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Republic of South Sudan

Ministry of Health

SOUTH SUDAN HEALTH SECTOR TRANSFORMATION PROJECT (HSTP) (P181385)

Updated Stakeholders Engagement Plan (SEP)

(Additional Financing – 2 and Restructuring Version)

August 2026

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Table of Contents

Table of Contents

Table of Contents ii
Acronyms and abbreviations iv
1. Introduction of the project 1
2. Summary of previous stakeholder engagement activities 5
3. Stakeholder identification and activities 7
4. Stakeholder engagement programme 11
5. Grievance Redress Mechanism 24
Please see annex 2 for detailed description of the grievances redress mechanisms. 30
6. Monitoring and reporting 33
7. Resources and responsibilities for implementing stakeholder engagement activities 34
Annex 1: HSTP Draft Transitional Communication Plan 36
Objectives: 36
Users of the Transitional Communications Plan: 37
Overarching Key Messages for the Transition Phase: 37
7. Timing: 37
Target Audiences Internal/ Health Sector: 38
External: 38
Communication Activities: 39
Flexibility and agility: 40
Key Events: 40
HSTP Visibility and Communications Strategy for mid-2024 and beyond: 41
Annex 2: HSTP Restructuring Communication Plan 41
Annex 2: Detailed description of GRM 53
Training 54
Reporting 54
Closing the loop 54
Stream 2: BHWs' diaries 55
Rationale 56
Training 56
Reporting and tools 57
Closing the loop 57
Stream 3: Women's AAP Champions 57
Rationale 58

Official Use Only

Training 59
Reporting 59
Closing the loop 59
Stream 4: Health facilities 60
Rationale 61
Training 61
Reporting and tools 61
Closing the loop 63
Stream 5: Community health dialogues 63
Rationale 63
Organization 65
Reporting and tools 65

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Acronyms and abbreviations

AAP	Accountability to Affected Populations
AEFI	Adverse event following immunization
BHC	Boma health committee
BHI	Boma Health Initiative
BHW	Boma health worker
CERC	Contingent Emergency Response Component
CERHSPP AF	COVID-19 Emergency Response and Health Systems Preparedness Project and its Additional Funding
CHD	County health department
COVID-19	Coronavirus Disease
CBO	Community-based organization
CSO	Civil society organization
EPI	Expanded Program on Immunization
ESS	Environmental and Social Standard
FAQs	Frequently asked questions
FBO	Faith-based organization
GBV	Gender-based violence
GRM	Grievance Redress Mechanism
ICMN	Integrated Community Mobilization Network
IDP	Internally displaced person
IOM	International Organization for Migration
KAP	Knowledge, attitudes and practices
NGO	Non-governmental organization
NVDP	National Vaccine Deployment Plan
PESHP	Provision of Essential Health Services Project
POC	Protection of Civilians
PSEA	Prevention of sexual exploitation and abuse
RCCE	Risk communication and community engagement
SEA	Sexual exploitation and abuse
SEP	Stakeholder Engagement Plan
TWG	Technical working group
WASH	Water, sanitation and hygiene
WHO	World Health Organization

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1. Introduction of the project

South Sudan inherited a weak health system at independence in 2011, following systemic underfunding and neglect. The health system further deteriorated following the disruptions caused during the 2013 and 2016 crises. Given the unprecedented humanitarian crisis arising from the disruptions, support to the health sector has mainly focused on delivery of basic essential lifesaving health services and humanitarian response. The delivery of most health services is supported geographically with World Bank funding through UNICEF in three states and two administrative areas, and Health Pool Fund (HPF) in seven states. Only about half of all health facilities are supported and the support through the community-based Boma Health Initiative (BHI) is only covering approximately 40 per cent of the population. In other words, about half of the population is grossly underserved with health services. World Bank funding through UNICEF is fully committed until end of 2024, while HPF funds will continue through to early 2024. These fast-approaching timeline triggered discussions among the donor community and other health stakeholders about the future of health in South Sudan leading to the proposed Government led implementation buttressed by a country-wide multi-donor trust fund supported Health Sector Transformation Project (HSTP).

The multi-donor trust fund for health (MDTF) model can be a powerful and potent platform for advocacy and holding all levels of Government committed to co-financing of the health sector. As seen in other social services sectors, UNICEF, Ministry of Finance and Planning, and partners are already engaged in setting up systems and building capacity for improved Public Finance Management with promising progress and results in the education sector. The health sector has requested for similar support through the Minister of Health; in response UNICEF and partners have integrated Public Expenditure Review and Public Expenditure Tracking Survey in our 2023-2024 work plan.

Given the important role of coordination, a better future for health will benefit from multi-pronged coordination arrangements among the donors and development partners, the MOH, State Ministries of Health and State Governments, and the local authorities at county level. It is anticipated that a better future for health will include strong principles of community and other stakeholders' engagement, participation, and ownership of the service delivery and health system strengthening plans in their respective locations. The community provides an ideal, bottom-up framework for integrating various sectors that align with local interests, needs and various community contexts. Lessons learned have proven that investing the limited resources in the Primary Health Care system at community and in health facilities, along with proper referrals to hospitals, has the best chances of achieving equitable and large-scale health coverage.

The HSTP is made up of the following components and sub-components shown in table 1.

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Table 1: HSTP Components and brief description of supported interventions.

Components	Brief description of interventions supported through the sub-components
Component 1: Provision of Essential Health Services Nationwide. Implemented by UNICEF and Competitively selected pharmaceutical procurement and logistics.	Component 1 will ensure nationwide delivery of essential integrated health and nutrition service delivery in South Sudan building on service delivery through the COVID-19 Emergency Response Health Systems Preparedness Project (CERHSPP) and Health Pool Fund (HPF) supported implementation with adjustments to improve service availability. Component 1 will deliver a selection of prioritized serviced from the Country's Basic Package of Health and Nutrition Services (BPHNS) including: child health; nutrition; maternal and neonatal health; Basic and Comprehensive Emergency Obstetric and Newborn Care (BEmONC and CEmONC); family planning and sexual and reproductive health services; Sexual and Gender Based Violence Services (SGBV); mental health; disability; infectious and noncommunicable diseases; emergency and surgical services; and Behavior Change Communication (BCC), health promotion, and education. The component will include a strong focus on improving childhood vaccination, focusing on reaching zero-dose children through community level services. Malaria prevention, diagnosis, and treatment will also have a special focus recognizing the diseases represents 8.07 percent of total Disability Adjusted Life Years (DALYs) lost and relates to the Country's annual floods, anticipated to become more severe with climate change. The project will aim to expand access to health services of host communities and refugees, remote and rural populations, women, and other marginalized groups (*Subcomponent 1.1: Delivery of high impact essential health and nutrition services Nationwide through Health Facilities*). Expanded access to the package of health services will be delivered at the community level through the Boma Health Initiative (*Subcomponent 1.2: Boma Health Initiative*). Recognizing the importance of health systems strengthening paired with health service delivery to strengthen health service access, the component will include pharmaceutical supply chain delivery (*Subcomponent 1.3: Pharmaceutical and Medical Supply Procurement and Last Mile Delivery*). Close attention will be paid to the impact of climate change and climactic shocks on health service delivery, including climate sensitive planning and service provision (*Subcomponent 1.4: Climate Resilient Health Service Delivery*). Conflict sensitive approaches will be used to ensure equitable access of the population to service delivery while minimizing the impacts of conflict on service delivery and the supply chain through appropriate stakeholder's engagement activities.

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Components	Brief description of interventions supported through the sub-components
Component 2: Health Systems Strengthening. Implemented by WHO.	This component will undertake activities to strengthen South Sudan's health system to facilitate health service access and capacity improvements. The component will focus on strategic mechanisms to strengthen services in South Sudan, given the low-infrastructure, conflict-impacted context including strengthening system's ability to prepare for and respond to health emergencies and control diseases by strengthening emergency preparedness, laboratory, and disease control systems (*Sub-component 2.1: Health emergency preparedness and response, laboratory strengthening, and disease control*); strengthening of blood bank and transfusion system (*Sub-component 2.2: Blood Banking and Transfusion*); improving quality of care (*Sub-component 2.3: Health Service Quality Improvement*); developing systems and procedures for the national Health Information System (HMIS) (*Sub-component 2.4: Health Management Information Systems*); and developing capacity for health sector stewardship and financing capacity at national and state level (*Subcomponent 2.5: Health Sector Stewardship and Financing*).
Component 3: Monitoring and Evaluation and Project Management.	Component 3 will finance costs related to monitoring and management of project activities. The project will ensure that independent and credible data on health service delivery (*Subcomponent 3.1: Third Party Monitoring*); health service coverage, and commodities are generated, and that the data are usable and used (*Subcomponent 3.2: Data analysis and visualization platform*). This component will develop the capacity of the PMU to manage health service delivery contracts focusing on monitoring health service delivery performance and taking actions; resolution of disputes related to health service contracts; review and feedback on contractor deliverables; liaisingand coordinating with other relevant departments within the MoH to provide technical guidance to contractors; providing field-level supervision to contractors; and developing a contract management manual. Subcomponent 3.3: Contract and program management capacity development. The sub-component will also provide capacity development support for day-to-day and strategic program management of the PMU along with capacity development for specific technical areas as needed (*Subcomponent 3.3). Sub-component 3.4 focuses on Project management*. This *sub-component 3.4* will finance the day-to-day operations of the PMU including project supervision, management, and oversight. Additionally, MoH will undertake a pilot on direct implementation by contracting 4 NGOs Implementing Partners in 4 lots

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	currently managed by UNICEF under component 1.

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Components	Brief description of interventions supported through the sub-components
Component 4: Contingent Emergency Response Component (CERC).	The objective of this component 4 is to improve the country's response capacity in the event of an emergency, following the procedures governed by Paragraph 12 of the World Bank Investment Project Financing (IPF) Policy. During the implementation of past WB funded health projects, the CERC has been instrumental in responding to the Ebola Virus Disease, nutrition, and food insecurity crisis in South Sudan in a timely manner.

The Second Additional Financing (AF2) provides US30$million in IDA grant financing and US$15.658 million from the Pandemic Fund to address a persistent financing shortfall and expand Health Emergency Preparedness and Response (HEPR) capacity. The AF2 introduces US$5 million in Performance-Based Condition (PBC) financing linked to four results: increased female BHW participation (PBC1), reduction in malaria incidence and case fatality rate (PBC2), integration of nutrition indicators into DHIS2 (PBC3), and strengthened health worker salary systems (PBC4). The project closing date has been extended from July 31, 2027 to June 30, 2029. The HSTP currently supports service delivery across 715 health facilities nationwide, and the BHI has expanded to 965 Bomas, including additional Bomas in zero-dose counties supported through Gavi financing.

2. Summary of previous stakeholder engagement activities

The SEP was originally prepared and updated with the evolution of previous WB supported projects including Provision of Essential Health Services Project (PESHP 2019-2021) and the COVID-19 Emergency Response and Health Systems Preparedness Project and its Additional Funding (CERHSPP 2021- 2025). The latest project supported delivery of essential integrated health and nutrition services in Unity, Upper Nile, Jonglei states and in Greater Pibor and Ruweng Administrative Areas. The project supported the COVID-19 National Vaccine Deployment Plan (NVDP) and climate sensitive cold chain deployment and solarization targeting communities, refugees, and host communities.

