ACT Alliance

Global Response to the COVID-19 Pandemic – ACT201

ACT201_SARF

(Southern Regional Forum)

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Project Summary Sheet

Project Title	**Joint ACT SARF response supporting people at COVID-19 outbreak**
Project ID	ACT 201_SARF
Location	Southern African Region countries of Madagascar, Zambia, and Malawi
Requesting Forum	**Southern African Regional Sub Forum (SARF)** ☒ The ACT Forum officially endorses the submission of this Sub-Appeal (tick box to confirm)
Requesting members	For Madagascar SAF/FJKM and SMT/FLM. for Zambia United Church of Zambia for Malawi Christian Aid, CARD and ELDS
Contact	Name: Clemens von Heimendahl Email: clemens@saf-fjkm.org Other means of contact (WhatsApp, Skype ID): Tel.: +261 34 288 2950 WhatsApp: +491719064899 Skype: cvh52000
Local partners	Local ACT Churches / ACT local members.
Thematic Area(s)	☐ Public Health ☐ Community Engagement ☒ Preparedness and Prevention ☐ WASH ☒ Livelihood ☐ Education ☐ Other: _____ ☐ Shelter and household items ☐ Food Security ☒ MHPSS and CBPS ☒ Gender ☒ Engagement with Faith and Religious leaders and institutions ☐ Advocacy
Project Outcome(s)	1. Outcome 1: Enhanced timely sensitisation and accurate information dissemination of COVID-19 prevention messages overall the Southern African Region 2. Outcome 2: Improved access to protective materials and basic hygienic facilities to prevent and control the possible spread of COVID-19 pandemic in the areas of operation and enable facilities to provide services to the public 3. Outcome 3: Reduced hunger and food insecurity related to COVID-19 lockdown measures for most vulnerable households / people in targeted areas by December 2020 4. Outcome 4: Protecting and maintaining the dignity of women and girls
Project Objectives	1. To share timely and accurate information on COVID-19with communities, combat misinformation, build trust with communities through advocacy and support community led solutions.

	2. To contribute to prevention, management and stopping the spread of COVID-19 through provision of healthcare services to targeted community members. 3. To support health care systems and educational institutions, with supplies and equipment, trainings and community-based psychosocial support services for COVID-19 affected communities. 4. To provide food security and livelihood support to vulnerable groups directly impacted by COVID-19 as cash transfers for essential needs, food etc. 5. To integrate disaster risk reduction to reduce long term hazard risks, identify families and areas most at risks due to overcrowding and high density and increase shelter standards
Target Recipients	**Profile** ☐ Refugees ☐ IDPs ☒ host population ☐ Returnees ☒ Non-displaced affected population No. of households (based on average HH size of 6 persons): **1´337´534 HH**

Sex and Age Disaggregated Data:									
	0-5	**6-12**	**13-17**	**18-49**	**50-59**	**60-69**	**70-79**	**80+**	**Total**
Madagascar	-	600.000	880.000	1.600.000	560.000	200.000	120.000	40.000	**4.000.000**
male	-	306.000	448.800	816.000	285.600	102.000	61.200	20.400	**2.040.000**
female	-	294.000	431.200	784.000	274.400	98.000	58.800	19.600	**1.960.000**
Zambia		490.000	860.520	650.000	570.000	185.000	12.688	8.000	**2.776.208**
male		240.100	421.655	318.500	279.300	90.650	90.000	3.920	**1.444.125**
female		249.900	438.865	331.500	290.700	94.350	6.471	4.080	**1.415.866**
Malawi	-	110.000	200.000	470.000	325.000	115.000	25.000	4.000	**1.249.000**
male	-	53.900	98.000	230.300	159.250	56.350	12.250	1.960	**612.010**
female	-	56.100	102.000	239.700	165.750	58.650	12.750	2.040	**636.990**
						Total beneficiaries			**8.025.208**

Reporting Schedule

Type of Report	**Due date (proposed)**
Situation report	First SitRep due **Mid October 2020** afterwards quarterly
Final narrative and financial report (60 days after the ending date)	31 July 2021
Audit report (90 days after the ending date)	31 August 2021

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/, Appeal Code ACT201.

Please inform the Director of Operations, Line Hempel (Line.Hempel@actalliance.org) and Finance Officer, Marjorie Schmidt (Marjorie.Schmidt@actalliance.org) of all pledges/contributions and transfers. 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:

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All other countries/Forums not supported by ACT Regional Offices/staff can get in touch with the Head of Humanitarian Affairs in Geneva (Alwynn.Javier@actalliance.org)

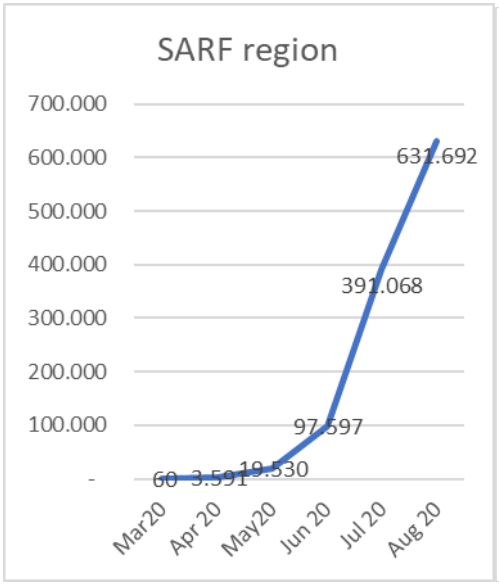
Visit the ACT COVID-19 webpage: https://actalliance.org/covid-19

