EMERGING FROM OBSCURITY TO AUTHORITY:

Assessing Sexual and Reproductive Health and Rights in four Counties

Preliminary Report by:

Center for Population and Reproductive Health

December 2, 2024

Research Team:
Mbalu W. Jusu
Nya Parwon
Kaa Williams

Cover Photo by:
CPRH

Copyright© CHI 2024
All rights reserved. No part of this publication may be used or reproduced in any manner without written permission of the Institute except in the case of brief quotations embodied in critical articles and reviews.

Disclaimer:
CHI accepts no responsibility for suitability of any materials submitted by the contributors of this publication. CHI assumes no responsibility or liability for errors or inaccuracies. The author accepts all responsibility for opinions expressed. Use of this research report constitutes acceptance and understanding of these disclaimers.

For more information, write to:
Community Healthcare Initiative (CHI)
Kpan's Town, Mamba Kaba District
Email: info@chiliberia.org
Website: www.chi.org
Tel: (+231) 886-593-202/777-213-269

Cite as:
Community Healthcare Initiative (CHI), (2024): *Sexual and Reproductive Health and Right in Liberia. An Exploratory Research in four counties of Liberia*.

CONTENTS

TABLES AND FIGURES iii
ACKNOWLEDGEMENT...vi
EXECUTIVE SUMMARY...vii
1 INTRODUCTION
1.1 Survey Objectives 1
1.1.1 General Objective...2
1.1.2 Specific Objectives...2

2 RESEARCH IMPLEMENTATION
2.1 Sample Design...3
2.2 Questionnaires.... 4
2.3 Training of Field Staff 5
2.4 Pretest...5
2.5 Fieldwork 5
2.6 Data Processing... 6

3 RESEARCH FINDINGS
3.1 Response Rates 7
3.2 Background Characteristics of Respondents..8
3.2.1 Age Structure..9
3.2.2 Marital Status..10
3.2.3 Residence...10
3.2.4 Educational Attainment 10
3.2.5 Occupation...11
3.3 Theme 1: Availability and Accessibility of SRH Services.......................13
3.3.1 Available SRHR services..13
3.3.2 Accessibility of SRH Services...14
3.3.3 Barriers to SRH Services..16
3.3.4 Role of men about SRH services..17
3.4 Theme 2: SRHR Knowledge, Attitude and Behavior (KAB).....................18
3.4.1 SRHR Knowledge...18

3.4.2 Attitude towards SRHR..19
3.4.3 Behavior towards SRHR..20
3.5 Theme 3: Facility Resource Gaps and Quality of Care.................................21
3.5.1 SRH Available Services..21
3.5.2 SRH Service Utilization..21
3.5.3 Facility Resource Adequacy..22
3.5.4 Theme 4: Socio-Cultural Factors..22

4 RESEARCH RESULTS..23
5 CONCLUSION..26
6 RECOMMENDATIONS..27

REFERENCES..29

ANNEXES..30

A-1 Questionnaires

A-2 Distribution of Health Facility by County

A3 List of Health Facility by County

TABLES AND FIGURES

2 RESEARCH IMPLEMENTATION

Figure 2.1 Implementation Sequence..2

Table 2.1 Distribution of Sample Size by County, District and Household...........4

3 RESEARCH FINDINGS

Table 3.1 Results of Community and Facility Surveys......................................7

Figure 3.2.1 Research Population Pyramid..9

Table 3.2.1 Distribution of Respondents by Background Characteristics...........12

Figure 3.3.1 SRH Accessibility Score..15

Acronyms/Abbreviations

ANC:	Antenatal Care
CAPI:	Computer-Assisted Personal Interviewing
CHI:	Community Healthcare Initiative
CPRH:	Center for Population and Reproductive Health
DHS:	Demographic and Health Survey
FGD:	Focus Group Discussion
GBV:	Gender-Based Violence
IPPF:	International Planned Parenthood Federation
IRB:	Internal Review Board
HIV:	Human Immunodeficiency Virus
KII:	Key Informant Interview
LISGIS:	Liberia Institute of Statistics and Geo-Information Services
MCH:	Maternal and Child Health
NPHC:	National Population and Housing Census
PPS:	Probability Proportional to Size
SRH:	Sexual and Reproductive Health
SRHR:	Sexual and Reproductive Health and Rights
STIs:	Sexually Transmitted Infections
UHC:	Universal Health Coverage
UNFPA:	United Nations Population Fund
VSLA:	Village Savings and Loan Association
WHO:	World Health Organization
WRA:	Women of Reproductive Age

ACKNOWLEDGEMENT

The SRHR research was undertaken by CHI to assess the prevailing status of SRH/SRHR services in four targeted counties (i.e., Gbarpolu, Grand Bassa, Margibi and Montserrado). The research was conducted amid the realization that poor socio-economic conditions, geographical isolation, cultural norms, religious beliefs, limited access to quality SRH services, and the fragmentation of existing SRH services continue to contribute to unfavorable health outcomes among women and young people. In recognition thereof, the research sought to identify the range of available SRH services to local vulnerable populations, the rate at which SRH services are accessible to local vulnerable populations, and the level of uptake for such services among local vulnerable populations. In addition, the research pursued the identification of lingering socio-economic and cultural factors that affect access to reproductive health services among women and young people and assessed knowledge, attitude and behavior of women and young people towards SRHR. Conducted by the CPRH with support from CHI, the research augmented available and accessible information desired for designing and developing programs for SRH/SRHR.

The successful conduct of the research is anchored in the invaluable contributions of the several people and organizations that participated at various levels of implementation. To begin with, we acknowledge the support from CHI during the conduct of the research, and for providing the opportunity to have such a crucial health-related activity undertaken. The inclusion of Gbarpolu was significantly strategic for programmatic reasons. Gratitude is also expressed to the local health authority and frontline actors in Gbarpolu, Grand Bassa, Margibi and Montserrado for the cooperation extended the research teams. Moreover, we remain appreciative to all organizations that granted interviews to the research team particularly the MoH/FHD, MoGCSP, UNFPA, USAID, and WHO. Furthermore, we recognize the contributions of community leaders and focal persons who organized FGDs that provided valuable interactions and information and to all respondents for your time and consent. Finally, the IPPF is acknowledged for funding the research at such a crucial juncture in the evolution of SRH/SRHR in Liberia. Your support is laudable and will remain monumental to the annals of SRH/SRHR development in Liberia.

EXECUTIVE SUMMARY

Sexual and Reproductive Health, along with the associated rights, continue to gain relevance within development contexts. The assessment of the prevailing SRH/SRHR status in Gbarpolu, Grand Bassa, Margi, and Montserrado highlights the lingering variability that exists for the demand for SRH services among adolescent girls and women of reproductive age and the available supply of such services at institutional and community levels. There is a significant variation in the accessibility and availability of SRH services. Access to SRH services is significantly low averaging less than one SRH healthcare provider per 10,000 population of adolescent girls and women of reproductive age, and this situation is exacerbated by confounding factors such as cost of service, distance from health facility, limited information of available SRH services, and lack of respectful SRH services. Disparity in the availability of SRH services is pronounced and is more available to care-seekers aged 20-29 compared to other age groups. SRH services are disproportionately skewed towards family planning services leaving other SRH services more opportunistic than routine. Moreover, such services are more likely to be available in urban residents than rural residents.

Although some of the target population has easy access to services, others face considerable barriers. SRH services are largely service-related in comparison to social, cultural and religious factors. Limited SRH training, stigma, attitude of health workers and poor quality of care are more effective barriers to SRH services than cultural and religious beliefs. Notwithstanding, cultural and religious beliefs are more effective in sustaining misguided SRH perceptions amongst care-seekers, and these misconceptions continue to shape attitudes and behavior towards SRHR than otherwise anticipated. Knowledge of SRH/SRHR is predominantly reflective of contraceptive methods in comparison to the full gamut of SRH services. SRH/SRHR misconceptions continue to influence the cognition of adolescent girls and young women due to limitation in SRH educational opportunities. SRH/SRHR knowledge is tilted more towards community awareness campaigns which are limited both in scope and contents. This limitation continues unabated partly due to the lack of youth-friendly centers and the non-existence of structured platforms or media for comprehensive SRH/SRHR education.

1. INTRODUCTION

The Sexual and Reproductive Health and Rights (SRHR) exploratory research was commissioned by the Community Healthcare Initiative (CHI) for implementation across Gbarpolu in the North-western region, and Grand Bassa, Margibi and Montserrado counties in the South-central region of Liberia as part of the "Holistic SRHR for ALL" project. Funding for the research was provided by the International Planned Parenthood Federation (IPPF) and conducted by the Center for Population and Reproductive Health (CPRH). Data collection took place from November 12-20, 2024 followed by data analysis to determine findings. This preliminary report presents the findings from the research and will be followed-up with a comprehensive final report.

1.1 Research Context

Sexual and Reproductive Health and Rights (SRHR) are central to achieving gender equality, reducing poverty, and improving health outcomes globally. Defined by the World Health Organization (WHO) as a state of physical, emotional, and social well-being in all matters relating to the reproductive system, SRHR encompasses access to contraception, safe childbirth, prevention of sexually transmitted infections (STIs), and the right to make informed decisions regarding reproductive health (WHO, 2014). Despite international commitments, significant challenges persist in ensuring equitable SRHR access, particularly in low-income countries like Liberia.

Liberia faces high adolescent pregnancy rates, with 30% of girls aged 15-19 already having begun childbearing (DHS, 2020). Contributing factors include limited access to modern contraception, poor health infrastructure, and persistent socio-cultural barriers. In rural areas, gender norms and economic hardships further exacerbate inequalities, leaving adolescent girls and women of reproductive age underserved and vulnerable to preventable SRHR issues.

Globally, socio-economic disparities and entrenched gender norms perpetuate inequalities in SRHR access, impacting millions. In Liberia, these challenges are compounded by harmful practices such as early marriage and taboos surrounding discussions of sexual

health. Such barriers not only impede service utilization but also perpetuate stigma, especially for unmarried adolescents and marginalized populations (UNFPA, 2023).

This research, conducted by the Center for Population and Reproductive Health (CPRH) under the guidance of the Community Healthcare Initiative (CHI), seeks to provide a comprehensive analysis of SRHR services across Montserrado, Margibi, Grand Bassa, and Gbarpolu counties. Through a multi-level approach—examining community, health facility, and national factors—the study aims to identify actionable solutions to enhance service delivery and utilization.

1.2 SURVEY OBJECTIVES

1.2.1 General Objective

The overall objective of the research was to assess the current situations of SRH services in Gbarpolu, Grand Bassa, Margibi, and Montserrado counties.

