THE CIVIL SOCIETY FUND

SMALL-SCALE DEVELOPMENT PROJECT

(budget up to DKK 500,000)

Project title	Strengthening the capacity at community level to prevent, detect and treat NCDs in 5 sub-counties in Kamuli district, Uganda				
Danish applicant organisation	Hope Denmark	E-mail: info@hope.ug			
Other Danish partner(s), if any					
Contact person for the intervention	Name: Hans Christian Hansen	E-mail: hcthansen@gmail.com			
Local partner organisation(s) *(please insert the necessary rows below)*	Country(-ies)	Country's GNI per capita			
Kamuli Network of Non Governmental Organisations (KANENGO)	Uganda	US$ 605 (2012/13)			
Commencement date	01.08.2015	Completion date	31.07.2017	Number of months	24
Amount applied for (DKK)	**416.942,-**				
Is this a re-submission?	[X] No [ ] Yes, please note the ref.no.(j.nr.):				
Is this	[X] a new project? [ ] a project in extension of another project previously supported (by the Civil Society Fund or others)?				
Do you want a response letter in (choose one)	[ ] Danish or [X] English				
Do you want the Assessment Committee's notes about the application in (choose one)	[ ] Danish or [X] English				

Synthesis (maximum 10 lines – must be written in Danish, even if the rest of the application is in English)

Et af de væsentligste problemer i Kamuli distriktet i Uganda, i lighed med mange andre områder i Uganda og udviklingslande, er andelen af befolkningen, der lider af ikke-smitsomme sygdomme (NCDs), som fx diabetes og forhøjet blodtryk. De primære årsager er de lokale sundhedsmyndigheders svage kapacitet og borgernes manglende viden.

Hope Danmarks partner, KANENGO, etablerer frivillige, lokale og demokratiske organisationer, Neighbourhood Assemblies (NAs), som bl.a. udvælger frivillige Village Health Workers (VHWs)

Projektets mål er, i 5 sub counties i Kamuli distrikt, at øge befolkningens viden om NCDs i samarbejde med den nationale alliance mod NCDs, UNCDA. Samtidig vil projektet indsamle data om NCDs via VHWs som dokumentation ifm. fortalervirksomhed. Endelig vil projektet kapacitetsopbygge NAs og KANENGO, så de kan være befolkningens talerør overfor myndighederne – også på sundhedsområdet .

06.04.2015

Date Mårslet	Person responsible (signature) Hans Christian Hansen, Hope Civil Society team lead and vice chair person
Place	Person responsible and position (block letters)

2. Application text

A. THE PARTNERS

A.1 The Danish organisation

Hope Denmark (Hope) has been present in Kamuli area, Uganda since 2007 and has since 2009 had a partnership with the Community Based Organisation (CBO) “Hope Foundation Uganda”, based in Kamuli. Hope has since December 2014 had a partnership with Kamuli Network of Non Governmental Organisations (KANENGO).

Hope focuses on three different initiatives:

1. In partnership with Hope Foundation Uganda to provide Danish children and youth, primarily in Odder, skills in cross-cultural dialogue, and assist our Ugandan partner in their work amongst orphans, underprivileged children and youth.
2. Sponsorship programme for school children in Kirolo, Kamuli district
3. Civil society development in Eastern Uganda, primarily Kamuli district, in partnership with KANENGO. Annex I explains the vision, mission and strategies for this partnership.

During the last two summers, Hope participated on camps with craft shops and information, reaching at least 5000 people.

Hope Denmark is a democratic organization, currently with 75 members. An annual general assembly meeting is held according to Hope’s statutes. The general assembly elects the board, to which it is accountable. All the work in Hope is done on a voluntary basis, organized in sub committees, all accountable to the board. One of its committees is the Civil Society Committee, which is responsible for this project.
Hope Foundation Uganda and Hope Denmark had a partnership identification entitled: “Hope Foundation, Uganda – potential partner in South”, supported by DUF with DKR 37.500. The two partners completed a preparatory study and a joint pilot project in 2011-12, training young leaders in the Hope Foundation network in leadership and life skills. The project, named “Leadership development – Life Skill Training” was supported by DUF with DKR 143.000. Hope Denmark contributed to the project with international advocacy, fundraising, monitoring and evaluation.

Qualifications of relevant staff/members/volunteers

Hope Denmark has local representation in Uganda, as Jette and Henning Fausholt have lived in Jinja since August 2014. Jette Fausholt was a general practitioner doctor in Denmark for 8 years, and is now working in a clinic in Jinja and will be involved in this project on the health topics.
Henning Fausholt has for many years worked in Denmark in projects with fundraising, budget and accounting, as well as lobbying and networking. He will be involved in this project on the logistics side.
The financial control and reporting will be the responsibility of Brian Rostved, who had the same role in the DUF funded projects mentioned above. Brian has been administrator for 5 years in Dansk Oase (Budget: DKK 2.000.000). In this position also the financial control and reporting for a one week event with 5000 participants (Budget: DKKR 3.500.000).
In Denmark the project coordinator will be Hans Christian Hansen, who for several years has worked as project manager in a large company in DK). He has had several board positions.

A.2 The local organisation

Kamuli Network of Non- Government organizations (KANENGO) is a network of civil society organizations with head office in Kamuli district, Uganda. KANENGO started in 1994 and registered in 2000. KANENGO´s reason for existence was to form a platform, which could bring together all the CBOs, NGOs and non-partisan groups in the private sector in Kamuli district, with a common goal to share issues of concern and propose alternative interventions and solutions to

overcome them collectively. KANENGO has 103 members, of which 88 are CBOs, 10 registered NGOs, 2 private sector and 10 individual expatriates in different fields.

