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Date: 15/05/2018

GRANT APPLICATION FORM

GENERAL INFORMATION ON ORGANIZATION AND PROJECT PROPOSAL

ORGANIZATION

¨ Full Name	International Federation of Red Cross and Red Crescent Societies (IFRC)		
¨ Date established	1919		
¨ Permanent address	Route du Pre-Bois 1, 1214 Vernier, Geneva, Switzerland		
¨ Name and the Title of Head of Organization	Elhadj As Sy, Secretary General		
¨ Contact person	Carmen Corminboeuf, Senior Officer, Partnerships and Resource Development		
¨ City	Geneva	¨ Phone number	+41 (0)22 730 42 78
¨ State/Province	Geneva	¨ Email	Carmen.corminboeuf@ifrc.org
¨ Country	Switzerland	¨ Fax number	+41 (0)22 730 4200
¨ Registration certificate (required)		¨ Website	www.ifrc.org

PROJECT PROPOSAL

¨ Project title	Contributing to Cholera Elimination in three High Risk Countries in Africa.		
¨ Sector	Water, Sanitation and Hygiene (WASH) & Public Health.	¨ City	N/A
¨ Beneficiary country(s)	Ghana, Malawi and Uganda.	¨ Region	Africa
¨ Total Project Budget in US$ **6,058,340**		¨ Provinces/Districts in each of the three target countries considered as cholera 'High Risk '. **Uganda**: Nebbi district **Ghana:** Eastern, Ashanti and Central regions **Malawi**: District Palombe	

DETAILED INFORMATION ON ORGANIZATION

Objectives (Objectives Briefly outline your organization's objectives)

¨ The IFRC Strategy 2020 is guiding the actions of the International Federation of Red Cross and Red Crescent Societies (IFRC) throughout this decade. It defines three strategic aims for the IFRC and its member National Societies to achieve a common vision and objective:

'to inspire, encourage, facilitate and promote at all times all forms of humanitarian activities by National Societies, with a view to preventing and alleviating human suffering, and thereby contributing to the maintenance and promotion of human dignity and peace in the world'

The strategic aims of Strategy 2020 are:

1. Save lives, protect livelihoods, and strengthen recovery from disasters and crises
2. Enable healthy and safe living
3. Promote social inclusion and a culture of non-violence and peace

Founded in 1919, the IFRC comprises over 190 member Red Cross and Red Crescent National Societies, a secretariat in Geneva and more than 60 delegations strategically located to support activities around the world. The Red Crescent is used in place of the Red Cross in many Islamic countries. The IFRC carries out relief operations to assist victims of disasters, and combines this with development work to strengthen the

capacities of its member National Societies. The IFRC's work focuses on four core areas: promoting humanitarian values, disaster response, disaster preparedness, and health, WASH and community care. https://media.ifrc.org/ifrc/

2.2 Major achievements (Outline any major achievements accomplished during the past 4-5 years)

¨ IFRC and its membership continues to be a significant worldwide humanitarian actor responding to major crises, both natural and man made especially complex and protracted crises and in the last five years especially in Syria and surrounding countries; the Ebola Epidemic in West-Africa; earthquake in Nepal; Cholera and food insecurity in the Horn of Africa, Haiti, Nigeria and Yemen; refugee operations in South Sudan/Uganda and Myanmar/Bangladesh; migration in Europe as well as many other smaller scale operations and crises.

In longer term Health and WASH programming, especially in disease specific multi-country projects containing and reducing the impact of epidemics; Malaria; Polio; Tuberculosis; Cholera and other WASH related diseases; HIV/Aids; Zika and infant and neo-natal diseases including harm reduction. In WASH we have been active in over 100 countries worldwide and during the last ten years reaching over 40 million people with improved access to sustainable water and sanitation facilities while promoting improved hygiene and behavior change, and in both humanitarian and developmental contexts. We have implemented WASH projects in partnership with OFID in Somalia, DR Congo and Zambia in the last three years.

We have been actively supporting present humanitarian and development activities in the three target countries for example WASH, Cholera Preparedness programming & community health in Ghana; WASH and Refugee Programming in Uganda; and WASH and Health programming in Malawi. National Societies have responded to cholera outbreaks in Uganda, Ghana and Malawi in recent years often together with Government and other humanitarian partners and supporters such as UNICEF. There have been recent outbreaks in Malawi and Uganda. These three countries are included in over 20 countries we have targeted for increased programming to combat cholera over the next 5 years (One WASH Phase 1).

We maintain a global WASH and Health team at every level, internationally, regionally, at country down to community level and especially at community level where we have several million Red Cross and Red Crescent volunteers worldwide often recruited from target populations. IFRC and the membership often acts as auxiliary to Government efforts and usually in alignment with their policies and strategies. IFRC and National Society staff and volunteers regularly are trained and retrained in the key skills required to respond to disasters and crises, in health and WASH programming and to undertake developmental activities while maintaining a global logistics, supply and administrative capacity and network.

Annual Report 2016 http://media.ifrc.org/ifrc-pages/

2.3 Funding Sources

¨ Name	¨ Contact details	¨ Contributions in USD
IFRC Annual Audited Accounts 2017 http://media.ifrc.org/ifrc/wp-content/uploads/sites/5/2018/04/IFRC-Report-2017.pdf	**Andrew RIZK, CA, CPA (Illinois), CBV, MPA** ***Director, Finance & Administration*** International Federation of Red Cross and Red Crescent Societies Route de Pré-Bois, 1 | 1214 Vernier | Geneva | Switzerland Tel. +41 (0) 22 730 4649 | Fax +41 (0) 22 730 4200 | Mob. +41 (0) 79 200 9312 Email andrew.rizk@ifrc.org | Skype andrew.rizk	**Contributions Summary:** Red Cross/Red Crescent 138 M USD Governments 68 M USD Corporations 18 M USD Multilateral Organisations 38 M USD Others 15 M USD **Total 2017 277 M USD**

EXECUTIVE SUMMARY
please include a brief (10 lines maximum) abstract of the project

The project will reduce the incidence, impact and severity of cholera outbreaks and epidemic's and resultant morbidity and mortality among the target population. The target population are at present considered 'high risk' living in cholera 'hot spots' subject to regular and recurring cholera outbreaks. The project intends therefore to reach 150,000 vulnerable men, women and children in Ghana, Malawi and Uganda with improved access to safe, affordable and sustainable water supply. adequate basic sanitation and knowledge and practice of improved hygiene behavior (WASH) the lack of which contributes significantly to cholera incidence. The project will also deliver to the target population public health programming components to raise further awareness of cholera and its transmission, means by which it can be better controlled, (the use of Oral Cholera Vaccine – OCV and timely rehydration and treatment) and improved community based cholera surveillance. This project is in alignment with and reflects the Global Task Force on Cholera Control (GTFCC) Cholera Roadmap, the IFRC 'One WASH' cholera initiative and will contribute to UN SDG 6 and SDG 3. The target population will also benefit significantly from secondary project impacts in overall improved health, dignity, safety and increased productivity with a focus upon women and children, those with disabilities and the disenfranchised while promoting environmental sustainability. The three countries chosen are included in over 20 countries that IFRC have targeted in the next 5 years for increased impact on cholera reduction.

BACKGROUND AND SITUATION ANALYSIS

Problem analysis
Please specify
- the core problem that you wish to address and the constraints
- the root cause of the problem and the effect it is having on the target group

¨ The Core problem is that Cholera is a disease of inequity—an ancient illness that today sickens and kills only the poorest and most vulnerable people. The map of cholera is essentially the same as a map of poverty. Every death from cholera is preventable with the tools we have today, putting the goal of ending its public health impact within our reach. Cholera has been eliminated in Europe, North America and Latin America by the provision of sustainable WASH services and improved public health services. We now focus upon contributing to the same process elsewhere

and with new tools such as OCV.

