Sawa Le Baad - Together for Each Other

An Integrated Social and Behavior Change Strategy for Family Planning and Maternal, Newborn and Child Health

Breakthrough ACTION South Sudan

October 2022

TOGETHER FOR EACH OTHER

USAID
FROM THE AMERICAN PEOPLE

Breakthrough ACTION
FOR SOCIAL & BEHAVIOR CHANGE

Acknowledgements

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Table of Contents

List of Acronyms

ANC	Antenatal care
BHW	Boma health worker
CM	Community mobilization
FP	Family planning
GBV	Gender-based violence
mCPR	Modern contraceptive prevalence rate
MCH	Maternal and child health
MNCH	Maternal, neonatal and child health
RH	Reproductive health
SBA	Skilled birth attendance
SBC	Social and behavior change
SBCC	Social and behavior change communication
USAID	United States Agency for International Development
WASH	Water, sanitation, and hygiene

Background

Breakthrough ACTION South Sudan

Breakthrough ACTION is a global social and behavior change (SBC) project funded by the United States Agency for International Development (USAID) that is designed to increase the practice of priority health behaviors and enable positive social norms, including gender norms, for improved health and development outcomes, with an emphasis on family planning/reproductive health (FP/RH), HIV, maternal, newborn, and child health (MNCH), zoonotic diseases, and malaria.

Breakthrough ACTION South Sudan (the Project) is a two-year social and behavior change project designed to nurture an enabling environment that leverages and grows the existing system of community support for increased and equitable access across the service delivery continuum. The Project is tasked to co-design, develop, pilot, and refine SBC packages that will be utilized and implemented by multiple USAID-supported projects and host country government programs as well as donor and multilateral supported activities that focus on family planning and reproductive health (FP/RH), gender-based violence (GBV), maternal, neonatal and child health (MNCH), water, sanitation, and hygiene (WASH), and resilience.

Context

The information summarized in this section should be supplemented by other data sets available in-country and any additional insights gained by partners. Combined, this information will allow a better understanding of the challenges and potential design processes that could be used to place the user in the center of efforts to improve health outcomes in South Sudan.

Independence in 2011 brought high hopes and new opportunities for the people of South Sudan to rebuild the fragile health care system that had been shattered by the long-standing war with Sudan. However, the 2013 and 2016 Civil War caused serious political unrest across the country making it difficult to achieve the desired health outcomes. Additionally, social norms, knowledge gaps, and access to care hamper demand-side efforts to increase the use of essential health interventions. These necessary services include family planning (FP), antenatal care (ANC), skilled birth attendance (SBA), and improved sanitary and hygienic practices. The shortage of qualified healthcare providers, lack of infrastructure, and a poor referral system contribute to low demand for and access to high-quality services. These factors ultimately lead to poor health outcomes, especially for mothers, newborns, children, and adolescents.

While the literature reviewed provides an important foundation for understanding why many health outcomes in South Sudan are poor; there remains a dearth of information that provides deeper explorations about the root causes of these poor outcomes. For example, available literature identifies gender roles and gendered decision-making as a barrier for women seeking

reproductive health services but does not speak in great depth to efforts to influence gender and social norms, including men's attitudes and beliefs toward family planning. Other areas with limited information available include past SBC interventions. SBC interventions in South Sudan are relatively new and standards for best practice in the context of South Sudan have not yet been established. While there is rich information available that illustrates the relationship between service uptake, quality of services, and provider attitudes, there is very limited information regarding interventions aimed at influencing provider behaviors. Several studies posit that the factors determining provider behavior transcend clinical training.

The information provided below highlights the findings from key research studies conducted in South Sudan between 2010 and 2021, including peer reviewed studies, gray literature, and unpublished survey results.

Literature Review

Gaining its independence from Sudan in 2011, the Republic of South Sudan is the world's youngest country. Decades of war, and renewed conflicts in 2013 and 2016, have weakened the country's health system and demand for and access to quality services remains low. There is a need for skilled health care providers at all levels in the country. Public sector health care providers experience low morale and have few opportunities to develop further skills or to receive quality supportive supervision. There are several key issues that impede demand side efforts to increase use of key health interventions, including FP, early antenatal care, skilled birth attendance (SBA), and improved hygiene and sanitation practices. Lack of access to quality health care services and poor utilization of the health care services leads to poor health outcomes, especially for mothers, newborns, children, and adolescents.

At 1,150 deaths per 100,000 live births, South Sudan has one of the highest maternal mortality ratios in the world[1]. Contributing to this are (1) low rates of antenatal care visits with only 17% of pregnant women attending four or more visits; (2) under-utilization of skilled birth attendants (SBA) with only 17% of deliveries attended by a doctor or nurse-midwife; and (3) low awareness of best practices surrounding MNCH topics[2]. The proximate causes of maternal death are hemorrhaging, sepsis, hypertensive disorders, eclampsia, prolonged or obstructed labor, and unsafe abortion. However, these are often linked to low use of modern contraceptives by women of reproductive age, which leads to high fecundity and inadequate spacing of pregnancies[3]. The average number of children per woman is 7.5 and the unmet need for contraception is 31%[4]. Societally, large

[1] World Bank. (2017). Maternal mortality ratio (modeled estimate, per 100,000 live births) - South Sudan. Data. https://data.worldbank.org/indicator/SH.STA.MMRT?locations=SS.

[2] Doherty, T., & O'Connor, K. (2017). (publication). Improving maternal and child health through media in South Sudan. BBC Media Action. Retrieved from http://downloads.bbc.co.uk/mediaaction/pdf/country-reports/south-sudan-global-grant.pdf

[3] Makuei, G., Abdollahian, M., & Marion, K. (2020). Optimal Profile Limits for Maternal Mortality Rates (MMR) Influenced by Haemorrhage and Unsafe Abortion in South Sudan. Journal of Pregnancy, 2020, 1–13. https://doi.org/10.1155/2020/2793960

[4] South Sudan. Family Planning 2020. (2020, June 30). http://www.familyplanning2020.org/south-sudan.

families are valued and, though married couples are encouraged to immediately have children, birth spacing through traditional methods is generally an encouraged and expected practice. Efforts by foreign agencies to introduce FP are viewed with distrust and, by health providers, as an attempt to deny the populace its right to have children[5].

Men are typically perceived to be the FP decision-makers though it is women who face community punishment for unplanned pregnancies after recently giving birth, forcing women to seek contraception without their husband's knowledge. Current use of contraception among women who are married or in union aged between 15-49 years is 4%. Of those using contraception, 1.2% are using modern contraception and 2.8% are using traditional methods. Preferred traditional methods include periodic abstinence and the withdrawal method.

Practices contributing to women's limited economic and social power include societal acceptance of early marriage and high rates of adolescent birth. South Sudan ranks among the top ten countries globally for teen pregnancy with childbearing already beginning in 31% of girls between 15-19 years. Rates of early marriage are among the top ten in the world, with 52% married by the age of 18 and 9% before the age of 15 years. Within this age group, approximately 2% use contraception (1% modern methods, 1.3% traditional methods). Another factor contributing to women's limited economic and social power is low formal education rates, with only 19% of girls completing formal schooling and an overall literacy rate of 29% literacy of females, compared to 40% of males[6].

In addition, attitudes about and high incidence of sexual and gender-based violence impedes women's abilities to protect their health and challenge gender roles. Many women are exposed to practices such as forced marriage and systemic sexual violence. Though GBV acceptance varies by State, it remains high nationally, with the highest acceptance rates in Warrap (88%) and lowest in Western Bahr El Ghazal (74%)[7]. Impacts of GBV are exacerbated due to lack of relevant policies and programs.

With very little SBC efforts and limited health focused community engagement, most health practices are dictated by traditional beliefs and limited evidence-based health information. This results in low trust and use of facility-based care and interventions that are viewed as "external" to the cultural context. These interventions include FP, delivering in a health facility, and seeking antenatal care before showing the signs of pregnancy.

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[5] Kane, S., Kok, M., Rial, M., Matere, A., Dieleman, M., & Broerse, J. E. W. Social norms and family planning decisions in South Sudan. BMC Public Health, 16(1). https://doi.org/10.1186/s12889-016-3839-6

[6] UNESCO UIS. (2017, April 12). South Sudan. UNESCO UIS South Sudan. http://uis.unesco.org/en/country/ss.

[7] UNICEF Multiple Indicator Cluster Surveys (MICS). (2010). Household Health Survey 2010. South Sudan - Household Health Survey 2010. https://microdata.worldbank.org/index.php/catalog/2588/related-materials.

South Sudan is a highly patriarchal society with individuals strongly identifying with their ethnic groups, which have varying gender norms. Generally, men are viewed as the head of the household and primary decision-makers as they relate to finances, healthcare, and education.

Traditional expectations of women and girls may support societal acceptance of unhealthy norms such as low rates of female formal education, early age of marriage, low rates of ANC, unattended labor and delivery, restricted use of contraception, and GBV. These expectations may also challenge widespread use of FP[8]. In addition, it is often seen as culturally appropriate to expect women whose bride price was paid to produce many children and for married women to fulfill their biological roles by bearing children.

It is not culturally appropriate or acceptable for women and girls to use modern contraceptives, especially without her husband's consent (some providers are more likely to provide contraceptives to young girls, rather than married women due to fear of spouses). Some related modern contraceptive use to having an abortion, going against the natural gift of producing children, a criminal offense, falling out of love with their partner, going against God's commandment to humans to "go fill the world", and committing a sin. Providers mirror norms in the community, with some believing that contraception prevents repopulation following decades of war.

The belief that girls should get married once they reach menarche is most prevalent in rural areas (in urban areas this belief is rejected), along with her readiness to bear children, and the decision about girl's marriage is often left to the father and/or male relative. Influencing factors include a mother who married early, bride price, education (and increased value in educating girls), and burden of care. It is a taboo for a woman to initiate or talk about sex, and those who do so are labelled as sex workers. In addition, structural stressors, such as conflict and financial stress, results in an upward shift in male marriage age (connected to the ability to raise bride price)[9].

Several enabling factors exist at various levels. The South Sudanese government has demonstrated commitments enabling health promoting behaviors and ending harmful practices and societal inequities. The government's investment in FP is illustrated through their FP2020 Commitment made in 2017[10], and the current development of a FP Costed Implementation Plan and Demand Generation Framework, as well as the existence of SBC and FP technical working groups. The country has also committed to ending child marriage by 2030, acceding to the Convention on the Rights of the Child in 2015, and the Convention on the Elimination of All Forms of Discrimination Against Women in 2015, which obligates states to ensure free and full consent to marriage. South

[8] Ackerson, K., & Zielinski, R. (2018). "Family planning will mean that there will not be any babies" - Knowledge, beliefs, and acceptance of contraception among South Sudanese women. Clinical Obstetrics, Gynecology and Reproductive Medicine, 4(2). https://doi.org/10.15761/cogrm.1000212

[9] A Qualitative Assessment of Social Norms in South Sudan (2021, November). IMA World Health.

[10] Government of South Sudan. (2017). Family Planning 2020 Commitment. London, UK. http://www.familyplanning2020.org/sites/default/files/Govt.-of-South-Sudan-FP2020-Commitment-2017-Update-2.pdf

Sudan has affirmed its political will to increase gender equity in its constitution which states the equal rights of men and women and sets a 35% representation of women at all government agencies[11].

At the community level, sources of resilience include norms supporting mutual support, reconciliation, and cooperation between ethnic groups. Existing norms supporting transparent and inclusive decision-making may also facilitate participation of women, youth, and other marginalized groups in community-driven solutions[12]. Furthermore, the current era of peace and stability, and aspirations for a better life, creates opportunities to challenge existing gender norms. Community influencers are important in making decisions about family planning.

Urban participants able to identify modern contraceptive methods, there is a social norm that married couples should abstain from sex for 2-3 years after childbirth, and there is a positive perception that child spacing is connected to healthy children or child wellbeing. Some study participants identified birth spacing, reducing unintended pregnancies, controlling family size, improving child's health, ability to invest in a child's wellbeing, and school continuation as benefits of modern contraceptive use. In addition, there are signs that attitudes and beliefs are beginning to change with some younger respondents cited the ability to access FP services in private (empty clinic, at home) as being very important[13].

A summary table of the literature is provided in **Annex A.**

[11] Intergovernmental Authority on Development. (2018). Revitalised Agreement on the Resolution of the Conflict in the Republic of South Sudan (R-ARCSS). Addas Ababa, Ethiopia. https://www.peaceagreements.org/viewmasterdocument/2112

[12] USAID. (2018). (rep.). Community-Driven Development Methods for South Sudan: Key Findings and Recommendations. Retrieved from https://www.globalcommunities.org/publications/2018-SouthSudan_USAID_PROPEL_CDD.pdf

[13] A Qualitative Assessment of Social Norms in South Sudan (2021, November). IMA World Health.