The lessons learned from the implementation of stakeholder engagement activities for the previous projects have been used to update the current stakeholder's engagement plan given the change in approach from 3rd party to government led implementation and the expanded national scale of the Health Sector Transformation Project (HSTP). A draft transitional communication plan was developed in May 2023 followed by updates in August and October 2023. The communication plan aims at facilitating a coherent, coordinated communication and messaging around the HSTP with leadership of the MOH. As part of the Implementation of the plan, a fact sheet and frequently asked briefing note were drafted in July 2023 and have been used in the development of various briefing notes for meetings between the MOH, donors, and UNICEF. The HSTP inception workshop convened in August 2023 brought together different stakeholders and interested parties. During the inception workshop, detailed presentations on the proposed HSTP were made by the MOH, UNICEF, and HPF. Since May 2023, the MOH, donors, WHO, UNICEF, Health Pool Fund (HPF) and other stakeholders have engaged in a series of

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meetings and discussions on the HSTP. Two virtual meetings with over 120 potential HSTP Implementing Partners attending each of the meetings, were convened in August and October 2023 to present and discuss the details on the Call for Expression of Interest (CFEI) for Implementing Partners.

Since the inception of the HSTP, the broader HSTP footprint has also been rationalized from an originally planned **1,158 facilities to 816 during year one implementation and later to 715 facilities** following the Mid-Term Review in November 2025. This reduction means that communities currently receiving services through facilities transitioning out of HSTP support may experience reduced access to essential health and nutrition services, particularly in areas where alternative supported facilities are not readily accessible. Therefore during the transition, MoH took a careful approach in engaging stakeholders in a wider consultations including country leadership, State Governors, State Ministries of Health, County Health Departments, to decide on which health facilities to be dropped based efficiency, adjacency to similar health facilities, and accessibility to ensure equitable access to essential health services to affected communities. Rationale for restructuring, the planned transition date, alternate services, and available complaint mechanisms were disclosed. MoH also developed a clear communication plan and engaged with affected communities through communities radios talk shows and press statements, and consideration of further measures, such as referral arrangements, mobile clinics and intense outreaches to maintain continuity of essential services for populations affected by the change in facility coverage.

The lessons learned from previous stakeholder engagement activities have also informed acceleration of the transition processes by undertaking a Pilot on Direct MoH Implementation (PDI) under HSTP, which seeks to strengthen sustainability and government ownership by shifting selected Lots from the existing third-party implementation model to direct MoH management of Implementing Partner contracts. Under the pilot, the MoH/PMU will assume greater responsibility for contracting, supervision, coordination, and fiduciary oversight, while UNICEF will support the transition and handover of facilities, plans, data, and inventories to the MoH and selected IPs. The pilot covers four Lots — out of a total of 40 HSTP lots — across Central Equatoria, Eastern Equatoria, Lakes, and Northern Bahr el Ghazal, involving 85 health facilities (1 teaching hospital, 1 state hospital, 3 county hospitals, 33 PHCCs, and 47 PHCUs). In addition, the AF2 introduces a separate procurement modality whereby the MoH will contract a dedicated firm to procure, supply, and distribute a full cycle of medical supplies and pharmaceuticals, replacing the previous UNICEF-managed arrangement; stakeholder engagement with health workers and facility managers regarding this transition in supply chain management will be embedded in the updated engagement plan , and will generate evidence on the feasibility, efficiency, and scalability of direct government-led implementation, with an eight-month review informing the decision on potential expansion to additional lots.

Building directly upon these foundations, the current SEP incorporates the **HSTP restructuring** and the newly integrated **Pandemic Fund Grant**. The incorporation of the Pandemic Fund Grant expands the project's strategic objectives to explicitly include **Pandemic Prevention, Preparedness, and Response (PPR)**. This shifts the SEP from a localized emergency response framework to a nationwide health security and system-strengthening paradigm.

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The lessons learned from implementing stakeholder engagement activities in previous projects have been utilized to update this SEP. This update accounts for the shift from a third-party model to a **government-led implementation** structure, the expanded national scale of the HSTP, and the multi-sectoral health security requirements introduced by the Pandemic Fund Grant.

3. Stakeholder identification and activities

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

- Are impacted or are likely to be impacted directly or indirectly, positively, or adversely, by the project (also known as 'affected parties)
- 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 project outcomes in any way.

Under component 1: The stakeholders include direct beneficiaries of the services, care givers, special groups including vulnerable groups, such as children, women, elderly, Internally displaced persons, refugees, Women groups and leaders, , the youth groups and leaders, communities and community representatives and gate keepers, traditional leaders, cultural leaders, religious leaders at all levels, general public, local authorities, Boma Health Committees, Boma Health workers, Community Nutrition Volunteers, Health workers in health facilities, County authorities, County Health Departments, state level authorities, state Ministry of Health, other state level Ministries including South Sudan Relief and Rehabilitation Commission (SSRRC), Departments and Agencies, Implementing Partners, and the national Government including MOH, and other national Ministries, Departments and Agencies, UN agencies, humanitarian actors, other development partners, MDTF donors, national and local media outlets. Under the **Pandemic Fund,** the category expands to include **Community Surveillance Volunteers, Local Veterinary Extension Workers, and Community-Led Early Warning Teams** who act as frontline sentinels for zoonotic and infectious disease outbreaks.

Under component 2, the stakeholders are same as for Component 1 given the supportive role of health systems to integrated service delivery, whereas component 3, the stakeholders include MOH, the PMU, the Managing Organization, and the MDTF donors and component 4 the same as for component 1.

Cooperation and negotiation with the stakeholders throughout development of the project 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 for the group's interests in the process of engagement with the project. Community representatives may provide helpful insight into the local setting, and act as the main conduits for dissemination of 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's leaders may also be helpful intermediaries for information dissemination in a culturally appropriate manner, building trust in government programmes including provision of essential services.

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 community stakeholders. The legitimacy of community representatives can be verified by talking informally to a random sample of community members

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and listening to their views on who can represent their interests most effectively. Under the **Pandemic Fund Grant**, this verification process will actively include **local traditional healers, community-based livestock owners, and pastoralist leaders** to ensure that disease tracking, health messaging, and emergency preparedness plans are representative, trusted, and inclusive of hard-to-reach populations.

3.1. Methodology

To ensure the use of best practice approaches, the project will apply the following principles for stakeholder engagement:

- **Human-centered design (HCD)**: The approach prioritizes the beneficiaries through a thorough process of understanding the needs and the specific context.
- **Openness and life-cycle approach:** Public consultations for the project(s) will be arranged during the whole life cycle, carried out openly, free from 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 will be provided for stakeholders to communicate feedback, and for their comments and concerns to be analyzed and addressed.
- **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 always 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 people, 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)*

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

- **Affected parties** – persons, groups, and other entities within the project's area of influence who 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 who 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
- **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[1] and who may require special engagement efforts to ensure their equal representation

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in the consultation and decision-making process associated with the project.

3.2. Affected parties

Affected parties include local communities, community members, communities served by transitioning-out facilities and other parties that may be subject to direct impacts from the project. Specifically, the following individuals and groups fall within this category:

- Populations and groups targeted for integrated health and nutrition services.
- Populations living in the catchment areas of the 715 health facilities in all the 10 states and 3 administrative areas of South Sudan.

- 80 county health departments
- 13 State ministries of health
- Over 2000 Boma governance structure in the country.

3.3. Other interested parties

Project stakeholders also include parties other than the communities directly affected, including:

- Civil society organization (CSO) implementing partners engaged by UNICEF
- United Nations and other agencies working in the field of immunization (WHO, International Organization for Migration [IOM], Gavi)
- Agencies working in combating communicable diseases (Global Fund, AAA, IPs)
- The Drug and Food Authority, Directorate of Pharmaceuticals of the Ministry of Health
- National and local mass media organizations and outlets,
- National Public Health Institute (NPHI) — a MoH-affiliated institution that plays a central coordinating role in national health security, disease surveillance, and emergency response. Under the AF2, the NPHI is a key coordination partner for WHO in implementing and monitoring Pandemic Fund-financed HEPR activities, including laboratory strengthening, disease surveillance, and outbreak response, and should be engaged through inter-institutional technical working groups and regular coordination meetings.

3.4. Disadvantaged/vulnerable individuals or groups

It is particularly important to understand whether the project's 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[1] may stem from a person's origin, gender, age, health condition, economic deficiency and financial insecurity, disadvantaged status in the community or communities served by transitioning-out facilities (e.g., minorities or

[1] 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.

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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 project-related decision-making so that their awareness of and input into the overall process are commensurate to those of the other stakeholders.

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

- Internally displaced persons (IDPs), including inhabitants of Protection of Civilians (POC) settlements, communities affected by acute humanitarian emergencies such as flooding or conflict, hard-to-reach populations, etc.
- Refugees
- Host communities competing for limited resources with refugees and Internally Displaced Persons (IDPs)
- Elderly people, persons with disabilities, youth, and women.
- Religious minorities, nomad population and animist traditional beliefs

Vulnerable groups within the communities affected by the project will be further confirmed and consulted through dedicated means, as appropriate. The methods of engagement that will be undertaken by the project are described in the following sections. For any integrated health and nutrition programme, the Stakeholders Engagement Plan (SEP) will include targeted, culturallyappropriate, and meaningful consultations with disadvantaged and vulnerable groups.

The project's Grievance Redress Mechanism (GRM) will be culturally appropriate and accessible for the various ethnic groups in South Sudan, considering their customary dispute settlement mechanism.

Frontline Health, Surveillance, & One Health Workforce

- **Facility-Based Healthcare Workers:** Doctors, clinical officers, nurses, midwives, and nutritionists operating within the 715 target facilities.

- **Community Health Networks:** Frontline community workers including **Boma Health Committees (BHCs), Boma Health Workers (BHWs), and Community Nutrition Volunteers (CNVs)**.

- **Disease Surveillance and Laboratory Personnel: National and State Public Health Laboratory technicians**, epidemiologists, Point of Entry (PoE) border screening officials, and Community Surveillance Volunteers responsible for early warning monitoring under the Pandemic Fund.

- **Animal and Environmental Health Field Workers:** Local **veterinary extension workers**, livestock officers, and environmental monitors managing field-level zoonotic risks.

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4. Stakeholder engagement programme

Stakeholder engagement activities during project development and planned to take place during project implementation are detailed in the following section, including specialized stakeholder engagement required for activities related to emergency preparedness and response activities. The engagement space was expanded to include refugees and host communities in Maban, Upper Nile state, and Pariang county, and other communities in Unity state and elsewhere in South Sudan. This SEP Plan is intended to be a 'live' document that is updated throughout the Project's lifecycle to guide the implementation of the Project's community engagement and communication strategy and changing Project work plans.

4.1. Summary of stakeholder engagement for activities under the HSTP including activation of Contingent Emergency Response Component (CERC)

Table 2 outlines the key stakeholders who will be consulted about the project, including individuals, groups or communities who are affected or likely to be affected by the project, including disadvantaged groups. Table 2 also includes the primary engagement method, as well as timing. In addition, the public may have an interest in the project. UNICEF South Sudan will also use social media, radio, and print media throughout the project duration to make the public aware of the project and inform them how they can obtain further information.

Table 3 outlines the Implementation accountability and stakeholder engagement under the direct implementation pilot arrangement in the four MOH- Direct NGO pilot states. The restructuring introduces two distinct implementation and accountability arrangements. The four Lots under the Direct MoH Implementation pilot operate under MoH/PMU contractual and supervisory oversight, while the remaining HSTP Lots continue under the applicable management arrangements. In both arrangements, community engagement remains a project responsibility and must comply with this SEP and the GRM. The mapping below clarifies the primary engagement oversight, GRM intake and reporting pathway. Local intake does not limit a complainant's right to approach the PMU directly.

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' – an Arabic pidgin – is widely spoken. At the community level, stakeholder consultations will take place in the local language of the population being served. Existing linguistic profile mapping will be used to ensure appropriate language use with the target stakeholder group of any engagement activity.

