ADDENDUM

This Addendum is established **pursuant to the agreement signed between International Union for Health Promotion and Education (IUHPE) and BENASHA Health Consortium (BENASHA) signed July 13, 2020**.This Addendum shall be effective from May 19, 2021 ("**Addendum Date**"). The following sections are added as indicated:

SCOPE OF WORK:

Project: Phase 2 COVID-19 Response in Africa and India: Enabling healthy and resilient communities

Activity Dates: May 2021-September 2021

Project Overview: Phase 2 is to build on the work currently underway in Africa and extend to India, where the toll from COVID-19 continues to grow, especially among the most disadvantaged communities.

The project is funded by Vital Strategies. Installments to project partners are transferred by IUHPE.

Deliverables	Due Date
Intervention Planning Templates completed by Kenya, South Africa, and India Country Leads	Mid-May 2021
Final Country Reports including project monitoring & evaluation	End of September 2021
See Annex B: Project Timeline with deliverables.	

PAYMENT SCHEDULE:

In consideration for the work to be performed in fulfilment of the obligations described in in this Addendum's Scope of Work, **IUHPE shall pay BENASHA**:

Accomplished Deliverable	Payment Amount
Signature of contract and request for payment (50%)	USD $12 500
Completion of deliverables listed in Scope of Work (50%)	USD $12 500

1. The total maximum amount of this Addendum shall not exceed U.S. $25,000.

2. Any gain or loss related to exchange rate fluctuation shall be borne by BENASHA.

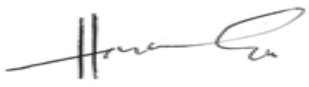
The parties are signing this agreement on the date set forth in the introductory clause

INTERNATIONAL UNION FOR HEALTH PROMOTION

June 24, 2021

Name: Liane Comeau
Title: Executive Director

BENASHA HEALTH CONSORTIUM



June 25, 2021

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Name: Hans Onya
Title: Owner/Director

Annex A
Budget

Budget (March to July 2021)

Item	Tasks	Resource Type	Cost in USD
Administration and project support	Administrating overall grant and financial reporting to funder; technical support to scientific and communications activities	IUHPE Secretariat Staff	5 900 $
Country-level budget (upscaling of current RCCE interventions in South Africa)	Includes Human resources; Materials; Logistics; Admin costs	As required within each country budget	25 000 $
Country-level budget (upscaling of RCCE interventions in Kenya)	« «	« «	25 000 $
Country-level budget (Initiating RCCE interventions in India)	« «	« «	25 000 $
School-based projects in Zambia and Zimbabwe through the end of the school year (5K each)	« «	« «	10 000 $
Subtotal			90 900 $
Overhead- 10% of total cost (non-labour costs to IUHPE International Secretariat and Management and Working Groups-material, communications and logistical costs)			9 090 $
Total amount requested			**99 990 $**

In-kind contribution from IUHPE		
Project oversight and expert input to Project Management Group		12 000 $
In-kind contribution from partners		
India (VHAI): capital cost such as office space and set-up at national and regional level, technical expertise of senior professionals and part salary of a national coordinator.		6 000 $
Zimbabwe National Association of Primary Heads: space on school grounds to hold training and teachers volunteering to review educational materials. Midlands State University: 200 litres of alcohol-based sanitizers 500 washable face masks for teachers. The project team shall contribute toward transportation wear and tear.		600 $
South Africa: staff time		3 000 $
Total in-kind contribution		**21 600 $**
Total value of project		**121 590 $**

Annex B

Project Timeline with Deliverables - IUHPE Phase 2 COVID-19 Response in Africa & India 2021

Project Overview	Description of work	Completion date
Project Management Meeting	Kick-off Meeting with Project Partners and IUHPE Project Management Group	26 April 2021
Project Milestone	Set up project agreements and contracts	May 2021
Deliverable	Intervention Planning Templates completed by Kenya, South Africa and India Country Leads Dissemination activities planned – Zimbabwe & Zambia	Mid-May 2021
Project Management Meeting	Update on intervention plans - Kenya, South Africa and India Review Monitoring and Evaluation plans Dissemination plan delivered in Zimbabwe and Zambia	End of May 2020
Project Milestone	*Implementation of Community Interventions* Phase 2 interventions implemented in Kenya, South Africa and India. Monitoring & Evaluation underway - Phase 2 baseline indicators being collected.	May/June 2021
Project Management Meeting	Updates on intervention delivery - Kenya, South Africa and India Phase 2 monitoring and evaluation plans Dissemination plans delivered in Zimbabwe and Zambia	End of June 2021
Project Management Meeting	Review progress on interventions and training. Dissemination outputs from Zambia and Zimbabwe – Guide book/Policy Briefs	End of July 2021
Deliverable	Zambia and Zimbabwe dissemination reports completed	End of August 2021
Project Management Meeting	Meeting to review progress and project monitoring and evaluation updates	End of August 2021
Project Management Meeting	Draft Final Reports from Country Leads	Mid-September 2021
Deliverable	*Final Country Reports including project monitoring & evaluation.* ***Feedback to funders***	End of September 2021

Annex C

IUHPE – UIPES

INTERNATIONAL UNION FOR HEALTH PROMOTION AND EDUCATION
UNION INTERNATIONALE DE PROMOTION DE LA SANTÉ ET D'ÉDUCATION POUR LA SANTÉ
UNIÓN INTERNACIONAL DE PROMOCIÓN DE LA SALUD Y EDUCACIÓN PARA LA SALUD

Phase 2 COVID-19 Response in Africa and India: Enabling healthy and resilient communities

Revised Proposal submitted by:

International Union for Health Promotion and Education (IUHPE)

February, 2021

Contact: Liane Comeau (lcomeau@iuhpe.org)

Table of Contents

Introduction

Overview of project in relation to Phase 1

This proposal addresses Phase 2 of the project currently funded by Vital Strategies and seeks to build on work underway to date with country partners in Africa, consolidating and expanding the benefits of project interventions with local underserved communities, and extending the reach of this initiative to partners working in India, where the toll from COVID-19 continues to grow, especially among the most disadvantaged communities.

While welcome progress has been made in developing vaccines for COVID-19, it is clear that communities will have to live with the virus for some time to come and this will require sustained and renewed efforts in preventing community transmission. Effective and culturally appropriate risk communication will continue to play a critical role alongside community empowerment and capacity building strategies in order to ensure effective health protection, the promotion of healthy behaviours, and resilient communities in response to the COVID-19 pandemic and its secondary impact. Socio-behavioral interventions continue to be the most feasible and effective response in controlling the spread of the virus. The first phase of this project has demonstrated that health promotion approaches can support the design and implementation of community-based approaches based on effective RCCE methods adapted to local needs.

The aim of this second phase of the project is to consolidate a health promotion approach to the development of effective risk communication and community empowerment approaches. This will contribute to strengthening the resilience of local communities in living with, and controlling the spread of, COVID-19.

Central to this community-based health promotion approach to the COVID-19 crisis is the need to increase people's control over their health, to enhance social cohesion and community solidarity and accountability, and to build public trust and collective responsibility for population health promotion and protection. This includes enabling individuals and communities to develop the knowledge, skills and efficacy to take preventive action and access support and services that will protect and promote their health in the face of the pandemic.

Effective methods and approaches have already been developed by country partners in South Africa and Kenya, Zambia and Zimbabwe in Phase 1, and there is now an opportunity to develop these interventions further, building on current work, andembedding the learning from these initiatives in local African communities and also extending the reach to India through a South-South collaboration with IUHPE international partners at the Voluntary Health Association of India (VHAI).

The interventions will focus on underserved and vulnerable communities in South Africa, Kenya and India, while in Zambia and Zimbabwe the focus will mainly be on school settings.

