Ministry of Health Liberia

National Reproductive, Maternal, Newborn, Child & Adolescent Health + Nutrition Policy

2024-2031
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Foreword

The launch of this seven-year National Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition (RMNCAH+N) Policy 2024-2031 is a great milestone, turning the tide of high maternal, newborn, child and adolescent mortality and morbidity from preventable causes, including the reduction of the incidence of stillbirths. The survival, health and well-being of women, children and adolescents are essential to ending extreme poverty, promoting development and resilience, and achieving the SDGs. The new RMNCAH+N policy is aligned with and built upon the essential elements of the Global Strategy for Women's, Children's and Adolescents' Health (2016-2030) and the Liberia National Health Policy 2022-2031, which this new policy seeks to support. These elements include:

- Support for country-led health plans
- Integrated delivery of health services and life-saving interventions and commodities
- Stronger health systems
- Enough skilled and well-equipped health workers
- Good-quality services
- Innovative approaches
- Improved monitoring, evaluation and accountability

When the Government, health development partners and all stakeholders, including the community, embrace these elements and collaborate in supporting targeted action to implement game-changing priority interventions to save lives, improvement in RMNCAH+N outcomes will become the motivating factor to increase support for the sub-sector.

As we begin to implement this policy, let us remember that this requires a concerted effort by all stakeholders to ensure coordinated and harmonised interventions, reducing duplication of funding and interventions. We should all keep in mind the shrinking funding base and, therefore, seek to build a country health system that will adopt sustainable approaches to mobilise and use its various resources efficiently, effectively and transparently to meet population health needs, including RMNCAH+N, where efficiency is determined by the product derived from given resources and the benefit obtained from their allocation.

This RMNCAH+N policy will depend on the ability of the Government and its health development partners to set in motion a versatile multisectoral approach to meet the various components that the policy intends to deliver. I therefore wish to express my appreciation to our esteemed partners for the support they have rendered in the past and will render in the future for this policy to transform the health of the mothers, newborns, children and adolescents of Liberia in the next seven years.

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Acknowledgements

The development of the Reproductive, Maternal, Newborn, Child and Adolescent Health + Nutrition (RMNCAH+N) Policy 2024-2031 marks a significant milestone in our collective efforts to enhance the health and well-being of women, children and adolescents in Liberia. This policy is the culmination of extensive collaboration, dedication and hard work from various stakeholders. We extend our heartfelt gratitude to everyone who contributed to its creation.

We express our deepest appreciation to the Department of Planning, led by Hon. Malayah Tamba Cheiyoe, Deputy Minister for Policy and Planning; Hon. George P. Jacobs, Assistant Minister for Policy and Planning; Mr. G. Martin Dumoe, Director for Policy and Planning; and the entire planning team for their invaluable contributions to the development of this policy.

Special thanks to my team: Assistant Minister for Preventive Services Dr. Cuallau Jabbeh-Howe, Assistant Minister for Curative Services Dr. Teyah Sackie, Dr. Nowai-Gorpu-Dolo Dennis, and the Family Health Division (FHD) for spearheading this initiative and ensuring its comprehensive and evidence-based development. Our sincere gratitude goes to the RMNCAH+N Technical Working Group, whose expertise and insights were crucial throughout the policy formulation process.

We also recognise the significant contributions of our County Health Teams (CHTs), implementing partners, including non-governmental organisations, international agencies and community-based organisations. Their support and collaboration were instrumental in shaping this policy.

The Ministry of Health is particularly grateful to UNICEF for their technical and financial support in developing this RMNCAH+N Policy. We also extend our appreciation to USAID, WHO, UNFPA, the World Bank, Last Mile Health, Jhpiego and the Carter Center for their technical leadership and guidance during the policy's development.

This policy is a testament to what we can achieve when we work together towards a common goal. It is our hope that the RMNCAH+N Policy 2024-2031 will serve as a robust framework for improving the health and well-being of women, children and adolescents in Liberia, ensuring that everyone has access to high-quality, equitable and sustainable healthcare services.

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Acronyms

AA-HA!	Global Accelerated Action for the Health of Adolescents
ANC	Antenatal Care
BEmONC	Basic Emergency and Obstetric and Newborn Care
CEmONC	Comprehensive Emergency Obstetric and Newborn Care
CHT	County Health Team
CRC	Convention on the Rights of Children
DHIS	District Health Information System
DHT	District Health Team
EmONC	Emergency Obstetric and Newborn Care
FHD	Family Health Division
HCC	Health Coordination Committee
HIS	Health Information System
HIV	Human Immunodeficiency Virus
HMER	Health Monitoring Evaluation and Research
HSCC	Health Sector Coordination Committee
IC	Investment Case
iCCM	Integrated Community Case Management
ICT	Information and Communications Technology
IMNCI	Integrated Management of Newborn and Childhood Illnesses
LDHS	Liberia Demographic Health Survey
LHEF	Liberia Health Equity Fund
MOH	Ministry of Health
MPNDSR	Maternal, Perinatal Newborn Death Surveillance and Response
M&E	Monitoring & Evaluation
NICU	Neonatal Intensive Care Unit
PHC	Primary Health Care
PNC	Postnatal Care
RMNCAH+N	Reproductive Maternal Newborn and Child Health + Nutrition
SDG	Sustainable Development Goals
SRH	Sexual Reproductive Health
TB	Tuberculosis
TWG	Technical Working Group
UHC	Universal Health Coverage
UNICEF	United Nations Children Fund
WHO	World Health Organization

1. Introduction

1.1. Background

Reproductive, Maternal, Newborn, Child and Adolescent Health & Nutrition (RMNCAH+N) has remained at the center of global and country-level health concerns for over two decades. These global and regional initiatives have sought country-level commitment and have influenced national health policy development and initiatives with minimal or no impact on the overall reduction in mortality rates. Liberia is a signatory to and the people of Liberia share the beliefs expressed in international human rights instruments such as the Universal Declaration of Human Rights, the Convention on the Rights of the Child, the African Charter on the Rights and Welfare of the Child, and the Convention on the Elimination of All Forms of Discrimination against Women. Liberia, has continued to show its commitment by aligning its major policy documents with the Sustainable Development Goal (SDG) 2030, the Global Initiative for Universal Health Coverage (UHC), the Global Strategy for Women's, Children's and Adolescent Health 2030, the Campaign on Accelerated Reduction of Maternal Mortality in Africa, and the Maputo Call to Action to ensure it achieves UHC for all in Liberia through its different layers of the health care system in collaboration with global actors.[1]

