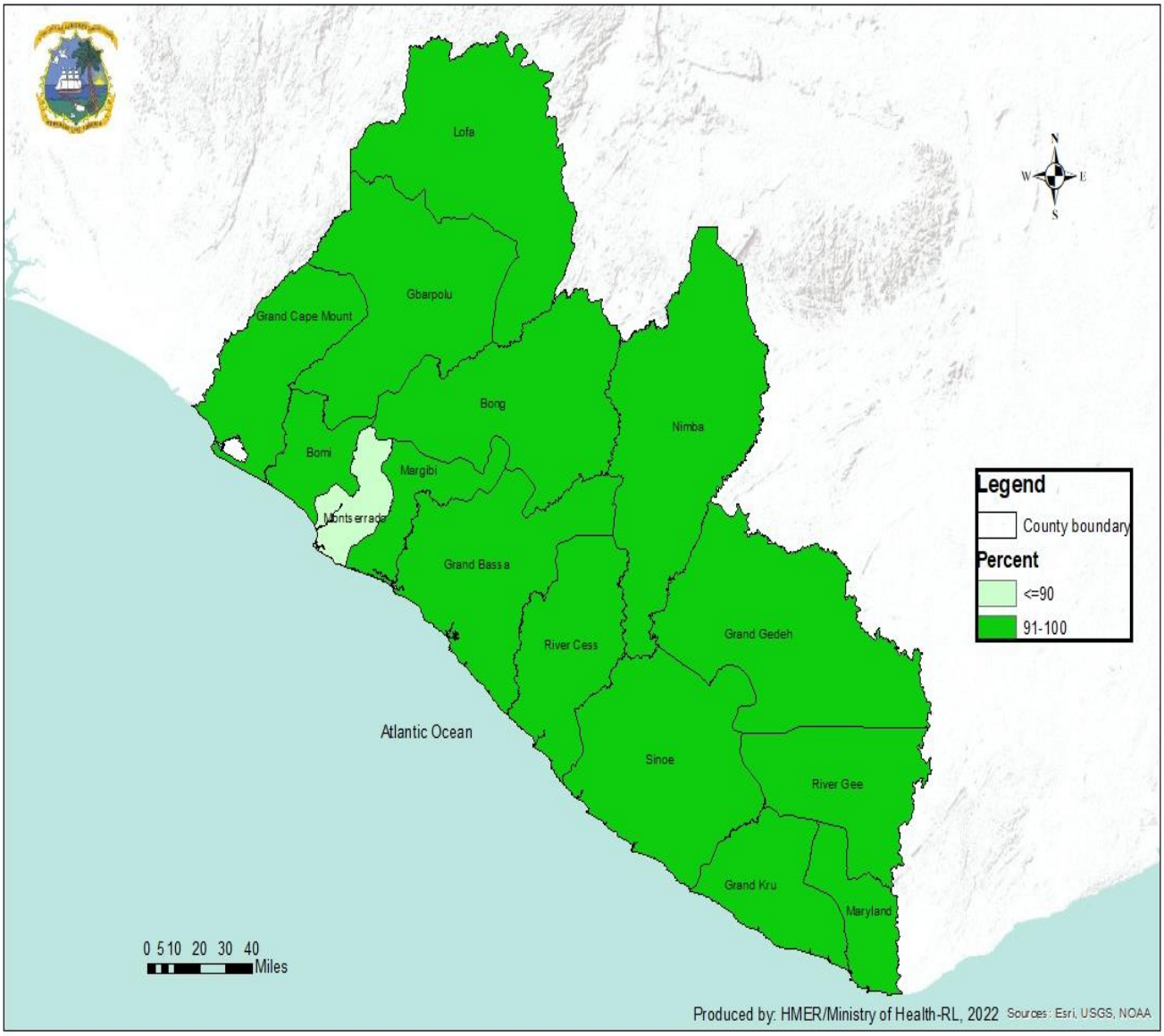
LIBERIA REPRODUCTIVE HEALTH COMMODITY AND SECURITY SURVEY

A Sample Health Facilities Survey

Final Report 2022

Figure 1: 2022 Survey of Availability of Modern Contraceptives and Essential Lifesaving Maternal and Reproductive Health Medicines in Service Delivery Points in Liberia



PREFACE

The UNFPA Supplies Partnership Program to enhance Reproductive Health Commodity Security has designated Liberia as one of the top nations to support the expansion of family planning and reproductive health initiatives with both technical and financial assistance.

It is a great pleasure for Government of Liberia through the Ministry of Health to accomplish this Survey in collaboration UNFPA. Since 2013, a survey on the "Availability of Modern Contraceptives and Essential Maternal and Reproductive Health Medicines in Service Delivery Points" has been conducted annually in Liberia. We thank UNFPA for entrusting the Family Health Division and the Health Information System, Monitoring and Evaluation and Research (HMER) Department with conducting this survey to provide evidence-based information for the implementation of family planning and reproductive health services at service delivery points.

Government of Liberia through the Ministry of Health and UNFPA appreciate the contributions of various individuals and institutions towards the success of the 2022 survey. We acknowledge the technical oversight of the Health Information System, Monitoring and Evaluation and Research (HMER) of the MOH, Family Health Division and Liberia Institute of Statistics and Geo-Information Services (LISGIS) in leading the conduct of this survey.

We also like to express our gratitude to the County Health Teams (CHTs) for their invaluable assistance. We also thank each and every one of the respondents from the various health facilities across the country for their contributions to the data collection process. We also like to express our gratitude to the Liberia Board of Nursing and Midwives (LBNM) for their technical know-how and financial administration of this survey. Having the UNFPA constantly prepared to offer financial and technical support for this annual exercise is a tremendous opportunity, and we hope that support will continue.

This survey provides timely inputs into strategic decision making for the National Family Planning and reproductive health Programs.

Signed:_____
Bidisha Pillai
Resident Representative
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Signed:_____
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LIST OF ABBREVIATIONS AND ACRONYMS

ANC	Anti Natal Care
ART	Anti-Retroviral Therapy
ARV	Anti-Retroviral
ASFRs	Age Specific Fertility Rates
BEmONC	Basic Emergency Obstetrics and Neo-natal Care
BMI	Body Mass Index
BPHS	Basic Package of Health Services
CEmONC	Comprehensive Emergency Obstetric and Neonatal Care
CHT	County Health Team
CHW	Community Health Worker
CPR	Contraceptive Prevalence Rate
CSB	Commodity Security Branch (UNFPA Headquarters, New York)
CSEntry	MFC Application of CSPro for Data Entry
CSExport	MFC Application of CSPro for Data Export (to another application)
EmONC	Emergency Obstetric and Neonatal Care
EPHS	Essential Package of Health Services
FANC	Focused Antenatal Care
FHD	Family Health Division, Ministry of Health
HHPs	Household Health Promoters
HIV/AIDS	Human Immuno Virus/Acquired Immuno Deficiency Syndrome
HMIS	Health Management Information System
ICT	Information Communication Technology
IEC/BCC	Information, Education and Communication/Behavioural Change Communication
IMR	Infant Mortality Rate
IPC	Interpersonal Communication
ITNs	Insecticide Treated Bed Nets
IUD	Intra Uterine Device
IV/IM	Intravenous/intramuscular
LAN	Local Area Network
LBNM	Liberia Board of Nursing and Midwivery

LDHS	Liberia Demographic and Health Survey
LISGIS	Liberia Institute of Statistics and Geo-Information Services
LMDC	Liberia Medical and Dental Council
LMIS	Logistic Management Information System
MDGs	Millennium Development Goals
MICS	Multiple Indicator Cluster Survey
MOH	Ministry of Health
NDS	National Drugs Service
NGO	Non-Governmental Organization
NPHC	National Population and Housing Census
OiCs	Officers-in-Charge
PAC	Post Abortion Care
PMTCT	Prevention of Mother to Child Transmission
PNC	Post Natal Care
pps	Probability Proportional to Size
RH	Reproductive Health
RHCS	Reproductive Health Commodity Security
RHTC	Reproductive Health Technical Committee
SCMP	Supply Chain Master Plan
SCMU	Supply Chain Management Unit
SDP	Health facilities Service Delivery Points
SOPs	Standard Operating Procedures
SPSS	Statistical Package for Social Scientists
SRH	Sexual Reproductive Health
STIs	Sexually Transmitted Infections
TTMs	Trained Traditional Midwives
U-5MR	Under Five Mortality Rate
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

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Executive Summary

A core requirement to track accountability levels whilst being result oriented is deeply rooted in conducting a performance monitoring surveys to generate information on number of key indicators-investigating if there have been increased and improvement in the processes overtime, and the impacts inputs and processes have on improved outcomes and better health status.

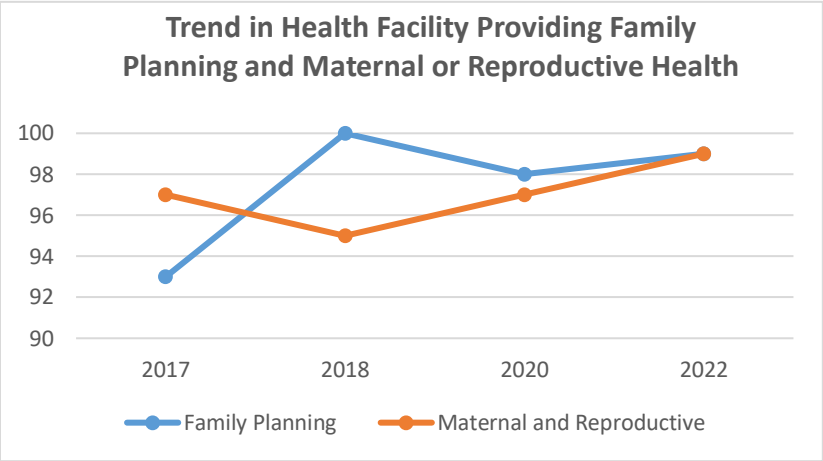
As a result, UNFPA provides assistance annually to make sure that such survey is conducted. In the same vein, the government of Liberia also depends on those data as essential to its effort to fast track SDGs achievement. Thus, a study was conducted in 2022 to determine the availability of modern contraceptives and essential lifesaving maternal and reproductive health medicines in service delivery points in Liberia with emphasis on the following outcome levels indicators:

(i) Percentage of Health facilities offering at least three modern methods of contraceptives
(ii) Percentage of Health facilities with at least five (5) modern methods of contraceptives,
(iii) Percentage of Health facilities where seven (7) lifesaving essential maternal and reproductive health medicines from WHO 2012 list[1] are available in all facilities providing delivery services and
(iv) Percentage of Health facilities with 'no stock outs' of contraceptives within the last six months before the survey.

The country was divided into five survey regions and assessed 102 health facilities that included all tertiary (2) in Montserrado and Nimba, 28 secondary facilities, and 72 primary facilities were assessed in August 2022. Health facilities were selected using probability proportionate to the total number of facilities in each county, thus Montserrado having the highest distribution of facilities.

An adapted structured questionnaire was used to elicit information from Officers-in-Charge on reproductive health commodities and security including stock out. The deployment of data collectors lasted between 8 and 11 days, including travel days.

Overall, the distribution of counties by provision of family planning and maternal or reproductive health services revealed that 11 of the fifteen counties are offering all these services. Please list the 4 counties that are not providing all the services.



Within three months or a quarter, 89% of all health facilities would receive their supplies. Male condoms, injectable contraceptives, and oral pills continue to be the three modern contraceptives that are most widely distributed among healthcare facilities, while female and male sterilization remain the least prevalent. According to assessments conducted in 2022, every health facility in the nation offers at least three (or more) modern contraceptive methods, compared to 93% of healthcare facilities that assessed offering five (or more) modern contraceptives methods. When compared to survey data from 2020, this demonstrates an increase trend.

Modern contraceptives and essential, life-saving maternal or reproductive health medicines' accessibility was assessed. In comparison to the 2020 report, there has been no change in the availability of seven key lifesaving maternal and reproductive health medications at around 93% of the health facilities assessed.

The percentage of health facilities nationwide that had contraception in stock at the time of the survey provides a quick snapshot of the situation. In contrast to 67% in 2020, 46% of the facilities assessed did not experience any sort of stock out on the survey day.

At primary facilities, most nurses (OICs) are in charge of placing medical supply orders, and pharmacists are in charge at secondary and tertiary facilities.

The extent of 'no stock out' at the time of the survey gives a snap shot of the availability of contraceptives at the Health facilities across the country. On the overall, 71 percent of the facilities assessed did not experience any form of stock out on the day of the survey compared to 66% in 2020.

Most nurses (OICs) across facilities are responsible for ordering medical supplies at primary facilities, similarly with pharmacists at secondary and tertiary facilities.

The main source of routine medicines and supplies to health facilities in Liberia is the central medical store (81%) with 89% of public facilities assessed mentioning central medical as the main sources of medicine and supplies.

A cold chain's existence ensures the security of reproductive health products by maintaining the effectiveness of several vital vaccines that save lives and need a consistently cold temperature environment. 13.7% of health facilities lack a cold chain compared 11.5% in the 2020 survey. Solar panels, which are primarily seen at primary facilities, are the primary source of power for fridge utilized in the cold chain. About 86% of all facilities assessed had atleast some of cold chain available compared to 89% in 2020.

Training of staff to provide family planning services is an essential part of on-the-job training that enhances their capabilities and makes service delivery effective and efficient. Generally, the percentage of health facilities with trained staff to provide family planning services and insertion and removal of implants was 86.6% and 87.7% respectively. This shows similar trend in the 2020 survey. Distribution by facility types shows 100% in secondary and tertiary facilities with staffs trained.

The limited availability of some contraceptives, particularly female condom female condoms are excess in some public health facilities and we planning to distribute some private health facilities in the next two months., sterilization services, emergency contraception, and IUDs in these facilities, has been highlighted by this survey in both private and public health facilities. The percentage of health institutions offering IUD and female condom has increased from 61% and 63% in 2020 to 99% and 97% respectively, this may be as a result of recommendations from the previous year to enhance sensitization on some contraceptive methods, such as the use of female condoms and IUDs. Additionally, at least three of the modern contractive methods are available in all health facilities assessed. Despite the fact that the facilities assessed offer at least three contraceptive methods, 53% of health facilities at the time of the survey had modern contraceptive methods on hand.

The 2022 reproductive health commodities and security survey offers very crucial data at this point for decision-making, necessitating the development of an improvement plan that gathers all important stakeholders and can be used to strengthen the current weaknesses in the provision of reproductive health services in Liberia.

SECTION I: INTRODUCTION

Country Background Information

Liberia is situated in West Africa, bordering Sierra Leone on the west, Guinea to the north and Cote D'Ivoire to the east. It covers an area of 111,369 square kilometres and is home to about 4.4 million people. It is a low-income country with an estimated Gross Domestics Product (GDP) per capita of USD 622 in 2019, a 8.8% declined from 2018[2]. The country is geographically divided into five regions and 15 counties, with populations ranging from 74,317 in Grand Kru County to 1,434,974 in Montserrado County[3].

According to the 2019 United Nations Development Program (UNDP) Human Development Index, Liberia ranked 176 out of 189 countries which is among the lowest in the world. The report stated that the average life expectancy in Liberia is estimated at 65 years (66.5-females and 63.5-males) and the adult literacy rate is 52% for women and 75% for men[4]. Progress is being made on some of the Sustainable Development Goals (SDG)—for example, access to improved drinking water is 84 percent, and 47 percent of households have access to improved sanitation facility with services concentrated in urban (35 percent) than rural areas (9 percent). Similarly, 24% of households have access to electricity (39% of urban households and 4% of rural households), while 41% of females and 30% of males age 6 and older have no formal education [5].

Over three-quarters of the Liberian population is below 35 years (63 per cent is less than 25 years old and 32.8 per cent is 10-24 years old)[6]. Among the youth are the excombitants, face formidable challenges, suchhigh unemployment rate and lack of stable source of income as well as sexual and reproductive health information and services. For girls, sex work, early marriage and teenage pregnancy are major challenges

2 Liberia GDP Per Capita 2000-2020. www.macrotrends.net. Retrieved 2020-11-30.

3 Liberia National Population and Housing Census projected figure in 2020

4 http://hdr.undp.org/en/data

5 Liberia Demographic and Health Survey, 2019-20

6 Republic of Liberia (September 2011c) – 2008 Population and Housing Census: Analytical Report on Youths and Adolescents, Liberia Institute of Statistics and Geo-Information Services (LISGIS), Monrovia, Liberia.

they are faced with. At ages 11-14, approximately 11 per cent of females begin sexual life. With 67 per cent of adolescent's girls without edication being mothers, it shows that teenage pregnancy a siginificant contributor to the dropout rate among this group[7], when compared with the 17 per cent who have secondary and tertiary education[8]. Pregnancy among teens increase by age; that is 11 per cent girls get pregnant at the age of 15 and increase to 62 per cent by age 19. Additionally, among pregnacncies experienced in this group, 26 per cent are unintended and out of this number, 30 per cent result into unsafe abortion[9].

Consequently, there is a growing problem when it comes to adolescent sexuality and fertility since children are giving birth to children. Teenage childbearing, unsafe abortion and subsequent low status of women confound maternal deahts.

On March 16, 2020, Liberia reported her first confirmed case of COVID-19. At the end of March 2020, Liberia had three confirmed cases, 434 contacts line listed and 70 samples tested. By 31st December 2021, 1,845 confirmed cases were recorded across Liberia including 83 deaths, 222 health workers' infection and five deaths among health workers. All 15 counties recorded at least a case of COVID-19 with Montserrado being the epicenter[10].

Despite increases in facility-based deliveries (80%) and deliveries assisted by a skilled attendant (84%), maternal deaths in Liberia remains one of the world's highest. According to the Liberia Demographic and Health survey, Liberia has a current maternal mortality ratio of 742 deaths per 100,000 live births, a 31% declined from the 2013 estimate (1,072)[11]. The DHS results also indicate that infant mortality rate in Liberia increased from 54 deaths per 1,000 live births in 2013 to 63 deaths per 1,000 live births in 2019-20 thus disrupting the gains made in previous years towards achievement of the Sustainable Development Goal 3 (SDG 3). The under-5 mortality rate declined slightly from 94 deaths per 1,000 live births in 2013 to 93 in 2019-20. Mortality during the first month of life (neonatal) is higher than post- neonatal deaths (37 deaths per 1,000 births versus 25 deaths per 1,000 births) and accounts for 59 percent of overall infant

[7] Ministry of Health (March 2011) – Road Map for Accelerating the Reduction of Maternal Mortality and Newborn Morbidity and Mortality in Liberia (July 2011 – June 2016), Ministry of Health, Republic of Liberia: p.5.
[8] UNFPA (2012) – 'Country Programme Document for Liberia 2013-2017, United Nations Population Fund, Liberia Country Office, Mamba Point, Monrovia, Liberia: para.3.
[9] Ministry of Health (March 2011), op. cit.: p.5.

[10] Liberia National COVID-19 Lab Pillar presentation at the IMS September 29, 2021

[11] Liberia Demographic and Health Survey, 2019-20

mortality.

The total fertility rate has further declined to 4.2 with rural women most likely to have more children (5.5 births per woman) than those in urban areas (3.4 births). The modern contraceptive prevalence rate (MCPR) increased from 19 percent in 2013 to 24 percent in 2019-20. However, the unmet need for family planning increased from 31 percent to 33 percent during the same period.

Unwanted pregnancies, HIV infections and STIs are the results of low use of modern family planning methods. Ninety-five (95%) of women and 96% of men age 15-49 have heard of HIV. Seventy-three percent (73%) of women know that using condoms reduces the risk of HIV transmission, and 79% know that the risk of transmission can be reduced by having one uninfected sexual partner. Among men, 83% know that using condoms reduces the risk of transmission, while 85% know that the risk of HIV transmission can be reduced by having only one uninfected sexual partner[12]. According to the National AIDS and STI Control Program (NACP), the number of people living with HIV stands at 39,414 with HIV prevalence rate among adults (15- 49 yrs.) estimated at 2.1%. ART coverage rate is 53%; viral load suppression at 63% and prevention of mother to child transmission (PMTCT) coverage is 84% (NACP report 2019)[13]. About two-third (64%) of health facilities have HIV diagnostic capacity[14]. According to the SARA 2018, 85% of health facilities offer BEmONC services and 60% of hospitals provide CEmONC services. However, only 44% of hospitals are ready to provide CEmONC services and less than 1% of primary health facilities are ready to provide BEmONC services.

Liberia is a signatory to the Every Woman and Every Child initiative with a commitment to spend at least 10% of the health sector allotment on RMNCAH. In addition, Liberia is a signatory to the 2030 Sustainable Development Goals (SDGs), FP 2020, the African Health Strategy, the Paris Declaration, the Maputo Call to Action, and the UN Secretary General's Global Strategy for RMNCH Accountability and Results[15].

