

**United Nations Children Fund (UNICEF)  
South Sudan COVID-19 Emergency Response and Health  
Systems Preparedness Project  
Second Additional Financing (P180277)**

**Stakeholder Engagement Plan**

**Updated Version: 22 February 2023**

## 1. Introduction of the project

The risk of the emergence of infectious diseases has heightened over the last few decades, with the rapid increase in human population, climate change and more interconnectivity between nations amongst some of the key drivers of this threat. Since the first documented cases of what has now been characterized as Corona Virus Disease caused by Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) in December 2019, more than 183 million cases and almost 4 million deaths have been recorded in every continent as of the first week of July 2021. In South Sudan, since the index case was reported in April 2020, there have been a total of 10,868 cases and 117 deaths recorded as of the same period, despite the existing challenges in case detection and surveillance.

The South Sudan COVID-19 Emergency Response and Health Systems Preparedness Project (CERHSPP) aims to prevent, detect, and respond to the threat posed by COVID-19 in South Sudan, increase access to an essential package of health services in the states of Unity, Upper Nile and Jonglei (Greater Upper Nile), and develop South Sudan government health sector stewardship and system preparedness capacity.

The CERHSPP comprises the following components:

1. Vaccine Deployment, Cold Chain Equipment and Community Engagement for COVID-19 vaccination, which shall target the strengthening of the cold chain infrastructure, support the implementation of the National Deployment and Vaccination Plan, including activities to increase community awareness and acceptance of COVID-19 vaccinations.
2. Continued Provision of Essential Health Services in Upper Nile, Jonglei and Unity, where high impact services will be provided to the general population in these two most vulnerable states.
3. Building Institutional Capacity and Strengthening Health Emergencies Preparedness. This component will focus on developing the capacity of the of the MoH personnel to manage future projects with a focus in essential project management concepts and practices. It will also cover the work of WHO to improve the government's capacity to prepare for, prevent, detect and respond to public health emergencies.
4. Monitoring, Evaluation and Learning component will cover third party monitoring arrangements for first two components, and for the functioning of routine health information systems.
5. Contingent Emergency Response which can be activated if needed if emergency situations should occur.

Components 1 and 4 of the Project will be implemented across the country. Component 2 will be implemented in Greater Upper Nile (Upper Nile, Jonglei, and Unity states as well as Greater Pibor Administration Area). Component 3 of the project will be implemented in Juba.

The CERHSPP is being prepared under the World Bank's Environment and Social Framework (ESF). As per the Environmental and Social Standard ESS 10 Stakeholders Engagement and Information Disclosure, the implementing agencies should provide stakeholders with timely, relevant, understandable and accessible information, and consult with them in a culturally appropriate manner, which is free of manipulation, interference, coercion, discrimination and intimidation.

The overall objective of this SEP is to define a program for stakeholder engagement, including public information disclosure and consultation, throughout the entire project cycle. The SEP outlines the ways in which the project team will communicate with stakeholders and includes a mechanism by which people can raise concerns, provide feedback, or make complaints about project and any activities related to the project. The involvement of the local population is essential to the success of the project in order to ensure smooth collaboration between project staff and local communities and to minimize and mitigate environmental and social risks related to the proposed project activities. In the context of infectious diseases, broad, culturally appropriate, and adapted awareness raising activities are particularly important to properly sensitize the communities to the risks related to infectious diseases. For COVID-19 vaccination programs, stakeholder engagement is key to communicating the principles of prioritization of vaccine allocation and the schedule for vaccine rollout, reaching out to disadvantaged and vulnerable groups, overcoming demand-side barriers to access (such as mistrust of vaccines, stigma, cultural hesitancy), and creating accountability against misallocation, discrimination and corruption.

## 2. Brief summary of previous stakeholder engagement activities

The SEP was originally prepared for activities under Component 2 and 4, congruent with activities under the prior project Provision of Essential Health Services Project (PESHP) and has now been for all activities under the CERHSPP. The project is primarily providing support to continue delivery of essential health services and monitoring & evaluation previously provided ESHP as well as to provide support to the COVID-19 National Vaccine Deployment Plan (NVPD).

Component 1 activities were not supported under PESHP. Stakeholder engagement activities and leveraged the consultations undertaken by the MOH (MOH) and all relevant partners in the formulation of the COVID-19 NVDP (see section 4.2 for detailed information).

Project components (2 and 4) of the project are existing activities under the parent project (CERHSPP) which were developed in a consultative manner with relevant stakeholders. The previous stakeholder engagement has been disclosed publicly and can be found at <https://documentsinternal.worldbank.org/Search/33170394>. In addition, the insights from ongoing consultations with beneficiaries of CERHSPP (as outline in section 5.0) were factored into the design of the project.

With the expansion of activities via the CERC activation into Unity State, additional consultations have been held on state and local level. Core consultations with government, local leaders, and communities took place between October 5-14, 2022. The Boma Health Initiative engagement with communities is being rolled out to the new geographic areas equally, being the core measure of regular engagement with local beneficiaries.

The development of the Government health sector stewardship project provided for under project component 3 was undertaken in a consultative approach with the national MOH under the leadership of the World Bank.

## 3. Stakeholder identification and activities

Project stakeholders are defined as individuals, groups or other entities who:

- (i) are impacted or likely to be impacted directly or indirectly, positively or adversely, by the Project (also known as 'affected parties'); and
- (ii) may have an interest in the Project ('interested parties'). They include individuals or groups whose interests may be affected by the Project and who have the potential to influence the Project outcomes in any way.

Cooperation and negotiation with the stakeholders throughout the Project development often also require the identification of persons within the groups who act as legitimate representatives of their respective stakeholder group, i.e., the individuals who have been entrusted by their fellow group members with advocating the groups' interests in the process of engagement with the Project. Community representatives may provide helpful insight into the local settings and act as main conduits for dissemination of the Project-related information and as a primary communication/liaison link between the Project and targeted communities and their established networks. Community representatives, cultural leaders and women leaders may also be helpful intermediaries for information dissemination in a culturally appropriate manner, building trust for government programs or vaccination efforts.

Women can also be critical stakeholders and intermediaries in the deployment of vaccines as they are familiar with vaccination programs for their children and are the caretakers of their families.

Verification of stakeholder representatives (i.e., the process of confirming that they are legitimate and genuine advocates of the community they represent) remains an important task in establishing contact with the community stakeholders. Legitimacy of the community representatives can be verified by talking informally to a random sample of community members and heeding their views on who can be representing their interests in the most effective way. With community gatherings limited under COVID-19, it may mean that the stakeholder identification will be on

a much more individual basis, requiring different media to reach affected individuals.

### 3.1 Methodology

In order to meet best practice approaches, the Project will apply the following principles for stakeholder engagement:

- *Openness and life-cycle approach*: public consultations for the project(s) will be arranged during the whole life cycle, carried out in an open manner, free of external manipulation, interference, coercion or intimidation;
- *Informed participation and feedback*: information will be provided to and widely distributed among all stakeholders in an appropriate format; opportunities are provided for communicating stakeholders' feedback, for analysing and addressing comments and concerns;
- *Inclusiveness and sensitivity*: stakeholder identification is undertaken to support better communications and build effective relationships. The participation process for the projects is inclusive. All stakeholders at all times are encouraged to be involved in the consultation process. Equal access to information is provided to all stakeholders. Sensitivity to stakeholders' needs is the key principle underlying the selection of engagement methods. Special attention is given to vulnerable groups, in particular women, youth, elderly, persons with disabilities, displaced persons, those with underlying health issues, and the cultural sensitivities of diverse ethnic groups.
- *Flexibility*: if social distancing inhibits traditional forms of engagement, the methodology should adapt to other forms of engagement, including various forms of internet communication. (See Section 3.2 below).

For the purposes of effective and tailored engagement, stakeholders of the Project can be divided into the following core categories:

- **Affected Parties** – persons, groups and other entities within the Project Area of Influence (PAI) that are directly influenced (actually or potentially) by the project and/or have been identified as most susceptible to change associated with the project, and who need to be closely engaged in identifying impacts and their significance, as well as in decision-making on mitigation and management measures;
- **Other Interested Parties** – individuals/groups/entities that may not experience direct impacts from the Project but who consider or perceive their interests as being affected by the project and/or who could affect the project and the process of its implementation in some way; and
- **Vulnerable Groups** – persons who may be disproportionately impacted or further disadvantaged by the project(s) as compared with any other groups due to their vulnerable status<sup>1</sup> and that may require special engagement efforts to ensure their equal representation in the consultation and decision-making process associated with the project.

### 3.2. Affected parties

Affected Parties include local communities, community members and other parties that may be subject to direct impacts from the Project. Specifically, the following individuals and groups fall within these key categories:

- Populations and groups targeted for COVID-19 vaccinations as detailed in the South Sudan NDVP;
- Populations living in the catchment areas of the health facilities in Upper Nile, Jonglei, and Unity states;
- 25 County Health Departments;
- Two state Ministries of Health;
- 170 Boma health Committees in two states.

### 3.3. Other interested parties

The projects' stakeholders also include parties other than the directly affected communities, including:

- CSO Implementing partners engaged by UNICEF, HPF and others working on their own mandate in the field of vaccination (Medair, MSF, John Snow International etc);
- UN and other agencies working in the field of immunization ( WHO, IOM, GAVI);

---

<sup>1</sup> Vulnerable status may stem from an individual's or group's race, national, ethnic or social origin, colour, gender, language, religion, political or other opinion, property, age, culture, literacy, sickness, physical or mental disability, poverty or economic disadvantage, and dependence on unique natural resources.

- Drug and Food Authority, Directorate of Pharmaceuticals MoH; and
- National and local mass media organizations and outlets etc.

### 3.4. Disadvantaged / vulnerable individuals or groups

It is particularly important to understand whether the Project impacts may disproportionately fall on disadvantaged or vulnerable individuals or groups, who often do not have a voice to express their concerns or understand the impacts of a project and to ensure that awareness raising and stakeholder engagement with disadvantaged or vulnerable individuals or groups on infectious diseases and medical treatments in particular, be adapted to take into account such groups or individuals particular sensitivities, concerns and cultural sensitivities and to ensure a full understanding of project activities and benefits. The vulnerability may stem from person's origin, gender, age, health condition, economic deficiency and financial insecurity, disadvantaged status in the community (e.g., minorities or fringe groups), dependence on other individuals or natural resources, etc. Engagement with the vulnerable groups and individuals often requires the application of specific measures and assistance aimed at the facilitation of their participation in the project-related decision making so that their awareness of and input to the overall process are commensurate to those of the other stakeholders.

Within the Project, the vulnerable or disadvantaged groups may include and are not limited to the following:

- Internally displaced persons (IDPs) including inhabitants of Points of Concentration, communities affected by acute humanitarian emergencies like flooding, conflict, hard to reach populations etc.
- Refugees.

Vulnerable groups within the communities affected by the project will be further confirmed and consulted through dedicated means, as appropriate. Description of the methods of engagement that will be undertaken by the project is provided in the following sections. For any vaccination program, the SEP will include targeted, culturally appropriate and meaningful consultations for disadvantaged and vulnerable groups before any vaccination efforts begin.

The Project Grievance Redress Mechanism (GRM) will be culturally appropriate and accessible for the various ethnic groups in South Sudan, taking into account their customary dispute settlement mechanism.

## 4. Stakeholder Engagement Program

While there is a lot of overlap and similarities of the stakeholders for all components of the Project, it is important to note the specialized stakeholder engagement required for activities related to COVID-19 vaccine deployment. In addition, COVID-19 vaccine related activities are new under the current Project and were not supported under PEHSP. Therefore, this section of the SEP provides dedicated sections related to stakeholder engagement activities during Project development and planned to take place during Project implementation.

### 4.1. Summary of stakeholder engagement for activities previously under PESHP

Ongoing stakeholder engagement activities for Project component activities under PEHSP continuous are leveraged to inform programme adjustments and actions and therefore informed the Project. Table 1 outlines the key stakeholders who were and will be continue consulted about the Project, including individuals, groups or communities that are affected or likely to be affected by the project, including disadvantaged groups. Table 1 also includes the primary engagement method as well as timing. In addition, the general public may have an interest in the project. Project documents and progress will be publicly disclosed on both World Bank and UNICEF websites. UNICEF South Sudan will also use social media, radio and print as mediums throughout the project duration to make the general public aware of the project and inform them how they can obtain further information.