Alwynn JAVIER
Head of Humanitarian Affairs
ACT Alliance Secretariat, Geneva

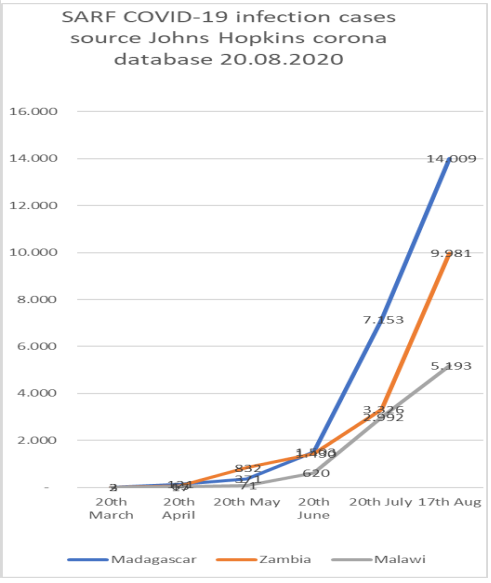
BACKGROUND

Context and Needs

In just a few moths from January through to June 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 outbreaks. In terms of severity, from Asia, to Europe to the Middle East and North America overall 22,5 Million people have been infected worldwide and 781 000 people died[1] on COVID-19, means the case fatality rates have raised to around 5%, considerably affecting higher with older people and those with underlying conditions. Importantly, severe disease and death can also occur in younger adults. Statistics report about 200 000 cases in Africa, with majority in the more developed countries like Egypt, Tunisia and Morocco and South of the Sahara clearly indicating South Africa as a hotspot. While figures have exploded since March in Europe, Latin America, the Asian countries and the Northern American continent, Africa remained relatively low. But since mid May the cases in Africa are also doubling and tripling daily. Only in the past month the case load in the SARF region has doubled. Low coverage of testing kits and facilities including laboratories may have also added to uncertain case load, common diseases like pneumonia and malaria absorb death rates and fatality registrations.



Graph 1: [2]



Graph 2:[3]

At the area of the ACT South African sub regional forum (SARF) the pandemic was mainly spread in the most developed areas of South Africa, followed by Madagascar, Zambia, Malawi, Zimbabwe, Mozambique, and Angola. With the beginning of cases in Europe and Asia in March very few COVID-19 infections were registered in the African region, but immediately confinements were ordered, mainly copying the reaction of the rest of the world. All these countries have experienced a hike of case loads only from mid of May 2020, when confinements started to be lifted partially, because they could not be carried on. The choice was to have the populations starving or getting infected. The confinements issued and carried out in the different countries brought most of the population into severe challenges. The most vulnerable immediately transferred into a dire

[1] https://coronavirus.jhu.edu/map.html source: Johns Hopkins University on August 20th, 2020

[2] case loads of the SARF region (RSA 592 144 infected) on August 20th, 2020 same source as above

[3] caseload of requesting members Madagascar, Zambia and Malawi

situation, without allowed to get out of the house, having the markets shut down, the daily wages and thus the income fell apart.

It is assumed that urban zones suffered far more from the consequences of the COVID-19 pandemic than rural areas. On the one hand, there was increased control of curfews by law enforcement officers and the military; on the other hand, food sources were relatively reduced due to the stoppage of all activities. In rural areas, one had the impression that the pandemic was neither understood nor that contact restrictions and curfews were observed.

However, the secular sector suffered from the restrictions, for example churches were closed for almost 6 months due to the ban on assembly. In these societies where the people live literally by the hand in the mouth, the very small reserves depleted within days. Countries like South Africa had kilometers of people waiting for the few food distributions organized by government and charities, the needs overwhelming everybody. Chaotic scenes of distributions, lack of social distancing and not wearing the obligatory masks, fights over food are only a few experiences faced.

Meanwhile today the confinements are lifted[4], some countries have still partial confinements or areal movement restrictions, but markets are open, and the populations has returned to normal lives. But what means normal lives? In most of the countries the economic impact is just at the brink of developing. Many businesses had to close, jobs are falling apart, livelihoods, food security and life visions are destroyed. The impact of trade reductions and limitations is not foreseeable, many countries highly dependent on Tourism and see already a major shift to the bad – in Madagascar since March no tourist has been able to come, hotels, restaurants, the whole service and supply industry is down, again causing massive reduction of jobs and loss in sales.

Consequent to the above described COVID-19 challenges each of the SARF countries carried out respective Rapid Needs assessments, all showing more or less the same results over the region: As poorer the people are as more they are affected, additional the lock down of public spaces, as churches and parishes, have severely affected the parishes and reduced incomes to pastors and church staff living from the weekly collections.

