Iraq

EARLY CHILDHOOD DEVELOPMENT

SABER Country Report
2014

Policy Goals	Status
1. Establishing an Enabling Environment Early childhood development (ECD) has not yet been a priority of the Iraqi government. A multisectoral ECD strategy does not exist, nor do mechanisms for intersectoral coordination. Iraq does have some laws to promote health care for pregnant women and young children. Currently there is no way to determine the level of spending on young children in the country, but the sector may be underfunded.	Latent
2. Implementing Widely Iraq has established a variety of health and nutrition programs, but fewer in social protection and child protection. Access to these services could be expanded. Enrollment in preprimary education is very low. There is fairly equitable access to essential health and nutrition services, but large disparities in learning opportunities for children from different socioeconomic backgrounds.	Emerging
3. Monitoring and Assuring Quality Iraq collects a variety of survey data. The types of administrative data collected for the health, nutrition, social protection, and child protection sectors could be expanded to better gauge access and outcomes. Some documents containing standards and regulations date from the Baathist era and do not reflect current ECD best practices. There are some service delivery standards for preprimary schools but no construction standards.	Emerging

This report presents an analysis of the early childhood development (ECD) programs and policies that affect young children in Iraq and recommendations to move forward. This report is part of a series of reports prepared by the World Bank using the Systems Approach for Better Education Results–Early childhood development (SABER-ECD) framework and includes analysis of early learning, health, nutrition, social protection, and child protection policies and interventions in Iraq, along with regional and international comparisons. [1]

Iraq and Early Childhood Development

Iraq is a country of approximately 35 million people and has a young and growing population. Its gross national income (GNI) per capita, using the Atlas method, in 2013 was US$6,710, making it an upper middle income country. In 2013, it ranked 120th out of 186 countries in the Human Development Index. In 2012, almost 19 percent of the population lived at or below the national poverty line.

The country has experienced years of conflict, instability, and violence. This has had devastating consequences for the country's young children and their families, with internal displacement, large numbers of widows and orphans, and psychological trauma. The government is incapable of providing basic services in many places, and infrastructure is failing.

Until now ECD has not been a priority of the Government of Iraq (GOI). The country lacks an ECD strategy or a lead ECD coordinating body. It provides some basic health and nutrition services, but is weak on social protection and child protection. Very few children attend preprimary education, even though Iraq's constitution stipulates that education at all levels is free. Many of the regulations concerning early childhood education date back to the Baathist era and do not reflect the current knowledge in the field, nor the values of a democratic country.

Iraq has the opportunity to develop an early childhood strategy incorporating the latest (and ever growing) body of evidence in the field. Implementation will be a challenge, given the government's weak capacity to deliver services and the security situation in many parts of the country. A key part of building the support necessary from government and citizens for investing in ECD may be to raise awareness on the importance of children's earliest years for the country's economic and social development. Table 1 shows several ECD indicators in Iraq, alongside figures for several other countries in the region.

Table 1. Snapshot of ECD Indicators in Iraq with Regional Comparison

	Iraq	Egypt	Jordan	Turkey	Yemen
Infant mortality (deaths per 1,000 live births, 2012)	28	18	16	12	46
Below-five mortality (deaths per 1,000 live births, 2012)	34	21	19	14	60
Moderate and severe stunting (below-five, 2008–12) (%)	22.6	28.9	7.7	12.3	57.7
Preprimary net enrollment rate (3–5 years of age) (%)	7% (2007)	23% (2012)	34% (2012)	31% (2012)	1% (2011)
Birth registration 2005–12 (%)	99.2	99.0	99.1	93.7	17.0

Source: UNICEF MICS, UNESCO Institute for Statistics database.

[1] SABER-ECD is one domain within the World Bank initiative, Systems Approach for Better Education Results (SABER), which is designed to provide comparable and comprehensive assessments of country policies.

Systems Approach for Better Education Results–Early Childhood Development (SABER-ECD)

SABER-ECD collects, analyzes, and disseminates comprehensive information on ECD policies around the world. In each participating country, extensive multisectoral information is collected on ECD policies and programs through a desk review of available government documents, data and literature, and interviews with a range of ECD stakeholders, including government officials, service providers, civil society, development partners, and scholars. The SABER-ECD framework presents a holistic and integrated assessment of how the overall policy environment in a country affects young children's development. This assessment can be used to identify how countries address the same policy challenges related to ECD, with the ultimate goal of designing effective policies for young children and their families.

What should be in place at the country level to promote coordinated and integrated ECD interventions for young children and their families?
Health care
• Standard health screenings for pregnant women • Skilled attendants at delivery • Childhood immunizations • Well-child visits
Nutrition
• Breastfeeding promotion • Salt iodization • Iron fortification
Early learning
• Parenting programs (during pregnancy, after delivery, and throughout early childhood) • High-quality child care for working parents • Free preprimary school (preferably at least two years with developmentally appropriate curriculum and classrooms, and quality assurance mechanisms)
Social protection
• Services for orphans and vulnerable children • Policies to protect rights of children with special needs and promote their participation/access to ECD services • Financial transfer mechanisms or income supports to reach the most vulnerable families (could include cash transfers, social welfare, and so on.)
Child protection
• Mandated birth registration • Job protection and breastfeeding breaks for new mothers • Specific provisions in judicial system for young children • Guaranteed paid parental leave of least six months • Domestic violence laws and enforcement • Tracking of child abuse (especially young children) • Training for law enforcement officers in regard to the particular needs of young children

presents an abbreviated list of interventions and policies that the SABER-ECD approach looks for in countries when assessing the level of ECD policy development. This list is not exhaustive but is meant to provide an initial checklist for countries to consider the key policies and interventions needed across sectors.

Three Key Policy Goals for Early Childhood Development

SABER-ECD identifies three core policy goals that countries should address to ensure optimal ECD outcomes: *establishing an enabling environment, implementing widely* and *Monitoring and Assuring Quality*. Improving ECD requires an integrated approach

to address all three goals. As described in figure 1, for each policy goal, a series of policy levers are identified, through which decision makers can strengthen ECD.

Strengthening ECD policies can be viewed as a continuum. As described in

Table **2**, countries can range from a latent to advanced level of development within the different policy levers and goals.

Box 1. A Checklist to Consider How Well ECD Is Promoted at the Country Level

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Figure 1. Three Core ECD Policy Goals

Table 2. ECD Policy Goals and Levels of Development

ECD policy goal	Level of development			
	Latent ●○○○	Emerging ●●○○	Established ●●●○	Advanced ●●●●
Establishing an enabling environment	Nonexistent legal framework; ad hoc financing; low intersectoral coordination	Minimal legal framework; some programs with sustained financing; some intersectoral coordination	Regulations in some sectors; functioning intersectoral coordination; sustained financing	Developed legal framework; robust interinstitutional coordination; sustained financing
Implementing widely	Low coverage; pilot programs in some sectors; high inequality in access and outcomes	Coverage expanding but gaps remain; programs established in a few sectors; inequality in access and outcomes	Near-universal coverage in some sectors; established programs in most sectors; low inequality in access	Universal coverage; comprehensive strategies across sectors; integrated services for all, some tailored and targeted
Monitoring and ansuring quality	Minimal survey data available; limited standards for provision of ECD services; no enforcement	Information on outcomes at national level; standards for services exist in some sectors; no system to monitor compliance	Information on outcomes at national, regional, and local levels; standards for services exist for most sectors; system in place to regularly monitor compliance	Information on outcomes from national to individual levels; standards exist for all sectors; system in place to regularly monitor and enforce compliance

Policy Goal 1: Establishing an Enabling Environment

➢ Policy Levers: Legal Framework • Intersectoral Coordination • Finance

An enabling environment is the foundation for the design and implementation of effective ECD policies (Britto, Yoshikawa, and Boller 2011; Vargas-Baron 2005). An enabling environment consists of the following: the existence of an adequate legal and regulatory framework to support ECD, coordination within sectors and across institutions to deliver services effectively, and sufficient fiscal resources with transparent and efficient allocation mechanisms.

Policy Lever 1.1: Legal Framework

Emerging ●●○○

The legal framework comprises all the laws and regulations that can affect the development of young children in a country. The laws and regulations that impact ECD are diverse due to the array of sectors that influence ECD and because of the different constituencies that ECD policy can and should target, including pregnant women, young

children, parents, and caregivers. Box 3 lists key laws governing ECD in Iraq.

