Ministry of Health Liberia

LIBERIA CHILD SURVIVAL STRATEGY (CSS)

2024-2028

Republic of Liberia

Ministry of Health Liberia

LIBERIA CHILD SURVIVAL STRATEGY (CSS)

2024-2028

Republic of Liberia

Ministry of Health Liberia

LIBERIA CHILD SURVIVAL STRATEGY (CSS)

2024-2028

Republic of Liberia

Table of Contents

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 decades has been on the decline, and there is an urgent need for accelerated action to get back on track and be among the countries poised 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. Various initiatives and frameworks have been developed and implemented by the health sector to address the problem of high under-five mortality. However, despite these interventions, under-five mortality remains high.

The Government of Liberia, through the Ministry of Health, other ministries, and partners on child survival and development, is committed to reversing the situation in the country. It aims 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 that need to accelerate its actions towards child survival, we, as a country, have developed this five-year Child Health Strategy and a three-year Action Plan to further 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 tackling key bottlenecks. Furthermore, it provides a costed action plan with clearly marked timelines for implementation to facilitate resource mobilisation, monitoring, and evaluation, and scaling up of proposed child health interventions. All stakeholders working towards the improvement of the health of children in Liberia are expected to buy into this plan and collaborate towards scaling up the child survival interventions to significantly reduce neonatal, post-neonatal, infant, childhood, and adolescent deaths, thereby attaining the goals and objectives as outlined in this document.

Dr. Louise M. Kpoto
MD, MPH, MMed-OBGYN, Ph.D
Minister of Health,
Republic of Liberia

Acknowledgement

This Child Health Strategy 2024–2028 was developed with contributions from various individuals, experts, and organisations working on child survival. The Family Health Division extends sincere gratitude and appreciation to the Minister of Health, Dr Louise M. Kpoto; the Deputy Minister for Health Services and Chief Medical Officer, Republic of Liberia, Dr Catherine Thomas Cooper; and Hon. Maylee Tamba Chyloe, Deputy Minister of Policy, Planning and Monitoring & Evaluation. The Ministry is also grateful to the health team at UNICEF Liberia for their technical and financial support throughout the development and validation of the Child Survival Strategy (CSS) and Action Plan.

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 the above, the Family Health Division wants to recognise and express sincere thanks and profound gratitude to the heads of the Health Financing, Monitoring & Evaluation, and Health Information System units/divisions from the Ministry of Health. The contributions of the Reproductive Health (RH) supervisors in 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, and 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
MD Deputy Minister for Health Services/Chief Medical Officer-RL
Ministry of Health
Republic of Liberia

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	Convention on the Rights of the Child
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

Executive Summary

Liberia was among the nations that achieved the Millennium Development Goals for child health in 2015. It was expected that Liberia would have sustained the gains made in child health for mortality reduction and even improved further. However, the Liberia Demographic Health Survey (LDHS) 2019/2020 showed that the country had regressed on childhood mortality instead of improving on its earlier gains.[1] This current downward trend and slow progress in child health have precipitated the development of a five-year Child Survival Strategy, inclusive of a three-year costed Action Plan.

A thorough inception report was conducted depicting the current situation of child health, which highlighted key bottlenecks affecting the smooth delivery of child health services in Liberia. Key bottlenecks identified include insufficient domestic funds and resource mobilisation for child health services; persistent stock outs due to a challenging supply chain system; limited competence of healthcare workers to provide quality care; limited and uneven distribution of qualified human resources; weak monitoring and evaluation of child survival data and services; weak programme management and coordination among national stakeholders and international partners; weak integrated approaches to the quality of care for child health services and programmes; weak public and private partnerships for child survival; and limited levels of advocacy and social mobilisation for child health. While these were identified as the major bottlenecks, the principal causes of mortality, as per child health categories, were also shown and highlighted. Neonatal deaths contributed to 39% of under-five deaths in 2021. The three major causes of neonatal deaths are prematurity, birth asphyxia, lower respiratory infections, and neonatal sepsis.[2] In the 1–59 months age group, which accounts for 61% of under-five deaths, malaria, measles, lower respiratory infections, and diarrhoeal diseases are the leading causes of child morbidity and mortality in Liberia.[2]

While Liberia subscribes to strengthening equitable and comprehensive child health programmes focused on children aged 0 to 18 years, it is worth noting that Liberia is among 59 countries that are lagging or, simply put, are off track in attaining SDG targets aligned with the Child Survival Action (CSA) Initiative vision of ending preventable deaths of children by 2030, with all countries reducing under-five mortality to 25 or fewer deaths per 1,000 live births. Considering the current child mortality trend, the Child Health Technical Working Group (CHTWG), consisting of the Ministry of Health (MoH) and key technical partners, has been established to accelerate the reduction of child mortality and improve children's lives. The Ministry of Health in Liberia agreed that this five-year Child Survival Strategy and three-year Action Plan should be primarily geared towards addressing the plight of children under five, while subsequent operational plans and policies will seek to address issues affecting children aged six to eighteen years. This is not to imply that health issues of children aged 6–18 years will not be addressed.

This Child Survival Strategy and Action Plan has an ambitious goal of reducing the under-five mortality rate from 93 per 1,000 live births in 2019/2020 to 52 deaths per 1,000 live births by 2028.1 This constitutes a 44% reduction over a five-year period. While this may appear very ambitious, it is what the country must strive to achieve if it is to save the lives of under-fives, who are the future of the nation, and reach the SDG target in child health reduction by 2030. To achieve this goal, the Child Survival Strategy and Action Plan is developed in alignment with the Every Newborn Action Plan/Ending Preventable Maternal Mortality

1 The Government of Liberia. (2020). Liberia Demographic Health Survey (LDHS) 2019/2020

2 UN Inter-agency Group for Child Mortality Estimation. (2023). UNIGME Report 2023.

(ENAP/EPMM), aiming to reduce neonatal mortality from the current figure of 37 per 1,000 live births to 13 per 1,000 live births.[3,4] This emphasises the continuum of care for children throughout pregnancy and beyond because a mother's health has a profound impact on her child's survival. The general aim of the strategy is to reduce under-five mortality and promote optimal growth, protection, and development of all newborns and children aged under five years through a comprehensive life course approach. The strategy will achieve this through five specific objectives, which are outlined as follows:

Enhance evidence-based practices for routine and emergency care, including Emergency Triage and Treatment (ETAT), Emergency Obstetric and Neonatal Care (EmONC), and care for Small and Sick Newborns, by building the capacity of healthcare workers to provide improved quality of care.

Strengthen and expand the 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).

Strengthen interventions and their integration that 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).

Strengthen birth registration, Maternal, Perinatal, and Newborn Death Surveillance and Response (MPNDSR), and paediatric death audits to count and review stillbirths, newborns, and under-five deaths, promoting data-informed continuous process improvement (quality of care) and sustaining health outcomes for newborns and under-five children.

Promote advocacy, community mobilisation, and behavioural change communication for newborn and child health care services.

This document provides relevant country information based on a comprehensive report on the situational analysis of child health in Liberia. It outlines the basis for the strategies and activities detailed here, aimed at addressing the unfinished child survival agenda[5]. The Child Health Strategy and Action Plan consists of nine distinct strategies and fifty-nine activities. The strategies mentioned in this document are as follows:

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.

This document outlines the main intervention packages and their application at various levels in the health system, categorising the interventions into protect, treat, and prevent. It also examines the current partner mapping, which depicts areas of support and the intervention packages provided, and includes a SWOT analysis outlining the current strengths, weaknesses, opportunities, and threats to the child health programme in Liberia.

The Child Survival Strategy and Action Plan have a set of twenty-five indicators which will be used to track performance towards achieving the outcomes and impact of the Child Survival goal and objectives, along with those for ending preventable newborn deaths and stillbirths by 2023 through the ENAP/EPMM developed for implementation during the same period.[4,5] The agreed indicators with corresponding targets were developed in line with global and national strategies and were based on consensus from all key stakeholders. There are available sources of information to track the performance of these indicators, primarily through the Health Management Information System (HMIS), the LDHS, the National AIDS Control Programme (NACP), and the National Public Health Institute of Liberia (NPHIL).

The various Divisions and Programmes of the MoH will implement different aspects of the Action Plan, working in synergy with the strategic plan for comprehensive service delivery and other interrelated Ministries and Agencies, such as Gender, Children and Social Protection, Financial and Development Planning, and the National Public Health Institute of Liberia. The programmes supporting child survival activities, including nutrition, immunisation, water and sanitation, health promotion, and child protection at national, county, and district levels, will implement the Child Survival Strategy and Action Plan (CSSAP) together with the ENAP/EPMM. This is in the spirit of accelerating the life course continuum by focusing on both neonatal and post-neonatal care (1–59 months), with special attention to high-risk children such as small and sick newborns and children with malnutrition. Child Survival focal persons will be appointed at the regional and district levels to oversee activities related to newborn and child care on behalf of the respective County Health Management Teams (CHTs) and District Health Teams (DHTs).

1. Introduction

Liberia made tremendous progress in child health during the Millennium Development Goals (MDGs) era, achieving MDG 4 by successfully reducing the mortality rate among children under five years old by two-thirds between 1990 and 2015.[6] The LDHS showed an under-five mortality reduction from 222 deaths per 1,000 live births in 1986 to 94 per 1,000 in 2013, while the neonatal mortality rate declined from 68 deaths per 1,000 live births in 1986 to 26 deaths per 1,000 live births in 2013. However, progress has stalled since 2013. The under-five mortality rate has remained relatively unchanged, standing at 93 deaths per 1,000 live births, and the neonatal mortality rate has increased from 26 deaths per 1,000 live births in 2013 to 37 deaths per 1,000 live births in 2020 (Figure 1).[1,7,8,9] According to the UN Inter-Agency Group for Child Mortality Estimation, the reduction rate has significantly decreased in the last decade (Table 1).[2]

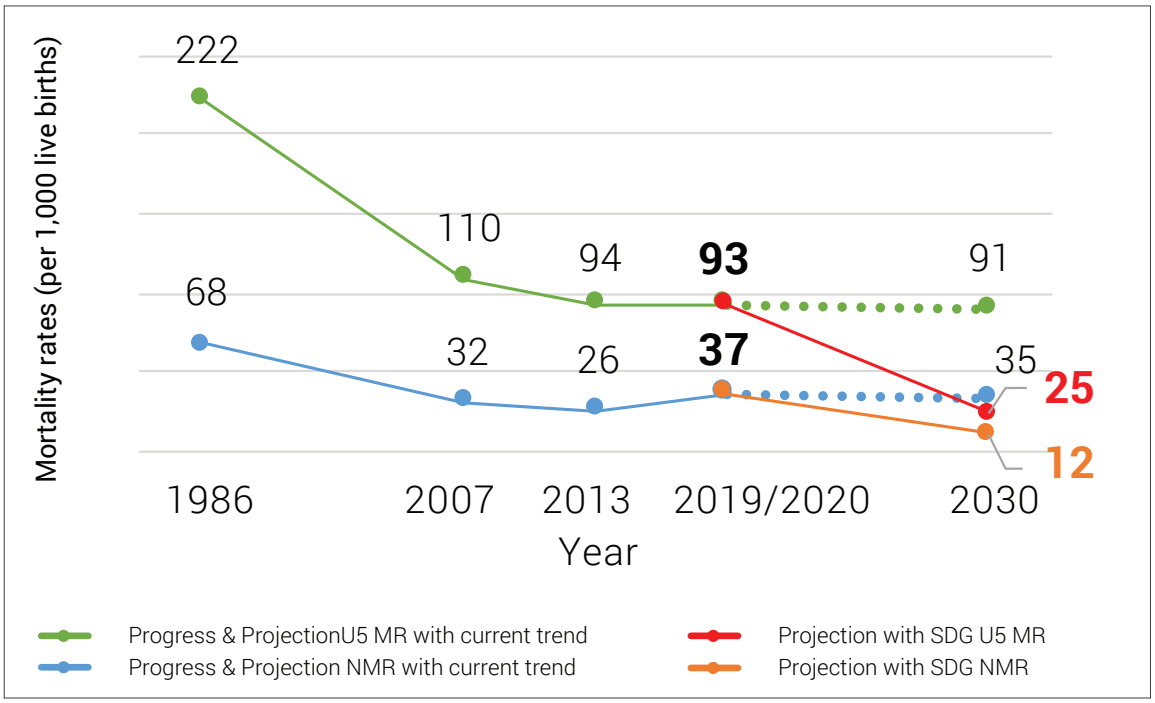

Figure 1: Trend, target and projections in U5 and neonatal mortality from 1986 to 2020[1,7,8,9]

Table 1: Average annual rate of reduction in under-five and neonatal morality[2]

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

6 United Nations. (2000). United Nations Millennium Declaration
7 The Government of Liberia. (1986). Liberia Demographic Health Survey (LDHS) 1986
8 The Government of Liberia. (2007). Liberia Demographic Health Survey (LDHS) 2007
9 The Government of Liberia. (2013). Liberia Demographic Health Survey (LDHS) 2013

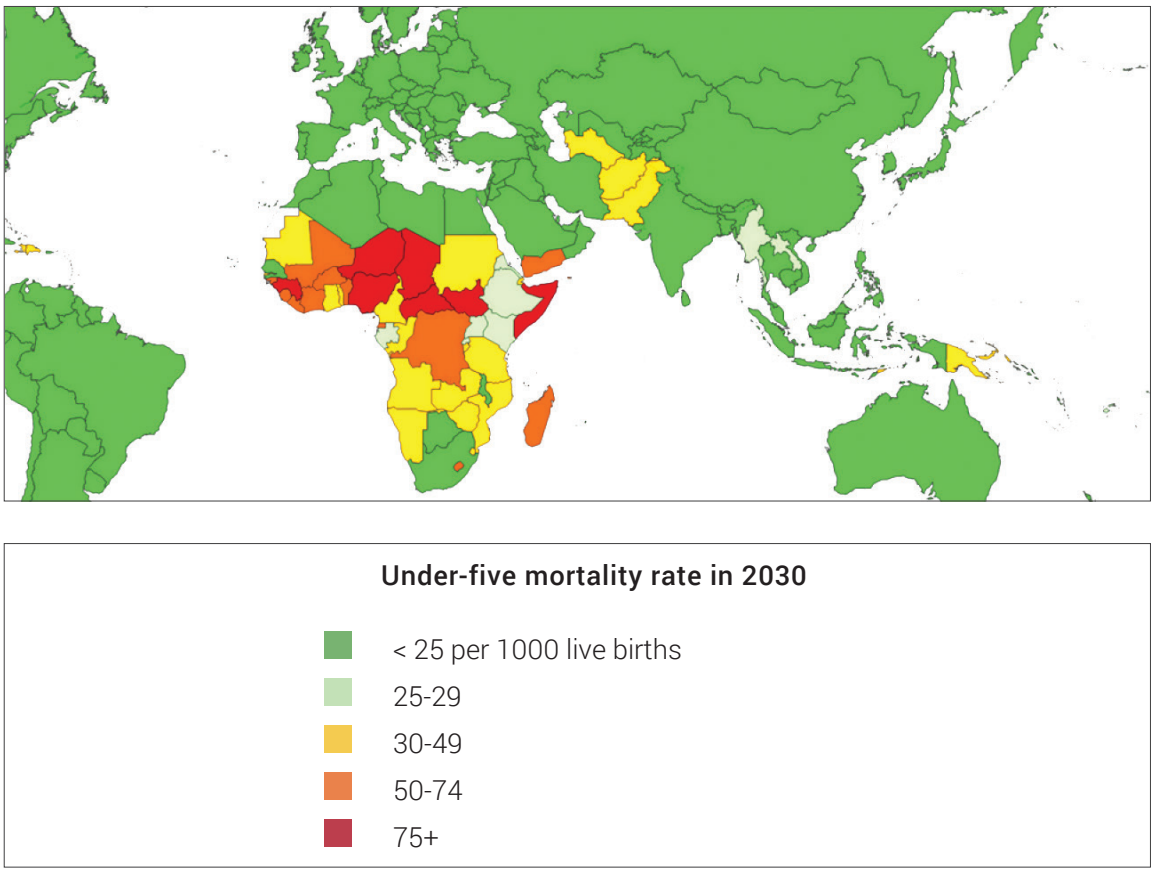

Figure 2: Projections of child mortality rates in the world in 2030[2]

Liberia is among the fifty-nine countries across the globe that are lagging far behind in reaching the 2030 Sustainable Development Goals (SDGs) target 3.2 of under-five mortality.[2] If Liberia continues with the current trend, 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 in 2030. This indicates that getting Liberia back on track to achieve the SDGs target could avert over 37,400 under-five deaths by 2030. To achieve the SDGs targets, a 73% reduction in under-five mortality from 93/1,000 to 25/1,000 live births and a 68% reduction in neonatal mortality rate from 37/1,000 to 12/1,000 live births are necessary.[1,10] Given the current status of childhood mortality in Liberia, the country needs to accelerate the efforts 5 times more for children under five and 13 times more for newborns to reach the SDG targets.[2]

10 United Nations (2015), Transforming our world: the 2030 Agenda for Sustainable Development. https://sdgs.un-.org/2030agenda

Children's nutritional status in Liberia poses a significant threat to their survival and well-being. The LDHS 2019/2020 show some progress in stunting reduction from 32% in 2013 to 30% in 2020. While 55% of all children aged 0–5 months were exclusively breastfed and 53 per cent of children aged 6–8 months were introduced to timely complementary feeding, 23 per cent of children aged 6–23 months are receiving minimum dietary diversity requirements (four out of eight recommended food groups). Despite the gains made, the stunting prevalence is still classified as 'very high' based on the WHO-UNICEF threshold of ≥30 per cent.[1]

The main drivers of stunting among children under the age of five in Liberia are sub-optimal Infant and Young Child Feeding (IYCF) practices. Children who escape stunting are likely to be more developed and have better life chances – they live longer and healthier, do better in school, and grow into more productive adults and pass-on good practices on to future generations and become more responsible parents to their children. The main causes of poor diet in Liberia can be attributed but not limited to poverty, food insecurity, limited awareness and cultural practices.

Political commitment to improve child health in Liberia and save the lives of the children exists at the highest level as exemplified by the fact that Liberia is a signatory 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. Liberia enacted the Children's Law of 2011, which is the first comprehensive legal framework for the protection and promotion of the rights and welfare of children in Liberia.

The MoH has undertaken several initiatives and frameworks to combat the high under-five mortality rate. The country has taken actions by committing to the Monrovia call for action for Community Health and by developing the Maternal Newborn Health Acceleration Plan for EPMM and ENAP. These efforts also include the previous Child Survival Strategy (CSS) (2008-2011), the National Health Policy (2022-2031), and the National Health Sector Strategic Plan (2022-2026). The Basic Package of Health Services evolved into the Essential Package of Health Services (2022), serving as a strategic service delivery document outlining service availability per level of care. Other areas include the Expanded Program for Immunization (EPI), the National Malaria Communication Strategy (2016-2020), through the scale up of malaria case management, and the Community Health Program Strategy (2023-2032), with the introduction and subsequent scale up of the iCCM program among others.

