COMMON APPROACHES

CONTRACEPTION BY CHOICE

COMMON APPROACH
COMPREHENSIVE OVERVIEW

CONTENTS

ACRONYMS

ANC – Antenatal Care
ARSH – Adolescent Reproductive and Sexual Health
ASFR – Age Specific Fertility Rates
ASRHR – Adolescent Sexual and Reproductive Health and Rights
BBT – Basal Body Temperature
BCS+ – Balanced Counseling Strategy Plus
CAC – Community Action Cycle
CBD – Community-Based distributor
CBOs – Community-Based Organizations
CEDAW – Committee on the Elimination of Discrimination Against Women
CEFM – Child, Early and Forced Marriage
CVA – Cash and Voucher Assistance
CHWs – Community Health Workers
CIC – Combined Injectable Contraceptives
CMAM – Community Management of Acute Malnutrition
CMR – Clinical Management of Rape
COCs – Combined Oral Contraceptives
CPR – Contraceptive Prevalence Rate
CRC – Convention on the Rights of the Child
CRPD – Convention on the Rights of Persons with Disabilities
CSE – Comprehensive Sexuality Education
CVR – Contraceptive Vaginal Ring
CYP – Couple Years of Protection
DHIS2 – District Health Information Software 2
DHS – Demographic and Health Surveys
DPOs – Disabled Persons Organizations
EBF – Exclusive Breast Feeding
EC – Emergency Contraception
ECPs – Emergency Contraception Pills
FA – Fertility Awareness
FACT – Fertility Awareness for Community Transformation
FAM – Fertility Awareness Methods
FP – Family Planning
GMP – Growth, Monitoring and Promotion
HF – Health Facility
HIP – High Impact Practices
HTSP – Healthy Timing and Spacing of Pregnancies
ICPD – International Conference on Population and Development
IEC – Information, Education, and Communication
IP – Infection Prevention
IPC – Interpersonal Communication
IPV – Intimate Partner Violence
IUCDs – Intrauterine Contraceptive Devices
IUDs – Intrauterine Devices
IRH/GU – Institute for Reproductive Health at Georgetown University
IUS – Intrauterine Systems
IVR – Interactive Voice Response
IYCF – Infant and Young Child Feeding
KMC – Kangaroo Mother Care
LAM – Lactational Amenorrhea Method
LAPM – Long-Acting and Permanent Methods of Contraception
LARCs – Long-Acting and Reversible Contraception
LMICs – Low and Middle-Income Countries
LMIS – Logistics Management Information System
MCH – Maternal and Child Health
MICS – Multiple Indicators Cluster Surveys
MISP – Minimum Initial Service Package
MIYCN – Maternal, Infant, and Young Child Nutrition
MOH – Ministry of Health
MOU – Memorandum of Understanding
NGO – Non-Governmental Organization
PAC – Postabortion Care
PDQ – Partnership Defined Quality
PLWAs – People Living with HIV/AIDS
PLWD – People Living with Disability
PMTCT – Prevention of Mother-to-Child Transmission
POPs – Progestogen-Only Pills
QI – Quality Improvement
RANMs – Roving Auxiliary Nurse Midwives
RH – Reproductive Health
RHS – Reproductive Health Surveys
SBC – Social and Behavior Change

IAWG – Inter-Agency Working Group
iCCM – Integrated Community Case Management

SDGs – Sustainable Development Goals
SDM – Standard Days Method
SMS – Short Message Service
SDP – Service Delivery Point
SGBV – Sexual and Gender Based Violence
SIGI – Social Institutions and Gender Index
SRH – Sexual and Reproductive Health
SRHR – Sexual and Reproductive Health and Rights
STIs – Sexually Transmitted Infections
TA – Technical Assistance
TBA – Traditional Birth Attendant
TFR – Total Fertility Rate

SBCC – Social and Behavior Change Communication
SC – Save the Children
TOT – Training of Trainers
UHC – Universal Health Care
UNFPA – United Nations Population Fund
USAID – United States Agency for International Development
UNOCHA – United Nations Office for the Coordination of Humanitarian Affairs
VCAT – Values Clarification and Action Transformation
VYAs – Very Young Adolescents
WHO – World Health Organization
WRA – Women of Reproductive Age

POLICY COMPLIANCE

Our Save the Children Position on Sexual and Reproductive Health and Rights (SRHR)

In 2015, the Save the Children movement formalized a position on SRHR that is applicable to every Save the Children entity -member, country or region. This position is found here and states that all Save the Children Members and Save the Children International are governed by this position, which has specific guidance on Save the Children programming, advocacy and media on SRHR. It states that "Save the Children does not support abortion as a means of routine contraception in family planning". The Global SRHR Position also includes specific guidance on global sign-off on such advocacy and media activities. This position is independent of any donor or government position or policy and implementation of this Common Approach must be in line with the SRHR Global Position and its parameters.

The Common Approach incorporates evidence, definitions, standards and recommendations developed by WHO and the Interagency Working Group (IAWG) for Sexual and Reproductive Health in Emergencies. These standards and recommendations are about contraception and do not include safe abortion care as a method of contraception. They state that family planning/contraception reduces the need for abortion and unsafe abortions. Save the Children follows a rights-based approach and recognizes that critical to the empowerment and survival of adolescent girls and women is access to quality contraceptive services as stated in this Common Approach. This Common Approach is not about rights-based comprehensive sexual and reproductive health care.

Protecting Life in Global Health Assistance Compliance

In addition, Save the Children International, Save the Children India and any other non-U.S. Save the Children entity that receives U.S. government global health funding in the future must comply with the U.S. Government's "Protecting Life in Global Health Assistance" (PLGHA) policy. This means that those Save the Children entities and their staff may only perform, actively promote, or provide financial support for safe abortion care in cases where the life of the mother would be endangered if the foetus were carried to term or in cases of rape or incest. For more information on PLGHA and SCI's obligations under PLGHA, please refer to OneNet where you may find a webinar, FAQs, an e-learning module and other resources. Nothing in the Common Approach should be interpreted to indicate that Save the Children International or Save the Children India perform, actively promote, or support safe abortion care "as a method of family planning," as defined in PLGHA. (Footnote: According to the U.S. Government's PLGHA policy, "Abortion is a method of family planning when it is for the purpose of spacing births. This includes, but is not limited to, abortions performed for the physical or mental health of the mother and abortions performed for [foetal] abnormalities, but does not include abortions performed if the life of the mother would be endangered if the [foetus] were carried to term or abortions performed following rape or incest.")

INTRODUCTION

Use of contraception for healthy timing, spacing and limiting of pregnancy is one of the most important lifesaving interventions for reducing maternal mortality and morbidity, improving maternal and child health outcomes and achieving Save the Children's (SC) three breakthroughs that all children SURVIVE, LEARN, and be PROTECTED in humanitarian and development contexts. Individuals and couples have a fundamental right to freely decide whether, when and how many children to have.

Family Planning and Contraception

"Family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility. A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy." (Family Planning Technical Reference Materials)

"Contraception prevents pregnancy by interfering with ovulation, fertilization and/or implantation." (IAFM, 2018)

Both terms will be used as appropriate in this Common Approach.

"Contraceptive prevalence is the percentage of women who are currently using, or whose sexual partner is currently using, at least one method of contraception, regardless of the method used. It is usually reported for married or in-union women aged 15 to 49." (WHO)

Unmet Need: "Women with unmet need are those who are sexually active and fertile, are not using a method of contraception and report not wanting any more children or wanting to delay the next child. The concept of unmet need points to the gap between women's reproductive intentions and their contraceptive behavior." (WHO)

Informed Choice: Decisions based on accurate information: "The best decisions about FP are those that people make for themselves, based upon accurate information and a range of contraceptive options. People who make informed choices are better able to use FP safely and effectively." Programs should support the freedom of individuals to choose voluntarily the number and spacing of their children. Decisions regarding FP should be based on free choice and not obtained by forms of coercion. Individuals should have access to information on a wide variety of FP choices, including the benefits and health risks of particular methods. (FP Technical Reference Materials)

The Contraception by Choice Common Approach is client-centered and grounded in global standards for quality family planning (FP) programs. Though centered on women and adolescent girls (ages 10 – 19), it recognizes the importance of ensuring that whole communities – women, men, and adolescents – are provided with correct information, quality counseling and voluntary contraceptive services, to ensure an enabling environment for family planning. The term "contraception" was selected for the title of the Common Approach given that contraception is a broad term inclusive of individuals wishing to use it for family planning as well as adolescents and others who may be using it to prevent unplanned pregnancies. Contraception terminology supports integration into a range of health care services and is the terminology used in the "My Sexual Health and Rights Common Approach."

PROBLEM STATEMENT

As of 2017, an estimated 214 million women of reproductive age (15–49 years) in developing regions have an unmet need for family planning.[1] Unmet need for family planning among postpartum women in 21 lower- and middle-income countries (LMICs) is 61%.[2] An estimated 308,000 women in developing countries died from pregnancy-related causes in 2017.[1] Darroch et al. state that fully meeting the unmet need for modern contraception would result in an estimated 76,000 fewer maternal deaths per year.[1]

There is an increased risk of maternal death, miscarriage and induced abortion when pregnancy occurs within six months after a live birth.[3] There is conflicting evidence regarding healthy spacing after an abortion and an international cohort study is planned to review inter-pregnancy interval recommendations for high-income countries.[3,4]

Studies on spacing between pregnancies have shown that intervals shorter than 36 months and longer than 59 months were associated with increased risks of neonatal and infant mortality including enhanced risk for birth defects, increases in preterm births, low birth weight and small for gestational age babies. A short inter-pregnancy interval was also associated with maternal nutritional and folate depletion and poorer birth outcomes for the newborn and mother.[5,6]

According to WHO estimates, maternal conditions are the leading cause of death for adolescent girls 15 to 19 years of age.[7] Not only are adolescent mothers at a higher risk of maternal morbidity and mortality, their children are at a higher risk of neonatal, infant and child mortality and morbidity. Unmet need for contraception among adolescent girls results in an inability to fulfill their reproductive health (RH) rights, early unplanned pregnancy, non-completion of education, and possible lower participation in the labor force. As a result, they

are less able to contribute to household income, therefore perpetuating the cycle of poverty and increasing the risk of poorer health outcomes for themselves and their families.[8] For women and girls who wish to avoid an unplanned pregnancy, effective contraception is an essential strategy to preserve and even improve their overall mental health and wellbeing.[9]

The United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA) estimates that there were 134 million people in need of humanitarian assistance in 2018, of whom one-fourth were girls and women of reproductive age (15-49 years of age).[10] In these contexts, amidst multiple priorities including water, shelter and food, women and girls are at increased risk of sexual violence and unsafe abortions yet have even less access to quality comprehensive reproductive health/family planning services including emergency contraception and adolescent sexual and reproductive health services. If contraceptive services are available in humanitarian settings, they are often limited to short-acting and barrier methods (common examples of these methods are male and female condoms, pills and injectables) rather than the full range of methods recommended for quality family planning services.[11–13] Moreover, the age and gender-based barriers preventing women from accessing these services are frequently exacerbated in humanitarian settings.

The Contraception by Choice Common Approach focuses on modern contraceptive methods that are listed by category in the table below. Annex 6 provides a description, information on effectiveness and mechanism of action for each method of modern contraception as well as for traditional methods.

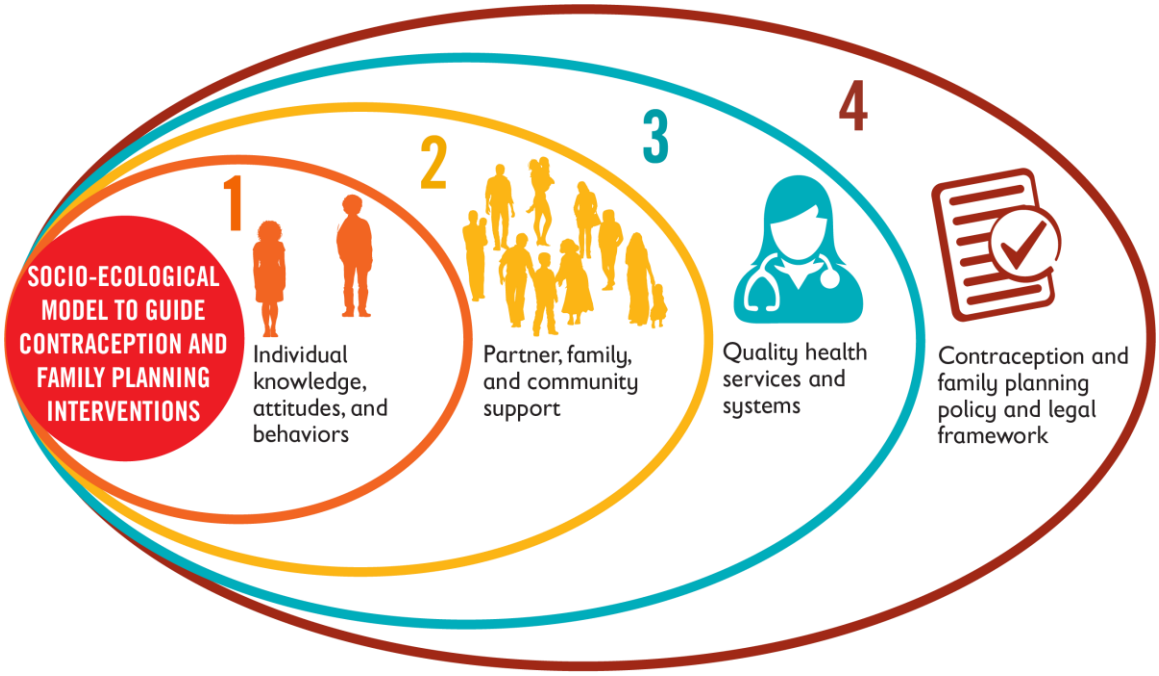
CATEGORY OF CONTRACEPTIVE[14]	CONTRACEPTIVE METHOD
Short-acting methods	Pills, Injectables, Male and Female Condoms, Contraceptive Patch, Contraceptive Ring, Cervical Cap, Sponge Spermicides, Diaphragm
Long-Acting Reversible Contraceptives (LARCs)	Implants, Intrauterine Devices (IUDs) also known as Intrauterine Contraceptive Devices (IUCDs), or Intrauterine Systems (IUS)
Other methods	Permanent methods; fertility awareness methods (FAM) – Standard Days Method (SDM), TwoDay Method, Sympto-thermal Method; and Emergency Contraceptive Pills

DESCRIPTION OF THE APPROACH

The post-2015 development agenda highlights the importance of family planning and humanitarian to development programming and these elements are prominently reflected in the United Nations' Sustainable Development Goals (SDGs), the "Global Strategy for Women's, Children's and Adolescent's Health 2016 – 2030," FP2020, the draft commitments for the upcoming Nairobi Summit on ICPD25 and the Ouagadougou Partnership.[15] The Common Approach is rights-based and works to empower women and girls to exercise their rights to accessing quality contraceptive services while ensuring all people have the right to information and services to achieve their reproductive choices.

CONTRACEPTION BY CHOICE – COMMON APPROACH

Recognizing that gender inequalities and unequal power dynamics contribute to root causes of unmet need for contraception among women and adolescent girls, the Common Approach for increasing access to and voluntary use of contraception is presented in the socio-ecological model below, and is aligned with Save the Children's Global Position on Sexual and Reproductive Health and Rights and Save the Children's Behavior Change and Community Health Integrated Social and Behavior Change Framework. Interventions and strategies are aimed at improving individual knowledge, attitudes and behavioral factors, supporting an enabling environment, providing access to quality health services and influencing policies with overall system strengthening.



In order to improve knowledge and behavior at the individual and community level, the Common Approach works to address the determinants of contraception access and use including gender equality dimensions and social norms. Policies, standards, guidelines and tools are often restrictive at the service delivery level as well as at the individual and family level; therefore, the approach advocates for evidence-based policies at local, national and international levels to improve access to quality family planning for all women, men, girls and boys. These interconnected elements are managed using a systems approach.

The Common Approach implementation takes into account the following key principles related to family planning: 1) supply and demand; 2) rights-based approach; 3) gender equality; 4) social and behavior change; 5) integration into other sectors; and 6) humanitarian development nexus.

SUPPLY AND DEMAND

Essential elements of supply include provision of a broad range of contraceptive methods to allow clients to choose the best method for their needs; ensuring a continuous reliable supply of contraceptive methods and supplies; ensuring a sufficient number of qualified providers delivering quality contraceptive services, free from discrimination through multiple service delivery channels; and contraceptive services that are culturally acceptable and targeted to comprehensively meet the needs of the population including the most vulnerable such as populations who are displaced, people with disabilities and adolescents. Furthermore, services need to be client centered and affordable, and potential clients need to be aware of where to access the services.

In order to improve knowledge, attitudes and behaviors related to contraception, a range of demand activities are undertaken such as interpersonal communication (IPC) including one-to-one communication, small group discussions, peer and facilitator led discussion, mass media, couples' communication, engagement of men and community capacity strengthening. In addition to sharing knowledge, these activities work to foster supportive and non-discriminatory gender and social norms related to contraception.

RIGHTS-BASED APPROACH

The ability of women and girls to be empowered and to exercise their right to access quality contraceptive services depends upon a set of priority actions that policy makers, managers, health providers and other key stakeholders need to take. This includes ensuring access for the most vulnerable groups including adolescents, urban poor, rural populations, people with disabilities, people living with HIV and people affected by crises – internally displaced populations, refugees and host populations. Access is further influenced by community power dynamics, discriminatory gender and social norms and religious and other cultural values. The Ensuring Human Rights in the Provision of Contraceptive Information and Services: Guidance and Recommendations provides a rights-based framework for the contraception Common Approach with the key actions integrated throughout the activities listed under each outcome. Critical elements of the framework include: non-discrimination in provision of services; availability, acceptability, affordability and accessibility of information and quality services and products; accountability; participation; and privacy and confidentiality. Additional instruments such as The Convention on the Rights of Persons with Disabilities (CRPD) and the Convention on the Rights of the Child (CRC) include access to quality information and reproductive health services including family planning and require a non-discriminatory approach to empowerment.

A rights-based approach also ensures there is voluntary, non-coerced and informed choice through dissemination of information at the community level and through quality counseling at the health facility (HF) level to increase knowledge about contraceptive methods, including side effects of the methods, and to enable girls, women, couples and men to make their own informed choice.

GENDER EQUALITY

Our approach will promote gender equitable norms among adolescents, youth, women and men, couples and community members with the aim to be gender transformative (or gender sensitive at a minimum). In humanitarian contexts, programs may initially seek to be gender sensitive, but ultimately, our approach aims to be transformative. Save the Children's Gender Equality Marker is a tool to assist in designing projects to ensure they are gender sensitive at a minimum and gender transformative when possible and is complemented by the Save the Children Gender Equality Program Guidance.

Gender sensitive is when the different needs, abilities and opportunities of boys and girls, and men and women, are identified, considered and accounted for. Save the Children believes all our work should be gender sensitive as a minimum standard.

Gender transformative is when we use a gender sensitive approach and promote gender equality, while working with key stakeholders to identify, address and positively transform the root causes of gender inequality with and for women, men, girls and boys.
Save the Children strives to utilize gender transformative approaches whenever possible across our programs, advocacy and organization. (Save the Children Gender Equality Policy)

Gender sensitive projects must consistently include gender equality considerations throughout the project cycle (e.g., needs assessment, project design, implementation, monitoring and evaluation and adaptation), along with technical and financial resources to promote and evaluate progress toward gender equality. Examples of gender sensitive programming are setting clinic hours that are friendlier to women's and girls' schedules, operating mobile clinics to improve access and ensuring female workers are present during clinic hours to improve safety.

Gender transformative projects are gender sensitive and work with key stakeholders to positively transform the root causes of gender inequality for girls, boys, women and men. This may be achieved by: challenging discriminatory social norms which reinforce gender inequalities across all levels of society (e.g., within government, community, family); advocating for and fostering legislation and policies that promote gender equality; and working with communities and stakeholders at all levels to create lasting changes in relation to gender equality in the lives of girls, boys, women and men. Examples of gender transformative programming include: 1) dialogues with men, women, girls and boys about women's and girls' bodily integrity and their right to choose if and how many children they want to have and with whom; 2) challenging forms of masculinity that restrict women's mobility, increase sexual and gender based violence (SGBV) and limit men from having loving relationships with their children and partner; and 3) working with traditional, community and religious leaders to end practices that are harmful to women and girls, including child, early and forced marriage (CEFM).

SOCIAL AND BEHAVIORAL CHANGE (SBC)

Our approach embeds Save the Children's Integrated Social and Behavior Change Framework throughout. The Integrated SBC framework draws from four sets of determinants during design: social and behavioral; community capacity strengthening; quality service; and

resilience. This systematic approach allows for measurement of changes in determinants of SBC and appropriate course adjustments along the way and fits nicely within the Contraception by Choice Common Approach socio-ecological model. The framework also facilitates the development of an SBC communication (SBC/C) strategy that will guide program planning and implementation, addressing the unique needs of a program. It ensures that audiences are segmented in an effective manner by age, gender, cultural background, disability and specific situation (e.g., emergency or development context).

INTEGRATION

Family planning contributes significantly to maternal, newborn and child health, making integration through appropriate platforms an essential component to increasing coverage of comprehensive information and services. When intentionally implemented, integration within health and nutrition services may improve the experience of providers and family planning clients by increasing efficiencies of services. This will be achieved through integration with other relevant Common Approaches such as "My Sexual Health and Rights," "Nourishing the Youngest," "Saving Newborn Lives," "Ready to Learn," "Literacy Boost," "Numeracy Boost," and "Resourcing Families for Better Nutrition," among others. Community and school-based platforms offer an entry point for integration with food security and education respectively. New integration areas for Save the Children are included under the innovation section of the Common Approach. The Common Approach includes the use of tested integration areas such as within postabortion care (PAC), family planning counseling during antenatal care (ANC), postnatal care - postpartum family planning (PPFP), family planning and immunization, family planning and nutrition and family planning/HIV service integration.

When considering whether or not integration is appropriate, it is essential to consider the following: 1) Is there a service entry point that will reach the target audience with a minimum of effort and will benefit both interventions, not just one? 2) What management and training support, and supplies are required to provide quality service delivery? 3) How much will this cost and are there sufficient resources? 4) What will be the impact of this intervention on the existing program? If integration is not suitable, programs may consider establishing a partnership with a government or non-government organization (NGO) that is able to provide quality family planning services.[16]

HUMANITARIAN-DEVELOPMENT NEXUS

The recently revised Minimum Initial Service Package (MISP) for reproductive health includes a new objective to prevent unintended pregnancies, and it is a priority for Save the Children to provide family planning services as part of emergency health programs. Save the Children, donors and international and national partners are working to define the nexus between humanitarian and development settings and to determine models for working in fragile settings with strengthening health systems being one approach to creating linkages between humanitarian and development programming. Family planning preparedness must be routinely considered when planning for a health response in emergency preparedness planning at the country office level in order to ensure its inclusion at the onset of a response.

