

Global ACT Appeal

Section 1: Overview of response																				
Project Title	ACT Alliance Global Response to the COVID-19 Pandemic – ACT201																			
Location/s	<p>Project locations will be determined using a tiered selection methodology guided by objective criteria. External references such as the Global Humanitarian Response Plan (GHRP) priority countries will be consulted for identifying ACT priority countries. In addition, the following criteria will be applied for selecting priority countries/localities:</p> <ol style="list-style-type: none"> 1. National/Local Context <ul style="list-style-type: none"> - Existing humanitarian crises; ongoing member response - Urban poverty - Refugee and IDP camps - People on the move, including shelters - Access to health services and facilities - Availability of health and essential commodities in markets 2. Spread and severity of COVID-19 <ul style="list-style-type: none"> - number of confirmed cases - % of localities affected (geographic spread) - Number of local transmission - Number of imported cases - % of deaths among reported cases - % of cases who are healthcare workers - (weak) capacity for management of cases (testing, contact tracing) 3. ACT presence and capacity <ul style="list-style-type: none"> - Existence of ACT Forum (where there is no ACT Forum, demonstrated coordination among members) - Updated EPRP and/or COVID-19 Contingency Plans - Relevant ongoing programmes for introducing COVID-19 programming - Proven track record and technical capacity to implement humanitarian programmes - Proven engagement in humanitarian coordination with government and/or other humanitarian actors - Strong relationship with churches and local faith actors 																			
Project start date	15 April 2020																			
Duration of project	15 April 2020 - 14 April 2021 12 months																			
Budget (USD)	USD 12,000,000 (indicative)																			
Sectors/Thematic Focus	<table style="width: 100%; border: none;"> <tr> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;">Shelter / NFIs</td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;">Food Security</td> </tr> <tr> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;">Health / Nutrition</td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;">Protection/Psychosocial</td> </tr> <tr> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;">WASH</td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;">Education</td> </tr> <tr> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;">Early recovery / Livelihoods</td> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;">Cash transfers</td> </tr> </table> <p><i>Tick the relevant sectors of intervention</i></p> <table style="width: 100%; border: none;"> <tr> <td style="text-align: center;"><input checked="" type="checkbox"/></td> <td style="text-align: center;">Other sectors</td> <td style="text-align: center;">Advocacy, Preparedness, Community Engagement, Engaging with Churches and Religious Leaders</td> </tr> </table>	<input checked="" type="checkbox"/>	Shelter / NFIs	<input checked="" type="checkbox"/>	Food Security	<input checked="" type="checkbox"/>	Health / Nutrition	<input checked="" type="checkbox"/>	Protection/Psychosocial	<input checked="" type="checkbox"/>	WASH	<input checked="" type="checkbox"/>	Education	<input checked="" type="checkbox"/>	Early recovery / Livelihoods	<input checked="" type="checkbox"/>	Cash transfers	<input checked="" type="checkbox"/>	Other sectors	Advocacy, Preparedness, Community Engagement, Engaging with Churches and Religious Leaders
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Forum	Requesting ACT Forums/members to be determined as part of selection process and guided by criteria. ACT Secretariat will administer the funds globally with support from a Steering Committee composed of ACT members.																			
Requesting members	ACT Alliance Secretariat <i>(Requesting members to go through respective ACT Forums to be able to access Appeal or RRF funds – see Project Selection Criteria below)</i>																			

Local partners	In view of the localization agenda of the ACT Alliance, requesting members are strongly encouraged to work with local partners, churches and other local faith actors, and local governments
Impact (overall objectives)	<p>Contribute to the Strategic Priorities of the Global Humanitarian Response Plan (GHRP):</p> <ol style="list-style-type: none"> 1. Contain the spread of the COVID-19 pandemic and decrease morbidity and mortality; 2. Decrease the deterioration of human assets and rights, social cohesion and livelihoods; and 3. Protect, assist and advocate for refugees, IDPs, migrants and host communities particularly vulnerable to the pandemic.
Expected outcomes	<ol style="list-style-type: none"> 1. Reduced morbidity and mortality of COVID-19 patients through public health interventions, community preparedness and prevention, and community engagement. 2. Improved and sustained access to humanitarian assistance across multiple response sectors, and protection services for human assets and rights, social cohesion, and livelihoods. 3. Religious leaders, churches and other communities of faith mobilized in managing beliefs and attitudes and ensuring community inclusivity and cohesion. 4. Appropriate action by duty bearers to provide assistance and ensure protection of refugees, IDPs, migrants, women, and other communities and groups particularly vulnerable to the pandemic.
Expected outputs	Outputs will be defined at proposal level, with clear links to the Outcomes above and using the programmatic guidelines outlined in this Appeal (see section on Proposed Response).
Main activities	Activities will be defined at proposal level based on the programmatic outputs outlined in this Appeal (see section on Proposed Response).
Project Selection Criteria	<p>The Appeal will adopt a tiered approach for project and beneficiary selection using objective and contextual criteria.</p> <p>Project Selection</p> <ol style="list-style-type: none"> 1. <u>Rapid Response Fund (RRF)</u> Proposals for the bespoke RRF funding will be submitted directly by ACT national members, with official sign-off from the ACT Forum (except in countries with no formal ACT Forums). A call for RRF proposals will be issued as soon as pledges are made for this Appeal. A deadline for submission for the first batch of proposals will be set, and additional guidance will be provided by the ACT Secretariat as needed. Specific criteria will be issued along with the call, which would include proposals for urgent action/life-saving response, and where appropriate, interventions for preparedness and/or prevention. 2. <u>ACT Appeal proposals</u> Proposals for Appeal funding will be submitted by ACT Forums, i.e. Forums are the nominal requesting entities. Within each application, specific requesting

	<p>members and other decisions about the proposal will be made by the Forum as a whole. Funding and reporting accountability will remain with specific requesting members as in regular ACT Appeals, but any demonstration of strong value-add of Forum coordination will be an advantage. Participation in the Appeal is open for both national and international members.</p> <p>Call for proposals with a rolling deadline will be issued by the ACT Secretariat after a coordination meeting with prospective funders/donors.</p> <p>Funding Decisions</p> <p>Funding will be decided using the tiered criteria outlined above and standard quality requirements. Amounts and timeframe of implementation will be guided by the actual donor contributions received. The Secretariat will administer the funding process, with support from a COVID-19 Steering Committee that will be organized by the Secretariat and composed of members with appropriate expertise.</p>
<p>Beneficiary Selection Criteria</p>	<p>Most affected and at-risk population groups due to their vulnerabilities and capacities:</p> <ol style="list-style-type: none"> 1. People suffering from chronic diseases, undernutrition due to food insecurity, lower immunity, disabilities, and old age. 2. Internally displaced persons (IDPs), refugees, asylum-seekers, returnees, migrants, persons with disabilities, marginalised groups and people in hard-to-reach areas. 3. Children losing or being separated from primary caregivers due to quarantine or confinement measures are at increased risk of neglect, abandonment, violence and exploitation. They may also lack access to health treatment, and suffer mental health and psychosocial impacts, and malnutrition. 4. Women and girls who have to abide by socio-cultural norms related to seeking healthcare and receive appropriate treatments, or who lack power to take decisions, are at greater risk of not being detected with the disease and treated. Women caring for others and pregnant women. 5. People who have frequent social contacts and movements for labour or other livelihood activities. Household members in charge of fetching water, wood (who are often women and children), of agricultural labour, or submitted to repeated forced displacement have greater contacts with potentially infectious people. 6. People who are losing their income. Daily workers, small-scale agricultural producers, petty traders and similar groups in the informal sector who cannot access their workplace, land, or markets due to COVID-19 mobility restrictions. Families of affected without economic compensations measures, like bonus. Large families where the breadwinner is affected. 7. Frontline health workers in health care services and other workers in potentially infectious environments.
<p>Section 2: Narrative Summary</p>	
<p>Background</p> <p>In just eleven weeks from January through to mid-March 2020, the outbreak of COVID-19 has progressed from a discrete outbreak in one Chinese city, to clusters of cases in many countries, through to a pandemic with most countries reporting cases, and many countries experiencing significant</p>	

outbreaks. In terms of severity, from Asia, to Europe to the Middle East and North America, overall case fatality rates have been above 3%, considerably higher with older people and those with underlying conditions. Importantly, severe disease and death can also occur in younger adults. At the beginning of March, COVID-19 was primarily a disease of the northern hemisphere. However, sporadic cases and even clusters are now being reported from almost all countries in different climatic zones of Africa, South America, and the Caribbean. The explosive epidemic potential of this virus in Europe and the Middle East became clear in the first weeks of March. The disease is spreading very fast in areas of high population density, including urban areas, camps and camp-like settings, overburdening often weak health systems. It is now clear that this epidemic potential is an inherent characteristic of this virus, not the setting or season. Without decisive action, significant outbreaks will happen around the world.