Despite these initiatives, progress towards improvement of the health status of the population had been marred by systemic deficiencies within the health sector. These include weak coordination of reproductive health services especially at the county level and between and among health facilities, inadequate staffing, long distances to facilities, weak referral systems, ineffective supervision and monitoring in the

[12] National Health Observatory_Final Draft Report_Sept_30_2021
[13] NACP report 2019, Liberia
[14] Liberia Service Availability and Readiness Assessment, 2018
[15] National Health Observatory_Final Draft Report_Sept_30_2021

sector, frequent stock outs due to poor logistic management systems, ineffective private sector involvement, inadequate and ineffective budgetary allocation and inadequate health infrastructure[16].

Liberia continues to face human resource challenges such as; high attrition, poor working conditions, inadequate remuneration, low motivation and uneven distribution of health workers across counties and health care facilities. These issues pose major stumbling blocks to the delivery of quality healthcare services.

In 2020, the health workforce was 17,434, of which 76.6% (13,355) were public health workers. The proportion of public healthcare workers that are civil servants is 60%, 29% are contractors while 11% are volunteers. There are 367 medical doctors, 9,606 registered nurses, 5,217 certified midwives, 1,300 physician assistants and 546 laboratory technicians in Liberia. Clinical staff constitutes 49% of MOH workforce, clinical support staff accounts for 16%, while administrative and others amount to 35%. The doctor to population ratio is 8.1 to 100,000 people and the core health worker density ratio is 12.8 per 10,000 inhabitants. This is nearly half of what is recommended by WHO (23 per 10,000 people) to achieve 80% of skilled birth attendance.

Maternal, newborn, child and adolescent health are core components of the essential package of health services that the Government is committed to providing the Liberia people. The government has introduced policies and strategies directed towards improving the sexual and reproductive health of the population since 2003. Experiences gained from the implementation of the 2006 Road Map for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality in Liberia (2006-2015) served as the foundation for the preparation of the current road map[17] and the associated National Sexual and Reproductive Health Policy[18]. In 2006, all clinics were made free of payments to the public to enhance access to health services nationwide. And then in 2008, the National Strategic Plan for Comprehensive Condom Programming in Liberia (2009-2013) was implemented by the government[19]. Liberia is currently imlplementing it's investement case that prioritized "reproductive maternal newborn child and

[16] See, for examples, Ministry of Health (March 2011), op. cit.: pp.7-8, and Ministry of Health (July 2012) – 'Accelerated Action Plan to Reduce Maternal and Neonatal Mortality', Family Health Division, Ministry of Health, Government of Liberia: pp.15-20.
[17] Republic of Liberia (March 2011a) – Road Map for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality in Liberia (July 2011-June 2016), Ministry of Health, Monrovia, Republic of Liberia
[18] Republic of Liberia (March 2011b) – National Sexual and Reproductive Health Policy, Ministry of Health, Monrovia, Republic of Liberia
[19] Republic of Liberia (December 2008) - National Strategic Plan for Comprehensive Condom Programming in Liberia (2009-2013), Ministry of Health, Monrovia, Republic of Liberia

adolescent health" developed since 2016. The 2018 SARA found that 87% of health facilities offer child preventive and curative services, 81% offers routine childhood immunization, 83% providers adolescent services and 85% offers basic obstetric care services.

Liberia has a Supply Chain Master Plan (SCMP) developed in 2010 to facilitate quantification of drugs, supplies and monitoring across Liberia. The Supply Chain Management Unit (SCMU) at the Ministry of Health quantifies drugs and medical supplies with support from partners (USAID, PMI, Global Fund, etc.) guided by the SCMP. A consolidated procurement plan is developed and executed based on the availability of funds. Upon execution of procurement, drugs, medical supplies and equipment are stored at the Central Medicine Store (CMS) for last mile distribution to counties and health facilities. Public health facilities continue to experience stock-out of drugs and medical supplies because of limited budgetary support from the Government. According to the 2018 SARA Report, only 35% of health facilities had essential drugs. The assessment found that 62% of hospitals has all tracer drugs, 51% of health centers and 43% of clinics. As a result, persistent stock-outs of essential medicines, patients are often given prescriptions by clinicians to purchase drugs outside of health facilities.

The latter practice has implications for high out-of-Pocket expenditure. Additionally, the constant stock-out of drugs and medical supplies is associated with the free health care reign that is been implemented with insufficient funds to procure the require quantity of drugs and medical supplies and the non-adherence to the rational use policy. The most available medicines and drugs in health facilities are Oxytocin injectable (81%) and Ampicillin powder for injectable (76%) while the most unavailable tracer medicines was Cefixime cap/tab (11%). The least available medicine for children was morphine granule injectable/ Capsules/tablets (1%) and Procaine benzyl penicillin powder for injection (32%).

In 2012, Liberia was upgraded from a Stream 2 to Stream 1 Country on UNFPA's Reproductive Health Commodity Security (RHCS). UNFPA Supplies Partnership is a UNFPA flagship programme that supports state actors to ensure access of their national populations to a reliable supply of contraceptives, condoms, essential lifesaving reproductive health medicines and equipment and relevant information for family planning, HIV/STI prevention and maternal health services.

Rationale and Objectives of the Survey

With the increased demand for accountability and the need to demonstrate results, information is needed to track how health systems respond to increased inputs and improved processes over time, and the impact such inputs and processes have on improved health outcomes and better health status.

A core requirement of the UNFPA technical and financial support to governments through the UNFPA Supplies Partnership [formerly referred to as "Global Programme on Reproductive Health Commodity Security (GPRHCS)"] requires yearly performance monitoring surveys to generate information on a number of key indicators.

Therefore, the survey is designed to evaluate both the availability of RH commodities and salient aspects of service delivery facilities that underpin good RH programs by using scientifically sound methodological approaches.

In addition to assessing the availability and stock out of RH commodities, the survey also assessed supply chain (including cold chain); staff training and supervision; availability of guidelines and protocols; Information, Communication Technology, and quality of service delivery at the health centers.

The survey uses framework that facilitates international comparability of program successes and failures and provides data that inform country level RHCS planning, decision-making on administrative and policy issues on reproductive health, and implementation and co-ordination of family planning programmes. The annual survey is expected to help country level RHCS planning, decision-making on administrative and policy issues on reproductive health, and implementation and co-ordination of family planning programmes across the country.

General Objective

The general objective of the study is to assess the service availability, distribution and stock-out of essential lifesaving Reproductive Health (RH) commodities, contraceptives and family planning services at public and private health sectors across the country. The 2020 survey had 7 objectives and are shown below.

The specific objectives of the study are:

1. To assess the number (percentage) of Service Delivery Points (SDPs) offering three and five modern methods of contraceptives including permanent methods.
2. To assess the availability and stock out of seven life-saving maternal/RH medicines (Magnesium Sulphate and Oxytocin plus any other five) from the WHO list, including contraceptives in the public and private sector health facilities.
3. To explore the issues around supply chain management (including cold chain)
4. To identify gaps in staff training and supervision for provision of quality RH services
5. To assess the availability of national guidelines, protocols, standards and job-aids on provision of quality RH services in the health facilities.
6. To assess the issues around availability and use of Information Communication Technology
7. To assess the issues around methods of waste disposal

Survey Organization and Management

The the conduct of the survey was led by the Research Unit of the HMER and the Family Health Division of the Ministry of Health (MOH) with technical support from LISGIS, LBNM & UNFPA. These institutions, which make up the technical team, were responsible for the final outcome of the survey.
UNFPA Liberia Country Office supported the country to implement the survey and provided technical and financial support to ensure that the objectives of the RHCS survey are achieved.

The field data collection across the country was divided into five survey zones as follows:

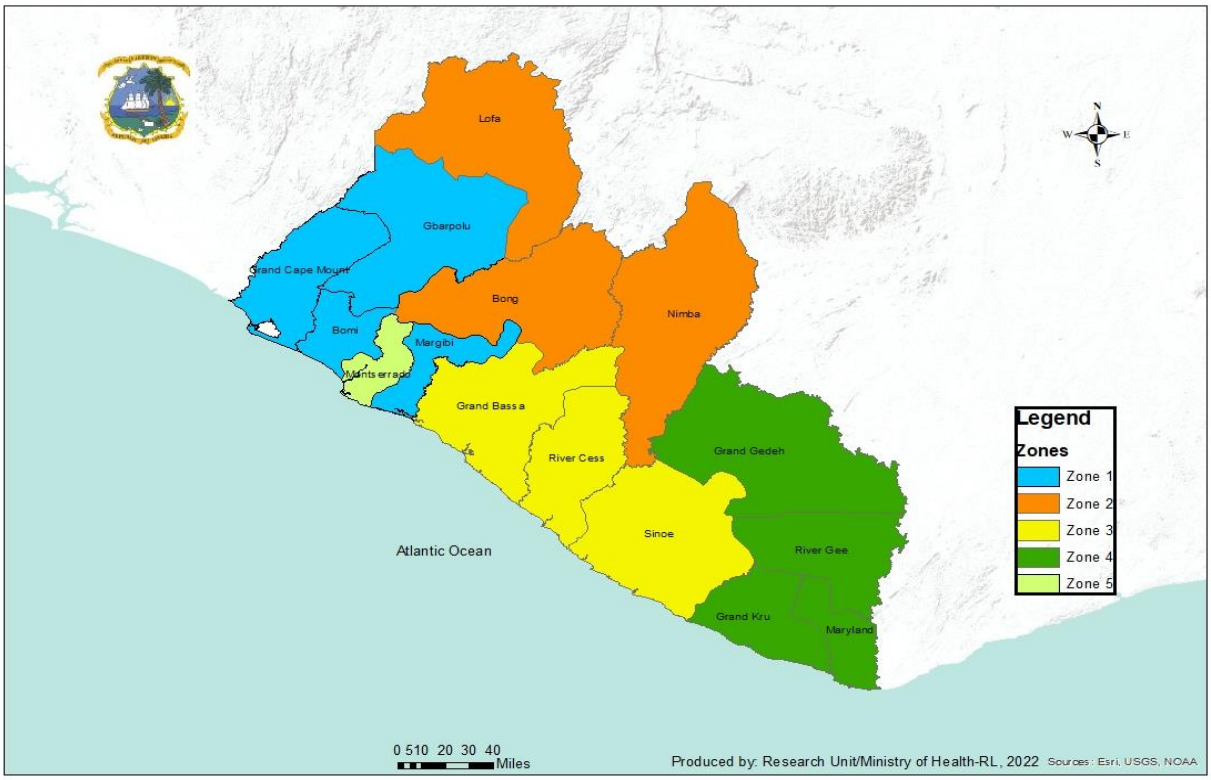
1. Zone 1: Grand Cape Mount, Bomi, Margibi and Gbarpolu Counties;
2. Zone 2: Montserrado County.
3. Zone 3: Bong, Nimba and Lofa Counties;
4. Zone 4: Grand Bassa, River Cess and Sinoe Counties;
5. Zone 5: Grand Gedeh, River Gee, Maryland and Grand Kru Counties

The zones were created in such as manner as to even out the workload for the field teams. Each survey zone was under the control of a field supervisor who supervised the two survey teams in the zone. Each

team had two enumerators. Therefore, a field team of five – four enumerators and a supervisor covered the entire survey.

Montserrado was taken as a zone because it is host over one-third per cent of the service delivery points (Health facilities) in the country. The rest of the workload was evenly distributed among the other zones having regard to the number of Health facilities in the county, the distances to be covered and nature of the terrain. The field teams were also monitored and supported by field coordinators across the five zones with each zones being covered by a coordinator.

Figure 2: Map of Liberia Showing the 2022 reproductive health Survey Zones



Methodology and Limitations

1.4.1 The RHCS performance monitoring country questionnaire was adopted used to conduct the RHCSS at sampled health facilities across the fifteen counties of Liberia. The below four outcome indicators contained in the RHCS performance-monitoring framework was emphasized using a standardised methodology.

1. Number of Stream One countries with Service Delivery Points (Health facilities) offering at least three modern methods of contraceptives,
2. Percentage of Health facilities with at least five (5) modern methods of contraceptives,
3. Number of Stream One countries where seven life-saving maternal/RH medicines (Magnesium Sulphate and Oxytocin plus any other five) from the WHO list[20] is available in all facilities providing delivery services and
4. Number of Stream One Countries with Service Delivery Points with 'no stock outs' of contraceptives within last three months.

As a requirement requested by Commodity Security Branch (CSB), Stream One Countries should maintain the tradition of a standardised methodology as follows:

- Use of a uniform research format so as to enable cross country comparisons;
- A standard uniform format of reporting in line with the three or four global indicators;
- Conduction of annual reproductive health monitoring survey
- Use of a standard survey methodology for international comparability: TOR, work plan, timeframe, questionnaire, sample taking, field procedures, table layouts, report format, etc.

The procedure for data collection followed a stratified sampling with a random start within each of the undermentioned categories of Health facilities providing modern contraceptives and maternal/reproductive health medicines and services; otherwise considered as stratum:

1. Stratum 1: Primary level care Health facilities
2. Stratum 2: Secondary level care Health facilities
3. Stratum 3: Tertiary level care Health facilities

In each stratum, the probability of selection of a unit to be included in the sample was proportional to the size (pps) of that stratum. The final sample was drawn from each county systematically based on the sampling interval calculated for that county. In addition to the distribution of these Health facilities in the counties, the type of services they provide (some may provide one and some both) was relevant to the study.

[20] According to the WHO priority life-saving medicines, for women and children, 2012

1.4.2 Sampling Frame

The list of accredited health facilities (901) that operate in the Republic of Liberia for 2021 was generated from the Liberia Master Facilities Listing (see table 1 below) and form part of the sampling frame for the survey.

Table 1::Types of functional health facilities in Liberia by County as of 2021

County	Clinic	Health Center	Hospital	Grand Total
Bomi	25		1	26
Bong	53		3	56
Gbarpolu	15		1	16
Grand Bassa	33		3	36
Grand Cape Mount	31	3	1	35
Grand Gedeh	22	2	1	25
Grand Kru	14	5	1	20
Lofa	52	4	4	60
Margibi	45	10	2	57
Maryland	25	2	1	28
Montserrado	364	25	7	396
Nimba	67	5	5	77
River Gee	17	2	1	20
Rivercess	15	1	1	17
Sinoe	33	2	1	36
Grand Total	**807**	**61**	**33**	**901**

Source: Liberia HIS (DHIS2)

The main categories of the health facilities (primary, secondary and tertiary) were considered as the attributes and the total sample was chosen in such a manner as to contain a minimal number of each type of facility to support a good estimation of the parameters of the population.

In using this relation, only the categories of the health facilities were taken into consideration. The inter-country variations in the distribution of Health facilities per category did not affect the results of the survey since the Health facilities were regarded as 'standalone' entities.

1.4.3 Sample Selection

Selection of samples was by a stratified random sampling methodology, which started by summarizing the distribution of Health facilities by county and level of service delivery. In cognizance of the insufficiency of secondary and tertiary level health facilities in the distribution of Health facilities, the estimating formula has a tendency of according them a higher probability of inclusion in the sample and

provides a guide for choosing a sample of the primary facilities. Hospital in this case is secondary while health centers and clinics were called primary facilities. The following distribution of health facilities in the sampling frame by county and level of healthcare is presented in Table 2 below

1.4.4.1Calculation of Sample size

About sixteen percent 16% (12.2%) of the total number of functional health facilities (901) in Liberia was systematically selected to form part of the 2022 reproductive health commodities and security survey. In this distribution, all Tertiary facilities (2) and non-specialized Secondary Hospitals (30) were all selected while about eleven percent 11% (8.8%) of health centers and clinics (80 health facilities) combine were also selected for the survey.

One Hundred and two (102) health facilities out of the one hundred ten (110) health facilities were assessed during the field exercise. The assessment of health facilities was 92.7% completed. The team were not able to assessed 8 primary health facilities (Genoyah and Nemiah-Grand Kru; B&P Clinic-Grand Gedeh; Gondalahun-Lofa; Fen-River Clinic-River Cess; Druebo Clinic-River Gee and Sis. D. Medical & Gbarpolu Community Clinic- Gbarpolu County) due to several challenges faced by the teams especially in counties where there were no access to health facilities due to huge downpull of rain and flooding. The disaggregation by type of health facilities assessed is as follows:

- Tertiary Hospitals–2
- Secondary Health Facilities (Hospitals)-30
- Primary Health Facilities – (Clinic and Health Centers-72)

Health Facilities by ownership are as follows:

- Government/Public – 81
- Private-21

1.4.4.2 Distribution of Sample Sizes for Counties

The table below 2 shows the distribution of health assessed by counties and by ownerships. The study reveals that Montserrado, which host Monrovia City, had the highest distribution (27%) of the overall sample size. These samples were formed based on probability proportionate to the size of the total health facilities in counties.

By defult, government health facilities had the highest distribution of facilities assessed as show above.

Table 2: Distribution of Health Facilities Assessed by Counties

Counties			Facility Type

	Total Facilities	Total Assessed	Clinic	Health Center	Hospital
Bomi	3	3	2	0	1
Bong	8	8	5	0	3
Grand Bassa	5	5	3	0	2
Grand Cape Mount	4	4	1	2	1
Grand Gedeh	4	3	1	1	1
Grand Kru	6	4	2	1	1
Lofa	10	9	4	1	4
Margibi	8	8	4	3	1
Maryland	4	4	1	2	1
Montserrado	28	28	13	8	7
Nimba	11	11	5	2	4
River Cess	5	4	3	0	1
Sinoe	5	4	3	0	1
River Gee	4	4	2	1	1
Gbarpolu	5	3	2	0	1
Total	110	102	51	21	30

1.4.5 Survey Instrument

Since 2010, UNFPA, through the Reproductive Health Commodity Security (RHCS), has supported the conduct of an annual survey on the availability and stock-out of contraceptives and essential maternal health medicines in 13RHCS Stream 1 countries. The focus of the past RHCS surveys was on three outcome indicators in the monitoring and evaluation framework as follows: (a) Service Delivery Points (Health facilities) offering at least three modern methods of contraceptives; (b) seven lifesaving maternal and RH medicines (Magnesium Sulphate and Oxytocin plus any other five) from the WHO list[21] available in all facilities providing delivery services, and (c) 'no stock outs' of contraceptives within the six months before the survey.

The questionnaire used in the 2022 round of RHCS surveys is an extensive revision of the 2018 & 2020 instruments. The adapted instrument consists of two modules and 13 sections as follows, with additional questions for males and females condoms.

MODULE 1: AVAILABILITY OF COMMODITIES AND SERVICES

Section 1: Facility Identification (Name, Location and Distance)

Section 2: Health Facility Type and Services Provided

Section 3: Modern Contraceptive Methods Offered at Health Facility

Section 4: Availability of Maternal/RH Medicines

Section 5: No Stock-Out of Modern Contraceptive Methods at Health Facility

MODULE 2: HEALTH FACILITY RESOURCES

Section 6: Supply Chain

Section 7: Existence of Cold Chain At HEALTH FACILITY

Section 8: Staff Training for Family Planning

Section 9: Staff Supervision for Reproductive Health Including Family Planning

Section 10: Availability of Guidelines Check-Lists and Job Aids

Section 11: Availability and Use of Information Communication Technology (ICT)

Section 12: Waste Disposal

Section 13: Charging of User Fee

1.4.6 Training of Data Collectors and Supervisors

A three-day intensive training of the data collection teams (supervisors and enumerators) followed by half a day field practice was carried out. Training participants included 14 data collectors, 4 supervisors and 3 coordinators and 2 programmers. The supervisors were given an orientation on survey methods and supervision in addition to the interviewers' specific training. The enumerators were selected from a pool of individuals with clinical skills and had previous experienced in collecting data. The supervisors and enumerators review the questionnaire and practice using them.

During training of the field staff, a lot of emphasis was placed on caution to be exercised for assessing availability and stock-out of contraceptives and female and male sterilisation.

The training took into consideration infection prevention and control (IPC) training with emphasis on keeping health prevention protocols especially COVID-19. All team members were advised to carry along with them sanitizers and facemask.

1.4.7 Data Collection

The field data collection exercise lasted for a period of 13 days, survey teams were assigned in every county. The Field Supervisors closely guided the daily conduct of Enumerators and ensured proper field

editing of the completed questionnaires to minimise errors and eliminate the need for recalls after the conclusion of fieldwork. There were 3 national coordinators who monitored the fieldwork in various Counties through in person or virtual means and communicated with the teams on a regular basis to ensure a smooth implementation of the assignment. These included high-level personnel from the Divisions of Family Health; and Monitoring, Evaluation and Research (MOH). There were six teams of 3 assesors, each team had a supervisor. Each team was responsible for collecting data from the assigned health facilities.

Community Entry

Upon arriving at the county, supervisors and interviewers meet with the County Health Teams and later authorities of the selected health facilities to provide an initial briefing (communications were sent to the county prior to the team's arrival at the those assigned facilities.

For superviosrs, they were responsible for the assessment teams' management and the initial review of the completed data collection instruments. Each collection form was checked fpr accuracy and completeness before the team leaves the field. The consultants were doing counter check of all data collection instruments before passing them on for data entry.

