Sierra Leone Family Planning Costed Implementation Plan

2018-2022

Sierra Leone Ministry of Health and Sanitation

Funding and technical support provided by the Health Policy Plus project, funded by the U.S. Agency for International Development. The information provided in this document is not official U.S. Government information and does not necessarily represent the views or positions of the U.S. Agency for International Development.

Suggested citation: Government of Sierra Leone. 2017. *Sierra Leone Family Planning Costed Implementation Plan*. Freetown: Ministry of Health and Sanitation.

ACKNOWLEDGMENTS

The Government of Sierra Leone would like to express its sincere appreciation to the many partners and stakeholders who provided input and guidance throughout the development of the Family Planning Costed Implementation Plan, starting with the Reproductive Health and Family Planning Programme Division of the Ministry of Health and Sanitation for its leadership in developing the Plan, with support from additional sectoral ministries:

- Ministry of Education, Science and Technology
- Ministry of Finance and Economic Development
- Ministry of Social Welfare Gender and Children's Affairs
- Ministry of Health and Sanitation – National Aids Control Programme
- Ministry of Health and Sanitation – Central Medical Stores
- Ministry of Health and Sanitation – Department of Policy Planning and Implementation
- Ministry of Health and Sanitation – Expanded Programme of Immunisation
- Ministry of Health and Sanitation – Health Education Department
- Ministry of Health and Sanitation – National Aids Control Programme
- Ministry of Health and Sanitation – Nutrition Department
- Ministry of Health and Sanitation – Reproductive Health and Family Planning Department
- Ministry of Youth Affairs

This publication is made possible through the funding and technical support from the U.S. Agency for International Development through the Health Policy Plus (HP+) project.

In addition to the above, numerous development partners, implementing partners, professional associations, and for-profit organizations also provided valuable inputs and feedback throughout the process via in-person meetings, through the Reproductive Health Commodity Security Working Group and the Costed Implementation Plan Strategic Advisory Groups, and ongoing electronic communications. These organizations include:

- Annie Walsh Memorial School
- Avenir Health
- Clinton Health Access Initiative
- Conservation Alliance
- CORDAID
- Forum of Sierra Leonean Youth Network
- FOSYLN Youth
- Girl Child Network, Sierra Leone
- Girl Up Vine Club, Sierra Leone
- Hellen Keller International
- IPAS
- John Snow, Inc.
- Johns Hopkins Center for Communications Programs
- Marie Stopes, Sierra Leone
- National Aids Secretariat
- National Commission for Children
- National Secretariat for the Reduction of Teenage Pregnancy
- National Social Security Insurance Trust
- Peagie Woobay Scholarship Fund
- Lifeline
- Planned Parenthood Association of Sierra Leone
- President's Recovery Priorities
- Princess Christian Maternity Hospital
- Restless Development
- Save the Children
- Track20
- United Nations Population Fund
- U.S. Agency for International Development
- Women's Forum
- World Health Organization
- Members of the Reproductive Health Commodity Security Working Group

FOREWARD

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. It is a key strategy in the *Agenda for Prosperity: Road to Middle Income Status: Sierra Leone's Third Generation Poverty Reduction Strategy Paper (2013–2018)*. The rate of population growth has been decreasing, but we recognize that we need to do more to ensure that every baby born is wanted and that the state and the family have the resources to care for that precious life. Therefore, at the global level, Sierra Leone made public commitments to improve the uptake of family planning during the London Family Planning Summit 2012 as part of the FP 2020 initiative.

In 2013, our President himself, His Excellency Ernest Bai Koroma, launched the *National Strategy for the Reduction of Teenage Pregnancy* (GOSL, 2013) in response to the high rate of pregnancies among adolescents; family planning is a key component of that strategy. Although the Ebola outbreak in 2014 reversed some gains we had made in sexual and reproductive health, we have continued to place emphasis on this area as one of our post-Ebola priorities.

From the Ebola outbreak, we learnt that by working collaboratively and engaging stakeholders at all levels even the toughest battles can be won. Sierra Leone can make family planning 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*.

_____

Honourable Dr Abu Bakarr Fofanah
Minister of Health and Sanitation
Freetown
30 June 2015

REMARKS

The Ministry of Health and Sanitation is proud to have completed the country's first costed implementation plan (CIP) for family planning. The process has been highly consultative and rigorous, and has built on our current approach of focusing on evidence-based interventions. We ensured that the timing of this strategy was in sync with the larger umbrella strategy of the *Reproductive Maternal Newborn Child and Adolescent Health (RMNCAH) Strategy, 2017–2021*, as well as other linked strategies such as the *Adolescent Pregnancy Reduction Strategy, 2017–2021*, the follow-on to the *National Teenage Pregnancy Reduction Strategy, 2013–2015*.

Over the past five years, with support from our partners, we have made progress in training health workers to provide high-quality family planning services. The firm foundation built through this extensive training gives us the confidence that the CIP operational objective to "increase the modern contraceptive prevalence rate (mCPR) amongst all women of reproductive age from 23 per cent in 2017 to 33.7 per cent by 2022" 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 2022 target of a modern contraceptive prevalence rate (mCPR) of 33.7 percent among women of reproductive age.

_____

Dr Brima Kargbo
Chief Medical Officer
Ministry of Health and Sanitation

CONTENTS

LIST OF FIGURES

LIST OF TABLES

ABBREVIATIONS

AFP SMART	Advance Family Planning SMART Approach
AIDS	acquired immune deficiency syndrome
ANC	antenatal care
AYFHS	adolescent- and youth-friendly health services
BPEHS	Basic Package of Essential Health Services
CAIPA	Crown Agents and IPA
CHP	community health post
CHW	community health worker
CIP	costed implementation plan
CMS	Central Medical Stores
CPR	contraceptive prevalence rate
CS	contraceptive security
CYP	couple years of protection
DC	demand creation
DFN	Directorate of Food and Nutrition
DHMT	District Health Management Team
DHS	Demographic and Health Survey
DSA	Daily Subsistence Allowance
EC	emergency contraception
EPI	Expanded Programme on Immunizations
F	financing
FBO	faith-based organization
FP	family planning
GOSL	Government of Sierra Leone
HED	Health Education Division
HF3	Facility Summary Form for Reproductive Health Services
HIV	human immunodeficiency virus
HMIS	health management information system
HP+	Health Policy Plus Project
HSRP	Health Sector Recovery Plan
ICPD	International Conference on Population and Development
IEC	information, education, and communication
IP	implementing partner
IUD	intrauterine device
LARC	long-acting reversible contraception
LAPM	long-acting and permanent method
MCHP	maternal child health post
mCPR	modern contraceptive prevalence rate
MDGs	Millennium Development Goals
MEST	Ministry of Education, Science, and Technology
MMR	maternal mortality ratio
MOFED	Ministry of Finance and Economic Development

MOHS	Ministry of Health and Sanitation
MSSU	Marie Stopes Sierra Leone
NACP	National AIDS Control Programme
NHSSP	National Health Sector Strategic Plan
NPPU	National Pharmaceutical Procurement Unit
PEE	policy and enabling environment
PHC	primary health care
PHU	peripheral health unit
PoA	Programme of Action
PPASL	Planned Parenthood Sierra Leone
QI/QA	quality improvement/quality assurance
RHCS	reproductive health commodity security
RHCSWG	Reproductive Health Commodity Security Working Group
RHD	Regional Health Directorate
RHFPP	Reproductive Health and Family Planning Programme
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
RNCH	Reproductive, Newborn, and Child Health
RRIV	report, review, and issue voucher
SAG	strategic advisory group
SBCC	social and behavior change communication
SD	service delivery
SDG	Sustainable Development Goals
SDM	standard days method
SECHN	tate enrolled community health nurse
SLDHS	Sierra Leone Demographic and Health Survey
SLFPCIP	Sierra Leone Family Planning Costed Implementation Plan
SLL	Sierra Leone leone
SMA	stewardship, management, and accountability
SRH	sexual and reproductive health
SRHR	sexual and reproductive health rights
STM	short term method
TFR	total fertility rate
TST	technical support team
USAID	U.S. Agency for International Development

PROCESS AND FORMULATION OF THE SLFPCIP

Sierra Leone began the process of developing the *Sierra Leone Family Planning Costed Implementation Plan (2018–2022)* (SLFPCIP) in November 2016, with technical support provided by the Health Policy Plus Project (HP+) funded by the U.S. Agency for International Development (USAID). A technical support team (TST) was assembled to provide expertise and guidance throughout the process, under the leadership of Ministry of Health and Sanitation (MOHS) Reproductive Health and Family Planning Programme (RHFPP). Led by the RHFPP program manager, the TST worked from November 2016 to July 2017 to conduct a comprehensive situational analysis, including a desk review and consultations; identify strategic priorities; solicit strong stakeholder input (through group consultations, in-person meetings, and electronic communications); develop and refine activities; and estimate costs. The team was guided throughout the process by the Reproductive Health Commodity Security Working Group, a group of experts drawn from the government, development partners, and implementing partners.

The TST, in collaboration with partners and under the guidance of the Reproductive Health Commodity Security Working Group, developed the technical strategy through an inclusive, country-driven process that included a situational analysis, goal setting, results formulation, and activity planning. The SLFPCIP technical strategy was built on a comprehensive understanding of the family planning (FP) issues, gaps, and opportunities at the service delivery (SD), program, and policy levels in Sierra Leone, and it follows the fundamental elements of sound FP program design.

In November 2016, the TST began by conducting a situation analysis to gather information and data—comprising a desk review, secondary analysis of statistical data, and stakeholder consultations—to gather information. In addition to holding multiple formal meetings with the Reproductive Health Commodity Security Working Group (RHCSWG) and four strategic advisory groups (SAGs) addressing service delivery, demand creation, contraceptive security, and youth, respectively, the team conducted consultations and key informant interviews with more than 20 partners, donors, and other government sectoral ministries and bodies to ensure that they assessed the perspectives of various stakeholders. The team took into account their inputs on current ongoing activities and potential activities to address barriers at the national, regional, district, and community levels.

The situational analysis was also used to inform an application of the FP Goals Model, supported and funded by Avenir Health's Track20 project. The FP Goals Model used demographic data, information from the situational analysis about existing FP programs and activities, and additional information collected during the application process to establish a baseline for the country. Then, based on discussions with MOHS stakeholders, priority interventions were identified, and two levels of scale-up—steady and significant—were defined for each intervention. During a workshop in March 2017, the MOHS and FP stakeholders reviewed the two scenarios generated by the FP Goals model and identified strategies that would have the highest impact on increasing demand for and use of high-quality FP services by Sierra Leoneans. This discussion led to the development of a final model scenario, which then drove the strategic priorities of the SLFPCIP.

The technical strategy was informed by the country goal of increasing the modern contraceptive prevalence rate (mCPR). The mCPR targets for married and unmarried women were further refined as part of the application of the FP Goals Model. The model showed that if adequate resources are provided to support the SLFPCIP strategic priorities, the country can expect to achieve an increase in mCPR to 33 percent by 2022. However, the strategic priorities cannot be accomplished in a vacuum—the technical strategy of the SLFPCIP addresses all of the key issues

that were identified during the situational analysis and provides a roadmap for the specific activities, their timelines, and required inputs to fully meet the national vision to accelerate the reduction of preventable maternal, child, and adolescent deaths (Sierra Leone Government, MOHS, 2011). The plan and activity matrix was presented in various forms to expert groups throughout the process, including the RHCSWG and the four SAGS. The plan was refined based on their feedback and input at these meetings and via electronic communications. A list of key issues and associated causal factors was developed from the detailed situational analysis and stakeholder consultation work. The TST then conducted a root-cause analysis of the issue list to identify the context and interrelationship of problems, develop a comprehensive list of interconnected causal factors for each key issue, and identify discrete issues that could be addressed by various interventions. This information was then organized, classified, and entered into a results matrix as issues. The strategic priorities reflect the highest impact interventions that were identified and agreed to by stakeholders during the FP Goals Workshop, and proposed again to stakeholders for vetting, refinement, and approval.

The team next converted issues into results (strategic outcomes), drafted an implementation framework detailing the strategic results; activities; sub-activities; outputs, including targets; and timeline. This framework was then circulated to stakeholders (including the RHSCW) for additional feedback and edits. The matrix was further detailed and refined through stakeholder meetings. At these meetings, participants assigned prioritization rankings for the impact and feasibility of the success of various interventions in the local context. In addition, stakeholders provided additional feedback on various iterations of the framework through one-on-one and small-group consultations and electronic communications.

In addition, the team identified and considered global best and high-impact practices, analyzed them for applicability in Sierra Leone, and included relevant intervention activities in the SLFPCIP for consideration (including activities for piloting and evaluation before larger scale-up), as appropriate to the country context and according to stakeholders' expert opinions. The costing was developed based on international best practices and customized to the Sierra Leone context to include local costs (refer to Costing Assumptions section for further information and details). Finally, the GOSL (GOSL) circulated the draft version of the complete SLFPCIP to its partners and stakeholders before the plan was finalized and approved.

During implementation, further refinement of the technical strategy will become necessary as information is generated from performance monitoring of the SLFPCIP. After the mid-term review, but before the final evaluation is completed, the process for developing a new SLFPCIP for 2023–2028 should commence. This process for developing a revised plan should be informed by the mid-term review and by preliminary results from the final evaluation.

LANDSCAPE ASSESSMENT

Background

The *Sierra Leone Family Planning Costed Implementation Plan (2018–2022)* (SLFPCIP) details the country's plans to achieve its vision and goal to improve the health and well-being of its population and the nation by supporting each person's right to choose whether and when to have children, and how many children to have. This document serves as the blueprint for Sierra Leone to follow in order to achieve the following consensus-developed outcome:1

- To increase the mCPR among currently married women from 15.6 percent in 2013 (16.6% for all methods) (Statistics Sierra Leone [SSL] and ICF International, 2014) to 33 percent by 2022 (34.3% all methods contraceptive prevalence rate [CPR] in 2022)
- To increase the mCPR among all women from 20.9 percent in 2013 (22.1% for all methods) (SSL and ICF International, 2014) to 33.7 percent by 2022 (34.3% for all methods CPR)

Sierra Leone's commitments to FP and the costed implementation plan (CIP) align with the most recent medium-term development policy framework: *The Agenda for Prosperity: Road to Middle Income Status: Sierra Leone's Third Generation Poverty Reduction Strategy Paper (2013–2018)*. Thus, the SLFPCIP contributes to Sierra Leone's developmental vision of vision being of a middle-income country in 25 years, as it aligns with the deliberate and decisive actions that need to be taken to achieve a robust and consistent level of high economic growth (through investing in FP as a component necessary to achieve a demographic dividend), and to contribute to sustained improvements in human development indicators in health and women's empowerment (GOSL, n.d.c).

At the global level, the July 2012 London Summit on Family Planning renewed enthusiasm and commitment to FP and led to many countries developing CIPs with the aim of accelerating progress towards their FP goals. The SLFPCIP was developed to facilitate fulfillment of Sierra Leone's FP2020 pledges (Figure 1) and aligns with key FP, population, health, and other sectoral policies and strategies in Sierra Leone, including *The Agenda for Prosperity: Road to Middle Income Status: Sierra Leone's Third Generation Poverty Reduction Strategy Paper (2013–2018)*; *National Health Policy, (2002)*; *Health Sector Recovery Plan (HSRP), 2015–2020*; *Sierra Leone Basic Package of Essential Health Services (BPEHS), 2015–2020*; *National Human Resources for Health Strategic Plan, 2017–2021*; *National Community Health Worker Policy, 2016–2020*; *National Strategy for the Reduction of Teenage Pregnancy, 2013–2015*; and the *National Strategic Plan on HIV/AIDS, 2016–2020*. These policies and strategies, among others, are detailed further in Table 5: Government of Sierra Leone policies and strategies.

In addition, access to FP and contraception is a fundamental dimension of sexual and reproductive health and reproductive rights, as clearly stated in the United Nations International Conference on Population and Development (ICPD) Programme of Action (PoA) held in Cairo, Egypt in 1994. ICPD's consensus framework directly targeted a goal of comprehensive sexual and reproductive health and rights (SRHR) based on a human rights framework and inclusive of FP, maternal health, prevention of STIs, and adolescent reproductive health (UNFPA, 1995).

Sierra Leone has upheld the importance of protecting the population's sexual and reproductive health and reproductive rights through the development and implementation of its policies. The

[1] These targets were set through a process called FP Goals in January through March 2017. Track 20 FP Goals: http://www.track20.org/download/pdf/FP%20Goals%20Overview%20for%20Website%20(2016.5.19).pdf.

1993 Population Policy articulates the rights of all people, "Population policy should be humane and responsible, fully respecting individual freedoms and rights as well as religious beliefs and cultural values. The national policy should recognize that all couples and individuals have the basic right to decide freely and responsibly on the number and the spacing of their children and to have information, education and the means to do so" (National Population Policy for Development, Progress and Welfare, 1993). *The Agenda for Prosperity: Road to Middle Income Status: Sierra Leone's Third Generation Poverty Reduction Strategy Paper (2013–2018)* emphasizes the promotion and protection of human rights through two of its pillars: accelerating human development and governance and public sector reform (GOSL, n.d.c). Collectively, these pillars aim to reduce high infant, under-five, and maternal mortality; improve adolescent reproductive health and rights; promote equality; and provide legal protection and an overall environment supportive of rights. The *National Strategy for the Reduction of Teenage Pregnancy* also strives to ensure policy and legal protection for the rights of adolescents and young people (GOSL, 2013). The *Reproductive, Newborn, and Child Health (RNCH) Strategy, 2011–2015,* and the *Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) Strategy*, *2017–2021* both have guiding principles that aim for the strategy to be gender responsive and respectful of human rights, and to ensure equal rights and access to sexual and reproductive health services (Sierra Leone Government, MOHS, 2011). For example, the RNCH Strategy states, "All women, men, adolescents, newborns, and children will have access to health services without discrimination based on ethnicity, gender, disability, religion, political belief, economic or social condition, or geographic location. Special attention will be given to the needs of underserved and vulnerable groups. The rights of health care users shall be respected and protected and gender issues shall be mainstreamed in the planning and implementation of all health programmes" (Sierra Leone Government, MOHS, 2011). Furthermore, the RMNCAH Strategy supports this by stating, "Gender has an impact in access to and utilization of RMNCAH services. Access to quality RMNCAH services is a right. This strategy identifies and addresses gender related barriers to access and utilization of services" (Sierra Leone Government, MOHS, 2017).

However, despite a significant number of national policy instruments supportive of sexual and reproductive health services and rights, as described in *Table 5: Government of Sierra Leone policies and strategies*, many people in Sierra Leone, particularly girls and women, are unable to realize their sexual and reproductive rights and access these critical reproductive health services due to a number of hindering factors, including, but not limited to, poverty, early and polygamous marriage, low levels of education and literacy, and community and sociocultural norms promoting early childbearing and large family size. These factors affect the lives of women and girls who are thus unable to realize their rights to education, health, and work due to the lack of services, information, and a supportive environment that could enable them to delay motherhood to the time of their choosing and plan their family size.

Operating under this context, the SLFPCIP was designed to align with the 10 components of the FP2020's *Rights and Empowerment Principles for Family Planning*: agency and autonomy; availability; accessibility; acceptability; quality; empowerment; equity and nondiscrimination; informed choice; transparency and accountability; and voice and participation (FP2020, 2014). These rights fall into three broad categories: the right to reproductive self-determination; the right to SRH services, information and education; and the right to equity and nondiscrimination, all of which are underpinned by accountability and participation in the FP program. A full definition of each right is available in Annex C. The SLFPCIP is further guided by the principles of the *Reproductive Maternal, Newborn, Child and Adolescent Health (RMNCAH) Strategy, 2017–2021* that emphasizes selection of evidence-based interventions and gender-responsive, rights-based, and equity-focused approaches.

Rationale for and Use of the SLFPCIP

The SLFPCIP is the guide for all FP programming for the government across all sectors, development partners, and implementing partners. The SLFPCIP details the necessary program activities and costs associated with achieving national goals, providing clear program-level information on the resources the country must raise domestically and from partners. The plan gives critical direction to Sierra Leone's FP program, ensuring that all components of a successful program are addressed and budgeted for by government, donors, implementing partners, and all actors.

More specifically, the SLFPCIP will be used to do the following:

- **Ensure that one unified country strategy for FP is followed by government, development partners, and implementing partners:** The SLFPCIP articulates Sierra Leone's consensus-driven priorities for FP. The SLFPCIP has been developed through a consultative process—and thus, it becomes a social contract for donors and implementing partners. The plan will help ensure that all FP activities are aligned with the country's needs, prevent fragmentation of efforts, and guide current and new partners in their FP investments and program. All stakeholders must align their FP programming to the strategy detailed in this document. In addition, the MOHS must hold development and implementing partners accountable for their planned activities and realign funding to the country's needs identified as priorities. At the same time, the SLFPCIP details commitments, targets, actions, and indicators to make the MOHS ultimately accountable for their achievement. All other sectoral ministries should work in tandem with the MOHS to implement the SLFPCIP and coordinate efforts.
- **Define key activities and an implementation roadmap:** The SLFPCIP includes all necessary activities, with defined targets appropriately sequenced to deliver the outcomes needed to reach the country's FP goals by 2022.
- **Determine impact:** The SLFPCIP includes estimates of the demographic, health, and economic impacts of the FP program, providing clear evidence for advocates to use to mobilize resources.
- **Define a national budget:** The SLFPCIP determines detailed commodity costs and program activity costs associated with the entire FP program. It provides concrete activity and budget information to inform the MOHS budget requests for FP programs aligned with national goals between 2018 and 2022. It also provides guidance to the MOHS and partners to prioritize the funding and implementation of strategic priorities.
- **Mobilize resources:** The SLFPCIP should also be used by the GOSL and partners to mobilize needed resources. The plan details the activities and budget required to implement a comprehensive FP program; as such, the MOHS and partners can systematically track the currently available resources against those required as stipulated in the SLFPCIP, and conduct advocacy to mobilize funds from development partners to support any remaining funding gaps.
- **Monitor progress:** The SLFPCIP's performance management mechanisms measure the extent of activity implementation and help determine that the country's FP program is meeting its objectives, ensuring coordination, and guiding any necessary course corrections.
- **Provide a framework for inclusive participation:** The SLFPCIP and its monitoring system provide a starting point to address and improve the participation of stakeholders within and outside of government; in addition, where appropriate and feasible, activities strive for inclusiveness of relevant groups and representatives from key populations in the implementation and monitoring of the plan (Health Policy Project, 2015).

Global Context

FP is one of the most cost-effective interventions to prevent maternal, infant, and child deaths (Copenhagen Consensus Center, 2014). Through a reduction in the number of unintended pregnancies in a country, it is estimated that one-quarter to one-third of all maternal deaths could be prevented. FP is a contributor to positive health outcomes. For example, FP interventions contribute to reducing poverty, increasing gender equity, preventing the spread of HIV, reducing unwanted teenage pregnancies, and lowering infant deaths (Singh et al., 2013). Additionally, each dollar spent on FP initiatives on average results in a savings of US$6 on health, housing, water, and other public services (PMA2020, n.d.). Universal access to SRH services by 2030 and the elimination of unmet need for modern contraception by 2040 have been calculated to have annual costs of US$3.6 billion and annual benefits of US$432 billion, thus resulting in US$120 of benefits for every dollar spent (Kohler and Behrman, 2014).

Lack of access by adolescent girls to FP, including contraceptive information, education, and services, is a major factor contributing to unwanted teenage pregnancy and maternal death. In low- and middle-income countries, complications of pregnancy and childbirth are the leading causes of death among adolescent girls ages 15–19 (World Health Organization [WHO], 2011).

As of July 2016, there are an estimated 894 million women of reproductive age in the 69 FP2020 countries. Of these, more than 300 million are using a modern method of contraception, which amounts to 30.2 million additional women and girls who are using modern contraception since 2012. This is a significant increase from 2003, when the number of contraceptive users in these countries stood at 200 million. Across these 69 FP2020 countries, the mCPR of all women averaged 33.5 percent in 2016, compared to 32.4 percent in 2012 (weighted averages). And in 2016, 22 percent of married or in-union women of reproductive age across the FP2020 focus countries had an unmet need for modern methods of contraception, meaning that they desired to space or limit pregnancies but are not using modern contraception (FP2020, n.d.a).

FP2020 is the initiative responsible for coordinating the global leaders and stakeholders who committed to support, expand, and fund voluntary, rights-based FP at the 2012 London Summit on Family Planning. At the summit, leaders from around the world agreed on the goal to "mobilise global policy, financing, commodity and service delivery commitments to support the rights of an additional 120 million women and girls in the world's poorest countries to use contraceptive information, services and supplies, without coercion or discrimination, by 2020" ("London Summit…," n.d.). Achieving this ambitious target would prevent a staggering 100 million unintended pregnancies, 50 million abortions, 200,000 childbirth-related and maternal deaths, and 3 million infant deaths (Family Planning Summit Metrics Group, 2012).

The GOSL made several significant commitments to FP at the 2012 London Summit (see Figure 1: Sierra Leone Country Commitments to FP2020 (FP2020, n.d.b)).

Figure 1: Sierra Leone Country Commitments to FP2020 (FP2020, n.d.b)

Sierra Leone strives to increase CPR to 25 percent in 2015 and 30 percent in 2020, as well as decrease unmet need to 18 percent in 2015 and 10 percent by 2020 and decrease teenage pregnancy rates to 30 percent in 2015 and 15 percent in 2020.

POLICY and POLITICAL COMMITMENTS

A solid policy platform for FP is already in place. This includes:

- National Health Sector Strategic Plan
- Reproductive, Newborn and Child Health Policy and Strategy
- Reproductive Health Commodity Security Strategic Plan
- Sexual and Reproductive Health Strategic Plan for Adolescents and Young People
- The Ministry's 5-year Results and Accountability Framework
- CARMMA
- IHP+ Sierra Leone

FINANCIAL COMMITMENTS

Sierra Leone commits to increasing the annual health budget from 8 percent to 12 percent by 2013, gradually increasing it until the Abuja target of 15 percent is achieved. The GOSL will increase the family planning budget line from 0.42 percent in 2012 to 1 percent by 2020, recognizing that this will be 1 percent of a projected increasing budget for health overall, and secure additional funding for FP by partnering with donors.

PROGRAM AND SERVICE DELIVERY COMMITMENTS

Sierra Leone will engage private sector providers and strengthen human resources for health in order to scale up FP services and community outreach to marginalized populations, including young people. Other commitments include piloting voucher schemes to increase access for the poor, and partnering with CSOs for family planning advocacy and monitoring availability and access to voluntary FP.

Building on the commitments of the Millennium Development Goals (MDGs), the global Sustainable Development Goals (SDGs) are designed to address domestic and global inequalities by 2030 ("United Nations…," n.d.). Goals 3 and 5 include direct and indirect outcomes related to FP. Goal 3 specifies "Ensure healthy lives and promote well-being for all at all ages." The targets include the following:

- **3.1:** By 2030, reduce the global maternal mortality ratio to less than 70 per 100,000 live births
- **3.7:** By 2030, ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programs
- **3.8:** Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines for all

Further, Goal 5, "Achieve gender equality and empower all women and girls," includes target "5.6: Ensure universal access to sexual and reproductive health and reproductive rights as agreed in accordance with the Programme of Action of the International Conference on Population and

Development and the Beijing Platform for Action and the outcome documents of their review conferences."

In addition, all of the SDGs are linked to rights-based FP; for example, it will not be possible to end poverty and hunger (Goals 1 and 2), ensure quality education for all (Goal 4), and promote sustained economic growth (Goal 8) without ensuring that every woman has access to quality, rights-based FP services ("United Nations…," n.d.).

Regional Context

The total fertility rate (TFR) is high for many countries in West Africa due to low contraceptive prevalence rates. In addition, maternal and infant mortality remain high (see Table 1). Although Sierra Leone has a lower fertility rate than many neighboring West African countries, it has one of the highest maternal and infant mortality rates.

Table 1: Reproductive health indicators for selected countries in West Africa, latest available data

Country	TFR (ICF International, 2015)	mCPR, Married Women2	Maternal Mortality Rate per 100,000 Live Births ("Millennium Development…," 2014)	Infant Mortality Rate per 1,000 Live Births ("Millennium Development…," 2015)
Benin	4.9	13.3	405	56.2
Burkina Faso	5.5	21.4	371	64.1
Ghana	4.2	27.0	319	52.3
Guinea	5.1	6.1	679	64.9
Liberia	4.7	19.6	725	53.6
Mali	6.3	13.9	587	77.6
Niger	7.6	13.7	553	59.9
Nigeria	5	12.4	814	74.3
Senegal	5	21.7	315	43.9
Sierra Leone	4.9	15.8	1360	107.2

Sierra Leone Context

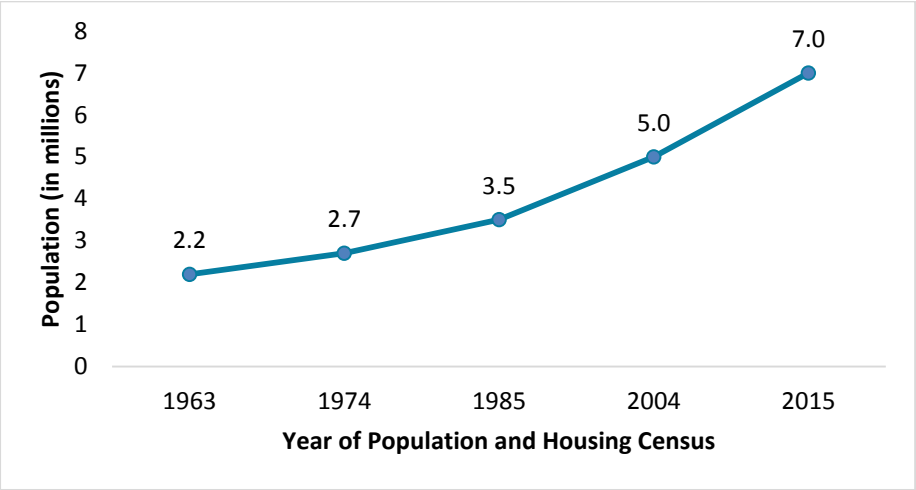
Population

Sierra Leone's first Population and Housing Census reported that the country had a total population of about 2.2 million in 1963 (SSL and ICF International, 2014; SSL, 2016).Over 50 years

[2] For MCPR: All were data from 2015 as reported in the 2016 FP2020 Progress Report. Data was produced using the Track20 FPET model. Available at: http://www.track20.org/pages/participating_countries/countries_country_page.php?code=SL.

later, the population size has since tripled to approximately 7 million (Figure 2) (SSL, 2016). Past censuses have also noted variations in the country's annual population growth rate. From 1974 to 1985, the annual population growth rate was 2.3 percent. This decreased to 1.8 percent from 1985 to 2004, and then once again increased, rising to 3.2 percent from 2004 to 2015. Recent statistics project that the annual population growth rate will decrease to 1.9 percent, with an increase to 2.7 percent annual urban population growth rate during 2015 to 2030 (UNICEF, 2016).

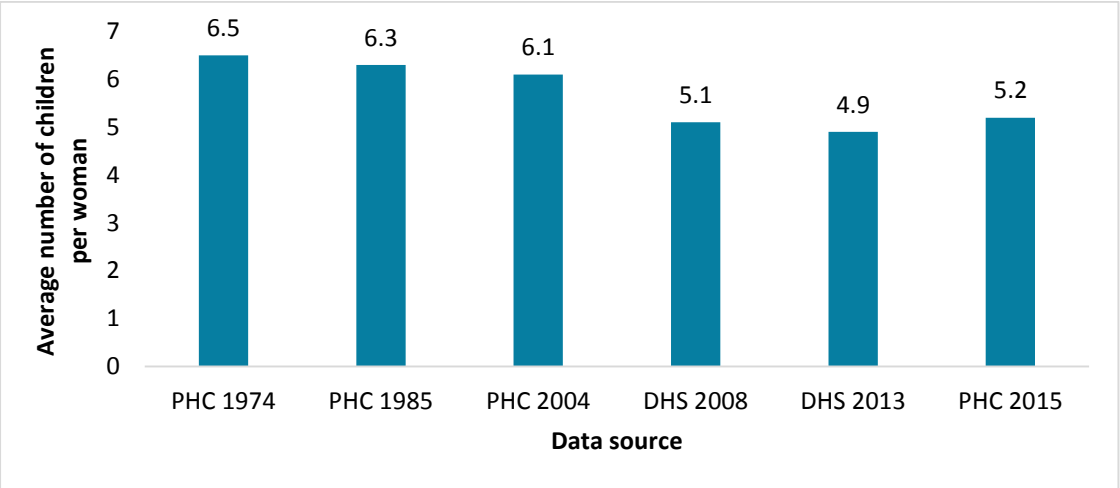
Figure 2: Total population of Sierra Leone, in millions, 1963–2015



The demographic profile of Sierra Leone is characterized by a relatively youthful population (SSL and ICF International, 2014). The 2015 Population and Housing Census estimates that 40.9 percent of the total population is under 15 years of age, while only 3.5 percent are 65 years and older (SSL, 2016). Additionally, a larger proportion of the population lives in rural areas (59%; 4,187,016 people) compared to urban areas (41%; 2,905,097 people).

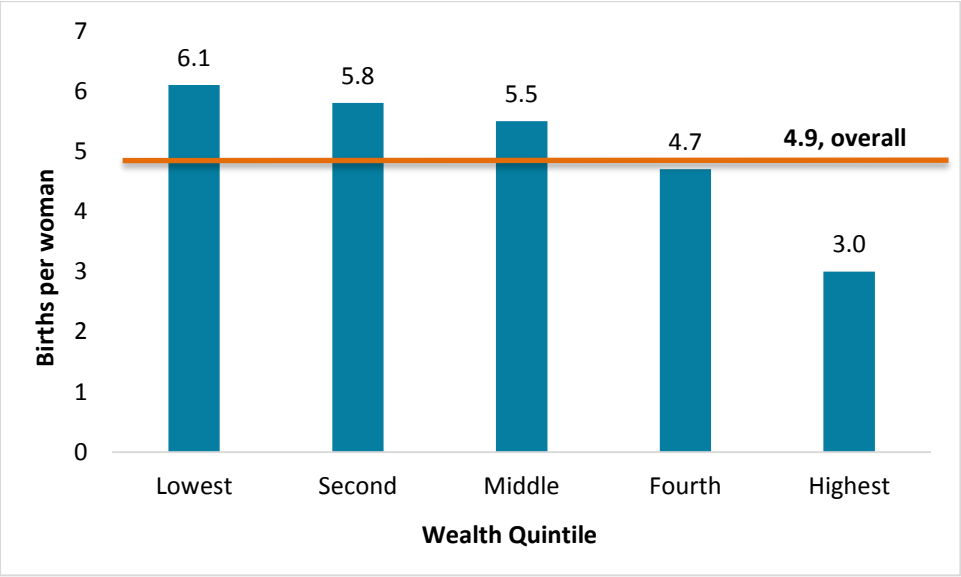
Sierra Leone's TFR has decreased over the past years. As shown in Figure 3, the 1974 Population and Housing Census reported that on average, women had 6.5 children (SSL, Central Statistics Office, 1985). This has continued to decline to an average of 5.2 children per woman by 2015 (SSL, 2016). However, fertility varies greatly across regions—from 5.6 children per woman in the Northern region, to 5.5 children per woman in the Southern region, and 5.4 children per woman in the Eastern region, to a low of 4.0 children per woman in the Western region (SSL, 2016).

Figure 3: Trends in total fertility rate in Sierra Leone, 1974–2015 (SSL, Central Statistics Office, 1985; SSL and ICF International, 2014b; SSL, 2016)



Although fertility levels have decreased nationwide, disparities still remain across wealth, residence, and educational level (World Bank, 2011). TFR is the highest among Sierra Leoneans who were at the lowest wealth quintile, with an average of 6.1 children per woman in 2013 (SSL and ICF International, 2014). In comparison, those at the highest wealth quintile had, on average, only three children, half as many children as those in the lowest wealth quintile (Figure 4). Women living in rural areas also tend to have more children compared to those in urban areas (5.7 vs. 3.5 children per woman). Additionally, the average number of children per woman decreases with more years of education (average of 5.6 children among women with no education vs. 3.0 children for women with secondary or higher education).

Figure 4: Total fertility rate, by wealth quintile, 2013 (SSL and ICF International, 2014a)



The marriage and family formation patterns in Sierra Leone also significantly influence the context for FP in the country. Two-thirds of women and half of all men ages 25–49 are in polygamous marriages. Men marry at a median age of 25 years and women at a median age of 18

years. Sex before or outside marriage is common. Sexual debut for girls is 16.4 years and 18 years for boys (SSL and ICF International, 2014a).

With Sierra Leone's characteristic youthful population, it is important to recognize that high fertility is seen among adolescents as well. Sierra Leone has one of the highest rates of teenage pregnancy in the world; 28 percent of female adolescents between the ages of 15 and 19 are either mothers or are pregnant with their first child (SSL and ICF International, 2014b). Almost half (46.8%) of deaths among adolescent girls are related to complications in childbirth (SSL and ICF International, 2014b). A 2013 survey by Marie Stopes found that 95 percent of people ages 15–35 who were surveyed reported being sexually active; however, only 45 percent reported using contraceptives (Evidence for Action, 2014).

The reduction of adolescent pregnancy is a top concern for the government and partners to tackle. Several factors have been identified as driving the high rate of teenage pregnancy, including poverty, a high number of girls not in school, inadequate parental guidance, and a lack of knowledge on sexual and reproductive health matters among young people. Other factors identified by stakeholders include peer influence, use of child labor, social media and pornography, low contraceptive use, and lack of or low moral values (Health Policy Plus, 2016a).