This collaborative initiative will contribute to the global effort in sharing expertise and knowledge in containing the virus and mitigating its impacts while strengthening health promotion capacity in building healthy and resilient communities, representing a good investment for the future. The proposed interventions and approach set the foundation to address other ongoing and competing issues and community concerns that are both directly and indirectly affected by COVID-19, while simultaneously fostering community-determined solutions and decision-making.

Aim: Building on Phase 1, this second phase of the project aims to engage with key partners in Africa in consolidating and extending the reach of the current community-based health promotion approach to the COVID-19 crisis, and in developing an effective South-South collaboration with the Voluntary Health Association in India. Planning and implementing effective risk communication and community engagement measures, based on health

promotion principles, that will control the spread of the virus within communities, while equitably protecting people's basic needs and their physical and mental health.

Country Leads: Phase 2 of the project will continue to include the four current participating countries: Kenya, South Africa, Zimbabwe and Zambia. The Country Leads are: Dr. Mary Amuyunzu-Nyamongo (Kenya), Professor Hans Onya (South Africa), Professor Davison Munodawafa (Zimbabwe) and Professor Oliver Mweemba (Zambia).

The collaboration with the Voluntary Health Association of India (VHAI) will be led by the Chairman, Dr Alok Mukhopadhyay, and the Chief Executive, Dr Bhavna Mukhopadhyay. VHAI is a federation of 24 State Voluntary Health Associations linking together more than 4500 health and development institutions across the country. Over the last five decades, VHAI has played a leading role in primary health care in India as well as in the implementation of innovative health and development programmes at the grassroots level with active participation of the local communities. VHAI's programmes are largely sustainable as they are community-based, low cost, utilising local resources and talents. VHAI also plays an important role at the national level on policy formulation, implementation, research and advocacy as a member of various advisory committees of the Government of India.

All country leads are well-established and experienced health promotion experts who have strong links with IUHPE and have committed to this project and mobilized existing partners (academic and other institutions, NGOs, individual experts) and networks, including government and UN agencies within their countries. They have demonstrated their ability to integrate the proposed health promotion interventions within the broader COVID-19 response implemented in each country, thus avoiding duplication of efforts while adding value to and filling gaps in existing interventions.

Expected project outcomes:

- Local communities and key stakeholders are engaged in the COVID-19 response and are empowered toreduce its spread.
- Local communities can protect themselves and, their families in taking effective behavioural action tostop the spread of the virus in their community.
- Community-level implementation is informed by best available knowledge, research and resources oneffective risk communication and community engagement.
- Community coalitions are formed to coordinate local responses adapted to the needs of local communities.
- Health promotion capacity for building healthy and resilient communities is strengthened and evidence-based approaches are developed and translated across country settings.

Rationale for Phase 2

The project will benefit greatly from its continuity in Phase 2. From a knowledge translation perspective, an enormous amount has been learned in Phase 1 that will directly benefit the proposed Phase 2. This includes the following:

- From a practice and programme delivery perspective, there is an opportunity to strengthen the implementation of the community-based health promotion strategies developed in Phase 1 and extend their reach to other underserved communities, thereby leading to longer-term interventions and more sustainable outcomes, including local capacity building.

- Expertise in intervention planning and implementation together with a project monitoring and evaluationhas been established in Phase 1. The sharing and dissemination of this knowledge will be an important aspect of Phase 2, both among the participating partners in Africa and India and the wider health promotion community through dissemination activities such as project presentations, webinars and publications.

- The project will also strengthen intervention research in the field of RCCE implementation strategies and will contribute to establishing an evidence-based and practice-to-theory health promotion model of community empowerment approaches for strengthening the resilience of local communities.

- The project will also contribute to strengthening health promotion partnerships, both within and across countries, in undertaking culturally appropriate and evidence-informed approaches based on mutual trust, respect and a spirit of inclusion together with supportive project management structures and processes. The development of a South-South collaboration in this second phase is a unique aspect of thisproposal, which will strengthen capacity to carry out collaborative projects that are successful in terms ofboth quality and quantity of scientific and culturally appropriate processes and outputs.

Phase 2 priority actions

1) Effective risk communication that will enable people to protect themselves, their families and communities from the virus

Interventions will involve providing easy-to-understand and culturally appropriate information at a community level, taking into account the unique local needs, assets and levels of vulnerability. In applying health literacy principles, this project aims to ensure that local communities can access, understand and implement basic health information concerning the severity of the virus and its transmission through key actions such as hand washing, physical distancing, symptom recognition and appropriate help-seeking and self-isolation measures. Risk communication strategies have been developed in Phase 1 and tailored to meet the health literacy needs of local community groups employing the most appropriate and effective local channels of communication. This second phase will entail building on what has already been developed at the country level and ensuring access within and across communities.

2) Empowering communities in adopting effective responses and managing the psychosocial impacts of the pandemic

Successful community engagement, supported by digital opportunities for safe communication, is key to coping successfully with this crisis and its many disruptive consequences in terms of physical and mental health and social wellbeing. Working in collaboration with key community stakeholders, Phase 1 of this project has involved equipping local community health workers, volunteers, and responders with skills in supporting effective action at a community level. Training is being provided on undertaking two-way communication on the virus and its impact and tackling ‘infodemics’. Community insights on tracking rumours, sources of stigma, misinformation and disinformation have been collected in the course of the project development to date. These will also be increasingly important in the context of vaccine roll out in dealing with disinformation and misinformation

concerning its up-take and effects. Training is also being provided to community health workers and local community leaders, including the provision of psychosocial support such as training in Psychological First Aid in dealing with the mental health impacts of the virus. In the course of Phase 1, community health promotion coalitions have engaged communities in actively keeping themselves, their families and each other safe and building trust in the local services. Phase 2 will seek to consolidate these community structures in strengthening capacity for sustainable community engagement and empowerment strategies that can be applied during and beyond the pandemic.

3) Strengthening capacity and systems to support community-based health promotion and prevention

The capacity of local communities to address COVID-19 will be strengthened in Phase 2 through the training of community health workers, school personnel, volunteers, non-health professionals, community leaders e.g., traditional, religious and political leaders, as well as women and youth groups. The development of peer-to-peer and participatory training will cover the prevention measures as well as disease control aspects that require communities to remain vigilant against COVID-19. Communities will be empowered to create and sustain COVID-19 coalitions as part of an active community engagement approach to halt the transmission chain. This process will be implemented through training of trainers (ToTs) and will be extended through peer-to-peer training given the limited movement into communities.

These models of capacity development at the community level will be documented and their impact evaluated in Phase 2 so that they may serve as evidence-based and theory-informed practiceexamples of community health promotion that can be applied into the future to address a wider range of community health promotion issues.

4) Monitoring the implementation and documenting the effects of the intervention

A Consolidated Evaluation Framework for the project has been developed in Phase 1 to facilitate the monitoring and evaluation of project activities. Using the RE-AIM framework as a guide, the main questions to be answered include: How effective are the project interventions in supporting local communities in reducing the spread of COVID-19 across the targeted areas of intervention? What are the implications of project findings for country-wide application? This evaluation framework employs a mixed methods evaluation methodology to explore the following questions:

- **Reach** - How many community members accept the use of the project RCCE strategies for COVID-19control?
- **Effectiveness** - What are the effects of the project interventions on protective behaviours in reducingCOVID-19 transmission rates, both positive and negative?
- **Adoption** - What is the level of uptake and institutionalisation of RCCE measures for COVID-19 bycommunity members, healthcare workers and school settings?
- **Implementation** - What is the extent to which RCCE measures for COVID-19 are implemented asintended in the local community and school settings?
- **Maintenance** - What is the extent to which RCCE measures for COVID-19 are sustained over time?