Health Facility Interviews

The health facility interviews were in two parts. The first part of the questionnaire involved interviews with the Officers-in-Charge (OIC) of the various health facilities. The questions pertained to facility-based information on availability and stock-out of the maternal and reproductive health and contraceptive commodities and services.

The teams' superviors were tasked to inform the authorities of the Health facilities and seeked their permission before the client interview section could be completed for a particular HEALTH FACILITY.

The interviewer informed the client about the purpose of the client interview and conducted the survey in private (Steps should be taken to ensure that no other person is present for the interview) locations.

Although ethical issues were strongly mainstreamed into the questionnaire and field procedures, clearance to implement the survey was also obtained from the Ministry of Health of Liberia. Strict observance of the code of ethics was required of Field Staff and Coordinators.

1.4.8 Data Management, Analysis and Presentation

Data management involved officers checking for completeness, accuracy and internal consistency of entries on the questionnaires. The field data collection was done using handheld devices and transmitted to a central server, electronic editing was done through an application in CSPro where edit specifications were set. Preliminary frequencies were observed and queries on some abnormal occurrences were verified or corrected. Nearly all the tables were produced in CSPro, but the data file was exported to SPSS using CSExport MFC Application to produce tables that needed further calculations through the SPSS analysis command; for example, averages. Using SPSS, Excel and ArcMap, data analysis involved descriptive statistics, using percentage distributions of the variables in crosstabs and annotations like maps, charts and graphs.

The distributions of the various attributes were with reference to national guidelines, protocols and laws relating to the delivery of contraceptive commodities and/or maternal/reproductive health services. In analyzing the responses, the sections relating to the availability of contraceptives and their stock out were analysed with reference to only those sampled Health facilities that offer family planning services. Similarly, the section relating to the availability of maternal/RH medicines was analysed with reference to the sampled Health facilities that offer delivery services.

1.4.9 Limitations of the Survey

The very noticeable challenged faced with was the lack of access to assess 8 primary health facilities due to very bad road conditions especially during the rainy season. For example, teams had to spent 3 days each on their way to Lofa and Grand Gedeh due to lack of road access. Those facilities were distributed in six counties (Gbarpolu-2, Sinoe-1, Rivercess-1, Lofa-1, Grand Kru-2 and Grand Gedeh-1). There were less facilities (102) this time around assessed compared to 2020 and 2018 surveys. However, the study being a sample survey still represents the current look of things across health facilities and it is representative of the distribution of health facilities in Liberia.

1.1 Outline of Report

There are three broad sections of this report: the Preliminary Section, Main Body and Closing Section. The preliminary section of the report is as follows:

- The Forward and Acknowledgement;
- The meaning of abbreviations used in the document compiled and presented in alphabetical order in the Acronyms;
- Lists of tables, charts and appendices provided alongside the Table of Contents, and
- A succinct summary of the main findings of the report presented in the Executive Summary.

The second section presents the main body of the report in the form of the findings of the survey and is divided into five parts.

Part One is the introduction that gives the country background information; rationale and objectives of the survey; research methodology including sampling procedures, questionnaire, fieldwork/data collection and data analysis; the limitations of the study and outline of the report.

Part Two explained a summary of the national guidelines, protocols and laws that regulate the conduct of providers of contraceptives and essential lifesaving maternal/RH commodities in the different categories of Health facilities in the country

The third part detailed the findings of the research with respect to the availability of commodities and services. It has nine subthemes. Part 3.1 gives general information about service delivery points in the country with respect to their geographic distribution, management and distance from the source of supplies. Part 3.2 discusses the modern contraceptives offered by the facilities. It examined national and subnational level variations with respect to the various categories of Health facilities in the country. Tables, diagrams and maps illustrated the health facilities offering at least three types of contraceptives. A subsection discusses the reasons why three modern methods of contraceptives were not provided in some facilities. In addition to giving a general picture, peculiar reasons, as related to specific methods, were highlighted.

Part 3.3 dealt with the availability of maternal RH medicines, bringing out the national and sub-national dimensions in the discussion. The discussion also captured the key essence of the indicator (availability of seven essential lifesaving medicines) in the various types of Health facilities in the country. Tables and diagrams were used to further explain the research findings. In this section, the reasons why the

medicines were not available were provided; bringing out the subnational dimension and the peculiarity of these reasons to specific Health facilities.

Part 3.4 discussed the incidence of 'no stock out' of modern contraceptives, bearing in mind that 'no stock out' is taken to mean a situation in which a family planning HEALTH FACILITY in a country does not run out of supplies of any one or more of the modern methods of contraceptives at any point in time over the previous 6 months and, therefore, had supplies on hand to serve clients at all times. The discussion focuses on the occurrence of 'no stock out' in the last six months as well as the occurrence of 'no stock out' on the day/moment of the survey. In addition, the occurrence of product specific 'no stock out' for each contraceptive method is examined; with the aid of tables, diagrams and maps. Also, the reasons why the stock outs occurred were analysed.

Part 3.5 investigated aspects of supply chain including sources of supplies; use of logistics forms; method of determining commodity needs; frequency and transportation of supplies and existence of cold chain. Information on staff training for family planning and their supervision (including frequency and purposes of supervisory visits) were discussed in Part 3.6. Part 3.7 discussed the availability of guidelines, check-lists and job aids at Health facilities. Information on the availability and use of information communication technologies as well as method of waste disposal used by the Health facilities were explained in Part 3.8. Part 3.9 concerned items for which the facilities charge fees (including for consultation, commodities and services) and instances of exemptions were noted.
In Part 4 of the report, the conclusions and key recommendations, based on the findings were presented, generally focused on each of the three indicators.

The Closing Section of the report is the annex which contains lists of documents consulted and cited under the Bibliography; the survey instrument; and additional tables and diagrams, etc.

SECTION II: SUMMARY OF NATIONAL GUIDELINES, PROTOCOLS AND LAWS FOR DIFFERENT HEALTH FACILITY CATEGORIES

2.1 Introduction

This section discusses the national guidelines, protocols and laws that currently exist in Liberia relating to the provision of contraceptives and maternal/reproductive health medicines. This was recommended by the Commodity Security Branch, New York, in the 2012 round of the reproductive health and commodities

security Survey and has been accentuated in the questionnaire. This is because national guidelines and protocols are crucial for reproductive health commodity security and for enhancing quality health services. Consequently, the survey report provides summary of the national protocols, guidelines and laws which underline the provision of contraceptives and maternal/reproductive health commodities in the different categories of service deliver points (Health facilities) in the country.

Liberia has developed national guidelines, protocols and laws for enhancement of quality care at facilities for maternal, newborn health/reproductive health and family planning. These are within the framework of the revised National Health and Social Welfare Policy and Plan 2011-2021 which is based on Basic Package of Health Services (BPHS) adopted in 2008; revised and contained in the Essential Package of Health Services (EPHS) in 2011[22]. The EPHS is in two phases, with the first phase from 2011-2013. The purpose includes the expansion of standard primary packages of health services, provision of equitable access to essential hospital services, and strengthening service delivery networks and operational plans for development.

The National Health and Social Welfare Policy and Plan 2011 is committed to the improvement of health and social protection within the context of United Nations Millennium Development Goals (MDGs), national vision and economic transformation by 2030 designed to positively increase health services including sexual and reproductive and child health services. It aims to provide health and social welfare to the population on an equitable basis and make services affordable.

One of the specific objectives of this policy is to improve maternal and newborn health and reduce pregnancy-related morbidity and mortality and improve family planning services. The plan endeavors to reduce maternal mortality and teenage pregnancy through ensuring availability of full range of contraceptive methods including effective prevention and management of reproductive tract infections, HIV and AIDS and provision of “youth friendly” adolescent reproductive health services.

2.2 Levels of Health Service Delivery

[22] Ministry of Health & Social Welfare, Essential Package of Health Services, 2011

There are three main levels of provision health service delivery to the population with each level performing as a gatekeeper for the next level. They are primary, secondary and tertiary levels of healthcare.

2.2.1 Primary Healthcare

The primary level is composed of services provided at the community level. The community health volunteers include Household Health Promoters (HHPs), Trained Traditional Midwives (TTMs) and community health volunteers. Thus, the community level services include standard outreach, health promotion and referral services through preventive services like antenatal care; and family planning, curative services at facility through distribution of limited medicines and commodities. The community health workers serve as a link between the community and facility (Figure 3).

The clinic is the basic unit of the health system at the primary level. The clinic provides preventive and curative services, including maternal and child care with immunization and delivery attendance on a permanent basis. Clinics may have beds and or laboratories. A clinic is intended to have two professional staff, a nurse and a midwife, as well as a licensed practical nurse and TTM who would refer to the health centers as needs may arise. In remote areas with clustered catchment population of 1,000–3,500 people, clinics are small facilities with basic teams. In urban areas, clinics are large structures with the capacity to deal with many outpatient users and occasionally offer double shifts. Clinics do not offer round the clock attention although health workers are on call in rural areas. In principle, regular clinics should provide services for catchment populations of 3,500-12,000.

2.2.2 Secondary Healthcare

Secondary levels include health centers and hospitals. Health centers are the transition between primary and secondary levels of care. While providing mostly primary care, their inpatient capacity makes them a referral facility. They offer 24-hour primary care services complemented by a small laboratory and inpatient capacity of up to 40 beds for a catchment population of up to 25,000 to 40,000. Health center must have at least two physician assistants, a nurse, four certified midwives and other supporting staff to handle other clinical capacities that can occasionally include emergency surgery. Health centers are small hospitals and should provide Basic Emergency Obstetrics and Neo-natal Care (BEmONC). Although health centers are placed within secondary level, their major functions are merely primary care level.

Hospitals include public and private facilities, which receive referral from the community, clinics and health centers. The hospitals provide general surgery, pediatrics, general medicine, obstetrics and gynecologic services including Comprehensive Emergency Obstetrics and Neo-natal Care (CEmONC). The hospital must have 100 beds or more with and intensive care unit, a laboratory and radiology services. It must have at least a medical doctor, 10 nurses, three physician assistants, six midwives and other supporting staff. The hospitals are expected to provide 24 hours services.

The tertiary level consists of specialized referral facilities (Figure 3) and teaching hospitals for physicians, sub-specialists and allied health professionals. They may have 500 beds or more with advanced specialists, laboratory and radiology capabilities.

2.3 Summary of Health Service Interventions and Services

2.3.1 Summary of Guidelines, Protocols and Laws for Provision of Modern Contraceptives/Family Planning

Pregnancy and childbirth are normal parts of life. However, has been acknowledged there are some hazards associated with pregnancy and childbirth particularly when they occur too close. At such, they may present complications and cause deaths among women of childbearing age as many in developing countries including Liberia. The maternal mortality deaths for Liberia though still high have become to decrease from 1072 in 2013 to 742 deaths per 100,000 live births in 2019 according to the DHS findings. The major causes of maternal death in Liberia are hemorrhage (bleeding in pregnancy), sepsis (infection) complicated by limited or no access to emergency obstetric care upon arrival at health facilities, inadequate family planning services and high teenage pregnancy rate[23],[24]

Though the total fertility rate has reduced to 4.2 and modern contraceptive prevalence rate (MCPR) increased from 19 percent in 2013 to 24 percent in 2019-20, the unmet need for family planning increased from 31 percent to 33 percent during the same period according to the DHS 2019-2020.

Family planning use is still far below the threshold to affect fertility levels and decrease the morbidities and mortality associated with pregnancy and averting unwanted pregnancies among adolescents and older women. The total number of children per woman for Liberia was 7.1 in 1984, 5.8 children per woman

[23]Liberia Service Availability and Readiness Assessment, 2018 report
[24] Liberia Demographic and Health Survey 2019-2020

in 2008 census[25] and 4.7 in 2013 and 4.2 in 2019[26].This is still high and associated with shorter birth intervals and child spacing. Births interval which is the length of time between two live births is essential in understanding the health status of children. This is so, because it has been documented that children born too close are at increased risk of health problems and dying at early age. Longer birth intervals or child spacing contribute to improvement in the health of mother and child. The 2019/2020 Liberia Demographic & Health Survey shows that the median birth interval is now 40.2 months compare 36.4 months in 2007. Birth intervals increase with age, from 26.0 months among women age 15-19 to 46.7 months among women age 40-49.

Family planning services has been integrated into primary health care for achieving socio-economic development within the Family Planning Law as well as the National Policy on Population for Social and Economic Development. The guidelines and protocols for provision of modern contraceptives and delivering other family planning services as stipulated within the Essential Package of Health Services required that information about the benefits of birth spacing and supplies of contraceptives should be available at all levels of the health system. Community-based promoters and distributors should supply pills and male and female condoms. However, injectable contraceptives, implants, syndromic management of sexual transmitted infections for males and females. Injectable contraceptives, implants, intra-uterine devices and prevention of mothers-to-child transmission and voluntary confidential testing for HIV should be available at clinics and other health facilities, while surgical contraception should be available in referral hospitals[27]. See table 36 in annex for further elaboration.

2.3.2 Summary of Guidelines, Protocols and Laws for Provision of Maternal/Reproductive Health Medicines, and Maternal and Newborn Health

2.3.2.1 Maternal and Newborn Health

The Liberian Government has made the provision of quality maternal and newborn care services as number one prority thereby developing the RMNCH investment case. In order to attain the desire goal of reducing maternal and newborn mortality, Liberia has also developed significant policies, standards and strategic guidelines which include the Road Map for Decreasing Maternal and Neonatal Mortality; Reaching Every District and Reaching Every Pregnancy; the Accelerated Action Plan to Reduced Maternal

[25] Liberia Institute for Statistics and Geo- Information Services, Fertility and Nuptiality in Liberia, 2011
[26] Liberia Demographic and Health Survey 2019-2020
[27] Ministry of Health, Essential Health Package Services, July 2011, Monrovia, Liberia

and Neonatal Mortality, etc., all which have been embedded in the National Health and Social Welfare Policy and Plan.

The guidelines and protocols for provision of maternal/reproductive health and newborn health services are specified within Essential Package of Health Services and requires that diagnose, pregnancy (clinic), screen for high risk, including short height, information, education/behavioral change communication on diet and rest during pregnancy and lactation, on the importance of antenatal care, birth preparedness and danger signs, home delivery and family planning at community and all health facilities levels simple and minor interventions and services at other levels. The guidelines and protocols specified that complications of pregnancy, labor and delivery should be referred at hospitals. See table 37 in annex for further distribution.

2.3.2.2 Emergency Obstetric and Neonatal Care (EmONC)

The EPHS divide Emergency Obstetric and Neonatal Care (EmONC) into two categories: Basic Emergency Obstetric and Neonatal Care (BEmONC) and Comprehensive Emergency Obstetric and Neonatal Care (CEmONC) as follows:

Table 3 Basic and Comprehensive Emergency Obstetric Care Guidelines and Protocols

Basic EmONC in Health Centers	Comprehensive (EmONC) in Hospitals
IV/IM Antibiotics IV/IM Oxytocin IV/IM Anticonvulsants Manual removal of placenta Assisted vaginal delivery Removal of conception retained products Essential Newborn Care	All seven basic EMONC functions plus: Caesarean section Blood transfusion

Source: Essential Health Package Services, Ministry of Health, 2011

2.3.2.3 Postnatal Care

Globally, approximately half of maternal deaths occur within the first 24 hours after delivery. The WHO guidelines recommend that women receive a postnatal health care check within the first 24 hours after delivery irrespective of the place of birth. In line with this global consideration, policy guidance provided

by the MOH demands that every mother and her newborn are provided comprehensive postnatal care for the mother and newborn, including the first vaccines for the newborn within 24 hours after birth.

The Postpartum and Newborn Protocols clearly describe the care to be provided, procedures, and specific time of care during this critical period (MOH 2015c; MOH 2015d). In addition, there may be a variety of other minor complaints that require advice or management. The percentage of women who received a postnatal check within 2 days of birth increased from 71% in 2013 to 80% in 2019-20. Over the same period, the percentage who received postnatal care within 4 hours of birth rose from 56% in 2013 to 69% in 2019. On the other hand, proper care for newborns is essential to reduce neonatal problems and death. According to WHO, postnatal care services for newborns should start immediately after birth since most neonatal deaths occur within the first 48 hours of life (WHO 2015b). Three quarters (76%) of newborns received a postnatal checkup within 2 days of birth, and 66% received a checkup within 4 hours[28].

The guidelines and protocols for postnatal care, as stipulated in the Essential Package of Health Services, cornerstone of the National Health and Social Welfare Plan and Policy specified that mother's condition should be checked by the midwife immediately after delivery. Mother should be seen at the end of the first week by midwife or traditional midwife to assess her general condition, the presence of anemia, uterus and breast. The protocols and guidelines mention on the provision information on breast-feeding, contraception and birth spacing at community and all health facilities while minor intervention and services at others facilities. Furthermore, complications for the managements of puerperal sepsis, and others should be referred at hospital[29]. See table 38 in annex.

2.3.2.4 Adolescents and Youth Specific Sexual Reproductive Health Program

It has been documented that adolescents and youth possess the capacity to decide the future of every nation. Hence, health and well being of adolescents and youth are critical and essential to the overall development of any society and therefore they must be protected against threats that limit opportunities for growth. Available evidence indicates almost half of the world's 7 billion people are under the age of 25 and in the developing world young people constitute a significant proportion of the population.

[28] Liberia Demographic and Health Survey 2019/2020
[29] Ministry of Health, Essential Package of Health Services, July, 2011

2.4 Summary of Standards for the provision of Essential Package of Sexual and Reproductive Health Services for Adolescent and Young People

The adolescents and youth between ages 10 and 24 years constituted 32.8 percent and 63 percent less than 25 years of age of the 3,476,608 population of Liberia in 2008. Liberia has developed standards for the provision of essential package of sexual and reproductive health services for adolescent and young people[30]. These services are free, friendly and provided through the health system of Liberia.

For HIV services, the standards required that information and health education/inter personal communication/ advocacy, provision of condoms and psychosocial support at community and all health levels including pharmacies. Others services, such as VCT, management of opportunistic infections, support for ARV and follow up clients on ARV, treatments and home based care, prophylaxis, PMTCT as well as first line ARV treatment are available at all hospitals.

Treatment by syndromic, partner approach and diagnosis with laboratory should be provided at clinics and health centers. Specific treatment and management of complications of sexually transmitted infections are available at hospitals. Information about the benefits of birth spacing and supplies of contraceptives should be available at all levels of the health system. Community-based promoters and distributors supply pills and both male and female condoms. Injectable contraceptives, implants, spermicide, and IUDs should be available at all Health facilities, and surgical contraception is available in referral hospitals.

Counseling, PNC, maternal and child nutrition on delivery of services including the provision of condoms, family planning, home-based neonatal care and immunization should be available at community and all health levels. However, other services such as therapeutic abortion service, safe and clean normal labor & delivery, PAC and PMTCT at clinic level and Cesarean Sections are referred and available at health centers and hospitals. See tables 39-41 in annex for further distribution.

[30] Ministry of Health & Social Welfare, Standards for the Provision of Essential package of Sexual and Reproductive Health Services for Adolescent and Young People, pp.7-9, July2012

SECTION III: SURVEY FINDINGS

3.1 General Information about the Health facilities

3.1.1 Health Facility Type and Services Provided

Primary, secondary, and tertiary levels of care are the three tiers of the health care system in Liberia. The primary level of care is the lowest level of treatment that a patient receives. It is comprised of community-based distributors for specific products and services, primary healthcare clinic levels 1 and 2, and integrated outreach programs. Additionaly, health centres, which receive referrals from primary health clinics levels 1 and 2 and referrals from the community and district health systems. Health centers are the transition between primary and secondary levels of care. The secondary level referes to district and county hospitals that receive referrals from the primary levels mainly through the health centers. Tertiary healthcare facilities cater to the national referral health system.

Unlike the 2018 survey, health facilities forming part of the 2020 and 2022 surveys grouped health centers and clinics as primary, hospitals as secondary facilities, while referral hospitals are classified as tertiary hospitals. The tertiary facilities considered were John F. Kennedy Medical Center in Monrovia and Jackson F. Doe Memorial Hospital Tapita in Nimba County.

Table 4 indicates that over 98% of the healthcare institutions that were assessed provide family planning as well as maternal or reproductive health goods and services. This fits in line with what was discovered in the assessment of 2020. When compared to the statistics from 2018, which reported 100%, there has been a reduction in the number of services that have been delivered. Each and every secondary hospital and tertiary hospital offers the respective services at a rate of one hundred percent. See table 4 below for further distribution.

