Overview

Investment in young children in Liberia is a critical aspect to Liberia’s development agenda. While progress is being made, greater momentum is needed to ensure that young children develop and thrive along physical, cognitive, language and socio-emotional dimensions. The quality and quantity of early experiences in the first 1,000 days lay the foundation for children’s brain development; this includes good nutrition, early stimulation, and safe and secure environments. Healthy brains in turn influence health and education outcomes in subsequent years which translates into economic growth. Investments in early experiences yield better health, better school readiness, and higher academic performance which in turn leads to higher economic productivity. The pathway to early childhood development (ECD) starts in utero, therefore, investments in pre-natal services and healthy pregnancies are the starting points to healthy childhoods and productive adulthood.

Investment in the early years is a proven gateway to a country’s economic growth and development. Every dollar invested in ECD returns 13% of value per annum¹ which is unarguably one of the best investments the Government of Liberia (GoL) can make. ECD programs have long been established as a social determinant for health and development, and a powerful equalizer to close socio-economic gaps and reduce both health and social inequities². Psychosocial stimulation in a child’s early years can raise his or her adult income by up to 25%³. This serves not only to narrow existing income gaps, but also translates into better economic productivity for the country. Reducing stunting also has a high economic return: addressing stunting yields the average country 7% more GDP per capita⁴.

To reap full benefits of ECD investments, it is critical to start early and integrate programs across health, nutrition, education, and social/child protection sectors. ECD outcomes have underlying multi-sectoral determinants. Poverty as well as maternal indices such as age at birth, birth order (number of children), length of birth interval and level of education remain important differentials of child survival and development across the years. Adequate health and nutrition of children and their mothers (from adolescence through preconception and birth) to the first five years of life, coupled with exposure of children to early stimulation and learning, protection against harm, and access to social amenities such as water, sanitation and hygiene (WASH) are all important differentials of child development. These determinants underscore the importance of holistic investments in interventions that improve Reproductive, Maternal, Newborn, Child and Adolescent health (RMNCAH), Early Childhood Education (ECE), and maternal education/female literacy. Also, protection of children against effects of extreme poverty and deprivation is a critical pathway for promoting child development outcomes in Liberia.

Over the past three decades, Liberia made some improvements in the wellbeing of the youngest in the country. There has been a decline in under-five mortality (from 220 per 1,000 live births in 1986 to 70 in 2015). During this period, infant mortality rates declined from 144 to 53 per 1,000 live births, and neonatal mortality rates also declined from 68 to 24 per 1,000 live births (figure 1). The rate of stunting fell from

39% in 2007 to 32% in 2013\textsuperscript{5}. However, compared to child mortality rates around the world, Liberia still ranks in the bottom quintile and currently has the 6\textsuperscript{th} and 8\textsuperscript{th} worst stunting rate in West Africa for male and female stunting respectively\textsuperscript{6}. Beyond child survival and other critical health outcomes, the number of students enrolled in ECE rose from 91,394 to 539,660 between 1981 and 2015; this represented a Gross Enrolment Ratio (GER) of 38% and 116% respectively\textsuperscript{7} reflecting an increased demand for ECE services across age groups.

Despite progress, coverage of services remains low across the ECD continuum from conception through birth to child health and pre-school packages. Only 57.5\% of pregnant women attended four or more antenatal care consultations by a skilled provider and 51.7\% had a skilled birth delivery\textsuperscript{8}, a reduction from 61\% recorded in 2013 DHS, an aftermath from the Ebola disease outbreak. Micronutrient deficiency is prevalent with one in two pregnant women and women of reproductive age group anemic and seven out of ten children anemic\textsuperscript{10}. Among children under 2 years, one in five is stunted. By ages 3-5, this rate has increased to two in five reflecting barriers to appropriate feeding with the introduction of complementary feeding. Similarly, coverage on indicators for child health such as full immunization of children under 1 year was only 60\% in 2016 lower than the 65\% 2013 baseline\textsuperscript{11}. Finally, only 29\% of pre-school age children are enrolled in ECE centers\textsuperscript{12}, with many more enrollees overage for grade. Patterns of age enrollment as seen in figure 3 below show a lag in age appropriate enrollment which peaks at least one to two years after the appropriate age for each level, and extends to five years or more for all levels.

