Government of Sierra Leone

FP2030 COMMITMENT

"A global partnership centered on family planning

SIERRA LEONE'S 2030 VISION STATEMENT

By 2027, we envision a Sierra Leone where everyone is empowered to make informed choices, has affordable and equitable access to quality, rights-based family planning and sexual and reproductive health services and is fully capacitated to participate in national development, leaving no one behind.

COMMITMENT OBJECTIVES

Commitment objective 1
Improved policy and legal environment

Commitment objective 2
Increased access to quality family planning services

Commitment objective 3
Strengthened supply chain

Commitment objective 4
Transformed social and gender norms

Financial objective
Sustainable financing for family planning

COMMITMENT OBJECTIVES

01 COMMITMENT OBJECTIVE 1
IMPROVED POLICY AND LEGAL ENVIRONMENT

Objective statement

To achieve Universal Health Coverage by 2030 through effective integration of family planning in national development plans as a vital driver of human capital development.

Timeline

2023-2030

Rationale

Sierra Leone's policy environment is generally conducive to and supportive of family planning. General health sector policies and strategies identify the improvement of maternal health outcomes and reduction of teenage pregnancy as priorities. Health sector policies identify family planning as a high-impact intervention and highlight its integration into mainstream government systems. The policies also recommend resource allocation to emphasize preventive and primary health care including family planning. An ambitious national target is also set to meet over 90 per cent of the family planning demand by 2030.

The Government has taken notable measures to curb the high rate of adolescent pregnancy and child marriage which is preventing young girls and young women from realizing their full potential. This includes the first ever policy on radical inclusion in education which especially gives teenage mothers – a historically marginalized group – a second chance by encouraging them to return to school after childbirth. The establishment of the National Secretariat for the Reduction of Teenage Pregnancy as well as the development of the National Strategy for the Reduction of Adolescent Pregnancy and Child Marriage (which is currently under revision) is also a testament to the Government's commitment. However, there are still policy and legal barriers to accessing family planning services.

Access to family planning for adolescents and young people: Although there are no policies or guidelines that ban the provision of family planning services to adolescents,[1] there is no specific affirmative law or policy that supports their access to these services without authorization from a parent, spouse or provider. Were there such a law, it would provide the necessary legal basis for social and behaviour change programmes that could counteract social and traditional norms and customs restricting access for young people to family planning services. Currently, in the absence of such an affirmative law, health care providers are uncertain about the legal or policy implications of providing family planning services to adolescents under 18. Efforts, however, are underway: A "School Health Policy" (a joint effort between the health and education sectors) explicitly states that students will receive Comprehensive Sexuality Education and life skills training in school. However, this policy is yet to be endorsed and implemented. Also, a safe motherhood and reproductive health bill to protect the sexual and reproductive health and rights of women is under review and is likely to be approved, However, given the amount of time taken so far, there is the risk of delay in the enactment of this bill.

1. Sierra Leone has a dualist legal structure. Formal legislation such as the Child Rights Act (2007) and the Sexual Offences Act (2012) stipulate that "a person aged under 18 years cannot consent to sex, making sex below this age illegal." The Registration of Customary Marriage and Divorce Act (2009) also states that a person can only legally marry if they are over the age of 18 years. However, the percentage of teenagers who have given birth or are pregnant with their first child has decreased since 2013 (28 per cent) but is still high at 21 per cent. 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. This is even more common among rural, less educated teenagers. This affirms the fact that marriages are still happening for girls under the minimum age stipulated in the formal law through social and customary arrangements. Though the rate is falling, the practice of child marriage is still high (29.6 per cent of women aged 20-24 years were married before their 18th birthday in 2019 compared to 38.9 per cent in 2013). This also shows that the formal law is not consistently implemented or enforced.

Rationale

Service providers (limited number and scope of work): Currently only 45 per cent of the required health care workforce as defined in the Basic Package of Essential Health Services (2015-2020, currently under review) is available. Over half the available health workers are in the Western Area districts. Some health care workers who are working in the health facilities around the country are not on the civil service payroll which may affect their motivation to provide quality health services. On the other hand, Community Health Workers (CHWs) are limited by what family planning methods they can offer clients: Currently, they can only provide condoms and refills of contraceptive pills. Evidence from various countries shows that trained CHWs can safely provide pills (including the first dose) and injectable contraceptives. With a limited paid health care workforce in the public and private sector, there needs to be consideration of task-shifting or task-sharing to allow CHWs to provide additional family planning methods in the communities they reach that are underserved by the current health infrastructure.