Table 4: Percentage Distribution of Health Facilities Providing Family Planning and Other Maternal Health Services: Liberia 2022

Healthcare Level	Distribution in Sample		Percentage Providing	
	Frequency	Percent	Family Planning	Other Maternal or Reproductive Health
Primary	72	70.6	98.6%	98.6
Secondary	28	27.5	100	100.0
Tertiary	2	1.9	100	100.0
Total	102	100.0	99.0	99.0

3.1.2 Geographic Distribution of Facilities

The distribution of health facilities between rural and urban areas as well as their county-level distribution are covered in Table 11 below. Findings show that 100% of rural health facilities offer family planning and 98% of them offer reproductive health services. These numbers are in line with the 2020 assessment, but they are higher than the 98 and 95% of rural-urban health facilities that offer family planning and reproductive health services, respectively in 2018.

Overall, the distribution of counties by provision of family planning and maternal or reproductive health care found that, with the exception of Montserrado (96.4%), all institutions surveyed (in 14 of the fifteen counties) provide all of these services. For a more detailed breakdown per county, see Table 5 below.

Table 5. istribution of Health facilities by Urban-Rural Residence and Spread by County:

Healthcare Level	Frequency	Percentage Providing	
		Family Planning	Maternal or Reproductive Health
Rural-Urban Residence			
Urban	67	98.5%	98.5%
Rural	35	100.0%	100.0%
Total	102	99.0%	99.0%

Distribution by County			
Bomi	3	100.0%	100.0%
Bong	8	100.0%	100.0%
Grand Bassa	5	100.0%	100.0%
Grand Cape Mount	4	100.0%	100.0%
Grand Gedeh	3	100.0%	100.0%
Grand Kru	4	100.0%	100.0%
Lofa	9	100.0%	100.0%
Margibi	8	100.0%	100.0%
Maryland	4	100.0%	100.0%
Montserrado	28	96.4%	96.4%
Nimba	11	100.0%	100.0%
River Cess	4	100.0%	100.0%
Sinoe	4	100.0%	100.0%
River Gee	4	100.0%	100.0%
Gbarpolu	3	100.0%	100.0%
Total	102	99.0%	99.0%

3.1.3 Management of Facilities

In general, the Liberian government owns a little more than two thirds of all of the health facilities that are located across the nation. With reference to non-governmental organizations, the Ministry of Health has created certain provisions in order for some facilities to be operated by such NGOs. Table 6 demonstrates that methods of family planning are made available in all publicly run health facilities (100%) which is comparable to the results of the year 2020 but higher than those of 2018 (98%). In addition, we discovered that 98 percent of all public health facilities provided additional reproductive or maternal health services, which is comparable to the results of the 2020 assessment but lower than the 100 percent figure from the 2018 survey. This distribution demonstrates a significant engagement of the private sector in the delivery of maternal or reproductive health care; yet, there has been a 5% reduction in the supply of family planning services (95%). See table 6 below.

Table 6: Percentage Distribution of Health Facilities Providing Family Planning and Maternal Health Services by Management of Health facilities

	Percentage Providing

Distribution by Ownership	Frequency	Family Planning	Maternal or Reproductive Health
Government	81	100.0%	98.8%
Private	20	95.0%	100.0%
Others	1	100.0%	100.0%
Total	**102**	99.0%	99.0%

3.2 Modern Contraceptives Offered by Facilities

3.2.1 Contraceptives Offered by Type of Facilities

In accordance with the national protocols, guidelines, and/or legislation governing the provision of family planning techniques throughout the country at every level of the service delivery continuum[31]. The majority of the nine kinds of modern methods of contraception that are offered in Liberia include injectables, intrauterine devices (IUDs), oral tablets, implants, male and female condoms, and sterilization procedures for both male and female. Emergency contraception is also one of the ways that is offered. On the other end of the spectrum, it is anticipated that only approximately a third of the facilities would provide both male and female sterilisation services. The remaining modern contraceptive have to be made available at the various health facilities around the nation. In addition, the two tertiary hospitals are obligated to provide patients with access to all of the modern methods of contraception.

Although short-term contraceptives (male and female condoms, emergency contraceptives, oral pills and injectables) should be provided at all primary and tertiary health facilities, some secondary health facilities are not required to provide female condoms and injectables. This is because secondary and tertiary health facilities are held to a higher standard than primary health facilities (Table7). According to the findings, 97% of health facilities are to offer both implants and IUDs, which is an increase from 93% and 91% of health facilities offering implants in 2020 and 2018, respectively. However, there is a decrease when asked about facilities currently offering these services. About 73.5%, 94.1%, 27.5% and 13.7% are currently offering IUD, Implant, Female and Male sterilization respectively. Although it was to be predicted, the provision of long-lasting contraceptives like methods such as male and female sterilization

[31] Reference to national protocols and regulations wasintroduced in the 2012 round of surveys to ensure that provision of family planning commodities and services are in line with government's set guidelines.

remained low at 64 and 75% respectively among secondary health facilities while all tertiary facilities are offering these methods.

The provision of these services necessitates the participation of higher-order medical professionals, who are not part of the regular staffing of the primary Health facilities. As a result, such contraceptives are often made available in secondary and tertiary healthcare facilities, as the table below shows.

Table 7: Percentage Distribution of Health facilities by Level of Service Delivery According to National Protocols/Guidelines Supposed to Offer Modern Contraceptives

Modern Contraceptive Method offered	Per Cent Supposed to Offer at Level of Service Delivery			
	All Health facilities	Primary	Secondary	Tertiary
Male Condoms	100.00%	100.0%	100.0%	100.0%
Female Condoms	99.53%	98.6%	100.0%	100.0%
Oral Pills	100.00%	100.0%	100.0%	100.0%
Injectables	100.00%	100.0%	100.0%	100.0%
Emergency contraception	88.17%	68.1%	96.4%	100.0%
IUDs	97.70%	93.1%	100.0%	100.0%
Implants	97.40%	95.8%	96.4%	100.0%
Female Sterilization	61.10%	8.3%	75.0%	100.0%
Male Sterilization	57.07%	6.9%	64.3%	100.0%

3.2.2 Primary Facilities Offering At least Three Types of Modern Contraceptives in line with national protocols and guidelines

The availability of various family planning methods for clients whenever they need them forms part of the concept of reproductive health commodity security (RHCS). The collection of information concerning number of facilities offering at least three modern contraceptives at the national and subnational levels gained relevance in 2010.

A key country level indicator in the reporting framework for the UNFPA Supplies Partnership yearly assessments for which comparisons are done is the availability of at least three modern methods of contraceptives. The study reveals that 98.1% of all facilities assessed are providing at least three modern

contraceptives all levels as compare 95.2% in the 2018 and 89% in 2017 surveys. Comparison between facility types also shows similar trend of 97% for primary and 100% for both secondary and tertiary health facilities. Disaggregation by counties reveals that all counties assessed except Montserrado (93%) had all facilities (100%) offering at least three modern contraceptives. This finding has improved compared 87 of health facilities offering these services in 2018 findings. See table 8 below for further description.

	This HEALTH FACILITY offers at least three (three or more) modern contraceptive methods	**This HEALTH FACILITY does not offer at least three modern contraceptive methods [offers less than three methods]**
Bomi	100.0%	0.0
Bong	100.0%	0.0
Grand Bassa	100.0%	0.0
Grand Cape Mount	100.0%	0.0
Grand Gedeh	100.0%	0.0
Grand Kru	100.0%	0.0
Lofa	100.0%	0.0
Margibi	100.0%	0.0
Maryland	100.0%	0.0
Montserrado	100.0%	0.0
Nimba	100.0%	0.0
River Cess	100.0%	0.0
Sinoe	100.0%	0.0
River Gee	100.0%	0.0
Gbarpolu	100.0%	0.0
Total	100.0%	0.0
Primary	100.0%	0.0
Secondary	100.0%	0.0
Tertiary	100.0%	0.0
Total	**100.0%**	**0.0**

Table 8: **Percentage Distribution of Primary Health facilities offering At least Three Modern contraceptive methods by county**

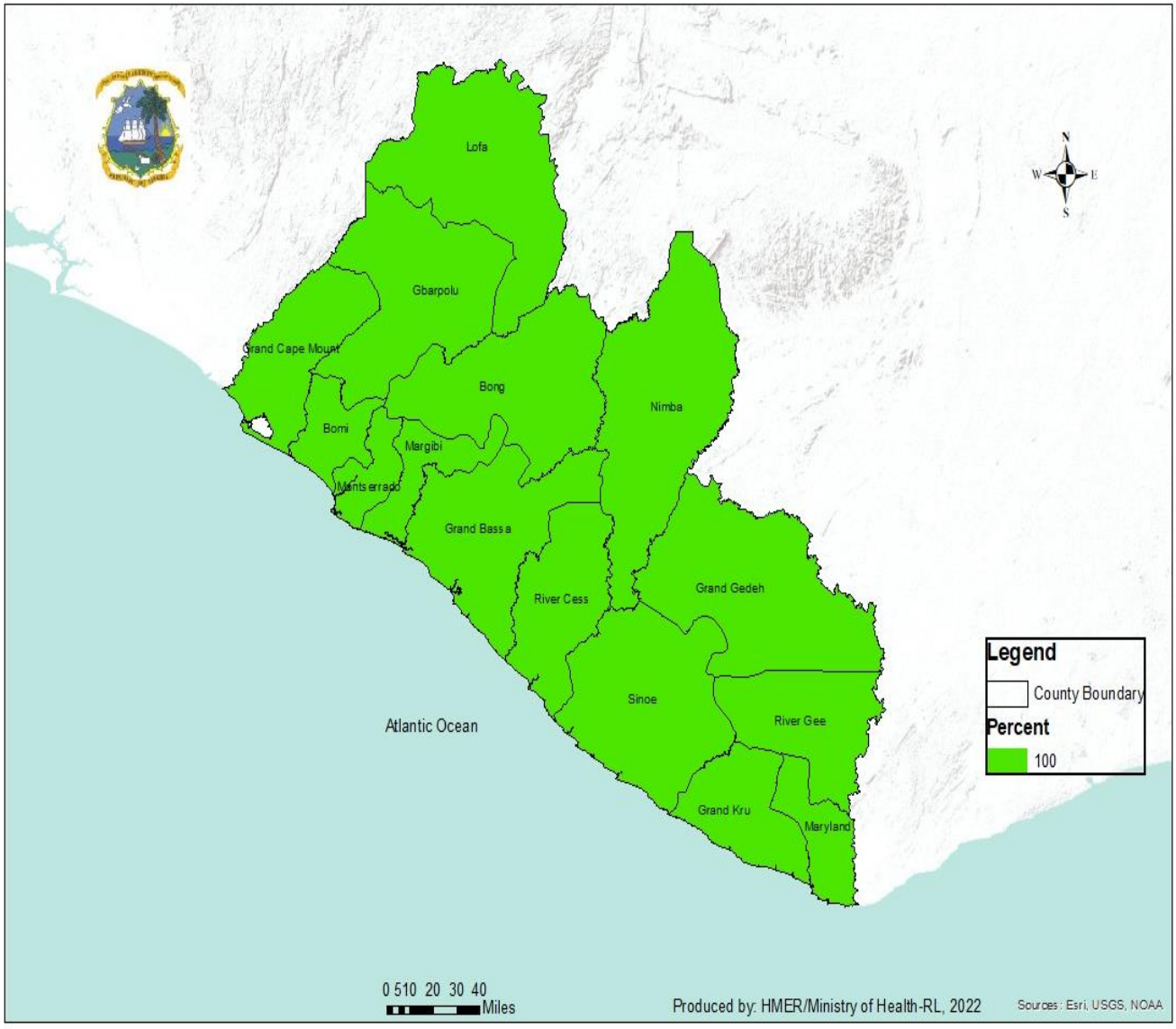
Similarly, urban and rural disaggregation (table 9) reveals that all facilities surveyed (100%) provide at least three contemporary contraceptives, while the 2020 survey revealed that only rural institutions offered 100 percent and urban facilities offered 96.7%. Both of them, at 98.4% and 90.5%, show an upward trend when compared to 2018 survey results.

Even health facilities with more than an hour distant from the warehouse of regular supply depots continue to give clients with at least three contemporary contraceptives. The same conclusions were reached in 2020 and 2018, respectively.

Table 9: Health Facilities that offer at leat three modern contraceptives by distance from Nearest Warehouse by Urban-Rural Residence and by Management of Facility

Characteristic	This HEALTH FACILITY offers at least three (three or more) modern contraceptive methods frequency and percentage	This HEALTH FACILITY does not offer at least three modern contraceptive methods [offers less than three methods] Frequency (%)
Urban	100.0%	0.0%
Rural	100.0%	0.0%
Total	100.0%	0.0%
Government	100.0%	0.0%
Private	100.0%	0.0%
Total	100.0%	0.0%
00 - 04 Minutes	100.0%	0.0%
05 - 09 Minutes	100.0%	0.0%
10 - 14 Minutes	0.0%	0.0%
15 - 19 Minutes	100.0%	0.0%
20 - 24 Minutes	100.0%	0.0%
25 - 29 Minutes	0.0%	0.0%
30 - 34 Minutes	100.0%	0.0%
35 - 39 Minutes	100.0%	0.0%
40 - 44 Minutes	0.0%	0.0%
45 - 49 Minutes	100.0%	0.0%
50 - 54 Minutes	100.0%	0.0%
55 - 59 Minutes	100.0%	0.0%
One hour and over	100.0%	0.0%
Total	100.0%	0.0%

Figure 3:: Percentage Distribution of Primary Health Facilities Offering at Least Three Modern Contraceptive by County



3.2.3 At least five modern contraceptives offered as part of Health Facility's regular and normal service delivery

The distribution of health facilities delivering at least five modern contraceptives at the level of service delivery is shown in Table 10. 93%, compared to 88.5% and 68.6% in 2020 and 2018, respectively, of all surveyed health institutions provide at least five contemporary contraceptives as part of their standard services. Distribution by facility type suggests a rise in main facility delivery from 85.9% in 2020 to 92.2% in 2022. The findings show that 93% and 100% of secondary and tertiary health institutions provide at least five or more contemporary contraceptives as part of their standard service delivery, consistent with data from 2020. There is a notable rise from 2018 across all types of healthcare facilities. The distribution of facilities that provide at least five (5) contraceptive techniques as part of regular and normal services was broken down by urban and rural areas. In both locations, the majority of evaluated facilities provided over 90 percent of the services. This provision indicates a rise in the number of urban facilities offering at least five contraceptives, from 85 percent in 2020 to 59 percent in 2018.

Comparable distribution by county is shown in table 10 below, which reveals that 12 out of 15 counties now have facilities that offer at least five or more modern methods of contraceptive as part of their regular and normal service delivery. This represents a 90% or higher rate of coverage. This is an improvement compared to six counties in 2018, in particular Montserrado, which now have 92% of their facilities assessed offering at least five modern contraceptives, respectively. In 2018, only 50% of the county's facilities offered at least five modern contraceptives. Further disaggregation by management type reveals that 91% and 100% of privately managed and publicly managed facilities, respectively, offer at least five modern contraceptives. This compares to 89% and 88% of facilities in the findings from 2020, and 70% and 57% of facilities in the findings from 2018. The graphic explanation is found in Figure 4 below.

Table 10: Percentage distribution of SDPs offering at least five [5] modern contraceptive methods as part of their regular and normal service delivery by facility type, residence, ownership and county

Categories	SDPs offers at least five (five or more) modern contraceptive methods	SDPs does not offer at least five modern contraceptive methods
Primary	93.0%	7.0%
Secondary	93.0%	7.0%
Tertiary	100.0%	0.0%
Total	93.0%	7.0%
Bomi	100.0%	0.0%
Bong	75.0%	25.0%

Grand Bassa	100.0%	0.0%
Grand Cape Mount	100.0%	0.0%
Grand Gedeh	100.0%	0.0%
Grand Kru	75.0%	25.0%
Lofa	100.0%	0.0%
Margibi	100.0%	0.0%
Maryland	75.0%	25.0%
Montserrado	92.3%	7.7%
Nimba	90.9%	9.1%
River Cess	100.0%	0.0%
Sinoe	100.0%	0.0%
River Gee	100.0%	0.0%
Gbarpolu	100.0%	0.0%
Total	93.0%	7.0%
Urban	94.0	6.0
Rural	91.4	8.6
Total	93.0	7.0
Government	91.4%	8.6%
Private	100.0%	0.0%
Others	100.0	0.0
Total	93.0	7.0%

Figure 4:: Distribution of Counties with Secondary and Tertiary Health Facilities Offering at Least Five Modern Contraceptives

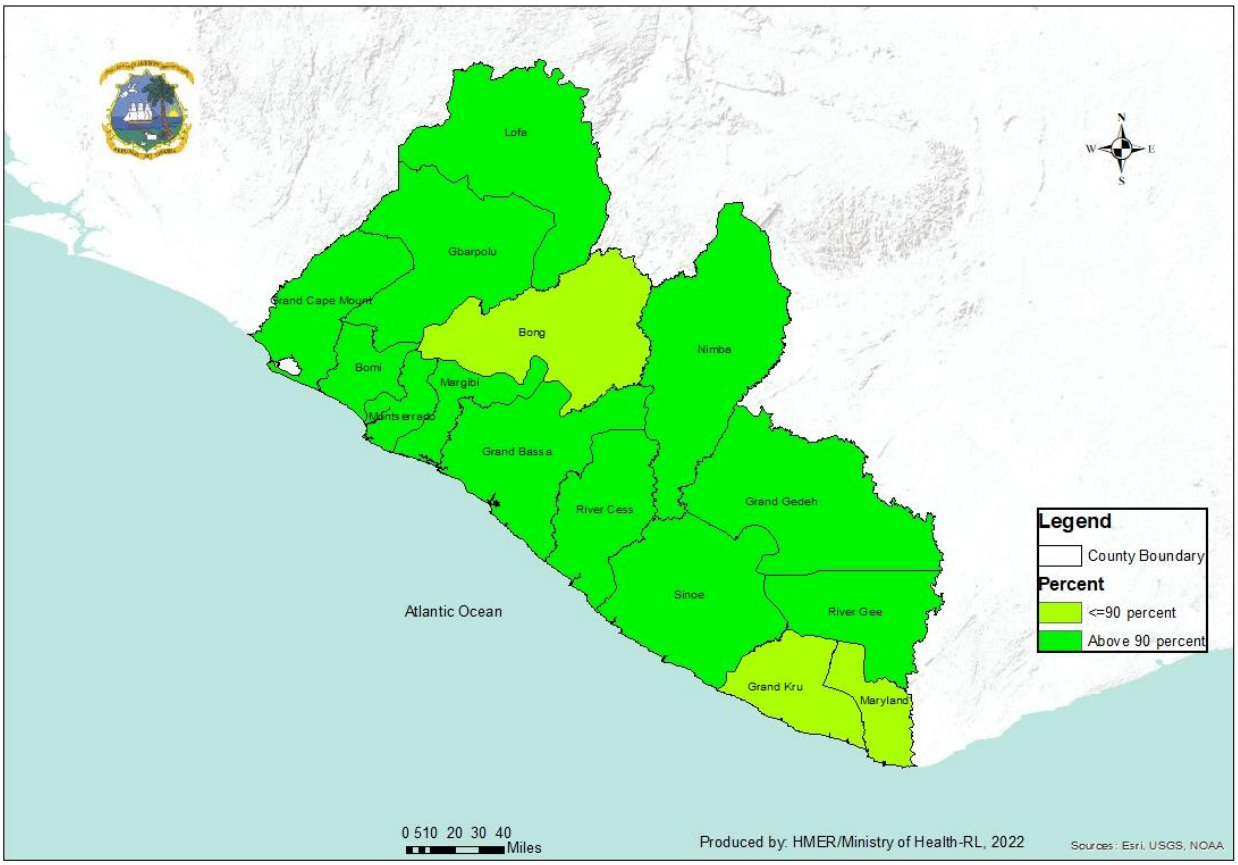


Table 11 indicates that as of 2022, 92% of health care facilities within a hour away provide at least five modern contraceptives, up from 83% in 2020 and 66% in 2018. Similarly, the findings do not provide an explanation for a statistically significant trend or outcomes connected to distance among the health facilities assessed.

Table 11: Percentage distribution normal service delivery by distance (in minutes) from nearest warehouse/source of supplies

Distance	This SDP offers at least five (five or more) modern contraceptive methods	
00 - 04 Minutes	97.3%	2.7%
05 - 09 Minutes	77.8%	22.2%
10 - 14 Minutes	0.0%	0.0%
15 - 19 Minutes	100.0%	0.0%
20 - 24 Minutes	100.0%	0.0%
25 - 29 Minutes	0.0%	0.0%
30 - 34 Minutes	100.0%	0.0%
35 - 39 Minutes	100.0%	0.0%
40 - 44 Minutes	0.0%	0.0%
45 - 49 Minutes	100.0%	0.0%
50 - 54 Minutes	100.0%	0.0%
55 - 59 Minutes	50.0%	50.0%
One hour and over	92.3%	7.7%
Total	**93.1%**	**6.9%**

3.3 Availability of Maternal and Reproductive Health Medicines

When medications and services for maternal and reproductive health are readily available, the high rates of maternal and newborn morbidity and mortality in Liberia may be drastically decreased. Preterm labor management, incomplete abortion, and miscarriage rates can be lowered, as can the prevalence of maternal sepsis, severe pre-eclampsia and eclampsia, post-partum hemorrhage, pneumonia, sexually transmitted infections, tetanus in mothers and newborns, and the prevention of mother-to-child transmission of malaria, HIV, etc.

