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UK AID MATCH PROPOSAL FORM

This completed form will provide detailed information about your proposal and will be used to assess your proposal and inform funding decisions. It is very important you read the **UK Aid Match Guidelines for Applicants** and related documents before you complete this proposal form to ensure that you understand and take into account the relevant funding criteria.

How: You must submit a Microsoft Word version of your proposal and associated documents using the templates provided, by email, to **UKAidMatch@dfid.gov.uk.** The form should be completed using **Arial font size 12**. We do not require a hard copy.

When: All documentation must be received by the published funding round deadlines. Documents received after the deadline will not be considered.

What: You should submit the following documents: (all templates are on the UK Aid Match web page: www.gov.uk/uk-aid-match.

1. **Narrative Proposal**: Please use the form below, noting the following page limits:

- **Sections 4 – 7 : Maximum of 15 (fifteen) A4 pages.**

For applications for projects which will work in more than 1 country, you may use an additional 2 pages for each additional country (ie. an application for working in 3 countries can be a maximum of 19 pages).

- **Section 8 : Maximum of 3 (three) A4 pages per partner**

NOTE: Please complete **section 8 information** for your own organisation AND for each partner organisation involved in delivering your project.

Please do not alter the formatting of the form and guidance notes. Proposals that exceed the page limits or that have amended formatting will not be considered.

UK Aid Match funded projects can work in up to 3 countries. For proposals to work in more than one country or in different regions within a country, you will need to include information about each country/region where the project context, beneficiaries, approach or the expected results are different. This is to enable DFID to assess your proposal within each of the contexts you plan to use UK Aid Match funds in.

2. Logical framework and activities log: Please refer to the UK Aid Match Log-frame guidance and use the Excel log-frame template provided.

3. Project budget: Please use the template provided and refer to the UK Aid Match Guidance for Applicants (G1), the Budget Template Guidance (G3), and all tabs on the budget template. You also need to provide detailed budget notes (in the budget template) to justify the budget figures.

For proposals to work in more than one country or in different regions within a country: Where there are substantial differences in the costs of the project in different countries or regions within a country, you need to include these in the budget and provide an explanation for the differences.

4. Risk register/matrix: This should include the main risks related to the project and how you will manage these risks. Please use your own format for this.
5. Project organisational chart / organogram: All applicants must provide a project organisational chart or organogram which includes all the implementing partners and explains the relationships between them. Implementing partners are defined as those that manage project funds and play a prominent role in project management and delivery. The chart should also include other key stakeholders. (Please use your own format for this).

6. Project schedule or Gantt chart: All applicants must provide a project schedule or Gantt chart to show the scheduling of project activities (please use your own format for this).

7. Communications Plan: You will also need to complete a Communications Plan and submit this with your application. The plan is comprised of two parts (communications plan and activity timetable). You must also include final written evidence of commitment from your communications partner(s).

Before submitting your application, please ensure that you have included all relevant documents by completing the table at section 9.

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SECTION 1: INFORMATION ABOUT THE APPLICANT		
1.1	**Lead organisation name**	Sense International (SI)
1.2	**Contact person**	Name: Philip Middleton Position: Programme Funding Manager Email: philip.middleton@senseinternational.org.uk Tel: 02075200980

SECTION 2: BASIC INFORMATION ABOUT THE PROJECT		
2.1	**Project title**	Establishing Early Intervention services for infants with sensory impairments in Kenya and Uganda
2.2	**Country(ies) where project is to be implemented**	Kenya and Uganda
2.3	**Locality(ies)/region(s) within country(ies)**	Nairobi (Kenya) and Entebbe/Kampala (Uganda)
2.4	**Duration of grant request (***in months***)**	36 months
2.5	**Project start date** (*month and year)*	1st April 2016
2.6	**Total project budget?** *In GBP sterling*	£711,076
2.7	**How much do you expect your appeal to raise ? What percentage is this of the total project/programme budget ?**	£330,000 46%
2.8	**Please specify the % of project funds to be spent in each project country**	Kenya 53% Uganda 47%

3.1	**Which of the following Millennium Development Goals (MDGs) is the project contributing to (if any)?** - Please identify **between one and three** MDGs in order of priority (insert '1' for primary MDG focus area; '2' for secondary MDG focus area and; '3' for tertiary MDG focus area)	
	1. Eradicate extreme poverty and hunger	2
	2. Achieve universal primary education	
	3. Promote gender equality and empower women	
	4. Reduce child mortality	1
	5. Improve Maternal Health	

	6. Combat HIV/AIDS, malaria and other diseases	
	7. Ensure environmental sustainability	
	8. Develop a global partnership for development	
	None of the above (please explain below)	

SECTION 4: PROJECT DETAILS	
4.1	**ACRONYMS** For words which you would normally use acronyms for, please write these words in full the first time you use them, followed by the acronym in brackets, and use the acronym after that. Where you feel that it would be useful to provide an explanation of any acronym, please add these here.

- Congenital Rubella Syndrome (CRS)
- Early Intervention (EI)
- Expanded Programme of Immunisation (EPI) Laboratory, Ministry of Health, Uganda
- Global Alliance for Vaccines and Immunisation Alliance (GAVI)
- International Centre for Evidence in Disability (ICED)
- Kenya Medical Research Institute (KEMRI)
- Occupational Therapy (OT)
- Sense International (SI)
- Uganda Virus Research Institute (UVRI)
- Village Health Teams (VHTs)

4.2	**PROJECT SUMMARY: maximum 5 lines -** Please provide a brief project summary including the overall change(s) that the initiative is intending to achieve and who will benefit. Please be clear and concise and avoid the use of jargon *(This should relate to the outcome statement in the logframe).*

Working with hospitals and primary health centres in poor peri-urban centres of Kenya and Uganda, the first sensory screening programme for children aged 0-3 years will be established. Infants born with complex sensory impairments will have improved developmental outcomes, through accessing a specialist Early Intervention health service. This will contribute to reducing child mortality, developing the case for Governments to roll-out the approach and introduce the rubella vaccination.

4.3	**PROJECT RATIONALE (PROBLEM STATEMENT)** Describe the context for the proposed project, by considering the following questions. What specific aspects of poverty is the project aiming to address? What are the causal factors leading to poverty and/or disadvantage? (If applicable) what gaps in service delivery have been identified and how has your proposal considered existing services or initiatives? Which specific groups/people do you expect to benefit? Why and how were these groups chosen?

	How does the proposal fit with national/regional development plans ? How does it fit with activities of other development actors ? Why has the particular project location(s) been selected and at this particular time? Please also refer to your response to section 3.1 (fit with MDGs) when answering this section.

Specific aspects of poverty and causal factors leading to poverty and/or disadvantage:

People with disabilities and their families incur additional costs to achieve a standard of living equivalent to that of non-disabled people (WHO, 2011). Recent research by the International Centre for Evidence in Disability (ICED) shows that households with disabilities in low and middle-income countries spend significantly more of their income on health care than families without a member with a disability. World Health Surveys show families in poverty are more likely to take drastic measures to finance urgent treatment; like selling assets, taking out loans or reducing consumption of other necessary household items ('The Economic Costs of Exclusion and Gains of Inclusion of People with Disabilities'; ICED/CBM/LSHTM/Banks & Polack, 2014). The research highlights further additional barriers to accessing health care which are brought about by disability and poverty, with communication and physical barriers (e.g. accessibility and transport challenges), financial barriers (e.g. affordability is often cited as a primary reason people with disabilities do not seek or receive health services), attitudinal and institutionalised barriers (e.g. misconceptions and stigma can hinder provision of healthcare and signs of illness can be mistaken for being disability related). Disabled people face these barriers in both urban and rural areas – access to health care for people with disabilities is an indicator of equity in health systems (MacLachlan; Mannan & McAuliffe, 2011).