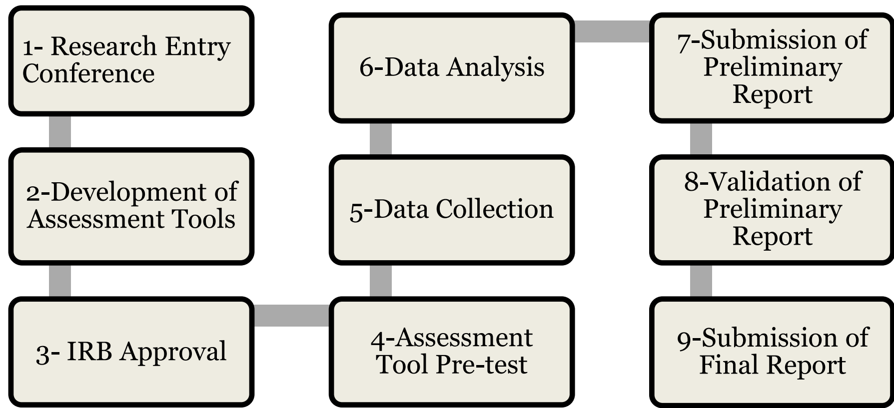
1.2.2 Specific Objectives

The specific objectives of the research were to gather the following information and data for analyses:

- Secondary data from the health statistics on service uptake or utilization for reproductive health services including maternal health, family planning, and STIs/HIV for reproductive-age women and young people (15-24) at the county-level;
- Information on knowledge, attitude, and behavior toward sexual and reproductive health and rights among women of reproductive age (15-49) and young people (15-24) in and out of schools;
- Assess quality of services for prevailing sexual and reproductive health services provided locally for women of reproductive age and young people (15-24); and,
- Assess the availability of, and accessibility to quality sexual and reproductive health services, specifically related to maternal and child health, family planning, and STIs/HIV, for reproductive-age women and young people (15-24); and,
- Other SRHR-related information relevant to the research.

2 RESEARCH IMPLEMENTATION

Figure-2.1: Implementation Sequence



The research was implemented through four phases; inception, data collection, data analysis, and reporting. To begin with, the inception phase was started with an entry conference on October 1, 2024, and followed by a intensive desk review of relevant project-related documents and other open-sourced literature, the development, review and approval of the research tools, and the acquisition of approval from the Internal Review Board (IRB) for the conduct of the research. In furtherance of the implementation process, the data collection phase entailed an on-spot collection of primary data from sampled respondents through community-level surveys, facility-level interviews and Focus Group Discussions. Interviews with SRH Experts from designated partners and donors were also undertaken during this phase. Furthermore, the data analysis phase involved the generation and interpretation of descriptive and inferential statistics from gathered quantitative and qualitative data. Finally, presentation of the findings from information generated from the analysis phase was presented initially in a preliminary report that was validated and comprehensively compiled into the final research report.

2.1 SAMPLE DESIGN

The sampling frame used for the research was based on the 2022 National Population and Housing Census (NPHC), conducted by the Liberia Institute of Statistics and Geo-Information Services (LISGIS). Liberia is divided into 15 counties grouped into five geographical regions, with each region consisting of three counties. Each county is divided into districts and each district into clans. Therefore, a 2-stage stratified sampling design was used to determine the sample size for the research. The first stage, counties were stratified into urban and rural settings reflecting the socio-demographic and infrastructural diversity. In the second stage, Probability Proportional to Size (PPS)

sampling was employed to identify districts and communities within each stratum. This ensured equitable representation of target populations across geographic and socio-economic contexts.

At the community level, households were randomly selected, and women of reproductive age (15-49 years) and adolescents (15-24 years) were surveyed. A total of 503 adolescents and women of reproductive age participated in the community survey. For the health facility assessment, 13 facilities were systematically selected to reflect the distribution and diversity of SRH services available in the study areas.

The research utilized the on-spot community-level surveys; therefore, in the absence of household listing, eligible respondents were not predetermined. Deficits of eligible respondents that were experienced by the one-spot community-level surveys were compensated by other available respondents found in other communities.

Table-2.1: Distribution of Sample Size by County, District and Household

County	Female Population[1]	WRA @ 15%	Estimated Sample	Admin. District	Sample District[2]	Estimated Household[3]
Gbarpolu	44,874	6,731	15	5	2	4
Grand Bassa	143,409	21,511	55	7	2	14
Margibi	152,247	22,837	60	6	2	15
Montserrado	978,406	146,761	372	15	5	93
Total	1,318,936	197,840	503[4]	33	11	126

2.2 QUESTIONNAIRES

Four sets of questionnaires were used for the research: Community-level Questionnaire, Facility-level Questionnaire, Focus Group Discussion, and Knowledgeable Informant Interview Questionnaire. These questionnaires, based on the research themes, were adapted to reflect the research objectives, and the targeted population along with their respective SRHR issues. Suggestions were solicited from CHI and complemented with inputs from prevailing SRH reports on Liberia. Following the finalization of the questionnaires, they were uploaded into survey gadgets for data collection. The

[1] Data sourced from 2022 Census Report
[2] Sample districts derived at 30% quota per county
[3] Estimated household is based on average 2022 NPHC household size of 4 people.
[4] Research Sample size

Community-level Questionnaire was used to collect information from all eligible women age 10-49. These women were asked questions on the following topics:

- Background characteristics (i.e., age, education, marital status, and occupation)
- Accessibility and Availability of SRH services
- Knowledge and Awareness of SRH services
- Knowledge, attitudes, and behavior related to SRH services
- Barriers to accessing SRH services
- Personal experiences with SRH services
- Socio-economic factors affecting SRHR
- Cultural and religious practices affecting SRHR

2.3 TRAINING OF FIELD STAFF

Eleven participants comprising three males and eight females attended training for the data collection process. Three of the participants were seconded by CHI. The training outline included familiarization with the contents of the questionnaire including the core themes, utilization of the software application installed on the data collection gadgets, and interview methods. The training occurred over a 2-day period (9 & 11, November) and the training methodology consisted of lectures, demonstrations, procedures, and practice interviews. .

2.4 PRETEST

Thirty-four volunteers comprising 31 females and 3 males consented to be surveyed during the pretest exercise on November 11, 2024. The pretest utilized a blended approach concurrently using paper questionnaires and based questionnaire with computer-assisted personal interviewing (CAPI) which is an electronic data capture system programmed on the survey gadgets to enhance the skills of the enumerators.

2.5 FIELDWORK

Data collection occurred 11-21 November beginning in Montserrado County due to the significant proportion of the sample size for Montserrado. Following the completion of Montserrado, simultaneous data gathering commenced in the other counties. Data gathering involved surveys in rural and urban communities to ensure parity in the geography for data gathering sources. Except for Gbarpolu where paper-based surveys were ultimately conducted as the mitigating alternative to the CAPI data gathering system,

all data gathering was conducted using the CAPI data capture system. Responses were transmitted to the central database in real-time which enhanced the field supervision of various aspects of the research.

2.6 DATA PROCESSING AND ANALYSIS

The data processing phase included secondary editing that involved resolution of computer-identified inconsistencies and coding of open-ended questions. Data editing for the community-level and facility-level questionnaires was performed using the KoboCollect software. The TurboScribe software was subsequently used for transcription and editing of all FGDs and Expert interviews.

Analysis for the community-level surveys was categorized by Response Rates; Background Characteristics of Respondents; SRH Accessibility and Availability; Barriers to SRH Services; and, Knowledge, Attitude and Behavior towards SRHR. Descriptive statistics were used to summarize demographic data and service utilization patterns. This phase of the analysis was supported with tables and graphs for situations where additional visual conceptualization is required.

Thematic analysis was used to identify patterns and insights from FGDs and KIIs. Data were coded using predefined themes (e.g., availability, accessibility, quality, barriers) and analyzed for convergence and divergence. Analysis for the facility-level surveys was categorized by Availability of SRH services; Utilization of SRH services; Resource Adequacy; Quality of Care; and, Socio-cultural Factors affecting SRH service utilization. . Expert interviews were also analyzed through the use of the thematic analysis framework. This qualitative data analysis method aligns the research themes with assigned codes and selected excerpts to determine the similarity and variation from participants regarding the themes of the discussions.

Findings from qualitative and quantitative methods were compared to validate and enrich the results. Triangulation of data across tools (surveys, FGDs, KIIs) was conducted to ensure consistency. Outliers and anomalies were flagged and reviewed with field teams for clarification. Supporting themes included Socio-Economic Barriers, Utilization, Quality of Care, and Cultural and Religious Beliefs.

3 RESEARCH FINDINGS

3.1 RESPONSE RATES

Response rates are crucial for the level of voluntary consent received from respondents and reflect the adequacy of the questionnaire to attract the desired responses. A total of 126 households were sampled for the community-level survey. Afield, 125 households consented to the on-spot survey, accruing a household response rate of 99.4 per cent. For the on-spot surveyed households, a total of 503 respondents comprising adolescent girls and women of reproductive age were sampled. On-spot, a total of 501 respondents were successfully surveyed yielding a response rate 99.6 percent. Thirteen of the 15 sampled health facilities were surveyed yielding an 87 per cent response rate. The non-response rates are less than 1 percent among adolescent girls and women; and, 13.4 per cent among facilities. The narrow gaps between the various categories of the samples and the on-spot surveys reflect the value of utilizing the on-spot surveys in comparison pre-selected respondents generated through a verification exercise. The relatively high response rates might be an indication of the simmering concerns associated with SRH services within communities; but more significantly, it reflects the willingness of adolescent girls and women of reproductive age to make contributions to lingering SRH inadequacies confronting them both as individuals and as social units. Inherent in this observation are opportunities for call to action, commitment to service, and social mobilization amongst the target populations.

