Liberia Family Planning Costed Implementation Plan

2018-2022

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ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
ANC	antenatal care
ASRH	adolescent sexual and reproductive health
BCC	behavior change communication
CBIS	community-based information system
CHA	community health assistant
CHDD	community health development committee
CHO	county health officers
CHSS	community health services supervisor
CHT	county health teams
CHVs	community health volunteers
CHW	community health workers
CIP	costed implementation plan
CMS	central medical stores
CPT	contraceptive procurement tables
CRHTC	county reproductive health technical committee
CS	commodity security
CSA	Civil Service Agency
CSE	comprehensive sexuality education
CSO	civil society organization
CTU	contraceptive technology update
DD	demographic dividend
DFID	Department for International Development
DG	demand generation
DHIS2	District Health Information System 2
DHOs	district health officers
DHT	district health teams
DTP	diphtheria, pertussis, and tetanus vaccine
EC	emergency contraceptives
EE	enabling environment
EPI	Expanded Program for Immunization
EU	European Union
EVD	Ebola virus disease
F&Q	forecasting and quantification
FAM	fertility awareness methods
FBO	faith-based organizations
FHD	Family Health Division
FP2020	Family Planning 2020
GDP	gross domestic product
GFF	Global Financing Facility
GOL	Government of Liberia
GPRHCS	Global Program to Enhance Reproductive Health Commodity Security
HCC	health coordination committee
HFD	Health Financing Division
HIV	human immunodeficiency virus
HMIS	health management information systems
HP+	Health Policy Plus project
HR	human resources
HRIS	human resources information system
HSCC	Health Sector Coordination Committee
HTSP	healthy timing and spacing of pregnancies
IEC	information, education, communication
INGO	international nongovernmental organization
IPC	infection prevention control
iPRS	Interim Poverty Reduction Strategy
IUDs	intrauterine contraceptive devices

JICA	Japan International Cooperation Agency
JISS	joint integrated supportive supervision
KM	kilometers
LAM	lactational amenorrhea method
LARC	long acting and reversible contraceptives
LDHS	Liberia Demographic Health Survey
LISGIS	Liberia Institute of Statistics and Geo-Information Services
LMHRA	Liberia Medical and Health Regulatory Authority
LMIS	logistics management information system
M&E	monitoring and evaluation
mCPR	modern contraceptive prevalence rate
MDG	Millennium Development Goals
MEC	medical eligibility criteria
MFDP	Ministry of Finance and Development Planning
MIS	Liberia Malaria Indicator Survey
MMD	materials and message development
MNO	mobile network operators
MOE	Ministry of Education
MOH	Ministry of Health
MOIA	Ministry of Internal Affairs
MOYS	Ministry of Youth and Sports
N/A	not applicable
NACP	National AIDS Control Program
NDS	national drug stores
NFP	natural family planning
NGO	nongovernmental organization
NHCS	National Health Communication Strategy
NPSPHP	National Policy and Strategic Plan on Health Promotion
NYSC	National Youth Steering Committee
OR	operations research
OFM	Office for Financial Management
OOP	out-of-pocket
PA	physician assistant
PEP	post-exposure prophylaxis
PNC	postnatal care
PPAL	Planned Parenthood Association of Liberia
PPFP	postpartum family planning
PPIUCD	postpartum intrauterine copper device
PPP	private-public partnership
PRS	poverty reduction strategy
PSA	public service announcement
QA	quality assurance
RAPID	Resources for the Awareness of Population Impacts on Development
RH	reproductive health
RHCS	reproductive health commodity security
RHS	regional health supervisors
RHTC	reproductive health technical committee
RMNCAH	reproductive, maternal, neonatal, child, and adolescent health
RN	registered nurse
SAG	strategy advisory groups
SARA	service availability and readiness assessment
SBA	skilled birth attendants
SBCC	social behavior change communication
SC	supply chain
SCMP	supply chain management master plan

SCMU	supply chain management unit
SCTWG	supply chain technical working group
SD	service delivery
SDGs	Sustainable Development Goals
SDM	standard days method
SDP	service delivery point
SIDA	Swedish International Development Cooperation Agency
SMC	senior management committee
SRMNCAH	sexual reproductive, maternal, newborn, child, and adolescent health
TFR	total fertility rate
TOR	terms of reference
TOT	training of trainers
TST	technical support team
TTI	Teachers Training Institute
TWG	technical working group
UN	United Nations
UNFPA	United Nations Population Fund
UNMIL	United Nations Mission in Liberia
USAID	U.S. Agency for International Development
USD	U.S. Dollars
WHO	World Health Organization
WRA	women of reproductive age
YFS	youth-friendly service

FOREWORD

Liberia's maternal mortality ratio is 1,072 maternal deaths per 100,000 live births, with a total fertility rate (TFR) of 4.7 children per woman, while the modern contraceptive prevalence rate (mCPR) is at 19 percent. There has been gradual increase in the mCPR for the past five years, from 19 percent to 31 percent among people of reproductive age. This indicates that the country is exerting efforts toward the reduction of maternal mortality through the provision of family planning services as one of its key strategies.

Liberia has a youthful population, with 63 percent of its 4.2 million inhabitants under age 25. Although the data show an increase in the mCPR, the high rate of teenage pregnancy (31 percent) is a risk factor for maternal mortality, and the development of obstetric fistulae still remains a major challenge. This can only be addressed by creating demand for rights-based family planning services, especially among adolescents (ages 10-24 years) as a cost-effective strategy for the reduction of teenage pregnancy and maternal mortality.

Therefore, the development of this five-year costed implementation plan (CIP) for family planning is timely and will serve as an advocacy tool and roadmap for domestic resource mobilization and facilitate efforts in the reduction of teenage pregnancy and unsafe abortion as a result of unwanted pregnancy. This in return will yield substantial socioeconomic benefits for the growth and development of Liberia.

The CIP provides scientifically proven, strategic interventions with detailed activities as well as a timeline and budget to guide the concerted efforts of the Ministry of Health and partners, including all stakeholders, toward reducing maternal mortality and further increasing the mCPR.

I would like to express my heartfelt gratitude to the U.S. Government for providing the funds and to all partners and stakeholders for their cooperation and support for the development of the CIP. Finally, special thanks to the Palladium Group for its technical assistance during the development of the CIP.

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Minister of Health
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ACKNOWLEDGMENTS

The *National Family Planning Costed Implementation Plan* details the strategic interventions, activities, and costs to implement the national family planning agenda for the next five years (2018–2022). Led by the Family Health Division on behalf of the Ministry of Health (MOH), this plan was funded by USAID with technical assistance from Palladium and was developed from May 2017 to April 2018. Its core objective is to provide a multiyear costed plan that serves as a guide for sourcing and allocating resources as well as strategic interventions.

The Ministry extends its sincere gratitude to the U.S. Government and to the USAID mission in Liberia for the provision of funds. To our technical lead partner, Palladium, we express our sincere appreciation, especially to Mrs. Christine Lasway, for her time and technical oversight in the development of the plan.

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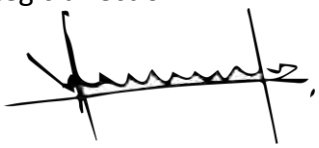
Finally, special thanks go to all the county health officers and county reproductive health supervisors from the 15 counties for their presence during the kickoff and consultative discussions as well as provision of real-time information that guided the development of the strategic direction.



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INTRODUCTION

OVERVIEW

The *Liberia Family Planning Costed Implementation Plan (2018–2022)* (CIP) details the country's roadmap to achieve the vision that every person in Liberia enjoys the highest quality of sexual and reproductive health (SRH), including family planning services; can fully exercise their sexual and reproductive rights; manage their own fertility choices; and have equitable access to the services they choose close to where they live. Specifically, this plan describes costed priority interventions to increase the modern contraceptive prevalence rate (mCPR) to 39.7 percent in 2022, by ensuring that all couples, individuals, and adolescents have access to the full range of quality and affordable family planning services at a location of their choice.

Achievement of the results articulated in this plan is estimated to avert more than 600,000 unintended pregnancies and nearly 216,000 abortions and will prevent more than 3,300 maternal deaths between 2018 and 2022. This plan contributes to several strategic goals and commitments. In 2012, Liberia was one of 24 countries to make commitments to family planning at the 2012 London Summit. In 2017, Liberia had an opportunity to update its country commitments in launching the Reproductive Maternal Neonatal Child Adolescent Health (RMNCAH) Investment Case 2016-2020, which aims to halve the maternal mortality ratio to 600 per 100,000 live births, reduce teenage pregnancy to 25 percent, and reduce total fertility rate to 25 percent by 2020.

By reducing the threats to the nation's development, including maternal and child deaths, teenage pregnancies, and high population growth, this plan, is intended to contribute to the achievement the nation's goal to become a middle-income economy by 2030, achieving the national Vision 2030 of "One people, one nation, united for peace and sustainable development."

RATIONALE FOR AND USE OF THE CIP

Alongside the national family planning strategy, this plan serves as a roadmap to guide all family planning programming for the government across all levels and sectors, development partners, implementing partners, civil society, and the private sector. The plan details evidence-based strategic activities and the costs associated with achieving national goals, providing clear program-level information on the resources the country must raise domestically and from foreign sources. Specifically, the CIP does the following:

- **Facilitates one unified country roadmap for all stakeholders (government, development partners, implementing partners, civil society and private sector):** The CIP articulates consensus-driven priorities for family planning. The plan will help ensure that all family planning activities are aligned with the country's needs, prevent fragmentation of efforts, and guide current and new partners in their family planning investments and programs. This plan calls upon all stakeholders to align their family planning programming to the strategy detailed in this document.

- **Reflects priority intervention areas for family planning programming:** The plan articulates identified priorities for family planning based on a consultative process among key family planning stakeholders.

- **Identifies financial resource requirements:** The plan includes cost estimates to enable the government and partners to understand the family planning program's budgetary needs for the next five years. Thus, this plan functions as a resource mobilization tool to secure donor and government commitments for the family planning program, identify funding gaps, and inform advocacy efforts.

- **Stipulates desired performance at various levels:** The CIP provides benchmarks and indicators that the government can use to monitor annual performance and progress toward its goals. It defines performance targets at various levels of the results framework, including goals, outcomes, and outputs.

- **Estimates impact:** The CIP includes estimates of the demographic, health, and economic impacts of the family planning program, providing clear evidence for advocates to use to mobilize resources.

The total cost of the plan from 2018 to 2022 is approximately US$46 million (LRD 6.0 billion), which will increase the number of women using modern contraception from approximately 390,000 in 2018 to 515,000 by 2022.

THE CIP DEVELOPMENT PROCESS

Liberia began the process of developing the *Liberia Family Planning Costed Implementation Plan (2018–2022)* in May 2017, with technical support provided by the Health Policy Plus Project (HP+) funded by the U.S. Agency for International Development (USAID). The effort followed a 10-step process recommended by FP2020. To support the process, a technical support team (TST) was assembled to provide expertise and guidance under the leadership of the Family Health Division (FHD) of the Ministry of Health (MOH). Strategy advisory groups (SAGs) provided technical input. Led by the director of the FHD in collaboration with the family planning program coordinator, the TST worked from May to July 2017 to conduct a comprehensive situational analysis, including a desk review, secondary data analysis, and stakeholder consultations. The formal kickoff was conducted in July 2017 and was directly followed by stakeholder consultations and in-person meetings. In July 2017, the monitoring and evaluation (M&E) unit of the MOH, with technical support from the Avenir Health/Track 20 project, reviewed and updated projections for the goal to be reached by 2022, expressed as mCPR among all women and men. A goal of 30.3 percent by 2022 was agreed in July 2017, but in January 2018 it was updated to 39.7 percent based on new data from the latest Malaria Indicator Survey (MIS) that showed Liberia's mCPR had reached 30.7 percent as of 2016.

From August to September 2017, the TST, in collaboration with the SAGs, developed the technical strategy through an inclusive and consultative process based on key findings from the situational analysis. The formulation of the technical strategy considered evidence-based, high-impact practices. The process also involved validation of a draft results framework that defined the outcomes and outputs and associated targets to be achieved under five thematic areas: service delivery, demand generation, commodity security, youth, and enabling environment. This exercise was quickly followed by the development and prioritization of intervention strategies (later described as activities) to be implemented over five years. The high-impact, evidence-based interventions selected for the CIP were reviewed for the feasibility of success with implementing them in the Liberian context. The TST then developed the detailed implementation plan for validation before costing. The TST consulted extensively with partners on different technical areas to ensure proper

contextualization of activities. In November 2017, the TST convened a validation meeting with a small group of technical experts to review and validate the final technical draft before costing. Parallel to this process, the TST modeled the impact of contraceptive uptake on averting maternal and child deaths using the ImpactNow tool. In February 2018, the TST hosted a pre-validation meeting to share, discuss, and gather input and consensus on the first narrative of the CIP. The team also shared results from the ImpactNow modeling. Later in April 2018, the TST convened a final validation meeting with a broader group of stakeholders, including representatives from the SAGs and county health teams (CHTs). The meeting reviewed and endorsed the final CIP.

Along with developing the CIP, the TST worked to prepare for execution of the plan upon launch. Specifically, the team collected data from implementing partners to inform a financial and program gap analysis. This exercise provided information on current investment allocations for family planning against CIP priorities, geographical mapping, and areas that are under- or overfunded for the CIP's first year (2018). This information is useful to guide an active resource mobilization process, which is central for the success of the CIP. During the results formulation stage in September 2017, the TST also worked with SAGs to identify key results that would be critically important to regularly monitor. In April 2018, the TST worked with the M&E unit of the MOH and representatives of organizations working on M&E to review key performance indicators based on performance targets already included in the CIP. This information fed into the CIP performance dashboard intended to support monitoring progress of the CIP during the execution period.

FAMILY PLANNING LANDSCAPE

GLOBAL CONTEXT

Family planning is one of the most cost-effective interventions to prevent maternal, infant, and child deaths.[1] 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 are preventable.[2] Family planning is a contributor to positive health outcomes. For example, family planning interventions contribute to reducing poverty, increasing gender equity, preventing the spread of HIV, reducing unwanted teenage pregnancies, and lowering infant deaths.[3] Additionally, each dollar spent on family planning initiatives on average results in a $6 savings on health, housing, water, and other public services.[4] Universal access to SRH services by 2030 and the elimination of global unmet need for modern contraception by 2040 has an estimated cost of US$3.6 billion annually but would generate benefits valued at US$432 billion per year – an estimated US$120 return on every dollar invested.[5]

Poor access to family planning services by adolescent girls, including contraceptive information, education, and services, is a major factor contributing to unwanted teenage pregnancy and maternal death, together with early marriage, being out of school, low income, and sexual coercion and violence.[6] In low- and middle-income countries, complications of pregnancy and childbirth are the leading causes of death among adolescent girls ages 15–19.[7]

As of July 2017, an estimated 909 million women are of reproductive age in the 69 FP2020 countries. Of these, more than 309 million are using a modern method of contraception, an increase of 109 million since 2003, and an increase of 38.8 million women and girls since 2012 when the Family Planning 2020 partnership was launched.[8] Among women across the FP2020 countries, the mCPR is growing at an annual average rate of 0.3 percent, ranging from 0.2 in South Asia to 1.2 percent in East and southern Africa. Despite these advances in modern contraceptive uptake, over one in five married or in-union women of reproductive age had an unmet need for modern methods of contraception in 2017.[9]

When the FP2020 partnership launched in July 2012, leaders from around the world agreed on a goal to "mobilize 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."[10] Achieving this ambitious goal would prevent a staggering 100 million unintended pregnancies, 50 million abortions, 200,000 childbirth-related and maternal deaths, and 3 million infant deaths.[11] The Government of Liberia (GOL) was one of 24 countries to make commitments to family planning at the 2012 London Summit, and in 2017 had an opportunity to update these commitments (Box 1).[12]

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. Goal 3 ("Ensure healthy lives and promote well-being for all at all ages") and Goal 5 ("Achieve gender equality and empower all women and girls") include direct and indirect outcomes related to family planning. Goal 5 also aims to ensure universal access to sexual and reproductive health and reproductive rights in accordance with the Program of Action of the International Conference on Population and Development and the

Beijing Platform for Action. The GOL launched its Agenda 2030 for Sustainable Development in January 2016 to set the stage for its implementation over the next 15 years.

Box 1: Liberia Country Commitments to FP2020

July 2012

Liberia strives to increase CPR to 16 percent in 2015 and 20 percent in 2020.

Liberia commits to keeping all family planning services free of charge to improve access. Family planning is currently included in various health documents:

- *Road Map for Accelerating the Reduction of Maternal and Newborn Morbidity and Mortality in Liberia*
- *National Reproductive Health Commodity Security Strategy and Operational Plan*
- *10-Year National Health Plan*
- *Essential Package of Health Services*

FINANCIAL COMMITMENTS

Per the *Road Map*, Liberia plans to commit the following to family planning intervention costs:

- Year 1: $893,697
- Year 2: $1,161,308
- Year 3: $1,355,104
- Year 4: $1,556,54
- Year 5: $1,765,743
- Total: $6,732,393

PROGRAM AND SERVICE DELIVERY COMMITMENTS

1. Expand availability, access to, and choices of safe, effective, acceptable, and affordable contraceptive methods by using integrated approaches at both facility and community levels to minimize missed opportunities.
2. Increase the number and capacity of health workers at the facility and community level to deliver safe, effective, and acceptable family planning services.
3. Strength the contraceptive commodity supply chain to ensure adequate supply at all levels of facility- and community-based services.
4. Strengthen key systems and infrastructure, including management, monitoring, evaluation, and supervision to support family planning services at the facility and community levels.
5. Strengthen and expand family planning through the private sector, including NGOs, faith-based organizations, social marketing, the commercial sector, private clinics, and pharmacies.
6. Use advocacy to increase demand for and utilization of family planning and reproductive health services to decrease unmet need for family planning and increase the mCPR.
7. Improve the health system's capacity to increase utilization of family planning and reproductive health services among underserved or vulnerable populations, including adolescents, young adults, victims of sexual exploitation, rape survivors, refugees, and men.

July 2017

PROGRAM AND SERVICE DELIVERY COMMITMENTS

1. Increase mCPR among adolescent from 16.4 percent to 20 percent by the year 2020 with an expected reduction of adolescent birth rate by 27 percent (from 177/1,000 live births to 150/1,000 live births) and a 5 percent reduction of teenage pregnancy.
2. Increase percentage of women and men ages 15-49 who use private sector sources for family planning methods from 30.3 percent to 40.3 percent, with an accompanying policy environment enhanced to expand family planning services in the private sector.
3. Reduce stockouts of essential drugs and family planning commodities from 56 percent of facilities reporting no stock outs of tracer drugs including family planning commodities to 80 percent.
4. Increase government financial contribution by 5 percent per annum.
5. Increase mCPR by 100 percent, with significant reduction of unmet family planning needs.

REGIONAL CONTEXT

Relative to other regions in sub-Saharan Africa, West Africa has experienced a slow uptake in modern contraceptives, resulting in the average number of births per woman in the region to be exceptionally high, together with maternal mortality rates. Table 1 summarizes the latest health indicators of West African countries, including Liberia. Although Liberia has lower fertility rate than many neighboring countries, it has one of the highest maternal mortality rates in the region.

Table 1: Reproductive Health Indicators for Selected Countries in West Africa

Country	TFR[13]	mCPR, All Women[14]	Maternal Mortality Ratio per 100,000 Live Births[15]	Infant Mortality Rate per 1,000 Live Births[16]
Benin	4.9	15.7	405	56.2
Burkina Faso	5.5	22.4	371	64.1
Ghana	4.2	22.3	319	52.3
Guinea	5.1	11.0	679	64.9
Liberia	**4.7**	**25.3**	**725***	**53.6**
Mali	6.3	13.1	587	77.6
Niger	7.6	13.1	553	59.9
Nigeria	5	14.7	814	74.3
Senegal	5	15.7	315	43.9
Sierra Leone	4.9	25.9	1360	107.2

** Note that the LDHS 2013 reports the MMR to be 1072. DHS data on MMR is unavailable for all countries. For consistency, the figure of 725 is included here to allow for country comparisons. MMR data for all countries listed above is based on data from the Millennium Development Goal Indicators Database.[15]*

COUNTRY CONTEXT

Geographically, Liberia is divided into five main regions: North Western, North Central, South Central, South Eastern A, and South Eastern B.[17] Regions are further divided into 15 counties, 90 districts, and many clans. According to World Bank classifications, Liberia is a low-income economy driven by iron-ore and rubber exports, construction, and the service sector. Liberia experienced an annual GDP growth rate of 8.7 percent in 2013, which subsequently declined to -1.2 percent in 2016. The economy is projected to pick up pace and grow by 5.7 percent by 2019.[18] Many Liberians are poor: a 2014 household income and expenditure survey reported that 54.1 percent of Liberians live below the national poverty line, with 7 out of 10 rural residents falling under this category, versus 4 of 10 in urban areas.[19]

Liberia has gone through periods of conflict and disease outbreaks that have affected the population's health. From 1989 to 2003, Liberia experienced a civil war, driven by a variety of factors such as a closed political system, corruption, power struggles, and ethnic and class animosities.[20] The conflict resulted in approximately 270,000 deaths with hundreds of thousands of refugees and displaced persons, many of whom live below the poverty line. The conflict also drastically damaged both governance institutions and infrastructure, and limited the population's access to health services, safe and potable water, education, and

food. The civil war ended with the signing of the Accra Comprehensive Peace Agreement.[21] National efforts have been made to help the country recover from the war's effects, including through the development of Liberia's Interim Poverty Reduction Strategy (iPRS) and Poverty Reduction Strategy (PRS). Both plans called for efforts to enhance national security, build the economy, strengthen governance, and restore infrastructure and the ability to deliver basic services.

The progress made during these post-conflict development efforts halted for some time during the Ebola virus disease (EVD) outbreak (March 2014–May 2015) and three subsequent resurgences.[22] The outbreak resulted in approximately 5,000 deaths, including health workers.[23] It affected the country's economy and uncovered the shortcomings of the health system. During the outbreak, the country also experienced declines in the utilization of health services during August to December 2014.[24] Some of the main factors affecting this decline were the temporary closure of facilities, growing mistrust of communities toward the health system, and discrimination against patients believed to have contracted Ebola. Despite the losses of life in the EVD outbreak, the event reinvigorated the country's efforts to rebuild the current standing of the health system. This can be seen in efforts to improve facility infrastructure, strengthen referral systems, build the capacity of surveillance and laboratory institutions, and implement infection and prevention control measures.

DEMOGRAPHIC AND SOCIOECONOMIC PROFILE

Liberia's most recent population and housing census reported a total population of 3.5 million in 2008.[25] Based on annual growth projections, the population increased to 4.7 million by 2017.[26] The annual population growth rate has decreased from 3.3 percent in 1974 to 2.4 percent in 2016.[27] Based on the 2008 annual growth rate of 2.1 percent, **the population is expected to double by 2041.**

Further analysis shows that **there is a fairly even split between the population residing in urban and rural areas**.[28] The most densely populated counties are Margibi, Maryland, Bomi, and Nimba.[29] Collectively, those counties have an estimated population density of 100 to 210 persons per square mile. The counties with the least population density include Gbarpolu, Grand Gedh, Grand Kru, Rivercess, River Gee, and Sinoe, with an estimated density of 22 to 40 persons per square mile.

Liberia's demographic profile is **characterized by a youthful population,** with nearly 42 percent of the population under age 15 and only about 3.2 percent of the population ages 65 years and over.[30] Table 2 provides a breakdown of the ages of the female population.

Table 2: Distribution of the Female Population by Age Group

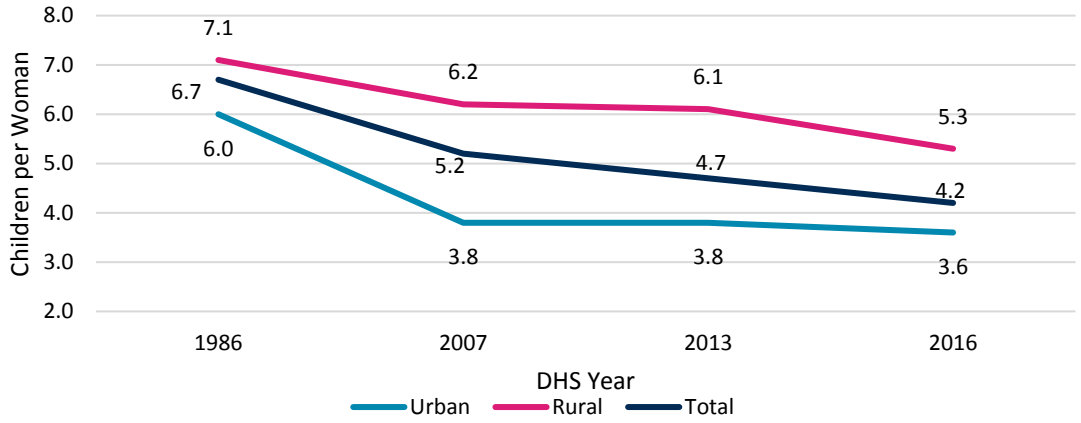
Age Group (Years)	Total[31]
Total female population, 0-80+	1,736,663
10–14	206,807
15–19	186,288
20–24	180,979
25–29	150,852
30–34	112,306
35–39	104,400
40–44	74,067
45–49	54,908
15-49	863,872

Women of Reproductive Age (WRA)	Percentage
Percentage of Total Females, WRA	50
Percentage of WRA, Adolescents 15–19 Years	22
Percentage of WRA, Youth 15–24 Years	43
Percent of WRA, Young 10–24 Years	67

FERTILITY TRENDS

Liberia's total fertility rate (TFR) has decreased over the past 27 years. The latest Liberia Malaria Indicator Survey (MIS) reported that the TFR decreased to 4.2 children per woman in 2016 from 6.7 children per woman in 1986.[32] Similar TFR trends can be seen in TFR by residence (Figure 1), and there was a significant decline in the number of children per woman living in both urban and rural areas. However, the TFR among women residing in rural areas is consistently higher than that of urban women for all LDHS years. When comparing the TFR from 2007 to 2016, it seems changes in TFR in the urban areas are plateauing.

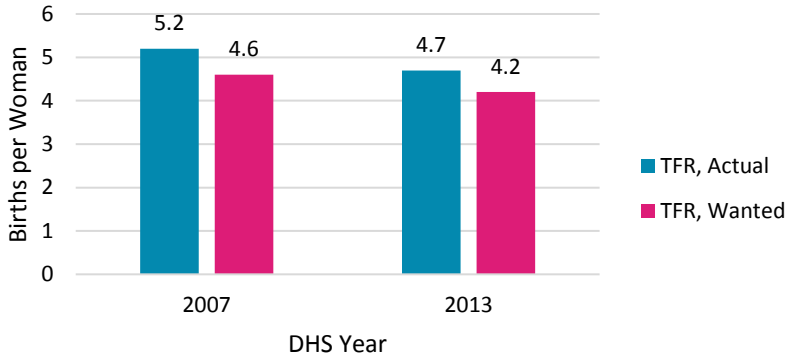
Figure 1: Total Fertility Rates by Residence (Urban/Rural), 1986-2016



Regional variations in TFR also exist. The highest TFR is recorded at 5.5 children per woman in the North Western area, while the lowest is 4.4 children per woman in the South Central area.[33] Montserrado County, which includes the capital of Monrovia, has the lowest recorded TFR at 3.2 children per woman.[34]

Generally, the national level mean ideal number of children for women in Liberia has also decreased over time. In 1986, women ideally wanted to have 6.0 children.[35] By 2013, this declined to 4.8. Taking a closer look at the LDHS data, there is a discrepancy between the wanted and actual TFR. As shown in Figure 2, the actual TFR is slightly higher than the wanted fertility rate. Despite this gap, both the actual and wanted TFR have decreased over these past two LDHS years. The MIS 2016 did not measure wanted fertility rates; however, based on the actual TFR measured of 4.2, it appears that the wanted fertility rate of 4.2 logged in 2013 has been reached. It is likely that the wanted TFR has declined further since 2013 with changing fertility preferences.

Figure 2: Total Fertility Rate among Women 15-49: Actual vs. Wanted

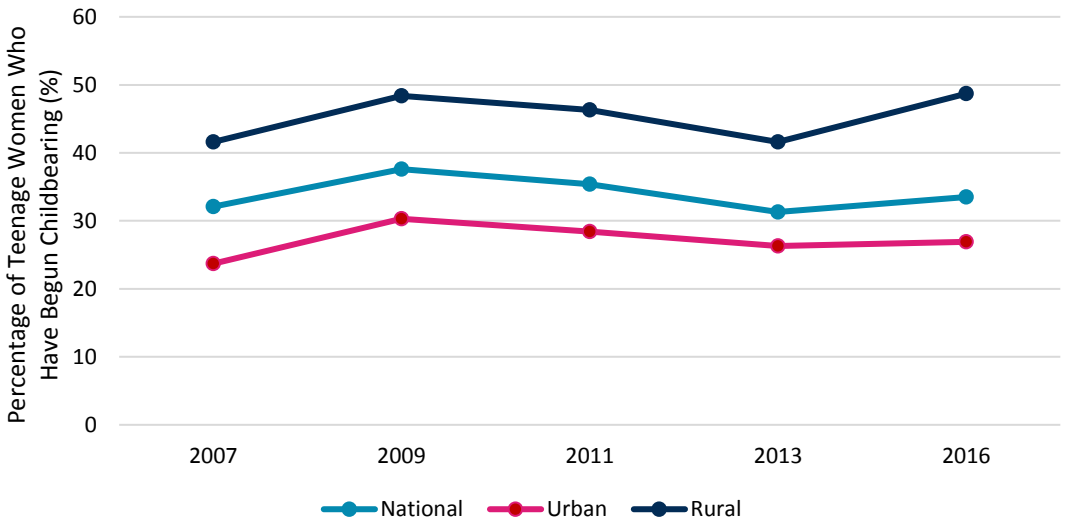


ADOLESCENT FERTILITY AND TEENAGE PREGNANCY

According to the 2016 MIS, the total age-specific fertility rate among adolescents ages 15–19 is 150 live births per 1,000 women.[36] The rate is higher for rural compared to urban adolescents – 198 compared to 126. This reflects similarities with the national level TFR data in the sense that **rural fertility rates appear to be greater than urban rates**.

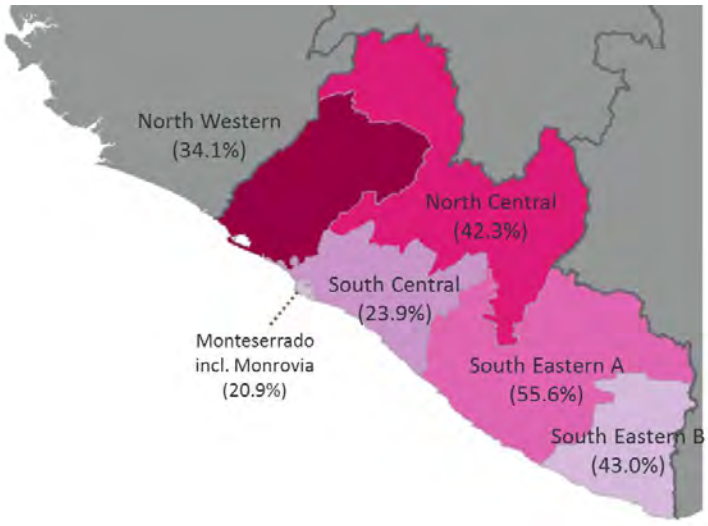
Liberia has a high rate of teenage pregnancies – 33.5 percent of young women ages 15–19 have begun childbearing.[37] In the last almost 10 years, childbearing among teenagers has not experienced a significant decline, from 32.1 percent in 2007 to 31.3 percent in 2013, and then it rose to the current 33.5 percent (Figure 3). Rates of teenage pregnancy in rural areas is much higher than in urban areas. Generally, teenagers residing in rural areas with no or limited educational attainment and part of the lower wealth quintile are more likely to begin childbearing compared to adolescents from urban areas with higher educational attainment and belonging to wealthier quintiles.

Figure 3: Percentage of Teenage Women Who Have Begun Childbearing, 15–19 years, 2007–2016



There are also considerable regional variations in rates of teenage pregnancy. The North Western region has the highest percentage of women ages 15-19 who have begun childbearing (45.7 percent).[38] Monrovia has the lowest percent of teenage women who have begun childbearing (22.8 percent) among all regions (Figure 4).

Figure 4: Percentage of Teenage Women Who Have Begun Childbearing by Region, 2016



Teenage pregnancy rates also vary with age among adolescents. Table 3 provides a more in-depth breakdown of the percentage of women in this age group who have had a live birth, are pregnant with their first child, or have begun childbearing. Across each indicator, the percentage significantly increases as a young woman progresses through her teenage years. Hence, at least half of 18- and 19-year-old adolescents have begun childbearing.

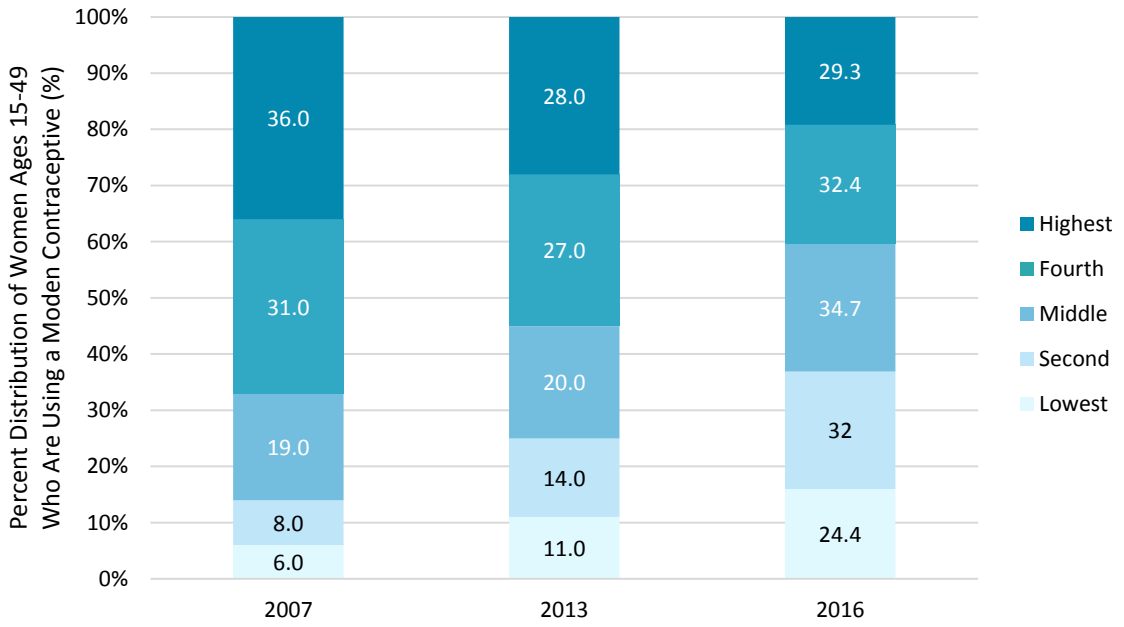
Table 3: Age-Specific Indicators for Teenage Pregnancy and Motherhood, 2016 MIS

Age	Percent Women Ages 15-19 Who Have Had a Live Birth	Percent Women Ages 15-19 Pregnant with First Child	Percentage Women Ages 15-19 Who Have Begun Childbearing
15	4.4	2.9	7.4
16	13.8	1.1	15
17	29.8	5.8	35.6
18	39.5	11.2	50.8
19	55.3	3	58.3

FAMILY PLANNING USE

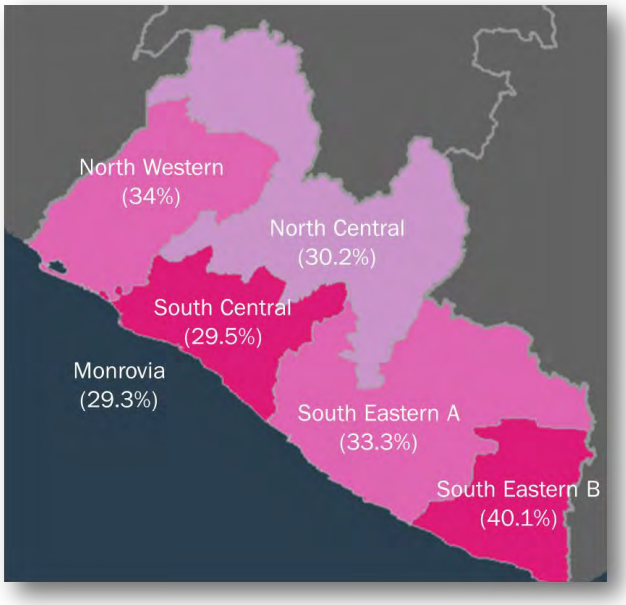
Trends in Contraceptive Use. The mCPR among all women currently stands at 30.7 percent.[39] The mCPR has changed significantly over the past decade – nearly tripling from 2007 (11.7 percent). Growth in the uptake of modern contraceptives was more pronounced among women below age 35. The increase in mCPR over the past 10 years was at least 60 percent for age groups 15-19 years, 20-24 years, 25-29 years, and 30-34 years. Modern CPR has also changed by wealth over time, with the wealthiest quintile seeing a drop in family planning use while the three poorest quintiles saw an increase in uptake (Figure 5). Further, women in urban areas have slightly higher mCPR (31.6 percent) than their rural counterparts (29.1 percent).[40] However, **the urban-rural gap is increasingly narrowing as more rural women use modern contraceptives.** Within just three years (2013 to 2016), rural mCPR grew by 12.8 percentage points.

Figure 5: Profile of Women Using Modern Contraceptives by Wealth, 2007-2016



Contraceptive rates also vary significantly by region, with high rates seen in South Eastern B (40.1 percent for married women), and the lowest rates of 29.3 percent among all women in the Greater Monrovia region (Figure 6).

