FP TECHNICAL STRATEGY

2019 – 2023

1.0 BACKGROUND

South Sudan has an ambitious target, of reducing the unmet need for contraception by 10 percent before the year 2020 - a target, which would significantly address the country's high maternal mortality ratio. According to FP2020 track 20 the total unmet need for contraception services in South Sudan was 30.8% percent. Increased investment in comprehensive SRH programs would yield multiple benefits that would enable adolescents, especially girls and married women, to stay healthy, avoid unintended pregnancies, complete education, engage in productive work, and have healthier babies as and when they choose to do so.

A great deal of progress has been made in improving sexual and reproductive health (SRH) and increasing access to family planning among the women in eight hubs of South Sudan. However, despite improvements in some metrics major disparities persist.

Teenage pregnancies South Sudan are as high as 52%, with girls in the age group 15 – 18 years having given birth to at least one child. This situation is partly attributed to cultural practices such as early marriages, poverty and early school drop outs. Statistics further indicate that 9% of the girls are married off at the age of 15 and 50% of the remaining ones are also married off by the time they are 18 years old.[1]

The early marriages contribute to the high fertility rate of women in Sudan, which currently stands at 6.7 children per woman. The percentage of the population that is below the age of 30 years stands at 72% and that below 15years stands at 44.3%, (FP Policy – MoH, South Sudan)

The implementation of SRH has been undermined by a weak health system, inefficient integration, and poor quality of service delivery, strong provider biases and culturally strong norms that promote myths and misconceptions on family planning. Other factors that contribute to this gap include frequent stock-outs of commodities in the health facilities leading to limited choice by the women who access the services, structural barriers affecting the work of village community health workers, harmful cultural norms and practices and lack of accurate information on reproductive health.

Unequal social relations between men and women produce inequalities in health outcomes, as well as access to and use of reproductive health information and services. Gender issues and sexual and reproductive rights are closely interrelated and jointly affect the productive and reproductive health of both men and women. Although reproductive rights are human rights recognized in South Sudan laws, men still exercise predominant power in nearly every sphere of life including, access to information and personal decisions regarding the size of families and women's own reproductive health.

For the goals of the Sustainable Development agenda to be met, large increases in the use of modern contraception need to occur from 40 to 55 percent across East Africa including South Sudan. These achievements will require sustained, effective interventions particularly focusing on underserved groups such as adolescents and youth and the hard to reach populations.

[1] Source – UNICEF, State of the World's Children 2016

1.1 HPF Phase III – Family Planning Component Goals and Objectives

The third phase of the Health Pool Fund, which commenced in July 2018 will run till 2023. The essence of this phase is provision of support for delivery of essential primary health care at the community, primary healthcare facilities and secondary referral hospitals. It will enable the strengthening of the referral system at all levels of health care. In addition, HPF3 will support the stabilization of local health systems and the strengthening of community ownership and governance structures. Finally, HPF3 will be responsible for the procurement and supply chain management of essential medical commodities.

HPF supports services in eight coordination hubs of South Sudan in the states formerly known as: Central Equatoria, Eastern Equatoria, Lakes, Northern Bahr el Ghazal, Unity, Warrap, Western Bahr el Ghazal and Western Equatoria. The direct beneficiaries are the South Sudanese people, with particular focus on mothers, pregnant women and children under five years of age.

HPF III Program Deliverables

Goal

HPF 3 seeks to increase awareness of, access to, and use of contraception services among women and young people/ adolescents in South Sudan.

Program Impact:

Improved health and nutrition status for the population that saves lives and reduces morbidity contributing to the overall impact

Expected outputs:

Output 1: Enhanced delivery of integrated health services through a network of health facilities.

