilitate the success of project activities.

The buy-in of the IKEA/UNICEF project by the county, the community, the willingness of CHWs and ECD teachers going an extra mile to make sure that every child is being reached and is being helped and the whole coordination process, was another enabler for success, recommended by

key informants. The support from the implementing team and the CEC education members, were very responsive to the program.

The improved coordination established from the key informant interviews collaborates with the teacher’s views on management and coordination that was set up by the IKEA/UNICEF Project. Teachers were asked what their opinion was on how the Let’s Play Project was coordinated and managed in both Isiolo and Samburu counties. As has been mentioned by key informants, the teachers also identified various components of coordination as having contributed to the achievement of project objectives. These components ranged from alignment to ECD framework to the ability to roll out project activities efficiently with high ratings as outlined in Table 13 that enabled successful implementation of the project activities.

Table 13: Teachers Perspectives on project Coordination and management

Components	Isiolo	Samburu	Total
County Government Supported classrooms	63%	71%	66%
Sufficient Guidelines for Technical Working Group	48%	47%	48%
Fidelity to implementation design	86%	74%	81%
Project Aligned to ECD Framework	84%	74%	80%
Project enhanced access of ECD services	100%	92%	97%
Project was relevant to community needs	100%	84%	94%
Fidelity to project activities implementation plan	84%	71%	79%
Project activities efficiently rolled out	80%	68%	76%

A majority of the teachers (81%) reported that the design of the project was appropriate and followed as was set out. What was equally encouraging was that a majority of the teachers (94) believed that the project interventions had captured the community needs and nearly all the teachers (97%) reporting that IKEA/UNICEF project had promoted access to EDC services.

4.2.2 Outcome 2: Responsive Caregiving Practices for Under 5 years

The target of the IKEA/Unicef let’s play project for kids to be kids project under Outcome 2 was to have “At least 80% of trained parents and caregivers with improved child-caring practices” by the end of the project.

The key findings are:

- Improved child caring and rearing practices of children (newborns) being put to breast milk immediately.
- Reduced ignorance on the birth registration process.

Outcome 2: Responsive Caregiving Practices for Under 5 years

a) Nutrition and Feeding Practices: Following the implementation of IKEA/Unicef the let’s play project there has been improvement mainly in the nutrition and feeding practices of mothers and caregivers. Figure 2 and Figure 3 show the increased number of caregivers who reported receiving information on good nutrition and those that reported increased “practice of putting newborns to breast milk immediately” respectively. The number of caregivers trained on good nutrition increased by 23% in Isiolo and Samburu counties respectively with the support attributed to the implementation of the IKEA/UNICEF project that targeted improved child caring and rearing practices at the ECD and health facilities as well as household level.

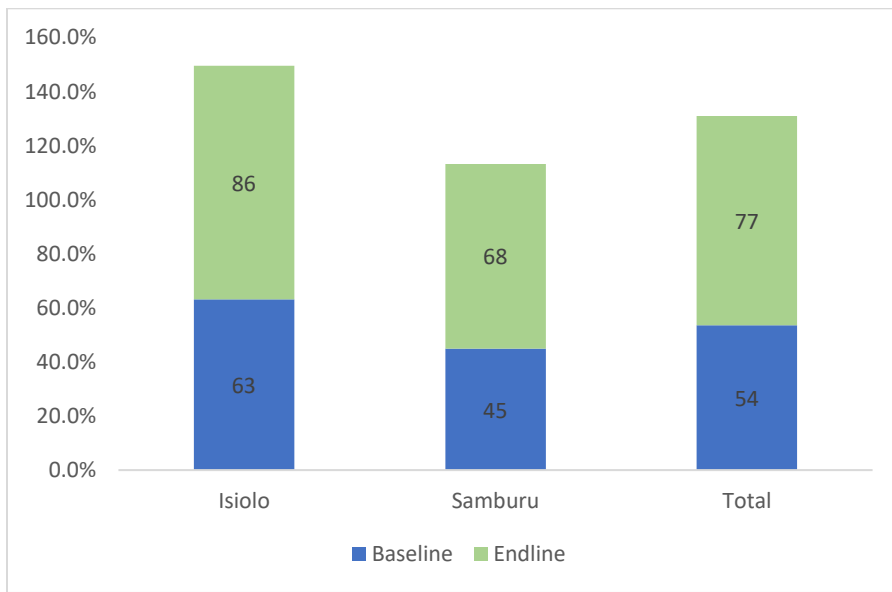


Figure 2: Caregivers who have received information on good nutrition

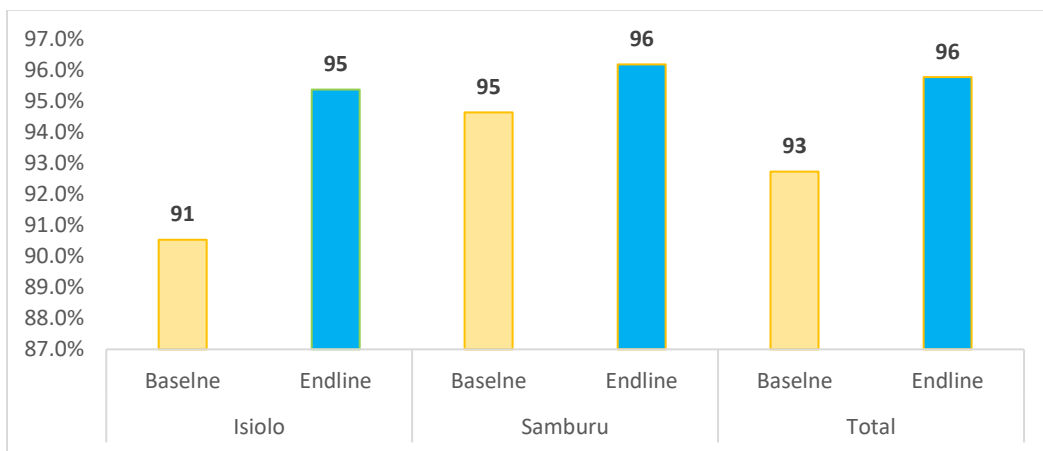


Figure 3: Caregivers who put their children to breast milk immediately

Figure 3 indicates improvement realized among caregivers of 96% overall at endline study for both Isiolo and Samburu, with a difference of 3% from the endline results. Isiolo had a (4%) point increase while Samburu had one (1 %).

b) Birth registration: Training of caregivers on birth notification of their children conducted as a component of the let’s play project has improved the status of the number of children with such notification. Table 14 below shows that there has been an overall increase across the board. Increases have been realized in the issuance of birth notification by (Isiolo 7% and Samburu 20%); Ignorance or unawareness of notification reduced (Isiolo & Samburu 11%), However, despite the fact that the level of ignorance has gone down on birth notification awareness, there is limited evidence of increased applications being done in both study counties. Perhaps there is a need for constant reminders and campaigns for caregivers to engage in the exercise.