TARGET GROUP

The Contraception by Choice Common Approach aims to improve access to quality, voluntary contraception for women, men and adolescents in development and humanitarian contexts. The approach works with contraception users and non-users, and seeks to integrate family planning into postnatal or postpartum care[1], immunization services, nutrition, and other health services to avoid missed opportunities and to advance infant and child health through birth spacing.

The primary targets of the common approach are women, men and adolescents of reproductive age. A wide network of target groups that influence access to and voluntary use of contraception will be identified through the situational analysis conducted in development and humanitarian settings. Target groups might include husbands and partners, mothers-in-law, caregivers, religious leaders, community leaders, traditional healers, traditional birth attendants (TBAs), health care providers, ministry of health (MOH) leadership, civil society organizations and others who can influence access to and use of contraception. The approach aims to decrease stigma and create an enabling environment to facilitate voluntary access to contraception. Through the Common Approach, Save the Children aims to use contextualized approaches to reach specific marginalized groups such as adolescents, persons with disabilities, refugees, displaced populations, migrants, rural and urban poor and nomadic pastoralists.

FIDELITY AND QUALITY OF IMPLEMENTATION

Any country implementing the Contraception by Choice Common Approach must implement the following over the life of the award for the approach to be implemented in full; these interventions and efforts collectively address facilitators and barriers to access and use of contraception:

1. An intervention to provide knowledge and improve attitudes and behaviors related to contraception
2. An intervention to promote a supportive social environment through partners, families and/or communities
3. An intervention to strengthen the health services and systems to increase availability of quality information, counseling and contraceptive services
4. Advocacy efforts to promote supportive policies or implementation of the existing supportive family planning policies to make voluntary quality contraceptive services accessible to all individuals.

In the event that an outcome is already adequately covered by the government or other organizations, the family planning program will not be required to include the relevant

[1] "Postnatal care" refers to the first month after birth and is an ideal time to discuss and provide contraception. The term "postpartum family planning" is more commonly used. Postnatal and postpartum family planning integration are mentioned in the Common Approach and refer to the 42 day period when infant and maternal visits and care are critical.

outcome in the program. The proposal/design should document how the program will coordinate or collaborate with partners on activities. Please refer to Annex 5 for a list of indicators to monitor quality of implementation along with quality benchmarks for each key activity. What follows is a description of the recommended interventions for the Contraception by Choice Common Approach; interventions appropriate to the context should be selected based on the findings of the situational analysis.

SITUATIONAL ANALYSIS AND PROGRAM DESIGN

An initial assessment is needed to understand the family planning context. Following is an illustrative but not exhaustive list of important situational analysis activities:

1) With attention to your program focus, review national family planning, sexual and reproductive health (SRH) and adolescent health policies including those related to integration points such as maternal newborn health, HIV/AIDS, early childhood nutrition, and postnatal care to identify type of provider able to provide different types of family planning methods by health service level, provisions that discriminate against women and girls (e.g., spousal or parental consent for access to contraceptives), Comprehensive Sexuality Education (CSE) policies for secondary schools and existence of puberty education in primary schools, among other policy level information. Assess current legislation regarding abortion.
2) Analyze country level commitments made to family planning: Has the country made FP2020 commitments? What are these commitments (e.g., look for the costed implementation plan at national and subnational levels)? Are they part of the West African Ouagadougou Partnership for Family Planning? Has the country ratified the Committee on the Elimination of Discrimination against Women (CEDAW), CRC, CRPD, Maputo Protocol? Any other commitments? Are there national and local level FP/RH working groups?
3) Review secondary data such as Demographic and Health Surveys (DHS), existing program reports, population studies and MOH data including health service statistics, and MOH or Save the Children District Health Information Software 2 (DHIS2) data. Collect information on contraceptive prevalence, available method mix, unmet need, met need for family planning, age at marriage, age at first sexual encounter, knowledge about contraception, age and disability (if available), disaggregated data to learn about who is accessing and using contraception including adolescents and decision-making regarding the use of contraception.
4) Review/conduct qualitative assessments to understand myths and misconceptions about family planning in the community, men's and healthcare provider attitudes toward family planning, decision making power and household gender dynamics, beliefs about family planning among religious leaders, facilitators and barriers to accessing voluntary contraception, who the primary audiences trust for support or advice, community structures and how communities organize, formal and informal leadership, how decisions are made and who makes them and gender-based barriers experienced by women, girls, men or boys that may prevent them from fully accessing, participating in and benefiting from interventions related to family planning.
5) Conduct baseline assessments including HF assessments, population-based assessments, and qualitative assessments exploring social norms and social reference groups among health workers and community members.

6) Assess national level capacity to provide competency-based family planning training: Is there an updated national curriculum? Are there national clinical trainers? What quality assurance mechanisms are in place?
7) Engage vulnerable groups such as adolescents, sex workers, people with disabilities, people living with HIV, crisis affected populations, rural populations and urban poor in program design, implementation, monitoring and evaluation in humanitarian and development programming.
8) In humanitarian contexts, in coordination with health and SRH coordination mechanisms (e.g., health cluster and SRH working group), contribute to mapping of who is doing what, where and when. Gather rapid information on family planning methods used by the affected population and other relevant MISP-related information.

The socio-ecological model describes factors influencing access and use of quality family planning services starting with knowledge, attitudes, and behaviors at the individual level which is discussed under outcome level one below. This is followed by community level interventions addressing IPC with husbands, partners, family members, legal guardians, caregivers, peers, community leaders, volunteers and networks. Outcome three relates to strengthening systems and quality service delivery at the HF and community level through community-based distribution (CBD) and that are integrated with other services to more efficiently provide contraceptive services. Outcome four relates to favorable policies that facilitate access to quality contraceptive services. Each of these outcomes are interconnected and therefore must be taken into consideration when designing a family planning project.

OUTCOME 1, INDIVIDUAL LEVEL: INDIVIDUALS HAVE IMPROVED KNOWLEDGE, ATTITUDES AND BEHAVIORS RELATED TO CONTRACEPTION

As previously highlighted, there are multiple knowledge and psychosocial factors as well as social and gender norms that can facilitate or prevent women, adolescents and men from accessing family planning services.

This section details three key evidence-based interventions that are used to increase knowledge and uptake of family planning.

1. Media – mass, social and digital media
2. Interpersonal communication (IPC) and group-based approaches
3. Comprehensive sexuality education

Evidence from family planning programs demonstrates that knowledge and access should be combined to ensure that knowledge garnered can be transferred into positive contraception seeking behaviors. Family planning programs that address individual contraceptive needs require a multi-pronged approach combining individual level skills such as confidence, agency and negotiation, increasing individual knowledge and access to contraception service delivery channels. Family planning programs that are implemented in silos without a comprehensive approach have been shown to have limited impact on sustainable uptake and long-term family planning use. Individual behaviors are influenced by the following social and behavioral determinants: Information, habit, motivation, ability to act and norms. The Integrated SBC

Framework explains the meaning of each determinant that must be considered when designing interventions targeted at individual decision making. In addition to reaching women and adolescents, interventions are designed to improve the SRH knowledge, attitudes and behaviors among men not only as contraceptive users themselves (e.g., condoms or vasectomy), but also as partners who will engage in open communication about contraception with their female partners and as advocates for gender equality and contraception use.

Media – mass, social and digital media

Reaching women, men and adolescents directly with family planning information can take place through IPC, digital, social and mass media. Mass media includes radio, press, television and print materials. It is essential to engage specific groups such as adolescents in developing media materials to ensure they are tailored to their interests and needs, and to segment information by audience. For example, very young adolescents (VYAs) – aged 10 to 14 years – need accurate information about family planning methods and where to access them as part of laying the groundwork to foster equitable norms. Please refer to My Sexual Health and Rights Common Approach for more information on reaching VYAs.

Healthy timing and spacing of pregnancies (HTSP) messages are evidence-based and may be integrated across communication channels.

1) Women should delay their first pregnancy until at least age 18.
2) After a live birth, women should wait at least 24 months before attempting another pregnancy in order to reduce the risk of adverse maternal, perinatal and infant outcomes.
3) After a miscarriage or induced abortion, women should wait at least 6 months before attempting another pregnancy to reduce risks of adverse maternal and perinatal outcomes.
4) It is best for women to have children before age 35 and to have fewer than 5 births.

Digital health options such as online platforms, SMS, WhatsApp or Facebook, are rapidly being adopted, and free hotlines staffed by trained health workers offering information on RH topics including contraception are successful in providing information to displaced populations.

When considering the use of media, social access and overall media consumption by women, adolescents, men and vulnerable populations such as persons with disabilities, people living with HIV, female sex workers, lesbians and displaced populations should be included in the situation analysis and considered in the design phase. Media interventions, such as **radio programs**, **TV**, **newspapers**, **social media** and **billboards** can reach large audiences, and when used effectively can generate considerable demand for contraception and create conversations on contraception at the household and community level. To be effective, it should be part of a broader program intervention, engage with the audience and use repeated messages. Evidence has shown that there is a strong link between exposure to messages about contraception in the media and uptake of services. [17,18] Radio programming that challenges myths surrounding family planning through a narrative-based approach has also been shown to be successful in a variety of urban contexts.

Different media platforms work in different contexts, so mapping should always be conducted to ensure that the channels being considered will reach the intended audience. Consideration should also be paid to using a mix of complementary media approaches to ensure maximum

reach; for example, radio programming can be combined with billboard and SMS engagement, and sign language interpretation can be included on video and TV materials. Media interventions should also be combined with wider programmatic interventions, such as small listening groups and complementary information, education and communication (IEC) materials for community workers to utilize on home visits, and one to one engagement to ensure a comprehensive programmatic approach.

Mobile phone ownership and internet access has increased exponentially over the past decade in middle- and low-income countries. Mobile health interventions are emerging as promising tools to engage individuals on accurate family planning information and positive SRH behavior change. Some studies have shown that those with sufficient exposure to mHealth programming may be more likely to adopt modern contraceptive methods than those who have had no exposure; however, this is highly dependent on context, internet access, mobile phone access and demographic. When considering mHealth applications it is vital that these are also linked with other interpersonal approaches (community group engagement, mass media and home visits) for greater impact. The target end line users must also be included from the initial planning stages to ensure that it addresses their needs considering issues such as access (families may share one phone between them), network availability and literacy level. The Principles for Digital Development are meant to provide guidance to programs on when and how to use digital health.

IPC and group-based approaches

IPC interventions employ face-to-face interaction between health promotors, peer mobilizers, educators, communicators, service providers and clients and allow for dyadic interactions between members of the group and the promoter/facilitator. Examples of IPC include reaching women through home visits/household outreach by community workers, peer education and peer mobilizers. **Home visits** by trained community health workers (CHWs) have been shown to be successful in increasing contraception uptake by married women and girls (particularly first-time mothers). Family planning information may be integrated through postnatal care home visits and is effective in rural locations where access to services and community interventions can be limited. Emerging evidence has demonstrated that **peer mobilizers** in urban settings can also be effective in reaching unmarried women and girls when combined with other interventions (such as direct marketing, accessible clinics and adequate training).[17] **Peer support** such as mothers' support groups, and among disabled populations between women and girls with the same impairment, is one way to change behaviors and attitudes and encourage self-esteem and agency.[18] This may be accomplished by working with youth and women's associations, Disabled Persons Organizations (DPOs) or other local actors. **Peer mobilizers** may be trained to incorporate life skills training into their IPC to increase individual skills such as confidence and negotiation skills as well as family planning and sexual and reproductive health rights (SRHR) knowledge. However, it is essential to plan for adequate supervision and resources for this approach to be effective. It should be noted the literature shows that peer mobilizers / educators for adolescent reproductive and sexual health (ASRH) and general population have mainly benefitted from information and services, rather than their target beneficiaries.[19]

Small group-based methodologies are often used by Save the Children to increase knowledge, build life skills and support reflection and dialogue on social norms, behaviors and beliefs. They can act as a 'safe space' for small groups of similar age to increase their knowledge about contraception (including side effects), dispel myths and misconceptions, and foster non-discriminatory, supportive social and gender equitable norms. Small group methodologies are effective for engaging with segmented population groups such as adolescents, new parents and women with disabilities either through specific groups or inviting them into existing groups, same sex groups and mixed groups.

Small groups can embrace a number of activities, such as interactive games, songs and trigger discussion exercises and typically meet once a week or biweekly for a specific period of time with a trained facilitator following a tailored curriculum. They can also include referral and counselling opportunities for women and couples individually.

Small group methodologies can be particularly influential when combined with wider programmatic activities such as mass media interventions. Radio listening groups, with complementary discussions with trained health workers or peer-to-peer conversations can have a significant impact on family planning knowledge and uptake. Small group participatory sessions can also contribute to enhancing women's decision-making power and in some studies have been linked to higher levels of contraceptive use when combined with other social behavioral change strategies and service delivery.

When engaging young people and adolescents, small group methodologies work well when combined with life skills, mass media and health service linkages. Small groups can build protective assets and support reflection and dialogue amongst young people that can enhance their knowledge and skills on family planning and stigma reduction. The enabling environment is further expanded by engaging communities in dialogue around the importance of ASRH and establishing linkages with health services through training and referral systems.

Small group methodologies addressing family planning should always be part of a comprehensive programmatic approach to ensure maximum impact and reach. Access to family planning services and referrals should always be a key aligned component. In humanitarian contexts, safe spaces are particularly useful in reaching women and girls with integrated SRH information and services and/or referral to services such as health, protection, livelihood and nutrition.

Comprehensive Sexuality Education (CSE) and puberty education in schools and non-formal community settings is a curriculum-based process of teaching and learning in schools and non-formal community settings. It empowers adolescents through multiple channels of learning to make informed decisions related to their sexuality, health and well-being. Furthermore, it provides an entry point for contraception and serves as a link between adolescents and family planning services provided by trained providers. Through these linkages, adolescents may receive correct information and access voluntary contraceptive services. Please refer to the My Sexual Health and Rights Common Approach for more information on this approach.

OUTCOME 2, PARTNER, FAMILY AND COMMUNITY LEVEL: PARTNERS, FAMILY MEMBERS AND COMMUNITIES SUPPORT CONTRACEPTION

The lack of a supportive partner, spouse, in-law or peer is a major barrier to women's and girls' access to and continued use of contraception. Male partners play an important role in challenging inequitable gender norms and fostering supportive environments for family planning use, by not only modeling positive behaviors and attitudes for peers and family members, but also by supporting and making decisions jointly with their partners. Men also have their own SRH needs that differ across age and life stage, as they strive to fulfill societal roles while exhibiting behaviors that can either facilitate or inhibit healthy sexual relationships.[20] It is important for family planning programs to engage boys and men as change agents in families and communities to foster gender equitable norms and catalyze behavior change. As women and girls may not be the primary decision-makers about their own health behaviors, gender transformative approaches that promote equitable decision making between partners and improve partner support for family planning are more likely to enable women to seek services and sustain family planning use.[20]

- **Interpersonal communication approaches** that reach men or influential family members such as mothers-in-law to provide information and engage them one-on-one in discussions about SRH topics or health counseling, such as hotlines or household visits conducted by male community volunteers, can motivate men and family members to support family planning and practice healthy SRH behaviors. Please refer to Annex 1 for tools.
- Establishing **champions** (e.g., male champions, satisfied FP users, etc.) can promote family planning use and gender equitable norms through one-on-one and group discussions. The Male Motivator Curriculum was used in Malawi to identify men who use family planning and were willing to be trained as "male motivators." Their role was to facilitate discussions with other men about gender and social norms and enhance male initiated couple conversations about family planning.
- **Small group activities** can help men learn about fertility, family planning methods and their side effects, and encourage critical reflection about social and gender norms that are barriers to family planning access and use. Husbands' groups and videos of husbands or in-laws modeling gender equitable behaviors to spark discussions in small groups and encourage behavior change have been successfully used. You may refer to Annex 1 for links to approaches.
- **Mentorship-based approaches** can teach and support men to build skills to promote positive conflict resolution behaviors, reduce SGBV, practice gender-equitable behaviors with their families and promote behaviors and attitudes that are supportive of family planning. Please refer to Annex 1 for tools.
- **Couples counseling approaches** help men and women build skills to communicate and make decisions with their partners around family planning use, fertility intentions and future desires to enable use of a family planning method. You may refer to Annex 1 for tools.

Community group activities that engage and mobilize communities in dialogue, reflection and action for healthy sexual relationships play an important role in establishing, maintaining and changing social norms.[21] It is essential to map community networks comprising groups such as

community-based organizations (CBOs), women's associations, youth groups, DPOs, village development committees, health committees, religious leaders, and CHWs. Save the Children's Integrated SBC Framework includes analysis of community capacity-strengthening determinants which are used to address gaps in capacity or leadership of communities to mobilize for collective action. The following evidence-based community support activities are recommended by the Common Approach:

- Support to **CHWs** for outreach using contextualized job aids and tools to ensure integrity of information and linking them with **health committees** and health care facilities is a documented best practice and one of the key activities of the Family Planning Common Approach. Essential for both humanitarian and development contexts.
- Engaging **custodians of culture (religious and cultural leaders including traditional healers)** in ongoing reflection and action to create a supportive environment for family planning by creating forums for discussion of values and beliefs and stimulating dialogue around stigma and its negative effect on access to family planning services for groups such as youth and people with disabilities, social and gender norms and their influence on equality. In Kenya, Save the Children used signed commitments (fatwas) by Muslim religious leaders among the Somali communities.
- **Community Capacity Strengthening** – Save the Children has developed the Community Capacity Strengthening Guide to design key interventions.
- **Small group** engagement focuses on working with segmented population groups (e.g., adolescents, persons with disabilities, LGBTQI[2] communities, displaced populations and poor) outside of the health system to influence individual behaviors and social norms related to contraception using group dialogue, rather than targeting individuals alone. Additionally, the small groups can provide feedback on services and suggestions for improvement.
- Save the Children's Mobilize Communities for Health and Social Change guides the user through the community action cycle (CAC) that engages community members in diagnosing problems affecting family planning use, developing solutions to support family planning use, and implementing the solutions and monitoring them. This approach can be used to engage local governments in the process as well.
- **The Partnership Defined Quality (PDQ) approach** fosters social accountability to improve access to respectful and quality health care services. PDQ engages community members and service providers in defining and sharing perceptions of quality of care, which then form the basis for collaborative quality improvement (QI) plans. The approach works to address the underlying causes of health problems, such as social inequality and other contextual barriers. The PDQ process supports communities and health services to participate actively together towards improving

[2] Lesbian, Gay, Bisexual, Transgender, Queer, Intersex and Asexual (LGBTQIA) people face different risk factors related to sexual reproductive health (SRH) and it is important to acknowledge each population within this group based upon the context. Due to the discrimination by the health system and community that this group frequently faces, it is important to engage with LGBTQIA groups and health providers to improve access to quality SRH including contraceptive services.

health quality through ongoing dialogue, planning, collective action and monitoring of outcomes.

- **Group learning and community theatre** interventions spread fertility awareness and family planning information among hard to reach communities. The FACT project demonstrated that trained community youth agents are acceptable to the community and able to facilitate these interventions. The approach successfully improves self-efficacy and attitudes around family planning, including intent to use family planning. **Media based approaches** as discussed under Outcome 1 may be used.

OUTCOME 3, HEALTH SERVICES AND SYSTEMS LEVEL: INCREASED AVAILABILITY OF QUALITY INFORMATION, COUNSELING AND CONTRACEPTIVE SERVICES ACROSS THE CONTINUUM OF CARE

Clients and providers face numerous barriers when attempting to access and provide quality services such as a limited range of contraceptive method choice, providers with insufficient training and skills, little to no integration of contraceptive services into other health services, lack of adequate infrastructure and weak systems.

Save the Children uses a household-to-HF continuum of care approach that includes services at all levels of the health system (CBD, independent self-care, health center, referral health centers and hospitals). The health services are frequently government supported but may be private sector or, in humanitarian health responses, provided directly by Save the Children. The Family Planning 2020: Rights and Empowerment Principles for Family Planning outlines rights principles that are necessary for contraceptive services and quality of care is one of the elements of a rights-based client centered approach.

Quality of care includes: 1) competent and trained health providers; 2) clear and medically accurate information about contraceptive methods that includes risks and benefits of each method; 3) client-provider interactions that respect voluntary choice and confidentiality; 4) consistent supply of contraceptives and medical supplies; 5) adequate physical structure for quality service delivery (HF and community level); 6) community engagement approaches such as PDQ and "PDQ for Youth"; 7) infection prevention (IP) to ensure client and health worker safety; 8) referral systems (community to HF, within HF, and HF to HF); 9) data for action processes at all levels of service delivery with links to the MOH; and 10) continuous QI, a management approach to improving systems at the community and facility level to ensure quality of care.

The key interventions in this section are framed by the WHO building blocks for health system strengthening and Save the Children US's strategic priorities discussed in "Building Viable and Resilient Systems for Health DGH Strategic Orientations 2017 – 2020." In addition, Save the Children's Integrated SBC Framework lays out quality services determinants that guide provision of those services: key care practices that are evidence-based; effective communication that is respectful; products and services; functional referrals; and accountability. A quality family planning program should ensure the following elements that align with the WHO building blocks are taken into consideration when designing and implementing a family planning program.

High quality contraceptive services

A systematic approach to quality improvement that is owned by health facility staff and management, community health volunteers and community members contributes to sustained quality of care and fosters accountability. There are a number of approaches to quality improvement that use data for decision making processes. The "Plan, Do, Study, Act" model provides a framework to identify problems, test improvements on a small scale and evaluate. The "Client-Oriented Provider-Efficient (COPE)" approach is a model for quality improvement at the health facility level, and the PDQ approach links communities with health facilities with the aim to jointly define quality, identify problems and develop action plans to address those problems. WHO has developed a checklist for monitoring quality of care in contraceptive information and services that may be adapted and used by managers. You may access these tools in Annex 1, under outcome three resources.

Functioning referral systems are an essential component of ensuring quality contraceptive services within the continuum of care from the household to the health facility. Contraceptive users need to be informed of side effects, danger signs and where to go for care, and they must have the means for reaching care through referral mechanisms from the community to the facility, and facility to facility.

In order to provide confidential and safe services, programs need to plan for adequate infrastructure that complies with standard IP procedures to reduce the risk of clients acquiring nosocomial and anti-microbial resistant infections. The Family Planning Handbook: A Global Handbook for Providers included in Annex 1 provides minimum standards for providing clean and safe family planning services. The IP practices should match the level of services provided (short-acting, LARCs and permanent methods), and safe disposal of needles for self-administration of injectables. In all settings, basic preventive services (e.g., water, soap, chlorine, sterilization equipment, incinerator and other IPC supplies) are required. Providers must be well-trained, motivated, supervised and mentored to follow IP practices including handwashing, decontamination and sterilization processes, and have the necessary supplies and equipment to consistently implement IP.

Support to Ministry of Health System and Health Facilities

In development and humanitarian settings, it is essential to work with the MOH to identify system strengths and weakness and jointly work to strengthen facilities and systems with strong linkages to the community including community health services. In collaboration with the MOH, an analysis of the health system and health facilities is used to guide the selection of activities based upon the health system building blocks to provide a full method mix and quality family planning services that are accessible to the community.