The evaluation will focus on assessing the process of delivery and the impact of the project's RCCE interventions on community knowledge, attitudes, practices, beliefs and culture-specific norms, as well as cultural and other misconceptions concerning COVID-19. The use of the RE-AIM framework will enable performance monitoring and evaluation of project inputs, process, outputs and impacts based on the following:

- Behavioural and process indicators will be established, with participation of intendedbeneficiaries and local authorities, prior to implementation of Phase 2 interventions
- Behavioural and process monitoring tools will be developed and data collection processesestablished
- Data analysis and results interpretation will be conducted in a participatory manner, involvinglocal communities and local authorities
  Report writing and consensus on the results and recommendations shall involve communities and project implementers
- Project outcomes shall be disseminated widely in order to benefit local communities as well aspolicy-level decision makers and programme implementers.

The use of a common monitoring and evaluation framework will facilitate reporting across the various interventions and countries involved, as well as the knowledge-sharing component between regions/countries. This contributes to a body of knowledge on transferable, evidence-based practices in risk communication, community engagement and behaviour change.

Timeframe, Budget, and Governance: The overall project will be managed by the IUHPE Project Management Group who will receive regular reports from the African and India Country Leads. **The proposed Phase 2 of the project will run for 5 months from March to July 2021.**

All project activities will be implemented in adherence with COVID-19 public health measures with limited personal interactions maintaining physical distancing and employing electronic/remote communication supports.

Project Objectives

Considering the efforts of local governments, health service providers as well as other organizations, as well as other international partners such as WHO, UNICEF, IFRC, World Bank and much larger NGOs operating on the continent such as CARE International, World Vision, this project will continue to pursue the following objectives in Phase 2:

Objective 1: To engage local communities and key stakeholders in the COVID-19 response and empower them to reduce its spread.

Objective 2: To enable local communities to protect themselves, their families and communities by taking effective behavioural action to stop the spread of the virus in their community.

Objective 3: To ensure that community level implementation is informed by best available knowledge, research and resources on effective risk community and community engagement.

Objective 4: To create community coalitions to coordinate local responses adapted to the needs of local communities

Central to this initiative is implementing effective risk communication and community engagement measures based on the following core actions:

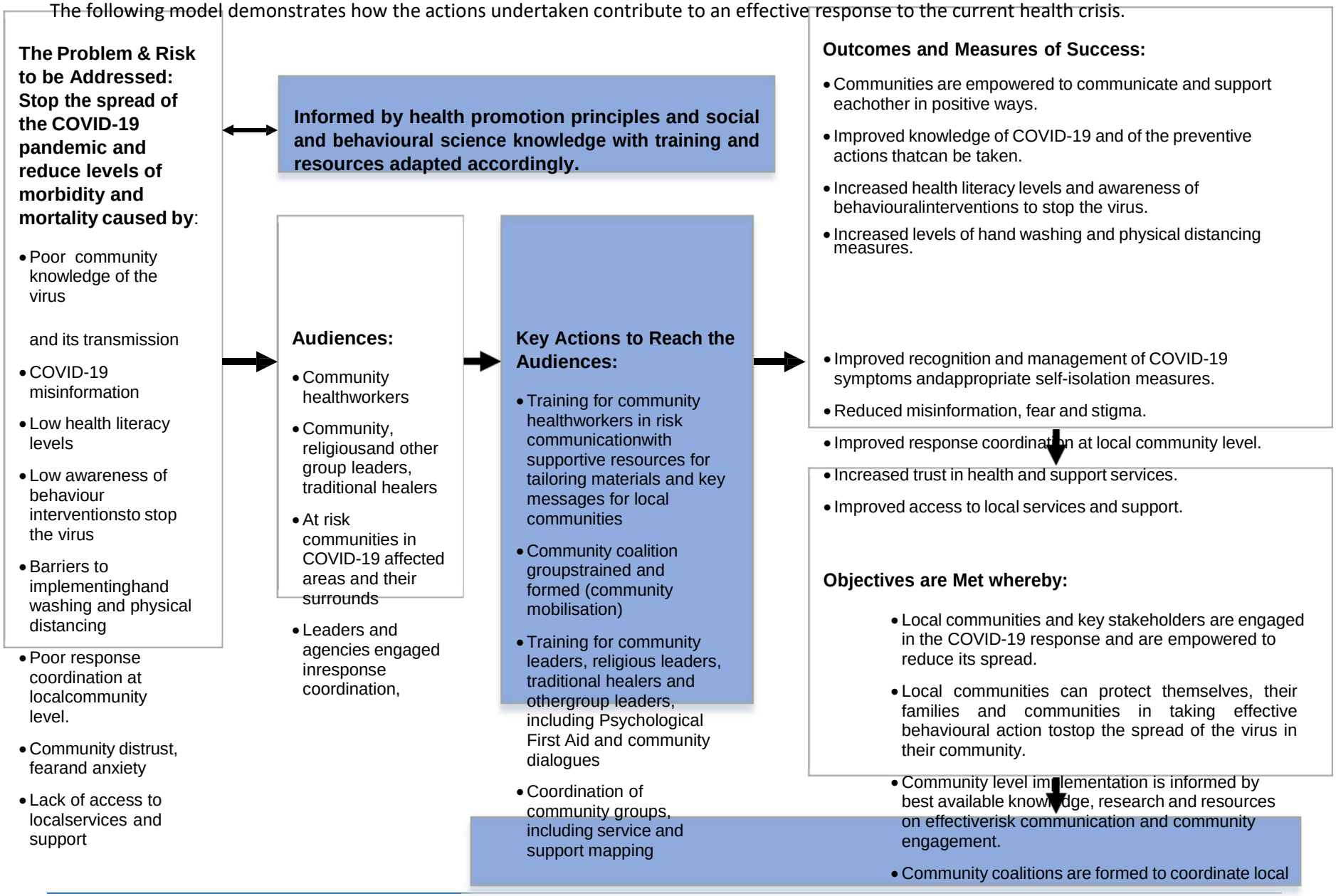
- Training for community health workers in risk communication with supportive resources for tailoringmaterials and key messages for local communities
- Community coalition groups trained and formed (community mobilisation)
- Training for community leaders, religious leaders, traditional healers and other group leaders, includingPsychological First Aid and community dialogues
- Collaboration of coordination groups, including service and support mapping.

The project logic model developed in Phase 1 (see Figure1) and overall plan is guided by recommended pandemic Risk Communication and Community Engagement (RCCE) response frameworks[1] and informed by experience of developing effective community engagement strategies in Phase 1. The further implementation, evaluation and dissemination of the project interventions will be an important focus in Phase 2, as well as sharing intervention implementation knowledge and evaluation data across the participating sites.

[1] https://www.who.int/publications/i/item/risk-communication-and-community-engagement-(rcce)-action-plan-guidance

Figure 1. Logic Model

The following model demonstrates how the actions undertaken contribute to an effective response to the current health crisis.



Ultimate Impact: Effective community engagement in implementing behavioural measures to stop thespread of the virus as quickly as possible.

Phase 2 Country Specific Actions

Within each country the target communities and key community stakeholders have been identified by the respective Country Leads in collaboration with the country-level partners in each of the countries. Within each community the main target audiences include: community health workers and volunteers; community, religious and other group leaders, traditional healers; school staff and students; youth and women's groups and at-risk communities in COVID-19 affected areas and their surrounds; leaders and agencies engaged in response coordination, including the Ministries of Health and Education.

The Phase 2 project activities will complement the work of other existing agencies, avoiding duplication and filling gaps in community support in the local settings. The specific country-level partnerships involve a mix of both urban and rural communities and a range of local statutory and voluntary partnerships. Project actions will fill a gap in the existing response at the community level. Efforts will focus specifically on reaching populations in need/at risk in the context of the epidemic and documenting effective models of community working based on community engagement strategies and intervention-based research.

