BARRIERS IN ACCESSING SEXUAL AND REPRODUCTIVE HEALTH SERVICES AMONG YOUTH IN LIBERIA

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Abstract

Introduction Liberia has a youthful population with about more than 50 percent below the age of 25 years. Despite the need for sexual and reproductive health services(SRHS), youths in Liberia face many barriers to accessing SRHS. This paper considers the factors that influence access to sexual and reproductive health services among adolescents and youth and specific strategies to improve access to SRHS in Liberia.

Methodology A literature review was done using peer and non- peer articles written in English. PubMed and google scholar data bases were searched considering publications from 2010 to 2020. Websites of different international organizations were searched. This review included articles on adolescents(age 15 to 19 years) and youths(age 20 to 24 years). Specific interventions explored included STI/HIV and contraception. The socio-ecological frame work was used to analyse the research objectives.

Findings The study identified key barriers to accessing SRHS. These barriers include; lack of information on various contraceptive methods, Fear of side effects, perceived infertility, feeling ashamed and fear of condemnation for method use and partner or spousal refusal. Inadequate supply and stock-out, negative attitude of service provider and violation of confidentiality. The gender expectations, position in the society and the economic power dynamics also pose as barriers to access of SRHS.

Conclusion Though policy on the SRHR for youth exists, there is a gap between the intention of the policy and the actual implementation. Actions to address barriers in access to YSRHS need a multi-faceted approach addressing the individual, community, organizational and the policy level.

Key words The Key search teams were focused on these specific variables: Adolescents, youth, sexual and reproductive health, contraceptives services, sexually transmitted diseases, HIV, enablers and barriers.

List of abbreviation

AFHS	ADOLESCENT FRIENDLY HEALTH SERVICE
AIDS	ACQUIRED IMMUNODEFICIENCY SYNDROME
ARH	ADOLESCENT REPRODUCTIVE HEALTH
ASRH	ADOLESCENT SEXUAL AND REPRODUCTIVE HEALTH
CSO	CIVIL SOCIETY ORGANIZATION
GPI	GENDER PARITY INDEX
HIV	HUMAN IMMUNODEFICIENCY VIRUS
ICPD	INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT
IEC	Information, education and communication
IPPF	INTERNATIONAL PLAN PARENTHOOD FEDERATION
LDHS	LIBERIA DEMOGRAPHIC HEALTH SURVEY
MCP	MARKET CONTRACEPTIVE PROJECT
NGO	NON-GOVERNMENTAL ORGANIZATION
OOPE	OUT OF POCKET EXPENDITURE
OPD	OUT PATIENT DEPARTMENT
PEP	POST EXPOSURE PROPHYLAXIS
PPAL	PLANNED PARENTHOOD ASSOCIATION OF LIBERIA
RHS	REPRODUCTIVE HEALTH SERVICE
RN	REGISTERED NURSE
SEM	SOCIO-ECOLOGICAL MODEL
SRH	SEXUAL AND REPRODUCTIVE HEALTH
SRHS	SEXUAL AND REPRODUCTIVE HEALTH SERVICE
STI	SEXUALLY TRANSMITTED INFECTION
UNFPA	UNITED NATION POPULATION FUND
UNICEF	UNITED NATION INTERNATIONAL CHILDREN FUND
VCT	VOLUNTARY TESTING AND COUNSELLING
WHO	WORLD HEALTH ORGANIZATION
YFSRHS	YOUTH FRIENDLY SEXUAL AND REPRODUCTIVE HEALTH SERVICE

Definition of keys Terms

Words	Definition
Adolescent/ youth	Is defined as a person between 10- 19 years of age while youth is between the ages of 15-24(1).
Sexual health	is defined as a state of physical, emotional, mental, and social well-being with sexuality; it is not merely the absence of disease, dysfunction, or infirmity(2).
Reproductive Health	is defined as physical, mental and social wellbeing in all matters relating to the reproductive system and functions at all stages in life(2).
Adolescent sexual and reproductive health	health refers to the physical as well as the emotional well-being of adolescents and includes their ability to be healthy and remain free from unwanted pregnancy, unsafe abortion, maternal death and disability, all forms of sexual violence and coercion, sexually transmitted diseases, including HIV/AIDS(3).

Introduction

The Sexual and Reproductive Health (SRH) policy of Liberia 2010 states that one of the mandate of the government of Liberia is to ensure adolescents have access to the full range of SRHS leading to the improvement of SRH of young people, however there are still barriers to improved SRH access for young people(4).

I worked as a Registered Nurse (RN) at the Out-patient Department (OPD) at one of Liberia's biggest hospital in the central part of the country. When I was working at this department I interacted with many patients of different ages and health conditions. But predominantly took interest in the young people. This was because of the unintended pregnancies and repeated STIs seeing among these youths because of the perceived knowledge about condom and family planning. I listened to youths expressing their embarrassment and fear of accessing care from SRH providers who were far older in age. With embarrassment some shy away from seeking SRH services. As a young person working among those elderly service providers, many young people preferred coming to me for services related to contraception and STIs.

This paper considered the barriers and specific strategies to access sexual and reproductive health services in Liberia. This research is more important for Liberia at this time because Liberia has a youthful population and neglecting Youth Sexual and Reproductive Health (YSRH) will be devastating to the transitioning of the population to adulthood and can lead to lifetime complication and some instances death.

Chapter 1: Background

1.1: Demographic Features

Liberia is located on the west coast of Africa, with a land area of 11,080 sq.km and a coastline of 560km that stretches along the Atlantic Ocean. The country is bordered by Sierra Leone to the west, Guinea to the northwest, and Cote d'Ivoire to the northeast and the Atlantic Ocean to the south. The country is divided into fifteen counties that are further subdivided into districts and clans. Liberia has a population of approximately 4.3 million people, with an average life expectancy of 59 years(5).

1.2 Religious and Traditional Beliefs practices

Officially, 86 per cent of Liberia's population identify themselves as Christian, while 12 per cent is Muslim and the remaining hold to their traditional tribal beliefs. In Liberia, both Monogamy (one man having one wife) and polygamy (one man having more than one wife) are practiced(6).

1.3 Education

Generally, about 64.7% of the total population of Liberians aged 15 to 49 years are literate with the rate in rural Liberia being 40% lower than those in urban Liberia. Also, on average, males have a 30% higher literacy rate than the females and the poorest groups are 50% less literate than the richest groups. The average literacy rate for youths above 15 years is 45.6% with over 50% not having pre- primary education (7).

There have been positive changes in the Gender parity index (GPI) of Liberia of recent. At the elementary and junior high levels, GPI stands at 0.96 and 0.98 respectively. Notably, female literacy has realized a significant increase over the past eight years. According to the Demographic and Health Survey (DHS), women's literacy rose from 41 per cent in (2007) to 48 per cent in (2013). In 2013 69 per cent of 15-19 years old female were literate, compared to 29 per cent of female aged 40-44 suggesting great gains among younger females in literacy acquisition(8). A study showed that Liberian youths especially the uneducated ones who have either not gone to school at all or stopped at elementary school levels, are confronted with considerable SRH challenges(9).These challenges stem from lack of relevant knowledge on available contraceptive services. They also tend to have little or no knowledge on HIV testing. These challenges may contribute to the high rate of unintended pregnancy amongst them.(10).

