

Making Non Communicable Diseases Prevention and Control a Development Priority in East Africa

Danish

**NCD**

**Alliance**

# List of abbreviations

BNCDA Burundi NCD Alliance

CHW Community health workers

CISU Civilsamfund i Udvikling

CSO Civil society organisation

CRD Chronic respiratory disease

CVD Cardiovascular disease

DCS Danish Cancer Society

DDA Danish Diabetes Association

DNCDA Danish NCD Alliance

EA East Africa

EAC East African Community

EANCDA East Africa NCD Alliance

GDP Gross Domestic Product

HRBA Human rights based approach

HMIS Health Management Information System

HLM High-Level Meeting

LICs Low-income countries

LMICs Low- and middle-income countries

M&E Monitoring & Evaluation

MoH Ministry of Health

MoU Memorandum of understanding

NCD Non Communicable Disease

NCDA (Global) NCD Alliance

NCDAK NCD Alliance Kenya

NDP National Development Plan

NGO Non-Governmental Organization

PANT Participation, accountability, non-discrimination and transparency

PLWNCD People Living with NCD

RNCDA Rwanda NCD Alliance

SDG Sustainable Development Goals

STEPS WHO stepwise approach to surveillance

ToC Theory of Change

TNCDA Tanzania NCD Alliance

TWG Technical Working Groups

UN United Nations

UNCDA Uganda NCD Alliance

UNDP United Nations Development Programme

WHO World Health Organisation

ZNCDA Zanzibar NCD Alliance

Photo: WHO/Patricia Goldschmid – Young woman at a Uganda NCD Alliance screening.

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# 1. SUMMARY AND CONTEXT

## 1.1 Summary

### 1.1.1 Summary of objective and key strategic approaches

**Programme Title:**

**Making Non Communicable Diseases prevention and control a development priority in East Africa**

The programme aims to contribute to the achievement of Sustainable Development Goal (SDG) 3 on health and well-being, more specifically target 3.4 that has also been chosen as our development goal.

**Development goal (SDG target 3.4):**

**By 2030, reduce by one-third premature mortality from NCDs through prevention and treatment and promote mental health and well-being.**

Non Communicable Diseases (NCDs) are clearly linked to the SDG agenda and a series of SDG targets relates directly to NCDs. However, the achievements of the NCD targets demands action well beyond the health sector.

In short we aim to develop the capacity of NCD Alliances (patient organizations) in East Africa (EA) to be sustainable and independent alliances with the ability to mobilize adequate and sustainable financial and human resources for NCD prevention and control and to effectively influence NCD prevention and control policies at all political levels. Our advocacy work is underpinned by the recognition that NCD-related issues are also urgent economic and social justice issues of our generation. We work for and with People Living with NCDs (PLWNCDs)[[1]](#footnote-1) and we demand their meaningful involvement.

In East Africa (our programme area) and other low- and middle-income countries (LMICs), NCDs exacerbate poverty and pose a major barrier to development, due to vicious cycles of low incomes, chronic ill health, and impoverishment caused by the cost of treatment. Underpinning these challenges, many health systems in LMICs are designed to respond to single episodes of care rather than chronic conditions such as NCDs - structural barriers that further exacerbate the burden placed on health workers and infrastructure, and limit the quality of services. Already, one third of deaths in East Africa are attributable to NCDs, and NCDs are expected to become the biggest cause of death in the region in a few years, overtaking communicable diseases like HIV/AIDS and malaria[[2]](#footnote-2). Focus should be on prevention and targeting the most vulnerable (poor, women and youth). Basic NCD services should be available at the lowest levels of the health system where they are needed the most. This is sensible both from a social and an economic perspective.

The programme will concentrate on 5 strategic intervention areas, namely:

1. Evidence based NCD advocacy at national level informed by experiences gained locally, regionally and internationally
2. Advocacy for prioritization of NCDs at the Health Secretariat and beyond at the East African Community
3. Establish effective networks of PLWNCDs/Mobilize and organize PLWNCDs with a special focus on youth for them to act as change agents across conditions
4. DNCDA and the Global NCDA maintain continuous dialogue with the regional and national alliances on all issues related to good governance and resource mobilization and offers technical support and advice on both topics
5. Increased collaboration with National Research Institutions as well as Universities both in EA and Denmark focusing on improved NCD data-collection (including better utilization of statistical material obtained at outreaches)

### 1.1.2 Overview of partners and countries/regions

In the Danish NCD Alliance (DNCDA) we work exclusively in East Africa. Our programme partners will be: The East Africa NCD Alliance (EANCDA), Uganda NCD Alliance (UNCDA), Tanzania NCD Alliance (TANCDA), Zanzibar NCD Alliance (ZNCDA), Rwanda NCD Alliance (RNCDA), Burundi NCD Alliance (BNCDA) and NCD Alliance Kenya (NCDAK). We will also continue to maintain a close relationship with the Global NCD Alliance.

## 1.2 Context

### 1.2.1 Global context

NCDs have become one of the world’s most relevant health challenges. NCDs have traditionally considered four main diseases cancer, diabetes, heart and lung diseases, which are the major drivers for mortality globally. These diseases are largely driven by four main modifiable risk factors, namely tobacco use, unhealthy diet, physical inactivity, and harmful use of alcohol. The Political Declaration adopted by Heads of State and Governments at the 2018 United Nations (UN) High-Level Meeting (HLM) on NCDs calls for an even broader understanding of NCDs, moving from what is known as the 4x4 approach (four diseases and four risk factors), to a 5x5 approach, including mental health as an increasingly relevant NCD and air pollution as a risk factor. NCDs accounted for 72% of all deaths in 2016[[3]](#footnote-3), of which nearly half were people younger than 70 years (so-called premature deaths). Nearly three fourths of NCD deaths and most premature deaths (82%) occur in LMICs. The human toll from NCDs should be reason enough for taking urgent action, and the economic consequences of inaction underscore the fact that the world cannot afford to stand by and watch NCDs destroy lives, families and communities[[4]](#footnote-4).

Historically, NCDs have been considered diseases of the rich and the elderly, however they are now severely impacting the poorest and at younger ages. Four out of five people with an NCD live in a LMIC. The costs imposed on individuals and society of healthcare and loss of income-earners hampers efforts towards poverty reduction and sustainable development. Even if some progress has been made in some countries to address NCDs and their risk factors, the global burden of NCDs is expected to continue to increase dramatically, especially under business-as-usual attitudes and policies.

In 2017 the WHO has put forward a toolbox of cost-effective and recommended interventions known as the ‘Best Buys’; a list of policies that countries can implement to effectively prevent and control NCDs in their particular contexts. The WHO have highlighted that around 10 million premature deaths from NCDs can be avoided by 2025 if governments implement these “Best buys”. Their implementation would prevent 17 million strokes and heart attacks by 2030 in the poorest countries, generating $350 billion USD in economic growth. According to WHO estimations, for every $1 USD that is invested in implementing these proven interventions for NCDs, there will be a return of at least $7 USD by 2030.

In response to the alarming impact of NCDs on global health, including poverty reduction, the UN has already convened three HLMs on NCDs in 2011, 2014 and 2018 to address the global burden of NCDs at the highest political level.

Although some progress has been achieved globally in the prevention and control of NCDs, especially in prevention and through the strengthening of primary health care and of health systems in general, there is still a long way to go to comply to the targets of the 2030 SDG agenda. Progress across countries has been uneven, with the weakest advances seen in LMICs. WHO recommends that efforts ought to be focused on reducing risk factor prevalence, especially in the most affected regions and countries[[5]](#footnote-5). For example, has the decrease in tobacco consumption in LMICs been significantly slower than in high-income countries.

To face the global challenge of NCDs, countries must strengthen their national systems and include NCD prevention and control as a critical component, particularly addressing the gaps in affordability and accessibility of basic health technologies and essential medicines. Challenges of access relate to weak health systems in many LMICs, including the lack of adequate preparation and training of the health workforce, insufficient financial resources, poor procurement policies and weak supply chains, inefficient information systems, as well as a lack of patient education and low health literacy[[6]](#footnote-6). While over half of countries in 2017 reported having cardiovascular disease guidelines, only 23% of low-income countries (LICs) had these. In terms of access to medicines, while more than half of countries in Europe and other high-income countries reported having a general availability of all NCD medicines and technologies, no single LIC reported this[[7]](#footnote-7).

The availability of health services for NCDs is inequitable and disproportionate in LMICs, and so are the health outcomes and wellbeing of the population as a result of this. Hence, actions that seek to guarantee effective policies and services on NCD prevention and control will yield positive health outcomes among the poorest countries and regions. In this context, as the progress in fulfilling global commitments is still insufficient, civil society plays a major role in mobilising the community, especially people living with NCDs and marginalised groups, as well as in advocating their countries and regions to scale up and accelerate efforts to adopt such commitments.

### 1.2.2 Regional context

*General context:*

The East African region is comprised of six countries: Burundi, Kenya, Rwanda, South Sudan, Republic of Tanzania and Uganda. The region has an estimated population of 192 million people. It has an intergovernmental regional cooperation, the East African Community (EAC), created by treaty, and has a specific mandate on health that provides for regional cooperation in health among the Partner States to take joint action towards the prevention and control of communicable diseases and NCDs. The EAC has a regional Council Health Ministers meeting aimed at harmonising health issues.

Although ethnically diverse, East Africa has several factors that help to facilitate unity and collaboration: ethnic groups (dominated by the Bantu and Luo groups) have similar cultural practices and languages, and many of these cut across borders, creating blood relations that cut across borders. The region also has a unique language, Kiswahili, spoken in all countries by a significant proportion of the people, but also English is widely spoken.

Civil society space is to a varying degree limited in the East African countries, especially within certain stigmatised areas like interventions targeted gay people. As NCDs are not stigmatized to the same extend and generally receives support from governments, the main issue in this area is the general, mainly administrative constraints placed on civil society organisations (CSOs) in the region as well as the fact that senior politicians, in general, do not like being “argued against” in public.

*Health and NCDs:*

East Africa faces a high risk of NCDs, which are now responsible for 32.6% of deaths in East Africa, with an increase from 29.8% in 2015[[8]](#footnote-8). All our five East African countries are among the top 14 countries in Africa in terms of incidence and risk of cervical cancer and among top 19 in mortality rates[[9]](#footnote-9). In terms of NCD risk factors, 20.6% of people in the region have raised blood sugar; 7.4% practice harmful use of alcohol; and 6.6% are obese[[10]](#footnote-10). In many cases, people have multiple risk factors.

In East Africa, households and private sources bear the greatest burden of the cost of health. Governments contribute only 27.2% of the total health spending, while households and employers contribute 40.5%, and donors 32.3%[[11]](#footnote-11). This means that the already poor people bear a huge cost on healthcare due to out-of-pocket expenditure. Health expenditure as a percentage of government budgets is also low, averaging 6.5%,[[12]](#footnote-12) way below the committed 15% in the Abuja Declaration. There is also limited reliable data. An example of this is the relationship between health insurance and government contribution to NCD treatment through health budgets; because NCDs are not normally covered by public health insurance, it is difficult to determine the percentage of health budget allocated to NCDs within the health budget.

In East Africa, individuals can hardly afford to pay for health insurance, as employers mainly provide it. Health insurance coverage is low, but varies significantly across the region. Uganda has a coverage level of less than 2%, Kenya 25%, Tanzania 28% and Rwanda 92%[[13]](#footnote-13). Another important challenge is the fact that not all employees have workplace health insurance, which means that out of pocket constitutes a big portion of these 40.5%.

For example, in the specific case of Uganda, according to the WHO stepwise approach to surveillance (STEPS) survey, 76.1% of people with high blood pressure are not taking medications to lower it; among those with raised blood glucose, 89% were unaware of their status. These statistics refer to the lack of NCD services at primary health care level where these can be easily detected and addressed quickly.

*Policy framework:*

Although political declarations – of intentions to address health issues in general and NCDs in particular – have been widely expressed, there is very limited commitment to follow up with concrete actions and financing the response. 19 years after the Abuja Declaration pleading to use 15% of the national budgets on health was signed, no East African country has yet achieved the 15% budget allocation. On NCDs, most of the countries have developed policies/strategic plans (with the exception of Uganda and Burundi which have drafts) but implementation of these plans is weak due to low prioritisation of NCDs and lack of funding.

Policy makers/technocrats are often keen to address NCDs, but the political will is very low, and this is the place where resource allocation is determined. NCDs are seen as too expensive yet they do not bring immediate and tangible or even sensational political capital. This is worsened by the limited resources amidst competing needs. As a result, undefined ideas around public-private partnerships and citizen-contribution insurance schemes are becoming increasingly attractive with governments as a ‘lip service’ response to NCDs.

Responsibility is subtly placed on the individual as governments attempt to duck responsibility. However, these moves are seen as unsuitable due to poverty levels of citizens and profit-motivation of the private sector that is increasingly being fronted to be more involved in providing health services.

At the EAC level there has been a lack of focus on NCDs. The EAC suffers the same level of political will found at the national level. While it has the mandate and specific provisions on health and NCDs, little focus has been given to the issue. Most work on health is on communicable diseases.

*Key development challenges:*

* There is significant poverty across the region. On average, 37.6%[[14]](#footnote-14) of East Africans are below the poverty line and many more hover just above, and keep going in and out of poverty. Because NCDs are very expensive diseases, they are now a key driver of poverty due to catastrophic health expenditures.
* The limited state resources and the curative approach and lack of ‘preparedness’ to address NCDs also mean that countries in East Africa face a major long-term development challenge if no urgent action is taken.
* There is inadequate access to NCD care at the lower level health centres, with health care systems still oriented towards addressing one-off communicable diseases.
  + This limits access to care for the majority poor and creates a barrier for early detection and prevention leading to late diagnosis. Poor rural people living with NCDs have to travel long, costly distances to access NCD care at districts headquarters of regional referral hospitals, which is accompanied by increased out-of-pocket expenditures is catastrophic for already poor people.
* The multisectoral nature of NCDs require a response from other sectors outside health, posing another layer of costly complications for the resource-limited East African countries.
* Corruption and less participatory policy-making processes of governments and regional bodies and therefore not easy to influence.
* There are political sensitivities for some countries with less democratic and transparent governments, especially in terms of accountability and monitoring policy compliance.

### 1.2.3 Country contexts[[15]](#footnote-15)

**Burundi**

*General context:*

Burundi is a small country in Central-East Africa bordering Tanzania, Rwanda and the Democratic Republic of Congo. It gained its independence from Belgium in 1962 as the Kingdom of Burundi, but the monarchy was overthrown in 1966 and a republic established. It is a densely populated country, with almost 11.5 million people, and a high population growth rate, factors that combined with land scarcity and poverty place a large share of its population at risk of food insecurity. About 90% of the population relies on subsistence agriculture. Food shortages, poverty, and a lack of clean water contribute to a 60% chronic malnutrition rate among children.

A lack of reproductive health services has prevented a significant reduction in Burundi’s maternal mortality and fertility rates, which are both among the world’s highest. With two-thirds of its population under the age of 25 and a birth rate of about 6 children per woman, Burundi’s population will continue to expand rapidly for decades to come.

Political violence and non-democratic transfers of power have marked much of its history; for example, Burundi's first democratically elected president was assassinated in 1993 after only 100 days in office. The internationally brokered Arusha Agreement, signed in 2000, and subsequent ceasefire agreements with armed movements ended the 1993-2005 civil war. Pierre Nkurunziza was elected president in 2005 and 2010, and again in a controversial election in 2015 which, amongst other things, involved approximately 1000 people fleeing the country. Burundi continues to face many economic and political challenges[[16]](#footnote-16) which is also evident through a very low GDP pr. capita of only $275.43.

*Health and NCDs:*

Burundi is facing a serious shortage of qualified health workers. A recent study revealed that out of a total of 18,570 health care personal, 3% are doctors, 37% are nurses, 0.4 % are midwives and 40% are unskilled support staffs.[[17]](#footnote-17) These limited qualified health workers are compounded by uneven geographical distribution, where more than 36% of all doctors are located in urban areas. The government's effort to solve this problem has been hampered by the lack of incentives, housing, low salaries to move to remote areas etc.

The health budget depends upon external aid which accounts for 62% of total health sector funding. The household contribution is around 19%, while the government domestic resources represents 13%. This makes the country very vulnerable to the fluctuation and unpredictability of aid flows.

The financial situation is eroded by the uneven distribution of funds. The resource allocation appears to favour treatment and care (84% of funds), and prevention services are largely underfunded (only 1% in 2014). The resource allocation is challenged by the lack of data on public health issues, which would inform the prioritization.

Currently, Burundi is facing a double burden of communicable diseases and undernutrition, while NCDs are substantially rising. Since 2015, NCDs have been declared a public health problem. According to WHO, estimates of the risk of premature deaths due to NCDs rose from 28% to 32% between 2015 and 2016. The prevalence of diabetes almost doubled, increasing from 2.4% to 4.2% between 1999 and 2010, during the same time, the prevalence of hypertension rose from 27% to 31%. Similarly, Burundi is still experiencing the highest underweight and wasting prevalence worldwide, representing 59% and 28%, respectively, while the prevalence of obesity has doubled in the past two decades among adult women and men, ranging between 3.6% to 8.6%, and 0.8% to 2.1%, respectively.

*Policy framework:*

The President is directly elected by absolute majority popular vote for a 5-year term, and is eligible for a second term. The last election was held on 21 July 2015 (next to be held in 2020).

According to the WHO NCDs Progress Monitor 2017[[18]](#footnote-18), Burundi has developed national NCD targets, however there is not accurate mortality data, risk factor survey, nor has it a national integrated NCD policy/strategy or action plan. It has partially achieved the development of guidelines for management of cancer, cardiovascular disease (CVD), diabetes and Chronic respiratory disease, but it has not achieved drug therapy/counselling to prevent heart attacks and strokes, nor has it public education and awareness campaigns on physical activity. In terms of policies and interventions to reduce the alcohol consumption and attributable morbidity, Burundi has signed the global strategic action plan aiming at reducing the harmful alcohol use as part of SDG and UN HLM. However, little has been implemented at the national level.

*Key development challenges:*

The country is marked by several development issues:

* Since independence, Burundi has been plunged in cyclic ethnic and political conflicts, causing instability affecting sectors such as health, food security, education, and development.
* Low total public health expenditure also compared to the Sub-Saharan Africa.
* Historically, migration flows into and out of Burundi have consisted overwhelmingly of refugees from violent conflicts. In the last decade, more than half a million Burundian refugees returned home from neighbouring countries, mainly Tanzania.
* International aid organisations have reduced their assistance because they no longer classify Burundi as a post-conflict country. However, conditions have deteriorated since renewed violence erupted in April 2015, causing another outpouring of refugees.
* Highly dependent upon foreign aid and thus vulnerable to aid fluctuations.

**Kenya**

*General context:*

Kenya is a lower-middle income county in Sub-Saharan Africa. The country is divided into 47 counties and has a total of 580,367 square kilometres, only 20% of which is arable. Kenya has a population of 51.4 million (2018), life expectancy at birth of 67 years (2017) and a GDP pr. capita (current USD) at 1,710.51 (2018)[[19]](#footnote-19). The Kenyan economy is predominantly agricultural with a strong industrial base.

Kenya’s economic development is aligned to Vision 2030, a long-term development agenda, and the President’s Big Four development priority areas: manufacturing, universal health coverage, affordable housing and food development.

Kenya achieved some of the Millennium Development Goals including reduced child mortality, near universal primary education and narrowed gender gaps in education. Although the country has made significant political, structural and economic reforms that have driven sustained economic growth to a large extent, social development and political gains, development challenges including poverty, inequity, governance, climate change and the vulnerability of the economy to internal and external shocks need to be addressed in order to achieve sustained growth rates and transform lives of ordinary citizens.