Save the Children Managed Health Facilities/Mobile Clinics

In humanitarian settings, Save the Children establishes and operates health facilities and mobile clinics in the absence of functioning health services. These are temporary services until they can be transitioned to the MOH system. Contraception is a component of the package of health services offered. The range of contraceptive methods offered will depend upon the mobile clinic set-up or level of facility supported in accordance with WHO and national standards and policies. At a minimum short-acting methods (condoms, pills and injectables), Lactational Amenorrhea Method (LAM) and FAM may be provided along with referrals to

LARCs and permanent methods. LARCs may be offered if privacy, IP and follow-up conditions are met.

Support to private sector: private clinics, pharmacy and local CBO/NGOs

In fragile non-permissive environments, such as Syria, engagement of the private sector or local NGOs/CBOs in the provision of contraceptive services is essential. Save the Children in such contexts may take a contracting role by sub-granting the private sector or NGO/CBO and providing technical assistance (TA) as needed.

Integration

There are a number of missed opportunities to provide family planning while women are accessing other services such as routine care for chronic disease, postnatal care, immunizations for their children, mental health care and clinical management of sexual violence. Well thought out integration can expand access to voluntary family planning services either at point of care or through referral. However, it is essential to put in place supportive policies, service delivery guidelines and tools, trained and competent health care providers and managers, and strong logistics systems to ensure availability of supplies and acceptance by communities and health workers for successful integration to occur.[22]

Integrated Counseling Tool

The Balanced Counseling Strategy Plus (BCS+) approach to family planning counseling uses family planning services as an entry point to facilitate integration and linkages with other services such as maternal newborn health, HIV testing and treatment and gender-based violence. For more information on BCS+, refer to resources and tools in Annex 1.

Postabortion care (PAC) and family planning

Provision of contraceptive services at the same time and location where a woman receives postabortion services is an evidence-based practice. Women are more likely to choose a contraceptive method if they receive the method as a part of PAC services. Stigma is frequently associated with PAC and it is therefore essential to engage communities and train providers, MOH partners and program managers to examine personal values and attitudes, understand international and national policies and consider special needs of vulnerable women and girls such as adolescents, minorities and people with disabilities (e.g., sensory, intellectual or psychosocial impairment) when providing family planning and PAC.[23]

Postnatal or postpartum family planning (PPFP)

Women and girls frequently wish to use contraception after delivery yet family planning is not consistently integrated into postpartum care. PPFP includes conducting whole-site orientations for staff on PPFP, integrating PPFP information into community outreach and during ANC and assisting pregnant women to select the most suitable method for them. Encourage couple communication on family planning throughout the antenatal, intrapartum and postnatal/postpartum period and ensure continuity of care. Offer contraceptive counseling and services as part of facility-based childbirth care prior to discharge from the HF.[24] Please refer to Annex 1 for resources such as the WHO compendium for selecting a postpartum method of family planning.

Kangaroo mother care (KMC), postnatal care home visits and pregnant and lactating women support groups offer excellent opportunities for integration of family planning counseling and services. Postpartum IUDs may be provided immediately and up to 48 hours after delivery while postpartum implants may be provided immediately after delivery and any time after as long as medical eligibility requirements are met.[25]

Immunization and family planning

Childhood immunizations offer an ideal time for integration of family planning counseling and services for both men and women. Reaching postpartum women through immunization contacts could decrease overall unmet need for family planning by 3.8 percentage points.[26] Initiate 6 month contact point postpartum visits to provide a high impact intervention package of services benefiting maternal and child health and nutrition status. The package includes voluntary family planning, vitamin A supplementation, infant and young child feeding (IYCF) and catch-up vaccinations.[27] Routine immunization integration allows for multiple contacts at birth, 6 weeks, 10 weeks, 14 weeks and 9 months as recommended by WHO. Because a woman's chance of conceiving increases over time following delivery, multiple contacts between women and providers postpartum are particularly important.[28] This is also an opportunity to raise men's awareness around healthy timing and spacing, providing education on family planning methods for both men and women. This also has the added value of reinforcing the value of immunization and primary health care systems overall.[29]

HIV and family planning

Family planning services are an important entry point for HIV prevention, care and treatment, SGBV and other reproductive health services – and vice versa. Recent findings from the Evidence for Contraception Options and HIV Outcomes (ECHO) study showed no substantial difference in HIV risk among intramuscular (DMPA-IM), Levonorgestrel implant and the copper-bearing IUD, and therefore concluded that all three methods are safe and there should be increased access to these three methods. WHO recommended an increased focus on integrated family planning, HIV and STI services, particularly in countries with a high burden of HIV.[30] The potential advantages of providing family planning and HIV services in an integrated manner are several: leveraging resources; minimizing missed opportunities leading to greater service uptake; improved quality of care; minimizing stigmatization and discrimination; and improved health and socio-economic outcomes among the population. The BCS+ tool includes screening for HIV risk and recommending actions to be taken such as referral for HIV testing, treatment and offering condoms for dual protection. In addition, family planning services may be offered throughout the HIV continuum of care for prevention, care and treatment. This may be in drop-in HIV centers, HIV testing services, community-based HIV treatment programs, facility-based HIV care, treatment and support and prevention of mother-to-child transmission (PMTCT).[31] One of the four prongs of PMTCT programming includes prevention of unintended pregnancy among women living with HIV. Resources and tools for integrating family planning and HIV may be found in Annex 1.

Nutrition and family planning

Basic nutrition or Maternal, Infant and Young Child Nutrition (MIYCN) integration with family planning reinforces positive gender and socio-cultural norms and reduces the amount of time women spend in accessing services. By integrating family planning into nutrition programs at community and facility levels, programs can promote healthy timing and spacing of

pregnancies (HTSP) and reduce major risk factors for adolescents and women experiencing undernutrition, low birth weight and sub-optimal IYCF which leads to child undernutrition. In addition, family planning contacts provide an opportunity for uptake of nutrition services such as MIYCN counseling and iron-folic acid supplementation. Integrating family planning into nutrition programs increases uptake of family planning services through several community and facility level nutrition contacts such as community dialogue on MIYCN, community management of acute malnutrition (CMAM) and growth monitoring and promotion (GMP) services. Nutrition programs promote exclusive breastfeeding (EBF), an entry point for discussing LAM and other methods of PPFP.

Health workforce that is sufficient in number, well trained and able to provide quality family planning services

Women, adolescents and their partners frequently face multiple negative provider attitudes and barriers when seeking family planning services and there is often an overall lack of trained providers able to provide quality family planning counseling, LARCs and permanent methods. To address these barriers, it is important to ensure that the health workforce is well trained on contraceptive technology for each method, as well as how to provide quality counseling that includes providing accurate information on the effectiveness, risks and benefits of each method, while ensuring client choice. The training should use competency-based techniques that include role plays, demonstrations, and practice with insertion and removal of LARCs on models and clients under supervision by a clinical trainer. An initial training needs assessment of provider skills in comprehensive family planning service delivery should be conducted along with a training site assessment. Based upon assessment findings, the competency-based training package can be tailored and delivered by certified trainers (e.g., MOH trainers, SC trainers or consultant trainers). There are a number of options for trainers. It is best to engage with and support national trainers to conduct the training. Depending upon the level of the national trainers, Save the Children may provide additional training expertise by either deploying a Save the Children clinical trainer or hiring a consultant. In humanitarian settings, Save the Children frequently deploys clinical trainers to conduct initial trainings and establish a plan for follow-up. Provider training should be in line with global standards for training with an adequate number of qualified trainers to ensure mentoring and coaching during the practical component. For training packages and tools, please refer to Annex 1 under Outcome 3.

Due to health workforce shortages in many environments, particularly those plagued with humanitarian crises, task sharing and shifting to other cadres of health providers that is coordinated with the national MOH may be piloted and scaled up to national levels. These efforts should also be linked with advocacy and policy efforts. Learning new skills can be very motivating for staff and can be an approach for staff retention and motivation. Furthermore, in humanitarian settings, surge support by midwives, nurses and doctors is frequently needed to meet the immediate gaps in health workforce availability. Trained providers also need regular supportive supervision and coaching that is well structured, consistent and aided by the use of supervision checklists to support providers in practicing new skills.

The aim of competency-based training is to increase knowledge, foster positive attitudes towards contraception and increase skills. This training includes principles of rights-based family planning services, contraceptive technology on a full range of family planning methods that are on the country's essential medicine list, quality counseling, clinical practice on

mannequins for insertion and removal of LARCs and permanent method procedures followed by practice on clients under supervision by a clinical trainer. To address program staff and provider biases and attitudes, Save the Children conducts training on values clarification and action transformation (VCAT) related to family planning and PAC in emergency and development programs. VCAT workshops are designed to help participants: challenge deeply-held assumptions and myths; clarify and affirm their values and potentially resolve values conflicts; potentially transform their beliefs and attitudes that impact behaviors; and state their intentions to act in accordance with their affirmed values.

Save the Children has a standardized FP training package that may be used to either update national training packages or be adapted for training, a supportive supervision package and VCAT toolkit for family planning and PAC that may be accessed in Annex 1 along with other training resources.

Community-Based Distribution by CHWs helps to mitigate geographic and social mobility access barriers, health worker shortages and barriers due to insecurity.[24] While Save the Children frequently works with existing CHWs, it is important to consider gender balance, inclusion of specific groups such as refugees, ethnic minorities and persons with disabilities and other factors as relevant when selecting CHWs. Save the Children has extensive experience with facilitating training and support for community-based distributors of short-acting family planning methods including injectable methods. The services may be free or have minimal costs associated with the consultation. CBDs can be a link between marginalized populations and the health system. The use of CHWs for family planning services might be linked with Save the Children's integrated community case management (iCCM) work in both development and humanitarian settings.

The High Impact Practices (HIP) for CHWs offers the following practical steps for working with CHWs: ensure trainings are practical and incremental; train and engage CHWs in behavior change communication, unconscious bias, disability sensitization training and VCAT training; increase the variety of methods CHWs can provide (e.g., condoms (male and female), oral contraceptive pills and injectables) as contraceptive uptake is considerably higher when CHWs provide the method directly when compared to referrals; implement multilevel QI teams that connect CHWs, health center staff and district staff to reinforce correct and consistent use of resupply procedures and address bottlenecks; employ incentives to attract and retain CHWs (financial and non-financial); certify CHWs to professionalize and drive quality standards; and recruit CHWs from beneficiary communities.

WHO provided new recommendations on self-care interventions for family planning that include self-administration of injectable contraception and over-the-counter oral contraceptive pills (OCPs) without a prescription for those currently using OCPs. These new recommendations are in addition to existing ones such as consistent and correct use of male and female condoms, particularly among key populations, to prevent sexual transmission of HIV and sexually transmitted infections (STIs).[32]

A well-functioning health information system

Regular use of data for decision making is used across all aspects of program delivery. Programs should establish data for action processes such as regular data audits at all levels of

the health system to ensure quality of data; routine analysis of data from the community level to HF, and from HF to district, province and national levels; monitoring of trends and tendencies for key indicators in discussion with key stakeholders to identify problems; brainstorming solutions; and development of joint action plans. The process may be led by the MOH partner or initiated by Save the Children in collaboration with the MOH partners. Save the Children developed the PDQ approach, which engages the community and health providers in analyzing data and improving quality. Programs may also use data to influence policy decisions at local and country levels.

Availability of high-quality contraceptives and medical supplies

Reliable supply chain mechanisms to ensure a consistent supply of LARCs, permanent methods, supplies and equipment, and less frequently short-acting methods of contraception are a consistent challenge. This challenge is heightened in humanitarian contexts. A broad mix of contraceptive methods and consistent supply is an essential component of quality services. Please refer to Annex 6 for the WHO list of commonly available contraceptive methods and a short description of each method. Based upon assessment findings, a program needs to determine the best mechanisms for supply chain management to ensure a consistent supply of all contraceptives and renewable supplies. In acute emergency responses, international and local procurement is frequently required while support or linkages with the national supply chain system should be established as soon as possible. Communities may be engaged to manage inventory and supplies using the PDQ in a variety of contexts including fragile settings. United Nations Population Fund (UNFPA) is a key partner for emergency supplies as well as for contraceptives in development settings. In countries with supply chain challenges, it is important to work with UNFPA through a Memorandum of Understanding (MOU) to access contraceptives and reproductive health kits that include contraceptives for emergency response. This can be negotiated as part of the country emergency preparedness plan. Alternatively, family planning kits and reproductive health kits may also be ordered directly from UNFPA.

The following table provides some examples of health system strengthening interventions based upon the context:

Comparison of humanitarian and development specific interventions

HUMANITARIAN SETTING	DEVELOPMENT SETTING
Flash trainings (training 3 to 5 providers at the health facility – developed by Save the Children and currently being tested)	Comprehensive family planning training package
Provision of contraceptive supplies	Strengthening supply chain systems
Informing community of FP services	Strengthening or establishing CBD of short-acting methods of family planning and linking to health facilities for LARCs and PM
Establishing FP health information system	Supporting or establishing FP health information system

Sustainable Financing

Many countries where Save the Children has programming have made financial commitments to FP2020. As part of a landscape analysis, Save the Children managers implementing the Common Approach should be aware of their FP2020 Country Commitments. As many countries work more broadly to provide universal health care (UHC) and deliver on their FP2020 commitments, Save the Children family planning programs have a unique opportunity and obligation to engage in national discussions and share evidence from field projects to inform family planning policies. Moreover, it is essential to promote and support social accountability mechanisms led by civil societies and other local partners to further sustainable financing for family planning.

Leadership and Governance

It is essential to share learning from the Contraception by Choice Common Approach projects at the policy level to inform national family planning policies. This may be accomplished through active participation in national and decentralized family planning / reproductive health platforms, collaboration with government family planning departments to update technical training and implementation packages as needed, and the building up of the national family planning clinical training capacity. The following outcome will go into more detail.

OUTCOME 4, POLICY LEVEL: IMPROVED LEGAL, POLICY, ADMINISTRATIVE AND FINANCIAL ENVIRONMENT FOR FAMILY PLANNING AT NATIONAL, REGIONAL AND GLOBAL LEVELS

Many settings or countries may have restrictive policies that limit the level of health workers who can provide contraception especially LARCs, require parental consent for adolescent contraception, restrict sexual and reproductive health education in schools or require the husband's consent for women to access family planning services. Moreover, policy makers frequently lack knowledge that contraception is lifesaving and many national budgets have allocated limited to no funding for family planning. Women and girls with disabilities frequently participate at a lower rate in education, employment, social protection schemes, health care and community life which puts them at a considerable disadvantage for accessing family planning services.

Advocacy at local, national, regional and global levels is needed to ensure policies reflect rights-based access to family planning, the latest evidence and WHO standards. The situational analysis includes a review of policies, standards, guidelines, tools and budgets related to family planning that will inform an advocacy agenda to address outdated or non-rights-based family planning policies. The advocacy agenda should be aligned with WHO standards and the Universal Human Rights Instruments such as CEDAW, CRC and CRPD along with Save the Children's Global Position on SRHR. Effective leadership is one of the resilience determinants of Save the Children's Integrated SBC framework and is an essential role for Save the Children to play when advocating for favorable family planning policies at the national and global level.

The Contraception by Choice Common Approach links to local, national and global levels through participation in platforms such as FP2020, the Inter-agency working group for

reproductive health in crises (IAWG), family planning networks and taskforces, and emergency reproductive health working groups to contribute knowledge and learning generated from our programs to family planning policies, standards, strategies, and implementation plans. In addition, Save the Children works to engage civil society organizations (CSOs) to strengthen their capacities to develop their own advocacy agenda, advocate for their communities and hold leadership accountable for commitments made. In addition, it is essential to include emergency preparedness in community and national advocacy and policy discussions to ensure that family planning is integrated into national and decentralized disaster preparedness plans. Following is a list of advocacy priorities that may be adapted based upon a contextual analysis:

- Family planning needs to be part of the UHC package of services covered and countries need to raise domestic resources to pay for them.
- Funding should be increased to ensure universal access to the full range of family planning services with a particular focus on hard to reach areas that are frequently affected by humanitarian crises.
- Addressing inequity is a priority in order to make progress towards universal access to FP/RH services between and within countries and particularly for youth, poor, minorities, rural and remote populations, and those with little education.
- Adolescents need to be at the center of global family planning efforts, which should commit to end child marriage and support the rights of all adolescents, married and unmarried, to universal access to essential health care, including comprehensive SRH/FP information and services.
- Task sharing and task shifting of family planning service providers to include contraception that is self-administered, safely provided by CHWs and midwives is evidence-based and improves access to quality contraceptive services.
- Family planning is crucial to ending preventable maternal and child deaths and achieving SDGs 3.1 and 3.2.

EVIDENCE OF EFFECTIVENESS

Family planning is a development "best buy" and contributes to the achievement of the SDGs.[15,33] For every additional dollar spent to provide family planning in developing countries, there is a decline in unplanned pregnancies and a savings of $2.20 on maternal and newborn

care.[1]

Starbird et al. summarize these contributions under the key goal themes of people, planet, prosperity, peace and partnership within the SDG framework.[15] For example, family planning contributes to improved nutrition when women are able to space pregnancies and replenish essential nutrients. Healthy timing of pregnancies allows a woman to wait until she is over 18 years, improves adolescent growth and development and improves overall birth outcomes by reducing stunting, low birthweight and pre-term births. SDG goals 3.7 and 5.6 in particular support "universal access to sexual and reproductive health-care services, including family planning and universal access to sexual and reproductive health and reproductive rights."[15,34] Providing a complete package of essential maternal newborn care and family planning services and satisfying the unmet need for family planning would result in an estimated 2.2 million fewer newborn deaths each year and a 29% reduction in maternal deaths globally.[1,35] Healthy spacing of pregnancies would reduce prematurity, low birthweight, fetal death and early

neonatal and infant death.[36]

OUTCOME 1: INDIVIDUALS HAVE IMPROVED KNOWLEDGE, ATTITUDES AND BEHAVIORS RELATED TO CONTRACEPTION

Mass media as described under this Common Approach set of recommended activities is an evidence-based intervention that may be used to support healthy reproductive behaviors including family planning and can lead to positive social changes such as increased community discussions about contraception and improved norms that are supportive of contraception. It also impacts the individual level by increasing awareness, knowledge, self-efficacy and risk perception, and fostering supportive attitudes, beliefs and values.[37] Twelve studies in Asia and Africa with strong evaluation designs demonstrated that mass media contributes to increased contraception use.[37] Furthermore, mass media can be more effective when combined with interventions that engage peers, family members and the community through IPC and community engagement.[37,38] To be effective, these demand generation interventions should be linked to the supply side of quality family planning services and a comprehensive family planning program package. [37,39,40]

Interpersonal communication (IPC) as described in the recommended activities in this Common Approach is an intervention for demand creation in family planning programs that includes one-to-one communication, small group discussions and facilitator-led discussions using a curriculum. One systematic review noted a positive effect on short-term outcomes of knowledge, attitudes and beliefs, as well as behavioral outcomes such as contraceptive use and unintended pregnancies.[39] Combined IPC and community group engagement approaches are successful strategies for demand creation.[33,41]

Small group methodologies engage with community groups to influence individual behaviors and social norms and therefore shift the focus from individuals to groups. They rely on active participation of community groups and community leaders and work through a variety of small group methodologies such as exploratory games, mapping exercises, social network activities, peer support groups, and prioritization exercises, among others. Community group engagement is associated with higher contraception use and has been identified as a promising HIP in family planning based upon studies from a number of different countries spanning Africa and Asia. Small group methodologies are usually part of a wider SBC strategy and need to be linked with family planning services.[18,41] A WHO Evidence Brief includes engaging religious and male community leaders to support family planning in communities.[33] One cross-sectional study in Nigeria documented the positive impact of religious leaders (Muslim and Christian) on contraception use. The project implemented a package of interventions that included demand creation, advocacy and service delivery and with significant religious leader engagement. Study results found approximately 2 in 5 women reporting hearing family planning messages from religious leaders over the past year. According to the study's authors, "There was a higher uptake of modern contraceptives among women with high exposure to the project interventions (35.5%) compared with respondents in the low or medium exposure categories (14.5% and 24.5%, respectively). The multivariable analysis revealed significantly higher contraceptive uptake among women who had exposure to family planning messages from religious leaders relative to those with no exposure."[42]

Digital health is increasingly used as smartphone ownership and internet use is rapidly increasing in many developing and developed nations around the world. It is among one of the promising practices for family planning programs identified by HIP as studies have shown it can improve SRH knowledge, influence social norms and attitudes, increase self-efficacy, and increase partner dialogue about family planning; however, the impact of digital health on contraceptive use remains unclear.[43] There is a rapidly increasing number of young people using smartphones and other digital technologies which provides an opportunity to disseminate accurate information to this population. Three out of five studies (Cambodia, Mozambique, and Nigeria) used a combination of short message service (SMS) and interactive voice response (IVR), and noted an increase in modern contraceptive use in the short-term.[43]

OUTCOME 2: PARTNERS, FAMILY MEMBERS AND COMMUNITIES SUPPORT CONTRACEPTION

Strategies for outcome 2 include IPC, mass media and small groups in addition to the following:

Engagement of men and boys: Men play an important role in challenging inequitable gender norms and fostering positive norms, especially among peers and with their children, and influence contraceptive use either by their partner(s) or themselves; yet, they have frequently been overlooked in family planning programs. Findings from a recent study in rural India assessed gender equity and family planning interventions.[44] Interventions included three sessions of counselling provided by male health workers to married men. Contraceptive use increased during the study period, with 29.2% of women using modern contraceptives at the beginning of the period, increasing to 51.7% after 18 months**.** Furthermore, findings from a recent qualitative study conducted in Togo explored the attitudes of 72 married men aged from 18 – 54. Results indicated that men have specific views on family planning, based on their knowledge and understanding of why women might use contraception. Most men had a positive response to discussing family planning and being engaged with related decisions and services. Study recommendations suggest that future attempts to engage men in family planning programs should pay specific attention to men's concerns, misconceptions and their roles in family planning decisions. Interventions should educate men on the socioeconomic and health benefits of family planning while explaining the possible side effects and dispelling myths.[45]

Men's SRH needs differ across life stages, from adolescents to those who have completed their family size. Throughout their lives, men and boys work to fulfill their roles in society and have behaviors that can either support or inhibit healthy sexual relationships and contraceptive use by their partner or themselves. The following emerging and proven interventions are supported by a systematic review of gray and peer reviewed literature as well as the HIP strategic planning guide for engaging men and boys in family planning programs: 1) make contraceptive information and services available to men and boys when they need them and in places where they are comfortable (e.g., pharmacies, drug shops, integrated into other development activities targeting men); 2) engage men as contraceptive users or as partners using methods requiring their active participation; 3) address gender norms that inhibit and facilitate equitable access to contraception; 4) encourage couple and community communication that fosters equitable gender norms and encourages men and boys to talk

with partners about contraception; 5) address men's needs while ensuring autonomy for women and girls; 6) talk with boys about healthy sexual relationships and how to prevent unplanned pregnancy; 7) analyze national policies and advocate for inclusion of men as contraceptive users in the policies; 8) scale up successful strategies for engaging men and boys; and 9) encourage men and boys to advocate for gender equality and family planning in their facilities and communities.[20,46] In addition, couple communication regarding methods and side effects promotes continued family planning use including switching methods if problems arise.[33]

CHWs provide an essential link between communities and health care services through bringing family planning services to communities experiencing financial, social and geographic barriers to services and referrals to family planning services.[24,47] When CHWs are well trained, supported and equipped they improve knowledge and attitudes about family planning, and they increase demand and access to contraceptive services. This approach has been recommended for general implementation as part of a comprehensive family planning strategy.[24] This recommendation is based upon evidence from several countries and settings such as Ethiopia, DRC, India, Guatemala, Bangladesh and Nigeria.

