Republic of South Sudan

Ministry of Health

COVID-19 Pandemic: Standard Operating Procedures for Risk Communication and Community Engagement

Juba, South Sudan
April 2020

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1. Introduction

Coronavirus disease (COVID-19) is an infectious disease caused by a newly discovered coronavirus. The COVID-19 virus poses a significant risk to international public health security and has been declared as a pandemic. South Sudan registered her first confirmed COVID-19 case on 5th April 2020.

Individuals, families and communities need to be informed about the virus to be able to take adequate precautionary measures that will prevent COVID-19 local transmission and keep them safe. For that end, effective and efficient community engagement is needed with strong linkages between community networks, responders, and health service providers that will ensure early detection and contact tracing, early isolation, early diagnosis, early treatment, surveillance, and responsible burial services meeting the expectations of communities.

This Standard Operating Procedures (SOP) provide guidance on the implementation of Risk Communication and Community Engagement (RCCE) efforts during the COVID-19 prevention and response in South Sudan. While it specifically addresses social mobilizers and their role in the communities, the same activities can be fulfilled by other trusted community members that work with implementing partners (IPs), including community health workers, home hygiene promoters, teachers, nutrition volunteers, boma health teams, etc.

1.1 Functions of RCCE

Effective RCCE is done through the usage of integrated approaches which include, but are not limited to, public communication, mass media communication, social mobilization, community engagement, interpersonal communication, health promotion and social media. Therefore, RCCE interventions focus on the following while observing the preventive measures like physical distancing:

1. **Awareness raising and two-way communication**: to foster understanding of COVID-19 risks among different communities and understand risk perception patterns of targeted audiences.
2. **Trust-building**: to promote the credibility and acceptance of the COVID-19 prevention and response measures, including of the front-line workers and health systems.
3. **Behaviour change**: to guide communities on how to change their daily behaviours or habits with the sole purpose of reducing risks of local transmission of the COVID-19 virus.
4. **Accountability to affected population**: to establish and/or strengthen community feedback mechanisms and participatory processes for effective and democratic planning of preventive and response measures.

1.2 Definitions of key terms

- **Risk communication**: refers to the exchange of real-time information, advice and opinions between experts and people facing threats to their health, economic or social well-being. The ultimate purpose of risk communication is to enable people at risk to take informed decisions to protect themselves and their loved ones. For the purpose of the SoPs, it will include the development and dissemination of tailored, accurate, and up-to-date information regarding COVID-19 risks, mitigation strategies and behaviors.
- **Social mobilization:** Social mobilization is a broad movement to engage people's and build consensus for achieving a specific goal, taking into account the felt needs of the people. Social mobilization embraces the principle of community involvement and seeks to empower individuals and groups to make informed decisions.
- **Community engagement**: Community engagement is a process through which people are enabled to become actively involved in defining their issues of concern, making decisions, and formulating and implementing planned actions to achieve the desired change.

2. Purpose and scope of the standard operating procedures

The purpose of these standard operating procedures (SOPs) is to provide operational guidance to implementing partners (IPs) on the roles of RCCE and the implementation modalities of recommended activities at the different levels to curtail the spread of COVID-19.

2.1 Responsibilities and oversight

The RCCE TWG is chaired by the Ministry of Health (MoH) and co-led by UNICEF at national level. The TWG reports to the National Steering Committee. It is recommended that the TWG at national and subnational level form subcommittees/subgroups to oversee the different thematic areas of operation like messages development and clearance, community engagement and social mobilization, training, media engagement, rumor tracking etc.

Under the leadership of MoH, implementing partners, including managers, supervisors, mobilizers and community volunteers, shall strive to adhere to the provisions of these SOPs when conducting RCCE activities. Partners implementing RCCE activities in the field are expected to effectively coordinate with other IPs to avoid duplication of efforts, meet minimum requirements of reporting, participate in the RCCE technical working group meetings and the RCCE pillar at the national, state and county levels, and provide adequate support and supervision for social mobilizers.