Table-3.1: Results of Community and Facility Surveys

Survey	Urban	Rural	Total
Community-level			
Sampled household	54	72	126
Surveyed household	53	72	125
Response rate[5]	98.1	100	99.2
Respondents			
Sampled respondents	215	288	503
Surveyed respondents	214	287	501
Response rate[6]	99.5	99.6	99.6
Facility-level			
Sampled facility	10	5	15
Surveyed facility	9	4	13
Response rate[7]	90	80	86.6

[5] Household surveyed/Household sampled
[6] Respondents surveyed/Respondents sampled
[7] Facility surveyed/Facility sampled

3.2 Background Characteristics of Respondents

Key Findings

At least half of the respondents are aged 15-24

More than three-quarters of the respondents are unmarried

Almost three-fifths of the respondents reside in rural settings

One-third of the respondents have tertiary education

Three-fifths of the respondents earn no income

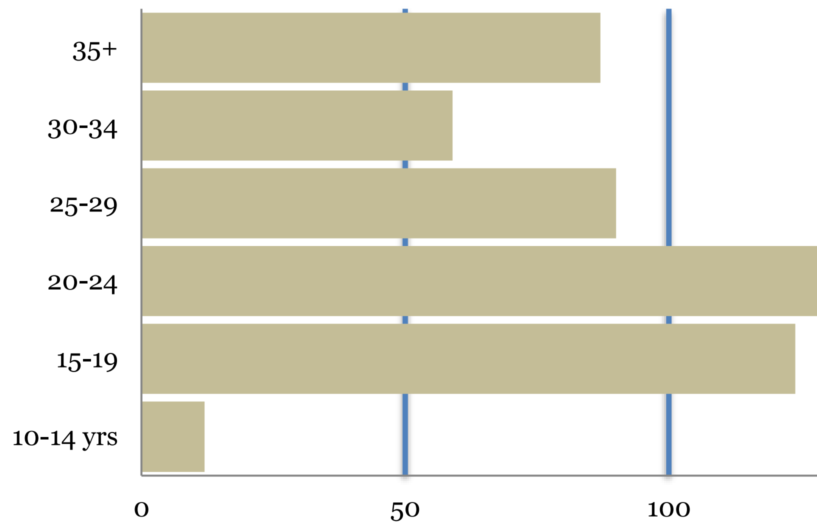
This section of the report presents a profile of the respondents (i.e., adolescent girls and women of reproductive age) that were surveyed. To begin with, information on background characteristics at the time of the survey including age, marital status, residence, educational level[8] and occupation is disaggregated by county to provide additional context. Analysis of the variables reflects the demographic and health (i.e., SRH) context within which the research was conducted and subsequently examined. In addition, descriptive analysis of the background characteristics is also provided to further demonstrate the diverse conglomeration of the respondents. The community-level questionnaire used for data gathering from the respondents included a section that gathered information from both the on-spot *de jure*[9] and *de facto*[10] respondents. Information about religion and ethnicity were excluded from the questionnaire in consideration of the principle of inclusivity which aligns with the "*Holistic SRHR for ALL*" project. While there are few inferences to religion in the findings of the research, such inferences are simply illustrative and bear no significance to the research findings. Consequently, the findings herein presented should shape the demographic confines for the core SRHR services that align with improved health outcomes, the extent of the availability of these services, and the prevailing rate of utilization of these services amongst the population of adolescent girls and women of reproductive age residing in these counties.

[8] Educational level refers to the highest level of schooling attended regardless of completion.
[9] Usual residents of household
[10] Respondents visiting household at the time of survey

3.2.1 Age Structure

The proportion of respondents in each age group decreases with increasing age and reflects the youthful age structure of the respondents. More than two-thirds (69%) are aged below 30 years with the age group 20-24 being the median age group. The parity between age group 15-19 and age group 20-24 reflects the lowering fertility rate among women of reproductive from 4.7 children per woman to 4.2 children per woman during the past 12 or more years. This also mirrors the inroads of contraception among women of reproductive age. With at least half (50%) of the respondents between ages 15-24, the demand for SRH services is inherently imperative to compensate for the associated supply of SRH services through access and availability within the targeted counties. Added to the inherent demand for SRH services among a youthful population is the inherent need for expanding SRH education for a wider range of target groups particularly adolescents. The participation of respondents aged 10-14, though just two percent of all respondents, indicates that the spectrum for SRH services is widening and gaining the attention of adolescent girls much younger than otherwise anticipated. To the extent that this age group is bound to have a longer span of their lives as childbearing women, the long-term SRH imperatives for this age group are crucial and concerning. More than one-quarter of the respondents (29%) are aged 30 years or older. Older women are less likely to get wedded and the SRH concerns of these women might require additional attention for dedicated SRH contraception interventions such as long-term contraceptive methods or hysterectomy in limited situations.

Figure 3.2.1:Research Population Pyramid



3.2.2 Marital Status

A startling 99% of the respondents are either single or cohabiting with a man considered as partner. However, respondents who are single are almost twice as many as those respondents who are cohabiting with a partner. The proportion of respondents in the age groups of 15-19, 20-24, and 25-29 seem to be more aligned with unmarried respondents. In contrast, no respondent reported being married at the time of the survey implying early marriage might be gradually becoming a thing of the past for young Liberian women. These women might have become more concern with gaining an education or may have dedicated themselves to some other priority other than childbearing.

3.2.3 Residence

For operational context, urban residence is the municipalities of the researched counties including their suburbs. Rural residence in contrast is residence of respondents beyond 5 miles (i.e., 8.05 km) of those municipalities. To ensure functional application of this threshold, districts for the research were administrative districts as identified by the NPHC 2022 and carefully selected to ensure a balance between rural residence and urban residence. In Grand Bassa, St. John district wherein Buchanan is situated was certified as the urban residence while the Commonwealth district fitted the threshold for rural residence. Similarly, Bopolu and Gbarma districts were certified as urban and rural residence respectively. Kakata district was certified as the urban residence in Margibi with the Mamba Kaba district being the rural residence. In Montserrado, the situation was more complicated. Paynesville and Gardnerville districts were certified as urban residence in consideration of their proximity to Monrovia and the municipal status of Paynesville. Johnsonville, Caldwell, and Careysburg were all certified as rural residence. With this framework, selecting surveyed communities proved both adequate and feasible for data gathering. Based on the criteria for residence, findings show that more than half (57%) of the respondents reside in rural setting unlike 43% of those respondents who reside in urban setting.

3.2.4 Educational Attainment

Education is the sole social institution that sustains a society. Other supporting social institutions (i.e., political, religious, economic, and marriage) would lose continuity

without education. Findings from the research indicate that an increasing number of Liberian adolescent girls and women are intently pursuing education. Two-thirds (66%) of the respondents reported attending, or having received primary or secondary education. One-third (33%) reported either attending, or receiving vocational education. Others reported they are pursuing university education. The confidence to make pertinent SRH decisions, access SRH services, and advocate for SRHR to curtail harmful cultural and social practices over time are just but a few of the inherent benefits to be accrued by adolescent Liberian girls and women should this trend in educational pursuit continues.

3.2.5 Occupation

Occupation is integral to socio-economic profiling and enhances a woman's ability to demand SRH services and absorb the costs associated with those services. Occupation for women also demonstrates their economic empowerment which in turn reflects their independence to make decisions individually, or their relevance in collective decision-making. Within the geographic and health realms of the research, 61% of the respondents who desire, or deserve SRH services are being inhibited because they are primarily occupied as student or tagged as unemployed. With this inhibition, SRH services are less likely to be sought by these girls and women regardless of their community or residence within their counties. Despite this dismal reality, 36% of these women and girls are engaged in some form of petty trade or business venture. Three percent of the respondents are either farmers or are gainfully employed with public and private entities.

In general terms, the background characteristics of the respondents indicate there are critical SRH/SRHR signals bearing indication of hope and opportunity within the researched counties. To begin with, the population of adolescent girls and women is quite youthful, and burgeoning between the ages 15-24. This demographic reality bears enormous SRH and SRHR implications. This population of adolescent girls and young women are largely unmarried though at least one-in-three cohabit either voluntarily or involuntarily. Delayed marriage enables adolescent girls and young women to more likely promulgate SRHR influences especially when they reside in rural communities needing SRH. Finally, with occupation come skills, knowledge and economic empowerment to increase the ability of adolescent girls and young women to access SRH/SRHR services.

Table 3.2.1: Distribution of Respondents by Background Characteristics and County

Background Characteristic	Gbarpolu	Grand Bassa	Margibi	Montserrado	Total
Age Group					
10-14	0	0	4	8	12
15-19	3	19	8	94	124
20-24	6	13	15	95	129
25-29	4	7	13	66	90
30-34	0	6	8	45	59
35+	1	8	8	70	87
Marital Status					
Single	10	36	29	244	319
Cohabiting	4	16	27	128	175
Married	0	0	0	0	0
Divorced	0	0	0	1	1
Widow	0	1	0	5	6
Residence					
Urban	7	26	26	155	214
Rural	7	27	30	223	287
Education					
No Education	0	0	0	6	6
Primary	2	11	8	54	75
Secondary	6	30	30	188	254
Tertiary	6	12	18	130	166
Occupation					
Trader	1	16	28	136	181
Student	11	13	16	124	164
Unemployed	0	21	10	111	142
Farmer	0	3	1	3	7
Employed	2	0	1	4	7

Note: Tertiary education refers to both university and vocational levels.
Employed indicates both public and private sector employees.

3.3 SRH Availability and Accessibility

Key Findings

Low access and limited availability of SRH services

Family Planning is the most widespread SRH service

Health facility remains the largest point-of-access for SRH services

Misconceptions of SRH services persists

Access to health care means having "the timely use of personal health services to achieve the best health outcomes" (IOM, 1993). Aligned with these personal health services are dedicated healthcare provision that are especially significant for women and girls. Hence, SRH services involve a dedicated continuum of service for adolescent girls and women of reproductive age. The research established three tiers of continuum of service. Tier-1 services include family planning, ante-natal care, and gender-based violence. Tier-2 services include HIV testing and counseling, STI diagnosis and treatment, and menstrual health. Tier-3 services include postnatal care, safe abortion, adolescent health care, and cancer screening (i.e., cervical and breast). Respondents provided information on the SRH services that are available in their communities, the point-of-access for those services, the factors that largely impede them access to those services, and some misconceptions in regards to the use of SRH services.

3.3.1 Available SRH Services

Ninety percent of the respondents reported family planning as the paramount SRH service available in their community. This finding is reflected in all counties except in Grand Bassa where family planning and gender-based violence are fairly apportioned as the paramount SRH services. At least 50% of the respondents reported ante-natal care, gender-based violence, HIV testing and counseling, STI diagnosis and treatment as other SRH services available in their community. Although SRH services are largely available, administering these services is usually impeded by the lack of the accessories and supplies that are required to administer the services.

3.3.2 Accessibility of SRH services

More than three-quarters (i.e., 80%) also reported that they access SRH services from the health facility. While the majority (i.e., 72%) reported that SRH services are easily accessible, at least a quarter (i.e., 26%) reported to the contrary. Further probe to ascertain the prevailing status of SRH accessibility relative to factors such as cost, distance, information, stigma, and cultural belief provided additional insights. Eighteen percent reported cost of service as an impeding factor to SRH accessibility while 15% reported that the distance to the health facility impedes SRH access. Less than 10% of the respondents reported lack of information, stigma, and cultural/religious belief as impeding factors to access for SRH services.