South Africa

Context: South Africa is the African continent's worst-hit country by coronavirus, accounting for around 43 percent of the continent's diagnosed coronavirus infections. The number of people in South Africa who have tested positive for coronavirus has reached a total of 785, 139 COVID – 19 cases and 21, 439 deaths since the start of the pandemic. South Africa experienced its peak between July and August when daily new cases averaged around 12,000 and the number started to decline (NDoH, 2020). However, recent statistics released by the health ministry show a steady increase in the number of cases, with 2,019 new COVID-19 cases on Friday, 27 November 2020 and the total number of coronavirus-related deaths rising to 18,370.

The project is based in Limpopo province, which is one of the nine provinces in South Africa with a population of about 5.9 million people (2019 estimate). The inhabitants of this province are predominantly 'Black' (97.1%) by ethnic classification. During the apartheid years all South Africans were classified in accordance with racial groups. The provision of services occurred along "racially" segregated lines with the 'Black' communities marginalized. The disproportionate provision of services to different 'racial groups' led to inequalities in the health care system. This unfortunate situation continues to linger even to the present day in South Africa. Limpopo province is one of these communities, a rural region, characterized mainly by per-urban townships, tribal villages and informal settlements. Large families live in deprived conditions in the region, lacking satisfactory water supply, sanitation and access to basic services. As one of the poorest provinces, Limpopo spends less on health services, including health promotion activities, than other provinces. While government COVID-19 mitigation measures are spread across the country, most intervention activities are concentrated in major cities including the few urban centres in Limpopo province.

The main goal of the South Africa intervention is to engage with key partners on the ground in the districts of Limpopo Province to plan and implement a range of risk communication and community engagement measures, based on health promotion principles, that will stop the spread of COVID 19 within communities, equitably, while protecting people's basic needs and their physical and mental health.

In pursuing this aim, the following activities have been completed in Phase 1:

- Identified and reviewed available communication/IEC materials in the province and from IUHPE Google drive and produced customised and adapted posters, flyers, branded promotional items such as t-shirts. These items were then translated into local languages. They are being distributed to catchment communities and are used for training purposes.

- Developed a mobile phone Application for use by Community Health Workers during household preparedness visits in the province. There are 8000 CHWs in the province. The Provincial Department ofHealth gave each of them a mobile phone to capture data related to COVID 19 during routine home visits.

- Trained key Community Health Workers in all three districts.

- Trained community leaders, religious leaders, traditional healers and other group leaders, includingPsychological First Aid have been completed in two districts and community dialogues is continuing.

Community coalition groups have been formed in three of the sub-districts of Limpopo Province. Members of these group have be trained to assist with household visits for information dissemination and data collection.

Aim: The aim of Phase 2 is to expand the reach of the outcome of Phase1 to communities in the current three districts that did not benefit from the interventions taking place to date. Phase 2 will also include interventions that will be effective in driving the up-take of COVID-19 vaccines that is being rolled out in South Africa. This will entail addressing some key challenges that will face the rollout including vaccine hesitancy, as misinformation about vaccines circulates across the continent, as well as adapting strategies to target adults, when typically vaccination campaigns target children. The health workers trained in phase 1 who will be involved in implementation of COVID-19 vaccination will be re-trained to have adequate knowledge and skills in order to ensure safe and effective administration.

Phase 2 will move beyond previous interventions by including:

- Mobilization of support for the project from local partners and the surrounding community.
- Re-training of health workers trained in phase 1 who will be involved in implementation of COVID – 19vaccination to have adequate knowledge and skills in order to ensure safe and effective administration.
- Systematic teaching in order to change culture-specific norms, attitudes and beliefs (particularly misconceptions, misinformation and infodemic) which prove to be related to health compromising practices - strengthening of norms, attitudes and beliefs which may represent a key or gateway to adhering to positive public health practices directed towards preventing the spread of COVID -19 in thecommunity.
- Mobilization of target groups, especially community members with underlying condition and elderlycitizens who are at greater risk of COVID – 19 infection and prioritizing them for the early phase of vaccine administration to ensure uptake.
- Retraining of Health Workers

Specific objectives of the South Africa Phase 2 project

The project will have five specific objectives:

1. To examine the content and design of materials used in Phase 1 South Africa interventions in light of new research evidence and relevant theory and guidance in order to identify and improve sub-optimal elements and aspects.
2. To increase the knowledge and skills of community health workers trained in phase 1 who will be involved in implementation of COVID-19 vaccination to have adequate in order to ensure safe and effective administration.
3. To reduce on culture-specific norms, attitudes and beliefs, addressing misinformation, misconceptions, myths and stigma as well as coronavirus vaccine mistrust.
4. To evaluate Phase 2 activities through a combination of quantitative and qualitative research approaches.

Kenya

Context: The African Institute for Health and Development (AIHD)is implementing the COVID-19 Health Promotion Project in Kenya in partnership with the Division of Health Promotion and the Nairobi Metropolitan Services (NMS) (August 2020 – February 2021). During Phase 1, the project employed health promotion strategies to promote behaviour change in the communities, including an observation of the adherence to Ministry of Health (MoH) prevention guidelines: (i) wearing of masks; (ii) handwashing and sanitizing; (iii) no handshaking; and (iv) social distancing. Although the MoH has a risk communication and communication engagement (RCCE) strategy, the challenge has been that the information is relayed at the national level with little focus on communities and their varied information needs.

The Nairobi project activities have entailed facilitating the health and administrative team (chiefs, community health assistants and ward administrators) in Kasarani sub-County to identify community own resource persons (CORPs). The CORPs have included local influencers, leaders (youth, market, women), leaders of people with disabilities, religious leaders, and administrative leaders (chiefs, assistant chiefs, ward administrators, etc.). The CORPs (70) were trained on COVID-19 on the symptoms, and the critical role of the key actions pronounced by the MoH towards prevention. The CORPs have been facilitated to share information with their target groups at strategic places such as bus/matatu terminus, churches, markets, group meetings, etc. Following the training, the project has seen an improvement in the uptake of the prevention mechanisms. The CORPs have continued to talk about COVID-19 in their communities, even when the facilitation from the project has stopped. It is intended to trial this approach outside of Nairobi.

The County team of Kisii is keen to be part of this project. In discussions with the County Executive Committee (CEC) Member of Health (who is like the Minister of Health), she indicated the possibility of the County allocating some resources towards the intervention, which will not only engender commitment; it will also signify sustainability of the structures put in place in the county beyond the project funding.

Problem Statement

Until a vaccine or an effective antiviral treatment is universally available, the only possible response to the current pandemic outbreak is socio-behavioral actions to stop the spread of the virus and strengthen healthcare systems to meet the needs of people who need hospital and critical care. Furthermore, although the Government opened learning institutions for the finalists and those preparing for national exams, there have been reported infections

in schools leading to death of mainly teachers and principals. The planned re-opening of schools in January 2021, should be accompanied by a coordinated BCC campaign between the Division of Health Promotion, Ministry of Education and the County Health team (since health is a devolved function).

The distrust of the government on the magnitude of the disease and the numbers reported by the MoH seems to be influencing behavior negatively. Further, misconceptions on COVID-19 and its impacts are still rife in communities. Consequently, there is an apparent relapse in the behavior of individuals and communities:

i. People are not wearing masks and if they wear them, they are not properly worn;
ii. Social gatherings have become the norm with large numbers in attendance (religious gathering,funerals, weddings, political rallies, etc.);
iii. Inadequate attention to social distancing, sanitizing and handwashing in public places such assupermarkets, eateries, bars etc.;
iv. Public service vehicles and boda boda (motorbike) riders have stopped observing the recommendedetiquette; and
v. A mentality of waiting for the Government to solve the COVID-19 problem (lack of ownership).