It is the responsibility of the Ministry of Health to ensure that risk communication and community engagement activities for COVID-19 are undertaken in accordance with these SOPs and WHO guidance note(s) on COVID-19. Within the MoH, the Health Promotion/Education Department is responsible for leading COVID-19 RCCE activities. At the State level, the State health team is responsible for planning and implementing subnational level activities.

The National and State COVID-19 task forces, along with the national, state and county RCCE technical working groups (TWGs), support the MoH and SMoHs by providing technical oversight and coordination for planned interventions and activities.

2.2 Minimum recommended requirements for participation in the RCCE pillar registration

1. Prior to start of RCCE activities, IPs must register with the relevant RCCE TWG pillar as well as register for the respective subcommittees by notifying the chairperson or using the online registration form. The record of all registered IPs will be shared with the COVID-19 national steering committee, the state task forces and the public health emergency operations centre.
2. For suggested new activities and/or activities in new locations, IPs must consult with the national/state RCCE TWGs and the MoH and SMoH prior to implementing it. Adjustments may be required to an IP's proposed locations to avoid duplication of efforts with existing/on-going activities and/or to address gaps in geographic coverage.
3. IPs must consult local authorities, community leaders, religious leaders and other community influencers
5. All planned activities must comply with local by-laws to get approvals prior to its implementation.

Participation in the RCCE TWG and pillar

1. IPs must attend RCCE TWG pillar meetings as per agreed upon schedules.
2. IPs must submit the completed partner mapping template, including the names, contact numbers and locations of all mobilizers and supervisors. Any changes must be immediately communicated to the RCCE TWG pillar at national/state levels.
3. IPs are expected to participate in weekly/daily planning exercises to coordinate activities in Counties/Payams/Bomas.
4. IPs are expected to follow the agreed COVID-19 RCCE strategy and plans.

Monitoring and reporting

1. IPs must submit weekly reports using the online reporting form to the TWG by each week's deadline.
2. IPs must demonstrate evidence of a functioning monitoring and supervision system for tracking and verifying the work of the mobilizers they support.
3. The national/state TWGs may request the schedule of an IP's mobilizer activities and make periodic supervision visits to monitor the work.

2.3 Support and supervision of social mobilizers

Selection, recruitment, and deployment

1. IPs should consult local leaders – local authorities, community influencers, youth and religious leaders – to get their input on selection and deployment of social mobilizers (including the existing ICMN mobilisers) in all settings including forcibly displaced populations
2. Selected mobilizers should include mobilisers who have worked well before during previous outbreaks or similar response and has the confidence of the community – They must be accessible and acceptable in the community and they should meet criteria for age, gender, and language skills to balance teams. Outside social mobilizers can be deployed to provide support to local mobilizers based in the community.
3. To ensure quality engagement and support, mobilizers should be expected to cover a realistic number of households/communities per day/week. It is not possible to implement quality engagement if mobilizers cannot spend the time needed to build relationships and trust in the community.

Training and preparation

1. All IPs are responsible for ensuring that their staff and mobilizers are fully oriented on these SOPs.
2. IPs must ensure their staff have the required knowledge, attitudes, behaviours, skills, and supervisory support to undertake community engagement.
3. Mobilizers (both staff and volunteers) in every county must receive comprehensive training on COVID-19 prevention, transmission and services; community-led approaches; interpersonal skills; safety and security; protection, specifically on child protection and safeguarding; referral to social services; prevention and addressing social stigma associated with COVID-19, Safe and dignified burials, Protection from Sexual Exploitation and Abuse (PSEA) and gender issues in community work; and monitoring.
4. IPs should ensure that their training manuals, approaches and messages are aligned with the MoH/national task force/TWG-approved messages and approaches.
5. Mobilizers must have access to up-to-date information and messaging via education and communication (IEC) materials, contact with supervisors, regular meetings, refresher trainings, and supportive supervision.
6. IPs and the state health management team should conduct periodic joint supervision and monitoring in implementing communities as appropriate.
7. Training must include a partner mapping and rumor tracking sections.

