KINGDOM OF BELGIUM
Federal Public Service
Foreign Affairs,
Foreign Trade and
Development Cooperation

Directorate-general for Development Cooperation – DGD

Service D5.1 – Humanitarian Aid

SINGLE FORM FOR THE FUNDING OF HUMANITARIAN ACTION[1]

(Legal basis: the law of 9/01/2014 modifying the law of 19/03/2013 on Development cooperation - Royal Decree of 19/04/2014, General expenditure budget, basic allocation 14 54 52 35.60.83).

1. GENERAL INFORMATION

1.1. Name of the humanitarian organisation/date of approval by the Minister for Development Cooperation (if required): Oxfam-Solidarité ASBL, 17/11/1997 (renewal: 12/12/2012 and 20/05/2016).

1.2. Title of the action: Agile response by the Belgian Alliance for Humanitarian International Action to control the spread of COVID-19 and mitigate its multi-dimensional effects on humanitarian crisis

1.3. Intervention area (country, region, locations): Sahel region (Mali, Burkina Faso, Niger), the Great Lakes region (Rwanda, Burundi, Uganda, Tanzania, DRC), the occupied Palestinian territory (Gaza and the West Bank, including East Jerusalem), as well as Syria, Lebanon, Jordan.

1.4. Action start date: 1st December 2020

1.5. Duration of the action in months (cf. Art. 17, §2): 12 months

1.6. Expenditure eligibility start date: Signature date granting Ministerial Decree.

1.7. Proposal and reports (Concerning the specific timeframes, cf. RD of 19/04/2014):

Initial proposal	date:	30-09-20
Revised proposal no.	date:	dd-mm-yy
Date of the granting Ministerial Decree	date:	dd-mm-yy
Unilateral Act date	date:	dd-mm-yy
Letter of acceptance date	date:	dd-mm-yy
Interim report	date:	dd-mm-yy
Final report	date:	dd-mm-yy

[1]The specifications used in this form have largely been reworked on the basis of the "Single Form" in use, for the same type of actions, in the European Commission (ECHO).
For a good understanding of these specifications, refer to the guidelines issued by ECHO:
http://ec.europa.eu/echo/about/actors/fpa_en.htm
The specific points relating to Belgian legislation (Royal Decree of 04 November 2014) are indicated and underlined in the text, following the specific point concerned.

At the proposal stage, complete the numbered paragraphs, except for those that begin with [INT] (to be completed at the interim report stage) and [FIN] (to be completed at the final report stage). At the interim and final report stages, only amend (cross out) the main information in the numbered paragraphs.

1.9 [FIN] List the exchanges of letters that took place following the submission of the interim report until the final report stage

2. NEEDS ASSESSMENT

BAHIA stands for "Belgian Alliance for Humanitarian International Action" and refers to the partnership between 7 Belgian NGOs registered to access Belgian funds for humanitarian aid. In 2020-2021, under a funding from the Belgian cooperation (DGD) to reduce the impact of the COVID-19 on preexisting humanitarian crisis, 7 Belgian humanitarian NGOs will set-up a coordinated response under a joint intervention logic. This project equally serves as a pilot to discover new ways of working, especially concerning the flexibility of funding for humanitarian NGOs and the coordination amongst them, both in Belgium as in the field. BAHIA is committed to the four humanitarian principles: humanity, neutrality, impartiality and independence and will ensure a safe programming approach.

2.1. Assessment date(s); methodology and information sources used; organisation/person(s) responsible for the assessment

Information sources used for the needs assessment are mainly secondary data available to the humanitarian sector (OCHA, WHO and clusters' situation reports, Reliefweb, etc.), in addition to a few primary data from needs assessments and reports conducted at country, regional and international levels by BAHIA members. At the project inception phase, more in-depth analyses and assessments will be conducted in the specific countries and territories selected for the project to ensure more country-specific needs assessments. Please refer to **Annex 1** for the full list of secondary and primary data.

The section 2.2 gives a general overview of the humanitarian situation linked to the COVID-19 pandemic in the Sahel, Great Lakes and Middle East regions. Data are provided for some of the eligible countries and regions to illustrate the impact of the crisis and the needs that are going to be addressed through this project.

2.2. Account of the problem and analysis of the stakeholders

On 31st December 2019, the WHO was informed of a cluster of cases of pneumonia of unknown cause detected in Wuhan City, Hubei Province of China; the first cases presented symptoms in early December. These people experiencing pneumonia were later determined to have been infected with a novel Coronavirus (nCoV), subsequently named COVID-19. On 11th March 2020, WHO declared COVID-19 a global pandemic. The global impact of COVID-19 has already been significant, and it represents the most serious global health threat resulting from a respiratory virus since the 1918 influenza pandemic. As the figures are evolving every day, BAHIA refers to the daily updated WHO dashboard for an overview of the last numbers. On 29/09/2020, a total of 33,249,563 confirmed cases and 1,000,040 deaths worldwide have been counted.

Before the COVID-19 pandemic, various countries in Sahel, the Great Lakes and Middle East regions were already confronting multiple and protracted risks and crises, deepened by the impact of climate change. Pre-existing drivers of humanitarian needs are being exacerbated, other risks being neglected as funding and attention shift to COVID-19, and new challenges are emerging. COVID-19 leads to rising vulnerabilities, higher pressure on existing infrastructures which are already not able to meet the needs due to weak health systems, governance and poor basic service delivery. Building on lessons learnt from Ebola crisis, the shift in attention of health infrastructures towards COVID-19 is expected to have long-term consequences on maternal and

child health. The spread of COVID-19 is likely to be much more widespread than shown by the officially reported number of infected cases, due to the lack of testing capacities. Official measures in response to the outbreak have included physical distancing and severe restrictions on movement.

These measures, along with the global scale of the crisis, although necessary, pose two main risks. First, such measures are associated with indirect humanitarian risks. Restrictions on movement and boarder closing are impacting livelihoods at large. School closures are affecting learning outcomes, food security and protection of millions of children. Limited access to social services (such as SRHR - Sexual and Reproductive Health and Rights-, police, protection) while increased risk of domestic violence is putting women and children from most vulnerable communities at high risk of abuse, violence, exploitation. Second, restriction measures pose an unprecedented challenge to the way we engage communities and draw attention to the role they play as humanitarian actors in their own right. In this context, community risk management committees' members/volunteers are being called upon to play a greater role in inclusively responding to the future or already ongoing health, economic and social crisis, in support of and in agreement with health and emergency response authorities. As first responders, and in exacerbated situations of isolation, their capacity to autonomously and inclusively implement IPC (Infection Prevention and Control) preparedness and response protocols will be key to containing the epidemic in accordance with the guidelines of the health and disaster management authorities. As access to humanitarian actors is limited and constrained, this crisis is an opportunity to strengthen and increase partnerships with local actors who have a greater capacity to operate locally.

Measures taken by governments

Great Lakes: since the first cases of COVID-19 appeared officially in early March, the region has experienced a moderate but steady spread of the virus[2]. Despite a general state of epidemiological alert in the region following the Ebola outbreak in DRC, the response from the different governments was extremely different. Most countries in the Great Lakes region implemented lockdowns and key public health measures early on, which helped slow the spread of the virus but came at great socio-economic cost. In Rwanda the early lockdown, selective quarantine and IPC measures at community level were swiftly complemented by a reinforced testing capacity, adequate attention conditions, a rapid response teams strategy at local (district) level among other measures, thus helping to have a very limited amount of deaths[3]. In DRC, strict measures were taken immediately: IPC measures at community level, closure of borders, limitation of movements in-country, selective quarantines and limitations on public gatherings amongst others. In Burundi, while officially there were measures taken, the government, after an initial stage of denial, fueled rumors and false information regarding COVID-19 through a reckless approach, where the withholding and mismanagement of information regarding the cases obliges to have a sceptic regard to the figures despite a change of discourse from the government once the new president took office in mid-June[4].

Sahel: to stop the progression of the disease and eventually eradicate it, the governments of the Sahel countries have taken measures which are, among others, the closing of land, air and rail borders, the quarantine of towns with at least one case confirmed, the closure of hotels, schools, basic essential services, restaurants and bars, the closure of markets, the stopping of public transportation, etc.

Middle East: the actual response started immediately in the Gulf area, but most governments

[2] https://ungreatlakes.unmissions.org/sites/default/files/20200611_COVID-19_-_glr_overview_final.pdf

[3] https://www.afro.who.int/news/COVID-19-rwanda-countrys-response

[4] https://www.hrw.org/news/2020/06/24/burundi-fear-repression-COVID-19-response

started to take more serious actions since March, including curfews, travel restrictions, selective quarantines, limitations on gatherings (including religious manifestations). While Jordan imposed a strict lockdown, Lebanon has been mitigating the risk of COVID-19 with more flexible measures. However, the emergency in Beirut has caused many precautionary measures to be relaxed, raising the likelihood of even higher transmission rates and an alarming caseload.

Cumulative number of cases[5]

Countries	Number of confirmed cases	Number of deaths
Great Lakes region		
DRC	10,623	271
Burundi	506	1
Uganda	7,777	75
Tanzania	509	21
Rwanda	4,832	29
Sahel region		
Burkina Faso	1,929	56
Mali	3,090	130
Niger	1,196	69
Middle East region		
Occupied Palestinian territory	49,695	353
Lebanon	37,258	351
Syria	4,102	194
Jordan	9,226	51

2.2.1 Public Health

The impact of COVID-19 and the governmental measures to contain it have been manifold. The already stressed health systems have required further strengthening from both the governments and the international humanitarian community regarding the training of staff, the implementation of isolation units, protocols, patient flows and IPC measures (and the provision of critically needed supplies) both in health structures as well as in the communities. In addition, there has been a major increase in the WASH needs in health structures in order to ensure the capacity of attention. Primary impact of COVID-19 on WASH infrastructure is among others: decline in the quantity and quality of WASH commodities and safe service delivery, decline in access to and increase in prices for WASH commodities and services due to rupture in global supply chains caused by restrictions or no movements of goods and essential consumables affecting continuity of services, increase in interruptions in WASH assistance to populations already affected by pre-COVID 19 humanitarian situations, inability to promote handwashing and cleaning water-stressed contexts, and likelihood to impact water scarcity.[6] The redistribution of government resources to contain the epidemic has affected also other areas of health attention as there has been a concentrated demand in certain areas and a large decrease in other services such as care for NCDs (Noncommunicable diseases)[7]. In this context, and given the weak health financing situation in the considered countries, the increase of the out of pocket expenditure has increased the

[5] https://covid19.who.int/?gclid=CjwKCAjw4MP5BRBtEiwASfwAL_RELeSlEkTkH1P1ghF7_oaS3-HyvXKqrMrBPbMaJpvwuvQ8dKBn4RoC0RkQAvD_BwE – As of 29/09/2020

[6] "COVID-19 and WASH: mitigating the socio-economic impacts on the WASH sector", https://www.sanitationandwaterforall.org/sites/default/files/2020-06/COVID%2019%20WASH%20Advocacy_Final-GWC-SWA.pdf

[7] https://www.who.int/news-room/detail/01-06-2020-COVID-19-significantly-impacts-health-services-for-noncommunicable-diseases

vulnerability of households[8].

To push forward a resilience developing and emergency preparedness agenda, it is paramount to capitalize the lessons learned and reduce the multiple impacts at the community level. Nevertheless, this is a difficult objective to accomplish given the difficulties for NGOs to operate under such constraints and that the resources gathered to even ensure basic health and address humanitarian needs during COVID-19 are far from what is required as the COVID GHRP has been financed only to 25,7%[9].

As effects that are appearing and will likely consolidate in the future, we can mention: the exhaustion of the health workforce, the deterioration of infrastructure, the backlog on the medical and food supply chain, the waiting lines and delays in medical procedures and of course the growing toll on mental health given the confinement and linked protection threats, the economic recession and the eventual grief[10] [11]. Based on lessons-learned from Ebola, sanitary crisis can also lead to decrease in routine vaccination, increase in maternal, neonatal and stillbirth deaths, as health systems are unable to catch up with the pre-crisis level. Regarding reproductive health and rights aspects, UNFPA warns that lockdowns and major disruptions to health services during the pandemic could result in 7 million unintended pregnancies in the following months, as 47 million women are losing access to contraceptives.

COVID-19 is associated with a significant sub-acute[12] and long-term care rehabilitation burden. Patients recovering from severe cases of COVID-19 who have experienced extended periods of mechanical ventilation, coupled with deep sedation and/or paralysis, will typically develop significant physical deconditioning, respiratory, swallow, cognitive, and mental health impairment, as well as psychosocial challenges. These symptoms are collectively referred to as Post Intensive Care Syndrome and can persist for months after discharge. They can have a particularly profound impact on older people and those with pre-existing chronic conditions and can delay or complicate hospital discharge. Therefore, rehabilitation and MHPSS (Mental Health and Psychosocial Support) have a core role in the sub-acute care of patients COVID-19 with impairments related to Post Intensive Care Syndrome. In countries facing a high transmission level, health services tend to be overwhelmed. Health facilities are unequally distributed and equipped across the territories, and understaffed to cope with the high transmission and gravity of the virus. Their local capacities for promoting IPC are severely lacking. Institutional emergency responders, who may be able to reduce the risks of transmission and to provide assistance to people who are in confinement or in quarantine, including persons with disabilities and vulnerable populations, are rarely in capacity to meet their basic and specific needs due to the magnitude of the crisis and the communication and transport difficulties in a containment situation.

2.2.1.1 Public Health needs in the Great Lakes region

The measures taken by the government in DRC were widespread in the territory, which was not unfamiliar with some of them given the recent Ebola, cholera and measles outbreaks, and they helped to reduce the spread of the virus, but had an enormous impact on food security, on the condition of the health system and on the gender gap, accentuating a set of crises that were already existing[13]. This situation is particularly complex in the East where an underlying conflict

[8] https://www.csis.org/analysis/no-time-complacency-COVID-19-pandemic-west-africas-sahel-region

[9] https://fts.unocha.org/appeals/952/summary

[10] https://www.ilo.org/wcmsp5/groups/public/---ed_dialogue/---sector/documents/briefingnote/wcms_741655.pdf

[11] https://www2.deloitte.com/fr/fr/pages/COVID-insights/articles/impact-COVID19-healthcare-systems.html

[12] Rapid Needs Assesment, August 2020, HAI

[13] https://www.eurac-network.org/fr/press-releases/communique-presse-riposte-face-au-COVID-19-region-grands-lacs-ne-doit-laisser

and recent natural disasters (flooding) hamper the capacity of the population to respect the hygiene measures needed to avoid the transmission of the virus. In this scenario, the already weak health system, particularly in rural areas, needed to be reinforced by the international community in order to ensure a proper response capacity[14].

In Burundi, the fragile political context, internal displacement of population and heavy rains have taken a toll on food security, supply chain and the health system by the total or partial destruction of crops, homes, schools, roads and health structures in a country where the health situation was already critical[15].

2.2.1.2 Public Health needs in the Sahel region

The overall needs in Sahel have been in the rise for several years following the food shortages, global warming, epidemics, dysfunctional health systems and terrorism among other factors. Currently, the COVID-19 epidemic has also affected the whole system deepening these crises, and in particular the health situation.[16] [17] [18]

Health indicators (please refer to **Annex 2**[19]) in the region are far from the SDG targets, with strong maternal mortality rates and deaths of children under five years of age, a weak family planning uptake, problems of accessibility, affordability, acceptability and availability of health services and the difficulties in guaranteeing the right to health. In Sahel's epidemiological profile, infections and parasitic diseases are most prominent (malaria, meningitis, dengue, measles, cholera, acute watery diarrhea among others); nevertheless, non-communicable diseases, particularly cardiovascular diseases and diabetes are becoming a major public health issue.

Most of the diseases that have an outbreak potential are constantly present in these countries and often there are peaks. In a scenario of pre-existent (and now deepened) food insecurity, acute malnutrition is ever present (Severe Acute Malnutritution/SAM and Moderate Acute Malnutrition/MAM) and the omnipresent chronic malnutrition is hardly ever treated.[20] Traditional medicine is a common practice, particularly in rural areas, both for cultural reasons as well as for the lack of availability and accessibility of formal health structures (public or private).

COVID-19 has spread in the region since late February; nowadays the different governments have taken measures to contain the transmission with different degrees of success despite the difficulties of working in a conflict and terrorism scenario. Currently, the evolution of the disease has been somehow controlled (according to official statements), but there is a major bias in this interpretation as the testing remains low and very centralized given the lack of availability of tests, laboratory capacity and overall strategy. IPC interventions in all countries have been greatly supported by NGOs who could ensure the timely provision of critically needed supplies.

Finally, universal health coverage is far from guaranteed. Need is to acknowledge that the national health systems are moving forward (albeit slowly and with many difficulties) with regards to absence of fees (Under year children (U5), Pregnant and Lactating Women (PLW), elder and homeless people) and the health financing systems (mutuality and insurance).[21]

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[14] https://www.plan.gouv.cd/wp-content/uploads/2020/07/Etude-Impact-COVID-en-RDC-2.pdf

[15] https://reliefweb.int/report/burundi/burundi-revised-humanitarian-response-coronavirus-disease-2019-COVID-19-may-december

[16] https://www.unocha.org/story/humanitarian-needs-rise-sahel-amid-COVID-19

[17] https://ec.europa.eu/echo/where/africa/sahel_en

[18] http://www.oecd.org/fr/csao/coronavirus-ouest-afrique/

[19] Médecins du Monde, Stratégie régionale Sahel 2020-2022

[20] https://www.refugeesinternational.org/reports/2020/6/11/augmentation-de-la-faim-au-sahelnbsp-limpact-involontaire-de-la-prvention-de-la-COVID19

[21] https://afriquedecryptages.wordpress.com/2020/05/13/le-COVID-19-au-sahel-pandemie-lente-mais-impacts-multiples/

2.2.1.3 Public Health needs in the Middle East region

The Middle East region is constituted by several countries with diverging capacities regarding their health systems and governance structures which has been reflected in a despair response to the pandemic. The cases started in the region during the month of January, and the increase have been substantial ever since, but not reaching the levels of Europe (with the exception of Iran)[22]. The rich countries of the Gulf have withstood the secondary (impact) with a certain ease, while in the poorer countries of the region all crises and cleavages have been exacerbated. Despite these measures, the region passed the milestone of one million cases in June following a major peak in the incidence attributed to the end of lockdown together with an increase on the overall testing capacity, and thus all countries were urged by WHO[23] to strengthen their measures and reinforce their health systems.

In Syria, the ravaging and long-lasting war, cholera epidemic and famine have frustrated any attempt to control the virus, and the remnants of the already torn health system have not been able to cope with the pandemic.

In occupied Palestinian territory, the weak health system and the continuation of aggressions with Israel have mitigated their response capacity.

