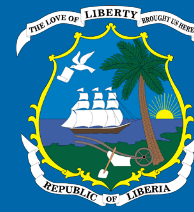

Ministry of Health Liberia

LIBERIA CHILD SURVIVAL ACTION PLAN (CSAP)

2024-2026
Republic of Liberia

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Foreword

Child health has been a priority for the Government of Liberia for many years. However, the achievement of major child health indicators over the last few decades has been declining, and there is an urgent need for accelerated action to get back on track and position the country to achieve the SDGs indicator on child health by 2030. Several interventions and initiatives have been implemented by the Ministry of Health and its partners to promote child survival and development. Despite these efforts and the development of various initiatives and frameworks by the health sector to address high under-five mortality, the reality is that under-five mortality remains high.

The Government of Liberia, through the Ministry of Health, other ministries, and partners focused on child survival and development, is committed to reversing this situation. The aim is to achieve the Sustainable Development Goal targets of reducing neonatal and under-five mortality to less than 12 and 25 per 1,000 live births, respectively. As Liberia is among the countries needing to accelerate its actions towards child survival, we have developed a five-year Child Health Strategy and a three-year Action Plan to strengthen our resolve to improve child health and reduce under-five mortality.

This document outlines a targeted strategy for accelerating the reduction of newborn and child morbidity and mortality in Liberia by addressing key bottlenecks. Furthermore, it provides a costed action plan with clearly marked timelines for implementation to facilitate resource mobilisation, monitoring, evaluation, and scaling up of proposed child health interventions. All stakeholders working towards improving the health of children in Liberia are expected to commit to this plan and collaborate to scale up child survival interventions, significantly reducing neonatal, post-neonatal, infant, childhood, and adolescent deaths, thereby achieving the goals and objectives outlined in this document.

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Our special appreciation goes to the members of the Child Survival Action initiative (Child Health Task Force, GFF, Save the Children, USAID, UNICEF, WHO) for their valuable contributions at specific stages during the development of the CSS.

In addition to those mentioned above, the Family Health Division wishes to recognise and express sincere thanks and profound gratitude to the Heads of the Health Financing, Monitoring & Evaluation, and Health Information System Units/Divisions within the Ministry of Health. The contributions of the Reproductive Health (RH) supervisors from Gbarpolu, Grand Cape Mount, Nimba, Grand Gedeh, Margibi, and Bong significantly influenced the trajectory of the CSS.

Finally, we extend special thanks to the Child Health Focal Person at the Ministry of Health, as well as the Liberia country offices, regional offices, and headquarters of USAID, UNICEF, and WHO for their technical leadership and guidance during the development of this Strategy and Action Plan.

Catherine T. Cooper
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Abbreviations/Acronyms

ANC	Ante-Natal Care
ART	Antiretroviral Therapy
ARI	Acute Respiratory Infection
BEmONC	Basic Emergency Obstetric and Newborn Care
BRIMS	Birth Registration Information Management System
CBIS	Community Based Information System
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CHA	Community Health Assistant
CHAI	Clinton Health Access Initiative
CHC	Community Health Committee
CHO	County Health Officer
CHP	Community Health Promoter
CHSS	Community Health Services Supervisor
CHT	County Health Team
CHTWG	Child Health Technical Working Group
CLTS	Community-Led Total Sanitation
CMO	Chief Medical Officer
CMS	Central Medicine Store
CRC	Child Rights Convention
CSO	Civil Society Organization
CSS	Child Survival Strategy
CSSAP	Child Survival Strategy and Action Plan
DHIS	District Health Information Software
DHO	District Health Officer
DHT	District Health Team
EmONC	Emergency Obstetric and Neonatal Care
ENAP	Every Newborn Action Plan
EPHS	Essential Package of Health Service
EPI	Expanded Program of Immunization
EPMM	Ending Preventable Maternal Mortality
ETAT	Emergency Triage and Treatment
FHP	Family Health Program
GAVI	Gavi, the Vaccine Alliance
GFF	Global Financing Facility
HCC	Health Coordination Committee
HFDC	Health Facility Development Committee
HHFA	Harmonized Health Facility Assessment
HIV	Human Immunodeficiency Virus

HMIS	Health Management Information Systems
HIS	Health Information System
HSCC	Health Coordination Committee
iCCM	Integrated Community Case Management
IHME	Institute for Health Metrics and Evaluation
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
IPT	Intermittent Preventive Treatment
IYCF	Infant and Young Child Feeding
JICA	Japan International Cooperation Agency
LBNM	Liberia Board of Nursing and Midwifery
LCPS	Liberia College of Physicians and Surgeons
LDHS	Liberia Demographic and Health Survey
LMDC	Liberia Medical and Dental Council
LMHRA	Liberia Medicine and Health Regulatory Authority
LMIS	Logistics Management Information System
LPB	Liberia Pharmacy Board
LSSN	Liberia Social Safety Net
MAD	Minimum Acceptable Diet
MCV	Measles-Containing Vaccine
MDD	Minimum Dietary Diversity
MDG	Millennium Development Goal
MFDP	Ministry of Finance and Development Planning
MMF	Minimum Meal Frequency
MoH	Ministry of Health
MPNDSR	Maternal, Newborn, Perinatal, and Stillbirth Death Surveillance and Response
NACP	National AIDS Control Programme
NPHIL	National Public Health Institute of Liberia
OIC	Officer in Charge
ORS	Oral Rehydration Salts
PAPD	Pro Poor Agenda for Prosperity and Development
PHC	Primary Health Care
PMTCT	Prevention of Mother to Child Transmission
PRS	Poverty Reduction Strategy
RHTC	Reproductive Health Technical Committee
RMNCAH	Reproductive Maternal Neonatal Child Adolescent Health
ROP	Rescue Our People
SBCC	Social Behavior Change Communication
SDG	Sustainable Development Goal
TB	Tuberculosis

TTM	Trained Traditional Midwife
TWG	Technical Working Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UHC	Universal Health Coverage
USAID	United States Agency for International Development
VPD	Vaccine-Preventable Diseases
WASH	Water, Sanitation and Hygiene
WB/GFF	World Bank/Global Financing Facility
WHO	World Health Organization
WUENIC	WHO/UNICEF Estimates of National Immunization Coverage

WARNING
TIMER
ALARM

Background

Liberia, a country with one of the highest childhood mortality rates globally, faces a daunting challenge to ensure every child survives and thrives. The newly developed Child Survival Action Plan (CSAP) is a critical step in operationalising the country's Child Health Strategy.

The strategy adopts a life-course approach, addressing the continuum of care for mothers and children—from pregnancy through the early and late newborn periods, to the postnatal period, infancy, and childhood. This approach strengthens the ENAP/EPMM/CSS as a continuum of care. It emphasises the importance of multisectoral and cross-programme coordination and collaboration, alongside strengthening key health systems and delivery platforms (Figure 1). This supports the high-quality integrated management of newborn and childhood illnesses (IMNCI) through a comprehensive multisectoral approach under the Action Plan in Primary Health Care (PHC), encompassing both facility-based interventions and community-level prevention, including iCCM.

High Impact interventions across the Continuum of Care.

