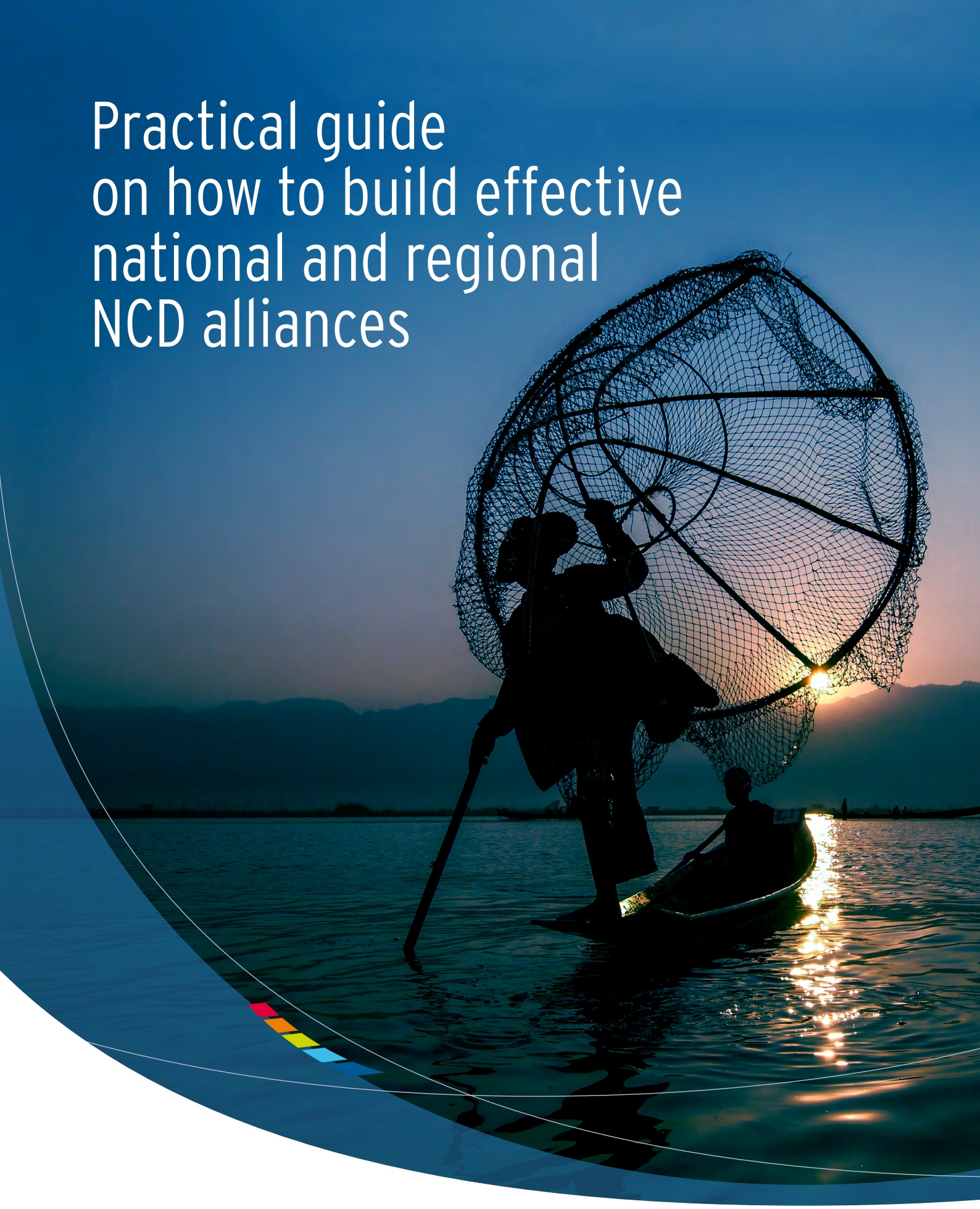
Practical guide on how to build effective national and regional NCD alliances



NCD Alliance

The NCD Alliance, 2016

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Acknowledgements

This practical guide aims to support the establishment of national and regional NCD alliances by offering a variety of tools, samples and resources that can be adapted and used to meet local needs. It was developed based on numerous inputs from several national and regional NCD alliances from across the world and from networks addressing nutrition and HIV/AIDS. It has also drawn on resources developed by various development partners that are relevant to civil society coalitions. Special thanks to the reviewers who enriched the guide with their valuable feedback.

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INTRODUCTION

Noncommunciable diseases (NCDs) constitute a major global health and development challenge, accounting for 68% of the 56 million global deaths in 2012. These include cancers, diabetes, cardiovascular diseases, chronic respiratory diseases and dementia among others. The four modifiable risk factors common to the first four NCDs are tobacco use, harmful use of alcohol, unhealthy diet and lack of physical activity. Action on NCDs and their risk factors call for a multisectoral approach and collective action by civil society organisations (CSOs).

Role of civil society in NCD prevention and control

Civil society plays a key role in four major areas in the prevention and control of NCDs (the four As):

AWARENESS

Targeting the general public or specific populations with initiatives aimed at increasing knowledge, changing attitudes and behaviours; raising public demand for improved rights and services.

ADVOCACY

Driving system change and influencing legislation, funding or policy for NCD prevention and/or control, empowering people living with NCDs.

ACCESS

Delivering health services, medications, patient support, legal support, practical support, access to healthcare services in humanitarian situations, etc.

ACCOUNTABILITY

Tracking national progress and actions of private and public sector against commitments and standards.

With its diverse roles, NCD civil society can engage and empower people living with NCDs and promote a whole of society response. Coalition building is an integral part in mobilising civil society on NCDs. Following the establishment of the global NCD Alliance, recent years have seen the organic emergence of national and regional NCD alliances across the world.

The NCD Alliance's Situational Analysis of National and Regional NCD Alliances published in November 2015[1] surveyed and interviewed national and regional NCD alliances to provide a snapshot of the current status of NCD civil society. The situational analysis revealed the capacity building need for guidance on building effective alliances.

The NCD Alliance has prioritised capacity development in its Strategic Plan of 2016-2020 to help drive regional and national action on NCDs by supporting the development and growth of effective and sustainable NCD civil society. To this end, the NCD Alliance has developed this practical guide on How to Build Effective National and Regional NCD alliances to support new alliances throughout their establishment phase.

This guide offers practical steps and tools to build and establish effective national and regional NCD alliances. It has been built on the experiences of coalition building for health and non-health goals. In particular, it has drawn on inputs from coalitions working on NCDs, nutrition and HIV/AIDS. The guidance provided in this document, including the diverse tools and samples, is meant to facilitate discussions and decisions by national and regional NCD alliances and does not imply NCD Alliance endorsement of any specific approach or model. It is strongly recommended that the guidance in this guide is adapted to suit local context and capacities.

1 Achieving 25 X 25 Though Civil Society Coalitions. A Situational Analysis of National and Regional NCD Alliances. NCD Alliance, 2015.

Objectives of the guide

The guide aims to:

DESCRIBE ALLIANCES, their types, purposes, benefits and challenges for NCD prevention and control

PRESENT KEY Steps in building effective national and regional NCD alliances

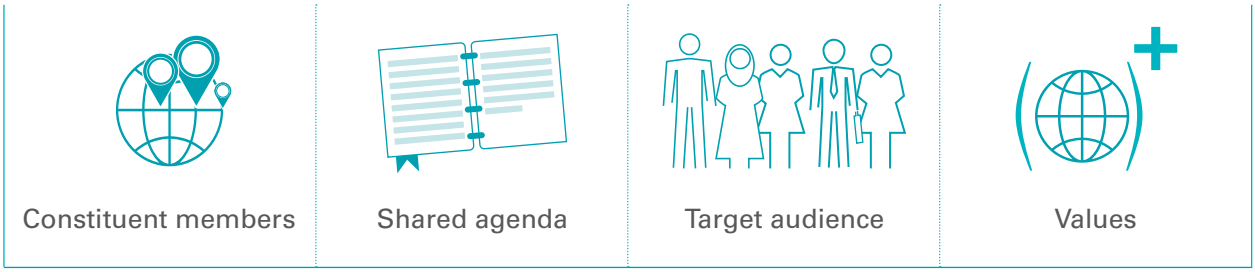
PROVIDE PRACTICAL TOOLS and templates that can aid alliance building

IDENTIFY CONCRETE MEASURES that improve the efficiency and outcomes of NCD alliances

Alliances/Coalitions

An alliance or a coalition can be broadly defined as a group of people or organisations that has a goal to pursue common policies, while each organisation maintains its autonomy. In the case of NCD alliances, the shared goal would mobilise the members to collectively act on specific policies that prevent and control NCDs.

By the definition above, an alliance would have:



Rationale for working in alliances

The efforts of individual entities may often be limited, isolated or dissipated. Working in alliances can:

- bring greater strength in numbers and visibility to NCD concerns
- secure better access to policy and power centers
- help achieve goals individual organisations could not accomplish on their own
- pool diverse skills, experiences and resources to overcome individual deficiencies in addressing NCDs

Members of the Richmond Group of Charities in London were initially working independently with the UK Department of Health (housed in Richmond House and hence the coalition name) on long term health issues. They recognised the value of collective action and formed the joint Charity to better influence health and social care policy and practice for each of the groups of people living with long term conditions they represented.

Meanwhile in Colombia, two groups of organisations were working separately on tobacco control and health rights. They were united by their common interest to challenge vested private interest in public health leading to the creation of the National Table for Health.

In Ethiopia, organisations working on the major NCDs wanted to build on the experience of securing a National Strategic Action Framework for Cancer and help the government develop a National Strategic Action Framework for each of the NCDs. They formed the Consortium of Ethiopian NCD Associations.

If not addressed carefully, alliances may run the risk of:

- compromising on priorities and positions
- competition for control, credits, visibility and resources
- lack of transparency and accountability to members and the public
- tarnishing the image of member organisations
- trespassing into members work or diluting their missions

Alliances are often divided on the question of whether they should focus prevention or treatment; a specific disease or a risk factor; advocacy or service delivery. Such concerns need to be resolved early on through strategic planning, taking into account the strengths and priorities of diverse organisations, the political opportunities and finding a shared agenda that is relevant to the membership. For instance, the NCD Alliance Argentina consists of groups working on tobacco control, healthy eating, women's rights, consumers rights, cancer, diabetes, human rights and the right to water. Following discussions, they unanimously decided to exclusively focus on NCD prevention, while patient groups and medical professional bodies outside the alliance attend to NCD treatment aspects.

There could also be concerns regarding whether the mission and priorities of member organisations will be diluted or displaced by the alliance. It is important that alliances include activities that support and add value to member organisations through capacity building and by sharing resources.

Limited resources often create difficulties in alliances. Fundraising efforts of the alliance could encroach into funding sources of members. Healthy Caribbean Coalition (HCC) addresses this by consciously avoiding fundraising from national donors and instead raising its resources from global and regional donors who are less likely to fund in-country CSOs. It also avoids implementation projects, which the members are supported to undertake through onward granting. Transparency and open discussions about fundraising are critical to avoid unhealthy competition.

The South Africa NCD Alliance found the insights from Bruce Tuckman's Model of Group Development into the stages an alliance might pass through useful in addressing its associated challenges. The tools T1 to address these challenges can help alliances anticipate, address and navigate these challenges.

TOOL 1 | Page 170
Group Development Stages and tools

Steps to building effective national and regional NCD alliances

While national and regional NCD alliances often have organic beginnings, a strategic approach to building them can help streamline the efforts and improve outcomes. Key steps to NCD alliance building are discussed in this section:

1. **Assess and define** the need for an alliance
2. **Scope** the landscape and identify potential partners
3. **Make** the case for partnership
4. **Develop** a shared agenda through strategic planning
5. **Determine** organisational design and governance

Assess and define the need for an alliance

The first step to building an alliance is to check if there is need for one! While the idea of forming an alliance might originate from an organisation or be inspired by an individual, it is good to get a handful of like-minded entities to examine the need in detail. Some questions to ask include:

1. Are there NCD goals that are better realised through collective action?
2. Are there NCD concerns that are not addressed by existing organisations?
3. Are there cross-cutting issues that are sensible for organisations to address together?
4. Are there challenges to NCD action that require coordinated response?
5. Are there opportunities that are better explored as a coalition?
6. Are there partners with likely interest in collective action?

SAMPLE 1 | Pages 37-59
SEARO NCD Mapping Report

A civil society mapping that explores the profile, current activities and needs of organisations whose work is relevant to NCD prevention and control could provide meaningful insights in this regard. For instance, the mapping could throw light on the gaps in the civil society response, approaches to address them, including interest and scope to build an alliance. On identifying the specific need(s), define it and articulate its rationale to see if there is interest for collective action among key stakeholders. Here S1 is a sample mapping that could be adapted to include all CSOs whose work is relevant to NCD prevention and control in the country and regional contexts.

Scope the landscape and identify potential partners

Once the need for an alliance is identified, it is time to determine who would need to be part of it. The partners need to be like-minded organisations/entities that share an interest in, and some common linkages with, NCDs and/or their risk factors. As Figure 1 indicates, an NCD alliance needs to consider CSOs and other relevant stakeholders who are:

- already addressing NCDs and their risk factors actively in the country
- those who may or may not be active but are critical to accelerate the response
- those who work on other issues that are relevant to the NCD response
- those who share an interest to partner on the issue

Fig 1. Potential stakeholders for partnership

Given that actions in the non-health sectors such as trade and agriculture often contribute to the NCD epidemic, it is strategic to partner with civil society actors addressing these issues. The newly adopted UN Sustainable Development Goals present a broad, new avenue to explore potential partners from the development community to join the alliance. As Figue 2 (page 8) outlines, this could include those working on maternal and child health, nutrition, communicable diseases, rights of various vulnerable groups, water, environmental concerns and rural and urban concerns among others.

The results of the civil society mapping described in the previous section offer a good place to start the search for partners. Further, use the Stakeholder Assessment Tool to develop a matrix of CSOs of relevance to various NCD issues listed against their interest and influence to identify those who could be invited to be members of the alliance and those likely to offer external support. T2

TOOL 2 | Page 171
Stakeholder Assessment Matrix

NCDs across the SDGs
A call for an integrated approach

Populations in low- and middle-income countries (LMICs) are at increased exposure to risk factors for NCDs, can experience loss of household income from unhealthy behaviors, poor health and premature death. The cost of treatment and/or loss of employment and income push vulnerable people and families deeper into the poverty cycle.

CLIMATE CHANGE and NCDs have shared causes, and can be addressed through co-benefit interventions such as divesting from fossil fuels, enabling active transport, and promoting sustainable food systems. **Rising temperatures and heat wave episodes lead to increasing rates of mortality from heart attacks or stroke.**

Changes to food and agriculture policies aimed at promoting more local, seasonal, plant-based diets can improve nutrition, minimise emissions from food transport, and support local farmers and markets.

Sustainable cities can combat physical inactivity, malnutrition, and exposure to air pollution and harmful chemicals by promoting active transport such as walking and cycling; **sustainable food** and agriculture systems; **responsible waste manageneme**nt; and **energy-efficient** buildings, industrial processes and infrastructure.

Nearly **75%** of deaths due to NCDs **in 2012 occurred in LMICs.** Lack of access to affordable, equitable, and essential health services and technologies places high financial strains on populations in LMICs.

Promoting full and productive employment and decent work for all includes investing in healthy workplaces and well-designed wellness programmes. NCDs cause disabilities that prevent people from finding and/or sustaining employment.

57% of people diagnosed with cancer have to **give up work or change roles**.

Almost **50%** of all stroke survivors are **unemployed after one year**.

Malnutrition in all its forms, overweight & obesity and undernutrition, are **risk factors for NCDs** such as heart disease, cancer, and type II diabetes.

GOOD HEALTH AND WELL-BEING

Education and literacy, particularly for health, **are essential for reducing exposure to common risk factors for NCDs**, such as malnutrition, physical inactivity, tobacco use, and harmful use of alcohol.

Women and girls are disproportionately affected by NCDs and their risk factors.

51% of NCD DEATHS are in women, many of whom are in the most productive years of their life.

Access to clean water is essential for nutrition and reducing pollution, all of which contribute to healthy lives.

3.8 million **premature deaths annually from NCDs** attributed to exposure to household air pollution. The most common source of household air pollution is unimproved cook stoves.

Outdoor air pollution causes

3.7 million premature deaths annually, a number which could be vastly reduced by transitioning to renewable energy sources.

Fig 2. NCDs across the SDGs. Click on the + for more information

Fill in the matrix by listing specific organisations/individuals, consider why they may be interested in NCDs and whether they may be a good fit for your NCD alliance. Include those outside the health sector whose work is relevant for NCD prevention and control. Some examples of potential partners are given in **this sample** S2. It also provides links to some of the international civil society networks of relevance to NCDs, whose in-country members could be included in the civil society mapping, stakeholder assessment and eventually invited to join your alliance. Some alliances choose to be multisectoral and include academia, research agencies and relevant private sector. The obvious exclusion for any NCD alliance would be entities such as the tobacco and alcohol industry or food and beverage companies whose core business undermines the achievement of the global NCD targets.

SAMPLE 2 | Pages 60-61
Potential Partners

Hear are some broad criteria to identify partners to be approached to join the alliance:

- well placed to address the identified need for establishing the alliance
- willingness to contribute to the alliance
- suitability of organisational design
- match in core values, principles
- access to advocacy targets and influencers
- outreach to the community being serviced
- reputation of work

Membership recruitment drives seem to have helped the formation of some NCD alliances. In Brazil, ACT Brazil organised a series of regional tobacco control advocacy workshops with women's groups that led to the country's tobacco control network that eventually expanded to become its NCD coalition (Aliança de Controle doTabagismo + Saude ACT+). Similarly, several of the NCD alliances in East Africa conducted workshops specifically to recruit and equip members. A sample programme of the workshop by Zanzibar NCD Alliance can be found **here** S3.

SAMPLE 3 | Page 62
Membership recruitment workshop agenda of Zanzibar NCD Alliance.

The NCD Alliance followed certain criteria when it was formed in 2009. It decided to invite only global federations that are like-minded and with similar structure to have the greatest impact and legitimacy. Given that the Alliance aimed to influence global platforms, it required its members to have international reputation and official relations with WHO, with members on the ground who would bring legitimacy to its work.

Making the case for partnership

Once you have a preliminary list of potential partners, it is time to approach them and make the case for starting an NCD alliance or joining an existing one. Some may be already convinced of the need for collective action, where as others might need some convincing. In other cases, the linkages between the CSO's work and NCDs may not be evident and need to be demonstrated.

Top tips to bring stakeholders on board the alliance

- Develop the alliance vision, mission and branding broad enough to appeal to a wide range of stakeholders
- Develop and convey clear added value of the alliance, ensuring that it does not duplicate the work of its members
- Engage leadership of organisations at early stage to ensure their commitment
- Build relationship and trust with individuals representing the organisations
- Clarify roles and responsibilities from the outset
- Create space in the alliance structure for different levels of association for various stakeholders
- Participate in meetings/networks addressing issues of relevance to NCDs and explore linkages
- Run pilot interventions with CSOs from other sectors and share learning
- Generate and present evidence on the co-benefits of co-interventions on NCDs and other issues
- Frame NCDs and their response as aligned to the goals of potential partners
- Develop joint position papers

For example, the NCD alliance in India intends to reach out to an audience beyond NCD-related organisations, and has therefore branded itself as the "Healthy India Alliance" with a stated vision to "catalyse multisectoral action to enhance health and quality of life". Meanwhile, Brazil's NCD coalition has set itself up as a core group that consults on governance and strategic matters, with a larger open, informal network of nearly 1000 CSOs who receive information on NCD concerns and lend support to the alliance campaigns. The NCD Forum Bangladesh reached out to networks working on nutrition, urban health and environmental issues and made the case for joint responses on NCD concerns at their meetings.

TOOL 3 | Page 172
Make the Case Tool

The third column (reason they would be interested) in the Stakeholder Assessment Matrix (see Tool 1) provides the starting point for making the case for the establishment of an NCD alliance. Building on that information, fill in the **"Making the Case" tool** T3 that would help identify how to position NCDs in the stakeholder's context and language.

Framing the issue for potential partners is critical. For example, an environmental NGO may be focused on reducing air pollution by promoting public transport. However, it would not take them much to sign on to a petition demanding walking and bicycle lanes that promote physical activity (an NCD intervention), if it could be shown to provide

last mile connectivity that would increase the use of public transport that they are championing.

It is important to create spaces for senior leadership of member organisations to ensure commitment and active contributions. This could include inviting them to special events of the alliance or involving them in governance. For instance, the Norwegian NCD Alliance has set up a steering group that brings together the Chief Executive Officers of its member federations who decided on its priorities. The staff from the member organisations follows these decisions through to implementation.

Develop a shared agenda through strategic planning

The first order of business for a new NCD alliance should be to identify a shared agenda that fits the mandate and interests of its members, while helping them to pursue certain common goals. Envisioning and agreeing to common goals are an important part of forming an NCD alliance. This process benefits from being done in a systematic way through strategic planning that involves its members and other key stakeholders in the external environment.

The process of strategic planning is as important as the plan itself. The key steps in NCD Alliance's (Global) strategic planning process showcases the steps involved and could help inform this process S4. Here are a few things to keep in mind as alliances embark on strategic planning:

- Engage a broad range of stakeholders internal and external to the alliance
- Create space for a consultative process that allows expression of diverse ideas and views
- Discuss how views of external stakeholders (e.g.: government, private sector) would be addressed in the planning
- Set clear timelines to avoid protracted planning, losing opportunities and delay implementation
- Develop a realistic plan matching alliance capacity, opportunities and timeframe

SAMPLE 4 | Pages 63-65
Strategic Planning Process of NCDA

The South African NCD Alliance adopted an inclusive, bottom-up and participatory process to developing its strategic priorities through a meeting of key stakeholders. Over 100 participants from CSOs, government agencies, research and academic institutions and the private sector undertook a SWOT analysis of the sectors (identifying Strengths, Weaknesses, Opportunities and Threats) and developed a national NCD Action Plan identifying priority areas for collective action. The meeting report S5 presents the national plan and provides insights to galvanise diverse stakeholders to contribute to alliance planning and action.

SAMPLE 5 | Pages 66-90
SANCDA National NCDs Stakeholders Meeting Report

Figure 3 shows a strategic planning framework that helps alliances to develop/refine their vision, mission, set goals, assess alliance capacity, develop strategic objectives and activities, as well as indicators to determine if their actions are working. In addition to setting the direction for work, a strategic plan is critical to attract resources to the alliance.

Fig 3. Strategic Planning Framework

TOOL 4 | Pages 173-174
Strategic planning questions

SAMPLE 6 | Pages 91-115
UNCDA draft strategic plan

All alliances might not be in a position to undertake the strategic planning as detailed in the figure above, or hire services towards it. The simple strategic planning tool T4 may be used by an alliance, engaging a relatively neutral and well-respected facilitator from within the group with limited resources. If resources permit, the help of a professional strategic planner can be hired to guide the alliance through its planning. A step by step guide to strategic planning S6 developed by International HIV/AIDS Alliance is referenced among the resources[2]. The draft strategic plan of Uganda NCD Alliance presents the core contents of a plan. See the NCD Alliance Advocacy Toolkit for some great tips and case studies from the field on building consensus-based alliances for NCD advocacy[3].

Determine organisational design and governance

These are often considered two of the more daunting tasks in the early days of an alliance. The challenge arises partly from the varying notions members may have about the structure an alliance needs to have and how it is to be governed. It is important that alliances are not overwhelmed by protracted discussions on design and legal status in the initial phase. Instead they could devote the early days to explore diverse partnerships and methods of work through short term goals and campaigns and evolve a shared agenda. On realising some early experience at working together and developing a shared agenda, alliances tend to be in a better place to firm up the overall alliance design and discuss a legal framework. Bearing this in mind, this sub section explores the various components of organisational design and governance that alliances could consider as its members begin to work together.

2 How to develop a Strategic Plan. A tool for NGOs and CBOs. International HIV/AIDS Alliance. https://www.k4health.org/sites/default/files/Developin_a_strategic_plan.pdf

3 NCD Alliance Advocacy Tool kit. http://www.uicc.org/sites/main/files/atoms/files/NCD_Alliance_Toolkit.pdf

Organisational design refers to the institutional framework that holds the alliance together and distinguishes it from its environment in which it operates. Governance determines who has power, who makes decisions, how other players make their voice heard and how account is rendered (Institute on Governance, Canada).

Once a shared agenda is developed through strategic planning, the next step is to agree on the kind of organisational design that would help realise it. The mantra to follow is "Form Follows Function"! Figure 4 suggests that the organisational design of alliances usually comprises of:

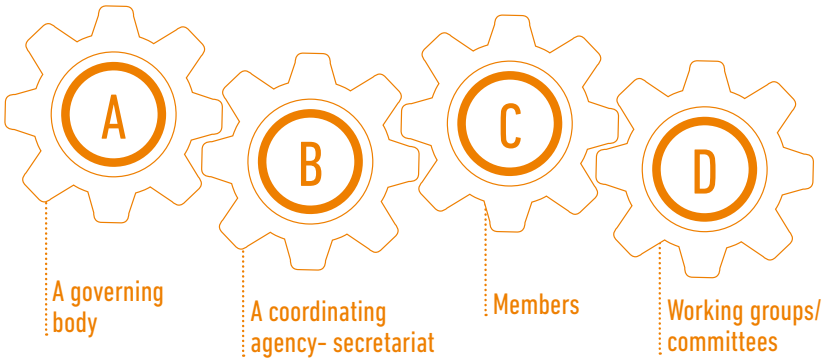


Fig 4. Organisational framework

A. Governing body

Each alliance needs to have a transparent decision making body that offers core governance. Individuals undertake this task in a voluntary capacity, to ensure sustainability. Alliances set up different kinds of decision-making bodies to manage their work. Some have an all-inclusive, flat structure such as a coordination committee, while others have executive committees/steering groups/boards that are either nominated or elected from among the members. This body can comprise of only organisational members of the alliance, only individual members, or both. Some of the commonly found structural models have been described here S7.

SAMPLE 7 | Page 116
Organisational designs

A governing body should:

- Know how well the organisation is meeting its aims
- Recognise and meet legal requirements
- Make strategic and timely decisions
- Explain where, why and how money has been spent
- Provide strong leadership to the alliance
- Treat members fairly and equally

Previous experience has shown the following to be important when determining the alliance decision-making body.

Six questions to help determine the governing body format

What kind of body can:

1. Help realise your shared agenda/strategic plan?
2. Facilitate swift and effective decision-making in the alliance?
3. Leverage contributions and commitments from members?
4. Represent key interest groups within the alliance?
5. Facilitate access to your external audience?
6. Manage the power equations within the alliance?

For example, the Australian Chronic Diseases Prevention Alliance (ACDPA) has a steering group consisting of the Chief Executive Officers (CEOs) of its five constituting members. While ACDPA is not legally registered, its constituent members are all legal associations. The chair is rotated among the members every two years. The member CEOs hold quarterly meetings of the steering group to decide on the strategic matters of the alliance. They also try to help connect the work of their respective membership base with that of ACDPA, where as the government relations officers of these organisations coordinate with ACDPA Executive Officer to implement alliance's advocacy efforts. The members pay fees. Additionally, the chair's organisation houses the alliance and provides operational support.

On the other hand, most alliances in East Africa are legal entities and consisting of member organisations that are themselves registered. They have formal Boards/Executive committees. For example, Zanzibar NCD Alliance consists of three member organisations (each working on diabetes, cancer and heart associations). Its general body comprising of 10 members from each of the member organisations elects the Chair, vice chair, general secretary and treasurer to its executive committee. Additionally, this committee includes 2 representatives from the member oganisations. While the Constitution requires the committee to meet every 3 months, it meets more frequently to provide close oversight over the projects. The general Secretary is involved in the daily functioning of the alliance, and the project manager reports to this position.

The alliances in Latin America have all chosen to remain non-legal, informal coalitions. For example, the Healthy Latin America Alliance has a working group with representatives of those working on tobacco control, consumers rights, cancer and heart issues. The working group functions as an informal group, where in members with advocacy experience across the region come together to assist any country that needs help in their NCD initiatives and work on shared goals. The group recently supported Chile to develop a strategy to counter industry influence on its food policy.

Roles and responsibilities

The governing body will:

- Set and safeguard the vision, values and reputation of the alliance
- Provide strategic, long-term direction to the alliance
- Oversee the performance and integrity of the organisation
- Approve the budget and annual accounts
- Appoint and dismiss the secretariat/chief executive
- Approve and dismiss members following due process
- Establish and dismantle working groups/committees
- Ensure that the alliance meets all its regulatory and statutory obligations
- Manage and support staff and volunteers where applicable

Selection process

Some alliances elect members to their governing body. Others have nominated members. For instance, the Healthy Caribbean Coalition has an elected board, where as the steering group of the NCD Alliance (Global) selects its own members. The alliances will need to develop a transparent selection process to the governing body. Some good practices in this regard include:

- Define clear criteria and process for representation on the governing body
- Advance announcements about positions and process to join the governing body to all stakeholders
- Equal opportunity for all competent members to be considered for the position
- Clear communication to the candidates and the alliance about the outcomes of the selection
- Mechanism to address concerns about the selection processes

The governing body sets the long term vision and protect the reputation and values of the alliance. To make a difference, it needs to have proper procedures and policies in place but it also needs to work well as a team and have good internal relationships. An effective governing body will provide good governance and leadership by:

- Understanding their role
- Ensuring delivery of organisational goals
- Work effectively both as individuals and as a team
- Exercising effective control
- Behaving with integrity
- Being open and accountable

Governance

As mentioned above, governance helps determine who has power, who makes decisions, how other players make their voice heard and how account is rendered. Robust alliance governance is essential for legitimacy.

Clear decision making process

As a first step, the governing bodies need to determine the roles and responsibilities of various parts of the alliance. For example, a governing body might decide to promote physical activity through urban planning among its strategic priorities, while it would delegate the campaign details to be worked out by the secretariat and the relevant working group of members.

The decision making processes, for instance, require to clarify the kind of decisions that would be taken at the level of the governing body, what it would need from the secretariat to make these decisions, who would be consulted on its decisions, how would consensus be sought and strategic decisions made, the boundaries for compromises and how its decisions would be conveyed to key stakeholders.

The RACI framework (Figure 5) provides a useful tool to determine who will be responsible, accountable, consulted and informed about the governance decisions of an alliance.

Fig 5. RACI Responsibility Chart

Decision making

Alliances are geared to undertake joint action and to enable this, different options exist for making decisions. Some seek consensual decision-making, whereas other seek majority votes within the governing body and among the members. The voting rules are to be included in the terms of reference for the governing body.

TOOL 5 | Page 175
Steps to building consensus

Six steps to building consensus in an alliance T5

Governance leadership

NCD alliances follow different approaches to select the leaders of their governing bodies. Some alliances go by seniority and experience, others rotate the leadership at fixed intervals, and still others elect their leaders through ballot. For example, a well-respected, senior medical professional chairs the Nigerian NCD Alliance, whereas the position of chairperson rotates among the founding members of the Uganda NCD Alliance. HCC has provisions to elect its chair and European Chronic Diseases Alliance has the representative of the host organisation serving as its chair.

The Chair of an NCD alliance needs to:

- Enjoy the trust of the governing body, members, secretariat and other stakeholders
- Provide visionary leadership in setting the direction of the alliance
- Facilitate objective and transparent decision making
- Steer all stakeholders towards agreed goals
- Assist and advise the head of the secretariat to ensure smooth running of the organisation

Some good practices in leading governing bodies

Rotational leadership

Where the head/chair of the governing body is changed at fixed terms. This positions the alliance to benefit from the strengths and interests of different members. The Nepal NCD Alliance, for example, rotates its coordinator's position among its members every 2 years. The rotational leadership gains importance particularly in alliances where the governing body is nominated/selected (and not elected). This would help avoid stagnation in leadership as well as potential resentment among members. The alliances with elected governing bodies, might include term limits to the chair's position to encourage diverse leadership.

Co-leadership

Alliances often have co-chairs/co-facilitators instead of a single leader in their effort to keep the structure less hierarchical and more democratic. For instance, both Mexico Salud-Hable and the Uruguay NCD alliance have facilitators steering their work, instead of a single leader.

United Nations Economic and Social Commission for the Asia and Pacific (UNESCAP) suggests nine characteristics of good governance that can be applied to your alliance (Figure 6).

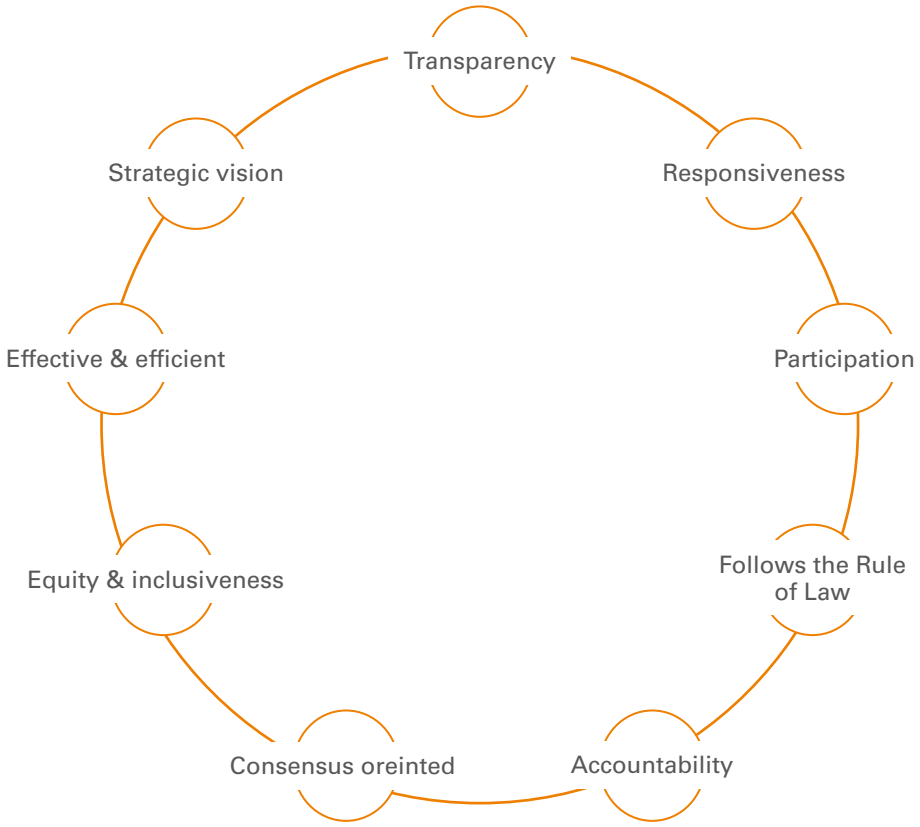


Fig 6. Nine Characteristics of Good Governance Source: UNESCAP, 2005.

B. Coordinating agency - secretariat

The work of the alliance and its governing body needs the support of a secretariat with qualified staff. The secretariat can be an independent entity separately located from its members, as in the case of the South Africa NCD Alliance S8. Alternatively, any of the member organisations may offer to provide staff and facilities to serve as the secretariat. Thus, the German NCD Alliance receives secretarial support from the German Diabetes Association, one of its members; the Colombian NCD Alliance is serviced by its member organisation - Educar consumidores.

SAMPLE 8 | Page 117
Independent secretariat

There are pros and cons to both the approaches. While an independent secretariat may be viewed as neutral and fair in its work with all members, it runs the risk of isolation, failing to understand the contexts of its members and requiring resources for its operation. On the other hand, a secretariat operated by a member organisation may find it challenging to retain its independence (or the perception of it) while benefitting from the host's resources and administrative, legal and staff support.

Alliances could have greater buy-in by having staff housed across key members at strategic locations. This distributed work model could help to keep constant flows of information between the members and the alliance secretariat. At the start of an alliance, the founding members could volunteer the staff time to the alliance. For example, in its early days, a number of organisations dedicated 30% of advocacy staff to the NCD Alliance (global). Currently, the Alliance has some staff housed in member organisations in New York and Geneva, which helps to reach to its key target institutions such as the UN and WHO in addition to partnerships with the hosting members.

Irrespective of the nature and location of the secretariat, establish clear and direct lines of reporting from the secretariat to the governing body of the alliance. In most NCD alliances, the head of the secretariat reports to the chair or the general secretary of the governing body.

The Norwegian NCD Alliance and European Chronic Disease Alliance rotate their respective secretariats at fixed intervals. This practice presents equal opportunities to all members, thus helping develop a sense of ownership and contribution among member organisations. It also helps not to over burden the host organisation and avoid any undue influence. However, the practice of rotating secretariat needs to take into account the hosting capacity of members as well as the sustainability and continuity of the work.

Good secretariat practices

- The selection of the secretariat needs to be an informed choice through an open and transparent decision-making process involving as wide a number of participating CSOs
- The secretariat's location, number of years and terms for hosting by any member organisation, and rotation of hosting needs to be agreed upon and captured in the alliance MOU
- The secretariat needs skilled and qualified staff, who can provide managerial, technical, coordination and operational support to the alliance
- Any member organisation hosting the secretariat needs to provide it with an effective operational platform
- Irrespective of its location, the secretariat should work on behalf of all alliance members and be primarily accountable to the governing body of the alliance, and not the host organisation
- The host should not exert undue influence over the secretariat's work plan or mode of operation, or over the alliance as a whole
- The secretariat should report regularly to the chair/facilitator of the governing body, while meeting administrative and financial requirements of the host organisation
- The secretariat is to share opportunities for resources, representation and collaboration with all alliance members and not be competing with its members

(Adapted from SUN Guide to Establishing A Civil Society Alliance In A SUN Country and experiences of Healthy Caribbean Coalition)[4].

4 SUN Guide to Establishing A Civil Society Alliance In A SUN Country.
http://scalingupnutrition.org/wp-content/uploads/2013/01/SUN-CSN-Establishing-a-CSA.pdf

A sample Terms of Reference of the Secretariat that outlines the Secretariat's key roles and responsibilities can be found here S9.

SAMPLE 9 | Page 118
Terms of Reference for the Secretariat

The fiscal management is an area where alliances need operational support. In the case of alliances that are not legal entities, the host organisation or a steering group member tend to serve as the fiscal agent. For instance, the financial matters of the European Chronic Disease Alliance are managed by the organisation hosting its secretariat. In the case of NCD Alliance (Global), one of its steering group members serves as its fiscal agent. When alliances are legally registered, fiscal management tends to be a function of the secretariat- either this can be outsourced to another org, or if the secretariat has the expertise it can be done by them. The fiscal role would include maintaining the books of accounts, handling all financial transactions (receipts and payments), preparing management accounts for the governing body and reporting to relevant government bodies.

C. Membership

Members form the core of any alliance, bringing the much needed legitimacy and expertise to meet its goals. Therefore membership considerations need to be an important factor in deciding organisational design and governance. The kind of members that alliances bring to their fold, how they are organised and their roles and responsibilities all need careful consideration.

An early task is to determine the best spaces that can be created for the potential members identified through the member scoping exercises discussed under Section II (2). Organise the members depending on their potential roles and their degree of contribution and association with the alliance (Figure 7). Alliances tend to have different categories of membership by stakeholder types or degree of association. Some may be full members, whereas others may be associate members.

The roles, privileges and responsibilities vary across categories and these should be clearly stated in the alliance MOU/bylaws. For example, a regular member would have full voting rights, whereas an associate member may be restricted from voting in the alliance or participating in its meetings. NCD alliances in high-income countries almost always have a membership fee. This usually goes towards meeting the core expenses of the alliances. On the other hand, those in low-income countries rarely have membership fees, or charge a minimal fee as it is found to place undue burden on member's limited resources.

Fig 7. Membership Circles by degree of association

Role of full members usually include opportunity to:

- Contribute to the development and implementation of the strategic priorities of the alliance
- Elect responsible leadership to the governing body of the alliance
- Offer to facilitate, participate, contribute to the committees/ working groups of the alliance
- Contribute to advocacy campaigns, position papers, media initiatives of the alliance
- Bring technical and financial resources to advance the alliance's work
- Ensure transparency and accountability in the alliance

D. Working groups/committees

Alliances, particularly those with a large membership or those intending to address a variety of issues, may set up committees and working groups on operational and thematic matters respectively. On the operational front, there could be committees that look into fundraising, membership matters and such. See how the Uganda NCD Alliance has organised its work through various sub-committees reporting to its Board here S10.

A sample Terms of reference for committees can be accessed here T6.

On the thematic front, there could be working groups, for instance, looking at the response to the individual diseases as distinct from those addressing risk factors. The sample S11 Terms of Reference of the Working Groups of the US Round Table drives the point home.

