



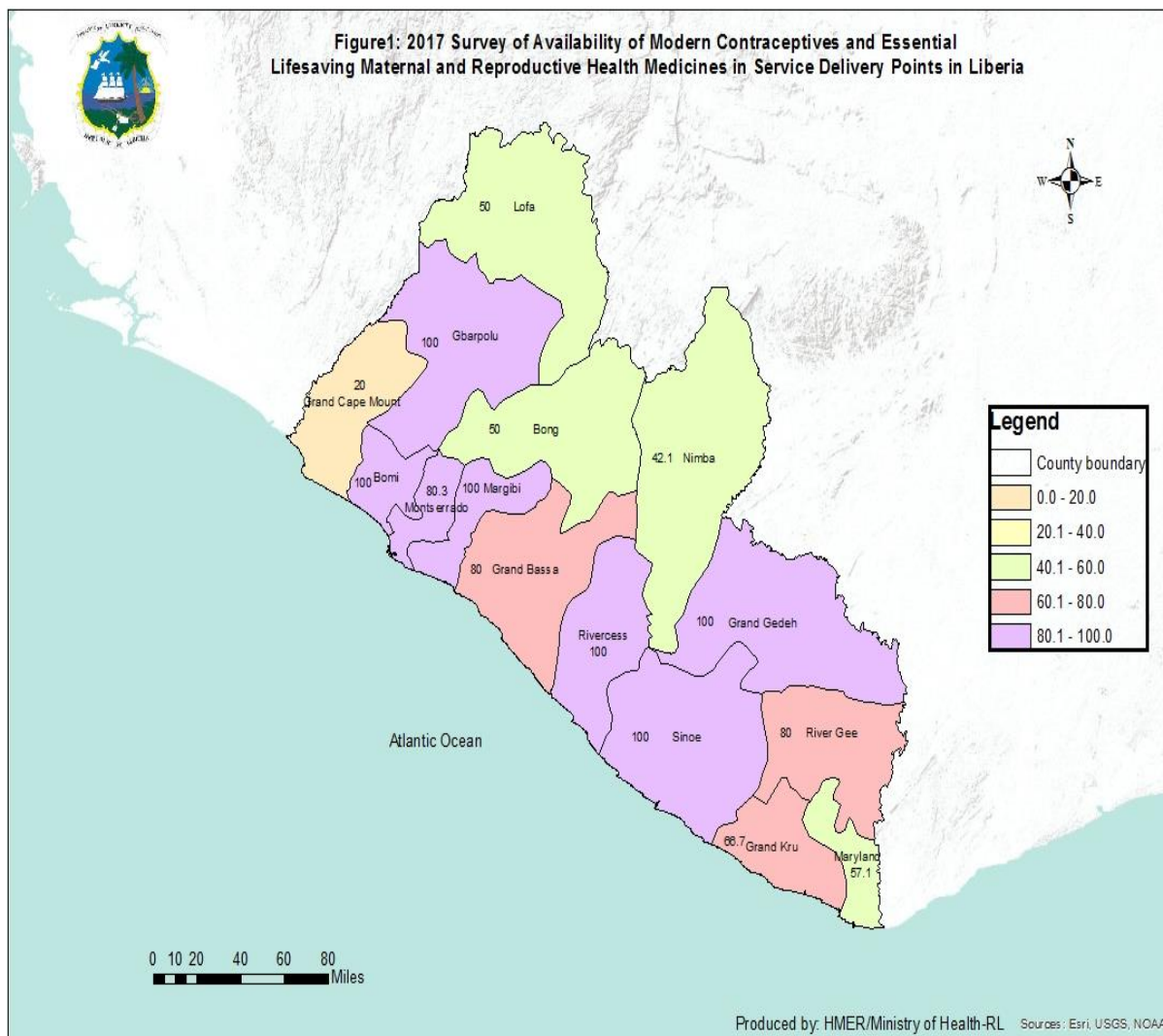
Liberia Reproductive Health  
Commodities and Security Survey  
A Sample Health Facilities Survey

2020

Final Survey Report



Figure 12020 Survey of Availability of Modern Contraceptives and Essential Lifesaving Maternal and Reproductive Health Medicines in Service Delivery Points in Liberia





## *PREFACE*

Liberia was classified as a Stream One country within the Global Program to enhance Reproductive Health Commodity Security (GPRHCS) of UNFPA in 2013. The GPRHCS gives Government of Liberia technical and financial support to scale up family planning and reproductive health programming. To better assist the country in the provision of evidence based information for the implementation of family planning and reproductive health services at service delivery points, an annual survey is conducted yearly on “Availability of Modern Contraceptives and Essential Maternal and Reproductive Health Medicines in Service Delivery Points” in Liberia since 2013.

This first annual report of the survey benchmarks three country level indicators:

- (a) Percentage of Service Delivery Points (Health facilities) offering at least three modern contraceptive methods;
- (b) Percentage of Service Delivery Points (Health facilities) offering at least five modern contraceptive methods;
- (c) 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, and
- (d) Percentage of Health facilities with ‘no stock-outs’ of modern contraceptives in the last three months prior to the survey

Government of Liberia through the Ministry of Health and UNFPA appreciate the contributions of various individuals and institutions towards the success of the 2020 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 study.

We are also grateful to the County Health Teams (CHTs), the various respondents across the country and survey field staff for their roles in the data collection exercise. We also strongly appreciate the Liberia Board of Nursing and Midwifery (LBNM) for their technical expertise and management of funds for this survey. It is a great opportunity to have the UNFPA always ready to provide funding and technical support for this annual exercise, we hope that said support will continue.

**UNFPA Global Program to Enhance Reproductive Health Commodity Security**  
Report on the 2020 Survey of Availability of Modern Contraceptives and Essential Maternal and Reproductive  
Health Medicines in Service Delivery Points in Liberia



This survey provides timely inputs into strategic decision making for the National Family Planning and reproductive health Programs. It informs planning for reproductive health commodity security (RHCS). The information will be used for implementation, co-ordination and repositioning of family planning, essential lifesaving maternal and reproductive health medicines and emergency obstetric and neonatal care (EmONC) by helping to fill the critical dearth of reliable, high quality and timely data for programme monitoring and evaluation.

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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
GPRHCS	Global Programme to Enhance Reproductive Health Commodity Security
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 Midwifery

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LDHS	Liberia Demographic and Health Survey
LISGIS	Liberia Institute of Statistics and Geo-Information Services
LMIS	Logistic Management Information System
<b>MDGs</b>	<b>Millennium Development Goals</b>
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
SDGs	Sustainable Development Goal
SDPs	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
Wi-Fi	Wide Fidelity



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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 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<sup>1</sup> 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.

Additionally, the study investigated the perception of clients seeking family planning related services through exit interviews.

The country was divided into five survey zones and assessed 105 health facilities that included all tertiary (2) in Montserrado and Nimba, 42 secondary facilities, and 61 primary facilities and 565 clients seeking family planning related service were interviewed in the Month of December 2018. 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 and facility exit interviews with family planning related service clients. Nine teams of three data collectors were deployed for the period of 8-10 days with travel days included as well.

Overall, the distribution of counties by provision of family planning and maternal or reproductive health services revealed that 10 of the fifteen counties are offering all these services. About 100% and 95% of all facilities in 2018 survey compared to 93% and 97% in 2017 are offering Family Planning and other



Maternal or Reproductive Health services respectively with no significant difference observed among urban and rural distribution. The distribution shows that almost all public facilities are offering both services at 97%. For family planning and other Maternal or Reproductive Health services provision, Grand Cape Mount and Sinoe counties are offering such services unsatisfactorily.

Geographical distribution reveals that about 50% of health facilities assessed are located within a one-hour or more distance from their main source of supplies.

Male condoms, Injectables and Oral pills are the three modern contraceptives mostly offered across health facilities with female and male sterilization being least offered. These findings are similar to the 2017 survey. The 2018 study shows that about 95% and 68.6% of all health facilities assessed across the country are offering at least three (three or more) and (five or more) modern contraceptive methods respectively. This shows an increasing trend when compare with 89% and 60% in 2017.

The availability of Modern Contraceptives and Essential Lifesaving Maternal or Reproductive Health Medicines was assessed. About 96% of health facilities assessed have available seven essential lifesaving maternal and reproductive health medicines compared with 92% in 2017, while tertiary level facilities offer at 100 percent in both 2017 and 2018 respectively.

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 during the day of the survey compared to 66% in 2017.

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 regional/county warehouse which account for 54% in 2018 of all supplies compared to 50.9 % in 2017. Distribution by rural and urban reveals 62% and 42% respectively.

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. About 14% of health facilities have no cold chain compared 16.7% in 2017. The main source of power for fridges used for cold chain is solar panels, mainly observed across primary facilities.

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 2017 survey. Distribution by facility types shows 100% in secondary and tertiary facilities with staffs trained.

An exit interview with clients was also conducted to understand their perceptions regarding family planning related services within the county.

The survey shows that majority of clients (80 per cent) come once in three months at health facility to seek family planning services similarly noticed in the 2017 survey. The county analysis of adherence to technical issues in family planning service delivery reveals that the items most adhered to are the provision of the methods chosen by the client at 99.9 and 98.1 percent Provider took clients preference and wishes into consideration.

Though there was an overall minimum waiting time of 25% as observed in 2017 (28%), 99 percent of the clients indicated that they were treated with courtesy and respect by staff of the health facility and were, therefore, generally satisfied with the attitude of the health providers (98.2%) towards them.

The study-investigated payment for family planning related services and reveals that only two counties (Grand Kru and Nimba) of the fifteen counties did not record clients paying for family planning services. On the overall, percentage distribution of payment for family planning was recorded as follows: Cards (1.8%), Laboratory test/x-ray (0.7%), Contraceptive received from service provider (10.1%), Contraceptive purchased from pharmacy (1.1%), Consultation fee (1.9%) and others (1.1%), with Margibi (10.8%) and Grand Bassa (8.1%) compared to others counties.

Access to reproductive health services is enhanced with the presence of good road networks with high connectivity and efficient transport systems. The modes of transport used by clients to visit the family planning clinics are: walking (62.8 percent), bicycle (5 percent), motorcycle (28.2 percent), bus or taxi (3.2 percent) and 0.9 percent of private vehicles and other means of transport. Most of the people in the counties walk to the health facilities with percentages ranging from 40.2% in Grand Bassa to 95% in Gbarpolu.

The 2018 reproductive health commodities and security survey provides very essential information at this time for decision-making and thus the need for the development of an improvement plan which brings together all key stakeholders that can be used to strengthen the current weaknesses in the provision of reproductive health services in Liberia.



## **SECTION I: INTRODUCTION**

### Country Background Information

Liberia population is currently projected at 4 million<sup>2</sup> with 53.9 years and 2.1 as life expectancy and annual growth rate respectively<sup>3,4</sup> and a replication time of 40 years<sup>5</sup>. By 2038, projection shows that the working population would double, hence adding more pressure on the job market with the number of women of child-bearing age most likely to be increased by 86 per cent. However, Liberia could benefit from its demographic bonus before its 2008 population doubles by 2048 if education and healthcare are affected by the right investments.

More than half (three-quarters) of the countries population is youth below 35 years (63 per cent is less than 25 years old and 32.8 per cent is 10-24 years old)<sup>6</sup>. Among the youth are the excombatants, face formidable challenges, such high 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 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 education being mothers, it shows that teenage pregnancy a significant contributor to the dropout rate among this group<sup>7</sup>, when compared with the 17 per cent who have secondary and tertiary education<sup>8</sup>. 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 pregnancies experienced in this group, 26 per cent are unintended and out of this number, 30 per cent result into unsafe abortion<sup>9</sup>.

Again, women of childbearing age (15-49) accounts for 24.9 percent of the population. Whereas the fertility rate of the population has declined from 6.2 in 2000 to 5.2 in 2007, socio-cultural norms

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<sup>2</sup> Republic of Liberia (September 2011a) – 2008 Population and Housing Census: Analytical Report on Population Projections, Liberia Institute of Statistics and Geo-Information Services (LISGIS), Monrovia, Liberia: Table 4.1, (median variant), p.20.

<sup>3</sup> *Ib. id.*: Table 3.1, p.16.

<sup>4</sup> Republic of Liberia (September 2011b) – 2008 Population and Housing Census: Analytical Report on Population Size and Composition, Liberia Institute of Statistics and Geo-Information Services (LISGIS), Monrovia, Liberia: Fact Sheet, p. viii.

<sup>5</sup> Republic of Liberia (September 2011a), *op. cit.*: p.19

<sup>6</sup> 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.

<sup>7</sup> 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.

<sup>8</sup> UNFPA (2012) – ‘Country Programme Document for Liberia 2013-2017, United Nations Population Fund, Liberia Country Office, Mamba Point, Monrovia, Liberia: para.3.

<sup>9</sup> Ministry of Health (March 2011), *op. cit.*: p.5.



preferring high fertility are dominant, making for a population increase over the next generation even if the 2013 total fertility rate of 4.7<sup>10</sup> were to be brought down to a replacement level.

Fertility rates differ among rural and urban women; according to the current observed age specific fertility rate (ASFR), during reproductive age, rural women will give birth to over two more children than their urban counterparts (6.1 and 3.8, respectively). In addition, among women aged 20-24, the highest current fertility is experienced. On the other hand, for females at ages 15-19, ASFRs is naturally higher than those for women 35 years and above<sup>11</sup>. 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 deaths.

The high number of teenage pregnancy means that sociologically and biologically, they are not prepared to withstand the burden imposed by pregnancy upon them. They may be deserted by their partners upon knowing of the pregnancy, and because of their immaturity (physiological) to have children, complications of pregnancy like fistulas can occur. Although the country lacks national representative data on fistulas prevalence, patients whose cases were repaired between 2007 and 2011, had an average age range of 11-20 years.

There is still a large accumulation of obstetric fistula cases demanding treatment<sup>12</sup>.

According to the DHS 2019, one in three currently married women has an unmet need for family planning (33%) compared to 34% in 2013. One in four married women have a met need for family planning (25%)—that is, they are currently using a contraceptive method and this has increased since 2013, when 20% of women had a met need for family planning.

The total demand for family planning among currently married women is 58%, and the total demand satisfied is 43%; this demand is satisfied almost entirely by modern methods (41%). Thus, if all married women who said they want to space or limit their children were to use family planning methods, the contraceptive prevalence rate (CPR) would more than double, from 25% to 58% in 2013 and 2019 respectively.

The used of modern contraceptive has also increased considerably over time among sexually active unmarried women, from 27% in 2007 to 37% in 2013 and 46% in 2019-20.

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<sup>10</sup> LISGIS and ICF International – ‘Liberia Demographic and Health Survey 2013 and 2019: Preliminary Report’, Liberia Institute of Statistics and Geo-Information Services (LISGIS), Monrovia, Liberia and Measure DHS, ICF International, Calverton, Maryland, USA: Table 3, p.9.

<sup>11</sup> *Ib. id.*

<sup>12</sup> UNFPA (2012), *op. cit.*: para. 6.

An alarming Maternal mortality ratio of 1,072 per 100, 000 live births in 2013<sup>13</sup>, an increase when compared to the 2007 (994 per 100,000 live births). Figure that almost triples the sub-Saharan Africa's of 450 per 100,000 live births. Maternal deaths are prevalent among women below 35 years of age. Complications of pregnancy and delivery, particularly hypertension in pregnancy, obstructed labour, ante and postpartum haemorrhage, sepsis, unsafe abortion, toxemia and anaemia are the underlying factors for the increased maternal mortality ratio (1072)<sup>14</sup>. Other factors include but are not limited to inadequacy of comprehensive reproductive health services to deal with these clinical problems. Outside of the clinical settings lie poverty, inadequacy of road and transport networks leading to low accessibility of certain communities to service delivery points, male-controlled practices affecting the status of women, the occurrence of the “three (or four) delays model” and harmful traditional practices.

The 2019 Liberia Demographic and Health Survey (LDHS) put neonatal mortality rate at 26 and post-neonatal mortality rate at 28. The key causes of neonatal mortality are asphyxia, sepsis, complications from pre-term birth and pneumonia. Approximately 45 and 75 per cent of neonatal deaths happened during/or within the first day and week of life respectively. Sadly, the main reason of maternal and neonatal mortality is that they are preventable or treatable in totality with the availability of emergency obstetric care, skilled birth attendance and adequate postpartum care<sup>15</sup>. The inspiring characteristic of mortality experience of children in Liberia is that there is a decline as the year goes by. Like in the 2013 Liberia Demographic and Health Survey (LDHS) revealed. However, the 2019 DHS reveals an increased infant mortality with 63% when compared to 2013. For the past 15 years, there have been rapid declines in the mortality levels as shown in (Table 1).

Table 1: Comparing the Trends in Early Childhood Mortality Rates over 13-year period (2007-2019)

Source of Data and Date	Infant Mortality Rate (1q0)	Child Mortality Rate (4q1)	Under-5 Mortality Rate (5q0)
2019 Liberia Demographic & Health Survey <sup>16</sup>	63	33	93
2013 Liberia Demographic & Health Survey <sup>17</sup>	54	42	94
2008 Population & Housing Census <sup>18</sup>	78	41	119

<sup>13</sup> Republic of Liberia – Liberia Demographic and Health Survey. Accessed March 2018.

<sup>14</sup> Ministry of Health (July 2012) – Accelerated Action Plan to Reduce Maternal Mortality and Neonatal Mortality, Family Health Division, Ministry of Health, Government of Liberia: p.11; “citing” Republic of Liberia (2012) – ‘One Year Summary Report of Maternal and Newborn Mortality in Liberia’, Ministry of Health, Republic of Liberia.

<sup>15</sup> *Ib. id.*

<sup>16</sup> LISGIS and ICF International (November 2019), *op. cit.*: pp. 11-12 and Table 6.

<sup>17</sup> LISGIS and ICF International (November 2013), *op. cit.*: pp. 11-12 and Table 6.

<sup>18</sup> Republic of Liberia (September 2011d) – 2008 Population and Housing Census: Analytical Report on Mortality, Liberia Institute of Statistics and Geo-Information Services (LISGIS), Monrovia, Liberia: Section 2.4, pp.6-8.

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2007 Liberia Demographic & Health Survey <sup>19</sup>	71	41	110
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As expected, majority of health facilities in Liberia are Clinic constituting 87.7%, Health Centres 7.5% and Hospitals 4.9%; and a little over half (56.7%) of the facilities are located in the rural areas according to SARA Report 2018<sup>20</sup>.

The same source reveals the health facility density of Liberia (facilities per 10,000 persons) to be 1.95 (as compared to 1.7 in 2016), though lower than the recommended WHO average of 2 per 10,000 population, there has been an increase compared to 2016.

The availability of core-health care workers is key to the provision of quality health care services. The SARA 2018 reveals the availability of core health workers at 11 health workers per 10,000 population as opposed to 11.4 in 2016. Majority of births (84%) in Liberia are assisted by skilled medical professional. This is a considerable increase from the 2013 LDHS, when only 61% of births were attended by a skilled provider. Assistance at delivery by a skilled provider is more common in urban (89%) than rural (79%) areas. There is a good deal of variation between regions and counties. Among regions, assistance at delivery is highest in North Central (92%) and lowest in North Western (78%). In the counties, delivery by a skilled provider ranges from 51% in Gbarpolu to 97% in Lofa.<sup>21</sup> **Admst these gains, a lot of work needs to be done.**

**Antenatal Care Services (ANC)** services are offered in all public health facilities as per policy. According to SARA 2018, 87% (765 health facilities) of health facilities offer ANC services, while 75% (as compared to 48% in 2016) had guidelines available for antenatal care; 90% had blood pressure apparatus; 84% (as opposed to 87% in 2016) had Folic Acid tablets and 78% had Iron tablets; 79% (as opposed to 83% in 2016) had Tetanus toxoid vaccine and 85% for IPT drug as compared to 83% in 2016.