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Table 2. Stakeholder analysis and primary method of engagement

Stakeholder	Importance of stakeholder / key characteristic	Stakeholder analysis	Degree of involvement in the project	Means of Engagement
Government				
Ministry of Health at national and state levels	Critical player	The Ministry of Health has the leadership in providing guidance, policy, and governance for the provision of health services in South Sudan.	Leadership, authorization, political support, policy, mobilization, and supervision	Regular update/review meetings on HSTP implementation at national and state level Regular consultations on specific issues related to HSTP implementation and to ensure the HSTP follows Ministry of Health policies, Health Sector Strategic Plan and guidelines and supports the national health system.
County health departments	Critical player	The County Health Department (CHD) is the entity with primary responsibility for the provision of health services and stewardship at county level. It is the primary interlocutor between facilities and the implementing partners that are supporting them through the HSTP. Under the restructuring and the Direct MoH Implementation (DIP) pilot, CHDs in participating areas are not only coordination counterparts but are part of the county-level implementation and accountability structure, with responsibilities for service delivery oversight, E&S compliance, stakeholder engagement, community feedback and coordination of referral and continuity measures.	Political support, mobilization, and supervision at county level Perform stewardship functions to support HSTP implementation at county level, especially in coordination and governance, health data management, human resource mapping and service-access monitoring, E&S risk management, GRM intake/referral and follow-up, supervision and reporting, in accordance with the applicable implementation arrangement.	Routine implementation and performance meetings with MoH/PMU and implementing partners; structured community consultations; participation in facility transition planning; supervision and monitoring visits; review of GRM trends and follow-up actions; quarterly performance/E&S reporting and immediate escalation of high-risk issues.

Stakeholder	Importance of stakeholder / key characteristic	Stakeholder analysis	Degree of involvement in the project	Means of Engagement
ONE HEALTH LINE MINISTRIES (Livestock & Fisheries, Agriculture, Environment & Forestry)	Important Actor	The integration of the Pandemic Fund Grant transforms the Stakeholder Engagement Plan (SEP) from a traditional, human-centric medical model into a comprehensive One Health framework. This approach recognizes that human health is inextricably linked to the health of animals and our shared environment. In South Sudan, where pastoralist livelihoods are prominent, the **Ministry of Livestock and Fisheries (MOH-LF)** and the **Ministry of Environment and Forestry (MOEF)** are no longer peripheral actors—they are critical, frontline institutional stakeholders.	Direct Management & Control, Active Partnership & Consultative Engagement	Inter-ministerial steering committees, technical working group (TWG) sessions, shared policy memos.
Health Workers	Critical players	Directly providing essential health and nutrition	Directly involved in service delivery a n d a secondary	Trainings Meetings
		services, engaging directly with both the MOH, SMOH, CHD, Implementing partners, communities, and beneficiaries	beneficiary through receipt of incentives, training, capacity building, supervision from HSTP	Supervision sessions

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Stakeholder	Importance of stakeholder / key characteristic	Stakeholder analysis	Degree of involvement in the project	Means of Engagement
South Sudan Relief and Rehabilitation Commission (SSRRC)/Relief Organization of South Sudan (ROSS)	Critical player	Coordination of efforts of implementing partners/non-governmental organizations (NGOs) Responsible for NGO activities at county level	Government/IOM coordination of development partners Strengthened coordination can improve service delivery.	Regular meetings and consultations between Implementing partners and SSRRC/ROSS to facilitate routine HSTP implementation Meetings and consultations with SSRRC/ROSS at county level by UNICEF staff during each supervision visit
International organizations				
World Bank	Critical player	Fund manager for the MDTF/SDTF for the HSTP, provides and manages the financial resources, signs agreement with donors and with the Government of South Sudan	Has supported the previous projects since 2019 in Jonglei and Upper Nile and the previous Rapid Result Health Project since 2012 in the project area and the current HSTP	Regular meetings Supervision visits Reporting through quarterly results matrix and biannual reports to PMU and the WB.
MDTF/ SDTF - donors	Critical players	Funding the HSTP through MDTF/SDTF mechanism	The donor will be involved at both decision making and technical levels	Engaged through both High-Level Steering Committee and Operational Steering Committee Regular and Ad hoc meetings Field missions
UNICEF	Critical player	Manging Organization for the HSTP and responsible for implementation. UNICEF is critical in the Health, Nutrition and Water, Sanitation and Hygiene (WASH) sectors.	Leads the implementation of the HSTP in coordination with implementing partners and in consultation with authorities at national, state and county levels	Regular meetings Supervision visits Reporting through quarterly

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Stakeholder	Importance of stakeholder / key characteristic	Stakeholder analysis	Degree of involvement in the project	Means of Engagement
WHO and NPHI	Key actor	United Nations partner agency and leading Health Systems Strengthening component of the HSTP. Leads on the health sector globally and in South Sudan Provides emergency health-care services and training around South Sudan, including water quality and malnutrition surveillance in target areas Coordinates emergency health assistance through the health cluster at national and state levels Core Implementing Partner for the Pandemic Fund Grant. Leads technical health security, IDSR network scale-ups, diagnostic procurement, and biosecurity frameworks. Under the AF2, WHO's output agreement has been updated to reflect the expanded scope of Subcomponent 2.1 (HEPR, Laboratory Strengthening, and Disease Control) financed by the	Provides technical support in child health, including through support to integrated management of neonatal and childhood illness (IMNCI) training and in Boma Health Initiative (BHI) roll-out training in close coordination with the NPHI for HEPR and Pandemic Fund activities. Supports emergency preparedness and response training and technical support for State Rapid Response Team (SRRT). In Jonglei and Upper Nile	Regular meetings Facilitation of key training in child health Inter-agency coordination meetings, progress reports, formal handover workshops.

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Stakeholder	Importance of stakeholder / key characteristic	Stakeholder analysis	Degree of involvement in the project	Means of Engagement
		Pandemic Fund, including revised monitoring, verification, and reporting arrangements developed in close coordination with the NPHI and PMU.		
UNHCR	Important actor	UN led partner in supporting refugee programmes and important actor in the HSTP given the coverage of population, refugees, and host communities.	UNHCR will complement integrated health and nutrition services in refugees and host community with other lines of support.	Regular coordination meeting Joint field missions and supportive supervision
WFP	Important actor	UN led partner in supporting food distribution programmes and important actor in the HSTP given the coverage of nutrition.	WFP will complement integrated health and nutrition services given the co-location with UNICEF in the nutrition sites in support of moderate malnutrition management.	Regular coordination meeting Joint field missions and supportive supervision
IOM	Important actor	United Nations partner agency	Provides complementary services in the project area Runs a clinic at the Malakal POC settlement	Regular meetings
UNFPA	Key actor	United Nations partner agency Leads in reproductive health and gender-based violence (GBV) sectors globally and in South Sudan	Provides technical support in reproductive health and clinical management of rape, including through facilitation of training and provision of family planning supplies and post-rape kits for the health facilities supported in Jonglei and Upper Nile	Regular meetings

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Stakeholder	Importance of stakeholder / key characteristic	Stakeholder analysis	Degree of involvement in the project	Means of Engagement
MSF, ICRC, and similarly structured organizations	Important actors	Provides specialist health and nutrition services during humanitarian crisis period.	These agencies support hospitals with specialised secondary level and emergency services that act as referral point for the HSTP supported facilities.	Regular coordination meeting
National Organizations-NGOs and CSOs				
HSTP implementing partners	Critical player	HSTP implementing partners have staff presence in the 31 lots covering all the 80 counties of South Sudan for the health sector, as well as nutrition and WASH for some implementing partners. Most have a long-standing presence in the counties where they work and have knowledge of the local institutional and community environment.	Implement the HSTP at county level and have primary responsibility for the provision of integrated health and nutrition services at county level Consult and engage closely with local authorities and CHDs to support HSTP implementation Support CHDs in performing their stewardship functions	Monthly bilateral meetings and ad hoc meetings/ working sessions with UNICEF at national and state levels to ensure smooth implementation of the HSTP and adequate provision of health services Quarterly review meetings to review performance together with county and state authorities Participation in capacity-building training and initiatives under the HSTP
MOH-Direct NGOs	Critical Player	The four Implementing Partners selected for DIP will cover continued service delivery four Lots across four states**,** involving 85 facilities: 1 teaching hospital, 1 state hospital, 3 county hospitals, 33 PHCCs and 47 PHCUs.	Implement continued service delivery while transitioning to direct MoH contractual management and participate in contract finalization, transition, reporting, supervision and performance monitoring.	Regular meetings with MOH and PMU including routine supervision; monthly and quarterly reporting; and performance review meetings

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Stakeholder	Importance of stakeholder / key characteristic	Stakeholder analysis	Degree of involvement in the project	Means of Engagement
Non-HSTP NGOs	Important actor	Provide services in the sectors of health, nutrition, WASH, and protection (GBV) Their presence in the 80 counties is positive, as they supplement HSTP efforts.	Complement HSTP efforts to ensure gaps in the provision of services not covered by the HSTP are addressed	Participation in monthly coordination meetings chaired by the CHD at county level Regular meetings with HSTP implementing partners and UNICEF to coordinate the provision of health services in Jonglei and Upper Nile states
Media	Important actor	Public aware of the project, raising issues of public interest and concern in relation to HSTP and inform them how they can obtain further information	Directly involved in raising awareness and concerns on project activities.	Training media Capacity building events Media briefings
Community-level actors				
Community traditional chiefs and cultural leaders	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 mobilization	Regular consultations and meetings with traditional chiefs by implementing partners and UNICEF during supervision visits

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Stakeholder	Importance of stakeholder / key characteristic	Stakeholder analysis	Degree of involvement in the project	Means of Engagement
Women's and youth groups	Critical player	Involved in mobilization of communities, outreach and sensitization of mothers and youth Have been trusted by people and can help the project achieve its aims Representatives of women's and youth groups are members of BHCs, which are the BHI governance body, and voice women's and youth's concerns at BHC meetings.	Community support to the project and a positive impact on the vulnerable group.	Regular consultation and engagement during HSTP implementation As active members of the BHCs, they are key actors in the implementation of the HSTP GRM and in raising community concerns, for women and youth.
Boma health committees	Critical player	The BHC is a multi-stakeholder platform for the governance of the BHI. BHC members must be selected by the community in a participatory and transparent process. BHCs contribute to ensure community buy-in, acknowledgement and appropriateness.	In their routine activities, BHCs ensure due diligence in service delivery and the use of drugs and hold monthly meetings to discuss overall service delivery and any concerns regarding access to services at community and health facility level. Through the HSTP GRM, BHCs are instrumental in enhancing local accountability and are a central entry-point for channelling community complaints or abuses.	Community engagement is sustained through monthly BHC meetings that discuss issues related to service delivery in the respective *boma*.

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Stakeholder	Importance of stakeholder / key characteristic	Stakeholder analysis	Degree of involvement in the project	Means of Engagement
Boma health workers	Critical player	The BHI is the government's nationwide strategy to improve access to essential health services. Boma health workers (BHWs) aim to improve access to essential primary health-care services in communities with limited access to health services.	BHWs provide a package of community preventive, promotional and curative health services in their respective *boma*, and maintain strong links with the nearest health facility. BHWs were trained, equipped and deployed in the first phase of the HSTP to provide community services, including life-saving treatment for common childhood diseases such as malaria, pneumonia and diarrhoea, in addition to creating awareness of increased service uptake at supported health facilities in Jonglei and Upper Nile.	Monthly meetings between BHWs and health facilities/implementing partners to address issues related to service provision at community level As community actors, BHWs play a key role in the implementation of the HSTP GRM by consulting household members during their routine consultations and channelling community concerns to implementing partners/health facilities.
Women's Accountability for Affected Populations (AAP) Champions	Critical player	Older and younger women trained at *boma* level as community actors in the HSTP GRM to channel women's concerns	The Women's AAP Champions serve as feedback and complaints channels, with a focus on women and vulnerable people. They have also been trained to confidentially communicate allegations of corruption and sexual exploitation and abuse	Regular consultation and engagement during HSTP implementation As active members of the BHCs, they are key actors in the implementation of the HSTP GRM and in raising concerns of women and vulnerable people.

