REDUCING TEENAGE PREGNANCY THROUGH INCREASED ACCESS TO SEXUAL REPRODUCTIVE HEALTH & FAMILY PLANNING SERVICES IN SOUTHEAST LIBERIA

Photo credit P4DP

BASELINE STUDY REPORT

August 2017 (Revised December 11, 2017)

Funded by:

SWEDISH GOVERNMENT/UNFPA EMPOWERED AND FULFILLED PROGRAMME

Implemented by:

Platform for Dialogue and Peace (P4DP)

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ACRONYMS

FGD	Focus Group Discussion
ASRH/FP	Adolescent Sexual Reproductive Health/Family Planning
AYFHS	Adolescent and Youth Friendly Health Services
BHC	Behwen Health Center
BRAC	Bangladesh Rural Advancement Committee
CHT	County Health Team
CODES	Community Development Services
CSE	Computer Science Engineering
FLY	Federation of Liberian Youths
FP	Family Planning
gCHVs	general Community Health Volunteers
GOL	Government of Liberia
GPS	Geographic Positioning System
HCT	HIV Counseling and Testing Center
HIV	Human Immunodeficiency Virus
KII	Key Informant Interview
LDHS	Liberia Demographic and Health Survey
LDHS	Liberia Demographic and Health Survey
LQAS	Lot Quality Assurance Survey
MIA	Ministry of Internal Affairs
MOE	Ministry of Education
MOH	Ministry of Health
MOJ	Ministry of Justice
MTI	Medical Teams International
NACP	National AIDS and STI Control Program
NGOs	Non-Governmental Organizations
P4DP	Platform for Dialogue and Peace
PSUs	Primary Sampling Units
SDGs	Sustainable Development Goals
SHR	Sexual and Reproductive Health
SIDA	Swedish International Development Agency
SPSS	Statistical Package for the Social Sciences
STIs	Sexually Transmitted Infections
VYAs	Very Young Adolescents
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
UNMIL	United Nations Mission in Liberia
USAID	United States Agency for International Development

ACKNOWLEDGEMENTS

We extend sincere thanks to UNFPA for managing and providing technical support to this project. Their support was provided throughout the design data collection phases. Special thanks also go to Brian Kironde, International Youth Specialist, and to Maybe Garmai Livingstone, Alfred Sayon, Michael Weah and Comfort Kollie for their invaluable support throughout the project's implementation.

Sincere appreciation is also extended to the Government and People of Sweden, and the Swedish Embassy near Monrovia, for the generous resources that enabled UNFPA to finance this undertaking.

We are especially grateful to the Ministry of Health, BRAC, UNICEF, Federation of Liberian Youth (FLY), and the four County Authorities for their invaluable contributions toward the completion of the fieldwork. To the entire P4DP's Team, especially- Sam Gotomo, Godfrey Eloho, Vlandy Freeman, Morris Kantuah, and Kennedy Berrain, this work would not have been possible without your untiring efforts.

Lastly, we express sincere gratitude to the youth communities and populations, and our support team - drivers, rental Car Company, etc. – who directly and indirectly contributed to this study.

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EXECUTIVE SUMMARY

This Baseline study was initiated to document the existing assets, determinants of Adolescents' access and utilization of ARSH information and services in the four (4) counties of Southeast Liberia, for the three years of the Swedish Government-funded Empowered and Fulfilled Project of UNFPA. It was also intended to guide all aspects of the project implementation.

The data represent county level conditions data which can be matched with those presented in the 2013 LDHS dataset. The project was funded by the Swedish Government, and it is being managed by UNFPA. The data collection tools were designed by P4DP with technical support from the UNFPA ASRH/FP staff. Thus, P4DP was solely responsible for data collection, processing, analysis and writing of this baseline study report.

METHODOLOGY

Both quantitative and qualitative approaches were deployed in the design, implementation, and analysis of data for this baseline study.

A multi-stage sampling method was used at the county level, and Lot Quality Assurance Survey (LQAS) was used to select sample survey in each community from a sample frame of young people provided by community leaders during initial Community Asset Mapping survey.

The data for this baseline study were collected from the twenty (20) communities that UNFPA approved for the Community Assets Mapping survey that preceded the baseline study. Thus, five (5) communities from each of the project counties constituted the Primary Sampling Units (PSUs) for this baseline study. The map in Figure 1 below provides a snapshot of the locations of the twenty (20) communities that participated in the baseline study. The map also shows the distances, in kilometres, of the communities from each other.

Data were collected through a structured questionnaire Key Informant interviews (KIIs), facilitation of Focus Group Discussion (FGDs), observation and transect walks. In order to minimize errors and ensure accuracy and integrity of the datasets, all of the data were collected electronically using the SurveyToGo electronic data collection software, which was installed on Android-powered tablets.

A Windows-powered laptop computer was set up as a server to receive the raw data in real time as they were collected and transmitted from the field, upon successful completion of each key informant interview, focus group discussion, and household survey. The raw data were subsequently cleaned and exported to SPSS software for analysis and production of tables, charts and diagrams for the baseline study report.

Figure 1: UNFPA Empowered and Fulfilled Project Communities Map with mileage

Data source: UNFPA's Empowered and Fulfilled Project Baseline Study (P4DP, 2017)

RESULTS

The following summarizes the main findings of the baseline study. The baseline survey population comprises of:

- 572 Adolescent youth consulted in 20 communities across four counties
- 55% (316) Female and 45% (256) male adolescents in all four counties
- 26% (150) of adolescent age 10-14 years and 74% (422) of adolescent youth age 15-19 years in all four counties
- 20 FGDs conducted with 160 female and male adolescent youths; 58.7% (94/160) females and 41.3 (66/160) males.
- 100 Community leaders/parents/School heads

Please refer to Table 1 below for the distribution of the 572-adolescent female and male respondents that participated in the baseline survey, disaggregated by county, gender and age group.

Table 1 below shows there were more females than males who participated in the baseline study. The data in Table 1 also show that more adolescent males above 15 years of age participated in the baseline study than the Very Young Adolescents (VYAs) (under 15 years).

Table 1: Distribution of Adolescent Respondents, disaggregated by county, gender, and age group

County	Gender	Age		
		10-14 yrs.	15-19 yrs.	Total
Grand Gedeh	Male	40	35	75
	Female	35	39	74
	Sub-Total	75	74	149
Grand Kru	Male	6	42	48
	Female	14	62	76
	Sub-Total	20	104	124
Maryland	Male	4	54	58
	Female	17	75	92
	Sub-Total	21	129	150
River Gee	Male	15	60	75
	Female	19	55	74
	Sub-Total	34	115	149
TOTAL				**572**

Data source: UNFPA's Empowered and Fulfilled Project Baseline Study (P4DP, 2017)

Table 1 also shows that there were more females than males that participated in the baseline study. Also, there were older adolescents than Very Young Adolescents (VYAs).

UTILIZATION OF SRH/FP BY YOUNG PEOPLE 10-19 YEARS

- In relation to the Utilization of SRH/FP commodity or method by young people between the ages 10-19 years, a total of 141 of the 307 of the respondents that answered the question on Utilization of SRH/FP indicated they or their partners have used a particular FP in the last 30 days before the survey, which accounted for 24.7% (141/572). This was followed by 27.1% (155/572) of the respondents who said they have not used a particular FP commodity or method in the last 30 days before the baseline survey; 1.9% (11/572) claimed that they 'don't know'. The rest of the adolescent respondents included in the sample, 46.3% (265/572), did not answer the question. This result suggests that more adolescents had not used any FP method in the last 30 days before the baseline survey.
- The rest of the adolescent respondents included in the sample i.e. 46.3% (265/572), did not answer the question. This greatly affected the statistical significance of this result because majority of respondents were not at ease answering this question and hence declined to respond despite various probing methods used by the research assistants.
- None of the adolescent female and male respondents under 15 years of age from Grand Gedeh interviewed said that they have used a particular family planning commodity or method in the last 30 days before the baseline survey.
- 14% (2/14) of the adolescent female respondents under 15 years of age, interviewed in Grand Kru, said that they have used a particular family planning commodity or method in the last 30 days preceding the survey, compared to 50% (3/6) of their male colleagues.

- 11% (2/17) of the adolescent female respondents under 15 years of age, interviewed in Maryland, said that they have used a particular family planning commodity or method in the last 30 days preceding the survey, but no male respondent reported to use family planning commodity or method in the same period.
- 42% (8/19) of the adolescent female respondents under 15 years of age, interviewed in River Gee, said they have used a particular family planning commodity or method in the last 30 days preceding the survey, compared to 46% (7/15) of their male counterparts.
- Generally, approximately a fifth (19.5%) of adolescents under 15 years have used a particular family planning service or method, with slightly more males in Grand Kru and River Gee said to have used family planning commodity or method compared to other counties.
- A proportion of the adolescent female respondents above 15 years, 23% (9/39), interviewed in Grand Gedeh, said that they and their partners have used a particular FP commodity or method in the last 30 days before the baseline survey, compared to 17% (6/35) of their male colleagues.
- 32% (20/62) of the female respondents above 15 years, interviewed in Grand Kru, said they have used a particular commodity or method of FP in the last 30 days before the survey, compared to 33% (14/42) of their male counterparts.
- 22% (17/75) of the female respondents above 15 years, interviewed in Maryland, stated they have used a particular commodity or method of FP in the last 30 days before the survey, compared to 9% (5/54) of their male counterparts.
- 31% (17/55) of the female respondents above 15 years, interviewed in River Gee, said they have used particular commodity or method of FP in the last 30 days before the survey, compared to 51% (31/60) of their male counterparts.

River Gee had the highest adolescents aged 15 years and above using SRH/FP services at 41% while Maryland had the lowest at 17%. With the exception of Grand Gedeh and Maryland, there were more male adolescents aged 15 years and above using family planning methods 30 days preceding the baseline survey.

Overall, adolescents aged 15 years and older had a higher percentage of use for SRH/FP services and methods i.e. 27.5% compared to their younger counterparts below 15 years at only 19.5%.

INCIDENCE OF TEENAGE PREGNANCY IN FOUR COUNTIES

- An average of 33% of adolescent girls in the age group of 15-19 years, interviewed in the four (4) project counties, said that they have been pregnant.
- 38% of adolescent girls in the age group of 15-19 years, interviewed in River Gee, said that they have been pregnant.
- 33% of adolescent girls in the age group of 15-19 years, interviewed in Grand Gedeh, said that they have been pregnant.
- 29% of adolescent girls in the age group of 15-19 years, interviewed in Grand Kru, said that they have been pregnant.
- 28% of adolescent girls in the age group of 15-19 years, interviewed in Maryland, said that they have been pregnant.

Generally, 39% of adolescent girls interviewed in this said that they got pregnant when they were between 17-19 years of age, while 54% of adolescent girls interviewed stated that "a girl can't get pregnant in just one exposure to sexual intercourse".

NUMBER OF HEALTH FACILITIES/HOSPITALS WITH INCREASED CAPACITY TO PROVIDE QUALITY[1] SRH/FP SERVICES TO YOUNG PEOPLE ANDREPRODUCTIVE HEALTH COMMODITIES AND SUPPLIES (RHCS) FOR YOUNG PEOPLE.

According to GoL Health Sector Assessment report (GoL, 2015), approximately 29% of the population in Liberia, particularly rural dwellers, commute for over 60 minutes or 5 kilometers to reach the nearest health facilities, in the absence of scaled Community Health Worker program. Of the 22 health facilities sampled in this baseline study, none demonstrated any capacity to deliver quality SRH/FP services, nor provide adequate reproductive health commodities to adolescents and adults alike as defined in the Ministry of Health standards and guidelines for ASRH service delivery and also benchmarking against WHO standards for Adolescent friendly SRH services. This condition existed prior to May-June 2017, the period of the baseline survey.

SOCIAL STRUCTURES[2] THAT ARE PROMOTING SRH/FP YOUNG PEOPLE'S ACCESS TO SRH AND RIGHTS

The baseline study uncovered the presence of various PTAs, CBOs, faith-based and cultural groups in all of the communities assessed; mainly for sports, community service, traditional dance, saving schemes, etc. There are no specific local structures which promote ARSH issues. However, interviews with PTA heads, community leaders and CBOs revealed the desire to cooperate with relevant organizations to create awareness about the dangers of teenage pregnancy and youth sexuality. See the Programme Mapping report that indicates all social assets in 20 communities across the four (4) project counties.

KNOWLEDGE [3]AND SKILLS ON SRH/FP INFORMATION AND SERVICES BY ADOLESCENT (10-19 YEARS)

- In assessing knowledge, the results of the baseline study show that 83% (472/572) of the adolescent respondents interviewed in the four (4) project counties said that they are not knowledgeable about SRH/FP information and services; and 17% (96/572) of the

[1] Quality SRH/FP services will be provided based upon adolescent health package consistent with national standards set by Adolescent Health Services in Liberia

[2] Social Structures include school clubs, and religious and cultural CBOs which promote access to youth friendly SRH and FP services in the four counties. See Project Logframe.

[3] In this study, knowledge refers to adequate awareness of SRH/FP, and is assessed based upon the following two criteria: 1. Information and awareness about means and methods of individual protection from STIs/HIV and unwanted pregnancy, e.g. via abstinence or the use of condom; 2. Information and awareness about at least three modern methods of family planning; 3. Information and awareness about areas of access to SRH and FP services.

adolescent respondents said that they are knowledgeable. Of the proportion of respondents that are knowledgeable, 13.1% (75/572) are adolescent females, and 3.7% (21/572) are adolescent males.

- In Grand Gedeh, 5.7% (2/35) of the adolescent female respondents under 15 years of age, said that they are knowledgeable about SRH/FP information and services, but none of the adolescent male respondents said that they have knowledge about SRH/FP information and services.
- In Grand Kru, 7% (1/14) of the adolescent female respondents under 15 years of age, said that they have adequate knowledge about SRH/FP information and services, but none of the adolescent male respondents said that they have knowledge about SRH/FP information and services.
- In Maryland, none of the adolescent female and male respondents under 15 years, said that they have adequate knowledge about SRH/FP information and services.
- In River Gee, 5.3 (1/19) of adolescents under 15 years of age, said that they have adequate knowledge about SRH/FP information and services. Compare to 5.3%(1/15) of males.
- Overall, these results show that very few adolescents (3.6%) under 15 years of age are knowledgeable about SRH/FP information and services with females knowing slightly more than males.
- Out of the 74 respondents above 15 years of age from Grand Gedeh, 33% (13/39), said that they have knowledge about SRH/FP information and services, compared to 11% (4/35) of their male counterparts.
- Out of 104 respondents above 15 years of age in Grand Kru, a high percentage of the female respondents i.e. 22% (14/62), said that they have knowledge about SRH/FP information and services, compared to 2.4% (1/42) of their male counterparts that said the same thing.
- Out of the 129 respondents above 15 years of age in Maryland, 21 % (16/75) of the female said that they are more knowledgeable about SRH/FP information and services, compared to 13 % (7/54) of their male counterparts that also said that they have knowledge about SRH/FP information and services.
- Out of 115 respondents above 15 years of age from River Gee, 51 % (28/55) of females said that they are knowledgeable about SRH/FP information and services, compared to 13% (8/60) of their male counterparts that said the same thing.
- Generally, 39% of the adolescent girls interviewed for this baseline study, said that they got pregnant when they were between 17-19 years of age.
- 50% of all of the adolescent respondents in this baseline study across the four (4) project counties favored premarital sex.

BARRIERS TO SRH/FP INFORMATION AND SERVICES BY ADOLESCENTS IN THE COUNTIES

- Only 17% of total respondents strongly agreed to the statement 'It is fine and OK with my parents to know that am in a sexual relationship'. This suggests that adolescents are prone to have secret affairs that may lead them towards negative reproductive outcomes.
- 54% of the respondents across the four counties indicated that 'a girl cannot get pregnant having sex for the first time.'

- Around 52% of the parents, especially none literate ones are barrier to SRH/FP information and services as well as influencing agents for teenage pregnancy. Parents consider it a taboo to discuss sexual matters with adolescents.

Although there are regimented health facilities, however the unavailability of Community-based Youth Friendly Centers poses barrier to young people access to SRH/FP in the entire Southeast.

GAPS IN SRH/FP POLICIES

- Most remote communities are still engaging in harmful practices such FGM in defiance of the SRH policy.
- Weak legal framework in the prosecution of those who violate laws intended to protect adolescents and promote better SRH practices.
- Disjointed and uncoordinated SRH Adolescent policies and noticeably absent of simple to understand, example SRH information in local vernaculars for community people to easily understand and know their responsibilities.
- Too many SRH policies are vague and broad.
- Lack of standardization of policy thus leading to inadequate coverage and unnecessarily complexity.
- A lack of a clarity in policy deployment and dissemination that makes policy operationally and ineffective.
- Life skills curriculum are not being taught in all schools. And wide variation between private and public schools.
- MoYS and MOE must work in unison for effective implementation and monitoring.

OPINION OF LEADERS

All of the interviewees expressed disapproval of teenage pregnancy, and blamed poverty and materialism among young girls as contributing factor for teenage pregnancy. The data 59% of respondents) from FGD sessions also corroborated this response. Community leaders interviewed expressed their willingness to permit teenagers access to SRH/FP information and services. However, expert support would be needed from relevant organizations for good results. They advocated for increased capacity and sustained presence of SRH/FP personnel within their communities.

COMMENTARY

As envisaged, the survey provides important information on a range of useful indicators and baseline data upon which the Empowered and Fulfilled Programme in the Southeast can be developed.

Utilizing Available SRH/FP Services

The survey findings show a general lack of use of SRH/FP information and services among adolescents. Less than half (46%) of the survey population admitted that they have not used a particular FP commodity useful in managing their reproductive life in the last 30 days prior the survey. Utilization of available sexual reproductive health commodity will help adolescent manage frequent unplanned sexual affairs that might have negative consequences. Thus, a better program on utilization of these commodities, void of myths, should be vigorously promoted at the community level.