Table 14: Caregivers Reporting Status on Birth Registration

	Isiolo		Samburu		Total	
	Base	Endline	Baseline	Endline	Baseline	Endline
Birth notification issued	80%	87%	66%	86%	72%	86%
Ignorance or unaware of notification	16%	5%	23%	12%	19%	8%
Birth certificate_ applied and received	36%	19%	37%	25%	36%	22%
Birth certificate applied but not received	37%	28%	42%	20%	39%	24%
Birth certificate not applied	28%	40%	22%	41%	25%	40%

In terms of child-caring, endline study interviews with key informants indicate that CHVs, parents/caregivers, and teachers were trained and sensitized by implementing partners that implemented the IKEA/UNICEF project. Capacity building was conducted to the health workers on early childhood development which included mentoring the mothers/caregivers on early childhood development, play and stimulation materials that were available in their facilities. There were established outdoor and indoor play areas, where the children who came and were sick could actually play and forget they were actually sick. These CHVs, were then expected to implement same at the household level to build the capacity of caregivers to better know of how to take care of their children and also ensure that all the components of the nurturing care are done.

On nutrition and child feeding, at the community level, CHVs were trained on child nutrition and feeding and were in turn expected to make home visits to screen for any cases of malnutrition and make referrals for further check-ups. In practicing this, they advised caregivers on how to

diversify their food, using those small farms (kitchen gardens) in the households. Caregivers were trained on how to provide a balanced diet to enable them to improve their children’s nutrition

Child early development – education/learning, was approached and facilitated at the health centre, ECD centre as well as household. CHVs conducted home visits to train mothers on the importance of play, and of course, they were also doing monitoring of the milestones, to check on the delay of children’s growth and development. CHVs trained parents on how to develop/make play materials using locally available materials. Inclusion of nutrition by the CHVs also led to noticeable behavior changes. Parents became more engaged in the development of their children including the development of learning materials at home and school. As said by an ECD coordinator during KIIs *“I remember we were collecting sticks and coloring them, stones, bottle tops, parents and teachers learned that they can make use of the locally available materials”*.

Learning and safe spaces were created for children at the health facilities by the project in terms of play spaces and equipment, play materials where kids play and learn to give them peace of mind as they were attended to my nurse or doctor and to encourage caregivers that when they go back home, whatever resources they have at home, whatever play materials that they have, the children learn to interact with the materials and the resources.

4.2.3 Outcome 3: Access to Quality ECD Services by Young Children

Under Key Performance Indicators-3, Outcome 3 sought to have 3,500 children in Samburu and Isiolo counties have access to quality ECD services by the end of the project. The Outcome indicator had four (4) key ECD thematic areas namely: a) nutrition; b) health; b) early learning; c) and child protection.

Key findings

- On nutrition, there was an increased intake of water, proteins, and vitamins compared to baseline.
- On health, on the overall majority of the caregivers know the main sign of a sick child (fever) but few recognize the sign of blood in the stool; more households are treating (purifying) their water for cooking and drinking compared to baseline.
- On early learning, there were over two times the proportions of homes that were stimulating under 5s through different activities compared to baseline with different family members taking up different roles; the assessment confirmed availability of materials in ECD centres even though disproportionately across the two counties (more in Isiolo).
- On child protection, the ECD centres were disproportionately secure with those from Samburu noted as more secure than those from Isiolo.

a) Nutrition:

Breastfeeding: The endline sought to report on the proportion of children who are breastfed within one hour of birth. The findings indicate that nearly all (96%) of the children aged less than two (2) years were put to the breast within 24 hours of birth (Isiolo County, 95%; Samburu County, 96%). The project had seen an increase in the number of children accessing breast milk in 24 hours after birth by a 3%-point from baseline (93 %) to endline (96%). The endline assessment sought the reasons for the delayed exposure of children to breast milk for the few cases that were reported and the main reasons indicated were cases where the mother was unwell, the baby refused to suckle and was unwell.

The high numbers recorded and improvement towards endline as reported was as a result of the numerous capacity-building programs that were conducted and targeted the parents or caregivers, teachers, and general coordination of the integrated ECD services. Therefore, these efforts led to the general improvement of the quality of ECD services. In one of the interviews, the ECD county Coordinator for Isiolo noted thus:

Yeah, again- Again, one thing that we dealt with, we did a lot of bringing closer the CHVs now from the health sector. So, we were able to- Because we've previously- Among the first trainings that we did was to train the health officials and ECD officials from sub-county and ward level on care for child development, which was actually that training from- which has been developed, designed by World Bank and UNICEF. So, we did all this with them. So, because of that, we were able to train vocational- I mean, community health volunteers.

Weaning: Weaning children is an important aspect of the holistic development of children. The endline assessment established the proportion of parents weaning their children at the right age. According to the findings, most of the caregivers (71.7%) introduced solid/semi-solid food to their infants at 6 months. This means about 30% of the parents did not wean their children at the appropriate age as was shown in Table 15.