Although Liberia is making significant progress towards achieving SDG 3 related to maternal and child mortality, the reduction is at a slow pace, and if there is no acceleration of the current rate of reduction, the country will not attain the expected reduction in under-five mortality by 2030. While there was a substantial reduction in child and infant mortality rates between 1986 and 2007, progress has somewhat stalled. All children have the right to health, in line with international human rights law. Specifically, the right of the child to health is enshrined in Article 24 of the Convention on the Rights of the Child, which states that children have the right to enjoy the highest attainable standard of health and access to health care services. The Liberia Demographic and Health Survey (LDHS) 2019/2020 results show that infant mortality increased from 54 deaths per 1,000 live births in 2013 to 63 deaths per 1,000 live births in 2019-2020, and the under-five mortality rate remained generally unchanged, at 93 and 94 deaths per 1,000 live births respectively. Neonatal mortality rates have reportedly increased from 26 deaths per 1,000 live births to 37 deaths per 1,000 live births from 2013 to 2019-2020. This highlights the need to address post-neonatal and neonatal mortality rates.[2]

Most of the newborn and under-five deaths are driven by preventable or treatable factors. In 2021, neonatal deaths accounted for 39% of under-five deaths. The primary causes of neonatal deaths are prematurity (40.8%), birth asphyxia (24.6%), lower respiratory infections (8.3%) and neonatal sepsis (5.9%). Among all under-five child deaths, the leading causes of death among children aged 1-59 months, which represent 61% of under-five deaths, are malaria (22%), measles (11%), lower respiratory infection (10%) and diarrhoeal diseases (6%). The records reveal a high stillbirth rate of 61 per 1,000 live births, reflecting poor quality of care during the peri-intrapartum period. The data also show that 30% of children under the age of 5 are stunted, which can be classified as "very high" based on the World Health Organization (WHO) and United Nations Children's Fund (UNICEF) threshold of ≥ 30%. Stunting has long-term consequences for children's survival and development due to

1 The Government of Liberia. (2022). Liberia National Health Policy 2022-2031

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

its effects on brain development, learning performance, and ultimately on adults' health and productivity, and its strong association with increased morbidity and mortality.

There has been a notable decrease in maternal mortality from 1,072 to 742 per 100,000 live births between 2013 and 2019/20 respectively.2 However, a lot is still needed to achieve SDG 3 of less than 70 per 100,000 live births by 2030.[3] The generally poor health indicators in Liberia may have been a result of the effects of the war, the Ebola virus outbreak of 2013 and 2014, and the COVID-19 pandemic in 2020. All these adversely affected resource generation, including human resources for health. The country has, however, shown resilience and commitment to reversing the negative impacts experienced over the years.

1.2. Policy Scope

The scope of this policy is to provide a holistic approach to improving the health outcomes of women, children and adolescents in Liberia, ensuring that everyone has access to high-quality, equitable and sustainable healthcare services. The expanded scope of the policy includes health system strengthening with an emphasis on healthcare infrastructure, human resources for health and health financing.

1.3. Policy Development Process

Through the stewardship of the Minister, the development of this RMNCAH+N policy (2024-2031) was led by the Department of Policy, Planning and Monitoring & Evaluation. The Family Health Division (FHD) coordinated the process through a technical working group (TWG) with the support of development and implementing partners. The National Health Policy 2022-2031 and the National Health Strategy 2022-2026 provided the framework for sub-sector policies, including the RMNCAH+N policy. The concept note provided a clear framework for the RMNCAH+N policy and was strongly rooted in the SDGs and UHC. It was further reviewed and adopted by the Health Coordination Committee (HCC) and the Health Sector Coordination Committee (HSCC). The TWG met regularly and provided updates during the HCC and HSCC meetings.

National and international consultants were hired to lead the development of this policy. A situational analysis was developed, informed by desk reviews, key informant interviews and focus group discussions held at national and sub-national levels. The process also involved the conduct of more than three policy dialogues and a validation exercise with key partners and Ministry of Health (MOH) technical staff. These exercises analysed and consolidated the data that identified key policy issues affecting RMNCAH+N in Liberia, their implications and policy recommendations. The process encompassed a week-long technical exercise to review and triangulate the RMNCAH+N policy with other policy documents of the MOH, including the National Health Policy 2022-2031 and the National Health Strategy 2022-2026.

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3 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

2. RMNCAH+N Situation Analysis

2.1. Leadership and Governance

Leadership and governance are crucial components of health systems, as presented in the WHO Health System Building Blocks. The Health System Governance Triangle framework highlights the relationship between three groups of actors: policy makers, service providers, and people—those who use the health services.[4] These actors together make up the governance structure and shape the health system.

The MOH and stakeholders have made some deliberate efforts to strengthen health leadership and governance with varying results. Recent assessments have shown some significant gains. However, much remains to be done to strengthen health leadership and governance, especially for RMNCAH+N, to reduce the double burden of maternal and neonatal deaths and positively impact other RMNCAH+N indicators.

The MOH National Health System Capacity Assessment Report shows progress in the system's leadership and governance capacity. Capacity in leadership and governance has moved from 46 percent in 2019 to 70 percent in 2023.[5] Though this score indicates the availability of foundational capacity, it falls only one point short of reaching functional capacity. This means many of the governance and leadership structures and systems are in place but only need sustained efforts and resources to make them fully functional. However, disaggregating the leadership and governance score by levels of the health system reveals that Central scored 43.2 percent, CHTs 67.7 percent, District Health Teams (DHTs) 76.6 percent, health facilities 51.0 percent, and communities 66.9 percent.[5] Surprisingly, Central MOH shows the least capacity in leadership and governance compared to the lower levels. This low score resulted from the Central MOH not conducting 'Regulatory Impact Assessments', which are critical governance functions to support quality health care delivery through functioning regulatory agencies that enforce health regulations.

The RMNCH Investment Case (IC) evaluation report also recognised improvements in leadership and governance and their role in motivating various stakeholders to engage in targeted interventions. The report indicated that the IC implementation fosters leadership and ownership, emphasising achieving results by enhancing accountability through effectively leveraging performance incentives, optimising efficiency through improved productivity, and integrating RMNCAH service delivery with other vertical programmes, including Human Immunodeficiency Virus (HIV), Tuberculosis (TB), and malaria.