Available evidence supports the use of CHWs. For example, a review of family planning programs in 10 developing countries found programs that combined CHWs with clinic-based service delivery were more cost-effective than either clinic-based or CHW programs alone.[48] Further to this, Scott et al.'s (2015) systematic review found strong evidence that CHW provision and family planning service in low and middle income countries is effective.[49] A total of 56 studies were included, from a variety of settings such as Bangladesh, Ghana, Pakistan and Uganda. Findings showed that approximately 93% of CHW family planning programs effectively increased the use of modern contraception, whilst 83% reported improvements in knowledge and attitudes concerning contraceptives. Based on these findings, strong evidence exists for promoting CHW programs to improve access to family planning services.[49] The CHW program in Ethiopia is frequently cited as highly effective. One qualitative study identified the following themes as contributing to increased uptake of contraception: 1) CHWs (called health extension workers in Ethiopia), responsible for raising awareness in the community, are trusted and valued by the community; 2) effective messages are "that contraception is useful to space pregnancies among married women" and "spacing is healthy for mother and child"; and 3) communicating to the entire community is effective in changing attitudes.[50]

In addition to CHWs, there are other cadres of community volunteers that play an important role within the health system by linking communities with health services including family planning.[47]

Women's and girls' empowerment and contraception: Evidence suggests that promoting gender equality and women's and girls' empowerment leads to better health and development outcomes including use of modern contraception. Taukobong et al.'s (2016) literature review suggests that if we fail to take gender inequalities into account, we may not only limit the achievement of heath and development impact, but could inadvertently lead to harm through this outmoded approach to development.[51] It is suggested that women with higher levels of decision-making power are more likely to have used modern methods of contraception and less likely to have an unplanned pregnancy.[52] Furthermore, the evidence for an association between equitable interpersonal relationships and family planning outcomes (contraceptive use, unplanned pregnancy, desired family size) was less robust in terms of geographic variation and odds ratio results, but still strong enough to assert that this is an important lever for women.

Prata et al.'s (2017) literature review explores the relationship between women's empowerment and contraceptive use, unmet need for contraception and related family planning topics in developing countries. Findings revealed that the relationship between empowerment and family planning is complex; efforts to promote reproductive rights and allow women to control their fertility will only have limited success unless women's individual resources and skill sets are expanded and the broader context in which they are operating is considered.[53]

Family planning HIP guidance suggests that economic empowerment is the ability to make and act on decisions that involve the control over and allocation of financial resources.[54] Women's influence over financial decisions is associated with increased use of preventative services by women and children – including the use of modern contraceptive methods. Therefore, interventions that aim to increase the economic power of women and girls may improve reproductive health behaviors – including the sustained use of modern contraception – when linked with investments that address reproductive health and family planning and/or gender norms.[20]

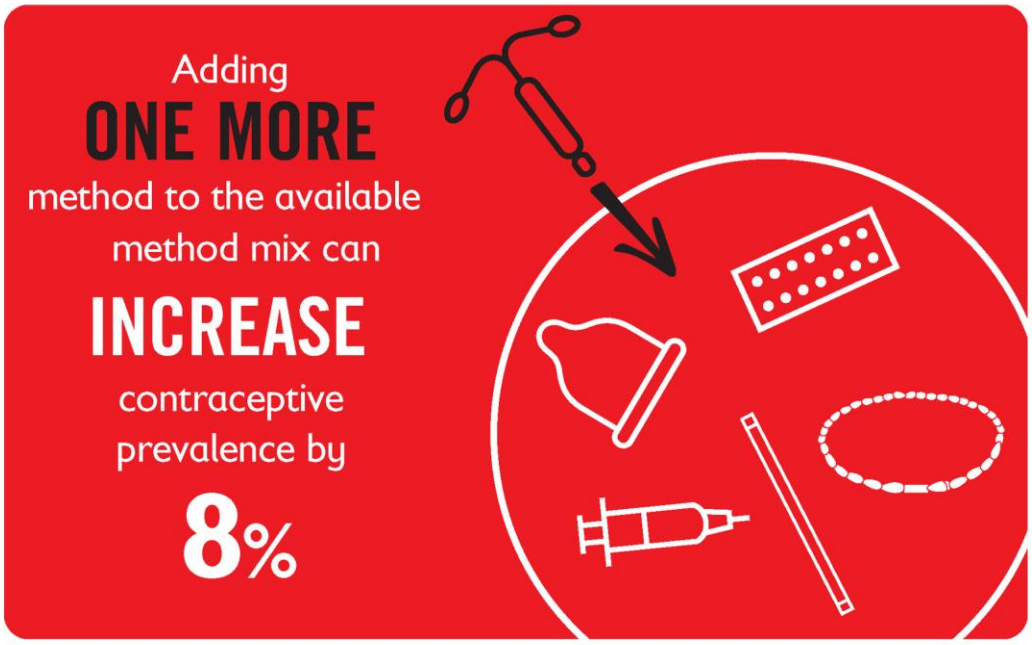
OUTCOME 3: INCREASED AVAILABILITY OF QUALITY INFORMATION, COUNSELING AND CONTRACEPTIVE SERVICES ACROSS THE CONTINUUM OF CARE

Health system functioning is a clear and critical determinant of the ability of countries to deliver high quality contraceptive services. Family planning services need to be integrated within primary care – and not operate as vertical programs. Thus, by strengthening the basic components of health systems, countries can advance contraceptive security.[55]

Effective contraceptive service delivery programs include the availability, affordability and accessibility of good quality contraceptive services, tailored strategies to reach marginalized groups, monitoring and evaluation systems, motivated and trained providers, a supportive supervision and mentoring structure for providers, and a focus on supply chain to ensure consistent availability of high quality contraceptives and medical supplies.[55,56] The provision of LARCs specifically requires a good understanding of service delivery systems and these latter three conditions.[56]

Supply chain, as one of the six building blocks of the WHO health system strengthening model, plays a key role in ensuring access to quality family planning services. Supply chain mechanisms must ensure high quality, low-cost contraceptive products and medical supplies, and continuous supply to the end user.[57] Evidence recommends a total market approach to supply chain mechanisms that strengthens the private and public sector to ensure a consistent supply at all service delivery points.[58] Critical elements for strengthening the supply chain based upon implementation experience are to: implement and maintain a robust logistics management information system (LMIS); undertake regular quantification exercises; support mechanisms for more flexible procurement; explore private-sector partnerships and outsourcing; strengthen supply chains to the last mile; and integrate services and products.[59]

Contraceptive services: Based upon a review of evidence, WHO recommends task sharing to improve coverage of services, broadening the types of providers and service delivery points (e.g., drugstores, mobile clinics, introducing community provision of Sayana Press), provider training, improving counseling, introducing user initiated methods such as pills and FAM, and introducing new technologies improves access to services for women, adolescents and men.[57] Furthermore, research has shown that adding one more method to the available method mix can increase contraceptive prevalence by 8%.[57]



Contraceptive self-care: Self-administered injectable contraception is a new strong recommendation supported with moderate-certainty evidence while there is a new strong recommendation to make available over-the-counter OCPs without a prescription for individuals using OCPs that is supported by very low-certainty evidence. In addition, the WHO guidance continues to recommend correct and consistent use of condoms for all key populations to prevent transmission of HIV and sexually transmitted infections (STIs) which is supported by moderate-quality evidence, and consistent and correct male and female condom use are recommended as highly effective for preventing sexual transmission of HIV, STIs, other conditions and preventing unintended pregnancy with non-specified evidence.[32]

The WHO *Medical Eligibility Criteria for Contraceptive use, 5th Edition* (MEC) provides evidence about the safety dimension for each of the contraceptive methods listed in this Common Approach. The MEC is updated on a regular basis by an expert panel using the latest scientific evidence. In response to recent evidence on contraception and HIV risk, WHO convened an expert panel to provide updated guidance, Contraceptive Eligibility for Women at High Risk of HIV. In addition, multiple studies on community-based distribution of injectables have demonstrated the safety of this approach and acceptability of this approach.[60]

Health workforce: As another of the six building blocks of the WHO health system strengthening framework, the health workforce plays a pivotal role. Health workforce training, coaching and supportive supervision are evidence-based approaches to improving health workforce performance in development and humanitarian settings.[33,57,61,62] In addition, evidence shows that client-oriented counseling with information on contraceptive options, management of side effects, benefits and the possibility of switching improves contraceptive use and reduces discontinuation.[57,63]

Quality of care is an essential component of the Contraception by Choice Common Approach and integrated throughout a family planning program. Evidence has shown an increase in voluntary contraception use, improved continuation and satisfaction when the client or couple are able to obtain their contraceptive method of choice and receive quality family planning counseling.[63] Quality of information and services are elements of the Right to Health.[64] Furthermore, studies have shown that using data to improve the quality of services contributes to both the supply and demand side of family planning in development and humanitarian contexts.[64,65] Findings from one study in DRC demonstrated high rates of contraception continuation in a humanitarian setting, reflecting there is a demand for contraception and that women may be supported to continue using family planning in these complex settings.[66]

Integration

Family Planning and Postabortion care (FP and PAC)

A systematic review of postabortion family planning counseling and services found that women who received postabortion family planning counseling and services had fewer unplanned pregnancies and fewer repeat abortions during the 12-month follow-up period.[67] There is strong evidence that there is greater acceptance and/or use of modern contraceptives in women who received PAC family planning counseling and services. Integrated FP/PAC services may also be provided in emergency settings as shown by the FP/PAC project in DRC, Somalia, Yemen and Pakistan. Furthermore, comprehensive PAC services can be implemented in politically unstable, culturally conservative settings even when abortion and modern contraception are sensitive or stigmatized issues.[68]

Family Planning, immunization, well baby and child health visits

Immunization services for children provide an ideal opportunity to reach mothers with family planning information. In countries where child health visits are standard, this provides an opportunity to provide advice and ask about family planning.[69] Such interventions can either be delivered during adolescence and pre-pregnancy when girls are vaccinated against HPV, or during the postnatal period when mothers bring their babies to receive their routine childhood immunizations. Integration of such services can make the most efficient use of limited resources, such as health workers, whilst respecting the burden on families travelling to health facilities.[70]

Family planning and HIV

FHI 360 compiled an evidence review of family planning integration into HIV models and the feasibility and benefit of this integration. For example, a few studies found that men preferred to obtain contraception at HIV clinics rather than family planning clinics that are oriented towards women. Several studies noted an increase in contraceptive access and use when family planning was either integrated or referral based. One research and one project document demonstrated improvements in HIV related indicators when the integration met client demands for contraception. There was a reduced unmet need for contraception noted by a mix of five research studies and project documents. Finally, two studies demonstrated that integration has the potential to reduce costs through gains in efficiency and is inexpensive. While the overall quality of the studies is low, they provide critical information on promising approaches.[71] One systematic review that included six studies with overall moderate rigor

noted that HIV testing services (HTS) uptake was generally higher when integrated with family planning services when compared with comparison or pre-integration sites. This suggests that while the evidence base is limited it is feasible to integrate HTS into family planning services and this offers an opportunity to simultaneously address unintended pregnancy and HIV.[72] New epidemiological evidence, particularly from one high-quality randomized clinical trial, the ECHO study, supports the recommendation that all women at high risk of HIV infection are eligible for all progestin-only contraceptive methods, copper bearing IUDs and LNG IUDs, and all combined hormonal contraceptives. In other words, the risk of HIV does not restrict contraceptive choices. Furthermore, this evidence supports the need to increase integrated HIV/STI testing and prevention services including those that are integrated with family planning and sexual and reproductive health packages.[73]

Nutrition and family planning

Family planning contributes to improved nutrition outcomes.[15] Women can time and space their pregnancies to ensure healthy nutritional outcomes. For example, pregnancies that are spaced at least 24 months apart are linked to reduction in stunting in children under 5.[74] Pregnancies that occur after age 18 improve adolescents' growth and development, whilst also reducing the risk of poor outcomes for their children – including stunting, low birth weight and preterm birth.[75] Spacing pregnancies helps women to replenish essential nutrients, such as folate.[6] Finally, spacing pregnancies provides mothers with the time, energy and resources to breastfeed their babies. When pregnancies are planned, research shows women can both breastfeed for longer periods of time and have improved breastfeeding practices – leading to improved nutrition for their babies.[76]

Postpartum family planning

If women are provided comprehensive counseling and are proactively offered contraception from a range of choices as part of childbirth care, between 20% to 50% of women will leave a facility with a method.[77] A systematic review of the cost effectiveness of family planning interventions in LMIC found that integration into maternal care, including postpartum care, is cost effective.[78]

OUTCOME 4: IMPROVED LEGAL, POLICY, ADMINISTRATIVE AND FINANCIAL ENVIRONMENT FOR FAMILY PLANNING AT NATIONAL, REGIONAL AND GLOBAL LEVELS

Enabling environment: Evidence from Turkey, Mexico and Indonesia shows an increase in contraception use when countries make budgetary commitments and work to strengthen systems for family planning at the national level. Regional and global commitments have led to partnerships such as FP2020, the Ouagadougou Partnership and other regional initiatives that re-energize governments to make and adhere to financial commitments, develop and update policies and ensure equitable access to contraceptive services.[79] There are three types of commitments supported by the evidence that lead towards a more enabling environment and improved access and use of voluntary contraception: 1) expressed commitment that entails development of policies, laws and implementation plans to increase access to family planning services; 2) institutional commitments involving the establishment of departments, taskforces or working groups focused on family planning; and 3) financial commitments which reflect the engagement of governments and the private sector to make family planning available.[79]

MEASURES OF SUCCESS

There is a comprehensive list of impact, outcome and output indicators to measure the success of the approach in Annex 5.

GUIDANCE ON ADAPTATION TO DIFFERENT CONTEXTS

This Common Approach is designed to be implemented in all contexts where Save the Children works. The examples of family planning programming in Annex 1 indicate the diversity of contexts where the approach is implemented across the organization. Based upon the context and appropriate situational analysis, the program will ensure inclusivity through integration of marginalized women and girls representing such groups as indigenous people and persons with disabilities. Some key considerations include:

- Barriers and facilitators identified in the situational analysis must be fully addressed in the program.
- Consider cultural and religious factors and preference or acceptability related to gender of health care providers trained on LARCs and SRH services.
- Contraception by Choice Common Approach programs will address all four outcomes of the socio-ecological model or collaborate with partners in cases where an outcome is already fully covered by another organization.
- The approach is designed to work at every level of the health care system and facility including the tertiary level, which will facilitate reaching women and girls with serious medical or disability conditions.
- The Common Approach may be integrated as a more formal part of the health system through partnerships and via formal contracts with governments
- Humanitarian settings: Family planning is one component of the MISP for SRH and therefore programs should be designed to ensure all six objectives of the MISP are implemented. The six objectives are: 1) ensure there is an SRH Coordinator; 2) prevent sexual violence and respond to needs of survivors; 3) prevent transmission of and reduce morbidity and mortality due to HIV and other STIs; 4) prevent excess maternal and newborn morbidity and mortality; 5) prevent unintended pregnancy; and 6) plan for comprehensive SRH services. Refer to IAWG for resources and tools.
- Use a "no missed opportunities" approach and identify integration points within the program portfolio (e.g., women's and men's groups based on livelihood, persons with disabilities groups, mother's groups in nutrition programs, school based programs).

GUIDANCE ON PARTNERSHIP, ADVOCACY AND PREPARING FOR SCALE

PARTNERSHIP

Partnerships are essential to all phases of the family planning Common Approach program cycle. Save the Children works with and through partners at the local, national, regional and global level. The nature of the partnership may range from informal collaboration to a formal contract with a MOU or sub-contract.

LOCAL AND NATIONAL PARTNERS	ROLES
Community members including adolescents	Engage in the design, implementation and evaluation of the FP Common Approach
National government agencies such as health, reproductive health, gender, youth, and disaster preparedness and response	Responsible for establishing policies, standards and guidelines, and for ensuring access to family planning services
Civil society organizations such as women's groups, people with disabilities, youth groups and women's empowerment groups, as well as religious leaders	Conduct advocacy, mobilize communities and facilitate linkages between communities and family planning services
National level RH, FP, ASRH development and emergency platforms and working groups	Coordinate actors engaged in FP and RH services in development and humanitarian contexts
Global and Regional Partners	
Interagency Working Group for RH in Emergencies (IAWG) and sub-working groups at global and regional levels	Provide a platform for continuous improvement in SRHR programming in humanitarian settings, and provide global leadership in areas such as research, advocacy, MISP implementation and voluntary contraception
International organizations and UN agencies such as WHO, UNFPA, UNHCR and UNAIDS	Establish global normative standards, and support governments in establishing policies, standards and policies
International NGOs	Support family planning programs and contribute to national policy change
Academic institutions in research and evaluation	Assist with building the evidence for the most effective family planning services
FP2020	Work with governments, civil society, multilateral organizations, donors, the private sector and the research and development community to enable contraceptive use
Donors	Provide leadership in establishing family planning funding priorities

ADVOCACY

Family planning advocacy is integrated throughout the Common Approach and used to share learning from programs with decision makers at the policy level. Outcome four highlights some of Save the Children's global advocacy priorities. In addition, Save the Children's Global Position on SRHR stresses the following advocacy and policy priorities: undertake medical services including family planning with the informed consent of service users; ensure family planning is an essential component of health services in humanitarian and development settings; guarantee access to SRH education and contraception for adolescents and adults; ensure contraceptive needs and choices of vulnerable groups are met; support stakeholders to actively engage in removing social taboos, stigma and customary barriers related to family planning; and ensure alignment with WHO guidelines for family planning programs.

Save the Children has made an organizational commitment to FP2020 and it is essential for family planning programs to participate in FP2020 global and national platforms working to make family planning universally available. The following countries where Save the Children has programs have made FP2020 commitments: Afghanistan, Bangladesh, DRC, Ethiopia, India, Indonesia, Ivory Coast, Kenya, Liberia, Madagascar, Malawi, Mozambique, Senegal, Sierra Leone, South Africa, Tanzania and Uganda. For an updated full list of countries, please go to http://www.familyplanning2020.org/entities on a regular basis.

Family planning programs should analyze how policies, government financial frameworks, health sector regulation (e.g., regulation of contraceptive quality and regulation of the quality of private sector health services) including decentralization of health service delivery affect access to quality family planning services and level of discrimination against women and girls. Discriminatory formal and informal laws, attitudes and practices restrict women's and girls' access to rights. The Social Institutions and Gender Index (SIGI) developed by OECD provides country level analysis that may be used to inform advocacy and policy work.

SCALE-UP

The aim of family planning programs is to work with local partners to identify what works and then embed the program within a system strengthening approach in order to facilitate scale-up based upon the results of the program. Some elements of system strengthening to keep in mind are the importance of community involvement in the design and implementation, availability of a skilled workforce and consistent supply of a full range of quality contraceptives and medical supplies. The WHO ExpandNet strategy has been effectively used in multiple settings and provides guidelines and tools for how to plan for scale and the steps for scaling up an innovation. Using a participatory approach and in close collaboration with the MOH partners, this same framework may be adapted at the country level and used for scale-up. Importantly, when thinking about scale up, and as the ExpandNet methodology advises, you must begin with the end in mind, thinking about scale from the start of the program's design.

GUIDANCE ON CROSS-CUTTING TOPICS

GENDER

Gender roles are developed according to cultural norms and traditions and define behaviors deemed appropriate by society. They are not static and can change over time. Gender is integrated throughout the Common Approach with gender considerations being a component of the initial situation analysis that informs how to address inequalities and promote equitable gender norms. The Save the Children Gender Equality Policy lays out the following six principles to guide our work: 1) equality is a right; 2) root causes should be addressed at social, institutional and policy levels; 3) holistic approaches should equally engage females and males and we should work with whole communities; 4) we must encourage meaningful participation of girls and boys in promotion of gender equality in their families, schools and communities; 5) gender is independent and cross-cutting; and 6) we must integrate gender analysis into research and learning. The Common Approach is aligned with the policy guidelines for programming, which are to: enable empowerment of women and girls through

activities such as information on sexuality; promote positive and diverse expressions of masculinities; prioritize gender analysis as a core element of the program design and implementation cycle; support and work to foster an environment that enables gender equality; and work to eliminate all forms of SGBV. In order to implement gender transformative or gender sensitive programs, the common approach focuses on the hard to reach individuals – including nomadic and semi-nomadic populations, those affected by disasters or conflict, those with disabilities, ethnic and linguistic minorities, urban poor and adolescents – through a rights-based approach, community engagement, interpersonal support, quality of family planning services and advocacy and policy. The Family Planning Common Approach seeks to remove barriers to services due to distance, cost and provider attitudes towards different types of clients. Please see Annex 1 for tools and resources to guide gender transformative and gender sensitive programming.

RESILIENCE

The Common Approach is designed to strengthen systems and therefore contribute to resilience among individuals, communities and health services and through advocacy and policy work. The SBC socio-ecological model includes resilience determinants such as information and services, access to services, effective leadership, social networks, local community engagement and self-help groups to mitigate, and finally resource mobilization. These approaches provide a framework for analyzing risks and taking measures to mitigate and recover from shocks in the community.

SAFEGUARDING

Save the Children programs are guided by the Child Safeguarding Policy that establishes measures protecting children under 18 from all forms of abuse and exploitative conduct. This includes access to quality information that is age appropriate and accessible including to those with disabilities or who may not be literate, confidentiality and non-discriminatory and adolescent responsive contraceptive services, and it involves training health care providers and all relevant stakeholders on the code of conduct, child safeguarding policy and zero tolerance of physical abuse, sexual abuse or exploitation and emotional abuse or neglect by health workers or any other person who represents Save the Children or is associated with our work. Moreover, services need to ensure that girls are not put at increased risk for accessing services by working to address community attitudes and negative perceptions related to adolescents using contraception. Our safeguarding obligation also extends to anyone over the age of 18 and we have a duty to ensure everyone is treated with respect and dignity. Programs must include measures and budget to prevent, manage and continuously monitor child and adult safeguarding risks identified during the situational analysis and throughout the program. A child/adolescent friendly reporting mechanism should also be put in place from the beginning to ensure continuous feedback and continuous customer service satisfaction monitoring. All of these measures are part of establishing adolescent responsive services that were defined under the situational analysis component of the Common Approach. Safeguarding should be embedded in public health materials, awareness sessions, training and continuous learning for service users, health workers, Save the Children staff, volunteers and relevant stakeholders. This should be considered from the design phase. These measures will also help to reduce the risk of service users and health workers themselves from being abused or exploited. Save the Children needs to support health centers to have their own

safeguarding mechanisms in place with a collective understanding of what is and is not acceptable behavior, how to report any concerns and for health center management to be able to respond to concerns and put the victim first. This means creating a safe environment for disclosure to be made and for HF staff to be aware, vigilant and have the confidence to report on a colleague who is abusing a child/adult/service user. This means ensuring that reporting mechanisms and key messages are visible and accessible at the health centers.

