



Sierra Leone Costed Implementation Plan

2023-2027



Sierra Leone Ministry of Health and Sanitation

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Christian Health Association Sierra Leone (CHASL)

Clinton Health Access Initiative (CHAI)

Crown Agents

Health Alert

Hellen Keller International (HKI)

Marie Stopes, Sierra Leone (MSSL)

National Secretariat for the Reduction of Teenage Pregnancy (NSRTP)

Planned Parenthood Association of Sierra Leone (PPASL)

Princess Christian Maternity Hospital (PCMH)

Restless Development (RD)

Sierra Leone Midwives Association (SLMA)

Sierra Leone Social Marketing and Development Agency (SLMDA)

United States Agency for International Development (USAID)

United Nations Population Fund (UNFPA)

World Health Organization (WHO)

FORWARD

Hon. Minister

The Government of Sierra Leone recognizes the importance of family planning as a means of boosting economic growth and improving the health and well-being of future generations. In 2017, Sierra Leone made a commitment (FP2020 Goals) to address strategic gaps in family planning (FP) programming that have hindered the accelerated increase in access to quality FP for its population. Through these commitments, we hoped to increase the number of women reached with FP services annually to over 755,939 by 2022 and increase the country's modern contraceptive prevalence rate (mCPR) to 33.7% in the same year. By 2019, Sierra Leone had achieved an mCPR of 21% and, while this fell short of our target, significant foundations were built for FP service delivery. Using learning from 2018–2022, in this costed implementation plan (CIP), we have set an ambitious but attainable goal of 32% mCPR by 2027.

This year, our President, His Excellency Julius Maada Bio, committed to the Safe Motherhood and Reproductive Health Rights Bill during the 10th Africa Conference on Sexual Health and Rights. Furthermore, the country developed its first national FP policy, which has the goal of providing comprehensive quality FP information and services that are acceptable and equitably accessible to all people in Sierra Leone. The CIP is the road map to achieving this goal. We call on all FP actors to use the CIP as the basis for their FP interventions. We recognize that resources are constrained and that vertical programming results in inefficiencies, therefore the CIP presents a carefully selected, prioritized set of well-defined, high-impact interventions that will be delivered through an integrated approach. The strategy focuses on three priority intervention areas: postpartum FP, stockout reductions, and increasing demand for FP through investments in social and behaviour change.

To ensure the three priority intervention areas are well delivered, we will prioritize health systems strengthening through community-based social and behaviour change, strengthening integration of FP into antenatal care and postnatal care and immunization, and improve supply change management by increasing data visibility. We will work to ensure no one is left behind, emphasizing the continuum of care and making FP accessible to men and women of reproductive age who want it. I ask all donors, technical support agencies, nongovernmental organizations, and civil society organizations to align their work and funding with the Sierra Leone Family Planning Costed Implementation Plan.

Dr. Austin Demby
Minister of Health and Sanitation
Freetown

REMARKS

Chief Medical Officer

The Ministry of Health and Sanitation, with support from the U.S. Agency for International Development, has completed its consultative engagement with partners and stakeholders to identify priorities for the Costed Implementation Plan (CIP) for Sierra Leone (2023–2027), which is the five-year strategy to implement the country’s new family planning policy. The process has been highly consultative and rigorous and has built on our current approach of focusing on evidence-based interventions. We ensured that this plan is aligned with the larger umbrella strategy of the Reproductive Maternal Newborn Child and Adolescent Health (RMNCAH) Strategy, 2021–2025.

Over the past year, we have made progress conducting three national-level consultations including a qualitative review of the 2018–2022 CIP. The Reproductive Health and Family Planning Programme and the Technical Support Team shared a baseline and situation analysis with health workers and discussed challenges and strategies to provide high-quality family planning services. They worked together to develop district-specific scenarios and targets using modern modelling techniques firmly grounded in the realities of the Sierra Leone context. The firm foundation built through this extensive consultation gives us the confidence that the CIP operational objective to “increase the modern contraceptive prevalence rate (mCPR) among all women of reproductive age from 26 per cent in 2022 to 32 per cent by 2027” is within our reach.

I take this opportunity to appeal to all directorates and programs named in the plan: Nutrition Directorate, School and Adolescent Health Programme, Community Health Worker Hub in Primary Health Care Directorate, and others to work closely with the Reproductive Health and Family Planning Programme to ensure that we meet our 2027 target of a mCPR of 32% among women of reproductive age and various target set for each district from the district consultative meetings.

Dr. Sartie Kenneh
Chief Medical Officer
Ministry of Health and Sanitation

ABBREVIATIONS

ANC	Antenatal care
CHP	Community health posts
CHW	Community health workers
CIP	Costed implementation plan
DHMT	District health management team
DHS	Demographic and Health Survey
FBO	Faith-based organisation
FP	Family planning
GoSL	Government of Sierra Leone
IEC	Information, education, and communication
LARC	Long-acting reversible contraception
M&E	Monitoring and evaluation
MBSSE	Ministry of Basic and Senior Secondary Education
MCH	Maternal and child health
MCHP	Maternal and child health posts
MOHS	Ministry of Health and Sanitation
MSSL	Marie Stopes, Sierra Leone
NGO	Nongovernmental organization
OCP	Oral contraceptive pill
PHU	Peripheral health units
PNC	Postnatal care
PP	Postpartum
PPASL	Planned Parenthood Association of Sierra Leone
PPFP	Postpartum family planning
RH	Reproductive Health
RHFPP	Reproductive Health and Family Planning Programme
RMNCAH	Reproductive, maternal, newborn, child, and adolescent health
SBC	Social and behaviour change
SDP	Service delivery points
SRH	Sexual and reproductive health
SSL	Statistics Sierra Leone
TST	Technical Support Team
UNFPA	United National Population Fund
USAID	United States Agency for International Development

THE CIP DEVELOPMENT PROCESS

The process of developing the Costed Implementation Plan (CIP) for Family Planning (2022–2027) commenced in September 2021 with financial support from the U.S. Agency for International Development’s MOMENTUM Country and Global Leadership (MOMENTUM). A Technical Support Team (TST) drawn from MOMENTUM grantees, Avenir Health, and the Institute for Development was assembled to provide expertise and guidance throughout the process to the Ministry of Health and Sanitation (MOHS) Reproductive Health and Family Planning Programme (RHFPP).

The current CIP process was unique in its tailored approach to context, history, and focus on sub-national consultations. In typical CIP processes, the technical team provides the format, the process, and the tools for engagement with stakeholders. This CIP adopted an iterative process with the MOH, taking the position that the program knows best its context, strengths, and needs. In so doing, the process was necessarily slowed down, adopting in practice the “pause and reflect” process to give the program time to review analyses and to engage in a back and forth with the lead consultant/local institution in Sierra Leone. This led to changes in the detail, in the administrative levels engaged in the prioritization process, and in the way districts were engaged, arguably providing richer detail and a better strategy. Districts, formerly recipients of guidance, selected the priorities and the scale to which they believe they can manageably implement. Many CIPs describe the government stewarding the process, but the TST in this instance worked intentionally to make that happen. A big part of the lessons learned is that time is itself a key stakeholder; time to consult, to reflect on rather than repeat prior history, to test multiple ideas, to do and redo analyses, making the CIP less of an external event to be completed but rather part of the organic process of work within the MOHS in Sierra Leone. This CIP was also managed and developed by the same local institute that worked on the prior CIP (2017–2021). In this instance, this was an asset. Documents reviewed and data analyses from the prior CIP were easily available for the new CIP process while the practical and theoretical knowledge of work remained with the same institution. This type of legacy, with properly curated and managed data, is typically unavailable at the start of a new CIP, but critical for an effective process.

Not only was the CIP development process unique, but so is the structure of this final CIP document. This CIP aims to highlight high-level strategic priorities, both nationally and sub-nationally, and set out high-level targets for achievement. Detailed work planning, which is often included within CIP documents, is not captured here but rather will be integrated into existing annual work planning processes. Removing this detailed planning process freed up stakeholder time to focus on more strategic decision-making and allowed for more thoughtful engagement with district-level stakeholders.

PAUSE AND REFLECT

This CIP adopted an iterative process with the Ministry of Health and Sanitation, recognizing that the program knows best its context, its strengths and needs... where the process was necessarily slowed down, adopting in practice, the “pause and reflect” process to give the program time to review analyses, to engage in a back and forth with the lead consultant/local institution in Sierra Leone. This led to changes in the detail, in the administrative levels engaged in the prioritization process, and in the way districts were engaged, arguably providing richer detail and a better strategy.

TIMELINE

- September 2021 to February 2022: Three national level consultations with data analysis and documentation in between meetings (situation analysis)
- April 2022 to August: High-level programmatic costing
- May 2022: Three district-level consultations clustering districts into three regions
- June 2022: Pulling the CIP together
- October 2022: Final dissemination meeting review analyses

The TST worked from September 2021 to June 2022 to conduct a comprehensive situational analysis, including a desk review and consultations to identify strategic priorities and solicit strong stakeholder input through three national-level meetings, three district-level meetings, and other online communication and data collection. The team used the FP Goals model to develop and refine scenarios and a separate programmatic costing approach to estimate costs of interventions in the refined scenarios.

The TST worked with stakeholders to design meeting agendas that resulted in thoughtful interactions with engaged participants. The first meeting was a qualitative review of the 2018–2022

CIP. During this meeting, stakeholders were reminded of the targets in the 2018–2022 CIP and the RHFPP manager gave a detailed presentation on progress against the CIP targets. Through this approach, the stakeholders had the opportunity to reflect deeply on the progress and suggest strategies to overcome challenges in areas where there was limited progress. At this meeting, the TST set the stage for data collection by informing partners of the types of data they would be seeking to collect.

Following this meeting, the TST collected data from MOHS implementing partners who were providing family planning (FP) services, ranging from partners like Marie Stopes Sierra Leone (MSSL), who provides direct services to clients, to others who undertake demand creation activities, such as community sensitization. The TST collected data from partners in whatever format aligned with their reporting systems and then reconfigured the data. This approach reduced the burden on partners and contributed to the success rate of the data collection exercise.

In the second meeting, the TST shared data analyses from the Demographic and Health Survey (DHS), DHIS2, and data collected from partners about FP services they were providing. Finally, during the third meeting, the TST shared the comprehensive situation analysis and participants discussed emerging issues and initially agreed to retain the three top priority interventions from the 2018–2022 CIP: postpartum family planning (PPFP), stockout reductions, and increase availability of long-acting reversible contraception (LARC). Based on further consultations at the district level, a reprioritization was done to elevate districts' priorities for the national priorities.

Using the data collected, the TST developed scenarios for each district showing the potential increases in modern contraceptive use because of scaling up different interventions. The team held three district-level consultation meetings in Makeni, Bo, and Freetown with participants, such as district medical officers, district pharmacists, FP coordinators, and other FP stakeholders, from every district in the country. At these district-level meetings, the TST shared district scenarios with senior staff at the district health management teams (DHMTs), explained how the FP Goals model works, the data used to inform the modelling, and the scenarios suggested from the model for their district. The senior DHMT staff then reviewed the scenarios and decided on

the levels of intervention scale-up they believed were feasible for their district. As the 2018–22 CIP only worked at the national level, being able to disaggregate to the district level with district stakeholder buy-in was a significant advancement.

The DHMTs suggested setting up a WhatsApp group where the TST could share notes from the meeting and receive final agreements on the intervention scale-up scenarios. WhatsApp has high uptake in Sierra Leone and is used extensively within the MOH. The WhatsApp group was set up and serves as a platform for communication with key stakeholders on the CIP. The platform holds significant potential for tracking progress on CIP targets and sharing experiences in the future.

Finally, as the CIP was developed at the same time as the new national FP policy, the TST ensured there was close collaboration with the policy team from the World Health Organization. This CIP is therefore well-aligned with the policy.

KEY ISSUES ADDRESSED IN THE NATIONAL FAMILY POLICY

- Quality of FP services with a focus on improving staff capabilities, service integration, and efficient commodity supply chain with an expanded method choice.
- Increasing access to FP services by minimizing unnecessary medical, financial, legal, and regulatory barriers.
- Stimulating community demand for FP services by creating awareness and encouraging stakeholder participation to address social and cultural barriers through effective social behaviour change and communication strategies.
- Financing for FP, advocating for increased government resource allocations and effective and equitable spending.
- Leadership and governance: promoting strategic multisectoral collaborations with other relevant government sectors, civil society, the private sector, and development partners.
- Evidence guided planning and service provision that ensures internal and local research to inform decisions and planning.

SITUATION ANALYSIS IN BRIEF

Progress Against CIP 2018–2022

The Government of Sierra Leone (GoSL) set an ambitious target in 2018 of increasing the modern contraceptive prevalence rate (mCPR) for currently married women from 15.6% in 2013 [1] to 33% in 2022.[2] For all women, the target was to increase from 20.9% to 33.7 % in 2022 [2]. These targets were set out in the country’s 2018–2022 CI).

The 2018–2022 CIP identified three strategic priorities and how their scale-up would contribute to overall growth:

Strategic Priority #1 (SP1): Improve PFP (responsible for 51.5% of potential growth)

Strategic Priority #2 (SP2): Reduce stockouts (responsible for 27.3% of potential growth)

Strategic Priority #3 (SP3): Increase LARC via peripheral health units (PHUs) (responsible for 3.4% of potential growth) (with focus on implant scale-up)

In addition, the following were also included in the model and were estimated to contribute to growth in mCPR with steady investments and efforts:

- Community health workers (CHWs) (5.4% of growth)
- Public sector mobile outreach (4.4% of growth)
- Youth-focused interventions (3.5% of growth)
- Private-sector facilities (3.3% of growth)

By 2019 the country had achieved 20.9% mCPR among currently married women [3] and 24% mCPR among all women. This put the country *behind the growth trajectory* to be on track with the CIP target. Progress would need to have accelerated significantly for the country to achieve the 2022 CIP goal (Figure 1). Recent data from DHIS2 do not indicate this acceleration has happened since 2019.

Figure 1: mCPR among all women, DHS trends versus 2018–2022 CIP goal

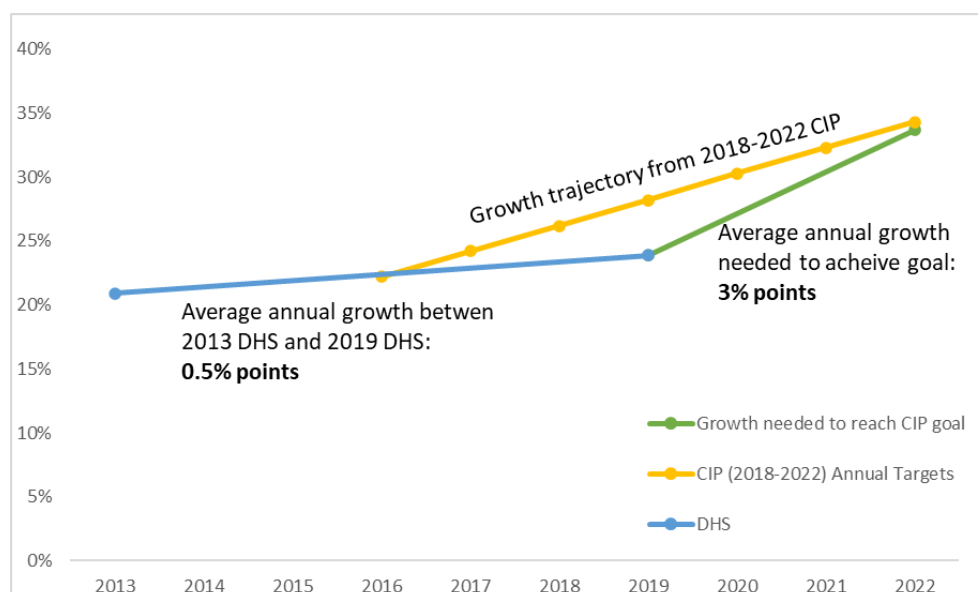


Table 1 describes the intended scale-up and current status for the prioritized interventions of the 2018–2022 CIP. We see that progress was modest and provides the context for why mCPR growth shown in Figure 1 was low overall and failed to reach the targets established in the CIP. While the quantitative targets have not been fully met, a range of preparatory activities have been undertaken that set the stage for movement towards the targets in this new CIP.

One of these activities, as shown in Table 1, is the training of providers. Stockouts have declined significantly although there were stockouts of implants due to their increased acceptability. At the national level, high levels of stockouts have persisted, though some reductions were seen between the 2018 and the 2019 National Assessment on the Availability of Reproductive Health Commodities (from 89% to 77% of facilities reporting stockouts of any method). At the time of developing this CIP, stockouts remain high across multiple methods.

In a review with stakeholders of the current status, participants identified the following key challenges in meeting national targets and prioritization plans:

- Shortage of resources within the MOHS
 - Inadequate coordination
 - Lack of alignment of resources with activities in the CIP
 - Lack of data to visualise intervention scale-up, partner mapping

The full situation analysis, including description of the country context is in Annex 3.

Table 1: Modelled scale-up for each intervention using the FP Goals model and progress to date

Intervention	Baseline	Scale-up in 2018 to 2022 CIP	Progress to Date	Activities Implemented and Challenges
PPFP	7.25% of women using PPFP in 2013 at 12 months (Source: DHS 2013)	50% of pregnant women reached by CHWs, 50% of facilities offering immediate PPFP services	Small increase in share of women using PPFP at 12 months (4% points increase) from 7.25% in 2013 to 11.42% in 2019. (Source: DHS 2013, 2019)	<ul style="list-style-type: none"> National guidelines for PPFP were developed and training rolled out to some service delivery points (SDPs), with an emphasis on immediate postpartum (PP) IUDs and PP implants, including post caesarean section. RHFPP and partners have trained service providers for immediate PPFP services (IUD and implants) in all comprehensive and basic emergency obstetric and newborn care facilities. Lower-level facilities provide immediate PP implants. Information education and communication (IEC) materials for PPFP were developed and disseminated PPFP indicators were integrated reporting tools <p>Challenges:</p> <ul style="list-style-type: none"> Less than 50% of SDPs have been trained <p>Bottlenecks included</p> <ul style="list-style-type: none"> Inadequate funding for full- scale rollout Unavailability of equipment in some SDPs, mostly Kelly Forceps for PPIUDs Demand-side barriers are addressed in Annex 3

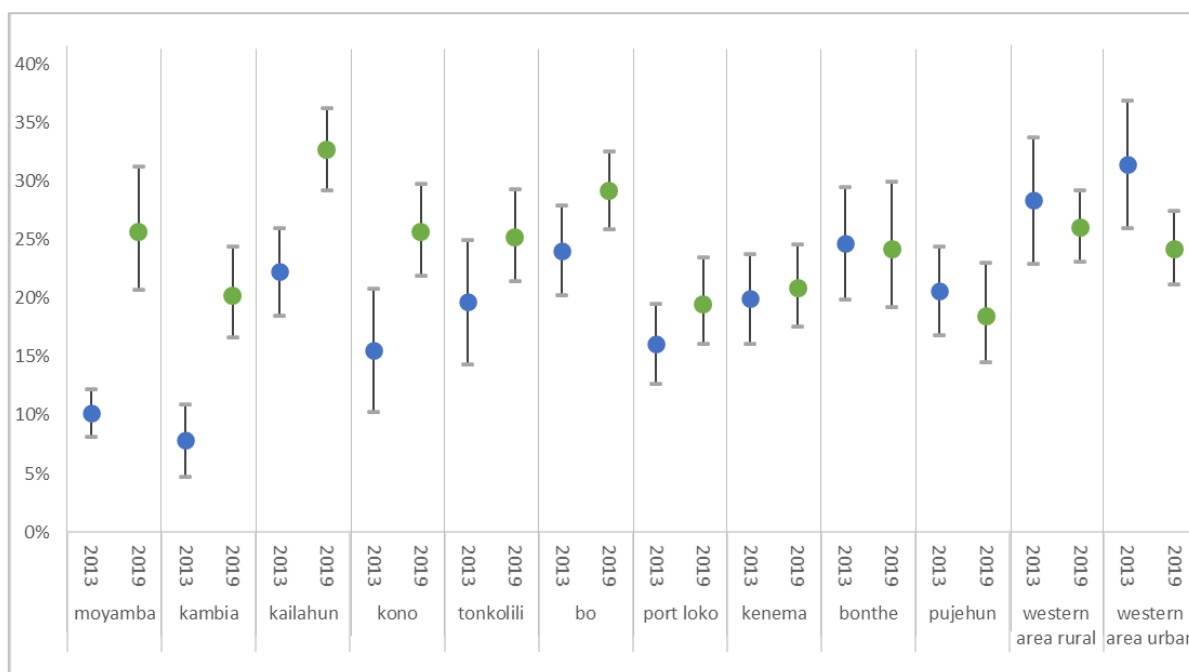
Intervention	Baseline	Scale-up in 2018 to 2022 CIP	Progress to Date	Activities Implemented and Challenges
Stockout reductions	Persistently high stockouts	50% reduction in stockouts	There has been some reduction in stockouts. The national assessment on availability of reproductive health commodities and services in 2019 showed doubling of “no stockout” from 10.8% in 2018 to 22.9% in 2019 [12]	<ul style="list-style-type: none"> • The first-mile distribution was adjusted to provide six months of stock per cycle • Last Mile distribution remains a bottleneck • New initiatives to address stockouts were started, including the electronic Report Request and Issue Vouchers pilot and restocking during in-charges' meetings • Resupply pilot by Project Last Mile provided resources to DHMTs to supply commodities to SDPs. These pilots provided good results and can be scaled up. • FP data clinics were started in six districts that help identify supply chain issues at health facilities • District FP teams need resources for monthly supervision. These supervisions can also provide an opportunity for emergency supplies for PHUs that are out of stock
Increase LARC provision at PHUs	<ul style="list-style-type: none"> • 63% of PHUs provide implants • 10% of PHUs provide IUDs 	All PHUs provide implants, IUD provision is scaled up to half of facilities	98 % of SDPs surveyed in 2019 offer implants. However, only 50% of SDPs meant to offer IUDs do so as demand for IUDs and numbers of trained providers remain low	<ul style="list-style-type: none"> • Nationwide training of health workers in LARC provision • Mentoring of health workers and quality assurance processes • Supply of commodities

Sub-national Variations

On a sub-national level, there are huge mCPR variations. The mCPR for all women increased nationally from about 21% in 2013 [1] to about 24% in 2019 [3]. Women in urban areas are more likely to use a contraceptive method compared to women in rural areas (26% and 19%, respectively) [3].