Pandemics are some of the most complex crises to plan for in terms of humanitarian response. The humanitarian infrastructure is not particularly designed for quickly scaling up to respond to a crisis that is affecting multiple countries all at the same time, including those that traditionally mobilize humanitarian funding. In addition, the current context in many countries is such that urban agglomerations and informal settlements have grown tremendously (e.g. Delhi, Kolkata, Dhaka, Manila, Jakarta, Johannesburg, Sao Paolo), and mega-camps have been maintained to cope with massive and protracted displacements (e.g. Darfur, Dadaab, Zaatari, Cox's Bazar). In addition, people on the move (e.g., Venezuela, Central America, Turkey-Greece border, Syria-Turkey border, Sahel, etc.) are a major vulnerable group, with infections expected to rise exponentially when COVID-19 hits small shelters and holding/detention centers.

The Global HRP is articulated around three strategic priorities, which can serve as a minimum guidance for framing the ACT Alliance Response:

- 1) Contain the spread of the COVID-19 pandemic and decrease morbidity and mortality;
- 2) Decrease the deterioration of human assets and rights, social cohesion and livelihoods; and
- 3) Protect, assist and advocate for refugees, IDPs, migrants and host communities particularly vulnerable to the pandemic.

Beyond the GHRP, it has to be recognized that ACT Alliance and other similar faith-based networks of international, national and local faith actors have a special niche and value-add that is generally underrepresented in globally coordinated humanitarian response. Lessons from the Ebola Response in West Africa show that faith actors across the world could play a game-changing role in the fight against this pandemic. In the Ebola response, faith actors played an essential role not only in terms of community outreach and messaging relevant to prevention (i.e. in promoting safe spacing precautions and essential behaviour change), but also in terms of dealing with the mental impact and dealing with mortal remains. Faith actors hold huge influence to spread positive messages in a way that is more trusted by local communities, complementing and reinforcing the work of national authorities and the global public health and humanitarian response.

Faith communities often play a vital role in helping the most vulnerable to have access to soap, water, hygiene kits etc, and can mobilise the wider community to take away the stigma of quarantine and sickness, and to support families in self-isolation.

Our experience in the Ebola response and other public health crises is that UN agencies and other big INGOs do not always have the capacity, partnerships or ways of working conducive to engaging practically on the ground with faith leaders without support from faith-based humanitarian agencies. This is particularly true in conflict-affected humanitarian contexts, where relations between the UN and government agencies with local community leaders and populations is shaped by the conflict. This is

where international FBOs, working in partnership with local FBOs and faith leaders, can play vital intermediary and capacity-strengthening roles.

Humanitarian Needs

It is complex to project how the pandemic will affect people's lives in the next few months due to the rapidly changing context and rate and spread of cases, along with the impact of measures introduced by governments to "flatten the curve." Two scenarios are envisaged as defined in the Global HRP:

1. Quick containment and slow pandemic

The pandemic is slowed down in the coming 3-4 months and there is a relatively quick recovery, both from a public health and economic impact perspective.

2. Rapidly escalating pandemic in fragile and developing countries

The rate of infection and spread accelerates drastically especially in less developed countries, particularly in Africa, Asia and parts of the Americas. This leads to longer period of closed borders and limited freedom of movement, further contributing to a global slowdown that is already underway. Countries are unable to adequately equip their health systems, the virus continues to spread, and mitigating measures such as lockdowns etc., continue for longer periods. The public health implications and socio-economic implications of COVID-19 are more severe, experienced worldwide, and last much longer (about 9-12 months).

An extensive spread of the disease in countries with ongoing humanitarian crises could take a heavier toll on the economy than in countries which currently see a rapid spread of the virus. Furthermore, the pandemic spreads at the same time as a high number of countries approach their annual lean season, the hurricane and monsoon seasons loom, and a number of already fragile countries have planned elections. Political stability and security will also be at stake.

Though it is non-discriminating in terms of infection, COVID-19 will have a differential impact on lives and livelihoods at the community level. People who are left behind or at the bottom of the pyramid are the hardest hit. It is impacting communities which are malnourished or undernourished; who live in densely populated areas like slums, ghettos and camps. Lockdowns and social distancing measures are impacting the livelihoods of laborers in informal markets; beggars, small and petty traders on the streets; rickshaw and van pullers; domestic workers, etc. These people are either being laid off or don't have sufficient business to meet their needs. People who are worst affected also include the homeless, the disabled, elderly people, people with chronic health conditions and displaced populations. These groups who mostly live in slums, ghettos and the marginal areas make up 40 to 50% of the population of the larger cities in the Global South. A disproportionate number of them are women.

Food access and supply becomes an issue especially for governments that have declared a lockdown or state of emergency. This presents a challenge for people with difficulty in mobility, elderly people, malnourished or undernourished people, single-parent household with children, and people dependent on food aid. In some cases, countries have suspended or have limited public transportation. Net importing countries of basic commodities and essential items may experience scarcity as supply chain bottlenecks may occur. Food access will be a critical issue in contexts such as Venezuela, Colombia, Greece and Turkey, with migrants and refugees trapped along borders or without registration in the host countries.

The protection of children, youth and teachers as well as educational facilities is particularly important in preventing the potential spread of COVID-19 in school settings; however, care must also be taken to avoid stigmatizing students and staff who may have been exposed to the virus. Education settings should continue to be welcoming, respectful, inclusive, and supportive environments to all. Measures taken by schools can prevent the entry and spread of COVID-19 by students and staff who may have

been exposed to the virus, while minimizing disruption and protecting students and staff from discrimination. Education can encourage students to become advocates for disease prevention and control at home, in school, and in their communities by talking to others about how to prevent the spread of viruses.

In several countries the governments have taken the decision to close schools to prevent the spreading of COVID-19. The closure of schools (from primary to higher education) and Early Childhood Development centres mean that children may be deprived of their education and therefore be exposed to various protection issues. There is a need to put in place interventions to make sure that parents, caregivers, learners, teachers and other educational personnel and communities are sensitized and provided with necessary utilities to cushion them from the closure of the schools. The longer vulnerable children stay away from school and other learning opportunities, the less likely they are to return. It is critical to give them alternative ways to learn and rebuild a routine. Provision of alternative education opportunities must be in place in close collaboration with respective governments and education authorities. The resilience of communities and education structures must be strengthened to respond to the current situation and prepare communities for any potential shocks, particularly affecting access to safe quality education. In similar situations in the past, such as the Ebola outbreak, schools have tended to be used as hubs for medical care in contexts where the demand overcomes the existing health care services and facilities capacity. The impact of the use of schools for these purposes can not only impact the time that the school remains closed but also the perception that communities (parents, learners and even teachers) have of schools as no longer a safe space.

During a pandemic, such as the COVID-19 outbreak, people's mental health and psychosocial wellbeing is at risk due to various factors, including fears of falling ill or dying, losing livelihoods, being quarantined and separated from loved ones and caregivers. A particular stressor to the COVID-19 outbreak is the uncertainty of the virus itself, symptoms and mortality projections, but also of its magnitude and impact on a long-term perspective. Successful responses to mental health and psychosocial wellbeing must be grounded in the local context, and as the virus spreads across countries, tailored responses based on pre-existing and ongoing issues at community level will be required.

COVID-19 is not just a pandemic, it is also an 'infodemic', the proliferation of rumours, misinformation and fake cures can be as harmful as the virus itself. There is an urgent need to reach communities, especially the most vulnerable to COVID-19 with timely, accurate, accessible information. We will work with FBOs to ensure that communities, and in particular the most vulnerable people, have access to the correct information to enable them to take the necessary precautions, free from fear and misinformation. As misinformation spreads differently from country to country, community engagement and awareness raising interventions will be tailored for context, gender, age, language, and local culture to improve communities' uptake of information. We will prioritise people who may be most impacted such as women and elderly people, access to information and available services recognising the gendered nature of information flows.

