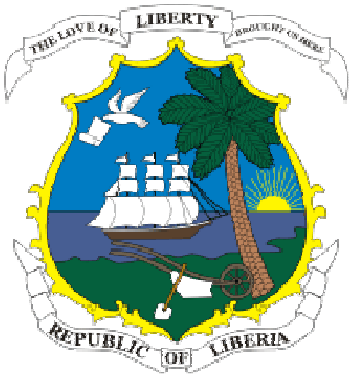

THE MINISTRY OF HEALTH AND SOCIAL WELFARE

NATIONAL STRATEGY FOR CHILD SURVIVAL IN LIBERIA

(2008-2011)

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LIST OF ACRONYMS

ACT	Artemisinin based Combination therapy
AFRO	WHO Regional Office for Africa
AMTSL	Active Management of Third Stage of Labor
ANC	Antenatal Care
ARI	Acute Respiratory Infections
BF	Breastfeeding
BPHS	Basic Package of Health Services
CBPHC	Community Based Primary Health Care
CCM	Community Case Management
CHT	County Health Team
CFSNS	Comprehensive Food Security and Nutrition Survey
CHAL	Christian Health Association of Liberia
CHDC	Community Health Development Committee
CHI	Clinton Foundation
CHV	Community Health volunteer
CHW	Community Health Workers
CM	Certified Midwife
CORPs	Community Resource Persons
CS	Child Survival
DPT	Diphteria, Pertussis, Tetanus vaccine
EBF	Exclusive Breastfeeding
ECQ	Existing interventions that need to be improved in Coverage and Quality
EDL	Essential Drug List
EmONC	Emergency Obstetric and Newborn Care
EPI	Expanded Program on Immunization
EU	European Union
FP	Family Planning
GAVI	Global Alliance for Vaccines and Immunization
GFATM	Global Funds for AIDS, Tuberculosis and Malaria
GOL	Government of Liberia
HBM	Home Based Management of Malaria
HF	Health Facility
Hib	Hemophilus Influenzae type B
HIS	Health Information System
HIV/AIDS	Human Immunodeficiency Virus/ Acquired Immuno-Deficiency Syndrome
HRH	Human Resources for Health
HR	Human Resources
HW	Health Workers
IBF	Infant Breastfeeding
ICC	Inter-agency Coordination Committee
IEC	Information, Education, Communication
IMCI	Integrated Management of Childhood Illness
IPCCS	Inter Personal Communication and Counseling Skills

IPT	Intermittent Preventive Treatment of Malaria
ITN	Insecticide treated nets
IYCF	Infant and Young Child Feeding
LLINs	Long Lasting Insecticide Treated Nets
MDG	Millennium Development Goal
MOH&SW	Ministry of Health & Social Welfare
NACP	National AIDS Control Program
NGO	Non-governmental Organization
ORS	Oral Rehydration Solution
ORT	Oral Rehydration Therapy
PHC	Primary Health Care
PMTCT	Prevention of Mother-to-Child Transmission (of HIV)
POA	Plan of Action
RH	Reproductive Health
SBA	Skilled Birth Attendant
SCF-UK	Save the Children-United Kingdom
TT	Tetanus Toxoid vaccine
TTM	Trained Traditional Mid-wife
TM	Traditional Mid-wife
U<1	Children under one year old
U<5	Children under five years old
UNICEF	United Nations Children Funds
VAS	Vitamin A Supplementation
WCO	WHO Country Office
WHO	World Health Organization

FOREWORD

After more than fourteen years of civil unrest and violent conflict in Liberia, peace has been restored, a democratically elected government is in place, and Liberians are wholeheartedly ready to move forward as a united country. This bright new atmosphere in Liberia gives us the opportunity to create programs that will help our nation to not only recover, but even to flourish. Essential to Liberia's recovery and development is an effective Child Health Strategy, which is part of the Basic Package of Health Services.

Liberia, through implementation of innovative health sector interventions, has made great strides in improving child survival, however the national Infant and Child Mortality Rates are still high at about 72/1000 live births and 110/1000 live births respectively. The leading causes of morbidity and mortality in children under-five years of age still remain: neonatal conditions, ARI-pneumonia, malaria, diarrhea, and measles with malnutrition as an underlying cause. The high maternal mortality ratio of 994/100,000 live births, and the fact that over 60% of births occur outside of health facilities and unskilled birth attendants perform over half of all deliveries, also contribute significantly to the neonatal causes of under-five mortality.

The Government of Liberia, through the Ministry of Health and Social Welfare, other ministries and partners in child survival and development is committed to reversing the situation in the country. It aims to achieve and surpass the MDG target of reducing under-five mortality by two-thirds. After discussion with key partners, the Ministry of Health and Social Welfare formed a Technical Committee on Child Survival with a goal of preparing a comprehensive National Child Survival Strategy and Implementation Plan for the reduction of under-five mortality. This document is the outcome of this effort.

The strategy addresses the underlying conditions that account for 90% of child mortality plus malnutrition and HIV/AIDS, the two most important underlying causes of death. It focuses on high impact/low cost interventions and is a major component of the newly released Basic Package of Health Services (BPHS). The overall objective is to reduce the current under-five mortality of 110/1000 to 93.5/1000, a 15% reduction by 2011 with a continued effort from 2011-2015 to surpass the MDG goal of a two-thirds reduction in child mortality.

The strategy does not replace, but complements other related sector and developmental plans that address maternal, new born and child health and development and will be used hand in hand with these. It will be the driving force and guide for developing and implementing action plans for child survival interventions. The main strategic areas that have been identified include improving IMCI and focusing on prevention through provision of essential inputs, capacity building of community health providers, intensified communication for behavior change, and community mobilization, among others.

I believe that this document will be instrumental in scaling up the child survival interventions through the active participation of the community, the relevant sectors, local and international partners and other stakeholders to enable Liberia to significantly reduce neonatal, infant and childhood deaths.

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EXECUTIVE SUMMARY

In Liberia, an estimated 40,000 children die before reaching their fifth birthday. Twenty-nine percent (29%) of under fives deaths occur during the first month of life and 35% occur during the post-neonatal period- one to 11 months. (LDHS 2007). These infant and child death rates are among the worst in the world. The following conditions are the leading causes of under-five mortality: malaria, ARI, diarrhea and neonatal conditions. Underlying the infectious disease deaths is the wide spread problem of malnutrition. Yet, there are effective low cost, high impact interventions to prevent the majority of these deaths.

Following high level discussions involving the Ministry of Health and Social Welfare/Liberia and national and international partners, a Child Health Technical Committee was formed to address child survival issues and develop a national child survival strategy. The Ministry of Health and Social Welfare has therefore developed this National Strategy for Child Survival as a mechanism to drive her commitments to child survival and development into action.

The goal of the strategy is to reduce childhood mortality by **15%** during the period, 2008-2011 in Liberia. The vision is to keep all children in Liberia healthy and free from all common childhood illness so that they survive, grow and develop to their fullest potential. Working within the context of the Basic Package of Health Services (BPHS), this strategy hopes to reach the majority of children under-five in Liberia with strategic high-impact interventions (IMCI, Nutrition, Malaria control, EPI, etc).