Table 15: Practices on child Weaning

Age (Months) when introduced to solid/semi-solid food	Baseline			Endline		
	Isiolo	Samburu	Total	Isiolo	Samburu	Total
> 6 Months	3.5% (14)	7.5% (34)	5.6% (48)	13.1% (11)	14.4% (34)	13.7% (45)
6 Months	79.8% (323)	72.9% (331)	76.1% (654)	67.8% (312)	75.5% (320)	71.7% (632)
7 Months	14.3% (58)	12.1% (55)	13.2% (113)	15.0% (41)	2.4% (5)	8.6% (46)
< 7 Months	2.5% (10)	7.5% (34)	5.1% (44)	4.1% (6)	7.7% (16)	5.9% (22)

Feeding of Infants: To facilitate good health of the children, they have to be fed using clean and appropriate containers. The study findings revealed that only 28.9% of the children were fed using a bottle with a teat (Isiolo County 38.4% while Samburu County 19.5%) as shown in Table 16.

Table 16: Feeding Containers used by caregivers

	Baseline			Endline		
	Isiolo	Samburu	Total	Isiolo	Samburu	Total
Bottle with nipple/teat	18.8% (76)	14.5% (66)	16.5% (142)	38.4% (142)	19.5% (73)	28.9% (215)
Cup with holes	23.5% (95)	26.0% (118)	24.8% (213)	41.6% (154)	30.4% (114)	36.0% (268)
Cup with nipple/teat	36.0% (146)	47.1% (214)	41.9% (360)	37.8% (140)	49.9% (187)	43.9% (327)
Cup/ bowl with no cover and spoon	19.8% (80)	9.9% (45)	14.6% (125)	12.4% (46)	28.0% (105)	20.3% (151)
Feeding with palm/hands	1.0% (4)	.4% (12)	.7% (6)	2.2% (8)	1.1% (4)	1.6% (12)
Others types	1.0% (4)	2.0% (9)	1.5% (13)	0.0% (0)	1.6% (6)	0.8% (6)

The number of caregivers reporting using the right feeding containers at endline was almost double the overall figures of 16.5% that were reported at the baseline (Isiolo County 38.4% while Samburu County 19.5%). This equally highlights the success story that IKEA Project had in improving the feeding habits in the two counties.

Liquids as Part of the Meals: For a healthy diet, liquids should form part and parcel of the meals. The endline assessment sought to find out the proportion of the children who had taken liquids the day before the survey, the night, or the day preceding the survey. A majority of the caregivers (89.4%) reported that their children had taken water as shown in Table 17.

Table 17: Proportion of children that had taken the following liquids the day of the survey, the night or the day preceding the survey

	Baseline			Endline		
	Isiolo	Samburu	Total	Isiolo	Samburu	Total
Plain water	83.0%	75.1%	78.8%	89.7%	89.1%	89.4%
Milk	45.9%	49.3%	47.7%	70.0%	72.3%	71.1%
any other liquid	49.9%	43.4%	46.4%	28.9%	37.9%	33.4%
Soup	12.3%	5.9%	9.0%	36.5%	10.4%	23.4%
juices or juice drinks	11.9%	7.9%	9.8%	18.6%	8.3%	13.4%
infant formula	3.2%	.4%	1.7%	.8%	.8%	.8%

Besides water, the other popular liquid at the time of endline assessment in the two counties was milk (71.1%). This is no surprise given that most of the caregivers are pastoralists and milk is readily available. Juices or juice drinks at 13.4% (Isiolo County 18.6% and Samburu County 8.3%)

and infant formula at 0.8% (Isiolo County 1.7% and Samburu County 0.8%) were not common. Notable is the increased number of caregivers giving their children fluids. For instance, the proportion of the caregivers giving water at baseline was 83.0% but moved to 89.4% at endline while those giving their children milk doubled from 47.7% at baseline to 71.1% at endline.

Food Eaten the Day of Survey the night or the day preceding the survey: Children require a healthy diet for holistic growth. This means food from all the categories including and not limited to proteins, carbohydrates, and vitamins. The endline assessment sought to find out the proportion of the children who had taken the following set of foods the day before the survey, at night, or the day preceding the survey. The findings revealed that at endline, children were being exposed to a variety of foods for a balanced diet as was shown in Table 18.

Table 18: Proportion of children that had taken the following foods the day of the survey, the night or the day preceding the survey

	Baseline			Endline		
	Isiolo	Samburu	Total	Isiolo	Samburu	Total
Proteins						
Yoghurt	5.9%	2.2%	4.0%	11.1%	8.5%	9.8%
Fresh or dried fish etc.	.7%	.4%	.6%	1.6%		.8%
Foods made from beans, peas, etc.	64.0%	56.8%	60.2%	67.0%	50.4%	58.7%
Liver, kidney, heart or other organ meats	5.2%	3.5%	4.3%	25.1%	6.4%	15.7%
Meat, such as beef, pork, lamb, goat, chicken etc	21.7%	23.8%	22.8%	51.9%	23.5%	37.6%
eggs	5.9%	5.3%	5.6%	28.9%	7.5%	18.1%
Cheese or other food made from milk, etc.	4.2%	9.0%	6.8%	8.1%	13.6%	10.9%
Carbohydrates						
Foods made from grains	64.4%	62.1%	63.2%	74.9%	55.2%	65.0%
White potatoes, white yams, manioc, cassava, etc.	57.5%	41.4%	49.0%	47.0%	29.1%	38.0%
Commercially fortified baby food e.g. CERELAC	5.2%	1.3%	3.1%	4.3%	5.6%	5.0%
Other solid, semi-solid, or soft food, etc.	68.1%	59.3%	63.4%	45.4%	38.4%	41.9%
Vitamins						
Other fruits or vegetables	31.9%	18.5%	24.8%	36.5%	21.3%	28.9%
Pumpkin, carrots, squash, etc.	18.5%	5.3%	11.5%	14.1%	9.1%	11.5%
Dark green, leafy vegetables, etc.	42.7%	31.7%	36.9%	59.5%	41.9%	50.6%
Ripe mangoes, papayas etc.	12.6%	6.2%	9.2%	8.1%	11.5%	9.8%

Overall, the endline assessment reveals that based on what the children had eaten in the last 24 hours, the two counties expose children to protein foods more while vitamins the least

prioritized. However, from baseline to endline, there has been an increase in the variety of foods that children are exposed to; highlighting the impact of the nutrition aspect of the project.

b) Health

Early Signs of Health Problems: The study sought to establish whether the caregivers were able to read signs of a child who requires medical attention. The findings were as shown in Table 19.