KANENGO is a democratic organization with its 103 members owning the organization. An annual general assembly meeting (AGM) is held to review, adopt, and make resolutions on annual reports and audited accounts. A delegate conference is held every three years where they democratically elect a competent board of directors. These 7 board directors are the policy makers of KANENGO, and they monitor the secretariat, the administration unit and the participation of member organizations on thematic committees.
The secretariat is the implementing unit / administration center for KANENGO programs. The staff develops policies, takes them for adoption to the board of directors and to AGM for approval. The secretariat is headed by a coordinator, and includes three professional program officers, one office messenger, three technical advisors and five part time volunteers.

KANENGO has a long experience in managing donor funds. They have received funds from Japanese Embassy Uganda for water and sanitation = 61,000 US dollars. From FHRI 10 Million UGX. From Kamuli Local government 15 Million UGX. From AWEPON 20 million UGX. From Oxfam, Novib through CEWI-IT 15 million UGX. From Bugaya local government 5 million UGX. All records, reports and audited accounts are in place.

For the last 20 years KANENGO has been working in Kamuli, Buyende and Kaliro districts, formerly one district, on human rights violations, as activists on gender, child abuse, HIV/AIDS, democratic governance, as well as community mobilization for livelihood improvement. They work through networking, lobbying and advocacy for citizen concerns. On several occasions, KANENGO has provided the leadership, working with other CSOs, at decentralized levels. In some other cases, KANENGO has joined National CSO Networks to work on Citizen National Concerns. KANENGO has experience and capacity with regard to this particular project. It has experience and capacity in empowering communities to actively make public decisions and engage in development processes.

Qualifications of relevant staff/members/volunteers for this project:

- The Coordinator, Moses Kyewalyanga, is a social worker with 25 years of experience in managing community based development programmes, especially implementing advocacy, networking, capacity building of CSOs, communities and local government interventions. Moses leads the Kanengo office, which will manage the project locally. Moses is a national trainer of Neighbourhood Assemblies (see later) and through networking with other NGOs (Accord (Netherlands), Action Aid (UK), and RWECCO (Ugandan)) he has helped to start up Neighbourhood Assemblies in 8 other districts in Uganda.
- Getrude Nabiryo is a senior clinical officer holding international health diploma from Netherlands, with 23 years of experience in health management, supervision of staff, strengthening community structures for health, and health education. She represents all clinical officers at National Medical Stores (NMS) drug allocation committee and will be the supervisor for the Village Health Workers in the project.
- John Kyakulaga is part time staff with 30 years of experience in project development, participatory planning and management, and advocacy for vulnerable groups. John will be responsible for monitoring the project and tracking its results
- Dr. Sam Okuonzi is a medical practitioner with a PHD, and works with the Ministry of Health as head of policy unit. He is a senior lecturer at Makerere and Mukono Universities, and works as a consultant on WHO and World Bank projects. Sam will be responsible for providing technical support and guidance.

A.3 The cooperative relationship and its prospects

The partners have been in contact for one and a half years. Members of the HOPE Board have visited Kanengo twice during the period and shared on a number of issues, such as cooperation, a draft strategic plan, networking, capacity building and advocacy. They also shared with citizens at Neighbourhood Assembly meetings.

In June 2014 the Hope board approved the charter for its Hope Civil Society Committee, and it was decided that Hope DK should work with Kanengo as partner in this field. Kanengo and Hope started working on a more formal partnership agreement, and this agreement was finalised and signed by the boards of the two organizations in December 2014, supervised by the Kamuli District Resident Commissioner.

How the project applied for will develop the partnership

Until now, and through many meetings, talks and workshops, Hope and KANENGO have concluded that we share the same general vision and values, as stated in the partnership agreement. The project will show this "in action", and particularly identify each partner's strengths and weaknesses, and how the two partners can benefit each other: Hope's expertise in both health, organisational development and financial control, and KANENGO's long experience in civil society development "on ground". Hope's local representation in Jinja, Uganda, and the possibility of frequent physical meetings and volunteer activities will particularly strengthen the partnership. As they both are members of Hope's civil society committee and the Hope board, their experiences will also benefit Hope's members in Denmark.

What each partner will contribute (in addition to money) to the project concerned

KANENGO will be responsible for the implementation of project activities as well as monitoring and evaluation of the project activities carried out by Neighbourhood Assemblies (NAs), and their Village Health Workers (VHWs). KANENGO will work with Ugandan NCD Alliance (UNCDA), using their expertise and experience in training and advocacy related to Non-communicable Diseases (NCDs)

Hope has the overall project responsibility of ensuring that the project is implemented within the guidelines of CISU. Hope will contribute its expertise in working with donors in Denmark and will use its extensive networking experience and contacts in providing knowledge, scientific research background, as well as contributing to the project with experts in nursing and health on a voluntary basis. Doctor Jette Fausholt from Hope will provide medical guidance to the project and train and supervise the nurses. She will also be in charge of creating questionnaires and overseeing the collection of data.

Hope will discuss and coordinate its activities with the Danish NCD Alliance, to make sure that experience and learnings from other NCD initiatives will be utilized in the project wherever relevant. See annex K

B. PROJECT ANALYSIS

B.1 How has the project been prepared?

The planning of the project has involved Hope, KANENGO, community members and other stakeholders including district, sub county and community leaders. During the summer, 2014, KANENGO and Hope agreed that the two partners would work on a project in Kamuli district. Through Focus group discussions with the community and consultations with Neighbourhood Assemblies and other stakeholders, KANENGO identified Non Communicable Diseases (NCDs) as a core problem, affecting local communities in Kamuli district. The Neighborhood Assemblies were seen as a valuable tool to increase the awareness, prevention and detection of these diseases. Kanengo wrote the first draft for a project description and Hope DK commented and revised the document.

Hope DK started identifying available funding initiatives related to NCDs, and found out that Denmark already was engaged at a national level. CISU was funding a project managed by the Danish NCD Alliance, in partnership with the Uganda NCD Alliance, UNCDA. In November 2014, Jette Fausholt visited UNCDA in Kampala, together with two board members from KANENGO and the program coordinator. A good relationship between the parties was established, including the Danish NCD Alliance.

