REPRODUCTIVE HEALTH *at a* GLANCE

LIBERIA

April 2011

Country Context

Since the end of the 14 years of devastating civil war in 2003, Liberia has made steady strides towards peace, stability, recovery and economic growth.[1] A majority of the population continues to live in poverty with 84 percent of the population still subsisting on less than US $1.25 per day.[2] One of the legacies of the two consecutive civil wars (1989–1996 and 1997–2003) is the devastation of basic infrastructure including the country's health system. Currently, 80 percent of Liberia's health services are provided by NGOs.[3] Over the past five years, significant progress has been made in the health sector to improve access to health services in Liberia. Access to Basic Package of Health Services (BPHS) has increased from 35 percent in 2009 to 80 percent in 2010.[4]

Liberia's large share of youth population (49 percent of the country population is younger than 15 years old) provides a window of opportunity for high growth and poverty reduction—the demographic dividend.[5] For this opportunity to result in accelerated growth, the government needs to invest more in the human capital formation of its youth.

Gender equality and women's empowerment are important for improving reproductive health. Higher levels of women's autonomy, education, wages, and labor market participation are associated with improved reproductive health outcomes.[6] In Liberia, the literacy rate among females ages 15 and above is 53 percent.[2] Fewer girls are enrolled in secondary schools compared to boys with a 75 percent ratio of female to male secondary enrollment.[2] Seventy percent of adult women participate in the labor force[2] that mostly involves work in agriculture.

Greater human capital for women will not translate into greater reproductive choice if they lack access to reproductive health services. It is thus important to ensure that health systems provide a basic package of reproductive health services, including family planning.[6]

Liberia: MDG 5 Status

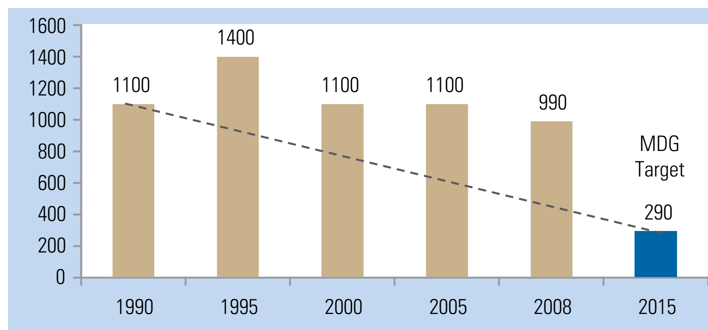
MDG 5A indicators	
Maternal Mortality Ratio (maternal deaths per 100,000 live births) *UN estimate*[a]	990
Births attended by skilled health personnel (percent)	46.3
MDG 5B indicators	
Contraceptive Prevalence Rate (percent)	11.4
Adolescent Fertility Rate (births per 1,000 women ages 15–19)	177
Antenatal care with health personnel (percent)	79.3
Unmet need for family planning (percent)	35.6

Source: Table compiled from multiple sources.
[a] *The 2006–07 DHS estimated maternal mortality ratio at 994.*

MDG Target 5A: Reduce by Three-quarters, between 1990 and 2015, the Maternal Mortality Ratio

Liberia has made insufficient progress over the past two decades on maternal health and is not on track to achieve its 2015 targets.[7]

Figure 1 ▪ Maternal mortality ratio 1990–2008 and 2015 target



Source: 2010 WHO/UNICEF/UNFPA/World Bank MMR report.

World Bank Support for Health in Liberia

The Bank's current ***Joint Country Assistance Strategy*** is for fiscal years 2009 to 2011.

Current Projects:
P105282 LR-Health Systems Reconstruction.