Table 19: Signs of A child who Deserves Medical Attention

	Baseline			Endline		
	Isiolo	Samburu	Total	Isiolo	Samburu	Total
Child develops fever	92.6% (375)	91.2% (414)	91.9% (789)	88.9% (329)	91.2% (324)	90.1% (671)
Not able to drink or breastfeed	58.0% (235)	79.1% (359)	69.2% (594)	54.3% (201)	67.5% (253)	60.9% (454)
Child has fast breathing	37.5% (152)	42.1% (191)	39.9% (343)	33.5% (124)	22.4% (84)	27.9% (208)
Has difficulty breathing	51.1% (107)	31.5% (143)	40.7% (350)	34.1% (126)	44.8% (164)	39.5% (294)
Has blood in stool	29.4% (119)	15.2% (69)	21.9% (188)	18.6% (69)	17.6% (66)	18.1% (135)
Others	7.4% (30)	12.8% (58)	10.2% (88)	21.6% (80)	34.7% (130)	28.2% (210)

Overall, at the time of the endline, the awareness levels on medical issues that deserve urgent medical attention was still low. Other than signs of a fever (90.1%) and inability to breastfeed (60.9%), most caregivers did not think that a child who has blood in the stool (81.9%), has a fast breathing problem (72.1%) and difficulty breathing (60.5%) deserved to be taken to a health facility immediately.

Access to Quality and Safe Drinking Water: Households unable to access safe drinking water are prone to poor hygiene manifested through water-borne diseases such as diarrhea, typhoid, amoeba, etc. which affects the growth of under 5 children. This was one area that the IKEA Project identified for interventions. However, the results in the two counties were mixed as shown in Table 20.

Table 20: Access to Safe Drinking Water

	Isiolo		Samburu		Total	
	Baseline	Endline	Baseline	Endline	Baseline	Endline
Safe water for drinking	91.9%	76.0%	64.1%	75.7%	77.2%	75.8%
Safe water for cooking	93.8%	91.9%	74.2%	78.3%	83.5%	85.2%

The overall figure shows that from baseline to endline the caregivers reporting access to safe and quality drinking water reduced by 1.4%. Although this could be a result of the community's lack of knowledge of the concept of safe drinking water at the beginning of the project and any water identified to be quality enough for drinking.

When data was disaggregated by county, Samburu County realized an increase in the number of households reporting access to quality and safe drinking water from baseline (64.1%) to endline (75.7%).

The households indicating the ability to access quality water for cooking improved by 1.7% (83.5% at baseline to 85.2% at endline). The noted improvements in access to quality and safe drinking water is linked to the interventions that the IKEA project put in place. For instance, from baseline to endline, there was an increase in the number of households that accessed water treatment chemicals that were distributed by the project. When a comparison of the methods used for water purification was done between baseline and endline, the results were as shown in Table 21.

Table 21: Methods of Water Purification

	Isiolo		Samburu		Total	
	Baseline	Endline	Baseline	Endline	Baseline	Endline
Boiling	68.4%	76.3%	61.1%	29.3%	65.2%	61.9%
Use chemicals to treat	6.7%	50.3%	31.1%	72.0%	17.5%	57.0%
Filter with cloth	17.3%	1.8%	5.0%	6.7%	11.9%	3.30%

The Table reveals that at baseline, a sizeable proportion of the households in the two counties (11.9%) utilized traditional but inefficient water purification methods like using a piece of clothes to filter the water. However, project awareness campaigns reduced this figure to 3.3% at the endline. Besides, it was notable that the project campaigns contribute to the increase in the number of households using water purification chemicals from 17.5% at baseline to 57% at endline and also maintained the proportion of caregivers boiling their water from baseline (65.2%) to endline (61.9%).

The assessment also confirmed that ECD centers had also received Water and Sanitation and Health (WASH) support as shown in Table 22.

Table 22: Observation of Availability of WASH Facilities at ECD Centre

WASH Facilities	Isiolo	Samburu	Total
Hand washing areas	66.7%	50.0%	58.6%
Toilets	43.3%	82.1%	62.1%
Drinking water	43.3%	71.4%	56.9%
Hand Washing Equipment	70.0%	46.4%	58.6%

The WASH facilities were available in most of the ECD centers. Most of the schools visited (62.1%) had a toilet, 58.6% had a handwashing area, and handwashing equipment while 56.9% had drinking water. When disaggregated by county, Samburu County had more toilets (82.1%) than

Isiolo (42.3%) and schools with access to drinking water (71.4%) than Isiolo (43.3%). However, Isiolo County had more hand washing areas (66.7%) than Samburu (50.0%) and hand washing equipment (70.0%) than Samburu County (46.4%).

c) Early Learning

Mental Stimulation of Under 5 Children at Home: The involvement of family members in various learning activities is highly encouraged in the integrated ECD approach and equally in the new CBC curriculum. The endline assessment examined the popularity of the various mental stimulation activities at home and presented it in Table 23.

Table 23: Mental Stimulation of Under 5 Children at Home

Mental Stimulation by activity	Isiolo		Samburu		Total	
	Baseline	Endline	Baseline	Endline	Baseline	Endline
	Read books or pictures	17.8%	37.6%	10.8%	27.9%	14.1%
Tell stories to child	21.0%	58.1%	19.4%	59.5%	20.1%	58.8%
Sing songs to child	22.5%	91.3%	17.4%	79.8%	19.8%	85.6%
Take walks with child	25.7%	69.4%	22.7%	46.3%	24.1%	57.9%
Play with child	30.9%	91.3%	26.2%	83.9%	28.4%	87.6%
Named, counted and drew things	18.3%	32.1%	9.5%	33.4%	13.6%	32.8%

The Table shows that mental stimulation activities have become common at households in Samburu and Isiolo counties. The popular mental stimulation activities at endline were playing with the child (87.6%), singing songs to children (85.6%), and telling stories to a child (58.8%) while naming and counting together with reading books or pictures were the least both at 32.8%. Notable was the marked increase in the number of caregivers reporting involving children in mental stimulation activities from baseline to endline.

