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

Directorate-general for Development Cooperation – DGD

Service D5.1 – Humanitarian Aid

SINGLE FORM FOR THE FUNDING OF HUMANITARIAN ACTION[1]

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

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

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

1. GENERAL INFORMATION

1.1. Name of the humanitarian organisation/date of approval by the Minister for Development Cooperation (if required):

Rode Kruis-Vlaanderen Internationaal v.z.w.

(Belgische niet-gouvernementele organisatie, erkend door de Staatssecretaris voor Ontwikkelingssamenwerking op 13/11/97, onder identificatienummer: 17043/97, overeenkomstig het Koninklijk Besluit van 18/07/1997 betreffende de erkenning en subsidiëring van niet-gouvernementele ontwikkelingsorganisaties en van hun federatie.)

1.2. Title of the action

"Enhancing community resilience to epidemics and hydro-meteorological hazards in the African Great Lakes region"

1.3. Intervention area (country, region, locations):

Rwanda:
Districts of Rubavu, Ngororeo and Rutsiro

Uganda:
Districts of Kibuube, Kyegegwe and Ntoroko

Tanzania:
Kyela district, Mbeya region

1.4. Action start date:

01.08.2019

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

24 months

1.6. Expenditure eligibility start date:

Signature date granting Ministerial Decree.

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

Initial proposal	date:	14-01-19
Revised proposal no.	date:	dd-mm-yy
Date of the granting Ministerial Decree	date:	dd-mm-yy
Unilateral Act date	date:	dd-mm-yy
Letter of acceptance date	date:	dd-mm-yy
Interim report	date:	dd-mm-yy
Final report	date:	dd-mm-yy

1.8 [INT] List the exchanges of letters that took place following the signature of the unilateral act until the interim report stage

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

ABBREVIATIONS

AFAM	***African First Aid Materials***
AWD	***Acute Watery Diarrhoea***
BDRT	***Branch Disaster Response Teams***
BRC	***Burundi Red Cross***
BRC-FL	***Belgian Red Cross - Flanders***
CBPS	***Community-Based Protection Services***
CBS	***Community Based Surveillance***
CEA	***Community Engagement and Accountability***
CRC	***Canadian Red Cross***
DAPS	***Dignity, Access, Participation and Safety***
DP	***Disaster Preparedness***
DRR	***Disaster Risk Reduction***
ECV	***Epidemic Control for Volunteers***
EPC	***Epidemic Preparedness and Control***
EPR	***Epidemic Preparedness and Response***
HRP	***Humanitarian Response Plan***
GESI	***Gender Equality and Social Inclusion***
HM	***Hydro-meteorological***
HNS	***Host National Society***
ICRC	***International Committee of the Red Cross***
IFRC	***International Federation of Red Cross and Red Crescent Societies***
LDRT	***Local Disaster Response Teams***
MIDIMAR	***Ministry of Disaster Management and Refugee Affairs (Rwanda)***
MoU	***Memorandum of Understanding***
MSC	***Minimum Standard Commitments***
NDRT	***National Disaster Response Teams***
NO	***National Office***
NS	***National Society***
OPM	***Office of the Prime Minister (Uganda)***
PCA	***Project Cooperation Agreement***
PIP	***Project Implementation Plan***
PMF	***Project Measurement Framework***

PNS	***Partner National Society***
PoA	***Plan of Action***
PSS	***Psychosocial Support***
RANAS	***Risks, Ability, Norms, Attitude and Self-regulation***
RC	***Red Cross***
RCM	***Red Cross and Red Crescent Movement***
RRC	***Rwanda Red Cross***
SGBV	***Sexual and Gender-based Violence***
TRCS	***Tanzania Red Cross Society***
ToT	***Training of Trainers***
URCS	***Ugandan Red Cross Society***
WASH	***Water, Sanitation and Hygiene***
WHO	***World Health Organisation***

2. NEEDS ASSESSMENT

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

The needs assessment for this project proposal is the result of a lengthy consultation process with different stakeholders. These consultations were held both at national level and regional level.

In October 2018, BRC-FL's Head of Humanitarian Assistance undertook a field visit to Rwanda and Tanzania to kick-start the development of this proposal. In both countries, meetings with the National Societies' higher management were held in order to discuss the strategic direction of their partnership with BRC-FL in disaster preparedness and response. The strategic meetings were combined with field visits to the refugee camps near Kigoma, Tanzania, where humanitarian needs and priorities were discussed with other humanitarian actors present. Meetings with Belgian diplomatic representatives were also held in Kigali and Dar Es Salaam, during which local operational needs were analysed against the framework laid out in the Call for Proposals that led to this submission.

Based on additional information gathered in Burundi and Uganda, and using a similar methodology as above, a basic concept note was drafted, outlining the rationale and broad objectives of the proposed program tentatively titled: "Strengthening community-based preparedness and response to hydro-meteorological hazards and infectious disease outbreaks in the African Great Lakes region".

The BRC-FL country delegates translated this concept note into an operational framework following multiple meetings with HNS staff. For an overview of the dates and participants to these meetings, we refer to the country-specific attachments under Annexes 1A through 1D. Simultaneously, a country-specific secondary literature review was performed on the chosen thematics of the proposal; an overview of the sources consulted can also be found in the attachment. At HQ level, the BRC-FL received significant online support from the Canadian Red Cross -renowned experts in the field of epidemic preparedness-, especially from Ayham Alomari (Technical Health Officer) and Jennifer Vibert (Manager Emergency Programming), in the development of the Epidemic Preparedness and Control (EPC) component of the programme.

<u>Introductory word on the rationale of intervention</u>

BRC-FL has been implementing Disaster Preparedness (DP) programmes with the support of DGD in the African Great Lakes region for the past 2,5 years focusing mainly on increasing and improving institutional response preparedness at the Red Cross HQ and Branch level. Since then, and as shown in the interim reporting of the initial Disaster Preparedness programme (launched late 2016), the regional Red Cross capacity to respond to disaster has been significantly bolstered.

The logical next step is to pivot support from the Red Cross institutional level "down to" communities at risk. This new proposal aims to increase both the overall resilience and the immediate disaster preparedness of those people at risk for two major threats prevalent in the wider region: (i) disasters caused by hydro-meteorological hazards[2] and (ii) infectious disease outbreaks, including those that are not a direct consequence of the HM hazard.

Although the focus of this proposal shifts to the most "local" level, i.e. the community, this programme is designed to still simultaneously ensure a minimal level of continued institutional DP support to the Red Cross National Societies, both branches and HQ, in order to maintain a sufficient response capacity level.

After all, community volunteers can only flourish when adequately supported by their respective Red Cross branch. In turn, RC branches can only function at full capacity when supported by their RC headquarters. During the needs assessment, BRC-FL learnt that the current capacities of the NS to respond to infectious disease outbreaks vary from almost non-existent to advanced. Hence why this proposal foresees

[2] Meteorological hazards: Extreme temperatures, fog, storm. Hydrological hazards: floods, landslides, wave action. For reading purposes, hydro-meteorological will be abbreviated to "HM'

customised institutional support in the field of epidemic preparedness and response (EPR) at all levels of each NS.

The success stories and lessons learnt of the currently operational DP programmes are duplicated in the proposed logic of intervention. In particular, the component of peer-to-peer learning through regional exchange events proved to be an effective tool for finding solutions to shared challenges. This regional component is fully integrated into the present proposal, which covers 3 countries simultaneously: Rwanda, Uganda, and Tanzania.

First and foremost, putting communities on the forefront of humanitarian action implies that the focus should be on risks that can adequately be tackled at the local level. While protection issues are caused by supra-local and complex geopolitical factors on which communities can exercise little influence, disease outbreaks and disasters caused by HM hazards can be prevented or mitigated by community members themselves. Within EPR specifically, one of the key lessons learned from the West African Ebola virus epidemic (2013-2016) is that putting communities at the centre of the response became a turning point in the battle against the deadly epidemic. Communities are a country's primary source of information about disease outbreaks, and when affected communities can identify, report and refer cases of infectious diseases at an early stage, they can prevent outbreaks from becoming public health emergencies.

The same logic applies to HM hazards. Not only are community members the first responders when disasters strike, well-prepared communities take measures to mitigate the impact extreme events have on their daily lives. They are aware of the existing vulnerabilities in their communities, apply risk reduction practices and set up functional early warning systems to ensure timely last-minute evacuation.

Several linkages can demonstrably be made between natural hazards and disease outbreaks. Floods overflow sanitation systems and contaminate the environment. Limited access to food and the ability to cook, which is likely in floods and droughts, can result in malnutrition and lower stomach acid, increasing the risk of infection. In general, disasters, whether they are a consequence of political turmoil or extreme weather, cause population displacement and crowding. Not only does this increase the pressure on adequate water and sanitation facilities, the chaotic mobility of people holds the risk that diseases are uncontrollably introduced in new areas. Above-average rains only aggravate Cholera outbreaks in refugee settings and host communities.

One might rightfully wonder why this proposal focuses on enhancing resilience to natural hazards and infectious diseases in a region that is often associated more with massive forced displacement caused by political instability and violence. In fact, the human and socio-economic costs of disasters of natural origin and epidemics are both a consequence of, and a catalyst for, further internal disruption and conflict within the region. Ultimately, therefore, the humanitarian needs and proposed interventions identified in this document are not mutually exclusive from the population movement dynamics in the African Great Lakes region. Rather, they are inextricably linked.

2.2. Account of the problem and analysis of the stakeholders

A. Problem Statement

Disasters caused by natural hazards are on the rise worldwide. More than 3,751 natural hazards have been recorded over the last 10 years, of which 84,2% had weather-related triggers[3]. Figure 1 displays the IFRC's share of emergency operations by disaster category for Africa, and shows the vast majority of Red Cross operations are in response specifically to epidemics and floods. This is specifically true for the African Great Lakes Region targeted in this intervention. Since January 2017, 9[4] DREF operations have been issued in the four targeted countries, for epidemics and HM hazards alone. With almost 10,3 million people affected and

[3] IFRC, World Disaster Report 2018, https://media.ifrc.org/ifrc/world-disaster-report-2018/
[4] Own calculations based on information gathered through http://www.ifrc.org/en/publications-and-reports/appeals

an economic loss of around 476.880.000 USD[5] during the last decennium, the human and socio-economic costs of disasters of natural origin are significant. They are both a consequence of, and a catalyst for, further internal disruption and conflict within the region.