Despite the development of those policy documents and the scale up of child health interventions, there is a need for improvement in both the coverage, quality of care and integration of high impact interventions throughout the child's life continuum. These efforts should be seamlessly linked across various interventions and sectors. The MoH provides the leadership and oversees the implementation of this strategy under the guidance and direction of the CHTWG and Reproductive Health Technical Committee (RHTC), in close collaboration with key programs namely Malaria, Nutrition, HIV/Tuberculosis (TB), and community health through the health facility and community platforms. The health activities will also be elevated to the Health Coordination Committee (HCC) and the Health Sector Coordinating Committee (HSCC).

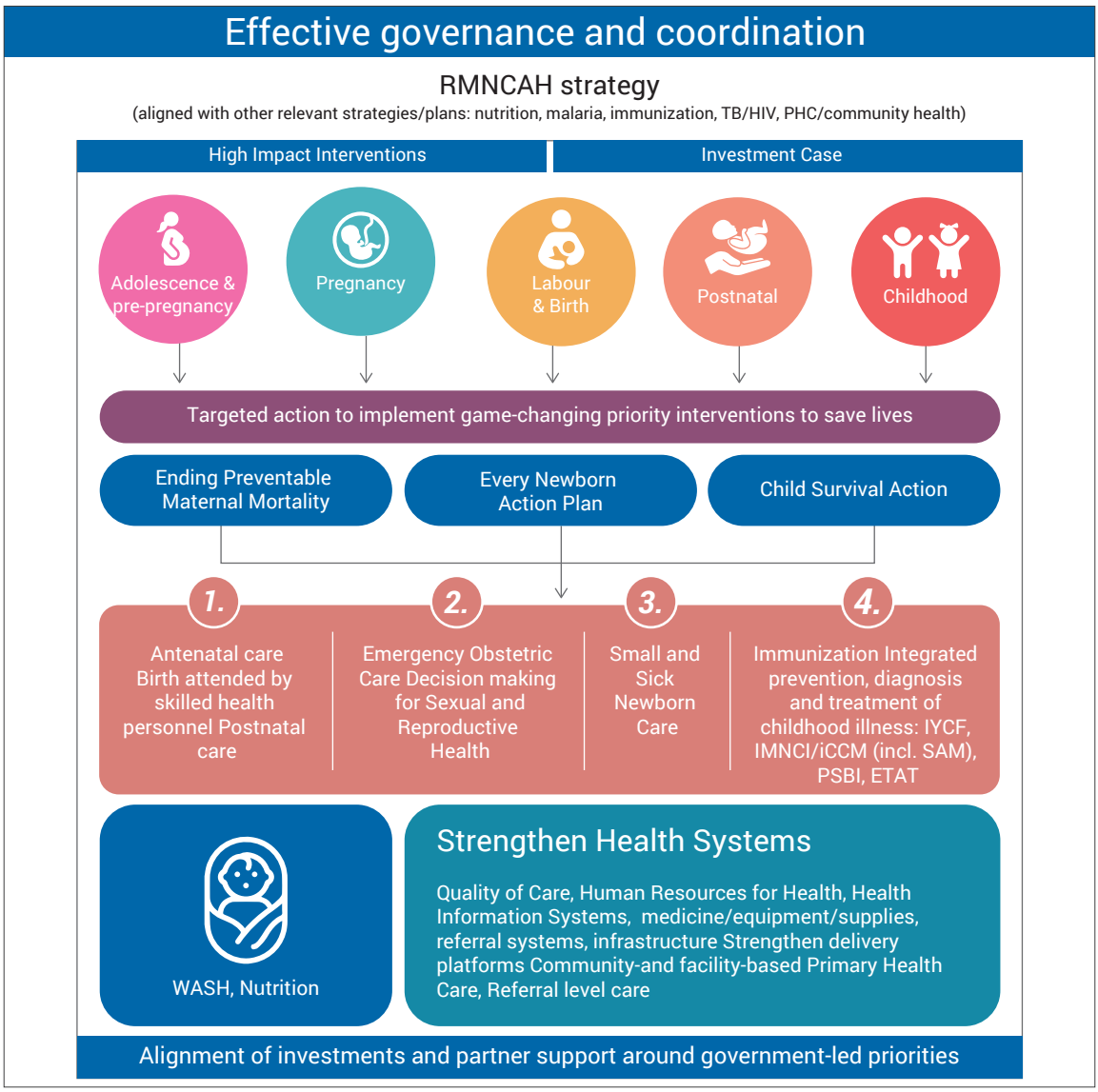

Figure 3: Continuum of care for mother and child – with targeted plans to advance the scale and quality of high impact interventions for survival (ENAP, EPMM, CSA) and recognition of cross-cutting systems requirements and multisector action

This strategy aims to scale up and accelerate the implementation of game-changing interventions and raise the profile of child health until the SDG targets related to child health are achieved. The strategy takes a life course approach that addresses the continuum of care for mothers and children; from pregnancy, the early and late newborn periods, to infants, and children. This strengthens the ENAP/EPMM/CSS as a continuum of care, as the maternal status impacts on newborn, infant and child survival. This approach underscores the importance of multisectoral and cross-program coordination and collaboration alongside strengthening of key health systems functions and delivery platforms (Figure 3). This delivers high-quality integrated management of newborn and childhood illnesses (IMNCI) that provides a comprehensive multisectoral approach under the Action Plan in Primary Health Care (PHC) including facility-based interventions as well as prevention and iCCM.

Figure 4: PHC approach at the core of comprehensive response

The PHC approach shall be the bedrock for the implementation of child health interventions (Figure 4). PHC is an entry point for individuals and a key to enhance child healthcare services, encompassing iCCM for Community Health Assistant (CHA), including immunisation, nutrition and the prevention & treatment of malaria pneumonia, and diarrhoea with engagement and empowerment of community. Moreover, it serves as the cornerstone of Universal Health Coverage (UHC), contributing to health equity. UHC also plays a fundamental role in addressing poverty alleviation, promoting quality education, fostering gender equality, and empowering women.[11]

Furthermore, the costed action plan with clearly marked timelines for implementation was also developed to facilitate resource mobilisation, monitoring, and evaluation, and scaling up of the proposed newborn and child interventions.

11 Child Health Task Force. (2024). Child Survival Wheel. https://www.childhealthtaskforce.org/resources/guide/2024/child-survival-wheel

2. Country Profile

2.1. History and Demography of Liberia

Liberia was founded by the American Colonisation Society, an organisation of freed slaves from America in 1847. The West African state of Liberia is Africa's oldest republic.[12] Liberia is bounded to the north by Guinea; on the west by Sierra Leone, on the east by Côte d'Ivoire and on the south by the Atlantic Ocean.[13] Liberia has three branches of Government: The Executive, Legislative and Judiciary with the government being headed by a President, who is elected once every six years. Liberia is a unitary state and has a bicameral legislature. Liberia is divided into five regions (North Central (Lofa, Bong and Nimba Counties), Northwestern (Gbarpolu, Grand Cape Mount and Bomi Counties), South Central (Montserrado, Margibi and Grand Bassa Counties), Southeastern A (Rivercess, Sinoe and Grand Gedeh Counties), and Southeastern B (Rivergee, Grand Kru and Maryland Counties), comprising 15 counties (Figure 5), sub-divided into 93 health districts, which are further subdivided into clans.[14] Each county is administered by a Superintendent who is appointed by the President.

Figure 5: Geo-political map of Liberia[12]

12 Van Der Kraaij, F. P. (2022, April 1). The Colony of Liberia and the suppression of the slave trade. Liberia: Past and Present of Africa's Oldest Republic. Retrieved December 5, 2023, from http://www.liberiapastandpresent.org/

13 Holsoe, S. E., Jones, A. B., & Petterson, D. R. (2023, December 5). Liberia | History, Map, flag, population, & Facts. Encyclopedia Britannica. Retrieved December 5, 2023, from https://www.britannica.com/place/Liberia

14 The Ministry of internal affairs, the Government of Liberia; directorate of localities. Retrieved December 5, 2023, http://www.mia.gov.lr/2content.php?sub=210&related=40&third=210&pg=sp

2.2. Socio-Political Situation

The country has experienced its share of turbulence, including a coup in the 1980s and a brutal 14-year civil crisis, which resulted in loss of lives and destruction of property. Liberia returned to normalcy in 2003 and held its first post-war elections. This was followed by two peaceful elections, including a peaceful change of Government in 2017 and in October/November 2023. Liberia is gradually transitioning from short-term relief and recovery to long-term national development within the context of stability and economic growth under a legitimate Government. The successful attainment of political stability in the country is a key factor in social transformation and economic recovery. The Pro-Poor Agenda for Prosperity and Development (PAPD), a follow-up developmental agenda to the Poverty Reduction Strategy (PRS) of the previous Government, articulates the Government's plans for medium-term development.

The health sector is led by the Ministry of Health (MoH), which sets the health agenda for the country. In line with the National Government Decentralisation Policy, the MoH operates a decentralised health sector. The MoH is divided into three departments: the Department of Health Services, headed by a Deputy Minister of Health Services, who is also the Chief Medical Officer (CMO); the Department of Policy and Planning, headed by a Deputy Minister of Policy and Planning; and the Department of Administration, headed by the Deputy Minister of Administration. All programmes fall under the Bureau of Preventive Services within the Health Services Department. At the subnational level, health services are led by County Health Teams (CHTs) and District Health Teams (DHTs). The CHT is headed by a County Health Officer (CHO), who is the highest health authority at the county level. The DHT is headed by the District Health Officer (DHO), the highest health authority at the district level. The CHTs and DHTs provide supervision and other technical and programmatic support to hospitals, health centres, primary health care clinics, and community services. Operationally, the CHOs head health service delivery at the counties, and DHOs supervise the districts, while Medical Directors head the hospitals and Officers in Charge (OICs) manage health centres and clinics.

2.3. Socio-Demographic Situation

The Liberia Census 2022 shows that the total population of Liberia is estimated at 5,250,187. Women and girls constitute 49.6% of the population. Disaggregation of the population reveals that children aged 0–17 years make up 41.5%, with those under five years constituting approximately 10.5%. Populations below 35 years of age account for 74.6%. Of the 15 political subdivisions, the most populous counties are Montserrado, Nimba, Bong, Lofa, Grand Bassa, and Margibi, which together account for 75.7% of the total population, while 24.3% reside in the remaining nine counties. The urban population exceeds the rural population by 4.5%.[15] The country has a young population with a significant demographic imbalance between different age groups. This age structure therefore poses challenges for the delivery of social services, including health services where Reproductive, Maternal, Neonatal, Child, and Adolescent Health (RMNCAH) services are critical.

15 The Ministry of Liberia. (2022). Liberia Census 2022

3. Structure of the Health System Delivering Newborn and Child Health Services

Liberia has a three-tier health system comprising primary, secondary, and tertiary levels. The primary level consists of services provided at the community level, the secondary level provides care at the district, county, and regional levels, and the tertiary level provides care at the national level. Liberia is currently implementing the Essential Package of Health Services (EPHS) II, which identifies a minimum standard package of preventive and curative services to be provided at all levels of the health system. The list of interventions is described in the EPHS and defined per level based on the capacity at each level.

The following outlines the composition of the health system levels in Liberia, upon which RMNCAH services are articulated in the EPHS.[16] Primary care is also responsible for nutrition services, including the distribution of supplements, health education, and early detection of malnutrition. Some health centres and all hospitals have inpatient and outpatient departments for malnutrition screening and treatment.

Table 2: Composition of the health system levels in Liberia[16]

*1 Not all of health center has MD

*2 Not all of county hospitals has specialized medical doctors

Level of Care	Facilities	Occupation	Geo-political Subdivision			
Primary	Non-permanent SDP Clinic (CHAs and CHSS)	CHA, CHSS, CHP, TTM, Ns, MW	Community	District	County/ Regional	National
Secondary	Health Center	MD (general practitioner)*1, PA, Ns, MW, Lab tech				
	District Hospital	MD (general practitioner), PA, Ns, MW, Lab tech				
	County Hospital	MD (specialised)*2, PA, Ns, MW, Lab tech, radiologist				
	Regional Hospital	MD (specialised), PA, Ns, MW, Lab tech, radiologist				
Tertiary	National Referral Hospital	MD (specialised), PA, Ns, MW, Lab tech, radiologist				

16 The Ministry of Health Liberia. (2022). National Health Sector Strategic Plan A Roadmap to Universal Health Coverage 2022-2026

3.1. Primary Care

Community Health System:

This is the main primary care provider and includes:

a. **Community Level Services**: The community level has a governance structure consisting of the Community Health Committee (CHC) and the Health Facility Development Committee (HFDC). These two committees provide governance for community-level services at the community and health facility levels. Additionally, the community level has cadres that include Community Health Services Supervisors (CHSS), Community Health Assistants (CHA), Community Health Promoters (CHP), and Trained Traditional Midwives (TTM). The CHSSs, who are professional licensed health workers, are assigned to the nearest clinic and are responsible for providing clinical supervision for the services implemented by CHAs. The CHAs are responsible for implementing Integrated Community Case Management (iCCM) activities beyond five kilometres from an existing facility, as well as health promotion services. The CHPs, who operate within five kilometres, and the TTMs, who work within and beyond five kilometres, are responsible solely for outreach, referral, and health promotion services.

b. **Primary Health Care (PHC) Clinic, Levels 1 & 2**: These clinics are open for eight hours on weekdays and operate on a 24-hour basis for emergencies and deliveries/Basic Emergency Obstetric and Neonatal Care (BEmONC). They serve isolated clustered communities with populations ranging from 3,500 to 12,000 for Levels 1 and 2, respectively. This is linked to the community-level services.

3.2. Secondary Care

District Health System:

The District Health System receives referrals from the community health system. The district health system has a catchment population of 25,000 to 40,000 and has either of the following:

a. **Health Centers**: These centres are open 24 hours a day and receive referrals from PHC clinics in the district. They have up to 40 beds and a laboratory.

b. **District Hospitals**: These hospitals operate 24 hours every day, with higher clinical capacity, including emergency surgery and Comprehensive Emergency Obstetric, Neonatal Care (CEmONC). This includes neonatal intensive care units and/or paediatric wards for critical care in some district hospitals. It is important to note that not every district has a health centre and a district hospital.

County and Regional Health System:

The County Health System provides expanded services within the secondary level of care. It consists of:

a. **County Hospitals**: Every county has at least one county hospital within reasonable distance from the regional hospitals, for which they play a capacity-building role and serve as training sites. Open 24 hours every day and receive referrals from the community and district health systems, and provide general surgery, paediatrics, general medicine,

obstetrics, and gynaecological services (including CEmONC). It should have 100 or more beds with an intensive care unit, a laboratory and basic radiology services.

b. **Regional Hospitals**: These hospitals serve a catchment area of three to five counties and receive referrals from county hospitals.

3.3. Tertiary Care

National Health System:

The National Health System is the main provider of tertiary level care. It consists of two types of hospitals:

a. **The National Referral Hospitals**: Liberia has two national referral hospitals: the John F. Kennedy Medical Centre (JFKMC) and the Jackson F. Doe Memorial Hospital (JFDMH). These hospitals possess advanced specialist, laboratory, and radiology capabilities. They serve as specialised referral facilities and teaching hospitals (in collaboration with Regional Hospitals) for physicians, sub-specialists, mid-level healthcare providers, and allied health professionals.

4. Child Health Situational Analysis

4.1. Newborn and Under-Five Mortality Rates in Liberia

In Liberia, under-five, infant, and neonatal mortality rates are alarming, given the previous history of significant declines. About 1 child out of 11 in Liberia does not survive to their fifth birthday. While there were substantial reductions in under-five and infant mortality rates between 1986 and 2007, progress has since somewhat stalled. Under-five mortality remained generally unchanged from 2013 to 2019/2020 (94 and 93 deaths per 1,000 live births, respectively). During this period, post-neonatal mortality (between the first month of life and the first birthday) experienced a slight reduction from 28 to 25 deaths per 1,000 live births. However, neonatal mortality (within the first month of life) surged from 26 per 1,000 live births to 37 per 1,000 live births over the same period. This increase contributed to the rise in infant mortality (between birth and the first birthday) from 54 deaths per 1,000 live births in 2013 to 63 deaths per 1,000 live births in 2019/2020. The increasing trend in neonatal mortality is particularly alarming, especially considering the decrease in home deliveries from 43.8% in 2013 to 19.6% in 2020 and the rise in skilled birth attendance from 61% to 84%.[1,7,8,9]

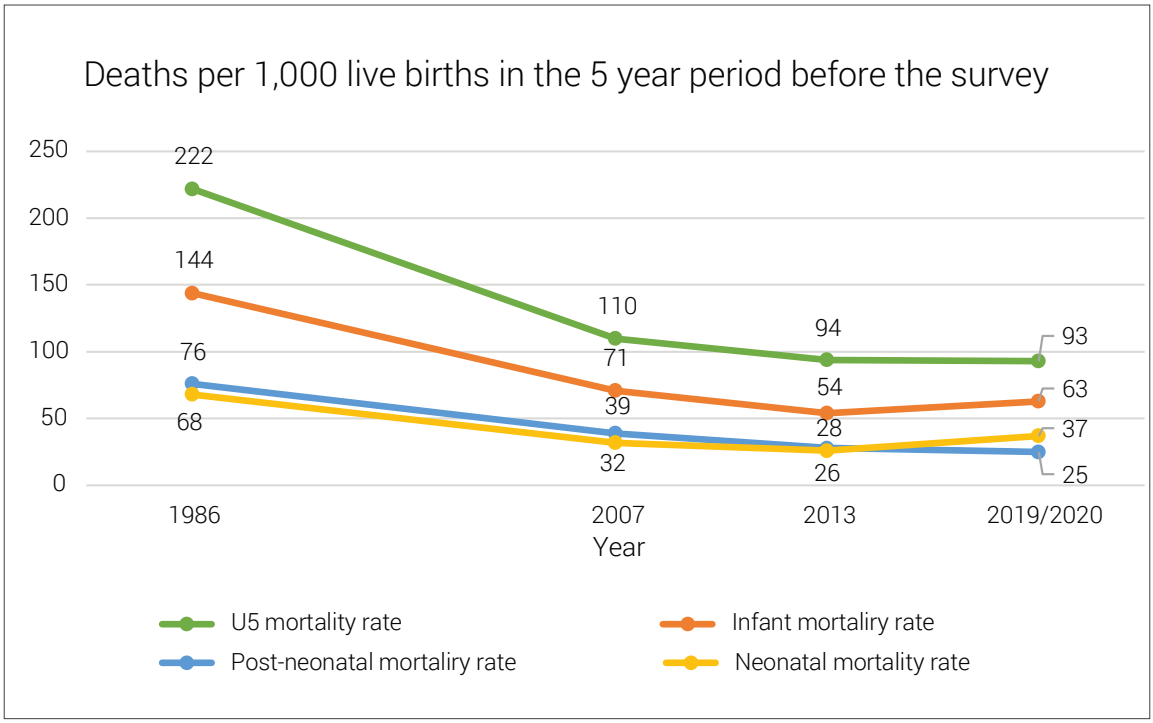

Figure 6: Trend in U5, infant and neonatal mortality from 1986 to 2020[1,7,8,9]