Safety and security

1. All mobilizers are expected to avoid and pre-empt risks associated with the COVID-19 or violence, they must be prepared for this possibility. IPs must take responsibility to provide their mobilizers with adequate information, guidance and support. Mobilizers should be trained on core areas of safety and security, including entering and exiting communities; protection against COVID-19; negotiating with communities; physical distancing and emergency protocols.
2. IP staff should provide support and supervise mobilizers on a regular basis, including by regular field visits and by telephone. IP staff should have knowledge of mobilizer whereabouts when they are conducting RCCE work.
3. Mobilizers must be identified with the IP supporting their work. Means of identification may include, but not be limited to, identity card, t-shirt, cap, or letter of engagement.
4. Mobilizers will be provided with designated contact numbers for national, state and County focal points for use in emergencies and should always have these contact numbers available during their deployment.
5. IPs should ensure that mobilizers are properly introduced to key stakeholders, know the local bylaws, and receive a security update from a designated point of contact in the community.
6. Mobilizers should always be equipped with soap and/or 70 per cent alcohol-based hand sanitizer, masks (as per guidelines), a charged mobile phone and top-up vouchers (where possible), transportation or enough money for transport, and IEC materials and tools like megaphones for their mobilization activities.
7. Social mobilisers are always to use a mapping form - for visibility and efficiency.

Payment and incentives to mobilizers

1. Payments and incentives (monetary and non-monetary) should be provided in line with the Ministry of Health established incentive policy. Payments should only be made to mobilizers who are working according to structured work plans with clear deliverables.

2. Making payments that are out of proportion to the work and the standards of other IPs may set unrealistic and unsustainable expectations that can have a negative effect on all IPs. The goal is for all IPs to align mobilizer payments to ensure a harmonized, consistent approach.
3. IPs should discuss and agree with mobilizers in advance about the type, method, and amount of payments and incentives, and make sure expectations are clear.
4. IPs should ensure agreed payments to mobilizers are paid on time.
5. Within communities, the behaviour change required for COVID-19 prevention must be based on the voluntary actions of communities. Payments to community members for attending meetings in their own communities or monetary compensation for following COVID-19 - prevention guidelines or by-laws should be strictly avoided and actively discouraged.

3. Considerations for effectively working in communities

Because of their roles as trusted sources of support and information on COVID-19, trained social mobilizers play an important intermediary role between the community and the COVID-19 response.

While some alerts come directly from the community, mobilizers should be included in all alerts from the emergency operations centre, and ideally work in coordinated, integrated teams with front-line service providers (See SOP 4.7). The emergency operations centre and the RCCE pillar of the state health team will coordinate IPs in response to alerts so they do not duplicate efforts or overwhelm the community.

3.1 Considerations for effective community engagement

While IPs may use a variety of RCCE approaches to achieve the goal of social and behavioural norm change, all IPs should always follow the minimum standards of good practice for community engagement while observing recommended physical distancing of atleast 2 metres apart.

1. Consider community leaders as experts in their own culture, traditions and practices. Include community leaders and influencers in planning, implementation, and evaluation of programmes and messaging. Engage well-respected leaders as key influencers.
2. Work through existing community structures to engage and deliver messages.
3. Consider community empowerment approaches that help community members develop action plans to prevent COVID-19 in their community. NB: Adherence to the preventive measures while conducting these activities is mandatory.
4. Do not draw undue stigma or attention or discriminatory actions / talks to individuals or families affected by COVID-19.
5. Consider the most vulnerable, specifically elderly, people with other chronic diseases, like diabetes, heart diseases, hypertension, and people with low immunity such as people living with HIV including people with disabilities when developing and disseminating messages.
6. Identify activities and messages to be conveyed through community dialogues and household visits, anticipating questions and concerns before they are raised.
7. Adopt participatory (two-way) communication for all communication channels, including radio call-ins, community dialogues, and household visits using megaphones and loudspeakers.
8. Recognize and promote people in the community who continue to practice behaviours that stop the spread of COVID-19, and who help others do the same maintaining physical and social distancing.
9. Continually evaluate activities and adapt messaging and strategies as needed. A common reporting tool, key indicators and Monitoring & Evaluation framework should be agreed by all IPs to monitor activities and track progress.