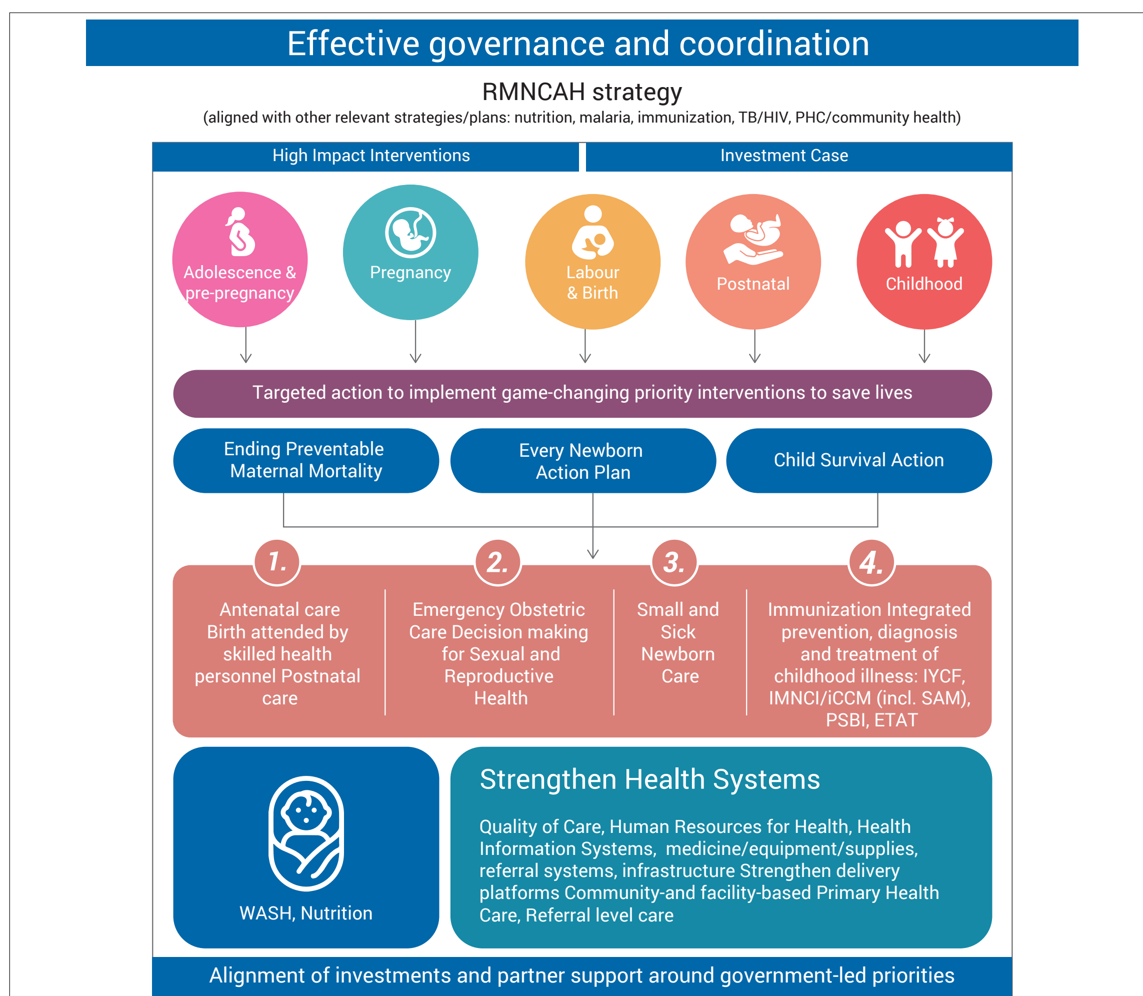

Figure 1: Continuum of care for mother and child – with targeted plans to advance the scale and quality of high impact interventions for survival (ENAP, EPMM, CSA) and recognition of cross-cutting systems requirements and multisector action

The Child Survival Strategy spans five years from 2024 to 2028, with a three-year Action Plan from 2024 to 2026. This allows for a mid-term review in 2026 to adjust strategies based on progress, ensuring more successful implementation and efficient resource allocation in the remaining two years.

Liberia's political commitment to child health is strong, demonstrated by its signatory status to the Child Rights Convention (CRC) since 1993, the Abuja Declaration of 2001, and the African Charter on the Rights and Welfare of the Child in 2007. The Children's Law of 2011 further protects and promotes children's rights and welfare.

Success hinges on collective effort. The Ministry of Health, relevant stakeholders, county health teams, communities, and healthcare professionals must all play their part in implementing and supporting the CSAP. With unwavering commitment and collaborative action, this plan can pave the way for a Liberia where every child has the opportunity to reach their full potential.

Goal:

The goal outlined in the Child Survival Strategy is to achieve an under-five mortality rate of 52 per 1,000 live births by 2028. This aligns with the national goal of 70 per 1,000 live births by 2026 as stated in the National Health Policy.

General Objectives

Reduce under-five mortality rate and promote optimal growth, protection and development of all newborn and children under five.

Specific Objectives

1. Enhance evidence-based practices for routine and emergency care, including Emergency Triage and Treatment (ETAT), Emergency Obstetric and Neonatal Care (EmONC), and Small and Sick Newborn Care, by building the capacity of healthcare workers to provide improved quality of care.
2. Strengthen and expand coverage and quality of Integrated Management of Newborn and Childhood Illness (IMNCI) and Integrated Community Case Management of childhood illness (iCCM), with an emphasis on early detection and treatment of Possible Serious Bacterial Infections (PSBI) and Severe Acute Malnutrition (SAM).
3. Strengthen interventions and their integration to protect children from preventable diseases by promoting child health practices, including infant and young child feeding (IYCF), early initiation of breastfeeding (EIBF), immunisation, nutrition, and Water, Sanitation, and Hygiene (WASH).
4. Strengthen birth registration and Maternal, Perinatal, and Newborn Death Surveillance and Response (MPNDSR), and paediatric death audits to count and review stillbirths, newborn, and under-five deaths to promote data-informed continuous process improvement (quality of care) and sustain health outcomes for newborns and under-five children.
5. Promote advocacy, community mobilisation, and behavioural change communication for newborn and child health care services.

The Child Health Strategy and Action Plan consists of nine distinct strategies and fifty-nine activities. The strategies mentioned in this document include the following:

Strategy	Description
Strategy 1:	Mobilise resources for the delivery of quality newborn and child health services.
Strategy 2:	Strengthen procurement and enhance equitable distribution of quality essential medicines, medical devices/equipment, and commodities for newborn and child health.
Strategy 3:	Strengthen the capacity of healthcare workers, including Community Health Assistants, to improve the quality of care for newborn and child health.
Strategy 4:	Strengthen the production, availability, and equitable distribution of qualified and competent healthcare workers for newborn and child survival across the country at various levels of care.
Strategy 5:	Strengthen health information systems, monitoring and evaluation, and research for effective delivery of evidence-based newborn and child health services.
Strategy 6:	Strengthen programme management and coordination mechanisms for effective implementation of newborn and child survival interventions.
Strategy 7:	Strengthen integration for improved quality of care and efficiency for newborn and child survival services.
Strategy 8:	Strengthen public-private partnerships for newborn and child survival services.
Strategy 9:	Strengthen advocacy, communication, and social mobilisation to increase awareness of the importance of newborn and child survival.

Summary of Situation Analysis

During the Millennium Development Goals (MDGs) era, Liberia made remarkable strides in improving child health, achieving MDG 4 by significantly reducing the under-five mortality rate by two-thirds from 1990 to 2015. The Liberia Demographic and Health Survey (LDHS) highlighted a dramatic decrease in under-five mortality from 222 deaths per 1,000 live births in 1986 to 94 per 1,000 in 2013. Similarly, neonatal mortality saw a substantial decline from 68 deaths per 1,000 live births in 1986 to 26 per 1,000 in 2013 (Figure 1).[1,2,3]

1 The Government of Liberia. (1986). Liberia Demographic Health Survey (LDHS) 1986
2 The Government of Liberia. (2007). Liberia Demographic Health Survey (LDHS) 2007
3 The Government of Liberia. (2013). Liberia Demographic Health Survey (LDHS) 2013

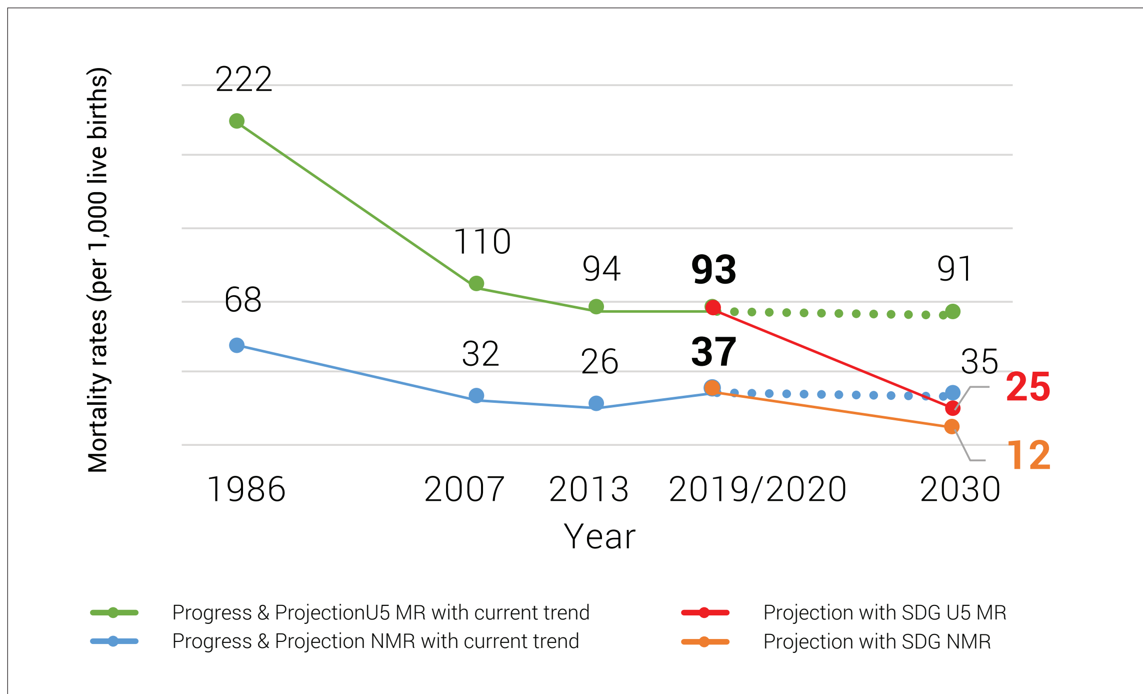

Figure 2: Trend, target and projections in U5 and neonatal mortality from 1986 to 2020[1,2,3,4]