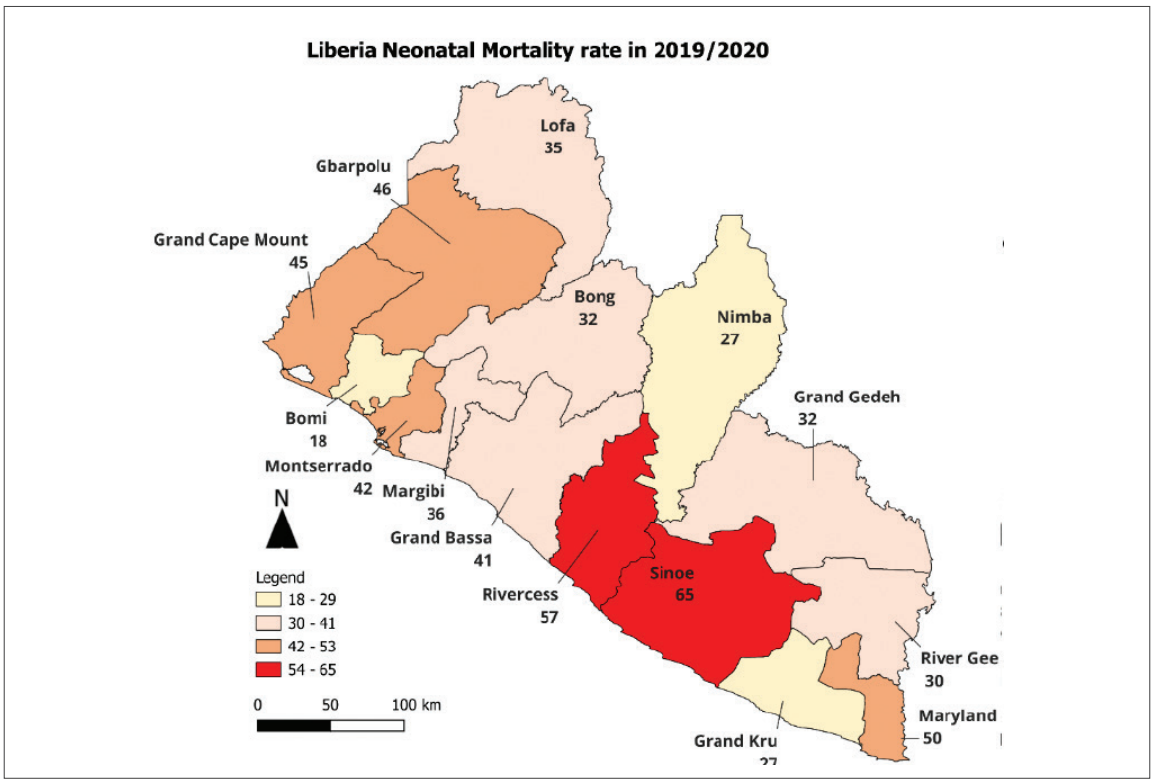

Figure 7: Neonatal mortality rate by region for the 10-year period preceding the survey[1]

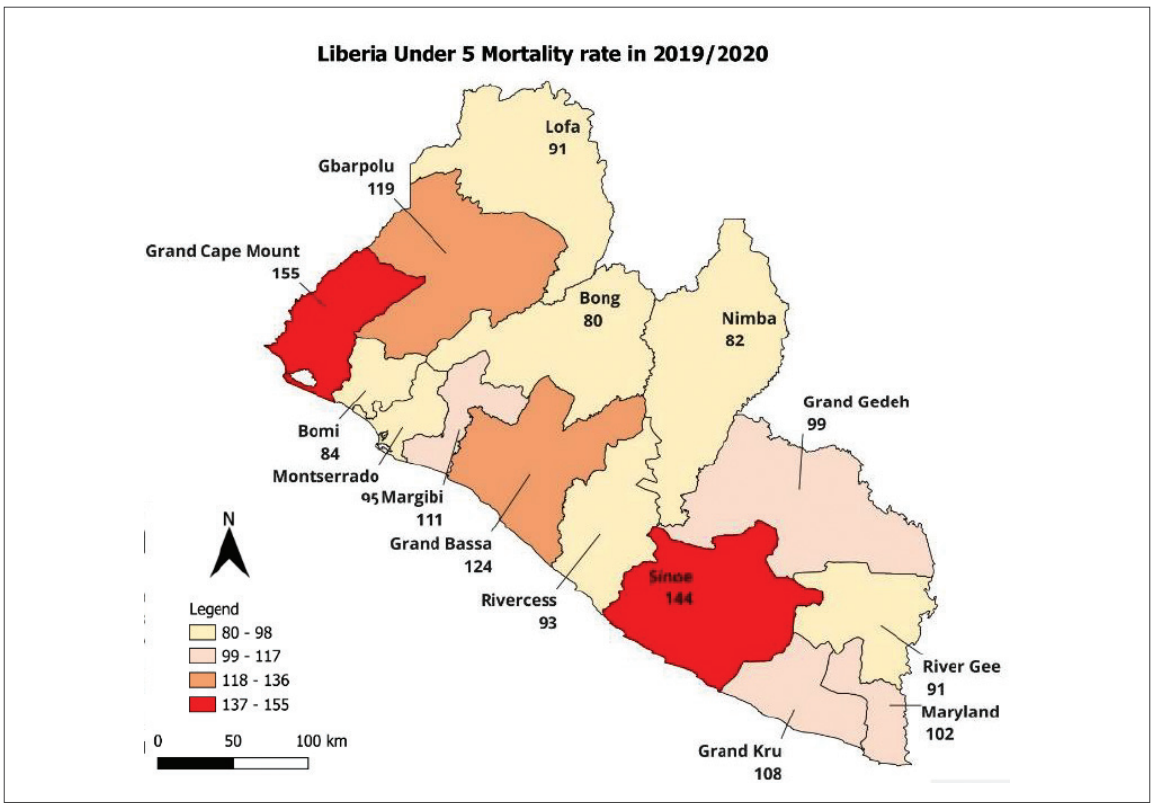

Figure 8: Under-five mortality rate by region for the 10-year period preceding the survey[1]

Figures 7 and 8 show neonatal and under-five mortality rates by region. Neonatal mortality rates are highest in Sinoe (65 per 1,000 live births), followed by Rivercess (57) and Gbarpolu (46). Similarly, under-five mortality rates are highest in Sinoe (144 per 1,000 live births), followed by Grand Cape Mount (155) and Grand Bassa (124). While the reasons that Sinoe has the highest rates in both categories are unclear, road conditions might be a contributing factor. Conversely, Nimba and Bomi counties have consistently lower mortality rates for both age groups. This indicates substantial regional differences, highlighting a pressing issue of equity in access to and quality of healthcare services, and emphasises the need for differentiated resource allocation, targeted interventions, and further analysis of contextual barriers to address these disparities and ensure more equitable health outcomes for all children.[1]

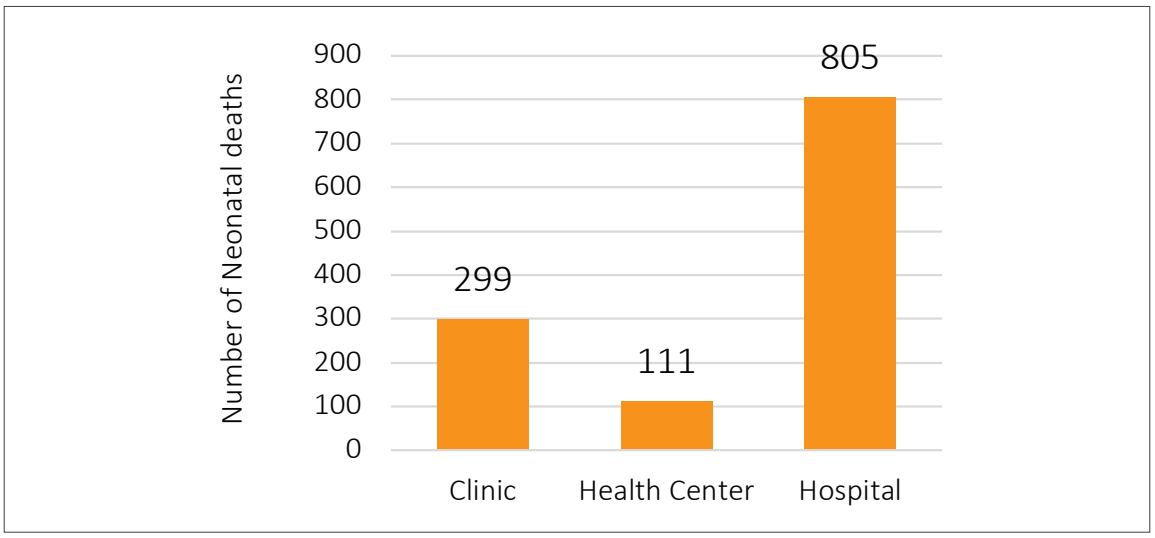

Figure 9: Number of neonatal deaths reported DHIS2 in 2022[17]

Analysis of the District Health Information Software (DHIS) revealed that 66% of neonatal deaths occurred in hospitals (n=805), 9% (n=111) at health centres, and 25% (n=299) at clinics, including those in communities, in 2022 (Figure 9). This suggests that individuals are seeking care at health facilities. However, deaths are occurring more frequently at health facilities rather than within communities covered by clinics.[17] This is due to several factors, including delays in referral, limited infrastructure, shortages of essential drugs and equipment, and a lack of competent healthcare staff.

17 The Government of Liberia. (2022). DHIS Liberia

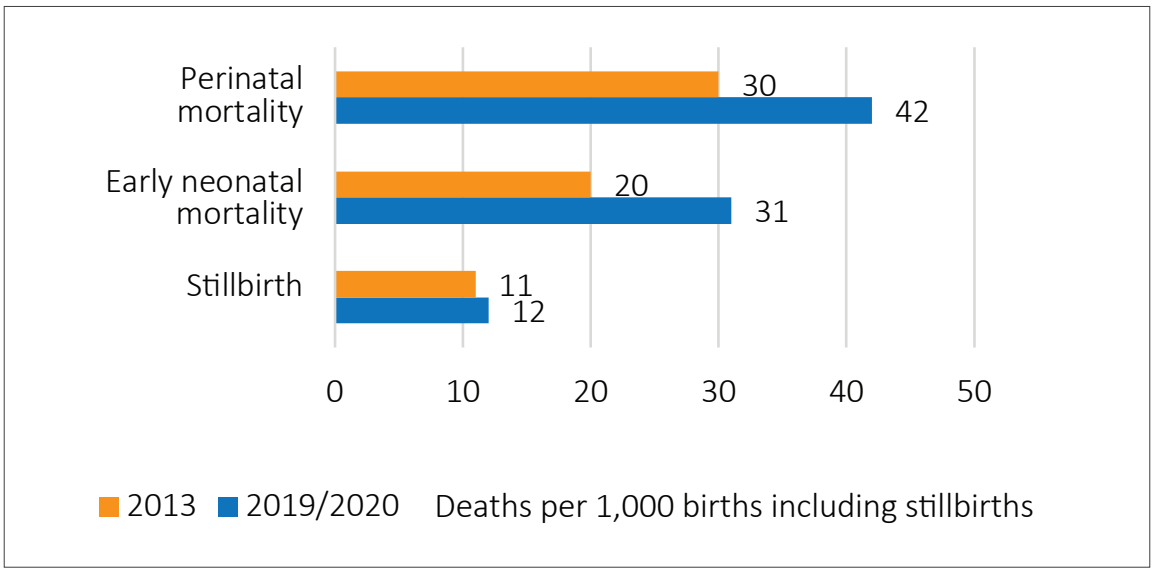

Figure 10: Perinatal mortality, early neonatal mortality and stillbirth rates[1]

Perinatal mortality, defined as the total of stillbirths past 28 weeks of pregnancy and early neonatal deaths (up to 7 completed days of life) per 1,000 total births (live and stillbirths), is an indicator of healthcare quality before, during, and after birth. The perinatal mortality rate increased from 30 to 42 per 1,000 births between 2013 and 2019/2020. Of this, 27% were stillbirths and 73% were early neonatal deaths. Similarly, the stillbirth rate slightly increased from 11 to 12 per 1,000 live births, and early neonatal mortality rose from 20 to 31 per 1,000 live births over the same period. Furthermore, of early neonatal mortality, deaths on Day 0 increased significantly (from 5 to 20 deaths per 1,000 live births), while deaths on Days 1-6 decreased (from 15 to 11 deaths per 1,000 live births). This underscores the pressing need to enhance the quality of care at health facilities, and WHO and UNICEF data indicate the high impact of scaling up interventions during this period for better child health outcomes.[18]

18 World Health Organization (WHO). United Nations International Children's Emergency Fund (UNICEF). (2020). Ending preventable newborn deaths and stillbirths by 2030. https://www.unicef.org/reports/ending-preventable-newborn-deaths-stillbirths-quality-health-coverage-2020-2025

4.2. Causes of Newborn and Under-Five Child Deaths

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

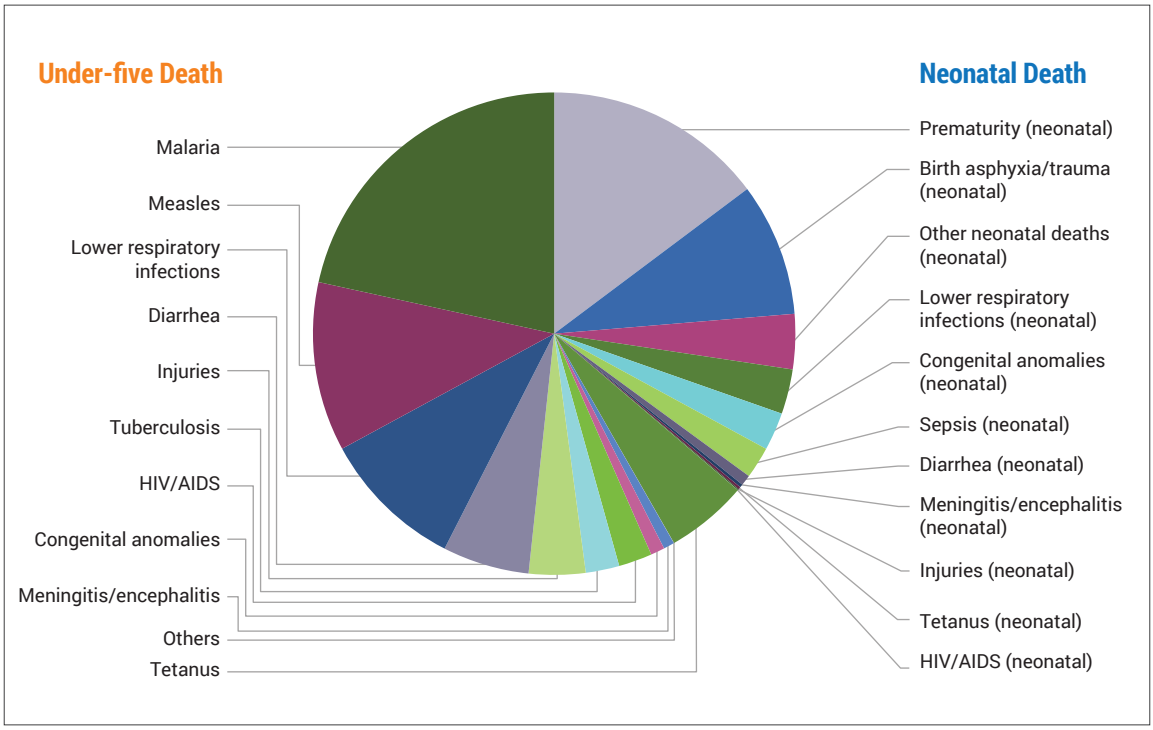

Figure 11: Causes of Newborn and Under-five death in Liberia (2021)[2]

Table 3: 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%

According to UNIGME data, neonatal deaths accounted for 39% of the total deaths among children under five in 2021, with the larger proportion occurring after the first month of life (61%).[2] Most 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, malaria (22%), measles (11%), lower respiratory infections (10%), and diarrhoea (6%) are the leading causes of death. The outbreak of measles may have occurred due to disruptions in routine vaccinations during the COVID-19 pandemic and vaccine stockouts. Consequently, measles may be considered an atypical cause of under-five mortality during this period; however, pandemic preparedness remains a critical issue in Liberia.[2]

The LDHS 2019/2020 reported that acute respiratory infections (ARI), including pneumonia, malaria, and diarrhoeal diseases, are the leading causes of child morbidity and mortality in Liberia, with underlying malnutrition being a major risk factor for death.[1] Four percent of children under age 5 had symptoms of ARI in the two weeks before the survey, with 78% receiving advice or treatment. Similarly, 25% and 16% of children experienced fever and diarrhoea, respectively, with treatment rates of 81% and 66%. These prevalence rates may fluctuate depending on seasonality and environmental factors. However, a significant gap exists between the percentage of children experiencing symptoms and those receiving any advice or treatment, highlighting potential barriers to accessing appropriate healthcare services for children under five.[1]

Malnutrition contributes to the majority of child deaths due to preventable diseases. The prevalence of stunting among under-fives has remained stagnant over the past decade, at 32% in 2013 and 30% in 2019/2020. Specifically, 41% of children aged 2 to 3 years and 21% of those aged 6 years are stunted. Stunting is more prevalent in rural areas (35%) compared to urban areas (25%) and is more common among boys (32%) than girls (28%). Furthermore, stunting rates vary at the county level, ranging from 21% in Montserrado to 41% in River Cess, indicating a relationship with household wealth quintiles.[1]

