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REPRODUCTIVE HEALTH *at a* GLANCE

SIERRA LEONE

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Country Context

Since the end of the war 1961–2002, Sierra Leone has been moving towards building a peaceful nation and is now governed by a democratic government. This long period of political instability has posed many development challenges. And, despite 6 years of steady growth, over half of the population still subsists on less than US $1.25 per day.[1] The growing concentration of wealth and basic public services—including electricity and water—in urban cities is further widening the gap between the rich and the poor.

Country's large share of youth population (43 percent of the country population is younger than 15 years old) provides a window of opportunity for high growth and poverty reduction—the demographic dividend. But for this opportunity to result in accelerated growth, the government needs to invest more in the human capital formation of its youth. This is especially important in a context of decelerated growth rate observed since 2008.

Gender equality and women's empowerment are important for improving reproductive health. Higher levels of women's autonomy, education, wages, and labor market participation are associated with improved reproductive health outcomes.[2] In Sierra Leone, the literacy rate among females ages 15 and above is 29 percent; 63 percent of the female school-age population attend primary school and only 25 percent attend secondary school.[1] Fewer girls are enrolled in secondary schools compared to boys with a percent ratio of female to male secondary enrollment of 66.[1] Two thirds of adult women participate in the labor force that mostly involves work in agriculture. Gender inequalities are reflected in the country's human development ranking; Sierra Leone ranks at the bottom of the Gender-related Development Index.[3]

Greater human capital for women will not translate into greater reproductive choice if women lack access to reproductive health services. It is thus important to ensure that health systems provide a basic package of reproductive health services, including family planning.[2]

Sierra Leone: MDG 5 Status

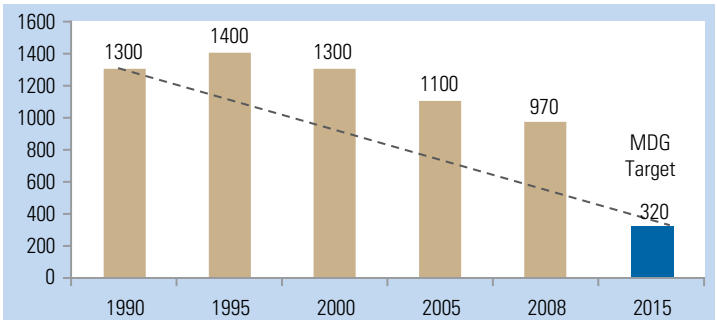
MDG 5A indicators	
Maternal Mortality Ratio (maternal deaths per 100,000 live births) *2008 UN estimate*[a]	970
Births attended by skilled health personnel (percent) – 2005	42.4
MDG 5B indicators	
Contraceptive Prevalence Rate (percent) – 2008	8.0
Adolescent Fertility Rate (births per 1,000 women ages 15–19) – 2008	146
Antenatal care with health personnel (percent) – 2005	88.9
Unmet need for family planning (percent) – 2008	28

Source: Table compiled from multiple sources.
[a] The 2008DHS estimated maternal mortality ratio at 857.

MDG Target 5A: Reduce by Three-quarters, between 1990 and 2015, the Maternal Mortality Ratio

Sierra Leone has made insufficient progress over the past two decades on maternal health and is not on track to achieve its 2015 targets.[4]

Figure 1 ▪ Maternal mortality ratio 1990–2008 and 2015 target



Source: 2010 WHO/UNICEF/UNFPA/World Bank MMR report.

World Bank Support for Health in Sierra Leone

Current Projects:
P110535 SL-Reproductive & Child Health - Phase 2 (FY11) Closing date 10/31/2013
P103740 SL-Health Sect Reconstruction & Development -Add Fin (FY07) Approval date 5/22/2007

Pipeline Projects: None

Previous Projects:
P073883 SL-HIV/AIDS Response (FY02)
P074128 SL-Health Sec Reconstruction & Development (FY03)
P103712 SL-Reproductive and Child Health (FY07)
CAS: Current Joint country assistance strategy period FY2010–2013

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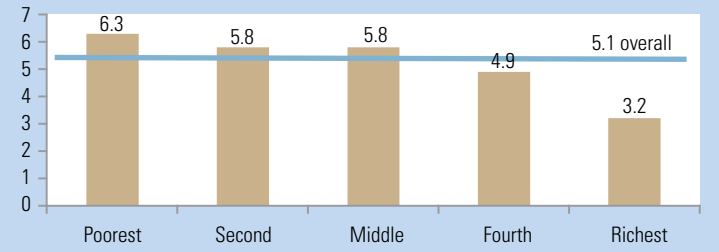
Key Challenges

High fertility

Fertility has been declining but still remains high, especially among the poor. Total fertility rate fell slightly from 6 births per woman in 1990 to 5.1 in 2008.[5] TFR among women in the lowest wealth quintile is almost than twice those in the highest wealth quintiles (Figure 2). Disparities exist between women in rural areas at 5.8 births per woman compared to 3.8 for those in urban areas, and vary by education levels at 5.8 births per woman with no education, and 3.1 with secondary education or above.