In Lebanon, the government and the economy were on a heavy decline before the epidemic and have been unable to ensure the resources needed to limit the spread of the virus and guarantee adequate care for the affected population. Following the blast in Beirut on August 4th, the health care system that was already struggling to deal with demand, the damage to health facilities and impact on healthcare workers add additional pressure.[24] According to the Ministry of Public Health, a total of 7,413 cases have now been detected in Lebanon and 89 deaths (as of 13/08/2020). The source of over half of the new coronavirus infections was unknown as the contact tracing capacity of the country is overwhelmed. The rapid rise in cases has caused alarm across the country.

2.2.2 Food security, livelihoods and economic recovery

The pre-existing food insecurity in several of the covered countries have been exacerbated given the close of borders, the contraction of markets and the disruption of supply lines[25]. The COVID-19 pandemic presents an unprecedented challenge with deep social and economic consequences, especially on food security and nutrition. According to FAO-WFP joint report[26], people in 25 countries are set to face devastating levels of hunger in coming months due to the fallout from the COVID-19 pandemic. The number of acute food insecure people could increase from 149 million pre-COVID-19 to 270 million before the end of the year.

The measures that are being taken to reduce the spread of COVID-19 disease, such as social distancing, movement restrictions and market and borders' closure have a major impact on people's livelihoods and food security. As of 24th of June 2020, IMF projects a contraction of 4,9% in global gross domestic product (GDP), which could further decrease due to containment measures in response to a second wave. Well-resourced governments have taken measures to make funds available to support businesses, services and workers affected by the outbreak, but these measures may not be available to the most vulnerable people who will be affected by the outbreak and have no safety net. More than one billion people live in informal settlements in cities in the least developed parts of the world, the impact in these areas may be unprecedented. The

[22] https://www.nato-pa.int/document/COVID-19-pandemic-and-mena-region-draft-special-report-gsm-p-folliot

[23] https://www.middleeastmonitor.com/20200702-who-issues-stark-COVID-19-warning-to-mena-region/

[24] Rapid Needs Assesment, August 2020, HAI

[25] https://blogs.worldbank.org/opendata/monitoring-impact-COVID-19-and-climate-change-pastoral-populations-sahel

[26] https://reliefweb.int/sites/reliefweb.int/files/resources/WFP-0000117706.pdf

loss of livelihoods for vulnerable communities in fragile contexts who are already facing other humanitarian crises will be significant. It is especially in such contexts amongst Africa and the Middle East where BAHIA will implement its activities. The main impacts on the food situation and livelihoods of vulnerable households are felt on different levels :

- Many face a loss or reduction of income, especially people involved in informal petty trade and street vendors in cities or rural markets, owners or employees of micro and small businesses (restaurants, transport, tourism, …) and daily workers involved in formal and informal jobs. Special attention here should be made to households headed by women, who are disproportionately represented in the informal sector;
- People are facing a reduction or loss of remittances. The World Bank has warned for a precipitous drop in global remittance flows of roughly 20% this year, which is the severest decline in recent memory. The forecast is a direct consequence of the economic downturn triggered by coronavirus and the subsequent global lockdowns that have lowered wages and taken jobs in their wake. This trend has hit migrant communities working in host countries especially hard;
- The mitigation measures limit the possibilities for seasonal migration, which is an adaptation strategy for many vulnerable households;
- In areas where large outbreaks happen, households are facing an increase of their expenditures (medicines, health services, funerals) while market disruptions lead to increases in prices, reducing the purchasing power of families;
- There is a risk for a reduction of primary production due to limited access to essential inputs as seeds, vodder, vaccines, etc. impacting the availability of food, agricultural production and food supply chains;
- An impact on nutrition is caused by a lack of access to nutritious and diversified food, closure of school canteens and disruption or discontinuity of government and humanitarian nutrition programmes, leading to the exacerbation of existing chronic hunger;
- The virus may prove particularly dangerous for the food insecure and malnourished populations. With weakened immune systems, they have reduced ability to fight infections. The survival rate of patients suffering from Ebola, for example, was affected by their “preceding nutritional status” or the baseline nutritional health of people affected by the virus (WHO/UNICEF/WFP, 2014);
- Coping strategies such as the use of savings and the increase of debt will undermine households by reducing their resilience and increasing their vulnerability to future disaster;
- Vulnerable families and communities will likely see a huge drop in vital remittances from family members working abroad, as job losses in wealthier countries take their toll. World Bank projections show global remittances are set to decline 20% in 2020 due to the COVID-induced economic crisis.

2.2.2.1 Food security, livelihoods and economic recovery in the Great Lakes region

The World Bank analysis of the economic impact of COVID-19 in Sub-Saharan Africa estimates that agricultural production is expected to experience a contraction of output between 2,7 and 7%. Various regional-specific factors contributed to the impact of the COVID-19 pandemic on the food & livelihood sector:

- In various countries as Burundi, Rwanda and DRC, the overwhelming majority of the population relies on agriculture as the main source of income and is directly impacted by the COVID-19 containment measures such as the closing of borders, the restriction of non-essential economic activities and the restricted access to food markets for producers. Moreover, transborder food trade within and outside the region represents an important contributor to regional food stocks. According to EURAC, the European Network for Central Africa, the food insecurity will likely affect the urban-poor the most, as well as

those rural producers who highly depend on markets for their consumption and small traders in the middle of the chain, whereas peasant farming households show more productivity, resilience and sustainability;

- Before the onset of the pandemic, the food-security situation in the region was already highly problematic. WFP estimated that 16,7 million people across the region were severely food insecure, where 13,6 million people were estimated to be facing hunger. The heavy rainfall, flooding and landslides that affected nearly 958.000 people in Burundi, DRC, Rwanda, Tanzania and Uganda since November 2019 temporarily displaced almost 55.000 people and damaged crops significantly. In May 2020, almost 4 million Congelese (7% of the population) were reported as Food insecure (IPC Phase 4)[27];
- The desert locust plague which is badly affecting Eastern Africa, has its consequences for countries in the Great-Lakes as well. By February 2020, swarms were already affecting crops in Uganda and Tanzania, and FAO has warned that sustained desert locust reproduction over the next months will likely increase the spread to North-eastern Uganda as a result of high soil moisture, wind patterns and above normal vegetation, which have created conducive ecological conditions for the ongoing locust outbreak;
- Ongoing conflicts in DRC (Kasai Region, North Kivu, South Kivu, Ituri, Maniema and Tanganyika Provinces) continue to negatively affect household's abilities to access typical livelihood activities. It's in those areas that the outlook for October 2020 - January 2021, when the eligibility for this project begins, looks the grimmest, with many areas phasing crisis or emergency based on their IPC (integrated phase classification) -score.

2.2.2.2 Food security, livelihoods and economic recovery in the Sahel region

The pandemic's secondary impacts and the health and socio-economic crisis they cause are likely to be serious in the Sahel region in many contexts, particularly countries with other ongoing epidemics (malaria, cholera), existing humanitarian crises, protracted crises and fragile state settings and pre-crisis high levels of food insecurity. Negative impacts of the epidemics and of the measures put in place to curb the spread of the disease on health systems, food security and income generation, inability of the most vulnerable to meet their basic needs, disruption to markets, and spill-over effects from the global economic slowdown are all expected and, for some of them, already visible.

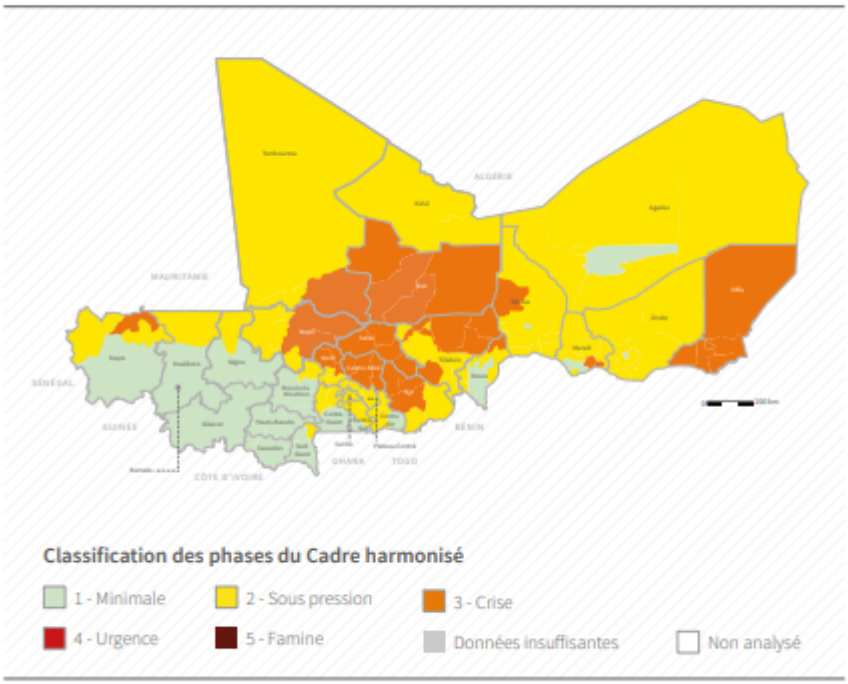
The restrictions and measures taken by governments in Sahel particularly affect daily workers, small agricultural producers (difficulty in producing and selling plant, animal and fishery products), small traders and similar groups in the informal sector, seasonal migrants. The closure of land borders has also been a big obstacle to transhumance, which raised the already existing conflicts between breeders and farmers.

The health crisis very quickly turned into a major socio-economic crisis which exacerbates the fragility of vulnerable households, in already very fragile contexts. Losses of jobs, income and livelihoods have plunged much of the population into food insecurity. This situation has prompted the governments of the Sahel to take mitigating measures by ordering the opening of points of sale of cereals at subsidized prices; securing stocks of consumer goods, in consultation with actors in the supply chain and reinforcing economic price control in the country; donating food to vulnerable people in closed markets; acquiring agricultural inputs and livestock feeding to support food and pastoral production; establishing a solidarity fund for the benefit of actors in the informal sector (in particular for women) for the revival of fruit and vegetable trade activities. These examples of mitigation measures provide very short-lived relief for the affected populations.

[27] http://www.ipcinfo.org/fileadmin/user_upload/ipcinfo/docs/IPC_DRC_AFI_2019July2020May_French.pdf

However, they are far from offsetting the real impact of the health crisis and the control measures on all economic sectors of the country. In sum, the impact on food consumption and livelihoods remains overall "negative, medium to strong".

Situation projetée de l'insécurité alimentaire aiguë au Burkina Faso, au Mali et au Niger (juin-août 2020)



Source de la carte: Cadre Harmonisé, mars 2020. La carte est conforme aux cartes des Nations Unies pour le Burkina Faso, août 2018; Tchad, mars 2014; et Mali, février 2020.

As OECD reports, the state of food and nutrition security in West Africa was already alarming before the pandemic. In December 2019, 9.4 million people were estimated to require emergency food assistance according to the Food Crisis Prevention Network, with the primary cause being insecurity. At that time, global acute malnutrition rates already exceeded the emergency threshold (>15%) in several conflict-affected areas of Burkina Faso and Mali. IDPs and host communities had seen their vulnerabilities increase in terms of food insecurity, water, hygiene, sanitation, and health. Similarly, humanitarian access was already experiencing difficulties due to armed groups undermining the provision of food assistance. In April 2020, the Food Crisis Prevention Network (RPCA) declared the situation in West Africa an unprecedented humanitarian crisis as 11.4 million people were at that time in need of immediate food and nutrition assistance. The Network warned that, if appropriate measures were not taken, 17 million people would be facing a crisis situation or worse between April 2020 and the lean season. This is more than double the number of people usually affected, and the primary cause is insecurity. This forecast is currently being confirmed in Burkina Faso, Mali and Niger, facing an increase in the number of food insecure people:

- In Burkina Faso, ongoing work to assess the socio-economic impact of COVID-19 on food security is showing a further deterioration in the situation across the country. The security situation has also continued to deteriorate during the pandemic, increasing risk factors for food insecurity. COVID-19 restrictions, combined with insecurity, threaten market functioning and livelihood, especially for informal workers. Access to field and grazing for farmers and agro-pastoralists may be further disturbed, especially in the borders areas with Niger and Mali;
- In Mali, COVID-19 related measures increase the vulnerability to food insecurity in urban areas and for household normally receiving remittances. The early hunger gap in the

western Sahel, Liptako-Gourma and in parts of the north and the drop in income related to COVID-19 are leading poor households to resort to negative coping strategies in order to meet their food needs;

- In Niger, due to the impact of the economic downturn and containment measures, 5,6 million people will be at risk of food insecurity between June and September, i.e. 23% of the population, compared to 2 million anticipated (OCHA). Poor households have a limited access to free seeds distributed because of COVID-19 distribution.

In July, the RPCA alerted that, despite the situation going back to 'normality' in most of the regions, the situation in West Africa is still alarming:

- In Niger, there is a general tendency to rise of food prices and gaps in food availability where markets are functioning;
- Pastoral situation is still very difficult in Mali, Niger and North-West of Burkina Faso principally because the land borders are still closed and hinder the transhumance;
- Regarding the Income Generating Activities, Mali, Niger and Burkina Faso are in alert (limited, very limited or absent on a significant proportion of the territory); this situation is aggravated by the lack of access to means of production in the conflict areas;
- Risk of desert locust outbreak is still very high and closely monitored. The good conditions for reproduction (due to the arrival of rains) let fear an increase of locust population in August and September.

2.2.2.3 Food security, livelihoods and economic recovery in the Middle East

Across the Middle East, millions already live with little or no healthcare, food, water and electricity, as well as volatile prices and destroyed infrastructure. Humanitarian organisations such as the International Comité of the Red Cross (ICRC) has indicated how some of the regions' most vulnerable people struggle to survive and rebuild their lives against vast odds:

- In Syria, as the conflict enters its 10th year, over 9 million people are considered food insecure, an increase of 20% in the past 12 months. The impact of COVID-19 has now created hundreds of thousands of newly vulnerable people - 300,000 people, each representing a family, were registered recently by the government for a social benefits programme. In June, WFP delivered food assistance to 4,6 million people. It finalized the pre-positioning of more than two months' worth of food stocks inside north-western Syria in anticipation of the 10 July expiry of the Security Council resolution. The Bab al Salama border crossing, near Aleppo, has indeed been closed[28]. Food prices skyrocketed in June, increasing by 48% from May, and have now tripled in just eight months[29]. Livestock has been the most affected sector by the COVID-19 control measures, although all agricultural sectors have been impacted.[30]
- In Jordan, Syrian refugees who had started businesses have lost the majority of their income, as public health restrictions on movement and curfews impacted their enterprises.
- In Gaza, restrictions introduced to contain the spread of the virus affected restaurants and small grocery stores, as well as the livestock farmers who sold produce to them, and who were already struggling to deal with falling prices for their stock.
- In Lebanon, the COVID-19 pandemic and restrictions introduced to contain it in the country come on top of months of a deteriorating economic situation. Food and non-food prices have dramatically increased over the past eight months, with some goods rising by more than 90%. These dramatic socio-economic figures were registered even before 2

[28] https://reliefweb.int/report/syrian-arab-republic/wfp-syria-country-brief-june-2020

[29] https://reliefweb.int/report/syrian-arab-republic/wfp-syria-situation-report-6-june-2020

[30] https://reliefweb.int/report/syrian-arab-republic/syrian-arab-republic-situation-report-june-2020

explosions occurred at the port of its capital city Beirut on August 4th 2020, resulting in at least 10 to 15 billion USD in property damage and making an estimated 300.000 people homeless (figures August 10th).

2.2.3 Protection and social impact

The lockdown and emergency measures are generating an immediate threat for all populations in terms of loss of access to livelihoods, increasing the vulnerability of people relying on informal work, and putting at risk their life because they are not able to meet their basic needs and access basic services. Conflict dynamics have been influenced, bringing in some cases to a halt of ongoing hostilities or in other cases to an increase in violence and tension due to the use of force by police, armed groups, the discontent of host communities or inter-communal violence. According to the Global Protection cluster, 80% of countries where the protection cluster is active report escalating conflicts and/or political instability since the COVID-19 outbreak, as well as a significant spike of armed conflict in May. This situation leads to more displacements and reduced access to basic services. Self-isolation and physical distancing are essential measures that are not applicable in highly densely populated settlements and in urban settings where the spread of the virus would have devastating consequences. The lack of legal status for IDPs, refugees and vulnerable populations in some countries further exposes them to threats and compromises their access to services and assistance, as it implies a restricted or denied access to rights.

Different emerging trends following COVID-19 have been highlighted by the Global Protection Cluster[31] with reference to global protection concerns and social impact[32]:

- People face barriers in accessing services and information; unavailability of safe, timely access to emergency and protection services;
- Humanitarian actors face obstacles in delivering services;
- The interplay between conflict and COVID-19 remains a major area of concern as in several operations, armed groups are taking advantage of COVID-19 and protection space is reduced;
- Restrictions on freedom of movement and borders closures impact access to basic services, livelihoods and markets; leads to refoulement and denial of citizenship;
- Social exclusion, discrimination and lack of access to basic services;
- Stigmatization of people and communities accused of carrying virus, sometimes leading to abuse and exploitation of specific groups, increased conflict and/or civil unrest;
- Physical and sexual violence, including gender-based violence (surge in early, child and forced marriage, female genital mutilation, sexual exploitation and survival sex); women and children continue to face risks of violence and access to protection services for women and children is limited;
- Impact on service delivery.

Those protection concerns will lead communities and vulnerable people to adopt negative coping strategies such as for example child labour, lower food consumption, selling of assets, debt, early, child and force marriage and forced prostitution.

The pandemic has further exposed vulnerabilities of certain groups, based on gender, age, ethnicity, disability and legal, social and economic status, among others. Mobility restrictions such as physical distancing, self-isolation, extreme lockdown and quarantine are likely to increase

[31] https://www.globalprotectioncluster.org/2020/04/09/COVID19-protection-risks-responses-situation-report-no-2/?utm_source=SUBSCRIBE+TO+GPC+UPDATES&utm_campaign=43e9b2e9bf-EMAIL_CAMPAIGN_2020_04_09_08_10&utm_medium=email&utm_term=0_f7f07c0884-43e9b2e9bf-47552629

[32] COVID-19, Protection guidance, Oxfam

Sexual and Gender-based Violence (SGBV), especially intimate partner violence and domestic violence, leading to impact on individual mental and physical health and rights violation in a context where the specific management of these cases is seldomly existent. Sexual violence in conflict zones may be exacerbated, and survivors may not be able to seek refuge or access any services (including PEP kits) within their communities, or in other countries due to border closures and travel restrictions. Women and girls, generally in charge of caregiving for their families and communities, suffer disproportionally from the effects of the pandemic. Through the Global Protection Cluster, 19 operations report SGBV and over 60% say it is occurring with high impact due to COVID-19. Girls, adolescent girls and young women are particularly at risk of sexual violence in an environment where obstacles are increasingly preventing them from reporting incidents of sexual violence and accessing quality, survivor-centered, safe, confidential services. Globally, *domestic violence*, resulting from quarantine or physical distancing measures, is rising, with decreasing access to protection services and networks. Tensions from economic crisis and loss of livelihoods are affecting household dynamics, parental frustration and result in increased experience and risk of violence. Evidence from analysis of adolescent girls in crisis indicates that adolescent girls are not only concerned about the constant presence of armed men, but also about GBV within families.
Psychosocial distress and mental health are affected by isolation, school dropouts, economic stress, anxiety linked with COVID-19 communication, as well as separation of children from their caregivers due to quarantine measures, hospitalization of caregivers or death of caregivers.