The Specific Objectives are:

1. To increase the use of LLINs among children under five from the 45% to at least 80%
2. To increase and ensure timely initiation of the onset of Exclusive Breastfeeding (EBF) prevalence up to 6 months, from current the prevalence of 19% to 50%
3. To ensure that at least 60% of under-five children with diarrhea receive immediate first aid (with ORS + zinc) at home
4. To increase the coverage of ANC 3+ visits to 50% of pregnant.
5. To increase Pentavalent-3 coverage 88% to 90%
6. To maintain measles vaccine coverage at a minimum of 90%.
7. To increase the proportion of skilled delivery from current rate of 46% to 60%
8. To provide appropriate treatment to at least 90% of children presenting with malaria, ARI-pneumonia and diarrhea- current rates of treatment are 59%, 70%, and 53 % respectively
9. Expand the availability of effective EmONC services to at least one functional health facility per county (services are currently available in 14 of the 15 counties).
10. Increase access of services for HIV exposed and infected infants and children

The strategy calls for accelerated child survival and development, which implies:

- The selection of priority target conditions that commonly cause childhood morbidity and mortality and ensuring that these conditions are addressed through interventions that are proven to be cost effective and have a high impact.
- The implementation of phase one activities during the first six months of the strategy and then scaling up and expanding the implementation of interventions at all levels of the health system. (see annex) This means that a combination of service delivery modes (i.e. individual-oriented clinical services, family-oriented community based services, population-oriented scheduled services) is used to achieve the expected high coverage targets.
- That service will be provided in the context of a continuum of care from the community to the health facility, to meet the needs of the pregnant woman, the newborn, infant and the child.

The child survival strategy outlines clear targets to be achieved by 2011. This will depend on strategic partnerships and reliable sources of funding for the initiatives. The Ministry of Health and Social Welfare will coordinate the implementation of the interventions outlined in this strategy and will ensure high performance and financial accountability, to achieve the anticipated outcomes.

The main strategic areas that have been identified include increased coverage of immunization, nutrition, safe drinking water, improving maternal and child health and increased use of ITNs. Others includes IMCI, focusing on prevention through provision of essential inputs, capacity building of professional health workers and community health providers, and intensified communication for behavior change, and community mobilization, among others.

I – INTRODUCTION

1.1 Background

Liberia is emerging from 14 years of destructive war and civil unrest that severely disrupted health and social services. The elections of 2005 ushered in a new leadership and optimism that have resulted in significant improvements in the health sector, as well as all sectors of government. While tremendous progress has made in revitalization of health services, there is room for improvement and this bright new atmosphere in Liberia provides us with an opportunity to revitalize programs and develop strategies, to not only recover but to flourish as a united country.

In general, children in Liberia suffer from poor health. The national Under-five Mortality Rate is 110/1,000[1], implying that almost one in every nine children born in Liberia die before reaching their fifth birthday. The Millennium Development Goal (MDG) target for child survival aims to reduce these child deaths by two thirds by 2015. Tools have been developed and low cost/high impact interventions have proven effective in reducing child mortality toward achieving this goal.

The Ministry of Health and Social Welfare (MOH&SW) has made it a priority to improve access to quality health care. It has developed Basic Package of Health Services (BPHS), the cornerstone of the national health plan, to meet this ambitious goal. The BPHS, which is being implemented through a decentralized system based on primary health care, includes essential preventive and curative services at each level of the health system. Following high-level discussions with key partners, the MOH&SW has developed this National Child Survival Strategy to serve as a major component to individual-oriented clinical services for implementation of the BPHS.

1.2 Geo-Demography

Liberia is situated in the southern part of West Africa, bordering the North Atlantic Ocean, Sierra Leone, Guinea, and Côte d'Ivoire. The country has a land area of 111,370 sq km. The terrain is characterized by mangrove swamps and beaches along the coast, wooded hills and semi deciduous scrublands along the immediate interior, and dense tropical forests and plateaus in the interior. The climate is tropical with a wet season from May to October and a dry season from November to April. The average annual rainfall is 4,150 mm and average temperature ranges from 22 degrees Celsius to 27 degrees Celsius.

Liberia is divided into 15 counties: Bomi, Bong, Gbarpolu, Grand Bassa, Grand Cape Mount, Grand Gedeh, Grand Kru, Lofa, Margibi, Maryland, Montserrado, Nimba, Rivercess, River Gee and Sinoe. Monrovia is Liberia's largest city and its administrative, commercial, and financial capital.

[1] Liberian DHS 2007

MAP OF LIBERIA:

The Government of Liberia has conducted a national census in April 2008, the 2008 National Population and Housing Census: Results place the population of Liberia at approximately 3.48 million with a growth rate of 2.1%. With a population density of 93 per square mile, 75.2% of the population predominantly lives in six of the fifteen counties, with the south-eastern region of the country very sparsely populated. An estimated 33% of the population resides in the capital city, Monrovia, due to high migration from other counties during the 14 year civil war and more recently for economic reasons[2].

Liberia has a young population, with 47 % of the population below 15 years of age. Nineteen percent (19 %) of the population is under the age of five; Women make up just over half of the population; 25 % of women are of reproductive age (15-49 years). Life expectancy at birth is estimated at 42 years, and the total fertility rate is 5.2. By the age of 18, more than 38% of females have had a child or are currently pregnant. Most of the women of child bearing age are involved to some degree, in child bearing or rearing as supported by the large percentage of under 14 year-olds, and the high rate of women 20-24 who have had a child. The young population and number of women involved in child rearing add additional challenges for the country, economically. (LDHS 2007)

The war resulted in profound levels of social disruption. More than 250,000 people were killed and up to 80% of the rural and urban populations were displaced at least once during the course of the 14–year conflict. The majority of returnees returned before 2005 and by end of 2006, only 7% and 3% percent of the population were still displaced in rural Liberia and Greater Monrovia respectively.

[2] 2008 LIBERIA NATIONAL POPULATION AND HOUSING CENSUS: RESULTS

1.3 Literacy

In Liberia the young people are less literate than their parents. Latest literacy rates show a national literacy rate of 55 percent. In rural areas, 31 percent of adult males and 62 percent of adult females have no schooling. Age appropriate net-enrolment rates are low at 37 percent at primary level and 15 percent at secondary school level. Forty-four percent (44%) of girls aged 6-18 years have never attended school. There is now gender parity in school enrolment at primary school level, with enrollment rates lower in rural compared to urban areas. A gender disparity begins to appear at secondary school level in favor of males[3].

1.4 Health Care delivery in Liberia

There are a total of 448 functional health facilities in Liberia, comprising of county hospitals, Health centers and clinics which are managed by the Ministry of Health and Social Welfare and other partners. Four hundred forty-eight health facilities comprising of county hospitals, Health centers and clinics have been rehabilitated and are functional. Community level services are provided by a network of community health workers including both trained and untrained traditional midwives (TMs and TTMs), community health workers and hygiene promoters. These community health workers are typically members of the community and volunteering their services.

[3] Draft Nutritional Policy 2008 MOH Liberia

II - SITUATION ANALYSIS OF CHILD HEALTH IN LIBERIA

2.1 Morbidity Pattern in Liberia

Liberia's health services which were severely disrupted during the conflict are now being revitalized; however, the health sector is faced with many challenges with only 41% of the population having access to basic health services.