Additional probe also determined that more than half (53%) of the respondents reported that available SRH services are sufficient to meet the needs of their community in contrast to 45% who disagreed. Respondents who reported that the available SRH services are insufficient to meet the needs of adolescent girls and women outlined additional SRH services they believed should be scaled-up or initiated in their community. The outlined services included family planning options, HIV/STI services, youth-friendly services, safe abortion/post-abortion care, and emergency obstetric care. These outlined services also aligned with SRH services the respondents have heard or learnt about from health facility, family/friends, school, community health worker, radio/television, social media and religious or community leaders. Social media and community/religious leaders ranked the least sources of SRH information while health facility and family/friend ranked the highest source of such information.

The contraceptive methods that majority of the respondents (i.e., ≥ 50%) confirmed they have ever heard of include injectables, pills, condoms (i.e., male/female), implants, withdrawal, and emergency contraception. Other contraceptive methods respondents reported as being less heard of include tubal ligation, intra-uterine device (IUD), vasectomy, and rhythm (i.e., female awareness method). At least two-thirds (66%) of respondents also believe people in their community need more SRH information. In order of preference, they cited HIV/STI prevention, family planning, menstrual health,

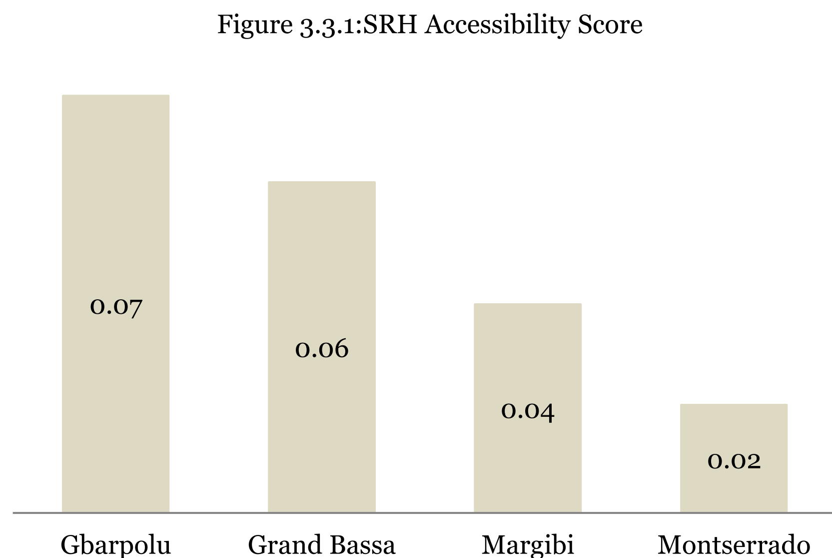
adolescent sexual health, gender-based violence, and safe pregnancy and childbirth as concerning topics that require more information for people in their community.

To further solidify these findings, the research proceeded to further determine access to SRH services using the Floating Catchment Area (FCA) method. This method determines access to health services by:

1. Determining the catchment areas around each healthcare facility;
2. Calculating the supply of healthcare services and the corresponding demand for those services in each catchment area; and,
3. Computing the accessibility score based on the ratio of supply to demand.

$$Accessibility = \#of\ Healthcare\ Providers/Population\ within\ Catchment\ Areas$$

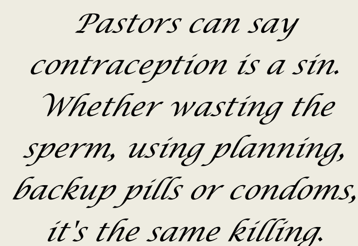
Based on the formula used to determine SRH accessibility, the accessibility score for the research area is 0.03. This indicates SRH demand outweighs supply across the researched counties with less than one (0.03) SRH healthcare provider for every 1,000 adolescent girl or woman of reproductive age in these counties. When viewed within each county, Gbarpolu appears to have a slightly favorable accessibility score compared to the other counties. This more favorable SRH accessibility score might be attributed to the comparatively low population of adolescent girls and women of reproductive age in Gbarpolu. Similarly, the least favorable SRH accessibility score in Montserrado would likely be attributed to its high population of adolescent girls and women of reproductive age. Access to SRH services is uniformly and critically low across all counties and worsens with confounding factors such as cost of service, distance to health facility, etc.



3.3.3 Barriers to SRH services

The research inquired from respondents what service-related barriers, and cultural and religious barriers that persists in preventing them from accessing available SRH services. The inquiry began by ascertaining from respondents whether they had personally used SRH services in the last 12 months. Over half (i.e., 53%) affirmed they had personally used or sought SRH services, and contraceptive needs stood out as the main SRH service used or sought. The inquiry probed further as to whether the SRH services received were satisfactory. While 60% of the respondents affirmed their satisfaction with the SRH services received, further information from those respondents who expressed dissatisfaction with SRH services received during the past 12 months proved valuable. In chronological order, the identified service-related barriers they reported included poor quality of care, long waiting time for service, lack of privacy, and unfriendly staff.

Cultural and religious beliefs do not particularly appear to be a source of despondence for the prevention of SRH use among adolescent girls and women of reproductive age. Sixty percent reported that cultural and religious beliefs do not discourage or dampen their quest for SRH services. This finding is also of much interest when the comments of the respondents are viewed and sufficiently put in context. The significance of this finding is an indication that adolescent girls and women of reproductive age are becoming more independent in their thoughts, actions and the choices they make for SRHR. They are not perturbed by religion, culture or other social affiliations whether manifest or benign. Indications from the finding also point to the assertion that when information, education and communication are adequately transmitted for behavior change, the anticipated change in people's behavior becomes inevitable though gradual. However, additional analysis will be required to determine whether this finding indicates a silent wave of SRH transformation is underway among the target populations in these counties or whether this is the emergence of an inevitable outcome.



3.3.4 Role of men about SRH services

The role of men in decision-making about the use of SRH services by young women and adolescent girls was found to be seemingly polarized between men who are supportive and [*would*] make decisions on behalf of their women; and, men who are not supportive and [*would*] discourage SRH service use. Ninety percent of the respondents believed that men's role in their community is generally supportive of women and adolescent girls use of SRH services or effective in decision-making on behalf of those women. In contrast, 77% of the respondents viewed men's role in their community as neither supportive of the use of SRH services, nor encourages use of SRH services among young women and adolescent girls. Given the strong divergence of opinion on men's role, it is very likely that additional efforts are required to further transform the role of men in communities to overwhelmingly support the use of SRH services by their partners or dependents. Meanwhile, the role of men in communities continues be a source of schism and therefore meets the threshold of being a barrier to SRH/SRHR services for adolescent girls and women of reproductive age.

Men supposed to make all the decisions.

Respondents were further probed on measures that could be undertaken to reduce barriers to SRH services in their communities. Ninety-seven percent reported that more education and awareness campaigns are required to reduce barriers to SRH/SRHR services. More than half (58%) of the respondents noted that reduced cost of services would reduce barriers to SRH services in their communities. Less than half (41%) of respondents reported that more youth-friendly services would reduce barriers to SRH services while 30% proposed improved transportation is required to achieve a reduction in these barriers within their communities. A sobering 16% reported that cultural/religious beliefs would need to be addressed to reduced barriers to SRH services in their communities. This finding bears similarity to an earlier finding wherein cultural and religious beliefs do not appear to be particular source of despondence that prevents the use of SRH services among adolescent girls and women of reproductive age. These findings are largely reflective of the 15-24 age groups across all counties, and this group appears to be growing in both confidence and conviction regardless of their background or circumstances.

3.4 Knowledge, Attitude and Behavior towards SRHR

Key Findings

SRH knowledge is largely associated Family Planning services

Attitude towards SRHR is deeply influenced by Social and Gender dynamics

Behavior towards SRHR is marred by risk factors and indifference

Cultural and Religious practices minimally affect SRHR

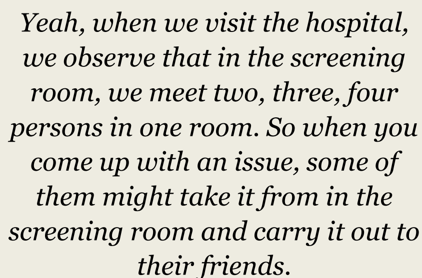
Knowledge, Attitude and Practice surveys are interviews in which people are asked standardized questions dealing with their knowledge of, attitudes towards, and use of contraceptive methods (Last, 2001). This structural guidance provided the framework for assessing knowledge, attitude and behavior (KAB) for the research.

3.4.1 SRHR Knowledge

Participants demonstrated varying levels of their knowledge of SRH/SRHR with a focus on family planning, protection, and prevention. Knowledge of SRHR was basically demonstrated as an encapsulation of contraceptives or modes of contraception. Protection and prevention, in contrast, were used more as a connotative expression by the adolescents. Among adolescent girls, protection and prevention connoted delayed pregnancy and adolescent sexual health. In parallel, adolescent boys projected protection and prevention as preventing early parental responsibilities. Combined, both perspectives indicate safety for sexually active individuals that involve unwanted pregnancy for boys and management of menstrual cycle for girls. Knowledge of SRH/SRHR as expressed by the participants largely indicates their knowledge of SRHR is contingent on personal beliefs generated from informal sources of information. Knowledge of SRH/SRHR is unrecognizably misguided and inadequately packaged for the recipient populations. Among implications for this prevailing knowledge defect is the need for better SRHR information dissemination for adolescents and young women. In addition, the *"rights"* associated with SRHR are, more often than not, clouded by the *"health contents"* of SRH. The rights associated with SRH are inherently significant and require recognition as reflected in SRH practices.

3.4.2 Attitude towards SRHR

More often than not, attitudes are influenced by perceptions that might be imagined or real. Attitudes are therefore influenced by people's way of thinking and their thought processes. Findings from the research indicate that perceptions of SRH/SRHR are shaped by social and gender dynamics. Among adolescent girls and young women, the fear and stigma inherently associated with seeking care for SRH services is associated with the behavior of service providers who are largely viewed as non-confidential. This fear often discourages the care-seeking desires of adolescent girls and young women to freely access these services. Female participants also added that social structures result in having them socially ostracized for accessing SRH services. Male participants equally emphasized that men experience financial strain when SRHS are not provided, as they are pressured to assume responsibility in such cases particularly sexually-related cases. Religious and cultural beliefs reportedly do not prevent individuals from accessing SRH/SRHR, yet these services remain a religious or culturally-based stigma. Adolescent girls and young women also highlighted how the political and social framework of society often marginalizes women, making SRH/SRHR access more challenging due to societal judgment, gender intolerance, religious intransigence, and economic restraints. In the Johnsonville district, parents confirmed that they encourage their adolescent youth into early marriages as an outlet for these adolescents to evade drug addiction which they believe has become inevitable for the adolescents. The justification underlying this attitude is based on the logic that upon marriage, these adolescents will pursue childbearing as parents which in turn leads them into domestic responsibilities. Unfortunately, negative perceptions such as pregnancy is inevitable upon sexual debut, or using condom during sex leads to abdominal discomfort continue to influence attitudes towards SRH/SRHR.