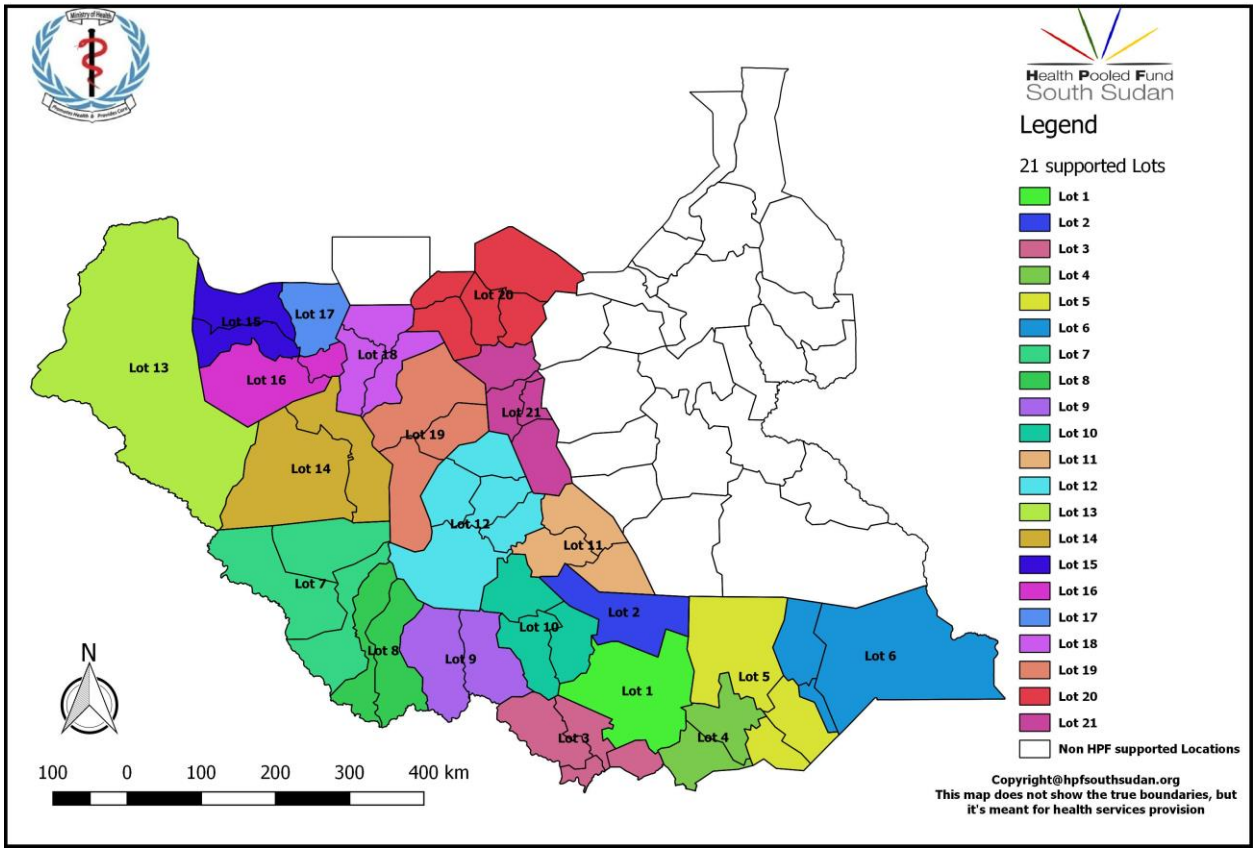
Output 2: Expanded Community health services for the prevention and treatment of common conditions based upon the Boma Health Initiative Guidelines.

Output 3: Strengthened management of the Supply Chain for essential drugs and commodities.

Output 4: Stable health systems that are responsive and accountable to the needs of communities and individuals accessing health services.

Program Coverage

MAP SHOWING HEALTH POOLED FUND PHASE III (HPF3) LOTS BOUNDARIES



2.0. LESSONS LEARNT

Lessons derived from the Family Planning interventions under Health Pooled Fund2, in the last five years will be used as pointers for decisions on pathways to take in provision of FP services under HPF3. Highlights from the lessons are captured below:

Experience has demonstrated the need to coordinate closely with other international NGOs and new players in the field of family planning service provision in South Sudan — such as Intra Health, IPPF - country member association – RHASS and IRC that is leading on WISH2Action and other key stakeholders like UNFPA and FP2020 country lead. Establishing strong working relationships with these stakeholders will put in place systems to address challenges and avoid duplication.

Providers who are newly trained in family planning, particularly LARC, require robust supervision, including clinical mentorship and ongoing/ update training to ensure their confidence and skills in providing such services. During implementation of HFP2, it was realized that some of the providers lacked confidence, knowledge and skills to provide LARC methods thus the promotion of short term methods. Moving into HPF3, a broad quality of care framework is to be rolled out, implemented by IPs with support of HPF team. The framework has been developed to give a comprehensive process in which areas of needs and support will be identified and appropriate technical support provided to the IPs or health care providers. Under FP component, a

streamlined clinical mentorship strategy will go a long way to build capacity, skills and competency of service providers.

It is important to include key stakeholders, particularly County Health Department and State MOH, in FP training and supervision of health care providers and the facilities in general to ensure support for interventions and continuous buy-in of FP services. While in HPF2, the team played a key role in direct training of service providers, in HPF3, IPs will have a central role in conducting trainings and all health facility capacity building activities including supply chain management to avoid stock out and increase choice of methods by women who seek for services. The CHD and SMOH will be part and parcel of the training process while at the national level, MOH will be involved in quarterly joint support supervision.

To increase access to services for young people, it is crucial that clinical staff are not only trained upfront but also continuously updated on youth-friendly services (YFS). In HPF2, there was limited engagement and access of services by the youth. Lack of access for FP services could have been related to other issues including lack of training of IPs in YFS as well as provider bias and lack of YFS space within the health facilities.