Some national laws promote health care for pregnant women and young children, but aspects could be strengthened. The Iraqi constitution guarantees health care for all citizens; it also ensures protection of motherhood and childhood. The National Strategy on Reproductive Health and Maternal and Child Healthcare guarantees that pregnant women receive antenatal visits and a skilled delivery. According to interviews with health officials, pregnant women are routinely screened for HIV, and referrals to treatment services are provided if necessary. Data on HIV prevalence in Iraq are scarce, but the number seems to be very low.

Ministry of Health (MOH) regulations and the National Strategy on Reproductive Health and Maternal and Child Healthcare establish that young children should receive a full course of immunizations. Young children are not required to receive well-child visits, which are an important component of children's health care. Regular checks are necessary to identify and treat children who are not developing in a healthy manner.

The GOI could do more to promote the practice of breastfeeding. According to a 2011 International Baby Food Action Network report, Iraq had drafted laws to comply with the International Code on Marketing of Breastmilk Substitutes. It is not clear that this legislation has since been passed and implemented. The Code provides countries with guidance on how to structure policies and regulatory frameworks to encourage breastfeeding and infant feeding according to World Health Organization (WHO) guidelines. Currently no policy mandates that employers provide new mothers with breastfeeding breaks or facilities for breastfeeding.

Between 2008 and 2012 the rate of exclusive breastfeeding for babies below 6 months of age in Iraq was approximately 20 percent (UNICEF MICS). The low rate may be explained by a lack of understanding among the public of the importance of the practice. Breastfeeding could be particularly beneficial in Iraq, where many families do not have consistent access to clean water to mix with formula powder. Dirty water can cause diarrhea, which can have serious health consequences for very young children.

Families may need to be educated on the many health benefits of breastfeeding. Babies who are breastfed have lower incidence of mortality and morbidity than those who are not. It also costs nothing. See box 2 for ideas on how Iraq could promote breastfeeding in ways that would be most appropriate and applicable for the country.

Laws to promote appropriate dietary consumption by pregnant women and children could be expanded. Public Health Law No. 89 (1981) and the National Nutrition Strategy 2012–2021 mandate salt iodization. In the Kurdish Regional Government (KRG), the Ministry of Health is in the process of mandating salt iodization.

Iron fortification of staples, such as wheat or rice, is encouraged but not mandatory. The anemia rates for young children and pregnant women in Iraq are 56 percent and 38 percent, respectively (WHO 2008). According to the WHO, that level of prevalence in young children constitutes a severe public health problem, and that level among pregnant women is a moderate public health problem (WHO 2008). Anemia can have adverse health effects: mild anemia may impair work productivity, and severe cases can increase risk of maternal and child mortality, as well as birth defects.

While those figures may be outdated, they nevertheless suggest that efforts to improve iron consumption may be necessary. The GOI could mandate iron fortification of staples. It could also target nutrition interventions to young children and pregnant women, including through vitamin supplements and provision of iron-rich foods. Parasites may reduce the body's ability to absorb iron, so clean drinking water and access to basic health care may also reduce anemia rates.

National laws promote opportunities for mothers to provide care to newborns and infants in their first year of life but could be further strengthened. The Labor Law No. 71 (1987) gives mothers working in both the public and private sector 72 days of paid maternity leave. Women working for the government can extend this by another 6 months at full pay, and then another 6 months for 50 percent pay. Women in private sector jobs can request an additional 12 months of unpaid leave. No paternity leave (paid or unpaid) is offered.

Box 2. Brazil's Campaign to Promote Breastfeeding

Summary: Brazil's campaign to promote breastfeeding is an example of successful efforts to change public perceptions and health care practices, resulting in a significant increase in breastfeeding. The campaign was initiated in 1980 by the National Food and Nutrition Institute. UNICEF and the Pan-American Health Organization helped to develop public awareness materials that addressed the lack of informational materials on breastfeeding in Portuguese. Instructional brochures were widely distributed to mothers. A media campaign featured radio, television, and print media spots and endorsements by well-known personalities. The WHO and UNICEF held training courses on breastfeeding for health care workers and managers, and the Baby Friendly Hospital Initiative was widely implemented to initiate early feeding. A coalition of actors helped make the campaign a success. The Catholic Church, mothers groups, associations of medical professionals, community leaders, politicians, and the media were all engaged in the effort. The exclusive breastfeeding rate rose from approximately 4 percent in 1986 to 40 percent in 2006.

Key recommendations for Iraq drawing on Brazil's experience:

- ✓ Develop and disseminate Arabic language materials on the benefits of breastfeeding for a variety of audiences. These could include training materials for health care workers, awareness pamphlets for community leaders and nongovernmental organizations (NGOs), and instructional brochures for mothers.
- ✓ Encourage breastfeeding from an Islamic perspective and engage religious organizations and leaders to spread awareness.
- ✓ Train health care workers to educate mothers on the benefits of breastfeeding and to support them to initiate and maintain the practice.
- ✓ Engage the support of NGOs, women's associations, health workers, community leaders, and others.

(*Source:* Implementation of Breastfeeding Practices in Brazil, http://www1.paho.org/English/DD/PUB/NutritionActiveLife-ENG.pdf)

There is no right to return to a job after pregnancy and maternity leave, no explicit prohibition on discrimination based on pregnancy or parental status, and no guarantee of accommodations for breastfeeding. Lack of employment protections for pregnant women and new mothers can make it difficult for them to maintain their jobs while also adequately caring for infants.

The adult female labor force participation rate in Iraq in 2013 was 15 percent (World Bank). The labor force participation rate for women with young children is not clear, but it is likely lower. Ensuring nondiscrimination at the workplace and implementation of longer maternity leave policies for private sector employees could help improve female labor participation. Many families struggle financially to provide the necessities of life. Income earned by a mother can improve her family's access to nutritious food, health care, education, and housing.

Box 3. Key Laws Governing ECD in Iraq

- The Iraqi constitution (2005) provides a right to health care. It obliges the state to protect motherhood and childhood, and guarantees free education at all levels.
- Care for People with Disabilities and Special Needs Law No. 38 (2013) establishes inclusive and equal education and free health care for citizens with disabilities.
- Regulations for State Homes No. 5 (1986) establishes residential care homes for orphans or children whose parents cannot care for them.
- Regulations for Nurseries No. 1 (1992) gives authority to license and supervise nurseries to the Ministry of Labor and Social Affairs and lays out licensing requirements.
- Birth and Death Registration Law No. 148 (1971) requires birth registration with the Ministry of Health.

Iraqi law mandates free education, but very few children receive preprimary education. Iraq's constitution guarantees citizens free education at all levels. The constitution does not specify what these levels are, and preprimary education is not explicitly mentioned. Children must attend first grade, starting at approximately age six. Attendance in preprimary schools in Iraq is very low. UNESCO reported a preprimary net enrollment rate of approximately 7 percent of 2007.

(More recent figures are not available.) The gross enrollment rate was also approximately seven percent.

In 2012 the preprimary net enrollment rate for the Arab region was 25 percent; table 3 shows enrollment rates in several Arab countries. While enrollment has increased across the region in recent years (in 2003, the regional rate was 16 percent), it remains lower on average than in any other region in the world except Sub-Saharan Africa. Even within a region with relatively low preprimary enrollment rates, Iraq's rate of approximately 7 percent stands out as low.

Table 3. Preprimary Enrollment Rates in Arab Countries *(%)*

	Iraq	Egypt	Jordan	Syria	Yemen
Preprimary net enrollment rate (%)	7 (2007)	23 (2012)	34 (2012)	11 (2012)	1 (2011)

Source: UNESCO Institute for Statistics.

In 2011, the Ministry of Labor and Social Affairs (MOLSA) and MOE records indicated the existence of 109 public nurseries (for children below age 4), 661 kindergartens (for children age 4 and 5), and 21,228 primary schools in the federal areas. There were 49 private for-profit nurseries and five private not-for-profit nurseries. By 2013, the number of private for-profit kindergartens had increased to 454, with 6 private not-for-profit schools. That same year there were 400 private primary schools.

In KRG in 2013, there were 389 public kindergartens and 3592 public primary schools, in addition to 403 Kurdish primary schools in Kirkuk province.

The National Strategy for Higher Education 2011–2020 lays out the goal of increasing enrollment in kindergartens (*riyadh*) from 7 percent to 30 percent (Iraq's National Strategy for Higher Education 2011-2020). It also mentions a project to increase awareness of the importance of preprimary education through media, and to provide incentives to poor families and those in remote areas to enroll their children in preprimary school. It is not clear that these activities have been implemented, or if there are any clear plans on how to increase preprimary enrollment.