Growth rates have varied between districts: Moyamba district showed the most growth between surveys, while two districts (Western Area Urban and Pujehun) declined slightly (Figure 2). Kailahun started with a good baseline in 2013 and maintained the lead in mCPR in the country. Due to a change in administrative boundaries for four districts (Falaba, Bombali, Karene, and Koinadugu), the changes in mCPR were not comparable and therefore not included in the analysis. This is significant as it means this CIP does not provide mCPR variations for a quarter of the districts in the country. Additionally, it is worth noting that many of the small changes shown in Figure 2 are not statistically significant, indicating that no meaningful change has occurred in mCPR in that district.

Figure 2: Change in mCPR by District (all women)



In summary, the FP program failed to meet its ambitious targets with changes at the margin on prioritized interventions. The complete situation analysis is provided in Annex 3.

COSTED IMPLEMENTATION PLAN 2023–2027

This CIP was developed to address the challenges observed in implementing the prior CIP. The CIP provides a clear roadmap to achieving the commitments made by the GoSL to increase contraceptive use and to ensure the rights of Sierra Leoneans to determine and act on their reproductive goals in the new national FP policy. The CIP defines the country’s vision, goal, and strategic priorities and provides an estimate of the cost of achieving them. To ensure that resources are mobilized and directed towards the highest impact interventions, the CIP defines strategic priorities that were identified through the FP Goals model and validated by stakeholders as critical for achieving the ambitious national targets for increasing mCPR and reducing unmet need by 2027.

The CIP aligns with broader development and health objectives, including the country’s Midterm National Development Plan.¹ It also contributes to related health sector plans including strategic plans for reproductive, maternal, and child health; human resources for health; and reduction of teenage pregnancy.

Specifically, the CIP provides details on key interventions and the intensity of focus that should be done in each district along with the associated costs. This allows for better stakeholder coordination and planning so donors, implementing partners, and the MOHS understand which districts require which interventions and at what intensity to collectively reach the mCPR target set by the CIP. District-level prioritization and intensity are informed by a strong evidence base and were agreed to by district-level officials, reflecting the needs, potential impacts, and district context.

CIP Objectives

The goal of the 2022–2027 CIP is to increase mCPR among all women of reproductive age from 26% in 2022 to 32% in 2027 (Table 2). This represents an average increase of 1.2% points a year. While modest, this would more than double the growth rate that was seen in Sierra Leone between the 2013 and 2019 DHS. The target is more modest than the previous CIP reflecting the integration of new information on the constraints faced to implement interventions and the resources now available to expand implementation. It was also developed using a bottom-up approach, with changes modelled at a district level (see below) then aggregated up into a national-level change.

Table 2: CIP 2022–2027 goal for mCPR (all women)

	2022	2023	2024	2025	2026	2027
Trend needed to achieve CIP goal	26%	27%	28%	30%	31%	32%
Women of reproductive age	2,267,044	2,338,132	2,409,221	2,480,309	2,551,398	2,622,486
Modern users	591,550	637,337	684,781	733,880	784,636	837,048

Table 3 shows the mCPR (all women) goals by district. The average annual change in mCPR across districts ranges from 0.6% points to 2.7% points. District-level goals were informed by selected district investments (see next section) and account for district-specific contextual factors.

¹ <http://moped.gov.sl/mtndp/>

Table 3: mCPR (all women) goals by district

	mCPR		% point change	
	Baseline	CIP Goal	Total	Annual
National	26%	32%	6%	1.2%
Kailahun	36%	39%	4%	0.7%
Kenema	23%	29%	6%	1.3%
Kono	28%	31%	3%	0.6%
Bombali	29%	36%	7%	1.4%
Falaba	14%	17%	3%	0.6%
Koinadugu	19%	27%	8%	1.6%
Tonkolili	27%	31%	3%	0.6%
Kambia	22%	35%	13%	2.7%
Karene	24%	29%	5%	1.0%
Port Loko	21%	33%	12%	2.4%
Bo	32%	40%	8%	1.6%
Bonthe	26%	36%	9%	1.9%
Moyamba*	28%	32%	4%	0.8%
Pujehun	20%	28%	7%	1.5%
WA Rural	28%	32%	4%	0.8%
WA Urban	26%	31%	4%	0.8%

**Model projects 2 percentage points of unrealized growth in Moyamba due to limited demand not shown here*

Projected Method Mix

Assumptions

The estimated method mix for all women at baseline was taken from the 2019 DHS. The FP Goals model was used to project a new method mix in 2027, informed by the interventions driving changes in mCPR. For example, the growth in mCPR attributed to increasing access to LARCs at PHUs would be expected to increase the proportion of LARC within the method mix, while growth in mCPR from more general activities, like broad investments in social and behaviour change (SBC), were not expected to lead to any method mix shifts. A linear trend was used to estimate method mix for 2023–2027.

These projections are to be understood as the best-guess projections for a future method mix and are not to be interpreted as reducing user choice for any particular method. In addition, the volume of commodities that need to be procured each year will be determined not only by us, but also by levels of stock already in the supply chain and other considerations. Therefore, while the CIP includes a general estimate of commodity expenditure, *actual forecasts and procurement of FP commodities should be determined through existing quantification processes that regularly review and update forecasts and procurement needs.*

Results

At the time of the 2019 DHS, injectables were the most common method used by 42% of modern method users, followed by implants at 34%. Projected changes to method mix are modest, with these two methods still accounting for most modern contraceptive use in the country (Table 4).²

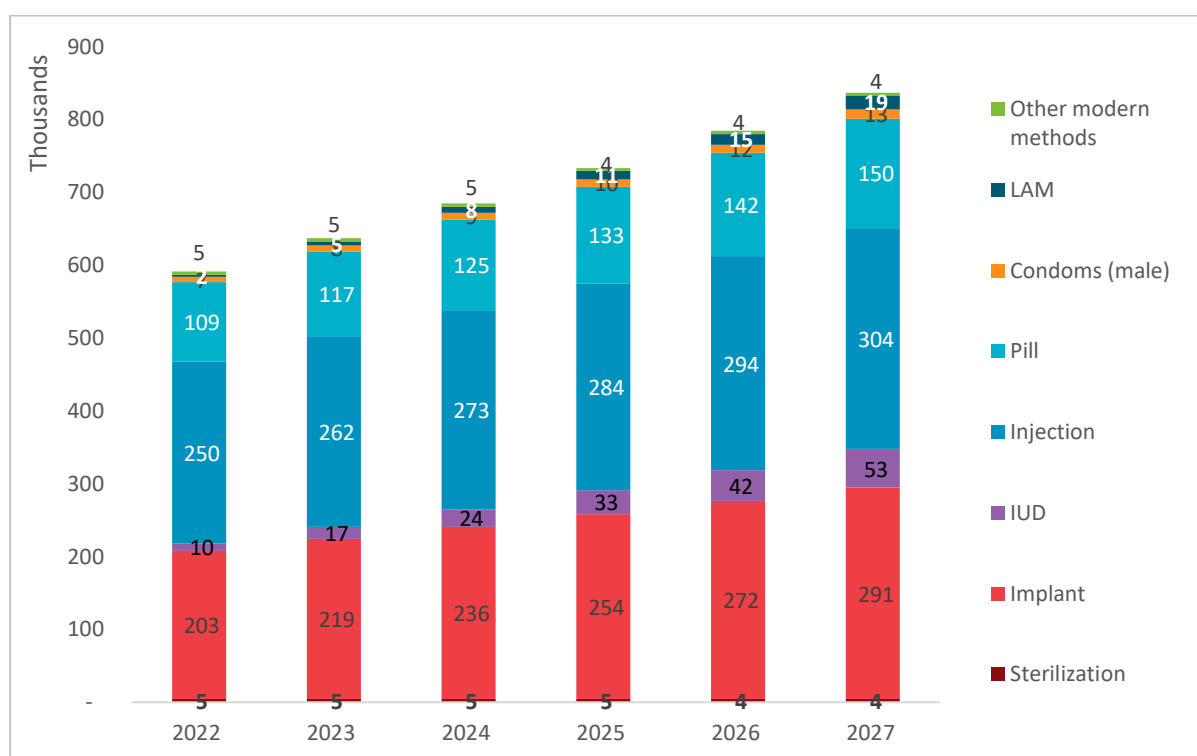
Table 4: Change in modern method mix (all women) and modern users by method

	Modern Method Mix		Users by Method	
	2022	2027	2022	2027
Sterilization	1%	1%	4,950	4,230
Implant	34%	35%	202,959	290,681
IUD	2%	6%	9,900	52,647
Injection	42%	36%	249,986	303,713
Pill	18%	18%	108,905	150,359
Condoms (male)	1%	2%	7,425	12,870
LAM	0%	2%	2,475	18,946
Other modern methods	1%	0%	4,950	3,603

When changes in method mix are overlaid with the projected increase in modern contraceptive users, users by method can be estimated. Implants are projected to see the largest increase in users (+87,700) followed by injectables (+53,700), IUDs (+42,700), and pills (+41,500). Figure 3 shows these changes in method users by type over the CIP period.

² The FP Goals model was used to project changes in method mix based on the expected method mix delivered through different interventions and the relative contributions of those interventions to overall change in contraceptive use. A modest increase in the use of some methods was projected, leading to a relative decline in the share of women using injectables. However, the absolute number of injectable users are projected to increase.

Figure 3: Total modern FP users by method, 2022–2027



Impact

The FP2030 Annual Indicator Calculator was used to calculate the health impacts of achieving the mCPR goals (Table 5). These calculations estimate the total impact of contraceptive use in the country, including the benefits that the women of Sierra Leone already experience from existing contraceptive use. In other words, these impacts show total number of unintended pregnancies, unsafe abortions, and maternal deaths that did not happen because women were using modern contraceptives.

Table 5: Health impacts of achieving the mCPR goal

	Annual Impacts					Total over 5 years
	2023	2024	2025	2026	2027	
Users	637,337	684,781	733,880	784,636	837,048	3,677,682
Unintended pregnancies averted	244,758	262,599	281,021	300,022	319,599	1,407,999
Unsafe abortions averted	87,379	93,748	100,324	107,108	114,097	502,656
Maternal deaths averted	1,973	2,117	2,265	2,418	2,576	11,349

CIP Strategic Priorities

The 2023–2027 CIP was developed through a consultative process with district-level stakeholders. Using the FP Goals model, district-level scenarios were developed showing the potential increase in mCPR resulting from scaling up a range of interventions to different levels. Based on review of these

results, as well as consideration of district context and what activities are already underway in each district, district stakeholders agreed on the level of effort which should be put into each intervention area. District considerations included their baseline data, planned activities (often with support from partners), their estimation of partners' willingness to support future activities, and experience of successful or challenging implementation. Having consultations at the level where implementation must occur, such as the districts in Sierra Leone, allows for the infusion of feasibility into the ambition sought by a program.

The changes at district level were then aggregated to estimate the national-level change in mCPR shown in Table 2. Ultimately, three key intervention areas were found to be responsible for most of the increase in contraceptive use. These three intervention areas are therefore considered the strategic priorities for this CIP:

- Strategic Priority #1: Improve PFP uptake
- Strategic Priority #2: Reduce stockouts
- Strategic Priority #3: Increase demand for FP through investments in SBC

The first two strategic priorities carried over from the previous CIP. Investments in SBC is a new priority for this CIP. Previously, increasing LARC at PHU was a strategic priority; however, due to the good progress made on this, especially for implants, this no longer rises to the level of strategic priority.

Developing district-level investment plans

As noted earlier, district-level decision-makers were engaged in a consultative and iterative process to develop tailored investment plans for each district. These plans considered a range of potential intervention areas (Table 6). For each intervention area, initial scenarios were developed using the FP Goals model to estimate the increase in mCPR resulting from a steady level of investment or a significant level of investment (see Annex 2 for details). The results from these scenarios were summarized into district fact sheets, which were used to aid discussions. During consultation workshops and through follow-up discussions, districts selected the level of investment they felt was appropriate for each intervention area:

- Maintain current efforts (e.g., no further scale up)
- Steady investment
- Significant investment

District priorities change based on district preferences

In some cases, districts specified a scale-up target that may not have aligned with the initial steady versus significant scenarios. In these cases, the district-specified target was used in the FP Goals model and classified as either "steady" or "significant" depending on how closely it aligned with the previous targets. A summary of levels of investment by key intervention area and district is shown in Table 6. As can be seen, some districts chose more ambitious scale-up scenarios, selecting significant levels of investments for most or all intervention areas while other districts chose to focus significant investments on just a few key intervention areas. Detailed district investment plans can be found in Annex 2.

Table 6: Summary of district scale-up scenarios

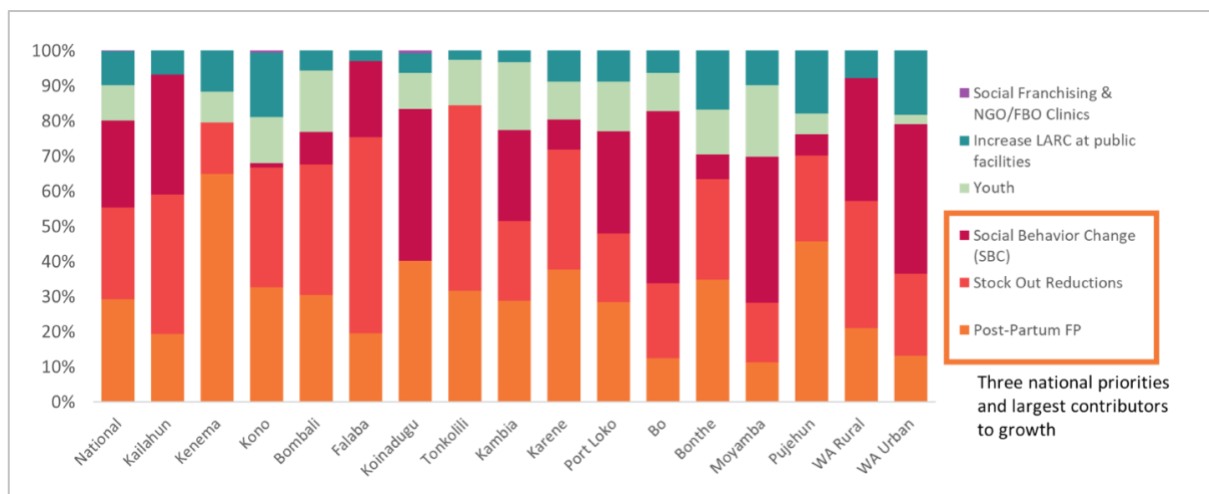
		Kailahun	Kenema	Kono	Bombali	Falaba	Koinadugu	Tonkolili	Kambia	Karene	Port Loko	Bo	Bonthe	Moyamba	Pujehun	WA Rural	WA Urban	
PPFP	Community-based SBC	steady	sig	steady	steady	steady	sig	steady	sig	steady	sig	steady	sig	steady	sig	sig	sig	
	Integration into Delivery & ANC	steady	sig	steady	sig	steady	sig	steady	sig	sig	sig	steady	steady	steady	steady	steady	maintain	
	Integration into PNC	steady	sig	steady	sig	maintain	sig	steady	sig	maintain	sig	steady	sig	steady	sig	steady	steady	
	Integration into immunization	steady	sig	steady	sig	sig	sig	steady	sig	maintain	sig	steady	sig	steady	sig	steady	steady	
Reduce Stockouts		steady	steady	steady	sig	sig	maintain	steady	sig	sig	sig	steady	sig	steady	sig	steady	sig	
LARC at Public Facilities	Implants	sig	sig	sig	sig	maintain	sig	sig	sig	sig	sig	sig	sig	sig	sig	sig	steady	sig
	IUDs	steady	steady	steady	steady	maintain	sig	steady	sig	steady	sig	sig	steady	steady	sig	steady	sig	
CHW Provision of FP		task-sharing to allow CHWs to provide injectables was discussed; agreed not to include in scale-up																
NGO-led Mobile Outreach		mobile outreach not included in scale-up; further discussion needed around role given increases in LARC access at PHUs																
Franchising/NGO and FBO Clinics		maintain	maintain	steady	n/a	n/a	sig	maintain	n/a	maintain	n/a	maintain	n/a	maintain	maintain	maintain	maintain	
Youth-Focused	Multi-component	maintain	steady	steady	sig	maintain	sig	steady	sig	steady	sig	sig	sig	steady	sig	steady	sig	
	In-school SRH				steady				sig		sig							
SBC	Mass media	sig	maintain	steady	sig	steady	sig	steady	sig	steady	sig	sig	sig	sig	steady	maintain	sig	
	Counselling via CHWs	maintain	maintain	TBD	steady	sig	sig	TBD	sig	steady	sig	sig	sig	sig	maintain	sig	sig	

Sig, significant; ANC, antenatal care; PNC, postnatal care; NGO, nongovernmental organization; FBO, faith-based organization; SRH, sexual and reproductive health; TBD, to be decided

Contraceptive Growth by Key Intervention Areas

A final scenario was modelled using FP Goals that aligned to the selected levels of investment for each district for every intervention area. The FP Goals model takes into account the effectiveness of scaling up each intervention (drawing from a global evidence base), the level of scale-up specified, and contextual information about each district. District contextual information includes the size and structure of the health care system (e.g. number of facilities by type), as well as baseline levels of coverage (e.g. baseline levels of facility delivery, baseline levels of contraceptive use). The model projects an increase in mCPR in each district with the increases attributed to specific interventions. These results were aggregated across districts to develop the national-level goal. Figure 4 shows the relative contribution of each key intervention area to increases in mCPR. Nationally, three intervention areas account for nearly 80% of the increase in mCPR; these three intervention areas have been selected as the national priorities. The role of these priorities varies across districts based on contextual differences and differences in district investment strategies.