All medical institutions should provide standard preventative care items such gentamicin, metronidazole, and tetanus toxoid, as per national policy. In addition, all medications should be available in secondary and tertiary health facilities, with the exception of Mifepristone, Misoprostol, and Nifedipine.

3.3.1 Availability of Seven Essential Life-Saving Maternal and Reproductive Health Medicines

Each year, a survey is conducted to determine the "Percentage of Health facilities where seven selected essential lifesaving maternal and reproductive health medicines (including two mandatory medicines - magnesium sulfate and oxytocin) are available in facilities providing delivery services." This survey focuses on the availability of modern contraceptives and essential lifesaving maternal or reproductive health medicines.

Similar to the results of the 2020 study, this one found that 93% rather than 96.8% of health care institutions stocked with seven important lifesaving maternal and reproductive health drugs in 2018 (table 12).

If we break down the total percentage for all facilities, we find that tertiary and secondary level facilities both got 100%, but primary level facilities only achieved 90%. When compared to the results from 2020 and 2018, these data demonstrate a consistent pattern of improvement from 92 to 94 to 100 to 100 percent.

The table further displays the proportion of clinics in urban and rural areas that stock seven (including two essential) medications. According to the data disaggregated by location, we found that 98% of hospitals in urban areas and 83% of hospitals in rural areas provided seven (including two essential) drugs for maternal/reproductive health. This is a drop from previous years when optimal coverage was found in urban areas (in both 2020 and 2018) and when 85% and 95% of rural health care facilities provided seven (including two critical) medications for reproductive and maternal health, respectively. Though the rural areas where the majority of Liberians reside showed good results, they still need to be improved upon in light of their potential to save lives.

At the county level, the availability of seven essential life-saving medications was also evaluated to determine their national distribution (Table 12). The findings indicate that availability varies from 75% to 100%. (also see Figure 5). Despite the high score in Montserrado, there is occasionally an insufficient supply of these medicines, a situation that has a ripple effect on clients because private facilities charge consultation and in-patient bed fees and provide

prescriptions for patients to purchase the necessary medications outside the facility. This year, total availability increased to 93.1% from the national average of 81.1% in 2018.

Table 12: Percentage distribution of service delivery points with seven (including 2 essential) life-saving maternal/reproductive health medicines available by county, urban/rural residence and Owenrship

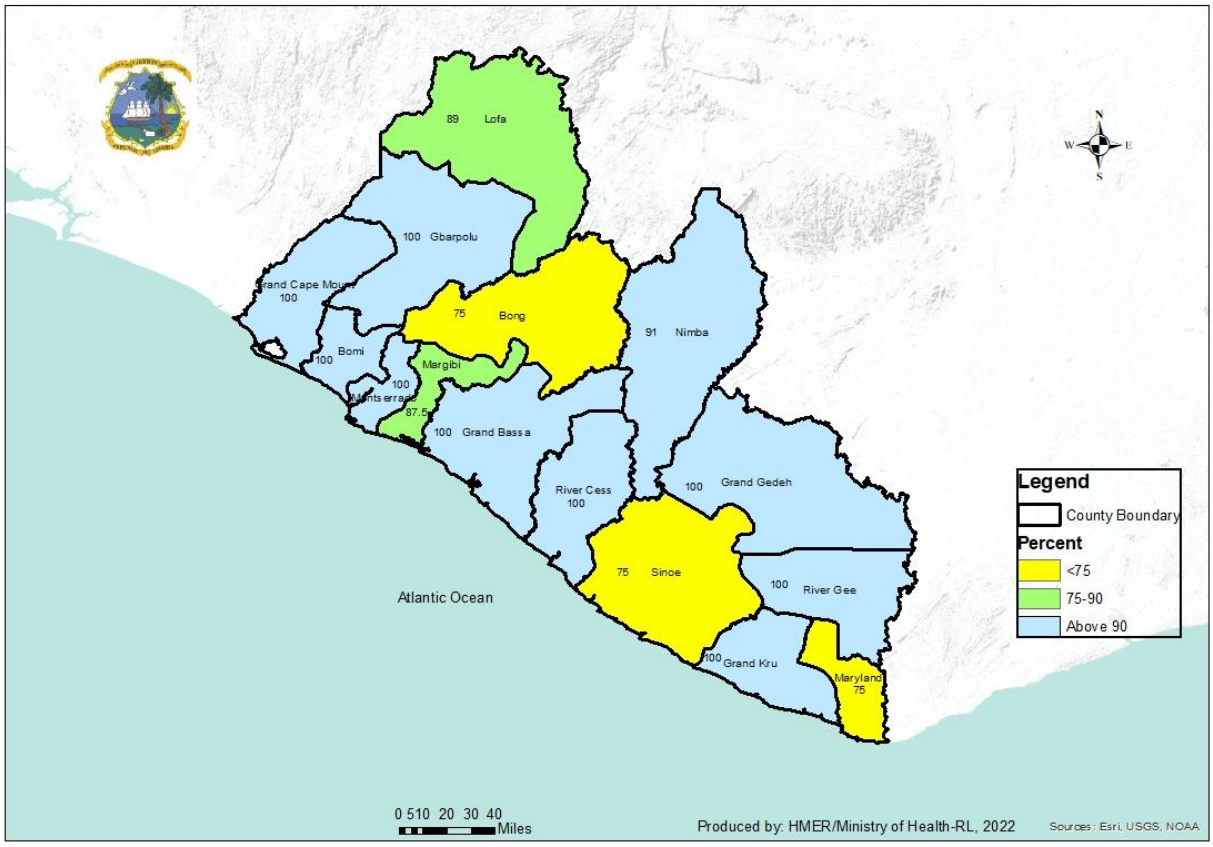
Categories	Seven (including 2 essential) life-saving maternal/reproductive health medicines available	Seven (including 2 essential) life-saving maternal/reproductive health medicines not available
Primary	90.1%	9.9%
Secondary	100.0%	0.0%
Tertiary	100.0%	0.0%
Total	93.1%	6.9%
Urban	98.5%	1.5%
Rural	82.9%	17.1%
Total	93.1%	6.9%
Government	92.5%	7.5%
Private	95.0%	5.0%
Others	100.0%	0.0%
Total	93.1%	6.9%
Bomi	100.0%	0.0%
Bong	75.0%	25.0%
Grand Bassa	100.0%	0.0%
Grand Cape Mount	100.0%	0.0%
Grand Gedeh	100.0%	0.0%
Grand Kru	100.0%	0.0%
Lofa	88.9%	11.1%
Margibi	87.5%	12.5%
Maryland	75.0%	25.0%
Montserrado	100.0%	0.0%
Nimba	90.9%	9.1%
River Cess	100.0%	0.0%
River Gee	100.0%	0.0%
Sinoe	75.0%	25.0%
Gbarpolu	100.0%	0.0%
Total	93.1%	6.9%

Despite a national level increase (93.1%) in the availability of atleast seven maternal and other reproductive health commodities at health facilities, disaggregation by specific commodities shows different picture of 70.5% average across individual commodities. Also, less than half of health facilities assessed had Cefixime and Mifepristone while the most availability commodities were Oxytocin (97.3%) and Magnesium Sulfate (94%). Disaggregation by health facility shows that about 60%, 67.5% and 83.7% of Clinic, Health Center and Hospitals had all of the 17 Maternal and other Reproductive Health commodities assessed. See table 12.B below for further description.

Table 12. B: Disaggregation of Maternal and Reproductive Health Commodities by Health Facility Type

Reproductive Health Commodities	***Clinic***	***Health Center***	***Hospital***	***Average***
Ampicillin	52.0	57.1	80.0	63.0
Azithromycin	48.0	61.9	86.7	65.5
Benzathine benzylpenicillin	70.0	81.0	96.7	82.5
Either Betamethasone	44.0	38.1	86.7	56.3
Calcium gluconate	78.0	81.0	83.3	80.8
Cefixime	38.0	42.9	60.0	47.0
Gentamicin	76.0	85.7	100.0	87.2
Hydralazine	30.0	57.1	76.7	54.6
Magnesium sulfate	82.0	100.0	100.0	94.0
Methyldopa	40.0	47.6	60.0	49.2
Metronidazole	86.0	81.0	93.3	86.8
Mifepristone	38.0	38.1	50.0	42.0
Misoprostol	58.0	71.4	93.3	74.3
Nifedipine	38.0	42.9	80.0	53.6
Oxytocin	100.0	95.2	96.7	97.3
Sodium Lactate	66.0	90.5	93.3	83.3
Toxoid Tetanus	78.0	76.2	86.7	80.3
Average	***60.1***	***67.5***	***83.7***	***70.5***
Total Health Facility	**50**	**21**	**30**	

Figure 5::**Percentage Distribution of Health facilities with Seven (including Two Essential) Lifesaving Maternal/Reproductive Health Medicines Available by County, Liberia 2022**



The data on the availability of seven lifesaving medications based on the distance to the warehouse of regular supply does not indicate how distances distant from the warehouse of regular supplies impact the availability of maternal/reproductive drugs. All healthcare institutions within 0 to 1 hour provide these medications at rates above the national average. However, there were no facilities within 10 to 14 minutes and 40 to 44 minutes, similar with data from 2020. There is no significant variation in the index between facilities that are closer than five minutes from the warehouse and those that are the furthest distant (one hour and over). Due to the lack of clarity, it is possible that distance is not a determining factor in the availability of the medications and that other factors are more significant. See table 13 below for distribution details.

Table 13: **Percentage distribution of SDPs with seven (including 2 essential) life-saving maternal/reproductive health medicines available by distance**

Distance in Minutes	Seven (including 2 essential) life-saving maternal/reproductive health medicines available	PerSeven (including 2 essential) life-saving maternal/reproductive health medicines not available cent
00 - 04 Minutes	91.9%	8.1%
05 - 09 Minutes	100.0%	0.0%
10 - 14 Minutes	0.0%	0.0%
15 - 19 Minutes	100.0%	0.0%
20 - 24 Minutes	100.0%	0.0%
25 - 29 Minutes	0.0%	0.0%
30 - 34 Minutes	100.0%	0.0%
35 - 39 Minutes	100.0%	0.0%
40 - 44 Minutes	0.0%	0.0%
45 - 49 Minutes	100.0%	0.0%
50 - 54 Minutes	100.0%	0.0%
55 - 59 Minutes	50.0%	50.0%
One hour and over	92.1%	7.9%
Total	93.1%	6.9%

3.4 Incidence of 'No Stock out' of Modern Contraceptives

3.4.1 'No Stock Out' at the time of Survey

For the purposes of this study, "no stock out" of modern contraceptives refers to a period in which a health facility that is supposed to offer family planning services and commodities does not experience any short fall in supplies of one or more of the modern methods of contraception and, thus, has supplies on hand to serve couples and individuals who would like to make use of the facilities. The percentage of health care facilities reporting "no stock out" of contraceptives at the time of the survey provides a snapshot of current availability. In this section of the report, the term "no stock out" refers to a situation that did not exist throughout the time of enumeration.

Overall, table 20 reveals that 53.5% of health facilities had a'stock out,' compared to 32.7% and 28.6% in the 2020 and 2018 studies on the day of the survey, while the two tertiary institutions in the nation were not experiencing any stock out on the day of the survey. An increase of nearly 18% in the variety of healthcare institutions without basic supplies on survey day is demonstrated here.

Table 14 below also shows by county whether or not there were any stock-outs on the day of the survey. Fifteen of the counties had "no stock out," although just five (Bong, Grand Kru, Lofa, Montserrado, and River Gee) ranged from 50% to 77%. All stores in Bomi, Grand Gedeh, and Sinoe ran out of stock completely.

Because of how much below the national average they are, they need immediate attention. 50 percent or less of the facilities evaluated in Bong, Lofa, and River Gee counties in 2020 had "no stock out," which is satisfactory but might be better. Modern methods of contraception were more evenly distributed in urban and rural areas this year at 50% vs 40% in 2020 and 71.2 % versus 61.9 % in 2018. The distributions reveal a dramatic decline in commodity availability over time.

Most drugstores are located in urban areas, as shown by the high percentage of urban health care institutions (see table 14) that did not run out of stock on the day of the survey. When compared to the national average of 43.1%, stock levels in facilities of all management types on the day of the enumeration were 44.4% and 52.6%, with 46.5% overall, which is much lower than the results in 2020 of 63% and 81% for public and private facilities, respectively. When compared to last year's study, every health facility management type performed poorly.

Table 14: No stock out at the time of survey by type of facility, county, residence and ownership of facility

Categories	Modern contraceptive method in stock at the time of the survey ['no stock out']	Modern contraceptive method not in stock at the time of the survey [stock out']
Primary	39.4%	60%
Secondary	60.7%	39.3%
Tertiary	100.0%	0.0%
Total	46.5%	53.5%
Bomi	0.0%	100.0%
Bong	75.0%	25.0%
Grand Bassa	20.0%	80.0%
Grand Cape Mount	50.0%	50.0%
Grand Gedeh	0.0%	100.0%
Grand Kru	75.0%	25.0%
Lofa	77.8%	22.2%
Margibi	25.0%	75.0%
Maryland	25.0%	75.0%
Montserrado	63.0%	37.0%

Nimba	36.4%	63.6%
River Cess	25.0%	75.0%
Sinoe	0.0%	100.0%
River Gee	50.0%	50.0%
Gbarpolu	33.3%	66.7%
Total	46.5%	53.5%
Urban	50.0%	50.0%
Rural	40.0%	60.0%
Total	46.5%	53.5%
Government	44.4%	55.6%
Private	52.6%	47.4%
Others	100.0%	0.0%
Total	46.5%	53.5%

In accordance with national protocols, standards, and/or legislation, on the day of the survey, the distribution of service delivery sites with "no stock out" of any modern contraceptive technique is displayed in by distance from the closest warehouse/source of supplies (Table 15 below). There seems to be no correlation between physical distance and the distribution of facilities that have access to a modern form of contraception on the day of the survey. On the day of the evaluation, about 50% of available modern contraceptive techniques were accessible within 1 hour or less, 55-49 minutes, 20-24 minutes, and 15-19 minutes, respectively, at nearby health facilities. Comparatively, the 2020 study found that 100% all health care facilities within 15–19, 25–29, 35–39, and 45–49 minutes of the warehouse offered modern contraceptive techniques. Below, Table 15 displays further dispersion.

Table 15: No stock out at the time of survey by distance away from health facility

Distance from the Nearest Warehouse of Regular Supply	Modern contraceptive method in stock ['no stock out'] on the day of the survey	Modern contraceptive method not in stock ['stock out'] on the day of the survey
0 - 4	54.1%	45.9%
5 - 9	11.1%	88.9%
10 - 14	0.0%	0.0%
15 - 19	50.0%	50.0%
20 - 24	50.0%	50.0%
25 - 29	0.0%	0.0%

30 - 34	40.0%	60.0%
35 - 39	100.0%	0.0%
40 - 44	0.0%	0.0%
45 - 49	33.3%	66.7%
50 - 54	0.0%	100.0%
55 - 59	50.0%	50.0%
One hour and over	48.7%	51.3%
Totol Health facilities	46.5%	53.5%

3.4.2 'No Stock Out' in the Last Three Months of three modern contraceptives

Health facilities with 'no stock outs' of modern contraceptives in the six months prior to the survey is the third criteria used to compare Stream One countries on the UNFPA Supplies Partnership to enhance Reproductive Health Commodity Security. However, it now only has a three-month lifespan. People have easier access when there is a low supply outage, and the opposite is true as well.

Three modern methods of contraception were made available without any shortages across all three categories of institutions (primary, secondary, and tertiary) as required by established guidelines. We found that more than two-thirds of all health facility types had over 75% of modern contraceptive methods in stock in the last three months before the assessment. In contrast to the findings of the 2020 survey, which showed that only 50% of tertiary facilities had three modern modern contraceptive methods in stock in the last three months before the assessment, primary and secondary facilities were at 71% and 82%, respectively (see Table 16). In general, stock-out situations in health facilities, broken down by facility type, are good. When compared to the results of the surveys in 2020 and 2018, these findings show substantial improvement.

Table 16 shows the results of a comparison between rural and urban facilities, with the latter doing somewhat worse (83.3%) than the former (91.4%). The survey results for 2020 demonstrate that 71% and 88% of urban and rural facilities, respectively, did not experience a stockout in the three months prior to the study being conducted, in contrast to 52.4% and 22.2% in 2018. This is a tremendous advance in quality. Distributions by ownership also show that in the three months before to the survey in 2020, at least three modern contraceptive methods

were available at 89.5% of government health facilities, compared to 63.5% at 82 private health facilities. The distribution by counties shows that in contrast to the 2020 projection of seven counties (Grand Cape Mount, Grand Kru, Maryland, River Cess, Sinoe, River Gee and Gbarpolu), in 2022 six counties (Bong, Grand Cape Mount, Grand Bassa, River Cess, Sinoe, River Gee, and Gbarpolu) had all facilities assessed with no stock out of at least three modern contraceptives in the past three months leading up to the day of the survey.

Table 16: Incidence of 'No Stock Out' of 3 modern contraceptives in the last three months

Categories	Three modern contraceptive methods in stock in the last 3 months	Three modern contraceptive methods not in stock in the last 3 months
Primary	88.7%	11.3%
Secondary	78.6%	21.4%
Tertiary	100.0%	0.0%
Total	86.1%	13.9%
Bomi	66.7%	33.3%
Bong	100.0%	0.0%
Grand Bassa	100.0%	0.0%
Grand Cape Mount	100.0%	0.0%
Grand Gedeh	66.7%	33.3%
Grand Kru	75.0%	25.0%
Lofa	100.0%	0.0%
Margibi	75.0%	25.0%
Maryland	75.0%	25.0%
Montserrado	92.6%	7.4%
Nimba	63.6%	36.4%
River Cess	100.0%	0.0%
Sinoe	75.0%	25.0%
River Gee	75.0%	25.0%
Gbarpolu	100.0%	0.0%
Total	86.1%	13.9%
Urban	83.3%	16.7%
Rural	91.4%	8.6%
Total	86.1%	13.9%
Government	85.2%	14.8%
Private	89.5%	10.5%
Others	100.0%	0.0%
Total	86.1%	13.9%

In table 17 below, we can see that there is no obvious pattern in the behavior of the variables when we compare the number of days in which there was no stock out to the distance from the warehouse or supply facility. As far as we could tell, the availability of FP items was not an issue even at the greatest distances from the health facilities. This year's data demonstrate that all facilities had no stock out three months before to the day of the survey, in contrast to 2020 when roughly 78% of health facilities within an hour of the warehouse or institution of supply had no stock out. This is a crucial part of providing contraceptive services to the public, since it ensures the safety of the population's access to the commodity. To the extent that there is a limited supply, convenience is increased, and vice versa.

Table 17: Percentage Distribution of Health facilities with (3) Modern Contraceptive Methods in Stock at the Time of the Survey by Distance (minutes)

Distance from the Nearest Warehouse	Three modern contraceptive methods in stock in the last three months	Three modern contraceptive methods not in stock in the last three months
0 - 4	81.1%	18.9%
5 - 9	77.8%	22.2%
10 - 14	0.0%	0.0%
15 - 19	100.0%	0.0%
20 - 24	100.0%	0.0%
25 - 29	0.0%	0.0%
30 - 34	80.0%	20.0%
35 - 39	100.0%	0.0%
40 - 44	0.0%	0.0%
45 - 49	100.0%	0.0%
50 - 54	100.0%	0.0%
55 - 59	100.0%	0.0%
One hour and over	89.7%	10.3%
Total Health facilities	86.1%	13.9%

3.4.3 'No Stock Out' in the Last Three Months of five modern contraceptives

Distribution of "no stock out" of five modern contraceptives among facilities, counties, residence, and ownership in the three months preceding the survey is detailed in table 18 below. Overall, 98 percent of all health centers surveyed had "no stock out" of atleast five modern contraceptives three months prior to the survey, up from 94 percent in 2020. This year, government- and privately-run hospitals had a 98.8% and 94.4% decrease in stock-outs, respectively, compared to 97% and 86% in 2020 and 90.2% and 61.9% in 2018. Similarly, to results in 2020, this year all counties had at least five moderns contraceptive in stock three months before to the day of the survey, as shown by the distribution of service delivery sites with no stock of five moderns contraceptive by county. The average was above 98% regardless of whether the data was aggregated from urban or rural areas.