Sample Terms of Reference for working groups can be found here T7.

SAMPLE 10 | Page 119
UNCDA Working committees

TOOL 6 | Page 176
TOR Committees

SAMPLE 11 | Pages 120-121
TOR of US RT Working Groups

TOOL 7 | Page 177
TOR Working Groups

Aligning organisational structures of members and the alliance

Apart from shared goals and functions, another factor to consider while determining the alliance structure is its match with that of its members. The Malaysian NCD Alliance, for instance, built on the commitment of its early individual supporters and constituted itself as an alliance of individual members. Alliances in Latin America are mostly not legally registered, thus allowing the inclusion of a wide variety of organisational structures and movements that may or may not be legal entities. On the other hand, several alliances in East Africa focused their initial efforts on building organisational structures and capacity of constituent/ potential members so that they can interact and function seamlessly with the coalition's legal structure and ensure institutional alignment. This factor gains significance when establishing regional alliances that would need to accommodate the institutional framework of national alliances of varying structures.

The organisational design and the governance of an alliance can be captured in a Memorandum of Understanding (MOU) to be agreed among the members, or in the constitution/bylaws of the organisation. A sample MOU from European Chronic Diseases Alliance (non-legal

entity) can be accessed here S12. A sample by laws of Healthy Caribbean Alliance (with a legal entity) can be found here S13.

As alliances think of seeking legal status, consider the points to ponder here T8.

SAMPLE 12 | Pages 122-130
ECDA MOU

SAMPLE 13 | Pages 131-145
HCC Bylaws

TOOL 8 | Page 178
Points to Ponder

Types of NCD alliances

No two NCD alliances are the same! As Figure 8 indicates, the alliances come in all shapes and sizes, and serve a wide variety of purposes. Thus, while some alliances have fixed members (e.g. The Norwegian NCD Alliance), others are open to new members (e.g. Uruguay NCD Alliance). Some consist of a handful of members (e.g. Danish NCD Alliance); others have membership running into hundreds of organisations (e.g. Brazil's NCD coalition). Some are meant exclusively for organisations, while others consist of individuals (e.g. Malaysian NCD Alliance) or admit them as well. Some include academic, research and international oragnisations (e.g. Healthy Caribbean Coalition), while others consist of medical societies (e.g. Chilean NCD Alliance), journalists (e.g. Nepal NCD Alliance) and still others have trade unions and rights-based movements on board (e.g. Mexico NCD Alliance). Some NCD alliances provide for government and/or political representation within their fold (e.g. Bangladesh NCD Forum); others remain strictly non-governmental. Some allow varying degrees of association with the private sector (e.g. NCD Round Table, USA), while many consciously exclude them (e.g. Healthy Latin America Coalition).

Alliances could be limited in purpose and short term in nature. For instance, there could be a campaign coalition working to get a soda tax for the duration of a government budget session. Most known NCD alliances work on a range of issues over several years.

Some alliances are legally registered (such as the Kenya NCD Alliance), almost all in Latin America are informal entities. As the Organogram here S14 indicates, some such as the Healthy Caribbean Coalition (HCC) have a hybrid model with a legal entity managing governance, and a broader, informal member base. The NCD Alliance (Global) has a more elaborate structure. It is governed by a steering group, guided by an advisory group, supported by a supporters consultation group, with an extended, informal network of national and regional NCD alliances, a steering group member serving as its fiscal agent – all managed by an operational team spread across countries. The detailed structure of the NCD alliance can be found at: https://ncdalliance.org/who-we-are/ncd-alliance-structure

Refer to the recent NCD Civil Society Situational Analysis by the NCD Alliance for a detailed view of the unique features of each alliance, and trends and diversity within the movement[5].

SAMPLE 14 | Page 146
Hybrid Governance Structure of HCC

5 Achieving 25 X 25 Though Civil Society Coalitions. A Situational Analysis of National and Regional NCD alliances. NCD Alliance, 2015.

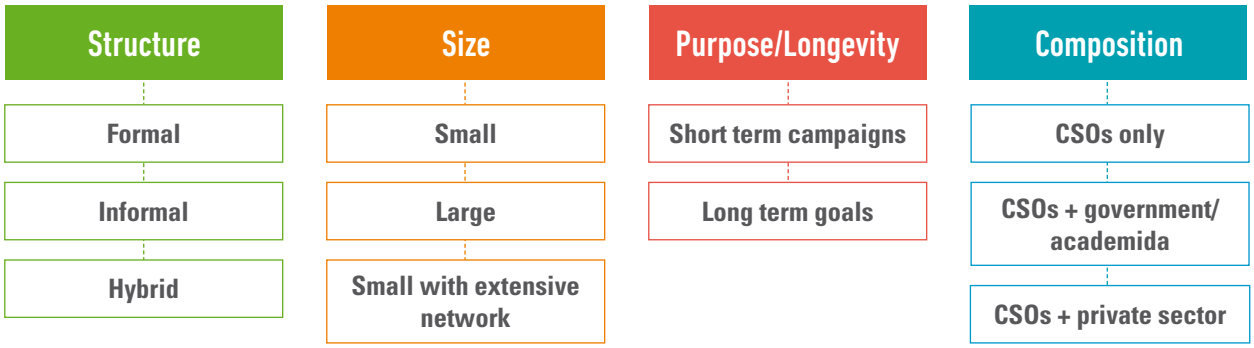


Fig 8. Types of alliances

Establishing effective national and regional NCD alliances

Once the basic building blocks of an alliance are put in place, it is time to consider the next steps that would help establish them.

Resource the work of the alliance

Resources are critical to build an effective alliance. As mentioned earlier, the strategic plan constitutes the stepping-stone to resource mobilisation helping to identify priorities for fundraising and indicating organisational intent and direction to potential donors. Figure 9 demonstrates the steps from strategic planning to resource mobilisation. A donor mapping can help identify donors whose funding priorities match with those of the alliance.

Based on the priorities in the resource mobilisation plan, prepare a brief on the potential business opportunities for the alliance and further a business case for openings you intend to pursue. Actively pursue competitive grants and submit proposals where you sense a funding possibility. A sample resource mobilisation plan template can be accessed here T9. The USAID Resource Mobilisation Implementation Kit provides useful guidance in this regard[6].

TOOL 9 | Page 179
Resource Mobilisation Plan

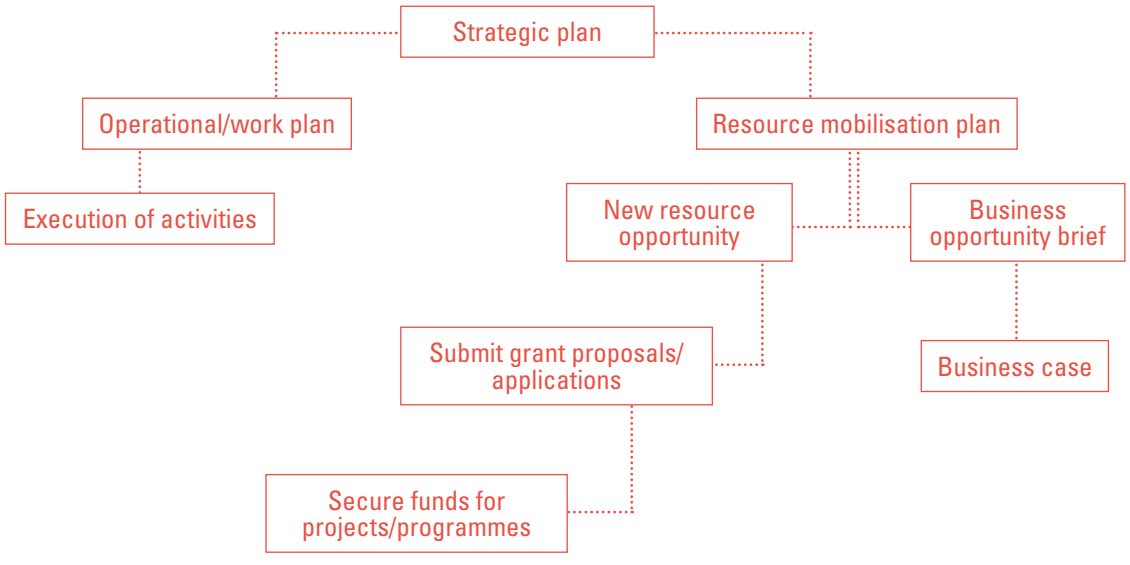


Fig 9. Strategic Plan to Resource Mobilisation

6 Resource Mobilisation Implementation Kit. Health Communication Capacity Collaborative. http://sbccimplementationkits.org/resource-mobilization

Six questions that can get you started on your resource mobilisation plan

1. What are you raising funds for?
2. Who in the alliance is responsible for resource mobilisation and are they clear about their roles and expectations?
3. Who are your priority donors?
4. How will you identify, approach, and cultivate your priority donors and who will do it?
5. When will you execute your action steps?
6. Systems - what kinds of practical systems do you need in place to support your RM efforts?

SAMPLE 15 | Pages 147-151
HIA Workplan

Here is a sample S15 workplan from Healthy India Alliance that showcases its priorities for funding in the first year.

Build legitimacy and credibility

NCD alliances need to build credibility with the public they represent and legitimacy with the governments and other stakeholders they work with. Nothing works like "early wins" in building credibility with the various players in the external environment of an alliance. The "early wins" could be in terms of successful campaigns, organising an innovative event, building a functional partnership or even securing a grant.

SAMPLE 16 | Pages 152-158
DNCDA PowerPoint on Legitimacy-Transparency-Accountability

The four pillars of credibility are captured in Figure 10 S16. While good governance ensures effective and accountable decision making, transparency brings in open processes and public disclosures, accountability places responsibility to act as per commitments and expectations and legitimacy ensures that activities and impact of the alliance relate to its core values. Refer to a PowerPoint presentation by the Danish NCD Alliance that elaborates upon these concepts.

SAMPLE 17 | Pages 159-160
US NCD Round Table Principles

The US NCD Round Table has a set of principles S17 of transparency, accountability and integrity that its members comply with. Consider the Frequently Asked Questions on alliance transparency here T10.

TOOL 10 | Page 180
FAQs on transparency

Fig 10. Pillars of Credibility

Some key ways to build legitimacy and **credibility include**:

- **Clarity of vision** and unity in mission
- **Evidence-based** advocacy
- **Involvement** of people living with NCDs
- **Consistent**, **unified** messaging
- **Publishing** reports and accounts
- **Identify**, **monitor** and **address** conflict of **interests**

Managing conflict of interest

Of the measures that can affect civil society credibility, real or perceived conflicts of interest are particularly important for NCD alliances to manage and address. This is on account of the role private sector plays both in contributing and responding to the NCD epidemic.

Definition: Conflicts of interest are circumstances that create a risk that professional judgment or actions regarding a primary interest will be unduly influenced by a secondary interest. These occur when someone has multiple relationships or connections, which could keep them from being independent in thought, action, or opinion. This could happen at the level of the governing body, staff, members or the interactions, positions and partnerships of an alliance as a whole. A perception of a conflict of interest can be just as significant as an actual conflict of interest.

Implications of conflict of interest

- Compromises goals, agenda and positions
- Lowers trust among members that challenges joint action
- Causes an NCD Alliance to lose credibility with the public and scope to represent pubic interest
- Affects an NCD alliance's legitimacy with policy makers and blunts the advocacy edge

Reducing risk of conflict of interest

NCD alliances can put systems in place to mitigate the risk of real or perceived conflict of interest. Alliances can require members to submit disclosure forms in line with the alliance conflict of interest policy. A membership can conduct due diligence of applications before admitting members. A disclosure form cum due diligence checklist is available here T11.

In the event of perceived or real conflicts of interest T12, here's a flow chart that demonstrates the process to address them.

TOOL 11 | Page 181
Disclosure Form cum Due Diligence checklist

TOOL 12 | Page 182
Conflict of Interest Management Flow Chart

How to prevent conflict of interest?

- Include transparency, accountability among organisational values and principles
- Develop and implement a conflict of interest policy
- Require due diligence and full disclosure of potential conflict of interest from all members and partnerships
- Institute a model code of conduct for members

Some of the issues a **Model Code of Conduct for the members** on interactions with the private sector could address are:

- Positions of the alliance, including about partnerships
- Meetings outside the public domain
- Resources for projects
- Sharing platforms
- Co-branding, co-publishing
- Using private sector research
- Staff recruitments
- Policy on acceptance of gifts

Detailed guidance and tools specific to conflict of interest will be available soon.

Communicating internally and externally

The NCD alliance's communications need to address both internal and external audience.

The internal audience primarily involves the governing body and the members. All governing body communication needs to be held in confidence and duly recorded. It would typically comprise of governance and fiduciary matters, work of sub committees and working groups, operational updates from the secretariat, decisions taken, follow up actions and any other matter that its members find relevant to address. Communication to the members needs to include timely updates of the decisions and actions of the alliance, as well as alerts regarding opportunities for action and collaboration. Alliances often set up email lists, messaging groups and conference calls for internal communication.

External communication is meant to convey an alliance's message to stakeholders in the external environment. NCD alliances use a variety of media platforms to broadcast their messages. The South African NCD alliance updates its members of their activities through periodic newsletters. Mexico Salud-Hable uses Twitter to elicit support for its campaigns. Alliances regularly use print and television, sometimes as a way of responding to opposition to alliance positions.

TOOL 13 | Page 183
Communication plan template

A detailed communication plan in line with the alliance's strategic plan, that aligns its key messages with influential messengers in appropriate media platforms, needs to be developed to address both internal and external communication. A communication plan template can be found here T13

Ensuring accountability

The public interest nature of the causes that NCD alliances espouse calls for accountability to the primary constituency they represent - the public. This can be done formally through annual reports. Social media and alliance website can also be used strategically to communicate its major activities and plans to the stakeholders.

The alliances would also want to monitor their own progress in implementing the strategic plan and evaluate progress. Additionally, they may have reporting requirements to the registration/licensing authorities in the country in which they operate and to donors. It is important that alliances monitor and communicate their work to the relevant stakeholders and regulators.

Internal Financial controls is a key means to ensuring accountability in alliances. The controls need to apply to the governing body to ensure accountability to its members or the general body. It also needs to apply to secretariat and/or fiscal agent to ensure accountability to the governing body.

Controls within the Board

Financial transparency demands the roles and responsibilities of the governing body and the secretariat are clearly delineated. For instance, it is not advisable for the treasurer of an alliance to double up as its accountant. In alliances with limited staff support, where governing body steps in to manage operations including resources, it is important to have co-signatories from the board approving expenses by the treasurer or any other member of the body. As the alliance represents the collective resources of its members held in trust, it is important that expenses by board members (if any) are discussed and decided by the governing body. For example, any travel of board members (including Chair and other office bearers) on behalf of the alliance need to be approved by the entire board. As such all expenses are to be within the approved budget of the alliance. The governing body therefore needs to approve annual budgets towards alliance expense.

Controls over the secretariat

The Head of the secretariat may be delegated to make payments upto a certain threshold towards alliance operations as per approved budget. It is also a good practice to set thresholds for pre-approvals and signatures by the governing body for expenses and payments exceeding certain value. Where the secretariat is located within a member organisation, it will be good to involve the alliance treasurer or a member of the governing body in the oversight over alliance resources. It is strongly encouraged to maintain separate bank accounts for the alliance, irrespective of hosting arrangements.

The records of expenses along with their supporting documents be maintained as required by national audit laws. The secretariat needs to submit the alliance accounts for annual audits, which needs to be reviewed and adopted by the general body or the governing body as the case may be. Regular financial update from the secretariat is critical for the governing body to make informed and sound financial decisions on behalf of the alliance.

Some of **the areas** that require regular monitoring are:

Areas for monitoring	Relevant documents
Functioning of the governing body	MOU Minutes of meetings Strategic Plan
Work of the secretariat	Workplan Reports to governing body Reports to regulatory authorities
Efficiency of working groups/committees	Reports Plans Outcome documents
Advocacy campaigns and events	Campaign plans, event reports
Communication	Media releases Social media reports Newsletters
Strategic plan and operational plan	Annual report Financial report
Resource mobilisation plan	Fund raising report
Service delivery	Programme report Expenses report

SAMPLE 18 | Pages 161-167
DNCDA PowerPoint on Internal control

A PowerPoint used by NCD alliances in East Africa to orient members on internal control procedures can be found here S18.

Capacity building of members

An alliance is the sum of its parts! The greater the capacity of its members, the more effective the alliance will be in its efforts. The SWOT analysis recommended under strategic planning can help identify areas for strengthening member capacity. While extensive capacity building initiatives can evolve over a period of time, some areas for early orientation include:

- national/regional NCD action plans
- good governance practices for alliances
- organisational development of members
- resource mobilisation strategies

Several NCD alliances in East Africa undertook detailed capacity building initiatives with members in their early days of formation. In Uganda, the alliance members began by familiarising themselves with good governance practices and then proceeded to adjust their organisational structures to meet their collective focus on patient advocacy. For instance, the Heart Association, which formerly consisted solely of medical professionals, was reorganised as Heart Research Foundation to accommodate CSOs and undertake research and advocacy on patient issues. The Zanzibar NCD alliance conducted a three-day fund raising training for its members that helped them develop resource mobilisation plan.

REGIONAL ALLIANCES

The East Africa NCD alliance (EANCDA), Healthy Caribbean Coalition (HCC), European Chronic Disease Alliance (ECDA) and Healthy Latin America Coalition (HLAC) are four active regional NCD alliances, with a fifth one emerging in the ASEAN region. Establishing and sustaining regional alliances present unique challenges and call for specific approaches. Some of these challenges and approaches are listed below.

	Challenges	Strategies
1	Identifying an alliance structure that can accommodate the organisational framework of country alliances	EANCDA addresses this by building institutional framework and running capacity building workshops for country alliances.
		HCC has health NGOs from 16 Caribbean countries as its voting members, with non-health NGOs, academia, private sector, individuals and international organisations in accommodated in various membership categories.
2	Determining the membership of regional alliance	ECDA exclusively permits European organisations related to chronic diseases with activities in Europe to be its members.
		ASEAN NCD Alliance has been considering if it should recruit only regional members of the federations that constitute the global NCD Alliance or if it needs to additionally include alliances that are emerging in countries across the region.
3	Managing countries of varying population, size and power	Latin America has countries and NCD alliances of different size within its fold. HLAC addresses this by admitting CSOs and individuals working on NCDs in countries across the region. Its organising committee has representatives from heart, tobacco, cancer and consumer groups.
4	Addressing diverse priorities, principles and practices	HCC addressed this by developing a strategic plan that represents the shared agenda of the country alliances. The plan was developed through survey among key stakeholders and a large consultation meeting with its members from 16 countries, consolidated by a drafting group.
		ECDA members jointly develop and implement an advocacy strategy that is reviewed annually.
5	Sharing limited resources	HCC runs competitive grants that provides equal opportunities for its members from different countries. It also works with country partners to identify funding opportunities specifically available to them.

Samples

REGIONAL MEETING ON STRENGTHENING NCD CIVIL SOCIETY ORGANISATIONS, WHO SEARO
New Delhi, 9-10 July 2015

Background Paper

Mapping of NCD Civil Society Organisations in the WHO South East Asia Region

World Health Organization
Regional Office for South-East Asia

Outline

I. BACKGROUND

The WHO Regional Office for South-East Asia (SEARO) in collaboration with the NCD Alliance is organizing a Regional Meeting on strengthening NCD Civil Society Organizations in the region, in New Delhi on 9-10 July 2015. The meeting aims to strengthen the Noncommunicable Diseases (NCD) civil society movement in the region.

The specific objectives of the Regional Meeting are to:

a) Review the current status and facilitate sharing of experiences among regional NCD civil society organizations;

b) Strengthen the capacity of NCD civil society organizations in forming alliances to drive advocacy, policy, and accountability;

c) Foster effective collaboration between CSOs within and across countries, with governments and WHO to better support implementation of regional NCD priorities.

WHO SEARO and the NCD Alliance commissioned a mapping of civil society organisations (CSOs) working on NCDs in the region to inform the discussions at the Regional Meeting. The mapping aims to describe the current status of civil society action on NCDs in the region, its challenges, gaps and needs. It also explores effective strategies that have worked to advance work on NCDs in SEAR countries in the South East Asia Region (SEAR) and potential partnerships that could accelerate civil society action.

The SEAR NCD Civil Society Meeting is part of a series of such meetings in various WHO regions that are being organised in preparation for the first ever Global NCD Alliance Forum in Sharjah in November 2015. The outcomes of the SEAR meeting and the results of the preceding mapping would therefore inform the future directions of the larger civil society action on NCDs around the world.

II. MAPPING METHODOLOGY

The mapping exercise comprised of an online survey among civil society organisations working on NCDs in the region and in-depth interviews with key informants from SEAR countries.

Survey: The online survey was administered between 18 and 26 June. The in-depth interviews were conducted from 23 June to 3 July.

The respondents were selected by purposive sampling. A multi-pronged approach was adopted to maximise response from the sample population within the limited timeframe of the survey. The sampling frame for the online survey consisted of the following:

- Participants of the Regional Meeting for NCD Civil Society Strengthening in WHO South East Asia Region (SEAR)
- SEAR members of six of the international NCD Alliance federations
- Civil society list of the NCD programmes of the WHO country offices in SEAR
- National NCD Alliances in SEAR

An online questionnaire was developed, pre-tested and administered using Survey Monkey software application. The survey received responses from 9 out of the 11 SEAR countries.

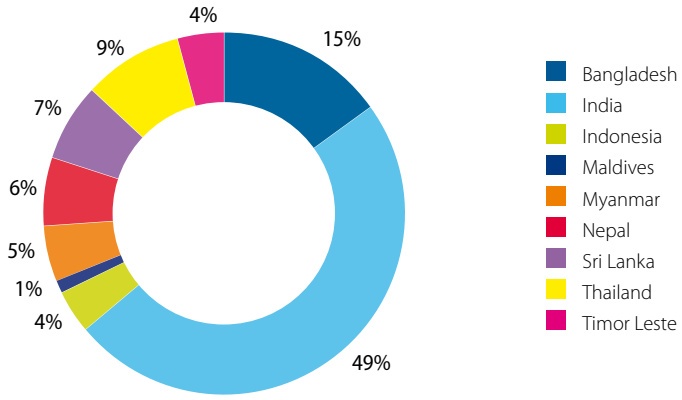


Fig 1. Respondents by Country

Out of the 101 responses to the survey, 21 incomplete or duplicate responses were excluded from the data. The remaining 80 responses were analysed. The questionnaire is in Annex 1.

A large proportion of the survey response has been from civil society working on NCDs in India though there are responses from eight other countries in the SEAR region as well. The proportion of response from countries seems to correspond to the perceived size of the NCD civil society movement therein. Notably, the survey received responses from Myanmar, Timor Leste and Maldives, where civil society initiatives for NCDs are in their early stages of development.

Key Informant Interviews: In-depth interviews were conducted using a discussion guide (Annex 2) with 10 key contacts drawn from various SEAR countries. A key informant from each major NCD and from each of the common risk factors and Alzheimer's Disease was interviewed. The discussion guide explored the survey variables in detail and information was analysed along thematic lines. The details of key informants can be found in Annex 3.

III. SCOPE AND LIMITATIONS

This is the first ever mapping of civil society organisations working on NCDs in WHO SEARO. It is extensive in that it covers all the countries where NCD-related civil society is known to exist in WHO SEARO (9 out of 11 countries). Between the online survey and in-depth interviews, the mapping has also made a reasonable attempt to cover the civil society response to all the major NCDs and their risk factors in the researched countries. The results provide an indication of the overall trends in civil society involvement, achievements, needs and challenges on NCDs in SEAR.

However in the absence of a verifiable database of NCD civil society in the region, the sample of responses analysed cannot be claimed to be a true representation of the population of organisations working on these issues. While every attempt has been made to provide equal opportunity to all CSOs working on NCDs in SEAR to participate in the survey, there may be certain organisations working on these issues that might not have been covered by the survey. Where these gaps in data have been observed in the survey, every attempt has been made to address them specifically through in-depth qualitative interviews of country key contacts. Despite best efforts, no information on NCD related civil society in Bhutan and Democratic People's Republic of Korea could be accessed for this mapping.

IV. SURVEY AND INTERVIEW RESULTS

The analysis of the survey results and interview data were synthesised against major themes. The synthesis is discussed below.

1. Profile of NCD Civil society in WHO South East Asia Region

a)Type of Organisations: Majority of the respondent organisations (60%) working on NCDs in the region appear to be health NGOs. However, the involvement of non-health NGOs in the SEAR NCD civil society movement appears to be significant. Notably, there were more non-health NGO (15%) respondents than those from medical associations* (6%), research agencies (6%) and academic institutions (8%). Several of the interviewees confirmed the role of non-health or rights-based organisations in NCD work in their countries. This needs to be factored into the design of capacity building interventions and advocacy strategies, so as to maximize the multisectoral response required for NCD prevention and control.

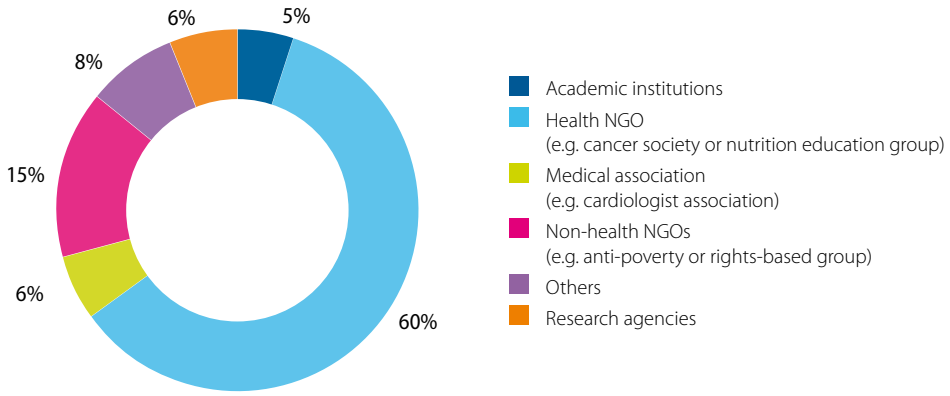


Fig 2. Nature of Organisations

b) Years of Work on NCDs: Nearly one-third of the respondent organisations have been working on any one or more of the NCDs or their risk factors for over twenty years. There seems to have been a slight increase in the number of organisations working on NCDs newly in the last five years (19%), after a dip in the previous 5-year term (down to 16% from 24% 10 years back). In depth interviews corroborated that the increasing global attention on NCDs (e.g. UN High Level Summit of 2011, subsequent World Health Assembly discussions) has drawn the attention of civil society organisations to NCDs in SEAR countries in recent years. Two-thirds of the organisations worked at the national level, 30% at the sub-national level and the rest in multiple countries in the region.

In depth interviews with key informants from SEAR countries reveal an interesting pattern in terms of the stage of entry of various types of civil society organisations into the NCD arena. Medical professional associations and medical professionals seem to play a critical role in the initial phase of NCD civil society movement in SEAR countries. They build and present evidence on NCDs making the public health case and preparing a fertile ground for later action. Health NGOs and risk factor groups come along next, and translate the evidence to messages for the public

* Organisations representing medical professionals and specialists.

and Government, and advocate for policy changes. Non-health organisations tend to join the movement in its more advanced stages, helping make the socio-economic and environmental case for action on NCD and creating in-roads to non-health parts of the Government and the broader public. Several key informants of this research stressed the need for the movement to rope in risk factor, advocacy and non-health groups to translate the evidence to policy ends.

Thus, SEAR countries that have had a relatively long history of NCD action such as Bangladesh, Nepal, Sri Lanka, Thailand, India and Indonesia, by now have active risk factor groups in the NCD civil society arena, following initial stage-setting by medical associations. Notably, in most of these countries involvement of medical associations in NCD advocacy have dwindled in recent years. They seem to be focussing more on matters affecting the profession or treatment options. However, countries where civil society action on NCDs is in its early stages such as Myanmar, Maldives and Timor Leste, medical bodies are at the forefront of initiating the dialogue on NCDs, whereas risk factors groups are yet to emerge.

2. Action on NCDs

a) Target Groups: In terms of target groups, 50% of the respondents considered the public to be the priority target of their interventions, followed by over 25% working with the government. Health NGOs tend to have the broadest variety of targets ranging from the public, NCD affected groups, Government to WHO. However, medical associations seem to work largely within their membership, NCD affected groups and Government, with no reported work targeting the public, media, NGOs and WHO. A similar trend is observed with academic institutions and research agencies too. This points to the need to create more channels for the transfer of subject expertise from such centers to inform a broader range of stakeholders.

Analysis of top priority target audience with number of years of work on NCDs indicates that organisations across the age spectrum appear to be catering to the public as well as government. However the two largest groups in the survey in terms of years of work on NCDs (21+ years and 10-15 year groups) seemed to be catering largely to the public and working with fewer stakeholders. The newest organisations in the NCD space reported targeting primarily government agencies, though they do work with other stakeholders as well.

b) Focus within the NCD agenda: Tobacco control seems to receive the most attention from the surveyed SEAR civil society followed by cancer and the other major NCDs and their risk factors. Indoor air pollution and mental health tend to be areas that receive least civil society attention (Figure 3). Other NCDs that were reported in the mapping include Alzheimer's and Thalassemia. Country interviews indicate that civil society action on unhealthy diet is also in its nascency throughout the region.

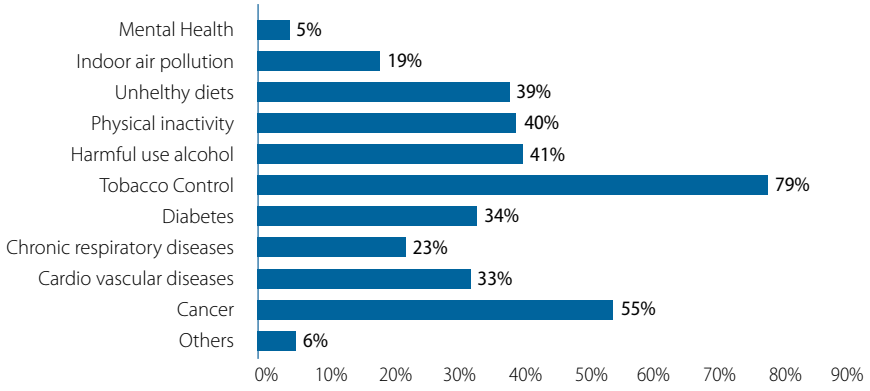


Fig 3. Focus of Work

C) Priority Area of Interventions: As Figure 4 indicates, 40% of the surveyed CSOs consider reducing exposure to risk factors as their primary area of intervention, followed by early diagnosis (16%). This seems to suggest that prevention and early detection of NCDs seems to be the priority focus areas for a large number of organisations working on NCDs in the region. Mobilising civil society response to NCDs, patient care and rehabilitation figure prominently among the second priority focus.

Further analysis of the number of years of work on NCDs with the type of interventions undertaken in Figure 5 provides some interesting insights. Firstly, all groups appear to be working to reduce exposure to risk factors. Secondly, organisations in the 10-15 years and 21+ years have the broadest variety of interventions on NCDs. If these information are coupled with the earlier-stated finding about these two groups working primarily with the public, then it could be deducted that their work with the public is geared largely to reduce exposure. Organisations in the 1-5 years group who are also working on risk factor reduction could therefore be primarily targeting Governments. Organisations in 21+ category also appear to be focused on early diagnosis which ties in with an earlier finding that the overall emphasis of CSOs appears to be more on prevention than treatment and care.

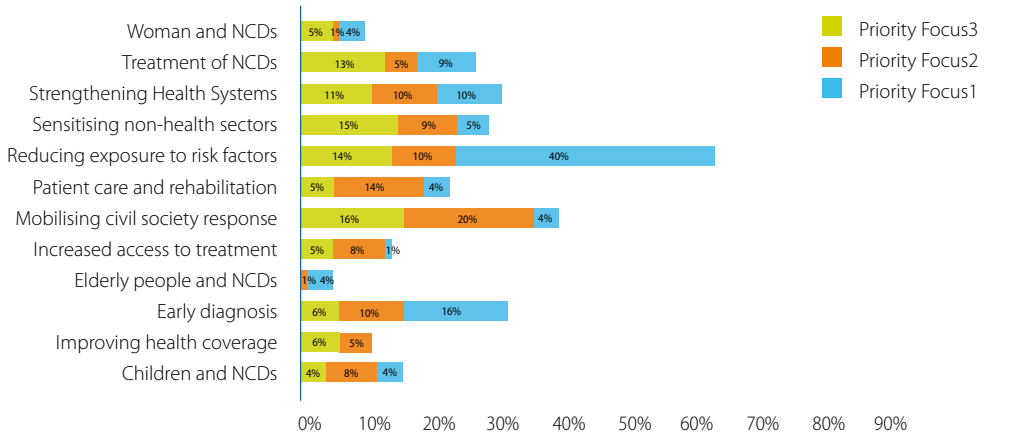


Fig 4. Priority Focus of Interventions

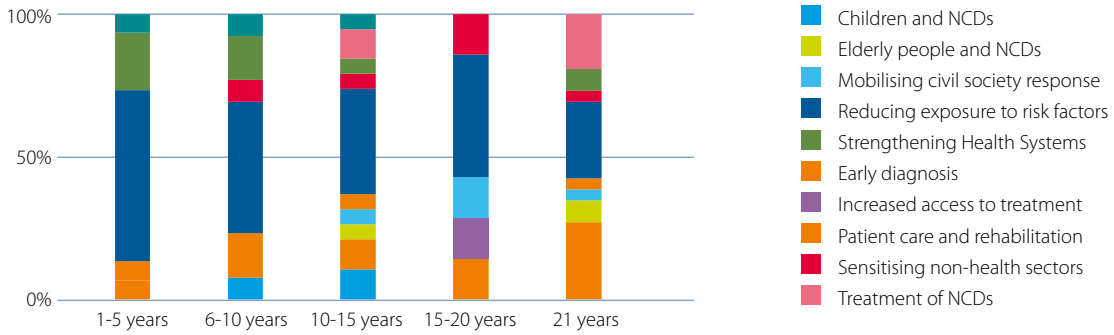


Fig 5. Vintage of Organisation Vs Primary Focus Areas Identified

3. Challenges, Gaps, Solutions and Capacity Needs

a) Challenges: The online survey also enquired about the key challenges to civil society action. The major challenges faced by organisations working at national and sub national levels tend to be largely in the policy and political arena. The responses indicate the biggest challenges to be lack of political will and poor implementation of programmes and policies along with inadequacy of policies designed to target NCD prevention or control. Insufficient funds were reported as a challenge at sub national, national and regional levels, but second only to policy challenges. Lack of understanding of NCDs outside the health sector and interference by industry with conflicting interest were reported as key second priority challenges.

While several SEAR countries have National NCD Plans in line with the WHO Global Action plan, there has been limited to no civil society involvement in their development and implementation. The tuberculosis prevention and control programme in most SEAR countries has guidelines for NGO involvement that has facilitated extensive Government-CSO partnership right from development to implementation of its plans. It is important to urgently develop such guidelines and draw on civil society strengths in NCD programme implementation as well.

Interviewees also mentioned several challenges that are intrinsic to NCDs. One being that NCDs and their risk factors present a complex cluster of issues, each of which require distinct action across multiple sectors. Another challenge revolves around making NCDs a national priority in SEAR countries, which are still dealing with the burden of communicable diseases, maternal and child health concerns and other competing health and development priorities. Thirdly, NCDs are often wrongly projected to be about individual responsibility to reduce exposure to its risk factors, which builds resistance to behaviour change, health promotion and community mobilisation. Lastly, some of the NCD concerns such as unhealthy diet cannot have standardized messaging, but require nuanced communication relevant to local context.

There are country-specific challenges, geography being one among them. Effective roll out of NCD prevention activities, policy implementation and service delivery becomes difficult in countries with large geographies such as India, those with hilly terrains such as Nepal, Bhutan and Myanmar, or those that are island nations such as Maldives, Timor Leste, Indonesia and Sri Lanka. With NCDs accounting for 62% of globaldeaths, in the SEAR region with 25% of the world population the sheer scale of interventions to cover its massive population is a challenge unique to Governments and civil society in the region. Several of the countries do not have adequate specialists, screening, treatment and care facilities and are dependent on countries in the neighbourhood for these services. This makes civil society support in this arena more challenging. Political instability has also been delaying the advocacy for NCD policies in certain countries in the region.

b) Gaps: The respondents identified a range of gaps in civil society response to NCDs at the country level. Financial constraints, lack of coordinated response at national level and limited interest of NGOs at large in NCDs were the most reported gaps. Low engagement of non-health NGOs, lack of continuity in civil society response and lack of technical expertise each were also reported by nearly half the respondents (Figure 6).

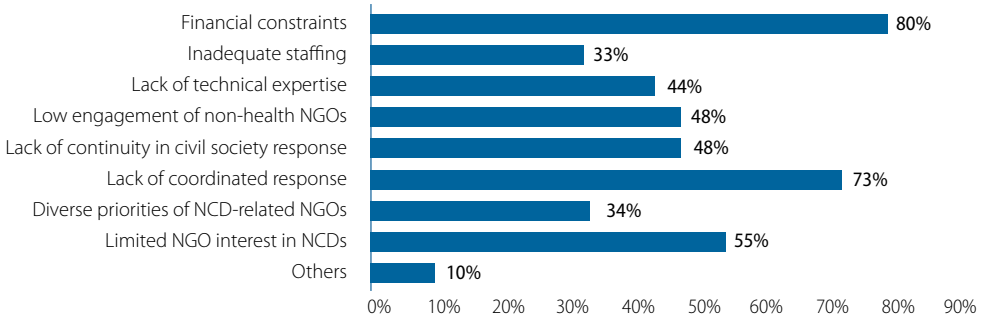


Fig 6. Major Gaps in Civil Society Response

Several interviewees mentioned gaps specific to the civil society response to unhealthy food, contrasting it against tobacco control advocacy strategies. Thus, civil society campaigns on unhealthy food are yet to develop clear policy goals and target groups, generate outrage against industry manipulations and its implications, delineate approaches to tackle small, medium and large businesses and mobilise public health and other groups for advocacy. Industry influence over government, civil society and other key stakeholders was also cited as a barrier to action on unhealthy food. Several countries in the region reported a recent surge in diversionary campaigns by food and beverage companies that project promotion of physical activity while defocusing unhealthy eating. These campaigns often rope in civil society players to earn legitimacy with the target audience.

Similarly, indoor air pollution and chronic respiratory diseases (perhaps with the exception of tuberculosis) seem to suffer from low prioritisation by civil society groups. The reported gaps include limited involvement of CSOs in consolidating evidence on solid fuel use and their implications, exploring affordable, safer alternatives, lack of engagement of grassroots organisations for community level changes in the use of solid fuel, neglect of indoor air pollution by environmental groups and absence of regional platforms to mobilise lung health professionals.

c) Solutions & Capacity Needs: Respondents recommended civil society capacity building, integration of NCDs into existing programme priorities and building coalitions as top solutions to the highlighted problems (Figure 7). Some of the top capacity building needs identified by respondents include building skills in the areas of strategy and campaign planning and advocacy and campaigning (Figure 8). Support for resource mobilization, access to NCD best practices and orientation to good governance and organization building followed closely.