Figure 4: Contribution of intervention areas to projected mCPR increases (2023 to 2027) by District



The following sections provide more details on what specific interventions were scaled up for each of the intervention areas noted above.

Strategic Priority #1: Improve PPF uptake

Addressing the FP needs of postpartum women is important to ensure healthy timing and spacing of births. Despite being prioritized in the previous CIP (2018–2022), use of contraception during the postpartum period remains low (5% of women using at six months postpartum according to the 2019 DHS). However, the situational analysis revealed that the foundation for progress has been built, with PPF-focused training rolled out across the country.

The FP policy calls for FP services to be fully integrated into a wider set of programs, including adolescent health, sexually transmitted infection testing, breast and cervical cancer screening, sexual violence/sexual assault–gender-based violence, HIV (including counselling and testing, prevention of mother-to-child transmission, HIV management, and antiretroviral therapy), Expanded Programme on Immunization, and integrated management of neonatal and childhood illnesses, chronic conditions such as hypertension and diabetes, TB, and disability. While these other integration

efforts are recognized as important, the CIP focuses on a prioritized effort to strengthen integration into maternal and child health services in order to strengthen PFP.

During this CIP period, coordinated efforts are needed to ensure that messages about the importance of PFP use are integrated throughout pregnancy and that services are readily available to women where they deliver and when they continue to interact with the health care system during their child's first year of life.

These specific interventions are included as part of increasing PFP:

- **Community-based SBC via CHWs:** In settings where women seek care well before active labour, FP counselling can be incorporated into care around the preparation for childbirth. Women and their partners often have limited understanding about contraceptive options, return to fertility, and risks of a closely spaced or unintended pregnancy soon after childbirth. This high-impact intervention allows CHWs to inform women of their options, to address concerns about side effects and risks of contraception on breastfeeding, and to have a healthy postpartum period free from a risk of an unintended pregnancy soon after giving birth.
- **Integration of PFP into ANC care (counselling) and delivery (immediate):** PFP is a high priority activity for the Sierra Leone health system. Where privacy and continuity of care is provided in a delivery setting, immediate PFP is a high-impact intervention. Offering modern contraception services as part of care provided during childbirth increases postpartum contraceptive use and is likely to reduce both unintended pregnancies and pregnancies that are too closely spaced. Providing information during the antenatal period (at ANC visits), prior to delivery, can help prepare expectant mothers for their fertility risks postpartum, increase awareness of safe methods, and lead to better uptake of immediate PFP post-delivery. Where women have the opportunity and care to recuperate in a facility after birth, provision of PFP counselling and services by trained staff can increase knowledge, attitudes, and use of PFP. When maternity staff are trained and supported to counsel, provide respectful care, and provide contraceptive methods, the contraceptives, consumables, and necessary instruments to administer the methods must be provided.
- **Integration of PFP into PNC and/or immunization:** Offer FP information and services proactively to women in the extended postpartum period during routine postnatal care visits and/or baby immunization. The extended postpartum period is defined as the 12 months following a birth and includes multiple touch points through which women come to health facilities for the care of themselves and their babies (i.e. during postpartum check-up, well baby visits, baby immunization visits). Integration offers benefits such as mitigating constraints related to transportation costs and time while also reducing the burden on the overall health system and, potentially, on individual workloads. Note that integration into PNC and integration into immunization are modelled separately, accounting for different levels of use.

In developing district investment plans, districts considered:

- Baseline coverage of each integration opportunity (e.g. the share of women who deliver in a health facility)
- Baseline levels of integration
 - In some districts, very little had been achieved in terms of integration of PFP into maternal health care while in others, more progress had been made. Nationally, it is estimated² that only around one-quarter of facilities offer quality integrated PFP services, indicating room for expansion.

- Scale-up of community-based SBC via CHWs. This means CHWs are providing focused counselling on the benefits of PFP to pregnant women. Across districts, investment scenarios include targets of CHWs reaching between 20% and 50% of pregnant women with this type of counselling.
- Integration into facility delivery. Baseline levels of PFP integration at facility delivery were estimated to range between 12% and 35% across districts. District investment scenarios ranged from maintaining baseline values to increasing to 85% across districts.
- Integration into PNC, which was estimated to have the same baseline as integration into facility delivery due to limited data. District investment scenarios ranged from maintaining baseline values to increasing to 50% across districts.
- Integration into immunization, which was assumed to be only 5% at baseline across all districts due to the unavailability of data. District investment scenarios ranged from maintaining baseline values to increasing to 20% across districts.

Strategic Priority #2: Reduce stockouts

At baseline, levels of stockouts for the most commonly used method, injectables, ranged from 33% to 80% of facilities reporting a stockout on the day of the assessment across zones; stockouts of other methods were variable, ranging from 0% to 47% [12]. Despite being a priority in the previous CIP (2018–2022), stockouts have remained a persistent challenge. The situational analysis revealed that, while the first-mile distribution was adjusted to provide six months of stock per cycle, the last-mile distribution remains a bottleneck. Some interventions for strengthening last-mile distribution that have been piloted showed promising results and should be considered for further scale-up under this CIP.

Table 1 describes some of the interventions that were piloted and now need to be scaled as well as additional bottlenecks in intervention implementation. The range of interventions vary by district given current levels of interventions implemented. Hence, across districts, investment scenarios ranged from not needing any further efforts to reduce stockouts to achieving up to a 50% reduction in stockouts.

Districts were encouraged to consider district-specific bottlenecks contributing to stockouts, including ordering, procurement, distribution, and stock management. Efforts to reduce stockouts should also consider availability of supplies needed to administer FP methods in addition to the commodities themselves.

Strategic Priority #2 is fully aligned with the National Family Planning Policy.

Strategic Priority #3: Increase demand for FP through investments in SBC

Demand-side interventions are a critical component of successful FP programs. These interventions can address myths and misconceptions about using contraception and promote the benefits of health timing and spacing of births. Overall, women in Sierra Leone desire large families. The mean ideal number of children was 4.7 at the time of the 2019 DHS, declining only slightly from 4.8 in the 2013 DHS. The maximum prevalence demand curve suggests that, even without a change in desired family size, most districts could still see further increases in mCPR. However, in some districts (namely Kailahun, Bo, and Moyamba), further increases in mCPR are unlikely without underlying changes to the social norms that influence demand. SBC efforts under this CIP should be coordinated to ensure clear and consistent messages that resonate with community members are delivered across a range of delivery channels.

Two specific interventions were included as part of SBC investments:

- Using mass media channels to support healthy reproductive behaviours
- Interpersonal communication on FP via CHWs

In developing district investment plans, districts considered baseline levels of exposure to existing SBC interventions and efforts required to achieve different levels of scale-up. More specifically, the following were included:

- **Mass media:** At baseline, the share of women who recalled hearing FP messages on mass media ranged from only 2% to 57% across districts (based on DHS 2019). District investment scenarios ranged from maintaining baseline reach to increasing reach up to a maximum of 50%, unless the district was already higher than this.
- **Counselling via CHWs:** At baseline, the share of women who discussed FP with a fieldworker ranged from 5% to 55% across districts (based on DHS 2019). District investment scenarios ranged from maintaining baseline reach to increasing reach up to a maximum of 30%, unless the district was already higher than this.

SBC interventions are particularly important in the three districts (Kailahun, Bo, and Moyamba) that sit right on the demand curve (see situational analysis in Annex 3). Little progress is likely to be seen in these districts without investments to shift norms and behaviours.

Note that SBC investments are also captured under the strategic priority for PFP through a specific focus on CHWs reaching and counselling pregnant women. The CHW role here includes reaching the wider community, not just pregnant women.

Strategic Priority #3 is fully aligned with the National Family Planning Policy.

Other key interventions included

INCREASE LARC AT PHUS

Increasing the availability of LARC at PHUs was a strategic priority under the 2018–22 CIP. Given the large increases already achieved around increased availability, especially for implants, this intervention area no longer rises to the level of strategic priority. However, some further progress can still be made, especially in select districts.

At baseline, on average, 86% of community health posts (CHPs) and 79% of maternal and child health posts (MCHPs) provided implants; however, there was wide variation across districts ranging from 50% and 100% of CHPs and 25% and 100% of MCHPs. District investment scenarios ranged from increasing availability of implants to between 85% and 100% at CHPs and 50% to 100% at MCHPs.

At baseline, on average, 12% of CHPs and 8% of MCHPs provided IUDs with variation across districts ranging from 3% to 25% for CHPs and 0% to 23% for MCHPs. These low levels of provision are likely a combination of lack of availability (due to not having trained providers, commodities, and supplies) as well as limited client demand for this method. District investment scenarios ranged from maintaining baseline coverage to increasing to 20% to 100% for CHPs and 10% to 50% for MCHPs.

NGO CLINICS

Data shared by partners indicates a modest presence of NGO- or FBO-run clinics in most districts with around 50 total in the country. In the district investment scenarios, most districts chose to just maintain current efforts for these clinics. One district opted for a steady increase in the number of NGO facilities and one for a significant investment increase in the number of facilities. This equated to only four additional facilities.

YOUTH PROGRAMMING

Youth-focused interventions included scale-up of multi-component youth sexual and reproductive health (SRH) interventions that employ a variety of sectors and channels to reach adolescents, combining both demand-side (e.g. behaviour change interventions) and supply side (e.g. youth-friendly service delivery) elements.

Scenarios included interventions aimed at both married young people and unmarried youth.

Baseline data on reach of existing interventions was limited, but partner data indicated modest reach in a few districts (50% in Western Area Rural, 30% in Bo, and 30% in Kenema).

District investment scenarios ranged from not scaling up any youth investments to scaling up to reach between 10% and 40% of young people with multi-component interventions.

Of note, school-based curriculum-based SRH education was only included in district investment scenarios for three districts. Most districts felt that, while important, these interventions were outside of their purview and that further discussions with the Ministry of Education would be needed.

Interventions Excluded from Scale-up Scenarios

Task-sharing to allow CHW provision of injectables

A scenario was developed for consideration by districts that included task-sharing to allow for CHWs to provide injectable contraceptives. While current policy allows CHWs to distribute condoms and pills (resupply only), their role as FP services providers has been limited with more of a focus on providing counselling, information, and referrals. This scenario explored what would happen if task-sharing policies were implemented that led to half of CHWs being able to distribute injectables. Upon further consultation with districts, it was agreed that task-sharing to allow CHW provision of injectables would not be considered at this time. Most district staff expressed the view that CHWs would not be able to administer injections safely and, if they are allowed to provide injectable contraceptives, they might overstep their boundaries and start delivering other injections. However, the new FP policy includes task-sharing and self-care. As the situation evolves, this scenario could be revised.

DISTRICT AGENCY IN PRIORITISATION – NGO CLINICS

What does it mean to prioritise work that requires a partner?

Data shared by partners indicates a modest presence of NGO- or FBO-run clinics in most districts, with around 50 in total in the country. In the district investment scenarios, most districts chose to just maintain current efforts for these clinics, i.e. where an NGO clinic existed in a district, DHMT staff assumed the clinic would continue to run. One district opted for a steady investment of a 150% increase and one for a significant investment of a 200% increase in the number of facilities. These were cases where DHMT staff were aware that NGOs were planning to open new clinics or where the DHMT was signing MOUs with NGO or FBO clinics in their districts to deliver free FP services, with the commodities being provided by the government. This equated to only four additional facilities.

NGO-led mobile outreach

NGO-led mobile outreach services have contributed to expanding access to LARCs. Given the increased capacity to provide LARCs at PHUs, it was agreed that further scale-up would not be prioritized in district investment scenarios. Rather, districts agreed on how to ensure the sustainability of increased capacity of PHUs to provide LARCs and, if needed, to use traditional mobile outreach approaches in more targeted ways to reach those without access to PHUs.

Interventions Beyond What Is Captured in FP Goals

There are several interventions that may be required to provide the regulatory framework for achieving implementation of priorities in FP. These would include having a robust FP policy, a safe motherhood and reproductive health rights bill, and the necessary health worker training for values clarification and behavioural change to enable clients with disabilities to receive quality services. These interventions do not themselves have a direct link to contraceptive use but, without these, districts will face legal constraints and a poorly prepared workforce. Furthermore, this CIP assumes that FP will be included in emergency preparedness plans and costed separately.

SUMMARY OF CIP INTERVENTION SCALE-UP

Table 7: Summary of national-level scale-up as a result of district investment scenarios

Intervention area	Sub-area	National scale-up for CIP
CIP Priority #1: Improve postpartum family planning (PPFP) uptake	Community-Based SBC	37% of pregnant women reached
	Integration into Delivery & ANC	Increase % of facilities offering quality PPFP integrated into delivery and ANC from 23% to 58%
	Integration into PNC	Increase the % of facilities offering quality PPFP integrated into PNC from 23% to 40%
	Integration into immunization	Increase the % of facilities offering quality PPFP integrated into immunization from 5% to 15%
CIP Priority #2: Reduce stockouts		Reduce stockouts by one-third
CIP Priority #3: Increase demand for FP through SBC investments	Mass media	Increase the share of women reached by mass media campaigns from 32% to 39%
	Counselling via CHWs	Increase the share of women reached with FP messages via CHWs from 21% to 27%
Increase availability of LARC at public facilities	Implants	Increase the share of CHP offering implants from 86% to 99%, increase the share of MCHP offering implants from 79% to 94%
	IUDs	Increase the share of CHP offering IUDs from 12% to 41%, increase the share of MCHP offering IUDs from 8% to 26%.
CHW Provision of FP		Not included in scale-up
NGO-led mobile outreach		Not included in scale-up
Franchising/NGO and FBO clinics		Increase the number of facilities from 46 to 50
Youth-focused	Multi-component	Increase the share of young people reached from 10% to 31%
	In-school SRH	n/a*

*In-school SRH was only included in three districts; it is considered to be important but it falls under the purview of the Ministry of Education. More broadly, in line with the national FP policy, platforms such as the National Secretariat for the Reduction of Teenage Pregnancy, which includes a range of stakeholders outside the MOH, should continue coordination and be involved in the delivery of the multi-component youth programming.

Table 8. Quantification of targets

Strategic area	Objective	Modelled contribution to increasing mCPR	Strategic Intervention	Indicators	Baseline (2022)	Annual Targets				
						2023	2024	2025	2026	2027
#1: Increase PFP use	Increase the share of women using PFP at 6 months from 5% to 21%	1.7% points	Community-based SBC to promote PFP	# pregnant women reached with PFP messages (via CHWs)	0	21,352	42,705	64,057	85,409	106,762
			Integration into delivery (and ANC)	# facilities offering quality PFP integrated into delivery	310	408	505	603	700	798
			Integration into PNC	# facilities offering quality PFP integrated into PNC	310	358	406	454	502	550
			Integration into immunization	# facilities offering quality PFP integrated into immunization	68	95	121	147	173	200
#2: Reduce stockouts	Reduce stockouts by one third	1.5% points	Targeted interventions to address supply chain barriers	# facilities reporting stockouts	723	674	626	578	530	482
#3: Address barriers to use though SBC	Increase the number of women reached with evidence-based SBC interventions	1.4% points	SBC via mass media channels	# women reached via mass media with FP messaging	700,293	766,509	832,725	898,940	965,156	1,031,372
			SBC via CHW counselling	# women reached via CHWs with FP messaging	468,812	514,789	560,767	606,744	652,721	698,698

Strategic area	Objective	Modelled contribution to increasing mCPR	Strategic Intervention	Indicators	Baseline (2022)	Annual Targets				
						2023	2024	2025	2026	2027
Increase availability of LARC at public facilities	99% of CHP and 94% of MCHP will offer implants from baselines of 86% and 79% respectively 41% of CHP and 26% of MCHP will offer IUDs from baselines of 12% and 8% respectively	0.6% points	Provision of LARCs at public facilities: Implants	# public facilities offering implants	1,157	1,191	1,224	1,257	1,290	1,324
			Provision of LARC at public facilities: IUDs	# public facilities offering IUDs	237	290	343	397	450	503
Increase FP provision via the private sector	Increase the share of women accessing FP services through private-sector providers	0.003% points	Increase FP provision via social franchising and NGO/FBO clinics	# of private clinics offering FP	46	47	47	48	49	50
Increase uptake of FP services by young people	Increase mCPR among married youth from 33% to 36% Increase mCPR among unmarried youth from 39% to 42%	0.6% points	Reach young people via multi-component comprehensive youth programming	# young adolescents and girls reached	63,617	88,893	114,169	139,445	164,721	189,997

COSTING

Costing Assumptions

The cost of the plan is estimated based on three separate factors³

- The cost of the programmatic inputs that will lead to improved quality and use of FP
- The costs associated with direct service delivery
- The costs associated with administering the FP program at the national and district levels

Programmatic Inputs

The estimate of programmatic inputs is based on a series of unit costs where the units are outputs that are easily translated into different assumptions about scale-up. For example, the cost associated with mass media is based on units of “women reached” leading to a unit cost denominated as Leones per woman reached. The reason for taking this approach is two-fold: 1) Unit outputs correspond to the units which are used in the FP Goals applications. By matching these units, alternative scenarios of scale-up are easily translated into costs. 2) Although careful analyses of FP program costs are scarce, unit outputs are the typical measures used as denominators in these studies.

The sources for programmatic costs include the following:

- Global reviews of specific FP program costs
- Careful country studies of program costs
- Implemented budgets where units of outputs can be identified
- Extrapolations from analyses mentioned above

Direct Service Delivery

Health provider salaries, benefits, and incentives

The provision of FP services is made as part of regular service delivery and therefore not easily disentangled from the provision of other essential maternal and child health services. Estimates of service delivery costs for health provider salaries, benefits, and incentives are made with an ingredients approach based on the methods used in “Adding it up: Investing in sexual and reproductive health 2019” [2]. In this approach, the anticipated number of FP acceptors and users are multiplied by estimates of the needed human resources. This product is then multiplied by unit cost estimates of labour. The salary costs for health personnel were obtained from the MOHS [4]. The projections of users and acceptors by method are based upon the FP Goals projections mentioned above.

Commodities

For the CIP, the total commodity costs are aligned to the final forecasted cost presented in the “National Needs Assessment and Forecasting of Contraceptive Supplies, 2022-2025”[3] applying a linear trend to estimate costs for 2026 and 2027. Traditionally, CIPs develop separate commodity

³ As an implementation plan, this report addresses only costs related to the FP program. A separate, complementary business plan will address the health sector and social sector cost savings that will be achieved by healthier spaced and limited births.

estimates based on users by method; however, given that the country has already developed a multi-year forecast, it was elected to align with this. Including these in the CIP costs provides an estimate of the level of funds required to procure commodities; however, this value should be updated regularly through the routine quantification processes.

Management and Administrative Costs

Most of the FP program is managed and administered by the district health teams. The costs involved with management and administration include planning, supervision, monitoring and evaluation, research, training, advocacy, etc. At the district level, we assumed these costs would be 10% of the sum of the programmatic costs. At the national level, we assumed that administration and management costs would be 5% of the sum of district programmatic costs.

Costing Summary

Each district is costed separately reflecting the priorities described in previous sections. The national estimate of cost is the sum of the district costs plus the 5% management and administration estimate mentioned above. An annex describes in more detail the cost estimates and detailed assumptions used.

The total cost of the plan from 2023 to 2027 is \$35.92 million (474.4 million Sierra Leonean leone). Table 9 and Figure 5 presents a breakdown of the costs by service delivery vs programmatic costs vs administration. More than half of the cost is accounted for by the programmatic costs. Commodity and supplies are also an important component at about one-third of the total cost.