Social and Behavior Change Communication

One of the key functions of the Ministry of Health is to implement the health communication strategy. While there have been several interventions conducted in South Sudan, this strategy uses a multi-level and coordinated approach to social and behavior change that can help to bring partners together.

Evidence from regional and global experience shows that communication programs are more effective when the following concepts are considered:

- To change people's behaviors, focus on their aspirations - things people hope for and want. People's belief that they can practice new behaviors and get ahead in life – future thinking - is critical to bringing about behavior change.
- Messages alone do not achieve behavior change.
- People adopt new behaviors when they can practice those behaviors repeatedly
- It is difficult to change "big" behaviors. It is better to get families to try small, “do-able” actions if we want to change practices, we need to work at all levels.
- To maximize public health impact, reach each person through as many channels as possible. Use cross-cutting, multi-channel communication approaches that integrate interpersonal communication, support groups and mass media.
- Improving the quality of services, including interpersonal communication of service providers, can help families practice new behaviors.
- Home visits help people think about how they can adopt the practice, strategize about how to overcome their barriers to change and give mobilizers an opportunity to demonstrate how to practice the new behavior. These are also the most important strategies for getting people to adopt the behavior.
- Group meetings help people support each other as they try new behaviors and adopt them.
- Radio can raise awareness; model improved interpersonal communication and influence social norms.
- People are more likely to change if they think that others around them are practicing the new behavior. Using testimonials - or having people who have overcome the same barriers to practicing the new behavior share their stories - is an effective method to influence individual and community actions.
- When people see benefits, they are more likely to continue with the new behavior.
- Counseling is not enough. Communities must mobilize to bring about lasting change.
- Solutions must originate from the people and at the community level.

Taking into consideration the above, this Strategy:

- Works to create a more supportive household for the woman and her partner to discuss and access maternal and child health services, including trained birth attendants and community members.

- Focuses on personal commitment, creating a network of support and future thinking.
- Targets people who are most influential at the household and community level as the primary agents of change, including the woman's mother, birth supporters, husbands, and health care providers, such as the Boma Health Workers (BHWs).
- Uses messages that align with local context and feedback from the community level.

Principles of Engagement

Projects seeking to implement this strategy should elevate the importance of the lens and framing through which they engage with and view the people of South Sudan. These principles will guide how projects should conduct and frame activities. These principles include approaches that:

- Center agency for developing solutions within communities; local solutions solve local problems best.
- Recognize the resilience of the South Sudanese and account for collective trauma, while acknowledging their aspirations for freedom and a better life.
- View stakeholders at all levels through a strength-based lens; everyone has strengths and experience to bring to the table.
- Amplify the voices typically underrepresented in community decision-making processes; focus on the concept of co-design.

Strength-Based Approach

A strength-based approach shifts away from focusing on perceived problems and deficits and instead highlights and leverages strengths, existing assets, and aspirations. In this approach, communities are seen as being full of resources. Through this, individuals are encouraged to identify and foster enabling social environments and health care providers are encouraged to collaborate with their clients and the communities they serve. Guiding principles of this approach include:

- Recognizing individuals as having many strengths and the capacity to continue to learn, grow and change.
- Basing interventions on self-determination.
- Commitment to fostering the power of individuals and/or groups to act on their own behalf and to achieve a greater measure of control in shaping their lives and future.
- Framing problems as the result of interactions between individuals, organizations, or structures rather than deficits within individuals, organizations, or structures.

Conflict Transformation Approach

Justice and fairness are key factors to effective engagement in a fragile context[14]. In South Sudan, societal norms are challenged by a changing environment, including migration and ethnic conflict. Partners working in South Sudan should aim to strengthen opportunities for consensus by adopting a conflict transformation lens. This **relationship-centric** approach will increase opportunities for inclusion of groups traditionally underrepresented in community decision-making processes, such as ethnic minorities, women, and young people. This approach requires intentional effort that:

- Acknowledges underlying conditions giving rise to intergroup conflict.
- Seeks creative solutions aimed at addressing what is happening in human relationships at a deeper level.
- Envisions a framework that holds these together and creates a platform to address the content, the context, and the structure of relationships.

Trauma-informed Tools and Practices

A **strength-based lens** also requires a deliberate shift from "What is wrong with you?" to "What happened to you?" The people of South Sudan have endured decades of violence and displacement due to a protracted Civil War with Sudan and conflict between South Sudanese ethnic groups. In a survey across six states, 40% of respondents showed symptoms consistent with post-traumatic stress disorder[15]. Trauma impacts health seeking behavior and provider trust.

Trauma-informed care increases the agency of communities and individuals in decisions about their health care, increasing trust with providers and decreasing provider burnout. The design and development of SBC tools and processes will apply these principles:

- **Safety** - feeling physically and psychologically safe.
- **Trustworthiness and transparency** - operations and decisions are made with transparency to promote trust among all parties.
- **Peer support** - provision of support when someone has experienced an instance of harassment, abuse, or trauma.
- **Collaboration and mutuality** - establishing accountability measures so that power dynamics are openly acknowledged.
- **Empowerment of voice and choice** - placing the safety and consent at the center of any decision involving them (taking power away from someone who is experiencing abuse/harassment can make healing very difficult).

[14] World Bank. 2012. Societal Dynamics & Fragility: Engaging Societies in Responding to Fragile Situations. Washington, DC. https://openknowledge.worldbank.org/handle/10986/27226

[15] Ng, L. C., López, B., Pritchard, M., & Deng, D. (2017). Posttraumatic stress disorder, trauma, and reconciliation in South Sudan. Social Psychiatry and Psychiatric Epidemiology, 52(6), 705–714. https://doi.org/10.1007/s00127-017-1376-y

- **Cultural, historical, and gender** - incorporates policies, protocols, and processes that acknowledge the ethnic and cultural needs.

Gender and Power

Projects should systematically integrate gender across their work. including each health area in addition to research, monitoring, and evaluation activities, and project operations by:

- Applying SBC methodologies that address intractable or challenging gender-related attitudes, norms, and behaviors that lead to sustainable change in health outcomes.
- Expanding the integration of SBC approaches in service delivery programs that address gender-related factors.
- Strengthening capacity of country partners (e.g., governments, non-governmental organizations, and community-based organizations) to design, implement, and evaluate gender transformative approaches using SBC.

Strategy Objective

To reduce maternal, newborn, and child mortality and morbidity through improving the health seeking experience and reducing provider bias; encouraging timely health-seeking behaviors and practices through increased awareness and knowledge; increasing acceptance and demand of family planning [birth spacing] services; and, contributing to a more enabling environment through education and promotion, community dialogue and more equitable gender norms.

"Sawa Le Baad"

"Sawa Le Baad'' translates to "Together for Each Other". It is an overarching and original SBC brand that provides a culturally appropriate framework to design SBC interventions that seek to build trust, achieve gender equity, balance inequitable power dynamics, and sustain healthy behaviors. The concept reflects the importance and meaning of providing a level playing field - the idea of "justice and fairness" especially regarding gender equity and power relations between men and women, health providers and clients, and community leaders and members. The brand is designed to be unifying and flexible – a "big tent" brand – that encourages trust and inspires equitable access to and engagement with health services.

Brand Manifesto

SAWA LE BAAD

TOGETHER FOR EACH OTHER

سوا لبعض

"Sawa Le Baad" *which translates to "Together for Each Other"* is a call for unity and empathy for one another.

Together we are stronger.
Together we are healthier.
Together we can prosper.

Together as men and women, fathers, and mothers.
Together as one country. Together as one community.

Together for each other starts in the home: men and women making decisions together, listening to each other and supporting one another, setting goals together.

Together for each other is how we build strong communities, with healthy families, with mothers and wives empowered to make decisions, help decide the future of their families and their health.

Guidance

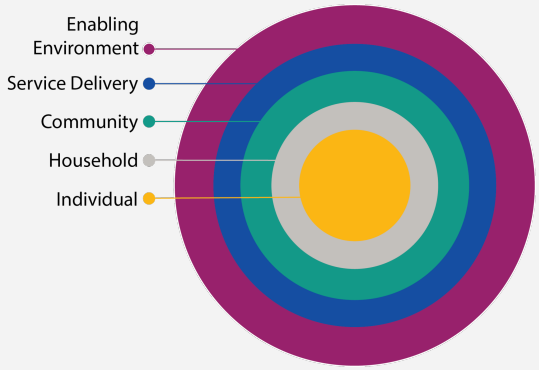
An overarching concept can be used to develop integrated SBC programs designed to cohesively address more than one health or development issue within the same program. Typically, this involves developing a logical and unified SBC strategy that addresses multiple topics and/or behaviors and considers how they relate to, or interact with, one another. A concept like "Sawa Le Baad" can be a launchpad for addressing health topics such as family planning [birth spacing], safe motherhood, antenatal care, delivery at a health facility, and menstrual hygiene.

An overarching concept or brand can be used to:

- Address multiple health topics under a common theme and to group behaviors that are related to each other.
- Bring together partners, communicating the same messages for the same purpose.
- Communicate a vision and program values, such as shared decision-making and gender equity.

Framework

Barriers to change simultaneously exist and operate at multiple levels of the social system. Utilizing a framework to help guide program planning can identify opportunities for collaboration and highlight where projects may need to focus efforts. Breakthrough ACTION South Sudan developed a framework called Pathways™ to Improved Health to identify causal pathways to health behavior outcomes via the socio-ecological model.



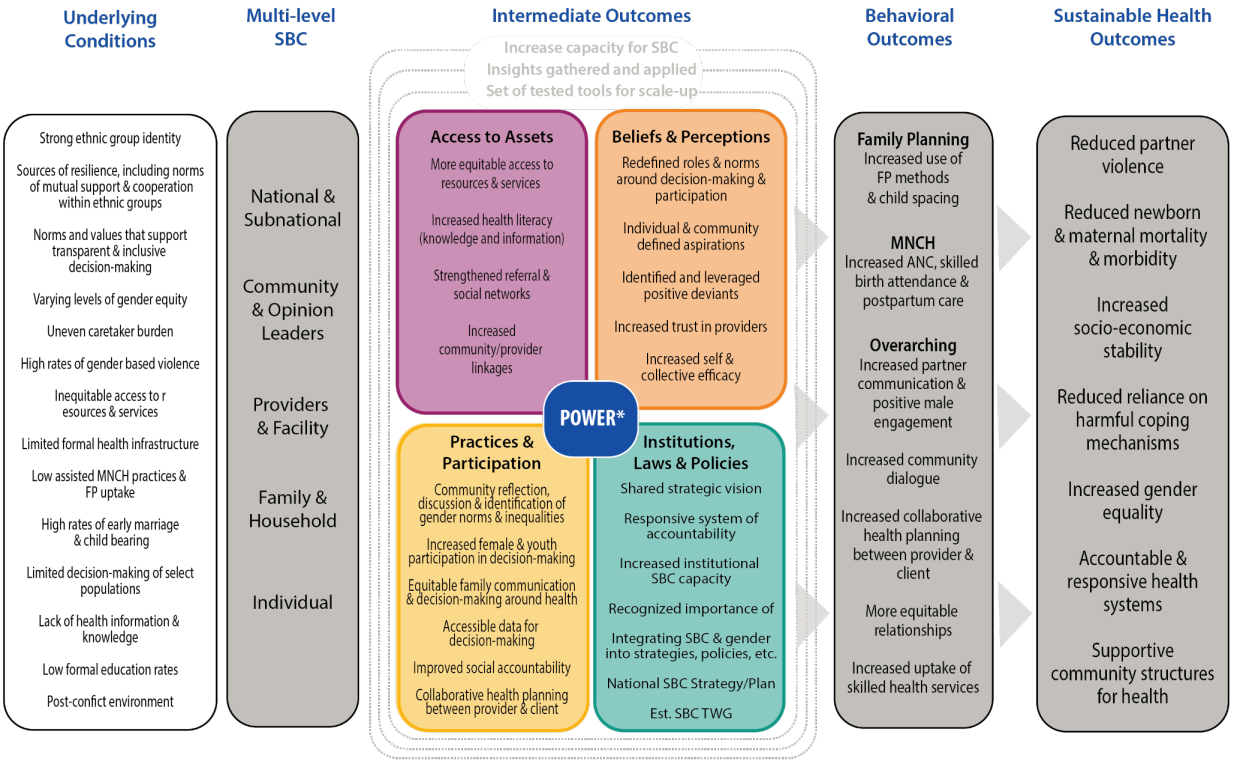
The Socio-Ecological Model recognizes that the determinants of health behaviors extend beyond the individual and exist at multiple interrelated levels[16]. These can include the household and community level through families, peers and community members; through service delivery outlets including outreach channels, clinics and other health facilities; and can be influenced by those policies and guidelines set forth at the national level.