EI services for newborns and infants with sensory impairments will provide them with support as early as possible and give them the best possible chance of not needing more expensive medical interventions later in life, alleviating some of the extra costs that families with disabled children incur. Furthermore, evidence shows the importance of EI services for cognitive, emotional and social development, supporting people with sensory impairments to reach their full potential and participate in the community, including livelihood opportunities in the future. There is a wide body of evidence showing the critical importance of EI, particularly in the earliest years, which can reduce both private (individual and family) and public (government and societal) costs later in life (e.g. 'Early Intervention: smart investment, massive savings'; UK Cabinet Office, 2011*).* For example, *"The importance of the link between children's health, education, and well-being and poverty reduction is gaining recognition by policy makers working in international development"* ('Africa's Future, Africa's Challenge, Early Childhood Care and Development in Sub-Saharan Africa'; World Bank/Garcia et.al, 2008). Across the disability sector and Sense International's experience in East Africa there is substantial evidence to suggest that having a disabled child can be a cause of family break-up, for example fathers leaving when they cannot accept their child has a disability, putting more pressure on remaining family members to earn income as well as being primary carers, which can lead to poverty. Through providing family counselling, regular support of social workers and Community Health Workers, EI services will help to reduce these challenges.

Mortality for disabled children is as high as 80% even in countries where under-five mortality is below 20% (DFID, 2000). Latest available figures from Kenya and Uganda show that 7% of the population do not reach their fifth birthday, with child mortality rates of 73 per 1,000 in Kenya and 69 per 1,000 in Uganda (World Bank, 2012). The evidence shows the disproportionately high child mortality for children with disabilities (DFID, 2000; UN Enable website) and consequently EI services will help to reduce the risks children with sensory impairments would otherwise face. For example, people with disabilities may be more susceptible to developing chronic co-morbid conditions, are at greater risk of being exposed to violence and have higher risks of unintentional injury and premature death (WHO, 2011). *"EI can prevent ill health and reduce mortality and morbidity for children and young people"* (UK Dept. of Health, 2013).

Therefore, the project will contribute to both MDGs 1 and 2 which remain off-track in Kenya and

Uganda, focusing on a particularly vulnerable population excluded from services due to the various disability and poverty factors described.

Gaps in service delivery identified, consideration of existing services:
In both Kenya and Uganda, there are no screening and EI services for children with sensory and multi-sensory impairments. This means that newborn babies are not screened for visual and hearing impairments, nor provided with appropriate support in these crucial early years of development. Consequently, a model of screening and EI services needs to be established, which once demonstrated to be effective will be expanded to other hospitals/health centres in Kenya and Uganda. Following our discussions with Ministry of Health officials in both countries we have received confirmation that the different aspects of the proposed programme, including screening and research on rubella, will complement their priorities and fill a key gap. The Permanent Secretary in Uganda has stated that; *"The Ministry welcomes the introduction of screening of babies for congenital sensory impairments at Entebbe hospital as it will enable a much greater percentage of babies with congenital sensory impairments to be identified in the first few months of life when interventions such as sensory stimulation can have the biggest effect on the individuals future capacity to be able to use whatever residual vision and hearing they have to interact with the world around them"* (Dr. Stanley Bubikire, MoH Uganda on behalf of the Permanent Secretary, 17th November 2014). In Kenya, the Head of the Directorate of Preventative and Promotive Health Services stated; *"Improvement of Mother and Child Health is a key priority in our health strategies and the burden of rubella infection, congenital rubella syndrome and congenital malformations falls under this key priority area. This study will therefore be very important in providing much needed data on the burden of congenital rubella syndrome and other congenital malformations"* (Dr. Jackson Kioko, MoH, Kenya, 18th November 2014). Copies of letters enclosed and available at the following hyperlink:
http://www.senseinternational.org.uk/sites/default/files/Letters-of-support.pdf

Without EI, living with a complex disability becomes even more challenging, given the difficulties multi-sensory impaired people face in communication, mobility, learning, forming social relationships and being included in their communities. Children with sensory and multi-sensory impairments would otherwise face years of neglect or mis-diagnosis. These challenges are entrenched further when living in poverty. The project approach (ref. section 4.7) is to work with existing infrastructure – involving hospitals, health centres and Community Health Volunteers – to establish new and sustainable capacity to provide EI services. Data collected from the hospitals highlights that the majority of patients live below the poverty level, while working with community health centres and volunteers will ensure also that the poorest people unable to access the hospitals will not be left out.

Specific groups/people to benefit, why and how these groups were chosen:
By establishing screening equipment and skills required to identify sensory impairments, all newborns and infants in the target area will benefit – we estimate that 300,000 infants will be screened in the space of three years in the participating health services (2 hospitals and 6 primary health centres). All these children will be screened for sensory impairment (our experience in India shows that 10% of the 'at-risk' category of babies screened have been referred for EI support with the most 'at risk' babies including those born prematurely for example). While the EI programme will focus on the most complex multi-sensory impairments identified (deafblind and/or single sensory with associated disabilities), children with single sensory impairments will be referred to the relevant service within the existing health care system. So that the beneficiaries are not limited to those at the hospitals, the approach includes identification in communities by working with primary health centres and Village Health Team volunteers, to ensure an inclusive and wide reach.

The two partner district hospitals were selected for several reasons, including their strategic location within peri-urban areas of Wakiso district and Dagoretti sub-county, providing significant scope for the services established to be replicated later in other areas. Surveys within the target areas show

that 70% live below the globally recognised poverty level of $1.25 per day based on individual and household income analysis (please find details of surveys under 'Project location selection' below). In response to key feedback points from the concept note, this confirms the work is accessible to the poorest. In addition, for people for whom regular travel to the hospital may not be possible and to reach those children that are not born in hospital, the inclusion of 6 community health centres within the project design will ensure wider reach and rural engagement (this had led to an increase in the project costs overall, although we are confident this still provides value for money and will enable the project to benefit more people).

Fit with national/regional development plans:

Reducing child mortality and eradicating poverty, as part of the global MDGs, are both priorities of the Governments of Kenya and Uganda. Under-five mortality rates remain relatively high, at 71 per 1,000 live births (7.1%) in Kenya and 66 per 1,000 live births (6.6%) in Uganda (World Bank, 2013). *"Progress on the Millennium Development Goals is patchy, and especially weak on maternal and child health. New approaches to providing basic services such as health and education are needed if the millions of poor Kenyans are to prosper"* (DFID, 2013). In Uganda, *"Everyday, 16 women die whilst giving birth and over 90,000 children die each year before reaching their first birthday"* (DFID, 2013). DFID's Operational Plans 2011-2015 for both countries aim to contribute to health related MDGs by increasing the number of births attended by a skilled attendant. Kenya's National Development Plan, "Vision 2030" (2008-2030) makes special provisions for people with disabilities and previously marginalised communities while Uganda's "Vision 2040" includes human capacity building as one of its key tenets. We propose that this project can support DFID's upcoming announcement of a disability framework and the post-2015 agenda aiming to reach some of the most vulnerable children in developing countries as part of leaving no-one behind.

Fit with the activities of other development actors:

In addition to the aforementioned fit with the priorities of the Governments of Kenya and Uganda, including the respective Ministries of Health and contribution to DFID country priorities, the implementing partners (district hospitals and national research institutes) selected are those actors best placed to deliver the project outputs. Collaboration with community health centres will ensure people who cannot travel to the hospitals will not be left out. Establishing new research from the experience of East Africa's first EI programme for infants with sensory impairments and collecting data on the prevalence of rubella infection as the leading preventable cause of sensory impairments will build the case for applying to GAVI for funding to roll-out the national rubella immunisation by providing the data required that is specific to both Kenya and Uganda.