Strategies

- Ensure unnecessary medical and administrative barriers such as notification or consent requirements for adolescents and young people are resolved within the full legal framework of the country, to ensure access to services, e.g., advocate for an affirmative law that can resolve ambiguities around age of consent to access the services.
- Advocate implementation of the School Health Policy.
- Provide task-sharing policy or legislation to guide the registration and licensing of CHWs and other lower cadre health professionals such as MCH-Aids to provide specific family planning services.
- Support policy and market analysis to guide policy decisions towards greater investments by private sector and faith-based organizations in reproductive health and family planning.

02 COMMITMENT OBJECTIVE 2
INCREASED ACCESS TO QUALITY FAMILY PLANNING SERVICES

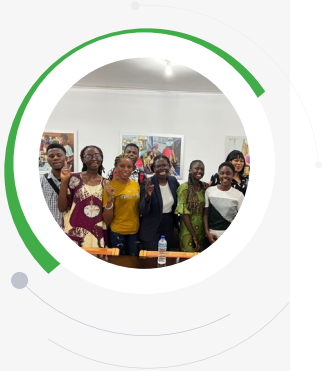
Objective statement

To increase modern contraceptive prevalence rate (mCPR) for all women to at least 32 per cent using evidence- and rights-based practices and services to expand family planning access and choice across the country, including ensuring continuity of services during emergencies, by 2027.

Timeline

2023-2030

Rationale



The mCPR in Sierra Leone has been increasing for the last 15 years (6.7 per cent in 2008 to 16 per cent in 2013 to 21 per cent in 2019 for currently married women).[2] Ninety per cent of the Service Delivery Points (SDPs) do offer at least five contraceptive methods.[3] However, the 2022 mCPR estimate (26 per cent for all women) has fallen short of meeting the 34 per cent target,[4] per the FP2020 commitment and the previous family planning costed implementation plan (2018-2022).

On the other hand, over half of unmarried women are currently using contraception, making Sierra Leone among those countries in sub-Saharan Africa with the fastest growing proportion of unmarried women who are using contraception. In this regard, it is also important to note that a large proportion of women of reproductive age (WRA) in Sierra Leone (62.4 per cent) are either married or living together with their partner, and unmarried women account only for 11 per cent of WRA.[5]

However, the first-year contraceptive discontinuation rate in Sierra Leone is high, signifying low service quality. One out of every three women (35 per cent) who began using family planning discontinued it within 12 months, most commonly for a method-related reason such as side effects and other health reasons.

Moreover, 25 per cent of currently married women have an unmet need for family planning, 17 per cent for spacing and 7 per cent for limiting. Only 46 per cent of the demand for family planning is satisfied. The trend since 2008 also shows that unmet need has been persistently stagnant and high (27.6 in 2008, 25.0 in 2013 and 24.8 in 2019 for currently married women). Per the 2019 Demographic Health Survey, the proportion of currently married women with an unmet need for spacing births is highest among those aged 15 to 19 (27.9 per cent).[6]

The family planning costed implementation plan (FP CIP) has identified the improvement of postpartum family planning (PPFP) uptake as the first high-impact and strategic priority. While the National Family Planning Policy calls for integration of family planning into a wider set of programmes, the FP CIP recommends a prioritized effort to strengthen its integration into maternal and child health services to strengthen postpartum family planning.

2. Sierra Leone Demographic Health Survey 2008, 2013, 2019.
3. Health facility assessment of availability of RH commodities and services, 2022.
4. Track 20, FP2020 commitment and FP Costed Implementation Plan (2018-2022).
5. Sierra Leone 2015 Population and Housing Census Thematic Report on Population Projections (October, 2017).
6. Sierra Leone Demographic Health Survey 2008, 2013, 2019. Note that data for 'All women' and 'Unmarried women' is not available in 2008 and 2013 DHS reports.

