United Nations Children Fund (UNICEF)
South Sudan COVID-19 Emergency Response and Health
Systems Preparedness Project

Stakeholder Engagement Plan

11 May 2021

1. Introduction of the project

The project is to support preparedness and deployment of vaccines in South Sudan, deliver of essential health service delivery in the states of Upper Nile and Jonglei States, while developing Government capacity for health sector stewardship. The project has four components:

1. Component 1: The first component will support COVID-19 vaccination cold chain, logistics, and delivery.
2. Component 2: The second component will support delivery of essential health services to Jonglei and Upper Nile States, managed by UNICEF and ICRC, and building off service delivery in these areas under Provision of Essential Health Services Project (PEHSP).
3. Component 3: The third component will finance development of Government health sector stewardship capacity to allow a gradual transition to a government-led implementation modality in future World Bank projects.
4. Component 4: The fourth component will support project monitoring, learning and evaluation, including third party monitoring.

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

2. Brief summary of previous stakeholder engagement activities

The project is primarily providing support to continue delivery of essential health services and monitoring & evaluation previously provided under the PESHP as well as to provide support to the COVID-19 National Vaccine Deployment Plan (NVPD).

Component 1 of the project leveraged the consultations undertaken by the Ministry of Health and all relevant partners in the formulation of the COVID-19 NVDP.

Project components (2 and 4) of the project are existing activities which were developed in a consultative manner with relevant stakeholders. The previous stakeholder engagement has been disclosed publicly and can be found here. In addition, the insights from ongoing consultations with beneficiaries of PESHP (as outline in section 5.0) were factored into the design of the project.

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

3. Stakeholder identification and activities

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

South Sudan is a multilingual country, with over 60 indigenous languages spoken. The official language of the country is English. Some of the indigenous languages with the most speakers include Dinka, Nuer, Bari and Zande. In addition, "Juba Arabic" is widely spoke within is an Arabic pidgin. At the community level, stakeholder consultations will take place in local language of the population being served. Exiting linguistic profile mapping will be used to ensure appropriate language use with the target stakeholder group of any engagement activity.

Table 1: Stakeholder analysis and primary method of engagement

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

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

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

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

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

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

Can approach elder women/women group leaders and AAP female champion (community actor part of GRM) as channel to raise their concern on provision of health services |

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

Crucial for meeting needs (as long as they can access primary healthcare services) | Vulnerable group | Integrated during regular community consultations and engagement during PEHSP implementation |

4. Grievance mechanism

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

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

Any GRM must acknowledge and, as far as possible, seek to address these challenges by capitalising on the government's commitments and existing ways of doing things. Yet, to ensure vulnerable community members have

a voice, it should also seek to improve upon and add to current arrangements and plans, and to create an enabling environment for social accountability relationships. This can be done through targeted trainings, incremental interventions and by cultivating allies at all levels of the health sector.

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

Figure A below displays the AAP mechanism. Information flows in Stream 1 are represented by green arrows, Stream 2 by blue, Stream 3 by yellow, and Stream 4 by dark red. The black dashed arrow represents data reported to UNICEF from partners and the purple dashed arrows the sharing of reports with findings and analysis among stakeholders.
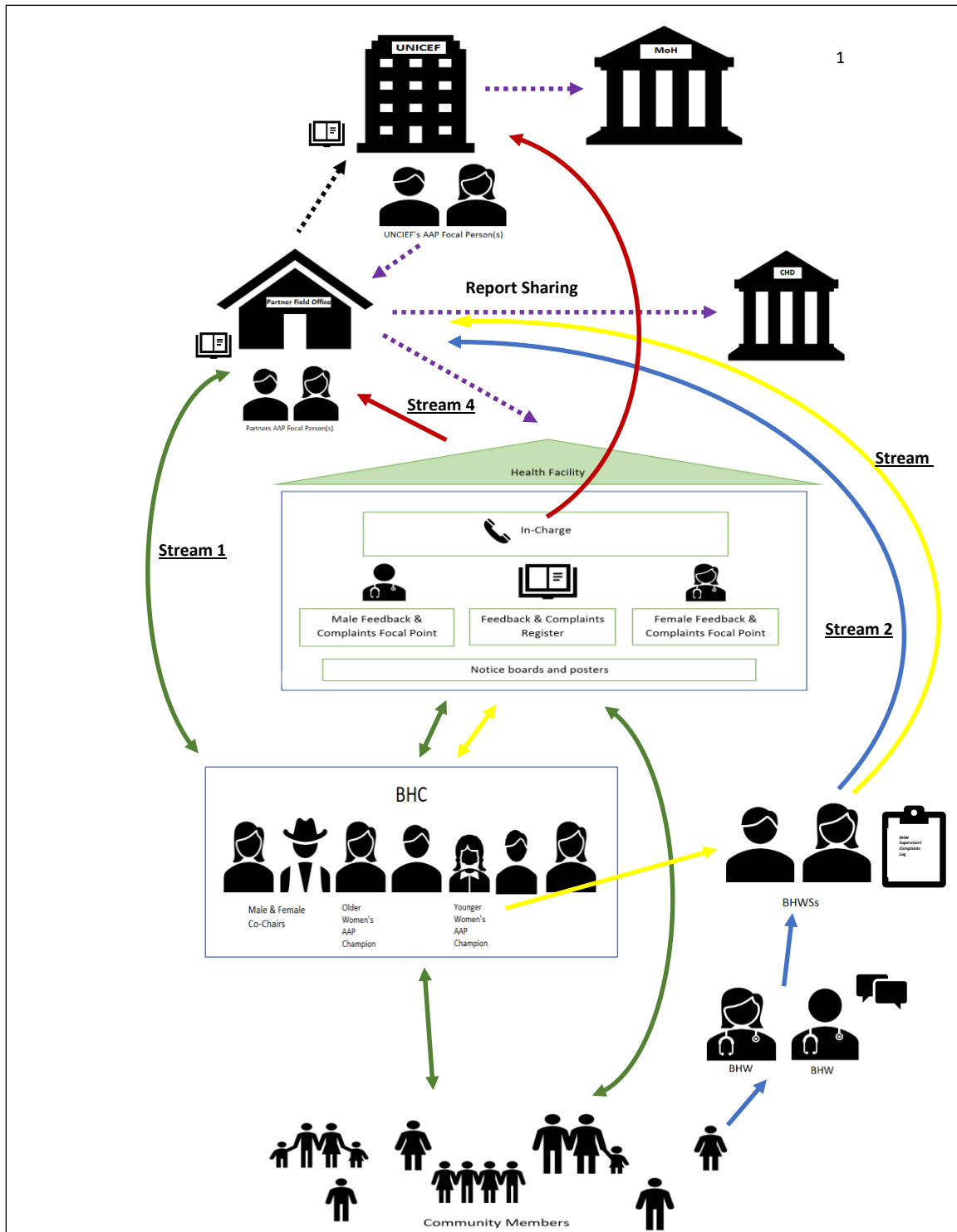
Figure A: Multi-stream AAP mechanism