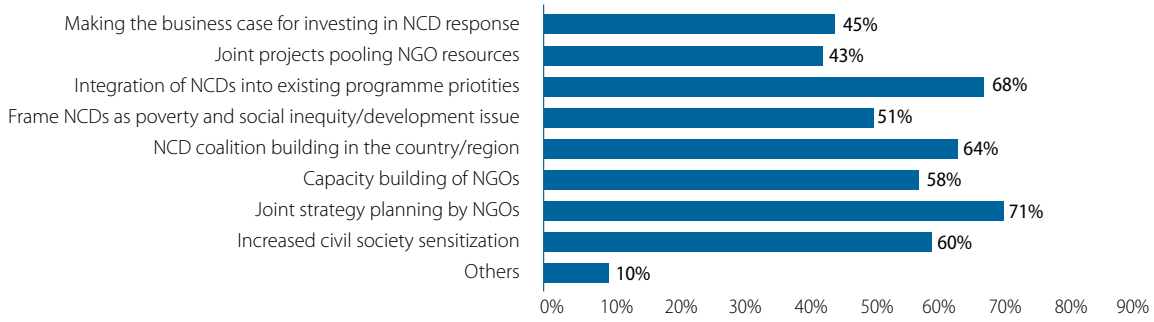


Fig 7. Solution to Address Gaps

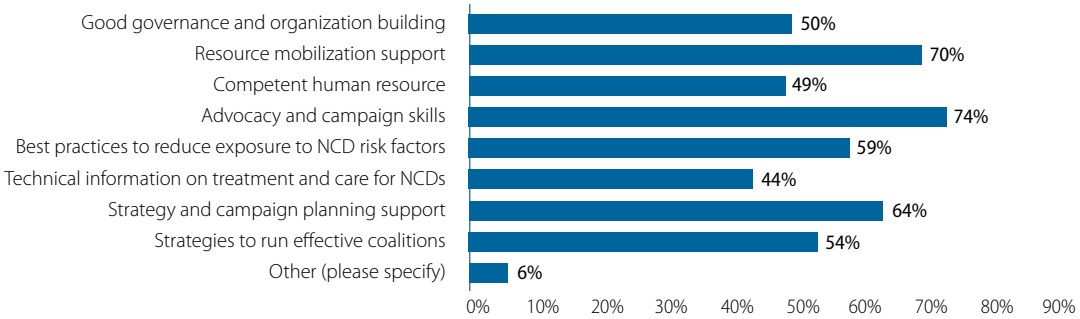


Fig 8 . Major Capacity Needs

A cross analysis of gaps in civil society response with capacity needs indicates areas for future interventions and investments. The call for support in resource mobilization as a prime area of capacity need to address financial constrains, which was identified to be a major gap in civil society response to NCDs drives this point home. One possibility is that the need for finances could come down if the capacity needs could be met in kind such as by helping in grant proposal development. Similarly, the respondents identified a series of capacity needs in terms of strategies to run effective coalitions, strategy and campaign planning support, advocacy and campaign skills to address the lack of coordinated response to NCDs.

The gaps in civil society response to NCDs were also examined against the nature of organisations in Figure 9 to see if there is any divergence in response. Lack of coordinated response, financial constrains and lack of interest of NGOs in NCDs was cited irrespective of the nature of the respondent organisations. However, lack of engagement of non-health NGOs in NCDs was more likely to be identified as a gap by health NGOs when compared to other types of organisations. This could be an indication of a "felt need" of this constituency for greater involvement of non-health NGOs who could in turn provide access to non-health sectors of the government for NCD advocacy. Notably, medical associations, academic institutions and research agencies tend to notice this gap to a lesser extent.

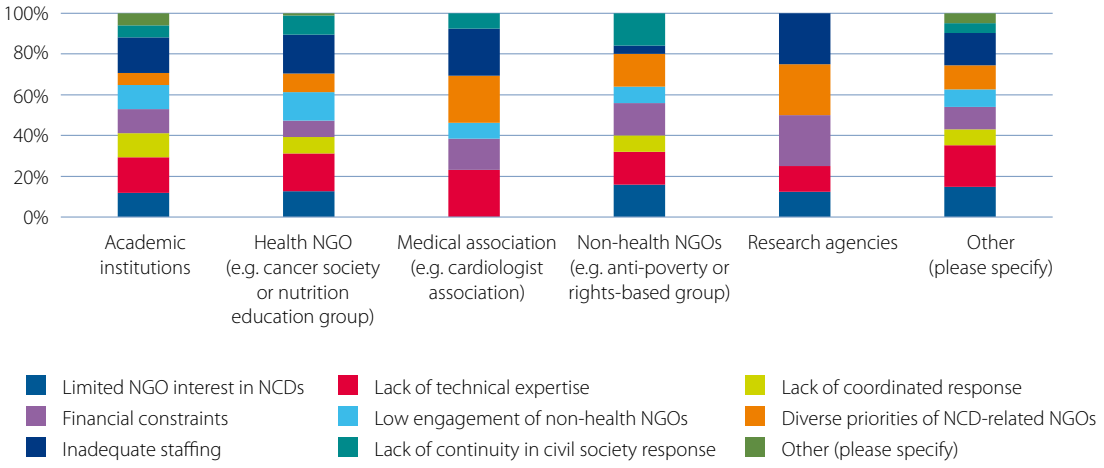


Fig 9. Major Gaps in Civil Society Response to NCDs Vs Nature of NGOs

4. Opportunities and Good Practices

a) Opportunities

While the survey did not specifically enquire about the opportunities, nearly all the interviewees mentioned the United Nations High Level Meeting on NCDs in 2011 as invigorating in-country civil society action on the issue. The political declaration of the meeting represents both the mandate as well as the opportunity for civil society action to help Governments to translate their commitments to action in countries.

SEAR countries are at different stages of development and implementation of National NCD Plans. Lack of accountability seems to be a major factor impeding progress of these plans in most SEAR countries. This presents an opportunity for proactive civil society advocacy and monitoring to stimulate and hold the government accountable for its action/ inaction.

Adoption of the Framework Convention on Tobacco Control (FCTC) was identified as a factor that galvanized tobacco control civil society in the region. The legally binding nature of this international treaty presents an opportunity to press for its accelerated implementation in countries.

In the area of physical activity, some interviewees reported the emergence of health clubs and gymnasiums and sports physicians in urban centres as an opportunity that could improve the community's health consciousness and health seeking behaviour. Given that several countries in the region are contemplating the development of new cities, there are opportunities for civil society to advocate that they provide for healthier lifestyles, health care and public transport facilities.

Recent technological and media advances present opportunities for NCDs as well. Increasing use of mobile phones and social media in SEAR countries could prove an asset in health promotion, industry monitoring as well as social mobilization for policy change.

b) Snapshot of Good Practices

Civil society across countries in the region reported tried and tested strategies that contributed to meaningful outcomes in NCD prevention and control. Below is a snap shot of good practices that are emerging from the region. A deeper elaboration of country civil society best practices is required to provide a comprehensive presentation.

Using courts to advance tobacco control: India has a long history of using Public Interest Litigations (PILs) to move public policy. CSOs working on tobacco control have effectively engaged this tool to challenge Government apathy, expedite policies and implementation, defend sound policies and oppose industry interference. Thus, India's national tobacco control law was the results of a PIL. Subsequent litigations have successfully defended regulations banning advertising, pictorial health warnings and exposed and terminated industry interference in national and sub-national courts.

Diabetes educators in community health system: Access to timely diagnosis and treatment is a challenge in most island nations. The Diabetes Society of Maldives (DSM) along with the World Diabetes Foundation initiated "Project 200 Islands" in 2009 to address the gaps in quality diabetes care in the island nation of Maldives. The project aimed to address the gap by training and contracting a diabetes educator for every one of the 200 inhabited islands in the country. Health care workers from the health system were trained to this end, serving as a sustainable model helping local communities to take timely preventive, diagnostic and early treatment steps across the islands.

Improving accessibility and affordability of medicines: In Sri Lanka, early campaigns by several medical associations and renowned professionals have led to the development of a national drug policy that provides essential medicines, including for NCDs, at affordable prices to the public. Sustained and targeted campaigns led to two specific outcomes: a) medical practitioners increasingly prescribe generic drugs that are affordable to the masses and b) public behaviour change whereby people now demand generic alternatives from their doctors.

"Sin" tax for resourcing NCD control: Thailand provides a significant example of the impact of civil society advocacy for sustainable resourcing for NCDs. In 2001, the Government of Thailand in partnership with key civil society players set up the Thai Health Promotion Foundation funded by a 2% excise tax surcharge on tobacco and alcohol produced or imported into the country. The Foundation's annual revenue of USD 120 million has become a sustainable source of funding that has set up civil society groups, commissioned research to inform policies and funds advocacy for policies addressing NCD risk factors.

Lessons from environmental and human rights campaigns: Interviewees repeatedly cited environmental and human rights movements to be offering relevant lessons to NCD civil society. The visibility offered by dramatic actions that are part of environmental and rights-based advocacy helps gain public and policy maker attention and creates a favourable climate for public dialogue and policy formulation.

5. Regional Priorities, Mechanisms and Partnerships

a) Regional Priorities: The top regional priorities identified were strategies to address NCD issues with cross border implications (e.g.: cross-border promotion, taxation and trade of tobacco, alcohol, unhealthy food, automobiles) and monitoring NCD commitments made by governments (Figure 10). It is important to note that respondents also indicated development of such monitoring mechanisms prominently among areas for support from intergovernmental and international organisations that is discussed later. Such a mechanism needs to monitor policy actions, evidence of impact in terms of outcome indicators and ultimately impact on equity. Networking and capacity building of NGOs figured significantly among the second priority for regional action.

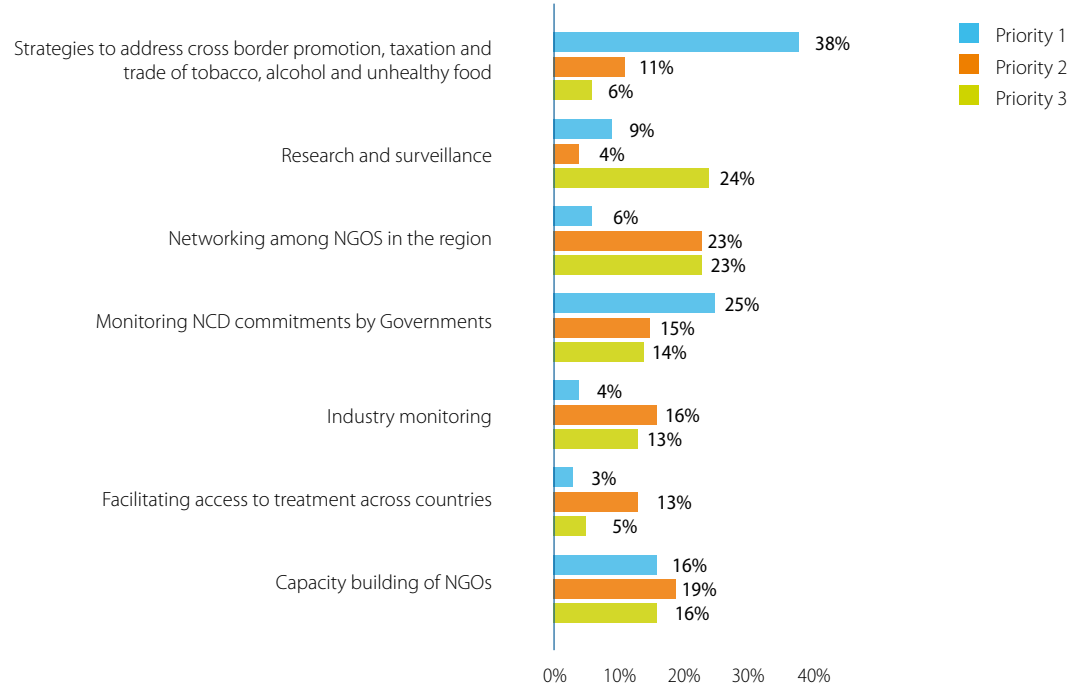


Fig 10. Priorities for Action at Regional Level

b) Mechanisms for Regional Collaboration: Networking opportunities and information sharing platforms were the most preferred means of regional collaboration that were reported to enhance work in SEAR countries. It is noteworthy that a regional coalition was the second lowest priority among the respondents, coming only after identifying areas for joint action, access to NCD information and good practices from other countries and establishing platforms that offer advocacy support.

Interviewees reflected this matured approach to regional civil society collaboration. Some pointed to the differences in political systems, resources and cultures within the SEAR that limits the scope for collaboration. Others pointed to common issues that could mobilise issue-based, short term campaigns through informal coordination.

Interviewees elaborated that a regional mechanism could begin as an informal information platform that i) facilitates sharing of knowledge, tools and best practices, ii) identifies areas of convergence iii) supports campaigns across borders, and iv) form temporary issue-based partnerships. It was also suggested that existing regional networks of NCD federations such as of the International Diabetes Federation in South East Asia consider expanding the scope of their programmes to address NCDs and their risk factors more broadly.

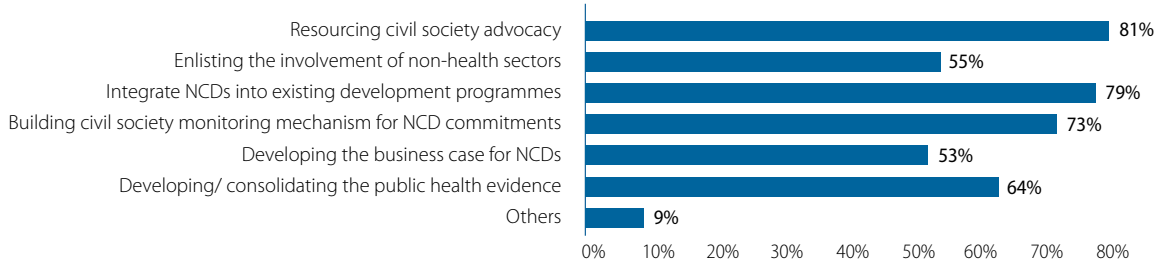


Fig 11. Areas for Support from Intergovernmenal/ International Organisations

c) Partnerships: The survey asked how multilateral agencies such as the WHO or UNDP can support civil society action on NCDs in the region. As Figure 11 indicates, the most reported responses include support for civil society advocacy, integration of NCDs into existing development programmes, and the creation of a civil society monitoring mechanism for NCD commitments.

In turn, civil society can support the work of intergovernmental agencies by building political will (81%), preparing local communities (78%), developing best practice models for effective intervention (78%) and advocating for integration of NCDs in national development plans (76%).

Most interviewees called for closer partnerships between civil society and WHO in countries and at regional level, with civil society building the political environment for WHO's proposed NCD targets, while having the opportunity to inform and contribute to the technical and programmatic work of WHO country and regional offices in this area. Some also mentioned that WHO could facilitate civil society's contribution through national NCD monitoring mechanisms.

Several of them also referred to on-going partnerships between UN agencies and civil society in SEAR countries for a host of health and development issues and called for their extension to address NCDs. For example, UNICEF's maternal and child health nutrition programmes in the region could be broadened to address concerns around unhealthy diet. Similarly, UNDP's climate mitigation initiative could promote alternatives to solid fuel use for cooking and help reduce indoor air pollution, and UNAIDS health care delivery programmes could be leveraged to deliver NCD treatment as well. Integration of NCDs in National Development Plans is an area that was also identified for close work with UNDP country offices. Orientation of civil society to the development planning process within the countries and that of UNDP was suggested as the first step in this direction.

The South Asia Association for Regional Cooperation (SAARC) was identified as a geo-political body that must be leveraged to advance action on NCDs in South Asian countries within SEAR. Civil society action is urgently required to follow up on the NCD specific recommendations of the SAARC Technical Committee on Health and Population. A specific, time-bound opportunity in this context is the Sri Lankan SAARC President's commitment to NCD prevention and control that can be used to influence the SAARC agenda at the level of Heads of States.

Interviewees expressed a range of expectations about the NCD Alliance's role at the regional level. An oft-repeated one was sensitizing and mobilizing country members of the individual international NGO federations

that constitute the NCD Alliance for broader NCD advocacy. There was an equal call for the NCD Alliance to undertake capacity building activities of NCD civil society in advocacy skills, strategy planning, managing coalitions and resource mobilisation. Some thought the NCD Alliance could influence international donors to commit to funding NCD action in SEAR countries. Some were concerned that the work of NCD Alliance was currently limited to global fora and expected it to better represent country voices to shape national and international agendas.

V. MAPPING RECOMMENDATIONS

Based on the findings from this mapping, below are some recommendations for key NCD stakeholders in the SEAR region.

For Civil Society

- Increase advocacy on NCDs and their risk factors, with special focus on issues that are yet to receive government attention
- Improve engagement of medical associations, academic institutions and non-health NGOs in advocacy
- Participate in national and subnational NCD multisectoral bodies and support the government and other stakeholders in developing and implementing NCDs priority actions
- Monitor progress and hold the Governments accountable to NCD commitments
- Advocate for integration of NCDs into national health and development plans
- Liaise with intergovernmental agencies to integrate NCDs into existing programmes and platforms

For Governments

- Provide policy and programme frameworks to address NCDs and their risk factors
- Build NCD infrastructure at national and sub national levels, including human and technical resources
- Increase budgetary allocation to NCD programmes, including for civil society action
- Develop guidelines for greater CSO involvement in policy planning and monitoring of implementation of National NCD Plans

For WHO Country and Regional Offices

- Engage civil society in the development of technical resources for governments in the region
- Support civil society advocacy and capacity building to prepare the public and governments for action on NCDs
- Promote participation of civil society in policy formulating and monitoring mechanisms set up by governments and regional bodies
- Facilitate opportunities for civil society advocacy to leverage regional platforms at SAARC, ASEAN, SEAR and UN regional levels for NCD advocacy

For other multilateral agencies and development partners

- Help make the business case for NCDs
- Connect with relevant resources, ministries and help sensitise them on NCDs
- Integrate NCD prevention and control into existing in-country programming
- Involve NGOs in NCD-related programme implementation

For the NCD Alliance

- Identify and nurture civil society organisations in countries where it is yet to emerge
- Conduct capacity building activities to address gaps in advocacy, governance and resource mobilization
- Encourage international NCD federations to mobilise their members in WHO SEARO to actively engage in NCD advocacy and monitoring
- Develop communication, advocacy, monitoring and fundraising tools for civil society

For coordination among civil society

- Build multisectoral coalitions at national and sub national levels
- Establish regional platforms for networking, information sharing and advocacy support
- Build regional partnerships through SAARC and networks of NCD Alliance federations

VI. CONCLUSION

The civil society response to NCDs and their risk factors in WHO South East Asia Region has seen increases in recent years. But these seem to be concentrated in a few countries, addressing a limited number of issues within the NCD agenda. The response to NCDs and civil society movements in countries in the region are at different stages of development and consolidation, calling for unique approaches to address countries respective challenges and needs. A broad range of organisations, in particular non-health NGOs, play a significant role in advancing civil society advocacy on NCDs in the region. Future interventions and investments need to build on the strengths and needs of the broad variety of organisations working in this area and promote linkages among existing and future contributors to NCD civil society advocacy.

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ACKNOWLEDGEMENTS:
Sincere thanks to all respondents and interviewees who provided their inputs to the mapping exercise. WHO NCD teams in countries, key contacts of international federations and national alliances addressing NCDs and their risk factors helped actively to disseminate the mapping tools to potential respondents. But for the active support of the teams at WHO SEARO NCD Programme, the NCD Alliance and the statistical expert at Polizy Matters, it would not have been possible to complete the mapping in a timely manner.

Annex 1
Survey Questionnaire

NCD Civil Society Mapping in the WHO South East Asia Region

Purpose

This survey by the NCD Alliance aims to map the profile, activities, achievements to date, challenges, needs and potential collaborations of civil society organisations working on Noncommunicable Diseases (NCDs) and their risk factors in WHO's South East Asia Region.

Findings

An analysis of the findings will be shared with all respondents and a summary report will be presented at the Regional Meeting on Strengthening NCD Civil Society Organisations in South East Asia Region in July 2015.

Confidential

The responses will be anonymised – therefore not attributed to individual respondents. Any comments or attachments you indicate as confidential will be respected as such.

Instructions

The survey should take less than 15 minutes to complete. You will need to respond to all questions to enable its inclusion in the survey. Incomplete forms will need to be rejected. Please return the form latest by 29 June, Monday Noon to searomapping@ncdalliance.org

If you have any questions about the survey, please email us at the above email.

Thank you - we really appreciate your input!

Survey Questionnaire

1. What is the full name of your organisation?

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.....

2. Which country does your organization work in? Choose from the drop down list.
(drop down list -Bangladesh, Bhutan, Democratic People Republic of Korea, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand, Timor Leste).

3. What is the nature of your organization? Tick one that best describes your organization.

- ☐ Medical association (e.g. cardiologist association)
- ☐ Health NGO (e.g. cancer society or nutrition education group)
- ☐ Non-health NGOs (e.g. anti-poverty or rights-based group)
- ☐ Research agencies
- ☐ Academic institutions
- ☐ Other (please specify) .....
- ☐ Don't know

4. How many years has your organisation worked in the area of Noncommunciable Diseases (NCDs) or their risk factors? Tick the one that applies.

- ☐ 1-5 years
- ☐ 6-10 years
- ☐ 10-15 years
- ☐ 15-20 years
- ☐ 21 years and more

5. The main strength of your organisation's work on NCDs is at: Tick the most relevant one.

- ☐ District level
- ☐ Provincial/State level
- ☐ National level
- ☐ South East Asia Regional level
- ☐ Other (please specify) .....

6. Who are the top three target audiences of your work? Tick only three.

- ☐ Public
- ☐ NCD-affected groups (e.g. survivors and families)
- ☐ Government
- ☐ NGOs
- ☐ Medical Associations
- ☐ Media
- ☐ WHO
- ☐ Other (please specify) .....

7. Which diseases/risk factors does your organization primarily focus on? Tick those most relevant.

- ☐ Cancers
- ☐ Cardio Vascular Diseases
- ☐ Chronic respiratory Diseases
- ☐ Diabetes
- ☐ Tobacco control
- ☐ Harmful use of alcohol
- ☐ Physical inactivity
- ☐ Unhealthy diets
- ☐ Indoor air pollution
- ☐ Other (please specify) .....

8. What are the top three focus areas of your work on NCDs? Number your choices 1-3 in the decreasing order of priority.

- ☐ Reducing exposure to risk factors
- ☐ Early diagnosis
- ☐ Treatment of NCDs
- ☐ Patient care and rehabilitation
- ☐ Strengthening Health Systems
- ☐ Improving health coverage
- ☐ Increased access to treatment
- ☐ Mobilising civil society response
- ☐ Sensitising non-health sectors
- ☐ Women and NCDs
- ☐ Children and NCDs
- ☐ Elderly people and NCDs

- ☐ Indigenous populations and NCDs
- ☐ Other (please specify) .....

9. **What are the top three NCD-related activities of your organization? Number your choices 1-3 in the decreasing order of priority.**

- ☐ NCD related research
- ☐ Public education on NCDs and risk factors
- ☐ Advocacy with policy makers for improved policies
- ☐ Patient support
- ☐ Technical support to Government agencies
- ☐ Monitoring Government's NCD commitments
- ☐ Evaluating NCD interventions
- ☐ Capacity building of NGOs
- ☐ Developing Information-communication materials
- ☐ Running information networks/ newsletters
- ☐ Using media for advocacy
- ☐ Sensitisation of media
- ☐ Litigation
- ☐ Other (please specify) .....

10. **What are the top three of your organisation's strategies that have led to specific outcomes vis a vis various targets groups. Please follow the example below and use the rows thereafter to provide details.**

TARGET GROUP 1	EDUCATION DEPARTMENT
STRATEGY USED	ENGAGED PARENT TEACHER BODIES IN SCHOOLS TO ADVOCATE HEALTHIER MEALS IN SCHOOL CANTEENS
ITS OUTCOME	DEPARTMENTAL GUIDELINES ON SCHOOL CANTEEN MENU
TARGET GROUP 1	
STRATEGY USED	
ITS OUTCOME	

11. **What are the top three challenges to work on NCDs in your country? Number your choices 1-3 in the decreasing order of priority.**

- ☐ Lack of political will
- ☐ Inadequate policies for NCD prevention and control
- ☐ Poor implementation of programmes and policies
- ☐ Lack of understanding of NCDs outside the health sector
- ☐ Insufficient civil society advocacy and monitoring

- ☐ Interference by industry with conflicting interest
- ☐ Challenges from bilateral and multilateral agreements (e.g. trade and investment agreements)
- ☐ Lack of technical expertise
- ☐ Inadequate human resources
- ☐ Insufficient funds
- ☐ Other (please specify) .....

12. **What do you see are the major gaps in the civil society response to NCDs in your country? Tick all that apply.**

- ☐ Limited NGO interest in NCDs
- ☐ Diverse priorities of NCD-related NGOs
- ☐ Lack of coordinated response
- ☐ Lack of continuity in civil society response
- ☐ Low engagement of non-health NGOs
- ☐ Lack of technical expertise
- ☐ Inadequate staffing
- ☐ Financial constraints
- ☐ Other (please specify) .....

13. **What do you think are the potential solutions to address the gaps in civil society response to NCDs in your country? Tick all that apply.**

- ☐ Increased civil society sensitization
- ☐ Capacity building of NGOs
- ☐ Joint strategic planning by NGOs
- ☐ NCD coalition building in the country / region
- ☐ Frame NCDs as poverty and social inequity/development issue
- ☐ Integration of NCDs into existing programme priorities
- ☐ Joint projects pooling NGO resources
- ☐ Making the business case for investing in NCD response
- ☐ Other (please specify) .....

14. **What are the major capacity needs of the civil society in your country in addressing the NCD concerns in your country? Tick all that apply.**

- ☐ Strategies to run effective coalitions
- ☐ Strategy and campaign planning support
- ☐ Technical information on treatment and care for NCDs
- ☐ Best practices to reduce exposure to NCD risk factors

- ☐ Advocacy and campaign skills
- ☐ Equipped human resource
- ☐ Resource mobilization support
- ☐ Good governance and organization building
- ☐ Other (please specify)

15. **What do you think are the top three priority areas for action at the regional level to combat NCDs in the South East Asia region? Number your choices 1-3 in the decreasing order of priority.**

- ☐ Strategies to address cross border promotion, taxation and trade of tobacco, alcohol and unhealthy food
- ☐ Facilitating access to treatment across countries
- ☐ Monitoring NCD commitments by Governments
- ☐ Industry monitoring
- ☐ Capacity building of NGOs
- ☐ Networking among NGOS in the region
- ☐ Research and surveillance
- ☐ Other (please specify)

16. **What kind of regional and global collaboration can enhance your work on NCDs? Tick all that apply.**

- ☐ Information sharing platforms
- ☐ Mechanisms for advocacy support
- ☐ Regional coalition to address trans-border issues
- ☐ Joint areas for action
- ☐ Networking opportunities for NGOs in the region
- ☐ Guidance on NCD policies and good practice
- ☐ Any other (please specify)

17. **What are the specific areas in which WHO, UNDP, World Bank and other international organizations could support civil society advocacy regarding NCDs in your country? Tick all that apply.**

- ☐ Developing/consolidating the public health evidence
- ☐ Developing the business case for NCDs
- ☐ Building civil society monitoring mechanism for NCD commitments
- ☐ Integrate NCDs into existing development programmes
- ☐ Enlisting the involvement of non-health sectors
- ☐ Resourcing civil society advocacy
- ☐ Any other (please specify)

18. What are the ways in which civil society can support WHO, UNDP and other international organizations to contribute to the prevention and control of NCDs?

- ☐ Building political will for NCD policies and programmes
- ☐ Improving community preparedness for NCD interventions
- ☐ Provide linkage to public and communities
- ☐ Developing best practice models for intervention
- ☐ Shadow reports on country commitments on NCDs
- ☐ Advocate for NCDs in national development plans
- ☐ Any Other (please specify)

19. Please provide any other brief comments you think would help the NCD Alliance better understand]your organisation's work.

.....

.....

.....

.....

.....

Please send any documents that complement your survey inputs to: SEARmapping@ncdalliance.org

Thank you. This is the end of the survey. If you are ready to submit your responses, please click on the "DONE" button below. The survey closes on Friday, 26 June 2015 5pm IST.

Annex 2
List of Key Informants

Dr. Sohel Chowdhury
National Heart Foundation Bangladesh
Bangladesh

Ms. DY Suharya
Alzheimer's Indonesia
Indonesia

Dr. Vijj Kasemsup
ThaiNCD
Thailand

Dr. Srinath Reddy
Public Health Foundation of India
India

Mr. Vimal Hooda
Cancer Relief Society
Nepal

Dr. Pubudu Sumanasekara
Alcohol and Drug Information Center
Sri Lanka

Mr. Amit Khurana
Centre for Science and Environment
India

Ms. Bungon Rithiphakdee
South East Asia Tobacco Control Alliance
Thailand

Dr Aishath Shiruhana
Diabetes Society of Maldives
Maldives

Dr Rana J. Singh
The Union South East Asia Regional Office
India

Potential partners for NCD alliances by issues of focus

INSTRUCTION: *This is just an indicative listing of CSOs whose work is likely to be relevant to NCD prevention and control in general. Alliances are encouraged to consider all civil society organisations whose work can potentially advance their specific goals.*

I. PARTNERS BY NCD RELATED ISSUES AND SECTORS

Nongovernmental organisations addressing	Professional Bodies of	Academia & research agencies	Development partners
Cancer	Teachers	Universities	UN country teams
Diabetes	Nurses	Colleges	WHO
Cardio vascular disease	General Practitioners	Schools	UNDP
Chronic respiratory disease	Physicians	Vocational training centers	UNICEF
Mental health	Oncologists	Public health researchers	FAO
Trauma and injuries	Diabetologists/ Endocrinologists	Medical researchers	ILO
Tobacco control	Cardiologists	Health economics researchers	World Bank
Alcohol control	Chest physicians	Environmental researchers	Development donors
Unhealthy diet	Gynaecologists	Development researchers	Philanthropies
Physical activity	Pediatricians		
Indoor air pollution	Psychiatrists		
Nutrition	Psychologists		
Stress reduction	Trauma specialists		
De addiction	Geriatrists		
Geriatric care	Surgeons		
Road safety	Public health professionals		
Sports	Architects		
Women's health	Urban planners		
Children's health	Health economists		
Consumer rights	Economists		
Poverty alleviation	Lawyers		
Women's rights	Agriculturists		
Health rights	Engineers		
Child rights	Nutritionists		
Workers rights			
Affordable drugs			
Health Systems strengthening			
Trade treaties			
Youth organisations			
Parents associations			
Farmers associations			
Street vendors unions			
Environmental groups			
Faith based organisations			
Public health movements			
Right to health campaigns			

II. LINKS TO INTERNATIONAL NETWORKS

The local associates of these international networks may be included in the civil society mapping and considered to join the national/regional NCD alliances.

	ORGANISATION	WEBSITE
1	**Federations in NCD Alliance Steering Group**	
	The International Union Against Tuberculosis and Lung Diseases (IUATD- the Union)	http://www.theunion.org/where-we-work
	World Heart Federation (WHF)	http://www.world-heart-federation.org/no_cache/members/current-members/
	Framework Convention Alliance (FCA)	http://www.fctc.org/about-fca/membership/membership-directory
	International Union for Cancer Control (UICC)	http://www.uicc.org/membership
	Alzheimer's Diseases International (ADI)	http://www.alz.co.uk/associations
	Management Sciences for Health (MSH)	http://www.msh.org/our-work/where-we-work
	International Diabetes Federation (IDF)	http://www.idf.org/membership/meet-our-members
2	**National and regional NCD alliances**	
	https://ncdalliance.org/who-we-are/the-ncd-alliance-network/national-and-regional-alliances	
3	**International Health Networks**	
	Young Professional Chronic Diseases Network (YP CDN)	http://www.ncdaction.org/join
	International Society for Physical Activity and Health (ISPAH)	http://www.ispah.org
	World Obesity Federation	http://www.worldobesity.org/who-we-are/
	Scaling Up Nutrition Civil Society Network (SUN CSN)	http://suncivilsocietynet.wixsite.com/suncsnblog/members
	White Ribbon Alliance	http://whiteribbonalliance.org/national-alliances/india/

SAMPLE 3 | Membership recruitment workshop agenda of Zanzibar NCD Alliance

Programme for membership recruitment and campaign workshop
from 20-22/11/2013

Time	Session	Activity
DAY ONE		
9.00	Welcome address and presentation of Z-NCDA and DNCDA	Board member and Susanne Volqvartz
9.30	Presentations	Presentation of each participant
10:00	The burden of NCDs in Zanzibar	Zuhura from NCD desk MoH
10:30	Who would like to become members of the TANCDA member associations and why?	Introduction by Steffen Jørgensen Group work in mixed groups
11:00	Coffee break	
11:30-12:30	Where do we find the potential members What fee do we charge the members?	Introduction by Steffen Jørgensen Group work in mixed groups
13:30	Launch	
14:30	Why would people become members?	Brief presentation by Steffen Jørgensen followed by group work in mixed groups
15:30-16:00	Winding up the day	All/plenum
DAY TWO		
9:00-11:00	Making a recruitment pamphlet and poster/drafting a text	Brief presentation by Steffen Jørgensen followed by group work in mixed groups
11:00-12:00	Conclusions on membership recruitment	Plenum
12:00-13:00	Launch	
	Making a campaign	
13:00	Presentation of campaign concepts Examples from Danish campaigns like ECCO Walkathon, Relay for Life and the Full Grain Bread campaign What is expected in the project document? Aim of the campaign	By Steffen Jørgensen and Susanne Volqvartz
14:30	How can we promote our messages in the campaign	Ideas are written on post-it labels
15:00	Coffee	Meanwhile the post-it labels are put up in thematic groups
15:30	Prioritising campaign elements by voting	All
16:30-17:00	Reality checks of selected campaign elements	Facilitated by Omar, Zuhura and Susanne
DAY THREE		
10:00	Development of Action plan/who do what and when? What happens next? How do we communicate?	Facilitated by Omar, Zuhura and Susanne Planning in thematic groups
10:30	Coffee	
11:00-13:00	How to make an action plan	Presentation by Omar and Susanne
13:00	Lunch	
14:00-15:00	Closing ceremony and hand out of diplomas	Omar and Steffen

NCD Alliance Strategic Planning Process

Overview

Introduction

The NCD Alliance (NCDA) current Strategic Plan runs for the period 2012-2015. The Plan has four main strategies, which have guided the direction of NCDA during this time, namely global advocacy; national action; building the demand; and building the alliance. These four pillars have proven very effective in shaping NCDA post-2011, with a gradual shift from focusing solely on global advocacy to supporting more national capacity building activities. The Plan has also formed the basis for NCDA fundraising, with an associated business plan for the period 2014-2015 and a dedicated budget.

The current Strategic Plan was informed by an independent NCDA Strategic Review conducted in November 2011 – April 2012. The purpose of the Review was to evaluate the performance and achievement of NCDA; define future strategic priorities for NCDA; and propose recommendations for appropriate organisational and governance arrangements for NCDA. It was conducted by AHISMA, an experienced global health consultancy, and included key informant interviews by NCDA partners, a questionnaire for the Boards of the four Steering Group (SG) organisations, and an electronic survey completed by the NCDA network.

With the current Strategic Plan's end date approaching, a clear process to develop the future NCDA Strategic Plan has been discussed with both SG and Presidents Oversight Committee (POC). The key points are outlined below:

Planning Process

The NCDA POC and SG proposed the following components of a strategic planning process:

- **Independent Evaluation:** Conduct a light touch independent evaluation of NCDA. The evaluation would be competitively tendered out with a clear terms of reference. It will review progress of NCDA against the objectives of the current Strategic Plan; assess relevance, efficiency, effectiveness and sustainability of NCDA; identify key areas of operational services for improvement; as well as guidance on strategic priorities and governance and organizational structures going forward. Key partners will be invited to participate in the review, including NCDA POC, NCDA Supporters Consultation Group, Campaigns Group, focal points in national/regional NCD alliances etc.
- **Strategic Plan framework:** Based on the insights of the independent review, a draft framework for the Strategic Plan will be developed. This will provide an outline, with the vision, mission, and strategic objectives. This document will form the basis for consultation.
- **Consultations:** Consult widely on the Strategic Plan framework, including with the POC (and related Board's), the Expert Advisory Council, and SCG. There will be continuous communication throughout the process, to ensure buy in and ownership of the Plan.

Outputs

These processes will result in a report of the independent review; and the NCD Alliance Strategic Plan. In addition, 2-year business plans and budgets will be developed to facilitate fundraising (as is currently done).

The process will be conducted under the oversight of the NCDA SG, and managed by the NCD Alliance Executive Director with support from consultants as required.

Proposed Timeline

In order to ensure adequate time for discussion and consideration by all relevant parties, the following timeline was proposed by the POC for the strategic planning process:

- **January - June 2015:** Independent evaluation of NCDA.
- **June - July 2015:** Consultation on draft Strategic Plan framework (including with POC and Boards). This will also enable SG organisations to align their own strategic planning processes with NCDA, where possible.
- **August - December 2015:** Finalise the Strategic Plan.
- **January 2016:** Launch of new NCDA Strategic Plan at a global health forum, for example the WHO Executive Board, January 2016.

Points for further discussion:

There are a number of issues remaining to be discussed on the strategic planning process. These are outlined below, with options and recommendations to inform discussion.

1. Strategic Plan – Timeline:

The current NCDA Strategic Plan was for a period of four years, from 2012-2015. This was designed to cover the post-UN Summit period and lead up to the adoption of the post-2015 development agenda.

For the new NCDA Strategic Plan, the timeline could coincide with the following global milestones:

- **2018:** The next UN High-Level Review on NCDs (i.e. three year plan)
- **2020:** The end of the current WHO Global NCD Action Plan 2013-2020 and five years into the post-2015 era, when there will likely will be some sort of UN summit/review (i.e. five year plan)

2. Independent Evaluation – Scope of Work:

The SG needs to agree a clear scope of work (SOW) for the Independent Review. This will inform the RFP for a consultant to undertake this work.

Four focus areas are provided below as recommendations for a SOW, with corresponding objectives.

Focus area 1: Evaluation

Objective 1: To undertake an assessment of NCDA efforts to achieve its aims and objectives, as set out in the Strategic Plan over a period from 2012-2015, as well as examine perceived organisational strengths and opportunities.

Focus area 2: Strategic priorities

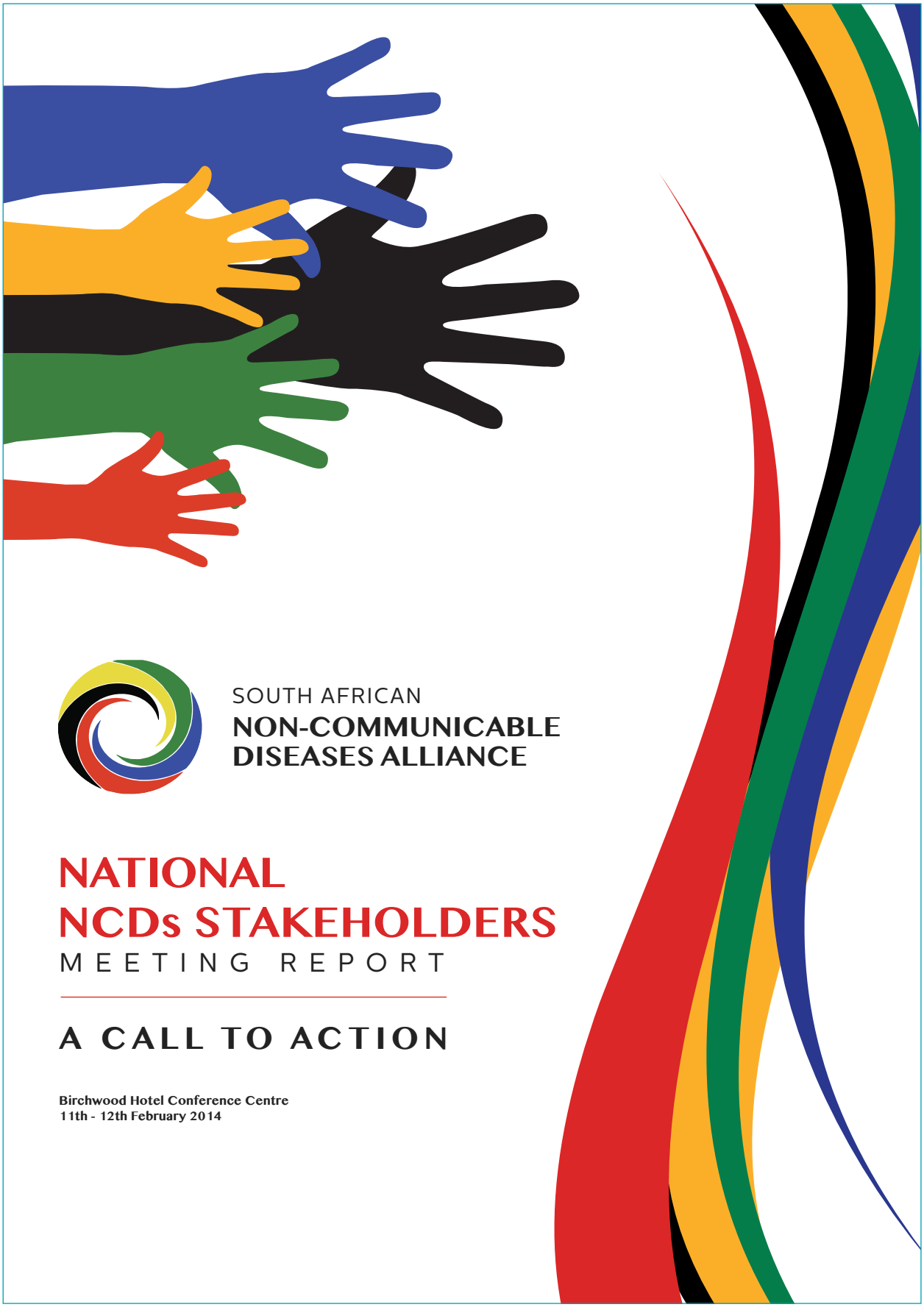
Objective 2: To conduct a consultation and review process with specific NCDA key stakeholders to recommend key strategic priorities going forward; and development of a draft framework for the new Strategic Plan to form the basis for consultation.