Strategies

- Improve PPFP uptake through integration of PPFP into delivery (immediate), antenatal care (counselling), postnatal care and immunization. Consideration will be given to the network of EmONC facilities for the integration of PPFP.
- Institutionalize a continuous quality improvement structure and process at every service delivery level where gaps are identified and continuously improved, e.g., strengthening data clinics at the level of District Health Management Teams.
- Capacity-building of service providers so that they can provide quality counselling to address issues related to side effects and to counter myths, misconceptions and misinformation, while also strengthening pharmacovigilance.
- Ensure family planning training and services are underpinned by a rights-based approach respecting contraceptive and reproductive choices, and informed decision-making while also strengthening the training database.
- Ensure all peripheral health units (PHUs) provide adolescent-friendly and young people-friendly family planning services including outreach services in schools and other learning centres.
- Regularly obtain client feedback concerning contraceptives and other services through suggestion boxes, exit interviews etc., and use the information to plan service improvement efforts.
- Strengthen the capacity of CHWs to conduct regular outreach to adolescents, especially to girls who are not in school.
- Strengthen partnerships with the private sector (private pharmacies and drug shops) to improve access of family planning services to adolescents (given their convenience of access and less stigma).
- Build the capacity of service providers relating to the Minimum Initial Service Package (MISP).

COMMITMENT OBJECTIVES

03 COMMITMENT OBJECTIVE 3
STRENGTHENED SUPPLY CHAIN

Objective statement

To strengthen the national integrated supply chain management system to improve the incidence of 'no stock-out' of any modern contraceptive method to 60 per cent by 2027 (from the 2022 levels of 39.3 per cent).

Timeline

2023-2030

Rationale

The national health supply chain in Sierra Leone relies on multiple actors to act in a coordinated and aligned manner to deliver access to needed essential medicines for the population. The principal actors include the Directorate of Pharmaceutical Services (DPS/MoHS), the National Medical Supplies Agency (NMSA), districts, partners and health programmes including the Reproductive Health and Family Planning Programme (RHFPP). Specifically, the following two entities are the leads in the health supply chain:

DPS/MoHS: As the overarching Government oversight body for the pharmaceutical sector, it has a mandate to set a strategic direction for the delivery of pharmaceutical services, and the coordination and implementation of other MoHS strategic guidance affecting the pharmaceutical sector.

The National Medical Supplies Agency (NMSA): It is a public service agency responsible for procurement, warehousing and distribution of drugs and medical supplies for and on behalf of all public institutions in Sierra Leone. It was established by an Act of Parliament which was signed into law on 26 October 2017.

Medicines and medical products represent the largest area of cost for the health sector, and expenditure has been largely dependent on external donor support. Hence, the MoHS has undertaken to develop an integrated National Health Supply Chain Strategy (NHSCS), to guide investments and interventions in this critical and strategic pillar of the health sector programme delivery for the next five years (2023-2027). The NHSCS is the outcome of a multi-disciplinary, multi-stakeholder consultative process, and the Reproductive Health and Family Planning Programme had also engaged actively in the process. This strategic plan document will provide a coordinated, harmonized framework to guide the efforts of all partners and stakeholders committed to ensuring the availability of essential health commodities including reproductive health commodities to Sierra Leoneans.

The findings of the 2022 National Assessment on Availability of RH Commodities and Services showed an improvement in the percentage of SDPs with no stock-out of any modern contraceptive method offered, in line with national protocols, guidelines and/or laws in the last three months of 2022, at 39.3 per cent, compared with 22.9 per cent in results in 2019 and 10.8 per cent in 2018. The objective is to further improve the incidence of no stock-out to 60 per cent.

Strategies

- Strengthen supply chain governance and performance monitoring through active engagement in the national and district level health supply chain coordination structures to harmonize the planning and deployment of investments in health commodities and supply chain systems (e.g., forecasting and supply planning of contraceptive supplies, and defining a monitoring and evaluation plan with Key Performance Indicators).

- Strengthen the capacity of NMSA to coordinate and manage commodity procurements in the health sector (including RH commodities), leveraging strategic procurement management systems and pooled financing mechanisms that promote financial and operational self-sufficiency of the agency.

- Design and implement a national, integrated distribution system that leverages the district's role in active facility-level inventory management to cost effectively respond to patient and product requirements.

- Integrate the Logistics Management Information System (LMIS), Health Management Information systems (DHIS 2) and Warehouse Management Information Systems (mSupply) with distribution and supply planning (including GFPVAN), strategically phasing in the digitization and automation of data capture, and reporting and analysis tools at service delivery, including providing support to DHMTs for data analysis and decision-making.

- Implement a coordinated and harmonized human resources capacity development plan for the national supply chain, including measures to institutionalize supply chain roles in the health sector scheme of service (including creating a civil service classification for supply chain positions), and to ensure professionalization of the supply chain in the health sector.