**The availability of Basic Obstetric and obstetric care is key to ensure safe delivery.** In Liberia, 85% of health facilities offered delivery services. The readiness score for health facilities with Guidelines for essential childbirth care was 62% as compared to 52% in 2016. Also, comprehensive emergency obstetric care was available in 60% of hospitals as compared to 51% in 2016. Caesarean section was provided in 89% of the hospitals and 12% of the health centers in 2018 compared to 80% and 2% in Hospitals and Health centers in 2016.

However, the current high maternal and child mortality situation is a disaster, but a logical assumption can be made that there exist an opportunity that when resources are adequately committed to a cost-effective health services and commodities, mortality can be considerably reduced in shorter time<sup>22</sup>.

Table 2 below shows a summary of general service availability by counties, in 2018 SARA.

<sup>19</sup> Republic of Liberia (February 2010) – National Sexual and Reproductive Health Policy, Ministry of Health, Republic of Liberia: p. 5.

<sup>20</sup> SARA 2018 Final Report-Ministry of Health

<sup>21</sup> LISGIS and ICF International, 2013 & 2019

<sup>22</sup> See, for example, UNFPA Sierra Leone (August 2011) – ‘Population, Reproductive Health, HIV/AIDS and Gender (PRHG) Analysis’, UNFPA, Freetown, Sierra Leone: p.17.



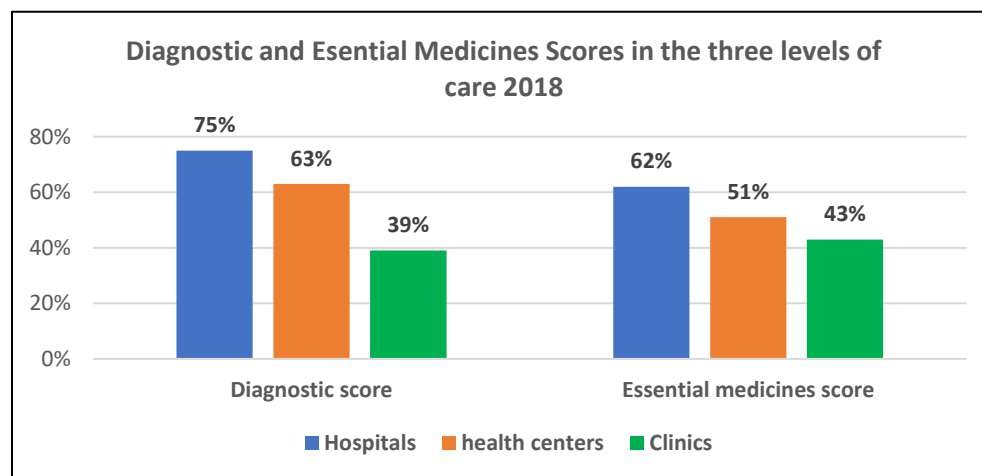
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Table 2: Summary of General Service availability by counties, Liberia 2018

Row Labels	In patient Beds per 10,000 population	Health facility density per 10,000	Health Work force density per 10,000	Out patient Utilization per 10,000
Bomi	18.2	2.2	14.4	1.1
Bong	16.5	1.3	9.9	1.1
Gbarpolu	11.6	1.5	7.3	0.68
Grand Bassa	12.6	1.3	7.1	1.1
Grand Cape Mt	5.6	2.2	7.7	0.84
Grand Gedeh	14.9	1.6	10.5	1.1
Grand Kru	25.0	2.7	12.3	1.7
Lofa	22.6	1.7	9.9	1.6
Margibi	24.3	2.1	10.6	1.1
Maryland	13.9	1.6	9.6	1.1
Montserrado	18.4	2.4	14.0	1.1
Nimba	20.3	1.3	7.7	1.1
River Gee	10.6	2.4	9.6	1.4
Rivercess	14.5	2.2	6.4	1.1
Sinoe	17.4	3.6	10.8	1.3
Grand Total	16.4	1.95	10.7	1.12

Figure 2: Distribution of **Diagnostic and Essential Medicines Scores by Health Facility Level**



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By 2030, the National Vision expects a country that will develop a system to become a middle income and prosperous by 2030<sup>23</sup> “... supportive of social capital development” and with a clear strategy for operationalization that includes (among others): Developing policy measures to address issues of youth education, responsibility and empowerment, and strengthening rights, including gender-based rights, human and child rights. But the population characteristics present huge challenges to the nation’s development aspirations. Liberia’s vision of being among the middle-income countries by 2030 is closely intertwined with the development of its human capital through the health sector.

Failure for health indicators to meet minimum internationally accepted standards have had a trickle-down effect on the achievement of the MDGs, unless these challenges are addressed, it is difficult to envisaged that the SDGs will as well be achieved. Progress towards improvement of the health status of the population had been marred by systemic deficiencies coupled with the occurrence of multiple outbreaks including Ebola and now COVID\_19 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 sector, frequent stock outs due to poor logistic management systems, ineffective private sector involvement, inadequate and ineffective budgetary allocation and inadequate health infrastructure<sup>24</sup>.

Children under five and all women of childbearing ages are at high risk within the health sector. With respect to high mortality and morbidity, the age and sex of these groups have exposed them to lack access to basic social services. Using the coverage rates in 2016 for the Ministry of Health – there are 234 physicians; 3,077 nurses, and the health expenditure of US\$ 29- and examining trends in healthcare needs under the medium fertility scenario, the projected needs arrived at are displayed in Table 2.

This demonstrates a need for 647 more physicians, 3,218 nurses, 821 health centers, 37 hospitals are required, over 41 million dollars additional annual healthcare expenditure and about 2.1 million persons at high risk by the year 2028 according to the Human Resource for Health census, 2016 when matched with WHO’s level considering 2018 projection. It should be noted that these required numbers of physicians and nurses are the maximum and do not take into consideration those who retire during the period or cease

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<sup>23</sup> National Vision 2013 – ‘Draft Vision Statement (Gbangba Declaration)’, Gbangba, Bong County, Liberia: 11<sup>th</sup> December 2012.

<sup>24</sup> 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.

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to serve due to death, immigration, change of jobs and other reasons).<sup>25</sup> See below in table 3 for distribution.

Table 3: Projected Number of Physicians, Nurses, Primary Health Centers, Hospitals, Annual Expenditure and Population at High risk by 2028, Liberia.

Health Sector Needs	Projection	2008	2013	2018	2023	2028
Physicians required	Current situation	113	128	142	157	173
	WHO level <sup>26</sup>	699	877	881	976	1073
Nurses required	Current situation	1,399	1,573	1,756	1,941	2,129
	WHO level <sup>27</sup>	4,989	5,624	6,295	6,974	7,663
Health Centers required (Private & Public)		467	525	586	648	711
Hospitals required		31	35	39	43	47
Additional Annual Health Expenditure (millions US\$)		101.3	113.9	127.1	140.5	142.3
Population at high risk (millions)		1.4	1.6	1.8	1.9	2.1

Source: Republic of Liberia (September 2011a) – 2008 Population and Housing Census: Analytical Report on Population Projections, Liberia Institute of Statistics and Geo-Information Services (LISGIS), Monrovia, Liberia: Table 6.3, p.29.

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<sup>28</sup> and the associated National Sexual and Reproductive Health Policy<sup>29</sup>. 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

<sup>25</sup> Republic of Liberia (March 2018) – 2016 Human Resource for Health Census p.20: Analytical Report on Population Projections, Liberia Institute of Statistics and Geo-Information Services (LISGIS) 2008, Monrovia, Liberia: pp.28-29.

<sup>26</sup> Estimation of Physicians required, based on WHO Doctor Patient Ratio of 1:5,000

<sup>27</sup> Estimation of Nurses required, based on WHO Nurse Patient Ratio of 1:700

<sup>28</sup> 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

<sup>29</sup> Republic of Liberia (March 2011b) – National Sexual and Reproductive Health Policy, Ministry of Health, Monrovia, Republic of Liberia

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government<sup>30</sup>. The supply Chain Master Plan (SCMP) was developed in 2010 as a detailed strategic road map for building a strong public health supply chain in the country. Nevertheless, the outcomes of plan implementation vary. Achievements include: (a) asset of Supply Chain Management Unit (SCMU), and (b) the roll out of the Standard Operating Procedures (SOPs) and Logistic Management Information System (LMIS).

With the big difference between what is in stock and what is required to make a significant impact on the reproductive health situation of the population, UNFPA signed a Memorandum of Understanding with Government of Liberia for technical and financial support for the purchase and security of reproductive health drugs and commodities. In 2012, Liberia was upgraded from a Stream 2 to Stream 1 Country on UNFPA's Global Program to enhance Reproductive Health Commodity Security (GPRHCS). GPRHCS is a UNFPA flagship program 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 [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.

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<sup>30</sup> Republic of Liberia (December 2008) - National Strategic Plan for Comprehensive Condom Programming in Liberia (2009-2013), Ministry of Health, Monrovia, Republic of Liberia

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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 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
8. To appraise and assess clients' perception about the cost for family planning services

### **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 GPRHCS 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;

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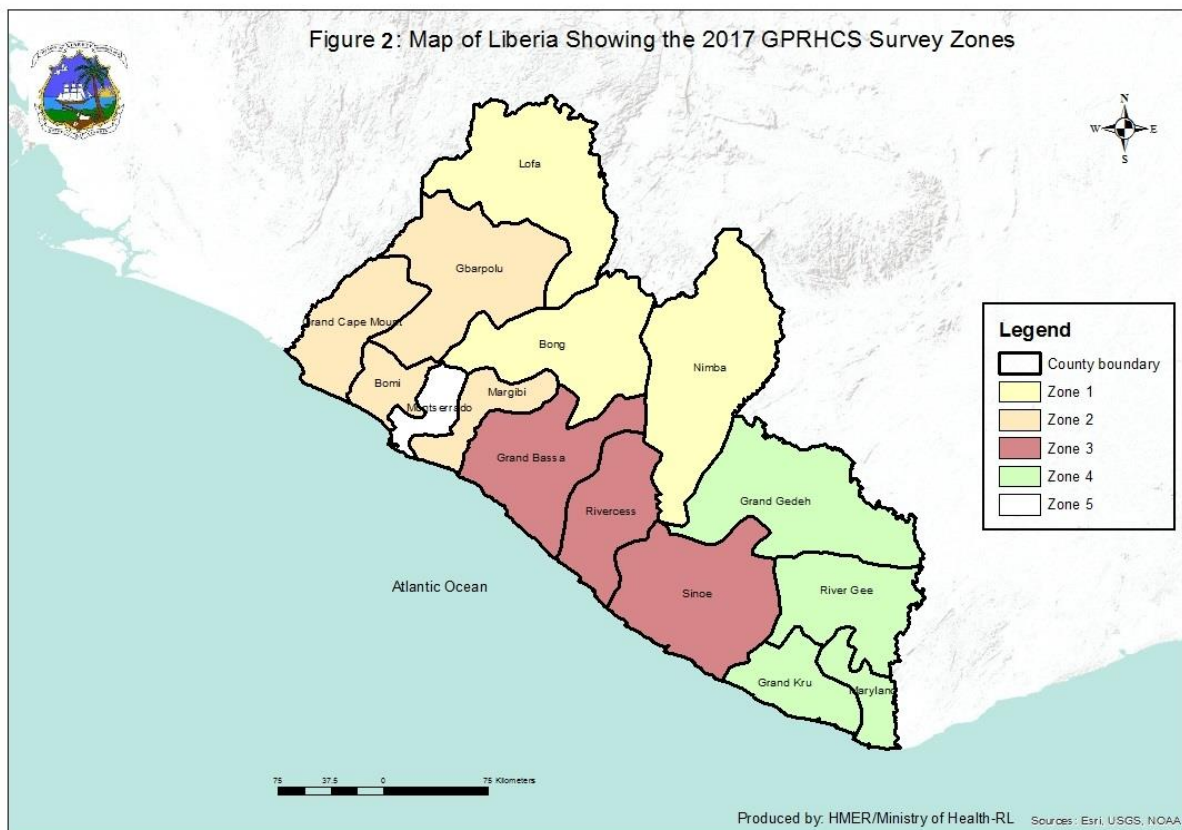


2. Zone 2: Montserrado County.
3. Zone 3: Bong, Nimba and Lofa Counties;
4. Zone 4: Grand Bassa, River Cess and Sinoe Counties;
5. Zone 5: Grand Gedeh, River Gee, Maryland and Grand Kru Counties

The zones were created in such a 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 home to about 39 per cent of the service delivery points (Health facilities) in the country. The rest of the workload was virtually 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 2020 GPRHCS Survey Zones





## Methodology and Limitations

### 1.4.1 Survey Design and Sampling of Facilities

The GPRHCS 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 GPRHCS 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<sup>31</sup> 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

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<sup>31</sup> According to the WHO priority life-saving medicines, for women and children, 2012

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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.

**1.4.2 Sampling Frame**

The list of accredited health facilities (831) that operate in the Republic of Liberia for 2018 was generated from the Liberia Master Facilities Listing. The accreditation process takes into consideration the ability of a health facility to implement the Essential Package of Health Services (EPHS) and Standard Operating Procedures (SOP). An extract (650) of the 831-health facilities currently reporting through the Health Information System (HIS) was used as the sampling frame for this study as shown below in table 4.

Table 4: Types of functional health facilities in Liberia by County as of March 2020

County	Clinic	Health Center	Hospital	Grand Total
Bomi	24		1	25
Bong	39		3	42
Gbarpolu	14		1	15
Grand Bassa	28	1	3	32
Grand Cape Mount	30	2	1	33
Grand Gedeh	20	2	1	23
Grand Kru	14	4	1	19
Lofa	53	3	4	60
Margibi	39	11	2	52
Maryland	21	2	1	24
Montserrado	159	13	8	182
Nimba	61	6	4	72
River Gee	16	2	1	19
Rivercess	18	1	1	20
Sinoe	34		1	35
Grand Total	<b>570</b>	<b>47</b>	<b>31</b>	<b>650</b>

**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 5 below

#### 1.4.4.1 Calculation of Sample size

About sixteen percent (16%) of the total number of functional health facilities (650) in Liberia was systematically selected to form part of the 2020 reproductive health commodities and security survey. In this distribution, all Tertiary facilities (2) and non-specialized Secondary Hospitals (32) were all selected while about eleven percent (10.9%) of health centers and clinics (71 health facilities) combine were also selected for the survey.

One Hundred and four (104) health facilities out of the one hundred five (105) health facilities were assessed during the field exercise. The disaggregation by type is as follows:

- Tertiary Hospitals–2
- Secondary Health Facilities (Hospitals)-31
- Primary Health Facilities –(Clinic and Health Centers-71)

Health Facilities by ownership are as follows:

- Government/Public – 76
- Private-28

#### 1.4.4.2 Distribution of Sample Sizes for Counties

The table 5 below shows the distribution of health assessed by counties and by ownerships. The study reveals that Montserrado, which host Monrovia City, had the highest distribution (30.7%) of the overall sample size. These samples were formed based on probability proportionate to the size of the total health facilities in counties.

By default, government health facilities had the highest distribution of facilities assessed.



**Table 5: Distribution of Health Facilities Assessed by Counties**

Counties	Health Facility Distribution by Counties		Grand Total
	Government	Private	
Bomi	3	1	4
Bong	7	1	8
Gbarpolu	3		3
Grand Bassa	2	3	5
Grand Cape Mount	3	1	4
Grand Gedeh	3	1	4
Grand Kru	4		4
Lofa	4	4	8
Margibi	3	2	5
Maryland	3		3
Montserrado	22	10	32
Nimba	8	4	12
River Cess	4		4
River Gee	3	1	4
Sinoe	4		4
<b>Grand Total</b>	<b>76</b>	<b>28</b>	<b>104</b>

#### **1.4.5 Survey Instrument**

Since 2010, UNFPA, through the Global Program to enhance Reproductive Health Commodity Security (GPRHCS), has supported the conduct of an annual survey on the availability and stock-out of contraceptives and essential maternal health medicines in 13 GPRHCS Stream 1 countries. The focus of the past GPRHCS 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<sup>32</sup> 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 2020 round of GPRHCS surveys is an extensive revision of the 2018 instrument. The new instrument consists of two modules and 15 sections as follows, with additional questions for males and females condoms.

#### **MODULE 1: AVAILABILITY OF COMMODITIES AND SERVICES**

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- 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
- 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

MODULE 2: EXIT INTERVIEW - CLIENTS' PERCEPTION AND APPRAISAL OF COST FOR  
FAMILY PLANNING SERVICES

- Section 14: Exit Interview - Clients' perception
- Section 15: Exit Interview - Clients' appraisal of cost for family planning services

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 20 data collectors, 5 supervisors and 5 coordinators. 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 table along with them sanitizers and facemask.



#### 1.4.7 Data Collection

The field data collection exercise lasted for a period of 12 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 five national coordinators who monitored the fieldwork in various Counties 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 five teams of 4 data collectors, each team supervised by a supervisor. Each team was responsible for collecting data from the assigned health facilities as well as carry out exit interviews.

#### **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 supervisors, they were responsible for the assessment teams' management and the initial review of the completed data collection instruments. Each collection form was checked for 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 second part of the questionnaire concerned exit interviews with clients. The clients of Health facilities were interviewed as they left the health facilities to learn about their opinion and satisfaction with the services received and their appraisal of various cost elements related to accessing family planning services.

The teams' supervisors 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.

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Although client exit interviews were not expected to be based on representative samples of the population, however, efforts were made to ensure that they are representative of those who visited the facility on the day of the survey. In this respect, the interviewers ensured that those interviewed were systematically selected. Therefore;

In primary Health facilities, the interviewer talked to atleast 3-5 clients visiting the facility on the day the client interview while for secondary and tertiary Health facilities, with high attendance, the interviewer talked to a sample of five clients.

However, due to the limited time for the field exercise and for the fact clients accessing family planning services scheduled themselves or visit the facilities based on recommended visits, it was difficult to identify and interview the proposed sample per facility type. About 299 clients were interviewed during the exit interview.

It was recognised that these limits depended on the number who attended the Health facilities at the time of the survey. It was, therefore, left to the survey team of each county to devise strategies for collecting information from as many persons as possible. Depending on the county, specific times of the day (e.g., morning hours), specific days (market days for some rural communities), or designated clinic days, etc., could be explored to reach as many attendees as was possible.

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 Du-Side hospital. Also common to almost every study in Liberia is the bad road and network connection across the country. There were less facilities (104) this time around though similar to the 2018 survey and data collection took place for a minimum time of 12 days including traveling. 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.

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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.