South Sudan is a multilingual country, with over 60 indigenous languages spoken. The official language of the country is English. Some of the indigenous languages with the most speakers include Dinka, Nuer, Bari and Zande. In addition, "Juba Arabic" is widely spoke within is an Arabic pidgin. At the community level, stakeholder consultations will take

place in local language of the population being served. Exiting linguistic profile mapping will be used to ensure appropriate language use with the target stakeholder group of any engagement activity.

Table 1: Stakeholder analysis and primary method of engagement

Stakeholder	Importance of stakeholder/key characteristic	Stakeholder analysis/Interests	Degree of involvement in the project	Means of engagement
<b>Government</b>				
MOH at national and State level	Critical player	MOH has the leadership in providing guidance, policy and governance for the provision of health services in South Sudan. MoH would want to see services reach the population as government has limited resources to do so.	Authorization, political support, policy, mobilization and supervision	Regular update/review meetings on the PEHSP implementation at national and State level.  Regular consultations on specific issues related to the PEHSP implementation and to ensure the PEHSP follows MOH policies and guidelines and supports the national health system in the States of Jonglei, Upper Nile, and Unity.
County Health Departments	Critical player	The County Health Department (CHD) is the primary responsible for the provision of health services at county level. CHD is the primary interlocutor between facilities and the implementing partners that are supporting them through the PEHSP. CHDs are keen on implementing partners supporting the delivery of health services to the population of their county as government has limited resources to do so.	Political support, mobilization and supervision at county level.  Perform stewardship functions in support to the PEHSP implementation at county level, especially in coordination and governance, HIMS data management, Human resource mapping and management, supervision and monitoring in the provision of health services	Regular meetings and consultations between Implementing partners and CHDs in the routine PEHSP implementation  Meetings and consultations with CHDs by UNICEF staff during each supervision visit
South Sudan Relief and Rehabilitation Commission	Critical player	Coordination of efforts of IPs/NGOs. Responsible for NGO activities at county level.	Government/IO Arm of coordinating Development partners.	Regular meetings and consultations between Implementing partners and SSRRC/ROSS to

Stakeholder	Importance of stakeholder/key characteristic	Stakeholder analysis/Interests	Degree of involvement in the project	Means of engagement
(SSRRC)/Relief Organisation of South Sudan (ROSS)			Strengthened coordination can improve service delivery.	facilitate the routine PEHSP implementation  Meetings and consultations with SSRRC/ROSS at county level by UNICEF staff during each supervision visit
<b>International organizations</b>				
World Bank	Critical player	Donor for the PEHSP, brings the financial resources for the PEHSP implementation	Supports the PEHSP since 2019 in Jonglei and Upper Nile and the previous Rapid Result Health Project since 2012 in project area	Regular meetings Supervision visits Reporting through quarterly matrix and bi-annual reports
UNICEF	Critical player	Project implementer. UNICEF is critical in the Health, Nutrition, and WASH sectors.	Leads the implementation of the PEHSP in coordination with Implementing Partners and in consultation with authorities at national, State and county level.	
WHO	Key actor	UN Partner agency. Leads on the health sector globally and in South Sudan. Provides emergency healthcare services and training around South Sudan, including water quality and malnutrition surveillance in target areas. Coordinates emergency health assistance through health cluster at national and State level.	Provides technical support in child health, including through support in IMNCI training and in BHI roll out training.  Supports emergency preparedness and response training and technical support for SRRT In Jonglei and Upper Nile	Regular meetings Facilitation of key trainings in child health
IOM	Important actor	UN Partner agency	Provides complementary services in the project area. Runs clinic at Malakal PoC,.	Regular meetings
UNFPA	Key actor	UN Partner agency. Leads in reproductive health and GBV sectors	Provides technical support in reproductive health	Regular meetings

Stakeholder	Importance of stakeholder/key characteristic	Stakeholder analysis/Interests	Degree of involvement in the project	Means of engagement
		globally and in South Sudan.	and Clinical Management of rape, including through facilitation of trainings and provision of family planning supplies and post rape kits for the supported health facilities in Jonglei and Upper Nile	
UNHCR	Key actor	UN Partner agency	Provides complementary services in the project area. Supports healthcare projects among refugees and other persons of interest in Upper Nile project with IMC, DRC and Relief International	Regular meetings
<b>NGOs and CSOs</b>				
PEHSP implementing partners	Critical player	PEHSP implementing partners have office and staff presence in the 25 counties in Jonglei and Upper Nile States in the sector of health as well as nutrition and wash for some implementing partners. Most have a longstanding presence in the counties where they work and have knowledge of the local institutional and community environment.	Implement the PEHSP at county level and are the primary responsible for the provision of health services at county level. Consult and engage closely with local authorities and CHDs to support the PEHSP implementation. Support CHDs in performing their stewardship functions.	Monthly bilateral meetings and ad hoc meetings/ working sessions with UNICEF at national and State level to ensure smooth implementation of the PEHSP and adequate provision of health services  Quarterly review meetings to review performance together with county and State authorities  Participation in capacity building trainings and initiatives under the PEHSP
Non PEHSP NGOs	Important actor	Provide services in the sector of health, nutrition, wash and	Complements PEHSP efforts to ensure gaps in provision of services	Participation in monthly coordination



Stakeholder	Importance of stakeholder/key characteristic	Stakeholder analysis/Interests	Degree of involvement in the project	Means of engagement
		protection (GBV). Their presence in the 25 counties of Jonglei and Upper Nile is positive as they supplement the PEHSP efforts.	not covered by the PEHSP are addressed	meetings chaired by CHD at county level  Regular meetings with PEHSP IPs and UNICEF in the coordination for the provision of health services in the States of Jonglei and Upper Nile
<b>Community level actors</b>				
Community traditional chiefs	Critical player	Widespread legitimacy, legacy of participation, able to resolve community level issues, links with government officials, mandated by law to be local authorities	Community mobilisation	Regular consultations and meetings with traditional chiefs by IPs and UNICEF during supervision visits
Women and youth groups.	Critical player	Involved in mobilization of communities, carrying out reaches and sensitization of mothers and youth. Such groups make the project more known and appreciated by communities. Have been trusted by people and can help the project to achieve its aims. Representatives of women and youth groups are members of the Boma Health Committees (BHC), which are the BHI governance body and voice women's and youth's concerns in the BHC meetings.	Community support to the project, positive impact to the vulnerable group, which eliminates elite capture.  Must be consulted since most service delivery issues impact them either directly or indirectly.	Regular consultation and engagement during PEHSP implementation  As active members of the BHCs, they are key actors in the implementation of the PEHSP Grievance Redress Mechanism (GRM) and to raise community concerns, in particular for women and youth.
Boma Health Committees	Critical player	The Boma Health Committee (BHC) is a multi-stakeholder platform for the governance of the BHI. BHC members must be selected by the community in a participatory and	BHCs in their routine activities ensure due diligence in service delivery, drugs use and hold monthly meetings to discuss overall service delivery and any concern regarding access to	Community engagement is sustained through BHC monthly meetings that discuss issues related to service delivery in the respective Bomas.

Stakeholder	Importance of stakeholder/key characteristic	Stakeholder analysis/Interests	Degree of involvement in the project	Means of engagement
		transparent process. Boma Health Committees contribute to ensure communities buy-in, acknowledgement and appropriateness.	services at community and health facility level. Through the PEHSP GRM, BHCs are instrumental to enhance local accountability and are a central entry point to channel community complains or abuses.	
Boma Health Workers	Critical player	The Boma Health Initiative (BHI) is the government's nationwide strategy to improve access to essential health services. Boma Health Workers aim at improving access to essential primary healthcare services in communities with limited access to health services.	<p>Boma Health Workers provide a package of community preventive, promotional and curative health services in their respective bomas and keep strong linkages with the nearest health facility.</p> <p>Boma Health workers were trained, equipped and deployed in the first phase of the PEHSP to provide community services, including lifesaving treatment for common childhood diseases such as malaria, pneumonia and diarrhoea, in addition to creating awareness for increased service uptake at supported health facilities in Jonglei and Upper Nile.</p>	<p>Monthly meetings between BHWs and health facilities/IPs to address issues related to provision of services at community level.</p> <p>As community actor, Boma Health Workers play a key role in the implementation of the PEHSP Grievance Redress Mechanism (GRM) by consulting household members during their routine consultations and channelling community concerns to IPs/health facilities.</p>
Women AAP Champions	Critical player	Older and younger women trained at boma level as community actors' part of the PEHSP GRM to channel women's concern	The AAP women's Champions serve as feedback and complaints channels, with a focus on women and	Regular consultation and engagement during PEHSP implementation

Stakeholder	Importance of stakeholder/key characteristic	Stakeholder analysis/Interests	Degree of involvement in the project	Means of engagement
			vulnerable people. They were also trained to communicate allegations of corruption and SEA into UNICEF's existing systems in a confidential manner.	As active members of the BHCs, they are key actors in the implementation of the PEHSP Grievance Redress Mechanism (GRM) and to raise concerns of women and vulnerable people.
Community Nutrition Volunteers	Important actor	Members of the community playing vital role in awareness and sensitization on nutrition mostly to mothers about children. Mostly funded by UNICEF and other donors.	Community support and involvement to the project, creates awareness. Complements the BHI efforts at community level covering bomas/areas not covered by BHI, particularly for nutrition services.	Regular meetings at community level to ensure complementarity with BHI
Religious leaders	Important actor	Trusted interlocutors and sources of information are generally thought to be neutral mediators, able to help chiefs resolve intra- and inter-communal conflicts, although activity beyond spiritual matters vary.	Can be approached by community members on some issues.	Integrated during regular community consultations and engagement during PEHSP implementation
Women and girls	Beneficiary	Beneficiaries and vulnerable group. Women and girls are typically left out of decision-making processes and do not generally hold public positions of authority in communities. Women and young girls are also particularly vulnerable to sexual violence.	Must be consulted since most service delivery issues impact them either directly or indirectly.	Integrated during regular community consultations and engagement during PEHSP implementation  Can approach elder women/women group leaders and AAP female champion (community actor part of GRM) as channel to raise their concern on provision of health services

Stakeholder	Importance of stakeholder/key characteristic	Stakeholder analysis/Interests	Degree of involvement in the project	Means of engagement
				Can raise concern related to SEA in a confidential manner through the PSEA hotline.
Internally displaced persons outside POCs	Beneficiary	Beneficiaries and vulnerable group. Crucial for meeting needs (as long as they can access primary healthcare services)	Vulnerable group	Integrated during regular community consultations and engagement during PEHSP implementation
Internally displaced persons inside POCs	Partial beneficiary	Beneficiaries (though also receiving healthcare from POC clinics outside the RRHP)	Vulnerable group	Integrated during regular community consultations and engagement during PEHSP implementation
Persons with disabilities and elderly persons	Beneficiary	Beneficiaries, generally requiring additional levels of healthcare support  Crucial for meeting needs (as long as they can access primary healthcare services)	Vulnerable group	Integrated during regular community consultations and engagement during PEHSP implementation

#### 4.2 Summary of stakeholder engagement done during project preparation specific to COVID-19 vaccine deployment

The Government of South Sudan joined Gavi AMC platform to implement COVID-19 vaccination. The technical working group (TWG) for COVID-19 vaccination was entrusted to provide technical support to the MOH of the Government of Republic of South Sudan in its effort to successfully implement COVID-19 vaccination activities. The group is composed of representatives from the technical agencies and implementing partners such as WHO, UNICEF, JSI, HPF, etc.

The TWG conducted regular meetings to prepare and implement the roadmap for development of the NDVP. Amongst the COVID-19 prevention and response related restriction on gathering, the meetings were conducted appropriately, face-to-face as well as virtual platform, on bi-weekly basis starting in January 2021 till March 2021, when the meetings were held daily to fast-track the development of NDVP until the actual vaccination activities kick started on 6 April 2021.

All the subcommittees of TWG supported the development of the respective areas of NDVP based on their technical scope e.g., regulatory preparedness, vaccine safety and surveillance, supply chain management, training, demand generation, service delivery, and monitoring and evaluation. WHO took a lead in the overall coordination and planning as well as technical lead in the areas of vaccine safety and surveillance, monitoring and evaluation. UNICEF was the technical lead for supply chain management, and demand generation whereas JSI led training activities, and HPF, the service delivery. UNICEF and WHO jointly worked on COVID-19 Vaccine Introduction and deployment

Costing tool (CVIC tool) for costing and budgeting the NDVP.