Costs are lowest in the first year to account for initial planning before interventions are scaled. Costs are similar across the subsequent four years though the actual distribution of these costs will depend on scale-up plans. This contrasts with previous CIPs that assumed large up-front investments that would be followed by reduced maintenance costs. In this CIP we assumed that media and multi-component youth program costs would scale up linearly over the course of the CIP. Upgrades to facilities for PFP and long-acting methods and improved district/facility stock management would require significant continuous expenditure for supportive supervision and training updates.

Table 9: Breakdown of the costs by service delivery vs programmatic costs vs administration

	2023	2024	2025	2026	2027	Total
Programmatic costs	\$2,620,576	\$4,225,533	\$3,420,144	\$3,490,221	\$3,350,068	\$17,106,542
Direct service delivery						
Health provider salaries, benefits, and incentives	\$379,155	\$406,710	\$435,204	\$464,639	\$495,014	\$2,180,722
Commodities and supplies	\$2,249,365	\$2,514,159	\$2,807,522	\$3,100,885	\$3,394,248	\$14,066,179
District management and administration	\$262,058	\$422,553	\$342,014	\$349,022	\$335,007	\$1,710,654
National management and administration	\$131,029	\$211,277	\$171,007	\$174,511	\$167,503	\$855,327
Total	\$5,642,182	\$7,780,232	\$7,175,893	\$7,579,278	\$7,741,840	\$35,919,424

Figure 5: Breakdown of the costs by service delivery vs programmatic costs vs administration

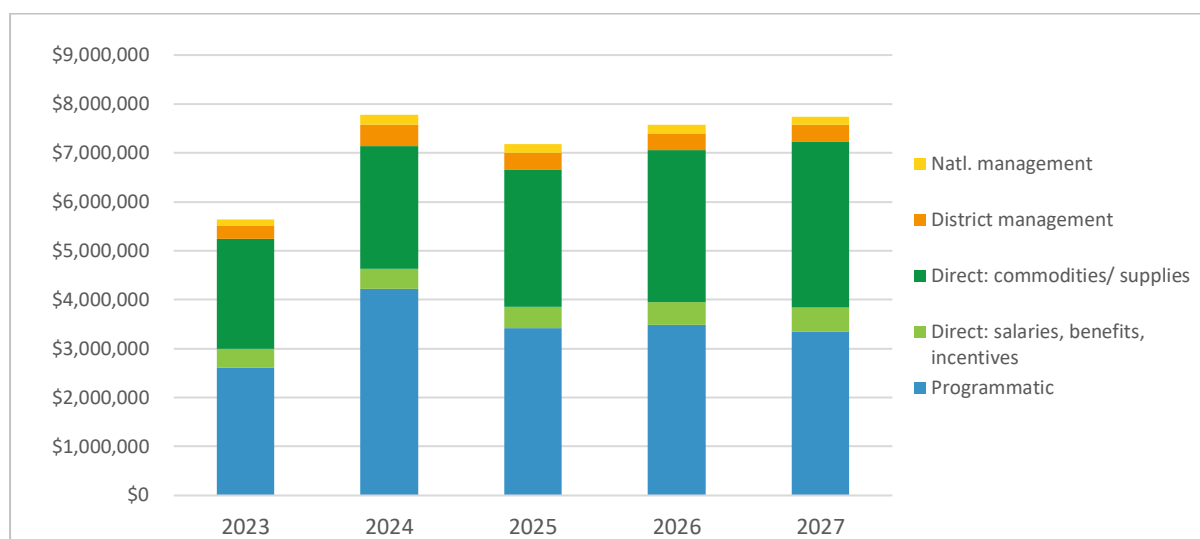


Table 10 presents a disaggregation of the programmatic costs by intervention area. The two most costly interventions are increasing PFPF use and interventions addressing youth. Both of these are time- and cost-intensive activities. PFPF requires both service delivery upgrades and behaviour change on the part of providers. Successful youth-oriented activities require time-intensive interaction with target populations. While reducing stockouts is a priority, its relatively low costs reflect that only around 240 facilities require stockout reduction interventions (on average scenarios addressed 33% of stockouts). The relatively small amounts allocated to social franchising and NGO/FBOs expansion reflect relatively low priority assigned to them by the district teams.

Table 10: Programme improvement costs by priority area

Priority Interventions	2023	2024	2025	2026	2027	Total
CIP Priority #1: Increase PFPF use	\$1,178,186	\$1,738,239	\$1,186,777	\$1,209,001	\$1,164,554	\$6,476,757
CIP Priority #2: Reduce stockouts	\$176,191	\$261,445	\$170,507	\$170,507	\$170,507	\$949,158
CIP Priority #3a: SBC– Mass media	\$64,009	\$128,017	\$128,017	\$128,017	\$128,017	\$576,077
CIP Priority #3b: SBC– counselling via CHWs	\$143,559	\$191,412	\$239,265	\$287,119	\$191,412	\$1,052,768
Increase LARC at public facilities	\$408,508	\$606,173	\$395,330	\$395,330	\$395,330	\$2,200,672
Social franchising and NGO/FBO clinics	\$161,028	\$322,055	\$322,055	\$322,055	\$322,055	\$1,449,249
Interventions aimed at young people	\$489,096	\$978,191	\$978,191	\$978,191	\$978,191	\$4,401,861
Total	\$2,620,576	\$4,225,533	\$3,420,144	\$3,490,221	\$3,350,068	\$17,106,542

Table 11 shows the breakdown of programmatic costs by district. For the most part, the differences across districts reflect the relative intensity of effort the districts indicated were feasible and/or necessary. In some cases, for example Western Area Urban at the high end and Falaba at the low end, overall population in the district also has an influence.

Table 11: Breakdown of programmatic costs by district^{a-d}

	2023	2024	2025	2026	2027	Total
Kailahun	\$58,403	\$89,619	\$74,151	\$78,057	\$70,244	\$370,475
Kenema	\$226,992	\$339,469	\$233,286	\$236,063	\$230,508	\$1,266,319
Kono	\$180,769	\$321,010	\$285,175	\$286,740	\$283,611	\$1,357,305
Bombali	\$221,391	\$366,056	\$295,906	\$298,098	\$293,714	\$1,475,164
Falaba	\$29,236	\$42,690	\$32,167	\$33,920	\$30,413	\$168,426
Koinadugu	\$231,593	\$405,888	\$358,937	\$362,386	\$355,488	\$1,714,293
Tonkolili	\$129,528	\$218,199	\$186,551	\$189,621	\$183,482	\$907,381
Kambia	\$237,220	\$384,527	\$308,600	\$313,261	\$303,938	\$1,547,547
Karene	\$102,505	\$162,920	\$124,714	\$126,008	\$123,419	\$639,567
Port Loko	\$358,071	\$573,531	\$452,907	\$460,236	\$445,579	\$2,290,324
Bo	\$171,798	\$269,046	\$213,874	\$220,334	\$207,415	\$1,082,467
Bonthe	\$151,994	\$240,005	\$181,514	\$183,345	\$179,684	\$936,543
Moyamba	\$92,685	\$146,614	\$115,676	\$118,282	\$113,070	\$586,327
Pujehun	\$202,061	\$314,723	\$231,857	\$234,035	\$229,678	\$1,212,354
Western Area Urban	\$109,285	\$167,421	\$151,815	\$163,663	\$139,967	\$732,151
Western Area Rural	\$117,043	\$183,815	\$173,014	\$186,171	\$159,857	\$819,900
National	\$2,620,576	\$4,225,533	\$3,420,144	\$3,490,221	\$3,350,068	\$17,106,542

^a In a few cases it was impossible to find analyses or budgets where a particular program had been carried out. In these cases, an estimate of the relative effort needed to implement a program was made.

^b Riley T et al., 2020.

^c National Needs Assessment and Forecasting of Contraceptive Supplies, 2022-2025. 2021.

^d Personal communication obtained by Regina Bash-Taqi.

INSTITUTION ARRANGEMENTS FOR IMPLEMENTATION

The GoSL has provided the MOHS with the mandate to ensure that FP services are available to all people of Sierra Leone. Within the MOH, the RHFPP is one of three programs within the Reproductive and Child Health Directorate and is responsible for FP and other reproductive health services. RHFPP will be responsible for providing stewardship and leadership, including mobilizing support and resources from domestic sources, for partners and private-sector players to successfully implement the activities described in this document. The RHFPP is committed to a decentralised approach. For this CIP, all districts will have clear targets that dedicated personnel will monitor on a quarterly basis.

Implementation of this broad-based plan calls for a multisectoral approach and coordination and partnerships at various levels, including with relevant ministries, national government agencies, regional and district health management teams, CSOs, NGOs, development partners, academia, media, the private sector, traditional and religious authorities, and communities to realize the great benefits and goals stated in this document. The common objective of stakeholders to achieve CIP objectives by 2027 calls for government leadership and functional processes to track and ensure performance assessment and accountability.

Monitoring CIP Implementation

This CIP expects to see growth in mCPR over a period of five years to reach 32% mCPR (All Women) by 2027. Growth is based on assumptions that extra resources will be made available to scale-up priority intervention implementation in the districts according to the levels of scale-up identified for each district. The CIP also depends on continued maintenance of existing programmes that are routine, including staffing, supportive supervision, and management. The CIP rests on the assumption that there will be no significant changes in the current architecture of service provision for FP.

Table 12 describes the monitoring and evaluation (M&E) plan for this CIP, including the objectives, indicators, means of verification, and assumptions.

Table 12: M&E plan for CIP

Objectives (What we want to achieve)	Indicators (How change will be measured)	Means of Verification (Source of information)	Assumptions (What underlies our expectations)
<p>Goal: To achieve modern contraceptive prevalence of 32% among all women by 2027</p>	<p>mCPR</p>	<p>DHS</p>	<p>There are no significant health shocks during the time period that may restrict access and availability of services. Policies and systems exist to support CIP priorities.</p>
<p>Outcomes:</p> <ul style="list-style-type: none"> Expand PFP uptake: 320,000 pregnant women reached with FP messages, 6000 facilities offering integrated FP with ANC, PNC, and immunization Decrease Stockouts from 723 facilities at baseline to nearly half or 482 facilities reporting stockouts Address barriers to use through SBC: 4.4 million women reached via mass media and 3 million women reached via CHWs Increase availability of LARC at public facilities from 1,157 to 1,324 Increase # of young women reached with multi-component programming from 66,000 to 190,000 by 2027 	<ol style="list-style-type: none"> 37% of pregnant women reached via community-based SBC 58% of facilities offering quality PFP integrated into delivery from baseline of 23% 40% of facilities offering quality PFP integrated into PNC from baseline of 23% 15% of facilities offering quality PFP are integrated into immunization from baseline of 5% 33% of stockouts fully eliminated 99% of CHP and 94% of MCHP will offer implants from baselines of 86% and 79% respectively 41% of CHP and 26% of MCHP will offer IUDs from baselines of 12% and 8% respectively At least 50 NGO/FBO facilities will provide social franchising contraceptive services Increase the share of young people reached with IEC and services from 10% to 31% 	<ol style="list-style-type: none"> DHS2 annual CHW reports (maternal, newborn, child health home visits) DHS2 annual reports DHS2 annual PNC reports DHS2 annual immunization reports UNFPA supply survey 2023 DHS annual reports on CHPs and MCHP disaggregated by method DHS annual reports on CHPs and MCHP disaggregated by method Partner reports, annual Partner reports, annual 	<ul style="list-style-type: none"> Financing for scale-up and program implementation and monitoring exists DHS2 data elements can capture information on reach Partner reports provide additional detail on reach

Objectives
(What we want to achieve)

<p>Outputs</p>	<ol style="list-style-type: none"> 1. Facilities are upgraded and providers trained to offer immediate PFP post-delivery and during PNC and immunization in selected districts 2. CHP and MCHP providers trained in implant procedures and facilities are stocked adequately 3. Selected CHP and MCHP facilities have trained providers with adequate stocks of IUDs 4. Selected private providers and clinics integrated into social franchising networks 5. Activities designed to optimise IEC materials and services for youth 	<ol style="list-style-type: none"> 1. DHIS district reports of % of facilities providing PFP disaggregated by delivery, PNC, and immunization 2. DHIS2 reports on % of planned facilities providing implants and IUDs by district 3. Partner reports on clinics participating in social franchising by district 	<ul style="list-style-type: none"> • There is sufficient staff time to monitor services and systems in place to obtain required reports • There is a routine mechanism where performance is discussed on an annual basis • MOHS leverages district data from DHIS2, monitors performance annually
<p>Activities</p>	<p>Detailed activity plan developed in conjunction with annual workplan to adjust for commodity and funding availability for priority outcomes</p>	<p>MOHS annual workplan and budget</p>	<p>MOHS stewards process of developing annual workplans and budget aligned with CIP priorities</p>

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ANNEX 1: DETAILED PROGRESS AGAINST STRATEGIC PRIORITIES

The strategic results that were expected by 2022 and the progress to date are set out in the table below.

Strategic Result	Progress to Date
<p>Stewardship, Management, and Accountability (SMA) 1. Oversight of FP program is improved. RHFPP and DHMT FP managers will be trained on leadership skills, and supportive supervision will be strengthened through the incorporation of the FP supervision checklist into the national checklist. Supervisory visits will take place more frequently at all service delivery levels through integration with other program areas (such as Expanded Programme of Immunization, nutrition, etc.)</p>	<ul style="list-style-type: none"> • Training database • Development of a mentorship framework • Perception of supervisory support assessments conducted • Trainer of Trainers – to cascade trainings at district level • Preservice training at midwifery schools
<p>SMA 2. National coordination, partnership, and integration of FP among government and all stakeholders, including governmental and NGOs, and development partners, is improved. The Reproductive Health Commodity Security Working Group will be strengthened through the development of six subcommittees (which roughly align to the thematic areas of the CIP, with the combination of policy and enabling environment and financing into one subcommittee and the addition of a youth subcommittee). Each subcommittee will focus on addressing the key issues and operational bottlenecks that are limiting implementation of priority activities.</p>	<p>Lead partner/stakeholder coordination (technical working groups, supply chain, resource mobilization,)</p>
<p>Sub-national coordination will be improved by holding quarterly meetings at the district level to identify upcoming opportunities to promote FP during district health events and to address challenges faced over the previous quarter and any issues raised through client feedback mechanisms.</p>	<p>FP structures at district and national level</p>
<p>SMA 3. FP data are collected, analysed, and used for decision-making. The RHFPP will develop an electronic performance monitoring system to coordinate partner inputs and track CIP implementation, and an M&E focal point will join the staff at RHFPP to input and update data for the CIP performance management system to track progress on implementation of the CIP. Reproductive Health Commodity Security Working Group meetings will be used to review progress and identify opportunities to improve coordination or address barriers. Annual meetings will be held to bring together key stakeholders, including district and regional FP coordinators to review FP priorities and align partner activities with any changes to the national goal or objectives.</p>	<ul style="list-style-type: none"> • M&E (data sharing in quarterly bulletin, meetings at all levels) • Worked with Avenir Health to develop the 2030 framework • Innovation (data clinics, electronic Integrated Disease Surveillance and Response System [eIDSR] tablets for reporting commodity stocks) • Marie Stopes International reporting in DHIS2

Annex 1: Detailed Progress Against Strategic Priorities

Strategic Result	Progress to Date
<p>SMA 4. The CIP is assessed at midterm and end of plan to inform future FP activities and programming. Consultants will be hired to conduct midterm and endline assessments of the progress towards achieving the objectives set out in the plan.</p>	
<p>SMA 5. The reproductive health and FP programme has the capacity and resources required to provide stewardship of the FP program. The capacity of RHFPP to provide leadership for the CIP will be strengthened through the hiring of two seconded staff to work with existing RHFPP staff to coordinate and monitor the implementation of the CIP. Additional resources required to effectively implement the program will be procured, including a vehicle to be used for CIP management and supervision. The RHFPP resource centre will also be updated to ensure staff are able to conduct their work in a conducive environment. RHFPP staff will participate in a series of job-specific skills trainings in order to improve their technical and management capacities.</p>	

ANNEX 2: DISTRICT-LEVEL IMPLEMENTATION DETAILS

Table 13: District-level implementation details

	National	Kailahun	Kenema	Kono	Bombali	Falaba	Koinadugu	Tonkolili
CIP SP#1: INCREASE PFP								
Community-based:								
# preg women reached at baseline	0	0	0	0	0	0	0	0
# preg women reached at endline	106,762	4,454	11,637	5,954	3,911	1,623	4,319	5,287
Additional women reached in endline year	106,762	4,454	11,637	5,954	3,911	1,623	4,319	5,287
Cumulative additional reach over 5 years	320,285	13,363	34,911	17,861	11,732	4,869	12,958	15,862
Integration into delivery (and ANC)								
# facilities offering at baseline	310	16	32	25	19	9	10	25
# facilities offering at endline	798	23	114	50	67	19	41	49
Additional facilities offering services	488	8	81	25	48	9	30	25
Integration into postnatal care (PNC)								
# facilities offering at baseline	310	16	32	25	19	9	10	25
# facilities offering at endline	550	23	67	34	40	9	24	37
Additional facilities offering services	239	8	35	9	21	0	14	12
Integration into immunization								
# facilities offering at baseline	68	4	7	5	4	2	2	5
# facilities offering at endline	200	9	27	10	16	9	10	11
Additional facilities offering services	131	4	20	5	12	7	7	5
CIP SP#2: REDUCE STOCKOUTS								
# facilities with stockouts at baseline	723	29	45	32	37	21	23	50
% reduction	33%	25%	25%	25%	50%	50%	0%	25%
# facilities with stockouts reduced	241	7	11	8	19	10	0	12

Annex 2: District-Level Implementation Details

	Kambia	Karene	Port Loko	Bo	Bonthe	Moyamba	Pujehun	Western Area Rural	Western Area Urban
CIP SP#1: INCREASE PFPF									
Community-based:									
# preg women reached at baseline	0	0	0	0	0	0	0	0	0
# preg women reached at endline	6,798	3,595	11,880	5,084	4,981	2,687	9,403	13,557	11,590
Additional women reached in endline year	6,798	3,595	11,880	5,084	4,981	2,687	9,403	13,557	11,590
Cumulative additional reach over 5 years*	20,394	10,785	35,641	15,253	14,944	8,061	28,209	40,671	34,770
Integration into delivery (and ANC)									
# facilities offering at baseline	8	13	12	34	13	29	36	10	18
# facilities offering at endline	59	54	83	68	27	44	63	19	18
Additional facilities offering services	50	40	71	34	13	15	27	10	0
Integration into postnatal care (PNC)									
# facilities offering at baseline	8	13	12	34	13	29	36	10	18
# facilities offering at endline	35	13	49	50	41	37	53	19	20
Additional facilities offering services	26	0	37	15	28	8	16	9	2
Integration into immunization									
# facilities offering at baseline	3	3	5	7	4	5	5	3	3
# facilities offering at endline	14	3	20	14	16	11	21	5	6
Additional facilities offering services	10	0	15	7	12	5	16	3	3
CIP SP#2: Reduce Stockouts									
# facilities with stockouts at baseline	32	30	46	95	55	71	70	42	46
% reduction	50%	50%	50%	25%	50%	25%	50%	25%	10%
# facilities with stockouts reduced	16	15	23	24	27	18	35	11	5