1.4 Economy

Liberia is a low-income country; it is among the poorest countries in the world. The Human Development Index (HDI) 2018 puts Liberia at 0.46, ranking Liberia at 176 out of 196 countries. According to the world Bank, about 54 per cent of the population of Liberia live below the poverty line. This means they live on less than US 2.00 per day. It further noted that poverty was higher in rural areas compared to urban; 70 per cent verse 43 per cent respectively. Also, a greater part of the population live in the urban areas (9).

1.5 Health System

Liberia has a total fertility rate of 4.2%, with a total health expenditure per person of about $65 USD of which 26% is out of pocket expenditure (OOPE). The effective universal health coverage (UHC) index of Liberia was 47.6% as at 2019. The maternal mortality rate as of 2017 was 661/100,000 live births. Unsafe sex is major driver of the cause of death at 22.1% and HIV/AIDS is the 6th highest cause of death accounting for 30.2% of the total annual mortality for 2019(8).

The Liberia Health System is based on three main levels: Primary, secondary and tertiary. The primary level consists of both community and facility-based services; at the health post facility, essential preventive, curative and health promotion and basic emergency care are provided. The community-based services focus on health promotion and education while linking the community to the facility (9 According to a survey of health facilities done in 2019, the total number of health facilities was 753. Six hundred and ninety-nine(699) of these health facilities were classified as functional while the rest were non-functional(11). The secondary level includes all aspect from the primary with provision for 24/7 hospitalizations. The tertiary provides all secondary services and specialized consultation-based services. Most rural dwellers live more than 1 hour walk away from a health post facility. Emergency care usually need to be referred. However, there is a greater burden on the health system because the patients bypass due to self- referral and end up at the wrong healthcare levels10). There is also a strong public - private partnership in the health care system in Liberia. This is done by capitations of most of the faith based and large private clinics and hospitals scattered around the country to improve accessibility. These private providers are regularly supervised by the county clinical supervisor and other members of the county health team. Apart from the capitations, diagnostic materials and essential drugs and supplies are provided to these private providers to ensure that they comply with the agreed protocols (2).

1.6. SRH policy

The Liberia SRH policy refers to essential SRH as part of a package known as the basic package of health services (BPHS). It comprises of maternal and new-born health, family planning, GBV/SGBV, reproductive tract diseases, and adolescent health. Emphasis is placed building the capacity of the health care workers and encouraging male involvement. Provision for mitigating against SGBV in the BPHS include the promotion of advocacy and social mobilization, establishment of effective reporting system for incidents of SGBV and the provision of an accessible comprehensive service for survivors of SGBV. This includes the collection of medicolegal evidence and is done in collaboration with the social and legal sectors like the police force. Further provisions in the BPHS for STI/HIV prevention include provision of counselling services in the health facilities in addition to public education

campaigns and provision of free treatments for STI in the government health care system (12)(13)(4).

1.7. Family planning policy

Also, as part of the BPHS, the family planning policy package include Guaranteeing the accessibility and delivery of a complete range of family planning methods. The clients must be well informed on the available options to help them decide which method they can choose from. The BHSP also provides for emergency contraception to prevent unintended pregnancies especially in cases of rape where it is combined with the post-exposure prophylaxis (PEP). Emphasis is placed during post rape counselling on both the prevention of STIs/HIV and unintended pregnancy. The BPHS also provides for the accessibility of contraceptive services to adolescents by making contraceptive options free in government health facilities. The strategy for increasing the access to contraceptive services is by consolidating community-based contraceptive provision. The policy also encourages integration of SRH services by providing comprehensive SRHS at most government maternal and child health care centres (12).

1.8. HIV policy

The Liberian HIV policy is aimed at making sure there is provision of proper counselling and prevention services. Emphasis is also placed on adequate services to manage cancers of the reproductive tract and infections, such as STIs and HIV. The policy also encourages the use of relevant information, education and communication (IEC) and messaging that improve behaviour change that reduces or improves infections of the reproductive tract or STI/HIV across all stages of care. Also, guidelines and protocols for the management of STI/HIV are designed and provided in the policy. Other aspects addressed by this policy is the procurement and provision of essential drugs to treat these conditions according to the protocols including diagnostic supplies(13).

Chapter 2: Problem statement/justification and objective

2.1: problem statement and justification

This chapter comprises of the problem statement, Justification and Objectives.
In 1994, when the international conference on population and development (ICPD) took place, the development-related priorities world's population changed. more emphasis was placed on social inclusion, human rights and the importance of addressing the needs and developing the capacities of the youths. These global commitments have been articulated in international agreements, including convention on the Elimination of All Forms of Discrimination against women (1979), The sustainable development goals (SDG) 3 and 5 targets 3.1, 3.7 and 5 which focuses on achieving universal access to reproductive health and gender equality(14), United Nations Commission on Population and Development (UNCPD) (2012), and the Bali Global Youth Forum Declaration (2012).

Global challenge

Youth sexual and reproductive health (YSRH) is a global public health concern since youths face a lot of challenges. An estimated 222 million women Including youths in the developing world have Unmet need for modern method of contraception with Sub-Saharan Africa and Central Asia together accounting for 59 per cent (15). High rate of unintended pregnancies amongst youths and adolescents is most common in poorer and marginalized settings especially due to lack of education, poverty and unemployment. Other causes of unintended pregnancies include sexual violence. This is so serious in some countries where more than a third of girls report sexual coercion in their first sexual encounter(16).Secondly, In the least developed countries about 39% of girls get married under the age of 18 years and about 12% of girls under 15 years. Though in most instances they are pressured into these marriages, other girls prefer to get pregnant and married early since they lack education and do not have any means of livelihood. Moreover, the society value marriage and motherhood in most of these societies(17)(18). An Estimated 25.1 million unsafe abortion occurred between 2010 to 2014, with 97% of the 25.1 million is from a developing country(19)(20). Forty-one per cent of unsafe abortions in developing regions are among young people aged 15-24 years, and 15 per cent among those aged 15-19 years old(21). Youths are confronted with poor SRHR indicators, for instance, the highest rates of sexually transmitted diseases (STDs) occur among 20-24 years old, followed by 15-19 year old(22). Sub-Saharan Africa is the region where persons age 10- 19 years constitute the largest proportion of the population(23). Youth in this region are particularly at high risk for HIV infection with 2.2 per cent of young women and 1.1 per cent of young men living with HIV as of 2013(24).

SRH Issues in Liberia

Limited access to health services is one of the causes of poor SRH indicators of Liberia(such as early unintended pregnancies, challenges in having access to either contraceptive services or the contraceptive, and challenge accessing safe abortion services)(25). In Liberia contraceptive use among the youth is low. According to the DHS report (2019), the unmet need for family planning in Liberia is 42.7% (age 15 – 19 years) and 35.8% for (age 20 – 24 years). Also, 49.1% of women age 15 – 19 years have had a live birth(8). By the age of 18, up to 48 per cent of girls have begun childbearing(13). One of the consequences of unmet need for family planning (FP) among adolescents and young people aged 15-24 years is teenage pregnancy. Adolescent's pregnancies are common as a result of early onset of sexual debut and societal pressures on these youths to get married early and bear children, early marriage in Liberia constitute 13 per cent(10). The LDHS showed that 26% of all adolescent pregnancies are unintended and 30 per cent and end up in unsafe abortion respectively. The prevalence rate of HIV among women in Liberia have been on a downward trend with the recent rate being 1% for between 2018 and 2019(26).

The low access to sexual and reproductive health services and low uptake of contraceptive in the country for young people has increased SRH problems including risky behaviours leading to the transmission of STIs, HIV/AIDs, ad high teenage pregnancies(10).