Project location selection:

The project locations, focusing on both urban areas and rural communities, have been selected strategically for several reasons:

1) To have optimum impact and potential for scale, it is important to establish the EI approach and demonstrate this within well connected urban hospitals, so that the EI service model can be more easily replicated at other hospitals in the future.

2) The hospitals selected are public district hospitals, not centralised private hospitals that would be inaccessible to poor people. Sample survey data collected by Entebbe Hospital over one month (9th Sept-9th Oct 2014) show that the poorest people are accessing services – 22% of the patients attending the hospital and 14% of their spouses are living on the equivalent of less than $1.25 per day. The average income of all patients (mothers) surveyed was $3.75 per day, showing that even those living above the internationally recognised poverty line are still in a very low income bracket. Taking this analysis further, it is important to analyse what these income levels mean for the overall household or family unit - when considering the average income of all 302 respondents where both parents provided data, which is $4.63 per day for both parents combined, if all of these households had four family members or more (based on average of 2 children or more per household) then the majority of families are living below the poverty line of $1.25 per person – 70% of families are

earning less than $5 per day combined, in other words less than $1.25 per person on average. Another recent study from Dagoretti sub-county in Kenya, around Mbagathi hospital, found the average income per household was $50-67 per month (Mwangi/Nairobi City Council, 2014) – this means that divided by 30 days, the majority of individuals are living on less than $1.25 per day income equivalent, apart from any households where there are only 1 or 2 inhabitants and we can estimate that most family sizes are much larger than this – the study itself says that the average number of persons per households in this region is 5, with a number of households headed by single mothers.

3) Working with community volunteers and health centres will enable people in rural communities outside of these urban hubs to benefit also, at the same time raising awareness and ensuring more people with sensory impairments are referred to hospitals for appropriate support.

4.4 TARGET GROUP (DIRECT AND INDIRECT BENEFICIARIES)

Who will be the DIRECT beneficiaries of your project ? Describe the direct beneficiary groups, and state how many people are expected to benefit, differentiating between male and female beneficiaries where possible, as well as other sub-groups.

DIRECT:	a) Description of groups:	• Infants screened: <u>300,000</u> • Infants/babies screened receiving EI for multi-sensory impairments: <u>360</u> • Parents/guardians supported in EI programme: <u>720</u> (360 x2) • Hospital/health centre staff trained: <u>294</u> • Village Health Team volunteers trained: <u>610</u>
	b) Number of beneficiaries:	Total: 301,984 Female (150,992) Male (150,992)

Who will be the **indirect (wider)** beneficiaries of your project intervention and how many will benefit? Please describe the type(s) of indirect beneficiaries and then provide a total number.

INDIRECT:	a) Description	• Other infants/babies with single sensory impairments referred for appropriate support (based on 10% prevalence rate): <u>30,000</u> • Other family members/siblings benefiting from the infants/babies improvements from EI: <u>1,080</u> (360 x 3)
	b) Number	Total: 34,080 Female (17,040) Male (17,040)

4.5 POTENTIAL PROJECT IMPACT

Please describe the anticipated impact of the project in terms of poverty reduction. What changes are anticipated for the beneficiary target groups identified in 4.4 (both direct and

	indirect beneficiaries) within the lifetime of the project?

Anticipated impact in terms of poverty reduction

The impact this initiative intends to achieve is improved health and development of newborn babies and infants identified with sensory impairments in Kenya and Uganda. Definitions of poverty increasingly recognize the importance of health in a wider concept of poverty:

"*Poverty is pronounced deprivation in well-being, and comprises many dimensions. It includes low incomes and the inability to acquire the basic goods and services necessary for survival with dignity. Poverty also encompasses low levels of health and education, poor access to clean water and sanitation, inadequate physical security, lack of voice, and insufficient capacity and opportunity to better one's life"* (World Bank 'Poverty and Inequality Analysis', 2011).

"Absolute poverty is a condition characterized by severe deprivation of basic human needs, including food, safe drinking water, sanitation facilities, health, shelter, education and information. It depends not only on income but also on access to social services" (Copenhagen Declaration, World Summit for Social Development, 1995).

The provision of EI services, including the training of professionals and provision of assistive devices where needed, will ensure that babies and infants with sensory impairments are supported from an early stage. Improving health outcomes will reduce poverty and better cognitive, emotional and social development from EI will increase future chances for children with sensory impairments to perform better in education and life opportunities. This will respond also to the challenges identified earlier that households with people with disabilities face additional health care related costs and people with disabilities themselves face additional barriers in reducing poverty.

Changes anticipated for target groups - direct beneficiaries:

A target of 300,000 infants and their families will benefit from screening services. Following screening and EI services, an estimated 360 children born with complex sensory impairments will have improved health, orientation and mobility, communication, speech and language, cognitive and educational development. Their families will be given the confidence to know they are caring for and interacting with their child in the best way to maximise their developmental potential – this will directly benefit 720 parents. 294 hospital/health centre based health professionals and local administrative staff will be trained to provide ongoing screening and EI services, ensuring sustainability beyond the project. Furthermore, there will be a reduction in stigma and negative attitudes towards persons with disabilities, as a result of 610 trained VHTs raising-awareness and benefiting families of disabled children.

Changes anticipated for target groups - indirect beneficiaries:

It is estimated that up to 10% (e.g. Government of Uganda, Demographic and Health Survey, 2011) of the population have some form of sensory impairment. While those with more complex impairments will receive direct EI support, others with less severe sensory impairments (estimated at 30,000 of those screened) will still be identified by the screening so that their families can follow-up where needed with assistive devices for example. Beyond the target groups benefitting from direct services in the project, other family members (1,080) including brothers and sisters will benefit from the improved health and development of their relative with sensory impairments, which will reduce the burden for parents/guardians/carers. There will be wider community awareness about sensory impairments and the availability of EI services. As referenced within Section 4.1 and considering key feedback points received on the concept note, we have received letters of support from the Ministry of Health confirming that they will support the future roll-out of this model to other hospitals beyond the project, providing even wider impact once the model has been demonstrated.

The prevalence of congenital sensory impairments and Congenital Rubella Syndrome (CRS) will be

established – providing the evidence required in building the case for the governments of Kenya and Uganda to apply to the Global Alliance for Vaccines and Immunisation Alliance (GAVI) for funding to roll-out national rubella immunisation campaigns. The rubella virus in pregnancy is the leading cause of preventable congenital defects, including deafblindness. Rubella has been eradicated as a cause in the UK, yet remains a major challenge in East Africa where immunisation is not yet provided. The Ministry of Health and project partners have confirmed their support to this too. If rubella is eradicated in Kenya and Uganda, this will benefit pregnant mothers in the future who would otherwise be at-risk of their child being born with congenital defects resulting from Rubella.

4.6	**DESIGN PROCESS** Describe the process of preparing this project proposal. Who has been involved in the process and over what period of time? How have the intended beneficiaries and other stakeholders been involved in the design?

Learning from SI's experience innovating EI in India and Romania has influenced the design process, along with discussions in East Africa and the UK over the last 12 months. We have refined our model of EI for adaptation in other countries. We have planned this project in partnership with KEMRI, MoH EPI, World Health Organisation (WHO) and staff from all relevant departments within Entebbe Hospital and Mbagathi District Hospital, while consulting also with relevant staff at the staff at the 6 primary health centres, Kenyatta National Hospital in Kenya and Mulago National Referral Hospital in Uganda. The enclosed letters of support confirm the involvement and support of key MoH personnel in the design process. We have consulted through meetings with a variety of partners and associations of parents of deafblind people, including mothers who contracted Rubella during pregnancy in order to ensure that the services established will meet the priority needs of the target group.

4.7	**PROJECT APPROACH** Please provide details on the project approach proposed to address the problem(s) you have defined in section 4.3. Why do you consider this approach to be the most effective way to achieve the project outcome ? Please justify the timeframe and scope of your project and ensure that the narrative relates to the logframe and budget.