\textsuperscript{6} Based on analysis of most recent World Development Indicators (WDI) data
\textsuperscript{7} 2016 Liberia Education Sector Analysis report. Reflects ECE demand across all age groups beyond official ECE age of three to five years
\textsuperscript{9} Ministry of Health and Sanitation, Joint Annual Health Sector Review Report 2016
\textsuperscript{10} World Bank Health, Nutrition and Population Statistics database, 2011 data
\textsuperscript{11} Ministry of Health and Sanitation, Joint Annual Health Sector Review Report 2016
\textsuperscript{12} This is the net enrollment rate (NER) defined as the total number enrolled in ECE within the official age group for ECE expressed as a percentage of population for that age group. The Gross Enrollment Ratio (GER) is defined as total number enrolled in ECE regardless of age expressed as a percentage of the total population for the ECE age group. Currently, GER in Liberia is 116\% and NER 29\% reflecting most children enrolled in ECE are overage for the ECE level.
CHALLENGES

Uptake of key nutrition interventions remain low, worsened by underlying food insecurity in Liberia. Factors contributing to childhood malnutrition patterns seen in Liberia include low uptake of exclusive breast feeding and appropriate feeding practices for children less than two years (only 55.2% of children aged zero to six months are exclusively breastfed and only 4.1% of children aged 6-23 months are fed per the three recommended Infant and Young Child Feeding practices\(^{13}\)). Other key determinants of malnutrition include high prevalence and exposure to childhood illnesses including diarrheal diseases, malaria and other febrile illnesses; high levels of food insecurity (i.e. poverty) with only 50% of population considered as food secure\(^{14}\); poor access to social amenities such as WASH and health services, and rapid increases in urban and peri-urban population.\(^{15}\)

Lack of parental awareness and perception of unaffordability of fees are key determinants of overage enrollment in ECE services. 75% of ECE enrollees are overage in Liberia\(^{16}\). Parental perception of high ECE costs (tuition fees/indirect costs from materials and distance to school)\(^{17}\), coupled with lack of parental awareness on ECE benefits for children aged three to five years is a major barrier to demand for age appropriate ECE services. Parents tend to keep children at home till they are overage for ECE grades leading to a potential crowding-out effect on ECE services for the appropriate age group. Furthermore, a spillover effect from overage enrollment at the primary level due to lack of school readiness possibly from malnutrition and possibly cognitive delays worsens overage enrollment at the ECE level.

\(^{13}\) Liberia DHS 2013; 3 IYCF practices cover breastfeeding/consumption of milk or milk products through age 2, introduction of solid and semisolid foods at age 6 months with appropriate dietary diversity, and gradual increases in the amount of food given and frequency of feeding as the child gets older

\(^{14}\) Liberia Comprehensive Food Security and Nutrition Survey (LCFSNS), 2013

\(^{15}\) LCFSNS, 2013

\(^{16}\) 2016 Liberia Education Sector Analysis report

\(^{17}\) Public ECE centers are permitted to charge 3,500 Liberian Dollars/semester as tuition (2016 Liberia Education Sector Analysis report)
Fragile delivery systems continue to pose challenges to access and quality of services. Access to health, education, and other social service delivery in Liberia is further constrained due to fragile delivery systems such as inadequate trained human resource, inadequate supplies of commodities and materials, and infrastructure challenges posing constraints to further gains in Early Childhood Development (ECD) in the country. For example, Liberia has fewer than 1.15 skilled health personnel per 1,000 population, far below the recommended minimum threshold of 2.3 skilled health personnel per 1,000 population, and 50% of health facilities experience frequent shortages of essential medicines and medical supplies, including supplies necessary to address critical health conditions among pregnant women and children. Similarly, at the ECE level, 50% of teachers have no teaching certificate (figure 4 above), in addition, 35% of ECE classrooms were considered makeshift constraining access to quality services in a safe and welcoming environment for children. ECE service delivery quality is further compromised by lack of standardized Government approved ECE teaching qualification and overage enrolment leading to high student-teacher ratios in ECE grades.

Low access to improved water and sanitation facilities is a risk to disease outbreaks. Only 14.2% of households have access to improved sanitation facilities with close to one out of two households practicing open defecation. Access to safe drinking water and good sanitation facilities (both in the households and communities) is necessary for infection prevention and control which in turn is an underlying determinant of good nutritional status. A recent nationwide survey of schools found only 56% of toilets functional, many schools have no access to clean water or handwashing facilitates which undermines other ongoing efforts to combat malnutrition and promotes the transmission of disease.