Adolescents and youths are faced with systemic barriers that predisposes them to experiencing less informed choice, lack of education and money reducing their ability to access health information and services. Furthermore, they are faced with barriers like laws and policies restriction to accessing contraceptives and other sexually related services(27). The attitude of healthcare workers due to personal bias or reluctance to appreciate the sexual and reproductive health needs of adolescents and youths further acts as barrier to accessing SRHS. Liberia recognizes the importance of providing sexual and reproductive health services as evidenced by the development of SRH policy In Liberia(13).

There is a high need for Liberia to adopt more pragmatic interventions since adolescents and young people are a very important part of the population with special needs including sexual and reproductive health services provision. This study intends to discover strategies and interventions at the individual, interpersonal, community, Organisation and public policy that can fit in the Liberia setting for adequately addressing sexual and reproductive health services access and utilization. This will have a positive impact on the population by preventing youth against SRH related morbidity and mortality by empowering the youth and enabling them to pursue education and employment.

2.2: Objectives

2.2.1 General Objective

To identify factors that influence access to sexual and reproductive health services among adolescent and young people (15-24 years) in order to formulate policy recommendations to improve access to sexual and reproductive health services in Liberia.

2.2.2 Specific Objectives

1. To identify factors at the individual, interpersonal and the community levels that influence youth access to sexual and reproductive health services in Liberia.
2. To identify factors at the organization and policy level that influence access to sexual and reproductive health in Liberia.
3. To identify and discuss approaches and strategies to address factors influencing access to sexual and reproductive health services in Liberia.
4. To formulate policy recommendations to improve access to adolescent sexual and reproductive health services in Liberia.

Chapter 3: Methodology

A literature review was done to meet the above research objectives using peer and non-peer-reviewed articles. Electronic databases such as PubMed, google scholar were accessed. Websites of different international organizations were searched including world health organization (WHO), United Nations Children's Fund (UNICEF), United Nations Population Fund (UNFPA), International Planned Parenthood Federation (IPPF), World Bank, United States Agency for International Development
(USAID), the Guttmacher institute. National websites including the Ministry of Health & Social Welfare, Republic of Liberia, Liberia Institute of Statistics and Geo-Information Services (LISGIS), and Liberian demographic and health survey (LDHS).

Inclusion criteria

According to the World Health Organization (WHO), and United Nations (UN) young people are defined as those aged 10-24. This review therefore included articles on adolescents and youths(28)(1). This study was therefore, limited to adolescents (age 15 to 19 years) and youths (age 20 to 24 years) because these age groups comprise of a greater population of Liberia and the SRH. Also, the challenges amongst these age groups represent a greater public health burden in Liberia. Articles or reports for all age groups including information on youth will also be used. Where information was insufficient from Liberia, articles from other countries in west Africa and sub- Saharan Africa with similar contexts were used.

Table 1: Inclusion and Exclusion criteria

CATEGORY	INCLUDED	EXCLUDED
Population of interest	Adolescents (age 15 to 19 years) and youths (age 20 to 24 years)	All age below 15 years and above 24 years
Article type	Peer-reviewed articles and grey literature	
Intervention	STI/HIV and contraception	Any other article describing a different intervention
Publication date	Any publication between 2010 and 2020 excluding 1998(framework)	Publications before 2010
Language	English language	Other languages

3.1: Keywords

Keywords used include using AND, OR

- geographic focus: Liberia-, Africa-, low- and middle-income countries or low resource settings, developing countries, sub- Saharan Africa.

- SRHR related topics like; youth, adolescents, young people, reproductive health, sexual and reproductive health, sexual and reproductive services, family planning, contraceptives services, sexually transmitted diseases, HIV, health services, enablers and barriers.
- Framework factors considered, organization, provider, institution, policy, community, norms, value and society, population perspectives, household, interpersonal, families and social network, individual knowledge, attitude and perception.

THEORITICAL FRAMEWORK

To provide a theoretical framework for the narrative review, several frameworks were considered by the researcher. These included the Levesque model on access to health services(29). This was not utilized because it does not take into account the different levels of wider perspectives of the barriers that are applicable to these specific demographic groups and the conceptual framework of youth and adolescent health by Robert W. Blum, Nan Marie Astone, Michele R. Decker and Venkatraman Chandra Mouli(30). The ecological approach to health care by conceptualising access at the interface of health systems and populations was however utilized(31). This ecological model in figure 2 was considered because it has an intersectoral and holistic approach in describing factors influencing access to sexual and reproductive health services. This framework was used to develop the objectives and define key terms. I also used it for the analysis and structure of this paper.

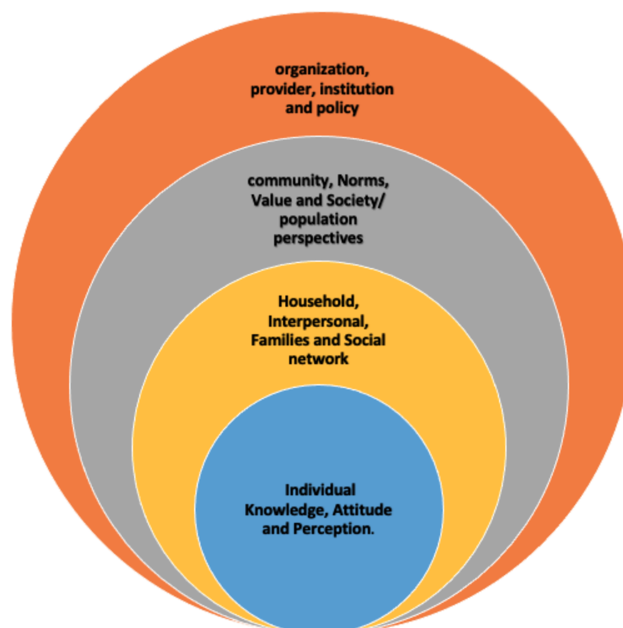

Figure 1: The socio ecological framework(31)

The model defines four levels of interactions (see table 2). The intrapersonal or Individual level looked at characteristics of an individual that can influence the individuals' behaviours such as individuals' knowledge and attitude. The interpersonal level explored how other people like families, friends and social network influence both negatively and positively youth SRH care-seeking behaviour. Community level examined how norms and values influence adolescent and youth SRH care and the barriers it can cause. Sexual and reproductive health needs an intersectoral approach to be successful. The level of organizations, public policy and policies, therefore, looked at other sectors and how they influence the sexual and reproductive need of young people, Policies that have enabled the sexual and reproductive health of young people, the laws and agencies at every level of government was examined to find out more effective ways of dealing with sexual and reproductive health issues of young people.

Table 2: A Description of Social Ecological Model (SEM) Levels(31)

SEM Level	Description
Individual	• Characteristics of an individual that influence behavior including knowledge, attitudes, behavior, self-efficacy, developmental history, gender, age, religious identity, racial/ethnic/caste identity, sexual orientation, socio-economic status, financial resources, values, goals, expectations, literacy, stigma, and others.
Interpersonal	• Formal (and informal) social networks and social support systems that can influence individual behaviors, including family, friends, peers, co-workers, religious networks, customs or traditions.
Community	• Relationships among organizations, institutions, and informational networks within defined boundaries, including the built environment (e.g., parks), village associations, community leaders, businesses, and transportation.
Organizational, Policy/Enabling Environment	• Organizations or social institutions with rules and regulations for operations that affect how, or how well, for example, MNCHN services are provided to an individual or group; schools that include MNCHN in the curriculum.

