ACT Alliance Appeal

Global Response to the COVID-19 Pandemic – ACT201

Sub-Appeal - ACT 201-SSD

South Sudan Response to the COVID-19 Pandemic

Budget Requested: USD 989,942

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TEL.: +4122 791 6434 – FAX: +4122 791 6506 – www.actalliance.org

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Project Summary Sheet	
Project Title	South Sudan Response to the COVID-19 Pandemic
Project ID	ACT 201-SSD
Location	*Region(s) / Impact Areas: Central Equatoria State- (Yei River, Juba), Eastern Equatoria State- (Torit, Magwi), Jonglei State- (Twic East, Duk, Pibor, Gumuruk), Western Bahr el Gazal State- (Jur River, Baggari), Northern Bahr el Gazal State- (Aweil), Upper Nile State-(Malakal), Unity State- (Rubkona, Leer, Mayendit)*
Project Period	*The project will be for a maximum of one year.* Start Date 1st July 2020 End Date 28th March 2021 No. of months 09
Requesting Forum	ACT South Sudan Forum (ASSF) ☒ *The ACT Forum officially endorses the submission of this Sub-Appeal*
Requesting members	The Lutheran World Federation (LWF), Christian Aid (CA), Finn Church Aid (FCA), ICCO-Cooperation (ICCO), Norwegian Church Aid (NCA) & Presbyterian Relief and Development Agency (PRDA).
Contact	Name: Alex Gupirii Email: alex.gupirii@nca.no/AGupirii@christian-aid.org Other means of contacts: +256772937852 (WhatsApp), omodialex11 (Skype ID)
Local partners	*Sudanese Fellowship Mission (SUFEM), Christian Action Relief and Development (CARD), Caritas Wau -(NCA), Global Aim, Child Hope-(ICCO), Universal Intervention and Development Organization (UNIDOR)-Christian Aid*
Thematic Area(s)	☒ Public Health ☒ Community Engagement ☒ Preparedness and Prevention ☒ WASH ☒ Livelihood ☒ Education ☒ Shelter and household items ☒ Food Security ☒ MHPSS and CBPS ☒ Gender ☒ Engagement with Faith and Religious leaders and institutions ☒ Advocacy
Project Outcome(s)	1. Improved and sustained access to humanitarian assistance across multiple response sectors, and protection services for human assets and rights, social cohesion, and livelihoods 2. Reduced morbidity and mortality of COVID-19 patients, and increased preparedness and resilience of communities through public health interventions, community preparedness and prevention, and community engagement 3. Improved psychosocial well-being through increased access to basic psychosocial information and reduced effects of social stigma on populations affected by COVID-19.
Project Objectives	1. To share timely and accurate information on COVID-19 with communities, combat misinformation, build trust with communities through advocacy and support community led solutions.