IKEA/UNICEF Project contributed to the reported sharp increase in the number of children involved in mental activities at the household level. One of the key activities in the implementation of IKEA/UNICEF project activities was building the capacity of parents to engage children in stimulating learning activities at home. There was a consensus among the informants that the training of caregivers on the need to involve in children's learning had a positive impact at the family level as shown in the excerpt below.

Now, the CHVs came in, they were on the ground, they were doing home visits, they were introducing play items like they were telling the mothers how... importance of play, and of course, they were doing also monitoring of the milestones. We had the mother-child booklet. So, the CHVs came, they were taken through the mother-child booklet with 42 of the... why play is important and the milestones. So, that is what they did, and of course if they noted a labda (maybe) delay of milestones maybe, they were to refer to the health facility. And then at the health facility, the CHV also were... engage the mothers. Before... as they wait on the line to be served, the CHVs and the

mothers, they... we had a spot in every... In the facilities that we had... we were working with, we had a spot, a certain area that... play area, that children's mat was placed, and then the children could come together with the caregivers, they could use the play items, of course, they would be sanitized before and after to avoid contamination, as they wait on the line. And of course, this was also supervised by the... the... the nurses at the health... the MCH. So, that is what they've been doing. We've also trained the teachers, ECD teachers, on the same, on care for child development, because we were also working with 30 ECD centres across Isiolo.

ECD County Coordinator

The endline assessment investigated who was involved in the stimulation of children. This is presented in Table 24.

Table 24: Family members Involved in Stimulation of Children

	Who stimulates the children	Isiolo		Samburu		Total	
		Baseline	Endline	Baseline	Endline	Baseline	Endline
Reading	Mother	55.6%	26.4%	53.1%	24.2%	54.5%	24.4%
	Father	5.6%	12.3%	20.4%	14.7%	11.6%	13.3%
	Other members	38.9%	63.1%	26.5%	61.1%	33.9%	62.2%
Stories	Mother	51.8%	62.7%	47.7%	53.2%	49.7%	57.9%
	Father	8.2%	7.5%	11.4%	6.9%	9.8%	7.2%
	Other members	40.0%	29.9%	40.9%	39.9%	40.5%	34.9%
Songs	Mother	65.9%	82.9%	72.2%	71.0%	68.8%	77.4%
	Father	1.1%	0.9%	3.8%	0.4%	2.4%	0.7%
	Other members	33.0%	16.1%	24.1%	28.7%	28.8%	21.9%
Walks	Mother	46.2%	32.9%	46.6%	19.0%	46.4%	27.4%
	Father	4.8%	37.9%	21.4%	13.3%	13.0%	28.1%
	Other members	49.0%	29.2%	32.0%	67.7%	40.6%	44.5%
Plays	Mother	29.6%	27.8%	28.6%	18.9%	29.1%	23.6%
	Father	3.2%	11.1%	3.4%	5.6%	3.3%	8.5%
	Other members	67.2%	61.1%	68.1%	75.5%	67.6%	67.9%
Count and Name	Mother	37.8%	19.8%	53.5%	13.2%	43.6%	16.4%
	Father	9.5%	9.9%	18.6%	14.0%	12.8%	12.0%
	Other members	52.7%	70.3%	27.9%	72.8%	43.6%	71.6%

Overall, mothers remain key in stimulation activities at households as they are engaged more in the stimulation of children at home. For instance, 77.4% sang to their children, 57.9% told stories, 27.4% walked and 24.4% supported their children in reading. However, a sizeable proportion of fathers (28.1%) walked with their children and a further 12.0% helped children in counting and naming.

Besides, the mother, the other members were the most involved in stimulation activities with children. For example, counting (71.6%), playing (67.9%), reading (62.2%) and walking (44.5%). These are preferably older siblings.

Exposure of Under 5s to Learning Materials: One of the crucial components of integrated ECD services is in enhancing their access to learning materials. In this case, the endline assessment established the proportion of ECD children exposed to books whose findings were as captured in Figure 4.

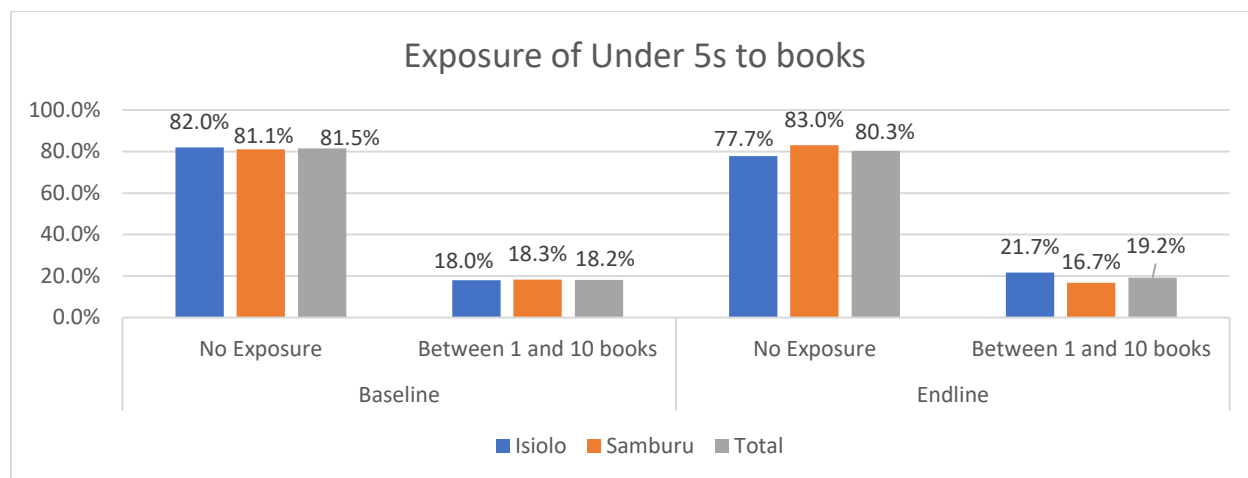


Figure 4: Exposure of Under 5s to Books at Home

Both the baseline and endline findings indicate that majority of the caregivers (over 77%) are not exposing children to books. Whereas there has been a positive overall change, this was not significant.