This framework encourages projects to design and test SBC interventions across social-ecological levels, as appropriate: at the individual, family and household, community and opinion leaders,

[16] High-Impact Practices in Family Planning (HIPs). Social and Behavior Change: A Critical Part of Family Planning Programs. Washington, DC: USAID; 2018 Apr.

provider and facility, and subnational and national levels. The framework links specific indicators to multiple outcomes and arranges intermediate outcomes in a gender analysis framework, providing a structure for organizing information about gender roles and relations.

Pathways™ to Improved Health



*Adapted from: Gender Analysis Toolkit (2016). https://gender.jhpiego.org/analysistoolkit/

Guidance

SBC programs are more effective when they are based on social and behavioral science theories or frameworks. A program theory or framework provides a map for looking at the problem, designing interventions and evaluating program success. Based on results from the analyses, we select a theory that will guide the strategy development.

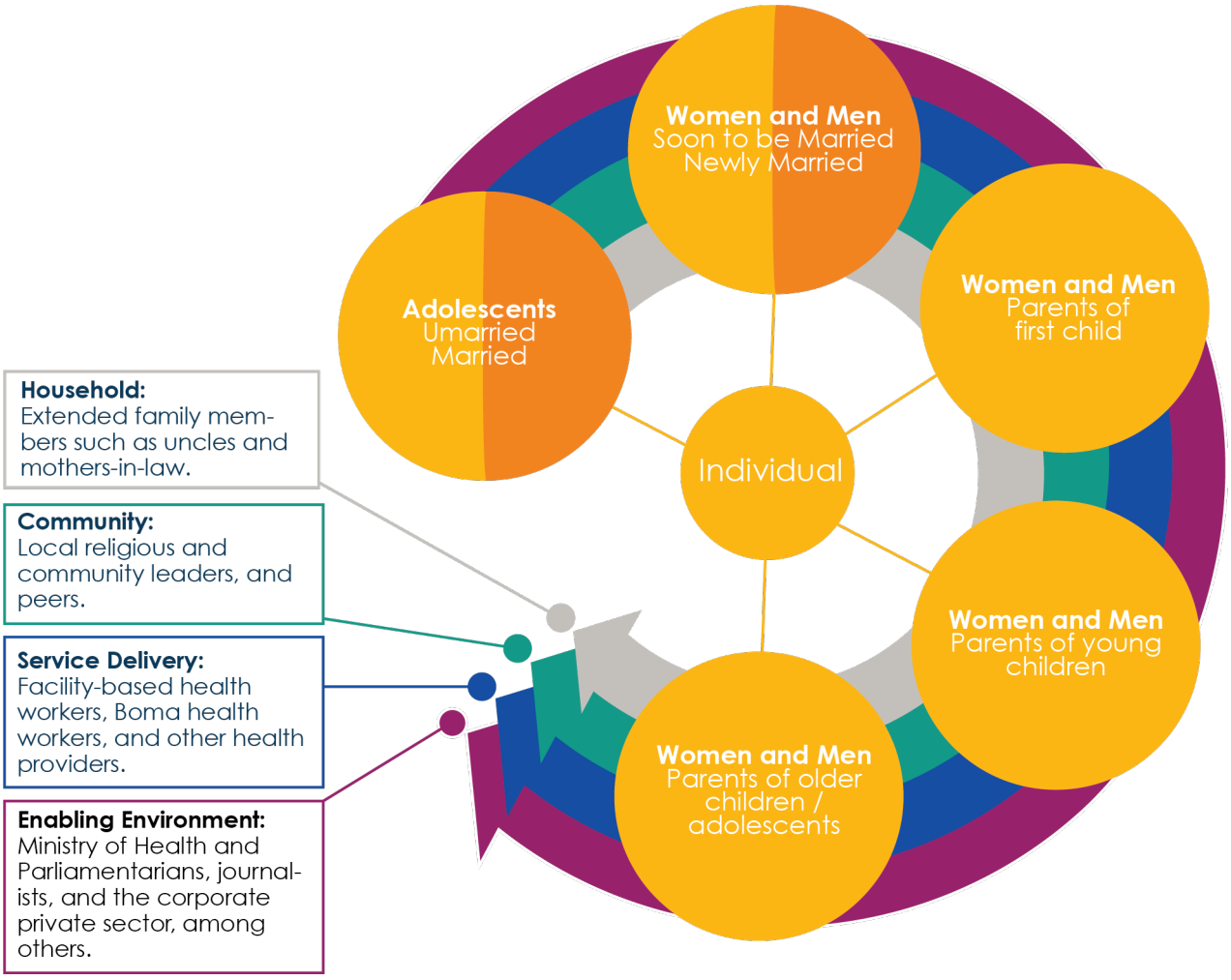
The Pathways model recognizes that social and behavior changes take time, and it outlines what needs to happen to reach those sustainable health outcomes. For the Pathways for Improved Health, we adapted a gender model developed by jhpiego, making it relevant for SBC.

The Pathways model looks at what the **underlying conditions** are and considers what needs to happen across the socio-ecological model to achieve multi**-level SBC**. The **intermediate outcomes** are what we are working towards and can help to inform program design. For example, looking at access to assets, beliefs and perceptions, practices and

participation and institutions, laws, and policies. By designing programs where partners address these intermediate outcomes, we can begin to move towards the **behavioral outcomes**, and over time reach the **sustainable outcomes** collectively identified by stakeholders.

Audience

Described below are audiences grouped across the levels of the socio-ecological model, as well as how audiences at the individual level can be broken up by life stage.



Segmentation "is the process of dividing a large audience into smaller groups of people - or segments - who have similar needs, values or characteristics" within the group with significant

differences from other groups. It "recognizes that different groups will respond differently to social and behavior change communication (SBCC) messages and interventions."[17]

The **lifestage approach** helps to segment the audience and to promote health choices at critical junctures in life based on what is most important and meaningful to people at those times. Identifying and segmenting the audience by life stage takes the perspective that people's own definitions of health and well-being change according to their particular stage in life. In this way SBC interventions can not only identify the primary audience but also the segments within that audience, and to prioritize what is most relevant to that group of people.

- **Individual Level:** At the individual level, the following audiences are identified:
    - Adolescents – Married and Unmarried
    - Women and Men – Soon to be Married/Newly Married
    - Women and Men – Parents of first child
    - Women and Men – Parents of Young Children (2–3 kids, at least 1 or 2 under age five)
    - Women and Men – Parents of older/adolescent children
- **Household Level:** Recognizing that many families live in communal households, it is important to look at who helps and prevents change at the household level. These groups include those extended family members such as uncles and mothers-in-law.
- **Community Level:** There are many community members who influence the above groups, such as local religious and community leaders and peers.
- **Service Delivery Level:** A positive health experience can facilitate continued seeking of health care. Therefore, it is important to explore the relationship between the above individuals and facility-based health workers, Boma health workers, and other health providers.
- **Enabling Environment Level:** Policies and guidelines at the national level can help facilitate change. Therefore, for the project to succeed it is important to work with the Ministry of Health and Parliamentarians to advocate for better health services, journalists for more accurate health reporting, and the corporate private sector, among others.

Guidance

Communication should not be designed to address everyone. Just because two people have the exact same demographic characteristics (age, income, gender, occupation, nationality, etc.), does not mean we should address them in the same ways to change their behavior. Simply put, a 30-year-old woman in an urban area who has never used family planning is not the same as a woman with the same demographic characteristics who has

[17] Source: How to Do Audience Segmentation. (2019). Compass. https://www.thecompassforsbc.org/how-to-guides/how-do-audience-segmentation

had experience with modern contraception in the past. And the way they hear, receive, or understand messages will be very different.

While the audiences listed above begin to segment the general population, they are still broad. For more effective programming, you should further segment based on existing data, research, and experience. Being able to fully understand the needs, challenges, and support systems (or lack thereof) of individuals will help you think through who your program should reach with SBC messaging and interventions. The more you can segment audiences, the more specific you can be in your design.

To see an example of how family planning clients and providers can be segmented see Annex B.

To further understand audience segmentation, please look at How to do Audience Segmentation and Applying Segmentation to SBC in Family Planning for additional support and guidance.

Communication Objectives

Family Planning

- To increase in-depth knowledge of modern family planning [birth spacing] methods [among the audience].
- To increase the self-efficacy [of the audience] to discuss, agree upon as a couple, and plan to access family planning [birth spacing] services.
- To increase the knowledge and understanding [of the audience] of what to do if they have side effects.
- To increase adoption and use a modern family planning [birth spacing] method for at least 2 years after delivery [among the audience].
- To increase those who feel empowered and supported to make their own decisions regarding their family planning [birth spacing] choice.
- To increase the number [of the audience] who access family planning [birth spacing] services.

Maternal Health

- To increase the number [of the audience] who know the importance of attending antenatal care.
- To increase the number [of the audience] who go for timely (within the first trimester) antenatal care.
- To increase the number [of the audience] who go for ANC at least four times to the health facility or skilled birth attendant.
- To increase of the understanding of the importance of having a birth plan.

- To increase the number [of the audience] who can identify the three delays to reaching care during delivery. (1) deciding to seek appropriate medical help for an obstetric emergency; (2) reaching an appropriate obstetric facility; and (3) receiving adequate care when a facility is reached.
- To increase the number [of the audience] who can identify danger signs during and after pregnancy.
- To increase the number [of the audience] who experience danger signs and seek care at the health facility.
- To increase the number [of the audience] who know the importance of receiving postnatal care at 3 and 7 days after delivery for both the mother and baby.
- To increase the number [of the audience] who attend postnatal care (at 3 days, at 7 days, at both) at the health facility.
- To increase the number [of the audience] who sleep under a LLIN every night (correctly and consistently) with her family.
- To increase the number [of the audience] who know the signs and symptoms of malaria.
- To increase the number [of the audience] who seek testing and treatment (if positive) for malaria within 24 hours of onset of fever (during and after pregnancy).

Community Support

- To increase the number [of the audience] who feel empowered and supported to make their own decisions regarding their family planning [birth spacing] choice.
- To increase the number [of the audience] in communities who support women in seeking MCH services.
- To increase the number of individuals that feel all women should be able to equally access health services.
- To increase of number of households and communities that challenge the notion that having a child is solely the responsibility of the woman [care] or man [decision-making, financial] and will support redefined gender norms for men.
- To increase the number of individuals, households and communities will feel inspired to overcome barriers and challenges, working to create a supportive environment that facilitates change, justice and fairness, and togetherness.

Health-Seeking Experience

- To increase the number [of the audience] who have a positive perception of the health facility.
- To increase the number [of the audience] in the clinic's catchment area that feel they were treated with respect by the clinic staff.
- To increase the number [of the audience] who have confidence and trust in the public health sector.

- To increase the number [of the audience] who will continue to demand safe and effective health services for planning their families, including family planning [birth spacing] counseling and MNCH services.
- To increase the number [of the audience] who go to the health facility for treatment and care.

Gender

- To increase the number of women of reproductive age (and her partner) who have the self-efficacy to discuss, agree upon, and plan how best to keep their family healthy.
- To increase the number [of the audience] who provide constructive support (emotional, financial, and/or shared responsibilities) for family planning [birth spacing] and maternal and child health.
- To increase the number [of the audience] who agree that it is important to critically examine social norms that govern men's and women's roles, responsibilities, and expectations.
- To increase the number [of the audience] who recognize that some gender-related social norms [including gender-based violence] are harmful.
- To increase the number [of the audience] who appreciate and equally value sex- and gender-based differences.
- To increase the number [of the audience] who equitably share decision-making and household resources.
- To increase the number [of the audience] who believe that they can make individual, familial, and/or community changes.
- To increase the number [of the audience] who take action to eliminate harmful social norms [including gender-based violence] and/or to support positive social norms.

*__Note:__ The audience should be clearly defined based on who you have prioritized.

Guidance

Communication objectives clearly and concisely state the intended impact of communication efforts. They answer the question, "What can communication do to help reach the vision given the key constraint?" Communication objectives should focus on addressing the key constraint, or biggest communication challenges.

There are several communication objectives identified in this section, and there are many more that can be developed. You do not need to use them all, or you may need to create additional ones.

Review the vision or overall objective set for the work to be sure the communication objectives contribute to that vision. Then, based on the key constraint for each audience

segment, determine what needs to change. The program may need to change behaviors, skills, knowledge, policies, norms, or attitudes. Another way to look at it is to ask, "What do we want our audience to know/feel/do in response to the work?"[18]

To further understand how to develop communication objectives, please look at How to Develop an SBCC Strategy for additional support and guidance.

18 https://thecompassforsbc.org/how-to-guide/how-develop-communication-strategy

Inside the Strategy

Approach

As mentioned above, social and behavior change is the coordinated use of a range of different channels or approaches applied across the social-ecological model to achieve individual and collective behavior change. These can be through the strategic use of communication, community mobilization, social marketing, and knowledge management, as well as best practices from disciplines like human-centered design, behavioral economics, other behavioral sciences, or a combination of overarching approaches.