Pregnancy

When it comes to pregnancy, adolescents and opinion leaders both expressed strong disapprovals of teenage pregnancy as a societal ill. Many respondents attributed its causes to poverty, peer pressure, and materialism among young females. In the survey, female respondents seemed generally averse to speaking openly about pregnancy. The survey discovered, however, that this aversion is easily overcome when more information is made available to the respondent, especially if such information pertains to the prevalence and how to prevent it. This was specifically the case in Maryland County.

Health Facilities/Hospitals With Limited Capacity To Provide Quality SRH/FP Services

The survey found a dire shortage of trained personnel and reproductive health commodities on SRH/FP. All (100%) attendant facilities in the health centers surveyed did not provide adolescents the right space to access such services. Without functional SRH/FP services, young people are less equipped to deal with sexual activities and related overtures.

Community and School-Based Structures

The existence of various associations and clubs across the communities provide ample space for young adolescents to express themselves in diverse social ways. Some of these include Social clubs, football, SUSU schemes, PTA, school clubs etc. However, none of these structures deliberately focused on SRH/FP information and services. The survey found this gap to be the result of social reticence, ie, speaking openly about teenage pregnancy or SRH/FP. Many respondents are unfamiliar and unaware that there exist specialized experts with good knowledge in term of dealing with these matters. In this regard, a helpful response would be placing SRH/FP specialist within community programs to help identify and strengthen useful socializing structures and mainstream SRH/FP activities into their programs, instead of creating new groups.

Adolescent Knowledge of SRH/FP Services

Limited knowledge of SRH/FP information and services in the Southeast is prevalent, and is borne out by our survey findings. Over 80% of adolescents interviewed demonstrated inadequate knowledge needed to guide decision-making about sexual and reproductive choices. To address this gap, more programming must be designed with awareness-creation in mind, and a corresponding practical demonstration of the means and locations of SRH/FP services in the communities, social groups, schools and other young-friendly places.

Community Level Barriers On SRH/FP Information and Services' Access by Young People Aged 10-19 Years in The Targeted Counties

The study identified a number of key community level barriers, as well as precipitating factors underlying the rise in teenage pregnancy. Some of these factors include unavailability of SRH/FP centers at community levels, inability of parents to talk about sex, myths about the damage FP commodity use can cause for future reproductive lives etc. To help young people manage their sexual and reproductive lives, greater levels of awareness and advocacy must occur at various levels of national, county and community engagement levels, involving various stakeholders, including parents, teachers, and youth leaders, religious and cultural leaders. This must be done to empower local structures with needed skills and knowledge to promote SRH/FP practices.

Some SRH/FP Interventions

The Government has made some progress towards settings standards and providing a modicum of information in SRH/FP through the following:

- Free provision FP commodity in government facilities
- Free HCT in good government facilities
- Reduction maternal mortality, STI and SRH related diseases.
- Managing the Tracking and recording of ANC and disaggregation based on age
- Teenage mothers in some communities have received skill training and employment to help be more focus on normal life

However, more sectorial engagement would be needed ensure goo results. In this regard, efforts should be made to tackle some of the gaps by expanding the range of stakeholders, i.e., going beyond mainstream actors but involving others through programs, for example, that target and recruit those who are linked cultural and religious practices. This will help remove some of the local barriers and taboos in terms of educating adolescent about the effect of SRH and teenage pregnancy. Also, there are too many broad policies and lack of effective coordination in the enforcement and implementation of SRH policy.

RECOMMENDATIONS

Based on the aforementioned, the following recommendations were noted during the Community Mapping study involving participants that were consulted through KIIs and FGDs. Others suggestions have been added by P4DP's team based on observation during the study in order help UNFPA and partner address the problem of teenage pregnancy associated with adolescents' lack of access and utilization of ARSH/FP services.

Recommendations from Baseline Survey Respondents

- Much stereotypes exists around open discussions about sexual and reproductive issues, as well as early adolescent sexuality. Many adolescents also appear to see sexual intercourse as the primary way of demonstrating valued friendship. Another common myth concerns the burden which females carry as the person, within a relationship, most responsible for contraception precautions. Survey respondents advocated for the provision of more information and awareness in order to challenge and eradicate these myths, specifically targeting schools and other youth centers.
- SRH/FP information and services must be more decentralized by establishing them in youth-friendly centers in easy-to-reach locations across communities. Respondents advocated for increased availability of information as it is more likely to increase access.
- Respondents also advocated for the need to improve community awareness about adolescent sexuality and support as a means of protecting themselves from sexually transmitted diseases such as HIV and AIDS. Testing and counselling services are also urgently needed.
- Respondents also expressed the need for programs that focus on persuasive advocacy. Such programs could appeal to the minds of parents and help them understand the importance of permitting their adolescent children access to the full range of available ASRH/FP information and services in order to prevent early pregnancy. This will enable parent to acquire better understanding how they can in tend help their children how to deal with sexual activities, until they are of accepted ages to make the right decisions about child-bearing.

P4DP Recommendations
In order to contribute to the reduction of poverty which is at the core and the roots of many cases of teenage pregnancy and early marriages, we recommend:

- More empowerment programs for girls, and greater access to education and finance for small businesses. We also recommend the strengthening of existing awareness programs educating girls on the danger and impact of early pregnancy.
- Efforts must be made to undermine existing myths about FP commodities. More programs of education and awareness are thus needed in the respect.
- To the extent possible, and within available resources, public health facilities must be equipped with trained ASRH/FP personnel and available services, while at the same time exploring the possibilities of establishing outreach posts in catchment communities more than a kilometer away.

- We advocate further actions by national ASRH/FP policy stakeholders in developing a plan of action which mandates, but also provided support to, parents in their efforts to support their children throughout adolescence. Cultural and religious communities also have a role to play in this regard.
- We also recommend the commissioning of further studies to understand other wide-ranging issues not covered under the scope of this survey. Finding from such study would aid in the development of a more holistic understand and approach to confronting early pregnancy and its adverse effects.
- Finally, there is a need for proper coordination among all ministries and agencies working on SRH policies for effective implementation and monitoring.

BACKGROUND

Liberia is recovering from 14-year civil conflict. The devastation that resulted from this conflict has come in the form of thousands of lost lives and the destruction public infrastructures, including health.

The gaps left in human capital development, harsh socio-economic conditions, coupled with increased unmet needs of adolescents in accessing sexual reproductive health (SRH) and family planning (FP) education and services have created more reproductive health difficulties for adolescent in the age range of 10-19 years. Reproductive health issues in Liberia, especially in rural communities, are taboo subjects rarely discussed by parents and young adolescents, or amongst adolescents themselves. The outcome has been high prevalence in early teenage pregnancy and STIs among teenage girls.

A report on the state of adolescent sexuality has placed the median age of first sexual debut at 16.2 years for females, and 18.2 years for males. Teenage pregnancy is at an estimated 31%; early childbirth is at 59.1%, where adolescent girls become mothers by age 19, are forced into early marriages or abortions (claiming 30% of pregnancies amongst adolescents).[4]

According to a study done by SOS in 2013, three (3) out of every nine (9) girls in Liberia would have one or two children before their eightieth birthday. Meanwhile, high prevalence of STIs/HIV/AID is observed among young adolescents, compared to adults.[5] Limited access to SRH/FP information and services continues to pose great challenges to young people's future, becoming great stumbling blocks to peace and development in Liberia. These particular challenges are further impediments to the successful achievement of Goal 3 of the Sustainable Development Goals (SDG).

Poverty is pervasive throughout Liberia. But it is more pronounced in rural communities due to the significant and historical socio-economic divides, and political inequality between Greater Monrovia and the rest of 'Hinterland Liberia'. According to a recent study, populations outside of Monrovia were 2 to 3 times more likely to have limited or no education, and belong to the poorest asset group.[6]

A government focused on investing within "development corridors" of only five counties that represent the greatest portion of the population, has resulted in limited assistance to more remote

[4] See LDHS, 2013.

[5] See reports by NACP (2014) and LDHS (2007).

[6] Vinck, Patrick and Pham, Phuong and Kreutzer, Tino, Talking Peace: A Population-Based Survey on Attitudes About Security, Dispute Resolution, and Post-Conflict Reconstruction in Liberia (June 2011). Available at SSRN: https://ssrn.com/abstract=1874025 or http://dx.doi.org/10.2139/ssrn.1874025.

communities, in particular the Southeast. Major development reports on Liberia have placed the Southeast region of the country as the most at risk to food insecurity, health and education achievements[7]. Consequently, South-eastern counties are not only considered the least developed and poorest in Liberia, but hard to access due to limited impassable roads. The geography of the region, coupled with the cost of transport and limited economies of scales, combined to make delivery of any intervention difficult and costly. All of these conditions tend to pose serious challenges for intervention meant to improve access to reproductive health and family planning services.

This baseline study, therefore, focused on the Southeast region of Liberia, comprising of Grand Gedeh, Grand Kru, Maryland, and River Gee Counties. The populations of these counties are mainly rural, with only a handful of government and NGOs services present.

RATIONALE FOR THE BASELINE STUDY

UNFPA has worked in Liberia since 1979, supporting the Government of Liberia (GOL) through programs on reproductive health, population and development, gender equality, adolescent health and HIV/AIDS. For a considerable period, UNFPA has also provided adolescent sexual reproductive health information and services, including sexuality education in over 250 schools across Liberia.

This current UNFPA program has been motivated by the relatively high incidence of teenage pregnancy among adolescents between 10-19 years of age across Liberia. These youths drop out of school or leave other technical vocational education and training geared toward moulding them into better and more productive adults.

The Swedish Government-UNFPA joint Adolescent Sexual Reproductive Health Programme therefore seeks primarily to contribute to the reduction in high teenage pregnancy in four (4) South-eastern counties, namely: Grand Gedeh, Maryland, Grand Kru, and River Gee.

In Liberia, like most of Africa, systematic and disaggregated data on adolescent and youth sexual reproductive health are hard to come by, or scanty at worst. This could be one possible explanation for the limited effectiveness of public health practitioners and programs which target specific adolescents and young groups. This situation also reflects the dire needs in existing data collection mechanisms and systems. Accordingly, the baseline study designed by UNFPA sought to address this gap by collecting and providing information about adolescents' access to SRH/FP services, as well as their levels of knowledge, attitude and skills about SRH and FP. Also sought was data on barriers in communities against SHR/FP information and services acquisition. Furthermore, this baseline study wanted to document gaps, identify factors and actors which tend to shape national and sub-national programs focusing on SRH/FP for adolescents.

Baseline Survey Objectives

The general objectives of this baseline survey were to:

- Conduct a baseline survey amongst the targeted audiences of the Empowered and Fulfilled Programme on young people aged 10-19 years;

[7] Locke, R, (September 2012) USAID Liberia Draft Fragility Assessment.

- Gather data on access to sexual reproductive health and rights, as well as family planning information and services at national and in the Programme targeted counties.

More specifically, the baseline survey:

- Investigated determinants of young people's access and utilization of sexual reproductive health and family planning information and services at households, communities, schools and health facilities.
- Assessed young people's knowledge, attitude and skills on sexual reproductive health and family planning.
- Identified community-level barriers to access of SRH/FP information and services by young people aged 10-19 years in the targeted counties.
- Established gaps, factors and actors influencing national and sub national level policies and programs on sexual reproductive health and family planning services targeting young people especially those aged between 10 and 19 years.

METHODOLOGICAL APPROACH

Survey Sample

The sample for this baseline study was fixed to a specific size per county to facilitate the use of descriptive and predictive statistical analysis techniques at the level of the county. The four project counties were purposively selected by the UNFPA based on data evidence from the 2013 LDHS that show the teenage pregnancy rate to be very high. At the County level, a multi-stage sampling was deployed in the selection of health districts in each county. Within each county, the sample was designed to be representative of the population and disaggregated by age and sex ranges (e.g., 10-17, and 18-19). See Table 1 below for the distribution.

The sampling frame for the study was adolescents (10-19 years), and the sample size was drawn from population figures of community data for each of the targeted counties using UNFPA's community mapping data. The sampling design for this baseline study was the Lot Quality Assurance Survey (LQAS) approach. In order to obtain relatively precise estimates of the quality level for the entire areas sampled, the research team deployed Lot Quality Assurance Sampling (LQAS) as part of the multi-dimensional approach for the baseline study. LQAS was considered appropriate because it can also provide data on health behaviours and health outcomes at the household level.

The first stage was the selection of health districts, in which communities were selected from each county. At the level of the health districts, 5 communities were selected using the Community Assets Mapping results.

Table 2: Primary Sampling Units (PSUs), by Community, Health District and County

S/N	Community	District	County
1.	Pennokon	Putu Health district	Grand Gedeh
2.	New Zwedru	Tchien Health district	Grand Gedeh
3.	Kpasuah	Tchien Health district	Grand Gedeh

4.	Nao Janzon	Cavalla Health district	Grand Gedeh
5.	Ziah Town	Cavalla Health district	Grand Gedeh
6.	Sass Town	Sasstown Health District	Grand Kru
7.	Gekan	Jroah Health district	Grand Kru
8.	Barclayville City	Barclayville Health district	Grand Kru
9.	Behwan City	Trehn Health district	Grand Kru
10.	Garraway City	Lower Kru	Grand Kru
11.	Pleebo	Peebo/Sodoken	Maryland
12.	Harper	Harper Health district	Maryland
13.	Karloken	Karluway #1	Maryland
14.	Barriken	Pleebo/Sodoken	Maryland
15.	Glofarken	Barabo Whorjah	Maryland
16.	New Market	Sarbo Health district	River Gee
17.	UNMIL Community	Potupo Health district	River Gee
18.	Worfiken	Sarbo Health district	River Gee
19.	Sweaken	Sarbo Health district	River Gee
20.	Gbaweleken	Tuobo Health district	River Gee

Data source: UNFPA's Empowered and Fulfilled Project Baseline Study (P4DP, 2017)

In each community, households and schools were selected for the structured questionnaire to be administered to them. For qualitative data, FGD and KII Guides were used to gather data from purposively selected FGD participants and key informants, in two phases in parallel, as follows:

Phases of Data Collection

Phase One: This centred on the Asset Mapping exercise in 20 Communities. Community leaders and other key stakeholders were interviewed and did a transect walk with research team to document community assets and produced community assets maps. HMC data from ANC record were also collected through the County Health team officials in each County.

Phase Two: Collection of community level data from adolescent youth leaders through household surveys using random sampling and the knowledge of local networks. In this phase also, FGDs and KIIs were facilitated with Adolescent youth of age 10-19 years and adults who are stakeholders of the Communities.

Phase Three: This included the gathering of qualitative data from national level stakeholders/organizations/Ministries that are shaping ASRH/FP policies and standards for Liberia.

- The Data Collection Instruments
- Sample for Qualitative Data

Key Informant Interviews (KII) involving key stakeholders of schools, health facilities and community leaders as well as parents on their views on SRH/FP issues that motivated the study. These interviews were carried out with both male and female adults with understanding of SRH/FP in each research

location. A total of 100 interviews were conducted in all four (4) Counties. No KII was conducted with adolescent youth of 10-19 years of age. The asset mapping data collection tool was designed by UNFPA with inputs from P4DP.

Focus Group Discussions (FGD) were conducted with male and female adolescents in each research location representing 58.7% (94/160) females and 41.3 (66/160) males. Participants were selected from in-school and out-of-school adolescents, mixed gender with age range of 10-19 years criteria. There was no homogenous FGD in the four (4) project counties.

Survey Instruments

The data collection tool both quantitative and qualitative were designed by P4DP in collaboration with UNFPA's ASRH focal staff. These data tools include: the survey questionnaire, key informant interview guides and the focus group discussion guide. See annex for details.

The survey questions were framed in a variety of format. Open-ended questions (questions that give fixed response choice to respondents e.g. yes/no, true/false) were used where appropriate.

Selection of Indicators

In line with the programme logframe, indicators to be included in the Baseline data collection instruments were agreed upon by both P4DP and UNFPA. Indicators were included on their program merit and priority, and thorough review of relevant information from current data sources to help strengthen the instruments.

Training and Fieldwork: Supervisors and Data Collectors

Two teams of experienced supervisors and 12 enumerators were recruited and deployed for the baseline study. The team members are mentioned in the acknowledgement section. Each team comprises of 6 Enumerators and 1 supervisor and they worked in two counties. The supervisors are graduates with vast experience in conducting health researches and all enumerators, except one who was a final year student at the University, the rest have first degree with years of experience conducting research all over Liberia. Deliberate efforts were made to balance the team in terms of gender. The role of the data collectors was to conduct surveys while supervisors facilitated all interviews and focus group discussion sessions.

Training

Supervisors were recruited months before the training on the merit of experience working on baselines and similar studies. A two (2) day workshop was organized to select capable enumerators to handle the fieldwork. 18 experienced enumerators applied and all were invited for the training but 12 were successful for the Baseline fieldwork. The training focused on understanding the rationale for the

baseline, techniques on administering the Baseline questionnaire using Android –powered tablets and how to facilitate face-face KII and FGD with community stakeholders and adolescents. The workshop climaxed with an experimental field practice on the questionnaire, KII and FGD data collection tools in non-study sites around Montserrado County that share similar characteristics with study sites. Supervisors were particularly trained on how to administer the questionnaires with electronic tablets, quality-check enumerators' work before submission to central server, check GPS location and troubleshoot whenever possible.

Fieldwork

The field work for the 20 communities in four (4) project counties was carried out simultaneously in three weeks by two research teams of 12 enumerators and 2 supervisors. Both research teams travelled to the Southeast region and stayed, each completed the targeted communities in a county and moved to the next county until the work was completed. Fieldwork in the four (4) project counties - Grand Kru, River Gee, Grand Gedeh, and Maryland – commenced late May 2017 and was completed on June 10, 2017.

Data Management

Closed-ended questions were pre-coded into the Android-powered tablets before they were administered, whereas open-ended questions were re-coded based on the responses from the field. The SurveyToGo Data Collection software was used to collect the raw data from study sites, quality-checked by supervisors and the Data based Manger/analyst, thereafter exported to Statistical Package for the Social Sciences (SPSS) V20 for analysis. Data cleaning and validation was completed on the June 15. Qualitative data from KIIs and FGDs audio recordings were transcribed and thematically coded for analysis.