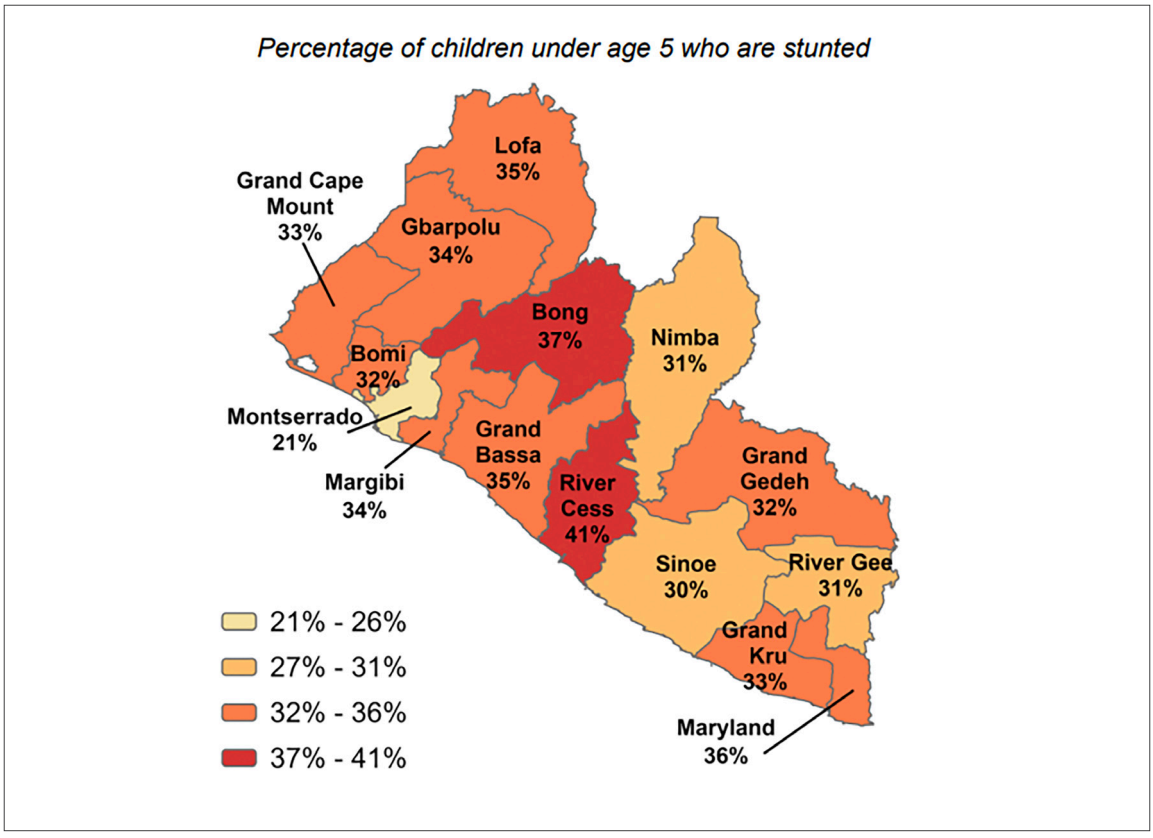

Figure 12: Stunting among under-five children by county[1]

5. Key Interventions to Protect, Prevent and Treat Primary Causes of Under-Five Deaths

The interventions for child survival shall be placed into three fundamental categories—namely, interventions to protect, interventions to prevent, and interventions to treat. The table below depicts the interventions per category as well as the levels of care. Primary care encompasses CHCs and HFDCs at the community level. Secondary care involves health centres and district/county/regional hospitals at the district/county/regional level. Tertiary care refers to national referral hospitals at the national level. This strategy outlines comprehensive key interventions encompassing Nutrition, Immunisation, Malaria, WASH, Social Protection, and Social Behaviour surrounding children in Liberia.

Table 4: Child Survival Interventions by level of care

INTERVENTIONS	LEVEL OF CARE
PROTECT	
Antenatal Care and Postnatal for Mothers and Newborns	Primary
	Secondary
	Tertiary
Exclusive Breastfeeding	Household
	Primary
	Secondary
	Tertiary
Screening of Children with Disability for Timely Interventions	Primary
	Secondary
	Tertiary
Maternal, Perinatal, and Newborn Death Surveillance and Response (MPNDSR)	Primary
	Secondary
	Tertiary
Birth Registration	Primary
	Secondary
	Tertiary
PREVENT	
Emergency Obstetric and Neonatal Care (EmONC)	Primary
	Secondary
	Tertiary
Essential Newborn Care (skin-to-skin contact, early initiation of breastfeeding and neonatal resuscitation)	Primary
	Secondary
	Tertiary
Cord Care for Newborn	Primary
	Secondary
	Tertiary
Integrated Management of Newborn and Childhood Illness (IMNCI)	Secondary
	Tertiary

Integrated Community Case Management of Childhood Illness (iCCM)	Primary
Vaccination (BCG, PENTA,TdDPT, PCV, measles, malaria)	Primary Secondary Tertiary
Timely Routine Child Health Services and Referral to the Next Level When Necessary	Household Primary Secondary Tertiary
Distribution of Insecticide Treated Nets	Primary Secondary Tertiary
Utilisation and Distribution of Indoor Residual Spraying	Household Primary Secondary Tertiary
Intermittent Preventive Treatment (IPT) of Malaria in Pregnancy	Primary Secondary Tertiary
Co-trimoxazole for HIV Positive Children	Primary Secondary Tertiary
Preventive Therapy for TB Expose Children	Primary Secondary Tertiary
Distribution of Vitamin A Supplementation, Zinc and Food Supplementation	Primary Secondary Tertiary
Infant and Young Child Feeding (IYCF) Practice	Household Primary Secondary Tertiary
WASH Services (handwashing, safe drinking water, sanitation and hygiene)	Household Primary Secondary Tertiary
Environmental Health: Reducing Indoor Air Pollution, Reducing Ambient Particulate Matter Pollution	Household Primary Secondary Tertiary
TREAT	
Management of Complication of Pregnancy	Secondary Tertiary

Management of Small and Sick Newborns Including Kangaroo Mother Care (KMC), Safe Administration of Oxygen, Management of Jaundice, Preterm Respiratory Distress and Other Diseases	Secondary
	Tertiary
Treatment of Children with ARI with Antibiotics (e.g amoxicillin DT)	Primary
	Secondary
	Tertiary
Treatment of Children with Confirmed Malaria with Anti-malarials	Primary
	Secondary
	Tertiary
Treatment of Children with Diarrhoea with ORS and Zinc	Primary
	Secondary
	Tertiary
Treatment of Moderate to Severe Malnutrition	Primary
	Secondary
	Tertiary
ART for HIV Positive Children	Primary
	Secondary
	Tertiary
Treatment with Children Diagnosed with TB	Primary
	Secondary
	Tertiary
Treatment of Severe Childhood Illnesses	Secondary
	Tertiary
Treatment of Child Injuries	Primary
	Secondary
	Tertiary

5.1. Nutrition

Breastfeeding is one of the most cost-effective ways to promote child health and survival. It is uncontaminated and contains all the nutrients needed by children during their first six months of life. WHO and UNICEF recommend the early initiation of breastfeeding within one hour of birth, exclusively breastfeeding for the first six months of life, and continuing up to two years of age or beyond. Newborns who receive early initiation of breastfeeding within the first hour of life are more likely to survive, benefiting from the transfer of beneficial bacteria from their mother's skin to improve their immune systems and establishing breastfeeding over the long term. Exclusive breastfeeding for six months prevents infections and provides all the nutrients and liquid an infant requires for optimal growth and development. Supplementing breast milk before six months of age may increase the likelihood of contamination during preparation and may lead to an increased risk of diarrhoeal diseases.[19]

In Liberia, the percentage of children who received early initiation of breastfeeding within the first hour of birth is higher when healthcare professionals assist with deliveries (67%) compared to traditional midwives (64%) in 2019/2020.[1] Additionally, 55% of children under

19 World Health Organization. (2021). Infant and young child feeding. [Online]. Retrieved from [https://www.who.int/news-room/fact-sheets/detail/infant-and-young-child-feeding]

six months of age were exclusively breastfed. The rate declined with age, from 73% among children aged 0-1 months to 59% among those aged 2-3 months and 37% among those aged 4-5 months. The remaining 45% received inappropriate feeding, which increases the risk of diarrhoeal diseases and malnutrition.[1] The 'Stronger with Breastmilk Only' initiative emphasises exclusive breastfeeding without water, other liquids, or foods during the first six months of life.[20]

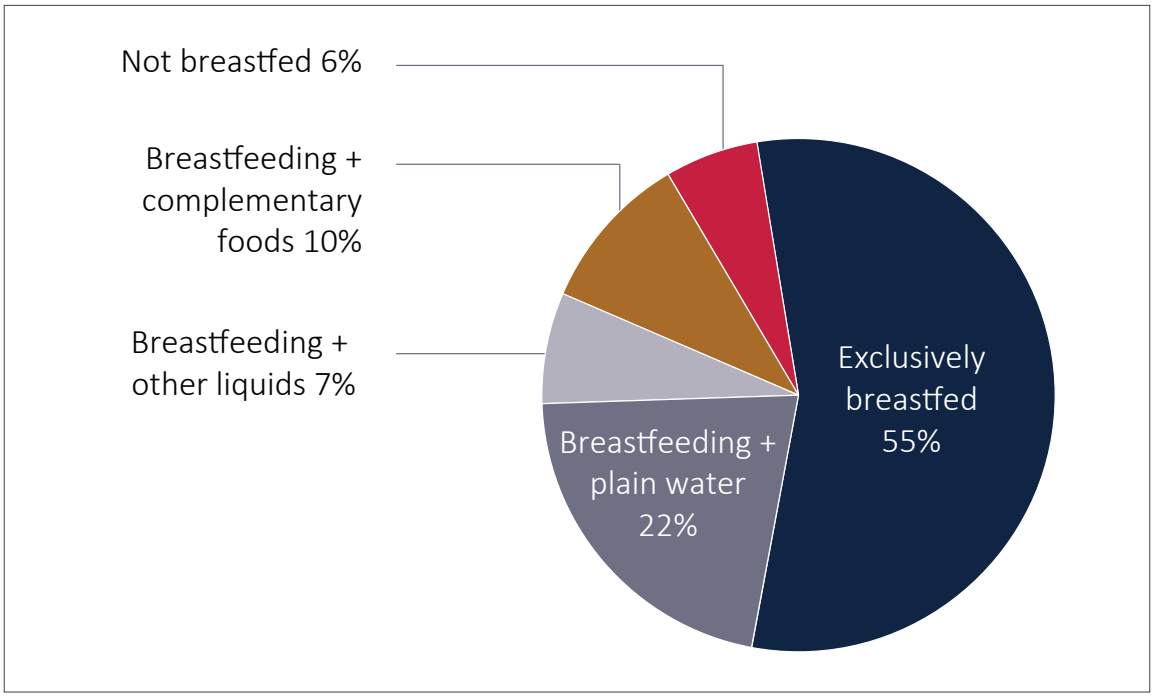

Figure 13: Breastfeeding Status for Children Under 6 Months[1]

A poll conducted by UNICEF in 2019 in West and Central Africa, including Liberia, found that 56% of young people incorrectly believe that babies need water in their first six months, and 46% thought that breastmilk alone was not sufficient for babies' growth.[21] To address these misconceptions, more widespread and accessible education is crucial to equip individuals with accurate information and empower them to make informed decisions.

The Minimum Acceptable Diet (MAD) is a set of criteria that defines a diet meeting the essential nutritional needs of children aged 6 to 23 months. It is a tool for assessing the status of Infant and Young Child Feeding (IYCF) practices. The MAD consists of two components: Minimum Dietary Diversity (MDD) and Minimum Meal Frequency (MFF).[22] In 2019/2020, only 3% of children aged 6-23 months were fed an acceptable diet (Figure 14). This low percentage could be attributed to limited access to a diverse range of fruits, vegetables, and other nutrient-rich foods, which is often characteristic of regions with limited local food production. Such dietary constraints may contribute to the high prevalence of

20 UNICEF and WHO. (2021). Stronger With Breastmilk Only Resources Catalog. https://www.aliveandthrive.org/sites/default/files/catalogue-en.pdf

21 UNICEF. (2019). Only 3 out of every 10 babies under six months exclusively breastfed in West and Central Africa, water the main barrier. https://data.unicef.org/wp-content/uploads/2018/05/180509_Breastfeeding.pdf

22 Black, R. E., Allen, L. H., Bhutta, Z. A., Caulfield, L. E., de Onis, M., Ezzati, M., ... & UNICEF (2008). Maternal and child nutrition: The Lancet Series on Maternal and Child Nutrition. Lancet, 371(9612), 1195-1329. doi: 10.1016/S0140-6736(08)60964-1

stunting among children under five years old, currently standing at 30%.[1] This population faces a higher risk of mortality due to common illnesses among children such as pneumonia, malaria and diarrhoea.

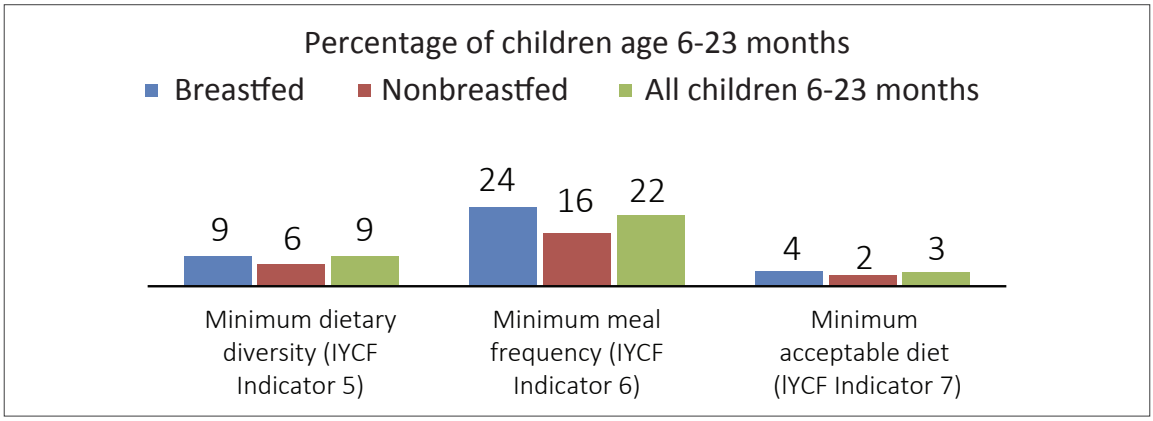

Figure 14: IYCF indicators on Minimum Acceptable Diet[1]

5.2. Immunisation

Universal immunisation of children against Vaccine-Preventable Diseases (VPDs) is crucial in reducing infant and child mortality. In Liberia, 13 vaccines are provided targeting major VPDs: Tuberculosis, diphtheria, pertussis, tetanus, poliomyelitis, measles, hepatitis B, Haemophilus influenzae type B, yellow fever, rotavirus, pneumonia, human papillomavirus, and typhoid fever.

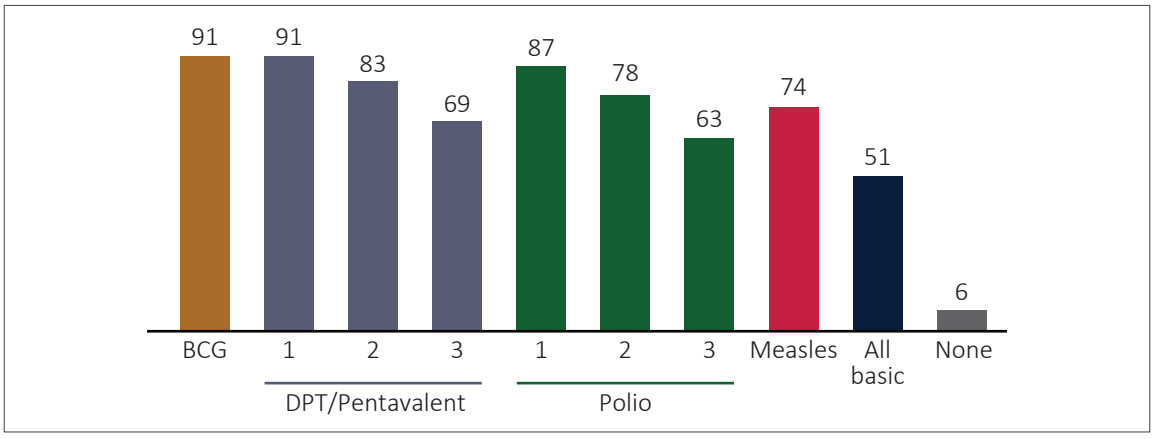

Figure 15: Percentage of children aged 12-23 months vaccinated at any time before the survey[1]

Data from the LDHS 2019/2020 shows a concerning trend in childhood vaccination rates in Liberia. Figure 15 illustrates the percentage of children aged 12 to 23 months vaccinated according to different types of vaccines. Reference is the LDHS 2019/2020. Additionally, Table 5 displays the coverage rates for basic and age-appropriate immunisations among children aged 12-23 months and 24-35 months. The proportion of children who received all basic vaccinations dropped from 51% for those aged 12-23 months to 44% for those aged 24-35 months. Fewer children received those vaccinations on time. This may collectively put many children at risk of preventable diseases.[1]

Table 5: Percentage of vaccine coverage for basic and age-appropriate immunization among children aged 12-23 and 24-35 months[1]

Age group	Received all basic vaccinations	Received all basic vaccinations by12 months	Received all appropriate vaccinations	Received appropriate vaccinations by 12months	Received appropriate vaccinations by 24months
12-23 months	51%	46%	39%	35%	35%
24-35 months	44%	39%	31%	27%	27%

WHO/UNICEF Estimates of National Immunization Coverage (WUENIC) reported notable progress in the coverage of tracer antigens over the past three years. DTP1 coverage was 81% in 2021, 93% in 2022, and 99% in 2023, while DTP3 was 66%, 78%, and 82% respectively. However, there were still 1,626 zero-dose infants (1% of surviving infants) and 27,648 under-vaccinated infants (17%) in 2023. Efforts to reach these vulnerable children remain crucial to ensuring that no one is left behind and to providing equitable and timely access to all required vaccines to protect children from preventable diseases.

The analysis of DHIS 2018-2021 estimated that 14% of under-5 deaths are associated with households with a zero-dose child.[23] These zero-dose children often have mothers who had either no or few antenatal care visits and did not deliver the baby in a healthcare facility. Considering this situation, the Immunization Agenda 2023 emphasises the importance of embedding immunisation services into primary healthcare (PHC) to reach children in remote areas with limited access to healthcare services.[24]

This strategy seeks to integrate health interventions with routine immunisation services, including outreach services and campaigns at all levels, especially at the PHC, for targeting zero-dose and under-vaccinated children.