- **Social and Behavior Change Communication** is the use of communication to change behaviors and the social context in which an individual lives and makes decisions, including service utilization, by positively influencing knowledge, attitudes, and social norms. SBCC is more than just an advertisement or website. SBCC coordinates messaging across a variety of communication channels to reach multiple levels of society.
- **Community Mobilization** is a capacity-building process through which community individuals, groups, or organizations plan, carry out, and evaluate activities on a participatory and sustained basis to improve their health, education, food security, and other needs, either on their own initiative or stimulated by others. Community Mobilization is a continual and cumulative communicational, educational, and organizational process that produces a growing autonomy and conscience.
- **Provider Behavior Change** looks at healthcare providers through a holistic lens. Healthcare providers play a critical role in any health system. Providers need proper support to deliver quality care and help improve health outcomes among clients. Provider behavior is the outcome of a complex set of factors that are both internal and external to providers. Provider behavior change aims to positively shape and influence provider behavior by reducing barriers and challenges to behavior change.
- **Social Marketing** is an approach that uses marketing principles and concepts, such as product and packaging design, pricing, place, and promotion, to influence demand and supply and promote use. The objective is to ensure user-friendly product design, appropriate pricing, efficient sales and distribution, and effective communications to influence the behaviors that benefit individuals and communities for the greater good[19].
- **Knowledge Management** is a strategic process that seeks to collect, curate, and adapt the latest evidence and best practices, and to provide the tools that make it easy to share with those who need it the most. Knowledge Management provides the latest, up-to-the-minute, evidence-based information so that professionals on the ground can do their job well.

[19] Infographic. Social Marketing can Make People Healthier: The Evidence that Social Marketing Works. Population Services International. https://www.psi.org/wp-content/uploads/2017/04/SMEB-infographic_Feb2017.pdf

- **Human Centered Design** is part of a suite of tools that helps to improve outcomes within complex social systems by keeping the human at the center. It is a structured process for moving between a current state and desired future state that sits between empathy, research, and creativity. Human Centered Design seeks to uncover the flaws and opportunities in a particular context, based on an understanding of people's lived experience within it. The insights gathered are then used to co-create potential ideas, build, and test prototypes, and act.
- **Behavioral Economics** is the study of decision-making and behavior in the real world. Behavioral Economics posits that decision-making is subject to systematic and predictable biases and that behavior is strongly influenced by context, such as the timing and presentation of choices or social influence. Behavioral Economics seeks to explain why individuals make decisions the way they do, and why they sometimes do not act in their own best interest so that SBC interventions are better designed, making it easier for individuals to follow through.

Guidance

Decide how the program will accomplish its communication objectives by selecting strategic approaches. Typically, several approaches will be used, either in a phased manner or at the same time.

Review the summary for information about audience needs/preferences and the communication environment. Make a list of approaches that would reach audiences and accomplish communication objectives. Consider the following when selecting approaches:

- Complexity, sensitivity, and magnitude of the problem being addressed
- Effectiveness of the suggested approach for the problem being addressed
- Literacy levels among audiences
- Desired reach
- Cost of approach
- Age, media and digital access, and other relevant audience characteristics
- Theories selected[20]

To further understand how to select the right approach, please look at How to Develop SBCC Creative Materials for additional support and guidance.

The strategic approaches discussed below are illustrative of the types of approaches relevant to this topic. No one approach should be used independently, rather a strategic selection should be developed based on the audience, desired behavior change, communication objectives, and

[20] https://thecompassforsbc.org/how-to-guide/how-develop-communication-strategy

messages. A thoughtful media mix with consistent messaging across the different media can help to ensure "dose response" and have a more meaningful impact.

Table 1: Overview of Forms of Strategic Communication[21]

	**Advocacy:** Operates at the political, social, and individual levels, and works to mobilize resources and political and social commitment for social change and/or policy change. Advocacy aims to create an enabling environment at any level, including the community level (e.g., traditional government or local religious endorsement), to ask for greater resources, encourage allocating resources equitably, and remove barriers to policy implementation.
	**Counseling:** Based on one-to-one communication and is often done with a trusted and influential communicator, such as a counselor, teacher, or health provider. Counseling tools or job aids are usually also produced to help clients and counselors improve their interactions with service providers trained to use the tools and aids.
	**Digital Media:** Fast growing and evolving approach, with an increasing reach throughout the world. This approach includes web sites, short message service (SMS), e-mail, listservs, Internet news feeds, chat rooms, virtual learning, and eLearning, eToolkits and message boards. Digital media is unique in being able to disseminate highly tailored messages to the intended audience, while also receiving feedback from them and encouraging real-time conversations, combining mass communication and interpersonal interaction. Interactive digital media providing such tailored health information can be effective in helping people manage diseases, access health services, and obtain social support or provide assistance in changing behaviors.
	**Distance Learning:** Provides a learning platform that does not require attendance at a specific location. Rather, the students access the course content either through a radio or via the Internet and interact with their teacher and fellow classmates through letters, telephone calls, SMS texts, chat rooms or Internet sites. Distance learning courses can focus on training communication specialists, community mobilizers, health educators and service providers.
	**Entertainment Education:** Entertainment Education is designed to both entertain and educate, intentionally weaving important health and social issues into powerful storytelling that draws in viewers by the millions. Entertainment Education, when designed in a way that resonates with the audience, can be a catalyst for change.

[21] Adapted from: Demand Generation I-Kit for Underutilized, Life Saving Commodities https://sbccimplementationkits.org/demandrmnch/strategic-approaches/

	**Interpersonal Communication/Peer Communication:** Based on face-to-face communication—could be peer-to-peer communication or communication with a community health worker, community leader, or religious leader.
	**Mass Media:** Mass media can reach large audiences cost-effectively through the formats of radio, television, newspapers, and social media. According to a review, mass media campaigns that follow the principles of effective campaign design and are well executed can have small to moderate effect size not only on health knowledge, beliefs, and attitudes, but on behaviors, as well[22]. Given the potential to reach thousands of people, a small- to moderate-effect size will have a greater impact on public health than would an approach that has a large effect size, but only reaches a small number of people.
	**Mid Media:** Mid-media's reach is less than that of mass media but may allow for greater engagement. Mid-level media may include activities such as roadshows, health fairs, sports competition, and community or folk theater.
	**Print Media:** Print media, such as flipcharts, job aids, posters, and leaflets, is often used to address the informational needs of clients and support client-centered counseling.

Messaging

This section outlines the overarching key messages for the priority areas identified above. These messages focus on the idea that decisions individuals and families make now will have an impact on their future health.

To see the complete list of Sawa Le Baad materials see Annex C.

22 Noar, Seth M. (2006). A 10-year retrospective of research in health mass media campaigns: where do we go from here?

Guidance

When SBC materials and interventions carry well-designed messages that are closely linked to audience needs and the communication objectives developed, they will more effectively persuade the priority audience to change or adopt new behaviors.

As you apply this strategy, you may need to adapt the messages for your identified audiences. For each audience, outline the core information – key message points – that should be conveyed in all messages and activities, by all partners implementing the strategy. These key message points will be delivered in different ways depending on the approach. Keep in mind, key message points are not the same as the final creative messages delivered via the various approaches and channels. They are the main ideas that should be included in the final creative messages[23].

To further understand message development, please look at How to Design SBCC Messages for additional support and guidance.

Priority Area: Maternal, Newborn and Child Health

Together, we are going to the health center for antenatal care.

- Having a healthy baby begins with ANC.
- As soon as you think you are pregnant, visit the health facility (with your partner).
- Tell someone you trust about your pregnancy early on so they can support you.
- Pregnant women should attend ANC at least 4 times before delivery and once within the first 3 months of pregnancy.
- Support your partner during pregnancy for the health of her and the baby.

- [MEN] Accompany your partner for antenatal visits from the first trimester.
- [FAMILY] Encourage your daughter to go for early ANC during the first trimester.
- [HW] Encourage pregnant women to go for early ANC during the first trimester.
- [HW] Support the pregnant woman during pregnancy for the health of her and the baby.

Together, we're building a better future.

[23] https://thecompassforsbc.org/how-to-guide/how-develop-communication-strategy

Together, we are making a plan for our baby.

- It is important to plan carefully for a child's birth and to have a birth plan in place.
- Even a normal pregnancy can end up in a complicated delivery needing emergency care. Families should prepare for it beforehand by saving money, arranging transport and deciding about the appropriate health facility for emergency care.
- Having a birth plan will help ensure a healthy outcome for you and your baby.

- [MEN] Support your partner during pregnancy for the health of her and the baby.
- [FAMILY] Support your daughter to make a plan for her and baby.
- [HW] Support the pregnant woman during pregnancy for the health of her and the baby.
- [HW] Advise and plan with pregnant women for early safe delivery at HF.

Together, we're building a better future.

Together, we are learning the danger signs during pregnancy to keep mama and baby safe.

- All couples should learn about and know the danger signs of pregnancy. These include:
  - Bleeding even if it is a single spot
  - Fits/seizures
  - Severe headache or blurring of vision
  - Swelling on hands or feet
  - Severe pain in lower abdomen
- If you experience any of the danger signs, visit your health care provider immediately.

- [MEN] Support your partner during pregnancy for the health of her and the baby.
- [HW] Support the pregnant woman during pregnancy for the health of her and the baby.

Together, we're building a better future.

Together, we are delivering our baby at a clinic.

- If you are expecting a baby, make a plan to deliver at a health facility. It is the safest way for mama and baby,

- [FAMILY] Support your daughter to plan early for safe delivery at HF.
- [HW] Advise and plan with pregnant women for early safe delivery at HF.

Together, we're building a better future.

Together, we are going to the health center for post-natal care.

- Going for postnatal care can save the life of you and your baby.
- The days following childbirth are critical in the lives of mothers and newborn babies.
- All mothers and their new babies should receive a post-natal check-up before leaving the health facility and again from a Boma health worker within two and seven days of delivery, even if you do not have a problem.

Together, we're building a better future.

Together, we are learning the danger signs after delivery to keep mama and baby safe.

- All couples should learn about and know the danger signs for the mother and child after delivery. These include:

  Mother:
  - Severe bleeding or persistent bleeding even in smaller amounts
  - Fits/seizures
  - High fever

  Newborn:
  - Unable to feed
  - Blue/dusky discoloration of body
  - Fits
  - All babies born early
- If you experience any of the danger signs, visit your health care provider immediately.

Together, we're building a better future.

Together, we are protecting ourselves and our baby against malaria.

- Anyone can get malaria but pregnant women and children under five are at most risk. To keep you and children healthy, sleep under a long- lasting insecticide treated net every night, consistently and correctly all year round.
- Long lasting insecticide treated bed nets are safe for everyone in the family.
- Everyone in the family should sleep under a long lasting insecticide treated net correctly and consistently.
- All pregnant women receive a free net during ANC.
- If you have a fever, visit the health facility immediately for malaria testing and treatment (if positive).

- [MEN] Encourage your partner to sleep under a treated bed net every night.
- [FAMILY] Advise your daughter to sleep under a treated bed net every night.
- [HW] Advise pregnant women to sleep under a treated bed net every night.

Together, we're building a better future.

Priority Area: Family Planning [birth spacing]

Together, we are planning our family.

- Family planning [birth spacing] methods are safe. If you have side effects, talk to your healthcare provider before you stop using.
- Modern contraceptive methods are a safe way to plan your family to ensure mama and baby have the health and happiness they need.
- Choose short term, long acting, or permanent family planning [birth spacing] methods according to your needs.
- Discuss with your partner on how best to plan your family and make healthy choices as a couple.
- Talk to your healthcare provider early about family planning [birth spacing] options so that you can find the right method after delivery and plan for your family's future.

Together, we're building a better future.

Pretesting

Concept and pretesting are two parts of the process that bring together members of the priority audience to react to the components of a communication campaign before they are produced in final form. For SBC campaigns and materials to be most effective, they should be tested at several stages of development including concept testing, stakeholder reviews, pretesting, and field testing. Although it is not always possible to do all four, at a minimum it is essential that all materials be pretested with the relevant audience.

Concept testing is the process of sharing creative concepts with the intended audience to get their feedback and identify the best idea before designing materials. Results from creative concept testing help the creative team to revise concepts, drop ones that do not resonate well with the

audience and identify the ones the audience likes best. **Pretesting** measures the reaction of the selected group of individuals and helps determine whether the priority audience will find the components understandable, believable, and appealing for social and behavior change campaigns.

The overarching concept and materials provided in this strategy have been both concept and pretested, as well as designed through a co-design process. It is recommended that if the materials are further refined or adapted for specific audiences or for specific regional context, that they be pretested with those groups.

