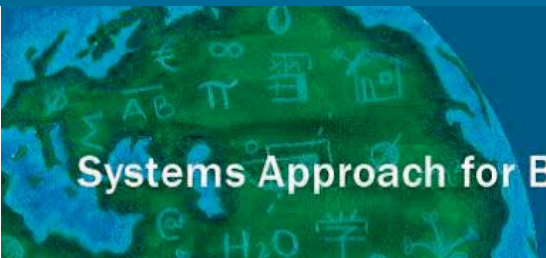
100061

The Democratic Republic of Congo

EARLY CHILDHOOD DEVELOPMENT

SABER Country Report
2014

Policy Goals	Status
1. Establishing an Enabling Environment The 2012 National Policy on the Integrated Development of the Young Child and the inclusion of ECCE in the recently revised National Education Law of 2014 are important achievements toward the construction of a strong ECD system. However, these frameworks lack government endorsement and costed implementation plans. Tracking and allocating a clear budget toward ECD could also improve effectiveness of delivery.	Emerging
2. Implementing Widely The Democratic Republic of Congo has some of the highest under-five mortality rates in the region and one of the lowest enrollment rates for preprimary education. The devastation of the five-year conflict (1998 to 2003) made it difficult to provide comprehensive ECD services to children in their early years. Despite established health, nutrition, and education services in all provinces, few are mandatory and most have fees, making access difficult for most of the population.	Emerging
3. Monitoring and Assuring Quality Data to monitor standards and ensure quality are not available. Standards for learning environments such as infrastructure exist but are not enforced, and although there are no standards for number of students per teachers, the national average is above international standards, with overpopulated classrooms that make it difficult for educators to teach.	Emerging



Systems Approach for Better Education Results

WORLD BANK GROUP

Overview

This report presents an analysis of the Early Childhood Development (ECD) programs and policies that affect young children in the Democratic Republic of Congo and recommendations to move forward. This report is part of a series of reports prepared by the World Bank using the SABER-ECD framework[1] and includes analysis of early learning, health, nutrition, and social and child protection policies and interventions in Democratic Republic of Congo, along with regional and international comparisons.

The Democratic Republic of Congo and Early Childhood Development

Situated in central Africa, the Democratic Republic of Congo is the second largest country in Africa by area and the eleventh largest in the world. The mainly francophone country of 75 million people is recovering from Africa's ''world war'' in which millions died between 1998 and 2003. Nearly half of the victims were children under five years of age who died from malaria, diarrhea, pneumonia, and malnutrition. Eastern regions continue to be unstable despite the 2013 peace agreement.

The devastation of the five-year conflict made it difficult to provide comprehensive and key ECD services to children in their early years. As a result, the Democratic Republic of Congo has some of the highest under-five mortality rates in the region, as shown in table 1. Enrollment rates for preprimary education are also unsatisfactory with just 4 percent of children enrolled, well below the regional average of 20 percent.

However, the country has taken steps to include ECD within its national education policy. In 2012 a multisectoral ECD strategy was endorsed by nine relevant government sectors. Also in 2012, the Ministry of Education formalized an institutional anchor to coordinate ECD across sectors that had started in 2006 as a working group. And in 2014, the country's revised national education law, Cadre de l'enseignement National 2014, included guaranteeing children ages three through five preschool education (although the law does not make it mandatory or free).

The Democratic Republic of Congo has much to do to ensure the necessary services for children to reach their full potential, but building blocks are established.

Table 1: Snapshot of ECD Indicators in the Democratic Republic of Congo with Regional Comparison

	Congo, Dem. Rep.	Angola	Nigeria	Burundi	Cameroon	Zambia
Infant mortality (deaths per 1,000 live births, 2012)	100	100	78	67	61	56
Under-5 mortality (deaths per 1,000 live births, 2012)	146	164	124	104	95	89
Moderate and severe stunting (under 5, 2008–12)	43.4%	29%	35.8%	57.7%	32.5%	45.4%
Attendance in early childhood education (2005–12)	4.9	N/A	42.6	4.7	N/A	N/A
Birth registration (2005–12)	27.8%	36%	41.5%	75.2%	61.4%	14%

[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 countries' 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.

Box 1 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

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, etc.)
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 for young children) • Training for law enforcement officers in regard to the particular needs of young children

Figure 1: Three Core ECD Policy Goals

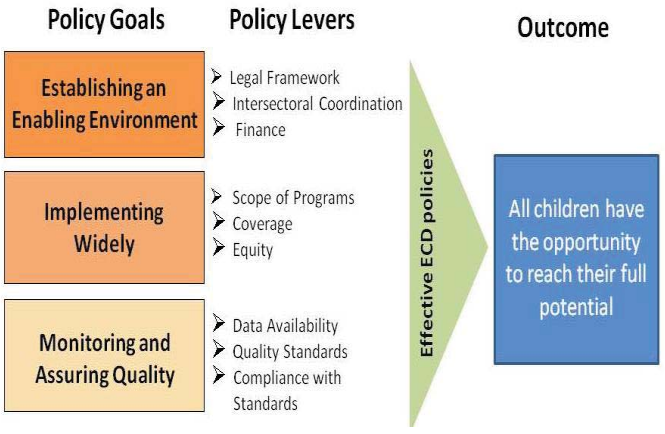


Table 2: ECD Policy Goals and Levels of Development

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 Assuring 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.[2] *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 of the laws and regulations that can affect the development of young children in a country. The laws and regulations that impact ECD are diverse because of 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.

National laws and regulations promote appropriate health care for pregnant women and young children, but at a cost. The Democratic Republic of Congo does not provide free antenatal visits or skilled attendants. The Health Ministry, in its 2011 Standards and Guidelines for Maternal, Newborn, and Child Integrated Interventions, recommends four prenatal consultations, but they are not free. The country does provide, however, standard health screenings for HIV and STDs for pregnant women, with follow-up procedures and referral services. As stated in the National Vaccination Program, young children are required to receive a complete course of childhood immunizations and well-child visits on a regular basis.