Table 18: Incidence of 'No Stock Out' of five [5] modern contraceptives per facility types, counties, residence and ownership

Categories	Five [5] or more contraceptive methods available at SDPs	Five [5] or more contraceptive methods not available at SDPs
Primary	100.0%	0.0%
Secondary	92.9%	7.1%
Tertiary	100.0%	0.0%
Total	98.0%	2.0%
Bomi	100.0%	0.0%
Bong	100.0%	0.0%
Grand Bassa	100.0%	0.0%
Grand Cape Mount	100.0%	0.0%
Grand Gedeh	100.0%	0.0%
Grand Kru	100.0%	0.0%
Lofa	100.0%	0.0%
Margibi	100.0%	0.0%
Maryland	100.0%	0.0%
Montserrado	96.3%	3.7%
Nimba	90.9%	9.1%
River Cess	100.0%	0.0%
Sinoe	100.0%	0.0%
River Gee	100.0%	0.0%
Gbarpolu	100.0%	0.0%
Total	98.0%	2.0%
Urban	97.0%	3.0%
Rural	100.0%	0.0%

Total	98.0%	2.0%
Government	98.8%	1.2%
Private	94.7%	5.3%
Others	100.0%	0.0%
Total	98.0%	2.0%

Table 19 shows the distribution of modern contraceptive methods that were in stock ['no stock out'] in the three months leading up to the day of the survey. There were a total of five different methods. There is not a discernible difference between facilities that are placed close to the sources of regular supply and those that are located a substantial distance away. In several instances, facilities that were farther away from their supply center did not have any "stock out" of any of the five modern contraceptives, although facilities that were closer did have stock out.

Table 19: 'no stock out' of five [5] modern contraceptives by distance (in minutes) from nearest warehouse/sources 2022

Distance in minutes	Five [5] modern contraceptive methods in stock ['no stock out'] in the last three months	Five [5] modern contraceptive methods not in stock ['stock out'] in the last three months
0 - 4	97.3%	2.7%
5-9	100.0%	0.0%
10-14	0.0%	0.0%
15 - 19	100.0%	0.0%
20 - 24	100.0%	0.0%
25 - 29	0.0%	0.0%
30 - 34	80.0%	20.0%
35 - 39	100.0%	0.0%
40 - 44	0.0%	0.0%
45 – 49	100.0%	0.0%
50 - 54	100.0%	0.0%
55 - 59	100.0%	0.0%
One hour and over	100.0%	0.0%
Total	98.0%	2.0%

When considering facilities that had stockout of any of the modern contraceptives on a given day in the last 3 months prior to the survey, there were few of them across facilities. The most noticeable of all were Emergency Contraceptives (30%), IUDs (21%), Female Condoms (17%) and Implants (11%). Stockout of sterilization was noticed only within health centers and hospitals. Also, facilities mostly out of stock of one or more of these commodities were GW Harley Hospital, SDA Cooper Memorial Hospital, Benson

Hospital, Fish Town Hospital, JFK, Hospital, ST. Francis Hospital, LGH Bomi, St. Timothy Hospital, Soniwein Health Center, Saclepea Comprehensive Health Center, etc. Table 18 below give description by County, facility type and ownership.

Table 19.B Distribution of modern contraceptives stockout 3 months prior to the survey

Family Planning Commodities	Clinic	Health Center	Hospital	Average
Male condoms	0.0	0.0	3.3	1.1
Female Condoms	22.0	9.5	20.0	17.2
Oral Contraception	2.0	4.8	10.0	5.6
Injectables	6.0	9.5	3.3	6.3
Emergency contraception	40.0	33.3	16.7	30.0
IUDs	22.0	23.8	20.0	21.9
Implants	6.0	19.0	10.0	11.7
Sterilisation for Females	NA	14.3	10.0	12.1
Sterilisation for Male	NA	14.3	16.7	15.5
Average	***14.0***	***14.3***	***12.2***	***13.5***
Total Health Facility	50	21	30	

Table 20 below shows the distribution of Health facilities by persons responsible for ordering medical supplies by type of health facilities, residence and ownerships. The study reveals that officer in-charge (49.0%) and pharmacist (43.1%) are the two known cadre of health workers responsible for ordering of medical supplies. This finding shows slight difference when compare to the 2020 survey, the percent OIC responsible for ordering medical supplies reduced by 5% while the percent Pharmancist ordering medical supplies inceeased by 5%. Only 1% of the facilities assessed mentioned medical doctor as cadres responsible for ordering drugs and medical supplies while in 2020, none of the facilities assessed mentioned medical doctor,

Ordering of drug by officer in-charge mostly occur at primary health facilities (69.4%) while ordering by pharmacist mostly occur at secondary (96.4%) and tertiary (50.0%) health facilities.

The urban-rural spread of the orders for medical supplies shows that Officers-in-Charge make the highest proportions of orders particularly in rural (82.9%) compared to 31.3% in urban. Similarly, most orders in the urban areas are provided by pharmacist (59.7%) compared to 11.4% in rural health facilities Pharmacists are far more important in urban than rural areas eventhough most OICs are nurses in Liberia.

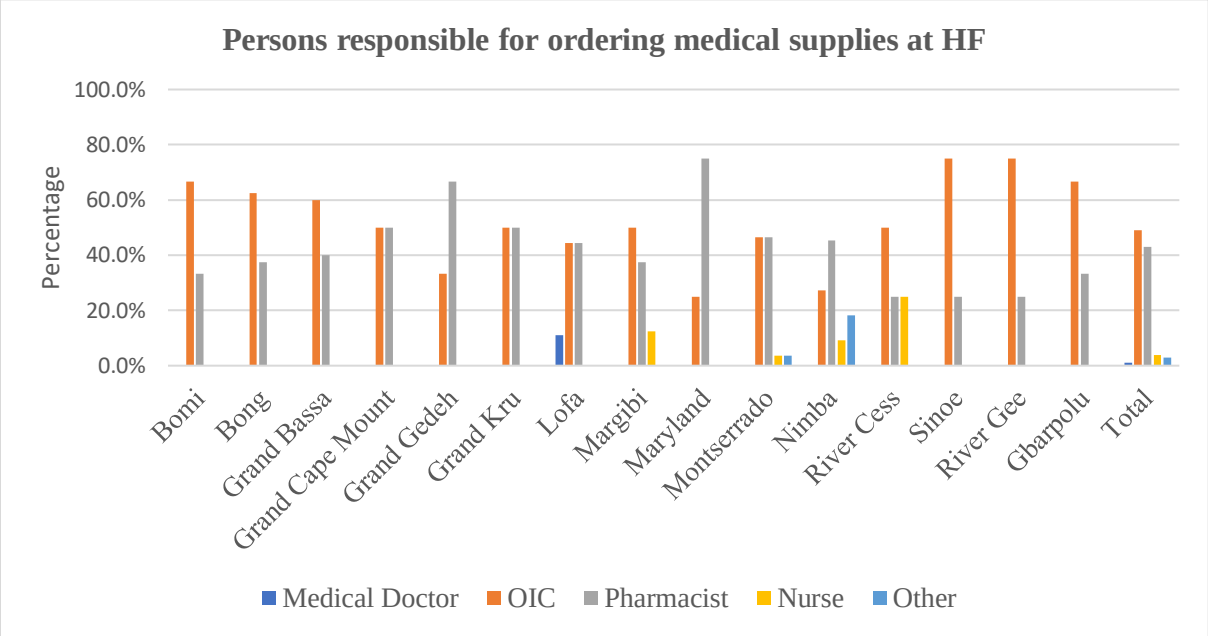
Table 20: Percentage distribution of Health facilities with persons responsible for ordering medical supplies by type of Health facilities 2022

Type of Facility	Percent of Health Facilities with Responsible Persons for Ordering Supplies				
	Medical Doctor	Officer-in-Charge	Pharmacist	Nurse	Others
Primary	0.0%	69.4%	22.2%	5.6%	2.8%
Secondary	3.6%	0.0%	96.4%	0.0%	0.0%
Tertiary	0.0%	0.0%	50.0%	0.0%	50.0%
Total	**1.0%**	**49.0%**	**43.1%**	**3.9%**	**2.9%**
Urban	1.5%	31.3%	59.7%	4.5%	3.0%
Rural	0.0%	82.9%	11.4%	2.9%	2.9%
Total	**1.0%**	**49.0%**	**43.1%**	**3.9%**	**2.9%**
Government	0.0%	51.9%	43.2%	2.5%	2.5%
Private	5.0%	35.0%	45.0%	10.0%	5.0%
Others	0.0%	100.0%	0.0%	0.0%	0.0%
Total	**1.0%**	**49.0%**	**43.1%**	**3.9%**	**2.9%**

Considering the distribution of health facilities with persons responsible for ordering medical supplies by county, on the overall, Officers-in-Charge (OICs) and Pharmacists constitute about 49.0% and 43.1% of orders made at the national level and are involved in the ordering of medical supplies for majority of the counties. (Figure 6 below).

With the distribution of health facilities with persons responsible for ordering medical supplies by counties Pharmancist ordering were higher (75%) in Maryland than the rest of the counties while OICs ordering were higher, constituting 75% in Sinoe and River Gee. Theses trend of ordering medical supplies similar when compared with the 2020 survey (see figure 6 below.)

Figure 6:: Percentage Distribution of Health facilities with Persons Responsible for Ordering Medical Supplies by County



3.5.2 Use of Logistics Forms

By preserving accurate and timely information, a good logistics management information system in the supply chain enhances health outcomes. The use of logistics forms for reporting and ordering supplies accounted for 94.1% while 82.4% of the health facilities had their use of the logistical forms for reporting and ordering supplies verified by the enumerator, showing an improvement from 92.3% and 78.8% in 2020 when compared. Additionally, compared to 7.7% in 2020, 5.9% of health facilities did not use logistics forms for reporting and ordering supplies.

The use of logistics forms at health facilities in 2022 have increased when compared to 2020. The 2022 survey recorded 79.0%, 89.0% and 100% compared to 76.1% of primary and 87.1% of the secondary and 50% of tertiary facilities that used logistics forms in 2020.

Rgarding county distribution, facilities reporting not having logisistics forms for recording should higher percentage in Gbarpolu (33.3%), Grand Gedeh (33.3%), Grand Kru (25%) and Margibi (25.0%).

Disggregation by ownership reveals that 96.3% of public health facilities and 85.0% private health facilities had logistics forms for recording during the day of the survey.

Compared to 5.7% in the rural areas, 6.0% of health facilities in urban areas lack logistics forms. The re-supplies for the contraceptives must be estimated or quantified in order to use the logistical forms. On

the overall, staff members of the health facilities perform 77.5% of the quantification in 2022 compared to 78.8% in 2020 while about 11.5% of the quantification is resupplied by their warehouses or the National Drug Service. Seven of the counties have all their resupply quantities determined by staff members of the Health facilities, compare to 2020 of only Grand Bassa quantities are determined by the institution/warehouse responsible for supplying their facilities, the 2022 revealed Grand Cape Mount having the highest percentage of health facilities (75%) reporting that quantities are determined by the institution/warehouse responsible for supplying their facilities.

3.5.3 Frequency and Transportation of Supplies for Health facilities

Since the frequency and transportation of supplies for Health facilities is an important element in the commodity security chain, it is hereunder discussed having regard to the main source of supplies, responsibility for transportation, estimated time between order and receipt of supplies, and frequency of resupply. The main source of routine medicines and supplies to health facilities in Liberia is the central medical store (81.4%) compared (58.7%) in 2020 while regional/county warehouse accounts for 10.8% compared to 34.6% of all supplies. Some facilities also supplied by the regional deports are also at times supplied by the CMS. See description below in table table 21 for further distribution.

Table 21. Main Source of Supplies by Health Facility Levels, Residence and Ownership

Health Facilty Level	Central Medical Stores	Regional/district Warehouse or institution	Local medical store on the same site	Private
Primary	81.9%	9.7%	1.4%	6.9%
Secondary	78.6%	14.3%	0.05%	7.1%
Tertiary	100.0%	0.0%	0.0%	0.0%
Total	**81.4%**	**10.8%**	**1.0%**	**6.9%**
Ownership				
Government	89.0%	11.0%	0.0%	0.0%
Private	50.0%	10.0%	5.0%	35.0%
Total	**81.4%**	**10.8%**	**1.0%**	**6.9%**
Residence				
Urban	74.6%	14.9%	1.5%	9.0%
Rural	94.3%	2.9%	0.0%	2.9%
Total	**81.4%**	**10.8%**	**1.0%**	**6.9%**

Similary, most facilities (80.4%) supplies are transported from national level to either county, district or direct to the health facility level. This is as a result of the increase of drug supply from the central medical store to health facilities level as their main source of drug supply. Table 22 and 23 below shows further distribution.

Table 22: Distribution of main sources of Transportation of supplies to facility by Facilitylevel, Ownership & Residence

Facility Level	National	County/District	Health Facility	Partners
Primary	81.9%	2.8%	9.7%	5.6%
Secondary	75.0%	3.6%	10.7%	10.7%
Tertiary	100.0%	0.0%	0.0%	0.0%
Grand Total	**80.4%**	**2.9%**	**9.8%**	**8.8%**
Ownership				
Government	82.1%	3.6%	8.3%	6.0%
Private	72.2%	0.0%	16.7%	11.1%
Grand Total	**80.4%**	**2.9%**	**9.8%**	**8.8%**
Residence				
Urban	73.5%	2.9%	13.2%	10.3%
Rural	94.1%	2.9%	2.9%	0.0%
Grand Total	**80.4%**	**2.9%**	**9.8%**	**8.8%**

Table 23: Distribution of main sources of supplies to facility by County

County	National	County/District	Health Facility	Partners
Bomi	66.7%	0.0%	0.0%	33.3%
Bong	87.5%	0.0%	12.5%	0.0%
Gbarpolu	100.0%	0.0%	0.0%	0.0%
Grand Bassa	33.3%	33.3%	33.3%	0.0%
Grand Cape Mount	75.0%	0.0%	0.0%	25.0%
Grand Gedeh	66.7%	0.0%	33.3%	0.0%
Grand Kru	75.0%	0.0%	25.0%	0.0%
Lofa	60.0%	20.0%	10.0%	10.0%
Margibi	88.9%	0.0%	11.1%	0.0%
Maryland	75.0%	0.0%	0.0%	25.0%
Montserrado	77.8%	0.0%	7.4%	14.8%
Nimba	91.7%	0.0%	8.3%	0.0%

River Cess	100.0%	0.0%	0.0%	0.0%
River Gee	100.0%	0.0%	0.0%	0.0%
Sinoe	100.0%	0.0%	0.0%	0.0%
Grand Total	**80.4%**	**2.9%**	**9.8%**	**8.8%**

The projected time between placing an order and receiving supplies serves as a summary of the effectiveness of the supply chain system based on the transportation and related arrangements. The transportation and delivery arrangements are more efficient the less time there is between them, and the opposite is also true. Compared to 30.8% and 13.5% in 2020, the survey shows that in Liberia, roughly 24.5% and 19.6% of the health facilities to receive supplies would do so in less than two weeks and more than two months, respectively, see (Table 24). In difficult-to-reach places, where facilities received their supplies every three months, the larger percentage of facilities receiving supplies for more than two months is also evident. With health facilities receiving supplies more than 3 months with regards to urban-rural differentials; urban aras account for 38.9% while rural area account for 54.3%.

About 89% of all health facilities would receive their supplies in less than three months or within a quarter. Also, about 10.8% of all primary facilities received their supplies after a quarter. Considering that primary healthcare, with the largest number of Health facilities and serving the biggest proportion of the population, is the bedrock of the health service delivery system, such extended delays could reduce the timeliness, efficiency and effectiveness of the sector interns of health care delivery.

The urban-rural differentials in receipt of orders are marked. Within less than two-weeks period, 26.9% of health facilities received supplies in urban while 20% of rural facilities get supplies within similar time. Within less than 4 months, 91% of rural facilities received supplies against 88% of their urban counterparts. Though the percent difference within less than 4 moths to receive supplies is minimum, but this could perhabs explain why why the availability of modern contraceptives and essential lifesaving maternal and reproductive health drugs exhibited a strange distribution whereby Health facilities farther away from their regular supply sources seemed to be better served than those closer to them. At the Health facility levels, private entities received most (60%) their supplies in less than a week compared to 14.8% of government facilities. Table 24 below shows further distribution.

Table 24: Estimated Length of Time between Order and Receipt of Supplies and by Level of Service Delivery, Urban-Rural Residence, and Management of HEALTH FACILITY, Liberia 2022

Characteristics	Time Interval					
	<2 Weeks	2 Weeks-<1 Month	1 Month -<2 Months	2 Months -<4 Months	More than 4 Months but not up to six months	More than 6 months
Level of Service Delivery						
Primary	22.2%	13.9%	11.1%	44.4%	5.6%	2.8%
Secondary	28.6%	32.1%	14.3%	7.1%	10.7%	7.1%
Tertiary	50.0%	50.0%	0.0%	0.0%	0.0%	0.0%
Total	24.5%	19.6%	11.8%	33.3%	6.9%	3.9%
Urban-Rural Residence						
Urban	26.9%	19.4%	14.9%	26.9%	7.5%	4.5%
Rural	20.0%	20.0%	5.7%	45.7%	5.7%	2.9%
Total	24.5%	19.6%	11.8%	33.3%	6.9%	3.9%
Management of HEALTH FACILITY						
Government	14.8%	19.8%	12.3%	39.5%	8.6%	4.9%
Private	60.0%	20.0%	10.0%	10.0%	0.0%	0.0%
Others	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total Per Cent	24.5%	19.6%	11.8%	33.3%	6.9%	3.9%

There are varities in the receipt of supplies among couties. Over 50% of health facilities assessed in Bomi (60%), and Gbarpolu (66.7%), received their orders in less than two weeks. Table 25 below shows more details.

Table 25: Percentage Distribution of Clients by Estimated Length of Time between Order and Receipt of Supplies and by County, Liberia 2022

County	Estimated Length of Time between Order and Receipt of Supplies					
	<2 Weeks	2 Weeks-<1 Month	1 Month -<2 Months	2 Months -<4 Months	More than 6 Months but not up	More than six months

					to six months	
Bomi	33.3%	0.0%	0.0%	33.3%	33.3%	0.0%
Bong	12.5%	0.0%	12.5%	75.0%	0.0%	0.0%
Grand Bassa	60.0%	20.0%	20.0%	0.0%	0.0%	0.0%
Grand Cape Mount	25.0%	0.0%	25.0%	25.0%	25.0%	0.0%
Grand Gedeh	33.3%	33.3%	33.3%	0.0%	0.0%	0.0%
Grand Kru	25.0%	0.0%	0.0%	75.0%	0.0%	0.0%
Lofa	33.3%	33.3%	0.0%	33.3%	0.0%	0.0%
Margibi	25.0%	0.0%	12.5%	25.0%	25.0%	12.5%
Maryland	0.0%	25.0%	25.0%	50.0%	0.0%	0.0%
Montserrado	14.3%	14.3%	14.3%	39.3%	10.7%	7.1%
Nimba	27.3%	36.4%	18.2%	18.2%	0.0%	0.0%
River Cess	25.0%	75.0%	0.0%	0.0%	0.0%	0.0%
Sinoe	25.0%	25.0%	0.0%	50.0%	0.0%	0.0%
River Gee	25.0%	50.0%	0.0%	25.0%	0.0%	0.0%
Gbarpolu	66.7%	0.0%	0.0%	0.0%	0.0%	33.3%
Total	24.5%	19.6%	11.8%	33.3%	6.9%	3.9%

3.5.4 Types of Cold Chain Available

One of the best and safest ways to prevent disease in the general population is through vaccination. However, in order to maximize the benefits of vaccination, both in terms of improving vaccination coverage and, more critically, ensuring that tracer vaccinations reach the intended recipient, vaccine cold chain management is crucial. A cold chain's existence ensures the security of reproductive health products by maintaining the effectiveness of several vital vaccines that save lives and need a consistently cold temperature environment. There is a slight reduction in the percentage 86% (86/102 Health Facilities) of health facilities mentioning having cold chain when compared to the report from 2020 which accounts for 92%. There were 13.7% facilities without cold chain compared to 11% in 2020.

Although it is generally believed that the cold chain prevents vaccine inactivation caused by heat exposure, it is also important to emphasize potency loss caused by freezing temperatures. The survey assessed the type of cold chain available in health facilities. According to the sample distribution in Table 26 below, the disaggregation by health failities with cold chain reveals that 24%, 20.5% and 45.5% used electric fridge, Ice Box and Solor when compared to 38.6%, 20.5% and 39.8% in 2020.

The percent of Health facilities with no cold chain available were quite similar in both urban (13.4%) and rural (14.3%) areas. All tertiary facilities use electric fridge. Further distribution shows most electric fridges (44.4%) are used in urban, similarly, higher (66.7%) solar fridges being used in rural areas. This trend is similsr to the 2020 findings. See Table 26 for further distribution.