- Institutionalize a last mile assurance mechanism to improve the visibility, management, safeguarding and use for intended purposes of RH commodities.

04 COMMITMENT OBJECTIVE 4
TRANSFORMED SOCIAL AND GENDER NORMS

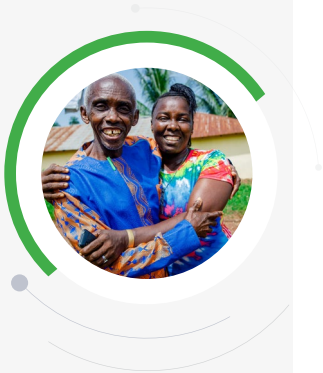
Objective statement

To establish and strengthen community, district and national mechanisms to change social and gender norms that hinder the agency and autonomy of women and girls, and limit access to rights-based family planning and sexual and reproductive health information and services for young people, people living with disability, key vulnerable populations and men, by 2030.

Timeline

2023-2030

Rationale



Knowledge of contraceptive methods is nearly universal in Sierra Leone, with 98 per cent of currently married women and 99 per cent of men knowing at least one modern method.[7] Despite this knowledge, demand for modern contraceptives stands at only 46 per cent. Fifty-four per cent of currently married women express no need for family planning, the most commonly cited reasons being breastfeeding, and norms and beliefs (respondent opposed, fatalistic, husband/partner opposed).[8] Obviously, breastfeeding women may be at risk of getting pregnant without realizing it.

The marriage and family formation patterns influence the context for family planning in the country. Sixty-two per cent of women and 51 per cent of men are currently in a union. Marriage is nearly universal: By age 40-44, only 4 per cent of men and women have never been married. Moreover, the practice of child marriage is still high in Sierra Leone: Of women aged 20-24 years, 29.6 per cent were married before their 18th birthday, in 2019.[9] This is typically higher in rural areas and the poorest households. Child marriage usually leads to girls dropping out of school, thus eroding protective factors for the use of modern family planning methods. An estimated 62 per cent of women aged 15-49 report having experienced physical or sexual violence, according to the 2019 SLDHS. More than half of 15-year-olds and older (57 per cent) are illiterate and half of those leaving primary school are unable to read and write. The school dropout rate is high which can be largely attributed to the intersection of poverty and gender norms, involving issues such as transactional sex, early marriage and the burden of having to perform a disproportionate share of household chores.

Regarding sexual debut, the median age at first sexual intercourse is 16.1 years among women and 18.3 years among men aged 20-49. By age 15, over a quarter (26 per cent) of women had already started sexual intercourse. 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.

Gender norms play a significant role in determining women's willingness to use modern contraceptives: For example, women in Sierra Leone who condemn wife beating or those who have the ability to refuse sex are more likely to use modern contraceptives. [10]

7. GFPVAN: Global Family Planning Visibility Analytics Network
8. Sierra Leone Demographic Health Survey 2019. .
9. Sierra Leone Demographic Health Survey 2019. Child marriage was at 38 per cent in 2013. Education and health policies and initiatives to address harmful traditional practices may have contributed to this decline.
10. P. Agbadi, T. T. Eunice, A. F et al., "Complex samples logistic regression analysis of predictors of the current use of modern contraceptive among married or in-union women in Sierra Leone: Insight from the 2013 demographic and health survey," PLoS One, vol. 4, no. 15, 2020.

Rationale

This proven link between women's empowerment and modern contraceptive use underscores the reasoning behind their inclusion in Sustainable Development Goals 3.7 and 5.6 and the objectives of the FP2030 initiative. In vital activities such as the uptake of postpartum family planning, a study in Ghana found that personal conviction and partner approval were the main factors determining postpartum family planning uptake. [11] Personal conviction is often shaped by prevailing gender norms revealed through attitudes such as the acceptance of wife beating and sexual and gender-based violence.[12]

Overall, women in Sierra Leone desire large families. The mean ideal number of children was 4.7 at the time of the 2019 DHS, declining only slightly from 4.8 in the 2013 DHS. The maximum prevalence demand curve suggests that even without a change in desired family size, most districts could still see further increases in mCPR. However, in some districts, namely Kailahun, Bo and Moyamba, further increases in mCPR are unlikely without underlying changes to the social norms that influence demand.[13]

