Contributing to Liberia's COVID-19 vaccination journey to reach the 90% target

Telling Our Story

April 2021 to December 2022

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Context

Figure 1: Community mobilization in Buchanan for COVID-19 vaccination

Liberia is in West Africa with 15 counties and 93 health districts and has a total population of 4.9 million with life expectancy of 62.9 years (LDHS 2019/2020). The country experienced the devastating Ebola Virus Disease (2014-2016) epidemic and continues to suffer recurrent Lassa fever and Measles outbreaks, and the ongoing 2020-2022 COVID-19 pandemic.

Liberia recorded her first confirmed case of COVID-19 on 16 March 2020 and is one of the countries within the sub-region with fewer cases and deaths associated with the ongoing COVID-19 pandemic. The COVID-19 pandemic has affected nearly all sectors of life, despite its low fatality rate in Liberia. Several strategies and interventions were adopted by the Government of Liberia (GOL) through the National Incident Management System (IMS), to prepare, respond and contain the outbreak in Liberia. One of these interventions is the rollout of COVID-19 vaccination among high-risk groups as well as the general population. The uptake of COVID-19 vaccine was slow at the beginning of the process partly due to high levels of community resistance and hesitancy, misinformation, and general mistrust in public health interventions. As a result of national efforts through the EPI Program, COVID-19 vaccines were slowly introduced initially at selected sites in Monrovia. The focus at the time were major markets and some temporary sites in Monrovia.

With insignificant results from the introduction of the vaccines, a nationwide campaign (Phase 1) was launched to increase vaccination coverage in the country. The government led this campaign with the support of all partners. However, little progress was recorded in achieving the desired result. As an attempt to accelerate vaccine uptake, the government through the IMS was prompted to assign a number of counties per partner for comprehensive support and improve coordination (Phase 2). With better-coordinated partner support and government leadership, the coverage increased from 0.4% (Phase 1) to 40% (Phase 2). To build better on phase 2 performance, the decision to retain coordinated partners' support in assigned counties was upheld (Phase 3) to push toward the 70% target, which was achieved by July 31, 2022.

As of 31st December 2022, 4,474,600 eligible persons had received the first dose of COVID-19 vaccines, while 3,749,044 persons had completed the primary COVID-19 vaccination series, representing 81% of the country's population that was fully vaccinated.

This document is a comprehensive account of all the intensive COVID-19 vaccination campaigns (April 2021 to December 2022), incorporating all COVID-19 vaccination activities (strategies and enablers) across all levels of health governance structures (county-national level). Key strategies included: Fixed/static Sites, Outreach and Mobile vaccination, and enablers: micro-planning, vaccine prepositioning and distribution, demand creation, social mobilization, training of personnel, supervision, monitoring, coordination, printing and distribution of vaccination cards/certificates, data management, mobile money, and robust logistical support. The document further provides a snapshot of key challenges, best practices and lessons learned.

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Chapter 1

Reaching towards 90%: Our chronology of events

This section describes WHO operational processes and inculcates key strategies, enablers, and other complementary actions toward contributing to the achievement of 90% COVID-19 vaccination coverage in Liberia.

Figure 2: A schoolgirl showing her vaccination card after receiving her vaccination

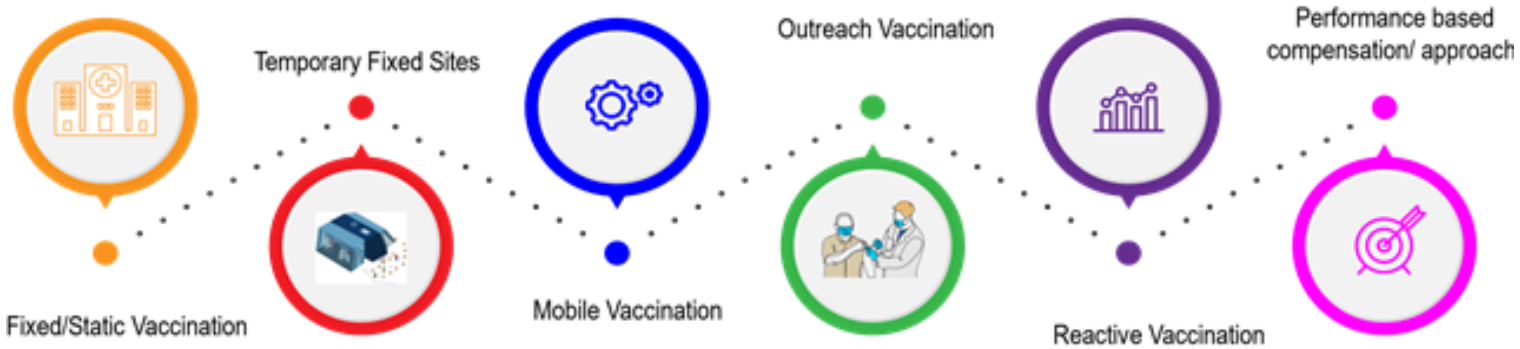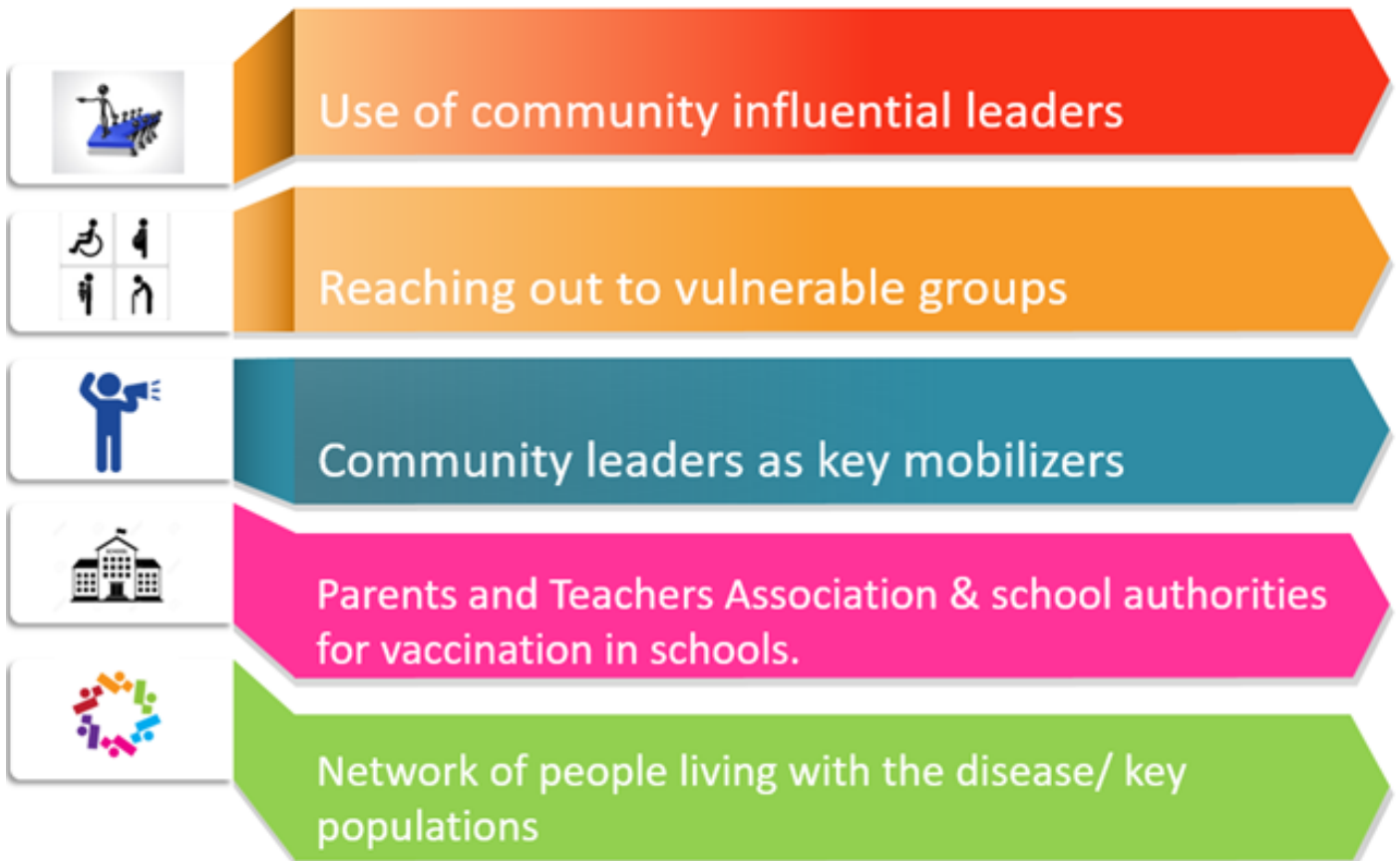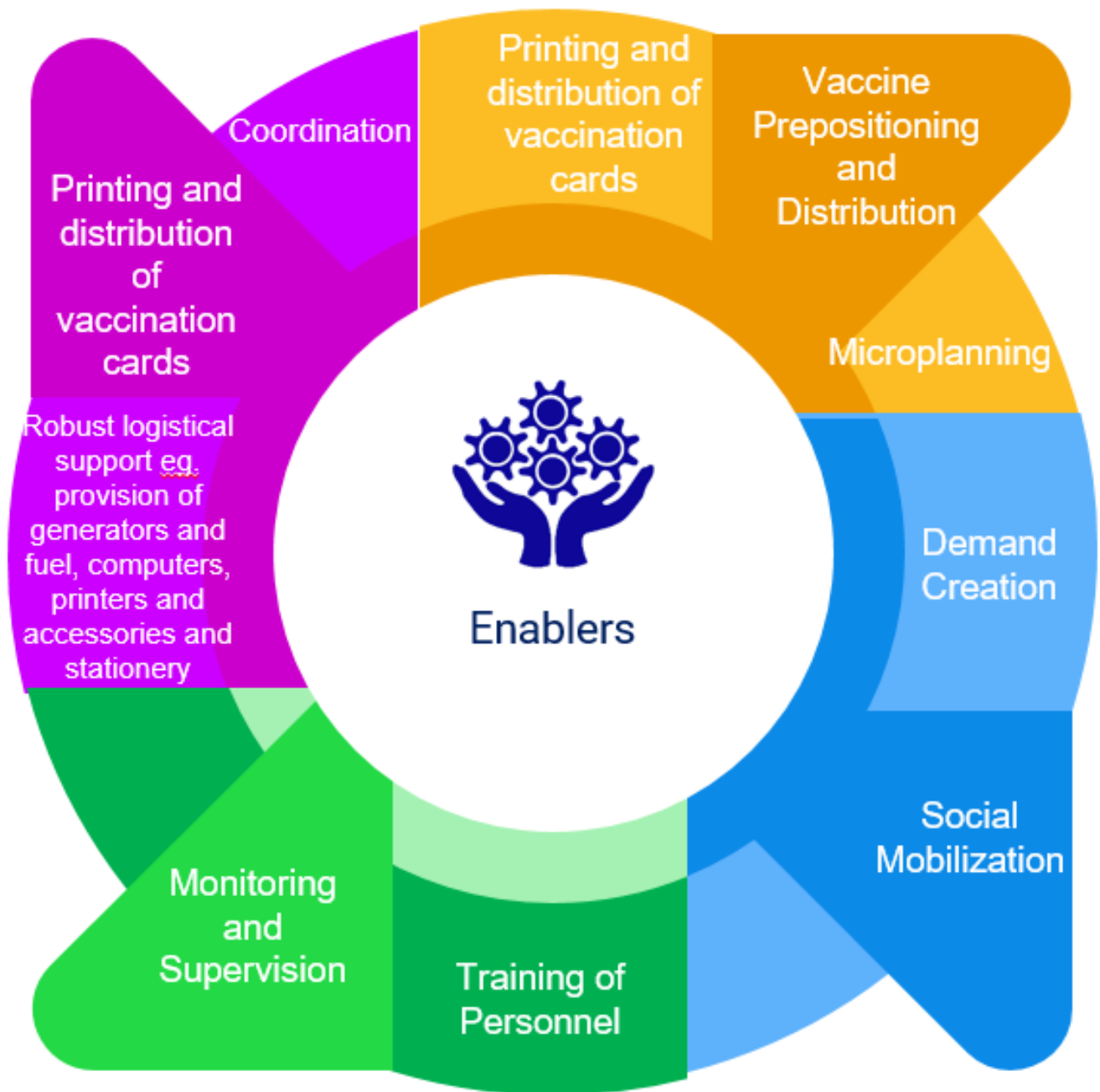# Strategies