In December 2014 participants from Hope DK board, Kanengo board, Kanengo staff and Neighborhood Assembly representatives, in a 4-day workshop, discussed and together formulated the core problem, causes, target groups, and the Logical Framework for the project, which is described in this application. The workshop was opened by the Kamuli District Resident Commissioner.

During the last day of the workshop, the participants visited a Local Council, level 3 (LC3) office, a hospital and a Neighborhood Assembly (NA), and talked to politicians, LC3 staff, a doctor, and shared problems and simple preventative actions in the meeting with the NA's village representatives. Since then, the document has been finalized in physical meetings in Uganda and through E-mails between Kanengo and Hope in both Uganda and Denmark.

During the workshop in December 2014, a representative from UNCDA, introduced the work of UNCDA to the group. Jette Fausholt from Hope and five people from KANENGO visited the UNCDA campaign in Luuka district to see what UNCDA can do.
A future partnership of KANENGO and UNCDA is discussed. The formation of a local UNCDA branch and peer-to-peer patient groups in Kamuli district are planned as part of the project. UNCDA will also provide training in advocacy about NCDs, and the project will use NCD materials from UNCDA.

Target groups and participants involved in preparing the project
During the context analysis, KANENGO conducted focus group discussions (FGD). Separate FGDs were conducted for adult men, adult women, female youth, male youth and children (boys and girls). Each of these groups gave their views and opinions, which resulted in the identification of the core problem – high levels of NCDs, the causes of the problems and proposed solutions for managing NCDs. Each focus group had 8 – 10 participants and two communities participated in the process. Other stakeholders involved included community, religious and cultural leaders.

B.2 In what context is the project placed?

Relevant geographic, political, social and cultural conditions
The proposed project focuses on Kamuli district in Busoga region in Eastern Uganda. Busoga region is one of the underprivileged regions of Uganda, which is one of the least developed and highly indebted countries. Uganda's nominal GDP per capita was US$ 605 in FY 2012/13 and life expectancy is currently at 54 years. There are huge inequalities within the Ugandan society. For instance, in the Northern and Eastern regions of the country, more than 60% of the population live below the poverty line.
In spite of reported improved economic growth, service delivery at community level is still poor, especially in the health, education, water and sanitation and production sectors. A number of factors account for the poor service delivery, including inadequate funds to finance the budgets, and leakages of resources along the supply chain, due to weak internal controls and corruption. Also weak capacity of local authorities and citizens to monitor the implementation of service delivery actions in the community; and lack of forums for citizens and their leaders to engage each other on effective service delivery.

There is widespread poverty among the communities, due to poor returns on agriculture, which is the main economic activity. Therefore, they cannot afford to pay for the rather expensive medical services, such as diabetes and hypertension.
At community level there are low levels of awareness on basic health issues such as personal health and hygiene, preventive measures for life style disease conditions, and generally low accessibility to modern medical services. A large number of people still rely on traditional herbs and myths and beliefs (e.g. witchcraft). The communities are not well sensitized and mobilized on how they can access better medical services at mobile health clinics, health units and referral hospitals. The functions of mobilizing and sensitizing the communities are expected to be the responsibility of the local authorities, the Village Health Workers and the elected leaders. However, in most of the Busoga districts, these structures are only present in name, they are not functional any more. Alternative structures like the Neighbourhood Assemblies are instead seen as more active and relevant in complementing this function.
The local authorities, on the other hand, do not have adequate resources to finance critical aspects of the budget like testing, diagnostics and treatment of diabetes, hypertension, as well as tropical diseases. This situation is even worsened by the widespread corruption, also at district level.

Conditions within the health sector
In Uganda, communicable diseases still contribute to the major (75%) disease burden; but the burden of NCDs is markedly increasing, posing a threat of double burden of communicable and non-communicable diseases. A 10-fold increase is projected in the cases of diabetes by 2025 if no interventions are initiated. Estimates suggest that as many as 8% of people living in Kampala have type 2 diabetes.
Non-Communicable Diseases (NCDs) have nationally been recognised as a silent killer, more than HIV/AIDS and other infectious diseases. NCDs are currently responsible for 35 percent of all deaths in low and middle-income countries, and this alarming figure is predicted to rise in the near future.

A high prevalence of NCD risk factors has been documented in Uganda. An association between obesity, hypertension, and risk of type 2 diabetes was found in a study among women, of whom nearly 80% were overweight. The STEPS survey in Kasese (a semi urban area) has demonstrated that chronic non-communicable diseases and their risk factors constitute a public health problem in Kasese district, with at least one in five men smoking tobacco, one in five has high blood pressure, one in ten has a positive family history of diabetes mellitus, with 1 in 5 being pre-diabetic, and 1 in 5 overweight/obese. The majority of people with raised blood pressure did not know that they had such medical problem. Only 3.7% of people found with high blood pressure were on treatment. This reflects the low level of knowledge of the dangers of untreated hypertension in the population and the ineffectiveness of the health system. Generally, the knowledge about NCDs and their prevention and control is alarmingly low in the population. Even knowledge about the danger of smoking and excessive alcohol use is nearly non-existing.

The Ministry of Health has only recently started to prioritize the issue amongst other competing priorities. A national NCD survey[1] has been conducted by the Uganda Bureau of Statistics (UBOS). The Uganda NCD Alliance, set up in 2010, has been at the centre of lobbying government's continued commitment to NCDs. The alliance has opened up 10 branches, 8 of which are in rural areas to create awareness, provide screening services and lobby for government commitment to address NCDs.

The health units at community level are lacking critical staff, medical equipment, medical supplies and facilitation that can ably respond to the huge disease burden at the grassroots.

[1]This was communicated during a national multi-stakeholder workshop organized by the Uganda NCD Alliance held on 6th November 2014 in Kampala by an official from the Ministry of Health.