Part Four of the report focused on the results of the exit interview in three subsections. Part 4.1 presented the background characteristics of the clients. Part 4.2 presented information on clients' perception regarding various aspects of service delivery and Part 4.3 dealt with Clients' estimation of the cost of family planning services. In Part 5 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 GPRHCS 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<sup>33</sup>. 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.

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<sup>33</sup> Ministry of Health & Social Welfare, Essential Package of Health Services , 2011





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 Sustainable Development Goals (SDGs) 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

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

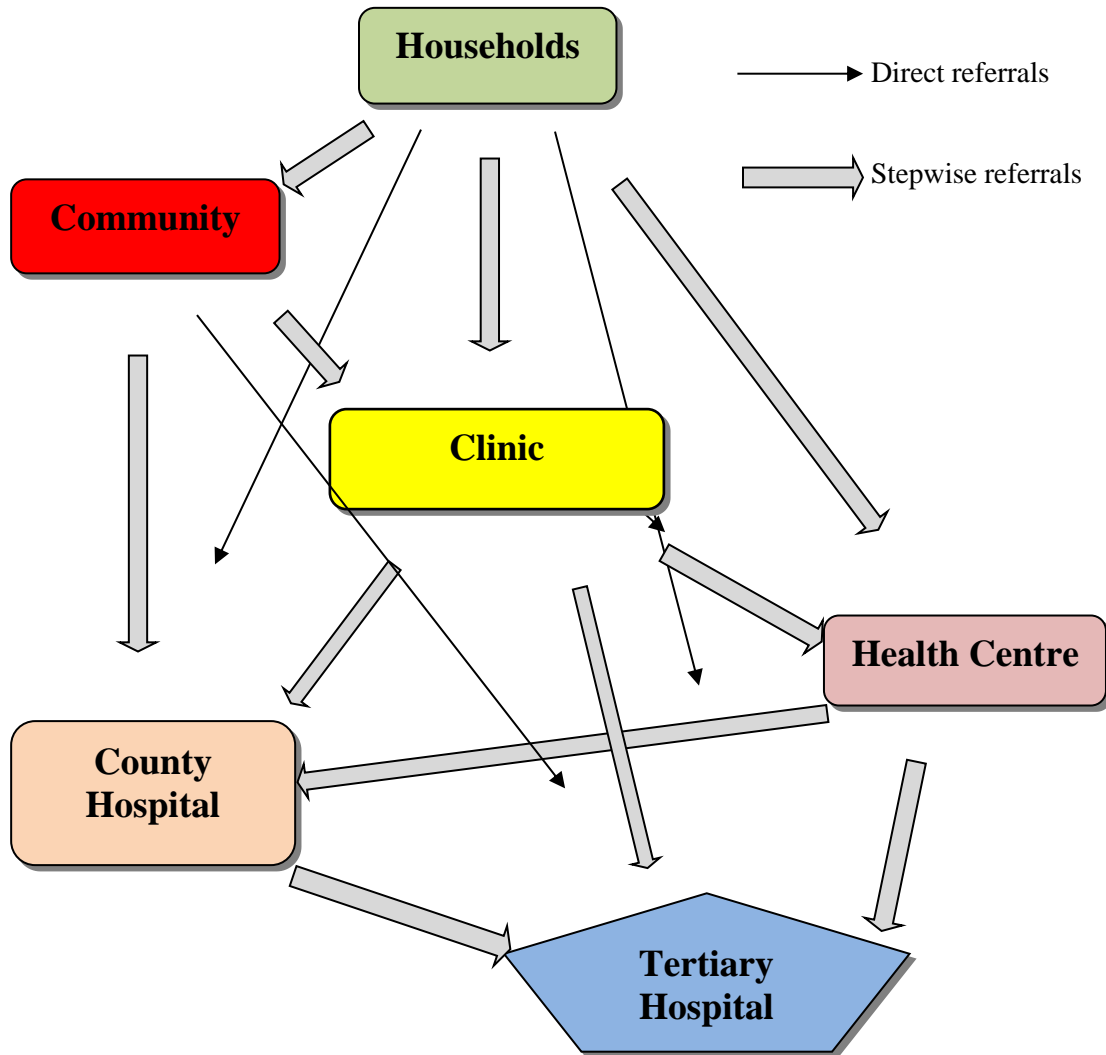
The primary level is composed of services provided at the community level. The community health volunteers include Household Health Promoters (HHPs), Trained Traditional Midwives (TTMs) and community health volunteers. Thus, the community level services include standard outreach, health promotion and 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 (Figure 3). 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.

Figure 3: Schematic Flow of Health Referral System in Liberia.



### 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 an 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 2) 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, it 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.

Family planning services have 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 primary goal of the policy is to improve the quality of life of the people. One of the targets is to “increase the use of modern contraceptive among all sexually active women to 68 percent in 2020<sup>34</sup>”. The strategic considerations identified education, dissemination of information on modern contraceptives, training of health workers and active involvement of men for the availability of comprehensive range of modern contraceptive methods to individuals and couples of reproductive ages and increase to obstetrics care.

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

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<sup>34</sup> Republic of Liberia, National Population for Social and Economic Development, Monrovia, Liberia (2005 edition)

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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<sup>35</sup>.

**Table 7: 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

<sup>35</sup> Ministry of Health, Essential Health Package Services, July 2011, Monrovia, Liberia



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**

Liberia has one of the highest maternal and neonatal mortality in the world. While there are evidences of improvement in the provision of MCH services such basic and comprehensive EmONC serices as well as improved health facility based delivery and delivery by skilled staffs, there are still challenges in the provision and availability of essential lifesaving maternal and reproductive health medicines to health facilities. In order to attain the desire goal of reducing maternal and newborn mortality, Liberia has 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 and Neonatal Mortality, the RMNCAH investment case, etc., all which have been embedded in the Pro-poor Agenda for Prosperity and Development (PAPD).

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.

Table 6: 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	Yes	Yes	Yes	Yes

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falciparum malaria				
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

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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



### 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 7: Basic and Comprehensive Emergency Obstetric Care Guidelines and Protocols

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

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

### 2.3.2.3 Postnatal Care

Postnatal care is essential for both mother and child to be treated for medical needs and provided social care for possible complications and problems occurring from delivery. It is period to make available to mother with important information on how to care for herself and child. This is so, because it is a period when eclampsia, puerperal sepsis and secondary haemorrhage may all be life-threatening. In addition, there may be a variety of other minor complaints that require advice or management.

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<sup>36</sup>.

<sup>36</sup> Ministry of Health, Essential Package of Health Services, July, 2011





Table 8: 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 Puerperium				
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 ophthalmia neonatorum	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

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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
Asphyxia	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 (kernicterus)	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

#### 2.3.2.4 Adolescents and Youth Specific SRH 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. Attention within the development community is increasingly focused on the young population given the size and that they are directly or indirectly linked to all goals of the SDGs.



**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<sup>37</sup>. 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 facilities 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.

**Table 9: Standards for the Provision of HIV and Sexually Transmitted Infections Services for Adolescent and Young People**

	Community	Public, Private (Non &	Public & Private Health	Public & Private hospitals	Pharmacies
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<sup>37</sup> 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

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		Profit) Clinic	Centers		
<b>HIV</b>					
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
<b>Sexual Transmitted Infections</b>					
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 10: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
<b>Family Planning</b>					
Information and Health	Yes	Yes	Yes	Yes	Yes

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Education/IPC					
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
<b>Adolescent Pregnancy</b>					
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
Intermittent 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 11: Standards for the Provision of Delivery Services for Adolescent and Young People**

<b>Delivery Services</b>					
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

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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.



### SECTION III: SURVEY FINDINGS

#### 3.1 General Information about the Health facilities

##### 3.1.1 HEALTH FACILITY Type and Services Provided

In Liberia, there are three classification of health facilities in the health system, namely they are primary, secondary and tertiary health facilities. The primary level of care consists of community-based distributors for certain products/services, primary healthcare clinic levels 1 and 2, and integrated outreach programs. Secondary care health facilities are health centres, which receive referrals from primary health clinics levels 1 and 2 and district and county hospitals that receive referrals from the community and district health systems. Health centers are the transition between primary and secondary levels of care and provide mostly primary healthcare and are the entry point for referrals from primary healthcare clinics. Tertiary healthcare facilities cater to the national referral health system.

Unlike the 2018 survey, health facilities forming part of the 2020 survey grouped health centers and clinics as primary, hospitals as secondary facilities, while only 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.

As shown in table 12 below, 98 percent of all health facilities assessed are providing family planning; while 97.6 percent are also providing maternal or reproductive health commodities and services. There is a decrease in those services provided when compare with the findings from 2018 which recorded 100%. All secondary hospitals and tertiary hospitals are providing both services at 100 percent.

Table 12: Percentage Distribution of Health facilities Providing Family Planning and Other Maternal Health Services: Liberia 2020

Healthcare Level	Distribution in Sample		Percentage Providing	
	Frequency	Percent	Family Planning	Other Maternal or Reproductive Health
Primary	71	68.3	97.2	95.8
Secondary	31	29.8	100	100.0
Tertiary	2	1.9	100	100.0
Total	104	100.0	98.1	97.1



### 3.1.2 Geographic Distribution of Facilities

Table 13 below discusses the distribution of health facilities at rural-urban levels as well as how county spreads them. Accordingly, the percentage of rural Health facilities offering family planning and reproductive health services are 100 percent and 98 percent respectively; those percentages are higher than family planning and reproductive health services provided at the urban level at 98 and 95. Percent respectively.

Overall, the distribution of counties by provision of family planning and maternal or reproductive health services revealed that all facilities assessed (in 14 out of the fifteen counties) are offering all these services except for Montserrado. See table Table 13 below for further distribution by counties.

Table 13: Distribution of Health facilities by Urban-Rural Residence and Spread by County:

Healthcare Level	Frequency	Percentage Providing	
		Family Planning	Maternal or Reproductive Health
<b>Rural-Urban Residence</b>			
Urban	43	95.1	95.1
Rural	61	100	100
Total	104	97.1	97.1
<b>Distribution by County</b>			
Bomi	4	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	4	100.0	100.0
Grand Kru	4	100.0	100.0
Lofa	8	100.0	100.0
Margibi	5	100.0	100.0
Maryland	3	100.0	100.0
Montserrado	32	90.6	90.6
Nimba	12	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	104	98.1	97.1
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### 3.1.3 Management of Facilities

In general, little over two-thirds of all health facilities in the country are owned by the Government of Liberia. With regards to non-governmental organizations, there are some arrangements made by MOH for some of those facilities to be managed by those NGOs. Table 14 reveals that family planning and other maternal or reproductive health services are offered 98.1% and 97% at all facilities sampled as compared to 100% in 2018 survey. This distribution shows a strong private sector involvement in the provision of family planning and maternal or reproductive health services.

Table 14: Percentage Distribution of Health facilities Providing Family Planning and Maternal Health Services by Management of Health facilities

Distribution by Ownership	Percentage Providing		
	Frequency	Family Planning	Maternal or Reproductive Health
Government	76	100.0	97.4
Private	26	92.3	96.2
Others	2	100.0	100.0
<b>Total</b>	<b>104</b>	<b>98.1</b>	<b>97.4</b>

## 3.2 Modern Contraceptives Offered by Facilities

### 3.2.1 Contraceptives Offered by Type of Facilities

As per national protocols, guidelines and/or laws concerning the provision of family planning methods at all levels of service delivery continuum<sup>38</sup>, across the nation. Largely, emergency contraception, oral pills, implants, male and female condoms, male and female sterilization, intrauterine devices (IUDs) and injectables are the nine types of modern methods of contraception that are provided in Liberia. At the other extreme, just about a third of the facilities are expected to offer male and female sterilisation. The rest of the modern contraceptive methods should be on offer at the various Health facilities in the country. Moreover, all the modern contraceptive methods are supposed to be offered at the two tertiary facilities.

<sup>38</sup> Reference to national protocols and regulations was introduced in the 2012 round of surveys to ensure that provision of family planning commodities and services are in line with government's set guidelines.

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Although short-term contraceptives (male and female condoms, emergency contraceptives, oral pills and injectables) should be offered at all the primary and tertiary Health facilities, some of the secondary Health facilities are not mandated to offer female condoms and injectables (Table 15). Over 93% and 63% of all health facilities compared to 91% and 47% in 2018 provide implants and IUDs. As expected, the provision of long lasting contraceptives such as male and female sterilization remains low at 21% and 30% and relatively the lowest in primary (clinics) facilities at 1.4%.

The provision of these requires the services of higher order medical personnel that are not part of the regular staffing of the primary Health facilities. Thus, such contraceptives are normally offered at secondary and tertiary health facilities as shown in the table below.

**Table 15: Percentage Distribution of Health facilities by Level of Service Delivery According to National Protocols/Guidelines Supposed to Offer Modern Contraceptives**

Modern Contraceptive Method offered	<u>Per Cent Supposed to Offer at Level of Service Delivery</u>			
	All Health facilities	Primary	Secondary	Tertiary
Male Condoms	97.8	97.2	96.8	100.0
Female Condoms	61.2	70.4	58.1	50.0
Oral Pills	98.4	98.6	96.8	100.0
Injectables	98.4	98.6	96.8	100.0
Emergency contraception	37.0	25.4	41.9	50.0
IUDs	63.2	67.6	67.7	50.0
Implants	93.8	90.1	93.5	100.0
Female Sterilization	30.1	1.4	51.6	50.0
Male Sterilization	21.7	1.4	25.8	50.0

**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 GPRHCS 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 contraceptive all levels as

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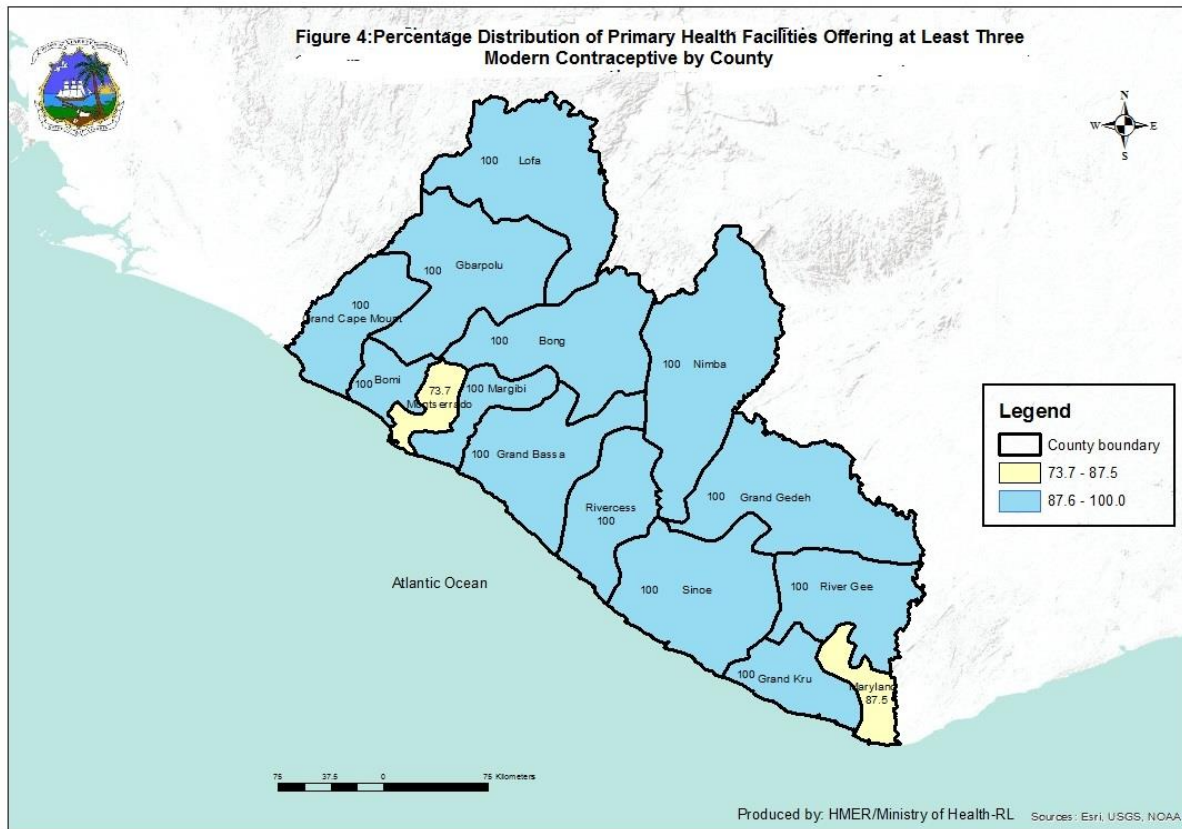
compare 95.2% in the 2018 and 89% in 2017 surveys. Comparison between facility types also shows similar trend of 97% for primary and 100% for both secondary and tertiary health facilities. Disaggregation by counties reveals that all counties assessed except Montserrado (93%) had all facilities (100%) offering at least three modern contraceptives. This finding has improved compared 87 of health facilities offering these services in 2018 findings. See table 16 below for further description.

Table 16: Percentage Distribution of Primary Health facilities offering At least Three Modern contraceptive methods by County

	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]
<b>Bomi</b>	100.0	0.0
<b>Bong</b>	100.0	0.0
<b>Grand Bassa</b>	100.0	0.0
<b>Grand Cape Mount</b>	100.0	0.0
<b>Grand Gedeh</b>	100.0	0.0
<b>Grand Kru</b>	100.0	0.0
<b>Lofa</b>	100.0	0.0
<b>Margibi</b>	100.0	0.0
<b>Maryland</b>	100.0	0.0
<b>Montserrado</b>	93.8	6.3
<b>Nimba</b>	100.0	0.0
<b>River Cess</b>	100.0	0.0
<b>Sinoe</b>	100.0	0.0
<b>River Gee</b>	100.0	0.0
<b>Gbarpolu</b>	100.0	0.0
<b>Total Percent</b>	98.1	1.9
<b>Primary</b>	97.2	2.8
<b>Secondary</b>	100.0	0.0
<b>Tertiary</b>	100.0	0.0
<b>Total</b>	98.1	1.9



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



Similarly, disaggregation by urban and rural shows that 100% of rural facilities offer at least three modern contraceptives as compared to 96.7% urban facilities. These show an increasing trend when compared to findings from the 2018 survey at both 98.4% and 90.5% (Table 17).

Distances away from the warehouse of regular supply depots did not seem to have much complications on the provision of supplies at health facilities as even health facilities above one hour and above still provide at least three modern contraceptives to their clients. These findings were the same in 2018.

Table 17 below shows detail breakdown.



Table 17: Health Facilities that offer at least 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	96.7	3.3
Rural	100.0	0.0
<b>Total</b>	<b>98.1</b>	<b>1.9</b>
Government	100	0
Private	92.0	8
<b>Total</b>	<b>98.1</b>	<b>1.9</b>
<b>0 - 4</b>	<b>95.7</b>	<b>4.3</b>
<b>5 - 9</b>	<b>100.0</b>	<b>0.0</b>
<b>10 - 14</b>	<b>0.0</b>	<b>0.0</b>
<b>15 - 19</b>	<b>100.0</b>	<b>0.0</b>
20 - 24	100.0	0.0
25 - 29	0.0	100.0
30 - 34	100.0	0.0
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
<b>Total</b>	<b>98.1</b>	<b>1.9</b>

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

Table below 18 shows the distribution of health facilities offering at least five modern contraceptives at the level of service delivery. On the overall, 88.5 compared to 68.6% (in 2018) of all health facilities assessed offer at least five or more modern contraceptives as part of their normal service delivery. Distribution by health facility types reveals 85.9%, 93% and 100% of primary, secondary and tertiary health facilities are providing at least five or more modern contraceptives as part of their normal service delivery. There is a noticeable increase from the 2018 at all health facility type. The distribution of facilities offering at least five (5) contraceptive methods as part of regular and normal services was disaggregated by urban and rural. About 93% of rural facilities compare to 85% of urban facilities offer contraceptives as per the above standard. This provision shows an increase in urban facilities offering at least five contraceptives compared to 59% in 2018.