*Health and NCDs:*

WHO estimates that NCDs account for 27% of all deaths in Kenya[[20]](#footnote-20). Local data indicates that NCDs account for more than 50% of total hospital admissions and over 55% of hospital deaths in Kenya.

The results of the Kenya STEPS survey for NCD Risk Factors (2015) shows that 13% of Kenyans currently consume some form of tobacco products; about 13% consume alcohol on a daily basis; 94% consume less than 5 servings of fruits and vegetables per day; 23.2% always add salt when eating; 28% always add sugar to beverages. Overall, 56% of the people have never been assessed for raised blood pressure; 87.8% have never been measured for raised blood sugar, and among those diagnosed with elevated blood sugar, only 40.1% were on medication at the time of the survey. Four in ten adults have heard of cervical cancer screening while only 11.3% of women have ever been screened for cervical cancer.

NCD service delivery is impeded by lack of resources in health systems and accurate data to inform planning. These challenges coupled with poor awareness of NCDs among community members result in late diagnosis of NCDs, often when complications have become established, resulting in poor outcomes.

*Policy framework:*

The Constitution of Kenya (2010) provides for two levels of governance. The National Government is responsible for national referral health facilities, health policy and veterinary policy while the 47 County Governments are responsible for health service delivery and promotion of primary health care including prevention activities.

Kenya is committed to tackling NCDs in a coherent, effective and sustainable manner and has been a signatory to global agreements on accelerating success and monitoring achievements towards meeting the NCD targets.

Given the rising burden of NCDs, policy makers have developed various NCD strategies/guidelines.[[21]](#footnote-21) The National NCD Strategy 2015-2020 provides a framework for prevention and control of NCDs and presents an analysis of the current status of NCDs in the country.

According to the WHO NCDs Progress Monitor 2017[[22]](#footnote-22), Kenya has set national NCD targets, has risk factor surveys, and also counts with a national NCD policy/strategy or action plan. However, it has only partially achieved the development of guidelines for management of cancer, CVD, diabetes and chronic respiratory disease (CRD), and it hasn’t achieved drug therapy/counselling to prevent heart attacks and strokes, nor has it public education and awareness campaigns on physical activity.

*Key development challenges:*

The National NCD Strategy 2015-2020, identifies key challenges of addressing NCDs in Kenya, which include:

* Poor prioritisation of NCD prevention and control in government agenda setting, planning and budgeting at both the national and county levels;
* Lack of a NCD prevention and control infrastructure with regional focal persons to coordinate NCD prevention and control planning, programming, monitoring and evaluation;
* Lack of resources for public health initiatives for awareness and promotion of healthy lifestyles in the prevention and control of priority NCDs;
* Poor capture and reporting of NCD related indicators in the District Health Information System (with resultant inadequacy of planning data);
* Poor availability and affordability of quality, safe and efficacious basic technologies and medicines for screening, diagnosis, treatment and monitoring of NCDs;
* Lack of an enabling environment with appropriate regulatory and fiscal measures, laws and policy options to protect and empower individuals, families and communities to make informed healthy choices, among others.

Poor people in Kenya are disproportionately affected by NCDs due to their limited access to information and services. Similarly health burdens from NCDs are higher in women than in men.[[23]](#footnote-23) Lack of access to and control over resources to pay for health services, lower autonomy than men, reduced access to education and health-care information, and stigma exacerbate women’s experience of NCD. The youth have not been prioritised in NCD prevention and control services despite the increasing NCD prevalence among this age group and the fact that most NCD risk factors and mental health conditions are established during this life stage. Similarly, there is limited engagement of people living with NCDs in NCD decision making. The situation of the NCD patients and their caregivers is dire in context of poverty, which affects almost half of Kenya’s population.

**Rwanda**

*General context:*

Rwanda has one of the highest population densities in Africa (1,060/sq mi) with a young, mostly rural population. It has an estimated population of 12.3 million people in 2019.

Rwanda's economy suffered heavily during the 1994 genocide. Close to one million people lost their lives and infrastructure collapsed. This caused a large drop in GDP and destroyed the country's ability to attract private and external investment. Rwanda’s economy is based mostly on subsistence agriculture by local farmers using simple tools. An estimated 90% of the working population farms, and agriculture constituted an estimated 31% of GDP in 2017.

Rwanda’s long-term development goals are defined in a strategy entitled “Vision 2020. The second [Economic Development and Poverty Reduction Strategy](http://www.rdb.rw/uploads/tx_sbdownloader/EDPRS_2_Main_Document.pdf) outlines an overarching goal of growth acceleration and poverty reduction through five thematic areas: economic transformation, rural development, productivity, youth employment, and accountable governance. One aim is to achieve that less than 30% of the population live below the poverty line; and less than 9% in extreme poverty. Rwanda met most of the Millennium Development Goals by the end of 2015.

Despite the improvements made in Rwanda since the genocide, the country is still amongst the poorest and most challenged in the world. On the UN Human development index Rwanda is placed 158 of 189 countries. The country is still challenged with limited financial resources as evident by a very low GDP per capita of $773 USD [[24]](#footnote-24)

*Health and NCDs:*

The Government of Rwanda has made health care one of the priorities in the Vision 2020 development programme, boosting spending on health care to 6.9% of the country's GDP in 2019, compared with 1.9% in 1996. In recent years Rwanda has seen improvement in a number of key health indicators. Between 2005 and 2013, life expectancy increased from 55.2 to 64.8, incidence of tuberculosis dropped from 101 to 69 per 100,000 people[[25]](#footnote-25).Despite the increased health indicators in some areas, NCDs including cancer, diabetes, heart and lung diseases are increasing rapidly in Rwanda, and the burden of infectious diseases like HIV/AIDS, Malaria and tuberculosis is still overwhelming. With the new toll from the increase of NCDs, Rwanda is challenged by a double disease burden. NCDs are estimated to account for 44% of all deaths and the probability of dying between the age of 30 to 70 years from the main NCDs (Cancer, diabetes, cardiovascular diseases and chronic respiratory diseases) is 19 %. The most NCDs vulnerable are people limited by poverty and high out-of-pocket spending for health; these have limited access to both education and quality health care, as NCDs are expensive to treat and require knowledge to prevent.

A STEPS survey[[26]](#footnote-26) conducted in Rwanda in 2012/13 revealed a severe prevalence of risk factors for NCDs. Tobacco use is a major risk factor and 12.9% of the population is smoking. The prevalence of unhealthy diet is alarming. Only 0.3 % of the population eat the recommended amount of fruit and only 0.9 % eat the recommended amount of vegetables. 21.4 % of the population did not engage in physical activity. 22.3 % of the population were overweight and 2.7 % were obese. Alcohol consumption is a heavy burden in the Rwandan society. 23.5 % reported episodes of heavy episodic drinking and 42.3 % of the population were drinking alcohol.

The health system is significantly burdened by NCDs. In 2013, NCDs accounted for at least 51.86% of all District Hospital outpatients’ consultation and 22.3% of District Hospital admissions. The government of Rwanda has invested strategically in the health system over the last years and achieved significant improvements. However, NCDs which are an emerging health threat, have been rather neglected leaving a health system with a lack of trained health care workers, lack of equipment and specialized infrastructure, lack of access to primary and specialised NCD health services and lack of NCDs data management.

*Policy framework:*

The Rwandan Ministry of Health (MoH) recognises the threat that NCDs pose to health and development in Rwanda and in 2009 it articulated strategies to respond to them in the Health Sector Strategic Plan. As a response to the global developments like the UN Outcome Document from the 2014 HLM on NCDs, the government has developed a multi stakeholder plan and a multidisciplinary steering committee. Through the National NCD Technical Working Group, members of RNCDA have actively participated in developing the current NCD policy, strategic plan and treatment guidelines. However, these are still limited and require a better data foundation, more political attention and increased financial prioritisation.

The NCD stakeholders’ steering committee is currently engaged in developing a national NCD five years’ strategic plan and nearly half of that team is Rwanda NCDA members. This is being done under coordination of the Minister of Health. Policy makers are interested in the area of NCDs but are lacking reliable data about NCDs in Rwanda.

According to the WHO NCD Progress Monitor 2017[[27]](#footnote-27), Rwanda has partially achieved the development of risk factor surveys. However, the country still needs to set national NCD targets, collect mortality data on NCDs, as well as a national NCD policy/strategy or action plan. Rwanda has achieved the development of guidelines for management of cancer, CVD, diabetes and CRD; however, it hasn’t achieved drug therapy/counselling to prevent heart attacks and strokes, nor has it public education and awareness campaigns on physical activity.

*Key development challenges:*

* Chronic and multi-morbidity:NCDs frequently involve “multi-morbidity**”** one person may suffer from two or more NCDs, or other linked diseases, which leads to high costs of chronic diseases drugs, services and treatment.
* Young people must be change agents who go back to the community and create awareness and promote NCD prevention and work together with the health care providers.
* In Rwandan culture, women are the ones responsible for taking care of the family, preparation of the diet, looking for medications and family care to be sure that the family is in good health meaning that it crucial to include women in decision-making which is not currently the case.
* Lack of involvement of people living with NCDs in the policy development.

**Tanzania**

*General context:*

Tanzania borders Uganda to the north; Kenya to the northeast; Comoro Islands at the Indian Ocean to the east; Mozambique and Malawi to the south; Zambia to the southwest; and Rwanda, Burundi, and the Democratic Republic of the Congo to the west. Shortly after achieving independence from Britain in the early 1960s, Tanganyika and Zanzibar merged to form the United Republic of Tanzania in 1964. In 1995, the country held its first democratic elections since the 1970s.

The country has the largest population in East Africa (56.4 million people) and the lowest population density. Almost a third of the population is urban, and with a population composed of several ethnic, linguistic, and religious groups. Tanzania’s youthful population – about two-thirds of the population is under 25, and is growing rapidly because of the high total fertility rate of 4.8 children per woman.

Tanzania has achieved high growth rates based on its vast natural resource wealth and tourism with GDP growth in 2009-17 averaging 6%-7% per year. The economy depends on agriculture, which accounts for slightly less than one-quarter of GDP and employs about 65% of the workforce. Gold production has in recent years increased to constitute 35% of exports. All land in Tanzania is owned by the government, which can lease land for up to 99 years.

Dar es Salaam is the administrative capital, and Dodoma the legislative capital.[[28]](#footnote-28)

*Health and NCDs:*

Tanzania still faces several health challenges. For example, progress in reducing the birth rate has stalled. Communicable diseases like HIV and Malaria are still a major problem in Tanzania, which together with NCDs create a double disease burden.

In Tanzania the burden of NCDs has been increasing steadily[[29]](#footnote-29). According to WHO, 33% of all deaths are caused by NCDs, with the majority (13%) caused by cardiovascular diseases, followed by cancers (7%). The risk of premature deaths between 30-70 years is 18% across the population, without significant difference between men and women. In terms of access and treatment, less than 25% of primary health care centres reported offering CVD risk stratification, and there are no CVD guidelines utilised in health facilities. Additionally, only 6 of the 10 essential NCD medicines are generally available to the population, while only 4 of 6 essential NCD technologies are generally available[[30]](#footnote-30).

Tanzania National survey which was carried out in 2012, showed that the level of risk factors are high: current tobacco users (15.9%), current alcohol drinkers (29.3%), overweight and obese (26%), raised cholesterol (26%) and raised triglycerides (33.8%). The study also revealed a high prevalence of diabetes (9.1%) and hypertension (25.9%).

Lack of data on NCDs and surveillance of risk factors constitutes an additional challenge to the prevention and control of NCDs in the country. Capacity and resources for data collection and surveillance systems are generally limited.

*Policy framework:*

Good public policies are vital for protecting the health of the population. For the prevention and control of NCDs, a single national policy is essential. In Tanzania there is no national policy on NCDs. There is only draft legislation in place for tobacco control, alcohol consumption and control of food standards. More efforts are needed in terms of human and financial resources.

According to the WHO NCDs Progress Monitor 2017[[31]](#footnote-31), Tanzania has achieved the development of national NCD targets, however it has only partially achieved risk factor surveys, and has no mortality data on NCDs. Tanzania also doesn’t have guidelines for management of cancer, CVD, diabetes and CRD; drug therapy/counselling to prevent heart attacks and strokes; nor has it public education and awareness campaigns on physical activity.

*Key development challenges:*

* Tanzania is challenged by a high fertility rate, and thus a growing population, which can put more pressures on its economic development, but also in terms of demand on health services.
* It still has pending health challenges, related to the Millenium Development Goals, such as high maternal mortality rates (due to inadequate maternal health services and inequities in poor and rural areas), as well as other communicable diseases, namely malaria, HIV and tuberculosis.
* NCDs progressively becoming the leading cause of morbidity and mortality, which is partly attributed to increase in life expectancy, but also to changes in lifestyle.

**Uganda**

*General context:*

Uganda has one of the youngest and most rapidly growing populations in the world. Its total fertility rate is among the world’s highest at 5.8 children per woman. High numbers of births, short birth intervals, and the early age of childbearing contribute to Uganda’s high maternal mortality rate. Gender inequalities are a major problem, women are on average less-educated and participate less in paid employment. Even if the birth rate was significantly reduced, Uganda’s large pool of women entering reproductive age ensures rapid population growth for decades to come.

Population increase is expected to further strain the availability of arable land and natural resources and overwhelm the country’s limited means for providing food, employment, education, health care, housing, and basic services. The country’s north and northeast lag even further behind in terms of development compared to the rest of the country as a result of long-term conflict, ongoing inter-communal violence, and periodic natural disasters.

Uganda has been both a source of refugees and migrants and a host country for refugees. The emigration of Ugandan doctors and nurses due to low wages is a particular concern given the country’s shortage of skilled health care workers, which affects the health system as a whole.

The colonial boundaries created by Britain to delimit Uganda grouped together a wide range of ethnic groups with different political systems and cultures. These differences complicated the establishment of a working political community after independence was achieved in 1962. The rule of Yoweri Museveni since 1986 has brought relative stability and economic growth to Uganda.

*Health and NCDs:*

The health sector in Uganda is largely dependent upon donors’ policies that usually focus on HIV/AIDS and infectious diseases. Yet the double burden of infectious diseases and NCDs is escalating, and the Ugandan health system is increasingly overwhelmed by the amount of patients with heart conditions, diabetes and cancers. Consequently, many of these patients do not receive the necessary health treatment and medicine.

NCDs in Uganda are responsible for 33% of all total deaths, and the risk of premature death between 30-70 years is at 22%. Obesity and raised blood pressure are growing trends that need to change to reduce the number of people developing NCDs, which can be done through preventive efforts, information and advocacy. Only 5 of the 10 essential NCD medicines are reported as generally available to the population, and only 4 our 6 essential NCD technologies are reported as generally available[[32]](#footnote-32).

In 2014, Uganda assisted by the WHO conducted the first STEPS survey to assess NCD risk factors, which concluded that NCDs and their risk factors had become a public health problem. In 2018, the UNCDA conducted a survey on Health facility capacity assessment, which showed that the level of care do not meet WHO standards for essential tools and medicines needed to implement effective NCD interventions. Both surveys established inadequacy in human resources for health in numbers and NCDs care services knowledge and skills.

Although population-based data on common health conditions can be accessed at health facility level and through the Health Management Information System (HMIS), the major concern on NCDs in Uganda is the vast lack of empirical data. The HMIS as it is today, lacks comprehensive NCD indicators making it difficult to track, generate data and report on NCDs. The UNCDA’s survey on the assessment of the capacity of lower health facilities found a shocking lack of capacity in terms of knowledge and skills among health workers to generate, record and report on NCDs.

*Policy framework:*

Uganda has two levels of governance, the Central Government which includes, Ministries and Parliament, and Local Government; Districts and sub-counties. The process of policy formulation is generated at Ministry level and informed by data or actions at local government level. Data on development and health services is generated from the community by lower administrators upwards and vice versa for resource mobilization and allocation.

According to the WHO NCDs Progress Monitor 2017[[33]](#footnote-33), Uganda has achieved the development of risk factor surveys (specially through STEPS).

However, it hasn’t achieved the development of a national integrated NCD policy/strategy or action plan, nor has it national NCD targets or mortality data on NCDs. It’s important to highlight that Uganda does have guidelines for management of cancer, CVD, diabetes and CRD; but it doesn’t count with drug therapy/counselling to prevent heart attacks and strokes; nor public education and awareness campaigns on physical activity.

In recent times, the Ministry of Health has approved the transformation of the national NCD program, and there is now an NCD department working on Lifestyle Diseases, which has lead to an increased attention from policy makers. The improvements in the health system, and the integration of NCDs, are slow and financing and implementation strategies rarely follow the good intentions. Uganda has a comprehensive National Health Policy, and the policy framework on NCDs is embedded in it.

The political leaders at Parliament have taken keen interest into NCDs through; presence of NCDs parliamentary forum, the enactment of laws aimed at control and prevention of NCDs, e.g. the Tobacco Control Act 2105, the Alcohol Control Bill, the Uganda Cancer Institute Act, and Uganda Heart Institute Act are a clear indicator of political willingness to control NCDs in Uganda.

The NCD policy framework remain inadequate, with weak systems to generate, record and report data on NCDs, the most elaborate HMIS of the ministry of health lacks most indicators on NCDs and therefore the prevalence of NCDs cannot be precisely estimated. The NCDs Division within the Ministry of Health, has come up with a comprehensive NCDs strategic plan draft, but the source of funding for this plan is uncertain.

*Key development challenges:*

* Uganda faces numerous challenges that could affect future stability, including explosive population growth, power and infrastructure constraints, corruption, underdeveloped democratic institutions, and human rights deficits.
* The health sector is generally underfunded, which affects the NCDs department more because communicable diseases still constitute a large challenge to the country
* Lack of involvement of people living with NCDs (PLWNCDs) in planning and implementation of NCDs control and prevention strategies.
* The health care system lacks in medicines, staffing, technologies, supplies. The NCDs have taken the health care system by surprise, and it is not prepared to respond adequately.
* While young people and women bear the burden of the effects of NCDs, there has not been deliberate efforts to engage them and provide targeted interventions to them.
* Civil society face different challenges (such as access to funds) and are diverse in their function.

**Zanzibar**

*General context:*

Zanzibar comprises two main islands, Unguja and Pemba, and a number of sparsely populated smaller islands, all of which make up a total area of 2,643 square kilometres with a population of 1.3 million inhabitants. It is a semi-autonomous part in the Republic of Tanzania with its own government and democratic system formalised in the House of Representatives. The health sector is exclusively run by the Zanzibar Revolutionary Government.

Zanzibar has faced a long period of political and economic instability, but since 2001, the island has been relatively stable as the rivalling parties have reconciled to share power in parliament.

In terms of economic development, Zanzibar continues to face great challenges. Tourism is the territory’s biggest industry. However, most of the population have yet to benefit from it, as GDP per capita was only $919 in 2017.[[34]](#footnote-34)

*Health and NCDs:*

The WHO Steps survey mapped the prevalence of NCDs in Zanzibar in 2011. Based on this survey a NCD strategy has been developed by the MoH and a special unit to deal with NCDs has been established. The Ministry has identified and prioritized NCDs as a major concern of public health as stipulated in “Zanzibar Strategy for Growth and Poverty Reduction”. The NCD risk factors have increased dramatically in Zanzibar. The main risk factors include the major behavioural risk factors for NCDs, such as an unhealthy diet, lack of physical activity (especially in towns) and excessive alcohol and tobacco consumption.

In Zanzibar, the 2011 Step Survey showed that 37% of men and 29.4% of women had elevated blood pressure. The prevalence of diabetes was found to be 3.7%; while an assessment on cancers was not implemented. In principle, essential medicine is free of charge for the population; however, it is very often out of stock.