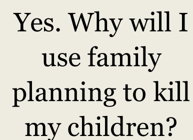


Yeah, when we visit the hospital, we observe that in the screening room, we meet two, three, four persons in one room. So when you come up with an issue, some of them might take it from in the screening room and carry it out to their friends.

–FGD, Bondi Community

3.4.3 Behavior towards SRHR

Behavior is a function of perceptions and attitudes over time. These interrelated social and behavioral variables were identified by the research as being among factors that continue to affect SRH/SRHR. Generally, the research findings noted a mixed behavioral pattern of indifference and intransigence among the respondents both at urban and rural residence. The indications of such a behavioral pattern are far-reaching. First, it leaves adolescent girls and young women exposed to early childbearing. Second, it promotes harmful cultural/traditional practices amongst adolescent girls and young women. Third, the tendency to lead a life of denial increases amongst adolescent girls and young women. This does not suggest that the respondents are not cognizant of the dangers posed by the prevailing limitation of access to SRH services, the inadequacy of available SRH services and the misguided knowledge, attitude and behavior affecting SRHR within their communities. Rather, the harsh reality is that they simply feel powerless to engage in any form of SRHR transformation process and therefore they are becoming psychologically immune to the benefits of any such process Unattended, these prevailing SRHR behavioral patterns constitute behavioral risk factors that are very likely to persist and become communicable not only through social transmission but also through social and communal acceptance.



Enormous efforts have been made to curtail behavioral epidemics such as gender-based violence and violence against women over the past decade. SRHR is integral to the social and gender dynamics that remain formidable challenges to the SRHR-GBV conundrum. Observations from the research suggest that representations for adults FGDs were broad-based and involved local authority, civil society organizations, and employees of development partners. Although these representatives were not participating in their official capacity, their participation indicates that SRHR is a concern that transcends individuals, homes, and affiliations. SRHR continues to attract interests from a wide range of stakeholders within communities and beyond. The surge in the interest of SRHR presents an opportunity for dedicated action, persistent pursuit, and enduring commitment to the improvement of adolescent, sexual, and reproductive health.

3.5 Facility Characteristics

Key Findings

Major SRH services provided are FP, Menstrual health, ANC and HIV/AIDS

Gender-Based Violence support services under-utilized

OICs acknowledge improved access is the most urgent SRH need

1-in-2 facilities not equipped for SRH case management

Health service provision is a function of essential healthcare services, health workforce, health financing and the availability of medicines and medical supplies. The adequacy of these variables bear testament to the availability and utilization of SRH services across the researched counties. Findings from the facility-level surveys indicate there are variations among SRH points-of-service across the counties.

3.5.1 SRH Available Services

Ninety-three percent of administered SRH services are dedicated to family planning consultations. Other SRH services also administered include menstrual health (79%), ANC (71%), and HIV Testing and Counseling also 71%. Additional SRH services administered include Post-natal care (50%), Adolescent Sexual and Reproductive Health Services also 50%, Gender-based Violence Support Services (43%), and infertility services (38%). Despite the availability of these services, demand for services is skewed more towards for family planning, ANC, HIV/STI services, and post-natal care.

3.5.2 SRH Service Utilization

Utilization of family planning services is 79% which far outweighs other SRH services. Respondents also reported that low awareness within the community, financial constraints, poor quality of services, and the distance from the facility as factors contributing to the under-utilization of other SRH services. Other contributing factors also include the lack of youth-friendly services and cultural or religious barriers. These findings corroborate similar findings from the community-level surveys. However, half

(i.e., 50%) of the respondents identified low awareness within community as the core contributing factor for the under-utilization of SRH services. This might suggest poor SRH messaging or a need for the development of new and more captivating SRH messaging for community awareness campaigns. The mode for dissemination for new SRH messaging might also need reconsideration.

3.5.3 Facility Resource Adequacy

Resource adequacy was also investigated and findings therefrom indicate that facilities are inadequately resourced to meet the SRH demands of communities. Seventy-eight percent of respondents affirmed this finding and identified trained staff, inadequate medical supplies and equipment, insufficient medication, low funding, and poor physical infrastructure (i.e., space and sanitation) as critical resources required to improve both the availability and utilization of SRH services. For cross-verification of this finding, the research made further inquiry to determine the main challenges to SRH utilization encountered at facility-level. Respondents reported financial constraints, lack of essential drugs and medical supplies, shortage of staff, limited training on SRH issues, high patient load, and lack of privacy in service delivery. When juxtaposed with the list of resource inadequacies to SRH availability and utilization, the commonality outweighs the variance.

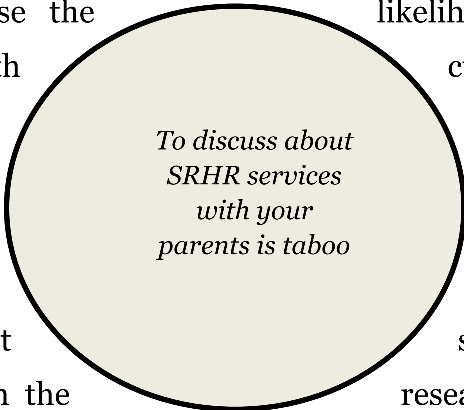
3.5.4 Socio-cultural Factors

Further inquiry was made to ascertain socio-cultural attributions that limit the use of SRH services by community. Findings revealed that 93% of the attribution that leads to limited community use of SRH services is due beliefs around family planning. Twenty-nine percent of this attribution is due to preference for traditional medicines, and 21% of the attribution for the limited use of SRH services by the community is due to the taboo around discussion regarding sexual health. This finding also corroborates similar findings gathered from FGDs with adolescents. The preference for traditional medicines and the taboo associated with discussing sexual health are critical findings relative to socio-cultural factors affecting SRH availability and utilization. Preference for traditional medicine is symptomatic of a deficiency in SRH utilization and taboo around discussing sexual health is symptomatic of a deficiency in SRH rights.

4 RESEARCH RESULTS

THhe results of the research align with the objectives established for its conduct. The research set out to determine the prevailing status of SRHR, the level of accessibility and availability to SRH services, and the existing knowledge, attitude and behavior towards SRHR in Gbarpolu, Grand Bassa, Margibi and Montserrado. Following analysis of information gathered, the results from the research are articulated for additional interpretation of the implications of the findings.

The research established that the access score of 0.03 for SRH services in the researched areas is significantly lower than acceptable. There exists less than one SRH healthcare provider per 1,000 adolescent girls and women of reproductive age across all four counties. Compounding the low level access for SRH services are other inhibiting factors that include cost of service, travel distance from the health facility, long waiting time for services and attitude of service providers. Although SRH services are available in these counties, they are primarily family planning services with a focus on contraception. Ante-natal care, menstrual health, post-natal care, HIV testing and counseling, diagnosis and treatment for STI are opportunistically provided. Service-related barriers to SRH services are more pronounced in contrast to cultural and religious barriers. Poor quality of care and lack of privacy featured prominently among service-related barriers to SRH services. The WHO defines healthcare quality as the extent to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge. Simplified, high-quality healthcare should be effective, safe, people-centered, timely, equitable, integrated, and efficient. Within the context of the research, the metrics for quality of care include patient outcomes, patient safety, patient satisfaction, clinical effectiveness and equity. Results from the research indicate that the demand for SRH services such as family planning options, HIV/STI services, youth-friendly services, safe abortion/post-abortion care, and emergency obstetric care should be scaled-up or initiated within communities. Patient safety and clinical effectiveness are less than optimal implying patients are apprehensive of the available services due to poor hygienic



conditions and the lack of confidentiality. It was also evident that equity remains a concern with no SRH service available to men and boys in contrast to women and girls. Collectively, these factors continue to adversely impact the quality of the supply of SRH services that is already overwhelmed by the surging demand for those services.

Notwithstanding, cultural and religious misconceptions are also contributing to minimum SRH care-seeking behavior. Knowledge of SRH services is being stifled by misconceptions and social myths particularly amongst adolescents. Attitude and behavior towards SRHR is indifferent and is characterized by acceptance and a steadily growing pattern of behavioral risk factors that is leading to denial and intransigence among adolescent girls and young women. This trend presents an institutional threat to SRHR and deserving populations for which these services are developed and supported. The ripple effect of this institutional threat exceeds local jurisdictions and communities. Its effects are all encompassing for a significant portion of the larger population.

The World Health Organization urges its member states to pursue Universal Health Coverage (UHC) for all its citizens. Universal health coverage (UHC) means that all people have access to the full range of quality health services they need, when and where they need them, without financial hardship. It covers the full continuum of essential health services, from health promotion to prevention, treatment, rehabilitation and palliative care (WHO, 2010). The existence of low access and opportunistic availability of SRH services as revealed by the research is certainly in contrast to the threshold of the WHO. The prevailing status for SRH services does not provide all people (i.e., adolescent girls and young women) access to the full range of quality [SRH] services they need. As evidenced by the research, the prevailing status of SRH services also does not cover the full continuum of essential SRH services as promulgated by the WHO.

The enormity of the implications associated with this dismal status for SRH/SRHR services are concerning. To begin with, the research shows that the female population of the researched counties account for approximately 25% of Liberia's population. Applying the conventional rate of 15% for women of reproductive within populations, more than half of the women of reproductive age residing in these counties have next to no access to SRH services. When they do gain access to SRH services, they are most likely to receive

opportunistic SRH service provision instead of routine SRH service provision. In addition, the 2020 DHS revealed that teenage pregnancy and motherhood among girls aged 15-19 residing in these counties was already alarming. In Gbarpolu, 45% had had a live birth while 48% had begun childbearing. In Grand Bassa, 38% had had a live birth and 39% had begun childbearing. For Margibi, 28% of these girls had already bore a child and 34% had begun childbearing. Montserrado was no exception with 18% of its teenage girls having a live birth while 23% had already begun childbearing. Unmitigated, these counties would undoubtedly erode the decrease in the national fertility rate from 4.7 in 2013 to 4.2 in 2020. This decrease may appear limited; yet, the lack of sustained efforts through effective SRH services is likely to lead to a surge in fertility rate by 2027.