Pipeline Project: None

Previous health project: P105282 LR-Adolescent Sexual and Reproductive Health Project

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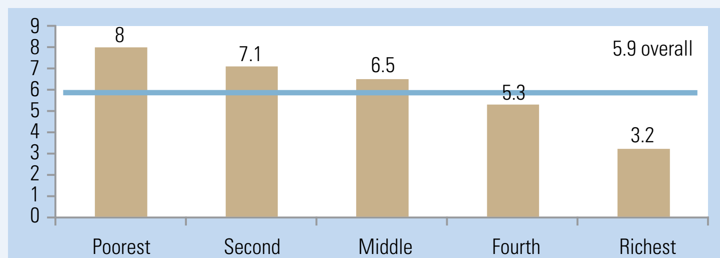
Key challenges

High Fertility

Fertility has recently increased. Total fertility rate (TFR) fell from 6.2 births per woman to 5.2 in 2007 but rose to 5.9 births per woman in 2009.[5] TFR is very high (over 6) among women in the lower three wealth quintiles (Figure 2).

Figure 2 ▪ Total fertility rate by wealth quintile



Source: Malaria Indicator Survey Final Report, Liberia 2009

It is higher among rural women (7.5) than urban women (4.2) and is twice higher among women no education (7.1) than those with secondary education or more (3.5).[5]

Adolescent fertility rate is high (177 births per 1,000 women aged 15–19 years) affecting not only young women and their children's health but also their long-term education and employment prospects. Births to women aged 15–19 years old have the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother.[6, 8]

Early childbearing is high but more frequent among the poor. While 51 percent of the poorest 20–24 years old women have had a child before reaching 18, 32 percent of their richer counterparts did (Figure 3). Furthermore, reduction in early childbearing mostly has taken place among the rich where younger cohorts of girls are less likely than older cohorts to have a child early in life.

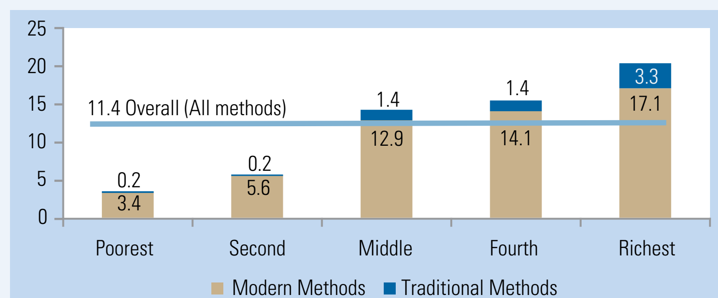
Figure 3 ▪ Percent women who have had a child before age 18 years by age group and wealth quintile

Source: DHS Final Report, Liberia 2007 (author's calculation)

Current use of contraception among married women is low. 11 percent of married women use contraception, most of them modern methods.[9] Injectables and the pill are the most commonly used method among married women. Use of long-term methods such as intrauterine device and implants are negligible.

There are important socioeconomic differences in the use of modern contraception among married women. It is high among women with secondary education or higher (18 percent), urban women (16 percent), and among the wealthiest (17 percent) (Figure 4).[9]

Figure 4 ▪ Use of contraceptives among married women by wealth quintile



Source: DHS Final Report, Liberia 2007

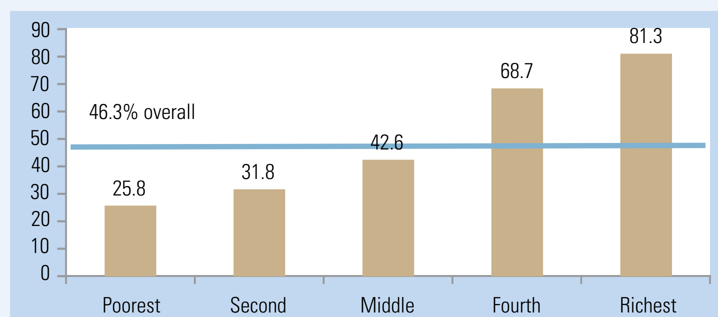
Unmet need for contraception is high at 36 percent[9] indicating that women may not be achieving their desired family size.[10]

Fear of side effects (thirty-two percent) and opposition to use (18 percent) are the predominant reasons women do not intend to use modern contraceptives in future.[9]