The social sector with especially health services were only very limited, or to say it frank not at all, prepared for the outbreak of such a pandemic and today especially availability of protection gears for the own staff are still very limited. Prices increased dramatically for PPE[5] and disinfectant liquids and made them in the first weeks nearly not affordable. Today, the prices have come back to normal and every country has its own supply resources, what lacks are the funds for procurement, as none of the requesting members had foreseen these expenses in their annual budgets and reserves are very limited. Through this the member churches are severely limited in the service delivery, which are so desperately needed by the poor.

Through the voluntarism approach self-help was quickly organized, hand washing facilities and disinfection units were set quickly operational where needed, information dissemination and sharing are happening, same as counselling and psycho-social support. But these people on the frontline need protection, trainings, and basic support.

The individual requesting members are in constant exchange with their individual churches and structures throughout the countries and the proposed response of this appeal focuses partial on

[4] with exception of Madagascar which had a second total confinement announced in mid July

[5] PPE personal protection equipment

ecumenical groups as part of the overall vulnerable groups, beside targeting the general output to the population.

The situation of funding overshadows the general situation of COVID-19 consequences, as Governments have received support of donors widely, but on the bottom nearly no funds have touched ground. While State medical structures are supported, the output to church structures is Zero. Madagascar has purchased hundreds of ambulances and operational vehicles, but health facilities nothing. Churches have been severely affected by the individual lock downs and meeting restrictions, Pastors were unable to collect the worship collection, costs for disinfecting churches and public spaces like health centers and dispensaries, including protection gear for staff and pastors have caused a major financial challenge. This chronical underfunded faith sector is faced with serious troubles and support urgently needed, as it was unforeseeable that these immense costs are occurring. The lack of support to faith actors and the general reduction of private donations on the other side challenge the actual support programs run in several countries of the targeted area.

In the process of development for this appeal, there was an initial application from all 7 members of the SARF forum, requested to do so by the ACT Regional Office in Nairobi. After review of the steering committee the appeal came back with the request to reduce the members applying. Pursued by a long discussion within the SARF forum, finally selecting the hardest hit countries for the appeal, followed by the withdrawal of RSA forum, who expected too much time passing while needs needed to be responded. In consequence it is now the three countries Malawi, Madagascar and Zambia requesting jointly for the present appeal. All three countries have harmonized quiet similar approaches and have in general agreed to work closer together and have exchanges in future.

Capacity to respond

All the requesting members are national faith-based organisations, which are represented in all the regions, states, and communities. There are extended experiences in responding to the national disasters of their regions, such as cyclones, droughts, storms, heavy rains and infectious disease outbreaks like cholera, pest and malaria, same as to manmade disasters as civil conflicts, IDP settlements/movements and arbitration of different conflict parties.

Madagascar has over 25 000 active volunteers, trained in Disaster Response and Preparedness and Disaster Management / Response on community level. With funds of the ACT201 RRF both members have started with large spread COVID-19 information dissemination through their national radio facilities (FJKM and FLM), disinfection of the churches and health facilities and the distribution of PPE at facilities and churches. Church Volunteers are mobilized and support/advise the population where possible. SAF/FJKM and FLM are operating own dispensaries and basic health centers throughout the country and in the capital Antanarivo. Finally, SAF/FJKM and FLM are responding since years to different infectious disease outbreaks, such as cholera, pest, measles, and SARS. The organizations are part of the respective national clusters and are linked with the National Disaster Management Authority.

For the ACT Forum Zambia, the UCZ has 2 hospitals and 7 rural health centres. UCZ have also 14 education institutions while the Council of Churches in Zambia (CCZ) has 2 educational institutions. These are resources which will be relied upon in implementing the strategy. All the members of the Zambian Forum have a cadre of volunteers with skilled staff within their ranks who have been

implementing previous projects. Besides this, the UCZ has 2 radio stations with wide coverage and in the process of opening of a TV station to propagate the Gospel, these will be used to spread the COVID-19 prevention and information dissemination. Youth Clubs and school ambassadors are supported same as students in universities.

The ACT Forum Malawi is led by Christian Aid Malawi on behalf of Act alliance Malawi. The two Act alliance members, CARD and ELDS, earmarked for managing this project, have the record capacity to implement response projects like of COVID-19. For instance, CARD implemented a complex Cyclone Idai Response Programme last year successfully. CARD and ELDS, have experienced professional staff who will manage this project. Additionally, both members have a vibrant network with the church as well as the health facilities which will form the major stakeholders of the project. Church leaders and health facilities will be pivotal in responding to COVID-19 in terms of awareness campaigns and prevention.

RESPONSE STRATEGY

A systematic approach has been developed, that involves the three national forums organised in the Southern African Region, which respond to their identified local needs and contribute to strengthening response capacities as a sub-regional forum of ACT Alliance. From phase one (protection of staff and information dissemination in the emergency phase) most countries have now moved to phase two – early recovery (livelihood support, gender support and ongoing protection and information dissemination).

Despite the rising numbers of infections in the region, many of the restrictions have been reduced, allowing small businesses to re-open and having the curfews reduced and travelling at least within the countries is sometimes allowed. This economic needed relaxation and bears the big danger, that people do not take the danger of the virus any longer serious enough, gatherings, non wearing masks and lack of social distancing are happening everywhere. While Europe and Asia are preparing for the “second wave” the Southern African region is still on a first rising peak! Therefore, no rehabilitation and build back better approaches are included in this proposal. Also, the actual communicated limitation of funding reduces large scale interventions with deeper impact, as the funding expected is low for each forum, always divided by the individual forum members.