Figure 6: Variations in Contraceptive Use by Region, 2016

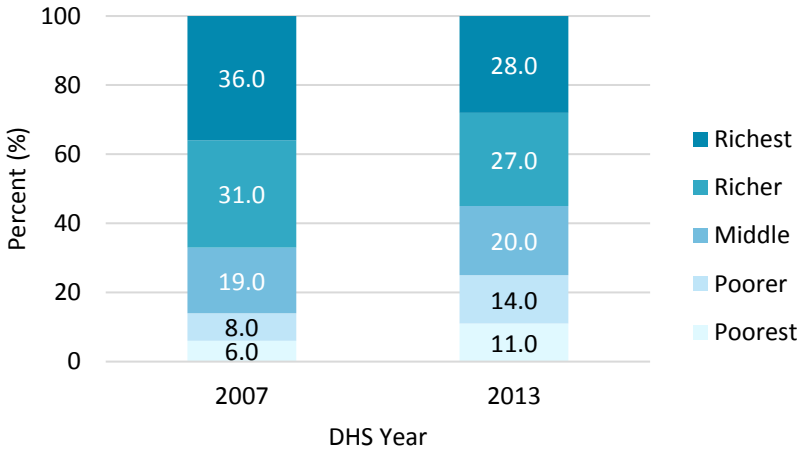


Analysis of the user profile based on LDHS 2013 data show that a typical Liberian family planning user is likely to be of middle income status or higher (86 percent), aged between 20-29 years (44 percent), and living in the urban area (69 percent).[41]

The program has made strides in closing the gap in contraceptive use by wealth and age. Compared to 2007, the program is increasingly reaching the lowest wealth quintiles (the poorer and poorest) of the population in 2013 (Figure 7). Furthermore, the program has

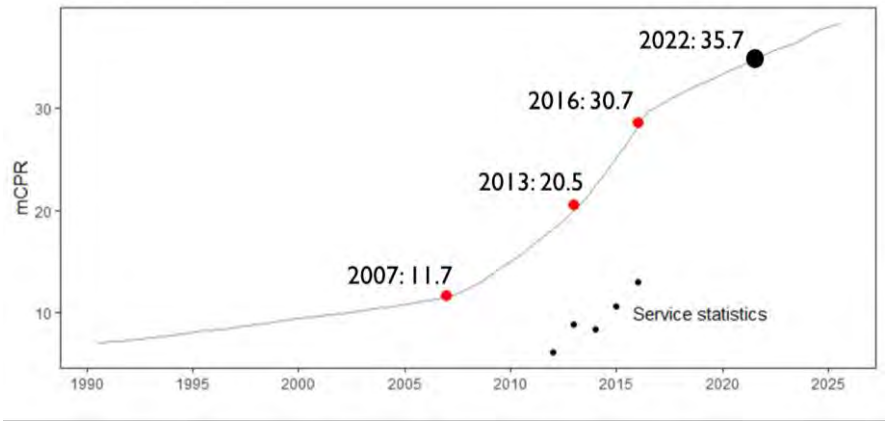
slightly increased its user profile to include more teenagers (ages 15-19): 18 percent of users in 2013 are teenagers, compared to 15 percent in 2007. Similarly, user profile according to residence remained the same between 2007 and 2013. However, there was a marked shift in the non-user profile – 59 percent of non-users in 2013 were from urban areas, compared to only 39 percent in 2007, signaling a potentially widening gap in service provision for urban residents.

Figure 7: Contraceptive User Profile by Wealth



Impact of Ebola on Contraceptive Use. With an estimated mCPR of 30.7 percent, Liberia has surpassed its original FP2020 goal of 20 percent by 2021 (Figure 8). Data from MIS 2016 estimated that the mCPR grew an average 3.4 percentage points a year between 2013 and 2016 and by an average 2.1 percentage points per year for the past nine years.[42] Despite this progress, the role of Ebola on family planning use should not be overlooked. In March 2014, there were an estimated 25,000 users.[i] At the height of Ebola just nine months later, this number plummeted to under 10,000. The number has steadily risen reaching a peak of nearly 40,000 in late 2016/early 2017.[43] Hence, despite the Ebola outbreak, family planning uptake has sustained growth rates over time.

Figure 8: mCPR Growth, Track 20

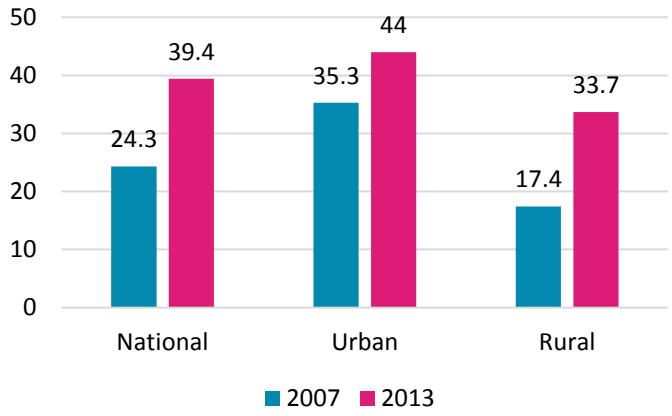


Demand Satisfied. In addition to significant increases in modern contraceptive uptake, **the proportion of women whose contraceptive demand has been satisfied has increased**,

[i] *Note that the facility response rate was low during the Ebola outbreak period.*

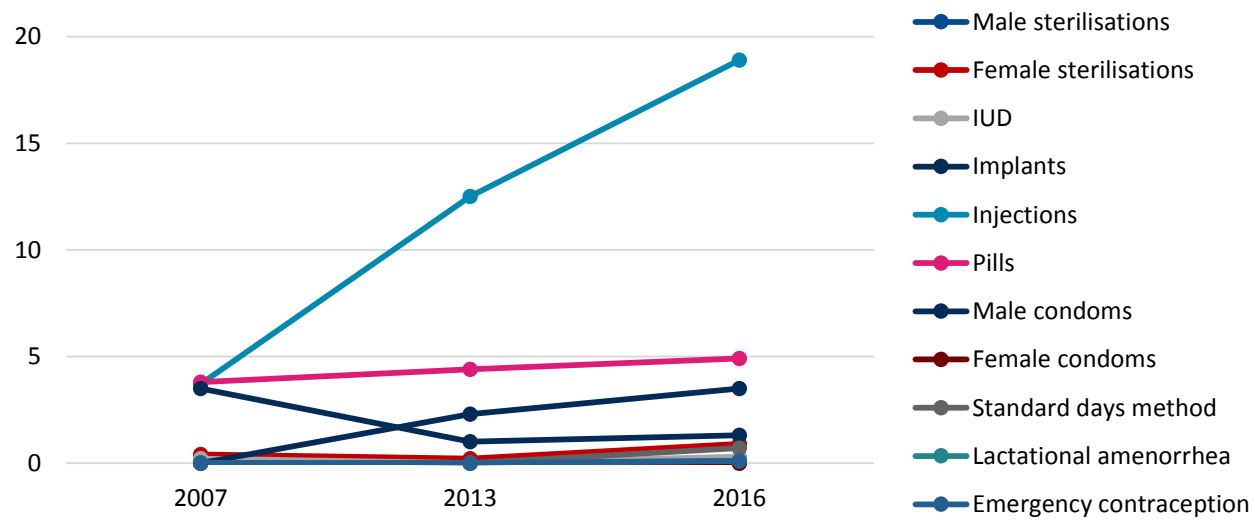
particularly among the rural dwellers, whose demand satisfied has doubled between 2007 and 2013 (Figure 9). This trend holds in relation to wealth, age group, and region. Poor and younger Liberians are increasingly having their contraceptive demand satisfied. **Demand satisfied among youth ages 15-24 have more than doubled,** from 13.6 percent in 2007 to 33.6 percent in 2013.[44] However, **disparities remain when it comes to region** – North Central, South Eastern A, and Montserrado lag behind in terms of growth in demand satisfied.[ii, 45]

Figure 9: Percentage of Demand Satisfied by Residence, 2007 and 2013



Method Mix. The mix of contraceptive methods used has shifted over time. While pill use has remained relatively consistent (around 4 percent) for the past decade, injectables have quickly become the preferred form of contraceptive, increasing from 3.7 percent in 2007 to 18.9 percent in 2016, followed by implants at 3.5 percent (Figure 10). Male condom use is on the decline, and male sterilization rates have not changed. Emergency contraceptives and standard days methods/CycleBeads have recently entered the market, registering uptake of 0.1 and 0.7 percent, respectively.

Figure 10: Method Mix Profile, 2007-2016

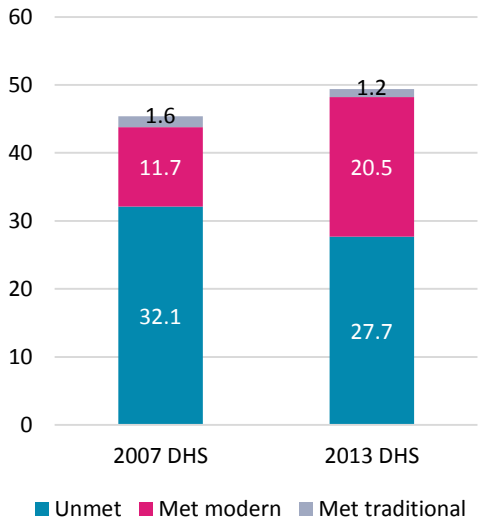


[ii] *Data is unavailable in the 2016 MIS, but it is likely that this trend and profile has shifted.*

DEMAND FOR FAMILY PLANNING

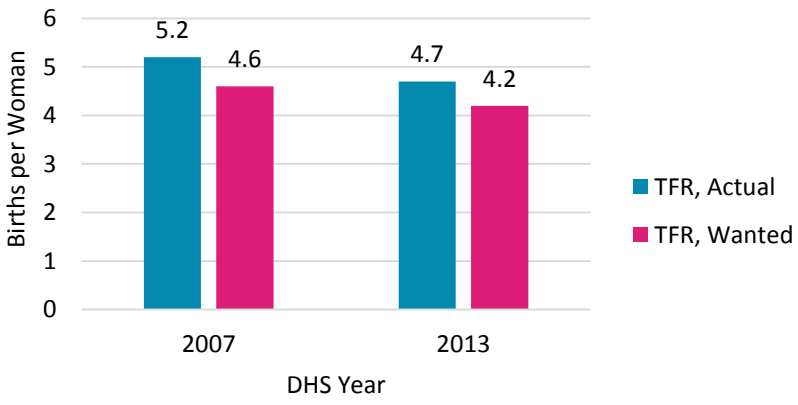
The demand for contraceptives over time is sizable and gradually rising, mainly for the purpose of child spacing, and is coupled with a high unmet need. Approximately half (49.4 percent) of Liberians demanded contraceptives in 2013, only a slight increase from 45.4 percent in 2007 (Figure 11).[46] The demand for contraceptives for child spacing (38.3 percent) is three times higher than that for limiting (11.1 percent).[47] The proportion of the total demand representing met need by modern contraceptives nearly doubled between 2007 (11.7 percent) and 2013 (20.5 percent); however, a considerable proportion of the total demand remains unmet. During the same period, unmet need only slightly declined, from 32.1 percent to 27.7 percent, with increased adoption of contraceptives.[48] There is a slight geographical variation in unmet need; more than a third of women residing in Grand Bassa, Maryland, Rivercess, and Nimba counties have an unmet need.[49] Top reasons contributing to non-use as reported in the 2007 DHS include fear of side effects and health concerns (32.2 percent), opposition (self, spousal, or religious) (18.1 percent), and lack of knowledge (13.6 percent).[50] Intent to use in the future among non-users is a good indicator for future demand. Liberians who are not using contraceptives increasingly report a future intent to use, from 34.4 percent in 2007 to 45.9 percent in 2013.[51] Unfortunately, the proportion of those not intending to use remains largely unchanged 47.5 percent and 48.5 percent in 2007 and 2013, respectively.[52]

Figure 11: Contraceptive Demand among All Women, 2007 and 2013



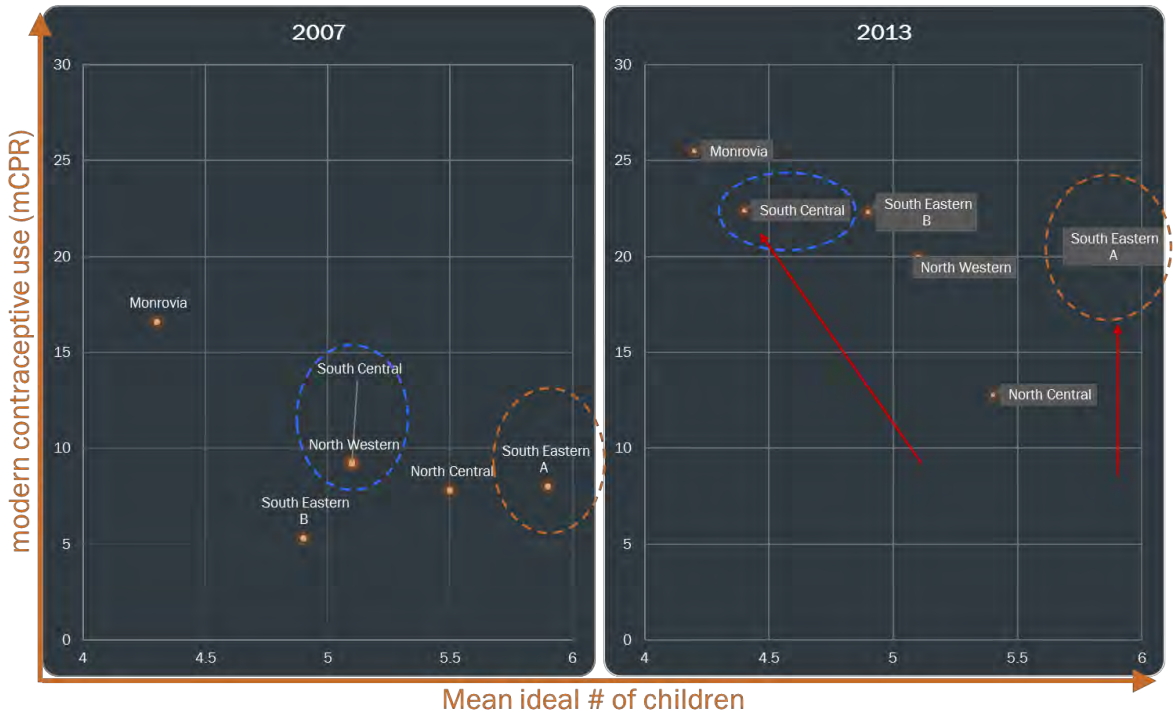
Liberians report wanting fewer children than they currently have (i.e., wanted fertility rates are less than actual fertility rates). In 2013, women reported wanting 4.2 births each, but the actual fertility rate was 4.7.[53] This gap continues to persist, despite falling fertility rates over time (Figure 12), and it is wider among the rural population, and among those with no education.

Figure 12: Total Fertility Rate among Women Ages 15-49 (Actual vs. Wanted)



Although childbearing preferences vary considerably between regions, they have not changed much over time. When comparing the relationship between the mean ideal number of children and modern contraceptive use between 2007 and 2013 across regions, most regions experienced increased contraceptive use but without an equivalent decrease in the ideal number of children (Figure 13). Monrovia, North Central, and South Central are the only regions that appear to have made the shift toward a desire for less children accompanied by increased contraceptive use. Childbearing preferences have not changed in South Eastern A despite an almost doubling of modern contraceptive use.[54] This supports the notion that the demand for, and use of, contraceptives in many of the regions is for spacing rather than limiting. Considering that Liberians experience sexual activity early, at age 16, and have their first baby soon thereafter at 16.9 years (more than 3 years younger than the WHO recommended age for a first pregnancy), the likelihood of women having a high fertility rate is likely to persist unless fertility preferences change.[55]

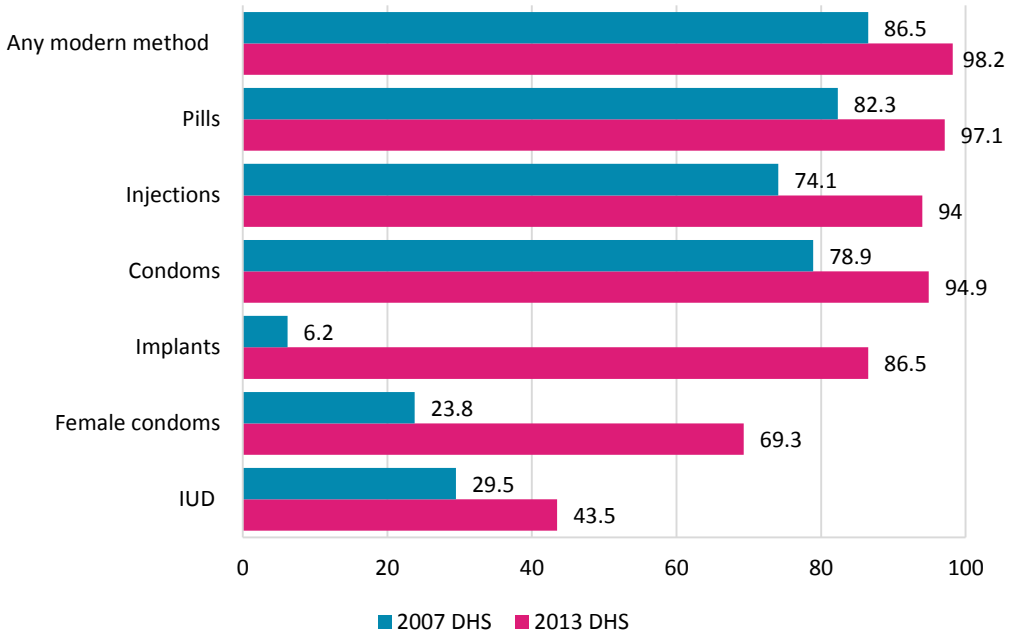
Figure 13: Childbearing Preferences and Modern Contraceptive Use by Region, 2007 and 2013 (LDHS)



Awareness of modern contraceptive methods is widespread among women, except for IUDs, lactational amenorrhea method, emergency contraceptives, and female and male sterilization. Less than 50 percent of women are aware of these methods.[56] Awareness of implants rapidly grew from 6.2 percent in 2007 to 86.5 percent in 2013 (the method was introduced in 2011) (Figure 14). This broad awareness, however, is not translating into widespread contraceptive adoption. Individual barriers include lack of comprehensive and accurate knowledge on fertility period, pregnancy risk, contraceptive methods, and return to fertility, especially in the postpartum period. Such knowledge gaps propagate myths and misconceptions that are deeply rooted in societal norms. Traditional, cultural, and religious beliefs continue to widen the know-act gap in Liberia. For example, the widespread belief that contraceptive use affects breast milk and harms babies, prevent women with a high unmet need from adopting modern contraceptive methods. Gender norms also impact contraceptive decision making and fertility preferences. Liberia is a patriarchal society

where males lead family decision making processes but are inadequately engaged in family planning promotion and services.[57]

Figure 14: Awareness of Methods, 2007 and 2013



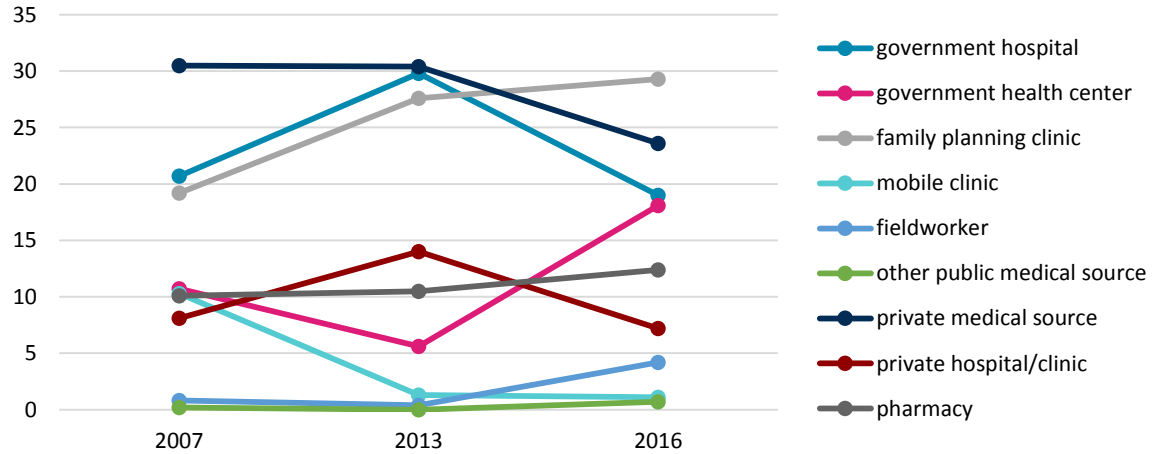
PROGRAM CONTEXT

In 2017, a situation analysis, comprising a secondary data analysis, literature review, policy analysis, and stakeholder consultations identified strategic issues and challenges facing the current family planning program to inform the development of this five-year plan. Key findings from the analysis are described below under the five technical areas identified as essential components of an effectively functioning family planning program.

SERVICE DELIVERY

Facility-based services. The government is the predominant provider of contraceptive services for the majority of women (72.4 percent). Services are mainly received from clinics (29.3 percent), hospitals (19 percent) and health centers (18.1 percent).[58] Of note, community-level platforms as a source of contraceptives have increased tenfold, from 0.4 percent to 4.2 percent in 2013 and 2016, respectively (Figure 15). This is partly attributed to the rapid scaleup of the CHA program. Compared to other levels of facilities in the public sector, health centers were a less popular source for contraceptive services in 2013,[59] with only a small segment of women (5.6 percent) reporting them as a source compared to 2007 (10.7 percent). One of the factors contributing to this scenario is poor availability of family planning services. A 2013 survey of the Global Program to Enhance Reproductive Health Commodity Security (GPRHCS) showed that only 50.7 percent of primary health centers were providing contraceptives.[60] The 2016 MIS shows that health centers had rebounded as a source, ranking third in popularity. Private pharmacies appear to be becoming increasingly popular with time.[61] Also, a subsequent GPRHCS survey in 2017 has shown improvements – 50.7 percent of primary health facilities provide five or more contraceptives.[62]

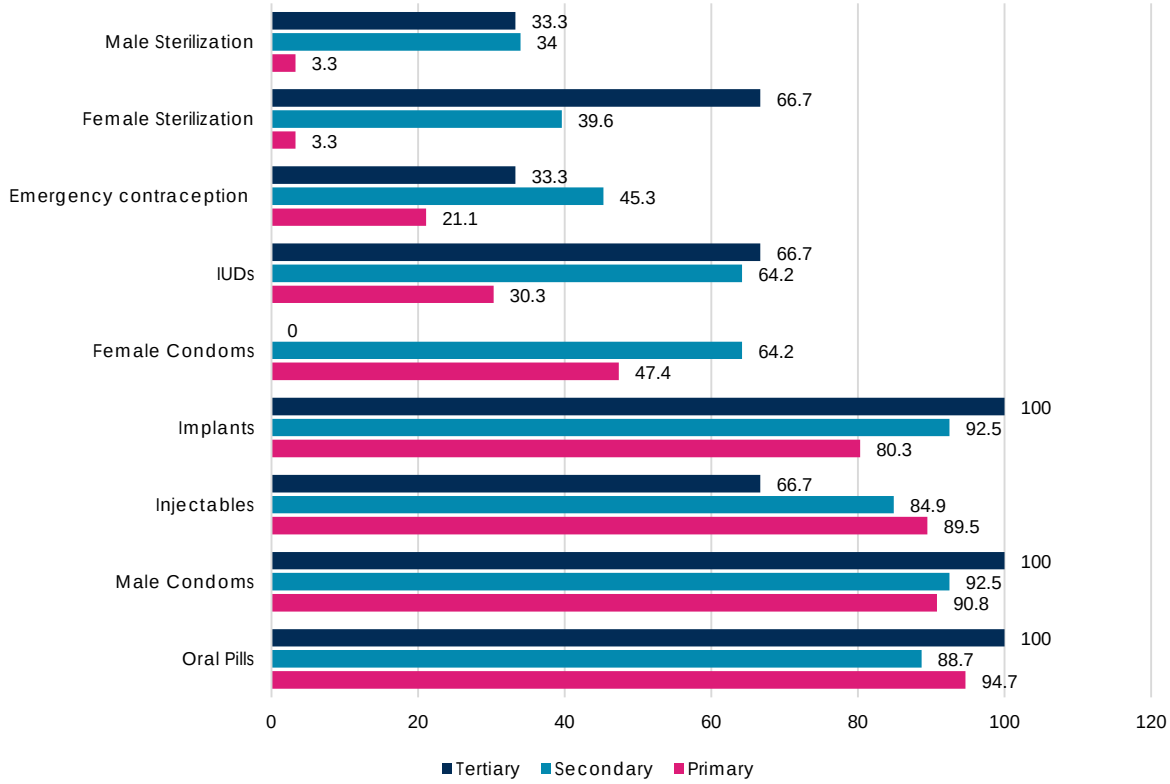
Figure 15: Sources of Contraceptive Services, 2007 and 2016



A 2017 GPRHCS report shows revealed variations in types of methods provided by level of facility (Figure 16). More than half of facilities, irrespective of level, can provide some short-acting methods (male condoms, pills, and injectables) and implants. Other short-acting methods, like female condoms and emergency contraceptives, are offered in fewer facilities. Few facilities at any level offer emergency contraceptives. Only 30.3 percent of primary health facilities offer IUD services.[63] As only higher-level facilities are expected to provide sterilization services, only about 3 percent of primary health facilities report having

sterilization services available.[64] Notably, more facilities provide implants than IUDs, despite their both being LARC methods.

Figure 16: Percentage of Facilities Offering Specific Family Planning Methods by Level



The MIS 2016 reports that most women get implants and injectables from clinics, health centers and hospitals, mainly government-owned. Pills are most often received from government clinics, government hospitals, health centers and private pharmacies,[65] while condoms are mostly sought from private pharmacies and government hospitals. Lower level service delivery platforms, such as community health workers and drug shops, are less used as sources of short-acting methods. Pills have been made increasingly accessible through the Community Health Assistant (CHA) program, with 5 percent of women now reporting CHAs as a source of the method, compared to only 0.8 percent in 2013.

The coverage and quality of family planning services at the facility level is affected by the inadequate number of and inequitably distributed skilled health providers. The 2009 National Census of Health and Social Welfare Workers reported that the majority (70 percent) of an almost 10,000 strong Liberian health workforce is either nonclinical or unskilled, and 50 percent of the workforce is based in Monrovia.[66] The census reported a ratio of 1.58 skilled birth attendants (SBAs) per 1,000 population, well below the WHO threshold of 2.28 per 1,000.[67] Existing SBAs are not equitably distributed between counties to the disadvantage of remote rural counties, with Nimba (0.33), Grand Kru (0.35), Grand Gedeh (0.41), Gbarpolu (0.46), and Maryland (0.48) having the lowest ratios of SBAs.[68] Government efforts to grow the skilled workforce have lessened shortages for nurses but not other critical cadres – physicians, physician assistants, and certified midwives – that represent an important workforce in family planning service delivery, especially for long-acting and permanent methods.

Factors such as insufficient numbers of new graduates from preservice institutions; high attrition rates and staff turnovers, especially in rural areas; and inadequate opportunities for family planning in-service training to match needs contribute to facilities lacking the required number of skilled providers to meet coverage and quality standards.[69]

Development partner-funded projects solely support funding for family planning in-service training countrywide; thus, providers are selected for training depending on project location and needs. Further, only a few providers can be accommodated during training events. A 2016 SARA report showed that only 14 percent of facility providers had received family planning training in the past two years.[70] The small amount of in-service training available, poor coordination, lack of a mechanism to track trained and untrained staff, and a weak participant selection process result in a lack of impact. In addition, incentives attached to workshop participation have led to the same participants repeatedly attending training.[71] Also, while the few who attend training are expected to cascade their learning to others, on-the-job training is scant and not regularly followed up post-training. The recently established Human Resources Information System (HRIS) does not support tracking provider training. Such data could be used to support better planning and coordination of training investments.

While the shortage of skilled family planning providers affects the uptake of all methods, experienced and confident providers of long-acting, reversible, and permanent methods are scarcer. Although family planning training does cover IUDs, the lack of demand and equipment for this method means providers have few opportunities to practice and bolster their newly learned skills.

Preservice training programs meant to increase or sustain the pool of providers are constrained by inadequate financial resources and insufficiently qualified faculty staff. Both, the family planning content in the institutional curricula and knowledge of family planning among preservice faculty staff is weak. These challenges affect the number and quality of graduates from preservice institutions.

Besides an inadequately skilled workforce, poor working conditions – including inadequate or lack of equipment and supplies, commodity stockouts, poor access to job aids/tools, few skill enhancement opportunities, and infrequent mentorship and supportive supervision opportunities – contribute to the inability of in-service providers to meet quality standards, which ultimately impacts quality of services.

Suboptimal facility conditions affect provision of family planning service provision. Only 59 percent of health facilities have the readiness to offer general health services.[72] Further, some facilities lack a private room needed to offer privacy and confidentiality.

The government has worked closely with partners to improve the quality of family planning services by improving adherence to quality standards. Several guidelines and protocols for staff responsible for service provision have been developed and disseminated, including the Balance Counselling Strategy, Medical Eligibility Criteria (MEC) wheel, and the Community Family Planning flipchart/book. However, some facilities and providers still lack these tools, and those who have them available do not regularly use them.[73] A 2016 SARA report showed that at least 48 percent and 62 percent of the facilities surveyed had family planning guidelines and job aids available, respectively, on the day of the survey.[74] Some guidelines are also out of date and need to be updated with new global guidance, including the RH Policy and Condom Strategy.

Despite the guidance on eligibility and informed choice, widespread provider bias contributes to the high levels of unmet need. Provider personal beliefs are barriers to fulfilling the family planning rights of certain populations, such as unmarried adolescents.[75] Further, myths and misconceptions propagated by irregular continuing education opportunities, together with lack of individual competencies and lack of time due to heavy workload, bias providers against certain methods, such as IUDs.[76] Finally, a general lack of awareness by clients of their rights to services and informed choice contributes to inequitable access.

Client satisfaction is an important aspect of quality. In a 2015 UNFPA Supplies Survey report, almost all clients (99 percent) reported to have been offered their method of choice, told how to use the method, and informed of side effects. Around 40 percent of clients perceived the waiting time for family planning services to be lengthy, but over 90 percent reported being satisfied with the cleanliness of facilities and the privacy of the exam rooms.[77]

The Joint Integrated Supportive Supervision (JISS) guideline calls for facilities to be visited for supportive supervision. It indicates that counties receive supervision from the central level on a biannual basis, while the districts receive supervision quarterly, and the health facility receives supervision monthly from the districts. During these visits, a checklist guides the assessment of service provision and availability of tools, guidelines, and protocols. Staff are mentored based on weaknesses identified, and additional information is provided. However, monitoring, supervision, and mentoring has been weak and irregular, mainly due to insufficient funding to cover logistical arrangements, inadequate staff time to conduct supervision visits or to allocate time to a single health area such as family planning.

Community-Based Service Delivery. Approximately 29 percent of Liberians and 60 percent of rural Liberians live more than a one-hour walk (5 km) from the nearest health facility.[78] In counties such as Gbarpolu, the rates are as high as 68 percent.[79] To improve service delivery in remote areas, the GOL has an active National Community Health Policy and National Community Health Strategic Plan (2016–2021), which outlines the scope and guidelines for the provision of health services at the community level in areas beyond 5 km from a health facility. The GOL introduced a new cadre in the health workforce, community health assistants (CHAs), who are expected to work for an average of four hours per day and are provided with a monthly incentive equivalent to US$70.[80,81] Though compensated, CHAs are not civil servants. The plan envisages deploying 4,000 CHAs to remote areas by 2021. A comprehensive training module has also been developed for building the capacity of the CHAs. Among other services, CHAs are responsible for providing family planning services to members of their community, which include promotion, counseling, provision of oral contraceptives and condoms, and referral for other methods such as injectables and long-acting and permanent methods. Before the enactment of the Community Health Policy in 2008, community-based health workers were mostly limited to health promotion roles.[82] While this expanded responsibility is a positive development, several challenges impede delivery of contraceptives at the community level.

First, community-based health workers are one of the least used sources of modern contraceptives, and demand for their services continues to weaken. The number of women who cited community-based distributors (CBD) agents as their source of supply declined from 0.8 percent in 2007 to 0.4 percent in 2013.[83] Second, client needs and preferences in method type are misaligned with what CHAs can offer. For example, the most popular

method is the injectable (11 percent), but current policy does not permit CHAs to provide this method despite the intervention's proven effectiveness and safety, as stated by WHO.[84,85] Although Liberia has tested this intervention locally, a decision is pending on whether to scale this evidence-based intervention to other counties and advance the policy change needed to allow CHAs to provide injectables.[86] The MOH is also exploring the introduction of Sayana Press – a subcutaneous injectable – as a complement or alternative for injectable provision at the community level.[87] The UNFPA has already procured 13,000 doses to support the MOH in this endeavor.[88]

Third, limited funding, mostly donor-driven, is a key contributing factor inhibiting scaleup of the CHA program. Although a total of 2,249 CHAs have been trained in all 15 counties (Table 4), there is still a gap in the coverage of community health services nationwide.[89] Furthermore, although CHAs have been trained in all counties, not all districts have been included in the implementation. For example, in Grand Bassa, only two districts, with support from Last Mile Health, are implementing the CHA program.[90] Where CHAs are introduced is also driven by partner geographical priorities.[91]

Table 4: CHA Mapping, June 2017[92]

	# of CHSS Fully Trained	CHAs Fully Trained in Module 1	CHAs Fully Trained in Module 2	CHAs Fully Trained in Module 3	CHAs Fully Trained in Module 4	Total CHA Trained in All Four Modules
Bomi	11	107	107	107	107	107
Bong	16	242	242	241	241	241
Gbarpolu	13	0	0	0	0	0
Grand Bassa	14	0	0	0	0	0
Grand Cape Mount	11	0	0	0	0	0
Grand Gedeh	25	216	219	219	64	64
Grand Kru	17	129	0	0	0	0
Lofa	35	364	364	358	358	358
Margibi	23	110	110	110	110	110
Maryland	20	114	114	114	114	114
Rural Montserrado	16	0	0	0	0	0
Nimba	76	770	770	770	770	770
River Gee	17	150	150	150	150	150
Rivercess	23	239	224	224	224	224
Sinoe	33	189	193	193	111	111
Total	350	2,630	2,493	2,486	2,249	2,249

Module I: Disease Prevention and Control; Module II: Reproductive Maternal and Neonatal Health; Module III: Child Health – ICCM (Malaria, Diarrhea, and ARI); Module IV: Special Services

Fourth, CHAs receive commodities from health facilities; however, systems and policies are not conducive for their distribution from facilities to the community level. For instance, community-level data is not well captured in the current HMIS/DHIS2 systems. The newly established Community-Based Information System (CBIS) is not yet integrated into the HMIS. Hence, commodity disbursements at the community level are unaccounted for in consumption data. Further, since health facilities also face stockout issues, preference for

limited commodities is given to facilities first, with community-level distribution being secondary. Both these factors contribute to persistent commodity stockouts at the community level. Finally, supportive supervision and monitoring of CHA activities through community health services supervisor (CHSS) is still a challenge due to limited logistics, human resources (one CHSS is supposed to supervise 10 CHAs[93]), and weak linkages with facilities. Furthermore, the lack of standards for family planning service provision by CHAs imposes challenges for quality improvement.

Outreach Services. Outreach efforts have shown to increase access to contraceptives, especially LARC and PMs, for people living in remote locations.[94] Liberia's scope of outreach services includes mobile outreach. Staff from catchment health facilities visit hard-to-reach communities to provide family planning services, and health facility staff from higher levels provide family planning services along with community mobilization, and advocacy to lower level health facilities or other community structures.[95,96] The coverage, frequency, and consistency of outreach activities are hampered by limited funding as well as reliance on donor funding, competing priorities, weak partner coordination, and poor planning. For instance, implementation of outreach activities by CHTs and facility staff remains ad hoc.[97] Often, there is a lack of vehicles, fuel, or staff to conduct outreach.

Furthermore, sometimes outreach services do not yield the desired results due to poor community engagement and mobilization activities. In the planning phase of the activities, the community is not adequately involved in the identification of the problem and therefore may show little or no interest. On the other hand, service providers do not have the skills to appropriately engage communities, due to their limited training in community mobilization efforts. Lastly, funding for community mobilization is sometimes a lower priority in outreach planning and budgeting.[98]

The FHD, along with partners, conduct contraceptive days campaigns to increase contraceptive uptake. Counties are also expected to include this activity in their annual implementation plans, but many are challenged to do so due to limited funding. During these campaigns, service providers reach out to communities (for example, in markets, schools, and palava huts) to provide family planning services. The public nature of these areas (within community high-traffic areas) hinders provision of long-acting methods like IUDs, because there is limited privacy and confidentiality.

The lack of consistency of outreach campaigns affects continued use of methods. For instance, according to the distribution protocol, clients are provided with three-month cycles of pills and Depo-Provera. However, since outreach efforts are inconsistent, clients fail to get a resupply. This issue could also be attributed to poor linkages of clients to health facilities.

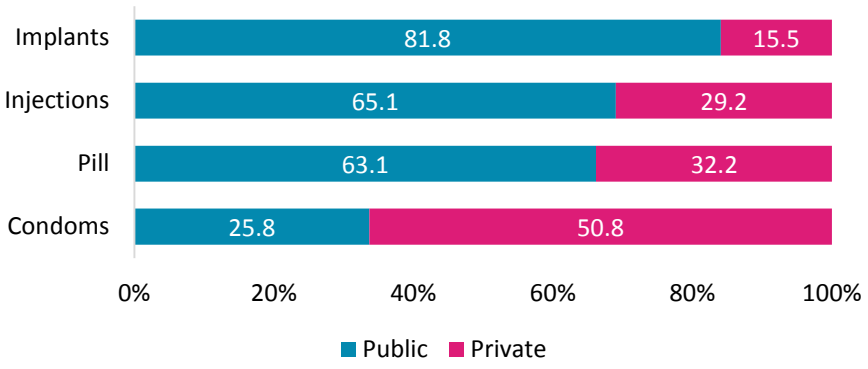
Moreover, since data on users in the registries and HMIS are not disaggregated by source at service delivery point, the contribution of outreach efforts to increase contraceptive uptake are not measured. Reports from outreach events are written at county level, but the information is not transmitted to the central level.

Integrated Service Delivery. Integration of family planning services into other health areas offers the benefit of reducing missed opportunities of reaching those who have a potential unmet need for family planning. For example, an analysis of LDHS 2007 data showed that at least 82 percent of women who were within two years postpartum experienced high unmet need for family planning.[99] Further, among women in this extended postpartum period, only

7 percent used any method of family planning, even though only 9 percent of women desired another birth within two years. These women, however, typically take their children for immunization services – among children aged 12–23 months, 75 percent received a first dose of DTP and 50 percent received the recommended three doses of DTP.[100] This represents a clear missed opportunity to reach the children's mothers with family planning services. This data informed a pilot project Bong and Lofa counties, which showed a positive uptake of family planning among women attending immunization services.[101] However, despite the success of this pilot, scale-up to other counties has proved unsuccessful, mainly due to lack of funding. Postpartum intrauterine copper device (PPIUCD) has also been introduced in Liberia, but experience challenges with scale. There are limited training opportunities for postpartum family planning (PPFP), and this topic has not been mainstreamed into current training modules, resulting in few providers with the essential skills to effectively provide it. Further, for those who are trained, there is lack of equipment (e.g., ring forceps, uterine sound, and tenaculum), resulting in low opportunities for practice.[102] Other integration models for service delivery have not been well explored for scale-up in Liberia, including family planning integration into HIV/AIDS services. Generally, integration interventions are also challenged by a lack of a tracking mechanism for referrals to the family planning clinic, and limited scale-up beyond pilot sites.