National laws and regulations promote appropriate dietary consumption by pregnant women and young children. Box 2 includes the most relevant laws governing early childhood in the country. Per the National Nutrition Policy, salt iodization is encouraged by national policy, but it is not mandatory, as is the fortification of cereals/staples with iron. In addition, the country has taken measures to legislate some aspects of the International Code of Marketing of Breast Milk Substitutes—an international health policy framework

[2] Britto, Yoshikawa, and Boller 2011; Vargas-Barón 2005.

for breastfeeding promotion adopted by the World Health Organization.

Box 2: Key Laws and Regulations Governing ECD in the Democratic Republic of Congo

- Framework for the National Education Law (2014)
- National Policy on the Integrated Development of the Young Child (2012)
- Standards and guidelines on integrated interventions for maternal, newborn, and children's health in the Democratic Republic of Congo (2011)

Other Laws and Policies Protecting Women and Children

- National Action Plan to Support Orphans and Vulnerable Children (2010)
- National Nutrition Policy (2013)
- Child Protection Act (2009)
- National Action Plan for the Prevention and Fight against Violence against Children in the Democratic Republic of Congo (2009)
- Labor Code (2002)
- National Program for Reproductive Health (2001)
- Family Code (2002)

Policies provide suitable opportunities for parents and caregivers to provide care to newborns and infants in their first year of life. Upon pregnancy, women have the right to suspend their work for 14 consecutive weeks, a maximum of eight weeks postpregnancy and six before childbirth. During this period, whether the child lives or not, the employee is entitled to two-thirds of her salary and continuation of the contractual benefits. Article 30 of the Labor Code also states that pregnancy should not be considered a cause for termination. Table 3 provides a regional comparison of maternity and paternity policies for the country. The Democratic Republic of Congo follows some guidelines in accordance with the ILO Maternity Protection Convention, such as women are guaranteed breastfeeding breaks and protection from employment discrimination, but it does not guarantee breastfeeding facilities. However, because of the high extent of the informal economy, many women do not benefit from maternity policies.

The education law does not mandate the provision of free preprimary education before primary school entry. The country's most recent national education law, the Framework for the National Education Law (Cadre de l'Enseignement National), 2014, guarantees children ages three through five preschool education but does not address its free provision. Most of the preprimary education is administered and provided by the private sector.

Child protection policies and services have been established, but little is done to promote the reduction of family violence. A policy mandates the registration of children at birth within the 2002 Family Code.

Table 3: Regional Comparison of Maternity and Paternity Leave Policies

Congo, Dem. Rep.	Cameroon	Burundi	Nigeria
98 days mandatory minimum paid maternity leave; fathers have a right to paternity leave with a minimum of 2 days of mandatory paid paternity leave	98 days mandatory minimum paid maternity leave; fathers have a right to paternity leave with a minimum of 3 days mandatory minimum paid paternity leave	84 days mandatory minimum paid maternity leave; fathers have a right to paternity leave with a minimum of 4 days mandatory minimum paid paternity leave	84 days mandatory minimum paid maternity leave; fathers do not have a right to paternity leave

Source: World Bank Women, Business, and the Law Database 2014.

The national judicial system also provides the following specific protections to young children: specialized training for judges, lawyers, and law enforcement officers and establishment of specialized courts and a child advocacy body. However, the government does little to promote the reduction of family violence and acts only if a complaint is filed or reported to the police. No training to prevent violence is provided to ECCE teachers, health workers, or family members, and no system is in place to report or track child abuse.

Social protection policies and ECD services do not reach vulnerable children. The country has a policy to provide orphans and vulnerable children with ECD services—the National Action Plan to Support Orphans and Vulnerable Children—but this policy has not been implemented. No laws are in place to protect the rights of children with disabilities and promote their participation and access to ECD services.

Policy Lever 1.2: Intersectoral Coordination

Latent

Development in early childhood is a multidimensional process.[3] 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.

There is an explicitly stated multisectoral ECD strategy. This strategy—Politique Nationale du Developpement Integré du Jeune Enfant (National Policy on the Integrated Development of the Young Child)—was established in 2006 but is not implemented. The strategy is endorsed by eight relevant sectors, which include the Ministry of Primary, Secondary, and Professional Education, Ministry of Tertiary and University Education, Ministry of Justice, Ministry of Planning, Ministry of Public Health, Ministry of Finance, Ministry of Budget, Ministry of Communication Media and New Citizen, as well as UNICEF, but lacks a costed implementation plan validated by the government.

A working group has been established to coordinate ECD across sectors but is not active. The working group was established in 2006 and was formalized by ministerial decree in 2012. Although the working group is composed of focal points, staff is not officially appointed. The decree establishes for the working group to meet once a month to discuss upcoming activities and evaluate what has been done in terms of ECD in the country, but this is not enforced.

No coordinated interventions ensure that children receive integrated services. The multisectorial working group was commissioned in 2012 by ministerial decree to be in charge of intensive work to elaborate a comprehensive national policy for the ECD in the Democratic Republic of Congo. A document was developed, called the National Policy on the Development of the Young Child, but lacks an implementation plan and has not been endorsed by the government yet. Currently only a couple of programs involve more than one ministry, shown in table 4.

Table 4: Multisectorial Programs in the Democratic Republic of Congo

Multisectoral Programs	Ministries Involved
Parenting Education Program	• Ministy of Primary, Secondary, and Professional Education • Ministry of Health and Nutrition • Ministry of Social Affairs
National School Health Program	• Ministy of Primary, Secondary, and Professional Education • Ministry of Health and Nutrition

Also, no mechanisms are in place for collaboration between government and nonstate stakeholders. UNICEF is the government's main partner for integrated ECD services.

Policy Lever 1.3: Finance

Latent

Although 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

[3] Naudeau et al. 2011; Neuman 2007; UNESCO-OREALC 2004.

child's life cycle and can lead to long-lasting intergenerational benefits.[4] 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 country does not have a transparent budget process for ECD spending. No explicit criteria are established to decide ECD spending at the national or subnational level. The country does not allocate specific budget for ECCE: Expenditures for ECCE are incorporated with that of primary education (Table 5). No reports are issued on the amount spent for ECD within the health, nutrition, and social protection sectors. The country does, however, report on funds given toward these sectors from external sources.