Focus area 3: Governance and organisational arrangements

Objective 3: To develop a mapping of key stakeholder perceptions as to current and potential partnership and organisational structures. This will also include a comparative analysis of other alliances and partnerships. Based on this analysis and the new Strategic Plan, provide recommendations on governance and organisational arrangements for NCDA going forward.

Focus area 4: Sustainability

Objective 4: To develop a set of recommendations, taking account of new strategic directions for NCDA together with governance considerations and proposed organisational arrangements, designed to ensure the strategic and financial sustainability of NCDA operations.


SOUTH AFRICAN
NON-COMMUNICABLE
DISEASES ALLIANCE
NATIONAL
NCDs STAKEHOLDERS
MEETING REPORT
A CALL TO ACTION
Birchwood Hotel Conference Centre
11th - 12th February 2014

CONTENTS

SOUTH AFRICAN
NON-COMMUNICABLE
DISEASES ALLIANCE

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Supported by:

The NCD Alliance
Putting non-communicable diseases on the global agenda

International Diabetes Federation · WORLD HEART FEDERATION · International Union Against Tuberculosis and Lung Disease · Alzheimer's Disease International · UICC

Made possible by a generous grant from:

Medtronic PHILANTHROPY

1. EXECUTIVE SUMMARY

The newly formed SA Non-Communicable Disease Alliance (SA NCD Alliance) held its first key stakeholder meeting on 11 &12th February 2014 in Johannesburg, South Africa.

Meeting goal:

- To galvanize awareness and unify support for non-communicable diseases (NCDs) prevention and management amongst key stakeholders with a "Call for NCDs Action".

Meeting objectives:

- To support the NCDs strategic plan within the South African context
- To develop priorities for NCDs advocacy and action
- To develop a network of support for NCDs advocacy and action.

100 delegates from five vital sectors networked on important NCDs issues:

- Civil society/ NGO
- Government/ policy
- Healthcare providers
- Industry
- Research organisations/ universities.

Prof Krisela Steyn outlined the escalating burden of NCDs in South Africa to the present unacceptably high levels. With the exception of tobacco use, the preventable NCDs "lifestyle" risk factors, (unhealthy diets, lack of physical activity and the harmful use of alcohol) have all increased.

Prof Mel Freeman presented the Ministry of Health's NCDs Strategic Plan 2013-2017. The plan outlines 10 ambitious NCDs targets that have broad support. Challenges relate to support, implementation and health system strengthening.

Katie Dain, NCD Alliance, outlined the global background to NCDs advocacy culminating in the WHO NCDs Global Action Plan 2013-2020 (GAP) with its nine NCDs targets. GAP is driving global action. In a separate presentation Katie Dain and Cristina Parsons-Perez explained the NCD Alliance's advocacy including the civil society advocacy tool: the civil society national advocacy status report (CSSR).

Stakeholder groups performed a SWOT analysis on the challenges of NCDs to each sector. All groups clearly saw their own strengths and the NCDs Plan as an opportunity for transparent multisector collaboration. Universal weaknesses and threats are:

- Data inadequacies resulting in reduced evidence based practice
- Lack of collaboration
- Insufficient resources and funding
- Healthcare system weaknesses
- Competition and lack of transparency between stakeholders.

SA NCD Alliance founding partners (Cancer Association of South Africa, Diabetes South Africa, Heart and Stroke Foundation South Africa and the Patient Health Alliance of Non Governmental Organisations) each made a presentation to introduce the organisation.

Lessons must be learnt from local NCDs best practice with two illustrative presentations:

- HIV/AIDS early effective monitoring and management(Henry Mkwanazi)
- Civil society legislative advocacy against tobacco products (Dr Yussuf Saloojee)

Sector work groups deliberated on collective ways to support the NCDs Plan. The reports of each group are reflected in the resolution. The delegates resolved to support the following for NCDs action:

1. National NCDs Plan supported with government accountability
2. Collaborate to fight NCDs (within and across sectors) in the NCDs Multisectoral Working Group (nMWG)
3. SA NCD Alliance as the lead organisation in the fight against the NCDs epidemic
4. Strengthen national NCDs research agenda and capacity.
5. The consensually developed and final civil society status report as a tool for national NCDs advocacy.
6. Unrelenting action to strengthen NCDs systems to culminate in a stakeholder meeting in August 2014.

2. MEETING GOALS AND OBJECTIVES

Goal:

- To galvanize awareness and unify support for NCDs prevention and management amongst key stakeholders in a "Call for NCDs Action".

Objectives:

- To support the NCDs strategic plan within the South African context
- To develop priorities for NCDs advocacy and action
- To develop a network of support for NCDs advocacy and action.

3. MEETING DESIGN FOR NCDs RESULTS

The mission of the meeting is to **galvanize** key stakeholders around NCDs prevention and control. It involves inspiring feelings and targeted activity in relation to NCDs

galvanize

verb: shock or excite (someone) into taking action.

"To galvanize awareness and unify support for NCDs prevention and management amongst key stakeholders."

synonyms: *jolt, shock, startle, impel, stir, spur, prod, urge, motivate, stimulate, electrify, excite, rouse, arouse, awaken, invigorate, fire, fuel, animate, vitalize, energize, exhilarate, thrill, dynamize, inspire*

This presents a number of challenges:

- To accept and work with the new SA NCD Alliance, albeit with known and trusted partners (CANSA, DSA, HSFSA and PHANGO).
- Collaboration between people and organisations (previously known or not) for the greater good of all South Africans
- Putting aside unnecessary competition.

A combination of plenary and stakeholder group sessions were used to increase galvanization. Active participation is really important to share the message and get the feeling. Participation was encouraged in relation to the awareness campaigns of the Heart & Stroke Foundation, CANSA and Diabetes SA. Delegates dressed in red, wore denim and donned wraps in wonderful variations. (See Figure 2: NCDs Stakeholder meeting delegates wear red to support the heart health of women and children and wraps to support CANSA.)

This stakeholder meeting was more than just another get together, a talk show. It provided a unique opportunity to galvanize and build alliances. Thus, the meeting's design is critical to the outcome of alliance building. This is lesson learned in the hard way, in the South African journey from its apartheid past.

3.1 Sector group work design

Group work used the opportunity to involving multiple sectors as a way of connecting participants and turning them into allies.

It is usually accepted that if you have the stakeholders on board from the beginning of a process you eliminate time-wasting later and everyone feels committed to the success of the project.

Prof Mel Freeman - National Department of Health

The following classification of stakeholder sectors is used throughout this document:

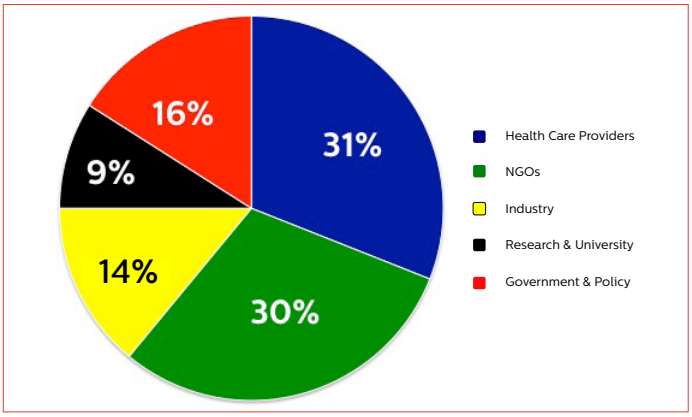
- NGOs and civil society (abbreviated as **NGOs**).
- Policy and government including national and provincial departments of agriculture, education, disabilities (abbreviated as **government**).
- Healthcare industry and relevant related industries, e.g. pharma, devices, food (abbreviated as **industry**).
- Healthcare providers including medical schemes (abbreviated as **healthcare providers**).
- Research institutions and universities (abbreviated as **research**).

It proved a resonant and robust way of grouping delegate by sectors **(see Figure 1: Group allocation of delegates by sector by sector on registration.)**

The registration form asked delegates to choose the sector to which they felt they belonged, with most responding as anticipated. A senior provincial official chose the healthcare provider group rather than the policy group. A professor of dietetics emphatically chose to be in the government group, "Policy is where my interest is."

Figure 1

Group allocation of delegates by sector on registration



The five stakeholder groups are the basis for the ongoing stakeholder mapping exercise. As each new stakeholder is revealed mapping becomes more complex and layered (see Figure 5: NCDs stakeholder network March 2014).

3.2 Invitation challenges

South Africa prematurely went into annual summer shutdown due to the death of our beloved former President, Tata Madiba. He went to his final rest during persistent rain with the gates of heaven widely open to welcome him home.

South Africa summer holidays, from 16th December to the middle of January, are sacrosanct with the country in recess. So for administrative and social reasons, the first invitations were made by email on 13th January 2014 to existing SA NCD Alliance founding partner networks. With under a month to the meeting electronic distribution was preferred.

- Over 300 direct emailed invitations
- 2000 hits on the events section on the website
- 1000 e-newsletter recipients.

SA NCD Alliance contacts database are actively and comprehensively maintained to target ensure that communication is targeted.

Two groups (professional groups and the pharma industry) were under-represented. In some instances, it was due to prior commitments and the short notice of the meeting. It was resolved to ensure that stakeholder groups, organisations and individuals are informed of developments with an open invitation to participate.

Rain at an African funeral

Rain leading up to or on the day of the funeral is interpreted as a good sign that the heavens and the spiritual world are welcoming the dead.

Figure 2:

NCDs Stakeholder meeting delegates wear red to support the heart health of women and children and wraps to support CANSA.

3.3 Common NCDs agenda

During South Africa's transition to democracy, the nation learned to be inclusive rather than exclusive, when determining agendas that involve more than one group.

The stated purpose of the meeting was to broaden and open up the agenda around NCDs. The strategy was successful with the issues and priorities determined by the group. **(See Table 2: Outcomes of the NCDs stakeholder meeting)**

4. NCDs IN SOUTH AFRICA
PAST, PRESENT & FUTURE

Presentation by Prof Krisela Steyn, University of Cape Town, Heart & Stroke Foundation of SA & SA Hypertension Society. To download a copy of the presentation click here.

5. INTRODUCING THE SA NCD ALLIANCE

Founding Members

The founding members took the opportunity to showcase each organisation in brief presentations. These presentations are shown as info-graphics.

SA NCD Alliance facts:

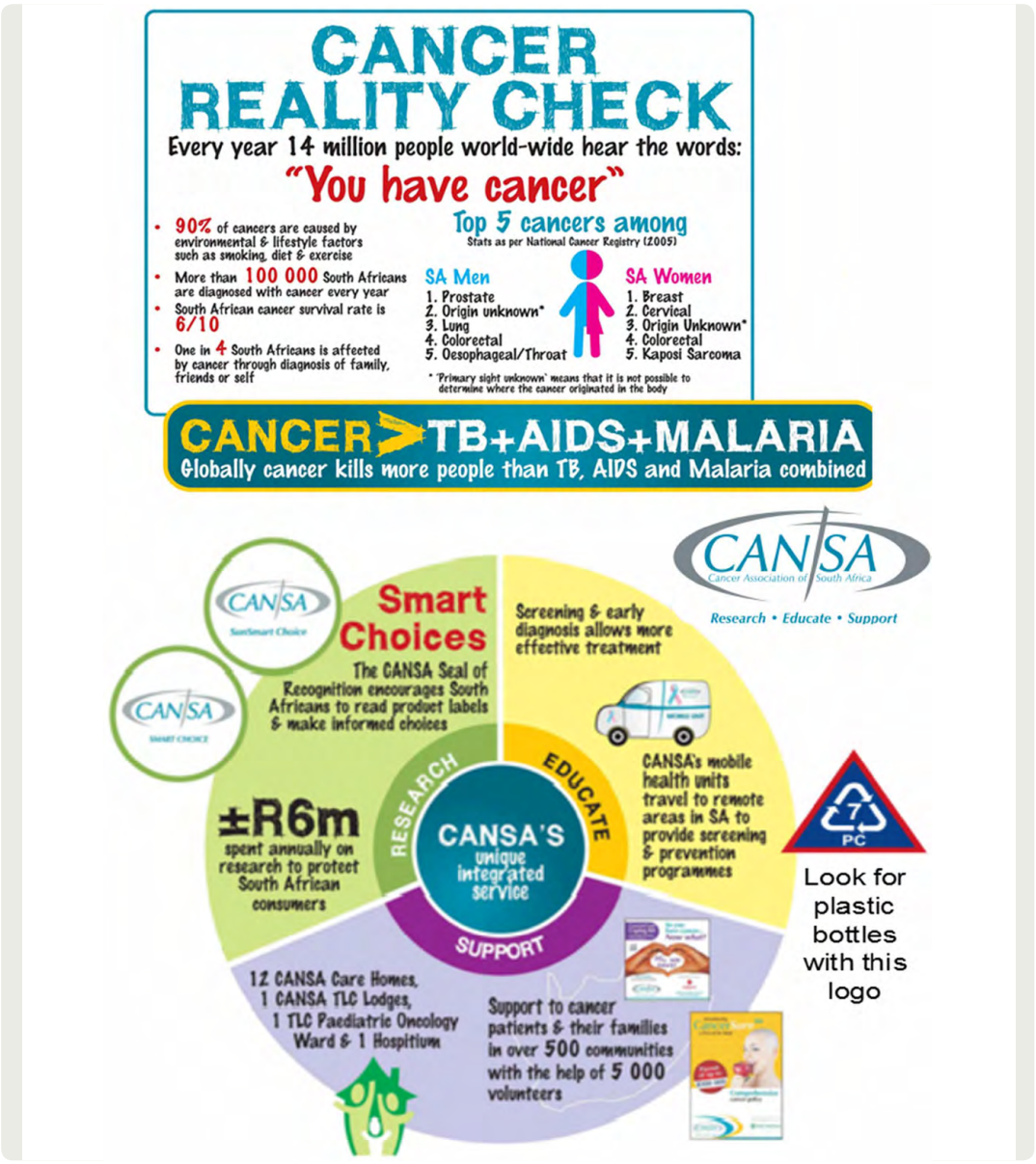
- Established July 2013 with founding members CANSA, Heart and Stroke Foundation, Diabetes SA & PHANGO.
- Over 160 years of civil society NCDs support and advocacy experience.
- Affiliated to and supported by the NCD Alliance, which unites a network of over 2,000 civil society organizations in more than 170 countries.
- Awarded a grant from Medtronic Philanthropy to Strengthen Health Systems, Support NCD Action Grant in September 2013 which funded this stakeholder meeting and other activities.
- One of only 7 national NCDs alliances in Africa
- Access to wide network of civil society organisations in South Africa through its founding members.
- CANSA has a national office supported by 31 CANSA Care Centres offering stoma support and organisational management; medical equipment hire
  - 12 CANSA Care Homes in the main metropolitan areas for out-of-town cancer patients
  - 1 hospitium based in Polokwane
    - CANSA-TLC lodging for parents and guardians of children undergoing cancer treatment
    - Member The Union for International Cancer Control
- Diabetes SA – 1 national office and 8 branches and a volunteer network of 100 community based groups
  - Member of the International Diabetes Federation
- Heart & Stroke Foundation SA – Leads the fight against preventable heart disease and stroke by: providing information and support to build healthy communities; advocating to minimise risk: supporting research for improved tools and methods of prevention
  - Member of the World Heart Federation, World Stroke Organisation.
- Patient Health Alliance of Non Governmental Organisations – 30 health & patient related NGOs including all founding members.
  - Member of International Alliance of Patients' Organizations

Figure 2:

SA NCD Alliance founding partner execs (Front) former CANSA CEO, Sue Janse van Rensburg, Vash Mungal-Singh, Heart & Stroke Foundation (Back) Leigh-Ann Bailie, Diabetes SA, Vicki Pinkney-Atkinson PHANGO

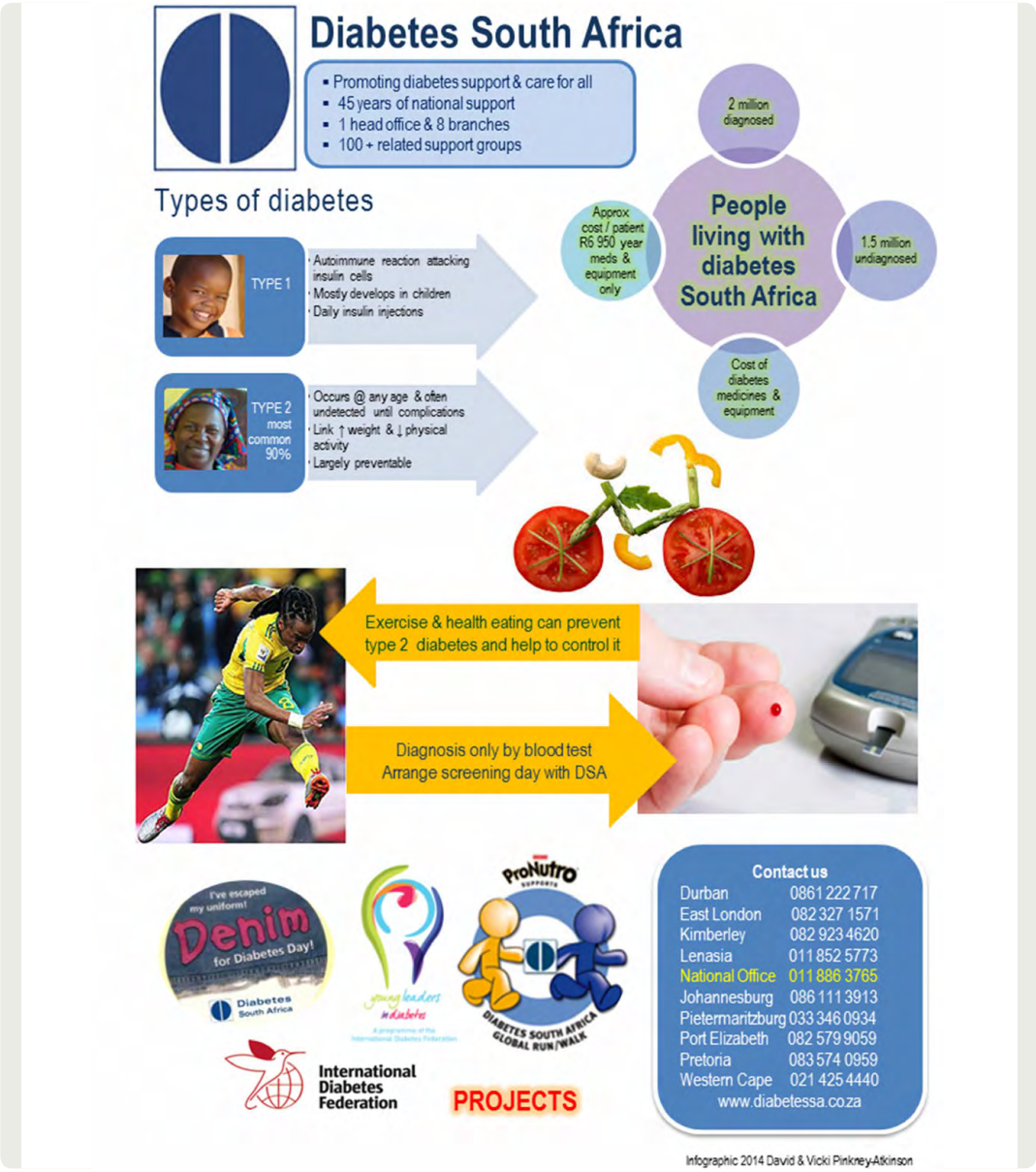
5.1 Cancer Association of South Africa (CANSA)

Presentation by Sue van Rensburg. To download a copy of the presentation click here.



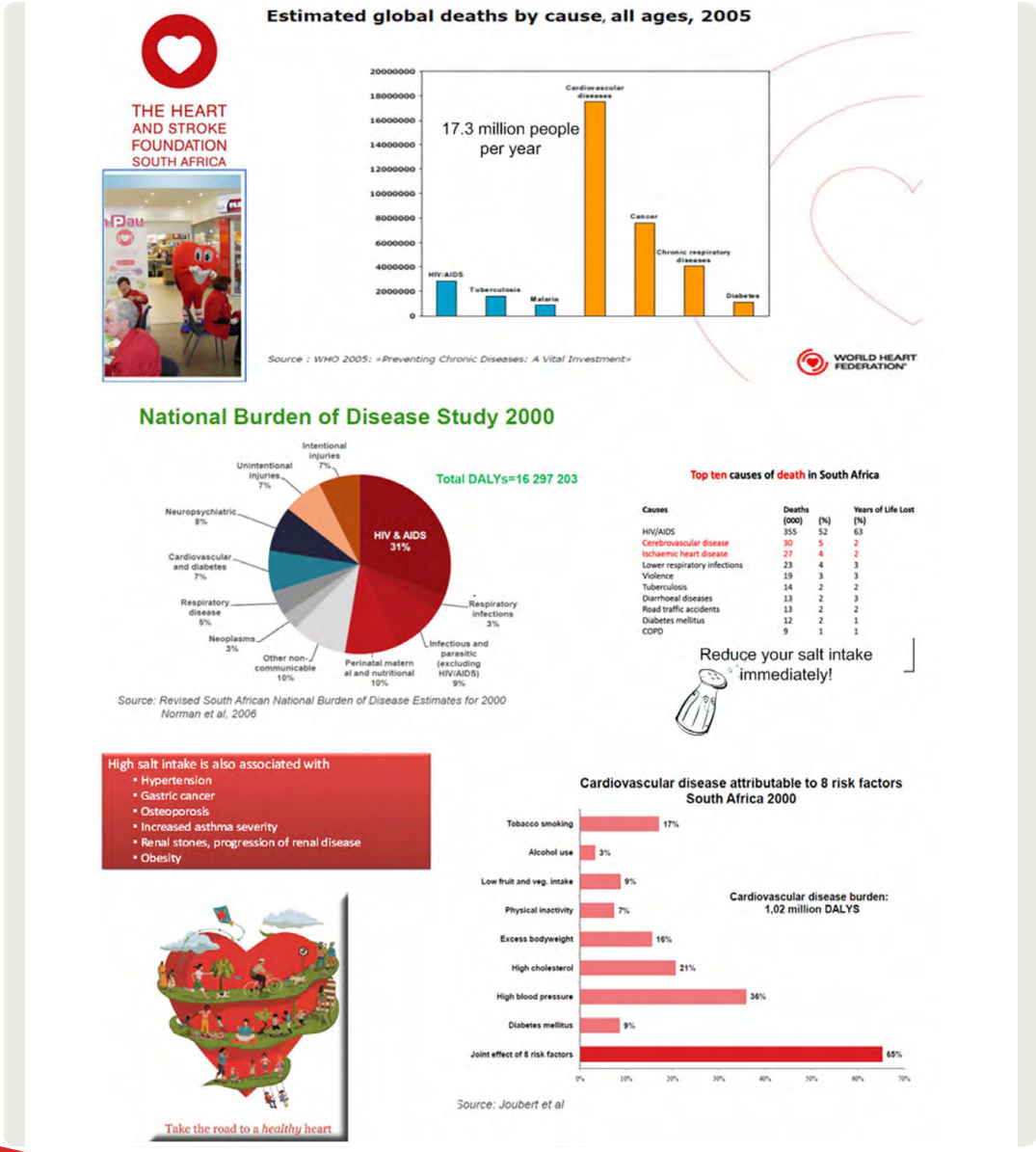
5.2 Diabetes South Africa (DSA)

Presentation by **Leigh-Ann Bailie**. To download a copy of the presentation **click here**.



5.3 Heart and Stroke Foundation of South Africa (HSF)

Presentation by Dr Vash Mungal-Singh. To download a copy of the presentation click here.



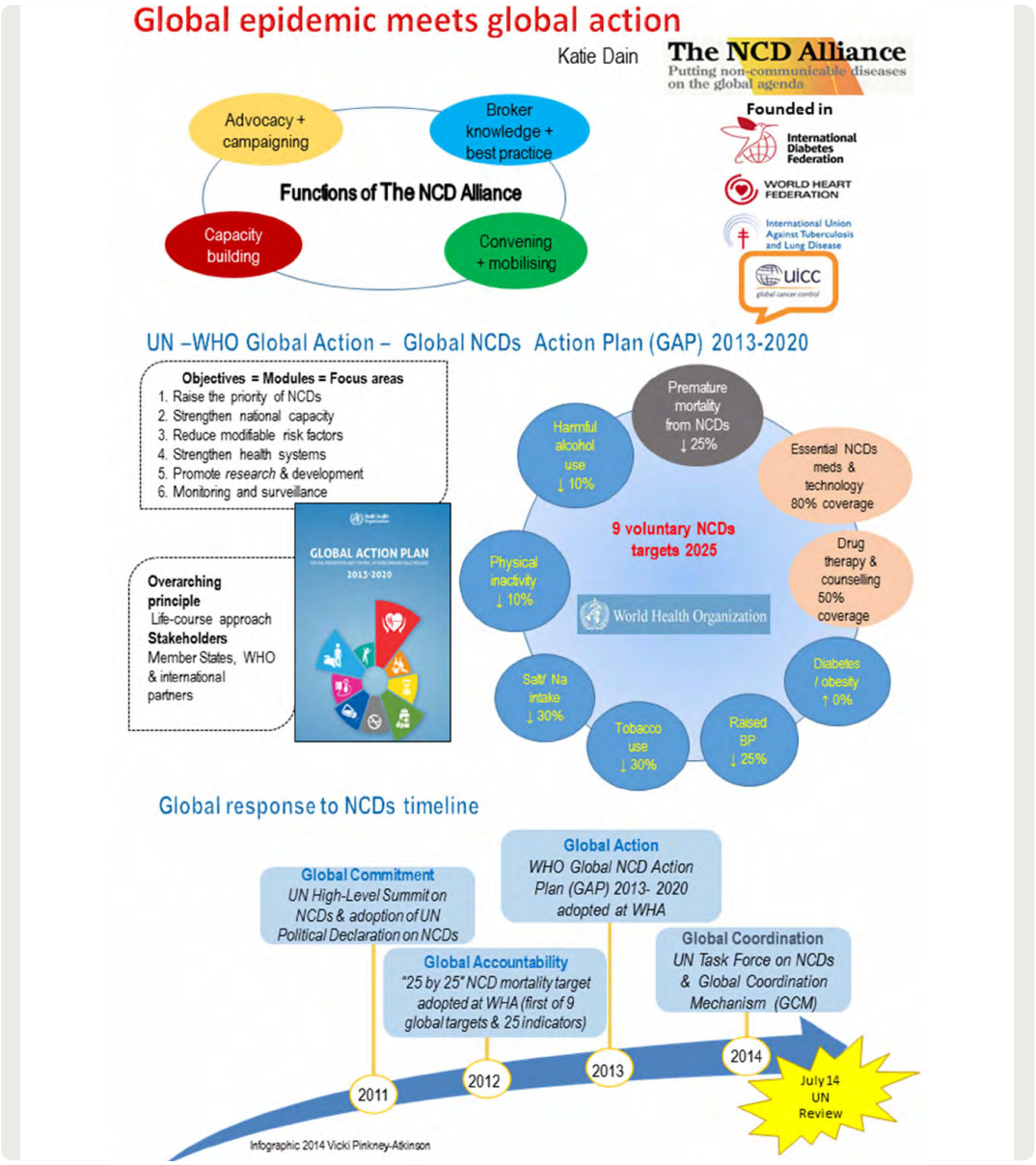
5.4 Patient Health Alliance of Non-governmental Organisations (PHANGO)

Presentation by Dr Vicki Pinkney-Atkinson. To download presentation click here.

6. THE NCD ALLIANCE

GLOBAL EPIDEMIC MEETS GLOBAL ACTION

Presentation by **Katie Dane**, Executive Director, NCD Alliance. To download a copy of the presentation **click here.**



7. UNPACKING THE NCDs STRATEGIC PLAN
TARGETS, STRENGTHS & CHALLENGES

Ministry of Health's Chief Director for NCDs, Professor Melvyn Freeman presented the new national NCDs Strategic Plan 2013-2017 (NCDs Plan). In a show of transparency he presented its strength and challenges which was highly appreciated by all delegates. Happily knowledge dissemination occurred when a copy of NCDs Plan was given to every delegate. To download a copy of the presentation click here .

Table 1: South Africa's NCDs Plan- targets, strengths & challenges

10 NCDs TARGETS BY 2030	STRENGTHS	CHALLENGES

1. ↓ by 25% the relative premature NCDs-related mortality (< 60 years of age)
2. ↓ by 20% tobacco use
3. ↓ by 20% the relative per capita consumption of alcohol
4. ↓ mean population salt intake to <5 g/day
5. ↓ by 10% the percentage of people who are obese and/or overweight
6. ↑ by 10% the prevalence of physical activity (150 minutes of moderate-intensity physical activity / week, or equivalent)
7. ↓ prevalence of people with raised BP by 20% (through lifestyle & medication)
8. Every women with sexually transmitted diseases (STD) screened for cervical cancer every 5 years. If no STD, every women screened 3 time in life (and as per policy for women who are HIV/AIDS positive)
9. ↑ 30% the % of people controlled for hypertension, diabetes and asthma in sentinel sites
10. ↑ by 30% the number of people screened and treated for mental disorders.
	• Ministry of Health involved most stakeholders at 2011 NCDs National Summit
	• Full political leadership backing (Minister & Deputy Minister of Health, provincial Ministers of Health, unanimous adoption National Health Council)
	• Contextualised by:
	  ◦ National Development Plan (NDP)
	  ◦ 3 primary health care re-engineering elements
	  ◦ Universal healthcare access (National Health Insurance) & other policy
	  ◦ HIV / AIDS epidemic
	  ◦ UN Political Declaration & subsequent WHO recommendations.
	• NCDs are not only a health problem (see social determinants of health/ disease)
	• Features of the NCDs Plan are:
	  ◦ Broad definition of NCDs (includes more than cancer, cardiovascular disease, diabetes, chronic respiratory conditions)
	  ◦ Common risk factors
	  ◦ Specific objectives, ambitious targets (see column) and indicators
	  ◦ Based on "best buys or "bang for our buck"
	  ◦ Comprehensive approach (promote health, prevent; control through health systems strengthening & reform: monitoring and research of NCDs and risk factors)
	• Assumes growing co-morbidity between communicable disease and NCDs
	• Linked to the care and treatment model for roll-out of HIV/AIDS programme (Integrated Chronic Disease Management Model)
	• Community level programmes (education campaigns, school interventions, screening)
	• Individual lifestyle behaviour change critical
	• Ongoing regulatory mechanisms critical e.g. already implemented tobacco control, ↓ salt, ↓ alcohol related harm, ↓ trans fat
		• Broad NCDs definition makes focus and prioritisation difficult
		• Targets are beyond those in the WHO Global Action Plan 2013-2020 with potential to embarrass and demotivation
		• Questionable data used as baseline
		• Data collections systems and monitoring
		• Scarcity of resources (human and financial) for full implementation
		• Full costing is difficult and incomplete with a trade-off for political backing
		o Some clinically oriented targets are lacking
		• Assumes a groundswell of advocacy which may not exist
		• Context of poverty and non-health promoting cultural norms

8. SWOT ANALYSIS OF NCDs

CHALLENGES BY SECTOR

STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
NGOs			
1. Infrastructure and technical expertise • National footprint • Community mobilisation • Volunteer network • Structured campaigns 2. Existing partnerships with all stakeholder groups • Government - strong political support • Existing alliances: NGOs and other 3. Integrity, ethics & good governance	1. ↓ inter-NGO collaboration due to competition for minimal resources 2. ↓ resources and funding • ↓ sustainable resources • Donors determine agenda & activities • Human resources e.g., ↓ volunteers 3. People Living with NCDs are not engaged or mobilised for advocacy & activations.	1. Establish working relationship with WHO Afro region and other organisations 2. Access to other resources & assets • Academia and research • Unions and nursing etc. 3. NGOs to hold government accountable for NCDs outcomes, policy & legislative framework.	1. Prevention is not prioritised & not all NCDs recognised 2. Socioeconomic factors • Geographical • Cultural differences and beliefs • Poverty 3. Industry • Health vs. business as a priority • Challenge policies and legislation
Healthcare providers			
1. Strategies in place with policies and guidelines 2. Experience with current programmes (e.g. HIV/AIDS) 3. Interdisciplinary teams: • Knowledge • Skills • Budget	1. Data neither adequate nor adequately shared • Resources: financial, human, material • Information systems and logistics • Physical infrastructure 2. Bureaucracy: ↓ structural commitment to support NCDs. 3. NCDs target evaluation difficult (monitoring and outcome data)	1. ↑ use of public-private partnerships (PPPs) 2. The use of new models to deliver care, data capturing, research etc. 3. ↑ appropriate use of technology	1. Political interference 2. Stigmatisation and cultural diversity 3. ↑ risk factors due to global economic and social dynamics 4. Traditional health providers
Industry			
1. Scale of reach locally or internationally such as: • Media & education programmes • Best practice or understanding • Rolled out effectively in other countries 2. Partnerships existing and link to NCD space. • Systems integration and data that exists. 3. Business approach to problems/ issues • Health is the business driven by outcomes via implementation. • Ethics & transparent agendas important.	1. Much data exists but may not well used • May not be what public sector needs. • Competition & sharing don't go together. • Companies drive different agendas & need to clarify these to enable collaboration. 2. Bureaucracy within the entire system. E.g., PPPs are often crippled before implementation by bureaucracy.	1. Tap into best practice: local and global. 2. Greater engagement be transparent as to desired objectives and outcomes. 3. Build capacity through existing educational programmes related to the products being sold.	1. Lack of transparent business agendas engenders ↓ trust 2. Legislation is not enabling the vision of universal access. E.g. no regulations in equipment & device industry. 3. Resourcing (human, financial, etc.) excluded from SA NCDs Plan. E.g., WHO voluntary global target 80% availability of essential medicines & basic technologies.
Research			
1. Provides an evidence base for planning, policy making and interventions. E.g., burden of disease on society is evident if epidemiological/ surveillance data is available. 2. Collaboration and sharing information between research institutions and broader networks 3. Responsiveness of policymakers	1. Sub-utilization of research by policymakers due to ↓ research translation with policymakers unable to implement recommendations. 2. ↓ NCDs researchers: silos, ↓ networking & bad research study designs. 3. ↓ funding, monitoring and evaluation	1. Responsiveness of policymakers & possible access to global NCDs funds. 2. Collaborative nature of research, creation of data banks & champions 3. Locally specific information is yielded by research if needs have been identified	1. Biased research, vested interests of industry and competing priorities of researchers (publish or perish), 2. ↓ funding 3. Brain drain: ↓ researchers ↓ succession planning & capacity building with failure to create attractive research careers.
Government			
1. Policy and enabling framework in place • Comprehensive health approach not silos. 2. Intersectoral across government 3. Common objectives: targets, problem	1. Implementation process and timelines 2. ↓ resources (people, money, equipment, standards, etc.) 3. Dissemination of the message including the NCDs Plan.	1. Share experiences, knowledge & information that S Africa can use. 2. Share meaning between sectors to prevent ideas & facts getting lost. 3. Develop common agendas using SA NCD Alliance network so that all important goals are emphasises and all sectors.	1. Some SA NCDs targets are more ambitious than WHOs GAP (page 5). 2. Disproportionate between NCDs vs. HIV/AIDS programmes E.g. budget allocation Mpumalanga HIV/AIDS R 880 million - NCDs, R 2 million 3. NGOs agendas may not be in the community interests but rather for profit.

9. NCDs NETWORK/COALITION FOR ACTION

In terms of NCDs advocacy, the formation of a network of stakeholders is an important milestone. Long before the last session it was apparent that all participants wanted to find a vehicle to work together to stop the epidemic of NCDs. It was just a question of who and how. The multisectoral groups will form the backbone of the NCDs Multistakeholder Working (nMWG) with the following delegates as volunteers:

- **NGOs** Mike Boddy (Chair, Arthritis Foundation SA), Karen Borochowitz (Dementia SA), Madeline Seguin (CANSA), Adri Ludick (CHOC)
- **Industry** Tanya Vogt
- **Healthcare providers** Lindsay van der Linden
- **Research** Prof Andre Kengne
- **SA NCD Alliance** Leigh-Ann Bailie, Elize Joubert, Vash Mungal-Singh, Vicki Pinkney-Atkinson

(E-mail addresses are hyperlinked so that you can contact the relevant groups.)

It was generally accepted that a special case exists for the government officials who are in a complex and sensitive position of both provider and policy maker. Melvyn Freeman and Vimla Moodley, on behalf of the Department of Health, indicated readiness to participate in the NCDs network without being a member.

The nMWG will meet by May 2014.

> Enable all providers (including nongovernmental organizations, for-profit and not-for-profit providers) to address noncommunicable diseases equitably while safeguarding consumer protection and also harnessing the potential of a range of other services such as traditional and complementary medicine, prevention, rehabilitation, palliative care and social services to deal with such diseases.
>
> WHO - Global NCDs Action Plan 2013-2025 p. 41

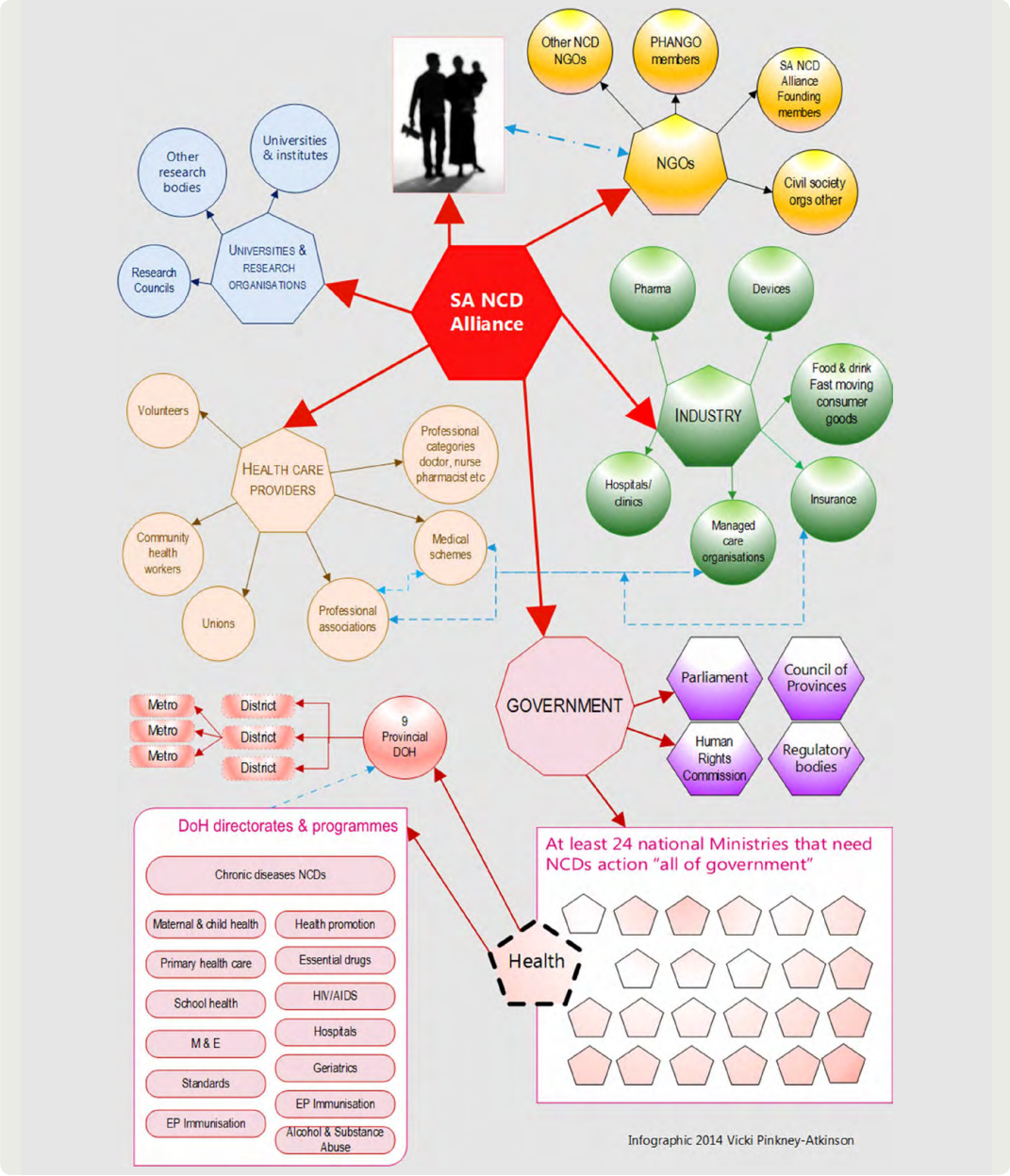
Thanks go to the following participants for serving as scribes and sector group work facilitators: Pauvi Bhatt, Kathy Dennill, Col. Fezeka Mabona, Vicki Pinkney-Atkinson and Lindsay van der Linden.