COVID-19 will significantly impact women and girls where factors affecting gender inequalities will be amplified. Women and girls who are already performing unpaid care work will be more exposed to the virus or will be burdened more from attending to those who are sick. Meanwhile, others, especially in informal settlements and refugee camps, will have lesser or no access to healthcare as health services are reduced or stopped. In home quarantine environments, incidents of sexual and gender-based violence will be on the rise. The situation will also be worse for women migrant workers or women on the move, groups that already face restricted access to healthcare under normal conditions. Daily wage earners are already affected by lockdowns or containments. In some countries the situation has been made worse as a consequence of the suspension of public transportation, upon which these groups depend for their livelihood activities. We also expect that this crisis will affect lesbian, gay, bisexual,

transgender, and intersex (LGBTI) people who typically face prejudice, discrimination and barriers to care, due to their sex, sexual orientation, and/or gender identity. ACT Alliance does not accept any discrimination on the basis of gender identity and sexual orientation, nationality, race, religion or belief, class or political opinion, insisting that the people shall have the same power to shape societies, faith and their own lives.

The COVID-19 crisis has already made the lives of people on the move increasingly dangerous and difficult, and the situation is likely to affect them disproportionately due to their often insecure status and already limited access to rights and services. Many refugees are forced to live in large settlements with insufficient access to health services, far away from host country infrastructure, compounded by poor hygiene standards and limited availability of basic medical and/or personal protective equipment. These camps are inherently ill-prepared to deal with potential epidemic outbreaks. Other groups of refugees live in poor urban settings where their low economic status, precarious living situation and lack of access to nutritious food and basic healthcare make them particularly susceptible to even minor health complications, let alone a pandemic. Being excluded from access to health services in many locations puts them at immediate risk during this time.

Refugees are often part of larger movements of undocumented migrants, who are also at increased risk from COVID-19. Moving between or residing in countries without an official status, many of them work in the informal economy and are not covered by health insurance or social benefits that might help protect them against the effects of an outbreak. Many of them are already hesitant to approach healthcare providers for fear of being reported, detained and deported during normal times, and might feel additionally anxious to do so during a time where being identified as sick might lead to them losing their jobs. In addition, there have already been several instances of xenophobic rhetoric blaming the spread of the virus on migrant communities, which is likely to further intimidate migrant populations and make them less likely to seek and receive necessary care.

Detention of refugees and migrants has emerged as a major concern during this crisis, since it exposes detainees to elevated risks of infection in closed facilities. From an operational standpoint, many of the service providers who assist refugees and migrants are heavily dependent on the work of volunteers, for many of whom it may become impossible to continue their involvement in the sector as restrictions on movement and curfews are becoming more common in many countries.

Finally, widespread travel bans have already made access to asylum a virtual impossibility in many places, having put a halt to resettlement procedures for refugees, as well as giving additional justification to preventing entry for spontaneous arrivals seeking protection. There is a danger that some of these restrictions on freedom of movement will remain in place even after the pandemic subsides, leading to permanent deteriorations in access to protection.

Needs Assessments

Country or context-specific needs assessments will be conducted by requesting ACT Forums/members and included in project proposals, in recognition of the rapidly changing situation. An initial scoping of the situation in different regions and a sample of “countries of interest” is included in this Appeal as **Annex 2**.

CAPACITY TO RESPOND

ACT members will work within the national ACT Forum mechanism from proposal stage to implementation, in keeping with the mandate of the ACT Global Strategy. The principle of capacity sharing will be applied, where members with specific expertise will work to complement the capacities of other members. Where there are existing humanitarian programmes, ACT Forums/members will seek to build on existing work so as to ensure timely and relevant response. Considering the combined

resources and geographic reach of ACT members, working in a coordinated manner at Forum level will demonstrate the comparative advantage of working together. A mapping of existing resources and operational capacities is already available in Forums that have completed their EPRPs and Contingency Plans.

ACT Forums/members will work with their local partners and other groups, especially local faith actors (LFAs), who can play a significant role in preventing and responding to COVID-19. They are closely linked to the community, and have built up strong rapport and trust with people. They can easily mobilize volunteers for crucial home care and disseminate key messages on the risk of virus transmission for hard to reach communities. They are also in a good position to reduce stigmatization and protect people from discriminatory practices arising from prejudices, disinformation or rumours due to the virus. Local faith actors are offering spiritual counselling that respects the local culture and beliefs. (Religious) youth groups can help in community outreach, especially where communities are not yet used to online media. This approach implies both an intensified strategic and mutual networking between ACT Forums/Forum Members and local Christian churches, National Christian Health Associations and National Councils of Churches as well as similarly strong networking with local actors of other faith traditions and interreligious institutions.

An initial scoping was also done by the ACT Regional Offices with a small number of forums to help frame this Appeal and identify existing capacities and operational challenges in ACT Forums (see Annex 2).

PROPOSED RESPONSE

Does the proposed response honour ACT’s commitment to Child Safeguarding? Yes No

Guiding Principles for the Global ACT Response

The Global ACT COVID-19 Appeal was developed by the Secretariat with strong support from a COVID-19 Appeal Task Group from membership (see Annex 1).

The proposed ACT Alliance response will be largely grounded on the overall principles set out by the IASC in the Global Humanitarian Response Plan:

- Maximise the complementarity and synergies between ongoing responses and plans.
- Ensure flexibility to adjust the responses and targets to the fast-evolving situation and needs
- Build on existing coordination mechanisms.
- Full respect of humanitarian principles.
- Ensure inclusion of all people – notably vulnerable, stigmatized, hard to reach, displaced and mobile populations who are frequently left out of national plans, or who are inadequately included in such plans.

The overall intervention strategy presupposes that interventions to address COVID-19 in particular countries would: first, address the immediate risks or impact associated with the disease itself; and second, introduce COVID-19 programming in existing humanitarian programmes. As such, programmatic interventions will be rooted, as much as possible, in well-defined humanitarian sectors as well as in relevant interventions that form part of the longer-term and core work of ACT members. This would also include intersections with the strategic priorities of the Alliance as defined in the Global Strategy and other such opportunities for ‘nexus’ programming.

To aid the development and implementation of COVID-19 programmes, the following overarching principles embedded in the ACT Global Strategy and relevant ACT policies shall be adopted:



- Putting people at the centre, including survivor and community-led response (SCLR).
- Forum-led approach.
- Commitment to the localization agenda, and observing the primary role of national members and local partners especially in addressing the COVID-19 pandemic
- Strong engagement of local churches and religious leaders as humanitarian actors and long-term agents of change.
- Commitment to quality and accountability, as defined by CHS and Sphere and accompanying minimum standards.
- Consider gender implications of COVID-19 across all development and humanitarian programmes, as mandated by our commitment to gender justice.
- Prevention of sexual exploitation and abuse (PSEA) in all aspects of organizational and emergency operations.
- Engagement of youth and children in programme design and implementation
- Ensure due consideration of cash transfer modalities, as part of our commitments to the Grand Bargain.

Members may engage in the Global ACT Response through the following channels:

1. As requesting member for the Global COVID-19 Appeal (through national Forum).
2. As requesting member for the RRF under the Global COVID-19 Appeal (national members).
3. Participation in the **Total ACT Response**, i.e. managing own response but coordinating and sharing information with the ACT Forum and ACT Secretariat.
4. Integration of COVID-19 interventions in ongoing humanitarian and development work, with no significant diversion or reallocation of funding.
5. Funding/fundraising to support the Global COVID-19 Appeal.
6. Advocacy at global, regional and national level with relevant duty bearers.

Programming Guidance for ACT Response

The Secretariat and the Appeal Task Group recommend a typology of programmatic entry points organized within the overall outcomes of the ACT response, along with proposed objectives and outputs. In addition, Forums and members are strongly encouraged to consult the available programmatic guidance adopted by IASC and/or developed by other organizations: <https://interagencystandingcommittee.org/covid-19-outbreak-readiness-and-response>; and <https://spherestandards.org/coronavirus/>.

Please note that these are presented as indicative programmatic guidance, and does not preclude other formulations that a member or Forum would propose based on the local context.

