IMPROVING SCHOOL READINESS IN THE SAHEL:
The Role of Adaptive Social Protection Programmes

Authors
Nakawala Lufumpa
Anne Hilger
Odyssia Ng

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SUMMARY
The Sahel has some of the lowest levels of human capital worldwide, with children’s future productivity and earning potential being on average 65% below their potential due to poor health and education outcomes. Early childhood, especially the first five years of life, is a critical period for cognitive, social, emotional, and motor development. Adverse events during this period can have long-lasting impacts on human capital formation. According to a growing body of evidence, school readiness—defined as children having the skills and wellbeing to thrive academically—is essential for academic success and is linked to better educational outcomes, employment, and earnings. However, almost 90% of the population of 10-year-old children in the Sahel do not have an age-appropriate level of reading comprehension. This document discusses the importance of integrating school readiness measures into social protection programs to improve educational outcomes and strengthen human capital in the Sahel. It outlines the theoretical framework for school readiness, assesses the impact of school readiness interventions, details evidence-based measures, and concludes with safety net program recommendations and implementation guidance specific to the Sahel context.
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1. INTRODUCTION

The Sahel has some of the lowest levels of human capital worldwide. The future productivity and earning potential of children in the Sahel is on average 65% below its potential due to a combination of poor health and education outcomes.\(^1\) Human capital is critical in ensuring sustained economic growth and the eradication of poverty. Early childhood experiences, particularly in the first five years of life, are strong predictors of health, education, and economic outcomes in adulthood.\(^2\) Measures introduced at this point of the life cycle are an important approach to address poor health and education outcomes which are limiting the level of human capital in the region and impeding the reduction of poverty.

Early childhood is a critical period particularly for cognitive development. Importantly, children under five years old experience a significant and accelerated rate of brain development. Adverse life events experienced during this period of the life cycle can significantly disrupt the development of skills crucial for human capital formation and protection – social/emotional, cognitive, motor, and speech/language.

A growing body of evidence highlights the importance of school readiness in improving academic performance, educational attainment, and human capital formation. School readiness, defined as children having the skills and wellbeing to thrive academically, is a strong predictor of future academic performance and educational attainment.\(^3\) Ensuring that children, by the age of six, are ready for school is associated with improved reading and math test scores, decreased school dropout rates, increased likelihood of employment in adulthood, and improvements in future earnings.\(^4\) \(^5\) Benefits are ultimately accrued at the individual, community, and country level; and crucial for sustained economic development.

Almost 90% of the population of 10-year-old children in the Sahel are currently experiencing learning poverty.\(^6\) The learning poverty indicator, developed by the World Bank and UNESCO, estimates reading comprehension in end-of-primary school aged children and is a strong indicator for future levels of human capital. High levels of learning poverty highlight a need to further improve school readiness in children under six years old in the Sahel. Improving school readiness in the Sahel is an important strategy to address poor educational outcomes within the region and protect and strengthen human capital.

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This document examines school readiness measures that could be incorporated into social protection programmes in the Sahel. The document is organised as follows – the document first details the theoretical framework for school readiness and the related issue of early childhood development. The second section briefly details how the impact of school readiness interventions are assessed in LMICs within the literature. The third section details evidence-based school readiness measures, how they can be integrated into social protection programmes, and the preconditions necessary to maximise programme effectiveness. The fourth section provides an overview of the measures detailed in this document. The fifth and final section concludes this research with context-specific programme recommendations for the integration of school readiness measures into adaptive social protection programmes in the Sahel.

1.1. Conceptual Framework for School Readiness

The definition of school readiness has evolved over time with earlier definitions focusing on a child’s skills or wellbeing as a means to academic success and more recent definitions focusing on environmental characteristics that encourage academic success. UNICEF has developed a conceptual framework for school readiness which organises school readiness into three dimensions/levels – ready children, ready families, and ready schools.  

7 School readiness, as defined by UNICEF and similar institutions, focuses on children under six years old. In most settings, children typically begin primary school education at six years old. The first dimension of school readiness is dependent on a child’s skill level and general wellbeing. The second dimension encompasses a family’s ability and willingness to send children to school and improve early childhood development. This is dependent on sociocultural and economic factors. The third dimension is dependent on the quality and quantity of school facilities and staff. This research will focus on child and family readiness. The third dimension of school readiness, ready schools, is beyond the scope of social protection programming and best addressed by the education sector.

1.2. Theoretical Relationship between School Readiness and Early Childhood Development

Importantly, there is significant overlap between early childhood development and the child and family level dimensions of school readiness (Figure 1). Early childhood development and the child/family level dimensions of school readiness focus on developing cognitive, social, and emotional skills in children; and ensuring physical and mental wellbeing in children under six years old. Akin to both dimensions of school readiness, early childhood development depends heavily on the home environment, parenting decisions, and parent-child interactions. This is demonstrated in the conceptualisation of early childhood development which centres around the importance of nurturing care. There are five domains of nurturing care: (1) health, (2) nutrition, (3) responsive caregiving, (4) security and safety, and (5) early learning.  

Figure 1: Theoretical Relationship Between School Readiness and Early Childhood Development


9 Adapted from the UNICEF Conceptual Framework for School Readiness and the Nurturing Care Framework developed by WHO, UNICEF, WBG, ECDAN, PMNCH, and EWEC.
2. ASSESSMENT OF SCHOOL READINESS

This section will provide a brief overview of how the impact of school readiness measures are typically assessed in the literature and, specifically, this document. Given that this document centres on measures introduced in early childhood and before school attendance, indirect indicators can be used to assess the potential impact of measures on longer-term outcomes such as academic performance, school attendance, and educational attainment. Box 1 provides an overview of the indirect indicators, which are briefly detailed below.

Given the above-mentioned association between early childhood development and school readiness, indirect indicators included in the literature centre around one or more of the five domains of nurturing care. The health and nutrition domains are typically assessed through maternal or child mortality and/or morbidity. Assessments of morbidity largely focus on nutritional status—micronutrient deficiency and/or growth faltering. Indicators of responsive caregiving focus on the quality and quantity of parent-child interactions. Early learning is typically assessed through enrolment in early childhood education programmes and/or developmental markers in children. The security and safety domain of nurturing care is assessed through the quality of the home environment. This includes factors such as the prevalence of domestic violence/abuse, parental discipline techniques, and parental mental health.

**Box 1: Assessment of School Readiness**

Prior to school attendance, predictors of school readiness or academic outcomes are used to estimate future school readiness. Early childhood development indicators are strong predictors of school readiness and academic outcomes.

Health and nutrition domains of early childhood development are assessed using indicators of child and maternal mortality and morbidity. Maternal mortality and morbidity are strong predictors of future child health and nutrition. Assessment of morbidity, within this context, largely focuses on nutrient status. Micronutrient status is assessed through the prevalence or incidence of micronutrient deficiencies and associated health conditions and/or outcomes. For example, micronutrient deficiencies are associated with disruptions to intrauterine development or birth weight. Macronutrient status is assessed through anthropometric measurements—height and/or weight.