Once finalized by the country team, the draft NDVP was shared with the WHO/UNICEF regional offices (In Country Support team-IST) using “*Standard Review Form For National Deployment And Vaccination Plan For Covid-19 Vaccines*” for pre-review and feedback for quality improvement by. The feedback and comments of the pre-review team were attended by and addressed by the TWG and sub-working groups. The validated NDVP was cleared by MOH, and it was presented to Interagency Coordination Committee (ICC) by the MOH team led by Director General to seek approval for final submission. Following the approval from the ICC, the NDVP was submitted through WHO COVID-19 Partners Platform, an innovative digital ecosystem which operationalizes Strategic Preparedness and Response Plan (SPRP) for COVID-19 Pandemic. On 17 February 2021, the NDVP was approved, and the Government of Republic of South Sudan and immunization partners initiated the resource mobilization and activities implementation subsequently.

During Project preparation consultation meetings were conducted in past eight months with key stakeholders using multiple engagement platforms that included:

- Risk Communication and Community Engagement (RCCE) TWG meetings
- RCCE COVAX sub-committee meetings
- EPI TWG meetings
- COVAX TWG subgroup meetings
- Evidence generation including KAP studies and Community Rapid Assessments
- Community feedback initiatives to obtain community perceptions on COVID-19 and prevention including vaccines
- Toll-free hotline 6666 to share information, provide counselling and obtain feedback from communities on COVID-19 and prevention including vaccines.

UNICEF has used participatory planning and feedback mechanisms in the past six months to garner community and response authorities’ perceptions around COVID-19 vaccine, among other key COVID related topics. More than 2,000 households were reached in a community feedback project to solicit community centric areas of interest and concern around COVID -19 and its prevention including vaccines in the Greater Equatoria states. As part of evidence generation, Risk Communication partners under the leadership of MOH, South Sudan initiated a rapid KAP Assessment on COVID-19 targeting over 7,000 households in three rounds (a time series exercise) of the CRA survey to cover all the 10 states of South Sudan. In addition, over 125,000 people called on toll free number 6666 and 28000 called on toll free number 2222 for information on key health issues including COVID-19 and prevention.

Participants were members of the EPI/ RCCE and COVAX TWGs members, NGO partners and community respondents for the surveys conducted; MOH, Donors (including GAVI, FCDO, World Bank, CDC, USAID, KFW), organized forces and UN partners and agencies besides the general public that called into the toll-free hotlines.

Findings revealed from these initiatives has been presented to and informed plans of RCCE, EPI, COVAX TWGs and National Steering Committees. Many of these committees have taken up follow-up actions/meetings to discuss the ramifications for the COVID response including planning around the COVAX/vaccine introduction.

#### [4.3. Summary of project stakeholder needs and methods, tools and techniques for stakeholder engagement for COVID-19 vaccine deployment](#)

A precautionary approach will be taken to the consultation process to prevent infection and/or contagion, given the highly infectious nature of COVID-19. The following are some considerations for selecting channels of communication, in light of the current COVID-19 situation:

- Avoid public gatherings (considering national restrictions or advisories), including public hearings, workshops and community meetings.
- If smaller meetings are permitted/advised, conduct consultations in small-group sessions, such as focus group meetings. If not permitted or advised, make all reasonable efforts to conduct meetings through online channels.

- Diversify means of communication and rely more on social media and online channels. Where possible and appropriate, create dedicated online platforms and chat groups appropriate for the purpose, based on the type and category of stakeholders.
- Employ traditional channels of communications (TV, newspaper, radio, dedicated phone-lines, and mail) when stakeholders do not have access to online channels or do not use them frequently. Traditional channels can also be highly effective in conveying relevant information to stakeholders and allow them to provide their feedback and suggestions.
- Where direct engagement with project affected people or beneficiaries is necessary, identify channels for direct communication with each affected household via a context specific combination of email messages, mail, online platforms, dedicated phone lines with knowledgeable operators.
- Each of the proposed channels of engagement should clearly specify how feedback and suggestions can be provided by stakeholders.
- Identify trusted local civil society, ethnic organizations, community organizations and similar actors who can act as intermediaries for information dissemination and stakeholder engagement; engage with them on an ongoing basis. For effective stakeholder engagement on COVID-19 vaccination, prepare different communication packages and use different engagement platforms for different stakeholders, based on the stakeholder identification above. The communication packages can take different forms for different mediums, such as basic timeline, visuals, charts and cartoons for newspapers, websites and social media; dialogue and skits in plain language for radio and television; and more detailed information for civil society and media. These should be available in different local languages. Information disseminated should also include where people can go to get more information, ask questions and provide feedback.

In line with the above precautionary approach, different engagement methods are proposed and cover different needs of the stakeholders and will be informed by the learnings from previous national immunization campaigns (Polio /Measles/OCV/MNT/ EVD). Five key elements of the strategy have been developed in order to support the rollout and introduction of the COVID-19 vaccine at the national and state level. They include:

- Advocacy
- Capacity Building
- Mass media including social media
- Social mobilization and community engagement
- Crisis communication plans
- Details of the engagement methods that will cover different stakeholders are listed in the sections below.

#### 4.4. Strategy for information disclosure related to COVID-19 vaccination

Project stage	Target stakeholders	List of information to be disclosed	Methods and timing proposed
1. Pre-Campaign	<p><u>Media briefing</u></p> <p>All the major print and electronic media houses of the country</p>	<ul style="list-style-type: none"> <li>• Need and importance of COVID-19 vaccines</li> <li>• Operational plan for the campaign</li> <li>• Target groups</li> <li>• Vaccine to be used</li> <li>• AEFI and crisis communication planning</li> <li>• Time of the campaign</li> <li>• Technical information about the campaign</li> <li>• Social mobilization and community engagement for campaign</li> <li>• Role of media during the campaign</li> </ul>	<ul style="list-style-type: none"> <li>• Virtual and face to face briefing.</li> <li>• One week before the commencement of the campaign</li> </ul>
	<p><u>Community mobilization</u></p> <p>House to house mobilization by Community mobilizers</p>	<ul style="list-style-type: none"> <li>• Date, time and venue of the COVID-19 campaign</li> <li>• Safety and basic facts about the vaccine</li> <li>• Reasons for prioritization</li> <li>• Responding to community questions in interactive counselling sessions</li> </ul>	<p>Three days prior and ongoing to campaign through house-to-house mobilization and using communication materials</p>
	<ul style="list-style-type: none"> <li>• Rumour tracking to dispel rumours related to vaccine and its roll out, COVID -19</li> <li>• Toll free helpline to provide correct information and counselling</li> </ul>	<ul style="list-style-type: none"> <li>• Addressing rumours, misconceptions, doubts and concerns using the rumour tracking tool</li> <li>• Realtime allaying of concerns, questions and misconceptions around COVID-19 vaccine and its roll out</li> </ul>	<p>Ongoing activity starts one week prior to campaign</p>

Project stage	Target stakeholders	List of information to be disclosed	Methods and timing proposed
	<p><u>Orientation of influencers</u></p> <p>Key religious leaders from South Sudan Council of Churches and Islamic Council</p>	<ul style="list-style-type: none"> <li>• Need and importance of COVID-19 vaccines</li> <li>• Operational plan for the campaign</li> <li>• Target groups</li> <li>• Vaccine to be used</li> <li>• AEFI and crisis communication planning</li> <li>• Time of the campaign</li> <li>• Technical information about the campaign</li> <li>• Social mobilization and community engagement for campaign</li> <li>• Desired support of religious leaders during campaign to create trust among communities regarding the vaccine</li> </ul>	<ul style="list-style-type: none"> <li>• Face to face meetings</li> <li>• One week prior to campaign</li> </ul>
	<p><u>Advocacy meetings</u></p> <p>Mothers Union and other CBOs for sensitization on COVID-19 vaccination</p>	<ul style="list-style-type: none"> <li>• Need and importance of COVID-19 vaccines</li> <li>• Operational plan for the campaign</li> <li>• Target groups</li> <li>• Vaccine to be used</li> <li>• Time of the campaign</li> <li>• Technical information about the campaign</li> <li>• Social mobilization and community engagement for campaign</li> <li>• Desired support of women religious leaders and CBOs during campaign</li> <li>• Building trust for the vaccine</li> </ul>	<ul style="list-style-type: none"> <li>• Face to face meetings</li> <li>• One week prior to campaign</li> </ul>



Project stage	Target stakeholders	List of information to be disclosed	Methods and timing proposed
	Payam and BOMA chiefs in the areas targeted for the campaign	<ul style="list-style-type: none"> <li>• Need and importance of COVID-19 vaccines</li> <li>• Operational plan for the campaign</li> <li>• Target groups for phase one</li> <li>• Prioritization of population groups in phase one</li> <li>• Vaccine to be used</li> <li>• Reasons for AstraZeneca vaccine to be used in the country</li> <li>• AEFI and crisis communication planning</li> <li>• Time of the campaign</li> <li>• Technical information about the campaign</li> <li>• Social mobilization and community engagement for campaign</li> <li>• Roles and responsibilities of Payam and BOMA chiefs during the campaign</li> <li>• Building trust for the vaccine</li> </ul>	<ul style="list-style-type: none"> <li>• Face to face meetings</li> <li>• One week prior to campaign</li> </ul>
	<u>Mass media engagement</u> General public and target beneficiaries, policy makers and other stakeholders	<ul style="list-style-type: none"> <li>• Need and importance of COVID-19 vaccines</li> <li>• Operational plan for the campaign</li> <li>• Target groups for phase one</li> <li>• Prioritization of population segments in phase one and subsequent phases</li> <li>• Reasons for AstraZeneca vaccine to be used in the country</li> <li>• AEFI and crisis communication</li> <li>• Timing and technical information</li> <li>• Social mobilization and community engagement</li> </ul>	One week before and during the campaign

Project stage	Target stakeholders	List of information to be disclosed	Methods and timing proposed
	<u>Capacity building</u> Training of health workers, community mobilisers, Payam supervisors, County supervisors on community engagement activities	<ul style="list-style-type: none"> <li>• Importance of COVID -19 vaccine and FAQs</li> <li>• Operational plan for the campaign</li> <li>• Role of health workers and mobilisers</li> <li>• Target groups for phase one</li> <li>• Prioritization of key population segments in the campaign</li> <li>• Reasons for AstraZeneca vaccine to be used in the country</li> <li>• AEFI and crisis communication planning</li> <li>• Timeline and technical information about the campaign</li> <li>• Social mobilization and community engagement</li> <li>• FAQs</li> <li>• IPC/Community mobilization activities for COVID-19 campaign</li> </ul>	One week before the campaign
2. Intra-campaign	<u>Launch ceremony</u> General public and target beneficiaries, policy makers, media and other stakeholders	<ul style="list-style-type: none"> <li>• Need and importance of COVID-19 vaccines</li> <li>• Operational plan for the campaign</li> <li>• Target groups for phase one</li> <li>• Prioritization of key population groups in various phases</li> <li>• Reasons for AstraZeneca vaccine to be used in the country</li> <li>• AEFI and crisis communication planning</li> <li>• Technical information about the campaign</li> <li>• Social mobilization and community engagement for campaign</li> </ul>	National launch, first day of the campaign
	<u>House-to-house mobilization by community mobilizers</u>	<ul style="list-style-type: none"> <li>• Date, time and venue of the COVID-19 campaign</li> <li>• Safety and basic facts about the vaccine</li> <li>• Reasons for prioritization</li> <li>• Responding to community questions in interactive counselling sessions</li> <li>• Building trust around the vaccine and its roll out</li> </ul>	5 days during the campaign through house-to-house visits (in addition to three days prior to the campaign)

Project stage	Target stakeholders	List of information to be disclosed	Methods and timing proposed
	<u>Campaign monitoring and supportive supervision</u> County, Payam supervisors, national EPI/C4D officers, MOH and partners	<ul style="list-style-type: none"> <li>Monitoring of the campaign roll out</li> <li>Review meetings on social mobilization</li> <li>Supportive supervision and hands on support</li> <li>Compilation of social data</li> </ul>	During the campaign
<b>3. Post campaign</b>	Post campaign Review meeting	All partners and MOH and COVAX TWG	One week after the campaign
	Documentation of lessons learnt to inform next phase of the campaign Human-interest stories	MOH and partners	Immediately after the campaign
	Report writing and data collection	MOH and partners	Immediately after the campaign

In line with WHO guidelines on prioritization, the initial target for vaccination under the Project is to reach 20% of the population in each country, prioritizing health care workers, other essential workers, and the most vulnerable, including the elderly and people with underlying co-morbidities. As all people will not receive vaccination all at the same time, inadequate or ineffective disclosure of information may result in distrust in the vaccine or the decision-making process to deliver the vaccine.