3.2 Limitation of the methodology

The major limitation was the lack of sufficient data from Liberia, especially peer-reviewed literature. Therefore, data from other national grey literatures and international electronic sources were used. Also, studies from countries in the African region with similar setting

were reviewed as well. The research does not provide a comprehensive overview of all SRHR services but focuses on two of the SRH component of several issues. These are STI/HIV and contraception because, for the selected age groups, these components present a greater public health burden. Also, the analytical framework did not include the aspect of the proven strategies utilized to improve access to SRHS by youths and adolescents in Liberia.

Chapter 4: Results

This chapter uses an ecological approach to discuss the sexual and reproductive health for youths in Liberia by conceptualising the different levels at the interface of health systems and populations and how it influences access to sexual and reproductive health services (SRHS). The review followed the general objectives of the thesis. It aims to Identify factors that influence access to sexual and reproductive health services among adolescents and youths in Liberia. Emphasis is on contraception and STI/HIV comprehensive services. Also, in the final chapter, approaches and strategies to address the factors influencing access to SRHS were explored.

4.1 Individual Knowledge, Attitude and Perception

At this level the researcher reviewed literature of knowledge, attitude and perceptions of adolescents and youths concerning SRH with a focus on STI /HIV and contraceptive services.

Sexual Behaviour

Many adolescents and youths are not adequately prepared to manage the risks or results before they engage in early sexual debut. The gender expectations, position in the society and the economic power dynamics can all play a role in either engage in early sexual activity or even be able to negotiate a safer sexual behaviour(32). A clustered study done in selected urban slums in Monrovia, Liberia examined the inter-personal and psycho-social aspects within the physical and social environment to understand the ecological determinants that shape these sexual behaviours in boys and girls. The key focus of the study was at the levels of the individual knowledge, attitude and perception; the inter-personal, household, families and social networks and the community, Norms, Value and Society/ population perspectives(33). Individual and psycho-social elements played roles amongst the four groups studied. These groups where assessed for: "future goals and aspirations" , "individual determination", "respect for one's self", and "individual motivation" focus on one's personal attributes.

Themes that discouraged adolescent and youths from engaging in sexual activities included desire to strive towards education and career ambitions as well as having a strong(thick) character(having a strong personality that resist undue peer pressure); consequences of sexual activity which included pregnancy and or its complication HIV/AIDS and a worsening of their poverty – these themes tend to discourage adolescents and youths from engaging in sexual activities. For instance, according to a boy, "It have to do with my age, not having sex, because I am determined, let's say focus[ed] on education, my fear [of being] poor in the future. So, I prefer keeping myself than to put

myself into calamity … in the sense that my daddy still buying me shoes, then you tell me that if I go out and pregnant somebody daughter, you think my daddy will be able to buy me shoes? The money he using to buy me shoes, he will end all taking it to buy pampers for my children....” Another girl said, “When you small and get pregnant, your parents will give you to that man to get marry to you and then the man do not have [money], you will suffer, so I will stay from sex and achieve my goals...”(33)

On the other side themes emerged that increase sexual activities of both adolescents and youths such as “sex pressure” and “poverty”, “material things,” and “want new clothes” reflecting the desire for material things but being hindered because of poverty and having a weak ((thin) character)- a personality that can easily be swayed. For instance, a girl said, “seeing your friends with new things, and you want it at all costs.” Another girl said, “I have so many friends who wear new thing[s] every day, and I complain to my parents to buy the same cloth[es] my friends are wearing, they will tell you that they don't have money, you should manage with what you get, [but] I will find all means to get it … ”(34). These findings explain the role of transactional sex in encouraging risky sexual behaviours.

PERCEPTION ON UTILIZATION OF SRH SERVICES

There remain a lot of challenges in the perception and choices for SRH services amongst adolescents especially in the area of preventing unwanted pregnancies, HIV and treatment of STIs in Liberia. Youths in Liberia perceived infertility as a side effect of contraceptive(10). A survey among girls age 12 – 19 years across four African countries including Burkina Faso and Ghana. The study showed a poor attitude of youths towards available SRH services especially in the area of contraception, STI services and HIV testing displayed by a general lack of interest and ignorance of these services(35). Most of the sexually active youths and adolescents lack the knowledge of where to get access to these services. The main reason was due to fear/embarrassment or the cost of accessing these services. This survey further showed that these adolescents would prefer public clinics that would ensure the confidentiality of the services in an affordable and accessible, including the timing of the services. Though there were some differences among the gender and the different countries studied, the views were generally similar(35). According to Singh S et al., the high rate of early initiation of sex amongst young people in sub-Saharan Africa, the Caribbean and Latin America may be an indication of the lack of sex education. This might encourage them to engage in risky sexual behaviours since they lack the knowledge on how to protect their sexual health. (36). For instance, in another study done across four countries in SSA namely in Burkina Faso, Ghana, Malawi, and Uganda amongst adolescents aged 12 – 19 years showed that a better knowledge of the risks of unprotected sex was associated with a higher rate of condom use(37). The misconception

of lack of pleasure when using condom by youths expose them to STI. Also, other misconception that the use of modern method of family planning services will make women to find it difficult to get pregnant prevent them from using contraception(38). Furthermore, studies showed that the perception of available sexual and reproductive health services varied between girls and boys about the mode of services delivery. Access to FP services as part of integrated services by young girls were found to be good, while boys indicated that the integrated services were design for girls leading to feeling of embarrassment at accessing SRHS from the facility(39).

Access to Information and services

Research carried out amongst Liberian youths showed that the inability to read hinder their ability to access information about HIV as it limits their ability to comprehend the information related to HIV prevention (40). Further studies in West Africa found that only 19 per cent of adolescents knew where to obtain HIV testing(21). Though the knowledge of HIV transmission, prevention and the source of services has increased among youths, utilization is still low. The main route of transmission as shown by a study from sierra leone was unprotected sex(39). Furthermore, women and adolescents face different barriers like lack of information concerning various contraceptive methods, fear of side effects, perceived infertility, fear of social condemnation for method use, and perceived partner opposition(41). According to a study done In Ghana, a misconception about STI among adolescent and young people hinder their care-seeking behaviour. About 51 per cent of males and 37 per cent of female interviewed on the causes of STI, Stated that STIs are acquired through Witchcraft, juju, as punishment for adultery(42). They fear that contraceptive use would prevent them from getting pregnant when married and condom give less pleasurable desire when having sex or may steak within the vaginal. This is reflected in the refusal or low uptake of contraceptives(43). Twenty-six per cent heard of family planning from both radio and television, 16 per cent from radio only. Also in four Sub-Saharan African countries it was identified that 60 per cent of adolescents believed misconceptions or had poor knowledge about the prevention of unintended pregnancy and HIV, this is in agreement with one-third not knowing about sources where they can access contraceptive(27). Study done in Nigeria show that 52.9 percent of the study population had limited knowledge of STI, influencing risky sexual behaviour among youths. The sexual and reproductive health seeking behaviours of youths show that young people refuse access to SRH services for personal reasons attributed to side effects like missed menses or excessive bleeding during menstrual period(45). Also it was discovered that majority of the respondents 96 per cent knew at least one method of contraceptive but only 38 per cent were currently using any method (45). Embarrassment was one barrier seen among adolescent and youth in accessing sexual and reproductive health services in

while shyness was the most common reasons among adolescents boys (69 per cent), confidentiality was the first reason for adolescents girls and shyness was the second commonest reason for not accessing RHS(46)(47). Contraceptive use was also found to be linked with the level of education among young women. Older age as a positive factor associated with contraceptive use was identified as 22 percentages 20-24 per cent(48). A qualitative research conducted among adolescents' views on SRH in four Africans countries mentioned that young people got their information on SRH from various NGOs as sources; These NGOs used both outreach work in school and communities to share the information. The evidence from this research showed that religious leaders were less frequently cited as a source of information for young people. In all countries, mass media came out from young people as the primary source of receiving SRH information(49). Mass media was identified as one of the means from which adolescents heard of SRH issues, as evidenced by 71.9 per cent alluding to media as a source(50).