Provider biases and other stakeholders including the IPs can be a barrier in providing, access and delivery of FP services. In HPF2, bias and personal values were barriers to service provision in some of the states and health facilities. It therefore imperative to introduce value clarification and attitude transformation (VCAT) at various of program implementation. The could be at the early stages or later in the project once start up activities have been rolled out.

The limited community interventions and demand creation activities for FP services in HPF2 was a challenge and may have contributed to slow progress of women seeking for services. With limited demand creation activities and limited involvement of CHWs, the health care providers took the center role in health education within the health facilities. The integrated health education session conducted by the health care providers, was the main channel through which the clients got to know about the availability of FP services.

In HPF2, within some of lots, partners worked with champions to reach men and created awareness of FP services. Moving into HPF3, it is imperative to scale out this strategy — both male champions and young people to overcome barriers to access for women of reproductive age, including young women.

The state MOH level leadership play a vital role in increasing acceptance of FP within the communities. During HPF2, some states had no buy in for FP and acted as barrier to FP service delivery. Several advocacy meetings were held to solicit for their support. The SHR national policies were not shared to create conducive environment for provision of FP services.

Regular quarterly, structured review meetings have been invaluable forums through which partners receive feedback on their performance from the HPF team. However, moving into HPF3, these need to be further used as reflection and learning forums for partners to learn from one another and for HPF and partners to share the overall program perspective with all partners at the same time. These meetings should incorporate a simplified process for understanding a standardized health management information system, such as DHIS2 platform. Partners will need training, technical assistance, and support to obtain useful data from health facilities providers and community health workers.

3.0 TECHNICAL APPROACH/ FRAMEWORK

Implementation of the family planning component under HPF3 should be carried out within the context of the health systems strengthening framework. Implying that a systematic approach to contributing to the Health Systems Strengthening involving key building blocks such as strengthening service delivery, Health Information Systems, Commodity Management and Health Work force is pivotal to the success of HPF3.

This strategy will focus on strengthening the capacity of implementing partners to: i) deliver quality health facility based modern methods of family planning for women and young people of reproductive age; ii) support IPs to conduct community outreaches that deliver high quality, culturally appropriate SRH information and health education to women, youth of reproductive age and men via community health workers and BHTs; iii) serve as advocates when educating lower level leaders on the current status of SRH particularly family planning.

Implementing grassroot advocacy activities will garner support at CHD and SMOH level for expanded access to SRH services. Through support from HPF, IPs will employ various strategies and approaches that will contribute to significant engagement, transformation and success in delivery of quality FP services. The strategy also aims at providing guidance in advancing and integrating family planning into the other components of health care delivery as well as addressing the key issues and challenges faced in HPF2. The framework will continue to address some of the FP challenges encountered and opportunities that presented and ensure the implementation of the project is cognizant of the policy context at the national level – policies such as:

- The National Health Policy, 2016-2025
- The National Health Sector Strategic Plan 2017 – 2022
- The Health Sector Development Plan (HSDP) 2012 - 2016
- The Basic Package of Health and Nutrition Services for Primary and for Secondary/Tertiary Health Care in South Sudan 2011.
- Family planning Policy – Ministry of Health 2013
- BHI