a. Vaccine Delivery

Figure 3: Cumulative COVID-19 cases January-31 December 2022

b. Mobilization

Enablers

Most of the strategies and enablers above were deployed and guided the preparatory and implementation activities.

Preparatory Phase

Figure 4: COVID-19 vaccination mobilization at a high school in Grand Bassa

This section describes the strategies and activities conducted in preparation for rolling out the COVID-19 vaccination in Liberia:

1.Vaccine Delivery
- **Fixed/Static Vaccination sites**
  - These are primary vaccination sites (health facilities both public and private) These sites have capacity to stores vaccines and are used as main vaccination centers. Some of these facilities serve as secondary vaccine distribution sites.
- **Temporary Fixed Sites**
  - These are sites outside health facilities and allow clients to have access to vaccine closer to their locations without traveling long distances. These sites were identified/ designated by the County Health Teams and the Community to increase the vaccine delivery points. The number of vaccination sites was determined by use of data. This helped to estimate the resources for deploying the vaccines in each district and communities.

- **Mobile Vaccination**
  - This process involved the movement of vaccination teams from one vaccination point to another especially in the remote communities and reaching out to network of key populations as well as prisons.
- **Outreach Vaccination**
  - The outreaches are carried out in communities that were not adequately covered or people who were missed during the phase of the campaign.
- **Reactive Vaccination**
  - This approach was integrated with the community-enhanced surveillance during which voluntary testing, case management and vaccination were implemented in Montserrado and Nimba Counties. Circumscribed vaccination was conducted for all eligible people around a confirmed case. People who confirmed positive were not immediately vaccinated except those who were negative and not vaccinated at all.

2. Mobilization and Demand Creation

- Use of community influential leaders and other established community structures eg. Town criers
- Reaching out to vulnerable groups and hard to reach populations.
- Using community leaders as mobilizers (increased the uptake) ensured communities are adequately covered.

Two weeks prior to the start of the vaccination campaign, adequate engagement with County leadership, religious leaders, marketing associations, youth, and women groups, and civil society organizations was carried out to inform them about the campaign and its benefits to the population. To increase demand for the vaccine among the population, community health assistants (CHAs), community health volunteers (CHVs), community health services supervisors (CHSS), and community influential people such as town chiefs and town criers were incentivized on the spot as they mobilized unvaccinated people and informed the vaccination teams to vaccinate them. This process encouraged many community dwellers to get involved in demand generation in their respective communities. All the local radio stations were also incentivized to air and play COVID-19 vaccination messages in their local dialects. Prior to and during the campaigns, social mobilizers were deployed ahead of the vaccination teams to create awareness.

To motivate the people who received the vaccines, vaccination certificates were printed and issued as soon as someone receives the vaccine. Also, vaccine cards were readily made available for people who took the vaccine. This process reduced the delay in getting the vaccination certificates and reduced the stress of people looking for money to print their certificates in commercial internet cafes. This served as one of the motivating factors that increased the demand of the vaccine among the population as people used their proof of vaccination cards for travel and to apply for jobs in some places.

3. Micro-planning

With financial, logistical, and technical support, micro-plans were developed both at the district and health facility levels. In the micro-plans, target populations, number of teams, team members, vaccine doses and logistics were forecasted. Hard-to-reach communities and key populations were mapped. Anticipated challenges identified and addressed Cold chain challenges were identified, and solutions clearly laid down in the micro-plans.

4. Recruitment and deployment of vaccination team members

As community trust is needed to drive community initiatives, vaccination team members were recruited from their communities of residence. Other criteria for recruitment included: good moral character and trust by the community members. Community dwellers and their chiefs were asked to nominate people from their respective communities who could be trusted and be ably trained to form part of the vaccination teams. These nominated people were trained and assigned to their own communities where they can speak the local language and relate to the residents very well. It is important to note that vaccinators are trained health workers who normally administer the vaccines in those districts/ communities. This strategy helped reduced vaccine hesitancy and denial and increased demand and uptake.