The national health policy and health sector's strategic plan is emphatic on prevention and management of the emerging life style conditions, but there is shortage of resources to implement the strategies proposed. The national health policy also promotes community led health actions with elected leaders playing a critical role in mobilizing and sensitizing citizens, monitoring delivery of health services and allocating adequate resources to the health function in their budgets. However, it has been observed that most of the elected leaders in the Busoga region lack the necessary tools and equipment to undertake effective budgeting and monitoring function concerning the delivery of health services. The local governments have not come up with means of raising local resources to finance the health component of their budgets.

Kamuli district situation

Kamuli district is administratively divided into 13 sub counties, Kamuli town council, 79 parishes/wards and 689 villages. Poverty is high in the district, with 49.1% living below the poverty line of USD 1 per day.

The district has a total of 54 health units, including 2 hospitals (one private), 2 HC IV (small hospitals), 11 HCIII (health centers), and 39 HC IIs (health clinics). District health centers (HCIII) are not able to treat NCDs properly, neither is the Kamuli hospital, from where patients are referred to the bigger hospital in Jinja, but the capacity of the Jinja hospital is not much better. Furthermore, the patients explain that medicine is very expensive and very difficult to find in the Kamuli district. In addition, the district have very few, if any, trained health staff in NCD. The District Health officer (DHO) for the Kamuli district confirmed in a meeting with Moses Kyewalyanga and Jette Fausholt that Kamuli does not have a single diabetes physician.

Delivery of the health service in the Busoga region is strongly supported by other key stakeholders, such as the religious institutions, donor agencies and the private sector on the basis of Private for Profit or Private Not for Profit. However, reach out is limited.

KANENGO and Neighbourhood Assemblies

In 2011, KANENGO together with a National network of NGOs established the concept of Neighborhood Assemblies, commonly referred to as NAs. NAs are democratically elected 'parliaments' on parish level. NAs are non-governmental, and the assembly of 40-50 people is democratically elected by the 7,000-8000 people in the parish. Each NA chooses its own leadership, consisting of ´Speaker of Parliament´, ´Minister of Health´, ´Minister of Education´, ´Minister of Agriculture` etc. The NA meets once a month and discusses issues which people bring up. Sometimes the solution is within the community itself, but sometimes the solution requires other duty bearers, who can then be called to the NA to participate in a ´interface meeting´. Another way of solving problems is through a ´feedback meeting` where a target group inform the NA about all their problems and questions. After this first feedback meeting the NA works out a positioning paper on the topic and sends it to the responsible district head of department, the Chief Administrative Officer (CAO) and the district council (LC5). Then the NA calls the responsible head of department and those in charge at the sub county level to another `feedback meeting`, where they discuss the matter and often find a solution. Furthermore, the NAs also sometimes arrange `dialogue meetings` at sub county level involving all the NAs in the sub county, the responsible local council executives (LC3) and the sub county chief, to discuss issues which the NAs find important.

The NAs have also arranged a yearly `Manifesto Days` at sub county level where they gather everybody in the streets, do drama, have pamphlets, banners and t-shirts with questions to the government.

In this way the NAs have gained trust among local people and have brought not only hope but also self-esteem. The women in particular can now voice out issues, although traditionally they are taught not to say anything in public. There is a local proverb that says: "Omusadha kyakoba zeena kyenkoba" which literally translates to "what the man says is what I also say". Previously politicians and civil servants were considered untouchable and therefore no one could voice out a problem;

but now the community, including women and youth, are beginning to realize that they have power to make the leaders not only listen to them, but also solve their problems. The district leadership of Kamuli as a result has increasingly entrusted the NAs with information to communicate to the community.
It is important to note that even the Speaker of the National Parliament of Uganda, who is also a Woman Member of Parliament from Kamuli, listens to and supports the NAs.

The NAs are young and still learning to dare take a stand opposing the duty bearers.
KANENGO supervise, monitor and guide the NAs on their activities. It is in fact the major task for the KANENGO staff.
It should be noted that the NA's advocacy is primarily directed at parish (LCII) and sub county (LCIII) level, while KANENGO's advocacy is on county (LCIV) and district level (LCV).

Regarding NCDs, KANENGO is familiar with the local health conditions. All NAs have appointed volunteer Village Health Workers (VHWs), each to be responsible for 30 homes/families. The NAs often choose the government's Village Health Workers to be part of their VHWs, if they will work voluntarily. These VHWs go home visiting and refer patients to the nearest government health center and also report health issues back to the NAs, so that the NAs have a good knowledge of what is going on in their parish. The VHWs have experience with patient groups/peer-to-peer groups among HIV positive patients. When they find a new HIV positive patient, they find an old "expert" patient who can counsel the new one and also invite the new patient to be part of a patient group/peer-to-peer group.

A stakeholder analysis was carried out with the key stakeholders and the findings are summarised in Annex H.

B.3 Problem analysis

According to the communities and other stakeholders, the core problem to be addressed is **inadequate capacity at community level to prevent, detect and treat NCDs.**

Causes giving rise to this main problem

Through Focus Group Discussions and consultations with different stakeholders, the following causes of the core problem were identified:

a) There is limited knowledge and awareness about NCDs, both among citizens, health workers and duty bearers
b) The communities have limited awareness of their rights to demand services from their leaders. Most affected by this inability to exercise their rights are the poor and marginalized women, youths and the aged.
c) There is a lack of consultation and limited involvement in decision making on issues regarding their living condition. As a result, health services provided by government do not take into account the special needs of vulnerable groups.
d) There is lack of coherence between people's life styles and their livelihood. Whereas men are reluctant to seek medical advice; the women, on the other hand, depend on their husbands to seek health service
e) There is limited knowledge of what people do, which cause NCDs
f) There is also lack of interest in their health situation
g) Inadequate systems and structure to support the communities, both governmental and private sector
h) Available health units lack the capacity to address NCDs
i) Limited mobilization of citizens to engage duty bearers on health service delivery actions
j) Limited capacity to monitor service provision

C. PROJECT DESCRIPTION

C.1 Target group and participants

Target Population

The project targets the people in the five sub counties of Balawoli, Namasagali, Namwendwa, Nawanyago and Wankole in Kamuli district. According to Uganda Bureau of Statistics (UBOS) estimates, the five sub counties were estimated to have a total population of 206,600 in 26,805 households as per the table below. .