4.2 Household, Interpersonal, Families and Social network

At this level the roles of families, friends and social networks on youths sexual and reproductive health especially STI/ AIDs and contraception is explored.

Families and friends

Findings from a clustered mapping study conducted in Monrovia Liberia demonstrated that while friends discouraged participants from engaging in sexual activities, others encouraged such activities(34). For instance, exploring themes such as "respect for one's self," "positive encouragement," and "individual motivation". A girl said , "You will want to be like her …if you see your friend respectful, kind and good character..." On the other hand, other girls cited "peer pressure" as a reason for engaging in early sexual activities. Described as "wanting to do the same thing their friends are doing". As one girl put it, "we have our parents, but we can't listen to them, but as soon we see our friends going, we jump behind them...." Also, some of these boys explained that, "hearing "friends boasting" and wanting to be like their friends..."

The role of parental support also emerged: "positive encouragement", "good advice from role models" and "individual motivation" , "fear of negative repercussions," and "parental control''. A boy said, "parents know the important of school … So, they will let their children stay in school … because we the youth are the future leaders...." However, there are instances cited where some parents pressured the youths to engage in transactional sex on themes of "sex pressure" and "poverty" and "little positive encouragement". Describing pressure from parents and siblings, girls engage in transactional sex to provide them with money, food and other items. As a girl said, "Parents will see their friend[s'] children bringing money in their house and doing thing[s] for her parent, so she will tell her children say, "every day you in this house doing nothing, go and follow your friend and bring

things”. Another girl said, “most parents send [their daughters] out if they feel you big [enough] to go look for money for the house...” some complain that their families may send them away from the house or physical abuse them if they resist(34).

Families’ influence on youth care-seeking behaviour and the involvement of parents in youth sexual and reproductive health is essential for the success of their sexual and reproductive health needs; parental education on youth SRH issues influence the reproductive health behaviours of youths, encouraging and promoting the use of a condom (41). According to a study done on parental influence on the reproductive health behaviours of youths in Ibadan, Nigeria, mothers’ involvement in family life promote safe sexual practices through informing and educating youth about their sexual and reproductive health issues (41). Also, according to Ezenwaka U et al., HIV/AIDS and SRH issues in the families was shown to be important factors that deserved the attention on parent-child communication, and deserves the attention of all stake holders in public health(51). Studies in countries about sexuality showed that some parents acknowledged finding it difficult when communicating sex and sexuality with adolescent. Cultural and religious beliefs, misconceptions that early onset of contraceptive could lead to infertility and promiscuity, prevented parents from discussing SRH related matters. Reasons for poor parental communication to young people on SRH matters included lack of knowledge, poor communication skills along with time constraint(46)(51). However, it has been identified by evidence that dialogue between parents and adolescents is an effective method for communicating sexual and reproductive health information. Parents have an influence on their children emotional, social and cognitive developing which should allow them to be involved in addressing their SRH needs (44). On the issue of daily living environment, participants stated that living in one room apartments with regular exposure to parents and /or siblings’ sexual activity makes them to develop interest in engaging in sexual activities. While some of the participants view “exposure to sex” as the main cause of this increased interest in engaging in early risky sexual behaviours. This sentiment was described by one boy “You see your mother or father having sex … and the next day you want try experiment....” furthermore, some of the girls said “always [being] around boys” expose them to an increased risk of sexual assault and rape. They further expressed that the family practice of inviting men into their homes expose them to the risk of sexual assault or rape by some of those men that come to sleep in their house

Social networks. Studies showed that most adolescents preferred discussing sexual reproductive health issues with a peer of same-sex or sibling compared to their parents(48). Interestingly, peers pressure are the major contributing factors for youths

or young people engaging in risky sexual behaviour; youths reported that peer can influence their decision concerning sex even if they don't want to(52).

Female gatekeepers in communities and health facilities were discovered in a research as impactful recruiters for contraceptive use(1). According to Yesus and Fantahun,in a study done in Ethiopia, 83.3 percent of sexual and reproductive health information is learned from schools and friends by adolescents (52). Male influence especially the spouse or partners has been identified as one the strongest factor in women's decisions to utilize FP services(53).

4.3 community, Norms, Value and Society/ population perspectives

This level looked at the norms and values in the community that influence young and adolescents' access to sexual and reproductive health.

In the clustered study conducted in Monrovia Liberia, adolescents and youths both male and female cited issues related to the society and environment that play roles in their sexual behaviour(34). Some of these issues include poverty and daily living environment.. On the issue of "poverty", social and environmental factors at the community level was identified that put them at risk of sexual exploitation and abuse such pressure from their teachers and other school officials to have sex with them in exchange for good grades or for school fees for those that cannot afford their school fees since they don't want to get thrown out of school. The presence of numerous "entertainment centres", "drunk men," and "dark market building[s]" were all contributing factors that put them at risk of sexual violence. As stated by one girl, "in the market house when it is dark and you passing near the place, whole day the boys can be smoking and calling you and when you go there, they will damage you." Another said they were exposed to early risky sexual behaviours at the "drinking clubs" through exposure to pornography. Other boys said that "seeing girls bathing in the streets or wearing attractive clothing made us more interested in sexual activity..."(34).

Generally, communities in sub- Saharan Africa perceive sexual and reproductive health issues as only suitable for adults, as such it is inappropriate to discuss such with adolescents or youths (54). A study from Tanzania about community involvement in sexual and reproductive health showed that community members feel that it is inappropriate for girls 15-18 to access sexual and reproductive health services especially FP (55). Conjoh M et al., reported the use of "charmed" strings prepared by herbalist. It was considered as contraception, adolescents girls from rural sierra leone said that it was given to them by their parents to tie on their wrist to prevent them from becoming pregnant(56).

A qualitative study conducted in Certain Communities of Nigeria revealed societal level barriers of young people access to and use of contraceptives. These barriers include

negative peer and media influence and lack of social networks in accessing contraceptive services(51).

One social influence on participants utilization of SRH was religion. Religious teaching promotes the belief that sex among unmarried women is immoral. Therefore, sexually active adolescents felt guilty, ashamed or worried about immoral behaviour and sin, leaving them with the perception that it is only for adult. In this study, most participants describe religious as a primary cause on an internal conflict between moral values and personal desired action and needs for SRH (57).

Gender roles as barriers to SRH

Because of the gender norm that empowers men as the decision-makers, especially when it relates to sex, family life or in relationships, there is a limitation of access to SRH. This is applicable to both men and women especially the adolescents and youths. For the men, they feel ashamed to access SRH due to the "macho" feelings and gender expectations from the society. The women on the other hand since they do not have the economic power depend on the men. As such, they are not able to negotiate safe sex like the use of condoms(58). The gender norms that restrict engaging in sexual activities also limits access to SRHS by unmarried women. In some instances, these group of women may be denied access to contraceptives while married women may need to have the permission of their spouses in order to use contraceptives(59).