3.2 Considerations for the development and harmonization of key messages and materials

1. Ensure that all IEC materials are consistent with the MoH/national steering committee /TWG-approved messages, and available in a compendium of approved messages for various settings and scenarios.
2. All messages should emphasize what communities can do to stay safe and why they should make these choices.
3. All IPs who intend to produce new IEC materials or reprint the existing ones must obtain MoH approval guidance especially on use of logos through the national RCCE TWG.

4. Look for available evidence through recent anthropological studies and knowledge, attitudes and practices (KAP) surveys, and ask all pillars for data on community perceptions to assess current perceptions/fears/rumours.
5. Ensure that mobilizers understand the local COVID-19 and health services context, including data and issues related to the number of confirmed cases, availability of ambulances, availability of medical and food supplies, water and sanitation issues, referral services and others.
6. Note the literacy levels in the area (e.g., urban areas are generally more literate than rural areas). Pictorial materials with minimal text should be developed and promoted in low-literacy settings using the local dialects preferably.
7. Development of appropriate messages for people with special needs including disabilities should be give due consideration.
8. Ensure that IEC materials are in the local languages that the target audiences can read and / or understand.
9. Ensure that IEC materials and messages represent the current epidemic are not outdated and address current local barriers to adopting COVID-19 prevention practices. Engage local communities in re-shaping the messages as the pandemic and context shifts over time.

3.3 Considerations for people at higher risk from COVID-19

- COVID-19 does not distinguish between people, and disease could affect any population group or demography. However, RCCE messages and programming should take special consideration of people at higher risk likely to have devastating effects of the disease particularly the elderly, people with other diseases like diabetes, heart diseases and hypertension as well as people with reduced immunity such as people with HIV/AIDs.

3.4 Considerations for psychosocial and mental health support

1. All IPs should adopt a clear referral process for identifying and referring persons they find in need of psychosocial and mental health support and link them immediately to available services.
2. Mobilizers should not counsel persons requiring Psychosocial First Aid (PFA), unless trained in PFA.
3. Training of mobilizers should include specific instructions on the limits of their skill sets, and appropriate referral mechanisms. The SOPs on Psychosocial Support to Individuals, Communities and Health Workers Affected by COVID-19, offers guidance on this area of work.

4. SOPs for RCCE interventions and the role of mobilizers in COVID-19 response activities

4.1 SOPs for communicating COVID-19 pandemic information and health protection messages to the public through the mass media

The media are an important ally in emergency preparedness and response efforts. However, if not well-managed, the media can cause panic and confusion, leading to deaths that could otherwise have been prevented. It is important to establish arrangements that enable the media to receive and disseminate accurate information about the pandemic and dispel rumors and misinformation. The media may need to get the correct information and orientation or training to disseminate the correct information so that they do not make a wrong data/information even worse. Furthermore the media needs to be oriented not to inflict inflammatory or stigmatizing or discriminatory information regarding COVID-19. The designated spokesperson of the Ministry of Health, assisted by technical officers, is responsible for sharing information and updating the media on a regular basis.

The following are important guidelines for effective media engagement and management:

1. Map all the media houses and journalists and maintain an up-to-date database with their contact details, such as telephone numbers, email addresses and social media accounts.
2. Monitor the information being disseminated through the media including social media to ensure accuracy and consistency. Journalists can contribute to mitigating rumors and misconceptions by providing accurate information

3. Organize and conduct orientation for the journalists on the pandemic, covering relevant information such as: What is the current situation? Who is affected? How many cases have occurred and where? What are the patterns/trends? What does the response entail? etc.
4. Prepare an information kit on the pandemic that will be available to all journalists. This can include background information on the pandemic, press releases, posters, leaflets, a list of key messages, and contact information for local communication staff to help coordinate efforts.
5. Prepare for and conduct regular press briefings on the pandemic and response efforts.
6. Prepare and issue a press release after each press briefing. The press releases should be based on the official situation reports (Situation Reports) or other current information.