Liberia has a very high maternal and infant mortality estimated at 994/100,000 live births and 110/1000 live respectively (LDHS 2007). This situation of maternal mortality could be attributed to direct obstetric causes namely: obstructed labor, infections, hemorrhage, hypertensive disorder of pregnancy (eclampsia) and the complication of unsafe abortion. Some women who survive these complications develop life-long disabilities such as vesico/recto vaginal fistula and secondary infertility

Although coverage of antenatal care is high (79%), only 46% of births are delivered by skilled health professional but only 37 % of deliveries take place in health facilities[4]. Total fertility rate is estimated at 6.2 children per woman (LDHS 2007)

Malaria, acute respiratory infections (including pneumonia), diarrhea diseases, and neo-natal conditions (bacterial infection, jaundice etc) are the leading causes of child morbidity and mortality in Liberia**.** The 2007 Liberia DHS reported that 9 % of children under age five years whose mothers were interviewed in the survey were reported to have had ARI symptoms two weeks prior to the survey. For fever, a useful proxy for malaria, it was found to be 31%; the figure is slightly higher for diarrhea. Malaria is endemic in Liberia.

Malnutrition refers to a wide range of clinical conditions which occur when the individual's nutrient intake is inadequate to support the body's normal physiological activities including growth, tissue repair, prevention of and recovery from disease, regulation of body functions and reproduction. Malnutrition is an underlying cause of infant and child mortality resulting from the major childhood illnesses.

Acute malnutrition wasting or thinness, (weight for height <-2 standard deviation from the median of the reference population) is a result of rapid weight loss or a failure to gain weight occasioned by recent inadequate food intake and or disease. Chronic malnutrition, stunting or shortness, (height for age <-2 standard deviation from the median of the reference population), on the other hand, is a result of protracted inadequate nutrient intake and chronic ill health. Underweight (weight for age <-2 standard deviation from the median of the reference population) is a combination of acute and chronic malnutrition.

. The Liberia DHS 2007 results show that 39 % of Liberian children are stunted, 7% are wasted and 19% underweight. These rates, which are similar to other national nutrition survey results, are among the worst globally and constitute a major public health problem

2.1.1 Breastfeeding

Breastfeeding practices and introduction of supplemental foods are important determinants of the nutritional status of children. Promotion of immediate and exclusive breastfeeding should be a key component of any child survival strategy. Breast milk is uncontaminated and contains essential nutrients needed by children in their early months of life. Supplementing breast milk before six months of age may increase the likelihood of contamination and may lead to increased risk of diarrheal diseases.

[4] Liberia DHS 2007

According to the 2007 Liberia DHS, breastfeeding is very common in the country and the duration of breastfeeding is considerably long. Ninety seven percent (97%) of children aged 9-11 months and 82 % of those aged 12-17 months are still being breastfed. However, the survey also indicates that supplementation of breast milk starts early in Liberia, with only one-third of children under six months of age being exclusively breastfed. No information is provided on immediate breastfeeding.

2.1.2 Treatment of Children

Prompt diagnosis and treatment of, Malaria, ARI (including pneumonia) and diarrheal diseases is crucial in reducing child deaths. The Liberia DHS in 2007, reports that treatment is sought for 70% of children presenting with symptoms of ARI; the percentage being treated for diarrhea is estimated at 53%. There are differences noted in treatment-seeking behavior, depending on the gender of the child, the geographic location and education level of the mother. Female children were less likely to be taken for medical assistance, rural children-particularly those in the Southeast Region of the country- are less likely to be taken for treatment, and mothers with limited education often do not seek treatment for their children.

2.1.3 Vaccination of Children

The World Health Organization considers a child to be fully immunized if he or she has received a BCG vaccination against tuberculosis; three doses of DPT vaccine to prevent diphtheria, pertussis, and tetanus (DPT); at least three doses of polio vaccine; and one dose of measles vaccine- all of which should be received during the first year of life.

The 2007 EPI Administrative Records at the Ministry of Health and Social Welfare report coverage rates for BCG, measles and DPT3 reached 86%, 95% and 88% respectively for children 0-11momths. The DHS 2007 found that only 39% of children aged 12-23 months are fully immunized.

2.1.4 Malaria

The use of insecticide-treated mosquito nets (ITNs) while sleeping is one of the strongest weapons in the fight against malaria, and an important component of child survival. The Liberia DHS 2007 show that 30% of Liberian households own a mosquito net, and 45% of children under 5 years of age actually sleep under an ITN[5]. The data also show that 60% of children who had fever within two weeks prior to the survey had taken an antimalarial medicine.

2.1.5 HIV/ AIDS

Although HIV/AIDS has not been documented to be a leading cause of morbidity and mortality amongst children under five years in Liberia, it remains an important condition with potentially serious health effects. The current national prevalence rate for HIV/AIDS is 1.5%[6]; women have a higher rate of 1.8% while that of men is 1.2%. The ANC surveillance rate is 5.7% (2007 sentinel survey).

Table 1: Prevalence of common childhood illnesses- LDHS 2007

[5] National Malaria Control Program- MOH Liberia

[6] WHO Regional Report-Health of the People 2006

Indicator	Rate
Fever/malaria	35-40%
Cough/ARI	11%
Diarrhea	29%
Wasted	8%
Stunted	39%
Iron deficiency (6-35 months children)	86.7%

2.2 Mortality Pattern in Children

In general, children in Liberia suffer from poor health with a high under-five mortality rate of 110/1000 live births due to common illnesses such as malaria, diarrhea diseases, acute respiratory infections and underlying conditions such as malnutrition.

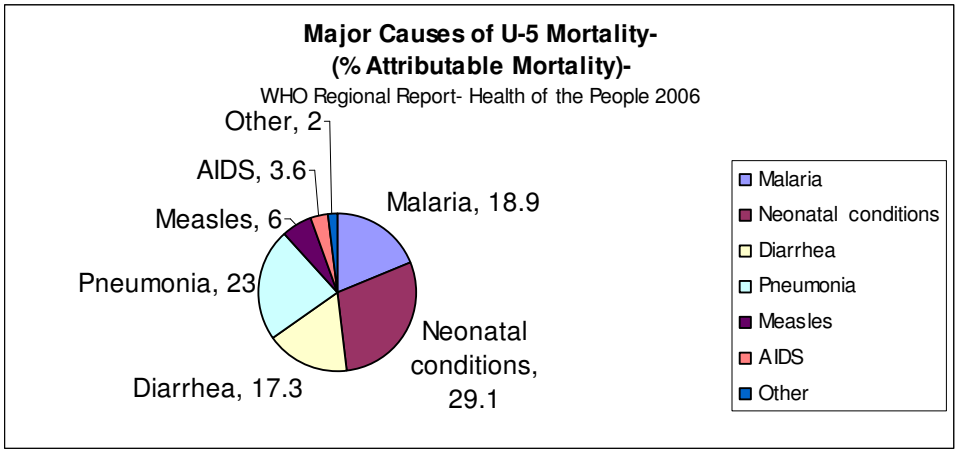
2.2.1: Childhood Mortality Rates:

Table 2: Neonatal, Infant and Under five mortality rates for Liberia, from the Demographic Health Survey (DHS) 2007

Indicator	Rate
Neonatal Mortality rate	32/1000 live birth
Infant mortality rate	72/1000 live birth
Under five mortality rate	110/1000 live birth

Between 1999 and 2007, the infant mortality rate fell from 157 to 72 deaths per 1,000 live births, while under-five mortality fell from 235 to 110 deaths per 1,000 births. These declines are largely attributed to the end of the conflict, the restoration of some basic services and increased immunity due to vaccinations. The Liberia DHS 2007 states that these figures may be an underestimation of the childhood mortality rates, as the data are derived from the birth history and many women interviewed had difficulty providing dates of birth of their children, while others were reluctant to discuss their dead children. Although the decline in child mortality rates is promising, there is still a great need to implement interventions that focus on the major causes of childhood illness and death.