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Similar distribution by county in table 18 below reveals that 11 out of 15 counties can boast of at least having facilities (91% above) that are offering at least five or more modern methods of contraceptive as part of their regular and normal service delivery. This is an improvement compared to 6 counties in 2018 particularly Montserrado and Grand Kru now have 80% and 100% of their facilities assessed offering at least five modern contraceptives compared to 50% in 2018. Further disaggregation by management type reveals that 89% and 88% of government and private managed facilities offer at least five modern contraceptives compared with 70% and 57% in 2018 findings. Figure 4 below shows graphical description.

**Table 18: 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
<b>Primary</b>	85.9	14.1
<b>Secondary</b>	93.5	6.5
<b>Tertiary</b>	100.0	0.0
<b>Total</b>	88.5	11.5
<b>Bomi</b>	100.0	0.0
<b>Bong</b>	75.0	25.0
<b>Grand Bassa</b>	100.0	0.0
<b>Grand Cape Mount</b>	100.0	0.0
<b>Grand Gedeh</b>	100.0	0.0
<b>Grand Kru</b>	100.0	0.0
<b>Lofa</b>	75.0	25.0
<b>Margibi</b>	80.0	20.0
<b>Maryland</b>	100.0	0.0
<b>Montserrado</b>	81.3	18.8
<b>Nimba</b>	91.7	8.3
<b>River Cess</b>	100.0	0.0
<b>Sinoe</b>	100.0	0.0
<b>River Gee</b>	100.0	0.0
<b>Gbarpolu</b>	100.0	0.0
<b>Total</b>	88.5	11.5
<b>Urban</b>	85.2	14.8
<b>Rural</b>	93.0	7.0
<b>Total</b>	88.5	11.5
<b>Government</b>	89.5	10.5
<b>Private</b>	88.0	12.0
<b>Others</b>	100.0	0.0
<b>Total</b>	89.3	10.7



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

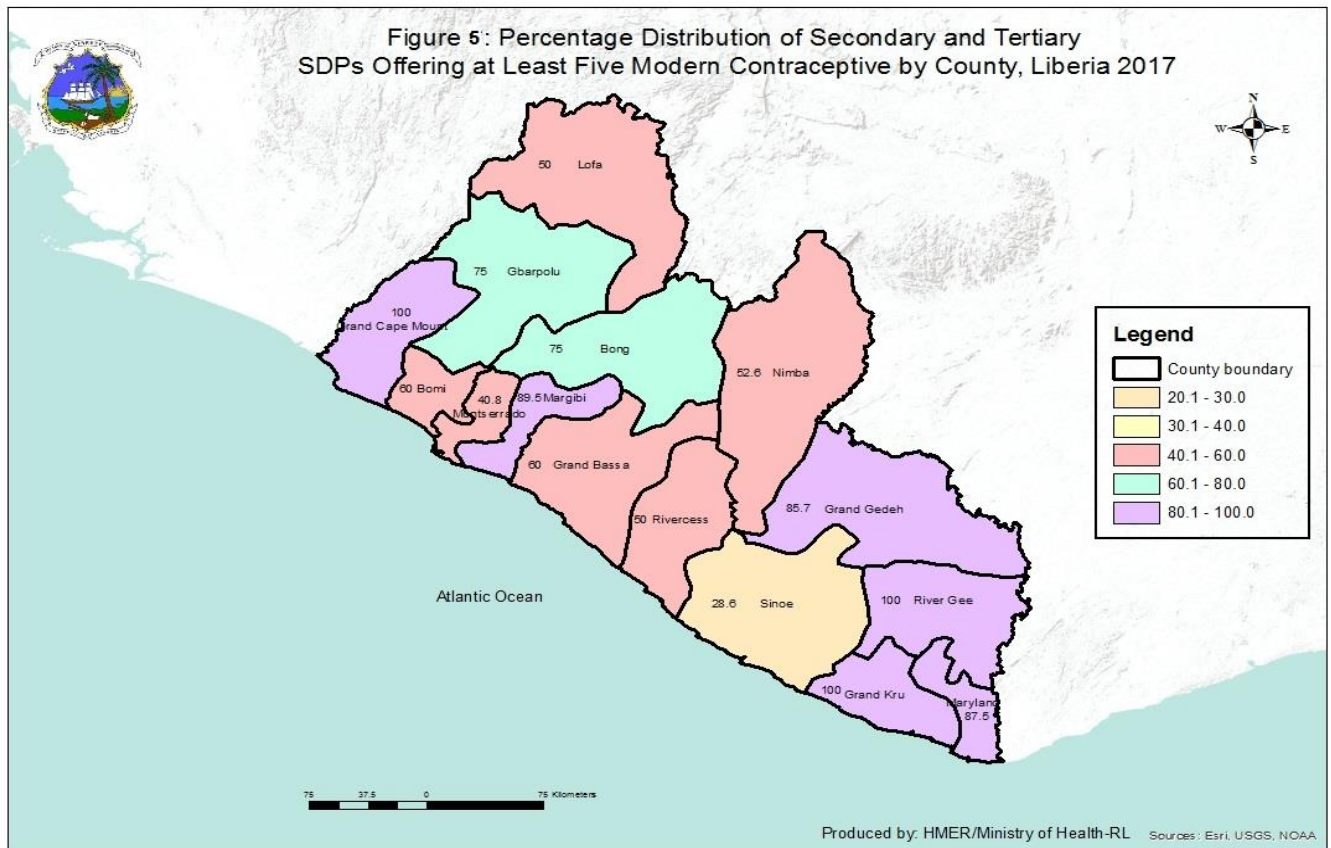


Table 19 below shows that about 83% of health facilities at one-hour distance or more offers at least five modern contraceptives compared to 66% in 2018. Again the findings in table 19 do not explain a significant trend or results associated with distance among health facilities assessed.

Table 19: 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	
0 - 4	100.0	0.0
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	100.0
30 - 34	100.0	0.0
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	60.0	40.0
One hour and over	83.9	16.1
Total	88.5	11.5

### 3.3 Availability of Maternal and Reproductive Health Medicines

The high level of maternal and neonatal morbidity and death rates in Liberia can be reduced significantly when there is an availability of maternal and reproductive health medicines or services. Maternal sepsis, severe pre-eclampsia and eclampsia, post-partum haemorrhage, pneumonia, sexually transmitted infections, tetanus in mothers and newborns, prevention of mother-to-child transmission of malaria, HIV, etc., preterm labour management, incomplete abortion and miscarriages incidences can be reduced when those medicines and vaccines are available.

The national protocol requests that gentamicin, metronidazole and tetanus toxoid are supposed to be offered at all health facilities. In addition, except for Mifepristone, Misoprostol and Nifedipine, at both secondary and tertiary health units, all drugs are supposed to be offered<sup>39</sup>.

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

The availability of Modern Contraceptives and Essential Lifesaving Maternal or Reproductive Health Medicines is undertaken annually specifically on 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”.

Using this indicator, 93% compared to 96.8 % (2018 survey) of health facilities have available seven essential lifesaving maternal and reproductive health medicines (table 23). This shows a decrease by 3% from 2018 survey.

Disaggregating the overall percentage for all facilities, tertiary level and secondary facilities scored 100 percent each, while primary level score 90%. These findings show similar trend when compare with the 2018 findings at 92% overall, 94%, 100% and 100% respectively.

Table 20 shows the percentage distribution of service delivery points with seven (including 2 essential) life-saving medicines by urban or rural. The urban-rural residence data reveals that 100% of urban (same in 2018 findings) Health facilities and 85% (95% in 2018) of rural Health facilities offered seven (including 2 essential) maternal/reproductive health medicines.

Though the rural zones where most Liberians live revealed high score, when compared to their life-saving importance, improvement is needed.



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At the county levels, the availability of seven essential lifesaving medicines was also analysed to see the aerial spread across the country (Table 20). According to the data, availability ranges from 66.7% in Maryland to 100.0% in Bomi, Gbarpolu, Grand Cape Mount, Grand Kru, Grand Gedeh, Rivercess, Montserrado, Nimba, Sinoe and River Gee (also see Figure 5). Despite the high score in Montserrado, there are at times an insufficient stock of those medicines a situation that has trickle down effects on clients because those private facilities charge consultation and in-patient bed fees and give prescriptions for patients to buy the required medicines outside due to its unavailability at the facility. The overall availability in Bong, Sinoe and Maryland is low, below national average of 81.1%.

Table 20: Percentage distribution of service delivery points with seven (including 2 essential) life-saving maternal/reproductive health medicines available by county, urban/rural residence and Ownership

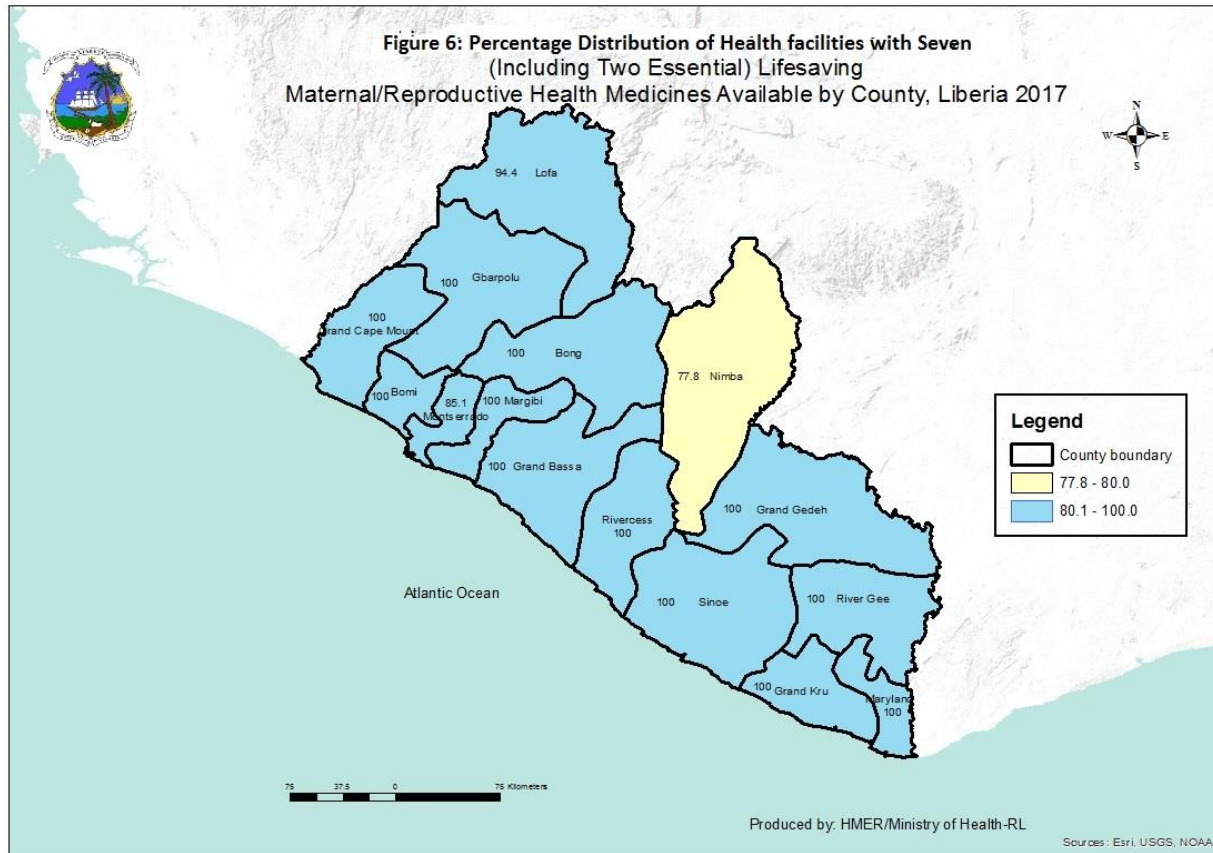
<b>Categories</b>	<b>Seven (including 2 essential) life-saving maternal/reproductive health medicines available</b>	<b>Seven (including 2 essential) life-saving maternal/reproductive health medicines not available</b>
<b>Primary</b>	90.6	9.4
<b>Secondary</b>	100.0	0.0
<b>Tertiary</b>	100.0	0.0
<b>Total</b>	93.8	6.2
<b>Urban</b>	100.0	0.0
<b>Rural</b>	85.7	14.3
<b>Total</b>	93.8	6.2
Government	93.2	6.8
Private	95.2	4.8
<b>Total</b>	93.8	6.2
<b>Bomi</b>	100.0	0.0
<b>Bong</b>	75.0	25.0
<b>Grand Bassa</b>	100.0	0.0
<b>Grand Cape Mount</b>	100.0	0.0
<b>Grand Gedeh</b>	100.0	0.0
<b>Grand Kru</b>	100.0	0.0
<b>Lofa</b>	87.5	12.5
<b>Margibi</b>	80.0	20.0
<b>Maryland</b>	66.7	33.3
<b>Montserrado</b>	100.0	0.0
<b>Nimba</b>	100.0	0.0
<b>River Cess</b>	100.0	0.0
<b>River Gee</b>	100.0	0.0
<b>Sinoe</b>	75.0	25.0

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<b>Gbarpolu</b>	100.0	0.0
<b>Total</b>	93.8	6.2

Figure 5: Percentage Distribution of Health facilities with Seven (including Two Essential) Lifesaving Maternal/Reproductive Health Medicines Available by County, Liberia 2017



Data on availability of seven lifesaving medicines by distance to the warehouse of regular supplies does not show how distances far from regular supplies affect the availability of maternal/reproductive drugs. All health facilities within the minutes of 0 to one hour and above are offering those drugs above the national average. However, facilities within 10-14 and 40-44 minutes were zero. There is no significant difference in the index with respect to facilities that are nearest to the warehouse (less than five minutes) and those that are farthest away (one hour and over). The lack of clarity means that distance might not be a defining factor in the availability of the drugs and other variables might be more important determinants. See table 21 below for further distribution.



**Table 21:** 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	Per Seven (including 2 essential) life-saving maternal/reproductive health medicines not available cent
	93.8	6.2
0 - 4	91.3	8.7
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	100.0	0.0
30 - 34	100.0	0.0
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	75.0	25.0
<b>One hour and over</b>	94.2	5.8

### 3.4 Incidence of ‘No Stock out’ of Modern Contraceptives

#### **3.4.1 ‘No Stock Out’ at the time of Survey**

‘No stock out’ of modern contraceptives may be taken to mean a period during which a health facility that is supposed to offer family planning services and commodities does not experience any short fall of supplies of one or more of the modern methods of contraception and, therefore, has supplies on hand to serve couples and individuals who would wish to avail themselves at the 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. The discussion of ‘no stock out’ in this part of the report focuses on its occurrence at the time of enumeration.

Table 22 below shows that there were about 32.7% of ‘stock out’ as compared to 28.6% % in 2018 study on the day of the survey at both primary and secondary level facilities, while the two tertiary facilities in the country were experiencing no stock out on the day of the survey same as in 2018. On the overall, 67.3 of the facilities assessed did not experience any form of stock out during the day of the survey, which shows over a 4% decreased from the 2018 study (71.7%). The occurrence of no stock out on the day of the survey by county is presented in also in table 22 below. Four counties (Bomi, Grand Bassa, River Cess and Gbarpolu) out of the fifteen counties of Liberia had 100% “no stock out” FP and MH commodities on the day of the assessment. Similarly two counties (Maryland and Grand Kru) had less than 35% of their facilities with “no stock out” on the day of the study. These are far below the national standards as such need speedy recovery. Though acceptable but require improvement; Bong, Lofa and River Gee counties had only 50% of all facilities assessed having “no stock out” on the days of the study. The urban and rural percentage distributions of available modern contraceptive methods were 71.2% and

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61.9% compared to 78.6% and 66.6% in 2018. These distributions show a decrease by about 8% and 5% when compared to 2018 survey. With high the proportion of urban Health facilities (see table 22) not experiencing stock out at the day of the survey, shows that majority of the medical stores are situated in urban places. The Stock levels in facilities of all management types on the day of enumeration were above satisfactory level 63% and 81% for public and private facilities when compared with national average of 43.1 percent. All facilities management levels were satisfactory but low when compared with 2018 survey.

**Table 22:** No stock out at the time of survey by type of facility, county, residence and ownership of facility

<b>Categories</b>	<b>Modern contraceptive method in stock at the time of the survey ['no stock out']</b>	<b>Modern contraceptive method not in stock at the time of the survey [stock out']</b>
<b>Primary</b>	63.2	36.8
<b>Secondary</b>	74.2	25.8
<b>Tertiary</b>	100.0	0.0
<b>Total</b>	67.3	32.7
<b>Bomi</b>	100.0	0.0
<b>Bong</b>	50.0	50.0
<b>Grand Bassa</b>	100.0	0.0
<b>Grand Cape Mount</b>	75.0	25.0
<b>Grand Gedeh</b>	75.0	25.0
<b>Grand Kru</b>	25.0	75.0
<b>Lofa</b>	50.0	50.0
<b>Margibi</b>	80.0	20.0
<b>Maryland</b>	33.3	66.7
<b>Montserrado</b>	55.2	44.8
<b>Nimba</b>	91.7	8.3
<b>River Cess</b>	100.0	0.0
<b>Sinoe</b>	75.0	25.0
<b>River Gee</b>	50.0	50.0
<b>Gbarpolu</b>	100.0	0.0
<b>Total</b>	67.3	32.7
<b>Urban</b>	71.2	28.8
<b>Rural</b>	61.9	38.1
<b>Total</b>	67.3	32.7
<b>Government</b>	63.2	36.8
<b>Private</b>	81.8	18.2
<b>Others</b>	50.0	50.0
<b>Total</b>	67.3	33.0



The distribution of service delivery points with ‘no stock out’ of any modern contraceptive method offered in line with national protocols, guidelines and/or laws on the day of the survey by distance from nearest warehouse/source of supplies is shown in (Table 23 below). On the overall, distance does not seem to show logical difference with the distribution of health facilities with Modern contraceptive method in stock on the day of the survey. Health facilities within 1 hour and over, 55-49, 30-34, 0-9 minutes had 60-69% of modern contraceptive methods on the day of the assessment. Also, facilities within 15-19, 25-29, 35-39 and 45-49 minutes distances away from warehouse had modern contraceptive methods in 100% of all health facilities. Table 23 below shows further distribution.