Table 5: ECD Budget across Sectors in the Democratic Republic of Congo for 2011 and 2012

	2011	2012
Education (primary and preprimary education)	$493,398,873	$470,447,130
Health	Not available	Not available
Nutrition	Not available	Not available
Protection	Not available	Not available

Source: Ministry of Budget estimates.

National laws and regulations promote appropriate health care and nutrition for pregnant women and young children, but almost all services require user fees. Among these fees are treatments for infectious diseases, medical consultations, and children's emergency services, as well as school fees such as uniforms, mandatory exams, contributions for teacher salaries, and transportation fees. Costs are not uniform and depend on the community. Antiretroviral treatment of HIV/AIDS and Prevention of Mother to Child Transmission of HIV/AIDS is free, but parents still have to pay fees for the consultation and doctor's appointment. Vaccine coverage (diphtheria, pertussis, and tetanus [DPT]) is also free, but parents have to pay for the vaccination carnet. Parents and the community also pay the salaries of community-based child care center professionals and health service professionals. Depending on the community, parents' school fees per child can range from $5 to 55 a month.

Data from the government are not available for health and nutrition expenditures. Data from the World Health Organizations report that in 2012 the amount spent on health care per capita was $15, 32 percent of which was from households' out-of-pocket (around $6). Out-of-pocket expenditure as a percentage of all private health expenditure is 66.8 percent—the lowest compared with the five comparison countries: Angola, Burundi, Cameroon, Nigeria, and Zambia (see table 6). Substantial investment in health and nutrition comes from international donors, such as USAID, UNICEF, the governments of Belgium and the European Union, and nongovernmental organizations such as the Global Alliance for Vaccines and Immunisation.

Table 6: Regional Comparison of Select Health Expenditure Indicators[5]

	Congo, Dem. Rep.	Cameroon	Zambia	Burundi	Angola	Nigeria
Out-of-pocket expenditure as a percentage of private expenditure on health	66.8%	94.2%	66.7%	69.7%	70.5%	95.7%
Private expenditure of health as a percentage of total expenditure on health	48.7%	66.5%	35.9%	40.5%	37.8%	68.9%
General government expenditure on health as a percentage of GDP	3%	2%	4%	5%	2%	2%
Routine EPI vaccines financed by government, 2012	10.6%	13.1%	No data	6.7%	100%	No data

Sources: WHO Global Health Expenditure Database 2012; UNICEF MICS Country Statistics.

[4] Hanushek and Kimko 2000; Hanushek 2003; Valerio and Garcia 2012; WHO 2005.

[5] 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.

Policy Options to Strengthen the Enabling Environment for ECD in the Democratic Republic of Congo

Legal Framework

➢ **Develop frameworks for children to age three.** In a country where close to 80 percent of people cannot afford the most basic nutritional needs, few families can afford access to health and nutrition interventions for their child's early years. It is important that the government consider making nutritional and health programs mandatory and more easily accessible to all.

Intersectoral Coordination

➢ **The government could consider endorsing an ECD national strategy.** The country has taken important steps to bring together focal points from different sectors to draft an ECD strategy, but unless is it endorsed by the government and includes a costed implementation plan, there will be insufficient commitment from the most important actors to implement it.

➢ **Include nongovernment actors in the conversation.** The private sector makes up more than half of the ECD service provision in the country. Including this sector in the conversation will be vital to find cost-effective ways to provide ECD services to all children.

➢ **Develop action plans for the National ECD Strategy on federal and provincial levels.** The current National Policy on the Integrated Development of the Young Child lacks a costed implementation plan. Additionally, despite the decentralization process that the country is going through, it does not mention the role of the provincial governments in reaching the set goals.

Finance

➢ **Establish a system to track investment in ECD. The** government of the Democratic Republic of Congo could consider adopting a methodology to track expenditure on programs involving children to age six. Each ministry could disaggregate program spending by ECD age group. The government could also continue to track investment on ECD from external sources and could include the private sector to have a full spectrum of ECD investment in the country. This type of financial information would help policy makers know where to best and more cost-effectively allocate resources.

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, and social 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

Emerging ●●○○

Effective ECD systems have programs established in all essential sectors and ensure that every child and expectant mothers have guaranteed access to the essential services and interventions they need to live healthfully. 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.

ECD interventions are mostly stablished in the health and nutrition sector, with a few programs focused on education and social protection. Figure 3 shows a selection of programs in the education, health, nutrition, and child and social protection sectors that target a range of beneficiaries in the Democratic Republic of Congo. The National Program for the Fight against Malaria and the National Program for Reproductive Health have a list of essential health interventions that are provided to all 11 provinces. Among these interventions are distribution of bed nets for pregnant women and children, prenatal health care, full immunizations for children, well-child visits and growth monitoring of young children, parental training on child development in health or community centers, and home visiting programs to promote health within parents—although not all interventions are free. However, health workers are not required to complete training in delivering messages on early childhood development. In

terms of ECD programs in the nutrition sector, three programs exist to target pregnant women and children: programs that promote breastfeeding, micronutrient support/food supplementation for pregnant women, and complementary feeding for children. A health program that covers children ages three to seven is the National School Health Program, which works to manage the health of students and prevent health problems in public and private schools; health monitoring includes hygiene, vaccinations, and disease detection.

The few ECD education interventions implemented and administered by the government are provided to all 11 provinces, but they are neither universal, mandatory, nor free. These public preschool programs are the Programme National d'Enseignment Maternel (National Preschool Program) and the *Espace Commnunitaire d'Eveil* (ECE; Community Space Awakening), both targeting children ages three to five. Although the government finances the National Preschool Program paying for teacher salaries, the ECE program is mostly funded by UNICEF and/or the community. A parental education program—*Encadrement Parentale*—targets mothers and fathers and covers education, health, and nutrition aspects of children in all 11 provinces.

Social protection programs are few—a couple programs exist for children in streets but lack funding and organization.