Figure 2 ▪ Total fertility rate by wealth quintile



Source: 2008 Sierra Leone Demographic Health Survey.

Adolescent fertility rate is high (146 reported births per 1,000 women aged 15–19 years[5]) affecting not only young women and their children's health but also their long-term education and employment prospects. Births to women aged 15–19 years old have the highest risk of infant and child mortality as well as a higher risk of morbidity and mortality for the young mother.[2, 6]

Early childbearing is overall high but more frequent among the poor. While 58 percent of the poorest 20–24 years old women have had a child before reaching 18, only 29 percent of their richer counterparts did (Figure 3). Furthermore, reduction in early childbearing has mostly taken place among the rich where younger cohorts of girls are less likely than older cohorts to have a child early in life.

Figure 3 ▪ Percent women who have had a child before age 18 years by age group and wealth quintile

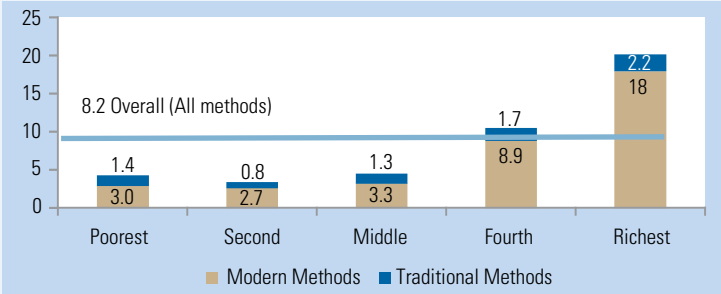
Source: 2008 Sierra Leone Demographic Health Survey (author's calculation).

Less than 10 percent of married women use contraception. Use of modern contraceptives is low (7 percent in 2008), but its use among wealthier women is six times higher than those of women in the poorest quintiles (18 and 3 percent, respectively) (Figure 4).[5] Injectables are the most commonly used method, followed by the pill. Use of long-term methods such as intrauterine device and implants are negligible.

Unmet need for contraception is high at 28 percent and highest (34 percent) among the age group 30-34 years.[5] This suggests that some women may not be achieving their desired family size.[7]

Opposition to use and health concerns in the use of modern contraceptive methods are the main reasons for most people not using them. More than a third (37 percent) of women not intending to use contraception express opposition as the main reason while another 14 percent cite health concerns or fear of side-effects. Cost and access are lesser concerns, indicating further need to strengthen family planning services.[5]

Figure 4 ▪ Use of contraceptives among married women by wealth quintile

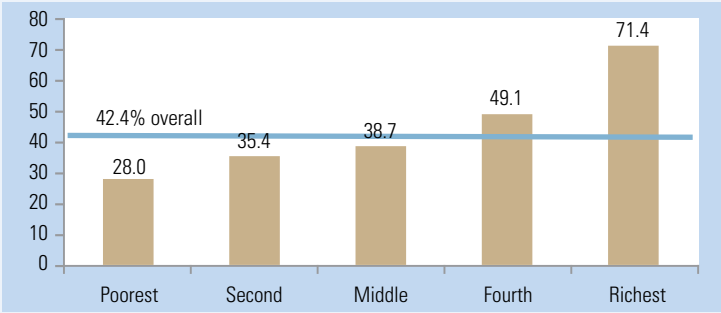


Source: DHS Final Report, Sierra Leone 2008.

Poor Pregnancy Outcomes

While use of antenatal care is high, births assisted by skilled birth attendants remain low. Nearly 9 in 10 (89 percent) pregnant women receive antenatal care but only 43 percent of births are attended by health personnel.[5] While 71 percent of women in the wealthiest quintile delivered with skilled health personnel, only 28 percent of women in the poorest quintile obtained such assistance (Figure 5). Further, 60 percent of all pregnant women have anaemia (defined as haemoglobin < 110g/L) increasing risk of preterm delivery, low birth weight, stillbirth and newborn death.[8]

Figure 5 ▪ Birth assisted by health personnel (percentage) by wealth quintile



Source: DHS Final Report, Sierra Leone 2008.

Postnatal care is effectively used mostly by those women who delivered in a health facility. Of those women who did not give birth in a health facility, 40 percent never received a postnatal care.