Currently, the availability of NCD medical services are improving with more trained health personal present at health facilities, however much more trained personal is still needed.

NCD data is not well documented, and it has proven to be very difficult to obtain (no national cancer registry etc.). Additionally, resources for NCD prevention and control are highly inadequate. Poor supply of NCD drugs leads to poor management of NCD patients, and as a result, patients gets predisposed to complications like coronary heart disease, increased cardiovascular accidents and renal failures.

*Policy framework:*

NCDs have been included in the National Development Plan (NDP) with dedicated NCD targets. In Zanzibar, NCDs were prioritised in the NDP and Growth and Poverty Reduction Strategy 2010–2015 as a key health constraint. The Zanzibar Strategy identifies the most prevalent NCDs nationally as hypertension, diabetes, asthma, cancer, road accidents and mental health[[35]](#footnote-35).

The involvement of influential Government leaders of Zanzibar has shown that they are committed to tackle NCDs as stipulated in the strategy, which states that the government will guarantee the control and management of NCDs. The MoH Strategic Plan 2014-2019 aimed at reducing NCDs through effective education, counselling in collaboration with NCD program and health education. The Government and the MoH have increased their commitment towards combating NCDs and related risk factors in Zanzibar. In terms of tobacco control, the Public and Environmental Health Act of 2012 regulates smoking in public places. Future NCD policies shall be integrated into the national health system, as well as into the national NCD plan, Health Sector Reform and Strategy for poverty reduction and economic growth.

*Key development challenges:*

* A poor health system that has made it difficult to improve the health outcomes for people living with NCDs.
* The Zanzibar Community have changed life style, including a dietary transition into a high consumption of industrial and unhealthy foods.
* Most of the population live below the poverty line, resulting in unhealthy diets, which in turn lead to overweight and other NCDs. Poverty plays an important role for people living with NCDs, because most of them cannot afford high priced NCDs medicines and, thus, are not able to adhere to their treatment.
* No availability of relatively inexpensive medications used for managing chronic diseases in public sector facilities; becoming a key challenge for low-income NCDs patients.
* Lack of data on NCDs and surveillance of risk factors.

**Main stakeholders covering all countries**

As the main stakeholders for the countries are very similar, we have decided to combine these as listed below:

* People living with NCDs and their caregivers - should be meaningfully engaged as the key drivers of the NCD response.
* Ministry of Health at national and county level - responsible for health policy, service delivery and are key influences for NCD prevention and control.
* Policy makers: including members of parliament, senate and Council of Governors involved in budget making and legislative processes, ministries and in Kenya County First Ladies who have unique access to policy makers.
* Private sector - pharmaceutical, food, beverage and agricultural industries.
* Professional and community bodies *e.g.* nutritionists, doctors, nurses, engineers, teachers, religious leaders and groups, women groups, student/youth and community groups.
* Academic and research institutions - capacity building and NCD research and data management.
* Global networks, agencies and donors *e.g.* Access Accelerated, The NCD Alliance, PATH, Amref, Red Cross, WHO, UNICEF, World Bank, USAID, World Diabetes Foundation, American Cancer Society.
* Alliance member organisations: Each of the national alliances have a number of patient organisations as members.
* Districts and cities: City councils, district committees etc. can assist in facilitation of screenings and campaigns and support branches, patient groups etc.
* Hospitals at national and regional level: They are one of the main collaboration partners, provides technical support and gives information to members. It is also a platform for recruitment of new members.
* Media: can provide access to the target groups and informs the public
* East African Community
* Community leaders: these are main stakeholders in the fight against NCDs.
* CSOs that advocate NCDs prevention and control or shares advocacy interests
* International Donors: CISU/Danida, World Diabetes Foundation, US aid etc.

# 2. CAPACITY, PARTNERSHIP AND LEARNING

## 2.1 Organisational capacity

### 2.1.1 Organisational capacity and resources

DNCDAs mother organisations the Danish Cancer Society (DCS) and Danish Diabetes Association (DDA) are major patient organisations[[36]](#footnote-36) with many years of experience in representing patients, research, advocacy and patient support. They have profound experience in good governance based on engagement of their members. DNCDA has since the beginning in 2009 developed its capacity for engagement in national, regional and global advocacy for NCDs and for partnering with (and in most cases supporting the establishment of) NCD alliances in East Africa[[37]](#footnote-37). Focus has been on establishing sustainable NCD Alliances, incl. advocacy (at all levels) for political initiatives for improvement and awareness.

The relatively small DNCDA secretariat (lead by a director) has the overall responsibility for the programme implementation (se annex 7.5 for brief secretariat staff CVs). The secretariat is supported by a steering committee consisting of two very senior employees from the member organisations. Both steering committee members have been involved from the very onset and have been instrumental in developing the alliance[[38]](#footnote-38) (see annex 7.5 for brief CVs of steering committee members).

The secretariat is not going to manage the programme alone. The secretariat will be supported by selected staff from the 2 mother organizations as were also the case with the projects. It is one of DNCDAs comparative advantages that it can utilize expert staff from the mother organizations (all together close to 900 professional staff is working for DDA and DCS). Several staff is expected to support guiding our programme development and some to conduct trainings in Africa within their field of expertise such as good governance, communication, volunteer management, patient support, fundraising, financial management etc. DCS is housing the DNCDA and provides it with access to multiple administrative resources. This includes an accounting department with 20 employees handling bookkeeping, bank transfers, financial procedures etc.

The ability of the secretariat to draw on expertise from the member organisations were assessed by the consultant in the CapApp and highlighted as a major asset: “Technical expertise and administrative support available to the secretariat from primarily DCS is considered relevant and effective. It is a major asset of DNCDA in its capacity building and advocacy to partners in East Africa that it can draw on a range of experienced staff members”.

Examples of this includes monitoring and training in financial and administrative procedures in all of our current projects, facilitated by one of the financial experts from DCS. This has significantly improved the procedures of our partners, so especially our older partners today have solid procedures. This was noticed by the director of CISU during a monitoring visit to Uganda, as he states: “Going detailed through the CISU financial checklist it turned out that except for a few remarks the systems are in place and functioning in accordance with the CISU financial standards - including the samples of statements, supporting documents etc. There are written down procedures, clear division of work and a planning-budgeting-reporting system for the single activity held in the field/with the local groups etc.”.

We have previously also used volunteers and members from our member organisations. Examples of this include Danish PLWNCDs participating in our global advocacy - complementing our East African advocates, volunteers assisting with popular engagement in Denmark and development of content for our webpage. As also recommended (the Assessment note - recommendation 1) we plan to engage both DDA and DSC staff - and following this the members from our mother organizations in our programme mainly through informing about our development work and the difference it makes. Eventually this could lead to direct participation in programme activities for volunteers (see also chapter 3.8).

We have a strong link to academia - not least so with Århus University and Associate Professor Per Kallestrup[[39]](#footnote-39). Per Kallestrup is used as sparring partner on many NCD/health issues - but even more importantly as trainer during research workshops as support in developing research projects.

Moreover Per has a network of PhD students in East Africa, through collaborations between Aarhus University and some of the East African Universities. These local resource persons have proved very important in our project implementation to date. To mention just one example - a Rwandan PhD student[[40]](#footnote-40) have trained our partners in data collection, and assisted them in developing a data collection tool, which will be instrumental for the data collection proposed in this programme. Our board members (often-specialized medical doctors) have also facilitated trainings and not least spoken frequently on behalf of EANCDA in international fora and as such functioned as additional resource persons.

Both local and Danish resource persons have been major assets for our partners and, thereby, ultimately for the beneficiaries in East Africa. A programme approach will allow us to increase the use of these resource persons, as we can use them more strategically - in ways that will be benefiting multiple partners at the same time. A programme will allow for activities to be better coordinated and resource persons will more easily be able to visit multiple partners during one trip and to work on issues relevant for more partners and not only one project. Local resource persons will for example play a key role in our future research efforts - the vast majority of the researcher will be local resource persons but also everything related to the outcome harvesting approach (see chapter 3.5.2) is expected to be by local experts (ref. to Assessment note recommendation 1).

### 2.1.2 Capacity and experience with context and stakeholder analysis

All of our project managers are local with vast experience in managing development projects and thus with extensive experience in context and stakeholder analysis. The managers will remain on-board and not least in terms of stakeholder analysis they can draw on the experience of the board members of whom the majority are senior medical professionals with widespread knowledge on what actors are influencing health policies. The individual strategic interventions and related program outcomes are based on learnings from previous project interventions (see section 2.4.1), and the context knowledge gained through the project implementations. The programme will allow us to take the individual components to the next level and merge them into an actual longer-term programme. We have very detailed stakeholder analysis in some countries while in other countries the analysis will be developed further in tandem with finalising the individual country result frameworks. We find that our biggest challenge is not identifying the stakeholders as such but rather prioritising our advocacy efforts as there is a rather large no. of stakeholders.

### 2.1.3 Current level of popular engagement

The purpose of our information work in Denmark has been focusing on creating awareness about NCDs as a major development issue. Special attention has been paid to students studying health related topics to motivate them to either study the topic in more detail and/or engage as volunteers in Denmark or in East Africa. We regularly do talks at the University College Copenhagen - Global Nutrition and Health and for (mainly foreign) students at Copenhagen University (Global Health). Several of our partners in the south host trainees from Denmark (facilitated by DNCDA). The trainees discuss their experiences with fellow students (and family) upon their return. Some trainees have used social media such as Instagram and blogs to get the message across. A no. of specialized staff - from our mother organizations - not normally working with Africa has been facilitating workshops with our partners widening also their own horizon.

Our most important communication tool is our website <https://www.cancer.dk/ncd/> alongside our Facebook: <https://www.facebook.com/dncda/>. We have had articles published in the Danida magazine “Udvikling” as well as on the Global NCD Alliance website. More importantly we have co-hosted/been keynote speakers at several larger events (with also a Danish audience present) latest a side-event at the UN High level Meeting for NCDs in N.Y. (with participation of health ministers).

We also actively participate in the Danish health NGO network “Sundhedsnetværket”. Collectively we have a strong voice that can and is being used towards policy makers in Denmark.

## 2.2 Partners

### 2.2.1 Key partners

All our current partners will be continued under the programme. We have known almost all of our partners from the very onset as DNCDA has played a key role in establishing the East African NCD patient organizations. Each individual NCD Alliance partner is made up from different small individual patient organizations that all have felt they did not have enough clout on their own and saw the potential in joining forces with organizations with similar objectives. Thus each individual Alliance is already a cooperation between numerous partners as illustrated below.



The partners have normally signed a memorandum of understanding (MoU) stating their common interests, including sound democratic principles for governance of the organization.

The different alliance boards consists of a mix of members from its member organizations. The vast majority of board members are devoted medical professionals or PLWNCDs. All board members share the belief that NCDs (both prevention and care) are not sufficiently prioritised and that NCDs are not only a health issue but also a development issue with the poorest and most vulnerable segment of the population paying the highest price for the lack of NCD prevention and care. On a day-to-day basis all alliances are run by a programme manager supported by a financial assistant. All alliances have grown exponentially the last 3-5 years partly due to increasing demands from MoHs for support on NCDs.

### 2.2.2 Proposed roles and division of labour

Until now, we have attempted to carefully design and plan each project in close cooperation with the individual partner. The programme is formulated and developed in a similar fashion. Latest we have had a 3 days workshop in Nairobi with participation of all partners. We aim at achieving as much joint ownership as possible although recognising that different roles and obligations exist within a partnership (not least so in a partnership where the money transfer goes only one way). DNCDA is ultimately responsible for the money (being put to good use) towards CISU and, thereby, the Danish taxpayers.

We do not start any project without a signed agreement on responsibilities related to the specific project (as is also a CISU requirement). Our agreements are rather comprehensive and cover a number of different areas (see annex 5.1 partnership strategy for additional details).

Over time we plan for a more decentralised structure with additional responsibility transferred to the partner organizations - not least the East Africa NCD Alliance (the umbrella organization). Although initially we will remain with more or less the current structure in place as this structure has proven to work well and will provide some initial stability. Each individual country alliance will remain fully independent and in charge of implementation of activities in the country, and at least during the first programme phase report directly to DNCDA. However, the programme focal point organisation will be the EANCDA, as they will be dealing with the majority of regional (incl. the East African Community) and international issues, research projects as well as compiling statistical data from the individual country alliances. EANCDA will compile and analyse the research results with a regional focus.

Overall EANCDA will be in charge of knowledge sharing - which is a crucial task as our partners can learn a lot from one another. A best practice in one country is in our region likely to also work well elsewhere. Furthermore, the EANCDA will be charged with establishing our future common homepage. In the long term it is our ambition to have the best NCD website in the region appealing to both health care professionals as well as PLWNCDS. The EANCDA will also be administrating all common meetings - as well as deciding on what staff should be offered short courses. We plan amongst other things to have staff attending courses at the Danida Fellowship Centre in the future. It is important to underline that the EANCDA board consists of 2 people from each of the national alliances and with a great mix of nationalities holding key positions. The exact speed of the planned decentralization and the exact level of future devolution will depend on how quickly the EANCDA is maturing. This includes the sustainability of the democratic structures we have established (including turnover of board members and staff), financial reviews/audit reports etc. We are in favour of as much responsibility lying as close to the beneficiaries as possible but mindful of the fact that we remain responsible for the money being well spend. Below some additional details on each alliance member and the global NCD alliance, with whom the global advocacy will be coordinated, and who will assist in the development of the EA alliances.

### 2.2.3 Alliance partners

**Global NCD Alliance:**

The NCD Alliance (NCDA)[[41]](#footnote-41) was founded in 2009 by three global federations: the International Diabetes Federation, the World Heart Federation, and the Union for International Cancer Control.

The NCDA is a registered NGO in Switzerland with an elected President and Board of Directors, and a growing membership base. As of August 2019, NCDA’s membership[[42]](#footnote-42) includes the founding members, 72 full members (including 31 national and regional NCD alliances), 5 associate members and 100 network members. Its broader global network comprises more than 2,000 organizations in 170 countries, including more than 60 national and regional NCD alliances, national NGOs, scientific and professional associations, academic and research institutions, private sector entities and dedicated individuals.

National and regional NCD alliances play a vital role in NCDA’s work and are a main cornerstone of the NCD community. Hence, the NCDA works to strengthen coalition building efforts (including through its Advocacy Institute), providing technical support for the translation of global commitments into national action, and the increased mobilization of the civil society community, particularly promoting the meaningful involvement of people living with NCDs (through its *Our Views, Our Voices* initiative).

During its first 10 years, the NCDA has built a strong track record, vision and expertise in focused, result-oriented and evidence-based advocacy, bringing about policy change at the UN, WHO and with governments. The NCDA is widely recognized as a convener of the NCD civil society community, providing thought leadership on global policy, setting priorities for the global NCD response, and mobilizing civil society. NCDA members are through NCDA provided with tools and opportunities to connect their national and/or regional work to the global level.

**East Africa:**

The NCD Alliance East Africa (EANCDA) was formed in 2014 as an informal network of the national NCD Alliances in Kenya, Rwanda, Tanzania, Uganda and Zanzibar. In 2016, with technical support from the DNCDA and financial support from CISU a secretariat was set up in Uganda. The Alliance is now officially registered and has since built partnerships with a broad range of organizations.

The emergence of the EANCDA reflects the urgent need for action on the prevention and control of NCDs in the East Africa. EANCDA has over this period implemented several projects on advocacy, research and capacity building at regional and international levels and its track record includes:

* Facilitating a side-event (with ministers) on PLWNCDs in East Africa at the UN High Level Meeting for NCDs in 2018;
* East Africa regional benchmark surveys on NCD, 2014 and 2018 to track progress and to use the same results to demand accountability;
* Engagement and advocacy at regional health meetings of EAC and WHO-AFRO Regional Committee Meeting
* Regional stakeholder engagement and development of The East Africa NCD Charter 2014 and 2018, a set of key actions signed and committed to by all stakeholders;
* Conducting a collaborative Regional NCD Research Conference with APHRC and IDRC;

The capacity of the EANCDA is drawn from the regional member alliances which include experts and academia in different areas of NCDs, advocates, intervention managers and patient organizations. The EANCDA is managed by a board drawn from the 6 members. Several of the current board members are among Africa’s leading experts on NCDs[[43]](#footnote-43). The EANCDA has good collaborative relations with key stakeholders including Ministries of Health (particularly the NCD Departments/Divisions/Units), EAC, WHO Country Offices and other regional and international NCD CSOs.

**Kenya:**

NCD Alliance Kenya (NCDAK, registered in 2012, emerged out of the need to comprehensively and sustainably address the rising prevalence of NCDs in Kenya. NCDAK’s mission: “*to be the lead membership organization in Kenya on all matters pertaining to NCDs”* envisions “*An NCD-free Kenya”.* The Alliance has a membership of 30 organizations (including networks), five individual members and is led by a board of technical experts with a passion to fight the unequal health system.

NCDAK has brought together multi-sectoral stakeholders to facilitate effective promotional and advocacy activities for prevention and control of NCDs and provision of quality NCD care services in Kenya. To date, NCDAK has created a national movement of different stakeholders including patient support groups; NCDAK Chair co-chairs the NCD Inter-agency Coordinating Committee and heads the related advocacy technical working group. The Alliance played a key role in the conduct of the STEP-wise Survey on NCDs and development of the National NCD Strategy 2015-2020. NCDAK members have contributed, as keynote speakers, in key NCD meetings and conferences locally, regionally and internationally.

NCDAK hosted the first multi-stakeholder workshop on Communication and Advocacy for NCDs in 2018, in which representatives of PLWNCDs and their care-givers participated. The Advocacy Agenda of PLWNCDs in Kenya, which documents the main asks of PLWNCDs, was the key outcome.

**Rwanda:**

Membership of the Rwanda Non Communicable Diseases Alliance (RNCDA) is drawn from the key organizations that fight against NCDs in Rwanda. These organizations have come together to create a powerful voice for NCD awareness raising and advocate for the prevention and control of the most common NCDs and their risk factors. The RNCDA was founded in 2016, as a collaborative effort of six organizations[[44]](#footnote-44). Its membership is now 25 organizations including groups of patients, different healthcare professionals, youth-led organizations etc.

Since its establishment, RNCDA has been working with the city of Kigali and through Car Free Day platforms organized by the Ministry of Health it has encouraged all citizens to take up physical activity. Thousands of people now understand what NCDs are, how they can be prevented and equally important have checked their own NCD status.  RNCDA is actively working on establishing branches in all provinces of the country. Among its most notable advocacy efforts is focus on early detection and further outreach of NCD desks.

**Tanzania:**

The Tanzania Non-communicable Diseases Alliance (TANCDA) was founded in 2013 by the Tanzania Diabetes Association, Heart Foundation of Tanzania, Tanzania Association for Respiratory Diseases and Tanzania Cancer Association but now several more partners have engaged for the prime purpose of stronger advocacy for NCDs.

TANCDA works closely with the Ministry of Health and the President’s Office, the NCD sections but also other strategic partners such as WHO. TANCDA uses different approaches to reach people with different services including the distribution of health education materials (brochures, newsletters), media (TV, radio and newspapers) as well as social media like blogs, Facebook, twitter and WhatsApp. Through these channels, more than 16 million people has been reached with messages on NCDs, including risk factors and prevention strategies/methods. In addition more than 16,000 people has been screened for blood glucose, blood pressure, weight and height and in some regions also for cancer. TANCDA has created a special journalist forum on NCDs - that is being attempted duplicated elsewhere.

**Uganda:**

Uganda NCD Alliance (UNCDA), founded in 2010, consists of Uganda Heart-Research Foundation, Uganda Cancer Society and Uganda Diabetes Association. UNCDA’s long term vision is “a society free from preventable NCDs resonating with the National plan for prevention and control of NCDs (by government), a tobacco free Uganda, improved lifestyles, strengthened health systems, access to affordable and good quality medicines and technologies and human rights for people living with NCDs”.