<table>
<tr><td></td><td>
2. To contribute to prevention, management and stopping the spread of COVID-19 through provision of healthcare services to targeted community members.
3. To support health care systems and educational institutions, with supplies and equipment, trainings and community-based psychosocial support services for COVID-19 affected communities.
4. To provide hygiene training, access to clean water, hygiene supplies and gender sensitive sanitation facilities in communities, healthcare centres and learning institutions to combat COVID-19.
5. To provide food security and livelihood support to vulnerable groups impacted by COVID-19 and cash transfers for essential needs, food and nutrition supplements to pregnant, women, nursing mothers and children.
6. To integrate disaster risk reduction to reduce long term hazard risks, identify families and areas most at risks due to overcrowding and high density and increase shelter standards.
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<tr><td>Target Recipients</td><td>
<table>
<tr><th>Profile</th></tr>
<tr><td>☒ Refugees ☒ IDPs ☒ Host population ☒ Returnees
☒ Non-displaced affected population</td></tr>
</table>
No. of households (based on average HH size): 18’967 HHs
Sex and Age Disaggregated Data:
<table>
<tr><th colspan="9">Sex and Age</th></tr>
<tr><td>LWF</td><td>0-5</td><td>6-12</td><td>13-17</td><td>18-49</td><td>50-59</td><td>60-69</td><td>70-79</td><td>80+</td></tr>
<tr><td>Male</td><td>520</td><td>505</td><td>500</td><td>480</td><td>320</td><td>311</td><td>278</td><td>520</td></tr>
<tr><td>Female</td><td>635</td><td>617</td><td>611</td><td>586</td><td>391</td><td>380</td><td>340</td><td>635</td></tr>
<tr><td>FCA</td><td>0-5</td><td>6-12</td><td>13-17</td><td>18-49</td><td>50-59</td><td>60-69</td><td>70-79</td><td>80+</td></tr>
<tr><td>Male</td><td>140</td><td>562</td><td>234</td><td>353</td><td>98</td><td>53</td><td></td><td></td></tr>
<tr><td>Female</td><td>339</td><td>1352</td><td>561</td><td>776</td><td>256</td><td>67</td><td></td><td></td></tr>
<tr><td>ICCO</td><td>0-5</td><td>6-12</td><td>13-17</td><td>18-49</td><td>50-59</td><td>60-69</td><td>70-79</td><td>80+</td></tr>
<tr><td>Male</td><td></td><td></td><td>150</td><td>200</td><td>50</td><td></td><td></td><td></td></tr>
<tr><td>Female</td><td></td><td></td><td>150</td><td>300</td><td>150</td><td></td><td></td><td></td></tr>
<tr><td>NCA</td><td>0-5</td><td>6-12</td><td>13-17</td><td>18-49</td><td>50-59</td><td>60-69</td><td>70-79</td><td>80+</td></tr>
<tr><td>Male</td><td></td><td>1300</td><td>2400</td><td>3400</td><td>3500</td><td>1000</td><td>800</td><td>800</td></tr>
<tr><td>Female</td><td></td><td>2100</td><td>3400</td><td>3600</td><td>3560</td><td>1240</td><td>950</td><td>780</td></tr>
<tr><td>PRDA</td><td>0-5</td><td>6-12</td><td>13-17</td><td>18-49</td><td>50-59</td><td>60-69</td><td>70-79</td><td>80+</td></tr>
<tr><td>Male</td><td>123</td><td>268</td><td>268</td><td>390</td><td>450</td><td>369</td><td>89</td><td></td></tr>
<tr><td>Female</td><td>125</td><td>320</td><td>314</td><td>467</td><td>398</td><td>428</td><td>231</td><td></td></tr>
<tr><td>CA</td><td>0-5</td><td>6-12</td><td>13-17</td><td>18-49</td><td>50-59</td><td>60-69</td><td>70-79</td><td>80+</td></tr>
<tr><td>Male</td><td>3,421</td><td>4,664</td><td>4,664</td><td>6,841</td><td>6,219</td><td>2,488</td><td>1,555</td><td>1,244</td></tr>
<tr><td>Female</td><td>3,553</td><td>4,845</td><td>4,845</td><td>7,107</td><td>6,462</td><td>2,584</td><td>1,615</td><td>1,292</td></tr>
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<tr><td>Project Budget (USD)</td><td>989,942</td></tr>
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Reporting Schedule

Type of Report	Due date
Situation report	01 October 2020 date. *First SitRep due* quarterly
Final narrative and financial report (60 days after the ending date)	31st May 2021.
Audit report (90 days after the ending date)	30th June 2021.

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

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

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

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

Please note that as part of the global approach for this Appeal, pledges/contributions are encouraged to be made towards the total budget of the Appeal ACT201, and subsequent allocations will be made based on the approved Sub-Appeals. For status of pledges/contributions, please refer to the spreadsheet accessible through this link http://reports.actalliance.org/, Appeal Code ACT201.

Please inform the Director of Operations, Line Hempel (Line.Hempel@actalliance.org) and Finance Officer, Marjorie Schmidt (Marjorie.Schmidt@actalliance.org) of all pledges/contributions and transfers. We would appreciate being informed of any intent to submit applications for back donor funding and the subsequent results. We thank you in advance for your kind cooperation.

For further information, please contact:

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

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

Alwynn JAVIER
Head of Humanitarian Affairs
ACT Alliance Secretariat, Geneva

BACKGROUND

Context and Needs

South Sudan confirmed the first case of COVID-19 on 5th April 2020, and thus became the 51st African country (out of 54) to confirm a case. As of 27th May, confirmed cases had reached 994 with 10 deaths. The COVID-19 outbreak in South Sudan has struck an already vulnerable country with pre-existing differences and has further aggravated these differences between women, men, girls and boys. For example, women and girls who make up most of frontline health workers, carers at home, community volunteers and mobilisers stand to be overwhelmed with more health and domestic responsibilities with the advent of COVID-19. The restrictions on movement places a higher risk on women to experience Gender Based Violence, Sexual Exploitation and Abuse, because women are confined in their homes or camps with abusers. Therefore, it is imperious that the national response plan on COVID-19 is grounded in a strong knowledge of gender dynamics, gender relations, sex and age disaggregated data that considers the differing experiences of all vulnerable groups (IDP's women and children, disabled women, women and children in refugee camps), the gendered roles, needs, responsibilities and dynamics.