However, since 2013, progress has stalled. The under-five mortality rate has remained almost unchanged at 93 deaths per 1,000 live births, and the neonatal mortality rate has unfortunately increased to 37 deaths per 1,000 live births by 2020.[4] The UN Inter-Agency Group for Child Mortality Estimation has noted a significant slowdown in the reduction rate over the past decade.[5]

Table 1: Average annual rate of reduction in under-five and neonatal morality[5]

Average annual rate of reduction	2000-2009	2010-2022
Under-five mortality	6.72%	2.57%
Neonatal mortality	4.04%	0.9%

Liberia is now among the 59 countries significantly behind in meeting the 2030 Sustainable Development Goals (SDGs) target 3.2, which aims to reduce under-five mortality. If the current trend continues, projections indicate that by 2030, the under-five mortality rate will be 91 per 1,000 live births, and the neonatal mortality rate will be 35 per 1,000 live births. Achieving the SDGs target could prevent over 37,400 under-five deaths by 2030.

To meet these targets, Liberia needs to achieve a 73% reduction in under-five mortality, bringing it down to 25 per 1,000 live births, and a 68% reduction in neonatal mortality, lowering it to 12 per 1,000 live births. This requires accelerating efforts fivefold for children under five and thirteenfold for newborns.[5]

4 The Government of Liberia. (2020). Liberia Demographic Health Survey (LDHS) 2019/2020
5 UN Inter-agency Group for Child Mortality Estimation. (2023). UNIGME Report 2023

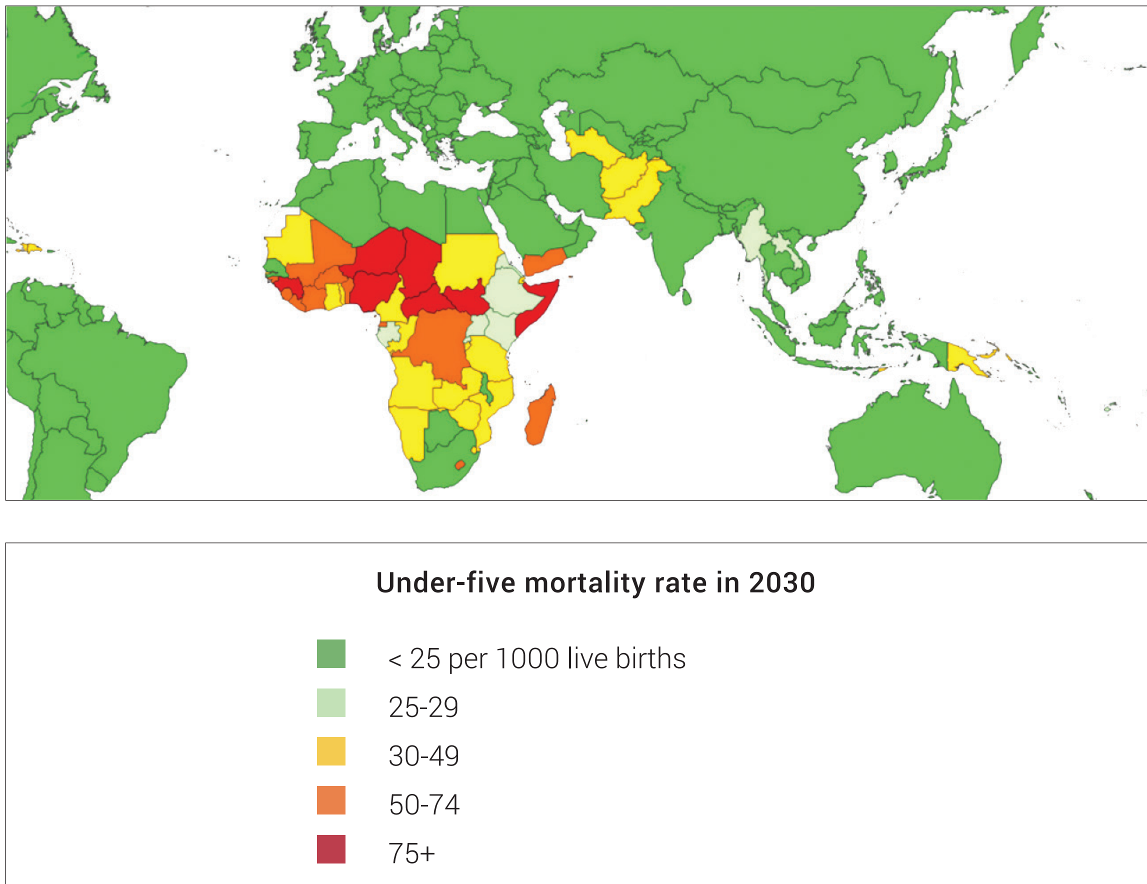

Figure 3: Projections of child mortality rates in the world in 2030[5]

According to UNIGME data, neonatal deaths accounted for 39% of the total deaths among children under five in 2021, with the majority (61%) occurring after the first month of life. Most of these newborn deaths are due to preventable or treatable conditions such as prematurity (15%), birth asphyxia (9%), and lower respiratory infections (3%). Among children aged 1-59 months, the leading causes of death are malaria (22%), measles (11%), lower respiratory infections (10%), and diarrhoea (6%).[5]

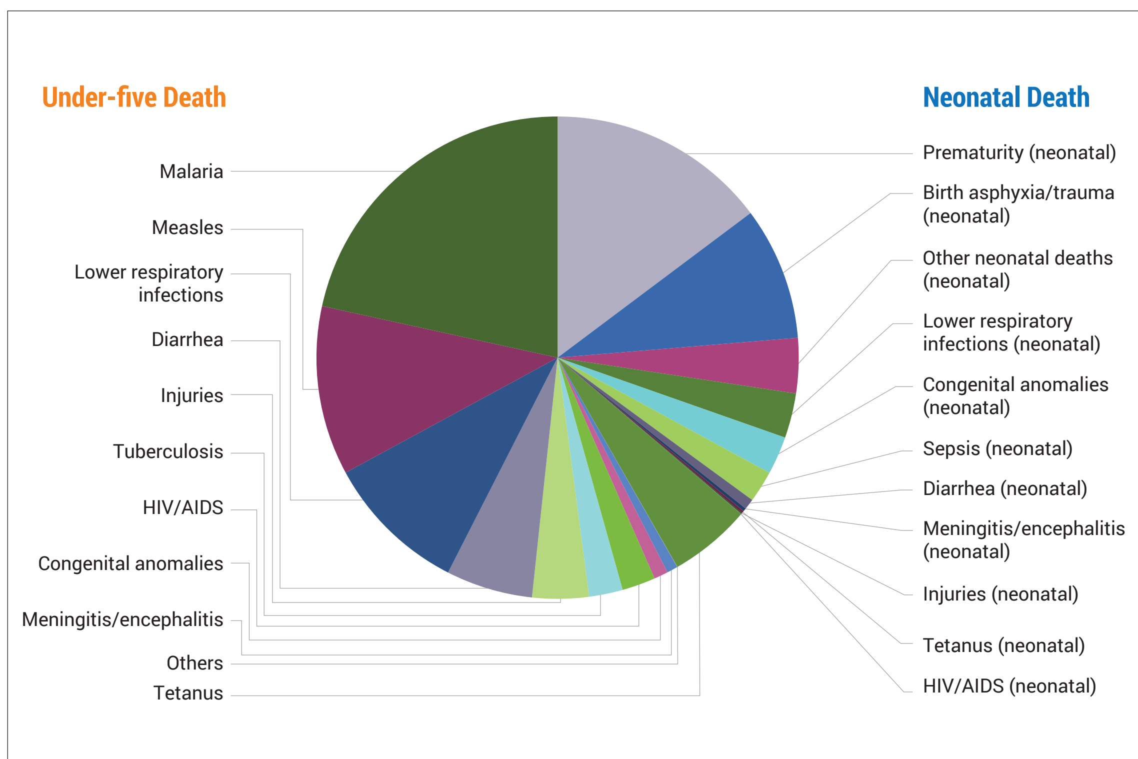

Figure 4: Causes of Newborn and Under-five Child Deaths in Liberia (2021)