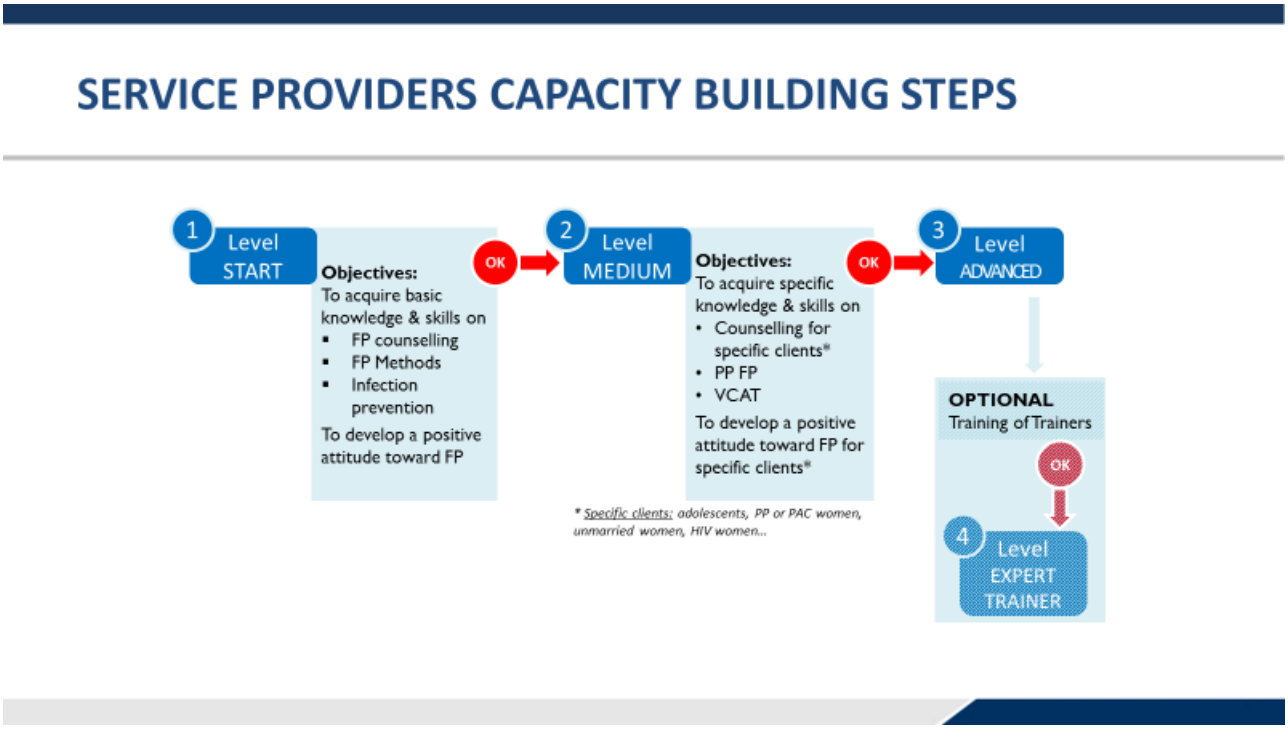
4.0 DETAILED APPROACH TO IMPLEMENTATION

Training of service providers:

Preliminary training will be needed for both IPs and health providers as well as CHD. Based on the needs/skill set analysis in as far as provision of FP, a training plan will be developed in collaboration with MOH. Refresher trainings – will be done from time to time to address gaps in FP provision such as provider biases in provision of FP to young people and adolescents and on job training for continued skilling and competence building for service providers.

Using the new FP training curriculum and register, partners will be trained at the national level and they in turn will cascade the training to the lowest level. Innovative training to address more complex and pertinent issues, such as provider biases, as well as to improve the sustainability of programs will be

introduced. Training module and tools to sensitize partner staff on the needs of young people and the provision of youth-friendly services will be developed and rolled out.



*Monitoring Quality of care: Using the QOC framework, s*elected quality indicators will be monitored and tracked at various levels including at IP, CHD, SMOH and HPF. Engagement with health facilities will be undertaken to ensure adherence to the minimum standards of technical competence, client safety, privacy and confidentiality, continuity of care, record keeping and informed decision. Both HPF teams and IPs teams will be responsible for enhancing adherence to set standards through monthly support supervision, conducting of quarterly support supervision, annual internal data audits and Joint MOH support visits. Quality outcomes of interest and standardized quality indicators and measures will guide the clinical compliance visits and on job training and CMEs.

Tracking provider and health facility performance

Feedback from joint support visits between HPF/MOH/IP/SMOH will be shared during health committee meetings for follow up and implementation. During these meetings, other issues like facility uptake trends will be discussed and graphs on trends of uptake drawn and data used to inform change of strategy and support tracking provider/ facility performance. A tool to tracker provider performance and health facility trends to be developed and piloted out before rollout.

Supply Chain and equipping:

Despite the well-defined and layered out system of commodity distribution, health facilities continue to have limited method mix thus limiting the choice of methods by clients. Limited method mix directly impacts on quality of care as some of clients' needs may not be met at the service points. Implementing partners play a key role in distribution of commodities from CHD to health facilities, several strategies including increase in forecasting and supply chain management at last mile, Record taking at health facilities to know how much in and out, capacity to forecast leading timely orders / orders for right mix should be considered. Training IPs in last mile distribution, use of stock cards and monitoring and usage of

method, method mix is to be strengthened in HFP3. Using facility assessment tool from HPF2, the partners will conduct a rapid facility assessment to identify needs and gaps and this will form a basis of support on equipping and stock management.

Provision of youth friendly services

HPF3 will explore inroads to provide RH services to youth and adolescents through training service providers in youth friendly service delivery. This will be achieved through targeted integration, addressing the fear of side effects and myths, as well as building the confidence and competence of delivery of integrated health education at various points. Partners are to be supported to ensure quality services, method mix to meet client needs. Through the SWOT analysis for PHF3, it was realized that limited space and lack of procedure room continues to impede privacy and confidentiality thus limiting access

Routine and joint support supervision

These are to be conducted between HPF and MOH with involvement of IPs, CHDs and SMOH. Through agreed upon work planned with MOH, HPF team will lead on the joint support supervision. The supervision will be guided by the QOC framework and a debrief to be provided immediately after the supervision and a detailed report with recommended areas of support, on job trained and CME shared with IP for follow up and implementation.