Almost one in ten women in Sierra Leone who decide not to use a modern contraceptive do so for religious reasons. Though they are apprehensive about contraception, religious leaders in Sierra Leone generally agree that birth spacing is vital for the well-being of women and the family. They also recognize that with the economic situation in Sierra Leone having large families can be financially difficult to manage. [14]

In Sierra Leone, radio is the most often accessed form of media, listened to by 24 per cent of women (age 15-49), whilst 3 per cent read a newspaper, and 15 per cent watch television. Only 1 per cent of women have access to all three media sources, while **70 per cent of women have no access to any of the specified media.** Thirteen per cent of women had used the internet in the past 12 months before the survey. Among them, 61 per cent of women report using it almost every day during the preceding month.[15] The high percentage of women who have no access to any specified media points to the need for outreach and community sensitization.

11. S. Eliason, F. Baiden, Q. Asare, et al., "Factors influencing the intention of women in rural Ghana to adopt postpartum family planning," Reproductive Health, vol. 10, no. 51, 2013.
12. Sierra Leone Costed Implementation Plan 2023-2027.
13. Ibid.
14. Christian Health Association of Sierra Leone, "Barriers to Family Planning in Sierra Leone," CHASL, Freetown, Sierra Leone, 2021.
15. Sierra Leone Demographic Health Survey 2019.

COMMITMENT OBJECTIVES

04 COMMITMENT OBJECTIVE 4
TRANSFORMED SOCIAL AND GENDER NORMS

Strategies

- Encourage the use of formative research to identify the social norms and reference groups relevant to behaviours around contraception and reproductive health.
- Carry out interpersonal communication on family planning through CHWs, e.g., focused counselling to women preparing for childbirth about contraceptive options, addressing concerns about side effects and the risks of closely spaced or unintended pregnancies.
- Support youth-led and women-led grassroots organizations as key agents of change (e.g., strengthen youth structures through capacity-building to engage their peers on SRH/FP).
- Use mass media channels to support healthy reproductive behaviours.
- Advocate with key stakeholders such as faith-based organizations (e.g., the Inter Religious Council) and traditional/community leaders.
- Identify Members of Parliament and Local Councils and provide education and conduct outreach to cultivate them as champions.
- Conduct intergenerational dialogue sessions on positive parenting.
- Implement male involvement strategies in family planning programmes.
- Develop appropriate (culturally sensitive) Information, Education and Communication messages that target different categories of audiences.
- Collaborate with the Ministry of Basic and Senior Secondary Education (MBSSE) in integrating Comprehensive Sexuality Education into the education curriculum to ensure young people are equipped with the knowledge, skills, attitudes and values they need to make informed choices.
- Strengthen the role of CHWs in Social Behaviour Change interventions.

COMMITMENT OBJECTIVES

FINANCIAL OBJECTIVE
SUSTAINABLE FINANCING FOR FAMILY PLANNING

Objective statement

To improve sustainable financing for family planning by allocating a minimum of 1 per cent of the national health budget annually and exploring additional innovative domestic financing mechanisms to increase financing for family planning by 2030.

Timeline

2023-2030

Rationale

One of the GoSL's overarching goals is to achieve Universal Health Coverage by 2030. The GoSL signed the Abuja Declaration to increase expenditure in health to 15 per cent of national expenditure. The GoSL also made the ICPD25 commitment to allocate 1 per cent of the health budget to family planning. To date, neither allocations nor actual expenditure have reached the desired target. Furthermore, within the inadequate allocation, expenditure on family planning accounts repeatedly for less than 0.1 per cent.[16]

The health care system is heavily dependent on donor funding. GoSL spending only accounts for about 10 per cent of total health expenditure; 40 per cent is by donors and another 40 per cent is paid out-of-pocket by households. Seventy per cent of household expenditure is on drugs. However, compared to its West African subregional neighbours, public health spending in Sierra Leone is higher. Sierra Leone's Government expenditure on health as a percentage of GDP is 1.84 per cent, which is higher than the West African subregional average of 1.44 per cent. In 2019, the budget share of the MoHS was second only to that of education. In 2022, 11.3 per cent of total discretionary expenditure was allocated to the health sector.[17]

The composition of health spending has favoured recurrent spending and, notably, wages. The share of personnel emoluments has crowded out the provision of goods and services such as drugs and medical supplies, creating shortages at health facilities. Moreover, rural primary health care is underfunded (73 per cent is spent on administrative services, 12 per cent on secondary and tertiary care services, and only 3 per cent on primary health care). According to the family planning costed implementation plan (2023-2027), the national estimated cost of the family planning programme from 2023 to 2027 is US$35.92 million. More than half of the cost is programmatic. Commodities and supplies account for one third of the total cost.