Justification

The aim of this project is to apply the lessons learnt in BCC activities to engage with key County level stakeholders to plan and implement a range of risk communication and community engagement (RCCE) measures, based on health promotion principles, which will limit the spread of the disease within communities, while protecting people's basic needs and their physical and mental health. Given the urgency of the pandemic situation, interventions to limit the spread of the virus must be implemented quickly while ensuring quality. To maximize intervention effectiveness, BCC actions must mirror the emergency/disease outbreak cycle or progression as targeted in the WHO framework and the MoH commitment to containing the virus.

The Kisii County team will be supported technically by the team from the African Institute for Health and Development (AIHD) and the National Health Promotion Division that is currently working with the Nairobi Metropolitan Services (NMT) to deliver a BCC program in Nairobi. Lessons learnt from the current project will be used to inform the activities in Kisii County.

Objectives

i. To engage local communities (through community own resource persons – CORPs) and key stakeholdersin the COVID-19 response and empower them to reduce its spread.
ii. To enable local communities to protect themselves, their families and communities by taking effectivebehavioral actions to limit the spread of the virus in their communities.
iii. To ensure that community level implementation is informed by the best available knowledge, researchand resources on effective risk communication and community engagement.
iv. To create community coalitions to coordinate local responses adapted to the needs of local communities.

Key outcome: At least 50% of households in the county are practicing the recommended measures to prevent the spread of COVID-19 in their communities.

Due to the limited resources and reduced timeframe, the project will be implemented in Kisii Central sub-county, where Kisii town is located. The evaluation activities will be similarly scaled down to be accommodated within the budget.

Priority Actions

i. Effective risk communication that will enable people to protect themselves, their families and communitiesfrom the virus

This will entail providing easy-to-understand and culturally appropriate information at the community level, taking into account the unique needs, assets and levels of vulnerability of the community members. The process will ensure that local communities can access, understand and implement basic health information concerning the severity of the virus and its transmission through key actions such as hand washing, physical distancing, symptom recognition and appropriate help-seeking and self-isolation measures. Risk communication will be tailored to meet the health literacy needs of local community groups employing the most appropriate and effective local channels of communication.

ii. Empowering communities in adopting effective responses and managing the psychosocial impacts of thepandemic

Working in collaboration with key community stakeholders, local community health workers, volunteers and responders will be equipped with skills in supporting effective actions at the community level. Training will be provided on undertaking community dialogues creating a two-way communication on the virus and its impact and tackling 'infodemic'. This will entail the regular collection of community insights on tracking rumors, sources of stigma, misinformation and disinformation.

Training will also be provided on Psychological First Aid in dealing with the mental health impacts of the virus and establishing community health promotion coalitions that will serve to engage communities in actively keeping themselves, their families and each other safe and building trust in the local health and community services.

iii. Strengthening capacity and systems to support community-based health promotion and prevention

Capacity of local communities to address COVID-19 will be strengthened through training of community health workers, volunteers, non-health professionals, community leaders e.g., traditional, religious and political leaders as well as women and youth. The participatory training will cover the prevention measures as well as disease control aspects that require communities to remain vigilant against COVID-19. Communities will be empowered to create and sustain COVID-19 coalitions as part of an active community engagement approach to halt the transmission chain including linkage to frontline health facilities. This process will be implemented through training of trainers (ToTs) given the limited movement into communities.

iv. Monitoring the implementation and documenting the effects of the intervention

- Indicators, targets, outputs and outcomes will be set before implementation of interventions with participation of intended beneficiaries and local authorities;
- Monitoring tools will be developed, data collection processes established and project staff for monitoringand evaluation designated;
- Data analysis and processing results will be conducted with the participation of local communities andlocal authorities;

- Report writing and consensus on the results and recommendations shall involve communities and projectimplementers; and
- Project outcomes shall be disseminated widely in order to benefit local communities as well as policy-level decision makers and program implementers.

It is notable that these activities shall be implemented with limited personal interactions maintaining physical distancing and employing electronic/remote communication support as appropriate.

Approach

Central to this initiative is implementing effective RCCE measures based on the following core actions:

- Close coordination of the activities with the health system including the health management team at theCounty and sub-County levels;
- Training for community own resource persons (CORPs) in risk communication with supportive resourcesfor tailoring materials and key messages for local communities;
- Formation and training of community coalition groups trained (community mobilization);
- Training CORPs on all aspects of the COVID-19 including Psychological First Aid and community dialogues;and
- Strengthening of the collaboration of coordination groups, including service and support mapping.

Target Population for the Intervention

The County has identified the following as the key populations to be targeted as CORPs.

Table 1: Category of targeted corps and the rationale

#	Category	Rationale	Who?
1.	Boda Boda	They ferry people to different parts of the county. Although the government has instructed that they wear masks and carry only one passenger, this rule has been overlooked. They could be a main conduit of infection.	-Association leaders -Area leaders -Influencers
2.	Matatu industry	The county has a lot of transport vehicles given its central location in the region. Although the government reduced the number each of the vehicles can carry (from 14 to 8) the industry has not been adherent. It is also served by drivers, conductors and other hang-abouts at the terminus.	-Association leaders -Matatu owners -Drivers -Conductors -Turn-boys
3.	Religious leaders	Churches have been allowed to operate with limitation in numbers (up to 100) and exclusions: people aged below 6 and above 65 years and those with pre-existing conditions. However, people do not seem to understand the exclusions. Religious leaders would therefore be instrumental in BCC.	-Key religious groups (Seventh Day Adventists, Catholics, Muslims, Pentecostal, etc)
4.	Markets	There are several big markets in the County with some operating throughout the week with specific market days. The interactions at the market are numerous and they pose a specific risk to the vendors, buyers and suppliers.	-Main markets in Kisii, Keumbu, etc -Market association and leaders -Influencers -Business owners
5.	Local leaders and influencers	Communities in the county have various management structures. There are village-level leaders and influencers that are respected. If these persons understand and start adorning marks, this will be likely taken up by other people. The influencers differ and this will need to be determined at the community. Local leaders know members of households. They are best placed to monitor how members are behaving towards COVID-19. They are at numerous levels and are a close link to health services and other service providers.	-Elders, women group leaders, youth group leaders, leaders of local associations, leaders of persons with disabilities, etc. Community health volunteers and other voluntary workers.
6.	Administrative leadership	Administratively, the two arms of government are represented in the community. The county system is structured in sub-county and wards, while the national system has the location and sub-locations. The leadership has varied influence at the community; therefore, the project team will rely on the people to identify the likely influencers. What we learned in Nairobi is that these leaders are very good at mobilizing community members.	Chiefs, sub-chiefs, elders, Sub-County leaders, Members ofCounty Assembly, ward administrators, community development assistants (CDAs), etc.
7.	School administrators	There are many schools in the county (primary and secondary) that would also require an intervention. The education leadership at the county and the school administrators will be key partners in this component of the project.	-County level leadership -Kenya National Union of Teachers -School heads, parents teachers' associations (PTAs) and Board of Managers

Zimbabwe and Zambia: Strengthening the Capacity and Readiness of Schools to address COVID-19

The focus of the project in Zimbabwe and Zambia is concerned with strengthening the capacity and readiness of schools to implement Ministry of General Education guidelines for COVID-19, working with the schools as an entry point for building school - community links to address COVID-19. Pilot projects have been conducted in Phase 1, focusing on strengthening the capacity of primary schools to adhere to the prevention and control measures recommended by WHO and their respective Ministry of Health and Ministry of Education guidelines. Training of school heads and teachers is being undertaken guided by findings from a rapid SOP assessment in the school districts. This work will be further developed and finalized during Phase 2 as outlined below.