We have chosen to adopt a multi-level approach to identifying infants with sensory impairments from engaging volunteer Village Health Teams to raise awareness at community level to screening newborn babies in maternity wards and infants aged 0-3 in immunisation clinics of primary health care centres and district hospitals. This approach has been chosen to give the greatest probability of identifying 100% of the infants with congenital sensory impairments within the target area as early as possible in their life, in order to have the optimum effect on learning and health outcomes as the child develops.

We have chosen an outreach model of delivering Early Intervention services to infants by training Village Health Teams (VHTs) to visit homes on a weekly basis in order to provide the necessary physical and communication therapy and sensory stimulation to the infants and to train parents how to perform the same therapy in between visits. Occupational Therapists, based at each hospital and health centre will assess the infants when first identified, will coordinate clinical assessments and medical interventions, and will oversee the home based therapy service in the local area surrounding their health facility by conducting monthly home visits in order to provide ongoing training to VHTs and periodic assessments of the infants' progress.

Output 1 – Capacity of two hospitals and six health centres built to provide screening and Early Intervention services for sensory impairments in infants.

We will develop the capacity of the 2 hospitals and 6 primary health centres to screen and identify sensory impairments in newborn babies in maternity wards and infants aged 0-3 years at immunisation clinics through the provision of specialist equipment and training for hearing and visual

testing. Occupational Therapy (OT) departments of each hospital will establish dedicated EI units capable of coordinating the EI programme, with assessment areas and equipment, and an office. We will also equip each of the primary health care facilities with an assessment and office area and equipment to enable the OTs stationed there to coordinate the EI service in their locality.

We will train 294 hospital and health centre staff and local administrators including - OTs, Nurses, Doctors, Clinical Officers, Counsellors and admin staff, on their involvement in the screening programme and Early Intervention service, including training on data management to ensure the effective monitoring of the project. In addition, Occupational Therapists will receive specialist training on Early Intervention from specialists from Sense (UK) and/or Sense (India). 614 Village Health Team volunteers will be trained to raising awareness about sensory impairments in infants within the community.

We have chosen to build the capacity of staff at hospital, health centre and community level in order to be able to maximise the chance of identifying, and providing an EI service to, all the infants with sensory impairments within the target area.

Output 2 - 300,000 infants between the ages of 0-3 years screened for sensory impairments.
The Early Identification system begins at Community Level with Village Health Teams raising awareness in the community about congenital disabilities through home visits to families and by engaging community groups and leaders. Parents will be given the knowledge to know when their baby has a problem with one or more of their senses and Village Health Teams themselves will also make this assessment during their regular home visits to families. Parents will then be encouraged by Village Health Teams to bring any children with suspected sensory problems to the local health centre for assessment. At Health Centre Level all the infants referred with suspected sensory impairments will be screened for hearing and visual impairments using specialist, easy to use equipment. In addition, all babies immunised at the health centres will be screened in the same way. Positive identifications at this level will be referred to the district hospital for assessment and for potential inclusion in the Early Identification programme. At District Hospital Level all babies delivered in the maternity ward, and all infants immunised at the hospital will be screened in the same way. In total an estimated 300,000 infants aged 0-3 years will be screened for congenital sensory impairments by specially trained staff. The hospitals will also be the coordination centres for the screening programme, Early intervention service and research into the prevalence of CRS.

Output 3 - 360 infants with complex sensory impairments are receiving a high quality home based Early Intervention service.
Children identified by screening as having complex sensory impairments (deafblind and/or single sensory with associated disabilities) will be admitted to the Early Intervention programme coordinated by the Occupational Therapy department of the hospital. The infant will be assessed by an Occupational Therapist as well as by the relevant specialist doctor (ENT and/or Ophthalmologist). Assistive devices, such as hearing aids, orthotics and sensory stimulation toys and equipment will be provided to each child as required. The OT department, who will receive specialist training on providing EI services, will coordinate the development of an Individual Development Plan for each child with input from the child's parents and relevant specialists leading to improved health. Parents will receive counselling so that they can come to terms with their child's disability and the infant will start to receive Early Intervention therapy on a weekly basis (including physical therapy, communication therapy and sensory stimulation) either at the hospital if they live close by or otherwise at a health centre through outreach clinics delivered by the OTs out of their mobile Early Intervention units that they will drive to each health centre for scheduled Early Intervention clinics. Through consultation with health centre staff and parents it was determined that only providing treatment at the hospital would be a barrier for some families where travel distances to the hospital were significant. Parents will learn from the OTs how best to care for and interact positively with their child at home to maximise their development potential. The OT team will make 6

monthly home visits to check on the progress of each child in the home environment and will coordinate 6 monthly reassessment of the child by the relevant specialists and will track the child's development milestones along the identified pathway in order to make adjustments to the pathway as required. The Occupational Therapists will arrange for Social Workers to support the families where appropriate.

Output 4 – Research is conducted in Kenya and Uganda into the prevalence of CRS using the data obtained from the screening programme.

Researchers at the Kenya Medical Research Institute (KEMRI) and the Uganda MoH Expanded Programme of Immunisation lab (MoH EPI) will conduct research to determine the prevalence of congenital sensory malformations and CRS which will lead to building the case for the governments to obtain funding from the GAVI Alliance to immunise against Rubella. MoH EPI will also test blood samples from infants identified with sensory impairments to find markers for Rubella that can be used to identify the virus during pregnancy or pregnancy planning. MoH letters of support included.

Output 5 – Early Intervention protocol, assessment tools and staff training manuals developed and research conducted into the effectiveness of the Early Intervention model.

Led by EI specialists from the UK we will develop and publish an EI protocol, assessment tools and training manuals in workshops consisting of MoH officials, medical professionals and parents. We have chosen to do this in order to provide a framework and knowledge base for rolling-out EI to many more hospitals throughout East Africa in the future, while containing quality standards to monitor and audit services in different locations.

Research will be conducted in parallel to the project activities to determine the effectiveness of the EI service model on children born with sensory impairments and their families. The research findings will be used to build the case for the governments of Kenya and Uganda to sustain the pilot EI services and with the anticipation these will be expanded to hospitals in other regions.

Choice of approach, timeframe and scope

In order to provide a comprehensive Early Intervention service likely to be sustained after the project finishes it is imperative to establish the service within the existing health system. Since the health system is structured around the district hospital with satellite health centres making health services accessible to the community and with Village Health teams providing the outreach service to households, we chose to establish the Early Intervention service utilising all levels of this existing structure. The service will therefore reach out into the poorest communities whilst maintaining its central coordination function from the OT department of the district hospital. In addition, we feel it is necessary to pilot the intervention within an entire district/sub-county in two separate countries in order to provide a robust demonstration of the efficacy of the model in different contexts. Lastly, to determine the impact on the health and learning outcomes of infants over the first three years of life it is necessary to run the pilot for three years.

4.8	**SUSTAINABILITY AND SCALING-UP** How will you ensure that the benefits of the project are sustained? How will costs of any posts or maintenance of infrastructure provided by the project be paid for after project funding finishes ? Please provide details of any ways in which you see this initiative leading to other funding or being scaled up through work done by others in the future.

Through the provision of training, specialist equipment and the establishment of an Early Intervention unit at Mbagathi and Entebbe hospitals and mobile units to conduct outreach clinics at primary health care centres the project will enable the screening programme and Early Intervention service to continue once the project has finished. The Early Intervention service has been specifically designed to reach poor people in their communities with transport costs to local outreach clinics minimised to ensure long term sustainability and affordability for families. The additional Occupational Therapists hired by the project will be retained by the health centres after the project

finishes with the hospitals expected to continue to fund the minimal costs for fuel and vehicle maintenance to keep the outreach services running in the long term.