Child labour is increasingly adopted by households as a negative coping mechanism due to the economic stress and loss of livelihoods. Paired with the massive school closures globally, the incentives are extremely low for children, adolescents and young people to rely on quality education rather than child labour, and to access decent job opportunities rather than survival and risky employment. Regarding child labour, girls and adolescent girls face significantly higher risk of sexual exploitation. Experience from past crises also point towards the incidence of Early, Child and Forced Marriage (ECFM), with girls and women particularly affected especially among the poorest and most marginalized groups. Increase in ECFM is affected by school closure, economic stress, high risks of violence; yet, root causes of ECFM also lie in pre-existing harmful social norms regarding the position of girls and women in society and stereotypes associated with traditional gender roles.
Disruption in *SRHR* services and protection systems due to the crisis exacerbates the incidence and impact of the crisis on children, adolescents and young people, especially girls and young women. They face challenges accessing menstrual hygiene management materials, SRHR information and services, that in turn have consequences in terms of early pregnancy, ECFM, etc.

Persons with disabilities and vulnerable persons are at greater risk of exposure to the COVID-19 pandemic because they face higher rates of exposure due to the need for close contact with personal assistants/caregivers, increased risk of infection and complications due to underlying health conditions and socio-economic inequalities, including inadequate access to health care. Vulnerable populations and persons with disabilities are disproportionately impacted by the COVID-19 pandemic in health, economic and social terms. Some individuals, households and communities face increased risks and consequences due to the higher exposure and barriers in accessing critical information, protection and other essential services. These risks often overlap with other pre-existing inequalities and are further compounded by gaps in preparedness and response plans. These gaps are variable and context-specific and may include:

- Risk and needs analysis are not inclusive, given the specific risks of exclusion and violation of the rights of people with disabilities and other groups such as women and girls, people

living with HIV, migrants or people on the move, etc. In the case of women and girls, harmful social norms are deeply rooted in societies, supporting and perpetrating harmful practices;
- Epidemic surveillance mechanisms, contingency, preparedness and response plans are not inclusive and accessible. For example, protocols for preparedness and protection of people with disabilities and/or their caregivers and families during hospitalization, isolation, quarantine or physical removal are lacking;
- Physical distance, breakdown of social support systems and/or separation of caregivers impose a disruption in the continuity of care (medical, social and rehabilitation care, etc.) that increases the risk of protection and exclusion from access to health services;
- Assistance may not reach all locations (rural or remote areas, institutions, prisons, orphanages, retirement homes, etc.), while the closure or disruption of centers and services raises protection concerns and the disruption of care affects physical and psychological well-being;
- Discrimination, misperceptions, stigmatization by the community, service providers and systems against people with disabilities and other groups are even greater in a pandemic situation (people with disabilities are perceived as more infectious), putting them at increased risk of isolation, physical and verbal abuse, denial of access and discrimination. Persons with disabilities may also be deprived or denied access to coronavirus treatment on the assumption that their chances of survival are lower than those of non-disabled persons;
- Physical inaccessibility of health services, transport systems, WASH infrastructures and services increases the risk of spread;
- The lack of protection and social support mechanisms for people with disabilities and their family leads to socio-economic vulnerability, reduced autonomy, reduced physical and psychological well-being (distress, anxiety, negativity).

Lack of access to adequate information on COVID-19: since COVID-19 is a new virus, research and information on prevention measures and treatments are in continuous development. The dissemination of updated information is essential for people to be aware of how to prevent transmission for self-protection and public health. There are populations who are not having access to information because they are living in more isolated or remote areas and/or have limited or no access to means of communication or because they don't speak the language. Rumors and disbelief in the virus increase complexity for humanitarians in responding. There is also risks that communication and messages are not inclusive and accessible to all and are not sufficiently diverse (child-friendly, gender- and disability-sensitive). Adults and children with disabilities and the elderly may have limited access to the communication modalities used (mass media, social media) or may not receive information if they are confined (institutions, prisons, orphanages, old people's homes, etc.) or live at a distance.
Eventually, COVID-19 is leading to *social stigma and discriminations* against certain ethnic groups and communities suspected to have contracted the virus, which can undermine social cohesion and lead to rising tensions between host communities and IDPS, refugees, especially when host communities already rely on humanitarian assistance.[33]

2.2.3.1 Protection and social impact in the Great Lakes region

Since March 2020, several countries in the Great Lakes region have reported increased occurrence of SGBV directly linked to state-imposed measures to contain the virus (i.e. lockdowns, isolations and movement restrictions during the pandemic). [34] Loss of income for women working in the informal sector, reduced opportunities for employment, along with the

[33] https://www.who.int/docs/default-source/coronaviruse/COVID19-stigma-guide.pdf
[34] The Pandemic and beyond : Oxfam in HECA

increased care burden on women occasioned by the spread of COVID-19 will compound already existing multiple and reinforcing layers of discrimination that women face, and put women, particularly marginalized women (IDPs, refugees, sexual minorities, poor women etc.), at an even greater risk of SGBV. Various protection threats mentioned in section 2.2.3 are occurring in countries in the Great Lakes region:

- The lack of information represents a concern in DRC where the dissemination of rumors can generate wrongful beliefs within the communities, including associated with sorcery.[35] There is also a risk of arbitrary detention or request of money from corrupted policemen if people are accused of not respecting the measures.[36]
- On 30th of June, the Government of Rwanda passed new resolutions which lifted lockdown measures, yet schools remain closed. There are over 3,6 million students out of school, of whom 500,000 in primary school. This number is expected to increase by September when schools will be receiving both already registered students and newcomers (Save the Children, August 2020). The impact of school's closure transcends education with additional ramifications for children's health and protection. These challenges are exacerbated by the impact of the pandemic on the global and localized economy with parents losing their livelihoods and forcing children, particularly girls, into child labour as a negative coping mechanism. Also, economic downturns, job losses - exacerbating economic stress due to loss of livelihood - and school closures will increase the risks of sexual violence, exploitation, trafficking, child marriage and harmful practices. Lockdown measures are having an impact on the access to safe reporting systems, as well as to SRHR services. The number of Violence Against Women and Girls (VAWG) cases reported by health centers is affected by the fact that the population cannot leave their home, leading to a decrease in the number of cases reported by health centers (UNWomen) ;
- In Uganda, the pandemic is unfolding against the backdrop of one of the world's largest refugee responses. Uganda hosts 1.4 million refugees, of whom 82% are women and children. (UNFPA July 2020) There have been cases of physical violence within the host community against people infected with COVID-19 or who are believed to have returned from areas with a large number of cases. About 15 million children have been out of school due to the nation-wide school closure decided in March. (Save the Children, March 2020) For vulnerable children, schools not only provide education: they also provide protection from violence and abuse and are the main source of safe water, nutrition and mental health support. Such massive de-schooling is exposing vulnerable populations, especially displaced children and girls, to various forms of exploitation including child labour. Prior to COVID-19, 40% of girls in Uganda are married before their 18th birthday and one in 10 is married before the age of 15. (Girls not Bride) The situation is expected to worsen, as the pandemic is putting a greater financial and social pressure on households, and particularly on girls and women, resulting in an increase in child marriage and early pregnancies. Underlying gendered negative social norms in most households and communities have been strengthened during the COVID-19 restrictions. This was observed from sampled study communities of Northern, East central and Eastern regions of Uganda during COVID-19 Rapid Gender Analysis, where women could not question some decisions of their husbands or male figures exposing them to increased domestic violence. (Plan International, July 2020) The access to SRHR services is very limited especially in the 40 border districts that are under total lockdown under COVID-19 restrictions.

[35] Protection Analysis COVID-19_14 April 2020_final Oxfam
[36] Ibid.

2.2.3.2 Protection and social impact in the Sahel region

In Mali, Burkina Faso and Niger, COVID-19 exacerbates the protection needs that were already acute due to the complex humanitarian crisis. Confinement measures in the context of IDP camps, fragile communities and resources already affected by severe crises are putting the most vulnerable populations at risk of further violence. Limited food is very likely to lead to adoption of negative coping mechanisms. In the Lake Chad Basin, movements of military groups increase risks of community transmission of the virus.

- In Mali, COVID-19 has had an impact on basic services and these challenges are further exacerbated by attacks on property, goods and livelihoods, among other protection incidents. In 2020, 442 violations have already been recorded between January and May.[37] Armed groups are exploiting COVID-19 to gain territory and control resources. The increased involvement of girls in small businesses is exposing them to various forms of exploitations and violence. Schools have been closed since mid-March, with a partial re-opening in July. Yet, most children remain out of school and with their education interrupted and not being in a safe place such as a school, are at a higher risk of abuse, neglect, violence and exploitation. Due to existing vulnerabilities, most of them, especially girls, are likely to drop out of school completely. (Save the Children, April 2020) COVID-19 is disrupting planned efforts to end child marriage, because of the wide-reaching economic consequences coupled with school closure, child marriage is adopted as a negative coping mechanism by households. (UNFPA, May 2020) The initial prevalence rate of SGBV could increase by at least 49% due to the consequences of COVID-19 while the protection systems have been affected by the pandemic. The access to psychosocial services and support for survivors of SGBV is currently limited due to the lockdown and the government-imposed curfew. (OCHA, July 2020) UNFPA Country Representative in Mali, reported that there was a 35% increase in SGBV, with 484 cases reported in April 2020 compared to 317 in April 2019. (UNFPA, July 2020) Regarding SRHR services, 66% of the resource persons establish a clear link between COVID-19 and Reproductive Health (RH), with repercussions such as the inability of women to decide on their RH due to the inability to access health centres, a possible break in the SR service offer due to the stock shortage of contraceptives and sanitary protections as well as an increase in "unassisted childbirth" due to malfunctions in transport to reach the maternity wards. (UNFPA and UNWomen, May 2020)
- Burkina Faso is currently experiencing one of the most rapidly deteriorating humanitarian crises in the world, exacerbated by the COVID-19 pandemic. By April 2020, the number of IDPs had risen to almost 848.000; 84% of whom are women and children. 2,2 million people are in need of humanitarian assistance. (Oxfam, May 2020) 2500 schools were already closed due to the growing insecurity, while some lockdown measures have been gradually lifted, schools only reopened for students who must pass a national exam at the end of the school year. (Plan International, June 2020 and UNICEF, June 2020) The massive de-schooling of girls, associated with the loss of livelihoods are all factors that contribute to an increase in domestic violence, abuse, child marriage and child trafficking. This situation has also undermined the economic situation of women and girls as providers for families, exposing them to exploitation and child labour. The analysis of Plan International's GBV sub-cluster and the data collected from the most vulnerable people in Burkina Faso converge to indicate that more than one million women and girls are faced with an increase in SGBV and lack of access to basic social services due to the coronavirus pandemic and the conflict. (Plan International, July 2020) In June, about 1,178

[37] GPC sitrep June 2020, https://www.globalprotectioncluster.org/2020/06/30/covid-19-protection-risks-responses-situation-report-no-6-as-of-30-june-2020/

people have had access to a safe and accessible channel to report sexual exploitation and abuse. (UNICEF, June 2020) Yet, the pandemic and its repercussion are still limiting victims' access to essential protection services, safe reporting mechanisms and justice systems. Women and girls are unable to access essential SRHR services and information, including comprehensive sexuality education. This is being exacerbated by the closure of many clinics, disruption in supply chains for contraceptives and anti-retroviral for those living with HIV. (Plan International, July 2020)

- In Niger, 1.2 million children and young people were pushed out of school at the peak of the restrictive COVID-19 measures, bringing the total number who were not receiving an education to 3,8 million. (UNICEF, June 2020 and Save the Children, July 2020) While the government decided to reopen all schools bar preschool classes on the 1st of June for a period of 45 days, vulnerable children and particularly girls are at risk of massive, long-term de-schooling. Many of Niger's out-of-school children did not have access to distance learning, weakening their chances to catch up and go back to school, pushing girls and adolescent girls to participate in the informal economy exposing them to child labour and child trafficking. (Save the Children, July 2020) In times of crises, families are also forced to consider child marriage as a strategy to cope with economic hardship. Plan International's research on adolescent girls in crisis in the Sahel identified that ECFM occurs to protect girls from violence or non-marital sex, and to keep families out of economic need if parents cannot afford to provide for their daughters. Reported incidences of GBV cases in Niamey more than doubled between January and April 2020, rising from 81 cases in January to 212 cases in April. (Plan International, July 2020) SGBV survivors currently face increased barriers to accessing protection systems and health services due to lack of mobility and the diversion or withdrawal of necessary funding and resources for SRHR services, including psychosocial support. Pregnant women and pregnant adolescent girls are particularly at risk if they cannot access critical maternal health information and services. During the 2014-2016 Ebola outbreak, maternal mortality increased by an estimated 75%, demonstrating the potential negative impact of the COVID-19. (Plan International, July 2020) New displacements are triggering tensions between IDPs and host communities as the displaced are perceived to spread the virus.[38] It is also reported that misinformation is spread by armed groups[39].

2.2.3.3 Protection and social impact in the Middle East

Lebanon and Jordan are hosts to the highest number of refugees by inhabitant in the region, mainly welcoming Syrian and Palestinian refugees. COVID-19 and its consequences have particularly impacted the most vulnerable individuals such as displaced women and girls, already living in fragile context, leaving them with no safety nets and exposing them to further forms and risks of abuse and violence.

- Recent trend analysis in Jordan showed that the rate of harassment and cases reported to the Family Protection Department has increased notably. (Plan International, July 2020) COVID-19 crisis is having a disproportionate impact on girls and young women in the most deprived communities, placing them at greater risk of SGBV and leaving the vast majority unable to earn an income. The pandemic has turned the education, and livelihoods of vulnerable children upside down, and this loss of mobility and personal power places them at great risk of exploitation and abuse such as child marriage and child labour. (Plan International, May 2020) In a recent study run by Plan International, 69% of respondents

[38] GPC sitrep June 2020

[39] Ibid.

agreed that SGBV has increased since the pandemic started, both within refugee camps and among host communities. Emotional, physical and domestic abuse were the most commonly reported. (Plan International, May 2020) Access to SRHR services and information, as well as safe reporting systems has also been limited due to the COVID-19 as The Azraq refugee camp's safe spaces for women and girls, run by the IRC with support from UNFPA, have been closed, leaving refugee women with little or no support. (UNFPA, April 2020)

- In Lebanon, COVID-19 mitigation measures have exacerbated an ongoing economic crisis. Since the 4th of August's double blast, women and girls are now battling hunger and facing increased risk of abuse, violence and poor hygiene. Across the country, refugees now make up 20% of Lebanon's population. They were already some of the worst affected by the economic crisis, as they already lack resources or a steady income. On top of this, many were living in temporary shelter and tents even before the explosion. (CARE International, August 2020) Such situation is exposing vulnerable individuals to abuses such as child labour and exploitation. Challenging social and economic conditions among displaced populations have been associated with an increase in harmful practices such as child marriage. (UNFPA, August 2020) An increase in SGBV is also expected, particularly among women refugees, who have less access to legal services to protect them. (Care International, August 2020) Women survivors in Lebanon are required to self-isolate or provide medical proof before being admitted into shelters. Though certain SRHR services and reporting systems are now available remotely, access to online services remains a challenge for many women and girls with limited access to the Internet or telephone. (UNWomen, July 2020)
- In Gaza, oPt, there is an almost total absence of face-to-face interaction and access to life-saving gender-based violence and child protection services. Several SGBV service providers in the oPt report an increase in the number of cases and calls to hotlines have reached quarterly averages within weeks. Most concerning is the increasing reports of high-risk cases including suicides and attempted suicide linked to domestic violence. Lockdown measures and restrictions in place limit access to services and information. Actors on the ground need to find new ways of working to respond to protection challenges, as many individuals have inadequate internet access or technology to access online services.

2.2.4 Stakeholders mapping

Stakeholders	Details and status (supporters/ beneficiaries/ Implementers/blockers)	Stakeholder analysis
Government, ministries and agencies	**Supporters**	BAHIA and its partners will coordinate with relevant authorities to ensure good acceptance of the project, avoid duplication and reinforce existing initiatives and infrastructures. Local authorities are key stakeholders in enabling or restricting humanitarian access.
Communities	**Supporters - Beneficiaries**	They represent community groups, such as women and youth, refugees and host communities, ethnic groups. Target groups might include women's associations, youth groups, savings and credit cooperatives, etc. They are an important entry point to engage

		traditionally less powerful groups in community engagement processes, project design, implementation, monitoring and evaluation.
Local NGOs	**Supporters - Implementers**	National and local NGOs have been responding to emergencies in various countries. Implementation of the project will be completely/partially done by local partners in the areas of intervention and they will be engaging community-based groups and organisations. Depending on the needs, some capacity building initiatives will be set up to strengthen their response capacities.
International NGOs	**Supporters**	International NGOs working on humanitarian crisis and COVID-19 response have been involved in responding to emergencies and coordination with them will be set up.
UN agencies and multilateral organisations	**Supporters**	BAHIA will take part to meetings including UN agencies and multilateral organisations, as clusters for example. The objective is to ensure coordination and complementary, and avoid overlapping in implementation, targeting, resources mobilisations, etc.
National and local companies	**Supporters**	Some private sector companies have a social responsibility agenda that could be used to mobilise resources to strengthen communities' resilience.
Local media	**Supporters – Implementers**	Written press and local radio journalists are key partners in publishing and broadcasting sensitization messages for community mobilization. It can also influence both policy and practices at local, national and international levels.
Armed groups	**Blockers**	Armed groups might negatively influence security situation at national and regional levels.

2.3. Please summarise the results of the assessment (if necessary, append a comprehensive report) by establishing a link to the action

The action proposed by BAHIA will focus on the three most outstanding needs presented in the section 2.2. The first axis aims to continue to curb the pandemic by sustaining the Public Health sector. The second axis aims to address the social-economic impact and tackle poverty by investing in Food, Livelihoods and Economic recovery. The third and last axis assists in the Protection of those people and communities who felt the repercussions of quarantines, bans and movement restrictions on their personal and communal safety. A gender/age/disability-based approach and focus on the localization of aid run as two transversal themes throughout the response, and will be further addressed in sub-chapters 5.1, 5.2 and 5.3.