Data Analysis

Data collection was done electronically through Android-power tablet with SurveyToGo software and transmitted in real-time to central server for quality check. When completed in all four Counties, the data were exported to the Statistical Package for Social Sciences (SPSS) and Microsoft excel cleaning and analysis. Analysis was carried out to run cross-tabulation, frequency counts and percentages.

Constraints and Limitations

Some of the challenges that surfaced include:

Refusal of parents especially mothers to allow their younger teenagers 10-14 years mainly females to participate in the study. Researchers with the support of P4DP's Executive Director have to use different persuasive measures- sometimes speaking to county Superintendents and influential stakeholders to intervene. Another challenge is that of poor coordination between some line Ministries and their County representative which stalled our work in some places. The research teams observed that female respondents were sometimes hesitant to divulge information about pregnancy.

Statistical Reliability and Limitation of the Data

While the research team applied every measure to ensure that data collected are accurate and present the true picture of the target population, it is important to note that adolescent girls that were consulted in this survey are only a sample of the total 'population' of adolescent girls who live in each county, district and locale the baseline study was conducted. As such, we cannot generalize that our findings apply to every girl in the age group of 10-19 years in Liberia.

Also, not all health facilities in each of the four project counties were visited rather, a sample was drawn with the assistance of the County Health Team officials. There will obviously be variances and some discrepancies when the entire local population was to be studied or taken into consideration. However, results reflecting 25-30% and above can be taken with much reliability in the context of the studied community and population.

RESULTS

Response Rate

A total of 572 adolescents in the age range of 10-19 years responded to the Empowered and Fulfilled Project baseline study, short of the initial sample of 600 planned for the baseline study. This represents a response rate of 95% achieved, which is far more acceptable for face-face baseline survey.

Across the four (4) project counties, Maryland yielded 100% response rate, Grand Gedeh and River Gee each has 99% response rate, whereas response rate in Grand Kru constituted 82%.

Twenty-eight (28) questionnaires were lost due data transmission error during data collection period, mainly from Grand Kru. Please refer to Table 1 below for the distribution of the response rate for 572 adolescent female and male respondents that participated in the baseline survey, disaggregated by county, gender, and age group.

Table 1 shows there were more females than males that participated in the baseline study. The data in Table 1 also show that more adolescent males above 15 years of age participated in the baseline study than the Very Young Adolescents (VYAs) (under 15 years). Also, there were older adolescents than VYAs.

Table 3: Distribution of Adolescent Respondents, disaggregated by county, gender, and age group

		Age		
County	Gender	10-14yrs	15-19yrs	Total
Grand Gedeh	Male	40	35	75
	Female	35	39	74
	Sub-Total	75	74	149
Grand Kru	Male	6	42	48
	Female	14	62	76
	Sub-Total	20	104	124
Maryland	Male	4	54	58
	Female	17	75	92
	Sub-Total	21	129	150
River Gee	Male	15	60	75
	Female	19	55	74
	Sub-Total	34	115	149

Data source: UNFPA's Empowered and Fulfilled Project Baseline Study (P4DP, 2017)

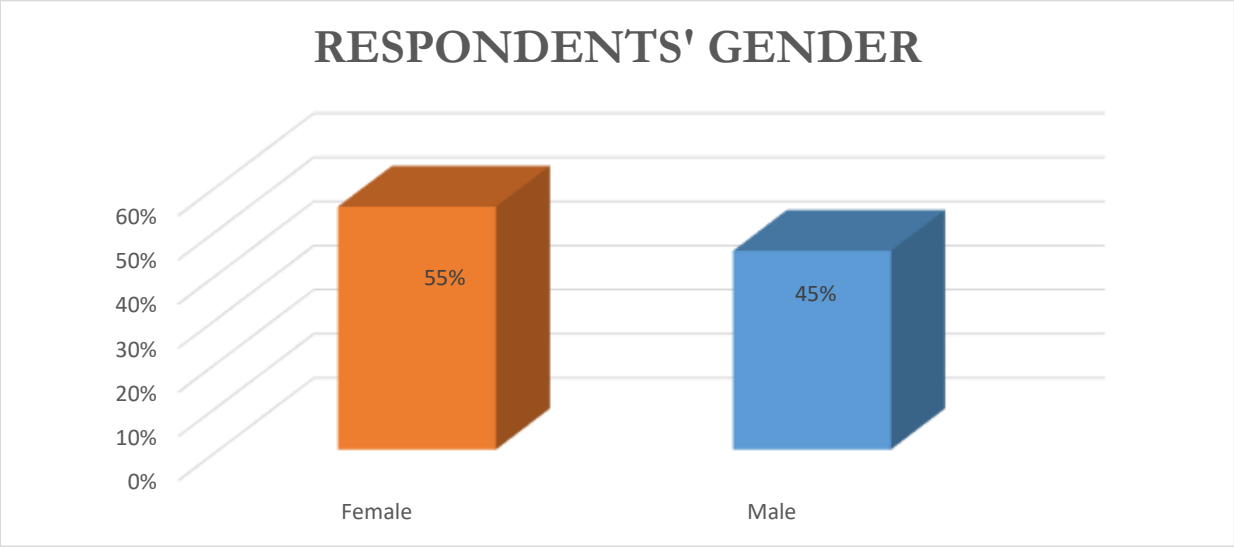
Qualitative data response rate was 98% as there was cooperation between study team and community leaders who aided in mobilizing respondents for the interviews and FGDs. There were few methodological constraints that hampered the collection of data, as listed in the methodology section above.

Respondents Demographics

Age and Gender of Respondents

Age and gender are two key variables in the Baseline study that give insights into the target groups. Other important variables are how sexual health, reproductive and family planning information are being utilized, and by which age categories and gender. The result shows that more females than male participated in the study. Figure 2 below clearly shows that 55% of respondents are females as against 45% males. The Baseline study tends to focus on the reduction of pregnancy cases in the Study areas, however, more females were willing and open to talk to enumerators even though some of them were shy at the beginning of interviews.

Figure 2: Distribution of Respondents, by Gender



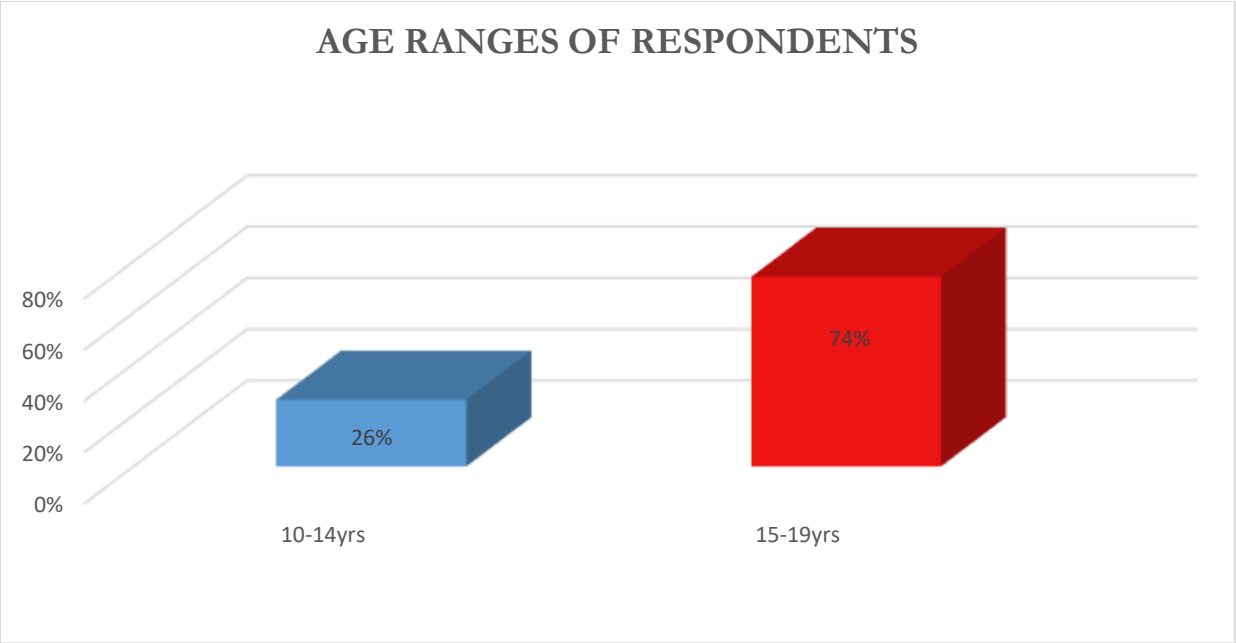
Data source: UNFPA's Empowered and Fulfilled Project Baseline Study (P4DP, 2017)

The baseline study attracted older adolescents than VYAs. Adolescents whose age category range from 15-19 years constituted 74% of total respondents; whereas younger adolescents whose ages are between 10-14 years was 26%. It can be deduced from the data that more of those adolescents 15-19 years were more willing to talk about their sexuality and related issues than the VYAs aged 10-14 years.

Also, most of the older adolescents are independent and do not need anyone's consent to talk to enumerators freely about their sexuality. On the other hand, respondents less than 15 years old were shy and in most cases their parents barred them from participating, citing that they are minors, hence do not have knowledge and experience about sexual activities.

Across the four (4) project counties, some parents also felt that allowing their VYAs daughters to participate in the study would expose them to sexual activities sooner. Based on these reasons, some Very Young Adolescent (VYA) girls who expressed interest in some of the targeted communities were not given the chance to talk about their SRH issues of the baseline study.

Figure 3: Distribution of Respondents, by Age Ranges



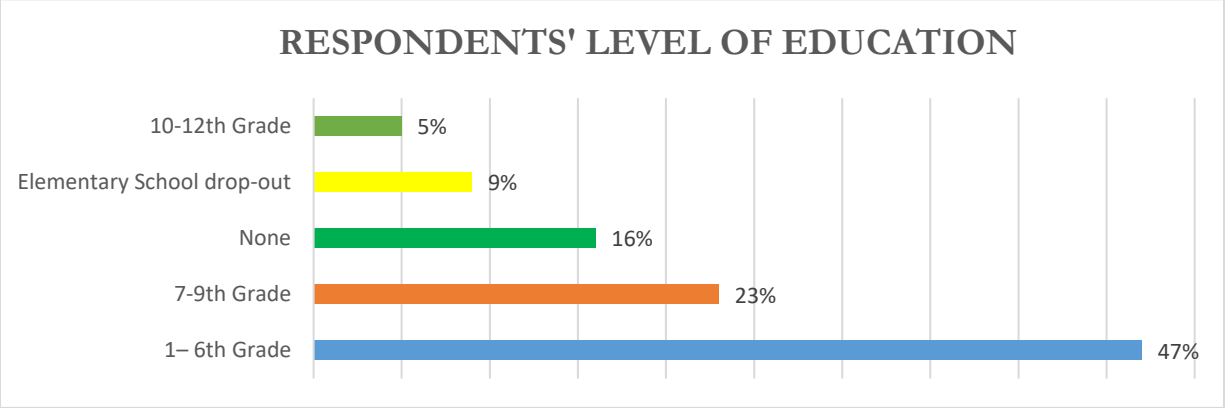
Data source: UNFPA's Empowered and Fulfilled Project Baseline Study (P4DP, 2017)

Levels of Education of Respondents

Educational attainment is an important factor in determining access to and use of SHR/FP information and services. In order to ascertain the educational levels of respondents at the time of the survey, they were asked to indicate their level of education.

The chart in Figure 4 below clearly shows that 47% of the respondents across the four counties are still at primary level of education (1st - 6th grades); followed by 23% of respondents that are at the level of junior high school (7th - 9th grades); 5% are at senior high school level of education (10th – 12th grades); 9% of respondents are primary school dropouts; and 16% of respondents said that they have no formal education.

Figure 4: Distribution of Respondents' Level of Education

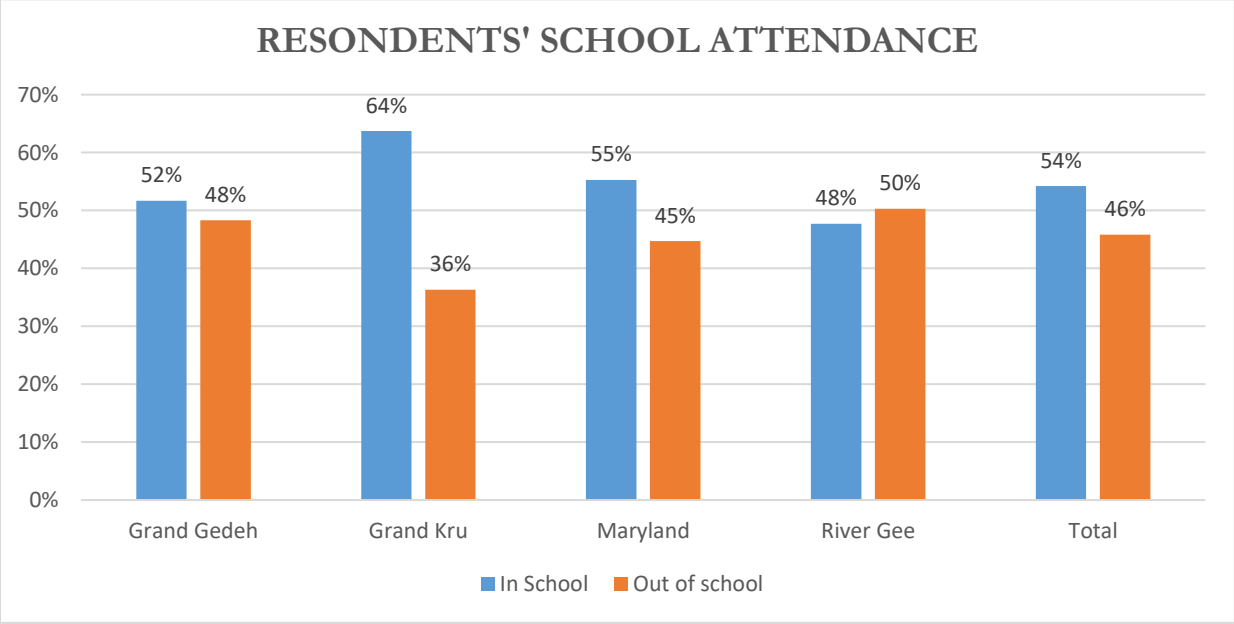


Data source: UNFPA's Empowered and Fulfilled Project Baseline Study (P4DP, 2017)

School Attendance

The baseline study design also took into consideration the in-school and out-of-school status of the adolescent respondents. The result of analysis of the baseline data shows that 54% (more than half) of the overall population of adolescents are in school, and 46% of adolescents are currently out of school. Grand Kru reported 64% of in-school adolescents followed by Maryland at 55%, Grand Gedeh 52% and River Gee recorded the lowest at 48%.

Figure 5: Distribution of School Attendance, by County



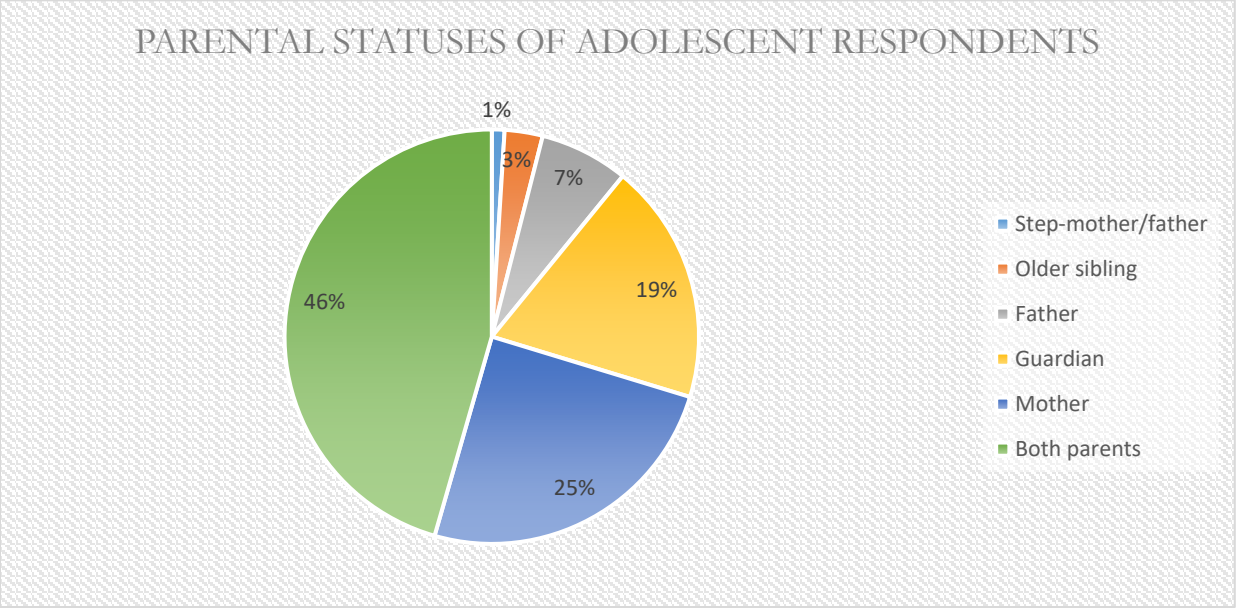
Data source: UNFPA's Empowered and Fulfilled Project Baseline Study (P4DP, 2017)

Adolescents' Background

Anecdotal evidence around adolescents in Liberia show that most of them have no parents or guardians and, therefore, engage in early sexual intercourse to make a living, thus ending up with early pregnancies.

However, the findings pointed out that most of the respondents live with both parents. As seen in the chart in Figure 6 below, 46% of the respondents said that they live with both parents; followed by 25% of respondents that said that they live only with their mothers; 19% of respondents said that they live with guardians; 7% of respondents said that they live with only their fathers; 3% of respondents said that they live with older siblings; and 1% of respondents said that they live with step mothers and fathers.

Figure 6: Distribution of Parental Statuses of Adolescent Respondents



Data source: UNFPA's Empowered and Fulfilled Project Baseline Study (P4DP, 2017)

The following chapters of the report is presented at two levels, the general results, which encapsulates the four (4) project counties, and county specific results, which basically uses proportion of each county's population.