4.4 The organization, provider, institution and policy level

At this level, the researcher will explore the factors at the level of organizations, provider, institution and policies that influence access to sexual and reproductive health of youths and adolescents in Liberia.

Health system

There are various barriers to the advancement of SRH at the organizations level. For instance, evidence from studies show that faith based healthcare providers play vital roles in health service provision especially in fragile settings like Liberia(60). According to a report of the centre for strategic and international studies(CSIS) global health policy centre, in Liberia, faith-based organizations serves most of the population mainly in the rural area; this is where a lot of people preferred seeking care because it is not for profit making(61). These religious organisations cover a significant part of the population and do enjoy the confidence of the community. They can thus mobilize the communities and effect positive behaviour change in vital adolescent SRH issues like HIV/AIDS, however, they are slow to respond on these challenges. This is because they try to avoid any form of conflict with the religious policy on SRH issues. For example, some HIV/AIDS prevention strategies like promoting the use of condoms are seriously opposed by religious

groups(62). The religious value systems do not sanction sexual activity outside of marriage. Many feel that providing youth or young people with the means to have safe sex encourages them to engage in sex, which is counter to their beliefs(63). However, as earlier noted from the study on the influence of society , poverty and family on youths and adolescents, access to information alone does not guarantee a positive or safe sexuality behaviour(34).

A study from Uganda shows that the lack of skilled providers was one barrier to family planning access. The inability of organizations to provide training services to health workers leads to ineffective service provision thus acting as a barrier to access (45). The lack of privacy and confidentiality from the service providers was another barrier identified in a study from Ghana (54). Another study also showed that hostile and judgemental attitude of some healthcare providers act as barrier to access of adolescents and youths to SRHS(64). Adolescents and youths identified friendly service provider as the most important aspect of a youth-friendly service centre for them(65). The environment in which consultation services are provided for the clients can also act as barrier to adolescent SRH access. This is especially so when the privacy of the client cannot be assured. Studies have shown that when the privacy and confidentiality of adolescents and youths are not assured, it will erode the self-confidence and their trust for the service provider and thus affect the rate at which services are utilized(66).

According to a study on provider's perception or behaviour SRH services provider perspectives on delivering services showed that providers admitted that their behaviours could be an impediment to youth seeking SRH care. Some providers acknowledged that they judged youth, others also admitted that youth needed to feel welcome to come back for services. Providers mentioned that they felt that youth saw them as a parent, or they saw themselves as taking parental responsibility. This parental role was linked to difficulty in communicating appropriate SRH information and counselling to young people(67).

Another study showed that at the public health system, constant stock out of contraceptives commodities and judgmental attitude of staffs towards adolescents and youths served as a health system barriers(51).

A systematic review on barrier to accessing SRHS named high cost, age requirement, discrimination and fear in young people from seeking SRHS. This was further confirmed by result from research done in Ghana on barriers to young people form seeking three most common reproductive health services (STI and HIV, abortion) and contraception. They reported being embarrassed of family and friends finding out, high cost, facing discrimination and judgment from service providers.

A review of literature from SSA countries showed several factors at the service provision level that affect access to SRH services. For instance, findings from a study done in

Tanzania, showed that staying long at the health facility to obtained treatment discouraged some young women from seeking care altogether (50). Inconvenient services hours indicated as a barrier to accessing sexual and reproductive health services (53).

Sexual and reproductive health policy

Liberia in agreement with international standard and after the conference of the ICPD 1994 formulated a National Sexual and Reproductive Health policy focusing on different SRH issues including maternal and new birth health, family planning, Gender-based violence and sexual gender-based violence (GBV/SGBV), STIs and HIV/AIDS. The aim is for every Liberian to enjoy sexual and reproductive health of the highest quality and to have the chance to freely exercise their sexual and reproductive rights. Other international instruments that Liberia is a signatory to include; the Convention on the Elimination of All Forms of Discrimination against Women(CEDAW) which was adopted over thirty(30) years ago(68). It must be emphasised here that though CEDAW refers mainly to "women" it has a life cycle approach and as such member countries are supposed to promote both women and girls' rights(69).

For adolescents and young people, the policy emphasized ensuring the scaling-up of SRH services, institute programs to increase the utilization of SRH services by adolescents and youth, 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 testing and counselling and appropriate information that promote safe sex and target the youths and adolescents thereby ensuring that they are incorporated in healthy decision- making, especially in the area of SRH.

Gap between policy and implementation

The perspective of policy makers and that of health workers differ regarding the implementation of the BPHS of which the SRHS is a part. This is reflected in various gaps between the actual policy and the real life implementation of the policy. Health workers who are the implementers of the policy link the policy issues to their poor working conditions and low salary. This make the workers to respond by not putting in their best efforts in the delivery of essential components of the BPHS including SRHS. They also establish their own private practice like open drug stores for profit and in some cases leave their work post for other personal activities(70). The effects of these behaviour is that, the SRHS which are included in the BPHS like facility based delivery, basic emergency obstetric care or contraceptive services are not fully implemented as was intended by the policy. Therefore, in as much as SRH is placed high on the political agenda of Liberia as reflected in the policy, there is a vital gap between the policy made and the level of implementation

(71). These constraints therefore limits the effective implementation of the policy as was intended

Considering the present situation of the extent in which SRHS has been prioritized in the national agenda of various countries, Ravindran et al., in a systematic review found that in most countries, the basic health package excluded critical components of SRH such as in the areas of safe abortion services especially for youths and adolescents and reproductive cancers. Also, due to poor international and domestic funding for SRH, there is a high burden of out of pocket expenditure(OOPE) consequently, there is the problem of inequity in the access to SRHS(72).

Chapter 6: Approaches and strategies to address the factors influencing access to sexual and reproductive health services in Liberia

This chapter explore strategies and approaches utilized to mitigate against the factors that influence access to SRHs by adolescents and youths in Liberia. These strategies include:

Youth friendly sexual and reproductive health services (YFSRHS) centre approach

One of the strategies to address access of youths and adolescents to SRH services is YFSRHS. This approach or strategy for YFSRHS does not only improve access to SRH service because young people also identified that there were also non-health benefit they received such as confidence building, information gap bridging and improving interpersonal communication skills (39). When YFSRHS are fully implemented, it makes youths and adolescents to feel more comfortable to seek for the information and or SRHS at the health facilities(48).

In summary, the main components of a YFSRHS can be found on the information box below.

SUMMARY OF EIGHT DOMAINS OF ADOLESCENT-FRIENDLY HEALTH CARE(73)

1. Accessibility of health care: location, affordability
2. Staff attitude: respectful, supportive, honest, trustworthy, friendly
3. Communication: clarity and provision of information, active listening, tone of communication
4. Medical competency: technical skills (procedures)
5. Guideline-driven care: confidentiality, autonomy, transition to adult health care services, comprehensive care
6. Age-appropriate environment: Flexibility of appointment times, separate physical 13 space, teen-oriented health information, clean, waiting time, continuity of care, privacy
7. Involvement in health care
8. Health outcomes: pain management, quality of life Ambresin et al. (2013), p. 678

Like most other countries in SSA, the level of support for youth- friendly centres in Liberia is weak. This weakness in institutional support serves as barriers to access of SRH services by youths and adolescents. A reflection of this narrative can be seen in the very few or absent youth-friendly centres, poor funding for even the few centres available. Even most of the providers lack adequate training on how to handle adolescent SRH service delivery(74). Another consideration is the organisation of the physical space for provision of adolescent SRH. This includes both the design and location of the facilities and the timing of the service provision. Because of the location and lack of privacy in some of these clinics, youths and adolescents are reluctant to go for care because they are scared to be recognised and stigmatized(51)

Health system approach

The Rebuilding Basic Health Services (RBHS) in 2010 initiated the Market Contraceptive Project (MCP) in Liberia's Capital City Montserrado through the Planned Parenthood Association of Liberia (PPAL). This initiated was to assist increase access amongst young people by removing barriers such as long distances to and long waiting times to accessing Contraceptive services. It was also aimed at providing access to short-term contraceptive at work and shop areas. This intervention showed increased use of contraceptive in Montserrado. This initiative was adopted by three different Counties for Contraceptive service delivery(12).An intervention of youth-friendly clinic services in Zambia concluded that positive changes in social and community-level factors played an important role in improving young people use of reproductive services. Another systematic review showed that interventions that combined training of clinic staff, facility-based and community-based activities improve young people health care utilization. This intervention had a sufficient level of evidence of effectiveness to be recommended for widespread implementation(35).