Child protection laws could be strengthened. The Birth and Death Registration Law No. 148 (1971) requires all births to be registered with the MOH, which provides free birth certificates. Birth registration is a critical component of child protection, and this law has been successful at achieving universal birth registration in the country.

Seventy-nine percent of children undergo violent discipline (UNICEF MICS). This high figure suggests that there may be widespread social acceptance of the use of violence to discipline children. Children who experience violent discipline are at risk of physical harm, psychological trauma, and even difficulty learning. Iraq's constitution states that violence and abuse in the family are prohibited, but there are few policies to this effect. The MOLSA in KRG has established a child protection hotline. The KRG passed the Law against Domestic Violence No. 8 (2011), which covers violence against children. Apart from this, there do not seem to be other policies to target reduction of family violence.

The federal government's legal system does not provide any interventions to protect children in the system. The KRG provides training for judges and specialized courts for children.

The GOI has established some social protection services but has not articulated a social protection policy for young children. According to the Regulation for State Homes No. 5 (1986), the Bureau of Social Services is to establish an office of state homes. These homes provide residential care to orphans and children whose families cannot care for them. It is not clear that these facilities provide or coordinate a range of services for young children besides housing. The GOI also provides financial support to orphans.

The Care for People with Disabilities and Special Needs Law No. 38 (2013) establishes that the MOE is to provide inclusive and equal education for children with special needs, including providing appropriate equipment and materials and training personnel "beginning at the early childhood level." The law mentions primary and secondary school, but preprimary school is not mentioned. Under the same act, the MOH is to provide free health insurance to citizens with disabilities and special needs, offer necessary treatments, and coordinate to provide other necessities of life.

Further discussion of the situation of children with special needs is discussed in the Policy Lever 2.3: Equity section of this report.

Policy Lever 1.2: Intersectoral Coordination

Development in early childhood is a multidimensional process (Naudeau and others 2011; UNESCO-OREALC 2004; Neuman 2007). To meet children's diverse needs during the early years, government coordination is essential, both horizontally across different sectors as well as vertically from the local to national levels. In many countries, nonstate actors (either domestic or international) participate in ECD service delivery; for this reason, mechanisms to coordinate with nonstate actors are also essential.

The GOI does not have a multisectoral ECD strategy. The MOLSA is currently developing a five-year National Child Protection Strategy. The strategy targets children below age 18 and is multisectoral, covering health, education, social protection, and child protection.

No institutional anchor is in place to coordinate ECD across sectors. No government body is designated as leading coordination between the sectors of education, health, nutrition, social protection, and child protection relating to young children. For federal areas, the Child Welfare Commission is responsible for policies affecting children of all ages. In KRG, the High Committee on Child Welfare is the focal agency for children's issues. There does not seem to be any staff on this committee devoted solely to young children, nor are there staff within ministries whose job it is to focus on ECD.

Mechanisms to coordinate services at the point of delivery are not in place. To ensure that children receive appropriate services, services should be coordinated at the point of care and delivery, which also reduces inefficiency. Mechanisms could include regular coordination meetings between implementers at the subnational level, as well as some kind of integrated service delivery manual or common plan of action.

No mechanism exists for collaboration between state and nonstate stakeholders. It is likely that Iraqi nongovernmental organizations (NGOs) and religious institutions provide many health and social welfare services to young children and their families. In some countries, nonstate actors such as these play an important role in delivering services and have close knowledge of the challenges facing families. For this reason, their input can be valuable to policy makers in setting policies.

Policy Lever 1.3: Finance

While legal frameworks and intersectoral coordination are crucial to establishing an enabling environment for ECD, adequate financial investment is key to ensuring that resources are available to implement policies and achieve service provision goals. Investments in ECD can yield high public returns but are often undersupplied without government support. Investments during the early years can yield greater returns than equivalent investments made later in a child's life and can lead to long-lasting intergenerational benefits (Valerio and Garcia 2012; Hanushek and Kimko 2000; Hanushek and Luque 2003). Not only do investments in ECD generate high and persistent returns, they can also enhance the effectiveness of other social investments and help governments address multiple priorities with single investments.

The budget process related to ECD expenditure lacks transparency. The GOI cannot report ECD expenditures, so it is impossible to gauge the level of spending devoted to young children. No explicit criteria are used to set ECD budgets at the national and subnational levels. Determining ECD spending is not a coordinated effort across ministries.

It is difficult to assess if the level of ECD financing is adequate to meet the needs of the population. Total spending on ECD is not known in Iraq, nor is the level of spending by sector available. It should be noted that financing for ECD services can also come from nongovernment sources, but that amount is not known for Iraq.

The burden of finance for ECD may not be distributed equitably across Iraqi society. Cost may be a barrier to accessing services. In the public health care system, the policy is that all preventive services are free, and Iraqi Dinars (ID) 500 (approximately US$0.40) is charged for treatment services. However, nearly half of total health expenditure in the country is out-of-pocket, suggesting that Iraqis use private health care or are paying large fees for their services in the public system. Table 4 shows health expenditure indicators for Iraq compared with other countries in the region.

Public primary schools charge fees for uniforms, meals, and transportation. Public nurseries (for children below

the age of four) in federal areas and KRG charge tuition and fees for meals and transportation costs.

Table 4. Regional Comparison of Select Health Expenditure Indicators[2]

	Iraq	Egypt	Jordan	Turkey	Yemen
Out-of-pocket expenditure as a percentage of all private health expenditure (%)	100	98	77	64	99
Out-of-pocket expenditure as a percentage of total health expenditures (%)	46	60	28	17	72
Government expenditure on health as a percentage of GDP (%)	4	5	10	6	6
Routine EPI vaccines financed by government, 2012 (%)	N/A	100	100	N/A	15

Sources: WHO Global Health Expenditure Database 2012; UNICEF Multiple Indicator Cluster Survey.

The level of remuneration of ECCE teachers may be inadequate to attract high quality personnel. At public early childhood care and education (ECCE) centers, wages are set by the central government. The starting annual pay for teachers of two-to-four-year-olds at public nurseries is ID 380,000 (approximately US$330). Starting pay for teachers at primary schools is ID 594,000 (approximately US$540), meaning teachers at the preprimary age group make 64 percent of primary teachers make when they begin their careers. All employees of MOE receive an ID 150,000 (approximately US$130) monthly incentive. Even with the "incentive," teachers earn far lower than the GDP per capita income of roughly US$6,670 in 2013. On top of this, the disparity in pay between preprimary and primary teachers can discourage talented individuals from pursuing jobs with very young children. There are no standards for wages in private schools and ECCE centers.

Policy Options to Strengthen the Enabling Environment for ECD in Iraq

Legal Framework

➢ **The GOI could mandate iron fortification of staples and take other steps to address anemia.** This could include public awareness on nutrition, more effective distribution of iron supplements for pregnant women and young children, and provision of iron-rich food. The anemia problem may also be related to poor-quality drinking water in many parts of the country, which can cause parasites. Better infrastructure and better primary health care to treat patients with parasites would also likely help reduce the problem.

➢ **The GOI could consider studying the reasons for the low rate of iodized salt consumption despite its salt iodization policy.** This may suggest that the law is not being fully implemented, that salt found in Iraqi markets are imports not required to be iodized, that Iraqis do not consume much salt, or other reasons.

➢ **The GOI could revisit its strategy to promote breastfeeding.** With a breastfeeding promotion program in place, it is likely more could be done to make the practice more widespread. The plan could include measures to promote public awareness on the importance of the practice to promote young children's health and address malnutrition and stunting. Health workers should also be educated to share messages with mothers.

➢ **The GOI could consider ways to increase the demand for and supply of preprimary education.** On the demand side, this could include advocacy work among policy makers to persuade them to support investment in ECE as key to the country's economic development. Public awareness to parents explaining the lifelong benefits of early stimulation and quality preprimary education could raise demand for services. On the supply side, the GOI could consider various modalities of service delivery. This could include attaching preprimary classrooms to primary schools, establishing informal programs at religious and community organizations, and interactive audio instruction. Radio or mobile phone technologies could be used to deliver services. It would be low cost and scalable, and require little infrastructure. Interactive audio instruction has been used to improve learning outcomes in a variety of challenging contexts.