UNCDA now has 10 branches nationally. The 11th branch is in the making in Kamuli as part of collaboration with KANENGO supported by Hope Denmark also receiving funding from CISU[[45]](#footnote-45). UNCDA has a solid network of 300 volunteers and more than 2000 people are members of the three founding associations. UNCDA has played a crucial role in getting NCD desk established at local health clinics. Furthermore, its advocacy work led to the introduction of a national cancer register and the establishment of a NCD group in Parliament. UNCDA has screened thousands of people and provided them with information on NCD prevention and care over the years.

**Zanzibar:**

Zanzibar Non-Communicable Diseases Alliance (ZNCDA) was created in 2012 by the Diabetes Association Zanzibar and the Zanzibar Cancer Association. Since its establishment ZNCDA has grown and now consists of 4 larger (in a Zanzibar context) patient NGOs. Achievements include the writing and wide distribution of several position papers including papers on nutrition (and informing participant and spectators at the yearly food festival of the close linkage between nutrition and NCDs) and a position paper on access to qualified NCDs healthcare workers. ZNCDA advocated for cancer and diabetes units being established at the main hospital (Mnazi Mmoja) which happened. Also ZNCDA advocated successfully for free insulin to diabetes patients. ZNCDA has effectively introduced NCD topics to a no. of influential members of Parliament and ensured coordination between ministries on NCDs most notably MoH and Ministry of Economics - and through pinpointing the connectedness between NCDs and reproductive health ZNCDA has gained access to many girls and young women.

**Burundi:**

**The Burundi NCD Alliance (BNCDA) was established in 2016. The original members were Burundi Asthma Association, Diabetes Association, Epilepsy Association and Cancer Association. BNCDA has since managed to more than double the no. of member organizations. It is in itself a major achievement to have gathered so many different patient organization - that can now speak with one voice. BNCDA has more than 50 active volunteers, including medical students, psychologists, economists, medical doctors and University lecturers who volunteer for NCD activities. BNCDA is now conducting regular outreach activities in vulnerable communities and small scale screening campaigns. They have a good working relationship with MoH but efforts are, of course, influenced by the fact that Burundi has been affected by conflict. The country is 5th from bottom on UNDPs latest HDI.**

### 2.2.4 Partner differences

Despite their similarities in structure and approaches, it is also important to highlight the different levels of capacity of our partners - as also evident from the examination of the different national alliances above. Our partners in Uganda, Tanzania and Kenya have a vast network of branches with volunteers reaching out to most areas of the countries, and therefore already have solid experience in service deliveries, good governance, and evidence based advocacy. Our partner in Zanzibar has a less elaborate structure, but they have developed strong capabilities in specific service deliveries and in integrating NCDs with other areas like maternal health and healthy foods. Our partner in Rwanda is young and is still in process of developing its structures and advocacy efforts; however, they do have a good platform and potential to do so. Finally, an unstable political environment challenges our partner in Burundi and slows their development ability. The programme will take into account the different capacities of our partners (reference is made also to the review of existing capacity mentioned in the TOC section) and make a strategic effort to ensure that synergies are reached to the benefit of all organizations with a special view to enhance the capacity of the less experienced partners (ref. to Assessment note recommendation 6). The space for CS is under pressure everywhere in the region as in most of the world. One way of measuring space is looking at the no. of opposition media especially newspapers and radio stations. In Rwanda there is hardly any pro opposition media and in Burundi and to a lesser extend also Tanzania opposition media is also under pressure while it is less so in Uganda and Kenya[[46]](#footnote-46).

### 2.2.5 The role as a catalyst/added value of DNCDA to partners

The programme will allow us to shift part of our attention from day-to-day project implementation to take a more strategic (helicopter) view, including but not limited to building up new relationships with relevant CSO’s and academia both locally and internationally in order to add pressure on relevant duty-bearers DNCDAs role as a catalyst will have greater potential in a programme - as it will allow the relatively young EA NCD Alliances to benefit more crosscutting from the long experience as successful patients organizations which the 2 DNCDA mother organizations have. They both have very solid governance and financial procedures in place - experiences that all alliance members have already but can continue to benefit from. Furthermore, both the Danish Cancer Society and the Danish Diabetes Association have long experience from working with volunteers.

Working with volunteers is inspiring and rewarding but getting the best out of your volunteer base is also challenging. Resource mobilization is another area where the Danish organisations can share experiences and offer new innovative ideas and sparring to our partners in the South. However, we expect our role as a catalyst to be most visible concerning the planned more in-depth cooperation with academia - north/south research cooperation and knowledge sharing between the alliances etc. The Danish organisations have great expertise within both prevention and cure as well as research capacity within two of the most common NCDs (cancer and diabetes) but equally important enormous expertise within all of the main NCD prevention areas namely smoking, exercise, healthy foods and alcohol consumption. Experiences they are happy to share with our counterparts. It should also be highlighted that we expect our partners to learn a lot from one another during the course of the programme (as well as us learning from our partners) - so especially the more experienced EA NCDAs will also act as catalysts; partly through peer-to-peer exchanges.

Thus besides the catalytic effects provided by the programme related to shared learnings and research, we also see the programme as a catalyst for combining efforts between the individual diseases covered under the NCD umbrella, something that makes a lot of sense from a professional health perspective, as many of the challenges are similar especially concerning prevention. Moreover, we unite PLWNCDs and stakeholders across the diseases to form a common voice, improve the capacity to organise people for common activities. In organizing people, we create a forum to share new and innovative ideas across diseases and improve access for the individual person and disease stakeholders to key policy makers

### 2.2.6 The relevance and challenges of working as an alliance

Working in alliances is not a new phenomenon in the development landscape and networks/alliances are becoming increasingly prevalent. Donors are often turning to networks to deliver aid interventions. NGOs are working through networks for collective advocacy and researchers collaborate across networks for greater policy influence[[47]](#footnote-47). Networks/alliances provide an effective mechanism for learning and innovation and enable collaboration beyond the usual institutional, cultural and functional boundaries; but they come with their own costs and risks[[48]](#footnote-48). It complicates matters when many partners are to agree on goals, causes, directions and not least how to get there. A classical argument is that because networks do not have a centralized leadership structure and clear lines of authority, they have real difficulties reaching consensus and setting goals. Alliances are also accused of causing unnecessary delays (reaching consensus takes time) and to have high transaction costs. However, we remain convinced that we have chosen the right way of organizing ourselves[[49]](#footnote-49). It should be underlined that we are still learning and cannot rule out adjustments to our structure. But for now we work as an alliance with more importance planned to gradually be moved to the umbrella organization the East Africa NCD Alliance as described above. This has been a consensus decision among the Alliance members - so it is not controversial. Advocacy is our main focus area and being several organizations together supports this task tremendously - an alliance structure also allows us to learn from one another in a way a more vertical hierarchal structure with fewer members would not do. However, we are well aware that in Alliances with many members’ occasional conflict is unavoidable (either between individual alliance members within the partner countries or between the national alliances, including cultural clashes). The best way to prevent conflict is - not surprisingly conflict prevention. Clarity on strategy, structure and procedures reduces conflict potential[[50]](#footnote-50). For an Alliance to remain relevant and vibrant, you need to maintain the best possible engagement of all participants[[51]](#footnote-51) (ref. to Assessment note recommendation 6).

## 2.3 Strategy and partner priorities

Prior to 2015 there was no mentioning of NCDs in any Global Development Framework. The Global NCD Alliance’s first task, and the main reason for its establishment, was to try to ensure that NCDs got included in the SDGs. As we are now well aware, they succeeded. Since then all NCD Alliances (Global, Regional and National) have linked their visions, goals and targets closely to the SDG’s and the SDG agenda. Fighting NCDs require a multi sectoral approach, which is why there is a clear link between NCDs and many of the SDGs (elaborated on below). Almost all NCD Alliances (including the Danish NCD Alliance and the EANCDA) have closely linked their respective strategies to the Global NCDA strategic plan 2016-2020 (see annex 3.2b) and this can be considered the overall Alliance strategic plan.

The proposed programme is well aligned with the strategies of our partners. Our overall ToC goal “to make Non Communicable Diseases prevention and control a development priority in East Africa” is the vision in the EANCDA strategic plan (see annex 3.4). Our ToC long-term impact goal is SDG target 3.4. which is one of 3 goals mentioned in the DNCDA strategic plan (see annex 3.2a). Also the underlying core values of the programme are closely in tune with our and our partners values. The 4 main values mentioned in the EANCDA strategic plan are: People and human rights centred, Strategic Partnerships, Transparency and accountability, Objectivity and independence.

The programme is also well in tune with the latest Danish development strategy “The World 2030” since its fulcrum is the SDG’s. Specifically our programme links up well with “The World 2030” strategic objective 4: “Freedom and development - democracy, human rights and gender equality” and equally important the “The World 2030” key focus on youth engagement. The latter also being one of our specific focus areas. Overall our strategic approach is rooted in the development triangle (see chapter 3.2.1 for further details).

### 2.3.1 NCDs and SDGs

The adoption of the 2030 Agenda for Sustainable Development in September 2015 was a landmark moment for the NCD community. This was the first time NCDs were included in a global development framework with dedicated targets to measure progress, providing an important platform for the NCD community to further consolidate NCDs as a development issue. Thanks to this, governments are now in consensus that NCDs are a poverty, inequality, and social justice issue[[52]](#footnote-52), allowing civil society to use them as a strategic platform for advocacy and to hold governments to account.

SDG 3 looks at ensuring healthy lives and promote well-being for all at all ages. This goal is particularly relevant - progress has been made in improving the health of millions of people, but many challenges still persist, including the need to increase life expectancy, reduce maternal and child mortality and fight against NCDs. Hence, this SDG specifically includes NCDs and its risk factors in three of its targets[[53]](#footnote-53):

* **3.4 -** By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being
* **3.5 -** Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol
* **3.A -** Strengthen the implementation of the World Health Organization Framework Convention on Tobacco Control in all countries, as appropriate.

SDG 3 also includes a series of targets that relate to NCDs, specifically target 3.7, which looks at achieving universal health coverage (UHC) and access to affordable essential medicines, which are particularly important for LMICs. Other targets look at reducing deaths due to air pollution (target 3.9), and to support research and development of vaccines and medicines for both communicable and non-communicable diseases (target 3.B).

There are also critical linkages between NCDs and other SDGs, and the achievement of the NCD targets demands action well beyond the health sector. We therefore call for an integrated and multisectoral approach, to address NCDs and their risk factors, and their underlying social and commercial determinants, especially in sectors as broad as agriculture, urban planning, energy, trade and education. We simply cannot reach SDG 3, and specifically target 3.4, without acknowledging that an integrated approach that guarantees synergies and coherence across economic, social and environmental policy areas to promote health. In annex 3.5 we have highlighted some of the most important SDGs closely interlinked with NCDs[[54]](#footnote-54) [[55]](#footnote-55):

Getting a specific SDG target has undoubtedly and considerably raised the profile of NCDs, their risk factors and their determinants at both global and national levels. These targets have contributed to committing national governments, donors and the international community to the NCD effort. However, donors and finances are still absent[[56]](#footnote-56) and preliminary analysis have stated that the planned reduction of NCDs is not attainable with the current level of funding and pace of implementation.

Besides the link between NCDs and SDGs as described above and in the annex (3.5), the intervention is not only linked to the SDGs through the NCDs, but also through the mode of intervention, especially related to SDG goal 16 and 17.

**Goal 16 Peace, justice and institutions** - Having a zero-tolerance policy towards corruption, and by investing in substantive good governance training of our partners we contribute to the reduction of corruption in our intervention countries. Moreover, we contribute to the promotion of inclusive decision-making and accountability of public institutions, by promoting the involvement of PLWNCDs in decision-making, and by holding governments and other public intuitions accountable through the promotion of a civil society to do so.

**Goal 17 Partnership for the goals** - Through training in resource mobilization and actual resource mobilization, both in north and south for capacity building of patient organizations, we promote mobilization of resources for developing countries and capacity building within these. We also promote increased South-South and North-South cooperation by facilitating knowledge sharing and meetings between our member organizations in north and partners in south and between our partners in south. Promoting capacity building for data collection, we do also build the ability of our partners, and national/regional East African institutions to collect reliable data following best international practice.

## 2.4 Lessons learned and results

### 2.4.1 Lessons learned

Since the establishment of DNCDA and during the 23 projects granted to us by CISU, various lessons have been learned. The main of which will be outlined below.

**Learning 1:** Unity makes strength. We have been confirmed in our initial idea that PLWNCDs are the best NCD advocates, not least because of their lived experience with their condition, giving them a unique insight into what currently works within the health system but equally important what does not, and what would they have benefitted from had it been offered (both in terms of prevention and care). Bringing PLWNCDs together have several advantages. From an overall advocacy perspective unity does create a much stronger voice and the different NCD Alliances have (although to different degrees) been able to firmly put NCDs on the map in their respective countries. All health ministers and people working within the health sector are now well aware that the fight against NCDs is a fight against time. We need also to broaden our advocacy work - to include other sectors/duty-bearers and not least to convince the ministers of finance that NCD prevention is good business. On an individual level bringing PLWNCDs together creates a safe space for them. Seeing that you are not alone and that your story matters empowers the individual.

**Learning 2:** The organizational foundation is key.Building strong and healthy CSO’s in East Africa takes time - partly because governments on purpose makes the registration processes very bureaucratic and cumbersome. The organizational and institutional structures of our partners simply needs to be in place and is a prerequisite for us to move towards our overall development target and for our partners to benefit from being part of the programme. During the projects, capacity building has been a main priority of ours and will continue to be so. We have come a long way in terms of building the capacity of our partner organizations, but continuous efforts are crucial in order to increase the sustainability of our work.

**Learning 3:** Financial management is key. We have experienced two cases of financial mismanagement and while it was very unfortunate, it did teach us a great deal about what systems that needs to be in place and the level of monitoring necessary to minimize, to the extent possible, the risk of anything similar happening in the future. We are fortunate that we have a highly professional finance department at the Danish Cancer Society that have since supported us in setting up new (and according to CISU efficient and user friendly) financial systems. All projects have received regular visits from DSCs financial management experts - providing guidance and support but also checking that things were in order. A further professionalization of our financial management systems will remain a priority - as we operate in countries were corruption (unfortunately) is epidemic.

**Learning 4:** Outcome based M&E is a work in progress. We have managed to improve our narrative reporting over the last years, however, the transition from activity based to outcome based reporting is not easy and will require time. It will be a steep learning curve for us but even more so for our partners. The East African educational system is not, to the same extent as our, based on asking questions but more on traditional “list what you have read” text book learning. Thus the change from strictly activity based reporting to more outcome based reporting requires also shift in mindset. We hope and expect that our chosen M&E methods “outcome harvesting” will facilitate this process and a longer term perspective as the programme provides is a blessing in this regard. For more details on M&E see section 3.5 (ref. to Assessment note recommendation 4).

**Learning 5:** Getting paying members and attracting local private sector NCD financing has proven more difficult than initially anticipated. We were probably a bit naive as we initially thought that we could (within a reasonably short time-frame) secure sustainability through individual membership fees. However, poverty combined with the fact that a membership culture simply does not yet exist in EA (not even football clubs can attract paying members) have made this a more long-term goal. We have had our biggest membership successes with people already somehow attached to the health sector and will continue to pursue this avenue further. Attracting local private sector funding has also proven difficult. Partly because the money is concentrated “on a few hands” only, partly because we will not accept funding from tobacco, alcohol or similar industries. Thus we have learned that we need to diversify our funding strategies further. We will continue to pursue financing opportunities - not least will we be looking into securing external funding for research projects together with academia. Together with partner universities, we will apply for both private and more traditional donor funding.

**Learning 6:** We have learned that a targeted information effort combined with screening provide a good platform to attract people, increase their knowledge and provide data for advocacy. Therefore, we will continue to pursue this strategy in the future. This entails building upon our efforts to establish NCD desks at the local health clinics at county level. It is our experience that the NCD desks provide a great way to reach a lot of citizens, not least in the rural areas, because there is a substantial flow of people coming through - especially women (antenatal care or giving birth).

**Learning 7:** Since establishing the EANCDA we have learned how big an advantage it is being a regional organization when having to organize events/kick in doors at international forums - such as the UN High Level meeting on NCDs and establishing contact to the EAC. We have also learned that peer-to-peer learnings are very well received. Admittedly, the learnings have mainly gone from the oldest and more established EA NCD alliances to the newest “kids on the block” - but the national alliances do bring something to the table that we cannot offer and, therefore, constitutes an excellent supplement to what DNCDA can provide in terms of skills.

**Learning 8:** We have learned that there is far from enough valid NCD Data in EA and that the data that we collect are crucial to our advocacy efforts because they provide more favorable prerequisite when presenting arguments for politicians. We have learned that to utilize the collected data in the best way possible and to obtain more valid data, research collaborations are very feasible. These collaborations consist both of collaboration within the East African region, but also with Danish partner universities. We will therefore develop these collaborations and relationships within the next four years to provide our partners with the best foundation and background for advocacy as possible.

**Learning 9:** We have learned that in order to secure sustainability it is crucial to cooperate closely with government at all levels. New actions such as NCD desks at local health clinics require government buy-in. We are constructively critical but not as controversial as other NGOs (promoting gay rights or similar) and thus we have easier access to policy makers than certain NGO colleagues - a fact we try to take advantage of. Often our partners have a very close relationship to civil servants in the health sector - who are often also frustrated about the fact that not enough money is allocated to the sector, its inefficiencies etc. and they more often than not welcome our input and sometimes clear our way to the policy makers. Government officials often change - so you need to broaden your advocacy work at all levels.

### 2.4.2 Learning and innovation of approaches

Due to the project nature and development status of our partners, the learning approach has been more entrepreneurial and less systematic, hence with more focus on testing new ideas and ways to improve the organisations. This approach has allowed the partner organisations to test ideas and develop basic organisational capacities - adapted to their local context and develop organically without being measured against and administratively burdened by a common learning scheme. The learnings captured in this entrepreneurial approach has formed the basis of our ToC and highlighted the difference and similarities of our partners in their development, formed by the local context.

Moving into a program modality, we see the development of a more structured learning scheme as a natural and necessary step in the continued development of our partners and our own capacities. A gradual transition from an entrepreneurial to a more structured focused and long-term approach reflects one of the overall transitions intended in the overall program strategy, and should thus be reflected in the learning approach.

As noted in the CapApp the Danish Cancer Society and the Danish Diabetes Association “offer substantial and extensive capacity to compile, analyse and apply data from a wide range of activities with the purpose of reviewing, updating and generating new approaches and strategies.” We intend to draw heavily on this capacity, when implementing a more structured learning scheme during the program.

A new learning scheme will be gradually implemented during the program (ref. to Assessment note recommendation 3), in order to progressively improve our partners’ capacity within this area, and to allow us time to test different methods, and shape the methodology and approach. The scheme will be based on learning questions related to the programme outcomes and incorporated in the monitoring and evaluation system. The form of the system will be further elaborated on in the monitoring and evaluation section (3.5).

# 3. PROGRAM OVERVIEW

## 3.1 Program aim and justification

In East Africa and other LMICs, NCDs exacerbate poverty and pose a major barrier to development, due to vicious cycles of low incomes, chronic ill health, and impoverishment caused by the cost of treatment. Underpinning these challenges, many health systems in LMICs are designed to respond to single episodes of care rather than chronic conditions such as NCDs - structural barriers that further exacerbate the burden placed on health workers and infrastructure, and limit the quality of services.