Community mobilization- community mobilization can foster intergenerational communication in support of ASRH. Through efforts at educating the public, the communities can know about ASRH issues in a manner that is sensitive to their culture. This can improve the chance of attitude change. Evidence show that when key gatekeepers in the community are involved as well as religious leaders, it can create more community support. However, few cases of community mobilization interventions have been evaluated of their impact, especially SRH(57). Create an enabling environment for adolescents, mass media and community-based program were identified as promising approaches to increasing the acceptability.

According to a study by Aninanya GA et. Al. in Ghana, aimed at comparing the effectiveness of Community-level and outreach for improving adolescents and young people SRH usage considered four components: 1-mobilisation to create a supportive environment, 2-health-worker training in YFHS approaches, 3-a school-based sexual health education and 4-out-of-school peer outreach. STI services usage increased from 3% to 17%; HIV counselling and testing increased from 3% to 13%. A result from the study concluded that school-based and peer-outreach interventions were feasible in the setting where the research was conducted and could, therefore, be used in similar settings(74).

It has been researched in LMIC that about 82 percent of Projects promoting sexual and reproductive health of youth use mobile health (mHealth) to facilitate knowledge sharing and behaviour change to improve YSRH. Using mHealth was therefore identified as a way the projects used to link youth to SRHS through mobile phone and other social media platform(75).

It is important to stress that there are some interventions aimed at promoting access to SRH by youths and adolescents which have been shown to be ineffective. Thus, though sexuality education has been found to be effective, peer education has been found to be less effective. Also, a one- off public meeting has been observed to be ineffective in effecting any meaningful form of behaviour change as opposed to stepwise repeated community engagements and focus group discussions. Another approach that has been found to be ineffective is the promotion of youth centres as stand-alone intervention(76). **School-based SRH education** study done in Burkina Faso, Ghana, Malawi and Uganda in 2003 showed that secondary education has been proven to be associated with a whole range of better SRH outcomes such as contraceptive use and STI, Schools and teachers were the important sources of information for SRH (43). Evidence from studies on School-based Adolescent sexual and reproductive health education program was an intervention implemented with teachers in primary and secondary school curricula, showed that knowledge of sexual and reproductive health, Family planning and transmission and prevention of STIs and AIDs was found to be significantly higher among the intervention than the control group. Health Facility-based was another invention tested in the research, results found that youth in the intervention groups reported significant improvements in knowledge and attitudes towards prevention of STIs, use of condoms and treatment-seeking behaviour(77).

Civil Society

The role of Civil Society Organization (CSO) as agents of change has been identified. They represent a special interest group and can advocate for special issues including SRH. When CSO are made up of young people they will usually have a better understanding of their situation. This will lead to practical solutions to their problem. They can tap into resources which are available to them in addressing specific issues including SRH. This has been identified to strengthen their ability and increase their confidence to speak out in the public(1)(63). Countries with various international funding from the European union such as Denmark, Sweden and the Irish fund, reports have shown the efficacy of involvement of CSOs in advocacy and creation of awareness among stake holders including the effecting of policy changes which has positively impacted the state of SRH in most African countries.

<u>Gender responsive interventions to improving access to SRH in Liberia</u>

Özler B et al., studied an intervention targeting the equipping of adolescent girls and youths with life skills to help them make safe and healthy life choices and protect them from sexual abuse and exploitation (SAE). This randomized clustered study assessed seven indicators (sexual violence, schooling, sexual and reproductive health (SRH), psychosocial wellbeing, gender attitudes, life skills, and protective factors). Findings indicated that, when cash transfer was attached to attendance, it had a positive outcome

on reducing child marriage, teenage pregnancy and risky sexual behaviour. However, this intervention was not effective in protecting girls from sexual violence. To further understand the mechanism by which cash transfer was able to influence these indicators whether directly or through interaction with other factors, there is a need for further studies(59).

Chapter 7: Discussion

Summary of findings

Sexual and Reproductive health of youths aged 15-24years, is a major life and health issue. It require multi-dimensional approaches to remove barriers to the development, improvement and sustainability of programs and services. The Literature review was focused on barriers in accessing sexual and reproductive health services among youth in Liberia with emphasis on STIs, HIV/AIDs and contraceptive. This was done by: identifying factors at the individual, interpersonal and the community levels that influence youth access to sexual and reproductive health services in Liberia. Also, the factors at the organization and policy level and the approaches and strategies being used to address these factors in Liberia were discussed.

This study therefore utilised an socio-ecological approach to health care by conceptualising access at the interface of health systems and populations by the framework to contextualized levels at which youth faced challenges and barriers in accessing Sexual and Reproductive health services.

Evidences generated globally from sub-Saharan Countries including west Africa and Liberia illustrate that at the personal level; poor knowledge, perception, misconception, shame and fear serve as barriers to access. Other barriers at the interpersonal level include: Families, friends, peer, partners, and social links. At the community level, norms, values, and religious factors was seen either as enablers or barriers. For the organizational level, negative attitude from service providers, limited knowledge about youth sexual and reproductive health services, high cost, lack of confidentiality and privacy, long waiting time and frequent stock-out limited their access to SRHS. The policy level gives a broader look at how Liberia has prioritized Sexual and reproductive health treaty, policy and standard. It was also noted that there are still gaps in the implementation of these policy in Liberia.

Like most other countries in SSA, the level of support for youth- friendly centres in Liberia is Weak. This weakness in institutional support serves as barriers to access of SRH services by youths and adolescents. A reflection of this narrative can be seen in the very few or absent youth-friendly centres, poor funding for even the few centres available. Even most of the providers lack adequate training on how to handle adolescent SRH service delivery. Another consideration is the organisation of the physical space for provision of adolescent SRH. This includes both the design and location of the facilities and the timing of the service provision. Because of the location and lack of privacy in some of these clinics, youths and adolescents are reluctant to go for care because they are scared to be recognised and stigmatized(51). Some organizations such as faith- based healthcare providers does not promote these services thus, serving as barrier in youth accessing

care. Female gatekeepers were discovered in a research as impactful recruiters for contraceptive use, however, they can also play a negative role and act as barriers to access to SRH by adolescents and youths. They are judgemental or lack a youth friendly approach in service provision. This underscores the need for training of the healthcare providers in order to mitigate against such barriers.