Table 26: Percentage Distribution of Type of Cold Chain Available by Type of Health facility, Urban-Rural Residence, and Management of Facility

Characteristics	No Cold Chain Available	Type of Cold Chain Available		
		Electric Fridge	Ice box	Solar Fridge
Primary	18.1%	22.0%	18.6%	59.3%
Secondary	3.6%	55.6%	25.9%	18.5%
Tertiary	0.0%	100.0%	0.0%	0.0%
Total	**13.7%**	**34.1%**	**20.5%**	**45.5%**
Government	14.6%	25.7%	22.9%	51.4%
Private	10.0%	66.7%	11.1%	22.2%
Grand Total	**13.7%**	**34.1%**	**20.5%**	**45.5%**
Urban	13.4%	44.8%	20.7%	34.5%
Rural	14.3%	13.3%	20.0%	66.7%
Grand Total	**13.7%**	**34.1%**	**20.5%**	**45.5%**

Table 27 below shows Percentage Distribution of Type of Cold Chain Available by county. According to the table below, about five of the fifteen counties namely Margibi (62.5%), Bong (37.3%), Grand Kru (25%), Grand Bassa (20%) and Montserrado (14.3%) had health facilities that did not have cold chain equipment. Ten (10) out of the fifteen (15) counties (see table 33 below) had all facilities assessed using either electric fridge, ice box or solar fridge. Less number of health facilities (20.5%) assessed used Icebox or coolers. The disadvantage of using coolers is that the Health Facility will have to regularly replenish the supply of ice. Though a significant number of health facilities have cold chain available, this however did not reflect if proper maintenance of the correct temperature in cold boxes, and fridges in meeting the appropriate standard, that is MOH or WHO criteria. (see Table 27).

Table 27: Percentage Distribution of Type of Cold Chain Available by County

Counties	Percentage			
	No Cold Chain Available	Type of Cold Chain Available		
		Electric Fridge	Icebox	Solar Fridge
Bomi	0.0%	33.3%	0.0%	66.7%
Bong	37.5%	60.0%	0.0%	40.0%
Gbarpolu	0.0%	0.0%	33.3%	66.7%
Grand Bassa	20.0%	25.0%	25.0%	50.0%
Grand Cape Mount	0.0%	0.0%	25.0%	75.0%
Grand Gedeh	0.0%	33.3%	66.7%	0.0%
Grand Kru	25.0%	0.0%	66.7%	33.3%
Lofa	0.0%	33.3%	33.3%	33.3%
Margibi	62.5%	0.0%	33.3%	66.7%
Maryland	0.0%	25.0%	50.0%	25.0%
Montserrado	14.35	45.8%	8.3%	45.8%
Nimba	0.0%	63.6%	0.0%	36.4%
River Cess	0.05	0.0%	25.0%	75.0%
River Gee	0.0%	50.0%	25.0%	25.0%
Sinoe	0.0%	0.0%	25.0%	75.0%
Grand Total	**13.7%**	**34.1%**	**20.5%**	**45.5%**

If the type of cold chain used is a fridge, the questionnaire solicited responses to indicate the source of power for this. The responses are five-fold: electricity from the national grid, generator plant at the health facility, portable generator at the health facility, kerosene or paraffin fuel and solar panels. About 26% and 8% facilities mentioned using electric grid and generator plant, followed by solar (65.9%) at the Health facilities, and the other power sources were not mentioned.

Solar panels power was found in 78% compared to 85 of the primary Health facilities assessed in 2020, 86% in rural localities and 55.2% in urban facilities, and they are the main power sources used by most Government facilities (74.3%) at management levels (Table 28). The main power source used in tertiary health facilities is electricity from national grid followed by generator.

Table 28: Percentage Distribution of health facilities by Source of Power for Fridges Used for Cold Chain by Type of Facility, Urban-Rural Residence and by Management of Facility,

County	Percentage					
	Electricity from National Grid	Generator Plant at the HEALTH FACILITY	Portable Generator at the HEALTH FACILITY	Kerosene/ Paraffin Fuel	Solar Panels	others
Level of Service Delivery						
Primary	15.3%	6.8%	0.0%	0.0%	78.0%	0.0%
Secondary	44.4%	11.1%	0.0%	0.0%	44.4%	0.0%
Tertiary	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**26.1%**	**8.0%**	0.0%	0.0%	**65.9%**	0.0%
Urban-Rural Residence						
Urban	37.9%	6.9%	0.0%	0.0%	55.2%	0.0%
Rural	3.3%	10.0%	0.0%	0.0%	86.7%	0.0%
Total	**26.1%**	**8.0%**	0.0%	0.0%	**65.9%**	0.0%
Management of HEALTH FACILITY						
Government	20.0%	5.7%	0.0%	0.0%	74.3%	0.0%
Private	50.0%	16.7%	0.0%	0.0%	33.3%	0.0%
Total Per Cent	**26.1%**	**8.0%**	0.0%	0.0%	**65.9%**	0.0%

The cold chain requires the use of a significant amount of energy to maintaining temperature ranges. All counties had health facilities that mentioned the used of solar as the source of power for their cold chain, though the West African Power Grid has extended from Ivory Coast through Nimba, Grand Gedeh, Maryland and now extending to Bong and River Gee. This development has led to an increase in the used of Nation or Power Grid by some health facilities.

It is commendable that solar panel deployment has advanced so far because it offers a dependable power source with low operating costs. This is a credible option with a promising future for Liberia's health and other service delivery systems given the escalating cost of petroleum products. The opportunity exists for accelerating progress toward achieving development milestones set at the national and international levels. For additional distribution, see table 29 below.

Table 29: Percentage Distribution of Health facilities by Source of Power for Fridges Used for Cold Chain by County

County	Percentage				
	Electricity from National Grid	Generator Plant at the HEALTH FACILITY	Portable Generator at the HEALTH FACILITY	Kerosene or Paraffin Fuel	Solar Panels
Bomi	33.3%	0.0%	0.0%	0.0%	66.7%
Bong	20.0%	40.0%	0.0%	0.0%	40.0%
Gbarpolu	0.0%	0.0%	0.0%	0.0%	100.0%
Grand Bassa	0.0%	25.0%	0.0%	0.0%	75.0%
Grand Cape Mount	0.0%	0.0%	0.0%	0.0%	100.0%
Grand Gedeh	0.0%	33.3%	0.0%	0.0%	66.7%
Grand Kru	0.0%	0.0%	0.0%	0.0%	100.0%
Lofa	33.3	0.0%	0.0%	0.0%	66.7%
Margibi	0.0%	0.0%	0.0%	0.0%	100.0%
Maryland	0.0%	25.0%	0.0%	0.0%	75.0%
Montserrado	41.7	4.2%	0.0%	0.0%	54.2%
Nimba	63.6	0.0%	0.0%	0.0%	36.4%
River Cess	0.0%	0.0%	0.0%	0.0%	100.0%
River Gee	25.0	25.0	0.0%	0.0%	50.0%
Sinoe	0.0%	0.0%	0.0%	0.0%	100.0%
Total Per Cent	**26.1%**	**8.0%**	0.0%	0.0%	**65.9%**

3.6 Staff Training and Supervision

3.6.1 Availability of Staff Trained to Provide Family Planning Services including for Implants

Being knowledgeable and skilled to carry out effective contraception consultation is important to Family planning services. Family planning service provider training is a crucial component of on-the-job training that improves employees' competencies and facilitates effective and efficient service delivery. Lack of trained people to provide the long-acting and permanent methods of contraception was one of the factors that contributed to the high quantity of stock out in the six months prior to the survey in many of the reports of UNFPA Supplies Partnership Stream One Countries.

The addition of questions about training-related issues to the questionnaire would make it possible to gauge the severity of the issue and better target plans for remedies.

In general, 94.1% of the health facilities surveyed had staff members who were trained to provide family planning services, while 92.2% had staff members who were trained to insert and remove implants. Both statistics show no appreciable change from 2020. (Table 30). The percentage of those trained to offer family planning services and to insert and remove implants varies slightly, from 93.1% to 91.7% in primary care to 100% in tertiary care. The same percentage (94%) of employees in rural areas has received training in both implant insertion and removal. The distribution by management of facility with trained staff to provide family planning service and provide implants is very satisfactory.

Distribution by counties shows little variation. Except other counties, 75% of health facilities in Bong and Grand Cape Mount, reported having both trained staffs for tche provision of family planning services and for the insertion and removal of implants. Table (30 & 31) below provides further distribution.

Table 30: Percentage Distribution of Health facilities with Staff Trained to Provide Family Planning Services and for the Insertion and Removal of Implants by Type of Facility, Urban-Rural Residence and by Management of Facility

Characteristics	Percentage of Health facilities with Staff Trained	
	Train to Provide Family Planning Services (Modern Contraceptives)	Train for Insertion and Removal of Implants
Primary	93.1%	91.7%
Secondary	96.4%	92.9%
Tertiary	100.0%	100.0%
Total	94.1%	92.2%
Urban	94.0%	91.0%
Rural	94.3%	94.3%
Total	94.1%	92.2%
Government	96.3%	93.8%
Private	90.0%	90.0%
Others	0.0%	0.0%
Total	94.1%	92.2%

Table 31: **Percentage Distribution of Health facilities with Staff Trained to Provide Family Planning Services and for the Insertion and Removal of Implants by County**

Percent of Health Facilities with Staff Trained		
County	**Train to Provide Family Planning Services (modern contraceptives)**	**Train for Insertion and Removal of Implants**
Bomi	100.0%	100.0%
Bong	75.0%	75.0%
Grand Bassa	100.0%	100.0%
Grand Cape Mount	75.0%	75.0%
Grand Gedeh	100.0%	100.0%
Grand Kru	100.0%	100.0%
Lofa	100.0%	100.0%
Margibi	87.5%	87.5%
Maryland	100.0%	100.0%
Montserrado	92.9%	89.3%
Nimba	100.0%	100.0%
River Cess	100.0%	75.0%
Sinoe	100.0%	100.0%
River Gee	100.0%	100.0%
Gbarpolu	100.0%	100.0%
Total	94.2%	92.2%

3.6.2: Health Facility Supervision

The performance of health professionals and the standard of healthcare delivery can both be improved with regular oversight. In the process of supervision, higher authorities motivate employees to perform to the best of their abilities in a friendly environment and reward them when they reach a high level of performance. Studies have indicated that systematic supervision using a set of objective metrics may enhance the effectiveness of health workers. A balance between monitoring and assessing services and offering assistance and motivation to personnel results from effective supervision. By asking respondents when their authority last visited and supervised staff members, the survey evaluated the supervision of health facilities.

Nearly two-thirds (63%) of all facilities assessed were supervised less than one month and 24% health facilities supervised between one to three months before the day of the survey. These breaks are routine

and predetermined by Liberian law. County and district officials frequently oversee health facilities once a month, while national teams escorted by county level teams provide joint supervision at a few selected health facilities once every three months.

Very few facilities (3.9%) reported not being supervised 12 months before the day of the survey; this has increased by 2% when compare to 2020 report. Disaggregation reveals that facilities not supervised in 12 months all were from all levels (2 primary, 1 secondary and 1 tertiary health facilities) and two of the facilities are located in Margibi County. See below in table 32 for further distribution. The majority of supervisory activities center on inventory shortages, employee availability, and reviews of job aids for reproductive health. Clinical procedures and data quality are further areas of emphasis.

Table 32: Distribution of the last time the facility was supervised in the past 12 months by type of SDP, residence, ownership and county

Categories	< One Month	One and three Months ago	Three and six months ago	Six month and one year ago	Not supervised in 12 month
Facility Type					
Primary	69.4%	22.2%	4.2%	1.4%	2.8%
Secondary	46.4%	28.6%	21.4%	0.0%	3.6%
Tertiary	50.0%	0.0%	0.0%	0.0%	50.0%
Residence					
Urban	58.2%	25.4%	10.4%	1.5%	4.5%
Rural	71.4%	20.0%	5.7%	0.0%	2.9%
Ownership					
Government	61.7%	25.9%	8.6%	1.2%	2.5%
Private	65.0%	15.0%	10.0%	0.0%	10.0%
Others	100.0%	0.0%	0.0%	0.0%	0.0%
County					
Bomi	33.3%	66.7%	0.0%	0.0%	0.0%
Bong	50.0%	37.5%	12.5%	0.0%	0.0%
Grand Bassa	100.0%	0.0%	0.0%	0.0%	0.0%
Grand Cape Mount	50.0%	25.0%	25.0%	0.0%	0.0%
Grand Gedeh	66.7%	33.3%	0.0%	0.0%	0.0%
Grand Kru	50.0%	50.0%	0.0%	0.0%	0.0%
Lofa	55.6%	11.1%	33.3%	0.0%	0.0%
Margibi	75.0%	0.0%	0.0%	0.0%	25.0%
Maryland	75.0%	25.0%	0.0%	0.0%	0.0%
Montserrado	67.9%	21.4%	3.6%	3.6%	3.6%
Nimba	72.7%	18.2%	0.0%	0.0%	9.1%
River Cess	25.0%	50.0%	25.0%	0.0%	0.0%
Sinoe	75.0%	0.0%	25.0%	0.0%	0.0%

River Gee	25.0%	75.0%	0.0%	0.0%	0.0%
Gbarpolu	66.7%	0.0%	33.3%	0.0%	0.0%
Total	**62.7%**	**23.5%**	**8.8%**	**1.0%**	**3.9%**

3.6.3. **Frequency of supervisory visits**

Additionally, regular supervision at health facilities guarantees that staff members, particularly the clinical staff, have increased capacity and can deliver services of high quality. Once more, the survey shows that 58% of the healthcare facilities assessed are supervised on a monthly basis, a decrease of 12% from the 2020 report. The survey also reveals that 23.5% of health facilities are subject to quarterly supervision in accordance with national standards. Table 33 shows further distribution.

Table 33: Frequency of supervisory visit by type of SDP, residence, ownership and county

Categories	Weekly	Monthly	Every three months	Every six months	Once a year	Never
Facility Type						
Primary	13.9%	61.1%	22.2%	0.0%	0.0%	2.8%
Secondary	10.7%	53.6%	28.6%	3.6%	0.0%	3.6%
Tertiary	50.0%	0.0%	0.0%	0.0%	0.0%	50.0%
Residence						
Urban	17.9%	50.7%	25.4%	1.5%	0.0%	4.5%
Rural	5.7%	71.4%	20.0%	0.0%	0.0%	2.9%
Ownership						
Government	13.6%	56.8%	25.9%	1.2%	0.0%	2.5%
Private	15.0%	60.0%	15.0%	0.0%	0.0%	10.0%
Others	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%
County						
Bomi	0.0%	66.7%	33.3%	0.0%	0.0%	0.0%
Bong	0.0%	62.5%	37.5%	0.0%	0.0%	0.0%
Grand Bassa	0.0%	80.0%	20.0%	0.0%	0.0%	0.0%
Grand Cape Mount	25.0%	50.0%	25.0%	0.0%	0.0%	0.0%
Grand Gedeh	0.0%	66.7%	33.3%	0.0%	0.0%	0.0%
Grand Kru	0.0%	50.0%	50.0%	0.0%	0.0%	0.0%
Lofa	33.3%	44.4%	22.2%	0.0%	0.0%	0.0%
Margibi	12.5%	37.5%	25.0%	0.0%	0.0%	25.0%
Maryland	25.0%	50.0%	25.0%	0.0%	0.0%	0.0%
Montserrado	21.4%	46.4%	28.6%	0.0%	0.0%	3.6%
Nimba	0.0%	90.9%	0.0%	0.0%	0.0%	9.1%
River Cess	0.0%	75.0%	0.0%	25.0%	0.0%	0.0%

Sinoe	0.0%	75.0%	25.0%	0.0%	0.0%	0.0%
River Gee	50.0%	25.0%	25.0%	0.0%	0.0%	0.0%
Gbarpolu	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%
Total	**13.7%**	**57.8%**	**23.5%**	**1.0%**	**0.0%**	**3.9%**

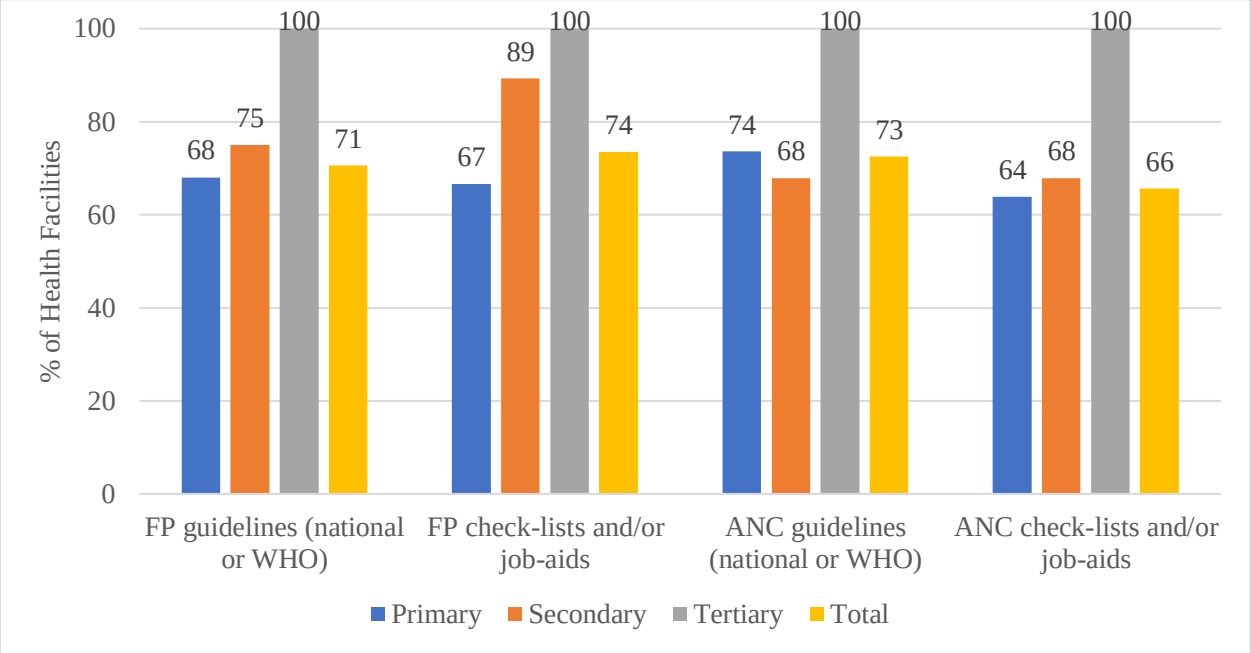
3.7 Availability of Guidelines, checklists and job-aids

Liberia has a number of demographic and reproductive health-related policies, regulations, and service delivery guidelines, all of which are helpful to some aspects of the security of reproductive health commodities. The Ministry of Health (MoH) develops family health protocols guidelines and job aids with assistance from partners.

To improve the quality of services, several health care delivery guidelines and checklists are offered according to the degree of health care delivery. One of the main goals of this survey has been to determine the availability of specific family planning guidelines and waste disposal recommendations. The verbal responses of the interviews were used to gauge the availability of such guidelines, job-aids, or checklists, and the availability of the same guidelines or job-aids was then verified.

Figure 7 shows that more than two-thirds of all health facilities assessed reported and verified possessing family planning guidelines, family planning checklists, and/or job aids, as well as ANC guidelines, ANC checklists, and/or job aids, respectively. Family planning check-list and/or job aids are more prevalent among primary, secondary, and tertiary health facility types, with percentages of 67%, 89%, and 100%, respectively. This is followed by ANC Guidelines.

Figure 7: Availability of Family Planning Guidelines, ANC/PNC Job Aids by Facility Type



Also at management level, public health facilities (64-73%) reported any of the guidelines while private health facilities vary from 75% to 90%. All counties assessed reported having some of guidelines, checklist or job-aids ranging from 25% to 100%. Among all counties, facilities assessed in Grand Cape Mount reporting having few forms of guidelines, checklists and job-aids.

3.8 Use of Information, Communication and Technology

Information and communication technologies (ICTs) have the potential to change how health services are provided across countries in ways that boost accountability and efficiency. The increase use of information and communication technology (ICT) in healthcare is a basic need for the development, implementation and further generation of innovative health care technologies that strengthen health care delivery. Any organization's healthcare structure should support procedures in order to produce better results for the organization overall and patient's outcome in particular. Health facilities were assessed also on the availability and use of the different types of ICT, how ICT was acquired and use of ICT in the health sector as well as method of waste disposal used.

Information communication technology used at health facilities assessed varies with mobile phones-smart phones (65.7%) followed by computer (26%) being the most common type of ICT available and used. Distribution of smart phones availability and used by health facility types reveals 100% used at Tertiary,

54% to 14% at secondary and primary health facilities.

3.9 Methods of waste disposal

The usage of incinerators at the health facilities was the most popular method of waste disposal, accounting for 72.6% of all disposal methods; this figure has increased by nearly 5% since the 2020 report. The burning of waste (12.5%) on the premises of the health facility was the second prevalent method of waste disposal (See Table 34 below). Tertiary facilities used incinerators exclusively (100%) whereas secondary and primary facilities respectively employed 80.6% and 60.6% for waste disposal. Over two-third (74%) of government health facilities compared to 65% of private health facilities used incinerators at the health facilities site. This reveal that the use of incinerator in private health facilities have increased by 15%.