OUTCOME 1: *Reduced morbidity and mortality of COVID-19 patients through public health interventions, community preparedness and prevention, and community engagement.*

A. Public Health

The following are some of the proposed Public Health intervention strategies for COVID-19

- Scale up case identification, testing and efficient management of patients.
- Create a special focus to the most vulnerable people/populations – including patients on hospice and palliative care, elderly people (60+), PLHIV, children, pregnant women, immunosuppressed individuals, patients with comorbidities of various kinds, and displaced communities

- Access to medical supplies and equipment: the lack of supplies like medicines has a direct impact on the disease outcome, but the lack of equipment creates risks among medical workers.
- Support health care staff with equipment and preparedness knowledge to be able to handle the work in safe ways by using appropriate infection prevention and control measures.
- Public Health Education for all – use available means to provide public health education to the population. This should be designed to meet regional differences in terms of existing public health facilities, access to local media, supplies, etc.
- Appropriate quarantine measures for PUIs/PUMs – should put the regional context and individual context in consideration (Quarantine approaches in some regions e.g. in Eastern Africa are forceful, in hotels and expensive hotels/places, and at the cost of the patient)

Objectives:

1. Provide public health interventions that will significantly contribute to prevention, management and arresting further clinical progression of COVID-19 pandemic, at both the health system and community levels.
2. Provide free access to priority healthcare services during the COVID-19 crisis for all community members in need.

Outputs:

- a. Access: Communities have access to primary health services at the appropriate level of the health system: household/community, peripheral health facilities, central health facilities, and referral hospitals (in line with Sphere standards)
- b. Commodities: Medical supplies and equipment (drugs/essential medicines as per WHO guidance), sanitizers, protective gowns, masks, boots, infrared thermometers, gloves, testing machines like Portable Rapid RT- PCR Machines should be made available to reduce the delays in diagnosis and treatment especially in the Global South countries that lack testing facilities
- c. Surveillance and Contact Tracing: The existing infrastructure, skills and clinical competencies (hospitals, medical professionals, medical laboratories, research facilities) are equipped to identify, screen, diagnose, treat new COVID-19 cases.
- d. At-Risk Populations: The disease prevention teams including community outreach health programs, HIV/AIDS care and treatment teams, palliative care programs and public health committees are engaged and equipped with sufficient resources to identify COVID-19 contact cases including the vulnerable and high risk populations (elderly, HIV/AIDS infected patients, women, girls and children), and follow-up in communities, quarantine or self-isolation facilities
- e. Awareness-Raising: Information and education materials in local languages specifically designed to offer public health education on prevention, early identification and available treatment options within their respective communities.
- f. Clinical Knowledge and Training: Frontline health workers in the COVID-19 response are equipped with skills and knowledge in managing the response.
- g. Post-Pandemic Recovery: Health facilities and public health systems are well equipped for recurrence of COVID-19, especially in managing mental and psychological impacts among patients and their families, and other preparedness measures for future outbreaks of any kind.

B. Community Engagement

How we undertake awareness raising and messaging will play an important role in the fight against this pandemic. In line with our commitment to CHS we will prioritise community engagement to ensure that people and communities are at the centre of our response work, reducing the spread of the pandemic and mitigating its impact. Our response will work through Faith-Based Organisations (FBOs) to put the voice and needs of those we work with at the centre of decision making, responding to their needs and adapting our programme in real time. Based on the local context and realities, local staff and

partners will work with communities to determine how to continue community engagement during social distancing, exploring traditional and innovative methods such as working through faith-based leaders and networks, radio, megaphone, mobile cinemas (where applicable), social media such as Facebook and Twitter, digital group engagement such as WhatsApp group cascade and a community-based focal point network, prioritising the most vulnerable.

Through FBOs and community representatives, using a do no harm approach, we will collect questions, rumours, fears and feedback as part of our response, record that using traditional and innovative feedback collection tools and use that data to target and correct misinformation with accurate information. We can share the gaps identified with the local health leads. This can reduce conflict and stigma whilst also providing accurate lifesaving information. The use of effective feedback mechanisms will reduce the time lag between hearing the voices of the community and using that data to inform and adapt our programmes.

Objectives:

1. Share timely, accurate information through trusted channels such as faith leaders and community representatives
 - a. Adapt health information and activities based on feedback collected from communities through the above
2. Understand and track beliefs, fears, rumours, questions and suggestions using traditional and innovative digital feedback collection tools
3. Build trust with the community to increase uptake of health information and reduce community fear, stigma and misinformation. This should include activities aimed at diffusing tensions among refugees, migrants and host communities related to the current situation.
4. Identify and support community-led solutions for ensuring people’s active participation in the response

C. Community Preparedness and Prevention

Preparedness and contingency planning are considered essential for responding effectively to outbreaks and epidemics. Sharing and aligning activities in the area of public health emergency preparedness adds large value to the efforts of single countries to strengthen their capacities and ensure coordinated and effective support when faced with cross-border health threats. Countries that are considered to be fragile or affected by conflict unfortunately also have the weakest health systems in the world and are the least prepared for COVID-19.

In some countries where health systems are weak but infection has not yet spread, preparedness actions become imperative to containing the spread of the virus. Actions will include strengthening their current health systems, informing communities about the COVID-19 virus and its seriousness of the infection, and supporting extended to health systems when supplies, equipment, and human resources are inadequate. These countries have to deal with low resource capacities, whether these are COVID-19 testing kits, personal protective equipment (PPE), or human resources.

In several countries, this will be the first time that forums will experience responding to an epidemic. In the past, forums were dependent on the support from members contributing to a response. This will also be the first time when the contributing members themselves are inundated with the same epidemic in their own countries. ACT members, especially local organisations, will have to mobilise their own resources and networks to respond.

The response will focus on supporting health systems to prepare for the outbreak and strengthen the capacities of ACT members, primarily local organisations, to provide such support and response.

Objectives and Outputs:

1. National forums and ACT members prepare their country's health systems for the impending epidemic
 - a. Provide support for medical supplies and equipment where ACT Alliance members have health care facilities
 - b. Partner with organisations that have health care facilities in place and support their services by providing medical expertise or other complementary assistance
2. Educate (vulnerable) communities about COVID-19 and the implications of being infected. This is in conjunction with community engagement and working with faith institutions, leaders, and lay people.
3. National ACT Forums build their capacities to respond to the gaps and needs of the community as a result of COVID-19
 - a. Support forums draft their emergency preparedness plans and contingency plans
 - b. Provide technical support for forums and members as they prepare to respond to the epidemic

OUTCOME 2: *Improved and sustained access to humanitarian assistance across multiple response sectors, and protection services for human assets and rights, social cohesion, and livelihoods.*

A. Water, Sanitation and Hygiene (WASH)

While a COVID-19 specific WASH response should have a strong focus on hand hygiene and hygiene messaging, at the same time measures should be taken to ensure the provision of basic WASH services to prevent other disease outbreaks and over-burden already stressed health systems¹. Potentially, the COVID-19 crisis imposes extra stress on existing, already poor WASH service provision in many countries in the world. The current situation potentially reduces government and community capacity to manage and maintain good water and sanitation service provision level due to restriction of movement interrupting supply chains, loss of financial and logistic means for operation and maintenance. This response especially targets high transmission risk densely populated areas such as refugee and IDP camps and informal settlements. In many cases, the lack of awareness, poor health facilities and nutrition status, and inadequate water and sanitary services (to practice hygienic behaviour) are the main factors to be considered while planning and targeting a WASH intervention.

The ACT WASH response has two main objectives: 1) to ensure that the cycle of virus transmission is interrupted; and 2) to ensure that water and sanitation services do not pose public health risks. Through the response, safe access to clean water, basic hygiene materials and handwashing facilities, and appropriate sanitation facilities will be ensured, in line with Sphere Standard. Through coordination with the WHO and local health authorities, appropriate key messages on infection prevention and hand washing will be promoted at individual, household and community levels, and public institutions with high-risk transmission probability (health facilities, schools, churches and other public places). In order to comply with social distancing, different approaches will be taken into consideration for preparing outreach workers and disseminating prevention messages to the communities, using radio, SMS, social media, cars with loudspeakers, etc., while avoiding big groups of people and keeping a safe distance. Community participation, including faith-based actors and ownership will be mainstreamed throughout the response.

¹ For example, many countries in sub-Saharan Africa and South Asia will face seasonal cholera seasons within the next few months.