Private Sector. The private health sector, both nonprofit and for-profit, supply a considerable proportion of healthcare services. At least 38 percent of health facilities are privately owned.[103] Some faith-based facilities, typically nonprofit, do not provide family planning. Also, it is estimated that there are over 600 drug shops and 112 retail pharmacies in Monrovia alone, where community members buy drugs for common conditions.[104] The private sector is a growing source of family planning services. The overall share of the private sector as a source for family planning services has not grown – the proportion of women users reporting a private-sector source for contraceptive services remained at 30 percent between 2007 and 2013.[105] However, certain types of private-sector facilities saw growth – women reporting private hospitals as a source almost doubled, from 8 percent in 2007 to 14 percent in 2013, and almost tripled for shops, from 0.9 percent in 2007 to 2.5 percent in 2013.[106] As compared with other methods, about half (50.8 percent) of people source condoms from the private sector, mainly from private pharmacies (Figure 17).

Figure 17: Source of Methods (Public vs. Private Sector), 2013



The private sector offers a potential platform for scaling family planning services nationwide, while complimenting public sector, but it faces several challenges. First, the private sector lacks appropriate incentives (policy and system) to provide family planning services. Second, private providers have limited opportunities to attend government-

organized training, and hence they may lack information concerning current best practices, which would raise concern about their ability to meet quality standards in delivering comprehensive family planning services. Even when opportunities are presented to the private sector, some decline due to competing priorities. Third, the Liberian private health sector is generally not well-regulated — there is no requirement for continuing medical education, or relicensing of providers.[107] Traditional supervision activities often exclude the private sector; and the private sector does not see itself as accountable to government supervisors.[108] Finally, family planning data from this sector is not regularly, systematically, or uniformly available within the national HMIS.

Albeit a low figure, 13 percent of women reported sourcing contraceptives from either a private pharmacy or drug shop.[109] Many private providers (especially pharmacists, other drug retailers, and informal providers) provide products and services they have not been trained to deliver. In addition, the lack of alternatives to private-sector commodities raises concerns that the supply of contraceptives, apart from condoms, relies largely on "leaks" from the public sector. Further, private providers have other challenges beyond those specific to family planning. For example, they may lack the means and resources to provide quality services. Lack of capital may mean poorly maintained physical infrastructure and equipment, shortages of qualified staff, drugs that are beyond the financial reach of clients, and lack of access to affordable laboratories and other support services.

COMMODITY SECURITY

The availability of a reliable supply of high-quality contraceptives is essential to ensuring that family planning demand is met at all levels of the healthcare delivery system. Commodity security is an essential part of a functional supply chain system, which requires, among other things, sufficient and sustainable financing, a strong supply chain system, supportive policies and regulations, and active coordination among partners.

Several initiatives by the GOL and partners to address commodity security at various levels of the health system have reduced stockout problems, but **frequent stockout of some contraceptive commodities at service delivery points (health facility, community level, and during outreach activities) remains a key problem** (Figures 18 and 19). As per the UNFPA Annual Supplies Survey, 74.8 percent of health facilities experienced a stockout of tracer commodities in the last three months before the survey in 2015, declining to 66.2 percent in

Figure 18: Contraceptive Stockouts, Urban vs. Rural Facilities, 2015 and 2016

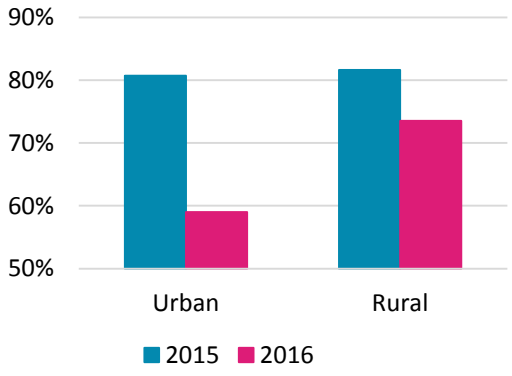
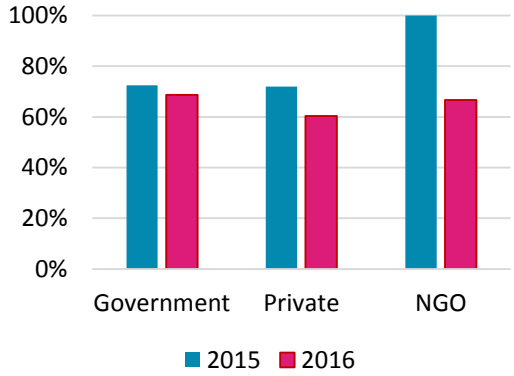


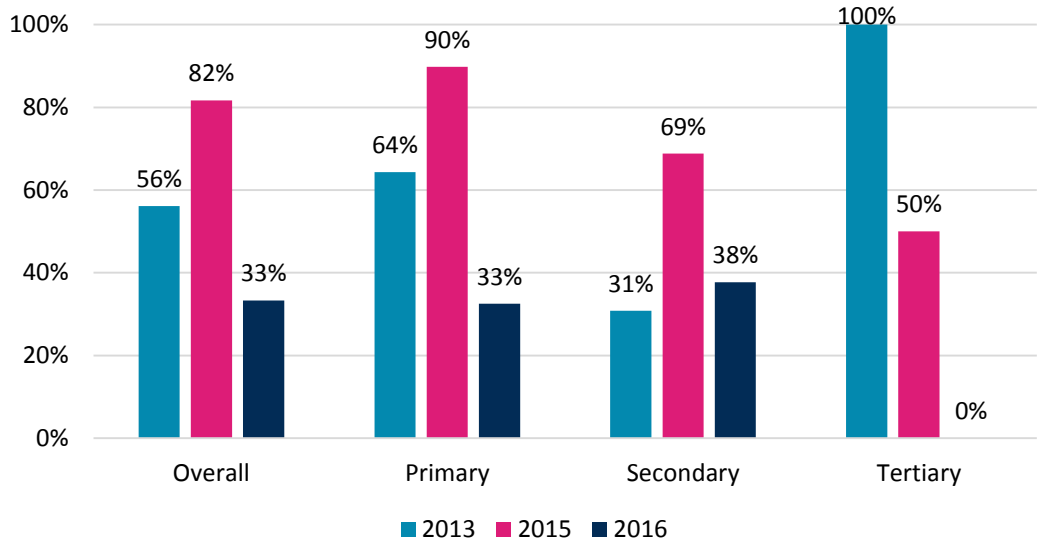
Figure 19: Contraceptive Stockout by Facility Ownership, 2015 and 2016



2016.[110,111] Further, the urban-rural gap stockout problem appears to be closing: between 2015 and 2016, three-month stockouts have been reduced across all facilities by type of ownership.[112 ,113]

A comparison of point-in-time stockout rates based on the same survey conducted in 2013, 2015, and 2016, shows that while on-the-day stockout rates were higher in 2015 and reflected a considerable increase since 2013 (likely due to the Ebloa outbreak), there has been a decline in 2016 across all levels of health facilities (Figure 20).[114,115,116] Also, the SARA 2016 report shows that emergency contraceptives were available in 10 percent of the health facilities, female condoms in 61 percent, while implants were observed in 60 percent of the health facilities.[117]

Figure 20: Percentage of Facilities where Modern Contraceptive Methods Were Out of Stock on Day Surveyed, 2013, 2015, and 2016



The GOL, with support from multiple partners, continues to strive to improve the effectiveness and efficiency of the supply chain system. In 2015, several strategic plans (the RMNCAH Investment Case 2015–2021 and the Supply Chain Master Plan, 2015–2020) were developed in support of improved commodity security system and supply chain functions. These plans highlight the need for integrating of services for last mile commodity management and delivery, improving storage facilities, developing a national logistics management information system (LMIS), and establishing a formal inventory control system, among other priorities.

Forecasting, Quantification, and Procurement: Forecasting and quantification exercises for commodities are conducted every year and reviewed quarterly. During reviews, technical updates are conducted against the forecast and supply plan with the use of issues data, which serve as a proxy for consumption data. The reviews help to ascertain forecast accuracy based on previous assumptions. A multiagency national forecasting and quantification (F and Q) committee has a responsibility to coordinate F and Q activities, while the responsibility of quantification rests on the vertical programs, such as malaria, HIV/AIDS, and FHD. The committee comprises the MOH, stakeholders, and partners supporting supply chain activities across all health programs. It is headed by the Supply Chain Management Unit and reports to the Supply Chain Technical Working Group (SCTWG). Supplies and equipment, essential for provision of clinical methods, are not

typically forecasted or procured with family planning commodities, but rather as part of essential medicines and supplies. The lack of essential consumables for contraceptive provision has been reported as a limiting factor in ensuring choice of methods.[118] Only in 2015 were consumables used for the insertion of the Jadelle implant quantified and procured as a kit by UNFPA.

Forecasting and quantification efforts face several constraints. First, there is **lack of timely, complete, and accurate data to inform forecasting and supply planning**, specifically, consumption and service statistics data reported through LMIS and HMIS systems, respectively. Lack of data is attributed to inadequately skilled human resources for data reporting at service delivery sites, made worse by overloaded and poorly motivated staff who lack incentives to accurately record in a timely manner. Supportive supervision exercises are limited in scope and frequency due to resources. Also, data systems, i.e., the LMIS and HMIS, are not functioning at optimal levels. For example, data recording is still paper-based at the facility level and electronic starting from the county level, which makes the process cumbersome and prone to errors. Further, community-level data is not well captured in the current HMIS/DHIS2 systems. The newly established CBIS is not yet integrated into the HMIS; hence commodity disbursements at the community level are unaccounted for in service statistics. Second, **the MOH lacks adequate technical capacity and resources to effectively conduct a forecasting and quantification exercise; therefore, it relies on technical support from partners**. Coordination of partners in the F&Q committee is inadequate: although the committee was established in 2015, members had their first review meeting in June 2017. (The committee is supposed to meet once a quarter.)

In the second quarter of 2017, the forecast review for contraceptives conducted for the period 2016 to 2018 showed that an estimated US$ 3.4 million was needed to procure commodities for the three years.[119] In 2016, 51 percent of funding was allocated, leaving a 49 percent gap.[120] Currently, financing for commodity procurement is exclusively covered by few development partners, USAID and UNFPA, without contribution from the GOL.[121] Competing priorities and a lack of a dedicated budget item for family planning commodities hinders the GOL's ability to fund contraceptive commodities. This results in unpredictability of supply availability for the family planning program. The lack of an active social marketing program or other private sector channels means that the overall burden for meeting country contraceptive needs rests on the shoulders of the MOH. Moreover, the actual procurement process is also handled by donor partners due to institutional requirements and accountability issues. USAID and UNFPA manage their procurements separately and provide regular procurement updates to MOH and partners during the Commodity Security Committee meetings.

Storage and Distribution: Inventory management at the central level is the responsibility of the NDS, now called the Central Medical Store (CMS) and USAID's lead supply chain partner, Chemonics. The county depot is managed by the county health team, led by the pharmacist, and at the facility level by the officer in charge or storeroom keeper. Several challenges exist with managing inventory of health commodities. First, current storage capacity at all levels is inadequate to meet current or projected needs. Indeed, many contraceptives are stored in containers (some climate controlled, some not) on the warehouse grounds at NDS. Commodities are also stored at a newly renovated warehouse at the Freeport of Monrovia, managed by Chemonics and the CMS. Several improvement efforts are currently underway, including the construction of a national warehouse.

Second, there is evidence of stock hoarding at county depots, as health facilities are not always stocked up to their maximum levels at the time monthly orders are placed, even though the county depot may have sufficient stock to fill the order. Causes include a lack of adequately trained staff and distribution capacity (e.g., fuel, vehicles, etc.). The national system calls for a quarterly distribution of commodities, but there are often delays due to limited resources and weak management of logistics operations. Also, there are no dedicated vehicles for transportation of commodities from county depots to health facilities except for delivery of commodities from NDS to the counties. This causes a logistical challenge for the last mile. Poor road conditions further hamper distribution of commodities to remote locations.

Finally, pilferage is rampant at all levels of the supply chain. This is due to challenges with last mile distribution and stock management and maintenance, including inadequate monitoring of drug consumption.

Logistics Management Information System (LMIS): The LMIS is expected to provide timely, reliable data for logistics management decision making at all levels in the system. Efforts have been made and resources invested to improve the effectiveness of the LMIS. For example, all counties have been assigned county supply chain coordinators to assist the county pharmacist in LMIS. They provide minimum mentoring support to health facilities in the compilation of facility LMIS reports, collection of monthly reports, and aggregation and analysis of the data.

However, the LMIS is still experiencing challenges. Not all facilities are using the revised system, and many partners providing services in the counties do not report logistics data through the national LMIS, but rather maintain their own systems and records. Without full implementation of the LMIS across the country by all county health teams, the ability of the LMIS to provide useful data for decision making will be limited. Reporting from health facilities to counties is also irregular and, when done, it is sometimes incomplete or inaccurate. This fact, in addition to the county pharmacists' ability to adjust facility orders based on their subjective reasoning, may be a contributing factor to continuing facility level stockouts.

DEMAND CREATION

For a family planning program to thrive, there must be a demand for contraceptive methods and services. Increasing demand fuels contraceptive uptake over time, provided services are made available and accessible. Great strides have been made to influence family planning behavior through various strategies — mass media, community-level activities, and interpersonal communication. Women's exposure to family planning messages via radio, television, or newspaper more than doubled between 2007 (35.9 percent) and 2013 (77 percent).[122] Men and women are equally exposed to these media channels (77 percent and 75.2 percent, respectively). However, there are urban-rural gaps, especially among females. **Women in rural areas are half as likely to have been exposed to family planning messages through mass media channels than their counterparts in urban areas**.[123] Due to funding constraints, mass media promotion efforts have been short term and lacked scale and consistency.[124]

Facility health providers are an important source of family planning information. Typically, health facilities organize daily health talks that integrate family planning messages to attending clients, and those who visit the family planning clinic are provided with one-on-

one sessions. However, there is still a considerable missed opportunity to reach people with family planning messages through providers. For example, in 2013, less than half of non-users reported discussing family planning with a provider when visiting a health facility or when visited by a community health worker. Efforts to integrate family planning messaging in other health services offered in a facility, such as immunization services, have been implemented in a few facilities in Lofa and Bong counties, but have lacked scale.[125] Those attending a one-to-one session with a provider face several issues, including provider bias (related to age, marital status, and method choice), lack of privacy, and incomplete or inaccurate information.[126] Providers are challenged by a lack of IEC/BCC materials, a high volume of clients, and inadequate space and skills to meet quality standards.

Community mobilization efforts have also been instrumental in promoting family planning services and challenging social norms. Community agents and providers visit markets and other public places, hold local radio shows, and convene community-based group discussions during dedicated contraceptive days and family planning weeks.[127] Other strategies have included engaging influential leaders to sensitize their communities about family planning.

At the national level, despite a supportive policy environment for family planning, there is low media visibility and public affirmation by leaders (political and other) on family planning matters. This is partly due to a lack of influential and dedicated champions, and efforts to engage and sensitize leaders on the role of family planning in health, social, and economic development.

The MOH recently launched national guidance for health promotion (the National Policy and Strategic Plan on Health Promotion, 2016-2021 and National Health Communication Strategy, 2016-2021). [128] The plans aim to increase the proportion of men and women of reproductive age who space their children at least two years apart by increasing knowledge, encouraging couple decision making, and building self-efficacy. Despite the existence of this guidance, the family planning program would benefit from translating the strategy to reflect a comprehensive and targeted family planning social and behavioral change action plan with key messages and tools. The lack of a dedicated family planning SBCC strategy contributes to a weak and uncoordinated demand-generation efforts, as does the absence of a social marketing program. Currently, demand-generation activities are integrated within different programs, including vertical and horizontal integrated programs such as RMNCH. Different programs adopt and implement different messaging with limited audience segmentation, cohesiveness, and targeting of messages. Programs also tend to prioritize shorter term behavioral change outcomes, such as those leading to service uptake, and give less priority to changing social norms. Further, investments toward demand-generation interventions have not been equitably distributed across counties and are short term. For instance, hard to reach areas, like the South Eastern region have not been a focus for intense demand-generation efforts.[129]

YOUTH

Meeting the special needs of young people is of paramount importance for the GOL. According to the 2008 Census, 32.8 percent of the population are adolescents and youth (10-24 years).[130] The median age for childbearing is 16.9 years, well below the age of 20 years recommended by the WHO.[131] Further compared to all other age groups, adolescents have the highest total demand for contraceptives (92.4 percent) and the highest unmet need (59.5 percent) of all age groups.[132] Low contraceptive use among this age group and other predisposing factors are key contributors to the high rates of teenage pregnancy: 31 percent of young people between the ages of 15 and 19 years have started childbearing.[133]

Box 2. Young People's Access Barriers

- Lack of knowledge and self-efficacy to practice family planning
- Fear of stigma, contempt, and discrimination
- Provider bias – due to personal beliefs, policy inconsistencies on the age of consent, and lack of adherence to the 10 rights of a client
- Lack of respect, privacy, and confidentiality for adolescents and youth from service providers
- Financial barriers related to service charges or transportation
- Inconvenient office hours and arrangements

Many factors surround inability of young people to use family planning services (Box 2). There are other challenges as well:

Limited Scope, Intensity, and Scale of ASRH Interventions. On August 2, 2017, the MOH established the Adolescent Unit to coordinate and lead adolescent and youth activities and serve as a liaison to other sectors. This unit is expected to operate in support of FHD. The MOH is guided by an ASRH strategy that, while recently validated, has yet to be printed due to lack of funding. Also, ASRH standards and counseling cards are currently in development.

There are limited youth-friendly centers nationwide. The Ministry of Youth and Sports (MOYS) being one of the government line ministries responsible for ensuring quality of services for youth, is operating 13 youth centers, which integrate family planning service provision as part of the services provided. The Planned Parenthood Association of Liberia (PPAL) operates 31 fixed-site market projects and 16 mobile market projects in ten 10 counties. However, there is still a gap in the coverage of services, since not all counties and markets are covered. Moreover, keeping youth centers active requires sustainable funding, a challenge given intermittent donor funding and GOL's resource constraints. As such, the MOH is currently shifting its strategy from youth centers to mainstreaming adolescent-friendly services within existing facilities. However, this intervention comes with challenges. For example, to accommodate times conducive for adolescents to access services, providers must work longer and later hours, which has proven to be expensive. Another challenge is that there is lack of data to support contraceptive uptake among adolescents due to inconsistencies of age reporting in HMIS data forms. Specifically, the ledger used by health facilities staff has not been updated to capture information for people who are between the ages of 10 and 14 years. In October 2017, the ledgers were amended to include the 15-19 age group.

Weak Multisectoral Coordination to Support a Holistic Programming Approach. Different ministries address youth issues, including MOH, Ministry of Education (MOE), and MOYS; however, there is a lack of a harmonized policy, especially around sexual and reproductive health. There is a plan is underway to develop a teen pregnancy reduction strategy using a multisectoral approach, involving MOE, MOYS, MOH, and the Ministry of Internal Affairs. Also, with funding from the Swedish Embassy and technical support from UNFPA, there is an

ongoing implementation of a four-year "Empower and Fulfill" project, attempting to adopt a multisectoral approach to SRH issues for young people. The project is expected to provide youth-friendly services in the South East, which has among the country's highest young-mother birthrates.

There are current advancements to strengthen collaboration with the MOE in providing family planning services to young people**.** Efforts to integrate contents from a Comprehensive Sexuality Education (CSE) manual in the MOE national curriculum is underway. However, the MOE has reservations about the amount and type of content to include. Also, the development of a new school health policy provides opportunities to integrate family planning, but it is currently unclear of the extent of the content of allowable interventions that may be included, e.g., whether services will be allowed in a school setting. Furthermore, under the school health program, schools are expected to provide sexual reproductive health education. Unfortunately, some faith-based institutions are hesitant to expose youths to sexual content. Advocacy on the part of partners and the government regarding the right to information and access to services is also not enforced.

The opportunity to leverage the HIV/AIDS prevention platform has been limited. The National AIDS Control program is known for its SBCC strategy for HIV/AIDS awareness. However this platform has not yet integrated dual-protection messaging: condoms are used mainly for the prevention of HIV/AIDS, not unintended pregnancy.

Limited Prioritization of ASRH Issues in Policy Agendas. Adolescent health matters, particularly teenage pregnancy, do not have sufficient clout at the policy level. To harness the demographic dividend as a nation, the country must invest in providing family planning services to the general population, particularly youth. This impacts the level of financial resource investments and attention paid to the problem at the political and policy level. In 2016, a roadmap was developed to describe different steps that Liberia must take to reap the benefits of a demographic dividend, the central understanding being that the youth population will be the dominant demographic for the next 30 years.[134]

ENABLING ENVIRONMENT

Legal and Policy Environment. The GOL has long demonstrated political will to enable people to have their desired number of children and to plan the spacing and timing of their births through several mediums. Liberia is a signatory to several international and regional conventions, including the International Conference on Population and Development – Cairo in 1994, the United Nations' Sustainable Development Goals 2030,[135] Every Woman, Every Child, Every Adolescent Global Strategy, African Health Strategy, Paris Declaration, Maputo Call to Action, and the UN Secretary General's Global Strategy for RMNCH Accountability and Results. Furthermore, Liberia is one of the first batch of countries that made commitments at the July 2012 London Summit on Family Planning, updating its commitments in 2017. There are, however, challenges in institutionalizing global agendas in national health, development, and political agendas.

Domestic Advocacy to Support National Adoption and Sustainability of Global Agendas Has Been Weak. First, the family planning stakeholder ecosystem lacks a robust local civil society network and local leadership (community and religious) to spearhead advocacy efforts, as many tend to be engaged in technical/programmatic activities. Second, family planning receives low visibility and prioritization in health, development, and political matters. Policymakers – internal and external to MOH at central and subnational levels – are

burdened with competing priorities and have limited resources. The health sector is increasingly receiving attention at political level, especially after the Ebola crisis, but issues related to teenage pregnancy and family planning receive minimal prominence. There is a paucity of events where national political leaders publicly express sustained concern for these issues; a lack of influential champions to shape agenda setting and sustain attention on these matters; and limited provision of financial, human, and technical resources commensurate with the severity of the problem. Third, there is an absence of locally generated evidence about the social and economic consequences of rapid population growth, and the benefits of family planning, for example on averting maternal mortality, abortions, and unintended teenage pregnancies. Such data is instrumental for advocacy efforts. Finally, family planning issues lack sufficient media visibility to spur public attention and discourse, and there have been few opportunities for engaging and training journalists in reporting family planning issues in a consistent manner.

The national agenda for family planning is reflected in several national policies and strategic plans (Annex C). Further, the GOL continues to refine its regulatory environment to support a conducive policy environment for family planning and efforts to combat teenage pregnancies and reduce maternal mortality. For example, in 2011, Liberia adopted the Children's Act, which disallows child marriage under age 18.[136] These revisions will help reduce adolescent pregnancy, delay sexual debut, and improve RMNCAH outcomes for women.

Despite these policy advances, there are prevailing issues and gaps in relation to policy, and a lack of family planning operational policies, as follows:

1. **Weak enforcement of laws on child marriage, sex with a minor, and rape** contribute to high rates of unwanted teenage pregnancies. UNICEF estimates that 36 percent of girls in Liberia are married before age 18.[137] However, the Children's Law 2011 states, "no person or society shall subject a child to marrying any person when she or he is still under the age of 18 years."[138] Rape is the second most commonly reported serious crime in Liberia, and a sizable proportion of reported victims (78 percent in 2015) are under age 18.[139]

2. **Lack of clarity on the age of eligibility or consent to access and use contraceptives** unintentionally creates barriers to access among unmarried, sexually active adolescents. This is particularly relevant for providers who are uncomfortable providing contraceptives to adolescents for fear of parental repercussion. People under age 15 are defined as children under the African Youth Charter (which Liberia has ratified) and the National Youth Policy.[140] However, in the context of family planning, services can be provided to adolescents 10-14 years who are sexually active. Both the Public Health Law and SRH policy are silent on contraceptive access to adolescents, or any other age group for that matter.

3. **Lack of classification of emergency contraceptives (ECs) as a family planning method for procurement and provision.** While regarded as an important, safe, and effective pregnancy prevention method after unprotected sexual intercourse, EC procurement and provision is confined to victims of sexual assault. EC pills are available as part of post-exposure prophylaxis (PEP) kits, but are not widely available for the general population.[141] ECs are one of the least known and least available methods in Liberia – only 28.7 percent of women are aware of it, and only 15 percent of health facilities offer it.[142,143]

4. **Weak enforcement of the fee-exempt policy for family planning services** is a barrier to access. The GOL pledged that all family planning services and commodities would be offered from public health facilities free of charge, but users report to being denied free service.[144] A 2015 UNFPA supplies survey showed that few public-sector facilities (1.9 percent) are charging user fees, and tertiary facilities are charging for consultation services and other undefined charges.[145] User fees are particularly relevant to access to clinical methods, such as injectables, implants, IUDs, and sterilization. This is because besides supply of free commodities, other costs for provision include provider staff time and equipment and supplies, which may not be compensated by the government.

5. **Lack of operational policy guidelines and standards** to provide explicit directives on the operational rules, regulations, guidelines, and administrative norms governing family planning services and programs; and the minimum acceptable levels of performance and expectations for service delivery and program implementation. Such guidance would be useful in ensuring uniformity and clarity to the implementation of a coherent and coordinated program. While a National Sexual and Reproductive Health Policy 2010 exists and reflects family planning as one of the essential SRH services, the policy lacks details in essential guidance and standards needed for quality service delivery and programs.

6. **Unfavorable policies and incentives for private sector engagement** limits the ability to expand the pool of family planning service delivery points and narrows choice for consumers. The MOH is committed to bolstering a private-public partnership (PPP) approach to healthcare delivery. Through the investment case for RMNCAH, a public-private partnerships coordinator will be hired to enhance effective engagement of the private sector. Beyond general PPP policy issues, matters specifically for family planning include clarity around the ability of the private sector to independently procure commodities, charge reasonable user fees, and provide certain methods. While there is a growing number of drug shops and retail pharmacies in Liberian urban areas, it is unclear whether these platforms can provide family planning services or which contraceptive methods they can provide.

7. **Inertia on policy decisions related to task sharing.** Injectables are currently the most popular methods, and future projections show this trend will continue. In 2012, a pilot study was conducted in rural Lofa and urban Montserrado counties to assess provision of injectable contraceptives by general community health workers (CHWs). The uptake of injectables increased more than tenfold in both counties and was the most preferred method.[146] A decision is pending on whether to scale this evidence-based intervention to other counties and advance policy change to allow CHWs to provide injectables.[147] In 2009, the WHO issued a statement to support this as a safe, effective, and acceptable intervention, and in 2017, 11 countries have made policy changes to allow CHWs to provide injectables.[148,149] The MOH is committed to advance this approach in a systematic manner, with further demonstration in additional sites. The MOH is also exploring the introduction of Sayana Press – a subcutaneous injectable – as a complement or alternative for injectable provision at the community level.[150]

Leadership, Governance, and Coordination. The MOH is the highest institution providing stewardship of family planning policy, programs, and services. At the central level, the FHD

of the MOH has the overall responsibility to steward, govern, and champion the family planning program, with support from other divisions, departments, and parastatal agencies including the National Drug Services, SCMU, HMIS, Training Unit, Community Health Service Department, and the National Health Promotion Department, among others. At the county level, the family planning program is managed and supervised by regional health supervisors (RHSs).

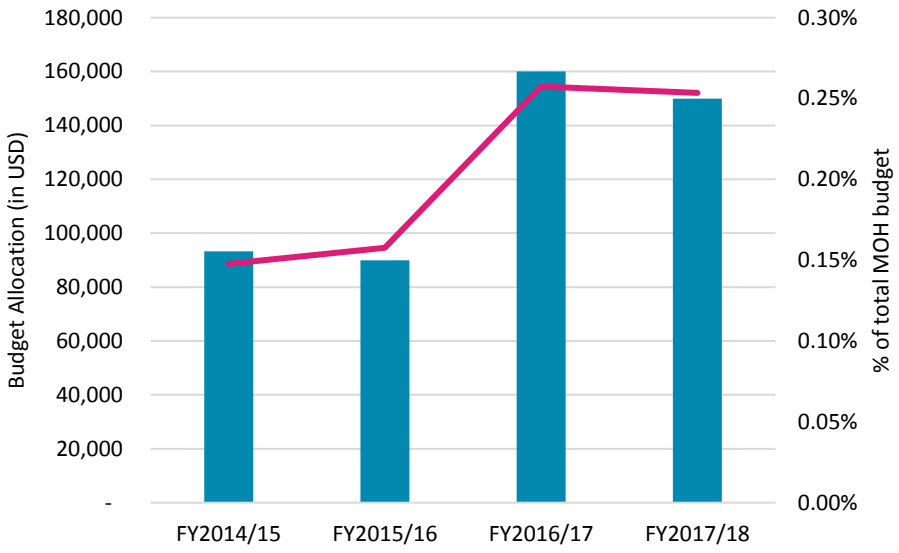
The governing unit for family planning program and services faces several challenges, including insufficient staff and resources. There is only one full-time dedicated staff, a family planning coordinator. Staff are leveraged from the HMIS and SCMU to support monitoring and evaluation, and commodity security, respectively. The monitoring and evaluation function is challenged by lack of timely and accurate data reporting for the HMIS, and reliance only on service statistics to assess program performance. The 2016 median facility reporting rate was 21.2 percent, representing a range between 5.6 percent in Montserrado county to 88.6 percent in Bomi county. This was an improvement over previous years, where very few facilities reported data at all. Further, a need has also been expressed to have a dedicated full-time M&E officer for the family planning program to effectively support performance monitoring efforts.

The FHD works collaboratively with multiple partners who are coordinated through the Reproductive Health Technical Committee (RHTC), a technical working group on all reproductive health issues, including family planning. The committee comprises four subcommittees: the Reproductive Health Commodity Security (RHCS) subcommittee; and the Service Delivery, Policy, and Education subcommittees. The RHCS subcommittee comprises relevant MOH departments, including Supply Chain Unit, Health Promotion, community health and the national drug services. It also includes implementing and donor partners, INGOs, local NGOs, UN agencies, and USAID. Despite the existence of these platforms, coordination challenges prevail. Meetings are infrequent and irregular, and there is inconsistent follow-up on decisions. There is no dedicated family planning technical working group, a missed opportunity to dedicate optimal time and attention to family planning matters. Partner coordination on activity implementation is also weak, resulting in duplication or overlap of efforts.

Financing for Family Planning. Funding limitations are a major barrier to advancing national goals across all health areas. The health budget has increased five times between FY2006/2007 and FY 2013/2014, from LRD 10.9 million to LRD 53.6 million, and government budgetary appropriations have also increased during the same period, with the percentage of the government budget toward the health sector increasing from 8.39 percent to 11.51 percent during the same period. The budget has continued to grow since then and, as of 2015, Liberia is one of the few countries that have met the Abuja target of allocating at least 15 percent of their annual budget to improve the health sector. The appropriations, however, have not always been fully disbursed to the health sector, partly attributed to the delay in the approval and disbursement of the national budget and the bureaucracy associated with processing payments and releasing quarterly allotments.[151] Donors and out-of-pocket (OOP) financing typically account for most health expenditures – in FY2011/2012, this amounted to 33 percent (donors) and 51 percent (OOP).[152] The majority of donor funds are channeled through NGOs and, only a small number of donors use the pool fund. As of late, donor funding to the pool fund has been declining.[153] Further, most donor support is limited to one- to two-year obligations, constraining planning to short-term periods.

Through its health sector budget, the GOL provides funding to support recurring operating costs for family planning services at facilities and for the supervision system. However, due to limited financial resources and competing priorities, it does not fund enhancement projects, commodities, provider training, or supervision activities. The government has two budget line items related to family planning, one for family planning supplies and the other to fund the Family Planning Association of Liberia (PPAL). However, funds have not yet been specifically allocated to family planning commodities, and the funding allocated and disbursed is inadequate to fulfill the country's budgetary needs. Figure 21 shows allocations in the annual government budget during FYs 2014/15 to 2017/18. Allocations as a percentage of the total MOH budget slightly increased, from 0.15 percent to 0.25 percent in FY 2014/15 to FY2017/18, respectively. However, in all four years, no funding was disbursed to family planning commodities, despite the budget allocation. Some funding was disbursed to PPAL in FY2014/15 and FY2015/16. In 2017, the GOL updated its FP2020 commitment to strive toward allocating 5 percent of its health budget for the provision of free family planning commodities and services nationwide.[154] However, there is lack of robust advocacy for resource mobilization. Further, CSOs are minimally engaged in budget advocacy at the government level. Most advocacy efforts conducted by CSOs pertain to demand generation at the community level. Development partners support procurement of family planning commodities and services. UNFPA, the Swedish International Development Cooperation Agency (SIDA), the Department for International Development (DFID), and USAID are the main funders for family planning. Lack of consistency and sustainable funding for supporting family planning continues to be a critical challenge to achieving family planning targets and the contraceptive prevalence rate.[14]

Figure 21: Family Planning Budget Allocation, FY 2014/15 to 2017/18



RESULTS FRAMEWORK

This plan reflects the united vision that every Liberian may fully exercise their sexual and reproductive rights, manage their own fertility choices, and have equitable access to family planning services where they live. The plan also serves as a common roadmap to achieving national goals for increasing contraceptive use and reducing teenage pregnancies and maternal mortality. The plan translates international commitments into action, including FP2020, Sustainable Development Goals 2030, and the Global Strategy for Women's, Children's And Adolescents' Health, among others.

VISION

Every person in Liberia enjoys the highest quality of sexual and reproductive health (SRH), including family planning services, can fully exercise their sexual and reproductive rights and manage their own fertility choices, and has equitable access to the services they choose close to where they live.

GOAL

To increase the modern contraceptive prevalence rate (mCPR) from 30.3 percent in 2016 to 39.7 percent in 2022, by ensuring that all couples, individuals, and adolescents have access to the full range of quality and affordable family planning services at a location of their choice.

To meet the mCPR goal of 39.7 percent by 2022, it is estimated that the mCPR will need to grow at an average of 1.5 percentage points per year, representing an estimated 515,000 modern contraceptive users, of which 30 percent (153,000) would be additional users.[155] Table 5 shows the breakdown of users of modern contraceptives that need to be served by year between 2018 and 2022. Given the country's current population profile, at least 40 percent of the users to be served will be young people ages 15 to 24.

Table 5: Number of Modern Contraceptive Users to Serve, 2018 to 2022

Indicator	2018	2019	2020	2021	2022
mCPR (%)	33.7%	35.2%	36.7%	38.2%	39.7%
Total number of users of modern contraceptives	390,000	419,000	450,000	482,000	515,000
Additional users relative to 2017*	28,000	57,000	88,000	120,000	153,000
Users: 15-19 years	87,789	94,317	101,295	108,498	115,927
Users: 20-24 years	69,303	74,456	79,965	85,651	91,516
Users: 25-29 years	68,016	73,074	78,480	84,061	89,816
Users: 30-34 years	50,622	54,386	58,410	62,564	66,847
Users: 35-39 years	49,764	53,464	57,420	61,503	65,714
Users: 40-44 years	34,281	36,830	39,555	42,368	45,269
Users: 45-49 years	30,225	32,473	34,875	37,355	39,913

**Additional users is a FP2020 core indicator, and is defined as the number of additional women (or their partners) of reproductive age currently using a modern contraceptive method compared to those in 2017. It reflects the difference between the baseline (2017) number of users and the estimated number of users for the years of the CIP 2018-2022.*

If the CIP is implemented fully, reducing maternal mortality and meeting the contraceptive needs of women will avert 600,000 unintended pregnancies and nearly 216,000 abortions, and reduce maternal deaths by 3,300 between 2018 and 2022.

OUTCOMES

The family planning program will enable more women and men to exercise their rights and access contraceptive services by implementing a set of interventions to achieve key outcomes specified under five thematic areas listed in Table 6. Each area is further detailed by activities, sub-activities, inputs, output indicators, and timeline information (Annex BANNEX B).

Table 6: Outcomes by Thematic Area

Thematic Area	Performance Indicator	Baseline (%)	Target (%)
1: Service Delivery	Percentage of demand satisfied by modern methods among all women and men, including adolescents	41.5	45.0[i]
2: Commodity Security	Percentage of facilities with no stockouts of modern contraceptives in the last three months	33.8[156]	75.0[ii]
3: Demand Creation	Percentage of women of reproductive age demanding family planning services	49.5	55.5[i]
4: Youth	Percentage of teenage women who have begun childbearing	31.0	25.0[iii]
5: Enabling Environment	Percentage of the GOL annual health budget allocated to family planning	0.0	5.0[iv]

i: Projected, ii: Global joint action plan for Women and Children's Health Commitment, 2015. iii: RMNCH Investment Case; iv: FP2020 Commitment.

STRATEGIC PRIORITIES

The strategic priorities identified in Table 7 represent critical interventions that must be carried out to meet the family planning outcomes and goal. They represent interventions that address fundamental bottlenecks facing the program and accelerate achievement of outcomes of interest. These priorities were identified through consultative meetings with government and stakeholders and are based on data on current performance and service gaps. They also form the basis for regular performance monitoring efforts to track progress of executing the plan. The total cost for implementing these strategic priorities is estimated to be $28,445,923.

Table 7: Strategic Priorities by Thematic Area

Thematic Area	Outputs	Priority Intervention Strategies	Total Cost
1: Service Delivery	SD1.1 The number and capacity of facilities offering a range of family planning services at acceptable levels of performance and quality, as per national standards increased	• Streamline and improve coordination of provider training • Exploration of the possibility of physician assistants and/or registered nurses to provide tubal ligation services	$6,068,329

Thematic Area	Outputs	Priority Intervention Strategies	Total Cost
1: Service Delivery	SD1.2 Family planning services offered through CHAs expanded and strengthened	• Introduction of community-based distribution of injectables, particularly Sayana Press	$92,599
1: Service Delivery	SD1.4 Integration of family planning services with other health services, particularly RMNCAH and HIV/AIDS services, strengthened and scaled	• Scale-up of family planning integration into immunization services	$538,343
2: Commodity Security	CS2.1 Adequate contraceptive commodities and supplies procured to cover all country needs (in accordance with annual contraceptive tables) to meet the CPR goal by 2022 CS 2.2 Improved supply chain management system for family planning commodities	• Reduce contraceptive stockouts • Improve the availability of data on consumption and stockouts • Reclassify emergency contraceptives (ECs) as a family planning method for procurement and provision	$12,675,355
3: Demand Creation	DG3.1 People have accurate knowledge and self-efficacy to adopt positive behavioral change to practice family planning	• Increase coverage and consistency of mass media/SBCC	$1,157,889
3: Demand Creation	DG 3.2 Positive shifts in social norms and attitudes to foster healthier and more behaviors around contraception	• Engage faith-based community to mobilize members to accept and use family planning services • Engage males to be effective enablers and/or primary users.	$434,215
4: Youth	Y4.1 Existing facility-based service delivery points offer family planning services that meet youth-friendly standards to facilitate access and use by young people	• Mainstream youth-friendly service delivery into existing health services (at all levels) at scale	$6,715,540
4: Youth	Y4.5 A multisectoral approach to support holistic programming toward teenage pregnancy reduction is strengthened	• Support scientifically accurate and comprehensive sexuality education programs within and outside of schools that include information on contraception and where to obtain it	$535,552
5: Enabling Environment	EE5.2 At least 5 percent of the GOL annual health budget allocated to family planning commodities and services by 2021, in line with the country's FP2020 commitment	• Advocacy to support allocation and disbursement of funding under the dedicated budget line item for family planning in national budget	$1,245
5: Enabling Environment	EE5.3 Resources mobilized from nongovernment (i.e., foreign/domestic donors) sources increased	• Diversify donor base beyond primary development partner	$4,577
5: Enabling Environment	EE6.1. Heightened and sustained political will and commitment toward family planning	• Gain prominence visibility, and support for family planning matters from the House of Representatives, senior leadership of the MOH, and the public	$113,338

Thematic Area	Outputs	Priority Intervention Strategies	Total Cost
5: Enabling Environment	EE6.2 A conducive policy environment, with clear and transparent operational directives, to guide effective implementation of the family planning program	• Develop and support use of FP/RH Policy Guidelines	$108,941

GUIDING PRINCIPLES

The following represent principles to guide stakeholders in developing and executing the implementation plan, including:

- The plan adopts approaches to facilitate resource efficiencies and promote institutionalization of key interventions while achieving scale.
- The plan reflects existing interventions that made notable contributions to outcomes of interest, and calls for smart scaleup of those interventions.
- Existence of regional disparities and the need to tailor interventions and reduce the regional performance gaps to advance attainment of the national goal.