Already, one third of deaths in East Africa are attributable to NCDs, and NCDs are expected to become the biggest cause of death in the region in a few years, overtaking communicable diseases like HIV/AIDS and malaria. The mortality transition is expected to happen earlier than by 2030, as previously projected by the World Health Organization (WHO), if no radical action is taken.

We aim at making non-communicable diseases prevention and control a development priority in East Africa and have chosen SDG target 3.4. - “By 2030, reduce by one-third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being” - as our development goal.

PLWNCDs must be involved in all levels of decision-making. Their lived experience of managing their condition and navigating health services, gives them a unique insight. We will continue to strengthen the capacity of our civil society partners[[57]](#footnote-57) (the EA NCD Alliances) who in turn will organize groups of PLWNCDs - inform them about their rights, knowledge on how best to live with their condition and most importantly support them in their advocacy efforts towards duty bearers at all levels.

Governments must address health and NCDs as an investment, not perceive them as a burdensome cost. In order to do evidence based advocacy DNCDA and our alliance partners will increase our collaboration with academia both in Denmark but most notably in EA. NCD data is scarce in EA and improved NCD data collection is one important tool for getting governments to prioritize NCD prevention and care. Tools on how best to collect NCD information at health clinics and beyond will be developed and research projects concerning implications of living with NCDs and risk behaviour initiated.

Through our organisational structure with local branches, national alliances, a regional alliance and a global NCD alliance, we have a setup capable of working and transferring knowledge all the way from local level to global level, and the other way around. We aim at delivering local stories and reports from the East African countries at key global meetings[[58]](#footnote-58) while bringing back WHO/UN targets and decisions to pressure national governments. The programme will allow us to work more strategically and coordinated with the interaction between the different levels and in this way creating better synergies between them.

We believe an integrated and multi sectoral (and multi-disciplinary) approach is needed to address NCDs and their risk factors, and their underlying social and commercial determinants. It is, therefore, crucially important that Governments and NGOs are working closely together. The EA NCDAs have proved good at fostering partnerships - not least with government and a programme will only facilitate this process further (SDG 17, see also chapter 2.3.1 for additional details on NCDs and the linkages to SDGs).

We aim at developing the capacity in NCD Alliances in East Africa to be sustainable and independent alliances with the ability to mobilize adequate and sustainable financial and human resources for NCD prevention and control and to effectively influence NCD prevention and control policies at all political levels.

## 3.2 Intervention logic (Theory of Change)

The ToC for the prevention and control of NCDs is presented annex 3.1. The ToC logic is described in two sections below, with section 3.2.1 describing the overall logic between the strategic interventions and the overall objective of the program, and section 3.2.2 for each strategic intervention describing the pathway of the program (ref. to Assessment note recommendation 7-8).

### 3.2.1 The strategic interventions and their logic

As described in section 1.2, it is recognized globally that development of NCDs are a challenge both for societies and for the individual PLWNCDs and that the prevalence of NCDs in LMICs is increasingly becoming a problem. To make NCD prevention and control a priority in East Africa is therefore important, and NCD Alliances representing PLWNCDs are well placed to engage in this. Making NCD prevention and control a development priority is therefore the focus of this program.

The overall logic of the program is that in order to make NCD prevention and control a priority in East Africa, and to reduce by one third premature mortality from NCDs through prevention and treatment and promote mental health and well-being (SDG Target 3.4) governments in East Africa need to understand the importance and long-term gains for individuals and societies as a whole from NCD prevention and control. In this way, Governments will also adhere to their commitments from signing declarations on human rights and the Abuja declaration on health.

For Governments to give priority to NCD prevention and control, evidence based advocacy is required and therefore forms an important part of the program (SI 1). The NCD Alliances representing PLWNCDs are in a strong position to influence Governments in this regard, but also recognize that engagement of other stakeholders including academia, UN and in particular WHO, and back donors is required. NCDs are cross cutting and prevention of NCDs encompass health measures, healthy living, traffic and pollution control, environmental health, etc and advocacy toward Governments should therefore not be restricted to the Ministries of Health.

The EAC plays an important role in the region as a forum for discussion of development priorities and cross regional issues. The EAC therefore provides an opportunity for influencing National Governments to address NCD prevention and control. The EAC already identifies NCD as a focal area and has the ambition to strengthening promotive, preventive, curative and rehabilitative health services for NCDs. Ensuring that the EAC gives further priority to NCD prevention and control is therefore seen as a cost effective way of advocating towards National Governments, and this therefore forms part of the program as SI 2.

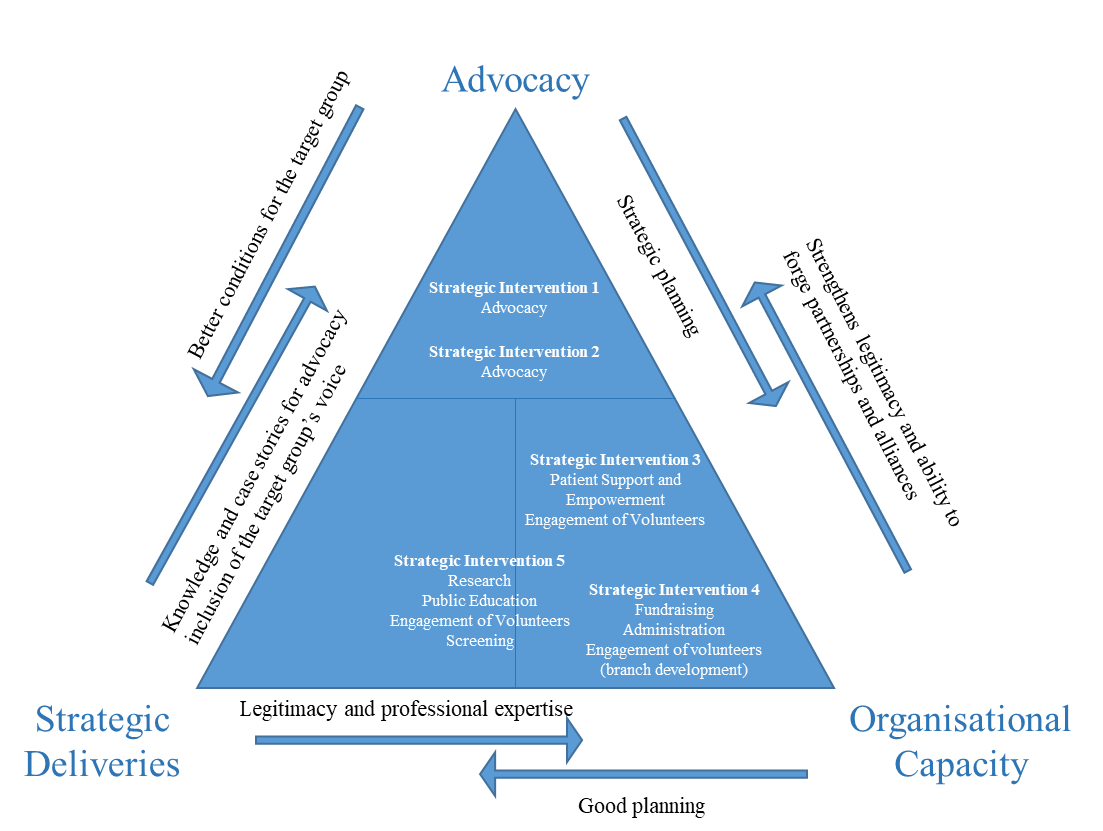
PLWNCDs are the best advocates for their own rights and have the right to participate and speak their rights and concerns towards Governments as established by the principles of participation accountability, non-discrimination and transparency (PANT). However, for the PLWNCDs to influence Governments, they need to be organized and have capacity to engage with local and national authorities as well as with academia and the press. NCDs affects both rich and poor and PLWNCDs include marginalized groups. NCDs influence women and men differently, with women in most cases being both care-giver and being susceptible to NCDs themselves. PLWNCDs being organized in inclusive PLWNCD groups will allow PLWNCD to hold Governments accountable and ensure that NCD policies and strategies are relevant to the needs of PLWNCDs. The program will therefore support the establishment of effective networks of PLWNCDs (more on this in section 3.3 target groups). Youth are at risk of attracting NCDs and behavioural change while young is important for NCD prevention. Youth are also in a good position to influence Government, and therefore organizing youth to advocate and act as change agents is important also for NCD prevention and control. Support to inclusive groups of PLWNCDs and to youth groups forms part of the program as SI 3.

In East Africa little documentation is available on the spread of, the costs of and the consequences for individuals living with NCDs. An important step making evidence-based advocacy possible is therefore to promote research and surveys on the impact of NCDs on individuals and society. The program will support dialogue with academia and strategic service delivery in the form of screenings and training of health personnel in health clinics under SI 5. Thereby, the program will also promote that NCD expertise is available at health clinics to increase outreach.

As mentioned above, NCD alliances are well placed to support and advocate for the rights of PLWNCDs. To do this, however, the NCD Alliances need to be recognised as trustworthy and effective organizations with robust organizational structures, governance and management systems. To ensure the sustainability of the Alliance, they also need to increase their resource mobilization from memberships, and external sources including the private sector, governments and external donors. And finally to be recognized as representing PLWNCDs, the NCD Alliances need to develop a national presence which is not only confined to the capital cities but also includes branches in other regions.

As previously described, NCD Alliances in East Africa are relatively young organizations and the program will therefore continue to support the individual alliances and the East Africa Alliance in developing their organizational capacity further (SI 4).

The synergy between the strategic interventions are depicted in the development triangle (ref. criteria 7) below which shows how empowerment of PLWNCD groups and organizational capacity development of NCD Alliances will allow NCD Alliances to engage with Governments and academia to promote that stronger evidence is established for the relevance and importance of NCD prevention and control. Based on the evidence on NCD implications, costs and ways of prevention and control, stronger NCD Alliances and groups of PLWNCDs will together with academia, Civil Society and International Organisations be able to influence Government through advocacy to make NCD prevention and control a development priority in East Africa.



The program builds on three key assumptions. Sufficient space for civil society to exercise their rights is a precondition for NCD Alliances to act and influence Governments to recognise its obligations. In East Africa civil society do in general have the freedom to be organised and speak their rights, but there are also indications of the fact that Civil Societies’ space is shrinking, also in East Africa, especially for those CSO’s fighting for the rights of minority groups facing restrictions. The space for Civil Society allowing PLWNCDs to be organised and advocate for their rights is therefore important for NCD Alliances to be able to influence Governments. Secondly, it is assumed that the security situation remains stable. This is in particular important in Burundi as a fragile context, but also areas in Kenya and Uganda experience instability with restricted access. Thirdly, it is assumed that no new diseases with instant high death tolls occur. If for instance the Ebola outbreak in DR Congo spreads into Uganda and Rwanda, national health authorities and the EAC will focus all resources on controlling the Ebola outbreak, and it will be difficult to convince Governments to give priority to NCDs also.

### 3.2.2 The program pathway for change

This section elaborates the pathway for change underpinning the Theory of Change (ToC). For each Strategic Intervention, the pathway is elaborated and the actual contributions of the program and the NCD Alliances are stated. Furthermore, each strategic intervention will have a (sub-) assumption attached with further assumptions elaborated in the narrative (ref criteria 7-8). The graphic presentation of the pathways for the Strategic Interventions leading to the predicted outcomes (casual chain) are attached (as annex 3.7).

Governments have committed to prevent and control NCDs by signing the SDG agreement. Advocacy for prevention and control of NCDs is therefore not controversial as such and as established in section 1.2 there are a number of economic gains from preventing and controlling NCDs. Advocating for better prevention and control of NCDs is therefore a question of Governments’ internalising the importance of NCD prevention and control and act accordingly. At the same time however, PLWNCDs do experience stigmatisation and marginalisation and overcoming stigmatisation working with the rights of PLWNCDs and the participation, accountability, non-discrimination and transparency (PANT) principles should therefore form part of the advocacy (ref. criteria 9). A number of stakeholders are engaging and have the possibility to influence Governments in this regard. Internationally the SDGs provide an important leverage for Government understanding and commitment to the prevention of NCDs, but engagement of international organizations, civil society and back donors also positively influence Government decisions. The NCD alliances representing PLWNCDs are in a strong position to influence Governments, but the Alliances also recognize the engagement of many other stakeholders including academia, UN and in particular WHO, in this regard. As in other contexts, the tobacco and food industry also have strong lobbies in East Africa already influencing Governments. It is an assumption that the negative effect of this lobbying will not be augmented.

In the program, the NCD Alliances will revise their advocacy strategies including a peer review process. The peer review will ensure that the advocacy strategies build on best practices from East Africa and Internationally. The NDC Alliance in Denmark and the Global NCD Alliance will form part of the peer review process. As part of the strategy development process, NCD Alliances will also identify other Civil Society Organisations with similar interests in advocating for NCD prevention and control with whom the NCD Alliances can team up.

The East Africa NCD Alliance together with the Danish and the Global NCD Alliance will compile existing data on NCDs in East Africa as evidence for the NCD Alliances advocacy. The secondary data will be supplemented with data from research, screenings and learnings from interviews with PLWNCDs (SI 5). The NCD Alliances will present the evidence to staff in line Ministries to persuade the technical staff to make decision makers prioritise NCD prevention and halt the invisible NCD epidemic including promoting the WHO best buys. The program builds on the assumption that technical staff can convince decision makers to give priority to NCD prevention and control if able to present convincing evidence for this.

To supplement and improve pressure on national government DNCDA will supported by Global NCD Alliance participate in a number of global events, to use these fora as a mode to influence the East African governments and to inform our partners and us about latest international trends. The global advocacy effort will be guided by the Global NCD Alliance strategy (see annex 3.2b) and amongst others include participation in World Health Assembly, the third Global NCD Alliance forum (on which DNCDA is a member of the planning committee) amongst others. For the global advocacy effort, an advocacy package with local East Africa NCD stories and latest NCD data for East Africa will be developed to improve the quality of this effort. This effort builds on the assumption that international forums can be used to apply pressure on national governments.

As mentioned, the EAC already has a focus on NCDs and provides a forum which can influence National Governments to give priority to NCD prevention and control. The EAC also provides opportunities for peer to peer engagement between National Governments. The EAC has established a desk function for NCD prevention in its Health Secretariat, however the position is currently not filled and in practice the EAC gives little priority to NCDs. The assumption in the ToC is that if technical staff are in place who have knowledge and capacity to communicate on NCD prevention and control with politicians, the EAC Secretariat can inform East African politicians of the importance of NCD prevention and control also from an economic perspective. Similarly, it is assumed that the Health Secretariat is in a position to engage technical staff from other Secretariats relevant for NCD prevention and control, i.e. infrastructure, environment and agriculture. Different stakeholders do already influence the East Africa Community, including the press, Civil Society Organizations, WHO and back donors, and the NCD Alliances representing PLWNCDs.

In the program, the East Africa NCD Alliance will engage with the EAC Secretariats and will invite other relevant stakeholders for a joint meeting to advocate for the importance of the EAC to prioritizing NCD prevention and control. The East Africa NCD Alliance will establish a MoU with the EAC Secretariat for Health as the basis for future dialogue between the EAC, the East Africa NCD Alliance and stakeholders engaged in NCD prevention and control. The dialogue is already initiated and the assumption is that the EAC Health Secretariat is committed to prioritising NCD prevention and control. As a result of the dialogue and the general recognition of the implications of NCDs, the Secretarial will commit to put NCDs on the EAC Health Secretariat meetings and that the post as NCD Focal person will be filled. A critical assumption in this regard is that there will be no new major outbreaks of communicable diseases, i.e. ebola, which will take up all resources of the Health Secretariat. As part of the program, the East Africa NCD Alliance will together with the EAC organize a technical stakeholder meeting with the aim of discussing the need and practical steps required for prioritization of NCD in EAC, and that stakeholders agree to appoint and fund a multi sectoral working group to develop position papers for the Council of Ministers of Health. The NCD Alliances will participate as technical experts in developing the position papers. It is assumed that costs of EAC and stakeholder participation in developing the position paper will be covered by the individual organisations or from external funding with a smaller contribution from the program, only. When the multisectoral working group has developed a position paper, this will be presented and discussed initially by the Council of Ministers of Health and subsequently other Ministerial Councils. Eventually the plan is that recommendations from the position paper can be presented and discussed at the Heads of States summit latest in 2022.

As mentioned above, PLWNCDs are the best advocates for their own rights and have the right to participate and speak their rights and concerns towards Governments. However, for the PLWNCDs to influence Governments, they need to understand NCDs and the policies for prevention and control of them, and they need to be organized and have capacity to engage with Local and National Authorities as well as with academia and the press. With the pathway of change for SI 3, the NCD Alliances will help PLWNCDs organize themselves to increase the knowledge amongst PLWNCDs about policies and rights, and to advocate towards Governments for their rights to participate and be heard. Experience of PLWHIV/Aids groups with advocacy and overcoming stigma can provide important learnings in this regard. The pathway of change builds on the assumption that PLWNCDs know about the NCD alliances, and recognize the Alliances as their representatives with a mandate to support PLWNCDs and promoting their rights. When organized in networks and groups, PLWNCDs can engage local politicians and local authorities to provide support for prevention and control of NCDs and they can engage against discrimination and stigmatization. The logic is based on the assumption that Local Authorities are willing to listen to PLWNCD groups and are receptive to the evidence based advocacy from these groups, not the least because members of NCD Alliances also include NCD experts.

NCDs are developed by the wealthy as well as the poor and NCDs influence women and men differently, with women being at risk of attracting NCDs and at the same time being the main care taker of PLWNCDs. Reaching out to marginalised people, women and men might also require different strategies. It is therefor important that the NCD Alliances are inclusive and have policies of non-discrimination and gender equality and are able to reach out also to marginalized, women and young PLWNCD. This is also supported under SI 4 and 5.

Young people may develop NCDs in the future, and is as such a risk group which needs to be informed and engaged to prevent further negative developments of NCDs. An easy and cost effective way of reaching the youth is through the school system. This requires that curriculum in schools allow for inclusion of NCDs or that schools can initiate after school activities providing information on NCD prevention and control.

In the program, the NCD Alliances will identify existing groups of PLWNCDs and NCD Alliances and their branches will provide information to groups on how to prevent and control NCDs and will inform groups of existing policies, rights and opportunities. The individual NCD Alliances have a good understanding of existing groups but a scan will be undertaken to identify more groups and possibilities for establishing emerging groups. The NCD Alliances will discuss with the groups how to include marginalized PLWNCDs and how to address the needs of both male and female PLWNCDs.

The NCD Alliances will also help PLWNCD groups in developing advocacy messages and information campaigns. The capacity of the NCD Alliance’s branches to undertake these actions will be developed as part of SI 4.

The program will specifically target youth though school based initiatives The assumption is that youth will act as agents of change towards their families and amongst peers and will advocate for the rights of PLWNCDs towards local government. The program will benefit from the educational materials developed by Global NCD Alliance “Our views, our voices campaign, which will be attempted introduced in schools.

It is assumed that with support from the NCD Alliances and with knowledge about policies and strategies for NCD preventions and control, PLWNCD and youth groups will actively engage local duty bearers addressing stigma and discrimination and not least the rights of PLWNCDs to participate in policy decision-making processes that affect their lives.

As mentioned above, the NCD Alliances need to be recognised as trustworthy and effective organization with robust organizational structures, governance and management systems for PLWNCDs to recognise the Alliances as their representatives.

The Alliances also need to be able to reach out to PLWNCDs across the countries and therefore need to have representations in more places than just the capital cities. The NCD Alliances already have established branch structures, but will aim at strengthening these. Attracting new members and retaining existing is a prerequisite for the continued positive development of the Alliances. Democratic governance ensuring inclusion and non-discrimination, accountability and transparency is a requirement for the Alliances being recognized as representing PLWNCDs. A strength of the Alliances is their participation in the Global NCD Alliance and their collaboration regionally which allow the Alliances to learn from international experience and sharing of experience regionally.