2.2.2: Causes of Child Mortality



As shown above, death due to neonatal causes contributes to 29% of the national under-five mortality. The most common neo-natal causes include: prematurity, neonatal sepsis, neonatal tetanus and birth asphyxia[7]; most of these can be attributed to poor access to emergency obstetric care- a contributing factor to Liberia's high rate of maternal mortality (994 deaths per 100,000 live births).

Table 3: Annual Preventable Under-5 Deaths in Liberia (WHO, 2006)

Condition	% Attributable mortality[8]	Attributable deaths	% Preventable deaths	Preventable deaths
Malaria	18.9	7.371	65	4.791
Neonatal conditions	29.1	11.349	55	6.242
Diarrhea	17.3	6.747	91	6.139
Pneumonia	23	8.970	88	7.893
Measles	6.0	2.300	100	2.300
AIDS	3.6	1.404	48	674
Other	2.0	780	0	0
Total	100	39.000	63	28.039

2.3 Determinants of Childhood Mortality

The most obvious causes of the high rates of child mortality stem from the population's limited access to preventive, promotive, and curative health services. However, there are significant variations in mortality by socio-economic determinants as well. Poverty not only affects food supply and access to health care

[7] Liberia DHS 2007
[8] WHO Regional Report- Health of the People, 2006

but it is also linked to higher fertility rate, which in Liberia, is reported to be 5.2. Maternal education is also a major determinant of child survival, influencing care-seeking behavior, morbidity and nutritional status. In Liberia, it is reported that 62% of women are illiterate, a contributing factor to the high rate of child mortality. The Liberia DHS 2007 found education level to be a major determining factor in seeking antenatal care. The antenatal care coverage rises from 74% among women with no education to 93% among those with at least some secondary education. Other determinants include the low contraceptive prevalence rate (11%), which results in a high abortion rate, reduced nutritional status, higher prevalence of low birth weight babies, and increased rates of maternal and infant mortality.

2.4 Current Health Interventions, Programs and Packages

The Government, through the Ministry of Health and Social Welfare, and NGO partners are involved in provision of basic health services in communities and at health facilities. These interventions are supported in about 65% of the 448 functional health facilities by NGOs. Their assistance, combined with national programs has made impressive improvements, particularly, in immunization coverage for pregnant women, infants and children.

The table below describes the package of health services and where interventions are implemented. These programs are supported by various organizations and sources of funding, and MOH&SW is proud to partner with the following organizations and the funding agencies: USAID, GOL,UNFPA, UNICEF, WHO, GAVI, GFATM, Canadian Coop, EU, CIDA, GF, Churches of Liberia, Churches of Sweden, EED, NCA, and ELCA . More information is available from MOH&SW regarding the health providers and implementing agencies. Additional information on mapping interventions and partners support can be found in Annex 1.

Table 4: Current Child Survival Interventions in Liberia

Package	Where
Antenatal care	Bomi, Bong, Cape Mount, Gbarpolu, Lofa, Margibi, Maryland, Nimba and Sinoe
Basic Life Saving skills	Bomi, Bong, Cape Mount, Gbarpolu, Lofa, Margibi, Maryland, Nimba and Sinoe
FP services	Bomi, Bong, Cape Mount, Gbarpolu, Grand Bassa, Lofa, Margibi, Maryland, Nimba and Sinoe. All 15 counties
Immunization	Bomi, Bong, Cape Mount, Gbarpolu, Grand Bassa, Lofa, Margibi, Maryland, Nimba and Sinoe.
Childbirth & Immediate. PNC Basic Life Saving skills	Bong, Nimba, Montserrado
Post Neonatal care Prevention of infections: exposed to HIV/AIDS – CXT, ARV prophylaxis	All 15 counties 5/15 Hospitals providing PMTCT services
Child Preventive care	
Community Nutrition	Maryland,Lofa, Nimba,Bong and Montserrado

Immunization	All 15 Counties
HIV testing & Counseling	71 testing site in all the Counties (LDHS 2007)
Growth Monitoring and Promotion	Lofa, Nimba, Montserrado
Child Treatment care	
C-Management of child illness (diarrhea)	Cape Mount
IMCI-Malaria/HF level	15 counties have started (some degree)

From Family Health Division Reproductive Health Bulleting March, 2008

Although there are currently a number of interventions and programs being implemented in Liberia that are aimed to address child survival, there is room for improvement. A successful strategy for child survival must incorporate interventions that span the perinatal period, and carry on through infancy and early childhood.

2.4.1 Factors that impact Child Health Programs

- Limited access to health facilities is resulting in very high levels of home delivery and low coverage of key interventions for child survival along the continuum of care.
- ANC visits, immunization contacts at the facility level, outreach and other scheduled activities provide important opportunities to ensure universal coverage of priority interventions
- Malaria, being a major cause of death among children under five and a source of co-morbidity for surviving children (low birth weight, anemia), deserves special attention in order to increase demand for access to malaria prevention and treatment
- Access to clean water, and personal hygiene must be part of any successful intervention
- Good record keeping and reporting systems are critical at all levels (community, county and central), in reducing the gaps in data collection, particularly for the neonatal period.

2.4.2 Policies for Child Health Programs

The Government of Liberia (GOL) is committed to providing high quality health services for its people. However, due to competing financial priorities, only 12% of the national budget is allotted to health[9]. A National Health Policy, including the Basic Package of Health Services (BPHS) has been developed. Newborn and child health is prioritized in the BPHS for universal coverage of key interventions, according to international rights of the child. The BPHS will help reach Liberia's goal of not only improved health, but also equity in health care, and includes interventions and services that address the following areas:

- Maternal and newborn care
- Reproductive and adolescent health
- Child Health
- Communicable disease control
- Mental Health

[9] National Budget, Liberia

- Emergency care services

The Basic Package will promote redistribution of health services in a way that ensures universal access to essential services throughout Liberia and child health and survival interventions a priority at the community, clinic and central levels.

Integrated management of childhood illnesses (IMCI) is one of the key strategies for child mortality reduction. In September, 2005, IMCI technical guidelines were adapted according to international standards, for the purpose of capacity building and health system reinforcement[10]. The community component of IMCI is being adopted and currently, some Non Governmental Organizations (NGOs) are at the early stages of implementing selected key family practices for child development, child health and survival.

The national Essential Drug List (EDL) includes selected drugs for case management of childhood illness in line with IMCI technical guidelines[11]

The two-year human resources for health (HRH) plan developed in 2008, is addressing the HRH gaps. In addition the MOH&SW is in the process of developing a national policy that will outline the role of community health workers (CHWs) and traditional birth attendants (TBAs) in providing primary health care.

There are gaps in financial strategies for health. Various sources of funding (Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM), GAVI, Clinton Foundation, UNICEF, PMI and others) can be mobilized for child health in the next four years. Several implementing partners or agencies are giving support to child health, however, improvement in coordination and standardization of interventions and integration of programmatic activities is a requirement for success.