The impact of the Ebola outbreak on teenage pregnancy has not been comprehensively studied. However, there is anecdotal evidence of the link between the outbreak and teenage pregnancy; this evidence has pointed to a number of factors that may have led to increases in pregnancy among youth: the closure of schools for almost an entire academic year, constrained social gatherings, lack of something to do during the epidemic, youth remaining at home while parents were working, and girls becoming vulnerable to advances from boys without parental supervision (Denney et al., 2015). In addition, girls were often sent out to earn an income, and commercial sex increased. The "no touch" policy, which was instituted by the government as a measure to prevent the spread of Ebola, was taken by wives to deny sex to their husbands, who took comfort in having sex with young girls who were looking for an income for survival (Denney et al., 2015). It is understood that the Ebola outbreak provided circumstances that enhanced chances for girls to get pregnant: they were impregnated by their peers, they had plenty of opportunity to do this while outside school, they were exploited by older men for resources, and they were impregnated by relatives (Denney et al., 2015). In addition, the healthcare system became overstretched, it was not trusted by people to be safe from Ebola, and access was restricted by travel and quarantine. Hence, access to FP was reduced. A survey carried out by GOSL UNFPA in 2015 reported pregnancies as early as among 11-year-olds among a cohort of 14,386 teenagers pregnant after the Ebola epidemic (Denney et al., 2015).

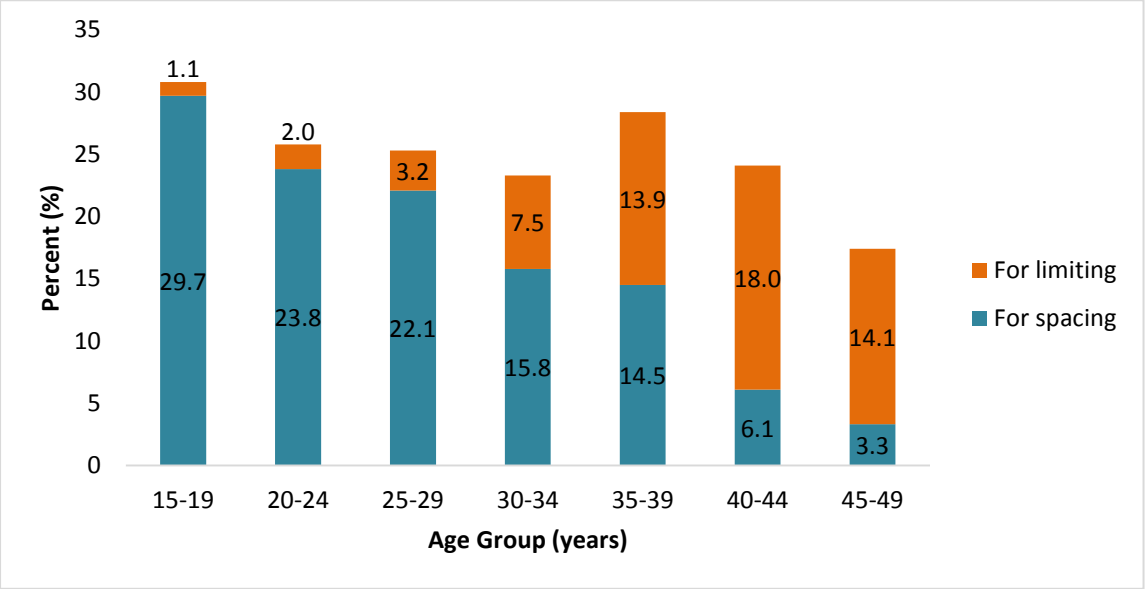
Unmet Need

Unmet need is the percentage of women who want to space their births or do not want to become pregnant but are not using contraception (The DHS Programme, 2014). Based on the results from the 2013 DHS, 25 percent of women ages 15–49 in Sierra Leone who are currently married have an unmet need for FP (SSL and ICF International, 2014a). More specifically, 17 percent of currently married women ages 15–49 have an unmet need for spacing births, while 8 percent have an unmet need for limiting births.

Unmet need is similarly high across location, education, and wealth (SSL and ICF International, 2014b). However, variations in unmet need are highest among the different age groups. Adolescents ages 15–19 have the highest overall unmet need (30.7 percent) (SSL and ICF International, 2014b). Unmet need for spacing births tends to decrease as one gets older, with its peak at 29.7 percent among adolescents ages 15–19 (Figure 5). On the other hand, unmet need

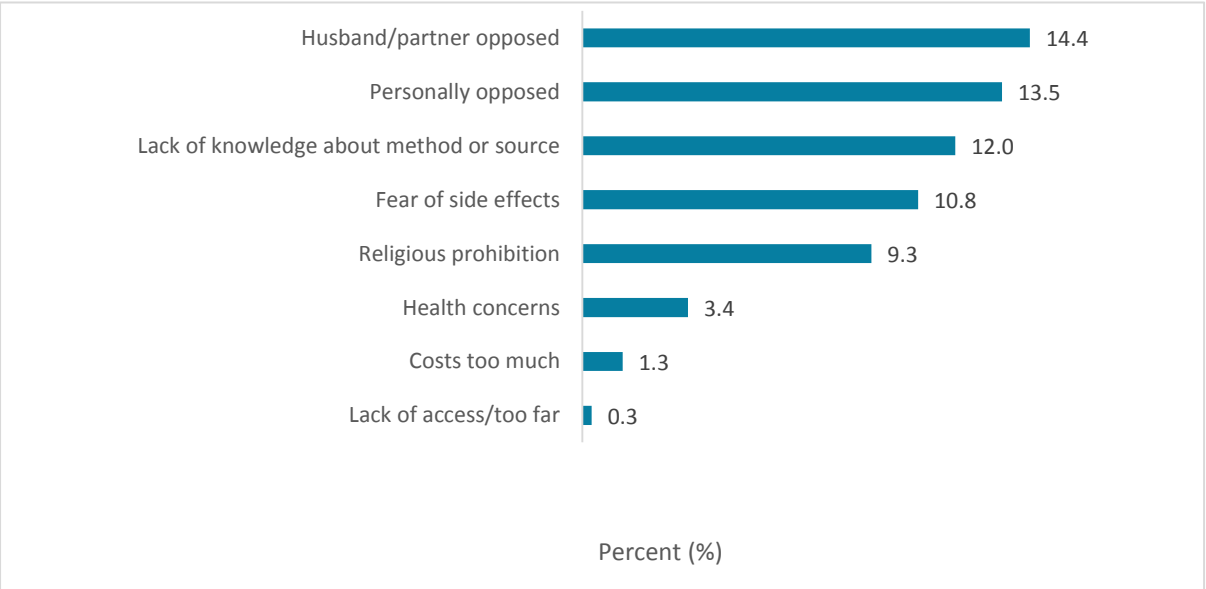
for limiting births increases in older age groups. The highest percentage of unmet need for limiting births is seen among women 40 years and older.

Figure 5: Unmet need for family planning, by age group (SSL and ICF International, 2014b)



Total demand for FP among currently married women ages 15–49 is 41.6 percent (SSL and ICF International, 2014b). However, the demand satisfied by use of modern contraceptive methods is only 37.5 percent. A variety of factors contribute towards the resultant high unmet need for FP. According to the 2008 Demographic and Health Survey (DHS), the most-cited reasons women give for not using contraceptives are opposition of partner or self (37 percent), a lack of knowledge of a method or source (12%), health concerns or fear of side-effects (14%), and religious prohibition (9%). Cost and access to FP services and methods also play a role in increasing Sierra Leone's unmet need (SSL and ICF Macro, 2009). The most popular reasons for not using contraceptives are summarized in Figure 6.

Figure 6: Most common reasons for not using a contraceptive method, 2008 (SSL and ICF Macro, 2009)

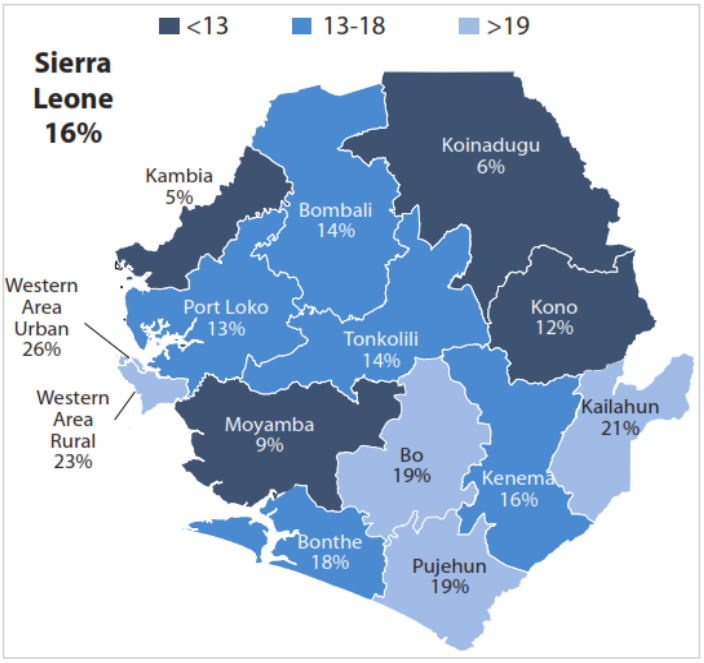


Contraceptive Use

According to the 2013 DHS, approximately 22 percent of all women are using a contraceptive method (SSL and ICF International, 2014a). More specifically, about 21 percent of women are using a modern contraceptive method, and about 1 percent are using a traditional method. Among the range of modern methods, the top three choices for all women in Sierra Leone are injectables (9.8%), pills (5.1%), and implants (3.8%). Women ages 20–24 are more likely to use contraceptives (29.1%), compared to the other age groups.

Contraceptive use also varies on the basis of a woman's education level, economic standing, residence, and regional- and district-level locations (SSL and ICF International, 2014a). Generally, uptake of FP methods—for all methods and modern contraceptives—increases for women with more education and wealth. The 2013 DHS also reports that contraceptive use is more than two times as high among women residing in urban areas as those in rural ones (26.6% vs. 13.0%). Women living in the Western Region of the country have the highest use of contraceptives (27.1%). This is evident in both rural (24.1%) and urban areas (27.9%) of the Western Region. The lowest contraceptive use is among women living in the Northern Region (12.3%), especially in Kambia (5.4%) and Koinadugu (6.5%) districts. For more detail about contraceptive use by district, refer to Figure 7.

Figure 7: Percent of married women currently using a modern method of family planning, by district, 2013 (SSL and ICF International, 2014b)



Despite these disparities, it is important to recognize that FP uptake in Sierra Leone is progressively increasing. Data from the 2008 and 2013 DHS show that the percentage of women using a contraceptive method has doubled for both currently married and sexually active unmarried women ages 15–49 years (Figure 8 and Figure 9) (SSL and ICF Macro, 2009). This increase has been largely driven by an increase in the use of injectables and implants. Over this time, a much larger gain in contraceptive method use is seen among sexually active unmarried women compared to those who are currently married. Among currently married women, use of injectables has increased from 2.9 percent in 2008 to 7.5 percent in 2013. For women who are unmarried and sexually active, the use of injectables has shown an even greater increase, rising from 7.1 percent in 2008 to 25.9 percent in 2013.

Figure 8: Contraceptive use among currently married women, 2008–2013 (SSL and ICF Macro, 2009)

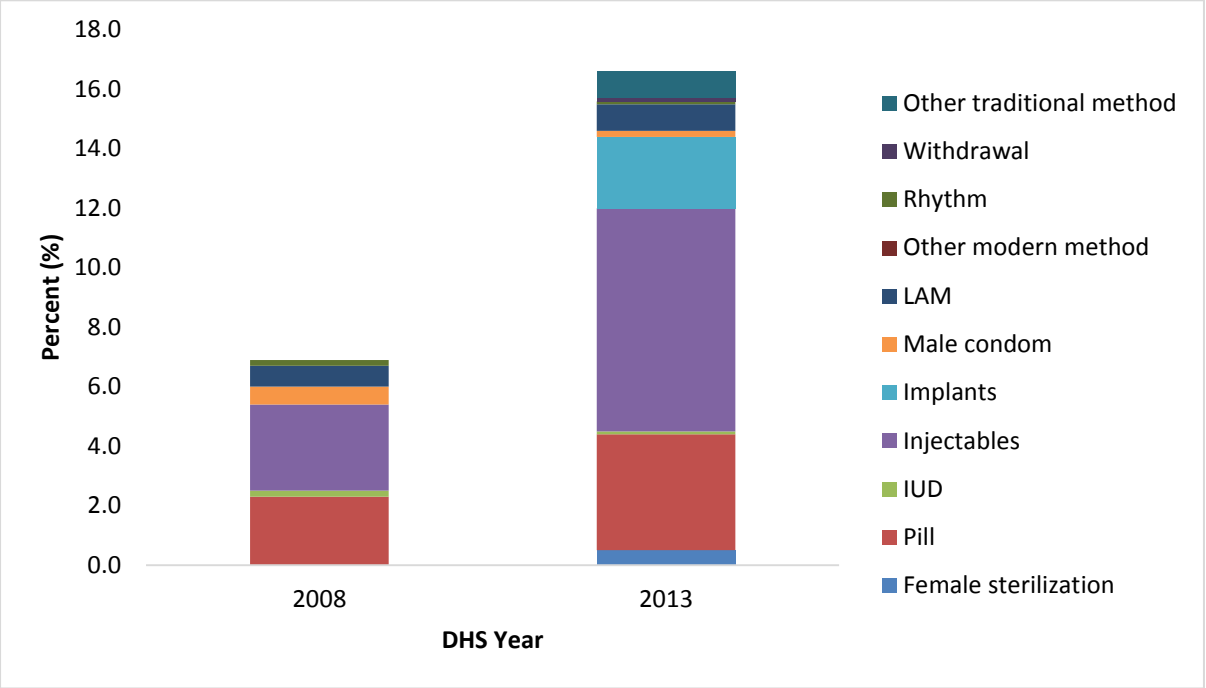
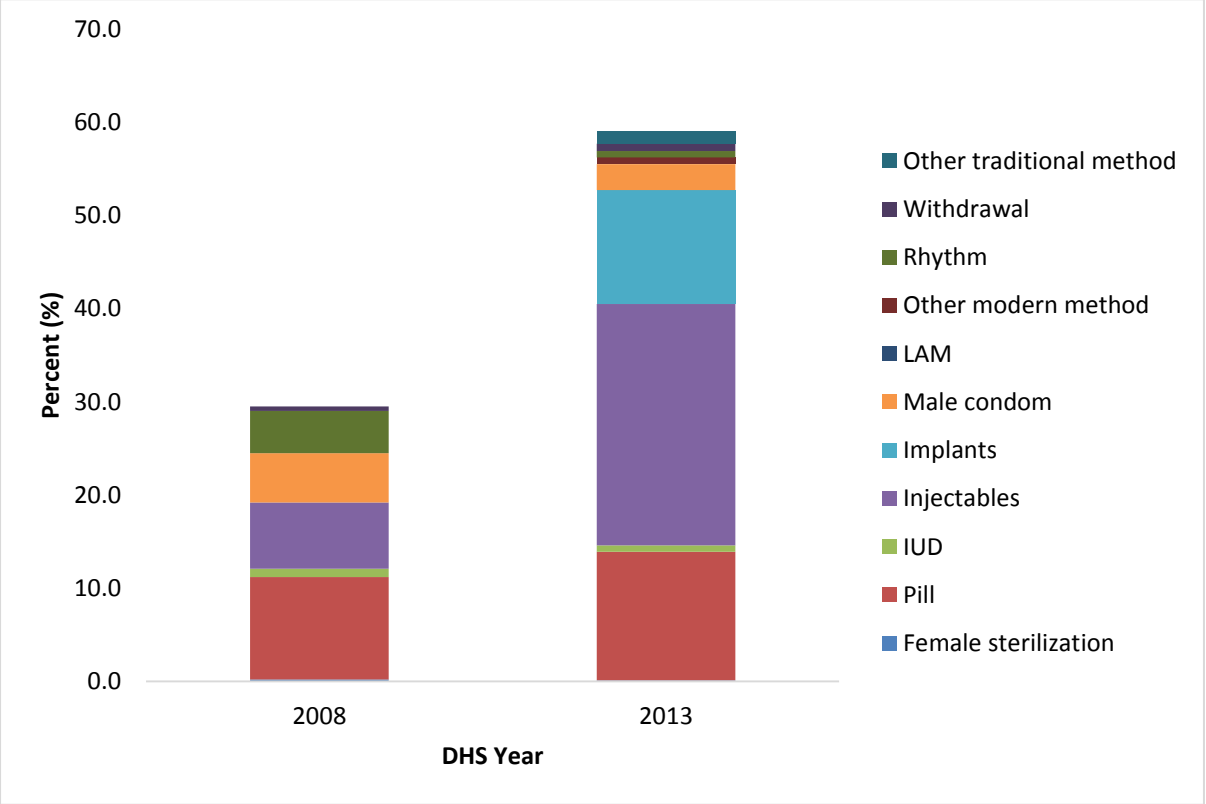


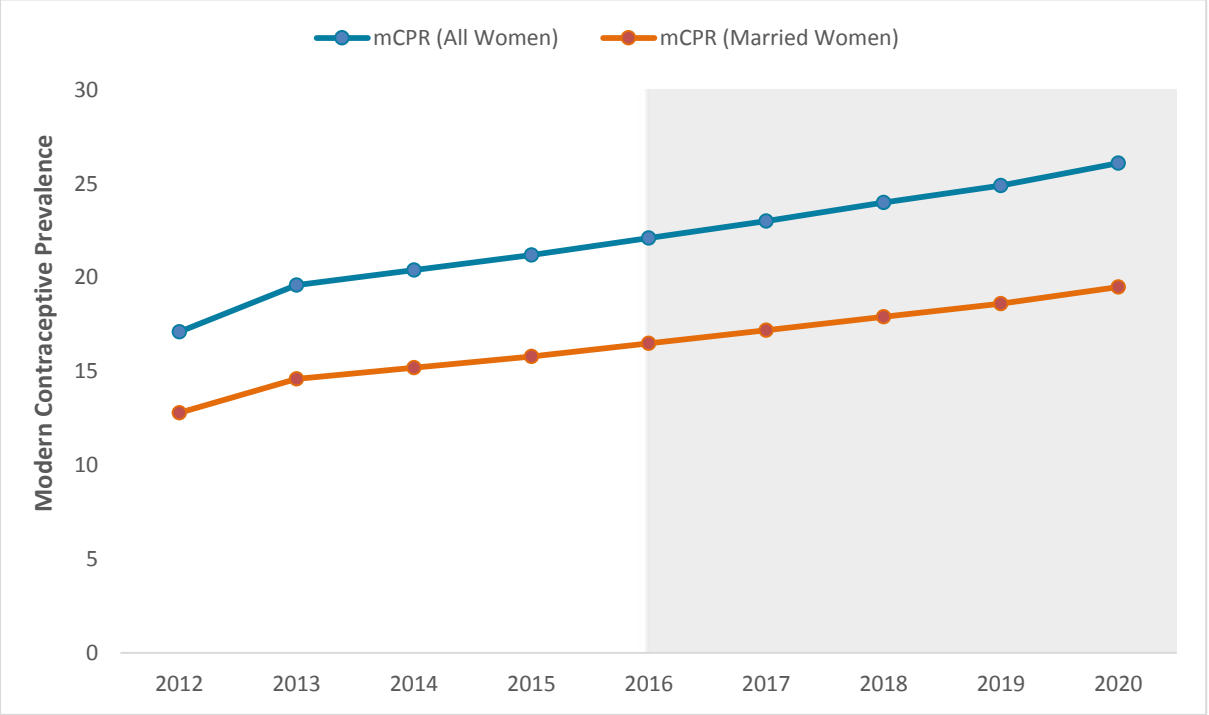
Figure 9: Contraceptive use among sexually active unmarried women, 2008–2013 (SSL and ICF Macro, 2009)



Current projections from Track20 estimate that without increased commitment to accelerating availability and access to FP, Sierra Leone will have an mCPR of 26.1 percent for all women and

19.5 percent for married women by 2020 (Track 20, 2016). Figure 10 shows the projected trends in mCPR for all women and married women from 2012 to 2020.

Figure 10: Trends in modern contraceptive prevalence (mCPR) for all women and married women, 2012–2016 and projections for 2017–2020 (Track 20, 2016)[3]



Key Issues and Challenges

Significant progress has been made to increase FP access in Sierra Leone in recent years, resulting in increased contraceptive uptake among both married and unmarried women. However, there are continued challenges and constraints that must be addressed to meet the country's ambitious FP goals and reduce maternal mortality.

Demand Creation (DC)

Knowledge about FP methods and services in Sierra Leone has significantly increased over the past years. As of 2013, approximately 95 percent of all women and 96 percent of all men reported knowing at least one contraceptive method (SSL and ICF International, 2014a). This is an increase in knowledge from 2008, when only 74 percent of women and 83 percent of men reported knowing at least one FP method. Currently, the most commonly known methods among both women and men are pills, male condoms, and injectables (SSL and ICF International, 2014b).

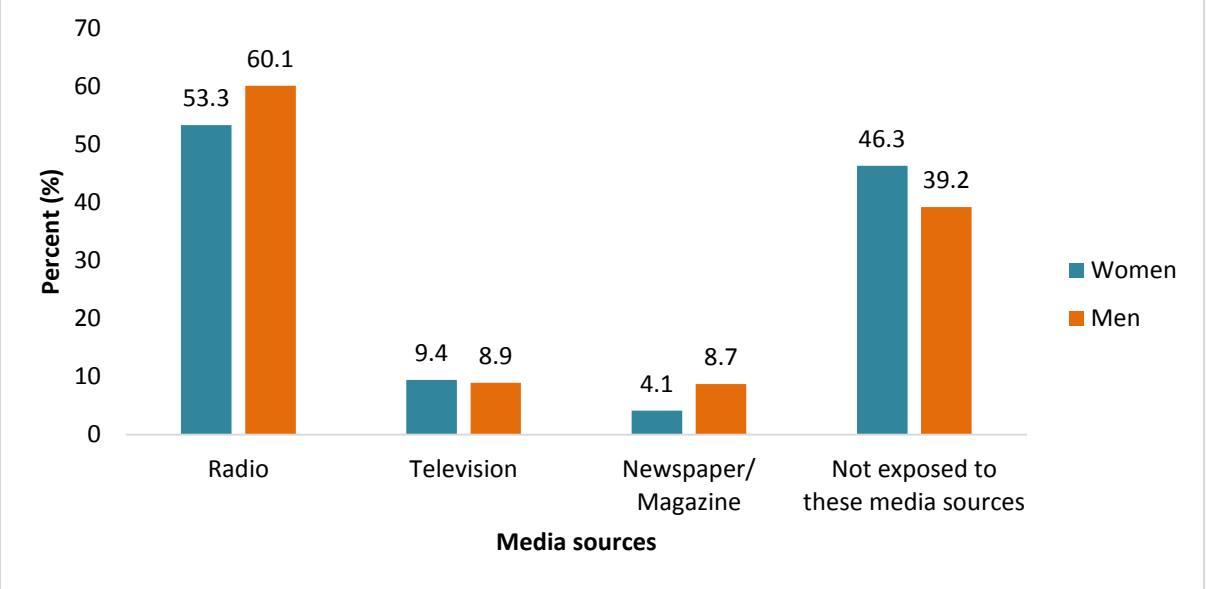
Despite high knowledge about FP methods, demand for FP services remains fairly low, contributing to the country's high fertility rate. The demand for FP among currently married women is 41.6 percent. However, only 16.6 percent of married women use contraceptives, meaning that 25 percent of women who are currently married have an unmet need for FP (SSL

[3] FP2020 uses a "rolling baseline" so values are recalculated each year based on the newest available data. The values in the grey area represent estimates of future prevalence if current trends continue.

and ICF International, 2014a). Unmarried sexually active women have greater use of contraceptives, at 59.2 percent.

FP messages are a key way to inform people about FP services within their communities. In addition to interpersonal forms of communication, three main forms of media outlets provide exposure to FP messages: radio, television, and newspapers or magazines (SSL and ICF International, 2014a). Among these, radio is the major source to obtain FP messages for men (60.1%) and women (53.3%), while newspapers or magazines are the least common media source for men (8.7%) and women (4.1%) in Sierra Leone (Figure 11). The production of community radio dramas (HP+, 2016b) and the distribution of information, education, and communication (IEC) materials (MOHS, 2015c) also contribute to information sharing about FP methods and services. However, there is no coherent, persistent, and nationwide campaign for FP (HP+, 2016c).

Figure 11: Exposure to family planning messages in the media



While knowledge about FP is high, the demand for FP services remains low. Almost-universal knowledge is not clearly translating into high demand for FP services. Stakeholders give a number of possible reasons. One reason is that because child mortality is high, the desire to have more children is also high to ensure that some children will survive. Spouses and boyfriends of sexually active women are also against the use of contraceptives, as they believe that it will lead to promiscuity and so actively discourage or forbid their partners to use contraceptives. Third, myths about the side effects of contraceptives, including long-term infertility, remain strong. Finally, religious leaders are often pronatalist and/or in opposition to "artificial" methods of contraception (HP+, 2016a). Past studies have noted that lack of access, opposition to contraception by women themselves or their partner or another person, and concerns about health risks or side effects are common reasons for not using contraceptives (Sedgh and Hussain, 2014). Additionally, frequent stockouts of commodities and the expression of negative attitudes and biases from providers have also limited, and at times prevented, people's access to contraceptives and reproductive health services (Health Policy Initiative, 2008).

Religious and cultural beliefs also play a role in shaping community perceptions about FP. For example, there is a stigma about FP among predominantly Muslim communities (HP+, 2016b). Cultural beliefs have contributed towards misconceptions about users of FP services and

commodities and side effects of certain methods. Examples of common myths about FP methods' side effects include that contraceptive pills get stored in one side of the body and result in a woman growing a larger belly, and that pills lead to long-term infertility. FP users have been associated with partaking in risky sexual behavior or prostitution (HP+, 2016d).

Youth also hold a number of misconceptions and myths about FP that are being passed on from adult figures in the community, such as parents, teachers, and religious leaders, to the youth (HP+, 2016d). In addition, adolescents are fearful of being reported if they access FP services at local clinics and are seen by family and friends. FP use by adolescents is stigmatized, as there is a strong push from families, communities, and culture to be abstinent prior to marriage. In addition, when adolescents access FP services, there can be an additional perception that they are not being taken care of well by their parents; therefore, they are resorting to transactional sex (HP+, 2016d).

FP demand creation in Sierra Leone has been hampered by a lack of consistent FP messages being delivered over time, resulting in the proliferation of myths, misconceptions, and lower use of FP compared to the fertility desires of adolescents, women, and men.

Service Delivery

As the country's main healthcare provider, the MOHS stands at the center of the healthcare system (SSL and ICF International, 2014a). 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) (MOHS, 2015c). There are three types of PHUs, consisting of maternal and child health posts (MCHP), community health posts (CHPs), and community health centres (CHCs). In addition to PHUs, community outreach also occurs at this level. The secondary care level is comprised of district hospitals. Lastly, 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 (BPEHS). Over 90 percent of primary facilities offer at least three contraceptive methods, with the highest provision in the Eastern region (100%) followed by the Northern region. In the Southern region, 90.5 percent of facilities provide at least three contraceptive methods, but in Western Area, only 75 percent of facilities provide three or more methods (UNFPA, 2016).

The main nongovernment service providers for FP are Marie Stopes Sierra Leone (MSSL) and Planned Parenthood Sierra Leone (PPASL). Marie Stopes has nine static centers; in addition, both MSSL and PPASL provide FP services through outreach services. Among these approaches, outreach in particular has been favorably received, especially among youth (HP+, 2016b). 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

Statistics from a recent study show that MSSL is the country's main provider for modern contraceptives, in particular intrauterine devices (IUDs) (77%) and implants (64%) (Evidence for Action, 2014). The distribution of health facilities by type and district is detailed in Table 3.

Table 2: Family planning services, by delivery level (MOHS, 2015c)

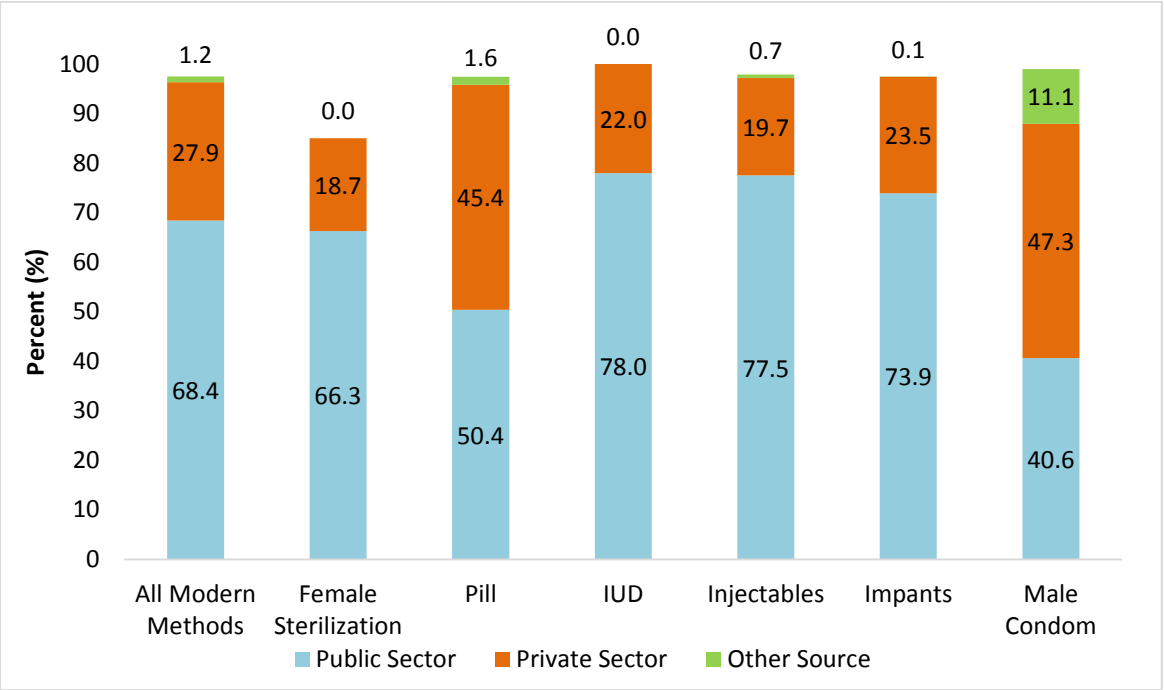
Service Level	Family Planning Methods Offered
Community health worker (CHW)	Counselling; condoms, pills (refills only)
Maternal and child health post (MCHP)	Same as CHW, plus initiating pills, injections; implants; IUDs
Community health post (CHP)	Same as MCHP
Community health centre (CHC)	Same as CHP, plus male and female sterilization
District, regional, and national hospitals	Same as CHC

Table 3: Distribution of health facilities in Sierra Leone (MOHS, 2015c)

District	Government					Mission		Private		NGO	Total
	CHC	CHP	MCH	Clinic	Hospital	Hospital	Clinic	Hospital	Clinic	Clinic	
Bo	23	12	50	1	1	1	6	0	11	3	108
Bombali	16	20	49	0	2	2	3	1	3	0	96
Bonthe	9	9	20	0	2	1	2	0	0	2	45
Kailahun	9	34	12	0	2	1	1	0	0	0	59
Kambia	11	8	31	0	1	0	2	0	0	1	54
Kenema	21	17	63	1	2	1	2	0	3	1	111
Koinadugu	12	6	33	1	1	0	0	0	0	1	54
Kono	11	15	46	0	1	0	1	0	4	4	82
Moyamba	12	6	56	1	2	0	5	0	0	1	83
Port Loko	11	21	55	0	2	1	4	0	1	0	95
Pujehun	14	10	25	0	1	0	0	0	0	0	50
Tonkolili	9	8	65	0	1	2	1	0	0	1	87
Western Area	20	10	15	7	12	2	11	2	23	3	105
Total	178	176	520	11	30	11	38	3	45	17	1029

Generally, most people access contraceptive methods from the public sector (SSL and ICF International, 2014a). The 2013 DHS states that 68.4 percent of current users of modern methods access FP commodities from public sector health facilities, while approximately 28 percent of users obtain commodities from private sector facilities (Figure 12). The most common source within the public sector is government health centers (33.6 percent). Women primarily come to these facilities to get injectables (41.1%), implants (29.0%), or pills (28.6%). In comparison, pharmacies (13.8%) and private hospitals or clinics (9.7%) are the most common sources for modern contraceptive methods within the private sector. The top method choice for women at pharmacies is male condoms (45.2%), while IUDs (20.8%) are frequently obtained at private hospitals or clinics.

Figure 12: Source of modern contraceptive methods accessed by current users ages 15–49



FP service delivery at static clinics or facilities faces a wide range of challenges. One of the most pressing issues is the shortage of health workers (MOHS, 2015c). When the *National Health Sector Strategic Plan* (NHSSP) 2010–2015 was launched in 2009, there was a total of 6,030 health workers in the country, and the health workforce shortage ranged from 40 to 100 percent of the staff needed to maintain an efficient health service delivery system (Table 4) (MOHS, 2009). Factors affecting staff shortage include poor service conditions, inadequate staff supervision and support, low payment or salary, and limited availability of benefits (GOSL, n.d.b).

Table 4: RCH health workforce distribution in Sierra Leone (MOHS, 2009)

Area of Specialization/Study	Number	Location				Needed	Gap	Shortfall (%)
		WA	South	North	East			
Public health	24	15	3	3	3	30	6	20
Physician	3	3	0	0	0	26	21	81
Clinical pharmacologist	1	1	0	0	0	24	23	96
Pharmacist	33	32	1	0	0	52	19	37
Pediatrician	2	2	0	0	0	30	28	93
Obstetrician/ gynecologist	5	4	1	0	0	26	21	81
Practicing midwife	95	95	0	0	0	300	205	68
SECHN	635	425	60	80	70	1500	865	58
State registered nurse	245	---	---	---	---	600	355	59
Pediatric nurse	0	0	0	0	0	72	72	100
MCH aide	825	225	200	220	180	1500	675	45

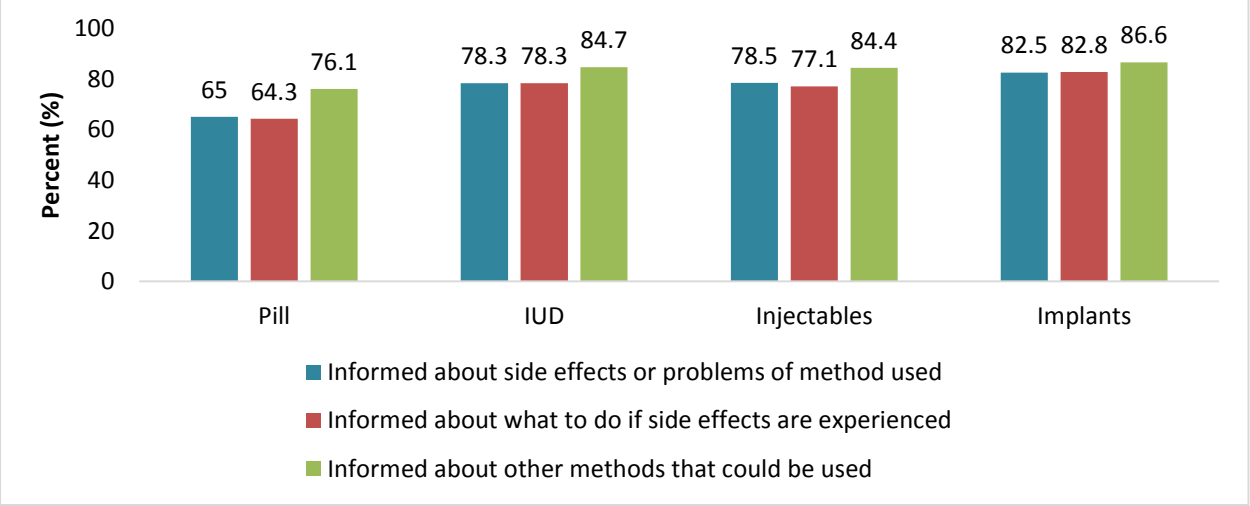
Issues related to the distribution and skill set of healthcare workers also affect FP service delivery in Sierra Leone (MOHS, 2015c). About half of the healthcare staff are situated in the capital city of Freetown; however, this city's population only represents an estimated 16 percent of the population of the entire country. Additionally, lack of training results in reduced access to long-acting reversible contraception (LARC) and a lower quality of counseling about FP methods, including provider-initiated discussions about side effects and information to dispel myths and misinformation. Collectively, this helps fuel high discontinuation rates (HP+, 2016b). Among women who reported discontinuing a contraceptive method in a 12-month period, 10.5 percent out of nearly 23 percent noted that they chose to discontinue because of health concerns (SSL and ICF International, 2014a). This was reported as the top reason among those who use injectables (14.3%). Other common reasons for discontinuation consist of switching to another method (4.5%) and the desire to become pregnant (4.0%). These data suggest that approximately 14 percent of contraceptive users will discontinue yearly without an alternative contraceptive method. The inability to obtain the contraceptive method of choice due to lack of provider training, coupled with frequent stockouts and high costs of services, can ultimately limit clients' access to FP (GOSL, n.d.b). As a result, some clients may even seek available services elsewhere from unskilled, "quack" providers (HP+, 2016d). Both counseling and referral services need to be improved in order to ensure that people are able to realize their right to quality reproductive health information and services.