At the school level, access to play materials is key in an integrated ECD approach. The endline assessment conducted observations in the 59 ECD centres that were visited and documented the availability of play materials as presented in Table 25.

Table 25: Observation of Availability of materials at ECD Centre

Play Materials	Isiolo County	Samburu County	Total
ECD Kits	80.0%	85.7%	82.8%
Balls	66.7%	89.3%	77.6%
Plasticine	73.3%	92.9%	82.8%
Building blocks	76.7%	82.1%	79.3%
Other indoor play materials	80.0%	67.9%	74.1%
Slides	93.3%	35.7%	65.5%
Swings	86.7%	39.3%	63.8%
See saw	86.7%	32.1%	60.3%
Other outdoor play materials	63.3%	39.3%	51.7%

ECD centers had different play materials that were accessible by under 5 children. The key informant interviews revealed that one area that the project had done well was to supply ECD centres with play materials that had made learning fun for the children and teachers. Some of the excerpts were as captured below:

There was the provision of play and- play- indoor play materials, which actually the county was unable to provide. That's one of the change- big changes that these visitors, brought, the indoor play kit, the ECD kit that is, they call it ECD kit, so there was a play- a box, where there was play equipment, play materials- they were indoor, for children to play with, County ECD Coordinator.

Before life skills promoters came eehh most of the facilities within the Merti sub-County, we don't have those items or the outdoors and the indoor play therapy were not there but eehh, after they came eeh they were able to install aaah outdoor. And also we were given the, the facilities were given the indoor so that the child can be able to play and enhance the child even at the facility level; feeding and also child developments within those facilities. Before there were no such facilities, but with the LISP we were able, we were being provided with those items and also most of the facilities in the healthcare workers and also the teachers were sensitized on the need for this outdoor and indoor play for the development, to enhance development for the child. MoH Official.

Other observations on the available ECD learning and teaching materials was conducted as shown in Table 26.

Table 26: Observation of Availability of Teaching and Learning Materials at ECD Centre

T/L materials	Isiolo	Samburu	Total
Talking walls	40.0%	42.9%	41.4%
Child friendly chairs	100.0%	89.3%	94.8%
Writing board	93.3%	100.0%	96.6%
Writing materials (crayons, pencils)	80.0%	82.1%	81.0%
Other learning materials	50.0%	25.0%	37.9%

Over 94.8% of the ECD centers visited had child-friendly chairs, 96.6% had writing board and 81% had writing materials. However, talking walls were only observed in 41.4% of the ECD centres. Schools reported that the learning materials were delivered through the collaborations of the IKEA/UNICEF Project and county governments.

d) Child Protection

Safety and Security of ECD Centres: Quality ECD centers are those that are secure and therefore allow learning to take place in safe places. The endline assessment established the safety and security features of the ECD centers and presented in Figure 5

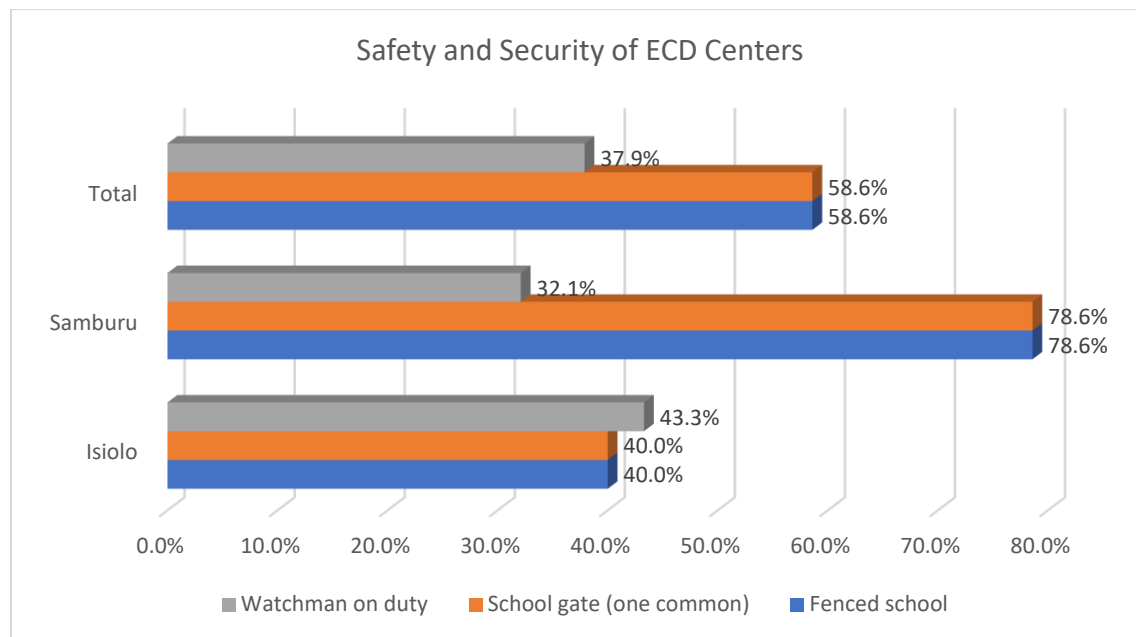


Figure 5: Safety and Security of ECD Centres

Most of the ECD centers visited (58.6%) had both a fence and a school gate and this is important in protecting the under 5 children while in school. However, only 37.9% of those schools had a watchman at the time the ECD was visited. This means most of the ECD centers (62.1%) including those with gates leave their gates unwatched or just did not have a watchman completely.

Child Discipline: For proper child development for the under 5 children, the home environment has to be full of positive discipline. This would involve caregivers ensuring that they positively correct the children and not abuse them in the pretext of discipline. The endline assessment examined disciplinary modes in use at home and the changes thereof from baseline and the findings were as captured in Table 27.