5. Training of vaccination teams

In order to improve the knowledge and skills of the vaccination teams and build their self-confidence, they were trained and/or refreshed each time the vaccination campaigns were scheduled. A total of 1625 teams were trained in WHO-supported counties with Montserrado having the highest number of trainees partly due to size of the population. Updated information about the vaccines were clarified and skills on vaccine administration improved. Teams were also informed on the adverse events and how they are identified, documented, and reported.

Personnel trained for COVID-19 vaccination in the WHO supported counties							
County	Vaccinators	Mobilizers	Recorders	Supervisors	Data clerks	Monitors	Coordinators	Total Cadre/County
Grand Bassa	39	39	39	25	12	18	10	182
Nimba	222	160	99	45	21	12	12	571
Sinoe	194	82	97	35	10	16	6	440
Mary Land	35	35	35	44	10	6	5	170
Montserrado	700	120	350	50	29	350	14	1,613
Lofa	93	60	87	35	16	30	12	333
Total	1283	496	697	194	121	388	38	3,217
Grand total	2,566	992	1,404	428	219	820	97	6,526

6. Prepositioning of vaccines and logistics

To get the vaccines and logistics to the point of utilization, WHO provided logistical support for the movement of the vaccines from national and regional depots to the districts, health facilities, and outreach teams. Availability of adequate logistics was critical in reaching rural communities due to the bad road network.

7. Coordination, Advocacy, and partnership

The Government of Liberia demonstrated solid political commitment and leadership and provided the enabling environment for a successful response to the COVID-19 pandemic. The leading governance architecture, including the Special Presidential Advisory Committee (SPACCO), National Response Coordinator, and the Incident Management System (IMS), were critical in driving the implementation of the COVID-19 response, including COVID-19 Vaccination activities.

Figure 6:Commited WHO Staff in the field-taking vaccines to the people

WHO continued to support the government in the counties where it has field presence. This is mainly in Montserrado, Nimba, Lofa, Grand Bassa Maryland,and Sinoe county In December, WHO was requested to support Margibi county for the sole purpose of increasing the vaccination coverage in that county.

This arrangement is intended to provide hands-on technical support for the planning, implementation, monitoring and supervision of COVID-19 vaccination in addition to other priority health programs. These field offices were critical in supporting the County Health Teams (CHTs) to coordinate the delivery of health services and increase overall preparedness and response to public health threats.

Vaccine acquisition and delivery

The Game changers

This section describes the game changer utilized by WHO in achieving the 90% and above coverage in its six counties. These include the following:

1. Robust Cold chain, Logistics, and Operational Support

WHO provided vehicles, gasoline, scratch cards, generators, computers, printers, stationery items, and rain gear for the team members and all supervisors. In addition, vaccines were timely delivered to districts and vaccination teams.
vaccination cards and certificates were issued on spot to people who have taken the vaccines. This process reduced the delay in getting the vaccination certificates and reduced the stress of people looking for money to print their certificates in commercial internet cafes.

2. Monitoring, Supervision, and Reporting

County-led innovative supervisory checklists were developed and used by supervisors to track vaccination teams' performances and provided corrective actions. The tool was also intended to hold the supervisors accountable for their work and to ensure the success of the vaccination. Each day, each supervisor was required to provide feedback to the district and the district provided supervisory feedback to the county on the vaccination exercise, identifying gaps and solutions highlighted to remedy the problem.

3. Data Entry and Management

The availability of ICT equipment, coupled with WHO support of communication cards and constant source of electricity (generators and fuel), enabled the county health teams to readily implement the data entry processes. WHO created a Google Sheet that facilitated real time data management for decision making.

4. Performance Based Compensation

This strategy is based on a compensation for every target achieved by the vaccination teams. This motivated the team to achieve set targets even before the set deadlines. With this initiative, each team was able to reach the set targets in the assigned community. Once supervisors had confirmed that the number of people expected to be vaccinated had been reached, vaccines accounted for, and data fully entered in the portal, the vaccination team was paid through Mobile money.

5. Mobile Money

This electronic cash transfer system ensured complete and timely renumeration of vaccination teams and supervisors. Money is paid directly to accounts of an approved recipient for the service rendered. Vaccination teams received the amount of money entitled for their work timely.

Chapter 2
Results

COVID-19 vaccination coverage

This section shows the segregation of data from all counties followed by the seven counties supported by WHO.

Table 1: Overall performance of COVID-19 vaccination in Liberia per county

County	Total Population	J&J	J&J Booster	AZD1222 Dose 2	AZD1222 Dose 1	AZD1222 Booster	Pfizer Dose 1	Pfizer Dose 2	Pfizer Booster	Booster Total	Number of Persons	Grand Total	FV Coverage
Boml	112,526	55,031		587	671		10578	2980		0	58598	69847	52%
Bong	446,099	302,005		1746	3203		70547	23889		0	327640	401390	73%
Gbarpolu	111,548	34,464		330	945		5261			0	34794	41000	31%
Gr. Bassa	296,560	247,255		1892	2675	1	37079	23068		1	272215	311970	92%
Gr. Cape Mt	169,990	55,326		750	1082		12138			0	56076	69296	33%
Gr. Gedeh	167,558	50,382		1143	3591		5543	1396		0	52921	62055	32%
Gr. Kru	77,470	23,409		689	740		8545	5571		0	29669	38954	38%
Lofa	370,361	286,260	1	3384	4000		48363	48633		1	338277	390641	91%
Margibi	280,815	215,497		20002	26559	1	70571	23312		1	258812	355942	92%
Maryland	181,845	126,029	4	1221	5206		45472	39458		4	166712	217390	92%
Montserrado	1,495,876	1,146,631	52	58785	66892	14	184439	200294	1912	1978	1405710	1659019	94%
Nimba	618,054	497,656	1	5835	8850		70852	62117		1	567805	645312	92%
River Gee	95,657	19,810		718	815	1	3573	3188		1	27458	28105	29%
Rivercess	89,345	20,970		293	645		7044	4389		0	25652	33341	29%
Sinoe	136,970	105,064		445	619		21028	21196		0	126705	148352	93%
Liberia	4,650,676	3,185,789	58	97,820	126,493	17	601,033	459,491	1,912	1,987	3,749,044	4,472,614	81%

Table 2: COVID-19 vaccination performance for WHO supported counties.

County	Total Population	J&J	J&J Booster	AZD1222 Dose 2	AZD122 2 Dose 1	AZD1222 Booster	Pfizer Dose 1	Pfizer Dose 2	Pfizer Booster	Booster Total	Number of Persons Fully Vaccinated	Grand Total	FV Coverage (Total Pop.)
Grand Bassa	296560	247255		1892	2675	1	37079	23068		1	272215	311970	92%
Lofa	370361	286260	1	3384	4000		48363	48633		1	338277	390641	91%
Margibi	280815	215497		20002	26559	1	70571	23312		1	258812	355942	92%
Maryland	181845	126029	4	1221	5206		45472	39458		4	166712	217390	92%
Montserrado	1495876	1146631	52	58785	66892	14	184439	200294	1912	1978	1405710	1659019	94%
Nimba	618054	497656	1	5835	8850		70852	62117		1	567805	645312	92%
Sinoe	136970	105064		445	619		21028	21196		0	126705	148352	93%
Liberia	3,380,481	2,624,392	58	91,564	114,801	16	477,804	418,078	1,912	1,986	3,136,236	3,728,626	93%
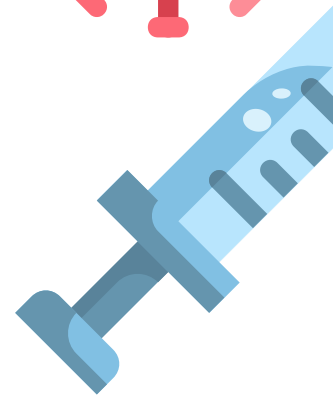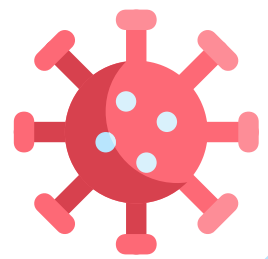
Figure 8: Geographic performance of COVID-19 vaccination in Liberia