2.2. Service Delivery

Liberia's health system has three tiers: Tertiary (National Teaching and referral hospitals), secondary (county hospitals and health centres), and primary (clinics and Community Health Services)[6]. The tiers are connected through a referral network but without gatekeeping. People go directly to secondary and tertiary facilities without first visiting the Primary Health Care (PHC) level, even for minor cases. This leads to overcrowding at these higher-level facilities

4 Bigdeli M, Rouffy B, Lane BD, et al. (2020). Health systems governance: the missing links. BMJ Global Health 2020
5 The Government of Liberia. (2023). National Health System Capacity Assessment Report
6 The Government of Liberia. (2022). Essential Package of Health Services II

and limits access for those who really need to be there. For instance, there is always a shortage of beds at the National Referral Hospital (John F. Kennedy Memorial Hospital).

The majority of Liberians, especially the poor and vulnerable populations mainly in rural and semi-urban communities, seek care at the primary level. About 70 percent of the poor people in Liberia reside in rural areas, and therefore their first point of contact with the health system is the primary level.[7] Interestingly, the PHC facilities are the least supported and least ready to provide care. The 2021 facility survey results show a 71 percent readiness score for hospitals, 62 percent for health centres, and 51 percent for clinics.[8] These findings were similar to those of the 2018 service availability and readiness assessment. These statistics justify why Liberia needs to put more emphasis on primary health care to accelerate progress towards universal health coverage.

Substantial progress has been made in reducing the maternal mortality ratio in Liberia, moving from 1,072 per 100,000 live births to 742 per 100,000 live births between 2013 and 2019/20.[2] This milestone came with significant increases in antenatal fourth visits from 78 to 87 percent and skilled birth attendants from 61 percent in 2013 to 84.4 percent in 2020. Despite these milestones, the overall results of RMNCAH+N outcomes have remained unsatisfactory over the last two decades. Neonatal mortality rates increased from 27 per 1,000 live births to 37 per 1,000 live births, and infant mortality rates from 45 per 1,000 live births to 63 per 1,000 live births during the same period from 2013 to 2019/206 (See Table 1).

The Ebola virus epidemic and the COVID-19 pandemic rolled back some of the post-war gains and contributed to the slow performance in key RMNCAH+N indicators in Liberia. During these health emergencies, programme resources were repurposed and diverted to response interventions, slowing down or stopping some of the routine health interventions. For instance, antenatal care, immunisation, and facility delivery, among many other RMNCAH+N services, were disrupted during these emergencies. The evaluation report of the Liberia Investment Case for RMNCAH+N affirmed that, while COVID-19 did not affect immunisation levels, it affected access and utilisation of essential health services (including RMNCAH+N indicators), which varied between 3% and 16% in 2020 and 3% and 8% in 2021[9].

Teenage pregnancy remains a major burden in Liberia, with 30.3 percent of adolescents aged 15–19 years having reported being pregnant or having a child. As expected, the percentage of women aged 15–19 who have begun childbearing increases with age, from 4% among those 15 years old to 55% among those 19 years old6. To reduce high levels of fertility and maternal mortality among adolescents linked to teenage pregnancy, Liberia needs strategic investments in health systems and quality, evidence-based RMNCAH+N services that reach adolescents everywhere.

Liberia faces food insecurity and undernutrition, with high acute malnutrition. Although stunting, wasting, and underweight among children under age 5 decreased between 2007 and 2019-20—from 39% to 30%, 8% to 3%, and 19% to 11%, respectively—stunting remains a serious public health concern in Liberia. Bomi, Bong, Grand Bassa, Grand Gedeh, Grand Kru, Margibi, Maryland, Nimba, River Cess, and Sinoe all had stunting prevalence among children under five years of age above the global threshold of 30 percent, with River Gee at 43

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7 Liberia Institute of Statistics and Geo-Information Services (LISGIS). (2016). The Liberian household and expenditure Survey of 2016

8 The Government of Liberia (2022). Liberia Harmonized Health Facility Survey Report

9 The Government of Liberia (2023). Liberia Investment Case for Reproductive, Maternal, Newborn, Child, and Adolescent Health 2016-2020, End-Term Evaluation Report

percent[6,10]. The determinants of stunting in Liberia are wide-ranging but include inadequate food intake, fetal growth retardation, low birth weight, and preventable diseases including malaria, diarrhoea, and pneumonia. For instance, only 51 percent of infants aged 0-5 months are exclusively breastfed, and the diets of only 11 percent of children aged 6-23 months meet the recommended minimum acceptable diets.[2]

The prevalence of anaemia is another concern among adolescent girls aged 15-19 years, at 55 percent. This situation poses serious challenges to girls' health, nutrition, and education, and work productivity, all of which affect their futures, as well as their children's health, growth, and development.[11] Additionally, poor maternal nutrition, especially among adolescents, is linked to poor child care and feeding practices. These factors are compounded by the weak implementation of policies, legislation, and guidelines. However, the National Nutrition Policy (2019-2024) prioritises the most nutritionally vulnerable groups, including infants, children under five years, school-age children, adolescents, and pregnant and lactating mothers.

Table 1: Key RMNCAH+N indicators[2]

Indicator	2000	2007	2009	2013	2019/20
Life expectancy at birth (years)	n/a	57	n/a	61	65
Fertility Rate (births per 1,000 people)	n/a	5.2	n/a	4.7	4.2
% of adolescence (age 15-19) who have begun childbearing	n/a	32	38	31	30
Maternal mortality ratio (per 100,000 live births)	578	994	n/a	1072	742
Neonatal mortality rate (per 1,000 live births)	n/a	32	n/a	27	37
Infant mortality rate (per 1,000 live births)	117	71	73	54	63
Under-five mortality rate (per 1,000 live births)	194	110	114	94	93
% of births attended by skilled birth attendant (nurses/ midwives/physician's assistant/doctors)	51	46	46	61	84
% of pregnant women who attended more than 4 ANC visits	n/a	n/a	n/a	78	87
% of mothers received postpartum care within 48 hours after delivery	n/a	n/a	n/a	n/a	80
% of newborns who received postnatal care service by skilled providers within 48 hours of birth	n/a	n/a	n/a	n/a	76
% of children under-five who are under-weight	23	19	n/a	15	11
% of stunting among U5 children	n/a	39	n/a	32	30
% of infants aged 0-5 months who are exclusively breastfeed	n/a	30	n/a	55	55
% of children aged 6-23 months receiving a minimum number of food group	n/a	n/a	n/a	8.3	8.6
% of children aged 12-23 months vaccinated-all antigens	33	39	n/a	55	51
% of Under 5 having ARI, who receive advice or treatment within 48 hours	n/a	n/a	n/a	n/a	33
% of Under 5 with a fever who received any ACT	n/a	n/a	n/a	n/a	41
% of Under 5 with diarrhoea who received ORS zinc	n/a	n/a	n/a	n/a	18

10 WHO/UNICEF. (2017). Public health prevalence thresholds

11 UNICEF. (2023). Adolescent Nutrition in School in Liberia, the prevalence of anaemia is high among adolescent girls

2.3. Supply Chain Management

Several health system challenges, including issues with the supply chain, have resulted in less optimal health service delivery in the country. Fifty-one percent of women cited stock-outs or the lack of essential medicines at public health facilities as a barrier to care.