PROMOTING LEARNING

There exists, as described, a strong evidence base to support the importance of contraception and the implications this has on the health and rights of women, girls, children and families. Further, programmatic research has shown that family planning services can be effectively implemented among demographically diverse populations in a variety of settings, including both humanitarian and development contexts. Despite this, there are a number of areas for further research and learning.

The following questions have been prioritized by Save the Children for learning as the Family Planning Common Approach is broadly implemented:

SERVICE DELIVERY LEARNING QUESTIONS

- What are effective strategies to reduce provider bias toward any particular populations (i.e. adolescents, refugees, married versus unmarried women, people with disabilities, LGBTQIA, etc.) and are there differences in humanitarian and development contexts?
- What are characteristics of a promising and scalable model to provide mentorship and supportive clinical supervision to health providers and CHWs?
- How can routinely collected data be used by providers, managers and HQ staff to improve the quality of family planning service provision?
- What is an effective follow-up system for family planning clients?
- How can we best disaggregate family planning data by disability?
- What are the most appropriate contexts for introducing self-care approaches for contraception (e.g., Sayana Press self-injection)?
- How can we effectively strengthen pre-service clinical training in family planning?

SOCIAL NORMS LEARNING QUESTIONS

- What are effective and scalable approaches to address harmful social and gender inequitable norms, attitudes and beliefs related to contraception?
- What are the most effective and scalable approaches of strengthening inter-couple communication about contraception among nomadic and semi-nomadic populations?
- What is the role of religious leaders in promoting family planning?
- What are the main attitudinal community and provider barriers and misconceptions towards persons with disabilities and access to family planning? What are some strategies for removing these barriers?

- What intervention components are critical for success? (a) What are the risks in undertaking norms-focused interventions including unintended harmful power shifts? (b) What are unintended effects or benefits? and (c) Under what conditions are norms-breaking social movement interventions more or less effective than incremental interventions?
- Building on limited evidence, are mother-specific groups more effective in increasing the uptake of long-term and permanent family planning methods when combined with referral mechanisms, and wider community awareness interventions?
- How can women's and girls' empowerment activities increase use of family planning? And how can male engagement and equitable decision-making power increase family planning use?

POLICY/ADVOCACY LEARNING QUESTIONS

- What changes need to be made, and what are the implications for the changes, to make family planning policies, strategies and implementation guides responsive toward the needs of women, girls and families in both humanitarian and development contexts?
- What are the most effective communication strategies to effectively advocate for stronger national commitments to family planning provision?
- How can Save the Children contribute to more equitable access to family planning for women and girls with disabilities according to Article 25 in CRPD?
- What are the social and service delivery barriers for people with mental health disorders in accessing quality rights based family planning services?

INNOVATION

Save the Children can build on past experiences of innovation in family planning programs such as the pilot of community-based provision of injectable contraceptives that has since been scaled up in a number of countries and adopted as a best practice globally.

Save the Children has widened its breadth and depth in family planning over the past few years in development and humanitarian settings. Save the Children is developing a model for delivering family planning services to nomadic and semi-nomadic populations through a pilot project in North East Kenya with the goal of creating an adaptable approach that can be replicated in other areas of East Africa and the Sahel.

Building on competency-based family planning training capacity, Save the Children is piloting a 2-3 day family planning and PAC training package in humanitarian settings (Flash Training Package) with the goal of implementing this training approach in other humanitarian responses.

Cash or voucher assistance (CVA) is an assistance strategy used in humanitarian programs that might be piloted for family planning. A related delivery strategy is working with the pilot sector to expand access to quality contraceptive services.

A crosscutting area for innovation is piloting ways of collecting and using data disaggregated by disability in order to improve access to quality family planning services for people with disabilities. In addition, Save the Children can develop and pilot guidance for providing family planning services to persons with severe mental disorders and intellectual disabilities including integration of disability sensitization training into family planning trainings for CHWs and health care providers.

CASE STUDIES

FAMILY PLANNING AND POSTABORTION CARE IN 10 COUNTRY HUMANITARIAN SETTINGS

The Reproductive Health in Emergencies Initiative supports reproductive health services, including family planning, in humanitarian settings by training and mentoring frontline health providers, providing commodities and supplies, strengthening supply chains and supporting communities to mobilize to increase awareness and use of health services. The initiative increases access to basic health services for the most vulnerable in the hardest to reach areas.

From 2011 to mid-2019, the initiative supported activities in more than 10 countries leading to more than 500,000 new contraceptive users.

Women and girls have improved knowledge about family planning and supportive attitudes

Through home visits with refugees in greater Cairo, Egypt, CHWs raise awareness about family planning and inform women and girls about where services are available.

Partners demonstrate support for family planning use

In the DRC, *couples lumière* (enlightened couples) are members of the community who have used a modern family planning method and have voluntarily agreed to raise people's awareness by sharing their experiences of family planning. By talking about the advantages of family planning and their own experiences, the Couples Lumière serve as an example and play a part in changing how family planning is regarded in the community.

Communities support family planning use

In Somalia, family planning is perceived as a very sensitive issue resulting in challenges when promoting the importance and acceptance of modern contraception. Key barriers include misconceptions about family planning, religious constraints and socio-cultural practices. To overcome these barriers and provide quality family planning services, Save the Children worked with female CHWs and community health committees to strengthen the supply of family planning services. To raise awareness and demand among community members, the project engaged religious leaders, held community forums for open dialogue, identified family planning champions and improved SBC material.

Increased availability of quality family planning information and services across the continuum of care

Save the Children has conducted competency-based training, supportive supervision and individual performance monitoring to increase health workers' skills and capacity on family planning and PAC in acute and protracted settings. In 2018 and 2019, global training of trainers (TOT) on family planning and PAC were conducted and resulted in deployment of trainers for training in Somalia, Rwanda, Uganda and a distance training for providers in Syria. To expand the range of trainings available through the global roster, two additional TOTs on *Values Clarificaiton and Attitude Transformation (VCAT)* and *Clinical Management of Rage (CMR) and Intimate Partner Violence (IPV)* were conducted. There are now 12 trainers able to train/co-faciliate on VCAT, 15 trainers for CMR and IPV, and 17 trainers for family planning and PAC.

An acute emergency is a challenging context for quality clinical training. Traditional competency-based training in a classroom setting is not an appropriate approach, as it causes service disruption. To overcome this, Save the Children has created a flash training approach to build the clinical capacities of small groups of three to five providers at the HF only.

Improved legal, policy, administrative and financial environment for family planning at national, regional and global levels

In Yemen, we have successfully demonstrated that midwives can provide quality implant services, including insertion and removal, to bring services closer to women who need them. According to national guidelines and practices, only doctors could provide implants at the hospital level. As a result, an important long-acting method of contraceptive was not easily accessible for many women. The local MOH in Lahj Province allowed Save the Children to pilot task-shifting provision of implants to senior midwives at health centers. The midwives were trained on implant insertions and removals, including supportive supervision and follow-up visits to ensure they were providing quality services.

The follow-up supervisions showed that trained senior midwives could provide good quality services. Save the Children will continue to work with the MOH and advocate for training of midwives and task-shifting. Save the Children also worked with CHWs to ensure they could speak about the availability of implant services and benefits of LARC methods.

THE FERTILITY AWARENESS FOR COMMUNITY TRANSFORMATIONS (FACT) NEPAL PROJECT

Save the Children and the Institute for Reproductive Health at Georgetown University (IRH/GU) designed and implemented the Fertility Awareness for Community Transformation (FACT) Nepal Project, funded by the United States Agency for International Development (USAID), from 2013 – 2018. FACT aimed to test approaches to improve fertility awareness and expand access to FAM at the community level in order to improve family planning use and reduce unmet need. FACT was implemented across five districts in Nepal and focused on reaching married and unmarried adolescents and adults from marginalized ethnic groups (Janajati, Dalit, Muslim and Chhetri). In order to improve fertility awareness, demand for family planning services and family planning services to improve family planning uptake and continuation, FACT included interventions at multiple levels of the socioecological model:

- women's and girls' knowledge about family planning and supportive attitudes and partner support;
- communities support family planning use;
- increased availability of quality family planning information and services across the continuum of care; and
- improved legal, policy, administrative and financial environment for family planning at national, regional and global levels.

Women's and girls' knowledge about family planning and supportive attitudes and partner support

"Pragati" community games – A series of 9 interactive games that diffuse information about fertility and family planning in group settings. In addition to increasing awareness, the games dispel the myths and misconceptions about the side effects of family planning methods and also facilitate discussion about the negative social and gender norms that influence RH behaviors, such as son preference and menstrual hygiene taboos. Through the games, participants critically reflect on their own attitudes and the social norms that impact reproductive health behaviors. The games were played in Health Mothers' Groups, in schools and across various community groups to reach as many individuals as possible. The games were also popular among men's groups, encouraging men to learn about and discuss fertility and family planning with their partners and to support their wives or daughters to use family planning services.

Communities support family planning use

Community engagement activities – In addition to the Pragati games, FACT also engaged the wider community to improve awareness and support of family planning through participating in community festivals and fairs to promote gender equality and maternal and reproductive health.

Increased availability of quality family planning information and services across the continuum of care

Linkages to health services – In all five project districts, the FACT project trained existing CHWs and HF staff to strengthen their family planning counseling skills and to improve referral systems to higher level facilities. In one of the districts, the FACT project also deployed a cadre of Roving Auxiliary Nurse Midwives (RANMs) to provide household-level family planning counseling services and family planning methods in hard-to-reach communities where women face social barriers to seeking facility services.

Improved legal, policy, administrative and financial environment for family planning at national, regional and global levels

Strengthening family planning policies at district and national level – The FACT Project collaborated with the national Family Planning Technical Working Group and provided TA to the Ministry of Health and Family Planning to integrate SDM into and update the national Curriculum on Family Planning.

Results from the project evaluation suggest improvements in knowledge of fertility and family planning methods among both women and men who played the games, compared to those

who did not play the games. Men and women who played the games were more likely to have a high fertility awareness score and report positive attitudes towards family planning use in their community. Women with high fertility awareness scores were also more likely to be using an family planning method (2.1 times) or have intentions to use an family planning method in the next 6 months (3.6 times) compared to control. Current family planning use was higher in the intervention arm than in the control group, increasing from 31% to 35% at endline. Men and women who played the games appreciated the approach of learning and talking about family planning and fertility, and that the games were accessible to everyone regardless of their education level. Pragati was so well-received that the intervention has been scaled up by local and international organizations in Nepal who have integrated the games into health and non-health programs.

ANNEX 1: APPROACH GUIDES AND TOOLS

The following table provides a list of resources organized by each of the four outcomes, with some resources being listed more than once. The recommended resources are highlighted in bold.

RESOURCES FOR OUTCOME 1: INDIVIDUAL LEVEL				
TOOLS/MATERIAL	TARGET POPULATION OR AGES / GUIDANCE ON WHEN TO USE	ORGANIZATION	COUNTRIES WHERE IT HAS BEEN USED/ADAPTED	LINK
Reproductive Health in Emergencies Knowledge Bank	**Program Managers, Technical Advisors, Clinical Supervisors and Trainers, Communications staff and Fundraisers, Humanitarian Responders, MEAL staff, Pharmacists, Logisticians / Training materials including e-learning modules, curricula, proposal templates, etc.**	**Save the Children**	**Bangladesh, DRC, Egypt, Niger, Pakistan, Rwanda, Somalia, Syria, Uganda, Yemen,**	**Access here (English, Arabic, French)**
Family Planning High Impact Practices (HIP): Proven, Promising and	**Program Managers, Technical Advisors / HIPs are effective service delivery or**	**Endorsed by more than 30 organizations including WHO, USAID, UNFPA,**	**Global**	**Access here (English, Spanish, French, Portuguese)**

Strategic Guidance Categories	**systems interventions that when scaled up and institutionalized, will maximize investments in comprehensive packages of services**	**IPPF, FP2020 and Save the Children**		
Guide women through their postpartum family planning options	Program Managers, Technical Advisors, Health Care Providers / Counseling tool	WHO		Access here (English)
Healthy Timing and Spacing of Pregnancies (HTSP) toolkit	Program Managers, Technical Advisors / Guidance on how to integrate HTSP into programs	ESD Project, World Vision		Access here (English)
Smart Client and Smart Couple: Digital Health Tools to Empower Women and Couples for Family Planning, Parts 1 – 4	Program Managers, Technical Advisors / Part One - background for the tools, vision and objectives, audience and behavioral objectives, tool specifics; Parts Two and Three - Smart Client character scripts and SMS reminders; Part Four - guidelines for adaptation	Health Communication Capacity Collaborative		Access here (English, French, Hausa, Yoruba, Pidgen)

RESOURCES FOR OUTCOME 2: COMMUNITY LEVEL				
TOOLS/MATERIAL	**TARGET POPULATION OR AGES / GUIDANCE ON WHEN TO USE**	**ORGANIZATION**	**COUNTRIES WHERE IT HAS BEEN USED/ADAPTED**	**LINK**
Family Planning High Impact Practices (HIP): Proven, Promising and Strategic Guidance Categories	Program Managers, Technical Advisors / HIPs are effective service delivery or systems interventions that when scaled up and institutionalized, will maximize investments in comprehensive packages of services	Endorsed by more than 30 organizations including WHO, USAID, UNFPA, IPPF, FP2020 and Save the Children	Global	Access here (English, Spanish, French, Portuguese)
FP and Nutrition	Program Managers, Technical Advisors, Service Providers, Policy Makers, Advocates / Guidance on how to integrate maternal, infant and young child nutrition and family planning (MIYCN-FP) services	Jhpiego, PATH, ICF International, Pathfinder International, USAID		Access here (English)
Guide women through their postpartum family planning options	Program Managers, Technical Advisors, Health Care Providers	WHO		Access here (English)
Partnership Defined Quality (PDQ and PDQ-Y)	Program Manager, Technical Advisor / Manual	Save the Children	Ethiopia, Egypt, Mozambique, Nepal, Pakistan, Philippines	Access here (English)

	describing a joint HF and community QI process			
Male Motivator Training Curriculum	Program Managers, Technical Advisors / Train male peer outreach workers - 5 day training program	Save the Children	Malawi	Access here (English)
The FOCUS Tool – An SBC/C Planner	Program Managers, SBC Practitioners, Technical Advisors / Online tool to develop a draft SBC strategy	Save the Children	Kenya	Access here (English)
Family Planning SBC Evidence Base	Program Managers, Technical Advisors / Searchable database by SBC intervention, region, family planning methods that can be used for program design and implementation	Health Communication Capacity Collaborative		Access here (English)
HIP: Mobile Outreach Services: Expanding Access to a Full Range of Modern Contraceptives	Program Managers, Technical Advisors / How to design and implement mobile outreach services	Endorsed by more than 30 organizations including WHO, USAID, UNFPA, IPPF, FP2020 and Save the Children		Access here (English, Spanish, French, Portuguese)
Engendering Transformational Change - Save the Children Gender Equality Program Guidance & Toolkit	Program Managers, Technical Advisors / Provides approaches that are key to facilitate gender-sensitive programming within Save the Children	Save the Children	Global	Access here (English)

Making Gender Equality a Reality - Theory of Change and Practical Actions for our Programmes	Program Managers, Technical Advisors / Overview of roles that gender inequalities play in our projects, across thematic areas, to help build a shared understanding of what we need to know and do; includes examples of practical interventions for projects to address common gender inequalities	Save the Children	Global	Access here (English)
HIP: Engaging Men and Boys in FP: a strategic planning guide	Program Managers, Technical Advisors / Guidance on strategies for engaging men and boys in FP	Endorsed by more than 30 organizations including WHO, USAID, UNFPA, IPPF, FP2020 and Save the Children		Access here (English, Spanish, French, Portuguese)
Healthy Timing and Spacing of Pregnancies toolkit	Program Managers, Technical Advisors / Guidance on how to integrate HTSP into programs	ESD Project, World Vision	Multiple country projects	Access here (English)
Gender Roles, Equality and Transformation (GREAT) Tool	Program Managers, Technical Advisors / How-to guide to improve ASRH and reduce GBV	Institute for Reproductive Health (IRH) Georgetown University	Niger	Access here (English, French, Portuguese)
Smart Client and Smart Couple: Digital Health Tools to Empower	Program Managers, Technical Advisors / Part One - background for the	Health Communication Capacity Collaborative		Access here (English, French, Hausa, Yorubo, Pidgen)

Women and Couples for Family Planning, Parts 1 – 4	tools, vision and objectives, audience and behavioral objectives, tool specifics; Parts Two and Three - Smart Client character scripts and SMS reminders, Part Four - guidelines for adaptation			
Gender Equality Marker Tool	SC Program Staff, Technical Advisors / Guidance on integration of gender into proposals	Save the Children	Global	Access here (English)
Save the Children Gender Equality Program Guidance	**SC Program Staff, Technical Advisors, Partners / Provides guidance and tools for promoting gender equality and addressing gender inequality in programs**	**Save the Children**	**Global**	**Access here (English)**
International Technical Guidance on Sexuality Education	Program Staff, Technical Advisors, Partners / Age range 5-18+ years in and out of school / Used to develop and implement education programs	UNESCO, WHO, UNFPA, UN Women, UNICEF, UNAIDS		Access here (English)
Expanding Access to FP through Group Learning and Counseling Implementation Handbook	Program Managers, Technical Advisors / Target Group: Youth Volunteers / Guidance for using group learning and counseling	IRH, Save the Children	Nepal	Access here (English)

	methodologies, supports linkages to health workers, fosters male involvement and facilitates healthy communication			
SRHR and HIV Linkages Toolkit	Program Managers, Technical Advisors / Guidance and case studies for design and implementation	WHO, IPPF		Access here (English)
Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings	Program and Humanitarian staff, Technical Advisors / Guidance on MISP and FP priorities in humanitarian settings	Inter-agency working group on RH in crises	DRC, Egypt, Haiti, Niger, Pakistan, Philippines, Rwanda, Somalia, Syria and Yemen	Access here (English)

RESOURCES FOR OUTCOME 3: HEALTH SERVICES AND SYSTEMS LEVEL				
TOOLS/MATERIAL	**TARGET POPULATION OR AGES / GUIDANCE ON WHEN TO USE**	**ORGANIZATION**	**COUNTRIES WHERE IT HAS BEEN USED/ADAPTED**	**LINK**
Reproductive Health in Emergencies Knowledge Bank	Program Managers, Technical Advisors, Clinical Supervisors and Trainers, Communications staff and Fundraisers, Humanitarian Responders, MEAL staff, Pharmacists, Logisticians / Training materials including e-learning modules, curricula, proposal templates, etc.	Save the Children	Bangladesh, DRC, Egypt, Niger, Pakistan, Rwanda, Somalia, Syria, Uganda and Yemen	Access here (English, Arabic, French)
Family Planning Handbook	**Program Managers, Technical Advisors, Partners, Trainers, Health Care Providers / A technical reference to ensure quality and safety of FP programs**	**WHO**	**Bangladesh, DRC, Egypt, Niger, Pakistan, Rwanda, Somalia, Syria, Uganda and Yemen**	**Access here (English)**
Medical Eligibility Criteria Wheel	**Health Care Providers during FP counseling sessions and Trainers during clinical trainings**	**WHO**	**Bangladesh, DRC, Egypt, Niger, Pakistan, Rwanda, Somalia, Syria, Uganda and Yemen**	**Access here (Bosnian, Burmese, English, French, Kmer, Spanish, Urdu)**

Balanced Counseling Strategy Plus (BCS+) Toolkit	Program Managers, Technical Advisors, Trainers / Target: Health Care Providers / A tool for integrated counseling	Population Council	Rwanda, Yemen	Access here (English)
Women and Young Persons with Disabilities: Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights	Program Staff, Technical Advisors, Partners, Service Providers / Guidance to ensure GBV and SRHR services integrate rights of women and young persons with disabilities; use for design, implementation and advocacy for GBV and SRHR services for women and young persons with disabilities	UNFPA Women Enabled		Access here (English)
Promoting sexual and reproductive health for persons with disabilities WHO/UNFPA guidance note	Program Staff, Technical Advisors, Partners / Guidance on SRH programming for persons with disabilities	UNFPA / WHO		Access here (English)
Benefits of Providing Family Planning Training Package and Full Training Resources Training Package	Program Managers, Technical Advisors, Clinical Trainers, Pre-Service Educators / Clinical training materials on FP topics in pre-service and in-service settings	Training Resource Package for Family Planning: USAID, WHO, UNFPA	DRC, Niger, Pakistan, Rwanda, Somalia, Syria, Uganda, Yemen	Access here (English, French)

Family Planning & Immunization Integration Toolkit	Program Managers, Technical Advisors / Information for implementation, sample job aids to assist immunizers; includes screening tools, referral card templates, job aids and training materials for service providers	FP and Immunization Integration Working Group (FHI 360 and MCHIP project)		Access here (English)
Family Planning High Impact Practices (HIP): Proven, Promising and Strategic Guidance Categories	Program Managers, Technical Advisors / HIPs are effective service delivery or systems interventions that when scaled up and institutionalized, will maximize investments in comprehensive packages of services	Endorsed by more than 30 organizations including WHO, USAID, UNFPA, IPPF, FP2020 and Save the Children	Global	Access here (English, Spanish, French, Portuguese)
Maternal Infant and Young Child Nutrition and Family Planning (MIYCN-FP) Integration Toolkit	Program Managers, Service Providers, Policy Makers, Advocates / Guidance to integrate maternal, infant and young child nutrition and family planning	Jhpiego, PATH, ICF International, Pathfinder International, USAID		Access here (English)
Guide women through their postpartum family planning options	Program Managers, Technical Advisors, Health Care Providers / Counseling tool	WHO		Access here (English)
K4Health Postpartum Family Planning Toolkit	Program Managers, Technical Advisors, Partners, Policy Makers /	MCHIP, USAID		Access here (English)