Table 27: How care givers discipline at Home

How care givers discipline	Isiolo		Samburu		Total	
	Baseline	Endline	Baseline	Endline	Baseline	Endline
Take away privileges	39.5%	22.5%	31.3%	32.6%	35.2%	27.5%
Talked and explained the wrong	34.8%	25.1%	35.7%	42.8%	35.3%	33.9%
Gave child something else to do	21.7%	26.9%	22.2%	56.6%	22.0%	41.6%

Average positive discipline	32.0%	24.8%	29.7%	44.0%	30.8%	34.3%
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The Table shows mixed results. In Samburu County, more caregivers (44%) at endline compared to 29.7% at baseline were utilizing positive disciplinary modes. This however, was not the case in Isiolo where caregivers reporting employing positive disciplinary modes from baseline to endline dropped by 7.2%.

Registration Services: Registration of children was one key component of improving the services available to under 5 children. The endline assessment established the status of birth registration of under 5 children. At baseline, only 72.4% of the birth notification had been issued but at the endline, this had increased to 86.3%. In addition, 19.3% of the caregivers had low awareness of birth notification at baseline but this had the proportion of the caregivers had been reduced to half (8.3%) at the endline.

4.2.4 Findings on the Enablers and Barriers to IKEA/UNICEF Project Goals

One of the objectives of the IKEA/UNICEF endline assessment was to document the barriers and enablers to achieving the stated project outcomes. The focus was to cast a wider view of the project by examining the design and the implementation process and speak to the factors that facilitated or hindered the overall achievements of the project goals. The data to respond to this objective was collected mainly from the key informant interviews from the implementing partners, officials at the county level, and project team at UNICEF.

a) Enabling Factors to Achievements of IKEA/UNICEF Project Goals

The IKEA/UNICEF let’s play project was viewed as perfect support due to the fact that the county government is still planning and restructuring ECD in line with its devolved functions that is now in the hands of county governments. Therefore, the IKEA/UNICEF proposals to strengthen the ECD subsector through a well thought out integrated model helped the county governments in testing a devolved function that had not entrenched structures at the county. Before the implementation of the let’s play project, county governments of Isiolo and Samburu were not investing in ECD in terms of the child play materials/equipment, however, the project has been a motivation of their involvement. The entry point of the let’s play project was the county governments.

The commitment of both county governments (Isiolo and Samburu) towards the implementation of let’s play project was noted to have been a big win in the success of the project as said by implementing partners, *“I want to say, if it were not for county governments, we wouldn’t have achieved some of the things we achieved, why? because the county government is like supporting*

the project from the initial stages". Due to this support demonstrated by county governments, other stakeholders and partners also supported the let's play project. Coordination of the let's play project was smooth because it originated from the county management teams both in Isiolo and Samburu counties. The teams included sub-county representatives from ministries of health, education-ECD officers and CECs, MCA's, agriculture, nutrition, children's department, religious groups among others.

Coordination and management of existing structures vis-à-vis the formation of new relevant ones as well as their active involvement enabled the project to achieve its objectives. Of course, key informants confirmed that before the project implementation, the planning stage involved the bigger structures - the County government. So the technical working groups, steering committees, etc. had compositions of various line ministries that were focusing on various issues affecting ECD but bringing the coordination component together and making it more effective. The multi-sectoral technical working group played a very key role in the implementation of the let's play project. The project also established a good mechanism with the county structures to support the ECD project. This helped in the coordination of the project activities between the project implementing partners and the county government.

The biggest enabler of the project is the buy-in by the county, by the community, and the willingness of the CHWs and ECD teachers to go the extra mile to make sure that every child is being reached and is being helped. The whole coordination process successful through the support of the team including the CEC (Chief Executive Committee) members from education and health. Having a team from the government that is very responsive to the program was effective and successful.

b) Enabling Factors to Achievements of IKEA/UNICEF Project Goals

IKEA/UNICEF let's Play project has generally succeeded in almost all its target objectives based on the endline assessment findings. However, this was not without some challenges. Some of the challenges that were mentioned are:

Insecurity was a barrier that led to some areas not fully being accessed. For example, Matola and Baragoi in Samburu County. It was reported that Samburu North was generally a conflict prone area which at times delayed implementation of the let's play project implementation since the teams including the ECD monitoring team from UNICEF had to wait for the conflict to end before continuing with their activities. This affected the timing the interventions were to be done and generally the impact that the project had.

During the implementation of the let's play project, there was also a rite of passage happening in the study counties. There was a mass circumcision for the boys, where people were migrating from their homesteads to another place, and hence targeting intervention schools at the time that was planned for them was difficult. In some cases, the implementers revised their schedules accordingly, while in other cases, alternative schools were picked.

The transverse characteristic of Samburu and Isiolo counties made logistical plans a challenge since moving from one part to another is quite a distance to cover especially if one had commodities/supplies for schools to deliver. There were delays also due to COVID 19, that posed a challenge and some implementers did not manage to complete their program and were still planning some of the activities that were not accomplished

Another challenge was to do with delays in disbursement of funds from UNICEF and when it was disbursed, and given that the project was spread thin in all the vast and diverse sub-counties of Isiolo and Samburu counties, the resources were never adequate for the anticipated impact and hence delayed implementation.

Whereas the project established a good rapport with the county governments, there were a few reported incidences where the working relationship with some of the county officials was strained particularly between implementers and county government officers. In some cases, this delayed implementation of planned activities.

Scarcity of water in the target region as WASH was a major component of the let's play project program including hygiene practices to be at high standards and sometimes these activities were not done to expected standards. For instance, sometimes you would find a school that doesn't cook because of missing water.

5.0 Conclusions and Recommendations

This section summarizes the lessons learned, conclusions, and recommendations for the project

5.1 Lessons learned on the IKEA/UNICEF Project

- Coordination and management systems of the IKEA/UNICEF project were known and participatory and were made all-inclusive to all stakeholders which positively influenced the implementation of other components of project activities. The success of any project depends on the participation of different stakeholders who in the IKEA/UNICEF project took ownership from the initial stages, particularly the county governments of Isiolo and Samburu as was identified with departmental representation, partner's participation and

ministries of education, health, agriculture including children’s department. The setting of specific structures with clear roles also helped in re-aligning the project to its course.