Figure 2: Essential Interventions during Different Periods of Young Children's Development

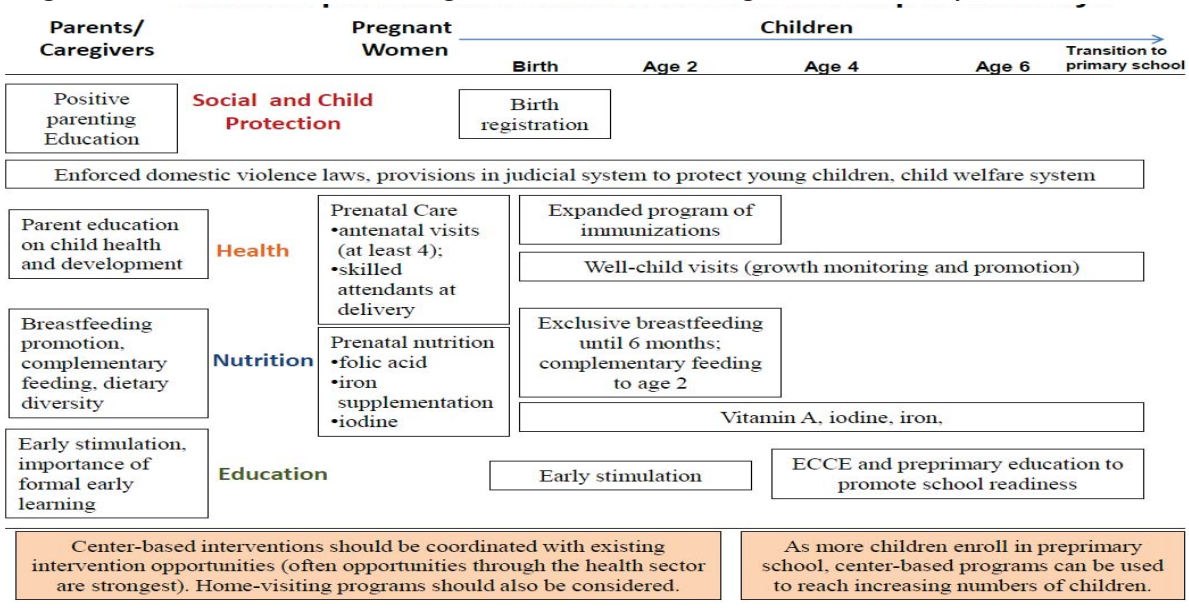


Figure 3: Scope of ECD Interventions in the Democratic Republic of Congo by Target Population and Sector

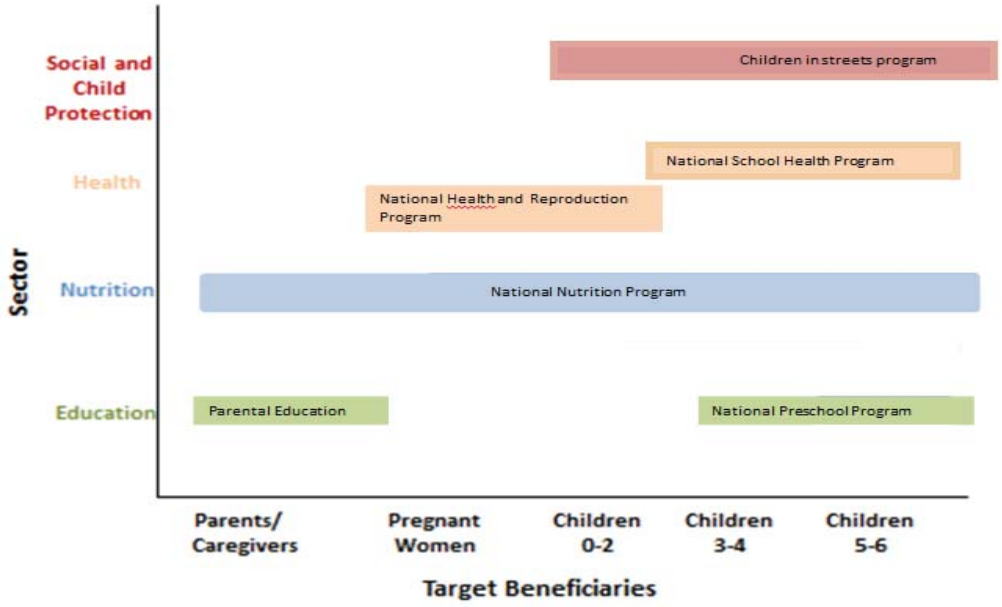


Table 7: ECD Programs and Coverage in the Democratic Republic of Congo

ECD Intervention	Scale		
	Pilot Programs	Number of Regions Covered	Universal Coverage
Education			
State-provided preprimary/kindergarten education (faith schools)		All provinces	
State-sponsored ECCE	-	-	-
Community-based ECCE	X		
Privately provided ECCE		All provinces	
Health			
Antenatal and newborn care		All provinces	
Integrated management of childhood illnesses and care for development		All provinces	
Childhood wellness and growth monitoring	-	-	-
National immunization program		All provinces	
Nutrition			
Micronutrient support for pregnant women		All provinces	
Food supplements for pregnant women		All provinces	
Micronutrient support for young children		All provinces	
Food supplements for young children		All provinces	
Food fortification		All provinces	
Breastfeeding promotion programs		All provinces	
Anti-obesity programs encouraging healthy eating/exercise	-	-	-
Feeding programs in preprimary/kindergarten schools	-	-	-
Parenting			
Parenting integrated into health/community programs		All provinces	
Home visiting programs to provide parenting messages	-	-	-
Special Needs			
Programs for OVCs (*boarding schools and children's homes*)	X	1 province (Kinshasa)	
Interventions for children with special (*emotional and physical*) needs	-	-	-
Antipoverty			
Cash transfers conditional on ECD services or enrollment	-	-	-
Comprehensive			
A comprehensive system that tracks individual children's needs	-	-	-

Table 7 displays the scale and range of ECD programs in the country that are established in the education, health, nutrition, and social protection sectors. Although most of these programs cover all 11 provinces, they do not have universal coverage.

Policy Lever 2.2: Coverage

Latent

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 expectant mother have guaranteed access to essential ECD services.