**Table 23:** 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	69.6	30.4
5 - 9	66.7	33.3
10 - 14	0.0	0.0
15 - 19	100.0	0.0
20 - 24	0.0	100.0
25 - 29	100.0	0.0
30 - 34	66.7	33.3
35 - 39	100.0	0.0%
40 - 44	0.0	0.0
45 - 49	100.0	0.0
50 - 54	25.0	75.0
55 - 59	60.0	40.0
One hour and over	67.3	32.7
<b>Total Health facilities</b>	<b>67.3</b>	<b>32.7</b>

#### 3.4.2 ‘No Stock Out’ in the Last Three Months of three modern contraceptives

The third indicator against which Stream One Countries are compared on UNFPA Global Programme to enhance Reproductive Health Commodity Security (GPRHCS) is the percentage of Health facilities with ‘no stock outs’ of modern contraceptives in the six months prior to the survey. But this was reduced to last three months. When the amount of stock out is small, people’s access is enhanced and vice versa.

The percentage distribution of facilities was disaggregated by primary, secondary, and tertiary levels with no stockout of three modern contraceptive methods offered in line with protocols. Table 24 shows that only 50% of tertiary facilities had three modern contraceptive methods in stock in the last three months before the assessment, while primary and secondary facilities were 71% and 82% respectively. In total, over two-third (78%) % of all levels of facilities had in stock at least three modern contraceptives in the

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last three months. The stock out situations across all Health facilities by type of facilities is satisfactory.

These findings have improved when compared to the 2018 survey.

Comparative analysis of rural/urban facility reveals almost equal proportion with rural facilities slightly doing better. Table 24 shows that 71% and 88% of urban and rural facilities compared to 52.4% and 22.2% in 2018 had no stockout in the last three months before the survey was conducted. This is a huge jump interms of improvement. Also, the distributions by ownership reveals 82% of government health facilities as compare to 63% private health facilities had at least three modern contraceptive methods in stock in the last three months before the survey. Distribution by counties shows that seven counties (Grand Cape Mount, Grand Kru, Maryland, River Cess, Sinoe, River Gee and Gbarpolu) had all facilities assessed with no stock out of at least 3 modern contraceptives in past three months before the day of the survey. See table 24 below for details.

Table 24: 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
<b>Primary</b>	82.4	17.6
<b>Secondary</b>	71.0	29.0
<b>Tertiary</b>	50.0	50.0
<b>Total</b>	78.2	21.8
<b>Bomi</b>	75.0	25.0
<b>Bong</b>	87.5	12.5
<b>Grand Bassa</b>	40.0	60.0
<b>Grand Cape Mount</b>	100.0	0.0
<b>Grand Gedeh</b>	75.0	25.0
<b>Grand Kru</b>	100.0	0.0
<b>Lofa</b>	75.0	25.0
<b>Margibi</b>	60.0	40.0
<b>Maryland</b>	100.0	0.0
<b>Montserrado</b>	79.3	20.7
<b>Nimba</b>	50.0	50.0
<b>River Cess</b>	100.0	0.0
<b>Sinoe</b>	100.0	0.0
<b>River Gee</b>	100.0	0.0
<b>Gbarpolu</b>	100.0	0.0
<b>Total</b>	78.2	21.8
<b>Urban</b>	71.2	28.8
<b>Rural</b>	88.1	11.9
<b>Total</b>	78.2	21.8
<b>Government</b>	82.9	17.1
<b>Private</b>	63.6	36.4
<b>Others</b>	50.0	50.0
<b>Total</b>	78.0	22.0



A cross tabulation of no stock out in the last three months with distance from the warehouse or institution of supply show that there is no clear-cut pattern in the behaviour of the variables in (Table 25) below. Even distances farthest from the health facilities did not pose challenge in terms of the availability of FP commodities. About 78% of health facilities one or more hours away from the warehouse or institution of supply had no stock out three months before the day of the survey. This is very a very important aspect of contraceptive service provision because continuous availability guarantees commodity security to the population. When the amount of stock out is small, people's access is enhanced and vice versa.

Table 25: 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
<b>0 - 4</b>	82.6	17.4
<b>5 - 9</b>	100.0	0.0
<b>10 - 14</b>	0.0	0.0
<b>15 - 19</b>	33.3	66.7
<b>20 - 24</b>	100.0	0.0
<b>25 - 29</b>	0.0	100.0
<b>30 - 34</b>	66.7	33.3
<b>35 - 39</b>	0.0	100.0
<b>40 - 44</b>	0.0	0.0
<b>45 - 49</b>	100.0	0.0
<b>50 - 54</b>	100.0	0.0
<b>55 - 59</b>	80.0	20.0
<b>One hour and over</b>	78.2	21.8
<b>Total Health facilities</b>	78.2	21.8



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

The distributions of no stock out of five modern contraceptives (table 26 below) in the last three months before the survey were distributed by type of facilities, counties, residence and ownership. On the overall, 94% of all health facilities assessed had no stock out of 5 modern contraceptives three months before the survey. Health facilities managed by government and private entities had 97% and 86% no stock out compared 90.2% and 61.9% in 2018. Distribution of service delivery points with no stock of five modern contraceptive by county (See Table 26 below) revealed that all counties had at least five modern contraceptive in stock three months before the day of the survey. Similarly the disaggregation by urban and rural had little difference with urban facilities offering at 89% as compared to 100% in rural.

Table 26: 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
<b>Primary</b>	94.1	5.9
<b>Secondary</b>	93.5	6.5
<b>Tertiary</b>	100.0	0.0
<b>Total</b>	94.1	5.9
<b>Bomi</b>	100.0	0.0
<b>Bong</b>	100.0	0.0
<b>Grand Bassa</b>	100.0	0.0
<b>Grand Cape Mount</b>	100.0	0.0
<b>Grand Gedeh</b>	75.0	25.0
<b>Grand Kru</b>	100.0	0.0
<b>Lofa</b>	100.0	0.0
<b>Margibi</b>	60.0	40.0
<b>Maryland</b>	100.0	0.0
<b>Montserrado</b>	89.7	10.3
<b>Nimba</b>	100.0	0.0
<b>River Cess</b>	100.0	0.0
<b>Sinoe</b>	100.0	0.0
<b>River Gee</b>	100.0	0.0
<b>Gbarpolu</b>	100.0	0.0
<b>Total</b>	94.1	5.9
<b>Urban</b>	89.8	10.2
<b>Rural</b>	100.0	0.0
<b>Total</b>	94.1	5.9



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<b>Government</b>	97.4	2.6
<b>Private</b>	86.4	13.6
<b>Others</b>	50.0	50.0
<b>Total</b>	94.0	6.0

Table 27 shows the distribution of Five [5] modern contraceptive methods in stock [‘no stock out’] in the last three months before the day of the survey. There is no significant difference between facilities located near the sources of regular supplies and those who are far away. In extreme cases, facilities farther from their supply center had no stock out of five modern contraceptives methods, while those in shorter distances had stock out. See table 27 below for details.

Table 27: ‘no stock out’ of five [5] modern contraceptives by distance (in minutes) from nearest warehouse/sources 2020

<b>Distance in minutes</b>	<b>Five [5] modern contraceptive methods in stock [‘no stock out’] in the last three months</b>	<b>Five [5] modern contraceptive methods not in stock [‘stock out’] in the last three months</b>
<b>0 - 4</b>	91.30	8.70
<b>5-9</b>	100.00	0.00
<b>10-14</b>	0.00	0.00
<b>15 - 19</b>	100.00	0.00
<b>20 - 24</b>	100.00	0.00
<b>25 - 29</b>	0.00	100.00
<b>30 - 34</b>	100.00	0.00
<b>35 - 39</b>	0.00	100.00
<b>40 - 44</b>	0.00	0.00
<b>45 - 49</b>	100.00	0.00
<b>50 - 54</b>	100.00	0.00
<b>55 - 59</b>	100.00	0.00
<b>One hour and over</b>	96.40	3.60
<b>Total</b>	94.10	5.90

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Table 28 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 (54.8%) and pharmacist (38.8%) are the two known cadre of health workers responsible for ordering of medical supplies. This finding is similar to 2018 survey. Surprisingly, not of the facilities assessed mentioned medical doctor as on of the cadres responsible for ordering drugs and medical supplies compared to 5% in 2018. Ordering of drug by officer in-charge mostly occur at primary health facilities (77.5%) while ordering by pharmacist mostly occur at secondary (83%) and tertiary (100%) health facilities, these have increase compared to 59% and 50% of orders in 2018 survey.

The urban-rural spread of the orders for medical supplies shows that Officers-in-Charge make the highest proportions of orders particularly in rural (86%) compared to 32% in urban. Similarly, most orders in the urban areas are provided by pharmacist (59%) compared to 9% in rural health facilities Pharmacists are far more important in urban than rural areas eventhough most OICs are nurses in Liberia.

**Table 28: Percentage distribution of Health facilities with persons responsible for ordering medical supplies by type of Health facilities 2020**

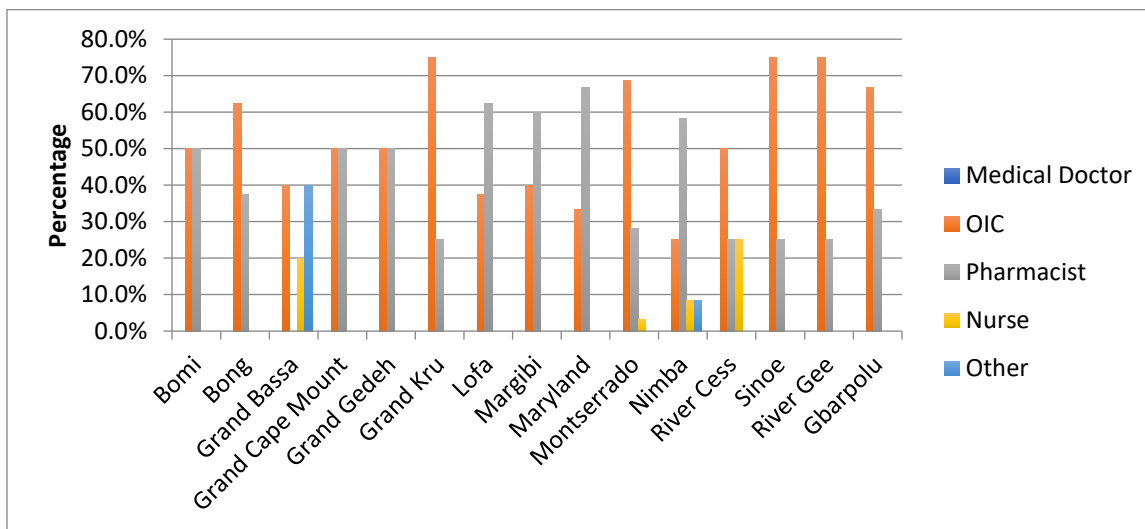
Type of Facility	Percentage				
	Medical Doctor	Officer-in-Charge	Pharmacist	Nurse	Others
Primary	0.0	77.5	16.9	4.2	1.4
Secondary	0.0	6.5	83.9	3.2	6.5
Tertiary	0.0	0.0	100.0	0.0	0.0
Total	0.0	54.8	38.5	3.8	2.9
Urban	0.0	32.8	59.0	4.9	3.3
Rural	0.0	86.0	9.3	2.3	2.3
Total	0.0	54.8	38.5	3.8	2.9
Government	0.0	59.2	36.8	3.9	0.0
Private	0.0	36.0	48.0	4.0	12.0
Others	0.0	100.0	0.0	0.0	0.0
Total	0.0	54.8	38.5	3.8	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 54% and 38% of orders made at the national level and are involved in the ordering of medical supplies for majority of the counties (Figure 6 below).

The other medical personnel involved in ordering medical supplies are Medical Doctors and Nurses, but these operate in selected counties and collective account for 3.8%. These trend of ordering medical supplies similar when compared with the 2018 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

The use of logistics forms for reporting and ordering supplies was recorded for 92.3% while 78.8% per cent of the Health facilities was verified by the enumerator, this show a decrease trend from 96 % and 83% in 2018. Also about 7.7% per cent of the Health facilities were not using logistics forms for reporting and ordering supplies compared to 3.8% in 2018.

The use of logistics forms at health facilities in 2020 have decreased compared to 2018. The 2020 survey recorded 76.1%, 87.1% and 50% compared to 95% of primary and 97.6% of the secondary and 100% of tertiary facilities that used logistics forms in 2018. In terms of county distribution, Gbarpolu (33.3%), Grand Gedeh (25%), Grand Kru (50%) and Montserrado (12.5%) had health facilities that reported not

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having logistics forms for recording. Disaggregation by ownership reveals that 94.7% of public health facilities and 84.6% private health facilities had logistics forms for recording during the day of the survey. In the urban areas, 8.1% of the Health facilities do not have logistics forms compared to 6.9% in the rural areas. To use the logistics forms, the re-supplies for the contraceptives will have to be determined or quantified. On the overall, Staff members of the Health facilities undertake 78.8% of the quantification in 2020 compared to 69% in 2018 while about 11.5% of the quantification is resupplied by their warehouses or the National Drug Service. Nine of the counties have all their resupply quantities determined by staff members of the Health facilities, while only Grand Bassa 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 (58.7%) while regional/county warehouse accounts for 34.6% of all supplies. The increase in the supply of drugs from the central medical store (CMS) is influenced by the fact that almost all hospitals, and health facilities in Montsreado are supplied by the CMS. Some facilities also supplied by the regional depots are also at times supplied by the CMS. See description below in table table 41.

**Table 29. Main Source of Supplies by Health Facility Levels, Residence and Ownership**

<b>Main Source of Supplies by Health Facilities</b>			
<b>Health Facility Level</b>	<b>Central Medical Stores</b>	<b>Regional/district Warehouse or institution</b>	<b>Local medical store on the same site</b>
Primary	40.6	49.3	5.6
Secondary	96.8	3.2	3.2
Tertiary	100	0	0
<b>Total</b>	<b>58.7</b>	<b>34.6</b>	<b>5.8</b>
<b>Residence</b>			
Urban	80.3	13.1	9.8
Rural	27.9	65.1	0
<b>Total</b>	<b>58.7</b>	<b>34.6</b>	<b>5.8</b>
<b>Ownership</b>			
Government	59.2	40	3.9
Private	53.8	19.2	11.5
Others	100	0	0
<b>Total</b>	<b>58.7</b>	<b>34.6</b>	<b>5.8</b>

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The Responsibility for transportation of supplies by type of Health facilities when assessed for facilities types reveals that majority of the health facilities drugs and supplies are transported from national level (50%) followed by county level (37.5%) respectively.

Table 42 and 43 below provide detail description.

**Table 30** Distribution of main sources of supplies to facility by Facilitylevel, Ownership & Residence

Facility Level	National	County/District	Health Facility
Primary	31.0	50.7	18.3
Secondary	90.3	9.7	0.0
Tertiary	100.0	0.0	0.0
<b>Grand Total</b>	<b>50.0</b>	<b>37.5</b>	<b>12.5</b>
<b>Ownership</b>			
Government	56.6	43.4	0.0
Private	34.6	15.4	50.0
Others	0.0	100.0	0.0
<b>Grand Total</b>	<b>50.0</b>	<b>37.5</b>	<b>12.5</b>
<b>Residence</b>			
Rural	30.2	62.8	7.0
Urban	63.9	19.7	16.4
<b>Grand Total</b>	<b>50.0</b>	<b>37.5</b>	<b>12.5</b>

**Table 43:** Distribution of main sources of supplies to facility by County

County	National	County/District	Health Facility
Bomi	0.0	75.0	25.0
Bong	50.0	37.5	12.5
Gbarpolu	33.3	66.7	0.0
Grand Bassa	60.0	20.0	20.0
Grand Cape Mount	25.0	75.0	0.0
Grand Gedeh	25.0	50.0	25.0
Grand Kru	25.0	75.0	0.0
Lofa	50.0	25.0	25.0
Margibi	40.0	40.0	20.0
Maryland	0.0	100.0	0.0
Montserrado	78.1	6.3	15.6
Nimba	58.3	33.3	8.3

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River Cess	25.0	75.0	0.0
River Gee	25.0	75.0	0.0
Sinoe	25.0	75.0	0.0
<b>Grand Total</b>	<b>50.0</b>	<b>37.5</b>	<b>12.5</b>

The efficiency of the supply chain system based on the transportation and allied arrangements is summed up in the estimated length of time between order and receipt of supplies. The shorter the difference in time, the more effective the transportation and delivery arrangements and the reverse is also true. The survey reveals that in Liberia, about 30.8% and 13.5% of all supplies would be received within less than two weeks and more than two months respectively compared to 25.5 and 26.4% in 2018, see (Table 44). This shows an increase and high level of efficiency in health facilities that received their supplies in less than 2 weeks time. Also the higher percentage in facilities receiving supplies more than two months could be located in hard to reach areas, where facilities received their supplies every 3-month period.

About 48% of all health facilities would receive their supplies from one month to upto three months. Also, about 7.7% of all primary facilities received their supplies after 4 months, and upto 6 or more months. 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, 37.7% of health facilities received supplies in urban while 20.9% of rural facilities get supplies within similar time. Within four to six months, 53% of rural facilities received supplies against 36% of their urban counterparts. This is probably the reason 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 (53.4%) their supplies in less than a week compared to 22% of government facilities. Table 44 below shows further distribution (see table 44 below).

Table 31: 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 2020

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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	26.8	16.9	8.5	43.7	4.2	0.0
Secondary	41.9	6.5	6.5	29.0	3.2	12.9
Tertiary	0.0	0.0	50.0	50.0	0.0	0.0
Total	30.8	13.5	8.7	39.4	3.8	3.8
Urban-Rural Residence						
Urban	37.7	11.5	13.1	31.1	1.6	4.9
Rural	20.9	16.3	2.3	51.2	7.0	2.3
Total	30.8	13.5	8.7	39.4	3.8	3.8
Management of HEALTH FACILITY						
Government	22.4	13.2	10.5	46.1	5.3	2.6
Private	53.8	11.5	3.8	23.1	0.0	7.7
Others	50.0	50.0	0.0	0.0	0.0	0.0
Total Per Cent	30.8	13.5	8.7	39.4	3.8	3.8

There are varieties in the receipt of supplies among counties. Over 50% of health facilities assessed in Bomi (75%), Grand Bassa (80%), Grand Cape Mount (100%) and Gbarpolu (66.6%) received their orders in less than two weeks. Table 45 below shows more details.

Table 32: Percentage Distribution of Clients by Estimated Length of Time between Order and Receipt of Supplies and by County, Liberia 2020

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 to six months	More than six months
Bomi	75.0	0.0	0.0	25.0	0.0	0.0
Bong	0.0	0.0	12.5	87.5	0.0	0.0
Grand Bassa	80.0	0.0	20.0	0.0	0.0	0.0
Grand Cape Mount	100.0	0.0	0.0	0.0	0.0	0.0

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Grand Gedeh	0.0	25.0	25.0	0.0	50.0	0.0
Grand Kru	25.0	0.0	0.0	50.0	0.0	25.0
Lofa	0.0	12.5	0.0	87.5	0.0	0.0
Margibi	40.0	20.0	0.0	20.0	20.0	0.0
Maryland	33.3	33.3	0.0	33.3	0.0	0.0
Montserrado	21.9	3.1	9.4	53.1	3.1	9.4
Nimba	16.7	41.7	25.0	16.7	0.0	0.0
River Cess	50.0	50.0	0.0	0.0	0.0	0.0
Sinoe	25.0	25.0	0.0	50.0	0.0	0.0
River Gee	50.0	25.0	0.0	25.0	0.0	0.0
Gbarpolu	66.6	33.4	0.0	0.0	0.0	0.0
<b>Total</b>	<b>30.8</b>	<b>13.5</b>	<b>8.7</b>	<b>39.4</b>	<b>3.8</b>	<b>3.8</b>

### 3.5.4 Types of Cold Chain Available

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. There 92 health facilities mentioned having cold chain out of 104 health facilities assessed. According to the sample distribution in Table 46 below, combine electric and solar fridges are used in 87% of health facilities assessed, while 13.0% of health facilities have no cold chain compared to 14.2% in 2018.