In 2022, 37 percent of health facilities had at least one essential medicine, compared to 35 percent in 2018. In the management of labour, Oxytocin injection was available in 82 percent of health facilities, followed by Magnesium Sulphate injection at 73 percent, and the least available was Misoprostol at 52 percent. The mean proportion of life-saving commodities for reproductive health at health facilities was 48 percent. The mean proportion of life-saving commodities for newborn and child health available at health facilities was 51 percent and 43 percent, respectively. The availability of oral rehydration salts was 69 percent, amoxicillin suspension 34 percent, and Zinc sulphate tablets, dispersible tablets, or syrup were 27 per cent.[12] This demonstrates that the availability and accessibility of quality services are critically challenged by shortages of medicines and medical supplies.

2.4. Health Financing

The Government of Liberia is determined to provide quality healthcare services through the National Health Policy and Strategic Plan, in line with the Global Strategy for Women, Newborn, Children, and Adolescents' Health 2016-2030, towards achieving Universal Health Coverage (UHC). Through its development agenda, the Government proposes to eliminate financial barriers, especially for vulnerable and socially excluded individuals, through the Liberia Health Equity Fund (LHEF) for UHC and interim social safety nets. It proposes shared costs for those who can afford it through the cost-sharing programme. This approach addresses the significant burden of household out-of-pocket payments, which account for 63 percent of total health expenditure. These payments remain the largest source of health expenditures and may contribute to the underutilisation of services due to the low socio-economic status of the target population.[13]

To enhance resource mobilisation for UHC, the Government acknowledges the need for robust capacities in designing, executing, and managing financing reforms. Effective harmonisation and alignment of donor support are crucial in this endeavour, especially in addressing the recent declines in both donor funding and government funding.[14]

2.5. Health Workforce

Human resources are the cornerstone of any health system, as no health system can function without a sufficient number of motivated and qualified health workers. Persistent shortages of adequately trained health professionals pose a major challenge to scaling up the availability and quality of health services. Health workforce density is estimated at 11 skilled health workers per 10,000 population, well below the WHO recommendation of 23 health workers per 10,000 population and the projection for UHC attainment at 44.5 per 10,000 population.[13] Additionally, the available limited health workforce is not equitably distributed, with more skilled staff in urban areas compared to rural settings. This disparity

12 The Government of Liberia. (2022). Liberia Harmonized Health Facility assessment (HHFA) Report
13 The Government of Liberia. (2024). National Health Accounts FY2018/2019 Report
14 The Government of Liberia. (2023). FY2023 Resource Mapping Report

is driven by urban-rural migration, poor working conditions, lack of basic social services and amenities in rural areas, family disconnection, unregulated transfers, and demotivation.

Human resource management showed the least progress in the National Health System Capacity Assessment Report of 2023, moving from 36.4 percent to 41.2 percent between 2019 and 2023. Human resource capacity at central MOH was 54.1 percent, CHTs 41.4 percent, DHTs 37.6 percent, health facilities 29.4 percent, and 25.6 percent at the community level. HR capacities are limited at all levels and decline from central to community levels. Hospitals show more capacity (43.3 percent) than health centres (29.6 percent), with clinics having the least capacity (27.0 percent). This calls for attention to the MOH's drive to strengthen Primary Health Care as a path to UHC. Additionally, public health facilities had better human resource capacity (34.2 percent) compared to private health facilities (18 percent).[15]

These assessment findings clearly demonstrate the significant shortage of skilled healthcare workers in Liberia to deliver quality care and the need to ramp up production without compromising quality. At the same time, it is crucial to optimise the use of available health workers by redeploying them equitably based on evidence of workload and to institute deliberate measures to motivate health workers to reduce maternal and neonatal mortality and move other RMNCAH+N indicators in the desirable direction.

2.6. Health Information System (HIS), Monitoring & Evaluation (M&E) and Research

The Liberia Health Information System, since its creation, has made tremendous gains, serving as the main source of routine health data for the MOH and its partners. The HIS has achieved over 90 percent report completeness, with data quality improving over the last five years. Despite these gains, HIS coordination is weak, and resources to support HIS, M&E, and research are fragmented. These challenges limit data collection, transmission, analysis, and utilisation. There is a lack of defined standards and weak Information and Communications Technology (ICT) infrastructure for digital integration and data systems interoperability across all health information systems. This makes the triangulation of data across the various HIS sub-systems and its use a serious challenge, which also affects effective RMNCAH+N service delivery and outcomes.

Liberia has succeeded in integrating its routine health management information system using the District Health Information System (DHIS-2). However, this success has been challenged by the emergence of different and parallel health information systems. Additionally, information collected through these parallel systems is not consistently shared with the MOH and other partners.

At both national and county levels, there are adequate national reports and policies to support internal planning and information use. However, challenges persist due to limited human resource capacity in terms of quantity and quality. The ability to capture, record, and interpret data is compromised, undermining effective information availability and use.

Monitoring and evaluation officers and data managers trained over the years have left the system due to low pay and poor working conditions. Some experienced healthcare workers in facilities who knew how to accurately capture data in various ledgers have also left. According to the MOH Data Quality Review Summary Report 2021, many health workers do

15 The Government of Liberia. (2023). National Health System Capacity Assessment report 2023

not use the reference guidelines printed at the back of the recording and reporting tools to enhance their work.[16] This alone undermines the quality of reported data and indicates that most personnel are new and have not been trained on data recording and reporting tools.

At the county level, there are problems with estimates and denominators of target population cohorts. This situation introduces distortion and a lack of confidence in the data. Although vital registration has expanded across the country, there are still issues with low capacity and inconsistent supplies of logistics, resulting in low birth registration and maternal, perinatal, and neonatal death surveillance and response (MPNDSR) in service centres across the country and at the central level. The surveillance and early warning system also remains weak, with limited capacity to detect and respond appropriately to events. Liberia has employed several strategies in various policies and strategic documents designed to improve the quality of routine data, archiving, and information use to enhance data-driven decision- making.[17] There is much that needs to be done to overcome these challenges, strengthen data systems, improve their integration, enhance integrity, and promote their use to facilitate evidence-based policy formulation, planning, and decision-making.