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

Table 2: Stream Actors and Mechanisms

Stream	Communities' Feedback and Complaints Lodging Channels	Actors Involved in the reporting chain	Recording Tools	Record Collected by / Sent to	Training
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 facility Feedback and Complaints Registers (2) Partners' Complaints Logs	(1) Health facility Feedback and Complaints Registers collected by partners monthly, data entered Partners' Complaint's Logs and sent to UNICEF monthly (2) Partners' Complaint's Logs sent to UNICEF monthly	To BHC Members: AAP, SA, PSEA, Corruption To BHC Women Co-Chairs: As above. To Partners: BHC Women Co-Chair nomination facilitation
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 BHW Supervisors	BHW Supervisors' Complaints Log	BHW Supervisors' Complaints Log collected monthly by partners and analysed. Feedback and complaints recorded in Partners' Complaints Log sent to UNICEF monthly	To BHW Supervisors: AAP, SA, PSEA, Corruption, recording BHWs' Diaries To BHWs: AAP, SA, PSEA, Corruption, Household question asking, GBV
3) Women's AAP Champions (yellow arrows)	*Verbal:* Approach from community members to	Women's AAP Champions report to either:	(1) Health facility's Feedback and	(1) Health facility Feedback and Complaints	To Women's AAP Champions: AAP, SA

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

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

Key Definitions

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Stream 1 - BHCs

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

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

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

Rationale

In some areas, BHCs are already considered to be platforms for receiving feedback and complaints by community members. They are also thought of as mechanisms through which they may raise their voices with health stakeholders. The Ministry of Health 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.[1] They will be attended by representatives of all linked BHCs, partners' APP Focal Person(s), CHD representatives, health facilities' AAP Focal Points and In-Charges. The meetings will also provide additional opportunities for feedback and complaints to be raised by community members, and for health stakeholders to communicate their responses to outstanding issues back to BHCs and wider communities.

Training

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

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

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[1] These will be in addition to monthly meetings that BHCs are currently meant to hold at the Boma level and are not intended to replace them.

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

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

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

> **Verbal to Paper to Digital System**
> South Sudan has low levels of literacy and is predominately an oral culture. Most BHC members are unlikely to be literate. However, 85% of health facilities are currently using paper registers to report on their activities. BHW Supervisors must also read and write to fulfil their CHIMS reporting routines.
>
> The proposed AAP system is largely oral. Incoming data is only recorded on paper at the facility level (in AAP registers) and by BHW Supervisors (on complaint's logs). Partners and UNICEF's MEL team will convert this to digital for analysis.

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

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

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

Stream 2 - BHWs Diaries
The AAP system's second stream utilises the BHWs' frequent contact time with households in difficult to reach communities and the trust that they are currently accruing to gather feedback and complaints.

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

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

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

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

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

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

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

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

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

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

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

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

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

Stream 3 - Women's AAP Champions[2]

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

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

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

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

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[2] The yellow arrows in Figure 2.

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

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

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

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

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

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

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

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

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

Stream 4 - Health Facilities
The AAP system's fourth stream consists of trained male and female AAP Focal Points within health facilities and an in-facility paper-based Register for the collection of basic feedback and complaints information from multiple sources.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Stream 5 - Community Health Dialogues
Community Health Dialogues are annual events at health facilities. They will be attended by health stakeholders – health facility staff, BHCs, partners' and UNICEF's AAP Focal Person(s) (field level), CHD representatives, the media and community members. During the events stakeholders will publicly commit to their AAP roles and celebrate their collaborations for the delivery of health services.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Resources and responsibilities for implementing stakeholder engagement activities

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

While the UNICEF South Sudan will be responsible to ensure all stakeholder activities are implemented, the UNICEF Deputy Representative will monitor the status of project implementation from a management oversight perspective. Tracking and feedback mechanisms will be carried out as per section 5 above. In addition, regular meetings with the Ministry of Health will discuss cross cutting issues and report back on progress of the project.

6. Monitoring and reporting

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

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

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