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Stakeholder	Importance of stakeholder / key characteristic	Stakeholder analysis	Degree of involvement in the project	Means of Engagement
			(SEA) to UNICEF's existing systems.	
Community nutrition volunteers	Important actor	Members of the community playing a vital role in awareness and sensitization on nutrition, mostly to mothers about their children Mostly funded by UNICEF and other donors	Community support for and involvement in the project creates awareness. They complement BHI efforts at community level covering *bomas*/areas not covered by the BHI, particularly for nutrition services.	Regular meetings at community level to ensure complementarity with the BHI
Community social mobilizers	Important actor	Defaulter tracking, finding children who missed their scheduled immunization dose, and conducting interactive sessions at household level to reach beneficiaries who have not been able to complete the vaccine course Complement the BHWs and community nutrition volunteers at facility and community levels	Linking communities and health facilities to scale up routine immunization coverage through referrals	Through household mapping and surveys, in-person contact with families, and community meetings
Religious leaders	Important actor	Trusted interlocutors and sources of information, able to help chiefs resolve intra- and inter-communal conflicts, although activity beyond spiritual matters varies.	Can be approached by community members on some issues	Integrated during regular community consultations and engagement during HSTP implementation

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Stakeholder	Importance of stakeholder / key characteristic	Stakeholder analysis	Degree of involvement in the project	Means of Engagement
Women and girls	Beneficiary	Beneficiaries and a vulnerable group	Beneficiaries and vulnerable group.	Integrated during regular community consultations and engagement during HSTP implementation Can approach older women, women's group leaders or Women's AAP Champions (community actors part of the GRM) to raise their concerns about the provision of health services Can raise concerns related to SEA confidentially through the prevention of sexual exploitation and abuse (PSEA) hotline in line with reporting protocols to OIAI
Communities served by transitioning-out facilities	Beneficiary	Beneficiaries and a vulnerable group	Beneficiaries and vulnerable group.	Integrated during regular community consultations and engagement with clear communication and consideration of measures to maintain continuity of essential services during transition from HSTP support.

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Stakeholder	Importance of stakeholder / key characteristic	Stakeholder analysis	Degree of involvement in the project	Means of Engagement
Frontline Community Health Workers & **ONE HEALTH FIELD WORKERS** (BHWs, BHCs, CNVs, Surveillance Volunteers)	Important Actor	Under the integrated **HSTP** and the **Pandemic Fund Grant**, frontline community workers are transformed from simple service providers into the primary defense line for Global Health Security. In a weak health system like South Sudan's, where infrastructure is limited, these community networks act as the critical links connecting remote settlements to the **715-facility national footprint**.	Delivers facility and community care; provides the baseline syndromic data feed for early outbreak tracking.	Monthly supervision meetings, training workshops, two-way SMS/radio networks.
IDPs outside POC settlements	Beneficiary	Beneficiaries and a vulnerable group	Beneficiaries and vulnerable group	Integrated during regular community consultations and engagement during HSTP implementation
IDPs inside POC settlements	Partial beneficiary	Beneficiaries and a vulnerable group	Beneficiaries and vulnerable group	Integrated during regular community consultations and engagement during HSTP implementation
Refugees	Beneficiary	Beneficiaries and a vulnerable group	Beneficiaries and a vulnerable group	Integrated during regular community consultations and engagement during HSTP implementation
Persons with disabilities and elderly persons	Beneficiary	Beneficiaries and a vulnerable group	Beneficiaries and vulnerable group	Integrated during regular community consultations and engagement during HSTP implementation

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Stakeholder	Importance of stakeholder / key characteristic	Stakeholder analysis	Degree of involvement in the project	Means of Engagement
Religious minorities and animist traditional beliefs	Beneficiary	Beneficiaries and vulnerable groups	Beneficiaries and vulnerable group	Integrated during regular community consultations and engagement during HSTP implementation
Nomad populations	Beneficiary	Beneficiaries and a vulnerable group	Beneficiaries and a vulnerable group	consultations and engagement during HSTP implementation
Public	Partial beneficiary	Beneficiaries and a vulnerable group	Beneficiaries and vulnerable group	Integrated during regular community consultations and engagement during HSTP implementation

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Table 3. Implementation accountability and stakeholder engagement under the direct implementation pilot arrangement in the four MOH- Direct NGO pilot states.

Implementation geography / arrangement	Implementation accountability	Community engagement oversight	Primary GRM intake	Escalation / reporting
Central Equatoria, Eastern Equatoria, Lakes, Northen Bahr el Ghazal – MoH-Direct NGO Lots	MoH/PMU; MoH-direct NGO, with State MoH/CHD oversight	CHD and MoH-contracted IP, under PMU oversight; PMU Social Specialist provides E&S/GRM oversight.	CHD, facility/Boma Health structures and MoH-contracted IP GRM/AAP focal points; direct PMU intake also available.	Unresolved, high-risk or transition-related complaints escalated to PMU within 2 working days; PMU Social Specialist reviews; reporting to PMU through routine and incident channels.

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4.2. Stakeholder engagement approach for the HSTP

The following are some considerations for selecting channels of communication on the HSTP:

- Consider national restrictions or advisories when conducting public gatherings, including public hearings, workshops, and community meetings.
- Conduct consultations in small-group sessions, such as focus group discussions. Other alternatives include 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 communication channels (television, 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.
- Engage community traditional chiefs and cultural leaders including traditional healers in conducting effective communication with ethnic and religious minorities and vulnerable community members in culturally appropriate manner.
- Where direct engagement with beneficiaries or people affected by the project is necessary, identify channels for direct communication with each affected household through a context-specific combination of email messages, mail, online platforms, and dedicated phone lines with knowledgeable operators.
- Each of the proposed channels of engagement should clearly specify how stakeholders can provide feedback and suggestions.
- 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, 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 media, 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 the media. These should be available in different local languages. Information disseminated should also include where people can obtain more information, ask questions, and provide feedback.

In line with the above approach, different engagement methods are proposed and cover different stakeholder needs, informed by the learnings from previous national immunization campaigns (polio, measles, cholera, maternal and neonatal tetanus, Ebola virus disease, COVID-19).

The five key elements of the strategy include:

- Advocacy
- Capacity-building
- Mass media, including social media
- Social mobilization and community engagement

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- Crisis communication plans.

Annex 1 details the communication strategy for the HSTP

4.3. Proposed strategy for information disclosure related to HSTP

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
- Includes an 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 addressing grievances
- Includes where people can obtain more information, ask questions and provide feedback
- Is communicated in formats that take language, literacy, and cultural aspects into account.

Over time, based on feedback received through the GRM 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 implementation of the HSTP including availability of medical supplies and commodities. The monitoring should cover all languages used in the country. If the government is considering the engagement of security or military personnel in the implementation of the HSTP, 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 about their conduct through the GRM.

4.4. Proposed strategy to incorporate the views of vulnerable groups

The project will carry out targeted stakeholder engagement with vulnerable groups, such as IDPs, poor people in urban areas, those in POC settlements, women, spear-masters/traditional healers, etc., to understand their concerns/needs in terms of accessing information and services and other challenges in their communities. The consultative process will be adopted to reach out to vulnerable populations and will include community leaders, such as *payam* and *boma* chiefs, and women's and youth group leaders, to involve them in the process of planning and executing the activities in their catchment area. The details of strategies to be adopted to effectively engage and communicate with vulnerable groups will be considered during project implementation.

It will be necessary to tap into the administrative (e.g., village health committees) and traditional (e.g., traditional birth attendants and traditional healers) systems that support communities. This will ensure that implementing partners better understand and challenge cultural barriers to service delivery. The community central as there will be consultative dialogues and discussion on

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the timings, venue, communication materials, etc. required for conducting campaigns in various communities. The project will carry out targeted stakeholder engagement with vulnerable groups to understand their concerns/needs in terms of accessing information, medical facilities and services, and other challenges they face at home, in the workplace 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 with vulnerable groups will be considered during project implementation.

4.5. 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 SEP and the GRM. The GRM outlined in Section 5 of this document also embeds feedback activities.

The Boma Health workers and community-based social mobilizers will be used for two-way communication with community-level stakeholders. These mobilizers will share information with the communities and collect feedback from them and relay it to the authorities and relevant stakeholders. They will also provide information to the communities in response to questions, queries and concerns raised by them. The rumor 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 information, education and communication materials and mass media messages (interactive radio talk shows, radio and television channels) will be updated/revised to reflect the community feedback and concerns. Robust online and offline tracking and monitoring tools will be used to inform the planning and project stakeholders, among others, of progress.

5. Grievance Redress Mechanism

The main objective of a GRM is to assist in resolving 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 GRM:

- Provides affected people with avenues for making a complaint or resolving any dispute that might arise during the implementation of projects
- Ensures that appropriate and mutually acceptable redress actions are identified and implemented to the satisfaction of complainants
- Avoids the need to resort to judicial proceedings.

The project will implement an existing multi-channel GRM developed and implemented under the COVID-19 Emergency Response and Health Systems Preparedness Project (CERHSSP) which aligns with the requirements of ESS 10 and other relevant E&S standards.

The GRM will be confirmed operational and accessible to all project-affected communities — including those in areas transitioning under the DIP pilot and those served by facilities transitioning out of project support — no later than 60 days after the project restructuring

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effectiveness date. The PMU Social Specialist will maintain oversight of GRM performance across all implementation arrangements, with monthly reporting from CHDs, MoH-direct NGOs, and UNICEF-led implementing partners.

South Sudan is a complex context in which many people are poor, live in hard-to-reach and isolated communities, and are socialized into engaging outsiders through representatives. In addition, many are likely to have different understandings of accountability to the project's planners and prefer to resolve issues within their communities. At the same time, the signing of an agreement in 2018 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 Ministry of Health's service model aims to include the chieftainship system, which, despite drawbacks, remains the most legitimate and primary organizing unit for communal life. It also promises a network of BHWs able to act as the eyes and ears of the Ministry of Health and its partners beyond health facilities.