Thanks go to the organising group: Leigh-Ann Bailie, Vash Mungal-Singh, David Pinkney-Atkinson, Vicki Pinkney-Atkinson, Sue Janse van Rensburg.

Figure 4

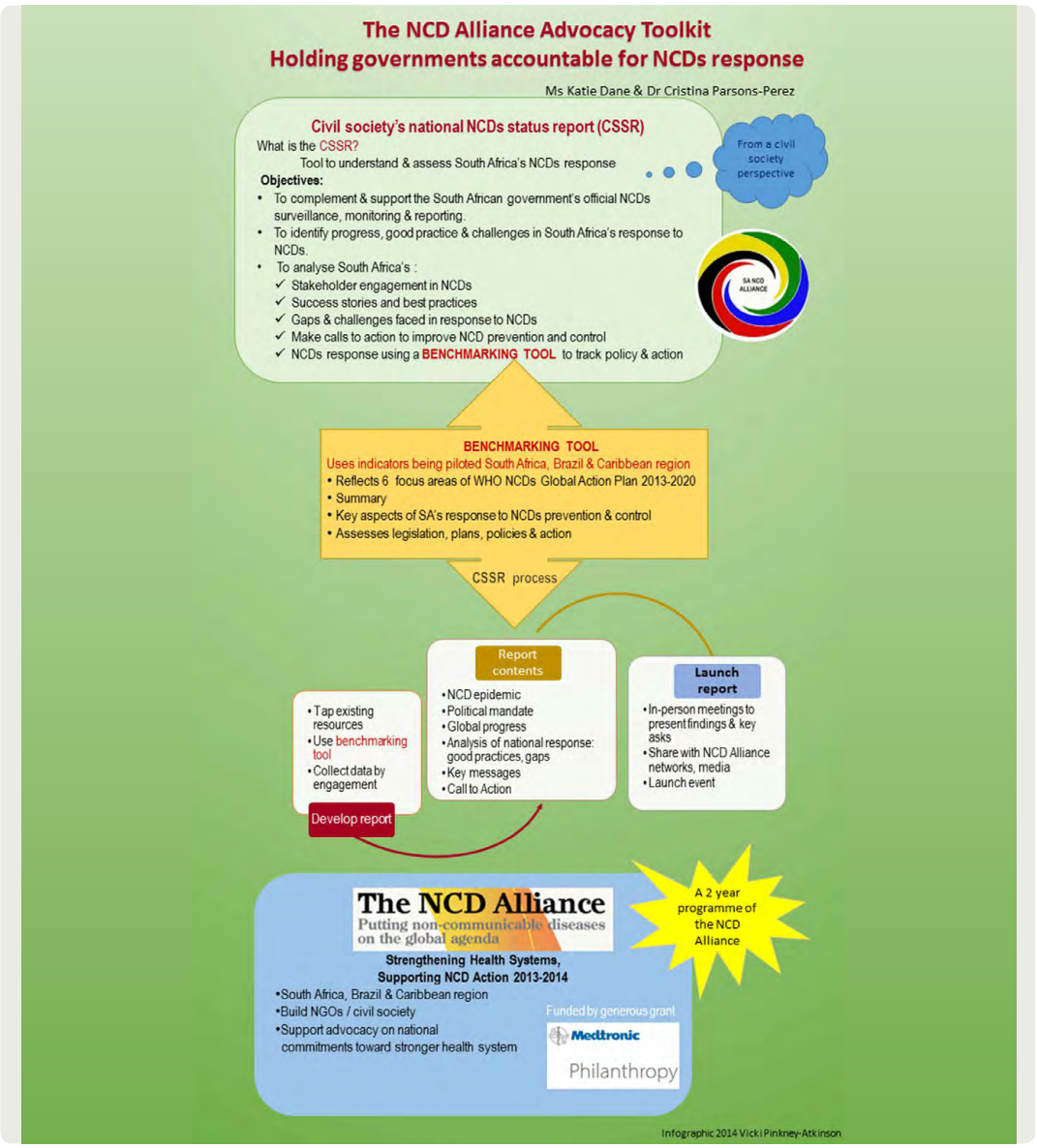
Elize Joubert, new Acting CEO of CANSA was introduced at the stakeholder meeting.

Figure 5: NCDs stakeholder network March 2014



10. NCD ALLIANCE ADVOCACY TOOLKIT:
NATIONAL STATUS REPORT & BENCHMARKING TOOL

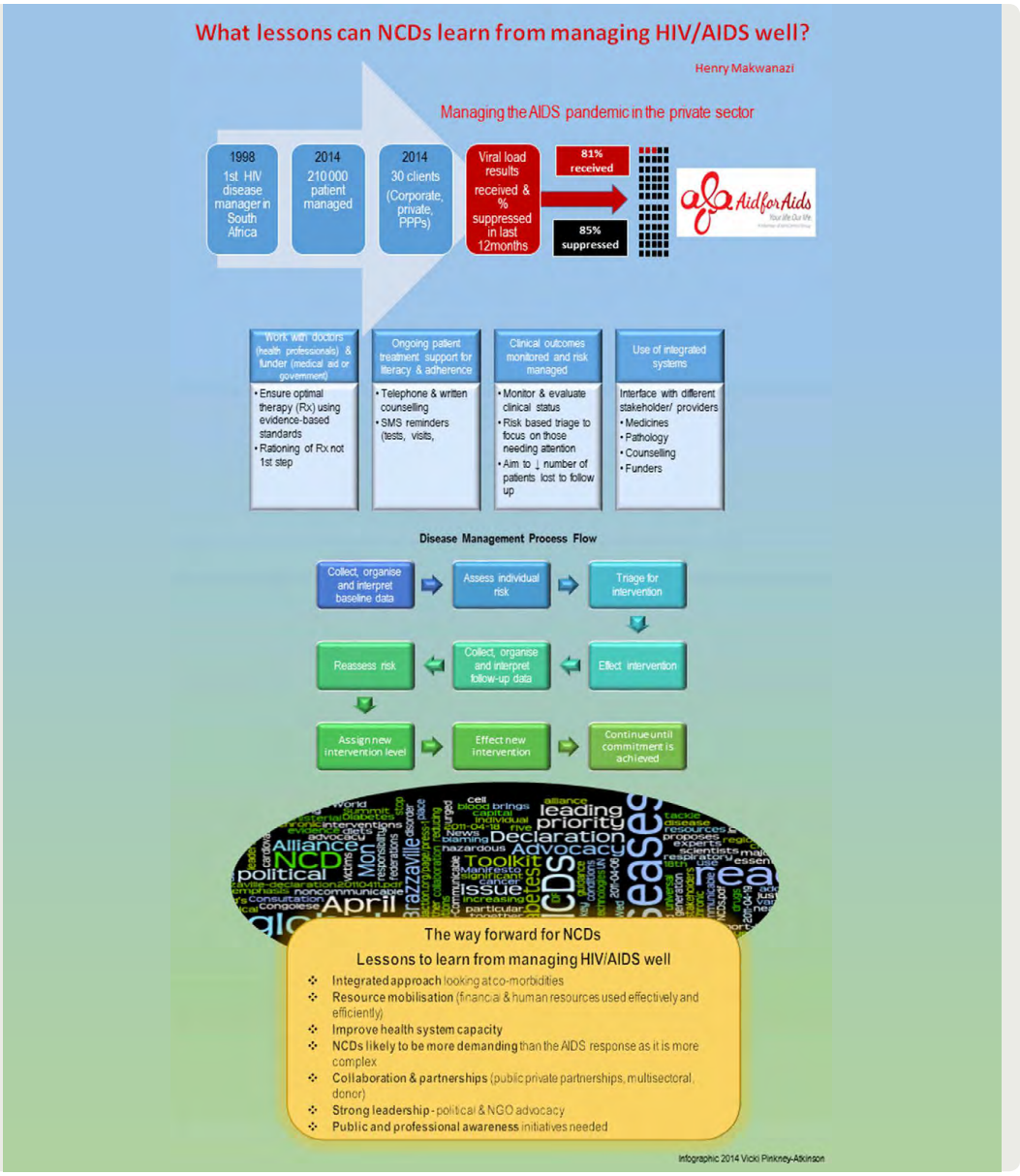
Presentation by Katie Dain and Dr Cristina Parsons Perez.
To download a copy of the presentation click here.



11. LESSONS LEARNED

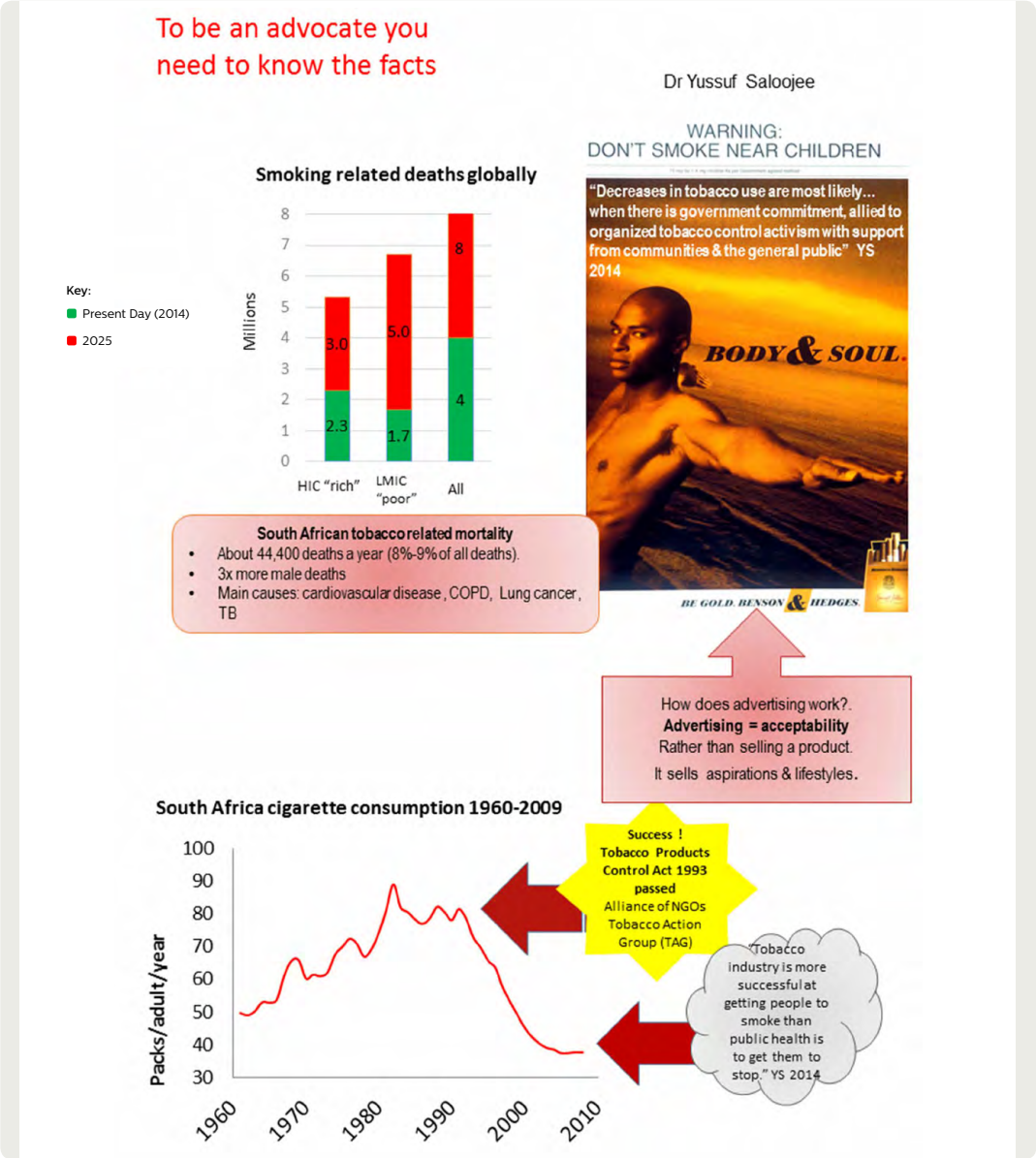
11.1 From HIV/AIDS management

Presentation by **Henry Mkwanazi**, Aid for AIDS .
To download a copy of the presentation **click here**.



11.2 From anti-tobacco advocacy

Presentation "So you want to change the world?" by **Dr Yussuf Saloojee**, National Council Against Smoking.
To download a copy of the presentation **click here**.



12. NCDs PRIORITIES FOR ACTION

The most important achievement of the final session was to get stakeholder inputs on the important issues that will influence the "next steps" to be taken by the SA NCD Alliance:

- Are you ready to participate as a sector group and an individual?
- How will your sector group work together?
- What will should the SA NCD Alliance do?

The final session was devoted to the report back of the sector groups on the task set for the groups in the text box (below)

- Presenters from each sector formed a panel to answer questions. However, presentations were accepted without any verbal objections.
- Dr Vash Mungal-Singh was responsible for enumerating and presenting the group feedback for this important session.
- Delegates unanimously agreed to the next steps or short-term action plan for NCDs action in Table 2. The table does not imply any order of importance.
- Delegates accepted the challenge of presenting them to their organisations within their various stakeholder sector groups. They also committed to furthering the outcomes.

Group task: Sector action and commitment.

1. How will your sector respond to the challenges outlined in this meeting?
2. How will you collaborate as a sector to achieve and strengthen the NCD action plan?
3. How will your sector collaborate with the other sectors? Elaborate.
4. What can we expect from your sector's group by the next stakeholder meeting in August 2014?
5. Briefly other important actions, issues or challenges that require attention and have not been dealt with during the meeting

Table 2: Short-term NCDs action plan from stakeholder meeting

1. National NCDs Plan supported with government accountability

1.1. The NCDs Plan appears acceptable to stakeholders but concerts for implementation, monitoring and health systems strengthening.
1.2. Monitor government's progress on implementation of the NCDs Plan – Spearheaded by the SA NCD Alliance and responsibility of all delegates
1.3. Raise awareness of the NCDs Plan with all stakeholder groups.
1.4. Disseminate printed and electronic version widely.
1.5. The government group recommended that the Department of Health convene an in-house workshop in April 2014. Objectives of workshops:
- To review NCDs Plan;
- To develop concrete actions
- To commit to indicators and targets
- To clarify working relationships between directorates and other government departments (e.g. Department of Basic Education, Agriculture, Disabilities, Women and Children).

2. Collaborate to fight NCDs (within and across sectors) in the NCDs Multisectoral Working Group (nMWG)

2.1. Delegates unanimously agreed to share contact details with each other to mark the start of the coalition.
2.2. Create the nMWG including all stakeholder groups and determine involvement categories: member, observers, volunteers, founders.
2.3. Convene nMWG meeting by the end of April 2014.
2.4. Develop a multisectoral collaborative NCDs Action Plan based on the NCDs Plan.
2.5. Engage with groups below that were under- or not represented at the meeting:
- NGOs
- Professional societies / bodies
- Funding bodies / entities
- Food sector
- Education sector (government and group)
- Sports and recreation (government and groups)
- Industry sectors
- Provincial NCDs focus areas in Health Departments who did attend the meeting: Eastern Cape, Free State, KwaZulu-Natal, Limpopo, Northern Cape

3. SA NCD Alliance the lead organisation in the fight against the NCDs

3.1. Delegates unanimously agreed there was a role for the SA NCD Alliance going forward.
3.2. Agreed roles and functions:
- Advocate for NCDs prevention, control, monitoring and research
- Hold accountable sectors, members and government for quality NCDs prevention, control, monitoring and research
- Develop and maintain:
  - Manage knowledge NCDs (creation, collating, sharing and dissemination)
  - National NCDs database for organisations, services, products (campaigns or programmes), personnel.
  - Synchronise communication nationally with health calendar and share materials
- Facilitate NCDs communication, coordination and resource mobilisation across sectors
- Reporting and monitoring on NCDs and the NCDs Plan
- Prioritise NCDs regular communications: website social and print media including media briefing as appropriate
- Strategic plan including secretariat (administration), financial resources and sustainability etc.

3.3 Clarify terms of reference and categories of affiliation

4. Strengthen national NCDs research agenda and capacity

4.1. Clarify and prioritise NCDs research nationally.
4.2. Disseminate available data.
4.3. Economists to quantify cost of NCDs.
4.4. Prioritise evidence-based best practice.

5. Use the completed civil society status report (CSSR) as a national NCDs advocacy tool

5.1. Participants agreed to give input and to critique of the first draft.
5.2. Use the CSSR as an advocacy tool with all levels of government with media launch.

6. Unrelenting action to strengthen NCDs systems culminating in a stakeholder meeting in August 2014

With input from nMWG and based on CSSR.

ANNEX A: KEY STAKEHOLDER MEETING FEBRUARY 2014 REGISTRATION & PARTICIPANT LIST

- Health care providers / professional societies / trade unions
- Industry including managed care organisations
- Policy and government
- Universities and research organisations
- NGOs and civil society organisations

	Surname	Name	Title	Company/ Organisation
1	Allie	Razana	Ms	Diabetes Educators Society SA
2	Asomugha	Chika	Dr	Gauteng Dept of Health
3	Atkinson	Mary	Dr	Roche Diabetes Care
4	Bailie	Leigh-Ann	Ms	Diabetes SA /PHANGO/ SA NCD Alliance
5	Banda	Patricia	Ms	Gauteng Dept of Health
6	Basu	Debashis	Dr	Wits School of Public Health
7	Bayat	Zaheer	Dr	SEMDSA / WITS
8	Bhatt	Pauvi	Ms	Medtronic Philanthropy
9	Black	Peter	Mr	Centre for Diabetes and Endocrinology
10	Boboko	Ishmael	Mr	North West Dept of Health
11	Boddy	Michael	Mr	Arthritis Foundation of SA/ PHANGO
12	Borochowitz	Karen	Ms	Dementia SA /PHANGO
13	Brown	Michael	Mr	Centre for Diabetes and Endocrinology
14	Carocari-Santana	Emma	Ms	Medtronic
15	Chambers	Cassey	Ms	SA Anxiety and Depression Group / PHANGO
16	Crickmore	Christelle	Ms	Heart and Stroke Foundation SA /PHANGO
17	Dain	Katie	Ms	The NCD Alliance
18	Dennill	Kathy	Ms	Kedibone Health System Consulting
19	Du Plessis	Janie	Mr	People Living with Cancer, PHANGO
20	Du Toit	Fanie	Mr	National Kidney Foundation of SA, PHANGO
21	Dube	Dudu	Ms	Gauteng Dept of Health
22	Faruk	Mahommed	Dr	Council for Medical Schemes
23	Freeman	Melvyn	Prof	Department of Health
24	Futshane	Zanoxolo	Ms	Ekurhuleni Metro Council
25	Gumede	Sarah	Ms	Mpumalanga Dept of Health
26	Haldane	Cathy	Ms	Roche Diagnostics
27	Hall	Keegan	Mr	International Diabetes Federation Young Leaders in Diabetes
28	Hall	Nicolette	Ms	University of Pretoria
29	Hall	Thandi	Ms	Novo Nordisk
30	Herbst	Michael	Prof	CANSA /PHANGO
31	Hoffman	Karen	Prof	School of Public Health, Wits University
32	Janse van Rensburg	Sue	Ms	CANSA /PHANGO/ SA NCD Alliance
33	Joubert	Elize	Ms	CANSA / PHANGO
34	Joynt	Dale	Ms	Pfizer
35	Kengne	Andre	Prof	Medical Research Council
36	Keulder	Leon	Mr	Biokinetics Association of South Africa
37	Khan	Naazneen	Ms	Nestle
38	Kalideen	Savera	Ms	Soul City
39	Kuni	Ranga	Mr	Diabetes SA / PHANGO
40	Ludick	Adri	Ms	CHOC Childhood Cancer /PHANGO
41	Mabaso	Puseletso	Ms	Gauteng Dept of Health
42	Mabona	Fezeka	Col	Retired SA Medical Services / University
43	Maemetja	Selaelo	Dr	Council for Medical Schemes
44	Maredi	Meshack	Mr	Gauteng Dept of Health
45	Masemola	Madithapo	Ms	Democratic Nursing Organisation SA
46	Matlare	Elizabeth	Ms	SA Anxiety and Depression Group/ PHANGO
47	Masina	Thembani	Ms	Ekurhuleni Metro Council
48	Mashozhera	Nyasha	Ms	SA NCD Alliance
49	Mawela	Virginia	Ms	Gauteng Dept of Health
50	Mazibuko	Lungi	Ms	Gauteng Dept of Health

ANNEX A: KEY STAKEHOLDER MEETING FEBRUARY 2014 REGISTRATION & PARTICIPANT LIST (continued)

- Health care providers/ professional societies / trade unions
- Industry including managed care organisations
- Policy and government
- Universities and research organisations
- NGOs and civil society organisations

	Surname	Name	Title	Company/ Organisation
51	Mbabazi	Christine	Dr	FHI360
52	Mdiya	Dominica	Ms	Ekurhuleni Metro Council
53	Mdolo	Kedibone	Ms	Democratic Nursing Organisation SA
54	Mkwananzi	Henry	Mr	Aid for AIDS
55	Moeng-Mahangal	Tshimi Lynn	Ms	National Department of Health
56	Mokgwasa	Bruce	Mr	Gauteng Dept of Health
57	Molebotsi	Queen	Ms	Department of Health
58	Molefe	Meshack	Mr	North West Dept of Health
59	Molokoane	Tom	Mr	Novo Nordisk
60	Mungul-Singh	Vash	Dr	Heart & Stroke Foundation /PHANGO/ SA NCD Alliance
61	Moodley	Vimla	Ms	National Department of Health
62	Motaung	Abram	Mr	Gauteng Dept of Health
63	Mothopeng	Deborah	Ms	Gauteng Dept of Health
64	Mthombeni	Dudu	Ms	Gauteng Dept of Health
65	Ndhambi	Angeline	Ms	Ekurhuleni Metro Council
66	Ngcwabe	Themakazi	Ms	Ekurhuleni Metro Council
67	Nkombua	Lushiku	Dr	University of Pretoria
68	Nkonde	Sophie	Ms	Ekurhuleni Metro Council
69	Parsons Perez	Cristina	Dr	The NCD Alliance
70	Pillay	Ravi	Mr	Nestle
71	Pinkney-Atkinson	David	Mr	SA NCD Alliance / PHANGO
72	Pinkney-Atkinson	Victoria	Dr	PHANGO/ SA NCD Alliance
73	Pretorius	Agatha	Ms	Occupational Health South Africa
74	Ramafoko	Lebogang	Ms	Soul City
75	Rispel	Laetitia	Prof	Wits School of Public Health
76	Saloojee	Yussuf	Dr	National Council Against Smoking
77	Schonfeldt	Hettie	Prof	University of Pretoria
78	Seguin	Magdalene	Ms	CANSA/PHANGO
79	Sennelo	Nonceba		Gauteng Dept of Health
80	Serapane-Setlhare	Shirley	Ms	North West Dept of Health
81	Setlhare	Itumeleng	Mr	North West Dept of Health
82	Steyn	Krisela	Prof	SA Hypertension Society/ CDIA (university UCT)/ Heart and Stroke Foundation
83	Strauss	Gerda	Ms	CANSA /PHANGO
84	Theoa	Regina	Ms	Sedibeng District Health
85	Thsehla	Evelyn	Ms	Council for Medical Schemes
86	Tshetlo	Madile	Ms	Ekurhuleni Metro Council
87	van der Linden	Lindsay	Ms	Occupational Health South Africa
88	van Vuuren	Unita	Ms	Western Cape Dept of Health
89	Venter	Vlooi	Ms	CANSA / PHANGO
90	Verwey	Corinne	Ms	Roche Diabetes Care
91	Vogt	Tanya	Ms	SA Medical Device Industry Association
92	Wilson	Zane	Ms	SA Anxiety and Depression Group /PHANGO
93	de Klerk	Piet	Mr	Medtronic
94	da Fonseca	Jose	Mr	Life Scan/ Janssen Pharmaceutica
95	Bologna	Lucy	Ms	CANSA
96	Seftel	Effie	Dr	NCDs specialist
97	Adonis	Leegail	Dr	Wits School of Public Health
98	Paget	Sue	Ms	Rotary Family Health Days
99	Skinner-	Elizabeth	Dr	Abt Associates
100	Maringa	Suzan	Ms	Ekurhuleni Metro Council
101	Pretorius	Lauren	Ms	Campaigning for Cancer
102	Schurink	Eveline	Dr	UFF Agri Asset Management

SOUTH AFRICAN
NON-COMMUNICABLE
DISEASES ALLIANCE

ANNEX B: THE NCD ALLIANCE BENCHMARKING TOOL

SECTION	#	QUESTION/ INDICATOR	ANSWER*
1) Raise priority of NCDs through international cooperation& advocacy	1.1	Inclusion of NCDs in national development plans	Yes/No/partial
		If yes to 1.1, are NCDs included in sub-national development plans?	Yes/No/partial
		If no to 1.1, are NCDs included in sub-national development plans?	Yes/No/partial
		If no to 1.1, are NCDs included in the national health sector plan?	Yes/No/partial
	1.2	(If a high income donor country uses this indicator) inclusion on NCDs in Official Development Assistance	Yes/No/partial
		(If a low/middle income country uses this indicator) Government Inclusion of NCDs in UN Development Assistance Frameworks (UNDAFs)	Yes/No/partial
	1.3	Operational national NCD alliance/coalition/network of NGOs that engages People Living with NCDs (PLWNCDs)	Yes/No/partial
	1.4	Government-led, supported or endorsed national NCD conference/summit/meeting held in the last 2 years with active NGOs participation	Yes/No/partial
	1.5	Government-led or endorsed public media campaign on NCD awareness of NCD prevention partnering with NGOs and held in the last 2 years	Yes/No/partial
2) Strengthening national capacity, multisectoral action, and partnerships for NCDs	2.1	Operational National NCD Plan (number of key elements outlined below): if score less than 4, refer to 2.2	Yes/No/partial
		2.1.1 National NCD Plan with a 'whole of government' approach, i.e. with areas for action beyond the health sector	Yes/No/partial
		2.1.2 Functional national multistakeholder NCD commission/mechanism (incl. NGOs, People Living With NCDs and private sector)	Yes/No/partial
		2.1.3 National budgetary allocation for NCDs (treatment, prevention, health promotion, surveillance, M &E, human resources)	Yes/No/partial
		2.1.4 NGOs and PLWNCDs engaged in national NCD plan development	Yes/No/partial
	2.2	Number of sub-national jurisdictions (province, district etc) with an operational NCD plan that meets the full criteria as outlined above	Yes/No/partial
	2.3	Number of operational NCD public-private partnerships (PPPs) supporting elements of National NCD Plans. If yes, list PPPs.	Yes/No/partial
	2.4	National Government partnerships with NGOs on NCD initiatives. If yes, describe the nature of the partnership and initiative focus.	Yes/No/partial
3) Reduce NCD risk factors and social determinants	3.1	Number of tobacco MPOWER policies/interventions in existence (of those listed below 3.1.1 -3.1.6):	Yes/No/partial
		3.1.1 Existence of recent nationally representative information on youth and adult prevalence of tobacco use	Yes/No/partial
		3.1.2 National Legislation banning smoking in health-care and educational facilities and in all indoor public places including workplace, restaurants and bars	Yes/No/partial
		3.1.3 Existence of national guidelines for the treatment of tobacco dependence	Yes/No/partial
		3.1.4 Legislation mandating visible and clear health warnings covering at least half of principal pack areas	Yes/No/partial
		3.1.5 Legislation banning tobacco advertising, promotion & sponsorship OR legislation comprehensively banning all forms of direct tobacco marketing, covering all media form & advertising	Yes/No/partial
		3.1.6 Tobacco taxation policy of between 2/3 and 3/4 of retail price	Yes/No/partial
	3.2	National strategies on the major NCD risk factors (out of total listed below)	Yes/No/partial
		3.2.1 Tobacco	Yes/No/partial
		3.2.2 Harmful use of alcohol	Yes/No/partial
		3.2.3 Unhealthy diet	Yes/No/partial
		3.2.4 Physical activity	Yes/No/partial
	3.3	Increased taxes on alcohol in last 5 years	Yes/No/partial
	3.4	National policies & regulatory controls on marketing to children of foods high in fats, trans fatty acids, free sugars or salt	Yes/No/partial
	3.5	National action on salt reduction	Yes/No/partial
		3.5.1 National policies/regulatory controls on salt reduction	Yes/No/partial
		3.5.2 Number of voluntary private sector commitments / pledges to salt reduction. Specify any the voluntary commitments	Yes/No/partial
	3.6	Physical education in schools with resources and incentives	Yes/No/partial
4) Strengthen & reorient health systems to address NCDs	4.1	Government initiatives strengthening the capacity of primary health centres for NCDs (out of the total list below 4.1.1 - 4.1.5)	Yes/No/partial
		4.1.1 Cancer - number of evidence-based guidelines for the cancers prioritized in the National Care Plan	Yes/No/partial
		4.1.2 Cardiovascular disease	Yes/No/partial
		4.1.3 Chronic respiratory diseases	Yes/No/partial
		4.1.4 Diabetes	Yes/No/partial
		4.1.5 Mental health	Yes/No/partial
	4.2	Government initiatives strengthening the capacity of primary healthcare for NCDS (see list below 4.2.1 -4.2.4):	Yes/No/partial
		4.2.1 NCD health promotion and prevention (advocates to add own indicators)	Yes/No/partial
		4.2.2 Screening and early detection (advocates to add own indicators)	Yes/No/partial
		4.2.3 Treatment and referral (advocates to add own indicators)	Yes/No/partial
		4.2.4 Rehabilitation and palliative care (advocates to add own indicators)	Yes/No/partial
	4.3	Number of NCD medicines included in the country essential drug list (EDL) made available at low cost to patients with limited resources	Yes/No/partial
	4.4	National EDL list updated since last time WHO updated EDL? If yes, are NCD medicines included in the update?	Yes/No/partial
	4.5	NCD-related services and treatments are covered by health insurance systems. If only partially implemented, specify why.	Yes/No/partial
	4.6	Operational NCD Surveillance system (number of elements below):	Yes/No/partial
		4.6.1 Cause-specific mortality related to NCDs included in national health reporting system	Yes/No/partial
		4.6.2 Population-based NCD mortality data and population-based mortality data included in national health reporting system	Yes/No/partial
5) Promote national capacity for R & D on NCDs	5.1	National research agenda for NCDs	Yes/No/partial
	5.2	Government funding support for national research on NCDs	Yes/No/partial
	5.3	Number of published articles on NCDs in country in the last 5 years.	Yes/No/partial
6) M & E for NCDs progress	6.1	National NCD targets/indicator with monitoring mechanisms in place	Yes/No/partial

The Uganda NCD Alliance Strategic Plan
DRAFT

2016-2019

Kampala, June 2016

Table of contents

Acronyms and abbreviations

Add more below:

CSO	Civil Society Organisation
GAP	Global NCD Action Plan
GoU	Government of Uganda
HIV	Human Immunodeficiency Virus
HSSP	Health Sector Strategic Plan
M&E	Monitoring and Evaluation
LMICs	Low- and middle-income countries
MDGs	Millennium Development Goals
NCD	Non Communicable Diseases
NGO	Non- Government Organisation
SDG	Sustainable Development Goals
UBOS	Uganda Bureau of Statistics
UDHS	Uganda Demographic Health Survey
UN	United Nations
UNCDA	Uganda Non Communicable Diseases Alliance
UNMHCP	Uganda National Minimum Health Care Package
WHO	World Health Organisation
MoH	Ministry of Health

Chapter 1- Introduction

This Strategic plan developed by The Uganda NCD Alliance is a xx year framework for the members of the Alliance and its stakeholders, to take coordinated and coherent action, to attain the xx of the nine voluntary global targets, including that of a 25% relative reduction in premature mortality from cardiovascular diseases, cancer, diabetes or chronic respiratory diseases by 2025 as stipulated in the Global Action Plan for the prevention of NCDs (GAP). This plan focuses on four types of non-communicable diseases viz cardiovascular diseases, cancer, chronic respiratory diseases and diabetes—which make the largest contribution to morbidity and mortality due to non-communicable diseases, and on four shared behavioural risk factors - tobacco use, unhealthy diet, physical inactivity and harmful use of alcohol.

1.1 About UNCDA

Uganda NCD Alliance (UNCDA) consists of Uganda Heart-Research Foundation, Uganda Cancer Society and Uganda Diabetes Association. It was founded in 2010 as a response to the global NCD epidemic which especially is striking hard in low income countries. These three associations are working together in the alliance, which is organised as an association with a constitution, annual general meetings and an elected board, in order to create synergies, to get more power and to avoid duplications in the combat of NCDs. The Alliance has a logical fundamental basis as these diseases share the same risk factors, and that they are all neglected by the government and their patients need a lot of support.

1.2 The Board of the NCD Alliance

The NCD Alliance is lead by a board of 9 representatives, three from each member association elected by the general meeting. As both the NCD Alliance and two of its member associations are rather young it has focussed on capacity building of its organisation since its inauguration in 2010. The structure of the alliance has been developed. The focus has been on governance, membership recruitment, patient support /empowerment, lobbying and fundraising. Each of the associations has put in place a Recruitment Committee as well as a Patient Support Committee. These committees were trained with support from the Danish NCD Alliance as part of first phase of the project. A lobby committee was established under the NCD Alliance Board which equally received training. The lobby committee has had great success in building partnerships in the fight against NCDs especially in Parliament as well as the Ministry of Health (MoH).

1.3 Patient support and empowerment

The strength in Patient support and empowerment is embedded in the mixed membership of the Patient Support Committees. About half the members are specialized nurses with a broad knowledge about the diseases, their prevention and control and patients reaction to the diseases. The other half, are survivors or people living with the diseases. They have been involved in patient support organised by their local organisations (now members of the Cancer Society) or the Diabetes Association for years and they have received additional training during this project. These volunteers contribute knowledge and personal commitment to peer counselling and organisation of awareness campaigns throughout the country.

1.4 Awareness campaigns

The volunteers from the Cancer Society and the Diabetes Association and heart research foundation have gained broad experience from organising awareness campaigns throughout the country in collaboration with various partners including private sector (mainly pharmaceutical industry), the hospitals and local health providers, faith based organisations, secondary schools and other health NGOs. All the associations have members with experience from working with media. Organising a broad mass media campaign will though need support from professionals from media and a strengthened secretariat.

1.5 Organisational growth and capacity building

Both the board and the committees have a number of members with skills in organizing new branches. The Diabetes Association in particular has experience from running and starting up branches all over the country. To date, UDA has got 19 braches. The cancer Society also has a broad experience in starting up small organizations countrywide.

1.6 The NCD Secretariat

The NCD Secretariat is fully established, run by a CEO, 3 permanent staffs based at the Secretariat and up to 250 volunteers spread within the 10 UNCDA's districts. The secretariat is located in the suburbs of Kampala within the vicinity of the National Referral Hospital- Mulago at Plot 731 Mawanda Road, Kamwokya. Main activities include; Awareness campaigns implemented in 10 districts. Patient support; counseling at the head quarter and during outreaches alongside screening and health education, Membership recruitment basically integrated in campaigns and outreaches, advocacy and lobbying by working with members of parliament, Ministry of Health (MoH) and other stakeholders including the press, Fundraising and Continuous development of UNCDA's own capacity.

1.7 Rationale for the UNCDA Strategic plan

In February 2016, UNCDA was evaluated by external consultants. The evaluation report notes that UNCDA had become a strong voice on NCDs in Uganda, with a functional governing Board and strong three association executive committees. The Alliance had been strengthened by district branch structures and local NCD committees in 10 districts within Uganda. It had developed a strong capacity building program and as a result the Alliance membership has increased tremendously through massive recruitment campaigns and public awareness drives. The Alliance has as a result of the project enhanced partnerships with MoH, Uganda NCD Parliamentary Forum and Mulago and Nsambya Hospitals, and contributed to the National NCD STEPS survey. The report however notes several challenges key of which is the lack of strategic plan, which has on many occasions seen conflict in prioritising activities to meet organisational objectives. This has made monitoring and evaluation of project activity difficult.
This strategic plan is meant to address this challenge so as to provide a strong overall direction for the organisation in order to fulfil its mandate in relation to the Global NCD Framework and the national priorities related to the fight against NCDs.

Chapter 2 – The NCD Situation Analysis

2.1 Introduction

This chapter outlines NCD global and country status and highlights the new opportunities for progress against NCDs.
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Non-communicable diseases (NCDs)—mainly cardiovascular diseases, cancers, chronic respiratory diseases and diabetes—are the world's biggest killers. More than 36 million people die annually from NCDs (63% of global deaths), including more than 14 million people who die too young between the ages of 30 and 70. Low- and middle-income countries already bear 86% of the burden of these premature deaths, resulting in cumulative economic losses of US$7 trillion over the next 15 years and millions of people trapped in poverty. Most of these premature deaths from NCDs are largely preventable by enabling health systems to respond more effectively and equitably to the health-care needs of people with NCDs, and influencing public policies in sectors outside health that tackle shared risk factors—namely tobacco use, unhealthy diet, physical inactivity, and the harmful use of alcohol.

2.2 The NCD global and country status

NCDs are currently responsible for 35 percent of all deaths in low and middle-income countries, and this figure is predicted to rise in the near future. The World Health Organization projects that the burden of disease due to NCDs will increase rapidly in the years ahead. From a projected total of 58 million deaths from all causes in 2005, it is estimated that non-communicable diseases will account for 35 million deaths, which is double the number of deaths from all communicable diseases (including HIV/AIDS, tuberculosis and malaria), maternal and perinatal conditions and nutritional deficiencies combined. This epidemiological transition in global health from infectious diseases to NCDs, is posing not only a threat to the health of those affected, but also places an enormous burden on the health systems of nations, particularly those of the least developed countries as they must now address a double burden of acute and chronic diseases amidst scarce resources. World Economic Forum has predicted that the loss of economic output in LMICs due to NCDs will be 500 billion US$ per year until 2025 if nothing is done. The increasing prevalence of NCD risk factors in the developing countries, particularly Sub-Saharan Africa (SSA), becomes a real threat to economic progress, adversely impacting on all the previous gains made in combating HIV, malaria, tuberculosis and other infectious diseases.

In Uganda, where acute, infectious, communicable diseases still contribute the major (75%) disease burden; with malaria, acute respiratory infections, and HIV/AIDS among the top 10 causes of illness and deaths, the burden of NCDs is markedly increasing posing a threat of double epidemics of communicable and non-communicable diseases. 50,000 individuals were affected by diabetes in the year 2003, and a 10-fold increase is projected in the cases of diabetes by 2025 if no interventions are initiated. Estimates suggest that as many as 8% of people living in Kampala have type 2 diabetes.

According to UBOS (2009), Non-Communicable Diseases (NCDs) and their risk factors are now an emerging problem in Uganda. The increase in NCDs is attributed to multiple factors such as adoption of unhealthy lifestyles, increasing ageing population and metabolic side effects resulting from lifelong antiretroviral treatment. The survey results (in Table 1) show that, overall, 91 percent of the population revealed that, they are currently not suffering from any NCDs. This is probably due to the fact that diseases of that nature usually develop over relatively long periods; at first without causing symptoms; but after disease manifestations develop, there may be a protracted period of impaired health. Differentials by respondent characteristics show that high blood pressure and heart disease are more common among females (5%) than males (2 and 3 percent) respectively. Findings further reveal that all the NCDs, increase with age.