The pandemic stands to exacerbate the vulnerability of women and girls even more so, an already acute food insecurity situation which can worsen and affect pregnant and breast-feeding women. Statistics reveal that 6.1 million of the population already face severe food insecurity and that nearly 1.3 million people aged between 6-59 months are acutely malnourished in South Sudan. Pregnant and breastfeeding women make up 12 percent of all people in South Sudan requiring feeding. The rate of COVID-19 infections is particularly threatening areas with high-density populations such as camps, contexts with weak provision of health care service, WASH facilities, and social protection settings.

Furthermore, South Sudan is vulnerable to COVID-19 due to its weak healthcare system, which has a severe shortage of health workers and is reeling from the effects of a disastrous six-year civil war. Only 22 percent of health facilities are fully functional which has rendered 3.6 million people without any health access and consequently 40 percent of the population have no access to primary health care services.

In addition to the health pandemic in fact, reports indicate South Sudan is among countries most at risk of a hunger pandemic. According to the World Food Programme (WFP), hunger and malnutrition in the country are at the most extreme levels since 2011 with almost 60% of the population struggling to find food every day. While the political violence has subsided in many parts of the country, sporadic inter-communal violence and cattle raids persist in Jonglei, Lakes and central equatorial state. Several factors will exacerbate humanitarian needs in the country over the coming months, including COVID-19, the desert locust invasion, seasonal floods and continued inter-communal clashes.

Indeed, the outbreak of this coronavirus disease 2019 (COVID-19) has created a national health crisis with deep impact in a country already sheltering cumulative paraphernalia of years of protracted conflict, enduring vulnerabilities and weak essential services that have even further left 7.5 million people more than two thirds of the population in need of humanitarian assistance (South Sudan Humanitarian Response Plan 2020).

In fact, the government has been urging humanitarian aid agencies to support the fight against COVID-19 through awareness raising and mass sensitization and organizations have since shifted attention

from readiness to response since South Sudan with its poor health care system require urgent efforts and resources to address the Corona virus (COVID-19) and its impact.

ACT Alliance members-(NCA, Christian Aid, LWF, PRDA, FCA and ICCO-Cooperation) recognizes that COVID-19 significantly impact on the most vulnerable people especially women and girls where already existing factors of gender violence and inequalities are expected to worsen.

To address these challenges in the country, we are responding in collaboration, coordination and cooperation with other humanitarian and faith actors to address most needed intervention in public health, water, sanitation, hygiene, community engagement, food security, livelihoods, community preparedness and prevention, shelter, Mental Health /community based psychosocial support, education and advocacy actions.

Capacity to respond

The ACT South Sudan Forum (ASSF) is active, cohesive, dynamic and vibrant forum consisting of 15 international and national members who have long term on- ground experience, surge capacity, established coordination and networking mechanisms with ecumenical bodies, UN, Cluster systems, NGO forum, government, CSOs, local authorities and communities in South Sudan. The forum has long history of responding to emergencies and successful implementation of ACT Appeals-(SDN141, SSD151,171,171, 191 etc.) through its technical humanitarian experts and empowered implementing partners who are well verse with the South Sudan context, Core Humanitarians Standard (CHS) operating principles with even capacity to reach the worst-affected populations.

RESPONSE STRATEGY

This proposed response strategy is multi-pronged in that it focuses on supply and demand side making the overall response effective. The former entails capacity development & preparedness at the level of health facilities and frontline health personnel with focus on surveillance, case identification, isolation and support with referral for testing. On the other hand, the demand side is woven with preventive measures such as dissemination of correct COVID-19 messaging, tackling misinformation & fake news while at the same time protecting the most vulnerable with existing preconditions or those facing food security & loss of livelihoods from secondary impacts of COVID-19.
This response is particularly designed to complement efforts of ACT members already on going appeals (SSD181 & 191) and other bilateral emergency projects which intends to bridge gaps and address specific needs aligned to impact of COVID-19 in the country.
To increase preventive actions on COVID-19 and to respond to the impact of this pandemic in the targeted communities, in Greater Equatoria, Jonglei, Upper Nile, Greater Bahr el Gazal and Unity, the intervention will work with high engagement of community-based systems, stakeholders (public institutions), faith leaders and market actors to ensure most vulnerable groups are identified and supported with multi sectoral needs.
In this response, much emphasis will also be given to awareness and sensitization, in-kind provision of hygiene kits and Personal Protective Equipment (PPE) In addition, response to the secondary impact on food security and livelihood, the intervention will use cash distribution to address most critical needs.