Total coverage/county
- ≤ 59% (7 counties)
- 60 - 89% (1 county)
- ≥ 90% (7 counties)
- ★ County Capital
- WHO Liberia Country Office
- WHO Field Team Offices
- Primary roads
- County Boundary
- International Boundary

Percentage of COVID-19 Fully Vaccinated People in Counties of Liberia, 10-December-2022

53% Female Fully Vaccinated

47% Male Fully Vaccinated

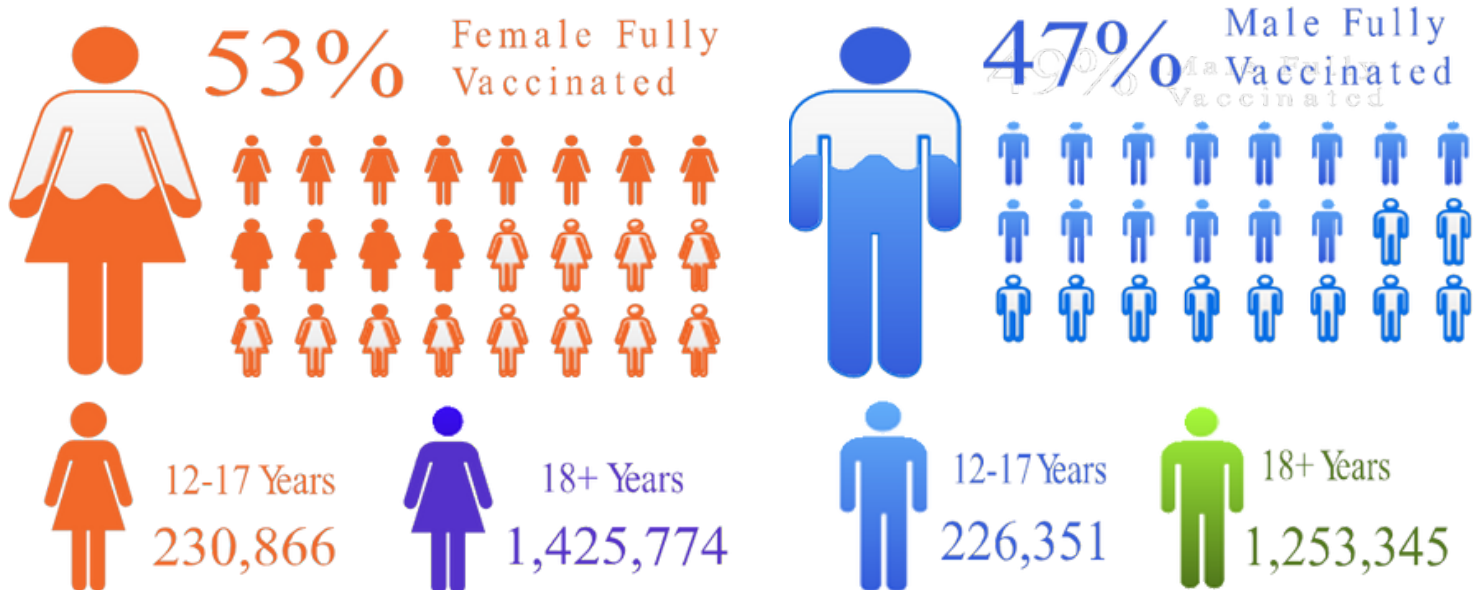| 12-17 Years	18+ Years	12-17 Years	18+ Years
230,866	1,425,774	226,351	1,253,345

Figure 9: Disaggregation of COVID-19 vaccination by gender and age based on WHO-supported counties

Counties	Disadvantaged Youth(3)		Elderly(2)		Health Workers (1)		Inmates		Refugees	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Grand Bassa	576	985	2983	5670	978	1269	31	68	0	0
Lofa	1	58	3667	4481	356	536	71	18	0	0
Margibi	120	23	12211	11780	389	423	276	45	0	0
Maryland	159	10	3025	4398	793	689	0	0	553	843
Montserrado	2991	1028	44497	53618	2900	3100	0	0	0	0
Nimba	0	0	0	0	1529	1375	175	0	5326	2794
Sinoe	151	0	2238	2917	281	139	17	1	0	0
Grand Total	3998	2104	68621	82864	7226	7531	570	132	5879	3637

Table 4: Disaggregation of COVID-19 vaccination by special category/groups

County	AIDS (PLWAs)		Diabetes		Hypertension		Tuberculosis	
	Male	Female	Male	Female	Male	Female	Male	Female
Grand Bassa	167	521	372	457	780	496	215	259
Lofa	347	424	326	217	1534	1254	571	245
Margibi	0	0	0	0	0	0	0	0
Maryland	521	167	0	0	0	0	259	215
Montserrado	538	380	90	276	112	102	7	12
Nimba	600	1219	0	0	1368	1038	336	174
Sinoe	683	196	106	61	467	336	0	0
Grand Total	2856	2907	894	1011	4261	3226	1388	905

Table 5: Disaggregation of COVID-19 vaccination by people with co-morbidities

Impact of COVID-19 on routine immunization

Vaccine Accountability

COVID-19 VACCINES ACCOUNTABILITY IN THE 06 COUNTIES SUPPORTED BY WHO AS OF 31 DEC 2022

Antigen	County	Qty received	Qty used	People Vaccinated	Qty expired	Wastage	Balance
Astra Zeneca	Grand Bassa	5,300	5,000	4,568	0	9.70%	0
	Nimba	15,410	15,410	14,685	0	9.60%	0
	Sinoe	1,200	1,200	1,064	0	1.80%	0
	Mary Land	6,580	6,580	6,427	0	2.00%	0
	Montserrado	134,050	126,270	125,691	7,780	0.80%	0
	Lofa	7,490	7,490	7,384	0	1.40%	0
Total		170,030	161,950	159,819	7,780	1.43%	0
J&J	Grand Bassa	249,790	249,730	247,255	0	1.00%	0
	Nimba	509,785	509,785	497,657	0	4.80%	8,960
	Sinoe	110,590	110,160	105,064	0	1.70%	4,395
	Mary Land	134,450	132,780	126,033	0	4.10%	5,670
	Montserrado	1,151,817	1,151,817	1,146,683	0	0.90%	0
	Lofa	286,661	286,661	286,261	0	0.70%	0
Total		2,443,093	2,440,933	2,408,953	0	8.89%	19,025
Pfizer	Grand Bassa	65,552	65,532	60,147	0	8.20%	0
	Nimba	134,924	134,024	132,969	0	2.90%	0
	Sinoe	50,252	48,976	42,224	3,276	7.70%	0
	Mary Land	92,160	85,428	84,930	0	11.00%	0
	Montserrado	392,482	332,482	386,645	3,500	3.50%	0
	Lofa	98,738	98,738	96,996	0	2.60%	0
Total		834,108	765,180	803,911	6,776	13.77%	0
Ground total		3,447,231	3,368,063	3,372,683	14,556		19,025

Table 6: Routine Immunization Coverage in Liberia, 2019

Impact of COVID-19 on routine immunization

The COVID-19 Pandemic has led to disruptions in routine health services, negatively impacting immunization services.   For example, the WHO UNICEF Best Estimate (WUENIC) measles coverage in 2018 was 74% and 68% in 2019, compared to 61% in 2020 and 58% in 2021[1]. In addition, the disruption in immunization services has led to the resurgence of vaccine-preventable diseases (VPD), including the ongoing measles outbreak with fatal consequences (6,789 confirmed measles cases with 79 deaths (CFR=1.2%) from 62 out of 93 health districts across the 15 counties and 883 cases of Pertussis with no death from 3 counties between 17th November 2021 to 18th September 2022).