Project sub county population

Sub counties	Male	Female	Total	Households	Poverty count
Balawoli,	24,400	25,200	49,600	6,457	39.3
Namasagali	17,500	17,500	35,000	4,691	36.9
Namwendwa	30,900	32,700	63,600	8,363	36.0
Nawanyago	14,600	16,500	31,100	3,998	37.3
Wankole	13,400	13,900	27,300	3,296	39.6
Total	100,800	105,800	206,600	26,805	37.8

Source: Profiles of Higher Local Governments by UBOS, June 2014

Primary target group

1000 citizens of 20+ years in 400 households, being visited regularly by the 40 Village Health Workers (VHW) who are members of the current 8 Neighbourhood Assemblies in the five sub counties. Each Village Health Worker visits 30 households on a regular basis, and they may all receive information about NCDs. Only 10 of the households per VHWs will be the project's primary focus. Each household has 2-3 adults and 5-6 children. Indirect target group is the (40x10x6)=2400 children and youths below 20 years in the same households.

The criteria for selection of households to be targeted will give priority to marginalised people, particularly households headed by women, persons with disability, people living with HIV/AIDS; and/or the elderly (above 60 years of age). Poor households will also be targeted. The selection of the beneficiary households will be done by KANENGO to avoid a selection based on local and family ties.

Secondary target groups

8 existing Neighbourhood Assemblies in the 5 sub counties, plus 10 new NAs in the same sub counties.

The NAs serve as social platforms on which citizens engage in planning and feedback processes as well as mobilising citizens to access services. They also mobilize and capacitate citizens to participate in productive activities including farming and livelihood improvement.

Within the five selected sub counties, the project will work with the existing eight NAs, and support the establishment of 10 new NAs. The NA members will be informed about NCDs, their causes, prevention and treatment.

90 (5 in each of the 18 NA) Village Health Workers (VHWs), who work voluntarily in the villages, each having responsibility for 30 homes.

200 strategic stakeholders (teachers, religious leaders, etc.) at sub county level

65 local authority duty bearers in the selected sub counties and 26 in Kamuli district council. They are targeted for advocacy on policy change in order to improve public service delivery on preventing, detecting and treating NCDs.

How the project benefits poor /marginalised people

The marginalised people will benefit in terms of better awareness and provision of information about NCDs through the NAs, about preventive measures and how to access services. They will be empowered through the NA structures to demand for services from their leaders/duty bearers. It should be noted that the marginalised people are also represented in the NAs.

The local partner's relationship to the target group and its roots (constituency)

KANENGO is a network of civil society organizations and bring together all the CBOs, NGOs and non-partisan groups in the private sector in Kamuli district, including the five target sub counties. It has NAs in the target sub counties. The membership for KANENGO includes CBOs for youth, women, people with disabilities and elderly people. The vulnerable and marginalised are represented in the decision-making structures of KANENGO. KANENGO empowers these people to demand accountability from their duty bearers.

C.2 The project's objectives and success criteria (indicators)

The overall objective is to **improve health of citizens** in the Kamuli district. The primary goal is to increase the knowledge about NCDs and their risk factors. Secondly, we want to increase the capacity of village health workers to prevent, detect and refer NCD cases to the public health sector while documenting what they do. Thirdly, we want to increase the capacity of KANENGO and NAs, and the number of NAs so that they can advocate for better public health care for NCDs on sub county and district level, using the documentation from their VHWs.

The project's development objective is to **Increase the capacity at community level to prevent, detect and treat NCDs in five sub-counties in the Kamuli district by July 2017**

The project's objectives and indicators:

Objective	Indicator	Means of Verification
1. Increased awareness about NCDs in the 5 sub-counties in Kamuli district by July 2017	A 30% increase during project period of people 20+ from primary target group, who can list at least 3 different NCDs	Questionnaire to 1000 persons in primary target group at baseline and end of project
	A 30% increase during project period of people 20+ from primary target group, who can list at least 3 risk factors for NCDs	Questionnaire to 1000 persons in primary target group, at baseline and end of project
2. Increased capacity in preventing, detecting and referring NCD cases in the 5 sub counties in Kamuli district by July 2017	A 30% increase in number of VHWs during project period, who can measure blood pressure correct in 3 out of 4 patients	Supervising nurses will test at baseline and end of project.
	A 30% increase in number of VHWs during project period, who can measure blood sugar correctly in 3 out of 4 patients	Supervising nurse will test at baseline and end of project
	By July 2017 90% of people 20+ from primary target group with high pressure or/and high blood sugar have been referred by the Village Health Workers to a health center	Reports from VHWs: Referrals counted at baseline and at the end of project

3. To capacitate KANENGO and NAs to advocate for NCDs to be on the political agenda at Sub County and District level by July 2017.	A 30% rise in the number of people from the district council (26 people) and five sub county councils (5x13=65 people) who can mention at least 3 NCDs	Interview by KANENGO at baseline and end of project
	A 30% rise in the number of people from the district council (26 people) and five sub county councils (5x13=65 people) who can list at least 3 risk factors for NCDs	Interviews by KANENGO at baseline and end of project
	At least once during the project period NCDs will be on the agenda and/or the minutes for Kamuli district council meeting and at least once for the five sub county meetings.	Agendas and minutes from district council meetings and sub county council meetings collected by KANENGO