[10] Family Health Division, MOH Liberia
[11] Pharmacy Division, MOH Liberia

III. OPPORTUNITIES AND MAJOR GAPS FOR THE CHILD SURVIVAL STRATEGY

The Government of Liberia has made improving child survival interventions a priority. With policy decisions in place to improve the health infrastructure, there is a strong context to support such actions. With the existence of strong domestic and international support, the Ministry of Health and Social Welfare and other partners now have the means to implement a successful Child Survival Strategy. This Strategy must take advantage of existing opportunities and address the challenges which may hinder implementation.

3.1 Opportunities

That ensures universal coverage of key interventions:

- Progressive increase in government budget allocation for health
- Increased awareness of ANC services through early contacts, outreach visits, immunization campaigns, motivation by TTMs and CHWs
- Increased awareness of family planning (FP) for youth through school systems, clinics and hospital visits
- Existence of 6 nursing schools and medical school for training
- The use of TTMs and health workers (HW) to support IBF and EBF
- The existence of committed partnerships in the health sector.

That improves the quality of services:

- The rehabilitation of health facilities (HF) for referral
- The development of Health Information System to collect data from implementing partners and improve quality of services.

That creates an enabling policy environment:

- The inclusion of a community health component in the new National Health Plan
- The development of the RH Road Map to accelerate the reduction of maternal mortality
- The availability of the WHO package with IMCI tools
- Ministry of Health and Social Welfare's effort in developing the Human Resources in Health (HRH) Plan
- Development of the Poverty Reduction Strategy (PRS)
- Development of the Basic Package of Health Services (BPHS)

That enhance role of family & communities:

- HRH strategy being developed includes Community Health Workers (CHWs)
- Existence of County Health Teams
- Community Interventions for Health that are addressed in National Health Policy
- The Existence of CHWs at the community level
- The Existence and partnerships with community radio stations
- Existence of County Health and Social Welfare board that includes partners such as the development superintendent, community development councils, NGOs, faith-based organizations amongst others

3.2 Major Gaps

In ensuring universal coverage of key interventions:

- Limited access to health facilities (about 41%)
- Insufficient qualified manpower
- Limited incentives to motivate health workers
- Poorly distributed qualified workforce
- Weak referral system
- Limited supply of commodities

To improve the quality of services:

- Inadequate drug and commodity supply system
- Limited trained and qualified staff
- Inadequate logistics and referral systems
- Lack of data for management decisions
- Lack of data for monitoring and supervision;
- Weak Monitoring and Evaluation system
-

To create enabling policy environment:

- MOH coordination mechanism not well established
- Competing priorities

To enhance role of family & communities:

- No defined strategy on Community Development Council.
- No community uniform structure in place

IV. TARGET CONDITIONS AND KEY HIGH IMPACT INTERVENTIONS

The discussion of child mortality in Chapter II shows that over 90% of child mortality in Liberia can be attributed to the following conditions:

Malaria
ARI- Pneumonia
Diarrhea
Neonatal conditions

The Lancet series on child survival[12] estimated that with 99% coverage of interventions currently available and for which there is sufficient evidence for effect in prevention or treatment it would be possible to prevent:

65% of deaths due to pneumonia,
55% of deaths due to neonatal complications,
91% of deaths due to malaria,
88% of deaths from diarrhea,
100% of deaths from measles, and
48% of those due to AIDS

Because the data on Liberia's causes of child mortality are the same as those outlined in the Lancet series from 2003, it is even more reason to implement a limited number of low cost/high impact interventions to address these target conditions.

4.2 Minimum Package of child survival interventions

4.2.1 Priority Setting and Selection Process for Interventions

Developing a minimum package of child survival interventions that can be implemented during the period (2008-2011), required a careful prioritization process. In this process, all potential options (interventions), that address the problems identified in the situation analysis, were reviewed according to specified criteria. The goal was to select interventions that are likely to have the greatest impact in relevant settings. Once appropriate interventions were identified, suitable strategies were developed to maximize the effectiveness of the interventions and an appropriate time line was outlined with a focus on Phase 1 (January- December 2009), then an extended plan to cover 2009-2011

[12] Jones G. et al, Lancet, 362:65-71

COMPREHENSIVE LIST OF CHILD SURVIVAL INTERVENTIONS PROVIDED AT COMMUNITY, CLINIC, HEALTH CENTERS AND HOSPITAL LEVELS

	Home and Community	First-level health facility	Referral
Pregnancy	1. Promote and support ANC 2. Birth and Emergency preparedness 3. Information and counseling on Self-care IEC/BCC • Nutrition • Safe sex • Breastfeeding • Family planning • Sleeping under ITNs	1. Tetanus Toxoid immunization 2. Birth and emergency planning 3. Information and counseling on Self-care IEC/BCC 4. Basic EnONC 5. PMTCT +HCT 6. Syphilis Test (RPR) 7. Family planning Services 8. Focus ANC	1 Management of complication of pregnancy 2. Information and counseling on Self-care IEC/BCC
Birth and 1-2 hours	1. Promote and support skilled care at birth 2. Promote and support key practices • Health facility delivery • Early initiation of breastfeeding • Newborn thermal care 3. Health Facility Delivery	1. Detection of complication of pregnancy and delivery 2. Clean delivery 3. Immediate newborn care • Resuscitation • Thermal care • Cord care • Early initiation of breastfeeding • Prevention of mother-to- child transmission of HIV	1. Clinical management of obstetric complications 2. Birth & Emergency planning 3. IEC/BCC level
Newborn Period (up to 7 days)	1. Promote and support key practices • Exclusive breastfeeding • Thermal care • cord care • Extra care of LBW	• Exclusive Breastfeeding • Thermal care • cord care • Extra care of LBW • Prevention of mother-to- child transmission of HIV	1. Management of severe newborn illness

		• Management of new born illnesses • Immunization • Family Planning and counseling	
Infancy and childhood	1. Promote key practices • Exclusive breastfeeding • Complementary feeding • Sleeping under Insecticides-treated-nets 2. Household water treatment and safe storage Sanitation (waste disposal, latrines, environmental health) 3. Hand washing 4. C-IMNCI • ORS + zinc for Diarrhea 5. Deworming 6. Vitamin A supplement	1. Immunization 2. Vitamin A supplementation 3. Standard case management including: 4. IMNCI standard case management • ORS and zinc for diarrhea • Antibiotic for pneumonia • Antibiotic for bloody diarrhea • Antimalarias 5. Care for HIV-exposed and infected children • Cotrimoxazole prophylaxis • ART • Deworming • Family Planning Counseling	1. Management of severe child illnesses

The process of developing the minimum package signifies a high- impact and low cost strategy. The minimum package has to be simple and scaleable during the three-year period (2008-2011). The specific interventions are outlined below:

Table 5: Minimum Package of High Impact Interventions for Child Survival and Development in Liberia