COMMODITY REQUIREMENTS

Method mix projections are made to estimate the volume of commodities needed to serve women for contraceptive services over a five-year period and meet the goal of 39.7 percent mCPR by 2022. When costed, this information is also used to project financial resource needs during the CIP period of performance. The projected method mix takes into consideration: historical method mix trends as reported in the DHS 2013 and MIS 2016, service statistics reported in the DHIS-2, commodity quantification reports, the mCPR goal, and assumptions based on expert consultations. The following assumptions have been made to compute the projections:

- Injectables will continue to dominate the method mix as the most popular method.
- Implants, pills, condoms, and IUDs are projected to only slightly increase in uptake. Increase in pill and condom use will be facilitated by the expanding community-based distribution interventions by CHAs. An enhanced focus on LARCs will also support increased adoption of IUDs and implants. However, use of implants is not expected to increase considerably because they offer less privacy – particularly during administration – compared with injectables. IUD uptake will continue to be limited by pervasive misconceptions, and women's unwillingness to use the method.
- CycleBeads will also slightly increase as it is being made increasingly available through public health facilities, and offers unique advantages being acceptable by women and couples who oppose modern methods on religious grounds.
- Uptake of female and male sterilization will stay the same.

Based on the method mix projections, the volume of commodities that need to be procured by method and year is shown below in Table 8. *Note: These projections should be reviewed on an annual basis as part of forecasting and quantification exercises for use to inform*

procurement. This information, and costing data, is best used to estimate annual resource requirements and for advocacy purposes.

Table 8: Projected Commodity Requirements, 2018-2022*

Commodity	2018	2019	2020	2021	2022
IUDs (/kit)	1,162	1,223	1,285	1,345	1,412
Implants (/kit)	22,095	24,235	26,460	28,725	31,142
Injectables (/vial)	1,235,282	1,338,233	1,445,673	1,556,544	1,672,379
Pills (/cycle)**	940,462	969,714	999,492	1,029,036	1,059,356
Male condoms (/piece)***	1,526,680	1,604,318	1,684,584	1,766,217	1,850,953
Female condoms (/pack)****	44,133	45,192	46,277	47,387	48,525
CycleBeads (/unit)	9,056	9,388	9,728	10,069	10,420

**Projections pertain to all women and men, not solely those who are married or in union. **Pills include all brands. ***Projections only pertain to use of condoms for family planning and excludes HIV/STIs. ****Projection for female condoms is based on the supply plan volume.*

PROJECTED HEALTH IMPACTS OF CONTRACEPTIVE UPTAKE

The ImpactNow model was used to calculate the impacts from which the Government of Liberia will benefit by increasing the mCPR. These demographic, health, and economic impacts include the following:

- Unintended pregnancies averted
- Abortions averted
- Unsafe abortions averted
- Maternal deaths averted
- Healthcare costs averted (in USD)

These calculations estimate that, if the CIP is fully implemented, the family planning interventions in Liberia will avert more than 600,000 unintended pregnancies and nearly 216,000 abortions, and will reduce maternal deaths by more than 3,300 (Figure 22) between 2018 and 2022. Additionally, the intervention will avert almost US$143 million just for maternal and infant healthcare costs during the five-year plan period.

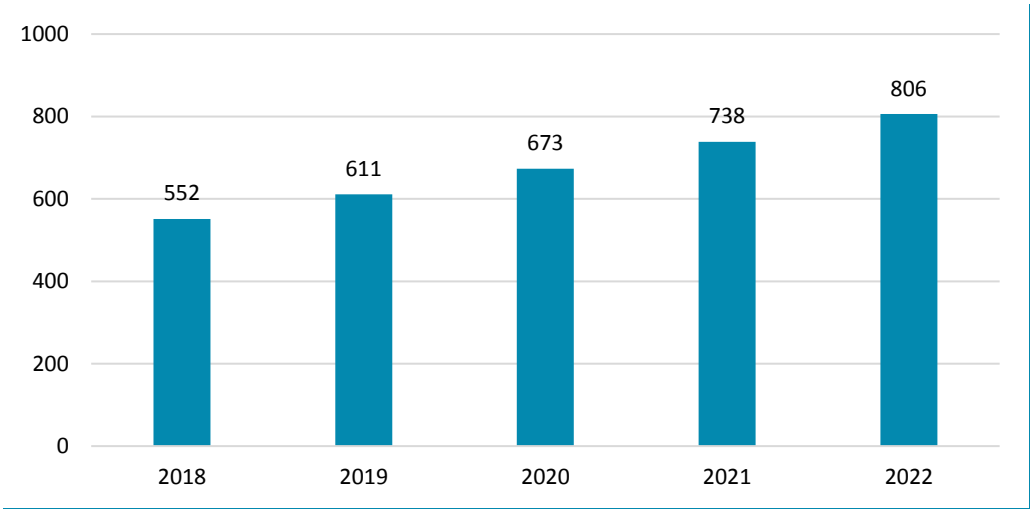
Table 9 forecasts the impacts of increases in family planning demand, use, and priorities for 2018-2022 in Liberia. The baseline numbers are drawn from the 2016 Liberia Malaria Indicator Survey (MIS) and projected outward based on full implementation of the CIP and reaching the stated mCPR targets all women of reproductive age. Projections shown in Table 9 are grouped into three main categories: demographic, health, and economic impacts. The data show how the scaled-up interventions will significantly affect outcomes in reproductive, maternal, and child health in Liberia.

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 family planning use and fewer unintended pregnancies, maternal deaths will decline.

Health Impacts. As a result of full implementation of the Liberia CIP, significant numbers of maternal deaths will be averted, as well as unsafe abortions, contributing to a healthier population.

Figure 22: Number of maternal deaths averted, 2018-2022



Economic Impacts. A key emphasis in the 2016-2020 RMNCAH Investment Case is to improve maternal and newborn health, the teenage pregnancy rate, unwanted pregnancy, along with creating awareness on youth education and employment. Thus, investing in the population structure serves as a means to harness economic development. Ultimately, the numbers shown in the projected economic impact holds particular significance. Increased family planning use, reduced unmet need for family planning, and increased contraceptive prevalence will result in government savings and economic impacts on the whole, but Table 9 shows the specific impacts on maternal and infant healthcare costs only.

The impact projections in Table 9 can further shape advocacy efforts for full implementation of the CIP. Additionally, it can be used to make the case for how implementation of the CIP also contributes towards the achievement of goals from Liberia's other national strategic plans. For instance, the 2016-2020 RMNCAH Investment Case states that poor family planning coverage and the high rate of teenage pregnancies are major issues resulting in the country's high maternal mortality rate.[157] Data from the ImpactNow analysis shows that by increasing the modern contraceptive prevalence rate (mCPR) or the percentage of women using modern contraception to CIP goal of 39.7 percent, there is a potential to save an estimated 3,300 maternal lives by 2022. This impact from the CIP is simply one contribution toward initiatives to reduce maternal mortality that were prioritized in the RMNCAH Investment Case. Therefore, it is essential to have the right investments and level of effort from all stakeholders leading the CIP.

Table 9: Health Impact of Increased Family Planning Uptake, 2018-2022

	2018	2019	2020	2021	2022	Total
Unintended pregnancies averted	98,055	108,645	119,714	131,264	143,298	600,976

	2018	2019	2020	2021	2022	Total
Abortions averted	35,300	39,112	43,097	47,255	51,587	216,351
Maternal deaths averted	552	611	673	738	806	3,380
Unsafe abortions averted	35,252	39,059	43,038	47,191	51,517	216,057
Disability-adjusted life years (DALYs) averted	178,619	197,909	218,072	239,112	261,033	1,094,746
Maternal and infant healthcare costs averted (US$)	23,315,863	25,833,930	28,465,843	31,212,240	34,073,760	142,901,636

COST ASSUMPTIONS

Costing elements are described and costed based on specific data from the MOH, 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. 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 come from various sources and include standards provided by the MOH, UNFPA, and other implementing partners. Where specific costs were not available (e.g., if an activity has yet to be implemented in Liberia), the costing data were drawn from a regional African or international source and noted as such.

Contraceptive costs are calculated from 2018 to 2022, using a 2017 baseline estimate of 30.3 percent mCPR. The 2016 Liberia Malaria Indicator Survey (MIS) method mix (for all women, modern methods) was used as a baseline assumption for the 2017 method mix. Thus, for the purpose of the CIP, an assumption was made that there is no significant change in the 2017 baseline method mix from the 2016 Liberia MIS method mix. For further information about the assumptions used to determine the method mix, refer to Annex A. The projections for 2022 were based on the national objective of reaching 39.7 percent mCPR among all women of reproductive age. The objective CPR for all women of reproductive age was then extrapolated for each intermediate year between 2017 and 2022. These inputs can be further updated when the next LDHS 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 idem rates, fuel costs, venue hire, etc.) are based on current costs as of April 2018 and have been automatically adjusted for a base rate of inflation of 2.5 percent annually. The inflation rate can be adjusted to accommodate changing conditions. All costs have been calculated in US$ and have been converted to Liberian Dollar using the exchange rate of US$1 is to LRD 132.10 as of May 17, 2018. The conversion rate can be adjusted to accommodate market fluctuation. The costing tool is available from the MOH for review, updating, or modification for other programs.

COST SUMMARY

The costs have been calculated using a tool developed specifically for this purpose, with methodology borrowed from other family planning plan costing activities regionally. The tool enables users to 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 approximately US$46 million (LRD 6 billion)[3].

Overall, US$11.5 million (LRD 1.8 billion), or 25 percent of the overall costs, are for commodities and consumables. These costs for commodities and consumables gradually increase over time as more women are reached. Among the activity-based or programmatic costs per thematic area, service delivery (36 percent) and youth-related (19 percent) activities are the highest costs. This is followed programmatic costs for demand generation (14 percent) and enabling environment (4 percent) and commodity security programs (2 percent).

The costs of the plan are comparable to other countries' similar family planning costed implementation plans. The cost per woman of reproductive age for activity costs is US$5.76 per year, which is slightly above the range of average costs in other countries of about US$2-5. The cost per user for family planning commodities and consumables is US$5.72 which is slightly above the average costs of US$4-4.20 seen in other countries. This is due primarily to the inclusion of 25 percent buffer quantity. A buffer stock is recommended when the supply chain is unstable, demand is variable, there is a significant level of stockouts, and when forecasts are unreliable due to lack of quality data. These conditions mirror the situation in Liberia.

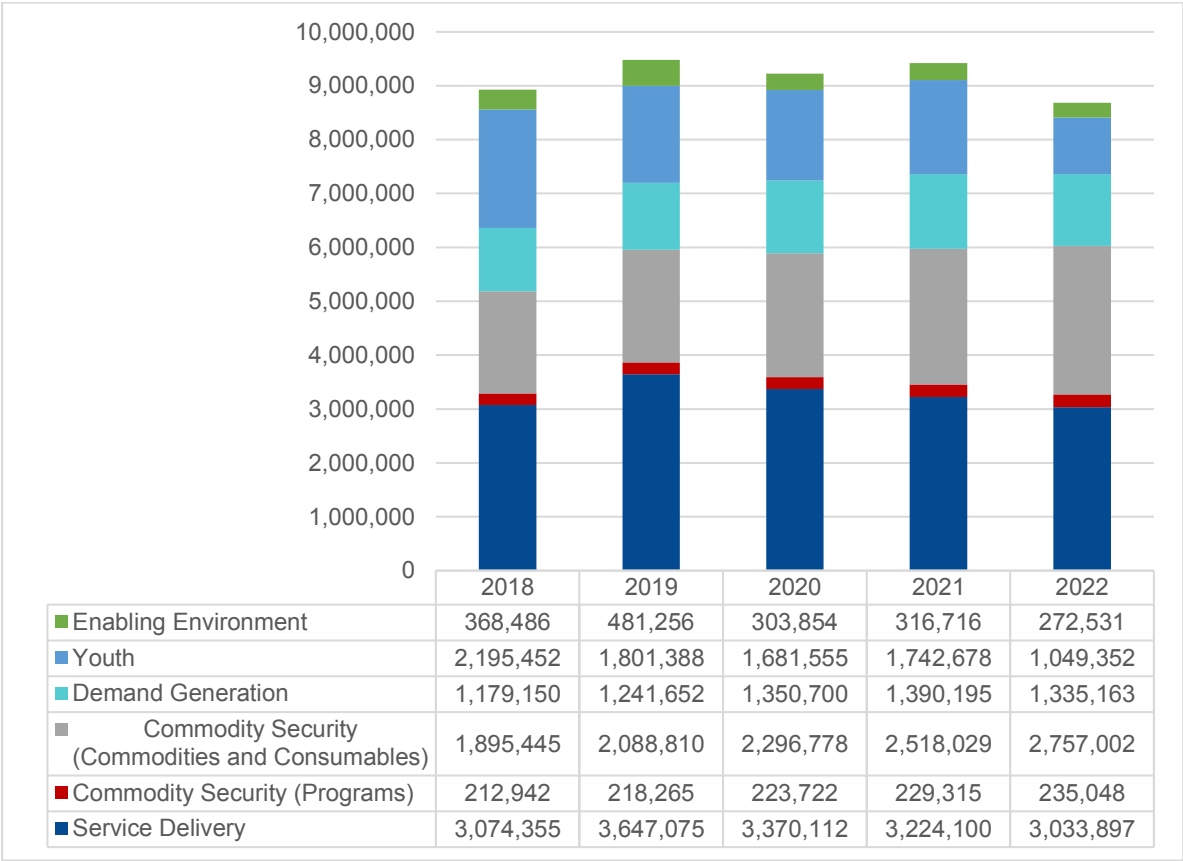
Table 10: Annual Costs by Thematic Area 2018-2022, in USD

Area	2018	2019	2020	2021	2022	Total	Percentage of Costs per Thematic Area
Service Delivery	$3,074,355	$3,647,075	$3,370,112	$3,224,100	$3,033,897	$16,349,539	36%
Commodity Security (Programs)	$212,942	$218,265	$223,722	$229,315	$235,048	$1,119,291	2%
Commodity Security (Commodities and Consumables)	$1,895,445	$2,088,810	$2,296,778	$2,518,029	$2,757,002	$11,556,064	25%
Demand Generation	$1,179,150	$1,241,652	$1,350,700	$1,390,195	$1,335,163	$6,496,860	14%
Youth	$2,195,452	$1,801,388	$1,681,555	$1,742,678	$1,049,352	$8,470,425	19%
Enabling Environment	$368,486	$481,256	$303,854	$316,716	$272,531	$1,742,843	4%
Total Costs per Year	$8,925,829	$9,478,446	$9,226,721	$9,421,033	$8,682,994	$45,735,023	

[3] Based on an exchange rate of 1USD = 132LRD

Area	2018	2019	2020	2021	2022	Total	Percentage of Costs per Thematic Area
Percentage of Costs per Year *(percentages do not equal 100 due to rounding)*	20%	21%	20%	21%	19%		

Figure 23: Annual Costs by Thematic Areas and Contraceptive Costs, in USD



	2018	2019	2020	2021	2022
Enabling Environment	368,486	481,256	303,854	316,716	272,531
Youth	2,195,452	1,801,388	1,681,555	1,742,678	1,049,352
Demand Generation	1,179,150	1,241,652	1,350,700	1,390,195	1,335,163
Commodity Security (Commodities and Consumables)	1,895,445	2,088,810	2,296,778	2,518,029	2,757,002
Commodity Security (Programs)	212,942	218,265	223,722	229,315	235,048
Service Delivery	3,074,355	3,647,075	3,370,112	3,224,100	3,033,897

INTERVENTION STRATEGIES

SERVICE DELIVERY

OUTCOME 1: The percentage of all women and men, including adolescents, whose contraceptive demand is satisfied by modern methods is increased from 41.5 percent in 2013 to 45 percent in 2022.

Based on the current mCPR, an estimated 284,000 women of reproductive age were using modern contraceptive methods as of 2017.[158] To achieve the goal of this plan, the service delivery platform must be capable to reach and serve existing and increasing numbers of users over the five-year period, representing an estimated 381,000 total users by 2022, of which 97,000 are additional users from a baseline year of 2017.[159]

Planned interventions, therefore, aim to expand coverage of quality family planning services by increasing the density of service delivery points with acceptable readiness to provide family planning services, bringing services closer to the people, particularly for those residing in underserved areas, leveraging existing platforms that are already reaching population segments with an unmet need for contraception, and supporting the provision of a broad range of contraceptive methods. The program aims to scale up, strengthen, and/or sustain intervention efforts that have been working well to produce intended results, for example, contraceptive days, integration of family planning into EPI, and family planning provision through the CHA platform. At the same time, the program intends to explore new interventions, such as community distribution of injectables, task-sharing opportunities to expand access to surgical sterilization services, and private sector engagement. Furthermore, the program plans to address persistent bottlenecks in service delivery, including issues related to provider bias, insufficient working tools (guidelines, job aids, and equipment), and inconsistent supportive supervision and mentoring, among others. Finally, advocacy will be directed toward resolving matters that are outside of the purview of independent action by the family planning program, for example, health workforce shortages, weakness in supply chain and logistics, and inadequate financial resources.

A summary of key outputs, and associated performance targets, contributing to this outcome are summarized in Table 11. The estimated total amount of resources required to deliver on the outputs during the five-year period is US$16,349,539.

Table 11: Service Delivery Results and Performance Targets

Outputs and Cost (USD)	Performance Targets		
	Indicator	**Baseline**	**Target**
SD1.1. The number and capacity of facilities offering a range of family planning services at acceptable levels of performance and quality, as per national standards increased. **Cost:** $6,389,438	Percentage of facilities with at least one health staff trained in family planning	90.2% (2015)[160]	100%
	Percentage of primary level health facilities providing at least three modern methods	61%[161]	75%
	Percentage of facilities providing IUDs, implants, ECs, and sterilization services	EC 15% IUDs 39% Implants 79% Vasectomy 2% Female sterilization 2% (2016)[162]	EC 30% IUDs 50% Implants 100% Vasectomy 5% Female sterilization 5%
SD1.2. Family planning services offered through CHAs expanded and strengthened **Cost:** $184,149	Demonstrated evidence of program and policy changes to support an expanded method mix offered by CHAs	Ministry decision to conduct pilot studies to assess safety and feasibility of Sayana Press by CHAs	Evidence generated from pilot studies, and consultations occur to support policy change for an expanded method mix
	Percentage of women currently using modern contraceptive methods who received their most recent supply or information from a fieldworker	4.1% (2016)[163]	25%
SD1.3. Clinical outreach services scaled and sustained to improve availability of and access to quality family planning services, particularly for underserved communities **Cost:** $8,363,112	Proportion of total users who are receiving services through clinical outreach	1.1%[164]	5%
SD1.4. Integration of family planning services with other health services, particularly RMNCAH and HIV/AIDS services strengthened and scaled **Cost:** $1,215,514	Percentage of non-users who report to have discussed family planning with a provider when visiting a health facility	43.8% (2013)[165]	55%
	Percentage of facilities with at least two providers trained to offer family planning services as part of immunization services*	5.1%[166]	50%

Outputs and Cost (USD)	Performance Targets		
	Indicator	Baseline	Target
SD1.5. Increased uptake of quality family planning services through the private sector **Cost:** $197,325	Percentage of women currently using modern contraceptive methods who received their most recent supply or information from a private health facility	23.6% (2016)[167]	33%[168]*
	Percentage of women currently using modern contraceptive methods who received their most recent supply or information from a pharmacy	10.5%	25%

**FP2020 commitment to increase clients' sourcing of contraceptives from the private sector by 10 percent.*

Strategy Description

SD1.1. The number and capacity of facilities offering a range of family planning services at acceptable levels of performance and quality, as per national standards increased.

Intervention Strategy: Enhance and streamline capacity building for in-service facility-based health workforce to improve coverage of quality family planning service provision

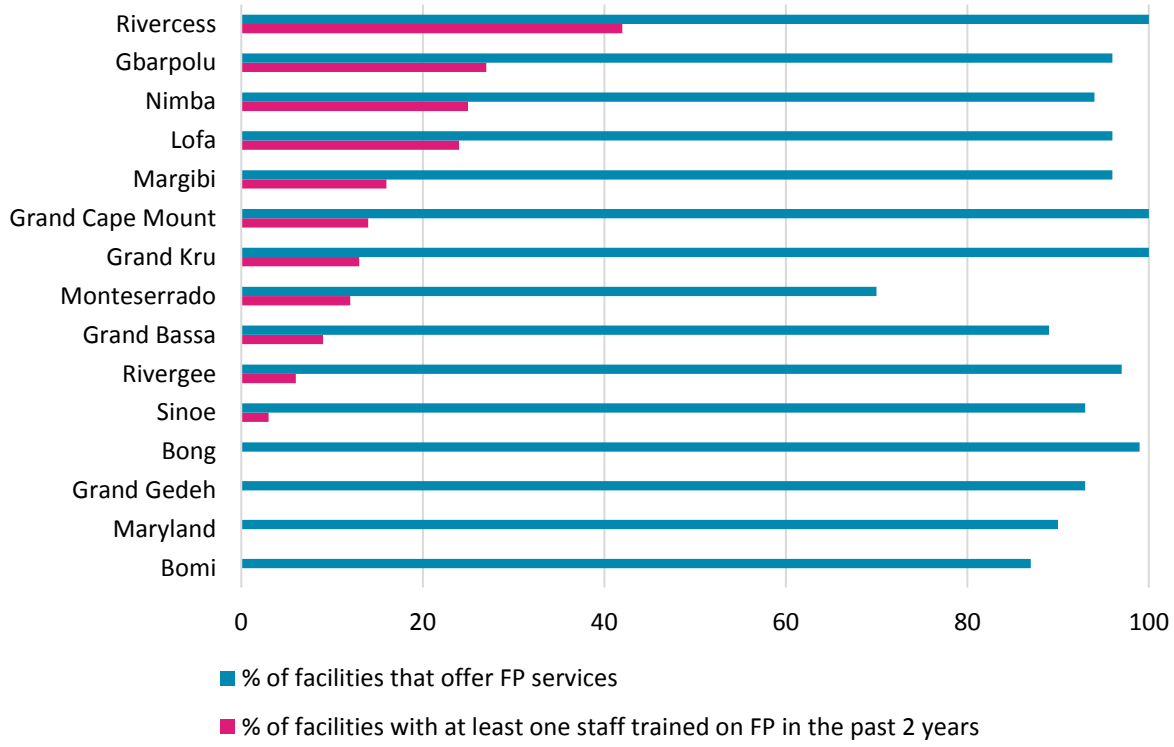
Ensuring that there are adequate skilled providers to deliver quality services will continue to be an important intervention toward the development and maintenance of health worker competencies for delivering quality family planning services. However, considering that substantial investments have been placed on in-service training over the years, an inequitable distribution of skilled providers persists. Liberia aims to streamline training investments to make them more efficient, effective, and sustainable. As such, a needs-based approach to in-service training will be adopted to foster better planning and coordination. Elements of this approach include (a) assessing provider knowledge, skills, and competency gaps in quality provision of family planning services and, based on these findings, developing a two-year training action plan; (b) tracking training through a mechanism that facilitates coordination among partners and the MOH (central and county levels) for the efficient, appropriate, and optimal use of the health workforce; (c) pooling resources among different partners to leverage economies of scale; and (d) mainstreaming several content areas within basic family planning training to avoid "silo" training on topics such as rights-based approaches, youth-friendly services, male involvement, interpersonal communication, PPFP, and contraception for the HIV/AIDS affected population, among others.

Training investments will be made to reduce the shortfall of skilled providers in both public and private sector facilities – the goal is to ensure every facility that is offering family planning services has a provider trained in the past two years (currently, only 14 percent of facilities do so.)[169] However, since at least 90.2 percent of health facilities have a provider trained in family planning, the strategy will focus on keeping the knowledge and skills of these family planning providers up to date through refresher training.[170] Step-down

(cascade) training will be encouraged at the facility level to facilitate knowledge and skill transfer to other providers.

The training plan will take into consideration the following: (a) regional disparities – availability of recently trained staff in facilities ranges from 0 percent to 42 percent; hence counties that have fewer recently trained providers (such as Bomi, Maryland, Grand Gedeh, Bong, Sinoe, River Gee, and Grand Bassa) will receive priority (Figure 24); and (b) method mix – to expand the pool of the health workforce with skills to provide long-acting and permanent methods, and emergency contraceptives. Currently, 75.8 percent of health facilities have a provider who has been trained on insertion and removal of implants.[171]

Figure 24: Disparities in Family Planning Service Delivery across Counties



Refresher training – offered after every two years of a training – will also be scheduled so that providers are equipped with up-to-date technical knowledge and guidance. To facilitate this envisioned scaleup, a pool of family planning trainers at national and county levels will be expanded, and equipment for practical training, such as pelvic, arm, and penile models, will be furnished. Furthermore, efforts are already underway to review and consolidate training materials, and this will continue into the first year of this plan, where standardized family planning in-service training curriculums will be produced, and other guidance material such as the family planning handbook and the WHO MEC wheels will be obtained and distributed to health workers.

Supportive supervision and mentorship are key components of health worker capacity building, but have so far been weak mainly due to limited resources and competing priorities. These exercises can also offer an important source of information on the status of health worker performance and working conditions, equipment/supply availability, client feedback, commodity consumption, and service uptake. Hence, biannual family planning supervision visits will be supported and strengthened by updating the family planning

section of the integrated supportive supervision tool, and by developing a standalone family planning supervision tool. The latter tool will allow for an in-depth supportive supervision and mentoring process dedicated to a broad range of family planning matters as well as data collection. District and county supervisors will be oriented to use the family planning supportive supervision tools. Furthermore, the existing UNFPA-supported Annual Supplies survey will be revised to allow data to be collected on client feedback and equipment availability. It is hoped that data from supervision efforts and the surveys will feed into continued quality improvement efforts at the facility, county, and central levels. Finally, annual meetings, involving health/family planning managers at the central and county levels will be held to facilitate discussions on progress and challenges based on supportive supervision findings and other data to inform future programming.

Intervention Strategy: Bolster family planning preservice education for the clinical health workforce

Family planning training through preservice education offers the promise of reducing costs for in-service training by ensuring students are adequately skilled to deliver quality services upon graduation. Under this plan, efforts will continue to strengthen preservice education curricula for key preservice institutions, including medical, nursing, and midwifery schools. Recently, the curricula for registered and certified midwives was enriched with maternal health and family planning content through working with their respective professional boards. This effort will extend to the medical and nursing schools to cover physicians, physician assistants, and nurses by working through professional boards and individual training institutions to review and update curricula and training resources. Furthermore, family planning knowledge/skills of preservice tutors will be enhanced to ensure that they can deliver the updated content.

Intervention Strategy: Explore feasibility of task-sharing opportunities to expand access to surgical sterilization services.

Task sharing – the process of enabling lay and midlevel healthcare professionals, such as nurses, midwives, clinical officers, and community health workers to provide clinical tasks and procedures safely that would otherwise be restricted to higher level cadres – can be a vital strategy in overcoming the shortage of doctors. In accordance with the 2012 WHO "Optimise4MNH" task-shifting guidance,[172] Liberia intends to explore the feasibility of the provision of tubal ligation and vasectomy services by physician assistants. This will involve dialogue with respective professional boards on the current needs for enhancing coverage of sterilization services, and review of WHO recommendations and other technical resources. Further, a core group of stakeholders, including decision makers, will undertake a study tour to countries where clinical officers (i.e., PAs), midwives, and nurses perform tubal ligation and non-scalpel vasectomy under local anesthetic (e.g., Uganda, Malawi, or Ethiopia) and generate practical recommendations for the introducing the interventions in Liberia. Following, an operations research study will be conducted to assess feasibility, safety, and effectiveness in addressing unmet needs for surgical sterilization. Finally, findings from the study will inform policy decisions.

SD1.2. Family planning services offered through CHAs expanded and strengthened

Intervention Strategy: Strengthen family planning provision through CHAs.

Extending family planning services through the CHA platform is a fundamental intervention to facilitate contraceptive uptake, especially among those who are underserved by the current facility-based network. More women are increasingly reporting to access contraceptives through CHAs – 0.4 percent and 4.2 percent in 2013 and 2016, respectively.[173,174] Liberia is halfway to achieving its target of 4,100 CHAs trained and deployed by 2022.[175] Alongside this scaleup is family planning service delivery extension to communities. Existing bottlenecks will be addressed by engaging and support the CHSS to ensure commodity security at community level, adherence to service standards, referral strengthening, and integration of CBIS reports into SDP reporting systems.

Intervention Strategy: Broaden the method mix offered by CHAs.

This plan aims to effectively leverage the CHA platform by expanding the method mix offered by CHAs to include injectables, emergency contraceptives, and CycleBeads. Building on two local studies that showed that CHW provision of injectables was feasible and safe, FHD will work the Community Health Department (CHD) to assess provision of a subcutaneous injectable, e.g., Sayana Press, through the CHA platform with the purpose of informing national program design and policy. As policy decisions are made to allow broadening of the method mix, content will be integrated in the CHA training curriculum (or an addendum will be created).

SD1.3. Clinical outreach services scaled and sustained to improve availability of and access to quality family planning services, particularly for underserved communities

Intervention Strategy: Scale and sustain clinical outreach in areas with poor access to health facilities.

With a considerable proportion of the population either living more than 5 km from a health facility, or in areas with few skilled providers, scaling and sustaining clinical outreach will be needed to meet the needs of the underserved. Efforts under this plan will build on successes and lessons learned with conducting contraceptive days, and strengthen weak points of this intervention, such as poor coordination and planning and insufficient community mobilization. An Outreach Taskforce/Committee – composed of stakeholders involved in outreach activities – will be established to facilitate coordination, planning, and optimal use of resources among partners, and to establish quality standards for outreach. Considering limited resources, better targeting of outreach activities will be necessary; hence the degree of outreach events will vary according to need – intense outreach efforts (i.e., four times a year per district) will be directed to counties with most need, while other counties will receive outreach efforts at a lesser degree, i.e., once or twice a year. For example, counties such as Gbarpolu, Sinoe, Grand Kru, Bong, and Rivercess, which exhibit poor access to care (the percent of individuals living within 5 km of a health facility is 32 to 61 percent), a high demand and low demand satisfied, will be part of tier-one counties receiving intense outreach efforts.

Whilst the proposed outreach efforts are necessary to accelerate contraceptive uptake, they are prone to fluctuate and be unsustainable given reliance on intermittent project funding. Hence, efforts will be made to facilitate longer term outreach events by strengthening

routine outreach efforts that are supposed to be (but generally are not due to lack of resources) carried out by health facilities.

SD1.4. Integration of family planning with other health services, particularly RMNCAH and HIV/AIDS services, strengthened and scaled

Intervention Strategy: Establish national operational guidance and standards on integration

Effective integration of family planning into other services often requires adjusting elements of the process and structure of the "base" service. Depending on the integration model adopted, these include elements such as the need to change data forms to capture family planning client data, revise roles/tasks of, and train health providers, equipping base services with promotional materials, among others. Clearly defining what can be integrated, how, and who is involved at each step is necessary operational guidance that will be developed to be followed by all stakeholders supporting integration efforts. This guidance will follow both lessons learned at country level and available global recommendations and will cover family planning integration in the entire span of RMNCAH and HIV/AIDS services. Based on this guidance, adjustments will be made to relevant HMIS/CBIS data collection forms and supervision tools.

Intervention Strategy: Offer postpartum family planning across a continuum

Preventing unintended, closely spaced pregnancies through the first 12 months following childbirth is a priority, given the high unmet need (82 percent) for contraceptive services during this period.[176] Small-scale pilots have already established that some models – Family Planning integration into the Expanded Program for Immunization (FP/EPI) and PPIUCD insertion – are feasible, increase contraceptive uptake among postpartum women, and hold potential to reduce unintended pregnancies among this population group when programmatic challenges are addressed.[177] Thus, under this plan the focus will be to strengthen and scale FP/EPI and PPIUCD services. CHAs will be an important conduit of information to women in the community, so as health workers who are offering antenatal care (ANC) services. The goal for this intervention is to mainstream family planning services so they are part of existing maternal and child health services, and not to establish standalone modalities. As such, the program will pursue opportunities to enrich training curriculums, service protocols, and job aids of health workers in ANC, postnatal care (PNC), and immunization/child health services. It will also furnish these service sites with essential IEC materials. It is envisioned that at a minimum, these health workers should provide information and facilitate intra-facility referrals for women with unmet need for family planning services.

Family planning service sites will also be strengthened to ensure quality provision of PPFP services. As the family planning training curriculum, service protocols, and job aids are currently being reviewed, updates will also include comprehensive coverage of PPFP knowledge and skills. Lack of equipment has been one of the deterrents to offer PPIUCD services, and under this plan, the mandate of the RHSC subcommittee will be expanded to include procurement of essential supplies and equipment for family planning service delivery. Further, the program will pursue the immunization platform to explore opportunities to hold joint outreach efforts as means to reduce efforts and reach postpartum women.

Intervention Strategy: Leverage the HIV/AIDS services platform to increase reach of family planning information and services

The HIV/AIDS platform will offer a good opportunity to promote dual protection and dual method use messaging at scale and reach youth (in school and out of school) as well as key vulnerable populations (female sex workers) who may have an unmet need for contraception. Under this plan, the program will strengthen ties with the National AIDS Control Program (NACP) to boost general HIV prevention and, specifically, condom promotion messages to incorporate information on dual protection. For example, continuous, consistent, and correct use of condoms is necessary for both pregnancy and HIV/AIDS prevention; but because some clients think that if both partners test negative on routine tests, then they can forgo using condoms, messaging around continued use of condoms or adoption of an alternative contraceptive method to prevent an unintended pregnancy should be reflected in HIV promotions.

While reducing new HIV infections by 50 percent among the general population, particularly young women, is a goal for the NACP, the high teenage pregnancy rates are an indication that youth are having unprotected sex, putting them at risk of HIV/AIDS infection. As such, the program will also advocate for the inclusion of teenage pregnancies as an indicator in HIV/AIDS programs with the aim to better leverage joint action toward dual protection messaging, and scaling family planning information to youth and key vulnerable populations.

SD1.5. Increased uptake of quality family planning services through the private sector

Intervention Strategy: Strengthen and expand quality provision of family planning services across private sector networks.

Ever since the inception of contraceptive services in Liberia, the MOH has been collaborating with the private sector to expand family planning service delivery. The private sector is a heterogeneous mix of platforms with varying contexts, needs, and challenges. Here they are categorized as the nonprofit, nonreligious; faith-based organization nonprofit; and commercial for-profit. For those willing nongovernmental institutions that are not for profit, the MOH has been supplying commodities free of charge with the understanding that they will be supplied to users free of charge. Under this plan, the program intends to resolve some fundamental bottlenecks faced by this sector. For example, it will extend capacity building efforts, including training and supportive supervision and furnishing IEC materials, to this sector. Policy issues related to fee for service, and other matters specific to private sector provision, will be addressed in the family planning policy guidance to be developed under this plan.

Some faith-based organizations (FBOs) do not support provision of family planning services on religious grounds; however, some support natural family planning (NFP). Fertility awareness methods (FAM), including standard days method (SDM), and the lactational amenorrhea method (LAM) are culturally appropriate and consistent with religious beliefs favoring NFP. Since FAMs are easy to offer and can be provided by non-clinically-trained staff, particularly CHWs and religious leaders, under this plan efforts will be made to reach out to FBOs to advocate for the provision of NFPs. Furthermore, since CycleBeads are now increasingly being procured, efforts will be made to supply willing FBOs with this method and other IEC materials to educate their members.

<u>Intervention Strategy:</u> Explore potential for enhanced engagement of drug stores, pharmacies, and wholesale distributors/suppliers in contraceptive sales

The commercial for-profit private sector has additional challenges that this plan intends to further understand and address. Policy, industry, and market conditions for commercial, for-profit private health services – and particularly for subsidized preventive services such as family planning – are suboptimal. Nevertheless, the commercial sector is a notable source for family planning services, especially in the urban areas. While it is uncertain whether the private sector is a viable platform for expanding access to family planning services in the near future, certain types of private sector facilities are growing in popularity, including private hospitals and drug shops. The MOH has the mandate and responsibility to ensure all citizens, regardless of their preferred source of method, receive quality services. As such, under this plan, the program intends to extensively reach out to private sector stakeholders across the value chain (i.e., wholesalers and distributions, retailors, associations) to understand barriers and facilitators for expanding availability of contraceptive services through the commercial private sector. For example, the program intends to understand the extent to which wholesalers procure and supply a range of contraceptive commodities, and the associated challenges and barriers. Furthermore, the program acknowledges that drug shops and pharmacies are popular sources of condoms and ECs. Therefore, efforts will be directed toward ensuring these methods are being provided as per national quality standards. A demonstration project will be piloted in Monrovia, where drug shops are mostly located, to assess the potential of using drug shops to increase access to these methods.

COMMODITY SECURITY

OUTCOME 2: The percentage of facilities with no stockouts of modern contraceptives in the last three months increased from 33.8 percent to 75 percent by 2022.

Whereas commodity security has gradually improved both at both ends of the supply chain, stockouts persist. Improvements downstream are complex to achieve and require system-level interventions beyond the purview of the family planning program. Liberia has several plans to address the supply chain system to address stockouts, including the National Investment Plan for a Resilient Health System, 2016–2021 (Goal: 95 percent of health facilities have no stockouts of tracer drugs); the SCMP (Goal: To reform the health sector to efficiently deliver quality health and social welfare services to the people of Liberia. We are dedicated to equitable, accessible and sustainable health promotion and protection and the provision of comprehensive and affordable health care and social welfare services.); and the RMNCAH Investment Case.