Through engaging Ministry of Health officials on the project Steering Committees it is expected that the Ministry will increase provisions for infants with sensory impairments during the course of the project with a view to scaling-up screening and Early Intervention services at other hospitals and health centres. The aforementioned letters of support from MoH officials confirm that; *"The Ministry will plan for continued screening services at the hospital after the project expiry and upon demonstration of the effectiveness of screening will plan for roll out of the service to additional hospitals."* (Dr. Stanley Bubikire, for Permanent Secretary MoH Uganda, 17th November 2014).

4.9	**CAPACITY BUILDING, EMPOWERMENT & ADVOCACY** If your proposal includes capacity building, empowerment and/or advocacy objectives, please explain how they these objectives contribute to the achievement of the project's outcome and outputs? Please explain clearly why your project includes these elements, and what specific targets you have identified. Refer to the Guidance for Applicants for advice on this.

Capacity Building

1) The Training of hospital and health centre staff on screening is essential to be able to obtain positive identification of infants with sensory impairments whilst minimising the occurrence of false negatives. 2) Training volunteer Village Health Teams is required so they can raise awareness in communities on sensory impairments in infants in make it possible to identify these children to provide them with Early Intervention therapy services. 3) Capacity building of the hospital Occupational Therapy departments using experts on Early Intervention will be provided by Sense in order to develop a knowledge base, protocol and training and guidance manuals that will support the delivery of a high quality Early Intervention service in line with international practice but specifically designed for the local context. 4) Capacity building of both medical and administration staff provided by KEMRI and MoH EPI (UVRI) is required to establish robust systems of data collection sufficient for providing evidence on the prevalence of CRS.

Output 1 of the project is focused primarily on capacity building, with targets and indicators to measure the change in 'Average level of knowledge of screening and referral protocol of staff involved in the screening and referral process (disaggregated by gender)', 'Average level of knowledge of Early Intervention of Occupational Therapists responsible for delivering the service, tested by subject area experts', 'Number of Village Health Team volunteers involved in the Early Intervention programme with a basic knowledge of sensory impairments in infants (disaggregated by gender).'

Empowerment

The project responds to the 'choice, challenge and change' definition of empowerment (DFID, 2012). Families of children with complex sensory impairments will be trained to support and rehabilitate their children. Empowered families supporting their own child will improve the child's life chances in the domains of health, education and eventually livelihoods. Occupational Therapists will be empowered to provide a specialist Early Intervention service, which although part of the remit of their job, without being empowered to do so through training and resource provision has been unachievable prior to now.

Advocacy

Whilst a significant level of government contribution and commitment is already in place, advocacy efforts will ensure this continues and grows. The advocacy strategy builds upon existing relationships with Ministries of Health in each country by involving key officials in Project Steering Committees. Steering committee meetings will be complemented by meetings with ministerial planning departments to discuss future budgetary allocations for Early Intervention for infants with sensory impairments. Awareness will be raised, through media and meetings with Government, to

benefit the wider estimated 48,935 multi-sensory impaired population of East Africa. Learning from project reviews, evaluations and an independent research study will provide evidence of the cost-effectiveness and impact of Early Intervention, so combined advocacy contributes to long-term impact. Outputs 4 and 5 of the project are focused particularly on advocacy, with targets including the 'Number of infants identified through the screening programme tested for Congenital Rubella Syndrome' and a 'Research report published on effectiveness and impact of Early Intervention model'. These will form part of the data and tools required for advocacy.

4.10	**GENDER AND SOCIAL INCLUSION** How are you addressing any barriers to inclusion of particular people/groups which exist in the location(s) where you are working? Please be specific in relation to gender, age, disability, HIV/AIDs and other relevant categories depending on the context (e.g. caste, ethnicity etc.). How does the project take these factors into account?

The proposed project will impact positively on the situation of women and girls, including people with disabilities and people living in poverty, in the following ways:

- Infants with sensory impairments will be identified at birth, following screening for all babies, with EI support made available without any discrimination.
- The development of Individual Intervention Plans (or Early Intervention Pathways) will address the individual and varying needs of both male and female infants with different levels of sensory impairments (which can be a spectrum from low vision or hearing to no vision or hearing).
- The project will mainstream gender at each stage of the project cycle. At the *Identification* stage, the individual needs of babies (both girls and boys) will be ascertained. In *Planning and Implementation*, the project recognises that women and girls face additional barriers, for example in locations where cultural norms prioritise opportunities for boys over girls where resources are scarce. The counselling service provided to parents as part of EI will consider the different needs of mothers (many of whom are single mothers) and fathers. The counselling will be sensitive to negative dynamics between parents and other family members that are often caused by children being born with disability. In *Monitoring, Evaluating and Learning*, the project will collect gender disaggregated data to facilitate gender analysis and maintain gender equality.
- The research being carried out by KEMRI and MoH EPI will determine the prevalence of Congenital Rubella Syndrome (CRS), which is caused by Rubella infection of mothers during the first or second trimesters of pregnancy. The research will benefit pregnant women or women planning on becoming pregnant as well as helping to build the case for the governments to roll-out national immunisation campaigns for Rubella which will benefit the entire population.
- In 2013, SI conducted an organisation-wide gender audit, including a survey of staff. This led to a gender policy which is being implemented and one of the recommendations was for a gender training workshop for staff which will take place in East Africa in early 2015. This will strengthen further staff awareness and contribute to the gender analysis within this proposed project.
- SI requires all partners to implement a 'Child and Vulnerable Adult Protection Policy'.

4.11	**VALUE FOR MONEY (VFM)** Please demonstrate how you have determined that the proposed project would offer optimum value for money and that the proposed approach is the most cost effective way of addressing the identified problems.

We consider the quality of impact, based on the real change resulting for each individual as a key measure of value for money (VFM). Using key questions established by BOND's VFM paper (2013), this project offers value for money in the different aspects of the programme cycle - Identification, Planning, Implementation and Monitoring, Evaluation and Learning:

<u>VFM in Identification:</u> The project targets finding a group of vulnerable infants by screening for sensory impairments. Identifying these impairments as early as possible in life reduces the extra medical costs that families with disabled people tend to incur if undetected.

VFM in Planning: The project has a clear theory of change, with EI reducing the risks of child mortality and reducing the extra costs families with disabled relatives incur for medical interventions; there is a relatively low ratio of organisational to programmatic costs; EI provides lifelong and sustainable benefits – cognitive development in early years is particularly important for a person's development; leverages contributions from other sources through its appeal funding and co-funding commitment; KEMRI and MoH EPI have been conducting research on the prevalence of CRS, funded by the WHO – this project will expand their sample size considerably by screening all newborns in two hospitals and providing services for those with sensory impairments.

VFM in Implementation: Cost effectiveness and sustainability will be achieved by working with existing hospitals and training staff with screening and EI continuing after this 36 month project timeframe. The cost *per beneficiary* can be estimated as £2.37 per person screened (300,000 infants). Per month, it will cost an average of £55 per person receiving regular EI services (360 infants with sensory impairments divided by 36 months) and £11 per family member (360 x 5 relatives considering 2 parents and 3 siblings) as well as £67 per health professional trained, based on the total budget divided by each key target group number we plan to reach.

VFM in Evaluation and Learning: Research into the effectiveness of the EI service model will build the case for the government to financially support the services after the project has been completed. Evidence from this pilot and data on prevalence of sensory impairments in babies born in two hospitals will provide learning for the Governments of Kenya and Uganda to justify further the need for Rubella immunisations. Ultimately, this will reduce child mortality and health costs by contributing to the eradication of Rubella as a cause of sensory impairments in East Africa.

4.12	**LESSONS LEARNED** What lessons have you drawn on (from your own and others' past experience) in designing this project? Please describe the outcomes achieved and the specific lessons learned that have informed this proposal. (please also note question 8.15 on evaluations)

There is a wide body of evidence that this EI approach is likely to be successful, with key findings from RAND Corporation research (2014) showing significant social and economic outcomes:

1) Early childhood intervention programme yields benefits in academic achievement, behaviour, educational progression and attainment, delinquency and crime, among other domains.