Equity and Gender Inclusion:

Unequal social relations between men and women produce inequalities in health outcomes, as well as access to and use of reproductive health information and services. Gender issues and sexual and reproductive rights are closely interrelated and jointly affect the productive and reproductive health of both men and women. This is will monitored through proxies such as male involvement activities, radio listening clubs within busy centers and other different FP activities. The information provided to the men on FP will aim at dispelling myths and misconceptions and increase the number of men who act on their desire for spacing and limiting the number of their children and adopt Family Planning and well as participate in reproductive health issues and discuss Family Planning with their partners/wives.

Development of BCC/IEC/ community and provider resource materials

Support partners to develop and produce quality promotional materials, develop message, art work, procure and distribute, Develop & distribute. Encourage partners to hold quarterly meetings with CHWs at the health facilities to review and provide necessary support required to conduct quality awareness meeting and client referrals. Develop targeted radio campaign (spots, testimonials, DJ mentions and family program sponsorships) Develop criteria for recruiting satisfied users, Document/record satisfied user stories, standardize satisfied user messages. Use satisfied user testimonies on radio

Quarter review meeting: Regular, structured review meetings can be invaluable forums for partners to share and learn from one another. This forum is also invaluable for HPF and partners to share the overall program perspective with all partners at the same time. This can also serve as a forum best practices learning and scale out as cross partners learning happens and is shared.

4.1. Summary Brief of Technical Approach

FP Issues and challenges	*Key Interventions*
Service Delivery	
Limited FP/ procedure rooms, this heavily affected and compromised privacy and confidentiality of service provision	IPs to work with CHDs and SMOH to create FP procedure rooms to ensure client confidentiality and privacy is maintained as one of cores of quality of care service provision.
Limited training of service providers; particularly in LARC methods compromised client choice of method.	IPs to develop training plans and share with HPF FP Specialist. The teams at HPF will ensure that trainings, which are conducted meet the minimum standards and right tools and resources are used.
Lack of national training curriculum; limited the quality of training as different partners used different tools and resources to train the providers.	IPs to be trained at the national level on the new FP register and Curriculum and they cascade the training to the lowest level. This will be realised with development of training plan and cascading process of the trainings to the lowest level of service points.
Limited reach and access of services by adolescents and young people	Adapt youth friendly services training guide and train IPs in YFS service delivery and this will be cascaded downward to the health facilities
Limited youth friendly health facilities with youth corners	Based on the level of health facility and space, YFS corners to be created as spaces for young people to create awareness and increases access to services.
FP biases among the various stakeholders including health care providers, IPs staff, CHD/SMOH leaders and the community	Introduction of value clarification and attitude transformation package will break down some of the barriers among personnel involved in service provision. Values clarification and attitude transformation (VCAT) helps ensure access to services. Other staff in organizations can create barriers to services based on their values and attitudes about SRH, particularly FP and young people's access to SRH information and services. All staff involved with the project require VCAT training to ensure overall buy-in for provision of the full range of services offered through the project and to reduce barriers they may create for clients
Limited focused support supervision of the health care providers to build their competencies, knowledge and skills in service provision	Implementing partners will be introduced and trained on the QOC framework. Through the framework, focused support supervision will be provided leading to identification of areas of CMEs, and on job training
Demand Creation	
Lack of community training strategy including guides,	IPs to be supported to develop community engagement strategies that