This intervention will target 18'967 HHs among refugees, IDPs, host communities, returnees, urban dwellers with special focus on the elderly, women, children, persons with disabilities, pregnant and lactating mothers who are in acute food insecurity due to the multiple impact of COVID-19 Pandemic including extra effects of conflict, flood and desert locusts' invasion that have destroyed crops and vegetation. Mental Health and Community-Based Psychosocial (MHPSS) Interventions including Sexual

Gender Based Violence (SGBV) will be prioritized greatly in this intervention among the communities and institutions of learning.

Impact

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

Outcomes

1. Improved and sustained access to humanitarian assistance across multiple response sectors, and protection services for human assets and rights, social cohesion, and livelihoods.
2. Reduced morbidity and mortality of COVID-19 patients, and increased preparedness and resilience of communities through public health interventions, community preparedness and prevention, and community engagement.
3. Improved psychosocial well-being through increased access to basic psychosocial information and reduced effects of social stigma on populations affected by COVID-19.

Outputs

1. Public Health

Output 1.1: Health facilities in targeted areas have enhanced preparedness & improved access to medical supplies and equipment to isolate and manage referral of COVID-19 cases

1.1.1 Procurement of essential medical supplies and PPE kit comprising of sanitizers, protective gowns, masks, boots, infrared thermometers & gloves

1.1.2 Distribution of essential medical supplies and protective equipment kits to the frontline health workers

1.1.3 Setting up 2 isolation centres in 2 counties (1 per county) to provide basic health support to the suspected COVID-19 cases and arrangement for sample collection and referral

1.1.4 Conduct minor renovation/rehabilitation at the selected health facilities to ensure adequate spaces for physical distancing

1.1.5 6 screening points supported to undertake surveillance and contact tracing measures.

Output 1.2: 30 frontline health care staff gain preparedness knowledge to be able to handle their work in safe ways using appropriate infection prevention and control measures

1.2.1 Conduct training for 30 frontline health workers on WHO & Ministry of Health guideline on COVID-19 management.

2. Community Engagement

Output 2.1: community led actions implemented with IDPs centers and host communities in targeted state counties.

2.1.1. Conducting of awareness sessions for communities to increase knowledge on public health (though use of microphones, smaller groups and hygiene measures)

2.1.2. Training of community and religious leaders on community empowerment and trust building on public health. The training will be with small groups of less than 10 people with consideration of COVID-19 distancing and hygiene measures.

2.1.3. Engaging community and religious leaders to build trust among community, to reduce fear, avoid stigma and not to use fake information.

2.1.4. Mobilization and training of faith leaders to disseminate accurate information on COVID-19 and its preventive measures.

3. WASH (Water, Sanitation and Hygiene)

Output 3.1 Communities and vulnerable people impacted by COVID-19 Pandemic have access to clean water, hygiene supplies and gender sensitive sanitation facilities.

3.1.1 Procurement and installation of hand-washing facilities in the entry points and the dense populated areas, Primary Health Care Centres (PHCCs)and Primary Health Care Units (PHCUs)

3.1.2 Provision of hand washing facilities and hygiene kits (soap, detergents, sanitizers) to poor and vulnerable households.

3.1.3 Training and deployment of community volunteer/community mobilizers to carryout community sensitization using megaphones in high risk neighbourhoods and public places e.g. markets.

3.1.4 Provision of in-kind health and hygiene kits comprising of handwashing bucket, soap, reusable face masks that meet WHO guideline to COVID-19 population at risk.

3.1.5 Procurement of materials and fabrication of handwashing facilities

3.1.6 Training on fabrication of tippy taps

3.1.7 Distribution of hand washing stations

3.1.8 Training of communities on social distancing and hand washing

3.1.9 Carrying out information and risk education in local languages on local radios specifically designed to reach people in villages.

3.1.10 Procurement and distribution of COVID-19 IEC materials (inform of leaflets) to the public.

4. Education

Output 4. 1: School continuity ensured through support of alternative distance (radio) learning programming and safe return to learning during school re-opening.