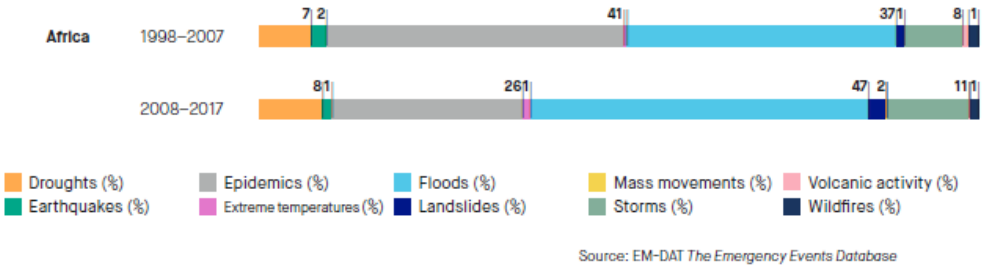

Figure 1 - Share of IFRC operations by disaster category, number of people targeted and budget, 1998-2007 and 2008-2017

The overall risk level to natural hazards in the African Great Lakes Region is classified by the Inform Risk Index[6] as 'high' and is significantly higher than the world's average[7]. Causes stem from 3 factors: high exposure, high vulnerability and low coping capacities. In terms of exposure, the flood hazard frequency in the river basins of lower Uganda, the whole of Rwanda, Eastern Burundi and Northern Tanzania is among the highest of the whole African continent[8]. The risks for devastating landslides[9], such as the one that struck the Mount Elgon region in Uganda in October 2018, are a natural consequence. Furthermore, destructive earthquakes and volcanic eruptions are prevalent alongside Uganda's Lake Albert, the Tanganyika Lake bordering Burundi and Northern Tanzania[10].

Besides the impact of HM hazards, the burden of disease on the population is high. Each of the 4 countries is burdened with epidemics of Acute Watery Diarrhoea (AWD), including Cholera[11]. Diarrhoeal disease is the highest cause of death in Tanzania[12] and Uganda[13], the third highest in Rwanda[14] and the fifth highest in Burundi[15]. Not only is diarrhoea the second leading cause of death in children, it is also the leading underlying cause of malnutrition which is responsible for 45% of all child deaths under 5 worldwide[16], despite the simplicity of basic prevention and treatment methods. About 88% of diarrhoea-associated deaths are attributable to unsafe water, inadequate sanitation and insufficient hygiene.

Most diarrhoeal deaths are preventable using simple, low-cost interventions. A study by the Center for Disease Control and Prevention (CDC) calculated that every $1 invested yields an average return of $25,50[17]. In addition, the treatment of AWD is simple. A solution of oral rehydration salts (ORS) is an inexpensive and life-saving remedy that prevents dehydration. However, reality shows that a lack of improved WASH infrastructures and healthcare, combined with the late notification of the prevalence of AWD cases in communities, leads to regular outbreaks throughout the whole region. The regional humanitarian snapshot

[5] Source: EM-DAT
[6] http://www.inform-index.org/Results/Global
[7] Average Risk Index for the world is 4,3, the average for our 4 partner countries is 5,7.
[8] http://sedac.ciesin.columbia.edu/data/set/ndh-flood-hazard-frequency-distribution
[9] https://www.aljazeera.com/news/2018/10/landslide-eastern-uganda-kills-dozens-destroys-homes-181012054813104.html
[10] https://www.preventionweb.net/files/7483_OCHAROCEAEarthquakesv2071219.pdf
[11] AWD is an umbrella term for a variety of diarrhoeal diseases caused by bacterial, viral, and parasitic organisms. Cholera is just one type of AWD. Acute bloody diarrhoea - also called dysentery - and persistent diarrhoea are other types of AWD.
[12] https://www.cdc.gov/globalhealth/countries/tanzania/
[13] https://www.cdc.gov/globalhealth/countries/uganda/
[14] https://www.cdc.gov/globalhealth/countries/rwanda/
[15] http://www.healthdata.org/burundi
[16] https://www.afro.who.int/health-topics/child-health
[17] https://www.cdc.gov/healthywater/pdf/global/programs/globaldiarrhoea508c.pdf

from May to June 2018 listed parallel outbreaks in Kampala (92 suspected cases) and Tanzania (2.740 cases, nearly double the number reported during the same period in 2017). In October 2017, an outbreak in Burundi lead to 336 cases and was responded to via the emergency fund of BRC-FL. The figures themselves, however, remain 'snapshots'. Reliable data are hard to find, in part due to the still-existing taboo on openly declaring Cholera outbreaks, which are a sign of poverty and disenfranchisement, and might negatively impact fragile tourism and investment industries.

Besides AWD, the fear for a regional Ebola (EVD, Ebola Virus Disease) outbreak is one of the major current regional humanitarian concerns. On August 1st 2018, just one week after the declaration of the end of the Ebola outbreak in Equateur province in the Democratic Republic of Congo, the nation's 10th EVD epidemic was declared in the provinces of North Kivu and Ituri, which are among the most densely populated provinces in the DRC and moreover share land borders with Uganda, Rwanda and Burundi. These provinces have been experiencing intense insecurity and a worsening humanitarian crisis with over one million internally displaced people (IDPs) and a continuous influx of refugees to eastern neighbours Uganda, Rwanda, Burundi and Tanzania. The current fatality rate stands at 356 deaths, including 308 from confirmed cases. As of 25 December 2018, a total of 585 EVD cases, including 537 confirmed and 48 probable cases[18], are reported, which makes for the second largest Ebola outbreak ever recorded. Numbers, especially around the city of Beni, are still on the rise and the fear is high that this epidemic will eventually become uncontrollable and spread across borders.

The chronic population displacement in the region is identified as a significant risk for disease transmission. WHO declared the risk of EVD spreading from the DRC as 'very high' after confirming two cases near the Ugandan border. WHO also identifies large-scale 'public defiance about vaccinations and intended fear-spreading' as a contributory factor to the outbreak. According to its risk profiles, WHO has categorised Uganda, Burundi and Rwanda as Priority 1 and Tanzania as Priority 2, respectively.

While the above presents the supra-national dynamics that shape the humanitarian needs in the region, BRC-FL is well aware of the specific contexts that exist at national and sub-national level. Reference is made to Annexes 1A through 1D for the individual problem statements of the 3 countries of intervention.

B. Stakeholder Analysis

Please refer to Annex 2: Stakeholder Analysis.

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

The assessments led to the following outputs: (i) a selection of the target areas based on the three elements of risk (exposure, vulnerability & coping capacities) and (ii) an overview of the current capacities of the National Society, from HQ to community level, within EPC and preparedness to respond to HM hazards.

A. Selection of target areas
   Please refer to Annex 4: Areas of Intervention.

B. Overview of current capacities
   Please refer to Annex 9: Capacities Overview of the Implementing Partners.

Based on the results of this assessment, a logic of intervention was formulated that responds to the expected outcomes.

C. Intervention logic

[18] http://apps.who.int/iris/bitstream/handle/10665/277405/SITREP-EVD-DRC-20181227-eng.pdf?ua=1

The focus on communities called for a programme design that would maximise the comparative advantage of working at the local level. Communities have the potential not only to respond, but also to tackle the root causes of disasters. Hence, a three-pronged approach is used, aimed at increasing the capacities for prevention/mitigation (1), early warning (2) and early response (3) simultaneously. This approach is used both for disease outbreaks and HM hazards, as presented in the table below.

	Prevention and mitigation	**Early Warning**	**Early Response**
Desired outcome	The programme aims to prevent or mitigate the impact of disease outbreaks or HM disasters by improving the resilience and readiness of communities at risk, and by preventing the transmission of pathogens amongst community members.	For those outbreaks or HM disasters that cannot be prevented, the programme aims to invest in the early detection of disease cases through community surveillance and in the set-up of operational and integrated early warning systems for the most common HM disasters.	The programme will include a component of early response by training communities in how to deal with disease outbreaks in complementarity with responses from public health authorities. For HM disasters, early response will be guaranteed through the release of funds via a crisis modifier or a forecast-based financing mechanism. The pre-positioning of relief goods or cash, the provision of a crisis modifier and the set-up of a forecast-based financing system.
Tools	AFAM, RANAS Community-based DRR	CBS	AFAM ECV

C/1 Evidence Base of the intervention logic

Before the detailed explanation on how the three-pronged intervention logic will be translated to effective implementation, it is important to underline the evidence base of this proposal. Ensuring that all activities are rooted in scientific evidence is a core principle within BRC-FL. To assist in this endeavour, BRC-FL created the Centre for Evidence-Based Practice (CEBaP) 10 years ago. This research centre uses an internationally recognised methodology to collect, systematise and evaluate relevant scientific evidence to underpin all activities.

Three products that BRC-FL has been testing and implementing with the support of CEBaP, are integrated into this proposal:

1. The RANAS approach to hygiene promotion

BRC-FL has partnered with Professor H.J Mosler of the EAWAG in Zurich in order to learn through primary research which elements define behaviour change in hygiene promotion in rural Malawi. Understanding why people do or do not apply safe hygiene practices helps to identify interventions that specifically target the desired behaviour change. The methodology used is called RANAS, short for “Risks, Ability, Norms, Attitude and Self-regulation”. Since the start of this partnership, BRC-FL has been using and testing the methodology in Tanzania and is currently starting in Rwanda. By comparing all RANAS experiences, Prof. Mosler came to the conclusion that despite context-specific particularities, “norms” always play an essential role. Stressing the exemplary role household members can play if they apply safe hygiene practices as hand-washing, might therefore be a cost-effective intervention that leads to better results in behaviour change. Currently, BRC-FL is developing 9 sessions for household visits that specifically target this “exemplary role”. Annex 3 shows an example of such a session. The community volunteers will be trained in these materials within the ‘prevention/mitigation’ part of the programme.

2. First Aid training through AFAM

Since 2010, BRC-FL has been developing and revising contextualised First Aid guidelines and materials for the African continent (African First Aid Materials, or AFAM for short). AFAM is developed through combining the latest scientific evidence, the expertise of African experts including experienced Red Cross first aid trainers, and the preferences of the target group. The techniques and advice are adapted to the context and can be well understood and carried out by laypeople. The techniques use, for example, locally available materials such as honey to soothe skin burns. There are specific AFAM guidelines available on how to treat diarrhoea, which is of particular importance when dealing with cases of AWD, including Cholera.

While AFAM guidelines are developed for lay people, BRC-FL is currently updating their portfolio with first aid guidelines for first responders (FAFR). This will include advanced FA techniques, but also the basics of mass casualty first aid management. Related to Cholera, the FAFR will research which other interventions besides rehydration are appropriate and feasible for first responders in case of an outbreak.

Moreover, BRC-FL is starting research on the cost-effectiveness of interventions of common infectious diseases in Sub-Saharan Africa, together with the Centre of Evidence-Based Healthcare of the University of Stellenbosch. At the time of proposal writing, it was still unclear whether or not this research will be concluded during the timespan of the programme. If so, the conclusions will be translated into the FA training curriculum.