	Use to develop and implement effective service delivery approaches to integrating FP with postpartum care			
FP and PAC in Humanitarian Setting E-Learning Modules	Program Managers, Technical Advisors, Clinical Trainers, Partners, Supervisors, Logisticians, Senior Management Staff / Each module is oriented to specific staff based upon their role	Save the Children	Bangladesh, DRC, Egypt, Niger, Pakistan, Rwanda, Somalia, Syria, Uganda, Yemen	Access here (English)
Family Planning SBC Evidence Base	Program Managers, Technical Advisors / Searchable database by SBC intervention, region, family planning methods that can be used for program design and implementation	Health Communication Capacity Collaborative		Access here (English)
HIP: Mobile Outreach Services: Expanding Access to a Full Range of Modern Contraceptives	Program Managers, Technical Advisors / How to design and implement mobile outreach services	Endorsed by more than 30 organizations including WHO, USAID, UNFPA, IPPF, FP2020 and Save the Children		Access here (English, Spanish, French, Portuguese)
Healthy Timing and Spacing of Pregnancies toolkit	Program Managers, Technical Advisors / Guidance on how to integrate HTSP into programs	ESD Project, World Vision	Multiple country projects	Access here (English)

Gender Roles, Equality and Transformation (GREAT) Tool	Program Managers, Technical Advisors / How-to guide to improve ASRH and reduce GBV	Institute for Reproductive Health (IRH) Georgetown University	Niger	Access here (English, French, Portuguese)
Values Clarification and Action Transformation (VCAT) Toolkit	All SC Staff, Partners and Health Care Providers / Workshop package designed to address stigma and knowledge gaps related to postabortion care among humanitarian and health staff	Ipas toolkit adapted for SC	DRC, Niger	Access here (English, French)
Reproductive Health Access, Information and Services in Emergencies (RAISE)	Trainers and Participant Guides / FP, PAC, EmOC clinical training and supportive supervision tools	RAISE Initiative	DRC	Access here (Arabic, English, French
Minimum Initial Service Package for Reproductive Health (MISP) Reference Sheet	Program Managers, Technical Advisors, Trainers / Guidance on priority RH interventions in humanitarian settings	IAWG	Bangladesh, Colombia, DRC, , Haiti, Mexico, Mozambique, Pakistan, Rwanda, Somalia, Uganda, Yemen	Access here (English)
It's Time to Strengthen Linkages between FP and HIV Interventions	Program Staff and Partners (e.g., MOH, NGOs, CBOs), Technical Advisors / Visual model providing links to guidelines and tools for linkages	WHO		Access here (English)
Contraceptive eligibility for women at high risk of HIV: Guidance Statement	Program Staff, Technical Advisors, Partners / Updated guidance on	WHO		Access here (English)

	contraceptive methods used by women at high risk of HIV after publication of results of the ECHO trial (August 2019)			
Smart Client and Smart Couple: Digital Health Tools to Empower Women and Couples for Family Planning, Part 1 – 4	Program Managers, Technical Advisors / Part One - background for the tools, vision and objectives, audience and behavioral objectives, tool specifics; Parts Two and Three - Smart Client character scripts and SMS reminders; Part Four - guidelines for adaptation	Health Communication Capacity Collaborative		Access here (English, French, Hausa, Yoruba, Pidgen)
International Technical Guidance on Sexuality Education	Program Staff, Technical Advisors, Partners / Age range 5-18+ years in and out of school / Used to develop and implement education programs	UNESCO, WHO, UNFPA, UN Women, UNICEF, UNAIDS		Access here (English)
Making health services adolescent friendly	Program Staff, Partners, Technical Advisors and Health Care Providers / Guidance on developing standards for quality adolescent friendly services	WHO		Access here (English)
Client-Oriented Provider-Efficient (COPE) Handbook: A process for	Program Staff, Technical Advisors, Health Care Providers, Partners /	EngenderHealth		Access here (English and French)

improving quality in health services	Guidance for setting up a health facility owned quality improvement process			
Tips and tools for learning improvement	Program Staff, Health Care Providers, MOH and other partners / Guidance and tools for health facility owned quality improvement process	University Research Co., LLC (URC)		Access here (English)
Quality of Care in Contraceptive Information and services, Based on Human Rights Standards: A checklist for health care providers	**FP Program Managers, Technical Advisors and Health Care Providers / A checklist that a provider or supervisor may use to monitor quality of care based on human rights at the facility level**	**WHO**		**Access here (English)**
SRHR and HIV Linkages Toolkit	Program Managers, Technical Advisors / Guidance and case studies for design and implementation	WHO, IPPF		Access here (English)

RESOURCES FOR OUTCOME 4: POLICY/ADVOCACY LEVEL				
TOOLS/MATERIAL	**TARGET POPULATION OR AGES / GUIDANCE ON WHEN TO USE**	**ORGANIZATION**	**COUNTRIES WHERE IT HAS BEEN USED/ADAPTED**	**LINK**
Reproductive Health in Emergencies Knowledge Bank	Program Managers, Technical Advisors, Clinical Supervisors and Trainers, Communications staff and Fundraisers, Humanitarian Responders, MEAL staff, Pharmacists, Logisticians / Training materials including e-learning modules, curricula, proposal templates, etc.	Save the Children	Bangladesh, DRC, Egypt, Niger, Pakistan, Rwanda, Somalia, Syria, Uganda and Yemen	Access here (English, Arabic, French)
Women and Young Persons with Disabilities: Guidelines for Providing Rights-Based and Gender-Responsive Services to Address Gender-Based Violence and Sexual and Reproductive Health and Rights	Program Staff, Technical Advisors, Partners, Service Providers / Guidance to ensure GBV and SRHR services integrate rights of women and young persons with disabilities; use for design, implementation and advocacy for GBV and SRHR services for women and young persons with disabilities	UNFPA Women Enabled		Access here (English)

Promoting sexual and reproductive health for persons with disabilities WHO/UNFPA guidance note	Program Staff, Technical Advisors, Partners / Guidance on SRH programming for persons with disabilities	UNFPA / WHO		Access here (English)
Family Planning High Impact Practices (HIP): Proven, Promising and Strategic Guidance Categories	Program Managers, Technical Advisors / HIPs are effective service delivery or systems interventions that when scaled up and institutionalized, will maximize investments in comprehensive packages of services	Endorsed by more than 30 organizations including WHO, USAID, UNFPA, IPPF, FP2020 and Save the Children	Global	Access here (English, Spanish, French, Portuguese)
Maternal Infant and Young Child Nutrition and Family Planning (MIYCN-FP) Integration Toolkit	Program Managers, Service Providers, Policy Makers, Advocates / Guidance to integrate maternal, infant and young child nutrition and family planning	Jhpiego, PATH, ICF International, Pathfinder International, USAID		Access here (English)
Guide women through their postpartum family planning options	Policy Makers, Program Managers, Technical Advisors, Health Care Providers / Counseling tool	WHO		Access here (English)
Family Planning: A key to unlocking the SDGs	Policy Makers, Program Managers / Short video highlighting the linkages between FP and all 17 SDGs	USAID, K4Health		Access here (English, French, Spanish, Bahasa Indonesian)
Values Clarification and Action Transformation (VCAT) Toolkit	All SC Staff, Partners and Health Care Providers / Workshop package	Ipas toolkit adapted for SC	DRC, Niger	Access here (English, French)

	designed to address stigma and knowledge gaps related to postabortion care among humanitarian and health staff			
Contraceptive eligibility for women at high risk of HIV: Guidance Statement	SC Program Staff / Updated guidance on contraceptive methods used by women at high risk of HIV after publication of results of the ECHO trial (August 2019)	WHO		Access here (English)
Strategic Considerations for Strengthening Linkages between FP and HIV/AIDS Policies, Programs and Services	Program Staff, Partners (e.g., MOH, NGOs, CBOs), Technical Advisors / Provides strategic considerations for integration	WHO, USAID, FHI		Access here (English)
Gender Equality Marker Tool	Program Managers, Technical Advisors, Policy Makers / Guidance on integration of gender into proposals	Save the Children	Global	Access here (English)
Save the Children Gender Equality Program Guidance	Program Managers, Technical Advisors, Policy Makers / Provides guidance and tools for promoting gender equality and addressing gender inequality in programs	Save the Children	Global	Access here (English)

International Technical Guidance on Sexuality Education	Policy Makers, Program Staff, Technical Advisors, Partners / Age range 5-18+ years in and out of school / Used to develop and implement education programs	UNESCO, WHO, UNFPA, UN Women, UNICEF, UNAIDS		Access here (English)
Making health services adolescent friendly	Policy Makers, Program Staff, Partners, Technical Advisors and Health Care Providers / Guidance on developing standards for quality adolescent friendly services	WHO		Access here (English)
SRHR and HIV Linkages Toolkit	Program Managers, Technical Advisors / Guidance and case studies for design and implementation	WHO, IPPF		Access here (English)

ANNEX 2: RESOURCES NEEDED

Guidance on resources required to implement the Contraception by Choice Common Approach.

OVERALL RESOURCES REQUIRED

The following components should be budgeted when designing and implementing the Contraception by Choice Common Approach. These costs will vary according to context (humanitarian or development), geographic location, existing country portfolio and types of interventions selected.

1) Situation analysis – a) Rapid in the case of an acute emergency response, and b) in-depth for protracted crisis and/or development programs
2) Partnerships with the relevant government ministry of health departments, civil society, private sector, local NGOs and other key actors
3) Adequate and qualified staffing
4) Program management, monitoring, quality improvement, evaluation and learning
5) Country, regional and international level advocacy activities including documentation, participation in key meetings, hosting advocacy events
6) Monitoring, evaluation, research and learning activities including publications and participation in local, regional and international conferences

The following areas should be taken into consideration when developing project budgets and are listed by outcome.

OUTCOME 1: INDIVIDUALS HAVE IMPROVED KNOWLEDGE, ATTITUDES AND BEHAVIORS RELATED TO CONTRACEPTION.

Human Resources

1) Technical expert to support formative assessments in development and protracted crisis settings – Save the Children, University or NGO partner, or consultant
2) Technical expert to support SBC strategy development in humanitarian and protracted crisis settings – Save the Children SBC technical team or consultant

3) Technical expert to develop/adapt curriculum and conduct training for IPC component – Save the Children, University or NGO partner, or consultant
4) Technical expert to support media assessment – Save the Children, University or NGO partner, or consultant
5) Technical expertise to support development/adaptation of content for mass media including digital and social media interventions – Technical partner or consultant
6) Technical expertise to support monitoring, evaluation and documentation – Save the Children, University or NGO partner, or consultant

Activities

1) Review of secondary data sources to identify if there is a need for additional primary assessments
2) Media assessments to identify who (assess by gender, socioeconomic status, ethnic group, geographic area – rural versus urban, humanitarian versus development setting, etc.) uses which type of digital and social media
3) Strategy development that includes evidence-based approaches and most effective media channels for reaching the target audience(s)
4) Formative assessments including costs for development of tools, training of enumerators, report write-up and dissemination costs
5) Costs for IRB review and approval, and publications if undertaking research
6) Strategy development workshop in development / protracted crisis context
7) Training of trainers and IPC package rollout
8) Identification, vetting and subcontracts to partners (CBO, local NGO, radio station, TV station, telephone company, etc.)
9) Implementation of IPC and mass media (including digital and social media) package
10) Costs for media equipment (tablets, smartphones, radios, TVs, other equipment) and IT support
11) Monitor activities
12) Refer to "My Sexual Health and Rights Common Approach" for information on how to budget for CSE activities

OUTCOME 2: PARTNERS, FAMILY MEMBERS AND COMMUNITIES SUPPORT CONTRACEPTION

The following budget considerations are in addition to those mentioned in outcome 1.

Human Resources

1) Technical expertise in community engagement methodologies (e.g., male engagement, couples communication, community action cycle, PDQ, etc.) to support steps laid out under outcome 1 – Save the Children SBC technical team or consultant

Activities

1) Review of secondary data sources to identify if there is a need for additional primary assessments
2) Formative assessments including costs for development of tools, training of enumerators, report write-up and dissemination costs
3) Costs for IRB review and approval, and publications if undertaking research
4) SBC strategy development workshop in development / protracted crisis context and identify key actors such as religious leaders, community leaders, women's and men's groups, youth groups, etc.
5) Community engagement job aids and materials
6) Pilot job aids and finalize
7) Training of trainers on community engagement methodologies (e.g., PDQ, community action cycle, male engagement strategies such as husbands' schools, etc.)
8) Identification, vetting and subcontracts to partners (CBO, local NGO, etc.)
9) Community engagement activities and include budget for training, supportive supervision, development of job aids, materials
10) Monitor activities – review data, supportive supervision visits, on the job training, coaching, mentoring
11) Meeting costs such as transport, per diem, food for participants and partners

OUTCOME 3: INCREASED AVAILABILITY OF QUALITY INFORMATION, COUNSELING AND CONTRACEPTIVE SERVICES ACROSS THE CONTINUUM OF CARE

Human Resources

1) Clinical trainers for competency based training on family planning including LARCs, permanent methods, counseling – SCI trainers, national trainers
2) Service providers – community and health facility level working for the MOH, private sector and/or Save the Children staff deployed to provide surge support in humanitarian contexts or SCI hired staff providing services in mobile clinics or fixed health facilities in humanitarian settings
3) Pharmacist/Medical logisticians

Activities

1) Health facility mapping and assessments
2) Training needs assessments
3) Training of trainers and cascade to training health providers at health facility and community levels
4) Clinical training costs – venue, models, clinical practicum sights, transportation, lodging

5) Provider evaluations 3 to 6 months post clinical training
6) Refresher training costs – on-the-job training
7) Incentives for health care providers – particularly in humanitarian settings
8) Supportive supervision costs
9) Procurement of supplies, commodities, transport and storage costs – particularly in humanitarian settings
10) Stakeholder workshop and training costs to strengthen systems such as supply chains, health information systems, use of data for decision making and integration

OUTCOME 4: IMPROVED LEGAL, POLICY, ADMINISTRATIVE AND FINANCIAL ENVIRONMENT FOR FAMILY PLANNING AT NATIONAL, REGIONAL AND GLOBAL LEVELS

Human Resources

1) Advocacy and communication focal points at national, regional and global levels – Save the Children or partner agencies
2) Researcher for evaluation and documentation – Save the Children, partner agency or consultant

Activities

1) Stakeholder meetings
2) Presentation of project results at national, regional and global meetings, conferences and other fora
3) Travel expenses for conference and meeting participation and conference costs
4) Publication in peer reviewed journals, case studies, social and digital media
5) Peer reviewed journal costs
6) Technical assistance to revise and update policies, guidelines, curricula, etc.

ANNEX 3: LIST OF MEMBERS IMPLEMENTING

MEMBER	KEY CONTACT	EMAIL ADDRESS
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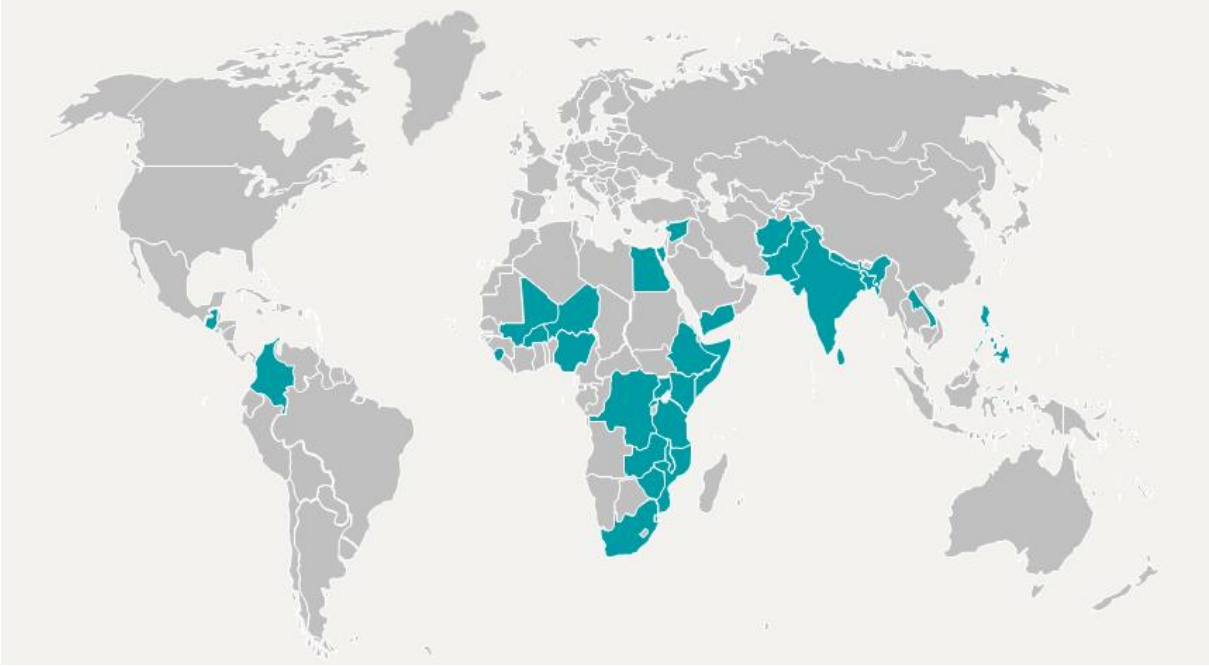
ANNEX 4: COUNTRY OFFICES IMPLEMENTING



COUNTRY	FAMILY PLANNING PROGRAMMING IN HUMANITARIAN, DEVELOPMENT OR BOTH	KEY CONTACT	EMAIL ADDRESS
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ANNEX 5: RECOMMENDED ACTIVITIES AND QUALITY BENCHMARKS, RESULTS FRAMEWORK AND MEASURES OF SUCCESS

RECOMMENDED ACTIVITIES

OUTCOME	INTERVENTIONS	KEY ACTIVITIES FOR IMPLEMENTATION	ILLUSTRATIVE QUALITY BENCHMARKS

Outcome 1: Improved knowledge, attitudes and behaviors related to contraception	Media – mass, social and digital media, IPC and group-based approaches	• Map out existing IPC and media channels and identify who are the users, who has access to mass media, social media and digital media.
		• Using human-centered design principles, use the most effective channels to design IPC, mass, digital and social media according to the following:
		  ○ with the users from the beginning, learn from past experiences of what worked and didn't work
		  ○ design for scale and sustainability, ensure use of data for decision making
		  ○ use open source options when possible
		• Implement mix of approaches that mutually reinforce key messages, and link with group-based methodologies, CHW and peer mobilizer activities, and services
		• Map out existing networks of community volunteers (e.g., CHWs, peer mobilizers) and groups
		• Using human-centered design principles, use the most effective channels to design individual outreach and group-based approaches according to the following:
		  ○ with the users from the beginning, learn from past experiences of what worked and didn't work
			• Media and IPC content is based on formative research and clearly addresses primary barriers and facilitators of contraception outcomes and contextual realities
			• IEC content is based upon interagency standards (humanitarian settings)
			• Group-based content is based on formative research and clearly addresses primary barriers and facilitators of contraception
			• Individual outreach and groups are led by a trained CHW/peer mobilizer/group facilitator

		○ design for scale and sustainability, ensure use of data for decision making • Develop content for individual outreach and group-based approach adapting existing materials or developing new content • Conduct training of trainers for CHW, peer mobilizers and group facilitators • Conduct individual outreach, group education and group-based activities as planned • Conduct supportive supervision of activities • Use data for decision making and adjust activities as needed	

	CSE	Refer to My Sexual Health and Rights Common Approach	

Outcome 2: Partners, family members and communities support contraception	IPC, small group, mentorship-based, and couples counseling approaches reaching men and influential family members	• Identify approach for engaging men and influential family members based upon formative research (e.g., husbands' schools, couples counseling, household visits) • Adapt existing or develop new content • Train trainers to lead the intervention • Conduct intervention as designed • Conduct supportive supervision of activities as designed • Monitor quality and fidelity of intervention using data for decision making approaches • Adjust intervention as needed	• Content and methodology of individual and small group methodologies is participatory (e.g., interactive sessions using discussion, activities, dialogue and games) • Content and materials are gender sensitive at a minimum in humanitarian settings • Content and materials are gender transformative • Content and methodologies address facilitators and barriers to contraception

	Community group activities	• Support existing community mobilization structures in humanitarian settings (e.g., CHW programs, health committees) • Identify the most effective approaches for engaging communities based upon formative assessments (religious leaders, segmented small groups, CAC, PDQ, group learning and community theater) • Adapt or develop content for community group activities • Conduct training of trainers • Implement intervention as designed • Conduct supportive supervision of activities as designed • Monitor quality and fidelity of intervention using data for decision making approaches • Adjust intervention as needed	• Content and methodology of community group methodologies is participatory (e.g., interactive sessions using discussion, activities, dialogue, and games) • Content and materials are gender sensitive at a minimum in humanitarian settings • Content and materials are gender transformative • Content and methodologies address facilitators and barriers to contraception

Outcome 3: Increased availability of quality information, counseling and contraceptive services across the continuum of care	High quality contraceptive services	• In collaboration with the MOH, review existing package of contraceptive services and identify strengths and gaps in existing services
		  ○ Assess quality of care based upon national and international standards and identify areas for strengthening
		  ○ Support / establish systems to strengthen quality of care
		  ○ Provide services with the user in mind (e.g., adolescent friendly, LGBTQI and disability accessible, accessible to displaced populations, and integrated)
		• In acute emergency response, integrate contraceptive services within Save the Children managed facilities and mobile clinics as appropriate
		• Ensure adequate infrastructure is in place (e.g., private, confidential space for counseling and services, lighting, water, infection prevention)
			• System in place for monitoring quality of care and continuous quality improvement

	Health workforce that is sufficient in number, well trained and able to provide quality contraceptive services	• In collaboration with the MOH, assess health facility and community provider capacity for provision of contraceptive services
		  ○ Identify capacity building needs and adapt / develop training package based upon training needs
		  ○ Identify and equip training facility and clinical training sites
		  ○ Conduct training of trainers to cascade training package
		  ○ Conduct competency based training inclusive of increasing knowledge and positive attitudes towards contraception and increasing clinical skills
		  ○ Conduct supportive supervision inclusive of mentoring and coaching using standardized checklists
		  ○ Use data for monitoring quality of service delivery and tailor supervision activities accordingly
		  ○ Establish criteria for "graduating" providers to level of mentor and trainer
		• In humanitarian settings, adapt above activities to the context (e.g., identify trained providers and conduct refresher training as needed, deploy trained providers to deliver services and provide on-the-job training)
			• Trained and qualified health facility and/or community workforce able to provide quality contraceptive services according to standards

	A well-functioning health information system	• In collaboration with the MOH:
		  ○ Review existing systems for data collection and identify areas for strengthening
		  ○ Adapt data collection tools and systems based upon gaps identified
		  ○ Develop training package
		  ○ Conduct training of trainers and cascade training
		  ○ Conduct monthly data collection and reviews at the service delivery level
		  ○ Adjust services based upon findings from reviews
		• Establish accountability mechanisms between communities and health facilities
			• System established to collect and use data for decision making