The Root Cause of Cholera can be controlled with a multi-sector approach—including giving sustainable access to basic water, sanitation, and hygiene (WASH) services; oral cholera vaccines (OCV); better awareness of diseases transmission; improved prevention and control of outbreaks and epidemics, better preparedness for response and disease surveillance. The constraints to addressing cholera are only global commitment in the long-term to at least 2030, and mobilizing the target communities, National and International level assets and capacities to address the problem based on the fact that we have succeeded to eliminate it elsewhere and we can replicate the same measures with some new tools and broadened experience, in those countries where it still has a significant impact.

Cholera continues to disproportionately affect the poorest and most vulnerable communities in high-risk countries. Cholera spread, incidence and severity are exacerbated by rapid and often unplanned urbanization and population growth, and by climate change, food insecurity, extreme weather events or trends and complex settings, especially where conflict and unrest are present and health and WASH services are weak.

- There are an estimated 2.9 million cholera cases and 95,000 deaths per year globally.
- 2.3 billion people still lack basic sanitation and water and are potentially at risk for cholera.
- 89 million people live in cholera "high-risk" areas in Africa alone.
- Providing access to basic WASH services requires between USD 40 and USD 80 per person

In **Uganda** diarrhea and other water and hygiene related diseases rank among the major causes of morbidity and mortality with recurring cholera outbreaks along lakes and borders. There are high incidences of diarrheal diseases in Uganda especially among children under the age of 5 years with 10% death caused due to diarrhea (UNICEF 2015). This has been largely attributed to the poor personal hygiene and improper human waste disposal. Only 64% of the total population in the country have access to safe water supply and 69% have access to basic sanitation facilities (Ministry of Water & Environment Sector Performance Report, 2014). This has further been complicated by the traditional cultural beliefs, nature of settlements and the soil formations which make it difficult to construct latrines.

In **Malawi** diarrhoea and other sanitation and hygiene related diseases rank among the major causes of morbidity and mortality and other developing countries in the region. There are high incidences of diarrheal diseases (including cholera) especially among children under the age of 5 years and this has been largely attributed to the poor personal hygiene and inadequate human waste management. Diarrheal diseases are the 3rd commonest cause of mortality in children under 5 years of age after malaria and acute respiratory tract infections (WHO/UNICEF Joint Monitoring Survey 2015).

In **Ghana** in 2016, diarrhoea and pneumonia together accounted for close to 25 % of under-five mortality only behind malaria which is the leading cause of child deaths. Ghana is among the most cholera prone countries in Sub-Saharan Africa, the last major cholera outbreak was in 2014, with over 29,000 cases and 250 deaths reported in 130 districts of all 10 regions of Ghana. Most cases emanated from urban metropolitan communities, normally associated with lack of access to water and sanitation as well as weak and or non-existent waste management systems exacerbated by unplanned urbanisation resulting in overcrowded informal settlements. Limited capacity of municipal WASH service delivery has exacerbated the challenges in managing the whole environmental sanitation chain including limited distribution of water network, toilet facilities, limited wastewater and septic sludge collection and transportation a lack of operational wastewater and sludge treatment facilities including inadequate solid waste collection from low-income areas, and absence of adequate solid waste disposal facilities.

For latest country WASH data http://www.who.int/mediacentre/news/releases/2017/launch-version-report-jmp-water-sanitation-hygiene.pdf

Alignment on national / sector strategy
please justify how the targeted problem are in line with the program/sector priorities

¨ IFRC, its membership and partners contribute to SDG 6 in the long-term (to reach Universal WASH Coverage by 2030) as a continuation of our Global Water and Sanitation Initiative (GWSI) having already reached over 25 million people worldwide with sustainable WASH services. Further to this we have also developed 'One WASH' during 2017 to prioritize and target countries that regularly succumb to cholera outbreaks or epidemics that are often attributed to poor WASH coverage. 'One WASH' was developed in alignment with the Global Task Force for Cholera Control (GTFCC hosted by WHO) to which IFRC is an active member with other key organisations such as UNICEF; WaterAid; Gates Foundation; ACF and others.

The International Federation of Red Cross/Crescent (IFRC), with its membership and in consultation with WHO; UNICEF; ECHO and other internal and external partners have (because of a Cholera Forum hosted by IFRC in November 2016) formulated a 'Cholera Framework for Africa' which lays out strategic and technical guidance on how IFRC and its partners may scale-up control and eventual elimination of cholera by 2025/30.

Collectively with GTFCC a new Roadmap for Cholera Elimination was developed and launched in 2017 with technical inputs for the WASH component from IFRC to which many health and WASH donors and actors have shown their formal endorsement. 'One WASH' is the IFRC's operational contribution to that roadmap focusing upon an integrated WASH and Public Health approach targeting cholera high risk countries and cholera hotspots in alignment with the roadmap including the four target countries in this grant application

GTFCC Roadmap http://www.who.int/cholera/publications/global-roadmap/en IFRC One WASH http://watsanmissionassistant.wikispaces.com/ONE%20WASH

In **Uganda** the National Integrated Comprehensive Cholera Prevention and Control Plan 2017-2022 (NICCP17-22) developed by the Uganda Government and partners including UNICEF and WHO recommends major areas of focus for prevention , control and eventual elimination as follows;- Social mobilization and community empowerment,(health promotion & education for disease prevention), promotion of access to safe water , good sanitation and hygiene , surveillance and laboratory confirmation of outbreaks , prompt case management and infection control , complementary use of OCV and coordination &stewardship for actors.

The Government of **Malawi** with support from its development partners, other development agencies and the private sector is committed to reduce cholera by 2030 and has started with Oral Cholera vaccination in high risk districts. The WASH sector is coordinated by the department of Irrigation and Water development in the Ministry of Agriculture in collaboration with the Ministry of Health.
The WASH Sector is implementing a number of activities (both development and response) to prevent and control cholera. This project is in line with the *Malawi National Cholera Prevention and Control Plan, 2017.* The main preventive activities recommended are: Undertaking assessments in cholera affected areas and high risk areas, Provision of safe water supply and sanitation services, Promotion of various technologies such as water filters and toilets, Hygiene education, distribution of water filters, chlorination, Open Defecation Free (ODF) campaigns, Oral cholera vaccination campaigns, etc.

Key target groups
Please indicate who is being targeted as beneficiaries and why. Distinguish between direct beneficiaries and ultimate beneficiaries

¨ In consultation with Government at country level and other key actors such as UNICEF, WHO and including our respective National Societies we have identified vulnerable communities where the lack of adequate access to sustainable WASH services and limited public health services have combined to make them vulnerable to cholera outbreaks and epidemics. In all our target areas in each country there have been recent and often recurring cholera outbreaks or epidemics. Using a combination of secondary data and our own base line studies we can identify who should be our direct beneficiaries in such cholera high risk areas or 'hot spots' in consultation with Government and other actors.

We target these populations as being at most risk and most likely to suffer from recurrent outbreaks which can spread to other areas that are at less risk. By targeting this way, we intend to reduce incidence in both high-risk groups and lower risk groups and the countries in line with the GTFCC Roadmap and our own cholera framework.

For these identified direct beneficiaries, we intend to increase their access to sustainable WASH coverage, improve the public health interventions to combat cholera and use of OCV when appropriate thus to decrease the cholera risk among those target communities. Ultimately a wider population or indeed the whole country should benefit by reducing cholera incidence in those areas where it is most prevalent and reducing the risk of spreading the disease to this wider ultimate beneficiary group. In targeting, we focus upon the communities that presently have no or very limited access to WASH facilities or public health inputs relevant to cholera control.