Community volunteers will receive AFAM (and in the later stages of the programme FAFR) training and refreshers so they are able to carry out the first response to people affected by HM disasters.

3. Forecast-based Financing (FbF)

Forecast-based financing releases humanitarian funding based on forecast information, for planned activities which reduce risks, enhance preparedness and response, making disaster risk management overall more effective. With the support of DGD, BRC-FL is currently doing research in Mozambique on how to select, prioritise and measure the impact of early actions activated through FbF. Moreover, BRC-FL is part of the “FbF by the DREF Scientific Advisory Committee” (SAC), which gives non-binding advice on improving the FbF methodology by reviewing, amongst others, scientific trends and best practices.

This experience, together with BRC-FL’s belief in the added value of FbF and the clear support from National Societies and donor organisations, led to the addition of a component of FbF within the “early action” segment in Rwanda. This FbF component does not stand alone, but is fully integrated in the three-pronged approach, acting as a capstone for early action when forecasted disasters are approaching the target areas. The capacity of the Rwanda Red Cross, the fragility index of the country, the overall integration with governmental disaster response and the absence of FbF support to the National Society, motivate the decision by BRC-FL to launch its first independent FbF project in Rwanda.

C/2 Infectious disease outbreaks - translating the logic of intervention into an implementation strategy

Disease outbreaks can be characterised by 4 “epidemic phases” as shown in Figure 2 here below. The proposed intervention foresees activities in anticipation (“prevention/mitigation”), early detection (“early warning”) and containment (“early action”) of the outbreak.

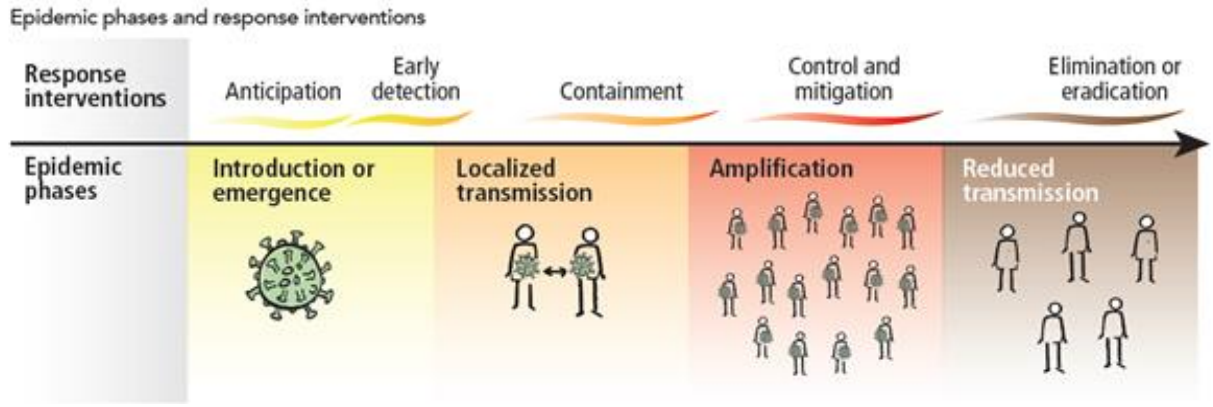

Figure 2 - Epidemic phases and response interventions. Source: WHO, Managing Epidemics: Key facts about major deadly diseases.

The activities in this proposal aim to bridge the time gap between the initial spread of an epidemic in a community setting and the onset of response and containment activities, while simultaneously increasing the resilience of those communities to such outbreaks. Strengthening local capacities will allow an early detection/early response mechanism. When communities understand what causes diseases, how they spread and how to prevent them, they stand a greater chance of containing epidemics. The combination of prevention, early detection and early response, tailored to the specific needs of each community in terms of the major epidemic threats identified and linked to district and national public health systems, have the potential to significantly reduce morbidity and mortality as a result of disease outbreaks.

1. Prevention/Mitigation

The key factor in preventing faecal-oral diseases such as Cholera is safe and sufficient water. A review of 67 studies of diarrhoeal morbidity and mortality indicated that reductions in diarrhoea-related morbidity were associated with both access to sufficient household water (27%) and improved hygiene (33%)[19]. Hence, the proposed intervention targets the three barriers that stop the faecal-oral transmission route of pathogens, presented in Figure 3 here below.

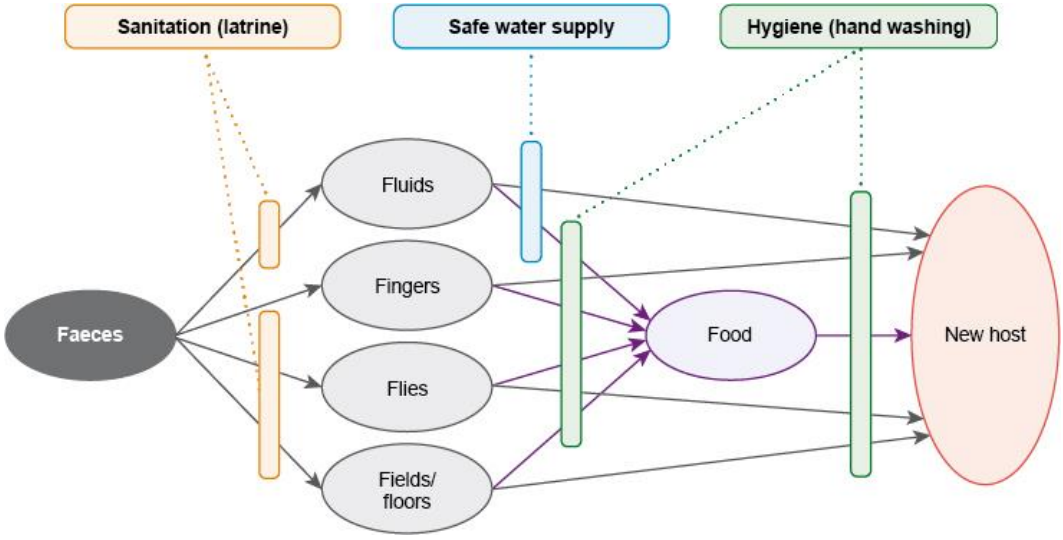

Figure 3: the F-diagram. The faecal-oral transmission route with various pathways starting from infected faeces and arriving at the new host. Three types of barriers are depicted, having an effect on different pathways.

[19] Rieckmann, A., Tamason, C. C., Gurley, E. S., Rod, N. H., & Jensen, P. K. (2018). Exploring Droughts and Floods and Their Association with Cholera Outbreaks in Sub-Saharan Africa: A Register-Based Ecological Study from 1990 to 2010. *The American Journal of Tropical Medicine and Hygiene*,*98*(5), 1269-1274. doi:10.4269/ajtmh.17-0778

This programme will therefore ensure the necessary WASH hardware and software are provided in the targeted communities. This will be accomplished in two ways:
- Firstly, by investing in small-scale rehabilitation of WASH-infrastructure, such as latrines or tippy-taps in schools, health centres or public places, and by providing the necessary tools for household-level water treatment and storage such as chlorine tablets and buckets.
- Secondly, by training community volunteers to promote hygienic practice in the community using the RANAS methodology. These RANAS sessions will be integrated into the broader "Community-based health and first aid" (CBHFA) framework which is used by Red Cross National Societies worldwide. CBHFA cannot be seen as a fixed manual, each National Society can apply their preferred methodologies. Similarly, this programme will apply as much as possible the evidence-based materials of the BRC-FL in the CBHFA approach.

Though these activities are implemented primarily to prevent AWD, other pathogens that are transmitted via the faecal-oral route will be tackled as well. Unfortunately, investing in safe water and hygiene will not completely eliminate the risk of EVD entering a community. There is currently no hard evidence on the transmission method from animals to humans; therefore, prevention measures cannot be imposed but merely suggested. The risk of a "new" Ebola virus originating from animal to human transmission is therefore not addressed in this project. Instead, the focus lies on the threat of Ebola virus spreading from human to human, from the DRC into the communities across its eastern borders.

2. Early Warning

All individual cases of AWD or Ebola should be detected and reported, as the first person with the disease can ignite the spread of the pathogen through bodily fluids such as vomit and diarrhoea. Also, early detection helps in unravelling the source of the contamination: people that have fallen ill might have used the same water source or eaten the same bushmeat. In practice, first cases are oftentimes not reported, delaying the response and resulting in action only being undertaken when the epidemic is already in the amplification phase. This is a consequence of many communities not having a system in place for community surveillance of epidemics. Additionally, people are hesitant to report potential cases because of negative effects on trade and tourism, the fear of being taken away from family, and sometimes plain misconceptions and rumours. In the DRC Ebola response, this has led to people distrusting and in some cases even attacking healthcare workers and facilities.

Therefore the programme will invest in the training and implementation of Community-Based Surveillance (CBS)**.** CBS allows the community to identify the risks they observe and provide a reliable 'real-time' communication structure to alert others. It is a simple, adaptable and low-cost public health initiative, that is managed by communities to protect communities. It acts as a proxy for formal community health surveillance and extends the coverage of existing surveillance to the most vulnerable populations.

Volunteers trained in CBS will receive mobile phones (or vouchers to use their own phones) by which they will send codes for diseases or symptoms via SMS to a CBS platform. Depending on the NS, the branch or HQ will monitor the platform and flag suspicious cases, for instance when the prevalence of diarrhoea is higher in a certain community than a predefined threshold. When this happens, the RC branch will investigate and assess the situation on the ground and alert local health authorities if suspicions are confirmed.

Within this programme, CBS interventions will happen at three levels:

1. Community: Community-based volunteers will have an enhanced knowledge of key warning signs and symptoms for AWD and Ebola, as well as procedures and community action plans for how to respond to potential disease outbreaks.
2. Health Facility (mobile and/or fixed): Assessment on the capacity of one or more health facilities to detect and respond quickly in case of outbreak. Health facilities will be orientated and engaged to support community-based volunteers to deliver feedback from collected analytics to the

community.

3. NS Branches/HQ (depending on the structure of the NS): Development of the branch/HQ CBS system where the community-collected data are gathered and analysed. Strengthening of the communication between the NS and key stakeholders, including the Ministries of Health and outbreak response working groups.

The role of the HNS is also to make sure the community members understand why the tracing of potentially infected people is necessary. As the community volunteers are the eyes and ears of the entire community, they play a crucial role in providing the information on the who, what, where, and when of the contacts between the first confirmed case and other community members. Crucial is also that sceptical community members understand why health workers wear the rather intimidating and alien Personal Protection and Equipment (PPE) and consequently will not fear them. Furthermore, community members understand that widespread vaccinations could take place in their community in case of an Ebola or Cholera outbreak and are not afraid to be vaccinated.