4.2 SOPs for communicating COVID-19 pandemic information and health protection messages to individuals and households through interpersonal communication

- Interpersonal communication at individual, and household levels is probably the most effective way to raise awareness to positively influence attitudes, and social and behaviour change. However, during the COVID-19 pandemic, interpersonal interactions with people must be done while observing physical distancing all the time. Social mobilizers are well-positioned to implement interpersonal communication, given that they live and work in the communities they serve. They are also more likely to be trusted than outsiders. It is recommended that social mobilisers observe physical distancing of at least 2 meters during the house to house awareness activities, wear face masks and use megaphones to announce key COVID-19 messages while ensuring that people observe physical distancing and do not gather in big groups.

The following steps are important to guide implementation:

1. Social mobilizers should meet every morning maintaining physical distance to prepare a movement plan and move to the assigned affected areas, based on needs and updated information.
2. Mobilizers should ensure they have the necessary IEC materials, megaphones, and batteries for use in the community or other public address system means.
3. In situations where the team is required to go to insecure places, mobilizers and sponsoring IPs should work with local authorities and security officials to guide access.
4. Respect and observe culturally acceptable practices like dressing and greeting with social distancing measures and introducing oneself to gain community trust and access. Make sure not to shake hands as part of the introduction.
5. Begin each visit by explaining the purpose of your visit and initiate participatory discussions.
6. Share key messages and allow time for clarification. Probe to establish understanding of the key messages. Listen attentively to community concerns, misperceptions and any misinformation, and respond appropriately.
7. Provide the household with IEC materials as reminders of the key messages and actions to take.
8. Thank the household members for their time and hospitality and for maintaining social distancing.
9. At the end of the day's assignment, prepare an activity report for sharing and discussion with other team members and the supervisor.

4.3 SOPs for managing rumors during COVID-19 pandemic

- During the COVID-19 pandemic, rumors may emerge and circulate because of the limited availability of information in an area. If not well-managed or corrected these can lead to panic, fear, violence and stigmatization of the affected, thereby worsening the situation. IPs should work with the TWG, official spokespersons at national and sub-national levels, and designated technical officers, to collect, report and address rumors within 72 hours.

The RCCE teams (TWG, IPs and social mobilisers) should deal effectively with rumours as follows:

1. The TWG created an online rumour tracking tool to be used IPs to report rumors and misinformation to the TWG on a weekly basis.
2. Using the online rumour-tracking tool, IPs and social mobilisers to carry out active listening and collect all information on people's concerns and fears about the pandemic through the radio, local leaders/influencers and other sources.
3. Identify and track sources of misinformation and rumors and rapidly verify the information collected and respond with accurate and consistent key messages.

4. Undertake rapid knowledge, attitudes and practices (KAP) assessments to understand what the community knows and believes about the disease, what language they use, and what their sources of information/misinformation are.
5. Utilize the channels identified in the rapid assessment to confirm, correct, or dispel rumours, and monitor the impact.
6. Report the rumors you come across here

4.4 SOPs for conducting rapid KAP assessments

- Rapid assessments of community knowledge, attitudes and practices in relation to COVID-19 are conducted to help refine messages and improve efficacy of interventions. These rapid assessments are conducted to gain quick insights during an evolving or emergent epidemiological situation, and do not replace more comprehensive, rigorous, nationally representative KAP studies which are conducted to develop broader strategies and establish socio-behavioural baselines.

Steps for conducting rapid KAP assessments include:

1. Identify and designate a rapid research team comprising specialists in public health, anthropology, communication and the social sciences in collaboration with the Directorate of Planning, Research, Monitoring and Evaluation.
2. Develop a study protocol and data collection tools, pre-test the tools and seek the necessary approvals from relevant institutions.
3. The research team identifies experienced data collectors at state/county level for data collection in collaboration with the state director-general for health.
4. Conduct quick training on rapid data collection for the data team, focusing on identifying information sources, interviewing skills for interviewing key informants, and conducting focus group discussions (FGDs) maintaining physical distancing.
5. Practice with the team how to take notes in key informant interviews and FGDs. If tape recorders are to be used, all members should practice how to use them and how to transcribe information.
6. Identify the key informants, opinion leaders and groups to participate in FGDs, and other relevant information sources. Assign responsibilities to each member of the data collection team. Distribute logistics materials, e.g., notebooks, recorders, pens, etc. to the team members and arrange transport for the members or teams.
7. Deploy the teams to collect the data. This should take two to three days.
8. After data collection, the county health director, M&E focal persons and social mobilizers, along with IPs, should review and verify completeness.
9. Use appropriate software packages or other means to analyse the data. Data can also be arranged and reported on thematically, depending on what was collected from the field.
10. The research team should analyse the data, write the report, and present it to the national task force, the county task force and other partners participating in the response.
11. Use the KAP findings to update the risk communication and community engagement interventions and messages. Clearly articulate the limitations and applicability of the findings and conclusions of the rapid assessment.
12. Give feedback on the KAP to the NTF, RCCE TWG and other stakeholders as necessary including affected communities and local mobilizers using the data collection team, if possible.

4.5 SOPs for effective community engagement/training/orientation meetings

- Community engagement, training or orientation meetings are characterized by bringing a group of people together at a specific location to interact with an aim of raise awareness and imparting knowledge and influencing social and behavior change. Such gatherings can increase the risk of transmission of infectious diseases such as Coronavirus. It is therefore recommended that, during the COVID-19 pandemic response, to avoid meetings that bring more than 10 people together. In addition, special precautions like physical distancing, washing hands with soap and water, using the mask must be taken to reduce the risk of transmission.

The steps below summarize how to conduct an effective community engagement, training or orientation meetings:

1. The county health team, led by the county health director, should identify a community that requires engagement. A county health team member, preferably a county health mobilizer, visits the identified community and informs the leadership of that area about the issue and planned community engagement session with not more than 10 people and ensuring physical distancing of 2 meters apart.
2. Hand washing facilities must be provided at the venue.
3. Together with the community leadership, the county health mobilizer sets a date and appropriate venue for the engagement.
4. On the day of the session, one community leader, the county health mobilizer and the mobilization team arrive at the meeting venue and facilitate the assembling of participants and ensuring adequate physical distancing. The session should be chaired by the community leader and the discussion facilitated by the technical team/ county health mobilizer.
5. The chairperson introduces the team and explains the purpose of the engagement. She/he gives a brief status report on the COVID-19 pandemic in South Sudan.
6. Together with the local leaders and with contributions from community members, the engagement team should identify the community's perceived needs, opportunities, problems/misperceptions and potential solutions.
7. Participants should identify how the community prefers to engage with the response teams, identify community roles, and agree on key action points.
8. Identify and agree on how the two-way information flow should be managed.
9. The community leader concludes the session by voicing appreciation for the contributions of all the participants, re-emphasizing the key action points and commitments for follow-up to prevent COVID-19 from spreading.

4.6 SOPs for mobilizers to support response teams

In addition to providing information to the public about COVID-19 and how to protect themselves, social mobilizers play an important role in supporting response teams. This support allows response teams, including ambulance teams, surveillance teams, and contact tracing teams, to more quickly and effectively do their jobs. Social mobilizers can provide support before teams arrive at a home, while they are there, and after they leave. It is important for mobilizers to remember that they are not a member of the specific response team and should not be doing the work of the team. However they should continue observing physical distancing and wearing face masks made from cloth.

Before a team arrives, mobilizers should:

1. Express empathy and help the family to stay calm. Express gratitude to the family for keeping themselves and their community safe by reporting the sick person using the alert system.
2. Discuss in detail with the family what is about to happen. This may include
    - arrival of an ambulance and removal of the sick or dead family member
    - arrival of the surveillance team to gather information
    - testing of the sick family member
    - if the person tests positive: what will happen at the treatment center, what the contact tracing team will do in the community and what isolation steps the family will be asked to take
    - support for families if the family member does not survive
3. Listen to the family's concerns, answer their questions, and emphasize the importance of cooperating with all team in order to protect their health, the health of the family, and the health of their community.
4. While they wait, discuss the key COVID-19 prevention methods, and how they can keep themselves safe and prevent spreading it to others. Discuss the signs and symptoms of COVID-19 and what to do if signs or symptoms occur.