In **Ghana** the target is 15 districts within three out of the ten regions of Ghana namely, Central, Eastern and Ashanti regions. The regions are among the most least developed regions prone to disease out breaks and natural disasters in particular floods,

Central Region
Central Region is one of the 10 regions of Ghana made up of 26 districts, with total population 2,201,863, six out of the 26 six districts with a population of 727,928 are classified as cholera hotspots. The last cholera outbreak was in 2016, most at risk are urban metropolitan communities normally associated with lack of access to water and sanitation as well as weak and or non-existent waste management systems exacerbated by urbanisation, overcrowded informal settlements. Limited capacity of municipal areas, faces serious challenges in managing the whole environmental sanitation chain including limited distribution of water network, toilet facilities, limited wastewater and septic sludge collection and transportation, lack of operational wastewater and sludge treatment facilities, inadequate solid waste collection from low-income areas, and absence of adequate solid waste disposal facilities.

Eastern Region
The Eastern is the sixth largest region in terms of land area with total population of 2,106,696; Almost a quarter (23.6%) of households in the region uses the river, stream, pond or lake as their main source of drinking water, only 19.4 % access water through pipe-borne water system located outside the premises and 8.8 % use pipe borne water located within the house. Only, 37.5%) of households have access to latrine located on their premises, while 29.8 % use public toilets of all kinds, the rest use open defecation. More than half (56.5%) of households in the region dispose of solid waste in public dumps, while a quarter (25.2%) dump their household waste anywhere.
Eastern region is prone to floods and diseases outbreak including yellow fever, meningitis, cholera and is prone to flood emergencies.

Ashanti Region

Is the most populated region with a population of 4,780,380 according to the 2011 census, main economic activities are gold mining, cocoa production and general subsistence farming and trade, only 72.14% of the urban population has access to safe water and 56 have access to sanitation, access water and sanitation in rural areas are limited. About one out of 10 households (12.2 %) have difficulties meeting their basic food needs. A lower proportion of rural poor households (10.8 %) have difficulties in meeting their basic food needs in contrast to 12.5 % of the urban poor. About one-third (31.5 %) of children under 5 years in the region are stunted.

In **Uganda**[1], the most recent data (2011-2016) reports that 18 districts have been responsible for 90 % of all cases reported in the country, with five districts of Nebbi-21%, Hoima-16%, Bulisa- 11%, Kasese-08% and Mbale- 05% accounting for 60% of the cases. In all cholera reported districts the common risk factors include: inadequate access to safe water, poverty, migratory living habits, and poor sanitation practices due to proximity to large water bodies making construction of put latrines difficult and low literacy levels. Targeting these communities will therefore lead to a reduction in number of cases by over 50%. The focus therefore will be Nebbi districts which reported over 2320 cases constituting 21% of all cases nationally during the 2011-2016 period. The project will target **25,000 people** with an integrated WASH package which will address the risk factors responsible for the large-scale outbreaks of Cholera. Nebbi district neighbours Arua district which is host to over 800,000 refugees. The risk of Cholera outbreaks in Nebbi district have the potential to cause a large humanitarian crisis in the refugee settlement camps which similar challenges of access to safe drinking water and hygienic sanitation.

Malawi has been reporting cholera outbreaks since 1998, and according to the Malawi National Cholera Prevention and Control Plan, 2017, the outbreaks are due to its location within the Great Lakes region and the disease is endemic among fishing communities along the lakes and main rivers. In addition, the Country Plan indicated that the case fatality rates ranging from 1.5- 6.7 % are reported occurring along these lake basin "high risk " mostly throughout the seasons, thus from November,1 to October, 31. And most of the cholera cases occur in Southern zone of the country in the districts like Machinga, Phalombe and Zomba. The target will be specifically vulnerable fishermen, children and women living along the shores of Lake Malawi (first phase Phalombe district, second phase Machinga and Zomba) in cholera 'high risk' areas. The project will target (15.000 children in schools + 7.500 households) a minimum of 22.500 direct beneficiaries and 110,000 indirect beneficiaries.

Although the primary objective is reducing cholera morbidity and mortality there are secondary benefits to those targeted such as generally improved health leading to better productivity, access to WASH services near to people's dwellings reducing the time and effort spent in seeking services at some distance from their homes. School attendance improvement especially for girls and young women when menstruating who often miss school due to poor WASH facilities that offer no privacy. Security and dignity especially for women and children by improving access to safe sanitation facilities near their homes while discouraging open defecation, still common in the four target countries. Improved personal hygiene and

[1] NICCP17-22

disease reduction by improving access to handwashing and bathing facilities both in the home and in schools and health strucures.

The broader benefits of WASH services are further elaborated here https://www.unicef.org/publicpartnerships/files/WASHTheCaseForSupport.pdf

JUSTIFICATION
Considering before, during, and after project implementation; please justify the impacts and necessity of this project

¨ The continuing incidence of cholera in the present time, exacerbated by factors such as rapid unplanned urbanization, climate change, population growth and in some parts of the world by conflict and severe poverty is unacceptable when the solutions are available and indeed even better understood now than ever before. We recognize elimination has already been accomplished in many parts of the world and we see the opportunity to reduce mortality by 90% by 2030 in those areas deemed at greatest risk and where we as the international community can make a long-term commitment and impact.

We are focusing upon target groups that suffer from recurrent outbreaks or that are at highest risk as a priority through the SDG lens:

- **Before:** Recognizing that our target communities have been impacted by recurrent or indeed ongoing cholera outbreaks and are therefore at high risk. That those communities also increase the risk of transmitting disease to the broader population.
- **During:** That during the project cycle while we address the long-term solutions to cholera we strengthen capacities to be able to respond to outbreaks more effectively, contain and reduce morbidity and mortality and strengthen coping mechanisms at all levels.
- **After:** We see at least lower incidence and severity of outbreaks if not elimination of outbreaks and see a better impact and understanding and awareness of response and coping mechanisms established at grass roots to combat cholera.

We also recognize that apart from the impact on cholera the project has as its primary goal there are many secondary benefits expected in poverty reduction, improved health, security and dignity that will result and especially for the most vulnerable especially women and children.

The project will also ensure that environmental protection (especially for water supply and sanitation systems) is fully embedded in the planning process reflecting 'Integrated Water Resource Management' principles, rules and by-laws. National Societies and IFRC are also fully committed to ensuring gender, diversity and disability inclusion is fully embedded in project planning and implementation.

STRATEGY
Please describe
- How and to what extent the identified problem will be addressed and the strategy that will be used to achieve the desired results
- Lessons learned & Complementarities
- Relevant lessons learned from previous interventions in the same field in the country, including those identified through past project evaluations. Explain why they apply and how the project strategy incorporates them
- How the project strategy complements or builds in earlier or ongoing project initiatives, including those undertaken by other organization and by other development partners

¨ The One WASH strategy focuses on two main actions that are closely interlinked and operate in full alignment with the GTFCC cholera road map, the IFRC Global Water and Sanitation Initiative and IFRC Cholera Strategy for Africa. The three countries chosen for this project are included in over 20 'high risk' countries we are targeting with this cholera strategy and initiative worldwide.

1. Improve preparedness, early detection and response to contain cholera outbreaks The One WASH programme will support communities to be well prepared for early response when an outbreak happens. It will support existing health care systems with community-based surveillance for early detection and monitoring of diarrhoeal disease outbreaks at community level. It will also improve access to care by providing community level treatment through provision of oral rehydration therapy, setting up Oral Rehydration Points and referrals of severe cases. Prevention activities such as water treatment, hygiene and health promotion are included as key parts of the approach to managing outbreaks. In addition, the approach will support local governments and partners with oral cholera vaccination campaigns in emergency situations as appropriate.