Objectives and Outputs

1. People and communities affected by COVID-19 demonstrate improved hand hygiene practices.
 - a. People affected by the crisis are aware of key public health risks related to COVID-19 and are able to protect and prevent the spread of the disease.
 - b. Provision of vouchers or cash for water; Hygiene training as a condition for receiving the cash or voucher
 - c. Provision of in-kind health and hygiene items
2. People and communities affected by the crisis have improved access to safe, appropriate and adequate WASH services enabling affected people to practice good hygienic behaviour at individual and collective levels.
 - b. People affected by the crisis have safe access to equitable, sustainable and adequate quantity of water for drinking, cooking and maintaining personal and domestic hygiene.
 - c. People affected by the crisis have access to safe, adequate and gender-sensitive sanitation facilities.
 - d. People affected by the crisis have access to appropriate materials, facilities and information to practice good hygiene.

B. Livelihoods

The focus of our interventions would be the poorest and the vulnerable, who are being nudged out, through a "Build Back Better" framework and approach to restore their livelihoods. Since measures to address this type of crisis are not always guided by institutional memory and knowledge, it is proposed that a detailed needs analysis be taken up before finalization of the design.

Objectives and Outputs:

1. Ensure informal workers' livelihood options are restored
 - a. Cash support to the community for food security and other life-saving needs before the business recovery.
 - b. Working with the health authorities towards fitness certification of the people infected with COVID-19.
 - c. Capacity building of the workers in informal sector for unskilled to skilled jobs.
 - d. In certain contexts, repatriation and reintegration support for migrant workers whose contracts are being suspended and who are being sent home as a result of the crisis.
2. Creation of alternative livelihood options through skills/placement and enterprise promotion.
 - a. Building skills of the community on gig economy work (food delivery, taxi driving, online grocery).
 - b. Engagement with the private sector for job creation, supporting public private partnerships for promoting an inclusive labour force market, while respecting decent work principles and core labour standards.
 - c. Business development training
 - d. Connecting the community with the formal and non-formal banking systems.
3. Promote business continuity
 - a. Supply of Personal Protective Equipment to small and petty traders, street vendors, rickshaw and van pullers.
 - b. Ensure that the business continuity or business recovery plans of communities who have been impacted, are in place.
 - c. Cash support/stimulus packages for restarting businesses to individuals/lending & savings groups and other community based financial and business institutions.

C. Education

Objectives and Outputs:

1. Increased hygiene and sanitation knowledge and practices on COVID-19 in and around schools and other learning spaces, including camp environments
 - a. Update or develop school emergency and contingency plans.
 - b. Reinforce frequent handwashing and sanitation and procure needed supplies.
 - c. Prepare and maintain handwashing stations with soap and water, and place alcohol-based hand rub (hand sanitizers) in each classroom, at entrances and exits, and near lunchrooms and toilets.
 - d. Schools should provide water, sanitation and waste management facilities and follow environmental cleaning and decontamination procedures.
 - e. Clean and disinfect school buildings, classrooms and especially water and sanitation facilities at least once a day, particularly surfaces that are touched by many people (railings, lunch tables, sports equipment, door and window handles, toys, teaching and learning aids etc.).
 - f. Implement social distancing practices.
 - g. Provide life-saving messages for schools and communities.
2. Ensure continuity of education during school closure through provision of alternative and distance learning opportunities.
 - a. Provide alternative education opportunities, such as radio learning, digital platforms, learning materials.
 - b. Development of distance learning content based on national curriculum.
 - c. Development and provision of distant learning guidance and parental tips on facilitating learning to parents and caregivers.
 - d. Development and provision of distance learning guidance – Teacher tips on remote facilitation of learning.
 - e. Provision of teaching and learning supplies.
 - f. Ensure that all learners return to school, especially young girls
 - g. Cash for education.
3. Strengthened community resilience.
 - a. Advocacy and raising awareness to the Right to Education (ensuring schools facilities are not used as shelters/health care centres; ensuring children come back to school)
 - b. Integrate psychosocial support to the COVID-19 response and provide psychosocial support to children, youth, teachers and other education personnel, parents, caregivers and communities
 - c. Community mobilization and sensitization on safe schooling and risk mitigation
 - d. Individual and/or school-level cash interventions to improve children’s access to school
 - e. Training on contingency planning, pandemic preparedness
 - f. Training for national/ local government/partner staff on EiE: prevention, preparedness, response and recovery

D. Shelter, Settlements and NFIs

The goal of any ACT Alliance Shelter, Settlements and NFI activity in the framework of the ongoing COVID-19 crisis will be to ensure occupancy of covered living space that can serve as minimally adequate shelter for disaster/crisis affected populations in an appropriate manner and provide the crisis-affected with adequate needs-based NFIs.

ACT Alliance emphasizes the use of ex-ante assessments and need to better gauge impacts, resources, and opportunities in COVID-19 affected areas. The core target group of proposed actions will be the most vulnerable among affected populations, particularly women and children, the elderly, considering

the differential risks to particular gender and age groups. Provision of support to these group may require technical assistance, rather than a reliance on self-help capacity. Shelter should be adequate, habitable, safe, private, and secure, cognizant of the Sphere standards with a possible need to engage in disaster risk reduction. Where possible and appropriate, the response will emphasize community-based approaches and reliance on local materials and labour, to enhance prospects for sustainability, cost-effectiveness, and livelihood generation.

ACT Alliance will, therefore, support shelter sector interventions that feature a settlements approach, thereby permitting identification of, and linkages with, other sectors, particularly agriculture and food security, livelihoods, WASH, and protection. Shelter sector interventions and needs-based NFI distributions will be designed to facilitate or “jumpstart” the recovery of affected populations by emphasizing transitions to the longer-term post-Covid19 recovery process.

ACT Alliance will also continue to integrate disaster risk reduction into its interventions, to include training programs where possible and appropriate, enhance prospects that interventions reduce long-term hazard risks in affected settlements. The intervention shall aim at continued work with other community actors, reliable faith-based initiatives and local authorities on relevant policy and technical issues to enhance local organizational capacity and highlight transition concerns (nexus).

In addition, the Global Shelter Cluster recommends the following actions for shelter interventions for COVID-19:

1. Undertake a mapping exercise to identify the areas most at risk and advocate for support: areas where people are living in particularly overcrowded conditions, with higher densities, with less space for expansion, more in contact with population at risk, with less access to health facilities or with higher proportion of vulnerable population.
2. Wherever possible, mitigation measures to reduce overcrowding should be put in place: Collective sites in which households are sharing the same shelter should be upgraded as much as possible to achieve minimum shelter standards of personal covered living space and household partitions rather than collective.
3. People living in individual accommodation below minimum shelter standards should be supported to improve those standards, particularly by increasing the covered living space in cases of overcrowding.
4. In places where several households are sharing latrines or cooking facilities, additional facilities should be built to reduce the number of households using the same basic facilities.
5. Additional land should be negotiated to allow for expansions.
6. Work closely with the Health Cluster, WASH Cluster and others as required, to align messaging and coordinate on priority locations for combined response as appropriate.
7. Coordinate with and support the Health Cluster in the provision of adequate and timely shelter support to displaced families, individuals and populations at higher risk of COVID-19.

E. Food Security

Food access and supply become an issue especially for governments that have declared a lockdown or state of emergency. This presents a challenge for people with difficulty in mobility, elderly people, malnourished or undernourished people, single-parent household with children, and people dependent on food aid. Informal urban settlements, where they may not have access to backyard gardens will have limited access to fresh produce that is much needed for nutrition. In some cases, countries have suspended or limited public transportation which makes it difficult for people to get food. Net importing countries for basic commodities and essential items may experience scarcity as supply chain bottlenecks may occur.

Food access and supply is quite crucial whether by providing it to the people who need it the most or by making it accessible to them. Since community food kitchens become difficult as we try to keep some distance from each other, we need to find solutions to limit communities coming together but still be able to supply the daily nutritional requirements for people that need it the most. Food assistance will also be linked to livelihood interventions as much as possible, to ensure community resilience.