Table 34: Percentage distribution of SDPs by how health wastes are disposed

Categories	Burning on the grounds at SDP	Bury in special dump pits at SDP	Use Incinerators	Centrally collected by specific agency	Disposed with regular garbage
Primary	12.5%	6.9%	66.7%	13.9%	0.0%
Secondary	0.0%	10.7%	85.7%	3.6%	0.0%
Tertiary	0.0%	0.0%	100.0%	0.0%	0.0%
Total	**8.8%**	**7.8%**	**72.6%**	**10.8%**	**0.0%**
Bomi	0.0%	33.3%	66.7%	0.0%	0.0%
Bong	25.0%	12.5%	62.5%	0.0%	0.0%
Grand Bassa	20.0%	0.0%	80.0%	0.0%	0.0%
Grand Cape Mount	0.0%	0.0%	100.0%	0.0%	0.0%
Grand Gedeh	0.0%	0.0%	100.0%	0.0%	0.0%
Grand Kru	0.0%	0.0%	100.0%	0.0%	0.0%
Lofa	0.0%	0.0%	100.0%	0.0%	0.0%
Margibi	25.0%	12.5%	62.5%	0.0%	0.0%
Maryland	0.0%	0.0%	100.0%	0.0%	0.0%
Montserrado	10.7%	7.1%	46.4%	35.7%	0.0%
Nimba	0.0%	0.0%	100.0%	0.0%	0.0%
River Cess	0.0%	25.0%	75.0%	0.0%	0.0%
Sinoe	25.0%	50.0%	25.0%	0.0%	0.0%
River Gee	0.0%	0.0%	75.0%	25.0%	0.0%
Gbarpolu	0.0%	0.0%	100.0%	**0.0%**	**0.0%**
Total	**8.8%**	**7.8%**	**72.6%**	**10.8%**	**0.0%**
Urban	4.5%	4.5%	74.6%	16.4%	0.0%
Rural	17.1%	14.3%	68.6%	0.0%	0.0%
Total	**8.8%**	**7.8%**	**72.6%**	**10.8%**	**0.0%**

Government	7.4%	9.9%	74.0%	8.6%	0.0%
Private	15.0%	0.0%	65.0%	20.0%	0.0%
Others	0.0%	0.0%	100.0%	0.0%	0.0%
Total	**8.8%**	**7.8%**	**72.6%**	**10.8%**	**0.0%**

3.10 Charges for user fees

According to the 2022 survey, medication (25.5%) is the most frequent issue that health facilities charge patients for, compared to 2020, when consultations accounted for 29.8% of all charges. Similar to 2020, the cost of any type of service rises with the level of the health facility, as seen by the finding that half of the tertiary facilities surveyed charged patients for family planning, antenatal, or maternal care services. More private facilities charged patients higher for consultations, medications and other maternal health services compared to public health facilities. Among facilities assessed in the 15 counties, majority of health facilities in Lofa charge patient for consultation and medication. This could imply the application of the revolving drugs fund in that part of the county. See table 35 below for more details.

Table 35: **Distribution of Health Facility who charge Patients for Service Area**

County	Charge patient for Consultation	Charge patient for Medication	Charge patient for any service
Bomi	0.0%	0.0%	0.0%
Bong	25.0%	25.0%	0.0%
Grand Bassa	20.0%	20.0%	0.0%
Grand Cape Mount	25.0%	25.0%	25.0%
Grand Gedeh	33.3%	33.3%	33.3%
Grand Kru	0.0%	0.0%	0.0%
Lofa	55.6%	66.7%	55.6%
Margibi	12.5%	25.0%	25.0%
Maryland	0.0%	0.0%	0.0%
Montserrado	25.0%	32.1%	28.6%
Nimba	27.3%	27.3%	27.3%
River Cess	0.0%	0.0%	0.0%
Sinoe	0.0%	0.0%	0.0%
River Gee	25.0%	25.0%	25.0%
Gbarpolu	0.0%	0.0%	0.0%
Grand Total	**21.6%**	**25.5%**	**20.6%**
Urban	25.4%	31.3%	28.4%
Rural	14.3%	14.3%	5.7%
Grand Total	**21.6%**	**25.5%**	**20.6%**

Primary	20.8%	22.2%	16.7%
Secondary	21.4%	32.1%	28.6%
Tertiary	50.0%	50.0%	50.0%
Grand Total	**21.6%**	**25.5%**	**20.6%**
Government	6.2%	7.4%	4.9%
Private	80.0%	95.0%	80.0%
Others	100.0%	100.0%	100.0%
Grand Total	**21.6%**	**25.5%**	**20.6%**

Conclusion

The 2022 reproductive health commodities and security survey offers very crucial data at this point for decision-making, necessitating the development of an improvement plan that gathers all important stakeholders and can be used to strengthen the current weaknesses in the provision of reproductive health services in Liberia. Family planning services was provided by all types of SDPs surveyed.

Comparing with previous years, male condoms, Injectable and Oral pills have been consistent as the three modern contraceptives mostly offered among health facilities as well as female and male sterilization being least offered. The 2022 reveal that all health facilities assessed across the country are offering at least three (three or more) where as 93% of health facilities assessed are offering (five or more) modern contraceptive methods. show an upward trend when compared to 2020 survey results. The extent of 'no stock out' at the time of the survey gives a snap shot of the availability of contraceptives at the Health facilities across the country. On the overall, 46% of the facilities assessed did not experience any form of stock out during the day of the survey compared to 67% in 2020.

The existence of a cold chain guarantees reproductive health commodity security in that it preserves the potency of certain essential lifesaving vaccines that require a constantly cold temperature regime. Similar to the 2020 report, about 12% of health facilities have no cold chain. The main source of power for fridges used for cold chain is solar panels, mainly observed across primary facilities. Generally, the percentage of health facilities with trained staff to provide family planning services and insertion and removal of implants was 94.1% and 92.2% respectively.

Recommendations

1. The Family Health Division should work along with counties and partners to develop an improvement plan that can be implemented by all stakeholders to enhance family planning and reproductive health services at all levels.

2. Strengthening of the health commodity distribution system across all levels should be given added focus to increase commodity security nationwide to address issues of frequent stock out especially in rural settings, but also urban settings.

3. Though some level of training is taking place each year, but attrition has become our main weakness preventing us from keeping our qualified staff. Thus the need to organize a comprehensive training that will provide health workers involve in the provision of reproductive health and family planning related services the requisite knowledge and skills needed.

4. Despite some progress, ongoing awareness is necessary to raise demand for some contraceptives, such as the IUD and female condom, which are occasionally out of supply because of low demand.

5. Regarding the availability of guidelines and job aids for FP, it is recommended that the MoH and its partners intensify the distribution and use of the guidelines and job aids in the different facilities where they were missing. They should ensure that all facility assessment for reproductive health commodities and services at all levels have the requisite job-aids in all departments that deliver FP services, and in position and form that is easily visible and usable.

6. Transport costs is one of the main impediments to hindering access to FP services mainly in hard to reach areas, government and its partners should consider taking FP services closer to the people or strategize a sustainable incentivize transportation mechanism on particular days to cater for those that cannot afford the cost of transport to attend FP. Service delivery points in such hard-to-reach areas should be supported to conduct supplemental integrated outreaches to reach the areas farther from health facilities.

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ANNEXES

Table 36: Family Planning Guidelines and Protocols

Interventions and service provided	Community (TTM & CHW)	Clinic	Health Center	County Hospital
IEC/BCC on birth spacing and family planning	Yes	Yes	Yes	Yes
Counsel on informed choice	Yes	Yes	Yes	Yes
Distribute male& female condoms and explain their	Yes	Yes	Yes	Yes
Distribute oral contraceptives and explain their use	Yes	Yes	Yes	Yes
Administer DMP and explain its use	Yes	Yes	Yes	Yes
Insert & remove IUD/explain its use	No	Yes	Yes	Yes
Permanent surgical methods	Refer	Refer	Refer	Yes
Syndromic management of STIs for men	Refer	Yes	Yes	Yes
Syndromic management of STIs for women	Refer	Yes	Yes	Yes
Voluntary confidential testing for HIV	Refer	Refer	Yes	Yes
Infertility counseling	Yes	Yes	Yes	Yes
Youth friendly & peer education of family planning and counseling for unintended pregnancies and others	Yes	Yes	Yes	Yes

Source: Essential Health Package Services, Ministry of Health, 2011

Table 37: Maternal and Newborn Healthcare Guidelines and Protocols

Interventions and service provided	Community TTM &CHW	Clinic	Health Center	County Hospital
Routine care				
Diagnose pregnancy (clinic) diagnosis	Yes	Yes	Yes	Yes
Screen for high risk, including short height	Yes	Yes	Yes	Yes

Monitor growth of fetus (height of fundus)	No	Yes	Yes	Yes
Monitor mother's weight gain	No	Yes	Yes	Yes
Give tetanus toxoid	No	Yes	Yes	Yes
Give prophylactic iron, folic acid, and multivitamins	Yes	Yes	Yes	Yes
Give intermittent preventive treatment for falciparum malaria	Yes	Yes	Yes	Yes
Give mebendazole for deworming	No	Yes	Yes	Yes
Screen for pre-eclampsia or hypertension	Refer	Yes. Refer delivery	Yes. Refer for delivery	Yes
Screen for and manage severe eclampsia or hypertension	No	Refer immediately	Refer immediately	Yes
Screen for and treat anemia	No	Yes	Yes (lab)	Yes (lab)
Treat anemia	No	Yes (lab)	Yes (lab)	Yes (lab)
Manage severe anemia(<7gm/dl) with symptom or in last trimester	Refer	Refer	Refer	Yes
Screen (RPR/) and manage syphilis and partner	No	Yes	Yes	Yes
VCT for HIV	No	Yes	Yes	Yes
Feel for mal-presentation or twins	No	Refer	Refer	Yes
IEC/BCC on the importance of antenatal care	Yes	Yes	Yes	Yes
IEC/BCC on diet and rest during pregnancy and lactation	Yes	Yes	Yes	Yes
IEC/BCC; birth preparedness and danger signs, home delivery, family planning	Yes	Yes	Yes	Yes
Promote and provide ITNs for pregnant women	Yes	Yes	Yes	Yes
Conduct nutrition assessment: hemoglobin and BMI	Yes	Yes	Yes	Yes
Provide supplement feeding programs for maternal nutrition	Yes	Yes	Yes	Yes
Managing Complications of Pregnancy				

Manage threatened or complete abortion	Refer	Yes	Yes	Yes
Manage incomplete abortion (Manual Vacuum Aspiration)	Refer	Yes	Yes	Yes
Manage complicated abortion	Refer	Refer	Refer	Yes
Manage ectopic pregnancy	Refer	Refer	Refer	Yes
Manage urinary tract infection	Refer	Yes	Yes	Yes
Manage fever/malaria (Rapid diagnostic test)	Refer	Yes	Yes	Yes
Manage vaginal discharge (syndromic method) and partner	Refer	Yes	Yes	Yes
No fetal movements	Refer	Refer	Refer	Yes
Ruptured membranes, not in labor	Refer	Refer	Refer	Yes
Labor and Delivery				
Assess and monitor progress in labor/ recognize delay	No	Partograph/ Refer	Yes	Yes
Conduct a clean deliver of baby	Yes	Yes	Yes	Yes
Active management of third stage of labor (Oxytocin and controlled cord tract	Refer	Yes	Yes	Yes
Episiotomy and repair of tears	Refer	Yes	Yes	Yes
Breech delivery	Refer	Yes		
Transverse lie		Refer		Yes
Antepartum hemorrhage	Refer	Resuscitate/ Refer		
Treat Shock	Refer	Initiate/ Refer	Yes	Yes
Bimanual compression of uterus	Refer	Yes	Yes	Yes
Manual removal of placenta	No	Yes	Yes	Yes
Manage convulsion or unconsciousness: eclampsia	No	Initiate/ Refer	Initiate/ Refer	Yes

Manage convulsion or unconsciousness with fever: malaria/ sepsis	Refer	Initiate/ Refer	Initiate Refer/	Yes
PMTCT Follow up for mothers	Yes	Yes	Yes	Yes

Source: Essential Health Package Services, Ministry of Health, 2011

Table 38: Postpartum Care Guidelines and Protocols

Interventions and service provided	Community	Clinic	Health Center	County Hospital
Immediate Postnatal Care				
Monitor vital signs, state of uterine contraction and vaginal bleeding	Yes	Yes	Yes	Yes
At End of First Week and Pueperium				
Manage postpartum psychosis	No	Refer	Refer	Yes
Detect and manage puerperal sepsis	Recognize and refer	Initiate/ refer	Refer	Yes
Detect and manage anemia	Refer	Yes, refer	Yes	Yes
Manage postpartum hemorrhage	No	Refer	Refer	Yes
Detect and manage urinary tract infection	No	Yes	Refer	Yes
Manage nipple or breast pain	Refer	Yes	Yes	Yes
Manage constipation, hemorrhoids and other symptomatic problems	Yes	Yes	Yes	Yes
Counsel on birth spacing	Yes	Yes	Yes	Yes
Newborn Immediate Care				
Keep dry, clear airway if necessary, cord care, put to breast	Refer	Yes	Yes	Yes
Resuscitate baby if not breathing	Refer	Yes	Yes	Yes
Tetracycline eye ointment to prevent opthalmia neo-natorum	Refer	Yes	Yes	Yes
Initiate breast feeding within the first hour of life	Yes	Yes		

During the First Month				
Manage low birth weight (1500gms-2500gms)	Refer	Yes/ Feeding difficulty: Refer	Yes	Yes
Manage very low birth weight baby (< 1500gms or- < 52 weeks gestation)	Refer	Refer immediately	Yes	Yes
Manage neonatal jaundice	Refer	Yes	Yes	Yes
Jaundice of prematurity	Refer	Initiate/refer	Initiate/refer	Yes
Manage hypothermia	Refer	Initiate/refer	Initiate/refer	Yes
Breathing difficulty	Refer	Initiate/refer	Initiate/refer	Yes
Necrotizing enterocolitis	Refer	Initiate/refer	Initiate/refer	
Intraventricular bleeding	Refer	Initiate/refer	Initiate/refer	Yes
Anemia	Refer	Initiate/refer	Initiate/refer	Yes
Low blood	Refer	Initiate/refer	Initiate/refer	Yes
Asphysia	Refer	Initiate/refer	Initiate/refer	Yes
Provide oxygen therapy	Refer	Initiate/refer	Initiate/refer	Yes
Nasogastric feeding	Refer	Initiate/refer	Initiate/refer	Yes
Manage convulsions or spasms	Refer	Initiate/refer	Initiate/refer	Yes
Diagnose and manage hemolytic jaundice	Refer	Initiate/refer	Initiate/refer	Yes
Diagnosis and manage bilirubin encephalopathy (kemictenus)	Refer	Initiate/refer	Initiate/refer	Yes
Manage lethargy and other non-specific signs incubation	Refer	Initiate/refer	Initiate/refer	Yes
Phototherapy	Refer	Initiate/refer	Initiate/refer	Yes
Counsel and support mother breastfeeding	Yes	Yes	Yes	Yes
Give newborn immunizations	Refer	Yes	Yes	Yes
Treat skin pustules or cord infection	Refer	Yes	Yes	Yes
Treat neonatal sepsis / severe skin or cord infection	Refer	Yes	Yes	Yes
Neonatal tetanus	Refer	Refer	Yes	Yes

Source: Essential Health Package Services, Ministry of Health, 2011

Table 39: Standards for the Provision of HIV and Sexually Transmitted Infections Services for Adolescent and Young People

	Community	Public, Private (Non & Profit) Clinic	Public & Private Health Centers	Public & Private hospitals	Pharmacies
HIV					
Information and Health Education/Interpersonal Communication (IPC)	Yes	Yes	Yes	Yes	Yes
Counseling	Yes	Yes	Yes	Yes	Yes
Communication/Advocacy	Yes	Yes	Yes	Yes	Yes
Psychosocial	Yes	Yes	Yes	Yes	Yes
Provide condoms	Yes	Yes	Yes	Yes	Yes
Testing(VCT&PICT)	No	Yes	Yes	Yes	No
Management of Opportunistic Infections	No	Yes	Yes	Yes	No
Support for ARV and follow up clients on ARV	No	Yes	Yes	Yes	No
Treatments and Home Based Care	No	Yes	Yes	Yes	No
Prophylaxis	No	Yes	Yes	Yes	No
PMTCT	No	Yes	Yes	Yes	No
First line ARV Treatments	No	No	Yes	Yes	No
All ARV Treatments	No	No	No	Yes	No
Sexual Transmitted Infections					
Information and Health Education/Inter Personal Communication (IPC)	Yes	Yes	Yes	Yes	Yes

Counseling	Yes	Yes	Yes	Yes	Yes
Communication/Advocacy	Yes	Yes	Yes	Yes	Yes
Psychosocial	Yes	Yes	Yes	Yes	No
Provide Condoms	Yes	Yes	Yes	Yes	Yes
Treatment by Syndromic	No	Yes	Yes	Yes	No
Partner Approach	No	Yes	Yes	Yes	No
Diagnosis with Laboratory	No	Yes	Yes	Yes	No
Specific Treatment	No	No	Yes	Yes	No
Management of Complications	No	No	No	Yes	No

Table 40: Standards for the Provision of Family Planning and Adolescent Pregnancy Services for Adolescent and Young People

	Community	Public, Private (Non & Profit) Clinic	Public & Private Health Centers	Public & Private hospitals	Pharmacies
Family Planning					
Information and Health Education/IPC	Yes	Yes	Yes	Yes	Yes
Counseling	Yes	Yes	Yes	Yes	Yes
Communication/Advocacy	Yes	Yes	Yes	Yes	Yes
Psychosocial	Yes	Yes	Yes	Yes	Yes
Provide Condoms	Yes	Yes	Yes	Yes	Yes
Oral Contraceptives Distribution	Yes	Yes	Yes	Yes	No
Injectables	Yes	Yes	Yes	Yes	No
Insertion and Removal of IUD	No	Yes	Yes	Yes	No
Insertion and Removal of Implant	No	Yes	Yes	Yes	No

Fertility Awareness Methods (e.g. cycle beads)	No	Yes	Yes	Yes	No
Surgical Methods	No	No	No	Yes	No
Spermicide	No	Yes	Yes	Yes	No
Adolescent Pregnancy					
Information and Health Education/IPC	Yes	Yes	Yes	Yes	Yes
Specific Counseling	Yes	Yes	Yes	Yes	Yes
Communication/Advocacy	Yes	Yes	Yes	Yes	Yes
Psychosocial	Yes	Yes	Yes	Yes	Yes
Provide condoms	Yes	Yes	Yes	Yes	Yes
Focused Antenatal Care (FANC)	Yes	Yes	Yes	Yes	No
Intermitted Malaria Prophylaxis	No	Yes	Yes	Yes	No
Insecticide Treated Net (INTNs)	Yes	Yes	Yes	Yes	No
Maternal & Child Nutrition Counseling & Referral	Yes	Yes	Yes	Yes	No
Post Abortion Care (PAC)	No	Yes	Yes	Yes	No
Therapeutic Abortion	No	No	Yes	Yes	No
PMTCT	No	Yes	Yes	Yes	No

Source: Ministry of Health & Social Welfare, Standards for the Provision of Essential package of Sexual and Reproductive Health Services for Adolescent and Young People, pp.7-9, July, 2012.

Table 41: Standards for the Provision of Delivery Services for Adolescent and Young People

Delivery Services					
Information and Health Education/ Interpersonal Communication (IPC)	Yes	Yes	Yes	Yes	Yes
Counseling	Yes	Yes	Yes	Yes	Yes
Communication/Advocacy	Yes	Yes	Yes	Yes	Yes
Psychosocial	Yes	Yes	Yes	Yes	Yes
Provide condoms	Yes	Yes	Yes	Yes	Yes
Postnatal Care (PNC)	Yes	Yes	Yes	Yes	No

Home based Neonatal care	Yes	Yes	Yes	Yes	No
Insecticide Treated Net (ITNs)	Yes	Yes	Yes	Yes	No
Maternal and Child Nutrition Counseling & Referral	Yes	Yes	Yes	Yes	No
Immunization	Yes	Yes	Yes	Yes	No
Family planning	Yes	No	Yes	Yes	No
Safe and Clean Normal Labor & Delivery					
Assisted Delivery	No	Yes	Yes	Yes	No
PMTCT	No	Yes	Yes	Yes	No
Cesarean Sections	No	No	Yes	Yes	No
Counseling & Management	No	Yes	Yes	Yes	No

Source: Ministry of Health & Social Welfare, Standards for the Provision of Essential package of Sexual and Reproductive Health Services for Adolescent and Young People, pp.7-9, July 2012.