2. A long-term integrated WASH approach to prevent cholera One WASH will invest in sustainable long-term water, sanitation and hygiene programmes, and will embed health and nutrition support as well as provision of water for livestock when appropriate. Year-round health and hygiene behaviour change communication and social marketing programmes will be implemented in communities, including advocacy and support to cholera vaccination campaigns. In essence, we should increase WASH service provision and access up to 80% or higher in the target areas from base line.

Hardware components of the project: In **Uganda,** the project will focus on improving access to safe drinking water through construction of 2 mini water supply systems, drilling of 6 new boreholes and rehabilitation of 12 existing ones. This additional supply will ensure an adequate, sustainable and equitable source of safe clean drinking water to the population at most risk. Sanitation improvement will focus on improving access to the target group most at risk and have the highest potential to catch and infect others with Cholera- the fishermen who crisscross the fishing and landing sites in both Uganda and DRC on the shores of Lake Albert. Others who will be targeted are school going children. Five communal latrines will be constructed, each with 5 stances/drop holes to target schools and landing sites. The general community will be targeted with promotional messages and technical support to enable them construct latrines with their own resources. The technical support will be in the form of demonstration activities, such as the technics to construct stable and long-lasting latrines in unstable soils.

Software Components: It has been proven that improving access to WASH infrastructure does not result into health benefits unless community embrace a behavior change and take up good practices which act as barriers to disease transmission. Trained Hygiene Promotion volunteers will organize households into groups of 10-15 households and take them through a training and problem identification process. These groups will then agree on specific workplans to achieve positive behavior change in identified risk practices among the Hygiene domains. These will include but not

limited to Food, Hygiene, Water Source, Water Point, Environmental Hygiene dormains including Human Excreta disposal. Poor practices will be identified related to the domains above and households assisted to work towards transformation. Hygiene promoters will follow up on agreed timeframes to monitor change against established baselines. In order to reach to a broader majority of households in the community, other methods to transmit messages and promote good hygiene practices will be through the use of songs, radio talk shows theater /drama and IEC materials to be designed and agreed with URCS and local district authorities.

Health promotion and Community Level Management of AWD and Cholera: Early detection, diagnosis and response; management of diarhoeral diseases such as AWD and Cholera has been demonstrated to save lives. Community Volunteers will be trained to be able to screen cases of AWD and Cholera and administer early management support such as preparation and administering of ORS. The volunteers working with support of health staff at the lowest level will be able to screen and refer cases for further management. Community based surveillance will be a critical component of this aspect, volunteers will collect and report on events related to disease outbreaks in the community where they work but with specific focus to AWD. The incidences reported will be collated and analyzed to enable quick action by community and health facility level staff. The CBS system will be active for a period of 3 months once established and take a passive mode once systems to collect and report on incidents has been established and tested.

Sustainable Management of WASH activities: Demand for continuous water supply services, Hygiene promotion monitoring and reporting on sustained observance of good behavior, whereas Community management of AWD and cholera will require a community level institutional capacity building and strengthening alongside a demonstrated value of cost arising from early detection and management of Cholera and other diarrheal diseases.

- **Water Supply:** Trained artisans and Water points committees (WPC) will be essential to ensure that systems are in place for operation and maintenance and management of the improved water systems (mini water systems and boreholes) Each Water source will have an independent WPC trained on financial sustainability in order to enable them raise resources which are needed to carry out preventive and corrective maintenance works. At least 2 technicians per water source will be trained to enable them carry out repair and maintenance works and also jointly with WPC ensure that the environment around the water point remain hygienic.

- **Sanitation and Hygiene Promotion:** Volunteers will be recruited from local community and trained on PHAST and PHASE methodologies. Locally recruited volunteers are known to be acceptable to communities and understand local context, norms and values and therefore very effective. The cost for delivering a sustainable Hygiene promotion package from locally recruited volunteers is also lower compared to situations when volunteers have to be on perpetual remuneration package. The volunteers level of motivation is maintained when they are assisting communities confront health challenges which affect them (volunteers) in their local context.

- **Sustainable ODF status and incremental pathway towards SDG Sanitation:** Trained Volunteers and trained community members will develop plans and clear objectives towards improving the type and level of sanitation facilities along the sanitation ladder principles. It has been demonstrated that effective sanitation solutions rely on community's willingness to improve the facilities or methods of human excreta disposal facilities they have. Cost of an option such as a VIP latrine may be out of reach to a household, however the household can attain a VIP level of Latrine if a defined pathway is agreed and the material needs and benefits of such a latrine facility are well appreciated by the concerned household.

In **Ghana,** the project shall focus on rehabilitation, expansion and development of mechanized systems equipped with solar power systems and supported through gravity distribution network. Installation of mechanized systems shall target semi urban or growth points with a population above 2000. This intervention has a potential to serve over 140,000 people in 72 communities. As part of building resilience and contributing to reduction in malnutrition through food security, in conjunction and partnership with relevant authorities and private partnership, the project will identify at least 3 most vulnerable communities to benefit food security initiatives, the project will provide water services in sufficient quantities and other partners will called on to contribute other inputs such land and other inputs.

Government of **Ghana** has adapted Community Led Total Sanitation (CLTS) approach with no subsidy as its strategy for household latrines to address sanitation challenges in the country. CLTS strategy concentrates on ending open defecation through meaningful behavior change.
The strategy encourages the community to take responsibility and take collective and individual actions, including for the construction and use of household latrines, with the ultimate aim of ending open defecation and taking up positive hygiene behavior. The project will build on already existing innovations aimed at improving on the household and institutional latrines solutions such as the bio digested latrine system, this is a compact on-site sanitation facility that combines flush toilet system and composting unit with absolutely no odor using a fully aerobic digester can last for over 10 to 15 years. The project shall make initial investment in the production and supply of bio digest latrine systems where part of products will go towards subsidized vulnerable groups and the rest provided to ordinary households at a cost. The funds recovered from non-subsidized sales will be used to serve more vulnerable communities.
Promote hygiene services through social mobilization and marketing
Hygiene in this context shall include promotion of handwashing, menstrual hygiene and food hygiene with particular emphasize on promotion of handwashing with soap and water during critical time. Handwashing with soap is among the most effective and inexpensive ways to prevent diarrheal diseases and respiratory infections which together are responsible for majority of child deaths.

Inclusivity and mainstreaming

Gender mainstreaming
Gender integration and mainstreaming at all levels of project design will be highly promoted and the needs of children, men and women will be equitably addressed. The project will build on and support the already existing Mothers Club structure of Ghana Red Cross. The Mothers clubs are the pivots of all maternal and child health related interventions supported by GRCS.

People living with disabilities
Disabled people are among the most marginalized and disadvantaged people in many communities and sadly have the least access to basic water and sanitation services, which contributes to their continued isolation, poor health and poverty. The project will ensure participation of people with disability at all levels of the WASH project. Inclusion of people with disability shall contribute to their dignity, self-reliance and improved health and wellbeing.

Support to WASH in school development

Ghana does not currently have a national program to address WASH in schools but has included WASH in its Education Strategic Plan (2010 –

2020) by pledging to "Expand and improve school health, sanitation and safety systems". Provision of water, sanitation and hygiene in the schools are the responsibility of the national Schools Health Education Program or SHEP, which oversees nutrition, health, safety, and HIV education. SHEP functions under the Environmental Health and Sanitation Directorate (EHSD) and the Community Water and Sanitation Agency (CWSA) which oversees water, sanitation and hygiene practices for the country.

In **Malawi** the proposed intervention wants to explore possible strategies that would offer meaningful solutions towards elimination of Cholera transmission through proper implementation of safe water supply, sanitation and hygiene interventions along Lake region.
The intervention will be expected to cover areas of safe drinking water supply especially to the fishermen households and institution like schools and health centers on the lake and the surrounding catchment areas through household water treatment, borehole drilling and water reticulation, rehabilitation and extension of existing water facilities. Revamp or establishment of WASH committees to assist in the maintenance of the waterpoints and promotion of sanitation facilities and improved hygiene practices.