Insufficient training given to FP/reproductive health providers also affects the quality of counseling received by clients. According to the 2013 DHS, approximately 76 percent of modern methods users ages 15–49 were informed about potential side effects of the method used; 75 percent of users were informed about what to do if side effects were experienced; and 83 percent were informed about other methods that could be used (SSL and ICF International, 2014a). Although these data show that generally, most clients are informed, a closer examination

of informed choice by method demonstrates potential areas for improvement. As shown in Figure 13, clients are not universally counseled on side effects and what to do about side effects if they are experienced, with incomplete counseling seen across all FP methods. Pill users are the least informed about side effects; 35 percent are uninformed about side effects. Counseling is somewhat improved for injectable, IUD, and implant users; however, with over 20 percent of IUD users not informed about side effects and what to do about those side effects if experienced, incomplete counseling is likely to contribute to higher discontinuation rates, as well as myths and misconceptions about FP, than complete counseling.

Poor counseling about FP has greatly affected adolescents and their use of contraceptives (HP+, 2016d). For instance, some providers express their own biases and beliefs as they counsel the youth on FP. This, accompanied by societal stigmatization of adolescent use of contraceptives, can deter and even prevent adolescents from going to clinics to access contraceptive services.

Figure 13: Informed choice, by family planning method used (SSL and ICF International, 2014a)



Despite these challenges, it is important to recognize that the MOHS and its partners are making efforts to improve FP service delivery in Sierra Leone. Their efforts can be seen with the launch of capacity-building programs such as trainings for nurses and midwives and the National Community Health Worker (CHW) Program (MOHS, 2015a). These programs aim to address the healthcare workforce shortage and ensure that services are available at the community level. The MOHS and various partners have been making concerted efforts in recent years to train additional healthcare workers in the placement of longer-term contraceptive methods (HP+, 2016e; WHO, 2016).

Contraceptive Security

Ensuring contraceptive security is a top priority for FP service provision in Sierra Leone. FP contraceptive security is characterized by active stakeholder engagement in the country. This is most evident in advocacy efforts of the National Reproductive Health Commodity Security Working Group (RHCSWG), which conducts annual forecasting, coordinates procurement, and more recently, has made efforts to ensure the distribution of FP commodities when the distribution of other free healthcare commodities has faced challenges (HP+, 2016a).

In 2012, the MOHS created the National Pharmaceutical Procurement Unit (NPPU). This agency was in charge of procurement, storage, and distribution of essential medical supplies to health facilities in Sierra Leone's 14 districts (Crown Agents USA, 2013). The NPPU was disbanded in 2016, primarily due to operational issues once the Free Healthcare Initiative took effect (HP+,

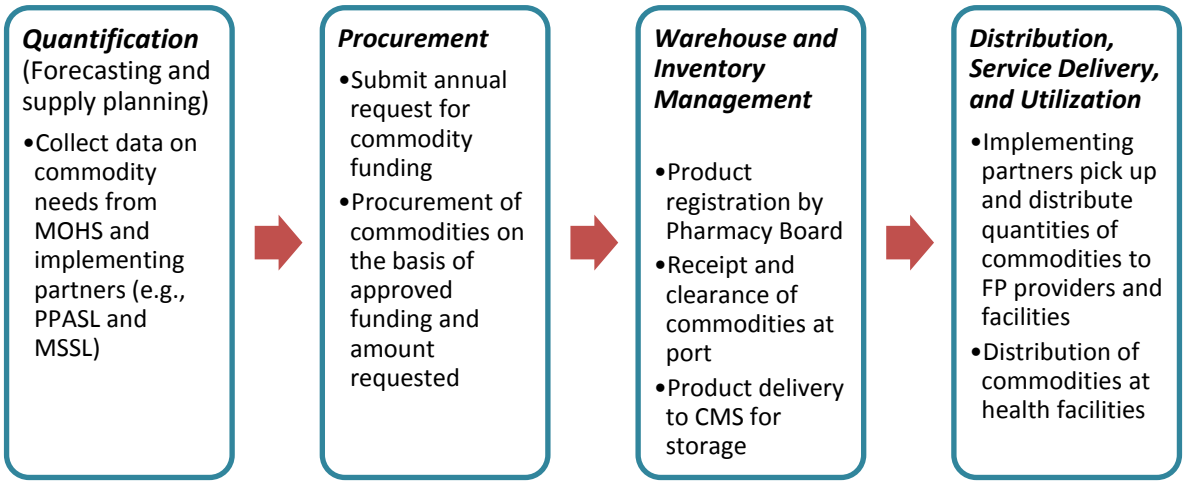
2016a). Since then, the NPPU's responsibilities have been redistributed to a mix of local and international organizations involved with the FP supply chain.

Currently, the RHCSWG completes the annual forecasting exercise. UNFPA is the primary organization managing procurement of FP commodities, in addition to providing funds for the procurement (HP+, 2016a). Central Medical Stores (CMS) is the agency that is responsible for storage, distribution, and oversight of drugs and commodities. It operates under the Directorate of Drugs and Medical Supplies of the MOHS. The Pharmacy Board is responsible for conducting quality assurance assessments for all health commodities coming into the country. This includes sampling at the port and post-market surveillance. It does this well for the private sector, but government drugs are exempt.

Quarterly distributions of commodities for the Free Healthcare Initiative are supported by DFID. These distributions are completed by AECOM as a private contractor; until December 2016, this was done by Crown Agents and IPA (CAIPA) (HP+, 2016a). The Clinton Health Access Initiative is also supported by DFID to strengthen ongoing routine operations and provide guidance in transitioning to the new agency post-NPPU in 2017. Other implementing partners and donors that support the supply chain include MSH, The Global Fund, USAID under the SIAPS Program, and UNICEF. UNICEF procures almost all of the non-FP commodities for the Free Healthcare Initiative.

Sierra Leone's supply chain process begins at the district level. Every month, hospitals and primary healthcare facilities submit a report, review, and issue voucher (RRIV) to the District Health Management Team (DHMT). The RRIV is used to collect information on opening and closing balances, quantities received and distributed, and requested quantities. Upon receipt of the RRIVs, district health information officers enter the data into a software used by CMS called Channel. Collectively, RRIV data feed into the RH supply chain's logistics management information system (LMIS). These data are also applied to the quantification of FP commodity requests by the MOHS and implementing partners such as MSSL and PPASL. However, commodity forecasting is based on population statistics and service provision assumptions, rather than on actual data on logistics or service delivery. This is done as a precautionary measure post-Ebola outbreak to prevent the use of compromised, incomplete, or non-accurate data. Then UNFPA Sierra Leone submits a series of requests to obtain commodities for in-country distribution. The first request is submitted to UNFPA Commodity Security Branch (CSB) in New York. Approved funding allows UNFPA Sierra Leone to then submit a procurement request to UNFPA Procurement Services Bureau (PSB) in Copenhagen. After that has been processed, the FP commodities are shipped to Sierra Leone's CMS, where they are eventually distributed to the health facilities and clients by implementing partners. AECOM is currently delivering DFID-procured commodities (which do not include UNFPA-procured FP commodities). This FP supply chain process is summarized in Figure 14.

Figure 14: The family planning supply chain in Sierra Leone



Despite stakeholder engagement and a general supply chain process in place, there are still gaps in Sierra Leone's overall commodity security system. As discussed in more detail in the financing section, not only is very limited funding allocated for commodity procurement, it is primarily from one donor, UNFPA. Sierra Leone is characterized as a donor-dependent country; therefore, it is reliant on funding, particularly with regards to FP service provision (HP+, 2016a). The Ministry of Finance and Economic Development (MOFED) has already established a budget ceiling for the FP/reproductive health program. As a result, MOHS can neither add to nor reduce money from the allocated amount (HP+, 2016a).

The process for quantification also has some problems, specifically with regard to the data that are used for forecasting (HP+, 2016a). As previously noted, forecasting analyses have been based on population statistics. In most cases, these data are taken from the country's 2013 DHS, and then adjustments by group are made based on historical trends, assuming an approximately 1.5 percent increase overall per year in CPR (HP+, 2016a). However, it is problematic to assume that the commodity method mix in 2013 is the same as the current contraceptive methods preferred by women now. In addition, the number of commodities for restocking are quantified based on assumptions that are standardized across districts by the type of health facility; no adjustments to the distributed method mix are made based on district population demographics. Due to this standardization process, it becomes quite difficult to have an accurate assessment of how many commodities are needed to fulfil the needs of the population.

Considering commodity security at a macro-level, there are also bottlenecks in coordination of the supply chain system and M&E efforts. Currently, there is very little coordination between the National Reproductive Health Programme, which is operated by the MOHS, and Central Medical Stores (CMS). The National Reproductive Health Programme is responsible for developing commodity distribution plans, while CMS is in charge of storage and distribution of contraceptives. Because of limited involvement of the RH Programme with CMS, this creates a gap in the quantities and availability of FP commodities that are expected to be distributed within the Free Healthcare Initiative. This drives the potential need for emergency shipments of commodities.

There is currently no framework for how nationwide M&E of FP should be accomplished (HP+, 2016a). As it stands, the Health Management Information System (HMIS) only captures information about FP by use of the facility summary form for reproductive health services (HF3).

This form collects data on FP methods and the number of new clients, continuing clients, and defaulters. With insufficient training for staff that work on HMIS and M&E, this can result in data entry errors and errors in tracking certain indicators. Therefore, data quality assurance and collection of FP-related commodity data is a current weakness.

Policy and Enabling Environment

Based on WHO estimates, Sierra Leone has been ranked as having the highest maternal mortality ratio (MMR) globally, with its peak in 1995 at 2,900 maternal deaths per 100,000 live births and currently standing at 1,360 maternal deaths per 100,000 live births (WHO, 2015). This problem of high maternal mortality has brought reproductive health and FP-related matters to the forefront as one of the country's top priority health issues that needs to be addressed.

Several key policies have recognized and operationalized efforts to improve reproductive health in Sierra Leone. In 2002, the National Health Policy identified that the status of reproductive health, especially with regards to maternal and neonatal mortality, was "unsatisfactory" (MOHS, 2002). The *National Health Sector Strategic Plan* (NHSSP) 2010–2015 prioritized improving reproductive, child, and adolescent health and placed an emphasis on the need for FP commodities (MOHS, 2009). This was also supported with the launch of the Free Health Care Initiative (FHCI) in 2010, which acknowledged that poverty and high healthcare costs were barriers to progress in maternal and child health; therefore, it enabled the provision of free healthcare services for pregnant women, lactating mothers, and children under five years old (Sierra Leone Government, MOHS, 2011). Most recently, the *Health Sector Recovery Plan (HSRP) 2015–2020* was developed as a means to rebuild a resilient national health system following the 2014–2016 Ebola epidemic (MOHS, 2015b). This plan addresses the shortcomings of the health service delivery system through five major pillars: patient and healthcare worker safety, health workforce, essential health services, community ownership, and information and surveillance. The revised *National Community Health Worker Policy 2016–2020* was also launched within the past year (MOHS, 2016). With this new policy, CHWs are authorized to distribute condoms, refill oral contraceptive pills, and provide counseling on FP methods and use. The RMNCAH Strategy 2017–2021 intends to accelerate efforts to reduce maternal, child, and adolescent mortality by strengthening national and community level health systems, ensuring quality RMNCAH services, and providing research and M&E support.

All of the aforementioned policies have and continue to shape Sierra Leone's health service delivery system. Sierra Leone's policy environment is generally conducive to and supportive of FP. General health sector policies and strategies identify the need to improve maternal health outcomes and reduce teenage pregnancy, and they highlight FP as a key strategy toward those goals. Table 5 highlights the relevant policies and strategies in Sierra Leone and summarizes the relevant FP components of these strategies.

Table 5: Government of Sierra Leone policies and strategies

Policy/Strategy Document	Summary of Relevant FP/RH Components
National Population Policy for Development, Progress and Welfare, 1993 (National Population Policy for Development, Progress and Welfare, 1993)	The goals of the policy included: • Make development planning and policy more comprehensive and effective by incorporation of the demographic dimension • Achieve a rate of population growth the economy could sustain • Contribute toward meeting the basic needs of the people and enhancing the quality and utilization of the nation's human resources • Promote the health and welfare of the people, especially those in the high-risk groups mothers and children • Moderate 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 • Guide rural-urban migrations, so as to minimize socioeconomic problems and optimize benefits to migrants and nonmigrants alike, in both rural and urban areas
National Health Sector Strategic Plan (NHSSP), 2010–2015 (MOHS, 2009)	This plan served as a guide to strengthen the national health system. Among the priority areas, improvements in reproductive and child health and adolescent health were emphasized. The national need for commodities, including those related to FP and reproductive health, were also addressed. All reproductive health outcomes were further outlined in the RCH Strategic Plan.
Sierra Leone Basic Package of Essential Health Services (BPEHS), 2015–2020 (MOHS, 2015c)	As an accompaniment to the NHSSP, the BPEHS enumerates and operationalizes which services are offered at the primary and secondary care levels of the health system. Reproductive, maternal, and newborn health are specifically prioritized through the following service delivery areas: **FP/reproductive health** • Examples of services include antenatal and postnatal care, care during labor and delivery, and provision of FP commodities and services. **School and adolescent health** • Examples of services include age-appropriate education/ counseling on topics about sexual and reproductive health, counseling on HIV/STI prevention, and prevention and response to teenage pregnancy.

Policy/Strategy Document	Summary of Relevant FP/RH Components
National Community Health Worker Policy, 2016–2020 (MOHS, 2016)	This revision of the Policy for Community Health Workers in Sierra Leone, 2012 (MOHS, 2012), aims to provide guidance on coordinating, implementing, and monitoring and evaluating the National Community Health Worker (CHW) Program and the overall scope of work for CHWs. The following FP-related services are specified in their scope of work: • Identify women at the early stages of pregnancy along with children and women of childbearing age who are eligible for RMNCAH interventions. This takes into consideration FP uptake and integrated community case management. • Provide pre-pregnancy counselling to all women of childbearing age. This counselling places an emphasis on the importance and availability of FP methods and gives CHWs the opportunity to distribute condoms and refill oral contraceptive pills. Additionally, counseling for adolescent girls includes discussions on the importance of delaying childbearing. • Conduct three antenatal home visits during a woman's pregnancy along with educating/counseling on FP use and referral to a nearby facility. • Conduct three postnatal home visits for the mother and baby on the first, third, and seventh day post-delivery along with educating/counseling on the importance of FP use.
National Ebola Recovery Strategy for Sierra Leone, 2015–2017 (GOSL, 2015)	This strategy served as a plan for rebuilding Sierra Leone by addressing the challenges encountered from the Ebola epidemic. This strategy was rolled out in two phases: The Early Recovery (six to nine months), July 25, 2015–April 2016 (Dalan Development Consultants & Forcier Consulting, 2016) and *The President's Recovery Priorities* (Phase 2), June 1, 2016–July 2017 (GOSL, 2016b). Overall, this strategy aimed to increase FP visits by at least 90 percent. The Early Recovery Phase focused on restoring basic health services through the expansion of the Free Health Care Initiative and the provision of reproductive, maternal, newborn, and child health (RMNCH) services. *The President's Recovery Priorities* had two specific key result areas that aimed to improve reproductive health outcomes through health and governance initiatives. These included the following: • Strengthening human resources for health • Increasing the capacity of CHWs • Reducing teenage pregnancy by increasing access to and availability of sexual and reproductive health services for adolescents • Improving service delivery through the prevention of stockouts of essential RMNCH commodities

Policy/Strategy Document	Summary of Relevant FP/RH Components
Health Sector Recovery Plan (HSRP), 2015–2020 (MOHS, 2015b)	Sierra Leone's health sector was greatly affected by the recent Ebola outbreak. Therefore, this plan was developed as a response to restore and rebuild the country's health system. In this plan's first implementation phase, "Getting to Zero and Transition Phase," one of the priorities is to restore critical elements of the Basic Package of Essential Health Services (BPEHS). This plan strives to achieve this priority by restoring RMNCH services, strengthening maternal and adolescent health, and addressing efforts to improve neonatal health and teenage pregnancy.
Reproductive and Child Health Strategic Plan, 2008– 2010 (MOHS, 2008)	This strategic plan was the predecessor document to the RNCH Policy and Strategy. The plan sought to reduce mortality rates among mothers, children under age five, and infants by 30 percent by 2010. In order to accomplish this, there was a push to strengthen the health system and ensure the provision of comprehensive and good-quality reproductive and child health services.
Reproductive, Newborn and Child Health (RNCH) Policy, 2011 (MOHS, 2011)	This policy seeks to improve reproductive, newborn, and child health and reduce inequalities experienced by mothers and children. Key reproductive health-related areas of action within the RNCH Policy include the commitment of the Government of Sierra Leone (GOSL) to providing comprehensive SRH services geared toward adolescents and young people, and increasing use of FP services.

Reproductive, Newborn, and Child Health Strategy, 2011–2015 (MOHS, 2011)	This strategy served as an implementation guide for the RNCH Policy. The following describes how the RH-related areas in the policy were to be operationalized:
	• Provide comprehensive, adolescent-friendly SRH services
	  ○ Implement the Adolescent and Young People's Health and Development Strategic Plan
	  ○ Deliver adolescent- and youth-friendly health services (AYFHS)
	  ○ Sensitize the community on RH issues focused on adolescents
	  ○ Further research on adolescent and young people's health issues
	• Reduce the number of unwanted pregnancies among women of reproductive age
	  ○ Have a range of contraceptive methods at facilities and communities to ensure availability, access, and use of FP services
	  ○ Accompany availability of FP methods with effective counseling
	  ○ Integrate FP with services for reproductive and maternal health and AYFHS

Policy/Strategy Document	Summary of Relevant FP/RH Components
Reproductive, Maternal, Newborn, and Child and Adolescent Health (RMNCAH) Strategy, 2017–2021 (MOHS, 2017)	The primary goal of the RMNCAH strategy is "accelerating reduction of preventable deaths of women, children, and adolescents in ensuring their health and wellbeing." To accomplish this goal, four strategic objectives have been outlined as follows: • Strengthened health systems for effective provision of RMNCAH services • Improved quality of RMNCAH services at all levels of service delivery • Strengthened community systems for effective delivery of RMNCAH services • Enhanced research, monitoring, and evaluation for effective delivery of RMNCAH services
Draft National Strategy for the Reduction of Adolescent Pregnancy and Child Marriage, 2018–2022	This strategy is an update to the National Strategy for the Reduction of Teenage Pregnancy, 2013–2015 (GOSL, 2013). The strategy's goal is to reduce the adolescent fertility rate to 74 per 1000 and child marriage to 25 percent by 2022 The strategy objectives are to: • Improve the policy and legal environment for the protection of adolescents and young people and to improve the capacity of implementing agencies to implement laws, policies, and protocols affecting adolescents • Ensure that a minimum package of adolescent- and young people-friendly healthcare services is provided in PHUs (including outreach services), hospitals and schools, including learning centres, in line with existing guidance and protocols. • Ensure that all adolescents (boys and girls) have access to comprehensive sexuality education and that the learning environment is enabling for adolescent girls and boys to thrive • Increase demand for adolescent- (boys and girls) and young people-friendly services • Engage with communities and empower them so that they take individual and collective responsibility for the reduction of adolescent pregnancy and child marriage. • Ensure that the strategy's activities are well coordinated, monitored, and evaluated, and that evidence is generated and used to inform decision making
National Strategic Plan on HIV/AIDS, 2016–2020 (National HIV/AIDS Secretariat, 2015)	This plan emphasizes the integration of services for HIV/AIDS, sexual and reproductive health (SRH), and youth-friendly reproductive health to ensure access and use. Additionally, a priority has been made to provide access to SRH education for adolescents.

Policy/Strategy Document	Summary of Relevant FP/RH Components
The Agenda for Prosperity: Road to Middle Income Status: Sierra Leone's Third Generation Poverty Reduction Strategy Paper (2013–2018) (GOSL, n.d.c)	The strategy serves as a guide to achieving the vision of developing Sierra Leone into a middle-income country by 2035. The primary focus is to address the country's social and economic development. Among its priorities, this strategy strives to ensure universal access to FP, to promote the importance of FP practices to stakeholders, and to increase investments in FP and overall population health.
Second Poverty Reduction Strategy, 2008–2012 (GOSL, n.d.b)	Sierra Leone has high rates of mortality and morbidity among mothers and children. In order to address this, a key strategic priority is to have an integrated service delivery approach. This consists of FP for adults and adolescents to address teenage pregnancies and child marriage, along with essential and emergency obstetric care.
National Health Policy, 2002 (MOHS, 2002)	The National Health Policy acknowledges that the country is experiencing poor reproductive health, specifically with regard to maternal and neonatal mortality. To address this, the government is responsible for ensuring clear and updated guidelines for service delivery at all health care levels. Services relevant to SRH consist of FP, STIs, antenatal care, and routine delivery services.
National Health Promotion Strategy, 2017–2021 (MOHS, Health Education Division, 2016)	This strategy brings health promotion to the forefront of the country's efforts in moving forward from the Ebola epidemic. Additionally, the following key health priorities have been outlined in this strategy: a communication plan in preparation for emergencies, improving human resources for health, capacity building, and strengthening M&E systems. The MOHS Health Education Division (HED) will be spearheading the efforts to achieve these priorities. This strategy also aligns with the MOHS's 10- to 24-Month Recovery Plan for Health, which prioritizes improved human resources for health in order to have better outcomes for reproductive, maternal, newborn, and child health (RMNCH).
Human Resources for Health Policy, 2012 (GOSL, 2012)	This was an update to the *Human Resources for Health Policy, 2006* (GOSL, 2006). It serves to provide a framework for building and strengthening the capacity of human resources for high quality and efficient healthcare delivery. An emphasis is placed on the following policy areas: • Establishing leadership and governance • Promoting training and continuing education • Improving management of the health workforce • Enhancing the collection, storage, and utilization of data • Strengthening partnerships among relevant stakeholders and development partners

Policy/Strategy Document	Summary of Relevant FP/RH Components
Draft Sierra Leone National Human Resources for Health Strategic Plan, 2017–2021 (GOSL, 2016a)	This is an update to the *Human Resources for Health Strategic Plan, 2012–2016* (GOSL, n.d.a). This plan serves as a guide to accomplish the goals and objectives set forth by the revised *Human Resources for Health Policy, 2017–2021*. Through the application of multisector and sector-wide approaches, this plan aims to build and maintain a resilient health workforce to ensure equitable, affordable, and high-quality healthcare service delivery.

However, despite the clear commitment to FP in the government's policies and strategies, there are a number of gaps in the policy environment that have led to uncertainty, resulting in negative impacts to program implementation.

While there are no policies or guidelines that ban the distribution of FP commodities to adolescents, there is no specific affirmative law or policy that supports youth accessing FP services without authorization from a parent, spouse, or provider. This type of definitive legal stance would provide the necessary grounding from which social and behavior change programs can counteract social and traditional norms and customs that may restrict young people's ability to access FP services. Without an affirmative law, healthcare providers may be uncertain as to the legal or policy status of provision of FP to adolescents under the age of 18. In addition, there is a lack of clear guidance on FP service delivery in schools—this policy should include the dispensing of FP commodities, in addition to the full range of services needed by in-school youth, including counseling and referrals.

There also need to be clear ministry guidelines on the rotation and training of health staff. The Sierra Leone *National Human Resources for Health Strategic Plan, 2017–2021*, currently under development, needs to have a clear policy on how staff will be rotated to ensure that FP and other specialist services are not negatively affected—particularly to ensure that lower-level facilities are not left without at least one provider trained in FP services. In addition, there are a lack of policy guidelines requiring that staff posted to adolescent health units must be trained in how to deliver adolescent- and youth-friendly services, as well as FP services. Without such a policy, staff may not be able to deliver the complete package of services that are needed by youth.

As detailed in Table 5, the *National Community Health Worker Policy*, *2016–2020*, has been developed, and the country is planning to formally engage 15,000 CHWs. Within this policy, the role of CHWs is to identify pregnant women early as well as children and women of childbearing age who are eligible for RMNCH 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 various countries has shown that trained CHWs can safely provide pills (including the first dose) and injectable contraceptives (Stanback et al., 2007; Stanback et al., 2010; Prata et al., 2011; Chin-Quee et al., 2013). 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 that are under-served by the current health infrastructure.

The Pharmacy Board is responsible for the regulation of pharmaceutical products. Presently it does so for the private sector, but it does not oversee the public sector. This means that

procurements for the public sector (which are done mostly by United Nations [UN] agencies and NGOs) are not checked when they are in Sierra Leone to ensure that they meet the quality standards set by the country.

While the policy environment is generally supportive of FP, politicians have been identified as a group that needs additional education and outreach in order to cultivate them as champions (HP+, 2016a).

Currently, the National Health Insurance scheme to be launched in 2018 assumes that development partners will continue to fund FP. However, various partners have noted that funding for FP is flat to declining, and that Sierra Leone should expect a reduction in funding in the next five years (this is on top of the 2016 reduction in commodity procurement financing from UNFPA, which has resulted in fewer commodities than needed in the country and regular stockouts) (HP+, 2016a).

The work of the government Health Financing Unit within MOHS in developing the national health accounts is crucial to planning for FP and other health sector planning in Sierra Leone. Yet, the Health Financing Unit has limited power to collect information. The government implementing partners (IPs), usually NGOs, are not mandated to provide information and coordination with the Service Level Agreement team, and thus the health financing information in the country is usually incomplete (HP+, 2016a).

In addition, legal and cultural issues negatively affect the measures to reduce teenage pregnancy, and these have not yet been effectively addressed. The GOSL legislation states that the minimum age for marriage is 18 but that it can be younger with parental consent (Denney et al., 2015). This provides a major loophole, as the Sexual Offences Act (2012) stipulates that it is illegal to have sexual relations with anyone under the age of 18. There is, therefore, a major disconnect between the formal law and the customary law. Under customary law, an adult is not defined by age but by social and customary ceremonies. Thus, girls as young as nine years old can be considered ready for marriage after cultural rituals (Denney et al., 2015). Moreover, the formal law is not consistently implemented or enforced. The Sierra Leonean Police are expected to implement formal laws; however, they are under-resourced, and the wider community norms do not provide a favorable social environment to enforce these laws. Most cases are sorted out of court, with the police merely acting as mediators. In most cases, girls who become pregnant end up being married, regardless of their age, because there is high stigmatization of pregnancy outside of marriage.

Financing

In 2012, at the London Summit on Family Planning, Sierra Leone pledged to increase the current annual health budget from 8 percent to 12 percent by 2013 and to gradually increase it until the 2001 Abuja Declaration commitment to allocate at least 15 percent of national budgets to the health sector is achieved (WHO Africa, n.d.).However, the GOSL's expenditures on health remain low; in 2017, the health sector was budgeted to receive only 6.1 percent of the non-salary, non-interest recurrent expenditures from the government.

Despite the need for improved healthcare delivery as outlined in the President's Recovery Plan, the 2017 government budget for health is also lower than budgets in previous recent years. The allocation as a percentage of the national budget declined from 7.8 percent in 2014, decreasing to 4.8 percent in 2015, before rising again in 2016 and again dropping to the current 6.1 percent in the 2017 budget. Nonetheless, there has been an increasing budgetary allocation in nominal value over the years, with the exception of 2015 (Table 6).

Table 6: National and health budgets, in millions of Sierra Leone leones[4]

	2014 Budget	2015 Budget	2016 Budget	2017 Budget
Total recurrent expenditure (including wages and salaries) and non-salary, non-interest recurrent expenditure	3,529,370	3,874,8775	4,292,566	5,587,137
Total recurrent expenditure (including wages and salaries)	2,615,014	2,841,864[6]	3,121,428	3,970,675
Non-salary, non-interest recurrent expenditure	914,356	1,033,013[7]	1,171,138	1,616,462
National budget (general services)	202,878.0	205,078.9[8]	262,184.7	498,076.4
MOHS budget	71,313.9	52,006.6[9]	91,855.8	94,936.9
Total share for health, as % of total non-salary, non-interest recurrent expenditure	7.8%	4.8%[10]	7.7%	6.1%

The process for budget development in Sierra Leone is that the MOFED sets budget ceilings, including for health and for the current reproductive health/FP line item in the MOHS budget. The MOHS then directs departments to plan and budget for their respective sectors. The cabinet approves the budgets and the parliament finally appropriates the budget for implementation (HP+, 2016a).

The GOSL provides funding for the salary of staff delivering FP services and provides the infrastructure for service delivery. However, there is currently no budget line item in the MOHS budget for the FP program, much less for FP contraceptive procurement. There is only a broader budget line for reproductive health/FP, which has been set by a budget ceiling that can only be adjusted by the MOFED. As a result, overall funding for FP programming is not commensurate with the need. Thus, more domestic funding support is needed. Lack of funds at the subregional level for FP programming also remains a huge challenge; even raising funds to pick up commodities from the regions to transport to the districts and health facilities is often a struggle (HP+, 2016a).

---

4 2013 to 2017 data: Ministry of Finance and Economic Development. Government of Sierra Leone–Budget Profiles: 2013-2017; 2014-2018; 2015-2019; 2016-2020; 2017-2021. Available at: http://mofed.gov.sl/annualbudgetrep.htm.

5 Figure with gap is presented; without gap: 3,392,005

6 Figure with gap is presented; without gap: 2,600,428

7 Figure with gap is presented; without gap: 791,577

8 Figure with gap is presented; without gap: 151,717.1

9 Figure with gap is presented; without gap: 32,063.3

10 Figure with gap is presented; without gap: 3.0%

Table 7: Reproductive health/family planning budgets, in millions of Sierra Leone leones[11]

	2014	2015	2016	2017
MOHS budget	71,313.9	52,006.6[12]	91,855.8	94,936.9
Reproductive health/family planning (under Reproductive and Child Health Care Services budget)	336.0	412.6[13]	459.4	459.4
Total share for reproductive health/family planning, as % of the health budget	0.47%	0.79%	0.5%	0.48%

Sierra Leone's FP program is highly dependent on donor support. All commodities are currently procured through donor funds (HP+, 2016a). The main financing source for FP commodities in Sierra Leone is UNFPA ("RHInterchange," n.d.); however, in 2016, funding was significantly reduced from the prior years' average of approximately US$1.4 million to approximately US$950,000, in alignment with UNFPA's funding reductions across the globe in 2016. In 2016, UNFPA estimated a US$750 million global funding gap for 2016–2020 just to maintain current activities, due to European donors such as Denmark and Finland making significant funding cuts to the agency (Glassman, 2016).

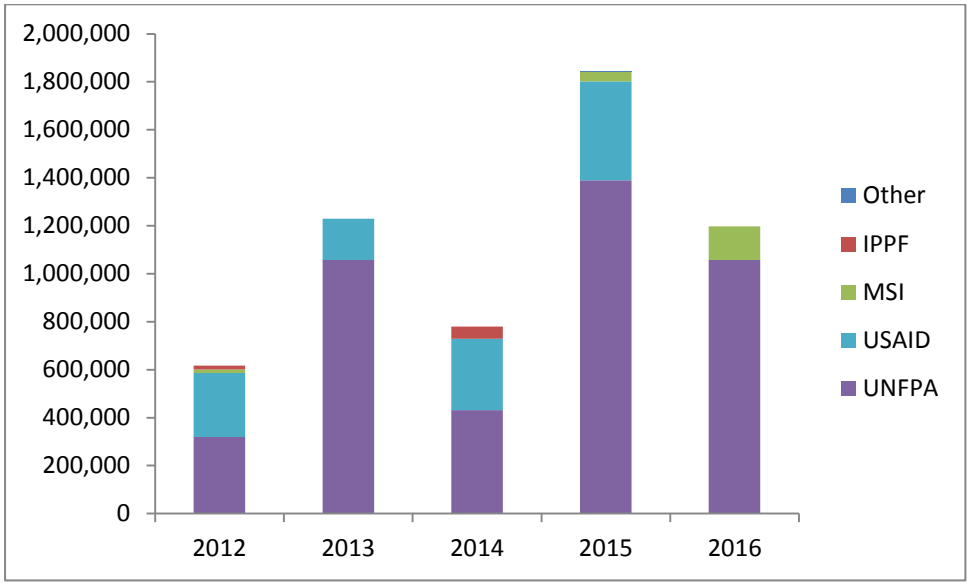
Donor fatigue has been identified as a huge threat to achieving FP goals, especially if there is not a considerable improvement in GOSL contributions (HP+, 2016a). Funding for commodities is a significant and continuing challenge, and indefinite commitments from government and donors on the procurement of contraceptives have created funding gaps and an inadequate supply of commodities, resulting in rationing and stockouts across virtually all facility levels (HP+, 2016a). Thus, the financing of contraceptives, services, and operations remains a challenge in the medium to long term.

[11] 2013 to 2017 data: Ministry of Finance and Economic Development. Government of Sierra Leone–Budget Profiles: 2013-2017; 2014-2018; 2015-2019; 2016-2020; 2017-2021. Available at: http://mofed.gov.sl/annualbudgetrep.htm.

[12] Figure with gap is presented; without gap: 32,063.3

[13] Figure with gap is presented; without gap: 254.4

Figure 15: Value of family planning commodity shipments, 2012–2016, in USD ("RHInterchange," n.d.)



In addition, many women, men, and adolescents cannot afford to access FP. While FP is currently included in free healthcare services, providers often ask for payment, and many people cannot afford to pay to travel to seek services (HP+, 2016a).A remaining uncertainty is if all methods of FP will be covered under the planned health insurance scheme, which is to cover both the formal and informal sectors (HP+, 2016a). In addition, there are questions about how adolescents will be able to access FP since the currently planned structure for health insurance scheme will require payment for everyone at and above the age of 15.

Stewardship, Accountability, and Management

According to the *National Health Sector Strategic Plan* (NHSSP), leadership and governance are one of the pillars of Sierra Leone's health system (MOHS, 2009). The MOHS serves as the main governing body of the health sector. The responsibilities of the MOHS include developing and establishing policies, standards, and regulations; strengthening current networks and expanding collaborations across all stakeholders; overseeing resource mobilization; and coordinating efforts of the health workforce at each level in the country's service delivery scheme. At the national level, the MOHS chairs the Health Sector Coordinating Committee, which is the primary decision maker in the health sector (WHO Africa, n.d.). At the district level, the DHMT is in charge of coordinating, planning, implementing, and conducting M&E of health services (GOSL, 2009). The DHMT operates under the leadership and guidance of the district medical officer (DMO).

In addition to this leadership framework, the MOHS developed a *Results and Accountability Framework (2010–2015)* (GOSL, 2012b) for the implementation of the NHSSP. This strategy emphasizes accountability through the collection of data and monitoring the status of implementation and overall performance of the NHSSP (GOSL, 2012). The data collected are intended to be used in decisions to improve the health sector and as a gauge for how these improvements are progressing. The *National Health Compact* (GOSL, 2011) also upholds accountability by defining the roles and responsibilities of the GOSL and all stakeholders involved with implementing the NHSSP (GOSL, 2011; MOHS, 2015b).

Although each of the aforementioned policies and strategies provide a general framework that addresses aspects of stewardship, accountability, and management, it is important to acknowledge that gaps still exist within Sierra Leone's FP context. The poor financing situation for

health in general, and for reproductive health and FP services, specifically, does not promote an enabling environment for the full implementation of the health management system.

Systems for M&E need to be improved as well (HP+, 2016a). Even though a *Results and Accountability Framework* was developed by the MOHS, there are still questions that arise when considering the national M&E framework for health. These concerns focus on the quality of data that are collected for all health indicators, including FP, and the implementation of a monitoring system.

Other areas of weakness are related to the management and supervision of FP service delivery. Although health facilities that provide FP services and commodities exist, there are instances in which service delivery is carried out in poorly structured facilities and clients receive poor quality of services (HP+, 2016a). Gaps are also present in the current management and supervision of the healthcare workforce. In order to address this weakness, the NHSSP has recognized that health staff—specifically, senior health managers at national and district levels—should undergo training to build their leadership and management skills (GOSL, 2009). Additionally, a management system to evaluate health staff based on performance reviews and contribute to their overall improvement needs to be established.

COSTED IMPLEMENTATION PLAN

The SLFPCIP was developed to provide a clear roadmap to achieving the commitments made by the GOSL to increase FP and ensure the rights of Sierra Leoneans to determine and act on their reproductive goals. The SLFPCIP defines the country vision, goal, strategic priorities, interventions, and required inputs, and provides an estimate of cost of achieving them. In order to ensure that resources are mobilized and directed towards the highest impact interventions, the SLFPCIP 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 CPR and reducing unmet need by 2022.

The SLFPCIP aligns with broader development and health objectives; including the country's poverty reduction strategy paper, *Agenda for Prosperity*, which highlights reduced fertility through access to FP as a key means of poverty reduction. The SLFPCIP also contributes to related health sector plans including strategic plans for Ebola recovery, human resources for health, and reduction of teenage pregnancy. Specifically, the SLFPCIP provides the detailed interventions and associated costs of allowing Sierra Leonean women to achieve their human rights to health, education, autonomy, and personal decision making about the number and timing of their childbirths, and to support the achievement of gender equality. More broadly, voluntary FP reduces preventable maternal mortality and morbidity, decreases unwanted teenage pregnancies, improves child health, facilitates educational advances, reduces poverty, and is a foundational element for the economic development of the nation.

CIP Operational Objectives

The goal of the SLFPCIP is to increase the modern contraceptive prevalence rate (mCPR) among all women of reproductive age from 23.0 percent in 2017 to 33.7 percent by 2022.

To facilitate the monitoring of the plan's success, the national objectives for 2022 have been translated into yearly progress objectives for CPR and mCPR (Table 8).