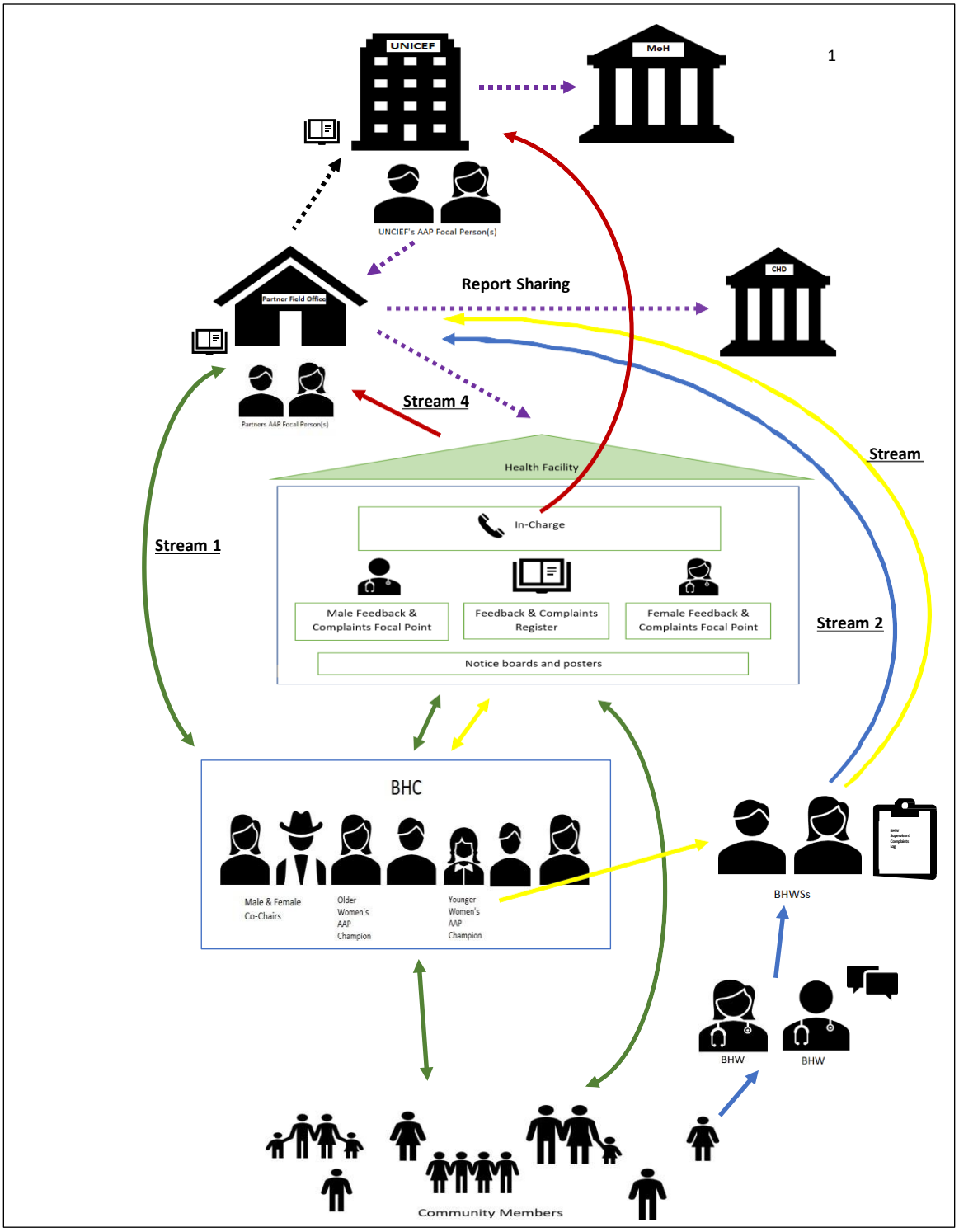
Any GRM must acknowledge and, as far as possible, seek to address these challenges by capitalizing on the government's commitments and existing ways of doing things. Yet, to ensure vulnerable community members have a voice, it should also seek to improve on and add to current arrangements and plans, and to create an enabling environment for social accountability relationships. This can be done through targeted training and 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 HSTP'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 1 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.

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Figure 1. Multi-stream AAP mechanism



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Table 4 provides an overview of the actors involved in the AAP mechanism, reporting mechanisms, information flows, tools and training required for all five streams. The following sections add further detail on their rationale and functioning.

Table 4. Stream actors and mechanisms

Stream	Communities' feedback and complaints channels	Actors involved in the reporting chain	Recording tools	Record collected by/sent to	Training
1) BHCs (green arrows)	*Verbal:* 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 facilities' feedback and complaints registers (2) Partners' complaints logs	(1) Health facilities' feedback and complaints registers collected by partners; data entered partners' complaints logs and sent to UNICEF monthly (2) Partners' complaints logs sent to UNICEF monthly	For BHC members: AAP, SA, PSEA, corruption For BHC women co-chairs: as above For partners: facilitation of BHC women co-chair nomination
2) BHWs' diaries (blue arrows)	*Verbal:* Approach from community members to BHWs during household visits during which health-related questions are asked	BHWs verbally report to their 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	For BHW supervisors: AAP, SA, PSEA, corruption, recording BHWs' diaries For BHWs: AAP, SA, PSEA, corruption, asking household

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Stream	Communities' feedback and complaints channels	Actors involved in the reporting chain	Recording tools	Record collected by/sent to	Training
					questions, GBV
3) Women's AAP Champions (yellow arrows)	*Verbal:* Approach from community members to Women's AAP Champions within communities at any point in time or at BHC bi-monthly meetings or at community health dialogues	Women's AAP Champions report to either: (1) Health facilities' focal points (2) BHW supervisors (for issues that involve or cannot be communicated to health facilities' focal points)	(1) Health facilities' feedback and complaints registers (2) BHW supervisors' complaints log	(1) Health facilities' feedback and complaints registers collected by partners; data entered into partners' complaints logs and sent to UNICEF monthly (2) BHW supervisors communicate issues to partners at monthly or ad hoc meetings; partners capture them in their own complaints log	For Women's AAP Champions: AAP, SA PSEA, corruption, safeguarding, GBV
4) Health facilities (red arrow)	*Verbal:* Approaches from community members to health facility staff	Health facility staff direct community members to health facility AAP focal points	(1) Health facilities' feedback and complaints registers (2) Sensitive feedback and complaints that involve partners' conduct handled by the in-charge	(1) Health facilities' feedback and complaints registers collected by partners; data entered into partners' complaints log and sent to UNICEF monthly	For health facility AAP focal points: AAP, SA, PSEA, corruption

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Stream	Communities' feedback and complaints channels	Actors involved in the reporting chain	Recording tools	Record collected by/sent to	Training
			(3) Feedback and complaints collected by UNICEF focal person(s) during supervisory visits	(2) Health facilities' in-charge communicates directly with UNICEF in person or by phone; recorded in UNICEF's complaints log (3) Recorded in UNICEF's complaints log	
5) Community health dialogues (not on diagram)	*Verbal:* Approaches from community members to stakeholders attending community health dialogues	BHC members, BHWs, BHW supervisors, health facility AAP focal points, partner and UNICEF AAP focal person(s), UNICEF health staff, CHD representatives, media	(1) Health facilities' feedback and complaints registers for all publicly declared issues (2) Partners' complaints log for issues communicated privately (3) UNICEF's complaints log for issues communicated privately	(1) Health facilities' feedback and complaints registers collected by partners; data entered into partners' complaints log and sent to UNICEF monthly (2) Partners' complaints logs sent to UNICEF monthly (3) UNICEF's complaints log analysed by UNICEF focal person(s) monthly	For partners and UNICEF AAP focal person(s): AAP, SA, PSEA, corruption, data recording and analysis

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5.1. Key definitions

BHC bi-monthly meetings – held at health facilities between representatives of all the 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.

BHW supervisors' complaints log – for recording BHWs' feedback and complaints gathered during their visits to households

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

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

Health facility AAP focal points – a male and a female health facility staff member responsible for handling feedback and complaints, organizing meetings and ensuring that responses to feedback and complaints are communicated back to communities

Partners' AAP focal person(s) – staff located inside partners' field offices who are responsible for handling feedback and complaints, collecting data, organizing meetings and ensuring that responses to feedback and complaints are communicated back to communities

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 AAP focal person(s) – staff located inside UNICEF offices (field and headquarters) who are responsible for handling feedback and complaints, collecting data, organizing meetings and ensuring that responses to raised feedback and complaints are communicated back to communities

UNICEF 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.

Women's AAP Champions – pairs of older and younger dedicated female volunteers sitting on BHCs and focused on AAP.

Please see annex 2 for detailed description of the grievances redress mechanisms.

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5.2. Description of the HSTP GRM

The HSTP will adopt the Grievances Redress Mechanism (GRM) established by the Government of South Sudan to handle grievances related to COVID-19 vaccination. They will be handled at the national level by the TWG under the leadership of the Director-General of Preventive Health Care.

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

- Overall, the country's Incident manager will be the nodal authority for HSTP related grievances.
- SMOH and CHDs coordinate implementing partners' activities.
- CSOs, NGOs and development/implementing partners will engage at community level.

The government GRM 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 have been proposed and 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. Grievances can be raised and addressed anonymously. 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
- Grievance logbooks at health facilities or suggestion boxes at clinics/hospitals for walk-ins to register complaints
- Feedback through radio talk shows or community engagement meetings.

Once a complaint has been received, regardless of the channel, it should be recorded in the complaints logbook or grievance Excel spreadsheet/database. For complaints related to HSTP facilities withdrawal or transition decisions, the local E&S focal point or implementing partner shall register the case and escalate it to the PMU within two working days. The PMU Social Specialist will review such cases and coordinate with the relevant Programme/Technical Team, SMoH and CHD to determine whether additional mitigation measures are required. The complainant will receive an initial substantive response within seven working days, subject to the approved GRM procedures, and the outcome will be communicated back **i**n writing, or orally where there is a literacy barrier**.** High-risk cases affecting essential service access will be escalated immediately and, where necessary, assessed before resolution proceeds.

Expanded scope of GRM

The Pandemic Fund introduces specific risk profiles that require dedicated intake classification:

- **Emergency Interventions and Rights:** Complaints regarding forced isolation, quarantine protocols, or discriminatory practices during border screening at Points of Entry (PoE).

- **Bio-risk and Environmental Safety:** Reports of improper disposal of hazardous laboratory waste, lack of Personal Protective Equipment (PPE) for frontline workers, or contamination risks near

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communities.

- **One Health and Resource Conflicts:** Disputes regarding the culling or quarantine of livestock by animal health teams without proper community consultation or compensation.

- **Procurement and Fiduciary Integrity:** Grievances concerning favoritism or corruption in deploying emergency funds, laboratory upgrades, or vaccine distribution.

While standard complaints regarding facility footprint transitions follow a 10-to-14-day resolution cycle, Pandemic Fund grievances involving biosecurity or human rights violations bypass standard timelines. All complaints are registered in a centralized, encrypted database managed by the MOH PMU Safeguards Officer. Grievances threatening immediate health safety (e.g., infectious waste spills or quarantine breaches) are flagged as Category 1 (Urgent) and automatically forwarded to the WHO Technical Lead and the National One Health Steering Committee. Initiate investigation and Fact-Finding mechanisms within 48 hours i.e. joint field verification teams comprising of MOH, WHO and line ministries.

5.3. Allegations of corruption and SEA

Section 13.0 of the Programme Cooperation Agreement signed with partners requires them to abide by UNICEF's 'Policy Prohibiting and Combating Fraud and Corruption' and the United Nations 'Special measures for protection from sexual exploitation and sexual abuse'. This requires them to report all concerns or suspicions of corruption and SEA through 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 GBV services will be given to health facilities' GRM focal points, GRM Champions and BHWs. These will be designed in consultation with UNICEF's Protection and PSEA teams.

UNICEF has developed and implemented a country office protocol community-based complaint mechanism: the GRM. A detailed description of the GRM is given in the CERHSP SEP. The mechanism enables all complaints to be reported verbally or in writing to: designated PSEA focal persons; Chiefs of Field Offices; Country Representatives; via phone (+211 920 111 333 [English] or (+211 920 111 888

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[Arabic]); or via email: SSD_PSEAinfo@unicef.org. This information is posted by the selected IPs at all health facilities. 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's GBV Action Plan. For clarity, the GRM is intended to complement and in no way conflict with existing reporting mechanisms and procedures within UNICEF.

6. Monitoring and reporting

The community dialogue mechanism outlined in Section 5 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 PMU on behalf of the MOH. 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 on the experience under CERHSPP third-party monitoring and leverage best practices from the experiences of both UNICEF and the World Bank.