Table 1: Distribution of population aged 10 years and above with Non-Communicable Diseases by Respondent Characteristics (%)

	Non-Communicable Diseases			
Respondent Characteristics	**Diabetes**	**High blood pressure**	**Heart disease**	**None**
Residence				
Urban	1.0	4.1	2.3	92.7
Rural	0.7	3.9	4.3	91.1
Sex				
Male	0.8	2.4	2.6	94.3
Female	0.8	5.3	5.3	88.7
Age category				
10-14	0.0	0.1	0.5	99.4
15-19	0.1	0.5	1.4	98.0
20-24	0.1	0.8	3.8	95.3
25-29	0.5	2.6	4.8	92.1
30-34	0.7	4.2	5.3	89.8
35-39	1.1	5.2	6.1	87.6
40-44	1.6	8.9	7.5	81.9
45+	2.7	13.8	8.4	75.2
Uganda	0.8	3.9	4.0	91.4

Source: UBOS, 2009 Uganda National Household Survey Report 2009/2010

In spite of the clear trends and this new evidence about the NCD epidemic in Uganda, NCDs have had scant attention from the government. The government is yet to make a national survey to document the full nature of NCDs in Uganda, and there no strategy and an action plan for NCDs. The first population survey using internationally standardized protocols to report the prevalence of risk factors was done in Kasese district by the NCD Alliance. It has been a milestone in the documentation of the problems and an invaluable tool for the lobbying and advocacy to make the government prioritize the area. The aim is to persuade the government to conduct a national survey and based on that, a national strategy and action plan with sufficient funding on the national budget.

3 – The new opportunities for progress against NCDs

3.1 Introduction

This chapter aligns this strategic plan to the existing international, regional and national policies and legal frameworks for UNCD interventions. NCDs are now widely recognized as a challenge for sustainable human development, particularly impacting upon low- and middle-income countries (LMICs) and vulnerable communities. A series of documents and reports have firmly placed NCDs as a priority for human development – including the 2011 UN Political Declaration on NCDs, the Global NCD Action Plan 2013-2020, and of most recent, the Sustainable Development Goals (SDGs).

3.2 The UN Political Declaration on the Prevention and Control of NCDs

In September 2011, Heads of State and Government met at the United Nations in New York for the United Nations High-Level Meeting on NCDs. This meeting was only the second time in history that the UN General Assembly has met on a health-related issue, the first being the successful UN Special Session on HIV/AIDS in 2001. As a result of the 2011 NCD Summit, Member States adopted the UN Political Declaration on the Prevention and Control of NCDs, shaping the global political agenda for NCDs.
The most significant outcome of the High-level Meeting was the Political Declaration (PD) on the Prevention and Control of NCDs. The PD was negotiated by all 193 UN Member States and adopted unanimously by the UN General Assembly. Although not legally binding, a Political Declaration is one of the most powerful tools within the UN for international cooperation and action.

This PD includes a series of commitments on NCDs, ranging from prevention, treatment, research, surveillance and monitoring. It positions NCDs as priority health and development issue, stating that NCDs are "*one of the major challenges in the twenty-first century*," pose *"a threat to the economies of many Member States," and "undermines social and economic development."*

3.3 The Global Action Plan for the Prevention and Control of NCDs 2013-2020

The Global Action Plan for the Prevention and Control of NCDs 2013-2020 was developed as a commitment by Heads of State and Government in the UN Political Declaration on NCDs to establish and strengthen, by 2013, multi-sectoral national policies and plans for the prevention and control of NCDs, and consider the development of national targets and indicators based on national situations. The World Health Assembly endorsed the WHO Global Action Plan for the Prevention and Control of NCDs 2013-2020 in May 2013. This Action Plan provides Member States, international partners and WHO with a road map and menu of policy options which, when implemented collectively between 2013 and 2020, are expected to contribute to progress on 9 global NCD targets to be attained in 2025, including a 25% relative reduction in premature mortality from NCDs by 2025.

The Global Action Plan whose vision is '*a world free of the avoidable burden of noncommunicable diseases*' .and whose goal is '*to reduce the preventable and avoidable burden of morbidity, mortality and disability due to non-communicable diseases by means of multi-sectoral collaboration and cooperation at national, regional and global levels, so that populations reach the highest attainable standards of health and productivity at every age and those diseases are no longer a barrier to well-being or socioeconomic development*.

3.3.1 Overarching principles of the Global Action Plan

- Life-course approach
- Empowerment of people and communities
- Evidence-based strategies
- Universal health coverage
- Management of real, perceived or potential conflicts of interest
- Human rights approach
- Equity-based approach
- National action and international cooperation and solidarity
- Multisectoral action

3.4 New global health measures passed by the 65th World Health Assembly

The Sixty-fifth World Health Assembly adopted 21 resolutions and three decisions on a broad range of health issues (Source, WHO, 2012). Some of the resolutions and decisions were on Noncommunicable diseases (NCDs) as below:

- Delegates approved the development of a global monitoring framework for the prevention and control of NCDs, including indicators and a set of global targets. Member States agreed to adopt a global target of a 25% reduction in premature mortality from non-communicable diseases such as cardiovascular disease, cancer, diabetes and chronic respiratory diseases by 2025.
- Another resolution focused on strengthening NCD policies to promote active ageing. The resolution urged Member States to encourage the active participation of older people in society, increase healthy ageing and promote the highest standard of health and well-being for older persons by addressing their needs.
- The building of partnerships at national and global levels are essential components of multisectoral action against NCDs. Member States discussed ways to prevent NCDs through action involving sectors other than health, to prevent premature deaths and to reduce exposure to risk factors for NCDs, mainly tobacco use, harmful use of alcohol, unhealthy diet, and physical inactivity.

3.5 The Sharjah Declaration on NCDs

The Sharjah Declaration (2015) on NCDs recognizes that Civil society is at the centre of the response to reduce the global NCD burden . They play important roles in advocacy, accountability, knowledge exchange and service delivery. The signatories who consisted of national and regional NCD alliances from across the world came together support for the 2030 Agenda, and committed to doing to doing their part to accelerate action and increase accountability to prevent and reduce deaths, disability, stigma, and discrimination caused by NCDs. Specifically the resolution urges governments and policy makers at local, national, regional levels to:

- Encourage high-level government authorities across all sectors to champion NCD prevention and control and integrate NCDs into national development plans and frameworks;
- Accelerate the implementation of agreed plans, political commitments, targets and goals and promote evidence-based, affordable and cost-effective, population-wide interventions;
- Allocate adequate, sustained human and financial resources to NCD prevention and control;
- Protect public health policies from interference by vested interests, particularly from the alcohol, tobacco and food and beverage industries, and from legal challenges under international trade and investment agreements;
- Protect the fundamental human right to health and create environments that empower individuals, families and communities to make healthy choices and lead healthy lives;

- Ensure all people living with NCDs have access to affordable, quality NCD services, medicines and technologies, across the entire continuum of care, including palliative care;
- Engage civil society6 and people living with or affected by NCDs in policy development, implementation, coordination mechanisms and monitoring, and provide capacity-building to NCD alliances and networks, particularly in low and middle income countries;
- Establish robust and transparent monitoring and evaluation systems in order to regularly report on NCD policy progress and health outcomes at national, regional and global level.

3.6 The Sustainable Development Goals (SDGs)

Recognizing the interdependence of health and development, the Sustainable Development Goals (SDGs) provide an ambitious, comprehensive plan of action for people, planet and prosperity and for ending the injustices that underpin poor health and development outcomes. SDG 3 aspires to ensure health and well-being for all, including a bold commitment to end the epidemics of AIDS, tuberculosis, malaria and other communicable diseases by 2030. It also aims to achieve universal health coverage, and provide access to safe and effective medicines and vaccines for all. SDGs also recognize that Non-communicable diseases (NCDs) impose a large burden on human health worldwide.

"Goal 3 Ensure healthy lives and promote well-being for all at all ages" with the indicator: "3.4 by 2030 reduce by one-third premature mortality from NCDs through prevention and treatment, and promote mental health and wellbeing". With the endorsement of the Sustainable Development Goals and inclusion of NCDs in these goals there is hope that there will be increased attention by global, regional and national actors to support the fight against NCDs.

3.7 The Uganda National NCD framework

3.7.1 The Health Sector Strategic Plan 111 2010/11-2014/15

The HSSP 111 recognises that Non-communicable diseases (NCDs) and their risk factors are increasing in Uganda as in other low income countries. During HSSP II, the MoH established a Programme for the Prevention and Control of Non-Communicable Diseases in 2006. A major challenge of controlling NCDs in the country is lack of local data, inadequate capacity of the health system to address chronic conditions and the high cost of medicines/supplies for treatment. The objective is *to reduce the morbidity and mortality attributable to Non-communicable diseases through appropriate health interventions targeting the entire population of Uganda.*

3.7.2 Strategies and interventions

Strengthen the policy environment for the control and prevention of NCDs.

- Formulate the national policy and medium term strategic plan for the NCD (end of 2011).
- Develop standards and guidelines for treatment of NCDs.
- Disseminate the national policy and strategic plan to all stakeholders.

Increase and sustain people's awareness about NCDs.

- Develop and implement an information and advocacy strategy on the public health importance of NCDs.

- Create community awareness on prevention and control of NCDs using a multisectoral approach.

Strengthen the capacity of health workers to manage NCDs effectively.

- Train health workers at all HC IVs and hospitals to correctly manage NCDs so as to prevent avoidable complications.
- Coordinate the different players in NCD control to ensure a comprehensive approach to NCD prevention and control.
- Carry out to determine the burden of disease and main risk factors for NCDs in Uganda.

3.7.3 Indicators with targets

- The burden of disease and main risk factors for non-communicable disease condition in Uganda established by 2012.
- Community awareness on NCDs/conditions increased to 80%.
- All districts implementing social mobilization for the prevention and control of NCD/conditions by 2015.
- NCD prevention and management integrated in the functions of all HC IVs.
- Cervical cancer screening services and activities using VIA and Cryotherapy established in all the Regional Hospitals by 2015.
- The proportion of HC IV with functional NCD clinics increased to 70% by end 2015.
- A comprehensive and integrated work-plan for NCD prevention, control and surveillance developed by 2012.
- A National NCD policy developed by 2012.
- Standards and guidelines for NCD prevention and control set by 2012.

3.7.4 The Uganda National Minimum Health Care Package (UNMHCP)

MoH has designed the Uganda National Minimum Health Care Package (UNMHCP) as a main vehicle for delivery of health services. The UNMHCP highlights prevention, management and control of non-communicable disease as one of its core objectives. Currently, the MoH has only 50% of the positions filled making it impossible to fulfill UNMHCP core objectives making it ill-prepared to handle the emerging epidemic of NCDs. The MoH has emphasized primary health care, focusing on disease prevention as the main strategy for addressing NCDs. It is anticipated that when the national NCD policy is in place, more resources will be made available to support NCD initiatives.

Chapter 4 – Strategic Direction

4.1 Introduction

In this Chapter, the vision, mission and strategic objectives of the NCD Strategic Plan are presented.

4.2 Vision

The vision of this strategic plan is '***A society free from preventable NCDs***'.

4.3 Mission

The UNCDA mission is to '***lead the CSO response against NCDs by placing people's health at the centre of the national agenda through advocacy, empowering and inspiring the population***'.

4.5 Overall Goal

The overall goal of this Strategic plan is to '***steer the civil society response in prevention and control of Non-communicable Diseases in Uganda in order to achieve the global target of 25% relative reduction by the year 2025***'.

4.6 Strategic Objectives

This strategic plan contains 4 strategic objectives as outlined below:

Objective 1: To advocate development and implementation of the NCD policy and practice in Uganda

Objective 2: To create increased understanding and awareness about NCDs through an NCD communication strategy

Objective 3: To provide comprehensive Patient support package for people living with NCDs

Objective 4 Develop and implement an organizational development plan for UNCDA as a lead Non-communicable Diseases civil society organization.

4.7 Detailed objectives and outputs

Objective 1: To advocate development and implementation of the NCD policy and practice in Uganda

The UNCDA is to scale up the national advocacy efforts to generate increased action on NCDs by the government and other stakeholders so as to shift the focus from national commitment to implementation. Already the GoU has made commitments towards this as stipulated by the HSSP 111 indicators below:

- A comprehensive and integrated work-plan for NCD prevention, control and surveillance developed by 2012.

- A National NCD policy developed by 2012.
- Standards and guidelines for NCD prevention and control set by 2012.

Already, these targeted dates have been overtaken by events and hence UNCDA will take lead in mobilizing other stakeholders to coordinate with MoH to fulfill these targets. Under this objective, UNCDA will work with other civil society organizations to promote the adoption and implementation of a national multisectoral NCD plan that has resources assigned to it and is incorporated into the long-term national planning priorities. This process will be in line with the Global NCD Framework such the UN General Assembly and the World Health Assembly which agreed that change has to be delivered at the national level through NCD Action plans. The process will also be used to generating multisectoral support and consensus around policies and plans; and producing and promoting case studies and recommendations.

Key activities under objective 1:

- Take lead in convening and facilitating coordination and collaboration processes among the multi-sectoral stakeholders in government, civil society and the private sector
- Establish and support expert working groups to research and develop policy recommendations and good practice guidelines.
- Participate in relevant national and regional meetings
- Participate through government consultations and working groups, in the development and implementation of a national NCD plan and disease specific plans for the 3 NCDs which is in line with the Global NCD commitments
- Advocate for inclusion of evidence-based policies and programmes across different sectors;
- Collect and disseminate data, evidence and policy research on the 3 NCDs
- Track progress by disseminating CSO NCD Status reports to highlight government commitment to implementation of the NCD policy.

Objective 2: *To create increased understanding and awareness about NCDs through an NCD communication strategy*

In order to achieve a fundamental change in the long-term, in how NCDs are understood by individuals and communities, and how NCDs are integrated into government policy-making, about the scale of the NCD epidemic, the inequities reflected in the burden of the disease, the human suffering caused by the lack of adequate access to treatment, and the causes behind the modifiable risk factors. Raising the voice and the rights of people living with NCDs will be critical to putting a human face to the problem. Popular demand will provide leverage to support the political and technical approaches to changing policy and resource allocation while popular understanding will sustain the changes.

In order to meet this objective, UNCDA will develop and implement a communication strategy which will focus on raising awareness and promoting solutions for NCDs country-wide. Through this strategy, UNCDA will build demand for action on NCDs at national and lower levels. The communication strategy will have three main components that will build the demand for action. The first, is promoting wider understanding of the scale of the epidemic and the inequities it imposes on communities by highlighting the human stories of people affected by NCDs to be more widely understood by the public. The voices of people living with NCDs – patients, survivors, carers, and those who have been bereaved – provide a powerful pressure in any

campaign for change and important lessons learnt and experience sharing. The second is about issues surrounding access to diagnosis and treatment while the last will promote wider understanding of the modifiable risk factors behind the rise of the NCD epidemic.

Key activities under objective 2:

- Develop and implement the UNCDA communication strategy
- Develop and distribute IEC materials on NCDs based on researched messages
- Conduct targeted community-based trainings and NCD outreaches to highlight NCD risk factors
- Conduct grassroot research into personal stories of people affected by NCDs and offer access to media outlets of personal stories
- Develop and conduct media campaigns on various national and regional platforms including open days, press releases and public dialogues to promote compelling stories to support the delivery of key NCD policies and programs
- Publish a quarterly/bi-annual NCD Newsletter, telling the story (patient perspectives) highlighting achievements, challenges and sharing best-practices in the NCD response
- Develop a website and a social media strategy via Facebook, Twitter or Whatsapp.

Objective 3: To provide comprehensive Patient support package for people living with NCDs

NCDs affect all groups in society though there is a distinct social disadvantage for the poor sections of society whom as patients, face more fatal problems owing to the poor health system in Uganda. It is characterised by treatment facilities which are lacking; inadequate health workers, poor accessibility to health units and often long distances to access them; compounded by high costs for transportation. Drugs are often out of stock and must therefore be purchased on the private market causing extra burden for the patients. There are no regular health checks and the monitoring is inadequate. Health literacy is low and awareness about healthy foods, importance of physical activity and healthy living is very limited among the growing number of patients. The patients are left in a vacuum with no support in place. There is a high rate of ignorance among the population about NCDs resulting in stigmatization of the patients. Patient support is a completely neglected area.

Under previous projects, patient support has been a key intervention for UNCDA. It was supposed to be a joint activity, but it turned out during the project period that it was an activity better fitted to the member associations. These associations have therefore been offering specific group support to disease specific groups of patients. During a strategic review of division of roles and responsibilities between UNCDA and the associations it was decided to implement patient support through associations and in the branches.

Key activities under objective 3:

1. Provide free screening for the 3 NCDs
2. Set up counseling and referral services for NCD patients
3. Lobby for improved access to essential medicines and technologies for the 3 main NCDs
4. Conduct continuous trainings for health workers, patients and volunteers on treatment and care for NCD patients

Objective 4 Develop and implement an organizational development plan for UNCDA as a lead Non-communicable Diseases civil society organization

According to findings contained in the UNCDA evaluation report by M & E external Consultants[1], UNCDA had become a strong voice on NCDs in Uganda, with a functional governing Board and 3 strong member associations and district branch structures and local NCD committees in 10 districts. The report also notes that UNCDA had a strong capacity building program which contributed to increased membership and public awareness on NCDs. UNCDA also has developed partnerships with external stakeholders such as MoH, Uganda NCD Parliamentary Forum and Mulago and Nsambya Hospitals. The report also highlights challenges such as lack of a strategic plan; lack of a clear communication plan; inadequate internal controls and procedures; inadequate data management systems for monitoring and evaluation. This resulted into to poor oversight by the board. In 2015, the Board recruited a new CEO mandated to revamp the organisational structures, processes and systems. In order to deliver the programs outlined in this strategic pan, the UNCDA to put in place an organizational strategy that will enable it increase its own capacity and effectiveness, supported by organizational planning, monitoring and evaluation.

Key activities under objective 4:

- Set up internal organizational and financial systems, policies and structures for UNCDA
- Implement the Human Resource Management policy including staffing structure, recruitment, training and deployment of staff and volunteers
- Develop membership criteria including recruitment, rules for participation and contribution to the Alliance
- Set up functional UNCDA branches in 11 districts
- Develop and implement a resource mobilization strategy to sustain all core activities of UNCDA and partners
- Support establishment of and participate in multisectoral NCD coordination mechanisms at national and district levels
- Develop detailed work plans and budgets income and expenditure forecasts.
- Work plans including objectives, activities and budgets for all areas of activity.
- Monitoring and evaluation plans.

4.8 Framework of Strategic Outcomes

Overall goal: 'To steer the civil society response in prevention and control of Non-communicable Diseases in Uganda in order to achieve the global target of 25% relative reduction by the year 2025'**.**

Impact indicator:

Objective	Outcomes
Objective 1	**To advocate development and implementation of the NCD policy and practice in Uganda**

[1] The evaluation conducted in in February 2015 was done by external consultants, namely Bruce Kisitu and Nicholas Mugabi.

Outcome 1.1 A multi-sectoral NCD plan and policies costed and integrated in all sectors **Outcome 1.2** Civil society capable to engage in policy-making and planning process.	
Outputs	• Multi-sectoral coordination processes for government, civil society and the private sector convened • Expert working groups to research and develop policy recommendations and good practice guidelines formed • Participation of UNCDA in national and regional meetings • Full participation in the development and implementation of a national NCD plan • Data evidence and policy research on NCDs collected and disseminated • CSO NCD Status reports to highlight government commitment to implementation of the NCD policy disseminated.
Objective 2: To create increased understanding and awareness about NCDs through an NCD communication strategy Outcome 2.1: Increased media coverage of NCD epidemic and key campaign demands. Outcome 2.2: Increased public recognition of the issues facing people living with NCDs, their causes, and need for solutions.	
Outputs	• A comprehensive UNCDA communication strategy developed and mainstreamed into UNCDA workplans • IEC materials (posters, bill-boards, leaflets, banners) on NCDs based on researched messages developed and distributed in xx districts • xx targeted community-based trainings and NCD outreaches to highlight NCD risk factors conducted • Media-friendly reports, feature stories, press releases and opinion columns on monthly basis, appear in leading dailies (Monitor and New Vision) and in vernacular papers on the NCD epidemic • A quarterly/bi-annual NCD Newsletter, telling the story (patient perspectives) highlighting achievements, challenges and sharing best-practices in the NCD response published • Active social network sites and pages (via Facebook, Twitter or Whatsapp) providing updates and links to campaign issues and activities within Uganda and the global level. • .People living with NCDs recruited by partners for participation in national advocacy campaigns • People living with NCDs requested by media and other contacts for inclusion in articles and events.

Objective 3: To provide comprehensive Patient support package for people living with NCDs	
	•
Objective 4 Develop and implement the UNCDA organizational development plan as a lead Non-communicable Diseases civil society organization	
• **Outcome 4.1:** UNCDA management implements 80% of set out obligations and targets as approved by the board • **Outcome 4.2:** Financial stability attained by raising xx% of budget from donors and xx% from local partners.	
Outputs	• Internal organizational and financial systems, policies and structures for UNCDA set up and approved by the Board • Human Resource Management policy including staffing structure established • Membership criteria developed • Fully functional UNCDA branches in xx districts • Resource mobilization strategy to sustain all core activities of UNCDA and partners • A multisectoral NCD coordination mechanisms at national and district levels established

Chapter 5 – Implementation Framework

Chapter 6 – Partnerships and coordination framework

6.1 Introduction

One of the resolutions adopted by The Sixty-fifth World Health Assembly was in recognition that building of partnerships at national and global levels are essential components of multi-sectoral action against NCDs. The resolution points to ways of prevention of NCDs through action involving sectors other than health, to prevent premature deaths and to reduce exposure to risk factors for NCDs, mainly tobacco use, harmful use of alcohol, unhealthy diet, and physical inactivity. This chapter presents the key stakeholders and stipulates the roles the play in implementation of the UNCDA Strategic Plan. It also describes the implementation and coordination frameworks for this plan.

The partnership proposed in this strategic plan is a Professional partnership which builds on elements from previous frameworks built under auspices of both the Danish and the Ugandan partnerships which gave rise to the UNCD Alliance. The framework for this partnership was 5- 6 years (starting 2010) after which the Ugandan partners were supposed to have developed their organisation to be less dependent on their Danish Partner. UNCDA was thereafter expected work with the local partners and other donors identified during the previous phase. The table below summarizes the roles and responsibilities of UNCD and the associations under this partnership.

Roles and responsibilities of UNCDA and Associations

Activities	UNCDA	Associations/Branches
Patient support	Supervisory	Implementation
Membership recruitment	Supervisory	Implementation
Awareness campaign	Coordination/strategic role	Implementation
Advocacy/lobbying	Implementation/Strategic role	Technical/Supportive
Fundraising	Core role	Technical role
Research/surveys	Core role	Technical role
Capacity development	Core role	Technical role

The character of the partnership under this strategic plan

The partnerships in this strategic plan was initially aimed at developing the capacity of UNCDA and its member associations through twinning activities and to work together in the global and national fight for awareness and political prioritisation of NCDs. The time horizon for the initial partnership activities was about 7 years (Starting 2010) after which the Ugandan partner was supposed to have developed a sustainable organisation. By the end of 2017, UNCDA is supposed to have developed into a solid organisation which works independent of DNCDA. It is also envisaged that DNCDA will be one of several partners and UNCDA will work with a number of partners and donors relevant for their strategy.

Partnering as a strategic tool

The composition of the member groups and volunteers is an important basis for the success of UNCDA. Volunteers at all levels are represented by both highly skilled experts within NCDs, patients, relatives and people concerned about NCDs. UNCDA sees itself as a **patient organisation** fighting to secure the right

to health, treatment and patient support. Prevention and secondary prevention is an important issue in relation to this.

Building alliances is part of the strategy. First of all UNCDA is working closely together with Health facilities at all levels, the Ministry of Health NCD desk, local health authorities and with the NCD Parliamentary Forum and its individual members. From the beginning doctors and nurses from the major hospitals were instrumental in starting up the member associations and in recruiting patients from their wards to work as volunteers alongside the professionals. Members of UNCD Parliamentary Forum supported the process of starting up branches first of all by helping with prioritisation of districts to roll out the first 10 branches. Secondly by helping to identify core volunteers to take the lead of starting up the branches. They also contributed to getting publicity to start the process by participate in the opening events. UNCDA benefited from this partnering by bringing on board skilled people with ability to network and organise the branches in the initial phase. The local health facilities were also important stakeholders owing to the skilled professionals to back up the activities in the branches and also in relation to engagement of patients in the work and in relation. The result is that the branches are run by patients, health professionals and local leaders.

Members of UNCDA Parliamentary Forum have also been important for advocacy at a central level. UNCDA developed a number of platforms for strengthening this collaboration. Firstly it offers specialist knowledge to the Members of Parliament (MoPs), secondly it gathers evidence through research (Kasese STEPS and the bench mark survey for implementation of Global Action Plan) and finally it offers a platform for debate and dissemination of knowledge at the annual multi stakeholder meetings. These meetings are backed with press campaigns which increase the profile of the issue and public support for political action. These meetings have attracted an increasing number of stakeholders. In 2013, 12 MoPs participated, and in 2014, 28 MoPs participated. The meeting in 2014 also attracted larger group representatives from other ministries and other CSOs who presented papers about how they could contribute to the prevention of NCDs. In total 106 participated against 70 in 2013 and it was backed by a comprehensive press coverage.

Partnering with MoH and WHO Uganda has been essential. Their resources are very few. By partnering about the activities we create synergy. UNCDA make MoH stronger by giving it a platform for advocacy and we add legitimacy to our activities by making them in collaboration with MoH and WHO Uganda. MoH are co- hosting the annual stakeholder meetings, and MoH partner with us about the national awareness campaigns. Opening the 10 branches is the beginning of organising a national movement of patients, relatives and professionals fighting for the right to health including diagnostics, treatment, control and prevention. The means for the branches mirrors the central organisation by organising members from all the member associations and by organising capacity development, awareness campaigns, membership recruitment and advocacy at local level.

The awareness campaigns which have been designed so they could be undertaken by the branches have been important instruments in both gathering local stakeholders in the efforts and in advocating to the stakeholders. The campaigns consist of a screening event combined with educational activities where the branch together with local health professionals and local leaders talk about prevention and control of NCDs. This is being backed by press campaigns and a cascade of information activities in local clinics. Local leaders have through their participation in these campaigns committed them to the political cause of increasing the response to NCDs and they have learned about the severity of the diseases impact on people and communities in the process. This helps UNCDA to make allies in the call on government to allocate resources to NCDs.
Collaboration in general is very important. More and more groups focus their work on NCDs. UNCDA sees them self as a broad platform and support all these initiatives and support them by inviting them to partner with them.

6.2 Roles of Key stakeholders

The Uganda Initiative for Integrated Management of Non-Communicable Diseases (UINCD)
In 2013 a group of doctors, researchers and government officials representing Uganda Ministry of Health, Makerere University College of Health Sciences, and Mulago National Referral Hospital together with colleagues from Yale School of Medicine formed The Uganda Initiative for Integrated Management of Non-Communicable Diseases (UINCD). Their work was catalyzed in 2013 by an Innovation Award and administrative support from the Yale Global Health Leadership Institute. UINCD was officially registered as a limited liability corporation in Uganda on February 25, 2014. UNCDA collaborate closely with this initiative. The main focus is to find better ways to address chronic diseases through an integrated approach to prevention, disease management, health services and healthcare worker training. The focus is to develop innovative models of training healthcare workers and caring for patients and communities- all focused on NCD integration.

The medical colleges in Uganda have received funding from various sources such as the US National Institutes of Health to support the training of more professionals in the NCD specialties. The heart specialty received the MEPI-CVD award which has supported 1 Ph D student and trained 3 fellowship students. It is currently training 2 PhDs students and 20 students in Masters of Medicine in the specialized management of heart disease.

The undergraduate medical students at Makerere College of Health Sciences have formed a NCD group and they organize periodic public activities where specialists are invited to talk about the diseases followed by screening for risk factors. The NCD study group was formed in the School of Public Health at Makerere College of Health Sciences which is assisting with the epidemiological survey and compiling of data on NCDs in the country. The NCD Alliance is merging up with these groups to form a strong concerted effort. **Ashipti Denmark**, a group of medical students under IMCC from Aarhus has been granted from DUFs Project Fund to starting up a NCD pilot project together with medical students in Uganda. This collaboration has been supported by UNCDA and DNCDA and collaboration is being planned.

Uganda Diabetes Association has via MoH received a considerable support from World Diabetes Foundation for development of its outreach through out Uganda and as a result it managed to reach 15.000 in 2014. An indept cleaning of the membership register in 2015 reveiled that only 8600 of these had been able to pay the subscription fee. The official number of members are therefore 8600 now.

Uganda Cancer Society is in its final negotiations with American Cancer Society and will most likely receive core funding including office at the cancer institute in the near future.

Chapter 7 Monitoring and Evaluation Framework

7.1 Introduction

Chapter 8 Costing and Financial Framework

8.1 Introduction

This chapter presents the costing and financial framework of the UNCDA Strategic Plan. It outlines the funding sources, costed interventions as well as conditions for successful implementation.

Annex 1 References

NCD Alliance, Friends of Cancer Patients, 2015, Sharjah Declaration on NCDs Civil Society United Towards 2030, Global NCD Alliance Forum, Sharjah UAE

The NCD Alliance, 2012, NCD Alliance Strategic Plan 2012 -2015, Putting NCDs on the Global Agenda

UBOS, 2009, Uganda National Household Survey Findings 2009/2010

WHO, 2012, New global health measures passed by the 65th World Health Assembly, Geneva.

WHO, 2013, Global Action Plan for the Prevention and Control of NCDs, 2013 -2020, WHO, Geneva.

Annex 2 Stakeholder analysis

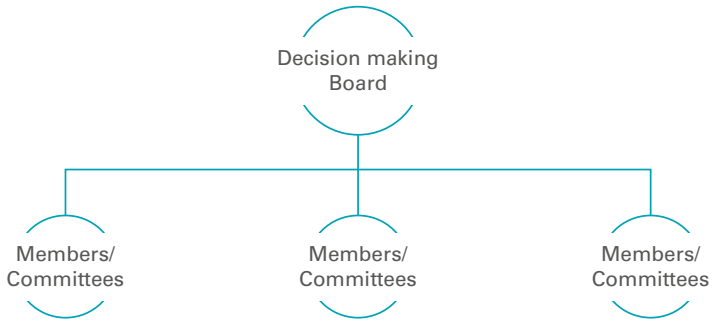
Alliance Organisational designs

1. Horizontal structure

All member organisations are involved in decision-making. This model works when the number of members is limited and each desire equal voice in decision-making. They might form sub-committees or groups to address specific aspects of governance or action such as fundraising or campaigns.

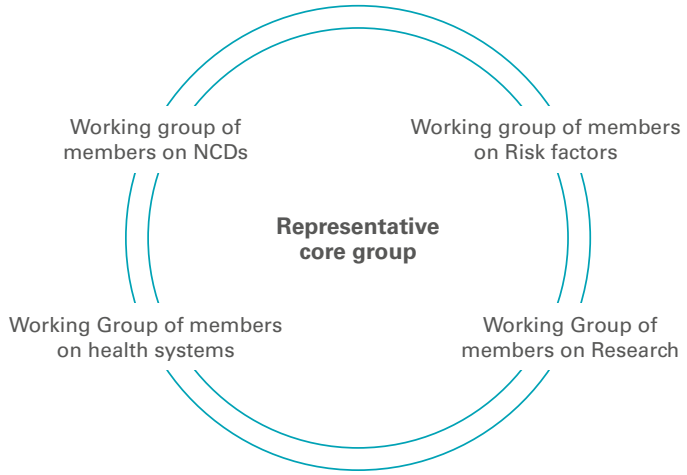
2. Vertical structure

Has an apex decision making body, nominated or elected by the general body of broader membership. The apex body may be self-nominated (e.g. comprising of founding/powerful members) or representative of the broader network. In some instances, the executive board is permanent whereas in other cases the board serves fixed terms. Networks usually employ this model when they have many members and a smaller group to take key decisions while providing equal opportunities to all.

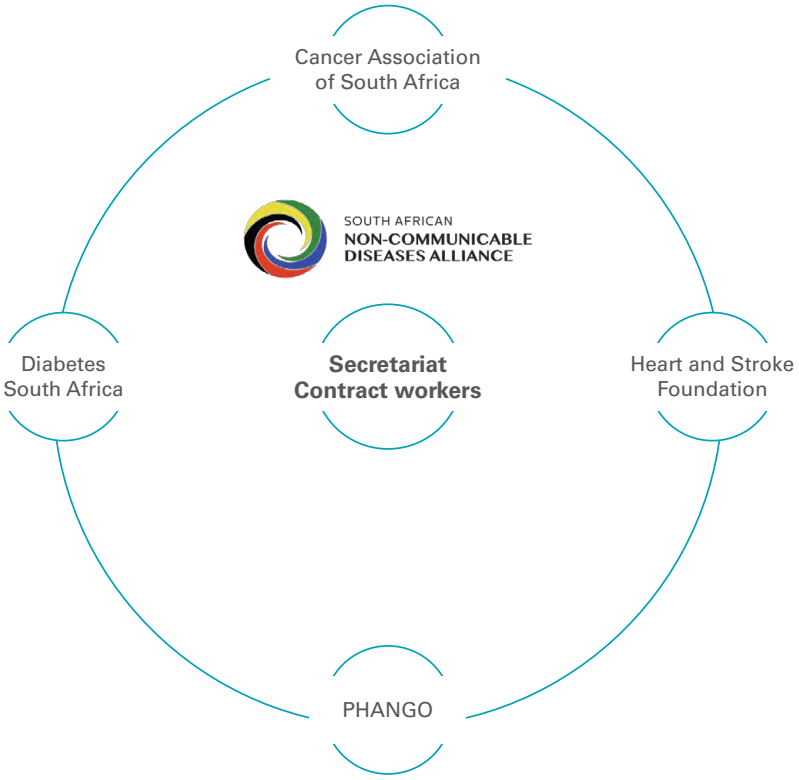


3. Layered horizontal structure

Alliances that prefer a horizontal structure but need to address a variety of issues, often constitute thematic working groups that address specific issues. A representative from each working group forms the core group that addresses any cross cutting and governance matters.



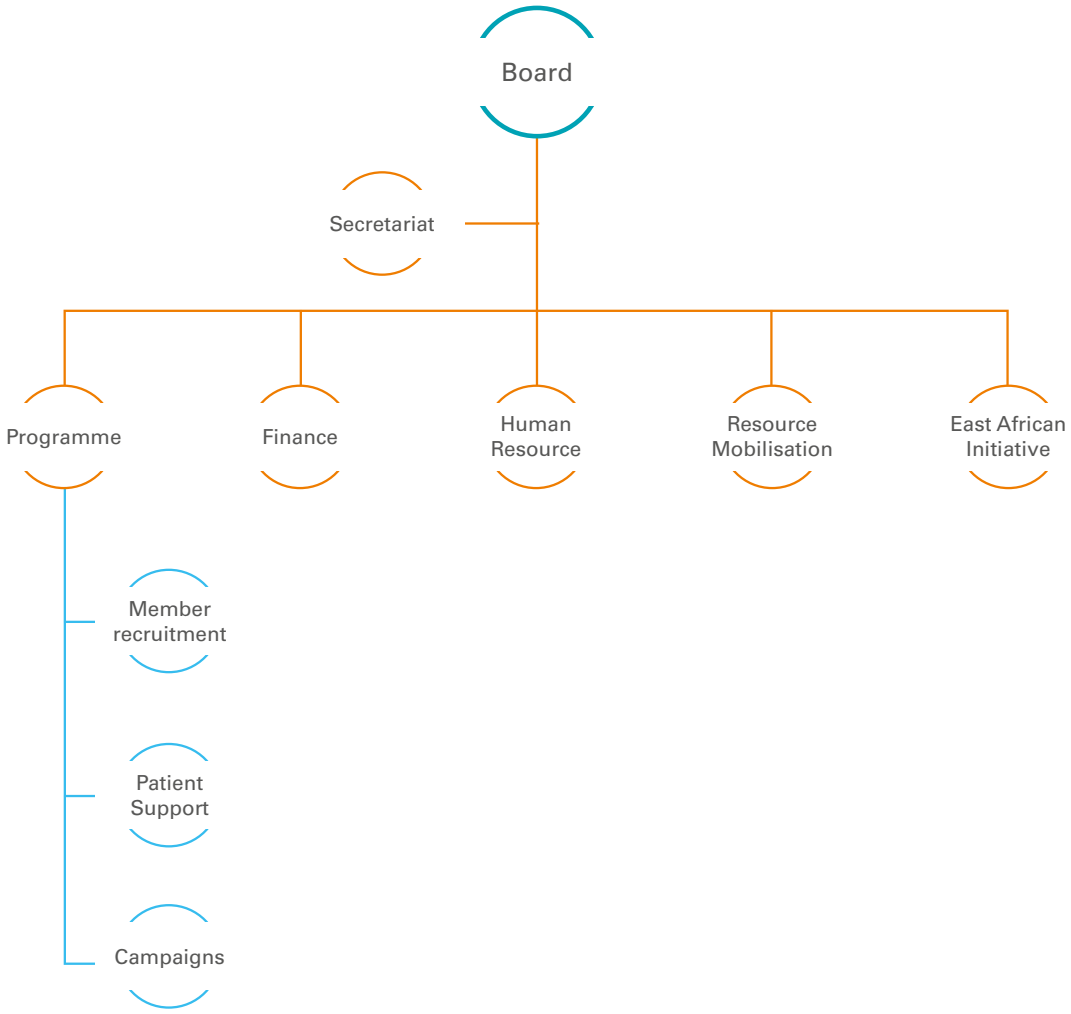
Independent Secretariat
South African Noncommunicable Diseases Alliance



Terms of reference for the secretariat

1	Encourage and foster an inclusive atmosphere and support members to be actively involved in implementing the strategic priorities, targets and activities as decided by the governing body
2	Plan, arrange and organise meetings of the Governing body and assist with development of long term and annual plans, their execution and reporting
3	Work with members in working groups/committees in meeting their specific mandates
4	Identify potential projects and funding opportunities for the alliance in partnership with member organisations
5	On behalf of the governing body, track the execution of projects and project accountability
6	Develop and manage the overall administration of the alliance, ensuring accurate documentation, good record keeping and good quality control
7	Provide support and responsibility for all financial matters, including the preparation of the annual budget, fiscal planning, book-keeping and accounting
8	Understand, contribute to, foster, develop and promote the brand of the alliance along with alliance members
9	On request from the governing body, represent the alliance and develop partnerships regionally and internationally
10	Plan and execute alliance led conferences and workshops when required
11	Respond to annual performance reviews to facilitate growth and development
12	Any other mutually agreed upon responsibility that the secretariat may be required to undertake

Working Committees of Uganda NCD Alliance



Terms of Reference of Working Groups of US Round Table

NCD Roundtable Working Groups
The Working Groups will work to create and provide tangible work products that can be used to support the goals outlined above. The Working Groups will consist of volunteer members of the NCDRT. Each Working Group will select a Leadership group to direct the efforts of the entire Working Group. Each Working Group should meet at least once a month and report back to the NCDRT at the monthly meeting. All NCDRT members will be required to commit time and expertise to at least one activity or Working Group.

Working Group 1: Communications and Engagement

The Communications and Engagement Working Group will track U.S. engagement in NCDs and provide the background research and building blocks to reinforce our policy and advocacy work. This includes the following priorities:

1. Compile a database of NCD-related global health programs and activities (existing and planned) supported by USG or US-based organizations including foundations, non-profits and the private sector
    - Track NCD investments made by USG and organizations, including global health budget allocations and expenditures within the USG
    - Track the results and impact the programs have achieved
    - Timeline: Start in October 2012. Complete by June 2013. Update once every two years.
2. Collect case studies of effective US-donor funded programs that address NCDs emphasizing personal stories, data and impact.
    - Provide links to information on an organization or institution's website if a short, easy-to-understand summary that addresses data and impact is available. If not, Working Group members will develop short, easy-to-understand summaries that include data and impact information.
    - Develop short, easy-to-understand case study summaries that include details about data and impact where there is no organizational or institutional summary available.
    - Timeline: Ongoing. Highlight a new case study each month at the NCDRT meeting. Review progress every 3 months.

NOTES:

- The exact outputs need to be determined by the Working Group Leadership (e.g. white paper, spreadsheet, fact sheets etc.).
- Need to find ways to publish and promote the NCDRT research findings.
- Follow key developments at USAID, Gates Foundation and the Bloomberg Philanthropies, International Food and Beverage Alliance, Yale Rudd Center for Food Policy, Medtronic, JNJ, IFPMA – Pharmaceutical Industry, Livestrong, AHA, ACS, etc. for new information, videos, etc.; Recommend having representatives from the different organization be a part of the NCDRT.