The overall annual growth rate needed for Sierra Leone to increase its mCPR from 23.0 percent (all women) in 2017 to 33.7 percent (married women) in 2022 is 2.1 percent a year, on average, for modern CPR and a 2.0 percent growth in total CPR per year.

Table 8: Objectives for CPR and mCPR growth among all women of reproductive age, by year

	2017	2018	2019	2020	2021	2022
Yearly objectives – all methods (CPR)	24.2%	26.2%	28.2%	30.3%	32.3%	34.3%
Yearly objectives – modern methods (mCPR)	23.0%	25.1%	27.3%	29.4%	31.6%	33.7%

To achieve the desired scenario, Sierra Leone must increase from 445,074 users of modern contraception in 2017 to 742,719 by 2022. This translates to an addition of nearly 60,000 users each year between 2018 and 2022; this is over 200,000 more than would be needed if the mCPR rate remained at the current rate of 23 per cent.

Thematic Areas

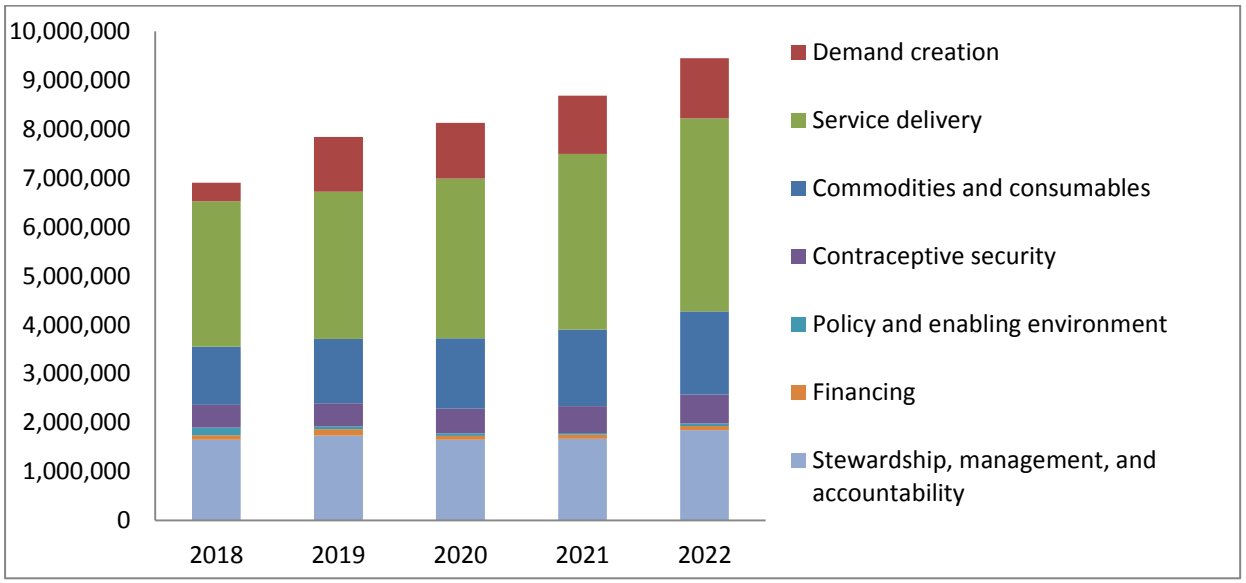
The SLFPCIP is structured around six main thematic areas:

1. Demand creation (DC)
2. Service delivery (SD)
3. Contraceptive security (CS)
4. Policy and enabling environment (PEE)
5. Financing (F)
6. Stewardship, management, and accountability (SMA)

Across the six thematic areas, there are a total of 29 strategic results for implementing a full FP strategy in Sierra Leone. Each area is further detailed by activities, subactivities, inputs, output indicators, and timeline information (see Annex A). Many of the strategic results listed in the framework map to strategic priorities.

The total cost of implementing the SLFPCIP is US$41.0 million (307.4 billion Sierra Leonean leones). The largest driver of the overall plan costs are activities to improve service delivery, which require US$16.8 million, or 41 percent of the total costs of the plan. This is followed by the cost of contraceptive commodities and consumables, accounting for US$7.2 million, or 17 percent of the overall costs. Another 12 percent of the costs is in demand creation, 6 percent in programming for contraceptive security, 1 percent in policy and the enabling environment, 1 percent in financing, and 2 percent in stewardship, management, and accountability (Figure 16).

Figure 16: Costs by thematic area and contraceptive costs, in USD



Strategic Priorities

The strategic priorities identified below are the critical issues and/or interventions that must be addressed in order for Sierra Leone to meet its FP objectives. These priorities were developed through consultative meetings with government and stakeholders and are based on data on current performance and service gaps. The strategic priorities came from the FP Goals modeling work, where the impact of scaling up key interventions were modeled based on achievement of

steady versus significant progress. Interventions that clearly contributed to increases in contraceptive use were prioritized to include the "significant" level of progress, while other interventions were allocated to the "steady" level of progress category owing to their lower impact or other considerations. Three interventions were highlighted. Based on these results, the CIP task force identified three strategic priorities, which will jointly contribute more than 75 percent of the increase in mCPR (Track 20, n.d.):

Strategic Priority #1 (SP1): Postpartum FP (51.5% of growth)

Strategic Priority #2 (SP2): Stockout reductions (27.3% of growth)

Strategic Priority #3 (SP3): LARC via Peripheral Health Units (PHUs) (3.4% of growth) (with focus on implant scale-up)

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)

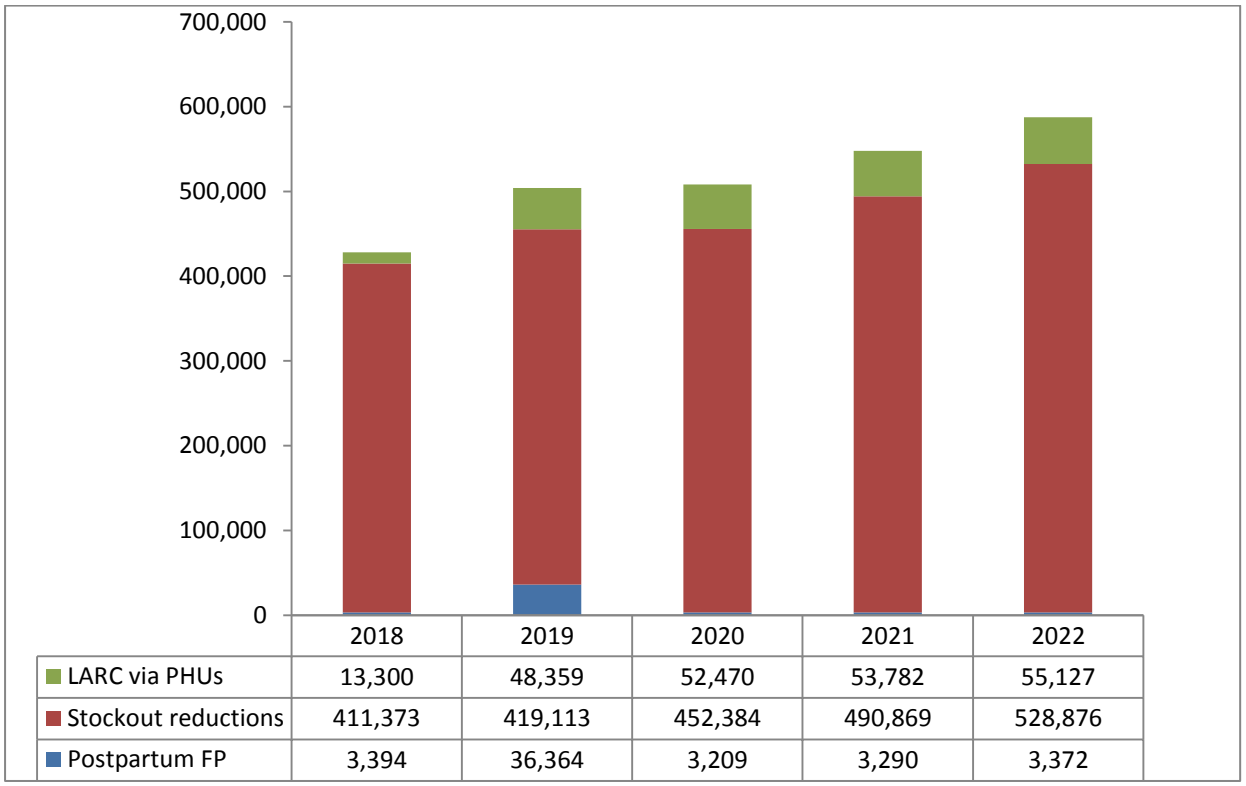
Table 9: Modeled scale-up for each intervention using FP Goals

Thematic Area	Intervention	Baseline	Scale-up	Level of priority
Service delivery	Postpartum (PP) FP	4% of women using PPFP	50% of pregnant women reached by CHWs, 50% of facilities offering immediate PPFP services	✓ Prioritize because high impact
Contraceptive security	Stockout reductions	Persistently high stockouts	50% reduction in stockouts	✓ Prioritize because high impact
Service delivery	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	✓ Implants: already rolled out trainings, should continue to meet high demand for implants IUDs: demand for IUDS remains lower, so do not want to invest in training providers who will not have clients wanting the service
Service delivery	Public sector mobile outreach	PHUs conducting some mobile outreach, FP coverage is low	2 outreach visits per month per PHU providing FP services (no LARC)	PHU outreach should be prioritized to focus on high-impact areas, full scale-up may not be needed everywhere
Demand creation	CHWs	CHWs doing some FP outreach, but coverage is low and quality varies.	Half of CHWs trained/supported to provide women with FP information and services	Given lower impact, it may be best to focus outreach to those areas where information is most needed (e.g., rural, under-served, low demand)
Policy and enabling environment	Adolescent interventions	35,000 young people reached through various interventions (5%) Assume no in-school comprehensive SRH education	20% coverage of comprehensive youth engagement + YFS (Pillar 2 + Pillar 5) Half of all schools provide comprehensive SRH education (Pillar 3)	Coordinate with Strategy for Reduction of Adolescent Pregnancy and Child Marriage
Service delivery	Private sector	Private pharmacies, clinics, and mobile outreach providing FP services	Increase provision of FP via private facilities	Impact may be limited due to # facilities and range of methods offered at pharmacies

Focusing on these priorities will ensure that limited available resources are directed to areas that have the highest potential to increase the CPR and reduce the unmet need for FP in Sierra Leone. In the case of a funding gap between resources required and those available, the priority activities should be given precedence to ensure maximum impact and progress towards achieving the plan's objectives—especially priorities #1 (PPFP) and #2 (stockout reductions), which collectively are estimated to drive more than two-thirds of the growth in contraceptive prevalence. Additionally, having priority activities identified enables the RHFPP to focus resources and time on effectively coordinating and leading execution of the SLFPCIP. Each priority activity is highlighted in the implementation framework in Annex A with a red star.

Taken alone, the strategic priorities do not reflect all of the components necessary for a comprehensive FP program (all those that support, complement, and complete the FP program). However, the strategic priorities highlighted here have been costed to help guide national priorities for additional and new funding and program development (Figure 17).[14]

Figure 17: Strategic priority costs by year, in USD



	2018	2019	2020	2021	2022
LARC via PHUs	13,300	48,359	52,470	53,782	55,127
Stockout reductions	411,373	419,113	452,384	490,869	528,876
Postpartum FP	3,394	36,364	3,209	3,290	3,372

[14] Although postpartum FP is projected to be the greatest contributor to the goal of an increase in mCPR, the direct and specific costs are low, as postpartum FP interventions are cross-cutting and integrated into the major results in various thematic areas, namely demand creation and service delivery. More specifically, demand creation for postpartum FP is a critical component of the integrated SBCC strategy. In addition, a significant intervention of training and supporting healthcare workers to integrate postpartum FP counseling and service delivery is included under general health worker training costs in pre-service and in-service trainings, as the postpartum emphasis is integrated into the standard training curricula. Thus, the only major direct cost is for updating the curricula and training the trainers to deliver the updated curricula.

Details on the Thematic Areas

Demand Creation

Strategy

Overall, knowledge about FP services and methods among women and men in Sierra Leone is quite high. The 2013 DHS reported that about 95 percent of all women and 96 percent of all men knew at least one contraceptive method (SSL and ICF International, 2014a). Despite high knowledge, the demand for FP is still relatively low, further contributing to the country's high fertility rate. Several important bottlenecks play a role in widening the gap between FP knowledge and demand. Nationally, Sierra Leone does not have a FP campaign that emphasizes a consistent message. This affects the overall quality and validity of information shared at the community level. In addition, it affects the efforts to dispel myths and misconceptions about FP. This issue regarding inconsistent messages also has an effect on the perceptions that youth have about FP. In many cases, adolescents who chose to use a contraceptive method face stigmatization from healthcare providers, other community members, and even their families (HP+, 2016c).

In order to address these bottlenecks, several activities have been proposed. The fact that there is no nationwide FP campaign calls for initial efforts to work toward the development and implementation of a targeted and evidence-based social and behavior change communication (SBCC) strategy. This strategy will address all audiences, including, but not limited to, postpartum women, women of reproductive age (20–24 years), married adolescents, men, religious leaders, parents, teachers, healthcare providers, youth, and the physically challenged. Particular attention will be paid to creating messages to encourage women who are expecting a baby to use postpartum FP. The strategy will also focus on creating an enabling environment for postpartum FP among women's families, communities, and healthcare workers, as that is a particular strategic priority that will contribute significantly to Sierra Leone's mCPR increase.

The formative research conducted prior to the development stage will examine past SBCC initiatives or activities; successful interventions; lessons learned from unsuccessful interventions; the status of current FP messages; and barriers that affect FP uptake. It will also outline the knowledge, attitudes, and practices of the audience so that the campaign addresses the actual needs of the target population (Bongaarts et al., 2012). Using the developed SBCC Strategy, the MOHS Health Promotion Unit, along with support from a media production firm, will work collaboratively to develop a mass media campaign. The development process for this campaign is designed to integrate several stakeholder consultations at the regional level and within Freetown. The purpose of these sessions is to gather feedback from stakeholders to inform and further revise the FP messages and materials. Additionally, stakeholders who are FP rights advocates and community representatives for groups such as youth and adolescents will also be involved to ensure that the created FP messages are rights-based. Successful SBCC campaigns can result in increased demand, open acceptance of FP in the home, increased knowledge and access to FP services, and advocacy among users of FP methods (EngenderHealth, 2003).

As the SBCC Strategy and the national FP mass media campaign are being implemented, additional efforts to increase demand will focus on the following initiatives. First, community-level communication about FP will be increased by strengthening the CHW program and building the capacity of community-based, faith-based, and civil society organizations. Materials and job aids for the CHW program will undergo a review and revision process. Using the revised materials, RHFPP staff will train and provide supportive supervision for the CHWs. As for the various organizations, staff from the RHFPP and implementing partners will equip them with communication materials on FP and rights. There will also be continuous mentorship and

assistance provided on new areas of need or advocacy-related opportunities. Social media will be used to further improve access to correct and rights-based information about FP. A platform on popular social media sites in Sierra Leone and discussion forums will be created that are led and monitored by FP experts from implementing partner organizations and the government. Multiple outlets—including mass media, IEC materials, interpersonal communications, advocacy campaigns, and champions—will increase demand and uptake of contraceptive methods and services (EngenderHealth, 2003).

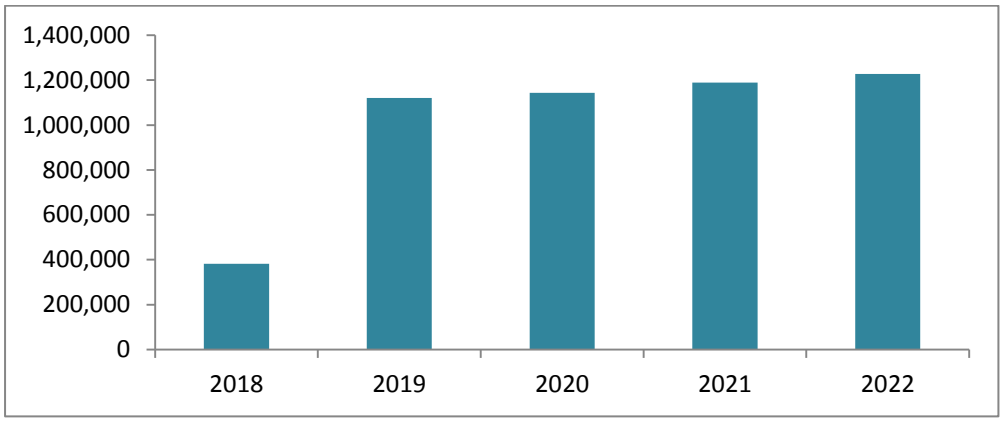
Strategic Results

- **DC 1. Acceptability and support for FP among potential users and gatekeepers are increased.** Evidence and data from formative research will inform the development of an SBCC strategy. The strategy will be shared through three regional meetings and one Freetown-based dissemination meeting. Implementation of the strategy will be spearheaded by a lead communication officer. This SBCC strategy will serve as the foundation to develop a national mass media FP campaign, which will be a collaborative effort from the MOHS Health Promotion Unit and a media production firm. All created communication materials for the campaign will be disseminated through various media events aimed at promoting awareness and acceptability of FP methods and addressing common myths and misconceptions.
- **DC 2. Number and visibility of FP champions at national and community levels, including parliamentarians, religious leaders, chiefs, mammy queens, and other prominent leaders, are increased.** Key FP champions will be identified at the national, district, and community levels. These champions will be given training to develop an action plan for visibility, with a focus on postpartum FP, and they will receive additional support and monitoring of their work.
- **DC 3. Community-level communication through CHW outreach and facilitated community discussions is increased.** This includes efforts to promote postpartum FP; increase parent–child communication about SRH and FP; encourage men to become involved in FP, initiate discussions on FP, and accompany women to FP clinics; and discourage men's desire for large family size and unprotected sex. To increase community-level discussions about FP, efforts will be focused on strengthening key community members and institutions that are the primary sources for FP information sharing. An extensive review and revision of the CHW training and job aids for facilitated discussion will be conducted. Using the revised materials, RHFPP staff will train and provide supportive supervision to CHWs. Institutional capacity building and mentorship will also be conducted for community-based, faith-based, and civil society organizations. These identified organizations will work with RHFPP and implementing partner staff to ensure that FP and rights-based communications materials are available and accessible.
- **DC 4. Access to accurate and rights-based information on FP on various media channels is improved.** Popular social media sites used in Sierra Leone will be leveraged as platforms for disseminating tailored FP information and for conducting regular discussion forums. This will be aimed at creating demand for FP and addressing myths and misconceptions.

Costing Summary

As shown in Figure 18, the total cost for demand activities will be US$5,062,575 from 2018 through 2022.

Figure 18: Demand costs, in USD



Service Delivery

Strategy

Sierra Leone has established significant policies that create a rights-based enabling environment for the delivery of reproductive health and FP services. As noted in the RMNCAH Strategy, 2017–2021, the country has recognized and upheld that "access to quality RMNCAH services is a right" (MOHS, 2017). However, even with the establishment of various policies and strategies, several major barriers still exist that affect all aspects of service delivery; shortage of healthcare workers throughout the country; uneven geographical distribution of healthcare workers; and limitations in the skillset of healthcare workers and insufficient training, specifically with regards to FP service provision. Collectively, each of these barriers have limited, and even prevented people, especially women, girls, and adolescents, from gaining full access to needed, high-quality reproductive health and FP services and counseling.

Therefore, a comprehensive, multi-targeted strategy will be employed to address bottlenecks and improve FP service delivery in Sierra Leone. The first step will focus on improving the quality of rights-based FP information and services provided at health facilities. Since it is critical that all healthcare workers respect the reproductive health and FP rights of their clients, an attitudinal change campaign and accompanying training will be developed and rolled out to the DHMT staff in each district. Additional service delivery trainings will also be provided to public and private sector staff, including on the provision of LARCs and adolescent- and youth-friendly health services. Staff attending the trainings will be provided with the necessary materials and equipment and receive follow-up supportive supervision through job aids and mentorship. Service delivery guidelines, standards, and protocols will also be reviewed to ensure that FP rights approaches are included. At the facility level, initiatives will be instated to reduce the number of clients lost to follow-up and to continuously improve the quality of care through the use of data collected during the annual exit surveys. At the community level, representatives from all groups will be encouraged to participate and provide feedback in the annual review meetings for facility governance.

To ensure that FP services are more available and accessible, efforts will be made to integrate it with other health services such as antenatal care (ANC) visits, deworming and vitamin A

supplementation, six-week postpartum and subsequent child immunizations, HIV treatment, and cervical cancer screenings. Access to postpartum FP services will also be increased through ensuring that healthcare workers are trained and equipped to provide FP counseling at antenatal visits, and counseling and FP services at postpartum visits. Collaboration with the Nutrition Department and key implementing partners will also help to ensure that FP is integrated into latter well-child visits to ensure improved postpartum FP uptake. In addition, regular and consistent mobile outreach services will be provided for women of reproductive age who live more than five miles from a health facility.

There will also be activities that are aimed at bridging the gaps in the skills and training of healthcare workers on FP. Skills labs will be set up for health staff in training to continue building and strengthening their skillset in FP service delivery. Additionally, all health staff at the pre-service level will receive a certificate in FP service delivery and data collection post-training. This will be followed up by quality spot checks and provider supervision to make sure that the skills from training are correctly employed at the health service delivery points.

Direct costs will be supported to ensure that the required amount of health workers is present at facilities. Indirect costs will also be supported to ensure that human resources development, transport and telecommunication, infrastructure, the health management information system, and general program management costs are included.

Strategic Results

- **SD 1. Quality rights-based FP information and services are provided in health facilities.** An attitudinal behavior change campaign grounded in formative research will be developed to ensure that all health workers respect their clients' FP and RH rights. This campaign will be implemented through developing a training-of-trainers curriculum for DHMT staff at each district and the display of consistent FP messages on staff registers. Additional training on rights-based FP services and LARC will be provided for public and private sector health staff and reinforced through supportive supervision, accessible job aids, and mentorship. All standards, guidelines, protocols, trainings, and supervision materials related to FP service delivery will also be reviewed and validated to ensure that the information is updated and addresses client rights. Recognizing the health workforce shortage and limitations in providers' FP skillsets, efforts will be made to ensure the presence of a health worker trained in the provision of FP and adolescent-friendly health services at each government and private health facility. Action plans for client follow-up and annual exit surveys will be created and implemented to serve as feedback mechanisms to reduce clients lost to follow-up and to continue working towards improvements in the quality of care at facilities. Lastly, RHFPP staff will advocate for greater community engagement in service delivery governance through the participation of representatives for women, men, youth, people with disabilities, and other community groups.
- **SD 2. Uptake of postnatal FP services is increased.** The current FP trainings will be updated to include comprehensive counselling on FP during all ANC visits, and to provide FP services during postpartum visits, and all current FP trainers will be trained on the updated training guidelines, specifically that the provision and counseling of FP services is a component of the six-week postpartum visit and subsequent immunization visits. Training sessions will cover FP in ANC and postnatal visits. The Nutrition Department and key implementing partners will work collaboratively to identify opportunities for the integration of FP and nutrition into six-month well-child visits and its future scale-up.
- **SD 3. FP information and services are integrated with nutrition, immunization, HIV, and cervical cancer screening.** To ensure integration with nutrition, FP information and referral

services will continue to be available when parents access vitamin supplements and deworming services. Health workers will also be trained to provide FP services and counseling during the six-week postpartum and follow-up immunization visits. This will be supported by the joint supervision of the RHFPP and Expanded Programme on Immunizations (EPI) Department staff, along with a thorough review and revision of supervision and IEC materials. Integration of FP with HIV services will be spearheaded through supportive supervision by the RHFPP and National AIDS Control Programme (NACP) staff. Efforts to incorporate FP in cervical cancer screening will include revising the criteria for staff training on cervical cancer screening so that all staff who will be trained must have prior training on long-term FP methods.

- **SD 4. All women of reproductive age who live more than five miles from a health facility have access to a full range of modern contraceptive services.** Mobile outreach services that offer short- and long-term methods (including LARCs, but excluding sterilization) will be used to reach women residing in remote areas. A health facility mapping exercise will be conducted to determine locations for mobile outreach. A rotation schedule will also be developed to maintain regular service delivery in the selected areas.
- **SD 5. FP services are available from a wide range of sources to match the needs and economic situations of all people in Sierra Leone.** The private sector—including staff from pharmacies, private hospitals and clinics, and faith-based, institutional, and workplace clinics—will be encouraged to strengthen their engagement with FP service delivery through participation in the existing government training for health staff and their use of the data collection system. The ultimate goal for this initiative is to improve linkages between private and public sector providers and to increase the regulation of private sector service providers.
- **SD 6. Health workers are certified to provide comprehensive counseling and information on FP and to deliver all FP services appropriate to their cadre when they graduate.** FP certification will be integrated into the training of health workers at the preservice level. This certification will be primarily focused on service delivery and data collection; with the certification, health workers from all cadres will be able to provide short- and long-term FP methods by the time they graduate. Additionally, RHFPP, Ministry of Education, Science, and Technology (MEST), and nursing, medical, and midwifery colleges will incorporate skills labs into their training curriculum and will be able to provide the corresponding training materials to their students.
- **SD 7. Service delivery points are equipped with the necessary health workers and supplies to provide rights-based FP services.** All direct costs at the facility level and indirect costs of implementing the FP program will be fully supported to enable the provision of a full method mix of FP services (Table 10).

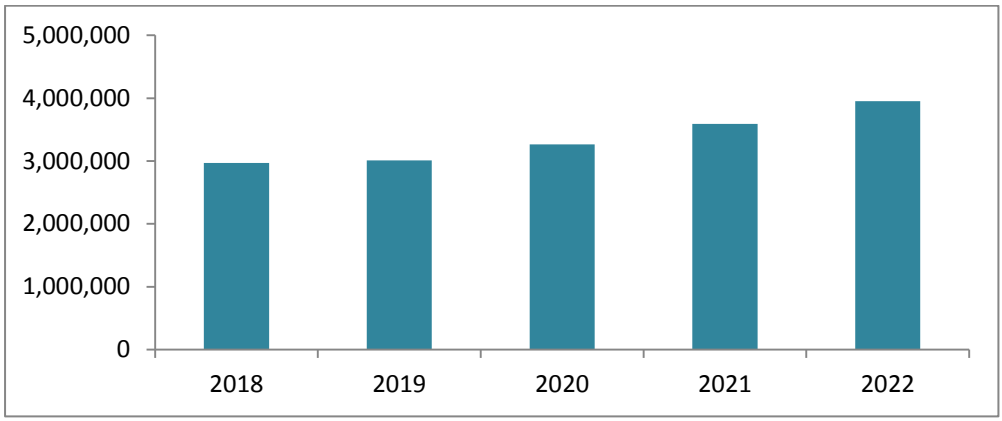
Table 10: Costs for Result SD7: Direct and indirect service delivery costs (excluding the cost of FP commodities and direct consumables)

	2018	2019	2020	2021	2022	Total
Direct costs	599,150	656,748	717,251	778,447	843,419	3,595,014
Indirect costs	1,672,520	1,831,229	1,997,935	2,166,414	2,345,377	10,013,475
TOTAL	2,271,669	2,487,977	2,715,186	2,944,861	3,188,795	13,608,489

Costing Summary

As shown in Figure 19, the total cost for service delivery activities will be US$16,783,295 from 2018 through 2022.

Figure 19: Service delivery costs, in USD



Contraceptive Security

Strategy

There are several key players that work together to ensure FP contraceptive security in Sierra Leone. Active stakeholder engagement can be seen through critical roles of the National RHCSWG, which is responsible for conducting the annual forecasting and procurement exercises; UNFPA, which is in charge of managing and providing the funds for procurement; and a number of other implementing partners who play various roles throughout forecasting, procurement, and distribution

It is important to recognize that there have been significant changes within the past year. In 2016, the National Pharmaceutical Procurement Unit (NPPU) disbanded as a result of operational issues following the rollout of the Free Healthcare Initiative. The reform process is currently underway and a new agency will be set up. In addition to the evolving management system for national pharmaceutical procurement, there are other existing barriers that affect the FP contraceptive security in the country. These include limited funding for commodity procurement, inaccurate and possibly outdated data used for forecasting and restock of commodities, supply chain coordination issues, and limited national monitoring and evaluation efforts for FP.

To address the current challenges facing FP contraceptive security, a number of activities will be implemented. Efforts will be made to improve governance, management, and coordination for procurement and logistics of FP supplies. RHFPP staff will be the main group responsible for answering inquiries about the NPPU reform and for strengthening the central level coordination with the NPPU caretaking team. In addition, the existing RHCSWG will be strengthened and a designated member within the group will be selected to participate in the Supply Chain Technical Working Group, once it is created. Along with improvements for governance, management, and coordination, emphasis will be placed on developing a risk management plan. The process of creating this plan will serve as a way to discuss and respond to ongoing risks for FP contraceptive security in the country.

Comprehensive forecasting, quantification, and procurement of FP commodities that match the national need will be conducted annually. RHFPP staff will be recruited to join this initiative with

the RHCSWG. Remote technical assistance and on-the-job mentorship will be provided to the RHFPP staff who will conduct the quantification and forecasting exercise to further build their capacity. Using the data from the quantification workshop, a procurement plan will be developed by the RHCSWG. Additionally, the RHCSWG will hold a quarterly meeting with the NPPU Caretaking Team and MOHS Directorates to reassess and strengthen national- and district-level quantification data. A gap analysis of the procurement plan will be conducted, and this will serve as the foundation for advocacy of commodity funding to the Reproductive Health Directorate.

In addition, all service delivery points will be provided with the necessary commodities and supplies to deliver rights-based FP services. To accomplish this, all indirect costs for the procurement and distribution of a full method mix of FP commodities and supplies will be supported.

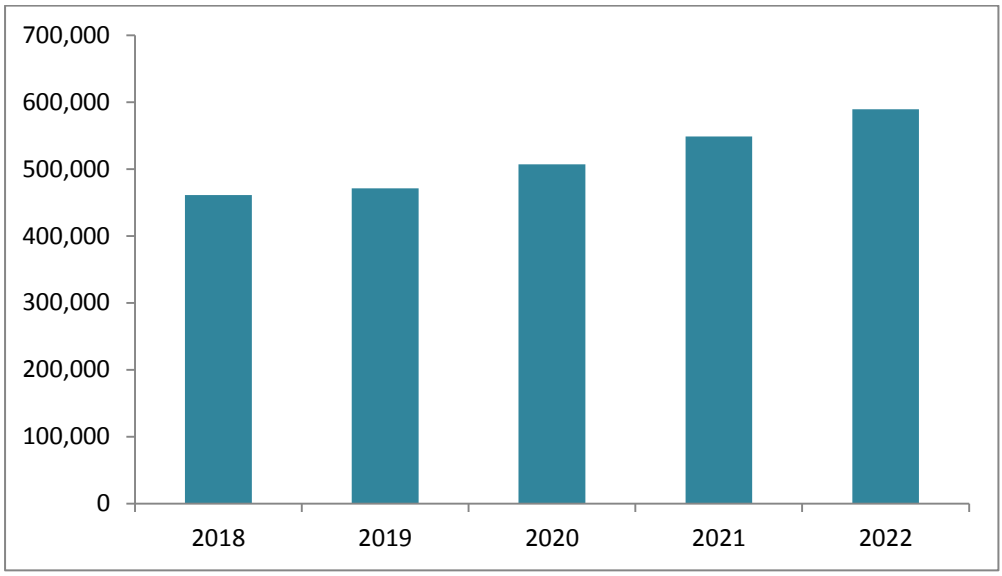
Strategic Results

- **CS 1. Governance, management, and coordination for procurement and logistics of FP supplies are improved.** While the NPPU reform is underway, involvement of RHFPP staff will be critical in establishing governance for procurement and logistics for FP supplies and strengthening the central-level coordination with the new agency. The RHCSWG will also need to be strengthened and a staff member will be involved and assigned to liaise with the Supply Chain Technical Working Group. A risk-management plan will be developed to help prevent as well as respond to issues that could impact contraceptive security.
- **CS 2. FP supplies are procured to match the national need.** Comprehensive forecasting, quantification, and procurement exercises will be conducted by the RHCSWG annually. National-and district-level quantification data will be strengthened through the implementation of M-Supply for pharmaceutical stock management and identification of other accurate and reliable data sources for quantification and forecasting. A gap analysis of the procurement plan will be conducted to use when advocating for commodity funding to the Reproductive Health Directorate.
- **CS 3. Service delivery points are equipped with the necessary commodities and supplies to provide rights-based FP services.** Full support will be provided for all indirect costs for FP commodity and supply procurement and distribution. The costs cover pre-shipment inspection, wastage, contraceptive procurement fees, clearing fees, freight charges, testing and oversight, insurance, distribution, and last-mile delivery costs.
- **CS 4. Emergency contraceptives are procured per the quantification and procurement plan.** As emergency contraception (EC) is not a component of the FP method mix, it will be procured per the annual quantification and procurement plans as a life-saving commodity.

Costing Summary

As shown in Figure 20, the total cost for contraceptive security activities will be US$2,577,340 from 2018 through 2022.

Figure 20: Contraceptive security costs, in USD



Policy and Enabling Environment

Strategy

Over the past decade, the GOSL has developed a number of interrelated policies and strategies that recognize the important role of FP in achieving national health and development goals. While the overall impact has been to create a positive environment for providing FP services, there are still policy gaps that lead to confusion, in addition to insufficient resources (human and financial) for the provision of FP information and services.

The SLFPCIP identifies five strategic results for policy development and advocacy. Results PEE1 and PEE2 have been identified by the GOSL as strategic priorities because of their focus on increasing demand for and accessibility of FP services for adolescents and youth. Achievement of these results will close critical loopholes in existing policies around youth access to FP by ensuring that all providers are aware of youth rights to FP and other SRH services, and ensuring that policies provide clear directives on the provision of FP information and services in the school setting at primary, secondary, and tertiary levels.

In additional to policy development, the RHFPP will work with stakeholders to conduct advocacy within the MOHS to update the staff rotation policy to ensure that each facility has at least one trained FP provider, conduct external advocacy across other government sectors to increase the visibility of FP as a development issue, and leverage support to ensure that all Sierra Leoneans have access to comprehensive FP information and services as part of the national health insurance scheme, which is currently under development.

Strategic Results

- **PEE 1. Adolescents and youth are able to act on their human rights, access FP services without facing discrimination, and are not turned away when unaccompanied by a parent or spouse.** RHFPP will create a directive to FP service providers affirming the rights of adolescents and young people to access FP services without authorization from a parent, spouse, or provider. Youth-serving organizations and service providers will provide input on the directive. In order to achieve this result, RHFPP will conduct advocacy to government officials to ensure they endorse and issue the directive. The targeted SBCC strategy

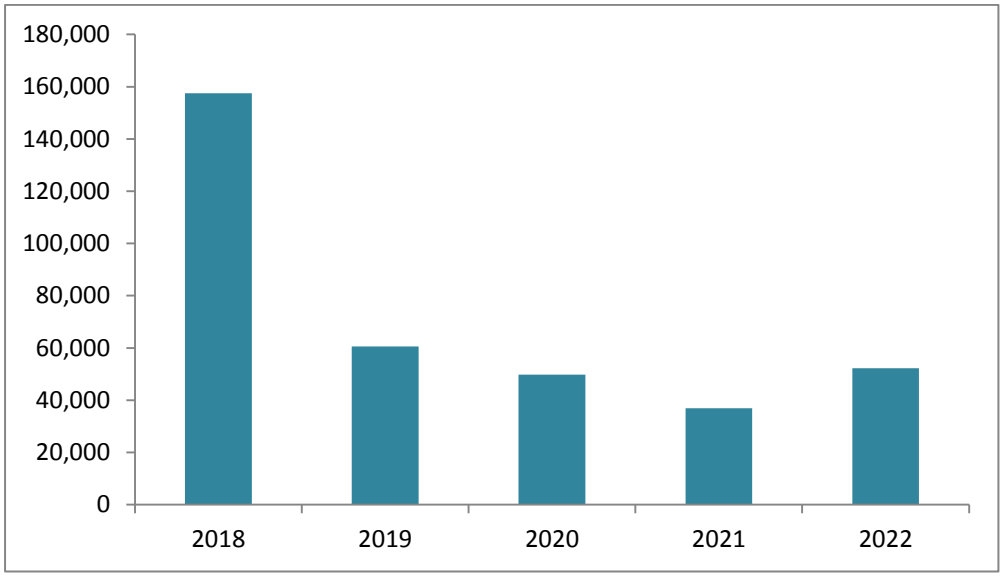
(developed under result DC 1) will include a component to ensure that adolescents are knowledgeable of their rights as well as how to access services to which they are entitled.

- **PEE 2. Education policy articulates what SRH and FP services can be provided in schools.** RHFPP will set up a task force to work with MEST to develop a clear policy on the FP information and services that can be provided at each school level. The task force will also ensure that age-appropriate SBCC materials are provided to schools, in line with the SBCC strategy and materials developed under result DC 1.
- **PEE 3. Every health facility in Sierra Leone is staffed with at least one certified FP practitioner who is able to provide all methods appropriate to that level.** RHFPP will work with stakeholders to develop and secure an endorsement for a policy to ensure that every facility has a member of staff who is trained to deliver FP services.
- **PEE 4. Policymakers recognize the importance of FP in achieving the larger development agenda.** RHFPP will develop a series of high-level advocacy briefs for ministers and parliamentarians on how FP impacts other sectors (e.g., agriculture, food security, environment, education, jobs, etc.), and engage national champions to share these messages with key decision makers.
- **PEE 5. The national health insurance scheme provides all Sierra Leoneans with comprehensive FP services, including the method of their choice.** Using the Advance Family Planning SMART (AFP SMART) process to identify key decision makers and identify the types of advocacy that need to be conducted, RFHP will work with stakeholders (including nongovernmental partners and civil society) to advocate for a national health insurance scheme that includes comprehensive FP services for all people, including youth, and allows users to choose from the full range of contraceptive methods.