Therefore, UNICEF will support the government to ensure that information to be disclosed:

- Is accurate, up-to-date and easily accessible;
- Relies on best available scientific evidence;
- Emphasizes shared social values;
- Articulates the principle and rationale for prioritizing certain groups for vaccine allocation;
- Includes an indicative timeline and phasing for the vaccination of all the population;
- Includes explanation of measures that will be used to ensure voluntary consent, or if measures are mandatory that they are reasonable, follow due process, do not include punitive measures and have a means for grievances to be addressed;
- Includes explanation of vaccine safety, quality, efficacy, potential side effects and adverse impacts, as well as what to do in case of adverse impacts;
- Includes where people can go to get more information, ask questions and provide feedback;
- Includes the expected direct and indirect economic costs of the vaccines and addresses measures should there be serious adverse impact on stakeholders due to the vaccine, such as serious side effects; and
- Is communicated in formats taking into account language, literacy and cultural aspects.

- Over time, based on feedback received through the Grievance Mechanism and other channels, information disclosed should also answer frequently asked questions by the public and the different concerns raised by stakeholders.
- Misinformation can spread quickly, especially on social media. During implementation, UNICEF will support the government to assign dedicated staff to monitor social media regularly for any such misinformation about vaccine efficacy and side effects, and vaccine allocation and roll out. The monitoring should cover all languages used in the country.
- If the government plans the engagement of security or military personnel is being considered for deployment of vaccines, UNICEF will support the government to ensure that a communication strategy is in place to inform stakeholders of their involvement and the possibility of raising concerns and grievances on their conduct through the Grievance Mechanism.

The communication strategy supports the COVID-19 vaccine rollout in South Sudan and seeks to disseminate timely, accurate and transparent information about the vaccine to allay apprehensions about the vaccine, address information needs of the people and ensure its acceptance and encourage uptake. The key approaches are outlined below.

#### **A. Advocacy:**

Advocacy seeks to ensure strong commitment by the stakeholders. Advocacy is a well-defined process based on demonstrated evidence to influence decision-makers, stakeholders and audiences to support and/or implement policies or actions related to the advocacy goal. Programme Advocacy reaches out to decision makers and community partners to boost their participation in local actions and programme decisions in support of COVAX vaccination campaign. Programme advocacy is used at the local community level to convince opinion leaders about the need for local action.

1. Media advocacy helps in creating an enabling environment for the introduction and acceptance of COVEX vaccine in the country. In case of COVID-19 vaccination advocacy should be done by MOH and SMOHs, along with key partners like WHO, UNICEF, CSOs, INGOs etc. to ensure that COVID-19 vaccination campaign is smoothly executed and cover the vast target of eligible population. Advocacy with the following groups is important for promoting and acceptance of COVID-19 vaccination in the country. Media plays a critical role in any public health initiative. In case of the COVID-19 campaign, it has an important role in creating and influencing perceptions of public on the campaign. Media engagement workshops need to be carefully planned at least two weeks prior to the launch.
2. Advocacy with public representatives & key government officials
  - a) State level/County
  - b) Payam level

Advocacy meeting must be planned for the government officers, to see that the offices are very well briefed on the objectives of the campaign. The expected support from government officers should also be highlighted. Local public representatives (Ministers), DGs, County Commissioners must be briefed well in advance about the need and planning for COVID-19 vaccination in the country.
3. Advocacy with Lobby Groups:
  - Identify all the lobby groups existing at the state level and establish an understanding about their position on COVID-19 vaccination.
  - Seek guidance from National level – MOH to develop state level Interventions to actively engage with the lobby groups.
4. Advocacy with Influencers:
  - Religious leaders including a close partnership with South Sudan council of churches, Islamic council, community leaders, Teachers, celebrities, sports persons and other possible celebrities.
  - NGOs, CBOs and faith-based organizations.

- Traditional Healers: In some parts of the country especially in rural and tribal areas, traditional healers play a major role and influence the decisions of the parents, caregivers and community members at large. Therefore, it is essential to identify and include them during the orientation

5. Advocacy with various line Ministries:

- Advocacy also to be directed towards Line Ministries and as they can influence the primary beneficiaries directly. FAQs for Line Ministries have been developed and should be shared with concerned line ministries so that they can deal with the queries of the public
- One to one meeting should also be utilized for advocacy. Information should be given out to the parents before the vaccination round – which includes the date of the vaccination advocating for the children to not miss school on that day.

**Key Components of the Advocacy Strategy**

Advocacy efforts will aim to engage the maximum number of people by promoting the benefits of COVID-19 vaccine and support in building an enabling environment. Various stakeholders and experts will lead the advocacy campaigns at national, state and district level. These include (but are not limited to):

- Parliamentarians
- ICC members
- National Health ministers and deputy ministers
- Under secretaries
- Ministers of other Line ministries
- State Governors
- State directors
- State Ministers
- County commissioners
- County executive directors
- Director Generals
- Development partners including NGOs/INGOs
- Faith based organizations like SSCC and Islamic council
- Paramount chiefs, Payam & BOMA chiefs
- Women and youth chiefs

**B. Capacity building of key stakeholders**

It will be important to orient and train all those stakeholders who will be responsible for the implementation of communications actions, in both urban, rural areas and IDPs. Communications training will be carried out in line with the training modules that have been developed to plan and implement communications actions at all levels. States will be required to identify training mechanisms to reach the extensive network of frontline workers, health care providers, community-based volunteers, influencers and other stakeholders in remote areas to ensure outreach to the last mile, while also ensuring an equal focus on the urban areas and the IDP camps and other hard to reach locations. Capacity building of key frontline staff and gatekeepers (health practitioners, call centre operators, community health workers, media personnel, leaders of CSOs and Faith Based Organizations (FBOs) etc.). These groups will acquire knowledge on the COVID-19 vaccine and obtain interpersonal communication skills to engage effectively with the primary and secondary audiences.

The following cadres will be trained/oriented to support the implementation of the communications plan:

- Communication team members at National, State and county levels
- Vaccination team members
- Social mobilisers
- Community leaders

- Payam and Boma
- NGOs/CBOs
- Key officials from various line ministries
- CSOs, FLWs, influencers, youth networks, volunteers, women’s networks
- Religious institutions and leaders
- Staff of National Hotline Call Centres (6666) and (2222)

**C. Mass media Including social media:**

The mass media component will focus on well-crafted campaigns that combine radio Talk shows in programmes and spots on both state and community stations. Mass media will be used to both provide information, as well as a call to action during the campaign. The radio talk shows will be organized from various national and vernacular radio stations focusing on the need and importance of COVAX vaccination in the country. Radio jingles will be played from all radio stations in targeted states as the Jingles will be produced in 10 widely spoken languages of the country. Mass media component will focus on well-crafted campaigns that combine radio talk shows in programmes and spots on both state and community stations. Mass media will be used to both provide information, as well as a call to action during the campaign.

Social media: social media platforms will be used to re-enforce other channels. Innovative use of mobile technologies will be explored to improve frequency of messaging and ensure efficient communication during COVID-19 vaccination campaign. The same could be explored with the help of vaccinators to trace the beneficiaries for vaccination.

**D. Social mobilization and community engagement**

Social mobilization actions will focus on risk communications and community engagement. It will respond to perceptions of communities and health service providers on the COVID-19 vaccines and ensure that all people perceive and understand the vaccination process correctly and act accordingly.

The social mobilization plan will focus on: (i) the phased vaccination plan (ii) addressing vaccine related doubts on one end and vaccine hesitancy on the other.

The social mobilization plan will be contextualized to state and community requirements, and address state-specific variations and vulnerabilities such as urban-rural, IDPs, Urban pockets and hard to reach pockets. While social mobilization actions will reach public across all categories, it will specifically focus on motivating and supporting the priority groups for COVID-19 vaccination and their family members through community consultations and inter-personal communication during the campaign.

The key stakeholders identified for social mobilization are:

- Community-based organizations, NGOs/INGOs Alliances
- Community leaders and chiefs
- Health functionaries and teachers
- Faith-based institutions and networks
- Social mobilisers of various NGOs/CBOs working in the field
- Youth and women networks
- BOMA health workers

The social mobilization activities will include community meetings, participatory activities, traditional media group performances, rallies, talk shows, Miking announcements, Boda Boda shows, road shows and home visits. Interpersonal communication and group consultations will be organized using frontline functionaries and local influencers to engage people to dispel misconceptions and fears regarding the vaccination process. All the above common Communications materials and tools like posters, banners, leaflets, pamphlets, FAQs, interactive videos will be widely used for easy communication

Evidence suggests that using multiple BCC approaches and channels to change behaviours is more effective than using one. As per the prior experience in the country, use of multiple channels is recommended for success of the campaign highlighted community health workers, ICMN community mobilisers, Radios, Megaphone announcements and house to house mobilization, health facilities, community events (e.g. drama, skits or songs) and radio as the key sources of information.

Identification of vaccine hesitant groups, groups requiring high information on the campaign beforehand and specific communication plans are required for different audiences/ settings; for example, schools, underserved communities, tribal populations, urban settings.

- Sensitizing and engaging of FBOs who have been extremely helpful in previous campaigns.
- Private and government school principals/ nodal teachers/management is critical and important for this campaign. They need to be sensitized by district and sub-district medical officials.
- Media sensitization to carry the positive articles/ videos and radio programmes supporting the campaign.
- Tackling negative media stories through proactive media engagement, opinion articles and media sensitization. Media package will be provided by MOH which can be circulated pre, and during campaign.

The previous vaccination/SIAs campaigns have brought forth multidimensional insights and immense lessons which are crucial to the effective roll-out of the campaign in the country and recommended certain changes in the communication strategy to address the challenges. Lessons learned from previous campaigns will be used to guide the COVID- 19 communication strategy in the country.

Community mobilization: The community mobilization component will engage relevant NGOs, FBOs, CBOs, community-based volunteers, and other civil society groups to roll out the communication Plans. Activities will include involvement in mass campaigns, sensitization among school-aged children; utilization of mother support groups and other identifiable groups, theatre performances, folk songs, sports events, dance performances, mobile information vehicles, and other creative outlets determined by communities. At the community level, local leaders and citizens, CBOs, FBOs, will be mobilized to increase awareness and to correct misconceptions about COVID-19

Interpersonal Communication; interpersonal communication (IPC) will be used to engage in dialogues to influence knowledge, attitudes and practices of specific audiences at the community level, with health service providers including social mobilizers having the responsibility of increasing demand for COVAX services and correcting misconceptions, promoting acceptance and utilization of the available preventive measures, ensuring prompt treatment seeking for COVID -19 symptoms and adherence to treatment options provided by the health workers. Apart from the facility-based health discussions, similar activities will be done in communities, targeting villagers in their local settings like churches, water points, IDPs and marketplaces. Community engagement activities through ICMN Mobilisers, BOMA health Initiative workers e.g. IPC during household visits, community and health facility events, will be given priority while mass media and IEC materials will be used to reinforce these community engagement activities.

#### Tapping into Community Systems

To initiate this process of ensuring COVID-19 vaccination -prepared communities, it will be necessary to tap into the administrative (e.g. village health committees) and traditional systems (e.g. traditional birth attendants) and Traditional healers that support communities. This will ensure that implementing partners better understand and challenge cultural barriers to COVID-19 prevention and control. The community will be on the centre stage of COVID-19 vaccination services in the country as there will be consultative dialogues and discussion on the timings, venue, communication material etc. required for conducting campaigns in various communities

#### **E. Crisis Communication Plan for COVAX campaign: Republic of South Sudan**

As part of the preparations for COVAX campaign, it is important to prepare to respond to any crisis that may arise during the campaign and require a communication response.

Adverse Event Following immunization: An adverse event following immunization (AEFI) is

- a medical incident
- takes place after immunization
- causes concern
- is believed to be caused by immunization or may also turn out to be “coincidental”.

Crisis communication: In the context of immunization, a crisis is a situation when there is a rumour or actual incident following immunization that may cause a negative effect on the vaccine uptake; people may lose confidence in the vaccine and refuse to accept it. In worst case situation, there may be death of a child/adult after being vaccinated. Whatever may be the reason for the situation, there will be a crisis-and an urgent need to communicate effectively to mitigate the damage it could do to the programme and subsequently to the health of the population. There may also be anti-vaccine groups who may have an interest in demotivating people from going for vaccination and can publish anti-vaccine sentiments in the media.

Usually, the crisis communication is not given as much attention as it should get. There may be inadequate capacity among health staff at various levels to respond to crisis or following adverse events following immunization. There may be lack of preparedness in terms of planning or being ready to respond to the situation. Therefore, a careful plan to deal with crisis communication is very important.