2) Well-designed early childhood interventions have been found to generate a return to society ranging from $1.80 to $17.07 for each dollar spent on the programme.

From our experience of establishing EI programmes for infants with sensory impairments in India and Romania we know that hearing screening within the first 24 hours of birth will pick up all hearing impairments and that visual testing in the first few weeks of life is effective in capturing the vast majority of visual impairments. In 2011, SI (India) piloted a successful screening programme at a hospital in Bihar and since 2012 has developing an EI programme with 8 hospitals across the western and southern regions of India – to date, with support from DFID, 2,536 babies have been screened, 166 were identified as deafblind and are receiving regular EI support. Since 2005, in Romania SI has supported 65,000 babies to have their hearing screened at birth and 12,000 have had their vision screened, with 123 with multi-sensory impairment receiving regular EI support. SI's experience of EI, as well as the recent consultation with hospitals and research institutes in both Kenya (August 2014) and Uganda (September 2014) provides strong evidence that this proposed project can be successful and responds to the priority needs identified. A specific lesson learned from both India and Romania is the importance of identifying sensory impairments as early as possible, to increase chances for appropriate support and improved developmental outcomes. This will be the first EI programme for single-sensory and multi-sensory impairments in East Africa.

4.13	**ENVIRONMENT AND CLIMATE CHANGE** What are the opportunities and the risks of the project in relation to environmental sustainability and climate change ? Please specify what overall impact (positive, neutral or

	negative) the project is likely to have on the environment and climate change. Where relevant, please also specify what impact the environment and climate change are likely to have on the project. In each case, what steps have you taken to assess any potential impact? Please note the severity of the impacts and how the project will mitigate any potentially negative impacts, as well as how it will make use of opportunities to increase the positive impacts.
	The proposed intervention will not have a negative impact on the environment, with its focus within the health sector. At the same time, we have considered the potential impact of travel of beneficiaries and staff, which will primarily use public transport means in Kenya and Uganda. Including both hospitals and primary health centres within the project approach ensures that there are more local options for families to access EI, meaning less travel distances need to be covered by public or private transport. Establishing EI resource centres will require the procurement and use of equipment, but with no expected negative environmental impacts. SI adheres to Sense's 'Environmental Policy' (updated May 2014), which will be referenced in partner agreements along with other policy documents. This confirms our commitment towards the environment, including: • Compliance with all relevant environmental legislation and regulations. • Minimising our use of energy, whether electricity, gas, oil, or petrol/diesel. • Ensuring that vehicles in our fleet are well maintained and over time, continuing to replace vehicles with ones which produce less emissions. • Continuing to introduce and promote the use of equipment which minimise staff travel. • Implementing statutory or local authority guidance on waste and recycling and wherever possible minimising our waste and increasing our recycling. • Considering the environmental performance of suppliers and wherever possible specifying products which are made from recycled materials or which can be recycled or reused. • Giving information to and encouraging our staff and service users to consider environmental issues. • Continuously improving our environmental performance, considering annual reports on our performance and reviewing whether our policy needs to be updated.

SECTION 5: PROJECT MANAGEMENT AND IMPLEMENTATION	
5.1	**PROJECT MANAGEMENT** Please outline the management arrangements for this project. This should include: • A clear description of the roles and responsibilities of each of the partners. This should refer to the separate project organogram, which is required as part of your proposal documentation. • A clear description of the added value of the each organisation within the project. • An explanation of the human resources required (number of full-time equivalents, type, skills).

<u>Implementing partners</u>

SI Kenya and SI Uganda will coordinate the implementation of the project by: 1) Distributing funds to other partners and managing finances, 2) Monitoring project activities, 3) Coordinating the steering committee and annual review and learning process.

Mbagathi District Hospital (Kenya) and Entebbe Hospital (Uganda) will manage the screening process at the hospitals whilst also coordinating the Early Intervention service through the Occupational Therapy department providing therapy both at the hospital and at outreach clinics at health centres.

KEMRI and MoH EPI (UVRI) will collate the data on the number of infants identified with Congenital

Sensory Impairments and will conduct research into the number of children being born with CRS.

Collaborative partners

Health Centres: will screen infants for sensory impairments referring those positively identified to the district hospitals. Health Centres will also coordinate the work of Community Health Workers/Village Health Teams in reaching out to communities to raise awareness of congenital disability.
(Kenya Health Centres: Woodley Health Centre II; Ngong Road Health Centre II; Riruta Health Centre II / Uganda health centres: Ndejje Health Centre IV; Kasangati Health Centre IV; Wakiso Health Centre IV)

Referral hospitals: Kenyatta national Hospital (Kenya); Mulago National Referral Hospital (Uganda) will provide specialist vision and hearing assessments for children in the Early Intervention programme on a 6 monthly basis.

Sense will provide the technical advice and expertise required to develop country specific protocols and training and guidance manuals for Early Intervention. WHO is providing funding to KEMRI and UVRI for the research element of the project and will be a key stakeholder in reviewing the progress.

Human resources (5 FTE; 4 males, 5 females across the existing staff)

SI Kenya and Uganda Country Representatives (0.8 FTE; 1 male, 1 female): i) Oversee project management and finances in each country ii) Lead on advocacy and awareness raising campaigns.
SI Kenya, and Uganda Finance and Administration Officers (0.8 FTE; 2 female): i) Managing the disbursement of funds to project partners and the timely receipt of financial returns.
SI Kenya and Uganda Drivers (0.8 FTE; 2 male): i) Supporting project transport needs.
SI Kenya and Uganda Project Officers – NEW POSITIONS (2 FTE; #male, #female): i) Coordinate and monitor project activities.
SI UK Programme & Finance monitoring (0.6 FTE; 1 male, 2 female): i) Monitor progress; ii) Monitor expenditure against budget; iii) Manage risks; iv) Quarterly monitoring visits; v) Reporting.

Please refer to the separate Project Organisation Diagram for further details.

5.2	**NEW SYSTEMS, INFRASTRUCTURE, AND/OR STAFFING** Please outline any new systems, infrastructure, and/or staffing that would be required to implement this project. Note that these need to be considered when discussing sustainability and project timeframes.

1) There will be a new system of screening infants for sensory impairments at district hospital level, health centre level and community level. Training will be provided for all personnel involved in this new screening service. 2) There will be a new system of outreach EI service provision with Occupational Therapists based at the hospitals and health centres training VHTs to conduct outreach therapy on a weekly and monitoring these services via their own home visits on a monthly basis. This service will be coordinated by the OT departments at the hospitals. The 6 additional OTs will be stationed at the participating health centres in order to oversee the outreach Early Intervention service in each location. 3) There will be a new system of data collection coordinated by KEMRI/Uganda MoH EPI. The system will be designed to provide all the data necessary to support the research projects into the prevalence of CRS, whilst also keeping comprehensive records of all cases of Congenital Sensory Impairments. 2 data officers will be required. 4) Finally a system of project monitoring, review and shared learning will be established coordinated by a new Project Officer, who will be a newly employed member of staff at both SI Kenya and SI Uganda. The Project Officer will manage the communications between all stakeholders, will coordinate the project steering committee, will monitor project progress and will capture and share learning from the project amongst stakeholders, including from annual project reviews.

5.3	**COLLABORATION AND COORDINATION WITH OTHER DEVELOPMENT ACTORS** How will you coordinate project implementation with other development actors and ensure no

	duplication of effort (including with other DFID funded activities)? How will you work with local/national government and private sector providers?

The project steering committee, which will meet quarterly, will help to co-ordinate project implementation, as described further in section 6.1 below.