The response focusses therefore mainly on:
- **protection** of own staff and health workers, exposed to COVID-19 in health clinics, churches, and other public activities, same as the volunteers and other active faith members. Some schools are targeted and youth clubs, who are same as the volunteers expected to do peer to peer information in prevention and protection to the pandemic. General population while visiting churches, health facilities and getting in contact with volunteers are better protected through the usage of PPE by the church staff.
- Massive **information dissemination** on the same has already started in the different countries and will be continued at all countries through TV spots, radio emissions and posters/leaflets reaching almost one third of the targeted region.
- **Supporting** and cooperating with faith institutions and leaders is common sense as almost every member of SARF are an operational church, with its respective structures and leaders and parishes. The wide lockdown and restrictions of gatherings over nearly 6 months now has resulted in a dire situation for the churches, their **pastors and church workers**, as their income has broken away. None of the churches of the region have big fund reserves or an outside funding mechanism, which jumps in to cover the additional costs. Salaries of pastors, deacons and church staff is paid

by collection during the services. These grassroot based church leaders are particularly important in serving the communities with advice and salvation, but also as peacekeepers, negotiators, sources of trust, arbitrators, counsellors and are organizing widespread social activities within their parishes. Therefore, they are one of the vulnerable groups affected by the COVID-19 consequences. Churches are still limited in many countries to maximum 50 people per service, which results in a chain of services every day and especially on Sundays. While the population is happy to re-join the faith services, the respective costs of operation are exploding for disinfection, safeguarding, protective gears and more.

- **Families of informal workers and migrant workers** are the also under extreme stress as the most affected as jobs have widely broken away, people are standing without work from one moment to the other, funds are stalled, and markets got closed. Movements back to their home villages cause quiet some stress as currently we see larger migration movements out of South Africa towards Mozambique, Zimbabwe, Malawi, and partial Zambia, while Madagascar is faced by migration workers returning from overseas. **Orphans, widows, elderly and handicapped people** have become one of the first indirect victims of the pandemic, therefore food aid/livelihood support as **cash transfers** are planned in the countries to ease the impact at least a bit.
- **Volunteering** has become a widespread success tool in building resilience at level of the different communities. Volunteers are motivated and want to do something now, the network of national volunteers will therefore be widened, and capacity trainings carried out, to increase the **knowledge of DRR and health and hygiene messages,** while it is necessary to protect them properly as part of the respective duty of care.
- **Women and children**, forced to stay at home at their respective families together often on smallest space, have massively experienced increased violence and abuse within their families, due to the stress of confinement. **Protection programs and GBV information leaflets** are needed as well as **counselling and psycho-social consultations**.

This is just a summary of activities, which all result from the developed EPRP´s / amended contingency plans and the carried-out needs assessments on level of the respective country forums in regard of the COVID-19 pandemic.

Impact

The overall impact of this response is to "***contain the spread of COVID-19 Pandemic, decrease morbidity, mortality and deterioration of human assets, rights, social cohesion and livelihoods"*** in Southern Africa.

Outcomes

Outcome 1: Enhanced timely sensitisation and accurate information dissemination of COVID-19 prevention messages overall the Southern African Region

Outcome 2: Improved access to protective materials and basic hygienic facilities to prevent and control the possible spread of COVID-19 pandemic in the areas of operation and enable facilities to provide services to the public

Outcome 3: Reduced hunger and food insecurity related to COVID-19 lockdown measures for vulnerable households in targeted areas by December 2020

Outcome 4: Protecting and maintaining the dignity of women and girls

Outputs

Madagascar:	**Targeted beneficiaries**
1. Provision of PPE materials to clinics, volunteers, and staff	Preparedness and prevention 500 persons Antananarivo and Antsirabe
2. National COVID-19 information dissemination through TV, Radio, Posters, and leaflets	Preparedness and prevention Outreach to 4 Mio persons nationwide
3. Vulnerable groups have access to unconditional humanitarian assistance in form of cash transfer to protect their livelihoods	Livelihood support: 4 000 HH = 20 000 persons nation wide
4. Form volunteers as Health & Hygiene informants for house to house visits, peer to peer information and supporting hand washing stations and disinfection of health facilities and churches	Preparedness and prevention: 600 volunteers reaching approx. 300´000 people in Antananarivo and Antisrabe
5. Psychosocial counselling for women GBV related including training for counsellors	Gender and MHPSS and Community Psycho-social: 2 000 women in need, around 120 volunteers trained and 20 000 GBV flyers produced
6. Trainings of pastors on transmission and prevention of COVID-19	Engagement with Faith and Religious leaders and institutions: 200 pastors