General Principles to follow: The main thing to keep in mind in a crisis is to be transparent about the situation and provide correct information quickly to minimize the negative impact of the situation. The team responsible for the crisis communication must be well informed about the crisis and must immediately act on the role assigned to them. Everyone associated with the planning and implementation of the COVAX campaign, should strictly inform the crisis management team about the situation in case of any issues and refer inquiries to the designated spokesperson(s).

Communication structures: Establish/activate crisis communication structures in place and identify spokespersons for various levels.

***Composition at National level:***

- Spokesperson (Ministry of Health or a neutral person-a public health specialist, medical doctor or anyone who is respected and well known and credible)- The Minister or any other designated spokesperson by the Ministry.
- National EPI manager
- Head of Health Promotion Unit
- Members of existing health promotion/communication sub-group (UNICEF, WHO and other partners?)-names and contacts of the members
- Someone from the pharmaceutical company involved in the campaign
- Composition at State level:
- Spokesperson (Ministry of State Ministry of Health or a neutral person-a public health specialist, medical doctor or anyone who is respected and well known and credible)- The Minister or any other designated spokesperson by the Ministry.
- State EPI manager
- Head of Health Promotion Unit at state level
- Members of existing health promotion/communication sub-group (UNICEF, WHO and other partners?)-names and contacts of the members
- Someone from the pharmaceutical company involved in the campaign

***Composition at County level:***

- County Health Departments.
- Head of Health Promotion Unit at county level.
- Members of existing health promotion/communication sub-group (UNICEF, WHO and other partners?)-names and contacts of the members.



**Communication tree:**

Determine and decide beforehand:

- Who will communicate if any crisis arises? How will it be relayed to other members?
- How quickly will the team meet and where? Decide beforehand and agree so that everyone is clear and will act immediately
- Have phone numbers of all the members.
- Roles and responsibility of the crisis communication team and spokespersons:
- Head of the Health Promotion Unit will lead on organizing emergency communication meetings at MOH.
- A pre-written press release will be prepared as a back-up and will be completed if/when a crisis arises -filling in the details.
- Spokesperson (who will have been oriented/trained beforehand) will be the one to speak to the media with the press release.
- The spokesperson will have the frequently asked questions, fact sheets and relevant documents as back up material
- Media briefing will be organized in a short frame of time, depending on the type of crisis

**Preparation before the campaign:**

- Be fully informed about the vaccine and the issue at hand
- Orient/train spokespersons on how to communicate in case of a crisis
- The crisis communication team should ensure that crisis communication will be part of health workers' training at all levels-keep it simple and do not create panic. It is about being ready to respond to crisis-not to create fear of possible AEFIs
- Understand what the media is looking for and what media can do
- Form good relationship with the media: supply accurate stories and facts on immunization from time to time
- Have a draft press release ready beforehand
- Develop a set of messages on dos and don'ts beforehand
- Develop and provide factsheets and relevant questions and answers about COVAX vaccination to spokespersons beforehand.
- Inform the public about the vaccination campaign using both traditional and new media by emphasizing key messages and by answering frequently asked questions.

**In case of a crisis:**

- Activate the communication tree to inform all members
- Meet immediately and discuss on and agree on key steps and messages and channels
- Depending on the seriousness of the case and if the news has been picked up by national media, organize a press conference immediately to inform media
- Release a press statement through relevant media. In the case of SSD, which media would be the best?
- If it is a district specific case, which has not been picked up by national media, the team at the national level will provide guidance to the district on what messages to give at state level
- Update media on what actions are being taken by the Government.

**Crisis at state level:**

- Social mobilisers should always be vigilant about possible rumours or AEFI and report cases of rumours to the health facility in-charge
- The spokesperson at the community level should talk to the affected child's family/care givers and re-assure them about the nOPV-2 vaccine being safe
- Do not let rumours float around-be compassionate but honest with the families. In low trust, high concern situations, empathy and caring often carry more weight than numbers and technical facts.
- Do not give false messages and false promises
- Admit uncertainty
- Convey that the AEFI will be reported and investigated fully
- Keep the community informed with follow-up information

### **Crisis Response Team**

It is essential to set up crisis response teams and RACI (Responsible, Actors, Consulted, Informed). The central and crisis response team must represent the individuals of the organizations and stakeholders who will be responsible for responding to a crisis. The RACI team should include all surrounding stakeholders who will have a role to play in resolving the crisis and/or in the crisis report).

The Crisis Response Team is the central group or at the levels of the departments of decision-makers and implementers who will have to respond to a crisis. In the context of South Sudan, however, it is very important to train crisis communication subgroups to monitor Rumours and coordination and to establish an appropriate and timely response at every level.

#### **4.5. Strategy to incorporate the view of vulnerable groups**

The Project will carry out targeted stakeholder engagement with vulnerable groups which includes IDPS, urban poor, POC, women etc the to understand concerns/needs in terms of accessing information and vaccination services for the campaign and other challenges in their communities. Consultative process will be adopted to reach out to the vulnerable population as will include the community leaders like Payam and BOMA chiefs to involve them in the process of planning and execution of the activities in their catchment areas. The details of strategies that will be adopted to effectively engage and communicate to vulnerable group will be considered during project implementation.

To initiate this process of ensuring COVID-19 vaccination, it will be necessary to tap into the administrative (e.g., village health committees) and traditional systems (e.g. traditional birth attendants) and traditional healers that support communities. This will ensure that implementing partners better understand and challenge cultural barriers to COVID-19 prevention and control. The community will be on the centre stage of COVID-19 vaccination services in the country as there will be consultative dialogues and discussion on the timings, venue, communication material etc. required for conducting campaigns in various communities The project will carry out targeted stakeholder engagement with vulnerable groups to understand concerns/needs in terms of accessing information, medical facilities and services and other challenges they face at home, at workplaces and in their communities. Special attention will be paid to engage with women as intermediaries. The details of strategies that will be adopted to effectively engage and communicate to vulnerable group will be considered during project implementation .

#### **4.6. Reporting back to stakeholders**

Stakeholders will be kept informed as the Project develops, including reporting on project environmental and social performance and implementation of the stakeholder engagement plan and GRM. The GRM outlined in section 5 of this document embeds feedback activities as well.

Specific to COVID-19 vaccination deployment activities some activities to report back to stakeholders include:

- A robust Integrated Community Mobilization Network (ICMN) of community based social mobilisers will be used for two-way communication with the community level stakeholders. These mobilisers will share information with the communities, collect feedback from them and relay these to the authorities and relevant stakeholders. They will also provide information to the communities on questions, queries and concerns raised by them.
- The rumour tracking tool and toll-free hotlines will be used to collect information and address any concerns. This information will flow both ways from the communities to the authorities and planners and from the authorities to the communities using these platforms of engagement.
- All IEC materials, mass media messages (interactive radio talk shows, radio and television channels) will be updated/ revised to reflect the community feedback and concerns.
- Robust tracking and monitoring system online and offline tools will be used to inform the planning and project stakeholders among others of the progress.
- Rumour analysis framework will be developed and used to categorize rumours into specific responsible sector of the system to address. Rumours that emanated from:

- Social media – Facebook, Instagram, WhatsApp, etc.
- Population specific focus group discussions (e.g., with men /women on gender-based barriers)
- Mini surveys using Internet of Good Things, CRAs
- RCCE and EPI TWGs, implementing partners forums
- Radio talks shows and call -ins

## 5. Grievance mechanism

The main objective of a Grievance Mechanism (GM) is to assist to resolve complaints and grievances in a timely, effective and efficient manner that satisfies all parties involved. Specifically, it provides a transparent and credible process for fair, effective and lasting outcomes. It also builds trust and cooperation as an integral component of broader community consultation that facilitates corrective actions. Specifically, the GM:

- Provides affected people with avenues for making a complaint or resolving any dispute that may arise during the course of the implementation of projects.
- Ensures that appropriate and mutually acceptable redress actions are identified and implemented to the satisfaction of complainants; and
- Avoids the need to resort to judicial proceedings.
- Rumour tracking analysis and response through radio talk shows, community engagement, house to house interpersonal communication as relevant.

The Project will implement an existing grievance redress mechanism (GRM) developed and implemented under PESHSP which aligns with ESS 10. The GRM will be updated as described in the LMP and consistent with ESS2. It will also be updated to leverage existing mechanisms under regular immunization programming to provide a grievance mechanism for national COVID-19 vaccine deployment stakeholder.

South Sudan is a complex context in which many people are poor, live in difficult to reach and isolated communities, and are socialised into engaging outsiders through representatives. In addition, many likely have different understandings of accountability to the project’s planners and prefer to resolve issues within their communities. At the same time, the recent signing of an agreement to form a coalition government gives hope that the current peace may be solidified and the government able to work on strengthening its vertically integrated health sector. Through the BHI, the MOH’s service model aims to include the chieftainship system which, despite drawbacks, remains the most legitimate and primary organising unit for communal life. It also promises a network of BHWs able to act as the eyes and ears of the MOH and its partners beyond health facilities.

Any GRM must acknowledge and, as far as possible, seek to address these challenges by capitalising on the government’s commitments and existing ways of doing things. Yet, to ensure vulnerable community members have a voice, it should also seek to improve upon and add to current arrangements and plans, and to create an enabling environment for social accountability relationships. This can be done through targeted trainings, incremental interventions and by cultivating allies at all levels of the health sector.

To do this, the GRM proposed below will be structured around the BHI, health facilities and the PESHSP’s existing monitoring, evaluation and learning routines. Its modular design means that its five streams can be implemented as key stakeholders’ capacities are built and buy-in is secured. Each stream is designed to complement the others, with the goal of providing an inclusive and safe GRM that closes the feedback loop with communities and builds trust, sensitively handles corruption and SEA allegations, and provides the project with actionable data through which to adjust and improve its programming. UNICEF uses the term Accountability to Affected Populations (AAP) to encompass activities which include a GRM therefore the term AAP is used throughout this section.

Figure A below displays the AAP mechanism. Information flows in Stream 1 are represented by green arrows, Stream 2 by blue, Stream 3 by yellow, and Stream 4 by dark red. The black dashed arrow represents data reported to UNICEF

from partners and the purple dashed arrows the sharing of reports with findings and analysis among stakeholders.

Figure A: Multi-stream AAP mechanism

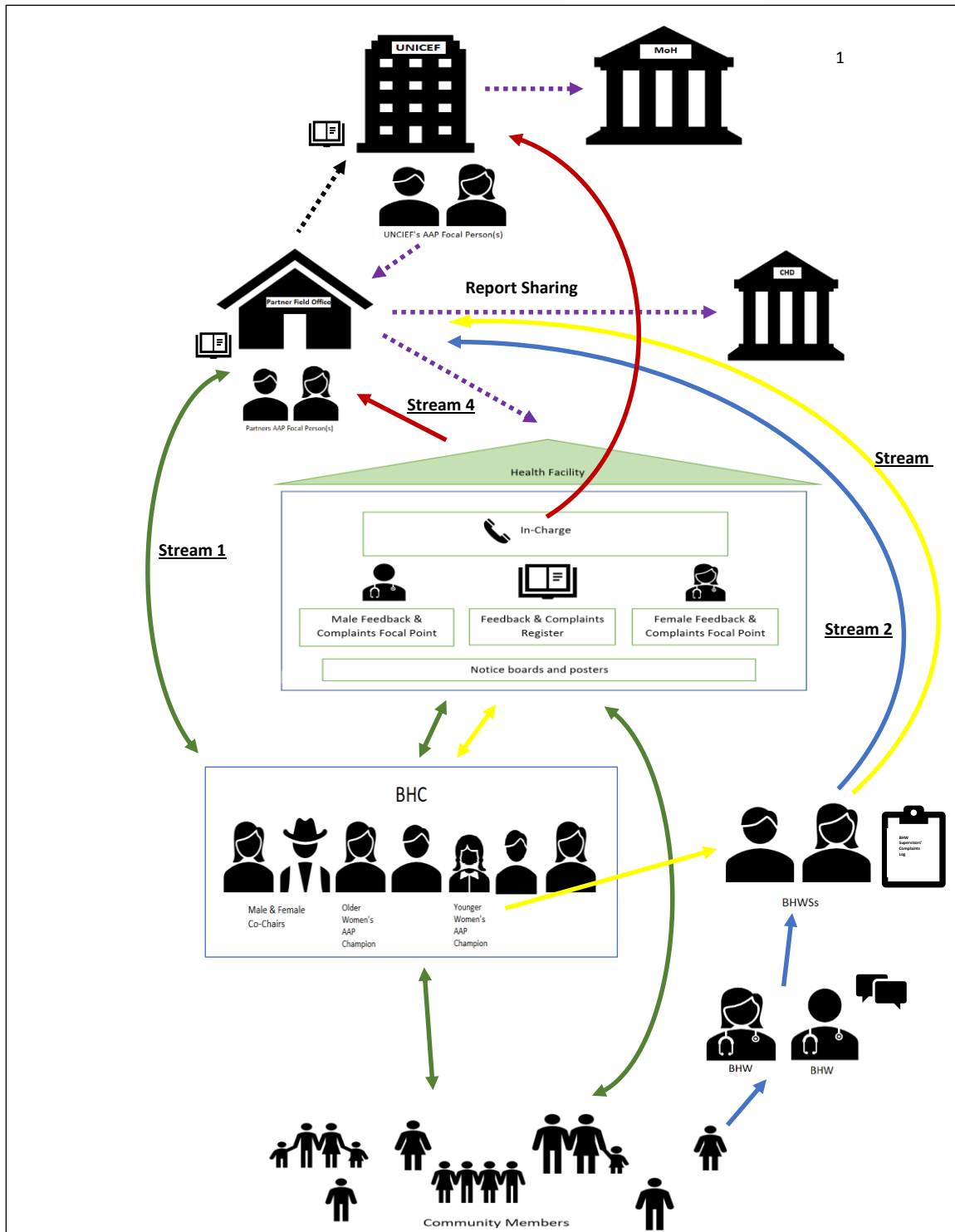


Table 2 overviews the actors involved, reporting mechanisms, information flows, tools and training required for all five streams. The following sections add further detail on their rationale and functioning.