Key Government stakeholders and partners have provided aforementioned statements of support confirming that they support fully the approach being proposed which will complement their efforts to support the most vulnerable people, with copies included at the following link: http://www.senseinternational.org.uk/sites/default/files/Letters-of-support.pdf

SECTION 6: MONITORING, EVALUATION, LESSON LEARNING
This section should clearly relate to the project logframe and the relevant sections of the budget.

6.1	How will the performance of the project be monitored? Who will be involved? What tools and approaches are you intending to use? What training is required for partners to monitor and evaluate the project?

The quality and effectiveness of training will be monitored by measuring: 1) Average level of knowledge of screening and referral protocol of staff involved in the screening and referral process; 2) Average level of knowledge on Early Intervention of Occupational Therapists responsible for delivering the service, tested by subject area experts; 3) Number of Village Health Team volunteers involved in the EI programme with a basic knowledge of sensory impairments in infants.

Data from the screening programme and laboratory blood testing will be monitored by the research teams at KEMRI and UVRI. Numbers of infants screened, numbers of infants identified with multi-sensory impairments, those found to have Congenital Rubella Syndrome after blood testing and the percentage of false positives from the screening programme (confirmed by clinical assessment) will all be monitored. All this data will be collated by Data Officers working at the district hospitals with the whole process of data management being overseen by KEMRI and Uganda MoH EPI. The Sense International Project Officers will liaise with the research teams in order to also monitor the progress and effectiveness of the screening programmes.

The Early Intervention service will be coordinated by the Occupational Therapy departments of the district hospitals and monitored by the Sense International Project Officers. The Project Officers will monitor the average satisfaction level of parents with the Early Intervention service using period questionnaires and will also monitor the average frequency of therapy sessions using hospital/health centre records. Occupational Therapists and Project Officers will monitor the progress made by infants in the Early Intervention programme by monitoring progress against Individual Development Plans. In addition infants will undergo six-monthly clinical assessments by ENT doctors and Ophthalmologists to assess any changes in sensory function. Satisfaction levels of parents with the service will also be monitored. Independent research will be commissioned and published to document the Early Intervention model and to demonstrate its effectiveness in order to facilitate the potential future scale-up of the service by governments. The quality of the Early Intervention protocol, assessment tools and training manuals will be evaluated through peer review by international experts. In order to ensure that all the relevant data is collated and analysed properly training on data management will be given to the Data Officers and Occupational Therapists at the hospitals and to staff at each of the health centres as part of their induction on the project.

Quarterly steering committee meetings involving hospital management, MoH staff, Sense International management, research teams and other key stakeholders will be conducted in order to review the progress of the project and achievement towards the project outcome. In additional participatory annual review and learning workshops will be conducted in each country on an annual basis to capture lessons learned and make adjustments to the project design.

6.2	Please use this section explain the budget allocated to M&E. Please ensure there is provision for baseline and on-going data collection and a final independent evaluation. If you think there is a case for undertaking an independent mid-term review of the project (eg. if the project is testing a new approach, or working in a particularly difficult or sensitive context, or is high value), please include costs for this in your budget.

The budget allocated to M&E includes provision for annual review and learning workshops involving all stakeholders, a final external evaluation, and an independent research study which will demonstrate to governments the effectiveness and value for money of the Early Intervention model.

A budget for training on data management for Data Officers and Occupational Therapists at the hospitals and for staff at each of the health centres is included as part of the budget for induction training for these staff. A budget to pay a stipend to Data Officers and to the research teams is also included as are costs for KEMRI/ Uganda MoH EPI to produce research reports.

A separate budget for a baseline survey is not required as baselines on the level of knowledge of sensory impairments in infants of parents within communities and the Village Health Teams tasked with raising awareness will be collected through surveys at immunisation clinics and at training of VHTs respectively. In the same way the baseline level of knowledge of Occupational Therapists on Early Intervention will be tested at the first training of Occupational Therapists by experts from Sense from the UK and/or India which will be scheduled for the start of the project.

6.3	Please explain how the learning from this fund will be incorporated into your organisation and disseminated, and to whom this information will be targeted (e.g. project stakeholders and others outside of the project). If you have specific ideas for key learning questions to be answered through the implementation of this project, please state them here.

Learning will be obtained from each target group and partner during annual project reviews. They will consider each output; discuss what went well and not so well; and what could be improved. Findings will be shared with Governments, District and county Health Offices, Hospitals, Health Centres, schools, families, DPOs, related NGOs, SI country offices, Sense, WHO, DFID, and co-funders. After each annual review and evaluation the steering committee will decide on changes to the project as a result of learning, and seek approvals from SI and DFID.

Recommendations for the future development of Early Intervention and its protocol will be provided, including an external research study on the impact and cost effectiveness of Early Intervention for infants with sensory impairments.

Ideas for key learning questions include: What are the most effective ways for increasing government commitment for Early Intervention and screening? What health and education outcomes of children with sensory impairments are improved by Early Intervention services?

SECTION 7: PROJECT RISKS AND MITIGATION	
7.1	How does your organisation identify and manage risks associated with the delivery of a project? Please include with your application a separate **risk register/matrix** showing the risks associated with your proposed project and how you will mitigate them, for which you should use your own format.

SI has a risk register to monitor organisational risks. For each project we have a risk matrix which includes mitigation measures if required. Please find enclosed the risk register with details on each of the identified project related risks, potential impact (low/medium/high), probability (low/medium/high) and mitigation measures. These are risks primarily within the control of the project, its planning and management, as described by the mitigation measures.

The overall risk rating is low. The logframe provides assumptions for each output.

SECTION 8: CAPACITY OF APPLICANT ORGANISATION AND ALL IMPLEMENTING PARTNER ORGANISATIONS (Max 3 pages each) Please copy and fill in this section for your organisation **AND for each implementation partner**						
8.1	**Name of Organisation**	Sense International				
8.2	**Address**	101 Pentonville Road, London, N1 9LG, United Kingdom				
8.3	**Web Site**	www.senseinternational.org.uk				
8.4	**Registration or charity number (if applicable)**	Registered number 3742986 Charity number 1076497				
8.5	**Annual Income**	Income (original currency): £1,421,778 Income (£ equivalent): £1,421,778 Exchange rate: N/A ***Start/end date of accounts (dd/mm/yyyy***) From: 01/04/2013 To: 31/03/2014				
8.6	**Number of existing staff**	10 (6 female, 4 male)				
8.7	**Proposed project staffing staff to be employed under this project (specify the total full-time equivalents - FTE)**	Existing staff	4 (contributing part of time in-kind)			
		New staff	0			
8.8	**Organisation category** (Select a maximum of two categories)					
	Non-Government Org. (NGO)	✓	Local Government			
	Trade Union		National Government			
	Faith-based Organisation (FBO)		Ethnic Minority Group or Organisation			
	Disabled Peoples' Organisation (DPO)		Diaspora Group or Organisation			
	Orgs. Working with Disabled People	✓	Academic Institution			
	Other... (please specify)					
8.9	**A) Summary of expected roles and responsibilities, AND** **B) Amount (and percentage) of project budget which this partner will directly manage.**					

A): Sense International will have overall oversight and project management responsibilities; co-ordinating with the project's implementing partners. The Senior Programme Manager for East Africa will manage and review quarterly reports from SI Kenya and SI Uganda, participating in regular monitoring visits to both project countries. The Programme Funding Manager will be responsible for preparing and submitting reports to DFID. The Finance Manager will support the completion of quarterly claims and financial reports, as well as providing technical support to the Finance & Administration Officers in Kenya and Uganda. The International Policy Officer will support efforts to raise awareness about the case for Rubella vaccinations and the impact of the programme.
B): As the applicant organisation, Sense International will be responsible for managing 100% (£711,076) of the project budget, transferring funds on a quarterly basis via Sense International (Kenya) and Sense International (Uganda). Please refer to other partner forms for the approximate amount and percentages each partner will directly manage.