Costing Summary

As shown in Figure 21, the total cost for policy and enabling environment activities will be US$356,980 from 2018 through 2022.

Figure 21: Policy and enabling environment costs, in USD



Financing

Strategy

To address the distance between the generally supportive official policy environment for FP and the low allocation of national financial resources to fully meet the need for FP services, particularly in line with the government's FP2020 pledge to allocate 1 percent of the health budget for FP commodities and programs, advocacy and monitoring will be a key driver for increasing government allocations. Improving financing from development partners, along with domestic resource allocations and funding from the private sector, will also support sustainability for the FP program.

There are three pillars to the SLFPCIP financing strategy. These are (1) to increase the funding allocation from MOFED, and ensure that it is specifically earmarked for FP; (2) increase the efficiency of the available resources through increased transparency and coordination; and (3) increase the available resources for FP programs by developing a formal resources mobilization strategy and directing districts to allocate a portion of their health budget specifically to FP.

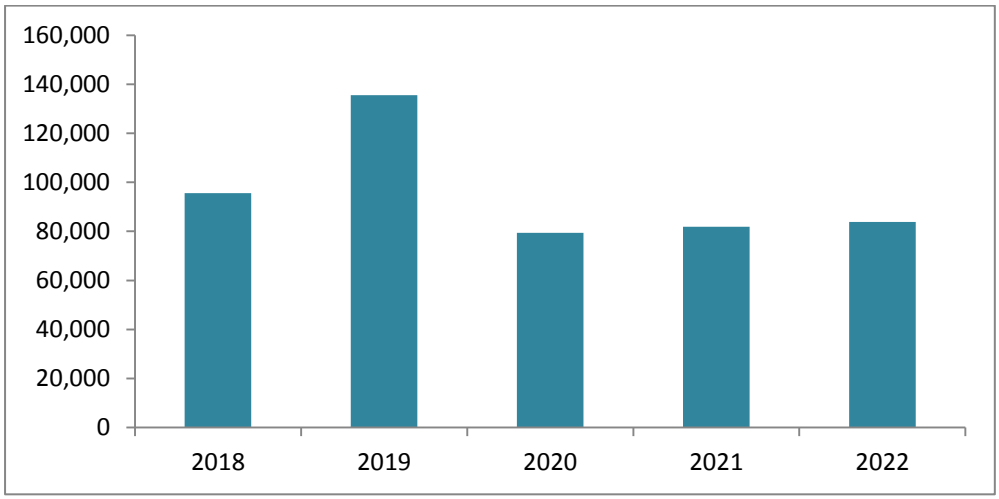
Strategic Results

- **F1. The MOHS budget for FP is increased, in line with the country's 2012 FP2020 commitment.** RHFPP will work the MOHS leadership and the Ministry of Finance and Economic Development (MOFED) to advocate for the adoption of a legal statute to direct the MOHS to allocate 1 percent of the health budget for FP commodities and programs and set up a budget tracking progress to ensure that funds are allocated and dispersed in a timely manner.
- **F2. Financing gaps for FP are identified, and available funding information is disseminated to ensure transparency and accountability for financing and results and to avoid duplication of efforts.** A gap analysis will be conducted annually in order to identify any SLFPCIP activities that do not have adequate resources to be implemented, and to ensure that the available resources are targeted towards the highest priority FP activities. Furthermore, the RHFPP will use the results of the gap analysis to advocate for additional resource allocations from MOHS leadership and the MOFED.
- **F3. Diversification of sources of funding for FP are increased.** RHFPP will design and implement a resource mobilization strategy that increases the diversity of FP funding sources from local and international organizations.
- **F4. Subnational budgets include FP financing leading to improved sustainability of programs.** The MOHS will issue a policy directive to local councils mandating that a portion of regional health budgets are allocated to FP and will develop a series of tools to be used at the regional level for resource mobilization and expenditure tracking. The RHFPP will provide supportive supervision to each DHMT to increase their capacity to use these tools.

Costing Summary

As shown in Figure 22, the total cost for financing activities will be US$476,148 from 2018 through 2022.

Figure 22: Financing costs, in USD



Stewardship, Management, and Accountability

Strategy

To meet the targeted increase in mCPR by 2022, strong monitoring, management, leadership, and accountability are necessary. The five results described below ensure that the leadership and management capacity of RHFPP, DHMT, and facility-level staff throughout the FP program are strengthened, and robust and effective supervision is carried out to ensure quality service provision is taking place. At the national level, the RHCSWG is a crucial body for coordinating partners and managing work at the central and national levels. Efforts will be undertaken to make the working group more effective, including reviewing and revising the terms of reference for the body and ensuring that meetings take place on a quarterly basis. Additionally, the RHSC Working Group will be strengthened by the addition of six subcommittees whose purpose is to monitor and support the implementation of the SLFPCIP, ensuring that operational challenges and programmatic bottlenecks are addressed quickly and efficiently, and elevating issues to the larger RHSC working group for attention when necessary.

The RHFPP team will also be strengthened in order to be able to become more effective stewards of the SLFPCIP. The RHFPP will identify an existing staff to serve as the CIP program leader. This person will be supported by two additional seconded staff who will share responsibility for coordinating government and partner activities in line with the SLFPCIP and collecting, analyzing, and sharing data on implementation through a performance monitoring dashboard. An M&E focal point will also join the RHFPP staff as a secondment from a development partner, and will be responsible inputting and updating data for a CIP performance management system to track progress on the CIP implementation. In order for these staff to work effectively, renovations will be made to the RHFPP resource center, and a vehicle will be procured for exclusive use by the RHFPP for SLFPCIP implementation.

Finally, an external evaluator will be hired to conduct a mid-term and endline evaluation to review the performance towards implementing the activities and priorities in the SLFPCIP, ensuring accountability to the goals and targets set by the document making recommendations on how to improve performance or revise objectives. These evaluations will also serve to inform the development of a new SLFPCIP for 2023 and beyond.

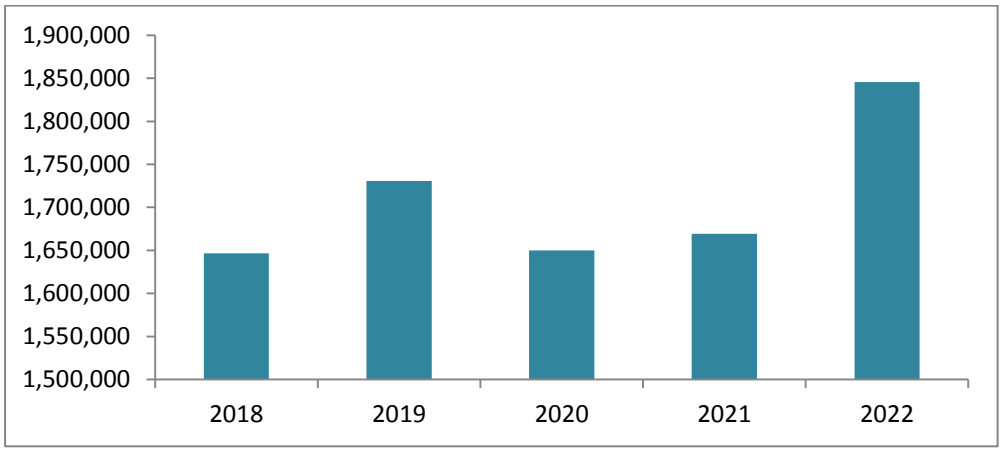
Strategic Results

- **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 EPI, nutrition, etc.)
- **SMA 2. National coordination, partnership, and integration of FP among government and all stakeholders, including governmental and nongovernmental organizations and development partners, is improved.** The RHCSWG will be strengthened through the development of six subcommittees (which roughly align to the thematic areas of the SLFPCIP, 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. Subnational 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.
- **SMA 3. FP data are collected, analyzed, 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. RHCSWG 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.
- **SMA 4. The SLFPCIP is assessed at mid-term and end of plan to inform future FP activities and programming.** Consultants will be hired to conduct mid-term and endline assessments of the progress towards achieving the objectives set out in the plan.
- **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 SLFPCIP will be strengthened through the hiring of two seconded staff to work with existing RHFPP staff to coordinate and monitor the implementation of the SLFPCIP. 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 center 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.

Costing Summary

As shown in Figure 23, the total cost for stewardship, management, and accountability activities will be US$8,541,963 from 2018 through 2022.

Figure 23: Stewardship, management and accountability costs, in USD



COSTING

Costing Assumptions

Elements are described and costed based on data provided by the MOHS, UNFPA, implementing partners, and local suppliers. The source for each input is cited in the costing tool; all inputs are also editable in the costing tool.[15] In addition, each activity's costing inputs for both unit costs and quantities can be changed (e.g., the specific input costs for producing a radio program, the number of programs to be produced, the cost of broadcasting the program, and the number of times it will be broadcast).

Costing inputs have come from various sources and include standards provided by the MOHS, donors such as UNFPA, and implementing partners. Where specific costs for items were not available (e.g., if an activity has yet to be implemented in Sierra Leone), the costing data were drawn from an Africa-regional or international source and noted as such in the costing tool.

Costs in the plan represent estimates for direct activity costs to achieve the FP program goals if implemented by the government. The CIP costing does include the staff time required for GOSL staff required to implement the activities, as well as indirect costs related to service delivery (including human resources development, transport and telecommunication, infrastructure, the health management information system, and general program management costs), but it does not include any additional indirect or overhead costs which may be incurred if an activity is executed by an implementing partner. Contraceptive costs are calculated from 2018 through 2022, using a 2017 baseline estimate of 23 percent mCPR (Family Planning 2020, 2017). The 2013 Sierra Leone Demographic and Health Survey's (SLDHS) method mix (all women, modern) was used as a baseline assumption for the 2017 method mix; thus, for the purpose of the CIP, the 2017 baseline method mix assumed no significant change from the 2013 DHS method mix. The projections for 2022 were based on the national objective of reaching 33.7 percent mCPR among all women of reproductive age. The objective CPR for all women of reproductive age was then extrapolated for each intermediate year from 2017 through 2022. These inputs can be updated when the next SLDHS is published and in intermediate years as new data become available. Additionally, the objectives should be updated if they are changed.

Unless otherwise noted, all consumable costs (e.g., salaries, per diem rates, fuel costs, and venue hire) are based on current costs as of June 2017 and have been automatically adjusted for a base rate of 2.5 percent annual inflation. The inflation rate can be adjusted to accommodate changing conditions. All costs have been calculated in USD and have been converted to Sierra Leonean leones (SLL) using the exchange rate of US$1 to 7494.14 SLL, as of June 9, 2017. The conversion rate can be adjusted to accommodate market fluctuation.

The costing tool is available from the MOHS for review, updating, or modification for other programs.

Costing Summary

The costs have been calculated using a tool developed specifically for this purpose, with methodology borrowed from other regional FP costing activities. The tool enables users to

[15] The generic (blank) Excel template can be accessed from: Health Policy Plus. 2017. "Family Planning CIP Costing Tool." January 2017. "Family Planning CIP User Guide." April 2017. Available at: http://www.healthpolicyplus.com/pubs.cfm?get=2101.

calculate the overall costs of the plan, as well as disaggregate the costs by activity area and year. It includes both initial (investment) costs and ongoing or sustainability costs for the plan's duration.

The total costs of the plan from 2018–2022 are US$41.0 million (307.8 billion SLL).

Overall, US$7.2 million, or 18 percent of the overall costs, are for commodities and consumables. These costs increase gradually over time as more women are reached. Of the activity-based costs, the largest cost driver is service delivery (41%), followed by demand creation (12%), contraceptive security (6%) and stewardship, management and accountability (2%). Financing and policy and enabling environment each contribute 1 percent to the total CIP cost.

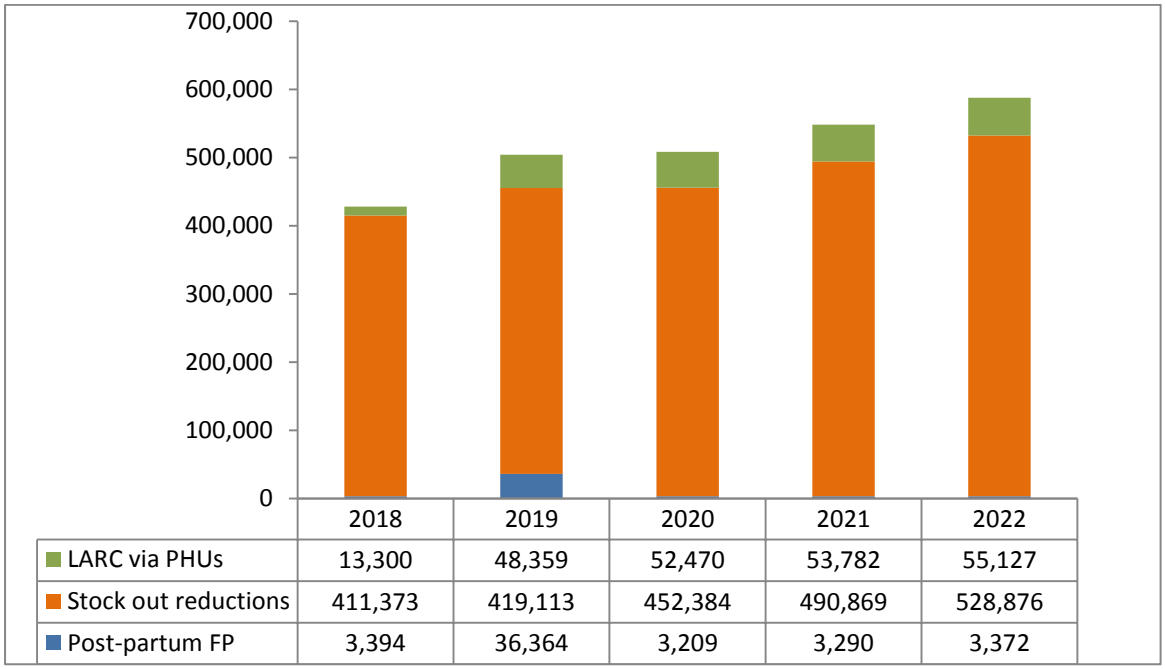
The costs of the plan are comparable to other countries' similar FP costed implementation plans. The cost per woman of reproductive age for activity costs is US$3.98 per year, which is in line with the range of average costs in other countries of about US$2–5. The cost per user for FP commodities and consumables is US$3.44, which is below the average costs of US$4–4.20 seen in other countries (Ministry of Health, Uganda, 2014). This is likely due to the inclusion of the various additional management costs for each commodity (e.g., pre-shipment inspection, wastage, contraceptive procurement fees, clearing fees, freight charges, testing and oversight costs, insurance, storage fees, distribution fees/last-mile costs), as part of the contraceptive security activity costs, instead of loading them as part of the direct commodity costs as has been done in some other countries' CIPs.

Table 11: Annual costs by thematic area, in USD

	2018	2019	2020	2021	2022	Total
Demand	$381,835	$1,120,725	$1,143,578	$1,189,035	$1,227,401	$5,062,575
Service Delivery	$2,968,243	$3,009,458	$3,262,909	$3,591,816	$3,950,870	$16,783,295
Commodity Security	$460,877	$471,199	$507,187	$548,531	$589,546	$2,577,340
Policy and Enabling Environment	$157,472	$60,558	$49,736	$36,960	$52,254	$356,980
Financing	$95,584	$135,522	$79,336	$81,830	$83,876	$476,148
Stewardship, Management and Accountability	$1,646,458	$1,730,655	$1,649,877	$1,669,410	$1,845,562	$8,541,963
Contraceptive commodities and consumables	$1,192,779	$1,312,183	$1,437,659	$1,563,835	$1,698,767	$7,205,222
Total	$6,903,247	$7,840,298	$8,130,282	$8,681,418	$9,448,277	$41,003,523

Strategic priorities make up a subset of the activity costs included in the plan. The total cost of implementing all activities and subactivities that have been identified as strategic priorities is US$2.6 million over the five years of the plan (see Table 12 for annual costs by priority area). This represents 8 percent of the overall activity costs.

Table 12: Costs to implement strategic priorities, by area, in USD



	2018	2019	2020	2021	2022
LARC via PHUs	13,300	48,359	52,470	53,782	55,127
Stock out reductions	411,373	419,113	452,384	490,869	528,876
Post-partum FP	3,394	36,364	3,209	3,290	3,372

PROJECTED METHOD MIX AND CONTRACEPTIVE NEEDS

Assumptions

The estimated method mix for all women for the 2017 baseline was set by using the 23 percent modeled estimate of mCPR in 2017, using the trend prepared for FP2020 (Family Planning 2020, 2017). The 2013 DHS method mix (all women, modern) was then applied to this new mCPR value; thus, for the purpose of the CIP, the 2017 baseline method mix assumed no significant change in method mix from the 2013 DHS method mix. The 2017 baseline and 2022 goal CPR method mix were reviewed and approved in stakeholder meetings. 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. For this reason, the actual forecasting for and procurement of FP commodities should be regularly reviewed and adjusted based on new and emerging data, including information on user preference and choice, as well as actual commodity use in the public and private sectors, which will be increasingly valuable as the quantity and quality of these data improve.

In addition, for the SLFPCIP, male and female condoms (due to their low prevalence, female condoms are included under “other modern method”) are included only in the method mix and costed for the amount required for FP usage alone—condoms used for the prevention of HIV and other sexually transmitted infections in addition to the use of another method by women are not included in this SLFPCIP costing, although these projections and costs are included in the larger national quantification projections for RH commodities.

Emergency contraception (EC) is not included as a percentage of the method mix, as EC is not promoted as a regular or consistent method of FP. Emergency contraceptives will be procured for public and private sector use as a lifesaving commodity—a method to be used when other primary methods are not used or fail. The procurement of EC per historical trends in the national quantification plan is included in the program costs under contraceptive security.

Table 13: Method mix, all women, 2008 and 2013 DHS surveys, 2017 estimates, 2022 goal method mix

Method Mix, All Women	2008 DHS	2013 DHS	Estimated 2017 Baseline	2022 Goal CPR-Proposed Method Mix
CPR	10.2%	22.1%	24.2%	34.3%
MCPR	8.2%	20.9%	23.0%	33.7%
Male sterilization	0%	0%	0.0%	0.0%
Female sterilization	0%	0.3%	0.4%	0.4%
IUDs	0.3%	0.2%	0.3%	2.4%
Implants	0%	3.8%	4.2%	7.2%
Injectables	3.2%	9.8%	10.8%	14.2%
Pills	2.9%	5.1%	5.7%	7.2%
Male condoms	1.1%	0.7%	0.8%	0.9%
Other modern methods, including female condoms	0%	0.1%	0.2%	0.2%
Lactational amenorrhea	0.6%	0.7%	0.8%	1.1%
Withdrawal	0.1%	0.2%	0.2%	0.1%
Rhythm	0.6%	0.1%	0.2%	0.1%
Cycle beads	0%	0%	0.0%	0.0%
Other traditional	1.3%	0.8%	0.8%	0.4%

The FP Goals model was used to project overall expected growth in mCPR to 2022, and identify the contribution from each of the prioritized intervention areas to this overall growth. This information was then used to project shifts in the method mix between the 2017 baseline and 2022, based on whether the intervention was expected to increase the use of certain methods over others. 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 new users accessing contraception due to improvements in services available from pharmacies and drug shops would drive up short-term methods as a proportion of the method mix (since pharmacies and drug shops cannot provide LARCs). In order to account for the likely impact of each of these interventions, assumptions were made about the method mix for each intervention area, and then collectively they were used to model the overall change in method mix. Tables 14 and 15 give the specific method-mix change assumptions for each strategic priority.

Table 14: Method-mix change assumptions 2017–2022

Method	% Point Increase 2017–2022	Assumptions
Postpartum FP	5.5%	Mix—more LARC (30% implant, 30% injectable, 20% IUD, 15% pill, 5% lactational amenorrhea)
Stockout reductions	2.9%	Stockouts—weighted based on stockouts for each method
Community health workers	0.6%	Even—same method mix as currently
Public sector Mobile Outreach	0.5%	Short Term Method—same method mix as currently, but increase only among short-term methods
LARC via PHUs	0.4%	LARC—60% implant, 40% IUD
Youth-focused interventions	0.4%	Even—same method mix as currently
Private sector facilities	0.3%	Mix—more LARC (30% implant, 30% injectable, 20% IUD, 15% pill, 5% lactational amenorrhea)
Pharmacies and drug shops	0.1%	STM—same method mix as currently, with increase only among short-term methods

Table 15: Different modern method-mix distributions to apply to increases from each strategic priority

Method	Prevalence by Method				
	Even—Based on Current Method Mix	LARC	STM	Mix (more LARC)	Stockouts
Male sterilization	0.1%	—	—	—	—
Female sterilization	1.6%	—	—	—	—
IUDs	1.1%	40.0%	—	20.0%	29.4%
Implants	18.2%	60.0%	—	30.0%	30.3%
Injectables	46.9%	—	59.4%	30.0%	27.3%
Pills	24.7%	—	31.3%	15.0%	8.9%
Male condoms	3.3%	—	4.2%	—	4.2%
Lactational amenorrhea	3.4%	—	4.3%	5.0%	—
Other modern methods, including female condoms	0.7%	—	0.9%	—	—

Details of the annual method mix, services/commodities, and contraceptive prevalence by method and total FP users for 2017 and projected for 2018–2022 are shown in Figure 24.

Standard units needed for one year of use rather than couple years of protection (CYP) factors were used for these calculations.[16]

Figure 24: Total FP Users, 2018–2022

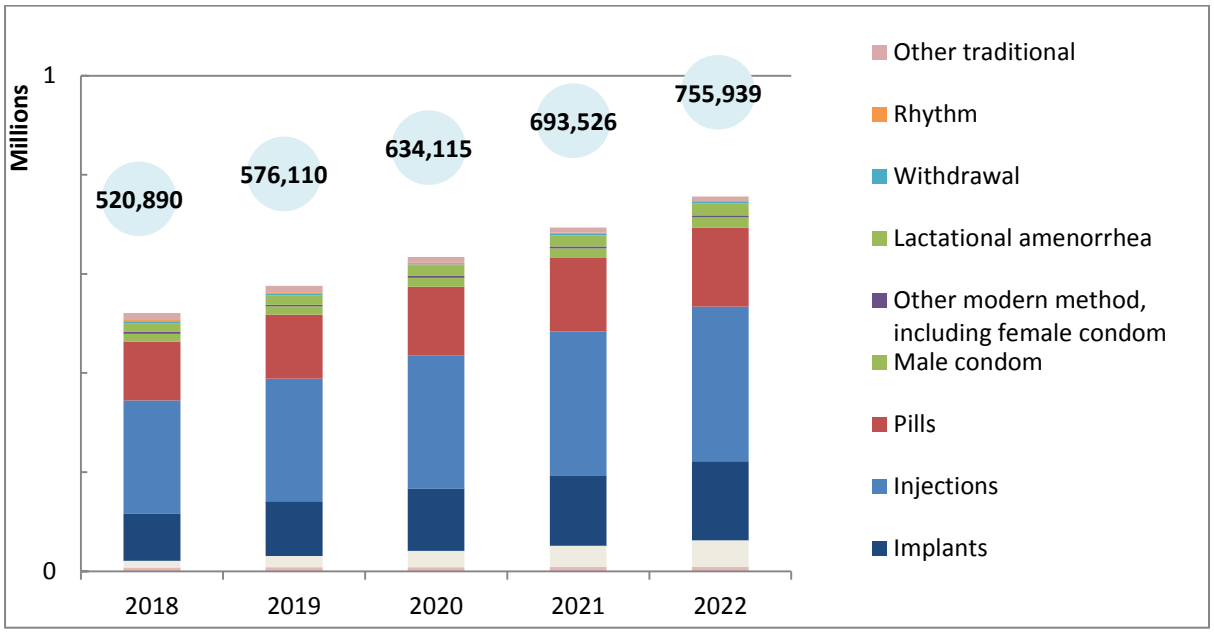


Figure 24 gives the total estimated number of FP users, by method, for each year of the plan. The number of users is lower in this figure than that in Table 16, as users of long-acting methods (sterilization, IUDs, and implants) do not need to be provided with services each year to be considered an FP user. Table 16 details the total number of current FP users for each method, by year, which corresponds to the method-mix targets for married and unmarried sexually active women.

[16] "The number of units needed for a year of coverage is an input to the model. This is slightly different from the CYP factor, because it does not include method effectiveness and wastage (user, not supply chain). Rather, it is the number of units that a woman would need to have a full year's worth of commodities (i.e., three units of four-month injections). Default global estimates are based on workings from the 2011 USAID CYP update" (Weinberger, et al., 2012).

Table 16: Projected number of FP users provided with services or commodities, 2018–2022[17]

	2018	2019	2020	2021	2022
Male sterilization	29	30	31	31	33
Female sterilization	805	835	867	882	915
IUDs	9,877	12,266	14,785	17,346	20,092
Implants	39,610	44,788	50,238	55,659	61,559
Injectables	227,795	247,620	268,428	289,632	311,903
Pills	119,020	128,592	138,635	148,845	159,568
Male condoms	15,694	16,840	18,041	19,259	20,538
Lactational amenorrhea	16,777	18,658	20,635	22,662	24,792
Cycle beads/standard days method (SDM)	0	0	0	0	0
Other modern methods, including female condoms	3,336	3,476	3,621	3,766	3,917
Withdrawal	3,576	3,264	2,933	2,578	2,203
Rhythm	3,576	3,264	2,933	2,578	2,203
Other traditional	14,303	13,055	11,733	10,311	8,814
Total	454,398	492,687	532,881	573,547	616,537

[17] This is the estimated number of services, by method, that would need to be provided to reach the FP goal. These have been calculated based on the total users needed to reach the goal, continued use of long-acting and permanent methods (LAPMs) from baseline use (from historic services or CPR), and method-specific discontinuation. The results are dependent on the method mix of services set for each year.

Table 17: Total FP users, projected 2018–2022[18]

	2018	2019	2020	2021	2022
Male sterilization	265	275	284	294	304
Female sterilization	7,426	7,690	7,965	8,234	8,516
IUDs	13,686	22,977	32,766	42,989	53,735
Implants	95,437	110,401	126,139	142,380	159,445
Injectables	227,795	247,620	268,428	289,632	311,903
Pills	119,020	128,592	138,635	148,845	159,568
Male condoms	15,694	16,840	18,041	19,259	20,538
Lactational amenorrhea	16,777	18,658	20,635	22,662	24,792
Cycle beads/SDM	0	0	0	0	0
Other modern methods, including female condoms	3,336	3,476	3,621	3,766	3,917
Withdrawal	3,576	3,264	2,933	2,578	2,203
Rhythm	3,576	3,264	2,933	2,578	2,203
Other traditional	14,303	13,055	11,733	10,311	8,814
Total users	520,890	576,110	634,115	693,526	755,939
Total users of modern methods	499,436	556,528	616,515	678,060	742,719

[18] This is the estimated number of users per method. These figures include continued use of LAPMs from baseline use (from historic services or CPR) and method-specific discontinuation. The results are dependent on the method mix of services set for each year.

IMPACTS

The ImpactNow model (Health Policy Project and Marie Stopes International, 2015) was used to calculate the impacts from which the GOSL will benefit by increasing the CPR. These demographic, health, and economic impacts include the following:

- Unintended pregnancies averted
- Abortions averted
- Unsafe abortions averted
- Maternal deaths averted
- Child deaths averted (due to improved birth spacing)
- Healthcare costs averted (in USD)

These calculations estimate that the FP interventions in Sierra Leone will avert more than 830,000 unintended pregnancies and nearly 300,000 abortions, and will lead to 20,000 fewer child deaths and more than 8,000 fewer maternal deaths between 2018 and 2022 if the CIP is implemented fully. Additionally, the intervention will avert almost US$23 million just for maternal and infant healthcare costs during the five-year plan period (Health Policy Project and Marie Stopes International, 2015).

Table 18 forecasts the impacts of increases in FP demand, use, and priorities for 2018–2022 in Sierra Leone. The baseline numbers are drawn from the 2017 application of the FP Goals Model and projected outward based on full implementation of the SLFPCIP and reaching the stated CPR targets of all women of reproductive age; they show how the scaled-up interventions will significantly affect outcomes in reproductive, maternal, and child health in Sierra Leone.

Demographic impacts. “Unintended pregnancies” averted refers to the number of births that will not occur, including live births, abortions, miscarriages, and stillbirths. The number of pregnancies averted, including abortions, also affects maternal mortality, given that women sometimes die from abortion complications. As the number of abortions decline due to increased FP use and fewer unintended pregnancies, maternal deaths will decline (Health Policy Project and Marie Stopes International, 2015).

Health impacts. As a result of full implementation of the SLFPCIP, significant numbers of maternal and child deaths will be averted, as well as unsafe abortions, contributing to a healthier population (Health Policy Project and Marie Stopes International, 2015).

Economic impacts. Increased FP use, reduced unmet need for FP, and increased contraceptive prevalence will result in government savings and economic impacts on the whole—including significant savings in public health, education, and infrastructure costs. Table 18 shows the specific impacts on maternal and infant healthcare costs only.

Table 18: Annual and total impacts of the SLFPCIP on maternal and infant healthcare costs

	2018	2019	2020	2021	2022	Total
Demographic Impacts						
Unintended pregnancies averted	124,324	144,031	164,879	186,954	210,22	830,509
Abortions averted	44,757	51,851	59,357	67,303	75,716	298,983
Health Impacts						
Maternal deaths averted	1,309	1,517	1,737	1,969	2,215	8,748
Child deaths averted	3,059	3,544	4,057	4,600	5,175	20,434
Unsafe abortions averted	44,696	51,781	59,276	67,212	75,613	298,577
Disability-adjusted life years (DALYs) averted	338,595	392,265	449,047	509,165	572,808	2,261,880
Economic Impacts						
Maternal and infant healthcare costs averted (USD)	3,463,532	4,012,540	4,593,366	5,208,327	5,859,335	23,137,101

INSTITUTIONAL 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. The Reproductive and Family Planning Programme (RHFPP) is the program within the MOHS that is responsible for FP and other reproductive health services. RHFPP is one of three programs within the Reproductive and Child Health Directorate of the MOHS. RHFPP will be responsible for providing stewardship and leadership, including mobilizing support and resources from domestic sources, and from partners and private sector players, to successfully implement the activities described in this document. However, 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 SLFPCIP objectives by 2022 calls for government leadership and functional processes to track and ensure performance assessment and accountability. The following section outlines a proposed management structure, defines roles, and describes the institutional coordination arrangements crucial to achieving results. The proposed structure is flexible and should be adapted and modified as necessary to achieve utmost output as it is rolled out operationally.

Management, Coordination, and Accountability Structure

The SLFPCIP is the common master work plan for 2018–2022, based on which annual work plans will be developed to help achieve the set targets of the FP program. The SLFPCIP encompasses all sectors within the FP landscape, including the private sector. To lead the implementation of the CIP, a streamlined management, coordination, and accountability structure will need to be designed and adopted. The structure should:

- Recognize that the MOHS is the overarching body responsible for health and will be the steward responsible for the planning, resource mobilization, financing, implementation, and performance monitoring of the SLFPCIP
- Leverage existing government structures in collaboration with other key stakeholders
- Validate the high priority attached to FP within government and the critical role it plays in harnessing demographic dividends for development and accelerating socioeconomic growth as the country progresses towards achieving its development goals
- Leverage existing FP operational structures such as the RHCSWG to implement the activities in the GFPCIP
- Show the broad-based approach needed for implementation of the SLFPCIP, involving multisectoral stakeholders such as CSOs, CBOs, professional associations, FBOs, the private sector, development partners, and related ministries and agencies, amongst others.
- Show that the implementation of the SLFPCIP will have to take place at all levels of government in order to achieve results, with multisectoral stakeholders taking part in the development, execution and monitoring of the plan.

Roles and Responsibilities

Ministry of Health and Sanitation (MOHS)—The MOHS is responsible for ensuring oversight of the effective and efficient implementation of the SLFPCIP. The MOHS will perform its core functions in the SLFPCIP through the Reproductive and Child Health Directorate, Reproductive Health and Family Planning Programme. The functions include executing performance management processes; ensuring accountability of resources provided for the roll-out of the SLFPCIP; managing, coordinating, and monitoring implementation of the plan to ensure achievement of performance targets by national and international stakeholders; mobilizing, monitoring, and ensuring efficient use of resources; developing policy frameworks and regulations that create an enabling environment to improve service delivery and access and ensure that policies are widely disseminated and implemented; setting guidelines and standards for program operations and service delivery; and recruiting the necessary staff needed for implementation of the plan and providing capacity-building mechanisms.

Central Medical Stores (CMS)—CMS is the agency that is responsible for storage, distribution, and oversight of drugs and commodities. It operates under the Directorate of Drugs and Medical Supplies of the Ministry of Health and Sanitation. The CMS will ensure proper warehousing and storage of contraceptive commodities and other RH commodities required for the implementation of the SLFPCIP.

Development partners—Development partners and UN agencies are key pillars of the successful implementation of the SLFPCIP, as they are critical to providing the necessary financial resources, technical support, and commodity supplies. Development partners and UN agencies will collaborate closely with the government and take a keen interest in monitoring the progress of SLFPCIP implementation. Key roles and responsibilities include supporting the modalities of the national response that government partners see as priority challenges in the absence of insufficient resources and/or technical expertise; they will make firm commitments to support areas of the SLFPCIP in line with their scope and work plans. Key development partners and donors supporting FP activities include DFID, UNFPA, and WHO, among others.

Civil society—Civil society includes a diverse group of organizations, including NGOs; faith-based organizations (FBOs); cultural, local, and international organizations; traditional authorities; media; private sector organizations; and academia. Collectively, civil society plays an instrumental role in advocacy to drive awareness and demand creation, accelerate access to FP services, and provide various levels of services. These groups will be particularly valuable in supporting community-level activities; thus, coordination and partnership, particularly at the subnational level, is needed to harness resources to implement the plan. Another important role will be to serve as ombudsmen to ensure social accountability and responsibility in implementation of the SLFPCIP so that limited resources are used judiciously and efficiently. Civil society can also advocate for the amendment of laws and policies.

Coordination Framework

The diversity and multisectoral complexity of the SLFPCIP calls for critical harmonization of resources and activities. A coordination framework should critically align roles and responsibilities so as to result in improved outputs, the ability to better track progress and milestones, and improve overall program efficiency; this will also prevent duplication of efforts and the waste of human and capital resources.

Reproductive Health Commodity Security Working Group (RHCSWG)—The RHCSWG is a platform to bring together stakeholders and organizations to coordinate and manage commodity security and quantify contraceptives requirements. Through the RHCSWG, an annual national quantification exercise on contraceptives, including condoms, is undertaken and reviewed with key stakeholders. The RHCSWG meets quarterly, in addition to specific quantification meetings held annually. The RHCSWG, through its subcommittees, will play a crucial role in implementation of the SLFPCIP.

The RHCSWG principally will be responsible for reviewing regular reports on SLFPCIP progress from the working group, in addition to its functions of providing a platform for FP dialogue and ensuring that commodity security remains within national requirements to prevent stockouts and gluts. It will continue to lead quantification, but its subcommittees will play instrumental roles in implementation of the SLFPCIP. The RHCSWG will work to achieve efficiencies and the collective effectiveness of different stakeholders by clarifying roles and responsibilities for implementation, including donor commitment areas, creating stronger synergies amongst implementing partner efforts, optimizing the flow of information across different stakeholders, and requiring accountability for performance and results from all partners and implementers for the overall success of SLFPCIP implementation.

Subcommittees of the RHCSWG—As detailed in the activity matrix, the following subcommittees of the RHCSWG will be formed: SBCC; Quality Service Delivery; Risk Management (Contraceptive Security focus); Finance and Advocacy; SMA/M&E; and Youth Reproductive Health. Based on terms of reference (TORs), the subcommittees will meet monthly or quarterly, in addition to specific ad hoc meetings detailed in the SLFPCIP.

Reproductive Health Family Planning Programme (RHFPP)—The RHFPP will be responsible for the coordination and monitoring of the CIP. It will be responsible for:

1. **Coordinating partner activities in FP:** This will include working with partners to develop annual work plans based on the CIP, organizing quarterly coordination meetings, communicating with districts and partners, and producing minutes of meetings, quarterly and annual reports. A CIP coordinator and a CIP officer will be responsible for the coordination. Both of these positions will be seconded to MOHS by development partners. The CIP coordinator will have a counterpart, who will be an MOHS staff member within RHFPP. The counterpart will work closely with the CIP coordinator and share skills and learning. The rationale for having secondees is twofold. First, the RHFPP does not have enough human resources to allocate staff to work solely on the CIP implementation. Second, the RMNCAH Strategy identified poor governance as a bottleneck to RMCAH service delivery and the need for improved leadership.
2. **Collecting CIP activity updates (activities, funds, etc.) and updating the performance monitoring plan**: This activity will be carried out by the CIP officer. It will involve receiving monthly reports from partners and districts, collating this information to inform quarterly reports, and updating the performance monitoring plan and related dashboards. At a district level, implementing partners will be asked to allocate a staff member who will work closely with the DHMT to ensure that all FP reports are sent in a timely manner to RHFPP.
3. **Provide technical leadership for FP activities and quality assurance of FP activities delivered by the MOH and partners**: An existing RHFPP staff member will be allocated to this role. A clear job description will be developed and the person specified will be developed. On- and off-the-job training will be provided to ensure that the member of staff can provide technical leadership for FP in the country, working closely with FP technical

partners. This will contribute to the development of a sustainable system in which the MOHS is able to provide technical leadership, instead of the current situation, where technical leadership mainly comes from partners.