16 The Government of Liberia. (2021). Data Quality Review (DQR) Summary Report 2021

17 The Government of Liberia. (2021). National Health Policy Plan 2011-2021

3. Policy Foundation

3.1. Vision

The vision of the RNMCAH+N Policy is to have a healthy population with a particular focus on the preventable deaths of newborns, women, children, and adolescents for the attainment of equitable growth and sustainable development.

3.2. Mission

The mission of the RMNCAH+N Policy is to support the Ministry of Health in promoting the well-being of women, newborns, children, and adolescents through interventions and the creation of an enabling environment for the effective delivery of quality RMNCAH+N services at all levels of the health service delivery system.

3.3. Goal

To improve the health and well-being of the Liberian population through RMNCAH+N services.

3.4. Objectives

The RMNCAH+N Policy objectives are aligned with the National Health Policy and Strategic Plan (2022-2031 and 2022-2026), respectively, as well as other international instruments. The objectives are to:

1. Strengthen RMNCAH+N leadership and governance for improved health outcomes.
2. Improve the provision of quality, equitable, accessible, and affordable essential RMNCAH+N services at all levels of the healthcare delivery system.
3. Increase the availability of essential RMNCAH+N health commodities at service delivery points.
4. Ensure the availability and optimise the distribution of qualified and motivated healthcare workers for RMNCAH+N services.
5. Ensure sustainable financing and effective management systems for RMNCAH+N services.
6. Ensure robust systems for data collection, management, and analysis to monitor the situation and progress, informing evidence-based decision-making.

3.5. Guiding Principles

In line with the National Policy and Plan 2022-2031, this RMNCAH+N policy is guided by the following principles:

a. **Health as a Human Right**: Access to quality healthcare is a basic human right and is a precondition for individual and societal development.

b. **Equity**: All people in Liberia shall have person-centred care and equal access across the life course to effective healthcare services without discrimination.

c. **Quality of Care and Safety**: The delivery of quality services that meet the seven quality dimensions (i.e., safety, timeliness, efficiency, effectiveness, equity, people-centred care, and integration) is fundamental to improving the health and well-being of the population. Decision-making will be predicated on doing the right thing, in the right way, at the right time, and making the best use of the resources available to satisfy patients and ensure their safety.

d. **Gender Sensitivity and Responsiveness**: Concerted efforts will be made by the MOH to understand the role gender plays in health and healthcare, and to design responsive systems that ensure services are accessible, available, and acceptable to all Liberians, regardless of gender or social status. Particular emphasis is placed on involving women, girls, and other socially marginalised groups in the planning, design, and implementation of healthcare programming so they are not socially excluded from accessing and utilising healthcare.

e. **Efficiency**: Allocative and technical efficiency will be pursued by all actors in the public health sector to ensure that available resources are deployed to attain the highest possible outputs. Resources will be allocated to various layers and levels of the health sector based on need demonstrated by evidence, and the share amount will be based on a combination of epidemiological, social, demographic, economic, and geographic variables. Efforts will be made to ensure that duplication, wastage, and abuse are eliminated.

f. **Accountability and Transparency**: Adequate political, financial, and administrative mechanisms are needed from the Government and all stakeholders to ensure that decision-makers are accountable for the transparent use of health resources, including physical assets, commodities, and time, among others. These mechanisms must encompass the whole sector, enabling the public to know how decisions are made, how resources are allocated, and how results are achieved. To this end, all resources, internal and external, public and private, shall be judiciously monitored, accounted for, and transparently reported on. The monitoring system will be designed to enable stakeholders to verify adherence to laws and regulations and to the primary healthcare principles underpinning this policy.

g. **Family and People-Centred Care**: The healthcare delivery system shall seek to promote health programmes targeting families to prevent and control illnesses. Programming should benefit families, communities, and individuals, not just one disease, condition, or patient. In the case of illness or other health conditions, the family shall have the necessary support system and tools to be resilient, regain their health status, and remain economically stable.

h. **Inclusive and Coordinated Partnership**: The MOH is committed to forming multi-sectoral partnerships to ensure that health is represented in all policies. The multi-sectoral approach used for the development of this policy will continue during implementation, and partners will be mobilised according to their comparative advantages to ensure better coordination, harmonisation, and alignment.

i. **Ownership and Leadership**: The MOH will ensure that the county and district health teams and partners align their operational strategies and plans with the national health policy and strategy to ensure the implementation of this policy by all partners.

4. Policy Domains, Thematic Areas and Statements

The RMNCAH+N Policy framework is organised into five domains: health system strengthening; reproductive and maternal, newborn, child, and adolescent health. The health system strengthening domain spans the continuum of care and includes the standard WHO health systems building blocks.18 Nutrition is also a cross-cutting concern in each of the five domains, and the National Nutrition Policy and Strategy address these domains.

4.1. Health System Strengthening

Under the Health Systems Strengthening domain, the RMNCAH+N policy includes policy statements that cross-cut the four domains of reproductive and maternal, newborn, child, and adolescent health.

Policy Statement:

The Government of Liberia shall prioritise health system strengthening in the following components: leadership and governance, human resources, health information systems, supply chain management, and financing for RMNCAH+N. This will help build a resilient health system that delivers quality RMNCAH+N services for women, newborns, children, adolescents, and their families in Liberia.

4.1.1. Leadership and Governance for RMNCAH+N

Effective leadership and governance are critical for achieving improved health outcomes. These elements are essential for ensuring coordination, collaboration, partnership, participation, and accountability across the health system. This policy aims to enhance robust governance structures for RMNCAH+N, ensuring that all health services are delivered efficiently and effectively, resulting in better health outcomes for women, newborns, children, and adolescents in Liberia.

- The Government and partners shall strengthen leadership and governance at all levels to ensure effective and efficient participation, ownership, and accountability.
- The Ministry of Health (MOH) and partners shall work with health regulatory authorities to enhance their capacities to effectively regulate the sector and its actors.
- Public-private partnerships for RMNCAH+N services shall also be strengthened.