Planned interventions, therefore, aim to complement and build upon existing efforts to support a continuous and uninterrupted supply of a wide range of contraceptive commodities offered through public and private facilities to meets client's needs by: (a) supporting procurement of adequate commodities in line with country needs; and (b) augment existing efforts to support an effective and efficient functioning of the supply chain system, particularly for family planning commodities, equipment, and supplies.

A summary of key outputs, and associated performance targets, contributing to this outcome are summarized in Table 12. The estimated total amount of resources required to deliver on the outputs during the five-year period is US$12,675,355. This includes both the

cost of commodities and consumbles, as well as programs to improve the supply chain through which they reach the end users.

Table 12: Commodity Security Results and Performance Targets

Outputs and Cost (USD)	Performance Targets		
	Indicator	**Baseline**	**Target**
CS2.1. Adequate contraceptive commodities and supplies are procured to cover all country needs (in accordance with annual contraceptive tables) to meet the CPR goal by 2022 **Cost:** $11,556,064	Percentage of annual commodity budget requirements funded as per the annual CPT tables	51[178]	100
CS2.2. Improved supply chain management system for family planning commodities **Cost:** $1,119,291	Percentage of commodity deliveries conducted by Central Medicine Store (CMS) from central to the county depots	50[179]	100
	Forecast accuracy	N/A	70
	Service delivery point (SDP) reporting rate through the Logistics Management Information System (LMIS)	83.7[180]	90

Strategy Description

CS2.1. Adequate contraceptive commodities and supplies are procured to cover all country needs (in accordance with annual contraceptive tables) to meet the CPR goal by 2022.

Intervention Strategy: Service delivery points are furnished with a broad range of commodities, essential equipment and supplies to ensure quality provision of family planning services as per standards

Full financing of commodities, together with ensuring coordinated and timely procurement and shipments, will remain a priority under this plan to ensure that there are adequate commodities to meet program needs. While in the past the focus has been primarily on commodities, essential equipment and supplies will also be included in procurement plans. The projected annual volume of contraceptive commodities to meet the needs of a population of women of reproductive age (WRA) (married and unmarried) is shown in Table 5. These estimates will be updated annually during quantification exercises and shared with government and development partners to inform actual procurement. Furthermore, the CMS will be supported to conduct quarterly commodity distribution to the county depot, and for last-mile distribution of family planning commodities (from county to facilities) to complement existing resources, particularly in emergency situations.

CS2.2. Improved supply chain management system for family planning commodities

Intervention Strategy: SCMU capacity building

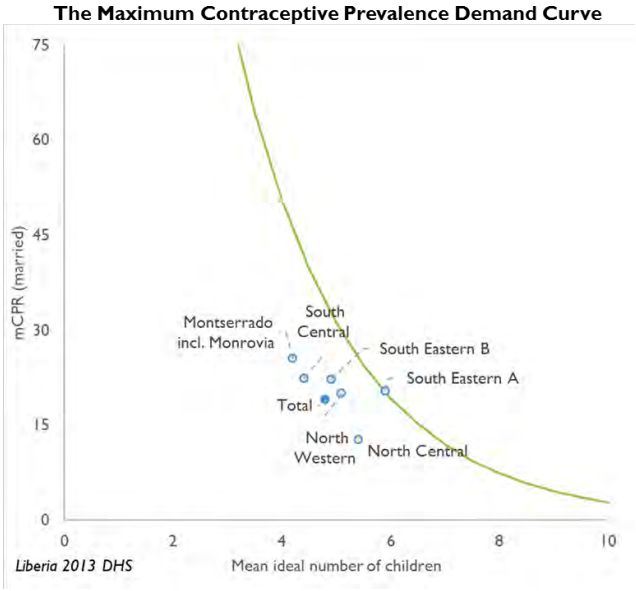
While the challenges related to the supply chain system are vast and beyond the auspices of the family planning program to fully address, this plan intends to intervene with the pervasive stockout problem of contraceptives that cripples the functioning of the family planning program. Specific activities include: (i) enabling the SCMU, through the National family planning F&Q committee, to conduct joint, systematic, and data-driven forecasting and quantification exercises and reviews, i.e., three-year forecasting, annual quantification, quarterly quantification reviews, and supply plans monitoring; (ii) improving coordination of commodity security stakeholders through consistent convening of the RHSC subcommittee, and a review/revision of the subcommittee terms of reference to ensure alignment with plans to resolve key supply chain issues; (iii) strengthening the capacity of providers (family planning providers, focal points, and facility in-charges) to use the LMIS tools; and (iv) conducting joint supportive supervision and mentoring visits to perform inventory checks at both the central and county levels on a monthly and quarterly basis. The plan is to support supervision in at least four counties each year.

DEMAND GENERATION

OUTCOME 3: The percentage of women and men of reproductive age demanding family planning services increases from 49.5 percent in 2013 to 55.5 percent by 2022.

The demand curve (Figure 25) shows that in general, a considerable gap between demand and use exists, and that additional growth in mCPR can be realized without changes in demand.[181] However, since there is notable variability in demand and fertility preferences across geographical regions, tailored demand-generation activities are needed to address the observed inequitable growth in mCPR across different regions. Furthermore, disparities in awareness of different methods, limited exposure to promotion messages through mass media, especially among rural populations, and deep-rooted myths and misconceptions mean that demand generation is necessary to enhance individuals' self-efficacy to adopt and sustain contraceptive use. Interventions aimed at creating new demand, however, will take into consideration the fact that among those who do not intend to use contraceptives in the future, only a small proportion (14 percent) do so because of a lack of knowledge; almost a third (32 percent) oppose contraceptives due to fear of side effects and health concerns, and 18 percent face opposition due to several reasons, including self or spousal opposition, and religious factors.[182]

Figure 25: Demand Curve



Planned interventions aim to increase demand for contraceptive uptake among women and men of reproductive age, including adolescents and youth by (a) enhancing reach and exposure levels of family planning messages, through an expanded platform of media

channels, tailored to different audiences, and implemented consistently over time; and (b) nurturing a conducive environment to reduce barriers for contraceptive adoption at the family level, community level (e.g., peers, relatives, teachers, community or faith-based leaders), national/regional level (e.g., policymakers, media personnel, government leaders).

A summary of key outputs, and associated performance targets, contributing to this outcome are summarized in Table 13. The estimated total amount of resources required to deliver the outputs during the five-year period is US$6,496,860.

Table 13: Demand Generation Results and Performance Targets

Outputs and Cost (USD)	Performance Targets		
	Indicator	**Baseline (%)**	**Target (%)**
DG3.1. People have accurate knowledge and self-efficacy to adopt a positive behavioral change to practice family planning **Cost:** $1,157,889	Percentage of currently married or in union women who are not currently using a contraceptive method who intend to use a method later [DHS]	45.9	70
	Percentage of women ages 15–49 years reporting no exposure to family planning messages on radio, television, or print in past 12 months [DHS]	23	10
	Percentage of women who know about IUDs, lactational amenorrhea method, emergency contraceptives, and female and male sterilization	IUD: 43.5 LAM: 7.8 ECs: 28.7 Female Condoms: 69.3 Female Sterilization: 42.1 Vasectomy: 19.9	IUD: 80 LAM: 30 ECs: 75 Female Condoms: 85 Female Sterilization: 60 Vasectomy: 30
DG3.2. Positive shifts in social norms and attitudes to foster healthier and more behaviors around contraception **Cost:** $5,338,972	Percentage of currently married or in-union women not using a contraceptive method and not intending to use in the future due to opposition (self, spousal, religious, etc.)	51	30
	Percentage of modern contraceptive method use requiring male cooperation – male condoms, vasectomy, (DHS)	1.0	1.39

Strategy Description

DG3.1. People have accurate knowledge and self-efficacy to adopt a positive behavioral change to practice family planning

<u>Intervention Strategy:</u> A sustained, comprehensive and targeted family planning social and behavior change campaign implemented at scale

Building upon the National Health Communication Strategy (NHCS) 2016-2021, the program will work through the Materials and Message Development (MMD) committee to develop comprehensive guidance for family planning SBC campaigns. The NHCS has already identified priority and influencing audiences, including women of reproductive age, postpartum women, adolescent males and females, men, providers, and community/religious/political leaders. The family planning SBCC guidance will expand and tailor specific messages for each of these audiences. It will also include a channel mix strategy/plan for each audience to describe the optimal blend of communication channels to best reach them. Further, it will include creative briefs to guide the development of materials for different media channels, such as scripts for radio and TV, social media, and print media, among others. Finally, the guidance document will include an annual action plan to drive coordinated and concerted efforts across different family planning projects. It is envisioned that the program will seek expertise from a local media company to develop creative materials in the local dialect, such as radio and television spots and radio dramas. There are ongoing efforts to develop family planning IEC messages and print materials in local dialect for use by CHAs, and hence the program will expand on this effort to generate print materials for other audiences (priority and influencers).

A host of media events will promote awareness and acceptability of family planning, as well as address common myths and misconceptions and challenge social norms. These include airing radio jingles and serial drama on national and regional media, holding public dialogues on radio, strategically airing television advertisements during peak hours, and disseminating print materials at strategic areas. The key will be to run a targeted campaign(s) in a consistent manner, and with extensive reach. Resources are expected to be a limiting factor to enable comprehensive campaigns at scale over time; as such, there will be efforts to rationalize resources, for example through use of regional media, which tend to be cheaper than national media and pulling resources from various projects to gain economies of scale. Lastly, there will be efforts to advocate to counties to allocate resources for SBCC activities in their own planning.

The program also intends to leverage the growing use of mobile phones in the country. According to the Liberian Telecommunications Authority, at least 75.7 percent of Liberians were using a mobile phone in 2016, and at least 62.6 percent of households own a mobile phone.[183] Given the availability of global family planning text messages tested in multi-country settings, Liberia will adapt existing messages to suit the country context. Furthermore, there will be negotiations with mobile network operators (MNOs) to incorporate these messages as part of their value-added service for free or aired at a discounted price. This will allow the service to be sustained over time. Currently, MNOs offer a range of information via text messaging at a small fee.

<u>Intervention Strategy:</u> Bolster family planning promotion and communication, including interpersonal communication/client-provider communication, at facility level (in-service and preservice)

Strengthening interpersonal communication efforts will be conducted to improve provider attitudes to promote unbiased and nonjudgmental communication and ensure a rights-based approach to family planning service delivery. The process of strengthening client-provider communication will be mainstreamed through ongoing efforts to develop a

standardized family planning in-service training curriculum (refer to Output SD1.1). Mechanisms to gather client feedback to inform further improvements will also be implemented, as described under Output SD1.1.

DG3.2. Positive shifts in social norms and attitudes to foster adoption and sustained use of contraceptives

Intervention Strategy: Community mobilization

Community mobilization efforts will work with and through community groups to influence social norms and individual behaviors. Opposition to use is a notable barrier to contraceptive adoption and is influenced by a multitude of factors, including cultural, gender, and social norms; religious beliefs; and family power dynamics; among others. Myths and misconceptions serve to worsen and propagate opposition to use. The program intends to leverage community health volunteers (CHVs) and CHAs to conduct community dialogues and dramas about gender, sexuality, healthy sexual relationships, and family planning. The connection between family planning and maternal mortality, teenage pregnancy, and household economic welfare will be established. Further, the program intends to carry out interactive public dialogues on regional radio (as described under Output DG3.1).

Intervention Strategy: Engage champions to stimulate social change in communities

Champions will be identified, mobilized, and supported to catalyze attention to family planning in their communities. Efforts will be made to engage men, religious and cultural leaders, parents of teenagers, and youth in their own communities to remove barriers to use and improve acceptance. Role models (for example, satisfied users in the community) will also promote family planning and challenge norms. The program will develop guidelines and orientation packages to systematically identify and train champions; it will also develop tools to for their use. CHTs will orient champions in the community and family planning advocacy working groups will be established at county level to support coordination and coalition building around common issues facing communities.

Intervention Strategy: Engage faith-based leaders/organizations to understand, accept, and support the provision of family planning at community level

By virtue of their influence and reach, faith-based leaders/organizations are uniquely positioned to educate and encourage their congregation to practice family planning, particularly healthy timing and spacing of pregnancies (HTSP), as means to achieve individual and family wellbeing. According to the 2007 LDHS, religious beliefs were reported by at least 4 percent of women as a reason they do not intend to use a contraceptive method in the future.[184]

The program intends to actively reach out to faith-based leaders to gain their support and acceptance for family planning – efforts will focus on understanding of the concept of family planning in the context of religious doctrine (i.e., Bible and Qur'an), and the role of the faith community to engender the wellbeing of mothers, children, and families as whole. The program will also support willing faith-based leaders to disseminate accurate information, and demystify myths and misconceptions surrounding family planning through their existing platforms, such as mission-supported health facilities, as well as marriage counseling and fellowship meetings for youth, men, and women. Activities will also include adapting global guidance documents to equip religious leaders with information and skills to better

communicate family planning messages in the context of their religious beliefs. Finally, the program will leverage the FBO health service network to provide family planning services appropriate to their context, e.g., by recognizing distinct levels of acceptance by different religious denominations and building on successes such as a decision by the United Methodist Church to offer a full range of contraceptive methods.[185]

Furthermore, the program is currently procuring CycleBeads, a modern NFP method that is acceptable in the context of Christian and Muslim religious beliefs, and hence will support procurement and distribution of these commodities to interested FBOs. Finally, efforts will be made to conduct outreach to faith-based institutions (churches) to educate and provide family planning methods.

Intervention Strategy: Engage and empower males and boys to (i) support their partners (enabler) and (ii) use modern contraceptives

Male involvement is an important intervention under this plan to support boys and men as clients of FP/RH services themselves, as supportive partners for women's use of contraceptives, and as agents of change within the community. The program aims to mainstream male involvement in all aspects of the program. To increase the capacity of health providers to be responsive to the needs of men, the training curriculum will incorporate rights-based approaches and specific male involvement strategies in clinical settings (Output SD1.1); the pool of providers skilled to provide vasectomy services will be increased (Output SD1.1); and demand-generation activities will include males/boys as a priority and influencing audience and as champions and role models. The program will also improve the capacity of family planning managers and supervisors at central and county levels to develop family planning, gender, and other strategies that engage men.

YOUTH

OUTCOME 4: Young people, ages 10–24 years, have increased access to, and use, family planning information and services.

Of the estimated 381,000 women of reproductive age that need to be served by the family planning program by 2022, 40 percent are between ages 15 and 24.[186] This, coupled by the pervasively high teenage pregnancy rate, makes empowering young people to use family planning services, including creating a conducive environment, of paramount importance. Past efforts have focused on use of peer educators for awareness raising and demand generation, and standalone youth centers or youth corners in health facilities as key service delivery points. However, global evidence shows mixed results on the effectiveness of this approach, and limited scale and sustainability related to financial and human resource constraints. Thus, under this plan, the strategy to provide youth-friendly services will shift from standalone youth centers to facility-based provision and elevate youth as a priority audience in mainstream social and behavioral change efforts. Family and societal factors that infringe on the ability of youth, and particularly adolescents, to use family planning services will also be addressed. Further, this plan recognizes the need to elevate efforts to curb teenage pregnancy from being solely a health sector response, to a holistic multisectoral response. This plan intends to champion a heightened multisectoral approach to teenage pregnancy reduction and invigorate high-level attention to the matter.

A summary of key outputs, and associated performance targets contributing to this outcome are summarized in 14. The estimated total resources required to deliver the outputs during the five-year period is US$8,470,425.

Table 14: Youth Results and Performance Targets

Outputs and Cost (USD)	Performance Targets		
	Indicator	**Baseline**	**Target**
Y4.1. Existing facility-based service delivery points offer family planning services that meet youth-friendly standards to facilitate access and use by young people **Cost:** $6,792,955	Percentage of demand for family planning satisfied by modern methods among women ages 15-19 and 20-24 *(Source: LDHS)*	15-19: 36.1% 20-24: 43.3%	15-19: 55% 20-24: 70%
	Number of family planning users per month among women ages 10-14, 15-19, and 20-24 *(Source: Service Statistics)*		Increasing trend over time
Y4.2. Existing youth centers operated by MOYS continue to offer contraceptive information and services **Cost:** $69,029	The extent by which established youth centers offering family planning information and services	Five youth centers offering family planning information and services	Five youth centers offering family planning information and services
Y4.3. Parents, guardians (including teachers and principals), and community members understand and are increasingly supportive on matters related to adolescent sexuality, teen pregnancy, and contraceptive services **Cost:** $220,766	Percentage of demand for family planning satisfied by modern methods among women ages 15-19 and 20-24 *(Source: LDHS)*	15-19: 36.1% 20-24: 43.3%	15-19: 55% 20-24: 70%
Y4.4. Relevant, age-appropriate, multimedia behavior change communication efforts tailored to young people designed and implemented **Cost:** $0 (*activities included under Demand Technical Area)*	Extent of SBCC materials produced specifically targeting young people		Demonstrated evidence of SBCC materials produced targeting young people
Y4.5. A multisectoral approach to support holistic programming aimed at teenage pregnancy reduction is strengthened **Cost:** $935,019	Extent by which teenage pregnancy reduction approaches are reflected in non-health sector policies, plans, and programs	N/A	Demonstrated evidence of teenage pregnancy reduction approaches in non-health sector policies, plans, and programs

Outputs and Cost (USD)	Performance Targets		
	Indicator	Baseline	Target
Y4.6. Increase political prominence of teenage pregnancy issues **Cost:** $268,680	Extent to which teenage pregnancies matters are acknowledged in public speeches by senior GOL officials	N/A	Demonstrated evidence of public speeches by senior GOL officials acknowledging teenage pregnancies matters
Y4.7. Data generated and used to inform decisions for ASRH **Cost:** $183,976	Extent to which data from research and routine health information systems is used to inform teenage pregnancy reduction efforts	N/A	Demonstrated evidence on use of data from research and routine health information systems to inform teenage pregnancy reduction efforts

Strategy Description

Y4.1. Existing facility-based service delivery points offer family planning services that meet youth-friendly standards to facilitate access and use by young people

Intervention Strategy: Mainstream youth-friendly service delivery into existing health services (at all levels) at scale

Under this plan, an YFS approach to routine family planning service delivery will be strengthened to address challenges that limit access by youth, first by assessing facility service readiness to understand existing gaps in meeting YFS standards.

Second, using information generated from the assessment, the CHT leadership will be consulted with the aim of securing buy-in for mainstreaming YFS into existing facilities. Operational recommendations elicited by the CHT for implementation of the approach will inform the design of the intervention to ensure adherence to YFS standards. For example, it is anticipated that facilities will need to operate for extended working hours to accommodate youth, and some refurbishment may be done to ensure privacy. Similarly, central and county level leadership of the CHA program, as well as implementing stakeholders, will be consulted on the same. Third, support will be provided to counties to include YFS activities in annual county action plans. Fourth, the in-service training curriculum, service protocols, and job aids for facility providers and CHAs will be reviewed and revised to ensure optimal alignment with YFS principles and standards, including to ensure they reflect rights-based principles. Similarly, updates to the preservice curriculum (Output SD1.1) will ensure inclusion of YFS approaches, principles, and standards. Fifth, providers' technical competency to provide youth-friendly family planning services will be improved, and supportive supervision and mentorship will enable continued improvement while facilities work to adopt YFS principles and standards. Sixth, the program will support finalization, printing, and dissemination of the ASRH strategy, counseling cards and job aids that are currently in development. Finally, facilities that adhere to YFS standards will be promoted to youth through multiple means, including posters, flyers, and facility directories in areas where youth congregate. A mobile texting service will disseminate family planning

information to youth; it will include a searchable directory of facilities that offer youth-friendly services.

Y4.2. Existing youth centers operated by MOYS continue to offer contraceptive information and services

Intervention Strategy: Support and scale provision of youth-friendly information and services (provided via outreach by facility staff) to MOYS-supported youth centers

While under this plan, the strategy to providing youth-friendly services is shifting from youth centers to facility-based provision, this plan will continue to support MOYS-operated youth centers to provide family planning information and services. The MOYS operates nine youth centers, and the family planning program will: (i) recruit and orient suitable peers who are members of existing youth centers to be the conduit of family planning information within the youth center and in the community and mobilize youth to use services; and (ii) liaise with facilities to support outreach of family planning staff from nearby facilities to the youth centers to provide family planning services at least once a month.

Y4.3. Parents, guardians (including teachers and principals), and communities understand and are increasingly supportive on matters related to adolescent sexuality, teen pregnancy, and contraceptive services

Intervention Strategy: Open dialogue on adolescent/youth sexuality and teenage pregnancy prevention matters via multiple channels to sensitize, raise awareness, and build a supportive environment for contraceptive uptake among young people

Parents, guardians (including teachers and principals), and the communities are key influencers for use of family planning services by youth. Hence, this plan intends to reach and sensitize them to support a conducive environment for youth to use family planning services. The program will organize and hold youth-led intergenerational public dialogues on radio and community platforms on adolescent/youth sexuality and teenage pregnancies with parents, young people, religious and traditional leaders, and ASRH experts.

Y4.4. Relevant, age-appropriate, multimedia behavior change communication efforts tailored to young people designed and implemented

Intervention Strategy: Conduct an SBCC campaign focusing on pregnancy prevention among different youth segments

Youth will be one of the priority audiences for the SBC efforts already described under Output DG3.1. Different segments of youth will be considered, including in- and out-of-school youth, as well as married and unmarried youth, among others.

Y4.5. A multisectoral approach to support a holistic programming toward teenage pregnancy reduction is strengthened

Intervention Strategy: Adopt and sustain a multisectoral approach to holistically address teenage pregnancies

Teenage pregnancy reduction efforts require a multi-sectoral approach to address the multiple dimensions that put a teenager at risk of an unintended pregnancy, at individual, family and community level. A move toward a multisectoral approach will require engagement of stakeholders from diverse sectors at the national level, including the MOH,

MOE, MOYS, MOG, MOIA, MOF, and civil society. All will be mobilized and engaged to systematically address the teenage pregnancy issue, with clear articulation of roles and contribution of each sector under updated terms of reference. The National Youth Steering Committee (NYSC), chaired by MOYS, will serve as the coordinating platform for all sectors on the teenage pregnancy reduction agenda. Currently, Liberia is reviewing and updating the School Health Policy, and appropriate interventions for pregnancy prevention will be integrated into this multisectoral platform.

Intervention Strategy: Support scientifically accurate and comprehensive sexuality education (CSE) programs within and out of schools

The program takes two approaches for reaching in- and out-of-school youth. Currently, efforts are underway to develop a CSE manual for the out-of-school program. This will be finalized, validated, and printed in the first year. CSOs and NGOs working with youth will be oriented and supported to integrate the manual in their work. Efforts directed at in-school youth will include: (i) a review of the national teaching curricular for primary and secondary schools to identify gaps and opportunities to integrate CSE; (ii) engagement of the MOE to discuss identified gaps and sensitize them on CSE principles; and (iii) a review and revision of the teacher training curriculum based on identified gaps and consensus with MOE on changes that should be made. The revised integrated curriculum will be piloted in a sample of school, and based on the pilot, the curriculum will be rolled out to the Teachers Training Institute (TTI) for national scaleup.

Y4.6. Increase political prominence of teenage pregnancy issues

Intervention Strategy: Advocacy to enhance visibility and attention of teenage pregnancy issue on health and economic agendas

Elevating the dire problem of teenage pregnancies in the country will help to mobilize various stakeholders toward a holistic response to the matter. This plan will strengthen the evidence base to support advocacy specifically targeting teenage pregnancy reduction. Advocacy efforts will aim to sensitize high-level policymakers, community and faith-based leaders, and the House of Representatives, particularly leveraging the demographic dividend (DD) agenda and Vision 2030. Further, youth-focused CSOs will be engaged and empowered to advocate for teenage pregnancy reduction.

Y4.7. Data generated and used to inform decisions for ASRH

Intervention Strategy: Data for Decision-Making

The DHIS-2 forms were recently amended to include disaggregation of family planning service statistics by age; changes also included tracking of family planning use among teenagers ages 10-14 years. Rollout of the revised forms to the facility level is also ongoing. Under this plan, we will support use of the disaggregated service statistics data in programmatic decision-making. For example, review of disaggregated service statistics will be featured in annual data consensus meetings, among other review platforms. Further, this plan aims to advance the local evidence base for tackling adolescent pregnancy issues. Research institutions will be engaged to conduct sound studies on priority research questions, including for example, the extent and impact of abortions among teenagers, the cost effectiveness of different approaches, e.g., youth centers vs. facility mainstreaming.

ENABLING ENVIRONMENT

The enabling environment thematic area has three outcomes, each described separately below.

OUTCOME 5: Adequate and sustainable financial resources mobilized from various sources to fulfill requirements of the family planning program.

An enhanced level of financial resources is required to advance planned interventions, and scale and sustain quality service provision. Liberia plans to strengthen mechanisms for mobilizing resources to finance the family planning program and services. While this plan provides cost estimates for programmatic interventions for the next five years, recurrent expenditures for service provision (for example, recurrent wage and nonwage expenditures) are not included. Interventions described in this plan take into consideration the need to secure diverse and sustainable sources of financing for both recurrent and development expenditures. Traditional sources include the public sector, OOP, and development partners; and new sources for exploration include coverage through health insurance, private sector, and other innovative solutions. The public sector has committed to achieve an allocation level of 5 percent of the health budget to family planning by 2020; based on the FY2017/2018 budget and projections, this represents an amount of US$3.6 million and US$3.8million in FY 2018/2019 and FY 2019/2020, respectively, out of the total health sector projected budgets.[187] In FY2016/2017, about US$100,000 was allocated for family planning supplies but was not disbursed.[188]

Planned interventions aim to elevate the resource envelope available for the family planning program by: mobilizing resources from diverse sources of traditional and new funders (the government and development partners), and working toward establishing sustainable sources of family planning financing.

A summary of key outputs and associated performance targets contributing to this outcome are summarized in Table 15. The estimated total amount of resources required to deliver on the outputs during the five-year period is US$344,807.

Table 15: Enabling Environment I Results and Performance Targets

Outputs and Cost (USD)	Performance Targets		
	Indicator	**Baseline**	**Target**
EE5.1. Capacity for conducting effective advocacy for family planning enhanced **Cost:** $120,071	Number of local CSOs engaging in advocacy for resource mobilization or policy matters	0	17
EE5.2. At least 5 percent of the GOL annual health budget allocated to family planning commodities and services by 2021, in line with the country's FP2020 commitment **Cost:** $213,395	Percent of the annual total health expenditures (THE) allocated to family planning commodities and services	0.25%*	5%
	Percentage of the annual commodity forecasts funded by the GOL	0%	5%

Outputs and Cost (USD)	Performance Targets		
	Indicator	Baseline	Target
EE5.3. Increased nongovernmental resources mobilized (i.e., foreign/domestic donors) **Cost:** $4,577	Increased number of development partners invested in family planning activities	4 – USAID, UNFPA, Swiss Aid, World Bank	13 – USAID, UNFPA, Swiss Aid, World Bank EU, JICA, Canada, WHO, China Aid, SIDA, Norway, Irish Aid, DFID
EE5.4. Opportunities for domestic resource mobilization for family planning explored and pursued **Cost:** $6,765	Number of private health insurance schemes include coverage of family planning services	0	10%

** Based on FY2017/2018 Government Budget*

Strategy Description

EE5.1. Capacity to conduct effective advocacy for family planning enhanced

Intervention Strategy: A tailored and evidence-based advocacy strategy applied

The use of evidence to justify the desired change and demonstrate the potential impact of the change is a best practice when carrying out effective advocacy. Under this plan, efforts will be made to review and strengthen the evidence base for family planning to facilitate advocacy efforts, mobilize resources, and enhance the visibility of family planning in the national agenda.

A landscape assessment will be conducted to gain an in-depth understanding of challenges and opportunities, financing trends, and determine key influencers and decision-makers at various levels. This assessment would build upon other evidence that has been generated. In 2012, a RAPID model was applied and generated projections of the social and economic consequences of rapid population growth for labor, education, and health sectors.[189] In 2016, a case on demographic dividend (DD) was also generated. As part of the development process for this plan, the ImpactNow Model has been applied to project achievements in reduction of maternal and child deaths upon achievement of the mCPR goal by 2022. Building on this work, the impact of family planning on population and development, and specifically on achieving the SDGs, will also be modeled to generate a strong collective investment case for family planning. Further, an interest group analysis exercise will be conducted to understand the position of key players on family planning issues. Based on the data generated, an advocacy strategy will be developed, which will also include key advocacy messages, materials (including advocacy video), and approaches for different target audiences (i.e., MOH senior leadership, Ministry of Finance, House of Representatives, and county leadership).

Intervention Strategy: Strengthen CSO engagement and capacity to support advocacy to increase and sustain political will toward family planning

The capacity of a carefully selected group of CSOs nationwide to conduct advocacy will be strengthened, particularly on areas related to advocacy techniques and how to use the generated evidence base for family planning to conduct targeted advocacy, while applying

materials in the advocacy strategy. Skills to conduct budget advocacy, including budget analysis, would be emphasized. Further, a coalition of CSOs will be established to promote coordination and linkages for family planning advocacy.

EE5.2. At least 5 percent of the GOL annual health budget allocated to family planning commodities and health services by 2021, in line with the country's FP2020 commitment

Intervention Strategy: Advocacy to support enhancing funding allocation and disbursements under the dedicated budget line item for family planning in national budget

The existence of a dedicated budget line item for family planning in the overall MOH budget has been repeatedly shown to facilitate the allocation of government funding to family planning in multiple countries.[190] The government budget has a line item to facilitate consistent allocation and disbursement of funding for family planning commodities. However, the funding allocated is minimal and has not been disbursed in the past three years. Champions from within government structures (including representatives of the Health and Social Welfare committee of the House of Representatives) and women leaders from CSOs, will be mobilized, sensitized, and supported to conduct advocacy to allocate and disburse funds for this budget line item. Sessions with the Planning Department, Health Financing Division (HFD), the Office for Financial Management (OFM), Ministry of Finance & Development Planning (MFDP) and the Health Care and Social Welfare Committee of the House of Representatives will be convened to present an investment case for family planning.

Intervention Strategy: Budget advocacy at county level

Through the ongoing decentralization process, counties are assuming the role of planning, budgeting, and accounting for county-level resources. Advocacy activities targeted at county leaders are needed to ensure allocation of adequate levels of both financial and non-financial resources and support the implementation of family planning services. Efforts will aim to garner county government commitments for resource allocation through several advocacy activities, including: (i) making an investment case for family planning at county level based on data generated under Output EE5.1 to the policymakers, including the county health boards; (ii) sensitizing and supporting civil society members and other county stakeholders to champion resource allocation and disbursements for family planning in annual county health budgets; and (iii) building the capacity of county RH supervisors to advocate for a family planning budget and increase visibility of family planning in county agendas.

Intervention Strategy: Budget Advocacy at the House of Representatives

On an annual basis, representatives from key relevant committees of the House of Representatives will be sensitized on the need for public sector investment in family planning. Key committees will include Health Care and Social Welfare, Gender Equity and Child Development, and Youth and Sport, and Human and Civil Rights. This effort is intended to prepare representatives to justify resource allocations and disbursements for family planning. Data from budget analysis will be presented annually to ascertain the percentage of total health expenditures for family planning and sources of funds.

EE5.3. Resources mobilized from nongovernmental (i.e., foreign/domestic donors) sources increased

Intervention Strategy: Diversify donor base beyond primary development partners

Donors are an important source of funding for the family planning program. Current bilateral family planning donors include USAID, the Swiss, and DFID; and multilateral donors include UNFPA, UNICEF, and the World Bank. UNFPA and USAID contribute the largest share of donor funding. Given the importance of family planning to health and development, and the presence of other donors, efforts will be made to reach and explore opportunities to fund the family planning program. A donor mapping exercise will be conducted to understand priorities and opportunities for funding family planning; and champions will be used to engage the donor group to demonstrate the need for and government commitment to family planning. On an annual basis, roundtables with donors will be convened to advocate for resource mobilization and share progress and funding gaps for the subsequent year.

EE5.4. Opportunities for domestic resource mobilization for family planning explored and pursued

Intervention Strategy: Advocate for coverage of family planning services in existing private health insurance schemes

Private health insurance schemes are gradually increasing coverage of health services, but family planning is usually not covered under standard benefits packages. This effort aims to advocate for expanded coverage of contraceptive services in private health insurance schemes by: (i) conducting an analysis of savings to insurance schemes after covering family planning services (resulting from a potential reduction in maternal health-related expenditures); (ii) sensitizing managers to cover family planning services; and (ii) encouraging large employers to include family planning in their health plans with private insurance schemes.

OUTCOME 6: The legal, policy, and political environment is increasingly conducive to effective functioning of the family planning program

A conducive policy environment is essential for successful implementation of all supply and demand elements of the program. Liberia has made significant steps toward improving the policy and political environment, which has advanced effective functioning of the family planning program. For example, family planning is part of the exempt policy on user fees allowing equitable access to services in the public sector. However, while this policy facilitates access to services, high wealth quintiles also benefit from this policy, creating undue burden on already constrained financial resources in the public sector. Segmentation approaches could support better targeting to facilitate equitable access.

Planned interventions aim to elevate the prominence of family planning in the national health and development agendas, establish clarity in policy guidelines for the family planning program and services, and address human resource shortages through innovative approaches.

A summary of key outputs and associated performance targets contributing to this outcome are summarized in Table 16. The estimated total amount of resources required to achieve deliver on the outputs during the five-year period is US$334,431.

Table 16: Enabling Environment II Results and Performance Targets

Outputs and Cost (USD)	Performance Targets		
	Indicator	Baseline	Target
EE6.1. Heightened and sustained political will and commitment towards family planning **Cost:** $127,809	Demonstration of commitment and support of family planning through public speeches by senior GOL officials		Evidence of public affirmation and support for family planning by senior GOL officials
EE6.2. A conducive policy environment with clear and transparent operational directives to guide implementation of the family planning program **Cost:** $206,622	Demonstrated evidence of a revised National Sexual and Reproductive Health Policy	Outdated National Sexual and Reproductive Health Policy	National Sexual and Reproductive Health Policy updated

Strategy Description

EE6.1. Heightened and sustained political will and commitment toward family planning

Intervention Strategy: Gain visibility and support for family planning matters from the House of Representatives, senior MOH leadership, and the general public

The GOL acknowledges family planning as an important health service to enable its people to exercise their rights to plan and decide on timing of births and family size. However, competing priorities and disruptions such as Ebola and civil conflict diminish the ability of the government and stakeholders to give the family planning agenda sustained and heightened attention. Under this program there will be deliberate efforts to elevate the prominence and visibility of family planning at all levels by (i) engaging and sensitizing political leaders (e.g., the House of Representatives) on the role of family planning in achieving the vision 2030 and national development plans; (ii) regularly and frequently engaging senior MOH leaders (including the Planning Division) to generate visibility and maintain focus to the family planning program; (iii) sensitizing and bolstering the capacity of media houses and journalists to increase visibility of family planning matters; and (iv) engaging broad stakeholder groups in a national family planning conference to sensitize and gain buy-in on the role of family planning in the health and economic development of the nation.

Intervention Strategy: Advocate for a multisectoral approach to family planning

Besides being a health intervention, family planning contributes to achievement of other sectoral goals. For example, one of the priorities under the *Getting to Best Education Sector Plan 2017–2021 (G2B-ESP)* is to improve female student learning outcomes.[191] Family planning contributes to this goal by reducing teenage pregnancies and thus allowing girls to remain in school. Further, achievement of some of interventions for family planning cannot be successful without the engagement of other sectors, including gender, community development, and youth, among others. Under this plan, efforts will start by establishing and implementing an intersectoral committee to act as a platform to engage different sectors on family planning matters.

EE6.2. A conducive policy environment, with clear and transparent operational directives, to guide effective implementation of the family planning program

Intervention Strategy: Update and support use of National Sexual and Reproductive Health Policy

Clarity and transparency on such things as which cadre of provider can provide which family planning services, process for registration of new commodities, user fees, the scope of private sector engagement in family planning service delivery, models for integration of family planning into health services, and so on, are important to guide the implementation of a coherent and coordinated program. The National Sexual and Reproductive Health Policy 2010 will be reviewed and updated to reflect additional operational guidance.

Under this plan, a small taskforce will be established under the RHTC to spearhead the review and revision process. The revision will provide explicit directives on (a) the operational rules, regulations, guidelines, and administrative norms governing family planning services and programs; and (b) the minimum acceptable levels of performance and expectations for service delivery and program implementation.

Intervention Strategy: Reclassify ECs as a contraceptive method

The National Sexual and Reproductive Health Policy 2010 specifies EC use, particularly as a PEP for rape survivors. A small taskforce, including representatives of the FHD, Pharmacy Division, and SCMU will be established to spearhead the reclassification process of ECs with the LMHRA as well as to ascertain distribution quantities and schedule.

OUTCOME 7: Strengthened leadership, management, and coordination capacity of the FHD at the central and county levels

Implementation of a vibrant and well-coordinated family planning program requires the requisite capacity and resources to steward the family planning program. Planned interventions aim to improve the capacity at the MOH to effectively lead, manage, and coordinate the family planning program; and improve data-driven decision making to improve effectiveness and efficiency of the program.

A summary of key outputs, and associated performance targets, contributing to this outcome are summarized in Table 17. The estimated resources required to achieve the outputs during the five-year period is US$1,063,605.

Table 17: Enabling Environment III Results and Performance Targets

Outputs and Cost (USD)	Performance Targets		
	Indicator	Baseline	Target
EE7.1. Capacity at the MOH to effectively lead, manage, and coordinate the family planning program is strengthened **Cost:** $579,970	Number of full-time family planning staff within the FHD	1	3

Outputs and Cost (USD)	Performance Targets		
	Indicator	Baseline	Target
EE7.2. Data-driven decision making is enhanced to improve effectiveness and efficiency of the family planning program **Cost:** $483,635	Median facility reporting rate for family planning services statistics (HMIS)	21.2% (2016)	60%

EE7.1. Capacity at the MOH to effectively lead, manage, and coordinate the family planning program is strengthened.

Intervention Strategy: Capacity support at MOH central and county level for family planning

The success of efforts described under this plan depends on having effective stewardship by the MOH at both the central and country level. Additional full-time staff will be hired at the central levels to support coordination and implementation of programmatic efforts and the national CIP. Additional capacity efforts are stipulated under output CS 2.2 to improve capacity for forecasting and quantification and to strengthen stakeholder coordination, and under output EE7.2 to improve reporting rates.

Intervention Strategy: Strengthen the family planning stakeholder coordination platform at all levels

Under this plan, a dedicated family planning technical working group/subcommittee of the RHTC will be established to facilitate expanded focus on family planning matters. Further, there will be an annual joint review as well as work plans that define what will be implemented in the respective year by different partners and the MOH.

EE7.2. Data-driven decision making is used to improve the effectiveness and efficiency of the family planning program

Intervention Strategy: Regularly track progress and performance of the program

Soon after the launch of this plan, there will be a concerted effort to establish a performance monitoring mechanism for the CIP. Annual data consensus workshops will enable stakeholders to review data for several core indicators, informed by service statistics and other data.