The GoSL and UNFPA are working in partnership towards progressively increasing domestic financing for family planning commodity procurement. This initiative has been formalized through a mutual agreement ('the Compact') that sets out the terms and conditions for the Government and partners and clarifies roles and responsibilities for a minimum of three years. In line with this, the Government has created a new budget line in the 2023 Government budget plan for the procurement of reproductive health commodities.

16. Family planning costed implementation plan, 2023-2027.
17. World Bank Group, "Sierra Leone Programmatic Public Expenditure Reviews 2021: Fiscal Policy for a Sustainable Recovery," 2021, © Macroeconomics Trade and Investment Global Practice.

COMMITMENT OBJECTIVES

FINANCIAL OBJECTIVE
SUSTAINABLE FINANCING FOR FAMILY PLANNING

Strategies

- Advocate for progressive allocation of public funding for family planning in line with the GoSL's ICPD commitment.
- Advocate for inclusion of family planning services under the Sierra Leone Social Health Insurance (SLeSHI) benefit packages.
- Support the routine tracking of family planning financial flows.
- Implement and monitor the family planning costed implementation plan and ensure updated estimates of programme requirements are available.
- Generate policy briefs with evidence-based arguments to position and integrate FP into multisectoral development interventions and an essential package of Sexual and Reproductive Health, Primary Health Care and Universal Health Coverage.

COMMITMENT CONSULTATION PROCESS

The commitment process benefited from rigorous situational analysis, review of progress to date, development of family planning policy, guidelines, implementation plans, family planning supplies needs identification and forecast, advocacy efforts involving decision makers and civil society organizations, and the development of strategic priorities based on district-level scale-up scenarios and consultations with stakeholders at all levels.

In particular, the FP2030 commitment benefited from individual exercises conducted in the course of the year 2022. These include (1) situational analysis and progress made since 2012 and towards targets of the FP2020 commitment and the previous costed implementation plan (2018-2022); (2) development of new costed implementation plan with focus on subnational consultations (2023-2027); (3) development of family planning policy and guidelines; (4) forecast and supply planning of contraceptive supplies (2023-2027); (5) process to secure mutual agreement between Government and partners towards increasing domestic financing for family planning commodity procurement; and (6) consultations led by civil society organizations (e.g., a youth conference which engaged more than 150 young people from all 16 districts).

Each of these processes adopted iterative approaches and engaged a wide range of stakeholders (including young people) at different levels: central, district and SDPs. The commitment benefited from the FP2030 commitment toolkit and the series of consultations (virtual and in-person) conducted with the FP2030 technical and leadership team facilitated by the FP2030 country level focal points system.

Finally, the process culminated in the formulation of the FP2030 vision and commitment objectives over a three-day stakeholders consultative meeting held from 21 to 23 November 2022.

COMMITMENT ACCOUNTABILITY APPROACH

The Government of Sierra Leone has provided the MoHS with the mandate to ensure that family planning services are available to all people of Sierra Leone. The RHFPP is the programme within the MoHS that is responsible for family planning and other reproductive health services. RHFPP is one of three programmes 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 these commitments.

For the Government to honour this commitment, a multisectoral approach, coordination and partnerships are critical. The MoHS is therefore committed to strengthening national and district level intersectoral multi-stakeholder accountability mechanisms involving civil society organizations, adolescent and youth councils and organizations, media organizations, faith-based and community-based organizations and the private sector.

Existing multisectoral platforms such as the Multi-sectoral Coordinating Committee established under the auspices of the National Strategy for the Reduction of Adolescent Pregnancy and Child Marriage will be employed to position and mainstream family planning agenda to the level that can help the country to harness the potential impacts of improved access to family planning services such as the prevention of maternal deaths, unintended pregnancies and unsafe abortions. At the national level, the National Family Planning Technical Working Group led by the RHFPP will continue to serve as a platform to convene national level stakeholders mandated to provide oversight and technical guidance.