The project will ensure improved sanitation and hygienic practices within the targeted communities for behavior change, by among other things will see to it that there is complete sanitation chain which shall involve the construction of institutional sanitary facilities. The project will further support the construction of HH latrines along the shores through awareness creation, provision of sanitation tool kits in schools and hygiene promotion using the approved approaches of CLTS and PHAST for the intervention communities and institutions respectively to ensure Open Defecation Free (ODF).

The emphasis on having the right balance between 'hardware' and 'software' in planning and implementation (a public health focused approach) and the increased impact upon sanitation coverage. MRCS will strive to equipping community members with participatory hygiene and sanitation transformation (PHAST), CLTS and community-based surveillance approaches. Promotion of integrated, community-based approaches to management of water supply, sanitation and environmental health in the target communities by establishing functional community management structures. Improved community-based surveillance and cholera management at community level through the early warning, early action mechanism, establishment of ORPs and improving the health care referral linkages with support from the trained pool of community based volunteers.

'One WASH' promotes a common yet adaptable approach among National Red Cross and Red Crescent Societies to establish large-scale, long-term sustainable water and sanitation programmes. One WASH also promotes broadening the scope of these programmes to prioritize, in both rural and urban settings, cholera elimination, provision of water for livestock where appropriate and strengthened delivery of improved hygiene. The integrated approach of One WASH aims, between now and 2030, to reach a minimum of 5.5 million vulnerable people in high-risk cholera countries to contribute to reducing cholera deaths by 90 per cent.

Lessons Learned Globally and Locally:

In our battle with cholera over many years we have learned only too well that responding to outbreaks though justifiable has not reduced the incidence and severity of outbreaks and in fact in a changing environment (climate, urbanization, population growth, conflict and weakening or overstretched public health service provision) we have failed to get to the root of the problem. We respond but we do not reduce the threat or indeed level of morbidity and mortality. It is this fact that has led us collectively (with the GTFCC and our internal and external partners including academia) to formulate the Roadmap and One WASH. It is only by a long-term commitment from all actors to achieve the Roadmap Goal (90% reduction in Morbidity and Mortality by 2030 and elimination in an increasing number of countries). This through the lens of the SDG.

LOGICAL FRAMEWORK

Development objective
Please describe
- The expected impact to which the project is expected to contribute
- How will the ultimate beneficiaries be affected by the project
- How the proposal is in line with the sector policy

¨ **Development Objective**: Contribute to Sustainable development goals (SDG 6 and SDG 3) through increased access to sustainable, equitable and affordable Water, Sanitation and Hygiene (WASH) services, public Health and hygiene promotion for 150,000 women, men and children in high risk cholera districts in three countries by 2022.

Indicators:

1.1 % percentage of population using safely managed drinking water services in high risk cholera districts (I. 6.1.1)
1.2 % of population using safely managed sanitation services, including hand washing facility in high risk cholera districts (I 6.1.2)

Project immediate objective
Please identify clear and measurable objectives

Establishment of integrated WASH and Health and hygiene sustainable services for 150,000 people by year 2022 in high risk cholera districts/areas in:

- Water supply
- Sanitation and hand washing
- Health and Hygiene promotion
- Increased knowledge and awareness of cholera including response capacity and surveillance.

Objective 1. Increased access to adequate, equitable and safely managed Water facilities for 150,000 people in high risk cholera districts by 2022

(Related SDG 6.1 target)

Objective 2. Increased access to adequate, equitable and safely managed sanitation facilities and Hand washing facilities for 150,000 people in high risk cholera districts by 2022 (Related SDG 6.2 target)

Objective 3. Strengthen community capacity and enhance knowledge levels for 150,000 people to sustainably manage water supply, sanitation, epidemics and environmental health in the target communities by 2022 through promotion of integrated community based public health approaches (related SDG 3.3)[2]

Indicators

Please select S.M.A.R.T. indicators to measure progress towards each objective - to check on performance and progress (of what …)-; set targets for each. (S.M.A.R.T.: SPECIFIC, measurable, attainable, Relevant and Time-bound)

Objective 1. Increased access to adequate, equitable and safely managed Water facilities for 150,000 people in high risk cholera districts by 12/2022 (Related SDG6.1 target)

1.1 % of water points contributing safe drinking water
1.2 % of schools, health centers and communities with access to safe water from a functional improved water points at the end of the project compared to the baseline
1.3 % of water samples with good bacteriological quality confirmed at the source and at the point of use (drinking purpose) at the end of the project compared to the baseline

Objective 2. Increased access to adequate, equitable and safely managed sanitation facilities and Hand washing facilities for 150,000 people in high risk cholera districts by 2022 (Related SDG6.2 target)

2.1 % communities declared open defecation free (ODF) following Community Led Total Sanitation (CLTS) process at the end of the project compared to the baseline
2.2 % of household with improved latrines used and maintained at the end of the project compared to the baseline
2.3 # of schools with improved institutional latrines with hand washing facilities (being used and correctly maintained) at the end of the project compared to the baseline

Objective 3. Strengthen community capacity and enhance knowledge levels for XXX people to sustainably manage water supply, sanitation, epidemics and environmental health in the target communities by 2022 through promotion of integrated community based approaches (related SDG 3.3)

3.1 % of at risk household adopting household water treatment and safe storage at the end of the project compared to the baseline
3.2 % of household with hand washing facilities at the end of the project compared to the baseline
3.3 % people who understand the critical time for handwashing and the relation to cholera at the end of the project compared to the baseline
3.4 % of WASH committees with revenue to cover running costs of the WASH facilities at the end of the project compared to the baseline
3.5 # of volunteers and community members trained in WASH, ECV, cholera, CBS and CBM at the end of the project
3.6 % of communities that are aware about their vulnerability and risks
3.7 # of functional community based early warning/early action systems in place.

PROJECT IMPLEMENTATION PLAN

Project output

Please indicate the products, capital goods and services that result from development interventions