➢ **The GOI could study the best ways to address the problem of violent discipline and child abuse.** A central component of this may be raising public awareness that child abuse is unacceptable. It could also include expanding child abuse tracking and reporting activities, establishing a task force for domestic violence prevention, training health care workers and educators

[2] Out-of-pocket expenditure is any direct outlay by households, including gratuities and in-kind payments, to health practitioners and suppliers of pharmaceuticals, therapeutic appliances, and other goods and services whose primary intent is to contribute to the restoration or enhancement of the health status of individuals or population groups.

to identify child abuse and neglect, and reviewing laws to ensure that they adequately protect children from abuse.

➢ **The legal system could provide training for judges, lawyers, and law enforcement on dealing with young children.** It could also establish a child advocacy body and specialized courts for children.

Intersectoral Coordination

➢ **The GOI could consider developing an explicit ECD strategy.** This could take the form of a multisectoral strategy, or specific ECD strategies within each sector, with a high level of intersectoral coordination. Progress in ECD is far less likely to be achieved without clear goals and a plan of action. Effective ECD frameworks usually have a high-level political endorsement to ensure the prominence of ECD on the national agenda, a defined institutional anchor, and the inclusion of stakeholders from a range of sectors, with clear responsibilities for policy development and implementation.

➢ **The GOI could develop coordination mechanisms for ECD-related agencies.** ECD interventions and policies typically include multiple ministries and government bodies, requiring coordination across ministries. The particular structure of coordination can vary greatly according to the country context, but some mechanisms to promote coordination are essential to ensure effective and efficient services. Nongovernmental stakeholders and service providers should also have a means to collaborate with the government.

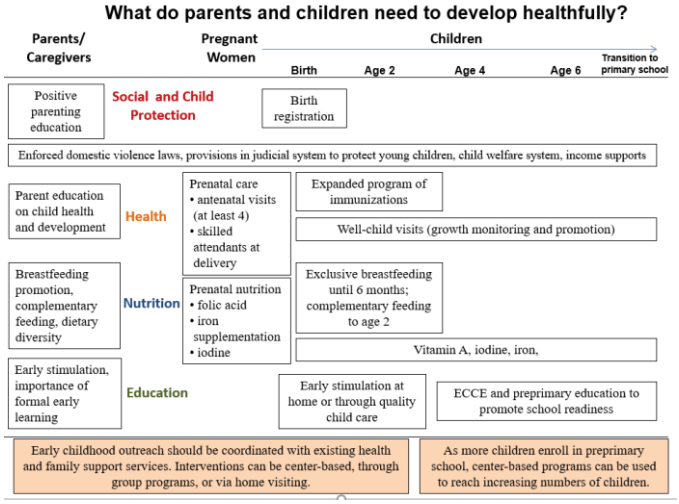
Finance

➢ **The GOI could establish mechanisms to track ECD spending.** It could put in place budgeting and information systems to allow for ECD-specific spending within each ministry and agency budget. It is essential to know how much the government currently spends on ECD or where this money goes.

➢ **The GOI could consider using explicit criteria and formulas to allocate ECD funding, which could promote a more efficient and equitable use of resources.** Criteria could include children's characteristics, such as socioeconomic status and internally displaced status.

➢ **The GOI may need to allocate or mobilize more resources for ECD.** An Organisation for Economic Co-operation and Development (OECD) study suggests that a public investment of one percent of GDP is the minimum required to ensure provision of quality early childhood care and education services. Given the lack of attention paid to the sector, it is likely that is it underfunded.

Policy Goal 2: Implementing Widely



➢ Policy Levers: Scope of Programs • Coverage •Equity

Implementing widely refers to the scope of ECD programs available, the extent of coverage (as a share of the eligible population), and the degree of equity within ECD service provision. By definition, a focus on ECD involves (at a minimum) interventions in health, nutrition, education, social protection, and child protection and should target pregnant women, young children, and their parents and caregivers. A robust ECD policy should include programs in all essential sectors and provide comparable coverage and equitable access across regions and socioeconomic status—especially reaching the most disadvantaged young children and their families.

Policy Lever 2.1: Scope of Programs

Effective ECD systems have programs established in all essential sectors and ensure that every child and expecting mothers have guaranteed access to the essential services and interventions they need to live healthy lives. The scope of programs assesses the extent to which ECD programs across key sectors reach all beneficiaries. Figure 2 presents a summary of the key interventions needed to support young children and their families via different sectors at different stages in a child's life.

Essential health programs exist to target some beneficiary groups. More could be done to support parents. The GOI routinely offers antenatal care, skilled delivery, comprehensive immunizations for infants, and growth-monitoring programs. In Erbil, Dohuk, and Sulaimaniya, mosquito bed nets are distributed to pregnant women and children to help prevent malaria. Well-child exams are not standard and can be crucial to identifying and treating health issues before they become more serious; they are an important part of promoting young children's development.

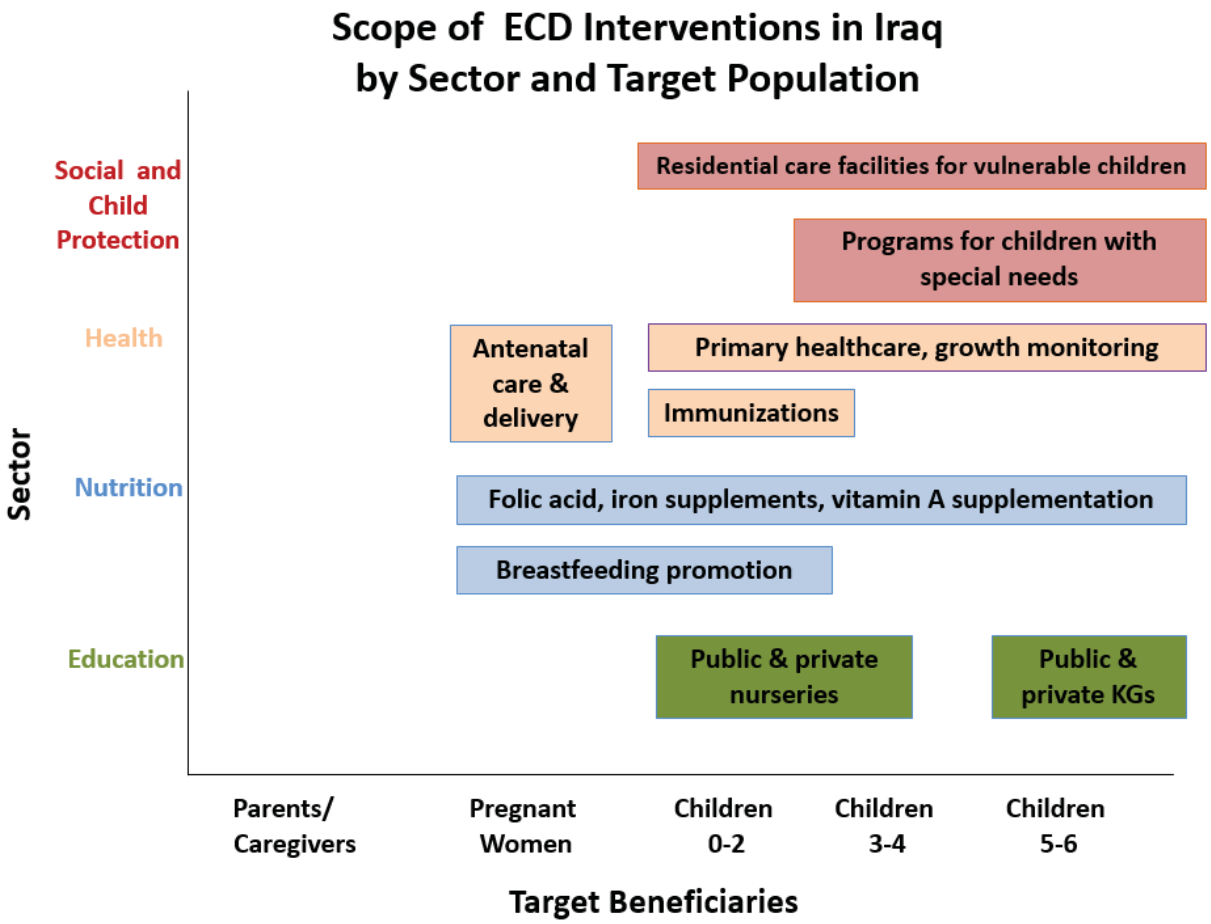
Currently no screenings are offered for maternal depression, nor are support services available for women who may be suffering from this. Given the very challenging situation facing many families in Iraq, it is likely that maternal depression is quite common.