4. **Resource mobilization**: Resource mobilization will be carried out by the program manager, with support from two of the new seconded staff, the CIP coordinator and CIP officer, who will join the RHFPP.

Resource Mobilization

Resource mobilization will be key to the effective and successful implementation of the CIP. Before the start period of the SLFPCIP in early 2018, a forum will be held for key stakeholders and partners to make commitments for responsibility and implementation of SLFPCIP activities. During this meeting, government agencies and development and implementing partners will agree to their roles and responsibilities for various results and activities.

Additionally, as described in the financing section of the SLFPCIP, an annual gap analysis will be conducted starting in early 2018 to identify unfunded gaps. A plan will be developed to raise resources, categorizing results according to level of priority. The framework will explore a number of strategies, which may include developing proposals to new donors for support, increasing advocacy at the district level for increased allocation of funds to FP, engaging CSOs to support advocacy for parliamentary support for increased funding, mobilizing resources and support from the private sector, harnessing resources from other sectors or programs and leveraging ongoing activities, and increasing the efficient use of funds.

REFERENCES

Advance Family Planning. (n.d.) "Advance Family Planning Advocacy Portfolio." Available at: https://advancefamilyplanning.org/advocacy-portfolio.

Bongaarts, J., J.C. Cleland, J. Townsend, J.T. Bertrand, and M. Das Gupta. 2012. *Family Planning Programmes for the 21st Century: Rationale and Design.* Available at: http://www.popcouncil.org/uploads/pdfs/2012_FPfor21stCentury.pdf.

Chin-Quee, D., J. Bratt, M. Malkin, M.M. Nduna, C. Otterness, L. Jumbe, and R.K. Mbewe. 2013. Building on Safety, Feasibility, and Acceptability: The Impact and Cost of Community Health Worker Provision of Injectable Contraception. *Global Health: Science and Practice* 1(3): 316-327. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4168589/.

Copenhagen Consensus Center. 2014. *Preliminary Benefit-Cost Assessment of the Final OWG Outcome*. Available at: http://www.copenhagenconsensus.com/sites/default/files/owg_ccc_preliminary_cost-benefit_final_assessment.pdf.

Crown Agents USA. 2013. "Sierra Leone Medical Stores." Available at: http://www.crownagents.com/en-us/our-work/projects/detail/sierra-leone-medical-stores.

Dalan Development Consultants & Forcier Consulting. 2016. *GoSL, 6–9 Month Early Recovery Priorities: Independent Evaluation and Assessment – Final Report.* Available at: http://media.wix.com/ugd/767c32_00256f549ff943b8b7dfcbe7adfe60e1.pdf.

Denney, L., R. Gordon, and A. Ibrahim. 2015. *Teenage Pregnancy after Ebola in Sierra Leone: Mapping Responses, Gaps and Ongoing Challenges*. Working Paper. ODI. Available at: http://www.securelivelihoods.org/publications_details.aspx?ResourceID=390.

EngenderHealth. 2003. Choices in Family Planning: Informed and Voluntary Decision Making.

Evidence for Action. 2014. Research Briefing: Knowledge, Attitude and Practices of Family Planning in 13 Districts of Sierra Leone. London: Evidence for Action. Available at: https://mamaye.org/evidence/our-publications/knowledge-attitude-and-practices-family-planning.

Family Planning 2020. 2017. *Sierra Leone.* Available at: http://www.familyplanning2020.org/entities/96.

Family Planning Summit Metrics Group. 2012. Technical Note: Data Sources and Methodology for Calculating the 2012 Baseline, 2020 Objectives, Impacts and Costings. Family Planning Summit, London.

FP2020. n.d.a. *Momentum at the Midpoint 2015–2016*. Available at: http://progress.familyplanning2020.org/.

FP2020. n.d.b. *Sierra Leone Country Commitments.* Available at: http://www.familyplanning2020.org/reaching-the-goal/commitments/all-commitments/commitment/.

FP2020. 2014. *Family Planning 2020: Rights and Empowerment Principles for Family Planning.* Available at: http://www.familyplanning2020.org/resources/4697.

Glassman, A. 2016. “Failing to Deliver on Family Planning? Funding in Crisis.” Center for Global Development. Available at: http://www.cgdev.org/blog/failing-deliver-family-planning-funding-crisis.

Government of Sierra Leone (GOSL). n.d.a. *Human Resources for Health Strategic Plan, 2012–2016.* Available at: http://www.nationalplanningcycles.org/sites/default/files/country_docs/Sierra%20Leone/hrh_strategic_plan_sl_dec2012.pdf.

Government of Sierra Leone (GOSL). n.d.b. *Second Poverty Reduction Strategy, 2008–2012.* Available at http://statehouse.gov.sl/wp-content/uploads/2017/12/afc.pdf.

Government of Sierra Leone (GOSL). n.d.c. The Agenda for Prosperity: Road to Middle Income Status: Sierra Leone‘s Third Generation Poverty Reduction Strategy Paper (2013–2018). Available at: http://www.undp.org/content/dam/sierraleone/docs/projectdocuments/povreduction/undp_sle_The%20Agenda%20for%20Prosperity%20.pdf.

Government of Sierra Leone (GOSL). 2006. *Human Resources for Health Policy in Sierra Leone for the Ministry of Health and Sanitation.* Available at: http://www.hrhresourcecenter.org/hosted_docs/HRH_Policy_Sierra_Leone.pdf.

Government of Sierra Leone (GOSL). 2011. *Health Compact.* Available at: https://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Country_Pages/Sierra_Leone/Government%20of%20S.%20Leone%20Health%20Compact.pdf.

Government of Sierra Leone (GOSL). 2012a. *Motivated Health Workforce Contributing to National Development.* Human Resources for Health Policy. Available at: http://www.nationalplanningcycles.org/sites/default/files/country_docs/Sierra%20Leone/hrh_policy_dec2012.pdf.

Government of Sierra Leone (GOSL). 2012b. *Results and Accountability Framework, 2010–2015.* Available at: http://www.nationalplanningcycles.org/sites/default/files/planning_cycle_repository/sierra_leone/results_and_accountability_framework.pdf.

Government of Sierra Leone (GOSL). 2013. *National Strategy for the Reduction of Teenage Pregnancy, 2013–2015.* Available at: http://hivhealthclearinghouse.unesco.org/sites/default/files/resources/Sierra_Leone_National_Strategy_for_the_Reduction_of_Teenage_Pregnancy.pdf.

Government of Sierra Leone (GOSL). 2015. *National Ebola Recovery Strategy for Sierra Leone, 2015–2017.* Available at: http://www.sl.undp.org/content/sierraleone/en/home/library/human_development/sierra_leone_recovery_strategy_enpdf/.

Government of Sierra Leone (GOSL). 2016a. Sierra Leone National Human Resources for Health Strategic Plan, 2017–2021.

Government of Sierra Leone (GOSL). 2016b. *The President’s Recovery Priorities: Key Results, Priority Initiatives, Sub-Initiatives and Milestones.* Available at: http://media.wix.com/ugd/767c32_5cefbb0c2b184caeb0d97809957709f5.pdf.

Health Policy Initiative. 2008. *Understanding Operational Barriers to Family Planning Services in Conflict-Affected Countries: Experiences from Sierra Leone.* Available at: http://www.healthpolicyinitiative.com/Publications/Documents/573_1_Refugee_IDP_Paper_Sierra_Leone.pdf.

Health Policy Plus (HP+). 2016a. Stakeholder consultations for Sierra Leone Family Planning Costed Implementation Plan, 2018–2022. Unpublished notes and analysis.

Health Policy Plus (HP+). 2016b. Stakeholder consultations for Sierra Leone Family Planning Costed Implementation Plan, 2018–2022. Strategic Advisory Group on Service Delivery and Demand Creation. Unpublished notes and analysis.

Health Policy Plus (HP+). 2016c. Stakeholder Consultations for Sierra Leone Family Planning Costed Implementation Plan, 2018–2022. Strategic Advisory Group on Youth. Unpublished notes and analysis.

Health Policy Plus (HP+). 2016d. Stakeholder Consultations for Sierra Leone Family Planning Costed Implementation Plan, 2018–2022. Strategic Advisory Group on Youth and Interviews. Unpublished notes and analysis.

Health Policy Plus (HP+). 2016e. Stakeholder Consultations for Sierra Leone Family Planning Costed Implementation Plan, 2018–2022. Various interviews. Unpublished notes and analysis.

Health Policy Project. 2015. *Costed Implementation Plans for Family Planning: The Basics.* Available at: http://www.healthpolicyproject.com/pubs/812_CIPTheBasicsFINAL.pdf.

Health Policy Project and Marie Stopes International. 2015. *ImpactNow: Estimating the Health and Economic Impacts of Family Planning Use*. Washington, DC: Futures Group, Health Policy Project.

ICF International. 2015. For TFR: Benin: 2011–12 DHS, Burkina Faso: 2014 MIS; Ghana: 2014 DHS; Guinea: 2012 DHS; Liberia: 2013 DHS; Mali: 2015 MIS; Niger: 2012 DHS; Nigeria: 2015 MIS; Senegal: 2014 DHS; Sierra Leone: 2013 DHS. *The DHS Program STATcompiler*. Available at: http://www.statcompiler.com.

Kohler, H.-P., and J.R. Behrman. 2014. *Benefits and Costs of the Population and Demography Targets for the Post-2015 Development Agenda: Post-2015 Consensus*. Working Paper as of 3 October 2014. Available at: http://www.copenhagenconsensus.com/sites/default/files/population_assessment_-_kohler_behrman_0.pdf.

"London Summit on Family Planning—July 11, 2012." n.d. Available at: http://www.who.int/workforcealliance/media/events/2012/LondonSummitonFamilyPlanningOverview.pdf.

"Millennium Development Goals Indicators." 2014. Available at: http://mdgs.un.org/unsd/mdg/Data.aspx.

*"*Millennium Development Goals Indicators." 2015. Available at: http://mdgs.un.org/unsd/mdg/Data.aspx.

Ministry of Health and Sanitation (MOHS). 2002. *National Health Policy.* Available at: http://www.mamaye.org/en/evidence/sierra-leone-national-health-policy.

Ministry of Health and Sanitation (MOHS). 2008. Reproductive and Child Health Strategic Plan, 2008–2010.

Ministry of Health and Sanitation (MOHS). 2009. *National Health Sector Strategic Plan, 2010–2015.* Available at: http://www.internationalhealthpartnership.net/fileadmin/uploads/ihp/Documents/Country_Pages/Sierra_Leone/NationalHealthSectorStrategicPlan_2010-15.pdf.

Ministry of Health and Sanitation (MOHS). 2011. *Reproductive, Newborn and Child Health Policy, 2011–2015*. Available at: https://extranet.who.int/nutrition/gina/sites/default/files/SLE%202011%20Reproductive,%20Newborn%20and%20Child%20Health%20Policy.pdf.

Ministry of Health and Sanitation (MOHS). 2012. *Policy for Community Health Workers in Sierra Leone.* Accessed on 12 October 2016 from http://chwcentral.org/sites/default/files/CHW-Policy%20Sierra%20Leone.pdf.

Ministry of Health and Sanitation (MOHS). 2015a. *Health Sector Annual Performance Report*. Available at https://mohs-portal.net/wp-content/uploads/2017/03/Health-Sector-Annual-Performance-Report-2015.pdf.

Ministry of Health and Sanitation (MOHS). 2015b. *Health Sector Recovery Plan, 2015–2020*.

Ministry of Health and Sanitation (MOHS). 2015c. *Sierra Leone Basic Package of Essential Health Services, 2015–2020.* Available at: https://mohs-portal.net/wp-content/uploads/2017/06/GoSL_2015_Basic-Package-of-Essential-Health-Services-2015-2020.pdf.

Ministry of Health and Sanitation (MOHS). 2016. *National Community Health Worker Policy, 2016–2020*.

Ministry of Health and Sanitation (MOHS). 2017. *Draft National Strategy for the Reduction of Adolescent Pregnancy and Child Marriage, 2018–2022*.

Ministry of Health and Sanitation (MOHS). 2017. *Reproductive, Maternal, Newborn, and Child and Adolescent Health (RMNCAH) Strategy, 2017–2021*.

Ministry of Health and Sanitation (MOHS), Health Education Division. 2016. *National Health Promotion Strategy, 2017–2021.*

Ministry of Health, Uganda. 2014. *Uganda Family Planning Costed Implementation Plan, 2015–2020.* Kampala: Ministry of Health, Uganda. Available at: http://www.healthpolicyproject.com/ns/docs/CIP_Uganda.pdf.

National HIV/AIDS Secretariat. 2015. *National Strategic Plan on HIV/AIDS, 2016 – 2020.* Available at: http://www.nas.gov.sl/images/stories/publications/Sierra%20Leone%20National%20Strategic%20Plan%202016%20-%202020.pdf.

National Population Policy for Development, Progress and Welfare. 1993. "Government Notice No. 82. 2 April 1993." *Sierra Leone Gazette* 124(15): 73-81.

PMA2020. n.d. “Performance Monitoring and Accountability 2020.” Available at: http://www.pma2020.org/about-fp2020.

Prata, N., A. Gessessew, A. Cartwright, and A. Fraser. 2011. Provision of injectable contraceptives in Ethiopia through community-based reproductive agents. *Bulletin of the World Health Organization* 89: 556-564. Available at: http://www.who.int/bulletin/volumes/89/8/11-086710/en/.

“RHInterchange.” Available at: https://www.unfpaprocurement.org/rhi-home.

Stanback, J., A.K. Mbonye, and M. Bekiita. 2007. Contraceptive Injections by Community Health Workers in Uganda: A Nonrandomized Community Trial. *Bulletin of the World Health Organization* 85(10): 768-73. Available at: https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/3406208.pdf.

Stanback, J., J. Spieler, I. Shah, and W.R. Finger. 2010. Commentary: Community-based Health Workers Can Safely and Effectively Administer Injectable Contraceptives: Conclusions from a Technical Consultation. *Contraception* 81: 181-184. Available at: https://www.k4health.org/sites/default/files/Stanback%20et%20al_Contraception.pdf.

Sedgh, G., and R. Hussain. 2014. “Reasons for Contraceptive Nonuse among Women Having Unmet Need for Contraception in Developing Countries.” *Studies in Family Planning* 45(2): 151-169. Available at https://www.guttmacher.org/sites/default/files/pdfs/pubs/journals/j.1728-4465.2014.00382.x.pdf.

Sierra Leone Government, Ministry of Health and Sanitation. 2011. *Reproductive, Newborn, and Child Health Strategy, 2011–2015*.

Singh, S., J.E. Darroch, and L. Ashford. 2013. *Adding It Up: The Need for and Cost of Maternal and Newborn Care—Estimates for 2012*. New York: Guttmacher Institute. Available at: http://www.guttmacher.org/pubs/AIU-MNH-2012-estimates.pdf.

Statistics Sierra Leone (SSL). 2016. *2015 Population and Housing Census Summary of Final Results*. Available at: https://www.statistics.sl/wp-content/uploads/2017/01/final-results_-2015_population_and_housing_census.pdf.

Statistics Sierra Leone (SSL), Central Statistics Office. 1985. *The Analytical Report: 1985 Population and Housing Census Sierra Leone*. Available at: https://www.statistics.sl/wp-content/uploads/2016/06/1985-Analytical-Report.pdf.

Statistics Sierra Leone (SSL) and ICF International. 2014a. *Sierra Leone Demographic and Health Survey 2013*. Freetown, Sierra Leone and Rockville, Maryland, USA: SSL and ICF International.

Statistics Sierra Leone (SSL) and ICF International. 2014b. Sierra Leone Demographic and Health Survey 2013: Key Findings. Rockville, Maryland, USA: Statistics Sierra Leone and ICF International. Available at: http://dhsprogram.com/pubs/pdf/SR215/SR215.pdf.

Statistics Sierra Leone (SSL) and ICF Macro. 2009. *Sierra Leone Demographic and Health Survey 2008*. Calverton, Maryland, USA: Statistics Sierra Leone and ICF Macro. Available at: http://dhsprogram.com/pubs/pdf/FR225/FR225.pdf.

The DHS Programme. 2014. “Unmet Need for Family Planning.” Available at: http://dhsprogram.com/topics/Unmet-Need.cfm.

Track 20. n.d. “FP Goals. Sierra Leone 2017.”

Track 20. 2016. “Sierra Leone: Projected Trends in mCPR.” Available at: http://www.track20.org/pages/participating_countries/countries_country_page.php?code=SL.

UNFPA. 1995. *International Conference on Population and Development – ICPD – Programme of Action.* A/CONF.171/13/Rev.1. Report of the International Conference on Population and Development.

UNFPA. 2016. Facility Assessment for Reproductive Health Commodities and Services in Sierra Leone.

UNICEF. 2016. *The State of the World’s Children 2016 – Statistical Tables*. Available at http://data.unicef.org/resources/state-worlds-children-2016-statistical-tables/.

“United Nations Sustainable Development Hub.” n.d. Available at: https://sustainabledevelopment.un.org.

Weinberger, M., F. Pozo-Martin, T. Boler, K. Fry, and K. Hopkins. 2012. *Impact 2: An Innovative Tool for Estimating the Impact of Reproductive Health Programmes*. London: Marie Stopes.

World Bank. 2011. “Sierra Leone–Reproductive Health at a Glance.” Available at: http://siteresources.worldbank.org/INTPRH/Resources/376374-1303736328719/SierraLeone42211web.pdf.

World Health Organization (WHO). n.d. *The Abuja Declaration: Ten Years On*. Available at: http://www.who.int/healthsystems/publications/Abuja10.pdf.

World Health Organization (WHO). 2011. *WHO Guidelines: Preventing Early Pregnancy and Poor Reproductive Health Outcomes amongst Adolescents in Developing Countries*. Available at: http://www.who.int/reproductivehealth/publications/adolescence/9789241502214/en/.

World Health Organization (WHO). 2015. Trends in Maternal Mortality: 1990 to 2015. Estimates by WHO, UNICEF, UNFPA, World Bank Group and the United Nations Population Division. Available at: http://apps.who.int/iris/bitstream/10665/194254/1/9789241565141_eng.pdf?ua=1.

World Health Organization (WHO). 2016. *Mid-Year Progress in Focus–2016: Sierra Leone.* Available at http://www.afro.who.int/index.php?option=com_docman&task=doc_download&gid=10419&Itemid=2593.

World Health Organization (WHO) Africa. n.d. *Analytical summary – Partnerships for health development.* Available at: http://www.aho.afro.who.int/profiles_information/index.php/Sierra_Leone:Analytical_summary_-_Partnerships_for_health_development.

ANNEX A. IMPLEMENTATION FRAMEWORK WITH FULL ACTIVITY DETAIL

There are three strategic priorities that have been identified by the government and stakeholders as being critical for achieving the CIP operational goals. Each activity that contributes to a strategic priority is identified by a red star and is followed with a numerical reference, for instance: ★Activity (SP X).

Strategic Priority #1 (SP1): Postpartum FP

Strategic Priority #2 (SP2): Stockout reductions

Strategic Priority #3 (SP3): LARC via PHUs (with focus on implant scale-up)

Area 1: Demand Creation (DC)

Strategic Result	Activity	Subactivity	Input	Output Indicators	Timeline
DC 1 Increased acceptability and support for FP among potential users and gatekeepers	DC 1.1 Gather evidence from existing research and primary data to inform an SBCC strategy and materials to ensure accurate, clear, and consistent rights-based FP messaging that targets specific audiences, including, but not limited to, postpartum women, women of reproductive age ages 20–24 years, married adolescents, men, religious leaders, parents, teachers, healthcare providers, youth, and the physically challenged	DC 1.1.1 Engage a research firm to: • Conduct an assessment and analysis of SBCC initiatives implemented to date. This should include a desk review of what research already exists • Identify which SBCC initiatives worked well to address myths and misconceptions and which ones did not • Evaluate why the current messaging is not resonating/reaching all subgroups of people, especially men • Use primary or secondary data to provide an in-depth analysis of known barriers to FP uptake.[19]	RHFPP staff time and technical support to draft request for proposals Staff time: 4 people for 3 days (1 RHFPP, 1 Health Education Division [HED]), 1 IP, 1 UN agency) Hire research firm (for 40 days)	Terms of reference produced Research conducted	Year 1: Quarter 1
		DC 1.1.2 Hold half-day stakeholder meeting with IPs and representatives from all districts to validate desk analysis findings	Hire venue in Freetown (small conference hall, half-day); refreshments (30 people) Daily Subsistence Allowance (DSA) and transport allowance for participants from 13 DHMTs	Stakeholder meeting held	Year 1: Quarter 2

[19] E.g., reasons for men's negative attitude towards contraceptives; how men can be encouraged to be more supportive of FP; the religious basis used for refuting contraceptives; how religious leaders can be encouraged to be more supportive of FP; the existing myths and misconceptions about FP and examples of how they have been overcome within current SBCC initiatives; why women use quacks and what can be done to limit use of quacks; reasons for low uptake of postpartum FP; reasons for missed appointments and loss to follow-up; reasons for the high birth rate among 20- to 24-year-olds; reasons for high birth rate among adolescents in the first year of marriage and a more in-depth understanding of the environment that fosters this behavior; people's knowledge of their right to FP; and other relevant topics discovered during the desk review.

Strategic Result	Activity	Subactivity	Input	Output Indicators	Timeline
DC1	DC 1.1	DC 1.1.3 Research firm produces reports	No additional cost. Time for report production included in the 40 days allocated in the first subactivity	Research report produced	Year 1: Quarter 2
	DC 1.2 Develop an evidence-based, comprehensive, targeted SBCC strategy to give direction to rights-based FP SBCC activities, including revised messaging. Use targeted communication channels as identified in research report, with a focus on postpartum FP, areas of low demand, and groups such as men whose attitude toward contraceptives is known to be a barrier to uptake of modern contraceptives.	DC 1.2.1 Engage a team to develop an SBCC strategy based on the research findings, and develop and test key communication messages for all audiences with the full participation and consultation of communities	RHFPP and IP staff time to draft request for proposals 4 people for 3 days each (1 RHFPP, 1 HED, 1 IP, 1 UN agency) Hire communication firm (40 days)	FP SBCC strategy developed and approved	Year 1: Quarters 2 and 3
	DC 1.3 Disseminate the comprehensive SBCC strategy	DC 1.3.1 Print SBCC strategy	Print 30 pages color (500 copies)	SBCC strategy printed	Year 1: Quarter 4

Strategic Result	Activity	Subactivity	Input	Output Indicators	Timeline
DC 1	DC 1.3	DC 1.3.2 Organize and hold 4 1-day dissemination meetings (1 in Freetown and 1 each in Eastern, Northern, and Southern provinces)	RHFPP staff time (2 people, 10 days each) Top-up mobile phones of RHFPP staff (150,000 SLL each) Hire venue in Freetown (large conference hall, 1 day) Hire venue (large conference hall in each of 3 regions, 1 day per region) Transport allowance and refreshments (250 people: 100 at national dissemination, 50 at each regional dissemination)	National and regional dissemination meetings for SBCC strategy held (Target: 1 national, 3 regional)	Year 1: Quarter 4
	DC 1.4 Implement the SBCC strategy and disseminate targeted rights-based messages	DC 1.4.1 Hire communication officer to lead implementation of SBCC strategy Team consisting of RHFPP, HED, IP, and UN agency representatives to draft job description, person specification, and advertisement, and the same team to shortlist and interview	Staff time (4 people, 5 days each: 1 RHFPP, 1 HED, 1 IP, 1 UN agency) Purchase ¼ page advertisement in national newspaper for 2 weeks Annual salary for communication officer (starting Year 1: Quarter 4)	Communication officer hired	Year 1: Quarter 3, then ongoing
		DC 1.4.2 Hire media production firm to work with MOHS Health Promotion Unit to develop and test (pre- and post-test) a mass media campaign on FP based on SBCC strategy—including creating context-specific communication materials, FAQs, flyers, audio visuals, posters, brochures, and billboards	Hire media production firm (60 days in Year 2, 30 days in Year 3) MOHS HPU staff time	Communication materials, drama, FAQ, audio visuals, flyers, posters, brochures, and billboards developed	Year 2: Quarters 3 and 4 Year 3: Quarters 1 and 2

Strategic Result	Activity	Subactivity	Input	Output Indicators	Timeline
DC 1	DC 1.4	DC 1.4.3 Hold three consultations (one in each region) with three groups (one each with young people, women, and men) to learn their feedback at the initiation stage and have them review FP messages and final materials (20 people/consultation)	Hold 3 1-day stakeholder meetings (2 meetings in Year 2 and 1 meeting in Year 3), including hall hire (1 day per meeting), refreshments, and printed materials for 30 people Staff time for 2 staff from MOHS Health Promotion Unit to pre-test and post-test materials, 40 days annually Transport, lodging, and daily allowance for field pre- and post-test by 2 staff from the Health Promotion Unit (4 days in each region) Regional hall hire, transport, printed materials and refreshments for 20 participants per session (3 1-day sessions in each of the four regions)	Communications materials pre-and post-tested	Year 2: Quarter 4 Year 3: Quarter 1

Strategic Result	Activity	Subactivity	Input	Output Indicators	Timeline
DC 1	DC 1.4	DC 1.4.4 Hold 2 1-day workshops in Freetown with 20 FP rights advocates and community representatives, including young people, to ensure communication materials include rights-based FP messages, 1 workshop at beginning of the process, and 1 once the messages have been drafted	Venue hire in Freetown (small conference hall, 1 day for each workshop) Transport allowance, refreshments, and 10 pages of printed materials (20 participants per workshop)	Number of workshops to review communications messages from a rights-based perspective (Target: two) Percentage of SBCC campaign materials with rights-based FP messages (Target: at least 50% of materials explicitly addresses one or more of the following: agency and autonomy; availability; accessibility; acceptability; quality; empowerment; equity and nondiscrimination; informed choice; transparency and accountability; and voice and participation)	Year 2: Quarter 3 Year 3: Quarter 2
		DC 1.4.5 Print and disseminate context-specific communication materials	Print communications materials: • Fliers: 15,000 annually • Posters: 3000 annually • Billboards: 14 annually (one per district)	Print fliers (Target: 15,000 annually) Print posters (Target: 3000 annually) Billboards mounted (Target: 14 annually)	Year 2: Quarter 1, then ongoing

Strategic Result	Activity	Subactivity	Input	Output Indicators	Timeline
DC 1	DC 1.4	DC 1.4.6 Hold a series of media events to promote awareness and acceptability of FP and to address common myths and misconceptions. These events will include the adaption of a radio drama which will be aired twice per week, and an on-air call-in show that will take place once per quarter where a registered nurse answers calls from listeners. Daily radio jingles will disseminate key messages developed under DC 1.2. Set up a radio drama advisory committee to identify all radio dramas that have been done on FP in the past 10 years and review content of dramas and chose an appropriate series for airing. • Hire a media company for 30 days to adapt radio drama as required • Air the drama twice per week (1 new show weekly, and 1 repeat airing of the show)	Staff time of radio show coordinator and FP experts from government and implementing partners to develop the concept for the radio show and an accompanying radio jingle or trailer (2 people, 10 days each) Hire media company (30 days per year) RHFPP and IP staff time (12 days per year) to develop quarterly call-in show, HED staff time (2 days per year) to organize with radio stations RHFPP staff time (1 day per quarter) and transport allowance (1 day per quarter) for registered nurse to attend radio station to host call-in show 30-second ad space on radio to play jingle (3 times daily during prime time – 7 days per week, 52 weeks per year beginning in Year 2, Quarter 3) 10-minute air time to host radio drama (2 per week, 52 weeks per year beginning in Year 2 Quarter 3) 30 minutes air time per quarter to host discussion sessions on radio (1 session per quarter starting in Year 2 Quarter 2)	Number of 30-second radio spots purchased and aired (Target: 548 in Year 2, 1095 per year in Years 3–5) Number of 10-minute radio dramas purchased and aired (Target: 52 in Year 2, 104 per year in Years 3-5) Number of 30-minute call-in shows aired (Target: three in Year 2, four per year in Years 3–5)	Year 2: Quarter 1, then ongoing

Strategic Result	Activity	Subactivity	Input	Output Indicators	Timeline
DC 1	DC 1.4	DC 1.4.7 Full day workshop in Freetown to orient journalists (including TV and radio presenters) on selected FP thematic topics, including SRH and rights and development for young people	Partner staff time to develop material to train journalists on FP, 20 days Print 50 pages black-and-white (20 copies) Venue hire in Freetown (small conference hall, 1 day in Year 3, 1 day in Year 5), refreshments, materials, and transport allowance (20 participants per workshop)	Materials developed to train journalists Number of journalists oriented on rights-based FP (Target: 20 in Year 3, 20 in Year 5)	Year 3: Quarter 1 Year 5: Quarter 1
		DC 1.4.8 Create a mailing list that includes contacts from television stations, radio stations, and newspapers, and regularly send information about FP resources to media contacts	Communication officer staff time (30 days annually starting in Year 2)	Number of outreach communication activities with journalists (Target: 2 communications per week)	Year 2: Quarter 1, then ongoing
DC 2 Number and visibility of FP champions at national and community levels, including parliamentarians, religious leaders, chiefs, mammy queens, and other prominent leaders, are increased	DC 2.1 Identify, train, and support FP champions at all levels of society	DC 2.1.1 Identify key named champions for FP at national, district, and community levels, including parliamentarians and religious and traditional leaders	RHFPP and TA time to identify and recruit champions (1 RHFPP staff, 1 IP staff, one UN agency for 3 days)	Number of champions identified 10 national champions and one per chiefdom or ward (Target: 168)	Year 1: Quarter 2

Strategic Result	Activity	Subactivity	Input	Output Indicators	Timeline
DC 2	DC 2.1	DC 2.1.2 Provide training and support to develop a simple action plan for visibility in their territory, with a focus on encouraging postpartum FP	7 2-day trainings (1 held nationally and 2 held in each region) for up to 25 people per training Venue hire (1 in Freetown, 6 at regional level—small conference hall, 2 days per training), transport allowance and daily subsistence allowance (DSA) (25 participants per training), transport allowance and DSA for 2 trainers to support all 7 trainings (14 days)	Number of champions trained and action plans developed (Target: 168)	Year 1: Quarter 3
		DC 2.1.3 DHMT and IP staff time to conduct biannual monitoring to each district and provide ongoing support and monitoring of champions' work. *Monitoring must include feedback to community/DHMT.*	Stipend for champions to implement action plans Transport allowance and DSA for supervisors to conduct monitoring visits to each of 14 districts (3 people, 12 days annually per district; includes 2 3-day visits and 2 x 3 days in office for report writing and dissemination)	Number of monitoring visits conducted annually (Target: 28)	Year 1: Quarter 4, then every 6 months of the strategy

Strategic Result	Activity	Subactivity	Input	Output Indicators	Timeline
DC 3 Community-level communication through CHW outreach and facilitated community discussions is increased. This includes efforts to promote postpartum FP; increase parent–child communication about SRH and FP; encourage men to become involved in FP, initiate discussions on FP, and accompany women to FP clinics; and discourage men's desire for large family size and unprotected sex.	DC 3.1 Work with the CHW program to review and revise training program and job aids for facilitated discussions at the community level	DC 3.1.1 Review job aids and training and supervision materials available for CHWs in FP	RHFPP staff time and technical support from UNICEF and CHW hub (3 staff, 3 days each)	Job aids printed and distributed (Target to be agreed with CHW program)	(To fit with CHW plans)
		DC 3.1.2 Hold discussion with CHW program to agree on job aids and training and supervision materials to be used	RHFPP staff time and technical support from UNICEF and CHW hub (3 staff, 1 day each)	Job aids and supervision materials to be used by CHWs are identified	(To fit with CHW plans)
		DC 3.1.3 Provide TA to revise existing job aids and/or develop new ones *(as determined by results of the review and agreement)*	RHFPP staff time and technical support from UNICEF and CHW Hub (3 staff, 3 days each)	Job aids for CHWs are revised and finalized	(To fit with CHW plans)
	DC 3.2 Strengthen CHW training and supervision to ensure positive and responsive client–provider interactions; unbiased, nondirective counseling that addresses side effects for chosen method; and attention to privacy, confidentiality, and client dignity. Work with CHW program to train CHWs on FP as part of the larger CHW training efforts.	DC 3.2.1 RHFPP staff to participate in the training of CHWs	RHFPP staff time (1 staff, 12 days per year) RHFPP staff DSA and transport allowance (13 days per year)	Number of trainings participated in (Target to be set with CHW program) Number of training reports produced (Target to be set with CHW program)	Year 1: Quarter 3, then ongoing
		DC 3.2.2 RHFPP staff to participate in the supervision of CHWs	RHFPP staff time (1 staff, 12 days per year) RHFPP staff DSA and transport allowance (13 days per year)	Number of supervisions attended (Target to be set with CHW program) Number of supervision reports produced (Target to be set with CHW program)	Year 1: Quarter 3, then ongoing

Strategic Result	Activity	Subactivity	Input	Output Indicators	Timeline
DC 3	DC 3.3 Build institutional capacity of community-based and faith-based organizations and civil society organizations based on their need to promote the reduction of objections against FP and raise awareness of FP and RH rights	DC 3.3.1 Hire a research firm to: 1. Identify and map faith-based organizations 2. Assess institutional capacity and needs of local religious and faith-based organizations to provide FP education and prioritize those that need support 3. Develop a report and present recommendations to RHSCS	Hire research firm (60 days per year)	A report and recommendation of the assessment of local organizations	Year 2: Quarter 1
		DC 3.3.3 DC 3.3.2 RHFPP and IP staff conduct outreach and advocacy to civil society and faith-based organizations identified during the capacity assessment and provide them with communication materials on FP and rights, including audiovisual materials, guidelines, and manuals	Staff time for RHFPP staff (2 staff, 40 days each) and IP staff (2 staff, 40 days each) Transport allowance for 30 trips within Freetown Print materials (50 copies of 10-page color materials)	Local organizations provided with technical support and supplied with office supplies, audiovisual materials, guidelines, and manuals	Year 2: Quarter 2
		DC 3.3.4 Hold national biannual one-day meeting with local organizations being supported, in order to identify new areas of need or opportunities for additional advocacy	Hire venue in Freetown (small conference venue, 1 day 2 times per year); refreshments, transport allowance, and print materials (30 people)	Number of review meetings annually (Target: 2)	Year 2: Quarter 4 Year 3: Quarters 2 and 4 Year 4: Quarters 2 and 4 Year 5: Quarters 2 and 4
		DC 3.3.5 RHFPP to provide continuous mentorship to local organizations	RHFPP (1 staff, 2 days per month each) and partner staff time (14 staff, 2 days per month each) Transport allowance and DSA for 6 day trips per district per year	Number of mentoring sessions held (Target: 6 per district per year = 84 per year)	Year 3: Quarter 1, then ongoing

Strategic Result	Activity	Subactivity	Input	Output Indicators	Timeline
DC 4 Improved access to correct and rights-based information on FP on various media channels	DC 4.1 Establish effective and efficient use of social media campaigns to create demand for FP and correct myths and misconceptions	DC 4.1.1 Leverage popular social media sites used in-country such as WhatsApp, Facebook, and Twitter to disseminate tailored FP information and regularly conduct discussion forums to create FP demand and address myths and misconceptions; • Assign implementing partner staff to develop social media platform and train staff • Recruit for a Social Media Coordinator to host weekly forum and post daily messages, including brief success stories (written and video format) • Assign FP experts in government and implementing partner organizations to provide FP information weekly to social media coordinator • Procure 1 laptop and 1 smartphone for use by the social media coordinator	Implementing partner staff time to develop platform (60 days) Social media coordinator staff time (100 days per year) RHFPP staff time (1 staff, 2 hours per week) and IP staff time (1 person, 2 hours per week) 1 laptop 1 smartphone with video functionality Internet bundle (2GB per month) and Talktime (120 minutes per month) for smartphone of social media coordinator	Social media platform developed Number of social media forums conducted (e.g., Tweet chats, Google hangouts, Facebook discussions) (Target: 2 per week) Number of FP messages posted on social media pages daily (Target: 2 per day)	Year 2: Quarter 1, then ongoing

Area 2: Service Delivery (SD)

Strategic Results	Activity	Subactivity	Input	Output indicators	Timeline
SD 1 Quality rights-based FP information and services are provided in health facilities	SD 1.1 Develop and implement an attitudinal behavior change campaign for health workers on FP to ensure that providers are aware of and act in accordance with clients' FP and RH rights	SD 1.1.1 Engage a research firm to conduct an in-depth study on the attitudes of health workers toward FP	RHFPP staff time (2 people for 3 days) and technical support from 1 IP and 1 UN agency (3 days each) to draft request for proposals Hire a research firm (60 days) Print 30-page report in color (500 copies)	Report on service providers' attitudes printed and presented to RHFPP	Year 1: Quarters 1 and 2
		SD 1.1.2 Plan and hold a 2-hour meeting in Freetown and each of the other 13 districts to disseminate research report on the study of health workers' attitudes toward FP	RHFPP and DHMT staff time (2 RHFPP staff for 28 days each and 14 DHMT staff for 5 days each) Travel for 1 RHFPP staff to attend each district dissemination; transport allowance and DSA (for 14 dissemination meetings) Venue hire in Freetown and 13 additional districts (medium conference hall, half day) Tea break (14 events with 30 people per event)	Dissemination meetings held (Target: 1 national, 13 at district level)	Year 1: Quarter 2
		SD 1.1.3 Engage a training specialist to design an attitudinal change training based on the research findings	RHFPP staff time and technical support to develop terms of reference (2 staff, 2 days each) Hire consultant (20 days)	Training module developed	Year 1: Quarter 3