3. Early action

Even when the outbreak is still limited but already detected based on data gathered through CBS, the local level can start an early response before health personnel from regional, national or international level intervene. The training package used for this early response stage is called Epidemic Control for Volunteers (ECV). Types of early actions are decided according to the context, but will generally include the dissemination of information to community households, the application of first aid techniques (e.g. in case of AWD the treatment of dehydration), the check-up or treatment of potentially contaminated water sources, and the protection of local health care facilities.

ECV training is structured as follows: first there is a Training of Trainers (ToT) at branch level during which ECV tools relevant for Cholera/Ebola are introduced to branch trainers. Community volunteers then receive a short “ECV Orientation Session” during their CBHFA-training. Only when an outbreak occurs, do the community volunteers receive a half-a-day training of “ECV just in time” from the branch trainers. This “just in time” approach maximises the effectiveness of the training, targeted towards the current outbreak and immediately implemented by the trainees. Besides training, volunteers will also be equipped with the necessary Information, Education and Communication (IEC) materials and personal protection equipment. For those NS where no readily accessible stocks of Oral Rehydration Therapy (ORT) kits or water disinfectant tablets exist, the programme will foresee the purchase of such stocks.

Important to note is that in case of Ebola, the community volunteers will by no means be involved in treatment or active case finding. These are tasks that require specific psychological and technical approaches in order to avoid panic, rumours, mistrust and most importantly contamination of the persons tracing or treating potentially infected people. These tasks will be carried out by a specialised Ebola response team.

C/3 HM disasters - translating the logic of intervention into an implementation strategy

In coherence with the EPC component of the programme, the implementation strategy for HM disasters is based on the same three-pronged approach. The programme combines preventive and responsive components, with a focus on community resilience as a means to mitigate the impact of extreme hydro-meteorological events on environment and population. Though the focus remains on communities, the programme will also include a component of support for NS response preparedness. This in the first place to maintain the capacities that were strengthened during the Disaster Preparedness programmes in the region, but also to extend those capacities towards branches responsible for disaster response should a HM hazard materialise in the communities targeted within this programme.

1. Prevention/Mitigation

Preventing HM risks or mitigating their impact starts at the community level for durable and sustainable effects, and focuses both on vulnerabilities and capacities. Community Risk Management Committees (CRMC) will be (re)established and trained in Disaster Risk Management. Links between these committees and the community volunteers of the NS will be established. In most countries, community volunteers will become an integral part of the CRMC. In the targeted communities, the IFRC VCA tool (Vulnerability and Capacity Assessment) will be used to identify the vulnerabilities and capacities and prioritise actions through disaster prevention micro-projects focused on the use of low-technology solutions implemented by the communities themselves. Based amongst others on the results of the assessment, community contingency plans will be drafted and geographical risk mappings will be completed. Moreover, government contingency plans at community level, will be informed by district-level contingency plans. Ensuring that these plans are complementary and harmonised will facilitate coordination of disaster response and grant community members more ownership of their protection and mitigation measures.

In addition to assessment and planning, community sensitisation sessions on climate change and disaster risk reduction will be organised. The tools used vary from mobile cinema to door-to-door visits to radio shows, billboards and wall paintings. Safe evacuation routes will be identified and signposted.

Complementary to community-based activities, the existing response structures at branch level, the Branch Disaster Response Teams (BDRT), will receive (refresher) trainings in order to be well prepared for responding to rapid-onset disasters. Special attention will be given to cash trainings. When the targeted branches are not yet supported through the ongoing cash preparedness project, they'll receive specific capacity building for the delivery of timely multi-purpose cash transfers in case of emergencies. At branch level, the pre-positioning or replenishment of relief goods is foreseen as well. Concerning potential cash distributions, the contracts with financial service providers that are currently being negotiated in the ongoing cash preparedness programme, will cover the newly targeted areas as well.

2. Early Warning

Despite preventive interventions and adequate longer-term preparedness, some HM threats will materialise in extreme events impacting the communities within our target area. Generating and disseminating timely and meaningful early warning messages to individuals, communities, and organisations, will enable them to act appropriately and reduce the impact of extreme events. "Early" signifies prior to the occurrence of the hazard in the community, while there is still time to reduce potential harm or loss. A "warning" is the message that announces imminent danger.

Figure 4 below shows the four components of a well-functioning Early Warning System (EWS), and the different intervention levels that can be targeted. While 'risk knowledge' and 'response capability' are already covered through the prevention/mitigation component of this programme as described above, the EW-component will specifically focus on the monitoring and warning communication at community level.

EWS components	Local/community or hazard-scape	National	Regional/global
Risk knowledge	Maps of hazard-scapes drawn by community members (i.e., through the VCA process, also known as community risk assessment).	GIS risk maps showing hazards and vulnerabilities throughout the country; computer network that receives and tracks major storm signals.	Satellite imagery from 30+ years can be overlaid on observation data to produce rigorous risk maps with layers portraying hazards and vulnerability.
Monitoring	Manual river and rainfall gauges; billboards to announce river levels.	Automated gauge system with information flowing into a central location in capital city.	Satellite-based monitoring system in real time with current global conditions and projections based on global climate models.
Response capability	Evacuation routes signaled by locally made (and where available, fluorescent coloured) signs and cyclone shelters designed locally.	Any response at this level will probably draw on the same technology found in warning communication below.	
Warning communication	Local devices for communication: word-of-mouth, runners, criers, drums, flags, bells, telephone, radio, television, megaphone, mosque speakers.	Radio, telephone, television.	Email and internet-based seasonal forecasts, RSS feeds

Figure 4 - Early Warning system components

Monitoring HM hazards at community level is for now limited to volcanic eruption monitoring and the use of river gauges which identify changes in water level and which will be installed at strategic locations along the rivers passing the targeted communities at risk for floods. When possible, this will be in close coordination with the governmental Water Authorities in order for the gauges to contribute to the current regional or national EW systems. Nevertheless, even if the community river gauges are not integrated into the (more professional) governmental warning system, they have the ability to sensitise and educate, and serve as understandable warning systems which tend to have greater community acceptance than top-down warnings. Community EW teams, often integrated in the CRMC, will be trained and equipped to set up, use and repair the river gauges, and analyse the data gathered through them. The river gauges are designed in a user-friendly way, using colour schemes to indicate hazardous water levels. The EW information gathered will be disseminated amongst the community and those that lie further downstream. The EW teams will be equipped with the necessary communication tools (megaphones, whistles, cellular phones, etc) to inform their fellow citizens of potential danger.

Though other HM hazards (in particular storms, cyclones and extreme temperatures) might not be monitored at the community level, it still is of major importance that early warnings issued by sub-local EW instances such as meteorological services, reach the communities timely. Hence why this programme will also focus on coordinating with national meteorological services, disaster management agencies and mobile communication companies to ensure the dissemination of EW messages has a country-wide immediate coverage.

3. Early Action

Despite RC investments to prevent and mitigate the impacts of disasters, people may still be affected throughout the implementation span of the project. A positive lesson learned from the ongoing Disaster Preparedness projects is that the inclusion of a Crisis Modifier (CM) allowing for the rapid disbursement of seed money for a first response not only serves the beneficiaries but also allows the implementing partner to put in practice the capacities acquired during the prevention/mitigation phase. Should no CM support be needed throughout the implementation of the programme, the CM budget will be *modified* to other budget lines. 18 months into the programme, the balance of the CM will be assessed and a plan for alternative expenditures in line with the intervention (such as procurements, training, cash disbursements)

will be drafted.

The Crisis Modifier is designed not to interfere with existing well-functioning instruments for Red Cross Disaster Response such as the DREF and the Emergency Appeals. Rather, it serves as a complementary tool which allows for other instruments to be used optimally, by for example financing the immediate needs assessment needed to apply for DREF funding, or to cover the transport and per diem of National or Branch Disaster Response Teams in the first hours or days immediately after the event. Also, response to events that are not eligible for DREF funding because of their limited scale or because of their recurrent nature can be served by the CM.

When disasters hit, both communities and Red Cross staff and volunteers are preoccupied with the emergency response. Ongoing activities related to prevention or mitigation are put on hold until a situation of relative normality returns. As this intervention both invests in and relies on the involvement of the NS branches and HQ, a countrywide eligibility for the CM is proposed.

In Rwanda, the programme aims to go one step beyond. The set-up of a Forecast-based Financing component for floods and windstorms, allows the NS not only to act early *immediately after* the flood or storm has passed, but already in the days and hours *before*. For several reasons, the FbF mechanism will be deployed in Rwanda alone:

1. There are no other existing FbF initiatives by other (Movement) partners.
2. The partner NS knows institutional stability and can count on a wide range of volunteers for immediate disaster response.
3. There are a variety of recognised and trustworthy meteorological agencies available.

Integrated into the Disaster Management unit of the NS, a dedicated FbF team will be set up, which will be in charge for defining the trigger, developing and testing the standard operating procedures for early actions (the Early Action Protocols or EAP), integrating these EAP into new or existing financial instruments for FbF such as the DREF, developing and implementing M&E tools to evaluate the EAP activation, and ensuring continuous FbF advocacy to relevant authorities and community members.

Adding a component of FbF ensures the proposed intervention bridges the divides between preparedness, early warning and early action. In a flood-prone district such as Rubavu in Rwanda, families living near the inundation zone will not only have been sensitised around the fastest evacuation route and safe hygiene

behaviours. But through early warning they will also know in advance when to seek shelter higher up, and trained disaster preparedness teams will distribute water purification tablets in the days prior to the forecasted flood.

Finally, by using the crisis modifier, rapid assessment teams will enter the stricken area and provide first aid for those who despite all preventive measures, still got injured. This holistic approach, inspired by the nexus between humanitarian assistance and development cooperation, will endow communities with the necessary tools to lower the risks caused by HM disasters. Not only because they'll be better prepared to avoid or mitigate their impact, but also because they'll receive assistance at an early stage, allowing for a quicker return 'back to normal'.

In Uganda, the development of FbF is currently implemented through URCS and the Netherlands Red Cross, financed by the IKEA "early warning early action" grant. In coordination with the above partners, a limited amount of extra support primary related to the training of NDRT members in the developed Early Action Protocols, is included in this programme.

2.4. [INT] If changes have taken place in the needs assessment at the interim report stage, please provide information

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

3. HUMANITARIAN ORGANISATION IN THE INTERVENTION AREA

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

From 2016 onwards, the first regional DGD-supported Disaster Preparedness programme started in Rwanda, Uganda and Burundi. The programme, ending March 2019, has focused on strengthening the response capacity of the National Societies by offering institutional support to mainly HQ and Branch levels. Trainings of National/Branch Disaster Response Teams, increasing the warehousing and transport capacities, pre-positioning of relief goods and response equipment such as first aid kits and water treatment tools formed the core components. In January 2017, an add-on disaster preparedness programme started, preparing the NS for the rapid disbursement of multi-purpose cash transfers in emergencies and extending the regional scope to Tanzania. In December 2018, in response to the sudden influx of Congolese refugees into Western Uganda flared up by intensified clashes in DRC's Ituri and North Kivu provinces, a complementary programme giving targeted DP support to the branches nearing the entry points kicked off.