Objectives and Outputs:

1. People with limited food supply and access will be able to meet their nutritional needs.
 - a. Cash support for daily wage earners to be able to buy food where markets are functional
 - b. Provision of food for people with limited mobility or access to food particularly sick persons, persons with disabilities, and the elderly
 - c. Provision of nutritional supplements for pregnant women, nursing mothers, and children.
 - d. Monitoring market availability and supply chain

Additionally, the IASC/WFP recommendations for adopting food distribution SOPs for COVID-19 is considered a key reference for any food response under the ACT Appeal:

<https://interagencystandingcommittee.org/other/interim-recommendations-adjusting-food-distribution-standard-operating-procedures-context>

F. MHPSS and Community-based Psychosocial Support

Community Based Psychosocial Support (CBPS) is an approach used by ACT Alliance members to meet the diversity of psychosocial needs in a community, following an emergency. While stand-alone CBPS interventions exist, evidence demonstrates that it is more effective to integrate psychosocial aspects into other sectors of humanitarian interventions, as this amplifies community participation and coverage. The CBPS approach is grounded in the IASC Guidelines on MHPSS in Emergencies and strives toward empowering community members to recognize their belief in their own capacity to make change and protect their wellbeing. Consequently, the added value of CBPS in programming is the emphasis on community involvement and participation – pre-requisites to realize own capacity – which help ensure that the response is based on existing needs but also that it makes use of existing capacities and resources. Since it works through existing community structures, CBPS is particularly suited to identify and engage persons of concern and understand their challenges with regards to accessing information, care and support.

Objectives and Outputs:

1. Community members have increased access to information about COVID-19 and basic psychosocial support, as well as information on where to seek more specialized support.
 - a. Trusted actors, such as local community leaders, are supported with knowledge of COVID-19 and basic psychosocial support skills (such as psychological first aid), and know how and where to refer community members in need of more specialized support.
 - b. Sufficient number of persons at community level in the targeted locations are supported with knowledge and skills to deliver psychosocial support to children, people with disabilities, GBV survivors and other vulnerable adults
2. Improved psychosocial wellbeing and decreased distress among target populations directly and indirectly affected by the COVID-19 pandemic.
 - a. Psychosocial aspects that address wellbeing and distress as identified by community members are integrated into all sectors in the appeal.
 - b. Community members are actively engaged in information and experience-sharing on identified positive coping strategies and self-care strategies that improve well-being

3. Decreased effects of social stigma related to COVID-19 among target populations directly and indirectly affected by the COVID-19 pandemic
 - a. Dissemination at the local community level of factual and evidence-based information about COVID-19 and the consequences of social stigma is integrated into all sectors of the response as a means to decrease uncertainty and prevent misinformation
 - b. Religious/community leaders are engaging with their respective communities regarding social stigma through for ex. prompting reflection about stigmatization and its consequences based on the lived experiences of community members themselves

G. Gender

COVID-19 will significantly impact women and girls where factors affecting gender inequalities will get worse. Women and girls who are already doing unpaid care work will be more exposed to the virus or will be burdened more from attending to those who are sick. Others, especially in informal settlements and refugee camps, will have lesser or no access to healthcare as health services are reduced or stopped. The situation will also be worse for women migrant workers or women on the move, groups that normally do not have access to healthcare. Daily wage earners are already affected by lockdowns or containments, with women disproportionately represented in informal sectors worldwide. Particular job profiles, such as domestic work, may become particularly exposed to transmissions, as employers shift more dangerous tasks to them, without providing adequate protection and care. The risk will be compounded in countries where public transportation has been halted. Intimate partner violence will increase, and in particular girl children who are already married may face further violations given the gender inequalities they face (see ACT Briefing Paper on Gendered Impacts of COVID-19, <https://actalliance.org/covid-19>).

We also expect that this crisis will affect lesbian, gay, bisexual, transgender, and intersex (LGBTI) people who typically face prejudice, discrimination and barriers to care, due to their sex, sexual orientation, and/or gender identity. The ACT Alliance does not accept any discrimination on the basis of gender identity and sexual orientation, nationality, race, religion or belief, class or political opinion, insisting that the people shall have the same power to shape societies, faith and their own lives.

Gender shall be mainstreamed in the other sectors of the response, ensuring that that assessments will include the gaps and needs of the different groups. We will safeguard the participation and voice of the communities and different groups, including LGBTI, during this response. Particular needs will be addressed through the following interventions:

Objectives and Outputs

1. Ensure women and girls having limited or no access to healthcare will be referred to or will have access to healthcare facilities including psycho-social support
 - a. Set up referral systems, particularly on sexual and reproductive health, in areas where there is limited or no access to healthcare
 - b. Provide healthcare services including sexual and reproductive health, targeting particularly groups that are more vulnerable
 - c. Provide psychosocial support for people with different needs
2. Ensure groups with differentiated needs, including LGBTI, will have access or will be provided information on their entitlements and rights to ensure their protection
 - a. Information on specific gender issues will be provided through different and overlapping communication channels
 - b. Set up referral and support systems on accessibility and protection services, and safe spaces, for incidences of gender-based violence

3. Groups that have differentiated needs, including LGBTI, will have access or will be supported in rebuilding their livelihood or income sources. This will be linked to other sectors especially Livelihoods.

OUTCOME 3: *Churches, religious leaders and other communities of faith mobilized in managing beliefs and attitudes and ensuring community inclusivity and cohesion.*

A. Engaging Religious Leaders, Churches and other Communities of Faith

In addition to the medical and material response, communities' beliefs and attitudes need to be mobilized to reduce the spread of COVID-19 and to strengthen community inclusivity and cohesion as important elements of health and resilience. Religious actors' status and trust can be an effective factor of positive change, including – where needed – of negligent and dangerous faith messages ('trust God, not health advice'). There is therefore a huge potential in the involvement of faith actors in a rights and gender-sensitive response.

Objectives and Outputs:

1. Faith Actors deliver evidence-based, credible information, counter stigma and fake news, advocate for the needs of most vulnerable and transform health-risking religious messages/theology
 - a. Leveraging of online Pastoral Letters, social media messages, and public media statements by trusted faith leaders who echo messages by health authorities and advocate for vulnerable groups. Broad dissemination of responsible online sermons and other scripture-based faith voices.
 - b. LFAs disseminate tailor-made information to hard-to-reach vulnerable people: those living in informal settlements, refugees, migrants, homeless persons, sex workers, informal combatants, etc.
2. Worship, rites and local faith life adapted to health advice to minimize virus spread while maintaining resilience building.
 - a. Suspended or effectively spaced and hygienic physical gatherings for Church services, weddings, funerals, Eucharist and other ceremonies, and virtual alternatives are offered.
3. Existing and new community resilience initiatives developed
 - a. Collection and dissemination of new practices of counseling of distressed for solace and meaning (online prayers, sermons, pastoral care, religious music, etc.); promotion of unity, solidarity, hope and humanity in times of hardship; practiced inclusivity and reduced tensions towards potentially discriminated groups; organized and informed home care volunteers.

OUTCOME 4: *Appropriate action by duty bearers to provide assistance and ensure protection of refugees, IDPs, migrants, women, and other communities and groups particularly vulnerable to the pandemic*

A. Advocacy

People on the move, including refugees and migrants, especially those without status, are facing an increased risk of exposure and infection during the COVID-19 crisis. This is due to their already limited access to rights and services in many settings during normal times, which is likely to be exacerbated by the many new measures that are being put in place by governments in response to the crisis. With additional or tightened restrictions on entry and movement, and uncertainty about the continuation of relief measures, refugees and migrants are being left out of governments' responses. Further, the use of detention is also negatively impacting these groups. Moreover, the negative economic and human rights impacts of the crisis are expected to be particularly pronounced among women and LGBTI groups, necessitating a mainstreaming of targeted measures. In addition, there is growing concern

about the availability of sufficiently flexible humanitarian funding to respond to the crisis, as well as the ability of humanitarian workers to be able to deliver assistance during periods of increased travel bans.

ACT Alliance and its members will therefore monitor and advocate with wider networks to hold governments accountable to their human rights obligations and to ensure participatory processes in designing and implementing national responses. While working with Forums to ensure regionally and nationally specific advocacy messages, the overall focus of advocacy efforts will include the following core elements:

1. **Access:** All persons, regardless of gender, sexual orientation, national origin or migration status should have access to:
 - a. Accurate information about COVID-19, including in migrant and refugee languages.
 - b. Essential WASH and public health services, including testing, care & treatment.
 - c. Emergency food and/or cash support in response to lost employment / lost income.
 - d. Appropriate and community-based psychosocial support.
2. **Stopping detention and deportation** of migrants and refugees amidst the health crisis
 - a. Detained migrants should be released to family or community allies, where safe and possible, to ensure they can socially distance and mitigate health risks to themselves and others.
 - b. Detention as a tool of immigration control should be suspended, and lessons learned from alternatives implemented during this time should feed into longer-term system reform.
 - c. Deportations, especially to countries with major confirmed outbreaks and/or inadequate health systems, should be suspended.
3. **Legal certainty**
 - a. Persons with refugee/asylum claims or migratory status adjustments in process should be protected for the duration of the health crisis.
 - b. If official processes (e.g., RSD, asylum, immigration applications) are suspended, ensure clock is paused on applications and filing deadlines are extended.
4. **Participation**
 - a. Affected communities, national and local actors need to be included on an equal basis in decision-making fora, CSO consultations and in the GHRP implementation process.
 - b. Youth should be enabled to contribute and lead the response among their own constituencies.
5. **Funding**
 - a. Dedicated and sufficiently flexible humanitarian funding should be made available to deal with the COVID-19 crisis.
 - b. Its impact on long-term funding streams including ODA, international development cooperation, humanitarian aid and climate financing, need to be monitored.