While a team is present, mobilizers should:

1. Make introductions and help facilitate the conversation between the team and the family. Look for signs of discomfort and look for ways to allay fear and anxiety.
2. Remind the family that they can ask the teams any questions they have about what they are doing.
3. Provide the team with additional relevant information about the community and family, based on the mobilizer's longer-term presence there. Always respect privacy and do not disclose confidential information to others (e.g., a family member's HIV status).

4. Share information with the family on how they can receive updates on the status of their family member and contact information for the case management official.
5. Stay with the family to support them until the team(s) leaves.

After teams leave, mobilizers should:

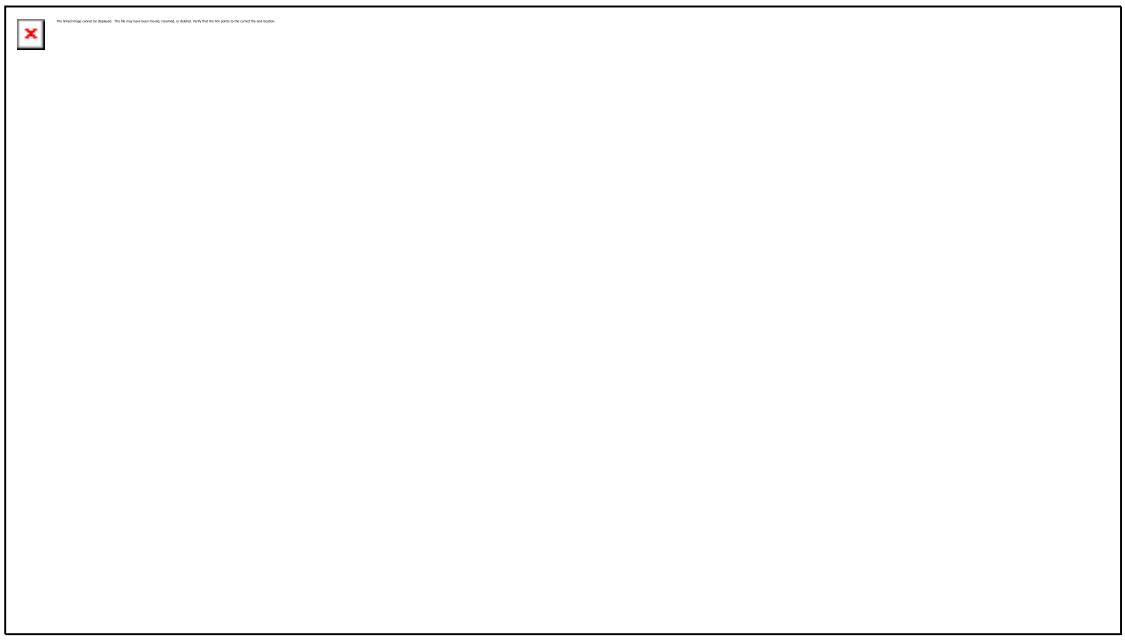
1. Answer any final questions the family has and ensure they have the contact information they need.
2. Ensure they understand any self-isolation order they may have received and the importance of following the order.
3. Report both positive and negative outcomes and experiences to the supervisor.
4. In the time following the visits, if there is a sense that isolation practices are causing concerns in the community, provide immediate feedback to the supervisor.
5. Following treatment and discharge, help patients reintegrate into their communities and address stigma and discrimination.
6. If a patient dies, ensure the family is connected to support resources that are available (i.e. psychosocial support).

Annex:

1. RCCE-TWG TORs

TORs - National COVID-19 RCCE-TWG

2. South Sudan COVID-19 Coordination Structure



3. Physical distancing guide

Physical_Social Distancing

4. Link to COVID key messages and materials
   http://bitly.ws/8DPR