FP Issues and challenges	*Key Interventions*
tool kits and resource materials for CHWs, and IEC materials health facility for the service points	align and meet the needs. Produce booklet with key messages and flipchart for community based reproductive health workers including IEC materials to be used at service points within the health facilities
Lack of accurate information about reproductive health issues and services resulting into widespread myths, rumours, and misconceptions	Social mobilization efforts to be combined with IEC/BCC with messaging targeting audiences
Social and cultural norms and values encompass gender issues that prevent women from making critical decisions about using health services and that also result in low male involvement in recognising and taking action on reproductive health issues that affect themselves and their partners.	Social cultural norms to be addressed through integrated activities under social inclusion including community dialogues were attempts will be made to address challenges that hold back communities to support women access SRH services
Fear of side-effects by non-users a deep belief in rumours and misconceptions	Messaging around issue addressing side effects and as well as frequently asked questions will address rumours, myths and misconceptions
Resistance of family planning from men as a result of low involvement in the sensitization of the population on the use of FP services; this has in turn seen more women take up injections or request to seek for permission before taking on any method, there has also been fear to use of implants due the possibility of their male counterparts seeing or feeling the implant on their arms.	Identify and train male champions reach out to men through community dialogues integrated with edutainment like community theatres, male only meetings and one to one sessions to address fears
Low and unfocused FP messages relayed by community health workers. In general, there was low involvement of CHWs in the mobilization. There has been no to effective focused messages and approaches for reaching and communicating to individual needs of potential clients.	Develop audience messaging and create a personalized way of reaching women of the reproductive age through small groups/ one to one sessions and home visits. This will be coupled with direct community awareness activities to be conducted by IPs with the aid of local groups on the importance of modern FP
Above the line channels like radio programs including talk shows and spots were used to reach out to the wider audience	HFP to work with IPs to sponsor Family Planning programmes on existing call-in talk shows on a variety of language stations, support partners produce short radio spots and have them passed on the radio in several languages, hold talk shows with various stakeholders including involving MOH, CHD and SMOH and service providers.
Health System Strengthening Low FP policy dissemination to lower levels leading to increased resistance to FP	HPF will work with IPs to develop excerpt from the various polices and disseminate at CHD and SMOH level during meetings and debrief meetings after joint support visits. This in turn with counter biases and create less restrictive environment within which the IPs operate.
Lack of systematic and standardized tools for CMEs and continuous skilling, competency building of health workers	Introduction and development guide to support on job training and CME on agreed upon areas of further skilling of service providers.
Lack of health care provider performance tracking systems	Mapping performance of health facility using adapted tool as a proxy to understand the utilisation of the services and the individual health care provider performance management and support. The health care provider performance reported on a quarterly basis to HPF will provide basis on the analysis, feedback to provide support to individual providers to build confidence, retention and skilling.
M&E Lack of data management tools. Given that there	Distribute and roll out FP registers to ensure good data recording and

FP Issues and challenges	*Key Interventions*
were FP registers, data may have been lost within the health facilities as provider recorded client details in their own note books.	reporting. IPs will have to train the health care providers in understanding and use of the register.
Supply chain Access to stocks remains a challenge mainly due to supply chain challenges between CHD and IP to the last mile. Facilities experienced stock out which in turn limited the choice of method by clients	Build capacity towards achieving real-time last mile distribution as well reinforce monitoring of commodity stock status and service delivery standards at facility level. Supervision reports can remain as vital sources of information from service delivery points. Training conducted at IP, CHD and SMOH level to include a component of FP to improve staff stock management at CHD and health facility level. During the training emphasis should be made on correct use of tools and standard operating procedures (SOPs) allowing no stock out of FP essential supplies in the HFs.

5.0 KEY INTERVENTIONS AND ACTIVITIES

Objective 1: Enhanced delivery of integrated health services through a network of health facilities.

Strengthening Partner Capacity for Sustainable Service Delivery: Implementing partner capacity will be strengthened to offer sustainable FP including youth friendly services, this will equally focus on institutional resilience, effectiveness, and efficiency. Capacity strengthening will focus on health care delivery, supply chain management; supervision; quality of care and monitoring, and evaluation. Additionally, Value Clarification and Attitude Transformation training will be introduced. Through technical support from HPF, IPs will be trained to conduct continuous medical education (CME) and on job training to further build competencies, skills and knowledge of the health care providers. VCAT cannot be a one-off activity — progress among those who have undergone training must be continually monitored to ensure that changes in attitudes are sustained.

Task-shifting and community distribution of commodities: For increased access and utilization of FP services, sayana press is to be distributed in the communities through trained CHWs/ BHTs. Initially women will access services at the health facilities through health care providers. The trained health care providers are to train on self-injection for the first and second dose of the injection. The proceeding injection, women will self-inject with observation from the health care providers once the women grasp the self-injection, then the rest they are to access though the trained distributors in the community.

Summary of key activities under service delivery component

- *Develop training plan in collaboration with MOH*
- *Roll out national IP training on FP service delivery*
- *Coordinate and distribute to partners contraception training kits*
- *Coordinate with MOH to print and distribute the FP register*
- *Train IPS to roll out sayana press and distribution by the CHWs*
- *Train IPs on QOC framework and rollout*
- *Support IPs to deliver modern FP services*
- *Plan, coordinate and develop quarterly joint support visit plans in collaboration with MOH*
- *Conduct routine support supervision with IPs/ CHD/SMOH to ensure quality of service delivery*
- *Develop and adapt training guides on YFS and VCAT*
- *Update, print, and distribute provider training guides and tools for youth friendly services (YFS) provision to partners*
- *Train providers as trainers on provision of YFS and roll out of YFS services in selected health facilities.*
- *Train IPs on Value Clarification Attitude Transformation (VCAT) and roll out to CHD. SMOH, CHWs and BHT*
- *Conduct routine and joint support visits with MOH/IPs/ SMOH and CHD.*
- *Develop provider/ health facility performance tracking tool and roll out to IPS track performance and trend on a quarter basis.*
- *Integrate family planning counselling in existing counselling sessions (ANC/PNC, and Immunization counselling, Nutrition, ICCM sessions) and to perform immediate post-delivery counselling*
- *Train provider on PPFP and rollout in facilities with high caseload of deliveries*
- *Conduct update training for continuing service providers on FP.*
- *Update, standardize, and distribute provider training guides and tools for service provision.*
- *Attend national, international and regional workshops on FP and other SRH thematic areas.*