High Impact Interventions	Operational Definition
For Prevention	
Insecticide-treated bed nets (ITNs)/ Long lasting insecticide-treated nets (LLIN)	• Protecting all pregnant women and children under five years of age from malaria by ensuring that they sleep under recommended ITNs • Care givers acquire ITNs and retreat these at least once a year
Intermittent preventive treatment (IPT) of malaria in pregnancy	• Administering at least two doses of recommended anti-malarials (SP), one month apart, for the prevention of malaria during pregnancy, starting from the second trimester
Breastfeeding (Exclusive Breastfeeding and Immediate breastfeeding)	• Breastfeed infants exclusively for six months, taking into consideration policies on HIV and infant feeding • Ensuring that newborns are breastfed immediately after birth
Complementary feeding	• Starting at six months, feed children energy- and nutrient-rich foods, while continuing to breastfeed for up to two years or longer
Immunization	• Ensure children complete a full course of immunizations [BCG, pentavalent, oral polio vaccine (OPV) and measles] before their first birthday
Antenatal care and clean delivery	• Ensure that every pregnant woman receives three or more antenatal visits and recommended doses of tetanus toxoid (TT3) vaccination • Ensure family and community support for pregnant women in seeking appropriate care during pregnancy and during the delivery and postpartum period • Ensure pregnant woman deliver at a health facility or are delivered by a skilled attendant. • Ensure the use of clean delivery kits (plastic sheet, thread, new razor blade, umbilical cord, and a bar of soap) • Ensure access to emergency obstetrical and newborn care (EmONC) in each facility • Ensure proper disposal of placenta using placental pit
Water and sanitation	• Dispose of all feces safely • Wash your hands with soap after defecation, and before preparing meals and feeding children
For Treatment	
Oral re-hydrations Solution (ORS) + zinc	• Continue to feed and offer fluids to children, including breast milk when they are sick • Children under five with diarrhea in the last fourteen days given ORT • Advise caregivers to give sick children extra fluids and to continue feeding
Anti-malarial treatment	• Treat children who have reported having a fever in the previous 2 weeks with locally recommended anti-malarial
Information for seeking immediate care	• Ensure caregivers of children are aware of at least tow of the following signs for seeking immediate medical care: o Child not able to drink or breastfeed o Child becomes sicker despite home care o Child develops a fever o Child has fast/difficult breathing o Child has blood in stool

	• Child is drinking poorly
Antibiotics for sepsis, pneumonia, ARI, and dysentery	• Ensure access to recommended antibiotics and administration by health care providers and authorized care givers for newborns with sepsis, children with pneumonia, ARIs or fast breathing and children with mucoid/blood stained stool • Ensure care-givers recognize when sick children need treatment outside of the home

TABLE 6: Expanded Package of Child Survival Interventions by Level: Community, First and Referral Facility

Priority Interventions selected for Family and community based-services	
Preventive interventions	
1	Counseling on ANC package
2.	ITNs for children
3.	Hand washing by mothers and caregivers
4.	Early Breastfeeding
5.	Thermal care
6.	Exclusive Breastfeeding
7.	Timely and appropriate Complementary Feeding
Treatment interventions	
8.	ORS plus zinc
Priority Interventions selected for Population-oriented schedulable	
Preventive interventions	
1.	Immunization – (Measles, OPV, Pentavalent) –
2.	Vitamin A Supplementation- Deworming through EPI
3.	Distribution of ITNs through EPI
4.	TT2 (outreach and Mobile)
5.	Refocused ANC: Prevention & TT of iron deficiency anemia in pregnancy ITNs for pregnant women through ANC IPT for pregnant women
Priority Interventions selected for Clinical individual oriented care- Clinical Primary Level	
Preventive interventions	
1.	ANC package – refocused Prevention & TT of iron deficiency anemia in pregnancy ITNs for pregnant women through ANC IPT for pregnant women
2.	EBF – Continued BF (9-11 mo)- Timely and Appropriate CF
3.	Skilled delivery care
Treatment interventions	
4.	Basic EmONC
5..	Resuscitation of asphystic NB at birth
6.	Integrated Management of Childhood Illness: AB for U5 pneumonia AB for dysentery Vit A for TT of measles Zinc for diarrhea management ACT for children

7.	ACT for pregnant women
Priority Interventions for Clinical individual oriented care – First Referral – County Hospital	
Preventive interventions	
1	Skilled delivery care
2	EBF and continued BF (9-11 mo) – CF, Immunization, Vit A
Treatment interventions	
3	Basic EmONC
4	Resuscitation of asphystic NB at birth
5	AB for Preterm Prelabor Rupture of Membranes
6	Detection & Mgt of Pre Eclampsia
7	Management of severe neonatal illness (asphyxia aftercare, mgt of serious infections, Mgt of VLBW infant)
8	PMTCT with ARV
9	Integrated Management of Childhood Illness Management of severe U5 childhood illness (diarrhea, pneumonia, malaria, malnutrition, pediatric HIV) Zinc for diarrhea management ACT for children
10	ACT for pregnant women
Priority Interventions: Clinical individual oriented care – Second Referral	
1	Skilled delivery care
2	Basic EmONC
3	Comprehensive EmONC
4	Resuscitation of asphystic NB at birth
5	AN steroids for Preterm labor
6	AB for Preterm Prelabor Rupture of Membranes
7	Detection & Mgt of Pre Eclampsia
8	Emergency NN care of asphyxia aftercare, mgt of serious infections, Mgt of VLBW infant
9	Management of complicated malaria
10	AB for opportunist infections
11	ART for children with AIDS
12	ART for pregnant women with AIDS
13	ART for adults with AIDS

V. THE CHILD SURVIVAL STRATEGY

Objectives and target outputs

Goal: To ensure a 15% reduction in child mortality in Liberia by 2011- (from 110/1000 live births to 94/1000 live births)

General objective

To reach 70% of children under 5 in Liberia with the child survival package of proven high-impact interventions

Specific Objectives

1. To increase the use of LLINs among children under five from the current coverage of 45% to at least 80%
2. To increase and ensure timely initiation of the onset of Exclusive Breastfeeding (EBF) up to 6 months, from current coverage of 19% to 50%
3. To ensure that at least 60% of child under five with diarrhea receive effective treatment at home
4. To increase the coverage of pregnant women ANC 3+ visits to 50% of pregnant women
5. To increase and maintain measles and Penta-3 vaccine coverage for children under one up to 90% from the current rates of 95% and 88% respectively
6. To increase the proportion of skilled delivery from current rate of 46% to 60%
7. To provide appropriate treatment to at least 60% of children presenting with malaria, ARI-pneumonia and diarrhea- current rates of treatment are 59%, 70%, and 53 % respectively
8. Expand the availability of EmONC services to include one functional facility in each county- currently available in 11 of the 15 counties.
9. ensure the availability of basic EmONC in three functional services in each county
10. Increase access of services for HIV exposed and infected infants and children

VI. IMPLEMENTATION OF CHILD SURVIVAL STRATEGY

6.1 Delivery Strategies and Specific Interventions and Activities

The MOHSW has developed a BPHS as a means of improving access to primary health care services in Liberia. It defines the minimum packages of health care services for the clinic, Health Center and Hospital levels. Additionally, the Ministry has established the community health services program to champion delivery of services at the community level.

It is the goal of MOHSW that Child Survival Strategy is implemented with the context of these new initiatives of effectively expanding services at all levels.