Finally, NCD Alliances need to have funding available to ensure continuity in their actions. The assumption is that external donors and the private sector will be willing to support the NCD Alliances considering the growing recognition of the impact of NCDs and since the private sector see the implications of NCDs in their work force. However, to attract external funding potential donors and private sector organizations needs to trust that the Alliances have robust system in place for fund management. Alliances are still young organisations and as earlier reported, there have been cases of mismanagement in Alliances. Thus financial management will be maintained as an important activity.

With the program, the NCD Alliances will review the capacity of the individual NCD Alliances, processes and procedures in place. In previous projects, some initiatives have been taken to develop the capacity of the individual Alliances, and for the Alliances to develop further, it is important to maintain organisational developments already made, and to develop capacities further. Furthermore, it is important to acknowledge that the Alliances differs and have different organisational strengths and weaknesses. The review of existing capacities will determine which concrete actions in support of organisational capacity development, the program will support. Focus will be on Governance, branch development and volunteer management, resource mobilisation and programme management. Strong and democratic governance structures and a branch network with active volunteers are preconditions for PLWNCDs to acknowledge NCD Alliances as their representatives. Resource Mobilisation is a precondition for the sustainability of the Alliances and having proper program management systems is a condition for attracting funding from external sources. The program will ensure peer learning through vitual dialogues and at the planned annual meetings. The organisational development will also be supported by monitoring visits from the Danish NCD Alliance. The pathway of change builds on the assumption that NCD Alliances can retain volunteers comprising their Governance as well at their program managers.

Evidence which can support advocacy towards Governments on NCD prevention is as mentioned previously scarce in East Africa. An important step making evidence based advocacy possible is therefore, to promote research and surveys on the impact of NCDs on individuals. To enhance research and analysis of NCDs Universities will need to give priority to research projects on NCDs and external funding will need to be available in support of the universities. Secondly, the health system will need to have capacity to engage in data collection for NCD research, having trained staff to monitor blood sugar levels etc., but also to promote healthy living to prevent NCDs. PLWNCDs will need to understand why data is compiled and to give their consent for their data to be used for research.

As part of the program, the EANCDA will compile existing research in East Africa undertaken by stakeholders in Denmark and East Africa and the Alliance will identify a few key partners with whom to collaborate directly. The DNCDA will sign a MoU with Århus University regarding research on NCDs. Together with key partners, the NCD Alliances and PLWNCDs will identify specific research projects to be developed further. Program funding will facilitate selected screenings for NCDs. The program does not allow for support to research projects, as such, but the NCD Alliances will together with partners from Universities apply for external funding, i.e. from Novo Nordisk Foundation or the World Diabetes Foundation. It is assumed that by raising awareness and creating information through screening campaigns, academia which is collaborating with the EA NCD Alliances will be able to attract funding from other sources. It is also assumed that researchers will welcome the collaboration with the NCD Alliances and allow the Alliances to use the research results.

NCD Alliances will also work with selected local health authorities to establish NCD desks[[59]](#footnote-59) at selected health clinics and NCD Alliance branches will conduct local campaigns promoting testing for NCDs. Data compiled from the screenings[[60]](#footnote-60) will provide evidence about implications of living with NCDs and inform about risk behaviour. The NCD Alliances recognize that screenings at health clinics or as part of campaigns will not inform about the prevalence of NCDs, as the samples will still be rather small and there will be a bias towards people having symptoms of NCDs being more interested in screenings.

## 3.3 Target groups

As with our previous projects, our programme will be targeting several different groups. Below we will concentrate on our main target groups namely people living with NCDs (PLWNCDs), youth and women (who have been identified as the most vulnerable at our screening/information campaigns) (ref. to Assessment note recommendation 9). Other secondary target groups will be described, but less space is devoted to them. Initially, we will outline why we have chosen a human rights approach to permeate our programmatic work.

### 3.3.1 A Human Rights Approach to Non-Communicable Diseases

Promoting poverty reduction has been the Danida fulcrum for decades. Since 2012, poverty reduction has also been closely linked to human rights and a human rights based approach (HRBA) to development[[61]](#footnote-61). The latest Danish Development Cooperation Strategy (2017) focused on the Sustainable Development Goals (SDGs), and retained the commitment to the HRBA. Human rights and NCDs are, seen from our perspective, integrated and indivisible.

A glance at major international declarations and treaties about NCDs reveals that ‘human rights’ are a fundamental overarching principle, namely within the Global Action Plan on NCDs 2013–20, the Political Declaration from the 2011 UN High-level Meeting, and the SDGs.

When discussing Human Rights and Health most references are made to the International Covenant on Economic, Social and Cultural Rights (ICESCR) that in article 12.1 recognises “the right of everyone to the enjoyment of the highest attainable standard of physical and mental health”[[62]](#footnote-62). It does not - and cannot - imply a right to be healthy. The treaties acknowledge that not all countries can offer this immediately to all; however, the maximum available resources must be offered without discrimination.

Under international human rights law, the government is the prime duty-bearer; it is under an obligation to promote and protect human rights across all sectors. Within government, in the context of NCDs, specific duty-bearers identified will range across many sectors such as agriculture, finance, taxation, education and transport. Just to underline what has been mentioned previously - that combating NCDs require a multi-sectoral approach. In addition, beyond the government there are a range of other duty-bearers that can be identified to have specific responsibilities. These may range from family members to multinational corporations and donors. In the area of NCDs, moreover, the private sector plays a significant role. However, since the private sector is not homogenous, diligent attention ought to be paid for any real or perceived conflicts of industry, especially when speaking about the unhealthy commodities industries.

Overall, integrating a HRBA to the efforts of addressing NCDs means that the realisation of health-related human rights becomes the central goal of these efforts, and that human rights principles should guide all actions towards this goal. In conclusion, a HRBA supports action to build the capacity of rights-holders to claim their rights, and duty-bearers to meet their obligations. Since bringing together PLWNCDs for advocacy purposes is our main *raison d’être,* trying to promote a HRBA is logical, but admittedly not necessarily easy to perform in practice. Put simply, it is not always straightforward for right-holders to knock the doors of the duty-bearers in rural Africa.

Human rights must be applied without discrimination - which means in practice that realizing rights will require a focus on the most vulnerable in society, who are less likely to have their rights upheld. This will from our perspective include but not be limited to PLWNCDs, youth and women. We must all be able to participate in and claim our rights and governments cannot cherry-pick which to uphold (PANT). There is a general agreement among key stakeholders that there are two main rationales for using a human rights approach to address NCDs. The intrinsic rationale, acknowledging that a human rights-based approach is the right thing to do, morally and/or legally; and the instrumental rationale, recognizing that a HRBA leads to better and more sustainable human development outcomes[[63]](#footnote-63).

### 3.3.2 People living with NCDs (PLWNCDs)

The primary target group for the programme are people living with NCDs (PLWNCDs), which is closely linked to especially strategic intervention no. 3. This group of people are the ones directly affected by NCDs, and our advocacy will ultimately seek to change their lives by ensuring that fewer people die prematurely from NCDs and preventing as many people as possible from getting a NCD in the first place.

The meaningful involvement of PLWNCDs is a critical element of an effective NCD response. From policymaking to awareness raising, clinical trials, academic research, advocacy, organizational governance and more, PLWNCDs can contribute to many different facets of the NCD response and act as change agents breaking barriers to inclusion. Promoting meaningful involvement requires recognition of the group’s importance by creating dedicated spaces for involvement in policy-making. Effectively addressing NCDs also requires understanding of how these diseases affect people disproportionately and the challenges and needs that people face as they navigate through healthcare systems and daily life. First-hand knowledge of NCDs is essential to improving policies, services, programmes as well as social beliefs.

Meaningful involvement avoids tokenism by building a reciprocal relationship with people, ensuring that they also benefit from the experience of being engaged and become role models to strengthen meaningful involvement. It is not prescriptive and can take place at different levels, from participation to collaboration and co-production (the three pillars of what the NCD Alliance identifies as the ladder of meaningful involvement), which are applicable across a wide range of different sectors and activities[[64]](#footnote-64).

We want to not only address behavioural factors, but also to dig deeper and address the underlying root causes for NCDs because we believe that combatting these will mean a positive change on the behavioural risk factors as well. This entails building upon the foundation already made during our projects and increase awareness and educate people on NCDs and risk factors. It furthermore entails developing their capacity in terms of advocacy work and strengthening their ability to speak up and draw attention to the central issue, which is their health. Governments must ensure provision of NCD services from prevention to rehabilitation, which are both accessible and affordable to citizens.

We encourage the people in the local organisations and societies to take ownership of the interventions, and thus we aim at anchoring the interventions in local societies to ensure that long-term change takes place. Finally, yet importantly, we want to create a safe space for discussing the NCD challenges with like-minded, often people suffering from the same diseases and/or caregivers facing similar challenges[[65]](#footnote-65). As per the Result Framework, we aim at establishing at least 79 new PLWNCDs groups during the programme.

### 3.3.3 Women and the most vulnerable/the poor

In order to drive forward progress on both NCDs and the achievement of the SDGs, a gender sensitive lens must be applied to health services delivery. We know that women and girls face multiple barriers in seeking health services; and that gender equality and equity, both components of basic human rights, remain a lofty goal for the majority of women and girls around the world. In many LMICs, underlying determinants such as traditional gender roles, illiteracy and low socioeconomic and political status limit the ability of women to protect themselves from NCDs and seek essential services and care. Women in settings constrained by poverty, limited health infrastructure, and human-resource capacity, are far less likely than women in high-resource settings to access timely, adequate, or affordable diagnosis and care[[66]](#footnote-66). Many female-specific conditions - such as breast and cervical cancer - carry a stigma, which acts as a barrier to detection and treatment. As a result, many NCDs are often detected at a late stage, increasing the likelihood of premature death.

We must also be mindful of the strong, reciprocal links between NCDs and poverty. Disadvantaged communities are at greatest risk of experiencing chronic conditions and poor outcomes. Women are often unable to participate in the formal economy[[67]](#footnote-67)and access social benefits, further increasing women’s impoverishment. Furthermore, women are often the sole caregivers for other members of their family who are living with an NCD.

Primary healthcare and health services can play an essential role in promoting low-cost and accessible prevention and treatment to marginalised women and girls; which are often the last to receive care and health information. Our programme will continue to have a strong focus on women and the most vulnerable. We aim at, in close coordination with the authorities, to establish a NCD help desk at primary clinics as close to the users as possible. To put it simply, the further out of the capital city you get, the closer you get to the most vulnerable, often being women and girls. Also we will continue our information and screening activities normally frequented mainly by females. Our work trying to move women out of the disproportionate risk relationship, empower them to speak for themselves and make them agents of change in their local communities has also been a strong focus in our current NCD and reproductive health projects in Tanzania and Zanzibar. Women living with NCDs and schoolgirls are targeted and educated on healthy living, motherhood and advocacy in order to make them future advocates for awareness creation about NCDs in reproductive health.

During the course of the program we aim at screening and/or supporting screening of 525.000 people (vast majority women) at outreaches and newly established NCD desks at health clinics and engaging more than 1000 new volunteers. Community health workers (CHW) have traditionally focused on reproductive, maternal, newborn and child health services and in many contexts they act as links between communities and health systems. With the growing burden of NCDs, and shortages of trained nurses, community health workers are increasingly being tasked with conducting screening, treatment adherence and follow up for common NCDs as members of multidisciplinary teams. While there are many benefits to this expansion of their skill sets and knowledge, there is an urgent need also for additional training and access to supplies etc. It is vital that CHW are recognized as active change agents, and involved in decision-making at every level.

### 3.3.4 Youth

An important sub-target are young people and especially girls. It is scientifically well documented that youth and adolescence is a crucial time for establishing healthy life habits. Young people are therefore an important focus in our preventive efforts in order for them to become change agents and advocates for their right to health and well-being. In East Africa NCD prevention is key as it is highly unrealistic that treatment will reach anything near satisfactory levels any day soon.

Two thirds of premature deaths in adults are associated with childhood condition and behaviours, and behaviour associated with NCD risk factors is common in young people. More than 150 million young people smoke, 81% adolescents do not get enough physical activity[[68]](#footnote-68), 41 million children under 5 years old are overweight or obese – and in every given year about 20% of adolescents will experience a mental health problem – most commonly depression or anxiety to mention just some figures. Apathy to change current behaviours will add to the current NCD burden, with severe consequences for future populations and their health systems. Youth will bear the brunt of future NCD costs, both financially and personally and youth everywhere therefore have a vested interest in NCD prevention.

In addition, young people are often targeted by companies advertising unhealthy food, tobacco or alcohol use, and many grow up today in environments that are not favourable to adopting healthy lifestyles, such as participating in sports and a balanced, healthy diet. This is particularly in low- and middle-income countries.

The youth population is, luckily, a resourceful group to be prioritised for meaningful and inclusive engagement. Compared to previous generations young citizens are more empowered and enthused to participate in shaping their everyday lives, including health. Investment in and celebration of the optimism, enthusiasm and skills they bring to the table should be utilized. Complementary to the technical expertise that older generations’ might offer, the voices of youth may offer new perspectives as well as new media channels (not least new social media avenues) and solutions to NCDs. Today’s youth generation are the people who will drive forward the SDGs and transform our societies for the future we want[[69]](#footnote-69). Theyneed a seat at the table and must be meaningfully included in policy discussions and decision-making. We will establish at least 64 new youth groups during the course of the programme and equip the youngsters with advocacy tools and learnings on how to prevent NCDs. The youth targeted through the PLWNCD youth groups will be in the age between 13 to 30 years old and the youth targeted for the educational part of the intervention will be in both primary and high school (age from 5 to 18 years old).

### 3.3.5 Secondary target groups

In order to improve the lives of our primary target groups, engagement of a number of secondary target groups will be essential in our strategic interventions. These target groups will include:

**Politicians and policy makers:**

Politicians and policy makers ought to be targets for advocacy and civil society interventions, but also beneficiaries of what civil society is doing. They can be true allies and accompanying stakeholders through the different activities launched by the programme. Although politicians are subject to electoral and political changes, the identification of allies can help advance with regulatory and policy processes that are complementary and/or central to different advocacy efforts made by the civil society alliances in East Africa. Due attention has been placed to the East Africa Community, as a relevant platform for interaction with high-level and relevant policy makers in the region, as well as to promote and disseminate civil society proposals and collaboration, which also represent an opportunity to promote the Human Rights-based Approach and a meaningful involvement of the primary target groups mentioned above.

**Researchers:**

Lack of data and surveillance is a key challenge for the identification of the NCD burden in all East African countries, as well as to help position the NCD agenda as a key social and economic development agenda. Hence, researchers, especially those working for universities and research institutions, ought to be seen as key stakeholders to include and collaborate with as part of civil society efforts. Although there is a lack of financing for NCD research and data collection, a partnership between civil society and researchers can lead to data collection initiatives for the benefit of their efforts, but also of government programmes and policies. The main group of researchers will consist of the participants in the three research groups established through strategic intervention 5.

**Governments:**

Governments are as implementer of policies important to influence as they have major influence on the effect and reach of legislation, and thus its effect on the primary target groups. Further, the governments are responsible for budgets and budget allocation to health and NCDs and thereby have a major influence on the amount of resources prioritised for the area. Moreover, a good working relationship with the six governments makes it easier to work with the ministries and collaborate on certain interventions. Therefore, advocacy towards this target group is a key component of strategic intervention 1.

**Ministries of Health and Ministries of Finance:**

A strong collaboration with the relevant health authorities, namely the Ministries of Health and their NCD units/departments, is key for the advancement of the programme and for civil society actions. Alliances in the region have been creating their own networks with the Ministries of Health to work together and/or to accompany their efforts, trying to increase the awareness and action on NCD prevention and control. Moreover, support from the Ministries of Health is important, as they need to support the intervention with staff at the health clinics, and assist in selecting clinics and promote the intervention.

Nevertheless, the NCD agenda must not be seen solely as a health issue, but rather as a broader development and policy issue. Hence, interaction and collaboration needs to happen with non-health sectors within and outside of the government. This is particularly relevant for Ministries of Finance, considering that financing for health, and consequently financing for NCDs, is still very low. Bridging the gap between different government ministries and agencies, and with the inclusion of civil society and other primary target groups, could help find innovative proposals to increase domestic and external financing sources.

**East African Community**

EAC covers all of the six geographical areas covered in this intervention. By promotion of new staff at the secretariat and engagement of four technical working groups with focus on NCDs and participation of multiple technical experts and stakeholders, we believe this target group have the capacity to influence the national governments and policies, and promote the NCD agenda regionally.

**The health sector at all levels, including health workers and employees:**

As mentioned, the health sector is particularly relevant for the NCD response, especially in countries where communicable diseases are still a major challenge for social and economic development. Proper integration of services and stakeholders, in the NCD response, especially those of malaria, HIV and tuberculosis, is key to achieve effective and strategic NCD services. Duplication must be avoided, and integration and collaboration must be searched. It is important to consider that the strengthening of the health system and of the NCD response is impossible without the health workers and other health employees. Guaranteeing an understanding of the challenges and needs of health workers is central for civil society efforts in the NCD response. Their increased valorisation, capacity and skills building is also relevant for NCD services. They are instrumental in the implementation of the intervention as the health personal at the 110 health clinics targeted is to conduct the proposed screenings and provide information about NCDs and risk factors. Therefore, they need to be the target for training efforts for them to acquire the necessary skills.

**Volunteers from the alliances – with special focus on branch leaders:**

Civil society and NCD alliances have become effective platforms for advocacy change. They often operate with limited funding and resources, and volunteers play an important role to ensure that the delivery of civil society activities and efforts provide positive outcomes to the communities. Hence, their valorisation and empowerment is key for this programme effort. Volunteers also need to strengthen their capacities and skills in order to be effective in their work. It is important to highlight that alliances’ volunteers might also be part of the programme primary target groups, so investing in volunteers will also result in positive outcomes for the primary target groups. For this intervention, we aim at involving 1195 volunteers mainly to facilitate and plan screening, run branches and PLWNCD groups and participate in advocacy efforts.

**The partner organizations and board members:**

It is extremely important to strengthen and empower partner organisations, as well as alliances, board members and regular members, as they have very useful and strategic links and networks with government officials, beneficiaries and others. Hence, this programme aims to invest in coalition building efforts, including through the strengthening of governance and decision-making processes within alliances, but also the strengthening and development of the capacities of alliances and their members. A strong alliance and a participative structure will result in more strategic action plans and activities, and thus increased benefits for the primary target groups.

## 3.4 Result framework

The full result framework matrix containing outcomes, indicators, targets, baseline and assumptions can be found in the annex (annex 4.1). In the following section the program objective, selected outcomes and the three overall program related assumptions will be presented (ref. to Assessment note recommendation 8). The individual country result frameworks will be attempted finalized shortly upon final approval of the programme[[70]](#footnote-70). The partner specific result frameworks will be revised yearly throughout the program period.

**Program objective**

*By 2030, reduce by one-third premature mortality from NCDs through prevention and treatment and promote mental health and well-being*

Our overall program objective is identical with Sustainable Development Goal 3.4. We are well aware that fulfilment of this objective requires significant efforts from multiple stakeholders and that this programme will only be a small, although important, contribution towards achieving the target. Including the SDG target as our development objective forces us and our partners to link all of our work to the SDGs and the global agenda - facilitating the link from global to the local level and thereby strengthening our partners legitimacy at all levels.

Based on the program objective, the program aim, the intervention logic and the target groups we have devised five outcomes.