CHAPTER 1

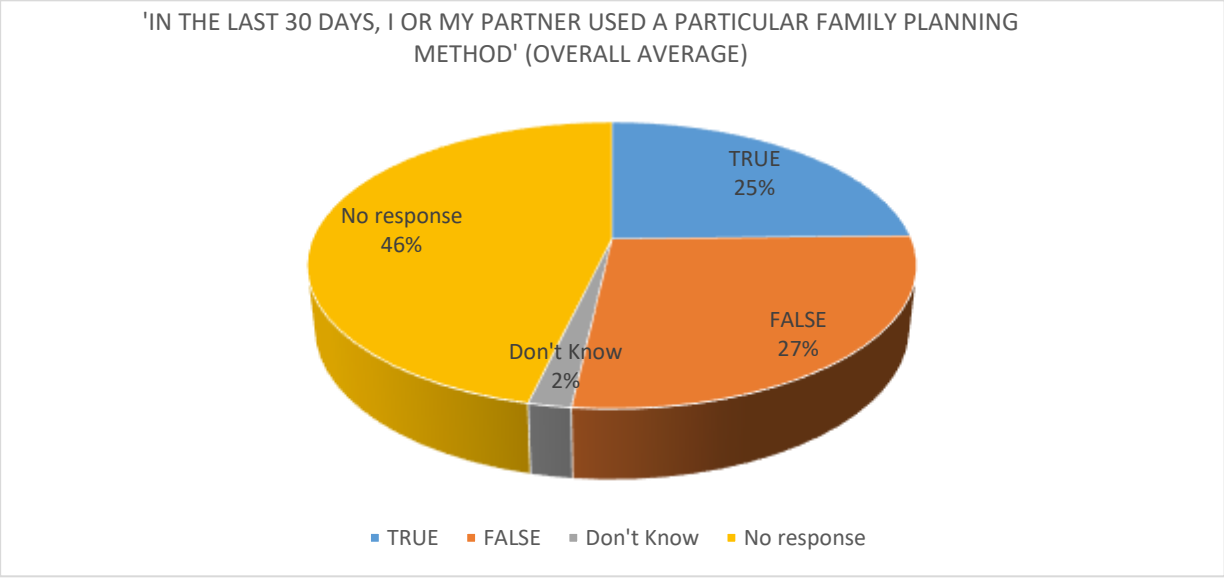
DETERMINANTS OF YOUNG PEOPLE'S ACCESS AND UTILIZATION OF SEXUAL REPRODUCTIVE HEALTH AND FAMILY PLANNING INFORMATION AND SERVICES

This section of the report focused on determinants of adolescent's access and utilization of SRH/FP information and services. Specifically, the report looks at the utilization, knowledge, incidence of pregnancy among teenagers.

To gauge SRH/FP commodity usage among adolescents in the age range of 10-19 years, adolescent respondents were asked to indicate, using 'true, false or don't know' options, to the question 'in the last 30 days, I or my partner used a particular family planning method'. More than half of the total 53.6% responded to the question compared to 46.3% that did not respond. The latter comprises of two categories- those that did not want to divulge this sensitive personal information, and the rest who claimed they are not in sexual relationship which determines utilization of a family planning method. The responses varied by age categories and counties.

On the overall, finding on the variable shows that most 24.7% (141/572) of the adolescents 10-19 years indicated 'true', meaning they or their partners have used a particular FP in the last 30 days prior the survey. This was followed by 27.1% (155/572) of the respondents who said they have not used a particular FP commodity or method in the last 30 days before the baseline survey, whereas 1.9% representing 11/572 stated 'don't know'. See Figure 9 below for distribution of responses to the question 'In the last 30 days, I or my partner used a particular family planning method, overall average. This result suggests that more adolescents in the four Counties have not used any FP method in the last 30 days before the baseline survey.

Figure 7: Distribution of Contraceptive Prevalence Rate (CPR) among Adolescent Respondents



Data source: UNFPA's Empowered and Fulfilled Project Baseline Study (P4DP, 2017)

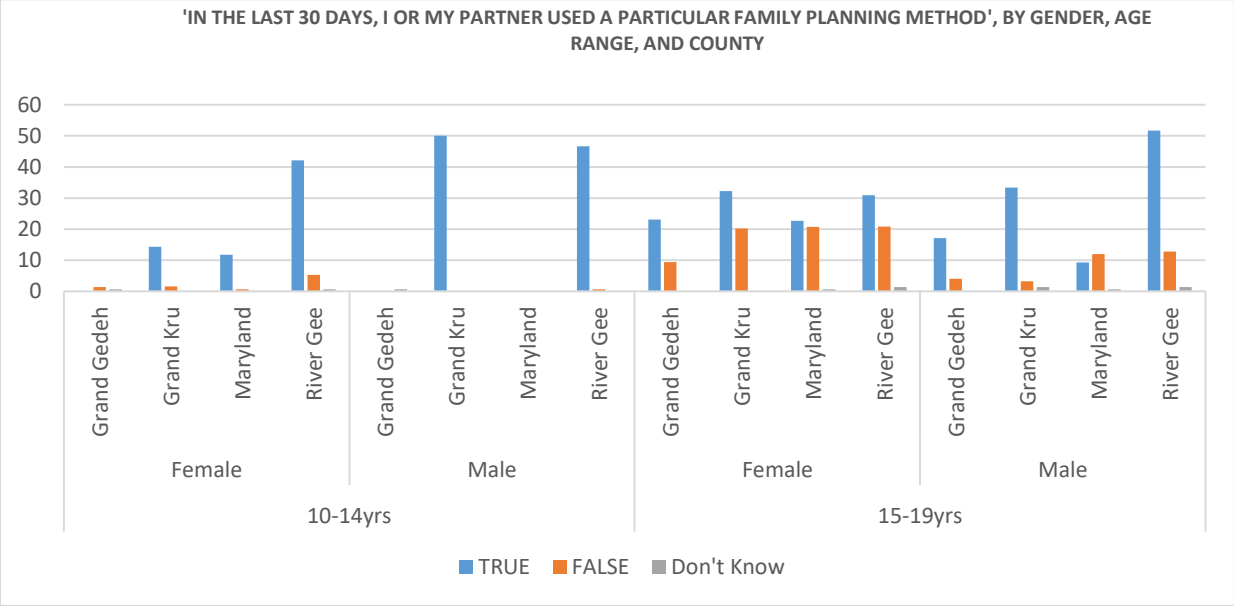
- Around 42% (8/19) of the adolescent female respondents under 15 years of age, interviewed in River Gee, said that they have used a particular family planning commodity or method in the last 30 days preceding the survey, compared to 46% (7/15) of their male counterparts. Though the general utilization level is very low, this reflects a slightly higher utilization among females than males. In Grand Kru County, more males 50% (3/6) reported having used a family planning method in the last 30 days against 14% (2/14) of females. This suggests a slightly higher utilization among male than females. 11% (2/17) of the adolescent female respondents under 15 years of age, interviewed in Maryland, said that they have used a particular family planning commodity or method in the last 30 days preceding the survey, but no male reported utilization of a family planning method in the same period. No female or male respondent under 15 years of age respondent to the question on the use of a particular family method in the last 30 days preceding the survey. This could be linked to lack of awareness about any family planning method or uneasiness in responding.
- On the overall, approximately a fifth (19.5%) of adolescents under 15 years have used a particular family planning service or method, with slightly more males in Grand Kru and River Gee using compared to other counties.

The result for young adolescents above 15 years of age is slightly different from those under 15 regarding the utilization of contraceptives in month before the survey.

- Around 31% (17/55) of the female respondents above 15 years, interviewed in River Gee, said they have used particular commodity or method of FP in the last 30 days before the survey, compared to 51% (31/60) of their male counterparts. Among 15-19 years adolescents in Grand Kru County, 32% (20/62) of the female respondents seem to have used a family method before the survey whereas 33% (14/42) of their male counterparts indicated same. Even though less than half of the population (27.4%) claimed to have used a particular FP method, more females have used family planning than males. This could be as a result of male always heaping contraceptive burden on females. For adolescent respondents above 15 years interviewed in Maryland County, 22% (17/75) of the females noted that they have used a certain family planning method in the last 30 preceding survey. This was followed by the 9% (5/54) of males who expressed similar position. Grand Gedeh adolescent respondents above 15 years of age appeared the least to have used a certain family planning method in the last month before the survey took place, compare to the rest three stated above. Around 23% (9/39), of female respondents in Grand Gedeh County stated they or their partners have used a particular family method while 17% (6/35) male colleagues stated same position.
- Across the four (4) project counties, River Gee County had the highest adolescents aged 15 years and above using SRH/FP services at 41% and Maryland the lowest at 17%. With the exception of Grand Gedeh and Maryland, there were more male adolescents aged 15 years and above using family planning methods 30 days preceding the baseline survey.

Overall, adolescents aged 15 years and older had a higher percentage of use for SRH/FP services and methods i.e. 27.5% compared to their younger counterparts below 15 years at only 19.5%.

Figure 8: Distribution of Contraceptive Prevalence Rate, by Gender, Age Range, and County



Data source: UNFPA's Empowered and Fulfilled Project Baseline Study (P4DP, 2017)

NUMBER OF HEALTH FACILITIES WITH CAPACITY TO PROVIDE QUALITY SRH/FP SERVICES TO YOUNG PEOPLE

This section of the report investigated heath facilities with capacities to provide quality and youth friendly SRH information and services as well as those without stock-outs for RH commodities and supplies that include contraceptives, RH drugs and kits and equipment. The study found that all the 22 facilities visited, none of them meet up with the six criteria for a functional youth center with adequate capacity as well as having stock out issue during the time of the survey – May-June, 2017. See Table 2 below for the distribution of health facilities visited.

Some of the communities and OIC attached to these health facilities during interviews claimed that their health facilities have SRH capacity and personnel assigned as well as space for outreach activities. However, most of these facilities, their outreach activities are done in market places, schools and community town halls at intervals. This goes to show that one facility meets up to three of the six criteria of Youth Friendly Center to adequately serve the SRH/FP needs of young people. Most of them have criteria two and three providers' competence and appropriate package of services. Apart from County Health Team members that help do the talk and display posters of SRH, the CHVs in each location that sometime anchor these outreaches for all adolescents and other targeted groups. Most of the facilities visited where SRH services are partially available are government owned, except one is owned by private individual in River Gee and two that are owned by the Catholic Church in Grand Gedeh and Maryland.

The government through National Drug Stores (NDS) is the main supplier of all RH commodities, with support from International Development partners like USAID and UNFPA, RH commodities are procured and handed over to NDS as part of the supply chain stock. A critical analysis of the health system, mostly in rural community reveals regular unavailability of drugs. In most cases because

majority health facilities are inaccessible due to deplorable road condition coupled with distance, it takes months to deliver SRH commodities and other essential drugs to the hospitals and health facilities in the Counties and subsequently communities.

Table 4: Distribution of Health Facilities in the four Project Counties

County	Health Facilities
Grand Gedeh	Christ the King Catholic Clinic, New Zwedru Martha Tubman Memorial Hospital(MTMH), Kpasuah Pennokon Clinic, Putu Pennokon Nao Janzon Clinic, Nao Jazon Zia Town Clinic. Ziah Town
Grand Kru	Barclayville Health Center, Barclayville City Behwen Health Center (BHC) Buah Health Center, Geken Community Domo Nemene Memorial Maternal Hospital. Sasstown Garraway Clinic, Garraway City
Maryland	Barriken Clinic, Barriken Glofarken Clinic, Glofarken Community J.J. Dossen Medical Hospital, Harper City Sacred Health Catholic Health Center, Harper City Josephine Allen Clinic, Harper City Karloken Clinic, Karloken City Pleebo Health Center, Pleebo City
River Gee	Tuobo Clinic, Gbeweleken Community Fishtown Referral Hospital, New Market Community Sarbo Health Center, Sweaken Life Support Clinic, UNMIL community
Total	22

Data source: UNFPA's Empowered and Fulfilled Project Baseline Study (P4DP, 2017)

INCIDENCE OF TEENAGE PREGNANCY IN THE FOUR COUNTIES

The incidence of teenage pregnancy is a major issue in the minds of residents of the four project counties covered by this baseline study. Young girls who the baseline study targeted are getting pregnant at a rate that seems abnormal, thus making girls to be left behind by their male counterparts considered as perpetrators of unwanted teenage pregnancies. Three data sources were used to assess pregnancy rate in the four counties. These include the baseline survey, Ante-natal Care(ANC) record and the 2013 LDHS.

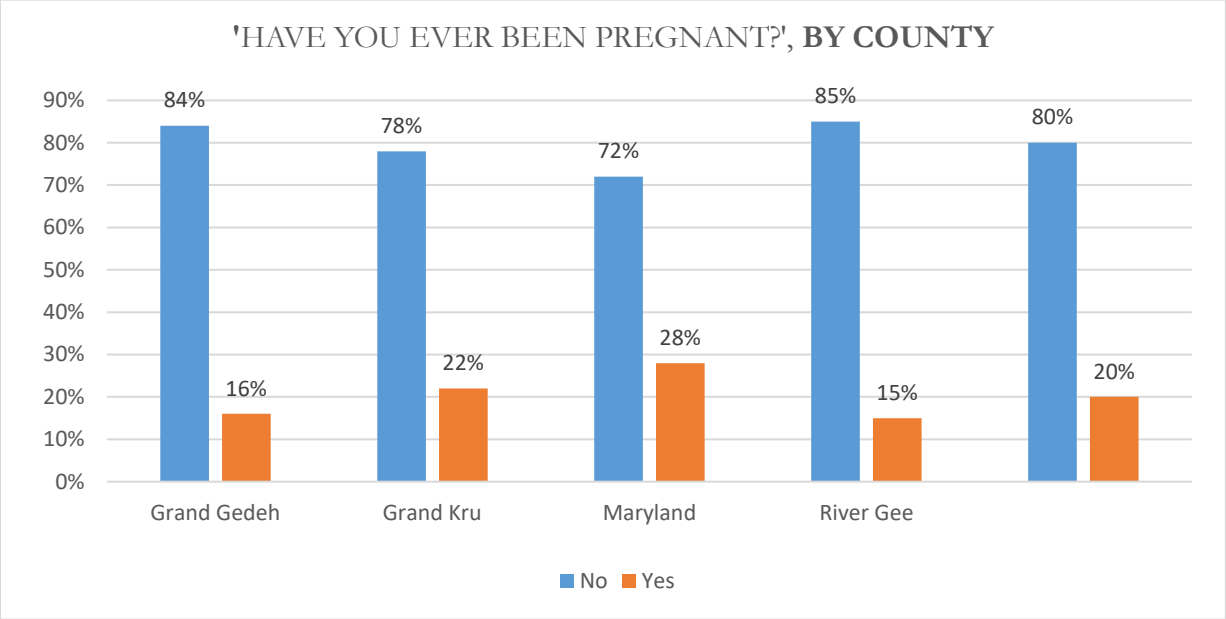
On the percentage of adolescent girls who have ever been pregnant, more adolescent girls (80% - 171/212) in the age range of 15-19 years indicated that they have not been pregnant, compared to 20% (41/212) who said that they have been pregnant, as the chart in Figure 9 depicts. This is also due to the reticence among females in this age category to give pregnancy information.

The research team observed that some adolescent female respondents were not too free to discuss their pregnancy outcomes, and those who did were shy in expressing their views. This varied from county to county.

More adolescent girls in answering the question 'who has ever been pregnant', 28% of adolescent female respondents from Maryland said that they have been pregnant; this is followed by 22% of adolescent female respondents from Grand Kru who said that they have been pregnant; 16% of adolescent female respondents from Grand Gedeh said that they have been pregnant; and 15% of adolescent female respondents from River Gee said that they have been pregnant.

On the overall, 20% of adolescent female respondents from the four (4) project counties said that they have been pregnant. This baseline data shows that there are more pregnancies occurring among the adolescent girls in the age range of 15-19 years in Maryland, than in the other three (3) project counties. The total response rate, 45%, was higher among respondents in River Gee County.

Figure 9: Distribution of Teenage Pregnancy Rate, by County



Data source: UNFPA's Empowered and Fulfilled Project Baseline Study (P4DP, 2017)

Data on teenage pregnancy was also gathered from antenatal care (ANC) records available in selected health facilities in the four project counties. However, these primary data from adolescent girls were compared with HMC data for young women who attended Ante-Natal Care (ANC) at those health facilities in the four counties in 2016.

The ANC data shows that 38% of pregnant young women in the age range of 10-19 years from River Gee received ANC at the health facilities included in the sample; this was followed by Grand Gedeh (33%); Grand Kru (29%); and Maryland (28%). In general, an average of 33% of adolescent girls in the age group of 15-19 years, interviewed in the four (4) project counties, said that they have been pregnant. See Table 3 below for comparative date on child births by adolescent girls and yound women in the four (4) project counties, by three different data sources.

From comparison of the primary data obtained from the baseline survey on teenage pregnancy with LDHS 2013 and the HMCs datasets, it can be inferred that teenage pregnancy still remains a serious societal problem in the southeast. It is understandable that the 2013 LDHS has a larger sample than the baseline survey. The research team observed that some of the adolescent girls were reticent about their pregnancy history, thus a true picture of the issue was not painted by these girls. For this reason, ANC data seem more plausible to be cited and used is final finding on the pregnancy data. However, the ANC data which were generated from the accumulated number of visits that pregnant adolescent girls made to the health facilities across the four (4) project counties, which are correct and are close to 2013 LDHS results.

Comparing these data with the 2013 LDHS, Grand Gedeh has the highest percentage (52.2%) of adolsecent girls that have birthed a child, in the age range of 15-19 years; this was followed by Grand Kru with 41% adolscent girls in the age range of 15-19 years; River Gee with 38.4% of adolscent girls in the age range of 15-19 years; and the lowest was Maryland with 31.8% of adolscent girls in the age range of 15-19 years that have had a child or children.

Table 5: Distribution of Data on Child Births by Adolescent Girls, by Data Sources

County	Baseline	HMC	2013 LDHS
Grand Gedeh	16%	33%	52%
Grand Kru	22%	29%	41%
Maryland	28%	28%	32%
River Gee	15%	38%	38%

Data source: UNFPA's Empowered and Fulfilled Project Baseline Study (P4DP, 2017)

The comparative data tabulated for pregnancy rates indicates that teenage pregnancy among adolescent girls in the age range of 15-19 years is highest in River Gee, followed by Grand Gedeh Grand Kru, and is lowest in Maryland.