1. Public Health

BAHIA members will implement several activities under different approaches in order to cater to these previously exposed needs as follows:

1) Increase the capacity of response towards COVID-19 by reinforcing the current response and the IPC measures:
    - By carrying out assessment and supporting health structures on their IPC needs and patient management circuits, PPE and protocols;
    - By increasing IPC measures at community level through IEC campaigns and making IPC material available;
    - By building capacity both at health workforce and community level.
2) Reinforce the health system:
    - Through rehabilitation of structures;
    - Through training of health care providers;
3) Contribute to the further development of people's resilience:
    - Through IEC campaigns;
    - By ensuring that contingency plans are inclusive and have sufficient coverage with regards of the population.

BAHIA members will also adopt a Community-centered Public Health Promotion ie. water and sanitation approach which will be taken forward as follows:

a) Understand communities' perception of the disease and the response 1) using digital and interactive solutions including social media and radio programming to advocate on the behalf of communities in fora they cannot access on their own and 2) adapt the project based on the feedbacks shared by communities, connecting with local actors and decision-making fora;
b) Support local solutions and capacity to prevent and reduce the infection risk which are inclusive and safe: 1) train local stakeholders and community-based volunteers, 2) support and fund community action plans, 3) develop/adapt information and communications strategies to minimize gender barriers to accessing information on humanitarian response for the epidemic,
c) Undertake tailored public health promotion activities to support people in adopting positive hygiene behavior and provide access to essential hygiene items and services;
d) Increase and ensure adequate and safe access to water and sanitation facilities and services at community and health centre level and in schools, quarantine and isolation centres and areas:
    - through the installation and/or rehabilitation of water points in crowded public spaces, transportation hubs and/or health, transition or quarantine centers and/or schools;
    - through the installation and/or rehabilitation of universally accessible handwashing stations equipped with soap wherever most needed;
    - through the provision of hygiene kits and/or cleaning materials

2. Food security, livelihoods and economic recovery

The COVID-19 pandemic is not only a health issue. It's a profound shock to societies and economies with a direct impact on people's capacities to satisfy daily dietary needs and continue their livelihoods activities, as explained under section 2.2. To address these needs, BAHIA will apply a range of intervention strategies to protect basic needs and livelihoods. These interventions have a dual focus:

1) Deliver immediate emergency response to cover urgent food and livelihood needs in affected communities:

- Through the provision of multipurpose cash and voucher assistance (CVA) or in-kind aid to support the most vulnerable to meet their basic needs, prevent assets depletion and protect livelihoods activities;
- Through the provision of cash-based assistance for housing related needs (rent, utilities, etc.) and maintenance of livelihoods ;
- Early warning and early response (via the crisis modifier) in case of new upcoming disasters (eg hurricane season) to enable people and humanitarian organisations to take early action to protect lives and livelihoods, whilst applying a “do no harm” approach by applying preventive measures to reduce the risks of spreading the virus through the emergency assistance delivered.

2) Contribute to the early recovery for those livelihood-strategies that were seriously affected by the COVID-19 pandemic:
   - Provision of basic start-up cash grants of in-kind inputs to restart livelihoods or create new micro-small and medium-sized enterprises;
   - Business orientation and individual coaching to facilitatee adaptation to current labour and market needs;
   - Setting up and strengthening market linkages between local, small business and consumers to support economic recovery and market functionality;
   - Facilitate access to loans for individuals, groups, small/medium businesses and restoring community-based microfinance systems (saving groups, mother clubs, …);
   - Provide assistance to affected communities to restore production and secure the upcoming campaign (e.g. inputs for farming, animal health, fodder production, fishing assets, etc).

3. Protection and social impact

To address the above-mentioned protection needs and social impact, BAHIA will:

1) Support community-based protection actions established by community protection structures, as well as new safe self-protection strategies spontaneously adopted by community members or groups, for example by:
   - Putting in place alternative to, or safety measures for, meetings, outreach visits and face-to-face interactions;
   - Provide technical support to communities in the development of community protection plans and contingency plans, capacity building;
   - Support communities’ isolation and solidarity strategies as there is a need to strengthen social cohesion, challenge stigmatization and mitigate potential incidents of violence. Support isolation strategies could counter domestic/intimate partner violence or child or elder abuse;
   - Support existing community-based protections actors to adapt and maintain their existing work not directly related to COVID-19. For example, this includes work on preventing eviction, supporting legal status, access to clinical care, child protection services and family tracing, safe, timely and confidential access to medical, psychosocial and legal services;
2) Ensure a safe access to quality information that may be essential to communities’ survival and coping mechanisms, as well as to avoid the stigmatization and further marginalization of certain groups by:
   - Informing and awareness-raising on the pandemic;
   - Assessment of referrals services, information and awareness-raising on it and how to access them safely;
   - Information on how to use certain technologies and communication devices to ensure remote programming is inclusive;

3) Ensure access to adequate resources and materials for communities' protection:
    - Provision of certain technologies and communication resources (phones, phone credit, Wi-Fi hotspots, etc.);
    - Resources necessary for the implementation of specific community-based protection activities, including cash. Different types of resources will be provided and could also include concerted action with other field clusters to compensate for the lack of access to livelihoods and basic needs;
    - Provide to the most vulnerable spaces and/or peer support groups;
    - Reinforcement of activities related to the management of SGBV survivors and mental health.

To ensure sustainability of the project's achievements, if a sudden crises arises, leading to acute humanitarian needs which are not directly COVID-19 related, members of BAHIA will evaluate its potential impact and if needs coming from it must be addressed through adapted activities. Support to other disasters whilst respecting all precautious measures will help to limit further spread of the virus.

2.4. [FIN] If changes have taken place in the needs assessment following the interim report, please provide information

3. HUMANITARIAN ORGANISATION IN THE INTERVENTION AREA

3.1. Presence of the humanitarian organisation in the intervention area: brief overview of the strategy and current or recent activities in the country

Humanity & Inclusion (HI)

HI has operational teams in the three priority zones of the DGD, where it has implemented comprehensive intervention tackling both emergency and development challenges and needs, and where it has developed a sound understanding of the local context, humanitarian issues and community acceptance as well as anchoring.

Indeed, HI has been present in the Sahel since 1991 (Burkina Faso) and now carries out interventions throughout the Sahel region since 2013 in 4 countries (namely: Burkina Faso, Mali, Niger, Chad) in a broad intervention framework including the three strategic pillars of intervention of this project – including emergency COVID-19 intervention. In Burkina Faso, the area of intervention was expanded in 2019 to meet the growing needs of IDPs. In Chad, a project funded by the DGD until March 2020 made it possible to do a mine clearance and release land to Chadian populations through the use of new technologies (UAVs, mobile data collection interface, etc.).

In addition, HI has been implementing projects in the Middle East since 1991. Today, HI is intervening in 6 countries of the region (Iraq, since 1991; Lebanon, since 1992; Palestine, since 1996; Jordan, since 2002; Egypt, since 2007; Intervention on Syria crisis since 2012). HI mainly provides support to local communities, organizations and institutions in the areas of Health, Protection, Inclusion, Economic recovery and Livelihoods, notably through DGD funding (in Iraq, Palestine and Syria) but has also developed more specific responses on Livelihoods and Economic recovery. Since March 2020, HI also provides support to the populations affected by the COVID-19 pandemic in the region. Notably, in Syria an emergency response project is responding to the three pillars of intervention of this project, as well as strengthening the transport (ambulances) and referral services for COVID-19 cases.

Finally, in the Great Lakes Region, HI has developed activities since 1994 (Rwanda) and has gradually expanded its areas of intervention (DRC, since 1995; Southern Sudan, since 2006; CAR, since 2016; Uganda, since 2017). HI supports the most vulnerable people with basic

(WASH, Livelihoods, etc.) and more specific (Psychosocial support, Physical rehab, Protection, Inclusion, etc.) needs. Thus, HI has regularly collaborated with the DGD in the framework of humanitarian and longer-term interventions, for instance, HI and DGD have signed a framework agreement in Rwanda covering the period 2017-2021. Partnerships with Plan International, the Belgian Red Cross and Doctors of the World Belgium have moreover enabled the implementation of several projects in Uganda (Plan International), DRC and Rwanda (Belgian Red Cross), and CAR (DOW/MDM-B). HI has adapted its activities in these countries to provide assistance to the populations affected by COVID-19. In order to coordinate and supervise the implementation of its activities, HI has Coordination offices in each of the capital of the mentioned countries and Operational offices in the project intervention areas.

Caritas

The Caritas Confederation is present in all countries of the world (with a few exceptions). Caritas-Belgium maintains close relations with its partners in Sahel and Great Lakes regions and is operationally active in Niger, Burundi, and the DRC. Part of the funds could be allocated there. Caritas Belgium will favor a response in the Middle East, an area with which it maintains solid partnership relations, and in particular in Lebanon which is affected not only by the consequences of the COVID crisis but also by a socio-economic crisis of great concern. Several considerations to justify this priority:

- Politico-socio-economic crisis which, already before the emergence of the COVID-19, led the majority of the population (natives, migrants, refugees alike) in an unprecedented spiral of impoverishment;
- The unpredictable nature of this situation, with, however, a virtual certainty that the year 2021 will not see any significant improvement, probably on the contrary, with a high possibility of total collapse of the State and / or of civil unrest that could even impact the regional situation;
- COVID crisis which occurs in a declining public health context (with certainly inadequate testing capacities), and whose economic consequences are further aggravating the households' livelihoods and circumstances;
- Needless to say, the impact of the recent blast in Beirut and its consequences in terms of damage and needs, makes it even more urgent to respond there, taking into account the unprecedented humanitarian challenges in the context of the Covid crisis
- Caritas-Lebanon is recognized as one of the main local humanitarian actors in the country by national authorities, UN agencies, other international or local humanitarian actors, with 50 years of experience in the fields of humanitarian emergency, health, social work, protection and development. Caritas Lebanon has a team of 650 staff and over 2800 volunteers, with an annual budget of USD 30 million.
- Quality partnership relationship with Caritas-Belgium, uninterrupted for several decades
- Proven experience in the design / implementation / accountability of publicly funded programs (currently ongoing programs with UNICEF, UNHCR, ECHO, DGD, Embassy of Belgium, other European governments, etc.)
- Caritas-Belgium, drawing on its private funds and donations, has already transferred 50.000 Eur to Caritas Lebanon to support their Early-Response Project after the blast.

Oxfam

Oxfam is an international confederation of 19 organizations working with partners and local communities in more than 90 countries. Oxfam's goal is to help create lasting solutions to the injustice of poverty. It is part of a global movement for change, enabling people to create a secure, just and poverty-free future. Oxfam's COVID-19 response is based on two pillars: communal and locally led public health response, and social protection.

Drawing on learning from Oxfam's responses to public health emergencies with a strong community engagement component, in combination with existing knowledge and expertise in gender, public health promotion, water and sanitation, community-based protection and digital technology, Oxfam works to ensure that poor, vulnerable and marginalized people are protected against the impact of COVID-19. In partnership, Oxfam will ensure a response that will contribute to the effective prevention and reduction of COVID-19 infection risk on the most vulnerable through trusted, clear and effective communication and meaningful engagement within targeted communities; reduce protection threats linked to COVID-19 and increase access to emergency and protection services, strengthen referrals relating to child protection, gender-based violence and legal assistance; advocate for a global emergency plan for public health to save lives now, rapid and flexible funding mechanisms for local organizations, and non-discriminatory response.
Oxfam also implement a gendered and inclusive social protection and livelihoods approach, working remotely with mobile technology, such as mobile cash and voucher and remote monitoring, and working with and through remote partnerships. The overall goal of Oxfam' Social protection response is to ensure that households can safely continue to access their food and other basic needs (goods and services) in order to save lives and protect quality of life. This will be achieved through mass and immediate social assistance; appropriate support to particular vulnerable groups to meet their food and basic needs and subsequently support recovery of their livelihoods; advocacy from national to global level for massive welfare investment through income support, equitable subsidies for lost wages and calls for debt relief, amongst other request.
Oxfam has worked in the Middle East and North Africa (MENA) region for over 40 years, applying the full range of our mandate - from humanitarian relief to transformative gender programming. Oxfam currently works in 11 MENA countries (Morocco, Algeria/WESA, Turkey, OPTI, Iraq, Lebanon, Jordan, Syria, Yemen, Egypt, Tunisia). For over 50 years, Oxfam has been working in the Horn, East, and Central Africa (HECA) region, implementing its programs in ten countries: Burundi, DR Congo, Ethiopia, Kenya, Rwanda, South Sudan, Somalia, Sudan, Tanzania, and Uganda. Oxfam is also active in the Central African Republic. Oxfam is active in Sahel since 1966 (Tchad) and further extended the response to Mali, Niger and Burkina-Faso, carrying out humanitarian and development projects and programs.
In those three regions, Oxfam has a strong experience in implementing projects funded by the Belgian Cooperation (D3 Development, D5.1 Humanitarian and D5.2 Transition).

Plan

Plan is a global organization that strives for all children to have the opportunity to lead, learn, decide and thrive by following a rights-based and gender-transformative approach. Plan is present in over 75 countries, working alongside communities on the following issues to advance children's rights and equality for girls: responding to humanitarian crises (be it rapid onset, protracted crises, conflict contexts), empowering adolescents and young people to be active drivers of change, keeping children safe from all forms of abuse, exploitation and other forms of violence, supporting young people to learn skills and become self-reliant including get decent jobs in order to reduce vulnerability, giving young children the best possible start in life through early childhood care and primary education, improving maternal, neonatal and child health as well as the sexual and reproductive health of young people. All actions implemented by Plan and its partners aim at addressing the root causes of gender inequality and empowering adolescent girls and young women to claim their rights including in emergency contexts. Under COVID-19 context, Plan re-oriented funding streams to fund the response to the pandemic and its consequences, focusing on supporting the delivery of health and WASH kits, cash and voucher assistance for food security, including menstrual hygiene management, strengthening protection mechanisms and supporting distance education, targeting IDPs, refugees, vulnerable host communities.

In Sahel, Plan has presence in Mali and Burkina Faso since 1976 and in Niger since 1998, with a dual mandate in all countries - both development and humanitarian. As a result, Plan can make the most of a long-term community-level presence across regions affected by the crisis that guarantees reliable access to communities. In all three countries, the COVID-19 response plan focuses on preventing the transmission of COVID19 and reducing the social impact within the most vulnerable communities, especially in IDP settings, with a specific attention towards girls, adolescent girls and young women who are disproportionately affected. In Mali, Plan is operating in Timbuktu, Mopti, Gao areas; in Burkina Faso, Plan is operating in Centre-Est, Centre-Nord, Est, Nord, Sahel regions; in Niger, Plan is operating in Tillabéri, Dosso, Diffa.
In the Great Lakes, Plan has presence in Rwanda since 2007, in Uganda since 1992, in Tanzania since 1991 with a response established in Kigoma region in 2015, with also a dual mandate humanitarian / development. All three countries' responses focus on refugee settings and surrounding vulnerable host communities. In all three countries, the COVID-19 response plan focuses on preventing the transmission of COVID19 and reducing the social impact within the most vulnerable communities, especially in refugee camps, with a specific attention towards girls, adolescent girls and young women who are disproportionately affected. In Rwanda, Plan is operating in all six refugee camps (Burundian and Congolese); in Uganda, Plan is operating in West Nile (South-Sudanese refugee response); in Tanzania, Plan is operating from Kibondo with satellite offices in the Nduta and Mtendeli refugee camps.
In MENA, Plan has presence in Lebanon since 2017 and in Jordan since 2016, with a dual mandate. Both countries focus on addressing the needs of Lebanese and Jordan children as well as refugee children (strong presence in Azraq camp), with a focus on adolescent girls and young women, working on child protection, SGBV and worst forms of child labour. Plan conducted mutli-sectoral needs assessment in April 2020 to document the impact of COVID-19 on vulnerable children and communities and established a response plan focused on children, adolescent and youth, particularly girls, to continue to be protected and access life-saving services.

Belgian Red Cross

The 2 entities of the Belgian Red Cross (CRB and RKV) are part of the worldwide Movement of the Red Cross and Red Crescent. As Partners National Societies (PNS), we support local national societies who are in charge of the implementation of the operations in their own country. We work together in a strong and long-term partnership with our local partners in Africa, in close coordination, complementarity and mutual support with the different entities of the Red Cross and Red Crescent Movement involved in the country (IFRC, ICRC, PNSs).

Belgian Red Cross - French Community (CRB)

CRB has a long-term presence supporting local national societies in French speaking Africa, namely Mali, Niger, Burkina Faso, DRC, Rwanda, Burundi, and more recently Benin and Senegal. We support the implementation of long term multisectoral resilience programmes in all these countries, coupled with long term accompaniment to achieve capacity building and organisational development of the local partners. We also support humanitarian activities through funding of live saving operations and building local partner's capacities to prepare and respond to crisis. In the context of the COVID-19 response, we adapted all our ongoing programmes to the new situation to insert specific COVID messaging and activities, we supported our local partners response plans with our own funds, and we seconded surge personnel to the IFRC in the Sahel to reinforce the coordination of the RCRC Movement response.

Belgian Red Cross - Flanders (BRC-Fl)

BRC-Fl has supported local national societies in the Great Lakes region since the 1990's, and currently has established partnerships and delegations in Rwanda (since 2003), Burundi (since 2007), Uganda (since 2009) and Tanzania (since 2017). The main fields of cooperation traditionally were blood transfusion, health (HIV/Aids, WASH and First Aid) and emergency relief

and rehabilitation. Since 2017, the start of the 5-year development programme “Rode Kruis-Vlaanderen helpt helpen: duurzame impact door inzet op zelfredzaamheid” , the focus lays on first aid and access to sufficient and safe water and sanitation. In the field of disaster preparedness, BRC-Fl is intervening in the Great Lakes region since 2016 with continued DP-programmes strengthening the response capacity of the National Societies and enhancing their capacities to use the cash-modality within disaster response. In the Middle East and North Africa (MENA), BRC-Fl has responded to the ongoing conflicts in Syria (2015-2018) and Iraq (2016) via our Red Cross Movement partners, with a focus on logistical support to the national Red Crescent organisations. Especially in Syria, major contributions to the upgrade of the national logistical hub in Tartous were accomplished with support of D5.1. The contributions of BRC-Fl have benefitted over 100.000 people in Syria and Iraq who have been served with in-kind distributions and cash-grants.