Annex 2: District-Level Implementation Details

	National	Kailahun	Kenema	Kono	Bombali	Falaba	Koinadugu	Tonkolili
CIP SP#3: SBC INTERVENTIONS								
Mass media								
# women reached at baseline	700,293	36,109	34,692	47,439	60,317	1,272	16,505	55,447
# women reached at endline	1,031,372	83,413	36,777	56,491	78,213	2,260	38,646	56,768
Increase in # women reached in final year	331,079	47,305	2,086	9,052	17,896	988	22,141	1,321
Cumulative additional reach over 5 years*	993,236	141,914	6,257	27,155	53,687	2,964	66,424	3,964
Counselling via CHWs								
# women reached at baseline	468,812	92,323	28,383	9,265	24,665	16,032	10,938	52,021
# women reached at endline	698,698	106,635	30,089	10,827	31,285	22,832	23,188	61,480
Increase in # women reached in final year	229,886	14,313	1,706	1,562	6,620	6,799	12,250	9,459
Cumulative additional reach over 5 years*	689,657	42,938	5,119	4,686	19,861	20,398	36,750	28,378
INCREASE LARC AT PUBLIC FACILITIES								
Implants								
# offering at baseline	1,157	83	115	81	73	41	35	104
# offering at endline	1,324	86	134	97	79	41	38	106
Additional facilities offering implants	166	3	19	16	6	0	3	2
IUDs								
# offering at baseline	237	18	34	23	16	7	4	12
# offering at endline	503	23	42	23	32	7	35	12
Additional facilities offering IUDs	267	5	8	0	16	0	30	0
SOCIAL FRANCHISING AND NGO/FBO CLINICS								
# clinics at baseline	46	3	2	3	4	0	2	0
# clinics at endline	50	3	2	5	4	0	4	0
Additional clinics opened/franchised	4	0	0	2	0	0	2	0

Annex 2: District-Level Implementation Details

	National	Kailahun	Kenema	Kono	Bombali	Falaba	Koinadugu	Tonkolili
INTERVENTIONS AIMED AT YOUNG PEOPLE: COMPREHENSIVE YOUTH PROGRAMMING								
# youth reached at baseline	63,617	0	15,094	0	0	0	0	0
# youth reached at endline	189,997	0	16,940	8,489	18,396	0	7,054	13,643
Increase in # youth reached in final year	126,380	0	1,846	8,489	18,396	0	7,054	13,643
Cumulative additional reach over 5 years*	379,140	0	5,539	25,467	55,187	0	21,162	40,928

	Kambia	Karene	Port Loko	Bo	Bonthe	Moyamba	Pujehun	Western Area Rural	Western Area Urban
CIP SP#3: SBC INTERVENTIONS									
Mass media									
# women reached at baseline	18,403	12,446	40,212	36,183	6,806	12,305	18,738	115,714	187,705
# women reached at endline	40,120	21,478	89,763	77,340	15,596	26,289	32,989	168,111	207,117
Increase in # women reached in final year	21,717	9,032	49,551	41,157	8,790	13,985	14,251	52,397	19,411
Cumulative additional reach over 5 years*	65,151	27,096	148,652	123,471	26,370	41,954	42,754	157,190	58,234
Counselling via CHWs									
# women reached at baseline	13,216	17,442	18,862	22,812	26,158	18,134	6,106	39,568	72,889
# women reached at endline	28,811	20,066	42,189	48,759	29,971	27,967	7,167	89,215	118,217
Increase in # women reached in final year	15,595	2,624	23,327	25,947	3,813	9,833	1,061	49,647	45,328
Cumulative additional reach over 5 years*	46,786	7,873	69,980	77,842	11,439	29,500	3,182	148,942	135,984
INCREASE LARC AT PUBLIC FACILITIES									
Implants									
# offering at baseline	69	56	86	133	55	78	81	36	32
# offering at endline	69	63	98	142	82	93	105	42	49
Additional facilities offering implants	0	7	12	9	27	15	24	6	17

Annex 2: District-Level Implementation Details

	Kambia	Karene	Port Loko	Bo	Bonthe	Moyamba	Pujehun	Western Area Rural	Western Area Urban
IUDs									
# offering at baseline	14	8	7	19	13	27	18	11	7
# offering at endline	44	8	67	39	20	31	70	16	39
Additional facilities offering IUDs	30	0	59	19	7	3	51	5	32
SOCIAL FRANCHISING & NGO/FBO CLINICS									
# clinics at baseline	0	2	6	2	0	3	0	9	10
# clinics at endline	0	2	6	2	0	3	0	9	10
Additional clinics opened/franchised	0	0	0	0	0	0	0	0	0
INTERVENTIONS AIMED AT YOUNG PEOPLE: COMPREHENSIVE YOUTH PROGRAMMING									
# youth reached at baseline	0	0	0	13,040	0	0	0	0	35,482
# youth reached at endline	16,252	5,256	20,309	19,513	7,217	4,437	7,235	5,433	39,823
Increase in # youth reached in final year	16,252	5,256	20,309	6,473	7,217	4,437	7,235	5,433	4,340
Cumulative additional reach over 5 years*	48,756	15,769	60,927	19,420	21,651	13,311	21,704	16,298	13,021

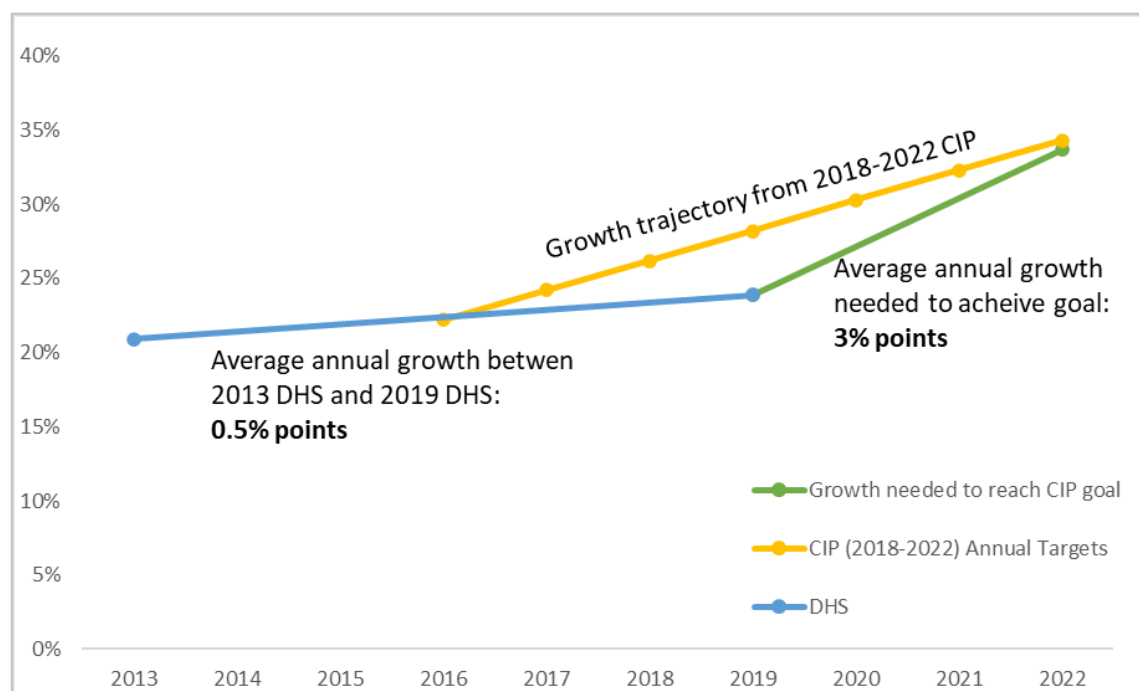
ANNEX 3: COMPLETE SITUATION ANALYSIS

1.0 General Progress and Context

1.1 Progress against existing targets

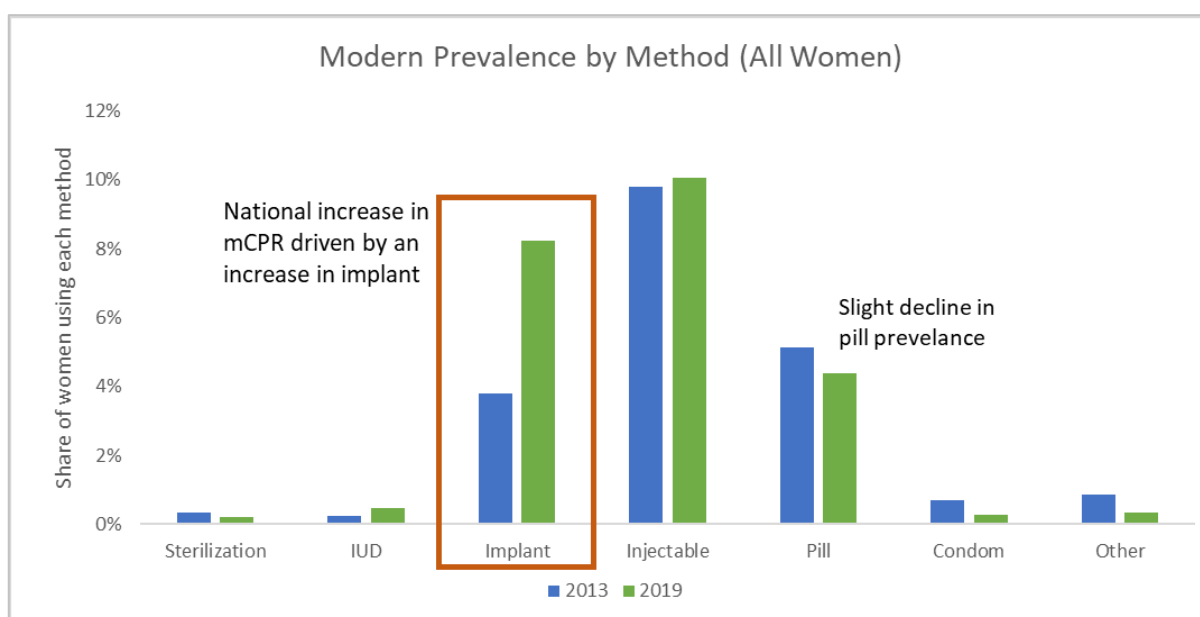
The Government of Sierra Leone (GoSL), with support from U.S. Agency for International Development (USAID), set an ambitious target in 2018 of increasing the modern contraceptive prevalence rate (mCPR) for currently married women from 15.6% in 2013 [1] to 33% in 2022 [2]. For all women, the target was to increase from 20.9% to 33.7% in 2022 [2]. These targets were set out in the country's 2018–2022 Costed Implementation Plan (CIP). By 2019 the country had achieved 20.9% mCPR among currently married women [3] and 24% mCPR among all women. This puts the country behind the growth trajectory to be on track with the CIP. Progress would have needed to accelerate significantly for the country to achieve the 2022 CIP goal (Figure 6). Recent data from DHS2 do not indicate this acceleration has happened since 2019.

Figure 6: mCPR among all women, DHS trends versus 2018–2022 CIP goal



While only 20.9% of currently married women were using modern contraceptives at the time of the 2019 DHS, over half (52.6%) of sexually active unmarried women were doing so. Among both currently married women and sexually active unmarried women, the most popular methods were injectables (9% of married women and 21.5% of sexually active unmarried women were using injectables) followed by implants (7% of married women and 19.9% of sexually active unmarried women were using implants) [3]. The oral contraceptive pill (OCPs) was the third most popular method (4% and 8.5% of women were using OCPs) [3].

For all women, the mCPR increased from 21% to 24% between the 2013 and 2019 DHS, an increase of 3% points (see Figure 7). This increase is almost entirely accounted for by an increase in use of implants; in 2013, 4% of women were using an implant which doubled to 8% in 2019. By contrast, OCP use declined slightly while other methods remained similar to the previous survey.

Figure 7: Increase in mCPR for All Women between 2013 and 2019 by method

1.2 Why FP progress has fallen short

In 2021, family planning (FP) stakeholders met to review progress and to identify why the country missed the planned targets so significantly. **Stakeholders concluded that FP interventions in the country had not been closely guided by the CIP. Thus, despite the shortage of resources within the MOH, better coordination and alignment of resources with activities in the CIP could have led to higher achievements against the set targets.**

Using the FP Goals model, stakeholders had agreed in 2018 on critical interventions that must be scaled up to achieve the targets. The 2018–2022 CIP identified three strategic priorities and how their scale-up would contribute to overall growth:

- **Strategic Priority #1 (SP1):** Postpartum FP (PPFP) (responsible for 51.5% of growth)
- **Strategic Priority #2 (SP2):** Stockout reductions (responsible for 27.3% of growth)
- **Strategic Priority #3 (SP3):** LARC via peripheral health units (PHUs) with focus on implant scale-up (responsible for 3.4% of growth)

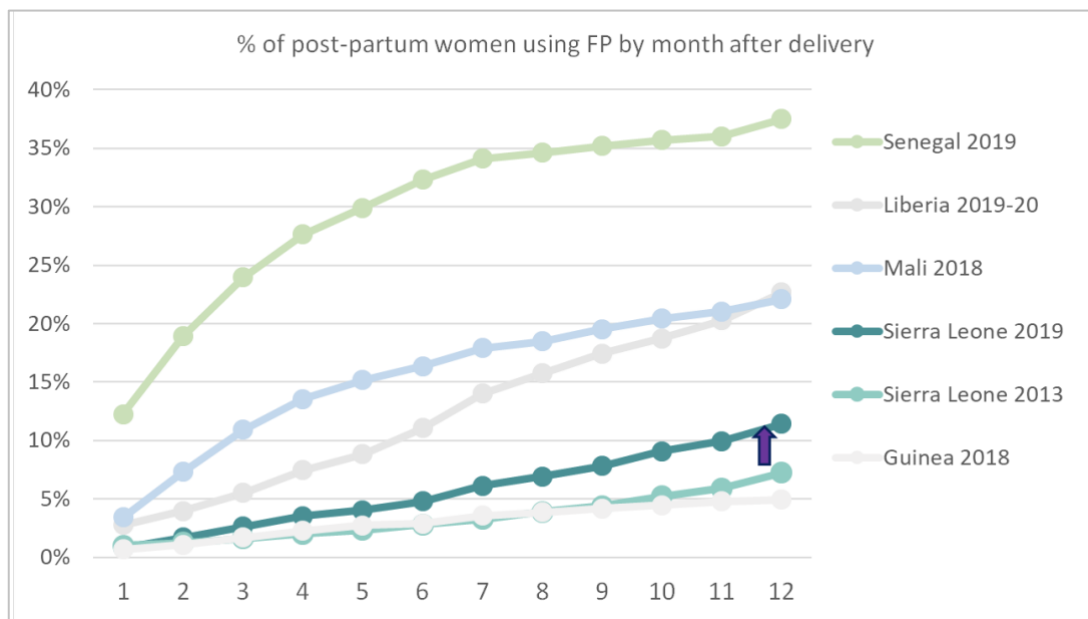
In addition, the following were also included in the model and contribute to growth in mCPR with steady investments and efforts:

- Community health workers (5.4% of growth)
- Public sector mobile outreach (4.4% of growth)
- Youth-focused interventions (3.5% of growth)
- Private-sector facilities (3.3% of growth)

Postpartum family planning was identified as the intervention with the most potential to contribute to Sierra Leone's mCPR growth. PPFP uptake is low in Sierra Leone with only 11.42% at 12 months postpartum [3]. It increased only 4% points between 2013 and 2019 [3] despite the call for focused attention on this area. It lags behind other countries in the region (Figure 8): at 12 months, PPFP

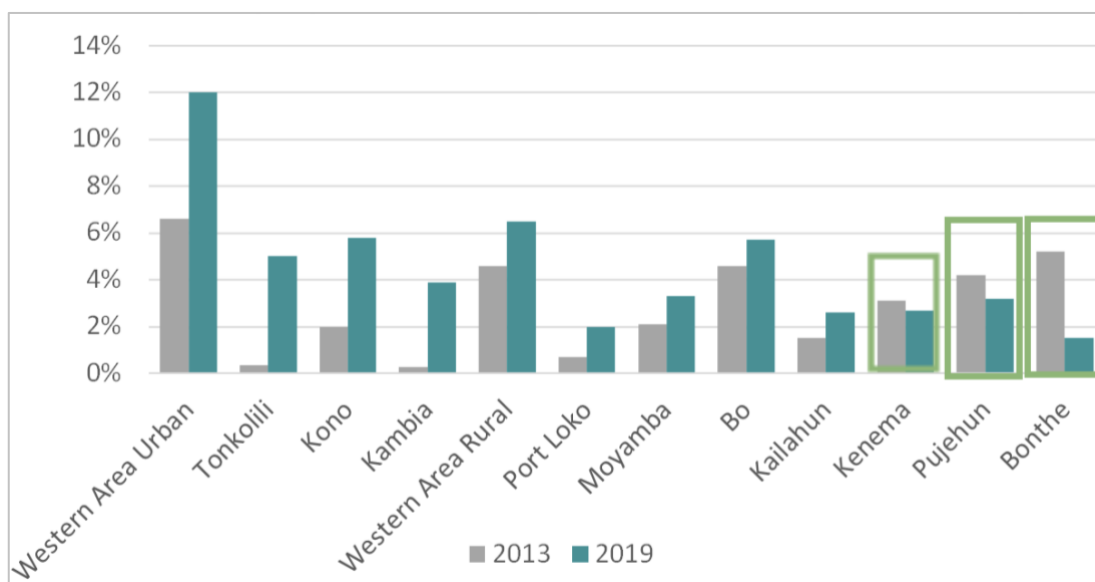
uptake is 37.5% in Senegal, 22.6% in Liberia, and 22% in Mali. Uptake of PFP in Sierra Leone is, however, higher than in neighbouring Guinea where it is only 5% at 12 months.

Figure 8: PFP uptake by month in Sierra Leone and similar countries



Between 2013 and 2019, PFP improved in all but three districts—Kenema, Pujehun, and Bonthe (see Figure 9). Western Area Urban saw the largest increase with PFP at six months, reaching 12%.

Figure 9: PFP uptake at six months by district, 2013 and 2019



For each recommendation, FP Goals was used to model a scale-up scenario (Table 14).

Table 14: Modelled scale-up for each intervention using FP Goals and progress to date

Intervention	Baseline	Scale-up in 2018 to 2022 CIP	Progress to date
PPFP	7.25% of women using PPFP at December 2013 (Source DHS 2013)	50% of pregnant women reached by CHWs, 50% of facilities offering immediate PPFP services	4% points increase from 2013 to 2019 (11.42% in 2019) RHFPP and partners have trained service providers for immediate PPFP services (IUD and implants) in all comprehensive and basic emergency obstetric and newborn care facilities. Lower-level facilities provide immediate postpartum implants.
Stockout reductions	Persistently high stockouts	50% reduction in stockouts	There has been some reduction in stockouts. The national assessment on availability of reproductive health commodities and services in 2019 showed doubling of “no stockout” from 10.8% in 2018 to 22.9% in 2019 [12].
Increase LARC provision at PHUs	63% of PHUs provide implants 10% of PHUs provide IUDs	All PHUs provide implants, IUD provision is scaled up to half of facilities	98 % of service delivery points (SDPs) surveyed in 2019 offer implants. However, only 50% of SDPs meant to offer IUDs do so as demand for IUDs and numbers of trained providers remain low.

While the quantitative targets have not been fully met, a range of preparatory activities have been undertaken that set the stage for movement towards the targets. These activities are described below.

POSTPARTUM FAMILY PLANNING

- National guidelines for PPFP were developed and training rolled out to some SDPs, with an emphasis on immediate PPIUDs and PP Implants including post C-Section. **However, less than 50% of SDPs have been trained.**
- IEC materials for PPFP were developed and disseminated
- PPFP Indicators were integrated into reporting tools

Bottlenecks included inadequate funding for full-scale rollout and unavailability of equipment in some SDPs, mostly Kelly Forceps for post-partum IUD.

More training of providers is also needed. Demand-side barriers are addressed in section 4.

STOCKOUT REDUCTION

- The first-mile distribution was adjusted to provide six months of stock per cycle, **but last mile distribution remains a bottleneck.**
- New initiatives to address stockouts were started including the electronic report request and issue vouchers pilot and restocking during in-charges' meetings. Also, a resupply pilot by Project Last Mile provided resources to DHMTs to supply commodities to SDPs. **These pilots provided good results and can be scaled up.**
- FP data clinics were started in six districts that help identify supply chain issues at health facilities. However, district FP teams need resources for monthly supervision. These supervisions can also provide an opportunity for emergency supplies for PHUs that are out of stock.