From the foregone results on teenage pregnancy, the findings show that while there are slight differences between 2013 LDHS and HMC, there exists a higher difference between HMC and the primary data obtained from the baseline survey. On the basis of this, the baseline study concludes that the available data from ANC records through the HMC reflect the actual current picture. Thus, that should guide the planning and implementation of program activities, which can help to further reduce the prevalence rate of teenage pregnancy in the four (4) counties that UNFPA's Empowered and Fulfilled program is targeting in Southeast Liberia. The baseline survey will not be adequate to conclude this particular variable due to female respondents' bias and reluctance to give full information, but only provided "socially acceptable" responses to the question on teenage pregnancy.

The qualitative data obtained from focus group discussions with adolescent participants, and key informant interviews conducted with local leaders, indicate that most unintended teenage pregnancies are the result of peer pressure, mothers' desires for grandchildren, cravings for material things, and poverty. In the perspectives of the respondents, these are the major causes of pre-marital sex that is driving up the numbers of unintended teenage pregnancies among adolescent girls that frequently drop out of academic schooling, and/or skills training geared towards improving their socio-economic livelihood outcomes in society. A parent in Grand Kru averred;

"Some of the reasons that are leading young girls to getting pregnant is greediness, because their desire for material things is high. A lot of beautiful things are coming and most of them do not have the money, and because they do not have the money and they want those things, they are forcing themselves on men and getting into early sexual activities."

Additionally, adolescent girls in the age range of 10-19 years were asked to indicate their ages at first pregnancy. The result of analysis of the baseline data obtained from respondents shows the following:

71% of the respondents noted that they got pregnant when they were between 15-19 years of age;

29% of the respondents said they were between under 15 years of age when they got pregnant; and

On county basis, 13%(8/62) of adolescent female respondents in Grand Kru County said they were in the age range of 15-19 years when they had their first pregnancy; compare with 29%(4/14) under 15 years. 4%(3/75) female respondents from Maryland said they had their first pregnancy when they were above 15 years of age and none under 15 responded

In River Gee 25%(14/55) of adolescent female respondents from stated that they were in the same age range (15-19 years) when they had their first pregnancies whereas 32%(6/19) said they were under 15 years. None of the under and above 15 years of age respectively from Grand Gedeh county answer the question on age at first pregnancy.

HOW OLD WERE YOU WHEN YOU HAD YOUR FIRST CHILD' FOR ADOLESCENT GIRLS AGE 10-19, BY AGE RANGE AND COUNTY

This finding suggests that older adolescent girls in the age range of 1-19 years are more likely to get pregnant than the VYAs females in most of the project counties. In River Gee, more VYAs tend to get pregnant than their older counterparts. It is important that this variation in age of pregnant females should be looked into in terms of varying programs that address specific age ranges.

Table 4: Distribution of 'First Time Pregnancies', by Age Range and County

County	Between 15-19yrs	%	Less than 15yrs	%	Total
Grand Gedeh	0	0	0	0	0
Grand Kru	8	12.9	4	28.6	12
Maryland	3	4	0	0	3
River Gee	14	25	6	31.6	20
Total	25	42.4	10	60.2	35
Total %	**71**		**29**		

Data source: UNFPA's Empowered and Fulfilled Project Baseline Study (P4DP, 2017)

STRUCTURES (SOCIAL ASSETS) THAT PROMOTE SRH/FP

According to the project logframe, social structures are the available assets (structures) in the communities, such as schools, churches, etc., that help promote SRH/FP programs and activities to help adolescent youths make the right choices about their sexuality. The baseline study found that every community selected for the Community Assets Mapping and the baseline surveys have social associations and clubs for young people for purposes other than SRH/FP. For example, some of the primary activities of almost all of the social groups in all of the selected communities are birthday celebration events, common welfare, personal asset building through savings, sporting activities, and cultural activities (traditional dancing, etc.).

Grand Gedeh County

All Social groups in Grand Gedeh County do actively engage in others social activities, such as birthday celebrations, susu clubs, traditional dancing, among others. There is none that is directly focusing on SRH/FP issues, but sometime those involved in advocacy touch on the SRH/FP issues from the empowerment angle. A case in point was stated by the Youth Leader from Maryland, thus:

"*Maryland Youth Association is into peace building, advocacy on mob justice and educating and advising young girls to not be carry away by what they see a man has on him and they prevent themselves getting pregnant while they are not ready for pregnancy.*"

Grand Kru County

There is no community-based organization that is involved in the distribution SRH/FP commodities to health facilities, nor rendering services to adolescents. One local non-government organization (LNGO) called Community Development Services (CODES) was mentioned. This LNGO is mainly involved with advocacy and local infrastructure development, but they sometimes include SRH/FP outreach activities in their work. It will be a viable LNGO to work with in the implementation of ASRH program activities, and it has local networks in most of the communities. The domicile community social groups are primarily involved in sports, susu clubs (revolving credit), birthday celebrations, traditional war dance, among others.

Maryland County

Among all of the associations and social clubs found in Maryland County, there is none that has a deliberate focus on ASRH, nor is there any that are directly involved in the suppliers of SRH/FP commodities, or assisting with dissemination relevant SRH information. Rather, local social groups are primarily involved in sports, susu (financial), birthday celebrations, traditional war dancing, among others.

River Gee County

All of the social groups in River Gee County are mainly focused on Savings Clubs, birthday celebrations, and traditional dancing activities. None has been involved in SRH/FP activities. All of the social groups have various interests, but none is focusing on SRH/FP directly, but, according to them, they are willing to incorporate ARSH services if they are supported.

CHAPTER 2

YOUNG PEOPLE'S KNOWLEDGE, ATTITUDE AND SKILLS ON SEXUAL REPRODUCTIVE HEALTH AND FAMILY PLANNING

This chapter of the report presents findings about adolescents' knowledge, attitude and skills on sexual reproductive health and family planning, from the four (4) project counties of Grand Gedeh, Grand Kru, Maryland, and River Gee.

Limited Knowledge about SRH/FP among Adolescents 10-19 Years of Age

In order to ascertain the level of knowledge on sexual and reproductive health and family planning that adolescents in the age range of 10-19 years in the four counties- Grand Gedeh, Grand Kru, Maryland and River Gee, they were asked the following three questions, of which all answers must be in the positive to determine the level of knowledge.

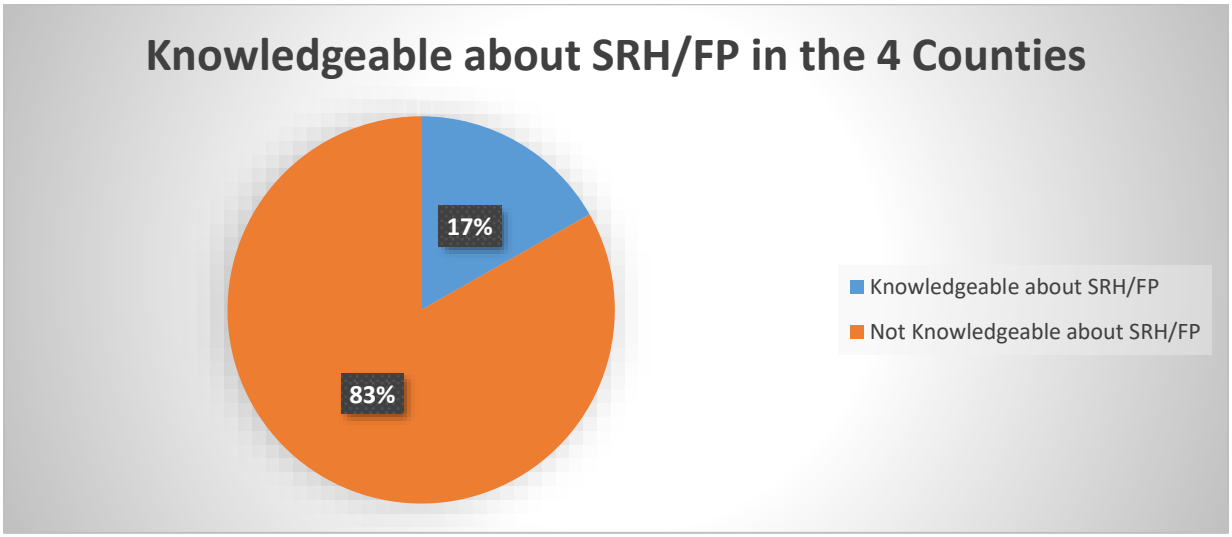
'I know how to get free and confidential emergency family planning materials' (Yes or No);

"what types of family planning services are available to you?'; and

'Have you ever visited a health facility or doctor of any kind to receive services or information on family planning, pregnancy, abortion or sexually transmitted diseases?'

The number of adolescents who responded positively to these questions were used to calculate the average for those who are knowledgeable, and vice versa. See figure 12 below for the distribution. In general, most adolescent respondents 83%(476/572) across the four project counties demonstrated lack of adequate knowledge about SRH/FP information and services. Also, 17%(96/572) of the respondents noted they have adequate knowledge about SRH/FP information and services. This connotes that majority of adolescents in the age range of 10-19 years in the four counties in Southeast Liberia do not have adequate knowledge of SRH/FP information and services. Such low level of knowledge speaks volume about the possible causes of high risk of sexual outcomes such as unintended teenage pregnancies, sexually-transmitted infections (STIs), etc. Also, most of the respondents that are knowledgeable are females 13.1% (75/572) while 3.7% (21/572) are adolescent males.

Figure 10: Distribution of Knowledge about Sexual Reproductive Health/Family Planning



Data source: UNFPA's Empowered and Fulfilled Project Baseline Study (P4DP, 2017)

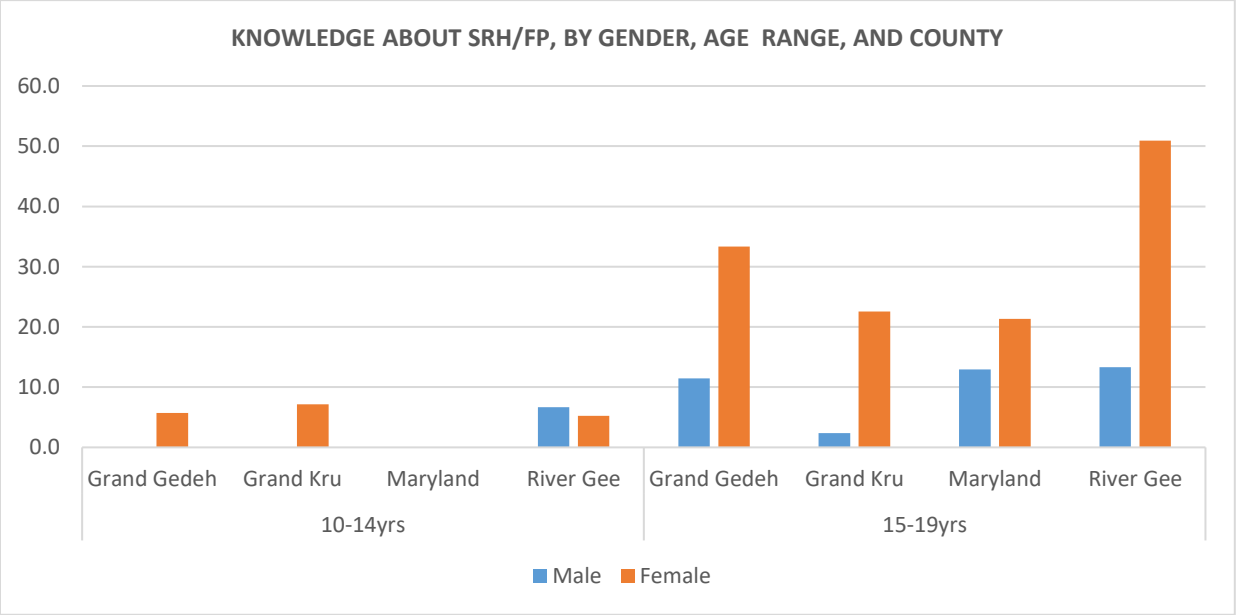
On County basis, the study shows that the VYAs are less likely to have adequate knowledge about SRH/FP information services than older adolescents especially females across the spectrum of the four counties. See figure 13 below for details.

- Around 5.7% (2/35) of the adolescent female respondents under 15 years of age in Grand Gedeh, said that they are knowledgeable about SRH/FP information and services, but none of the adolescent male respondents said that they have knowledge about SRH/FP information and services. This is followed by 7% (1/14) of the adolescent female respondents under 15 years of age from Grand Kru County, said that they have adequate knowledge about SRH/FP information and services, but none of the adolescent male respondents said that they have knowledge about SRH/FP information and services. For under 15 years adolescents from River Gee County, 6.7% (1/19) of adolescent female respondents under 15 years of age, said that they have adequate knowledge about SRH/FP information and services, compared to 5%(1/15) of males.
- Meanwhile, in Maryland County, none of the adolescent female and male respondents under 15 years, said that they have adequate knowledge about SRH/FP information and services. On the overall, these result show that only a minute proportion of the adolescent female respondents under 15 years of age are knowledgeable about SRH/FP information and services, compared to their male counterparts' complete lack of knowledge about SRH/FP information and services.
- Generally, these results suggest that very few adolescents (3.6%) under 15 years of age are knowledgeable about SRH/FP information and services with females knowing slightly more than males.
- More adolescent female respondents 51 % (28/55) above 15 years of age from River Gee County stated that they are knowledgeable about SRH/FP information and services, compared to 13% (8/60) of their male counterparts. This reflects more females being in the know than males of the same age category. For the female and male adolescent respondents above 15 years of age interviewed in Grand Kru, a high proportion 22% (14/62), of females,

posited they have knowledge about SRH/FP information and services, compared to 2% (1/42) of their male counterparts.

- Around 21 % (16/75) of female respondents above 15 years of age interviewed from Maryland, said they have adequate knowledgeable about SRH/FP information and services, compared to 13 % (7/54) of their male counterparts that have knowledge about SRH/FP information and services. Meanwhile, in for the adolescent female and male respondents above 15 years of age, a proportion of the female respondents 33% (13/39) interviewed in Grand Gedeh, said that they have knowledge about SRH/FP information and services, compared to 11% (4/35) of their male colleagues.
- On the overall, more adolescents (21%) above 15 years were knowledgeable of SRH/FP compared to their counterparts under 15 years (3.6%) and females were more knowledgeable than males.
- When asked if they will wait for marriage before sex, 50% of all of the adolescent respondents in this baseline study across the four (4) project counties favored premarital sex. The drive for sex in a premarital relation have a high propensity for unplanned pregnancy to occur.

Figure 11: Distribution of Knowledge about Sexual Reproductive Health and Family Planning



Data source: UNFPA's Empowered and Fulfilled Project Baseline Study (P4DP, 2017)

The adolescent respondents were asked, using the Like it scaled-question of 'agree' or 'disagree' to the statement, '*I will put off having sex until I meet someone I will live with'*. A significant number of the adolescent respondents contended that they will not put off sex until they meet someone they are ready to live with for the rest of their lives. As the chart Figure 14 below shows, 50% of the adolescent respondents disagreed with the statement; 38% of the respondents agreed; 8% of the respondents were unsure; and 4% of the respondents strongly supported the statement. These results show that the more than half of adolescents are inclined towards not waiting for marriage before engaging in sexual relationships.

County wise, table 14 below shows the detail distribution of responses across the four counties. Out of the total population, 60.7% of the adolescent respondents from Maryland and 59.7% from Grand Kru, respectively, indicated that they will not put off having sexual intercourse until they are married. This signifies that the majority of adolescents are inclined not to wait for someone that they will live with before engaging in sexual relationships. This is followed by 40.3% from River Gee County and 38.9% from Grand Gedeh County. However, 48% of the respondents from River Gee and 46% from Grand Gedeh, respectively, agreed with the statement, which suggests that they feel comfortable putting off pre-marital sex, unlike the respondents in Grand Kru and Maryland.

Figure 12: Distribution of Pre-Marital Sex Rate, by County

I'll put off having sex until I meet someone I will live with					
County	Agree	Disagree	Strongly agree	Unsure	Total
Grand Gedeh	69	58	7	15	149
%	46.3%	38.9%	4.7%	10.1%	100.0%
Grand Kru	38	74	1	11	124
%	30.6%	59.7%	0.8%	8.9%	100.0%
Maryland	40	91	5	14	150
%	26.7%	60.7%	3.3%	9.3%	100.0%
River Gee	71	60	11	7	149
%	47.7%	40.3%	7.4%	4.7%	100.0%
Total	218	283	24	47	572
%	38.1%	49.5%	4.2%	8.2%	100.0%

Data source: UNFPA's Empowered and Fulfilled Project Baseline Study (P4DP, 2017)

CHAPTER 3

COMMUNITY LEVEL BARRIERS ON SRH/FP INFORMATION AND SERVICES' ACCESS BY YOUNG PEOPLE AGED 10-19 YEARS IN THE TARGETED COUNTIES

This chapter presents findings on barriers that hinder adolescents' access to SRH/FP services and information. The baseline study asked various questions to the adolescent respondents to help understand barriers to SRH/FP information and services in the four (4) project counties.

To know if the parents of the adolescents sampled are aware of their sexual activities, the adolescent respondents were asked if 'it is fine that their parents know if they are in sexual relationships'. 50% of the adolescent respondents 'disagreed' with the statement; 34% of respondents 'agreed' that parents should be aware of their sexual relationships; and 17% of respondents 'strongly agree'. See table 15 for detail distribution.

These results indicate that the sexual affairs of the majority of adolescent respondents interviewed are secret that parents do not know about. This indicates that the majority of parents might object to the sexual relationships of their adolescent children, hence adolescent girls tend to keep it secret, which may also lead adolescents to conceal their preference for SRH/FP services and information.

On county basis, 56% of respondents from River Gee and 50% of respondents from Grand Gedeh, respectively, indicated that it is not fine that parents know about their adolescent children's sexual relationships; 48% of respondents from Maryland and 47% of respondents from Grand Kru, respectively, disagreed that it is not fine that parents know about their sexual affairs. This could be an indication that they do not want to be controlled or guided in their choice of sexual partners by their parents.