The Universal Health Coverage also urges states to ensure that all people have quality health services that they need, when and where they need them, and without financial hardship. The result of the research clearly identified cost of service and distance from health facility as core impediments to access to SRH services. Adolescent girls and young women in these counties continue to encounter difficulties in mobilizing financial resources to access SRH services. A common cost incurred for SRH services is the consultation fee which is branded as registration. In addition to this cost, care-seekers are usually requested to underwrite the cost of supplies and accessories to administer SRH services. These costs could range from buying gloves to purchasing SRH commodities from service providers. With three-fifths of these girls and women unable to earn income, more will be required to alleviate the financial hardship that continue to inhibit access to SRH services.

The low level of Social and Behavioral Change (SBC) efforts for increased SRHR knowledge, attitude and behavior among girls and young women in these counties is likely to increase behavioral risk factors such as denial, insensitivity, and misconceptions. This may not translate to the emergence of a behavioral epidemic in the short-term. However, if allowed to linger for the foreseeable future, denial, insensitivity, and misconception could gain social and cultural acceptance. The net outcome of such eventuality is SRH hesitancy which would present a much stronger challenge to mitigating interventions than would otherwise have been avoidable. SBC efforts are also required for improved quality of care by SRH service providers. Respondents expressed their dismay in the manner

through which SRH service providers demonstrated their inability to remain confidential with sensitive SRH case management. Minimum confidence or the lack thereof at institutional levels constitutes the basis for disintegration and possible demise. Combined with poor quality of care, the status of SRH services in these counties, which is integral to the national health outcomes, would simply become dismal and defining.

The results of the research bear measurable significance for SRH for adolescent girls and young women as male respondents did not participate in the community-level surveys. However, this limitation does not impact the findings in any meaningful manner. Men's health equally deserves recognition as that of women. As such, the findings of the research also bear value for men especially adolescent boys and young male adults

5 CONCLUSION

When CHI commissioned this research in on October 1, 2024, the purpose of the research was geared towards the assessment of the current situations of SRH services relative to availability, accessibility, and utilization by the local vulnerable populations of reproductive-age women and adolescent girls in four counties. In addition, the assessment was to also determine the current knowledge and attitude towards sexual and reproductive health and rights while identifying socio-economic and cultural factors affecting access to reproductive health services among women and young people in those counties. Following weeks of intensive investigation involving data collection and analysis, the research was concluded in accordance with purpose for which it was commissioned.

The assessment of the status of SRHR in the South-central region (i.e., Margibi, Grand Bassa and Montrserrado), and Gbarpolu has revealed significant gaps in several key areas, including low access to reproductive health services, stalled awareness of sexual rights, and inactive policy frameworks supporting SRHR. However, opportunities remain, particularly in reaching younger adolescents, ensuring comprehensive sexual health, and addressing SRH misconceptions and misguided SRHR perceptions.

The findings underscore the importance of continued investment in SRHR programs and policies to achieve equitable health outcomes for all individuals. The findings are also

extensive and expansive both in contexts and contents. Overall, the assessment highlights both the prevailing status and the existing opportunities needed to ensure that SRHR is fully realized for everyone, regardless of their background or circumstances.

Recommendations include strengthening community-based interventions, enhancing data collection and monitoring, and fostering partnerships between government, civil society, and international organizations. It is the ardent hope of the CPRH that the information provided herein will further assist to strengthen Liberia's health system and enhance the collective efforts of partners and the GoL as pursuit of appreciable health outcomes continue.

6 RECOMMENDATIONS

The research team remained guided by the objectives and purpose of the assignment to ensure strategic focus is maintained within the proposed suggestions. In compliance with this focus, the following recommendations are put forth for consideration and subsequent action:

CHI:

A. Access to SRH services was found to be well below acceptable levels. It is recommended that CHI expands its dedicated SRH services into designated SRH points-of-service in the targeted counties. Consideration of a mobile SRH service provision should also be considered to compliment for rural settings. The process should begin with consultations with the MoH to attract coordination and cooperation as well as to identify priority SRH interventions.

B. Map SRHR Service Delivery Points to identify key SRHR service delivery locations for prioritization. This targeted approach will enable focused interventions for strategic resource allocation.

C. Integrate Comprehensive SRHR Services - Ensure that health centers provide a holistic range of SRHR services, including contraception, safe abortion,

HIV/AIDS treatment, and STI management, to meet diverse community needs effectively.

D. Increase Advocacy and Awareness Campaigns through targeted advocacy and awareness initiatives to promote the utilization of SRHR services. Emphasis should be on educating communities on the available services and their respective benefits.

E. The availability of SRH services to care-seekers is more opportunistic than routine. This situation largely derived from the preference accorded to other health conditions compared to SRH and continues to affect utilization. It is recommended that SRH services be integrated with ANC days to begin the practice of routine SRH service days at health facilities in the targeted counties.

F. It was observed that CHI is limited in its operational presence within the assessed area for the research. This is not unexpected because of limitation to resources limitation and funding. It is recommended that CHI seek partnership with other organizations within the assessed counties to leverage expertise and resources for wider engagement to increase SRH/SRHR activities and services.

SRHR Partners:

G. SRH partners should conduct a thorough assessment of the prevailing SRHR service delivery framework through a collaborative effort to determine the supply chain management processes that are best fitted to SRH needs. This will minimize expiry of SRH commodities, delays in commodity distribution, and improve storage adequacy for SRH commodities.

H. Patient satisfaction and clinical effectiveness are functions of healthcare quality. To enhance quality of care, it is recommended that SRH partners identify and articulate specific service delivery needs for caregivers to streamline training for improved quality of service.

I. Barriers to SRH services are largely service-related. These service-related impediments include cost of service, poor quality of care, and lack of confidentiality for patient information. Other barriers include long wait time, and unfriendly service providers. It is recommended that a SRH mitigation package be developed in collaboration with the MoH to alleviate these barriers. The package would involve several components. First, Village Savings and Loan Association (VSLA) should be aligned with each designated facility providing SRH service provision. The VSLA would be absorbents for cost barriers. The second component should be the development of a month-long SRH mentorship, not training, to improve skills and competence of service providers as well as the quality of care. CHI could consider outsourcing this component or leveraging the expertise of other organizations through a comparative advantage mechanism.

J. The research established that misconception and negative perception are crucial drivers for the low knowledge, indifferent attitude, and intransigent behavior towards SRHR. It is recommended that a comprehensive messaging package be developed and disseminated incrementally beginning at facility-level and scaled-up to households, schools, places of worship, and public spaces. Consideration should be given the possibility of establishing a dedicated social media platform to enhance this package of SRH messaging.

K. To better inform SRHR interventions, it is recommended that routine monitoring and supervision be strengthened to develop a culture of data gathering and analysis that would inform decision-making.

MoH:

L. Enhancing accountability among healthcare providers is crucial to patients' outcomes and efficiency. It is therefore recommended that the MoH collaborates with health regulatory bodies to establish accountability mechanisms SRH healthcare providers for the quality of services rendered at both public and non-public SRH service delivery points.

M. Sustainability is pivotal milestone of development relative to health financing. It is recommended that a Sustainable Business Model for SRHR service delivery be developed to complement the transition from a cost-free service approach to a cost-effective service approach. This model will incentivize efficiency and accountability among providers while ensuring accessibility.

N. Strengthen Training and Security Protocols for Caregivers - Provide rigorous training for caregivers and security personnel to enhance service delivery. Clearly outline roles to ensure privacy, confidentiality, and efficiency in service provision.

The recommendations are not comprehensive, but provide the platform to further assess mitigation efforts that are required to address the prevailing SRH/SRHR status in these counties. A comprehensive and realistic mitigation framework supported by a practical action plan would be necessary to ensure a holistic approach is pursued to improve the prevailing SRH/SRHR status in these counties. Such a framework and action plan would require the involvement of the policymakers, partnering organizations, local actors (i.e., CBOs and CSOs), and donors for adequate resource mobilization.

REFERENCES

Global Financing Facility (2021); Advancing Legislative and Policy Reforms on Sexual and Reproductive Health and Rights-Liberia. www.globalfinancingfacility.org

Institute of Medicine (IOM). 1993. *Access to Health Care in America*. Washington, DC: The National Academies Press https://nap.nationalacademies.org/catalog/2009/access-to-health-care-in-america

Khadija Mitu & Afroza Bulbul. (2021); *Sexual & Reproductive Health and Rights for Adolescents and Youth* www.share-netinternational.org

Last, John M. (2001). *A Dictionary of Epidemiology (4th Ed.)* Oxford University Press, New York. https://www.oup-usa.org

Liberia Institute of Statistics & Geo-Information Service (2023); 2022 Population and Housing Census Final Report

Liberia Institute of Statistics and Geo-Information Services (LISGIS), Ministry of Health [Liberia], and ICF. 2021. *Liberia Demographic and Health Survey 2019-20*. Monrovia, Liberia and Rockville, Maryland, USA: Liberia Institute of Statistics and Geo-Information Services (LISGIS), Ministry of Health, and ICF.

Merrill, Ray M. (2010) *Introduction to Epidemiology* (5th Ed.) Jones and Bartlett Publishers, LLC https://www.jbpub.com

Tazinya et al. (2023) *Reproductive Health* 20:42 https://doi.org/10.1186/s12978-023-01594-z

UNFPA UNFPA Liberia Country Office Annual Report 2022

A-1 Questionnaires

Community Healthcare Initiative (CHI)

Field Survey Assessing Sexual and Reproductive Health Services

<u>Community Level KII</u>

Introduction: Hello, my name is _______________, and I am working for the Center for Population and Reproductive Health to collect information for Community Healthcare Initiative (CHI). We are conducting an interview to assess the availability and accessibility of sexual and reproductive health (SRH) services in this community. Your responses will help us understand the current situation and identify areas for improvement. Participation is voluntary, and all answers will remain confidential.

Do you agree to participate in this interview?