Intervention Strategy: Improve reporting rates for family planning services statistics

The timely availability of service statistics is crucial to inform progress and programmatic decision making. Central-level HMIS and M&E staff will conduct regular mentoring and supervision at the county level to monitor county M&E work plan implementation.

INSTITUTIONAL ARRANGEMENTS FOR IMPLEMENTATION

Implementation of the CIP will span the five years from January 2018 to December 2022, in alignment with the GOL fiscal year calendar. The GOL has responsibility for governance and stewardship of the family planning program and services, and therefore has the same oversight responsibility for the execution of this CIP and its implementation by a broad range of stakeholders. This section seeks to describe institutional arrangements for operationalizing the CIP to bring about sustained action and results, delineating the functions that will be carried out and by whom, including leadership and governance, stakeholder coordination, resource mobilization, and performance monitoring.

LEADERSHIP AND GOVERNANCE

The CIP is a common unified plan for all stakeholders involved in implementing the family planning program at all levels of the healthcare delivery system. The MOH will steward the execution of the CIP through engagement of a broad range of stakeholders, including key government ministries/agencies, development partners, civil society organizations, private sector, community-based organizations, and communities.

The structure:

- Recognizes that the MOH, in consultation with stakeholders, will lead the planning, resource mobilization efforts, financing, implementation, and performance monitoring of the CIP within existing governance structures.
- Recognizes that the CIP will be implemented by a broad group of multisectoral stakeholders, including other line ministries and agencies, development partners, civil society, community-based organizations, professional associations, faith-based organizations, voluntary agencies, and the private sector, among others.
- Acknowledges that the RHTC remains the coordinating platform for multisectoral partnership to coordinate planning, financing, implementation, and monitoring of the CIP. At the county level, the county coordination meeting will also address family planning issues and implementation. To further improve coordination, planning, financing, implementation, and monitoring of the CIP, the county RHTC will be revitalized and will report to the county coordination committee. Coordination of the multisectoral effort takes place at the national, district, and community levels. At each level, the coordination structures are multisectoral and comprise members from government, civil society/nongovernmental organizations, development partners, and the private sector.

The roles and responsibilities of key actors:

a) Office of the President

The Office of the President of Liberia, in its role to ensure the health and wellbeing of citizens, has made maternal mortality reduction a priority. Family planning as a strategy for the reduction of maternal mortality thus is a priority of the executive office. The Office of the President will lead interagency and inter-ministerial coordination structures to support the family planning program as well as champion mobilization of citizens to accept and use family planning methods.

b) Ministry of Health

The MOH is the principal the government entity responsible and accountable for the implementation of all health agendas, and this mandate extends to the national family planning program guided as by the CIP. Through the FHD, and with the support of partners, the MOH will perform the following key functions: (1) manage, coordinate, and monitor implementation of the plan to ensure attainment of performance targets by a wide range of national and international stakeholders; (2) mobilize, monitor, and ensure efficient use of resources; (3) formulate and implement enabling policies, laws, and regulations; and (4) set guidelines and standards for program and service delivery. The following key institutions within the MOH will support implementation of the plan as described below:

i) **Central Medicines Store (CMS).** As outlined in the Supply Chain Master Plan (SCMP) 2016, the CMS is responsible for the procurement, storing, and distribution of health commodities. UNFPA and USAID procure family planning commodities, while the CMS procures essential medicines and supplies (including equipment and consumables for family planning services), as well as stores and distributes all commodities in an integrated manner to all public and registered private health facilities. To foster commodity security, the CMS will ensure that procurement, distribution, and warehousing systems for contraceptives are effective and efficient. The CMS will participate in the SCTWG to improve forecasting and last-mile delivery of commodities.

ii) **The Liberia Medical and Health Regulatory Authority (LMHRA).** The LMHRA is mandated to oversee quality assurance (QA) for health commodities. LMHRA will strengthen the quality, safety, and efficacy of contraceptive commodities by regulating their importation, distribution, storage, and use. LMHRA will ensure the quality of the commodity through the qualification of manufacturing companies as per WHO standards and testing of all commodities once they enter the country.

c) Other ministries and institutions

Since the benefits of family planning interventions cut across multiple sectors beyond health, and impact of some interventions are facilitated through a multisectoral approach, engagement of other sectors is crucial in the implementation of this plan. Key ministries and institutions include:

i) **Civil Service Agency (CSA):** The CSA is responsible for employment, setting salary scales and employee regulations within the government sector. In support of the national agenda for health, they will increase employment at health facilities with qualified employees to deliver the essential package of health services. With qualified staff, there will be efficient implementation of the CIP with client satisfaction ensured.

ii) **The Liberia Institute of Statistics & GEO Information Services (LISGIS):** LISGIS works with the MOH and other ministries, donors, and partners to coordinate implementation of national surveys and census gear toward providing

demographic information for national planning. It will further be used to monitor and evaluate the CIP implementation.

iii) **Ministry of Finance and Development Planning (MFDP):** The MFDP is responsible for the development of a national budget with inputs from all other sectors. They are also responsible for allocating resources to different sectors according to national priorities. In accordance with its mandate, the MOH will collaborate closely with the MFDP in budget planning, timely disbursement of funds, and accounting for expenditures. This is geared toward ensuring government allocation to family planning efforts are in accordance with Liberia's FP2020 commitment, and contribute to timely implementation of activities, accountability and overall achievement of government priorities.

iv) **Ministry of Education (MOE):** The MOE is responsible for oversight of the whole education sector, including establishing the national curriculum, standards, and policies for all schools and educational programs. This includes oversight over tertiary education for healthcare workers. The MOH will collaborate with the MOE to ensure preservice curriculums for healthcare workers are up to date with the latest evidence-based guidance for family planning services. Further, since the MOE oversees the school health policy and teaching curriculums, the MOH will also work closely to ensure that the current development of the comprehensive sexuality education will be finalized, validated, and implemented to address health education at primary, secondary, and tertiary levels, as well as for out-of-school youth. This will contribute to the reduction of teenage pregnancy and improve access to rights-based family planning.

v) **Ministry of Gender (MOG):** The MOG is responsible for mainstreaming gender in all government policies and plans, an important component of the CIP. The issue of gender balance and male involvement will be enforced. Sociocultural issues (teenage pregnancies, early marriage, male dominance) faced in the family planning program will also be address through collaborative work with the MOG.

vi) **Ministry of Public Works (MPW):** The MPW is responsible for infrastructure development. It is evident that road network is a key stumbling block for access to services. The ministry will also play a key role in the development of roads over the next five years for beneficiaries to access family planning services.

vii) **Ministry of Youth and Sports (MOYS):** The MOH has a longstanding collaboration with the MOYS, and this partnership will be bolstered under this plan. MOYS will create an enabling environment for responding to the issues affecting youth. High on the agenda will be youth engagement in the development of policies and implementation of family planning services at the facility level. The MOYS will also facilitate improved coordination with other line ministries (MOH, MOE, and MOG) for efficient and effective services addressing youth as well as rights-based family planning.

viii) **Ministry of Internal Affairs (MOIA)** — The MOIA is responsible to coordinate the local government, which is influential in addressing sociocultural issues affecting health. MOH will ensure that local government authorities have the necessary

support and capacity to implement programs and services, including the allocation of resources, coordination of activities and stakeholders, and management of plan results at the county, district, and community levels.

d) Parliamentarians

Through the different committees on health (Senate Committee & House Committee on Health) an enabling environment will support implementation of the CIP. The different committees will advocate for increased budgets and allocations for health as well as effective policies, including promoting investments in family planning.

e) Research and academia

Research and academic institutions play a significant role in the national effort to increase the use of family planning services through technical guidance, research, and training of future professionals. Academic institutions will integrate family planning into a wide range of programs, especially in preservice institutions. Research institutions will be encouraged to generate new research evidence to improve operational performance and quality of service delivery.

f) Professional associations

Through various professional bodies (Medical and Dental Council, National Nursing and Midwifery Board, and the Pharmacist Board) and technical agencies, the MOH will monitor compliance to the laws and set standards to allow the ministry to concentrate on policy and strategic issues. These boards will support the implementation of the CIP in the areas of curriculum development and alignment, ethics, mentoring, and monitoring.

g) Development partners

Development partners and UN agencies are key in the successful implementation of the CIP through the provision of financial resources, technical expertise, and material supplies. Development partners and UN agencies will closely collaborate with the government in the areas of advocacy, management and human resources, development of policies and plans, infrastructure amongst others. Key roles and responsibilities include supporting the government in the areas of prioritization, effective allocation and use of financial resources in a coordinated manner to avoid duplication of service provision.

h) Civil society and nongovernmental organizations

Civil society will support the implementation of the CIP in all aspects, including advocacy, demand creation, and service provision. CSO local structures will be empowered to support family planning. Public sector procurement and service provision will be enhanced through the nongovernmental organizations. Through advocacy, CSOs will work to ensure accountability and transparency for funds allocated for family planning implementation.

i) Private sector

The Liberian health system has developed a foundation of public–private partnerships over the past two decades. Charities, faith-based organizations, nongovernmental organizations, and private providers have been major contributors to the health delivery system. At least 38 percent of health facilities are privately owned. The private sector is a growing source of family planning services, hospitals, pharmacies, and shops. Hence, under this plan, the MOH

will work closely with the private sector to ensure that family planning services are provided according to guidelines and standards, and to support scaleup of services.

SUBNATIONAL IMPLEMENTATION

Through the decentralized process the GOL, through the MOH, has increased the responsibilities of local government authorities, i.e., counties and districts, in the areas of planning, budgeting, monitoring, and overall implementation of services. The MOH will work with partners to provide guidance and technical assistance to counties for the implementation of the CIP. County action plans and budgets that emphasize family planning will facilitate county-level ownership and scaleup of family planning interventions. The county health officer (CHO) serves as the head of the county health teams (CHTs) while the county reproductive health supervisor (RHS) is the focal person for all reproductive health activities in the county. Through the office of the CHO and his team the decentralization effect will be attained. The county RHS will coordinate with all the district RHSs for implementation of RMNCH activities, including family planning. The district RH supervisors are a new cadre that have been added to support technical implementation of RMNCH services at the district level. Further, as part of decentralization of services, the district health officer (DHO) serves as the administrative head of health services in a district and oversees district-level implementation of services. The DHO and district RH supervisors will work with the CHO and county RHS to plan and budget efforts to support the implementation of the CIP at the district level. These supervisors will spearhead the technical implementation of the CIP at the district level with direct support to health facilities and the CHA program.

COORDINATION FRAMEWORK

Execution of the CIP will include several diverse partners and stakeholders over the five-year period. Therefore, there needs to be a harmonized coordination framework, building off current platforms, to ensure effective and efficient implementation of activities and use of resources and to avoid duplication. The MOH will lead coordination efforts among stakeholders through existing platforms. The current coordination structure will be maintained with emphasis on efficient use of resources, tracking progress and results, and information dissemination. Tracking of progress and results will include harmonization and integration of strategic priorities and activities with support from other sectors and include the planning department for resource mobilization and allocation.

The existing coordinating framework includes the below:

i) **The Health Sector Coordination Committee (HSCC):** This is a standing committee chaired by the MOH for the coordination of senior level management at all lines ministries, the donor community, and partner organizations for the implementation of health services. The HSCC is the highest level coordination structure of governance within the MOH, which will improve strong linkages with non-health ministries to realize a multisectoral approach in implementing the CIP. The HSCC will also ensure that increased resources are directed toward the achievement of plan outcomes, as well as elevate family planning as a priority development intervention area for the country's socioeconomic development agenda.

ii) **The Health Coordination Committee (HCC):** This is a technical committee that reports to the HSCC on all technical issues relating to health. Health policies and plans are high on the committee's agenda. This committee will support the implementation of the CIP through its technical support to donors, partners, and the ministry.

iii) **The Senior Management Committee (SMC)** The SMC, chaired by the Minister of Health, comprises a broader leadership group, including directors of programs and departments within the MOH. It is during these meetings that each program / department reports on progress and challenges for individual programs. Being the second highest level of governance within the MOH, the SMC will ensure that there are stronger linkages and improved coordination among the different departments and programs for implementation of the CIP. The FHD will also share and receive guidance on progress against CIP performance targets on a biannual basis.

iv) **The Reproductive Health Technical Committee (RHTC)** is a platform used for the coordination of all reproductive health partners and is chaired by the FHD director. It will play an advisory and guidance role to the MOH and family planning stakeholders and support implementation of the CIP through a variety of strategies, as well as provide a forum for stakeholder information dissemination and technical updates. The RHTC will provide technical advice for implementation of the plan and support resource mobilization efforts through its subcommittees for the five thematic areas (enabling environment, service delivery, youth, demand and commodity security) covered under the CIP. This committee includes four technical subcommittees (policy, service delivery, and commodity security & education). The subcommittees are chaired by the staff of FHD and report to the RHTC on progress and challenges. It has been decided that all issues relating to the different thematic areas of the CIP will be addressed in the subcommittees. This committee will also advocate for improved family planning policies. The FHD will also share and receive guidance on progress against CIP performance targets on a quarterly basis.

v) **The Reproductive Health Commodity Security Committee (RHCS)** is a subcommittee of the RHTC that is directly responsible for the security of RH commodities at all levels of the system. Availability of family planning commodities is high on the agenda of the RHCS through the regular review of stock status, family planning procurement pipeline, distribution channels and participate in forecasting of RH commodities. As a part of their responsibility is the monitoring of funding for family planning commodities as well as facilitate introduction of new methods.

vi) **The Supply Chain Technical Working Group (SCTWG)** provides technical support to the SCMU for the implementation of supply chain functions in the country. This is a platform used for the coordination of all SC partners. Through the National Forecasting and Quantification Committee, the SCTWG will ensure accurate and timely quantification of contraceptive commodities, as well as monitor supply plans and the pipeline. The working group will also improve coordination among partners who also serve as purchasing agents of contraceptive commodities, including USAID and UNFPA. Further, the SCTWG will monitor supply chain performance using key performance indicators such as forecast accuracy, stockouts, and on-time delivery to

ensure that the supply chain is performing at optimal level to prevent commodity stockouts, pilferage, and expirations.

vii) **The Policy Subcommittee** is responsible for the provision of technical support to RH policies. This committee will ensure that the right policies are developed for the implementation of the CIP.

viii) **Service Delivery Subcommittee** includes all partners and stakeholders involved with the provision of services. Its focus is on review and implementation of strategies for improvement in capacity, demand creation, and monitoring and supervision. This committee will provide technical guidance for effectiveness and efficiency in family planning services. There is not a specific committee for family planning, but a mechanism has been put in place for setting up separate ad hoc group, depending on the need to address specific family planning issues within the Service Delivery Subcommittee.

ix) **The Education Subcommittee** will focus on all aspects of capacity building, especially in the areas of curriculum development, revision, and integration. It will support the integration of family planning services in academic programs.

COUNTY COORDINATION MECHANISMS

At the county level, similar coordination structures exist called the **County Reproductive Health Technical Committee** (CRHTC), which reports to the County Coordination Committee. Currently, this structure has been dormant, but it will be revitalized in counties in which it existed, and initiated in new counties to replicate central level coordination at the county. The CRHTC will include local government, partners, civil society, and the DHTs.

RESOURCE MOBILIZATION FRAMEWORK

The successful execution of the CIP will require adequate and sustained financial resources. This plan envisages increased government allocation of a budget line for family planning in the national budget as well an expanded and diversified donor network. Further, the GOL anticipates mobilizing resources through the GFF mechanism funding efforts outlined in the RMNCAH Investment Case. The GOL will also explore other sustainable sources of family planning including health insurance and innovative forms of funding. Financial and program gap analysis will be conducted on an annual basis to inform resource allocation and mobilization efforts. During CIP development, the TST collected data from implementing partners to inform a financial and program gap analysis for 2018, the first year of this plan. This exercise provided information on current investment allocations for family planning against CIP priorities, geographical mapping, and areas that are under- or overfunded.

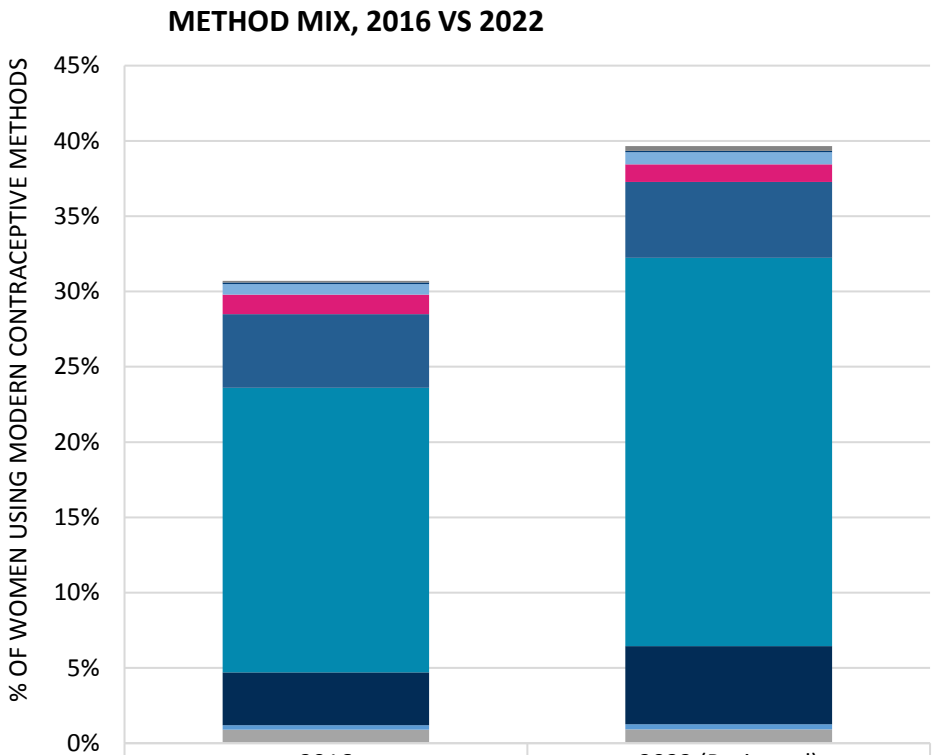
PERFORMANCE MONITORING

Measuring performance of the CIP over time generates essential information to guide strategic investments and operational planning and coordination. There will be regular monitoring of the CIP using various data sources and systems. Alongside the development of the CIP, the TST has prepared for future performance monitoring of the plan. Specifically, during the results formulation stage in September, the TST worked with each SAG to identify results that were critical to regularly monitor performance. These are referred to as key

results. In April 2018, the TST worked with the M&E unit of the MOH and representatives from different organizations working on M&E to review key performance indicators based on performance targets already included in the CIP. This information was fed into the CIP performance dashboard that will support monitoring of the CIP during the execution period.

The MOH has assigned an M&E Officer, who is also the appointed Track 20 M&E Officer, to manage the CIP performance monitoring process. Data to inform progress status will be collected on a quarterly basis from available data sources, including the Health Management Information System, partner reports, LMIS, and other sources. This data will be fed in to the CIP performance dashboard to generate status reports. Quarterly status reports will be shared and discussed during RHTC, and on a semi-annual basis status reports will be shared at both the RHTC and the SMC. Once a year, during data consensus workshop meetings organized by Track20, data to assess progress over a one-year period will be reviewed by stakeholders, with participation of the CHTs. The review will inform realignment of technical strategic priorities and resource allocation based on recommendations. It is also expected that the HSCC, through the HCC, will provided technical and programmatic recommendations for improvement and update for the next period.

ANNEX A: PROJECTED METHOD MIX, 2022



	2016	2022 (Projected)
Emergency Contraceptives	0.10%	0.31%
Lactational amenorrhea	0.10%	0.10%
Standard Days Method/CycleBeads	0.70%	0.80%
Female condoms	0.00%	0.00%
Male condoms	1.30%	1.17%
Pills	4.90%	5.03%
Injectables	18.90%	25.80%
Implants	3.50%	5.19%
IUDs	0.30%	0.34%
Female sterilisations	0.90%	0.91%
Male sterilisations	0.00%	0.00%

Method mix projections are made to estimate the volume of commodities needed to serve women in need for contraceptive services over a five-year period and meet the goal of 39.7 percent mCPR (all WRA) by 2022. When costed, this information is also used to project financial resource needs during the CIP period of performance.

The projected method mix takes into consideration (1) historical method mix trends as reported in the DHS 2007 and 2013, (2) service statistics reported in the DHIS2, (3) commodity quantification reports, (4) the mCPR goal, and (5) assumptions based on expert consultations.

The following assumptions have been made to compute the projections:

- Injectables will continue to dominate the method mix as the most popular method.
- Uptake of implants, pills, condoms, and IUDs is projected to only slightly increase. Increase in pill and condom use will be facilitated by the expanding community-based distribution interventions by CHAs. An enhanced focus on LARCs will also support increased adoption of IUDs and implants. However, implants are not expected to increase considerably, because they offer less privacy during administration compared to injectables. IUD uptake will continue to be limited by pervasive misconceptions.
- CycleBeads will also slightly increase as it is being made increasingly available through public health facilities and offers unique advantages to women and couples who oppose modern methods on religious grounds.
- Uptake of female and male sterilization will stay the same.

ANNEX B: COSTED IMPLEMENTATION PLAN TABLES

SERVICE DELIVERY

SD1.1: The number and capacity of facilities offering a range of family planning services at acceptable levels of performance and quality as per national standards increased

Intervention Strategy: Enhance and streamline capacity building for facility-based health workforce to improve coverage of quality family planning service provision

SD1.1A: Institute a needs-based approach to training planning and coordination for family planning providers

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD1.1Ai: Conduct a needs assessment/survey to determine provider knowledge, skills, and competency gaps in quality provision of family planning services (& availability of equipment to provide service)	2 reports generated (1 in 2018 and 1 in 2021)	$67,350 (1)	$0 (0)	$0 (0)	$72,529 (1)	$0 (0)	$139,879 (2)
SD1.1Aii: Convene a 3-day meeting to develop a multi-year training action plan based on findings from survey	2 training action plans generated (1 in 2018 and 1 in 2021), 100 copies printed	$9,838 (1)	$0 (0)	$0 (0)	$10,594 (1)	$0 (0)	$20,432 (2)

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.1Aiii: Assign dedicated staff to support coordination of implementation of the training action plan, including liaison with CHTs. **Roles include**: Managing a tracking mechanism for training of family planning providers to identify gaps and ensure equitable distribution of training investments; Coordinating partner investments for training, incl. resource pooling	1) One staff (MOH – staff or volunteer) is assigned to track family planning Training 2) One staff is provided with monthly phone vouchers to liaise with county staff and partners 3) One assigned staff visits 5 counties a year to collect data and support counties to track training (25 counties visited across all CIP years) 4) One partner training coordination meeting is conducted per quarter (20 meetings conducted across all CIP years) 5) Regularly updated database for tracking training family planning providers (based on excel-based dashboard)	$2,090 (1 staff 12 phone vouchers 5 staff visits 4 partner trainings 4 database updates)	$2,142 (1 staff 12 phone vouchers 5 staff visits 4 partner trainings 4 database updates)	$2,196 (1 staff 12 phone vouchers 5 staff visits 4 partner trainings 4 database updates)	$2,251 (1 staff 12 phone vouchers 5 staff visits 4 partner trainings 4 database updates)	$2,307 (1 staff 12 phone vouchers 5 staff visits 4 partner trainings 4 database updates)	$10,986 (5 staff 60 phone vouchers 25 staff visits 20 partner trainings 20 database updates)

SD1.1B: Review and revise the family planning in-service training curriculum(s)

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.1Bi: Conduct workshops to review and update in-service training curriculum(s)	Updated family planning Training Curriculum (i) Short-acting & Long-Acting Methods; (ii) Permanent Methods	$48,352 (4)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$48,352 (4)
SD 1.1Bii: Print curriculum and WHO MEC wheels, and order family planning Handbooks	Training materials printed	$24,000 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$24,000 (1)

SD1.1C: Expand the pool of family planning trainers at national and county levels

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.1Ci: Conduct a TOT workshop	30 more trainers added to the pool (1 TOT workshop)	$0 (0)	$59,690 (1)	$0 (0)	$0 (0)	$0 (0)	$59,690 (1)
SD 1.1Cii: Conduct refresher/CTU for trainers	51 trainers receive refresher training	$0 (0)	$0 (0)	$25,125 (30 trainers)	$0 (0)	$18,478 (21 trainers)	$43,604 (51 trainers)

SD1.1D: Equip trainers with equipment and supplies

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.1Di: Procure training equipment and supplies	Training kits (pelvic model, Arm Model, Penile Model, speculum, Forceps, Tenaculum) provided to each county	$0 (0)	$279,210 (1)	$0 (0)	$0 (0)	$0 (0)	$279,210 (1)

SD1.1E: Train health providers (public & private sector) on Family Planning

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.1Ei: Conduct training on family planning Basics + Short-acting & Long-Acting Methods	444 providers trained across all 5 years (25 participants per workshop, 2 facilitators)	$209,522 (125 prov)	$193,284 (113 prov)	$154,090 (88 prov)	$135,379 (75 prov)	$92,509 (43 prov)	$784,785 (444 prov)
SD 1.1Eii: Refresher training, including CTUs, offered to providers every 2 years after training	4,275 providers receive refresher training	$658,322 (855 prov)	$674,780 (855 prov)	$691,650 (855 prov)	$708,941 (855 prov)	$726,665 (855 prov)	$3,460,358 (4,275 prov)

SD1.1F: Supervise and mentor providers on clinical provision of family planning services

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.1Fi: Conduct bi-annual family planning supervision visits (2 visits/county/year)	176 facilities receive supportive supervision visits per quarter/year	$187,249 (2)	$191,930 (2)	$196,729 (2)	$201,647 (2)	$206,688 (2)	$984,243 (10)
SD 1.1Fii: Integrate questions to collect client feedback on family planning services in the UNFPA Annual Supplies survey (the survey should also assess equipment availability)	A half-day meeting to review and incorporate updates in the UNFPA Annual Supplies survey	$200 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$200 (1)

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.1Fiii: Develop family planning supportive supervision tools *(should also include client exit interviews, review of clinical skills competencies, equipment and supplies, implant removal tracking, service statistics reporting, YFS etc.)* and Enrich the family planning section of existing integrated supportive supervision tools *As part of supportive supervision – include questions to collect client feedback on family planning services to inform continuous quality improvement measures.*	1) Family planning supportive supervision tools developed & printed 2) Family planning section of the existing integrated supportive supervision forms/tools updated	$4,688 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$4,688 (1)
SD 1.1Fiv: Train the district and county supervisors on family planning supportive supervision tools	76 District Supervisors + 15 County Supervisors (2 trainings, 45 pax each)	$0 (0)	$28,589 (2)	$0 (0)	$0 (0)	$0 (0)	$28,589 (2)
SD 1.1Fv: Hold annual meetings (central and county level) to discuss progress and challenges in family planning based on supportive supervision findings, and other data, to inform programming	15 RHS + 10 pax FHD + 15 partners	$16,568 (1)	$16,982 (1)	$17,407 (1)	$17,842 (1)	$18,288 (1)	$87,087 (5)

Intervention Strategy: Bolster family planning preservice education for the clinical health workforce

SD1.1G: Work with professional boards/training institutions for nurses, midwifery, PAs, and physicians to bolster the family planning section of the pre-service curricula

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.1Gi: Conduct workshops to review and update training curriculum(s)	2 workshops held	$0 (0)	$76,334 (2)	$0 (0)	$0 (0)	$0 (0)	$76,334 (2)

SD1.1H: Equip preservice tutors with up to date knowledge/skills in family planning

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.1Hi: Orient preservice tutors on family planning	120 preservice tutors trained (25 participants per workshop)	$0 (0)	$0 (0)	$203,134 (100 tutors)	$41,642 (20 tutors)	$0 (0)	$244,776 (120 tutors)

Intervention Strategy: Explore feasibility of task-sharing opportunities to expand access to surgical sterilization services

SD1.1I: Conduct operations research study to assess safety, feasibility, and acceptability of PAs and RNs

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.1Ii: Advocacy to get consensus to explore provision of sterilization services by PAs and RNs	Two 1-day meetings with professional boards to discuss and get buy-in (Central level meeting)	$0 (0)	$3,075 (2)	$0 (0)	$0 (0)	$0 (0)	$3,075 (2)
SD 1.1Iii: Conduct a study tour - Uganda	5 representatives conduct a study tour to Uganda	$0 (0)	$18,812 (1)	$0 (0)	$0 (0)	$0 (0)	$18,812 (1)

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.1Iiii: Hire a research institution to conduct the O.R. study (study conducted over a 2-year period)	A report on the operations research study to assess safety and feasibility, and acceptability of surgical sterilization by PAs and RNs	$0 (0)	$0 (0)	$30,902 (0.5)	$31,674 (0.5)	$0 (0)	$62,576 (1)
SD 1.1Iiv: Conduct a workshop to develop intervention on task-shifting	Workshop to generate intervention for testing (central meeting at MOH)	$0 (0)	$0 (0)	$630 (1)	$0 (0)	$0 (0)	$630 (1)
SD 1.1Iv Conduct a workshop to disseminate findings, and generate recommendations for the way forward to inform MOH decision making	Advisors, influencers, and decision makers meet to review data generated from study and generate actionable recommendations and decisions	$0 (0)	$0 (0)	$0 (0)	$6,470 (1)	$0 (0)	$6,470 (1)
SD 1.1Ivi: Hold advocacy meetings to support decision making based on study findings	A report documenting decision by country on provision of surgical contraception by PAs and RNs	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$662 (2)	$662 (2)

SD1.2: Family planning services offered through CHAs expanded and strengthened

Intervention Strategy: Strengthen family planning provision through CHAs

SD1.2A: Review and develop an addendum to the CHA training curriculum

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.2Ai: Conduct workshops to review and update in-service training curriculum (s)	1) Addendum to the CHA Training Curriculum 2) 1,000 copies of the curriculum printed	$0 (0)	$0 (0)	$0 (0)	$91,551 (3 addendums 1 set of copies)	$0 (0)	$91,551 (3 addendums 1 set of copies)

SD1.2B: Engage and support CHSS to ensure: (i) commodity security at community level, (ii) service standards are adhered (quality improvement); (iii) referrals are strengthened; (iv) CBIS reports are integrated into SDP reporting systems

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.2Bi: Leverage bi-annual supportive supervision visits [Linked to Service Delivery Sub-activity **SD 1.1Fi**: Conduct biannual family planning supervision visits (2 visits per county per year). Supervision should cover both facility-based and community-based (CHA) programs.] *No additional costs for this sub-activity.	25% of the counties receive supervision visits per quarter	$0 (30)	$0 (30)	$0 (30)	$0 (30)	$0 (30)	$0 (150)

Intervention Strategy: Broaden the method mix offered by CHAs

SD1.2C: Introduce community distribution of injectables

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.2Ci: Establish a small taskforce to spearhead efforts to introduce injectable provision by CHAs (Taskforce includes representatives from FHD, Community Health, Nursing professional associations, and implementing partners)	Taskforce established (terms of reference and workplan defined and representatives selected)	$0 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (1)

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.2Cii: Hold study tour for taskforce team to learn the approach from other countries which have successfully introduced injectables (e.g., Uganda)	1) A joint report by the taskforce on lessons learned, and recommendations for introduction in the Liberian context 2) A debrief meeting for the taskforce held with other stakeholders	$26,813 (1 report 1 meeting)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$26,813 (1 report 1 meeting)
SD 1.2Ciii: Hire a research institution to conduct the O.R. study (2-year period)	An operations research study conducted to assess feasibility of introducing injectable provision through CHAs	$0 (0)	$30,148 (0.5)	$30,902 (0.5)	$0 (0)	$0 (0)	$61,049 (1)
SD 1.2Civ: Conduct workshop to disseminate findings, and generate recommendations for the way forward to inform MOH decision-making	1) A report documenting findings from the research study 2) Roll out of action plan	$0 (0)	$0 (0)	$4,106 (1)	$0 (0)	$0 (0)	$4,106 (1)
SD 1.2Cv: Advocacy meetings to support decision making based on study findings	A decision on introductions/rollout of injectable provision in the community	$0 (0)	$0 (0)	$630 (2)	$0 (0)	$0 (0)	$630 (2)

SD1.3: Clinical outreach services scaled and sustained to improve availability of and access to quality family planning services, particularly for underserved communities

Intervention Strategy: Scale and sustain clinical outreach in areas with poor access to health facilities

SD1.3A: Establish and operate a taskforce/committee of outreach partners to facilitate coordination, planning and optimal use of resources

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.3Ai: Establish taskforce to improve coordination of implementing partners on clinical outreach efforts – nominate secretariat, ensure participation of commodity security member to coordinate supplies, and demand generation for community mobilization, and M&E	Taskforce established (terms of reference and work plan defined and representatives selected)	$0 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (1)
SD 1.3Aii: Hold quarterly meetings of the taskforce to support planning and coordination. Generate annual work plans, pool & mobilize resources to ensure a comprehensive outreach event occurs	20 taskforce meetings held, annual work plan developed to guide a coordinated joint outreach effort	$1,200 (4)	$1,230 (4)	$1,261 (4)	$1,292 (4)	$1,325 (4)	$6,308 (20)

SD1.3B: Strengthen and support the family planning component of routine outreach activities managed by facilities

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.3Bi: Conduct a rapid formative assessment to understand the coverage, gaps, and challenges of family planning component in routine integrated outreach efforts conducted by facilities	A formative assessment conducted, and a report generated and shared. Recommendations outlined	$0 (0)	$72,288 (1)	$0 (0)	$0 (0)	$0 (0)	$72,288 (1)

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.3Bii: Review guidelines and strengthen the family planning section of routine integrated outreach efforts	Family planning section of routine integrated outreach efforts is strengthened	$0 (0)	$0 (0)	$6,743 (1)	$0 (0)	$0 (0)	$6,743 (1)

SD1.3C: Support clinical outreach events

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.3Ci: Conduct clinical outreach	Tier 1: 27 districts received clinical outreach and community mobilization activities once per quarter Low Demand Satisfied: Grand Bassa [8], Nimba [6], Lofa [6], Rivercess [2], Grand Cape Mount [5]	$876,704 (108)	$898,622 (108)	$921,087 (108)	$944,114 (108)	$967,717 (108)	$4,608,245 (540)
SD 1.3Ci: Conduct clinical outreach	Tier 2: 37 districts received clinical outreach and community mobilization activities twice per year Bong [12], Maryland [2], Margibi [4]) Gbarpolu [6], River Gee [2] Sinoe [7], Bomi [4]	$600,705 (74)	$615,722 (74)	$631,115 (74)	$646,893 (74)	$663,066 (74)	$3,157,501 (370)
SD 1.3Ci: Conduct clinical outreach	Tier 3: 12 districts received clinical outreach and community mobilization activities once per year	$97,412 (12)	$99,847 (12)	$102,343 (12)	$104,902 (12)	$107,524 (12)	$512,027 (60)

SD1.4: Integration of family planning services with other health services, particularly RMNCAH and HIV/AIDS services strengthened and scaled

Intervention Strategy: Establish national operational guidance and standards on integration

SD1.4A: Develop operational guidelines on integration (what can be integrated, how, packages, roles of different actors)

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.4Ai: Conduct workshops to develop operational guidelines on integration	National Operational Guidelines on Integration	$0 (0)	$14,696 (1)	$0 (0)	$0 (0)	$0 (0)	$14,696 (1)
SD 1.4Aii: Print copies of the National Operational Guidelines on Integration	1,000 copies of the National Operation Guidelines on Integration printed	$0 (0)	$12,300 (1)	$0 (0)	$0 (0)	$0 (0)	$12,300 (1)
SD 1.4Aiii: Disseminate National Operational Guidelines on Integration	Central FHD staff, county and district-level RH supervisors, as well as implementing partners oriented to the National Operational Guidelines on Integration (1 meeting per region)	$0 (0)	$19,106 (5)	$0 (0)	$0 (0)	$0 (0)	$19,106 (5)
SD 1.4Aiv: Convene meetings to advocate to mainstream family planning as a routine service in priority RMNACH services (adopting the "Promote & Refer" model)	Meetings convened to advocate to mainstream family planning	$300 (1)	$308 (1)	$0 (0)	$0 (0)	$0 (0)	$608 (2)

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.4Av: Equip non-family planning rooms in facilities with family planning IEC materials (Brochures and Posters) (Linked to Demand Generation Sub-activity **DG 3.1Cv**: Print Brochures, posters, plastic bracelets. Print materials will cater to different audiences – e.g., a different brochure for in- and out-of-school, men, young mothers, etc.) *No additional costs for this sub-activity.	Non-family planning rooms in all 701 facilities equipped with family planning Brochures and posters	$0 (0)	$0 (1)	$0 (1)	$0 (0)	$0 (0)	$0 (2)
SD 1.4Avi: Revise supervision tools to include integration & Revise HMIS/CBIS data collection forms to include integration [Linked to Service Delivery Sub-activity **SD 1.1Fii**: Integrate questions to collect client feedback on family planning services in the UNFPA Annual Supplies survey (the survey should also assess equipment availability)] *No additional costs for this sub-activity.	One 2-day meeting conducted to review and revise supervision and data collection tools	$0 (0)	$0 (0)	$8,004 (1)	$0 (0)	$0 (0)	$8,004 (1)

Intervention Strategy: Postpartum family planning across a continuum

SD1.4B: Scale-up FP-EPI integration model nationwide

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.4Bi: Establish and maintain a small taskforce to spearhead FP-EPI scale-up	Taskforce established (terms of reference and work plan defined and representatives selected)	$0 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (1)
SD 1.4Bii: Convene meeting with county health services for consensus and information dissemination to the counties	Taskforce convenes meeting with county health services	$0 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)
SD 1.4Biii: Convene a meeting to orient representatives from CHT, including RH and district supervisors	Representatives from CHT, including RH and district supervisors participated in meeting	$34,824 (3)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$34,824 (3)
SD 1.4Biv: Build capacity of health workers for EPI/family planning integration	Health workers trained (vaccinator & family planning provider) to provide EPI/family planning services (2 health workers per facility) 1,500 health workers trained total (6 workshops per year with 25 in each session)	$95,793 (6)	$98,188 (6)	$100,643 (6)	$103,159 (6)	$105,738 (6)	$503,519 (30)

SD1.4C: Advocate and liaise with the immunization stakeholders to hold joint outreach efforts

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.4Ci: Outreach taskforce convenes meeting with key immunization stakeholders to discuss the potential for leveraging the immunization campaign platform to offer postpartum family planning services	Meeting convened with outreach taskforce and key immunization stakeholders	$300 (1)	$308 (1)	$315 (1)	$323 (1)	$331 (1)	$1,577 (5)
SD 1.4Cii: Hold a trial/demonstration effort – family planning team offers PPFP during immunization campaigns	A demonstration effort conducted, and recommendations on future rollouts developed	$0 (0)	$16,641 (2)	$0 (0)	$0 (0)	$0 (0)	$16,641 (0)