Reflections on framework and review approach

The ecological approach to health care by conceptualising access at the interface of health systems and populations was used for this literature review. This framework was used to develop the objectives and define key terms. I also used it for the analysis and structure of this paper. Reflecting on the reason for choosing this framework, it has been possible to demonstrate the multi- dimensional perspectives of the various barriers that youth and adolescents face in accessing SRHS in Liberia. The framework was also helpful in the ordering of the results from this review and helped to adequately identify the level where the different intervention strategies targeted.

Limitations of this study

This study was concentrated on exploring the barriers to parts of the SRH of youths and adolescents such as STI/HIV and contraception. The reasons for this approach are because these are the aspects of the SRH challenges of youths and adolescents in Liberia that presents a greater public health burden. However, the findings from this review are also relevant to most other components of the SRH needs of Liberian youths and adolescents since most health care services in Liberia are provided using the integrated healthcare services provision strategy.

Proven effective Strategies

Approaches aimed at addressing barriers to youth accessing sexual and reproductive health services were not identified to be in a single direction but in a multi-dimensional way according to the settings, status, cultural value of youth. Thus, the health system approach utilise the training of health providers/ staff to improve their knowledge, attitudes and skills. This helps them to more appropriately respond to the needs of adolescents. Also, adjustments are made in the facilities to make them more adolescents or youth-friendly. Other approaches include the initiation of the Market Contraceptive Project (MCP) in Liberia's Capital City Montserrado through the Planned Parenthood Association of Liberia (PPAL). Implementation of youth-friendly clinic services in Zambia was found to produce positive changes in social and community-level factors and played an important role in improving young people use of reproductive services. Also, interventions that combined training of clinic staff, facility-based and community-based activities improve young people health care utilisation. This intervention had a sufficient level of evidence of effectiveness to be recommended for widespread implementation. Though few evaluations have been done so far, community mobilization was found to

foster intergenerational communication in support of ASRH. The involvement of key community gatekeepers, including religious leaders, in these community mobilization exercises can generate wider community support. Also, the Use of mHealth was identified as an effective way that projects used to link youth to SRHS through mobile phone and other social media platform.

Though more studies need to be done to ascertain the extent of its effectiveness, available evidence indicate that community mobilization can foster intergenerational communication in support of ASRH. Through efforts at educating the public, the communities can know about ASRH issues in a manner that is sensitive to their culture. This can improve the chance of attitude change. Using this approach has the potential to effect sustained behaviour change in the communities and is a powerful means to mitigate against negative societal norms and beliefs including religious inhibitions.

In a study done in Burkina Faso, Ghana, Malawi and Uganda in 2003, School-based Adolescent sexual and reproductive health education program was implemented with teachers in primary and secondary school curricula. Results showed that knowledge of sexual and reproductive health, Family planning and transmission and prevention of STIs and AIDs was found to be significantly higher among the intervention than the control group. These findings demonstrate the efficacy of introducing sexuality education in school curricula.

When health providers and or staff are trained. It improve their knowledge, attitudes and skills to more appropriately respond to the needs of adolescents. This will enable them to make adjustments in the facilities to make them more adolescents and youth friendly. This Health Facility-based activities on training of staffs to provide YFSRHS as an intervention was tested in the research, results found that youth in the intervention groups reported significant improvements in knowledge and attitudes towards prevention of STIs, use of condoms and treatment-seeking behaviour. It will be simplistic to assume that this will be an easy task especially with the negative societal and religious norms, but a multifaceted approach in the implementation would be a bold step in the right direction. The role of the private sector including the faith-based health care services providers, the non- governmental organisations and privately owned health services providers should be engaged for a sustained impact. For effectiveness and efficiency, adopting a sustained and transparent public-private partnership will ensure better service provision and ensure uniform quality of the services provided and optimize scarce resources.

Actions that remove the physical barrier of distance of services as well as convenience of the service and enabling environment will go a long way to mitigate against this barrier. It was also aimed at providing access to short-term contraceptive at work and shop areas.

This intervention showed increased use of contraceptive in Montserrado. This initiative was adopted by three different Counties for Contraceptive service delivery(12).

Civil Society Organization (CSO) has been identified to represent a special interest group and can advocate special issues including SRH, CSO groups comprising young people will usually have a better understanding of their situation which will lead to coming out with practical, feasible solution to their problem and can tap into resources which are available to them in addressing specific issues including SRH. Their role therefore in creating enabling governmental and societal by-ins on proposed interventions that can improve access to SRH for youths and adolescents is very vital.

Due to the low per capital spending on SRHS, there is high OOPE which contributes further to inequities in access to SRHS especially amongst youths and adolescents.

It is necessary to point out that though these strategies have been enumerated as effective interventions to enhance access to SRH among youths and adolescents, there are conditions that need to be fulfilled for it to be effective in achieving the desired objective. Interventions like youth centres as a stand- alone are ineffective unless SRH services are integrated and it is youth friendly both in the form of services provided and the timing and way the services are provided.

Organising just a one-off occasion of public meeting will not be effective as an intervention in behaviour change. This requires repeated community engagements and discussions involving different stakeholders. There is, therefore, a need to be selective in choosing the types of interventions that are proven to be effective by contextualising the various communities and coordination with all stake holders.

The effects of gender norm that empowers men as the decision-makers, especially when it relates to sex, family life or in relationships, there is a limitation of access to SRH. This phenomenon is especially relevant in Liberia because of the patriacal society perspectives that is re-enforced both by religion and cultural practices. This is applicable to both men and women especially the adolescents and youths. For the men, they feel ashamed to access SRH due to the "macho" feelings and gender expectations from the society. The women on the other hand since they do not have the economic power depend on the men. As such, they are not able to negotiate safe sex like the use of condoms. Another key driver that can improve access to the SRHS for adolescents and youths in Liberia is the need to improve the literacy rate in Liberia by engaging the legislature and other stakeholders to formulate policies that will encourage the proliferation of more schools and also by massive public awareness drives to encourage youths and adolescent enrolment in these schools. The free education policy being instituted in Liberia is a right step in the right direction.

Conclusion

This literature review identified various barriers in access to sexual reproductive health services for youth in Liberia and some strategies that were found to be effective in mitigating these barriers. There are existing policies that are intended to address some of these issues but lack implementation. Also, there are more actions that need to be taken at the intrapersonal, interpersonal, community and policy levels examined in order to remedy the many barriers discussed. The need for a multifaceted approach in tackling this phenomenon therefore cannot be over emphasised.

From experiences of best practices, civil society organizations have played major roles in supporting the program implementation and awareness creation of the SRH issues of adolescent and youths.

Recommendation

Based on the findings of this research, several critical issues have been highlighted that need to be considered by policy makers in the development and implementation of health interventions for the youth. The following recommendations therefore have been made:

- MOH to develop and implement the training of health providers/ staff to improve their knowledge, attitudes and skills to more appropriately respond to the needs of adolescents.
- Ministry of health to foster community mobilization in order to encourage intergenerational communication in support of ASRH utilising both rural and urban social network such as mHealth to promote sexual and reproductive health issues.
- The MOH to promote more research on what approach has worked well to addressing barrier to accessing SRH especially STIs, HIV/AIDs and contraceptive services.
- Sexual education needs to be provided at an earlier age in schools to mitigate against the trend of high rate of unwanted pregnancies amongst adolescents and youths.
- CSOs and other stake holders need to increase advocacy for government to prioritize SRHS as part of the BPHS in order to meet the UHC SRH goals by organizing awareness campaigns and engaging the legislatures to change hostile policies that act as barriers to access to SRHS.
- Government should implement a more sustainable health financing policy that will reduce OOPE for SRHS as a priority.

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