C.3 Outputs and activities

Regarding objectives	Expected outputs	Activities
1. Increased awareness about NCDs in the 5 sub counties in Kamuli district by July 2017	1.1. Information materials on NCD in Luganda language found and distributed. • Pamphlets • Posters • Video	1.1.1. Identification of relevant, and available material on NCDs from UNCDA (English and Ugandan languages) 1.1.2. Buy the identified materials 1.1.3 Dubbing video on diabetes into Luganda 1.1.4. Disseminate materials through NAs and VHWs
	1.2 200 strategic stakeholders at sub county level sensitized on NCDs and how to communicate NCD prevention	1.2.1 Awareness raising workshop in each of the five sub counties with strategic stakeholders (teachers, religious leaders, etc.) organized by the local NAs in cooperation with KANENGO
	1.3 3000 citizens (20+) will have heard the message about NCD	1.3.1 The 40 VHWs will visit each of their 30 families at least once a year for two years, adding up to 2400 home visits
	1.4 Established UNCDA branch in Kamuli district	1.4.1 The gathering of volunteers in formation of a UNCDA branch organized by KANENGO.
	1.5 One peer-to-peer group in each of the five sub counties has been established by the new local UNCDA branch	1.5.1 Conduct meetings with NCD patients at village level to form groups 1.5.2 Train patient groups in peer to peer activities for improving health situation 1.5.3 Meetings in peer-to-peer groups

2 Increased skills in preventing and detecting and referring NCD cases in the 5 sub counties by July 2017	2.1 6 trained nurses, working voluntarily for the project, have received training in NCDs	2.1.1 Two training days for 6 educated nurses done by Jette Fausholt + Getrude Nabiryo • in prevention and detection of NCDs • how to use NCD equipment • how NCD patients are referred 2.1.2 Buying training manuals for nurses
	2.2 40 village health workers in 8 existing NAs have received training in NCDs	2.2.1 Three training days for the 40 voluntary Village Health Workers (VHWs) led by the 6 nurses + Jette Fausholt • in prevention and detection of NCD • how to use NCD equipment • how NCD patients are referred • how to use questionnaire and gather information on NCD and lifestyle from primary target group 2.2.2 Purchase of 40 scales, 40 measuring tapes, 40 blood pressure machines, 40 blood sugar machines and 3000 strips to measure blood sugar and blood pressure of primary target group 2.2.3 The 40 VHWs gather basic data from at least 1000 people annually and share the data with KANENGO head quarter. 2.2.4 The 40 Village Health Workers are supervised quarterly by the 6 educated nurses, one nurse in each sub county and one nurse leading the 5 others.
	2.3 50 new village health workers in 10 new NAs have received training in NCD	2.3.1 Two training days for the 50 new village health workers from the 10 new NAs done by the 6 nurses + Jette Fausholt
3. To capacitate KANENGO and NAs to advocate for NCDs to be on the political agenda at Sub County and District level by July 2017.	3.1 Eight existing NAs have been strengthened in their knowledge of NCDs	3.1.1 Each of the 8 NAs will have a training day in NCDs done by Jette Fausholt + Getrude Nabiryo
	3.2 Eight existing NAs have increased their capacity in advocacy i.e. how to engage leaders.	3.2.1 A one day seminar in Kamuli on NCD advocacy skills led by UNCDA for the 5 executives from each of the 8 NAS= 40 people. 3.2.2 A seminar for each of the 8 NAs on NCD advocacy skills done by Kanengo
	3.3 10 new NAs are established in the 5 sub counties, by July 2016	3.3.1 Conduct 5 community mobilization meetings to inform people about the need for them to participate in community governance and local development activities through NAs 3.3.2 Facilitate 10 community meetings to

		elect representatives and form the 10 new NAs 3.3.3 Facilitate one meeting in each of the new NAs to orient the elected people in their roles 3.3.4 Teach the new NAs sustainable self-support initiatives through a start-up package of 1 mio ugx
	3.4 KANENGO staff strengthened in NCDs	3.4.1 One training day done by nurse or Jette Fausholt
	3.5 KANENGO staff strengthened in capacity in data collection, analysis, ICT and providing reports	3.5.1 KANENGO secretariat (4-5 people) will have received 5 days of IT/ICT training. 3.5.2 Kanengo secretariat will have created a homepage where the results of the project will be visible for all.
	3.6 Increased awareness about NCDs, their risk factors, and the project among Community leaders	3.6.1 Interview district council (26people) and 5 sub county councils (5x13=65 people) on their knowledge about NCDs and their risk factors at baseline survey and end of project by KANENGO 3.6.2 One sensitization meeting at district level and five on sub county level about NCDs and about the project.
	3.7. Leaders at sub county level have been engaged on NCDs	3.7.1 Eight existing NAs will each have produced at least one positioning paper, conducted at least one interface meeting, one dialog meeting and one feedback meeting about NCD 3.7.2 One manifesto day in each sub county, arranged by KANENGO in cooperation with local NAs
	3.8 Leaders at sub county and district level discus NCD issues.	3.8.1 Gathering of agendas and minutes from district council and sub county council meetings by KANENGO

C.4 Strategy: how does the project cohere?

The development objective is derived from the fundamental problem about inadequate capacity at community level to prevent, detect and treat NCDs. Following the same logic, the immediate objectives were derived from the causes of the fundamental problem.

The project focuses on strengthening the capacity of Neighbourhood Assemblies and the Village Health Workers, who are part of these assemblies, and work as volunteers. Their capacity will be improved both in the form of greater knowledge about NCDs and in how to prevent them, but also by making them able to detect some NCDs by providing some basic measuring machines.
The improved capacity of the VHWs will enable them to provide services to the communities' citizens. Each of the VHWs will on regular basis visit village families to create awareness about NCDs and how to prevent these diseases. They will make a simple screening for NCD diseases, refer the sick people to health clinics or hospitals, and together with a local UNCDA branch establish peer-to-peer patient groups, like the HIV patient groups already functioning. Part of the

baseline survey will be a questionnaire about the present lifestyle of the primary target group, so that we might be able to measure if increased awareness creates life style changes in the future.

The VHWs will be able to gather valuable documentation to the NAs. Once the capacity of the NAs to handle the data has improved, they can then, guided and supervised by KANENGO and UNCDA, advocate the relevant duty bearers to improve the health situation of the people in the communities.