Majority of women who indicated problems in accessing health care cited concerns regarding inability to afford the services and difficulty in getting to the health facility (Table 1).[5]

Table 1 ▪ Reasons for not delivery in a health facility (women age 15–49)

Reason	%
At least one problem accessing health care	89.0
Getting money for treatment	80.0
Distance to health facility	52.9
Having to take transport	50.0
Concern no drugs available	48.7
Concern no provider available	36.6
Concern no female provider available	20.8
Not wanting to go alone	20.2
Getting permission to go for treatment	7.9

Source: DHS Final Report, Sierra Leone 2008.

Human resources for maternal health are limited with only 0.016 physicians per 1,000 population but nurses and midwives are slightly more common at 0.168 per 1,000 population.[1]

The high maternal mortality ratio at 970 maternal deaths per 100,000 live births indicates that access to and quality of emergency obstetric and neonatal care (EmONC) remains a challenge.

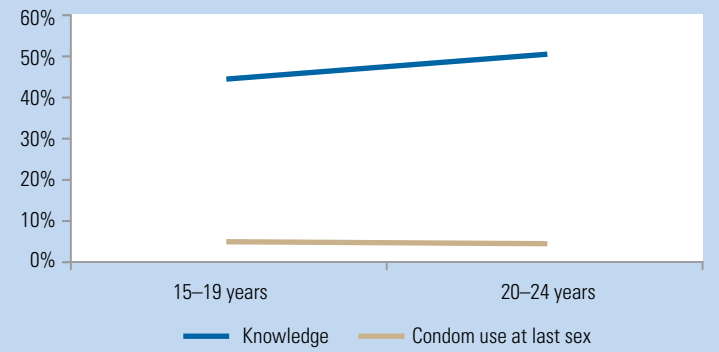
STIs/HIV/AIDS prevalence is low but a growing public health concern

HIV prevalence is low in Sierra Leone but women are one of the most vulnerable groups. Less than 2 percent of the adult population has HIV; prevalence among females is significantly higher than among males (1.7 percent and 1.2 percent respectively) with women of childbearing age comprising 59 percent of the HIV positive population.[5] Only one percent of pregnant women receive antiretroviral drugs.

Knowledge of prevention of Mother-to-Child Transmission of HIV is low. Only 19 percent of women know that HIV can be transmitted through breast milk and that the likelihood of passing HIV from mother to child can be reduced by taking antiretroviral drugs.[5]

The knowledge/behavior gap regarding condom use for HIV prevention among young women is wide. While 44 percent of young women are aware that using condom in every intercourse prevents HIV, only 5 percent of them report having used condom at last intercourse. This gap widens as young women get older as the likelihood of using condom as a form of contraception diminishes with marriage.

Figure 6 ▪ Knowledge behavior gap in HIV prevention among young women



Source: DHS Final Report, Sierra Leone 2008 (author's calculation).

Technical Notes:

Improving Reproductive Health (RH) outcomes, as outlined in the RHAP, includes addressing high fertility, reducing unmet demand for contraception, improving pregnancy outcomes, and reducing STIs.

The RHAP has identified 57 focus countries based on poor reproductive health outcomes, high maternal mortality, high fertility and weak health systems. Specifically, the RHAP identifies high priority countries as those where the MMR is higher than 220/100,000 live births and TFR is greater than 3.These countries are also a sub-group of the Countdown to 2015 countries. Details of the RHAP are available at *www.worldbank.org/population*.

The Gender-related Development Index is a composite index developed by the UNDP that measures human development in the same dimensions as the HDI while adjusting for gender inequality. Its coverage is limited to 157 countries and areas for which the HDI rank was recalculated.

Key Actions to Improve RH Outcomes

Strengthen gender equality

- Support women and girls' economic and social empowerment. Increase school enrollment of girls. Strengthen employment prospects for girls and women. Educate and raise awareness on the impact of early marriage and child-bearing.
- Educate and empower women and girls to make reproductive health choices. Build on advocacy and community participation, and involve men in supporting women's health and wellbeing.

Reducing high fertility

- Address the issue of opposition to use of contraception and promote the benefits of small family sizes. Increase family planning awareness and utilization through outreach campaigns and messages in the media. Enlist community leaders and women's groups.
- Provide quality family planning services that include counseling and advice, focusing on young and poor populations. Highlight the effectiveness of modern contraceptive methods and properly educate women on the health risks and benefits of such methods.
- Promote the use of ALL modern contraceptive methods, including longterm methods, through proper counseling which may entail training/re-training health care personnel.
- Secure reproductive health commodities and strengthen supply chain management to further increase contraceptive use as demand is generated.