The presence of BRC-FL in the region dates back to the 1990s, when BRC-FL supported the blood transfusion activities of Rwanda Red Cross. Since 2003, health programmes especially around HIV prevention and treatment, kicked off in Burundi and Rwanda. BRC-FL's first delegate in the region arrived in May 2006. Three years later, in 2009, the partnership with the Ugandan Red Cross started, focusing on first aid education and hygiene promotion. Since, all 3 countries targeted have received structural support in their organisational development in those 2 topics, which have become 2 fields of expertise in which BRC-FL applies its evidence-based methodology.

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

The soon-ending (March 2019) DGD-supported disaster preparedness programme of BRC-FL in the African Great Lakes Region (Uganda, Burundi, Rwanda and Tanzania) is strengthening response mechanisms at the National Societies headquarters and branches.

In addition, the DGD supported cash preparedness programme (Burundi, Rwanda, Tanzania) is empowering the respective National Societies to respond in cash, following detailed market assessments and Financial Service Provider mapping.

Finally, the DGD-funded programme strengthening the resilience of Congolese refugees in western Uganda has recently started (December 2018) and aims to improve the response to that particular humanitarian crisis, as well as strengthen the self-reliance of the refugees themselves.

These programmes, in combination with this very proposal, have been designed to inform and be complementary to each other, and are absent of any overlapping actions and funding.

As of yet, no donors besides DGD have been approached to fund humanitarian interventions by BRC-FL in the African Great Lakes region.

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

4. OPERATIONAL FRAMEWORK

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

Please refer to the maps in Annex 4: Areas of Intervention.

4.2. Beneficiaries

4.2.1. Total number of direct beneficiaries:

	Rwanda	Tanzania	Uganda
Disease outbreaks			
# staff trained	40	20	100
# (community) volunteers trained	250	100	200
# community members reached (individuals)	14.726	15.000 (the baseline study will determine the final indicators)	368.545
Hydro-meteorological hazards			
# staff trained	0	0	20
# (community) volunteers trained	420	100	4550
# community members reached (individuals)	191.857	TBD	25.982
Grand Total	207.293	15.220	399.397

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

Two groups of beneficiaries are targeted through this intervention:

1. Community households living in the target areas as described under section 4.1.
2. Staff and volunteers of the 3 NS who will receive training and capacity building both for preparedness and response to infectious disease outbreaks and HM hazards.

4.2.3. Mechanisms and criteria for the identification of the direct beneficiaries

The majority of the activities are implemented on the community level, for example communal DRR sensitisation sessions, communal contingency planning or early warning systems. The selection criteria for both the intervention areas and the community households is based on the selection criteria applied to identify the target area, which were:

1. Exposure to Ebola, Cholera and hydro-meteorological disasters.

2. Socio-economic vulnerability measured by poverty rate.
3. Not covered by other similar humanitarian interventions, not yet covered by ongoing BRC-FL support.
4. Cost-efficiency: target areas are regionally clustered, which will allow to organise joint activities, lowering the supporting costs of the programme.

For the selection of NS volunteers, the following criteria will be applied:

1. Literacy (ability to read and write).
2. Familiarity with Red Cross principles and Code of Conduct.
3. Residence in the respective branch/community.
4. Ability to speak the local language.

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

The Red Cross strategy for programme management emphasises participatory approaches whereby beneficiaries play a central role, from the design to the implementation and evaluation phase.
For the development of this proposal, beneficiaries could not be consulted directly. However, NS have been in touch with people directly linked with the population, especially the branch coordinators and committees.

Once the programme kicks off, the beneficiaries will be actively involved through a number of activities:

1. the vulnerability and capacity assessments which will be carried out in each community;
2. the establishment of the baseline for this programme especially aimed at evaluating the knowledge of the population on the disasters they face and the hygiene practices they apply;
3. the risk analysis which will take place and the community action plans which will be developed;
4. the implementation of preparedness and mitigation measures whereby the population will participate in various community works, attend different education sessions and attend bi-annual community coordination meetings;
5. joint lessons learned reflection and end evaluation.

Through community solidarity -a humanitarian value of the Red Cross- the beneficiaries will be encouraged to work together in supporting other beneficiaries, such as elderly or disabled people who have more difficulty in participating in certain activities. The beneficiaries will also be directly involved in monitoring of activities as well as the final evaluation, in order to ensure beneficiary accountability.

In addition, representatives elected by the community will be involved in periodic planning and feedback meetings allowing them to express their feeling and views on the most appropriate strategies designed to implement the programme.

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

The Governments of Uganda, Rwanda and Tanzania, and the humanitarian actors in the respective countries will benefit from the capacity building and planned response through this action. Therefore, indirect beneficiaries also include communities not specifically targeted by this intervention, through the replication of activities and awareness around health, sanitation and livelihood issues following epidemics and HM hazards.

The other branches of each NS will be benefiting from the action indirectly, as the expected capacity building, especially with regard to AFAM, RANAS, CBS and ECV methodologies can be replicated subsequently and increase their very own capacities to respond, and assist them to provide services in a

timely and professional manner.

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

Sector:	Number of beneficiaries
Health - Epidemics	398.271
Disaster Risk Reduction – Community and local level action	217.839 (Tanzania beneficiaries to be added)

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

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

[FIN] Estimate by type of beneficiary

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

4.3. Objectives, outcomes and activities

4.3.1. Operational overview of the action: logical framework[20] (3 pages maximum)

For the standard operational overview that will be applied in each of the 3 intervention countries, please refer to Annex 5: Logical Framework.

As each country has its own needs, priorities and capacities, variations among the countries may occur, which together with the specific baseline and target values, are included in Annexes 5A through 5D. Risks are analysed separately, in Annex 6: Risk Analysis.

4.3.2. More detailed information per outcome

4.3.2.1 Outcome 1: Improved ability of targeted communities to adopt positive health and hygiene practices.

At the proposal stage

- **Sector:** Health
- **Related sub-sector:** Epidemics
- **Beneficiaries (status + number):** 398.271 direct beneficiaries
- **Indicators for this outcome:**
  - % of respondents who correctly identified 3 key health & hygiene risks and 3 key health & hygiene practices (related to AWD and Ebola) in targeted communities
  - number of volunteers trained in RANAS
  - number of health & hygiene promotion sessions held in targeted communities
  - number of health and hygiene promotion supplies distributed to community members

Outcome-related activities

1. Trained and equipped volunteers at local level

Community-based health and first aid (CBHFA) is an approach to empower communities and their volunteers to take charge of their health. By using simple tools which are adapted to the local context, communities can be mobilised to address priority health needs. The major focus within CBHFA will be on applying hygiene promotion sessions through the RANAS methodology.

Through CBHFA, community volunteers will work with their own communities to increase knowledge and change behaviours related to key risk areas including AWD prevention/hygiene promotion, immunisation promotion, health seeking behaviour, good nutrition, reducing rumours around Ebola, etc.

By training the master facilitators first on a decentralised level, we allow the branches to upscale the number of needed trained CBHFA volunteers whenever needed, for instance when more health issues are occurring in a certain area. As a rule of thumb, one CBHFA volunteer will be responsible for covering 15 households through HH visits and participation in community sessions.

In order to conduct the activities on a local level, these trained CBHFA volunteers will be equipped with the necessary toolkits, training manuals such as RANAS flipcharts, and visibility items.

[20] This table must provide a comprehensive general overview of the different elements of the action. It will contain only concise information on the results and the activities. Any changes made to the logical framework at the interim or final report stage will be communicated.

Health authorities are encouraged to let local health centre employees take part in the CBHFA training. This to ensure that both NS and the governmental representatives are aware of the techniques which are being promoted at local level and if necessary, to adjust their guidelines.

2. Health and hygiene promotion sessions

CBHFA volunteers will disseminate knowledge and apply the techniques they're trained in during household visits. These household visits will simultaneously allow the volunteers to apply CBS activities, as by entering households they acquire information about who in the household is sick, which symptoms are present and how long the sickness lingers on.

Besides household visits, a range of other communal health and hygiene promotion methods will be applied. Countries acquainted with the methodology of "Hygiene clubs", will receive the necessary resources to set up and maintain new clubs (around 1 per 50 households) in the targeted communities. The community Hygiene Clubs cover different preventative health topics (especially disease prevention) on hygiene promotion during training sessions for community members and thus support the long-term sustainability of the behaviour change. In Tanzania, a similar technique focused on schools ("School WASH" or "SWASH" clubs) will be applied.

Also, the use of radio shows and mobile cinema sessions are a well-known element of community engagement and accountability within the region, a lesson learned from the two disaster preparedness programmes. To support the messages used during the radio shows, mobile cinema sessions and hygiene clubs, the use of billboards and wall paintings is promoted. They are highly visible within the community for a longer period of time.

3. Strengthening logistical capacity at local level

Promoting good practices is, in and of itself, not sufficient to achieve behavioural change if the community members don't have access to the tools needed for better health and hygiene practices. Some community members don't have the resources to buy health or hygiene materials or don't have access to safe drinking water or improved latrines.

Following sensitisation activities on a local level, the most vulnerable households will be identified in close cooperation with the community leaders. These households will be provided with first aid kits and hygiene materials. Those living in areas where no safe drinking water is available and no actions for a sustainable safe water source are foreseen in the near future need to make use of household water treatment. These households will be provided with materials for safe water storage and treatment such as jerry cans and chlorine tablets.

4.3.2.2 Outcome 2: Improved ability of HNS to prevent, detect and respond to disease outbreaks at the community level in all the districts.

At the proposal stage

- **Sector:** Health
- **Related sub-sector:** Epidemics
- **Beneficiaries (status + number):** 398.271 direct beneficiaries
- **Indicators for this outcome:**
  - % of epidemics/outbreaks within target area where a timely alert was generated through CBS system
  - Number of staff and volunteers trained on CBS and ECV
  - Number of CBS activities implemented at community level
  - Number of branch or HQ investigations into CBS alerts conducted
  - Number of households receiving visits from ECV volunteers during an outbreak

Outcome-related activities

1. Capacity building on risk management

Through the implementation of Community Based Health and First Aid (CBHFA), Community Based Surveillance (CBS) and Epidemic Control for Volunteers (ECV) in selected communities, the program aims to increase the preparedness and prevention capacity of the NS and targeted communities to respond to epidemics.