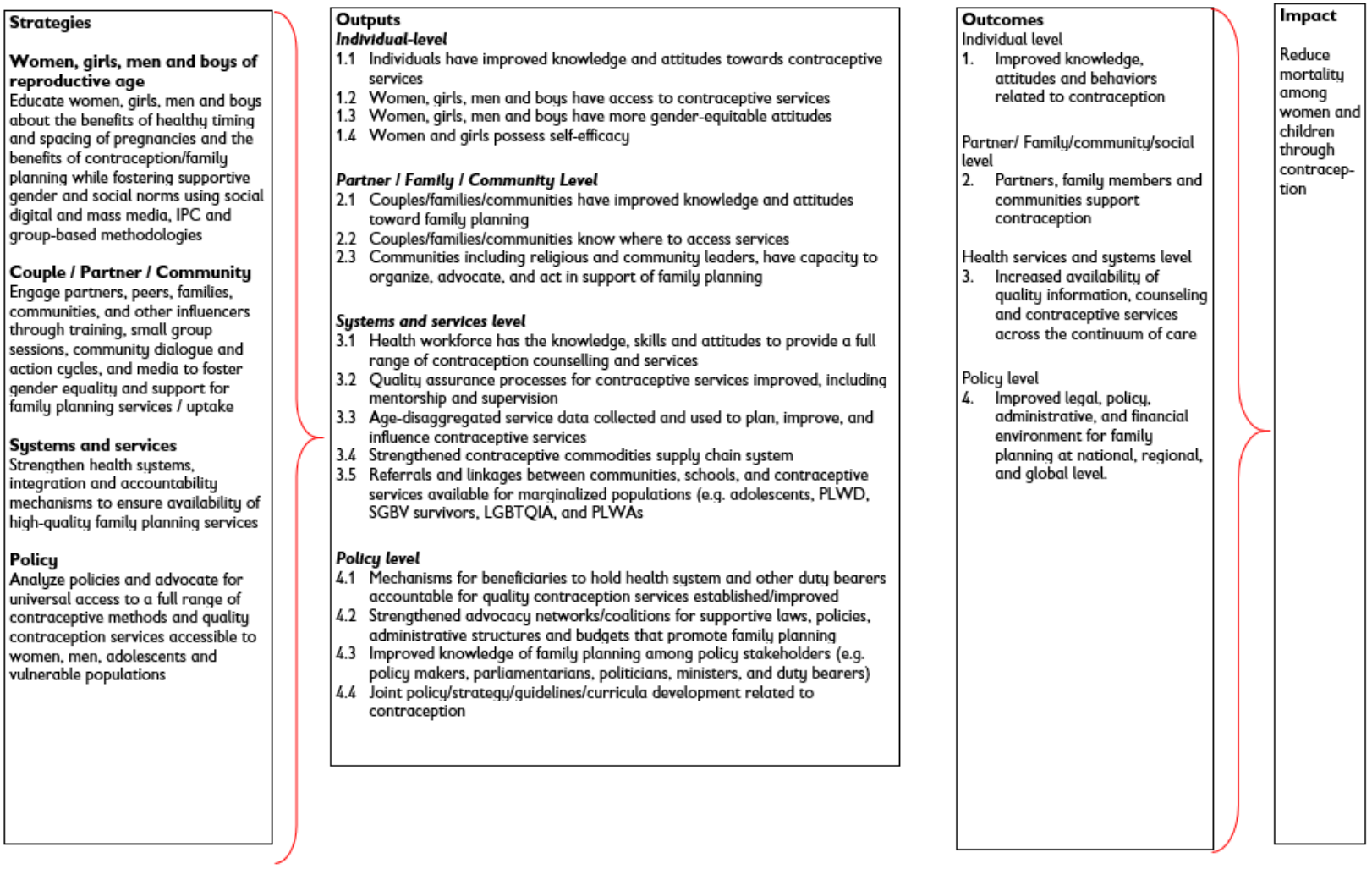
	Availability of high-quality contraceptives and medical supplies	• In collaboration with the MOH, assess contraceptive and medical supply chain mechanisms to identify strengths and weaknesses
		• Develop plan for ensuring continuous supply of quality contraceptives and medical supplies to prevent stock outs. The plan may include one of the following:
		  ○ Utilization and coordination with existing supply chain
		  ○ Reinforcement of existing supply chain
		  ○ Provision of supplies (common in humanitarian settings)
			• Quality contraceptives and medical supplies are available at all levels of service delivery

	Sustainable financing	• Refer to Outcome 4	

	Leadership and governance	• Refer to Outcome 4	
Outcome 4: Improved legal, policy, administrative and financial environment for FP at national, regional and global levels	Advocacy campaigns, education and technical assistance towards policy and decision-makers and coalition building	• Assess the current legislation, policies, standards, guidelines, and budgets related to family planning, UHC and health care financing at national and global levels • Identify and engage with existing global platforms such as FP2020, Implementing Best Practices (IBP) Initiative, and IAWG to promote universal access to rights-based quality contraceptive services in humanitarian and development contexts • Identify and engage with existing country level platforms, forums and partners (e.g., FP2020, UNFPA, WHO, UNICEF, UNAIDS, NGOs, CSOs, RH working groups) that are advocating for the same policies and standards promoting universal access to rights-based quality contraceptive services in humanitarian and development contexts • Develop advocacy plans and budget • Collect additional information or conduct additional assessments as needed • Conduct advocacy activities • Provide technical assistance to support development of costed implementation plans for delivery of quality rights-based family planning services that are accessible to all including populations in humanitarian settings, PLWD, people living with HIV, adolescents, etc. • Monitor and evaluate advocacy interventions and results	• Advocacy plans are based upon assessment of current legislation, policies, standards, guidelines and budgets related to FP • SC staff are actively engaged with and/or leading in global platforms related to contraception/family planning /reproductive health • SC staff are actively engaged with and/or leading in country and regional platforms related to contraception/family planning/reproductive health

RESULTS FRAMEWORK

"CONTRACEPTION BY CHOICE: FULFILLING HEALTHY LIVES" COMMON APPROACH LOGICAL FRAMEWORK



MEASURES OF SUCCESS

IMPACT	INDICATORS (DISAGGREGATION)	SOURCE	FREQUENCY OF COLLECTION	INDICATOR DEFINITION
Impact: Reduce mortality among women and children through contraception				
	Maternal Mortality Ratio (MMR)	Vital registration, service statistics and population-based surveys or surveillance	According to country level collection	The number of maternal deaths per 100,000 live birth
	Total fertility rate (TFR)	DHS, Multiple Indicators Cluster Surveys (MICS), Reproductive Health Surveys (RHS)	According to country level collection	TFR in simple terms refers to total number of children born or likely to be born to a woman in her life time if she were subject to the prevailing rate of age-specific fertility in the population (WHO)
	Adolescent age-specific fertility rate (ASFR) / adolescent birth rate Note: this indicator is in the "My Sexual Health and Rights Common Approach"	DHS, RHS, MICs Additional surveys where needed to measure adolescent birth rate among VYAs (10-14) Note: this indicator is in the "My Sexual Health and Rights Common Approach"	According to country level collection	The number of births to women ages 10 – 19 years per 1,000 adolescent females in that age group per year (WHO 2010) This is a subset of ASFR
	Contraceptive prevalence rate, modern methods (CPR) (Age)	DHS, PMA2020, MICS, RHS, other nationally representative surveys or population based surveys	According to country level collection	CPR is the percentage of women who are currently using, or whose sexual partner is currently using, at least one method of contraception, regardless of the

	Proportion of women aged 15-49 years using modern methods of contraception "Global Results Framework" GRF 1.1.1			method used. It is usually reported for married or in-union women aged 15 to 49 (WHO) May disaggregate by age (DHS or PMA2020), by wealth quintile (comparing the lowest to the highest quintile), marital status, etc. (FP2020 core indicators)[3]
	Demand satisfied by contraception (Age)	Estimated using data from surveys, such as DHS, MICS, PMA2020, RHS and other nationally representative surveys or modeling using surveys and service statistics (FP2020 core indicators)	According to country level collection Baseline, Endline	Percentage of women (or their partners) who desire either to have no additional children or to postpone the next child and who are currently using a modern contraceptive method Women using a traditional method are assumed to have an unmet need for modern contraception (FP2020 core indicators)
	Women and girls with an unmet need for family planning (Age)	Estimated using data from surveys such as the DHS, MICS, PMA2020, RHS and other nationally representative surveys or modeling using surveys and service statistics (FP2020 core indicators)	According to country level collection Baseline, Endline	Women with unmet need are those who are fecund and sexually active but are not using any method of contraception, and report not wanting any more children or wanting to delay the next child (WHO)

[3] FP2020 Core Indicators : http://www.track20.org/pages/data_analysis/core_indicators/overview.php

	Proportion of women of reproductive age who make informed decisions regarding sexual relations, contraceptive use and reproductive health care (Age)	DHS	According to country level collection	Proportion of women aged 15-49 who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care (SDG 5.6.1)[4]
OUTCOMES	**INDICATORS**	**SOURCE**	**FREQUENCY OF COLLECTION**	**INDICATOR DEFINITION**
Outcome 1: Individual Level Improved knowledge, attitudes and behaviors related to contraception	Number of new users, (age, method, disability - if appropriate)	HMIS system – MOH or Save the Children IMPACT	Monthly	Number of persons who adopt for the first time in their lives any (program) contraceptive method; to be reported for a defined reference period (e.g., one year) (Measure Evaluation) Definition for FP PAC program: A client who presents to the HF for the first time for a modern FP method OR receives a different type of modern FP method for the first time OR a client who used a method, took a break for more than 6 months, but has returned to the facility to use the same method (NEW to the facility and/or NEW to the method

[4] Sustainable Development Goal 5.6.1: https://sdg-tracker.org/gender-equality#5.6.1

				(includes women who switch methods))
	Percentage of intended audience members with favorable attitudes towards FP providers *(geographic area, sex, age category, marital status, parity)*	Survey	Baseline and endline	Numerator: Number of individuals from the intended audience who agree/strongly agree with statements expressing favorable attitudes towards FP providers Denominator: Total number of individuals within the intended audience (Breakthrough Action)
	Percentage of intended audience who believe that most people in their community approve of people like them using FP *(geographic area, sex, age category, current marital status, parity)*	Survey	Baseline and endline	Numerator: Number of individuals from the intended audience who agree/strongly agree with the statement "Most people in my community approve of people like me using FP" Denominator: Total number of individuals within the intended audience (Breakthrough Action)
	Percentage of intended audience who know of at least three modern FP methods *(geographic area, sex, age category, current marital status, parity)*	Survey	Baseline and endline	Numerator: Number of individuals from the intended audience who can correctly name at least three modern FP methods Denominator: Total number of individuals within the intended audience (Breakthrough Action)

	Percentage of intended audience who know where to obtain FP in their community *(Geographic area, sex, age category, current marital status, parity)*	Survey	Baseline and endline	Numerator: Number of individuals of intended audience who can correctly name at least one source of obtaining FP services/supplies in their community Denominator: Total number of individuals within the intended audience (Breakthrough Action)
	Percentage of women of reproductive age who were informed of potential side effects of any type of FP method during their visit, among those who visited an FP provider in the past 12 months (or a specified reference period) *(geographic area, sex, age category, current marital status, parity)*	Survey, client exit interview	Baseline and endline or as determined by project	Numerator: among WRA who visited an FP provider in the past 12 months, the number who report having discussed an FP method and being informed about potential side effects of any FP method (not FP in general) Denominator: Total number of WRA who visited an FP provider in the past 12 months and discussed an FP method (Breakthrough Action)
	Proportion of satisfied contraceptive users in communities served	Client exit interviews	Annually	Number of contraceptive users reporting they are satisfied with their services when they exit the family planning clinic (FP PAC) Denominator: Total number of family planning clinic clients surveyed

	Proportion of all new users who adopt LARCs (age)	Family planning register, HMIS system	Monthly	Number of clients accepting a LARCs (IUD or implant) out of the total number of new family planning clients (FP PAC Indicator)
	Proportion of all new FP adopters who are adolescents	Family planning register, HMIS system	Monthly	Number of clients that are adolescents (10 – 19 years) out of the total number of new family planning clients
	Couple years of protection (CYP)	Family planning register/service statistics, LMIS	Annually and less frequently monthly	The estimated protection provided by FP services during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period. The CYP is calculated by multiplying the quantity of each method distributed to clients by a conversion factor to have an estimate of contraceptive protection which is then totaled over all methods to calculate the total CYP. (Measure Evaluation) There are standard CYP conversion factors endorsed by USAID and posted on the USAID website.
	Percent of women using a modern family planning method who obtained their current method from a community-based worker	Population based survey or project report	Baseline, Endline	A "community-based provider" is a health worker or promoter not based at a traditional HF; sometimes they are referred to as

	(age)			"fieldworkers." CBD of FP methods is generally through a health post or individual provider at a non-commercial site, as well as other variations that are community-based. As measured in this indicator, a woman who is using modern contraception who purchased or was given her current FP method from a community-based provider is included, but this indicator does not include a woman who only talks with the community-based provider about FP (Measure Evaluation)
	Percent of FP clients who received HIV testing at the FP service delivery point (SDP) or were referred for HIV testing	Service delivery data, HF assessment or special surveys	Baseline, mid-term and endline	FP clients who received HIV testing at the SDP or were referred by the FP provider for HIV testing including any FP clients who are interested or in need of testing for HIV. Referral occurs if the client is advised where he/she can go to find an HIV testing source not provided at the site, and the referral is documented at the referral source as proof that a referral was made. Numerator: Number of FP clients provide or referred for HIV testing and Denominator: Total number of FP clients screened for unmet

				HIV testing need at a FP SDP (Measure Evaluation)
	Percent of clients at HIV SDPs who received voluntary FP counseling (including safe contraception/safe pregnancy counseling)	HF registers	Monthly	The clients measured in this indicator include all male and female HIV clients of reproductive age (15 – 49 for females and 15 – 54 for males) served an HIV SDP during the reporting period. Screening will be done during counseling sessions (Measure Evaluation)
	Percent of women who deliver in a facility and initiate or leave with a modern contraceptive method prior to discharge	Maternity delivery register, postnatal care register, FP register, HMIS	Monthly	This indicator combines women who receive a method inserted by a provider (IUD, implant) or tubal ligation, women who start using LAM, and women who leave with a method (pills, condoms) (MCSP, 2019)[5]
	Proportion of PAC clients who are counseled on FP	PAC register, HMIS	Monthly	Number of PAC clients counseled for FP / Total number of PAC clients (FP PAC Indicator)
	Proportion of PAC clients who accept method of FP	PAC register, FP register, HMIS	Monthly	Number of PAC clients who accept a method of PF before discharge from the facility / Total number of PAC clients (FP PAC Indicator)

[5] MCSP Postpartum Family Planning Indicators: https://www.mcsprogram.org/resource/postpartum-family-planning-indicators-for-routine-monitoring-in-national-health-management-information-systems/

	Average number of modern contraceptive methods known among women aged 15 – 19 years Note: this indicator is from the "Global Results Framework" GRF 1.6.1	Program survey	Baseline, Endline	Average number of modern contraceptive methods known among women aged 15 – 19 years (DHS)
	Proportion of women aged 15 – 49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care Note: this indicator is from the "Global Results Framework" GRF 1.2.1	Program survey	Baseline, Endline	Composite indicator measuring proportion of women aged 15 – 49 years who make their own informed decisions regarding sexual relations, contraceptive use and reproductive health care
Partner, Family, Community Level Outcome 2: Partners, family members and communities support contraception	Proportion of male partners/husbands of women who report their partner/wife makes her own decisions about seeking SRH services or jointly decides with her partner/husband *[Alternative: Proportion of women of reproductive age (WRA) who report making their own decisions about SRH services or making joint decisions with her partner/husband]*	Program survey or In-depth interview	Baseline, Endline	# of male partners/husbands who respond yes to having decided jointly about seeking SRH services and number of male partners or husbands who respond yes to his female partner or wife having decided about seeking SRH services by herself / Total number of male partners/husbands of women of reproductive age surveyed x 100
	Proportion of male partners/husbands who report having supportive attitudes and	In-depth interviews or Program Survey	As determined by program	Number of partners or husbands who self-report having positive attitudes supporting their partner or wife using an FP method / Total

	supporting their partner/wife using an FP method			number of men surveyed x 100. *Supportive may be defined as positive attitude toward contraceptive use through responses to hypothetical situations and reported actions/behaviors. RH practices refers to behaviors promoted by the RH program (contraception use, etc.) (Measure Evaluation)[6]
	Proportion of husbands / male partners who report the household invests resources to cover the cost of family planning services	In-depth interviews or Program Survey	As determined by program	Number of partners or husbands who self-report the household invests resources to cover the cost of family planning services / total number of men surveyed x 100
	Proportion of WRA who report that their partner/husband supports their decisions about contraceptive use	In-depth interviews or Program Survey	As determined by program or baseline, endline	Numerator: # of women of reproductive age who report that their partner/husband supports their decisions about contraceptive use Denominator: Total number of WRA surveyed
	Proportion of WRA who report self-efficacy in their relationship	In-depth interviews or Program Survey	As determined by program or baseline, endline	Numerator: # of WRA who report feeling confident to make decisions or raise discussions in their relationships Denominator: Total number of WRA surveyed

[6] MEASURE Evaluation Family Planning Indicators: https://www.measureevaluation.org/prh/rh_indicators/family-planning

	Proportion of adult community members who demonstrate support (i.e. accompanying a woman or girl to HF, providing financial support, advocating with family / community) for contraceptive services	In-depth interviews or Program Survey	As determined by program or baseline, endline	Numerator: # of adult community members who demonstrate support (i.e. accompanying a woman or girl to HF, providing financial support, advocating with family / community) for contraceptive services Denominator: Total number of adult community members surveyed
	Number/percent of married women under age 18 exposed to HTSP counseling/education who subsequently adopted a family planning method to delay first pregnancy Contributes to "My Sexual Health and Rights"	Program reports, special survey, interviews	Annually	Number/percent of married women ≤17 years of age who have never been pregnant; who have seen, heard, or read HTSP messages that have been promoted either through an IE campaign, IPC or community outreach; and who subsequently adopted a FP method to delay first pregnancy.
	Proportion of religious and community leaders who demonstrate support (i.e. discussing positively during religious activities, advocating with community) for contraceptive services	In-depth interviews or Program Survey	As determined by program or baseline, endline	Numerator: # of religious and community leaders who demonstrate support (i.e. discussing positively during religious activities, advocating with community) for contraceptive services Denominator: Total number of religious and community leaders surveyed

	Community members who believe that their religious leaders would approve of people like them using FP	Survey, qualitative assessment	Baseline and Endline	Number of community members from the intended audience who agree/strongly agree with the statement "My religious leader(s) would approve of people like me using FP" / Total number of individuals within the intended audience (Breakthrough Action Indicator Bank)
	Percentage of intended audience who believe that most people in their community approve of people like them using FP*	Survey, qualitative assessment	Baseline and Endline	Number of individuals from the intended audience who agree/strongly agree with the statement "Most people in my community approve of people like me using FP" / Total number of individuals within the intended audience[7] (Breakthrough Action Indicator Bank)
	Percent of respondents who report discussing FP with a health worker, CHW or other FP volunteer outreach workers in the past 12 months	Population based survey	Baseline and Endline	"Health worker, CHW or other FP volunteer outreach worker" will be context-specific. But generally, this can be broadly defined as an individual who provides FP information, which includes both community and facility-based providers.

[7] Breakthrough Action Social and Behavior Change Indicators for Family Planning: https://breakthroughactionandresearch.org/resources/social-and-behavior-change-indicator-bank-for-family-planning/

				Discussion of FP must be limited to the past 12 months. (adapted from Measure Evaluation)
	Percentage of intended audience that has encouraged others (friends, relatives, community) to use FP in the last 12 months (or a specified reference period) *(geographic area, sex, age category, category of persons they encouraged)*	Survey, qualitative assessment	Baseline and endline	Numerator: Number of individuals from the intended audience who reported having encouraged others (friends, relatives, community) to use FP in the last 12 months Denominator: Total number of individuals within the intended audience
Outcome 3: Health Services and System Level Increased availability of quality information, counseling and contraceptive services across the continuum of care	Proportion of SDPs meeting minimum quality standards for contraceptive services, including both facility and community-based service delivery points	HF assessment, project reports	Quarterly	Numerator: Number of SDPs that meet the minimum quality standards (as defined by the project or CO) Denominator: Total number of SDPs counted in assessment or target area (Measure Evaluation)
	Number of contraceptive SDPs that had no stock-outs (for more than 1 day) of methods in previous month	Stock registers	Monthly	Indicator measures stocks of all methods that are provided by the facility (IAFM indicator)
	Number of providers with technical competence to provide contraception	Supervision checklist with scoring	Quarterly	Supervisors should observe providers' competence using a checklist with each method and analyze results (Save the Children RHiE Knowledge bank)
	Percent of facilities meeting minimum standards with regards to	HF assessment, project reports	Quarterly	1) All essential equipment for LAPM services present,

	essential supplies and equipment to support provision of LARCs or long-acting and permanent methods of family planning (LAPM)			functioning, and located in the service delivery area or in reasonable proximity for utilization; 2) All essential medications and supplies for LAPM services present; and 3) At least one staff member assigned to the facility who has either pre-service or in-service training that qualifies them to provide LARCs or LAPM services following standard protocols (adapted from Measure Evaluation)
	Number or percent of SDPs that offer postpartum FP integrated with other services, by type of service	HF assessment	Baseline and endline	The number or percent of maternal and child health (MCH) SDPs in a designated area that offer PP FP integrated with other services. PP FP includes counseling and, if applicable, provision of method and/or referral (Measure Evaluation)
	Percentage of FP service providers reporting the use of FP communication materials in the past three months (or a specified reference period) *(geographic area, type of provider (community or facility-based), sex)*	Supervision visit checklist	Quarterly	Numerator: Number of FP service providers who report having used FP communication materials in the past three months (or a specified reference period) Denominator: Total number of FP service providers

Outcome 4: Policy Level Improved legal, policy, administrative and financial environment for family planning at national, regional and global levels	Evidence of international FP best practices incorporated into national health standards	FP guidelines, training packages, protocols, standards of practice, national health standards	Baseline and endline	Although there is no standardized definition of best practice, it is defined here as a specific action or set of actions with proven evidence of success in multiple applications and the potential for replication or adaptation. General criteria for an FP best practice includes: the potential for high impact on increasing CPR, increasing uptake of contraceptive use or decreasing contraceptive discontinuation (Measure Evaluation)
	Evidence that policy barriers to equitable and affordable FP services and information have been identified and/or removed	Policy document, legal and regulatory reviews – policy documents with evidence of government approval or submissions for approval, key informant interviews	Baseline, endline/ Annually	Verification that policy barriers enumerated at baseline have been identified and/or removed
	Annual expenditure on family planning from government domestic budget	COIA/WHO, NIDI/UNFPA, Kaiser Family Foundation, country availability will depend on COIA and NIDI implementation. All 69 FP 2020 countries expected to have this information	Baseline and endline	Total annual public sector recurrent expenditures on family planning. This includes expenditures by all levels of government (FP2020)