Médecins du Monde

Working in 65 countries worldwide, Doctors of the World - Médecins du Monde is an independent international movement of campaigning activists who provide care, bear witness and support social change. Through our 355 innovative medical programmes and evidence-based advocacy initiatives, we enable excluded individuals and their communities to access health and fight for universal access to healthcare. As an active member of this network, MdM – Belgium runs project in 12 countries, including Belgium.

Within the **Great Lakes region**, MdM network is mainly present in the Democratic Republic of the Congo in Kinshasa, South Kivu (Bukavu, Lemera, Bijombo, Itombwe/Minombwe, Kabambare – “*Hauts Plateaux*”) and Tanganykika (Nyemba, Moba), implementing humanitarian projects to provide access to healthcare (focusing on sexual and reproductive health) and protection of vulnerable populations (including survivors of sexual violence). In Kinshasa, MdM is the leader of a protection project for Children in Street Situations witt Reejer, a local partner. In Bukavu, MdM is partner of Dr. Mukwege (2018 Nobel Peace Prize winner and director of the Panzi hospital). As part of this partnership, MdM manages the service for Survivors of Sexual Violence at Panzi hospital. In “*Hauts Plateaux*”, a projects implemented in partnership with PIN addresses Nutrition, WASH and Primary Health care. In Tanganyika, MdM provides capacity building and access to health care for the victims of the ongoing conflict.

Within the **Sahel region**, MdM network is present in Niger, Burkina Faso, Mali, Mauritania and Senegal. On one hand, MdM implements humanitarian projects providing access to healthcare (with a particular focus on sexual and reproductive health and migrant population) and on the other hand, projects for the protection of vulnerable populations (including survivors of sexual violence - SSV) are carried out.

In Mali, MdM is present since 2002 and implements 2 humanitarian projects by supporting 45 health centres in Gao and Menaka region to reduce the morbidity and mortality of populations affected by the crises in Northern Mali by improving access to quality health care. In these projects, MdM provides: prevention through information (including COVID-19 IPC), education, screening and vaccination; quality health care at a community/proximity level for both sedentary and nomadic populations; continuity of care at a secondary level for referrals and complicated Severe Acute Malnutrition (SAM) cases; emergency response.

In Niger, MdM implements programmes supporting the public health system. In the municipality of Agadez, MdM care programme focuses on sexual and reproductive health among local populations and migrants in transit. MdM Belgium works in close collaboration with the Health District of the Commune of Agadez and the Regional Public Health Directorate, as well as the local NGO SongES on family planning issues. In the Tillabéri region, MdM is part of a Project to strengthening the resilience and social cohesion of vulnerable populations in the cross-border regions of Burkina Faso (Sahel region) and Niger (Tillabéri region). Carried out in health centres,

schools, associations, community spaces or in households, these activities are transmitted through numerous tools adapted to rural populations and intended to produce a change in behavior.
In addition to these onging projects, MdM implements COVID-19 IPC projects In Niamey, Agadez and Tillaberi region, to the most vulnerable people, especially young women and domestic workers, following MdM's networks SOP.
In Burkina Faso, MdM has partnered with the association Keoogo in Ouagadougou, which helps street children. The objective of this partnership is to allow them to once again consider a future off the street, in (re)integrating the school system, by reuniting with their families or – for the older – through vocational training. Keoogo runs several centres, in which the association offers health care, prenatal support or information and contraception. Some of the girls are pregnant or young mothers. Without this help, most of them would have no choice but to prostitution, which many did when Keoogo's employees have met them.

3.2. Ongoing actions and requests for funding submitted to other donors, in the same intervention area – please state how overlaps and double funding would be avoided

The list of actions and requests for funding submitted to other donors and performed during the project period will be included in the final report, depending on the countries and area selected in December 2020. To avoid double-funding, unique budget codes will be assigned to each cost line and expenditure will be carefully monitored on a monthly basis. Global output reporting guidelines will be used to ensure that beneficiaries are not double counted on the basis of similar thematic interventions from different donors.

3.3. [FIN] List the other operations performed by the humanitarian organisation or its implementation partners during the same period in this intervention area and describe how the risks of double funding were avoided

4. OPERATIONAL FRAMEWORK

4.1. Precise location of the action (please include a map making it possible to locate the project)

The project will be implemented in some of the following regions and countries: Sahel region (Mali, Burkina Faso, Niger), the Great Lakes region (Rwanda, Burundi, Uganda, Tanzania, DRC), the occupied Palestinian territory (Gaza and the West Bank, including East Jerusalem), as well as Syria, Lebanon and Jordan.

By December 2020, each member of BAHIA will fill in the grid "Definition of the intervention-Synergies-Process" (please refer to **Annex 3**) to detail the planned intervention (among others: country and more precise geographical area, type of activities and methodologies, beneficiaries, etc.) and develop a detailed concept note (please refer to **Annex 4 and Annex A** for the template) to be submitted to all members for their information. Choice of interventions will be needs based and take into consideration funding gaps and available technical support within each member of BAHIA. Each member decides where to intervene, with a maximum of two countries. Based on the above-mentioned grid and concept-note, a committee (composed by BAHIA members and the coordinator of the project) will identify the potential synergies across the interventions to ensure exchanges, coordination and collaboration, when relevant and possible. Sub-working groups will be set up as from January 2021 to discuss specific synergies and common topics, when relevant.

The option of not committing the entire envelope by December 2020 and to submit a second grid and concept note until May 2021 will be left to the members of the Alliance. Same process as in December will be applied. The objective is to leave the possibility to the members to react if a humanitarian situation is worsened due to COVID-19, or if there is an increased possibility to intervene (ex: vaccination campaign).
If a sudden crisis arises in one of the country of intervention selected through the CN process, following a humanitarian needs assessment, BAHIA members will have the possibility to activate a crisis modifier. The objective is to ensure sustainability of the action, avoiding that a sudden crisis impair the achievements of the intervention. The DGD will be informed when such a process is activated.

4.2. Beneficiaries

4.2.1 Total number of direct beneficiaries:

Total number of direct beneficiaries will be defined at start of the project and will be shared by each member through the Concept Note process.

4.2.2 Specificities of the direct beneficiaries (please specify, if possible, by referring to the groups as appropriate, e.g.: unaccompanied minors, people with disabilities, children, former combatants, etc.)

Direct and indirect negative impacts of the COVID-19 pandemic are to be expected (health, food security, socio-economic, protection, human rights) in particular for populations in vulnerable situations such as: women and girls, children, people with disabilities, displaced/refugees, the elderly and chronically ill. Thus, several risk groups are to be considered:

1) Those who have contracted the disease: in the context of the COVID-19 pandemic, it is imperative to identify COVID-19 cases, who can be distinguished according to the more or less severe reaction of the virus in them:
- People with risk factors for developing severe COVID-19 but symptomless;
- People with moderate symptoms without specific risk factors;
- People with moderate symptoms with risk factors that can lead to rapid complications;
- People with severe symptoms.

The members of the BAHIA and their partners will support the identification of the COVID-19 cases through screening in order to:
  - Reduce the mortality by referring/orienting to the appropriate health structures;
  - Prevent the spread of the pandemic by promoting hygiene to the households and communities surrounding these cases;
  - Reduce the negative impact of the pandemic on affected households by offering complementary services to individuals and their households.

2) Those who face barriers in accessing care services:
- The consequences for *unprotected workers and workers in the informal economy and food insecure people,* are immediate and dramatic at all levels, especially on their ability to cover their basic needs, including food security.
- *People with disabilities* are at greater risk of contact with the virus because they face higher exposure rates due to the need for close interactions with personal assistants/caregivers, increased risk of infection and complications due to underlying health conditions and socio-economic inequalities, including inadequate access to health care.
- *Women and girls* are also likely to be at greater risk of domestic violence due to the lockdown, increased caregiving burdens and disruption of protection mechanisms (incl. community-

based protection mechanisms, women and girls safe spaces, and protection service providers) and essential services (incl. SRHR, non COVID-related health services such as maternal and child health).

- *Children* who must adapt to school closures, which affect continuity of learning, the protective environment and access to basic services. This has an impact on their physical and psychological well-being, as well as on increased child protection risks, including domestic violence, child labour and teenage pregnancy.
- *Internally displaced people, refugees, asylum seekers, stateless persons and migrants* face an increased risk of exposure due to lack of emergency plans, poor living conditions, proximity of living spaces, increased difficulties in accessing available prevention materials, information and services.

3) Those at risk of developing a severe form of disease with high mortality among these groups:
   - *Older persons and those with chronic illnesses* are at greater risk of illness because of their limited resilience to shocks, and they face the inequities that their situation creates: difficulties in accessing services, loss of livelihoods, increased use of negative coping mechanisms, age discrimination, vulnerabilities to the risk of violence and/or abuse.

4) Those affected by sudden crises and disasters in the target zone of the project during the implementation period: those beneficiaries will be selected through community and local government identification methods, supported by an in-depth assessment based on pre-agreed selection criteria, which will be informed by the nature and location of the response.

The intervention will therefore take into account different vulnerability factors in order to provide assistance to the vulnerable groups of people detailed above and to reduce barriers in terms of access to essential services.

4.2.3 Mechanisms and criteria for the identification of the direct beneficiaries

The COVID-19 pandemic creates new vulnerability factors and thus new vulnerable groups. In order to target the population groups that are newly vulnerable in this context, the members of the BAHIA in collaboration with their partners will:

- Elaborate a rapid multi-sectoral needs assessment which will address most vulnerable groups as well as the priority needs that are not covered (number of people affected or at risk, most affected areas, most urgent needs, local/national existing responses, access to the communities, local resources for supply, etc.) ; this will be done through a variety of sources of information, particularly from communities combined with secondary data collection:
  - Interview with NGOs and with Cluster/Sectorial working Groups (OCHA)
  - Key informants interview at regional and local level,
  - Focus groups discussion,
  - Direct observation,
  - Stakeholders mapping.

- Once the project's target groups have been clearly identified, the members along with their partners will design an external communication strategy (targeting other actors, local partners, communities, etc.) on who the project will target and what activities will be implemented, as long as the disclosure of information is not harming the safety of the beneficiaries.

- Once the target groups of the project have been clearly identified, the places and modalities of identification will be defined in order to ensure that the activities that will be implemented target the people pre-identified, as well as the mechanisms that will allow to accompany them to the services they need to cover their most urgent and priority needs. For instance, the following criteria will be taken into consideration when selecting the beneficiaries according the proposed targeted sector:
    - *To identify/detect COVID-19 cases*: 1. People with risk factors for developing severe COVID-19 but symptomless; 2. People with moderate symptoms without specific risk factors; 3. People with moderate symptoms with risk factors that can lead to rapid complications; 4. People with severe symptoms; 5. People in contact with a suspected or confirmed COVID-19 case; etc.
    - *For secondary Health needs* (including WASH): 1. WASH: Data related to the presence of hygiene items at home and community levels, Sanitation data, etc.; 2. Psychosocial: People who have lost a relative due to the COVID-19, People with severe symptoms of COVID-19, etc.; 3. Access to health services; 4. Rehab: Washington group questions on disabilities, etc.
    - *The severity of the Food Security needs:* Food Consumption Score, Survival Strategy Index, Availability of agricultural inputs, etc.;
    - *For Cash distribution:* material vulnerability (presence and quality of furniture, level of income, type of job, type of habitat, etc.) and social vulnerability (disability, single women, unaccompanied children, elderly people, migrant/refugee, etc) will be taken into account.
    - For Protection issues, the tryptic Gender, Age and Disability will guide the identification of the most vulnerable populations, based on risks and needs assessments and community-based protection mechanisms assessments.

The full list of selection criteria will be developed at inception of the project by each BAHIA member following consultations and coordination with local actors and authorities, as well as other (I)NGOs in the areas of intervention.

4.2.4 Describe the scope of and the arrangements for the involvement of the direct beneficiaries in the development of the action

The principles of BAHIA members are based on the subsidiarity and participation of the direct beneficiaries which are the subjects of their recovery and development. This, during the design phase of actions and throughout the project implementation with participation mechanisms, consultations, complaints management and evaluations. To ensure a participatory approach, communities and beneficiaries will be involved at different stages of design, implementation and monitoring and evaluation of the project, in compliance with Core Humanitarian Standards 4 & 5. This will be achieved through regular consultations, community engagement and upscaling participation of women, youth and other vulnerable groups, through the establishment of age and gender responsive feedback mechanisms. At implementation stage, vulnerable groups will be engaged to influence the design of interventions, ensuring that it serves the groups according their needs. BAHIA will work closely with local partners to support community engagement approaches to identify vulnerable and minority populations and ensure that their views are represented, and their participation is actively encouraged in project activities.

In the COVID-19 context, two-way communication channels with communities will be strengthened to enable inclusive communication about the risks of the pandemic, community engagement, track rumours and address questions, which remain crucial for its containment and

for the success of the project. Risk communication will focus on behaviour change as COVID-19 can have a long incubation period and can be transmitted by apparently healthy individuals. In parallel, the management and information mechanisms of beneficiaries' feedbacks and complaints will be adapted to the lockdown and movement restrictions with the following measures:

- Establishment of remote communication channels with key interlocutors (focal points, community leaders, local authorities, etc.) to take or disseminate news, inform of false rumours, refer cases;
- Reinforcement of hotlines, if existing, allowing affected communities to join the Partners;
- Use of SMS/Bluetooth app to send grouped information;
- Use of remote means of communication such as radio to broadcast messages of community interest;
- Coordination with the other actors present in the intervention area to try to have unified communication methods and limit the number of communication systems in place. Coordination will also help to identify the most appropriate communication methods and the questions that people ask.

4.2.5 Other potential beneficiaries (indirect, catchment, etc.)

In general, through the communications made by the members of the BAHIA, the selected communities will have access to better information on the modes of transmission of the virus, the people most at risk, the protective measures and barrier actions, and the available services and their location. In addition, all those who have listened to the media on protection, stress management or inclusion of people with disabilities can also be considered as indirect beneficiaries of the project. Finally, beyond the direct assistance provided by the members of the BAHIA in collaboration with the various stakeholders, the capacity building component for humanitarian actors (in terms of managing their structure, improving the quality of their activities, raising awareness of ethical principles and inclusion, etc.) will allow for an improvement in humanitarian practices in the areas of intervention.

4.2.6 Direct beneficiaries by sector (refer to "ECHO's guidelines, Annex I", pages 26-29: http://ec.europa.eu/echo/about/actors/fpa_fr.htm)

Direct beneficiaries by sector will be defined at start of the project and will be shared by each member through the Concept Note process.

[FIN] In the event of a change, please provide information

[FIN] Estimate by type of beneficiary

Women:		… %,		Men:	(women + men total = 100 %)
Infants (aged < 5):	… %,	Children (aged < 18):	… %,	Elderly:	… %

4.3 Objectives, outcomes and activities

4.3.1 Operational overview of the action: logical framework (3 pages maximum)

Title of the action	Agile response by the Belgian Alliance for Humanitarian International Action to control the spread of Covid-19 and mitigate its multi-dimensional effects on humanitarian crisis			
Overall objective	Contribute to the preparedness and response to the primary and secondary impacts of COVID-19 on populations identified in the Global Humanitarian Response Plan.			
Specifc objective	Promote public health and support the protection of vulnerable populations from contamination to Covid-19 as well as increased protection risks while restoring their dignity and capacity to meet their basic needs.			
	Intervention logic	**Objectively verifiable indicators – *to be disaggregated by age and gender as well as disability whenever possible/relevant***	**Verification sources**	**Risks and assumptions**
Outcome 1: Public health	**Contain the spread of the COVID-19 pandemic through strengthened prevention and response capacities of communities, local and international actors.**	% of target population with adequate WASH services and hygiene practices % of target facilities (PHU, schools, markets) with basic WASH services functioning # of communities targeted # of health facilities and/or C-19 centers (quarantine, transition) supported # of schools supported	Activity reports KAP survey Baseline/endline	**Risks** The main challenges to implement the response include: • Border closures, import/export and port restrictions, fuel and commodity price fluctuations, and reduced commercial aviation and shipping operations affect the ability of partners to contract commercial service providers. • Delivery of COVID-19 essential response supplies is delayed due to ongoing global demand and shortages. • Travel restrictions, lack of transport options, and access impediments lead to slow or no response by humanitarian organizations. • Procedures are lacking in many aid organizations to change their operation and distribution modalities in order to reduce human-to-human transmission and limit public gatherings.
Output 1.1	Local, national and/or international actors reduce the spread of infection and build trust in the response through risk communication and community engagement (RCCE) approaches, including feedback mechanisms, mass communication and supporting community-led solutions. Activities and messages are adapted to specific groups notably children, elders and PWDs.	# of community leaders, influential people and IPC focal points identified and trained on IPC measures at community level # of people reached through health and hygiene social mobilization # of people reached through mass communication channels (radio, TV, social media) % of community feedback comments which are positive statements about the COVID-19 response (as a proxy for trust)	Activity reports Training reports Survey and review reports Planning documents Field visit reports Baseline/endline	
Output 1.2	Community-based disease control and health promotion are provided to the target population – facilities are adapted to specific groups notably children, elders and PWDs.	# of handwashing stations with soap set up; # of functional handwashing stations installed according to universal accessibility standards; # of sessions of sensitizations on the planning, design, building and monitoring of inclusive WASH facilities # of safe water points at public spaces, community or individual levels built up or rehabilitated # of community-volunteers trained in COVID-19 Community-based Health and First Aid (CBHFA) module # hygiene kits (could include storage materials) to individuals; # liters of antibacterial gel produced; # PPE kits to staff, partners staff, etc… # phone line set-up to provide recommendations on IPC at home		
Output 1.3	Transmission is limited through early identification and referral of suspected cases using community-based	# of volunteers trained in contact tracing, active case finding, screening, CBS (Community Based Surveillance); % of targeted number of contacts visited (contacted) per day; % of CBS alerts		