Programs aimed at improving parents' ability to care for and interact with their children can be very beneficial to children's development. Teaching parents about child development and positive parenting skills can help promote children's cognitive and social development. Many parents in Iraq face overwhelming stresses while trying to raise their children in very difficult circumstances. Any support that parents receive will likely benefit their children too.

Several nutrition programs target pregnant women and young children. Folic acid and iron supplements are offered to pregnant women. Young children receive vitamin A supplements. Other nutrition programs include breastfeeding promotion and feeding programs in nurseries (albeit very few children attend nurseries). Food supplements are not provided to pregnant women and young children. Healthy eating and exercise programs do not exist.

Several different types of early childhood care and education programs are in place. Service provision options include public nurseries and kindergartens, as well as private for-profit and not-for-profit kindergartens.

Figure 3. Scope of ECD Interventions in Iraq by Target Population and Sector



Few child protection and social protection programs are in place. Residential care facilities exist for orphans and children whose families cannot care for them, but there are few other child protection programs. No body within MOLSA in federal areas of the KRG is responsible for ECD child protection. No data are available on how many children are in the child protection system.

In the area of social protection, parents employed in the public sector receive a financial benefit per child for up to four children. No antipoverty measures are focused on ECD, such as cash transfers conditional on usage or ECD services. Orphans receive some financial support from the government.

Policy Lever 2.2: Coverage

Emerging

A robust ECD policy should establish programs in all essential sectors, ensure high degrees of coverage, and reach the entire population equitably—especially the most disadvantaged young children—so that every child and expecting mother have guaranteed access to essential ECD services.

Access to essential health interventions for pregnant women could be improved. Approximately 91 percent of women in Iraq have a skilled attendant when giving birth (UNICEF MICS). Forty-nine percent of women receive at least 4 antenatal care visits, and 78 percent of women receive at least 1 visit (UNICEF MICS). Maternal health and child outcomes would likely improve if more women received regular prenatal care. Table 6 shows indicators of access to health interventions for pregnant women and young children in Iraq with regional comparisons.

The level of access to health interventions for young children could be increased. The percentage of Iraqi children below age 5 with diarrhea who receive rehydration therapy is 23 percent (UNICEF MICS). The proportion of one-year-olds vaccinated for DPT3 is 69 percent (UNICEF MICS). A number of low- and middle-income countries have achieved universal or near universal vaccination rates. This requires reaching all children several times to administer a full course of immunizations. The percentage of children with suspected pneumonia who receive antibiotics is 67 percent (UNICEF MICS).

Table 5. ECD Programs and Coverage in Iraq

ECD intervention	Scale	
	Service is provided	Universal coverage
Education		
State-sponsored preprimary/kindergarten education	Yes	No
State-sponsored ECCE	Yes	No
Community-based ECCE	No	No
Health		
Antenatal and newborn care	Yes	No
Integrated management of childhood illnesses and care for development	No	No
Childhood wellness and growth monitoring	Yes	No
National immunization program	Yes	No
Nutrition		
Micronutrient support for pregnant women	Yes	No
Food supplements for pregnant women	No	No
Micronutrient support for young children	Yes	No
Food supplements for young children	No	No
Food fortification	Yes	No
Breastfeeding promotion programs	Yes	Yes
Anti-obesity programs encouraging healthy eating/exercise	No	No
Feeding programs in preprimary/kindergarten schools	Yes	No
Parenting		
Parenting integrated into health/community programs	No	No
Home visiting programs to provide parenting messages	No	No
Special Needs		
Programs for OVCs (boarding schools and children's homes)	Yes	No
Interventions for children with special (emotional and physical) needs	Yes	No
Anti-poverty		
Cash transfers conditional on ECD services or enrollment	No	No
Comprehensive		
A comprehensive system that tracks individual children's needs	No	No

The instability in the country may pose a challenge to the ability of the government to provide consistent services and the families' ability to access these services.

Table 6. Regional Comparison of Level of Access to Essential Health Services for Young Children and Pregnant Women *(%)*

	Iraq	Egypt	Jordan	Turkey	Yemen
One-year-old children immunized against DPT (corresponding vaccines: DPT3) (%)	69	93	98	97	82
Children below five with diarrhea receive oral rehydration/ continued feeding (%)	23	28	20	N/A	33
Children below five with suspected pneumonia taken to health care provider (%)	74	73	77	N/A	44
Pregnant women receiving antenatal care (at least four times) (%)	50	66	94	74	14

Source: UNICEF Multiple Indicator Cluster Survey 2012.

Better coverage of nutrition interventions is necessary to address stunting and anemia. In Iraq 23 percent of children below age 5 are moderately or severely stunted. Stunting is defined as having a height (or length) for age more than 2 standard deviations below the median according to international norms. It is an indicator of chronic malnutrition. Stunting early in life can have long-term effects: it can damage health and reduce an individual's cognitive development, educational performance, and economic productivity. This has negative consequences not only for the well-being of the individual, but the future of the country. As discussed in Policy Level 1.1: Legal Framework, increasing breastfeeding rates would likely be an effective and inexpensive way to decrease stunting rates. Table 7 displays indicators on access to nutrition interventions for young children and pregnant women in Iraq, plus regional comparisons.

In 2005, 56 percent of children below age 5 were anemic, and 38 percent of pregnant women had anemia (WHO Global Database on Anaemia 2008). This suggests that effective nutrition interventions are not reaching vulnerable populations. As discussed previously in this report, this may require a combination of mandating iron fortification of staples, micronutrient and food supplements, better medical and health education, and poverty alleviation for families who cannot afford nutritious food.

Despite mandatory salt iodization, the rate of iodized salt consumption is only 29 percent (UNICEF MICS). This suggests that the policy is not being implemented. It may be worth studying the extent of implementation among Iraqi producers and importers. Salt iodization is very inexpensive, at roughly 5 U.S. cents per year, and yields significant returns on investments.

Table 7. Regional Comparison of Level of Access to Essential Nutrition Services for Young Children and Pregnant Women *(%)*

	Iraq	Egypt	Jordan	Turkey	Yemen
Children below five with moderate/severe stunting (%)	23	29	8	12	58
Infants exclusively breastfed until six months of age (%)	20	53	23	42	12
Infants with low birth weight (%)	13	13	13	11	N/A
Prevalence of anemia in pregnant women (2005) (%)	38	45	39	40	58
Prevalence of anemia in preschool-aged children (2005) (%)	56	30	28	33	68

Sources: UNICEF Multiple Indicators Cluster Survey 2012; WHO Global Database on Anemia.

The net enrollment ratio in preprimary education is very low. As shown in table 3, in 2007 only 7 percent of Iraqi 3-5-year olds attended some kind of preprimary education. It is the exception rather than the norm for an Iraqi child to attend preprimary school.

Birth registration is universal. Birth registration reaches 99 percent of Iraqi children. Table 8 shows birth registration rates in Iraq and several regional countries.

Table 8. Regional Comparison of Level of Access to Birth Registration *(%)*

	Iraq	Egypt	Jordan	Turkey	Yemen
Birth registration (%)	99	99	99	94	17

Source: UNICEF Multiple Indicator Cluster Survey 2012.

Policy Lever 2.3: Equity

Emerging

Based on the robust evidence of the positive effects ECD interventions can have for children from disadvantaged backgrounds, every government should pay special attention to equitable provision of ECD services (Engle and others 2011; Naudeau and others 2011). One of the fundamental goals of any ECD policy should be to provide equitable opportunities to all young children and their families.

Because of limited availability of data, it is difficult to assess if access to ECD services is equitable across different areas of the country. Preprimary enrollment rates are not available for different provinces and districts, so it is not clear how regions compare in terms of enrollment rates. It may be that rates are lower in rural areas.

There is equity in access to preprimary school by gender. Boys and girls attend preprimary school at the same net enrollment rate of 7 percent.