Responsive caregiving is assessed directly through parent-child interactions. Responsive caregiving is defined as a parenting style in which parents observe children, interpret their actions, and respond appropriately. Responsive caregiving is usually observed during play or feeding time. Responsive caregiving is also assessed indirectly through parents’ attitudes.
and knowledge about this parenting style. Assessment of parenting styles is also sometimes used to assess early learning.

**Early learning is assessed through child enrolment in early childhood education programmes; and developmental markers – cognitive, behavioural, social, and/or emotional.** Enrolment in early childhood education programmes, particularly good quality programmes, is a strong predictor of improvements in developmental markers correlated with early learning. UNICEF has developed an early childhood development index (ECDI) and an associated list of questions to assess childhood development in four domains – literacy/numeracy, physical, learning, and socio-emotional. A complete list of the questions is available through UNICEF. This tool can be used to assess whether a child has met different development milestones. Developmental markers are also sometimes used to indirectly assess responsive caregiving.

**Security and safety afforded to a child are assessed through an examination of the environment a child is in, and/or levels of parental stress.** The microlevel and macrolevel environment can be assessed to approximate security and safety levels. At the microlevel, factors such as the primary method of discipline and the presence of domestic violence/abuse are strong indicators of an unsafe environment. At the macrolevel, conflict or fragility can also impact child development. Parental mental health is also considered a strong indicator for parent-child interactions and overall childhood development.

3. SCHOOL READINESS MEASURES

This section will detail evidence-based early childhood development measures that have been implemented in low- and middle-income countries (LMICs) and improved one or more aspects of school readiness. Early childhood development measures are presented according to the domains of early childhood development being addressed. As detailed in the previous section, the five domains of early childhood development are: health, nutrition, responsive caregiving, early learning, and security and safety. School readiness measures are further organised according to the life cycle – specifically, the age group being targeted or level of impact (i.e., child or parent). This section also briefly details how said measures could or have been integrated into social protection programmes. Figure 2, included on the following page, provides a summary of the measures that will be examined in additional detailed within this section.

Case studies are presented for each grouping of measures. Each case study included in this document summarises details of programme design, implementation, and impact. Interventions are included as case studies if they successfully impacted one or more aspects of early childhood development or school readiness as detailed in Box 1. Where feasible, case studies were identified from a similar Sub-Saharan African context. In instances where interventions were not successfully implemented in Sub-Saharan Africa, other low- and middle-income settings were identified.
**Figure 2:** School Readiness Measures by ECD Domain and Target Population, Adapted from Britto et al. (2017) 10 11


11 MMS – multiple micronutrient supplementation; LNS – lipid based nutrient supplements; IYCF – infant and young child feeding; WASH – water, sanitation, and hygiene
3.1. Health and Nutrition Measures

Evidence from LMICs has shown that poor child health, particularly nutrient deficiencies in the first few years of life, is associated with disruptions in cognitive, motor, and social development. Early childhood development (ECD) measures seeking to address health and nutrition are usually combined due to the relationship between both factors. The risk of undernutrition is larger in children with poor health and, conversely, the risk of poor health outcomes is larger in children who are undernourished. ECD measures within these domains either seek to provide health and nutrition services/products and/or to encourage clinically recommended behavioural changes. The following section details health and nutrition ECD measures that are introduced at different stages of the life course.

3.1.1. Women of Reproductive Age

The health and nutritional status of women, both preconception and during pregnancy, are important determinants of child health and nutritional status both in-utero and in early childhood. Maternal nutrient deficiencies are associated with an increased risk of intrauterine growth restriction, low birth weight, poor foetal health, and impaired foetal development. ECD strategies aiming to improve health and nutrition outcomes in early childhood should also address the role of poor maternal health – both physical and mental. Maternal depression and anxiety are associated with an increased risk of premature birth and low birth weight; and disruptions to child health, growth, and development in early childhood.

Measures introduced during this stage of the life course, to accompany social protection programmes, would largely centre on improving the nutritional status of women of reproductive age and encouraging the use of existing healthcare services, particularly during pregnancy.

Behavioural change interventions introduced either at preconception or during pregnancy can be used to modify the diets of women in adolescence or during pregnancy, and health seeking behaviour during pregnancy. The WHO recommends a minimum of eight antenatal visits while a woman is pregnant. Antenatal visits are an opportunity for healthcare providers to monitor the health of the

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mother and child, address health concerns early, and provide health/nutrition education. Importantly, alongside these measures, wider efforts should be made to improve the physical and financial accessibility of healthcare facilities and improve the quality of healthcare services provided at facilities.

Alongside behavioural interventions, the provision of food supplements to women of reproductive age preconception and during pregnancy has proven to be effective at addressing poor health and nutrition outcomes in-utero and early childhood. During pregnancy, women experience higher nutrient demand which, in low- and middle-income settings, is largely unmet by diet. A systematic review of evidence from LMICs demonstrates that multiple micronutrient supplementation (MMS) is associated with improvements in foetal growth and birth weight. Notably, a randomised control trial conducted in Indonesia found that MMS from pregnancy until three months postpartum was associated with improvements to cognitive and motor development at preschool age. MMS products typically contain between 13-15 micronutrients and are provided during antenatal care visits.

Food supplements containing both micronutrients and macronutrients have also proven to be effective at decreasing the risk of poor child health and nutritional status. Lipid-based nutrient supplements (LNS) are a common food supplement composed of both micronutrients and macronutrients. Evidence suggests that in Ghana, Burkina Faso, and Malawi the impact of LNS on foetal growth, birth weight, and birth height is comparable to that of MMS. Research from Ghana and Bangladesh further suggests the added benefit of continued LNS supplementation for the first 1,000 days of life – maternal supplementation during pregnancy and up to six months postpartum and child supplementation from six to around 24 months old. LNS programmes typically target households with pregnant women who are at risk of poor nutritional status or poor maternal health. Where feasible, similar food supplementation should be provided to reproductive age women, preconception, who are at risk of poor nutritional status or poor maternal health. General food distribution can similarly target households facing food insecurity.

**Box 2: Maternal Multiple Micronutrient Supplementation Case Study**

A maternal multiple micronutrient supplementation (MMS) intervention was introduced in Niger in 2004. Women of reproductive age were enrolled in this program if they were less than 12 weeks pregnant. MMS were distributed monthly during antenatal visits and were to be taken daily. Antenatal care was provided in healthcare facilities and communities to account for low attendance at healthcare facility based antenatal clinics.

To ensure adherence, healthcare workers kept track of MMS intake during each monthly antenatal visit. At each visit, healthcare workers would count the number of tablets that each woman had remaining from the previous visit. MMS was accompanied by behavioural change communication measures. Women were educated about the benefits of MMS alongside traditional health/nutrition education during antenatal visits.

In comparison to traditional Iron/Folic acid supplementation, the provision of MMS in this setting was associated with improvements in the mean birthweight (67 gram increase) and the prevalence of low birth weight (1.2 percentage point decrease).