Table 2: Stream Actors and Mechanisms

Stream	Communities' Feedback and Complaints Lodging Channels	Actors Involved in the reporting chain	Recording Tools	Record Collected by / Sent to	Training
<b>1) BHCs</b> (green arrows)	<i>Verbal:</i> Approach from community members to BHC members within communities, at any point in time or at BHC bi-monthly meetings, or at Community Health Dialogues	BHC members report to either:  (1) Health Facilities' Focal Points  (2) Partners' Focal Person(s)	(1) Health facility Feedback and Complaints Registers  (2) Partners' Complaints Logs	(1) Health facility Feedback and Complaints Registers collected by partners monthly, data entered Partners' Complaint's Logs and sent to UNICEF monthly  (2) Partners' Complaint's Logs sent to UNICEF monthly	To BHC Members: AAP, SA, PSEA, Corruption  To BHC Women Co-Chairs: As above.  To Partners: BHC Women Co-Chair nomination facilitation
<b>2) BHWs' Diaries</b> (blue arrows)	<i>Verbal:</i> Approach from community members to BHWs during household visits during which health related questions are asked	BHWs verbally report to their BHW Supervisors	BHW Supervisors' Complaints Log	BHW Supervisors' Complaints Log collected monthly by partners and analysed. Feedback and complaints recorded in Partners' Complaints Log sent to UNICEF monthly	To BHW Supervisors: AAP, SA, PSEA, Corruption, recording BHWs' Diaries  To BHWs: AAP, SA, PSEA, Corruption, Household question asking, GBV
<b>3) Women's AAP Champions</b> (yellow arrows)	<i>Verbal:</i> Approach from community members to	Women's AAP Champions report to either:	(1) Health facility's Feedback and	(1) Health facility Feedback and Complaints	To Women's AAP Champions: AAP, SA

Stream	Communities' Feedback and Complaints Lodging Channels	Actors Involved in the reporting chain	Recording Tools	Record Collected by / Sent to	Training
	Women's AAP Champions within communities at any point in time or at BHC bi-monthly meetings, and at Community Health Dialogues	(1) Health Facilities' Focal Points  (2) BHWs Supervisors (for issues that involve or cannot be communicated to Health Facilities' Focal Points)	Complaints Registers  (2) BHW Supervisors' Complaints Log	Registers collected by partners monthly, data entered Partners' Complaint's Logs and sent to UNICEF monthly  (2) BHW Supervisors communicate issue to partners at monthly or ad-hoc meetings. Partners' capture in their own Complaints Log.	PSEA, Corruption, Safeguarding, GBV
<b>4) Health Facilities</b>  (red arrow)	<i>Verbal:</i> Approaches from community members to health facility staff	Health facility staff direct community members to health facility Male or Female AAP Focal Points	(1) Health facility Feedback and Complaints Registers  (2) Sensitive feedback and complaints that involve partners' conduct handled by In-Charge  (3) Feedback and complaints collected by UNICEF Focal Person(s) during supervisory visits	(1) Health facility Feedback and Complaints Registers collected by partners monthly, data entered into Partners' Complaint's Log and sent to UNICEF monthly  (2) Health Facility In-Charge direct to UNICEF, in-person or by phone. Recorded in UNICEF's Complaints Log	To health facility AAP Focal Points: AAP, SA, PSEA, Corruption

Stream	Communities' Feedback and Complaints Lodging Channels	Actors Involved in the reporting chain	Recording Tools	Record Collected by / Sent to	Training
				(3) Recorded in UNICEF's Complaints Log	
<b>5) Community Health Dialogues</b>  (not on diagram)	<i>Verbal:</i> Approaches from community members to stakeholders attending Dialogues	BHC members, BHWs, BHWs Supervisors, health facility AAP Focal Points, partners and UNICEF's AAP Focal Person(s), UNICEF health staff, CHD representatives, media	(1) Health facility Feedback and Complaints Registers for all publicly declared issues  (2) Partners' Complaint's Log for privately communicated issues  (3) UNICEF's Complaints Log for privately communicated issues	(1) Health facility Feedback and Complaints Registers collected by partners monthly, data entered into Partners' Complaint's Log and sent to UNICEF monthly  (2) Partners' Complaint's Logs sent to UNICEF monthly  (3) UNICEF's Complaints Log analysed by UNICEF Focal Person(s) monthly	To partners and UNICEF's AAP Focal Person(s): AAP, SA, PSEA, Corruption, Data Recording and Analysis

#### Key Definitions

**BHC bi-monthly meetings** - held at health facilities between representatives from all of their linked BHCs, partners' AAP Focal Person(s), CHD representatives, and the health facility's AAP Focal Points and In-Charge. Community members may also attend.

**Community Health Dialogues** - annual events at health facilities attended by facility staff, BHC representatives, partners and UNICEF's AAP Focal Person(s) or health staff, CHD representatives, the media and community members,

**AAP women Champions** – pairs of older and younger dedicated female volunteer AAP focused leaders sitting on BHCs.

**AAP Health Facility Focal Points** – a male and a female health facility staff member responsible for handling feedback and complaints, organising meetings and ensuring responses to feedback and complaints are communicated back to communities.



**Partners' AAP Focal Person(s)** – staff responsible for handling feedback and complaints, collecting data, organising meetings and ensuring responses to feedback and complaints are communicated back to communities. Located inside partners' field offices.

**UNICEF Partners' AAP Focal Person(s)** – staff responsible for handling feedback and complaints, collecting data, organising meetings and ensuring responses to raised feedback and complaints are communicated back to communities. Located inside UNICEF's offices (field and headquarters).

**Feedback and Complaints Registers** – a carbon paper-based Feedback and Complaints Register kept in each health facility, maintained by AAP Focal Points and In-Charges.

**BHW Supervisors' Complaints Log** – for recording BHWs' feedback and complaints gather during BHWs' visits to households.

**Partners' Complaints Logs** – a record of basic information on the location and nature of all feedback and complaints submitted to partners. It also includes information on their handling and stakeholders' responses.

**UNICEF's Complaints Log** - a record of basic information on the location and nature of all feedback and complaints submitted to UNICEF by partners and other sources. It also includes information on their handling and stakeholders' responses.

**BHC bi-monthly meetings** - held at health facilities between representatives from all of their linked BHCs, partners' AAP Focal Person(s), CHD representatives, and the health facility's AAP Focal Points and In-Charge. Community members may also attend.

**Community Health Dialogues** - annual events at health facilities attended by facility staff, BHC representatives, partners and UNICEF's AAP Focal Person(s) or health staff, CHD representatives, the media and community members,

**AAP women Champions** – pairs of older and younger dedicated female volunteer AAP focussed leaders sitting on BHCs.

**AAP Health Facility Focal Points** – a male and a female health facility staff member responsible for handling feedback and complaints, organising meetings and ensuring responses to feedback and complaints are communicated back to communities.

**Partners' AAP Focal Person(s)** – staff responsible for handling feedback and complaints, collecting data, organising meetings and ensuring responses to feedback and complaints are communicated back to communities. Located inside partners' field offices.

**UNICEF Partners' AAP Focal Person(s)** – staff responsible for handling feedback and complaints, collecting data, organising meetings and ensuring responses to raised feedback and complaints are communicated back to communities. Located inside UNICEF's offices (field and headquarters).

**Feedback and Complaints Registers** – a carbon paper-based Feedback and Complaints Register kept in each health facility, maintained by AAP Focal Points and In-Charges.

**BHW Supervisors' Complaints Log** – for recording BHWs' feedback and complaints gather during BHWs' visits to households.

**Partners' Complaints Logs** – a record of basic information on the location and nature of all feedback and complaints submitted to partners. It also includes information on their handling and stakeholders' responses.

**UNICEF's Complaints Log** - a record of basic information on the location and nature of all feedback and complaints submitted to UNICEF by partners and other sources. It also includes information on their handling and stakeholders' responses.

#### *Stream 1 - BHCs*

This stream will encourage BHCs to become approachable feedback mechanisms for community members, encourage them to work with other health stakeholders and make them the public face of APP.

Under this stream, BHCs will become approachable (at any time) conduits for citizens' feedback and complaints. 'BHC bi-monthly meetings' will also be held at health facilities between representatives from all of their linked BHCs, the PEHSP's partners' AAP Focal Person(s), CHD officials, and health facilities' AAP Focal Points and In-Charges. Ordinary community members may also attend.

The stream will train BHC members on AAP, SA, PSEA and corruption, and it will establish female Co-Chairs within BHCs.

#### *Rationale*

In some areas, BHCs are already considered to be platforms for receiving feedback and complaints by community members. They are also thought of as mechanisms through which they may raise their voices with health stakeholders. The MOH has committed to supporting BHCs which they view as central to communities' participating in health services and to overseeing its network of BHWs. To fulfil these roles, BHCs capitalise on the widespread legitimacy of South Sudan's chieftainship system.

Stream 1 builds upon these foundations by formalising AAP roles for BHCs. BHC members will act as feedback and complaints receivers and handlers. They will also be given knowledge of how to identify and act upon corruption and SEA allegations. Lastly, they will help to communicate service providers' responses to raised feedback and complaints back to individuals and communities.

The central place of women in the AAP system will be cemented through their co-chairing of BHCs. This will publicly elevate women, sending a strong message that the monitoring of, and ownership over, health services are as much for them as men.

To ensure all stakeholders feel ownership of the AAP system and collaborate, BHC bi-monthly meetings will be held at facilities.<sup>2</sup> They will be attended by representatives of all linked BHCs, partners' APP Focal Person(s), CHD representatives, health facilities' AAP Focal Points and In-Charges. The meetings will also provide additional opportunities for feedback and complaints to be raised by community members, and for health stakeholders to communicate their responses to outstanding issues back to BHCs and wider communities.

#### *Training*

BHC members will be trained by the relevant trainee or AAP focal point person in the Partner Lot Leads or in the consortium partners. The training will include topics for awareness raising, general complaint and feedback handling, specific SEA and corruption complaint handling, and reporting mechanisms. Women BHC Co-Chairs will be given any training currently afforded male Chairs under the BHI. See Annex 9 for the table of contents of the training for BHC members.

Partners will be trained on how to nominate and select women BHC Co-Chairs.

---

<sup>2</sup> These will be in addition to monthly meetings that BHCs are currently meant to hold at the Boma level and are not intended to replace them.

### *Reporting*

BHC members will work with health facilities' Male and Female AAP Focal Points to record raised issues in facilities' Feedback and Complaints Registers (see stream 4).

BHC members will also be given the contact details of partners' AAP Focal Person(s) so they can report directly to them. Where possible, they may use phones to do so, or they may communicate issues to them during ad-hoc or BHC bi-monthly meetings.

BHC bi-monthly meetings, arranged by staff and partners, will be held at health facilities between representatives from all their linked BHCs, partners AAP Focal Person(s), CHDs, and health facility's AAP Focal Points and In-Charge. Community members may also attend. Ideally BHCs will send one male and one female representative to each meeting.