4.1.2. Human Resource for RMNCAH+N

In line with the National Health Policy, the MOH and partners shall continue to work with accredited training institutions, regulatory authorities, and the Government of Liberia to

18 WHO. (2010). Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategy. https://iris.who.int/bitstream/handle/10665/258734/9789241564052-eng.pdf?sequence=1

support training institutions in producing more health workers. Additionally, efforts will be made to increase the absorption and retention of trained personnel in both the public and private sectors to ensure quality RMNCAH+N services. This policy will pay special attention to the production and distribution of cadres of health workers that are in acute shortage, such as midwives, laboratory technologists/technicians, nurse anaesthetists, specialised nurses and midwives, dental professionals, paediatricians, and gynaecologists.

- The MOH shall deploy and redeploy available health workers based on evidence of workload to ensure equitable distribution for RMNCAH+N interventions.
- Capacity building and technical assistance, focusing on mentorship and coaching for service providers at all levels, shall be strengthened to ensure the implementation of quality RMNCAH+N services.

4.1.3. Health Information System for RMNCAH+N

Quality data is key for making informed policy decisions and improving health outcomes. The RMNCAH+N Policy will be implemented based on quality data collection, monitoring, and evaluation to ensure accountability for results and resources. Data collection and processing will build on existing MOH data systems, including DHIS2 and other health information platforms.

- The implementation of RMNCAH+N will build on existing MOH data systems for effective data collection, monitoring, and evaluation to avoid duplication of data collection and reporting systems.
- The RMNCAH+N Policy implementation will be informed by quality data generation and use.
- The RMNCAH+N programme will support Health Monitoring, Evaluation, and Research (HMER) systems for evidence-based decision-making.

4.1.4. Supply Chain Management for RMNCAH+N

Supply chain management remains one of the critical health systems building blocks that needs to be prioritised. Hence, this policy seeks to improve the availability of high-quality health commodities, medical equipment, and consumables for RMNCAH+N services.

The national supply chain system shall be strengthened to ensure that quality medicines, medical supplies, and consumables are readily available, accessible, acceptable, affordable, appropriate, and of high quality for RMNCAH+N service delivery.

4.1.5. Financing for RMNCAH+N

In line with the National Health Financing Strategy, the MOH is dedicated to improving financial protection for the health and well-being of women, newborns, children, adolescents, and families through robust and sustainable health financing mechanisms for RMNCAH+N services. Recognising the critical role that adequate and equitable financing plays in achieving Universal Health Coverage, the MOH is committed to mobilising resources and ensuring

efficient allocation and disbursement, with a priority on primary healthcare (PHC). The Government aims to address the unique health needs of the population, reduce disparities, and foster a healthier future for all in Liberia.

- The MOH shall develop and advocate for legislation of the national insurance programme to provide financial protection and improve access to RMNCAH+N services.
- The MOH shall ensure that all partners' resources are aligned with government RMNCAH+N priorities to enhance the allocative efficiency of available funds. Innovative financing options, such as performance-based financing and public-private partnerships, shall be explored for effective implementation of RMNCAH+N.
- The MOH shall commit to engaging communities in the design and implementation of health financing schemes that meet local needs.

4.2. Reproductive and Maternal Health

These policy statements are organised in accordance with the continuum of care approach, addressing pre-pregnancy, pregnancy, childbirth, and the postnatal period for the mother. In alignment with WHO guidance, the country will develop and implement a package of interventions for each life cycle period under the reproductive and maternal health domain, aimed at achieving the vision of zero preventable deaths of women, newborns, and children, and ensuring that the sexual and reproductive health (SRH) needs of women and adolescents are met. This policy also emphasises the importance of preventing and managing gender-based violence and sexual gender-based violence to address the underlying causes of violence and provide services to survivors.

Policy Statement:

The Government of Liberia, through the MOH in collaboration with partners, shall remain dedicated to reducing maternal deaths to 220 per 100,000 live births by 2031 in line with the National Health Policy. The Government is committed to ensuring that all women in Liberia have access to high-quality reproductive and maternal health services, including family planning services and Emergency Obstetric and Neonatal Care (EmONC), delivered in a safe and accessible manner.

4.2.1. Preconception

- All women of childbearing age, including adolescents and women with disabilities, shall be provided with quality comprehensive preconception services and products that address modifiable risks and optimise maternal and fetal health before pregnancy.
- Male counterparts or relatives shall be encouraged to participate in decision-making and/or facilitate preconception health-seeking decisions.
- Nutritional and health interventions shall be strengthened to prevent nutrient deficiencies among women of reproductive age.

4.2.2. Pregnancy

- Institutional systems shall improve access to and utilisation of timely, high-quality, and comprehensive Antenatal Care (ANC) services and packages that adhere to best practices and standards to ensure a positive pregnancy experience and outcome.
- The triple elimination of mother-to-child transmission of HIV, syphilis, and hepatitis during pregnancy shall be prioritised and addressed at the forefront of primary prevention in line with MOH standard treatment guidelines.

4.2.3. Labor and Delivery

- Quality, high-impact interventions for addressing the main causes of maternal and newborn mortality during labour and delivery shall be promoted to reduce the incidence of maternal deaths, newborn deaths, and stillbirths.
- Systems shall be strengthened to ensure the availability of and access to quality basic and comprehensive emergency obstetric and newborn care (BEmONC and CEmONC).
- The provision of quality and respectful care shall be enhanced at all levels to promote a positive childbirth experience.
- Interventions for the elimination of mother-to-child transmission of HIV and syphilis, including testing during labour, delivery, and postpartum, shall ensure that individuals who test positive are promptly enrolled in treatment.
- All maternal, perinatal, and neonatal deaths shall be notified, reported, and audited in accordance with the MPNDSR protocol.
- Referral systems for RMNCAH+N services at all levels shall be strengthened by ensuring the availability and functionality of ambulance and communication platforms.

4.2.4. Postnatal Care for Mother

- Postnatal care services and packages at both facility and community levels shall be strengthened to ensure access to quality and continuous service delivery in line with WHO national guidelines for Postnatal Care (PNC).
- Postpartum family planning, nutrition, mental health, and cervical cancer screening services shall be improved to provide comprehensive counselling.

4.3. Newborn Health

During the first 72 hours—the most critical period of life for newborns—the policy prioritises the implementation of tested and proven essential newborn care interventions during both the early and late neonatal periods. These interventions address the leading causes of mortality in the first 28 days of life, including prematurity, birth asphyxia, and neonatal sepsis.2 The policy further recognises that newborn and maternal health interventions are

interconnected; as such, the statements relating to reproductive and maternal health, as elaborated in the previous section, also apply to the newborn period.