Zambia:	**Targeted beneficiaries**
1. Provision of PPE materials to clinics and volunteers	Preparedness and Prevention: 8, 000 persons
2. Preparedness and rehabilitation of Health clinics	Preparedness and Prevention: approx. 244´800 users
3. COVID-19 information dissemination through TV, Radio, Posters, and leaflets	Preparedness and Prevention: Outreach to around 2,7 Mio people
4. Provision of one-time cash transfers to identified vulnerable groups, including training and post distribution monitoring	Livelihood support: support: 600 HH = 0ver 3´600 persons countrywide
5. Initiate youth safe clubs, create Youths Friendly Health Corners (YFHCs) and engage volunteer coordinators for YFHCs; conduct training on "journey of life" and PSS and conduct training on PSS and Anti CIVD19 awareness	Preparedness and Prevention: 14, 400 (Each one reaches out to 6 clubs monthly with a membership of 20 persons per club)
6. Church volunteers have increased capacity to manage COVID19 interventions	Engagement with Faith and Religious leaders and institutions: 200 pastors
7. Psychosocial counselling for women GBV related including training for counsellors	gender and MHPSS and Community Psycho-social: 2 000 women in need and around 120 volunteers and 20 000 GBV flyers produced

8. Trainings of pastors on transmission and prevention of COVID-19	Engagement with Faith and Religious leaders and institutions: 200 pastors

Malawi:	**Targeted beneficiaries**
1. Health care workers in 40 health facilities are provided with protection materials for COVID19 2. Health care facilities have improved infrastructure for delivery of quality health services	Preparedness and prevention 320 project and health staff and 20 health clinics
3. Communities have access to COVID19 prevention and treatment information	Preparedness and Prevention: 500,000 beneficiaries;
4. Vulnerable groups have access to unconditional humanitarian assistance in form of cash transfer to protect their livelihoods	Livelihood: 500 HH;
5. Church volunteers have increased capacity to manage COVID19 interventions	Engagement with Faith and Religious leaders and institutions: 200 pastors
6. Psychosocial counselling for women GBV related including training for counsellors	Gender and MHPSS and Community Psycho-social: 2 000 women in need and around 120 volunteers and 20 000 GBV flyers produced
7. Trainings of pastors on transmission and prevention of COVID-19	Engagement with Faith and Religious leaders and institutions: 200 pastors

Exit strategy

The forum members implementing this project are expected to document lessons learnt during project implementation, so that the benefits derived from this project are sustained after the project through use of the documented lessons. For instance, it is anticipated that the interventions included in this project are going to be mainstreamed in the subsequent projects so that the interventions should continue even after project closure. Following the experience of the COVID-19, its impact can be mitigated by interventions such as relief to address food insecurity, rehabilitation, and development to rebuild and resilience to enhance livelihoods.

Also the trainings and structures of volunteers involvement will extend the project life and it is expected, that especially the SGBV counselling and awareness campaigns, as well as Health Hygiene approaches can operate self sustainable in future and participate in the general behavior and awareness change of the population, if connected to the individual parishes.

A clear exit plan will be developed together with the communities so ensure that the local context is factored in the way the project will exit from the communities it will be implemented. In this way, when the project will be finally handed over to the communities, sustainability of the interventions implemented by the project will be ascertained.

The joint appeal process and handling will as well be a topic to be reviewed, to use and share the central points of success and challenges with other institutions and within the ACT family.

PROJECT MANAGEMENT

Implementation Approach

This is an appeal proposal from the ACT Southern African Sub Forum (SARF) for an entire region. All three national forums have been consequently submitting their individual proposals, which are all focussing on prevention/protection of health workers and own staff, food security, engagement with vulnerable groups and community engagement. Some individual approaches are worked into each proposal received, as also each country stands for its individual needs. As described in the entry section case loads are different and the individual governments have separate approaches, which need to be respected. The proposal has been developed in a participative way with the inhabitants of the several regions, districts and communities targeted by the seven national forums and pulled together by the appeal coordination. Based on the individual needs assessment and contingency plans developed and each forum proposed, what they see as the most needs and , in coordination with their national clusters and working groups of the UN system, other major stakeholders and the input of civil societies.

The SARF coordination has therefore one focal coordination point in each country for the implementation with its respective national members. These focal points will participate in the design of one regional, one national and one individual member monitoring plan, which captures data and shows impact and timely implementation according to planning. Certain importance is laid on data collection and their analysis, allowing a clear picture of every level. The monthly data show progress and failure and allow an element of intervention by each individual party. On the end of the operation it is further planned to have an impact questionnaire by KOBO data collection, which hopefully receives a proper feedback to show the appropriateness and impact of the action. The SARF Appeal Coordination will assemble the transmitted data and discuss, review the delivered data and information, to compile the quarterly and final reports.

For the cash distributions, the Cash Learning Partnership framework will be used. A security analysis to minimise risks and to explore the most appropriate modality will be carried out. Distribution dates will be announced discreetly to recipients only. Should cash in an envelope be the most suitable alternative, then the delivery of cash will be handled with extreme care, limiting a maximum number of deliveries per agent and per day within the project timeframe. In most of the countries “pay as you go” is available through the major cell phone network providers. This limits the risk for staff and beneficiaries during distributions and gives the necessary dignity to beneficiaries in the choice of purchases with the received funds.

This intervention will target approx. 8 Million people of the region of Southern Africa, living at Malawi, Madagascar and Zambia in urban and rural settlements, in host communities, who are directly affected by COVID-19, as they are pastors, small scale farmers, informal workers, migrant workers, returnees, urban dwellers in total, with special focus to the most vulnerable, as elderly, women, children/orphans, persons with disabilities and HIV, pregnant and lactating mothers as well as other direct affected vulnerable groups.