5.3. Child Health Preventive and Curative Services

According to the Liberia Harmonized Health Facility Assessment (HHFA) report, 87% of health facilities in Liberia provided preventive and curative care services for children under five years of age in 2021; however, this figure remained the same as in 2018. The three counties with the lowest percentages were Maryland (72%), Montserrado (74%), and Margibi (76%). The services were mainly offered in hospitals (92%) and health centres (88%), but less so in clinics (87%).[25] Figure 16 shows the percentage of health facilities providing preventive and curative services for children under five by type of service. There were concerning gaps in service availability, especially as less than half of facilities offered essential treatments such as pneumonia management with amoxicillin, malaria treatment, and malnutrition care.[27]

23 DHIS 2018-2021 Liberia
24 The Government of Liberia. (2023) Liberia Immunization Coverage and Equity Analysis
25 The Ministry of Health Liberia. (2022). Liberia Harmonized Health Facility assessment (HHFA) Report

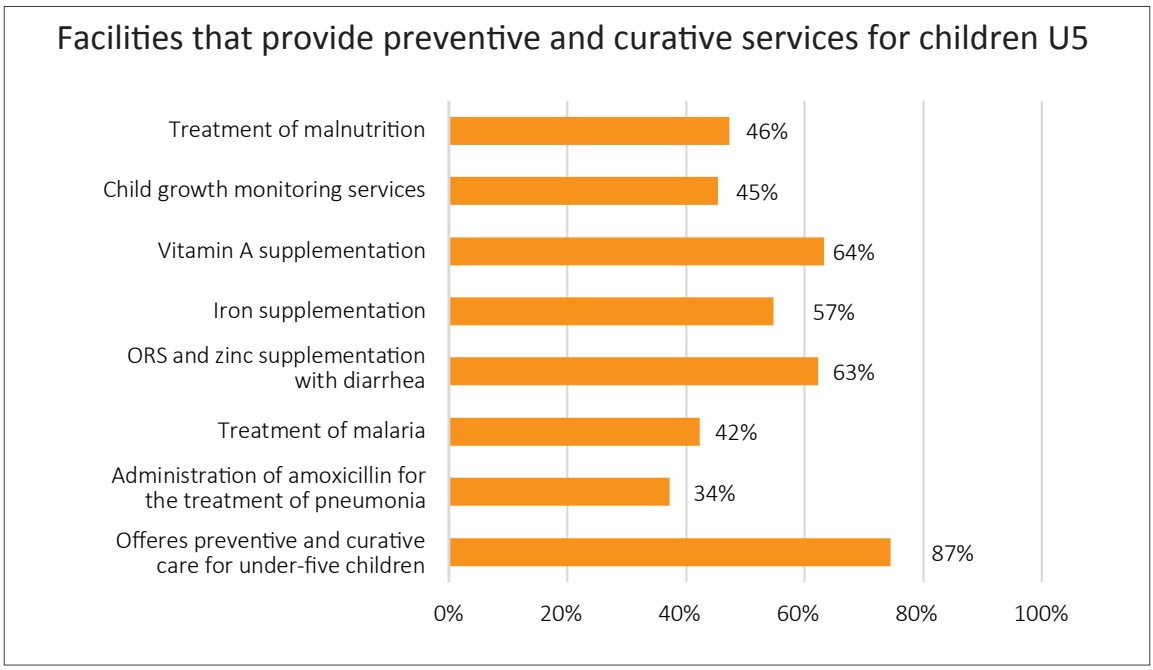

Figure 16: Facilities that provide preventive and curative services for children under-five[27]

The limited availability of tracer items underscores the need for a multifaceted approach to improve preventive and curative services for children under five. This includes strengthening staff capacity through training and providing clear guidelines, as well as ensuring the adequate procurement of essential medicines, supplies, equipment, and diagnostic tools (Figure 17).[27]

Facilities that have tracer items for children under-five preventive and curative services

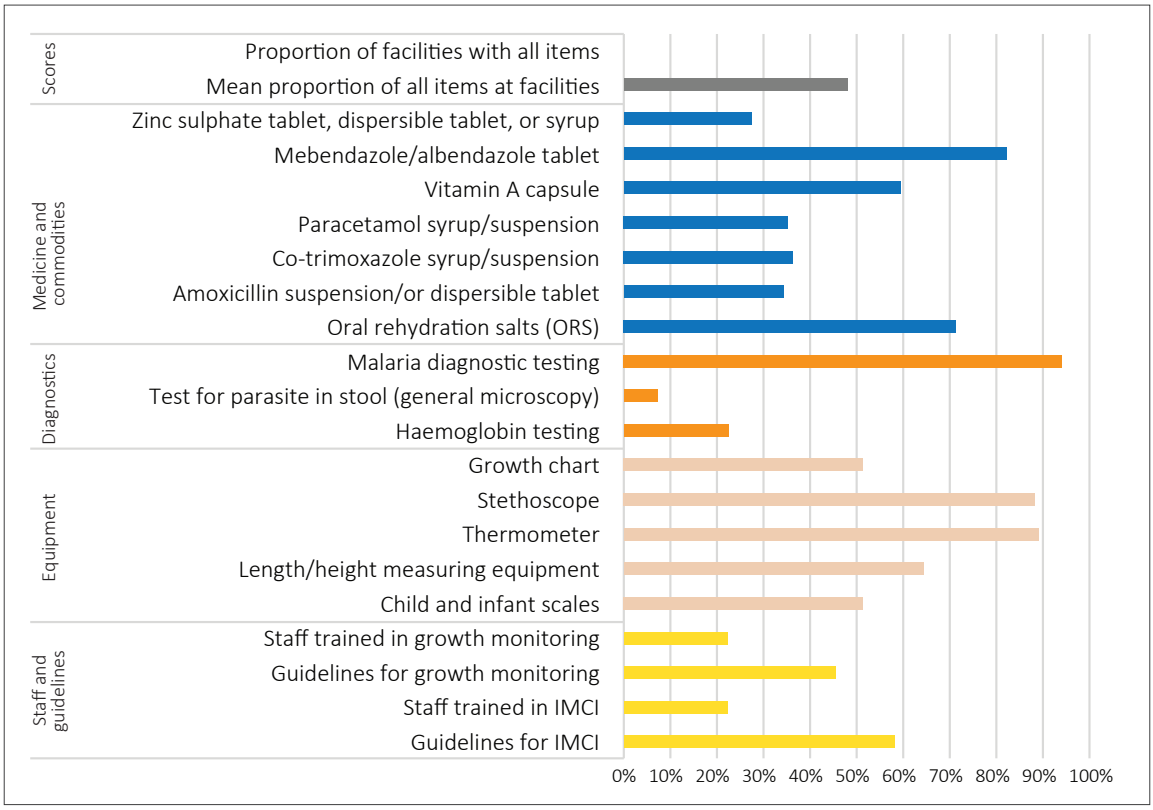

Figure 17: Facilities that have tracer items for children under-five preventive and curative services[27]

Despite efforts to address HIV transmission from mother to child, significant disparities persist in the availability of PMTCT services across health facilities in Liberia. Overall, 73% of health facilities provide Prevention of Mother to Child Transmission (PMTCT) services. However, a substantial gap exists between urban and rural areas, with 46% of urban facilities and 96% of rural facilities offering PMTCT services. In Montserrado, only 37% of facilities provide these services. While PMTCT services are more prevalent in public health facilities (93%), coverage is notably lower in private facilities (30%). Additionally, ARV prophylaxis for newborns and infants of HIV-positive pregnant women is provided in only 52% of facilities. Addressing these discrepancies is crucial to ensure equitable access to PMTCT services for all pregnant women and children.[27]

5.4. Water, Sanitation and Hygiene (WASH)

The Water, Sanitation, and Hygiene (WASH) Strategy Plan in Liberia is a comprehensive approach aimed at advancing the country's Vision 2030 by focusing on clean water access, sanitation facilities, and promoting good hygiene practices. The percentage of households with improved water facilities on their premises has shown significant improvement in urban areas, rising from 8.7% in 2013 to 27.4% in 2019-20, while there has been only a marginal increase in rural areas, moving from 4.4% to 6.8%. Overall, there has been an increase from 6.8% to 18.6% nationwide.[1]

In schools, there is a concerted effort to implement a "Hygiene for Health" campaign. This initiative ensures that schools are equipped with adequate WASH facilities and that students receive comprehensive hygiene education. The plan emphasises the importance of integrating hygiene behaviours into everyday practices across multiple sectors to safeguard children's health.

Healthcare facilities are recognised as environments highly susceptible to infections. Only 53% of healthcare facilities in Liberia have functional WASH facilities for hand hygiene, and only 67% have basic healthcare waste management services.[26] Efforts are directed at ensuring functional and gender-sensitive WASH facilities within these settings. By integrating WASH principles into the strategy, the goal is to prevent infections and provide crucial health services effectively.

In communities, particularly in rural and urban areas facing water and sanitation challenges, the focus is on promoting effective hygiene behaviours. The Community-Led Total Sanitation (CLTS) programme aims to eliminate open defecation and upgrade household latrines. This initiative is intended to empower communities to embrace better hygiene practices for improved health outcomes.

5.5. Social Protection

The social protection investments provide four minimum guarantees, of which (a) access to essential health care and (b) social grants for the elderly, pregnant women, and people living with disabilities are directly related to the reduction of child mortality and morbidity. The other guarantees include (c) basic income and food security for the whole family—especially children in the family environment (including vulnerable groups and people with disabilities)—and (d) strengthening the national commitment towards children.

A Rapid Assistive Technology Assessment (r-ATA) conducted by the MoH and WHO in 2022 on disability prevalence and the use of assistive technology reported that 6.4% of children aged 0-6 were found to have some level of difficulty in mobility, hearing, vision, communication, cognition, or self-care. Of these children, 96% do not currently have the appropriate assistive products to help manage their conditions.[27] This high unmet need necessitates interventions to institutionalise and standardise early screening and identification of disabilities and functional impairments in children, as well as timely referral to connect them with appropriate healthcare, including assistive products and other supportive services (inclusive education, play therapy). To address this issue, training for early functional/disability screening in children has started in target counties in 2024. This strategy highlights the commitment to leaving no one behind, especially vulnerable populations, including children with disabilities. It also underscores the urgent need to integrate interventions for these individuals within routine services to foster an inclusive society.

The five-year national development plan towards accelerated, inclusive, and sustainable development (July 2018–June 2023), popularly known as the Pro-poor Agenda for Prosperity and Development (PADP), has guided initiatives in Liberia to reduce child mortality and morbidity over the last five years.[28] The Government of Liberia is committed to implementing

---

26 WHO & UNICEF Joint Monitoring Programme for Water Supply, Sanitation and Hygiene (JMP). (2019). WASH in health care facilities: Global baseline report 2019

27 WHO. (2022). rapid Assistive Technology Assessment tool (rATA). https://www.who.int/publications/i/item/WHO-MHP-HPS-ATM-2021.1

28 The Government of Liberia. (2018). Pro-Poor Agenda for Prosperity and Development (PAPD). https://globalnaps.org/

the Child Welfare and Protection Policy and updating its accompanying five-year plan of action. Key interventions include family reunification, strengthening social protection investments, including the Liberia Social Safety Net (LSSN) project, the School Meals Programme, the new Birth and Death Registration and Certification Policy, and the development of the Birth Registration Information Management System (BRIMS) on the DHIS2 platform. This has resulted in significant progress over recent years, with under-five birth registration rates increasing from 7% in 2007 to 25% in 2013, and now 66% in 2019/2020.[1]

5.6. Behavioural Change

Behaviour change is complex and influenced by a variety of factors, including cultural beliefs and limited access to resources and opportunities. One important factor is the belief in witchcraft and the supernatural, which is deeply ingrained in many communities. This belief can influence people's health-seeking behaviours, such as the preference for home delivery, vaccine hesitancy, inappropriate infant feeding, nutrition, care-seeking, and even financial decisions. Another factor is the lack of access to resources and opportunities. Communities may not only have limited access to education on new practices but also face economic constraints that make it difficult to adopt such practices. For example, they might struggle to pay for medical treatment and nutritional foods.

Recognising the critical role of communication and information for health, the Government of Liberia launched several key policies in 2022. These included the National Health Policy (2022-2031), the National Health Sector Strategic Plan (2022-2026), and the National Community Health Strategy (2023-2027). These policies underscore the need for strengthened information and communication channels with families and communities, especially for children, adolescents, and families living in vulnerable situations. They emphasise the vital importance of investing in preventive health measures and empowering families and communities through effective communication. This approach aims to promote the sustained adoption of key healthy family behaviours and timely utilisation of basic services by using effective tools such as home-based records, ultimately leading to further reductions in child mortality and morbidity in Liberia.[29]

By understanding the factors that influence behaviour change and designing interventions tailored to specific needs, this strategy aims to make a positive impact on child health.

wp-content/uploads/2019/01/liberia-national-development-agenda-pro-poor-agenda.pdf

29 UNICEF. (2023). Social and Behaviour Change Strategy in Support of Programmatic Results and Children's Rights in Liberia, 2023-2025

6. Bottlenecks, Gaps and Challenges

The country had some of the worst child health indicators immediately after the cessation of hostilities. To accelerate the reduction of mortality and morbidity among children, the country must ensure that access to a full range of Essential Package of Health Services (EPHS) for the prevention and management of childhood illness is strengthened. In the Landscape Analysis of RMNCAH 2023, which included key informant interviews with stakeholders and clinicians, focus group discussions in communities, and a review of the implementation and acceleration of RMNCAH services, the following key bottlenecks, gaps, and challenges were identified.[5]

6.1. Insufficient Domestic Funds and Resource Mobilisation for Child Health Services

Financing for health in Liberia remains a challenge, falling short of the Abuja Declaration targets since the expiration of the MDGs. The national budget for the health sector was $76.6 million (9.4% of the total) in 2022 and $75.7 million (9.5%) in 2023.[30] External donor support plays a vital role in funding child health interventions. Additionally, there is no specific budget line for child health in the national budget, making it difficult to track resources specifically allocated to children's healthcare. Similarly, there is no information available on donor contributions, investment amounts, and funding designations. This lack of transparency and integration hinders efforts to ensure optimal allocation and efficient use of resources for improving child health.

6.2. Persistent Stock Out Due to Challenging Supply Chain System

The availability of essential medicines and equipment directly affects the quality of care in a healthcare facility. The unstable commodity supply is primarily a result of inadequate funding and diminishing support from health partners. Although the country has established four rounds of distribution from the Central Medicine Store (CMS) to county depots and ultimately to the last mile, the frequency of distribution is often disrupted, and reaching commodities to the last mile has been challenging. Figure 18 illustrates the percentages of facilities with child health and newborn health life-saving commodities available in stock.[27] This problem is compounded by the challenge of having adequately skilled health workers for efficient commodity management, including appropriate quantification, forecasting, and storage. Additionally, there is a weak information management and reporting system between the national and health facility levels concerning stock levels.

30 The Government of Liberia, Ministry of Finance and Development Planning. (2023), National Budget Fiscal Year 2023

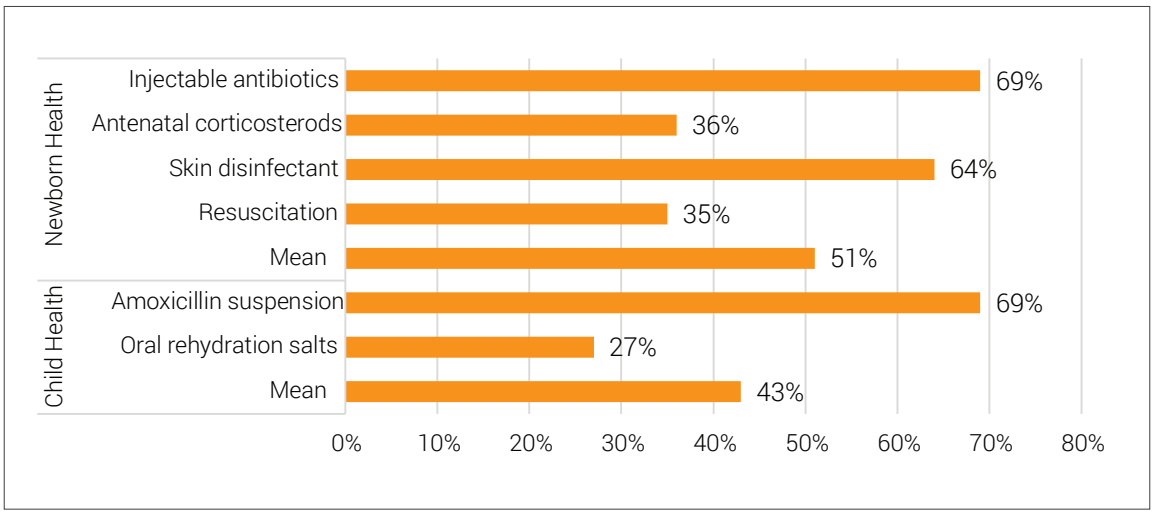

Figure 18: Percentage of facilities that have lifesaving and valid commodities observed in stock[27]

6.3. Limited Competence of Healthcare Workers to Provide Quality Care

The shortage of skilled healthcare workers can compromise the quality of care, leading to adverse health outcomes. In Liberia, home deliveries decreased from 43.8% in 2013 to 19.6% in 2020, skilled birth attendance increased from 61% to 84%, and the national density of midwives per 1,000 births reached 8, which is 2 more than the international benchmark. However, neonatal, perinatal, and infant mortality rates have increased.[1] Moreover, a significant number of neonatal deaths occurred in health facilities.[17] This underscores the urgent need to enhance care quality, encompassing both skills and attitudes, to improve child survival.

Pre-service education and in-service training, including refresher courses for healthcare workers to maintain quality care, have been performed sporadically and irregularly. For example, the HHFA report in 2022 shows that only 33% of health facilities had at least one trained staff member in newborn resuscitation, and 66% had trained staff in essential childbirth care within the past two years. Additionally, 78% of staff did not receive training in growth monitoring and Integrated Management of Neonatal and Childhood Illnesses (IMNCI) in the past two years.[27] IMNCI is among the least prioritised for training due to scarce resources.

Supervision of health services is another critical element for the assurance of sustained provision of quality child health services. The Liberia country supervision plan mandates that DHTs are responsible for conducting monthly supervisory visits in facilities within the district, while at the county level, the CHTs are expected to conduct supervision quarterly, covering at least half of the facilities within the county per quarter. At the national level, the MoH is expected to conduct supervision once a semester, covering at least 25% of all facilities within the country. However, there is a lack of consistency and regularity in these supervisory visits caused by inadequate finances, logistics, and sometimes competing priorities. Moreover, inadequate feedback from supervisory teams to facilities is cited as another bottleneck to improving the quality of care.

To strengthen supervision, the services of paediatricians and obstetricians should be more actively utilised in the provision of quality care. Including them in comprehensive monitoring, supervision, and training teams is essential. Moreover, their involvement in the MPNDSR committee is crucial for reviewing maternal, perinatal, and newborn deaths as well as child

deaths to improve care quality. To ensure sustainable and cost-effective capacity-building of health workers, the use of routine supervision and mentorship by district, county, and central supervisors and mentors is also recommended.[31]

6.4. Limited and Uneven Distribution of Qualified Human Resources

While Liberia has gradually improved its number of professional health workers over the years, with 11 skilled workers—midwives, physicians, physician assistants, and nurses—per 10,000 population, it is still far below the WHO recommendation of 23 skilled health workers per 10,000 population.[27] Contributing factors include limited or poor incentives for health workers, leading to low motivation, high staff attrition rates, and a large proportion of volunteers, all of which threaten workforce availability. Aligning with the Liberia Health Workforce Strategy, enhancing the availability of the workforce is a crucial area to focus on.