**Outcome 1.1**

*Implementation of effective NCD prevention and control policies with a multi-sectoral approach including increased national budgetary allocations*

All of the countries targeted in this program have signed the Abuja Declaration, pledging to aim at using 15% of their national budgets on health. Currently none of the countries are anywhere near fulfilling the pledge - and only a small percentage of the health budgets are used specifically on NCDs. Using data generated under objective 5.1 (both own data and second hand data) and through a targeted advocacy effort, amongst others from the PLWNCD groups (outcome 3.1), we believe it is possible to influence policy makers to increase the spending on health in general and on NCDs in particular. It is of critical importance that health budgets are increased. Increased budgets should be accompanied by efficient and innovative policies. The vast majority of the additional funds should be used on prevention rather than cure. Preventing NCDs are considerably cheaper than treating NCDs.

With the access to national experts, PLWNCDs and based partly on the data collected under outcome 5.1 our partners will possess the necessary legitimacy and technical knowledge required to influence the policies and improve the efficiency and positive effects of these to the benefit of PLWNCDs. This will especially have an effect on poor and marginalised people, as they are dependent on public interventions - while the wealthy can also access private clinics and/or seek treatment abroad.

**Outcome 2.1**

*The East African Community has an office dealing only with NCDs, NCDs are discussed in numerous Technical Working Groups and NCDs become a separate agenda item at the Heads of State Summit at EAC*

By influencing the EAC, it is possible to influence policy making in all of our target countries at once, and provide a standardized and efficient policy framework in the region. As identified in a recent meeting between EAC representatives and our partner alliances: “The different interventions at national level presented - provide a lot of scope for potential regional collaboration e.g. standardized policy, regulation of cross-border risk factors, clinical protocols, pool procurement of medicines etc.”. We aim at targeting our advocacy effort towards three levels within the EAC. We will target different officials - as NCDs are influencing many sectors but also ensuring that the NCD desk position[[71]](#footnote-71) is filled - as this would provide us with the most straightforward avenue facilitating increased NCD knowledge within the organization. The EAC Technical Working Groups (TWG) provide a forum where specific topics are addressed by experts and policy initiatives (including position papers for Heads of State) are prepared. We expect selected partners to be invited to sit on some TWGs and from the inside increase knowledge sharing and push for policy change. Finally, by getting NCDs on the Heads of State summit agenda it will be marked as a priority for the countries and provide expanded advocacy avenues both nationally and within EAC. With the links already established between our partners, especially EANCDA and EAC we believe our partners are in a position where it is realistic to expect that they will be able to influence EAC at all three levels - although we are aware that this is a time consuming process.

**Outcome 3.1**

*Involvement of PLWNCDs (especially youth) and their caregivers in the formulation, implementation and review of all NCD policies, legislation, strategies, guidelines and activities/PLWNCDs empowerment*

Organising and empowering PLWNCDs will improve their ability to influence policy makers, but also allow them to function as change agents in their local community, to increase the general knowledge about NCDs and eliminate stigma. More empowered groups of PLWNCDs will improve the legitimacy of our partners as “official” representatives for PLWNCDs while simultaneously providing them with a stronger voice in their advocacy efforts. Because of their lived experience of managing their condition, they possess great knowledge on most central issues, including whether policies have been followed up by action. The key rights of PLWNCs have been identified by the global NCD alliance through their project Our Views, Our Voices. These rights are as follows: The right to live in environments in which they can be healthy and thrive, right to education and information, to make healthy choices and manage diseases or conditions, right to access treatment, care, and support and right to be protected from discrimination and stigma.

**Outcome 4.1**

*Enhanced capacity of the regional and individual East African NCD Alliances based on democratic and inclusive principles, with a particular focus on national alliances capacity to coordinate activities at branch level and attract funding to diversify their funding base*

Well-functioning democratic alliances with the administrative capacity to handle funds and coordinate their work effort in accordance with best practice is a key necessity for all the other outcomes to be achieved. Our partners have come a long way in this process, however it is an area that needs continuous focus and further development. As cross-country coordination and local coordination with multiple stakeholders will increase significantly throughout this program, it is important to continue to improve our partners’ capacities in this area to ensure successful programme implementation. In order to further strengthen the national alliances outreach - establishment of strong and vibrant branches throughout the country is vital. Continued emphasis on fundraising is also highly important both related to general sustainability but not least in order to improve the planned research efforts further.

**Outcome 5.1**

*The national alliances are capable of collecting and processing further empirical data and utilize these to create awareness about NCD symptoms and risk factors among citizens and decision makers*

As NCD data is limited throughout EA, obtaining more data is of key importance. Establishing a coherent standardised data collection system in collaboration with national health authorities and being able to utilise these data in collaboration with research institutions, will significantly improve the ability of decision makers to make informed decisions. Moreover, it will position our partners much stronger as leading technical experts on NCD, and thus further improve their legitimacy and ability to influence policymakers and other relevant stakeholders, thereby strengthening their advocacy efforts. As an additional derived effect, fulfilment of this objective will also increase the knowledge of the general population, as part of the data will be collected at screening campaigns, where the participants are educated about NCDs and risk factors. Further, it will improve the capacity of local health clinics in NCD screening and their ability to collect the data from these screenings, which in time may be used for referral purpose in form of a patient log.

**Assumption 1**

*Sufficient space for civil society to exercise their rights and the governments recognizes its obligations*

Space for civil society is shrinking all over the world and EA is no exception. Fortunately, the NCD area is not highly controversial and governments have shown interest in working with our partners - regardless of us being critical. We believe this will continue to be the case, however, people with certain diseases are being stigmatised and we shall keep advocating for their rights - and work with likeminded NGOs and donors on promoting advocacy space in general.

**Assumption 2**

*Security situation remains stable (especially relevant in fragile context/Burundi)*

All of our intervention countries are currently relatively stable - although often with some small conflict/instable areas and generally peace in Burundi is very fragile. Our programme countries are surrounded by less stable countries (DR Congo, South Sudan, Somalia) and conflict or acts of terror could spill over. Our programme is focussing on the stable areas limiting our exposure to instability, however, should more countrywide instability occur in one of our programme countries it would affect the intervention.

**Assumption 3**

*No new diseases with instant high death tolls occur - changing mind sets to short-term thinking*

As seen with recent Ebola outbreaks, communicable diseases can have high death tools and seriously affect the health systems in the hit countries. We have had recent outbreaks of Ebola in DR Congo not far from the Ugandan/Rwandan border. However, until now our programme countries have been spared major Ebola outbreaks. Extensive preventive measures are being taken to keep Ebola out and/or deal with new cases swiftly. A major deadly disease outbreak would unavoidably cause severe pressure on the health sector which is already not geared for current no. of patients and, thereby, negatively affect the programme. We would continue our work in the none-affected areas while simultaneous looking into whether emergency organisations could make use of any of our volunteers.

## 3.5 Key outcomes (M&E)

### 3.5.1 Background

DNCDA has in the last years attempted to strengthen its monitoring and evaluation framework and has developed procedures and standards for quarterly and annual reports for alliance partners. The monitoring and evaluation framework has been focused on output indicators, using quantitative measures of numbers of meetings, numbers of people participating in trainings etc. The output based monitoring reflected the short term interventions DNCDA has supported till date with the short time frames limiting the possibilities for analysing outcomes and impact.

With the opportunity to receive longer program funding, DNCDA recognizes the need for combining the output based monitoring with monitoring at outcome and impact level, as well as a stronger need for monitoring of assumptions and risks (ref. to Assessment note recommendation 4 and 8). Considering that NCD alliance partners have limited experience with monitoring and evaluation at outcome and impact levels, and that the partnership aims at establishing a strong ownership by the individual partners in combination with joint learning, the monitoring and evaluation framework outlined below, will be further discussed and refined in dialogue with partners during the initial phase of the program.

### 3.5.2 Output level monitoring

The key outcome indicators identified in the result framework matrix (see annex 4.1) are mainly quantitative and will be broken down to country/regional specific result frameworks, with outputs and annual targets, supported by annual work plans. Achievements at output levels will then be measured against the annual work plans. The NCD Alliance partners will provide DNCDA with a quarterly (basis) report on planned activities - whether they have been achieved as well as reasons for possible deviations. Activity plans with targets for individual partners will be established during the annual joint monitoring, learning and planning workshop. In accordance with CISU’s guidelines, targets will be reviewed and adjusted considering changes which might affect the assumptions and risks underlying the ToC. Targets at output level will be established as part of the first annual planning meeting at the start-up of the program, and will include but not be limited to:

**Outcome 1:** Advocacy strategies developed, peer reviews of strategies undertaken, number of meetings with health authorities, activities undertaken to advocate for the rights of PLWNCD and reports presenting evidence.

**Outcome 2:** Meetings with EAC, concept note developed, position papers developed

**Outcome 3**: Seminars and workshops, youth groups established, support provided to groups of PLWNCD, and educational material

**Outcome 4:** Capacity assessments, capacity development activities for improved advocacy, governance, resource mobilisation, and program management, and monitoring visits,

**Outcome 5:** MoUs signed with academia, agreements with local health authorities and health clinics, local campaigns on NCDs, screenings on NCD.

### 3.5.3 Outcome and impact monitoring

The NCD Alliance partners will apply a qualitative analysis of outcomes and impact, to monitor the changes influenced by the program and to understand the underlying causes for these changes. There are a number of uncertainties in establishing the link between evidence based advocacy and Government policies to prevent and control NCDs in East Africa, not the least because of Governments’ limited knowledge about the costs and implications of NCDs to individual PLWNCD and the society, and because of the dynamic political East African environment where strategies needs to adopt to changes in the context. The limited evidence for advocacy on NCD, in combination with the East African NCD alliances being relatively young organizations as well as the limited tradition for patient organizations in East African and PLWNCDs being included in discussions and decision processes means that the ToC builds on a number of assumptions for the program to achieve the foreseen change.

With this uncertainty in mind, the NCD Alliances have looked into different qualitative methods used for monitoring and evaluations and have decided to apply an adapted Outcome Harvesting method, as described in the INTRAC Outcome Harvesting Guide from 2017 and the ALNAP publication on Outcome Harvesting from 2012[[72]](#footnote-72). Considering that Outcome Harvesting is designed to collect evidence of change (outcomes) and then work backwards to assess how the program and NCD Alliance Partners have contributed to this change, Outcome Harvesting is found relevant and suitable in a situation where the linear linkages between actions and change are more difficult to establish[[73]](#footnote-73). The NCD Alliances will seek external support to develop the outcome harvesting method and quality assure the results of the outcome harvesting.

Tentative Outcome Harvesting questions include:

1. What has been the programmes contribution to changes in the national budget allocation for Health and NCDs in partner countries?
2. What has been the program’s contribution to policies and actions for effective NCD prevention and control being established in East Africa?
3. How has the NCD Alliances contributed to the East Africa Community having a stronger focus on NCDs?
4. How robust are NCD Alliance partners with regard to Governance and funding base?
5. What are achievements and challenges for PLWNCDs groups being inclusive, and for PLWNCD’s being engaged in policy dialogue, and how has the program contributed in this regard?

The adapted outcome harvesting model will be applied mid-term of the program for partners to learn and to adjust the program approach if needed. At the end of the program the process will be repeated. The model applied is foreseen to include the following steps:

1. Review and detailing of questions to guide the analysis of changes relevant to the program outcomes.
2. Data Collection from reports, national budgets and other secondary data, as well as from interviews with key informants including MoH, Local Governments, PLWNCDs and individual patient organizations. The East Africa NCD Alliance will assist individual NCD Alliances with the document review. Interviews will be conducted by the partner NCD Alliances, and the individual NCD Alliances will write outcome description of the change and the contributions by the NCD Alliance partner. Engaging the individual NCD Alliance to undertake interviews and write the outcome description will ensure their internalization of learning.
3. Peer NCD Alliances including the EANCDA and the DNCDA will peer review the NCD Alliances outcome documents.
4. The individual country outcome descriptions will be discussed at the mid-term learning workshop, with peer NCD alliances questioning the findings in the outcome document to ensure robustness of the description and the contributions of the NCD Alliance partner. At the workshop, learnings from the outcome harvesting exercise will further be discussed and findings will be used to adjust the program for the last two years. The aim is that positive learnings of individual partners can help other partners work more effectively. The individual NCD Alliances will write a short report reflecting the contributions to the different outcome statements. The DNCDA and the EANCDA will combine these individual reports into a synthesis report.
5. The adapted outcome harvesting methodology will be repeated at the end of the program to further institute learning amongst partners.

As mentioned in section 2.4.2 three learning questions are identified as part of the ToC. The learning questions deal with the underlying reasons for the NCD Alliances contribution to change – the WHY – and include:

1. What has been the underlying reasons for NCD Alliances being successful in advocation for Government prioritisation of NCD prevention and control?
2. Which initiatives have successfully supported that groups of PLWNCD are inclusive and gender sensitive and what has been the underlying reason for the successful engagement of groups of PLWNCDs, and challenges encountered?
3. What have been the underlying reasons for successful regional learning and collaboration between NCD Alliances and with stakeholders?

The learning questions will also be discussed as part of the annual planning and learning workshop, and will be informed by the results of the outcome harvesting at mid-term and at the end of the program.

### 3.5.4 Monitoring assumptions and risks

The ToC builds on a number of assumptions. Key assumptions and means of verification are listed in the table below.

The NCD Alliances will on a yearly basis analyse if assumptions still hold, and will report any deviations in their yearly reports. As part of annual monitoring and planning workshop, the NCD Alliances will undertake a more thorough analysis of assumptions and the list will be amended if relevant. Changes will be consolidated and reported in the annual report to CISU from the DNCDA.

|  |  |
| --- | --- |
| **Key Assumption** | **Means of verification** |
| Sufficient space for civil society to exercise their rights and the governments recognizes its obligations | Interview with key informants from Governments and civil society organisations |
| Security situation remains stable (especially relevant in fragile context/Burundi) | OCHA reports |
| No new diseases with instant high death tolls occur - changing mind sets to short-term thinking | Reports from WHO and key informant interviews with Government, local authorities and CSOs |
| Based on evidence, technical staff can convince decision makers to give priority to NCD prevention and control (Outcome 1) | Key informant interviews with key politicians and technical staff |
| EAC and stakeholders will cover costs related to promoting NCD prevention and control with only a smaller financial contribution from the programme (Outcome 2) | EAC participation in meetings and workshops and key informant interviews with technical staff in EAC |
| PLWNCDs know about the NCD alliances, and recognize the Alliances as their representative (Outcome 3) | Focus group discussions with PLWNCD and PLWNCD groups based on a random selection |
| NCD Alliances can retain volunteers comprising their Governance as well at their program managers (Outcome 4) | Annual NCD Alliance reports and interviews with NCD Alliance headquarter staff and branches |
| NCD Alliances’ data will ensure interest from academia in researching in NCD prevention and it is possible to attract funding from other sources (Outcome 5) | Interest shown by academia to research in NCDs and reports from academia on external funds received for research on NCDs |

The Alliance partners have also identified a number of risks to the successful implementation of the program as well as to the program achieving the foreseen outcomes (see section 3.6). Developments in risks will be monitored by the Alliances on a quarterly basis, and if need be the program will be adapted accordingly.

### 3.5.5 Reporting

As previously, the NCD Alliances will continue to provide DNCDA with quarterly and annual narrative and financial reports.

The quarterly narrative reports will account for achievements at output level and will reflect numbers of people reached, meetings held and screening undertaken as reflected in the targets. Quarterly financial reports will include an account of expenditures in the last quarter, accompanied by reconciled and signed bank statements and an updated budget for the next quarter and a request for new funds as relevant.

The annual narrative reports for year one and three will similarly account for quantitative achievements of outputs against targets, and will include considerations regarding the learning questions. For year two and four narrative reports will in addition to the account on outputs also include an analysis of the program’s outcomes and it’s contribution to change based on the adapted outcome harvesting methodology described above. The narrative and financial reports from partners will follow DNCDAs existing quarterly reporting formats, and both narrative and financial reports and supporting documentation will be in English language and signed by the programme manager and the board chairperson of the individual NCD Alliance partners. DNCDA will on an annual basis consolidate reports from partners into a report to CISU. The quarterly and annual monitoring reports will be discussed at skype meetings with programme managers, and board members when relevant and the DNCDA will undertake regular monitoring visits to discuss progress.

## 3.6 Risks and sustainability

### 3.6.1 Risk Management

Our risk management system takes its point of departure in Danidas risk management guidelines. We are dealing with risks at three core levels namely: Contextual, institutional, and programmatic risks as described in annex 7.4. where a no. of risks are identified and assessed accordingly.

The matrix will serve as a starting point for identifying risks at country level where the matrix will be supplemented by a more thorough risk register. Some of our partners have already risk registers and others are in process of developing these. We expect those of our partners that do not yet have risk matrixes and registers to prepare these at the initial phase of the programme. Risk management will be a specific focus in the annual status reports as well as at the annual planning meetings with our partners. Cross-country learnings will be facilitated by EANCDA at the yearly meetings for all partners, where the common risks will be assessed and learnings shared (ref. to Assessment note recommendation 3).

### 3.6.2 Sustainability

As mentioned in the concept note, the programme will promote and focus on sustainability at four levels: Institutional/organizational, policy, environmental and financial.

Institutional/organizational: A big part of our structure and work is based on voluntarism. People only provide their time and resources (longer term) if they gain something from it - whether that is information, skills, feeling empowered, realizing that together they can move agendas/policies or simply just enjoying the togetherness. We provide initial structures/organizational support, but groups of PLWNCDs will only work long term, and thereby be sustainable, if they are driven by the voluntaries themselves. We believe that we have a quite sustainable concept - although admitting that devoted individuals are a requirement. Our alliance structure is supporting sustainability. The individual country alliances are not depending on individual members for their existence. Most of them can easily survive if one or two members “pull the plug” temporarily. The foundation is individual patient organizations committed to drive the alliance - realizing that by uniting they have greater impact - and importantly that they can learn from one another. The better the alliance become at including and involving their members - sharing resources, facilitate leanings across etc. - the better chance that you have motivated members willing also to contribute financially and, thereby, ensuring sustainability. Focus will be on optimising existing structures not developing new.

Our partners are highly motivated and very ambitious, which is normally a blessing. However, to ensure sustainability it is important also to be realistic. DNCDAs role is often to emphasise towards our partners to remain ambitious but also to be realistic - emphasising also what it is properly not possible to facilitate within a single four-year programme phase with a limited budget. This work will be supported by a policy note on capacity building priorities, to ensure expectations are in sink - prepared in the initial program phase as per the CapApp recommendation.

Policy: As explained in previous sections improved policy implementation and budget allocation to NCDs is a critical element in this program. If successful in our advocacy efforts to promote policy change and improve budget allocation, the effect of these measures will reach well beyond this program and thus be sustainable. To succeed - massive advocacy efforts towards multiple stakeholders at different levels is needed. However, we are confident that we will be heard - as in many respects we “preach” common sense - also from a (long-term) financial point of view (ref. to Assessment note recommendation 10). As noticed in the CapApp a programme will allow us a more strategic long term focus on advocacy, including continuous training of alliance members, branch, and PLWNCD volunteers and other relevant stakeholders. We aim at institutionalising advocacy methodologies with our partners. There is a lot of peer-to-peer potential in this area that we will support facilitating in tandem with our continued advocacy training - that will take place throughout the programme period.

Environmental: Environmental issues and NCDs are closely linked as evident when highlighting the SDGs interlinked with NCDs (see annex 3.5 goals 6, 7, 11 and 13 to mention just some). Household air pollution mainly from unimproved stoves causes 3.8 million premature deaths annually (women being mostly affected). Changing the local stoves slightly to become more energy efficient and producing less smoke (a fairly simple procedure) will benefit the environment as well as dramatically reduce the no. of respiratory patients.