Alongside arranging the meetings with facility AAP focal points, partners may have to provide refreshments and transport costs for BHC members to ensure regular attendance. However, it is understood that seasonal weather may disturb meetings.

BHC members will be trained to directly report corruption and SEA allegations into the relevant UNICEF system. Where possible, they may use phones to do so, or they may communicate them to partners during ad-hoc or BHC bi-monthly meetings.

### *Closing the loop*

BHC members will keep complainants informed about the status of complaints and responses to feedback. This will be done in person directly and by encouraging complainants to attend BHC bi-monthly meetings or Community Health Dialogues to hear feedback and responses to raised issues.

### **Stream 2 - BHWs Diaries**

The AAP system's second stream utilises the BHWs' frequent contact time with households in difficult to reach communities and the trust that they are currently accruing to gather feedback and complaints.

Using a standard set of questions, feedback, complaints, and perceptions data will be verbally gathered by BHWs from households visited as part of their current duties. This information will be verbally communicated monthly to BHW Supervisors for recording in their own written Complaints Logs.

The stream also trains BHW Supervisors to provide Women's AAP Champions (see stream 3) with an additional feedback and reporting channel that bypasses the BHC and health facilities.

### **Rationale**

Health facilities may not often be visited by members of difficult to reach and isolated communities. Nonetheless, their experiences and feedback are important to understand how services are meeting their needs. At the same time, emerging problems, including rumours and misconceptions, related to the provision of health services may be missed by formal AAP channels.

Research found that BHWs are already engaging household members, particularly women, in general conversations about the state of health services and other communal issues during their visits. These conversations may prove to be a complementary source of data to the AAP's other streams. It is also likely that they will help the programme to identify emerging issues and when activities or relayed information has been misunderstood by communities.

### **Verbal to Paper to Digital System**

South Sudan has low levels of literacy and is predominately an oral culture. Most BHC members are unlikely to be literate. However, 85% of health facilities are currently using paper registers to report on their activities. BHW Supervisors must also read and write to fulfil their CHIMS reporting routines.

The proposed AAP system is largely oral. Incoming data is only recorded on paper at the facility level (in AAP registers) and by BHW Supervisors (on complaint's logs). Partners and UNICEF's MEL team will convert this to digital for analysis.

### *Training*

BHWs will be trained by their Supervisors to ask households they visit as part of their normal duties a standard set of questions.

BHWs Supervisors will be trained to record feedback and individual complaints raised by households to BHWs during these sessions and summarise any emerging themes (e.g., a belief that vaccines are dangerous or that the programme is withholding supplies from their community) in their own BHW Supervisors' Complaints Log.

BHW Supervisors will also be trained to record feedback and complaints reported to them by Women's AAP Champions, and to identify and communicate suspected incidents of GBV and PSEA (see box).

Partners' AAP Focal Person(s) will be trained on how to add data from BHW Supervisors' Complaints Logs into their own Partners' Complaints Log.

### *Reporting and tools*

During BHWs' monthly reporting meetings with their BHW Supervisors, BHWs will be asked the same set of questions they asked visited households by their Supervisors. BHW Supervisors will record their verbal answers in their Complaints Logs (a paper-based booklet that makes carbon copies of filled out pages).

BHW Supervisors' CHIMS reports are often filled out during monthly meetings with partners at the health facility level. During these meetings, BHW Supervisors will also share their Complaints' Logs with partners, whilst retaining carbon copies.

Partners will enter the collected feedback and complaints data into their own Partners' Complaints Logs which are shared with UNICEF monthly.

Please see Annex 6 for the BHWs' questions for households and the BHW Supervisors' Complaints Log.

### *Closing the loop*

The results of the monthly summaries of submitted BHW diaries conducted by UNICEF's national level AAP Focal Persons will be fed back to partners for dissemination to facilities and BHCs. This will be done at the same time as the monthly AAP reports are shared and during Bi-monthly BHC meetings.

### **Stream 3 - Women's AAP Champions<sup>3</sup>**

The AAP system's third stream will establish pairs of dedicated female volunteer AAP Champions. The pairs will consist of a younger and an older woman leader from Bomas with BHCs. Ideally, they will already be BHC members (e.g., co-Chairs and women's youth leaders) but this is not essential.

The AAP Women's Champions will serve as feedback and complaints channels, with a focus on women and vulnerable people (e.g., PWDs). They will also be trained to communicate allegations of corruption and SEA into UNICEF's existing systems.

#### **Gender based violence**

PEHSP's partners are required to maintain a list of GBV services in their areas of operation. They should refer any survivors to them when they learn of them. Accordingly, AAP Focal Person(s) and BHWs will be trained to report those suspected of being perpetrators or survivors of GBV to partners for referral to services.

Any feedback or complaints received by the AAP Champions will be communicated to health facilities' AAP Focal Points or BHWs Supervisors. Corruption and SEA allegations will be communicated directly into the relevant UNICEF system.

---

<sup>3</sup> The yellow arrows in Figure 2.

### *Rationale*

The research found that women do not generally hold public positions of authority in communities. However, most communities include respected older women that are above child-bearing age and respected younger women. They both often act as interlocutors between other women and chiefs, raising issues discussed in informal women's groups or helping to resolve individual crises.

Having two women from different age brackets will ensure that feedback and complaints from different groups of women and vulnerable people are captured. Indeed, research suggests that some women and vulnerable people struggle to access the chieftainship system, especially if they have issues of a sensitive nature or if they are afraid of retribution.

The research findings also suggested that it is important that chiefs do not feel threatened directly by initiatives that engage women as this could undermine efforts toward AAP and SA. By encouraging older women already in established and accepted leadership roles to be in the AAP Champions pairings, this risk may be somewhat mitigated. The older women leader in the pair can also mentor and support the younger youth representative to move into more of a leadership role over time.

### *Training*

Women's AAP Champions will be trained by the relevant trainee focal person in the Partner Lot Leads (or consortium partners) at the same time as health facility AAP Focal Points. The training will include topics for awareness raising, health rights, SA, general complaint and feedback handling, GBV, and SEA and corruption complaint handling and reporting. See Annex 9 for the table of contents of the training manual.

### *Reporting*

Women's AAP Champions will report general feedback or complaints directly to health facilities' AAP Focal Points or to BHW Supervisors when they visit their communities.

The two reporting routes will ensure that feedback and complaints can be delivered with a measure of discretion should they concern other BHC members or health facility staff.

It is expected that the majority of Women's AAP Champions will not have strong literacy skills. Accordingly, feedback and complaints will be received and passed on verbally and recorded by those responsible for updating health facility AAP registers or within the BHWs Supervisors' own Complaints Logs.

Following UNICEF practice of not writing such issues down to protect those concerned, corruption and SEA allegations will not be recorded in the register. Instead, they will be communicated directly into the relevant UNICEF system by facility AAP Focal Points or BHWs Supervisors.

### *Closing the loop*

Women's AAP Champions will keep complainants informed about the status of complaints and feedback. This will be done in person directly to complainants; by being part of the general information channel for facilities' AAP Focal Points; and by encouraging complainants to attend BHC bi-monthly meetings to hear feedback and responses to raised issues.

### **Stream 4 - Health Facilities**

The AAP system's fourth stream consists of trained male and female AAP Focal Points within health facilities and an in-facility paper-based Register for the collection of basic feedback and complaints information from multiple sources.

### *Rationale*

Health facilities are already hubs for receiving feedback and complaints, and places through which partners meet with community members. The stream builds upon these foundations by formalising AAP roles for health facilities, whilst ensuring women have an identifiable female healthcare worker they can approach with issues. It also adds a reporting function for facilities which are currently one of the few places where literate stakeholders can be found within the wider health system.

### *Training*

Health facilities' Male and Female APP Focal Points will be trained by the relevant trainee focal person in the Partner Lot Leads or by consortium partners. The training will include topics for rights awareness raising, general complaint and feedback handling, specific SEA and corruption complaint handling, and reporting mechanisms. See Annex 8 for the table of contents of the training manual for Male and Female APP Focal Points.

### *Reporting and Tools*

Health Facility AAP Focal Points and facility In-Charges will be responsible for maintaining a paper-based Feedback and Complaints Register. Registers will be collected monthly by partners and their information entered into Partners' Complaints Logs.

Registers will provide a simple record of feedback and complaints, detailing the nature of the raised issue, by which category of user it was raised by, the Boma they come from and the method of its submission to the AAP system. Register will be carbon-paper to ensure duplicates are made of all entries. Please see Annex 3 for an outline of the draft of the proposed register.

Community members that provide feedback and complaints to health facility workers and BHC members that have collected feedback and complaints will enter their information into the register with the assistance of the health facilities' AAP Focal Points and/or the In-Charge (depending on literacy). With the supervision of partners, facilities' AAP Focal Points will also record issues raised during Bi-monthly BHC meetings and Community Health Dialogues.

Corruption and SEA allegations will not be recorded in the register. Instead, they will be communicated directly into the relevant UNICEF system by facility AAP Focal Points. Where possible, they may use phones, or they may communicate them to partners during ad-hoc or Bi-monthly BHC meetings.

Health facilities' In-Charges will also have working relationships with UNICEF's AAP Focal Person(s) (field based), including their mobile phone numbers. They will be encouraged to meet them in-person or phone them when issues arise that they believe are too sensitive for health facilities' Feedback and Complaints Registers or that concern partners.

Notice boards and posters will be prominently placed in health facilities with information on how to raise feedback and complaints, the identity of the health facility AAP Focal Points, and how community members may contact partners and CHDs directly with feedback and complaints (see Annex 11). They will also contain information on reporting corruption and SEA allegations directly to UNICEF. This information will also be regularly shared with communities through local radio, word-of-mouth and awareness raising events.

### **Grievances with facilities**

There are likely to be few incentives for facilities' AAP Focal Points to accurately report on their colleagues' misconduct. To ensure they are not bottle-necks, BHC members will be given direct lines to partners' AAP Focal Person(s) (see Stream 1).

They will be encouraged to view them as confidential reporting channels, reachable at BHI bi-monthly meetings, through mobile phones and during ad-hoc engagements.

### **Escalations**

Feedback and Complaints Registers allow for a record of the urgency of the issue. Outstanding or serious issues that require immediate responses can be escalated to partners by facilities' AAP Focal Points, In-Charges and BHCs. This can be done on an ad-hoc basis or during Bi-monthly BHC meetings.

However, as currently occurs, it is anticipated that most issues (e.g., staff misconduct) will be dealt with at facility level and not escalated to partners. Many issues that may be labelled 'urgent' in registers are also unlikely to be able to be responded to immediately by partners or wider programme (e.g., lack of medicine or dilapidated structures).

Feedback and Complaints Registers will be collected monthly by PEHSP's partners' AAP Focal Person(s) at the same time as the facilities' main activity register. Partners will digitise the information and communicate it to UNICEF's AAP Focal Person(s).

Carbon copies of entries will also be collected by UNICEF's monitoring and evaluation teams during their supervisory visits. They will be used to spot check that data is being communicated correctly by those in the reporting chain.

During supervisory visits UNICEF Focal Person(s) will spend dedicated time talking to health facilities' APP Male and Female Focal Points and conduct a short 30-minute focus group discussion with 4-6 BHWs from linked Bomas. If focus group discussions with BHWs gathered in one location are not feasible due to logistical constraints, UNICEF staff will aim to conduct a brief interview with each BHW Supervisor in their respective bomas.

These should be unstructured sessions to avoid the impression that they are about monitoring and evaluation and cultivate an open dialogue. Nonetheless, UNICEF should guide the discussions to focus on two areas:

1. Any issues or complaints that either stakeholder has that could not be raised through other channels.
2. How the AAP system is working, challenges, bottlenecks, recommendations for improvement and communities' engagement.

Feedback and complaints gathered during these sessions should be noted and later entered into UNICEF's Complaints Log. Challenges to do with the AAP system itself should be communicated to UNICEF's AAP Focal Person(s) at headquarters.

#### *Closing the Loop*

The health facility AAP Focal Points will build working relationships with BHCs, especially with the AAP women's Champions and Co-Chairs. This will help to ensure that they can organise BHC bi-monthly meetings (see Stream 1) and that health providers' responses to raised issues are communicated back to communities. The communication of responses can take place on an ad-hoc basis through BHCs, through BHWs, at BHC bi-monthly meetings and at Community Health Dialogues.