4.1.1. Identify teachers to support home-based learning and catch-up classes of small groups (with COVID-19 preventive measures respected)

4.1.2. Train 60 teachers and county education department staff in collaboration with ministry of health through webinars on methods of delivering distance learning.

4.1.3. Provide re-usable masks for smaller group catch-up classes. Estimated 5,000 children to be reached.

4.1.4. Design, print and disseminate IEC materials (posters, banners, leaflets) on COVID -19 prevention to 15 schools during re-opening time

4.1.5. Sensitization and awareness raising campaigns to 15 school communities targeting- (teachers, learners, Parent-teacher associations, school management committees, etc.) on COVID-19 risks and prevention measures

4.1.6. Provision of hand washing facilities in 15 schools to support hygienic preventive practices of COVID-19.

4.1.7. Back to School campaigns support to enhance children, teachers and parents with precautionary COVID-19 measures.

5. Food Security and Livelihood

Output 5.1. Food security and livelihood support to vulnerable groups impacted by COVID-19 and cash transfers for essential needs, food and nutrition supplements to pregnant, women, nursing mothers and children provided.

5.1.1. Unconditional cash distribution for people at high risk of COVID-19 to cover essential nutritional and medical needs for subsistence.

5.1.2. Conditional cash for food for vulnerable HHs (elderly, persons with disabilities, children, women, lactating mothers and pregnant women to increase access to food during COVID-19 pandemic

5.1.3. Monitoring markets for food commodities

5.1.4. Provision of hand washing facilities, and hygiene kits to vulnerable women engaged in small businesses (e.g. shops, petty trade, tea shops, fish selling etc.)

5.1.5. Provide PPE (Personal Protection Equipment) for vulnerable women engaged in small businesses

5.1.6. Conducting post-distribution monitoring (PDM) of utilization of cash, access to market, protection services.

6. MHPSS (Mental Health and Psychosocial Support) and Community Based Psychosocial Support (CBPS)

Output 6.1: Access to basic psychosocial support by people directly and indirectly affected by the COVID-19 pandemic

6.1.1. Training 60 community based CBPS committee members on COVID-19 risk prevention, response and psychosocial support skills. The CBPS committees will be composed of customary leaders, women, religious leaders, and elderly persons.

6.1.2. Support CBPS committees (60 members) to identify aspects of distress and cases of stigma in communities and Support the committees to provide awareness and advise on distress and stigma. At least 1,200 people will be reached.

6.1.3. Provide access to Sexual Gender Based Violence (SGBV) services to survivors through deployment of qualified clinical officers and midwives in Primary Health Care Centres (PHCCs).

6.1.4. Train community and faith leaders on Sexual Gender Based Violence (SGBV) preventive measures within communities impacted by COVID-19.

7. Shelter

Output 7.1. Integrated disaster risk reduction enhanced to reduce long term hazard risks, and families and areas most at risks due to overcrowding and high density identified, and shelter standards increased.

7.1. Procurement and distribution of shelter materials for identified HHs at high risk areas of COVID-19

8. Community Preparedness and prevention

Output 8.1. Health care systems supported with supplies and other assistance

8.1.1. Procurement and distribution of health supplies and equipment,

8.1.2. Educating /training of vulnerable communities on COVID-19 health preventive measures.

8.1.3. Provision of accurate information on COVID 19 as provide by the ministry of health and WHO through various medias.

8.1.4. Provision of personal protective materials to community volunteers mitigating spread of COVID-19.

Exit strategy

ACT South Sudan Forum members focuses on building capacity of communities and stakeholders through the active engagement of community members and local community structures. This proposed intervention critically will help to increase preventive measures and response to COVID-19 primary and secondary impacts. Therefore, from its inception, it aims to work on leadership strengthening, decision making and problem-solving capacities of communities including coping mechanisms. This approach provides them with skills that can be used in their future public health actions and will build their resilience to face disasters (pandemic). This approach is also believed to create ownership while paving the way for sustainability and exit from the beginning.

PROJECT MANAGEMENT

Implementation Approach

As ACT members, we are working to ensure all persons, especially those impacted by COVID-19, have access to accurate information, hygiene and health services, food and livelihoods, and psychosocial

supports. This response to COVID-19 Pandemic will use both cash and non-cash multi sectoral approach. The organisations will be in direct contact with the beneficiaries and other relevant stakeholders. At community level the project implementation will be centred on participatory approaches to identify the beneficiaries, market systems development and implementation of major activities. This ensures ownership and sustainability of the activities after the project closure. A market led approach is envisaged in livelihoods provision and protection where markets are assessed to sustain developed system, and transfer of goods and commodities. Linking of relief and resilience building approaches is innovative as it makes the project more sustainable and supporting communities not to spring back after times of shocks. The approach of supporting communities with unconditional cash transfer entails giving communities the freedom to choose what they deem necessary and what is best for them to curb food insecurity. Thus, cash transfer and vouchers system will be used depending on applicability.