The commitment is aligned with the family planning costed implementation plan in which clear targets are set for districts to enable monitoring on a quarterly basis. The monitoring will follow a decentralized approach. The existing health management information system, DHIS2, will be used to collect routine data from SDPs. The MoHS is committed to creating record-keeping and reporting tools at all levels. District Health Management Teams will be supported in undertaking regular district level data clinics where data quality assurance, analysis, identification of gaps and feedback is provided with respect to the SDPs in their catchment areas. The MoHS is committed to making available record-keeping and reporting tools at all levels. Civil society organizations will be encouraged and supported in undergoing independent monitoring of programme implementation to the last mile and tracking of progress towards set targets using tested tools and mechanisms. These mechanisms will also ensure engagement of service providers and clients. Youth-led organizations will be engaged including by granting them the opportunity to take the lead in advocacy and monitoring processes.

The annual multi-stakeholder consensus platform (including civil society organizations) on key measures of progress towards family planning commitments and national goals are set within the costed implementation plan. This provides the opportunity for an entire family planning programme review along with the national strategy and commitments, validation of FP2030 core indicators and an understanding from the perspective of surveys and service statistics. In general, it aims to establish a common language with regard to measurements used in family planning programmes. As a result, visibility and transparency can be ensured in sharing information on progress towards meeting commitments. This gives the opportunity for course correction in instances where progress falls short of planned targets.

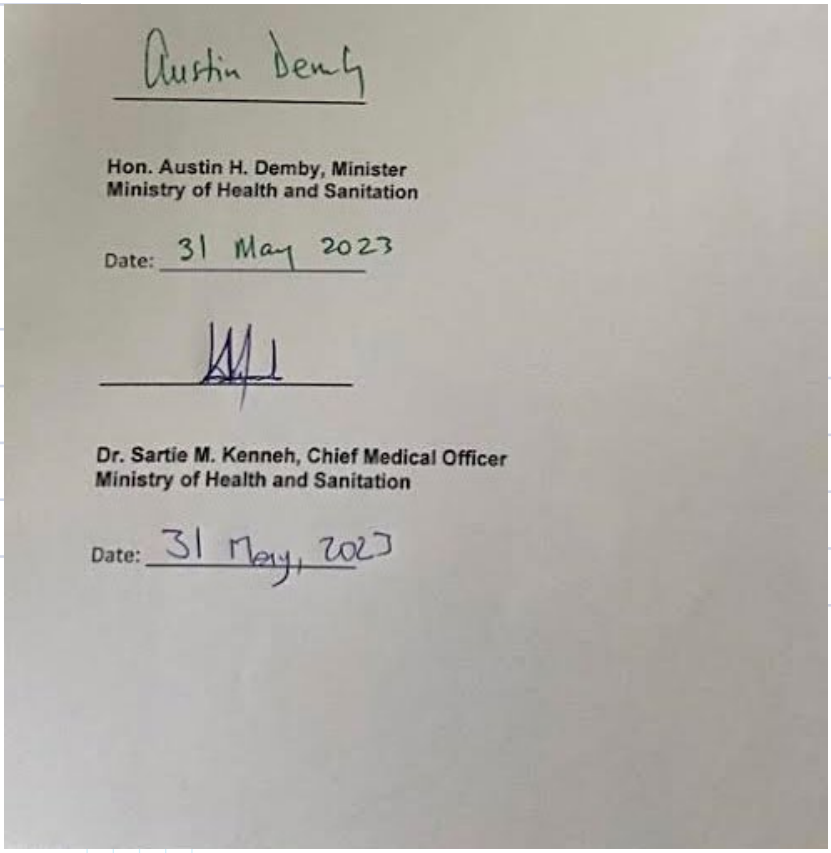
Family planning will be featured in annual performance reviews, reports and sharing of lessons for the health sector and sexual and reproductive health programmes. The annual progress report will feed into the periodic national level reviews of the country's progress towards internationally agreed upon commitments such as the Sustainable Development Go and the ICPD commitment.

In order to fully implement these approaches, FP2030 and partner support would be crucial, particularly but not limited to the following areas: (1) analysis and use of data and evidence for decision-making and accountability; (2) engaging the country team in regional and global collaborative learning and advocacy efforts; (3) creating opportunities for cross-sectoral partnerships; and (4) encouraging meaningful engagement of civil society, women-led and youth-led organizations, especially those at the grassroots level.

Government of Sierra Leone

FP2030 COMMITMENT

The undersigned, being authorized thereto, have signed the FP2030 Commitment of the Governement of Sierra Leone



Austin Demby

Hon. Austin H. Demby, Minister
Ministry of Health and Sanitation

Date: 31 May 2023

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

Date: 31 May, 2023