Guidance

The overarching concept and materials provided in this strategy have been both concept and pretested, as well as designed through a co-design process. It is recommended that if the materials are further refined or adapted for specific audiences or for specific regional context, that they be pretested with those groups.

To develop a pretest guide, please look at How to Conduct a Pretest for additional support and guidance.

Monitoring and Evaluation

Seeking stakeholder consensus for monitoring and evaluation of an integrated SBC program is important to set research priorities, allocate appropriate resources, select, and harmonize indicators, facilitate sharing and utilization of data, agree on reporting mechanisms (including how to prevent double counting), and disseminate findings.

As this consensus is reached, all stakeholders should have a clear understanding of the implications of integration on what will be required to effectively monitor and evaluate the program. For example, an integrated program may need to track more indicators than a vertical program would, because it addresses a broader range of health issues. The data collection and analysis may also be more complex, requiring multiple data sources and, therefore, additional resources.

It is important to let partners know early what kinds of information will be needed and which partners may need to be responsible for each (e.g., service delivery partners for service statistics or referral data, media partners for message dissemination data, community outreach partners for activity and event data, private sector partners for sales data, and so on). Collecting referral and service delivery data could be more challenging for integrated SBC efforts if different programs or organizations collect and manage different parts of the data needed. For example, the reproductive health program manages the family planning [birth spacing] service data while the MNCH program manages the child health data. As integrated programs complicate the "chain of custody"

of the data, partners must agree on who collects which data, how, and how often, as well as how to share, analyze, and report on it.

Open access to data can help technical and managerial stakeholders track progress more easily, without having to always rely on their research, monitoring, and evaluation teams. This may take the form of a Routine Health Information System, where SBC service utilization and other data is collected from health facilities and consortium partners on a routine basis and then aggregated into a single database. A dashboard function would allow stakeholders and technical and management staff to track progress and make course corrections, if necessary, as well as see how different program components are moving together.

Research, monitoring and evaluation should be on the agenda of all coordinating body meetings. There may also be a need to create additional working groups or task forces for research, monitoring, and evaluation. When creating such teams, involve those with quantitative as well as qualitative experience, those with expertise in the respective vertical health areas, as well as those with experience in program integration to the extent possible. Ensure all topical areas are represented, and clearly articulate roles and responsibilities[24].

For a complete table of recommended indicators, please see Annex D.

Guidance

A monitoring and evaluation plan is a document that helps to track and assess the results of the interventions throughout the life of a program. It is a living document that should be referred to and updated on a regular basis. While the specifics of each program's M&E plan will look different, they should all follow the same basic structure and include the same key elements.

The indicators provided relate to the communication objectives listed in this strategy. If additional objectives are developed or revised, the indicators should be revisited.

To develop a monitoring and evaluation plan, please look at How to Develop a Monitoring and Evaluation Plan for additional support and guidance.

[24] https://sbccimplementationkits.org/integrated-sbcc-programs/research-monitoring-and-evaluation/coordinate/

Annex A: Literature Review - Summary Table

Background Information

Title/Topic	Citation	Summary
Total Population	Population, total - South Sudan. Data. (n.d.). Retrieved September 21, 2021, from https://data.worldbank.org/indicator/SP.POP.TOTL?locations=SS	11,062,113 (2019)
Fertility Rate	South Sudan. Institute for Health Metrics and Evaluation. (2017, September 19). Retrieved September 21, 2021, from http://www.healthdata.org/south-sudan	5.5 (2019)
Maternal Mortality Rate	UNICEF (2021, April). Health briefing note. UNICEF South Sudan. Retrieved September 24, 2021, from https://www.unicef.org/southsudan/media/7691/file/Health%20Briefing%20Note%202021%20Q2.pdf	789 maternal deaths per 100,000 live births
Under five mortality rate	South Sudan (SSD) - demographics, health & infant mortality. UNICEF DATA. (2020, February 6). Retrieved September 21, 2021, from https://data.unicef.org/country/ssd/	96.2 deaths per 1000 live births Male: 101 Female: 91
South Sudan: COVID 19 and Family Planning	South Sudan. Family Planning, 2020. (2021, April 27). Retrieved September 21, 2021, from http://www.familyplanning2020.org/south-sudan	mCPR all women (2019): 3.9% mCPR married (2019): 5% Method mix: (2010) - LAM- 29.4% - Pills- 17.6% - Injectables- 23.5% - Sterilization- 5.9% - Condom- 23.5%

<table>
<tr><td>Top risk factors that drive the most death and disability combined</td><td>South Sudan. Institute for Health Metrics and Evaluation. (2017, September 19). Retrieved September 21, 2021, from http://www.healthdata.org/south-sudan</td><td>Malnutrition, WASH, Air Pollution and Unsafe Sex</td></tr>
<tr><td>What causes the most death and disability combined</td><td>South Sudan. Institute for Health Metrics and Evaluation. (2017, September 19). Retrieved September 21, 2021, from http://www.healthdata.org/south-sudan</td><td>● Neonatal disorders, lower respiratory infection
● Diarrheal disease
● Malaria</td></tr>
<tr><td>Female Population</td><td>Population, female - South Sudan. Data. (n.d.). Retrieved September 21, 2021, from https://data.worldbank.org/indicator/SP.POP.TOTL.FE.IN?locations=SS</td><td>5,525,584 (2019)</td></tr>
<tr><td>Male Population</td><td>Population, male - South Sudan. Data. (n.d.). Retrieved September 21, 2021, from https://data.worldbank.org/indicator/SP.POP.TOTL.MA.IN?locations=SS</td><td>5,536,529 (2019)</td></tr>
<tr><td>Male literacy rate</td><td>South Sudan. UNESCO UIS. (2017, April 12). Retrieved September 22, 2021, from http://uis.unesco.org/en/country/ss</td><td><table><tr><td>Ages 15-24</td><td>48.4</td></tr><tr><td>Ages 15 and older</td><td>40.3</td></tr></table></td></tr>
<tr><td>Female literacy rate</td><td>South Sudan. UNESCO UIS. (2017, April 12). Retrieved September 22, 2021, from http://uis.unesco.org/en/country/ss</td><td><table><tr><td>Ages 15-24</td><td>47.4</td></tr><tr><td>Ages 15 and older</td><td>28.9</td></tr></table></td></tr>
<tr><td>Adolescents out of school</td><td>South Sudan. UNESCO UIS. (2017, April 12). Retrieved September 22, 2021, from</td><td>Male: 161,869 (2015)
Female: 128,350 (2015)

Total Adolescents (15-24 years): 2,238,000</td></tr>
</table>

	http://uis.unesco.org/en/country/ss	
MICS 2010 household health survey	Household health survey 2010. South Sudan - Household Health Survey 2010. (n.d.). Retrieved September 22, 2021, from https://microdata.worldbank.org/index.php/catalog/2588/related-materials	Adolescents (age 15-19): • Birth rate 158 live births per 1,000 women and • TFR: 7.5 children per woman • 26% have given birth Northern Bahr El Ghazal and Western Bahr El Ghazal have the highest TFR - 8.1 children per woman Contraceptive use amongst married women is low- report states on 4% use any methods of contraception Range of TFR is 7.9-6.9 (poorest-richest); not much difference between urban and rural (7.4 and 7.5 respectively) In terms of age, 98% of the younger women (ages 15-19) who were married or in union did not use contraceptive methods, with only 1% using any kind of modern method. The methods specifically used are periodic abstinence/rhythm method (0.8%), male condoms (0.6%) and pills/withdrawal (0.3%) 15-49 years of age: 96% of women do not use any form of contraceptive methods. 1% use modern contraceptives 3% use traditional methods. Report notes that there is no difference in contraceptive method usage "across residence, age groups, economic status". Women with secondary and higher education were 14% more likely to use contraceptive methods than those with no education
SOUTH SUDAN FP2020 Core Indicator Summary Sheet: 2018-2019 Annual Progress Report	South Sudan FP2020 Core Indicator Summary Sheet: 2018-2019 Annual Progress Report. (n.d.). Retrieved September 21, 2021, from https://www.familyplanning2020.org/sites/default/files/Data-Hub/2019CI/South_Sudan_2019_CI_Handout.pdf	Unmet need for modern contraceptive for married women: 30.6% (2019) mCPR all women- 3.9% estimate for 2019
LQAS Survey Report	Devkota, B., Anguyo, R., Jeffery, C., Laku, D. R.,	The use of modern contraceptive methods in South Sudan is exceptionally low with only 4.3% of women 15-49 years

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<td></td>
<td>& Valadez, J. J. (n.d.). (rep.). Republic of South Sudan National Household Health Survey 2020 LATH-South Sudan 07 May 2021 (pp. 2–107).</td>
<td>old reporting use of modern methods such as the pill, condom, IUD, sterilization, injection, implant, diaphragm, or cervical cap

The measure of the unmet need in this study was women 15-49 years who were married or living together and not wanting child for next two years
and never used contraceptives either by herself or by her spouse/partner

Table below shows: Women 15-49 years who are currently using (or whose partner is using) any modern method of family planning

<table>
<tr><td>NHSSP Target*</td><td>2011</td><td>2015</td><td>2020</td></tr>
<tr><td>8%</td><td>6.5%</td><td>5.0%</td><td>4.3%</td></tr>
</table>
*NHSSP=National Health Sector Strategic Plan

Long distance to health facilities was reported as the leading barrier to access and continuous utilization of health care.
Efforts should be made to empower the boma health workers to deliver (at the community) all the packages of maternal, newborn and child health services that are within their mandate in order to improve geographical accessibility and timeliness of care.

</td>
</tr>
<tr>
<td>Water, Sanitation and Hygiene (WASH) in South Sudan Briefing note</td>
<td>Unicef. (n.d.). Water, Sanitation and Hygiene (WASH) in South Sudan Briefing note. Retrieved September 21, 2021, from https://www.unicef.org/southsudan/media/5086/file/WASH_Briefing_Note_June_Final.pdf</td>
<td>Nation-wide WASH indicators

40% have access to safe water
62% practice open defecation
Funding shortfalls have affected proper delivery of services.

</td>
</tr>
</table>

Social Norms and Attitudes towards Family Planning

Title/Topic	Citation	Summary
Social norms and family planning decisions in South Sudan	Kane, S., Kok, M., Rial, M., Matere, A., Dieleman, M., & Broerse, J. E. W. (2017, June 19). Social norms and family planning	Men usually have the most say in almost all decisions at home, including how many children a woman should have Friends, family and/or communities can be a huge hindrance to family planning, especially if they do not have as many children

	decisions in South Sudan. Vrije Universiteit Amsterdam. Retrieved September 21, 2021, from https://research.vu.nl/en/publications/social-norms-and-family-planning-decisions-in-south-sudan	Religion plays a huge role when it comes to family planning Health center service provision perceptions also play a role in hindrance of family planning use Overall side effects/perceived side effects of contraceptive use based on other community members prevent women from using the available methods
Social norms and family planning decisions in South Sudan (Western Bahr el Ghazal)	Kane, S., Kok, M., Rial, M., Matere, A., Dieleman, M., & Broerse, J. E. W. (2016). Social norms and family planning decisions in South Sudan. BMC Public Health, 16(1). https://doi.org/10.1186/s12889-016-3839-6	Traditional leader viewpoints: ● Bearing a child is a gift from God, if you give birth to 10-12 children then you are lucky ● Against back-to-back pregnancy. In support of child spacing Health personnel viewpoint: ● Health personnel claimed that if the young people want to have kids then they can because they have the rights to do so. This used to also happen in the past so shouldn't be an issue today. There's a belief that foreigners are attempting to deny their rights to having children Men viewpoint: ● Precedence set by previous generation (i.e. parents in the past did not use contraceptives) ● Conflicting understanding that spacing is not encouraged in the community (mocked by peers/family members, see below) Community viewpoint: ● When married couple have not been able to bear kids or aren't pregnant within the first 6 months or so, they are ridiculed and pressured to move on to other people who will help them bear children ● In general, birth spacing is very much encouraged. If a woman becomes pregnant right after having a child (within 2 years) then she (and her family) is frowned upon and punished.
Behavioral study on utilization of Safe Motherhood services in South Sudan	(2020). (rep.). Behavioral Study on Utilization of Safe Motherhood Services in South Sudan.	Sentiments expressed about FP: ● Unplanned pregnancy while the woman has a young baby- punishment by community ● Men insist on another child even if the woman is weak- they do not want to discuss family planning ● Women have to go behind their husband's back to attain contraceptives after giving birth- husband's objection ● In terms of attaining FP methods, important to users to follow social norms (i.e. not easy for people to do something that not everyone supports) ● Side effects of family planning has kept many away

		from using contraceptive method and rely on counting safe days ● The bearing of many children is considered a blessing and restitution of bride-wealth
Family planning attitudes, acceptance of contraception	Ackerson, K., & Zielinski, R. (2018). "Family planning will mean that there will not be any babies" - knowledge, beliefs, and acceptance of contraception among South Sudanese women. Clinical Obstetrics, Gynecology and Reproductive Medicine, 4(2). https://doi.org/10.15761/cogrm.1000212	*The participants in this study used to live in rural villages in South Sudan but have moved to camps since conflict* Contraceptives are not accepted as a cultural norm; however, this ideology has changed as the population has moved from their villages to populated refugee camps. Training for FP use is taken into consideration, however, hard to implement because it is not culturally accepted. Belief that contraceptive use indicates that the woman promiscuous (i.e., "loose behavior") High child mortality rate may contribute to birthing more children (to offset loss) Birth spacing is recognized but is done through abstaining sex rather than using contraceptive methods. Women want to learn but say that they won't use the methods Women who fail to abstain from sex during breastfeeding. There is a belief that engaging in sex will make breastfeeding child ill.
GAC share out meeting	BBC Media Action. (2021, September). Amplifying Women's Voices. GAC share out meeting. BBC Media Action.	School teachers, peers, parents, and health workers play a huge role in terms of debunking myths and social stigma around family planning
MICS 2010 household health survey	Household health survey 2010. South Sudan - Household Health Survey 2010. (n.d.). Retrieved September 22, 2021, from https://microdata.worldbank.org/index.php/catalog/2588/related-materials	Attitudes towards GBV: ● Women who face violence at home are assumed to agree with the statement that it is justified for husbands to be abusive towards their wives if they disobey ● There isn't a significant difference in the perception of GBV amongst women within different wealth quintiles or areas of residence (urban vs. rural). ● GBV acceptance is higher in Warap (88%) and lowest in Western Bahr El Ghazal (74%). Not much difference.