Disaggregation by those with cold chain reveals that 44.2 used electric fridge, 42.4% solar fridge and 13% used ice box (ice supply needs to be replenished regularly).

Health facilities with no cold chain available are situated in both urban (9.8%) and rural (14%) areas and are all primary facilities (16.9%) and managed by public (9.2%) and private ownership (19.2%). All secondary and tertiary facilities uses fridge. Further distribution shows most electric fridges (69%) are used in urban, similarly, higher (70%) solar fridges being used in rural areas. See Table 46 for further distribution.

**Table 33: 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	16.9	25.4	20.3	54.2
Secondary	0	77.4	0.0	22.6
Tertiary	0	100.0	0.0	0.0
<b>Total</b>	<b>11.5</b>	<b>44.6</b>	<b>13.0</b>	<b>42.4</b>
Urban	9.8	69.1	7.3	23.6
Rural	14	8.1	21.6	70.3
<b>Grand Total</b>	<b>11.5</b>	<b>44.6</b>	<b>13.0</b>	<b>42.4</b>



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Government	9.2	39.1	11.6	49.3
Private	19.2	61.9	14.3	23.8
Others	0	50.0	50.0	0.0
<b>Grand Total</b>	<b>11.5</b>	<b>44.6</b>	<b>13.0</b>	<b>42.4</b>

Table 47 below shows Percentage Distribution of Type of Cold Chain Available by county. According to the table below, about three of the fifteen counties namely Bong (37%), Margibi (20%) and Montserrado (25%) had facilities that did not have cold chain equipment.

Eleven out of the 15 counties (see table 47 below) had all facilities assessed using either electric or solar fridge. Less number of health facilities (13%) assessed used Icebox or coolers. The disadvantage of using coolers is that the Health Facility will have to regularly replenish the supply of ice (see Table 47).

Table 34: 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	0.0	25.0	75.0
Bong	37.5	60.0	0.0	40.0
Gbarpolu	0.0	33.3	33.3	33.3
Grand Bassa	0.0	40.0	0.0	60.0
Grand Cape Mount	0.0	0.0	25.0	75.0
Grand Gedeh	0.0	50.0	50.0	0.0
Grand Kru	0.0	50.0	25.0	25.0
Lofa	0.0	50.0	37.5	12.5
Margibi	20.0	75.0	0.0	25.0
Maryland	0.0	33.3	0.0	66.7
Montserrado	25.0	50.0	12.5	37.5
Nimba	0.0	58.3	0.0	41.7
River Cess	0.0	0.0	0.0	100.0
River Gee	0.0	75.0	0.0	25.0
Sinoe	0.0	25.0	0.0	75.0
<b>Grand Total</b>	<b>11.5</b>	<b>44.6</b>	<b>13.0</b>	<b>42.4</b>

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 16.3%

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and 21.3% of the facilities mentioned using electric grid and generator plant, followed by solar (60%) at the Health facilities, and the other power sources were not mentioned.

Solar panels power was found in 60% compared to 85 of the primary Health facilities assessed in 2018, 89% in rural localities and 43% in urban facilities, and they are the main power sources used by most Government facilities (67%) at management levels (Table 48). The main power source used in tertiary health facilities is electricity from national grid followed by generator. Table 48 below shows detail distribution.

**Table 35: 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
<b>Level of Service Delivery</b>						
<b>Primary</b>	10.6	6.4	0.0	0.0	80.9	0
<b>Secondary</b>	22.6	41.9	0.0	0.0	32.3	0
<b>Tertiary</b>	50.0	50.0	0.0	0.0	0.0	0
<b>Total</b>	16.3	21.3	0.0	0.0	60.0	0
<b>Urban-Rural Residence</b>						
<b>Urban</b>	25.5	29.4	0.0	0.0	43.1	0
<b>Rural</b>	0.0	6.9	0.0	0.0	89.7	0
<b>Total</b>	16.3	21.3	0.0	0.0	60.0	0
<b>Management of HEALTH FACILITY</b>						
<b>Government</b>	16.4	16.4	0.0	0.0	67.2	0
<b>Private</b>	16.7	33.3	0.0	0.0	38.9	0
<b>Others</b>	0.0	100.0	0.0	0.0	0.0	0
<b>Total Per Cent</b>	16.3	21.3	0.0	0.0	60.0	0

All health facilities mentioned the used of solar as the source of power for their cold chain except for Grand Gedeh, 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.

The significant progress made in deploying solar panels is commendable in that it provides a reliable power source that is inexpensive to run. Given the rising cost of petroleum products, this is a viable option that holds a bright future for the health and other service delivery systems of Liberia. An increased



use of solar energy has the potential to facilitate acceleration towards meeting nationally and internationally agreed development milestones. See table 49 below for further distribution.

Table 36: 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
<b>Bomi</b>	0	0	0	0	100
<b>Bong</b>	0	60	0	0	40
<b>Gbarpolu</b>	0	50	0	0	50
<b>Grand Bassa</b>	0	20	0	0	60
<b>Grand Cape Mount</b>	0	0	0	0	100
<b>Grand Gedeh</b>	100	0	0	0	0
<b>Grand Kru</b>	0	0	0	0	100
<b>Lofa</b>	0	20	0	0	80
<b>Margibi</b>	25	50	0	0	25
<b>Maryland</b>	33.3	0	0	0	66.7
<b>Montserrado</b>	23.8	23.8	0	0	52.4
<b>Nimba</b>	33.3	16.7	0	0	50
<b>River Cess</b>	0	0	0	0	100
<b>River Gee</b>	0	25	0	0	50
<b>Sinoe</b>	0	25	0	0	75
<b>Total Per Cent</b>	16.3	21.3	0	0	60

### 3.6 Staff Training and Supervision

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

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. One of the reasons why the amount of stock out in the six months before the survey was high in many of the reports of GPRHCS Stream One Countries was the lack of skilled personnel to administer the long acting and permanent methods of contraception. The inclusion in the questionnaire of questions on issues of training would allow measurement of the extent of the problem and inform plans geared towards solutions to be better tailored.

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Generally, the percentage of health facilities with trained staff to provide family planning services across health facilities assessed was at 93.3% compared to 86.6% in 2018, while those trained for insertion and removal of implants was 91.3% compared to 87.7% in 2018 (Table 50). The proportion trained to provide family planning services and for the insertion and removal of implants is slightly different ranging from 90.1% to 87.3% in primary to 100% across both secondary and tertiary levels of care. Also in rural localities, similar percentage (93%) of staffs is trained for both insertion and removal of implants family planning services. The distribution by management of facility for training on implants is very satisfactory.

Distribution by counties shows little variation. Except other counties, only 75% of health facilities in Bong and Grand Gedeh, and 87.5% in Nimba reported having train staffs for the provision of family planning services. Similarly, 75% of health facilities Bong and Grand Cape Mount and 81.3% in Montserrado had train staff for the insertion and removal of implants. Table (50) below provides further distribution.

**Table 37: 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	Train for Insertion and Removal of Implants
Primary	90.1	87.3
Secondary	100	100.0
Tertiary	100	100.0
<b>Total</b>	<b>93.3</b>	<b>91.3</b>
Urban	93.4	90.2
Rural	93	93.0
<b>Total</b>	<b>93.3</b>	<b>91.3</b>
Government	96.1	94.7
Private	88.5	84.6
Others	50	50.0
<b>Total</b>	<b>93.3</b>	<b>91.3</b>



<b>Staff trained to provide modern contraceptives and for the insertion and removal of Implants by county</b>		
<b>County</b>	<b>Train to Provide Family Planning Services</b>	<b>Train for Insertion and Removal of Implants</b>
Bomi	100	100.0
Bong	75	75.0
Grand Bassa	100	100.0
Grand Cape Mount	100	75.0
Grand Gedeh	75	100.0
Grand Kru	100	100.0
Lofa	100	100.0
Margibi	100	100.0
Maryland	100	100.0
Montserrado	100	81.3
Nimba	87.5	100.0
River Cess	100	100.0
Sinoe	100	100.0
River Gee	100	100.0
Gbarpolu	100	100.0
<b>Total</b>	<b>93.3</b>	<b>91.3</b>

### **3.6.2: Health Facility Supervision**

Regular supervision is key to improving health worker's performance and quality of health care delivery. Supervision is a process where higher authorities encourage personnel to optimize their performances in a supportive environment and recognize them when they attain a high level of performance. Some of the studies have shown that systematic supervision using an objective set of indicators could improve health worker performance. Effective supervisions lead to a balance between monitoring and evaluating services and providing support and encouragement to staff. The study assessed health facility supervision by asking respondents on the last time staffs were visited and supervised by their authorities.

Almost two-third (62%) of all facilities assessed were supervised less than one month and 28% health facilities supervised between one to three months before the day of the survey. These intervals are regular and established by policy in Liberia. Often, every month health facilities are supervised by county and district authorities while every quarter national teams escorted by county level teams provide joint supervision at selected health facilities.

Very few facilities (1.9%) reported not being supervised 12 months before the day of the survey. Disaggregation reveals that facilities not supervised at all were all primary facilities (2 health facilities) and located in Margibi County. See below in table 51 for further distribution. Most supervision carried out are focused on stock out (89.3%), staff availability (64%), Review use of specific guideline or job aid for reproductive health (62%). Other focus are on clinical practices and data quality.



**Table 51: 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
<b>Total</b>	62.5	28.8	6.7	0.0	1.9
<b>Primary</b>	64.8	26.8	5.6	0.0	2.8
<b>Secondary</b>	58.1	32.3	9.7	0.0	0.0
<b>Tertiary</b>	50.0	50.0	0.0	0.0	0.0
<b>Urban</b>	59.0	34.4	4.9	0.0	1.6
<b>Rural</b>	67.4	20.9	9.3	0.0	2.3
<b>Government</b>	68.4	22.4	7.9	0.0	1.3
<b>Private</b>	42.3	50.0	3.8	0.0	3.8
<b>Others</b>	100.0	0.0	0.0	0.0	0.0
<b>Bomi</b>	75.0	25.0	0.0	0.0	0.0
<b>Bong</b>	50.0	25.0	25.0	0.0	0.0
<b>Grand Bassa</b>	60.0	40.0	0.0	0.0	0.0
<b>Grand Cape Mount</b>	100.0	0.0	0.0	0.0	0.0
<b>Grand Gedeh</b>	25.0	50.0	25.0	0.0	0.0
<b>Grand Kru</b>	75.0	25.0	0.0	0.0	0.0
<b>Lofa</b>	62.5	25.0	12.5	0.0	0.0
<b>Margibi</b>	40.0	0.0	20.0	0.0	40.0
<b>Maryland</b>	100.0	0.0	0.0	0.0	0.0
<b>Montserrado</b>	50.0	46.9	3.1	0.0	0.0
<b>Nimba</b>	91.7	0.0	8.3	0.0	0.0
<b>River Cess</b>	25.0	75.0	0.0	0.0	0.0
<b>Sinoe</b>	100.0	0.0	0.0	0.0	0.0
<b>River Gee</b>	50.0	50.0	0.0	0.0	0.0
<b>Gbarpolu</b>	100.0	0.0	0.0	0.0	0.0
<b>Total</b>	62.5	28.8	6.7	0.0	1.9



### 3.6.3. Frequency of supervisory visits

Also, the frequency of supervision at health facilities ensures enhanced capacity for health facility staffs especially clinical staffs and the provision of quality services. Again, the survey reveals that 70% of health facilities assessed are supervised on a monthly basis, while 19.7% are supervised on a quarterly basis as per national standards. Table 52 shows further distribution.

Table 52: **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
Total	<b>8.7</b>	<b>70.2</b>	<b>19.7</b>	<b>0.0</b>	<b>1.0</b>	<b>1.0</b>
Primary	7.0	70.4	19.4	0.0	1.4	1.4
Secondary	12.9	67.7	0.0	0.0	0.0	0.0
Tertiary	0.0	100.0	19.2	0.0	0.0	0.0
Urban	8.2	72.1	18.0	0.0	1.6	0.0
Rural	9.3	67.4	20.9	0.0	0.0	2.3
Government	9.2	73.7	15.8	0.0	1.3	0.0
Private	7.7	57.7	30.8	0.0	0.0	3.8
Others	0.0	100.0	0.0	0.0	0.0	0.0
Bomi	0.0	50.0	50.0	0.0	0.0	0.0
Bong	0.0	62.5	37.5	0.0	0.0	0.0
Grand Bassa	20.0	60.0	20.0	0.0	0.0	0.0
Grand Cape Mount	0.0	100.0	0.0	0.0	0.0	0.0
Grand Gedeh	0.0	100.0	0.0	0.0	0.0	0.0
Grand Kru	0.0	100.0	0.0	0.0	0.0	0.0
Lofa	12.5	50.0	37.5	0.0	0.0	0.0
Margibi	0.0	40.0	20.0	0.0	20.0	20.0
Maryland	66.7	33.3	0.0	0.0	0.0	0.0
Montserrado	6.3	65.6	28.1	0.0	0.0	0.0
Nimba	8.3	91.7	0.0	0.0	0.0	0.0
River Cess	0.0	100.0	0.0	0.0	0.0	0.0
Sinoe	25.0	75.0	0.0	0.0	0.0	0.0
River Gee	25.0	50.0	25.0	0.0	0.0	0.0
Gbarpolu	0.0	100.0	0.0	0.0	0.0	0.0
Total	<b>8.7</b>	<b>70.2</b>	<b>19.7</b>	<b>0.0</b>	<b>1.0</b>	<b>1.0</b>



### 3.7 Availability of Guidelines, checklists and job-aids

Liberia has several policies, documents, and service delivery guidelines related to population and reproductive health; all of which are supportive to certain elements of reproductive health commodity security. Family health protocols guideline and job aids are developed by Ministry of Health (MoH) with support from partners.

Various health care delivery guidelines and checklists are provided as per the level of health care delivery for strengthening quality services. The status of availability of specific family planning guidelines and waste disposal guidelines has been one of the key objectives of this study. The availability of such guidelines, job-aids or the checklists was assessed through verbal response of the interviewees followed by verification of same guidelines or job-aids.

Over two-third of all health facilities assessed reported having family planning guidelines, family planning checklists and or job-aids; and ANC guidelines and ANC checklists and or job-aids respectively. Disaggregation by health facility types levels reveals increasing trend between primary and secondary at 71% and 93.3% while 50% of the tertiary facilities (2 facilities) reported having these guidelines, checklists and job-aids. Also at management level, public health facilities (76-84%) reported any of the guidelines while private health facilities vary from 57% to 65%. All counties assessed reported having some of guidelines, checklist or job-aids ranging from 20% to 100%. Among all counties, only Bong, Grand Bassa, Lofa, River Cess and Gbarpolu counties had 100% of facilities assessed reporting all forms of guidelines, checklists and job-aids. Table 53 in annex shows more details.

Categories	FP guidelines (national or WHO)-81	FP check-lists and/or job-aids-85	ANC guidelines (national or WHO) (87)	ANC check-lists and/or job-aids-84
	<b>FP (77.9) Verified</b>	<b>FP (74) Verified)</b>	<b>ANC (76) verified</b>	<b>ANC (70) verified</b>
Primary	71.8	71.8	71.8	67.6
Secondary	93.5	80.6	87.1	77.4
Tertiary	50	50	50	50
Total	77.9	74	76	70.2
Urban	77	65.6	70.5	60.7
Rural	79.1	86	83.7	83.7
Total	77.9	74	76	70.2
Government	84.2	81.6	81.6	76.3
Private	65.4	57.7	65.4	57.7
Others	0	0	0	0
Total	77.9	74	76	70.2





### 3.8 Use of Information, Communication and Technology

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. It is part of healthcare structure in any organizations to support the processes and consequently to deliver better outcome to organization and particularly to the patient. 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 (82%) followed by mobile phone-basic handsets (31%) 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, 83% to 81% at secondary and primary health facilities. See table 54 in annex.

### 3.9 Methods of waste disposal

The most common type of waste disposal among all the health facilities was the used of incinerators at the health facility (67.3%) followed by the burning of waste (12.5%) on the grounds of the health facility (See Table 55 below). All (100%) of Tertiary facilities (2) used incinerators, while 80.6% and 60.6% of secondary and primary facilities used incinerators for their waste. Over two-third (72%) of government health facilities compared to 50% of private health facilities used incinerators at the health facilities site.

Table 55: **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	Collected away from the SDP	Disposed with regular garbage
<b>Primary</b>	16.9	8.5	60.6	12.7	1.4
<b>Secondary</b>	3.2	6.5	80.6	9.7	0.0
<b>Tertiary</b>	0.0	0.0	100.0	0.0	0.0
<b>Total</b>	<b>12.5</b>	<b>7.7</b>	<b>67.3</b>	<b>11.5</b>	<b>1.0</b>
<b>Bomi</b>	0.0	25.0	75.0	0.0	0.0
<b>Bong</b>	25.0	0.0	75.0	0.0	0.0
<b>Grand Bassa</b>	20.0	0.0	80.0	0.0	0.0
<b>Grand Cape Mount</b>	25.0	0.0	75.0	0.0	0.0
<b>Grand Gedeh</b>	0.0	0.0	100.0	0.0	0.0
<b>Grand Kru</b>	0.0	0.0	100.0	0.0	0.0
<b>Lofa</b>	0.0	0.0	100.0	0.0	0.0
<b>Margibi</b>	40.0	20.0	40.0	0.0	0.0
<b>Maryland</b>	0.0	0.0	100.0	0.0	0.0
<b>Montserrado</b>	15.6	9.4	40.6	31.3	3.1

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<b>Nimba</b>	0.0	8.3	83.3	8.3	0.0
<b>River Cess</b>	25.0	0.0	75.0	0.0	0.0
<b>Sinoe</b>	25.0	50.0	25.0	0.0	0.0
<b>River Gee</b>	0.0	0.0	75.0	25.0	0.0
<b>Gbarpolu</b>	0.0	0.0	100.0	0.0	0.0
<b>Total</b>	<b>12.5</b>	<b>7.7</b>	<b>67.3</b>	<b>11.5</b>	<b>1.0</b>
<b>Urban</b>	6.6	6.6	67.2	18.0	1.6
<b>Rural</b>	20.9	9.3	67.4	2.3	0.0
<b>Total</b>	<b>12.5</b>	<b>7.7</b>	<b>67.3</b>	<b>11.5</b>	<b>1.0</b>
<b>Government</b>	11.8	9.2	72.4	5.3	1.3
<b>Private</b>	15.4	3.8	50.0	30.8	0.0
<b>Others</b>	0.0	0.0	100.0	0.0	0.0
<b>Total</b>	<b>12.5</b>	<b>7.7</b>	<b>67.3</b>	<b>11.5</b>	<b>1.0</b>

### 3.10 Charges for user fees

Most common issue for which user fee is charged for consultation (29.8%) in all SDPs was family planning services followed by antenatal care services. Payment for any form of service increases with health facility levels as all tertiary facilities assessed charged patients for family planning services, antenatal cares or maternal care services. More private facilities charged patients higher for consultations, medications and other maternal health services compared to public health facilities. See table 56 below for more details.