	surveillance, active case finding, and/or contact tracing	responded to within 24 hours; % of suspected or confirmed cases in target areas referred and captured through CBS activities # cleaning materials for home disinfection where people tested positive to C-19		• The full impact of the pandemic on the livelihoods and survival of the most vulnerable populations is not yet known; • Conflict being exacerbated by the crisis; new conflicts/internal violence and criminality may arise; • Covid-19 response operations to be perceived as discriminatory or negative by the local population or to be perceived as a vector of the disease. • Sudden crisis/disaster not COVID-19-related impair projects' achievements • Engagement with children, adolescents, youth and adult beneficiaries, their communities and other stakeholders can expose them to risks of abuse and other safeguarding issues; • Distribution of cash and voucher, food and NFIs, and provision of direct services to beneficiaries comes to similar SEA and safeguarding issues **Assumptions** • Markets are functioning • Governments not effect changes in policy in relation to participation of CSOs in humanitarian affairs • Collaboration and coordination with
Output 1.4	Health and/or C-19 quarantine and/or transition centers are supported to adapt to C-19 pandemic context, including PSS for health workers and rehabilitation for people with chronic diseases and COVID-19 cases WASH infrastructures of schools could also be upgraded under this component. as well as C-19 protocols, equipment…	# hygiene kits to supported centers # sterilisation and cleaning kits to supported centers # of PPE to supported centers (medical) staff # health workers trained (case management, referrals, SOPs for waste management, SOPs for dead bodies, SOPs for IPC activities in health centers, etc…) # health staff supported with MHPSS services # of vulnerable people enabled to access rehabilitation services % children reporting ability to perform improved hygiene practices at school	PDM Training reports Baseline/endline	
Outcome 2: Food security, livelihoods and economic recovery	**Preserve the ability of the most vulnerable and affected people to meet the additional food consumption and other basic needs caused by the pandemic, through their productive activities and access to social safety nets and humanitarian assistance.**	% Coping Strategies Index % Food Consumption Score	PDM Baselin/endline	
Output 2.1	HHs are provided with multipurpose cash assistance to address their basic needs.	# of households reached through cash assistance to cover their basic needs	Activity Reports Distribution lists Lists of businesses Baseline/endline	
Output 2.2	Small businesses are provided with small grants for their activity to rebound	# of businesses supported		
Output 2.3	HHs are provided with in-kind food distributions to address their basic needs. Individuals at quarantine and/or transition centers are provided with meals.	# of households reached through in-kind food distributions to cover their basic need # meals distributed to # individuals		
Output 2.4	HHs and/or cooperatives are supported with agricultural inputs (seeds and materials) to revive and/or strengthen subsistence activities	# of HHs supported # of cooperatives supported		
Output 2.5	The capacity of HHs and businesspersons to cope with economic shocks is strengthened	# of training sessions delivered # handbooks and materials produced	Sessions reports Attendance lists Training materials.	
Outcome 3: Protection and social impact	**Vulnerable affected communities have equal access to essential services and the most vulnerable people put in place mechanisms for protection and resilience in the face of distress and/or risk of violence and abuse.**	# of people who are vulnerable or in psychosocial distress supported through the provision of PSS and protection services # of safe spaces set up or supported # of beneficiaries accessing safe spaces supported % of survivors (or at risk) of violence who have experienced or are at risk of any form of violence, in particular SGBV, who self-report improved well-being and have received appropriate services. % of beneficiaries reporting improved coping skills, including the use	Baseline/endline	

		of positive coping mechanisms. % of community members / women and girls who report having relevant and sufficient skills and knowledge regarding SGBV and other protection risks		humanitarian actors, international donors, local authorities and technical services remain positive • International humanitarian actors are well accepted by local communities
Output 3.1	Mapping and assessment: Identification of protection risks, threats and concerns as well as at-risk/vulnerable populations; inclusive and accessible awareness raising on risks, protection monitoring	# Communication materials developed # awareness sessions # factsheet / briefing notes / key messages developed ; # information/awareness sessions on inclusion in COVID-19 responses # participants in the sessions	Activity reports Attendance lists	
Output 3.2	Identification, referral and case management: Facilitating safe and timely access to survivor-centred protection and emergency services	# persons externally referred/orientated # persons identified with psychosocial needs % of violence survivors reporting having benefitted from qualitative and safe services, respectful of their dignity # of communication equipment kit and/or MHPSS/Protection distributed containment kit # basic inclusive messages disseminated # inclusive messages developed in a participatory manner with beneficiaries	PDM Baseline/endline	
Output 3.3	Empowerment and promotion of vulnerable populations' well-being: Support the creation and/or reactivation of safe spaces to vulnerable and at-risk populations, including the provision of PSS services, life support activities, virtual and remote support...	# of menstrual and dignity kits distributed # of people supported thru Cash/voucher for protection # of persons who have accessed PSS support/Psychological First Aid # of persons who have benefited from personalised follow-up # of people who have had access to remote peer support spaces and/or groups ; % of SGBV survivors and beneficiaries at risk declaring having the psychosocial capacity *(agency, self-esteem and self-efficacy*) to enable their empowerment	PDM Baseline/endline	
Output 3.4	Promoting protective environments: Support (the continuity and/or reactivation of) community-based protection, including community sensitisation, preparedness and response management actions; support to local authorities thru capacity-building, equipment and materials to perform their role to protect the populations, advocate at local and/or international levels to remove barriers in access to protection and emergency services.	# community Emergency Preparedness, contingency and/or protection plans # training sessions # sensitization sessions; # of beneficiaries participating to at least one sensitization session % of community leaders declaring positive attitudes towards prevention of SGBV and any form of violence, and gender equality # advocacy-related tools and materials produced	Advocacy products Trainingn reports Attendance lists Baseline/endline	
			Prerequisites: Funding approved and contract signed	

4.3.2 More detailed information per outcome[40]

Based on the logframe, BAHIA members will select indicators and activities depending on their expertise and type of intervention. Working under the three outcomes is not compulsory as each member has a specific mandate. The lists of indicators and activities are not exhaustive and might evolve according to the context, the needs assessments and the MEAL tools to be developed at inception of the project.

4.3.2.1 Outcome 1: Public Health – Contain the spread of the COVID-19 pandemic through strengthened prevention and response capacities of communities, local and international actors

4.3.2.1.1 At the proposal stage

- **Sector:** Health
- **Related sub-sector:** primary health, secondary health, epidemics, reproductive health, mental and psycho-social support, GBV, community outreach, medical supplies, health infrastructures, capacity building (health)
- **Beneficiaries (status + number):** to be defined at start of the project
- **Indicators for this outcome:** please refer to the lists in the logframe under 4.3.1
- **Outcome-related activities:**

Output 1.1: *Local, national and/or international actors reduce the spread of infection and build trust in the response through risk communication and community engagement (RCCE) approaches, including feedback mechanisms, mass communication and supporting community-led solutions. Activities and messages are adapted to specific groups notably children, elders and PWDs.*

Activities may include:

- Adapt/translate existing risk communication and community engagement (RCCE) resources to local context and languages
- Perform RCCE trainings to staff, partners and volunteers
- Perform (rapid) community assessments to understand knowledge, attitudes, practices and perceptions around Covid-19
- Collect community-feedback (hotlines, Focal Group Discussions, social media, WhatsApp group, social mobilizers) to track, analyse and respond to community beliefs, rumours, questions and suggestions
- Perform social mobilization activities to reach community members with health and hygiene promotion for Covid-19 (household visits, interactive radio & TV shows, social media, mobile vans, …)
- Provide capacity training for community leaders and influential people on IPC measures at community level
- Identification of infection, prevention and control (IPC) focal points in communities
- Provide capacity training on a community level on IPC linked to COVID-19 including the correct use of PPE (masks, gloves, etc.)
- Create and disseminate IPC guidelines for home isolation
- Set up a phone line to provide recommendations on IPC at home

[40] For each result identified in the logical framework, more detailed information necessary for a proper understanding of the proposal/report will be gathered here. A specific sub-section per outcome at the proposal, interim report and final report stages has been provided for (please do not update the information of a previous stage in this section, please comment on the change in the appropriate sub-section for the outcome).

Output 1.2*: Community-based disease control and health promotion are provided to the target population – facilities are adapted to specific groups notably children, elders and PWDs.*
Activities may include:

- Establish and maintenance of handwashing stations in crowded and congested settings, rural areas, entrances to public buildings, transport hubs and other high traffic areas such as market places
- Provide sessions of sensitization to the partners and the staff on the planning, the design, the building and the monitoring of inclusive WASH facilities
- Procurement and distribution of soap
- Provide protective materials (PPE) to staff, partners and the community leaders and mobilizers (masks, gloves)
- Construction or rehabilitation and maintenance of safe water points in communities
- Distribution of hygiene kits to individuals, including cleaning materials for disinfecting homes with COVID-19 cases in isolation (bleach, gloves, etc) and drinking water (chlorine)

Output 1.3: *Transmission is limited through early identification and referral of suspected cases using community-based surveillance, active case finding, and/or contact tracing*
Activities may include:

- Rapid CBS assessment for expansion of current CBS system
- Training of volunteers on CBS
- Establish communication and engagement with communities related to CBS
- CBS activities and reporting
- Supervision of CBS activities and of data collection/reporting
- If requested by Government, involvement in screening or contact tracing activities by providing training, PPE and supervision to deployed volunteers

Output 1.4: *Health and/or COVID-19 quarantine and/or transition centers are supported to adapt to C-19 pandemic context, including PSS for health workers and rehabilitation for people with chronic diseases and COVID-19 cases. WASH infrastructures of schools could also be upgraded under this component as well as COVID-19 protocols, equipment…*
Activities may include:

- Carry out assessments to identify IPC needs in health centres, Covid-19 transition and/or quarantine centers and/or schools
- In health centers, Covid-19 transition and/or quarantine centers and/or schools, ensure basic access to water and sanitation for health (WASH)
- Set up a basic triage system in health centres following IPC COVID-19 measures
- Set up an isolation area for COVID-19 patients in health centres
- Set up a reliable referral circuit to transport suspected/confirmed COVID-19 patients to isolation or treatment centres
- Create SOPs for IPC activities in health centres Covid-19 transition and/or quarantine centers and/or schools (disinfection and cleaning, solid waste management, laundry, etc.)
- Provide IPC capacity training to health and non-health workers at health centres
- Identification of IPC focal points in health centres, Covid-19 transition and/or quarantine centers and/or schools
- Develop and implement a plan to monitor the health of workers at health centres, Covid-19 transition and/or quarantine centers exposed to suspected or confirmed COVID-19 cases
- Create a log and daily investigation report on workers at health centres infected with COVID-19
- Capacity training for workers at health centres on the correct use of PPE with regard to the type of activity carried out and specific IPC COVID-19 measures
- Provide capacity training on stress reduction for when full PPE is used

- Provide workers at health centres, Covid-19 transition and/or quarantine centers and/or schools with PPE
- Provide health centres, Covid-19 transition and/or quarantine centers and/or schools with materials for disinfection
- Set up an SOP protocol for the transfer of suspected or confirmed COVID-19 patients and disinfection of ambulances
- Set up an SOP for the management of dead bodies adapted to IPC COVID-19 measures
- Definition of safe circuits in health centres/hospitals (separate areas: red/green zone; suspected cases versus other patients) and capacity training for health workers and support staff on the correct use of the specific circuits
- Physical rehabilitation :
  - Promote the physical and functional recovery of COVID-19 patients (direct or through service capacity building)
  - Accompany/Strengthen/Promote the continuity of "non COVID-19" in rehabilitation services
- Psychosocial support to Health workers:
  - Provide psychosocial support to medical staff
  - Medical/paramedical staff and partners improve their capacity to care for their patients and/or beneficiaries

4.3.2.1.2 Final report

- **Indicators for the outcomes obtained**
- **Beneficiaries (status + number)**
- **Activities carried out**
- **Resources and related costs finally committed and incurred**

4.3.2.2 Outcome 2: Food security, livelihoods and economic recovery – Preserve the ability of the most vulnerable and affected people to meet the additional food consumption and other basic needs caused by the pandemic, through their productive activities and access to social safety nets and humanitarian assistance

4.3.2.2.1 At the proposal stage

- **Sector:** Food security and Livelihoods
- **Related sub-sector:** availability of, access to and consumption of food, short-term livelihood support, (un)conditional cash/voucher food assistance, food security information and analysis
- **Beneficiaries (status + number):** to be defined at start of the project
- **Indicators for this outcome:** please refer to the lists in the logframe under 4.3.1

- **Outcome-related activities:**

Output 2.1 *HHs are provided with multipurpose cash assistance to address their basic needs.*

- Map existing social protection schemes, assess feasibility of linking cash assistance with national SP
- Conduct Cash feasibility studies, market and need assessments to inform design options
- Implementation of a market and inflation monitoring system (evaluation, monitoring and follow-up): Regular monitoring of market prices and availability of key items will be held to provide information about effects of transfers on the market and take corrective measures, if needed.

- Supporting CVA (Cash & Voucher Assistance) capacity building to ensure that minimum requirements for a cash intervention are met
- Provide access to classroom or on-line trainings for CVA for targeted personnel and staff
- Establish participatory mechanisms to engage communities in planning selection and distribution processes
- Establish community feedback mechanisms to respond to questions and complaints
- Identification and registration of beneficiaries
- Contracting Financial Service Provider
- Unconditional/multipurpose cash distributions

Output 2.2 *Small businesses are provided with small grants for their activity to rebound*

- Identification and selection of core businesses to be supported
- Contracting Financial Service Provider
- Distribution of grants
- Follow-up with beneficiaries

Output 2.3 *HHs are provided with in-kind food distributions to address their basic needs. Individuals at Covid-19 quarantine and/or transition centers are provided with meals.*

- Identification and selection of beneficiaries
- Contracting NFI and food vendors
- Distributions of NFI and food

Output 2.4 *HHs and/or cooperatives are supported with agricultural inputs (seeds and materials) to revive and/or strengthen subsistence activities*

- Identification and selection of beneficiaries
- Contracting vendors
- Distribution of agricultural inputs

Output 2.5 *The capacity of HHs and businesspersons to cope with economic shocks is strengthened*

- Identification of trainers
- Training of trainers
- Developing training materials
- Delivering capacity-building sessions
- Mentoring and coaching sessions for follow-up

4.3.2.2.2 Final report

- **Indicators for the outcomes obtained**
- **Beneficiaries (status + number)**
- **Activities carried out**
- **Resources and related costs finally committed and incurred**

4.3.2.3 Outcome 3: Protection and social impact – Vulnerable affected communities have equal access to essential services and the most vulnerable people put in place mechanisms for protection and resilience in the face of distress and/or risk of violence and abuse

4.3.2.3.1 At the proposal stage

- **Sector:** Protection
- **Related sub-sector:** prevention and response to violence, documentation, status and protection of individuals, support to separate/unaccompanied children, GBV, protection information management and monitoring, protection information dissemination, protection advocacy, capacity building
- **Beneficiaries (status + number):** to be defined at start of the project
- **Indicators for this outcome:** please refer to the lists in the logframe under 4.3.1
- **Outcome-related activities:**

Output 3.1 *Mapping and assessment: Identification of protection risks, threats and concerns as well as at-risk/vulnerable populations; inclusive and accessible awareness raising on risks, protection monitoring*

- Gender and age responsive protection assessments (including rapid gender analysis) will be conducted in selected areas of intervention to identify inequalities, gaps and capacities and the specific impacts of the crisis on women, girls, men and boys and people living with disabilities (PWD) to design appropriate interventions to respond to gender, protection and safe programming gaps. This will involve remote (phone) consultations.
- Mapping of protection and emergency services; safety audit.
- Child protection rapid assessment (C19 related through use of technology and GBV saefty audits); Community-based mapping of risks and needs related to protection due to COVID-19 and associated confinement measures, led by youth with strong representation of adolescent girls and young women).
- Inclusion:
    1. Development of inclusive and accessible COVID-19 awareness-raising materials for at-risk groups ;
    2. Provision of Community Awareness & Dissemination of information / messages accessible and understandable for all ;
    3. Monitoring of risks of discrimination, exclusion, violence/abuse and barriers to access to services and production of papers to inform humanitarian advocacy
    4. Information/ awareness-raising of the COVID-19 response actors on the inclusion of vulnerable people in their interventions ;
    5. Capacity building and technical support to responders on the inclusion of people at risk in their interventions.

Output 3.2 *Identification, referral and case management: Facilitating safe and timely access to survivor-centred protection and emergency services*

- Capacity-building of service providers for age and gender responsive services (PFA for children, Communication with children and adolescents; best interest of child (assessments), comfort of children, confidentiality, non-discrimination and resilience));
- Identification & referral / case-management (identification facilitated through distributions of NFIs / cash) and psychological first aid by skilled and trained case-workers. Continue to Monitor CP/SGBV risk (CP monitoring) with a relevant link to SRHR. CP/SGBV data management. Prerequisite: staff must comply with global safeguarding policy of children, adolescents and youth.
- Support to other NGOs (international and local) to ensure mitigation measures are in

place to prevent violence against children and adolescents (e.g. support during distribution with adequate measures for vulnerable children and adolescents, set up of wash facilitates, adaptation of communication measures, set up of lightening system, how to refer...)

Psychosocial support to vulnerable people:

1. Develop Technical needs assessment, referral and/or remote referral of people at risk to external psychosocial and mental health care services. ;
2. Based on vulnerability criteria, provision of communication equipment and/or MHPSS/Protection containment kit to the most vulnerable people. ;
3. Provide Psychosocial support at a distance to the most vulnerable people, including those at risk of violence through New Information and Communication Technologies/ICT
4. Provision to the most vulnerable people, including those at risk of violence, of spaces and/or peer support groups for psychosocial and psychoeducational support, at a distance through NICTs
5. Implementation of mass awareness-raising on adaptation mechanisms MHPSS and protection ;

Output 3.3 *Empowerment and promotion of vulnerable populations' well-being: Support the creation and/or reactivation of safe spaces to vulnerable and at-risk populations, including the provision of PSS services, life support activities, virtual and remote support...*

- Reactivation (or creation) of child friendly spaces, youth / adolescent friendly spaces, Girls safe spaces with logistics/supply upgrade (COVID-19 measures);
- Provision of PSS;
- Key entry point for identification of protection cases
- Provide practical humanitarian assistance to help people stay safer. (E.g. solar lights, fuel-efficient stoves, emergency cash grants, etc.)
- Life skills and peer-to-peer support activities/network, including GBV prevention and dignity kits to girls at risk, SRHR and distribution of MHM kits;
- C19 child and adolescent friendly session
- Set-up of remote child and adolescent well-being activities (creating virtual safe spaces, remote PSS support, remote peer to peer groups....)

Output 3.4 *Promoting protective environments: Support (the continuity and/or reactivation of) community-based protection, including community sensitisation, preparedness and response management actions; support to local authorities thru capacity-building, equipment and materials to perform their role to protect the populations, advocate at local and/or international levels to remove barriers in access to protection and emergency services.*

- Capacity-building and reactivation of community-based protection mechanisms, including the preparation for remote support in case of future disasters or second wave of COVID-19 (incl. youth clubs, incl. girls & adolescent girls and young women).
- Community-based sensitization on protection, prevention of SGBV, promotion of positive parenting practices.
- Engage with caregivers to promote protective household environments. Adapt key messages and COVID-19 and disseminate all along with CP and SGBV information among community members through radio, home visits, community events (hotlines, numbers, service providers, e.g. psychosocial support, health centers, police stations...).
- Capacity-building and support to the relevant authorities to fulfil their protection role, working either on knowledge or attitudes, depending on specific and context-dependent stakeholder analysis. (Training, secondments, mentoring, practical assistance, etc.)
- Advocate to remove barriers in access to protection and emergency services

during Covid-19, including:

- maintenance of essential services;
- maintaining survivors at the centre;
- protective measures to be put in place at services;
- exemptions on movement restrictions;
- establishment of remote services where possible.