- Yes
- No

Signature of Interviewer: ____
Date: ________________

Section A: Demographic Information

1. **What is your Identity?**
   - Male
   - Female
   - Other (please specify): _______________
2. **How old are you?**
   - 10 -14 years
   - 15-19 years
   - 20-24 years
   - 25-29 years
   - 30-34 years
   - 35 years+
3. **What is your marital status?**

- Single
- Married
- Cohabiting
- Divorced
- Widow/Widower

4. **What is the highest level of education you have completed?**
    - No formal education
    - Primary education
    - Secondary education
    - Tertiary education
    - Vocational training
5. **What is your primary occupation?**
    - Farmer
    - Trader
    - Student
    - Health worker (e.g., CHA, midwife)
    - Other (please specify): _______________

Section B: Accessibility and Availability of SRH Services

1. **What sexual and reproductive health (SRH) services are available in your community?**
(Select all that apply)
    - Family planning services
    - Antenatal care (ANC)
    - HIV testing and counseling
    - Safe abortion services
    - STI diagnosis and treatment
    - Postnatal care (PNC)
    - Adolescent sexual health services

- Gender-based violence (GBV) support
- Cancer screening (e.g., cervical, breast)
- Menstrual health education
- Other (please specify): _______________

2. **Where do you typically access SRH services?**
   - Health facility (Clinic, Health Center or Hospital)
   - Youth Friendly Center
   - Family Planning Office
   - Pharmacy
   - Other (please specify): _______________

3. **Are the SRH services easily accessible to you?**
   - Yes
   - No
     If no, what are the challenges?
   - Distance to the health facility
   - Cost of services
   - Lack of information
   - Cultural or religious beliefs
   - Discrimination or stigma
   - Other (please specify): _______________

4. **Do you think SRH services in your community are sufficient to meet the needs of women and adolescents?**
   - Yes
   - No
     If no, what services are missing or inadequate?
   - Family planning options
   - HIV/STI services
   - Emergency obstetric care
   - Youth-friendly services

- Safe abortion and post-abortion care
- Other (please specify): _______________

Section C: Knowledge and Awareness of SRH Services

1. **Which of the following sexual and reproductive health services have you heard about?**
   (Select all that apply)
   - Family planning (e.g., contraceptives, sterilization)
   - Antenatal care (ANC)
   - Postnatal care (PNC)
   - HIV/AIDS testing and counseling
   - STI diagnosis and treatment
   - Safe abortion services
   - Cancer screening (e.g., cervical, breast)
   - Menstrual health education and management
   - Gender-based violence (GBV) support services
   - Adolescent sexual and reproductive health services
   - Infertility services
   - Other (please specify): _______________
2. **Where did you learn about these services?**
   (Select all that apply)
   - Health facility (clinic or hospital)
   - Community health worker
   - School
   - Friends or family
   - Social media
   - Radio or television
   - Religious or community leaders
   - Other (please specify): _______________
3. **Are there any misconceptions in your community about SRH services (e.g., family planning, HIV testing, etc.)?**
   - Yes
   - No

     If yes, please describe: _______________
4. **Have you ever heard of the following family planning methods?**
   (Select all that apply)
   - Female sterilization (tubal ligation)
   - Male sterilization (vasectomy)
   - IUD
   - Injectables (Depo-Provera)

- Implants
- Pills
- Male and female condoms
- Emergency contraception
- Withdrawal method
- Fertility awareness methods (e.g., rhythm method)
- Other (please specify): _______________

5. **Where did you learn about these family planning methods?**
   (Select all that apply)
   - Health facility
   - Community health worker
   - School
   - Friends or family
   - Social media
   - Radio or television
   - Other (please specify): _______________

6. **What SRH topics do you think people in your community need more information about?**
   (Select all that apply)
   - Family planning
   - HIV/AIDS and STI prevention
   - Adolescent sexual health
   - Safe pregnancy and childbirth
   - Menstrual health
   - Gender-based violence
   - Other (please specify): _______________

Section D: Barriers to Accessing SRH Services

1. **What prevents people in your community from accessing SRH services?**
   (Select all that apply)
   - Cost of services
   - Distance to health facilities
   - Lack of transportation
   - Fear of stigma or discrimination
   - Religious beliefs
   - Cultural beliefs or taboos
   - Lack of knowledge about available services
   - Poor quality of services
   - Language barriers
   - Health workers attitude
   - Other (please specify): _______________

2. **Are there any cultural or religious practices in your community that discourage the use of SRH services?**
   - Yes
   - No
     If yes, please describe: _______________

3. **What role do men in your community play in decision-making about women’s and adolescents' use of SRH services?**
   - Men are supportive
   - Men discourage SRH service use
   - Men make decisions on behalf of women
   - Other (please specify): _______________

4. **What could be done to reduce the barriers to SRH services in your community?**
   (Select all that apply)
   - More education and awareness campaigns
   - Reduced cost of services
   - Improved transportation
   - Addressing cultural/religious beliefs

- More youth-friendly services
- Other (please specify): _______________

Section E: Personal Experience with SRH Services

1. **Have you personally used any SRH services in the past 12 months?**
    - Yes
    - No
      If yes, which services?
      (Select all that apply)
    - Family planning
    - Antenatal care
    - Postnatal care
    - HIV/STI testing and treatment
    - Safe abortion or post-abortion care
    - Menstrual health management
    - Cancer screening (cervical, breast)
    - Other (please specify): _______________
2. **Were you satisfied with the services you received?**
    - Yes
    - No
      If no, what were the issues?
    - Long waiting time
    - Poor quality of care
    - Lack of privacy
    - Unfriendly staff
    - Other (please specify): _______________

Closing

Thank you for your time and participation. Your feedback is very valuable and will help us improve SRH services in your community. If you have any further questions or concerns, feel free to contact us.

Community Healthcare Initiative (CHI)

Field Survey Assessing Sexual and Reproductive Health Services

Health Facility Level KII

Introduction: Hello, my name is ________________, and I am working for the Center for Population and Reproductive Health to collect information for Community Healthcare Initiative (CHI). We are conducting interviews to assess the sexual and reproductive health services provided in health facilities like yours. Your feedback will help us understand the current situation and identify areas for improvement. This interview will take approximately 30–40 minutes. Your responses will remain confidential.

Do you agree to participate in this interview?

- Yes
- No

Signature of Interviewer:_____________________ **Date:** _____________

Section A: Facility Information

1. **What is the name of this facility? Location:** ______________
2. **What is your role at this facility?**
    - SRH focal person
    - MCH supervisor
    - Clinical Manager (CM)
    - Officer in Charge (OIC)
    - DHO or CHSS
    - Other (please specify): ______________
3. **How long have you been working at this facility?**
    - Less than 1 year
    - 1–3 years
    - More than 3 years
4. **What types of SRH services are provided at this facility?**
   (Select all that apply)

- Family planning
- Antenatal care (ANC)
- Postnatal care (PNC)
- HIV/AIDS testing and counseling
- STI diagnosis and treatment
- Safe abortion services
- Cancer screening (e.g., cervical, breast)
- Menstrual health services
- Gender-based violence (GBV) support services
- Adolescent sexual and reproductive health services
- Infertility services
- Other (please specify): _______________

Section B: Service Delivery and Capacity

1. **Are there any SRH services that are in high demand at this facility?**
    - Yes
    - No
      If yes, which services?
      (Select all that apply)
    - Family planning
    - ANC
    - PNC
    - HIV/STI services
    - Safe abortion/post-abortion care
    - Cancer screening
    - Other (please specify): _______________
2. **Are there any SRH services that are underutilized or less sought after?**
    - Yes
    - No
      If yes, which services?
    - Family planning
    - HIV/STI services
    - Cancer screening
    - Adolescent SRH services

- GBV support services
- Other (please specify): _______________

3. **What factors contribute to the underutilization of these services?**
   (Select all that apply)
   - Lack of awareness among the community
   - Cultural or religious barriers
   - Financial barriers
   - Distance to the facility
   - Lack of youth-friendly services
   - Poor quality of services
   - Other (please specify): _______________
4. **Does this facility have the resources and staff necessary to meet the community's demand for SRH services?**
   - Yes
   - No
     If no, what resources are lacking?
     (Select all that apply)
   - Medical supplies and equipment
   - Trained staff
   - Medications
   - Funding
   - Physical infrastructure (e.g., space, sanitation)
   - Other (please specify): _______________

Section C: Challenges and Barriers to SRH Service Provision

1. **What are the main challenges you face in delivering SRH services at this facility?**
   (Select all that apply)
   - Shortage of staff
   - Lack of essential drugs or medical supplies

- Limited training on SRH issues
- High patient load
- Cultural or religious barriers
- Financial constraints of the patients
- Lack of privacy in service delivery
- Other (please specify): _______________

2. **Do you encounter resistance from patients or the community regarding the use of certain SRH services?**
   - Yes
   - No

   If yes, what services face resistance?
   - Family planning
   - Safe abortion
   - HIV testing
   - GBV support services
   - Adolescent sexual health services
   - Other (please specify): _______________
3. **What are the key socio-cultural or religious barriers that limit the community's use of SRH services?**
   (Select all that apply)
   - Beliefs around family planning
   - Taboos around discussing sexual health
   - Preference for traditional or home remedies
   - Gender roles affecting women's access to care
   - Other (please specify): _______________
4. **Do you think the facility is adequately equipped to handle sensitive SRH issues like gender-based violence or safe abortion?**
   - Yes
   - No

   If no, what areas need improvement?
   - Training for staff

- Access to supplies (e.g., PEP kits, emergency contraception)
- Referral systems for survivors
- Other (please specify): _______________

Section D: Quality of Care

1. **How would you describe the quality of SRH services provided at this facility?**
    - Excellent
    - Good
    - Fair
    - Poor
      Please explain your rating: _______________
2. **Do patients express satisfaction or dissatisfaction with the SRH services they receive here?**
    - Satisfaction
    - Dissatisfaction
      If dissatisfied, what are the most common complaints?
    - Long wait times
    - Lack of privacy
    - Unavailability of services
    - Unfriendly staff
    - Lack of medicines or supplies
    - Other (please specify): _______________
3. **Are there any quality improvement initiatives currently in place at this facility to improve SRH services?**
    - Yes
    - No
      If yes, what initiatives?
    - Staff training
    - Infrastructure upgrades

- Community outreach
- Improved supply chains
- Other (please specify): _______________

Section E: Recommendations for Improvement

1. **What do you think are the most urgent improvements needed to enhance SRH services at this facility?**
   (Select all that apply)
   - More trained staff
   - Improved access to SRH medications and supplies
   - Better infrastructure and privacy for patients
   - Increased community awareness
   - Reduced costs for patients
   - More support for adolescents and marginalized groups
   - Other (please specify): _______________
2. **How can the facility better support staff in providing SRH services?**
   (Select all that apply)
   - Additional training and education
   - Improved working conditions (e.g., reduced workload, better pay)
   - Access to necessary tools and resources
   - Mental health and emotional support for dealing with sensitive cases
   - Other (please specify): _______________

Closing Remarks: Thank you very much for your time and valuable insights. Your feedback is critical to improving sexual and reproductive health services in this facility and the wider community. If you have any further thoughts or questions, feel free to reach out to us.