The level of access to essential ECD health and nutrition interventions for pregnant women is low. Fewer than 50 percent of pregnant women benefit from at least four antenatal visits. The available information from UNAIDS, the Joint United Nations Programme on HIV/AIDS that leads the world in achieving universal access to HIV care, reports that only 13 percent of HIV+ pregnant women and exposed infants receive antiretrovirals for preventing mother-to-child transmission. Additionally, WHO reports that more than 40 percent of pregnant women have anemia in the country. However, the country does have a moderate rate of births attended by skilled attendants (80.4 percent), which is similar to countries in the region, as shown in table 8.

The level of access to essential ECD health interventions for young children is also low. Only 26.6 percent of children below five years of age with diarrhea receive oral rehydration and continued feeding, placing the Democratic Republic of Congo in the average for its comparison countries (table 9). For children below five years of age with suspected pneumonia, only 40 percent receive antibiotics. And only 38 percent of children below five sleep under an ITN in at risk areas. For a country that, together with Nigeria, makes up 32 percent of the world's malaria cases and 40 percent of global malaria deaths, the lack of ITN coverage is concerning.

The level of access to essential ECD nutrition interventions for young children is fairly robust. Eighty-four percent of children between six and 59 months receive Vitamin A supplementation, and 58 percent of the population consumes iodized salt. The rates for breastfeeding, however, are lower. Only 37 percent of children are exclusively breastfed under the age of six months (table 10).

Table 8: Regional Comparison of Level of Access to Essential Health Services for Young Children and Pregnant Women

	Congo, Dem. Rep.	Angola	Burundi	Cameroon	Nigeria
1-year-old children immunized against DPT (corresponding vaccines: DPT3ß)	72%	91%	96%	85%	41%
Children below 5 with diarrhea receive oral rehydration/ continued feeding (2008–12)	26.6%	N/A	37.8%	17.2%	26%
Children below 5 with suspected pneumonia taken to health care provider (2008–12)	40.3%	N/A	42.6%	29.9%	39.7%
Pregnant women receiving antenatal care (at least four times; 2008–12)	44.7%	N/A	33.4%	62.2%	56.6%

Source: UNICEF Country Statistics 2010.

Table 9: Regional Comparison of Level of Access to Essential Nutrition Services for Young Children and Pregnant Women

	Congo, Dem. Rep.	Angola	Burundi	Cameroon	Nigeria
Children below 5 with moderate/severe stunting (2008–12)	43.4%	29%	57.7%	32.5%	35.8%
Infants exclusively breastfed until 6 months of age (2008–12)	37%	11%	69.3%	20%	15.1%
Infants with low birth weight (2008–12)	9.5%	12%	13%	11%	15.2%
Prevalence of anemia in pregnant women (2011)	49%	47%	31%	50%	58%
Prevalence of anemia in preschool-aged children (most recent year)	70%	N/A	56%	N/A	N/A

Sources: UNICEF Country Statistics 2010; WHO Global Database on Anemia.

Overview of Early Childhood Education in the Democratic Republic of Congo. The country's most recent national education law, Cadre de l'Enseignement National 2014, guarantees children ages three to five preschool education—*maternel*—in a cycle of three years but does not address its free provision and does not make its provision mandatory. The education sector has historically been administered at the central level; currently this and other sectors are moving toward a decentralized government, but it is unclear how this will affect preschool. Most of the preschool education is provided by the for-profit sector (51 percent), followed by state-provided preschools, which are more commonly

known as subsidized denominational preschools or faith-based preschools (48 percent) (see table 10). A small percentage of preschools are community based (1 percent). None of these preschools are free, and all have costs to the parents that range between $5 and $55 a month depending on the community.

State-provided preschools (where 48 percent of children are enrolled per government data) are categorized as "public" because they are administered by the government, but most of these schools are of faith-based and are mostly financed by parents and the community. The government pays for the teachers' salaries, but additional fees are funded by the children's parents. Table 10 also shows six major religious preschool teaching denominations. UNESCO's data on state and nonstate enrollment rates for ECCE vary from those of the government, showing that 83 percent of children enrolled in preschool are in nonstate schools, while 8 percent are enrolled in state schools.

Table 10 : Preschool Enrollment by Nonstate and State, 2012

	Nonstate	State
UNESCO data	83%	8%
Government data	52%	48%
State (faith-based schools)		48%
ENC (Non-conventional teaching)		12%
ECC (Conventional teaching Catholic)		15%
ECP (Conventional Teaching Protestant)		16%
ECK (Conventional teaching Kimbanguiste)		2%
ECI (Conventional teaching Islamic)		1%
ECF (Conventional teaching Brotherhood)		1%
Other		2%

Source: Ministy of Primary, Secondary, and Professional Education.

The most recent data from UNESCO's Institute for Statistics report the country's preschool gross enrollment rate at 4.3 percent, well below neighboring countries (see table 11) and the regional average of 20 percent.

Table 11: Regional Comparison of Gross Enrollment Ratio for preprimary Education

	Congo, Dem. Rep.	Angola	Burundi	Cameroon	Nigeria
Gross enrollment ratio for preprimary education	4.3%	86.55%	8.16%	29.79%	13.39%

Source: UNESCO Institute of Statistics 2010–13.