Mental Health and Community-Based Psychosocial (MHPSS) Interventions including Sexual Gender Based Violence (SGBV) will be prioritized greatly in this intervention among the communities and institutions of learning. The problem of gender based violence is based on the restrictions in movement, the compulsion to stay at home and certainly also the social deterioration (loss of jobs, dissolution of the informal labor market and increased abuse of alcohol and drugs as an abreaction). As a result, women, girls, and children in these patriarchal societies have become increasingly victims, those who are least able to defend themselves. The limitation of social control by pastors, social workers and volunteers went hand in hand with this. The proposed interventions are therefore based on the distribution of information, commitment and intensive training of church volunteers and pastors with an extended range of advice and support for victims, in order to stop the violence, but also to give the prosecution a chance. Here we build on a large network of socially committed grassroots groups with whom we want to cooperate at community level. Theater games and youth / girl groups complete the approach towards a more profound behavior change
In Detail the following programmatic inputs are planned, which are harmonized between the three applicants:

1. Madagascar: procurement and distribution of PPE materials to health clinics and staff, to protect those delivering services to the public. Cash support to special vulnerable groups, COVID-19 nationwide information dissemination through media and ecumenic resources, continuation of hand washing stations and disinfection of ecumenic health facilities and churches and training of volunteers for neighbourhood support, psycho social counselling to victims of GBV and information dissemination about gender and GBV and training of pastors and volunteers

2. Zambia : Conduct training for Peer educators; Conduct training for religious leaders; Induct peer educators;; Procure equipment for the YFHCs; Distribute equipment to the YFHCs; procurement and distribution of PPE materials to health clinics and staff, in order to protect those delivering services to the general public. Provide cash for livelihoods; COVID-19 nationwide information dissemination through media and ecumenic resources and training of pastors

3. Malawi: procurement and distribution of PPE materials to health clinics and staff, to protect those delivering services to the public. Cash support to special vulnerable groups, COVID-19 nationwide information dissemination through media and ecumenic resources, continuation of hand washing stations and disinfection of ecumenic health facilities and churches and training of volunteers for neighbourhood support, psycho social counselling to victims of GBV and information dissemination about gender and GBV and training of pastors

Implementation Arrangements

Every national forum will implement with its members the proposed actions individually. The proposed approach is the implementation through a consortium. We try to leave the maximum of liberty to each member, but are certain, that there is one framework and minimum standards of implementation to be used, which must be according to the Core Humanitarian Standards.

Therefore every forum will coordinate and cooperate with its respective national clusters and working groups, with the local and national authorities to avoid multiple targeting and to deliver an added value to its individual beneficiaries, as they did also in the planning process.

It is further planned that additional to the quarterly reporting, which will be carried out by the appeal coordination to ACT, the reviewing process will be started, to see how smooth and effective the response has been handled, in order to be ready for more coordinated joint approaches.

Project Consolidated Budget (see also Annex for details)

ACT Alliance Global Response to the COVID-19 Pandemic

Requesting Forum/Country	SARF region			
Appeal Number:	To be supplied by ACT Secretariat			
Appeal Title:	SARF COVID-19 response			
Implementing Period:	01.08.2020 - 30.04.2021			
EXCHANGE RATE: local currency to 1 USD				
Budget rate *(please input exchange rate here)*	1,00000	0,000259504	0,0536909	0,00135754
Please use exchange rate from this site:	https://www.xe.com/currencyconverter/	exchange rate of 17.Aug.2019	exchange rate of 17.Aug.2020	exchange rate of 17.Aug.2021

Please note:

This sheet is linked to the Individual Member Sheets including the Exchange Rate. Please make sure that the formulas are stil

	Appeal Total	ACT Madagascar	ACT Zambia	ACT Malawi
Direct Costs	**508.399**	**176.368**	**165.731**	**166.301**
1 Project Staff	**69.529**	**32.616**	**13.836**	**23.077**
1,1 Appeal Lead	11.029	11.029		-
1,2 International Staff	-	-	-	-
1,3 National Staff	58.500	21.587	13.836	23.077
2 Project Activities	**352.373**	**110.495**	**137.595**	**104.283**
2,1 Public Health	-	-	-	-
2,2 Community Engagement	-	-	-	-
2,3 COVID-19 Prepare and Prevention	127.241	26.625	40.644	59.971
2,4 WASH	-	-	-	-
2,5 Livelihood support	138.752	62.281	48.322	28.150
2,6 Education	-	-	-	-
2,7 Shelter and Household items	-	-	-	-
2,8 Food Security	-	-	-	-
2,9 MHPSS and Community Psycho-social	26.073	7.596	13.047	5.430
2,10 Gender	27.549	3.503	19.045	5.000
2,11 Engagement with Faith Leaders	32.758	10.490	16.537	5.732
2,12 Advocacy	-	-	-	-
3 Project Implementation	**15.901**	**6.689**	**2.862**	**6.350**
3.1. Forum Coordination	5.755	5.755	-	-
3.2. Capacity Development	10.146	934	2.862	6.350
4 Quality and Accountability	**41.081**	**11.159**	**1.235**	**28.687**
5 Logistics	**23.622**	**11.049**	**8.671**	**3.903**
6 Assets and Equipment	**5.893**	**4.361**	**1.532**	**-**
Indirect Costs	**45.000**	**15.000**	**15.000**	**15.000**
Staff Salaries	24.000	8.000	8.000	8.000
Office Operations	21.000	7.000	7.000	7.000
Total Expenditure	**553.399**	**191.368**	**180.731**	**181.301**
ICF (3%)	16.602	5.741	5.422	5.439
Total Expenditure + ICF	**570.000**	**197.109**	**186.153**	**186.740**