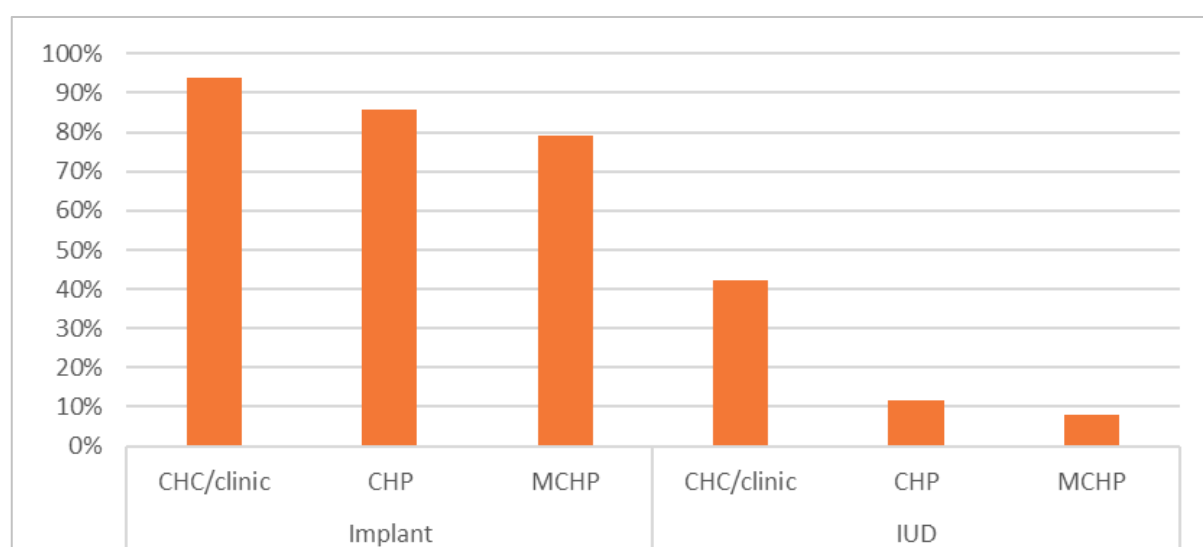
As shown above, while the scale-up of PFP has not reached the target, the foundation has been set with the training of providers. Stockouts have reduced significantly although there were stockouts of implants given their increased acceptability.

At the national level, high stockouts have persisted, though some reductions were seen between the 2018 and 2019 National Assessment on the Availability of Reproductive Health Commodities (from 89% to 77% of facilities reporting stockouts of any method). Stockouts remain high across multiple methods.

INCREASE PROVISION OF LARC AT PHUS

The provision of implants is now almost universal, so this target was met (Figure 10). However, while the commodities were available to provide IUDs there are two significant challenges: the current policy does not allow maternal and child health (MCH) aides (the most abundant cadre in the workforce) to be trained in the provision of IUDs. Learning from the success of the rapid growth in the use of implants, it is the availability of sufficient trained providers that accelerates use of a service, as this increases health service providers' confidence to recommend the method. Secondly, there is very low demand for IUDs; therefore, training of providers will need to be accompanied with significant community sensitization to create demand [4].

Figure 10: Share of facilities providing implants and IUDs



Source: DHIS2 analysis of 2019 data

COMMUNITY HEALTH WORKERS

GoSL policy dictates that PHUs share commodities received with CHWs. The CHW program reports that, in 2019, there were approximately 13,039 CHWs who received 10,613 FP commodities (pills and condoms) for distribution (Table 15). This translates to a very low coverage of commodities per CHW, and very low coverage of CHWs providing FP per woman. This is in line with findings from the DHS that show only 3% of women report getting their FP method from a CHW [30]

Often PHUs don't have enough to meet their needs while some health workers who may not understand how CHWs contribute to the country's FP goals may be reluctant to share the consumables with them. In addition, the limited range of methods offered (condoms and pills for refills only) also contributes to low utilization of FP services provided by CHWs, given the low use of these methods (see Figure 10 above).

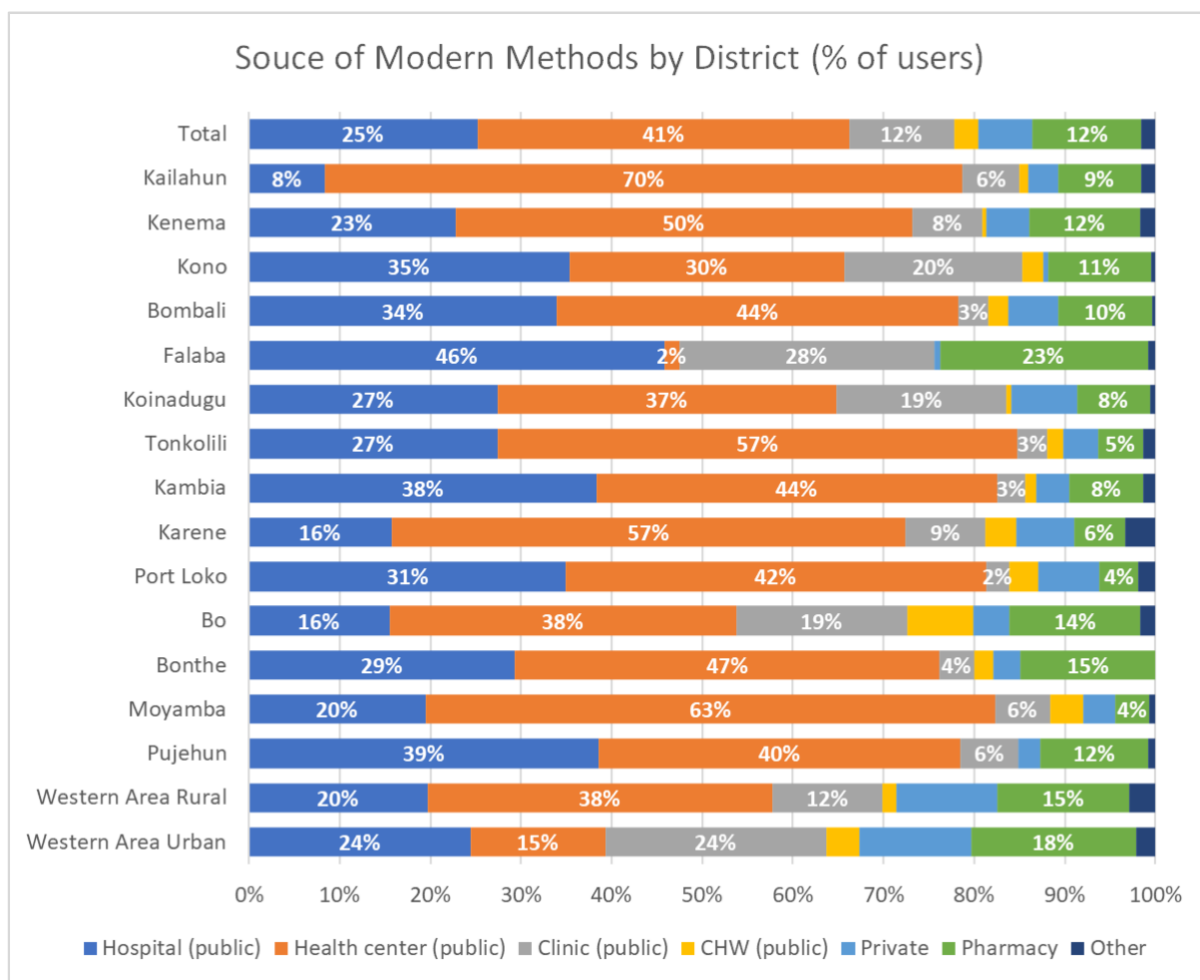
Table 15: CHWs FP commodity distribution by district

District	# CHWs per district	Aggregated FP commodities distributed	Average FP commodities per CHW
Bo	1,100	1,405	1.28
Bombali	670	505	0.75
Bonthe	873	79	0.09
Falaba	404	40	0.10
Kailahun	1,041	229	0.22
Kambia	900	2,328	2.59
Karene	690	719	1.04
Kenema	1,315	1,531	1.16
Koindugu	623	359	0.58
Kono	976	410	0.42
Moyamba	974	510	0.52
Port Loko	776	484	0.62
Pujehun	1,022	382	0.37
Tonkolili	670	227	0.34
Western Area Rural	500	911	1.82
Western Area Urban	505	494	0.98
Total	13,039	10,613	0.81

PRIVATE SECTOR

Private-sector facilities were meant to contribute 3.3% of the planned growth in the 2018–2022 CIP. Data from the private sector is not collected routinely (via DHIS2), so in the Western Area, for example, there is a significant risk that the level of provision is underestimated. Notwithstanding, the DHS 2019 reported that 18% of users accessed FP services from the private sector (private clinics and pharmacies). This is particularly relevant in the Western Area where 26% (Western Rural) and 31% (Western Urban) of users rely on private-sector providers or pharmacies (Figure 11).

Figure 11: Sources of modern methods use by district



MOBILE OUTREACH

Outreach was another activity identified as contributing to the country’s FP growth (4.4%) in the 2018–2022 CIP. All implementing partners attest that outreach provides a significant boost to FP use. Marie Stopes Sierra Leone (MSSL) is the main provider of outreach services in Sierra Leone. The number of clients reached in 2019 are shown in Table 16 below. Outreach services are provided both within PHUs and in community settings. As the capacity of PHU providers to provide LARCs increases, the role of mobile outreach may need to shift in the country.

Outreach is important not only for remote areas but, in the Sierra Leone context where women spend most of their time securing their livelihood, active community mobilization is necessary to encourage women to access FP. Furthermore, as men are often important decision-makers as to

whether a woman uses contraceptives or not, [5] outreach services provide an opportunity for women to quickly access a service without her absence being noticed. Finally, the service data from MSSL shows that uptake of contraceptives by adolescents also increases during outreach.

Table 16 shows clients reached by MSSL through outreach. MSSL service data includes ANC, PNC, FP counselling, and sexually transmitted infections testing.

Table 16: Clients reached by MSSL

District	No. Clients served by outreach (2019)
Bo	47,692
Bombali	28,088
Bonthe	54,619
Falaba	0
Kailahun	28,452
Kambia	40,522
Karene	0
Kenema	32,400
Koinadugu	46,469
Kono	36,379
Moyamba	36,276
Port Loko	27,873
Pujehun	51,144
Tonkolili	36,275
Western Area Rural	18,954
Western Area Urban	12,325
Total	497,468

1.3 Who has not been reached? A look at unmet need

Unmet need for FP (the percentage of women who want to postpone their next birth for two or more years or who want to stop childbearing altogether but are not using a contraceptive method, including women with mistimed or unwanted pregnancies and amenorrhoeic women whose last birth was mistimed or unwanted) [3] declined from 28% in 2008 to 25% in 2013 and has stagnated since [3]. The met need for FP increased from 8% to 21% between 2008 and 2019 and demand satisfied with modern methods also increased from 18% to 45% in the same period [3].

In 2013, 17% of currently married women aged 15–49 had an unmet need for spacing births while 8% had an unmet need for limiting births [1]. By 2019, this had barely changed with 17% having an unmet need for spacing and 7% for limiting births [3]. Adolescents aged 15–19 have the highest overall unmet need at 27.8% [3], a decrease from 30.7% in 2013 [1]. Unmet need for FP is highest in the Northwest and Western Area provinces (27% each) and lowest in the Eastern province (22%) [3].

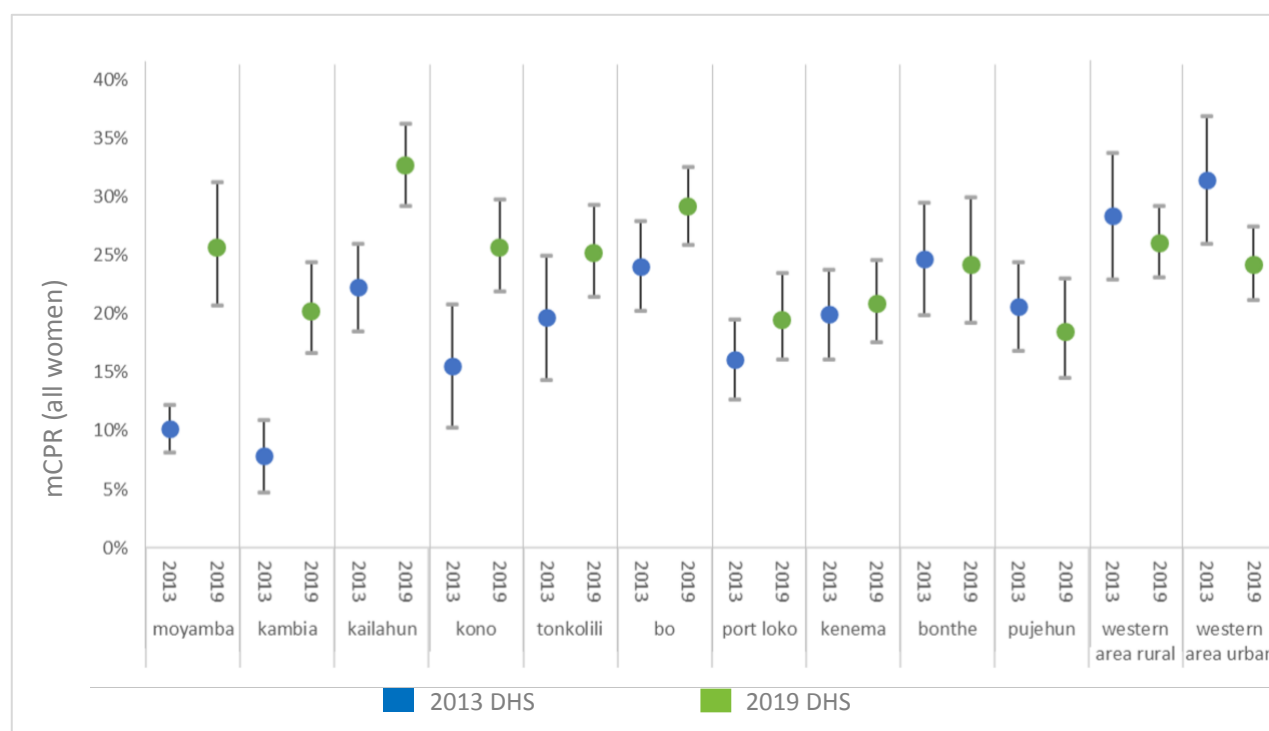
Unmet need, met need, and total demand for FP among currently married women are useful indicators to help evaluate the extent to which FP programs in Sierra Leone meet the demand for services. Twenty-five percent of currently married women have an unmet need for FP and 21% of married women are currently using a contraceptive method [3]. Therefore, 46% of currently married women have a demand for FP and, at present, only 46% of this demand for FP is being met [3].

1.4 Sub-national variations

On a sub-national level, there are huge mCPR variations. mCPR (all women) increased nationally from about 21% in 2013 [1] to about 24% in 2019 [3]. Women in urban areas are more likely to use a contraceptive method compared to women in rural areas (26% and 19%, respectively) [3].

Growth rates have varied between districts: Moyamba district showed the most growth between surveys, while two districts (Western Area Urban and Pujehun) declined slightly (Figure 12). Districts such as Kailahun started with a good baseline in 2013 and maintained the lead in mCPR in the country. Due to a change in administrative boundaries for four districts (Falaba, Bombali, Karene, and Koinadugu), the changes in mCPR were not comparable and therefore not included in the analysis. Additionally, it is worth noting that small changes in Figure 12 are not statistically significant, indicating that no meaningful change has occurred in mCPR in those districts.

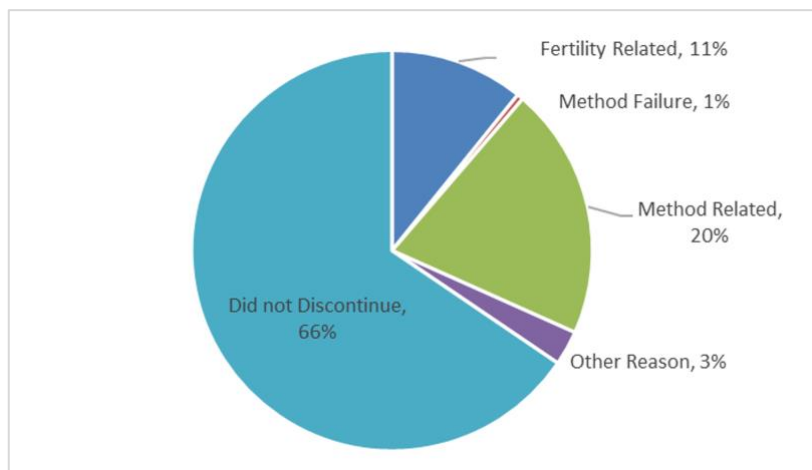
Figure 12: Change in mCPR by district (all women)



1.5 Discontinuation and non-use

More than one out of three women (35%) who began using FP discontinued within 12 months [3]. Shown in Figure 13, about 20% of all women using contraception discontinued for a method-related reason while 11% discontinued for fertility related reasons (e.g. wanted to become pregnant). Among method-related reasons, side effects and health reasons are the most commonly cited.

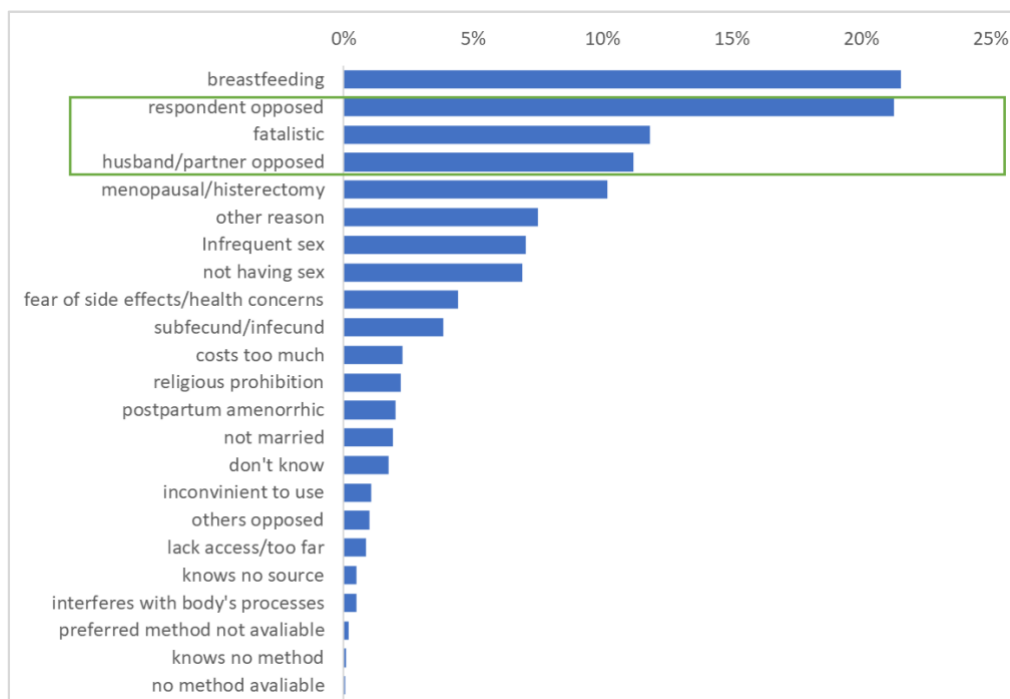
Figure 13: First-year contraceptive use discontinuation



The DHS asks women the reasons they are not using a method. This question is asked of non-pregnant non-users, who have had sex in the last 12 months and want no more children or want to wait two or more years to have a child. Women can give multiple responses so responses cannot be summed. The most commonly cited reason for non-use was that the woman was breastfeeding (22%). Of note, some of these women may actually be at risk of getting pregnant but not realize it. This should be explored further and could be integrated into messaging on PFP.