Figure 13: Distribution of Knowledge of Parents/Guardians' about Adolescents' Pre-Marital Sexual Relationships

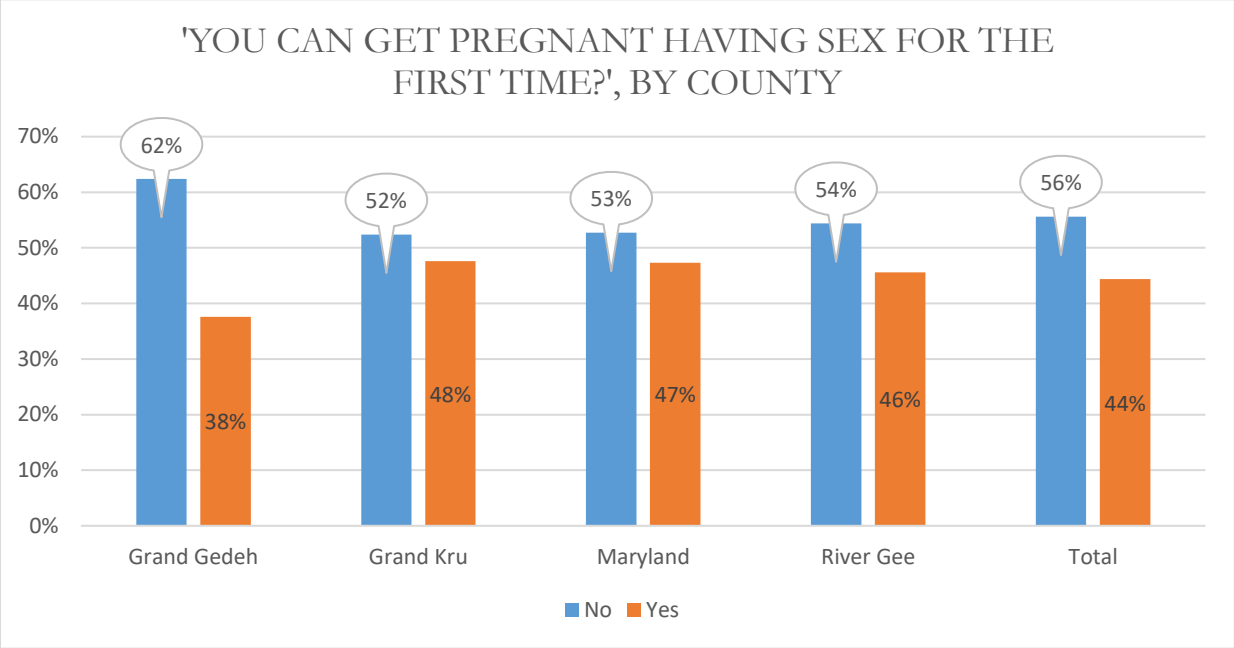
It is fine and ok with my parents to know that am in a sexual relationship Q_18					
County	Agree	Disagree	Strongly agree	Unsure	Total
Grand Gedeh	63	74	5	7	149
%	42.3%	49.7%	3.4%	4.7%	100.0%
Grand Kru	48	59	15	2	124
%	38.7%	47.6%	12.1%	1.6%	100.0%
Maryland	47	70	30	3	150
%	31.3%	46.7%	20.0%	2.0%	100.0%
River Gee	38	83	25	3	149
%	25.5%	55.7%	16.8%	2.0%	100.0%
Count	196	286	75	15	572
% Total	34.3%	50.0%	13.1%	2.6%	100.0%

Data source: UNFPA's Empowered and Fulfilled Project Baseline Study (P4DP, 2017)

One revealing aspect of the responses was what the adolescent respondents thought about pregnancy as an outcome of repeated sexual intercourse. The adolescent respondents were asked if a girl can get pregnant in just one exposure to sexual intercourse, and 54% answered 'no', meaning, that a girl cannot get pregnant from having sex for the first time. See Figure 16 below for the distribution.

This result shows that adolescent girls believe that before a girl can get pregnant, it must be more than one sexual intercourse with an opposite sex. Thinking in this direction can induce adolescent girls to experiment with unprotected sexual intercourse, which has varying sexual and reproductive health outcomes for both genders, especially the females.

Figure 14: Distribution of Adolescents' Perceptions on Sexual Intercourse and Pregnancy



Data source: UNFPA's Empowered and Fulfilled Project Baseline Study (P4DP, 2017)

Barriers to adolescents' access to ASRH information and services were highlighted during FGD sessions and were corroborated by some of the KIIs. Sometime parents do not talk about sex to their children and their children learn about their bodies from friends who later mislead them. Some of the girls also noted that because of their age, nurses will keep them waiting for a long, a treatment which discourages them to go back while some nurses do not have good manners in talking to them and sometime they discuss their patients' issues with friends in the community.

"*Because of our age, sometime when you go there, the Nurse will ask you to wait while they are attending to big people. Most time you wait and get tired because you have to get home to do some work".* Under 15 Adolescent in River Gee

OIC of a health facility, Maryland County, said,

"The major hindrance to the success of our intervention (FP) I think is adolescent girls who are in relationship with thirty to forty years old men are usually pressured by those men to bear child or children for them therefore those adolescent girls stop the family planning and get pregnant to keep their relationship. Secondly, some parents believe that family planning commodities have negative effect on adolescent as such those parents discourage their children from taking family planning commodities."

As a result of the conflict between societal values and people's behaviors precipitated by basic human needs, and the disapproving attitudes of parents and service providers, adolescents are frequently barred from reproductive health services and therefore ending up in bad situations.

Other parents feel it is taboo to talk about sex in public or to their children. As a result, children learn more about their sexuality from strangers, which has impact on their future. A respondent from Maryland posited that,

"Many people in the community see sex education for adolescents as their taboo." Elder, Maryland.

This position was corroborated by a School principal who averred that,

"*parents of yesterday are normally feeling very ashamed to discuss issues surrounding sexual reproductive health to their children, and that's how many of the children get in to becoming early parents."* School Principal, Maryland County

These findings suggest that parents do not share sexual information with their children or wards and this can cause their children to conceal their sexual escapade, which is usually counterproductive as the children eventually end up in situation that their parents/guidance are to avoid.

In addition, misconception about contraceptive use is another barrier that prevents young people from accessing and using SRH/FP commodities. This also has consequences for unintended pregnancy that sometime leads to unsafe abortion as they do not want anyone to know they are pregnant. Out of fear of the impact, an adolescent girl said that,

"*The three months' family planning, for some people who are taking it, they can be bleeding for the three months if it doesn't agree with them. And for the five years, I don't find it necessary for girls to take the five years' family planning, and some girls took it and I think after the five years it will have effect on their womb and they will not born."*

Yet another adolescent girl from Grand Gedeh County noted;

People here are saying that the five years family planning is not good because after the five years it may cause problem in my marital home, maybe I may not have child soon due to the family planning I put in the arm.

In other instances, apart from the barriers identified above, there are other facilitating factors which some of the adolescent respondents alluded to during FGD and KII sessions with the research teams. There are influential individuals in communities that somewhat influence adolescents into sexual union, which these girls do not plan for. The result of such endeavor can lead to unintended pregnancies and eventually undermine adolescent girls' future careers. A respondent from River Gee stated that,

"Some of the parents even ask their children to go and get pregnant because they don't know when they will die, so they need to hold their grandchild before they die. So, these are some of the things some unlettered parents do." PTA Chairman, River Gee

Yet another respondent in an FGD observed that;

"Some of the challenges people of our age experience in accessing SRH services is the influence of their parents that they want them to produce grandchildren for them and also the perception that you will not bear children after leaving the family planning." Mixed Adolescent FGD, River Gee County

A young female respondent narrated her experience during an FGD session:

"For me my mother doesn't allow me out of her sight so she forbids family planning but others who trust themselves that they are mature can carry themselves to take the injection." Female Participant, FGD, River Gee County

This notion has the tendency to lure an adolescent to start having unprotected sexual affairs to assuage their parents' pressure. Most of the parents who make such demand of their adolescent children are usually not literate, and may not understand the danger it poses to an adolescent person to have a child without proper preparation.

"Presently these days' young girls between the ages 8-10 years and above are at risk of getting pregnant due to their innocence which is mainly contributed to by their mothers and peer pressure. Example like my daughter who was born in 1993, while I'm encouraging her to go to school the mother is there encouraging her to have children and not go to school." School Principal, River Gee	*"Some of the difficulty people of my age experience is that they shy away from public gathering where these issues are discussed, lack of radio programs for kids to build interest in the topics, and many parents don't allow their children to partake in children's gathering where these SRH issues are discuss*ed." Female Participant, FGD, Grand Gedeh County.

Some of the difficulty people of my age experience is that they shy away from public gathering where these issues are discussed, lack of radio programs for kids to build interest in the topics, and many parents don't allow their children to partake in children's gathering where these SRH issues are discuss- Female Participant, FGD, Grand Gedeh County

For other adolescents, it is the none availability of the SRH/FP services at the community level that pose barriers for them. This was how a male participant in an FGD session explained it;

"Some of the difficulty is because there is only one group we have to tell us about these things, which is the nurses from the hospital but we don't have people in the community to teach us about ourselves like the town chief and other youth leaders." Male Participant, FGD, River Gee County.

Despite these community level barriers, most of the leaders embrace the idea of the availability of SRH/FP information and services to adolescents.

"The use of contraceptive is necessary for young folks to avoid and prevent unwanted pregnancy/STI, because if a female gets pregnant in her teen she will face difficulty during delivery, which might sometimes lead to operation. Therefore, it is necessary to give them FP until they reach the age 19, 20 and above before getting pregnant." School Principal, River Gee County

On the overall, most of the respondents noted that parents are both barriers to adolescents accessing SRH/FP and actors who lure adolescent to ignore SRH/FP messages and/or not to use FP commodities. Parents also do no share sexual information with their children and there are no SRH/FP available at community level but only at designated health facilities.

CHAPTER 4

FACTORS AND ACTORS INFLUENCING NATIONAL AND SUB-NATIONAL LEVEL POLICIES AND PROGRAMMES ON SEXUAL REPRODUCTIVE HEALTH AND FAMILY PLANNING SERVICES

This section reviewed SRH/FP policy context of Liberia, highlight some policies' thrust, their achievements, gaps and recommendations. The Ministry of Health (MOH) has the primary responsibility to design all reproductive health programs, standard and policies. MoH also monitors and supervises such programs with support from WHO, UNFPA, UNICEF, USAID, UN Women and other relevant international donor agencies. Others relevant GoL ministries that support MOH include: MYS, MGCSP, MIA, MoE and MoJ.

POLICY CONTEXT

Globally, 16 million adolescent girls aged 15-19 years and two million girls under age 15 give birth every year[8]. In the poorest regions of the world, this translates to roughly one in three girls bearing children by the age of 18. Liberia peace is still fragile after fourteen years of armed conflict (1989-2003). Although Liberia has managed to establish a full functioning, democratic elected government that remains committed to human development, equality, and sustainable peace, yet the huge gaps left in human capital development, harsh socio-economic condition coupled with increased unmet needs of adolescents in accessing Sexual health and reproductive (SHR) and Family planning (FP) education and services has created more reproductive health difficulties for adolescent - age 10-19 years.

Reproductive health issues in Liberia have far reaching implications not only for young people, especially adolescent girls who are already faced with multiple socio-economic challenges but critical for poverty reduction, peace and stability.

Peace, economic growth, and industrious society are critical elements for empowered youthful population. Various stakeholders remind us that fully engaged, educated, healthy and productive adolescents and youth can help break multi-generational poverty because they are resilient in the face of personal and societal threats, and, as skilled and informed citizens, they can contribute effectively to the strengthening of their communities and nations (UNFPA Strategy on Adolescents and Youth Towards realizing the full potential of adolescents and youth, 2013), (Liberia Youth Fragility Assessment, April 2009), Ministry of Education Republic of Liberia Getting to Best Education Sector Plan, 2017-2021, National, HIV & AIDS Strategic Plan, 2015 – 2020, National Sexual & Reproductive Health Policy, Ministry of Health and Social Welfare Republic of Liberia, 2010, etc.

While these policies in general focused on peace, economic revitalization, social welfare and security in different dimensions, there is a common line in terms of SRH as reflected in some of the GoL important policy documents. For example, the Government of Liberia's second poverty reduction strategy paper, the Agenda for Transformation, which was laid on the foundation of the first PRS (2008-2011), focused on four broad areas: Expanding peace and security; revitalizing the economy; strengthening governance and the rule of law; and rehabilitating infrastructure and delivering basic

[8] http://apps.who.int/iris/bitstream/10665/112320/1/WHO_RHR_14.08_eng.pdf

services. In a 2011 evaluation of PRS-1 the following results were found: Maintenance of macroeconomic stability with low inflation, maintenance of a balanced budget, reduction in external debt were found to be fully satisfactory. However, Health, water, sanitation, business and private sector, and civil service reform were found to be partly satisfactory. Transition of security to Liberian agencies, delivery of basic education, improvement of roads, environmental concerns, labor protection and crime prevention were marginally positive. The Sexual and Reproductive Health Policy of Liberia provides a framework for coordinating and monitoring reproductive health activities in Liberia. Coordination is central to a well-designed, comprehensive and focused SRH program.

- Currently, SRH interventions in Liberia are fragmented and poorly monitored and coordinated, making it difficult to determine the quality and effectiveness of these interventions. Indeed, reproductive health issues remain major challenges in Liberia's post war reconstruction process affecting young people, especially adolescent girls who are already faced with multiple socio-economic challenges. For example, according to the 2013 LDHS, median age at first sexual debut was 16.2 for females and 18.2 for males thus resulting into high teenage pregnancy rate—estimated at 31%, early childbirth where 59.1% of adolescent girls are mothers by age 19, early marriages, abortions (claiming 30% of pregnancies amongst adolescents). In another instance, there's an increased risk of STIs and HIV infections where young people aged 15-24 account for 34% of the 1,789 new infections within the reproductive age group (NACP 2014). While overall HIV prevalence is 1.5% (2007 LDHS), prevalence amongst the 15-24 age group is 1.8%, indicating a higher HIV prevalence amongst young people compared to the older age groups.
- Moreover, there are noticeably disparities in reproductive health issues between rural and urban settings. Study shows that girls and young women in Greater Monrovia live in a very fragile environment fraught with risks and problems which make them extremely vulnerable[9]. The combination of an unstable family environment, poverty, a high level of physical and sexual violence, cultural acceptance of abusive practices like transactional sex, and the fact that many girls are mothers themselves, is an extremely dangerous cocktail which puts girls and young women in a very vulnerable position. This affect girls' and young women's ability to participate in training, and to focus on it and be able to learn. This also impacts a successful transition from training to work and girls' and young women's ability to find and keep jobs.
- As often said, youth are the future leaders of every society. In an attempt to prepare Liberians youth for future their responsibility, the GoL through the Ministry of Education (MoE), developed education sector plan (ESP) to address the most urgent challenges facing the education sector in Liberia. Known as 'Getting to Best Education Sector Plan (G2B-ESP), the MoE uses the G2B-ESP to implement a series of strategic, evidence-based, and innovative programs to measurably improve the quality and relevance of teaching and learning for all students by June 2021. Among others, it includes on-going or planned activities which align with the Getting to Best priorities and implements the national development priorities in the Agenda for Transformation (2015-2017) and Liberia Rising: Vision 2030.
- Like other African counties, gender and income inequality are serious issues in Liberia. Liberia ranks 146 out of 155 on the UN Gender Inequality Index and most sources point to relatively high levels of income inequality (UN Human Development Report 2015)[10]. Sexual and Reproductive Health issues need to play pivotal role in Liberia Rising Vision 2010. Coordination is central to a well-designed, comprehensive and focused SRH program. There

[9] Liberia Economic Empowerment of Adolescent Girls and young Women project GIRLS' VULNERABILITY ASSESSMENT.
[10] According to the 2015 Human Development Report, 83.8% of Liberians are below income poverty line; 35.4% are in severe poverty; 21.5% are near poverty.

are major inequalities in education access, participation and learning outcomes by gender, urban-rural status, county of residence and household socio-economic status. In addition, disparities in the public resourcing of education and training is evident in major differences in key indicators by county and urban-rural status, such as pupil qualified teacher ratio and student-classroom ratios. Thus, although Liberia has made efforts to address GBV and SRH issues, many challenges remain, that if not effectively and urgently addressed, can hinder sustainable peace and development in the country. Such challenges include better coordination in the educational sector and the promotion of women's human rights, their protection and security and the prevention of all types of violence against women and girls.

- It should be acknowledged that there are several initiatives to address some of the problems adolescent girls faced. Example, 'Girl Up[11]' is a unique program that builds clubs to serve as venues for community dialogues on the tough topics of violence against women and female genital mutilation. 'Girls up' organizers do not only limit their intervention to building clubs but also engage local leaders in conversations about the negative effects of female genital mutilation and encourage them to advocate for the elimination of this practice. Female genital mutilation (FGM) is a taboo subject in Liberia and usually not discussed openly. The prevalence rate of FGM in Liberia is estimated to be 60%[12] and is mostly performed by the Mande speaking people of western Liberia (the Gola and Kissi).

While 'Girls Up" intervention helps to highlight harmful traditional cultural practice, it does not create an enabling policy and programme environment that promotes adolescent sexual reproductive health and rights including access to family planning services at national and sub national level. In addition, the initiative targets and focuses on local leader without considering the discriminatory effect of Liberia's educational policy against adolescent girls. Education is known to help break the vicious cycle of poverty, but the Government of Liberia policies on teenage pregnancy and social pressure do not support pregnant girls or child mothers to stay in school or return to school once they have given birth. The Liberian Ministry of Education has a policy which states that pregnant girls should attend 'night school' as opposed to continue mixing with their peers in classes during the day. In fact, some schools do not allow pregnant girls to stay in class for fear of 'influencing' and 'infecting' other girls but ironically allow in most instances boys who pregnant adolescent girls to remain in school. Although small number of school allow pregnant female students to continue their studies, the girls themselves often feel too ashamed and drop out.