	New and / or increased resources are committed at the national and/or subnational level to FP in the last two years	Budgets, resource tracking tools, key informant interviews to link increase in FP resources to FP services	Baseline and endline	These are not limited to financial resources but can also be material such as additional doctors, new facilities, mass media, furniture and vehicles. Resources can derive from many sources such as national / subnational governments, NGOs, donors, individual, foundations, etc… (Measure Evaluation)
	Number of government leaders who speak out in favor of FP *(type of government leader – local, regional, national)*	Survey	Baseline and endline	
OUTPUTS	**INDICATORS**	**SOURCE**	**FREQUENCY OF COLLECTION**	**INDICATOR DEFINITION**
INDIVIDUAL LEVEL				
Individuals have improved knowledge and attitudes towards contraception	Knowledge of at least 3 contraceptive methods (modern or traditional)	DHS, population based surveys	Baseline, endline	Percent of women 15 – 49 years old who have heard of three or more FP methods (modern or traditional) (DHS)[8]
	Knowledge of contraceptive methods (men)	DHS	Baseline, endline	Percentage of all men who know any contraceptive method, by specific method (DHS)
	Percent of population who know of at least one source of modern	Population-based survey	Baseline, endline	Sources of modern contraceptives services and/or supplies will vary

[8] Demographic and Health Survey Family Planning Indicators: https://dhsprogram.com/data/DHS-Survey-Indicators-Family-Planning.cfm

	contraceptive services and/or supplies			by location. They may be public or private and may include health facilities pharmacies and community-based distributors along with non-traditional sources such as hair stylists, taxi drivers, and shopkeepers (Measure Evaluation)
	Number/percent of target population who can state at least one benefit of delaying first pregnancy until after 18 years old	Population based survey, interviews	Baseline, endline	Target population describes group that is intended to benefit from HTSP messaging[9].
	Percent of audience reporting exposure to family planning messages on radio, television, electronic platforms, or in print Percent of audience with a favorable (or unfavorable) attitude toward the product, practice, or service Percent of audience who perceive risk for a given behavior	program reports, special survey, interviews	Baseline, endline	Measure Evaluation https://www.measureevaluation.org/resources/publications/fs-18-278b Number of individuals from the intended audience who agree/strongly agree with statements expressing favorable attitudes towards modern FP methods / Total number of

[9] HTSP recommendations preventing the following high risk pregnancies: Those too closely spaced (a birth-to-pregnancy interval of less than 24 months); Those that occur too early in a mother's life (before the age of 18); To delay first pregnancy until at least 18 years of age; Those that occur too late in a mother's life (at or after age 35); And after a miscarriage or induced abortion, the recommended minimum interval to next pregnancy should be at least 6 months (https://sbccimplementationkits.org/htsp/courses/the-htsp-implementation-kit/, https://www.measureevaluation.org/prh/rh_indicators/family-planning/htsp)

	Percent of audience who believe that the recommended practice/ product will reduce their risk Percent of nonusers who intend to adopt a certain practice in the future			individuals within the intended audience (Breakthrough Action Indicator Bank)
Women, girls, men and boys have access to contraceptive services	Obtained method of contraception of choice	PMA2020, client exit interview	Annually or at project baseline and endline	Percentage of women ages 15 – 49 currently using a modern contraceptive method, reporting they obtained their contraceptive method of choice
	Contraceptive method information index	PMA2020 (not currently presented in PMA publications), client exit interview	Annually	Percentage of recent/current users reporting they were informed about other methods and side effects and if informed of side effects, what to do
	Number/percent of women, with a child under age two, exposed to HTSP counseling/education, who subsequently adopted a family planning method in order to space their next pregnancy	Program records; health information systems; special survey; interviews	Quarterly/Baseline, endline	Number/percent of women with a child age 23 months or younger; who have seen, heard, or read HTSP messages that have been promoted either through an IEC campaign, IPC or community outreach; and who subsequently practiced a FP method to delay their next pregnancy.
	Percent of women using a modern family planning method who obtained their current method from a community-based worker	Surveys	Baseline, endline or as defined by program	Numerator: Number of women from the intended audience who received their current method of

				FP from a community-based health worker Denominator: Total number of individuals within the intended audience
	Number or percent of vasectomies performed	HMIS system / SCI IMPACT	Monthly or quarterly	The number of male sterilizations "vasectomies" using non-scalpel technique that have been performed within a given time frame (Measure Evaluation)
Women, girls, men and boys have more gender-equitable attitudes	Women, men, girls and boys have more gender-equitable attitudes	Population-based survey	Baseline, endline	Average score on modified GEM scale among women, men, girls and boys
Women and girls possess self-efficacy	Improved independence and decision-making power around FP amongst persons with disabilities, especially dependent women and girls *(sex, age, married, unmarried)*	Questionnaire, population-based survey, pre- and post-tests	Baseline, endline	Numerator: number of people with disability (may disaggregate by sex and age)who state they have decision making power (to be defined by project) Denominator: total number of people surveyed
	Percentage of women and girls of reproductive age who are confident in their ability to use FP	Population-based survey	Baseline, endline	Numerator: Number of women and girls who agree/strongly agree that they are confident in their ability to use FP (or a specific type of FP method) Denominator: Total number of individuals within the intended audience (Breakthrough Action)

	FP method chosen by self or jointly	PMA2020, special surveys	Annually or at project baseline and endline	Percentage of women ages 15 – 49 currently using a modern contraceptive method, reporting they decided on method themselves or jointly with a partner or provider
COUPLE / PARTNER / COMMUNITY LEVEL				
Couples/Families/communities have improved knowledge and attitudes toward family planning	Partners/spouses/caregivers*/legal guardians* have improved knowledge and attitudes toward family planning * caregivers/legal guardians of person with disability	Program survey (population-based or program participants)	Baseline and endline	a) Average score on GEM scale among partners and spouses (care givers and legal guardians as appropriate) surveyed b) Average score on FP knowledge – composite indicator among partners and spouses (caregivers and legal guardians as appropriate) surveyed (adapted from adolescent sexual and reproductive health rights (ASRHR) common approach)
	Proportion of male partners/husbands that show improved knowledge of select SRH topics (i.e. FP Methods, fertility awareness, etc.)	Pre-test/Post-test or Program survey	As determined by program or baseline, endline	# of male partners or husbands that show improved knowledge scores on select SRH topics on post-test / Total number of male partners or husbands that take post-test OR surveyed x 100
	Percentage of intended audience who recall hearing or seeing a specific FP message/campaign initiative (geographic, area, sex, age category, marital status, parity,	Periodic surveys	Baseline, endline, as determined by program	Numerator: Number of individuals from the intended audience who recall FP message/campaign initiative

	source of information (e.g., print, radio, TV, SMS)			Denominator: Total number of individuals within the intended audience
	Estimated number of intended audience in program areas reached by FP mass media (*type of mass media- radio, TV; geographic area)*	Project reports	Quarterly, semester or annually	
	Number of community members participating in community-level FP activities in the last six months (geographic area, sex, age category, activity type (e.g., community dialogues, support groups, commodity distribution, household visits, mobile clinics)	Project reports	Quarterly, semester or annually	
	Number of times FP messages were aired on television or radio in the last 12 months (or a specific reference period)	Project report	Annually	Number of FP messages aired disaggregated by television or radio
	Number of FP communication materials disseminated in the last 12 months (or a specific reference period) *(geographic area and type of material)*	Project report	Annually	Number of materials disseminated by type and audience
Couples/Families/Communities know where to access services	Percentage of intended audience who reported that they received FP information from a facility or community-based health provider in the last 12 months (or specified reference period) *(geographic area, age category, sex, current marital*	Surveys	Baseline, endline or as defined by program	Numerator: Number of individuals from the intended audience who received FP information from a facility- or community-based health provider in the last 12 months

	status, parity, community, or facility source)			Denominator: Total number of individuals within the intended audience
Communities including religious and community leaders, have capacity to organize, advocate and act in support of family planning	Proportion of communities with members who participate in advocacy and accountability efforts for family planning	Community assessments	Baseline, endline and as defined by project	Numerator: Number of communities where a minimum number of individuals (to be defined by the project) participate in accountability and advocacy efforts on at least a quarterly basis (this could include the establishment and functioning of community action groups) Denominator: Total number of project implementation communities (Adapted from ASRHR common approach)
	Average contraception knowledge among community leaders and community members (composite indicator) Proportion of community leaders and proportion of community members who agree that individuals should be provided with FP information and services	Program survey (population-based or program participants, based on project)	Baseline, endline	

HEALTH SERVICES AND SYSTEMS LEVEL				
Health workforce has the knowledge, skills and attitudes to provide a full range of contraceptive counseling and services	Number of providers trained on provision of LARCs and/or permanent methods of family planning	Training reports		Training should be competency based and using an up to date standardized curriculum (see RH knowledge bank for a training package)
	Percent of HIV health care workers who completed an FP training program	Training report		FP training program will depend upon the level of service the HIV health care workers will be providing. (adapted from Measure Evaluation)
	Health workers (facility and community) delivering quality, integrated MIYCN-FP services			
	Quality assurance processes for FP services are defined and implemented	Training reports, supervision checklists	Per need of project – by quarter, semester or annual	Quality assurance processes for FP services improved, including mentorship and supervision
Quality assurance processes for contraceptive services improved, including mentorship and supervision	Measure of integrated services at the HF	client exit interview	annually	Percentage of women ages 15 – 49 reporting they received FP information from a provider at a facility (adapted from PMA2020)
	Contraceptive services data are disaggregated by age	HMIS system, SC IMPACT	Monthly or quarterly	Age-disaggregated service data collected
	Age-disaggregated service data used to plan, improve and influence contraceptive services	HMIS system, SC IMPACT	Monthly or quarterly	Age-disaggregated service data used to plan, improve and influence FP services

Age-disaggregated service data collected and used to plan, improve, and influence contraceptive services	Number of contraceptive SDPs that had no stock-outs of methods in previous month	Stock registers	Monthly or quarterly	Number of contraceptive SDPs that had no stock-outs (for more than 1 day) of methods in previous month (IAFM 2018)
Strengthened contraceptive commodities supply chain system	Percentage of SDPs with at least 5 modern methods of contraception available on day of assessment	Survey report, service delivery statistics, facility assessments	Quarterly	This indicator considers methods (such as injectables), not products (such as 1 month or 3 month injectables) or brands (such as Depo Provera) (adapted form PMA2020)[10]
	Number of communication materials developed for FP in the last 12 months (or a specific reference period) *(type of materials – e.g., print, billboard, mobile application)*	Project report	Annually	Number of materials disaggregated by type and audience developed
Referrals and linkages between communities, schools and contraceptive services available for marginalized populations (e.g., adolescents, PLWD, SGBV survivors, LGBTQIA and PLWAs)	Percentage of ANC clients provided iron-folic acid, IPTp (in malaria endemic areas only) and mebendazole, and given information about a healthy diet, EBF, LAM, and other FP options	HF records	Monthly	Number of ANC clients who received iron-folic acid and mebendazole and were given information about a healthy diet, EBF, LAM, and other FP options (MIYCN-FP integration technical working group)[11]

[10]Performance Monitoring and Accountability 2020 (PMA2020) Family Planning Indicators: https://www.pma2020.org/glossary-family-planning-indicators
[11] K4Health Family Planning Monitoring and Evaluation: https://www.k4health.org/sites/default/files/miycn-fp-monitoring-and-evaluation-briefer_final_may2014.pdf

	Percentage of PNC clients counseled on maintaining a healthy diet, EBF, LAM, and other FP options	HF records	Monthly	Number of PNC clients counseled on maintaining a healthy diet, EBF, LAM and other family planning options (MIYCN-FP integration technical working group)
	Percentage of mothers given information about contraception options during well-child visits	HF records	Monthly	Number of mothers given information about FP options during well-child visits (MIYCN-FP integration technical working group)
	Number of HIV SDPs[12] that are providing integrated voluntary contraceptive services.	Service delivery statistics	Monthly or quarterly	Numerator: Number of SDPs that are providing integrated voluntary contraceptive services Denominator: Total number of SDPs providing HIV services
POLICY LEVEL				
Mechanisms for beneficiaries to hold health system and other duty bearers accountable	Proportion of key policy-makers demonstrating FP knowledge	Government meeting reports, project reports	Quarterly or as determined by project	Numerator: Number of key policymakers demonstrating FP knowledge (composite indicator)

[12] HIV SDPs include 1. Treatment services. This includes services where ART is initiated and monitored. This can also include Option B+ services, where a client is transferred from a PMTCT ward to an HIV treatment area. 2. Care and support service. This can include home-based care activities. Voluntary contraceptive services include safe conception as part of a comprehensive HIV package. 3. Antenatal/maternity services. This includes education on contraception and healthy timing and spacing messages in the ANC setting (when a woman in pregnant and receiving PMTCT services and/or contraceptive counseling and method provision postpartum). 4. Priority/key population prevention services. This includes priority/key population programming, such as drop-in centers (contraception integration can also take place across the clinical cascade for priority/key populations, including care and treatment) and prevention sites focused on adolescent girls and young women and other priority/key populations (i.e., LGBTQIA, sex workers). 5. HIV testing services. Contraceptive services can be made available with HIV testing services, especially for key populations and adolescent girls and young women as well as for HIV serodiscordant couples. (Adapted from Measure Evaluation)

for quality contraceptive services established / improved				Denominator: Number of key policymakers targeted/assessed
	Proportion of data for action reviews with key stakeholders at district/provincial level	Project reports	Semi-annual or as determined by project	Numerator: Number of data for action review meetings with key stakeholders held (within defined period) Denominator: Number of planned data for action review meetings with key stakeholders planned
Improved knowledge of FP among policy stakeholders (e.g., policy makers, parliamentarians, politicians, ministers, and duty bearers)	Number of policy/strategy/ guidelines/curricula developed to deliver family planning programs	Policy analysis, curricula reviews	Quarterly or as determined by project	Number of documents updated
Joint policy/ strategy/ guidelines/ curricula development	Number of FP2020 related events attended at global, regional and country level	Project reports	Quarterly or as determined by project	

ANNEX 6: FAMILY PLANNING METHODS[69]

MODERN METHODS

METHOD	DESCRIPTION	HOW IT WORKS	EFFECTIVENESS TO PREVENT PREGNANCY	COMMENTS
Combined oral contraceptives (COCs) or "the pill"	Contains two hormones (estrogen and progestogen)	Prevents the release of eggs from the ovaries (ovulation)	>99% with correct and consistent use 92% as commonly used	Reduces risk of endometrial and ovarian cancer
Progestogen-only pills (POPs) or "the minipill"	Contains only progestogen hormone, not estrogen	Thickens cervical mucous to block sperm and egg from meeting and prevents ovulation	99% with correct and consistent use 90–97% as commonly used	Can be used while breastfeeding; must be taken at the same time each day
Implants	Small, flexible rods or capsules placed under the skin of the upper arm; contains progestogen hormone only	Thickens cervical mucous to block sperm and egg from meeting and prevents ovulation	>99%	Health-care provider must insert and remove; can be used for 3–5 years depending on implant; irregular vaginal bleeding common but not harmful
Progestogen only injectables	Injected into the muscle or under the skin every 2 or 3 months, depending on product	Thickens cervical mucous to block sperm and egg from meeting and prevents ovulation	>99% with correct and consistent use 97% as commonly used	Delayed return to fertility (about 1–4 months on the average) after use; irregular vaginal bleeding common, but not harmful
Monthly injectables or combined injectable contraceptives (CIC)	Injected monthly into the muscle, contains estrogen and progestogen	Prevents the release of eggs from the ovaries (ovulation)	>99% with correct and consistent use 97% as commonly used	Irregular vaginal bleeding common, but not harmful

METHOD	DESCRIPTION	HOW IT WORKS	EFFECTIVENESS TO PREVENT PREGNANCY	COMMENTS
Combined contraceptive patch and combined contraceptive vaginal ring (CVR)	Continuously releases 2 hormones – a progestin and an estrogen- directly through the skin (patch) or from the ring.	Prevents the release of eggs from the ovaries (ovulation)	The patch and the CVR are new and research on effectiveness is limited. Effectiveness studies report that it may be more effective than the COCs, both as commonly and consistent or correct use.	The Patch and the CVR provide a comparable safety and pharmacokinetic profile to COCs with similar hormone formulations.
Intrauterine device (IUD): copper containing	Small flexible plastic device containing copper sleeves or wire that is inserted into the uterus	Copper component damages sperm and prevents it from meeting the egg	>99%	Longer and heavier periods during first months of use are common but not harmful; can also be used as emergency contraception
Intrauterine device (IUD) levonorgestrel	A T-shaped plastic device inserted into the uterus that steadily releases small amounts of levonorgestrel each day	Thickens cervical mucous to block sperm and egg from meeting	>99%	Decreases amount of blood lost with menstruation over time; Reduces menstrual cramps and symptoms of endometriosis; amenorrhea (no menstrual bleeding) in a group of users
Male condoms	Sheaths or coverings that fit over a man's erect penis	Forms a barrier to prevent sperm and egg from meeting	98% with correct and consistent use 85% as commonly used	Also protects against STIs, including HIV
Female condoms	Sheaths, or linings, that fit loosely inside a woman's vagina, made of thin, transparent, soft plastic film	Forms a barrier to prevent sperm and egg from meeting	90% with correct and consistent use 79% as commonly used	Also protects against STIs, including HIV

METHOD	DESCRIPTION	HOW IT WORKS	EFFECTIVENESS TO PREVENT PREGNANCY	COMMENTS
Male sterilization (vasectomy)	Permanent contraception to block or cut the vas deferens tubes that carry sperm from the testicles	Keeps sperm out of ejaculated semen	>99% after 3 months semen evaluation 97–98% with no semen evaluation	3 months delay in taking effect while stored sperm is still present; does not affect male sexual performance; voluntary and informed choice is essential
Female sterilization (tubal ligation)	Permanent contraception to block or cut the fallopian tubes	Eggs are blocked from meeting sperm	>99%	Voluntary and informed choice is essential
Lactational amenorrhea method (LAM)	Temporary contraception for new mothers whose monthly bleeding has not returned; requires exclusive or full breastfeeding day and night of an infant less than 6 months old	Prevents the release of eggs from the ovaries (ovulation)	99% with correct and consistent use 98% as commonly used	A temporary family planning method based on the natural effect of breastfeeding on fertility
Emergency contraception pills (ulipristal acetate 30 mg or levonorgestrel 1.5 mg)	Pills taken to prevent pregnancy up to 5 days after unprotected sex	Delays ovulation	If all 100 women used progestin-only emergency contraception, one would likely become pregnant.	Does not disrupt an already existing pregnancy
Standard Days Method or SDM	Women track their fertile periods (usually days 8 to 19 of each 26 to 32 day cycle) using cycle beads or other aids	Prevents pregnancy by avoiding unprotected vaginal sex during most fertile days	95% with consistent and correct use	Can be used to identify fertile days by both women who want to become pregnant and women who want to avoid pregnancy. Correct, consistent use requires partner cooperation.

METHOD	DESCRIPTION	HOW IT WORKS	EFFECTIVENESS TO PREVENT PREGNANCY	COMMENTS
			88% with common use (Arevalo et al 2002)	
Basal Body Temperature (BBT) Method	Woman takes her body temperature at the same time each morning before getting out of bed observing for an increase of 0.2 to 0.5 degrees C.	Prevents pregnancy by avoiding unprotected vaginal sex during fertile days	99% effective with correct and consistent use 75% with typical use of FABM (Trussell, 2009)	If the BBT has risen and has stayed higher for 3 full days, ovulation has occurred and the fertile period has passed. Sex can resume on the 4th day until her next monthly bleeding.
TwoDay Method	Women track their fertile periods by observing presence of cervical mucus (if any type color or consistency)	Prevents pregnancy by avoiding unprotected vaginal sex during most fertile days	96% with correct and consistent use 86% with typical or common use (Arevalo, 2004)	Difficult to use if a woman has a vaginal infection or another condition that changes cervical mucus. Unprotected coitus may be resumed after 2 consecutive dry days (or without secretions)
Sympto-thermal Method	Women track their fertile periods by observing changes in the cervical mucus (clear texture) , body temperature (slight increase) and consistency of the cervix (softening).	Prevents pregnancy by avoiding unprotected vaginal sex during most fertile days	98% with correct and consistent use Reported 98% with typical use (Manhart et al, 2013)	May have to be used with caution after an abortion, around menarche or menopause, and in conditions which may increase body temperature.

TRADITIONAL METHODS

Calendar method or rhythm method	Women monitor their pattern of menstrual cycle over 6 months, subtract 18 from shortest cycle length (estimated 1st fertile day) and subtract 11 from longest cycle length (estimated last fertile day)	The couple prevents pregnancy by avoiding unprotected vaginal sex during the 1st and last estimated fertile days, by abstaining or using a condom.	91% with correct and consistent use 75% with common use	May need to delay or use with caution when using drugs (such as anxiolytics, antidepressants, NSAIDS, or certain antibiotics) which may affect timing of ovulation.
Withdrawal (coitus interruptus)	Man withdraws his penis from his partner's vagina, and ejaculates outside the vagina, keeping semen away from her external genitalia	Tries to keep sperm out of the woman's body, preventing fertilization	96% with correct and consistent use 73% as commonly used (Trussell, 2009)	One of the least effective methods, because proper timing of withdrawal is often difficult to determine, leading to the risk of ejaculating while inside the vagina.

ANNEX 7: EXTERNAL REVIEWS

Here is a brief summary of feedback from the external reviewers.

Dr. Mario Philip Festin – Medical Officer, Human Reproduction Team, Department of Reproductive Health and Research, WHO Headquarters, Geneva, Switzerland. He is an Obstetrician/Gynecologist and his main area of work is on research and guidelines on family planning/contraception.

Dr. Mario Festin provided a number of recommendations that led to the following revisions: addition of references and technical reference materials; addition of a reference for classifications of the different contraceptive methods; correction of terminology was in a couple of places to align with WHO; and the addition of WHO references for quality of care and human rights in contraceptive services as well as the HIV and SRH linkages guidance documents. Specific recommendations related to the indicators were also incorporated into the final indicator list. We will include the following recommendations in relevant components of the rollout strategy and learning program: establishment of health extension workers in Ethiopia as an example of successful community health worker programs; and WHO documentation guidance for implementing and scaling up family planning programs.

Dr. Jimmy Nzau Mvuezolo – Family Planning Postabortion Care Project Director and SRHR Approaches Regional Teamlead, CARE USA, Atlanta Georgia.

Dr. Jimmy Nzau recommended we consider strengthening or including the following: social accountability; include linkages with the 17 commitments of post-ICPD; integration into other sectors such as education and protection; inclusion of key populations – sex workers and lesbians; expansion on how group-based methodologies are facilitated; inclusion of contraceptive methods that can be used with or without the support of a health care provider (self-care); inclusion of recommendations from the recent ECHO trial within the section on family planning and HIV integration; expansion on Save the Children's approach to strengthening local capacity including advocacy; expansion on links with ASRHR; and recommendations related to measurement including measures of attribution from contribution. These recommendations were all incorporated into the relevant sections of the Common Approach and will be taken into consideration when developing learning materials for rollout of the Common Approach.

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