National Family Planning Commitments and Strategies

Title/Topic	Citation	Summary
National health strategy	The Republic of South Sudan National Health Policy 2016-2026. (2016, May). Retrieved September 21, 2021, from https://extranet.who.int/countryplanningcycles/sites/default/files/planning_cycle_repository/south_sudan/south_sudan_national_health_policy_2016_to_2025_2.pdf	Inclusion of this document serves to highlight the absence of sexual and reproductive health from the national health strategy.
FP2020 South Sudan commitment for FP | actions for acceleration	Making a Commitment to FP2020. Family Planning 2020. (n.d.). Retrieved September 21, 2021, from http://www.everywomaneverychild.org/wp-content/uploads/2016/11/South-Sudan.pdf FAMILY PLANNING 2020 COMMITMENT GOVT. OF SOUTH SUDAN. FAMILY PLANNING 2020. (n.d.). Retrieved from http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2017/08/Govt.-of-South-Sudan-FP2020-Commitment-2017-Update.pdf South Sudan Actions for Acceleration . FAMILY PLANNING 2020. (n.d.). Retrieved September 21, 2021, from https://www.familyplanning2020.org/sites/default/files/South_Sudan_2	The government of South Sudan made the following policy commitments: ● Create enabling environment (e.g. policy on task shifting and community-based interventions, protocols, guidelines and tools) to support family planning and integrated SRH services and reproductive health rights; ● Develop National Costed Implementation Plan for Family Planning by 2019; ● Increase access to reproductive health information and services through implementation of the National Health Policy, Health Sector Development Plan and the Boma Health Initiative; and ● Develop a national action plan to combat early/ child marriage. The government of South Sudan made the following financial commitments: ● Increase the portion of national budget dedicated to health, from 1% in 2017 to 4% by 2020; ● Establish a dedicated budget line in the Ministry of Health (1% of MOH budget) for Reproductive Health and Family Planning from the 2017/18 budget The government of South Sudan made the following service delivery commitments: ● Increase the proportion of service delivery points providing rights-based family planning counselling and methods to at least 25% at all levels; ● Integrate information and services for gender-sensitive and age-appropriate family planning, sexual and reproductive health, HIV/ AIDS and gender-based violence prevention and treatment at facility and community levels; ● Strengthen coordination and collaboration between stakeholders to improve reproductive health service

	018-2019_Actions_for_Acceleration.pdf	delivery, capacity building, and supply chain management of reproductive health commodities; and • Promote public-private partnerships to enhance service delivery through the private sector, and support last mile distribution of reproductive health commodities to fulfil the unmet need of remote and under-served communities.
REPUBLIC OF SOUTH SUDAN MINISTRY OF HEALTH HEALTH SECTOR DEVELOPMENT PLAN 2012-2016	REPUBLIC OF SOUTH SUDAN MINISTRY OF HEALTH HEALTH SECTOR DEVELOPMENT PLAN 2012-2016. (n.d.). Retrieved September 21, 2021, from http://extwprlegs1.fao.org/docs/pdf/ssd175444.pdf	South Sudan has one of world's highest MMRs 90% of the population live in rural areas No changes in contraceptive prevalence rate in the periods covered which may indicate that the end goal may not be immediately attainable. Reproductive health is dependent on Development Assistance for Health (DAH) funding
South Sudan 2019 Sustainability Index and Dashboard Summary	South Sudan 2019 Sustainability Index and Dashboard Summary. (n.d.). Retrieved September 21, 2021, from https://www.state.gov/wp-content/uploads/2019/12/South-Sudan-SID-2019.pdf	Formal user fees exist for SRH services Condom procurement is not funded locally/domestically
The Boma Health initiative costing and investment case analysis, April 2019	The Boma Health Initiative Costing and Investment Case Analysis April 2019. (n.d.). Retrieved September 21, 2021, from https://www.unicef.org/southsudan/media/2031/file/South-Sudan-2019-BHI-Costing-Investment-Case-Analysis.pdf	Access to reproductive health services remain critically low Vast majority of women deliver at home Common barriers to seeking SRH services: lack of information, cultural attitudes, misinformation, lack of preparedness Boma SRH/FP service package: BHW work closely with Community Health Committees, Community Health Volunteers, and Champions and key opinion leaders BHWs will be trained to provide promotion, prevention and basic treatment services for: 1. Maternal and newborn health 2. Family planning 3. HIV/AIDs 4. GBV

		5. Adolescent and Youth SRH. The FP service package includes the following ● FP information and counselling ● Combined oral contraceptives (COCs) to new and revisit clients ● Progesterone only pills (POPs) to new and revisit clients ● Male condom as a means of birth spacing and HIV/STI prevention ● Emergency contraceptive pills ● Sayana Press (to new and revisit clients in hard-to-reach areas where BHWs have been trained) *Note about program limitations:* "Funded by international donors and largely managed by national and international NGOs, the government has had limited ownership and oversight of community health programmes in the absence of a detailed overarching community health framework."
South Sudan: Reproductive Health Commodity Security Situation Analysis	South Sudan: Reproductive Health Commodity Security Situation Analysis. USAID DELIVER PROJECT. (2014, July). Retrieved September 21, 2021, from https://www.rhsupplies.org/uploads/tx_rhscpublications/South_Sudan_Reproductive_Health_Commodity_Security_Situation_Analysis.pdf	Recommends behavior change communication campaign that increases contraceptive acceptance among both men and women. The report specifically recommends focusing on efforts need to destigmatize family planning and increasing child spacing. The recommendations state that SBC efforts should be directed toward the young, urban, and more educated population, who are more likely to accept the use of contraception. SBC opportunities to increase demand strategy include establishing a national SBC strategy in order to ensure messages are harmonized and standardized to support the delivery of RH service. Because of the favorable attitudes toward child spacing, the report recommends using the term "child spacing" instead of "family planning".
Analyzing, Interpreting, and Communicating Routine Family Planning Data in South Sudan	Analyzing, interpreting, and communicating routine family planning data in South Sudan. Analyzing, Interpreting, and Communicating Routine Family Planning Data in South Sudan - MEASURE Evaluation. (2019, May 20). Retrieved September 21, 2021, from http://www.measureeva	Lack of up-to-date FP guidelines and other relevant data, including availability of contraceptives Lack of data for communication specific to FP/RH at health facility level High level of unresponsiveness by health facilities regarding FP data

	luation.org/resources/publications/wp-19-231/	
Strengthening Sexual and Reproductive Health and HIV prevention amongst children and young people through promoting comprehensive sexuality education in Eastern and Southern Africa January-December 2017 Annual Report	UNESCO Annual Progress Report 2017: Strengthening sexual and reproductive health and HIV prevention amongst children and young people through promoting comprehensive sexuality education in eastern and Southern Africa: Digital Library: Comprehensive Sexuality Education Learning Platform. Our Rights, Our Lives, Our Future | Comprehensive Sexuality Education Learning Platform. Retrieved September 23, 2021, from https://cse-learning-platform-unesco.org/digital-library/unesco-annual-progress-report-2017-strengthening-sexual-and-reproductive-health-and	Partnership with a radio station called Wanasa Dukuri in South Sudan, UNESCO a radio programme was launched resulting in active engagement of more than five million young people, on CSE and other SRHR subjects Discusses challenges faced by young people which include peer pressure, early sexual debut, gender-based violence, adolescent pregnancies, early marriage, HIV among other health related topics *Note: this will be important to revisit when evaluation of the program and its elements becomes available*
Behind the scenes: International NGOs' influence on reproductive health policy in Malawi and South Sudan	https://pubmed.ncbi.nlm.nih.gov/29537338/	At the start of DFID's program, South Sudan was classified as having "unformed operating environments,' characterized by structural and systemic barriers to reform and service provision Abortion, though widely considered sinful and heavily stigmatized in both places, remains frequent, reflecting very low modern contraceptive prevalence rate Unsafe abortions are a major cause of South Sudan very heavy burden of maternal mortality, ranked first in East Africa

Maternal, Newborn, and Child Health (MNCH)

Title/Topic	Citation	Summary
Determinants of Health Facility Utilization at Birth in South Sudan- Jubek State	Tongun, J. B., Mukunya, D., Tylleskar, T., Sebit, M. B., Tumwine, J. K., & Ndeezi, G. (2019, July 9). Determinants of health facility utilization at birth in South Sudan. International journal of environmental research and public health. Retrieved September 21, 2021, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6651414/	Direct relationship between ANC visits associated and likelihood of health facility births (women who completed 4 or more ANC visitation were 1 time more likely to deliver at health facilities compared to those who did not attend ANC visits) Higher education correlates with likelihood to give birth in hospital and to engage in health seeking behaviors Women with higher socioeconomic status were more likely to give birth at facilities than those with lower socioeconomic status. Barriers to women with lower socioeconomic status included lack of transportation and inability to fulfill other indirect costs.
Barriers to institutional childbirth in Rumbek North County, South Sudan: A Qualitative Study	Wilunda, C., Scanagatta, C., Putoto, G., Takahashi, R., Montalbetti, F., Segafredo, G., & Betrán, A. P. (2016, December 15). Barriers to institutional childbirth in Rumbek North County, South Sudan: A qualitative study. PLOS ONE. Retrieved September 22, 2021, from https://journals.plos.org/plosone/article?id=10.1371%2Fjournal.pone.0168083#:~:text=Some%20qualitative%20studies%20have%20reported,country%20%5B7%2C%208%5D	**Access to transportation** to health facilities along with poor road infrastructure is a barrier to accessing health services. Some women note that even if people have money, the transportation barriers make it difficult to attain services. Women note that it could take almost a whole day to reach hospitals. Sense of powerlessness and hopelessness on the outcome of birth due to this matter among women was noted. Women in cattle camps note the gravity of this situation due to population movement that prioritizes finding good grazing grounds **Cost of childbirth services** at health facilities (*note: the report states that it was not clear whether these costs are official or under-the-table as participants were unable to differentiate*) Any user fee at health facilities increases negative attitudes in attending services for childbirth Some go to hospitals for help and end up returning as they do not have money to pay for the delivery. TBA at home was not associated with direct costs (women paid TBAs with alcohol, tobacco, calabash bowl for their help with delivery) **Insecurity of South Sudan** adds to the fear of delivering in hospitals. Examples include attacks from neighboring communities or inter-clan feuds, displacement of people, and destruction of property.