The next three most cited reasons were all related to norms and beliefs: respondent opposed (21%), fatalistic⁴ (12%), and husband/partner opposed (12%) (Figure 14). This suggests that, for a large share of women, significant demand-side barriers exist.

Figure 14: Reasons for non-use among select non-users

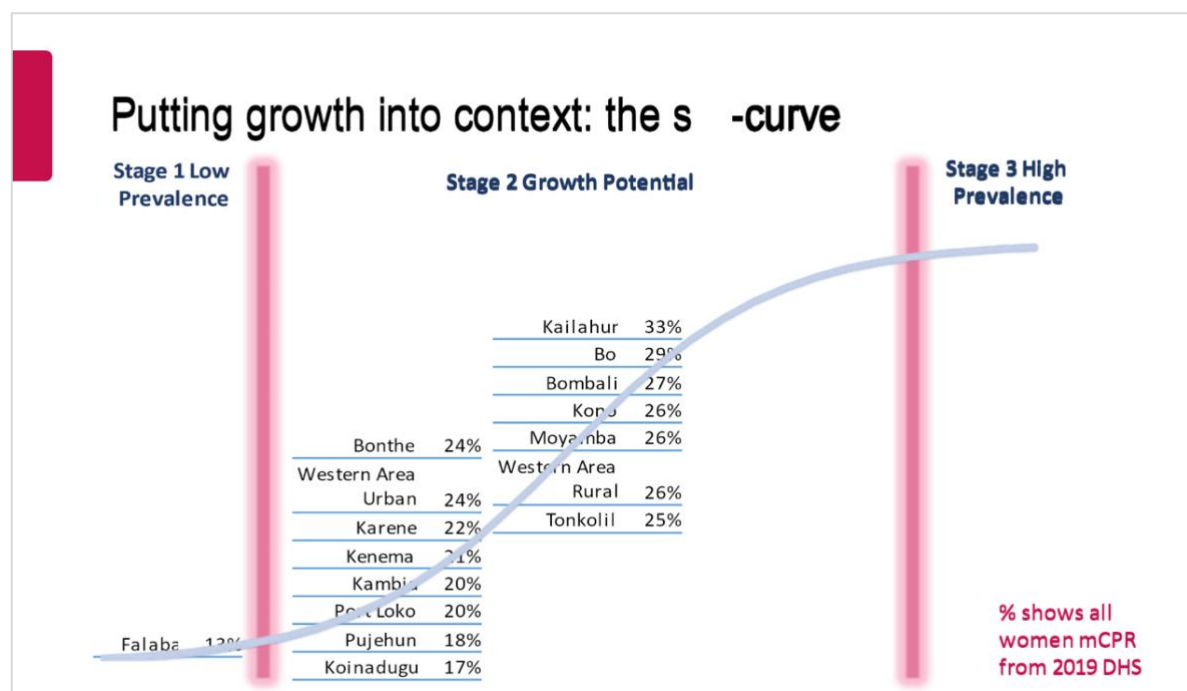


⁴ The DHS questionnaire asks about reasons for non-use, and included “up to god/fatalistic” as a possible response.

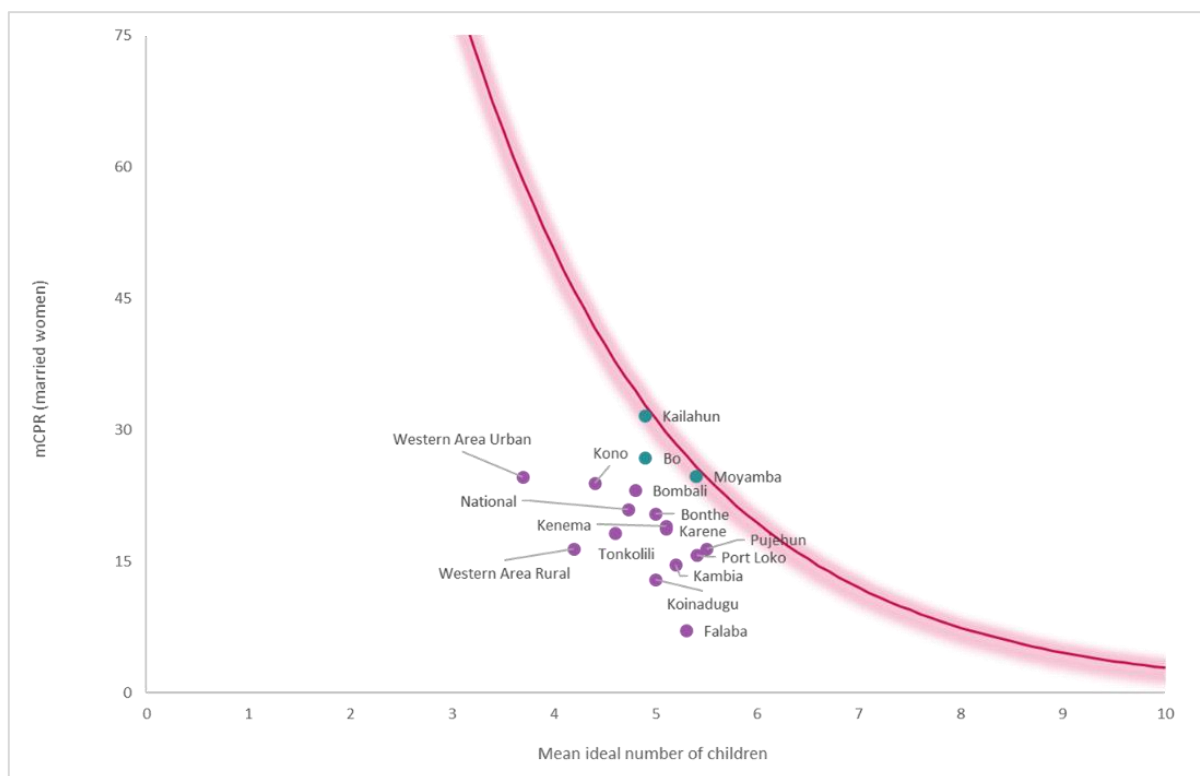
1.6 Growth and potential demand for contraception

Increases in contraceptive use generally follow an S-shape curve, with growth starting out slow when prevalence is low, accelerating during a period of growth potential, then levelling off at high levels of mCPR. Based on mCPR levels, most districts fall into stage two of the S-curve with the exception of the newly delineated district, Falaba, which is in stage 1 (Figure 15). This means there is a large potential for rapid growth in the country.

Figure 15: Putting growth into context



The maximum prevalence demand curve, based on global data, provides an indication of the likely maximum mCPR that could be reached given the current level of demand. The gap between where a country or region sits on the graph and the curve is the “potential use gap.” Figure 16 shows that most districts in Sierra Leone have a large to moderate potential use gap (indicated by the purple dots), where there is likely room for further mCPR growth from investments to improve and expand FP service delivery. Demand in these districts is less likely to be a constraint. However, there are three districts (Kailahun, Bo, and Moyamba - shown in the green dots) where the potential use gap is small, which could mean there is a need to prioritize interventions that address underlying social norms which influence demand or, at a minimum, to set realistic expectations about future growth given the limited demand.

Figure 16: Maximum prevalence curve per district

1.7 Hazards that could disrupt FP

The Ebola outbreak affected FP distribution in Sierra Leone. At the peak of the crisis, FP distribution decreased by 23% [6]. However, two years later, distribution levels were found to have increased by 27% above the pre-crisis level [6]. Another study that measured the number of FP consultations in one district (Pujehun) found that FP consultations decreased at the start of the outbreak but increased during the outbreak [7]. However, even with the increases, FP consultations did not reach pre-outbreak levels, which had been growing significantly. Furthermore, FP consultations decreased to levels even below those during the crisis after the outbreak. Quaglio et al. suggest this could be due to a range of factors, including a general decrease in the availability of health care staff, a reduction in international aid, or stockouts of FP methods. They also suggest that social factors arising from the experience of a disaster, such as the need to “rebuild” communities, may have contributed to the reduction in demand for modern contraceptive methods. However, it is worth noting the reduced uptake of FP consultations did not result in an increase in institutional deliveries [7].

To respond to the COVID-19 pandemic, Sierra Leone used what it had learned and added to structures built during the Ebola outbreak. While predictable challenges such as workforce shortages due to staff infections or reassignment to work in the response efforts, where health staff are often better compensated, were not entirely stemmed, the effect on FP utilization was minimal. Like the Ebola outbreak, utilization initially dropped at the start of the outbreak, but it quickly increased to levels matching pre-pandemic norms and higher (Figure 17).

Figure 17: FP clients in 2020 (total), Sierra Leone, by month, (DHIS2 data HF 3/PHU 3)



2.0 Enabling Policy Environment and Financing

2.1 General policy environment

Sierra Leone’s policy environment is generally conducive to and supportive of FP. A selection of policies that are relevant to FP are set out in Table 17.

Table 17: Sierra Leone’s FP policies

Policy level/ sector	Policy/strategy title and description	Summary of reference to FP/Sexual Reproductive Health
National	National Population Policy for Development, Progress and Welfare, 1993	<p>The goals of the policy include:</p> <ul style="list-style-type: none"> • Making development planning and policy more comprehensive and effective by incorporation of the demographic dimension. • Contributing to meeting the basic needs of the people and enhancing the quality and utilization of the nation's human resources. • Promoting the health and welfare of the people, especially those in the high-risk groups, mothers, and children. • Achieving a rate of population growth the economy can sustain. • Moderating the expected initial rise in the population growth rate and later progressively reduce the population growth rate through the spread of voluntary FP and norms of a small family to facilitate attainment of national economic and social targets. • Guiding rural-urban migrations to minimize socio-economic problems and optimise benefits to migrants and non-migrants alike, in both rural and urban areas.

Policy level/ sector	Policy/strategy title and description	Summary of reference to FP/Sexual Reproductive Health
National	Sierra Leone's Midterm National Development Plan (2019–2023): the country's five-year plan towards achieving middle-income status through sustainable inclusive growth that leaves no one behind	The plan recognizes the opportunity to benefit from Sierra Leone's demographic dividend by decreasing fertility through increased access to FP. It also identifies FP as a tool to reduce maternal mortality. Key policy actions include: <ul style="list-style-type: none"> • Increase the national health care budget allocation to 15% • Strengthen the National Program on Sexual and Reproductive Health for Adolescents in a bid to reduce teenage pregnancy through systems review and innovative SMART (specific, measurable, achievable, relevant, timely) mechanisms
National	National Strategy for the Reduction of Adolescent Pregnancy and Child Marriage, 2018–2022: The strategy details the commitments of multisector stakeholders across five government ministries to tackle the challenge of adolescent pregnancy and child marriage; the ministries are the Ministry of Health and Sanitation (MOHS), Ministry of Social Welfare, Gender and Children's Affairs (now split into two ministries), Ministry of Youth Affairs, Ministry of Basic and Senior Secondary Education (MBSSE), and the Ministry of Local Government and Rural Development.	The six pillars of the strategy all contribute to improving access to FP services for adolescents. <ul style="list-style-type: none"> • To improve the policy and legal environment for the protection of adolescents and to improve the capacity of implementing agencies to implement laws, policies, and protocols affecting adolescents. • To ensure that a minimum package of adolescent and young people friendly health care services is provided in PHUs including outreach services, hospitals, schools, and learning centres. • To ensure all adolescents have access to comprehensive sexuality education and the learning environment is enabling for adolescent girls and boys to thrive. • To engage with communities and empower them so they take individual and collective responsibility for the reduction of adolescent pregnancy and child marriage.
National	School Health Policy (not launched)	Endorsed by MOHS and Ministry of Basic and Secondary School Education, the policy aims to improve the health of school-age children in Sierra Leone so they can graduate and become productive adults.
Health	Free Health Care Initiative	This initiative was introduced to provide free health care to pregnant women, lactating mothers, and children under five. It also supports adolescent mothers and their children.
Health	National Health Sector Strategic Plan (2017–2021): a coherent, prioritized plan to drive coordination in the health sector	The strategy links to the CIP for FP and the Sustainable Development Goal target of 37.5% of married or in-union women of reproductive age having their need for FP satisfied with modern methods.

Policy level/ sector	Policy/strategy title and description	Summary of reference to FP/Sexual Reproductive Health
Health	Sierra Leone Basic Package of Essential Health Services (2015–2020) July 2015: the framework provides guidance for service delivery in all public health care facilities	<p>School and adolescent health services and prevention, response, and mitigation of teenage pregnancy are highlighted as key components of the package of services.</p> <ul style="list-style-type: none"> FP/reproductive health: Examples of services include antenatal and postnatal care, care during labour and delivery, and provision of FP commodities and services. <p>School and adolescent health: Examples of services include age-appropriate education/counselling on topics about SRH, counselling on HIV/sexually transmitted infection prevention, and prevention and response to teenage pregnancy.</p>
Health	Sierra Leone Reproductive, Maternal, Newborn, Child, and Adolescent Health Policy: provides a single national framework for reproductive, maternal newborn, child, and adolescent health programs	One of its four objectives aims to improve access to universal SRH services including FP, especially ensuring access for adolescents.
Health	Sierra Leone Reproductive, Maternal, Newborn, Child, and Adolescent Health Strategy (2017–2021): aims to address identified bottlenecks to access and utilization of high-impact interventions	<p>The strategy identifies FP as a critical intervention for preventing teenage pregnancies, averting unwanted pregnancies, and reducing unsafe abortions.</p> <p>The strategy had an mCPR target of 30% in 2021. The midterm review noted this was not achieved.</p>
Health	National Community Health Worker Policy ensures a standardized and well-coordinated CHW program at all levels	Sets out a clear role for CHWs in FP to: Identify pregnant women, children, and women of childbearing age who are eligible for RMNCAH-N interventions, including the uptake of FP methods, tetanus toxoid vaccination, and iCCM for sick children
Health	Sierra Leone National Strategic Plan on HIV and AIDS (2016 – 2020): aims to achieve zero new infections, AIDS-related death, and stigmatization.	<p>The strategy acknowledges low condom use among adolescents and young people as a barrier to its goals.</p> <p>It plans to promote consistent male and female condom use, recognizing the dual benefit of disease prevention and contraception. It aimed to increase condom use to 90% by 2020.</p>
Education	Education Act (2004): provided a reform of the education system.	The policy states that basic education is the right of every citizen and makes basic education compulsory, thereby providing safeguards against deprivation of basic education through, for example, early marriage or labour.

Policy level/ sector	Policy/strategy title and description	Summary of reference to FP/Sexual Reproductive Health
Education	The 2021 National Policy on Radical Inclusion in Schools: aims to remove all infrastructural and systemic policy and practice impediments that limit learning for any child.	The policy commits the Ministry of Basic and Secondary School Education to ensuring the curriculum includes the different components of comprehensive sexuality education and facilitates access to reproductive health services.
Social Welfare and Youth	The Child Welfare Policy (2014) aims to strengthen child welfare systems.	This supports the protection of all children, especially the most vulnerable and marginalized.
Social Welfare and Youth	Sierra Leone 2020 National Youth Policy aims to help youth feel empowered, especially female youth, to be key players in their own well-being and the socio-economic and political development of their communities.	The policy calls for the safeguarding of sexual and reproductive health rights.

Despite the availability of the policies listed above, a detailed policy assessment undertaken by FP stakeholders revealed several legal and policy gaps in the country that negatively impact FP program implementation. These are set out below.

INTEGRATION OF FP WITH OTHER SERVICES AND NATIONAL POLICIES

While there are policies and strategies that address FP, including the 2018–2022 CIP, the country does not have a national FP policy.⁵ Such a policy will be multi-sectoral and align strongly with key education, social welfare, youth, local government, and national finance policies and poverty reduction strategies. Furthermore, while the 2018–2022 CIP includes plans to increase the method mix and improve quality of the services and ensure equity of access, there is no plan that focuses on ensuring there are no missed opportunities, for example, integration with HIV services and post-abortion care.

PROVISION OF CONTRACEPTIVES TO THOSE AGED BELOW 18 YEARS

In March 2020, Sierra Leone lifted the ban on visibly pregnant girls attending school and taking public examinations after an Economic Community of West African States court ruled the ban illegal. Also, in 2021, the government developed the Radical Inclusion Policy that explicitly seeks to facilitate access to SRH services, including the provision of comprehensive sexuality education at school and in the community. These actions can positively impact the uptake of contraceptives for adolescents who need them. However, there is still a fair distance to travel. Communities and traditional/religious leaders will need to be brought onboard through significant advocacy and sensitization about the need to improve access for adolescents.

Of key importance is the need for multi-sectors to work to ensure the sexual and reproductive health needs and rights of adolescents and young people are met in school and within their communities. A positive start is the multisector strategy for reducing adolescent pregnancy and child marriage that includes five ministries (health, education, social welfare, youth, and local government).

⁵ A FP policy was being developed during the same period as the CIP.

A key document that has been developed but not yet launched (as of July 2023) is the School Health Policy, a joint effort between the MOHS and the Ministry of Basic and Secondary School Education. This document explicitly states that students will receive comprehensive sexuality education and life-skills training in school. Most importantly, going a step further than the Radical Inclusion Policy, it plans to provide contraceptive services and explicitly states that adolescent- and youth-friendly services can be provided in schools.

TASK-SHIFTING

The country updated its National Community Health Worker Policy in 2021. Within this policy, the role of CHWs is to identify pregnant women early and women who are eligible for reproductive, maternal, newborn, and child health interventions, including uptake of FP methods. However, in the policy, CHWs are limited in their scope of delivering FP methods and can only provide clients with condoms and refills of contraceptive pills. Evidence from several countries has shown that trained CHWs can safely provide pills (including the first dose) and injectable contraceptives [8–10]. CHWs can also potentially safely supply and deliver Syana Press for self-injection. With the limited paid healthcare workforce in the public and private sector, there needs to be consideration of task-shifting or task-sharing to allow CHWs to provide additional FP methods in the communities they reach which are underserved by the current health infrastructure.

Another debated workforce policy issue related to task-shifting is the restriction of maternal child health aides from being trained to insert IUDs. The argument is that, as the aides already perform invasive procedures, such as manual removal of placentas, they are suitable for training to perform this invasive FP method.

2.2 Financing FP provision

At the 2017 FP Summit, the GoSL made three key commitments, the first of which focused on diversifying the FP resource base through sustainable financing by 2020. The other two commitments focused on supply chain reforms and reducing unmet need for FP for adolescents. The second and third commitments are discussed in sections four and five, respectively.

FP commodities in Sierra Leone have mainly been funded by UNFPA, Foreign Commonwealth and Development Office, Care International, and the West African Health Organization [11]. The projected cost of FP commodities in 2022 is US\$2,249,365 and projected to rise to US\$3,132,780 by 2025. Detailed costs for the entire CIP from 2022 to 2027 are in section 7.

The GoSL signed the Abuja Declaration to increase expenditure in health to 15% of national expenditure. To date, neither allocations nor actual expenditure have reached the desired target. Furthermore, within the inadequate allocation, expenditure on FP accounts repeatedly are for less than 0.1%, despite the GoSL's pledge to commit 1% of health expenditure to FP.

2.3 Stewardship management and accountability

The National Health Sector Strategic Plan 2017–2021 has leadership and governance as the first of eight pillars of the plan. It recognizes the importance of appropriate legal and policy structures (discussed in 3.1. and 3.2); the MOHS structure, staffing and capacity; and sub-national management and decentralisation.

The 2018–2022 CIP acknowledged that strong monitoring, management, leadership, and accountability were necessary for the CIP goals to be achieved. The RHFPP is the unit within the MOHS responsible for the management and coordination of FP activities. The unit is part of the Reproductive and Child Health Directorate. Within this directorate, there are two other programs, the National School and Adolescent Sexual and Reproductive Health Programme and the Child Health and Expanded Program of Immunization.

The RHFPP has been leading the technical working group for FP, which brings together FP stakeholders including donors, relevant ministries such as education, NGO implementing partners, civil society, and faith-based organizations. The RHFPP has also been working with partners on issues of supply chain and resource mobilization.