Zimbabwe

Context: In Zimbabwe the schools project is being implemented in two school districts, namely Hwange (Matabeleland North Province) and Beitbridge (Matabeleland South Province). The project is led by Dr Davison Munodawafa, Professor of Community Medicine at Midlands State University, in collaboration with implementing partners from the National Association of Primary Heads (NAPH) and Midlands State University.

To date, funding for Phase 1 has achieved the following:

1. An Implementation Plan was agreed with the Ministry of Primary and Secondary Education and theMinistry of Health and Child Care, and NAPH.
2. Strategic planning meetings with local stakeholders have been held and an operational framework for thecapacity strengthening component of the project has been drawn up.
3. Recruitment of the Project team members was initiated and concluded. A research coordinator and 2enumerators were recruited and orientation on the project was done;
4. A rapid assessment was conducted in the 2 School Districts to collect information regarding the state of readiness of schools to manage COVID-19 prevention and control. Beitbridge District had a total of 74 Primary Schools and Hwange had 89 Primary Schools. A total of 163 School Heads and/or School Health Coordinators were interviewed by enumerators via telephone using the Open Data Kit (ODK) toolprocedures.
5. Capacity building workshops have been held to date in for both Hwange and Beitbridge School Districts and each district workshop had 20 participants in attendance making a total of 40 teachers trained.
6. The Workshop put forward recommendations for future activities address COVID-19 in schools.

The following thematic issues are identified as essential in order to wind this IUHPE – MSU project funded by Vital Strategies. It is believed these activities could go some ways to consolidate the gains made during Phase 1:

1. Dissemination of findings and recommendations from the rapid assessment. This would include participants from the 2 School Districts and officials from Ministry of Primary Education and Ministry of Health, and implementing partners at District levels.

2. Developing a *Guide for Building School and Community Links* to address COVID-19 in line with the COVID-19 Government Standard Operating Procedure (SOP) for Schools.

3. Providing technical support to our main partner, The National Association of Primary Heads (NAPH) to develop a Proposal for Resource Mobilization to implement and manage COVID-19 interventions in schools guided by the Government SOP.

In-kind contributions will include support from Midlands State University in the form of staff-time and a donation of sanitizers and masks. Furthermore, Midlands State University through the Project Team Lead, Prof Munodawafa will engage with UNICEF, and WHO Country Offices and WHO AFRO seeking further funding.

Zambia

Context: In Zambia the schools project is being implemented in the school districts of Kafue and Chirundu. The project is led by Dr Oliver Mweemba, Department of Health Promotion and Education, School of Public Health, University of Zambia, in collaboration with implementing partners from the Ministry of General Education and Ministry of Health. Approvals have been received from the Ministries of Health and General Education and the University of Zambia Biomedical Ethics Committee (UNZABREC)to implement the project activities with training being undertaken in two districts (Kafue and Chirundu) with school teachers and PTA members. Senior members of staff from both ministries serve on the Advisory board of the project. The project is focused on rural schools.

Site visits have been undertaken and engagement with five local schools has been undertaken with assistance from the District Education Office. Trainers from the Ministry of Health and Education, who will be in charge of conducting the training activities, have been identified and training materials developed. A situation analysis and training needs assessment was developed and monitoring strategies put in place.

The Ministry of General Education in conjunction with Ministry of Health and partners such as UNICEF and World Bank in Zambia have developed school guidelines for COVID-19. The guidelines outline the *"protective measures schools should take to minimize the risk posed by COVID-19 to their staff, learners and communities."* The objectives of the COVID-19 guidelines are to:

- Guide provincial education offices, district education offices and administrators of primary and secondary schools on measures for preventing the spread of COVID-19 among learners, teachers, support staff and parents/guardians.
- Promote and sustain a safe and healthy learning environment.
- Help schools to understand and follow measures for managing suspected and confirmed cases of COVID-19.
- Promote capacity building among stakeholders on the implementation of the COVID-19 prevention andcontrol provisions as well as other school health activities.
- Improve collaboration among line Ministries in planning and implementation of COVID - 19 preventionand control provisions in schools.

The guidelines also provide the specific areas and domains for action to tackle COVID-19. These include social distancing, use of face masks, hand washing and hygiene, sanitation, health education, health monitoring and disease management. The guidelines, therefore, recommend that every school should develop *Action Plans* for the above action domains to be implemented at school level.

The Zambia project team worked with the Ministry of General Education and Ministry of Health to conduct training with selected teachers and PTA members from 10 selected Schools in Kafue and Chirundu on the basic concepts on COVID-19 and the principles on preventing and management of COVID-19. The teachers and PTA members were also trained in the principles of risk communication and the positive health behaviours associated COVID-19. The training programme was implemented in November 2020 after a conducting a training needs assessment among teachers and PTA members.

Following the training on these topics, participatory research methods were used to work with the teachers and PTA members to develop *ACTION PLANS* for each school represented. A situation analysis was developed on the existing programmes and activities among pupils, teachers and parents/community in each of the action domains above and the gaps and challenges were identified in each group for each action domain. Following this, the participants then developed programmes and activities to reduce the gaps and the challenges in each school. Based on the activities implemented, a monitoring and evaluation plan was also developed.

Proposed remaining activities for the project (based on guidance given and available funds):

- Monitoring and evaluation visits to the schools to document implementation experiences (1 monitoring ofactivities and 1 final visit for evaluation)
- Data analysis and writing workshops on the needs assessment and situation analysis of the project andimplementation experience and impact evaluation (2 writing workshops for 2 papers)
- Dissemination workshop with partners at district and national levels on lessons learnt from the project
- Submit papers to peer reviewed journals

South-South Collaboration with the Voluntary Association of India

Context*:* The COVID-19 pandemic is spreading rapidly across India. As of November 30th 2020, India has the second highest number of COVID-19 cases in the world with a cumulative total of 9,431,691 confirmed cases and 137,139 deaths (case fatality ratio 1.45%). The pandemic has had a particularly adverse impact on vulnerable groups who face high levels of uncertainty in terms of their health and economic wellbeing. According to the United Nations University study in 2020, an estimated 104 million Indians could fall below the World Bank-determined poverty line of $3.2 a day for lower-middle-income countries. Where developed nations such as in European countries are limiting the overall socio-economic damage by focusing on building a strong recovery plan, for developing nations like India with limited capacity, weak health system and minuscule expenditure on health (1.2 % of the total GDP), managing COVID-19 emergency and its consequences is a herculean task.

This pandemic has exposed the fault lines in the health care system, as like most countries, India has struggled in influencing positive behaviour change and implementing risk communication strategies effectively. For instance, overcrowding in the markets during the festival seasons in India. It highlights the critical need of the hour – 'health promotion linked roadmap', to boost the nation's capacity. It requires collective action of the government and other stakeholders, including local communities, tailored to the local context, thereby and strengthening capacity for future preparedness.

VHAI's Experience:

The selection of India as a project setting in the South-East Asia Region is based on the high level of reported cases and the presence of a strong local Health Promotion partner, the Voluntary Health Association of India (VHAI). VHAI is a federation of 24 State Voluntary Health Associations linking together more than 4500 health and development institutions across the country. For the last five decades, VHAI has played a leading role in primary health care in India as well as in the implementation of innovative health and development programmes at the grassroots level with active participation of the local communities. VHAI's programmes are largely sustainable as they are community-based, low cost, utilising local resources and talents. VHAI also plays an important role at the national level on policy formulation, implementation and research and advocacy as a member of various advisory committees of Government of India. To name a few: Task Force on Tobacco Control, *Nasha Mukhti Abhiyan* (Committee on Preventive & Curative Aspects of NCDs), Advisory Group on Community Action, Task force on

School Health under Ministry of Health & Family Welfare. The organization finds significant representation in International committees by organisations such as World Health Organization and World Bank. Currently, International Post for IUHPE is based at VHAI, New Delhi to carry out systematic health promotion work in the South-East Asian Region.