		Influence of husbands/male partners is another driving factor- man decides where the woman gives birth. If they refuse to let the women go to the hospital, then a woman will not give birth in a hospital. **Lack of preparation for childbirth** because traditionally there is no preparation, so health facility attendance is abrupt and only when in labor **Traditional views** have led most women to deliver at home (e.g., handling of placenta and its burial). Home births have been the norm for generations. **Many are unaware of delivery benefits** at hospitals compared to at home. Although they note that some hospitals offer incentives and free of-charge delivery **Some perceive childbirth to be simple and low risk** and it is a practice that is heavily influenced by traditions and cultures (e.g., what the past generation did). Childbirth is perceived as a natural process that does not require hospital visitation. The decision to attend hospital if a woman is facing difficulties is often left to husbands/male relatives.
Risk factors for non-use of skilled birth attendants: analysis of SS household Survey, 2010	Mugo, N. S., Dibley, M. J., & Agho, K. E. (2016, June). Risk factors for non-use of skilled birth attendants: Analysis of South Sudan Household Survey, 2010. Maternal and child health journal. Retrieved September 22, 2021, from https://pubmed.ncbi.nlm.nih.gov/26961143/	Mother's level of education was strongly associated with the non-use of SBA (i.e., the higher her literacy level, the more likely she is to attend health facilities) **Non-use of SBA was higher among:** ● Women who were never married ● Mothers with first order children ● New mothers ● Mothers from poor households ● Women who faced no pregnancy complications ● Women who lived in rural areas. ● Women without education **Higher prevalence of SBA uses among those who:** ● Had received ANC services from skilled personnel ● Had 4 or more NC services, other tests such as blood pressure, blood, urine etc. ● Faced more than one complication during pregnancy as well as delivery/post-delivery complications ● We're not expecting to get pregnant
"The system here isn't on patients' side"- perspectives of women and men on the barriers to accessing and	Mugo, N. S., Dibley, M. J., Damundu, E. Y., & Alam, A. (2018). "The system here isn't on patients' side"- perspectives of women and men on the barriers to	This report mentions that geographical accessibility adds to the lack of preparedness for delivery (i.e., they will do what is most convenient for the household/woman) Attendance of few ANC visits due to financial constraints is common: ● User fee for antenatal care (10SSP or 0.14 USD) and visitations (5SSP or 0.071 USD)

utilizing maternal healthcare services in South Sudan	accessing and utilizing maternal healthcare services in South Sudan. BMC Health Services Research, 18(1). https://doi.org/10.1186/s12913-017-2788-9	• Can also lead to delayed care. • Men may only bring their wives to health facilities if they face complications, which in turn can increase costs Reduced income, irregular salaries as major constraints in accessing public health services. Sudden onset of labor despite going for ANC visits can be another reason for women to deliver at home. Increased violence at night due to inter-tribal conflicts: most people do not risk their life to access services that cannot be done at home **Health service availability issues:** • Stock out of medication • Lack of staff and hence, longer waiting times • Lack of space at maternity wards (discharging women after 2 hours of delivery was associated with post-delivery complications, hemorrhage, death) **Community norms and preferences:** • Women who are not ill can deliver their babies at home. • Only those that are ill having to deliver in the hospital
'You have a child who will call you "mama" ': understanding adolescent pregnancy in South Sudan	Kane, S., Miedema, E., Dieleman, M., & Broerse, J. B. (2019, January 8). *'You have a child who will call you "mama" ': Understanding adolescent pregnancy in South Sudan*. Taylor & Francis. Retrieved September 22, 2021, from https://www.tandfonline.com/doi/full/10.1080/16549716.2018.1553282	**Community attitudes:** • Without child a woman does not have value • Childbearing has high value and is equated to pride, like a certificate of honor, sense of fulfillment • Children aren't seen as burden, but rather being able to shoulder responsibility and hence labelled as an adult **Male attitudes toward fatherhood:** • For young men fatherhood is equated with becoming a man; "good and responsible man" • If men did not take care of their wife or child, then it was a matter of shame; many men would flee their towns as they could not fulfill such responsibilities **Female attitudes toward childbearing:** • "Instead of staying at school all day and not having money for breakfast it would be better to become pregnant and stay home" • Girls equate becoming a woman with happiness, owning a home and not needing anything • Unmarried girls with no husbands are insulted, and called useless within society
South Sudan maternal, newborn and child survival	South Sudan maternal, newborn and child survival initiative. Massachusetts	Main obstacle to quality maternal, newborn and child health (MNCH) is the lack of skilled MNCH care providers.

initiative	General Hospital. (n.d.). Retrieved September 22, 2021, from https://www.massgeneral.org/emergency-medicine/global-health/initiatives-and-programs/south-sudan-maternal-newborn-and-child-survival-initiative?TRILIBIS_EMULATOR_UA=aqkljlpwmmkitx%2Caqkljlpwmmkitx%2Caqkljlpwmmkitx%2Caqkljlpwmmkitx	
Transforming Maternal and Child Health in South Sudan	Transforming Maternal and Child Health in South Sudan. (n.d.). Maternal and Child Survival Program. USAID. (n.d.). Retrieved September 22, 2021, from https://www.mcsprogram.org/wp-content/uploads/2015/08/WV-S.-Sudan-FE-Brief1.pdf. **Contact info:** World Vision 34834 Weyerhaeuser Way S, Federal Way, WA 98063 arosales@worldvision.org; dcherian@worldvision.org +1 253-815-1000 | www.wvi.org/south-sudan	Home health promoters were effective in improving MNCH knowledge, assessing mothers and children, and initiating treatment for malaria and diarrhea. Interviews and focus group discussions with mothers indicated a link to the quality of health education in the project area. MaCHT struggled to improve supply-chain management and distribution of malaria medication and antibiotics for acute respiratory infections due to factors largely beyond its control. Future interventions would do well to explore new inventory management approaches. Increasing state and local level Ministry of Health motivation to focus on maternal and child health indicates that MaCHT has helped reposition the MNCH agenda. **Overall summary and/or lesson learned** ● Trained community health workers help in service delivery especially among those in hard-to-reach places ● Chronic supply-chain disruptions add a layer of complication in an already overstretched health system. ● To improve community-based health services in such an environment, improvements to drug supply management should include provision of basic drugs and supplies to home health promoters. ● South Sudan's Ministry of Health lacks human resources to confront the range of policy and planning

		needs, let alone lead coordination of donor projects and design of interventions.
LQAS Survey Report	Devkota, B., Anguyo, R., Jeffery, C., Laku, D. R., & Valadez, J. J. (n.d.). (rep.). Republic of South Sudan National Household Health Survey 2020 LATH-South Sudan 07 May 2021 (pp. 2–107).	The national proportion of women who had received at least one ANC by any provider was high at 79.9 %, this proportion reduced to 68.6% for those who are at least one ANC with a skilled provider. In South Sudan skilled providers include doctors, clinical officers, nurses, and midwives. These results suggest that while pregnant women could access health facilities for at least one ANC visit, they were not consistent in doing so multiple times.
Optimal Profile Limits for Maternal Mortality Rates (MMR) Influenced by Haemorrhage and Unsafe Abortion in South Sudan	Makuei, G., Abdollahian, M., & Marion, K. (2020, June 1). Optimal profile limits for maternal mortality rates (MMR) influenced by haemorrhage and unsafe abortion in South Sudan. Journal of Pregnancy. Retrieved September 21, 2021, from https://www.hindawi.com/journals/jp/2020/2793960/	The study results indicate that the most influential predictors of MMR are: ● Hemorrhaging (38%) ● Sepsis (11.5%) ● Obstructed labor (11.5%) ● Unsafe abortion (10%) ● Other indirect causes (e.g., anemia, malaria, and HIV/AIDs virus) (29%). The results also show that to obtain the UN recommended MMR levels of minimum 21 and maximum 42 by 2030, the Government and other stakeholders should simultaneously, reduce hemorrhaging from the current value of 62 to 33.38 and 16.69, reduce unsafe abortion from the current value of 16 to 8.62 and 4.31.

MCH: Provider Attitudes

Title/Topic	Citation	Summary
"You have to take action": changing knowledge and attitudes towards newborn care practices during crisis in South Sudan	Sami, S., Kerber, K., Tomczyk, B., Amsalu, R., Jackson, D., Scudder, E., Dimiti, A., Meyers, J., Kenneth, K., Kenyi, S., Kennedy, C. E., Ackom, K., & Mullany, L. C. (2017, December 13). "you have to take action": Changing knowledge and attitudes towards	Study provided training on newborn care practices and understanding danger signs. Findings indicated that although there may have been improvement in knowledge, adoption of acceptance of the intervention was unlikely. The study was able to change attitudes and behaviors while conducting delivery and prenatal and postnatal care. Baseline showed a clear lack of knowledge, but participants felt comfortable after the study intervention. Organizational barriers include lack of protocols, monitoring strategy, resources, supervision, training and staff, and space

	newborn care practices during crisis in South Sudan. Taylor & Francis. Retrieved September 22, 2021, from https://www.tandfonline.com/doi/full/10.1080/09688080.2017.1405677	in maternity wards
UNICEF SOUTH SUDAN – CASE STUDY	FAITH AND POSITIVE CHANGE FOR CHILDREN: GLOBAL INITIATIVE ON SOCIAL AND BEHAVIOUR CHANGE. UNICEF. (2019). Retrieved September 22, 2021, from https://jliflc.com/wp-content/uploads/2019/11/Sudan_case_study_31082019.pdf	Religious leaders are highly trusted within the community and have established networks that can be important in advocating positive behavior, attitudes, and policy changes. Important in steering information to disseminate among populations. "Religious leaders, in their everyday interactions, contribute to social and behaviour change mainly through the dissemination of their knowledge at their churches and mosques, and at community events through announcements" Media, specifically radio networks, are a key outreach opportunity. Of UNICEF's 42 radio partners, 10 are run by religious institutions. In one project with the Catholic Radio Network (CRN), UNICEF harnessed the widespread use of radio in the country to spread information. CRN broadcasts through community-based radio stations that have influential and highly localized reach, with an audience of an estimated seven million in total."- content is tailored to provide culturally sensitive information to the different localities Religious leaders have a huge impact on the population (e.g. during a measles outbreak, UNICEF reached out to religious leaders who then were able to successfully encourage 95% of the community to be vaccinated)
Barriers Faced by the Health Workers to Deliver Maternal Care Services and Their Perceptions of the Factors Preventing Their Clients from Receiving the Services: A	Mugo, N. S., Dibley, M. J., Damundu, E. Y., & Alam, A. (2018). Barriers faced by the health workers to deliver maternal care services and their perceptions of the factors preventing their clients from receiving the services: A qualitative study in South Sudan. Maternal	Barriers to providers delivering MNCH services: • Poor infrastructure within maternity rooms, delivery rooms, newborn intensive care units • Lack of utilities such as electricity, generators, fuels, water supplies • Lack of medical supplies or PPE (e.g. gloves, cotton, syringes, cord clips, and medication such as oxytocin for bleeding) • Lack of medical equipment in facilities and labs • Lack of human resources, specifically a shortage of skilled staff • Lack of incentives for staff such as low salaries and promotions

Qualitative Study in South Sudan	and Child Health Journal, 22(11), 1598–1606. https://doi.org/10.1007/s10995-018-2555-5	• Lack of security and safety at night, fear of danger Provider perceptions about low MNCH service uptake: • Lack of education and awareness within the community regarding MNCH leading to delayed care, which can pose grave risk to the mother and the child • Lack of awareness among women such as for ANC services and its benefits

Media Landscape

Title/Topic	Citation	Summary
South Sudan profile - Media	BBC. (2019, August 6). South Sudan profile - media. BBC News. Retrieved September 22, 2021, from https://www.bbc.com/news/world-africa-14019206#:~:text=Radio%20is%20the%20most%20popular,players%20in%20non%2Dstate%20radio .	Access to online reports on oppositions have been blocked Facebook is the most used platform Available media: • Juba Monitor - daily • Al-Masir (Destiny) - Arabic daily • SSBC (South Sudan Broadcasting Corporation) - state-run • Eye Radio - funded by US government aid body, USAID • Radio Miraya - operated by UN Mission in Sudan and Swiss NGO Foundation Hirondelle • Bakhita Radio - Catholic • Capital FM - privately-owned, from Juba • SSBC (South Sudan Broadcasting Corporation) - state-run • Gurtong Trust - news site • South Sudan News Agency - US-based news site • The New Sudan Vision -news site
Media landscape of South Sudan	South Sudan. Media Landscapes. (n.d.). Retrieved September 22, 2021, from https://medialandscapes.org/country/south-sudan/telecommunications/mobile-coverage	Mobile subscription has dropped from 22% to 12%- mostly due to the ongoing war 16.8% internet penetration Radio is the most used/trusted medium Mobile networks in South Sudan are limited to major towns (about 20 percent of the country), cutting out the population of remote areas.

Annex B: Audience Segmentation Examples

Family Planning Use of Nulliparous Young Women in South Sudan (15-24)

Breakthrough ACTION conducted a segmentation analysis of nulliparous young women in South Sudan (15-24) regarding their usage of FP and to better understand how gender-based violence could influence family planning [birth spacing] habits.

Four segments emerged from the analysis.

