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| **Project Proposal for:**  **IMPROVING NEEDY children’S ACCESS TO BASIC HEALTH SERVICES IN WAKISO SUB-COUNTY, WAKISO DISTRICT, UGANDA** **Prepared by:** Dr. KALYOOWA SAM:  project manager  KALAMBI COMMUNITY OUTREACH PROJECT,  P.O. BOX 35778  KAMPALA, UGANDA  ***Email address; kacopcommunity@gmail.com*** **To be implemented by:** ST. FRANCIS HEALTH CARE CENTRE, BULAGA-KALAMBI,  P.O. BOX 35778  KAMPALA, UGANDA **SUBMITTED 20/10/2012** |

**Introduction**

Kalambi Community Outreach Project (KACOP) is a local Ugandan Community-Based Organisation (CBO) started in 2009 by concerned residents of Wakiso Sub-County of Wakiso District in Central Uganda with the object of contributing to the reduction of poverty and improving the lives of the poor in the area through promotion of health, education and income generation initiatives. As a preliminary step, it has worked with local communities towards the goal of promoting poor people’s access to sustainable healthcare initiatives by carrying out grassroots health education campaigns in Bulaga-Kalambi and Kiwumu Local Council 1 Zones of Nakabugo and Buloba parishes respectively in Wakiso Sub-County.

This intervention followed a Community Needs Assessment done in the two local council zones of Bulaga-Kalambi and Kiwumu, in Nakabugo and Buloba parishes of Wakiso Sub-County, Wakiso District in August 2009, which, among other things, found that of 13,000 households studied, 11,050 (about 85%) were living in abject poverty (less than a dollar a day). One consequence of this was that they were unable to access even the most basic health services for their family members.

Subsequent Problem Analyses showed the underlying causes of this inability to lie, not just in the widespread poverty of the residents, but also in deep-rooted ignorance of good health practices for disease prevention, and relaxed attitudes to proper diagnosis and treatment practices. At least half of the households interviewed admitted to never boiling their drinking water, so that they were exceptionally vulnerable to diarrheal diseases. Another half claimed never to have used mosquito nets supplied by government despite having them, putting many of their number, especial young children below five years and expectant mothers, at great risk of malaria. Relaxed attitudes to antenatal care accounted for 45% of expectant mothers visiting a health care facility only when very close to delivery time, leading to a high incidence of miscarriages and child stunting. Moreover, at least 37% of expectant mothers were found to be below 18 years of age, having gotten pregnant while still in school and therefore having no sources of income to meet medical bills, even if they had wanted. There was also a high incidence of expectant mothers who had been abandoned by spouses for failure to shoulder the responsibility of care.

It was against this backdrop that KACOP sought to intervene by designing a project to carry out health education campaigns in the area, and to provide limited subsidization for some of the more desperate cases, especially young children, expectant mothers and the very elderly.

KACOP is in a particularly advantaged position to undertake this intervention because of its historical connection to St. Francis Health Care Centre, a well-known healthcare facility in the area with a qualified staff of dedicated personnel, who will carry out the community education in collaboration with local authorities and members of the community. The project seeks to engage the services of this Centre for treating its beneficiaries and implementing its health education campaigns.

There is little doubt that this intervention will contribute to alleviating the suffering of local communities and achieving Uganda’s national objectives in the health sector, as well as the global Millennium Development Goals (MDGs) by, among other things, reducing infant mortality rates, improving the welfare of expectant mothers and empowering the whole community to enjoy healthier and more productive lifestyles.

**Project Overview**

**Background & Context**

Wakiso is one of the 17 sub-counties that make up Wakiso District in Central Uganda. Though just 15 km outside Kampala, the capital, its setting is more rural than urban, subsistence farming is the chief economic activity and more than 85% of its inhabitants are desperately poor. Yet being near the capital, the Sub-County is very densely-populated, which encourages proliferation of diseases even as existing health services remain insufficient to meet people’s needs. Government hospitals and health centers[[1]](#footnote-2) are very far and under-facilitated[[2]](#footnote-3). Despite there being many private clinics in the sub-county, only a few relatively wealthy people can afford to get healthcare there. For the majority who are poor, it is clear that some form of subsidization is required if they are to receive the treatment they so badly need.

**Project Justification**

The people requiring subsidized healthcare are mostly the ordinary poor, an ‘invisible group’ who, being so-called ‘able-bodied’, do not evoke much pity from the world around them, which assumes they require no special assistance. Unlike special-interest groups[[3]](#footnote-4) who have attracted government and NGO attention in recent years, their crushing poverty is seen as just another sign of the times. This, of course, does not make them any less vulnerable, since the same poverty prevents them from enjoying the most basic of human rights - health. Frequent exposure to illnesses without the benefit of treatment also means their ability to engage in economic activity is reduced, so that they cannot extricate themselves from the poverty trap. Consequently, they cannot provide sufficient food or shelter for their families, send their children to school, or enjoy any of the other basic rights they are entitled to.

While giving such people increased access to medical care is no long-term solution to the underlying poverty, it will clearly save some of their lives and help free others from undue worry about their health, thus improving their ability to be economically productive, and to live in dignity.

**Involvement**

After nearly three years of operating St. Francis Health Care Centre[[4]](#footnote-5) on a commercial basis, its founders were moved by the plight of many suffering and even dying because they could not pay for even the most basic health services. Having witnessed poor people die of otherwise treatable conditions, they opened a charitable wing, giving free treatment to some of the most desperate cases. However, despite their best intentions, St. Francis’ financial resources are severely limited, threatening to bring their badly needed services to a standstill.