Table 2: Causes of Newborn and Under-five death in Liberia (2021)[2]

Neonatal death		Under-five death	
Prematurity	15%	Malaria	22%
Birth asphyxia/trauma	9%	Measles	11%
Other neonatal deaths	4%	Lower respiratory infections	10%
Lower respiratory infections	3%	Diarrhoea	6%
Congenital anomalies	3%	Injuries	4%
Sepsis	2%	Tuberculosis	2%
Diarrhoea	1%	Meningitis/encephalitis	2%
Meningitis/encephalitis	0% (less than 1%)	Congenital anomalies	1%
Injuries	0% (less than 1%)	HIV/AIDS	1%
Tetanus	0% (less than 1%)	Tetanus	0% (less than 1%)
HIV/AIDS	0% (less than 1%)	Others	5%

2024- 2026 Liberia Child Survival Action Plan

NATIONAL GOAL: To reach an under-five mortality rate of 52 deaths per 1,000 live births by 2028.				
Objective: Reduce under-five mortality rate and promote optimal growth, protection and development of all newborn and under five children.				
Bottleneck: 1. Insufficient domestic funds for child health services.				
Strategy 1: Mobilise resources for the delivery of quality newborn and child health services.				
Key Actions	Responsible Parties	Target 2024	Target 2025	Target 2026
1.1. Conduct a Public Financing for Child Health Analysis to track expenditure on child survival including newborns and develop sustainable financing mechanisms to optimise resource allocation.	MoH, UNICEF, WHO, USAID, WB/ GFF, other partners	■ Public Financing for Child Health analysis report available with the development of policy briefs and advocacy kits.	■ Annual resource mapping and expenditure for child health conducted and report available for 2025.	■ Annual resource mapping and expenditure for child health conducted and report available for 2026.
1.2. Conduct high level engagements with legislators through meetings, policy briefs, and testimonies to present a case for increment in domestic financing for newborn and child health.	MoH, MoFDP, MIAs	■ Legislators engaged with minutes available. ■ Newborn and Child Survival forum hosted for domestic and external resource mobilisation.	■ Increased domestic spending for newborn and child health services by 2% (2024).	■ Increased domestic spending for newborn and child health services by 2% (2025).
1.3. Engage with private sector entities, philanthropic organisations and NGOs to form partnerships aimed at funding newborn and child health initiatives.	MoH, UN, USG	■ Private sector entities, philanthropic organisations, and non-governmental organisations (NGOs) are engaged and at least five partners identified to form partnerships aimed at funding child health initiatives.	■ Private sector entities, philanthropic organisations, and non-governmental organisations (NGOs) are engaged and additional five partners identified to form partnerships aimed at funding child health initiatives.	■ Private sector entities, philanthropic organisations, and non-governmental organisations (NGOs) are engaged and additional five partners identified to form partnerships aimed at funding child health initiatives.

Bottleneck: 2. Persistent stock out due to a challenging supply chain system.				
Strategy 2: Strengthen procurement and enhance equitable distribution of quality essential medicines, medical devices/equipment and commodities for newborn and child health.				
Key Actions	Responsible Parties	Target 2024	Target 2025	Target 2026
2.1. Conduct quarterly technical procurement and logistics management system review sessions at the central, county and facility levels to improve tracking the logistic management information system (LMIS) and optimise inventory control of essential medicines and supplies for newborn and child health services.	MoH, WFP, WHO, UNICEF, UNFPA, USAID, other partners	■ One technical procurement and logistics management system review sessions conducted at all levels. ■ Procurement gaps addressed to achieve and maintain an 80% stock availability rate for essential medicines, supplies and consumables for newborn and child health services across 50% of health facilities.	■ Three technical procurement and logistics management system review sessions conducted at all levels. ■ Achieve and maintain a 90% stock availability rate for essential medicines supplies and consumables for newborn and child health services across all 70% health facilities.	■ Three technical procurement and logistics management system review sessions conducted at all levels. ■ Achieve and maintain a 98% stock availability rate for essential medicines, supplies and consumables for newborn and child health services across 90%.
2.2. Conduct costed annual quantification of maternal, neonatal child health medicines and supplies, which include the appropriate forecasting and updating of essential medicines (Oxygen, amoxicillin-DT, ORS/Zinc, commodities, diagnostic tests including pulse oximeters and devices, with the required specification and quality control) (See ANNEX I).	MoH, WHO, UNICEF, USAID	■ Annual quantification report for child health medicines and supplies including neonatal commodities conducted by the end of the third quarter of 2024 and integrated into National quantification exercise.	■ Annual quantification of child health medicines and supplies including neonatal commodities conducted by the end of the first quarter of 2025 and integrated into National quantification exercise.	■ Annual quantification of child health medicines and supplies including neonatal commodities conducted by the end of the first quarter of 2026 and integrated into National quantification exercise.

Bottleneck: 2. Persistent stock out due to a challenging supply chain system.				
Strategy 2: Strengthen procurement and enhance equitable distribution of quality essential medicines, medical devices/equipment and commodities for newborn and child health.				
Key Actions	**Responsible Parties**	**Target 2024**	**Target 2025**	**Target 2026**
2.3. Develop a five-year procurement plan based on the updated lists of essential medicines and supplies RH and neonatal Kits (Ultrasound, solar blood banks, and oxygen concentrators, pulse oximeters, Bakri balloon Tamponade, non-pneumatic anti-shock, garment, Incubators, radiant warmers, CPAP machine, respiratory care consumables, suctions apparatus, etc.).	MoH, WFP, WHO, UNICEF, USAID	■ The procurement plan developed by the end of the third quarter of 2024.	■ Review and update procurement plan updated by the end of the first quarter of 2025.	■ Review and update procurement plan updated by the end of the first quarter of 2026.
2.4. Upgrade existing 5 NICUs to level II comprehensively and establish 10 additional NICUs to ensure quality services delivery.	MoH, UNICEF, UNFPA	■ 5 existing NICU upgraded to level II comprehensively.	■ 5 new NICU established and upgraded to level II comprehensive in 2025.	■ 5 new NICU established and upgraded to level II comprehensive in 2026.
2.5. Develop and implement a distribution plan for equitable distribution of essential maternal, newborn and child health diagnostics, medicines and lifesaving supplies to the last mile for CHAs and targeted EmONC facilities.	MoH, WHO, UNICEF, UNFPA, USAID	■ Distribution plan developed, implemented quarterly and reviewed annually. ■ 50% of EmONC sites supplied timely.	■ Distribution plan developed, implemented quarterly and reviewed annually. ■ 80% of EmONC sites supplied timely.	■ Distribution plan developed, implemented quarterly and reviewed annually. ■ 100% EmONC sites supplied timely.
2.6. Initiate Community Pharmacies in one EmONC health facility in Lofa in line with the new national health policy and plan.	MoH	■ Pending	■ Pending	■ Pending

Bottleneck: 2. Persistent stock out due to a challenging supply chain system.				
Strategy 2: Strengthen procurement and enhance equitable distribution of quality essential medicines, medical devices/equipment and commodities for newborn and child health.				
Key Actions	Responsible Parties	Target 2024	Target 2025	Target 2026
2.7. Develop and implement a robust maintenance plan for newborn and child health equipment and medical devices and capacity and availability of biomedical technicians in collaboration with Healthcare Management and technology Unit.	MoH, UNICEF, USAID, CHAI	■ Maintenance plan developed, implemented as planned and reviewed annually. ■ Two biomedical technicians per county received training and logistical support.	■ Maintenance plan developed, implemented as planned and reviewed annually. ■ Number of newborn and child health equipment and medical devices maintained annually. ■ Additional two biomedical technicians per county received training and logistical support.	■ Maintenance plan developed, implemented as planned and reviewed annually. ■ Number of newborn and child health equipment and medical devices maintained annually. ■ Additional two biomedical technicians per county received training and logistical support.