For the last nine months, VHAI has been proactively working with the local communities in different settings of the country to educate and support them on COVID-19 prevention and management in close collaboration with the central, respective state and local governments. Concerted COVID-19 response became an integral part of the existing community-based programmes of VHAI on TB prevention, immunization, NCDs prevention and control among others. VHAI efforts are largely focused on development of IEC materials, information dissemination, risk communication and behaviour change as well as empowering the local communities to mitigate the impact of COVID-19, including the creation of hand washing facilities in the villages, supporting mask making initiatives, the promotion of kitchen garden, awareness through established peer and community networks and emergency supplies of dry ration to the most vulnerable families.

Aim & Objectives: Taking into account VHAI's extensive experience, together with the efforts of local governments and other organisations, the proposed project aims to build the capacity and resilience of the local communities and health systems to mitigate the future outbreaks as well as develop an innovative health promotion model for effective management and prevention of COVID-19 in the South East Asia Region and beyond with the following specific objectives:

1. To build the capacity of the local communities and other stakeholders in the COVID-19 response and empowerthem to mitigate its impact.
2. To facilitate positive behaviour change on COVID-19 prevention and management, and to build communityresilience for prevention of future disease outbreaks.
3. To create peer educator networks and community coalitions for knowledge sharing and to coordinate localresponses adapted to the needs of local communities.
4. To strengthen linkages between the local communities and the government system as well as strengtheningthe ongoing government programmes catering to the needs of the vulnerable population.
5. To develop a sustainable roadmap for effective management and prevention of COVID-19 as well as futureoutbreak based on the experiences and practices of the proposed actions & other partners in African region.

Proposed geographical area: The proposed action will focus on the most vulnerable communities, who underwent a worse crisis due to COVID-19 in one state of India - Odisha (District Ganjam). Building on VHAI's experience of working with these communities in the past, there is a firm basis on which to establish community empowerment and enhance community resilience and thus, the action will ensure a sustainable health promotion model that is replicable beyond this setting.

The region has poor literacy rates, high unemployment rates, below average labour force participation rate, migration of skilled population to other states.

Odisha is a cyclone-prone eastern Indian state with a population of 41.97 million of which more than 83% population is rural. The state has a sex ratio of 979 and literacy rate of 72.87%. The Labour Force Participation Rate (LFPR) is 47.5%. As per the NFHS 2015-16 survey, only 19.2% households use clean fuel for cooking. 21.3% women in the age group of 20-24 years are married before the age of eighteen. Post COVID-19 induced lockdown, as of June 2020, more than 500,000 migrant workers have returned home to Odisha. District Ganjam's economy has been dependent on agriculture, causing lakhs to migrate to other states for better employment opportunities.

As the District has a significant population working in the un-organised sector of other states, more than 200,000 have returned to the District. The district accounted for almost one-third of the total cases in the state and requires utmost support to control the impact of the virus.

Key project stakeholder groups: While governments have shown exceeding commitment to provide necessary support, these extraordinary prevailing conditions require additional support for the more vulnerable sections of the community. The proposed action will work closely with the local communities, especially with marginalized groups, and existing community platforms such as youth groups, self-help groups, village committees, religious leaders, along with government frontline workers such as ASHAs, AWWs, ANMs, teachers, Health & Wellness Centers staff. The project actions will be implemented in close coordination with the local (district and block administration), state and central governments along with other key stakeholders such as local NGOs/CSOs among others.

Specific objectives of the VHAI India project:

a. Rapid Assessment: A rapid community-based assessment will be conducted to assess the existing knowledge and practice as well as needs of the local communities in the proposed intervention areas.

b. Behaviour Change and Risk Communication: This will include formation and capacity strengthening of peereducator networks, the pre-existing COVID-19 team, if any, as well as the government frontline workers. The communication strategies & IEC material will be tailored as per the health literacy of the local community groups, employing the most effective channels of communication such as one-to-one discussion, small group discussions, consultations, street plays, films, social media etc.

c. Social Collective Action to build community resilience and support community-based health promotion: This will entail capacity strengthening of community groups, religious/political leaders, strengthening of local self-government to prepare COVID-19 resilient Gram Panchayat (Village Council) Development Planand active advocacy with the government for pro-vulnerable policies. This will help to build linkages between the communities, government and other agencies, thus ensuring the long-term sustainability ofthe proposed action.

d. Strengthening ongoing Government programmes: The proposed action is not a duplication of existing programmes. Rather, it will extend strong support to strengthen the ongoing government programmes and grass roots health systems such as Health & Wellness Centers. This will be done through liaising with the government departments to integrate health promotion as an important component in their ongoinghealth and development programmes at the grassroots.

e. Addressing Social Determinants of Health: The proposed action will be a community led process, which will also address some of the key social determinants of heath such as provision of hand washing facilitiesas well as strengthening of government health facilities**.**

f. Knowledge Development: Initial step will be to assess, collect and review existing resource material on COVID-19 prevention and management through secondary research. A set of IEC material such as a toolkit,training modules, leaflets and posters will be developed/adapted, taking into account the findings of thecommunity based assessment (knowledge, attitudes & perceptions about COVID-19), communication patterns as well as inequalities and vulnerabilities of the population.

g. Monitoring and Evaluation: Building on the Monitoring & Evaluation framework developed in Phase 1 of the project, the proposed project will track both process and behavioural indicators and the desired project outputs and outcomes. Monthly reports along with regular review meetings will also help to keepa track of the progress.

   Community- based monitoring and planning will be a crucial component of the proposed action as it will ensure that the needs of the local communities are adequately addressed, thus increasing community ownership of the action, which will be largely sustainable.

h. Documenting the evidence and best practices to develop a sustainable future roadmap: A document capturing the clear sustainable roadmap for effective management and prevention of COVID-19 as well as future disease outbreak will be prepared based on the key learnings and experiences of the programme,also drawing on examples from the other partner countries.

Evidence Based Outcomes:

INDIVIDUAL/COMMUNITY LEVELS

- Improved knowledge of the local communities on Health Promotion as well as COVID-19 prevention andmanagement.
- Reduction in public discrimination, stigma and fear related to COVID-19.
- Improved health behaviour of the local communities such as increasing levels of hand washing, wearing ofmasks in public places, physical distancing measures.
- Improved health-seeking behaviour of the local communities and better utilisation of the Governmentservices by the communities.

SYSTEMS/INSTITUTIONAL LEVEL

- Strengthened relationship between the Government health systems and local communities.
- Better coordinated COVID-19 response at the local level with active involvement of community groups.
- Improved local health services such as HWCs & delivery mechanism at the local level

Added Value: The proposed collaborative South-South action will gain from VHAI's five decades of experience in implementing similar community led programmes in most remote and difficult regions of India. VHAI has worked with the Government of India and State Government of Arunachal Pradesh to strengthen the existing Government health systems in difficult border areas of the State. Similarly, an innovative project "KHOJ" – an integrated health and development was implemented in 30 remote pockets in collaboration with the Government & EED-Germany. VHAI's experience and learning from these programmes were integrated in larger initiatives of the Government to tackle similar situations. Since the proposed programme's project design has taken into account the concept of community ownership, the intervention action will be sustained on the ground through community networks such as peer educator groups.

In addition, VHAI has worked with disease outbreaks and emergencies in the past. The organization collaborated with the Prime Minister's Office to rehabilitate the vulnerable communities affected by disasters such as post super-cyclone in Odisha. VHAI has worked in immediate relief and long-term rehabilitation of the local communities affected by Tsunami Bhuj and Kashmir Earthquake, assisting the communities in turning disaster into development.