Although the above case study highlights the success of a maternal supplementation programme in Niger, it is important to note that not all settings have seen similar success. In the context of Niger and similar settings, certain programme features encouraged success. First, the provision of supplements was integrated into a larger package of healthcare services – with additional focus on antenatal care. Second, antenatal care and surveillance of pregnant women was provided at the community level, improving access to healthcare services. The value of these two programme features is underscored when contrasting the impact of maternal supplementation in Niger to that in Malawi. In Malawi, the impact of SQ-LNS (a supplement comparable to MMS27) was limited by maternal health – specifically, HIV status. The impact of maternal supplementation on maternal and child outcomes was not significant among women with additional and/or untreated medical conditions.28 Third, and in addition to the above, maternal supplementation in Niger had a positive impact when provided for a sufficient period of time – more than five months. Lastly, maternal supplementation was provided alongside behavioural change communication which included both nutrition and health education.

### 3.1.2. Early Childhood

Health and nutrition measures introduced later in the life course focus on improving the health and nutritional status of children from birth until 5 years old, which is a critical period for development.

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The first five years of life is the period during which the brain grows and develops most rapidly.\textsuperscript{29} During this period, children are particularly sensitive to disruptions to general health or nutritional status.\textsuperscript{30} Measures focusing on this stage of the life course, to accompany social protection programmes, would largely centre on improving the nutritional status of children and encouraging the use of existing healthcare services.

**Behavioural change interventions during this life stage centre on improving caregiver practices relating to infant and young child feeding (IYCF), water, sanitation, and hygiene (WASH), child immunisation, and health-seeking behaviour.** This is typically done through health education classes – either group or individual sessions. Sessions can be hosted at healthcare facilities or in communities. In line with WHO guidelines, healthcare workers encourage breastfeeding until children are two years old – the first six months being exclusive breastfeeding. When complementary feeding begins, typically at six months old, caregivers are encouraged to ensure that the child’s diet meets age-appropriate recommendations regarding dietary diversity and meal frequency. Healthcare providers also encourage caregivers to use improved sanitation facilities and water sources; practice proper hygiene, particularly when preparing food and feeding children; ensure that children are vaccinated; and develop beneficial health-seeking behaviours.

**Mass media campaigns can also be used to encourage caregivers to immunise their children and routinely access healthcare facilities for child health visits.** During child health visits, healthcare providers typically assess child health and growth. Alongside interventions that encourage the use of healthcare services, it is important to ensure that healthcare services are accessible both physically and financially, and that the quality of care being provided is adequate. Healthcare services can be provided within communities alongside the provision of social protection services. For example, cash transfers can be conditional on the use of the recommended healthcare services or during the provision of cash/in-kind transfers, healthcare workers can be accessible to immunise children.

**Alongside behavioural interventions, and nutrient and food supplementation, the management of moderate/severe acute malnutrition can further ensure that children remain healthy.** These measures are particularly important in environments where there is widespread household food insecurity or inequalities in intra-household food distribution. Lipid-based nutrient supplementation (LNS) can be provided to children to prevent malnutrition and treat moderate/severe acute malnutrition if there are no additional clinical complications.\textsuperscript{31} In addition to preventing childhood malnutrition, it is also important to direct policy attention towards the treatment of moderate/severe acute malnutrition. Acute malnutrition, also commonly referred to as wasting, and concurrent stunting and wasting are associated with an increased risk of mortality.\textsuperscript{32} Food distribution can also be used to address household food insecurity and encourage household use of LNS products as intended.

\textsuperscript{32} Myatt M, Kharra T, Schoenbuchner S, Pietzsch S, Dolan C, Leijveld N, et al. 2018. Children who are both wasted and stunted are also underweight and have a high risk of death: a descriptive epidemiology of multiple anthropometric deficits using data from 51 countries. Archives of Public Health, 76(1):28.
Box 3: Social and Behavioural Change Intervention Case Study

In Ethiopia, a social and behavioural change intervention was introduced to address high rates of childhood undernutrition. The four components of this intervention were nutrition education; agricultural counselling; community mobilisation; and a mass media campaign.

Nutrition education was delivered by community healthcare workers at healthcare facilities or during home visits. Caregivers were taught about clinically recommended IYCF practices through counselling and, in certain instances, cooking demonstrations. Agricultural extension workers counselled caregivers about agriculture practices which encourage recommended IYCF practices. Community mobilisation was comprised of local events, hosted by respected community members such as priests, where recommended IYCF practices were encouraged. Lastly, through the mass media campaign, similar IYCF messages were delivered through radio dramas which incorporated music and the stories of caregivers in the region.

This intervention was associated with improvements in the growth and feeding practices of children 6-24 months old. There was an increase in the intake of eggs, vitamin A-rich foods, fruits/vegetables, and animal source foods. Additionally, there was a decrease in the prevalence of stunting (13 percentage points) and wasting (7 percentage points), and improvements in both linear and ponderal growth.


3.1.3. Integration into Social Protection Programmes

In low- and middle-income settings, health and nutrition measures are predominantly integrated into social safety net programmes. Social safety net programmes have been used to increase the use of healthcare services and increase the intake of nutrient supplements or food items. Conditional social safety net programmes have mostly focused on the use of healthcare services. Conditions of social safety nets for women of reproductive age have included regular accessing of antenatal care, use of safe birthing techniques – skilled attendant at birth and giving birth in a healthcare facility and accessing timely postnatal care. Conditional social safety net programmes for children have focused on child immunisation and regular accessing of growth monitoring and promotion clinics.

Unconditional programmes typically focus on the provision of food items or nutrient supplements to pregnant women, lactating women, and/or children who are no longer being exclusively breastfed – above 6 months old. Both conditional and unconditional programmes usually include an educational component to improve health literacy in communities. Topics taught during educational sessions include

discussions about improving diets or feeding practices, improving health-seeking behaviours, and what to expect during healthcare facility visits.

**Beyond transfer programmes, health and nutrition measures could be integrated into voucher programmes.** The pathways of impact for voucher and transfer programmes are similar. Voucher programmes would focus on making targeted healthcare services more financially accessible for reproductive aged women and children.

**Importantly, alongside the above measures, additional efforts should be directed towards ensuring that both food items and healthcare services are of appropriate quality and accessible - both financially and physically.** This would include efforts to improve levels of food security within a region and introducing health system strengthening solutions. Suitable food security and health system strengthening solutions will vary according to the context and needs of the population. An example of the integration of health/nutrition measures for women of reproductive age into social protection programmes is detailed below in Box 4.

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**Box 4: Conditional Cash Transfer Intervention Case Study**

A conditional cash transfer (CCT) programme in Honduras was used to improve the use of healthcare services among women (pregnant or new mothers) and young children. The programme targeted households with pregnant women or women with one or more children under the age of three. Cash transfers were conditional on the use of preventative healthcare services – antenatal care, postnatal care, and well-child visits. Well-child visits included growth monitoring and promotion, and immunisation. Use of healthcare services was monitored through participant submission of certified attendance slips at healthcare facilities following consultation.

Alongside cash transfers, concerted efforts were made to improve the quality of healthcare services provided in the targeted communities. Quality assurance teams were assigned to healthcare facilities. Team members were trained in quality-of-care assessment and management. Quality assurance teams developed an annual plan to improve the quality of healthcare services provided at their facilities of focus. Annual plans were developed within a preestablished budget.