Policy Lever 2.3: Equity

Emerging

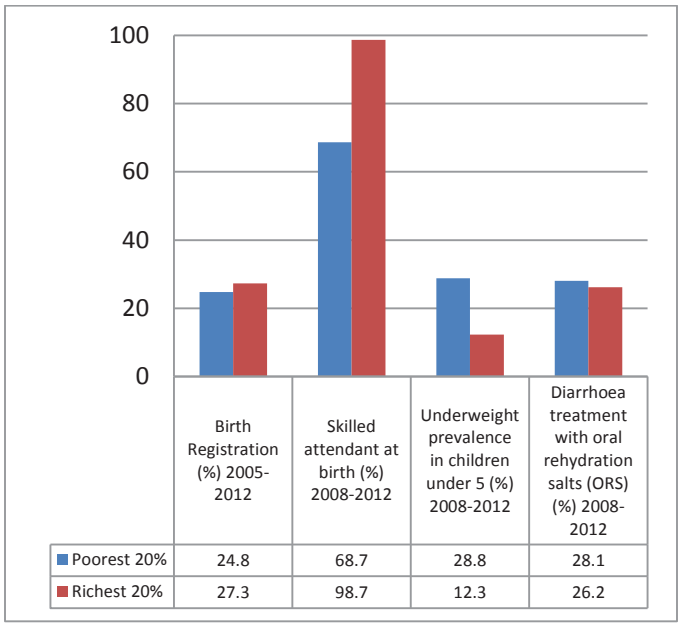
Based on the robust evidence of the positive effects ECD interventions can have for children from disadvantaged backgrounds, every government should pay special attention to equitable provision of ECD services.[6] One of the fundamental goals of any ECD policy should be to provide equitable opportunities to all young children and their families.

There is inequity in access to ECCE services at the subnational level. Including both private and public preschool enrollment rates for all 11 provinces, the ratio between the provinces with the highest (Kinshasa, 28.1 percent) and lowest (Maniem, 1.3 percent) enrollment rates is 21.3. Children from disadvantaged social status and rural areas do not have access to preprimary education mainly because of the high cost of private services and lack of nearby schools.

Access to ECD services is mildly inequitable between urban and rural areas and between poorest and richest. As figures 4 and 5 show, a significant difference exists of underweight children among the richest and poorest as well as urban and rural, with the poorest 20 percent being 2.3 times more likely than the richest 20 percent to have underweight prevalence in children. The difference in access to skilled attendants at birth is also high: Children in urban areas are 1.5 more likely to have a skilled attendant at birth than those in rural areas. However, outcomes for diarrhea treatment and birth registration for urban/rural and poorest/richest are mildly similar, despite parents paying a fee if they do not comply with birth registration in the first six months.

[6] Engle et al. 2011; Naudeau et al. 2011.

Figure 4: Equity in Access to ECD Services in the Democratic Republic of Congo

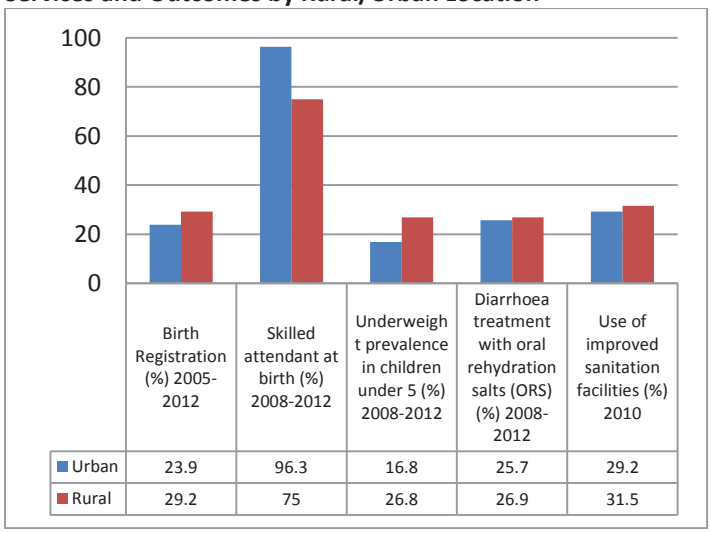


	Birth Registration (%) 2005-2012	Skilled attendant at birth (%) 2008-2012	Underweight prevalence in children under 5 (%) 2008-2012	Diarrhoea treatment with oral rehydration salts (ORS) (%) 2008-2012
Poorest 20%	24.8	68.7	28.8	28.1
Richest 20%	27.3	98.7	12.3	26.2

Source: UNICEF MICS Country Data.

Girls and boys have equitable access to ECCE services. Although disparities exist among socioeconomic levels, gender parity is seen for preprimary enrollment rates. In 2012 the government reported a total of 289,882 girls enrolled in preschool and 277,510 boys.

Figure 5: Equity in Access to Health and Child Protection Services and Outcomes by Rural/Urban Location



	Birth Registration (%) 2005-2012	Skilled attendant at birth (%) 2008-2012	Underweigh t prevalence in children under 5 (%) 2008-2012	Diarrhoea treatment with oral rehydration salts (ORS) (%) 2008-2012	Use of improved sanitation facilities (%) 2010
Urban	23.9	96.3	16.8	25.7	29.2
Rural	29.2	75	26.8	26.9	31.5

Source: UNICEF MICS Country Data.

Policy Options to Implement ECD Widely in the Democratic Republic of Congo

Scope of Programs

➢ **Consider implementing social protection and welfare programs for orphans or vulnerable children.** Only one program targets vulnerable children—those living on the streets—and it lacks financing, coverage, and organization. Children that are orphans or vulnerable only have the option to attend an orphanage or live on the streets. Despite almost 300 orphanages in the country, they are not regulated or nationally coordinated. Since no completely free health, nutrition, or education programs exist for children to age six in the country, children from low-income families who do not have the monetary means to cover their children's needs will not reach their potential. Having social protection or welfare programs in place could greatly improve health, nutrition, and education outcomes

Coverage

➢ **Create campaigns to disseminate the importance of ECD interventions.** The level of access to ECD interventions for mothers and young children is low. Despite a number of health and nutrition programs, health and nutrition outcomes for mothers and their children are low compared with neighboring countries and international standards. Health workers could inform families of the range of services that the government offers to improve their children's health and nutrition levels. Birth registration could also be promoted, and penalizing parents for registering their children after the first six months could be eliminated to encourage parents to register their children regardless of age.

Equity

➢ **Provide cost-effective community-based preschools in harder-to-reach areas.** The absence of day care and kindergarten facilities in rural areas and their high costs prevent families from using the services. Exploring informal or lower-cost ECD programs would increase access to these services. Including the private sector, nongovernmental organizations, and provincial governments in the discussion of experimental and pilot programs would increase the chances of implementing ECD interventions that target marginalized communities.