Additionally, Liberia faces an inequitable distribution of the available skilled workforce. Figure 19 illustrates the core health worker density per 10,000 population by county. Most of the higher-grade workforce is concentrated in urban settings and counties with easier access to Monrovia, the capital. There is also an uneven distribution of midwives. The lowest ratios of midwives per 1,000 deliveries were observed in Bong (5), Grand Cape Mount (3), Nimba (3), Sinoe (5), and Grand Bassa (3). Conversely, ten other counties met the international benchmark of 6 midwives per 1,000 births, with Montserrado notably achieving 17 midwives per 1,000 births.[27]

Beyond low compensation, inadequate housing for health workers poses a significant barrier to the placement of qualified staff in these communities. The lack of social amenities, including schools, entertainment, and other essential infrastructure, further complicates the process.

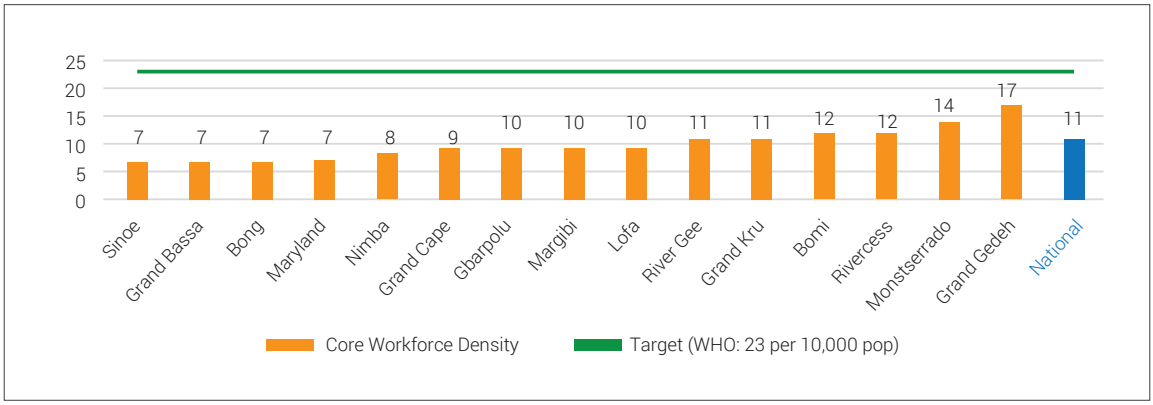

Figure 19: Core health workers density per 10,000 population per county[27]

6.5. Weak Monitoring and Evaluation of Child Survival Data and Services

The integrated monthly report is expected to be published, covering key child survival indicators captured through the Health Information System (HIS), which uses the District Health Information System Version II (DHIS2) platform for health facilities data management, and the Community Based Information System (CBIS) for integrated Community Case

31 The Ministry of Health Liberia. (2021). National Mentoring Guidelines for Reproductive, Maternal, Neonatal and Child and Adolescent Health (RMNCAH)

Management. However, these reports are not regularly submitted, leading to infrequent monitoring and evaluation of child survival activities at both national and subnational levels.

The Maternal and Perinatal Death Surveillance and Response (MPNDSR) committee in Liberia is crucial for reviewing maternal, perinatal, and newborn deaths, including stillbirths, to identify the causes of death, provide feedback, and recommend improvements in care quality. However, the MPNDSR committee's current scope does not include child deaths beyond the newborn period. To improve the quality of care across the board, child health audits should be incorporated into the committee's activities.[32] Furthermore, there is a pressing need to enhance the coverage of reported deaths, improve accuracy in death classification, and elevate both the coverage and quality of feedback provided to each health facility. It is also critical to involve paediatricians and obstetricians in this process, as they are not currently participating in the MPNDSR committee.

6.6. Weak Program Management and Coordination Among National Stakeholders and International Partners

Effective program management and coordination among all partners are essential to the success of any program. In Liberia, while a coordinating mechanism for the Child Survival program exists, it is currently weak. The Technical Working Group (TWG) was previously dormant and only recently was the National Technical Working Group on Child Health established. However, it still requires strengthening to improve coordination. Meetings are not held regularly or according to schedule. Additionally, the management of child survival programs is weak, characterised by limited logistics and insufficient motivation. There is minimal logistical support for supervision, review meetings, and a lack of resources to adequately motivate staff and enhance the work environment.

6.7. Weak Integrated Approach to the Quality of Care for Child Health Services and Programs

Despite the Integrated Management of Neonatal and Childhood Illnesses (IMNCI) and Integrated Community Case Management (iCCM) being standard packages for the delivery of child health services, their integration remains weak and requires further strengthening for improved care delivery. Although the interventions are all embedded in one package, the coordination of the various programs within this package is inadequate. For instance, the management of childhood illnesses encompasses areas such as nutrition, blood safety, malaria, HIV, water, sanitation, and hygiene. However, these interventions are managed as separate programs, leading to suboptimal coordination and thus diminishing the overall quality of care for children.

6.8. Weak Public and Private Partnership for Child Survival

The complexity of the health system underscores that no single ministry, agency, or sector possesses all the requisite resources, skills, and authority to address all the interventions needed to improve child health. A collaborative effort among all relevant sectors is essential for achieving a positive impact. In Liberia, there are 886 health facilities reporting to the

32 WHO & UNICEF (2021), Maternal and perinatal death and surveillance and response, https://www.who.int/publications/i/item/9789240036666

District Health Information System Version II (DHIS2) across the counties. Public health facilities account for 55%, while private health facilities make up 45%. The majority of these facilities are clinics (88%), followed by health centres (7%) and hospitals (4.2%). Most facilities are located in Montserrado.[27]

The Liberia private health sector assessment identified several bottlenecks to quality care, including limited in-service training, shortages of human resources and medicines, funding constraints, and frequent and lengthy power outages. The report also highlights a lack of communication between private and public facilities regarding patient referrals. Strengthening the partnership between the public and private sectors could address these issues by providing training opportunities, a qualified workforce, and essential supplies, ultimately improving the quality of care.[33]

6.9. Limited Level of Advocacy and Social Mobilisation for Child Health

Advocacy and social mobilisation for child survival in Liberia are limited, often occurring primarily during major campaigns. Although there are messages broadcasted on radio and television about newborn and child health, their translation into adequate service utilisation remains suboptimal. The Health Promotion Department of the Ministry of Health suffers from a very low profile and insufficient investment, facing significant challenges due to its extremely limited capacity for strategic social behaviour change programming. Consequently, the sporadic broadcasting of messages has not achieved the desired impact.

33 Gerrard, A. and S. Jain. (2019). Liberia Private Health Sector Assessment. Washington, DC: Palladium, Health Policy Plus. USAID. http://www.healthpolicyplus.com/pubs.cfm?get=17370

7. 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 target aligns with the national objectives set forth in the National Health Strategy, which aims to reduce the under-five mortality rate to 63 per 1,000 live births by 2026 and further decrease it to 25 per 1,000 live births by 2031. This trajectory is designed to accelerate progress toward the Sustainable Development Goal (SDG) of achieving an under-five mortality rate of 25 per 1,000 live births by 2030. Achieving these targets represents a significant milestone for child survival in Liberia. Figure 20 illustrates the under-five mortality targets outlined in both the National Health Policy and the Child Survival Strategy. The projections based on current efforts provide a benchmark, underscoring the urgent need for this strategy to accelerate progress towards these goals.

Target and Projections of U5 Mortality Rate

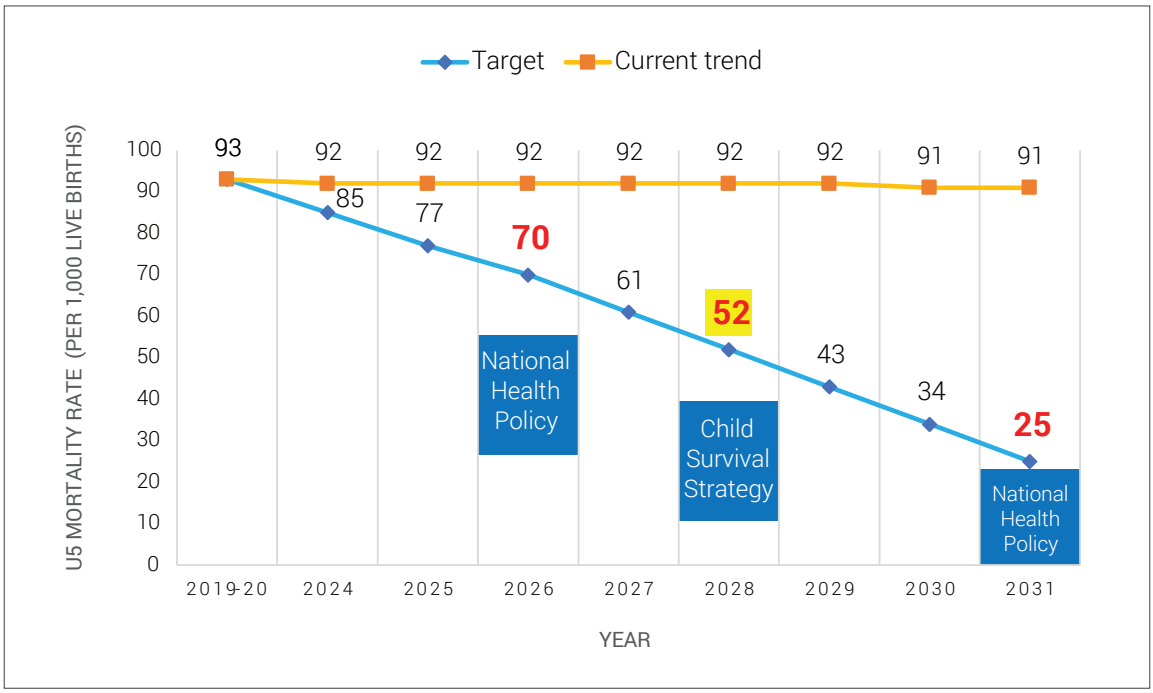

Figure 20: Targets of under-five mortality rate

8. Objectives

8.1. General Objectives

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

8.2. Specific Objectives

The specific objectives of this strategy are as follows:

1. **Enhance Evidence-Based Practices**: Improve routine and emergency care, including Emergency Triage and Treatment (ETAT), Emergency Obstetric and Neonatal Care (EmONC), and care for Small and Sick Newborns, by building the capacity of healthcare workers to provide improved quality of care.
2. **Strengthen and Expand Coverage**: Enhance the coverage and quality of the Integrated Management of Newborn and Childhood Illness (IMNCI) and Integrated Community Case Management (iCCM) of childhood illnesses, with a focus on early detection and treatment of Possible Serious Bacterial Infections (PSBI) and Severe Acute Malnutrition (SAM).
3. **Strengthen Interventions and Integration**: 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 Surveillance**: Improve birth registration and the Maternal, Perinatal, and Newborn Death Surveillance and Response (MPNDSR) system, as well as paediatric death audits, to monitor and review stillbirths, newborn, and under-five deaths. This aims to promote data-informed continuous process improvement and sustain health outcomes for newborns and under-five children.
5. **Promote Advocacy and Behavioural Change**: Advance advocacy, community mobilisation, and behavioural change communication to enhance newborn and child health care services.

9. Key Principles

This strategy is premised on the following key principles:

9.1. Country Ownership, Leadership and Governance

The child survival effort in Liberia will be owned and led by the Ministry of Health (MoH), which has the statutory mandate to formulate and implement both curative and preventive interventions for the health of the population. The Ministry will coordinate the response efforts through its technical divisions and programs.

The Family Health Program (FHP) holds the specific mandate for child health under the supervision and guidance of the Assistant Minister of Preventive Services. The FHP will lead these efforts, collaborating with other relevant MoH divisions and programs, as well as with external partners (see below 9.2). This collaboration will involve joint accountability for successful implementation, resource mobilisation, and monitoring and evaluation.

At the county level, the Child Survival Focal Person, under the supervision of the Community Health Department Director and the County Health Officer (CHO), will be responsible for overseeing the implementation, monitoring, reporting, and coordination of child survival activities. Counties will provide periodic reports to the central MoH through the Family Health Division. Additionally, the MoH will advocate with the Ministry of Finance and Development for domestic mobilisation and the creation of a dedicated budget line for child health services.

The Child Survival Strategy is aligned with the National Health Policy (2022-2031), the National Health Sector Strategic Plan (2022-2026), the updated Essential Package of Health Services (2022), and the Child Health Task Force Strategic Plan 2021-2025, which includes the Ending Newborn Deaths Action Plan (ENAP) and the Every Newborn Action Plan (EPMM).

9.2. Partnership and Coordination

The child survival response in Liberia is inclusive, involving several actors at various levels from national to peripheral. While the Ministry of Health (MoH) leads these efforts, it is supported by numerous stakeholders and partners across the health system. Key partners in child survival efforts include WHO, UNICEF, the United Nations Population Fund (UNFPA), the United States Agency for International Development (USAID), Gavi, the Vaccine Alliance (GAVI), and the World Bank/Global Financing Facility (WB/GFF), among others.

This strategy promotes a harmonised joint action by all partners to ensure that efforts and resource utilisation are as efficient and effective as possible, thereby reducing duplication. It supports the principle of a single national coordinating authority where implementation is a country-led process, incorporating one comprehensive action plan for child survival, including costed work plans, and a unified country-level monitoring and evaluation framework.

In line with the multi-sectoral approach principle, various child survival stakeholders and partners were involved in all stages of developing the Child Survival Strategy and Action Plan. This collaborative spirit will continue during implementation, with partners mobilised according to their comparative advantages to ensure improved coordination, harmonisation, and alignment.

To ensure effective coordination and avoid duplication or deviation from the National Strategy, enhanced coordination mechanisms will be established through the County Health

Technical Working Group (CHTWG) and the broader Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) Coordinating Committee.

9.3. Accountability and Transparency

The 2024-2028 Child Survival Strategy and Action Plans will serve as a key instrument to hold all stakeholders—such as the Ministry of Health (MoH), UN agencies, donors, implementing partners, Civil Society Organizations (CSOs), and local county authorities—accountable for their commitments and responsibilities towards newborns and children in Liberia. All resources allocated for child survival responses, whether from government sources, UN agencies, donors, or implementing partners, will be accounted for, transparently reported on, and utilised to support the objectives of this strategy. A monitoring and evaluation system will be established to include performance reviews of all parties involved in the strategy's implementation.

9.4. Primary Health Care for Resilient Health Systems

Incorporating primary health care is crucial for building more resilient health systems. Primary health care represents the first point of contact for children and their families with the health system, ensuring access to comprehensive and continuous health services. This approach emphasises the holistic well-being of the child by addressing physical, mental, and social health needs in a coordinated manner. By focusing on preventive care—such as immunisations and regular health screenings—primary health care facilitates early identification and management of health issues, thereby reducing the need for more complex and costly treatments later on. Additionally, it nurtures a strong relationship between healthcare providers and families, which is essential for effective health education and promotion, ensuring that children grow up in environments that support their health and development.

To strengthen health systems through primary health care, it is vital to invest in the training and retention of a skilled healthcare workforce knowledgeable in child health services. This includes not only doctors and nurses but also community health workers who are pivotal in reaching underserved populations. Equally important is the integration of health services, ensuring that children have seamless access to a range of services, from immunisation and nutrition to mental health support and disease prevention and management. Leveraging technology, such as digital health records and telemedicine, can enhance the efficiency and reach of primary health care services, making them more accessible, especially in remote or underprivileged areas. A robust primary health care system is the foundation of a resilient health system, ensuring that all children, regardless of their location, have the opportunity to achieve optimal health and well-being.

9.5. Equity

The strategy aims to achieve universal coverage of high-impact interventions and address equity issues by reaching poor and underprivileged groups, ensuring that no newborn child is left behind. It promotes quality health outcomes, which are closely linked to access to high-quality, unbiased health care, and aims to reduce the number of zero-dose children not only for immunisation but for all essential child health services.

The strategy will identify and address factors that impede equity in child health service provision, including gender mainstreaming and inclusion, to ensure that no child is excluded

in the pursuit of universal coverage and the Sustainable Development Goals for survival, good health, and well-being. Additionally, the strategy will focus on ensuring disability-inclusive child health services by addressing provider attitudes, knowledge, infrastructure and accessibility, and the availability of appropriate management options.

9.6. Quality of Care

Quality of care in health services is crucial for achieving Universal Health Coverage (UHC) and meeting the ambitious goals of ending preventable maternal, newborn, and child mortality, as outlined in the health-related Sustainable Development Goals (SDGs). This aligns with the World Health Organization's standards for improving the quality of care for children and young adolescents in health facilities, envisioning a future where every mother, newborn, and child receives high-quality care throughout pregnancy, childbirth, and childhood as a continuum. Quality care encompasses providing effective, safe, people-centred care that is timely, equitable, integrated, and efficient.[34]

This vision is also in line with the Global Strategy for Women's, Children's, and Adolescents' Health (2016-2030), which aims to create a world where every mother experiences a desired and healthy pregnancy, every child survives beyond their fifth birthday, and every woman, child, and adolescent can thrive and reach their full potential. Achieving these goals will lead to significant social, demographic, and economic benefits.[36,35]

9.7. Child Health Emergency

In Liberia, child health is facing a critical situation, with both current outbreaks and future threats requiring urgent attention. Outbreaks of malaria, measles, diarrhoeal diseases, and respiratory infections pose significant risks to children under five, especially in areas with limited healthcare access and poor sanitation. Building resilience among vulnerable populations, including children, is crucial to mitigating the impact of these current outbreaks and future threats. This strategy addresses underlying health determinants such as malnutrition and Water, Sanitation, and Hygiene (WASH), alongside enhancing the quality of health services.

9.8. Climate Change and Child Health

Liberia has areas that are particularly vulnerable to significant threats to child health, such as low-lying coastal regions susceptible to sea-level rise and extreme weather events. These conditions disrupt food and water supplies and increase exposure to vector-borne diseases. Children, with their developing bodies and immune systems, are especially vulnerable to these climate-induced health risks. Key health threats to children in Liberia associated with climate change include increased malnutrition, exacerbated diarrhoeal diseases, and a heightened spread of malaria.

In addition to these specific threats, climate change can contribute to a range of other health issues in children, such as respiratory infections, skin infections, and mental health problems. Weather-related disasters can also have psychological effects, potentially causing traumatic

---

34 World Health Organization. (2020). Standards for improving the quality of care for small and sick newborns in health facilities. Geneva: World Health Organization

35 World Health Organization. (2016). Global strategy for women's, children's, and adolescents' health (2016-2030): Every woman, every child, every adolescent, every day. Geneva: World Health Organization.

sequelae in young minds. Therefore, it is crucial for paediatric clinicians to understand, identify, and address these issues within a clinical setting, offering effective solutions to both children and their parents. At the national level, it is essential to have measures in place to respond to climate change emergencies promptly and effectively.