Financial: The vast majority of our partners now have solid financial procedures in place - which is a prerequisite for any substantial fundraising to take place. Attracting external funding is key to the continued sustainability of our partners, as all of them have DNCDA as their main and sometimes even only donor. Becoming a CISU programme organization is a seal of approval - which we hope can support our fundraising efforts. Admittedly, local funding has proven more difficult to attract than initially expected (se also 2.4.1). However, we will continue to work with our partners on this including exploring new avenues (chances being better in Kenya than in Burundi). Our partners have had more success seeking additional external funding (World Diabetes Foundation etc.), and we are confident that they - with our and Global NCDAs support - will continue to attract other external funding. One additional route to financing that will be explored in detail in the programme - and that we have not had much focus on earlier is applying for research funds alongside academia.

## 3.7 Program management

The programme will be administered by DNCDAs secretariat consisting of a Director of Development (DoD), a Programme Officer (PO) and a part time Programme Assistant (PA). A no. of key staff functions at the DCS supplements the secretariat. The overall programme responsibility lies with Director of Development[[74]](#footnote-74) who is setting the overall direction alongside the Steering Committee Members (see also section 2.2.2 and brief organigram in annex 7.6). On a day-to-day basis the DoD is supported by the PO and the PA. The latter two are often the first point of entry for the national alliances programme managers - especially on issues related to quarterly reporting. The accounting department at the DCS administer the Danish bookkeeping, and assures that the strict DCS financial guidelines are adhered to.

The partners have reported quarterly and will continue to do so (all reporting has been supplemented by frequent skype meetings). The reporting has been based on the result framework, budgets (financial templates/ guidelines) as well as assumptions/risk assessment. This will be maintained although a new reporting template will be developed over the course of the first programme phase taking into consideration the more stringent future focus on outcome monitoring.

The partnership agreements (between DNCDA/DCS and the individual NCD Alliance) stipulates who is responsible for what. Overall it is the board members who is responsible for programme implementation at country level. Day-to-day management is carried out by a programme manager supported by a financial assistant. Most financial reports and requests are prepared by the financial assistant and then first approved by the programme manager and then the board chairman (or cashier). Once a year the management and administrative procedures are reviewed by a financial expert from the Danish Cancer Society (based on CISUs financial guidelines). This is supplemented by training in for example financial administration, anti-corruption or similar. All the financial accounts are audited by recognized local auditors and then approved by the DCS and our auditor (Deloitte).

Currently the management relation between the Danish NCD Alliance and our partners is project based and through direct contact with each of the alliances. In the program, we will aim towards a more program-oriented relation with East Africa NCD Alliance as a focal point, to coordinate implementation and reporting. This will allow for greater synergies and coordination between the partners, and a more lean line of communication between our partners and us. However, this change in set-up will be a long-term process as it requires improved coordination capacity as well as procedural changes.

## 3.8 Development engagement

The primary aim of our development engagement and development education has been and will continue to be creating awareness about NCDs as a development issue (see also chapter 2.1.3) - linking it closely to SDG 3.4 (our development goal). Currently less than half the world’s countries are on track for meeting SDG goal 3.4.

We will maintain a strong focus on students studying health related topics and continue all our different activities related to this (see 2.1.3 for details). However, in the program period we will widen our target group and make a steered effort to try to reach more “ordinary” members of our mother organizations[[75]](#footnote-75). We see a huge untapped potential here as our organizations together have more than ½ million members.

Many people in Denmark is still considering NCDs a problem only for the wealthy and it will be a surprise for them to learn - that NCDs are troubling the African continent. We would like to communicate how an effort of building a civil society, increase awareness about prevention and civil rights and empowering people, can help improve the health among some of the most vulnerable people in the world. Thus we hope to get EA NCD stories published in some of the several different magazines published by our mother organizations as well as on some of their social media platforms. Initially we hope and expect to make in-house presentations on our work reaching more of the employees at the Danish Cancer Society and the Danish Diabetes Association. The monthly “house meeting” at the Danish Cancer Society is also broadcasted to employees elsewhere in the country and reaches about 800 people.

Furthermore, we aim at getting additional Danish patient organizations to become members of our alliance. Giving us the possibility of reaching more people all with an interest in health topics. We are in progressed talks with the Danish Lung Association.

Our own website [https://www.cancer.dk/ncd](https://www.cancer.dk/ncd/) will remain our most important communication tool alongside our facebook page https//www.facebook.com/dncda. Stories on and from our programme will be published here - including personal stories of PLWNCDs collected by our partners. The stories are highly personal and emotional and often easy to relate to by the recipient.

The written stories will be supplemented by video recordings of the people telling the story combined with further information on the issue to enable the recipient to connect a face to the story and to enforce the emotional appeal. We will also aspire to have stories published through other channels, among others Globalnyt and “Verdens Bedste Nyheder”. We will continue to work closely with the Global NCD Alliance (including their communication staff) and expect also in the future to be invited as keynote speakers at larger scale NCD events.

We will continue to share, coordinate and develop new approaches to our information work in Denmark through “Sundhedsnetværket”. This is a coordinating forum between most of the Danish development NGOs with a health-centred approach, which gives us a strong voice in relation to advocacy towards Danish policymakers.

## 3.9 Budget

### 3.9.1 Budget Summary

As presented in annex 2.1 there is a difference in funds allocated between the countries. The EANCDA will be the programme focal point and are allocated the highest amount of funds. As for the national alliances, the division in funds reflects partly their level of development and the nature of the country/area they cover. Our oldest and most developed partners in Tanzania and Uganda are allocated the highest amounts, as the expected output is also higher in terms of number of people screened, number of branches, PLWNCD groups etc. The allocation for Zanzibar is relatively lower due to relatively small size of the island, which allows for lower transportation costs and limits the amount of PLWNCD groups, screenings etc. needed. Burundi NCDA is working in a challenging environment and in a country where the general cost level is also lower, which again lower the costs and limits the number of activities possible to carry out. Global activities will include participating in different NCD related high-level meetings, WHO/UN meetings etc. The funds set aside is mainly to cover transportation costs. The CapApp found that there is a good link between the thematic allocation and the scope of the different strategic interventions, with most funds set aside for strategic intervention five covering both screenings, data collection and research in all six countries.

As noted in the assessment committee note (recommendation 11), the TA% is in the higher end (although not unprecedented when comparing to similar programs). This has several explanations including the number of partners being relatively high, requiring more time allocated to conduct trainings, monitoring etc. as seven organisations in six countries should usually be covered. The amount of partners also requires more time allocated to coordinate learning and knowledge sharing. Moreover, the nature of the program intervention requires rather substantial technical assistance from Denmark. A major advantage of the setup is that the Danish patient organisations can share a lot of their specialised knowledge through trainings etc. While this is a major advantage in the development of our partners, it does however, require many hours devoted from the Danish experts to facilitate good training and adopt their knowledge to an African context.

### 3.9.2 Approach to reviewing cost efficient spending in each country

Local budgets and financial reports, prepared by program managers, are reviewed quarterly with focus on efficient spending by the EA alliances boards and us. This review does also entail benchmarking between the countries, though keeping general difference in cost levels across these in mind. Moreover, several activities are planned in connection to reduce travel costs and costs are considered every time items are purchased. For Danish monitoring or activity visits flights, hotel etc. are booked with focus on ensuring the best price possible and the visits are normally planned in connection to reduce travel costs.

1. The term People Living with NCDs (PLWNCDs) refers to a broad group of people who have or have had one or more NCD, as well as those who are closely connected to someone with an NCD – such as relatives, close friends, and care partners (sometimes also referred to as carers or caregivers). [↑](#footnote-ref-1)
2. The mortality transition is expected to happen earlier than by 2030, as previously projected by the World Health Organization (WHO), if no radical action is taken.  [↑](#footnote-ref-2)
3. The Lancet 2018, Bertram, Sweeny, Lauer, et al. Investing in NCDs: an estimation of the return on investment for prevention and treatment services. [↑](#footnote-ref-3)
4. The cost of continued underinvestment in the fight against NCDS has been estimated at USD 47 trillion in lost GDP globally from 2011-2025 (world economic forum 2011, Bloom, Cafiero et.al. the global economic burden of NCDs). [↑](#footnote-ref-4)
5. WHO 2018. NCDs Country Profiles 2018. [↑](#footnote-ref-5)
6. NCD Alliance Campaign priorities. Available at: <https://ncdalliance.org/sites/default/files/resource_files/CampaignPriorities_ENGLISH.pdf> [↑](#footnote-ref-6)
7. WHO 2018. NCDs Country Profiles 2018. [↑](#footnote-ref-7)
8. Averaged from the WHO *Noncommunicable diseases country profiles 2018* [↑](#footnote-ref-8)
9. http://www.who.int/pmnch/media/events/2014/africa\_cancer\_mortality.pdf [↑](#footnote-ref-9)
10. Averaged from the WHO *Noncommunicable diseases country profiles 2018*; figures exclude South Sudan, no data [↑](#footnote-ref-10)
11. African Union (2018); *Africa Scorecard on Domestic Financing for Health, 2018* [↑](#footnote-ref-11)
12. African Union (2018); *Africa Scorecard on Domestic Financing for Health, 2018* [↑](#footnote-ref-12)
13. The East African Community health sector investment priorities framework (2018-2028) [↑](#footnote-ref-13)
14. Averaged from World Bank website [↑](#footnote-ref-14)
15. Several important country facts have been annexed – can be found and compared in annex 6.1. [↑](#footnote-ref-15)
16. CIA World Factbook. Burundi. Available at: <https://www.cia.gov/library/publications/the-world-factbook/geos/by.html> [Accessed 28 August 2019] [↑](#footnote-ref-16)
17. For instance, a survey has shown an average of 1 doctor per 17,765 population, whereas the WHO recommends 1 doctor per 10,000 population [↑](#footnote-ref-17)
18. WHO 2017. NCDs Progress Monitor 2017 [↑](#footnote-ref-18)
19. World Bank. Kenya. Available at: <https://data.worldbank.org/country/kenya> [Accessed 20 August 2019] [↑](#footnote-ref-19)
20. WHO 2018, NCDs country profiles 2018. Kenya. Available at: <https://www.who.int/nmh/countries/2018/ken_en.pdf?ua=1> [↑](#footnote-ref-20)
21. including the Cardiovascular Guidelines 2018, Cancer Control Strategy 2017-2022, National Diabetes Strategy 2010, Tobacco Control Act 2007; Alcohol Control Bill 2010 and Mental Health Amendment Bill, 32 of 2018 [↑](#footnote-ref-21)
22. WHO 2017. NCDs Progress Monitor 2017 [↑](#footnote-ref-22)
23. Embedding NCDs in the post-2015 development agenda, Alleyne G. et. al., Lancet 2013. [↑](#footnote-ref-23)
24. By comparison the GDP per capita in Denmark is $56,307 USD. [↑](#footnote-ref-24)
25. Source: World Bank and World Health Statistics 2017 from WHO [↑](#footnote-ref-25)
26. http://www.who.int/chp/steps/Rwanda\_2012\_STEPS\_Report.pdf [↑](#footnote-ref-26)
27. WHO 2017. NCDs Progress Monitor 2017 [↑](#footnote-ref-27)
28. CIA World Factbook. Tanzania. Available at: <https://www.cia.gov/library/publications/the-world-factbook/geos/tz.html> [↑](#footnote-ref-28)
29. [Mayige M, 2012](about:blank) [↑](#footnote-ref-29)
30. WHO 2018, NCDs country profiles 2018. Tanzania. Available at: <https://www.who.int/nmh/countries/2018/tza_en.pdf?ua=1> [↑](#footnote-ref-30)
31. WHO 2017. NCDs Progress Monitor 2017 [↑](#footnote-ref-31)
32. WHO 2018, NCDs country profiles 2018. Uganda. Available at: <https://www.who.int/nmh/countries/2018/uga_en.pdf?ua=1> [↑](#footnote-ref-32)
33. WHO 2017. NCDs Progress Monitor 2017 [↑](#footnote-ref-33)
34. <https://knoema.com/UNNAMAD2018/national-accounts-main-aggregates-database?tsId=1187920> [↑](#footnote-ref-34)
35. NCD Alliance (2014). A Civil Society Benchmark Report: Responses to NCDs in East Africa. Available at: <https://ncdalliance.org/sites/default/files/resource_files/East%20Africa%20NCD%20Alliance%20Civil%20Society%20Survey%20Report.pdf> [↑](#footnote-ref-35)
36. Together the 2 organisations have around 500.000 members in Denmark (The Cancer Society + 400.000 and the Diabetes Association almost 100.000). [↑](#footnote-ref-36)
37. DNCDA has successfully partnered with NCD Alliances in Uganda (since 2010) Tanzania (since 2011), Zanzibar (since 2013), Rwanda and Burundi (since 2017), Kenya (since 2018) and supported collaboration between NCD Alliances in The East African Community since 2014. [↑](#footnote-ref-37)
38. Ms. Charlotte Rulffs Klausen (DDA) has been instrumental in good governance training of the partners, and provided extensive legal counselling in matters of partnership contracts, MoUs etc. Ms. Una Jensen (DCS) has assisted with advocacy training and international advocacy as well as paving the way for DNCDA within the DCS where DNCDA is housed. Both have represented DNCDA at a no. of int. meetings. [↑](#footnote-ref-38)
39. Per Kallestrup has recently been employed as head of research unit for general practice in Århus. He will maintain his strong links to Århus University and keep his PhD students. Also Per has promised us that our close cooperation will continue. [↑](#footnote-ref-39)
40. Mr. Vincent Cubaka has finalised his studies and is today working for Kigali university - but continues to support us. [↑](#footnote-ref-40)
41. Access ncdalliance.org to get more information about its objectives, work and advocacy experience. [↑](#footnote-ref-41)
42. Read here for more information about the membership structure of the NCDA: <https://ncdalliance.org/who-we-are/ncd-alliance-network> [↑](#footnote-ref-42)
43. The current Chairperson, Prof. Yonga from Kenya, serves as a Board Member to the Global NCD Alliance; the Vice-Chairperson, Prof. Joseph Mucumbitsi from Rwanda, is an active member of the world Heart Federation (WHF) and the Pa African Society of Cardiology (PASCAR); Dr. Kaushik Ramaiya from Tanzania, is a Board Member of the World Diabetes Foundation (WDF) [↑](#footnote-ref-43)
44. Rwanda Diabetes Association; Rwanda Heart Foundation; Breast Cancer East Africa Initiative; Rwanda Cardiac Patient Network; Rwanda Palliative Care Network; and Rwanda Pharmaceutical Students Association. [↑](#footnote-ref-44)
45. This is an example of how DNCDA is cooperating with other Danish NGOs [↑](#footnote-ref-45)
46. The fact that opposition media exist is not necessarily the same as having an opposition with a lot of political influence. [↑](#footnote-ref-46)
47. Most literature on networks/Alliances are related to big businesses and not the NGO world. [↑](#footnote-ref-47)
48. ODI, not everything that connects is a network. S. Hearn and E. Mendizabel May 2011. [↑](#footnote-ref-48)
49. It should be noted that the Danish patient organizations are also increasingly working together in different networks such as “danske patienter” – and DNCDA mother organizations have also recently started working together on NCDs in Denmark. [↑](#footnote-ref-49)
50. UN Women have many good recommendations on conflict management and resolution, conflict analysis etc. as part of their virtual knowledge centre to end violence of women and girls. [↑](#footnote-ref-50)
51. We aim at seeking more inspiration on this in the 6 R’s as recommended by Kansas University community toolbox, namely: recognition, respect, role, relationships, reward and results [↑](#footnote-ref-51)
52. NCD Alliance (2017). NCDs across all SDGs – a call for an integrated approach. Available at: <https://ncdalliance.org/sites/default/files/resource_files/NCDs_Across_SDGs_English_May2017.pdf> [↑](#footnote-ref-52)
53. All SDG3 targets are available here: <https://sustainabledevelopment.un.org/sdg3> [↑](#footnote-ref-53)
54. NCD Alliance (2017). NCDs across all SDGs – a call for an integrated approach. [↑](#footnote-ref-54)
55. NCD Alliance (2018). 2018 UN High-Level Political Forum on Sustainable Development Advocacy Briefing: NCDs, Health and Environment. Available at: <https://ncdalliance.org/sites/default/files/resource_files/NCDA%20HLPF%202018%20briefing_to%20upload.pdf> [↑](#footnote-ref-55)
56. This particular issue was discussed during a 2- day conference hosted by the Danish MoFA together with Novo Nordisk and other stakeholders in Copenhagen in April 2018. [↑](#footnote-ref-56)
57. Well-functioning patient organisation need to have sufficient capacity within and work with the following areas: Fundraising, administration, public education, patient support and empowerment, engagement of volunteers, research and advocacy [↑](#footnote-ref-57)
58. WHO Health Assembly and UN High Level Meetings on NCDs and/or Universal Health Coverage among the most obvious but there are many more relevant global forums – also involving donors [↑](#footnote-ref-58)
59. NCD desks are designated areas at health clinics with screening equipment. This could include weight and height measure tools, blood pressure machines, blood sugar strips, cancer screenings etc. [↑](#footnote-ref-59)
60. Screening data will be compiled both through the promotion screening and information events and through the continues day to day screenings at the health desks. [↑](#footnote-ref-60)
61. In 2013, the Ministry of Foreign Affairs (MFA) issued a guidance note on a Human Rights-Based Approach (HRBA) to development [↑](#footnote-ref-61)
62. The Human Rights guide to the Sustainable Development Goals made by the Danish Institute for Human Rights provides many more details on the linkage between Good Health and Well-Being and Human Rights. [↑](#footnote-ref-62)
63. For more on HRBA as a practical methodology for analyzing and addressing determinants of NCDs see for example the following link: <https://lawexplores.com/a-human-rights-based-approach-to-non-communicable-diseases/> [↑](#footnote-ref-63)
64. NCD alliance (2018). Meaningfully involving people living with NCDs: What is being done and why it matters. Available at: <https://ncdalliance.org/sites/default/files/resource_files/MeaningfulInvolvingPLWNCDs_Report_FINAL_0.pdf> [↑](#footnote-ref-64)
65. See also Global NCDA’s Advocacy agenda for PLWNCDs on: <https://ncdalliance.org/sites/default/files/resource_files/AdovacyAgenda_FINAL_WEB.pdf> [↑](#footnote-ref-65)
66. Most of our partner countries (with the exception of Rwanda) cannot be proud of their ranking on the UNDP gender inequality index <http://hdr.undp.org/en/composite/GII> [↑](#footnote-ref-66)
67. The current rate of women in the global workforce is 49 per cent, compared to 75 per cent of men. [↑](#footnote-ref-67)
68. A recent Danish research project concluded that 75% of Danish children between 11-15 do not get the recommended (an hour a day) physical activity [↑](#footnote-ref-68)
69. Youth recommendations for the UN High-Level Meeting on NCDs <http://www.ncdchild.org/media/1347/07-2018-youth-recommendations-un-hlm.pdf> [↑](#footnote-ref-69)
70. By then we will also know the exact financial frame. [↑](#footnote-ref-70)
71. The position is apparently vacant due to budgetary constraints in our view a bizarre prioritization. [↑](#footnote-ref-71)
72. Intrac, 2017, outcome harvesting Richardo Wilson-Gray and Heather Britt, 2012, Outcome Harvesting (ALNAP) [↑](#footnote-ref-72)
73. It should be noted that this method also got recommended by colleagues from other development NGO’s. Furthermore, we have been aware that a few of CISUs programme organizations are applying this method and that they are happy to share their experiences. [↑](#footnote-ref-73)
74. The Director of Development is referring to a Directors Forum consisting of the 2 CEOs of the DCA and DDA respectively. [↑](#footnote-ref-74)
75. This we have not had the time to pursue earlier, however, we have also been somewhat reluctant to do so previously as we were not 100 % sure that we would exist years down the line. [↑](#footnote-ref-75)