This intervention was associated with significant improvements in accessing of antenatal healthcare services and preventative healthcare services for children. Over a two-year period, this intervention was associated with an 18.4% increase in the number of pregnant women with five or more antenatal care visits and a 14.9% increase in the number of children taken to a healthcare centre in the last month.

3.2. Responsive Caregiving and Early Learning Measures

In early childhood, children spend most of their time with their caregivers – familial and/or non-familial. Given that this is a critical period for development, caregiver-children interactions and parenting decisions made during this time can significantly impact childhood development and, consequently, school readiness. Responsive caregiving centres around caregivers’ attention, interpretation, and response to children’s behaviour or signals. Early learning focuses on creating opportunities, through interactions between children and their educators/caregivers, which foster learning and the development of critical skills. Importantly, there is overlap in the types of measures used to improve both domains of early childhood development. While early learning focuses on the types of interactions, responsive caregiving focuses on the quality of these interactions.

These measures are used to foster positive cognitive, social, emotional, and behavioural development in children. Measures can either be parent/caregiver focused or child focused.

3.2.1. Caregiver Education or Support Measures

Caregiver focused measures are largely social and behavioural change interventions which target parents of children under three years old and focus on encouraging/supporting responsive caregiving and psychosocial stimulation. Caregiving interventions have been shown to positively improve caregivers’ knowledge and behaviour, and multiple aspects of childhood development in LMICs. Caregivers are taught how to interact, play, and read with their children constructively. The most effective parenting measures introduced in LMICs use an interactive learning model. Caregivers typically attend regular sessions with their children. Caregivers are taught about constructive caregiving practices, given an opportunity to demonstrate these new skills while being observed by an instructor, and provided feedback for improvement. These sessions are taught by healthcare workers or trained peer educators. Sessions can either be conducted individually during home visits or in group settings within communities. These measures are developed with or by local stakeholders to ensure that the content, design, and implementation strategy are culturally appropriate. This is important in maximizing the impact of caregivers focused measures on parenting attitudes, knowledge, and behaviour.

Importantly, at present most caregiving interventions target parents, specifically mothers, without acknowledging the role/influence of other caregivers (familial or non-familial) in child rearing. To ensure that the above measures are as effective as possible, all caregivers of young children should be targeted through these measures. Furthermore, where feasible, social networks/structures that influence child rearing practices should be targeted through the educational component of these measures. Social networks or structures which caregivers may rely on for guidance on child rearing practices include grandparents or well-respected community members.

Box 5: Caregiver Focused Home-Visiting Programme Case Study

A home-visiting programme was introduced in Jamaica in the late 1980s to address poor child development outcomes. Over a period of two years, community healthcare workers conducted weekly home visits to selected low-income households. Households were included in this programme if there was a child between 9 to 24 months of age, at the start of the intervention, who was stunted (low height-for-age).

During weekly home visits, community healthcare workers would educate mothers about responsive caregiving and psychosocial stimulation. Community healthcare workers would demonstrate recommended parenting practices and allow mothers to practice the new skills. Mothers were also provided play and reading material which was rotated regularly. Home-visits were assessed monthly by supervisors and community healthcare workers regularly met with supervisors for additional advice and support.

A follow-up study, when participating children were 31 years old demonstrated that this programme was associated with significant improvements in cognitive, behavioural, and emotional development; academic performance and educational attainment; and income in adulthood.


In low- and middle-income settings where caregiver education/support programmes have been successful, evidence suggests certain programme features to increase programme effectiveness. First, ensuring that programmes are interactive and involve both caregivers and children. Interactive programmes provide caregivers with the opportunity to practice what they are taught, receive tailored feedback, and discuss teachings amongst each other. Second, including group-based activities for caregivers and young children – either alongside or in place of home-visits. Third, programme content that is culturally appropriate. This increases the likelihood of uptake of recommended practices. Lastly, in some settings peer learning was an important avenue to increase the likelihood of uptake of recommended practices among caregivers. In most settings mothers are the primary caregivers. As such, peer learning has largely centred around training local mothers to lead caregiver education/support sessions.

3.2.1.1. Integration into Social Protection Programmes

Existing social protection schemes can be used to identify or target households that would benefit most from caregiver education or support measures. Importantly, and differently from the proposed integration technique for health and nutrition measures, caregiver focused measures would not solely be integrated as accompanying measures of existing safety net programmes. Instead, targeting would be two-fold – reaching the poorest households with children under six years olds; and, more broadly, households with non-economic vulnerabilities and children six years old. The robust systems used to identify households in need of social assistance could also be used to identify households that would
benefit from caregiver focused measures to improve responsive caregiving and early learning. This could include households with a child who has a disability or marginalized populations.

Alongside the above, additional efforts need to be directed towards further strengthening existing social protection infrastructure. This includes, but is not limited to, a comprehensive identification system and an accurate targeting technique. A comprehensive identification system would allow government officials to identify households with children under six years old who could be targeted for caregiving focused measures. This requires increased birth registration and comprehensive social registries which are regularly updated. Additionally, appropriate targeting techniques are important for identifying vulnerable households at risk of poor school readiness among young children.

The effectiveness of caregiver focused education/support measures is further impacted by wider policies regarding parental leave and childcare. Well-established social assistance schemes or parental leave regulations would give parents additional time with new-borns and additional opportunities to learn about constructive parenting techniques. Social assistance schemes would be able to assist individuals who work in the informal sector. Furthermore, following parental leave, non-parental caregivers with training in responsive caregiving and early learning, and good quality childcare centres should be accessible to all households. Accessibility refers to both the financial and physical accessibility of trained caregivers and childcare centres.

**Box 6: Caregiver Focused Home-Visiting Programme Case Study**

In Rwanda, a home-visitation programme (Sugira Muryango) was introduced alongside multiple existing social protection schemes. The aim of the home-visitation programme was to address widespread inequalities in early childhood development and limit/eliminate harsh discipline. Existing social protection schemes implemented concurrently included unconditional cash transfers and public work programmes. Existing social protection schemes were used to identify households that would benefit from inclusion in the home-visitation programme.

Sugira Muryango targets low-income households with children under 36 months old. Community-based coaches (CBCs) provide education and coaching to parents about positive parenting and early learning. CBCs received on the job training and are paired with a supervisor – a CBC from an earlier cohort. Supervisors assessed CBCs’ performance in person for the first few weeks, and retrospectively through the assessments of audiotaped home-visitations. Supervisors were also available for regular communication with CBCs to troubleshoot any concerns.

In addition to teaching and coaching, this programme intentionally incorporated fathers; taught caregivers about emotional regulation, stress management, and problem solving; and emphasized the importance of healthy family units. 12 sessions were conducted over a three-to-four-month period. Sessions took place every week and lasted for about 1 hour 30 minutes.

Three months following introduction, this intervention was associated with statistically significant improvements in parent-child interactions and the implementation of positive parenting. There was
an increase in early childhood development stimulation implemented in homes and a decrease in the prevalence of harsh discipline (70% decrease).