➢ **Target rural and poor communities with health interventions.** Great disparity is found between underweight children in rural and urban areas and poor and rich sectors of the population. Working with provincial governments and communities to reach the most marginalized children will help decrease health disparities.

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 high quality, the impact on children can be negligible or even detrimental.

Policy Lever 3.1: Data Availability

Latent ●○○○

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.

Relevant administrative and survey data are collected on access to ECD for some interventions. Table 12 presents select indicators for administrative and survey data and whether they are collected or not. Survey data are more complete than administrative.

Data on ECCE access for special groups are limited. The only data collected on ECCE for special groups are those to differentiate gender. No data are collected from the government on access or outcomes for rural/urban, mother tongue, socioeconomic status, or special needs. No system tracks or keeps data on four interrelated domains of child development: cognitive, linguistic, physical, and socioemotional.

Table 12: Availability of Data to Monitor ECD in the Democratic Republic of Congo

Administrative Data	
Indicator	**Tracked**
ECCE enrollment rates by region	✓
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 (%)	✓
Anemia prevalence among pregnant women (%)	X
Children below the age of 5 years 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

Policy Lever 3.2: Quality Standards

Established ●●●○

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.[7]

Clear learning standards are established for ECCE. The Ministry of Primary, Secondary, and Vocational

[7] Bryce et al. 2003; Naudeau et al. 2011; Taylor and Bennett 2006; Victoria et al. 2008.

Education established learning standards in 1981 for children ages three to four as well as standards for children ages five to six. The existing preschool programs are based on pedagogical games and theories that were developed in 1996 during the "General State of Education" in Kinshasa. The curricula are given in the form of activities, which included 11 basic skills in 1996 and increased to 14 in 2009. The preprimary curricula are coherent and continuous with the curriculum for primary education. The essential content of what is covered in the third and last year of preprimary education is revised during the first year of primary education, as mentioned in the Programme National de l'Enseignement Maternel and in the Programme National de l'Enseignement Primaire.

Requirements for early childhood education professionals are robust. A high school diploma is needed to become a preprimary teacher, as well as specialized ECD training and adequate performance in a supervised internship. Regular in-service training is mandatory, is available once a year, and lasts for six days for five hours a day. The Ministry of Primary, Secondary, and Professional Education is the public authority in charge of regulating preservice training for ECCE professionals. Teachers are required to pursue a preservice practicum or fieldwork, but at their own expense, as is the case for in-service training. Health workers are not required to receive training to deliver ECD messages, such as developmental milestones, childcare, parenting, or early stimulation.

Infrastructure standards for ECCE facilities are more established than those of service delivery, but both are limited. Infrastructure standards include all elements (roof, floor, windows, structural soundness, building materials, and connection to electricity) as well as access to potable water and functional hygienic facilities. Standards also specify minimum hours of preprimary education per week for facilities, these being 3.5 hours, five times a week for children two to four years old, and five hours for five to six days for children ages five and six. All preschools, regardless of category, use this same standard.

Although there are no requirements for child-to-teacher ratios, the average ratio for preprimary education is high. The national average number of children per teacher is nearly 30:1 and ranges at a provincial level from 20 to 40 children per teacher. The greatest disparities among number of students per teacher are found between the state-faith and the private preschools. For instance, table 13 shows that Kinshasa has the lowest pupil/teacher ratio for state-faith schools with nine students per teacher, while Bandundu has 70. These ratios also vary within provinces based on state-faith/private schools. Private schools in Maniema have 10 children per teacher, while state-faith schools have 61. The national average of 29:1 is high by international standards and exceeds best practice, which states that to achieve the optimal learning environment the ratio of students to teachers should not exceed 15:1.

Table 13: Student-Teacher Ratio

	Total	Nonstate Schools	State Schools
Sud Kivu	40	20	59
Kasai Oriental	37	8	66
Bandundu	35	1	70
Maniema	35	10	61
Equateur	34	7	62
National	29	18	40
Katanga	27	38	17
Orientale	25	18	33
Bas Congo	23	29	17
Kasai Occidental	23	21	24
Nord Kivu	22	20	24
Kinshasa	20	30	9

Registration and accreditation procedures for ECCE and health facilities exist. ECCE facility requirements exist for both public and private preschools. They are made available semiannually but are not announced. As for health facilities, construction standards exist and are required for hospitals, health centers, and health posts.

Policy Lever 3.3: Compliance with Standards

Established

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.

The number of teachers who comply with professional requirements is high within registered schools. Nearly all ECCE teachers for both private and public preschools have the minimum qualifications (i.e., have teaching degrees and high school diplomas) (table 14). However, the quality of the training is unknown. It is notable to

mention that salaries of preprimary teachers are in parity with those of primary education teachers.

Table 14: Teacher Qualifications, All Preprimary Schools

< 4 Year Teaching Degree	4 Year Teaching Degree	6 Year Teaching Degree	6 Year State Degree/Other Sectors	Teaching Degree — Technical Graduate Degree	Specialization in Preprimary	
<D4	D4	D6	P6	G3 – A1	EM	Other
2.4%	9.7%	64.9%	4%	0.2%	16.5%	2.1 %

Source: Annuaire statistique de l'enseignement primaire secondaire et professionnel 2011–12.

State and nonstate ECCE facilities are required to comply with established service delivery. Both category of preschools comply with the 15 hours a week minimum standard for service delivery and provide 17.5 hours a week. No data report compliance of preprimary facilities with infrastructure standards. However, observation shows that public facilities comply with infrastructure standards more often than private ones.

Policy Options to Monitor and Assure ECD Quality in the Democratic Republic of Congo

Data Availability

➢ **Create a system to track program data.** The country collects very few data on spending, coverage, and impact of programs targeted to young children. Most of the data collected on ECD indicators come from international/household surveys that do not distinguish among program coverage. This lack of information makes it difficult to know if programs are cost-effective and reaching their goals. Since there are clear ECD goals within the ECD national strategy, once the strategy is endorsed and implemented by the government, data availability will be essential to see where to focus to reach the stated goals.