Bottleneck: 3. Limited competence of health workers to provide quality care.				
Strategy 3: Strengthen the capacity of healthcare workers including Community Health Assistants to improve the quality of care for newborn and child health.				
Key Actions	Responsible Parties	Target 2024	Target 2025	Target 2026
3.1. Develop/update key matvernal, newborn and child health training guides, Jobs Aids and SOPs, including IMNCI, PSBI, SSNM care, KMC, print and distribute to health facilities including private health facilities.	MoH, County Health Teams (CHTs), District Health Teams (DHTs), other partners	■ 70% of Health facilities have updated newborn and child health training guides, Jobs Aids and SOPs.	■ 90% of Health facilities have updated newborn and child health training guides, Jobs Aids and SOPs.	■ 100% of Health facilities have updated newborn and child health training guides, Jobs Aids and SOPs.
3.2. Conduct integrated training for healthcare providers in key maternal, newborn and child health services including IMNCI, PSBI, SSNB and KMC in all counties.	MoH, UNICEF, WHO, other partners	■ 35% health workers trained on revised IMNCI, PSBI, SSNB and KMC.	■ 50% health workers trained on revised IMNCI, PSBI, SSNB and KMC.	■ 65% health workers trained on revised IMNCI, PSBI, SSNB and KMC.
3.3. Support health facilities in each region to serve as Centers of Excellence (COE) for Maternal, Newborn and Pediatric Quality of Care demonstration and learning sites in a phased approach, and where COE can provide mentorship to surrounding lower-level facilities.	MoH, WHO, UNICEF	■ 50% of health facilities and 100% County health teams have Quality Improvement plans (QIPs) being implemented and tracked. ■ One health facility in each region selected as COE.	■ 100% of health facilities and 100% County health teams have reviewed and updated QIPS. ■ Three health facilities in each region selected as COE.	■ 100% of health facilities and 100% County health teams have QIPs. ■ Five health facilities in each region selected as COE.

Bottleneck: 3. Limited competence of health workers to provide quality care.				
Strategy 3: Strengthen the capacity of healthcare workers including Community Health Assistants to improve the quality of care for newborn and child health.				
Key Actions	Responsible Parties	Target 2024	Target 2025	Target 2026
3.4. Develop and implement a decentralised annual costed child health training, mentorship and supervision plans for healthcare professionals, including CHAs, by county based on evidenced data through health information systems and training database.	MoH, WHO, UNICEF, UNFPA, NGOs, CHTs, DHTs other partners	■ 50% of counties have 2024 costed training and mentorship plan by the end of second quarter of 2024.	■ 80% of counties have 2025 costed training and mentorship plans by the end of second quarter of 2024.	■ 100% of counties have 2026 costed training and mentorship plan by the end of second quarter of 2024.
3.5. Update supervision and mentoring tools including quality of care indicators and conduct bi-annual supportive supervision and mentoring from central to county level; quarterly from county to facility level; and monthly from district to facility and bimonthly to community level.	MoH, County Health Teams (CHTs), District Health Teams (DHTs), other partners	■ 70% of supervisory visits conducted at all levels.	■ 80% of supervisory visits conducted at all levels.	■ 90% of supervisory visits conducted at all levels.
3.6. Conduct refresher training for CHAs in iCCM for Malaria, ARI and diarrhoea to increase demand for Immunization and Nutrition services and ensure quality improvements in line with community health policy and strategy.	MoH, UNICEF, LMH, PIH, Plan, IRC	■ 1,000 CHAs refreshed and capacitated to provide iCCM services and increase demand for immunisation services.	■ 1,500 CHAs refreshed and capacitated to provide iCCM services and increase demand for immunisation services.	■ 2,000 CHAs refreshed and capacitated to provide iCCM services and increase demand for immunisation services.

Bottleneck: 3. Limited competence of health workers to provide quality care.				
Strategy 3: Strengthen the capacity of healthcare workers including Community Health Assistants to improve the quality of care for newborn and child health.				
Key Actions	Responsible Parties	Target 2024	Target 2025	Target 2026
3.7. Scale up quality IMNCI services including Paediatric Emergency Triage and Treatment (ETAT) through annual refresher training plan for health facility workers.	MoH, WHO, UNICEF	■ 30% of healthcare workers refreshed in IMNCI and ETAT.	■ 60% of healthcare workers refreshed in IMNCI and ETAT.	■ 90% of healthcare workers refreshed in IMNCI and ETAT.
3.8. Capacity building of healthcare providers including doctors, obstetric and neonatal technicians, nurses, midwives and laboratory technicians in advanced care of Maternal, neonatal and child health in targeted EmONC facilities (ENC, PPH, Birth Asphyxia, Neonatal sepsis, prematurity, maternal sepsis, hypertensive disorders, obstructed labour, care of the sick child with danger signs).	MoH, WHO, UNFPA, UNICEF	■ 30% of regional and tertiary hospitals received refresher training for healthcare workers in advanced care for Sick and Small Newborns (SSNB), child health and maternal care.	■ 60% of regional and tertiary received refresher training for healthcare workers in advanced care for SSNB child health and maternal care.	■ 90% of regional and tertiary hospitals refreshed the healthcare workers in advanced care of in advanced care for SSNB child health and maternal care.
3.9. Support scale-up of task-shifting programmes through the training of Nurses, midwives and Physician Assistants as Neonatal and Obstetric clinicians in the targeted CEmONC facilities.	MoH, WHO, UNICEF, UNFPA, Jhpiego, Last Mile Health	■ The list of trainees developed and received the task-shifting program at 5 targeted CEmONC facilities.	■ The list of trainees developed and received the task-shifting program at additional 7 targeted CEmONC facilities.	■ The list of trainees developed and received the task-shifting program at additional 7 targeted CEmONC facilities.

Bottleneck: 3. Limited competence of health workers to provide quality care.				
Strategy 3: Strengthen the capacity of healthcare workers including Community Health Assistants to improve the quality of care for newborn and child health.				
Key Actions	Responsible Parties	Target 2024	Target 2025	Target 2026
3.10. Promote appropriate rewards such as certificates of recognition and awards given to the best performing health facilities and healthcare workers.	MoH, CHTs, UNICEF	■ Best five performing health facilities and healthcare workers identified and rewarded by the end of 2024.	■ Best five performing health facilities and healthcare workers identified and rewarded by the end of 2025.	■ Best five performing health facilities and healthcare workers identified and rewarded by the end of 2026.
3.11. Develop, distribute and train healthcare providers on the use of screening forms for universal and routine, early functional screening in newborns and children (age 0-6), focused on key mobility, vision, and hearing developmental milestones, to facilitate timely identification of disabilities and referrals.	MoH, WHO, UNICEF, CHAI, LBNM, LMDC, PAs Association, other partners	■ Developed screening forms in newborns and children aged 0-6. ■ 30% of HFs distributed and utilised screening forms.	■ 60% of HFs distributed and utilised screening forms.	■ 90% of HFs distributed and utilised screening forms.
3.12. Conduct integrated training and mentoring of mid-level cadres on early functional screening and referrals.	MoH, WHO, UNICEF, CHAI, other partners	■ 50% of mid-level cadres trained and mentored on early functional screening and referrals.	■ 70% of mid-level cadres trained and mentored on early functional screening and referrals.	■ 100% of mid-level cadres trained and mentored on early functional screening and referrals.
3.13. Conduct integrated training for primary health care facilities to provide quality gender responsive mental health services.	MoH, WHO, UNICEF, The Cater Center	■ 30% of primary health care facilities trained in the quality of gender responsiveness of mental health services.	■ 60% of primary health care facilities trained in the quality of gender responsiveness of mental health services.	■ 90% of primary health care facilities trained in the quality of gender responsiveness of mental health services.