4.3.2.3.2 Final report

- **Indicators for the outcomes obtained**
- **Beneficiaries (status + number)**
- **Activities carried out**
- **Resources and related costs finally committed and incurred**

4.4 Work plan (e.g. annexed Gantt diagram)

Workplans will be developed at start of the project and will be shared by each member through the Concept Note process and the **Annex A**.

4.4.1 [FIN] Revised work plan in the event of changes following the proposal

4.5 Monitoring, assessment, auditing and other analyses

4.5.1 Monitoring of the activities (explain how, by whom)

The COVID-19 pandemic is characterized by the rapidity of its spread and by the difficulty to anticipate how the epidemic will evolve at country level. Considering this, a monitoring mechanism of the situation, of the needs and of the response activities is instrumental to rapidly adjust the interventions in the different countries.

In view of the current mobility constraints and the interpersonal contact restrictions, creative monitoring approaches will be applied by all members of the BAHIA. These will include remote monitoring through phone calls to key informants and households, and third-party monitoring.

Monitoring will be linked to real-time learning, enabling immediate action, adjustments and further improvements of the response. The monitoring framework includes two components:

- A situation and needs monitoring component to capture the fast-evolving expansion and contraction of the pandemic as well as the immediate and lagged effects on people's lives and livelihoods. The monitoring mechanism should also be able to identify new outbreaks in countries not initially prioritized in the Global HRP for Covid-19.
- A response monitoring component to capture the achievements of the collective response as well as the effectiveness of preparedness actions to respond to new occurrences or rapid deterioration.

Both components will be used together to decide on response adjustments as required, including the geographical scope of the program and types of interventions. Acknowledging mobility and access constraints, efforts will be made to disaggregate relevant indicators by gender, age, disability and, when appropriate, by other vulnerability and diversity criteria such as status of displacement.

Situation and needs monitoring

High-level situation and needs monitoring indicators are identified to capture the main changes in

the impact of the pandemic. More detailed indicators will also be collected by each organization according to the population, geographic and programmatic focus of their operations. Additional countries may be considered in the future based on broader monitoring at the global level.

Response monitoring

There will be two levels of MEAL framework:

1. For the global response of BAHIA: response monitoring indicators are identified to capture the progress and achievements of the BAHIA. The indicators are meant to follow the activities in a global manner for all members. They do not reflect all the components of the strategic priorities and specific objectives;
2. Additional detailed indicators will be collected by each organisation according to the population, geographic and programmatic focus of their interventions and in view of improving the specificity, measurability, and relevance of their action.

Proposed MEAL framework:

STEPS	WHAT	WHO	WHEN
1. Data Selection	The final indicators (outputs/outcomes; process; impact; quantitative and qualitative) will be defined for each member's intervention, paying attention to focus on standardized indicators agreed among all the members allowing for a consolidated analysis and a coherence with the logical framework	MEAL Officer MEAL Manager BAHIA coordinator	During the final needs assessment/Planning of each project.
2. Data collection	The members will define the most appropriate methods (including the sampling methods) for gathering the information needed to monitor the indicators in each intervention area. The sources of information to collect Data may include: Interviews, Focus on case studies, Post Distribution Monitoring, Observation, Pile ranking, Focus Groups Discussion, MSG & Timeline; Secondary sources; Stakeholders mapping; Feedback Mechanisms (Hot line numbers, Help desks, Community forum, Complaints boxes). In accordance with the principle of inclusiveness "leave no one behind", systematic collection of data will be disaggregated by gender, age and if possible disability. Data protection arrangements for beneficiaries will be strengthened and adapted to homework in order to ensure consent and security. Special attention will be paid to data collected in the most sensitive actions: management of protection and SGBV cases,	MEAL Officer MEAL Manager	Frequency to be defined according to the indicator (monthly, quarterly…)

	mental health and psychosocial assistance and identification of COVID-19 cases. The following measures will be put in place: ● Reinforcement of risk minimization measures when the sharing of sensitive information by phone or SMS is vital for the implementation of activities; ● Adaptation of data protection protocols and consent messages to the new means of communication ; ● Adaptation of data retention time and application of maximum-security precautions (limiting access, encryption, etc.). Verification of the legal data protection obligations of providers and mobile data services.		
3. Data entry	Database to ensure that activity and output monitoring results are immediately available for decision making. Keep accountability records complete for good management quality	MEAL Officer MEAL Manager	
4. Analysis and Interpretation	The analysis and interpretation of Data : - Should be participatory, including the beneficiaries and partners (Listen, Learn, Act); - Should be included in the action plan. <u>Quantitative data</u>**:** involves analysis of numbers; <u>Qualitative data:</u> consists of words, pictures, objects and observation, not numbers. The members will favor qualitative surveys in order to specify as much as possible the data analysis, quantitative data will also be collected to complete the analysis. Sampling strategies will be reviewed to target a smaller number of individuals. - The main outputs of the data analysis are: Regular MEAL reports, including a monitoring table with quantitative and qualitative indicators, in order to adjust the activities if necessary; Sitreps; Post-intervention monitoring; - Project review and lessons learnt workshop/report at the end of the Project. An analysis of the risks for the teams and communities will be systematically and regularly	Each MEAL Officer MEAL Manager	

	updated in order in particular to do not use data collection "at risk".		
5. Use of Data	**For Accountability:** Both towards the Donor and the beneficiaries. **For Programme Performance and Acting:** The analysis should define which actions are to be taken as a result of the lessons learned. This is related to project practices (activities, outputs) as well as to the monitoring system (new indicators, new data collection tools) **For Communication:** The means for communication vary depending on the intended audience: - Newsletters - Social networks - Reports. **For Learning:** The summary of data and answers highlights what works and what does not work in terms of activities, methods and policies. This may be recorded and used to improve the functioning of the Consortium and should be diffused to the NGO network and the scientific communities. Ex. Short videos on BPs	BAHIA Coordinator Communication Dpts	

While developing the monitoring and evaluation system, the following aspects are to be taken into consideration:

- The MEAL System should be light and dynamic to avoid heavy burden on staff;
- Clear and cost effective = not over complicated and understandable to both staff and project partners and should not require unnecessary reporting;
- Gender, Socially and Culturally sensitive and acceptable;
- Including unexpected consequences: the system should not assume that the Outcomes resulting from the project are limited to those anticipated. It should be able to record and analyse changes which were not anticipated.
- Open to alternative sources of information (both oral, visual and perceptions of persons not directly involved).
- Participative: the system should be based upon the participation of a wide range of stakeholders and the contributions of the various groups will be valued (linked to the stakeholder analysis completed in the planning phase).

4.5.2 Tick the boxes corresponding to the analyses that may be undertaken:

× External assessment during the action

□ External assessment after the action

× External auditing during the action

□ External auditing after the action

× Internal assessment or internal auditing relating to the action

4.5.3 Other analyses: × Please provide information:

BAHIA members and partners will ensure, individually and collectively, that the response is compliant with **principles** and **quality standards**:

- Individually:
  Each member (and its partners, when relevant) will be responsible to assess, monitor, and document its project(s) by collecting the above indicators. More specific indicators might be added according to the specificities of each local context and the nature of the response;
- Collectively:
  Whenever possible, for instance in the case two or more members work in the same geographical area, they will try to set up peer-review mechanisms that could improve the quality of their respective action, and eventually promote peer-learning and a collective effort of capitalization of lessons learnt. This will be done in consultation with the local partners.

Accountability

Each member (and its partners, when relevant) will set up "accountability to beneficiaries" mechanisms consistent with its usual quality standards and compliant with good international practice. In particular, *complaints and feedback mechanisms* will be organized and best practices and lessons-learned on how to set-up and manage those mechanisms will be thoroughly documented and shared among BAHIA members in order to feed into a collective learning process for the future. Where appropriate, timely action will be taken to respond to complaints and suggestions received from beneficiaries and to inform the community accordingly. The extent and modalities of involvement of the direct beneficiaries in the action are specified in section 4.2.3.

Safeguarding / Anti-corruption

BAHIA members and their partners will make sure to apply their safeguarding policies and mechanisms in order to prevent (or sanction, if need be) any kind of exploitation and abuse of beneficiaries by their agents. The *Complaint and feedback mechanisms* will help to report abuses, including sexual exploitation and harassment. They will also make sure that anti-corruption measures are implemented, in compliance with good international practice and adapted on local contexts. Training of staff and volunteers on these issues might prove necessary and if so, will be budgeted accordingly. Finally, documentation about these policies and their implementation will be shared within the group.

Learning

BAHIA members commit to implement regular learning activities and share experiences during the project's lifetime and after its evaluation. Thus, each project will have at its disposal a panel of methods adapted to its context to capture bad or good practices and thus promote continuous improvement. The Coordinator will play a key facilitating role in this, and design simple tools and

templates to enhance information sharing, as a project review and a lessons learnt workshop to provide a quick overview of practices to be improved, duplicated and to draw lessons for future projects. The outcomes of this learning process will be included in the projects' final report.

5 CROSS-CUTTING ISSUES

5.1 Please describe the expected level of sustainability and/or of connectedness[41].

The COVID-19 pandemic and its indirect socio-economic impacts are exposing strengths and vulnerabilities to shocks. Strong community structures, good public health policies and comprehensive social protection systems are paying off. Acute humanitarian needs arise where those structures stand weaker. By responding to those needs, we are gaining insight into where the regular systems lack the capacity to cope with today's risks.

The sustainability of the proposed intervention is largely shaped by its sensitivity to a nexus-based (5.2) and localized (5.3) response, which is explained in detail in the paragraphs here below. A couple of general elements that shape the sustainability of our intervention are worth mentioning over here:

- This project will address humanitarian needs but will invest in longer-term resilience at the same time, by investing in community health workers, in local water supply, in sustainable and diversified livelihoods, and in community-based protection mechanisms.
- Our recovery-efforts are meant to be as inclusive as possible. We want to invest in recovery that benefits the "last mile": those communities with the least access to the services they need and the most impacted every time a crisis hits.
- The members of BAHIA adhere to the principle of "do no harm", thus, while investing in resilience our investments should be "green". Even in the provision of immediate humanitarian support, localized market-based solutions will be preferred over imported relief supplies. But also in supporting the recovery of livelihoods and the capacities of health centres, solutions that take into account the effects of climate-change and that do not exacerbate unnecessary pressure on the natural environment, will be privileged and strongly encouraged.

5.2 Continuity strategy (links between emergency aid, rehabilitation and development)

COVID-19 is a health, humanitarian, and development crisis all at the same, with implications for peace and human rights. It is occurring in crisis zones with ongoing humanitarian operations, but also in developing countries with no pre-existing humanitarian crisis that are now putting in place such a response as well.

It is hard to make a distinction between the different kinds of responses that are required in all contexts. Humanitarian assistance is being used to provide medical treatment for those affected by the virus, but so too is development cooperation required to reinforce weak health systems in developing countries to cope with the disease outbreak. Development actors are meant to be leading the response to the socioeconomic impact, but humanitarian agencies are also implementing livelihood programs.

This dual approach is present in the three pillars of the intervention logic proposed by BAHIA. While (suspected, probable, confirmed, contact) Covid-19 patients will receive care, treatment, hygiene awareness and/or will be referred to external services, the capacities of health centers

[41] Sustainability and connectedness are similar concepts that are used to ensure that the activities are executed in a context that takes account of longer-term and interconnected issues.

will equally be reinforced on the longer term through training of staff and the development of SOP's. Immediate food and other basic needs will be met alongside investments in the structural recovery of livelihoods through f.e. vocational training or the provision of agricultural or entrepreneurial inputs. At-risk populations will be protected against immediate (health) risks and indirect risks related to COVID-19 and its associated measures (lockdown, restriction measures) and will be empowered and supported to promote inclusive protective environments.

5.3 Integration (e.g. reduction of disaster risks, children, human rights, gender equality, environmental impact, others to be specified)

Though the response to COVID-19 integrates many cross-cutting elements, BAHIA choose to put special emphasis on two in particular: gender and the localization of aid.

Gender:

Pandemics have different impacts on women and men. From risk of exposure and biological susceptibility to the social and economic implications, men and women experience this crisis in a different manner. The virus and its social and economic consequences lead to heightened risks of abuse, neglect, violence and exploitation for vulnerable populations such as women and girls and while the access to essential services has been negatively impacted too. With women and girls globally experiencing unacceptably high levels of violence, GBV is a shadow pandemic. The BAHIA members will therefore design and implement their interventions by using a gender-sensitive or gender-responsive approach to address specific vulnerabilities and needs. This approach is visible in multiple ways:

- We strive towards a meaningful participation of women and girls in all phases of the project management cycle, from assessment and design to implementation and evaluation;
- We strive to collect Sex-Age-Disability disaggregated data to measure the outcomes and outputs of our interventions, in order to assess the appropriateness of the response for women and girls;
- We understand that access to sexual and reproductive health and rights for women and girls may be reduced during the pandemic and will support the maintenance of acceptable access to those health services ;
- We understand that women make up 70% of the global health workforce and are consequently at high risk of frequent exposure. We aim to ensure equitable access to relevant training on IPC-measures and access to gender-sensitive PPE and essential products for hygiene and sanitation.
- We are aware that violence against women and children increases during lockdowns and as a consequence of loss of livelihoods and harmful social norms and will include services that prevent and address gender-based violence available for those most in need
- We are aware that inequities of access to information, care and financial and social protection are affecting those populations facing social exclusion and potentially exacerbate existing inequities. In all of our community-based interventions, a gender-sensitive approach will be used which aims to collect and address the specific needs of women and girls.

In its actions, the members will pay specific attention to the disability, age and gender factors generating inequalities and to how they interact with other factors (sexual orientation, socio-economic status, geographical location, ethnicity, religion and political opinion). These three

factors tend to reinforce each other when they intersect, combining into situations of multiple vulnerabilities and exclusion. During the COVID-19 crisis, pre-existing vulnerabilities are exacerbated. People with disabilities are at risk of exclusion from aid, especially where access to the field is limited and actions are carried out remotely; and are among those most affected by the virus and therefore in need of special protection. The intervention will therefore take into account the different factors of vulnerability in order to protect the most vulnerable and reduce barriers in terms of access to essential services.

Localization of aid:

Local actors, including civil society organisations as well as communities themselves, are critical in every humanitarian operation. Even more so in the current context that is shaped by restrictions on travel and movement because of COVID-19, which are impeding the international community to surge international staff and supplies at the usual scale and speed to provide expertise, capacity and support to staff and partners that are already working on the ground. Thus, the involvement of local partners in the design, implementation and monitoring of the project will be key to ensure its efficiency, by mobilizing their knowledge of the context (needs and systems in place, factors of exclusion, social perceptions and practices, means of communication, transmission of knowledge and practices, etc.) and by supporting local capacities and expertise. While local actors are also affected by preventive measures, they retain a comparatively greater possibility to maintain and even scale up operations. Localization is therefore both a necessity and an opportunity for effectively meeting humanitarian needs and recovery efforts post COVID-19.

The achievements of this COVID-19 project can only be reached through the partnership between the BAHIA members with their local partners. Specific contextual measures and guidelines are followed to strengthen and improve our responsible partnerships and reach a maximal level of localized response:

- We put the safety and well-being of the local staff and volunteers as an absolute requirement. We have a responsibility to ensure that we do not pass on unnecessary risks and that our local partners adhere to the “do no harm” principle. This includes f.e. the provision of high-standard PPE and health insurance for the local personnel.
- The COVID-19 contexts requires maximal flexibility due to the difficulties of operating environments, with changing movement restrictions and flare-ups of new infection hotspots. With support of DGD as back-donor, we therefore design this project as flexible and simplified as possible, in order to allow front-line local actors to deliver assistance rapidly and effectively within an ever-changing context.
- We will provide visibility for the local responders and their names and achievements will be explicitly acknowledged in all our public communications
- We support by all means the local leadership of our partners, enable their participation and active engagement in coordination mechanisms and decision-making processes at national and sub-national levels.

In the context of this project, special attention will be paid to:

- A joint risk analysis allowing the respect of the duty of care for all the teams involved in the implementation of the project.
- An analysis of the partner's capacities to identify its needs in terms of capacity building (organizational or operational) and to plan the necessary means to ensure that the project is implemented in accordance with ethics and quality policies.
- The development of learning questions and processes to identify and formalize lessons learned.

Environmental impact

The project should not have long-term or cumulative environmental effects. To avoid any negative environmental, stakeholders will be consulted during the design and implementation phase through participatory tools such focus groups discussions and key informant interviews. Through these consultations and reports from the communities and other actors, the environmental impact, if any, will be monitored and mitigation measures will be taken considering the environmental guidelines available.