Objective 2: Expanded Community health services for the prevention and treatment of common conditions based upon the Boma Health Initiative Guidelines

To complement service delivery, increase the FP methods acceptance in the general population and specifically to women in the reproductive age group, a community engagement strategy is to be developed and implemented by the partners. The strategy will address social norms, particularly those that perpetuate myths and misconceptions about family planning. The sensitivity of family planning calls for the need to develop adequate knowledge, messaging skills, and building confidence of community health workers to adequately reach communities with appropriate information. Various channels and methodologies of communication will aim at increasing accurate information and creating awareness on the availability of quality family planning. Focus on youth will be part of the design with the creation of youth spaces to ensure that information of SRH reaches them.

HPF will work with partners to strengthen community-facility linkages by engaging, training, and working with Boma Health Teams and community health workers to undertake community education and referrals. Demand creation will have two programmatic approaches including;

Community level: To build the capacity of CHWs to enable them expand access and knowledge, stimulate acceptance, and create awareness of FP at the grassroots. It is important that all implementing organizations are using the same language and supporting the same communication strategy. For this purpose, HPF3 will assist partners to develop a booklet with key messages on Family Planning. Given the sensitivity of FP, Male engagement strategies will be devised to reach the men thus increasing the number, who encourage and support their partners and peers to use contraceptives. The champion strategy used in HPF2 will be scaled out for increased FP uptake. The male involvement will happen both at the health facilities, where discussion with men that escort their wives for ANC/ immunization will be educated on FP and through community dialogues and men only meetings. These interventions are meant to improve the involvement of men by increasing their knowledge on contraceptives, dispelling myths and misconceptions and their fears around side effects. Additionally, community awareness meetings, drama and dialogues and men only meeting at busy centers and radio listening clubs at male gathering centers will be run by the CHWs.

Health facility level: Integrated health education by service providers played a vital role in HPF2 increasing FP uptake within the health facilities. An integration guide is to be developed/ adapted and used by IPs to introduce integration of health education and FP services. Given the level of stigma and biases attached to family planning in South Sudan, integration is a key strategy that should be used to mobilize women and increase uptake of FP.

Demand creation Summary activities

- *Adapt behaviour change communication training guide and tools/ job aids for CHWs*
- *Train IPS on implementation of BCC strategies and use of materials*
- *Conduct meetings with IPs to develop demand creation plans specific to the needs/ context of IP operation areas.*
- *In collaboration with IPs review to adapt and distribute IEC materials/ tools for education and reporting including posters in ANC rooms to promote awareness of acceptance of FP after delivery and for CHW s to increase focused and specific messaging for FP*
- *Coordinate production and dissemination BCC materials to partners to the lowest level*
- *Conduct training for IPS on roll out trainings for CHWs and BHTs*

- *Lobby and include FP reporting indicator on the BHT tools after the pilot testing of the tools*
- *Conduct training for IPs on job training and supervision of community health workers and Boma Health Teams to address myths and misconceptions and refer clients for services*
- *Adapt and roll out through IPs provider engagement and integrated health education tool to support health facility-based providers integrated health education at the different service points and streamline internal referrals to FP unit.*
- *Identify and support county-level champion providers to promote provision of FP*
- *Provider technical assistance to partners on establishing effective internal and external referral systems*
- Country office to ensure that radio broadcasts on family planning and PAC are performed on 8 local radio stations

Objective 3: Strengthened management of the Supply Chain for essential drugs and commodities.

Distribution of supplies and commodities remains a challenge at lowest service delivery points Facilities continue to experience stock outs on some of the commodities thus limiting client choice. Partner capacity to build an effective and robust supply chain management system, which ensure that relevant supplies and equipment for comprehensive FP service provision are available and no stock outs are experienced, needs to be enhanced. The IPS /CHD teams will need to be trained to improve staff stock management including use of stock cards within facility pharmacies.

Summary activities

- Conduct an update training for partners on commodities management and logistics
- Collaborate with partner to conduct a rapid assessment to inform facilities upgrade for FP procedure rooms and equip service delivery rooms informed by facility status report
- 0Ensure that health facilities have equipment and supplies needed to provide family planning services

Objective 4: Stable health systems that are responsive and accountable to the needs of communities and individuals accessing health services

HPF will help strengthen the health management information system as appropriate to improve data collection, storage, synthesis, sharing, and use. This will entail building partners' capacity for monitoring, and evaluation; developing tools; production and distribution; data quality audits; joint reviews with partners; and continuous technical support. HPF will also track other pertinent performance and learning indicators — including additional quantitative facility-level service delivery indicators, quantitative community-level service delivery indicators, qualitative community advocacy indicators. The data generated by the project will be used to document promising and best practices, as well as to disseminate them in at country, regional, and international platforms during internal or international conferences.