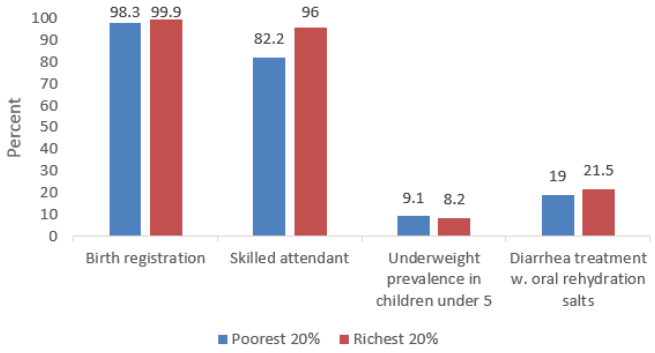
Quality ECCE services may not be accessible to many children with special needs. According to law, the GOI is to provide inclusive and equal education to children with special needs. It is not clear that this happens in education at the preprimary level. (Indeed, the vast majority of children *without* special needs in Iraq receive no preprimary education.)

A government report entitled "Assessment of the Situation of Children with Special Needs and the Services Offered to Them, 2009" describes the Center for Diagnosing Disability as the main service provider for young children with disabilities. The main center is in Baghdad, with 61 other centers in the rest of the federal area provinces. Committees at the centers decide if children should receive special education services starting at age three. Children identified as disabled are referred to specialists, and programs for children with hearing and vision impairments begin at age three. The report says that there are 6,409 beneficiaries at these centers, but clearly many more children have special needs than that. The report describes that many children who need the services are not enrolled for a variety of reasons: their disabilities may be severe, the centers may be too far from their homes, there is no appropriate transportation, or the family is not aware of these services. Centers may not have staff trained to deal with children with special needs.

The curriculum is available in the country's official languages of Arabic and Kurdish. According to Iraq's constitution, children have the right to an education in their mother tongue, which may include Syriac, Armenian, and Turkmen. Despite the existence of this policy, it is not clear that implementation extends to the preprimary level.

There is fairly equitable access to ECD services between socioeconomic levels. As figure 5 shows, access to several key ECD services is fairly equal between the wealthiest and poorest quintiles. Children from the wealthiest households have slightly higher birth registration rates, are slightly less likely to be underweight, and are a bit more likely to receive oral rehydration therapy for diarrhea. The rate of skilled delivery is 15 percentage points higher for wealthier women than for poor women. These disparities are smaller than those that exist in many countries.

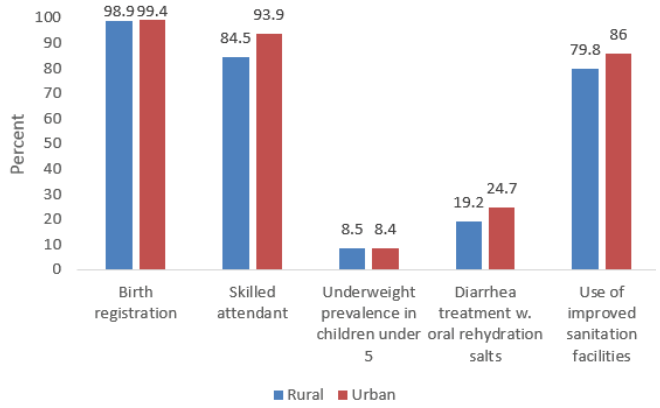
Figure 5. Access to ECD Services by Richest/Poorest Income Quintile



Source: UNICEF Multiple Indicator Cluster Survey

Access to ECD services is slightly lower in rural areas than urban areas, but it is relatively equitable. Iraqis living in rural areas are somewhat less likely to use improved sanitation facilities. Sixty-nine percent of Iraq's rural population had access to an improved water source in 2012 (World Bank) . Infrastructure may be worse in rural areas too. Underweight prevalence is virtually the same between young children in urban and rural areas. The rate of skilled delivery is about nine percentage points higher for women in urban areas than for women in rural areas. Figure 6 shows access rates to ECD services for rural and urban areas in Iraq.

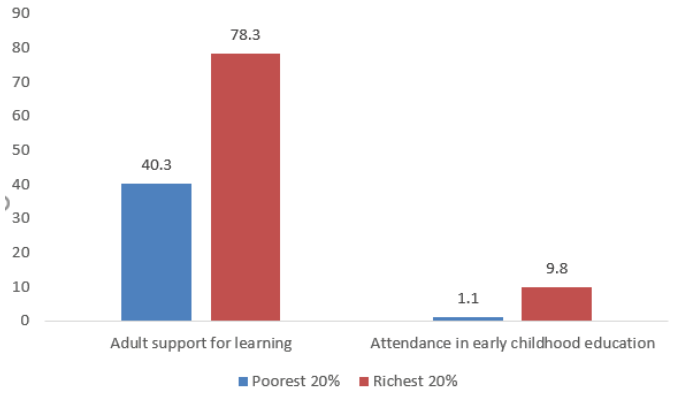
Figure 6. Rural vs. Urban Access to ECD Services



Source: UNICEF Multiple Indicator Cluster Survey

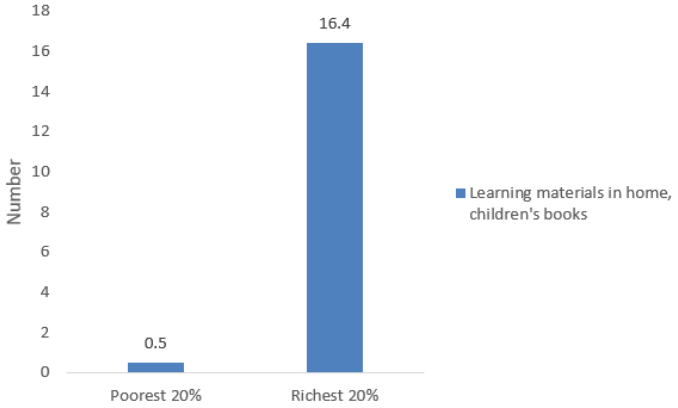
Clear differences are seen in the home learning environments of poorer and wealthier children. While access to some ECD services is fairly equitable between socioeconomic levels in Iraq, stark disparities are found in young children's home environments. As figure 7 shows, children in wealthier homes are much likely to have adult support for learning than children in poorer homes. This can include an adult reading books, singing songs, going outside, telling stories, or naming or counting objects with a child. While only 10 percent of children from the wealthiest quintile attend early childhood education, this is still 9 times higher than the rate of attendance by children in the poorest quintile, who stand to gain the most from preprimary education. Figure 8 shows the disparities in access to children's books in the home among wealthier and poorer children.

Figure 7. Early Learning Indicators by Poorest and Richest Quintiles



Source: UNICEF Multiple Indicator Cluster Survey

Figure 8. Children's Books in the Home by Poorest and Richest Quintiles



Source: UNICEF Multiple Indicator Cluster Survey

Policy Options to Implement ECD Widely in Iraq

Scope of Programs

➢ **The GOI could establish programs to screen and treat maternal depression.** Maternal depression can interfere with a mother's ability to care for and bond with a child and may increase the likelihood of language, cognitive, and behavioral impairments in children as they grow older. Efforts to support mothers and programs to prevent and treat maternal depression can yield high returns. In some places, home visiting programs by community outreach workers and community support groups have been shown to be effective in reducing maternal depression, while also being fairly inexpensive.

➢ **The GOI could establish programs to teach parents about positive parenting methods, child development, and early stimulation.** Such programs could also yield high returns for relatively low investment. These programs could take place through home health visits, or at religious institutions, women's organizations, and community centers.

➢ **The GOI could expand child protection and social protection programs.** This could include support services targeting young children whose families cannot care for them. The GOI could consider establishing financial incentives to poor families to access ECD services.

Coverage

➢ **The GOI could consider developing a comprehensive strategy and plan to increase health access for pregnant women and young children.** While many women and children receive basic health services, too many still do

not have access to these essential services. The lack of health care may stem from a combination of low government capacity to deliver services and a crumbling health care system. The strategy would need to address these issues to be effective.

➢ **The GOI could consider developing a comprehensive strategy to increase access to nutrition services for pregnant women and young children.** This is necessary to address stunting and anemia and may include offering iron supplements and feeding programs, promoting breastfeeding, improving access to health care, and instituting poverty alleviation measures.

Equity

➢ **The GOI could study ways to improve the quality of ECD services available to children with special needs.** These children should be able to attend school, and staff and facilities should be adequately equipped to care for them. Special needs may include obvious physical and mental disabilities, but could also encompass children who have been victims of conflict, displacement, and poverty. These children likely require extra socioemotional support. With properly trained staff, preschool can play an important role in helping children cope with stress and trauma, which in turn promotes their development.