5.4 [FIN] In the event of changes or issues to be dealt with, please provide information

6 SECURITY AND EMERGENCY MEASURES

6.1 Emergency measures (plan B/ mitigation measures to be taken if the risks and assumptions set out in the logical framework materialise)

Risks	Mitigation measures
Border closures, import/export and port restrictions, fuel and commodity price fluctuations, and reduced commercial aviation and shipping operations affect the ability of partners to contract commercial service providers.	• When possible, negotiate border crossing exemption for international staff and to guarantee emergency crossing; • Ensure hibernation supplies and kits are up to date; • Modify program contingency plans; • Perform close price monitoring; • Secure stocks of key project goods and items; • Maintain regular communication with donors and discuss the revision of activities/budget if needed; • Advise all staff to have supplies at home (private residences) and keep hibernation kit at office/guesthouse stocked; • Do not show valuables or money, pay in small bills, discreetly to avoid unwanted attention;
Delivery of COVID-19 essential response supplies is delayed due to ongoing global demand and shortages.	• Closely monitor restrictions; • Get in close contact with embassies for special flights; • Strength distance work procedures; • Identify staff with preexisting medical conditions;
Travel restrictions, lack of transport options, administrative access constraints imposed by governments/local authorities and access impediments lead to slow or no	• When possible (and only if the security environment permits it), negotiate with the government for lock-down / movement restriction exemption for NGOs staff – as

response by humanitarian organizations.	essential service providers; • Work through local partners; • Reinforce home working protocols and ensure all staff have the necessary equipment; • Develop good practice SOP for staff working on site; • Shift to remote implementation if needed; • Ensure hibernation kits; • Maintain close contact with government authorities; • Advocate for rapid authorization procedures for NGOs responding to the covid19 crisis: • Shift to remote implementation if needed:
Procedures are lacking in many aid organizations to change their operation and distribution modalities in order to reduce human-to-human transmission and limit public gatherings.	• Develop MEAL plans to collect lessons-learned from changes in modalities of intervention: • Follow up of international recommendations linked to COVID-19 projets; • Concertation among members of BAHIA to share successes and challenges of operations, distribution modalities linked to COVID-19:
The full impact of the pandemic on the livelihoods and survival of the most vulnerable populations is not yet known;	• Constant monitoring of the situation and information available (ex: OCHA, WHO, etc.); • Needs assessment at inception of the project to evaluate the impact (to be done jointly if possible, results to be shared within the group);
Conflict being exacerbated by the crisis; new conflicts/internal violence and criminality may arise;	• Reduce movements (by foot or by vehicle); • Closely monitor security incidents, report any changes to context to HQ, and join security interagency networks (if existing) ; • Update the program Contingency Plan and/or Security Plan; • Secure all premises, equipment and vehicles; • Ensure all staff receive regular communication on changes of the context, especially if confined or working from home; • Collect evidence to bear witness and to develop advocacy messages;
COVID-19 response operations to be perceived as discriminatory or negative by	• Assess the perception of the local population in regards to the planned

the local population or to be perceived as a vector of the disease.	intervention and adjust the response accordingly; • Always maintain a high level of communication with the local communities to avoid rumors; • Ensure the community participation in the definition of the action; • Collect evidence to bear witness and to develop advocacy messages;
Sudden crisis/disaster not COVID-19-related impair projects' achievements	• Crisis modifier to ensure the sustainability of the action: part of the budget is reoriented to the not COVID-19 related crisis
Sexual and exploitation abuse (SEA) risks: Engagement with children, adolescents, youth and adult beneficiaries, their communities and other stakeholders (service providers, local authorities) can expose them to risks of abuse and other safeguarding issues; Distributions of cash and voucher, food and NFIs, and provision of direct services to beneficiaries comes with similar SEA and safeguarding issues	• All beneficiaries, including children, adolescents and young people, are aware of feedback and relevant safeguarding mechanisms; • Project teams set-up feedback mechanisms that actively consult with all beneficiaries, including children, adolescents and young people and their communities; • All staff and volunteers are trained on PSEA training and an active policy to identify and report cases is in place throughout all responses; • All stakeholders involved are aware of safeguarding measures in place and are aware of reporting channels in place.

6.2 Security-related aspects

6.2.1 Situation in the field. Please provide a brief description

Analyses of the security situations in the countries of intervention will be developed at start of the project and monitored during the project lifespan. Overview of the security situations and the mitigation measures that have been taken will be shared through the final report.

6.2.2 Has a specific security protocol been drawn up for this action?

yes ✗ no ✗ Standard procedures

If yes, provide information:

6.2.3 Have the staff in the field and the expatriates received information and training concerning these procedures?

yes ✗ no ✗

6.3 [FIN] In the event of changes or issues to be dealt with, please provide information

7 COORDINATION IN THE FIELD

7.1 Coordination in the field (please indicate the participation of the Humanitarian Organization in coordination mechanisms with other stakeholders, such as clusters, NGOs, UN agencies, others (to be specified), as well as links to the Consolidated Appeals Process, if necessary)

Plan, Caritas, MdM, HI, the Red Cross and Oxfam are active members of existing humanitarian coordination structures (for example Food Security, Protection, WASH and health clusters) and initiatives in areas where responses are implemented. During the lifespan of the project, BAHIA members will participate to humanitarian structure meetings to ensure proper planning and coordination to build and strengthen linkages with overall humanitarian priorities.

Special partnerships shall be built with WHO national offices to align the intervention with WHO pillars response plan to COVID-19 pandemic.

BAHIA members will coordinate with local partners and actors through regular meetings, workshops and field visits. Due to their different implementation culture, NGOs members of BAHIA shall work with local partners depending their functioning and these local partners and CSOs might be part of the strategy of intervention.

BAHIA governance structure

To ensure effectiveness of the project delivery and identify areas of collaboration and coordination for learning and complementarity, BAHIA will instore a strong internal governance mechanism to exchange on potential synergies, lessons-learned and challenges, delivery of activities, etc. The internal governance mechanism can be found under **Annex 5**. A Steering Committee (SC) will be set up to develop strategic steer on alignment, priorities, discuss joint communication and learning activities, the main challenges that members might encounter, etc. A Program Management Unit (PMU) will be set up as well to follow up on the implementation of the project. Both organs will be led by the coordinator of the project. In addition to that, following identification of synergies, sub-working groups will be set up to ensure coordination and exchanges on those topics (among others: logistic, assessments and evaluations, beneficiaries, etc.). The governance structure might evolve during the project lifespan.

7.2 National and local authorities (relationships established, authorisations, coordination)

Prior to the intervention, national and local authorities will be informed of the intervention and authorizations will be requested. National and local authorities will be part of the needs assessment when relevant and will be asked to provide official data on the situation in every location.

BAHIA members will closely coordinate with them to evaluate the needs and to ensure the sustainability of the project and activities. Local and national authorities will be kept informed about the progress on project activities and achievements, especially the Ministry of Health.

Efforts will be made to exchange with both development and humanitarian actors, if needed and relevant. BAHIA members will ensure that the project doesn't overlap or contradict potential long-term plans of authorities and will seek necessary VAT exemption from the appropriate ministries, when the contract is signed.

7.3 Potential coordination with the Belgian diplomatic representation

BAHIA members will regularly keep the Belgian representation in countries and Brussels updated about the progress of the project, the context and the operational environment. If relevant, members of D5.1 will be invited to take part to strategic meetings of the project. BAHIA members will arrange field visits for the Belgian diplomatic representation and staffs from Brussels, if the sanitary situation allows it. If coordination mechanisms are launched by the Belgian representation in countries, BAHIA will actively participate and support the process.

7.4 [FIN] In the event of changes or coordination issues to be dealt with, please provide information

8 IMPLEMENTATION PARTNERS

8.1 Name and address of the implementation partner(s)

Implementing partners will be confirmed at inception of the project and information shared through the Concept Note process.

8.2 Status of the implementation partners (e.g.: NGOs, local authorities, etc.) and the role played by them

Under this project, depending on the mandate and type of activities, "implementation partners" can cover:

- The national Red Cross and Red Crescent, each National Society is an independent, impartial and neutral organization that carries out a range of humanitarian and development activities and programmes. As auxiliaries to the public authorities in the humanitarian field, they have both the status and the access to provide support to people in need. Rooted in local communities, they benefit from local trust and contextual understanding.
- Stakeholders in the project:
    - Disabled people's organisations (DPOs) are associations, self-help groups, federations and networks created and managed by people with disabilities;
    - Civil society associations or organisations (other than DPOs) are Non-governmental organisations (NGOs) and community-based organisations (CBOs) that are generally registered as such with the national and/or local governmental

authorities. This category may also include those associations whose status is not that of an NGO (churches, for example) and national NGO federation,

- Public entities - public services which provide activities and/or services that are regulated by governmental structure,
- Private entities providing public services which are businesses, or profit-making or non-profit-making establishments delivering services (but not registered as NGOs or associations) : Health care centres, private hospitals.

8.3 Type of relationship with the implementation partner(s) and the reports expected from the implementation partner

Partners will be identified and selected based on their technical complementarity/capacities and pre-defined eligibility criteria. Memorandum of understanding/contracts/agreements will be signed with the partners to specify the terms and conditions, determine roles and liabilities for the project's implementation. Regular meetings with be held with partners, and reporting schedule defined at inception of the project.

Partners will be required to comply with BAHIA members' code of conduct (data protection, safeguarding, etc.). Exchange of information related to the beneficiaries will be made in accordance with principles of medical ethics and will make sure that patients' medical and personal information is treated in respect of absolute medical confidentiality.

Local partners might support BAHIA members in its relations with the national authorities and efforts to obtain the authorizations required to implement and develop the project (visas, permits, authorizations...) and tax exemptions.

The involvement of local partners in the design, implementation and monitoring of the project will be key to ensure its efficiency, by mobilizing their knowledge of the context (needs and systems in place, factors of exclusion, social perceptions and practices, means of communication, transmission of knowledge and practices, etc.) and by supporting local capacities and expertise. Their local roots will be enhanced/searched to operate in areas of difficult access, with particularly excluded populations and/or in acceptance by local authorities. These partnerships will also guarantee the sustainability of the effects of the intervention, in view of a crisis whose impacts will be felt over time and which should modify social and community practices. BAHIA is committed to these partners in respecting the principles of equality, transparency, responsibility, complementarity and a results-oriented approach.

To the extent possible, BAHIA will involve its partners in all stages of the project cycle (Initial Diagnosis, Design, Launching, Implementation and Closing) including its two cross-cutting components of project monitoring and evaluation.

The Red Cross always operates within the partnership framework of the International Red Cross & Red Crescent Movement, working with the National Red Cross or Red Crescent Society as sole preferential partner. Principles of cooperation and capacity building are formalized Movement-wide in the IFRC 'Development Cooperation Policy (2007), the 'National Society Development Framework' (2013) and the 'Code of Good Partnership'. All Red Cross partners in this programme are strategic partners, meaning the commitment for cooperation within this humanitarian project is integrated in a long-term partnership which includes both humanitarian and developmental support.

The Belgian Red Cross by its two wings Croix-Rouge de Belgique-Communauté Francophone en Rode Kruis-Vlaanderen, being the responsible actor to the DGD Humanitarian Aid, will be responsible for the respect of the legal and statutory rules applicable to the project, as well as for the overall implementation of the project activities. The coordination and management of the project will be under the direction of the CRB-Cf and RKV through its delegations, who will thus be responsible for the overall monitoring of the programme in their country, its sound management (planning, monitoring, evaluation and reporting) and the organisation of evaluation and audit. Reports will be checked and compiled by the persons responsible for monitoring at CRB-CF and RKV headquarters.

8.4 [FIN] In the event of changes, please provide information

9 COMMUNICATION, VISIBILITY AND INFORMATION ACTIVITIES

9.1 Planned communication activities

The proposed project will adhere to the Belgian Development Cooperation's Strategic Note on Communication and all Partners' visibility and communication requirements. All visibility, communication and information activities carried out during the project implementation will inform the general public on the involvement of the Belgian Cooperation in all areas of intervention.

In areas of intervention: during workshops and all planned events, members will make visible the contribution of the Belgian Cooperation through media coverage, logos, and distribution of material. In addition, local partners implementing the operations will communicate on the projects through their website and social networks. During the last months of the action, the exit strategy will be jointly designed with communities, and will serve as a closing workshop to make visible the achievements made by this action. Project information will further be shared with all the official and institutional stakeholders through the various working group meetings that the project staff attend during the course of the project period.

Towards the Belgian and European public: the Belgian public will be informed about the project achievements through different channels of communication, including all members websites, social media (with adapted key messages depending on the audience), newsletters, communication with supporters, and any other printed/printable materials issued by the action. Communication materials include short videos, testimonies of beneficiaries and written case-studies. Every member will provide all the necessary information to the media through press releases to ensure media coverage on the activities of BAHIA. The objective of the communication and visibility plan will be to (i) raise awareness of the Belgian and European general public on COVID-related humanitarian issues in countries of intervention, with a focus on health, WASH, protection, food security related needs and associated risks, and (ii) showcase tangible results of the action, by highlighting positive messages regarding communities resilience, participation, empowerment and human-centered stories. Either in country or towards European audience, communication activities will be strictly in line with safeguarding guidelines, data protection regulation and dignity principles.

9.2 Outreach on durable equipment, the main supplies and on the project location

When the situation allows, sign posts with Belgian Cooperation and BAHIA members' logo will be installed at all key spaces, infrastructures of the action (healthcare facilities WASH facilities,

schools and temporary learning spaces, child and adolescent friendly spaces, women and girls safe spaces) and at distribution points (Cash and voucher, food and NFI). Both logos will be on all communication material to be disseminated under the execution of the action.

In regions facing security issues and requesting low-profile presence, a derogation on visibility rules is requested, in order to reduce the risk of humanitarian workers being targeted.

Additionally, staff, volunteers, implementing partners, frontline workers, case-workers and community-based committees will be equipped with t-shirts, caps, and jackets bearing the Belgian Cooperation logo and members and/or implementing partners' one.

Finally, pull up banners, tear drop banners and regular banners will be printed with the Belgian Cooperation and Partners logos and will be used during activity implementation, key meetings and will be placed in Partner's field offices.

9.3 Publication activities planned

BAHIA members will capitalize on the Alliance's global action and impact, using the successes, challenges and identified opportunities under this action implementation as case study for future joint programming. Lessons learned workshops will be organized, best practices will be documented, so that this first experience can nourish reflexion on the future way of funding humanitarian NGOs. As such, a publication will be planned for dissemination of good practices, challenges and lessons learnt, including programmatic and advocacy recommendation for joint actions in emergency settings.

9.4 [FIN] Report on relevant activities

10 HUMAN RESOURCES

10.1 Please state the overall figures by function and by status

(function)	Status[42]	Number of people	Number of people/months in the project	Comments
BAHIA Coordinator	Expatriate	1	100%	Based in Brussels. The Job description can be found under **Annex 6**

This table will be filled in by members at inception of the project and shared with the final report.

10.2 [FIN] In the event of changes, please provide information

[42] Expatriates, local staff, staff of the implementation partner, etc.

11 ADMINISTRATIVE INFORMATION

11.1 Name and title of the legal representative signing the agreement

Michel van den Hove – Programme and Advocacy Director
60 Rue des Quatre-Vents, 1080 Bruxelles, Belgique
T : Office + 32 (0)2 501 67 31 | Cell +32 (0) 489 67 86 37
Michel.vandenHove@oxfam.org

11.2 Name, telephone number, e-mail address and titles of the person(s) responsible for the management of the dossier

Anne-Sophie Winckelmans - Institutional Partnership Manager – DGD Humanitaire
60 Rue des Quatre-Vents, 1080 Bruxelles, Belgique
T : +32 (0)2 501 67 41
Anne-Sophie.Winckelmans@oxfam.org

11.3 Name, telephone and fax number and e-mail address of the representative in the intervention area

To be communicated at start of the project

11.4 Bank account

Name of the bank: CBC Banques et Assurances
Address of the bank agency: Avenue Albert Ier 60, 5000 Namur
Precise designation of the account holder: OXFAM-SOLIDARITEIT ASBL
IBAN code: BE18 7320 3057 5865
BIC code: CREGBEBB

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12 Budget

Budget Code	Titles	Total cost EUR	Ratio	R1 %	R2 %	R3 %	R1 EUR	R2 EUR	R3 EUR
S1	**Goods and services delivered to beneficiaries**	**€ 3.412.578**	60,00%				**€ 1.035.261**	**€ 1.830.179**	**€ 547.138**
S10	Food security related goods and services	142.500,00 €			100%		- €	142.500,00 €	- €
S11	Nutrition related goods and services	- €					- €	- €	- €
S12	Water, Sanitation and Hygiene related goods and services	437.750,00 €		100%			437.750,00 €	- €	- €
S13	Health related goods and services	422.039,93 €		100%			422.039,93 €	- €	- €
S14	Shelter and Non Food Items related goods and services	50.000,00 €		100%			50.000,00 €	- €	- €
S15	Disaster Risk Reduction related goods and services	- €					- €	- €	- €
S16	Cash for Work / Cash distribution program (vouchers) related goods and services	1.562.208,28 €			100%		- €	1.562.208,28 €	- €
S17	Planification, follow up and evaluation workshops related goods and services	141.185,49 €		40%	40%	20%	56.474,20 €	56.474,20 €	28.237,10 €
S18	Capacity building related goods and services	172.492,09 €		40%	40%	20%	68.996,84 €	68.996,84 €	34.498,42 €
S19	Mainstreaming (gender, HIV/AIDS, sustainable development, protection, etc) related goods and services	484.402,13 €				100%	- €	- €	484.402,13 €
S2	**Equipment**	40.258,05 €	0,71%				16.103,22 €	16.103,22 €	8.051,61 €
S20	Durable equipment (>500EUR)	38.258,05 €		40%	40%	20%	15.303,22 €	15.303,22 €	7.651,61 €
S21	Other	2.000,00 €		40%	40%	20%	800,00 €	800,00 €	400,00 €
S3	**Human Resources**	1.462.849,76 €	25,72%				585.139,90 €	585.139,90 €	292.569,95 €
S30	Local Staff	953.969,76 €		40%	40%	20%	381.587,90 €	381.587,90 €	190.793,95 €
S31	Expatriates staff	323.816,00 €		40%	40%	20%	129.526,40 €	129.526,40 €	64.763,20 €
S32	HQ staffs	185.064,00 €		40%	40%	20%	74.025,60 €	74.025,60 €	37.012,80 €
S4	**Running costs**	595.177,78 €	10,47%				238.071,11 €	238.071,11 €	119.035,56 €
S40	Running costs of vehicles	186.905,26 €		40%	40%	20%	74.762,10 €	74.762,10 €	37.381,05 €
S41	Travel costs	86.558,93 €		40%	40%	20%	34.623,57 €	34.623,57 €	17.311,79 €
S42	Communication, visibility, information	86.921,22 €		40%	40%	20%	34.768,49 €	34.768,49 €	17.384,24 €
S43	Buildings: rents and utilities	154.905,71 €		40%	40%	20%	61.962,28 €	61.962,28 €	30.981,14 €
S44	Supplies and materials	55.393,27 €		40%	40%	20%	22.157,31 €	22.157,31 €	11.078,65 €
S45	External services	24.493,40 €		40%	40%	20%	9.797,36 €	9.797,36 €	4.898,68 €
S7	**Other operationnal costs**	176.340,29 €	3,10%				70.536,11 €	70.536,11 €	35.268,06 €
S70	Bank and transfer costs	3.140,29 €		40%	40%	20%	1.256,11 €	1.256,11 €	628,06 €
S71	Evaluation/Audits	105.000,00 €		40%	40%	20%	42.000,00 €	42.000,00 €	21.000,00 €
S72	HQ Mission cost	32.200,00 €		40%	40%	20%	12.880,00 €	12.880,00 €	6.440,00 €
S73	Others	36.000,00 €		40%	40%	20%	14.400,00 €	14.400,00 €	7.200,00 €
	TOTAL DIRECT COSTS	€ 5.687.204	100,00%				€ 1.945.111	€ 2.740.030	€ 1.002.063
OX	**Administrative costs (5,5%)**	€ 312.796	5,21%				€ 106.981	€ 150.702	€ 55.113
OX000	Administrative costs	€ 312.796					€ 106.981	€ 150.702	€ 55.113
	TOTAL COSTS	€ 6.000.000					€ 2.052.092	€ 2.890.731	€ 1.057.176

13 Annexes:

- Annex 1 : Sources
- Annex 2 : Health indicators Sahel
- Annex 3 : Definition of intervention – Synergies – Process Excel synergies
- Annex 4 : Template Concept notes
- Annex 5 : Governance structure
- Annex 6 : Coordinator Job description
- Annex A : Template workplan BAHIA