The TPMA's revised Terms of Reference explicitly require monitoring and reporting on ESHS compliance across all project components and all implementing entities — including MoH-contracted NGOs and CHDs under the DIP pilot — through regular field-level assessments. The PMU will compile semi-annual ESHS performance reports incorporating inputs from UNICEF, WHO, MoH-direct NGOs, and CHDs (submitted 30 days after each reporting period end), and submit the compiled report to the World Bank no later than 45 days after the reporting period end. GRM performance data — including aggregate grievance volumes, resolution rates, pending cases, and cases referred — will be disaggregated by type, gender, and location and reported as part of the semi-annual ESHS reports.

Given the capacity 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 the ability to operate at the necessary capacity in South Sudan.

The primary mechanism for reporting back to community-based stakeholders is outlined above in Section 5: Stream 5 – Community health dialogues. This will be complemented by regular meetings and discussions at the national level with the Ministry of Health and the 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 roost cause analysis within 30 days.

Joint monitoring of project activities with the Ministry of Health and CSOs will be undertaken on an ongoing basis, leveraging existing platforms.

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The SEP will be periodically revised and updated as necessary during project implementation, 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 implementation. Any major changes to project-related activities or 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/preventive actions, will be collated by responsible staff, 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 key performance indicators in the project results framework.

7. Resources and responsibilities for implementing stakeholder engagement activities

The project budget includes provision for dedicated resources for the implementation of stakeholder activities. Under the restructured implementation arrangements and the Pandemic Fund, the MoH/PMU retains primary responsibility and overall oversight for SEP implementation and will ensure that stakeholder engagement obligations are embedded in all output agreements, contracts, and implementation arrangements with UNICEF, WHO, MoH-direct NGOs, and CHDs. The PMU Social Specialist provides E&S and GRM oversight across all implementation arrangements. UNICEF, WHO, MoH-direct NGOs, and CHDs are each responsible for implementing stakeholder engagement activities within their respective areas of operation in accordance with this SEP and the updated ESCP. Activities will be implemented by either UNICEF staff, UNICEF implementing partners, MOH-Direct NGOs or third-party monitoring parties. The project implementation manual will also consider key aspects and milestones of the SEP.While the UNICEF South Sudan Chief of Health and MOH-Direct NGOs will be responsible for ensuring that all stakeholder activities are implemented, the UNICEF Deputy Representative and MOH-Direct NGOs will monitor the status of project implementation from a management oversight perspective. Tracking and feedback mechanisms will be carried out as described above. In addition, regular meetings with the PMU-Ministry of Health will discuss cross-cutting issues and report back on the project's progress.

As the primary **Implementing Partner for the Pandemic Fund Grant**, WHO holds direct responsibility for ensuring the execution of stakeholder activities related to global health security, biosecurity upgrades, and pandemic preparedness. WHO will coordinate directly with the MOH/PMU to deploy specialized Risk Communication and Community Engagement (RCCE) strategies.

With the activation of the Pandemic Fund Grant, this coordination framework officially expands into a **One Health platform**. The MOH/PMU will collaborate with the **Ministry of Livestock and Fisheries** and the **Ministry of Environment and Forestry** to synchronize community engagement efforts—particularly regarding zoonotic disease spillovers within pastoralist communities and border points of entry. The project SEP budget supports, but does not fully cover, the overarching baseline operating costs of these institutional government mechanisms.

Given that the SEP considers existing national structures as outlined above, UNICEF, MOH-Direct NGOs and other partners will support the national Ministry of Health and PMU which coordinate both state- and national-level activities. The project SEP budget does not cover all costs of these government

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mechanisms.

The total cost of the SEP is estimated to be US$1.5 million, which includes budget lines for demand generation, dedicated project budgets for coordination meetings, the GRM, and costs embedded in complementary activities such as monitoring and inter-related activities in the GBV Action Plan. SEP will be part of all programme document to be developed with selected Implementing partners with clear budget line in the PDs. Also, the successful partners do situation analysis of all stakeholders in their counties or Lots.

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Annex 1: HSTP Draft Transitional Communication Plan



Objectives:

The Transitional Communication Plan is designed for use by the Ministry of Health (MoH) in South Sudan, as well as other key stakeholders, including the World Bank, UNICEF, the Health Pooled Fund, donors, other UN agencies, and implementing partners. The objective is to provide information on processes, activities and events for internal and external audiences, throughout the development of the 'Heath Sector Transformation Project' (HSTP), from now to the Project's formal approval in late 2023 and into the 2024 implementation phase – and to assure stakeholders that support for health service delivery will continue, with a smooth transition from existing to new programming.

Key transitional communications products will be developed together with the Ministry of Health, in collaboration with UNICEF, the World Bank and donors.

This strategy primarily serves to detail communications needs and key events and processes to various audiences during the transition – while the design and development a comprehensive visibility, branding, and communications strategy for the implementation of the project will begin in November, 2023 as the project is formally approved. Stakeholder and implementing partner engagement and feedback, as well as input into the project design, will be managed separately in dedicated design workshops.

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Users of the Transitional Communications Plan:

1. **Ministry of Health:** This plan is for use by the MoH, with the World Bank, UNICEF, WHO, Donors and HPF providing support with development and dissemination of products, as well as support with coordination and facilitation of key events.
2. **The World Bank:** For use with overall support in communicating about the project development and transition.
3. **Donors:** For use in communicating with home offices and embassy counterparts.
4. **UNICEF:** For support with defining and developing products and coordinating transition activities with the health sector.
5. **Health Pooled Fund:** For use with HPF communications and phase out activities.

Overarching Key Messages for the Transition Phase:

1. The vision of the HSTP is to transform the fragmented health sector in South Sudan into a Government of South Sudan led harmonized and coordinated health system.
2. This project aims to streamline governance, monitoring, reporting, and implementation processes for more effective and unified health service delivery across the whole country. Ensuring a continued basic package of health and nutrition services is delivered.
3. Present health service delivery in South Sudan operates primarily through the Health Pool Fund (HPF), in 7 States and 1 Administrative area and the COVID-19 Emergency Response and Health Systems Preparedness (CERHSP) Project, in 3 States and 2 Administrative Areas – which will both come to a close in 2024.
4. The new HSTP will be under the leadership of the Government of South Sudan with a high-level steering committee co-led by the Ministry of Health and the World Bank, and a Project Management Unit (PMU) to ensure delivery of services.
5. The project aims at an eventual transition out of the HSTP, to a fully government-run sustainable health care system. To enable this transition, the HSTP will support Government of South Sudan co-financing and investment arrangements.
6. UNICEF is the managing organization of the project, owing to its extensive experience in health service delivery, and strong presence across South Sudan. The agency has initiated advance measures to ensure continuity of lifesaving medical services through the transition phase in 2024 and onwards.
7. **Timing:**
    a. The development, design and transition to the HSTP project runs from May 2023, and will last until December 2024, with the end of the HPF and CERHSP Project phase out.

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b. Transitioning of the 10 states and three administrative area into the HSTP will occur in July 2024.

Target Audiences

Internal/ Health Sector:

- **Donors of the HSTP:** Provide operational updates and technical details regarding the transition, present timelines, milestones, and articulate the high-level vision to establish clarity.
- **Other Partners in the South Sudan Healthcare system:** Provide updates to other partners and donors potentially interested in joining the project.
- **All relevant Government stakeholders in South Sudan:** Assure the continuity of health coverage during the transition process, outline the steps towards transition, emphasize the project's long-term sustainability through government leadership and critical role of Government of South Sudan co-financing, and highlight the role of the High-Level Steering Committee and Project Management Unit (PMU).
- **Implementing Partners:** To communicate the transition process, ensuring a seamless handover and minimal disruption to day-to-day operations of the HPF and CERHSP Projects – with specific guidance when available (e.g. how to access funding modalities).
- **Senior Management at UNICEF, World Bank, and other Multilateral Agencies:** Communicate the overarching vision, project development and transition, and provide a high-level overview of the organizational structure, funding mechanisms, and key stakeholders.

External:

- **General Public:** Assure the South Sudanese population that health services will continue uninterrupted, and the transition will eventually result in broader and higher quality health coverage. Emphasize the government's leadership role in the project and proactively counter any misinformation that could potentially arise (e.g., rumors related to cost, gaps, etc.) – through social media, a press release in local media, and UNICEF's nationwide network of social mobilizers and through HPF's channels.

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Communication Activities:

Product	Description	Audience	Timeline
1. External Factsheet	A two-pager with a high-level overview of the vision, a brief on the structure, current stakeholders, and timelines	**All**	**July 2023**
2. FAQ document	Based on feedback from the inception workshop and other key meetings/events, develop a FAQ	**Internal Audiences**	**August, after inception workshop**
3. Health Sector Factsheet	A more detailed factsheet outlining technical details, roles and responsibilities for stakeholders and IPs, key changes, and the selection and engagement process for IPs	**Internal Audiences**	**December 2023**
4. Internal key messages document	A document to be shared internally with key messages, figures, and terminology for aligned use.	**MoH, Donors, UNICEF and World Bank**	**December 2023**
5. Workshops/Webinar	Meetings, workshops and webinars to provide transition plans, facilitate engagement, and update progress • More info below.	**Internal**	**August-December 2023**
6. Email mail outs	Announcements and subsequent updates for various stakeholders to keep them informed about the project's development and transition progress	**Internal**	**Inception Workshop then as needed.**
7. Press Release	A joint-press release announcing the transition and approval of the HSTP Project	**All**	**November/ December at the official approval of the new Project**
8. Social media	Regular updates of key milestones	**All**	**As appropriate.**

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Flexibility and agility:

The transitional communications plan will be updated based on new updates and progress from workshops and development meetings. Events, webinars, social media posts, and publications will be coordinated upon significant/unexpected developments or based on feedback throughout the process.

Key Events:

Event	Description	Timeline
1. FCDO/WB/UNICEF/HPF Transition Planning Workshop, Juba	- *done*	31 May 2023:
2. FCDO/WB/UNICEF/HPF Transition Planning Workshop, Juba	- *done*	31 May 2023
3. Implementing Partnership Planning meeting, Juba	- *done*	8 June 2023
4. HSTP Inception Workshop, Juba	- Done. The workshop achieved the initiation of the co-creation of the Health Sector Transformation Project (HSTP), ensuring ownership and accountability among all stakeholders.	3-4 August 2023
5. Transitional Planning Workshop	Formulated with input from Multi Stakeholder Inception Workshop, a living transitional plan will be drafted. The Transitional Planning Workshop will work to discuss and agree on the plan and proposed milestones.	2nd week of November 2023
6. Health summit, Juba	The Health Summit will bring together State Governors, Director Generals, State Minsiters, the Minster for Health and other senior governemnt officials, to discuss the new proposed HSTP	3rd week of November 2023
7. Co-Design Workshop	The Ministry of Health, together with key stakeholders and technical experts in the health sector, will convene to co-design the HSTP.	30-31 October 2023, Kit, Rajaf

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		Payam, Juba County
8. Supply and Logistics assessment workshop	The Ministry of Health and Supple and Logistics experts will discuss the assessment findings and proposed design of the workshop.	**TBD**
9. Workshop with all stakeholders & Additional workshop	-	**TBD**

HSTP Visibility and Communications Strategy for mid-2024 and beyond:

Design and develop a comprehensive visibility, branding, and communications strategy, in collaboration with MoH, World Bank, UNICEF, and Donors for the implementation of the project. The strategy will be developed starting in November 2023 for use for the full implementation period of the HSTP.

Annex 2: HSTP Restructuring Communication Plan

ANNEX: Restructuring & Pandemic Fund Communication Plan / Stakeholder Engagement Plan (SEP) FOR COMMUNITIES AFFECTED BY FACILITY WITHDRAWAL for inclusion during the transition.

1. Purpose

This annex provides a practical and community-friendly approach for communicating with people served by facilities that are transitioning out of project support. It ensures that communities are informed early, given an opportunity to raise concerns, and supported to understand where and how they can continue to access essential services. Community feedback will be linked to the project's Grievance Redress Mechanism (GRM).