➢ **The GOI could consider ways to support poor parents to enrich their children's learning environment in the home.** Parenting practices and stimulating environments for children can be promoted even in the face of minimal resources. This could include parenting programs on the importance of early stimulation, mobile libraries, and programs aimed specifically at increasing enrollment in ECCE among children from poor families.

Policy Goal 3: Monitoring and Assuring Quality

➢ Policy Levers: Data Availability • Quality Standards • Compliance with Standards

Monitoring and Assuring Quality refers to the existence of information systems to monitor access to ECD services and outcomes across children, standards for ECD services, and systems to monitor and enforce compliance with those standards. Ensuring the quality of ECD interventions is vital because evidence has shown that unless programs are of high quality, the impact on children can be negligible, or even detrimental.

Policy Lever 3.1: Data Availability

Established

Accurate, comprehensive, and timely data collection can promote more effective policy making. Well-developed information systems can improve decision making. In particular, data can inform policy choices regarding the volume and allocation of public financing, staff recruitment and training, program quality, adherence to standards, and efforts to target children most in need.

Administrative data on access to ECD and outcomes are not widely available, but many types of survey data are collected. A few types of administrative data for Iraq are available; these figures reflect total uptake of services and are gathered through a census. Available data include the number of children enrolled in public and private ECCE centers, training of education service providers, and child outcomes in education, health, and nutrition. Data on usage by young children of health, nutrition, social protection, and child protection services are not available. Table 9 displays several types of administrative data that are important to track in an ECD system, with an indication of whether these are tracked in Iraq.

Survey data are available for many indicators, often

through the UNICEF's Multiple Indicator Cluster Survey (MICS). Survey data are based on sampling a specific population and can yield useful information on levels of access to key ECD services. Table 9 displays several types of survey data that can be important for an ECD system to track, and an indication if these are tracked in Iraq.

Some data are available to differentiate access to ECCE by background characteristics. The GOI collects data on enrollment in preprimary education by gender, urban/rural location, and subnational region. It does not collect data in a manner that can identify enrollment by special needs status, mother tongue, ethnicity, or socioeconomic status.

Table 9. Availability of Data to Monitor ECD in Iraq

Administrative Data	
Indicator	**Tracked**
ECCE enrollment rates by region	X
Special needs children enrolled in ECCE (number of)	X
Children attending well-child visits (number of)	X
Children benefiting from public nutrition interventions (number of)	X
Women receiving prenatal nutrition interventions (number of)	X
Children enrolled in ECCE by subnational region (number of)	✓
Average per student-to-teacher ratio in public ECCE	✓
Is ECCE spending in education sector differentiated within education budget?	X
Is ECD spending in health sector differentiated within health budget?	X
Survey Data	
Indicator	**Tracked**
Population consuming iodized salt (%)	✓
Vitamin A supplementation rate for children 6–59 months (%)	X
Anemia prevalence among pregnant women (%)	✓
Children below the age of five registered at birth (%)	✓
Children immunized against DPT3 at age 12 months (%)	✓
Pregnant women who attend four antenatal visits (%)	✓
Children enrolled in ECCE by socioeconomic status (%)	X

Data are collected to measure child development in kindergartens but may not be applied in any useful way. Kindergarten teachers record information on individual children's cognitive, linguistic, physical, and socioemotional development on child assessment cards. It is not clear that these data are aggregated and analyzed at any higher level, but just remain with each teacher.

Policy Lever 3.2: Quality Standards

Emerging

Ensuring quality ECD service provision is essential. A focus on access—without a commensurate focus on ensuring quality—jeopardizes the very benefits that policy makers hope children will gain through ECD interventions. The quality of ECD programs is directly related to better cognitive and social development in children.

Learning standards are established for ECCE. In 1978 MOE introduced learning standards for early childhood education. These include developing motor, linguistic, social, artistic, and scientific skills, as well as knowledge of good health, nutrition, and exercise habits.

Two kindergarten curriculum guidelines are available from MOE: Educational Experiences (2012) and Educational Activities (2012). Educational experts developed these curricula, and they are intended to be coherent and continuous with the primary school curriculum. They cover all relevant subjects except physical education and art.

Entry requirements to become a preprimary teacher are minimal. Preprimary teachers must have completed upper-secondary school, and there is a preference for teachers who have completed a postsecondary course in education. However, some teachers who were hired before this requirement came into effect have not completed this level. No additional certifications are required. There is no requirement for teachers to complete a preservice practicum.

In KRG, MOE has raised the minimum qualification for primary school teachers to a Bachelor's degree in education. It has also begun a program to help current teachers meet these new standards.

In-service training opportunities are not regularly available for teachers. No requirements are in place for preprimary teachers to participate in in-service training, nor are there are any standard training courses. Many in-service programs are conducted based on support from international organizations and are not conducted in any systematic fashion.

Health workers are not required to receive training on delivering ECD messages. In many countries, frontline health care providers including doctors, midwives, nurses, and extension health service workers are trained on sharing messages on developmental milestones,

positive parenting, and early stimulation for young children. Since most parents of young children have contact with these workers, it can be a good opportunity to share this information.

Basic service delivery standards are established. Standards are established for teacher-to-child ratios in preprimary classes. For children below age one, it is 1:8; for one-to-two-year-olds, it is 1:10; for two-to-three-year olds, it is 1:15; for three-to-four-year-olds, it is 1:20; and for four-to-six-year-olds, it is 1:25. These are fairly high given the ages of the children. Particularly at the younger ages, ratios this high could mean lack of adequate caregiving and an unsafe environment.

Kindergartens are supposed to be open for a minimum of five hours a day, five days a week.

Many of the service delivery requirements for preprimary facilities are laid out in the Regulations for Nurseries No. 1 (1992). This law gives MOLSA the authority to open, operate, license, and supervise nurseries. It also spells out facilities requirements, such as space requirements, cooling and ventilation, refrigeration, separate kitchen facilities, sleeping space, age-appropriate furniture, and sanitary facilities. It also gives requirements for staff (all must be women, except the guard, who must be male). It states that nurseries are to establish conditions for children's natural and health growth and to "protect children from psychological and social deviations." The document does not seem to have been prepared by ECD experts.

The Regulations for Nurseries and several other regulations concerning education in Iraq are from the Baathist era, and the language they employ reflects this. It may be appropriate for the GOI to revisit these regulations and revise them according to the country's principles, informed by ECD specialists.

ECCE centers are not required to meet any construction standards. Standards requiring potable water and hygienic facilities apply to public nurseries and private nurseries, kindergartens, and primary schools. These standards do not apply to all public kindergartens and primary schools. It is not clear why this is the case.

No construction standards are in place for any public or private ECCE centers. A strong set of construction standards would typically include requirements for electricity, a roof, a floor, windows, structural soundness, and appropriate construction materials. The MOH has established construction standards for both public and private hospitals and health centers.

The MOLSA is responsible for licensing nurseries. In accordance with Regulations for Nurseries No. 1 (1992), MOLSA issues licenses to nurseries that comply with the regulations laid out in the document. If a nursery violates these conditions, MOLSA is to notify it to this effect. If the nursery does not remedy the violation within 15 days, it has another 30-day period to address it, after which the ministry can withdraw its license.

Policy Lever 3.3: Compliance with Standards

Establishing standards is essential to providing quality ECD services and to promoting the healthy development of children. Once standards have been established, it is critical that mechanisms are put in place to ensure compliance with standards.

It is difficult to gauge what proportion of ECCE professionals comply with qualification requirements. Given the available data from the MOE Statistical Department, it seems that approximately 25 percent of ECCE teachers in federal areas comply with the requirement of completion of upper secondary school.

Public ECCE facilities comply with some service delivery standards. Data on compliance with service delivery standards in private ECCE centers are not available. In federal areas, the teacher-to-child ratio in public kindergartens for children aged four to six is 1:28.9 in urban areas and 1:25.9 in rural areas. These are slightly above the established standard of 1:25. In KRG the average teacher-to-child-ratio is 1:16.3 for the same age group. It seems that most schools comply with the standard of a minimum of 25 hours of operation a week.

As there are no standards for construction for either public or private ECCE centers, there is no compliance to gauge.

Policy Options to Monitor and Ensure ECD Quality in Iraq

Data Availability

➢ **Data collection and monitoring are important features of a strong ECD system and are necessary for identifying needs and assessing programs.** The GOI could expand the administrative data it collects, particularly the number of young children and women reached by health, nutrition, social protection, and child protection programs.