Bottleneck: 4. Limited and uneven distribution of qualified human resources.				
Strategy 4: Strengthen the production, availability and equitable distribution of qualified and competent healthcare workers for newborn and child survival across the country at various levels of care.				
Key Actions	Responsible Parties	Target 2024	Target 2025	Target 2026
4.1. Review, update and implement the existing human resource of healthcare providers policy on transfer and rotation of key trained personnel.	MoH, partners	■ Rotation and transfer policy updated, printed and disseminated by the end of fourth quarter of 2024 and engaged with human resources for county health teams and healthcare facilities managers.	■ Policy operationalised to 60% across the country.	■ Policy operationalised at 100% and is fully monitor
4.2. Conduct human resource needs assessment for maternal, newborn and child health services.	MoH, Liberian College Physicians and Surgeons (LCPS), LBNM, WHO, UNICEF, USAID	■ Human resource needs assessment report finalised and priority actions identified.	■ 50% of prioritised actions implemented and midterm review conducted.	■ 50% of prioritised actions implemented and end of term review conducted.
4.3. Develop human resource redistribution plans for maternal, newborn and child health services.	MoH, partners	■ HRH redistribution plan finalised and implemented.	■ 50% of MCH human resource redistribution plan implemented.	■ 80% of MCH human resource redistribution plan implemented.
4.4. Enhance retention of maternal, newborn and child health staff in rural areas by setting rural packages of incentive to motivate staff.	MoH, Ministry of Finance Development and Planning (MFDP)	■ Advocated and engaged with senior management of MoH.	■ Incentivize rural health workers included in the MoH budget in 2025.	■ 20% of the quantity of the rural health workforce for newborn and child health care increased and the skill gap reviewed.

Bottleneck: 4. Limited and uneven distribution of qualified human resources.				
Strategy 4: Strengthen the production, availability and equitable distribution of qualified and competent healthcare workers for newborn and child survival across the country at various levels of care.				
Key Actions	Responsible Parties	Target 2024	Target 2025	Target 2026
4.5. Provide a performance-based motivational package for newborn and child health staff in urban and rural areas.	MoH, partners	■ Newborn and child health indicators included as part of the performance based motivational contract.	■ 40% of healthcare workers for newborn and child health received incentives based on the performance based motivational package.	■ 80% of healthcare workers for newborn and child health received incentives based on the performance based motivational package.

Bottleneck: 4. Limited and uneven distribution of qualified human resources.				
Strategy 4: Strengthen the production, availability and equitable distribution of qualified and competent healthcare workers for newborn and child survival across the country at various levels of care.				
Key Actions	Responsible Parties	Target 2024	Target 2025	Target 2026
4.6. Enhance training and equitable distribution of competent paediatric clinicians, paediatric nurses, nurses and midwives in collaboration with the paediatric association, nursing and midwifery associations of Liberia to provide quality health care services for newborns and children.	MoH, LCPS, UL, MCAI, UNICEF	■ Established a formal partnership between MoH, university of Liberia and paediatric association to standardise the training package for paediatric clinicians and conduct on-site mentoring.	■ Finalised package for the training paediatric clinicians and rolled out in at least two institutions of learning in quarter two. ■ Decentralised on-site mentoring conducted at least 50% in EmONC facilities across the country. ■ 40% of BEmONC facilities staffed with at least 2 paediatric clinicians and 2 neonatal clinicians, 5 nurses and 5 midwives. ■ 40% of CEmONC facilities staffed with at least 4 paediatric and 3 neonatal clinicians, 8 nurses/ midwives in EmONC facilities.	■ Decentralised on-site mentoring conducted at least 80% in EmONC facilities across the country. ■ 80% of BEmONC facilities staffed with at least 2 paediatric clinicians and 2 neonatal clinicians, 5 nurses and 5 midwives. ■ 80% of CEmONC facilities staffed with at least 4 paediatric and 3 neonatal clinicians, 8 nurses/ midwives in EmONC facilities.

Bottleneck: 4. Limited and uneven distribution of qualified human resources.				
Strategy 4: Strengthen the production, availability and equitable distribution of qualified and competent healthcare workers for newborn and child survival across the country at various levels of care.				
Key Actions	**Responsible Parties**	**Target 2024**	**Target 2025**	**Target 2026**
4.7. Establish/ strengthen an integrated health care workers in-service training database for RMNCAH+N, to quantify gaps in training and to inform needs for refresher training.	MoH, partners	■ iHRIS reactivated and 40 HR officers trained.	■ 100% of training needs of health workers identified and 40% identified training needs are addressed.	■ 80% identified training needs are addressed.
4.8. Enforce compliance with MoH's new continuing professional development (CPD) strategy for all cadres, including rolling out of eLearning platforms with offline capabilities that incorporate newborn and child health topics.	MoH, licensing and professional boards	■ CPD strategy reviewed and evaluated strategy for all cadres in line with the LBNM coordination.	■ CPD strategy implemented, reviewed and annually evaluated.	■ CPD strategy implemented, reviewed and annually evaluated.
4.9. Update pre-service training curricula based on current best practices, to ensure comprehensive coverage of RMNCAH+N topics and strengthen graduate competencies.	MOH, training institutions, licensing and professional boards	■ Engaged the LBNM to update pre-service training curricula and ensure the alignment of newborn and child survival competencies.	■ 40% of pre-service health workforce newborn and child survival competencies trained by new curricula.	■ 80% of pre-service health workforce newborn and child survival competencies trained by new curricula.

Bottleneck: 5. Weak monitoring and evaluation of child survival services.				
Strategy 5: Strengthen health information systems, monitoring and evaluation, and research for effective delivery of evidence-based newborn and child health services.				
Key Actions	Responsible Parties	Target 2024	Target 2025	Target 2026
5.1. Review and update newborns, perinatal and child health indicators including stillbirths in the DHIS2 to develop and disseminate RMNCAH Scorecards and wall charts.	MoH, WHO, UNICEF, LMH, USAID, UNFPA, Jhpiego, CHAI	■ Reviewed and updated newborn and child health indicators in the DHIS2. ■ Quarterly RMNACH scorecards reviewed.	■ 100% quality, timeliness and completeness of newborn and child health data in the DHIS2. ■ Quarterly RMNCAH scorecards reviewed.	■ 100% quality, timeliness and completion of newborn and child health data in the DHIS2. ■ Quarterly RMNCAH scorecards reviewed.
5.2. Strengthen the eCBIS system by training on data collection, verification and quarterly monitoring.	MoH, CHTs, DHTs, LMH	■ Trained and deployed the CHA, CHSS, CHPs and DHT with eCBIS data collection, reporting and monitoring.	■ 100% quality, timeliness and completeness of newborn and child health data in the eCBIS. ■ Monitored the data from the eCBIS system and received feedback from the central level to the counties, districts, facilities and communities. ■ eCBIS integrated into the DHIS2 (interoperability).	■ 100% quality, timeliness and completeness of newborn and child health data in the eCBIS. ■ Monitored the data from the eCBIS system and received feedback from central level to the counties, districts, facilities and communities.
5.3. Improve national and county newborn and child health data by leveraging digitalization for real time reporting to enhance evidence-based decision-making including the roll out the integrated eLMIS, mSupply and eCBIS platforms in all CEmONC facilities and strengthen the LMIS in targeted BEmONC facilities.	MoH/ HMIS, FHP, UNICEF, UNFPA, Jhpiego, LMH	■ Introduced Kobo platform and or related platform in all CEmONC facilities, coordinated supervision, implemented and real-time data on maternal, newborn child health indicators and supplies available.	■ Coordinated supervision, implemented and real-time data on newborn and child health indicators available from 80% of CEmONC facilities. ■ Introduced Kobo platform and or related platform in 20% of BEmONC facilities,	■ Coordinated supervision, implemented and real-time data on child health indicators available 95% of CEmONC and 50% of BEmONC facilities.