Liberia has a National Health and Social Welfare policy, which builds on the 2007 version of the National Health Policy, the 2008 Governance Commission Report, the 2009 National Decentralization Policy, the 2009 National Social Welfare Policy as well as the 2011Country Situational Analysis Report. However, in light of the competing priorities and resource scarcity within the Health care system, concerned partners are asked to wisely use every available resource and to do so in an inclusive, participatory manner by developing accessible, responsive system necessary to substantially improve the health and social welfare of the population. In this regard, focus is on program impact in terms of efficiency and effectiveness in order to ensure their maximum contribution to the development of the system[13]. To minimize unnecessary competition and ensure that heath care users,

[11] http://www.girlsdiscovered.org/map/health_and_wellbeing/

[12] World Health Organization http://www.who.int/reproductivehealth/topics/fgm/prevalence/en/index.html

[13] Health systems efficiency refers to the degree of extracting the greatest potential health gains from a set of measurable inputs. Health systems effectiveness equates to the timeliness of access to the full array of needed services, quality and safe care leading to improvement in health outcomes.

including adolescents' girls have adequate access to the full range of SRH services, the Health and Social Welfare National policy requires all actors to work together by:

Improving the timely access to high-impact, evidence-based interventions and strengthening referral between all levels of the system;

Increasing the utilization of services by improving the population's care-seeking behavior, the quality of care and the availability of essential drugs and equipment; and

Improving the coherence between strengthening the existing workforce, producing additional workers with the right skills mix, deploying according to service delivery needs and retaining skilled providers where they are most needed.

At the same time, the health and social welfare sector must become more effective (*by*:

Allocating resources among counties according to equitable criteria and optimally distributing resources to health facilities according to population size, utilization and workload;

Improving the coordination of all efforts to support health and social welfare services, eliminating duplication and minimizing gaps; and

Creating a culture at all levels of the system that values and strives to do more for the population within existing levels of resources. of care and the availability of essential drugs and equipment; and

Improving the coherence between strengthening the existing workforce, producing additional workers with the right skills mix, deploying according to service delivery needs and retaining skilled providers where they are most needed.

Others are:

- Maternal and New born care; to improve maternal and newborn health and reduce pregnancy-related morbidity and mortality;
- Adolescent health -to ensure that adolescents have adequate access to the full range of SRH services; Institute programs to increase the utilization of SRH services by adolescents;
- Promote the integration of adolescent health issues into schools and youth programs;
- Ensure the availability of and access to STI and HIV prevention and management including HIV counseling and testing (HCT) and appropriate information for safe sex targeting youth;
- Ensure that youth are incorporated in health decision-making, particularly in the area of SRH

Meanwhile, there is also a drive to making the health and social welfare sector becoming more efficiency by:

- Allocating resources among counties according to equitable criteria and optimally distributing resources to health facilities according to population size, utilization and workload;
- Improving the coordination of all efforts to support health and social welfare services, eliminating duplication and minimizing gaps; and
- Creating a culture at all levels of the system that values and strives to do more for the population within existing levels of resources.

Sadly, in spite of these well-articulated national health plan, the policy suffers a number of shortcomings. The plan states that all people in Liberia shall have access to effective health and social welfare services irrespective of socioeconomic status, origin, ethnicity, gender, age and geographic location without discrimination. It stressed that women and girls in particular will participate in the planning and design in the implementation of the program that reflects their social and economic determinants of their health[14]. However, it is very difficult to come across projects in which girls are fully involved in the planning and design processes. This study attempts to address this gap by asking adolescence to voluntarily share their experiences[15], when it comes to SRH problems in their community. The participatory approach adopted by this study enabled respondent to see themselves as the custodians of the information needed to help improve the sector. Whereas the study team enjoyed the participation of targeted groups, it must be stated that some parents refused to allow their children to participate. This was particularly in the case of some parents mostly (motherly) of adolescent female (teenagers 10-14 years) citing cultural reasons and earlier exposure of their children to sexual education.

Thus, there is a need to include adolescence in this development of SRH interventions as well as create an enabling policy and programme environment that promotes adolescent sexual reproductive health and rights including access to family planning services at national and sub national level.

ANALYSIS HIGHLIGHTING PROVISIONS AND GAPS ON TEENAGE PREGNANCY IN LIBERIA

Policies and standards have been designed by MOH and its partners to help young people manage their sexual reproductive lives meaningfully for better future opportunities. Some of these policies have are focused on proving service Family Planning commodities, life skills, HCT, STI, HIV/AIDs, ANC, (Ante Nata Care) and adolescent health with special attention to capacity building of service providers and male involvement and life skills that will adolescents manage their sexual and reproductive lives. Through these policies progress have been made in the following areas:

- The gradual improvement in the health care delivery system for adolescent and adult alike;
- Young people are gradually coming out to freely talk about their sexuality and those who understand the message are encouraging their peers to get involved.
- Free provision FP commodity in government facilities
- Free HCT in good government facilities
- Reduction in maternal mortality, STI and SRH related diseases.
- Managing Tracking and recording ANC and segregating information based on age
- Teenage mothers in some communities have received skill training and employment to help them be more focus on building normal life
- Gradual increase in the awareness about of SRH/FP especially in urban communities
- Formulation of CSE framework and approval to be included into national school curriculum
- Increased availability and accessibility of wide range of modern contraceptives method and strengthened health workers/service providers' skills to deliver efficient and quality SRH services at health facilities and community levels.

[14] See National Health and Social Welfare Policy and Plan 2011–2021. P.3 Section(3.2.2)

[15] See Consent form for Qualitative study

- Despite these successes, there are gaps in some areas of these policies and therefore we advance some ways to address them. The following gaps have been identified from some of the policies.
- Poor dissemination of SRH/FP policies due to inadequate copies of these policies at service centers to ensure total compliance with the policy. This was corroborated by the official of MOH during an interview. *There are limited copies of SRH policies to go around in all the places they should be accessible.*
- Monitoring system of these policies are very weak and uncoordinated. MOH via the Family Health Division is the Monitoring arm and there are various groups working on implementing these policies. For a single agency to handle such task for a country striving to improve it health sector and the same time attend to the needs of specific population group, it obviously becomes overwhelming and the desired outcome may not be realized. Thus, a need to dedicate this task to specific professional groups or entities.
- FGM aspect of Gender Based Violence is not frequently flagged like rape cases. This can lead to the continuation of such traditional practice on female and adolescent girls.
- The awareness around SRH/FP policies is very low at the community levels, in some case non-existent.
- There are few referral and one-stop centers throughout the Country to address some of the espoused SRH/FP prompts.
- Most essential SRH/FP commodities are not available to most adolescents rather they are available in private drug stores and pharmaceutical stores with exorbitant prices
- There is no specialized service preference towards adolescents with disability. There is need to create and include special program and care for people living with disability
- Due to paucity of fund, health resources including SRH/FP commodities are yet to be spread to most underserved communities
- Trained health workers particularly SRH/FP are yet to be evenly distributed throughout the country in communities
- Supply chain management of SRH/FP commodities to the Southeast due to less preference of that region based on government 'growth corridor' policy and terrible road conditions
- The huge burden of monitoring adolescents' policy is left with MOH, a ministry that has so much competing agenda and low expertise in this area.

National Adolescent Strategy

- Most remote communities are still engaging in harmful practices such FGM in defiance of the policy thrust
- Weak legal framework in terms of the enforcement and prosecution of crimes against adolescents
- All existing Adolescent policies should be integrated for easy reference and used, and they should be translated in simple user friendly and local vernaculars so that community people will know how they work and who has responsibility to do what.
- Too many policies without better coordination
- Lack of standardization of policy leading to confusion, complication and unnecessary gaps,
- Poor communication strategies in creating awareness about the existence and use of adolescent policies remain a major challenge.
- Operational research that ought to inform new SRH Policies are not being carried out yearly and timely

Life skill Curriculum

Life skills curriculum are not being taught in all schools, there is a wide variation between private schools and government school. MYS and MOE must work in unison for effective implementation and monitoring.

National Gender Policy

Free education for girls is not being fully implemented as many poor home cannot still send children to school, a situation that make them vulnerable.

HIV/AIDS Policy

Community level awareness around HIV/AIDs in not vigorous, thus most young people have scanty information about HIV/AID transmission and preventive measures at the community especially out of school youths.

The number of adolescent Volunteering for HCT through community-based service group are still very low due to fear of stigmatization.

STRUCTURAL CHALLENGES TO THE IMPLEMENTATION OF SRH/FP STANDARDS OR POLICIES

Whilst policies and standard are being developed by government via MOH and other concerned Ministries and agencies, and implemented by MOH local and international partners, there are structural impediments that these interventions are faced with. Major ones include the following:

Religion: Some religious rites and norms appear to pose a challenge to the SRH policies. Even though this observation is made in dominantly Islamic and Catholic communities covered by the study, elsewhere other studies by Moreau and colleagues found that sexually experienced adolescents, regularly practicing their religion, were less likely to use contraception[16]. Our survey confirmed that Muslim men, as a matter of religious norm, are averse to their partners using family planning pills. Similarly, the survey found confirmation amongst Catholic adherents who reject the use of a range of family planning commodities purely on doctrinal grounds. Our study found this practice particularly operative in the Sacred Health Catholic Hospital, Harper City, Maryland.

Culture: It is increasingly being recognized that development approaches in the areas of health, specifically Sexual and Reproductive Health (SRH) in the case of Sub-Saharan Africa, are not having the desired effects. Thus, a new approach that takes account the lifestyles, attitudes, beliefs and traditional practices that form the basis of a community´s perception of health and illness, life and death, and sexuality has come to be recognized as a potentially more effective way to intervene in

[16] L.M. Coleman, A. Testa (2008); Sexual health knowledge, attitudes and behaviours: variations among a religiously diverse sample of young people in London, UK, Ethn Health, 13 (1) (2008), pp. 55-72

matters related to SRH[17]..In Liberia, traditional and cultural myths surrounding the use of SRH/FP commodities remain strong. In many rural communities across Liberia, myths and misconceptions persist about the use of various family planning commodities. A number of respondents expressed the view that FP commodities cause profuse blood flows during women menstrual, making them sick or obese, and unable in the long run to birth a child when ready. This aversion was expressly tied to the popular belief that that children are wealth and gifts from God, and must never be circumvented from the natural process of procreation. The Baseline FGD support the presence of some of these myths.

Funding: The National Budget currently includes no line for SRH. Funding has been a critical challenge in the implementation of SRH policies and interventions, even that a number of international organizations have demonstrated perceived interest and funding for same. Thus, SRH programs are selectively implemented due to insufficient funding to cover all areas of need.

People's Behavior: Recent research publications acknowledge the influence of religion and culture on sexual and reproductive behavior and health-care utilization [18](The natural human tendency of aversion to change is ever-present in many communities, and pose difficulties in the fight to change old ways of reproductive activities.

Remedies

- All related Adolescent existing policies should be consolidated for easy reference and use, and they should be done in simple and vernacular so that community people will know how they work and who has responsibility to do what.
- National actors need to do more work in traditional and religious national stakeholder to drum up more support for SRH standards to be enforced
- Youth organizations at the community levels should engaged with more.

Recommendations

In the light of the Baseline survey findings, the following programmatic recommendations are put forward by participants during the KIIs and FGDs, sessions and by P4DP researchers in order to help UNFPA and its partner to effectively address some of the reproductive issues impeding adolescent youths' access and utilization of ARSH/FP services.

Recommendations from Survey Respondents

- Much stereotypes exists around open discussions about sexual and reproductive issues, as well as early adolescent sexuality. Many adolescents also appear to see sexual intercourse as the primary way of demonstrating valued friendship. Another common myth concerns the burden which females carry as the party most responsible for contraception precautions. Survey respondents advocated for the provision of more information and awareness in order to challenge and eradicate these myths, specifically targeting schools and other youth centers.
- SRH/FP information and services must be more decentralized by establishing them in youth-friendly centers in easy-to-reach locations across communities. Respondents advocated for increased availability of information as it is more likely to increase access.

[17] http://mdgfund.org/country/mozambique/story/UnderstandingtheRoleofCultureinSexualandReproductiveHealthinMozambique

[18] {1) "Understanding the Role of Culture in Sexual and Reproductive Health in Mozambique",Mdgfund. 2010 (www.mdgfund.org); {2) Thomas Bisika, "Cultural Factors that affect sexual and reproductive Health in Malawi. Journal of Family Planning Reproductive Health Care 2008 34(2)

- Respondents also advocated for the need to improve community awareness about adolescent sexuality and support as a means of protecting themselves from sexually transmitted diseases such as HIV and AIDS. Testing and counselling services are also urgently needed.
- Respondents also expressed the need for programs that focus on persuasive advocacy. Such programs could appeal to the minds of parents and help them understand the importance of permitting their adolescent children access to the full range of available ASRH/FP information and services in order to prevent early pregnancy. By so doing, parents can help their children manage curtail sexual activities until they are of proper ages to make the right decisions about child-bearing.

P4DP's Recommendations

- To the extent possible, and within available resources, public health facilities must be equipped with trained ASRH/FP personnel and available services, while at the same time exploring the possibilities of establishing outreach posts in catchment communities more than a kilometer. We advocate further actions by national ASRH/FP policy stakeholders in developing a plan of action which mandates, but also provided support to, parents in their efforts to support their children throughout adolescence. Cultural and religious communities also have a role to play in this regard.
- In order to contribute to the reduction of poverty which sits at the roots of many cases of teenage pregnancy and early marriages, we recommend more empowerment programs for girls, and greater access to education and finance for small businesses. We also recommend the strengthening of existing awareness programs educating girls on the danger and impact of early pregnancy.
- The capacity of existing social structures at the community and schools, such as sport clubs, susu clubs, birthday celebration clubs, school clubs, PTAs, etc., could be developed in the area of SRH/FP services to help create awareness and advocacy at the community level.
- All existing SRH/FP policies formulated by youth related ministries and agencies, could be condensed, printed in simple language, and disseminated in all public places especially youth rendezvous areas such as video club, cinemas, entertainment places, etc.
- Finally, we recommend the commissioning of further studies to understand other wide-ranging issues such as unmet needs of reproductive commodities and abortions plaguing adolescents that are not covered under the scope of this baseline study. Findings from such studies would aid in the development of a more holistic approach to confronting teenage pregnancy and its negative outcomes; and STI/HIV/AIDS.

Commentary

The baseline study, as planned, has provided some factual and empirical data on a number of indicators that can serve as baseline data against which the Empowered and Fulfilled Programme in the Southeast' four counties can be measured. Indicators used in the baseline mapping and survey were carefully developed and chosen in line with the anticipated Programme, and were focused in the targeted areas. The study findings have also provided valuable insights into the assets, perception, attitudes, beliefs and behaviors of adolescents in connection with reproductive health. When carefully applied, these insights will can help guide immensely in the proper design and targeting of key areas of intervention areas under the Programme.

INDICATORS

1. Utilizing available SRH/FP services among young people (10-19 years) in the four counties

➢ 24.7% of the adolescents 10-19 years across all four counties indicated they have used a particular FP method in the last 30 days preceding the survey. This suggest very low utilization. In general, out of this proportion, females are more adept in using a particular than males likewise, older adolescent tend to utilize a certain family planning method than the VYAs.

2. Pregnancy

➢ On the overall, 33% of adolescent girls have been pregnant aged between 15-19 years old in the four Counties
➢ 38% of adolescent girls aged 15-19 years have been pregnant in River Gee
➢ 33% of adolescent girls aged 15-19 years have been pregnant in Grand Gedeh
➢ 29% of adolescent girls aged 15-19 years have been pregnant in Grand Kru
➢ 28% of adolescent girls aged 15-19 years have been pregnant in Maryland

3. Health Facilities

➢ None of the 22 health facilities surveyed demonstrate lack of capacity to deliver adequate SRH/FP information and services to adolescents in the four Counties.

4. Knowledge and Skill of Adolescents About SRH/FP

➢ On overall, around 17% of young people aged10-19 years from the four Counties have adequate knowledge SRH/FP information and services method, whereas about 83% of the same group lack adequate knowledge to properly manage their sexual and reproductive lives.

5. Community Level Barriers to SRH/FP Services and Information

➢ Some of the barriers are parental pressure on adolescent to them grandchildren, parents threating sex education as taboo, and non-availability of Youth Friendly Centers in communities. among other

6. Social Structures That Promote SRH/FP Activities

➢ There are community-based and school-based structures for youths social, sports and thrift activities. Yet, none of these explicitly focused on SRH/FP activities.

7. SRH/FP Policy Gaps

➢ There are SRH/FP policies formulated in more than one ministry and there is little being done in the dissemination of printed copies, while cultural and religious barriers impede smooth implementation. Harmonization of all SRH/FP policies and proper dissemination strategies be adopted and cultural and religious stakeholders be more involved in implementing existing policies.

Documents Reviewed

1. National HIV/AID Strategic Plan 2015-2020

2. National Sexual and Reproductive Policy. Ministry of Health and Social Welfare. 2010
3. Foundation Life Skills Curriculum- A Peer Facilitated Life Skills Curriculum for Liberian Adolescents 10-19 years. Ministry of Youths and Sports. 2017
4. National Adolescent Empowerment Strategy. Republic of Liberia. 2017-2022
5. Adolescent and Sexual and Reproductive Health. Training Manual for Health Workers
6. Investment Plan for Rebuilding a Resilient Health system. Ministry of Health. 2015-2021

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5. WHO, 2014

ANNEXES OF UNFPA EMPOWERED & FULFILLED PROJECT BASELINE STUDY 2017

ANNEX 1: CRITERIA FOR FUNCTIONAL YOUTH FRIENDLY/HEALTH CENTER FOR SRH/FP ACTIVITIES

Adolescents' health literacy	Standard 1: The health facility implements systems to ensure that adolescents are knowledgeable about their own health, and they know where and when to obtain health services.
Providers' competencies	Standard 2: Health-care providers demonstrate the technical competence required to provide effective health services to adolescents. Both healthcare providers and support staff respect, protect and fulfil adolescents' rights to information, privacy, confidentiality, non-discrimination, non-judgmental attitude and respect
Appropriate package of services	Standard 3. The health facility provides a package of information, counselling, diagnostic, treatment and care services that fulfils the needs of all adolescents. Services are provided in the facility and through referral linkages and outreach
Community Support & Partnership	Standard 4: Partnership Established among adolescents and young people, health institution and community in the provision and utilization of AYFHS
Management and Enabling Environment	Standard 5: Health policies and management systems are in place to support the provision of AYFHS at the service delivery points.
Data and quality improvement	Standard 6. The health facility collects, analyses and uses data on service utilization and quality of care, disaggregated by age and sex, to support quality improvement. Health facility staff is supported to participate in continuous quality improvement.