#### *Stream 5 - Community Health Dialogues*

Community Health Dialogues are annual events at health facilities. They will be attended by health stakeholders – health facility staff, BHCs, partners' and UNICEF's AAP Focal Person(s) (field level), CHD representatives, the media and community members. During the events stakeholders will publicly commit to their AAP roles and celebrate their collaborations for the delivery of health services.

The Dialogues will also be used to discuss stakeholders' future plans for service delivery at facilities and through BHWs, and to make commitments for the coming year. At specific times during the events, community members will be able to engage health stakeholders to deliver feedback and complaints.

#### *Rationale*

AAP requires that all health actors understand their roles and responsibilities in a health delivery system. It also requires that communities understand these roles, where responsibilities lay for service delivery and what commitments have been made by providers.

Annual Community Health Dialogues will provide an opportunity for health stakeholders and communities to publicly discuss their roles and commit to them. Commitments and plans made at the events can be used by communities to hold stakeholders to account for the delivery of health services.

The joint attendance of partners, CHDs and UNICEF at the Dialogues will also address the concern of communities that they do not fully understand the roles and authority chains underpinning the health system. And it will present a united image of the health delivery system.

The Dialogues will ensure the PEHSP's AAP system also lays the foundations for SA relationships.

#### *Organisation*

PESHSP's partners will be responsible for organising the Annual Dialogues at health facilities. They can be held at any convenient time during the year.

Partners should ensure as many BHCs linked to the facility as possible attend alongside other health stakeholders. They must also publicise them through BHCs, BHWs and local radio well in advance to give members of the public the opportunity to attend. Efforts should be made to invite local politicians.

Partners will craft an itinerary in consultation with facilities and CHD representatives that should include:

- A public presentation of plans for the delivery of services for the coming year through health facilities and BHWs, and with In-Charges, CHD representatives, partners and UNICEF giving 10-minute addresses.
- A 20-minute talk on AAP channels and responses to received feedback and complaints will be jointly given by facility and partners' AAP focal points.
- An opportunity for health stakeholders to be engaged by members of the public in open forums. They should take the form of 90-minute question and answer sessions carefully and sensitively mediated by a suitable local notable(s) (ideally male and female).
- A public commitment by health stakeholders to their roles and to uphold AAP principles.
- At the first Annual Community Health Dialogue, BHCs will jointly sign an 'Accountability Charter' with the facility it is linked to, the PEHSP's partner organisations, CHDs and UNICEF.

These days should not follow a rigid format. Instead, they must be designed collaboratively to ensure they account for local needs, customs and challenges. The emphasis should be on celebrating services alongside AAP and SA.

#### *Reporting and tools*

A one-page Accountability Charter drafted by partners before the event in consultation with CHDs and UNICEF field offices. They will be signed on the day by representatives from each health stakeholder in attendance and displayed prominently in facilities (e.g., in the In-Charge's office or a hallway).

Partners should also compile a list of future plans for health services delivery and commitments made by stakeholders. These will be drafted as simple lists, later printed by partners and displayed alongside Accountability Charters in facilities.

Feedback given and complaints made should be collected in the facilities' AAP registers.

At the second Annual Community Health Dialogue, progress on commitments made by stakeholders will be reviewed during stakeholders' updates on their responses to raised issues.

### 5.2 Description of national COVID-19 vaccination GM

The government of South Sudan has established a mechanism to handle grievances related to COVID-19 vaccination which the Project will incorporate and follow. They will be handled at the national level by the TWG under the leadership of Director General of Primary Health Care.

The levels of redressal will follow the similar chain of management functions:

- Overall, the Country's COVID -19 Incident Manager will be the nodal authority for all COVAX related engagements.
- National RCCE TWG under the aegis of the MOH will be the nodal agency for the demand generation



component.

- State level EPI and relevant counterparts will engage at the sub-national levels.
- Country health departments coordinates implementing partner activities.
- CSOs, NGOs and development /implementing partners at community levels.

The government grievance mechanism process will follow the timeline of the roll out of the COVAX in the country as per the population group prioritization listed in the NDVP and will run concurrently with the vaccine roll out. The government grievance mechanism will provide an appeal process if the complainant is not satisfied with the proposed resolution of the complaint. Once all possible means to resolve the complaint has been proposed and if the complainant is still not satisfied then they should be advised of their right to legal recourse.

It is important to have multiple and widely known ways to register grievances. Anonymous grievances can be raised and addressed. Several uptake channels under consideration by the project include:

- Toll-free telephone hotline / Short Message Service (SMS) line
- E-mail
- Letter to Grievance focal points at local health facilities and vaccination sites
- Complaint form to be lodged via any of the above channels
- Walk-ins may register a complaint on a grievance logbook at healthcare facility or suggestion box at clinic/hospital
- Share feedback through radio talk shows or community engagement meetings.

Once a complaint has been received, by any and all channels, it should be recorded in the complaints logbook or grievance excel-sheet/grievance database.

The government mechanisms will address any complaints of side effects or adverse events following immunization report. COVID-19 vaccines are newly developed and have been tested over a relatively short-time compared to other vaccines; moreover, COVID-19 vaccines to-date have limited post-market experience. Some vaccine technologies are novel and will be deployed within a short interval between manufacture and actual use on large numbers of people. It is possible that some rare adverse events documented and undocumented will take place. Given that some of the vaccines will be used under Emergency Use List (EUL), it is imperative that adequate preparations are put in place to detect, manage, report and document all AEFIs.

South Sudan MoH instituted its AEFI Surveillance system by forming and training its National and the State Adverse Events Following Immunization (AEFI) Committees in 2017 and 2018 respectively to monitor and investigate AEFIs in the country. However, AEFIs are the concern of everyone including the community members who are affected by it and the EPI system from the facility level all the way up to the National EPI Program.

In the current system, once the client notifies any facility of an AEFI, the facility has to undertake two tasks – reporting of the AEFI to the national level through the County Health Department (County EPI Supervisor) and the State (State EPI Operations Officer). Serious AEFIs warrant immediate reporting while minor AEFIs are tallied and reported on a monthly basis with the EPI Monthly reports through DHIS2. Once a serious AEFI is reported, it triggers the State AEFI Committee to contact an investigation, the results of which are reported to the National AEFI Committee for causality assessment. The National AEFI Committee, in turn, gives feedback to the facility and the community in which the AEFI has occurred, whilst also reporting the incident to the Global Database. This is the ideal pathway that has been agreed upon.

In reality, there are many challenges to the efficient functioning of the AEFI system. We plan to use COVID 19 resources to strengthen this system. Additionally, instead of the AEFI Committees being triggered for response after occurrence of serious AEFIs, the County plans to engage the committees on full time basis during the vaccination and thereafter for as long as is required (to be informed by COVID 19 vaccine SOPs). There is also need to use innovation (e.g. WhatsApp) for faster real-time data transmission and reporting.

The existing system will be strengthened and used for surveillance during the roll-out of COVID 19 vaccination. It is worth noting that, given the novelty of the COVID 19 epidemiology and different priority target group of vaccination of adults, including older citizens, as opposed to the regular target of children under the age of five, it is important strengthen the AEFI surveillance system to respond to the unique sets of safety implications posed by COVID 19 vaccination. These may include higher incidence of coincidental AEFIs due to co-morbidities in the target group, interaction with medication being taken for underlying illnesses, larger volumes of AEFIs due to mass vaccination, and increased global reporting through WHO's VigiBase to ensure timely detection of global signals.

Being a novel vaccine, it is not clear what should be expected of COVID-1919 in terms of AEFIs. As such, there is need to prepare well in advance. To mitigate the occurrence of AEFIs, nurse vaccinators will be trained on vaccine handling, vaccine administration, and the contraindications to providing the specific vaccine. Also, the nurses will be trained on interpersonal communication and equipped with information that they will share with clients on what to do in case of an AEFI.

Given that vaccination will be taking place at the health facilities, every vaccination centre will be equipped with an AEFI kit with emergency drugs that would be used by the nurse to respond to AEFI. Nurses will be trained on how to respond to the AEFIs. Serious AEFIs that cannot be handled by the nurses shall be referred to the county hospital or an equivalent hospital in the county.

Each county will form an AEFI medical team consisting of clinicians headed by a medical doctor, who will be trained and propositioned to respond to serious AEFIs that cannot be handled by the nurse vaccinators and clinical officers at the peripheral health facilities. The team will be facilitated with communication and transport facilities to respond to the AEFI promptly.

### 5.3 Corruption and SEA Allegations

Section 13.0 of the Programme Cooperation Agreement (PCA) signed with partners requires them to accord with UNICEF's '*Policy Prohibiting and Combating fraud and Corruption*' and with the UN's '*Special measures for protection from sexual exploitation and sexual abuse*'. This requires them to report all concerns or suspicions of corruption and SEA via established reporting mechanisms. To ensure that the GRM complies with these reporting policies, training conducted as part of its roll out will focus on explaining and communicating these channels and procedures. Additional training modules on safeguarding children, handling sensitive and personal information, and linking to Gender Based Violence services will be given to health facilities GRM Focal Points, to GRM Champions and BHWs. These will be designed in consultation with UNICEF's Protection and PSEA teams. Reporting channels will also be displayed on posters and boards within health facilities. Actions related to SEA and GBV under the GRM will be fully coordination with the Project GBV Action Plan.

## 6. Monitoring and reporting

The Community Dialogue mechanism outlined in section 5 above provides an opportunity for stakeholders to provide inputs into the monitoring of the project. In addition, the project will have third party monitors engaged directly by UNICEF. The primary goal of the third-party monitors is to assess the status and performance of the project or emerging issues with an unbiased perspective on the issues and status, and to make recommendations for improvement, where relevant. Management of third-party monitoring arrangements will build upon the experience under PEHSP third-party monitoring and leverage best practices from both the experiences of UNICEF and the World Bank.

Given the capacity challenges and logistical challenges, it is anticipated that a mixed approach to selection of third-party monitors will take place under the project to ensure adequate technical expertise and coverage. Third party monitor selection will be undertaken using a competitive process to identify individuals, firms or institutions that provide value for money including a demonstration of an understanding of the context and ability to operate within at the necessary capacity within South Sudan.

The primary mechanism to reporting back to community-based stakeholders is outlined above in the Stream 5 - Community Health Dialogues in section 5. This will be complemented by regular meetings and discussions at the national level with MOH, Health Cluster and via the standardized reporting to the World Bank.

Outcomes of stakeholder engagement activities, including issues and opportunities, will be included in biannual reporting required under the project. Quarterly results reporting to the World Bank will include indicator level reporting on social safeguards and grievances. In addition, any stakeholder related issues triggering a Significant Event (as defined in the project financial agreement) will be reported to the World Bank within five days with subsequent root cause analysis within 30 days.

Joint monitoring of project activities with MOH and CSO will be undertaken on an ongoing basis, leveraging existing platforms.

The SEP will be periodically revised and updated as necessary in the course of project implementation in order to ensure that the information presented herein is consistent and is the most recent, and that the identified methods of engagement remain appropriate and effective in relation to the project context and specific phases of the development. Any major changes to the project related activities and to its schedule will be duly reflected in the SEP. Summaries and internal reports on public grievances, enquiries and related incidents, together with the status of implementation of associated corrective/preventative actions will be collated by responsible staff and referred to the senior management of the project and reported to the World Bank as per reporting requirements outlined in the Project documentation which includes defined KPIs in the project results framework.

## **7. Resources and responsibilities for implementing stakeholder engagement activities**

The project budget includes provision of dedicated resources for the implementation of stakeholder activities. UNICEF South Sudan Chief of Health will be responsible to ensure that all stakeholder activities are implemented as per this plan. Activities will be implemented by either UNICEF staff, UNICEF implementing partners and third-party monitoring parties. The project implementation manual will also take into account key aspects and milestones of the stakeholder engagement plan.

While the UNICEF South Sudan Chief of Health will be responsible to ensure all stakeholder activities are implemented, the UNICEF Deputy Representative will monitor the status of project implementation from a management oversight perspective. Tracking and feedback mechanisms will be carried out as per above. In addition, regular meetings with the MOH will discuss cross cutting issues and report back on progress of the project.

Given the SEP takes into account existing national structures as outlined above, UNICEF as well as other partners will support the national MOH COVAX and RCCE TWGs which coordinates both state and national level activities. The Project SEP budget does not cover all costs of the government mechanisms outlined above.

The total cost of the SEP is estimated to be \$1.5M which includes the dedicated project funding provided COVID-19 vaccination demand generation, dedicated project budgets for coordination meetings, GRM as well as costs embedded in complementary activities such as monitoring and inter-related activities in the GBV Action Plan.