So, after extensive consultations with community leaders and a Community Needs Assessment in August 2009, they came up with the idea of Kalambi Community Outreach Project (KACOP) as a Community Based Organisation (CBO) totally independent and separate from the health Centre, but which will work in collaboration with it to provide health services to the poor in this community and work to improve their quality of life through community health education campaigns.

This proposal seeks funding assistance to enable KACOP to actualize its worthy mission of giving ‘the invisible poor’ their right to healthcare, so that they can participate more productively in the lives of their community, their country, and their world.

1. . **Project Description**
   1. **Project Goal**

To contribute to the improvement of needy people’s access to basic health services in Wakiso sub-county, Wakiso District by strengthening the capacity of a selected local health facility toprovide them with subsidized health services.

* 1. **Beneficiaries**

This project is designed to **directly** benefit specific people from some of the poorest households to be identified in the target area (Wakiso Sub-County) who will fall sick during the project period and seek medical care at St. Francis Health Care Centre. Emphasis will be on the most vulnerable among these, especially children under five years, expectant mothers and HIV/AIDS patients seeking emergency relief from opportunistic infections.

There will also be **indirect** beneficiaries in the families of those helped, who will be relieved of anxiety about family members’ treatment, and therefore freed to concentrate on their other work.

It will also benefit members of the wider community, such as families and schools, who will be sensitized on preventable disease management practices.

Finally, it will benefit St. Francis Health Care Centre staff members, who will be able to work in an improved structure and therefore serve the patients more effectively.

* 1. **Methods & Implementation Strategy**
* Working together with local authorities, project staff will undertake a community survey to identify most needy households deserving free or subsidized healthcare with regard to a spectrum of the most prevalent diseases that can be managed with low cost treatment.
* Members of the identified households will be sensitized on the workings of the proposed healthcare subsidization scheme
* Treatment will be given on a ‘when-and-as’ basis throughout the year
* In the meantime, monthly community sensitization meetings will continue in 12 different locations in the target area, to familiarize communities with preventable disease management practices
* The project will work in close collaboration with the Ugandan ministry of health and other local and national authorities to ensure that its activities are in line with national guidelines and aspirations, as well as with the Millennium Development Goals of the United Nations   
  1. **Duration of Project & Exit Strategy**
* This project is planned for an initial period of 1 year, after which it will be evaluated to ascertain its impact on and usefulness to the community and considered for continuation over the coming years.
* Projections for sustainability are quite favourable, considering success stories that have been achieved by other organizations in community health education and treatment of vulnerable populations, for example in the fishing communities of Lake Victoria where such programmes have been running for several years, with resounding success in terms of attitude and behavior change among locals.[[5]](#footnote-6)
  1. **Assumptions & Risks**
* The fundamental philosophical assumption of this project is that helping poor people access basic health services will increase their chances of participating in meaningful economic activity that can improve their material welfare, since they will be freed from the debilitating effects of disease. The inherent risk is that not everyone who gets better will necessarily engage in work to improve their welfare
* Project success is also predicated on the assumption that the community will embrace the project due to its inherent usefulness, and give it the support it needs for its implementation

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* 1. **Monitoring & Evaluation**
* Project staff teams will convene regular meetings to review project direction and progress, as well as make any adjustments needed to achieve project objectives
* Project staff will compile regular reports on the progress of the project for review by donors, the community and other stakeholders
* Project staff teams will make field visits to observe project activity, monitor impact of project on beneficiary communities, and report on such for the purpose of informing adjustments and development
* The project will be evaluated by an external consultant at the end of the year

1. **Financial Summary** 
   1. **Required Funding & BudgeT**

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| **Activity Category** | **Beneficiary Description** | **Estimated Cost ($US)** |
| Human Resource Costs-– | Project Staff Salaries and incentives | 7,680 |
| Community Sensitization &Health Education | Community Members | 6,720 |
| Medical treatment | Vulnerable poor children and expectant mothers for subsidized medical treatment | 7,200 |
| Project Supplies – Stationery & Equipment - Printing Paper, Printer Cartridges, IEC material production | Project Staff, Community Members | 1,440 |
| **TOTAL** |  | **23,040** |

* 1. **Picture Appendix**



*Figures 5&6 beneficiary children standing in front of st. francis health care centre builDING AFTER AN IMMUNISATION SESSION IN JANUARY 2010*

1. Government health facilities in Uganda are in theory supposed to give free services, but in reality there are often no drugs, and the health workers are few and not well-paid, so that those supposedly free services are virtually nonexistent. [↑](#footnote-ref-2)
2. According to a health worker at St. Francis Health Care Centre, there is only one ‘Health Centre 2’ in the neighbourhood of St. Francis’, which the locals hardly bother to attend because there are no drugs and they have to queue long hours to see a health worker. [↑](#footnote-ref-3)
3. A lot of government and NGO programs have been set up over the past decade and a half for HIV/AIDS-affected people, from which they can get anti-retroviral therapy (ART) and nutritional assistance; there are special programs for the handicapped, and a host of other ‘special-interest’ groups. [↑](#footnote-ref-4)
4. This Health Centre is located in Bulaga-Kalambi Local Council 1 Zone, Musaale-A-Nakabugo Parish, Mumyuka-Wakiso Sub-County, Busiiro County, Wakiso District. [↑](#footnote-ref-5)
5. For example, Huys Link Community Initiative (HUYSLINCI), a local NGO, has been carrying out substantial community health education programs in Katabi and Kasanje sub-counties, also in Wakiso District, since 2007. They have largely been successful, enabling communities to take charge of their own health management activities after project completion. (Source: HUYSLINCI Annual Review, 2009; Programme Reports, 2010) [↑](#footnote-ref-6)