Our staff will work closely with community leaders, ministry of health and clusters' working groups, UN agencies, NGOs including the South Sudan Council of Churches Taskforce on COVID-19 to ensure guidelines are followed in this sensitive response.

Faith leaders will be fully involved in community engagements, psychosocial support and advocacy on COVID-19 social media misinformation, community stigmatization, xenophobia and emphasis on COVID-19 preventive measures.

Implementation Arrangements

In this response, as an implementation strategy, LWF, FCA, PRDA will work directly with the beneficiaries while NCA, Christian Aid and ICCO-Cooperation will work through partners using partnership approach and accompaniment model. Each requesting member will manage its implementation, monitoring, reporting and auditing of the appeal. However, the ACT Forum Coordinator will be fully engaged in consolidation of the appeal reports, initiating joint monitoring visits, ensuring quality and accountability.

Project Consolidated Budget

		Appeal Total	LWF	ICCO	PRDA	CA	FCA	NCA
Direct Costs		**832,910**	**147,263**	**137,509**	**138,114**	**136,237**	**137,125**	**136,661**
1	**Project Staff**	**236,195**	**30,452**	**37,950**	**37,089**	**55,315**	**31,548**	**43,841**
1.1	Appeal Lead	5,160	2,160	-	-	-	3,000	-
1.2	International Staff	22,209	9,411	-	12,798	-	-	-
1.3	National Staff	208,826	18,881	37,950	24,291	55,315	28,548	43,841
2	**Project Activities**	**458,409**	**99,154**	**88,800**	**66,375**	**66,960**	**87,180**	**49,940**
2.1	Public Health	35,385	11,925	-	-	23,460	-	-
2.2	Community Engagement	29,610	4,800	-	-	-	-	24,810
2.3	Preparedness and Prevention	-	-	-	-	-	-	-
2.4	WASH	85,470	27,500	-	28,620	17,000	-	12,350
2.5	Livelihood	55,100	12,600	16,000	-	26,500	-	-
2.6	Education	22,450	22,450	-	-	-	-	-
2.7	Shelter and Household items	9,000	-	-	-	-	-	9,000
2.8	Food Security	203,844	16,879	67,600	32,185	-	87,180	-
2.9	MHPSS and Community Psycho-socia	13,770	3,000	5,200	5,570	-	-	-
2.10	Gender	1,080	-	-	-	-	-	1,080
2.11	Engagement with Faith Leaders	2,700	-	-	-	-	-	2,700
2.12	Advocacy	-	-	-	-	-	-	-
3	**Project Implementation**	**13,580**	**1,000**	**900**	**10,900**	**-**	**-**	**780**
3.1.	Forum Coordination	6,525	1,000	-	5,225	-	-	300
3.2.	Capacity Development	7,055	-	900	5,675	-	-	480
4	**Quality and Accountability**	**57,468**	**3,958**	**4,500**	**9,200**	**11,160**	**7,700**	**20,950**
5	**Logistics**	**51,906**	**12,700**	**5,359**	**14,550**	**1,569**	**6,577**	**11,150**
6	**Assets and Equipment**	**15,352**	**-**	**-**	**-**	**1,232**	**4,120**	**10,000**
Indirect Costs		**132,909**	**13,902**	**23,972**	**23,040**	**22,929**	**24,040**	**25,026**
Staff Salaries		82,472	10,808	16,097	17,100	15,616	6,884	15,966
Office Operations		50,437	3,094	7,875	5,940	7,313	17,156	9,060
Total Expenditure		**965,819**	**161,165**	**161,482**	**161,154**	**159,165**	**161,165**	**161,688**
ICF (3%)		24,124	4,835	4,844	4,835	4,775	4,835	4,851
Total Expenditure + ICF		**989,942**	**166,000**	**166,326**	**165,989**	**163,940**	**166,000**	**166,538**

Project Monitoring, Evaluation and Learning

In line with the ACT M&E Framework, the requesting members will use participatory approach involving relevant stakeholders and beneficiaries in participation, decision making, monitoring field visits and reviews.
To ensure effective delivery of humanitarian assistance to the COVID-19 affected population, monitoring will focus on tracking output according to the key performance indicators as outlined on the log frame along with reference to the performance measurement framework.
All requesting members will conduct joint routine monitoring involving the ACT Forum Coordinator, prepare and submit regular SITREPs, interim, final narrative and financial reports to the donors through the forum and ACT Secretariat.