County	BCG	OPV1	OPV3	Penta 1	Penta 3	PCV 1	PCV 3	Rota 1	Rota 2	MCV1
Bomi	86%	91%	79%	92%	85%	92%	84%	90%	77%	87%
Bong	98%	101%	93%	101%	90%	101%	91%	98%	83%	93%
Gbarpolu	68%	78%	71%	78%	70%	82%	70%	76%	64%	70%
Grand Bassa	109%	99%	86%	99%	82%	96%	83%	95%	70%	81%
Grand Cape Mount	85%	94%	88%	94%	83%	95%	84%	91%	70%	87%
Grand Gedeh	83%	94%	84%	96%	84%	96%	84%	91%	75%	73%
Grand Kru	87%	86%	83%	88%	78%	87%	77%	86%	69%	88%
Lofa	88%	107%	100%	107%	90%	106%	91%	105%	85%	100%
Margibi	97%	96%	86%	95%	83%	95%	83%	95%	82%	87%
Maryland	68%	81%	78%	82%	77%	82%	76%	79%	69%	71%
Montserrado	89%	87%	81%	88%	78%	87%	77%	81%	68%	78%
Nimba	98%	103%	98%	104%	89%	105%	90%	96%	77%	100%
River Gee	66%	83%	82%	83%	72%	83%	73%	79%	63%	91%
Rivercess	85%	85%	82%	86%	73%	86%	74%	82%	63%	85%
Sinoe	95%	99%	94%	99%	87%	99%	86%	97%	84%	87%
Grand Total	91%	94%	87%	94%	82%	94%	82%	90%	74%	86%

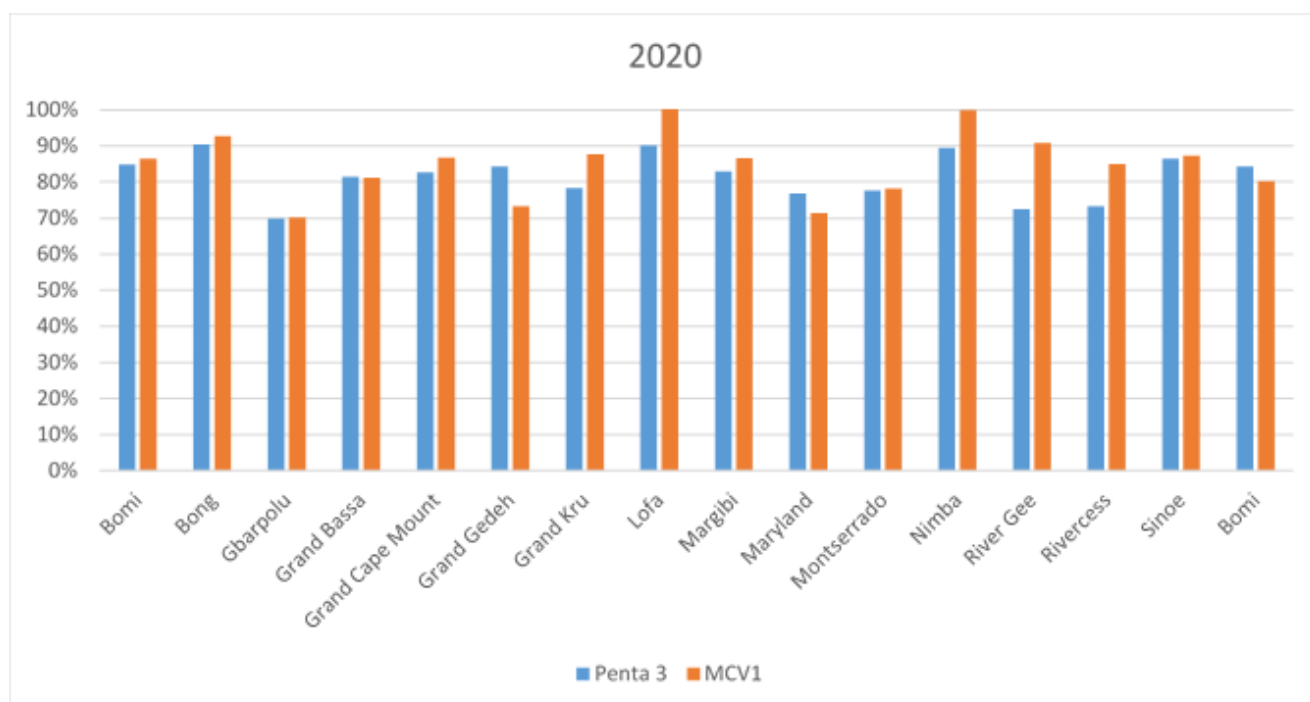Table 6: Routine Immunization Coverage in Liberia, 2019

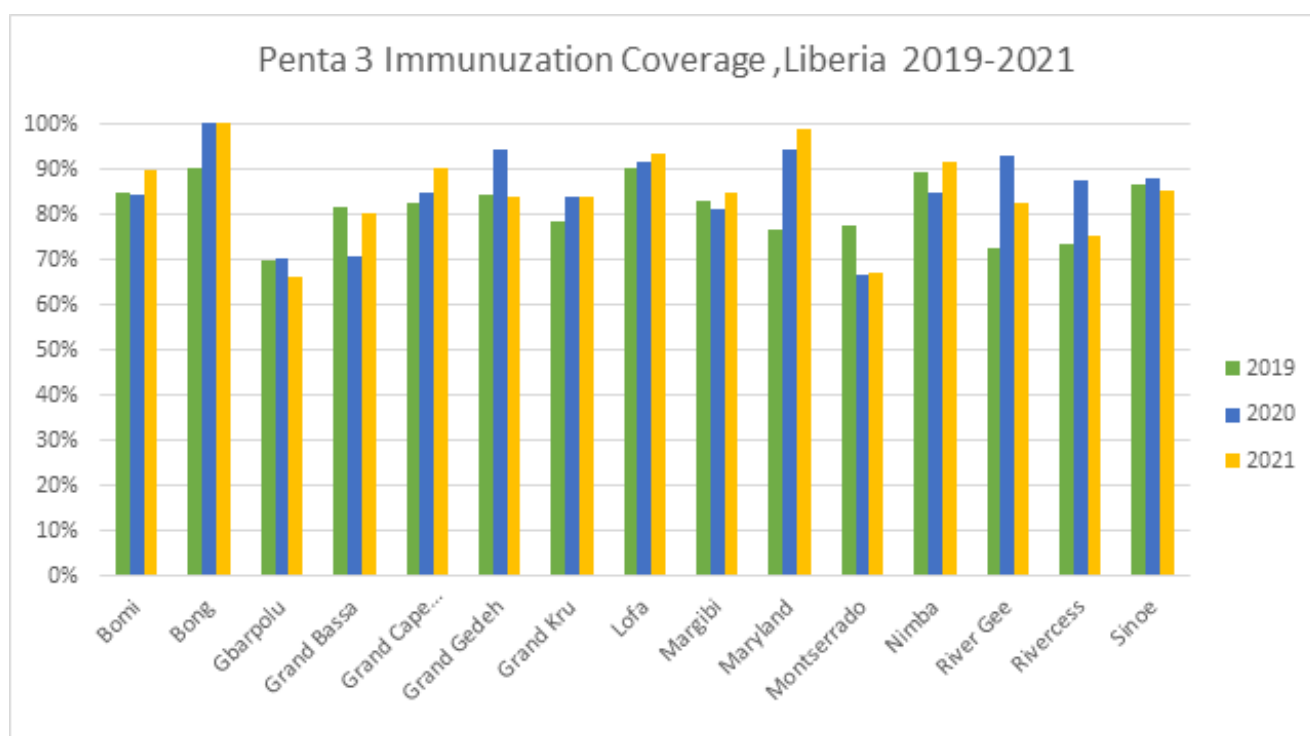Figure 11: Immunization coverage across Liberia for Penta 3 and MCV 1, 2020