Despite the allocation of less than 0.1% government budget published by GoSL, the RHFPP reports receiving zero operational support. Furthermore, while partners request more robust coordination by the MOH (as noted in section 4.5), the RHFPP team expresses similar frustration about lack of consultation from partners when they develop activities and the weak regulatory framework that allows partners to undertake activities without the involvement of the RHFPP. They also acknowledge limited staff capacity as a challenge. Within that, the RHFPP does acknowledge partners' input in advocacy for financing, technical guidance, and support, including data for monitoring and decision-making and the procurement of commodities.

3.0 Contraceptive Security and Service Delivery

3.1 Contraceptive security

The National Reproductive Health (RH) Quantification Working Group is responsible for assessing need, forecasting, and supply requirements of contraceptive commodities. The working group is headed by the National RH/FP Program Manager and the vice lead for the technical working group is a senior pharmacist at the Directorate of Pharmaceutical Services, while the program pharmacist of the National RH/FP Program is the secretary. The members include the National Medical Supplies Agency, DHMT representative–Western Area, referral hospital representative, secondary hospital representative, UNFPA, Clinton Health Access Initiative (CHAI), MSSSL, Planned Parenthood Sierra Leone (PPASL), and Care International.

The RH Quantification Working Group undertook a national needs assessment and forecasting of contraceptive supplies for 2022–2025. While limited to public health facilities, as public health facilities provide most FP services in Sierra Leone [3], the exercise produced a four-year forecast and a one-year supply plan. The projected cost of FP commodities is approximately US\$2.3 million in 2022, rising to US\$3.1 million in 2025. As shown in section 2.2, the GoSL provides less than 0.1% of the health budget to RHFPP and funding for commodities has been entirely met by GoSL partners/donors.

3.2 Service delivery

As the country's main healthcare provider, the MOHS is the main provider of FP services in Sierra Leone [3]. Service delivery in Sierra Leone is structured within a framework consisting of three care

levels: primary, secondary, and tertiary. At the primary care level, facilities are commonly referred to as peripheral health units (PHUs). There are three types of PHUs— maternal and child health posts (MCHP), community health posts (CHPs), and community health centres. Community outreach also occurs at this level. The secondary care level is comprised of district hospitals and the tertiary care level includes regional and national hospitals. Cost-effective and evidence-based services offered at these levels are specified in the Basic Package of Essential Health Services.

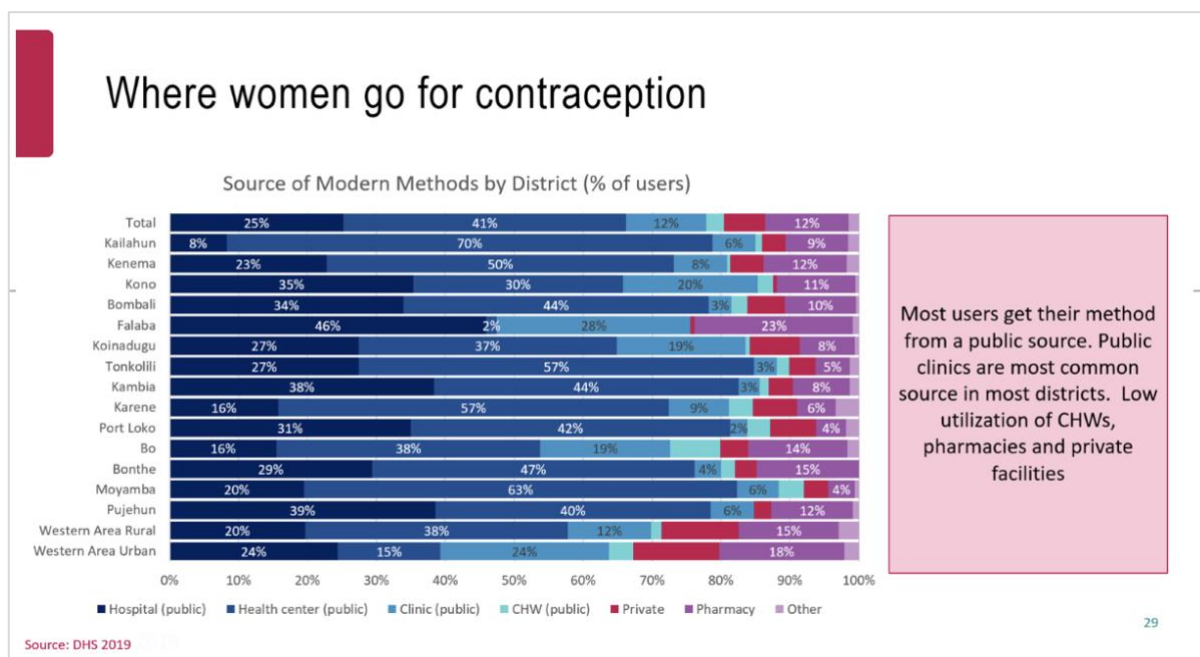
In 2019, 99% of primary facilities offered at least three modern contraceptive methods—up from 94% in 2017—while 97% of secondary facilities were doing so [12]. All SDPs in four of the five regions (Eastern, Northern, North-Western, and Southern) were providing at least three modern contraceptives in line with national protocols, guidelines, and/or laws while 95% of facilities in Western Area region reported so. In terms of urban-rural residence, all SDPs in rural locations and 97% SDPs in urban locations acknowledged providing at least three modern contraceptives in line with national protocols, guidelines, and/or laws. All government, NGO, and faith-based facilities and 86% of the privately managed SDPs were providing three or more modern contraceptives.

Nationally, four-fifths (80%) of the SDPs reported offering at least five modern contraceptive methods. This level of service delivery in 2019 is higher than results in previous years: 2018 (77%) and 2017 (70%). All tertiary SDPs, 77% of primary SDPs, and 87% of secondary SDPs reported providing at least five modern contraceptive methods in line with national protocols, guidelines, and/or laws [12].

Where facilities were not providing contraceptive methods in line with national protocols, guidelines, and/or laws, low or no demand was cited as the main reason. For example, 83% of SDPs reported low demand for female condoms, 77% for male sterilization, and 43% for IUDs. System delays to resupply contraceptives was mentioned as the main reason for not providing emergency contraception (48%) and male condoms (60%). More than 40% of the SDPs reported they were not providing implant services mainly because of lack of trained staff. Some SDPs not providing implants (40%) and IUDs (38%) cited non-availability of the commodity as the main reason while lack of equipment was least mentioned reason. Injectables were offered by all SDPs [12].

Figure 18 shows where women access the different types of modern contraceptive methods at a district level. Overall, 25% access FP services from hospitals, 53% from health centres and clinics, and the remaining 22% from CHWs and private facilities, including pharmacies.

Figure 18: Where women go for modern contraception



The main non-government service providers for FP are MSSL and PPASL. MSSL has nine static centres; in addition, both MSSL and PPASL provide FP services through outreach services. Among these approaches, outreach in particular has been favourably received, especially among youth. These outreach services take three main forms:

- Service provision in a specified place using an existing building, such as a school or community hall
- Mobile clinics with ambulances and a temporary canopy
- Service provision within existing government facilities, such as MCHPs, which do not usually provide the full range of FP methods

BEST PRACTICES AND CHALLENGES IN SERVICE DELIVERY

The MOHS and its implementing partners cite the availability of trained providers, equipment, and non-stockout of commodities as vital for effective service delivery. On the job training and mentoring have been particularly effective in building health worker capacity for effective service delivery. Addressing providers' personal biases in training is also crucial. In addition to lack of trained providers and stockouts, health workers' lack of willingness to implement what they have been trained to do, and poor record-keeping are other major challenges.

4.0 Local Norms That Affect FP Demand and Use

4.1 Contraceptive knowledge and gender norms

Knowledge of contraceptive methods is nearly universal in Sierra Leone, with 98% of currently married women and 99% of men knowing of at least one modern method. Among women, pills, injectables, and implants (96% each) are the most well-known contraceptive methods followed by male condoms (94%). Knowledge of male sterilization and the standard days method (29% and 31%, respectively) is relatively low. Among currently married men, the male condom is the most well-known contraceptive method (99%) followed by implants (94%).

Despite this knowledge, demand for modern contraceptives stands at only 46% [3]. Gender norms play a significant role in determining women's willingness to use modern contraceptives; for example, women in Sierra Leone who condemn wife beating or those who have the ability to refuse sex are more likely to use modern contraceptives [14]. This proven link between women's empowerment and modern contraceptive use underscores the reasoning behind the inclusion of women's empowerment in the SDG 3.7 and 5.6 and the objectives of the FP2030 initiative. In vital activities, such as the uptake of PFP, a study in Ghana (another west African country) found that personal conviction and partner approval were the main factors determining PFP uptake [15]. Personal conviction is often shaped by prevailing gender norms revealed through attitudes such as acceptance of wife beating and sexual and gender-based violence.

4.2 Contraceptive demand and education

Modern contraceptive use increases with educational attainment. It increases from 17% among women with no education to 25% among those with a primary education and peaks at 30% among those with a secondary education [3]. It decreases slightly to 29% among those with more than a secondary education [3]. Women in the highest wealth quintile are more likely to use contraception than those in the lowest quintile (26% versus 16%) [3].

4.3 Contraceptive demand and child marriage

Traditional family formation norms, including child marriage, are key barriers to women and girls' access to sexual reproductive health rights in Sierra Leone. Child marriage is a fundamental violation of human rights and it is also inextricably linked with adolescent pregnancy. Child marriage is typically higher in rural areas and among girls from the poorest households. It usually leads to girls dropping out of school, which erodes protective factors for use of modern FP methods.

The practice of child marriage is declining in Sierra Leone: 29.6% of women aged 20–24 years were married before their 18th birthday in 2019 [3] compared to 38.9% in 2013 [1]. Several education and health policies and initiatives (discussed in section 2), including those to address harmful traditional practices, may have contributed to this decline.

4.4 Contraceptive demand and religious beliefs

Almost one in ten women in Sierra Leone who decide not to use a modern contraceptive do so for religious reasons. A recent study commissioned by the Christian Health Association of Sierra Leone revealed that Christian religious leaders (whose views may influence their followers) are against the use of modern contraceptives and Muslim religious leaders, while not totally in favour, are more

open to FP use [16]. Religious leaders cited a range of reasons why they are against the use of modern contraceptive methods such as pills, injections, implants (locally known as Captain Band), or long-lasting intrauterine devices (“coil”). First, leaders feel they are artificial methods interfering with the natural processes that God has provided and modern contraceptives can have side effects. Secondly, they believe some of the providers are not well trained to provide the service [16].

However, despite their apprehensions about modern contraceptive methods, all religious leaders agree that birth spacing is vital for women’s health and the overall well-being of the family unit. They also recognize, with the economic situation in Sierra Leone, that having large families may be financially difficult to manage [16]. This appreciation by religious leaders about the value of birth spacing presents a point of mutual agreement between modern FP advocates and religious leaders.

4.5 Contraceptive demand and media exposure

Sierra Leonean women's exposure to FP messages through radio and television is positively associated with modern contraceptive use [17]. Adolescent girls are also known to trust health information from health workers, radio, and community sensitization delivered by health workers and NGOs [13]. Overall, women who listen to the radio/TV or are frequently exposed to any form of mass media are known to be more likely to adopt preventive measures that eventually translate into improved health outcomes [17].

In Sierra Leone, radio is the most often accessed form of media with 24% of women age 15–49, while 3% read a newspaper and 15% watch television. Only 1% of women have access to all three media sources while 70% of women have no access to any of the specified media. From the 2019 DHS, 13% of women had used the internet in the past 12 months [3]. Among those who have used the internet in the past 12 months, 61% of women report using it almost every day during the preceding month [3]. The high percentage of women who have no access to any specified media points to the need for outreach and community sensitization.

While culture, traditional beliefs, and access to FP messages play an important role, an overriding factor that promotes FP is the existence of an enabling policy environment that supports the work of FP providers and provides conditions for citizens to access their sexual and reproductive health rights.

4.6 demand CREATION, ADVOCACY, AND RESEARCH ACTIVITIES

The MOHS and its development partners have been undertaking a range of demand creation activities, including radio and television programs, community sensitization, and social marketing.

BEST PRACTICES AND CHALLENGES IN DEMAND CREATION

Implementing organizations identified radio as an effective medium to reach existing and potential users who have access to that medium. Similarly, they also recognized the use of CHWs, peer educators, and outreach as effective ways to reach those in remote, rural areas and those who may not have access to radio as only 24% of women aged 15–49 years have access to radio [3]. MSSL identified the use of the pedestrian public announcement system, known in villages in the south-east as *kpemamotui*, as an effective way to generate demand. They also found feedback to communities after research contributed to demand generation.

The GoSL implementing partners, however, also noted that funding gaps, duplication among partners, and insufficient coordination by the MOHS were challenges. More significantly, myths and misconceptions about FP were socio-cultural barriers to FP acceptance. Poor road networks made it difficult to reach some underserved areas. Sporadic outbreaks also affect partners’ ability to undertake demand creation activities. Finally, implementing partners were concerned about unavailability of stock to meet the demand they created.

5.0 Contraceptive Use and Access for Marginalized Groups

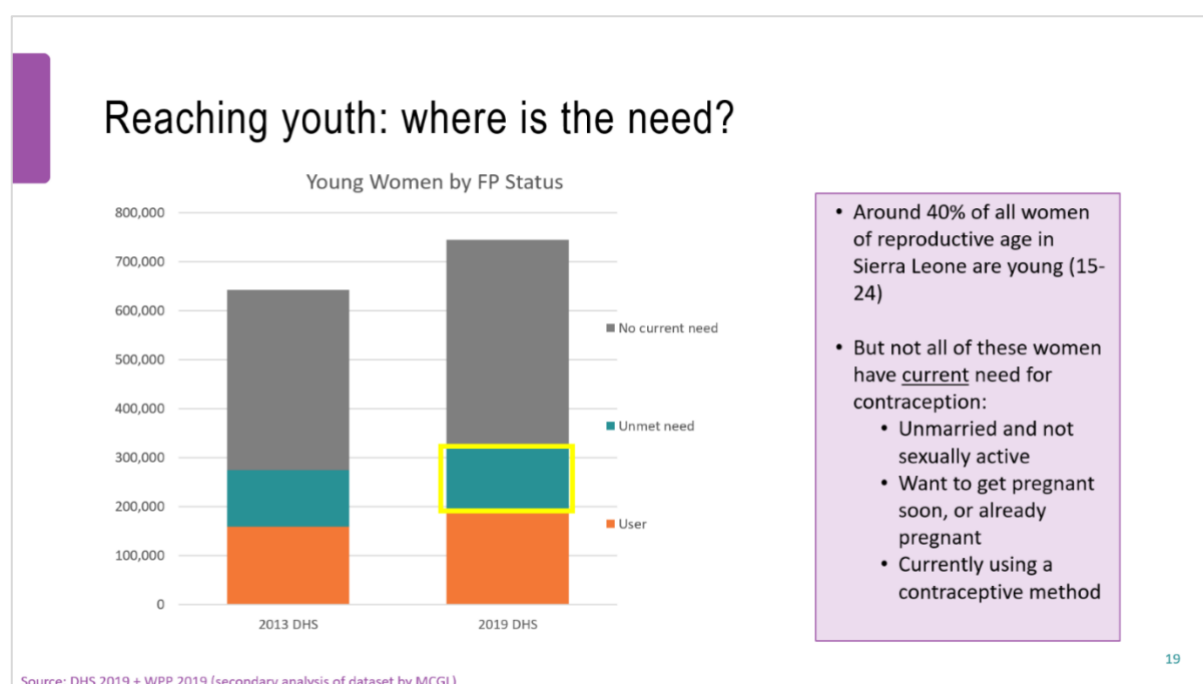
5.1 Adolescents and young people

The 2018–2022 CIP set as a priority adolescents and young people being able to act on their human rights, access FP services without facing discrimination, and not being turned away when unaccompanied by a parent or spouse [2]. Yet the midterm evaluation of the RMNCAH strategy found that barriers from community perception and health workers’ attitudes remain barriers to access for adolescents and young people [18]. Furthermore, as shown in section 3.1, policy challenges around the provision of comprehensive sexuality education and facilitation of access to contraceptives are affecting access for this sub-population.

Around 40% of all women of reproductive age in Sierra Leone are young women aged 15–24 years. However, not all of these women have a current need for contraception (see Figure 19). Those without a need include those who are:

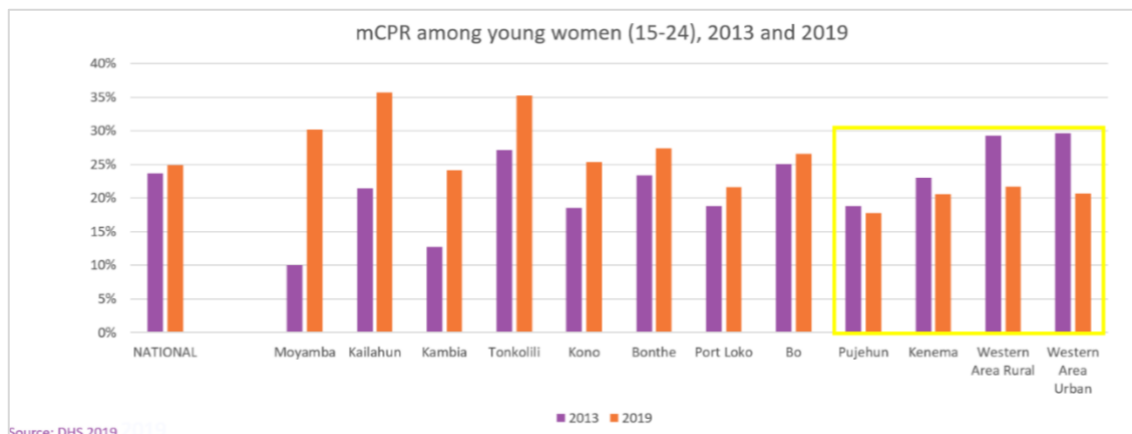
- Unmarried and not sexually active
- Want to get pregnant soon or are already pregnant
- Currently using a contraceptive method

Figure 19: Reaching adolescents and young people – where is the need?



There is a wide variation in mCPR for women 15–24 years old by district. Moyamba saw the largest growth between 2013 and 2019 [3] while four districts (Pujehun, Kenema, Western Rural, and Western Urban) saw a decline (see Figure 20).

Figure 20: Trend in mCPR among adolescents and young women aged (15–24 years)



Furthermore, unmet need varies significantly by status and district. Overall, unmarried sexually active women aged 20–24 years have the highest need with a significant proportion of these women living in the Western Area.

5.2 People with disabilities

The exact population of people with disabilities in Sierra Leone is unknown but, according to the 2015 Population and Housing Census, 1.2% of the population or 93,129 are persons with disabilities are women and girls. The Convention on the Rights of the Persons with Disabilities, whose purpose “is to promote, protect, and ensure the full and equal enjoyment of all human rights and fundamental freedoms of all persons with disabilities, and to promote respect for their inherent dignity”, was ratified by Sierra Leone in 2010. In 2011, Sierra Leone domesticated the convention and passed the People with Disabilities Act, resulting in the establishment of the National Commission for Persons with Disability in 2012 to ensure the act was put into practice. However, in spite of these huge strides in the legislative sphere, implementation of the act remains a challenge. Section 17 (1) of the Persons with Disability Act 2011 provides for free medical services for persons with disabilities, but free services are still not yet available for them.

A study conducted by Leonard Cheshire for MSSL found that MSSL has been proactively working to improve service delivery to women with disabilities. However, many challenges remain, including the attitude of health workers who sometimes assume they are beggars. Persons with disabilities usually also need to “tip” health workers to provide services for them because their needs are more complex, paradoxically making access more difficult for those with the most need. They also experience challenges with physical access and the need to travel long distances. MSSL has worked to meet this need by providing outreach services, but the setup of the outreach does not always ensure confidentiality.