### 3.2.2 Early Childhood Education Measures

Within environments where the adult literacy rate is low, the impact of caregiving interventions on reading comprehension may be limited and child focused interventions, detailed below, may be an appropriate complementary/supplementary measure to maximise impact on early learning. Child focused measures are largely used to further improve early learning among children before primary school attendance. Evidence demonstrates that preschool programme attendance is associated with improvements in academic performance, and cognitive and psychosocial development, particularly among children that are disadvantaged. Preschools are settings where children can further learn and develop skills that encourage school readiness.

This section highlights three types of preschools, which differ according to who teaches the children and their associated qualifications; funding sources and resources available; curriculum content; programme duration; and child age groups targeted. Centre-based preschools are typically referred to as formal preschools and community-based preschools are referred to as informal preschools. In some LMICs, home-based preschools are an additional category. Parental decisions about the type of preschool facility that their children will attend depends on factors such as the perceived benefits of preschool facilities; accessibility of preschool facilities – physical and financial; the content/structure of preschool programmes; and the age groups that the programmes cater to.

Centre-based preschools typically target children between 3-6 years of age and are attached to public primary schools. Children are taught by a professional teacher who has normally completed tertiary level education. Centre-based preschools attended by children from low-income households are regularly government funded and have access to the largest number of educational resources, in comparison to other preschool programmes. The curriculum of centre-based preschool programmes is the most structured of all three preschool programmes.

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Box 7: Centre-based Preschool Case Study

In Argentina, a robust public preschool education system exists which caters to children between 3 to 6 years old. Attendance is voluntary for children until the age of 5, at which point children are legally required to attend preschool. To facilitate attendance, an infrastructure programme in the late 1900s centred around the construction of public centre-based preschools. Public preschools are attached to public primary schools – physically and/or administratively; and are non-fee-paying schools.

The curriculum is standardised across all public preschools and focuses on the development of numerous skills – communication, behavioural, social, logical/mathematical, and emotional. All teachers are required to have tertiary level teaching education from a university or a college. Children largely attend for about 3.5 hours every weekday. Sessions are available both in the morning and the afternoon. Class sizes are typically around 25 students.

Berlinski et al (2009) estimate that public preschool attendance for a period of one year will result in improvements in third grade test scores for subjects such as Spanish and math. Furthermore, public preschool attendance was associated with additional improvements in child behaviour as reported by their teachers – attention, effort, discipline, and class participation.


Community-based preschools typically target children between 3-5 years of age and are located within communities. Children are taught by an educator who is recruited locally. Typically, community-based preschools do not require educators to have completed tertiary level education. Instead, all educators receive on-the-job training. Community programmes are normally funded by NGOs and have access to more educational resources than home-based programmes. The curriculum used within this setting is normally developed to mirror what is used in centre-based preschool facilities.

Box 8: Community-based Preschool Case Study

In the early 1900s, community owned and implemented preschools were introduced in three East African countries – Kenya, Uganda, and Tanzania. This intervention, Madrasa Resource Centres, emerged from a desire among community members to improve academic outcomes within their communities. The preschools largely cater to Muslim children. However, depending on the demographic composition within a community, limited spacing is available for non-Muslim children. Children attended preschool every weekday for half a day.

Given that these preschools were introduced in predominantly Muslim communities, alongside standard/secular teaching material and methods, children are taught about both Islam and the local culture. As a community-based preschool programme, community members are heavily involved in the design and implementation of numerous aspects of the preschool programme. Community
members make decisions about details such as the cost of attendance, location of the preschool, and curriculum. Decisions are made in collaboration with regional and national board members, business experts, and technical experts from the Aga Khan Foundation. Teachers are all female and selected from within the community. All teachers have a minimum of eight years of schooling. Additionally, teachers receive on the job training for a six-month period prior to starting the job, regular mentoring, and professional development.

In comparison to children who attended government centre-based preschools, those who attended the Madrasa Resource Centre Preschools experienced greater improvements in cognitive skills – mathematic/numeric, verbal, and non-verbal. Furthermore, among community-based preschools, higher cognitive skill levels were observed among children in higher quality preschools. In this context, community-based preschools were higher quality than government centre-based preschools due to additional training for teachers; a more child-centred approach; and the use of low-cost material to interact constructively with children.


**Home-based preschools are also located within communities and typically target children from birth until 6 years of age.** These programmes are usually run by a group of mothers, with one mother leading the group. The principal mother receives limited training and uses a curriculum that is intended to be reflective of what is used in centre-based preschools. These programmes are typically funded locally and consequently have limited educational resources available. Attendance to home-based preschools is typically less frequently, with weekly meetings for a smaller number of days and shorter number of hours. Furthermore, caregivers typically attend home-based preschools with their children.

**Among the three preschools detailed above – government centre-based; community-based; and home-based, each preschool has unique advantages and disadvantages and the facility best suited to encourage early childhood education will vary according to the context.** Government centre-based preschools are the most standardised and regulated, making transition to primary school more seamless. However, in many LMICs, these preschools are scarce and underfunded. Community-based preschools seek to emulate government centre-based preschools, however, there is significant variability in the structure of these programs in terms of the curriculum; funding; and teacher qualifications. However, community-based preschools have the potential to serve communities well, especially in settings where access to good quality government centre-based preschools is limited. Home-based preschools usually have educators with the lowest qualification levels; are the least regulated; and are the most infrequent. Consequently, the level of impact is likely lower than government- and community-based preschools. However, importantly, home-based preschools provide an opportunity for early childhood education in settings where community and government preschools are sparse or low quality.
In settings where preschool programmes are not accessible, evidence suggests that a child-to-child approach could be used to foster early learning and consequently improve school readiness among children 4 to 6 years old. This programme is designed to incorporate older children into school readiness measures for younger children. Older children, referred to within this programme as young facilitators, are typically children enrolled in grades five to eight. Young facilitators lead pre-planned interactive sessions with younger children. Sessions are held at primary schools and typically occur once or twice a week. Each session, which includes multiple young facilitator-child dyads, is supervised by a teacher who has received specific training for this programme and who also trained the young facilitators. Sessions seek to improve numeracy, reading, and writing skills of the young children.

This programme has been piloted in countries such as Bangladesh, Democratic Republic of Congo, Ethiopia, Tajikistan, and Yemen. However, only data from Ethiopia is publicly available. In some countries, a community component was incorporated into the programme design – a few sessions are conducted within communities. The programme was most effective when there was a higher frequency of contact between the young facilitators and young children, and with family and community involvement in the programme. In Ethiopia, this programme was associated with improvements in the social skills, and numeracy and literacy performance of children. Among young facilitators, there was an increased reporting of improved leadership and literacy skills.

3.2.2.1 Integration into Adaptive Social Protection Programmes

Adaptive social protection programmes are uniquely positioned to improve the accessibility of early childhood education measures to poor and vulnerable households. Additional efforts can be directed towards increasing the provision of preschool education. This would include either free attendance to preschools or preschool attendance at a reduced rate. This would also require preschools to be physically accessible to low-income and vulnerable communities. For example, preschools could be introduced within or in close proximity to low-income and/or vulnerable communities.

In addition to the above, safety net programmes and voucher programmes could be used to further address financial constraints that may be limiting preschool attendance. Support could be provided with or without conditions. Within this context, conditions would centre around preschool attendance for children between 3 to 6 years old. Vouchers to cover preschool fees could also be provided to households with financial limitations.