Policy Statement:

The Government of Liberia is committed to ending preventable illnesses and deaths for newborns, aiming to reduce neonatal mortality to 17 per 1,000 live births by 2031 in line with the National Health Policy.

- Utmost attention shall be given to interventions that address the leading causes of neonatal mortality at all levels.
- Quality and respectful health and nutrition interventions for newborns shall be integrated across the RMNCAH+N continuum of care to achieve efficiency and desired health outcomes.
- All mothers in Liberia shall be encouraged to initiate breastfeeding within one hour of birth and to continue exclusive breastfeeding for the first six months.
- Neonatal Intensive Care Units (NICUs) shall be scaled up to increase access to quality neonatal services.
- RMNCAH+N services for newborns shall be provided at the community level in line with the community health programme.
- All births shall be registered at health facilities in accordance with national policy.
- RMNCAH+N services, including newborn services, shall be strengthened through integrated outreach to improve service delivery in both rural and urban areas, including during emergencies.

4.4. Child Health

The child health domain addresses both the direct and indirect causes of morbidity and mortality among children under five in Liberia, including malaria, pneumonia, diarrhoea, malnutrition, as well as accidents and injuries in older children. The policy ensures a continuum of care for children from 28 days of life to 10 years of age. Additionally, the policy promotes interventions for child well-being and development.

Policy Statement:

Every child in Liberia shall have access to quality healthcare services, a safe environment, and the support needed to achieve their full potential for growth and development. The Government is committed to reducing the under-five mortality rate to 25 per 1,000 live births by 2031 in line with the National Health Policy.

- Every child shall have access to preventive and curative services for all under-five and childhood illnesses in accordance with national guidelines.
- Every child in Liberia shall have access to quality and timely immunisation services.
- Early detection and treatment of non-communicable diseases and other health conditions, including accidents and injuries, shall be provided for every child.

- Health promotion programmes shall be strengthened to raise awareness among parents, caregivers, children, and communities about child health, nutrition, and hygiene.

4.5. Adolescent Health

The policy prioritises resources for addressing the main causes of death, illness, and injury among adolescents aged 10 to 19 years, in alignment with the Global Accelerated Action for the Health of Adolescents (AA-HA!).

Policy Statement:

Barriers that prevent adolescents and young people from accessing quality healthcare services shall be identified and addressed to ensure that health services are adolescent and youth-friendly at all levels.

- Existing adolescent and youth-friendly services, including mental health and sexual and reproductive health (SRH) services, shall be strengthened to improve their quality, access, and utilisation, and to incorporate youth in health decision-making.
- The Government of Liberia shall employ a whole-of-government approach to eliminate harmful practices with health implications among adolescents, including sociocultural practices such as child marriage, forced marriage, and female genital mutilation.
- Adolescent health and nutrition issues shall be integrated with education, gender, social welfare, agriculture, and finance sectors.

5. Policy Enabling Environment

5.1. Legal Environment

The policy is developed in consideration of the roles, responsibilities, goals, and vision outlined in the Ministry of Health Act (2017), the Public Health Law (1976), and other relevant national and global ethical standards and policies. Globally, Liberia has signed the World Health Assembly Resolution, reaffirming member states' commitment to achieving Universal Health Coverage (UHC) by ensuring that all individuals have access to essential RMNCAH+N services without financial hardship. Additionally, the policy is guided by the National Government Development Agenda framework, the National Health Policy (2022-2031), and the Health Sector Strategy (2022-2026).

5.2. Regulation

The FHD, under the guidance of the Ministry of Health's Department of Policy, Planning, Monitoring, and Evaluation, will formulate all necessary regulations, guidelines, and standards to support the execution of this policy. These frameworks will be disseminated through various coordination channels to ensure effective implementation and compliance. Furthermore, the FHD will seek additional guidance from both national and international regulatory bodies with clearly defined mandates, in accordance with relevant national legislation.

5.3. Enforcement

The FHD, through the Department for Health Services and in collaboration with the Department of Policy, Planning, Monitoring, and Evaluation, the Office of General Counsel, and the RMNCAH+N Technical Working Group, shall ensure adherence to standards for the implementation of this policy. Routine monitoring will be conducted by the MOH senior management team, including regular updates and follow-up.

5.4. Risk and Assumptions

Anticipated Risks Include:

- Change in national health priorities.
- Insufficient financial resources to implement and sustain the RMNCAH+N policy.
- Public health emergencies or natural disasters that may divert resources toward response efforts.
- Cultural beliefs and social norms that may hinder the acceptance and utilisation of RMNCAH+N services.

Anticipated Assumptions Include:

- Strong leadership and governance.
- Availability of funding.

- The political environment will remain relatively stable, allowing for consistent policy implementation and support.
- Adequate, qualified human resources.
- Communities will actively participate in and support RMNCAH+N programmes.

6. Implementation, Monitoring and Evaluation

6.1. Implementation Arrangement

This policy will be implemented by the MOH through the FHD, with support from the RMNCAH+N Technical Working Group and implementing partners. The MOH shall ensure regular monitoring and supervision to support the efficient and effective implementation of the National RMNCAH+N Policy. The policy will be reviewed after five years, and a National RMNCAH+N Strategic Plan will be developed and reviewed every two years.

The policy provides guidance on the legal context of RMNCAH+N across different levels of care. At the central level, the program is responsible for ensuring sustained implementation through management, coordination, and continuous monitoring. This includes the development and dissemination of national policies and strategies, such as the Child Survival Strategy and Action Plan, along with a detailed monitoring and evaluation framework, guidelines, and tools.

Responsibilities will involve capacity building at both national and subnational levels with continuous follow-up to ensure adherence to national policies and standards. To align with the national decentralisation policy, specific roles and responsibilities will be implemented at the regional, county, district, facility, and community levels. The County Health Teams (CHTs) shall prioritise RMNCAH+N interventions and incorporate them into their annual plans and budgets.

6.2. Roles and Responsibilities

This section of the policy defines the roles and responsibilities of various stakeholders, including the Ministry of Health, other government ministries, agencies and commissions, development and implementing partners, civil society organisations, faith-based institutions, the private sector, and other non-state organisations. It also outlines the roles of academic and professional associations, individuals, and communities.