➢ **Preprimary schools could use data collected by teachers using the child assessment cards in a much more effective manner.** Ideally these data would be used to identify children experiencing developmental delays and provide early interventions to address them. Additionally, these data could be analyzed to gain an understanding of the situation of children in preschools. They could be used to set a baseline, determine priorities for intervention, and evaluate program impact.

Quality Standards

➢ **MOE could consider ways to improve the quality of preprimary teachers.** This could include some kind of preservice training, and regular, mandatory in-service training. Teachers working with young children need to have some knowledge of child development and pedagogy and a familiarity with the curriculum.

➢ **GOI could establish construction standards for all ECCE facilities**. The current lack of construction standards puts children's safety at risk. Current structures may not be structurally sound or sanitary. At the same time, compliance mechanisms could also be established to enforce these standards.

Compliance with Standards

➢ **The GOI could establish mechanisms to monitor ECCE centers for service delivery requirements.** It may need to establish incentives for facilities to meet standards and offer support so that they can improve their services if necessary. This will likely require training MOE and local education officials on ECD principles, and developing their commitment to supervision based on an understanding of the importance of these programs.

Comparing Official Policies with Outcomes

The existence of laws and policies alone does not always guarantee a correlation with desired ECD outcomes. In many countries, policies on paper and the reality of access and service delivery on the ground are not aligned. Table 10 compares ECD policies in Iraq with ECD outcomes.

The GOI has been successful at implementing mandatory birth registration, achieving universal coverage. The policy to iodize salt is less effective, with less than one-third of households consuming iodized salt. While public preprimary education is free (but not mandatory) under the Iraqi constitution's stipulation to provide free education at all levels, relatively few children attend preprimary school. In reality, Iraq has very few preprimary schools. It is not common for young children to receive this level of education, especially among poorer families. Young children are required to complete a full course of vaccinations, but approximately 30 percent of one-year-olds have not received a full course of DPT3 immunizations (UNICEF MICS). Table 10 compares ECD policies in Iraq with their outcomes.

Table 10. Comparing ECD Policies with Outcomes in Iraq

ECD policies	Outcomes
Iraq has national policy to encourage the iodization of salt →	Household iodized salt consumption **29%**
Preprimary school is free but not compulsory in Iraq →	Preprimary school enrollment: **7%**
Young children are required to receive a complete course of childhood immunizations →	Children with DPT3 (12–23 months): **69%**
Policy mandates the registration of children at birth in Iraq →	Completeness of birth registration: **99%**

Sources: UNICEF Multiple Indicator Cluster Survey, UNESCO UIS, World Bank SABER-ECD Policy Instrument for Iraq

Preliminary Benchmarking and International Comparison of ECD in Iraq

Table 11 presents the classification of Iraq's ECD policy within each of the 9 policy levers and 3 policy goals. The SABER-ECD classification system does not rank countries according to any overall scoring; rather, it is intended to share information on how different ECD systems address the same policy challenges.

Table 12 presents the status of ECD policy development in Iraq alongside a selection of other countries. Sweden is home to one of the world's most comprehensive and developed ECD policies and achieves a benchmarking of "Advanced" in all nine policy levers. Iraq's GNI per capita, using the Atlas method, in 2013 was US$6,710, making it an upper middle income country. Jamaica is included because it has a slightly lower GNI than Iraq (US$5,220), and Colombia's is slightly higher (US$7,560). In comparison with Jamaica and Colombia, Iraq performs the same or worse on policy levers. Yemen is the one other Middle East and North Africa (MENA) country in which SABER-ECD has been conducted. (Tunisia and Lebanon are currently under study.)

Table 11. Benchmarking Early Childhood Development Policy in Iraq

ECD policy goal	Level of development	Policy lever	Level of development
Establishing an enabling environment	●○○○	Legal framework	●○○○
		Intersectoral coordination	●○○○
		Finance	●○○○
Implementing widely	●●○○	Scope of programs	●●○○
		Coverage	●●○○
		Equity	●●○○
Monitoring and Assuring Quality	●●○○	Data availability	●●●○
		Quality standards	●●○○
		Compliance with standards	●○○○
Legend:	Latent ●○○○	Emerging ●●○○	Established ●●●○	Advanced ●●●●

Table 12. International Classification and Comparison of ECD Systems

ECD policy goal	Policy lever	Level of development				
		Iraq	Colombia	Jamaica	Sweden	Yemen
Establishing an enabling environment	Legal framework	●●○○	●●●○	●●●○	●●●●	●●○○
	Coordination	●○○○	●●●○	●●●○	●●●●	●●●○
	Finance	●○○○	●●●○	●●○○	●●●●	●○○○
Implementing widely	Scope of programs	●●○○	●●●○	●●●○	●●●●	●●○○
	Coverage	●●○○	●●●○	●●●○	●●●●	●○○○
	Equity	●●○○	●●○○	●●●○	●●●●	●○○○
Monitoring and Assuring Quality	Data availability	●●●○	●●●○	●●●●	●●●●	●●○○
	Quality standards	●●○○	●●○○	●●●○	●●●●	●●○○
	Compliance with standards	●○○○	●●○○	●●○○	●●●●	●○○○

Legend:	Latent	Emerging	Established	Advanced
				

Conclusion

The SABER-ECD initiative is designed to enable ECD policy makers and development partners to identify opportunities for further development of effective ECD systems. This Country Report presents a framework to compare Iraq's ECD system with other countries in the region and internationally. Each of the nine policy levers is examined in detail, and some policy options are identified to strengthen ECD are offered.

Table 13 summarizes the key policy options identified to inform policy dialogue and improve the provision of essential ECD services in Iraq. Iraq has undergone years of conflict and instability, at great cost to its children and families. Early childhood development has not yet been a priority of the government. Given the compelling body of evidence of the importance of investing in young children, Iraq should strongly consider focusing attention and resources on this area. While crisis seems to follow crisis, and other more immediate concerns may seem to demand priority, another generation of children grows up without the support to develop their full potential. Investing in Iraqi children may be the best investment Iraq can make in its future.

Table 13. Summary of Policy Options to Improve ECD in Iraq

Policy dimension	Policy options and recommendations
Establishing an enabling environment	• Mandate iron fortification of staples, expand salt iodization, promote breastfeeding, and increase coverage of other nutrition interventions to address anemia and stunting • Update existing legislation concerning ECD to reflect recent evidence in the field and the country's values • Expand policies and programs to address violent discipline and child abuse • Develop a multisectoral ECD strategy and implementation framework • Establish coordination mechanisms across ministries and ECD service providers • Establish mechanisms to track the level of spending on ECD in the country
Implementing widely	• Establish programs to screen and treat maternal depression • Establish programs to support parents to provide positive parenting, early stimulation, and enrich their children's home learning environment, especially those in poorer families • Consider different modalities to expand preprimary enrollment, while ensuring quality • Launch a public awareness campaign to educate the public and government officials on the importance of ECD • Examine barriers to access to existing health and nutrition programs • Examine the steps necessary to increase access of children with special needs to preprimary education and other support services. This includes displaced children and children who have experienced psychological trauma.
Monitoring and Assuring Quality	• Expand administrative data collected on access and outcomes in health, nutrition, social protection, and child protection • Establish preservice and in-service teacher for preprimary teachers to upgrade their skills • Establish construction standards for all ECCE centers to ensure children's safety, and mechanisms to monitor for compliance

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Acronyms

ECCE	early childhood care and education
ECD	early childhood development
ECE	early childhood education (used interchangeably with *preprimary* or *preschool*)
GNI	gross national income
GOI	Government of Iraq
KRG	Kurdish Regional Government
MICS	Multiple Indicator Cluster Survey
MOE	Ministry of Education
MOH	Ministry of Health
MOLSA	Ministry of Labor and Social Affairs
NGO	nongovernmental organization
OECD	Organisation for Economic Co-operation and Development
SABER	Systems Approach for Better Education Results
WHO	World Health Organization

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The **Systems Approach for Better Education Results (SABER)** initiative collects data on the policies and institutions of education systems around the world and benchmarks them against practices associated with student learning. SABER aims to give all parties with a stake in educational results—from students, administrators, teachers, and parents to policymakers and business people—an accessible, detailed, objective snapshot of how well the policies of their country's education system are oriented toward ensuring that all children and youth learn.

This report focuses specifically on policies in the area of **Early Childhood Development.**

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