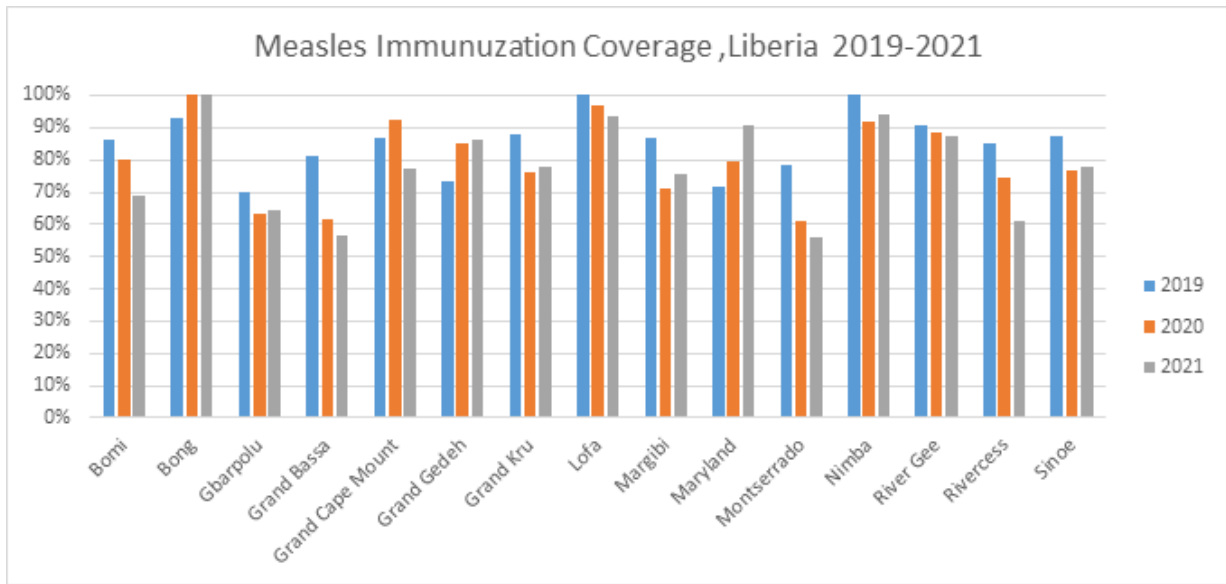Figure 12: Penta 3 Immunization coverage 2019-2021

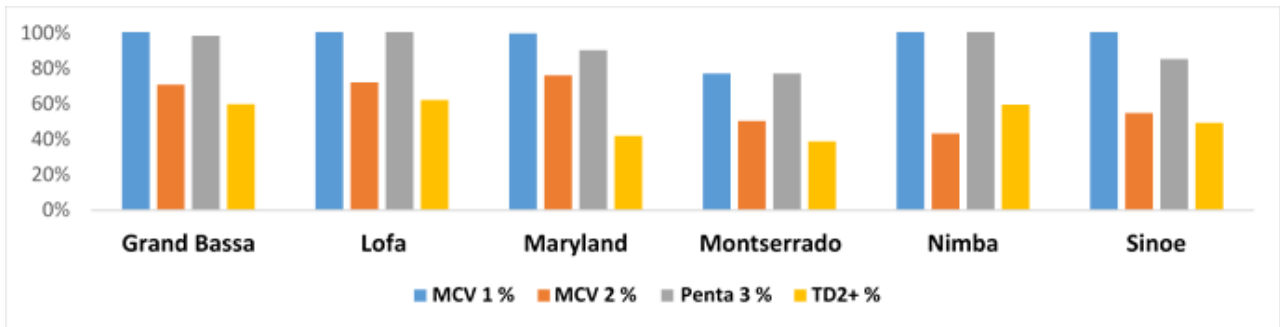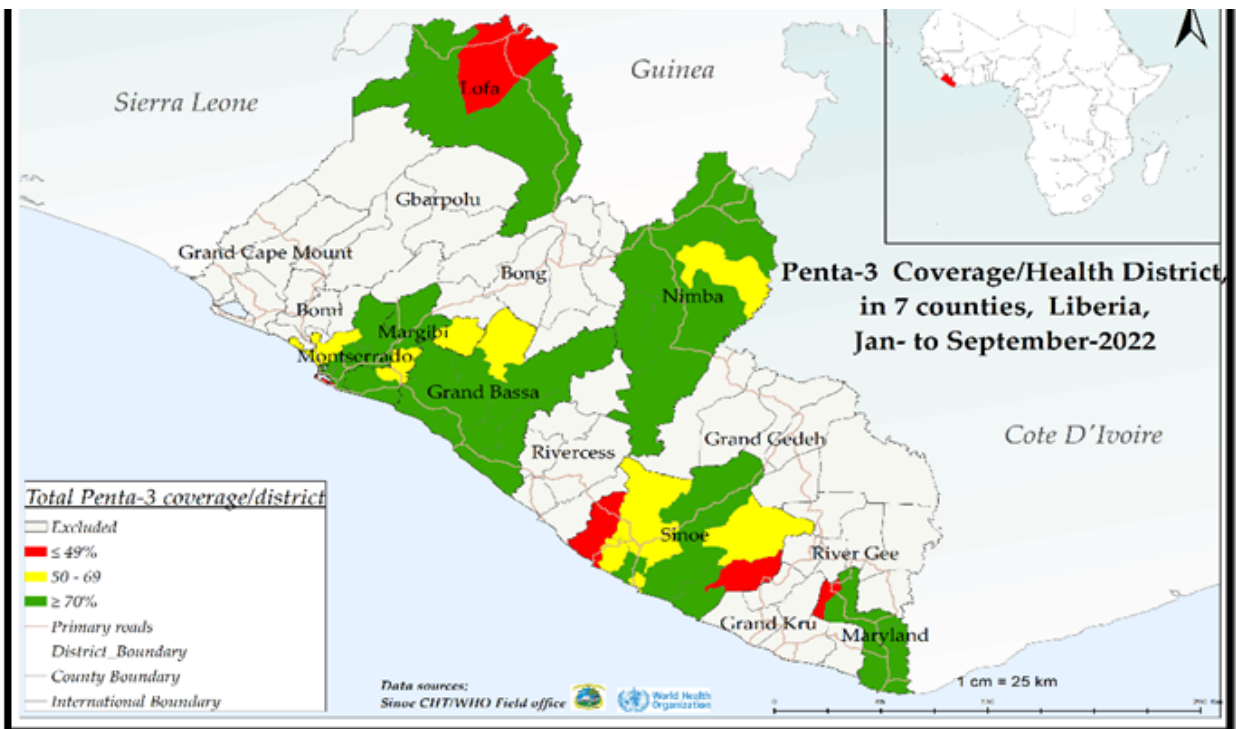Figure 13: Immunization Coverage 2019-2021

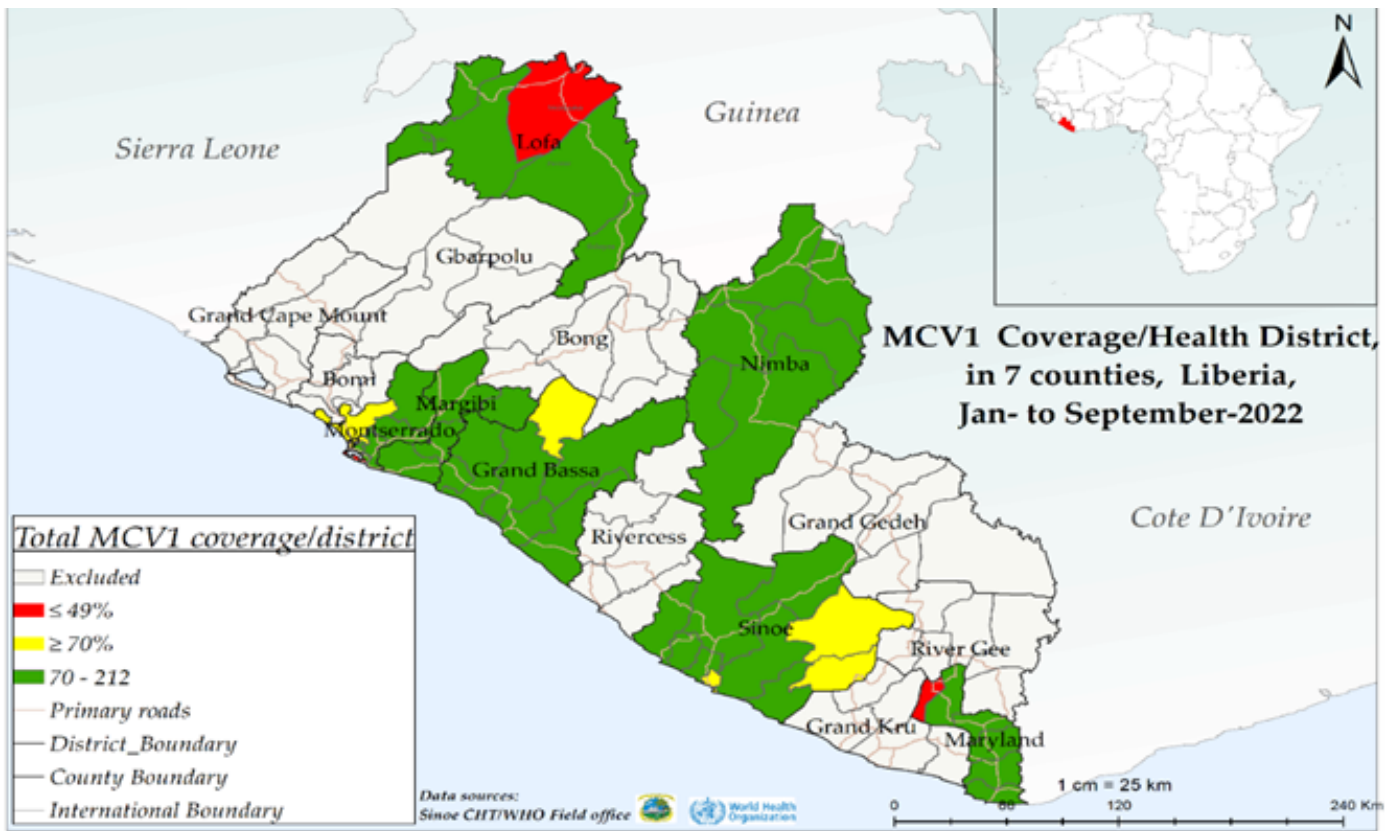Figure 14: Immunization coverage MCV1, MCV2 and Penta 3