Bottleneck: 5. Weak monitoring and evaluation of child survival services.				
Strategy 5: Strengthen health information systems, monitoring and evaluation, and research for effective delivery of evidence-based newborn and child health services.				
Key Actions	**Responsible Parties**	**Target 2024**	**Target 2025**	**Target 2026**
5.4. Strengthen and scale up birth registration in all health facilities.	MoH, UNICEF, CSO	■ 20% increase in health facilities providing birth registration and certificates.	■ 40% increase in health facilities providing birth registration.	■ 60% increase in health facilities providing birth registration.
5.5. Strengthen MPNDSR system and implementation by encouraging the timely conduct of maternal, perinatal (including stillbirths which should be desegregated into macerated and fresh), neonatal, and paediatric death audits and recommendations.	MoH, NPHIL, WHO, WB/ GFF, CHT, Health facilities	■ Developed and integrated maternal, newborn and paediatric death audits guidelines and trained healthcare workers at health facilities to perform accurate documentation in 30% of facilities. ■ 2 monitoring visits from central to county and 4 monitoring visits from county to facilities conducted, feedback meetings held and reports disseminated. 50% of MPNDSR recommendations implemented timely.	■ 4 monitoring visits from central to county and 8 monitoring visits from county and district to facilities conducted, feedback meetings held and reports disseminated. ■ Neonatal and paediatric death audits with clear recommendations and appropriate actions taken in 70% of facilities.	■ 6 monitoring visits from central to county and 12 monitoring visits from county and district to facilities conducted, feedback meetings held and reports disseminated. ■ Neonatal and paediatric death audits with clear recommendations and appropriate actions taken in 90% of facilities.
5.6. Conduct baseline, midline and endline client satisfaction surveys on MNCH services in all EmONC facilities to determine areas for improvement in quality MNCH service delivery.	MOH, UNFPA, UNICEF, Jhpiego, Last Mile Health, MCAI	■ A baseline Client satisfaction survey conducted, and report disseminated at the RHTC and CHTWG.	■ Mid-line Client satisfaction survey conducted, and report disseminated at the RHTC and CHTWG with clear recommendations agreed upon.	■ Endline Client satisfaction survey conducted, and report disseminated at the RHTC and CHTWG.

Bottleneck: 5. Weak monitoring and evaluation of child survival services.				
Strategy 5: Strengthen health information systems, monitoring and evaluation, and research for effective delivery of evidence-based newborn and child health services.				
Key Actions	Responsible Parties	Target 2024	Target 2025	Target 2026
5.7. Support the implementation-research around community mother support groups in the promotion of safe quality maternal newborn and child care and maternal, neonatal and paediatric deaths at community level.	MOH, NPHIL, UNFPA, UNICEF, LMH, CHAI, UL Tertiary Facilities	■ TWG created to support the implementation of the research. ■ Resources mobilised to conduct the research.	■ 2025 Operational RMNCAH research conducted and research findings operationalized.	■ 2026 Operational RMNCAH research conducted and research findings operationalized.

Bottleneck 6. Weak program management and coordination among national stakeholders and international partners.				
Strategy 6: Strengthen program management and coordination mechanism for effective implementation of newborn and child survival interventions.				
Key Actions	Responsible Parties	Target 2024	Target 2025	Target 2026
6.1. Conduct the quality monthly CHTWG meetings at the central level with quarterly tracking of the Child Survival Action Plan.	MoH, MoFDP, MoE, MoGCSP, NPHIL, UNICEF, USAID, WB/GFF	■ 12 CHTWG meetings held and 2 CSAP reviewed and recommendations made by CHTWG within the CSAP accountability framework.	■ 24 CHTWG meetings were held and 4 CSAP reviews and recommendations made by CHTWG within the CSAP accountability framework.	■ 36 CHTWG meetings were held and 4 CSAP reviews and recommendations made by CHTWG within the CSAP accountability framework.
6.2. Engage biannually with the Health Sector Coordination Committee on newborn and child health services and other partners for policy changes that would increase equitable access and improve the quality of care for IMNCI.	MoH, WHO, UNICEF, CHAI	■ Made presentations to the members of the Health Sector Coordination Committee and advocated for support of new policy.	■ Monitored actions pledged by the Health Sector Coordination Committee.	■ Monitored actions pledged by the Health Sector Coordination Committee.
6.3. Establish and strengthen at county level of CHTWG with defined terms of reference and membership and conduct regular meetings.	MoH/CHTs	■ 30% of counties (5 counties) have established CHTWG and at least 2 meetings are held with minutes available.	■ 70% of counties (11 counties) have established CHTWG and at least 6 meetings are held with minutes available.	■ 100% of counties (15 counties) have established CHTWG and at least 6 meetings are held with minutes available.
6.4. Conduct quarterly review of the CSSAP monitor and evaluate activities.	MoH, UNICEF, USAID	■ 2 CSSAP reviews and recommendations made by CHTWG.	■ 4 CSSAP reviews and recommendations made by CHTWG.	■ 4 CSSAP reviews and recommendations made by CHTWG.

Bottleneck 6. Weak program management and coordination among national stakeholders and international partners.				
Strategy 6: Strengthen program management and coordination mechanism for effective implementation of newborn and child survival interventions.				
Key Actions	Responsible Parties	Target 2024	Target 2025	Target 2026
6.5. Engage with Global Child Survival Action Taskforce and conduct quarterly meetings with the country to assess country's child health progress and provide global guidance.	MoH, UNICEF, USAID, WB/ GFF, WHO	■ Global Child Health Taskforce engaged 3 meetings held with minutes available.	■ 4 joint Country and Global Child health Taskforce meetings were held with minutes available.	■ 4 Joint Country and Global Child Task Force meetings held with minutes available.
6.6. Include and highlight maternal, newborn and child health activities in annual national and county health operational plans in line with national plan.	MoH, WHO, UNICEF, World Bank, CHTs	■ National and 50% of County 2024 Operational plans developed in line with national plan highlighting newborn and child health activities by the end of the third quarter of 2024.	■ National and 100% of County 2024 Operational plans developed in line with national plan highlighting newborn and child health activities by the end of the first quarter of 2025.	■ National and 100% of County 2024 Operational plans developed in line with national plan highlighting newborn and child health activities by the end of the first quarter of 2026.
6.7. Ensure that newborn and child health is a standing agenda in the HSCC and HCC meetings.	MoH, partners	■ Advocated for newborn and child health support in HCC quarterly and in HSCC half yearly. ■ Updates provided at each meeting.	■ Newborn and child health key updates provided in 90% of HCC and 100% of HSCC meetings.	■ Newborn and child health key updates provided in 90% of HCC and 100% of HSCC meetings.

Bottleneck: 7. Weak integrated approach to the Quality of Care for child health services and programs.				
Strategy 7: Strengthen integration for improved quality of care and efficiency for newborn and child survival services.				
Key Actions	Responsible Parties	Target 2024	Target 2025	Target 2026
7.1. Conduct regular collaboration briefing among partners (MNCH, Immunization, Malaria, HIV, Nutrition, WASH, Social Protection, Disability-inclusive care and Social Behavior) of child health at CHTWG meetings.	MoH, Ministry of Public Works (MoPW), NPHIL, MoGCSP, MoFPD, MoE, Youth and Sports, UN Agencies USAID, other partners	■ 4 collaboration briefing done at CHTWG meeting highlighting key integrations done in line with County and National operational plans.	■ 4 collaboration briefing done at CHTWG meeting highlighting key integrations done in line with County and National operational plans.	■ 4 collaboration briefing done at CHTWG meeting highlighting key integrations done in line with County and National operational plans.
7.2. Strengthen the conduct of joint integrated implementation and monitoring visits of newborn and child health interventions plans among partners (Immunization, Malaria, HIV, Nutrition, WASH, Social Protection, Disability-inclusive care and Social Behavior) in line with electronic joint integrated supportive supervision (eJISS).	MoH, MoPW, NPHIL, MoGCSP, MoFPD, MoE, MOA, WHO, UNICEF, USAID, other partners	■ 2024 Mapping of newborn and child health interventions and joint partnerships at all levels available. ■ CHTWG at county level strengthened (Action 6.3). ■ A partners joint monitoring plan developed and 2 visits conducted in line with the eJISS.	■ 2025 Mapping of Child Health Interventions and joint partnerships at County level available. ■ A partners joint monitoring plan developed and 4 visits conducted by CHTWG.	■ 2026 Mapping of Child Health Interventions and joint partnerships at County level available. ■ A partners joint monitoring plan developed and 4 visits conducted by CHTWG.