- The adoption of the existing government structures was cost-effective in the delivery of project interventions. The county governments were the focal point in mobilizing related government services to support integrated ECD services such as registration at the school level bringing the services closer to the citizens.
- The management and coordination structure that called for the active involvement of county governments helped in mobilisation of the beneficiaries and support was necessary for delivery of ECD services. This did not only promote ownership of the project at the county level but also was responsible for the parallel investment in innovation of ECD centres and also recruitment of ECD teachers.
- Purposive sampling of the IKEA/UNICEF project areas to tap into the existing structures by other organisations reduced costs. For instance, WASH interventions under IKEA/UNICEF project targeted areas where the county government or existing NGOs had set up water structures to leverage on that and improve the reach.
- The IKEA/UNICEF project was an eye-opener especially to the health practitioners – CHVs/CHWs and health facilities, including the fact that play materials were made available for children that accompany their parents to the hospital or for a check-up and can still have fun and learn. This was a plus for the project in strengthening the relationship between education and health and providing a rationale through play materials for children to justify the more reason why the two departments should continue to work together to support ECD integrated learning in Isiolo and Samburu Counties.
- Training enhances skills and practices and provides opportunities for discoveries. Caregivers, teachers, and CHVs have been trained and exposed to the importance of play materials by the IKEA/UNICEF project and have discovered that these play materials exist in the environment and can be modified and made suitable for learning as opposed to depending on ready-made ones bought from supermarkets and shops.
- Through consultation with the County Government, the project was designed to reach all the corners of the two counties. However, this led to spreading thin and reduced the impact. There is a need to consolidate the project’s geographic location to avoid spreading too thin and deepen efforts within smaller geographical confines for more impact.

5.2 Conclusions

The involvement of County government structures throughout the project cycle from designing, implementation, and monitoring ensured there was buy-in and support for the project

throughout and this also increases the likelihood of scalability and continuity of project interventions.

The IKEA/UNICEF project promoted strong community involvement in the management of ECD services and this enhanced ownership and sustained commitment to the project interventions which is the driving force in integrating nurturing care initiatives that promote holistic growth and development of children.

Caregivers can be great champions of the learning of their children with some support to know how to motivate their children using the natural environment. In this way, they are able to create a comfortable learning environment at home as opposed to the tradition that learning can only take place at school facilitated by teachers. The noted increased involvement of caregivers particularly in mental stimulation of the children is likely going to revolutionize children learning if sustained.

The IKEA/UNICEF project has resulted in a positive change of mindset among stakeholders who participated in the project (teachers, parents/caregivers, CHVs and ECD actors) that a child's learning requires motivation and stimulation that happens in their environment that they can see, touch/interact with and feel, and which helps them to enjoy and have fun and not necessary being always in class.

Collaboration in the various components such as the child's health, nutrition, protection, education among others supports a child's growth and development resulting in a healthy and school-ready child.

IKEA/UNICEF let's play project enhanced the participation of mothers and fathers (parents) and caregivers, demonstrating importance of collaboration of both parents towards improved development of their children. However, mothers were found to be more involved than fathers in school activities.

5.3 Recommendations

Based on the endline assessment findings and review of related literature, we recommend:

- ❖ Ensure there would be continuity and sustainability of benefits and interventions beyond the project period leveraging on close working relationships already created amongst stakeholders – TWGs, advisory committees, teachers, communities, parents, caregivers, implementing partners and other ECD stakeholders. There is a need to strengthen and consolidate the gains made as far as coordination and management of ECD at the county

level through a multi-sectoral approach by institutionalizing county steering committees and technical working groups as the focal points in the management of ECD services at the county level. This will allow the county governments to coordinate and leverage the existing strength to deliver integrated ECD services.

- ❖ Follow up on the positive gains that the UNICEF project has achieved and support continuity and sustainability of knowledge and experiences to be used and shared with generations to come to improve the education and well-being of the child. This can be done by creating and recognizing let's play project participants as champions of play for learning to escalate the benefits to children's development and quality education for lifelong learning by training others, creating model play spaces in schools, community including health facilities towards improving children's well-being.
- ❖ Following the success recorded by purposive sampling of the IKEA/UNICEF project areas which enabled the project to tap into the existing structures by other organizations and thereby reducing costs, the county governments should conduct mapping of existing efforts to support ECD services. Thereafter, develop a database on the types of organizations, their geographical reach, and available programmes in order to support their efforts for more impact and utilization of the available expertise.
- ❖ The one success story with IKEA/UNICEF project was the supply of play materials to project ECD centers. The county government worked closely as a partner to scale it up and ensure most of the ECD centers are supplied with durable but affordable play materials. This will mean to lobby for a budget for material supply to the ECD centers.
- ❖ The MoH working closely with the MoE to integrate the child-caring practices as part of the deliverables of the CHVs.
- ❖ To consolidate the benefits of IKEA/UNICEF, counties will need to include budgets and plans for integrated ECD services. This will ensure that funds are made available for expenses such as stipends for CHVs to visit households and schools.
- ❖ To enhance father's involvement in their children's education activities, schools can establish and follow an all-inclusive parent's participation programme, where parent's/caregivers engagement in school activities is shared between father and mother. This can be in form of specifying the arrangement to be alternated between the parents dubbed "*fathers school day*" and "*mothers school day*" an arrangement known by the teachers, children and parents/caregivers. For example, if the mother attends to a school activity let's say today, then tomorrow it will be the father to attend to another school activity. This could be a way to ensure fathers actively participate in their children's education affairs and hence develop interest to support their progress

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Annexes

Annex 1: Tools

Tool Type	Attached
Household tool_ Parents and Caregivers	 WERK Household Questionnaire - Paren
Headteachers Tool	 Headteacher Questionnaire - UNICI
Teachers Tool	 WERK Teachers Questionnaire (UNICE
Community Health Workers Tool	 CHW Interview Schedule - UNICEF Le
Health Centre Observation	 Health Center Observation - UNICEF
ECD Centre Observation	 ECD Centre Walkabout Schedule -