SD1.4D: Strengthen and scale PPIUCD

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.4Di: Train mentors and providers (Linked to **SD 1.1Ei** since PPIUCD is now part of the integrated training package)	N/A	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)
SD 1.4Dii: Setting up of Preceptor Corners in facilities manned by trained mentors	20 facilities are equipped with postpartum insertion kits	$0 (0)	$24,726 (20)	$0 (0)	$0 (0)	$0 (0)	$24,726 (20)
SD 1.4Diii: Provide supportive supervision to preceptor sites	20 facilities are provided with supportive supervision	$95,549 (2)	$97,938 (2)	$100,386 (2)	$102,896 (2)	$105,468 (2)	$502,238 (2)
SD 1.4Div: Develop policy guidance around PPIUCD	Conduct 2 workshops to develop policy guidance for PPIUCD	$0 (0)	$0 (0)	$44,572 (2)	$0 (0)	$0 (0)	$44,572 (2)
SD 1.4Dv: Include indicators in PPIUCD in the HMIS reporting tool	Indicators for PPIUCD included the HMIS reporting tool	$0 (0)	$0 (0)	$5,121 (1)	$0 (0)	$0 (0)	$5,121 (1)

Intervention Strategy: Integration of family planning into HIV/AIDS services

SD1.4E: Bolster PMTCT, HCT, Care & Treatment guidelines with guidance on integrating family planning in respective settings

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.4Ei: Conduct workshops to integrate family planning in the PMTCT, HCT, Care & Treatment guidelines	One workshop conducted (Training curriculum, protocols, training guidelines, job aids)	$0 (0)	$27,583 (1)	$0 (0)	$0 (0)	$0 (0)	$27,583 (1)

SD1.4F: Liaise with the HIV/AIDS stakeholders to support promotion of dual protection messages during IEC, mass media, and counseling and use teenage pregnancy as an indicator for unprotected sex

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.4Fi: Consult and coordinate with the HIV/AIDS program to promote dual protection messages	N/A	$0 (0)	$0 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)

SD1.5: Increased uptake of quality family planning services through the private sector

Intervention Strategy: Strengthen and expand quality provision of family planning services across private sector networks

SD1.5A: Train Providers from facility-based private providers

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.5Ai: [Linked to Service Delivery Activity **SD 1.1E**: Train health providers (public & private sector) on family planning] *No additional costs for this sub-activity.	N/A	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)

SD1.5B: Support private sector with IEC materials

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.5Bi: (Linked to Demand Generation Activity **DG 3.1C**: Hold a series of media events to promote awareness and acceptability of family planning, address common myths and misconceptions, and challenge social norms) *No additional costs for this sub-activity.	N/A	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)

Intervention Strategy: Explore potential for enhanced engagement of drug stores, pharmacies, and wholesale distributors/suppliers in contraceptive sales

SD1.5C: Conduct a formative assessment to explore facilitators and barriers, including challenges, for family planning provision, etc., via the entire drug store/pharmacy value chain

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.5Ci: Conduct a rapid assessment – key informant interviews on the extent of contraceptive service delivery in drug stores/pharmacies	A report from the assessments on the extent of contraceptive service delivery from drug stores/pharmacies	$0 (0)	$72,288 (1)	$0 (0)	$0 (0)	$0 (0)	$72,288 (1)
SD 1.5Cii: Convene workshop to review findings and develop actionable recommendations for engagement of drug stores, pharmacies, and wholesale distributors/suppliers in contraceptive sales	A report with actionable recommendations in support for enhanced engagement of drug stores and pharmacies in family planning provision	$0 (0)	$308 (1)	$0 (0)	$0 (0)	$0 (0)	$308 (1)

SD1.5D: Conduct an operations research study to assess feasibility of private sector pharmacies and medicine shops to offer contraceptive services

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.5Di: Hire research firm to conduct study	Operations research study conducted	$0 (0)	$0 (0)	$61,803 (1)	$0 (0)	$0 (0)	$61,803 (1)
SD 1.5Dii: Convene workshop to review findings and develop actionable recommendations for model for engaging drug stores, pharmacies, and wholesale distributors/suppliers in contraceptive sales	Workshop convened	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$17,131 (1)	$17,131 (1)

SD1.5E: Strengthen family planning provision (condoms & ECs) via drug stores and pharmacies

Sub-Activity	Activity-Level Target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
SD 1.5Ei: Adapt an existing curriculum on short-acting methods for the dispensers	Curriculum adapted	$16,576 (2)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$16,576 (1)
SD 1.5Eii: Train 75 dispensers in drug stores and pharmacies in family planning so they can: (i) Serve as promotion points for family planning (ii) Provide ECs and condoms as per national standards	75 dispensers in drug stores and pharmacies trained on family planning provision	$0 (0)	$0 (0)	$29,219 (75 pax)	$0 (0)	$0 (0)	$29,219 (75 pax)
SD 1.5Eiii: Equip drug stores & pharmacies with IEC materials [Linked to Demand Generation Activity **DG 3.1C**: Hold a series of media events to promote awareness and acceptability of family planning, address common myths and misconceptions, and challenge social norms] *No additional costs for this sub-activity.	N/A	$0 (0)	$0 (0)	$0 (1)	$0 (1)	$0 (1)	$0 (3)

COMMODITY SECURITY

CS2.1: Adequate contraceptive commodities and supplies are procured to cover all country needs (in accordance with the CIP method projections and as adjusted during annual quantification exercises) to meet the CPR goal by 2022

Intervention Strategy: Service delivery points are furnished with a broad range of commodities, essential equipment and supplies to ensure quality provision of family planning services as per standards

CS2.1A: Procure commodities

Sub-Activity	Activity-level target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
CS 2.1Ai: Commodity procurement	IUD (/insertion)	$697 (1,162)	$752 (1,223)	$810 (1,285)	$869 (1,345)	$935 (1,412)	$4,063 (6,426)
	Implant (/insertion)	$187,810 (22,095)	$211,151 (24,235)	$236,299 (26,460)	$262,940 (28,725)	$292,184 (31,142)	$1,190,384 (132,658)
	Injectable (/vial)	$1,049,990 (1,235,282)	$1,165,936 (1,338,233)	$1,291,031 (1,445,673)	$1,424,793 (1,556,544)	$1,569,094 (1,672,379)	$6,500,844 (7,248,111)
	Pill (/cycle)	$235,115 (940,462)	$248,489 (969,714)	$262,523 (999,492)	$277,040 (1,029,036)	$292,333 (1,059,356)	$1,315,500 (4,998,061)
	Male condom (/pc)	$45,800 (1,526,680)	$49,333 (1,604,318)	$53,096 (1,684,584)	$57,061 (1,766,217)	$61,293 (1,850,953)	$266,583 (8,432,752)
	Female condom (/pc)	$24,273 (44,133)	$25,477 (45,192)	$26,741 (46,277)	$28,067 (47,387)	$29,459 (48,525)	$134,017 (231,514)
	CycleBeads (/pc)	$13,584 (9,056)	$14,434 (9,388)	$15,330 (9,728)	$16,264 (10,069)	$17,252 (10,420)	$76,864 (48,660)
	Emergency contraceptive	$1,311 (1,748)	$1,750 (2,276)	$2,233 (2,834)	$2,761 (3,418)	$3,339 (4,033)	$11,393 (14,309)
	Shipping and handling	$287,402	$316,674	$348,159	$381,670	$417,830	$1,751,735

CS2.1B: Furnish facilities with essential equipment and supplies to ensure quality provision of family planning services as per standards

Sub-Activity	Activity-level target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
CS 2.1Bi: Procure essential equipment and supplies (primarily for LARCs)	IUD insertion kit	$3,113 (13)	$3,359 (14)	$3,618 (14)	$3,883 (15)	$4,177 (16)	$18,149 (71)
	Implant insertion kit	$28,172 (1,105)	$31,673 (1,212)	$35,445 (1,323)	$39,441 (1,436)	$43,828 (1,557)	$178,558 (6,633)
	Female sterilization consumales	$10,477 (1,104)	$11,070 (1,138)	$11,665 (1170)	$12,213 (1195)	$12,884 (1230)	$58,309 (5,837)
	Shipping and handling	$7,701	$8,714	$9,828	$11,028	$12,393	$49,664
CS 2.1Bii: Conduct distribution by leveraging distribution platforms for commodities [Linked to Commodity Security Activity **CS 2.2B**: Provide logistical support for last-mile distribution of family planning commodities (county to facilities), particularly for emergency situations]	N/A	$0 (1)	$0 (1)	$0 (1)	$0 (1)	$0 (1)	$0 (5)

CS2.2: Improved supply chain management system for family planning commodities

Intervention Strategy: SCMU capacity building

CS2.2A: Strengthen the SCMU to conduct joint, systematic, and data-driven quantification exercises and reviews on a regular basis

Sub-Activity	Activity-level target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
CS 2.2Ai: Conduct joint annual quantification exercises which include data collection and data analysis by the National family planning F&Q committee	National needs identified and report made available through the following process: 1. Data collection system that collects data from facilities – emails sent to share data 2. One annual 1-day data analysis and review meeting 3. One annual 4-day meeting to conduct quantification exercises	$9,908 (1 data collection; 1 one-day meeting; 1 four-day meeting)	$10,156 (1 data collection; 1 one-day meeting; 1 four-day meeting)	$10,410 (1 data collection; 1 one-day meeting; 1 four-day meeting)	$10,670 (1 data collection; 1 one-day meeting; 1 four-day meeting)	$10,937 (1 data collection; 1 one-day meeting; 1 four-day meeting)	$52,080 (5 data collection; 5 one-day meetings; 5 four-day meetings)
CS 2.2Aii: Quantification reviews, which include data collection and data analysis –bi-annual - National family planning F&Q committee (should include department of planning at MOH)	Quantification reviews conducted twice a year (10) and Revised Forecast needs and supply plan made available. Process for quantification reviews includes: 1. Data collection system that collects data from facilities – emails sent to share data 2. Bi-annual 1-day data analysis and review meeting 3. Biannual quantification review meetings	$8,480 (2 data collection; 2 one-day meetings; 2 quantification review meetings)	$8,692 (2 data collection; 2 one-day meetings; 2 quantification review meetings)	$8,909 (2 data collection; 2 one-day meetings; 2 quantification review meetings)	$9,132 (2 data collection; 2 one-day meetings; 2 quantification review meetings)	$9,360 (2 data collection; 2 one-day meetings; 2 quantification review meetings)	$44,574 (10 data collection; 10 one-day meetings; 10 quantification review meetings)
CS 2.2Aiii: Support convening of monthly meetings for the RHSC Subcommittee	12 monthly meetings conducted and meeting minutes made available (Meetings held at the central level in Monrovia at MOH or partners' offices)	$3,600 (12)	$3,690 (12)	$3,782 (12)	$3,877 (12)	$3,974 (12)	$18,923 (60)

CS2.2B: Conduct joint supportive supervision visits – facilities and NDS, etc.

Sub-Activity	Activity-level target	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
CS 2.2Bi: Conduct monthly inventory checks, which include data compilation and analysis, for national warehouse	Monthly inventory conducted	$1,920 (12)	$1,968 (12)	$2,017 (12)	$2,068 (12)	$2,119 (12)	$10,092 (12)
CS 2.2Bii: Conduct quarterly inventory for county depots (every quarter, 25% of the facilities are covered)	25% of the counties supervised every quarter (~4 counties per quarter = 80 county visits)	$189,034 (16)	$193,759 (16)	$198,603 (16)	$203,569 (16)	$208,658 (16)	$993,623 (80)

DEMAND

DG3.1. People have accurate knowledge and self-efficacy to adopt positive behavioral change to practice family planning

Intervention Strategy: A sustained, comprehensive, and targeted family planning social and behavioral change campaign implemented at scale

DG3.1A: Develop guidance for SBCC efforts building upon efforts under the existing National Health Communication Strategy (NHCS)

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
DG 3.1Ai: Conduct 12 focus groups with priority and influencing audiences identified in the NHCS to gain an in-depth understanding of barriers, facilitators, and preferred communication channels for reaching the audience. (This exercise will expand on work already done under the NHCS.) Audience considered includes, but not limited to, adolescents (in- & out-of-school), married adolescents, postpartum women, young mothers, men (young boys and adult males), parents, physically challenged, health providers, religious leaders and policymakers/political leaders.	1) Report on audience profiles of priority and influencing audiences, including their barriers and facilitators to behavioral adoption 2) 12 focus groups	$32,160 (1 report; 12 focus groups)	$0 (0)	$0 (0)	$0	$0	$32,160 (1 report; 12 focus groups)
DG 3.1Aii: Convene a 5-days meeting to develop guidance for family planning messaging based on findings from the audience analysis (audiences, key messages, and preferred channels)	Draft key messages for different audiences developed *(*to be achieved through a 5-day meeting held at central level)*	$12,178 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$12,178 (1)
DG 3.1Aiii: Conduct focus groups with different audience segments to assess acceptability, comprehension, and relevance of draft key messages	1) Report generated on acceptability, comprehension, and relevance of key messages 2) 12 focus group discussions, each with 8 members	$20,160 (1 report; (12 focus groups)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$20,160 (1 report; (12 focus groups)
DG 3.1Aiv: Conduct a 2-day workshop to incorporate findings from the focus group discussions into the key messages, and validate the messages	Final key messages for different audiences developed *(*to be achieved through a 2-day workshop)*	$6,418 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$6,418 (1)

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
DG 3.1Av: Print SBCC guidance document	100 copies of the guidance for family planning messaging, including creative briefs for priority & influencing audiences, key messages, and preferred channels	$200 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$200 (1)
DG 3.1Avi: Disseminate guidance document to CHTs and stakeholders to be used in developing materials and tools for SBCC for different priority audience segments	Orientation session of stakeholders involved in family planning promotion, including partners, national and CHTs etc.	$0 (0)	$16,638 (1)	$0 (0)	$0 (0)	$0 (0)	$16,638 (1)

DG3.1B: Adapt key messages for different media channels (print – newspaper, posters, billboards, brochures/flyers; radio spots, radio drama, mobile text, etc.) tailored for different audience segments

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
DG 3.1Bi: Hire a media/PR firm to adapt key messages for different media channels (posters, brochures/flyers; radio spots, PSA, mobile text, etc.) tailored for different audience segments	Final validated materials for different mass media channels *(*to be achieved through a 1 validation meeting)*	$70,938 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$70,938 (1)

DG3.1C: Hold a series of media events to promote awareness and acceptability of family planning, address common myths and misconceptions, and challenge social norms

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	***2019***	***2020***	***2021***	***2022***	
DG 3.1Ci: Air radio jingles/spot – 30 secs *(Liaise with Communication unit of MOH to negotiate PSAs from radio stations, and also radio buy in at discounted rates)* *Identify radio stations based on location and listener demographics (use national and regional media)*	1) National media radio spots *(**Intense mode**: 3 months period twice per year – airing 6 spots daily during prime time for 5 days per week)* 2) National media radio spots *(**Maintenance mode**: 3 months period once per year – airing 3 spots daily during prime time for 3 days per week)* 3) Regional media radio spots *(**Intense mode** - *applies same intense airing format as the national media radio spots setup)*	$7,992 (0)	$8,192 (0)	$16,793 (1 national intense mode; 1 national maintenance mode; 1 regional intense mode)	$17,213 (1 national intense mode; 1 national maintenance mode; 1 regional intense mode)	$17,643 (1 national intense mode; 1 national maintenance mode; 1 regional intense mode)	$67,833 (3 national intense mode; 3 national maintenance mode; 3 regional intense mode)
DG 3.1Cii: Support airing of a serial 5-10 mins radio/TV drama with stories to support positive shifts in social norms and attitudes	Serial radio drama held 2X a day – every other 3 months (quarterly). Specifically, in this format: 1) National media – 2 spots per month; 10 minutes air time to host radio drama 2) Regional media – 2 spots per month; 10 minutes air time to host radio drama	$6,579 (0) (0)	$6,743 (0) (0)	$13,824 (1 national; 1 regional)	$14,170 (1 national; 1 regional)	$14,524 (1 national; 1 regional)	$55,840 (3 national; 3 regional)
DG 3.1Ciii: Air public dialogues on family planning matters on radio	30 minutes air time per quarter to host discussion sessions on radio (1 session per quarter = 12 sessions total)	$600 (0)	$615 (0)	$1,261 (4)	$1,292 (4)	$1,325 (4)	$5,093 (12)
DG 3.1Civ: Air TV adverts (before or after news)	20 TV Advert aired per year *(5 adverts every quarter for 30 secs per advert)*	$250 (0)	$256 (0)	$525 (20)	$538 (20)	$552 (20)	$2,122 (60)
DG 3.1Cv: Print brochures, posters, plastic bracelets	1) 50,000 brochures printed 2) 30,000 A3 posters printed 3) 20,000 bracelets printed 4) 15,000 stickers printed	$99,875 (0) (0) (0) (0)	$102,372 (0) (0) (0) (0)	$209,862 (1 brochures; 1 posters; 1 bracelets; 1 stickers)	$215,109 (1 brochures; 1 posters; 1 bracelets; 1 stickers)	$220,487 (1 brochures; 1 posters; 1 bracelets; 1 stickers)	$847,705 (3 brochures; 3 posters; 3 bracelets; 3 stickers)

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
DG 3.1Cvi: Print and publish newspaper adverts (4 newspaper adverts published per year, with 1 per quarter)	Newspaper adverts printed (half-page adverts only)	$2,000 (0)	$2,050 (0)	$4,203 (4)	$4,308 (4)	$4,415 (4)	$16,975 (12)

DG3.1D: Promote family planning information and use through mobile phone text messaging services, particularly for youth men and women.

Intervention Strategy: Bolster family planning promotion and communication, including interpersonal communication/client-provider communication, at facility level (in-service and preservice)

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
DG 3.1Di: Negotiate with MNOs (LoneStar/Orange) to incorporate messaging as part of mhealth texts – aired at a discounted price	N/A	$0 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (1)
DG 3.1Dii: Conduct 2-day workshop to review and adapt global messaging for family planning text messages for Liberian context	One 2-day workshop	$0 (0)	$1,907 (1)	$0 (0)	$0 (0)	$0 (0)	$1,907 (1)
DG 3.1Diii: Conduct focus groups with different audience segments to assess acceptability, comprehension, and relevance of adapted messages	1) Repot generated on acceptability, comprehension, and relevance of key messages 2) Updated message finalized for programming into mobile text messages	$0 (0)	$1,722 (1)	$0 (0)	$0 (0)	$0 (0)	$1,722 (1)
DG 3.1Div: Add a "tag line" to promote text service in other media channels such as the brochures, bracelets, and posters that are disseminated as part of the series of media events (example: for more information, text "tag line" at "phone number")	N/A	$0 (0)	$0 (0)	$0 (1)	$0 (1)	$0 (1)	$0 (3)

DG3.1E: Strengthen IPC component of the training curriculum for family planning & RMNCAH service providers (facility and community health levels)

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
DG 3.1Ei: Conduct a 5-days meeting to review the in-service training curriculum for RMNCAH providers, including family planning, and other relevant training materials, to ensure comprehensive inclusion of IPC approach, principles, and standards to family planning service delivery. [Linked to Service Delivery Activity **SD 1.1B**: Review and review the family planning in-service training curriculum(s)] **No additional costs for this sub-activity.	The IPC component of the in-service training curriculum for RMNCAH, including family planning providers, strengthened	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)
DG 3.1Eii: Support inclusion of IPC approaches, principles, and standards in preservice curriculum for providers [Linked to Service Delivery Activity **SD 1.1B**: Review and review the family planning in-service training curriculum(s)] **No additional costs for this sub-activity.	N/A	$0 (0)	$$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)
DG 3.1Eiii: Review and revise supportive supervision and mentoring tools to enable assessment of the implementation of IPC principles and standards in family planning service delivery [Linked to Service Delivery Activity **SD 1.1B**: Review and review the family planning in-service training curriculum(s)] **No additional costs for this sub-activity.	N/A	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)

DG3.2: Positive shifts in social norms and attitudes to foster adoption and sustained use of contraceptives

Intervention Strategy: Community Mobilization

DG3.2A: Work with CHVs and CHAs to conduct community dialogues about gender, sexuality, healthy sexual relationships, and family planning

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
DG 3.2Ai: Finalize and validate the family planning BCC/IEC materials (CHA job aids, posters, brochures) through Messages and Materials Development (MMD) Group.	Set of validated family planning BCC/IEC tools [**No additional costs for this sub-activity, as it has occurred in 2017.]	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)
DG 3.2Aii: Produce and distribute BCC/IEC materials to CHTs in all 15 counties through CHSD and County Health Services.	5,000 hard copies of tools distributed to each CHT [**No additional costs for this sub-activity, as it has occurred in 2017.]	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)
DG 3.2Aiii: CHT, lead partners, and CHSS orient CHA/CHVs on how to use BCC/IEC materials through regular monthly meetings	All CHAs/CHVs oriented to use family planning tools [**No additional costs for this sub-activity, as it has occurred in 2017.]	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)
DG 3.2Aiv: CHSS, CHT, and others perform regular community supervision visits to monitor use of tools in the field.	All CHV/CHAs receive monthly supervision visit **Cost breakdown for the timeframe/ recurrence** *(with a goal of 4,000 CHAs deployed in remote areas by 2021, which is equivalent to 400 CHSS needed; annual increase in 12 CHSS)*: ***2018***: With 350 CHSS: 350 *12 monthly visits ***2019***: With 362 CHSS: 362*12 monthly visits ***2020***: With 374 CHSS: 374 *12 monthly visits ***2021***: With 386 CHSS: 386 *12 monthly visits ***2022***: With 400 CHSS: 400 *12 monthly visits	$168,000 (4,200)	$178,104 (4,344)	$188,608 (4,488)	$199,526 (4,632)	$211,932 (4,800)	$946,171 (22,464)
DG 3.2Av: Support CHVs/CHAs to conduct community dialogues/health talks with priority audiences, such as youth, men, community leaders on family planning	Three dialogues per quarter per district (for different communities/clans representing CHV/CHA catchment site in district) 90 districts	$270,000 (270)	$276,750 (270)	$283,669 (270)	$290,760 (270)	$298,029 (270)	$1,419,209 (1,350)

DG3.2B: Support interactive public dialogues on regional radio on family planning, teen pregnancies, myths and misconceptions, family planning rights etc. to spur social change at county levels

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
DG 3.2Bi: FHD develops concept note for radio program	Concept note is developed, reviewed, and finalized through 2 meetings (1 meeting for development and 1 meeting for review/finalization) *(*No cost applied to conduct this meeting for the concept note.)*	$0 (2)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (2)
DG 3.2Bii: CHTs advocate for free airtime with UNMIL and local radio stations	NHPD, FHD, CHT travel to meet with radio stations to advocate for free airtime for at least one radio station per county *(*No cost applied to conduct this meeting.)*	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)
DG 3.2Biii: CHTs coordinate with local partners to pool resources to fund radio call in shows	CHT has budget available to conduct monthly radio program (Monthly partners coordination meeting held annually)	$0 (12)	$0 (12)	$0 (12)	$0 (12)	$0 (12)	$0 (60)
DG 3.2Biv: CHT RH Supervisor conducts/host monthly radio talk show / call in programs, featuring CHDC, HPFP, CHAs, religious, community and traditional leaders, and other rotating guests.	Monthly radio program produced/aired (per county) *(1 per month – 12 every year in each county)*	$10,800 (12)	$11,070 (12)	$11,347 (12)	$11,630 (12)	$11,921 (12)	$56,768 (60)

Intervention Strategy: Engage champions to stimulate social change in communities

DG3.2C: Engage and support champions (community, religious, traditional leaders) and role models (satisfied users in the community) to promote family planning and challenge norms

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
DG 3.2Ci: FHD develops concept note to articulate engagement of champion/role model for family planning promotion/ advocacy, including criteria for selection, orientation, and support. Set up committee, and hold meeting to review ad finalize draft concept.	Concept note developed	$300 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$300 (1)

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
DG 3.2Cii: Develop any additional tools as recommended by the Champions required under the concept note	Additional family planning tools developed (MMD to develop through regular monthly CHA meetings)	$3,000 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$3,000 (1)
DG 3.2Ciii: Produce and distribute tools to CHTs in all 15 counties through CHSD and County Health Services. Leverage trips to the counties to conduct the distribution of the tools	1,500 hard copies of tools distributed to each CHT (100 copies per county)	$3,000 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$3,000 (1)
DG 3.2Civ: Identify champion/role models according to the concept note selection criteria (CHT, CHSS identify champions – travel to communities)	82 champions recruited (1 champion at central, one per county and one per district)	$300 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$300 (1)
DG 3.2Cv: CHT orients champions/role models on strategy and their roles	82 champions oriented to use family planning tools	$0 (0)	$20,910 (2 workshops)	$0 (0)	$14,060 (1.28 workshops)	$0 (0)	$34,970 (3.28)
DG 3.2Cvi: family planning champions' advocacy working groups will also be established at county level to support coordination and coalition building around common issues facing communities	Monthly meetings established where champions can gather and discuss progress and barriers	$464,400 (12)	$476,010 (12)	$487,910 (12)	$500,108 (12)	$512,611 (12)	$2,441,039 (60)

Intervention Strategy: Engage Faith-based leaders to understand, accept, and support the provision of family planning at community level

DG3.2D: Sensitize faith-based leaders on family planning matters

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
DG 3.2Di: Conduct two workshops to develop guidance and materials to advocate and communicate with FBO leaders on family planning in the context of religion	Guidance document and materials – family planning in the context of family planning (100 copies printed)	$0 (0)	$20,885 (1-time printing)	$0 (0)	$0 (0)	$0 (1)	$20,885 (2)
DG 3.2Dii: Conduct 1-day meeting with faith based leaders from religious councils on consent for involvement in family planning services at their levels.	A total of 300 faith-based leaders sensitized of engagement in family planning services	$0 (0)	$0 (0)	$50,441 (5 meetings)	$51,702 (5 meetings)	$0 (0)	$102,142 (10)

DG3.2E: Mobilize and conduct outreach to faith-based communities to promote family planning uptake by organizing a family planning club within faith-based institutions to promote family planning services within their membership

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
DG 3.2Ei: Identify family planning focal person and club members (3 faith based organizations per quarter/county)	Family planning club established to lead and provide family planning services (1 club per institution) - 45 meetings every quarter (3 meetings per county) **Each family planning club meets once per quarter for one day.	$0 (0)	$36,900 (180 meetings)	$0 (0)	$0 (0)	$0 (0)	$36,900 (180 meetings)
DG 3.2Eii: Develop TOR for the club during the regular family planning TWG meeting	TOR developed by means of a 2-day central-level meeting held at family planning TWG meeting in Monrovia	$0 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (1)
DG 3.2Eiii: Orient the family planning club members on family planning services for demand creation and distribute demand creation materials to the family planning club	Orientation provided for family planning club members	$0 (0)	$0 (0)	$42,544 (3 meetings)	$29,072 (2 meetings)	$0 (0)	$71,616 (5 meetings)
DG 3.2Eiv: Support facility providers to conduct outreach to faith-based institutions (churches) to provide family planning methods	3 faith-based institutions per county receive outreach services per year (45 FBOs with one main contact per site) – service provided once per month	$0 (0)	$38,745 (12)	$39,714 (12)	$40,706 (12)	$41,724 (12)	$160,889 (48)

Intervention Strategy: Engage and empower males and boys to support their partners (enabler) and use modern contraceptives

DG3.2F: Integrate male involvement as enabler and user into family planning curriculum

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
DG 3.2Fi: Review Family Planning Curriculum to ensure that information on male involvement in family planning is included (Linked to Service Delivery Activity **SD 1.1B**: Review and revise the family planning in-service training curriculum.) **No additional costs for this sub-activity.	Male involvement is included in family planning curriculum	$0 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (1)

DG3.2G: Engage and empower men through interactive communication to understand and accept use of family planning services

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
DG 3.2Gi: Conduct meeting to orientate male population on family planning services for support and users [Linked to Demand Generation Activity **3.1A**: Develop guidance for SBCC efforts building upon efforts under the existing National Health Communication Strategy (NHCS)] **No additional costs for this sub-activity.	1) Male involvement in family planning services for their family 2) 1 Quarterly meeting per county	$0 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (1)
DG 3.2Gii: Host community dialogues with male population for family planning services support and users (Linked to Demand Generation Activities: • **DG 3.1C**: Hold a series of media events to promote awareness and acceptability of family planning, address common myths and misconceptions, and challenge social norms. • **DG 3.1D**: Promote family planning information and use through mobile phone text messaging services, particularly for youth men and women.) **No additional costs for this sub-activity.	Male understand the importance and their roles for family planning for their family	$0 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (1)
DG 3.2Giii: Conduct outreach with Male Motivators and Peer Educators/Mentors (champions/role models) (Linked to: • Service Delivery clinical outreach activities **SD 1.3A**, **1.3B**, and **1.3C** • Demand Generation community mobilization activities **DG 3.2A** and **3.2B**) **No additional costs for this sub-activity.	N/A	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)

DG3.2H: Build capacity of MOH staff at central and county levels (FHD managers, RH Supervisors at county and district levels) on evidence-based strategies to engage men and boys

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
DG 3.2Hi: Conduct a 2-day orientation workshop on evidence-based strategies to engage men and boys	3 workshops held, each 35 representatives from FHD, county and district level, oriented on male involvement strategies	$0 (0)	$41,783 (3)	$0 (0)	$0 (0)	$0 (0)	$41,783 (3)

YOUTH

Y4.1: Existing facility-based service delivery points offer family planning services that meet youth-friendly standards to facilitate access and use by young people

Intervention Strategy: Mainstream youth-friendly service delivery into existing health services (at all levels) at scale

Y4.1A: Advocacy to gain buy-in and long-term support from CHTs and OICs for the integration of YFS into facilities

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
Y 4.1Ai: Conduct 2-day advocacy meetings to sensitize and gain buy-in from County Health Teams and facility officers-in-charge to adopt and support mainstreaming interventions, including supporting provision of family planning services outside for extended working hours, and the use of a whole clinic approach to service delivery	30 CHTs, 76 district supervisors and 750 OICs from all 15 counties engaged in advocacy meetings	$0 (0)	$114,218 (6)	$117,073 (6)	$120,000 (6)	$0 (0)	$351,291 (18)
Y 4.1Aii: Conduct 15 advocacy meetings with 15 County Health Teams per annum to facilitate inclusion of YFS action plans in county micro-plans	Family planning annual action plans in each county reflect work in the area of YFS (15 counties per year supported to develop action plans)	$0 (15)	$0 (15)	$0 (15)	$0 (15)	$0 (15)	$0 (75)

Y4.1B: Integrate YFS into training curriculum for family planning service providers (facility – pre-service, and community health levels)

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
Y 4.1Bi: Conduct a 2-days meeting to review the family planning in-service training curriculum, and other relevant training materials for in-service providers and CHAs to ensure comprehensive inclusion of youth-friendly service approach, principles, and standards to family planning service delivery	A youth-friendly family planning in-service training curriculum for family planning providers *(*to be achieved by through a 2-day meeting held at central level)*	$7,190 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$7,190 (1)
Y 4.1Bii: Support inclusion of YFS approaches, principles and standards in preservice curriculum for providers (Linked with Activity **SD 1.1G** Work with professional boards/training institutions for nurses, midwifery, PAs, and physicians to bolster the family planning section of the pre-service curricula) **No additional costs for this sub-activity.	YFS approaches, principles, and standards are integrated in the provider preservice curriculum	$0 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (1)

Y4.1C: Improve facility service readiness in accordance with YFS standards

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
Y 4.1Ci: Conduct an assessment to understand the extent by which facilities adhere to YFS standards in family planning provision, and determine gaps for improvement	One report documenting the extent by which facilities adhere to YFS standards in family planning provision, and recommendations for improvement	$67,350 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$67,350 (1)
Y 4.1Cii: Support facility refurbishment to ensure adequate privacy	(No performance targets or additional costs for this sub-activity as it is already covered in the Youth Empowerment Strategy)	$0 (N/A)	$0 (N/A)	$0 (N/A)	$0 (N/A)	$0 (N/A)	$0 (N/A)

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
Y 4.1Ciii: Create and post sign boards and facility signs to promote awareness of YFS for standard provision, including reflecting convenient hours of operation/services (Linked to Youth Activity **Y4.1F**: Promote YFS-FP services/facilities to young people) **No additional costs for this sub-activity.	N/A	$0 (1)	$0 (1)	$0 (1)	$0 (1)	$0 (1)	$0 (5)
Y 4.1Civ: Develop, print, and distribute IEC materials and rights-based approach brochures/posters in facilities [Linked to Demand Activity **DG 3.1A**: Develop guidance for SBCC efforts building upon efforts under the existing National Health Communication Strategy (NHCS)] **No additional costs for this sub-activity.	N/A	$0 (1)	$0 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (2)

Y4.1D: Support capacity building of providers to improve technical competency in YFS provision of family planning services

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
Y 4.1Di: Conduct training of health providers on YFS	1,500 health providers from 15 counties trained in YFS provision (2 staff per facility)	$386,916 (375 providers)	$396,589 (375 providers)	$406,504 (375 providers)	$416,667 (375 providers)	$0 (0)	$1,606,676 (1,500 providers)
Y 4.1Dii: Conduct regional training of CHAs on YFS	4000 CHAs from 15 counties trained in YFS after 5-year period	$825,821 (800 CHAs)	$846,467 (800 CHAs)	$867,629 (800 CHAs)	$889,319 (800 CHAs)	$911,552 (800 CHAs)	$4,340,789 (4,000 CHAs)

Y4.1E: Strengthen supportive supervision of health staff in adoption of YFS in family planning provision

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
Y 4.1Ei: Review and revise supportive supervision and mentoring tools to enable assessment of the implementation of YFS principles and standards in family planning service delivery (Should also include client exit interviews, review of clinical skills competencies, equipment and supplies, implant removal tracking, service statistics reporting, YFS etc.) (Linked with Service Delivery Activity **SD 1.1Fiii**: Develop family planning supportive supervision tools) **No additional costs for this sub-activity.	1 meeting conducted Supportive supervision and mentoring tools revised and reprinted	$0 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (1)

Y4.1F: Promote YFS-FP services/facilities to young people

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
Y 4.1Fi: Label health facilities that offer youth-friendly family planning services with placards and sign boards to raise awareness of service availability	16 placards and 32 sign boards developed Facilities labeled with YFS placards and sign boards (Messages developed & Partners logo placed on outputs created)	$6,880 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$6,880 (1)
Y 4.1Fii: Develop and distribute directories of health facilities offering YFS services to youth centers, youth CSOs, schools, higher-learning institutions & other areas patrolled by youth	Directories, flyers, posters printed & distributed (reprints annually for updates)	$51,000 (1)	$52,275 (1)	$53,582 (1)	$54,921 (1)	$56,294 (1)	$268,073 (5)

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
Y 4.1Fiii: Incorporate a directory of youth-friendly service facilities on mobile texting service [Linked to Demand Activity **DG 3.1D**: Promote family planning information and use through mobile phone text messaging services, particularly for youth men and women] **No additional costs for this sub-activity. Conducted same years as Demand Generation activity DG 3.1D.	Contract signed with two leading mobile companies for disseminating messages on health facilities offering YFS	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)
Y 4.1Fiv: Develop and distribute A3 Posters / Bill Boards to promote services, and inform on rights of youth to access RH/FP services to youth centers, youth CSOs, schools, higher-learning institutions & other areas patrolled by youth	300 A3 posters, 15 billboards, and 3,000 flyers printed and distributed	$32,400 (1)	$0 (0)	$0 (0)	$34,891 (1)	$0 (0)	$67,291 (2)

Y4.1G: Finalize and Print ASRH strategy, ASRH standards counseling cards & job aids

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
Y 4.1Gi: Conduct 2-day validation workshop to review, validate, finalize, and print the ASRH strategy	1,500 copies of the ASRH strategy printed	$46,278 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$46,278 (1)
Y 4.1Gii: Conduct a 5-day validation workshop to review, validate, finalize and print the ASRH standards & counseling cards	Validation workshop conducted	$0 (0)	$31,137 (1)	$0 (0)	$0 (0)	$0 (0)	$31,137 (1)

Y4.2: Existing youth centers operated by MOYS offer contraceptive information and services

Intervention Strategy: Support and scale provision of youth-friendly information and services (provided via outreach by facility staff) to MOYS-supported youth centers

Y4.2A: Strengthen and scale family planning information & services in existing youth centers

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
Y 4.2Ai: Recruit and orient peers who are members of existing youth centers to be the conduct of family planning information within the youth center and in the community, and mobilize youth to use services	5 peers per youth center (9 youth centers total located in the following counties: Montserrado, Grand Cape, Bassa, Bong, Nimba, Grand Gedeh, Margibi, Bomi, and Rivercess)	$0 (0)	$32,254 (1.8)	$0 (0)	$0 (0)	$0 (0)	$32,254 (1.8)
Y 4.2Aii: Liaise with facilities to support outreach of family planning staff from nearby facilities to youth centers to provide family planning services at least once a month	9 youth centers receive family planning services from outreach family planning staff at least once per month	$0 (0)	$8,856 (12)	$9,077 (12)	$9,304 (12)	$9,537 (12)	$36,775 (48)

Y4.3: Parents, guardians (including teachers and principals), and community understand and are increasingly supportive on matters related to adolescent sexuality, teen pregnancy, and contraceptive services

Intervention Strategy: Open dialogue discussions on adolescent/youth sexuality and teenage pregnancy prevention matters via multiple channels to sensitize, raise awareness, and build supportive environment for contraceptive uptake among young people

Y4.3A: Organize and hold public dialogues on radio on adolescent/youth sexuality and teenage pregnancies – engage parents, young people, religious and traditional leaders, and ASRH experts (including Youth-led intergenerational dialogues)

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
Y 4.3Ai: Hire a media/PR firm to support development, production, and airing of a series of radio programs on public dialogues - on different regional and national radio. Target radios in regions with high teenage pregnancies (Linked to Demand Activity **DG 3.1C**: Hold a series of media events to promote awareness and acceptability of family planning, address common myths and misconceptions, and challenge social norms. Conducted same years as Demand Generation activity DG 3.1D.)	Radio program aired (twice a month, every other quarter)	$0 (N/A)	$0 (N/A)	$0 (N/A)	$0 (N/A)	$0 (N/A)	$0 (N/A)
Y 4.3Aii: Conduct community public dialogues on adolescent/youth sexuality and teenage pregnancies, including in churches, mosques, markets etc.	2 events per county (30 events total per year)	$42,000 (30)	$43,050 (30)	$44,126 (30)	$45,229 (30)	$46,360 (30)	$220,766 (150)

Y4.4: Relevant, age-appropriate, multimedia behavior change communication efforts tailored to young people designed and implemented

Intervention Strategy: Conduct an SBCC campaign focusing on pregnancy prevention among different youth segments

* Activities included under Demand Technical Area

Y4.5: A multisectoral approach to support a holistic programming towards teenage pregnancy reduction is strengthened

Intervention Strategy: Adopt and sustain a multisectoral approach to holistically address teenage pregnancies

Y4.5A: Engage multisectoral stakeholders at national level to holistically address teenage pregnancy issues/ASRH (MOH, MOE, MOYS, MOG, MOIA, MOF, FLY etc.)