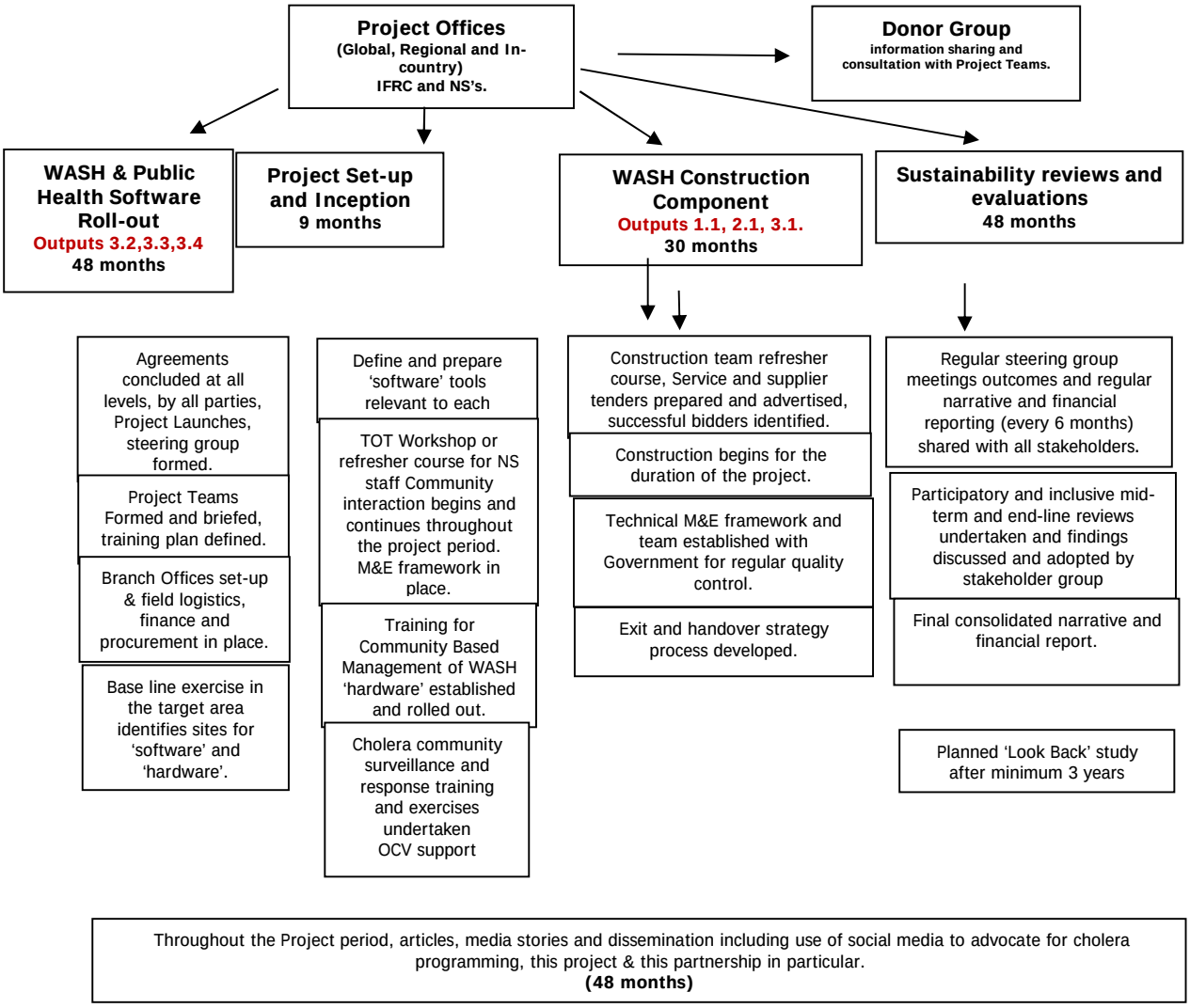
1.1 150,000 people have access to new or rehabilitated water points of good quality for different purposes that they use and maintain Regularly and do no harm to the environment
2.1 Schools and clinics in the target communities have access to improved latrines and water supply that they use and maintain regularly
3.1 All constructed household and school latrines have hand washing stations that are used and maintained regularly
3.2 Over 150,000 people reached with information promoting behavioral change messages and knowledge related to health (disease prevention, hygiene and environmental sanitation through community social mobilization activities)
3.3. Increased capacity of community structures including youths, mother's clubs, school health clubs, WASH committees, School health Committees focal to effectively manage WASH and public health activities at community level.
3.4 Increased capacity of community structures in preparedness and response to cholera and other epidemics.

WBS (Workbreakdown Structure)

Please set out a sequence and schedule of activities, sub-activities and tasks required to achieve each output/sub-output

¨ **WBS for the Project Implementation Period:** Many activities are complementary and will run concurrently over the project period.

[2] By 2030, end the epidemics of AIDS, tuberculosis, malaria and neglected tropical diseases and combat hepatitis, **water-borne diseases** and other communicable diseases



Project inputs

Please assigned resources (human resources, efforts, equipment, material, facilities, etc.) all non-financial resources required to carry out the project activities

- International or national staff including government recruited, suppliers of special services, consultants and experts
- Physical facilities, basic office premises, equipment and materials, office services, sub-contracting supplies, fellowships, training materials, etc.

Project Inputs:

- **Human Resources**: Most human resources are already in-place in each country. There will be a country team dedicated for this project in each country either existing local Red Cross National Society staff or locally recruited staff. Technical staff are often fully funded by the project in question, and administrative and support services staff are only partially supported by this project (as they service and support other projects on-going). We encourage Government staff to work with us either on-loan to the project by the Government (quite common) or contracted by the project at local Government rates. International IFRC staff will consist of only one full time Delegate based in Ghana and other IFRC staff from IFRC Regional Offices will be only partially funded relevant to the level of support they provide at country level in each country. Some limited technical support costs will be envisioned for project quality assurance at global level. Some HR inputs also to a limited extent will be provided by external consultants. or contractors where appropriate.
- **Logistics, fleet, transport and storage**: Most of these inputs a We encourage Government staff to work with us either on-loan to the project by the Government (quite common) or contracted by the project at local Government rates.
- **Equipment and materials:** Standard procurement procedures apply and to the greatest extent normally use locally sourced equipment and materials. We can import however when required to do so and usually under a duty-free basis due to our status with the country Governments we work with.
- **Contractors:** We commonly use local contractors when we see cost benefits and can assure quality control, especially for minor construction works such as latrine construction at schools and health structures. When developing groundwater sources we most commonly use borehole drilling contractors and geo-physical survey specialists.
- **Local offices**, both at National level and at branch or community level are already established and will continue in the long-term. The project will only contribute to project office running costs relevant to the level that they support the project implementation process.
- **Administration, finance management, IT** and other normal project inputs are provided by the Red Cross National Societies at the rate to which the project uses their services.

Project co-financier(s)		
¨ Name	¨ Contact details	¨ Contributions in USD
Nestlé S.A.	Christian Frutiger | Vice President, Global Head of Public Affairs | Nestlé S.A. | T: +41 21 924 3435 | M: +41 79 834 2530 | Christian.Frutiger@nestle.com	2,940,000 USD
Cartier Philanthropy	PASCALE DE LA FREGONNIERE DIRECTRICE / DIRECTOR CARTIER PHILANTHROPY Rue André-de-Garrini 3 CH – 1217 Meyrin-Geneva – Switzerland Tel : +41 22 808 2510 Cell : +41 79 175 7283 www.cartierphilanthropy.org	495,000 USD
Red Cross Internal Sources	Robert S M Fraser *Senior Officer WASH (Water, Sanitation & Hygiene)* IFRC Health & Care Dept. Route de Pré-Bois 1 I 1214 Vernier I Geneva I Switzerland Tel. +41 (0)22 730 4416 (0)79 217 3303 Robert.fraser@ifrc.org	200,000 USD
The OPEC Fund for International Development (OFID)	Shirin Hashemzadeh S.Hashemzadeh@ofid.org	2,423,320 USD
	Total Project Cost	6,058,320 USD

INSTITUTIONAL FRAMEWORK AND MANAGEMENT ARRANGEMENTS

Institutional analysis: please explain the project adequate institutional support strategy; identify the role of sector partners and potential partnership (including: Govt. , NGOs, Local communities)

- The roles and responsibilities of institutions and partners involved in the project and indicate why they have been selected. Emphasis should be put on government or organizations, agencies and departments.
- A succinct assessment of the existing structure and managerial, financial and technical capacity of the proposed organization that will implement the project, include a description of their strong and weak points, and their experience in dealing with the target group and with similar project.

¨ The National Societies with IFRC have a unique entry point and relationship with Government on the basis that each National Society has been established by act of parliament or Government authority, thus we are not considered a 'non-Government' organization. Although this is the case National Societies and indeed the IFRC is fully independent adhering to and bound by the 'Fundamental Principles' of our movement. https://media.ifrc.org/ifrc/who-we-are/fundamental-principles/

This unique position with Government allows us to participate fully in Government policy direction and planning to the extent we can interact in operational and programming terms with all arms of Government at all levels. This is always our starting point. Further to this we engage with the coordination structures also at all levels where other actors and stakeholders are represented such as UN; EU; NGO and CBO as well as private sector where dialogue is maintained and partnerships forged and experiences and indeed capacities may be shared or pooled. National Societies through their branch and volunteer network usually nationwide are also in constant dialogue with target communities many of whom are familiar and have engaged with National Societies over many years. For this project in four countries we would expect the usual interaction with all key stakeholders throughout the project cycle in the steering or management regular meetings, when seeking Government approval for undertaking planned activities or indeed partnering with them which is common (where we use Government officers to support activities such as monitoring public works or mobilizing community activities). We also will be in close collaboration with UNICEF and WHO for One WASH Programming at country level to share experience and lessons learned as well as use their resources when appropriate for example in joint training and joint assessment and evaluations including data collection and analyses, disease surveillance and tools development tailored to contextual requirements.