As the capacity assessment showed, while CBS and ECV are new to the implementing partners in most of the countries, CBHFA is already known. This means that a healthy basis for developing CBS and ECV capacity is already there. The first outcome of this program focuses on widening this basis even more by training a substantial number of additional local volunteers and other community actors in CBHFA.

As with the CBHFA approach we propose to work again in a double-phased training process. First we will train ToT (training of trainers) facilitators on CBS and ECV, after which they'll train the community volunteers at local level. The ECV training on local level will be done when a threat is actually identified. During the training, the volunteers will also learn how to work with the IEC materials and toolkits which are provided.

When training volunteers, local community health workers appointed by the local authorities will be invited to partake, to ensure permanent cooperation between Red Cross and governmental local actors. Training sessions or refresher trainings also include the dissemination of government-approved standardised procedures.

Epidemics or just even rumours about a possible epidemic outbreak can have a devastating impact on the social cohesion of a community. Suspected cases might be shunned by other community members and become outcasts, reducing their access to health care facilities or other means of communal support.

Sharing information on the surveillance activities and possible response activities in a transparent and timely manner is therefore crucial to gain the trust of the community members. As was observed during the ongoing Ebola operation in DRC, community members sometimes refused treatment from or contact with healthcare workers due to misinformation or lack of information. Integrating community-based psychosocial support (PSS) in any kind of epidemic-related activities is thus crucial in ensuring the viability of the relationship between health workers and community members. Therefore, each community will be provided with a trained PSS volunteer.

In order to consolidate the constant vigilance around epidemics within the NS, a technical working group on infectious diseases will be established. They will follow up on the preparedness activities, ensure the permanent contact with the Ministry of Health and its specialised agencies, and keep track of and integrate new relevant guidelines within the procedures of the NS.

The Red Cross Societies have the capacity to quickly scale up their activities due to the fact that they are active on different levels, namely national (NDRT), district (BDRT) and local level (LDRT). This allows them to support any community or district which is being overwhelmed by sending trained volunteers from either a higher level or a neighbouring district. Therefore a team of experienced NDRT will provide support to the volunteers on branch level or local level whenever is needed. This support will mostly consist of coordination of the different activities.

2. Early detection and early warning through mobile technology

Strengthening local capacities will allow an early detection/early response mechanism. Therefore, strengthening community capacity in community-based surveillance and linking it to national surveillance systems enables early action. Coupled with appropriate training at the community level on early response, this could significantly reduce the impact of epidemics.

Community volunteers will be trained to detect health risks in the community based on a predetermined community case definition. They will then be able to report these cases via mobile phone technology to the online Red Cross CBS platform which is currently under development by the IFRC. The NS will also share

such information at different levels of engagement (district, provincial, national) with key stakeholders including the Ministry of Health, depending on the nature of the health risk.

The surveillance activities highly depend on mobile data collection. In order to make full use of all the possibilities of mobile data collection tools, an advanced KOBO toolbox training for 30 staff and selected volunteers will be held.

The CBS/ECV systems which are set up will require not only a proper follow-up but also regular testing. Therefore, simulation exercises will be organised in all branches in close cooperation with the related governmental disaster management agencies.

3. Epidemics response activities in cooperation with the authorities

Through the implementation of Epidemic Control for Volunteers (ECV) in selected communities, the program aims to provide early response, by using just-in-time training on epidemics to quickly disseminate messaging to communities through volunteers and ensure that health facilities are protected and activate their response plans.

ECV will enable the branches to start an early response at the community level when the outbreak is still limited based on the local data from the communities through CBS or other local data. The NS will be able to build trusted communication with the communities and conduct social mobilisation actions when needed.

The national Ebola contingency plans clearly mentioned the need for well-established mobile health posts in case of an epidemics threat. These health posts should function as holding posts for possible infected patients prior to their transport to any specialised treatment centre. Considering the role of the Red Cross within the epidemics plans it's crucial to procure and pre-position several of these mobile health posts.

Interim report

- **Updating of the indicators**
- **Updating of the beneficiaries (status + number)**
- **Updating of the activities**

Final report

- **Indicators for the outcomes obtained**
- **Beneficiaries (status + number)**
- **Activities carried out**

4.3.2.3 Outcome 3: Improved resilience of communities living in high-risk areas and strengthened institutional capacity of the local Red Cross and other stakeholders to respond to HM disasters

At the proposal stage

- **Sector: Disaster** Risk Reduction / Disaster Preparedness
- **Related sub-sector:** Community and local level action
- **Beneficiaries (status + number):** 217.839 (Tanzania beneficiaries to be added)
- **Indicators for this outcome:**
  - Number of emergency committee members / members of volunteer groups in the project area showing skills in carrying relevant response tasks according to minimum standards in a coordination manner
  - Number of trained Community Risk Management Committees

- Number of community sensitisation sessions held
- Number of relief items and/or amount of cash pre-positioned
- Number of contingency plans drafted, number of evacuation routes signposted
- Amount of disaster prevention/mitigation activities concluded during timespan of the project
- Amount of Red Cross Branch volunteers trained in DRR-related topics

Outcome-related activities

1. Capacity building on risk management

Reducing the risks that hazards bring is a Red Cross priority, and is a very natural one for the world's largest voluntary network. With millions of members and volunteers living in communities in every corner of the world, Red Cross National Societies are uniquely positioned humanitarian actors. Because of their grassroots presence they can tap into local knowledge, help communities identify the dangers they face, assess their capacities and vulnerabilities, and come up with solutions.

Finding solutions starts with creating risk awareness at local level. This is done by setting up and training Community Risk Management Committees who analyse the risks, vulnerabilities, and capacities in their own community in a structured way and think of possible solutions. This way they take responsibility of their situation which improves their resilience to cope with any adverse events.

Trained BDRT and LDRT members who are part of these communities facilitate this process. Per Red Cross branch around 30 BDRT volunteers will be trained and/or refreshed in general disaster management including DRR. The same will be done on a local level where community volunteers will be trained at each community level. These volunteers can be involved in all the parts of the disaster management cycle, namely preparedness, mitigation, response, and recovery.

In addition, Branch Disaster Response Team members will be trained in performing 'vulnerability and capacity assessments' (VCA) before supporting the communities. VCA is a methodology and means of gathering information in a participatory way. Its purpose is to increase community members' awareness of risk and help them to plan activities for reducing vulnerability and increasing capacity before a disaster happens. They will also motivate the committee members and facilitate regular meetings.

The next step is to draft contingency plans. Based upon the information gathered by the Community Risk Management Committees, risk maps are drafted on community level and integrated with the maps existing at district/regional level. These maps form the basis to identify possible solutions to mitigate the impact of any disaster. One of these solutions is to identify, communicate and signpost safe evacuation routes per community. Combined with an early warning, such evacuations are crucial in saving human lives as well as livestock.

Another innovative way of making communities more independent from support of government or NGOs is to make mutual agreements between communities. Neighbouring communities sign an official agreement among each other long before disaster strikes. They provide mutual support by opening community shelters for evacuees, provide food and drinks for the first few days or weeks, and provide communal sanitation facilities. This already happens in an informal way between families but can be turned into a more formal and structured good practice.

2. Community sensitisation and community based activities

As is also the case for epidemics, the aim is to inform as many beneficiaries as possible in order to raise a bigger awareness in the targeted communities regarding disaster risk reduction. There are a great number of things community members can do themselves in order to reduce the impact of a disaster.

The solutions may lie in simple things like educating children on what to do in emergencies or planting trees on unstable hillsides to stop these from releasing landslides. More complex solutions include early warning systems, construction of rain water sewage systems and urban planning.

Again, systems which are well known to the public such as mobile cinema sessions and radio shows will be employed. These are not one-shot operations but recurring sensitisation activities over a longer period of

time. By complementing these with billboards and wall paintings, a quasi-permanent exposure to DRR messages within the target community is achieved.

A practice which was also used within the initial disaster preparedness project and proved highly effective is the organisation of DRR sensitisation sessions in schools using specially designed DRR booklets. Through this program, additional schools in other districts will also benefit from this good practice. Content-wise they are linked to the other means of community sensitisation; this way, all age groups receive similar messages through different means.

Besides the target districts, DRR will be given the necessary visibility throughout the rest of the target countries. The UN General Assembly proclaimed the International Day for Disaster Reduction in 1989 as a way to promote a global culture of risk awareness and disaster reduction. That includes disaster prevention, mitigation and preparedness. The UN General Assembly formally designated 13 October as the annual date. BRC-FL and its partners will pick up on this practice by organising an annual DRR awareness event on the same day. Having the indirect support of the UN will give the DRR message more weight.

3. Preparedness activities

Even though much is being invested in identifying the risks and becoming more aware of their potential threat, specific actions will still be required to prepare for the imminent disaster.

In order to allow both the branch and local disaster response teams to intervene in different life saving activities, they require more than just training. They also need the hardware in the field. This is why the program aims to identify the appropriate type of relief items/cash and pre-position the minimum required amount per strategic location.

Branches usually have limited resources. Vehicles are a rare luxury at the local level. Aside from one or two motorcycles, volunteers use bicycles to move around within the sectors. The major advantage of this mode of transport is the fact that they are low in running cost and therefore a durable solution to cover shorter distances.

Through the regional Cash Preparedness project funded by DGD, cash-based interventions (CBI) pilot projects are ongoing and will be launched in districts which are among the ones targeted in this proposal, owing to their vulnerability to floods, landslides and epidemics. Therefore, when training new disaster response teams, special attention will be given to adding skills in CBI in other districts as well as building upon the lessons learned within the Cash Preparedness programme.

Interim report

- **Updating of the indicators**
- **Updating of the beneficiaries (status + number)**
- **Updating of the activities**

Final report

- **Indicators for the outcomes obtained**
- **Beneficiaries (status + number)**
- **Activities carried out**

4.3.2.4 Outcome 4: Improved Early Warning (EW) systems at community level leading to a more targeted and effective Early Response, prior to the HM disaster or thereafter

At the proposal stage

- **Sector: Disaster Risk Reduction / Disaster Preparedness**
- **Related sub-sector: Hazard, risk analysis and early warning**

- **Beneficiaries (status + number):** 217.839 (Tanzania beneficiaries to be added)
- **Indicators for this outcome:**

  - number of community members in project area who receive early warning messages in a timely manner from at least one source
  - number of operational EWS that are understood by target population
  - number of community EWS integrated into national/regional EWS
  - number of people that receive in-kind/cash assistance by the programme
  - amount of validated Early Action Protocols

Outcome-related activities

1. Early warning systems

When disasters strike, Red Cross volunteers are often among the first to provide relief to the victims. But in most cases, more lives can be saved and suffering reduced if action is taken before disaster strikes. It is commonly accepted now that it is much more effective to evacuate people before a flood than to rescue people during the flood, or to provide relief to its victims. The Red Cross is investing more into people-centred early warning systems so that their early actions (preparedness and mitigation/prevention) are suited to face the rising risks of extreme weather events as a result of climate change.