**Table 56: Distribution of Health Facility who charge Patients for Service Area**

<b>County</b>	<b>Charge patient for Consultation</b>	<b>Charge patient for Medication</b>	<b>Charge patient for any service</b>
Bomi	0.0	0.0	0.0
Bong	50.0	25.0	12.5
Gbarpolu	0.0	0.0	0.0
Grand Bassa	40.0	40.0	20.0
Grand Cape Mount	25.0	25.0	25.0
Grand Gedeh	25.0	25.0	25.0
Grand Kru	0.0	0.0	0.0
Lofa	62.5	62.5	50.0
Margibi	0.0	20.0	20.0
Maryland	0.0	0.0	0.0
Montserrado	37.5	34.4	28.1
Nimba	41.7	41.7	33.3
River Cess	0.0	0.0	0.0
River Gee	25.0	25.0	25.0

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Sinoe	0.0	0.0	0.0
<b>Grand Total</b>	<b>29.8</b>	<b>27.9</b>	<b>22.1</b>
Rural	18.6	16.3	9.3
Urban	37.7	36.1	31.1
<b>Grand Total</b>	<b>29.8</b>	<b>27.9</b>	<b>22.1</b>
Primary	25.4	25.4	16.9
Secondary	35.5	29.0	29.0
Tertiary	100.0	100.0	100.0
<b>Grand Total</b>	<b>29.8</b>	<b>27.9</b>	<b>22.1</b>
Government	11.8	6.6	3.9
Private	80.8	88.5	73.1
Others	50.0	50.0	50.0
<b>Grand Total</b>	<b>29.8</b>	<b>27.9</b>	<b>22.1</b>



## **PART IV: SURVEY FINDINGS FROM EXIT INTERVIEW**

### **4.1 Background Characteristics of Clients**

The client interview provides an opportunity to incorporate the views of the clients regarding the experiences with the services provided by the health facilities. The chapter of the report focuses on the results of the exit interview and as a result discusses information from the exit interview for client's perception regarding various aspects of service delivery; and clients' estimation of the cost of FP. These client survey interviews were conducted as a regular process of program monitoring. It is necessary to be cautious when interpreting the results of exit interview because these are the opinions of men and women who had received services, so may not be representative of the general population. Also, clients' satisfaction is difficult to measure as it is affected by client's expectation and knowledge. Clients commonly underreport dissatisfaction, especially at exit interviews given that they are conducted at health facilities or they need to seek services from the same facilities in future as well.

### **4.1 Background Characteristics of Clients**

The background characteristics of the clients are taken to obtain the general profile of the clients attending the different health facilities. This chapter presents the general characteristics of the clients collected through client exit interviews in terms of their age and sex distribution, marital status, education and their visits to SDP. The analyses are based on total of 2600 clients interviewed and the data are assembled according to type of facility, development region, residence and management of the facility.

#### **4.1.2 Sex and distribution of Clients**

##### **4.1.1 Age and Sex Distribution**

The most basic classification of a population is its age and sex distribution. The distribution of all other attributes can be cross-classified by age and sex and the differentials are important for making decisions. The GPRHCS 2020 survey collected data on the clients/beneficiaries of family planning and reproductive health services and commodities offered by the Health facilities. The information is expected to enable the formulation of more responsive and sustainable program packages for clients.

**Table 51** below shows the total number of 299 respondents who participated in an exit interview at selected health facilities across the country. The result shows a low proportion of males constituting 2.3% compared to 4.6% reported in 2018. Women accounted for the remaining 97.7 percent, showing a rise of about 2.3 percent compared to the 2018 survey. The age distribution shows that with 26 percent of the clients polled, the modal age group of respondents was 20-24 years, compared to 28 percent in 2018. On contrary the extremes of the age distribution 10-14 years and 40 & above had the lowest population accounting for 1% and 2.3% respectively.



#### 4.1.1 Age and Sex Distribution

Table 51: Age and Sex distribution of Client seeking family planning and reproductive health care at Facility

**Table 51: Age and Sex distribution of client seeking family planning and reproductive health care at Facility**

County	Frequency	Age in Years						
		10-14 Years	15-19 Years	20-24 Years	25-29 Years	30-34 Years	35-39 Years	40 & Above Years
<b>Bomi</b>	11	0.0	27.3	63.6	9.1	0.0	0.0	0.0
<b>Bong</b>	9	0.0	33.3	11.1	22.2	11.1	11.1	11.1
<b>Grand Bassa</b>	31	0.0	32.3	25.8	16.1	9.7	12.9	3.2
<b>Grand Cape Mount</b>	7	0.0	14.3	42.9	28.6	0.0	14.3	0.0
<b>Grand Gedeh</b>	12	0.0	25.0	16.7	25.0	25.0	8.3	0.0
<b>Grand Kru</b>	18	0.0	38.9	38.9	16.7	5.6	0.0	0.0
<b>Lofa</b>	15	0.0	40.0	6.7	6.7	20.0	26.7	0.0
<b>Margibi</b>	16	0.0	12.5	12.5	31.3	31.3	12.5	0.0
<b>Maryland</b>	13	0.0	46.2	23.1	7.7	15.4	7.7	0.0
<b>Montserrado</b>	91	3.3	24.2	24.2	22.0	17.6	4.4	4.4
<b>Nimba</b>	21	0.0	9.5	23.8	28.6	19.0	19.0	0.0
<b>River Cess</b>	18	0.0	0.0	38.9	16.7	27.8	16.7	0.0
<b>River Gee</b>	16	0.0	0.0	37.5	43.8	18.8	0.0	0.0
<b>Sinoe</b>	13	0.0	7.7	7.7	30.8	15.4	30.8	7.7
<b>Gbarpolu</b>	8	0.0	12.5	50.0	25.0	0.0	12.5	0.0
<b>Total</b>	<b>299</b>	<b>1.0</b>	<b>22.4</b>	<b>26.4</b>	<b>21.7</b>	<b>16.1</b>	<b>10.0</b>	<b>2.3</b>

#### 4.1.2 Marital Status

The marital status profile investigated were never married or in a union, currently married or in a union, and formerly married (divorced, separated, or widowed). **Table 52** below shows that about 27% of the respondent are married compared to 32.3% in the 2018 report, while 71% of the respondents were never married compared to 64.8% and 1.3 % formerly married than 2.9% in 2018. At the county level, the percentage currently married ranges from 0% in Bomi and Bong to 61% in Sinoe County with considerable variations in between the counties. The category of formerly married persons is small and does not affect the overall distribution of the characteristic.

Table 52 Marital status of seeking family planning and reproductive health care at Facility

County	Count	Never Married or in union	Currently Married or in Union	Formerly Married
<b>Bomi</b>	11	100.0	0.0	0.0
<b>Bong</b>	9	100.0	0.0	0.0
<b>Grand Bassa</b>	31	67.7	25.8	6.5
<b>Grand Cape Mount</b>	7	85.7	14.3	0.0
<b>Grand Gedeh</b>	12	66.7	33.3	0.0
<b>Grand Kru</b>	18	66.7	33.3	0.0

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<b>Lofa</b>	15	86.7	13.3	0.0
<b>Margibi</b>	16	62.5	31.3	6.3
<b>Maryland</b>	13	76.9	23.1	0.0
<b>Montserrado</b>	91	73.6	25.3	1.1
<b>Nimba</b>	21	61.9	38.1	0.0
<b>River Cess</b>	18	61.1	38.9	0.0
<b>River Gee</b>	16	68.8	31.3	0.0
<b>Sinoe</b>	13	38.5	61.5	0.0
<b>Gbarpolu</b>	8	87.5	12.5	0.0
<b>Total</b>	<b>299</b>	<b>71.6</b>	<b>27.1</b>	<b>1.3</b>

#### 4.1.3 Education

During the training, field staff was trained to ask for the "highest grade completed" informal schooling, which was translated into the level of education attained with options of "no education", "primary" and "secondary or higher" levels in **Table 53** below. The percentages across these options were 20.4%, 32.8%, and 46.8% for No Education, Primary, and Secondary and Higher respectively. Hence, 32.8 percent of the population has primary and higher levels of education. Though there were very few males in the study, 71.4% of males compared to 46.2% of females have had secondary or higher education before the day of the survey.

#### 4.1.4 Frequency of Visit to HEALTH FACILITY for Family Planning

Data on the frequency of visits of clients to health facilities for family planning shows the majority of visitors (76.9 percent) come once in three months (**Table 54**). In comparison to the 2018 report, the current reports show a decrease in the frequency of clients' visits once in three months by 5%.

Although the reasons for the frequency pattern were not requested during the collection of data, the observed pattern is likely to indicate the use of the type of contraceptives that are most common among women (pills and Depo Provera or injectable are the most popular contraceptive methods used). While each pill is for one month, to minimize the number of visits to health facilities, supplies are typically provided for three months. The efficacy of the injectable lasts for three months, and if they have side effects due to use, the women could only make in-between visits. This could also indicate that the distances covered from clients' home to health facility might be linked to the clients once in every three months visit to a health facility. On the other hand, most of the women coded as visiting once per month were first-time visitors at the family planning clinics who opted for pills. The practice currently is for new users of pills to be supplied for the first month and to return afterward for evaluation of treatment adherence and side effects before deciding on continuing treatment.



Table 54: Percentage Distribution of Clients by Frequency of Visits to Health facilities for Family Planning and by Level of Service Delivery, Urban-Rural Residence, and Management of HEALTH FACILITY, Liberia 2020

County	Frequency of Visit to the Service Delivery Points				
	Count	Once in a month	Once in 2 months	Once in 3 months	Others
<b>Bomi</b>	11	0.0	0.0	100.0	0.0
<b>Bong</b>	9	33.3	0.0	66.7	0.0
<b>Grand Bassa</b>	31	32.3	3.2	64.5	0.0
<b>Grand Cape Mount</b>	7	0.0	0.0	100.0	0.0
<b>Grand Gedeh</b>	12	0.0	33.3	58.3	8.3
<b>Grand Kru</b>	18	5.6	5.6	88.9	0.0
<b>Lofa</b>	15	20.0	0.0	60.0	20.0
<b>Margibi</b>	16	0.0	0.0	100.0	0.0
<b>Maryland</b>	13	7.7	7.7	84.6	0.0
<b>Montserrado</b>	91	11.0	0.0	76.9	12.1
<b>Nimba</b>	21	4.8	0.0	90.5	4.8
<b>River Cess</b>	18	38.9	0.0	61.1	0.0
<b>River Gee</b>	16	12.5	0.0	87.5	0.0
<b>Sinoe</b>	13	53.8	0.0	38.5	7.7
<b>Gbarpolu</b>	8	0.0	0.0	100.0	0.0
<b>Total</b>	<b>299</b>	<b>15.1</b>	<b>2.3</b>	<b>76.9</b>	<b>5.7</b>

## 4.2 Client's Perception of Family Planning Service Provision

### 4.2.1 Provider Adherence to Technical Aspects

In the provision of family planning commodities, certain services go with it. These include technical issues relating to the choices people make, education on how to use the methods, side effects, and remedial actions, etc. as shown below in **Table 55**.

In this analysis, full adherence to any aspect should be reflected in a positive appraisal of the handling of the situation by all clients (100.0 percent). Any deviation is an instance of the provider being perceived as not marking up to expectation. Therefore, the point that the scores ranged between 94.5 and 99 is interpreted to mean that between one and five percent of the clients think that the family planning providers' adherence to technical details is less than desirable.

The county analysis of adherence to technical issues in family planning service delivery reveals that the technical issues most adhered to were the provision of the methods chosen by the client (97.3%) and information being provided to clients on what can be done regarding the side effects of the family planning method (97.5%). When compared to the 2018 report the technical issues



most adhered to were the provision of the methods chosen by the client (99.1%) and providers taking clients' preferences and wishes into consideration (98.1%).

However, providers' adherence to clients being taught how to use family planning shows an increase by 1% in 2020 compared to 2018 with adherence of 88.6. Additionally, the adherence to providers to informing clients about the common side effects saw a decline from 92.9% in 2018 to 92.0% in 2020. Most notably was the adherence to advising clients on what to do in the event of any serious complication. This rose from 91.7 percent in 2018 to 97.5 percent in 2020, by almost 7 percent. **Table 55** below shows that all counties met full compliance across the five regions of Liberia.

Table 55: Percentage Distribution of Clients' Perspective of Family Planning Service Provider's Adherence to Technical Issues by County, Liberia 2020

County	Count	Provided with the method of their choice	Provider took clients preference and wishes into consideration	The client taught how to use the method	Client told about the common side effects of the method	Provider informed client about what can be done regarding the side effects of the method	Provider informed client about what to do in case any serious complications occur	Client given date to return to HEALTH FACILITY for check-up and/or additional supplies
		Percent	Percent	Percent	Percent	Percent	Percent	Percent
<b>Bomi</b>	11	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<b>Bong</b>	9	100.0	77.8	100.0	88.9	100.0	87.5	77.8
<b>Grand Bassa</b>	31	100.0	74.2	58.1	87.1	100.0	100.0	96.8
<b>Grand Cape Mount</b>	7	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<b>Grand Gedeh</b>	12	100.0	91.7	100.0	100.0	100.0	100.0	83.3
<b>Grand Kru</b>	18	77.8	77.8	100.0	100.0	94.4	100.0	88.9
<b>Lofa</b>	15	86.7	93.3	93.3	86.7	92.3	84.6	93.3
<b>Margibi</b>	16	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<b>Maryland</b>	13	92.3	92.3	100.0	100.0	100.0	100.0	100.0
<b>Montserrado</b>	91	100.0	98.9	94.5	86.8	95.1	85.2	96.7
<b>Nimba</b>	21	95.2	85.7	90.5	85.7	94.4	100.0	90.5
<b>River Cess</b>	18	100.0	27.8	44.4	100.0	100.0	100.0	100.0
<b>River Gee</b>	16	100.0	25.0	87.5	100.0	100.0	100.0	100.0
<b>Sinoe</b>	13	100.0	100.0	92.3	92.3	100.0	100.0	76.9



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<b>Gbarpolu</b>	8	100.0	100.0	100.0	87.5	100.0	100.0	100.0
<b>Total Responses</b>	<b>299</b>	<b>97.3</b>	<b>84.6</b>	<b>88.6</b>	<b>92.0</b>	<b>97.5</b>	<b>94.6</b>	<b>94.6</b>

#### 4.2.2 Organizational Aspects

Clients' assessment on the provision of family planning services with respect to organizational aspects is in Table 56 below. The four components under the organizational aspects are: (a) perception of waiting time, (b) satisfaction with cleanliness of health facility, (c) satisfaction with privacy at the exam room and (d) satisfaction with the time allotted to her/his case. Across all counties, 26.4% of clients seeking family planning services reported that the average minimum perceived waiting period per client was too long. However a disaggregation by counties suggests that a significant proportion (72.2 percent) of clients in River Cess County stressed that the waiting period per client was too long. On overall, the findings across all counties may suggest that growing clients' satisfaction and the enhancing quality of family planning services could be due to shortening waiting times or the overall minimum perceived waiting period per client being considerate.

All of the counties recorded that all the respondents visiting family planning centers are satisfied with cleanliness of the health facility (95.0%), privacy at the exam room (93.6%) and time allotted to their cases (95.0%). Generally, there were satisfactions across all fifteen counties. Clients are generally reasonably satisfied (95.0 percent) with the organisational aspects of family planning service delivery in Liberia. Such satisfaction of clients with the organizational aspect of family planning service delivered in Liberia is an essential determinant of service uptake, compliance, and continuation in as such satisfied clients are more likely to revisit the service and even assist in the recruitment of new clients who can use the services.

Table 56: Percentage distribution of clients' perspective of FP service organizational aspects

Characteristics	Percentage				
	Count	Client perceived waiting time as too long	Client satisfied with the cleanliness of the health facility	Client satisfied with the privacy at the exam room	Client satisfied with the time that was allotted to his/her case
<b>Bomi</b>	11	0.0	100.0	100.0	100.0
<b>Bong</b>	9	33.3	88.9	66.7	88.9
<b>Grand Bassa</b>	31	22.6	100.0	100.0	100.0
<b>Grand Cape Mount</b>	7	14.3	100.0	100.0	100.0
<b>Grand Gedeh</b>	12	33.3	100.0	91.7	100.0
<b>Grand Kru</b>	18	55.6	83.3	94.4	55.6
<b>Lofa</b>	15	60.0	100.0	86.7	80.0

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<b>Margibi</b>	16	12.5	93.8	100.0	100.0
<b>Maryland</b>	13	38.5	100.0	100.0	92.3
<b>Montserrado</b>	91	9.9	90.1	90.1	98.9
<b>Nimba</b>	21	14.3	95.2	90.5	95.2
<b>River Cess</b>	18	72.2	100.0	94.4	100.0
<b>River Gee</b>	16	62.5	100.0	100.0	100.0
<b>Sinoe</b>	13	15.4	100.0	100.0	100.0
<b>Gbarpolu</b>	8	12.5	100.0	100.0	100.0
<b>Total</b>	<b>299</b>	<b>26.4</b>	<b>95.0</b>	<b>93.6</b>	<b>95.0</b>

#### 4.2.3 Interpersonal Aspects

The interpersonal aspects of family planning service provision discussed are whether the clients were treated with respect by the health facility staff, whether the method chosen was forced upon the client and whether the client was satisfied with the attitude of the healthcare provider. When asked if they felt that their privacy had been treated with courtesy and respect by health facility staff, 94.6% of clients replied in the affirmative and were thus generally satisfied with the attitude of health facility providers (94.6%) towards them. For the remaining 5.4% who felt that their privacy had not been treated with respect or courtesy might be of a result similar to the findings from Chavane, et al (2017) indicating that clients did not receive the respect and courtesy due to not being alone with the health provider, the door was kept open during consultation and others could see them in the room where the consultation was held.

A 100 percent of the clients in four counties (Bomi, Grand Cape Mount, Margibi, and Gbarpolu) were generally satisfied with the attitude of the healthcare providers. The lowest level of satisfaction with health staff attitude was found in Grand Kru County representing 72.2%. The remaining 27.8% from Grand Kru County who felt that their privacy had not been treated with respect or courtesy might be of a result similar to the findings from Chavane, et al (2017) as indicated above.

The reported incidences of forcing clients to accept a family planning method has reduced from 20.4% across all counties in 2018 to 10.4% in current report. This is highest in River Gee (37.5 percent) and Lofa (33.3 percent) and lowest in Bomi, Grand Cape Mount, Margibi, and Gbarpolu Counties. See Table 57 below for further distribution of responses.