Safety and Security plans

To deliver programmes in the context of COVID-19, ACT Forum members' staff, volunteers and partners must implement additional measures when engaging with community members to mitigate the risk for all stakeholders of contracting the virus. Our members have minimum standard operating procedures (SOPs) which are implemented to deliver on the organisations' duty of care obligations. These SOPs reflect on COVID-19 Global Response Plan and the latest guidance provided by World Health Organisation (dated 26th May 2020). Country teams adopted NCA Global Policy-COVID-19 contingency plan which was shared to members by ACT Security Group (ASG) and they have developed their own context specific plans on COVID-19. Additionally, the forum has EPRP in place which clearly stipulates our preparedness actions and response mechanism highlighting key humanitarian principles and standards. We therefore take into consideration 'Duty of Care' and 'Do No Harm' for our stakeholders and ensuring that the measures to be implemented respect any restrictions or regulations adopted by the government.

PROJECT ACCOUNTABILITY

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

☒ Yes ☐ No

Code of Conduct

ACT South Sudan Forum (ASSF) members commit to the ACT Code of Conduct and all staff are trained and signatories to it. In all aspects of delivering our work, we ensure protection, child-safe guarding, no sexual exploitation/abuse, no misconduct, fraud, exploitation, discrimination and corruption. We believe in informed consent and complaints response mechanism (CRM).

Safeguarding

All members subscribe to ACT global safeguarding policy and guidance document. In this response, members recognise that all children have equal rights to protection from harm and exploitation, and that some children, such as those with disability and children living in areas impacted by disasters, are particularly vulnerable. While promoting equal treatment of children, irrespective of gender, nationality or ethnic origin, religious or political beliefs, age or other, members will ensure that any decision concerning, or potentially impacting the wellbeing of children, will be taken according to the best interest of the child. Whenever there is a conflict of interest, members of this intervention will ensure that rights, needs and welfare of the child always come first.

Conflict sensitivity / do no harm

In this intervention, Christian Aid, NCA, LWF, FCA, ICCO, PRDA and all implementing partners will ensure the project activities are implemented in line with the COVID-19 contingency plans, WHO and Ministry of Health guidelines, CHS principles and standards, including the relevant clusters' working group guidelines in South Sudan.

Complaints mechanism and feedback

CRM is integral part of all ACT Forum members' response mechanism. All our partners are trained on complaint and feedback mechanism. In this intervention, our staff will ensure that, this mechanism is in place so that beneficiaries can use to address their concerns over services being offered/or against performance of certain staff in the community.

Communication and visibility

In this COVID-19 response, Christian Aid, NCA, FCA, ICCO, LWF, ICCO, PRDA will be required to follow the ACT Communication policy to guide in the use of media platforms. Members will also submit reports (SITREPS, Interim, and Final Narrative & Financial) as a mechanism of giving feedback on implementation progress, achievement and challenges. Visibility will be raised through co-branding with the ACT logo, humanitarian advocacy, and engagement with our ACT-Caritas ecumenical network including active participation in clusters working groups and coordination meetings at state and national levels.

Annexes

Annex *1 – Summary Table*

	Christian Aid (CA)	The Lutheran World Federation (LWF)	Finn Church Aid (FCA)
Start Date	1st July 2020	1st July 2020	1st July 2020
End Date	30th December 2020	28th March 2021	28th March 2021
Project Period (in months)	6 Months	9 Months	9 Months
Response Locations	Unity State- (Rubkona, Leer & Mayendit Counties)	Jonglei State- (Twic East & Duk Counties), Eastern Equatoria- (Magwi County)	Central Equatoria State- (Yei River County)
Sectors of response	☒ Public Health ☐ Community Engagement ☒ Preparedness and Prevention ☒ WASH ☒ Livelihood ☐ Education ☐ Shelter and household items ☐ Food Security ☐ MHPSS and Community Psycho-social ☐ Gender ☐ Engagement with Faith and Religious leaders and institutions ☐ Advocacy	☐ Public Health ☐ Community Engagement ☒ Preparedness and Prevention ☒ WASH ☒ Livelihood ☒ Education ☒ Shelter and household items ☒ Food Security ☐ MHPSS and Community Psycho-social ☒ Gender ☐ Engagement with Faith and Religious leaders and institutions ☒ Advocacy	☐ Public Health ☐ Community Engagement ☐ Preparedness and Prevention ☐ WASH ☐ Livelihood ☐ Education ☐ Shelter and household items ☒ Food Security ☐ MHPSS and Community Psycho-social ☐ Gender ☐ Engagement with Faith and Religious leaders and institutions ☐ Advocacy
Targeted Recipients (per sector)	10,557 HHs	1079 HHs/6474 Individuals	800 HHs/4800 Individuals
Requested budget (USD)	US$ 163,940	US$166,000	US$ 166,000