The overall advocacy strategy is to continue the constructive dialogue, which is already established with duty bearers on several levels. The NAs will be able to show how the volunteer VHWs can become a very effective instrument in mobilizing and sensitizing the communities about NCDs (and even other illnesses). The NAs can use the facts and results collected by VHWs, together with increased knowledge about NCDs, and argue for increased health services from the local governments on parish (LCII) and sub-county (LCIII) level.

Through improved capacity in using ICT (Information and Communication Technology), KANENGO and Hope Denmark will analyze collected data and make reports about NCD. These reports will give proven knowledge about the status of NCDs in the area, which will be used for advocacy purposes. KANENGO will be able to put forward strong arguments for necessary health services provided by local governments on county and district level.
In the future, KANENGO and UNCDA might be able to use the results to argue for improved services on national level.
KANENGO will also be able to initiate creation of more NAs, improve knowledge and skills of their VHWs, and use the results from the existing NAs to formulate parts of the vision and mission of the new NAs.
KANENGO staff will train the new NAs, supervise all NAs, and participate in a lot of meetings in the 5 sub counties. This will involve a lot of local transport between Kamuli and the sub counties, so the project budget includes the purchase of one motorcycle to be used by the KANENGO staff.

C.5 Phase-out and sustainability

Phased approach

This is the first project by the KANENGO and Hope DK partnership, so deliberately its scope and period is limited.
Creating awareness about NCDs in order to see a change in behaviour in trying to prevent NCDs requires a longer period than the two years. So does advocacy. Therefore, KANENGO and Hope DK think that a phase 2 of the initiative to “Strengthen the capacity at community level to prevent, detect and treat NCDs”, is necessary.

The next three year phase would focus on

1. Increasing awareness of NCDs and motivating people in the primary target group for lifestyle changes. The questionnaire from the phase 1 project’s baseline survey will be used for documentation
2. Capacity building: The 5 key VHW in each NA will now be capable of peer teaching the remaining 30 VHW in each parish in preventing, detecting, and referring NCD cases. This can also take place in the 10 new NAs.
3. Advocacy, where the aim is to see significant budget allocations for NCDs on district and sub county level, so that medicine and machinery for diabetes and hypertension is more available in the health centres in 5 sub counties in Kamuli district and more people with diabetes and hypertension are on daily relevant medication.
4. Creating a regional council of NAs in the Busoga region

Phase out of the phase 1

To ensure that local partners or target groups, especially the nurses are not left in an unfortunate position of dependency when the implementation period expires, the following measures shall be undertaken:

- Tell the volunteering nurses that the transport funding ends. Contract with nurses
- Monitoring at midterm and at the end of project
- End term evaluation
- Feedback of the findings from KANENGO to NAs in middle and end term (activity)

Sustainability

To ensure that the results of the project endures, the following strategies shall be adopted:
Project sustainability will be ensured through use of community-based approaches that enhance community participation and ownership of the results and outcomes of the project. The health workers trained will continue to provide services to many others, even after the expiry of the project. The equipment purchased for the use of VHWs will also continue to be used to provide services. KANENGO will own the equipment and develop guidelines for the use and storage of it. KANENGO will also sign a Memorandum of Understanding with VHW who have received the equipment on their use and storage. The project will be mainstreamed in the existing programmes and structures of KANENGO and its membership, so that it is owned, localized and domesticated. Both partners hope that achieving this outcome will result in similar initiatives in other counties and districts, working for the impact mentioned above. Results will be shared with UNCDA and others, to encourage others to initiate similar activities.

When financing finally ends, activities will continue to be facilitated by KANENGO. The community groups and associations, whose capacity will be improved, will continue operating on their own. As the linkages grow stronger, the stakeholders will be benefiting and continuity will be promoted. The community groups and their leaders, who will be trained, will be part of the beneficiaries. There will be local ownership of results since the beneficiaries have been involved in the project planning and will be fully involved in the project implementation activities. They shall have full responsibility and ownership of any benefits from the project.
We have been careful not to budget for benefits for volunteers at all levels, so that the volunteer lifestyle is not harmed by the project.

C.6 Assumptions and risks

Overall assumptions

- The 2016 election process will not interfere with the project
- Local councils will be supportive
- Social and economic structures (exchange rates) will not change considerably

Objective	Assumption
Increased awareness about NCDs in the 5 sub-counties in Kamuli district by July 2017	Village committee members (local council1) will cooperate in project activities
	The 1000 people in primary target group will be willing to be interviewed and tested
Increased skills in preventing and detecting and referring NCD cases in the 5 sub counties by July 2017	Village health workers will be cooperative
	There is a health seeking behaviour in the communities
	The government will to some extent provide the services necessary for NCD treatment
	The referred NCD patients will go to the Health Centers for medical attention
To capacitate KANENGO and NAs to advocate for NCDs to be on the political agenda at Sub County and District level by July 2017.	Village committee leaders will be supportive
	District and sub county council members will be supportive

Risks

Risk	Mitigation
Political interference and intimidation	KANENGO and partners will sensitize political leaders about the project and involve them in project activity planning and implementation
Corruption	KANENGO will own all equipment purchased in the project. KANENGO will develop guidelines and implement procedures for the use and storage of equipment.

KANENGO will seek to have a Memorandum of Understanding with the Minister of Health for import of equipment.

D. PROJECT ORGANISATION AND FOLLOW-UP

D.1 Division of roles in project implementation

The division of roles in project implementation will be governed by a Memorandum of Understanding (MOU) between HOPE Denmark and KANENGO.
The project will be implemented in partnership and coordination meetings to review progress will be held (as Skype meetings). The project, through monitoring and evaluation, will assess how the partnership has been functioning and any gaps and constraints will be identified and appropriate amendments taken.