Working Group 2: Advocacy

The Advocacy Working Group is responsible for driving the policy and advocacy agenda for the NCDRT. This includes the following priorities:

- Increase US engagement on NCDs:
  - NCDRT members to hold periodic, planned meetings with USG representatives to discuss:
    - Progress and updates on planned and existing initiatives (e.g. Clean Cookstoves, PEPFAR) that have implications on and potential to advance NCD agenda
    - U.S. position on the development and delivery of the WHO global monitoring framework, including voluntary global targets and indicators
    - U.S. position on NCDs in post-2015 agenda
    - What technical challenges still remain for the world to achieve its NCD promises?
  - Invite USG representative to give a talk once every 6 months to the NCDRT on the above points.
  - Find ways to make the progress updates public or distribute widely to our member organizations (count total individuals reached).

- Leverage DC based global health leaders:
  - NCDRT members to hold periodic, planned meetings with PAHO, the World Bank and other DC based stakeholders as well as the Gates Foundation and other donors, including the private sector, to do more to address NCDs globally.
  - Consider holding a Multi Stakeholder public event.
    - Suggested attributes of the event include:
      - Host a dialogue on NCDs
      - Get a media personality to lead the discussion
      - Partner with Kaiser or CSIS
      - Webcast the event
    - Suggested dates include:
      - 2nd year anniversary of UN HLM (i.e. September 2013). However, this coincides with the MDG Summit in NYC during the opening the GA in 2013.
      - Align with a DC-based NCD-focused event late 2013/early 2014

- Advocate for increased investment in NCDs by USG and donors. Using the evidence base from the Communications and Engagement Working Group, influence the NCD spending by US-based donors.
  - Plan for a Hill briefing, open Letter or event in DC by early 2014. Raise funds needed.

Logos of European Chronic Disease Alliance and members

Sample MOU adapated from that of European Chronic Disease Alliance

MEMORANDUM OF UNDERSTANDING

between

- **(***List the names of alliance members)*
- -------
- ------

for the management of the De Facto
EUROPEAN CHRONIC DISEASE ALLIANCE
(ECDA)

for the period

1st January 2016 – 31st December 2016

CONTENTS

1 PARTIES TO THE MEMORANDUM (PTM)

1.1 This Memorandum is between the main chronic diseases related European organisations with activities in Europe:

- ✓ **Names of member organisations with postal address**
- ✓ ----
- ✓ ---

1.2 The PTM agree to the rights and duties of Members, as set out in Annex I, vis-à-vis their involvement in ECDA's activities.

2 BACKGROUND

2.1 Over the period 2010-2011, the PTM expressed their interest in launching a joint initiative at EU level to reduce the incidence and impact of chronic non communicable diseases in Europe, promoting awareness, prevention, and quality treatment.

2.2 On 27 May 2011, representatives of the PTM met and discussed the strategic objectives of the ECDA and how best to achieve them.

2.3 In order to make it a reality, the founding members of the ECDA agreed, at a meeting on 25 November 2011, to establish a Secretariat to manage the alliance.

2.4 At meetings in 2012, the PTM agreed that the selection of the Secretariat management should be done following a voluntary expression of interest by members to carry out this task and a vote by the PTM. The Secretariat should be managed by the same organisation for a minimum period of 2 years, with possibility of renewal (maximum 4 years in total).
In October 2014, the majority of members voted in favour of the *XXX* candidacy for the Secretariat management in 2015 and 2016.

3 PURPOSE AND SCOPE

3.1 This Memorandum explains the key activities to be undertaken by the ECDA and its Secretariat.

3.2 The activities to be undertaken by the Secretariat for the PTM are:

Administration and management

- Secretariat should organise the Steering Committee meetings in Brussels
- Secretariat is maintained by one of the full members of ECDA
- Secretariat is responsible for general management of the Alliance:
  - Organise 3 to 4 meetings between the member organisations in Brussels (by default – other locations if in agreement with members)
  - Prepare minutes of the meeting and other meeting supporting documents for future reference
  - Prepare management accounts of the organisation on an annual basis
  - Prepare an annual report
  - Maintain membership register

Advocacy and cooperation

- Prepare, coordinate and follow-up all advocacy initiatives in coordination with ECDA members
- Alert members on possible initiatives or projects regarding chronic diseases and their prevention, including all enquiries and requests for collaboration received from external parties. Advise members on opportunities, advocacy plans & actions, etc.
- Provide support for project application involving ECDA and/or a majority of its members
- Participate in relevant events on behalf of ECDA and report back to members

Policy monitoring & dissemination of information

- Systematic monitoring of EU policies in relevant areas: public health, chronic diseases, research, etc.
- Circulate relevant information via regular emails to full members and / or associated members

Communication

- Maintain ECDA website and ensure it is up to date
- Prepare draft press releases and other communications materials, e.g. leaflets, posters, etc. for approval by members.
- Seize opportunities to communicate about ECDA & ECDA initiatives (articles in press, speakers at conferences, etc.) and inform the members (all articles and speakers to be approved by ECDA members)

4 TERM

4.1 This Memorandum commences on 1st January and ends on 31st December 2016. It can be renewed by the signature of a joint addendum defining additional terms.

5 OUTCOMES SOUGHT THROUGH THE MEMORANDUM

5.1 Through their joint initiative, the PTM seek to reverse the alarming rise in chronic disease by providing policy recommendations based on current evidence.

5.2 The PTM agree to develop and implement an advocacy strategy and to establish measurable milestones to assess the pertinence of their joint initiative for the main outcomes sought. In addition, the PTM agree to review the activities falling under the scope of this memorandum and of the advocacy strategy on a yearly basis.

6 OUTPUTS TO BE PROVIDED BY THE STEERING COMMITTEE

6.1 The activities of ECDA are conducted under the responsibility of a "Steering Committee". The ECDA Steering Committee is composed of all the members mentioned in the MoU.

If designated representatives have not been mandated by their organisation to make decisions and commitments concerning the management of the Alliance for the organization they represent, they will refer to their Board. Members of the Steering Committee will notify their decision to the other members of the Alliance within a month. Members of the ECDA may designate additional or alternative individuals to represent them on the Steering Committee.

For 2016, the Members of the Steering Committee are:

Steering Committee Members	
Name of the organisation	**Key representative, alternate representative**
…	

6.2 The ECDA Steering Committee agrees to meet 3 to 4 times in person in 2016 under the leadership of the designated Secretariat. It will review progress and results under the joint activities. As often as necessary, the PTM will communicate by email or by using teleconference facilities. Decisions concerning the management of the Alliance will be made by consensus. Where consensus cannot be reached members will vote by simple majority. Exception applies to decision-making on advocacy communications, as dXXXribed under point 9.2.

6.3 The role of the Chairperson shall be attributed to the representative of the member organisation managing the Secretariat. Any delegation of powers shall be clearly minuted after Steering Committee meetings.

6.4 The Steering Committee has the right to establish sub-committees.

6.5 Any new member must be approved by the Steering Committee. A new full member automatically becomes part of the Steering Committee. The Steering Committee remains free to refuse members without having to justify its decision. Exclusion of a current member from the alliance can be done following a vote by absolute majority.

6.6 Each full member is entitled to one equal vote. Associate members do not have any voting rights.

7 ORGANISATION OF ECDA IN 2016

7.1 The PTM agree to entrust *XXX* with the ECDA's Secretariat for the term of the present MoU. The coordination of ECDA activities is under the responsibility of *XXX*.

8 BUDGET AND RESOURCES

8.1 The PTM commit to pay their respective membership amount in one instalment, upon receipt of an invoice and before 28 February 2016. The payment will be made to the *XXX* account number: xx

8.2 The cost of the Secretariat management services is agreed at xx for 2016, representing an annual membership fee of xx per member. The annual membership fee is subject to review upon request by the members. In addition to the membership fee, each member agrees to pay xx euro for 2016 to cover expenses for catering, printing materials, website hosting, media subscriptions and mutually agreed unforeseen operating costs. Should the budget for additional expenses not be entirely spent in 2016, the remaining amount shall be transferred to cover similar expenses in 2017.
The expenses budget for 2016 will thus total xx euro.

8.3 Once a year, an Expense Report must be submitted to the Steering Committee for approval.

8.4 Any disbursement for ECDA activities will be authorised unanimously by the Steering Committee in writing. Authorisation will be kept for the record. The ECDA Secretariat will keep full accounts of all income and expenditure, which may be reviewed by Steering Committee members at all times.

8.5 Budgetary decisions between PTM must be made unanimously. They may be made electronically.

9 COMMUNICATION PROCEDURES

Representation at official meetings

9.1 Representation of ECDA at official meetings and/or events shall be done by members' representatives depending on the subject in question.

Official communication[1] and initiatives

9.2 It is agreed between the PTM that all joint communications and initiatives by ECDA will bear the ECDA logo solely if their content is agreed in unanimity.
Should one or more members request to opt out, then the action in question will no longer bear the ECDA logo and will not be supported by the Secretariat. In this case, the members who wish to carry on with the specific action will have to coordinate the action among them.
It will be assumed that members agree unless they express their disagreement to the Secretariat within 5 (five) working days from the date of request. In case of urgent matters, the Secretariat will ask members to respond within 2 (two) working days.

9.3 The Secretariat acts under the authority of the Steering Committee for official communication as well as joint ECDA position papers. Once agreed upon as described in art. 9.2, official communications will be signed by the Alliance Chairperson on behalf of ECDA members or by using the ECDA logo/header.

9.4 The Secretariat will hold an archive of all official incoming and outgoing ECDA correspondence. Only ECDA announcements and official correspondence to key policy makers will be copied to the Steering Committee.

[1] Press releases, position papers, letters to EU officials and other stakeholders, endorsement of/contributions to letters and positions of other stakeholders

9.5 All ECDA communication will be sent to the members of the Steering Committee who will be responsible for disseminating the information to relevant members of their respective organisations as well as their formal and informal networks.

9.6 All PTM (or their members) remain free to present individual projects to the European Union institutions.

9.7 The right of the individual organisations to make their own statements will be respected even where they may differ from the ECDA.

Copyright

9.8 Each PTM member has its respective logos and only grants the Secretariat the authorization to use this logo only within the scope of this agreement. Therefore, this does not grant any authorization to use or duplicate these logos outside the scope of this agreement. Materials & documents (memos, reports, creation of website...) covered by this MoU is the common ownership of the PTM and cannot be duplicated without the unanimous approval of the PTM members. The ECDA logo may only be used by individual members following the approval in unanimity, according to the procedure outlined in art. 9.2

10 PROCEDURES FOR EXTENSION AND AMENDMENT

10.1 This Memorandum can be amended or terminated during the present term or extended to future terms only if all PTM jointly agree to do so.

11 CONFIDENTIALITY

11.1 The PTM agree that any information and/or document involved within the scope of this agreement shall be treated as confidential (except such information and materials previously validated and approved for external dissemination). PTM members shall not disclose any confidential content except under the unanimous approval of the PTM members.

12 SIGNATURES

For each member of the steering group, list name of signing authority and sign.

Annex I

Criteria for Membership

Full members

Criteria:

European Scope – only European Associations can be full members

Not for Profit & Non-Governmental Organisation

Representing a disease or a group of diseases with common risk factors (e.g. tobacco use, poor nutrition, physical inactivity, alcohol consumption and environmental factors)

Activity related to the prevention of chronic non communicable diseases

Associations funded by the pharmaceutical industry must have **more than one** company pharmaceutical sponsor

Must have at least one health professional and/or patient organizations/disease-specific charity representative in their Board

Active promotion and involvement in the activities carried out by the Alliance

Upload information about ECDA on their website and actively disseminate information about the ECDA

Benefits:

Member of the steering committee, and invitation to attend all meetings (approximately 4 a year)

Possibility of being part of the spokesperson task force of the Alliance – this will depend on the topic addressed and the circumstances when a spokesperson is needed

Participate in drafting of all position papers or other official communication

Receive all relevant information on activities of the Alliance

Have their logo in all ECDA documents and/or ECDA header/joint logo

Have one voting right

Annual fee: EUR XX + EUR XX (VAT excl.) contribution to cover operating costs, transferrable to next year if not fully spent

Associate Members

Criteria:

International or National Scope

Not for Profit & Non-Governmental Organisation

Representing a disease or a group of diseases with common risk factors (e.g. tobacco, physical activity, nutrition, alcohol, environment)

Activity related to the prevention of chronic non communicable disease

Associations funded by the pharmaceutical industry must have **more than one** pharmaceutical company sponsor

Must have at least one health professional and/or patient organizations/disease specific charity representative in their Board

Benefits:

Receive all relevant information regarding the activities of the Alliance

Participate in one meeting a year with full members, i.e. Steering Committee

Participate in all public meetings organized by ECDA

Have their logo on all ECDA documents and information materials but not included in the joint ECDA logo/header

No voting right

Annual fee: EUR XX(VAT excl.)

BARBADOS

THE COMPANIES ACT 1982

BY-LAW NO.1

A by-law relating generally to the
Conduct of the affairs of:-

COMPANY No: 33961

BE IT ENACTED as the general By-Laws of **Healthy Caribbean Coalition Inc.** (hereinafter called the "Company") as follows:-

1. **INTERPRETATION**

1.1 In this by-law and all other by-laws of the Company, unless the context otherwise requires:

(a) "Act" means the Companies Act 1982 as from time to time amended and every statute substituted therefor and, in the case of such substitution, any references in the by-laws of the Company to provisions of the Act shall be read as references to the provisions substituted therefor in the new statute or statutes;

(b) "Regulations" means any Regulations made under the Act, and all regulations substituted therefor and, in the case of such substitutions of the Regulations shall be read as references to the provisions substituted therefor in the new regulations;

(c) "by-laws" means any by-law of the Company from time to time in force;

(d) special resolution means a two third majority vote of the common members listed in the register on the date the special resolution is voted on;

(e) all terms contained in the by-laws and defined in the Act or the Regulations shall have the meanings given to such terms in the Act or the Regulations; and

1

(f) the singular includes the plural and the plural includes the singular; the masculine gender includes the feminine and neuter genders; The word "person" includes bodies corporate, companies, partnerships, syndicates, trusts and any association of persons; and the work "individual" means a natural "person".

2. **REGISTERED OFFICE**

2.1 The registered office of the Company shall be in Barbados at such address as the directors may fix from time to time.

3. **SEAL**

3.1 The common seal of the Company shall be such as the directors may by resolution from time to time adopt.

3.2 The Company is authorised to have for use in any country other than Barbados or for use in any district or place not situated in Barbados, an official seal or seals which must comply with Section 25 (2) of the Act.

4. **DIRECTORS**

4.1 **POWERS:** The business and affairs of the Company shall be managed by the directors.

4.2 **NUMBER:** There shall be a minimum ofthree (3) and a maximum of ten(10) directors.

4.3 **ELECTION:**

4.4 Within one month of an upcoming General Assembly at which there is scheduled election of Directors, a Nominating Committee will invite nominations from members for election of President and Secretary/Treasurer and other members of the board of directors. Such Nomination Committee to be comprised of 2 directorsof the Company, excluding the President, and one of whom should chair the Nominating Committee and another individual who is not a member of the board of directors. The Nominating Committee will determine the number and names of the Directors for the ensuing two years based on submissions from members and on search by the Nominating Committee. The persons so identified will be presented at General Assembly for election at which time any member

entitled to vote may also nominate persons for election to become a member orofficer of the board of directors.

4.5 Members of the Board elected at General Assembly meetingshall within three months of election identify and invite up to a maximum of 5 persons to constitute a Committee of Advisers to the Board of Directors. These persons should be individuals considered likely to contribute significantly to assisting the Companyin discharging its mission and objectives and may be identified from among any category of membership of the Company. The Committee of Advisers to the Board of Directors will interact with and at the pleasure of the Board of Directors to assist with the development and best management and governance of the company.

4.6 **TENURE:** Board members shall serve for two (2) years after which they may be eligible for re-election.

4.6.1 A director shall cease to be a director:

(a) if he becomes bankrupt or compounds with his creditors or is declared insolvent;

(b) if he is found to be of unsound mind; or

(c) if by notice in writing to the Company he resigns his office and any such resignation shall be effective at the time it is sent to the Company or at the time specified in the notice whichever is later.

(d) if he is absent from four (4) consecutive meetings of the Board without good cause communicated to the Board in writing.

4.6.2 Vacancies among the directors of the Company, may be filled by a quorum of the directors of the Company under section 72 of the Act with the recommendation of the President.

4.7 **DELEGATION OF POWERS:** The directors may, subject to 80 (2) of the Act, delegate powers to committees, Managing Director or officers of the Company in accordance with the provisions of Section 80 and 93 of the Act.

5 **BORROWING POWERS OF DIRECTORS**

5.1 The directors may from time to time

(a) borrow money upon the credit of the Company;

(b) issue, re-issue, sell or pledge debentures of the Company;

(c) subject to section 53 of the Act, give a guarantee on behalf of the Company to secure performance of an obligation of any person; and

(d) Mortgage, charge, pledge or otherwise create a security interest in all or any property of the Company, owned or subsequently acquired, to secure any obligation of the Company, or any of its affiliates then owned by the Company.

5.2 The directors may from time to time by resolution delegate to any officer of the Company all or any of the powers conferred on the directors by paragraph 5.1 hereof to the full extent thereof or such lesser extent as the directors may in any such resolution provide.

5.3 The powers conferred by paragraph 5.1 hereof shall be in supplement of and not in substitution for any powers to borrow money for the purposes of the Company possessed by its directors or officers independently of a borrowing by-law.

6 **MEETING OF DIRECTORS**

6.1 **PLACE OF MEETING:** Meeting of the directors and of any committee of the directors may be held within or outside Barbados or virtually through the use of digital media.

6.2 **NOTICE:**

(a) Regular meetings shall be held with a frequency as determined by the President and will be held virtually through the use of digital media or face to face meetings as circumstances allow.

(b) Special meetings may be held at any time when called for by the President or a majority of Board members.

Subject to sub-section 76(1) of the Act the notice of any such meeting need not specify the purpose of or the business to be transacted at the meeting. Notice of any such meeting

shall be served in the manner specified in paragraph 19.1 hereof not less than two days (exclusive of the day on which the notice is delivered or sent but inclusive of the day for which notice is given) before the meeting is to take place. A director may in any manner waive notice of a meeting of the directors and attendance of a director at a meeting except where a director attends a meeting for the express purposes of objecting to the transaction of any business on the grounds that the meeting is not lawfully called.

6.3 **QUORUM:**A majority of directors shall form a quorum for the transaction or business and, not withstanding any vacancy among the directors, a quorum may exercise all the powers of the directors. No official business shall be transacted at a meeting of directors unless a quorum is present. However a quorum of one will suffice in circumstances as determined by the directors where there exists a conflict of interest requiring one or more directors to abstain from voting.Any member of the Board who has a financial, personal, or official interest in, or conflict (or appearance of a conflict) with any matter pending before the Board, of such nature that it prevents or may prevent that member from acting on the matter in an impartial manner, shall declare such interest to the Board and will offer to the Board to voluntarily excuse him/herself and will refrain from discussion and voting on said item.

6.3.1 A director may, if all the directors consent, participate in a meeting of directors or of any committee of the directors by means of such telephone or other communications facilities as permit all persons participating in the meeting to hear each other and a director participating in such a meeting by such means is deemed to be present at that meeting. If a director participating in such a meeting is then in Barbados, the meeting shall be deemed to have been held in Barbados.

6.4 **VOTING:** Questions arising at any meeting of the directors shall be decided by a majority of votes. In case of equity of voting the chairman of the meeting in addition to his original vote shall have a second or casting vote.

6.5 **RESOLUTION IN WRITING:** Notwithstanding any of the foregoing provisions of this by-law a resolution in writing signed by all the directors entitled to vote on that resolution at a meeting of the directors or any committee of the directors is as valid as if it had been passed at a meeting of the directors or any committee of the directors.

7 **REMUNERATION OF DIRECTORS**

7.1 The remuneration to be paid to the directors if any shall be such as the members may from time to time determine and such remuneration may be in addition to the salary paid to any officer or employee of the Company who is also a director, unless otherwise resolved by the members. The directors may award special remuneration to any director undertaking any special services on the Company's behalf other than the routine work ordinarily required of a director and the confirmation of any such resolution or resolutions by the members shall not be required.

8. **SUBMISSION OF CONTRACTS OR TRANSACTIONS TO MEMBERS FOR APPROVAL.**

8.1 The directors in their discretion may submit any contract, act or transaction for approval or ratification at any annual meeting of the members or at any special meeting of the members called for the purposes of considering the same and subject to the provision of section 89 of the Act, any such contract, act or transaction that is approved or ratified by a resolution passed by a majority of the votes cast at any such meeting (unless any different or additional requirement is imposed by the Act of by the Company's articles or any other by-law) shall be as valid and as binding upon the Company and upon all the members as though it had been approved, ratified or confirmed by every member of the Company.

9 **FOR THE PROTECTIONOF DIRECTORS AND OFFICERS**

9.1 No director or officer of the Company shall be liable to the Company for

(a) the acts, receipts, neglects or defaults of any other director or officer or employee or for joining in any receipt or act for conformity;

(b) any loss, damage or expense incurred by the Company through the insufficiency or deficiency of title to any property acquired by the Company or for or on behalf of the Company;

(c) the insufficiency or deficiency of any security in or upon which any of the money of or belonging to the Company shall be placed out or invested;

(d) any loss or damage arising from the bankruptcy, insolvency or tortuous act of any person, including any person with whom moneys securities or effects shall be lodged or deposited;

(e) any loss, conversion, misapplication or misappropriation of or any damage resulting from any dealing with any moneys, securities or other assets belonging to the Company;

(f) any other loss, damage or misfortune whatever which may happen in the execution of the duties of his respective office or trust or in relation thereto;

unless the same happens by or through his failure to exercise the powers and to discharge the duties of his office honestly and in good faith with a view to the best interests of the Company and in connection therewith to exercise the care, diligence and skill that a reasonably prudent person would exercise in comparable circumstances.

9.2 Nothing herein contained shall relieve a director or officer from the duty to act in accordance with the Act or regulations made thereunder or relieve him from liability for a breach thereof.

9.3 The directors for the time being of the Company shall not be under any duty or responsibility in respect of any contract, act or transaction whether or not made, done or entered into in the name or on behalf of the Company, except such as are submitted to and authorised or approved by the directors.

9.4 If any director or officer of the Company is employed by or performs services for the Company otherwise than as a director or officer or is a member of a firm or a member, director or officer of a body corporate which is employed by or performs services for the Company, the fact of his being a member, director or officer of the Company shall not dis-entitle such director or officer or body corporate, as the case may be, from receiving proper remuneration for such services.

10 INDEMNITIES TO DIRECTORS AND OFFICERS

10.1 Subject to section 97 of the Act, except in respect of an action by or on behalf of the Company to obtain a judgment in its favour, the Company shall indemnify a director or officer of the Company, a former director or officer of the Company or a person who acts or acted at the Company's request as a director or officer of a body corporate of which the Company is or was a member or creditor, and his personal representatives,

against all costs, charges and expenses, including an amount paid to settle an action or satisfy a judgment, reasonably incurred by him in respect of any civil, criminal or administrative action or proceeding to which he is made a party by reason of being or having been a director or officer of such Company, if:

(a) he acted honestly and in good faith with a view to the best interest of the Company; and

(b) in the case of a criminal or administrative action or proceeding that is enforced by a monetary penalty, he had reasonable grounds for believing that his conduct was lawful.

11 **OFFICERS**

11.1 **APPOINTMENT:** The directors shall, as often as may be required, designate such officers and appoint such officers as the Directors deem necessary.

11.2 **REMUNERATION:** The remuneration if any of all officers appointed by the directors shall be determined from time to time by resolution of the directors. The fact that any officer or employee is a director or member of the Company shall not disqualify him from receiving such remuneration as may be determined.

11.3 **POWERS AND DUTIES:** All officers shall sign such contracts, documents or instruments in writing as require their respective signatures and shall respectively have and perform all powers and duties incident to their respective officers and such other powers and duties respectively as may from time to time be assigned to them by the directors.

11.4 **DELEGATION:** In case of the absence of inability to act of any officer of the Company, except a Managing Director, or for any other reason that the directors may deem sufficient the directors may delegate all or any of the powers of such officer to any other officer or to any director.

11.5 **VACANCIES:** If the office of any officer of the Company becomes vacant by reason of death, resignation, disqualification or otherwise, the directors by resolution shall, in the case of Secretary Treasurer, and may, in the caseof any other office, appoint a person to fill such vacancy.

11.6 **TENURE:** Unless he vacates office under paragraph 11.1 or 11.5 hereof an officer, who is a director shall continue in office for as long as he is a director of the Company notwithstanding that, from time to time, his term of office as a director may expire and he may be re-elected a director of the Company.

12. **MEMBERS.**

Categories of Membership.

12.1 **Organization Member (Caribbean Health NGO),** being a chronic non-communicable disease (NCD) Caribbean based non-governmental health organization.

12.2 **Individual Member (Caribbean),** being an individual located in the Caribbean and involved in responding to chronic non-communicable diseases (NCDs).

12.3 **Associate member (Caribbean),** being a Not-for-profit organization, including voluntary associations, foundations, civic groups, professional associations, universities, unions, and other similar types of entities not intended to generate a profit for their owners, based in the Caribbean region.

12.4 **Supporting member (Caribbean),** being For-profit organizations that include corporations, partnerships, proprietorships, and others intended to generate financial gain for their owners, based in the Caribbean Region.

12.5**Supporting member (International),** being an individual, health NGO, Not-for-profit or For-profit organization, based outside of the Caribbean Region.

13.0 MEMBERSHIP AND ADMISSION TO MEMBERSHIP.

13.1 Caribbean NCD health nongovernmental organizations, other civil society organizations and institutions, business and academia, not-for-profit and for-profit organizations, and individuals, with an interest in NCDs, in the Caribbean and internationally will be encouraged and invited to become members of the HCC and once accepted by directors will be placed in appropriate membership category and contact details maintained by an officer of the board of directors and these lists maintained by the directors and officers of the Company will be considered to represent the official membership of the Company. Individuals, organizations or institutions may discontinue membership of the Company by requesting that removal from the official lists of members. Individuals,

organizations or institutions will be removed from the official list of members by the directors if in their judgment it is in the best interest of the Company for such action to be taken. There is no fee to become or to be a member of the Company. Conditions of admission to membership and of membership may be determined by directors from time to time as considered appropriate and in the best interest of the Company.
Individuals and/or organizations or institutions with any known association with the tobacco industry will not be encouraged, invited, or accepted as members of the Company.

13.2 ATTENDANCE AND VOTING AT GENERAL ASSEMBLY MEETINGS.

All categories of members of the Company may attend GENERAL ASSEMBLY Meetings. Voting and determination of quorum will be restricted to the category of Organization Member (Caribbean health NGO) as defined in 12.1, Individual Member (Caribbean) as defined in 12.2,Associate Member (Caribbean) as defined in 12.3, above and each member organization so defined will have a single vote on any matter under consideration.

14 MEMBERS' MEETINGS

14.1 GENERAL ASSEMBLY MEETING Subject to the provisions of section 105 of the Act, the General Assembly meeting of the members shall be held every two (2) years on such day and at such time as the directors may by resolution determine at any place within Barbados, outside Barbados or be held virtually through the use of digital media.

14.2 **SPECIAL MEETINGS:** Special meetings of the members may be convened by order of the directors at any date and time and at any place within Barbados, outside Barbados, or electronically.

14.3 **NOTICE:** A principal, written or typewritten notice stating the day, hour and place of meeting shall be given by serving such notice on each member entitled to vote at such meeting, on each director and on the auditor of the Company in the manner specified in paragraph 18.1 hereof, not less than twenty-one days nor more than fifty days (in such case exclusive of the day on which the notice is delivered or sent and of the day for which notice is given) before the date of the meeting. Notice of a meeting at which special business is to be transacted shall state (a) the nature of the business in sufficient detail to permit the member to form a reasoned judgment thereon, and (b) the text of any special resolution to be submitted to the meeting.

14.4 **WAIVER OF NOTICE:** A member and any other person entitled to attend a meeting of members may in any manner waive notice of a meeting of members and attendance of any such person at a meeting of members shall constitute a waiver of notice of the meeting except where such person attends a meeting for the express purposes of objecting to the transaction of any business on the grounds that the meeting is not lawfully called.

14.5 **OMISSION OF NOTICE:** The accidental omission to give notice of a meeting or any irregularity in the notice of any meeting or the non-receipt of any notice by any member, director or the auditor of the Company shall not invalidate any resolution passed or any proceedings taken at any meeting of the members.

14.6 **VOTES:** Every question submitted to any meeting of members shall be decided by a show of hands unless a person entitled to vote at the meeting shall demand a ballot and, if the article so provide, in the case of an equality of votes the chairman of the meeting shall on a ballot have a casting vote in addition to any vote to which he may be otherwise entitled. Where the meeting is held electronically votes may be submitted by saying "Yay" or "Nay" if there is no live video available.

14.6.1 At every meeting at which he is entitled to vote, every member, proxy holder or individual authorised to represent a member, who is present in person shall have one vote on a show of hands. Where the meeting is held electronically votes may be submitted by saying "Yay" or "Nay" if there is no live video available.Upon a ballot at which he is entitled to vote, every member shall, subject to the articles, have one vote for every share held by the member.

14.6.2 At any meeting, unless a ballot is demanded, a declaration by the chairman of the meeting that a resolution has been carried or carried unanimously or by a particular majority or loss or not carried by a particular majority shall be conclusive evidence of the fact.

14.6.3 A ballot may, either before or after any vote by a show or hands, be demanded by any person, entitled vote at the meeting. If at any meeting a ballot is demanded on the election of a chairman or on the question of adjournment it shall be taken forthwith without adjournment. If at any meeting a ballot is demanded on any other question or as to the election of directors, the vote shall be taken by ballot in such manner and either at once, later in the meeting or after adjournment as the Chairman of the meeting

directs. The result of a ballot shall be deemed to be the resolution of the meeting at which the ballot was demanded. A demand for a ballot may be withdrawn.

14.7 **PROXIES:** Votes at meetings of members may be given either personally or by proxy or, in the case of a member who is a body corporate or association, by an individual authorised by a resolution of the directors or governing body of that body corporate or association to represent it at meetings of members of the Company and a body corporate or association so represents shall be deemed to be present in person.

14.7.1 A proxy shall be executed by the member or his attorney authorised in writing and is valid only at the meeting in respect of which it is given or any adjournment thereof.

14.7.2 A person appointed by proxy need notbe a member.

14.7.3 Subject to the provisions of part V of the Regulations, a proxy may be in the following forms.

The undersigned member of
hereby appoints *or failing him*
of
as the nominee of the undersigned to attend and act for the undersigned and on behalf of the undersigned at the meeting of the members of the said Company to be held on the day of 20 *and at any adjournment or adjournments thereof in the same manner, to the extent and with the same powers as if the adjournment or adjournments thereof.*

Dated this *day of* 20 .

Signature of member

14.8 **ADJOURNMENT:** The Chairman of any meeting may with the consent of the meeting adjourn the same from time to time to a fixed time and place and no notice of such adjournment need be given to the members, unless the meeting is adjourned by

one or more adjournments for an aggregate of thirty days or more in which case notice of the adjourned meeting shall be given as for an original meeting. Any business that might have been brought before or dealt with at the original meeting in accordance with the notice calling the same may be brought before or dealt with at any adjourned meeting for which no notice is required.

14.9 **QUORUM:** Subject to the Act, a quorum of members is present at a meeting of members if at least 8 members entitled to vote at the meeting, are present in person or by proxy. Where the organization is comprised of less than 8 members a majority of those membersshall constitute a quorum. If a quorum is present at the opening of any meeting of the members, the members present or represented may proceed with the business of the meeting notwithstanding a quorum is not present throughout the meeting. If a quorum is not present within thirty minutes of the time appointed for a meeting of members, an informal discussion may be engaged in around the agenda and minutes of the meeting but no formal decisions or actions shall be taken. The meeting stands adjourned to the same day two weeks thereafter at the same time and place; and if at the adjourned meeting a quorum is not present within thirty minutes of the appointed time, the members present constitute a quorum.

14.10 **RESOLUTION IN LIEU OF MEETING:** Notwithstanding any of the foregoing provisions of this by-law a resolution in writing signed by all the members entitled to vote on that resolution at a meeting of the members is, subject to section 128 of the Act, as valid as if it had been passed at a meeting of the members.

15 INFORMATION AVAILABLE TO MEMBERS

15.1 Except as provided by the Act, no member shall be entitled to any information respecting any details or conduct of the Company's business which in the opinion of the directors it would be inexpedient in the interest of the Company to communicate to the public.

15.2 The directors may from time to time, subject to rights conferred by the Act, determine whether and to what extent and at what time and place and under what conditions or regulations the documents, books and registers and accounting records of the Company or any of them shall be open to the inspection of members and no member shall have any right to inspect any document or book or register or accounting

record of the Company except as conferred by statute or authorized by the directors or by a resolution of the members.

16. **CHEQUES, DRAFTS AND NOTES**

16.1 All cheques, drafts or orders for the payment of money and all notes and acceptance and bills of exchange shall be signed by such officers or persons and in such manner as the directors may from time to time designate by resolution.

17. **EXECUTION OF INSTRUMENTS**

17.1 Contracts, documents or instruments in writing requiring the signature of the Company may be signed by any director, who shall also affix the Common Seal of the company to any such document, and all contracts, documents and instruments in writing so signed shall be binding upon the Company without any further authorization or formality. The directors shall have power from time to time by resolution to appoint any officers or persons on behalf of the Company either to sign certificates for shares in the Company and contracts, documents and instruments in writing generally or to sign specific contracts, documents or instruments in writing.

17.1.1 An official seal which the Company may have as it is authorised to do by paragraph 3.2 hereof may be affixed to any document to which the Company in party in the country, district or place where such official seal can be used by a person appointed for that purpose by the Company by an instrument in writing under the common seal and a person who affixes an official seal of the Company to a document shall do so in accordance with section 25(6) of the Act.

18. **SIGNATURES**

18.1 The signature of any officer or director of the Company or of any officer or persons, appointed pursuant to paragraph 20.1 hereof by resolution of the directors may, if specifically authorised by resolution of the directors, be printed, engraved, lithographed or otherwise mechanically reproduced upon any certificate for shares in the Company or contract, document or instrument in writing, bond, debenture or other security of the company executed or issued by or on behalf of the Company. Any document or instrument in writing on which the signature of any such officer or person is so reproduced shall be deemed to have been manually signed by such officer or person whose signature is so reproduced and shall be as valid to all intents and purposes if such document or instrument

in writing had been signed manually and notwithstanding that the officer or person whose signature is so reproduced has ceased to hold office at the date on which such document or instrument in writing is delivered or issued.

19. **FINANCIAL YEAR**

19.1 The directors may from time to time by resolution establish the financial year of the Company.

20. **AMENDMENTS**

20.1 These by-laws may be amended by a two-thirds vote of Board members present at any meeting, provided a quorum is present and provided a copy of the proposed amendments(s) is provided to each Board member at least one week prior to said meeting.

ENACTED this 16Th day of September 2012

Corporate Seal

Director

SAMPLE 14 | Hybrid Governance Structure of HCC

Hybrid Governance Structure- Healthy Caribbean Coalition

HIA Workplan

Activities

A 360 degrees situational analysis of the NCD burden, stakeholders (civil society, political actors/policy makers), policies and programmes on major NCD risk factors. All mapping activities will be conducted at the subnational level across India and will collated into a national level Civil Society Status Report

Steps required to achieve each activity

– review of published and unpublished documents

– surveys and in-depth interviews with relevant stakeholders.

– a comprehensive mapping strategy will be developed to ensure synergy between the various components of the mapping being proposed.

Timeframe (in months)

Mapping strategy
1 to 2

SPECIFIC OBJECTIVE 1

To conduct a comprehensive and multisectoral mapping of NCD burden, civil society capacity, stakeholder engagement and policy environment for NCD prevention and control

Activities	Steps required to achieve each activity	Timeframe (in months)
Activity 1.1		
Civil society mapping to identify areas of strength, priorities, gaps in response and capacity building needs	Map all the civil society organisations (CSOs) that are directly or indirectly related to advancing NCD prevention and control in India.	2 to 3
	Map their strengths, priorities, gaps in civil society response to NCDs, capacity building needs, and potential areas for collective action, building up to the formation of a coalition and identification of its strategic priorities.	
	A SWOT analysis will be conducted to identify Strengths, Weaknesses, Opportunities and Threats – for coalition building for NCD prevention and control in India.	
Activity 1.2		
Mapping cross-sector policies and programmes, identifying priorities for action	Map policies and programmes across sectors that are directly or indirectly related to NCD prevention and control, to identify opportunities to advance action on NCD priorities. This will guide the development of the initial goals and priorities of the India NCD Alliance (Activity 3.4).	2 to 3
	A policy mapping including those of the health and non-health sectors of the Government) will be undertaken.	
	The NCD Alliance's benchmarking tool will be adapted and applied to assess India's progress on NCDs, in light of the fact that India was the very first country to adapt the global NCD targets to the national context.	
Activity 1.3		
Multi-stakeholder mapping including policy actors to identify priorities for action	Where possible, one-on-one, in-depth interviews will be conducted with stakeholders, to gauge their opinion on various strategies for the prevention and control of NCDs.	2 to 3
Activity 1.4		
Risk factor mapping to assess status and progress on addressing the key NCD risk factors (tobacco use, alcohol use, inadequate diet/ nutrition and physical inactivity)	The current status on Government and civil society action on control of each listed risk factors will be undertaken.	2 to 3
	This would involve a study in the Indian context, of the NCD burden posed by the risk factors, proven strategies to curb them (lessons learnt), law/legislation/guidelines that control the risk factors, as well as any ongoing legal cases which have a bearing on strategy planning.	
Activity 1.5		
Developing an India Civil Society Status Report with findings from the mapping exercise	The results of the mapping activities listed from 1.1-1.4 will be collated into an India status report which will be released at the National Consultation mentioned in Activity 2.1 and will inform the agenda and deliberations at the Consultation, as well as the scope and constitution of the proposed India NCD Alliance.	4

SPECIFIC OBJECTIVE 2

To develop a multisectoral NCD coalition and strategise priority civil society action and capacity building for NCD prevention and control

Activities	Steps required to achieve each activity	Timeframe (in months)
Activity 2.1		
Organising a National Consultation to deliberate on the constitution and functioning of a national NCD Alliance in India	The India NCD Alliance is envisaged as a coalition of multisectoral CSOs, which collectively and collaboratively plan and execute campaigns focused on meeting India's NCD targets. It is proposed to organise a National Consultation with active participation from various CSOs who are important for and interested in NCDs.	5
	Dissemination of the findings from the mapping activities carried out under Objective 1 will take place.	
	One of the important deliverables which will emanate from the National Consultation will be a strategic plan/framework for collaborative action.	
Activity 2.2		
Drafting short-term, mid-term and long-term goals for the India NCD Alliance, with lead/contributing organisations identified for implementing strategies/activities	The Alliance members will decide short-term, mid-term and long-term goals, activities therein and names of lead and contributing organisations for each activity. The scope of activities will be both upstream and downstream.	5
	Short-term goals/strategies/activities to be implemented within the grant period of one year (the first year of the India NCD Alliance). Mid-term and long-term goals/strategies/activities will be planned for the extended phase of the project (depending on lessons learnt/challenges/success in the initial phase).	
	Member organisations will also agree upon areas for collaborative action, synergies between partner organisations' existing/planned activities/campaigns and cross-pollination between sectors – pitching NCDs as a multi-dimensional health and development issue.	
	A monitoring and evaluation plan will be built-in to track progress on completion of activities and meeting goals.	
Activity 2.3		
Providing opportunities for establishing credibility and increasing visibility and outreach for the India NCD Alliance and its campaigns	During the nascent phase of the India NCD Alliance, it will also be important to identify and leverage opportunities to provide credibility and visibility to the Alliance and its campaigns.	5 to 12
	A comprehensive communication strategy will be developed to garner maximum outreach and impact for campaigns for policy makers, opinion makers, media and the public at large.	