ANNEX 2: BASELINE SURVEY STRUCTURED QUESTIONNAIRE

Demographic

Question ID	Question	Answer
1	What is your name?	
2	What is your Gender	Male Female
3	Your age?	10-14yrs 15-19yrs
4	What is your level of education?	None Elementary School drop-out 1– 6th Grade 7-9th Grade 10-12th Grade
5	What is your religion?	Christianity Islam Traditional Others, (specify)
6	Family Background: who do you live with?	Both parents Father Mother Older sibling Step-mother/father Guardian
7	Which is your County	Grand Gedeh Grand Kru Maryland River Gee
8	CAPTURE GPS POINT	
9	Which is your District?	Barclayville Health district Buah Health district Trehn Health district Jroah Health district Potupo Health district Sarbo Health district Tuobo Health district Tchien Health district Putu Health district Cavalla Health district Pleebo/Sodoken Harper Kaluway #2
10	Which is your town?	New Market UNMIL Community Sweaken Worfiken Gbaweleken

		Barclayville City Behwan City Garraway City Gekan Sass Town Pleebo Karloken Barriken Glofarken Harper City Putu Pennoken Nao Janzon Kpasuah Ziah Town Zwedu City
11	Which is your School?	Out of school In School Don't know

Section 1a: PERSONAL BEHAVIOR

Question ID	Question	Answer
12	What do you do to make money for yourself?	Nothing Employed Selling goods/small business Casual labor Farming Other(specify)
13	Have you ever had a boyfriend/girlfriend/partner?	Yes No
14	Are you a relationship currently?	Yes No
15	In your relationship do you have sexual intercourse?	Yes No
16	How old were you when you first have your boyfriend/girlfriend/partner?	Less than 10 yrs 10-14 yrs 15-19 yrs

BELIEFS ABOUT SEX AND RELATIONSHIPS

Question ID	Question	Answer
17	A relationship doesn't have to include sex	Strongly agree Agree Unsure Disagree
18	It is fine and ok with my parents to know that am in a sexual relationship	Strongly agree Agree

		Unsure Disagree
19	You don't have to have sex to keep a partner	Strongly agree Agree Unsure Disagree
20	My parent(s) or guardian is justified to push me into a sexual relationship to obtain support for my family	Strongly agree Agree Unsure Disagree
21	First, sex should be both special and planned	Strongly agree Agree Unsure Disagree
22	I should be given something material or monetary in exchange for sex	Strongly agree Agree Unsure Disagree
23	I'll only have sex in a long term serious relationship	Strongly agree Agree Unsure Disagree
24	I'll put off having sex until I meet someone I will live with	Strongly agree Agree Unsure Disagree
25	Sex is the only way to be satisfied in a relationship	Strongly agree Agree Unsure Disagree
26	It is ok to have sex on a one night stand	Strongly agree Agree Unsure Disagree
27	Having feelings or likeness (fancying someone) is a good enough reason for sex	Strongly agree Agree Unsure Disagree
28	Girls should be more responsible than boys for contraception	Strongly agree Agree Unsure Disagree
29	If your partner won't have sex at first, just keep trying	Strongly agree Agree Unsure Disagree
30	Having sex shows to your friends you're of age	Strongly agree Agree

		Unsure Disagree
31	Having sex once cannot make one pregnant	Strongly agree Agree Unsure Disagree

KNOWLEDGE OF CONTRACEPTIVES USE AND PREGNANCY

Question ID	Question	Answer
32	I know/have heard about the use of contraceptives	True False
33	If true, what are the types of family planning that are available to you?	Condom Pill Injections Others(specify)
34	I will be willing to use contraceptive if I understand how it works	True False Don't know
35	Even if family planning is used correctly, there is still a chance that a girl can become pregnant	True False Don't Know
36	You can't buy condoms if you're under 16	True False Don't Know
37	You can get pregnant having sex for the first time	Yes No
38	A girl can't get pregnant if she has sex standing up	True False Don't Know
39	A girl can't get pregnant during her period	True False Don't Know
40	Teenagers under 16 can get free condoms from the Family Planning clinic	True False Don't Know
41	I know how to get free and confidential emergency family planning materials (the morning after pill)	True False Don't Know
42	In the last 30 days I or my partner use a particular family planning method.	True False Don't Know
43	My partner/I have used condom	True False Don't Know
44	A girl can't get pregnant if she abstains from sex before marriage	True False

		Don't Know
45	Family planning can make a girl sick	True False Don't Know
46	Oral sex is safer than sexual intercourse because you can't get pregnant or catch STI	True False Don't Know
47	I have been forced against my will to have sexual intercourse	True False Don't Know
48	Do you know where to get family planning information/services?	Yes No
49	If YES, please tell us……:	
50	What is your gender?	Male Female

Section 1b. THESE QUESTIONS ARE TO BE ASKED TO GIRLS ONLY

Question ID	Question	Answer
51	Do you think you are physically able to get pregnant at the present time?	Yes No
52	Have you ever been pregnant?	Yes No
53	Have you ever had a live-born Child (children)?	Yes No
54	At the time you became pregnant, did you want to be pregnant?	Yes No
55	How old were you when you had your first child?	Between 10-13yrs Between 14-16rs Between 17-19yrs
56	How old were the man who got you pregnant?	Less than 14yrs Between 15-19yrs 20-25 yrs. 25+yrs
57	Have you ever tried to abort a pregnancy?	Yes No
58	How did you abort the pregnancy?	At the health center Used herbal medicine Red and black Capsules Washing powder solution
59	Has anyone you know tried to abort a pregnancy?	Yes No

Section 2: FAMILY PLANNING AND SRH CENTERS

Question ID	Question	Answer
60	Have you ever visited a health facility or doctor of any kind to receive services or information on family planning, pregnancy, abortion or sexually transmitted diseases?	Yes No
61	If NO, why?	
62	Were the services you received free of charge?	Yes No
63	How many times have you asked for information/use their service in the last 1 year?	Once Twice More than three times
64	The place you visited, is being run by who?	Government NGO Private Knowledgeable Individual School Environment Religious group Other(specify)
65	The place or individual you do visit, how often?	Seldom Frequently More than I can remember
66	The last you visited the center, what was your reason?	Family planning information Pregnancy Test STIs Advise on being pregnant Abortion Others(specify)
67	In the center did you see any family planning poster/materials?	Yes No
68	Did you request family planning services during the visit?	Yes No
69	Are you comfortable to ask question about family planning services?	Yes No
70	Were your questions/concerns adequately addressed?	Yes No
71	Were your information treated as confidential?	Yes No
72	Have you talked to friends about using family planning services?	Yes No
73	In the last 6 months, Have you talked to friends about using condoms?	Yes No
74	Have you bought condoms in the last 6 months?	Yes No

75	Have you received free condoms from a clinic or drop in center in the last 10 months?	Yes No
76	Have you practiced handling a condom on your own?	Yes No
77	Do you carry condoms with you when you go out ?	Yes No
78	Have you talked openly about sex with a boy/girl friend?	Yes No
79	Have you suggested using condoms with a boy/girl friend?	Yes No
80	Have you persuaded your boy/girlfriend to use a condom in the past?	Yes No

Section 3: SEXUALITY AND GENDER NORMS

Question ID	Question	Answer
81	It is alright for young boys/girls to have sex even if they are not married.	Strongly agree Agree Unsure Disagree
82	I feel that one has to have a boy/girlfriend before you are accepted	Strongly agree Agree Unsure Disagree
83	It is normal for boys to force girls to have an affair with them to show love	Strongly agree Agree Unsure Disagree
84	The good way to keep your relationship and make your boyfriend feels that you love him is to have a child for him.	Strongly agree Agree Unsure Disagree
85	Kissing, hugging or perking are alright in a relationship to show love but you don't have sexual intercourse	Strongly agree Agree Unsure Disagree
86	A girl should have at least one child at very young age so that age would not catch up with her	Strongly agree Agree Unsure Disagree
87	For boys having girlfriends is a pride and sign of manliness	Strongly agree Agree Unsure Disagree

88	Boys do not value and respect a lady who asks them to wait till marriage before sex	Strongly agree Agree Unsure Disagree
89	Virgin girls are not respected, so no need to wait till marriage	Strongly agree Agree Unsure Disagree
90	Having sex in a relationship is a sign of love	Strongly agree Agree Unsure Disagree
91	Some parents feel that once a girl reaches puberty she is an asset who can bring home money from men	Strongly agree Agree Unsure Disagree
92	It's my human right to do whatever I want with my body and my parents should not stop me.	Strongly agree Agree Unsure Disagree
93	Most boys who have sex before marriage always regret their action	Strongly agree Agree Unsure Disagree
94	Most girls who have sex before marriage always regret their action	Strongly agree Agree Unsure Disagree
95	When you don't have boy/girlfriend society feel that your body is not functioning and you are jeered at by friends	Strongly agree Agree Unsure Disagree
96	It is alright for boys to beat their girlfriends sometimes	Strongly agree Agree Unsure Disagree

Section 4: BARRIERS TO SRH SERVICES

Question ID	Question	Answer
97	My parent(s)/guardian will not allow me to seek family planning services from clinics, hospitals, youth center, youth friendly clinics, pharmacy or chemist to use contraceptive services?	True False Don't Know
98	It's culturally wrong to seek family planning services from clinics, hospitals, youth center, youth friendly clinics, pharmacy or chemist to use contraceptive services	True False Don't Know
99	My religion does not allow me to use family planning	True False Don't Know
100	If you openly talk about family planning (condom, pills) people brand you as promiscuous.	True False Don't Know
101	I worry about confidentiality and friendliness of the health workers at the clinics and youth centers	True False Don't Know
102	I don't have information on where the services exist or who provides them	True False Don't Know
103	Community members discourage us from going to use family planning	True False Don't Know
104	My teachers and school do not allow me to seek family planning services from clinics, hospitals, youth center, youth friendly clinics, pharmacy or chemist to use contraceptive services	True False Don't Know
105	I worry about being seen entering clinics, hospitals, youth center, youth friendly clinics, pharmacy or chemist to use contraceptive services	True False Don't Know
106	I worry about transportation to get to clinics, hospitals, youth center, youth friendly clinics, pharmacy or chemist to use contraceptive services	True False Don't Know
107	I worry about being judged by my friends	True False Don't Know
108	Any other reason(s) you don't seek family planning information and services?:	

Section 5: SEXUAL REPRODUCTIVE HEALTH (SRH) KNOWLEDGE AND SKILLS

Question ID	Question	Answer
109	How useful did you find the sources of information below when you were learning about sex and relationships (including pregnancy and contraception)? (Check all the questions by ticking the box that apply to you)	Boyfriend/Girlfriend Teacher at school NGO worker School nurse Visits from outside groups like health visitors and youth services Parents or guardians Brother / sister or other family member Family planning / Young person's clinic Doctor / nurse at GP surgery / hospital Youth worker Chemist or pharmacy TV /Radio Film Internet Books / leaflets Telephone Other(specify)
110	Who do you prefer talking to about your sexuality life (including pregnancy and contraception) amongst the following? (Check all the questions by ticking the box that apply to you)	Mother/ Stepmother Father/ Stepfather Grandparents Guardians Brother/step brother you get on good with Sister/step sister you get on best with Boyfriend /girlfriend Best friend School nurse School Teacher Community leader or NGO representative Other(specify)
111	Do you think sex and relationships education is aimed: (Choose only one)	More at boys than girls Equally at boys and girls More at girls than boys
112	How much do you know about growing up and changes in your body (i.e. puberty)?	Nothing at all Only a little Neutral Some A lot

113	How much do you know about sexual feelings and emotions?	Nothing at all Only a little Neutral Some A lot
114	How much do you know about Responsibility in relationships?	Nothing at all Only a little Neutral Some A lot
115	How much do you know about Gender and Sexuality?	Nothing at all Only a little Neutral Some A lot
116	How much do you know about Sexually transmitted infections?	Nothing at all Only a little Neutral Some A lot
117	How much do you know about Contraception (birth control)?	Nothing at all Only a little Neutral Some A lot
118	How much do you know about how to use a condom?	Nothing at all Only a little Neutral Some A lot
119	How much do you know about Termination of pregnancy(Abortion)?	Nothing at all Only a little Neutral Some A lot
120	How much do you know about Drinking and sex?	Nothing at all Only a little Neutral Some A lot
121	How much do you know about Drugs and sex?	Nothing at all Only a little Neutral Some A lot
122	Which of the following topics would you like to know more about? (Tick all that apply)	How girls' bodies develop How boys' bodies develop

		Sexual feelings, emotions and relationships Sexual intercourse How a baby is born Being a parent Contraception (birth control) Emergency ('morning after') contraception Teenage Pregnancy Termination (Abortion) Safer sex Sexually transmitted infections Female Genital Mutilation (FGM) How to be able to say 'no' to doing something sexual you don't want to do Having a blood test for HIV Ways in which HIV (the AIDS virus) can be passed on Other (Specify))

Section 6: KNOWLEDGE ABOUT STIS & HIV/AIDS

Question ID	Question	Answer
123	I know that HIV/AIDS is real in Liberia	True False Don't Know
124	I am aware of the prevalence of STIs (Sexually Transmitted Infections) in Liberia	True False Don't Know
125	You can catch an STI (sexually transmitted infection) during oral sex	True False Don't Know
126	Someone with an STI (sexually transmitted infection) might not know about it	True False Don't Know
127	If a friend was worried about STI (sexually transmitted infection), I'd know where to take them	True False Don't Know
128	Unprotected sex can cause STI	True False Don't Know
129	Merely looking at someone's face you can detect if he/she has STI such as HIV/AIDS	True False Don't Know
130	THANK YOU!	

ANNEX 3: DRAFT SEMI-STRUCTURED INTERVIEW GUIDES

PLATFORM FOR DIALOGUE AND PEACE

Empowered and Fulfilled Programme

SIDA-UNFPA Adolescent Sexual Reproductive Health

INTERVIEW GUIDES

Policy makers at National Level

1. What are some of the SRH policies in operation in Liberia?
2. How are the SRH National Policies implemented?
3. Who are some of the key actors involve?
4. What role are they playing to ensure compliance?
5. What are some of the interventions that have resulted from the SRH policies?
6. What are some of the success strategies in the promotion of SRH at the national level?
7. Talk about some of the challenges at policy level.(probe for cultural, religion and social Challenges)
8. Briefly describe which methods were used to monitor the intervention?

Community Leaders/Teachers

1. Do you think that young girls (10 & above) are at risk of teenage pregnancy?
2. What is your view about the use of contraceptive by young people to prevent unplanned pregnancy or STIs?
3. How best can Community groups support SRH in the community? What is your understanding of youth-friendly services?
4. Please tell us about some of the barriers that hinder young people's access to Sexual and reproductive information and services in your community?
5. What are some of the activities the community has for Sexual and reproductive information and services for adolescents? And how?
6. How appropriate is it for you to talk to boys and girls to about their sexuality?
7. Would you endorse sexuality education to adolescent? If yes, from what age? If No, why?

Adolescent Youths

1. What do you know about your sexuality?
2. How do you get information about your sexuality?
3. Are SRH information and services available to you and your friends?
4. Describe some of these services available and tell us how they can help young people?
5. What are some of the difficulties your friends experience in accessing SRH services?
6. What is your opinion on having sexual relationship with opposite sex outside marriage?
7. What is view about teenage pregnancy?
8. What is the perception of teenage pregnancy?
9. What are the facilitating factor(s) for teenage pregnancy?
10. Do you know about STIs/HIV/AIDS?
11. How can one contract STIs/HIV/AIDS?
12. Do you freely discuss SRH issues?
13. How do you make your reproductive health decision?
14. Have you ever visited SRH centre? (probe for the reason for visitation)
15. Do you know any available one around this community?
16. What are some of the local beliefs about pregnancy and child bearing at early age?
17. What are the challenges you have accessing SRH information and services?
18. Health/Youth Centre Managers
19. Are services on adolescent SRH being offered?
20. If yes, what are they? If no, why? How to intervene?
21. What are some of the services you render to young folks in community?
22. Which of them is mostly used by your target population?
23. Which of your services are less used?
24. Which strategies did you use in this intervention? (Interviewer: Probe for Others)
    [Peer education, Edutainment (fashion shows, movie nights, musical events, drama etc.) Youth friendly Clinic and outreach services, Mass media (Radio, TV, print media), Youth support structures (e.g. youth empowerment centers, youth groups), ICT (e.g. social networks, mobile tele-communication), Edu-sports, Life skills education, Mentorship, Adult behavior influencers (parents/guardians, community members, teachers, service providers) Advocacy.]
25. Describe how you used the strategies you have mentioned in this intervention.
26. Which one would you say is the most successful?
27. What components of SRH does/did the intervention address?
28. What type of clientele do you mostly serve? (probe for difference on gender, age, sex work, disability)
29. What factors have contributed to the success of the intervention? (Interviewer: Probe for information on environmental factors that affect the program such as policies, guidelines, economic, religious, geographical and socio-cultural)
30. What issues have hindered the success of the intervention? (Probe as above)
31. How can SRH information and services more accessible and available to adolescent youth.

County level officials

1. Are there existing programs on SRH? If yes, what specifically do they do?
2. Who are the key players?
3. What are some of the most successful strategies?
4. Is there coordination of activities among various actors?

5. What are the challenges?

County Structures/Parents

1. What role do you play in promoting SRH/FP towards adolescents?
2. Are some already promoting these services? If yes, what services and to whom?
3. What are some your strategies?
4. Which are more successful?
5. What are the barriers to these services?
6. Would you endorse sexuality education to adolescent? If yes, from what age? If No, why?