Open Strugglers
(36%)
"I believe in women's rights, I'm aware of FP, but contraceptives can be hard to access in my community"

Advantaged Adopters
(30%)
"I'm ready to have children and I understand how FP can help me achieve my goal"

Restricted Traditionalists
(20%)
"I'm well aware about FP but I cannot have it without getting permission"

Skeptical Adventurers
(14%)
"Having a child is probably many years away for me, I don't have a strong opinion and haven't thought about FP"

Family Planning Providers

Breakthrough Action conducted primary data and segmentation analysis of family planning [birth spacing] providers (e.g., nurses, health workers) in Juba and Wau to better understand their experience, training, and norms surrounding provision and counseling of FP.

Four segments emerged from our segmentation analysis.

Progressive Practitioner
(30%)
"I provide a lot of FP services including to youth. I think my clients have the right to make their own FP decisions"

Passionate Balancer
(20%)
"I like providing FP, I have received a lot of training, but believe women need their partner's consent and young clients don't always know what is best for them"

Restricted Reputationalist
(20%)
"Sometimes I find certain FP conversations challenging and worry about the reputation of my facility"

Unengaged Provider
(30%)
"I feel overworked and don't especially like providing FP. I also don't provide a lot of FP counseling and haven't been trained much on it"

Annex C: A Package of Assets for "Together for Each Other"

Family Planning

Posters

Radio Scripts

English

Target Behaviour: Use of modern contraceptive
Barrier Address: Safety: contraceptives affect fertility of women
Behavioral Technique: Framing and Reframing

HOME: At an elder's house. Mother in-law has brought her son and daughter- in -law to an elder so he can convince them to change their mind about contraceptives.

SFX: indoor ambiance

Mother: (Upset) Elder, we have come. Please help me talk sense to my son and daughter-in-law.

Male Elder: What seems to be the problem mama?

Mother: I found out that my son and daughter-in-law are using these so-called contraceptives. They want to deny me many grand babies**.**

Wife: No mama, it is not like that.

Husband: We feel it will help us plan our family better.

Mother: But they will make her infertile!

Male elder: No mama.. that is not true. Your granddaughter can still have babies. These modern contraceptive methods help our daughters plan their families. She can get pregnant again whenever she stops using them. We should support their decision to plan their family.

Mother: So, you mean, she can still have little ones?

Male Elder: Yes. And you will be their grandmama!

SFX: sounds of joy

M/VO: *Modern contraceptive methods are a safe way to plan your family. By making the decision together, to use contraceptives, you're giving your babies the best chance to grow healthier, stronger, and happier.*

Together for each other, as a community, we're building a better future.

Juba Arabic

HOME: At an elder's house
SFX: indoor ambiance

Mother: (upset) haboba, anina jaa, alek allah saidu ana wonusu ma weled taii wu mara ta weled taii.

Male elder: mushkila wen mama

Mother: ana ligo weled taii ma mara to gi istahmil dawayat al gi nadi mana himil de. Umon ma derr kede ana kun indu iyal ta iyal taii

Wife: lalala mama.. Kalam de ma zede

Husband: ana gi ainu de bi saidu anina nizamu usura tanina.

Mother: wu bi kutu ana ma bi kun indu iyal ta iyal taii

Male elder: lala mama. De ma hagiga. Binia ta binia taki lisa bi weledu. Dawayat ta mana himil al jedid de gi saidu banat tanina nizamu usura tomon. Umon bi akder tala hamilanin tani kan umon wegifu dawa de. Kede anina shaja umon fi khathwa tomon ta mana himil de.

Mother. Yani ita gasit inu umon bi akder weledu iyal lisa

Male elder. Aii ke wu ita bikun abuba tomon

SFX: sounds of joy

M/VO: *dawayat ta mana himil de ma indu tasir wu kaman bi saidu ita kef ita bi weledu iyal taki be nizam. Kan itakum wafig sawa ma rajil taki le istemal ta mana himil de, de bi mana itakum gi wedi le iyal takum ahsan fursa ashan umon bi raba fi saha al kues, gisim gowi, wa nurtaahin fi haya tomon.*

Sawa le badun anina bi abni ahsan mustakhbal.

Maternal and Child Health

Posters

Radio Scripts

English

Target Behaviour: Make a plan to give birth at a health facility: know where you are going, make sure you have transportation, be prepared
Barrier Address: Planning

Behavioral Technique: Stories close to home

HOME: Each woman is at their baby naming celebration
SFX & MUSIC: baby sounds and baby music.

WOMAN 1: It's like it was just yesterday when I held my Salwa for the first time - a beautiful healthy baby. Delivering her at the health facility wasn't something we had thought about before. But after hearing the advice of the healthcare provider at our village meeting, we decided to make a plan for it. Now, we know we made the right choice.

WOMAN 2: After we lost 2 babies due to complications at home, my friend suggested we consider giving birth at a health facility. I talked to my husband about it, and he agreed. When I got pregnant again, we started visits to the health facility that my friend had suggested, to prepare to welcome our next baby. It all paid off. Now, I have finally become a mama.

WOMAN 3: My husband and I chose to have our baby at a health facility. But the facility was quite far. I thought I may end up giving birth at home. Thankfully, one of our neighbors knew someone who has a Raksha. He gave us a ride and we had our Jidu at the facility, just like we wanted. It has made me so happy!

M/VO: *Everyday, more women in South Sudan are choosing to give birth at a health facility to be safer. You can be one of them. If you are expecting a baby, make a plan, together, to deliver at your nearest health facility. It's the safest way for a mama and baby.*

Together for each other, we're building a better future.

Juba Arabic

HOME: Each woman is at their baby naming celebration
SFX & MUSIC: baby sounds and baby music.

WOMAN 1: geni kaanu de umbari yau awel mara ana gi arfa jena taii Salwa fi eeden taii - jena giyafa wa fi saha al taman. Weledu to fi mustechfa de ma kan haja al anina fekir fogo gabli kida. Lakin zaman ana asuma irshadat ta dakatira fi intima tanina fi beled hini, anina ma rajil taii tawali bada kutu kalam de fi amal. Wa hasa anina aruf gali de ahsan haja yau anina amulu de.

WOMAN 2: baat ma anina fakhidu etnin iyal min kalam ta wilada fi bet, sabi taii bada weri le ana kaman jeribu wilada fi mustejfa. Ana wonusu kalam de le rajil taii, wa o wafig kaman. Zaman ana tala hamilan, anina bada doru fi mustejfa al sabi taii weri le ana de, ashan bi jahisu anina rahibu jena tanina al jedid de. Wu de felan haja kues. Hasa ana murtaa ashan ana biga uma.

WOMAN 3: ana wu rajil taii tifagu gali kele weledu jena tanina fi mustejfa. Lakin mustejfa de kan beyit shedid. Ana kan fekir gali imkin ana bi ja weledu fi bet. Lakin ana bi shukura allah

ashan fi jeran tanina tani kida al arufu zol al indu Raksha. O wosulu anina lahadi ana ja weledu jena tanina Jidu fi mustejfa, zema kan anina der. Wu de kuta ana tala murtaa shedid!

M/VO: *kulu yom, nasawin ketir fi Junub sudan hini gi azilu weledu iyal tomon fi mustejfa ashan kalam ta saha ta iyal tomon wa saha tomon kaman . ita bi akder kun wahid min nasawin del. Kan ita hamilan, kele itakum wu rajil taki amulu ahsan khathwa al huwa kathwa al ita bi weledu fi agrab mustejfa al gerib ma ita. Wu de yau ahsan teriga al ita bi akder kuta gisim taki wu jena taki kun fi saha al kues.*

Sawa le badun, anina bi abni ahsan mustakhbal.

Additional Assets Include:

- Radio Drama and Community Theater Guide
- African Transformation
- Community Mobilization [CAC+PDQ Toolkit]
- Provider Behavior Change Toolkit
- A set of Counseling Cards for FP
- Client Expectation Scenario Tool
- Together we Decide: Male Engagement for Family Planning
- Growing Together: Support for Menstrual Hygiene and Health
- Act! A Set of Scenarios to Increase Male Support for ANC
- Boma Health Chapter on Male Support for ANC
- Lido Game on Male Support for ANC

Annex D: Indicator Table

Input/ Output/ Outcome	Indicator	Reference Point (Baseline)	Target
Family Planning			
OUTCOME: In-depth knowledge	% Of [the audience*] who are able to name and describe at least three family planning [birth spacing] methods.		
OUTCOME: Self-efficacy	% Of [the audience*] who feel they have the confidence to discuss, agree upon as a couple, and plan to access family planning [birth spacing] services.		
OUTCOME: Self-efficacy	% Of [the audience*] who feel empowered and supported to make their own decisions regarding their family planning [birth spacing] choice.		
OUTCOME: Knowledge of side effects	% Of [the audience*] who have knowledge of what to do if they have side effects.		
OUTCOME: Use of modern family planning	% Of [the audience*] who adopt and use a modern family planning [birth spacing] method for at least 2 years after delivery.		
Maternal Health			
OUTCOME: Increased knowledge	% Of [the audience*] who know the importance of attending antenatal care.		
OUTCOME: Access to ANC services	% Of [the audience*] who go for timely antenatal care (within the first trimester) at the health facility or skilled birth attendant.		
OUTCOME: Access to ANC services	% Of [the audience*] who go for ANC at least four times to the health facility or skilled birth attendant.		
OUTCOME: Knowledge of benefits	% Of [the audience*] who understand the importance of having a birth plan.		

OUTCOME: Knowledge of 3 delays to receiving care during pregnancy	% Of [the audience*] who know the risks related to delaying and reaching care: (1) deciding to seek appropriate medical help for an obstetric emergency; (2) reaching an appropriate obstetric facility; and (3) receiving adequate care when a facility is reached.		
OUTCOME: Knowledge of danger signs during pregnancy	% Of [the audience*] who are able to identify danger signs during and after pregnancy.		
OUTCOME: Access to care	% Of [the audience*] who experience danger signs and seek care at the health facility.		
OUTCOME: Knowledge of benefits	% Of [the audience*] who know the importance of receiving postnatal care at 3 and 7 days of delivery for both the mother and baby.		
OUTCOME: Access to care	% Of [the audience*] who attend postnatal care (at 3 days, at 7 days, at both) at the health facility.		
OUTCOME: Sleeping under a bed net	% Of [the audience*] who sleep under a LLITN every night (correctly and consistently) with her family.		
OUTCOME: Knowledge of signs and symptoms of malaria	% Of [the audience*] who know the signs and symptoms of malaria.		
OUTCOME: Access to care	% Of [the audience*] who seek testing and treatment (if positive) for malaria within 24 hours of onset of fever (during and after pregnancy).		
Community Support			
OUTCOME: Support networks	% Of [the audience*] who feel supported to make their own decisions regarding their family planning [birth spacing] choice.		
OUTCOME: Support networks	% Of communities who support the audience to seek MCH services.		

OUTCOME: Support networks	% Of individuals that feel all women should be able to equally access health services.		
OUTCOME: Gender norms	% Of households and communities that challenge the notion that having a child is solely the responsibility of the woman [care] or man [decision-making, financial] and will support redefined gender norms for men.		
OUTCOME: Support networks	% Of individuals, households and communities who feel inspired to overcome barriers and challenges, working to create a supportive environment that facilitates change, justice and fairness, and togetherness.		
Health-Seeking Experience			
OUTCOME: Trust	% Of [the audience*] who have a positive perception of the health facility by the audience.		
OUTCOME: Respect	% Of [the audience*]in the clinic's catchment area that feel they were treated with respect by the clinic staff.		
OUTCOME: Trust	% Of [the audience*] who have confidence and trust in the public health sector and will continue to demand safe and effective health services for planning their families, including family planning [birth spacing] counseling and MNCH services by audience.		
OUTCOME: Access to care	% Of [the audience*] who go to the health facility for treatment and care.		
Gender			
OUTCOME: Self-efficacy	% Of [the audience*] (and her partner) who have the self-efficacy to discuss, agree upon, and plan how best to keep their family healthy.		

OUTCOME: Support networks	% Of [the audience*] who provide constructive support (emotional, financial, and/or shared responsibilities) for family planning [birth spacing] and maternal and child health.		
OUTCOME: Gender norms	% Of [the audience*] who agree that it is important to critically examine social norms that govern men's and women's roles, responsibilities, and expectations.		
OUTCOME: Gender norms (and GBV)	% Of [the audience*] who recognize that some gender-related social norms [including gender based violence] are harmful.		
OUTCOME: Gender norms	% Of [the audience*] who appreciate and equally value sex- and gender-based differences.		
OUTCOME: Gender norms	% Of [the audience*] who equitably share decision-making and household resources.		
OUTCOME: Gender norms, self-efficacy, collective efficacy	% Of [the audience*] who believe that they can make individual, familial, and/or community changes.		
OUTCOME: Gender norms	% Of [the audience*] who take action to eliminate harmful social norms [including gender-based violence] and/or to support positive social norms.		

***Note:** The audience should be clearly defined based on who you have prioritized.