All three National Societies described below have many years' experience in WASH and Health Programme development and delivery which continues to the present. Although that is the case, IFRC still maintains a key role in ensuring compliance with external partner requirements in overall project management, financial and narrative reporting, technical quality assurance and adherence to the planned project description and project cycle. IFRC level of support to National Societies often varies in intensity according to context as National Society capacities also vary.

The **Ghana Red Cross Society (GRCS)** is a humanitarian and developmental organization, founded on the fundamental principles of the Red Cross Movement, providing emergency response and developmental programs serving vulnerable communities and individuals in Ghana. It is established by an act of parliament of the republic of Ghana as auxiliary to Government authorities in humanitarian and development efforts. Its mission is to Save lives, improving livelihoods and encouraging healthy living, GRCS has one of the largest volunteer base (over 60,000 volunteers) network in Ghana providing services across the country, through community structures such as Mothers Clubs, Youths (School links) and Ordinary members as agent of change to inspire and promote positive behavioral change for development and risks reduction efforts within their respective communities. Volunteer network is recognized as key catalyst in addressing social economic challenges including Water Sanitation and Hygiene (WASH), Health, and Disaster Risk Reduction (DRR). The relevance of community based capacity structures was evident in curbing frequent cholera outbreaks in parts of Ghana and raising awareness on the potential risks to Ebola. The GRCS maintains a country wide network of branches, staff and volunteers including technical officers and project managers supported by a logistics and fleet base, finance and administration department, monitoring and evaluation department and warehousing.

The **Malawi Red Cross Society (MRCS)** is a leading humanitarian organization in Malawi with an established structure of 28 branches and a Network of about of 40,000 volunteers down to grass root level across the country. The WASH and public health interventions shall be implemented through the Health and Care Department, where a fully-fledged team of WASH and health technical professionals exist.
MRCS role will be expanded where practical in strengthening the enabling environment with Malawi Government and other key stakeholders at national, district and community levels, and the national level policy base. The MRCS has an established structure of both Governance and Managem
At national level, the governance arm is represented by the National Governing Board while the management arm is headed by
the Secretary General supported by the Director of Programs and Development. At division/ branch level, the governance arm is represented by the

Governing Board headed by the Division Chair and the management side is headed by the Project Officer supported by a team of technical staff resp for the actual implementation of the project activities. Logistics, vehicle fleet, administration and finance departments are all established and active.

The **Uganda Red Cross Society (URCS)** URCS has an established structure of both Governance and management arms. At national level, the governance arm is represented by the Central Governing Board (CGB) while the management arm is headed by the secretary general supported by a team of technical staff under the different directorates. At branch level, the governance arm is represented by the Branch Governing Board (BGB) and the management side is headed by the Branch manager supported by a team of technical staff responsible for the actual implementation of the project activities. The proposed project shall be implemented by a team of three staff, supported by the WASH program coordinator, Director Health, Finance, Audit, Supply chain and PMER. The project team shall closely collaborate with the respective line ministries, district and sub county technical staff with directly involvement in the capacity building programs of the project and supervision of the implementation process. The project staff shall actively participate in the WASH sector working groups, district coordination and strategic planning meetings.

IFRC Technical and Programming Support provided by IFRC technical staff based in-country, at IFRC Regional Offices and from HQ level in Geneva responsible for overall project implementation, quality assurance, timely and accurate narrative and financial reporting, technical support and guidance while managing the relationship with partners and donors. Regular field missions and agreement follow-ups. Participation in evaluations and reviews.

Management arrangements
Please identify who will oversee the implementation at the project level on a daily basis? What is the role of the project manager.

At the project level the respective Red Cross-National Societies have project managers, in this case technical staff from middle management, who oversee the day to day implementation of the project by managing a project team of staff and volunteers dedicated to the project who have a range of skills in WASH hardware; WASH software; community development and public health interventions including training skills. Other staff from the National Societies provide logistics, administration and finance management support services. The role of the project manager is therefore to ensure all these staff and support services contribute effectively to the project following the project document, plan of action and monitoring and evaluation framework. The technical and programming support provided to the project team in each country from IFRC is provided by International IFRC staff either based in-country or from regional office level undertaking frequent visits to the project with back stopping from senior IFRC staff based at global level. Although the respective National Societies are the primary project delivery mechanism ultimately the Global IFRC WASH and Health team in Geneva and at Regional and Country level are responsible for coordination of the technical and programming support and quality assurance throughout the project cycle.

The roles and responsibilities for project implementation, financial and narrative reporting and monitoring and evaluation are formalized in a project agreement between IFRC and the National Societies following standard internal procedures and protocols. In addition to the internal IFRC and Red Cross-National Society agreements, there are agreements between IFRC and donors according to their specific requirements, once again defining roles and responsibilities of each partner, reporting requirements and monitoring and evaluation procedures and protocols.

SUSTAINABILITY
Please highlight the main specific measure designed for sustaining the project results after the termination of the project

- Sustainability must be built into the project from the outset reflected in the project design process. Ultimately, sustainability according to context will rely upon Government line ministries, municipal authorities and the target groups themselves. Although the National Society is in a unique position as being permanently based in country and especially at community level there must be a point in time where the responsibility for maintaining sustainability is fully handed over to the pre-agreed holders and managers of the intervention and activities that have been designed to continue after the implementation period is concluded. Key to this process is the dialogue and agreement of roles and responsibilities before the project commences normally at the base line data collection period so that it is made clear what the exit strategy of the implementing partners is, who and when they will hand-over responsibility to and this not only the subject of dialogue bur pre-arranged agreement between the parties. Formal agreements where appropriate may be entered according to context.
- In our monitoring and evaluation framework and standard tools there are built in sustainability measurement and assessment, and at all stages of the project cycle and indeed after the implementation period is concluded. (The 'Look Back' study).
- Increasingly we consider the period towards the end of the implementation period the best time to ensure sustainability actions and structures are fully in place and indeed if gaps in capacity are identified we plan to retrain or remobilize partners in preparation for handover. It is also proven best practice that handover should be as much as possible undertaken in stages during the project cycle and not all at once at the end of the cycle. In some projects we are encouraging donors to extend low-key support activities beyond the project cycle period on a case by case basis, however this should be only considered with all stakeholders involved in such a dialogue.
- IFRC and its membership have set a minimum target for WASH sustainability post-implementation that at least 70% minimum of project investment (both 'hardware' and 'software' impact) should be measurable up to ten years after the implementation period. Studies done so far on this basis of which we have a few have shown us averaging at about 85% sustainability however more studies are required to have a greater evidence base over time.