Therefore the concept of 'early warning, early action' must be integrated into the modus operandi of NS branches. All BDRT members in the target area need to understand the fundamentals of early warning and how to identify the most suitable early warning systems for each context.

These BDRT members will work together with the local communities. Based upon the risk maps and the contingency plan which were developed, the most effective local community warning systems will be identified. After this, the needed hardware will be procured to set up the systems per community.

Early warning teams at local level will be tasked to operate the systems when needed and to maintain the hardware. These could be sirens, megaphones, whistles, coloured flags, billboards, etc. In order to give the required visibility to the team members operating the EWS prior to a disaster, they will be equipped with several visibility items such as polo shirt and/or cap. This differentiates the team members from anyone else performing public address for commercial or any other non-life threatening reasons.

The NS already receive regular weather updates from the meteorological agencies, but they currently don't include any specific triggers or initiate any further standardised warnings. In coordination with both the meteorological agency and the authorities for disaster management, specific protocols need to be drafted including triggers, communication flows and early actions. This needs to be formalised into a multi-actor agreement including all essential stakeholders.

This system, from the national level to the local level, needs to be tested on a regular basis. Following each test case of a real intervention, a detailed evaluation needs to be organised followed by a lessons learned workshop.

2. Crisis modifier

Cash will be deposited in the delegate account in-country or in the account of the selected financial service provider for rapid disbursement in case of sudden emergency. This money is meant to kickstart major relief operations by allowing for first response and needs assessment while awaiting other (inter)national budgets to be transferred; or for response to small scale disasters that are not eligible for international funding.

3. Forecast based financing (FbF)

The principle of forecast based financing is directly linked with the aforementioned system of early warning.

Based upon the previously mentioned risk mapping, a larger-scale risk analysis is done providing a clear picture of the major risks in the selected target areas. Together with the relevant specialised agencies, the

available data sets for each risk are researched. As with the early warning systems, thresholds or triggers that can initiate early actions are defined. These early actions are part of validated early action protocols.

Forecast-based financing is an innovative approach towards emergency management. It still requires adequate advocacy to both potential donors and community members. The time available to implement the early protocols is usually limited to a few days, so in order to succeed, all stakeholders need to be fully aware of the system. This will require training on different levels.

Interim report

- **Updating of the indicators**
- **Updating of the beneficiaries (status + number)**
- **Updating of the activities**

Final report

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

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

Please refer to Annex 10: Gantt Chart.

NOTE: The Gantt Chart attached in ANNEX 10 presents the Activity Planning for the programme as a whole. The implementation of activities may vary slightly in each country according to the specific logframes and operational capacities in-country.

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

4.5. Monitoring, assessment, auditing and other analyses

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

The activities will be directly implemented by the 3 NS and monitoring will be carried out jointly by the NS and BRC-FL. The following personnel will be under contract to the NS and directly involved in the monitoring of activities:

Function	Tasks
BRC-FL Country Delegates (Kampala, Kigali, Dar Es Salaam)	Daily programme management, planning, implementation and reporting, reports to BRC – FL HQ.
Regional Epidemic Preparedness Expert (based in Kampala)	Seconded by Canadian Red Cross. Provides the 3 HNS with technical expertise and guidance for the implementation, monitoring and evaluation of the EPR related activities of the programme.
Regional Disaster Preparedness Expert (based in Kampala)	Provides the 3 HNS with technical expertise and guidance for the implementation, monitoring and evaluation of the HM hazards-related activities of the programme. This person acts as the BRC-FL Country Delegate for Uganda.
Regional Forecast-based Financing Expert (based in Kigali)	Provides Rwanda Red Cross with technical expertise and guidance for the implementation, monitoring and evaluation of the FbF-related activities of the programme. This person acts as the BRC-FL Country Delegate for Rwanda.
HNS Project Officer (Kampala, Kigali, Dar Es Salaam)	Responsible for implementation and monitoring, assistance with the development of M&E tools, follow up of the data collection and analysis, support in narrative reporting.
HNS Branch Coordinators	Coordinating the daily programme implementation, mobilizing the communities and coaching the community volunteers, reporting to the Project Officer

Within each respective country of intervention, the BRC-FL country delegation will support the HNS in performing monitoring and evaluation activities. A regional technical expert on epidemic preparedness, seconded by the Canadian Red Cross, will assist the HNS technically and theoretically in rolling out the programme.

The consolidation of the monitoring, including the financial expenditure according DGD regulations, will be coordinated by the DRR Officer at HQ in Mechelen.

An external evaluation of the entire programme will be organised by BRC-FL at the end of the programme and an independent annual financial audit will take place in accordance with the guidelines of DGD.

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

☐ External assessment during the action
x External assessment after the action
☐ External auditing during the action
x External auditing after the action
☐ Internal assessment or internal auditing relating to the action

4.5.3. Other analyses: ☐ Please provide information:

5. CROSS-CUTTING ISSUES

5.1. Please describe the expected level of sustainability and/or of connectedness[21].

At the heart of this proposal is a shift in focus to the local community level. The very objective of this "localisation of aid" is to render it more sustainable. By investing mainly in human resources and "soft" activities such as the capacity building of local aid workers and communities, the project aims to reduce aid dependency and the need for long-term humanitarian assistance supplied by international organisations.

Furthermore, the involvement of local authorities and civil society are key aspects in the programme sustainability approach because they promote long-term support and involvement by the community in resolving community challenges, and promote the engagement of local authorities beyond the programme duration.

The National Societies will seek continuous support for emergency response operations through, amongst other, the modalities offered by the Red Cross Movement, such as Disaster Relief Emergency Fund (DREF), which in case of disaster, will contribute to replenishing the strategic stocks but will also provide funds to support volunteers teams during operations. Moreover, it is the intention of several National Societies (including Uganda and Rwanda) to assist the RC district branches in raising funds at local level, especially through membership fees and by developing income-generating activities, which provide additional funds to support the volunteers during operations at their level.

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

The localisation of aid takes place along a continuum from humanitarian interventions to development-oriented measures. The objective of this programme is to actively endorse the localisation of aid, by building the capacity of local Red Cross structures and communities to respond effectively to disease outbreaks and HM disasters and to prevent or mitigate their impact.

When communities are well-prepared and well-equipped, the humanitarian consequences of diseases or disasters will be less severe, lives will be saved and livelihoods protected. As generally accepted, localised aid is more sustainable and therefore more cost-efficient and effective than an international response. Self-reliance foregoes the need for a long-term aid operation. Hence, effective localisation of aid and strengthening resilience contribute to the long-term sustainability of community development efforts.

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

<u>Disaster Risk Reduction:</u>
The proposed action is complementary to three ongoing Belgian government-funded programmes:
- In the African Great Lakes region (Uganda, Burundi, Rwanda), a disaster preparedness programme (with special focus on institutional response capacity) is currently in its final stages of implementation.
- In the African Great Lakes region (Tanzania, Burundi, Rwanda), a cash preparedness programme (with special focus on Multi-Purpose Cash Transfers) is currently being implemented.
- In Western Uganda, the recently approved disaster response programme (increasing response capacity and strengthening resilience of Congolese refugees) has started as of 1 December 2018.

<u>Gender equality and children's rights:</u>
In line with the respective national gender policies in general and the National Societies' constitutions in particular, equity and equality between men and women will be fully taken into account during identification of the programme's target groups. The programme will ensure the protection of women and children's rights by providing access to information regarding diseases/disasters and engagement in programme activities on an equal basis. It will also make sure that the trainings and sensitisation strategies

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

are adapted to the audience, inclusive and varied, and allow for both men and women to attend in equal numbers.

Human rights:

The humanitarian principle at the core of the International Red Cross and Red Crescent Movement and its activities is founded on the concept of human dignity, which is also the foundation of many human rights. In this programme, making communities more self-reliant and resilient against diseases and HM disasters works towards achieving an adequate standard of living, as enshrined in art. 25 of the Universal Declaration of Human Rights[22]. As a specific example, WASH promotion activities have been regarded as a form of human rights promotion.[23]

Environmental protection:

The National Societies will explore opportunities within their respective communities in order to support environmental protection. The programme will work in close coordination with local environmental organisations in order to pass messages on environmental protection within the communities. Volunteers together with the communities will be engaged in sustainable exploitation of the environment, where the local context calls for it and allows for it.

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

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

[22] "Everyone has the right to a standard of living adequate for the health and well-being of himself and of his family, including food, clothing, housing and medical care and necessary social services, and the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control".

[23] Hulland K, Martin N, Dreibelbis R, DeBruicker Valliant J, Winch P (2015) *What factors affect sustained adoption of safe water, hygiene and sanitation technologies? A systematic review of literature*. London: EPPI-Centre, Social Science Research Unit, UCL Institute of Education, 6 (2015), 1-169, http://eppi.ioe.ac.uk/cms/Default.aspx?tabid=3475.

6. SECURITY AND EMERGENCY MEASURES

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

Please refer to Annex 6: Risk Analysis.

6.2. Security-related aspects

6.2.1. Situation in the field. Please provide a brief description

Uganda: The security situation in the country is stable. Along the borders with South Sudan and DR Congo there is an increased presence of elements of the Army and security personnel due to the high density of refugees. Roads, however, are open and checkpoints are seldom seen. Movements in the Field are coordinated with URCS who in turn receive regular updated security updates from UN and ICRC.

Tanzania: The security situation in the country is stable. Movements in western Tanzania near the refugee camps of Kigoma are subject to district-level security clearance. Reports of banditry and robbery are frequent, but humanitarian organisations are not specifically or systematically targeted. Due to the high presence of international NGOs and UN and ICRC in the area, security reports are regularly issued and monitored by TRCS and its international partners.

Rwanda: The security situation in the country is stable. The government maintains a firm grip on the country and there is unimpeded access to and movements around the targeted areas. Presence of Army and security personnel is high in the border areas with DR Congo (Rubavu), but international organisations have not been impeded in their work.

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

yes ☐ no X Standard procedures

Given the currently (relatively) stable security situations in Rwanda, Tanzania and Uganda, a specific security protocol is not established for this programme. However, in case of a sudden deterioration of the situation, all Red Cross actors in these countries will follow the safety procedures of the ICRC and the NS.

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

yes X no ☐

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

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

7. COORDINATION IN THE FIELD

7.1. Coordination in the field (please state the humanitarian organisation's participation in the coordination mechanisms with other stakeholders, such as "clusters", NGOs, the United Nations agencies, others (to be specified), as well as the links to the consolidated appeal procedure, if necessary)

General

At the country level, as part of the International Red Cross/Red Crescent Movement, all involved National Societies work with the IFRC, the ICRC and several partner National Societies, amongst whom of course the Belgian Red Cross-Flanders.