Reducing maternal mortality

- Given the use of antenatal care is high, augment the content of service provided to pregnant women. This will for instance address the issue of the prevalent anemia in pregnancy.
- Train more midwives and provide them incentives to accept posting in the rural areas and hard-to-reach areas.
- Implement risk-pooling schemes and provide transport vouchers to women in hard-to-reach areas.
- Ensure access to quality emergency obstetric and neonatal care in order to reduce the high maternal mortality.

Reducing STIs/HIV/AIDS

- Strengthen Behavior Change Communication (BCC) programs via mass media and community outreach to raise HIV/AIDS awareness and knowledge.
- Integrate HIV/AIDS/STIs and family planning in routine antenatal and postnatal care services.
- Focus on adolescents, youth and married women in providing information, education and communication on HIV/AIDS.

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SIERRA LEONE REPRODUCTIVE HEALTH ACTION PLAN INDICATORS

Indicator	Year	Level	Indicator	Year	Level
Total fertility rate (births per woman ages 15–49)	2008	5.1	Population, total (million)	2008	5.6
Adolescent fertility rate (births per 1,000 women ages 15–19)	2008	146	Population growth (annual %)	2008	2.5
Contraceptive prevalence (% of married women ages 15–49)	2008	8.2	Population ages 0–14 (% of total)	2008	43.3
Unmet need for contraceptives (%)	2008	27.6	Population ages 15–64 (% of total)	2008	54.9
Median age at first birth (years) from DHS	2008	19.3	Population ages 65 and above (% of total)	2008	1.9
Median age at marriage (years)	2008	17.2	Age dependency ratio (% of working-age population)	2008	82.2
Mean ideal number of children for all women	2008	5	Urban population (% of total)	2008	37.8
Antenatal care with health personnel (%)	2008	88.9	Mean size of households	2008	6
Births attended by skilled health personnel (%)	2008	42.4	GNI per capita, Atlas method (current US$)	2008	320
Proportion of pregnant women with hemoglobin <110 g/L	2008	59.7	GDP per capita (current US$)	2008	352
Maternal mortality ratio (maternal deaths/100,000 live births)	1990	1300	GDP growth (annual %)	2008	5.5
Maternal mortality ratio (maternal deaths/100,000 live births)	1995	1400	Population living below US$1.25 per day	2003	53.4
Maternal mortality ratio (maternal deaths/100,000 live births)	2000	1300	Labor force participation rate, female (% of female population ages 15–64)	2008	67.1
Maternal mortality ratio (maternal deaths/100,000 live births)	2005	1100	Literacy rate, adult female (% of females ages 15 and above)	2008	28.9
Maternal mortality ratio (maternal deaths/100,000 live births)	2008	970	Total enrollment, primary (% net)	—	—
Maternal mortality ratio (maternal deaths/100,000 live births) target	2015	320	Ratio of female to male primary enrollment (%)	2007	88.2
Infant mortality rate (per 1,000 live births)	2008	123	Ratio of female to male secondary enrollment (%)	2007	66.3
Newborns protected against tetanus (%)	2008	97	Gender Development Index (GDI)	2007	157
DPT3 immunization coverage (% by age 1)	2008	54.6	Health expenditure, total (% of GDP)	2007	4.4
Pregnant women living with HIV who received antiretroviral drugs (%)	2005	1.2	Health expenditure, public (% of GDP)	2007	1.4
Prevalence of HIV, total (% of population ages 15–49)	2007	1.7	Health expenditure per capita (current US$)	2007	13.5
Female adults with HIV (% of population ages 15+ with HIV)	2007	58.8	Physicians (per 1,000 population)	2008	0.016
Prevalence of HIV, female (% ages 15–24)	2007	1.3	Nurses and midwives (per 1,000 population)	2008	0.168

Indicator	Survey	Year	Poorest	Second	Middle	Fourth	Richest	Total	Poorest-Richest Difference	Poorest/Richest Ratio
Total fertility rate	DHS	2008	6.3	5.8	5.8	4.9	3.2	5.1	3.1	2.0
Current use of contraception (Modern method)	DHS	2008	3.0	2.7	3.3	8.9	18.0	6.7	–15.0	0.2
Current use of contraception (Any method)	DHS	2008	4.4	3.5	4.6	10.6	20.2	8.2	–15.8	0.2
Unmet need for family planning (Total)	DHS	2008	26.5	27.8	27.7	29.4	26.5	27.6	0.0	1.0
Births attended by skilled health personnel (percent)	DHS	2008	28.0	35.4	38.7	49.1	71.4	42.4	–43.4	0.4