Poor Pregnancy Outcomes

While majority of pregnant women use antenatal care, institutional deliveries are less common. Four-fifths of pregnant women receive antenatal care from health personnel (doctor, nurse, midwife, or physician assistant) with 66 percent having the recommended four or more antenatal visits.[9] However, a smaller proportion, 46 percent deliver with the assistance of health personnel predominantly in the public sector. It is just a quarter among the poorest (Figure 5). Further, 62 percent of all pregnant women are anaemic (defined as haemoglobin < 110g/L)

Figure 5 ▪ Birth assisted by skilled health personnel (percentage) by wealth quintile



Source: DHS Final Report, Liberia 2007

increasing their risk of preterm delivery, low birth weight babies, stillbirth and newborn death.[11]

Of those women who did not give birth in a health facility, 43 percent never received postnatal care, while 44 percent got a postnatal check-up within two days.[9]

About half of women who indicated problems in accessing health care cited concerns regarding inability to afford the services, unavailability of drugs, long distance, or transport difficulties (Table 1).[9]

Table 1 ■ Barriers in accessing health care (women aged 15–49)

Reason	%
At least one problem accessing health care	76.3
Getting money for treatment	53.6
Concern no drugs available	51.3
Having to take transport	49.8
Distance to health facility	48.6
Concern no provider available	40.9
Getting permission to go for treatment	7.9

Source: DHS final report, Liberia 2007

Human resources for maternal health are still limited with only 0.33 physicians per 1,000 population but nurses and midwives are slightly more common, at 0.52 per 1,000 population.[12]

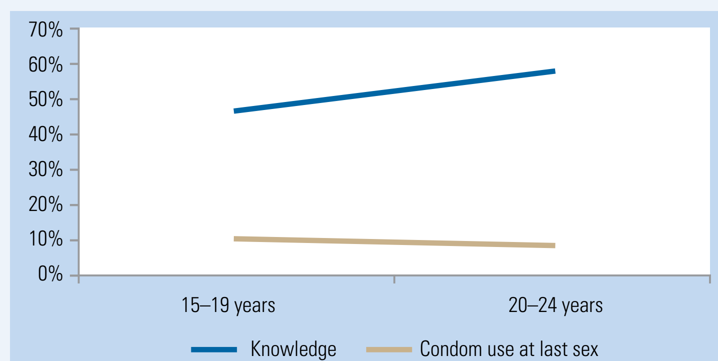
The very high maternal mortality ratio at 990 maternal deaths per 100,000 live births indicates that access to and quality of emergency obstetric and neonatal care (EmONC) remains a challenge.[7]

STIs/HIV/AIDS prevalence is low but a growing public health concern

HIV prevalence is low (1.3 percent) in Liberia but women are one of the most vulnerable groups.[9] Sixty one percent of women know that HIV can be transmitted through breast milk while just 14% know that the likelihood of passing HIV from mother to child can be reduced by drugs.[9]

There is a large knowledge-behavior gap regarding condom use for HIV prevention. While about 50 percent of young women are aware that using a condom in every intercourse prevents HIV, only 10 percent of them report having used condom at last intercourse (Figure 6). This gap widens among older women likely due to the fact that the chances of using condoms as a form of contraception diminishes with marriage.

Figure 6 ■ Knowledge behavior gap in HIV prevention among young women



Source: DHS Final Report, Liberia 2007 (author's calculation)

Technical Notes:

Improving Reproductive Health (RH) outcomes, as outlined in the RHAP, includes addressing high fertility, reducing unmet demand for contraception, improving pregnancy outcomes, and reducing STIs.

The RHAP has identified 57 focus countries based on poor reproductive health outcomes, high maternal mortality, high fertility and weak health systems. Specifically, the RHAP identifies high priority countries as those where the MMR is higher than 220/100,000 live births and TFR is greater than 3.These countries are also a subgroup of the Countdown to 2015 countries. Details of the RHAP are available at *www.worldbank.org/population*.