We will coordinate and facilitate related advocacy with our members in order to ensure appropriate and effective messaging. ACT Alliance has a central role to play in raising public awareness of the impact of COVID-19 on countries in Africa, Latin America, Asia and the Pacific in particular. As faith-based organisations, we are mobilising awareness and support for the international context.

ACT's Global Response centres on leadership of faith actors and recognition of the value of member organisations as faith-based organisations. From local to global level, we have an important role to support the role of faith actors, advocating for faith literate response and recognition of the role of faith actors and FBOs in the response.

Objectives:

1. Coordinate asks as ACT Alliance regarding advocacy and operational aspects of the response with collaboration from the secretariat (Geneva and regions), ACT EU, and participating members
2. Develop effective and light documentation and reporting sharing mechanisms where members can share information on the impact of COVID-19 on the rights holders they are working with, as

well as for key advocacy messages, including information on the role of local partners and faith actors and the challenges faced

3. Through our networks such as VOICE, ICVA, SCHR and Charter4Change, and through ACT forums, as well as access to decision-making bodies including Ministerial meetings—use information sharing mechanisms to raise awareness of our advocacy approach
4. Raise country-specific and thematic advocacy messages with geographic and thematic leads within regions and at UN level to support implementation of the Global Response.
5. With faith-based organisation networks at regional and UN level (e.g. Multi-Faith Advisory Council), and through the Council of Churches networks, coordinate activities to ensure donor response supports and recognises faith dynamics and the crucial role of faith actors in: provision of holistic psychosocial care, mobilising communities for safe hygiene practices and disseminating factual information for prevention measures and countering stigma, reaching hard to reach communities and promoting protection and health service provision for vulnerable groups. These include refugees, IDPs, migrants and in all settings women, girls and LGBTI communities.
6. Map and support existing CSO partner advocacy on the gendered impacts of COVID-19 and mainstream messaging into all briefings and ACT statements.
7. In donor and media engagements, communicate the pressing needs for organisations and partners, from humanitarian exemptions to coverage for risk and continuation of core funding.
8. Through the ACT Alliance and Religions for Peace statement and further ACT statements, disseminate key messages to policy makers, our CSO networks, faith partners and media.

Coordination

The ACT Alliance Secretariat and members have established coordination mechanisms at the global, regional and national levels. This includes coordinating with governments through respective disaster management and health authorities; the wider humanitarian community through HCTs, clusters, and NGO fora; among ACT members through the national ACT Forums; and with networks of partners, churches, and other stakeholders.

At the global level, ACT coordination will be supported by the Secretariat Office in Geneva through established coordination mechanisms such as the EPHR Reference Group, ACT Humanitarian Directors, and other relevant ACT platforms. Other COVID-19 specific coordination mechanisms have also been organized within the Secretariat and with members, and this Appeal would ensure coordination with these structures to ensure a holistic approach to the overall ACT response. Global and regional coordination calls with donors and requesting members will be sustained across the implementation period.

The Secretariat will liaise with all international members participating in the response as well as other coordination platforms such as IASC, ICVA, SCHR, and relevant UN agencies such as WHO, OCHA, UNICEF, UNHCR, IOM, ILO, and UNFPA. ACT Alliance members are also participating directly in global coordination platforms, including the Start Network, Integral Alliance, NGO VOICE, Charter for Change, etc. ACT Alliance EU will lead on EU-facing advocacy, with support from members and in coordination with global policy and advocacy staff. The Secretariat humanitarian team (global) has its own internal coordination setup.

At the Regional level, ACT Alliance members and Secretariat staff are already participating in several coordination platforms, including the Cash Working Group, Community Engagement Communities of Practice, and Gender in Humanitarian Action. Appropriate coordination of ACT members at regional/sub-regional level will be supported by the ACT Regional Offices.

At national level, ACT national forums will coordinate within their existing forum platform, as well as with national authorities and other humanitarian actors. Through their emergency preparedness and

response plans, members have committed to specific roles and responsibilities that will support the response. Members have also assigned and are participating at national level coordination platforms including Humanitarian Country Teams (HCTs) and response clusters. National ACT members also have well-established coordination mechanisms that link them to the communities through member churches or health institutions of their national networks. In several cases, they also work with inter-faith coordination platforms. In cases where there are no existing forums, participating members will coordinate directly with the ACT Regional Offices.

Depending on the success of fundraising, this Appeal will make budget provisions for necessary coordination costs by the Secretariat, Forum, and requesting members.

Communication

The COVID-19 pandemic presents numerous challenges in terms of communications. Although perceived as a global crisis, there might be a feeling in the population that priority must be given to national contexts rather than focusing on those communities who are considered “far away”. This perception might affect the fundraising efforts that traditionally are a key part of communications activities in previous appeals. Fundraising problems will be exacerbated by the unstable employment and economic conditions in traditional donor countries as citizens and local governments deal with this pandemic in their own context. This means that communications messages for fundraising will need to be carefully crafted so as not to appear “tone deaf” to the current situation, but to also bring hope to people who feel they can make a difference in helping others during this trying time.

The communications work will be focused on maximizing education efforts at church/community level and promoting a clear messaging that mainstreams the vision of “leaving no one behind” (Outcome 1).

Given the complexity of this global appeal, both in terms of activities and desired outcomes, the focus of communications material will be on needs and community interventions rather than specific activities. Infographics and other communication awareness material will be produced to mainstream general best practices with a focus on gender best practices during COVID-19. An example of awareness-raising infographic that serves both purposes could be illustrating what a hygiene kit contains, and why these are key resources in a refugee camp like Cox’s Bazar. Such material will need to be available in such a way that can be locally adapted and translated so as to be appropriate to the cultural context ACT members are working in.

ACT Alliance will collaborate with ACT Learn to produce webinars on best practices during COVID-19 both for member organizations internally, and for their humanitarian work externally. A webinar on the impact of COVID-19 on gender will be produced to ensure that the gender dimension of COVID-19 will not be disregarded.

An important element of information-sharing will be the www.actalliance.org/covid-19 page on the ACT Alliance website, where information will be constantly updated and will provide a key resource for practitioners and members. An additional resource will be the COVID-19 page on the ACT Learn/FABO platform: https://fabo.org/dca/programme_coronavirus.

Interviews with field operations staff will be produced and shared on social media, to increase awareness on the problems that vulnerable communities are facing during COVID-19 and publicize the efforts of the Alliance in terms of response.

Messages of religious leaders in different languages will also be developed and shared on social media to educate the communities they serve on the seriousness of the disease and hygiene best practices.

ACT Alliance will also ensure that appropriate media is informed about the response efforts of the Alliance, specifically the role of FBOs in educating communities and our efforts in complex and potentially dramatic situations like in refugee camps. A media kit will be developed and a media list compiled with the help of members involved in this appeal.

To coordinate and share information in a timely manner among communications staff of the Alliance, a WhatsApp group will be used. Members will ensure that the appropriate staff members will be part of it and will contribute with expertise and support.

Members engaging in the COVID-19 Appeal/RRF will be strongly encouraged to share more traditional material—photos, video, stories—to assist with the global storytelling of ACT’s response. This is also in line with the Global Strategy’s focus on raising local voices, storytelling, and engaging communications. In this response it will be virtually impossible to import communications resources like photographers or journalists, so this work will have to be undertaken locally by staff or by hiring local communications professionals to document the work.

Security and Risk Management

The ACT Security Group (ASG) and Global Security Advisor are actively coordinating with the Secretariat and members to provide security support. The ASG members have been sharing advisories and contacting other agencies for their advice and best practice around the COVID-19 issue, and this support will continue as ACT Alliance deals with the crisis in all areas of operation.