Bottleneck: 7. Weak integrated approach to the Quality of Care for child health services and programs.				
Strategy 7: Strengthen integration for improved quality of care and efficiency for newborn and child survival services.				
Key Actions	Responsible Parties	Target 2024	Target 2025	Target 2026
7.3. Reinforce existing community networks - which include adolescents and young people to contribute as actors in support of social protection, health, nutrition, WASH and social behaviour.	MoH, NPHIL, NWASHC, UNICEF and other partners	■ Relevant partners contributing newborn, child, adolescent and young people in the areas of social protection, health, nutrition, WASH and social behaviour involved in existing community networks including CHTWG.	■ Sustained the membership and engagement of adolescent and young people in community networks.	■ Sustained the membership and engagement of adolescent and young people in community networks.
7.4. Support the consolidation of Maternal, Newborn and Child Health (Big Belly Book and Child Health Passport) records through the roll out of the home-based Maternal Newborn and Child Health Record for optimised continuous care.	MOH, UNICEF, JICA, Breakthrough ACTION, AmeriCares	■ The integrated Home-based MNCH records developed.	■ The Home-based MNCH records rolled out in health facilities at 50%.	■ The Home-based MNCH records rolled out in health facilities at 100%.

Bottleneck: 7. Weak integrated approach to the Quality of Care for child health services and programs.				
Strategy 7: Strengthen integration for improved quality of care and efficiency for newborn and child survival services.				
Key Actions	Responsible Parties	Target 2024	Target 2025	Target 2026
7.5. Conduct awareness campaigns for the community and provide training for healthcare workers on exclusive breastfeeding for the first six months of life for healthcare workers by the partnership between Nutrition and Social Behavior Change and other relevant partners.	MoH, WHO, UNICEF, USAID,	■ Conduct Annual Community Awareness Campaigns on Exclusive Breastfeeding during Breast Feeding Week using existing community health structures (HFDC, CHAs, CHSS, CHVs, CHPs).	■ Conduct Annual Community Awareness Campaigns on Exclusive Breastfeeding during Breast Feeding Week using existing community health structures (HFDC, CHAs, CHSS, CHVs, CHPs). ■ 30% of healthcare workers trained through awareness campaigns and training sessions conducted by the integrated Nutrition, Social Change Behavior and other relevant partners team.	■ Conduct Annual Community Awareness Campaigns on Exclusive Breastfeeding during Breast Feeding Week using existing community health structures (HFDC, CHAs, CHSS, CHVs, CHPs). ■ 50% of healthcare workers trained through awareness campaigns and training sessions conducted by the integrated Nutrition, Social Change Behavior and other relevant partners team.

Bottleneck: 8. Weak public and private partnership on child survival.				
Strategy 8: Strengthen public-private partnerships for newborn and child survival services.				
Key Actions	Responsible Parties	Target 2024	Target 2025	Target 2026
8.1. Support the development of the national private-public collaboration framework and plan on newborn and child health for implementation including monitoring data and accountability in private sector health providers.	MoH, WHO	■ Develop/ revise national, public-private collaboration framework and integrate newborn and child health interventions.	■ Implement and track the national private-public collaboration framework.	■ Implement and track the national private-public collaboration framework.
8.2. Strengthen links and engagement with private health care facilities (e.g. Healthcare Federation of Liberia (HFL) through meetings including CHTWG, and joint monitoring visits.	MoH, CHT, private sector representatives	■ 2 engagement meetings held with Private healthcare facilities. ■ Conduct biannual joint monitoring visits conducted with recommendations tracked.	■ Quarterly meetings held with private healthcare facilities. ■ Biannual joint monitoring visits with recommendations tracked.	■ Quarterly meetings held with private healthcare facilities. ■ Biannual joint monitoring visits with recommendations tracked.
8.3. Distribute updated protocols, guidelines, checklists, tools, and SBCC materials for newborn and child health services to private providers.	MoH, CHT, Liberian Medical Dental Council (LMDC)	■ Updated protocols, guidelines, checklists, tools and other materials distributed to 30% of private providers by the last quarter of 2024.	■ The protocols, guidelines, checklists, tools and other materials distributed to 50% of private providers.	■ The protocols, guidelines, checklists, tools and other materials distributed to 100% of private providers.

Bottleneck: 8. Weak public and private partnership on child survival.				
Strategy 8: Strengthen public-private partnerships for newborn and child survival services.				
Key Actions	Responsible Parties	Target 2024	Target 2025	Target 2026
8.4. Conduct training/ refresher training for private sector healthcare providers to deliver quality newborn and under-five health services.	MoH, CHT, LMDC	■ Conducted training/refresher training for at least 10% of private health facilities.	■ Conducted training/refresher training for 30% of private health facilities.	■ Conducted training/refresher training for at 60% of private health facilities.

Bottleneck: 9. Limited level of advocacy and social mobilisation for child health.				
Strategy 9: Strengthen advocacy, communication and social mobilisation to increase awareness of the importance of newborn and child survival.				
Key Actions	Responsible Parties	Target 2024	Target 2025	Target 2026
9.1. Develop, implement and evaluate a focused advocacy and communication strategy and plan on newborn and child health; interpersonal communication, engagement with community, campaigns using mobile technology and other mass media for increased focus on newborn and child health.	MoH, FDP, Legislature, UNICEF, Break through Action, LMH, CHAI and other partners	■ A focused advocacy and communication strategy and advocacy plan on newborn and child health developed.	■ The advocacy and communication strategy on newborn and child health implemented and tracked.	■ The advocacy and communication strategy on newborn and child health reviewed and updated.
9.2. Conduct annual sensitization meetings for political and community leaders to reinforce local political leadership, ownership and accountability to recommit to newborn and child health as a public good and a basic right of every child.	MoH, MIA	■ Annual sensitization meetings conducted for political and community leaders.	■ Annual sensitization meetings conducted for political and community leaders.	■ Annual sensitization meetings conducted for political and community leaders.
9.3. Identify and support national and county champions for newborn and child health by working with communities to boost trust in the health care systems.	MoH, partners	■ National and county champions for maternal, newborn and child health mapped.	■ Work Plan developed and implemented for national and county champions for maternal, newborn and child health.	■ Work Plan implemented for national and county champions for maternal, newborn and child health.

Bottleneck: 9. Limited level of advocacy and social mobilisation for child health.				
Strategy 9: Strengthen advocacy, communication and social mobilisation to increase awareness of the importance of newborn and child survival.				
Key Actions	Responsible Parties	Target 2024	Target 2025	Target 2026
9.4. Commemorate child health days e.g.: 1. Day of the African Child, 2. World Prematurity Day, 3. World Pneumonia Day, 4. World Malaria Day and 5. World Breastfeeding Week, etc.	MoH, partners	■ Celebrations of Child Health Day, World Pneumonia Day, World Prematurity Day, World Breastfeeding Day etc. held to increase awareness.	■ Celebrations of Child Health Day, World Pneumonia Day, World Prematurity Day, World Breastfeeding Day etc. held to increase awareness.	■ Celebrations of Child Health Day, World Pneumonia Day, World Prematurity Day, World Breastfeeding Day etc. held to increase awareness.

Cost of Implementing the Child Survival Strategy and Action Plan

The total estimated cost of implementing the Child Survival Strategy and Action Plan to achieve the country's acceleration targets is $8,619,146 over a three-year period. The estimated cost per annum and per strategy is shown in the table below.

Table 3: Summary cost of the Child Survival Strategy and Action Plan by year (All costs are in USD)

Child Survival Strategy and Action Plan Costing 2024-2026				
Strategy	Year 1 (US$)	Year 2 (US$)	Year 3 (US$)	Total
Strategy 1: Mobilise resources for the delivery of quality child health services.	29,432	29,432	29,432	88,296
Strategy 2: Strengthen procurement and enhance equitable distribution of quality essential medicines, medical devices/ equipment and commodities for child health.	219,153	213,855	213,855	646,864
Strategy 3: Strengthen the capacity of healthcare workers including Community Health Assistants to improve the quality of care for child health.	1,770,963	1,124,925	1,124,925	4,020,813
Strategy 4: Strengthen the production, availability and equitable distribution of qualified and competent healthcare workers for child survival across the country at various levels of care.	30,208	25,050	25,050	80,308
Strategy 5: Strengthen health information systems, monitoring and evaluation, and research for effective delivery of evidence-based child health services.	928,998	250,845	250,845	1,430,688
Strategy 6: Strengthen program management and coordination mechanism for effective implementation of child survival interventions.	6,800	6,800	6,800	20,400
Strategy 7: Strengthen integration for improved quality of care and efficiency for child survival services.	166,998	166,998	166,998	500,994
Strategy 8: Strengthening public-private partnerships for child survival services.	29,832	25,000	25,000	79,832
Strategy 9: Strengthen advocacy, communication and social mobilisation for the delivery of quality child survival services.	706,115	521,548	523,288	1,750,951
TOTAL	3,888,499	2,364,453	2,366,193	8,619,146