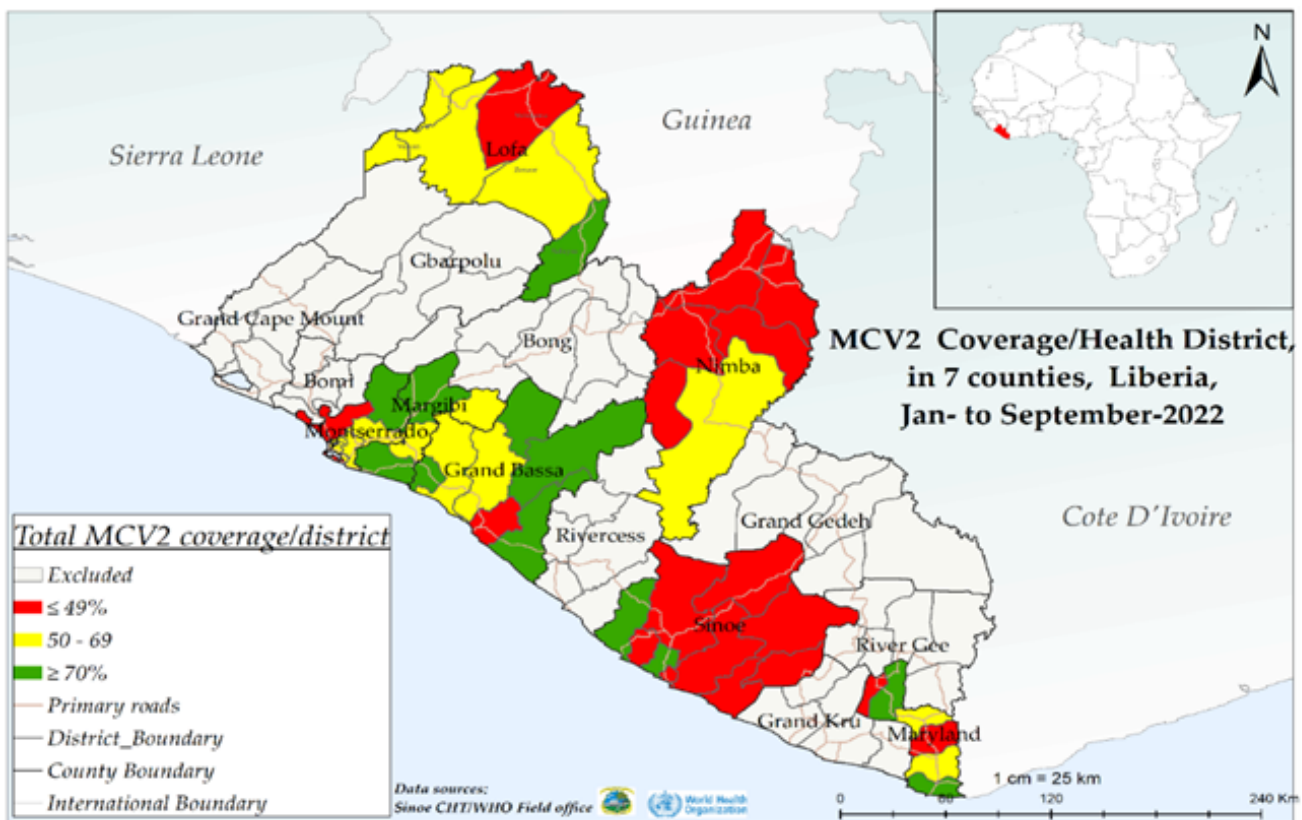Figure 16: Map showing Measles Immunization coverage 2022.

Figure 17: Map showing the Measles 2 immunization coverage in 2022.

The findings from the National Comprehensive Expanded Program on Immunization (EPI) review indicate critical gaps that need to be addressed to strengthen routine immunization services in the country. Key catch-up strategies include outreaches and Periodic Intensification of Routine Immunization (PIRI) to address missed opportunities for vaccination; to bridge the gap in routine immunization and COVID-19 vaccine coverages; to address logistical challenges for the administration of vaccines; to develop the national immunization recovery plan and to strengthen the surveillance for VPDs, COVID-19, Adverse Effect Following Immunization (AEFI).

Challenges

1. Vaccine stock outs and shortfalls in the inventory processes affected the flow of the vaccination campaign in some areas. Sub-optimal delivery of vaccines from the depots to the counties affected the vaccination exercise flow. This was the major challenge across all counties– the month of May was hardly hit with stockouts.
2. Poor access to some communities due to bad road networks which delayed the supply of vaccines from regional cold chain stores to counties.
3. Intermittent internet connectivity sometimes delayed the generation of codes for the printing of vaccination certificates.
4. Concurrent outbreak of measles overstretching the human resource capacity in the counties.
5. Frequent cross border movement including multiple and official entry points led to missed opportunities to vaccinate the eligible populations.
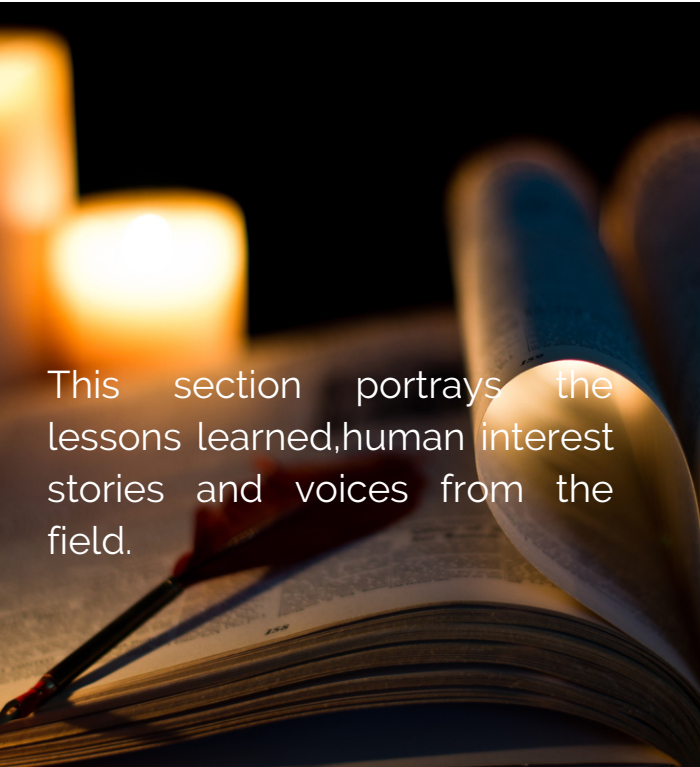

Figure 10 Reaching the last mile despite poor road networks

Chapter 3

Lesson learned, Human Stories and Voices from the Community and Partners

This section portrays the lessons learned, human interest stories and voices from the field.

Figure 9: A student at G.W. Gibson High School expresses her excitement after receiving her vaccine

1. Assigning counties among key partners and the active involvement of influential leaders at the community level accelerated vaccine uptake and improved vaccine deployment.

2. Developing and implementing robust County, district, and health facility micro-plans improved the achievement of results.