MONITORING AND EVALUATION
Please describe developed performance monitoring system and summarize the project M&E system including the processes, procedures and responsibilities foreseen for monitoring and evaluation activities. Specify the frequency and responsibilities for progress reporting

- There is a standard approach to project cycle management and monitoring and evaluation which consists of:

  - An inception report within the first 3 months of project start-up to capture that all project elements are in place and in progress as per the plan of action or WBS (WorkBreakDown) Structure is secured.
  - Regular and minuted project team/steering group meetings are held often with the participation of Government and other implementing partners to which donors may participate and indeed are encouraged to do so when practical. This is also the opportunity for dialogue and participation of the target population or their representatives and underlines accountability to target populations.
  - Standard IFRC Pledge Management Project Reports are every 6 months during the duration of the project. This capture both a narrative

report and financial summary including progress monitoring and measuring of achievement's and any challenges met

- A mid-term review is undertaken based upon an agreed TOR to which partners and donors may contribute and participate. The outcomes of the mid-term review are also to determine progress, quality assurance and identify any challenges that require addressing or if project planning needs revision for the remainder of the project cycle.
- An end-line evaluation is undertaken once again based upon an agreed TOR with all partners and donors may contribute and participate. This evaluation team should also include an external observer usually as team leader.
- A final detailed report both narrative and financial is produced at the end of the project cycle.
- IFRC also have established post-project studies ('Look Back' Studies) to establish project impact and sustainability at least some years after project completion. These studies also invite participation from partners and donors.

Standard tools for project M&E and 'Look Back' studies http://watsanmissionassistant.wikispaces.com/Monitoring%20and%20Evaluation

PROJECT BUDGETING

The detail activity-based budget and the project implementation period
in accordance with the with the project work breakdown structure. (What is the level and type of inputs required and the unit costs?
a Financial Breakdown Structure should complement the WBS)

The project implementation period and the planned starting date: four years (48 months) for Uganda and Ghana and 24 months for Malawi, starting from 1st September 2018.

In addition to the two tables below, please also refer to the enclosed detailed budget in Excel.

Sum of Total USD							
Mcode	**EL3_Name**	**EL2**	**OFID**	**CARTIER**	**NESTLE**	**IFRC**	**Grand Total**
CARTIER	Access to safe water	CARTIER		263,355			**263,355**
				263,355			**263,355**
	Reduction of open defecation	CARTIER		33,342			**33,342**
				33,342			**33,342**
	WASH knowledge and best practice	CARTIER		19,744			**19,744**
				19,744			**19,744**
	Hygiene promotion	CARTIER		178,559			**178,559**
				178,559			**178,559**
CARTIER Total				**495,000**			**495,000**
OFID	Access to safe water	OFID	1,587,712				**1,587,712**
			1,587,712				**1,587,712**
	Reduction of open defecation	OFID	351,629				**351,629**
			351,629				**351,629**
	WASH knowledge and best practice	OFID	162,860				**162,860**
			162,860				**162,860**
		OFID	7200				**7,200**
			7200				**7,200**
	Hygiene promotion	OFID	320,836				**320,836**
			320,836				**320,836**
		OFID Total	320,836				**320,836**
OFID Total			**2,430,237**				**2,430,237**
NESTLE	Access to safe water	NESTLE			499		**499**
					499		**499**
		NESTLE			1,946,399		**1,946,399**
					1,946,399		**1,946,399**
	Reduction of open defecation	NESTLE			340,202		**340,202**
					340,202		**340,202**

	WASH knowledge and best practice	NESTLE			186,827		**186,827**
					186,827		**186,827**
	Hygiene promotion	NESTLE			458,956		**458,956**
					458,956		**458,956**
NESTLE Total					**2,932,883**		**2,932,883**
IFRC	Access to safe water	IFRC				109,590	**109,590**
						109,590	**109,590**
	Reduction of open defecation	IFRC				16,780	**16,780**
						16,780	**16,780**
	WASH knowledge and best practice	IFRC				22,000	**22,000**
						22,000	**22,000**
	Hygiene promotion	IFRC				51,850	**51,850**
						51,850	**51,850**
IFRC Total						**200,220**	**200,220**
Grand Total			**2,430,237**	**495,000**	**2,932,883**	**200,220**	**6,058,340**

Budget by country (in USD)			TOTAL
UGANDA	Cartier	OFID	
	495,000	330,000	825,000
GHANA	Nestle	OFID	
	2,932,883	1,966,377	4,899,260
MALAWI	IFRC	OFID	
	200,220	133,860	334,080
TOTAL	Others 60 %	OFID 40 %	TOTAL
	3,628,103	2,430,237	6,058,340

Tentative financing arrangements

please describe how you expect the project to be financed: Government Funds, Donors' fund, Private Sector Investment, PPP, Budgets, Private Foundations, etc. please identify the potential co-financiers and their respective contributions

Existing co-financing from three sources (Nestle, Cartier and Red Cross as itemized above) amount to 3,628,103 USD for all three target countries. We propose that if this represents 60% of the total project budget we would seek a further 40% from OFID which would amount to 2,430,237 USD which would give a Total Project cost of 6,058,340 USD.

Project co-financier(s)

¨ Name	¨ Contact details	¨ Contributions in USD
1. Nestlé S.A. and Nestle Waters.	Christian Frutiger | Vice President, Global Head of Public Affairs | Nestlé S.A. | T: +41 21 924 3435 | M: +41 79 834 2530 | Christian.Frutiger@nestle.com	2,932,883 USD
2. Cartier Philanthropy	PASCALE DE LA FREGONNIERE DIRECTRICE / DIRECTOR CARTIER PHILANTHROPY Rue André-de-Garrini 3 CH – 1217 Meyrin-Geneva – Switzerland Tel : +41 22 808 2510 Cell : +41 79 175 7283 <pascale.delafregonniere@cartier.com>	495,000 USD
3. Red Cross internal sources	Robert S M Fraser *Senior Officer WASH (Water, Sanitation & Hygiene)* IFRC Health & Care Dept. Route de Pré-Bois 1 I 1214 Vernier I Geneva I Switzerland Tel. +41 (0)22 730 4416 (0)79 217 3303 Robert.fraser@ifrc.org	200,220 USD
4. The OPEC Fund for International	Shirin Hashemzadeh S.Hashemzadeh@ofid.org	2,430,237 USD

Development (OFID)		
	Total Project Cost (1 + 2 + 3 = 60%) & (4 = 40%)	6,058,340 USD

EXTRA MARK
Please mention any potential important project risks or critical assumptions should be presented in this preliminary description

¨ We assume that in the three target countries there will continue to be political and socio-economic stability. We also assume that the support, commitment and partnership with Government at all levels will continue as at present. We also assume that there will be no major climatic events or natural disasters to an extent that would impact negatively on the project delivery.

DISSEMINATE THE PLAN
Please list the dissemination plan that is being done about project findings and outcomes, e.g. Journal articles, conference presentations. Mention the publicity that the project will receive and list all the project deliverables to be submitted. For each, note the URL (your website) on the project or other web site, press coverage, awards.

¨ The project will be featured during the inception phase in country level launches at events where all local stakeholders (Government, Red Cross, donors, WHO, UNICEF and community representatives) will be present and local media will be invited. The media material produced for these events will be featured in IFRC and National Society Websites, Internationally and locally, and linked to the websites of Nestle, Cartier and if appropriate OFID. Social media will also be used to feature the launch, the ongoing threat of cholera, the GTFCC Roadmap and One WASH as our response to cholera and commitment over time to its elimination and reduction of morbidity and mortality.

Similar events will be planned at mid-term and end-line to raise awareness on project progress and our continuing efforts in contributing to the Roadmap, the SDG and One WASH.

Where appropriate, signage at key points in the project target area will identify the project scope, time scale and scale, expected outcomes and partners and donors involved.

Project mid-term, end-line and 'Look Back' studies, reports and findings will be shared with all stakeholders including academic institutions both at country and international level. A lesson's learned summary will also be developed towards the conclusion of the project to further share experiences that may feed into other One WASH projects.

Partners and donors including Red Cross will be encouraged to facilitate media missions to the project during implementation to provide media stories and articles for dissemination to as wide an audience as practical as an advocacy exercise for cholera elimination.