In response to increasing HIV/AIDS cases, VHAI, in close collaboration with Government of India & National AIDS Control Organisation (NACO), has implemented Link Workers Scheme in various settings of the country, which reached out to High- risk groups (sex workers, intravenous drug users) and other vulnerable sections in the rural areas with information, knowledge, skills on HIV/STI prevention and risk reduction.

Currently, VHAI is working with UNICEF on the Universal Immunization programme to support the Government of India in ensuring that no child suffers from diseases that can be prevented by vaccination in 6 states of India.

The impact and outcomes of the proposed interventions in the form of a theory-to-practice model (research document) will be shared with VHAI's network of more 4500 health and development institutions across the country and IUHPE's vast network of partners across the world. VHAI has an acceptable voice in the Central and State Governments, which will allow horizontal sharing of information and our experiences of the proposed actions, thus impacting and strengthening the Government policies and programmes. The theoretical framework will act as a readymade tool for policy makers, Governments, NGOs, researchers etc. in effective management and prevention of COVID-19 /future outbreaks in the South-East Asia Region and beyond.

Monitoring and Evaluation Framework

In line with global guidance by WHO and UNICEF, Phase 2 of this project will develop a robust monitoring and evaluation (M&E) framework to evaluate the implementation of the RCCE strategy, building on the Phase 1 framework and project findings. Applying the logic model presented in Figure 1 (see page 9), the monitoring plan will evaluate how well the objectives of the RCCE plan are being fulfilled in each country. This includes identifying the activities that each of the country teams perform and the outcomes they are designed to achieve with target audiences (communities, at-risk populations, schools, stakeholders, etc.). The M&E plan will include articulation of the specific behavioural determinants, such as knowledge, attitudes and skills that will be monitored during project implementation. Accordingly, the M&E framework will be comprised of both process and behavioural indicators for each desired behaviour output. Process monitoring of the quality, reach and frequency of media and communication channels will be a key responsibility of the Country teams. IUHPE has experience in media monitoring and more recently expanding this expertise to social media channels, as well as documenting reviews to capture the process.

The behavioural indicators will be jointly developed between the Country Teams and then formulated in an easy-to-use checklist that can be used by local NGOs/CBOs community health workers or volunteers, and/or identified community key informants /influencers. Data collection will entail using an SMS platform such as WHATSAPP, Viber or another common system easily accessible in-country. By collecting such data on a systematic basis (e.g. monthly), a database of first-hand observations will be established and the findings analysed over time (trend analysis). A sample checklist is shown below:

Table 1. Behavioural Monitoring: Sample Observation Checklist for COVID-19

(Purposive sampling – pick any 5 persons observed in a community)

Questions	Obs 1	Obs 2	Obs 3	Obs 4	Obs 5	TOTAL ❒ **Yes**	TOTAL ❒ **No**
1. Households practicing physical distancing							
2. Households practicing hand hygiene							
3. Households wearing masks							

A second source of data collection entails community surveillance using UNICEF U-report or WHO field reporting methodology. This approach facilitates providing a small set of simple questions that can be uploaded and answered on a mobile phone. This approach is based on UNICEF experience in responding to the Ebola outbreak during which mobile phones were provided to selected community workers and/or young people who provided regular feedback on RCCE-related activities and observations of community or peer group behaviours.

The Monitoring and Evaluation protocol will also include attention to qualitative data collection to better understand the reasons, obstacles, opportunities that a selected participant group may face as they try to change or the factors that cause them to reject changes. Such observations are important to document to support programme shifts and/or mid-course corrections. As such, data collection methods will be adapted to focus on

key informant interviews combined with a polling methodology. The latter are especially useful with exploring behavioural issues/observations of community members and key influencers.

An example of the process and behavioural criteria/indicators to be used to monitor RCCE response activities is shown in the Table below. By standardizing the collected information, IUHPE and its partners will be able to determine trends and make comparisons across the different interventions/activities. To ensure country-specific needs and realities are factored appropriate, the M&E framework will be developed and refined in consultation with Country Team Leads.

Table 2. RCCE Objective: Within the next 3 months, at least 90% of households are practicing the recommended measures to prevent the spread of COVID-19 in their communities.

Criterion	Definition	Standard (Target/Min	Minimum	Mandatory/Type	Remarks/ Means of Verification
Community Engagement teams active in affected areas	Team comprising local frontline paid mobilizer/ volunteers with 1-2 community leaders/key influencers trained and ready to engage in health education and promoting preventive behaviours.	5 teams of 2 each/ village of 25,000 people or 1 team for 500 people or 100 HHs (5 people per HH) to be reached or engaged twice a week	At least once a week engagement with each HHs	Yes/ Yes	List of identified key religious leaders (including priests, imams, pastors, tribal leaders) or community groups who promote COVID-19 preventive measures
Community engagement (CE) dialogues online/radio for feedback and local action for prevention	Local community teams (2-3 people such as leader, religious person, teacher, youth, women's group) discuss how community can protect itself against COVID-19	Community level meetings and events with family members who may be in attendance	CE team meets community at least once a week	Yes/ Yes	Describe CE team composition Self-report/ observations Radio program
Households practicing recommended preventive measures	Adults/children	# and % HHs where members practice -physical distancing -self-isolation -washing hands	Daily observation/	Yes/Yes	Self-reporting (SMS, WhatsApp) Observation
HH members who understand and accept the importance of taking preventive action against COVID-19	Parents/caregivers	# and % adults who perceive themselves at risk and know what they can do to prevent	Self-report		SMS triggers/nudges

Data analysis and results will be conducted with participation of local communities and local authorities. Report writing and consensus on the results and recommendations shall involve communities and project implementers. In addition, project outcomes shall be disseminated widely in order to benefit local communities as well as policy-level decision makers and programme implementer.

Budget (March to July 2021)

Item	Tasks	Resource Type	Cost in USD
Administration and project support	Administrating overall grant and financial reporting to funder; technical support to scientific and communications activities	IUHPE Secretariat Staff	5 900 $
Country-level budget (upscaling of current RCCE interventions in South Africa)	Includes Human resources; Materials; Logistics; Admin costs	As required within each country budget	25 000 $
Country-level budget (upscaling of RCCE interventions in Kenya)	« «	« «	25 000 $
Country-level budget (Initiating RCCE interventions in India)	« «	« «	25 000 $
School-based projects in Zambia and Zimbabwe through the end of the school year (5K each)	« «	« «	10 000 $
Subtotal			90 900 $
Overhead- 10% of total cost (non-labour costs to IUHPE International Secretariat and Management and Working Groups-material, communications and logistical costs)			9 090 $
Total amount requested			**99 990 $**

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In-kind contribution from IUHPE		
Project oversight and expert input to Project Management Group		12 000 $
In-kind contribution from partners		
India (VHAI): capital cost such as office space and set-up at national and regional level, technical expertise of senior professionals and part salary of a national coordinator.		6 000 $
Zimbabwe National Association of Primary Heads: space on school grounds to hold training and teachers volunteering to review educational materials. Midlands State University: 200 litres of alcohol-based sanitizers 500 washable face masks for teachers. The project team shall contribute toward transportation wear and tear.		600 $
South Africa: staff time		3 000 $
Total in-kind contribution		**21 600 $**
Total value of project		**121 590 $**

Budget justification

The greatest proportion of funds is allocated to country-level efforts, which will be supported by IUHPE staff andtwo committees a Project Management Group.

As the Chair of the Project Management Group and other IUHPE Executive Board members will volunteer their time on the project, we include this as an in-kind contribution from IUHPE. Other in-kind contributions are provided by project partners, as estimated in the budget lines above.

IUHPE staff will be responsible for technical support as required and will also manage and report on the grant, including the implementation of an accountability mechanism to release funds and to track expenditures at the country level. Overhead costs are applied to the total grant amount and will go toward office and non-labour costsassociated with activities of the IUHPE staff and of the Project Management Group.