Although preschool programmes have proven to be effective at improving early learning and school readiness in young children, it is important to note that the level of effectiveness depends heavily on the quality of the preschool programme. The quality of preschool programmes is associated with the quality of interactions between educators and children; the curriculum – the skills developed, and activities included, and the availability/type of educational material used. Additionally, research

suggests that the determinants of preschool quality and programme effectiveness may vary within different contexts, highlighting the value of context-specific solutions.43

In addition to the above, a family’s ability and/or willingness to send young children to early childhood education programmes can significantly impact programme effectiveness. Alongside the introduction of preschool programmes, sensitisation campaigns should be introduced within communities to promote the value of early childhood education programmes.

Box 9: Preschool Intervention Case Study

In Uganda, the World Food Program (WFP) provided cash transfers in communities where UNICEF-supported early childhood learning centres were present. Cash transfers were only provided to households with children between 3 to 5 years old who were attending a community-based preschool. The cash transfer amount was dependent on the number of children within a household that met the above conditions. Cash transfers were provided every six to eight weeks. Transfers were conducted electronically to the primary caregivers of the children. The associated community-based preschools were designed and implemented as described in earlier sections of this document.

The provision of cash transfers was associated with significant improvements in the cognitive test scores in young children. There were statistically significant improvements in the total cognitive score of children between 4.5 years old and 6 years old. Notably, there were improvements in visual reception, receptive language, and expressive language test scores.


3.3. Security and Safety Measures

Raising children in an environment that is both secure and safe is critical in ensuring adequate development in childhood and readiness for school. Exposure to violence in childhood and child maltreatment are associated with disruptions to social and emotional development.44 45 Strategies addressing levels of security and safety in early childhood typically focus on parental education or tackling the predictors of insecurity/danger. Messages about creating a safe and secure home environment for children, particularly in early childhood, can be integrated into parent education and parent support measures detailed in previous sections.46 As it pertains to security and safety, additional messages would centre around parenting practices that prevent child maltreatment.


3.3.1. Parental Mental Health and Stress Measures

Extensive research indicates that parental mental health and stress levels are strong predictors of child maltreatment and domestic violence – a common form of violence that children are exposed to in early childhood. Notably, the WHO has called for additional focus on the mental health of mothers during pregnancy and postpartum. This will be examined extensively in future work. However, briefly, psychosocial interventions addressing maternal mental health have resulted in improvements in parent-child interactions, exclusive breastfeeding, child growth, child development and child health. These interventions typically include regular counselling sessions for mothers. In different settings, counselling sessions are either led by specialists or non-specialists. The use of non-specialists in more common in LMICs – about 87.5%. Programmes vary in the duration and number of counselling sessions provided as well as the theoretical frameworks which underpin the counselling techniques.

### Box 10: Parenting Intervention Case Study

In Uganda, mental health services were provided to caregivers in predominantly rural settings. The aim of the programme was to improve maternal mental health and caregiver-child interactions.

This intervention included 12 sessions – six focusing on maternal mental health and six focusing on caregiver-child interactions. One session, led by a community volunteer, was held every two weeks. Volunteers received on the job training – before and during the programme. To be eligible, volunteers were required to be well-respected in their community, have well developed communication skills, and be fluent in the local language. The quality of services provided was regularly monitored by supervisors.

The six mother centred sessions were organised as follows – two were attended by mothers alone, two were attended by fathers alone, and two were attended by both mothers and fathers. During these sessions, caregivers were taught how to interact with each other, manage conflict, and communicate effectively. Sessions were interactive - including both group discussions and role-play.

Participation in this programme was associated with a decrease in the prevalence of self-reported symptoms of depression among mothers. Furthermore, participating mothers reported higher use of active coping strategies.


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Evidence examining the impact of maternal counselling/therapy programmes in LMICs is limited. This is further compounded by significant heterogeneity in programme design (i.e., the type of therapy underpinning programme design) and implementation. However, preliminary evidence from Pakistan, South Africa, and Uganda suggest programme features that could maximise programme effectiveness. First, incorporating spouses/partners in one or more of the counselling sessions. In addition to mothers receiving support and guidance on how to best manage stress/conflict in their households, ensuring that their partners develop these same skills will further strengthen programme impact. Second, framing the intervention to focus on improving child outcomes and managing caregiver stress, as opposed to mental health or depression. In many settings, there is significant stigma surrounding mental health issues. Reframing the intervention to community members will likely increase community participation. Third, ensuring that services are provided by community members—whether they are healthcare providers or volunteers. This increases the likelihood that the service provider is aware of the sociocultural factors impacting caregiver mental health in a specific community and is better suited to provide tailored assistance. Furthermore, this increases caregivers’ comfortability with the service provider, again increasing the likelihood of tailored assistance.

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3.4. Integrated Measures

Although this document has detailed individual measures to address school readiness in the Sahel, evidence suggests that an integrated approach may be most effective. In some settings, health, nutrition, and parenting measures have been integrated into one package. The combination of measures that will be most effective varies within different settings and should be determined alongside local stakeholders and/or experts.

**Box 11: Integrated Child Development Services Case Study**

India has one of the largest integrated early childhood development programmes worldwide. This programme targets women of reproductive age and children under six years old. Some of the key services provided through this programme include nutrient and food supplementation, nutrition and health literacy, immunisation, preventative healthcare visits, and community-based pre-school education. This programme has been jointly designed and implemented by numerous government ministries.

All services are provided at Anganwadi community centres. The community centres are managed by an Anganwadi worker – a female community member; and staffed by trained healthcare workers – i.e., nurses/midwives. Anganwadi workers have a minimum high school level education and receive additional on the job training. The Anganwadi worker also serves as a point person between the community and the government.

Exposure to the above programme during the first three years of life was associated with statistically significant increases in the amount of schooling completed. A similar, smaller effect was observed for those who were partially exposed to this programme.


4. SUMMARY OF MEASURES

This section provides a brief overview of the above-mentioned school readiness measures in early childhood. Interventions are organized according to the domains of early childhood development which are targeted. For each intervention, the following information is provided – (1) a brief description of the intervention, (2) the target population, (3) anticipated benefits detailed in existing literature, (4) favourable settings in which the intervention can be introduced – both the development context and existing systems, (5) a brief description of avenues for integration into social protection programmes, and (6) wider conditions/initiatives, across different sectors, which could increase programme effectiveness.