Summary of activities

- Conduct VCAT workshops for CHD/ SMOH leadership on FP services
- Lobby to include FP indicators into BHT tools
- Attend national MCH technical working group meetings
- Conduct routine monthly TA and monitoring site visits to support demand creation activities
- To re-enforce quality of data collection, use and management through data-training of staff
- Design and pilot a data audit to conduct in health facilities twice a year
- Collaborate with communication department to introduce FP knowledge resources and document best practices in FP programming among the partners.

- ❖ Coordinate and participate and conduct quarterly in program reviews to inform program strategy, reporting and direction.
- ❖ Conduct semiannual data quality audits in selected health facilities and lots.
- ❖ Client exit interviews

Deliverables As a result of the efforts detailed above, we expect the following outcomes.

- *Partners have stronger institutional systems to oversee continuous and sustainable delivery of SRH services.*
- *Selected Health facilities and providers have the capacity to offer quality FP services with a focus on youth-friendly services.*
- *Implementing partners serve approximately ---------- clients (women and young people of reproductive age in the 8 states with FP services*
- *Providers have the capacity to conduct integrated health education and give relevant SRH information including dispelling myths and misconceptions.*
- *Service delivery partners serve clients with contraception.*
- *Community Health Workers have the capacity to deliver SRH information on FP make referrals.*
- *Community members, particularly young people, are reached with information on contraception through selected strategies including radio.*
- *Contracted implementing partners have stronger capacity building systems, supervision systems, and supply chain management systems that support the provision of quality contraception services.*

We will measure progress at the facility level based on:

- the number of new health facilities upgraded and supported to offer quality family planning in each of the eight focus states;
- the number of providers who have the capacity to offer FP services, with a focus on youth-friendly services, in each eight states;
- the number of providers taken through VCAT contraception stigma and biases in each state;
- the number of providers taken through VCAT to address the needs and preferences of adolescents and youth in each state;

We will measure progress at the community level based on:

- the number of CHWs (Under BHI trained on FP) in each 8 states who are trained to deliver SRH information, modern contraceptive makes referrals using, opt-out approach whereby providers will give all clients information on modern contraceptives so that they can make informed decisions in choosing services; and
- increased knowledge and understanding of SRH among women and young people of reproductive age, contributing to an increased uptake, awareness and utilization of FP services.
- -------- CHWs and BHTs trained to deliver SRH information, distribute contraceptives (condoms and pills), and make referrals
- the number of trained CHWs each 8 states are actively delivering SRH information and making referrals, as well as addressing contraception stigma.

HPF PHASE III – FAMILY PLANNING COMPONENT RESULTS FRAMEWORK

OBJECTIVES	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
GOAL: increase awareness of, access to, and use of contraception services among women and young people/ adolescents in South Sudan.			
IMPACT 1) Increased access by women and youth to modern child spacing methods 2) Implementing Partners have stronger capacity building systems, supervision systems, and supply chain management systems that support the provision of quality contraception services	Number of women and youth who have taken up a modern method in the current phase Number of Health Facilities that are offering at least three modern methods Number of Implementing Partners that adopted news systems of managing and sustaining delivery of contraception services	Reports, HMIS	Existing policies support the FP interventions for women and youth
OUTPUTS **OUTPUT I** The Capacity of Partners to delivered FP services in a	**Output indicator 1.1:** Number of Health Facilities that are providing FP method mix; conducting	HMIS, Supervision reports	

OBJECTIVES	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
sustainable manner enhanced	clinical mentorship processes and the newly introduced systems of management		
	Output indicator 1.2: Number of HFs that have put in place stipulated standards and processes for ensuring quality delivery of FP services	Supervision reports	
OUTPUT II Targeted community awareness events, for increased access to FP services organized	**Output Indicator 2.1:** Number of community Reproductive health education events organized in each of the HPF3 implementation sites.	Supervision reports	
	Output Indicator 2.2: Number of YFS corners set up in different implementation sites.		
OUTPUT III Efficient and effective supply of FP commodities to each of the selected health facilities	**Output Indicator 2.3:** Number of Male champions who have been identified		
	Output Indicator 3.1. Number of facilities that have setup proper stock management practices	FP registers, Monitoring reports	
OUTPUT IV Information management for improved FP service delivery	**Output Indicator 4.1** Number of Health Facilities		

OBJECTIVES	INDICATORS	MEANS OF VERIFICATION	ASSUMPTIONS
strengthening at all levels	that are feeding information into the national/state level health information management system		