Strategic Results	Activity	Subactivity	Input	Output indicators	Timeline
SD 1	SD 1.1	SD 1.1.4 Train 28 trainers (two DHMT staff trained per district) on delivery of the attitudinal training	RHFPP staff time (2 staff, 3 days each) Consultant time (3 days) Venue hire in Freetown (medium conference hall, 3 days), refreshments, transport allowance and DSA for DHMT staff (3 days, 28 staff)	Number of trainers trained (Target: 28)	Year 2: Quarter 2
		SD 1.1.5 Develop key FP messages for display on facility registers as daily reminders to health workers	RHFPP and HED staff time to develop a standard FP message to display on staff registers (4 staff, 2 days each)	Messages developed and approved	Year 2: Quarter 3
		SD 1.1.6 Print and distribute FP message stickers for health facility registers	Printing (2000 stickers) RHFPP staff time (1 staff, 7 days) to find individuals/organizations going to districts to take stickers	Number of stickers distributed (Target: 1,400)	Year 2: Quarter 3

Strategic Results	Activity	Subactivity	Input	Output indicators	Timeline
SD 1	★ SD 1.2 Train public and private sector staff in the provision of rights-based FP services, including LARC (SP 3)	SD 1.2.1 Procure training materials and equipment for comprehensive training in FP, including training manuals, job aids, FP commodities, and plastic uteri and arms for each district	RHFPP and IP staff time to procure materials and equipment (1 RHFPP staff, 14 days, and 1 IP staff, 14 days) Procure equipment for trainings: • 140 plastic arms (10 per district, replace every 2 years) • 56 plastic uteri (4 per district) • IUD and implant equipment (2 sets per district). Equipment= sponge forceps, tenaculum, steel speculum, uterine sound, scissors, alligator, solution cup, kidney tray, cheatle forcep, cheatle jar, steel tray) • 500 laminated 10-page job aids • 500 black-and-white training packets (30 pages each) 18 30-page training manuals	Equipment and materials procured (Target: 500 training packs)	Year 1: Quarter 3 Year 3: Quarter 3 for replacement equipment Year 5: Quarter 5 for replacement equipment
		SD 1.2.2 Work with DHMT to identify staff for training	RHFPP and DHMT staff time (14 DHMT staff for 2 days each, 2 RHFPP staff for 14 days each)	Number of health workers identified for training (Target: 500)	Year 2: Quarter 1

Strategic Results	Activity	Subactivity	Input	Output indicators	Timeline
SD 1	★ SD 1.2	SD 1.2.3 Train facility staff in the provision of rights-based FP services; 28 trainings total (2 per district)	Venue hire (medium-sized venue, 10 days per training for 7 trainings per year); DSA, refreshments, and transport allowance (14 days per training for 20 participants and 2 facilitators for 7 trainings per year) Ministry staff time for training (2 facilitators for 14 days for 7 trainings per year)	Number of health workers trained (Target: 491, as per FP Goals scenario)	Year 1: Quarter 2 through Year 4: Quarter 4
		SD 1.2.4 Conduct ongoing supportive supervision to trainees to ensure correct application of knowledge and skills obtained from the training	RHFPP and DHMT staff time (2 RHFPP staff, 28 days per quarter each; 28 DHMT staff for 35 days per quarter each)	Percentage of trainees provided with at least one follow-up visit to ensure application of knowledge and skills (Target: 95%)	Year 1: Quarter 3, then ongoing
		SD 1.2.5 Provide certificate for all competent staff post-supervision and follow-up	Print 1-page certificate, 500 copies	Number of certificates printed (Target: 500)	Year 1: Quarter 3, then ongoing
	SD 1.3 Review current service delivery standards, guidelines, protocols, training, and supervision materials to identify opportunities to increase information and training on client rights, and articulate the providers' responsibilities related to ensuring those rights	SD 1.3.1 RHFPP to review and revise FP standards guidelines, protocols, and training materials Hold a workshop to review and validate the revised materials	RHFPP staff time (1 staff for 10 days) and IP staff time (1 staff for 10 days) Venue hire in Freetown (medium conference hall, 2 days); transport allowance, DSA, tea, and lunch (25 people for 2 days)	FP training curriculum revised Standards and protocols revised	Year 2: Quarter 4

Strategic Results	Activity	Subactivity	Input	Output indicators	Timeline
SD 1	SD 1.4 DHMTs to ensure every government and private health facility has a health worker who is trained to provide FP services and adolescent- and young people-friendly services	SD 1.4.1 Hold meetings with DHMTs to discuss provider placements and identify opportunities to ensure there is a trained provider in every facility	RHFPP staff time (2 staff for 28 days) DHMT staff time (2 staff for 2 days) DSA and transport allowance for RHFPP staff (2 staff for 28 days)	Minutes of meeting with DHMT List of facilities showing health workers with FP placed	Year 1: Quarter 4
		SD 1.4.2 Monitor staff rotation to ensure every facility has a health worker trained in FP services. DHMT to review staffing of facilities to ensure appropriate number of providers trained in FP during regular supportive supervisory visits to facilities, and report quarterly to RHFPP	RHFPP staff time (1 staff, 5 days per quarter) DHMT staff time (included in regular supportive supervision, no additional cost)	Percentage of DHMTs that send a list of health worker placements to RHFPP per quarter (Target: 100%) Percentage of facilities that have a trained FP provider (Target: 100%)	Year 2: Quarter 1, then ongoing
	SD 1.5 Reinforce training through supportive supervision, job aids, and mentorship to ensure that providers are providing respectful and comprehensive information and counseling to all clients, regardless of age, gender, class, ethnicity, or marital status	SD 1.5.1 RHFPP staff to work with DHMTs to develop a quarterly supportive supervision plan	RHFPP staff time (1 staff for 2 days per district per quarter) and DHMT staff time (1 staff for 2 days per district per quarter)	Number of supervision plans developed (Target: 14)	Year 1: Quarter 1, then ongoing

Strategic Results	Activity	Subactivity	Input	Output indicators	Timeline
SD 1	SD 1.5	SD 1.5.2 Undertake quarterly supportive supervision	4 RHFPP staff for 15 days per quarter each 4 staff per DHMT for 30 days per quarter each Travel allowance and DSA for 5 days per quarter in each district (12) Mobile top-up to support communication, 1 per quarter for each district (12)	Number of supervision reports from DHMT with clear action plans for solving problems (Target: 14 per quarter)	Year 1: Quarter 1, then ongoing
	SD 1.6 Improve follow-up of FP clients who have not returned to the facility in order to reduce clients lost to follow-up	SD 1.6.1 Work with DHMT to collect and analyze data on clients lost to follow-up and to develop and implement action plans to follow up clients, and provide airtime to service providers to make phone calls and send texts to clients who are late in returning to facilities/CHWs to help with follow-up in communities	RHFPP, IP, and DHMT staff time (4 RHFPP staff for 10 days per quarter; 4 IP staff for 10 days per quarter; 13 DHMT staff for 10 days per quarter; 1 DHMT staff [Western Area DHMT] for 20 days per quarter) 60 minutes of airtime per month for 500 healthcare workers	Number of reports on lost to follow-up clients and accompanying action plans produced (Target: 14 per quarter)	Year 1: Quarter 2, then ongoing
	SD 1.7 RHFPP to work with Primary Health Care (PHC) Department and other programs, including Nutrition, to implement annual exit surveys at every facility to examine and make improvements at the facility level to improve quality of care	SD 1.7.1 Hold a meeting with PHC and Nutrition department to review and revise existing exit surveys Engage civil society groups and NGOs to conduct quarterly exit surveys Collate survey results and create management reports RHFPP to work with DHMT to develop and implement action plans to address issues identified in exit surveys	RHFPP, PHC, Nutrition staff time (4 staff for 5 days per quarter) Health worker staff time/civil society and NGO staff time (28 staff, 30 days per year)	Exit survey reports published (Target: 28 per year)	Pre-strategy commencement Year 2: Quarter 4, then ongoing

Strategic Results	Activity	Subactivity	Input	Output indicators	Timeline
SD 1	SD 1.8 Increase participation of communities in service delivery, emphasizing the participation of young people, women, men, people with disabilities, etc.	SD 1.8.1 RHFPP to prepare and send letters to advocate for service institutions to include community representatives (using existing platforms such as health development committees/facility management committees), and including young people on management teams and service delivery teams DHMTs to include community participation as an agenda item in annual review meetings of facility governance	RHFPP staff time to prepare advocacy messages, send letters, and conduct follow-up (1 person for 20 days in year 2, and then 10 days per year in each of the following years of the plan)	Percentage of facilities that engage young people and other community representatives in their governance structures (Target: 90%)	Year 2: Quarter 1, then ongoing
SD 2 Uptake of post-natal FP services is increased	★ SD 2.1 Ensure health workers are trained to counsel at all visits and provide FP services at 6-week postpartum visit and subsequent immunization visits (SP 1)	SD 2.1.1 Engage consultant to review and adapt current FP pre- and in-service trainings to train health workers to provide comprehensive counseling on FP during all ANC visits, and during delivery of postpartum FP. Review must include social, cultural, and religious reasons for low take-up and provide recommendations	RHFPP staff time (2 staff for 20 days each) Hire consultant (30 days)	Adapted training module developed	Year 2: Quarter 1
		SD 2.1.2 Train trainers on including FP in ANC and postnatal FP	RHFPP staff time (2 staff for 20 days each) Medium-size venue hire in Freetown for 5 days; transport allowance, DSA, refreshments, conference materials, and didactic materials for 28 people for 5 days	Number of trainers trained (Target: 28)	Year 2: Quarter 2

Strategic Results	Activity	Subactivity	Input	Output indicators	Timeline
SD 2	★ SD 2.1	SD 2.1.3 Ensure that any planned training on FP includes unit on providing postnatal FP services	RHFPP staff time (1 person for 5 days per year)	Number of health workers trained (Target: 491)	Year 2: Quarter 2, then ongoing
	SD 2.2 Work with Nutrition Department and implementing partners to scale up integration of FP and nutrition at 6-month well-child visits	SD 2.2.1 Hold biannual meetings with Nutrition Department and their implementing partners to identify opportunities to incorporate FP and nutrition into 6-month well-child visits, and agree on an MOU for scale-up	Staff time for RHFPP and Directorate of Food and Nutrition (DFN), (2 RHFPP staff and 2 DFN staff for 4 days per year per person)	Minutes of meeting (Target: 2 per year)	Pre-commencement of strategy, then ongoing
SD 3 FP information and services are integrated with nutrition, immunization, HIV, and cervical cancer screening	SD 3.1 Continue to provide FP information and referral services for parents accessing vitamin A supplementation and deworming services	SD 3.1.1 Hold meetings with Nutrition Department to discuss continuation of provision of FP information and referral services when parents access vitamin supplementation and deworming services (Combine with SD 2.2)	HFP, Nutrition, MOHS staff time (No additional time—combine with SD 2.2)	Minutes of meetings (Target: 2 per year)	Pre-commencement of strategy, then ongoing
		SD 3.1.2 Participate in joint supportive supervision with Nutrition department	RHFPP staff time to conduct supervision (2 staff for 12 days per year) DSA (2 staff for 12 days per year)	Joint supervision reports (Target: 2 per year)	Year 1: Quarter 1, then ongoing
		SD 3.1.3 FP information and services are integrated with reproductive and child health activities (adolescent sexual and reproductive health, HIV, cervical cancer screening)	RHFPP staff time (2 staff for 4 days per year); school health staff time (2 staff for 4 days per year); National HIV/AIDS Secretariat staff (2 staff for 4 days per year)	Number of health services in which FP information or services are provided (Target: 3)	Year 1: Quarter 1, then ongoing

Strategic Results	Activity	Subactivity	Input	Output indicators	Timeline
SD 3	★ SD 3.2 Train health workers to ensure that counseling and provision of FP services are integrated into the 6-week postpartum visit and subsequent immunization visits (SP 1)	SD 3.2.1 Hold meetings with EPI department to advocate for inclusion of messaging about FP during child immunization visits	Staff time (2 RHFPP staff for 4 days per year each, 2 EPI staff for 4 days per year each)	Minutes of meetings (Target: 2 per year)	Pre-commencement of strategy, then ongoing
		SD 3.2.2 Participate in joint supportive supervision with EPI department twice per year	RHFPP staff time (2 staff for 10 days per year each) Transport allowance and DSA for 2 RHFPP staff (12 days)	Joint supervision reports (Target: 2 per year)	Year 1, Quarter 1, then ongoing
		SD 3.2.3 Review and revise supervision materials and appropriate IEC	RHFPP staff time (1 staff for 15 days)	Supervision and IEC materials revised and disseminated	Year 1, Quarter 3
	SD 3.3 Include as criteria for staff who can be trained on cervical cancer screening that they must have already been trained on long-term FP methods	SD 3.3.1 Hold meetings with department responsible for cervical cancer screening to discuss criteria for staff to be trained in cervical cancer screening	RHFPP and cervical cancer screening staff time (2 RHFPP staff for 4 days per year; 2 cervical cancer screening staff for 4 days per year)	Minutes of meetings (Target: 2 per year)	TBD (depends on timeline of cervical cancer screening initiative)
		SD 3.3.2 Contribute to the development of criteria for staff to be trained in cervical cancer screening	RHFPP staff time (2 RHFPP staff for 6 days per year)	Criteria for who can be trained in cervical cancer screening includes FP	TBD (depends on timeline of cervical cancer screening initiative)
	SD 3.4 Work with NACP to ensure that FP is fully integrated into HIV services	SD 3.4.1 Hold meetings with NACP to prepare a joint supervision plan and to review and revise supervision materials	RHFPP staff time (2 RHFPP staff for 8 days per year each; 2 NACP staff for 8 days per year each)	Minutes of meetings (Target: 2 per year)	Pre-commencement of strategy and then annually
		SD 3.4.2 RHFPP to conduct joint supportive supervision with NACP	RHFPP staff time (2 staff for 10 days annually) Transport and DSA for 2 joint supervision visits per year (2 staff for 12 days)	Joint supervision reports (Target: 2 per year)	Year 1: Quarter 1, then ongoing

Strategic Results	Activity	Subactivity	Input	Output indicators	Timeline
SD 4 All women of reproductive age who live more than five miles from a health facility have access to a full range of modern contraceptive services	SD 4.1 Provide robust mobile outreach services, including all contraceptive methods available (short- and long-term, except sterilization), including LARCs, to reach all remote areas at regular intervals	SD 4.1.1 Map all areas where nearest health facility is more than 5 miles away or facilities without a LARC provider	RHFPP staff time (1 staff, 20 days); Primary Care staff time (1 staff, 20 days); DHMT staff time (1 staff per district, 20 days)	Updated map produced (Target: 1 per year)	Year 1: quarter 2
		SD 4.1.2 Recruit a team of volunteer State Enrolled Community Health Nurses (SECHNs) in each district to conduct regular mobile outreach, and procure a 4x4 vehicle and tent for each team.	RHFPP staff time (2 people, 2 days each) to develop terms of reference and post newspaper advertisement Recruitment advertisement to run in newspaper for 2 weeks DHMT staff time for recruitment (3 staff per district for 5 days each) Procure vehicles and tents for conducting mobile outreach (1 vehicle and 1 tent per district)	Number of volunteers engaged (Target: 70, 5 per district)	Year 1: Quarter 2
		SD 4.1.3 MOHS to provide support to DHMTs to develop an annual regular outreach schedule	RHFPP staff time (1 staff per district for 3 days each), DSA and transport allowance (4 days per district); DHMT staff time (1 staff per district, 2 days each) DHMT staff time for recruitment (3 staff per district for 5 days each)	Mobile outreach schedule produced (Target: 14 per year)	Years 1–5: Quarter 3

Strategic Results	Activity	Subactivity	Input	Output indicators	Timeline
SD 4	SD 4.1	SD 4.1.4 SECHNs to conduct outreach in each district based on schedule	Monthly stipend to SECHNs (4 SECHNs per district, 12 months per year) Monthly salary for driver (1 driver per district, 12 months per year) Fuel (200 liters per district per month) Commodities and supplies will be carried from district hospital stock	Number of villages receiving regular outreach	Year 1: Quarter 4, then ongoing
		SD 4.1.5 Undertake spot checks on outreach with DHMTs	RHFPP staff time (4 staff for 12 days per quarter); DHMT staff time (2 staff for 12 days per quarter) DSA and Transport Allowance (4 RHFPP staff and 28 DHMT staff, 12 days per quarter)	Spot check reports (Target: 14 per year)	Year 1: Quarter 4 and ongoing
SD 5 FP services are available from a wide range of sources to match the needs and economic situations of all people in Sierra Leone	SD 5.1 Engage the private sector and provide training in FP service provision and use of data collection system so they can provide a wide range of FP methods	SD 5.1.1 Consult with private sector including pharmacies, faith-based clinics, private hospitals and clinics, institutional clinics (e.g., universities), workplace clinics (e.g., mining companies) on FP services provided to assess willingness and barriers to collaboration with government	RHFPP staff (4 RHFPP staff for 20 days); Pharmacy Board staff (4 staff for 20 days), IP staff (2 staff for 20 days)	Consultation report produced	Year 2: Quarter 1
		SD 5.1.2 Provide free training and data collection system to private sector providers on FP services (by including them in existing government training), provision, and data collection	No additional cost—included in ongoing trainings Travel costs	Number of private sector health workers trained (Target: 15 per year)	Year 2: Quarter 1 then ongoing

Strategic Results	Activity	Subactivity	Input	Output indicators	Timeline
SD 5	SD 5.1	SD 5.1.3 Collect data on FP services provided by private sector providers including data quality assurance systems	DHMT M&E staff time (1 person for 2 days per month, per district)	Number of data collection reports produced (Target: 12 per year per district)	Year 2: Quarter 4, then ongoing
		SD 5.1.4 Facilitate accessibility to commodities/removal of financial barriers by improving the linkages between private and public sector providers, and increasing the regulation of private sector service providers	RHFPP and DHMT staff time (2 people for 4 days per year), staff time from relevant regulatory bodies (e.g., Pharmacy Board, Medical and Dental Council)	Clear guidance is available on regulation of private sector service providers	Year 2: Quarter 2, then ongoing
SD 6 Health workers are certified to provide comprehensive counseling and information on FP and to deliver all FP services appropriate to their cadre when they graduate	★ SD 6.1 Include FP certification (including service delivery and FP data collection) in the training of all health workers at the pre-service level, so that all cadres are able to provide both short- and long-term FP methods upon graduation (SP 3)	SD 6.1.1 Conduct advocacy with training institutions for the inclusion of FP in pre-service training	RHFPP staff time (2 staff for 4 days each)	Number of meeting minutes with institutions (Target: 2)	Year 2: Quarter 1

Strategic Results	Activity	Subactivity	Input	Output indicators	Timeline
SD 6	★ SD 6.1	SD 6.1.2 RHFPP staff to provide on the job training to faculties at training institutions to capacitate (train and equip) them to provide training to students in short acting, LARC and permanent FP methods	RHFPP staff time (2 people for 10 days each), IP staff time (2 people for 20 days each) Equipment for training: • 20 plastic arms (5 per faculty) • 8 plastic uteri (2 per faculty) • IUD and implant equipment (4 sets per faculty) (Equipment= sponge forceps, tenaculum, steel speculum, uterine sound, scissors, alligator, solution cup, kidney tray, cheatle forcep, cheatle jar, steel tray) • Print 100 laminated 10-page job aids; 100 black-and-white training packets (30 pages each)	Number of faculties trained (Target: 4)	Year 2: Quarter 3

Strategic Results	Activity	Subactivity	Input	Output indicators	Timeline
SD 6	★ SD 6.1	SD 6.1.3 Provide regular continuing professional development (CPD) for training institution faculty	RHFPP staff time (2 people, 10 days each), IP staff time (2 people for 10 days each) Equipment for training: • 20 plastic arms (5 per faculty) • 8 plastic uteri (2 per faculty) • IUD and implant equipment (4 sets per faculty) (Equipment=sponge forceps, tenaculum, steel speculum, uterine sound, scissors, alligator, solution cup, kidney tray, cheatle forcep, cheatle jar, steel tray) • Print 100 laminated 10-page job aids; 100 black-and-white training packets (30 pages each)	Number of faculties that participated in CPD sessions (Target: 4)	Years 3–5: Quarter 1
		SD 6.1.4 Monitor the quality of pre-service training through spot checks, pre- and post-tests, and new provider supervision	RHFPP staff time (2 people for 10 days each per year, starting in Year 3)	Number of new FP providers scoring above 80% on post-training exams immediately following training (Target: 95%) and 6 months following the completion of training (Target: 90%)	Year 3: Quarter 1, then ongoing

Strategic Results	Activity	Subactivity	Input	Output indicators	Timeline
SD 6	SD 6.2 Health workers have access to quality skills building and adequate practice during their training	SD 6.2.1 RHFPP to coordinate with MEST and with nursing, medical, and midwifery colleges to ensure that training curriculum includes skills labs appropriate to students' level of training, and to audit school labs to ensure that students have access to appropriate training materials	RHFPP and DHMT staff time (2 RHFPP staff for 15 days, 14 DHMT staff for 5 days each) Transport allowance, DSA (15 staff for 5 days)	Number of college labs audited	Year 2: Quarter 1
		SD 6.2.2 MOHS designates practice sites to be affiliated with each of the medical, nursing, and midwifery schools	1 RHFPP and 14 DHMT staff time (4 days each)	Number of practice sites designated	Year 2: Quarter 1
SD 7 Service delivery points are equipped with the necessary health workers and supplies to provide rights-based FP services	SD 7.1 Support all direct and indirect costs to provide a full method mix of FP services	SD 7.1.1 Support direct costs for service delivery points to provide a full method mix of FP services	Additional cost for direct service personnel only. Costs of anticipated contraceptive commodities and consumables are included in the costing section.	Direct FP costs at the facility level are fully supported	Year 1: Quarter 1, then ongoing
		SD 7.1.2 Support indirect costs for service delivery points to provide a full method mix of FP services	Support indirect costs for all FP services, including program management, staff supervision, M&E, human resources development, transport and telecommunication, health education, advocacy, infrastructure, commodity supply systems, and health management information system improvements	Indirect costs of implementing the FP program are fully funded	Year 1: Quarter 1, then ongoing

Area 3: Contraceptive Security (CS)

Strategic Results	Activity	Subactivity	Input	Output Indicator	Timeline
CS 1 Governance, management, and coordination for procurement and logistics of FP supplies are improved	★ CS 1.1 Contribute to the resolution of governance for procurement and logistics for FP supplies (NPPU and new agency being formed) (SP 2)	CS 1.1.1 RHFPP to respond to requests for consultations regarding NPPU reform	RHFPP staff time (1 person for 10 days per year)	Number of times that RHFPP provides consults on NPPU reform	Pre-commencement of strategy, then ongoing
		CS 1.1.2 Revise TOR for membership of the RH Commodity Security Committee	RHFPP staff time and IP support (4 people for 3 days: 1 RHFPP, 2 IPs, 1 UN agency)	Revised TOR	Year 1: Quarter 1
	★ CS 1.2 Strengthen existing RH Commodity Security Committee (SP 2)	CS 1.2.1 Organize and attend quarterly meetings, providing written reports and feedback to RHFPP staff	RHFPP staff time (2 RHFPP staff for 8 days per year per staff)	Number of meetings organized and attended (Target: 4 per year)	Year 1: Quarter 1, then ongoing
		CS 1.2.2 Appoint a focal person from the RH Commodity Security Committee to participate in supply chain technical working group, and to provide written report and feedback to RH Commodity Security Committee	RH Commodity Security Committee staff time (1 RHFPP staff for 8 days per year)	Number of supply chain TWG meetings attended by RH commodity security focal point (Target: 4 per year)	Years 1–4: Quarter 1
	★ CS 1.3 Focal person from the RH Commodity Security Committee to participate in supply chain technical working group once established (SP 2)	CS 1.3.1 Follow up and carry out activities allocated	RH Commodity Security Committee staff time (1 person for 4 hours per month)	Number of actions undertaken by the committee	Year 1: Quarter 1, then ongoing

Strategic Results	Activity	Subactivity	Input	Output Indicator	Timeline
CS 1	★ CS1.4 Strengthen central-level coordination between the RHFPP and NPPU caretaking team (SP 2)	CS 1.4.1 RHFPP and UNFPA to take part in weekly standing meetings with the NPPU caretaking team	RHFPP and UNFPA staff time (2 people for 4 hours per week) Transport allowance for within Freetown (52 per year)	Number of NPPU caretaking team meetings attended by RHFPP and UNFPA per year (Target: 52 per year)	Year 1: Quarter 1, then ongoing
		CS 1.4.2 RHFPP or UNFPA to dedicate four hours per week to follow up and complete actions allocated to them during weekly meetings with NPPU caretaking team	RHFPP and UNFPA staff time (1 RHFPP staff for 25 days per year, 1 UNFPA staff for 25 days per year)	Number of actions undertaken by RHFPP and UNFPA	Year 1: Quarter 1, then ongoing
	★ CS 1.5 Develop a risk management plan for contraceptive security (SP 2)	CS 1.5.1 Add the issue of risk management to the agenda at the Reproductive Health Commodity Security Working Group (RHCSWG) and set up a subcommittee to meet once a month	RHFPP staff time (3 people for 12 days per year)	Agenda and meeting minutes from the RHCSWG subcommittee on risk management (Target: 12 per year)	Year 1: Quarter 1, then ongoing
		CS 1.5.2 Risk management subcommittee develop risk management plan and meet monthly to review and respond to ongoing risks to FP commodity security	RHFPP and CMS staff time (1 RHFPP staff and 1 CMS staff for 10 days each); staff time from 5 IPs (5 people for 10 days each)	Risk management plan developed	Year 1: Quarter 1
		CS 1.5.3 RHCSWG to validate risk management plan	No additional cost – plan to be validated during regular RHCSWG meeting	Risk management plan validated	Year 1: Quarter 1

Strategic Results	Activity	Subactivity	Input	Output Indicator	Timeline
CS 1	★ CS 1.5	CS 1.5.4 Risk management subcommittee meets monthly to review and respond to any risks to commodity security, including challenges in financing, procuring, storing, and distributing FP commodities	RHFPP and CMS staff time (1RHFPP staff and 1CMS staff for 12 days each per year); staff time from 5 IPs (5 people for12 days each per year)	Number of meetings of the risk management subcommittee (Target: 12 per year)	Year 1: Quarter 1, then ongoing
CS 2 FP planning supplies are procured to match the national need	★ CS 2.1 Undertake comprehensive forecasting, quantification, and procurement of FP commodities, and align with financing activities to ensure adequate resources are mobilized (SP 2)	CS 2.1.1 Recruit RHFPP staff to be assigned to the RHCSWG	Staff time for recruitment committee (1 RHFPP staff, 1 UN agency, 1 IP staff) (3 people for 3 days)	RHFPP staff assigned to RHCSWG	Year 1: Quarter 1
		CS 2.1.2 Build the capacity of staff to conduct appropriate quantification and forecasting through remote TA and on the job mentorship	Staff time (1 RHFPP staff, 1 UN agency staff, and 1 IP staff for 20 days each per year) Staff time from IP (1 person for 40 days in Years 1 and 2, 30 days in Years 3 and 4, and 20 days in Year 5)	Improved capacity for quantification and forecasting by RHCSWG	Year 1–5: Quarter 4
		CS 2.1.3 RHCSWG to plan for and conduct annual quantification workshop, conducting data analysis in advance of the workshop, presenting data to participants, and developing a procurement plan based on the quantification	Venue hire in Freetown (medium-sized conference hall, 2 days), refreshments and conference materials for 25 people, DSA and transport for 14 people DHMT staff time (1 person from each district for 5 days each), staff time (3 RHFPP staff for 6 days each), IP staff time (8 staff for 6 days each)	Number of presentations made by RHCSWG during FP commodity quantification workshops (Target: 3 per year)	Years 1–5: Quarter 1

Strategic Results	Activity	Subactivity	Input	Output Indicator	Timeline
CS 2	★ CS 2.1	CS 2.1.4 RHCSWG to hold quarterly meetings with NPPU caretaking team and other MOHS directorates to strengthen quantification data at national and district levels, including implementing M-Supply for pharmaceutical stock management and working collaboratively with other government and nongovernment actors to identify other data sources for quantification and forecasting	RHFPP staff time (2 days each per quarter)	Number of districts reporting data on the quantity of FP commodities dispensed to users (Target: 14 per quarter)	Year 1: Quarter 1, then ongoing
		CS 2.1.5 Prepare and publish annual forecasting report to include data sources and methods	Staff time (2 RHFPP staff and 2 IP staff for 20 days per person) Print 20-page report in color (40 copies)	Annual forecasting report produced	Year 1: Quarter 1, then ongoing
		CS 2.1.6 Conduct a gap analysis of the procurement plan to align quantification with available financing and ensure funding gaps are identified, and disseminate results to the RHSC committee to ensure all stakeholders work towards joint mobilization of resources to fill any gaps identified	Communication costs: Internet access (3GB), mobile top-up for 3 staff Staff time (1 RHFPP staff, 1 UN agency staff, and 1 IP staff for 10 days per person)	Finance gap analysis presented at RHSC meeting (Target: 1 per year)	Years 1–5: Quarter 2

Strategic Results	Activity	Subactivity	Input	Output Indicator	Timeline
CS 2	★ CS 2.1	CS 2.1.7 Include procurement plan gaps in agenda for the RHCSWG to advocate for commodity funding to Reproductive Health Directorate	Communication costs: Internet access (3GB per month), mobile top-up for 3 staff UNFPA and RHCSWG staff time, included in SMA, 3 staff time from each of the 3 agencies	Number of RHSC meetings discussing the FP procurement plan (Target: 2 per year)	Year 1, Quarter 1, then ongoing
CS 3 Service delivery points equipped with the necessary commodities and supplies to provide rights-based FP services	★ CS 3.1 Support all indirect costs to procure and distribute a full method mix of FP commodities and supplies (SP 2)	CS 3.1.1 Support indirect costs for procurement and distribution of all FP commodities and supplies	Support all indirect costs for FP commodity and supply procurement and distribution, including pre-shipment inspection, wastage, contraceptive procurement fees, clearing fees, freight charges, testing and oversight, insurance, and costs for distribution, including costs for last-mile delivery	The indirect costs of procuring and distributing FP commodities and supplies are fully funded	Year 1: Quarter 1, then ongoing
CS 4 Emergency contraception (EC) is procured per the quantification and procurement plan	CS 4.1 Procure EC per the quantification and procurement plan	CS 4.1.1 Ensure that EC is procured as a life-saving commodity	Include EC in standard RH quantification and procurement plan	Full procurement and distribution of EC along with other FP commodities to meet national need	Year 1: Quarter 1, then ongoing

Area 4: Policy and Enabling Environment (PEE)

Strategic Results	Activity	Subactivities	Inputs	Output Indicators	Timeline
PEE 1. Adolescents and youth are able to act on their human rights, access FP services without facing discrimination, and are not turned away when unaccompanied by a parent or spouse	PEE 1.1 RHFPP to create a directive to FP service providers affirming the rights of adolescents and young people to access FP services without authorization from a parent, spouse, or provider, with input from youth-serving organizations and service providers	PEE1.1.1 RHFPP to draft a directive and host a consultative meeting with 3 RHFPP staff and 20 relevant FP stakeholders, including youth-serving organizations and service providers, to gather their input on the contents of the directive	RHFPP staff time (3 staff for 15 days each), IP and service provider staff time to attend the meeting (20 people for 1 day each) Medium-sized conference venue in Freetown (1 day), tea break and lunch (23 people), transport allowance (20 people)	Directive is updated as per meeting minutes	Year 1: Quarter 1
	PEE 1.2 Conduct advocacy to secure endorsement of directive by key government officials and behavior change at the service delivery level	PEE1.2.1 Prepare for and hold a 1-day meeting for 30 people to conduct an AFP SMART (Advance Family Planning, n.d.) process to identify key decision makers, identify what types of advocacy need to be conducted for the decision makers to issue the directive, support civil society groups to identify opportunities to advocate for the change	Conference venue in Freetown (medium conference hall, 1 day); tea break and lunch (20 people); transport allowance (20 people) RHFPP and IP staff time to plan for and hold the meeting, and to implement the advocacy strategy (2 RHFPP staff, 20 days each, 3 IP staff, 20 days each)	Directive endorsed	Year 1: Quarter 2
	PEE 1.3 Issue directive and ensure supportive supervisory visits review implementation of youth-friendly services directive by health service providers	PEE1.3.1 Provide advocacy support and engage FP stakeholders	No additional cost (cost of revising supportive supervision tools included in SMA 1.1)	Directive is issued	Year 1: Quarter 4, then ongoing

Strategic Results	Activity	Subactivities	Inputs	Output Indicators	Timeline
PEE 1.	PEE 1.4 Build the capacity of adolescents and young people to act upon their human rights to access FP services	PEE1.4.1 Develop, print, and disseminate fliers and posters about youth FP/RH rights to be displayed in facilities	No additional cost (cost of flier and poster development and printing included in DC 1.4)	Percentage of facilities with posters visible promoting adolescent and young people's rights to FP (Target: 100%)	Year 2: Quarter 3
PEE 2. Education policy articulates what SRH and FP services can be provided in schools	PEE 2.1 Update the education policy to clearly articulate which SRHR and FP services can be provided at different school levels, and to acknowledge youth rights to comprehensive FP information and services	PEE 2.1.1 MOHS (RHFPP and School and Adolescent Health Programme (SAHP)), and MEST to initiate a task force consisting of the MOHS, HED, donors, and other implementing partners to meet quarterly to identify opportunities to collaborate on health policies for adolescent youth in school	MOHS and MEST staff time, (4 staff for 8 days each per year)	Number of meetings held (Target: 4 per year)	Year 1: Quarter 2, then ongoing
		PEE 2.1.2 Plan for and host 3 1-day consultative meetings with 20 relevant stakeholders, including key ministry staff, youth-serving organizations, and school representatives, to gather their input on the contents of the guidelines/policy	Venue hire in Freetown (medium-sized conference hall, 3 days); tea break and lunch (25 people per day) RHFPP staff time (2 people for 10 days each)	Meeting minutes	Year 1: Quarters 3 and 4
		PEE 2.1.3 Hire local consultant to draft policy document articulating FP and SRHR available to youth in schools	Hire local consultant (30 days)	Policy drafted	Year 2: Quarter 1
	PEE 2.2 Task force to advocate with MEST to ensure adoption of the policy	PEE 2.2.1 Task force to engage FP stakeholders, including the MOHS, HED, donors, and other implementing partners to implement an advocacy plan to support the MEST to adopt the policy	Staff time RHFPP, SAHP, I UN agency, and IP for advocacy (4 people for 30 days each per year)	Number of meetings of task force on youth-friendly service policy adoption (Target: 12 meetings per year)	Year 2: Quarter 2, then ongoing

Strategic Results	Activity	Subactivities	Inputs	Output Indicators	Timeline
PEE 2	PEE 2.3 Develop and distribute age-appropriate FP materials and job aids (e.g., posters, pamphlets, flyers) to inform adolescents/youth about their options to receive services in school, as well as at clinics	PEE 2.3.1 Hold 1 2-day workshop and annual half-day meetings for 40 people with the HED, MEST, and key youth-serving organizations to ensure alignment and agreement on the SBCC materials developed under DC 1	Venue hire in Freetown (large conference hall, 2 days), tea break and lunch (45 people), transport allowance (40 people) RHFPP staff time for ongoing coordination and review of materials, (3 people for 10 days each)	Number of meetings held to establish a consistent FP/RH message for adolescents (Target: 2)	Year 2: Quarter 2
		PEE 2.3.2 Ensure that the development of any materials aligns with the SBCC materials development process detailed in DC 1	No additional costs (inputs Included in DC 1)	Age-appropriate FP materials developed	Year 2: Quarter 2
		PEE 2.3.3 Print and disseminate adolescent-friendly FP materials to schools	No additional costs (inputs Included in DC 1)	Age-appropriate FP materials are printed and distributed to schools	Year 2: Quarter 3
PEE 3. Every health facility in Sierra Leone is staffed with at least one certified FP practitioner who is able to provide all methods appropriate to that level	PEE 3.1 Develop a policy to stipulate that during rotation, DHMTs must ensure that every facility has a staff member who is trained to deliver FP services	PEE 3.1.1 Gather relevant policies and documents plan for and conduct a half-day consultative meeting with 30 relevant stakeholders	Venue hire in Freetown (medium-sized conference hall, half-day); tea break and transport allowance (30 people) RHFPP staff time (3 people for 3 days each)	Meeting held	Year 1: Quarter 2
		PEE 3.1.2 Hire a consultant or engage an IP to develop FP staff rotation policy, and suggest any changes necessary to ensure that allocation of health workers takes into account provider skills and certification in providing FP services	Hire local consultant (20 days)	Staff rotation policy developed	Year 1: Quarter 3