The Gender-related Development Index is a composite index developed by the UNDP that measures human development in the same dimensions as the HDI while adjusting for gender inequality. Its coverage is limited to 157 countries and areas for which the HDI rank was recalculated.

National Policies and Strategies that have Influenced Reproductive Health

2005 National HIV/AIDS policy

2007 National health policy and plan

2007 Basic Package of Health Services – 2007

2007 Roadmap for the Reduction of Maternal and Newborn Morbidity and Mortality

2008 Strategy for Reproductive Health Commodity Security

2009 National Reproductive Health Policy

2009 National Nutrition Policy

2009 National Malaria control policy

Key Actions to Improve RH Outcomes

Strengthen gender equality

- Support women and girls' economic and social empowerment. Increase school enrollment of girls. Strengthen employment prospects for girls and women. Educate and raise awareness on the impact of early marriage and child-bearing.
- Educate and empower women and girls to make reproductive health choices. Build on advocacy and community participation, and involve men in supporting women's health and wellbeing.

Reducing high fertility

- Address the issue of opposition to use of contraception and promote the benefits of small family sizes. Increase family planning awareness and utilization through outreach campaigns and messages in the media. Enlist community leaders and women's groups and emphasize community-based distribution.
- Provide quality family planning services that include counseling and advice, focusing on young (in-school and out-of-school) and poor populations. Highlight the effectiveness of modern contraceptive methods and properly educate women on the health risks and benefits of such methods.
- Promote the use of ALL modern contraceptive methods, including long-term methods, through proper counseling, which may entail training/re-training health care personnel.

Reducing maternal mortality and morbidity

- Promote institutional delivery through provider incentives and possibly, implement risk-pooling schemes. Provide vouchers to women in hard-to-reach areas for transport and/or to cover cost of delivery services. Provide baby starter kits to women who deliver at health facilities in rural settings.
- Strengthen Basic and Comprehensive EmONC health services at the county public and private health centers and hospitals.
- Improve access to maternal health services through the provision of outreach service and service delivery points in hard-to-reach rural and underserved communities.
- Address the inadequate human resources for health by training more midwives (in basic life saving skills and EmONC) and deploying them to the poorest or hard-to-reach districts.
- Strengthen the referral system by instituting emergency transport, training health personnel in appropriate referral procedures (referral protocols and recording of transfers) and establishing maternity waiting huts/homes near health facilities to accommodate women from remote communities who need to stay close to the facilities prior to delivery.

Reducing STIs/HIV/AIDS

- Integrate HIV/AIDS/STIs and family planning services in routine antenatal and postnatal care.
- Lower the incidence of HIV infections by strengthening Behavior Change Communication (BCC) programs via mass media and community outreach to raise HIV/AIDS awareness and knowledge.

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LIBERIA REPRODUCTIVE HEALTH ACTION PLAN INDICATORS

Indicator	Year	Level
Total fertility rate (births per woman ages 15–49)	2009	5.9
Adolescent fertility rate (births per 1,000 women ages 15–19)	2009	177
Contraceptive prevalence (% of married women ages 15–49)	2007	11.4
Unmet need for contraceptives (%)	2007	35.6
Median age at first birth (years) from DHS	—	—
Median age at marriage (years)	2007	18.6
Mean ideal number of children for all women	2007	5
Antenatal care with health personnel (%)	2007	79.3
Births attended by skilled health personnel (%)	2007	46.3
Proportion of pregnant women with hemoglobin <110 g/L	2008	62.1
Maternal mortality ratio (maternal deaths / 100,000 live births)	1990	1100
Maternal mortality ratio (maternal deaths / 100,000 live births)	1995	1400
Maternal mortality ratio (maternal deaths / 100,000 live births)	2000	1100
Maternal mortality ratio (maternal deaths / 100,000 live births)	2005	1100
Maternal mortality ratio (maternal deaths / 100,000 live births)	2008	990
Maternal mortality ratio (maternal deaths / 100,000 live births) target	2015	290
Infant mortality rate (per 1,000 live births)	2008	100
Newborns protected against tetanus (%)	2008	91
DPT3 immunization coverage (% by age 1)	2007	47.2
Pregnant women living with HIV who received antiretroviral drugs (%)	2005	0
Prevalence of HIV, total (% of population ages 15–49)	2007	1.3
Female adults with HIV (% of population ages 15+ with HIV)	2007	59.4
Prevalence of HIV, female (% ages 15–24)	2007	1.3