SPECIFIC OBJECTIVE 3

To build the capacity of civil society actors to work across levels to augment NCD action

Activities	Steps required to achieve each activity	Timeframe (in months)
Activity 3.1		
Capacity building of member civil society organisations, with a specific focus on state level organisations	Capacity building will be the cornerstone of this project and will be integrated across activities. Capacity building needs will be emerge from the CSO mapping exercise (Activity 1.1). Members of the Alliance will share global and national best practices/ successful models of civil society action on NCDs, including National NCD Alliances from other countries. During preliminary discussions, state-based organisations have already expressed the need for garnering more information about the global and national developments in the NCD field, India's national targets and how can they align and integrate their ongoing activities with those of other organisations and make them more relevant to the current policy context. Information sharing will be an important component to promote capacity building and collaborative action.	4 to 12
Activity 3.2		
Consultations (formal and informal) with relevant ministries of the Union and State Governments on working collaboratively with civil society, with tha aim of progressing towards India's NCD targets	Active civil society participation would be the mainstay of the India NCD Alliance, bringing about change at the national and state level. However, the Alliance will not be homogenous and will have organisations from the grassroots working with their State Governments, patients and caregivers as well as national organisations addressing policy and programmatic components across sectors. Organisations that are based in states and work with grassroots, will ensure percolation of these efforts with the State Governments. The Regional and state-based hubs of the Indian Alliance will ascertain collective and coordinated working with Governments across the country and at the Centre.	5 to 12
Activity 3.3		
Promoting civil society-led action for comprehensive systems strengthening at the national and state levels.	The India NCD Alliance will strive for comprehensive systems (including but not limited to health systems) – at national and state levels, since NCD prevention and control needs a coordinated response from across sectors. The Secretariat and other partner organisations active at the national level will dialogue with the national NCD Cell at MoHFW to operationalise cross-sectoral linkages at the national and state levels by providing guidelines on the multisectoral component of the National Monitoring Framework and Action Plan for NCD Prevention and Control. In the first year, the guidelines could be a set of monitoring mechanisms or adoption of best practices that can be easily built into existing programmes and interventions. Similarly, organisations that are state-based, will work across sectors on common guiding principles, as presented to the Central Government. Subsequently, it is envisaged that the guidelines for integration will be notified at the Centre and will be mandated for the state NCD cells to follow. The national and state NCD Cells referred to in Activity 3.2 will facilitate this holistic systems strengthening.	5 to 12

Activities	Steps required to achieve each activity	Timeframe (in months)
Activity 3.4		
Actively engaging and empowering groups affected by NCDs, including high risk populations (women, youth etc.), patients with NCDs and their care givers to lead campaigns – at national and state level	Existing active groups will be identified through the mapping exercise listed above in Activity 1.1 and will be encouraged to become members of the Alliance. These groups will be identified from various regions of the country, to seek and encourage participation of active patients or caregivers. Patient-led groups for each of the major NCD (cardiovascular diseases, cancer, diabetes and chronic respiratory disorders) will be mobilised and their capacities built to lead a strong patient empowerment movement focused on access to care and treatment and prevention. Not only patients, but representatives from their families and care givers will also be involved in this effort.	5 to 12
Activity 3.5		
Following-up on GoI's work on NCDs during the September 2015 UN meeting on the post-2015 development agenda	The India NCD Alliance will also serve as a conduit for mobilising international support for key NCD related issues in India (tobacco control, alcohol control, diet & nutrition, physical activity and other key issues, particularly under the ambit of the post-2015 development agenda, focusing on the inclusion of NCDs within the Sustainable Development Goals (SDGs). Key opportunities for supporting and leveraging global NCD advocacy campaigns will also be identified so as to add credibility and visibility to the India Alliance's activities. Meeting with officials, issuing press statements, mobilising support letters/appeals etc., will be some of the activities to achieve this.	1 to 12

Danish Cancer Society | HJERTEFORENINGEN Danish Heart Foundation | the danish diabetes association

The Uganda/Denmark NCD Alliance Partnership

Seminar for Uganda NCD Alliance Board members and members from the Uganda Cancer Society, Diabetes Association, and Heart Research Foundation

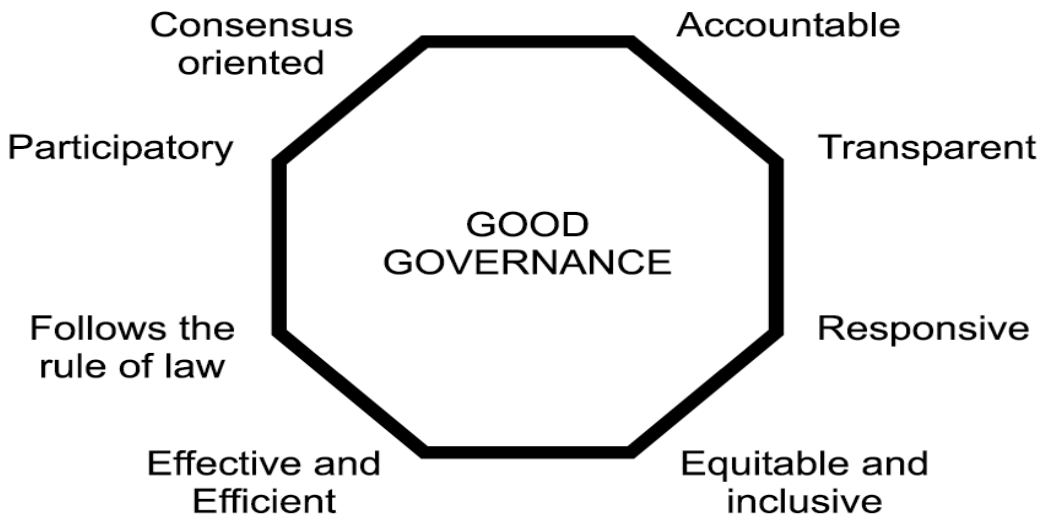
Saturday November 12th 2011

Good governance, legitimacy, Transparency and Accountability

Charlotte Rulffs Klausen
Director of Politics
Danish Diabetes Association

1

Danish Cancer Society | HJERTEFORENINGEN Danish Heart Foundation | the danish diabetes association



Source: Unescap (2005)

2

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Good NGO Governance

Example of a definition:

"A transparent decision-making process in which leadership of a civil society organization, in an effective and accountable way, directs resources and exercises power on the basis of shared values."

CEE Working Group on NGO Governance

3

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Key issues

- Organizational forms & structures
- Leadership & decision-making
- Process of acquiring power in the NGO
- Division of roles and responsibilities
- Conflict of interest issues
- Ensuring proper participation from stakeholders
- Evaluating both process and impact

Reference: ICNL – The International Centre for Not-for-Profit-Law

4

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Transparency:

Refers to the openness of processes, procedures and values of the organization, the proactive public disclosure and dissemination of information that should be in the public domain

Ex:

- Open meetings
- financial disclosure statements
- clear board elections and governance procedures
- information on political positions
- budgetary review, audits etc.

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Transparency

- A transparent organization is understandable and clear to it's own members, to it's supporters beneficiaries and stakeholders

- Transparency is one means to be accountable because once you have gone public with values, mission, plans, resources etc. You cannot reverse without problems

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Accountability

Refers to the requirement to accept responsibility to act based on the organizations own promises and subsequently justified expectations by various stakeholders. Accountability is about being open and sharing information

Ex:

- It's transparent what the organization is doing, is planning to do and how it is performing in relation to the goals it has set itself
- This information should be access able for donors, members etc. and should be timely
- Accountability also involves engaging individuals and groups in the activities and decisions that effect them (both internal and external stakeholder

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Accountability

Is a means to achieve legitimacy
and therefore the right
to act as foreseen and whished for

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Legitimacy

Refers to the perceptions by key stakeholders that the existence, activities and impact of the organization is justifiable and appropriate in terms of central values and institutions.

Ex:
Legitimacy in big things requires accountability in processes (decision-making, elections etc.) and transparency in action and promise (strategy , goals and activities)

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Legitimacy

In the LTA context, legitimacy is the outcome achieved through accountability and transparency

LTA is part of the culture
NOT just procedures

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How can the law help?

- Prescribe multiple bodies to govern and manage the organization
- Prescribe collective leadership (highest decision-making body)
- Minimum requirements for what should be in bylaws
- Ensure financial oversight (e.g. supervisory board)
- Give general guidance regarding board responsibilities
- Require conflict of interest policies

Reference: ICNL – The International Centre for Not-for-Profit-Law

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Good Governance
Why bother?

12

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Because transparency, the rule of law and accountability leads to:

- credibility and reliability
- support from the population /members
- prevention of rumors on nepotism and abuse of resources
- independency of persons – the cause is greater than the person

and all of this leads to larger impact on decision-makers

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Thank you

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NCD Roundtable
Membership Principles
March, 2014

All members of the NCD Roundtable (NCDRT) are expected to uphold the membership principles outlined below. It is the responsibility of all members to ensure that the principles are being honored at all times. Should a member suspect a violation of the principles, they agree to bring the situation to the attention of the NCDRT Co-Chairs.

1. I, (NAME OF INDIVIDUAL), on behalf of (MYSELF or NAME OF ORGANIZATION), agree that non communicable diseases (NCDs), including but not limited to cancer, diabetes, cardiovascular disease, chronic lung disease and mental illness, collectively represent one of the most important threats to health today. By joining the NCD RT, I am hereby committing (MYSELF or MY ORGANIZATION) to helping create awareness about this global threat, mobilizing prevention, diagnosis, treatment and care related to NCDs, and doing MY/OUR utmost to eliminate the conditions that cause NCDs, including but not limited to tobacco use, physical inactivity, harmful use of alcohol and unhealthy diets.

2. The primary purpose of the NCDRT is to be a neutral platform and credible voice for information sharing, advocacy, communications, collaboration and best practices around NCD issues among members, and with global health decision makers in Washington, DC, with a particular focus on the executive and legislative branches of the United States (U.S.) Government and multilateral institutions. We believe it is important the NCDRT be a leading voice in working with the U.S. Government to address strategic global NCD priorities.

3. When representing the NCD RT, I/WE strive for equity, transparency and aspire to high ethical standards conduct in all activities and representations and recognize that the work of the NCDRT is based on shared interests.

4. I/WE understand that when representing the NCDRT the interests and goals of the NCDRT come before the interests and goals of an individual organization or institution.

5. Membership in the NCDRT consisting of representatives from organizations and institutions committed to advancing the mission of the NCDRT is strongly encouraged with the following exceptions:
   a) Given the recognition of the "fundamental conflict of interest between the tobacco industry and public health" in the UN Political Declaration on NCDs, membership is not open to those organizations and individuals representing tobacco interests.
   b) Because government and multilateral agencies are among the focus of the advocacy efforts of the NCDRT, individuals who are government or multilateral agency employees cannot be members of the NCDRT per se. However, the NCDRT will make every effort to share information with government and multilateral agency representatives in a transparent and expeditious manner. Further, the NCDRT welcomes input from these individuals and institutions, as it enriches the understanding of the policies and

programs the NCDRT intends to affect and maintains open communication channels.

6. NCDRT Co-Chairs will strive to ensure that membership guiding principles are met and upheld

7. Membership in the NCDRT is contingent upon agreement to the principles and to having your organization/company logo displayed on the NCDRT website. For individual members, membership is contingent on agreement to the principles.

8. Members of the NCDRT agree that a multi-sectoral approach to NCDs is required, and that the combined efforts of advocates, researchers, healthcare providers, patients, private sector representatives, and funders must all be involved in together finding solutions. Groups from any of these sectors are strongly encouraged and welcome to join the NCDRT, so long as they agree to abide by its membership principles.

9. As a member of the NCDRT, unless if elected as co-chair, I/WE agree to join at least one of the NCDRT Working Groups, and to participate actively in its work by having as an objective, a one hour per week commitment to advancing the goals of the NCDRT.

10. An important and critical part of the work of the NCDRT is joint advocacy. I/WE agree to make a good faith effort to review each joint advocacy initiative created by the Roundtable and to provide timely responses to NCDRT requests for approval and endorsement.

11. I/WE recognize that potential conflicts of interest related to NCD initiatives and advocacy efforts may arise, and I/WE strive to be transparent and to make every reasonable attempt to ensure the integrity of the policy, advocacy, and communications produced and promoted by the NCDRT.

12. From time to time the NCDRT may make additional requests of members for assistance, in terms of funding or other resources. I/WE commit to making a good faith effort to consider these requests in a timely manner, and to respond to each request.

13. As a member of the NCDRT, I/WE agree to contribute to information, contact and other intangible resources towards advancing the goals of the NCDRT.

14. Co-chairs must approve promotion of NCDRT initiatives or activities by individual member organizations.

15. Use of the NCDRT logo is mainly for internal purposes but also might be used on external-facing materials, such as the NCDRT website or event promotional materials. Policy positions, statements, and other collateral produced by the roundtable might still be subject to organizational/member sign-on as indicative of support.

Date: _____ Signature: _____

NCD RT Principles 2

Financial Procedures and Internal Controls

Internal controls
Why is this so important?

Internal control – why is this so important?

- Create valuable information on to the leadership on financial matters – informed decision making
- Defines measurements of success
- Strengthen value of external reporting through its reputation
- Accountability
  - Internal: Board/Secretary General/employees
  - External: ZNCDA/donors/member/beneficiaries/governmental institutions
- Secure trust of donors, partners and beneficiaries
- Minimize the risks of:
  - Errors
  - Fraud
  - Corruption

What are the characteristics of organisations with strong internal controls

- Strong information system:
  - Complete reporting
  - Timely reporting
  - Relevant
  - Understandable
  - True and fair
  - Etc.
- Transparent procedures
- Segregation of duties
- Sufficient skills
- Clear roles and responsibilities
- Quick and timely response to challenges and problems
- Order

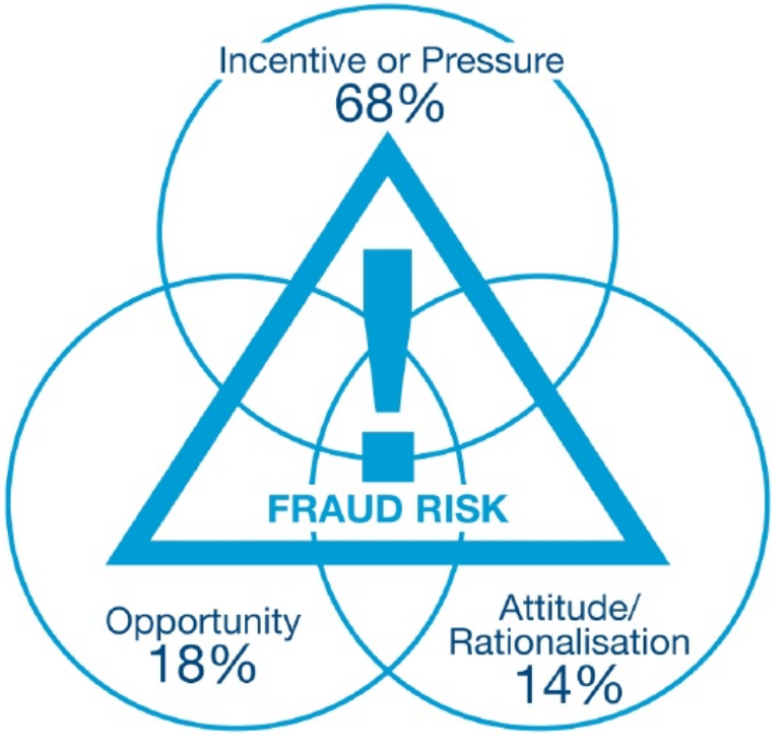
Internal control tools

- Proactive controls
  - Limitations (physical barriers, user settings etc.)
  - Segregation of duties
  - Acquire and maintain sufficient skills
- Reactionary controls
  - Reporting
  - Approvals
  - Documentation of decisions and accountabilities
  - Internal and external auditing
- Supervision

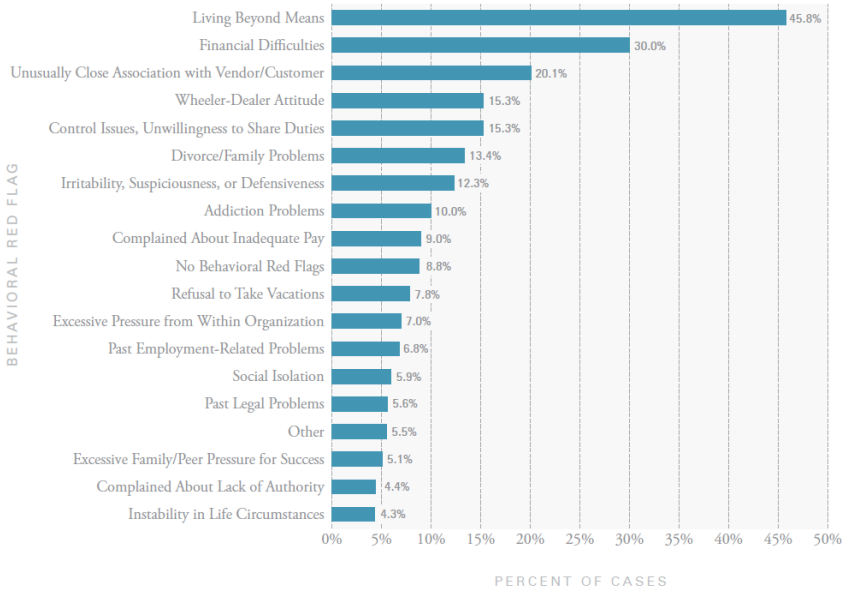
Pointers on internal control

- The risk of fraud is always there
- The possible cost of fraud should be limited
- Errors and fraud should be revealed as fast as possible
- Balanced control level – make risk analysis
  - Evaluate cost of control against cost of fraud and errors
  - Control levels in relation to risk
  - Think trust vs. control vs. bureaucracy

Fraud
Theory and reports



ACFE – observed behavioral red flags in fraud cases

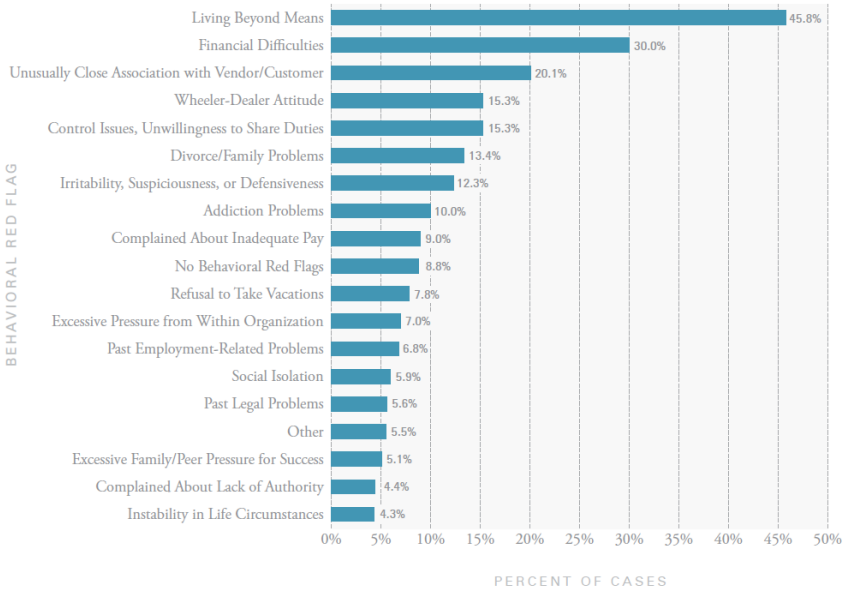


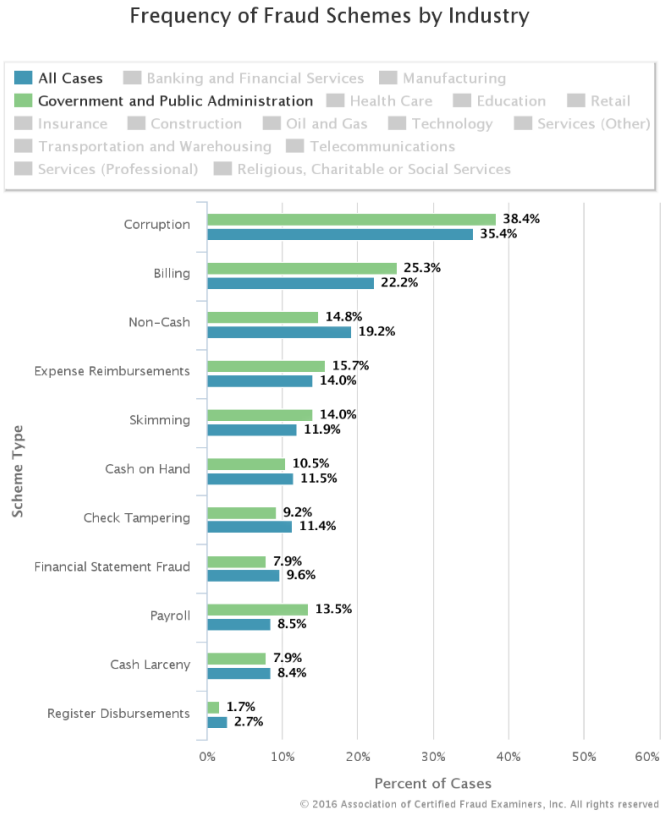
KPMG's profile of a fraudster

- Survey done i 2007
- Based on 360 cases from Europe, Middle East and Africa

- The typical fraudster:
  - A member of the leadership
  - Often connected to the financial department
  - Exploits knowledge of the internal controls
  - Drived by opportunity of personal gain
  - Works alone in the fraudulent activities
  - Has been doing it for more than 6 months

ACFE report – behavioral red flags





Control weaknesses

Tools of a fraud

- Forgery of documents and accountabilities
- Witholding information and registration of transactions
- Giving misinformation to management and auditor

Tools

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TOOL 1

Tuckman Stages with Tools

Forming	Storming	Norming	Performing	Adjourning
Team acquaints and establishes ground rules. Formalities are preserved and members are treated as strangers.	Members start to communicate their feelings but still view themselves as individulas rather than part of the team. They resist control by group leaders and show hostility.	People feel part of the team and realize that they can achieve work if they accept other viewpoints.	The team works in an open and trusting atmosphere where flexibility is the key and hierarchy is of little importance.	The team conducts an assessment of the year and implements a plan for transitioning roles and recognizing members' contributions.
				
Clarify Roles	Communicate & Collaborate	Reflect on group process		After Action Review
Build Goals (SMART criteria)	Negotiable ideas	Experiment (Trial and Error)		Share Lessons Learned
Establish Timeline	Resolve Conflicts	Learn/Move beyond Failure		Self/Group evaluations
Identify/Assign Tasks	Give Effective Feedback	Test Assumptions		
Discuss working agreements	Escalate Appropriately	Conduct Interin Check-ins		
		Present Outcomes		
Tools: Technology to Use, Time Management	Tools: de Bono's 6 Thinking Hats, Ask, Speak, Listen; Ladder of inference; L-Column	Tools: Kolb's Experiential Cycle		

http://wheatoncollege.edu/sail/leadership/student-involvement-handbook/strengthening-group/leadership-teambuilding/

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TOOL 2

Stakeholder Assessment Matrix

First discuss the following questions:

1. Which are the existing NCD CSOs who should be invited to join the alliance?
2. Which are the non-NCD CSOs whose work is relevant to NCD prevention and control?
3. Which are the CSOs (the unusual suspects) whose presence in the alliance would critically advance action on NCDs?

Fill in the table below listing specific organisations/individuals, considering why they would be interested in NCDs and whether they may be a good fit for an NCD alliance.

Stakeholder category e.g. NGOs, Academia	**Potential Partner organisation**	**Reasons they could be interested**	**Current interest in NCDs** (Rate 1 to 5)					**Influence/power** (Rate 1 to 5)					**Partner structure** (organisation/ individual, legal, informal movement)	**Involve as a member?**		**Keep informed about alliance work**	
														Yes	No	Yes	No
			1	2	3	4	5	1	2	3	4	5					
			1	2	3	4	5	1	2	3	4	5					
			1	2	3	4	5	1	2	3	4	5					
			1	2	3	4	5	1	2	3	4	5					
			1	2	3	4	5	1	2	3	4	5					
			1	2	3	4	5	1	2	3	4	5					
			1	2	3	4	5	1	2	3	4	5					
			1	2	3	4	5	1	2	3	4	5					
			1	2	3	4	5	1	2	3	4	5					
			1	2	3	4	5	1	2	3	4	5					
			1	2	3	4	5	1	2	3	4	5					
			1	2	3	4	5	1	2	3	4	5					
			1	2	3	4	5	1	2	3	4	5					
			1	2	3	4	5	1	2	3	4	5					

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TOOL 3

Make the Case for Partnership

First discuss the following questions:

1. Which are the non-NCD CSOs whose work is relevant to NCD prevention and control?

2. Which are the CSOs (the unusual suspects) whose presence in the alliance would critically advance action on NCDs?

Fill in the table below listing specific organisations/individuals, considering why they would be interested in NCDs and whether they may be a good fit for an NCD alliance.

Name of potential partner	Primary area of work	Relevance of partner's work to NCD prevention and control	Frame the benefit of NCD work in partner's context/terms
e.g. Rural development NGO	Rural livelihood-agriculture	To address unhealthy food and beverages, an NCD risk factor	Growing fruits and vegetables can improve farmer livelihoods, earnings, access to locally produced, healthy food and therefore their health and wellbeing, thus contributing to the realisation of the partner's priority goal of improving rural life. At the same time it supplies healthier foods to replace junk food consumption by people across the country and help mitigate NCD risks.

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TOOL 4

Strategic Planning Questions

I. SITUATIONAL ANALYSIS

1. Strategic priorities

a) Based on data, which of the concerns raised by NCDs and their risk factors in the country are important for your alliance to address?
b) What can the alliance do to address these top concerns?

2. External Scan

a) What are the opportunities in the external environment that the alliance can seize?
b) What are the threats in the external environment that the alliance need to overcome?

3. Internal Review

a) What are the strengths of the alliance that can help it to overcome the threats?
b) What weaknesses in the alliances need to be addressed to seize the opportunities?

II. DEVELOP STRATEGY

1. Vision

a) What is the desired end, or an image of the future, toward which your alliance wants to work?

2. Mission

a) What does the alliance do?
b) Who does the alliance serve?
c) What needs does the alliance meet?
d) What specific purpose would allow the alliance to realise its mission?

3. Values

a) What makes your alliance different and valuable?
b) What are your core beliefs?

4. Goals

a) What are the current problems that the alliance needs to address to be able to achieve its vision?
b) How would you rewrite these problems into positive statements?
c) How would you rewrite these positive statements to be goals?

III. BUILD THE PLAN

1. Objectives

a) What Specific, Measurable, Achievable and Realistic measures would help you achieve each of the goals in a Time bound manner? (SMART objectives)

2. Activities

a) What tasks can help the alliance achieve each of its objectives?

3. Performance indicators

a) What results have your activities yielded?
b) What do you measure to assess progress of activities?
c) How do you measure them?

4. Finances

a) How much does the plan cost?
b) How do you resource the plan?

IV. MANAGE THE PLAN

1. Roll out

a) To whom would you need to communicate your strategic plan?
b) What is the best way to do it?

2. Operational plan

a) How would you implement the strategic plan?
b) Who would be responsible for the agreed activities?
c) What are the timelines for each activity?
d) How would work be coordinated?

3. Review

a) How are we doing?
b) What are the gaps between the plan and its output?
c) How can the gaps be addressed?
d) What in the plan needs to be modified?

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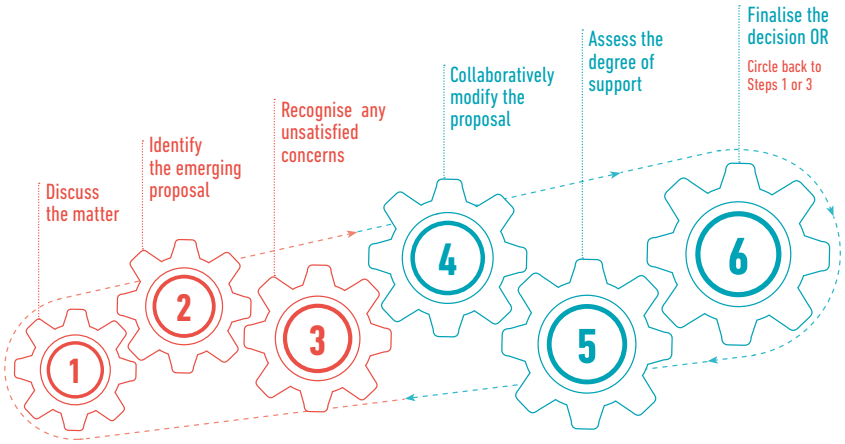
TOOL 5

6 Steps to building consensus



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TOOL 6

Sample Template
Terms of Reference of Committees

Instruction: *Modify the right hand side column as relevant to your committee's purpose.*

Objectives of the committee	To build the alliance's member base
Anticipated duration	Ongoing
Frequency of meetings	Quarterly
Co-Conveners/ Co-facilitators	Representatives of two member organisations
Tasks of members	Undertake civil society mapping to understand the landscape
	Conduct stakeholder assessment to identify potential partners
	Develop membership categories and criteria
	Develop information materials about the alliance and its membership
	Undertake regular membership outreach activities
	Review membership applications and recommend for governing body approval
	Organise member orientation initiatives
	Address and advise the governing body on membership related concerns
Nature of decisions of the working group	Recommendatory and facilitative
Approving authority	Governing body
Expected outcomes	A full fledged membership recruitment plan
	Clear and transparent member recruitment process
	A broad-based alliance of members from diverse sectors, disciplines and strengths
	Members empowered to fully contribute to the alliance
	A functional grievance redressal mechanism
Secretariat's role	Support civil society mapping and stakeholder assessment
	Administrative support in processing applications and grievances
	Organise member support activities

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TOOL 7

Sample Template
Terms of reference for Working Groups

Instruction: *Modify the right hand side column as relevant to your working group.*

Purpose of the working group	To address obesity and unhealthy eating
Anticipated duration	Three years (renewable, subject to review)
Frequency of meetings	Monthly
Co-Conveners/ Co-facilitators	Diabetes Federation and Teacher's union
Role of conveners/facilitators	Facilitate meetings
	Oversee development and implementation of action plan
	Involve members in implementation
	Report periodically to the governing body
Tasks of members	Identify priority concerns and policies to advocate
	Prepare an action plan for alliance approval and resourcing
	Recognise member strengths, resources and fix responsibilities
	Roll out the plan with periodic reviews and improvements
	Report at regular intervals to the governing body and the larger alliance
Nature of decisions of the working group	Decisions on method of work of the group
	Decisions about roles and responsibilities of group members
	Recommendations on concerns and potential action
	Propose a campaign plan
Approving authority	Governing body or the general body of members (as per alliance MOU) would be the approving authority of the working group recommendations
Expected outcomes	Effective activities addressing priority concerns
	Alliance action gets the attention of key targets
	Member capacity enhanced in this area
	Alliance attracts resources to advance its work
Secretariat's role	Offer administrative, secretariat assistance
	Set up communication channels
	Maintain minutes, records of working group meetings
	Support fundraising for the work of the group
	Link working group with opportunities, potential partners and resources
	Facilitate regular updates to the governing body

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TOOL 8

Setting up alliances as legal entities or not? Points to Ponder

Alliances may find it important to seek legal status at some stage in their lifecycle. Here is some guidance from the White Ribbon Alliance in making that decision (adapted to NCD context).

Deciding whether to Register the alliance is an individualised decision. It is beneficial to make informed decision based on the advantages and disadvantages, the requirements of your country, and the duration of the process. Knowing this information can help you determine whether obtaining legal status is a worthwhile endeavor for helping to sustain the alliance or whether it does not make a substantial difference to operate without registration. Registration as a legal body usually entails:

1. **Compliance with national laws.** The laws for registering civil society alliances vary across countries; and even across jurisdictions within countries. By and large, alliances qualify to be registered under non-profit laws, trust laws or companies laws. It is important to find out the implications of each of these laws for tax exemption, legal implications and operational burden. For example, while Ungandan law permits NGOs to register as a limited guarantees company, it attracts taxes. In Ethiopia, only organisations receiving 90% of their funding from domestic sources can engage in advocacy with the government. Further, the law prohibits their partnership with those that are mainly foreign funded.

2. **Changes to organisational design:** The relevant law often requires applicants to modify their structure to meet with its requirements. For instance, registration in some instance could require setting up a general body of members who need to be gathered annually for elections to its board.

3. **Applying for tax-exempt status:** In some places, the tax exemption is better for certain types of CSOs. e.g.: those with research goals

4. **Approvals to receive foreign funds:** Indian law, for instance, allows foreign funding only after three years of an organisation's existence.

5. Ensuring that your Alliance is in proper legal form to receive state, federal, corporate and foundation money.

6. **The membership of your Alliance will need to discuss registration.** Do members prefer to register or not to register? Sometimes it may be necessary; for example in Burkina Faso, an organization must obtain legal status to be recognized and to collect donations. This is mandatory and non-negotiable. In other cases, registration may not be required by law and can be a detriment in terms of restrictions to be part of. Find out what the situation is in your country so you can weigh the facts about the pros and cons of registration in considerations with members.

7. If you decide to register, **make sure that the Alliance retains its identity, beliefs and philosophy.** It can be quite difficult to avoid being transformed into the registered NGO/non-profit agency after status is granted.

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TOOL 9

Resource Mobilisation Plan Template

Strategy	Description	Target Audience	Resource Goal	Cost	Person Responsible	Deadline
[Insert Type of Fundraising Strategy]	[Insert Description of the Activity]	[Insert the Audience You Would Like to Target]	[Insert The Amount of Funding/ Resource You Would Like to Receive]	[Inster the Cost of The Activity]	[Insert the Person/s Responsible for the Activity]	[Instert the Exact or Estimated Deadline for the Activity]

Restricted grants	
Events	
Direct Mail	
Major Gifts	
Online gifts	

Adapted from USAID Health Communication Capacity Collaborative 's Resource Mobilization Implementation Kit.

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TOOL 10

Frequently Asked Questions about Transparency in alliances

with inputs from Healthy Caribbean Coalition

1. WHAT ARE SOME AREAS IN A COALITION'S WORK THAT CALL FOR TRANSPARENCY?

a. Applying for grants
b. Selection of sub grantees for onward granting projects
c. Selection of consultants for contracts
d. Selection of beneficiaries for capacity building initiatives
e. Selection of participants for events
f. Selection of governing board
g. Selection of secretariat

2. HOW ARE THESE BEST ADDRESSED?

a. Involve members with relevant expertise in projects
b. Clearly define the selection criteria and disseminate in the alliance
c. Advertise consultancies and select consultants on the basis of clearly defined criteria
d. Offer participation in various opportunities to all relevant members; rotate opportunities that are limited

3. WHAT KIND OF MECHANISMS CAN BE BUILT INTO ALLIANCE'S GOVERNANCE STRUCTURE TO ENSURE TRANSPARENCY IN ITS WORK?

a. Decisions regarding projects/ consultants/ meetings are discussed and are taken by the governing body on consensus basis, if not votes.
b. All large projects / consultancies to be passed by the governing body, based on pre-determined thresholds.
c. Daily operational matters can be decided between the Chair of the governing body and the secretariat
d. On technical matters, or a nominee board with relevant expertise or a technical working group can guide the work of the secretariat
e. Report on accounts and work plans systematically to the general body

NCD Alliance

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TOOL 11

Disclosure Form cum Due Diligence Checklist

INSTRUCTIONS: *This form is to be supplied to potential members along with the conflict of interest policy of the national/regional alliance. Review the form based on the policy. Adapt tool to suit alliance policies.*

(Name and logo of national/ regional alliance)	**Full name of the organisation**	
	National affiliations	**a.**
		b.
	International affiliations	**a.**
		b.

	Yes	No	**Review committee remarks** (For alliance use only)
Submitted annual report			
Work relevant to NCD prevention and control			
Audited statement of accounts			
Known Financial irregularities			
Provide details of irregularity:			
Current or past civil or criminal cases			
Provide details of legal cases:			
Membership of any political party			
Membership of any banned outfits			

Association with industries of conflicting interest for NCD prevention and control
(as defined by the alliance conflict of interest policy):

	Yes	No	**Review committee remarks** (For alliance use only)
Collaborate on activities			
Receive financial or other resources			
Hold private meetings			
Have board members from industry			
Sit on industry boards			
Cobranding on products, events			
Industry included in public meetings			
Consulted on position papers			
Hold industry shares for investment			
Hire staff from industry			

Submitted by: Chief Executive, Applicant Organisation	**Name:**	**Signature:**

For alliance use only	**Recommendation** (tick the relevant one)	**Description**
	Approved	*(state category of membership recommended)*
	Call for further information on	*(state further information required)*
	Rejected	*(State reason for rejection)*

Verified by:	**Head, Membership/ Due Diligence Committee, NCD alliance:**	**Signature:**

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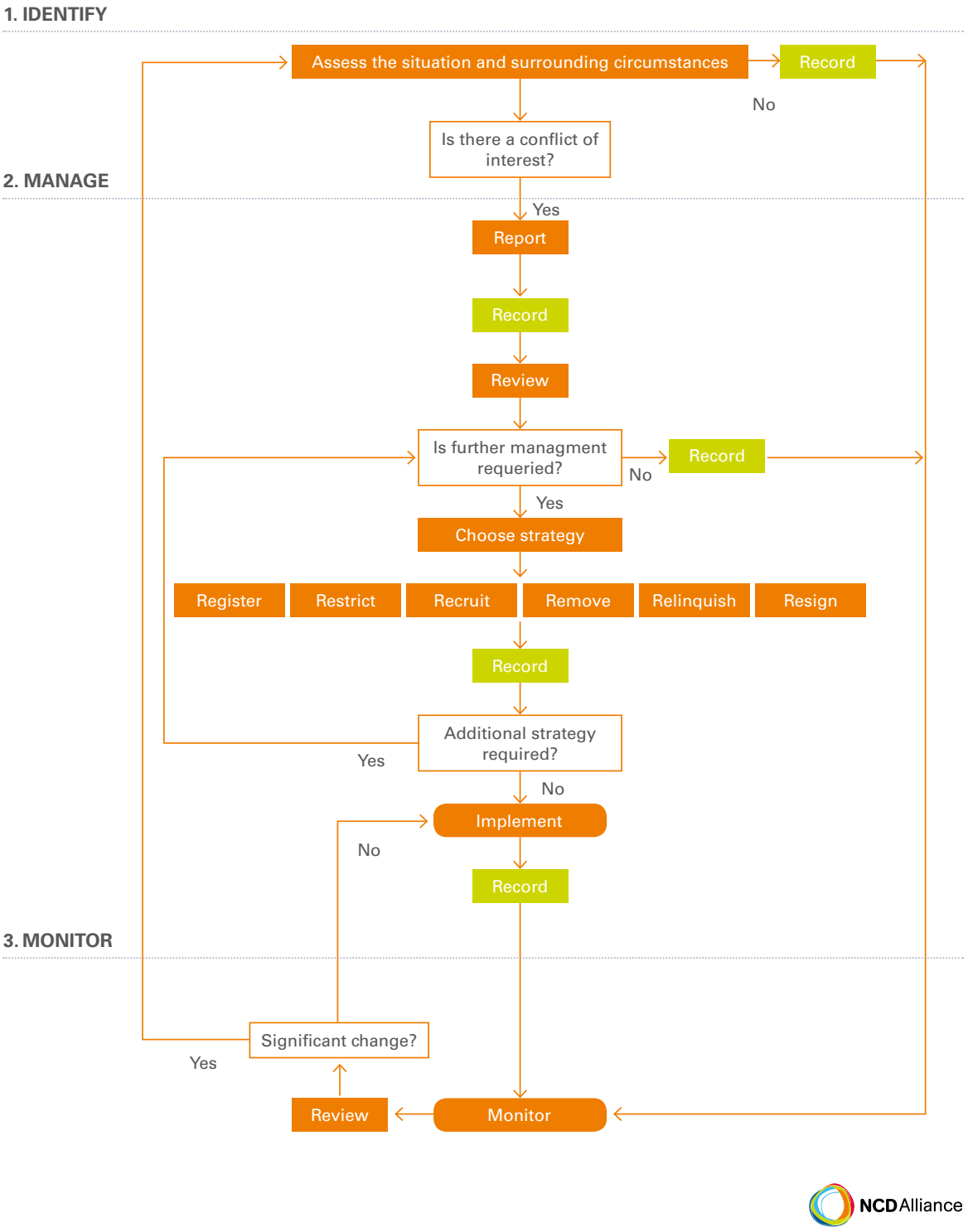
TOOL 12

Conflict of interest management flowchart

Process flow chart for identifying and managing conflict of interest



NCD Alliance

Practical guide
on how to build effective national and regional NCD alliances

TOOL 13

Communication Plan Template

Communication objective	Target audience	Key Message	Messenger	Timing	Frequency	Media Platforms	Person responsible
Why?	**To Whom?**	**What?**	**Who?**	**When?**	**How Often?**	**Where?**	**Contacts**
e.g. To secure a soda tax	Minister of Finance	Soda tax can get additional revenue while helping to address the country's NCD problem.	Country's chief economic advisor, leading health economists	During the annual budget preparation months	Frequent messaging at the start, middle and end of the budget prep period	Campaign on minister's most watched Financial TV, most read papers, Social media mobilise public opinion	Jack & Jill

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MAKING NCD PREVENTION AND CONTROL A PRIORITY, EVERYWHERE

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