	ICCO Cooperation	Norwegian Church Aid (NCA)	Presbyterian Relief and Development Agency (PRDA)
Start Date	1st July 2020	1st July 2020	1st July 2020
End Date	30th March 2021	31st September 2020	30th March 2021
Project Period (in months)	9 Months	3 Months	9 Months
Response Locations	Eastern Equatoria State- (Torit & Magwi Counties)	Northern Bahr el Gazal State- (Aweil County), Western Bahr el Gazal State- (Jur River & Baggari Counties), Jonglei- (Pibor/Gumuruk County)	Upper Nile State- (Malakal County)
Sectors of response	☐ Public Health ☐ Community Engagement ☐ Preparedness and Prevention ☐ WASH ☒ Livelihood ☐ Education ☐ Shelter and household items ☒ Food Security ☒ MHPSS and Community Psycho-social ☐ Gender ☐ Engagement with Faith and Religious leaders and institutions ☐ Advocacy	☐ Public Health ☒ Community Engagement ☒ Preparedness and Prevention ☐ WASH ☐ Livelihood ☐ Education ☒ Shelter and household items ☐ Food Security ☐ MHPSS and Community Psycho-social ☐ Gender ☒ Engagement with Faith and Religious leaders and institutions ☐ Advocacy	☐ Public Health ☐ Community Engagement ☐ Preparedness and Prevention ☒ WASH ☐ Livelihood ☐ Education ☐ Shelter and household items ☒ Food Security ☐ MHPSS and Community Psycho-social ☐ Gender ☐ Engagement with Faith and Religious leaders and institutions ☐ Advocacy
Targeted Recipients (per sector)	1,000 HHs/6,000 Individuals	4,824 HHs	707 HHs/4,240 Individuals
Requested budget (USD)	US$ 166,326	US$166,538	US$ 165,989

Annex 2 – Security Risk Assessment

Principal Threats:

Threat 1: Potential COVID-19 lockdown and restriction on humanitarian work.

Threat 2: Local conflict dynamics negatively impacting on the project

Threat 3: Secondary impact of COVID-19 such as border closer impacting availability of supplies including PPE and food items in the market

Threat 4: Resurgence of national level conflict in case of power vacuum created by COVID-19

Threat 5: Lack of acceptance by community of COVID-19 measures

Impact / *Probability*	**Negligible** *(no delays)*	**Minor** (*Same delays)*	**Moderate** *(Some delays and disruption)*	**Severe** *(Severe disruption)*	**Critical** *(Potential closure anticipated)*
Very likely	Low	Medium	High	Very high	Very high
Likely	Low	Medium	High	High	Very high
Moderately likely	Very low	Low	Medium	High	High
Unlikely	Very low	Low	Low	Medium	Medium
Very unlikely	Very low	Very low	Very low	Low	Low

Annex 4: Counties' Incident and Vulnerability Map

COUNTY NAME	RISK SCORE 0-12	INTERSECTORAL VULNERABILITY 0-25
RUBKONA	10	13
YEI	10	13
JUBA	9.75	12.75
PARIANG	8.5	14.5
MAGWI	8.5	7.5
WAU	8.5	9.5
MALAKAL	8	12.5
AWEIL WEST	7.5	9.5
KOCH	7.25	11.25
KAJO-KEJI	6.5	12
PANYIJIAR	6.5	11.5
RENK	6.5	14
AWEIL NORTH	6.25	11.25
BOR SOUTH	6.25	11.75
GOGRIAL WEST	6.25	11.75
TWIC	6.25	11.75
AWEIL EAST	6	12.5
MAYOM	6	11.5
FASHODA	5.5	15