Rwanda

Rwanda Red Cross organises an annual meeting of all its partners (national and international). The aim of this meeting is on the one hand to share best practices identified during the implementation of activities, and on the other hand to mobilise new financial resources for supporting vulnerable people in the country.

Externally, the Rwanda Red Cross also participates in many coordinating bodies:

a. National coordination with MIDIMAR

• Participation in *Disaster Management Task Force* (DMTF) coordinated by the MIDIMAR which meets quarterly with various stakeholders in disaster management: Ministries and other government agencies, United Nations (UNICEF, UNDP, WHO, WFP, FAO, UN HABITAT), Red Cross Movement and international NGOs.

b. Coordination at the district and sector level

• Participation in the Joint Action Forum which gathers all district partners quarterly in each district;
• Organisation by the RRC of programme steering meetings that bring together local authorities and organisations in connection with the programme and representatives of volunteers and beneficiaries;
• Organisation by the RRC at each district level of a commission meeting which essentially discusses the disaster management issues (risk maps, contingence plans) and relevant DRR/DP actions which could be undertaken. Participants are police, local authorities, BDRT volunteers and organisations involved in disaster management at district level.

Tanzania

The TRCS participates in several coordinating bodies:

a. National coordination with

• Office of the Prime Minister: Disaster Preparedness Department through the bi-annual *National Platform for Disaster Risk Reduction*
• Ministry of Health, through the quarterly *(Health) Emergency Preparedness & Response Platform*

During the design of the Cash Preparedness programme (mentioned under section 5.3), the TRCS was also invited to participate in the Cash Working Group co-chaired by the WFP and UNHCR in Dar Es Salaam, in order to jointly discuss harmonisation of Multi-Purpose Cash Transfer interventions in the future.

b. Coordination at regional and district level

• Programme steering meetings, organised by the TRCS, that bring together local authorities and organisations in connection with the programme and representatives of volunteers and beneficiaries

Uganda

a. National coordination

• Member of the *National Platform for Disaster Risk Reduction*, which brings together government sector ministries, humanitarian and development actors, and the academic and the business communities on matters of DRR. The forum is hosted by the Office of the Prime Minister (OPM) and chaired by the Commissioner for Disaster Preparedness and Management on behalf of the Permanent Secretary. The OPM takes the lead in case of a disaster (see also: stakeholders table)
• With the *Office of the Prime Minister* (OPM), Department of Relief, Disaster Preparedness and Management. This Department has as one of its key functions the coordination of all emergency operations country-wide.
• Quick assessments are done in mixed teams with government officials and NGOs, including URCS. Depending on the emergency and the needs identified on ground, different players take up their role. Some examples: Save the Children responds to the (playing) needs of children, Red Cross focuses on WASH needs and tracing needs (with the support of ICRC), UNHCR takes the lead in refugee emergencies, World Food Program responds with emergency food provision, Médicins sans Frontières provide medical assistance, etc.
• Member of UNHCR-organised Inter-Agency Coordination Meetings

b. Coordination at regional and district level

• The URCS district branches work closely with the District Disaster Management Technical Committees (DDMCs) which coordinate disaster activities and approaches at their specific level. The management of emergencies by URCS always aims to be in line with the disaster management policy and protocols of the government of Uganda. In these documents, the role of the URCS in supporting the Chief Administrative Officer of the district has been clearly defined.

In short, coordination is done at national, regional and local levels with all (other) stakeholders, including the government, the local authorities and UNHCR for technical support and standardisation of approaches. Finally, URCS often supports the work of other players through its network of volunteers, e.g. by carrying out (food or NFI) distributions or camp management.

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

See section 7.1. All four NS involved are auxiliary to the public authorities and have a special status allowing for easy negotiation and smooth collaboration with public services. Represented in the districts, sectors and cells through their local committees, the NS are closely linked to the state institutions. As part of this programme, the local authorities at central, district and local level will be actively involved in the programme activities.

7.3. Potential coordination with the Belgian diplomatic representation

The delegations of BRC-FL based in the 3 countries in the African Great Lakes region will maintain regular contact with the Belgian diplomatic representation to share information on the progress of programmes, organise field visits, and attend eventual learning events, thus building on pre-existing relationships.[24]

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

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

[24] For example, BRC-FL's country representative in Uganda and the Head of Humanitarian Assistance have already been in close contact with the Belgian embassy there to prepare and organise the recent disaster response programme for Congolese refugees (mentioned under section 5.3).

8. IMPLEMENTATION PARTNERS

8.1. Name and address of the implementation partner(s)

Rwanda
Rwanda Red Cross
BP 425
Kacyiru, Kigali
Rwanda

Tanzania
Tanzania Red Cross National Society Headquarters
Plot 53, Block C, Mwai Kibaki Road
Mikocheni B, Kinondoni
P.O. Box 1133
Dar Es Salaam
Tanzania

Uganda
Uganda Red Cross Society
Plot 551/555 Block 8
Rubaga Road
PO Box 494
Kampala
Uganda

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

Status:
BRC-FL and the four HNS involved (RRC, TRCS and URCS) are non-profit organisations registered according to the laws and norms of their respective countries. The action will be implemented in respect of their own internal rules and in full compliance with the procedures of DGD.

All four HNS are key actors in disaster preparedness and response within their respective countries. They have been part of past DP projects funded and supported by DGD, which have strengthened their capacities sufficiently to prepare them for participation in this programme. Furthermore, they are members of the International Red Cross and Red Crescent Movement and support the public authorities in their own countries as independent auxiliaries to the government in the humanitarian field. Their local knowledge and expertise, access to communities and infrastructure enable the Movement to get the right kind of help effectively and timely.

Role:
In this programme, the BRC-FL acts as a back donor to the HNS, who are the implementing partners. While the HNS are in the driving seat during implementation, BRC-Fl will be in charge of the delivery of day-to-day technical expertise and will closely monitor the compliance of implementation with DGD regulations.

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

BRC-FL always operates within the partnership framework of the International Red Cross & Red Crescent Movement and work with the National Red Cross or Red Crescent Society as sole preferential partner.

Principles of cooperation and capacity building are Movement-wide formalised in the IFRC 'Development Cooperation Policy (2007), the 'National Society Development Framework' (2013) and the 'Code of Good Partnership'. All Red Cross partners in this programme are strategic partners, meaning the commitment for cooperation within this 2-year Disaster Preparedness programme is integrated in a long-term partnership which includes both humanitarian and developmental support.

Within the HNS, the Programme Officers takes up the role of project coordinator, responsible for the overall monitoring of the programme's progress and the coordination between the different activities under their authority. At the local level, branch coordinators and assistants will work together with the the Programme Officer, who will also be responsible for reporting on activities implemented at branch level.

The BRC-FL delegates in-country will be in charge of overall country-specific monitoring of the programme, its good management (planning, monitoring, evaluation and reporting) and the organisation of the final evaluation. Reporting will be monitored and compiled by the Business Controller and PMER officer based at BRC-FL Headquarters, under the supervision of the Head of Humanitarian Aid.

The individual delegations of BRC-FL in the African Great Lakes region will be responsible for the correct reporting and the organisation of the final evaluation and audit, in close collaboration with the PMER departments, and the Humanitarian Assistance department at BRC-FL headquarters.

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

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

9. ACTIVITÉS DE COMMUNICATION, DE VISIBILITÉ ET D'INFORMATION

9.1. Planned communication activities

In Belgium:
BRC-FL will inform the interested Belgian public about the programme, acknowledging the Belgian government as main donor and partner. The objective is to explain the value of the programme, highlight its results and challenges, and stress the importance of investment in localisation, effectiveness and preparedness as essential prerequisites for effective disaster response.

To this end, content of programme activities and the origin of its funding will be published in press releases, website content, human interest blogs, and audio-visual material and spread through traditional media outreach, social media and on the intranet site of BRC-FL.

Within the partner countries:
The programme will be communicated to the outside world as a programme of the involved National Society, in partnership with BRC-FL and funded by the Belgian government. The communication service of the NS will be in charge of the media coverage of the programme. The activities will be regularly published in the newsletter, websites and social media platforms of the NS, and will be communicated during the coordination meetings they are involved in.

The National Societies will take care to acknowledge the Belgian government's funding and partnership in each publication and in all its communications concerning the programme.

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

The logo of the donor will be inserted, if the security situation allows, on all relief goods purchased within the project. During the regional exchanges and media outreaches, efforts will be made to mention the back-donor of the project.

Also, to promote the visibility of the programme, panels will be located on the programme sites. Promotional materials (t-shirts, caps, flyers) with messages related to programme activities will be produced and distributed to volunteers and staff involved in the programme activities.

9.3. Publication activities planned

See "Planned communication activities".

Furthermore, in the four involved countries, the programme plans to produce a documentary film on the programme activities from the beginning to the end. This film will also feature testimonies to show the appreciation of the programme impact among the beneficiaries. The film will be widely distributed among the local partners and other partners involved. In addition, the programme activities will be included in each of the NS' annual reports which are shared among all its partners.

9.4. [INT] In the event of changes, please provide information
9.5. [FIN] Report on relevant activities

10. HUMAN RESOURCES

10.1. Please state the overall figures by function and by status

Please refer to Annex 7: Human Resources.

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

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

11. ADMINISTRATIVE INFORMATION

11.1. Name and title of the legal representative signing the agreement

Prof. Dr. Philippe Vandekerckhove, Director General

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

Tiene Lievens
Manager International Cooperation
Tel +32 15 44 33 57 | Mobile +32 497 93 44 03
E-mail: tiene.lievens@rodekruis.be

Elien Danckaerts
Focal Point Disaster Risk Reduction
Tel: +32 15 44 35 08 | Mobile: +32 470 87 16 64
E-mail: elien.danckaerts@rodekruis.be

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

Rwanda:

Claire Schamps

Country Representative BRC-FL in Rwanda

Phone: +250 787 170 252

Claire.Schamps@rodekruis.be

Tanzania:

An Vanderheyden

Country Representative BRC-FL in Tanzania

Phone: +255 682 132 728

An.Vanderheyden@rodekruis.be

Uganda:
Petrus Herpoele
Country Representative BRC-FL in Uganda
Phone: +256 786 804 222
E-mail: Petrus.Herpoele@rodekruis.be

11.4. Bank account

Name of the bank: KBC
Address of the bank agency: Grote Markt 27, 2800 Mechelen
Precise designation of the account holder: Rode Kruis-Vlaanderen Internationaal v.z.w.
Complete account number (including bank code(s)): To be communicated upon acceptance of proposal
IBAN code: /
SWIFT code: KREDBEBB

12. BUDGET OF THE INTERVENTION

Please refer to Annex 8: Budget.

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