Capacity for financial management:
KANENGO's financial management live up to the CISU financial standards.
See Annex B

D.2 Monitoring and evaluation in project implementation

A baseline survey will be conducted in the 5 target sub counties as the first initial activity to determine the baseline values of the project outcome indicators. At the inception of the project, a

monitoring and evaluation plan will be developed which will be used jointly by Hope Denmark, KANENGO and stakeholders at grassroots to track the delivery of the project outputs and to initiate corrective measures when necessary. Monitoring will be done at three stages: pre-; during and after the project has ended. At each stage, the findings will be used to guide the next plan of action, including corrective measures or scaling up of certain aspects.

Data Analysis, Reporting and Utilization
KANENGO's M&E officer will analyse data aggregated by gender, age group, and disability. Dissemination of data will be done during review meetings at sub county and district levels. District officials, cooperative officer, sub county leaders, and communities will be involved in utilization of data.

Monitoring and Quality Assurance
The staff and volunteers involved will be trained in participatory monitoring and evaluation. The KANENGO staff will conduct supervision visits to the community-based facilitators to check correctness of the data collected.
Quarterly field visits will be carried out by KANENGO board to assess the progress of the project. In addition, data collected at household level will be compiled and analysed and a report presented to the Board of KANENGO and to HOPE Denmark. Effort will be made by HOPE Denmark's Civil Society team members from Denmark to attend at least one field visit annually.

Annual reviews
There will be annual review of the project, to be attended by both KANENGO and HOPE Denmark boards. This will be at the end of each project year.

Project evaluation
The external evaluation of the project is planned to be done by AnjaC Consult, based in Jinja, Uganda. See Anja C Sakaly's CV as Annex P

E. INFORMATION WORK

E.1 Has project-related information work in Denmark been planned?
Articles about the project and its result will be brought in the Oasemag (3700 copies), the magazine for the Hope DK's support base, as well as on Hope's and Dansk Oase's web-site.
Hope is active on Facebook, so Hope's members in Uganda will frequently upload posts, pictures and videos about the project activities. This will also give Facebook users, who are following Hope, the chance to ask questions and give comments.

Hope will contact organizations and institutions in Denmark, or even in other countries, which are considered having an interest in the project's purpose. If they show interest, Hope and KANENGO will jointly write articles about the project provide material and give interviews.
The information provided via different media will focus on how NAs and voluntary Village Health Workers can help in creating awareness about NCDs, assist in establishing peer-to-peer groups, and encourage people with NCDs to seek and demand health services.
Hope will share its findings and results related to NCD with Danish NCD Alliance

Hope will, as part of the information activities, list and describe the different ways short-term volunteers can be involved in the project activities, like training, graphical work, ICT implementation, etc.

3. Budget summary

A detailed budget with budget notes must be submitted in Annex C 'Budget scheme' and enclosed the application. NOTICE: Remember to open all tabs in order to fill in each of the relevant five spreadsheets.

See also 'Guide to budget preparation' at www.cisu.dk.

Below please fill in a summary of the main budget items as follows:
Fill sheet 1-4 in Annex C 'Budget scheme' - the budget summary will then automatically appear on sheet 5. This should be copied from Annex C and pasted below.

Budget summary

Budget summary		**Currency**
Indicate the total cost (i.e. contributions from the Civil Society Fund as well as others)	416.942	DKK
Of the total cost, the Civil Society Fund is to contribute	416.942	DKK
Of the total cost, the amount to be contributed by other sources of finance, including self-funding by the Danish organisation or its local partner, if any.	0	DKK
Indicate total cost in local currency	181.995.107	UGX
Indicate exchange rate applied	436,5	UGX

Main budget items	Full amount	Of the full amount: from the Civil Society Fund	Of the full amount: from other financial sources
1. Activities	110.573	110.573	0
2. Investments	46.815	46.815	0
3. Expatriate staff	17.992	17.992	0
4. Local staff	77.088	77.088	0
5. Local administration	26.484	26.484	0
6. Project monitoring	62.200	62.200	0
7. External evaluation	10.000	10.000	0
8. Information in Denmark (max. 2 % of no. 1 – no. 7)	7.023	7.023	0
9. Budget margin (min. 6 % and max. 10 % of no. 1 – no. 8)	21.490	21.490	0
10. Project expenses in total (no. 1 – no. 9)	379.665	379.665	0
11. Auditing in Denmark	10.000	10.000	0
12. Subtotal (no. 10 + no. 11)	389.665	389.665	0
13. Administration in Denmark (max. 7 % of no. 12)	27.277	27.277	0
14. Total	**416.942**	**416.942**	**0**

4. ANNEXES

OBLIGATORY ANNEXES

The following annexes must be submitted both in print by post and electronically by email:

A. Basic information about the Danish applicant organisation (filled in and signed by the Danish organisation)
B. Factsheet about the local organisation (filled in and signed by the local partner. It can be submitted in a copied/scanned version)
C. Budget format

The following annexes about the Danish organisation must be submitted in print by post:

D. The organisation's statutes
E. The latest annual report
F. The latest audited annual accounts (signed by the auditor and the management/board of the organisation)

NOTE: If the Danish organisation estimates that the expected annual consumption in the Civil Society Fund exceeds 5 million DKK, the application must be accompanied by a summary of the expected future consumption for the coming three-year period.

SUPPLEMENTARY ANNEXES (max 30 pages):

Annex no.	Annex title
G	Abbreviation list and facts
H	Stakeholder analysis
I	Partnership agreement, Hope and KANENGO
J	Project time frame
K	Email from Danish NCD Alliance
L	CV, Hans Christian Hansen, Hope
M	CV, Brian Rostved, Hope
N	CV, Jette Fausholt, Hope
O	CV, Henning Fausholt, Hope
P	CV, Anja C Sakaly, AnjaC
Q	CV, Moses Kyewalyanga
R	CV, Getrude Nabiryo

***Notice**: All annexes should be submitted in print in three copies (no magazines, books, newspaper cuttings or ring binders, but copies of relevant excerpts thereof).*