Under the integrated **Health Sector Transformation Project (HSTP)** and the **WHO-led Pandemic Fund (PF) Grant**, this annex also ensures that rationalized areas do not become surveillance blind spots, preserving community-level disease monitoring during and after service transitions.

2. Key Engagement Commitments

- Affected communities will receive clear information before the facility withdrawal.
- Formal community notification will be provided at least 30 days before the planned withdrawal date; 45 days or more is preferred where feasible.

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- Communication will be two-way, allowing communities to ask questions, raise concerns and suggest practical solutions.
- Information will be shared through channels that communities can realistically access, including community meetings, local leaders, Boma Health/community health workers and other appropriate local channels.
- All complaints and serious concerns will be recorded and linked to the GRM for follow-up and response.
- Communities that are geographically isolated or do not have a reasonable alternative facility will receive additional assessment, consultation and continuity measures.

3. Community Engagement Sequence

Stage	Timing	What will happen	Responsible	Record / Follow-up
1. Identify affected communities	60–45 days before withdrawal	Confirm affected catchment communities and assess alternative facilities, distance, transport, cost, capacity and access. Identify isolated or high-risk communities.	PMU Programme Team with State MoH, County Health Department and facility management	Community/service-access assessment
2. Prepare communication	45–40 days before withdrawal	Prepare simple, clear messages on the change, withdrawal date, affected services, alternative services, continuity arrangements and GRM contacts.	PMU Communications Team with MoH programmed Team and State MoH	Approved communication materials
3. Brief local leadership	At least 40 days before withdrawal	Brief State/County authorities, traditional and community leaders, Boma Health teams and relevant facility/community structures before wider notification.	PMU / State MoH / County Health Department	Briefing record and agreed engagement schedule
4. Notify communities	At least 30 days before withdrawal	Hold community meetings and use appropriate local communication	State MoH / County Health Department, supported by	Attendance and key issues documented

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		channels. Explain the planned date, services affected, alternatives and continuity arrangements.	PMU Communications Officer and Boma Health/Community Health Workers	
5. Listen and collect feedback	30–21 days before withdrawal	Give communities time to ask questions, raise objections and identify access barriers, with attention to remote and vulnerable groups.	State MoH / County Health Department / Community Health structures	Feedback and concerns log
6. Review concerns and respond	21–14 days before withdrawal	Review concerns and agree feasible mitigation measures, including referral arrangements or other continuity measures where needed.	PMU Programme Team with MoH, State MoH and County Health Department	Response/action matrix
7. Use the GRM for unresolved concerns	Throughout engagement	Register complaints or objections through available GRM channels, acknowledge them and follow the approved GRM process for investigation, response and escalation.	GRM Focal Point / PMU with State and County GRM structures	GRM case/record and response
8. Final reminder	14–7 days before withdrawal	Repeat the withdrawal date, alternative service points, referral arrangements, emergency contacts and GRM channels, especially through community-level	PMU Communications Officer / State MoH / County Health Department / Boma Health teams	Reminder completed; outstanding concerns tracked

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		channels for hard-to-reach areas.		
9. Final readiness check	7–3 days before withdrawal	Confirm that alternative services, referral arrangements and community awareness are in place. Escalate critical service-continuity risks.	PMU Programme Team / State MoH / County Health Department	Readiness and escalation record
10. Follow up after withdrawal	Within 30 days after withdrawal	Check whether communities can still access essential services and identify any new gaps or complaints.	PMU / State MoH / County Health Department / Community Health structures	Post-withdrawal follow-up report

4. Additional Measures for Isolated Communities

Where an alternative facility is not reasonably accessible because of distance, poor roads, insecurity, transport costs, seasonal access or limited-service capacity, the community will be treated differently from communities with a practical alternative.

- Carry out a specific access assessment and discuss the findings with the affected community.
- Identify practical continuity measures, such as strengthened referral arrangements, outreach/mobile services, scheduled outreach or stronger Boma Health/community health worker linkages, where feasible and approved.
- Escalate any critical, unmitigated risk to access essential services to the appropriate MoH/PMU decision-making level before withdrawal.
- Continue monitoring after withdrawal and review arrangements where communities report serious access problems or repeated grievances.

6. Link to the Grievance Redress Mechanism (GRM)

During every community notification and consultation, communities will be told how to raise a complaint, objection, question or suggestion through the available GRM channels. Concerns raised during meetings will be documented, and complaints requiring formal action will be registered through the GRM.

GRM Action	Responsible	Indicative timing
Explain GRM channels during community engagement	State & County GRM Focal Points	At notification and consultations

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Receive and register complaint/objection	GRM Focal Point/ CMOs, CHWs, Incharge	As soon as received; target acknowledgement within 2 working days
Assess, refer and seek resolution	GRM Focal Point with responsible technical/programme unit	Within approved GRM timeframe
Provide response and escalate unresolved/high-risk cases	Responsible MoH/PMU unit / GRM Focal Point	Target initial substantive response within 7 working days, subject to approved GRM procedures
Close and monitor recurring issues	GRM Focal Point / PMU	Ongoing; reviewed during post-withdrawal monitoring

7. Main Responsibilities

MoH, SMOHs, PMU Leadership and PMU Communications Team: Coordinate the communication sequence, prepare messages, support community engagement, ensure accessible information and document communication activities reach the intended audiences.
MoH Programme/Technical Team: Confirm affected facilities and service-continuity arrangements and provide/approve technical information.
SMoH and County Health Department: Lead local engagement, coordinate community leaders and support referral and continuity arrangements.
Facility Management and Boma Health/Community Health Workers: Support local notification, reach households, explain service options and channel community feedback.
GRM Focal Point: Register, track and coordinate resolution of complaints and concerns.
Community representatives: Participate in consultations, raise concerns and provide feedback on access and continuity of services.
7. Minimum Notification and Decision Rule
Facility withdrawal notifications must be provided to affected communities at least 30 days before the planned withdrawal date. Where feasible, the process should begin 45 days or more in advance. If engagement identifies a critical and unmitigated risk to access to essential services, particularly for isolated communities, the issue must be assessed and escalated before withdrawal.
8. Documentation

- Maintain a simple community engagement register showing date, location, audience, method, responsible staff and key issues raised.
- Maintain a feedback/action log showing the concern, responsible party, action and status.
- Link formal complaints to the relevant GRM case/reference number.
- Include key community concerns, unresolved issues and mitigation measures in restructuring progress reporting.

Implementation note: This annex should be read together with the approved Restructuring Communication Plan, SEP and GRM procedures. Timelines should be aligned with the final restructuring schedule and approved project requirements.

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1. Purpose and Strategic Objective

This joint communication plan provides a unified, phased, and government-led framework for communicating recent HSTP cost-saving measures and programmatic adjustments arising from the recommendations of the Mid-Term Review conducted in November 2025.

The plan is designed to:

- Ensure accurate, timely, and consistent communication on HSTP adjustments
- Prevent misinformation, panic, and reputational risk
- Protect frontline health workers and service continuity
- Maintain public trust through transparency and sequencing
- Reinforce MoH leadership and partner alignment

Strategic Note: Communication will follow a strict cascade model, with Ministerial leadership at the center, followed by structured dissemination to states, implementing partners, facilities, and communities.

2. Background and Context

HSTP is a nationwide flagship health program led by the Ministry of Health, funded by the World Bank, and implemented by WHO and UNICEF through 28 implementing partners.

As the project enters the 2026 implementation cycle, structural adjustments have been required due to:

- Global and country-level funding constraints
- The need for fiscal discipline and value-for-money optimization
- A strategic shift toward sustaining essential services through mid-2027

Key adjustments include:

- Withdrawal of direct HSTP support from 101 facilities
- Downgrading financial support for 6 hospitals.
- Sliding scale reduction of health workers' incentives; reduction in UNICEF overall operational cost including direct and indirect costs;and; reduction in PMU/TPM budget lines.

- Proposed pilot on direct MoH implementation usher in transition and to ensure sustainability and ownership.

These changes are not performance-related but sustainability-driven.

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3. Communication Objectives

The plan aims to:

- Standardize messaging through a single "source of truth"
- Sequence information flows to avoid confusion and backlash
- Mitigate operational and political risks, including strikes.
- Facilitate two-way dialogue through grievance and feedback mechanisms.
- Preserve confidence in government stewardship and partner collaboration.

4. Core Communication Principles

- Government-led: All official announcements are led by MoH.
- Sequenced disclosure: Internal stakeholders are briefed before public communication.
- Transparency with reassurance: Honest explanations are paired with service-protection messaging.
- Protection of frontline workers: Clear framing on incentive safeguards and equity.
- Consistency: One narrative, one Q&A, one fact sheet across all actors.

5. Key Audiences

Primary Decision-Makers

- State Governors
- State Ministries of Health (SMoH)
- County Health Departments (CHDs)

Operational Stakeholders

- Health facility in-charges
- Health workers
- Implementing Partners (IPs)

Other Health Actors

- MSF, Health & Nutrition Clusters, humanitarian partners

Communities & Public

- Service users
- Community leaders
- General public (via radio and approved media channels only)

6. Core Message Pillars (High-Level)

- HSTP adjustments are driven by funding realities, not failure.
- The priority remains protecting essential services and frontline workers.

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- Decisions are evidence-based, consultative, and equity-informed.
- Adjustments are required to keep HSTP operational through mid-2027
- Government leadership and partner collaboration remain strong.

(Detailed message matrix, Q&A, and fact sheets to be developed separately.)

7. Sequencing Logic & Channels

- Ministerial letters first to assert stewardship.
- System alignment before public rollout (SMoHs, CHDs, IPs, facilities)
- Radio as the backbone, especially community FM stations.
- Staggered disclosure of sensitive details.
- No media engagement without MoH clearance.

RESTRUCTURING COMMUNICATION PLAN

Communication Timeline and Responsibilities

The communication plan should ensure that all affected facilities and relevant health authorities receive timely, clear and coordinated information before any facility withdrawal. Facility withdrawal notifications should be issued at least 30 days before the planned withdrawal date, with 45 days preferred where feasible.

Communication Action	**Target Audience**	**Timeline**	**Minimum Notification Period**	**Responsible Person/Unit**
Finalize list of facilities affected by restructuring/withdrawal	MoH, PMU, implementing partners	45–60 days before planned withdrawal	N/A	PMU / MoH Programme Team
Develop and approve communication messages	MoH, PMU, partners	At least 20 days before withdrawal	N/A	PMU Communications Officer/Com team, MoH
Official notification to affected facilities	Facility management, State MoH, County Health Departments	At least 30 days before withdrawal	Minimum 30 days' notice	MoH,SMoH / PMU
Notification to State Ministries of Health and County Health Departments	State and county authorities	At least 30 days before withdrawal	Minimum 30 days' notice	PMU / MoH
Community/public communication where required	Communities, beneficiaries, local leaders	Following facility notification	Before withdrawal	PMU Communications / State MoH

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		and before withdrawal		
Partner and stakeholder briefing	Development partners, UN agencies and other stakeholders	30–45 days before withdrawal	N/A	PMU / MoH
Reminder and follow-up communication	Affected facilities and local authorities	14–7 days before withdrawal	Follow-up	PMU Communications Officer / State MoH
Final confirmation of withdrawal	Facility, State MoH, County Health Department	1–3 days before withdrawal	N/A	PMU / MoH Programme Team
Documentation and reporting of communication process	PMU management and stakeholders	Within 5 working days after withdrawal	N/A	PMU Communications Officer

N.B
Facility withdrawal notifications shall be communicated formally to affected facilities and relevant State and County health authorities at least 30 days prior to the planned withdrawal date. No facility withdrawal should proceed without the required minimum notification period, except where an approved emergency or exceptional circumstance applies.
If the projected withdrawal date changes, the communication timeline will be **updated accordingly**, while maintaining the requirement that formal notification to affected communities precedes the actual withdrawal by **a minimum of 30 days**. Any significant change to the transition schedule will also be communicated to affected communities through the established channels.