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Table57: Percentage Distribution of Clients Perspective of Family Planning Service Interpersonal Aspects by County, Liberia 2020

County	Count	Percentage		
		Client Indicated he/she was Treated with Courtesy and Respect by Staff at the HEALTH FACILITY	Client indicated his/her Health Service Providers Forced him/her to Accept or Insisted he/she Should Accept the Family Planning Method	Client Satisfied with the Attitude of the Health Provider towards him/her Generally
<b>Bomi</b>	11	100.0	0.0	100.0
<b>Bong</b>	9	88.9	22.2	88.9
<b>Grand Bassa</b>	31	93.5	3.2	96.8
<b>Grand Cape Mount</b>	7	100.0	0.0	100.0
<b>Grand Gedeh</b>	12	91.7	16.7	91.7
<b>Grand Kru</b>	18	72.2	11.1	72.2
<b>Lofa</b>	15	93.3	33.3	93.3
<b>Margibi</b>	16	100.0	0.0	100.0
<b>Maryland</b>	13	76.9	23.1	92.3
<b>Montserrado</b>	91	98.9	2.2	98.9
<b>Nimba</b>	21	100.0	23.8	95.2
<b>River Cess</b>	18	94.4	5.6	94.4
<b>River Gee</b>	16	100.0	37.5	87.5
<b>Sinoe</b>	13	92.3	15.4	92.3
<b>Gbarpolu</b>	8	100.0	0.0	100.0
<b>Total</b>	<b>299</b>	<b>94.6</b>	<b>10.4</b>	<b>94.6</b>

#### 4.2.4 Outcome Aspects

Client satisfaction, which normally depends on quality and access, is important to the decision of clients to use and to continue using services and is essential to long-term sustainability. This in turn influences their decision whether to recommend the service to other potential users. However, findings on the outcome aspect of clients' perspectives revealed for the services they received as 97.7% the clients expressed satisfaction with the services they received; also 95.7% expressed interest to return or to continue to visit the health facility while 95.3% expressed that they would recommend the health facility to relative and friends. A geographic analysis of the spread of the outcome variables associated with clients' perception presents an aerial picture of widespread satisfaction with family planning services in Liberia by the visiting clients. Eight counties registered 100 percent satisfaction on all of the scales of measurement. They are Bomi, Grand Bassa, Grand Cape Mount, Grand Gedeh, Margibi, River Gee, Sinoe, and Gbarpolu Counties. **Table 58** below shows further information.



Table 58: Percentage Distribution of Clients Perspective of Family Planning Service Outcome Aspects by County, Liberia 2020

County	Count	Percentage		
		Client satisfied with the Service Received	The client will Continue Visiting this HEALTH FACILITY in Future	Client would Recommend this HEALTH FACILITY to Relatives or Friends
<b>Bomi</b>	11	100.0	100.0	100.0
<b>Bong</b>	9	100.0	88.9	88.9
<b>Grand Bassa</b>	31	100.0	100.0	100.0
<b>Grand Cape Mount</b>	7	100.0	100.0	100.0
<b>Grand Gedeh</b>	12	100.0	100.0	100.0
<b>Grand Kru</b>	18	72.2	66.7	61.1
<b>Lofa</b>	15	93.3	93.3	86.7
<b>Margibi</b>	16	100.0	100.0	100.0
<b>Maryland</b>	13	92.3	92.3	92.3
<b>Montserrado</b>	91	100.0	97.8	98.9
<b>Nimba</b>	21	100.0	95.2	95.2
<b>River Cess</b>	18	100.0	94.4	94.4
<b>River Gee</b>	16	100.0	100.0	100.0
<b>Sinoe</b>	13	100.0	100.0	100.0
<b>Gbarpolu</b>	8	100.0	100.0	100.0
<b>Total</b>	<b>299</b>	<b>97.7</b>	<b>95.7</b>	<b>95.3</b>

#### 4.3 Clients' Appraisal of Cost of Family Planning Services

##### 4.3.1 Payment for Family Planning Services

On the day of the interview, 11.7 percent of clients paying to obtain family planning services were recorded in the exit interview (Table 59). This report revealed a decrease of about 4 percent clients paying for family planning services on the day of interview compare to 2018. Six counties (Bomi, Grand Cape Mount, Grand Kru, Margibi, Maryland, and Gbarpolu) of the fifteen counties did not report clients paying for family planning services.



Table 59: Percentage of clients that reported paying for Family Planning services

County	Count	Percent
Bomi	11	0.0
Bong	9	22.2
Grand Bassa	31	9.7
Grand Cape Mount	7	0.0
Grand Gedeh	12	8.3
Grand Kru	18	0.0
Lofa	15	26.7
Margibi	16	0.0
Maryland	13	0.0
Montserrado	91	17.6
Nimba	21	4.8
River Cess	18	27.8
River Gee	16	6.3
Sinoe	13	15.4
Gbarpolu	8	0.0
<b>Total</b>	<b>299</b>	<b>11.7</b>

Table 60 below displays the disaggregation of payment for items during services and the items include were patient cards, laboratory tests or X-rays, contraception received from service providers, contraception purchased from pharmacies, and consultation fees. On the overall, percentage distribution of payment for family planning was recorded as follows: Cards (29.7%), Laboratory test/x-ray (10.8%), Contraceptive received from the service provider (37.8%), Contraceptive purchased from the pharmacy (37.8%), Consultation fee (5.4%) and others (18.9%).

Payment for family planning services is highest in Nimba (100%) and Sinoe (100%) compared to other counties. The actual proportion of health facilities demanding pay-for-service might be small, but the idea behind it is wrong. The government of Liberia has an overall no-payment policy for medical care. The health officers who ask for pay are obviously in breach of the relevant law and their acts may cause others to stumble, posing untold risks for a population that is slowly recovering from more than a decade of traumatic events that have increased levels of poverty. See **table 60** below for further distribution.

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Table 60: Percentage Distribution of Clients Reporting Paying for Services and Medical Items by Average Amount Paid by Level of Service Delivery, Urban-Rural Residence, and Management of Health Facility, Liberia 2020

County	Count	Card	Laboratory test/x-ray	Contraceptive purchased from Provider	Contraceptive purchased from Pharmacy	Consultation	Others
<b>Bomi</b>	11	0.0	0.0	0.0	0.0	0.0	0.0
<b>Bong</b>	9	0.0	50.0	50.0	50.0	0.0	0.0
<b>Grand Bassa</b>	31	33.3	0.0	66.7	0.0	0.0	0.0
<b>Grand Cape Mount</b>	7	0.0	0.0	0.0	0.0	0.0	0.0
<b>Grand Gedeh</b>	12	0.0	0.0	0.0	0.0	0.0	0.0
<b>Grand Kru</b>	18	0.0	0.0	0.0	0.0	0.0	0.0
<b>Lofa</b>	15	0.0	60.0	0.0	20.0	0.0	20.0
<b>Margibi</b>	16	0.0	0.0	0.0	0.0	0.0	0.0
<b>Maryland</b>	13	0.0	0.0	0.0	0.0	0.0	0.0
<b>Montserrado</b>	91	47.1	0.0	35.3	29.4	0.0	35.3
<b>Nimba</b>	21	0.0	0.0	100.0	0.0	0.0	0.0
<b>River Cess</b>	18	0.0	0.0	40.0	60.0	0.0	0.0
<b>River Gee</b>	16	0.0	0.0	0.0	100.0	0.0	0.0
<b>Sinoe</b>	13	100.0	0.0	100.0	100.0	100.0	0.0
<b>Gbarpolu</b>	8	0.0	0.0	0.0	0.0	0.0	0.0
<b>Total</b>	<b>299</b>	<b>29.7</b>	<b>10.8</b>	<b>37.8</b>	<b>37.8</b>	<b>5.4</b>	<b>18.9</b>
<b>SEX</b>							
		<b>Card</b>	<b>Laboratory test/x-ray</b>	<b>Contraceptive received from service provider</b>	<b>Contraceptive purchased from pharmacy</b>	<b>Consultation fee</b>	<b>Others</b>
<b>Male</b>	0	0.0	0.0	0.0	0.0	0.0	0.0
<b>Female</b>	35	29.7	10.8	37.8	37.8	5.4	18.9
<b>Total</b>	<b>35</b>	<b>29.7</b>	<b>10.8</b>	<b>37.8</b>	<b>37.8</b>	<b>5.4</b>	<b>18.9</b>

### Travel Costs Paid by Clients

Access to reproductive health services is enhanced with the presence of good road networks with high connectivity and efficient transport systems. The inadequacy of these make for high transport costs, delay in travelling to health facilities and consequent reduced accessibility to reproductive health services.

The modes of transport used by clients to visit the family planning clinics are: walking (62.8 percent), bicycle (5 percent), motorcycle (28.2 percent), bus or taxi (3.2 percent) and 0.9 percent of private vehicles and other means of transport. Most of the people in the counties walk to the health facilities with percentages ranging from 40.2% in Grand Bassa to 95% in Gbarpolu. The motorcycle is the main



motorist in the country, accounting for between 3.1 percent of all trips to reproductive health clinics in Grand Kru to 57.4 percent of the means of transport used in Nimba on that day. The bicycle is most important in Grand Cape Kru County (15.6 percent) whilst buses or taxis were only rode in 3 counties; Montserrado (6.1 percent), Grand Cape Mount (13.3) and Margibi (21.6 percent). Montserrado County (3.0 percent) and Bong County (2.4 percent) recorded the use of some private vehicles (**Table 61 below**).

Table 61: Percentage Distribution of Clients by Mode of Transportation, Distance Travelled and Cost of Transportation by Type of Facility, County, Urban-Rural Residence and by Management, Liberia 2018

County/Characteristics	Modes of transportation					
	Walked	Bicycle	Motorcycle	Bus/Taxi	Private Vehicle	Others
Total	62.8	5	28.2	3.2	0.7	0.2
Bomi	83.3	5.6	11.1	0	0	0
Bong	53.7	9.8	34.1	0	2.4	0
Grand Bassa	40.5	2.7	56.8	0	0	0
Grand Cape Mount	43.3	0	43.3	13.3	0	0
Grand Gedeh	76.7	13.3	10	0	0	0
Grand Kru	81.3	15.6	3.1	0	0	0
Lofa	65.6	4.7	29.7	0	0	0
Margibi	43.2	10.8	24.3	21.6	0	0
Maryland	76.9	3.8	19.2	0	0	0
Montserrado	71.7	1	18.2	6.1	3	0
Nimba	42.6	0	57.4	0	0	0
River Cess	69.2	0	30.8	0	0	0
River Gee	72	4	24	0	0	0
Sinoe	52	12	32	0	0	4
Gbarpolu	95	0	5	0	0	0

#### 4.3.3 Time Spent by Client

In four counties: Grand Kru (19%) Sinoe (19%), Grand Gedeh (17%) and Nimba (17%) waiting times before receiving services are exceptionally long. Return journeys in Grand Gedeh (22) and Maryland (19) can also be too time-consuming. Bong and Gbarpolu Counties recorded the lowest times for moving to and from the Health facilities to receive family planning services. **Table 62** below shows further description.

Table 62: Average Time (in minutes) Spent by Client for Family Planning Services by Type of Facility, County, Urban-Rural Residence and by Management, Liberia 2018

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Characteristics	Average Time Spent		
	Average travelling time (in minutes) from place of residence to the SDP	Average waiting time (in minutes) for and Receiving Services	Average traveling time (in minutes) from the SDP to place of residence
Bomi	3	6	12
Bong	8	15	8
Grand Bassa	11	8	13
Grand Cape Mount	12	8	14
Grand Gedeh	18	17	22
Grand Kru	9	19	15
Lofa	14	9	12
Margibi	13	5	10
Maryland	14	15	19
Montserrado	16	17	18
Nimba	17	17	18
River Cess	14	11	15
Sinoe	15	19	15
River Gee	13	14	17
Gbarpolu	3	13	6
Total	13	13	15
Sex			
Male	17	12	13
Female	13	14	15
Total	13	13	15

## Conclusion

The 2018 reproductive health commodities and security survey provides very essential information at this time for decision-making and thus the need for the development of an elaborate improvement plan with the involvement of all key stakeholders that can be used to strengthen the current weaknesses in the provision of reproductive health services by the study.

## *Recommendations*



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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. In consultant with the family health division procure and timely supply modern contraceptive methods across facilities with emphasis in both primary and secondary facilities to address issues of frequent stock out especially in rural settings, but also urban settings.
3. Measure should be taken against Health facilities asking for pay-for-service from visiting clients when providing family planning services, which is clearly in violation of the applicable laws especially in public facilities.
4. Though some level of training is taking place each year, but attrition has become our main weakness preventing us from keeping our qualify 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.
5. In general, there is need for Sensitization to increase the demand for some contraceptives like the IUD, female condom which are sometimes out of stock due to lack of demand.
6. 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.
7. 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.



## *ANNEXES*

### ANNEX A: BIBLIOGRAPHY

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**ANNEX B: Availability of family planning guidelines, ANC/PNC job aids and Waste disposal guidelines by type of SDPs, administrative unit, residence and management**

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	Yes	not verified	No	Yes	not verified	No	Yes	not verified	No	Yes	not verified	No
<b>Total</b>	<b>77.9</b>	<b>8.7</b>	<b>13.5</b>	<b>74</b>	<b>11.5</b>	<b>14.4</b>	<b>76</b>	<b>11.5</b>	<b>12.5</b>	<b>70.2</b>	<b>14.4</b>	<b>15.4</b>
<b>Primary</b>	71.8	12.7	15.5	71.8	11.3	16.9	71.8	15.5	12.7	67.6	15.5	16.9
<b>Secondary</b>	93.5	0	6.5	80.6	9.7	9.7	87.1	3.2	9.7	77.4	12.9	9.7
<b>Tertiary</b>	50	0	50	50	50	0	50	0	50	50	0	50
<b>County</b>	<b>Computer</b>	<b>Mobile Phones Handsets</b>	<b>Mobile phones - smart</b>	<b>Tablets</b>	<b>Internet LAN</b>	<b>Wi-Fi</b>	<b>Base radio</b>	<b>TV</b>				
									25			
									0			
<b>Grand Bassa</b>	100	0	0	100	0	0	100	0	0	100	0	0
<b>Grand Cape Mount</b>	75	0	25	75	0	25	75	0	25	75	0	25
<b>Grand Gedeh</b>	75	0	25	75	25	0	75	0	25	75	25	0
<b>Grand Kru</b>	50	25	25	25	25	50	25	0	75	25	25	50
<b>Lofa</b>	100	0	0	100	0	0	100	0	0	100	0	0
<b>Margibi</b>	20	80	0	60	40	0	20	80	0	40	60	0
<b>Maryland</b>	100	0	0	33.3	33.3	33.3	100	0	0	0	66.7	33.3
<b>Montserrado</b>	62.5	9.4	28.1	59.4	12.5	28.1	68.8	15.6	15.6	59.4	15.6	25
<b>Nimba</b>	91.7	0	8.3	83.3	8.3	8.3	83.3	0	16.7	83.3	0	16.7
<b>River Cess</b>	100	0	0	100	0	0	100	0	0	100	0	0
<b>Sinoe</b>	100	0	0	100	0	0	100	0	0	75	0	25
<b>River Gee</b>	100	0	0	75	25	0	50	50	0	50	50	0
<b>Gbarpolu</b>	100	0	0	100	0	0	100	0	0	100	0	0
<b>Total</b>	<b>77.9</b>	<b>8.7</b>	<b>13.5</b>	<b>74</b>	<b>11.5</b>	<b>14.4</b>	<b>76</b>	<b>11.5</b>	<b>12.5</b>	<b>70.2</b>	<b>14.4</b>	<b>15.4</b>
<b>Urban</b>	77	4.9	18	65.6	13.1	21.3	70.5	9.8	19.7	60.7	16.4	23
<b>Rural</b>	79.1	14	7	86	9.3	4.7	83.7	14	2.3	83.7	11.6	4.7
<b>Total</b>	<b>77.9</b>	<b>8.7</b>	<b>13.5</b>	<b>74</b>	<b>11.5</b>	<b>14.4</b>	<b>76</b>	<b>11.5</b>	<b>12.5</b>	<b>70.2</b>	<b>14.4</b>	<b>15.4</b>
<b>Government</b>	84.2	7.9	7.9	81.6	11.8	6.6	81.6	10.5	7.9	76.3	14.5	9.2
<b>Private</b>	65.4	7.7	26.9	57.7	7.7	34.6	65.4	11.5	23.1	57.7	11.5	30.8
<b>Others</b>	0	50	50	0	50	50	0	50	50	0	50	50
<b>Total</b>	<b>77.9</b>	<b>8.7</b>	<b>13.5</b>	<b>74</b>	<b>11.5</b>	<b>14.4</b>	<b>76</b>	<b>11.5</b>	<b>12.5</b>	<b>70.2</b>	<b>14.4</b>	<b>15.4</b>

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			phones					
<b>Bomi</b>	25.0	0.0	100.0	50.0	0.0	75.0	25.0	0.0
<b>Bong</b>	12.5	12.5	37.5	0.0	0.0	50.0	25.0	0.0
<b>Grand Bassa</b>	40.0	60.0	100.0	0.0	0.0	60.0	40.0	20.0
<b>Grand Cape Mount</b>	25.0	0.0	100.0	25.0	0.0	100.0	0.0	0.0
<b>Grand Gedeh</b>	50.0	50.0	75.0	25.0	0.0	75.0	50.0	25.0
<b>Grand Kru</b>	25.0	50.0	100.0	0.0	0.0	100.0	0.0	0.0
<b>Lofa</b>	25.0	25.0	37.5	0.0	0.0	62.5	0.0	0.0
<b>Margibi</b>	0.0	0.0	80.0	0.0	0.0	80.0	0.0	0.0
<b>Maryland</b>	33.3	100.0	66.7	66.7	0.0	66.7	66.7	0.0
<b>Montserrado</b>	31.3	6.3	87.5	0.0	6.3	81.3	3.2	16.1
<b>Nimba</b>	50.0	100.0	100.0	0.0	8.3	75.0	0.0	16.7
<b>River Cess</b>	0.0	75.0	100.0	0.0	0.0	100.0	0.0	50.0
<b>Sinoe</b>	0.0	25.0	100.0	25.0	0.0	100.0	0.0	0.0
<b>River Gee</b>	50.0	50.0	75.0	25.0	0.0	100.0	0.0	50.0
<b>Gbarpolu</b>	33.3	0.0	100.0	33.3	0.0	66.7	0.0	0.0
<b>Total</b>	<b>28.8</b>	<b>31.7</b>	<b>82.7</b>	<b>8.7</b>	<b>2.9</b>	<b>77.9</b>	<b>9.5</b>	<b>13.7</b>
<b>Urban</b>	44.3	32.8	88.5	9.8	4.9	73.8	7.0	19.3
<b>Rural</b>	7.0	30.2	74.4	7.0	0.0	83.7	13.2	5.3
<b>Total</b>	<b>28.8</b>	<b>31.7</b>	<b>82.7</b>	<b>8.7</b>	<b>2.9</b>	<b>77.9</b>	<b>9.5</b>	<b>13.7</b>
<b>Government</b>	23.7	31.6	85.5	10.5	1.3	86.8	7.0	11.3
<b>Private</b>	46.2	34.6	73.1	3.8	7.7	50.0	18.2	22.7
<b>NGO</b>	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
<b>Others</b>	0.0	0.0	100.0	0.0	0.0	100.0	0.0	0.0
<b>Total</b>	<b>28.8</b>	<b>31.7</b>	<b>82.7</b>	<b>8.7</b>	<b>2.9</b>	<b>77.9</b>	<b>9.5</b>	<b>13.7</b>

**Annex C: Table 54: Percentage of SDPs with types of Information Communication Technology available**