Project Monitoring, Evaluation and Learning

A clear framework is essential to guide effective monitoring and evaluation. Therefore, the requesting ACT Forum members will define a framework, which increases the understanding of the program's goals and objectives, defines the relationships between factors key to implementation and articulates the internal and external elements, that could affect the program's success. The appeal coordination will initiate and run this participative process and coordinate / exchange with the country forums accordingly. National Forums oversee their individual forum members and their monthly data contribution. The participative planning and implementation with the communities on the ground allow appropriate and timely feedback on the situation, implementation status and eventual needs of amendments. Delays and implementation constraint can be thus identified quickly, and possible alternative solutions found.

Forum members in this appeal will train /refresh all involved staff on SPHERE and Red Cross Code of conduct to ensure it is adhered prior to implementation of the emergency response. No major constraints in this regard are today foreseen. CHS will be used as a reference tool and projects will aim to achieve international standards in humanitarian assistance. To ensure adherence to principles and standards, staff will be trained on CHS standards to ensure that CHS is applied in all response areas. Part of staff training will therefore be dedicated to have discussion and agreement on CHS standards to ensure that CHS is mainstreamed in all responses. Accountability will also be emphasized to ensure the complaint handling mechanism is applied through all project areas. The complaints handling mechanism will be indeed established to encourage beneficiaries to safely provide feedback on the project. Implementing forums are strongly encouraged to work with participative community agreements and response mechanism, which allow all time critical feedback especially in regard of selection processes and distribution handling.

At the end of the program (in April 2021) a final data compilation with the usage of KOBO data collection tools will be carried. Here the focus will also target lessons learnt from the joint appeal system if funds received in the forums in time and no further outbreak/confinements limit the implementations. See also Log frame and risk analysis.

Safety and Security plans

All requesting forum members staff have undergone security training and have Standard Operating Procedures (SOPs), which include undertaking continuous joint risk assessments, security management checks and protocols, contingency plans, security training, communication, and equipment. The key risk prevention and mitigation measures will integrate localized and constantly updated conflict and Do No Harm analysis during the intervention and to use of clear and transparent targeting criteria for selection of project sites and beneficiaries.

These SOPs reflect on COVID-19 Global Response Plan and the latest guidance provided/published by World Health Organisation. Additionally, the forum has respective EPRP´s in place which clearly stipulate the preparedness actions and response mechanisms, highlighting key humanitarian principles and standards. The individual forum members and SARF as such therefore take into consideration 'Duty of Care' and 'Do No Harm' for our stakeholders and ensuring that the measures to be implemented respect any restrictions or regulations adopted by the respective national governments.

PROJECT ACCOUNTABILITY

Does the proposed response honour ACT's commitment to safeguarding including PSEA? All staff and volunteers of requesting members, particularly those involved with the response, will be required to sign the requesting members' Code of Conduct. If you don't have one, members can use ACT's Code of Conduct.

X Yes ☐ No

Code of Conduct

Staff of the SARF forum members have all signed and will adhere to ACT Alliance's Code of Conduct and will continue to ensure that staff, partners, volunteers, contractors, visitors, consultants, and community stakeholders follow it. Complaints mechanisms are trained, put in action and are ready to respond if needed. A refresher of introduction and behavior about the code of conduct will be organized by each forum member at the beginning of the operation.

Safeguarding

All SARF forum members will adhere to ACT Alliance's Child Safe-guarding policy, which seeks to promote greater accountability among staff, partners, and community stakeholders especially on the protection of children. SARF member staff have signed the Child Safeguarding policy.

Conflict sensitivity / do no harm

All requesting agencies and partners will conduct conflict sensitivity analysis have a local presence and will ensure that the project does not create conflict or harm to project beneficiaries. Requesting members will seek to understand the interaction between the intervention and the context, and act upon that understanding, to avoid negative impacts and maximize positive aspects of the situation. In addition, SARF members will consult widely and involve respective community participation during beneficiary selection and prioritizing the most critical needs as they evolve. Community agreements (where applicable) will justify the approach, in case of the support of pastors, also a participative agreement will be negotiated, ensuring that only the most vulnerable clerics are supported.

Complaints mechanism and feedback

In line with (CHS) Core Humanitarian Standards, SARF individual members will welcome and address complaints and feedback from the community. All implementing organizations will ensure that communities and people affected by the crisis have access to safe and responsive mechanisms to handle complaints.

Feedback will be collected by periodic reflective sessions with community members for verbal feedback on the project intervention. The requesting SARF members commit to addressing all issues and complaints lodged by the community, including issues of sexual exploitation, abuse of power, corruption and breach of the ACT policies and standards. The development of a Community Response Mechanism (CRM) will ensure that it reflects communities' preference and is accessible by men women boys and girls.