➢ **Track outcomes on children with special needs and special groups.** No data are collected on special needs children or special groups. The ECD National Strategy states as one of its goals to provide birth registration, protection against violence, free medical attention, and vaccinations to "all children ages 0-3, including vulnerable children or children with learning disabilities." To reach this goal, it will be necessary to include special needs children in the data collection.

Quality Standards

➢ **Explore covering the (partial) costs of preservice and in-service training for teachers.** Although more than 90 percent of teachers in registered private and public schools have teaching qualifications, teachers are required to cover their preservice and in-service training. Decreasing training qualification expenses could encourage more teachers to enter the field. Since the average national ratio of teachers to students is 30:1, having more teachers available could potentially improve the quality of instruction.

➢ **Evaluate teacher certification.** As mentioned above, nearly all teachers comply with the minimum requisites to teach preprimary education. However, no indications show whether the quality level of the certification or training that teachers receive. Teachers also receive a full week of in-service training a year, but it is also unclear how effective this is. Ensuring that preservice and in-service training are of high quality will greatly improve learning outcomes for children in preschool.

Compliance with Standards

➢ **Track compliance with infrastructure standards.** Despite clear infrastructure standards that both private and public preprimary schools must follow, no mechanisms ensure compliance. Because the learning environment has proven to be an important factor in children's learning outcomes, ensuring that all schools have the necessary infrastructure regardless of their location or target population will be essential to help children reach their full potential.

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 15 compares ECD policies in the Democratic Republic of Congo with ECD outcomes. For example, despite mandating the registration of children at birth, child registration is low. However, fees are levied on parents if they register their children after the first 90 days, which could explain the low birth registration because parents may avoid the fee and the registration

altogether. And the lack of free or no mandatory preschool education could explain the low enrollment rates.

Table 15: Comparing ECD Policies with Outcomes in the Democratic Republic of Congo

ECD Policies	Outcomes
Law complies with the International Code of Marketing of Breast Milk Substitutes →	Exclusive breastfeeding rate (> 6 months): **37%**
Dem. Rep. Congo has national policy to encourage the iodization of salt →	Household iodized salt consumption **58.6%**
Preprimary school is neither free nor compulsory in Dem. Rep. Congo →	Preprimary school enrollment: **4.3%**
Young children are required to receive a complete course of childhood immunizations →	Children with DPT (12–23 months): **72%**
Policy mandates the registration of children at birth in Dem. Rep. Congo →	Completeness of birth registration: **27.8%**

Preliminary Benchmarking and International Comparison of ECD in the Democratic Republic of Congo

Table 16 presents the classification of ECD policy in the Democratic Republic of Congo within each of the nine policy levers and three 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 17 presents the status of ECD policy development in the Democratic Republic of Congo alongside a selection of countries in East and West Africa. The level of development in the Democratic Republic of Congo can be compared to that of Uganda and Nigeria, while Kenya has achieved slightly higher levels of development.

Table 16: Benchmarking Early Childhood Development Policy in the Democratic Republic of Congo

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 17: International Classification and Comparison of ECD Systems

ECD Policy Goal	Policy Lever	Level of Development				
		Congo, Dem. Rep.	Ethiopia	Kenya	Nigeria	Uganda
Establishing an Enabling Environment	Legal Framework	●●○○	●●●○	●●○○	●●●○	●●○○
	Coordination	●○○○	●●○○	●●●●	●●○○	●●○○
	Finance	●○○○	●○○○	N/A	●○○○	●○○○
Implementing Widely	Scope of Programs	●●○○	●●○○	●●○○	●●○○	●●○○
	Coverage	●○○○	●○○○	●●●○	●○○○	●●○○
	Equity	●●○○	N/A	N/A	●●○○	●○○○
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 the Democratic Republic of Congo's ECD system with other countries in the region and internationally.

Each of the nine policy levers are examined in detail and some policy options are identified to strengthen ECD are offered.

Despite recovering from an extended period of conflict, the country has many advances on ECD that could be capitalized on. Various stakeholders have produced a national ECD strategy that, despite lacking a costed implementation plan and funding, includes standards, goals, and next steps to advance ECD in the country. The strategy already has the support of many government sectors, suggesting a certain consensus from the various ministries involving the needs of young children. Additionally, a ministerial decree has established an ECD Working Group, and even though the group does not convene in practice, the building blocks have been established.

This is not to say that there are no challenges to improve the ECD system in the country. Table 18 summarizes the key policy options identified to inform policy dialogue and improve the provision of essential ECD services in the Democratic Republic of Congo.

Table 18: Summary of Policy Options to Improve ECD in the Democratic Republic of Congo

Policy Dimension	Policy Options and Recommendations
Establishing an Enabling Environment	• Develop frameworks for children to age three. It is important that the government make vaccinations, nutritional and health programs mandatory and more easily accessible to children in their first three years. • Have the government endorse a national strategy for ECD and include a costed implementation plan and an action plan at the provincial and federal levels • Include nongovernment actors in the conversation to make ECD accessible to all • Establish a system to track investment in ECD. The government could also continue to track investment on ECD from external sources and could include the private sector to have a full spectrum of ECD investment in the country.
Implementing Widely	• Implement public social protection and welfare programs for orphans or vulnerable children • Create campaigns to disseminate the importance of ECD interventions. Health workers could inform families of the range of services that the government offers. Birth registration could also be promoted, and penalizing parents for registering their children after the first six months could be eliminated. • Provide cost-effective community-based preschools in harder-to-reach areas. Include the private sector, nongovernmental organizations, and provincial governments in the discussion of experimental and pilot programs to increase the chances of implementing ECD interventions that target marginalized communities. • Target rural and poor communities with health interventions. Working with provincial governments to reach the most marginalized children could decrease health disparities.
Monitoring and Assuring Quality	• Create a system to track ECD-related program data • Track outcomes on children with special needs and special groups • Cover the costs of preservice and in-service training for teachers • Evaluate teacher certification • Track compliance with infrastructure standards

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Acronyms

ECCE	Early Childhood Care and Education
ECD	Early Childhood Development
ECE	Espace Commnunitaire d'Eveil (Community Space Awakening)
EPI	Extended Program on Immunization
ILO	International Labour Organization
ITN	Insecticide-Treated Net

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

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