10. Key Child Survival Strategies with Corresponding Actions

Strategy 1: Mobilise Resources for the Delivery of Quality Newborn and Child Health Services

Health financing is critical to promote equitable access to high-quality integrated services while minimising financial hardship, and this is a top priority in the country. This strategy emphasises the need for sustainable financial mechanisms, innovative funding models, and effective allocation of resources through collaboration, joint monitoring, and integrated programmes to bolster and sustain the delivery of comprehensive and effective newborn and child health services.

This strategy shall be undertaken:

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.

1.2. Conduct high-level engagements with legislators through meetings, policy briefs, and testimonies to present a case for an increase in domestic financing for newborn and child health.

1.3. Engage with private sector entities, philanthropic organisations, and NGOs to form partnerships aimed at funding newborn and child health initiatives.

Strategy 2: Strengthen Procurement and Enhance Equitable Distribution of Quality Essential Medicines, Medical Devices/Equipment and Commodities for Newborn and Child Health

For the successful implementation of child survival programmes in Liberia, procurement and supply management of essential medicines and other medical devices, equipment, and commodities need to be a priority action and a key strategy. To achieve this, the following activities shall be undertaken:

2.1. Conduct quarterly technical procurement and logistics management system review sessions at the central, county, and facility levels to improve tracking of the logistics management information system (LMIS) and optimise inventory control of essential medicines and supplies for newborn and child health services.

2.2. Conduct costed annual quantification of maternal, neonatal, and child health medicines and supplies, which includes 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 III).

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, oxygen concentrators, pulse oximeters, Bakri balloon tamponade, non-pneumatic anti-shock garment, incubators, radiant warmers, CPAP machine, respiratory care consumables, suction apparatus, etc.).

2.4. Upgrade existing 5 NICUs to level II comprehensively and establish 10 additional NICUs to ensure quality service delivery.

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.

2.6. Initiate Community Pharmacies in one EmONC health facility in Lofa in line with the new national health policy and plan.

2.7. Develop and implement a robust maintenance plan for newborn and child health equipment and medical devices and enhance the capacity and availability of biomedical technicians in collaboration with the Healthcare Management and Technology Unit.

Strategy 3: Strengthen the Capacity of Healthcare Workers Including Community Health Assistants to Improve the Quality of Care for Newborn and Child Health

For the smooth delivery of newborn and child health services and interventions, the skills of the providers of care need to be at the optimal level possible. The skills of doctors, midwives, general nurses, and community health assistants in the provision of quality health services for newborns and children under five will be upgraded through competency-based training. Retention of these skills will be sustained through robust onsite supportive supervision visits, mentorship, and coaching. A desk review has revealed that supportive supervision was weak and ineffective and has not been conducted regularly or on schedule. Other skilled attendants such as general nurses, physician assistants, and general physicians will be trained to acquire skills to provide essential newborn and child care and timely referral. Additionally, training for the proper management of childhood illnesses will also be emphasised to enhance staff performance.

To achieve the above skills, the following activities shall be undertaken:

3.1. Develop/update key maternal, newborn, and child health training guides, job aids, and SOPs, including IMNCI, PSBI, SSNB care, and KMC, and print and distribute them to all health facilities, including private health facilities.

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.

3.3. Support health facilities in each region to serve as Centres of Excellence (COE) for Maternal, Newborn, and Paediatric Quality of Care demonstration and learning sites in a phased approach, where COE can provide mentorship to surrounding lower-level facilities.

3.4. Develop and implement a decentralised annual costed Child Health training, mentorship, and supervision plan for healthcare professionals, including CHAs, by county based on evidence data through health information systems and training databases.

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.

3.6. Conduct refresher training for CHAs in iCCM for malaria, ARI, and diarrhoea to increase demand for immunisation and nutrition services and ensure quality improvements in line with community health policy and strategy.

3.7. Scale up quality IMNCI services including Paediatric Emergency Triage and Treatment (ETAT) through an annual refresher training plan for health facility workers.

3.8. Build the capacity 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).

3.9. Support the scale-up of the task-shifting programme through the training of nurses, midwives, and physician assistants as neonatal and obstetric clinicians in the targeted 9 CEmONC facilities.

3.10. Promote appropriate rewards such as certificates of recognition and awards given to the best performing health facilities and healthcare workers.

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.

3.12. Conduct integrated training and mentoring of mid-level cadres on early functional screening and referrals.

3.13. Conduct integrated training for primary health care facilities to provide quality gender-responsive mental health services.

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 Level of Care

Ensuring the adequate number and skilled healthcare workers and the equitable distribution of competent health workers at various levels of service delivery is essential for the implementation of this strategy. The strategy will include promoting equitable distribution of skilled workers, especially obstetricians, paediatricians, and midwives; promoting staff retention; and providing additional incentives to professionals who take up assignments in difficult terrain.

To achieve this, the following key activities and actions shall be undertaken:

4.1. Review, update, and implement the existing human resource policy on the transfer and rotation of key trained personnel.

4.2. Conduct a human resource needs assessment for maternal, newborn, and child health services.

4.3. Develop human resource redistribution plans for maternal, newborn, and child health services.

4.4. Enhance retention of maternal, newborn, and child health staff in rural areas by setting rural incentive packages to motivate staff.

4.5. Provide a performance-based motivational package for newborn and child health staff in urban and rural areas.

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.

4.7. Establish/strengthen an integrated healthcare workers in-service training database for RMNCAH+N to quantify gaps in training and to inform needs for refresher training.

4.8. Enforce compliance with the MoH's new continuing professional development (CPD) strategy for all cadres, including rolling out eLearning platforms with offline capabilities that incorporate newborn and child health topics.

4.9. Update pre-service training curricula based on current best practices to ensure comprehensive coverage of RMNCAH+N topics and strengthen graduate competencies.

Strategy 5: Strengthen Health Information Systems, Monitoring and Evaluation, and Research for Effective Delivery of Evidence-Based Newborn and Child Health Services

Monitoring, evaluation, and research are critical to ensuring the successful implementation of interventions in child health. Monitoring provides an ongoing assessment of progress. Research and evaluation give a broader view of the whole programme, promote transparency, and provide long-term use of data for planning and decision-making across all levels. This strategy aims to enhance health information systems, including community-based health information systems (CBIS).

This strategy also addresses inadequate disease surveillance and data processing mechanisms, resulting in insufficient and unreliable data, including from MPNDSR and child death audits. Inconsistencies from different data sources create difficulties in obtaining a comprehensive and accurate overview. In addition, the data obtained have not been adequately reviewed, interpreted, analysed, or used to improve service delivery based on the information from health facilities. This affects the effectiveness and efficacy of interventions throughout the health system.

The following activities will be implemented:

5.1. Review and update newborn, perinatal, and child health indicators, including stillbirths, in the DHIS2 to develop and disseminate RMNCAH scorecards and wall charts.

5.2. Strengthen the eCBIS system by training on data collection, verification, and regular monitoring.

5.3. Improve national and county child health data by leveraging digitalisation for real-time reporting to enhance evidence-based decision-making, including the roll-out of the integrated eLMIS, mSupply, and eCBIS platforms in all CEmONC facilities, and strengthen the LMIS in targeted BEmONC facilities.

5.4. Strengthen and scale up birth registration in all health facilities.

5.5. Strengthen the MPNDSR system and implementation by encouraging the timely conduct of maternal, perinatal (including stillbirths, which should be disaggregated into macerated and fresh), neonatal, and paediatric death audits and recommendations.

5.6. Conduct baseline, midline, and end-line client satisfaction surveys on MNCH services in all EmONC facilities to determine areas for improvement in the quality of MNH service delivery.

5.7. Support the implementation of research around community mother support groups in the promotion of safe, quality maternal, newborn, and child care and maternal, neonatal, and paediatric deaths at the community level.

Strategy 6: Strengthen Program Management and Coordination Mechanism for Effective Implementation of Newborn and Child Survival Interventions

For the effective management of child survival activities, the Family Health Programme and other units within the MoH responsible for child survival need to be strengthened and empowered to effectively monitor and coordinate these activities. Additionally, the coordinating mechanisms established at central and county levels also need to be fully functional and strengthened, with clearly defined terms of reference for staff dealing with child survival at both levels. These terms of reference should be reviewed and updated where appropriate to reflect current realities. To achieve this strategy, the following activities and actions need to be undertaken:

6.1. Conduct high-quality monthly CHTWG meetings at the central level, with quarterly tracking of the Child Survival Action Plan.

6.2. Engage biannually with the Health Sector Coordination Committee on newborn and child health services and other partners to advocate for policy changes that would increase equitable access and improve the quality of care for IMNCI.

6.3. Establish and strengthen the CHTWG at the county level with defined terms of reference and membership, and conduct monthly meetings.

6.4. Conduct quarterly reviews of the CSSAP to monitor and evaluate activities.

6.5. Engage with the Global Child Health Taskforce and conduct quarterly meetings with the country to assess progress and provide global guidance.

6.6. Include and highlight maternal, newborn, and child health activities in annual national and county health operational plans in line with the national plan.

6.7. Ensure that newborn and child health is a standing agenda item in the HSCC and HCC meetings.

Strategy 7: Strengthen Integration for Improved Quality of Care and Efficiency for Newborn and Child Survival Services

Integrated programming is an approach to development and humanitarian response that intentionally "links the design, delivery, and evaluation of programmes across disciplines and sectors to produce an amplified, lasting impact on people's lives." This strategy strengthens integration for Child Survival services among Health, Immunisation, Malaria, HIV, Disability-inclusive care, Nutrition, WASH, Social Protection, and Social Behaviour.

For the adequate management of IMNCI in PHC facilities and at the community level, the integrated approach has been the strategy adapted and used in line with recommendations from WHO. The iCCM is another multi-faceted strategy that addresses critical challenges

in child health. These strategies are crucial for achieving progress towards universal health coverage, reducing child mortality, and promoting healthier communities. However, said integration has weaknesses and needs to be strengthened.

Activities to be conducted to strengthen said integration include the following:

7.1. Conduct regular collaboration briefings among partners (MNCH, Immunisation, Malaria, HIV, Disability-inclusive care, Nutrition, WASH, Social Protection, and Social Behaviour) of child health at CHTWG meetings.

7.2. Strengthen the conduct of joint integrated implementation and monitoring visits of child health intervention plans among partners (Immunisation, Malaria, HIV, Disability-inclusive care, Nutrition, WASH, Social Protection, and Social Behaviour) in line with electronic joint integrated supportive supervision (eJISS).

7.3. Establish/reinforce adolescent mothers to serve as support groups in communities for improving services related to health, nutrition, WASH, social protection, and social behaviour.

7.4. Support the consolidation of Maternal, Newborn, and Child Health records (Big Belly Book and Child Health Passport) through the rollout of the home-based Maternal Newborn and Child Health Record for optimised continuous care.

7.5. Conduct awareness campaigns for the community and provide training for healthcare providers on early and exclusive breastfeeding for the first six months of life through partnerships between Nutrition, Social Behaviour Change, and other relevant partners.

Strategy 8: Strengthen Public-Private Partnerships for Newborn and Child Survival Services

Private sector health providers include hospitals and clinics, pharmacies, and medicine sellers, as well as traditional treatment practitioners (TTMs) and traditional healers in communities. Private-sector providers will deliver the minimum essential package of newborn and child health interventions along the continuum of care. Private-sector providers are required to use national standards and guidelines for all aspects of clinical care. Given that the private sector is a major player in the delivery of health services, a strong public-private partnership will advance the agenda of any health programme, and child survival is no exception.

The following activities are articulated herein for a stronger public-private partnership for the advancement of child survival:

8.1. Support the development of the national public-private collaboration framework and plan on newborn and child health for implementation, including monitoring data and accountability in private sector health providers.

8.2. Strengthen links and engagement with private healthcare facilities (e.g., Healthcare Federation of Liberia (HFL)) through meetings, including CHTWG, and joint monitoring visits.

8.3. Distribute updated protocols, guidelines, checklists, tools, and Social Behaviour Change Communication (SBCC) materials for newborn and child health services to private providers.

8.4. Conduct training/refresher training for private sector healthcare providers to deliver quality newborn and child health services.

Strategy 9: Strengthen Advocacy, Communication and Social Mobilisation to Increase Awareness of the Importance of Newborn and Child Survival

Social behaviour change will work to create an enabling environment that fosters the adoption of positive behaviours by promoting positive behaviours and demand for quality services, and by building support for the cause of children. While knowledge and awareness of childhood diseases may exist among the population, health-seeking behaviours may not be as prevalent. Given this context, advocacy, communication, and social mobilisation efforts must be amplified and sustained. The MoH will take the lead, collaborating with counties, communities, and partners to disseminate child survival information through diverse channels.

This strategy intersects with other strategies to promote resource mobilisation, integration among partners, and public and private partnerships. Strategy 9 focuses on community awareness through advocacy and communication for child health.

To strengthen advocacy, communication, and social mobilisation, and other community-based interventions to improve child health outcomes, the following activities shall be undertaken:

9.1. Develop, implement, and evaluate a focused advocacy and communication strategy and plan on newborn and child health; including interpersonal communication, engagement with the community, campaigns using mobile technology, and other mass media for increased focus on newborn and child health.

9.2. Conduct annual sensitisation meetings for political and community leaders to reinforce local political leadership, ownership, and accountability, in order to recommit to newborn and child health as a public good and a basic right of every child.

9.3. Identify and support national and county champions for newborn and child health by working with communities to boost trust in the healthcare systems.

9.4. Commemorate child health days, such as: 1. Day of the African Child, 2. World Prematurity Day, 3. World Pneumonia Day, 4. World Malaria Day, and 5. World Breastfeeding Week, etc.

11. Implementation Arrangements

Family Health Program strategic and operational plans are developed in line with the objectives of the Essential Package of Health Services of the Health Services Department. The CMO of the Health Services Department approves the division's plan for the year. Annual operational planning for the MoH begins before the close of the calendar year, which coincides with the national budgeting period. The FHP will coordinate child health annual planning across different relevant departments and collaborate with all partners at all levels. This will ensure alignment with the MoH's operational planning to increase service efficiencies and optimise resource utilisation.

All child survival stakeholders will be encouraged to contribute to information sharing, joint planning, and the monitoring of the performance of child survival interventions. A detailed mapping and inventory of all partners involved in child survival activities in the country will

provide a basis for engagement and rationalisation of resources. Implementation roles and responsibilities will be determined based on comparative advantage.

Table 6: Proposed implementation levels and roles of key stakeholders

Implementation Level	Stakeholder	Role
National	Ministry of Health	■ Policy formulation ■ Supervision ■ Capacity building ■ Quality assurance ■ Setting standards and guidelines ■ Partner coordination ■ Planning ■ Reviews ■ Surveys ■ Monitoring and evaluation ■ Resource mobilisation and financing of child health services ■ Surveillance ■ Operational research
	Ministry of Finance and Development Planning (MFDP)	■ Resource mobilisation ■ Budget allocation ■ Financing the Child Survival Strategic Plan ■ Financing Primary Health Care
	Other Ministries and Agencies (Education, Gender, Public Works, International Affairs etc.)	■ Foster a multi-sectoral partnership with MoH leveraging on their respective mandates

Implementation Level	Stakeholder	Role
	WHO	■ Technical guidance in the implementation of child survival interventions ■ Financial support to implement interventions ■ Evidence-based norms/standards to guide the implementation of interventions ■ Technical assistance in procurement and distribution of commodities ■ Assistance in conducting monitoring and evaluation activities, such as surveys and operational research
	UNICEF	■ Technical guidance in the implementation of key child health interventions ■ Financial support to implement child survival interventions ■ Technical assistance in procurement and distribution of commodities ■ Assistance in conducting monitoring and evaluation activities, such as surveys and operational research ■ Provide technical assistance on data analytics of routine health information system data
	USAID	■ Financial support to implement child survival interventions ■ Technical assistance in procurement and distribution of commodities ■ Assistance in conducting monitoring and evaluation activities, such as surveys and operational research ■ Technical guidance in the implementation of child survival interventions
	Other Bilateral & Multilateral Partners	■ Financial/commodity support to implement child survival interventions ■ Technical assistance in procurement and distribution of commodities ■ Assistance in conducting monitoring and evaluation activities, such as surveys and operational research ■ Technical guidance in child health interventions

Implementation Level	Stakeholder	Role
	Regulatory Authorities (LMHRA, LMDC, LCPS, LBNM, LPB)	■ Quality control of essential medicines ■ Regulate professional standards of doctors, nurses, midwives, pharmacists, etc.
	Local and INGOs	■ Implementation of child survival intervention
	Civil Society Organisations	■ Advocacy ■ Demand generation ■ Child health performance tracking
	Health Training Institutions	■ Collaborate in capacity building
	Corporate Entities	■ Provide financial support through corporate social responsibility
	Universities and Research Institutions	■ Conduct research to provide technical evidence for policy formulation and capacity building
	Media Institutions	■ Promote child survival through airing of messages
County	Superintendents	■ Chair county health board ■ Advocacy ■ Resource and community mobilisation ■ Supervision of implementation
	County Health Teams	■ Planning, management, and supervision of health facilities, community, and private sector/NGO ■ Data compilation and transmission to MoH ■ Coordination of partners at county level
	Local Political Leadership	■ Advocacy ■ Resource and community mobilisation ■ Supervision of implementation
	INGOs/NGOs	■ Partner with the MoH to provide technical assistance for child health implementation
	Civil Society Organisations	■ Advocacy ■ Community mobilisation ■ Holding implementers accountable to citizens and beneficiaries
	County Hospitals	■ Implementation and supervision of health centres and clinics ■ Data collection and transmission to county

Implementation Level	Stakeholder	Role
District	District Health Teams	■ Planning and implementation of child survival interventions ■ Supervision of health centres, clinics, and communities ■ Data collection and transmission to county health teams
	Health Facilities	■ Service provision for childhood illnesses ■ Supervision of communities ■ Data generation for collection and transmission by district health teams
Community	CHAs	■ Health promotion ■ iCCM implementation ■ Referrals ■ Keeping health records
	TTMs and CHPs	■ Health promotion ■ Community engagement and mobilisation ■ SBCC activities ■ Referrals
	Community-Based Organisations	■ Advocacy ■ Community mobilisation ■ Holding implementers accountable to citizens and beneficiaries

12. Partners Mapping

Below is a depiction of the current partner mapping for newborn and child health in Liberia during the development of the Child Survival Strategy. We distributed the questionnaire to various partners across the country and received responses from 19 organisations, including USAID, GFF/World Bank, JICA, CHAI, WHO Liberia, UNFPA Liberia, UNICEF Liberia, Last Mile Health, Help a Mother and Newborn Initiative, NPHIL, Community Health Service Division, ROP, and county health teams in Montserrado, Gbarpolu, Nimba, Rivercess, Grand Kru, Grand Cape Mount, and Grand Gedeh.