Community Healthcare Initiative (CHI)

Field Survey Assessing Sexual and Reproductive Health Services

Introduction:

Hello everyone and thank you for joining this discussion. My name is _____________, and I am working for the Center for Population and Reproductive Health to collect information for Community Healthcare Initiative (CHI). We are conducting a focus group discussion to learn about the sexual and reproductive health services in your community and how accessible they are. Your views are very important and will help us understand the current situation and make improvements. Everything you share will remain confidential, and you are free to share as much or as little as you feel comfortable with. We will be asking about your knowledge of the available services, challenges you or others might face in accessing them, and your thoughts on what could be improved. This discussion will last about an hour.

Do you give your consent to be part of this discussion? [Record responses in Consent Form] Yes/ No

Do you have any questions before we begin?

Warm-Up Questions

1. **To start off, can you all introduce yourselves?** (Ask for names and what role they play in the community, e.g., mother, CHA, adolescent, CSO etc.)
2. **What does "sexual and reproductive health" mean to you?**

Section A: Availability and Accessibility of SRH Services

1. **What sexual and reproductive health services are available in this community?**
   - Probe: What types of services (e.g., family planning, antenatal care, HIV testing, etc.) do you know about?
2. **How do people in this community typically access these services?**
   - Probe: Where do people go for SRH services (e.g., clinics, CHAs, traditional midwives, drug store, black beger, pharmacy)?
3. **Are there enough SRH services available to meet the community's needs?**

- Probe: Are some services more available than others? Are there specific services that are lacking?

4. **Are SRH services accessible to everyone in the community, including women, adolescents, and vulnerable groups?**
   - Probe: Are there challenges specific groups face, such as unmarried women or adolescents?

Section B: Knowledge and Awareness of SRH Services

1. **How well do people in this community understand the different SRH services?**
   - Probe: Are there services that people are more familiar with? Are there services that people don't know much about?
2. **Where do people in this community usually get information about sexual and reproductive health?**
   - Probe: Does this information come from health workers, family members, schools, or other sources?
3. **What are some common misconceptions or misunderstandings about SRH services in your community?**
   - Probe: For example, are there myths about contraception, HIV testing, or other services?

Section C: Barriers to Accessing SRH Services

1. **What are some of the barriers that people face when trying to access SRH services in this community?**
   - Probe: Are there financial barriers, transportation issues, or social stigma?
2. **Do cultural or religious beliefs play a role in how people access SRH services?**
   - Probe: Are there specific practices or traditions that discourage the use of certain services (e.g., contraception or HIV testing)?
3. **Do men and women face different challenges when it comes to accessing SRH services?**
   - Probe: How do gender roles in the community affect who can access these services?

4. **What can be done to make SRH services easy to access for everyone in the community?**
    - Probe: Are there suggestions for improving education, reducing costs, or changing social norms?

Section D: Attitudes Toward SRH Services

1. **How do people in this community feel about the use of SRH services?**
    - Probe: Are services like family planning and HIV testing widely accepted, or is there hesitation?
2. **Are there any negative attitudes or stigmas associated with certain SRH services?**
    - Probe: Are people who use family planning or HIV services treated differently in the community?
3. **What role do family members, especially men, play in making decisions about SRH service use?**
    - Probe: Are men supportive of women and adolescents using SRH services? Are women supportive of young adolescents using SRH services?

Section E: Improving SRH Services

1. **What changes would you like to see in how SRH services are provided in this community?**
    - Probe: Are there any specific services that need to be improved or expanded?
2. **How can the community better support adolescents and women in accessing SRH services?**
    - Probe: What role can schools, community leaders, parents and health workers play?
3. **Are there ways to make SRH services more youth-friendly?**
    - Probe: Do young people feel comfortable using these services? How could services be made more appealing to them?

Closing Questions: Is there anything else about sexual and reproductive health services in your community that we haven't discussed but you think is important?

Closing Remarks: Thank you all very much for your time and your contributions. This discussion has been incredibly helpful, and your thoughts will contribute to improving the sexual and reproductive health services in your community. If you have any further questions or concerns, feel free to reach out to us.

Community Healthcare Initiative (CHI)

Field Survey Assessing Sexual and Reproductive Health Services

National Level Assessment

Introduction: Hello, my name is __________________, and I am working for the Center for Population and Reproductive Health to collect information for Community Healthcare Initiative (CHI). We are conducting interviews to assess the sexual and reproductive health (SRH) landscape in Liberia, focusing on national policies, programmatic challenges, and strategies to improve service delivery. Your expertise will help inform our assessment, and we appreciate your time and insights. This interview will take approximately 40–50 minutes, and your responses will remain confidential.

Do you agree to participate in this interview?

- Yes
- No

Signature of Interviewer:_________________________ Date: ________

Section A: National Policies and Strategies on SRH

1. **What are the key national policies or strategies in place to support sexual and reproductive health services in Liberia?**
   - Probe: Are there specific policies targeting women, adolescents, and marginalized populations?
2. **How effective have these policies been in increasing access to SRH services?**
   - Probe: Can you highlight successes and any areas where improvements are needed?
3. **Are there any new SRH policies or initiatives currently under development or planned for the near future?**
   - Probe: How are these policies expected to address current gaps or challenges?
4. **Does the Ministry of Health have specific goals or targets related to SRH, particularly in areas like Montserrado, Margibi, Grand Bassa, and Gbarpolu counties?**

- Probe: What are the mechanisms to monitor progress towards these targets?

Section B: Availability and Accessibility of SRH Services

1. **From your perspective, what are the most critical SRH services that need improvement in Liberia?**
    - Probe: Are there gaps in services such as family planning, HIV/STI prevention, safe abortion, or adolescent health?
2. **What are the main challenges to ensuring that SRH services are available and accessible to all population groups, particularly vulnerable populations (e.g., women of reproductive age, adolescents, marginalized groups)?**
    - Probe: What barriers exist in rural versus urban areas?
3. **What role do international partners (e.g., WHO, USAID, UNFPA) play in supporting SRH service delivery in Liberia?**
    - Probe: Are there particular programs or initiatives that are more impactful?
4. **How does the health system ensure that SRH services reach remote and underserved communities?**
    - Probe: Are community-based health workers (e.g., CHAs) effective in this regard?

Section C: Challenges in SRH Service Delivery

1. **What are the most significant challenges faced at the national level in implementing SRH programs?**
   (Select all that apply)
    - Insufficient funding
    - Lack of trained healthcare providers
    - Political or religious resistance
    - Supply chain disruptions (e.g., contraceptives, essential medicines)
    - Weak referral systems
    - Other (please specify): _______________
2. **What are the socio-cultural and religious factors that influence access to and use of SRH services at the national level?**

- Probe: How are these challenges being addressed?

3. **Are there specific SRH services that face greater resistance (e.g., family planning, abortion services, HIV/AIDS care)?**
    - Probe: What strategies have been used to overcome these challenges?
4. **How is the government working to address gender-based violence (GBV) and its links to SRH outcomes?**
    - Probe: Are there any national programs or initiatives specifically targeting GBV?

Section D: Role of Data, Monitoring, and Evaluation

1. **How does the government or your organization track progress towards improving SRH services?**
    - Probe: What indicators are used to monitor the accessibility, quality, and utilization of SRH services?
2. **What role does data play in shaping SRH policies and programs in Liberia?**
    - Probe: Are there gaps in data collection that affect decision-making?
3. **Are there any key research studies or evaluations planned to assess the impact of SRH interventions?**
    - Probe: How is this data used to inform policy?
4. **What systems are in place for monitoring and evaluating the effectiveness of SRH programs, especially in rural or underserved areas?**
    - Probe: How does the Ministry of Health ensure that the data from these areas is reliable?

Section E: National-Level Recommendations for Improvement

1. **What are the key actions needed to strengthen the SRH service delivery in Liberia?**
   (Select all that apply)
    - Increased funding for SRH services
    - Improved training for healthcare providers
    - Strengthened supply chains for essential medicines
    - More community outreach and education programs

- Enhanced referral systems between communities and health facilities
- Addressing socio-cultural barriers to SRH access
- Other (please specify): _______________

2. **What role can the Ministry of Health and international organizations play in addressing SRH service gaps in underserved areas?**
    - Probe: What specific support (e.g., financial, technical) is needed to improve these services?
3. **Are there areas where greater collaboration between government, civil society, and international organizations could enhance SRH outcomes?**
    - Probe: What would this collaboration look like in practice?
4. **What specific steps should be taken to improve SRH services for adolescents and young people?**
    - Probe: How can services be made more youth-friendly and accessible?

Section F: Impact of COVID-19 on SRH Services

1. **How has the COVID-19 pandemic affected SRH services at the national level?**
    - Probe: Are there particular services that were more impacted (e.g., antenatal care, family planning)?
2. **What steps have been taken to ensure continuity of SRH services during health emergencies like COVID-19?**
    - Probe: Have there been any lessons learned from managing SRH services during the pandemic?
3. **What are the priorities for strengthening SRH service resilience in the face of future health crises?**
    - Probe: How can these services be integrated into broader emergency preparedness strategies?

Closing Remarks Thank you very much for your time and the valuable insights you've shared. This information will contribute to improving sexual and reproductive health services in Liberia, particularly in underserved areas. If you have any further thoughts or suggestions, we would love to hear them.

Interview Notes

Name of Interviewee: _________________

- **Organization: ________________________**
- **Interviewer: __________________________**
- **Date: _______________________________**
- **County/ Location: ____________________**
- **Position of Respondent: _______________**
- **Duration of Interview: ________________**

A-2: Distribution of Health Facility by Name and County

Health Facility	Gbarpolu	Grand Bassa	Margibi	Montserrado	Total
Gbarma Health Facility					1
Jorieun Clinic					
God Favor Medicine					
Well Baby Clinic					3
Yarnwullie Clinic					
Diam Health Facility					2
Duport Road Health Center					
Anthony Memorial Clinic					
Samson Urgent Care Health Center					
Ma Tuwor Clinic					
FAM Pharmacy					
Johnsonville Community Clinic					
G&D Medicine Store					7

A-3: Applying the Accessibility Score

It is important to properly understand the interpretations of the accessibility score to grasp its full contextual implications. As applied in the research, the accessibility score was calculated based on the sample of the research. Hence, the score of 0.03 should be interpreted as less than one SRH healthcare provider for every 100 population of the sample. Further interpretations are:

1. Less than one SRH healthcare provider per 1,000 population of adolescent girls and women of reproductive age when the accessibility score is applied to each county.
2. Less than one SRH healthcare provider per 10,000 population of adolescent girls and women of reproductive age when the accessibility score is applied to the four counties combined.

A-4: Sampling