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
Y 4.5Ai: Leverage and strengthen the existing National Youth Steering Committee (NYSC)-chaired by MOYS – to integrate ASRH issues as part of the committee's agenda	12 meetings held every year and agenda items include ASRH	$8,400 (12)	$8,610 (12)	$8,825 (12)	$9,046 (12)	$9,272 (12)	$44,153 (60)
Y 4.5Aii: Review and update Terms of Reference of different ministries to reflect their respective clear roles in ASRH, and identify focal point persons from each ministry	TORs updated and Focal persons identified	$300 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$300 (1)

Y4.5B: Integrate pregnancy prevention/ASRH in the School Health Policy

Intervention Strategy: Support scientifically accurate and comprehensive sexuality education programs within and outside of schools

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
Y 4.5Bi: Validate the pregnancy prevention/ASRH section integrated in the School Health Policy	Pregnancy prevention/ASRH section for the School Health Policy validated through a 2-day meeting at central level	$6,418 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$6,418 (1)
Y 4.5Bii: Print the updated School Health Policy	6,000 copies of the update School Health Policy are printed	$120,000 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$120,000 (1)
Y 4.5Biii: Disseminate the updated School Health Policy via a regional dissemination approach	Regional approach applied for the dissemination of the updated School Health Policy	$36,290 (5 meetings)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$36,290 (5 meetings)

Y4.5C: Establish an Out-of-School CSE Manual

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
Y 4.5Ci: Finalize and validate the Out-of-School CSE Manual	Out-of-School CSE Manual developed and validated	$41,938 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$41,938 (1)
Y 4.5Cii: Print Out-of-School CSE Manual	6000 Out-of-School CSE manuals printed	$72,000 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$72,000 (0)
Y 4.5Ciii: Train & Disseminate the Out-of-School CSE manual to NGOs & CSOs (applying a county approach – one workshop per county)	10 CSOs and all NGO partners (20+) involved in School Health are trained and receive the Out-of-School CSE Manual	$256,107 (15)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$256,107 (15)
Y 4.5Civ: Raise awareness about the out-of-school CSE manual at the community level for parents, influential leaders, etc.	Awareness creation activities conducted *(*This will be achieved through half-day community meetings with about 50 participants per meeting. The estimated total number of meetings from 2019 – 2021 is 150 with 10 meetings per county. Thus, there will be 50 meetings for each of these three years.)*	$0 (0)	$53,813 (50 meetings)	$55,158 (50 meetings)	$56,537 (50 meetings)	$0 (0)	$165,507 (150 meetings)

Y4.5D: Establish an In-School CSE Manual

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
Y 4.5Di: Review and identify gaps in the existing the national teaching curriculum for all level (primary and secondary)	A report on the assessment of existing national teaching curriculum	$0 (0)	$46,586 (1)	$0 (0)	$0 (0)	$0 (0)	$46,586 (1)
Y 4.5Dii: Engage the MOE on curriculum changes, and sensitize on CSE	MOE staff engaged on the proposed curriculum changes	$0 (0)	$14,975 (1 meeting)	$0 (0)	$0 (0)	$0 (0)	$14,975 (1 meeting)
Y 4.5Diii: Review & Revise the teacher training curriculum based on gap definition and integrate CSE in national curriculum	Updated Teacher Training Curriculum integrated with CSE	$0 (0)	$61,039 (3 meetings)	$0 (0)	$0 (0)	$0 (0)	$61,039 (3 meetings)

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
Y 4.5Div: Pilot in 30 schools	1) Schools (*specifically emphasis on principals and teachers) are sensitized to the updated Teacher Training Curriculum 2) 30 teachers trained on the updated Teacher Training Curriculum (*one teacher per school attending this training) 3) Ongoing monitoring conducted (*no costs associated for this target – will be using existing monitoring systems)	$0 (0)	$0 (0)	$42,299 (1)	$0 (0)	$0 (0)	$42,299 (1)
Y 4.5Dv: Rollout of Teacher Training Institutes (TTIs)	Tutors trained on the revised curriculum	$0 (0)	$0 (0)	$0 (0)	$27,477 (1 training)	$0 (0)	$27,477 (1 training)

Y4.6 Increase political prominence of teenage pregnancy issues

Intervention Strategy: Advocacy to enhance visibility and attention of teenage pregnancy issue on health and economic agendas

Y4.6A: Conduct high level advocacy around teenage pregnancy reduction

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
Y 4.6Ai: Generate the evidence-base to support the advocacy on teenage pregnancy reduction	1) Model data validation meeting conducted 2) Print model application final technical product 3) Model application product disseminated	$74,486 (1 model app process)	$76,348 (1 model app process)	$0 (0)	$0 (0)	$0 (0)	$150,834 (2 model app processes)
Y 4.6Aii: Develop advocacy materials and plan for sensitizing high level policy makers and house of representatives on teenage pregnancy reduction	1) Two meetings conducted for the development of the advocacy materials 2) One validation meeting conducted 3) Flyers and briefs printed	$40,052 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$40,052 (1)
Y 4.6Aiii: Implement advocacy events with high level policy makers and house of representatives on teenage pregnancy reduction	Host organized meetings (quarterly) 30 pax per meeting (US$100 rate)	$14,800 (4)	$15,170 (4)	$15,549 (4)	$15,938 (4)	$16,336 (4)	$77,794 (20)

Y4.6B: Engage and empower youth-focused CSOs to advocate for teenage pregnancies reduction

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
Y 4.6Bi: Support and work with Youth focus CSO Platform under the MYS to advocate for teenage pregnancy reduction (Linked to Enabling Environment Activity **EE 5.1B**: Build capacity of CSOs and champions to conduct family planning advocacy) **No additional costs for this sub-activity.	Support and work with youth-focused CSOs Platform	$0 (0)	$0 (0)	$0 (1)	$0 (0)	$0 (0)	$0 (1)

Y4.7: Data generated and used to inform decisions for ASRH

Intervention Strategy: Data for Decision-Making

Y4.7A: Improve use of disaggregated service statistics data in programmatic decision-making

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
Y 4.7Ai: Support HMIS Rollout of new HMIS forms capturing 10–14, 15–19, 20–25+ years	N/A	$0 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (1)

Y4.7B: Conduct research and disseminate findings to inform decision-making on ASRH matters

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
Y 4.7Bi: Engage research institutions to conduct sound studies on priority research questions, including extent and impact of abortions among teenagers; cost-effectiveness of approaches - youth centers vs. facility mainstreaming, etc.	At least 3 research studies conducted, and findings disseminated to inform decision-making	$58,825 (1 study)	$0 (0)	$61,803 (1 study)	$63,348 (1 study)	$0 (0)	$183,976 (3 studies)

EE5.1: Capacity for conducting effective advocacy for family planning enhanced

Intervention Strategy: A tailored and evidence-based advocacy strategy and tools

EE5.1A: Review and strengthen the evidence-base for family planning to facilitate advocacy efforts, including for resource mobilization and enhancing visibility of family planning in the national agenda

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 5.1Ai: Establish an advocacy taskforce to guide efforts forward. Taskforce meets monthly for a one-day meeting	Monthly meetings for the first 2 years. 1 meeting held every 2 months for the remaining 3 CIP years	$0 (12)	$0 (12)	$0 (6)	$0 (6)	$0 (6)	$0 (42)
EE 5.1Aii: Conduct a landscape assessment to have an in-depth understanding of the advocacy challenges and opportunities, including key influencers and decision-makers. Assessment should also assess family planning financing trends. The landscape will also consolidate and review/update existing data from RAPID Model, Demographic Dividend, and ImpactNow	A report on an assessment of the family planning advocacy landscape generated and shared	$58,620 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$58,620 (1)
EE 5.1Aiii: Based on data, generate an advocacy strategy with key advocacy messages, materials, and approaches for different target audiences (MOH sr. leadership, Ministry of Finance, House of Representatives, county leadership, etc.)	Advocacy Strategy developed	$23,860 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$23,860 (1)

Intervention Strategy: Strengthen CSO engagement and capacity to support advocacy to increase and sustain political will toward family planning

EE5.1B: Build capacity of CSOs and champions to conduct family planning advocacy

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 5.1Bi: One representative from three selected CSOs and champions to attend a regional workshop	Representatives from three CSOs (1 per CSO) and champions attended regional workshop	$7,906 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$7,906 (1)

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 5.1Bii: Establish coalition of CSOs to promote coordination and linkages for family planning advocacy	1) TOR established, CSOs recruited, secretariat established, work plan developed 2) Quarterly meetings convened	$1,200 (1) (4)	$1,230 (0) (4)	$1,261 (0) (4)	$1,292 (0) (4)	$1,325 (0) (4)	$6,308 (1) (20)
EE 5.1Biii: Conduct 5-days workshop to build capacity of CSOs and champions to conduct family planning advocacy (include techniques for advocacy, evidence-base for family planning based on advocacy strategy). Representatives who attend the regional workshop to cascade learning to other CSO members engaged in advocacy.	One 5-day capacity building workshop for CSOs and champions (2 workshops total – 1 in 2018 and 1 in 2020)	$11,400 (1)	$0 (0)	$11,977 (1)	$0 (0)	$0 (0)	$23,377 (2)

EE5.2: At least 5% of the GOL annual health budget allocated to family planning commodities and health services by 2021, in line with the country's FP2020 commitment

Intervention Strategy: Advocacy to support enhancing funding allocation and disbursements under the dedicated budget line item for family planning in national budget

EE5.2A: Support the Family Health Division to advocate for funding allocation and disbursement under the budget line item for family planning in the overall MOH budget

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 5.2Ai: Ensure that the discussion on funding allocation and disbursement budget line in the national budget remain an agenda item at all RHTC meetings	RHTC agenda include family planning as a budget line in the MOH budget	$0 (12)	$0 (12)	$0 (12)	$0 (12)	$0 (12)	$0 (60)

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 5.2Aii: In collaboration with champions, convene advocacy meetings with key target audiences (influencers and decision-makers) to raise awareness of government FP2020 financial commitment, and make a case for the need for allocation and disbursement of funds under the family planning budget line item. Meetings will include both group and one-on-one sessions. Audiences include the Planning Department, Health Financing Division (HFD), the Office for Financial Management (OFM), MFDP and the Health Care and Social Welfare Committee of the House of Representatives	Meetings with decision makers and influencers to facilitate a decision on a budget line item for family planning in the MOH budget	$0 (0)	$615 (3)	$630 (3)	$0 (0)	$0 (0)	$1,245 (6)

Intervention Strategy: Budget advocacy at county level

EE5.2B: Conduct advocacy meeting with county-level policy makers and county health boards to present an investment case for family planning contextualized to the county-level issues

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 5.2Bi: Convene a 1-day meeting with county-level policymakers and county health boards	Annual county level pledges/ commitments to finance family planning (1-day meeting held in each of the 15 counties)	$0 (0)	$19,680 (15)	$20,172 (15)	$20,676 (15)	$21,193 (15)	$81,722 (60)

EE5.2C: Orient and support county-level civil society members and other county stakeholders to champion family planning agenda in annual operational planning and resource allocation efforts

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 5.2Ci: Conduct a 3-day workshop for civil society members on family planning advocacy and budget analysis for family planning in county budgets	Five champions per county identified and supported	$0 (0)	$13,665 (1)	$0 (0)	$14,357 (1)	$0 (0)	$28,022 (2)

EE5.2D: Build the capacity of, and support the county RH supervisors to advocate for a family planning budget and increase visibility of family planning in county agendas, for example ensuring that family planning is discussed in the County Coordination meetings

Intervention Strategy: Budget advocacy at the level of House of Representatives

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 5.2Di: Hold a 4-day workshop for RH supervisors and CHOs on family planning advocacy and budgeting for family planning in county budgets	Workshop on family planning advocacy and budgeting conducted	$0 (0)	$21,669 (1)	$0 (0)	$0 (0)	$0 (0)	$21,669 (1)
EE 5.2Dii: Participation of central level FHD (& TWG) in County Coordination Meetings to support RHS to advocate for family planning (1 visit per county per year)	At least two representatives of the central-level family planning TWG representatives participate in one county coordination meeting per year during annual operational planning (family planning included on the County Coordination meeting agenda and on the meeting minutes)	$0 (0)	$12,608 (15)	$11,923 (15)	$13,246 (15)	$13,577 (15)	$52,353 (60)

EE5.2E: Sensitize relevant committees of the House of Representatives on the need for public sector resource allocation for family planning

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 5.2Ei: Sensitize, with clear evidence to the key relevant committees of the House of Representatives for public sector allocation to family planning. Key committees include Health Care and Social Welfare, Gender Equity and Child Development, Youth and Sport, & Human and Civil Rights (occurs during budget season)	Annual sensitization meetings with House of Representatives	$5,400 (1)	$5,535 (1)	$5,673 (1)	$5,815 (1)	$5,961 (1)	$28,384 (5)

EE5.3: Resources mobilized from nongovernmental (i.e., foreign/ domestic donors) sources increased

Intervention Strategy: Diversify donor base beyond primary development partners

EE5.3A: Mobilize resources from development partners to the family planning program

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 5.3Ai: Conduct a donor mapping exercise to understand priorities and opportunities for funding family planning	Mapping report made available to RHTC & Family Planning Committee	$3,000 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$3,000 (1)
EE 5.3Aii: Engage a champion to advocate for donor resource allocation to the family planning program	A champion is identified to liaise with other donors for family planning resource mobilization	$0 (1)	$0 (1)	$0 (1)	$0 (1)	$0 (1)	$0 (5)
EE 5.3Aiii: Host annual round tables with donors to advocate for resource mobilization, share progress and funding gaps (Informed by CIP performance monitoring and annual gap analysis efforts) (Linked to Enabling Environment Activity **EE 7.1C**: Develop annual joint review and workplans, defining what will be covered/implemented and what will not in the respective year by different partners and MOH)	1 meeting a year is convened with development partners	$300 (1)	$308 (1)	$315 (1)	$323 (1)	$331 (1)	$1,577 (5)

EE5.3B: Advocate and closely liaise with the Global Financing Facility to ensure that family planning is included as a priority investment area in GFF-funded projects

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 5.3Bi: Closely liaise with the GFF focal point to ensure family planning is a priority investment in current and future GFF funded projects	GFF is engaged on an annual basis to ensure that family planning is a priority investment	$0 (1)	$0 (1)	$0 (1)	$0 (1)	$0 (1)	$0 (5)

EE5.4: Opportunities for domestic resource mobilization for family planning explored and pursued

Intervention Strategy: Advocate for coverage of family planning services in existing private health insurance schemes

EE5.4A: Advocate to expand coverage of contraceptive services in private health insurance schemes

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 5.4Ai: Conduct analysis of savings to insurance schemes after covering family planning services (resulting from a potential reduction in maternal health-related expenditures)	A report on the analysis of savings from family planning insurance coverage is developed	$0 (0)	$6,150 (1)	$0 (0)	$0 (0)	$0 (0)	$6,150 (1)
EE 5.4Aii: Hold technical consultation meetings with private insurance companies to review results and make recommendations (Conduct individual meetings with companies to follow up on individual corporate decision making)	One meeting conducted with private health insurance scheme providers	$0 (0)	$308 (1)	$0 (0)	$0 (0)	$0 (0)	$308 (1)
EE 5.4Aiii: Sensitize large employers to include family planning in their health plans with private insurance schemes	1 meeting conducted with large employers	$0 (0)	$308 (1)	$0 (0)	$0 (0)	$0 (0)	$308 (1)

EE6.1: Heightened and sustained political will and commitment towards family planning

Intervention Strategy: Gain prominence visibility, and support for family planning matters from the House of Representatives, Senior Leadership of the MOH, and the general public

EE6.1A: Engage and sensitize political leaders (House of Representatives) on role of family planning in achieving the vision 2030. Demographic dividend, rapid population growth, etc.

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 6.1Ai: Activity linked to EE Output 5.2 (Linked to Enabling Environment Activity **EE 5.2E**: Sensitize relevant Committees of the House of Representatives on the need for public sector resource allocation for family planning) **No additional costs for this sub-activity.	Daily rate for Congress men/women = US$100/(10 members)	$0 (1)	$0 (1)	$0 (1)	$0 (1)	$0 (1)	$0 (5)

EE6.1B: Engage Senior Leaders of the MOH, including the Planning Division to generate visibility and focus to family planning program

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 6.1Bi: Hold regular presentations (once a quarter) to the Health Services Meeting – for Directors on the status of the family planning program	Quarterly presentations to the Health Services Meeting held	$0 (4)	$0 (4)	$0 (4)	$0 (4)	$0 (4)	$0 (20)

EE6.1C: Sensitize and bolster the capacity media houses and journalists to increase visibility of family planning matters on media

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 6.1Ci: Work with the Media and Communications Unit of the MOH to bolster family planning visibility in mass media	1) Orientation of journalists on messaging and provision of messages and drama conducted 2) Host orientation session with selected media firm (2 hours)	$0 (0)	$60,588 (1)	$0 (0)	$0 (0)	$0 (0)	$60,588 (1)

EE6.1D: Convene a National Family Planning Conference

Intervention Strategy: Advocate for a multisectoral approach to family planning

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 6.1Di: Convene broad stakeholders in a National family planning Conference	One family planning Conference convened	$52,750 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$52,750 (1)

EE6.1E: Establish and implement an intersectoral committee to act as a platform to engage different sectors on family planning matters, for example school heal policy, leveraging youth centers (MOYS, MOIA, MOE, MOG, MOH, MOF etc.)

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 6.1Ei: Set up an intersectoral committee (generate a TOR and assign members/focal points, and secretariat) -- conducted by family planning Program Manager	Intersectoral committee established	$0 (0)	$0 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (1)
EE 6.1Eii: Hold quarterly meetings to discuss how different sectors can be leveraged to further the family planning program	Quarterly meetings conducted at central level	$0 (0)	$3,485 (4)	$3,572 (4)	$3,661 (4)	$3,753 (4)	$14,472 (16)

EE6.2: A conducive policy environment, with clear and transparent operational directives, to guide effective implementation of the family planning program

Intervention Strategy: Update and support use of RH Policy Guidelines

EE6.2A: Review and update the RH policy

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 6.2Ai: Establish a taskforce under RHTC to work on revisions	Taskforce established with agreed upon terms of reference, and selected members	$0 (0)	$0 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (1)
EE 6.2Aii: Conduct a 4-days workshop to review and revise the family planning component of the RH policy	4-days workshop held	$0 (0)	$10,486 (1)	$0 (0)	$0 (0)	$0 (0)	$10,486 (1)

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 6.2Aiii: Convene a 2-day validation workshop	2-day validation workshop held	$0 (0)	$10,506 (1)	$0 (0)	$0 (0)	$0 (0)	$10,506 (1)
EE 6.2Aiv: Print the updated RH policy	RH policy printed	$0 (0)	$20,500 (1)	$0 (0)	$0 (0)	$0 (0)	$20,500 (1)
EE 6.2Av: Hold a dissemination meeting – central level (representation at this meeting is anticipated to include 2 persons per county + 15 participants from central level)	Central-level dissemination meeting held	$0 (0)	$11,080 (1)	$0 (0)	$0 (0)	$0 (0)	$11,080 (1)
EE 6.2Avi: Hold a dissemination meeting – county level (representation at this meeting is anticipated to include 15 CHO, 15 CHDC, 15 RHS, 76 DHOs, 76 DHS, 15 CHS)	County-level dissemination meeting held	$0 (0)	$53,293 (5.3 wksp)	$0 (0)	$0 (0)	$0 (0)	$53,293 (5.3 wksp)
EE 6.2Avii: Orient family planning Providers on the policy guidelines & distribute these guidelines (Linked to Service Delivery Activity **SD 1.1F**: Supervise and mentor providers on clinical provision of family planning services. The various sub-activities under SD 1.1F occur across the 5 CIP years) **No additional costs for this sub-activity.	Orientation of family planning providers held	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (0)

Intervention Strategy: Reclassify ECs as a contraceptive method

EE6.2B: Support policy change to reclassify ECs as part of the contraceptive method mix

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 6.2Bi: Establish and maintain a small taskforce to spearhead efforts to reclassify ECs (Representatives would include representatives of the FHD, Pharmacy Division, SCMU, implementing partners, and donors)	Taskforce established (terms of reference and work plan defined and representatives selected)	$0 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (1)

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 6.2Bii: Taskforce hold meetings with the Pharmacy Division to advocate for ECs – reclassification for the MOH to approve	Two advocacy meetings with influencers and decision-makers for EC reclassification	$1,500 (1)	$0 (0)	$1,576 (1)	$0 (0)	$0 (0)	$3,076 (2)

Intervention Strategy: Explore task-sharing opportunities to expand access to surgical sterilization services

EE6.2C: Conduct an operations research study to assess safety and feasibility, and acceptability of PAs and RNs

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 6.2Ci: Conduct advocacy to get consensus to explore provision of sterilization services by PAs and RNs	Two 1-day meetings at central level with professional boards to discuss and get buy-in	$0 (0)	$3,075 (2)	$0 (0)	$0 (0)	$0 (0)	$3,075 (2)
EE 6.2Cii: Conduct study tour - Uganda	5 representatives conduct a study tour in Uganda	$0 (0)	$18,812 (1)	$0 (0)	$0 (0)	$0 (0)	$18,812 (1)
EE 6.2Ciii: Hire a research institution to conduct the O.R study (2-year period)	A report on the operations research study to assess safety and feasibility, and acceptability of surgical sterilization by PAs and RNs	$0 (0)	$0 (0)	$30,902 (0.5)	$31,674 (0.5)	$0 (0)	$62,576 (1)
EE 6.2Civ: Hold workshop to develop intervention	Workshop held at central level to generate intervention for testing	$0 (0)	$0 (0)	$2,311 (1)	$0 (0)	$0 (0)	$2,311 (1)
EE 6.2Cv: Hold workshop at central level to disseminate findings, and generate recommendations for the way forward to inform MOH decision-making	Advisors, influencers and decision-makers meet to review data generated from study and generate actionable recommendations and decisions	$0 (0)	$0 (0)	$0 (0)	$7,816 (1)	$0 (0)	$7,816 (1)
EE 6.2Cvi: Hold advocacy meetings at central level to support decision-making based on study findings	A report documenting decision by country on provision of surgical contraception by PAs and RNs	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$3,091 (2)	$3,091 (2)

EE7.1 Capacity at the MOH to effectively lead, manage, and coordinate the family planning program is strengthened

Intervention Strategy: Capacity support at MOH central and county level for family planning

EE7.1A: Hire additional staff 100% dedicated to coordination and implementation of the National CIP for family planning at FHD

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 7.1Ai: Develop TOR for new staff, and mobilize support and resources for hiring additional staff	TOR developed and shared with family planning TWG	$0 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (1)
EE 7.1Aii: Advertise position(s) and conduct interviews	1-week advert in 2 newspapers	$250 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$250 (1)
EE 7.1Aiii: Hire staff (2 staff) – family planning program officers (5-year contract)	Staff have contract of employment	$30,000 (12)	$30,750 (12)	$31,519 (12)	$32,307 (12)	$33,114 (12)	$157,690 (60)

Intervention Strategy: Strengthen family planning Stakeholders coordination platform at all levels

EE7.1B: Establish and implement a dedicated family planning Technical Working Group/Subcommittee of the RHTC to facilitate expanded focus on family planning matters

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 7.1Bi: Continue to conduct advocacy with the RHTC for instituting a family planning TWG at Central and Count Levels -- Include discussion of family planning on the RHTC agenda *(Work with the RHTC focal person to include family planning discussion on the agenda)*	Agenda includes family planning TWG	$0 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (1)
EE 7.1Bii: Host family planning TWG meetings monthly	Monthly national family planning TWG meetings held	$7,200 (12)	$7,380 (12)	$7,565 (12)	$7,754 (12)	$7,947 (12)	$37,846 (60)
EE 7.1Biii: Host regular County level family planning collaborative linkages between MOH and CHTs on family planning matters)	Monthly county-level family planning TWG meetings held	$46,200 (12)	$47,355 (12)	$48,539 (12)	$49,752 (12)	$50,996 (12)	$242,842 (60)

EE7.1C: Develop annual joint review and work plans, defining what will be covered/implemented and what will not in the respective year by different partners and MOH

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 7.1Ci: Collect information from partners to inform the work planning session	Information collected from work planning session	$0 (1)	$0 (1)	$0 (1)	$0 (1)	$0 (1)	$0 (5)
EE 7.1Cii: Conduct an annual gap analysis based on work plan (FHD CIP Focal Point with support from Planning division)	Annual gap analysis conducted	$0 (1)	$0 (1)	$0 (1)	$0 (1)	$0 (1)	$0 (5)
EE 7.1Ciii: Conduct a 3-day meeting to support joint annual work planning/progress reviews for the Family Planning Program	Annual work planning sessions conducted in beginning of CIP year	$26,890 (1)	$27,562 (1)	$28,251 (1)	$28,958 (1)	$29,682 (1)	$141,343 (5)

EE7.2. Data-driven decision making is enhanced to improve effectiveness and efficiency of the family planning program

Intervention Strategy: Regularly track progress and performance of the program

EE7.2A: Establish and Implement a planning/performance monitoring mechanism/system for the CIP/program

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 7.2Ai: Adapt the global FP2020 CIP performance monitoring tools to track progress of the CIP and improve coordination amongst the partners (FHD M&E focal point sets up the tool for Liberia's use)	Dashboard for CIP performance monitoring is developed and maintained	$0 (1)	$0 (0)	$0 (0)	$0 (0)	$0 (0)	$0 (1)
EE 7.2Aii: FHD M&E focal point for family planning collects and analyses data for the CIP Performance Monitoring Dashboard and shares in the family planning TWG meeting and MOH Directors meeting (quarterly)	Dashboard updated on a quarterly basis and shared at family planning TWG and MOH Directors meetings	$0 (4)	$0 (4)	$0 (4)	$0 (4)	$0 (4)	$0 (20)

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 7.2Aiii: Host bi-annual CIP performance review meetings to review family planning data in the CIP performance management system (annual meeting combined with annual planning meeting). Meeting include a data consensus session on service statistics	Two semiannual CIP performance review meetings conducted per year	$15,800 (2)	$16,195 (2)	$16,600 (2)	$17,015 (2)	$17,440 (2)	$83,050 (10)

Intervention Strategy: Improve reporting rates for family planning services statistics

EE7.2B: Conduct regular mentoring and supervision at county level

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 7.2Bi: Central-level HMIS & M&E staff monitor county M&E work-plan implementation. Staff will also support data harmonization and verification through PBF mechanism	Quarterly monitoring report made available (3 facilities per quarter per county) Semiannual harmonization and verification report (3 facilities per county)	$16,560 (4 reports)	$16,974 (4 reports)	$17,398 (4 reports)	$17,833 (4 reports)	$18,279 (4 reports)	$87,045 (20 reports)
EE 7.2Bii: Share harmonization and verification reports with CHT (via email)	Harmonization and verification reports shared with CHT	$0 (4)	$0 (4)	$0 (4)	$0 (4)	$0 (4)	$0 (20)
EE 7.2Biii: Host 1-day county annual feedback meeting with county health teams (1 meeting per county per year for one day with a total of 15 meetings every year)	One day county annual feedback meeting held	$50,850 (15)	$52,121 (15)	$53,424 (15)	$54,760 (15)	$56,129 (15)	$267,284 (75)

EE7.2C: Conduct annual national data consensus workshops

Sub-Activity	Activity-level Target(s)	Annual Financial Target in USD (annual performance target)					Total Sub-Activity Cost in USD (total performance targets)
		2018	*2019*	*2020*	*2021*	*2022*	
EE 7.2Ci: Conduct 2-day annual data consensus workshops	Data consensus workshops conducted	$8,800 (1)	$9,020 (1)	$9,246 (1)	$9,477 (1)	$9,714 (1)	$46,256 (5)

ANNEX C: KEY POLICIES AND STRATEGIES REFLECTING FAMILY PLANNING

POLICIES AND STRATEGIES	IMPLICATION TO FAMILY PLANNING
Vision 2030	The National Vision 2030 takes its inspiration from the Accra Comprehensive Peace Agreement signed in 2003 to end 14 years of civil hostilities in Liberia. The intent of this vision is to provide a long-term perspective that would boost reconciliation, cohesion, self-reliance, and development that is sustainable and equitable. This vision captures four future possibilities as outlined in four scenarios. One of the scenarios, the Developmental State Scenario, provides an image of the future that all Liberians would like to realize. Significantly, it incorporates ideas about the requisite critical action for structural and systemic transformation of Liberia. It envisages a harmonious nation united in diversity, democratic and culturally vibrant, innovative, creative, self-reliant and prosperous, amid a beautiful and flourishing environment. When family planning information and services are available and utilized with limited barriers in accessing services, young people will be in a better position to continue their education and fully exploit opportunities to ensure that they contribute to the kind of Liberia the vision 2030 document has envisaged.
National Health Policy and Plan 2011-2021	The NHPP document focuses on the reinforcing the implementation of various aspects of the EPHS in which the maternal and newborn care service sections includes seven component areas including family planning. According to the NHPP counseling for family planning will be initiated at ANC and PNC, while family planning commodities will be made available at community. This is a clear indication of the commitment of the MOH to implement family planning services from the health facility to the community level. It highlights the significance of family planning in maternal and newborn health services.
Liberia investment plan for building a resilient health system	Crafted because of the unprecedented Ebola virus disease outbreak, the Liberia investment plan is a viable document that is intended to boost the implementation of health services in much more resilient manner. Five out of the nine investment areas directly affect the implementation of family planning services: • Build a fit-for-purpose productive and motivated health workforce that equitably and optimally delivers quality services. • Put in place a cost-effective and efficient supply chain management system for essential medicines and supplies; ensure that family planning commodities are at the heart of this investment area. • Enhance service delivery systems to ensure quality of care for clients and a safe working environment for health staff. • Strengthen the health information, research, and communication systems to ensure service provision will be based on evidence and need. • Strengthen community engagement and involvement in preventive health service delivery. Backed by effective leadership, governance, and health financing strategies and practices, these investment areas, when implemented, will greatly improve family planning service delivery in the country.
Essential Package of Health Services	The essential package of health services, which replaced the basic health packages in 2011, emphasizes the need to ensure maternal health services, including family planning, are available to all women and men of reproductive age. Both the primary and secondary/tertiary levels emphasize standards of care that focuses on clients' needs. Client-centered care that ensures access to family planning services is built around investments that strengthen human resources, effective supply chain, Health information management system and quality service provision at all levels.

POLICIES AND STRATEGIES	IMPLICATION TO FAMILY PLANNING
National Policy for Sexual Reproductive, Maternal Newborn, Child and Adolescent Health (SRMNCAH)	Family planning is one of several strategic interventions defined in the SRMNCAH policy. With an aim to enhance family planning services and increase the CPR, to reduce maternal mortality and teenage pregnancy, the policy emphasizes that the government of Liberia will ensure the following: • Availability and provision of a full range and supply of contraceptive methods • Support training and supervision, mentoring, and coaching of service providers and equip facilities accordingly • Uphold the principle of informed choice and rights for individual women, men, couples, and young people • Ensure that postpartum family planning counseling and services are available • Ensure that family planning counseling emphasizes dual protection against STIs/HIV and unintended pregnancies • Ensure that the provision of adolescent and youth-friendly family planning services are in line with standards • Strengthen community-based family planning provision, awareness, and sensitization using multimedia channels, including local traditional methods of communication • Promote male involvement in SRMNCAH programs and services
GFF Investment Case for the Reduction of Maternal and Newborn Morbidity and Mortality in Liberia 2016–2021	The investment case prioritizes integrated RMNCAH approaches and building on ongoing performance-based financing activities. It seeks to improve the delivery of emergency obstetric and neonatal care services and enhance the delivery of RMNCAH services at community level. In parallel, it proposes to target adolescents with a specific focus on family planning and on strengthening the health system, including human resources for health, primary and secondary health facility infrastructure, and drug and commodity supply chain management. The plan intends to increase contraceptive prevalence rate to 26 percent, reduce teenage pregnancies to 25 percent, and increase demand satisfied by modern methods to 60 percent by 2021.
Community Health Policy Liberia Community Health Road Map 2014–2017	With approximately 28 percent of the population more than one hour distant from any healthcare facility, the importance of a vibrant community health policy and strategy cannot be overemphasized. Although the document is skewed to child healthcare, the policy has endorsed the provision of community-based family planning service by CHVs. The distribution of oral contraceptives and condoms by CHAs is a welcome initiative in family planning, particularly since it will increase access to information as well as referral services for more comprehensive family planning services.
National Reproductive Health Commodity Security Strategy and Operational Plan, 2013–2017	This plan identifies critical needs in commodity supply, financial and technical support, coordination, and specifies the interventions required to ensure continuous availability of contraceptives and vital RH medicines at all health services delivery and commodity distribution points.
National Policy and Strategic Plan on Health Promotion, 2016–2021	The NPSPHP provides guidance on the provision of accurate, relevant, and appropriate health information, including family planning. Specifically, the NPSPHP emphasizes communicating that family planning is safe, free, and effective, with the goal of increasing the proportion of men and women of reproductive age who space their children at least two years apart.
National Family Planning Strategy, 2017–2021	This strategy document represents a renewed commitment of the GOL, aiming to coordinate efforts to increase the use of family planning services by ensuring that couples, individuals, and adolescents of reproductive age have access to the full range of quality affordable family planning services at a location of their choice, by the end of 2021.

ANNEX D: LIST OF KEY STAKEHOLDER PARTICIPANTS DURING CIP DEVELOPMENT

NAME	DESIGNATION & ORGANIZATION
Abdul-Rahman Bah	Life of African Mothers
Agnes Kyne Thompson	Maryland Co. Health Team
Ami Wates	Last Mile Health
Amos Williams	FLY
Andrew A. Z. Mambu	UNFPA
Anna S. Kollah	Project Coordinator/LPMM
Anne Foster	MCSP/Jhpiego
Asatu M Dono	CHSIS MOH
Assatu K. Kpainyea	MOH/FHD
Barbara Jones	PACS
Barsee Y. Zoggbaye	County RHS/Bong County Health Team
Bento Z. Tehongue	H6 Coordinator/WHO
Bill Winfrey	TRACK 20
Cecelia M.D. Bundeh	MOH/MCHT
Charlesetta M. Johnny	RH Supervisor/Rivercess Co. Health Team
Chrisneh L. Mulbah	Adolescent & Youth Unit/MOH
Christine Lasway	PALLADIUM
Clifftina C. Grove	PHIL
Comfort S. Wiles	County RHS/BACHT
Comfort T Gebeh	MCSP/JHPIEGO
Damawah Y.Saye	Liberia Midwives Association
Dr. Cuallau Jabbeh-Home	Director, County Health Services/MOH
Dr. Birhanu Getahun	MCSP/Jhpiego
Dr. John S. Doedeh	County Health Officer/Sinoe County Health Team, MOH
Dr. Joseph L. Kerkula	Director/FHD
Dr. Methodius T. George	County Health Officer/Maryland County MOH
Dr. Orulemi Sogenro	Country Representative/UNFPA
Dr. Philips K. Sahn	County Health Officer/Bomi County
Dr. Annette Brima-Daris	Deputy Director/FHD - MOH
Dr. Ngormbu Ballah	MOH
Dr. Yatta S. Wapoe	County Health Officer/MCHT
Emma K. Katakpah	FHD/MOH
Emmanuel T. S. Dahn	M & E Officer/MOH
Erika E. Richards	Community health services Division/MOH
Ernree B. Neeplo	PPAL
Esther Argba	RH Supervisor/LOFA County Health Team

NAME	DESIGNATION & ORGANIZATION
Faith Kojo	Bungeon
Farzee P. Johnson	County RHS/River Cess County
Fatima M.L Guindo	Clinical Mentor/PIH
Fatu Anna Nyain	Big Belly Business/OSIWA
Fatu J Holmes	County RH Supervisor/Bomi County
G. Moses Kwalula	Big Belly Business/OSIWA
Garmetta T. Brown	FARA
Georgla Manue	FHD/MOH
Grace Dorbor-quiah	HRH-in -service Training/MOH
Hawa K. Kromah	RH Supervisor/Grand Cape Mt Co. Health Team
Helen Loewenstein	Life of African Mothers
Helena Bungay	PHIL
Helena G. Suah	JFKMC
Henry Kolenky	SWAAL
Irene Tucker	District RHS/NCHT
J. Anthony Garmokollie	FHD/MOH
Jemimah Brown	FHD/MOH
Jordan Hatcher	PALLADIUM
Josephine T. Wacheka	UNFPA
Joyce Kilikpo Jarwolo	PHIL
Julius Stewart	SWAA-L
Justin DeNormandie	PSI
Kebeh Beyan Paulumah	Last Mile Health
Komassa S.Tennih	CCMCHT
Kumba Mayah	NSG Division/MOH
Lawrence Mumbe	FHD/World Bank
Leemue W. Porte	CHS/MOH
Lincoln Morris	UNFPA
Lorpu Sherman	FHD/MOH
Louise S Brooks-Jallah	LPMM
Lovely W. Sie	PSI
M. A. Razzaque Khan	BRAC
Mama J.K .Philips	MaCHT/MOH
Mamai Kollie	County RHS/Gbarpolu
Mandain P. Jallah	FHD/MOH
Margaret Reeves	USAID/Washington
Marlene K. Tokpa	FHD
Marthalyn T Geleplay	County RHS/River Gee CHT
Mary W. Tiah	Liberia Board of Nurses & Midwives

NAME	DESIGNATION & ORGANIZATION
Matilda Billy	RH Supervisor/Grand Gedeh County
Maureen Morris	Ministry of Youth & Sports/ASRH program
Maxcy K. Tobii	NAC
Maybe Livingstone	UNFPA
Mettee Johnson Moris	Big Belly Business/OSIWA
Minnie Sirtor-Bowier	Consultant/Palladium Group
Musu Washington	MOH
Nancy Gysue	FHD
Nanela L.C. Warner	Liberian Nurses Association
Nyenekon N. Won	SCMU/MOH
Ophelia D. Tango	CHSD/MOH
Pamalia Zaizay	RH Supervisor/Margibi
Pamela B. Sawyer	FP-RH Specialist/USAID
Patience Tokpah	MCHT
Princess B. Jobo	RH Supervisor/GKRU
Priscilla S. Mablah	Nimba County Health Team
Queenie Nah	NACP
Ruth Wakor	FHD
Samson Arzoaquoi	CMO/MOH
Sarah Layweh	FP Coordinator/FHD
Shadrach L. Bestman	NHPS/MOH
Sheikh Idissa Swary	UMABGCO
Suena S. Flomo	Consultant/Palladium Group
Sumo Nuwolo	NPHIL
Taymie Mulbah Fissibue	Sinoe County Health Team
Thomas Harris	GHSC-PSM/Chemonics
Tima Brenah	UNICEF
Tracy N. Pency - King	NHPD/MOH
Vera Mussah	PBF/MOH
Virginia Kaydor	FHD/MOH
Wilhelmina Flomo	Liberia Midwifery Association

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