From a risk perspective, all ACT members must consider the following:

1. **Do No Harm:** Take measures to not place communities we work with at an increased level of risk through our programming activities
2. **Duty of Care:** Put in place measures to ensure staff health and safety and reduce the chance of exposure to the virus or spread to other staff. Specific provisions for staff access to testing and health services should be built in project design and operations.
3. **Business Continuity:** The presence of COVID-19 only complicates the valuable work we do around the world as an Alliance. Climate change, gender justice, peace and security, and all other member-driven programs need to continue as much as possible. Additional guidance for COVID-19 contingency planning has been provided by the ASG and ACT Secretariat to all ACT Forums.

Monitoring and evaluation

The Monitoring and Evaluation (M&E) plan for this program will be done as per ACT guidelines, principles and standards. ACT implementers in the different regions will fulfil all commitments of the Core Humanitarian Standard (CHS) and Sphere standards throughout its intervention. Members in each forum will be responsible for monitoring activities and reporting to track project performance, identify results and learnings associated with the projects and address potential delays at an early stage.

Requesting members are committed to accountable and transparent processes for working with all stakeholders. For this reason, ACT members have well-established complaints and feedback mechanisms “with appropriate cultural and local practices respected” in place and make sure that all right holders and key stakeholders can provide feedback, and that they are informed about the possible channels and that all complaints are handled in a transparent and consistent way. Requesting members will ensure that local partners have the necessary mechanisms in place to receive beneficiary feedback. The procedure for complaints will be reviewed regularly to ensure and incorporate learning and improvement towards ACT member accountability. In addition to refer cases in need to other projects or service providers, and address protection concerns and other forms of exploitation and violence.

ACT members commit to addressing all issues of sexual exploitation, abuse of power, corruption and breach of the ACT member policies and standards.

Requesting members will provide regular situation reports, narrative and financial reports consolidated by forums to ACT secretariat regional office, and then the regional offices will play an active role in compiling/ consolidating reports from forums into a global appeal report describing the proceedings as well as resulting initiatives and lessons learned. Implementing members will have to provide an audited report by the end of the appeal.

Joint monitoring/evaluation and peer reviews will take place towards the 4th quarter of the Appeal timeframe. The outputs from these exercises will serve as learning and guide the development of a global appeal approach and tools. Information/database management protocols will be set up to ensure data security and facilitate efficient information dissemination guided by existing data protection laws and policies.

Knowledge management

ACT members are committed to mutual learning through joint analysis, action and reflection. With an M&E plan in place, members will track project performance, identify results and learnings associated with the projects and address potential delays at an early stage. ACT members are committed to ensuring high standards of project implementation. This involves proactively sharing learnings and good practices with member organizations and other stakeholders to improve knowledge in humanitarian action and putting these lessons into practice. ACT members will highlight the innovations and/or good practices and formulate recommendations to address the gaps, and provide benchmarks for future humanitarian interventions.

Reporting requirements (Global)

Type of Report	Due date
Situation report	15 July 2020 15 January 2021
Interim narrative and financial report	15 October 2020
Final narrative and financial report (60 days after the ending date)	15 June 2021
Audit report (90 days after the ending date)	15 July 2021

Specific project reports (Appeal or RRF) will have their own reporting schedule as part of the project selection process. All reports from approved projects under the COVID-19 Appeal and RRF will be consolidated to form a single global report based on this timeframe. All donors will receive the global report, unless otherwise requested because of possible earmarking.

Section 3: Budget Summary

The indicative total budget for the Global ACT Response is **USD 12,000,000**.

Of this total, \$9 million will be allocated for the ACT Appeal, and \$3 million for the COVID-19 RRF. Within each funding strand, the standard parameters for budgeting under the ACT humanitarian mechanism will apply.

Note for requesting forums/members: A Call for Proposals for the COVID-19 RRF and Appeal will be issued by the Secretariat with additional guidance and budget parameters as soon as initial donor pledges are received.

Note for donors/funders: A Donor Coordination Call will be organized by the Secretariat as soon as this Appeal is issued. Specific guidance for fundraising and accessing the two funding streams will be issued by the Secretariat upon further consultation with donors and ACT forums.

Section 4: Annexes

Annex 1- Appeal Task Group members

Annex 2 - Summary of Regional Context (separate attachment)

Please kindly send your contributions to either of the following ACT bank accounts:

US dollar

Account Number - 240-432629.60A
IBAN No: CH46 0024 0240 4326 2960A

Euro

Euro Bank Account Number - 240-432629.50Z
IBAN No: CH84 0024 0240 4326 2950Z

Account Name: ACT Alliance

UBS AG
8, rue du Rhône
P.O. Box 2600
1211 Geneva 4, SWITZERLAND
Swift address: UBSWCHZH80A

Please note that as part of the global approach for this Appeal, pledges/contributions are encouraged to be made towards the total budget of the Appeal, and subsequent allocations will be made through proposal submissions assessed using the defined criteria. Detailed narrative documents and budgets of approved proposals will be communicated to donors of the Appeal. For status of pledges/contributions, please refer to the spreadsheet accessible through this link <http://reports.actalliance.org/>.

Please inform the Director of Operations, Line Hempel (Line.Hempel@actalliance.org) and Finance Officer, Marjorie Schmidt (Marjorie.Schmidt@actalliance.org) with a copy to the Regional Representative/Regional Programme Officer of all pledges/contributions and transfers, including funds sent directly to the requesting members.

We would appreciate being informed of any intent to submit applications for back donor funding and the subsequent results. We thank you in advance for your kind cooperation.

For further information please contact:

Africa

ACT Regional Representative, Elizabeth Kisiigha Zimba (Elizabeth.Zimba@actalliance.org)
Humanitarian Programme Officer, Caroline Njogu (Caroline.Njogu@actalliance.org)

Asia and the Pacific

ACT Regional Representative (interim), Femia Baldeo (Femia.Baldeo@actalliance.org)
Humanitarian Programme Officer, Cyra Michelle Bullecer (Cyra.Bullecer@actalliance.org)

Latin America and the Caribbean

ACT Regional Representative, Carlos Rauda (Carlos.Rauda@actalliance.org)
Humanitarian Programme Officer, Sonia Judith Hernandez (Sonia.Hernandez@actalliance.org)

Middle East and North Africa

ACT Regional Representative, Rachel Luce (Rachel.Luce@actalliance.org)
Humanitarian Advisor, George Majaj (George.Majaj@actalliance.org)

ACT Website: <https://actalliance.org/covid-19>; FABO: https://fabo.org/dca/programme_coronavirus

Alwynn Javier

Head of Humanitarian Affairs
ACT Alliance Secretariat, Geneva



ANNEX 1 – COVID-19 APPEAL TASK GROUP

Main Task: Work with the ACT Secretariat in developing the ACT Global COVID-19 Appeal, providing technical inputs to the programmatic design and advice on the overall implementation and funding strategy.

Members

1. Markus Larsson – Senior Psychosocial Advisor, Act Church of Sweden
2. Eija Alajarva – Head of Humanitarian Assistance, Finn Church Aid
3. Dr. Paul Mmbando, Health Programs Director, ELCT Tanzania
4. Lara Martin – Executive Director, UMCOR
5. Niall O'Rourke – Humanitarian Operations and Performance Manager, Christian Aid
6. Shakeb Nabi – Bangladesh Country Director, ICCO Cooperation
7. Clovis Mwambutsa – Emergency Program Coordinator, Lutheran World Federation
8. Kirsten Kok – Programme Officer, Kerk in Actie
9. David Myers – Senior Advisor, Presbyterian Disaster Assistance
10. Jørgen Thomsen – CoP Religion and Development/DanChurchAid

Additional Support

1. Simon Daffi – Deputy Secretary General, ELCT
2. Steve Ringel – Head of Humanitarian Aid (ad interim), HEKS
3. Corrie van der Ven – CoP Religion and Development, Kerk in Actie
4. Dietrich Werner – CoP Religion and Development, Bread for the World
5. Marjo Mäenpää – Humanitarian Advisor, Finn Church Aid
6. Samantha Sercovich – Emergency Livelihoods Advisor, Finn Church Aid
7. Åshild Skare - Humanitarian WASH Advisor, Norwegian Church Aid
8. Arild Isaksen - Humanitarian Coordinator, Norwegian Church Aid
9. Silje Heitmann - Senior Advisor GBV, Norwegian Church Aid
10. Christer Laenkholm – senior Humanitarian Advisor, DanChurchAid