6.1.1 Specific Activities by Delivery Level

Home and Community-based interventions

Regular Provision of essential inputs

- Distribute ITNs/LLINs at distribution points in 88 Districts
- Provide adequate IEC/BCC on hand washing
- Provide ORS + zinc in communities
- IEC/BCC on HIV/AIDS

Capacity building of community health providers

- Develop/adapt standardized training materials on promotion of Exclusive Breast Feeding, personal hygiene, including hand washing, ORT, use of ITNs and timely care seeking for malaria treatment
- Orient CHVs and community-based organizations on basic child survival package
- Train CHVs in promoting EBF, ORT, use of ITNs and timely care seeking for malaria treatment
- Organize training of trainers in every districts
- Train community women groups on Exclusive Breast Feeding
- Train TMs in Home Base Life Saving Skills
- Implement CCM in 2 region to treat malaria, pneumonia and diarrhea
- Develop C-IMCI on CCM
- Growth Monitoring in communities (Weighing)
- Resubmit the code of National Legislation Breastfeeding substitutes
- Monitor community health providers' activities
- Identify, employ, motivate and retain skilled Health Workers

Intensified communication for behavior change strategy

- Produce IEC/BCC materials/messages on C-IMNCI, EBF, ORT, use of ITNs and timely care seeking for malaria treatment and HIV/AIDS counseling and testing care and support.
- Conduct social mobilization among health and community members for child survival
- Organize media campaigns on C-IMNCI, EBF, ORT, use of ITNs, HIV prevention and timely care seeking for malaria treatment
- Monitor activities at community level.

Support Community Mobilization:

- Establish ORT corners
- Promote and support community mobilization and behavior change to include child survival

Outreach interventions

Provision of essential supplies:

- Identify and procure regular equipment/commodities for ANC, immunization and nutrition activities
- Supply facilities with equipment/commodities ANC, immunization and nutrition activities
- Strengthen of supply chain management system

Capacity building of health workers on outreach activities:

- Identify, employ and redeploy skilled health workers
- Identify training needs
- Develop standardized materials for training and follow up after training
- Conduct training of staff at facility level
- Monitor outreach activities

CBC activities

- Review, update, adopt and distribute IEC/BCC policy/guidelines
- Identify IEC/BCC materials, pre-test and print
- IPCCS training
- Develop and distribute IEC/BCC materials
- Conduct IEC/BCC activities among target population
- Community based distribution of Vitamin A supplement and Deworming
- Community based treatment of malnutrition

First Level Health Facility Interventions

Provision of essential inputs:

- Procure drugs and medical supplies to target functional health facilities
- Produce an adequate number of training materials
- Provide an adequate quantity of health promotion material

Capacity building:

- Update IMNCI training materials including Newborn, HIV, and ORS with Zinc
- Provide Refreshers trainings for IMNCI trainers
- Conduct training of Health Workers in IMNCI case management in 15 counties
- Train county supervisors on follow up after training
- Conduct training of HW in Life Saving Skills (ANC, PNC, PMTCT, Skilled Delivery, EmONC) using standardized materials
- Conduct follow up after training in selected functional health facilities
- Develop check lists for monitoring trainees' capacities and facility management
- Referral Level (Hospital) interventions

Referral Level (Hospital) Interventions

Provision of essential inputs:

- Supply County Hospital with drugs, laboratory equipment and commodities
- supply County Hospitals with drugs and medical commodities for EmONC
- Supply County Hospital with drugs and medical commodities for treatment of childhood illnesses, including complicated malaria
- Produce an adequate number of training materials on appropriate case management of childhood illnesses (complicated malaria, pneumonia, etc) in the County Hospitals

Capacity building:

- Review, revise training materials for HCT and PMTCT
- Review, revise and produce CBC/BCC materials
- Train county hospital staff in appropriate case management of complicated malaria and other childhood illnesses
- Train laboratory technicians
- Conduct supportive supervision/coaching of trained staff in complicated malaria and other childhood illnesses
- Carry out M&E of trainers for complicated malaria case management

6.2 PHASE I: January to December, 2009

In order have the greatest impact on child survival, and focus on the interventions along the continuum of care outlined in section 6.1.1 the following activities will take place during the first year of implementation at the three delivery levels: community, first (clinic) and referral (hospital) sites. The Ministry of Health serves at the executive level, with the responsibility of development of policies and training materials.

COMMUNITY LEVEL	
Operational Strategy	**Activities**
Regular Provision of Essential Inputs	• Distribute ITNs at distribution points in 88 Districts • Distribute ORS with Zinc packets to communities (1,152) • Distribute Vitamin A supplement
Capacity Building of Community Health Providers	• Develop/adapt standardized training materials on promotion of EBF, appropriate complementary feeding personal hygiene, including hand washing, ORT, use of ITNs and danger signs of common childhood illnesses (malaria, pneumonia, diarrhea and malnutrition) and timely care seeking for treatment • Orient CHVs and community-based organizations on basic child survival package (community IMCI) • Train CHVs in promoting EBF, ORT, use of ITNs and timely care seeking for malaria treatment • Train community women groups on EBF • Resubmit the code of National Legislation on Breastfeeding code • Develop and distribute posters, leaflets and fact sheets on home chlorination, hand washing, and Cholera/Diarrhea, as well as

	Nutrition, HIV/AIDS and other child survival issues • Train TMs in Home Base Life Saving Skills • Pilot CCM in 2 regions to treat malaria, pneumonia and diarrhea • Implement C-IMCI on CCM • Growth Monitoring in communities (Weighing)
Intensified communication for behavior change strategy:	• Develop IEC/BCC materials/messages on EBF, ORT, proper hand washing, chlorination of water, use of ITNs and timely care seeking for malaria treatment • Produce IEC/BCC materials/messages on EBF, ORT, use of ITNs and timely care seeking for malaria treatment • Conduct social mobilization among health and community members • Implement National Campaign on Cholera/Diarrhea Prevention Media Plan
Support Community Mobilization:	• Expand Breastfeeding Advocacy Group (BAG) program operation • Establish ORT corners • Establish CDCs and train in community mobilization • Establish Emergency transport system encourage economic strategy for child survival
OUTREACH INTERVENTIONS	
Regular Provision of Essential Inputs	• Identify and procure regular equipment/commodities for ANC, immunization and nutrition activities • Supply facilities with equipment/commodities ANC, immunization and nutrition activities • Strengthen of supply chain management system
Capacity Building of Community Health Providers	• Identify, employ and redeploy skilled health workers • Identify training needs • Develop standardized materials for training and follow up after training • Offer refresher courses for health care providers • IPCCS training
Intensified communication for behavior change strategy:	• Review, update, adopt and distribute IEC/BCC policy/guidelines • Develop and distribute IEC/BCC materials • Conduct IEC/BCC activities among target population
FIRST LEVEL HEALTH FACILITY	
Regular Provision of Essential Inputs	• Procure drugs and medical supplies to target functional health facilities • Produce an adequate number of training materials • Provide an adequate quantity of health promotion material
Capacity Building of Community	• Update IMCI training materials including Newborn, HIV, and ORS with Zinc

Health Providers	• Provide refreshers training for IMCI trainers • Conduct training of HW in IMCI case management in 15 counties • Conduct training of HW in Life Saving Skills (ANC, Skilled Delivery, and EmONC) using standardized materials • Monitor and evaluate interventions
REFERAL LEVEL HEALTH FACILITY	
Regular Provision of Essential Inputs	• Supply County Hospital with laboratory equipment and commodities • Supply County Hospital with drugs and medical commodities for treatment of childhood illnesses, including complicated malaria • Produce an adequate number of training materials on appropriate case management of childhood illnesses (complicated malaria, pneumonia, etc) in the County Hospitals
Capacity Building of Health Providers	• Update IMCI training materials including Newborn, HIV and ORS with zinc • Provide refresher training for IMCI • Conduct training of HW in IMCI case management in 15 counties • Conduct training of Hw in Basic Life Saving Skills (ANC,Skilled Delivery and EmONC} using standardized materials • Monitor and evaluate interventions

All of the activities outlined for Phase I & 11 will be continued throughout the remaining period (2010-2011).