Indicator	Year	Level
Population, total (million)	2008	3.5
Population growth (annual %)	2008	2.1
Population ages 0–14 (% of total)	2008	42.9
Population ages 15–64 (% of total)	2008	54
Population ages 65 and above (% of total)	2008	3.1
Age dependency ratio (% of working-age population)	2008	85.3
Urban population (% of total)	2008	47
Mean size of households	2009	5.1
GNI per capita, Atlas method (current US$)	2008	170
GDP per capita (current US$)	2003	222
GDP growth (annual %)	2008	7.1
Population living below US$1.25 per day	2003	83.7
Labor force participation rate, female (% of female population ages 15–64)	2008	69.1
Literacy rate, adult female (% of females ages 15 and above)	2004	53
Total enrollment, primary (% net)	—	—
Ratio of female to male primary enrollment (%)	2008	89.5
Ratio of female to male secondary enrollment (%)	2008	75.4
Gender Development Index (GDI)	—	—
Health expenditure, total (% of GDP)	2007	10.6
Health expenditure, public (% of GDP)	2009	15
Health expenditure per capita (current US$)	2009	29
Physicians (per 1,000 population)	2009	0.33
Nurses and midwives (per 1,000 population)	2009	0.52

Indicator	Survey	Year	Poorest	Second	Middle	Fourth	Richest	Total	Poorest-Richest Difference	Poorest/Richest Ratio
Total fertility rate	MIS	2007	8.0	7.1	6.5	5.3	3.2	5.9	4.8	2.5
Current use of contraception (Modern method)	DHS	2007	3.4	5.6	12.9	14.1	17.1	10.3	–13.7	0.2
Current use of contraception (Any method)	DHS	2007	3.6	5.7	14.2	15.4	20.4	11.4	–16.8	0.2
Unmet need for family planning (Total)	DHS	2007	32.3	37.4	38.1	37.9	31.6	35.6	0.7	1.0
Births attended by skilled health personnel (percent)	DHS	2007	25.8	31.8	42.6	68.7	81.3	46.3	–55.5	0.3

Development Partners Support for Reproductive Health in Liberia

Chinese Government: Essential drugs, construction of a hospital, training of health workers

Clinton Foundation: BPHS, HIV/AIDS

DFID: Maternal and child health, training of midwives

EU: Primary health care and training institutions

GAVI: Immunization services and health system strengthening, M&E,

Global Fund: Malaria, STIs and HIV/AIDS

Italian government: Training of medical doctor, renovation Medical College

Irish Aid: BPHS implementation

JICA: Renovation of Maternity Hospital, training of health workers

McCoil McBain: Construction of a hospital, Midwifery Training

SIDA: Support for SGBV

UNFPA: Reproductive health and rights, maternal health programs, and training of midwives

UNICEF: Support to maternal health, under-5 mortality and child protection, training of health professionals, BPHS implementation, nutrition

USAID: Health systems strengthening, implementation of BPHS, family planning, performance based contracting for reproductive health delivery, supply chain, training institutions.

WAHO: Maternal and child health and nutrition

WHO: Maternal and child health, immunization programs

World Bank: LR-Health Systems Reconstruction project

World Food Program (WFP): Maternal and child nutrition

Local and International NGO, FBOs Private Sectors: Delivery of health services at health facilities in Reproductive health, maternal and child health