This approach ensures that communities are not notified after decisions have already been implemented and that responsibility for each communication action is clearly assigned.

Phase 1: Ministerial & Institutional Notification (Early January)

Activities

- Minister-signed letters to Governors, SMoHs, CHDs.
- Official notification to Implementing Partners.

Lead: MoH (with UNICEF coordination)
Output: Signed letters, with an annex of the affected facilities.

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Phase 2: Technical Clarification & Internal Alignment (Mid-January)

Activities

- Develop and approve:
  - Core Narrative
  - Neutral Fact Sheet (102 + 6 facilities)
  - Q&A and incentive clarification
- Conduct internal briefings (States, IPs, UNICEF field teams)

Lead: PMU / UNICEF
Output: Approved briefing pack, aligned stakeholders

Phase 3: Joint Dissemination & Public Communication (Mid–Late January)

Activities

- Coordinated dissemination across MoH–UNICEF–WB platforms
- Nationwide radio talk shows (national & state level)
- Selective media engagement with trusted journalists

Lead: MoH Communications / PMU
Output: Harmonized public messaging, radio programs aired

Phase 4: Feedback, Monitoring & Adjustment (Late January)

Activities

- Activate Grievance Redress Mechanism (GRM)
- Collect feedback from facilities, IPs, communities
- Refine messaging based on emerging concerns

Lead: PMU / MoH
Output: Feedback summary, updated materials

9. Stakeholder Mapping & Targeted Messaging (Summary)

Audience	Key Concern	Channel	Core Message	Status
Development of key response documents	Comms plan, Q and A, Fastsheet and letters	Official channels	For internal and external use	All done but letters pending MoH internal review
Governors / SMoH	Political & service impact	Letters, briefings	Sustainability and system protection	Ongoing

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Implementing Partners	Budgets & staffing	Technical meetings, FAQs	Standardization and predictability	Partially done but with limited detials
Health Workers	Incentives & job security	Facility meetings, radio, GRM	Equity, transparency, feedback	Pending
Communities	Access to services	Radio, BHI, leaders	Essential services prioritized	Pending
Donors	Value for money	Technical reports	Optimized impact and sustainability	Done

10. Risk Management & Mitigation

Key Risks

- Misinterpretation as project failure
- Health worker anxiety or resistance
- Politicization at state level
- Misinformation and rumors

Mitigation Measures

- Early political engagement
- Unified documentation
- Phased rollout
- Two-way communication via GRM

11. Crisis & "Flashpoint" Protocol

In case of strikes or public protest:

1. Immediate response by CHD/SMoH within 24 hours
2. Narrative anchor: Emphasize continuous review and feedback channels
3. Escalation to National PMU within 48 hours if unresolved

12. Monitoring & Evaluation

Success indicators include:

- Number of facilities with GRM materials displayed
- Nature of GRM queries (clarification vs misinformation)
- Stability of service delivery post-rollout

13. Next Steps

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- Finalize Ministerial letters
- Approve fact sheet, Q&A, and spokesperson briefs
- Confirm radio schedules and dissemination dates
- Develop detailed budget separately

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Annex 2: Detailed description of GRM

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 their linked BHCs, the HSTP'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.[2] 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.

[2] 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.

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Training

BHC members will be trained by the relevant training or AAP focal point/person in the Partner Lot Leads or in the consortium partners. The training will include topics such as 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 received by 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.

Verbal to paper to digital systems

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 are only recorded on paper at the facility level (in AAP registers) and by BHW supervisors (in complaints logs). Partners and the UNICEF Monitoring, Evaluation and Learning team will digitize the data for analysis.

Reporting

BHC members will work with health facilities' 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 that they can report directly to them. Where possible, they may use phones or communicate issues during ad hoc or bi-monthly BHC meetings.

BHC bi-monthly meetings, arranged by staff and partners, will be held at health facilities between representatives of all their linked BHCs, partners' AAP focal person(s), CHDs, and health facilities' 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 to the relevant UNICEF system. Where possible, they may use phones to do so, or they may notify partners during ad hoc or bi-monthly BHC 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 issues raised. For complaints related to HSTP facilities withdrawal or transition decisions, the BHC focal points or implementing partner shall register the case and escalate it to the PMU within two working days. The PMU Social

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Specialist will review such cases and coordinate with the relevant Programme/Technical Team, SMoH and CHD to determine whether additional mitigation measures are required. The complainant will receive an initial substantive response within seven working days, subject to the approved GRM procedures, and the outcome will be communicated back **i**n writing, or orally where there is a literacy barrier**.** High-risk cases affecting essential service access will be escalated immediately and, where necessary, assessed before resolution proceeds.

Stream 2: BHWs' diaries

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The AAP system's second stream uses the BHWs' frequent contact time with households in hard-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 will be gathered verbally by BHWs from households visited as part of their current duties. This information will be communicated verbally each month 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 BHCs and health facilities.

Rationale

Health facilities may not be visited often by members of hard-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 other AAP streams. It is also likely that they will help the programme to identify emerging issues and when activities or information has been misunderstood by communities.

Training

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

BHW supervisors will be trained to record feedback and individual complaints raised by households to BHWs during these sessions and summarize 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. They 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.

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Reporting and tools

During BHWs' monthly reporting meetings with their supervisors, BHWs will be asked the same set of questions by their supervisors that they asked the households they visited. BHW supervisors will record their verbal answers in their complaint's logs (a paper-based booklet that makes carbon copies of completed pages).

Gender-based violence

HSTP 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 BHW supervisors will be trained to report those suspected of being perpetrators or survivors of GBV to partners for referral to services.

BHW supervisors' Community Health Information System (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, while retaining carbon copies.

Partners will enter the feedback and complaints data into their own partners' complaints logs, which are shared with UNICEF monthly *(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 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. For complaints related to HSTP Direct implementation Pilot facilities withdrawal or transition decisions, the implementing partner shall register the case and escalate it to the PMU within two working days. The PMU Social Specialist will review such cases and coordinate with the relevant Programme/Technical Team, SMoH and CHD to determine whether additional mitigation measures are required. The complainant will receive an initial substantive response within seven working days, subject to the approved GRM procedures, and the outcome will be communicated back **i**n writing, or orally where there is a literacy barrier**.** High-risk cases affecting essential service access will be escalated immediately and, where necessary, assessed before resolution proceeds.

Stream 3: Women's AAP Champions

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 or women's youth leaders), but this is not essential.

The Women's AAP Champions will serve as feedback and complaints channels with a focus on women and vulnerable people (e.g., persons with disabilities). They will also be trained to

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communicate allegations of corruption and SEA to UNICEF's existing systems.

Any feedback or complaints received by the Women's AAP Champions will be communicated to health facilities' AAP focal points or BHW supervisors. Allegations of corruption and SEA will be communicated directly to the relevant UNICEF system.

Rationale

Research has found that women do not generally hold public positions of authority in communities in South Sudan. However, most communities include respected older women 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

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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 are afraid of retribution.

The research findings also suggested that it is important that chiefs do not feel threatened by initiatives that engage women, as this could undermine efforts towards AAP and SA. This risk may be somewhat mitigated by encouraging older women already in established and accepted leadership roles to become AAP Champions. The older woman 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 training 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 such as 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 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 BHW supervisors' own complaints logs.

Following UNICEF practice of not writing such issues down to protect those concerned, allegations of corruption and SEA will not be recorded in the register. Instead, they will be communicated directly to the relevant UNICEF system by facility AAP focal points or BHW 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 issues raised. For complaints related to HSTP facilities withdrawal or transition decisions, the Women's AAP Champions focal point or implementing partner shall register the

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case and escalate it to the PMU within two working days. The PMU Social Specialist will review such cases and coordinate with the relevant Programme/Technical Team, SMoH and CHD to determine whether additional mitigation measures are required. The complainant will receive an initial substantive response within seven working days, subject to the approved GRM procedures, and the outcome will be communicated back in writing, or orally where there is a literacy barrier. High-risk cases affecting essential service access will be escalated immediately and, where necessary, assessed before resolution proceeds.

Stream 4: Health facilities

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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 where partners meet with community members. The stream builds on these foundations by formalizing AAP roles for health facilities, while ensuring that women have an identifiable female health-care 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.

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 bottlenecks to feedback, 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 BHC bi-monthly meetings, by mobile phone and during ad hoc engagements.

Training

Health facilities' male and female APP focal points will be trained by the relevant training focal person in the Partner Lot Leads or by consortium partners. The training will include topics such as awareness-raising on rights, 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 issue raised, the category of user it was raised by, the *boma* they come from and the method of its submission to the AAP system. The register will use carbon paper to ensure duplicates are made of all entries *(see Annex 3 for an outline of the draft of the proposed register)*.

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Community members who provide feedback and complaints to health facility workers and BHC members who 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.

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 the wider programme (e.g., a lack of medicine or dilapidated structures).

Allegations of corruption and SEA will not be recorded in the register. Instead, they will be communicated directly to the relevant UNICEF system by facility AAP focal points. Where possible, they may use phones, or they may notify partners during ad hoc or bi-monthly BHC meetings.

Health facilities' in-charges will also have working relationships with UNICEF's field-based AAP focal person(s), 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 allegations of corruption and SEA directly to UNICEF. This information will also be regularly shared with communities through local radio, word of mouth and awareness-raising events.

Feedback and complaints registers will be collected monthly by HSTP partners' AAP focal person(s) at the same time as they collect facilities' main activity register. Partners will digitize 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 check that data are being communicated correctly by those in the reporting chain.

During supervisory visits, UNICEF focal person(s) will spend dedicated time talking to health facilities' male and female APP focal points and conduct a short 30-minute focus group discussion with between four and six 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 *boma*. These should be unstructured sessions to avoid the impression that they are about monitoring and evaluation,

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and should cultivate open dialogue. Nonetheless, UNICEF should guide the discussions to focus on two areas:

- Any issues or complaints that either stakeholder has that could not be raised through other channels
- 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 Women's AAP Champions and co-chairs. This will help ensure that they can organize BHC bi-monthly meetings *(see Stream 1)* and that health providers' responses to issues raised are communicated back to communities. The communication of responses can take place on an ad hoc basis through BHCs and BHWs, and at BHC bi-monthly meetings and community health dialogues. For complaints related to HSTP facilities withdrawal or transition decisions, the The health facility AAP focal point or implementing partner shall register the case and escalate it to the PMU within two working days. The PMU Social Specialist will review such cases and coordinate with the relevant Programme/Technical Team, SMoH and CHD to determine whether additional mitigation measures are required. The complainant will receive an initial substantive response within seven working days, subject to the approved GRM procedures, and the outcome will be communicated back **i**n writing, or orally where there is a literacy barrier**.** High-risk cases affecting essential service access will be escalated immediately and, where necessary, assessed before resolution proceeds.

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 field-level AAP focal person(s), 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 lie for service delivery and what commitments have been made by providers.

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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 chains of authority underpinning

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the health system. It will also present a united image of the health delivery system.

The dialogues will ensure the HSTP's AAP system also lays the foundations for SA relationships.

Organization

The HSTP partners will be responsible for organizing the annual community health 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 publicize 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, given jointly 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 to which it is linked, the HSTP's partner organizations, CHDs and UNICEF.

These events 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 should be drafted by partners before the event in consultation with CHDs and UNICEF field offices. They will be signed on the day by representatives of 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 service 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 issues raised.

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