VII. COORDINATION & MANAGEMENT

In February 2007, the MOHSW put in place a Technical Committee on Child Survival, composed of MOH&SW staff and representative from key partners including WHO, UNICEF and USAID. This Committee was tasked, to develop a transitional child survival strategy (2007-2008) to address child morbidity and mortality in Liberia. Furthermore, this Committee was tasked with supporting strategic linkages with the Road Map for maternal mortality reduction and building partnerships toward improving maternal, newborn and child programs.

The Child Survival Technical Committee continues to function in line with the agreed TOR, including revision of policies, development of training manuals, development of monitoring systems and tools, to facilitate the flow of information among all actors.

With the release of this Strategy, the Technical Committee will support capacity building of County Heath Teams for planning, implementation and monitoring of the strategy, in consultation with implementing agencies.

Rapid capacity building of existing staff at facility and community levels, using the standardized minimum package, may require innovative strategies such as contracting with external organizations. Coordination mechanisms at national and county levels will ensure that communication between national and county coordination committees continues. The micro planning process and the M&E plan are two major entry points to establish strong linkages.
The following existing coordination structures will be used and/or strengthened as a platform for planning, implementing and monitoring the National Child Survival Strategy.

At National Level

The HSCC is acting for policy-making, resource mobilization while the technical component is led by the Child Survival Technical Committee. The CS-TCC is composed of child health related programs, supporting partners and other sectors with clear TOR. The committee is overseen by the Chief Medical Officer of the MOH&SW.

At County Level

The County Health and Social Welfare Board is the extension of the CS-TCC which includes different coordination structures such as the County Development Council (CDC), the Community Health Development Committee (CHDC). The County Health Board is in charge of coordinating Child Survival program and has received TOR from the national level. The County Health Board meets once a month.

VIII. MONITORING & EVALUATION PLAN

8.1 Key indicators for monitoring and evaluation

The MOHSW will create a National Technical Committee chaired by the Division of Preventives Services and using the existing ICC as a basis for child survival. The Technical Committee for Child Survival will include key partners/stakeholder and will develop, adapt or update policies, training, supervision and monitoring materials that are necessary for rapid implementation.

Global Child Health monitoring and evaluation guidelines will be utilized in the monitoring and evaluation system during to the transitional period. Selected indicators have been adopted to inform the progress of implementation and to provide opportunities for timely problem solving at county and central levels. Frequency and source of data will be defined by the Technical Committee for Child Survival.

Table 7. Selected Target indicators

	Outcomes	Outputs	Inputs
1	80% of Under five children who sleep under an ITN C=2.6% -	70% of households with at least one ITN being used to sleep at night	National policy of making ITNs free to children Under 5 and pregnant women in place Regulation/control on net sales Targeted community education and involvement
2	60% of children up to 6 months who are exclusively breastfed	% TBA, CHW trained on counseling on early IBF, EBF and continued BF up to 24 months % of target communities with CHVs trained on EBF % of CHVs reporting on C-IMCI activities % of newborn put to breast milk within one hour of delivery	National policy on IYCF Adapted training package Adapted recording form Funds Every facility should have regular mother, child health education programs to include IBF &EBF
3	60% of Under 5 with diarrhea who received ORT (increased fluids) and continued feeding C= 60% (ORT only) - T= 45% (ORT+CF)	% of CHVs trained in home management of diarrhea % of functional HF with ORT corner % of mothers who know about home management of diarrhea	Adapted training materials to reflect National policy ORS and commodities for ORT corners Funds
4	90% of all CHVs providing information and education on proper hand washing techniques	% of trained CHVs on counseling on hand washing % of HF providing Hand washing training through outreach % of mothers who know proper hand washing technique	Adapted training materials on personal hygiene and proper hand washing technique
5	50% of pregnant women who received at least 3 ANC visits	% of trained CHVs on counseling on ANC package % of HF providing ANC	National policy on ANC package and schedule of visits Essential Drugs & equipments

		package % of pregnant women know the schedule of ANC visits	
6	90% of Under 1 who received vaccine against measles and received the Penta-3 vaccine C=88% -	% of counties that had an immunization campaign in the last 6 months % HF providing vaccination./ against measles using outreach strategy % HF providing vaccination services in fixed facilities % of mothers who know when to seek care for vaccination including measles	Use of the RED approach Schedule for standardized outreach activities Vaccines Funds
7	50% of pregnant women who are deliver by a skilled health professional (Doctor, nurse, midwife or physician assistant)	% of TBA trained in supportive care and timely referral % of pregnant women referred for skilled delivery % of communities in the catchment's areas of functional HF having a transportation mechanism for emergency	National policy on MPS Adapted materials for training and refresher courses Community roles for emergency preparedness Reach Every District/Community (RED Approach)
8	30% of sick children having ARI, malaria and diarrhea who receive appropriate treatment at health facility	% of HW taking care of children in the HF trained in IMCI % of HW who have received a follow up visit within 4-6 months after training % of HF with no stock out of essential drugs, & equipments	Adapted training materials for IMCI Drugs and commodities for treatment of pneumonia, malaria & diarrhea Trained supervisors on Follow Up after training Funds
9	Number of County hospitals providing Emergency Obstetrical and Neonatal Care in the 15 counties	% of county hospitals with necessary drugs and equipment for Emergency Obstetrical and Neonatal Care % of county hospitals with trained staff for Emergency Obstetrical and Neonatal Care % of maternal deaths reported by health facility % of infants deaths reported per health facility % of skilled health workers per facility	Norms & procedures for EmONC Drugs and equipments for EmONC Funds

In order to achieve selected health outcomes, output indicators were identified based on delivery strategies and activities to be implemented during the period.

During Phase I, it is expected that the national coordination team will continue to concentrate efforts in developing key training materials and other key inputs to facilitate the rapid implementation as planned during the next three years.
The monitoring of the implementation will use the selected outputs indicators as a guide at county, regional and national level for the reporting system.

IX. ASSUMPTIONS

Political commitment

- An increase in government budget allocation for health from 8% (2006) to 12% (2008)
- Political support from the national leadership for health sector reform process
- Continued support from partners with a focus on maternal, newborn and child health

Supportive Priorities at MOH&SW

- Programs that :
  - Protect the poorest and hard-to- reach population
  - Promote community empowerment for priority actions for child survival
  - Ensure a performing systems for drug supply, referral care and health information
  - Create a multi sectoral platform for child health
- Rolling out the Basic Package of Health Services (BPHS)

Human Resource for Health

- Development of a strategy for staff development and retention
- Trainings in place to upgrade skills of existing staff
- Existing partnership with universities, professional bodies and private sector

Financial Commitments

- Continued financial support from USAID, DFID, EU/ECHO, increase in Government allotment to the Ministry of Health and Social Welfare and other sources of funding to NGOs.

CONCLUSION

The Government of Liberia has declared her commitment in improving the child survival and development through this National Child Survival Strategy. This document represents our aspirations for improving the lives of the children of Liberia by focussing on implementing effective interventions that focus on target conditions that cause common childhood morbidity and mortality.

The Government hopes, that with the help of key partners in child survival and development, these strategies can be implemented with the same passion, commitment and energy demonstrated during the planning stage. It is also the hope of the government that all stakeholders will refer to and use this document during planning, implementation, monitoring and evaluating of all child-centered interventions