4.1. Health and Nutrition Measures

<table>
<thead>
<tr>
<th>Behavioural change communication</th>
<th>Population</th>
<th>Benefits</th>
<th>Favourable Settings</th>
<th>Integration into SP Programmes</th>
<th>Conditions to Increase Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Promote healthy diets, antenatal care visits, and postnatal care visits</td>
<td>Women: 15 - 49 y.o.</td>
<td>Improved foetal growth and development &lt;br&gt; Improved birth outcomes &lt;br&gt; Early detection and treatment of maternal, foetal, and newborn health concerns</td>
<td><strong>Context</strong>&lt;br&gt;Poor maternal health and birth outcomes&lt;br&gt; <strong>Systems</strong>&lt;br&gt;Well-trained and ample community healthcare workers&lt;br&gt; Invested community leaders</td>
<td>Plus component of safety net programmes&lt;br&gt; Conditions of safety net programmes&lt;br&gt; Services provided through a voucher</td>
<td>High quality healthcare system&lt;br&gt; Affordable healthcare services&lt;br&gt; Physically accessible healthcare facilities&lt;br&gt; Affordable nutrient rich food&lt;br&gt; Adequate supply/physical access to nutrient rich food</td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>Supplementation</th>
<th>Population</th>
<th>Benefits</th>
<th>Favourable Settings</th>
<th>Integration into SP Programmes</th>
<th>Conditions to Increase Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provision of MMS or LNS, and/or food items</td>
<td>Women: 15 - 49 y.o.</td>
<td>Improved foetal growth and development&lt;br&gt; Improved growth and development in the first six months of life</td>
<td><strong>Context</strong>&lt;br&gt;Poor maternal nutrition, foetal growth, and weight/height in children under 6 months&lt;br&gt; <strong>Systems</strong>&lt;br&gt;Well-trained and ample community healthcare workers</td>
<td>Plus component of safety net programmes&lt;br&gt; Goods provided through a voucher</td>
<td>Affordable nutrient rich food&lt;br&gt; Adequate supply/physical access to nutrient rich food</td>
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</table>

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<thead>
<tr>
<th>Behavioural change communication</th>
<th>Population</th>
<th>Benefits</th>
<th>Favourable Settings</th>
<th>Integration into SP Programmes</th>
<th>Conditions to Increase Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Children: &gt; 6 months</td>
<td>Improved cognitive and physical development in the first five years of life</td>
<td><strong>Context</strong>&lt;br&gt;Poor child nutritional status and health outcomes</td>
<td>Plus component of safety net programmes</td>
<td>High quality healthcare system&lt;br&gt; Affordable healthcare services</td>
</tr>
</tbody>
</table>
### 4.2. Responsive Caregiving and Early Learning Measures

<table>
<thead>
<tr>
<th>Population</th>
<th>Benefits</th>
<th>Favourable Settings</th>
<th>Integration into SP Programmes</th>
<th>Conditions to Increase Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caregiver education/support</td>
<td>Caregivers of children under 3 y.o.</td>
<td>Improved caregiver knowledge and behaviour, Improved childhood development: social, cognitive, behavioural, and emotional</td>
<td>Context All contexts</td>
<td>Utilise targeting systems to identify recipient households, Plus component of safety net programmes, Integration into behavioural change communication programmes which promote improved child/maternal health and nutrition</td>
</tr>
</tbody>
</table>

**Improving child feeding, WASH practices, immunisation, and health-seeking behaviour**

- Decreased prevalence of disease
- Improved treatment seeking behaviour

**Supplementation**

- Provision of LNS, and/or food items
  - Children: > 6 months
  - Improved cognitive and physical development in the first five years of life

**Systems**

- Well-trained and ample community healthcare workers
- Invested community leaders

**Context**

- Poor child nutritional status
- Invested community leaders

**Integration into SP Programmes**

- Conditions of safety net programmes
- Services provided through a voucher

**Physically accessible healthcare facilities**

- Affordable nutrient rich food
- Adequate supply/physical access to nutrient rich food
### 4.3. Early Learning Measures

<table>
<thead>
<tr>
<th></th>
<th>Population</th>
<th>Benefits</th>
<th>Favourable Settings</th>
<th>Integration into SP Programmes</th>
<th>Conditions to Increase Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Centre-based preschool</strong></td>
<td>Children: 3 - 6 y.o.</td>
<td>Improved cognitive and psychosocial development</td>
<td><strong>Context</strong>&lt;br&gt;Poor primary school enrolment and academic performance</td>
<td>Provision of preschool education through employers</td>
<td>Affordable preschool facilities</td>
</tr>
<tr>
<td>Features</td>
<td></td>
<td>Improved school performance</td>
<td><strong>Systems</strong>&lt;br&gt;Well-trained and ample educators</td>
<td>Vouchers or transfers to cover attendance fees</td>
<td>Physically accessible preschool facilities</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Invested community leaders</td>
<td>Conditions of safety net programmes</td>
<td>Good quality preschools</td>
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<td></td>
<td>Caregiver willingness to send children to preschool facilities</td>
</tr>
<tr>
<td>Attendance fee</td>
<td></td>
<td></td>
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<tr>
<td><strong>Community-based preschool</strong></td>
<td>Children: 3 - 5 y.o.</td>
<td>Improved cognitive and psychosocial development</td>
<td><strong>Context</strong>&lt;br&gt;Poor primary school enrolment and academic performance</td>
<td>Provision of preschool education through employers</td>
<td>Affordable preschool facilities</td>
</tr>
<tr>
<td>Features</td>
<td></td>
<td>Improved school performance</td>
<td><strong>Systems</strong>&lt;br&gt;Limited centre-based preschools</td>
<td>Vouchers or transfers to cover attendance fees</td>
<td>Physically accessible preschool facilities</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Well-trained and ample educators</td>
<td>Conditions of safety net programmes</td>
<td>Good quality preschools</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>Invested community leaders</td>
<td></td>
<td>Caregiver willingness to send children to preschool facilities</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Ability to transition children to centre-based preschool at 5 y.o.</td>
<td></td>
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<tr>
<td>Home-based preschool</td>
<td>Children: &lt; 6 y.o.</td>
<td>Improved cognitive and psychosocial development</td>
<td><strong>Context</strong> Poor primary school enrolment and academic performance</td>
<td>Conditions of safety net programmes</td>
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</tr>
<tr>
<td><strong>Features</strong></td>
<td></td>
<td>Improved school performance</td>
<td>Limited centre-based and community-based preschools</td>
<td>Plus component of safety net programmes</td>
<td></td>
</tr>
<tr>
<td>Local educators, limited on the job training</td>
<td></td>
<td></td>
<td>Systems Well-trained and ample educators Invested community leaders</td>
<td>Integration into behavioural change communication programmes which promote improved child health and nutrition</td>
<td></td>
</tr>
<tr>
<td>Least access to educational resources</td>
<td></td>
<td></td>
<td></td>
<td>Physically accessible preschool facilities</td>
<td></td>
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<tr>
<td>Least structured curriculum</td>
<td></td>
<td></td>
<td></td>
<td>Good quality preschools</td>
<td></td>
</tr>
<tr>
<td>Least frequently scheduled school attendance</td>
<td></td>
<td></td>
<td></td>
<td>Caregiver willingness to send children to preschool facilities</td>
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<tr>
<td>No attendance fee</td>
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<table>
<thead>
<tr>
<th>Child-to-child learning</th>
<th>Children: 4 - 6 y.o.</th>
<th>Improved cognitive and psychosocial development</th>
<th><strong>Context</strong> Poor primary school enrolment and academic performance</th>
<th>Conditions of safety net programmes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Features</strong></td>
<td></td>
<td>Improved school performance</td>
<td>Limited centre-based and community-based preschools</td>
<td>Plus component of safety net programmes</td>
</tr>
<tr>
<td>Educators are older children – in grades 5 to 8</td>
<td></td>
<td></td>
<td>Systems Well-trained and ample educators Invested community leaders</td>
<td>Physically accessible education facilities</td>
</tr>
<tr>
<td>Interactive sessions</td>
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<td></td>
<td></td>
<td>Good quality education facilities</td>
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<tr>
<td>Structured curriculum</td>
<td></td>
<td></td>
<td></td>
<td>Caregiver willingness to send children to education facilities</td>
</tr>
<tr>
<td>Infrequent scheduled sessions</td>
<td></td>
<td></td>
<td></td>
<td>Caregiver willingness to have older children participate in the programme</td>
</tr>
<tr>
<td>No attendance fee</td>
<td></td>
<td></td>
<td></td>
<td>Willingness of older children to participate in the programme</td>
</tr>
</tbody>
</table>
### 4.4. Security and Safety Measures