All requesting members further uphold and respect children's rights to participate in decision-making processes on issues affecting them and to have their views heard and acted upon. Both requesting members will develop a contextualised, accessible, and child-friendly complaints and response mechanism in consultation with community members (including children) to guide the process of receiving and acting on various complaints, or in the event of policy violations. All aspects of this appeal will involve consultation with rights holders, including children.

Communication and visibility

Each national forum and its members will have the obligation to comply with the mandate of visibility. Each member will communicate through relevant media to visualise the work realised. It is a commitment of the participating members to ensure the logo of ACT Alliance will be applied in terms of communication and visibility, considering the following measures:

1) Talk about the program through different communication media.
2) Keep a social network in which summaries of activities will be presented.
3) Creation and presentation of photos, videos and text that show activities.
4) Write and present success stories.
5) Assistance at events and conferences related to topics relevant to the program.
6) Maintain contact with colleagues and relevant organisations/stakeholders.
7) Generate alliances that are beneficial for the program.

In relation to communication, spaces of dialogue will be created, to consolidate key actors and tables of dialogue, present workplans to different sectors of the community, virtual sharing, establishing links of solidarity, photographic and audio-visual archives of activities, radio broadcasts, etc. The ACT SARF forum will be responsible to watch over adequate communication between participating member organisations throughout the duration. In all printed documents and publications, the logo of ACT Alliance will be used. The general public will be informed trough a campaign of information, education and communication using Facebook, Instagram, WhatsApp as well as radio and television broadcasts at the provincial and national level.

Annexes

Annex *1 – Summary Table*

	ACT Forum Madagascar (SAF/FJKM and SMT/FLM)	ACT Forum Zambia (UCZ)	ACT Forum Malawi (CA, CARD and ELDS)
Start Date	01.09.2020	01.09.2020	01.09.2020
End Date	31.05.2021	31.05.2021	31.05.2021
Project Period (in months)	9 month	9 month	9 month
Response Locations	Antananarivo (capital area); Antsirabe;	Lusaka, Siavonga, Nakonde, Livingstone, Sesheke and Kazungula ditricts,	district councils in Chikwawa and Nsanje
Sectors of response	☐ Public Health ☐ Community Engagement ☐ Preparedness and Prevention ☐ WASH ☒ Livelihood ☐ Education ☐ Shelter and household items ☐ Food Security ☒ MHPSS and Community Psycho-social ☒ Gender ☒ Engagement with Faith and Religious leaders and institutions ☐ Advocacy	☐ Public Health ☐ Community Engagement ☒ Preparedness and Prevention ☐ WASH ☒ Livelihood ☐ Education ☐ Shelter and household items ☐ Food Security ☒ MHPSS and Community Psycho-social ☒ Gender ☒ Engagement with Faith and Religious leaders and institutions ☐ Advocacy	☐ Public Health ☐ Community Engagement ☒ Preparedness and Prevention ☐ WASH ☒ Livelihood ☐ Education ☐ Shelter and household items ☐ Food Security ☒ MHPSS and Community Psycho-social ☒ Gender ☒ Engagement with Faith and Religious leaders and institutions ☐ Advocacy
Targeted Recipients (per sector)	preparedness : 4 Mio Livelihood : 4 000 Gender : 20 000 women Engagement Faith 200 MHPSS : 2 000 sessions	Preparedness 2,7 Mio people Livelihood : 600 HH Gender : 20 000 women Engagement Faith 200 MHPSS : 2 000 sessions	Preparedness 0,5 Mio people Livelihood : 500 HH Gender : 20 000 women Engagement Faith 200 MHPSS : 2 000 sessions
Requested budget (USD)	US$ 197´890	US$ 185´375	US$ 181´296
Start Date	01.09.2020	01.09.2020	01.09.2020

Annex 2 – Security Risk Assessment

Principal Threats:

Threat 1: Potential return of COVID-19 lockdowns and restriction on humanitarian work.
Threat 2: Local conflict dynamics negatively impacting on the project
Threat 3: Secondary impact of COVID-19 such as border close impacting availability of supplies including PPE and food items in the market
Threat 4: delay or non availability of funds for project implementation
Threat 5: Lack of acceptance by community of COVID-19 measures

Impact / *Probability*	**Negligible**	**Minor**	**Moderate**	**Severe**	**Critical**
Highly likely	Low Click here to enter text.	Medium Click here to enter text.	High Click here to enter text.	Very high Click here to enter text.	Very high Click here to enter text.
Likely	Low Click here to enter text.	Medium Click here to enter text.	High Click here to enter text.	High Click here to enter text.	Very high Click here to enter text.
Moderately likely	Very low Click here to enter text.	Low Threat 3	Medium Threat 1	High Threat 4	High Click here to enter text.
Unlikely	Very low Click here to enter text.	Low Threat 5	Low Click here to enter text.	Medium Threat 2	Medium Click here to enter text.
Very unlikely	Very low Click here to enter text.	Very low Click here to enter text.	Very low Click here to enter text.	Low Click here to enter text.	Low Click here to enter text.