The map below shows the counties in which each partner is operating, and Table 8 also details the respondents' areas of intervention for child survival. The number under each mark indicates the number of implementing agencies in each county. We received feedback from seven county health teams; however, the rest of the county offices were also included on the map as representatives of their respective counties.

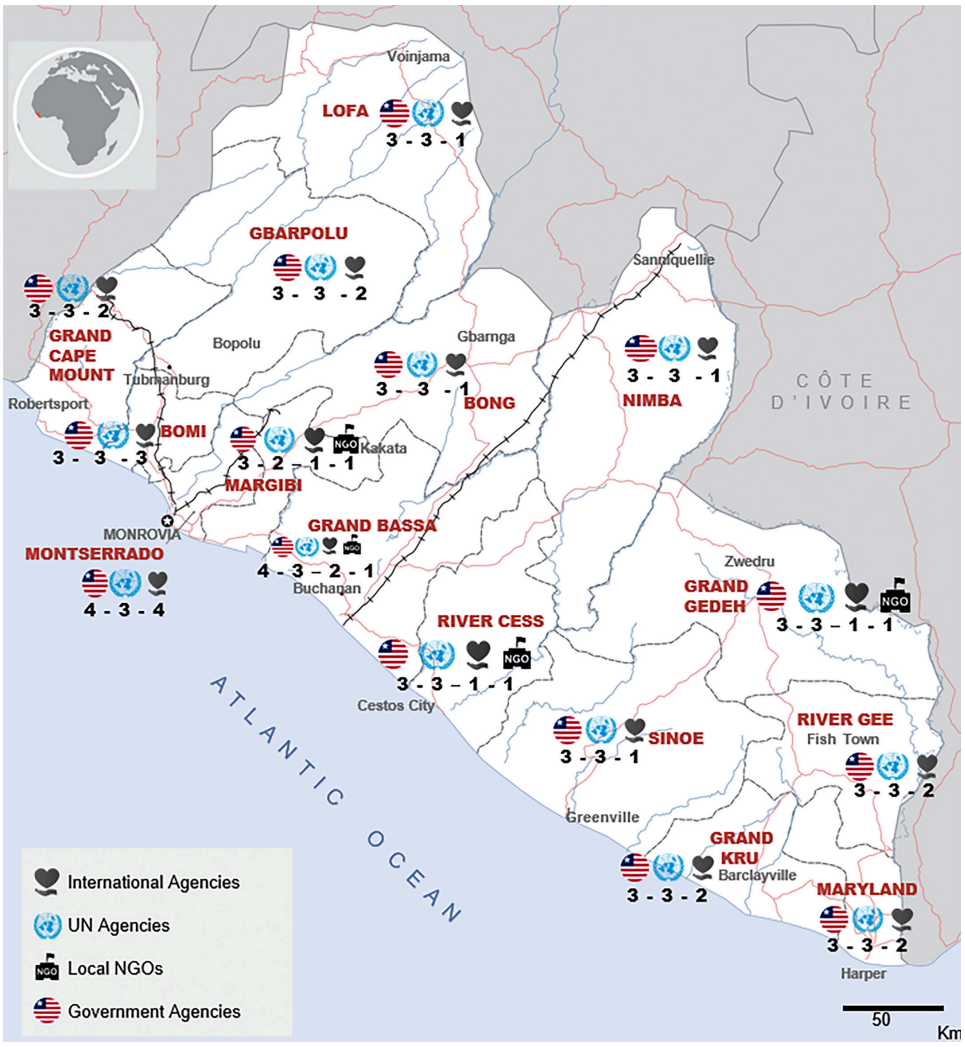

Figure 23: Partners' operation mapping across the country

Table 7: Partners' classification for the mapping

International Agencies	UN Agencies	Local NGOs	Government Agencies
USAID	WHO	Last Mile Health	15 County Health Teams
GFF/World Bank	UNFPA	Help a Mother and Newborn Initiative	Community Health Services Division
JICA	UNICEF		NPHIL
CHAI			ROP

Table 8: Area of interventions for Child Survival by Partners'.

	Immunisation	Nutrition	Social protection	WASH	Management of diarrhoea	Management of pneumonia	
USAID	✓				✓	✓	
GFF/WB	✓	✓	✓	✓	✓	✓	
JICA							
CHAI						✓	
WHO	✓	✓		✓			
UNFPA							
UNICEF	✓	✓	✓	✓	✓	✓	
Last Mile Health	✓	✓			✓	✓	
Help a mother and Newborn Initiative		✓					
NPHIL				✓			
Community Health Services Division	✓	✓	✓	✓	✓	✓	
ROP	✓		✓	✓			
Montserrado CHT	✓	✓	✓	✓	✓	✓	
Gbarpolu CHT	✓	✓			✓	✓	
Nimba CHT	✓	✓		✓	✓	✓	
Rivercess CHT	✓	✓			✓	✓	
Grand Kru CHT	✓	✓		✓	✓	✓	
Grand Cape Mount CHT	✓	✓			✓	✓	
Grand Gedeh CHT	✓	✓	✓	✓	✓	✓	
Total	16	13	6	10	12	12	

	Management of malaria	HIV/ PMTCT	Child health governance	Child health emergencies	Health promotion	Data management	Other	Total
	✓	✓	✓	✓	✓	✓		9
	✓	✓	✓	✓	✓			11
							✓	1
					✓	✓	✓	4
	✓	✓	✓	✓	✓	✓		9
					✓		✓	2
	✓	✓	✓	✓	✓	✓		12
	✓				✓	✓		7
					✓			2
					✓		✓	3
	✓	✓	✓	✓	✓	✓	✓	13
	✓				✓			5
	✓	✓			✓	✓		10
	✓	✓	✓	✓	✓			9
	✓	✓		✓	✓			9
	✓	✓	✓	✓	✓			9
	✓	✓		✓	✓	✓		10
	✓	✓		✓	✓	✓		9
	✓	✓	✓	✓	✓	✓		12
	14	12	8	11	17	9	4	

Table 9: Counties and areas of intervention of 19 responders

No	Name of Partners	Countries of Intervention (#)	Areas of Intervention in Child Survival
1	US Agency for International Development (USAID)	Bomi, Bong, Grand Bassa, Grand Cape Mount, Grand Gedeh, Grand Kru, Lofa, Margibi, Montserrado, Nimba, River Gee (11)	■ Immunisation ■ Management of diarrhoea ■ Management of pneumonia ■ Management of malaria ■ HIV/PMTCT ■ Child health governance ■ Child health emergencies ■ Health promotion ■ Data management
2	Global Financing Facility/ World Bank	Bomi, Gbarpolu, Grand Cape Mount, Grand Kru, Maryland, Montserrado, Rivercess, River Gee, Sinoe (9)	■ Immunisation ■ Nutrition ■ Social protection ■ WASH ■ Management of diarrhoea ■ Management of pneumonia ■ Management of malaria ■ HIV/PMTCT ■ Child health governance ■ Child health emergencies ■ Health promotion
3	Japan International Cooperation Agency (JICA)	Montserrado (1)	■ JICA Areas of intervention in CS - Other (Management of the healthcare services at facilities)
4	Clinton Health Access Initiative (CHAI) Liberia	Bomi, Gbarpolu, Grand Bassa, Montserrado	■ Management of pneumonia ■ Health promotion ■ Data management ■ Other (Medical oxygen; universal/early disability screening; early provision of assistive technologies (AT); community sensitisation on child disability issues; play as a component of ECD)

No	Name of Partner	Countries of Intervention (#)	Areas of Intervention in Child Survival
5	World Health Organization (WHO) Liberia	Bomi, Bong, Gbarpolu, Grand Bassa, Grand Cape Mount, Grand Gedeh, Grand Kru, Lofa, Maryland, Montserrado, Nimba, Rivercess, River Gee, Sinoe (14)	■ Immunisation ■ Nutrition ■ WASH ■ Management of malaria ■ HIV/PMTCT ■ Child health governance ■ Child health emergencies ■ Health promotion ■ Data management
6	United Nations Population Fund (UNFPA) Liberia	All 15 counties	■ Health promotion ■ Other (Procurement of life-saving commodities and prevention & treatment of maternal complications)
7	United Nations Children's Fund (UNICEF) Liberia	All 15 counties	■ Immunisation ■ Nutrition ■ Social protection ■ WASH ■ Management of diarrhoea ■ Management of pneumonia ■ Management of malaria ■ HIV/PMTCT ■ Child health governance ■ Child health emergencies ■ Health promotion ■ Data management ■ Procurement of life-saving commodities
8	Last Mile Health	Grand Bassa, Grand Gedeh, Rivercess (3)	■ Immunisation ■ Nutrition ■ Management of diarrhoea ■ Management of pneumonia ■ Management of malaria ■ Health promotion ■ Data management ■ Digital health ■ Community health supply chain management ■ Health financing

No	Name of Partner	Countries of Intervention (#)	Areas of Intervention in Child Survival
9	Help a Mother and Newborn Initiative	Margibi (1)	■ Nutrition ■ Health promotion
10	Community Health Services Division	All 15 counties	■ Immunisation ■ Nutrition ■ Social protection ■ WASH ■ Management of diarrhoea ■ Management of pneumonia ■ Management of malaria ■ HIV/PMTCT ■ Child health governance ■ Child health emergencies ■ Health promotion ■ Data management ■ Other
11	National Public Health Institute of Liberia (NPHIL)	All 15 counties	■ WASH ■ Health promotion ■ Other (Disease surveillance, Child health emergencies)
12	Rescue Our people (ROP)	Grand Bassa, Montserrado (2)	■ Immunisation ■ Social protection ■ WASH ■ Management of malaria ■ Health promotion
13	Montserrado County Health Team (CHT)	Montserrado (1)	■ Immunisation ■ Nutrition ■ Social protection ■ WASH ■ Management of diarrhoea ■ Management of pneumonia ■ Management of malaria ■ HIV/PMTCT ■ Health promotion ■ Data management

No	Name of Partner	Countries of Intervention (#)	Areas of Intervention in Child Survival
14	Gbarpolu CHT	Gbarpolu (1)	■ Immunisation ■ Nutrition ■ Management of diarrhoea ■ Management of pneumonia ■ Management of malaria ■ HIV/PMTCT ■ Child health governance ■ Child health emergencies ■ Health promotion
15	Nimba CHT	Nimba (1)	■ Immunisation ■ Nutrition ■ WASH ■ Management of diarrhoea ■ Management of pneumonia ■ Management of malaria ■ HIV/PMTCT ■ Child health emergencies ■ Health promotion
16	Rivercess CHT	Rivercess (1)	■ Immunisation ■ Nutrition ■ Management of diarrhoea ■ Management of pneumonia ■ Management of malaria ■ HIV/PMTCT ■ Child health emergencies ■ Health promotion
17	Grand Kru CHT	Grand Kru (1)	■ Immunisation ■ Nutrition ■ WASH ■ Management of diarrhoea ■ Management of pneumonia ■ Management of malaria ■ HIV/PMTCT ■ Child health emergencies ■ Health promotion ■ Data management

No	Name of Partner	Countries of Intervention (#)	Areas of Intervention in Child Survival
18	Grand Cape Mount CHT	Grand Cape Mount (1)	■ Immunisation ■ Nutrition ■ Management of diarrhoea ■ Management of pneumonia ■ Management of malaria ■ HIV/PMTCT ■ Child health emergencies ■ Health promotion ■ Data management
19	Grand Gedeh CHT	Grand Gedeh (1)	■ Immunisation ■ Nutrition ■ Social protection ■ WASH ■ Management of diarrhoea ■ Management of pneumonia ■ Management of malaria ■ HIV/PMTCT ■ Child health governance ■ Child health emergencies ■ Health promotion ■ Data management

13. Performance Framework

There are sets of indicators proposed in this performance framework, as outlined in the table below, which will be used to track performance towards achieving the outcomes and impact of the Child Survival objectives and goals, respectively. The agreed indicators and corresponding targets were formulated based on consensus from all key stakeholders.

The tracking of achievements of outputs, outcomes, and impact will utilise a variety of sources, including routine HMIS, population-based household surveys (LDHS and HHFA), and other surveys. Additional information sources will include administrative data, reports, meeting minutes, attendance records, distribution plans, demographic surveillance systems, commodity distribution data, and operational research.

HMIS will provide continuous data from patient care settings, while surveys will complement this data with population-based information, albeit intermittently (LDHS is conducted every five years). LDHS provides stratified data on equity, including urban/rural, region/county, mother's education, and wealth quintile. The gathered information will be compiled and synthesised, with feedback provided through periodic reports, bulletins, newsletters, and various presentations to summarise the information obtained. This strategy emphasises analysing indicators with a focus on key stratifications for in-depth investigation. The collective documentation will be made available to partners, donors, and communities through numerous opportunities and channels, including conferences/workshops, coordination and technical working group meetings, annual review and planning meetings, and peer-reviewed publications.

Table 10: Performance Framework

Performance Framework Child Survival Strategy								
Indicator		Baseline		Targets (%)				
		Source (Year)	Value (%)	Year 1 (2024)	Year 2 (2025)	Year 3 (2026)	Year 4 (2027)	Year 5 (2028)
Impact								
1	Under-5 Mortality Rate (per 1,000 births)	LDHS (2019/2020)	93	85	77	70	61	52
2	Neonatal Mortality Rate (per 1,000 births)	LDHS (2019/2020)	37	33	30	27	25	23
3	Infant Mortality Rate (per 1,000 births)	LDHS (2019/2020)	63	57	51	45	42	39
4	Prevalence of stunting among children under 5 years of age	LDHS (2019/2020)	30	27	26	25	24	23
Coverage								
Nutrition								
5	Percentage of children initiating breastfeeding within the first 1 hour of birth, following delivery by a healthcare professional	LDHS (2019/2020)	67	75	80	85	90	95

Performance Framework Child Survival Strategy								
Indicator		Baseline		Targets (%)				
		Source (Year)	Value (%)	Year 1 (2024)	Year 2 (2025)	Year 3 (2026)	Year 4 (2027)	Year 5 (2028)
6	Percentage of children up to 6 months who are exclusively breastfed	LDHS (2019/2020)	55	60	65	70	75	80
Immunisation								
7	Percentage of under 2 who received the Penta-3 Vaccine	HMIS (2022)	89	94	99	100	100	100
8	Percentage of counties that have at least 80% of children 0-11 months vaccinated with three doses of DTP-containing/Penta Vaccine	DHIS2 (2021)	73	80	90	95	100	100
9	Percentage of children aged 5-15 months who received Malaria Vaccine	TBD	TBD	TBD	TBD	TBD	TBD	TBD
Child Health								
10	Percent of newborns who received postnatal care service by skilled providers within 48 hours of birth	HMIS (2023)	92	94	96	98	100	100
11	Percentage of Under 5 having ARI, who receive advice or treatment within 48 hours	LDHS (2019/2020)	33	40	50	60	70	80
12	Percentage of Under 5 tested positive for Malaria who received ACT within 24 hours by CHAs	HMIS (2023)	73	75	80	85	90	95
13	Percentage of under 5 with diarrhoea who received ORS and zinc by CHAs	HMIS (2023)	89	91	93	95	97	99
Maternal Health								
14	Percentage of pregnant women who delivered by a skilled health professional (doctor, nurse, midwife or physician assistant)	LDHS (2019/2020)	84	87	89	91	93	95

Performance Framework Child Survival Strategy								
Indicator		Baseline		Targets (%)				
		Source (Year)	Value (%)	Year 1 (2024)	Year 2 (2025)	Year 3 (2026)	Year 4 (2027)	Year 5 (2028)
15	Percentage of pregnant women who attended more than 4 ANC visits	LDHS (2019/2020)	87	90	93	96	99	100
16	Percent of mothers received postpartum care within 48 hours after delivery	HMIS (2023)	92	94	96	98	100	100
HIV								
17	% of HIV positive children under 5 initiated or placed on the appropriate ART	NACP (2023)	TBD	TBD	TBD	TBD	TBD	TBD
WASH								
18	Percentage of households having sustainable access to clean, safe and adequate water	LDHS (2019/2020)	84	86	87	88	89	90
19	Percentage of households with access to improved sanitation	LDHS (2019/2020)	47	49	51	53	55	57
Social Protection								
20	Percentage of children under age 5 whose births are registered with the civil authorities	LDHS (2019/2020)	66	70	75	80	85	90
Health Facility and Human Resource								
21	Percentage of health facilities with life-saving commodities available in stock for child health	HHFA (2022)	43	51	59	66	73	80
22	Percentage of health facilities with life-saving commodities available in stock for newborn health	HHFA (2022)	51	57	63	69	75	80
23	Percentage of health facilities with oxygen for obstetric and newborn care services	HHFA (2022)	13	21	29	36	43	50

Performance Framework Child Survival Strategy								
Indicator		Baseline		Targets (%)				
		Source (Year)	Value (%)	Year 1 (2024)	Year 2 (2025)	Year 3 (2026)	Year 4 (2027)	Year 5 (2028)
24	Percentage of healthcare workers trained in IMNCI at least within 2 years	HFFA (2022)	22	35	50	65	80	90
25	Number of Community Health Assistants trained or refreshed in the management of ARI, diarrhoea and Malaria (iCCM) at the community	eCBIS	TBD	TBD	TBD	TBD	TBD	TBD

14. SWOT Analysis of Child Survival Program in Liberia

The table below depicts a SWOT analysis of the child survival programme, examining its strengths, weaknesses, opportunities, and threats:

Table 11: SWOT analysis of the child survival program

STRENGTHS	OPPORTUNITIES
■ Availability of a functioning National CH TWG. ■ Developed policies, strategies, protocols, and guidelines. ■ Involvement of partners and stakeholders in child health care services. ■ Existing community structures that can be leveraged for child health. ■ Availability of accredited health care training institutions.	■ Community engagement in encouraging preventative care practices, promoting behaviour change related to child health issues, and supporting health facilities and staff. ■ Awareness of the urgency of child survival in Liberia among partners to secure funding for activities. ■ Increased awareness of Ante-Natal Care (ANC) services and facility delivery through early contacts, outreach visits, immunisation campaigns, and motivation by TTMs and CHAs. ■ Technological advancements, e.g. development of health data digitisation.
WEAKNESSES	**THREATS**
■ Staff attrition. ■ Inadequate staff to provide child health care services. ■ Inadequate mentorship and supervision of healthcare workers. ■ Insufficient refresher training. ■ Limited essential medical supplies, equipment, and supply management. ■ Poor and unstable health facility infrastructure. ■ Limited infrastructure, e.g. bad road conditions. ■ Insufficient resources for data collection and utilisation. ■ Weak referral system. ■ Poor integration between child health services. ■ Interventions among partners.	■ Personal financial limitations. ■ Influence of cultural beliefs and practices on healthcare-seeking behaviours. ■ Staff attitudes. ■ Harsh weather conditions (floods, landslides, etc.). ■ High reliance on donor support. ■ Economic constraints. ■ Political instability.