<table>
<thead>
<tr>
<th>Population</th>
<th>Benefits</th>
<th>Favourable Settings</th>
<th>Integration into SP Programmes</th>
<th>Conditions to Increase Effectiveness</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychosocial support</td>
<td>Caregivers of children under 5 y.o.</td>
<td>Context:</td>
<td>Conditions of safety net programmes</td>
<td>Healthcare systems designed to identify and treat mental health issues in patients, particularly in new mothers</td>
</tr>
<tr>
<td></td>
<td>Improved parent-child interactions</td>
<td>Poor maternal mental health</td>
<td>Plus component of safety net programmes</td>
<td>Social/cultural beliefs that discourage child maltreatment and domestic violence</td>
</tr>
<tr>
<td></td>
<td>Decreased child maltreatment and domestic violence</td>
<td>Prevalence of harsh discipline or child maltreatment</td>
<td></td>
<td>Social systems designed to identify and penalise child maltreatment and domestic violence</td>
</tr>
<tr>
<td></td>
<td>Improved child development and health</td>
<td>Prevalence of factors known to increase parental stress (i.e. high poverty rates, unemployment, and conflict)</td>
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<tr>
<td></td>
<td></td>
<td><strong>Systems:</strong> Well-trained and ample community healthcare workers or volunteers</td>
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<tr>
<td></td>
<td></td>
<td>Invested community leaders</td>
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</tbody>
</table>

- **Context**: Poor maternal mental health, prevalence of harsh discipline or child maltreatment, prevalence of factors known to increase parental stress (i.e., high poverty rates, unemployment, and conflict).

- **Systems**: Well-trained and ample community healthcare workers or volunteers; invested community leaders.

- **Conditions to Increase Effectiveness**: Healthcare systems designed to identify and treat mental health issues in patients, particularly in new mothers; social/cultural beliefs that discourage child maltreatment and domestic violence; social systems designed to identify and penalise child maltreatment and domestic violence.
5. THE SAHEL CONTEXT

This document concludes with a short examination of the early childhood development measures best suited to improve school readiness in the Sahel. Earlier sections of this document have examined school readiness measures which address one or more domains of early childhood development - health, nutrition, responsive caregiving, early learning, and security and safety. However, the most effective combination of measures varies according to the context. An effective combination of measures depends on the policy/development issues of concern within a region, and political/administrative feasibility. This section will begin with a brief overview of the Sahel context, drawing attention to school readiness related development issues. This is followed by a summary of the recommended combination of measures to maximise impact in the Sahel.

The Sahel has one of the lowest levels of human development globally – encompassing assessments of health, education, and economic outcomes. The human development index tier system classifies the level of human development as low in all six Sahel countries – Senegal, Burkina Faso, Mali, Mauritania, Niger, and Chad. Furthermore, four Sahel countries are among the ten countries with the lowest levels of human development worldwide. Low levels of human development are reflective of inadequate investments in human capital formation, particularly in early childhood.

Low levels of human capital in the Sahel are further compounded by increasing occurrences of conflict and climate shocks.53 In the current fiscal year, the World Bank classified four Sahel countries as heavily impacted by fragility or conflict.54 Chad is categorised as institutionally/socially fragile; and Burkina Faso, Mali, and Niger are categorised as conflict affected areas. Beyond conflict related shocks, idiosyncratic and climate shocks are also prevalent in the Sahel.55 Idiosyncratic shocks prevalent in the Sahel include illness, death, and theft. The most prevalent climate shocks in the region are droughts and, to a smaller extent, floods.

Given the above-mentioned Sahel context, development issues that require additional policy attention in the region centre around the impact of household level disinvestments in human capital, particularly in early childhood, due to frequent shocks. Specific development issues include high levels of food insecurity and the associated prevalence of malnutrition among reproductive age women and children; and poor academic performance in primary school despite increasing rates of enrolment. The following section details the recommended combination of measures to address these development issues effectively within the Sahel context through adaptive social protection programmes.

5.1. Recommendations for Adaptive Social Protection Programmes

Efforts to address malnutrition and primary school performance in the Sahel through social protection programmes would be best directed towards safety net programmes. The plus component of these safety net programmes would be designed to address the three development issues highlighted above – food insecurity, malnutrition, and poor academic performance. First, behavioural change communication could be used to improve diets among pregnant women, lactating women, and children; health-seeking behaviour; and caregiver-child interactions particularly around responsive caregiving and early learning. Due to the level of fragility and/or conflict in some Sahel regions, community-based events and mass media campaigns may be the most effective way to encourage widespread behavioural change. Mass media would be used to sensitise community members to the messages being disseminated in detail through community-based events hosted by trained volunteers and healthcare workers.

In addition to behavioural change communication, goods/services can be provided to targeted/vulnerable households. First, small-quantity lipid-based nutrient supplements (SQ-LNS) could be provided to pregnant or breastfeeding women, and children between six months and five years old. The provision of food supplements would be complementary to the above behavioural change communication intervention. Second, for children who are particularly vulnerable to low levels of school readiness, home visitation programmes and the introduction of community-based preschools would be an effective strategy to improve academic outcomes. Home visitation programmes would provide caregivers with one-to-one education and support on how to interact constructively with young children and encourage early learning within the home. Where feasible, this would also include the provision of items/tools to facilitate early learning in the home.

The introduction of community-based preschools is another invaluable service that could be provided to targeted/vulnerable communities. This is particularly useful in settings where centre-based preschool facilities are not accessible. Furthermore, supporting community ownership and implementation of early childhood education facilities is an invaluable way to provide services in hard-to-reach communities. Attendance fees would be covered either by safety net transfers or vouchers. Similar to the above, a strategy to sensitise community members to the value of early childhood education would be required.

Lastly, where feasible, efforts to improve parental stress and mental health could be used to further strengthen caregiver-child interactions and consequently improve childcare practices and early learning in the home. This is particularly relevant in the Sahel where shocks are prevalent. Social protection programmes are uniquely positioned to tackle the financial constraints placed on households, and associated parental stress, as a result of experiencing one or more shocks. However, the provision of counselling, particularly to mothers who are pregnant or postpartum, could be an important avenue to further strengthen the impact of social protection programmes on parental stress and mental health. Counselling could also be provided as the plus component of safety net programmes.
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