3. Ensuring the availability and regular supply of vaccines to the last mile.

4. Applying a performance-based strategy/ approach improved demand generation, increased motivation, and accountability.

5. Issuing prompt vaccination cards and certificates increased trust and vaccination coverage.

6. Parenting of county supervisors whereby a supervisor was assigned an entire county: District supervisors who performed poorly were replaced; county supervisors were deployed in the affected districts for the entire campaign to enhance performance.

7. Recognizing the work of the CHTs and partners through the presentation of Awards and Certificates motivated the CHTs and WHO field teams.

Human Interest Stories

Alice Sumaz, Battery Factory Community- Monsterrado County

IMy name is Alice Sumazer from Battery Factory Community. I saw the covid 19 vaccine not good for my family but after my brother came down with the virus, and I heard all the health workers telling him ,if he was not going to be vaccinated ,he was going to die ,I then said to myself that the vaccine is good and not harmful .Therefore I encouraged my family to be vaccinated and today I can tell other Liberians to make use of the vaccine to keep protected

Jerrys S. Bahway, a community leader for Juah'S Town community- Grand Bassa County

I am Jerrys S. Bahway, a community leader for Juah'S Town community. At first, I though the whole idea of COVID-19 was a fake news in Liberia because the information on the international news about COVID -19 was quite different from what was unfolding in Liberia. I decided not to take the vaccine at all. On one faithful day, all the community leaders were called to COVID-19 awareness meeting by the CHT which was supported by WHO. In that meeting, all the information about COVID-19 and vaccination were clarified. Immediately, I was encouraged to be vaccinated and received my VRN code right at the vaccination site. I went back in my community and encouraged many to be vaccinated as well.

I am Bendu Karngar, a 12th grade student from W.P.L Brunskine high School, I got vaccinated on campus and did not experience any side effect after the administration. Most of my school mates took the vaccine the next day because I broke the storm to be vaccinated.

Bendu Karngar-12th grade student-W.P,L Brunskine High School-Grand Bassa County

Figure 10: Students at a school display their vaccination cards

Voices from the Community and Partners

Lassana Jabateh, Director of Community Health PIHL- Maryland County

At PIH, we work in partnership with rural, impoverished communities — helping them to advocate for and realize their right to health. Together with the Government, we are building resilient, responsive systems in Maryland County. We know that health is everybody's business. In our fight against COVID-19, we joined the Ministry of Health, Ministry of Education, Ministry of Internal Affairs, WHO, community-based organizations, local leadership, and religious and traditional healers to raise awareness and promote COVID-19 vaccination. We are proud that we reached 91% of our population, fully vaccinated in October 2022. We won't rest until all communities are protected. Community Health Promoters and other community cadres will continue to reach every school and household, encouraging eligible populations to take the vaccine and make other healthy decisions. Maryland will be a model county for universal health care and COVID-19 vaccination coverage.

Dr. Methodius George, CHO, Maryland County

In April 2020, I can record Maryland County reported her first COVID-19 case. It was challenging but having had the experience from the Ebola outbreak, I was able to set up the response team with support from WHO & PIH to quickly respond. The strong coordination with partners, local authority, and community engagement calmed the outbreak. The experience gained over time and the system built, we launched COVID-19 vaccination in 2021 with low uptake despite the effort made. The team continues to engage the community to have them protected. Not until March 2022, with the massive support from WHO the team (CHT & partners) going all out to engage and vaccinate the community members, we saw a dramatic change in COVID-19 vaccine uptake that led us to achieve 91% of the population fully vaccinated. Together we can defect COVID-19 through vaccination of the population.

Dr. Methodius George, CHO, Maryland County

Hon. Nelson N. Korquio Superintendent , Nimba County.

AThe county adminstration as a whole took their vaccines and engaged the citizenry who came through for their vaccination as a result of the awareness done by us. I am proud of this achievement. We appreciate the WHO family as a whole for the support. We continue to advocate for more people in the community to get vaccinated. Every sector in Nimba was involved in raising awareness including the community radios that played a great role. A big thank you to all our partners once again including WHO.

Chapter 4
Prospectives for 2023 on immunization

Figure 11: WHO Representative congratulates the COVID-19 task force Chairperson for her able leadership.

WHO will continue to work with the government to support the sustenance of high vaccination coverage against COVID-19 and facilitate the integration of COVID-19 into routine immunization. Other priority areas of of focus include:

2023 Prospectives for Immunization in Liberia

Introduction of pediatric vaccine to cover 5-11 years of age against COVID-19

Strengthening of the health system by leveraging on COVID-19 vaccination integration into routine immunization

Introduction of the new malaria vaccine for continuity of strengthening essential health services for under 5
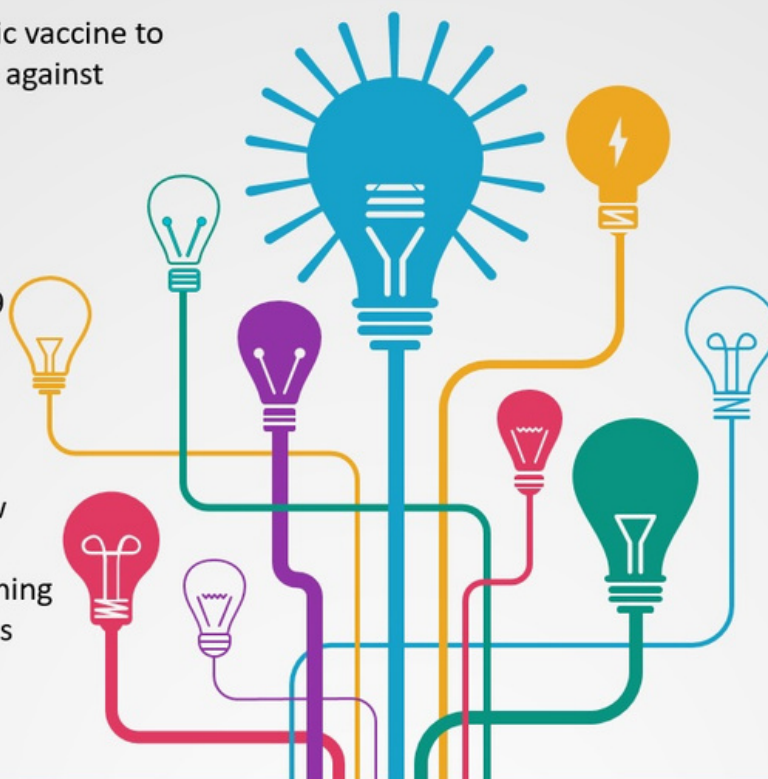
Administration of booster doses to enhance protection of the population against COVID-19

Supporting the Ministry of Health on COVID-19 vaccination for low performing counties to reach the unreached

Brokering and engaging the gov't on co-financing for improving access to essential healthcare services.

Acknowledgement

We express our heartfelt gratitude to the Government of Liberia (GoL), the Ministry of Health, County Health Teams, the communities, and partners who contributed to the success of vaccinating the people of Liberia.

Our sincere thanks and appreciation go out to the German and American governments, the European Union, the French government, the UN system and the COVAX Partnership for providing the necessary vaccines and funds for the entire vaccination exercise.

Special thanks to the WHO field colleagues for the expertise and dedication they provided which has been instrumental in the achievement of this milestone. Your commitment has enabled us to turn our vision into a reality.

Finally, we would like to acknowledge the tireless efforts of our team of WHO staff at the country, regional and Global levels who worked relentlessly to ensure this exercise was a success. Thank you for your unwavering commitment to saving lives and promoting good health and well-being. Your support will always be appreciated.
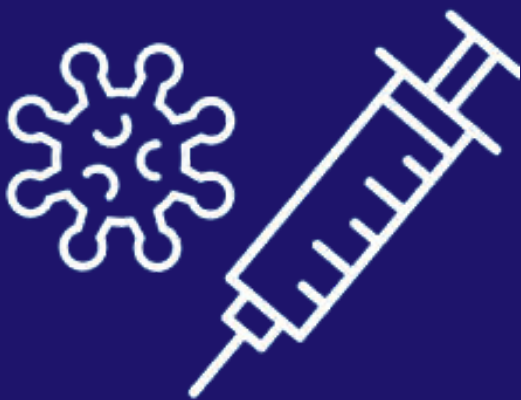
VACCINES SAVE LIVES

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