6.2.1. Ministry of Health Shall

- Create an enabling environment for the full implementation of this policy through a multi-sectoral approach.
- Provide leadership in resource mobilisation for the implementation of RMNCAH+N services.
- Hold partners accountable for the implementation of the RMNCAH+N Policy.
- Ensure that partners' resources are aligned with Government priorities for RMNCAH+N interventions.
- Coordinate the implementation of the RMNCAH+N Policy.
- Oversee monitoring and evaluation, as well as regular review, of the RMNCAH+N Policy.
- Ensure compliance, accountability, and transparency in the implementation of the RMNCAH+N Policy.
- Identify and define RMNCAH+N research priorities.

6.2.2. Development Partners and Other Non-State Actors Shall

- Provide technical and financial support for the implementation of the RMNCAH+N Policy.
- Advocate with bilateral and multilateral organisations and donors to support the implementation of the RMNCAH+N Policy.
- Use the existing Health Partners Group to hold the Government accountable for the implementation of the RMNCAH+N Policy.
- Ensure and advocate for the alignment of healthcare financing with this RMNCAH+N Policy.
- Participate in the monitoring and implementation of the policy.

6.2.3. Health Regulatory Bodies Shall

- Ensure adherence to ethical standards and guidelines to promote the quality of care.
- Provide continuous professional development programmes.

6.2.4. Academic and Health Training Institutions Shall

- Conduct research on RMNCAH+N.
- Produce human resources and build capacities.
- Organise symposiums, research, and publish articles on RMNCAH+N interventions.

6.2.5. Private Sector Shall

- Implement the RMNCAH+N Policy.
- Complement Government efforts in financing the implementation of the RMNCAH+N Policy.
- Support Government efforts in implementing high-impact interventions for the RMNCAH+N Policy.
- Align the delivery of RMNCAH+N interventions with Government policies, strategies, and guidelines.
- Participate in the review, monitoring, and evaluation of the RMNCAH+N Policy.

6.2.6. Communities and Individuals Shall

- Support the delivery of RMNCAH+N interventions through community structures.

- Assist in managing health facilities to ensure ownership and accountability.
- Increase demand for and use of RMNCAH+N services at all levels of service delivery within the community.
- Advocate for and hold the Government and other actors accountable in delivering quality and accessible RMNCAH+N services at all levels.
- Engage in positive behaviours and practices to promote and uptake quality RMNCAH+N services at all levels of health service delivery.
- Participate in the implementation, monitoring, and evaluation of the national RMNCAH+N Policy.

6.3. Monitoring and Evaluation of the Policy

The achievement of the goals and objectives of the national RMNCAH+N policy is crucial and remains a priority within the Ministry of Health's (MOH) monitoring and evaluation (M&E) framework. This framework systematically supports and assesses the progress of RMNCAH+N policy implementation. Monitoring and evaluation will be conducted through various methods, including revising progress or achievements and demonstrating results. It will also assess performance against set strategic objectives, document implementation challenges, and present lessons learned. The central M&E, in collaboration with the Health Information System (HIS), will coordinate the collection, processing, and analysis of data to verify whether activities and interventions are implemented as planned and to ensure accountability. Through the M&E framework, program results at the input, process, output, and outcome levels will be measured to inform decision-making. Midterm and terminal evaluations of the program will be coordinated in line with the M&E framework to provide feedback to the MOH and stakeholders and to inform future plans.

Monitoring and Evaluation of the RMNCAH+N Policy shall be led by the central M&E unit in collaboration with other relevant units and stakeholders, fostering systematic data collection, analysis, and tracking of implementation, performance, and achievements throughout the policy's lifespan. Monitoring of this RMNCAH+N Policy will be consistent with relevant targets and indicators aligned with the National Health Policy (NHP) and global targets.

The successful implementation of the National RMNCAH+N Policy will adhere to the MOH national monitoring framework. The evaluation of the RMNCAH+N Policy will focus on two levels: Level One will monitor the implementation of the policy, while Level Two will assess the impact of the policy in achieving its set goals and objectives. Through annual review meetings led by the MOH's Family Health Division (FHD), the alignment of stakeholders with the national RMNCAH+N Policy will be reviewed. To support the evaluation of the policy's achievement of its goals and objectives, the country will develop a short-term five-year Child Survival Strategy, a three-year Action Plan, and a detailed monitoring and evaluation framework. These will be used to evaluate the impact of the policy against set targets as per the short-term strategy and monitoring and evaluation framework. To the extent possible, monitoring and evaluation will utilise existing national health information systems. This RMNCAH+N Policy spans eight years, with a policy review scheduled every five years and necessary revisions implemented.

Table 2. RMNCAH+N monitoring and evaluation framework (indicators, baselines and targets)[1]

No	Indicator	Baseline	Year	Source	Target 2026	Target2031
1	Maternal mortality rate (100,000 live births)	742	2019/2020	LDHS	520	220
2	Under 5 mortality rate (1,000 live births)	93	2019/2020	LDHS	70	25
3	Infant mortality rate (1,000 live births)	63	2019/2020	LDHS	45	30
4	Neonatal mortality rate (1,000 live births)	37	2019/2020	LDHS	27	17
5	Percentage of births attended by skilled health personnel	84	2019/2020	LDHS	90	95
6	Proportion of women aged 15-49 years who have their needs for family planning satisfied with modern methods	25	2019/2020	LDHS	40	50
7	Fertility rate (average children per woman)	4.2	2019/2020	LDHS	3	3
8	Percentage of children under age 5 whose births were registered	66	2019/2020	LDHS	75	80
9	Adolescent birth rate per 1,000 women	Girls (10-14yr):4 Adolescents(15-19yr): 128	2019/2020	LDHS	Girls:2 Adolescents: 100	Girls: 0.5 Adolescents: 60
10	Modern contraceptive prevalence rate among all women (mCPR) (%)	24	2019/2020	LDHS	30	35
11	Percentage of infants fully immunised	51	2019/2020	LDHS	75	85
12	Percentage of children under 1 yr who received DPT3/ penta-3 vaccination	69	2019/2020	LDHS	90	95
13	Percentage of pregnant women provided 3rd dose of IPT for malaria	40	2019/2020	LDHS	80	90
14	Malaria parasite prevalence (mRDTs or microscopy) among children 6-59 months	45	2016	LMIS	20	10
15	Percentage of children under 5 who are stunted	30	2019/2020	LDHS	25	20
16	Incidence of low birth weight among newborn	17.3	2022	HMIS	14	10
17	Anaemia prevalence in children (%)	71	2019/2020	LDHS	63.9	55.4
18	Anaemia prevalence in women of reproductive age (%)	44.5	2019/2020	LDHS	37.8	30.3