Policies for an enabling environment exist, in some cases, are outdated with low policy awareness and weak implementation arrangements. The 2011 inter-sectoral ECD policy emphasizes greater family and community involvement, integration of services, and inter-sectoral coordination and collaboration. Policy awareness however remains low amongst staff in implementing agencies across Health, WASH, and Social Protection sectors; higher awareness amongst Education sector staff could be due to the assigned lead responsibility of this sector to manage and coordinate integrated ECD programs. Coverage of integrated interventions such as school-based nutrition/health interventions, early stimulation and parenting programs is low and highly donor driven. Integration of other ECD services along the continuum of care from conception to five years remain weak, and disproportionately center or facility-based where available. In addition, the 2008 multi-sectoral nutrition policy is due for a review. Furthermore, where policies exist, these sometimes lack accompanying detailed prioritized and costed strategic/implementation plan which should serve as a road map to achieve highlighted policy goals.

Financing for both integrated and non-integrated ECD programs is low, and highly donor dependent posing sustainability constraints. In a recent rapid assessment of the Early Year’s landscape, inadequate financing was cited as a constraint to scaling up services and monitoring quality of services provided at the sub-national level. Line ministries currently do not have a dedicated budget line for many ECD services, Government stakeholders are therefore forced to rely on financing from donors. The low contribution of GoL resources and volatility of donor contributions further prevents long-term planning of ECD programs and services.

18 2016 Liberia Service Availability and Readiness assessment (SARA) report
19 Based on key informant interview results from a rapid assessment of the Early Years landscape conducted by World Bank Africa Early Years Fellow in September 2017. Many Government and non-Government stakeholders interviewed from Health, WASH, Social Protection/Child Protection had low awareness of the existence/content of the integrated ECD policy.
20 Based on key informant interview results from a rapid assessment of the Early Years landscape conducted by World Bank Africa Early Years Fellow in September 2017
Availability of disaggregated data by key ECD age groups remain a challenge: Monitoring and quality assurance on data, as well as availability of disaggregated data were highlighted as challenges hampering information to appropriately plan and integrate ECD services. Furthermore, Liberia currently lacks an appropriate baseline measure to track proportion of children who are developmentally on track (an important indicator to monitor impact of ECD interventions, as well as track progress against SDG 4.2 which is focused on ECD).

RECOMMENDATIONS
Prioritize investments in the Early Years with emphasis on integration of services through existing programs and platforms. Investments in the Early years is a proven gateway to economic growth and development. Ongoing programs such as the Liberia RMNCAH program, the National Community Health Assistant’s (NCHA) program, Performance-based Financing for health facilities, the Liberia Social Safety Nets (SSN) program, and the Getting to Best Education Sector reform can be leveraged and expanded to deliver integrated packages of nutrition, early stimulation, and other nurturing care interventions for young children. To achieve this, efforts could include:

i. Monitoring results of ongoing programs highlighted above and prioritize resources to expand and scale up these programs based on evidence.
ii. Prioritizing the scale-up of these efforts for most disadvantaged geographical regions and targeting vulnerable socio-economic groups.
iii. Integrating early stimulation programs for children from birth to three years as a key component of existing health, nutrition and education programs in the country. This component is currently missing from existing ECD programs.
iv. Expanding Social Protection programs beyond cash transfers to include exemptions on fee-paying services such as ECE services for the poorest.

Review and revise ECD-related policies with clear costed plans and monitoring systems. The 2011 Integrated ECD policy and the multi-sectoral Nutrition policy could be reviewed and revised (as necessary). Institutional arrangements for ECD policy implementation and monitoring will need to be clearly specified and communicated within decentralized accountability lines. Regular updates and monitoring dashboards could facilitate reporting and place an emphasis on achieving better ECD outcomes in the country.

Prioritize development of Community-based approaches for integrated and low cost service delivery. Given domestic resource constraint, GoL is unlikely to be able to significantly increase resources for ECD services across all sectors. Therefore, a focus on community-based approaches remain the most important window of opportunity to rapidly scale-up services at lower costs to reach rural and remote communities. Such platforms already exist in the health sector via the NCHA program. The Education sector is also currently piloting community-based ECE programs. GoL should review feasibility of bundling cross-sectoral ECD services such as nutrition, early stimulation and associated parental awareness programs unto such delivery platforms with a view to rapidly scale-up prioritizing the most disadvantaged groups.

Existing guidelines for Center/Facility-based delivery of ECD services should be reviewed and revised to ensure integration of services. Health sector platforms such as health facilities should be prioritized for zero to three age group given these have the greatest number of interactions with children and their caregivers at this age. A review of maternal, newborn, baby-friendly and nutrition care packages is necessary to integrate important aspects of nurturing care such as responsive caregiving and early

21 Based on key informant interview results from a rapid assessment of the Early Years landscape conducted by World Bank Africa Early Years Fellow in September 2017
stimulation. Education sector platforms such as school facilities can be strengthened for three to five age group. Emphasis should be made to accelerate implementation of school health policy and packages, as well as, delivery of nutrition and WASH services.