Strategic Results	Activity	Subactivities	Inputs	Output Indicators	Timeline
PEE 3	PEE 3.1	PEE 3.1.3 Secure policy endorsement and implement it at the national level through 2 meetings with 4 policymakers (director of HR, director of Primary Health Care, chief medical officer, director of Reproductive and Child Health)	RHFPP staff time (2 people for 5 days each)	Staff rotation policy endorsed	Year 2: Quarter 1
PEE 4. Policymakers recognize the importance of FP in achieving the larger development agenda	PEE 4.1 Develop a series of high-level advocacy briefs for ministers and parliamentarians on how FP impacts other sectors (e.g., agriculture, food security, environment, education, jobs)	PEE 4.1.1 Develop and print 3 short policy advocacy briefs; 1 in 2018, 1 in 2020, and 1 in 2022 Review and finalize at regular RHCSWG meetings	Staff time (2 RHFPP staff and 2 IP staff for 15 days each) Print 2 pages in color, 300 copies per year in 2018, 2020, and 2022)	Number of copies of policy brief printed (Target: 900)	Years 1, 3, and 5
		PEE 4.1.2 Engage FP champions (identified in DC 2) to distribute advocacy briefs to local members of parliament and other policymakers	No additional cost (staff time already included in DC 2)	Number of copies of policy brief disseminated (Target: 900)	Years 1, 3, and 5
PEE 5. The national health insurance scheme provides all Sierra Leoneans with comprehensive FP services, including the method of their choice	PEE 5.1 Review current national health insurance scheme and advocate to ensure that all methods of FP are included and that the scheme, including comprehensive FP services for all people, including youth, is approved by policymakers	PEE 5.1.1 Hold 1-day workshop for 25 people, including 2 RHFPP staff, IPs, and representatives of civil society, to develop an advocacy strategy to ensure full method mix availability in the NHIS package The workshop will use the AFP SMART (Advance Family Planning, n.d.) process to identify key decision makers, identify what types of advocacy need to be conducted, and support civil society groups to identify opportunities to advocate for change	Venue hire in Freetown (medium-sized conference hall, 1 day); tea break and lunch (25 people) RHFPP staff time (2 people for 3 days each)	Advocacy strategy completed and adopted	Year 1: Quarter 2

Strategic Results	Activity	Subactivities	Inputs	Output Indicators	Timeline
PEE 5	PEE 5.1	PEE 5.1.2 Advocate for approval by the National Insurance taskforce (MOHS, DFID, etc.) and senior staff at the National Social Security Insurance Trust	Government and IP staff time to implement the advocacy strategy (1 RHFPP staff for 20 days, 1 IP staff for 20 days, 2 civil society members for 20 days each)	Advocacy strategy implemented	Year 1: Quarter 2

Area 5: Financing (F)

Strategic Results	Activity	Subactivities	Inputs	Output Indicators	Timeline
F 1. MOHS budget for FP is increased, in line with the country's 2012 FP2020 commitment	F 1.1 Develop and implement a legal statute for the MOHS to allocate 1% of the health budget for FP commodities and programs, which is separate from the budget line item for reproductive and child health Services	F 1.1.1 Hold a 1-day meeting for 20 people to conduct an AFP SMART (Advance Family Planning, n.d.) process and design an advocacy strategy to identify key decision makers, identify what types of advocacy need to be conducted for the decision makers to issue the policy change, and support civil society groups to identify opportunities to advocate for the change	Venue hire in Freetown (small conference hall, 1 day), transport allowance and refreshments (25 people)	Legal statute for MOHS developed	Year 2: Quarter 1
		F 1.1.2 Engage with key ministry staff (e.g., MOFED and MOHS) and parliamentarians to advocate for specific budget allocation for FP	RHFPP and IP staff time to implement the advocacy strategy (3 staff for 5 days each)	Number of informal meetings held with key policymakers (Target: 5)	Year 2: Quarter 2
		F 1.1.3 Hold annual meetings with key MOHS staff and parliamentarians to provide a forum for advocacy discussions on FP financing	RHFPP and SAHP staff time (15 people for 1 day each) Venue hire in Freetown, (small conference venue), transport allowance, refreshments (15 people)	Number of formal meetings held with key MOHS staff and parliamentarians (Target: 1 per year)	Years 2–5: Quarter 1
		F 1.1.4 Set up a budget tracking process and assign 1 RHFPP staff to monitor the budget quarterly and report to the RHCSWG biannually	RHFPP and MOFED staff time (3 staff for 10 days each in Year 2, 1 RHFPP staff for 20 days per year starting in Year 2)	Budget tracking system developed	Years 2–5: Quarter 1

Strategic Results	Activity	Subactivities	Inputs	Output Indicators	Timeline
F 1	F 1.1	F 1.1.5 Include budget tracking review in annual RHCSWG meetings to review the current FP budget tracking report and to plan for advocacy to ensure that the minimum 1% is allocated for FP financing and is released annually	No additional cost	Number of times FP budget allocations are reviewed at RHCSWG meeting (Target: 2 times per year)	Years 2–5: Quarter 1
	F 1.2 Advocate with the GOSL and the MOHS leadership to ensure that funds for FP are securely allocated and disbursed in a timely manner, as specified in the legal statute	F 1.2.1 Develop a policy brief advocating for increases and timely delivery of FP line items Review and finalize the policy brief at a regular RHCSWG meeting	RHFPP staff time (4 staff for 15 days each) Printing (2 pages color for 500 copies)	Number of copies of policy brief printed and disseminated (Target: 500)	Year 2: Quarter 2
		F 1.2.2 Engage with key ministry staff (e.g., MOFED and MOHS) and parliamentarians to advocate for specific budget allocation and expenditure for FP annually	RHFPP staff time (2 people for 7 days each per year)	Number of informal meetings held with key policymakers (Target: 5 per year)	Years 2: Quarter 1, then ongoing

Strategic Results	Activity	Subactivities	Inputs	Output Indicators	Timeline
F 2. Financing gaps for FP are identified, and available funding information is disseminated to ensure transparency and accountability for financing and results and to avoid duplication of efforts	F 2.1 Conduct an annual FP gap analysis to identify activities and results established in the CIP that are not aligned with available funding from development and implementing partners	F 2.1.1 Hire a consultant or request for TA to conduct the gap analysis process, which includes the following steps: • Complete Excel workbook detailing which activities in the CIP are currently funded, and by whom • Analyze data to identify activities that are not currently funded • Develop a presentation for the FP TWG highlighting which areas of the CIP have funding and any priority activities that are currently unfunded • Validate results with the RHCSWG • Prepare a resource mobilization brief highlighting gaps identified through the analysis	Hire consultant (40 days per year) Print 2 pages color (200 copies per year)	Gap analysis report produced (Target: 1 per year)	Years 1–5: Quarter 2
		F 2.1.2 RHCSWG to conduct annual review of gap analysis results with MOHS, MOFED, Health Financing Unit, Service Level Agreement Team, UN agencies, and NGOs	No additional costs (included in regular RHCSWG meetings)	Number of meetings held (Target: 1 per year)	Years 1–5: Quarter 3
		F 2.1.3 RHCSWG to conduct advocacy to raise additional needed funds based on annual gap analysis review	RHFPP staff time (2 people for 10 days each), IP staff time (3 people for 10 days each)	Percentage of funding raised (Target: 100%)	Year 1: Quarter 3, then ongoing

Strategic Results	Activity	Subactivities	Inputs	Output Indicators	Timeline
F 3. Diversification of sources of funding for FP are increased	F 3.1 Design and implement a resource mobilization strategy with a focus on diversifying funding sources for FP	F 3.1.1 Hire a consultant/request TA to develop a resource mobilization strategy	Hire consultant (30 days)	Resource mobilization strategy developed	Year 1: Quarter 3
		F 3.1.2 Present and review resource mobilization strategy at regular national RHCSWG meetings	No additional cost (included in regular RHCSWG meetings)	Number of times the resource mobilization strategy is presented/reviewed at national RHCSWG meetings (Target: 4 times per year)	Year 1: Quarter 1, then ongoing
	F 3.2 Identify potential organizations (local and international) that can contribute towards funding FP, with a focus on unfunded or underfunded CIP activities	F 3.2.1 Implement the resource mobilization strategy to secure funding, including meeting with donor organizations and local private sector organizations in Freetown and attending international meetings or forums to raise support, as appropriate	RHFPP staff time (2 people for 20 days per year) 1 international trip per year: international flight, DSA, lodging (7 days per year)	Additional FP funding allocated by nontraditional sources	Years 1–5, annually
F 4. Subnational budgets include FP financing leading to improved sustainability of programs	F 4.1 Develop policy directives, guidelines, and tools to assist subnational levels to allocate resources to FP	F 4.1.1 MOHS to issue policy directive to local councils mandating that a portion of regional health budgets are allocated to FP	RHFPP staff time (3 staff for 5 days each)	Number of District Councils with a separate line item in their annual budget for FP (Target: 6)	Year 1: Quarter 4
		F 4.1.2 Develop a series of guidelines and tools for allocating FP resources that can be used at subnational levels • Hire consultant to draft tools • RHFPP and consultant to jointly conduct field testing in each district • Consultant to update tools based on field test and finalize with RHFPP staff • Print the guidelines and provide each DHMT with 20 copies	Hire consultant (40 days) RHFPP staff time (2 staff for 20 days each) Transport allowance, DSA and lodging (3 staff for 15 days each) Print 20-page guideline/tool (300 copies: 20 per district and 20 at national level)	Percentage of DHMTs with resource mobilization guidelines (Target: 100%)	Year 2: Quarter 1

Strategic Results	Activity	Subactivities	Inputs	Output Indicators	Timeline
F 4	F 4.1	F 4.1.3 Working with MOFED, conduct capacity building to ensure that DHMTs are able to use tools for FP resource allocation • Team of 2 people (1 from MOHS, 1 from MOFED) to visit each district for 3 days each year prior to budget development to conduct supportive supervision on guidelines, 12 districts and Western urban and Western rural	RHFPP and MOFED staff time (1 RHFPP staff for 45 days; 1 MOFED staff for 45 days) Transport allowance, DSA, and lodging (2 people for 42 days each)	Number of DHMTs trained (Target: 14)	Year 2: Quarter 2
	F 4.2 Conduct supportive supervision from national-level to regional Health Directorates to make evidence-based decisions related to programming, budgeting, and tracking expenditures for FP to ensure that it is fully integrated and that subnational budgets reflect increased finances for FP	F 4.2.1 RHFPP staff to advocate with and provide technical support to Regional Health Directorates (RHDs) to program, budget, and track expenditures for FP	RHFPP staff time (4 staff for 8 days per year each) Transport allowance, DSA, and lodging (2 people for 3-day visits to each region 2 times per year)	Number of supportive supervisory visits conducted annually to each RHD by RHFPP staff (Target: 2 visits to each RHD per year) Number of District Councils with a separate line item for FP in their annual budget (Target: 6)	Year 1: Quarter 2, then ongoing

Area 6: Stewardship, Management, and Accountability (SMA)

Strategic Results	Activity	Sub-activities	Inputs	Output Indicators	Timeline
SMA 1. Oversight of FP program is improved	SMA 1.1 Strengthen supportive supervision of FP service providers, including CHWs, by improving leadership capacity and updating supportive supervision tools and job aids to enforce rights-based programming	SMA 1.1.1 Hold a 2-day workshop in Freetown to review the FP checklist and any FP items in the national checklist, and align and integrate the two, with an emphasis on inclusion of rights-based programming for FP service delivery	RHFPP staff time (4 people, 2 for 10 days, 2 for 20 days each) DHMT staff time (12 people for 2 days) Other organization staff time (UN agency, IP staff time to plan and host event, as well as revise the documents (1 UN staff, 2 IP staff, 8 days each) Venue hire in Freetown (medium-sized conference venue, 2 days), tea break and lunch (20 people), transport allowance and DSA (12 DHMT participants)	FP supervision checklist is revised and integrated into national checklist	Year 1: Quarter 3
		SMA 1.1.2 Printing, lamination, and distribution of revised national checklist	Printing: (10 black-and-white pages, 50 copies) Laminating: (10 pages, 50 packs)	Tools and aids printed, laminated, and distributed (Target: 50)	Year 1: Quarter 3
		SMA 1.1.3 Working in partnership with other MOHS programs, hire a leadership and management consulting firm to design an on-the-job leadership and management training program for FP managers at the DHMTs that uses the experience and expertise of managers in the health system and best practices in leadership and management, and pilot the program in 2 districts	Hire consulting firm (60 days) RHFPP staff time (5 people for 3 days each for training, 5 days each for supportive supervision), DHMT staff time (12 staff for 3 days each for training, 5 days each for supportive supervision) DSA, transport refund for 5 RHFPP staff managers to provide supportive supervision to the districts (1 3-day trip each)	Percentage of FP managers trained who demonstrate required competencies in their day-to-day work (Target: 70%)	Year 2: Quarters 2 and 3

Strategic Results	Activity	Sub-activities	Inputs	Output Indicators	Timeline
SMA 1	SMA 1.1	SMA 1.1.4 Conduct supportive supervision of FP service providers, including CHWs	No additional cost (supportive supervision is included and costed in SD 1.2.4 and SD 1.5.2; joint supervision of CHWs is included in DC 3.2.2; supportive supervision conducted jointly with other departments (Nutrition, EPI, and HIV) is included under SD 3.1, 3.2 and 3.4)	Percentage of FP service providers overseen with supportive supervision at least twice annually (Target: 95%)	Year 1: Quarter 1, then ongoing
	SMA 1.2 Effective quality improvement/ quality assurance (QI/QA) approaches to improve the quality of FP service provision are implemented at facility and community levels	SMA 1.2.1 Participate in the QI process for the health sector and ensure that FP is included in approaches to address shortcomings in service delivery	RHFPP staff time (2 staff for 10 days each)	Participation of key FP stakeholders in health sector QI	Year 1: Quarter 1, then ongoing

Strategic Results	Activity	Sub-activities	Inputs	Output Indicators	Timeline
SMA 2. National coordination, partnership, and integration of FP among government and all stakeholders, including government and nongovernmental organizations and development partners, is improved	SMA 2.1 Improve coordination and effectiveness of RHCSWG meetings through a broadened mandate and a creation of subcommittees	SMA 2.1.1 Review and update the mandate and composition of the RHCSCWG, ensuring that meetings are taking place quarterly, and nominate one "patron" to galvanize political will at higher levels, especially related to financing FP, and provide facilitator honorarium RHP staff to work with the following subcommittees to develop or review TORs and membership: • SBCC • Quality Service Delivery • Risk Management (Contraceptive Security focus) • Finance and Advocacy • SMA/M&E • Youth reproductive health	Honorarium for patron (1 person for 5 days per year) RHFPP staff time to reinvigorate subcommittees (5 staff for 20 days per year each)	Number of meetings of the RHCSWG (Target: 4 per year) TORs developed for RHCSWG subcommittees (Target: 6)	Year 1: Quarter 2, then ongoing Year 1: Quarter 3
	SMA 2.2 Improve FP stakeholder coordination and performance monitoring at the district level	SMA 2.2.1 Conduct quarterly meetings of FP stakeholders at the district level, focusing on upcoming opportunities to promote FP during district health events, challenges faced over the previous quarter, and any issues raised through client feedback mechanisms	DHMT staff time (4 people per district for 12 days per year each) to plan, host meetings, and report in each district RHFPP staff time, DSA, and transport allowance (1 person for 8 days per year per district) Other staff time of IPs (10 people for 4 days per year per district)	Number of meetings held (Target: 4 per year per district)	Year 1: Quarter 1, then every quarter

Strategic Results	Activity	Sub-activities	Inputs	Output Indicators	Timeline
SMA 3. FP data are collected, analyzed, and used for decision making	SMA 3.1 Implement an electronic planning/performance monitoring mechanism/system to track progress of the SLFPCIP and improve coordination among the partners	SMA 3.1.1 Customize an existing CIP performance management system to track progress on CIP implementation, and identify a focal point to be responsible for inputting and updating data	Hire international consultant to set up and maintain system (60 days in Year 1, 20 days annually thereafter) Hire M&E focal point to be seconded to RHFPP (1 person, annual salary)	Dashboard for CIP performance monitoring is developed and maintained	Year 1: Quarter 1, then ongoing
	SMA 3.2 Hold regular review meetings to monitor CIP performance	SMA 3.2.1 Hold quarterly meetings of the RHCSWG to review FP data in the CIP performance management system • Establish a small working group to track implementation progress and report barriers or bottlenecks to implementation to the RHCSWG based on M&E data	No additional costs	Dashboard indicating progress implementing CIP is updated and presented at RHSCS meetings (Target: 4 times per year)	Year 1: Quarter 2, then ongoing
		SMA 3.2.2 Plan for and hold annual meeting to review performance monitoring data, review and update priorities, and align work plans and funding: • Include RHFPP, donors, IPs, civil society • Include 3 staff from each DHMT (FP focal point, M&E and planning point people)	RHFPP staff time to analyze data to inform the annual review meeting (3 staff for 10 days each per year) Hire venue in Freetown (large conference venue, 2 days), lunch and tea break (80 people) Transport allowance and DSA for district staff (42 staff for 3 days each)	Number of annual review meetings held (Target: 1 per year)	Years 1–5: Quarter 4

Strategic Results	Activity	Sub-activities	Inputs	Output Indicators	Timeline
SMA 4. The SLFPCIP is assessed at mid-term and end of plan to inform future FP activities and programming	SMA 4.1 Conduct a mid-term and end-of-plan evaluation of the SLFPCIP	SMA 4.1.1 Hire a consultant to provide technical support to conduct the mid-plan review together with a team that includes at least 1 RHFPP staff. The mid-plan review includes the following key steps: • Design a plan for evaluation • Collect, analyze, synthesize, and validate data on CIP performance, including 1 trip to each region for 3 days to collect data • Produce an evaluation report with recommendations • Disseminate results and recommendations and circulate report to all stakeholders and partners	Hire consultant (60 days), RHFPP staff time (1 staff for 20 days) Transport allowance and DSA (2 people for 12 days each)	Mid-term review completed and recommendations submitted to RHSCS	Year 3: Quarters 3 and 4

Strategic Results	Activity	Sub-activities	Inputs	Output Indicators	Timeline
SMA 4	SMA 4.1	SMA 4.1.2 Hire two consultants to provide technical support to conduct the end-term evaluation together with a team that includes at least 1 RHFPP staff. The end-term evaluation includes the following key steps: • Design a plan for evaluation • Collect, analyze, synthesize, and validate data on CIP performance, including a 5-day trip to each region to collect primary data • Produce an evaluation report that includes recommendations for future programming success post-CIP • Disseminate results and recommendations and circulate report to all stakeholders and partners • Determine if new or revised CIP is needed to achieve objectives, and if FP objectives should be revised or updated based on progress over the previous year	RHFPP staff time (2 staff, 30 days each) Hire two consultants (80 days each) Transport allowance and DSA (4 people for 20 days) Print: 30-page color document (200 copies)	End of plan evaluation report completed and recommendations submitted	Year 5: Quarter 4
		SMA 4.1.3 Review evaluation results with relevant FP stakeholders and key ministry staff	No additional cost (to be included in annual review meeting under SMA 3.2)	Review meeting held (Target: 1 in Year 3, 1 in Year 5)	Years 3 and 5

Strategic Results	Activity	Sub-activities	Inputs	Output Indicators	Timeline
SMA 5. The Reproductive Health and Family Planning Programme has the capacity and resources required provide stewardship of the FP program	SMA 5.1 Hire additional staff and supply them with adequate resources to effectively manage and monitor the implementation of the activities outlined in this plan	SMA 5.1.1 RHFPP to request two secondees from their implementing partners—a CIP coordinator and a CIP officer—who will work alongside the MOHS counterpart for CIP coordination. Both secondees will require a laptop.	Hire 2 full-time staff Procure 2 laptops	Number of staff seconded to RHFPP to provide support for the implementation of the CIP (Target: 2)	Year 1: Quarter 1, then ongoing
		SMA 5.1.2 Procure a vehicle for use by the FP program for CIP implementation and stewardship, and provide regular maintenance and fuel top-ups to ensure that it remains in use through the duration of the plan	Procure 1 4x4 vehicle Conduct annual vehicle maintenance, and provide fuel for traveling within Freetown and to districts for training and supervision	Number of vehicles supporting the FP program (Target: 1)	Year 1: Quarter 1
	SMA 5.2 Improve the capacity of RHFPP staff in computer skills, project reporting formats for different donors, project proposal development, advocacy, project management and supply chain management (quantification, procurement, clearing, and forwarding), partnership management	SMA 5.2.1 Liaise with other programs and Directorates to organize joint training Request technical assistance to support the process RHFPP staff and other programs deliver the training	RHFPP and other Directorate staff time (3 RHFPP staff and 5 Directorate staff for 20 days per year)	Number of internal training workshops organized (Target: 4 per year) Number of staff trained (Target: 20 per year) Percentage of staff rating training as useful (Target: 70 %)	Year 1: Quarter 2, then ongoing

Strategic Results	Activity	Sub-activities	Inputs	Output Indicators	Timeline
SMA 5	SMA 5.2	SMA 5.2.2 Provide sufficient computers for RHFPP staff and ensure computers are well maintained Review Internet supplier and choose provider with reliable service	Procure laptop computers (6 in year 1) Hire IT consultant (10 days in Year 1, 5 days in Years 2-5) RHFPP and procurement unit staff time (1 RHFPP staff, 1 procurement unit staff, 3 days each in year 1) Internet costs already in RHFPP budget – no new costs	Number of computers procured (Target: 6) Staff report good access to internet 90% of the time or more Reliable internet service provision in place (as reported by RHFPP staff) IT maintenance service in place	Year 1: Quarter 2, then ongoing
	SMA 5.3 Improve and extend the resource center lighting, standby electricity, generator, ventilation, and projection facilities and train RHFPP support staff to maintain facilities	5.3.1 Work with the architecture department of the MOHS to extend the RHFPP office and redesign the resource room Engage a contractor to undertake building work Procure materials and equipment, including a standby generator	Work with the architecture department of MOHS to extend the RHFPP office and redesign the resource room Engage a contractor to undertake building work Procure materials and equipment Procure materials and equipment, including a standby generator	RHFPP office extended and maintained Resource room remodeled and maintained	Year 2: Quarter 1 and ongoing maintenance
	SMA 5.3	SMA 5.3.2 MOHS Cleaning Company and Support Services to devise a training program for support staff Deliver the training with MOHS Cleaning Company and Support Services	MOHS Cleaning Company and Support Services staff time (2 staff for 5 days each)	Number of support staff trained	Year 2: Quarter 2

ANNEX B. COSTING OF ACTIVITIES, IN USD

Area 1: Demand Creation

No.	Activity	2018	2019	2020	2021	2022	Total
1	DC 1.1 Gather evidence from existing research and primary data to inform an SBCC strategy and materials to ensure accurate, clear, and consistent rights-based FP messaging that targets specific audiences, including, but not limited to, postpartum women, women of reproductive age ages 20–24 years, married adolescents, men, religious leaders, parents, teachers, healthcare providers, youth, and the physically challenged	32,231	0	0	0	0	32,231
2	DC 1.2 Develop an evidence-based, comprehensive, targeted SBCC strategy to give direction to rights-based FP SBCC activities, including revised messaging. Use targeted communication channels as identified in research report, with a focus on postpartum FP, areas of low demand, and groups such as men whose attitude toward contraceptives is known to be a barrier to uptake of modern contraceptives.	31,324	0	0	0	0	31,324
3	DC 1.3 Disseminate the comprehensive SBCC strategy	16,956	0	0	0	0	16,956
4	DC 1.4 Implement the SBCC strategy and disseminate targeted rights-based messages	6,762	702,089	657,065	690,359	716,258	2,772,533
5	DC 2.1 Identify, train, and support FP champions at all levels of society	283,546	337,583	346,022	354,673	363,540	1,685,363
6	DC 3.1 Work with the CHW program to review and revise training program and job aids for facilitated discussions at the community level	8,988	0	0	0	0	8,988
7	DC 3.2 Strengthen CHW training and supervision to ensure positive and responsive client–provider interactions; unbiased, nondirective counseling that addresses side effects for chosen method; and attention to privacy, confidentiality, and client dignity. Work with CHW program to train CHWs on FP as part of the larger CHW training efforts.	2,029	2,079	2,131	2,185	2,239	10,663

No.	Activity	2018	2019	2020	2021	2022	Total
8	DC 3.3 Build institutional capacity of community-based and faith-based organizations and civil society organizations based on their need to promote the reduction of objections against FP and raise awareness on FP and RH rights	0	47,607	124,770	127,889	131,087	431,353
9	DC 4.1 Establish effective and efficient use of social media campaigns to create demand for FP and correct myths and misconceptions	0	31,367	13,590	13,930	14,278	73,164
	Total	**381,835**	**1,120,725**	**1,143,578**	**1,189,035**	**1,227,401**	**5,062,575**

Area 2: Service Delivery

No.	Activity	2018	2019	2020	2021	2022	Total
1	SD 1.1 Develop and implement an attitudinal behavior change campaign for health workers on FP to ensure that providers are aware of and act in accordance with clients' FP and RH rights	77,947	8,829	0	0	0	86,776
2*	SD 1.2 Train public and private sector staff in the provision of rights-based FP services, including LARC	13,300	27,265	27,947	28,646	29,362	126,520
3	SD 1.3 Review current service delivery standards, guidelines, protocols, training, and supervision materials to identify opportunities to increase information and training on client rights, and articulate the providers responsibilities related to ensuring those rights	187	191	196	201	206	982
4	SD 1.4 DHMTs to ensure every government and private health facility has a health worker who is trained to provide FP services and adolescent- and young people-friendly services	0	0	0	0	0	0
5	SD 1.5 Reinforce training through supportive supervision, job aids, and mentorship to ensure that providers are providing respectful and comprehensive information and counseling to all clients, regardless of age, gender, class, ethnicity, or marital status	0	0	0	0	0	0
6	SD 1.6 Improve follow-up of FP clients who have not returned to the facility in order to reduce clients lost to follow-up	0	0	0	0	0	0
7	SD 1.7 RHFP to work with Primary Health Care (PHC) Department and other programs, including Nutrition, to implement annual exit surveys at every facility to examine and make improvements at the facility level to improve quality of care	0	0	0	0	0	0
8	SD 1.8 Increase participation of communities in service delivery, emphasizing the participation of young people, women, men, people with disabilities, etc.	0	0	0	0	0	0
9*	SD 2.1 SD 2.1 Ensure health workers are trained to counsel at all visits and provide FP services at 6-week postpartum visit and subsequent immunization visits	0	33,407	178	183	187	33,955
10*	SD 2.2 Work with Nutrition Department and implementing partners to scale up integration of FP and nutrition at 6-month well-child visits	543	556	570	585	599	2,853
11	SD 3.1 Continue to provide FP information and referral services for parents accessing vitamin A supplementation and deworming services	2,589	2,654	2,720	2,788	2,858	13,610

No.	Activity	2018	2019	2020	2021	2022	Total
12*	SD 3.2 Train health workers to ensure that counseling and provision of FP services are integrated into the 6-week postpartum visit and subsequent immunization visits	2,851	2,401	2,461	2,522	2,585	12,821
13	SD 3.3 Include as criteria for staff who can be trained on cervical cancer screening that they must have already been trained on long-term FP methods	543	417	0	0	0	960
14	SD 3.4 Work with NACP to ensure that FP is fully integrated into HIV services	2,885	2,957	3,031	3,107	3,185	15,166
15	SD 4.1 Provide robust mobile outreach services, including all contraceptive methods available (short- and long-term, except sterilization), including LARCs, to reach all remote areas at regular intervals	595,727	325,668	333,810	342,155	350,709	1,948,069
16	SD 5.1 Engage the private sector and provide training in FP service provision and use of data collection system so they can provide a wide range of FP methods	0	25,208	14,829	15,200	15,580	70,817
17*	SD 6.1 Include FP certification (including service delivery and FP data collection) in the training of all health workers at the pre-service level, so that all cadres are able to provide both short- and long-term FP methods upon graduation	0	21,094	24,523	25,136	25,765	96,518
18	SD 6.2 Health workers have access to quality skills building and adequate practice during their training	0	8,633	0	0	0	8,633
19	SD 7.1 Support all direct and indirect costs to provide a full method mix of FP services	2,271,669	2,550,176	2,852,643	3,171,293	3,519,833	14,365,615
	Total	**2,968,243**	**3,009,458**	**3,262,909**	**3,591,816**	**3,950,870**	**16,783,295**

Area 3: Contraceptive Security

No.	Activity	2018	2019	2020	2021	2022	Total
1*	CS 1.1 Contribute to the resolution of governance for procurement and logistics for FP supplies (NPPU and new agency being formed)	4,581	348	356	365	375	6,025
2*	CS 1.2 Strengthen existing RH Commodity Security Committee	814	835	856	877	599	3,981
3*	CS 1.3 Focal person from the RH Commodity Security Committee to participate in supply chain technical working group once established	204	209	214	219	225	1,070
4*	CS1.4 Strengthen central level coordination between the RHFP and NPPU caretaking team	38,124	39,077	40,054	41,056	42,082	200,394
5*	CS 1.5 Develop a risk management plan for contraceptive security	40,114	21,745	22,288	22,845	23,417	130,409
6*	CS 2.1 Undertake comprehensive forecasting, quantification, and procurement of FP commodities, and align with financing activities to ensure adequate resources are mobilized	88,980	87,902	86,528	88,691	87,155	439,255
7*	CS 3.1 Support all indirect costs to procure and distribute a full method mix of FP commodities and supplies	238,556	268,997	302,088	336,816	375,024	1,521,481
8	CS 4.1 Procure EC per the quantification and procurement plan	49,504	52,086	54,803	57,662	60,669	274,724
	Total	**460,877**	**471,199**	**507,187**	**548,531**	**589,546**	**2,577,340**

Area 4: Policy and Enabling Environment

No.	Activity	2018	2019	2020	2021	2022	Total
1	PEE 1.1 RHFFP to create a directive to FP service providers affirming the rights of adolescents and young people to access FP services without authorization from a parent, spouse, or provider, with input from youth-serving organizations and service providers	20,507	0	0	0	0	20,507
2	PEE 1.2 Conduct advocacy to secure endorsement of directive by key government officials, and behavior change at the service delivery level	22,358	0	0	0	0	22,358
3	PEE 1.3 Issue directive and ensure supportive supervisory visits review implementation of youth-friendly services directive by health service providers	0	0	0	0	0	0
4	PEE 1.4 Build the capacity of adolescents and young people to act upon their human rights to access FP services	0	0	0	0	0	0
5	PEE 2.1 Update the education policy to clearly articulate which SRHR and FP services can be provided at different school levels, and to acknowledge youth rights to comprehensive FP information and services	6,568	22,638	1,141	1,169	1,198	32,714
6	PEE 2.2 Task force to advocate with MEST to ensure adoption of the policy	0	34,067	34,918	35,791	36,686	141,462
7	PEE 2.3 Develop and distribute age-appropriate FP materials and job aids (e.g., posters, pamphlets, flyers) to inform adolescents/youth about their options to receive services in school, as well as at clinics	0	3,505	0	0	0	3,505
8	PEE 3.1 Develop a policy to stipulate that during rotation DHMTs must ensure every facility has a member of staff who is trained to deliver FP services	14,806	348	0	0	0	15,154
9	PEE 4.1 Develop a series of high-level advocacy briefs for Ministers and Parliamentarians on how FP impacts other sectors (e.g., agriculture, food security, environment, education, jobs)	13,018	0	13,677	0	14,369	41,064
10	PEE 5.1 Review current national health insurance scheme and advocate to ensure that all methods of FP are included and that the scheme, including comprehensive FP services for all people, including youth, is approved by policymakers	80,216	0	0	0	0	80,216
	Total	**157,472**	**60,558**	**49,736**	**36,960**	**52,254**	**356,980**

Area 5: Financing

No.	Activity	2018	2019	2020	2021	2022	Total
1	F 1.1 Develop and implement a legal statute for the MOHS to allocate 1% of the health budget for FP commodities and programs, which is separate from the budget line item for reproductive and child health services	0	10,553	1,511	1,548	1,587	15,199
2	F 1.2 Advocate with the GOSL and the MOHS leadership to ensure that funds for FP are securely allocated and disbursed in a timely matter, as specified in the legal statute	0	5,649	0	512	524	6,684
3	F 2.1 Conduct an annual FP gap analysis to identify activities and results established in the CIP that are not aligned with available funding from development and implementing partners	42,905	43,977	45,077	46,203	47,359	225,520
4	F 3.1 Design and implement a resource mobilization strategy with a focus on diversifying funding sources for FP	21,000	0	0	0	0	21,000
5	F 3.2 Identify potential organizations (local and international) that can contribute towards funding FP, with a focus on unfunded or underfunded CIP activities	19,157	19,636	20,127	20,630	21,146	100,696
6	F 4.1 Develop policy directives, guidelines, and tools to assist subnational levels to allocate resources to FP	509	43,394	0	0	0	43,903
7	F 4.2 Conduct supportive supervision from national-level to regional Health Directorates to make evidence-based decisions related to programming, budgeting, and tracking expenditures for FP to ensure that it is fully integrated and that subnational budgets reflect increased finances for FP	12,013	12,314	12,622	12,937	13,260	63,146
	Total	**95,584**	**135,522**	**79,336**	**81,830**	**83,876**	**476,148**

Area 6: Stewardship, Management, and Accountability

No.	Activity	2018	2019	2020	2021	2022	Total
1	SMA 1.1 Strengthen supportive supervision of FP service providers, including CHWs, by improving leadership capacity and updating supportive supervision tools and job aids to enforce rights-based programming	32,220	46,343	0	0	0	78,563
2	SMA 1.2 Effective quality improvement/ quality assurance (QI/QA) approaches to improve the quality of FP service provision are implemented at facility and community levels	679	696	713	731	749	3,567
3	SMA 2.1 Improve coordination and effectiveness of RHCS Committee meetings through a broadened mandate and a creation of subcommittees	5,093	1,743	1,786	1,831	1,876	12,329
4	SMA 2.2. Improve FP stakeholder coordination and performance monitoring at the district level	1,039,831	1,065,827	1,092,473	1,119,784	1,147,779	5,465,694
5	SMA 3.1 Implement an electronic planning/performance monitoring mechanism/system to track progress of the SLFPCIP and improve coordination among the partners	474,000	457,150	468,579	480,293	492,301	2,372,323
6	SMA 3.2 Hold regular review meetings to monitor CIP performance	9,705	9,947	10,196	10,451	10,712	51,011
7	SMA 4.1 Conduct a mid-term and end-of-plan evaluation of the FP-CIP	0	0	46,017	0	134,417	180,434
8	SMA 5.1 Hire additional staff and supply them with adequate resources to effectively manage and monitor the implementation of the activities outlined in this plan	71,255	36,067	14,275	37,893	38,840	198,330
9	SMA 5.2 Improve the capacity of RHFPP staff in computer skills, project reporting formats for different donors, project proposal development, advocacy, project management and supply chain management (quantification, procurement, clearing, and forwarding), partnership management	13,676	12,067	10,229	12,677	12,994	61,644
10	SMA 5.3 Improve and extend the resource center lighting, standby electricity, generator, ventilation, and projection facilities and train RHFPP support staff to maintain facilities	32,220	100,816	5,610	5,750	5,894	118,069
	Total	**1,646,458**	**1,730,655**	**1,649,877**	**1,669,410**	**1,845,562**	**8,541,963**

ANNEX C. FP2020 Rights and Empowerment Principles for Family Planning

- **Agency and Autonomy**: Individuals have the ability to decide freely the number and spacing of their children. To exercise this ability, individuals must be able to choose a contraceptive method voluntarily, free of discrimination, coercion, or violence.
- **Availability**: Healthcare facilities, trained providers, and contraceptive methods are available to ensure that individuals can exercise full choice from a full range of contraceptive methods (barrier, short-acting, long-acting reversible, permanent, and EC). Availability of services includes follow-up and removal services for implants and IUDs.
- **Accessibility**: Healthcare facilities, trained providers, and contraceptive methods are accessible—without discrimination, and without physical, economic, sociocultural, or informational barriers.
- **Acceptability**: Healthcare facilities, trained providers, and contraceptive methods are respectful of medical ethics and individual preferences, are sensitive to gender and life-cycle requirements, and respect confidentiality.
- **Quality**: Individuals have access to contraceptive services and information of good quality, which are scientifically and medically appropriate. Quality of care is a multifaceted element that includes but is not limited to the following: a full choice of quality contraceptive methods; clear and medically accurate information, including the risks and benefits of a range of methods; presence of equipped and technically competent providers; and client-provider interactions that respect informed choice, privacy, and confidentiality, and client preferences and needs.
- **Empowerment**: Individuals are empowered as principal actors and agents to make decisions about their reproductive lives, and can execute these decisions through access to contraceptive information, services, and supplies.
- **Equity and non-discrimination**: Individuals have the ability to access quality and comprehensive contraceptive information and services free from discrimination, coercion, and violence. Quality, accessibility, and availability of contraceptive information and services should not vary by non-medically indicated characteristics, such as age, geographic location, language, ethnicity, disability, HIV status, sexual orientation, wealth, marital, or other status.
- **Informed choice**: Individuals have the ability to access accurate, clear, and readily understood information about a variety of contraceptive methods and their use. To exercise full, free, and informed decision making, individuals can choose amongst a full range of safe, effective, and available contraceptive methods (barrier, short-acting, long-acting reversible, permanent, and EC).
- **Transparency and accountability**: Individuals can readily access meaningful information on the design, provision, implementation, and evaluation of contraceptive services, programs, and policies, including government data. Individuals are entitled to seek remedies and redress at the individual and systems levels when duty bearers have not fulfilled their obligations regarding contraceptive information, services, and supplies.
- **Voice and participation**: Individuals, particularly beneficiaries, have the ability to meaningfully participate in the design, provision, implementation, and evaluation of contraceptive services, programmes, and policies.