8.10	**EXPERIENCE:** Please outline this organisation's experience in relation to its roles and responsibilities on this project (including technical issues and relevant geographical coverage). Please include details of any external evaluations of this organisation's work (relevant to the proposed project) which have been completed and whether they are available.

Sense International was established in March 1999 and since then has managed projects for deafblind people in Europe, East Africa, South America and South Asia. The current portfolio of projects includes projects in Bangladesh (DFID CSCF), East Africa (European Union), India (DFID GPAF and EU EIDHR) and Peru (European Union), as well as several other projects funded by individual donors or trusts.

8.11	**FUND MANAGEMENT:** Please provide a brief summary of this organisation's recent fund management history. Please include source of funds, purpose, amount and time period covered.

For the year ended 31 March 2014, main sources of funding are voluntary income (£579,201), activities for generating funds (£437,536), and incoming sources from statutory authorities (£404,690). Statutory income includes Big Lottery Fund, DFID, EU and Jersey Overseas Aid Commission. For any donor grant for either specific projects, activities or with specific terms and conditions that apply to their funding we operate fund accounts. When this restricted income is received a fund is set up in the donor's name noting any restriction given (e.g. country, project, and activity of use). This ensures that these funds can only be spent as per the donor's requirements. On a quarterly basis the expenses incurred in country are then reconciled to the fund balances and the balances amended. We are able to report all income and expenditures that have gone through a fund account to ensure that all the required restrictions have been adhered to.

8.12	**CHILD PROTECTION (for projects working with children and youth (0-18 years) only)** How does this organisation ensure that children and young people are kept safe? Please describe any plans to improve the organisation's child protection policies and procedures for the implementation of this project.

Sense International has a child protection policy which all project partners are also required to adhere to. This policy was recently reviewed and updated in April 2012.

8.13	**FRAUD:** Has there been any incidence of any fraudulent activity in this organisation within the last 5 years? How was the fraud detected ? What action did your organisation take in response ? How will you minimise the risk of fraudulent activity occurring?

There have been no incidences of fraudulent activity.

8.14	**DUE DILIGENCE:** Please provide brief details of any due diligence assessments of the organisation conducted on behalf of DFID or other donors within the past 5 years. Please include date, organisation responsible for the assessment, brief comments, and a link to the assessment, if available.

Sense International received a due diligence site visit from KPMG from 3rd-4th November 2011. The assessment noted the following examples of good practice at the Grantee:
Governance: Grantee oversight of sub-grantee;
Systems, processes and procedures: Strong IT systems and data protection;
Results and impact: Detailed monitoring plan for logframe.
Please find details in the report at the following link:
http://www.senseinternational.org.uk/sites/default/files/KPMG-DFID-GPAF-Due-Diligence-Report.pdf

8.15	**EVALUATION:** Please provide details of any independent evaluations of the organisations work that are relevant to the project proposal. Are these published? If not, can they be shared with DFID?

Sense International commissions independent evaluations of all its major programmes. Please find the recent evaluation listed below, all of which are available to share with DFID upon request. The hyperlinks to evaluations of the most relevant projects are included, from East Africa where experience of community-based rehabilitation highlighted the needs of deafblind people and from India where an early intervention/screening programme has been started at hospitals.

East Africa Regional EU:
Title: 'Developing a Sustainable Infrastructure for the Inclusion of Deafblind and Multi-Sensory Impaired People in East Africa: External Evaluation report'
Contract Number: DCI-NSAPVD/2009/219-813. Date/Year: March 2013. Author: Nicholas Young
http://www.senseinternational.org.uk/sites/default/files/YOUNG-EC-REGIONAL-EVALUATION-(FINAL).pdf

Tanzania EU:
Title: Final Project Evaluation: 'Promoting Access to Education for Deafblind and Multi-Sensory Impaired (MSI) Children in Tanzania'
Contract Number: NSA/PVD/2008/149-665. Date/Year: November 2013. Author: Kokuteta Mutembi

Bangladesh DFID:
Title: Developing a Sustainable Infrastructure for the Inclusion of Deafblind people in Bangladesh: End Term Evaluation Report
Contract Number: CSCF-440. Date/Year: June 2013. Author: Moumita Saha and Julian Francis

India DFID:
Title: Mid-term Evaluation DFID Global Poverty Action Fund Programme: Expanding Services for Deafblind People in India 2012-2015
Contract Number: GPAF-IMP-009. Date/Year: June 2014. Author: Aloka Guha
http://www.senseinternational.org.uk/sites/default/files/DFID-GPAF009-Mid-Term-Evaluation-Final-June-2014.pdf

India EU:
Title: 'Developing a model of services and sustainable infrastructure for the integration of deafblind people in India: End of project evaluation'
Contract number: ONG-PVD/2006/119572. Date/Year: April 2012. Author: Aloka Guha

Peru EU:
Title: 'Final Assessment Report of the Project: Development of a Service Model and a Sustainable Infrastructure for the Integration of Deafblind People in Peru'
Contract Number: ONG-PVD/2007/133-828. Date/Year: December 2012. Author: Julio Guerra

Latin America BLF:
Title: 'Final Evaluation for the Project: Promoting the Social Inclusion of Deafblind People in Latin America'
Contract Number: ICB/1/010252011. Date/Year: December 2011. Author: Julio Guerra

KENYA

SECTION 8: CAPACITY OF APPLICANT ORGANISATION AND ALL IMPLEMENTING PARTNER ORGANISATIONS (Max 3 pages each)
Please copy and fill in this section for your organisation **AND for each implementation partner**

8.1	**Name of Organisation**	Sense International (Kenya)	
8.2	**Address**	*Physical:* Internet business Centre, Plums Lane, off Ojijo Road, Parklands *Postal:*P.O. Box 53597, 00200 Nairobi, Kenya	
8.3	**Web Site**	N/A	
8.4	**Registration or charity number (if applicable)**	no. OP.218/051/2004/0380/3458	
8.5	**Annual Income**	Income (original currency): Kes 27,776,081 Income (£ equivalent): £218,537 Exchange rate: 127.1 ***Start/end date of accounts (dd/mm/yyyy***) From: 01/04/2013 To: 31/03/2014	
8.6	**Number of existing staff**	5	
8.7	**Proposed project staffing staff to be employed under this project (specify the total full-time equivalents - FTE)**	Existing staff	3 – Part time (1.2 FTE equivalent) Country Representative 0.4 FTE Finance & Admin Officer 0.4 FTE Driver 0.4 FTE
		New staff	Project Officer 1 FTE

8.8	**Organisation category** (Select a maximum of two categories)				
	Non-Government Org. (NGO)	✓	Local Government		
	Trade Union		National Government		
	Faith-based Organisation (FBO)		Ethnic Minority Group or Organisation		
	Disabled Peoples' Organisation (DPO)		Diaspora Group or Organisation		
	Orgs. Working with Disabled People	✓	Academic Institution		
	Other... (please specify)				

8.9	**A) Summary of expected roles and responsibilities, AND** **B) Amount (and percentage) of project budget which this partner will directly manage.**

A): 1) Project management & coordination of the project within Kenya 2) Monitoring 3) Advocacy for project uptake by government.

B): Approximately 53% (£376,870).
Please note this includes the allocations for other partners also in Kenya as funds will be transferred from Sense International in the UK to Sense International Kenya. The amount attributable to SI Kenya specific activities is approximately 30% (£213,323) of the total.

8.10	**EXPERIENCE:** Please outline this organisation's experience in relation to its roles and responsibilities on this project (including technical issues and relevant geographical coverage). Please include details of any external evaluations of this organisation's work (relevant to the proposed project) which have been completed and whether they are available.

The organization has worked with deaf blind and MSI children in Nairobi, Kwale & Kericho for the last seven years during this period, the organization has provided technical and administrative support to deaf blind people, their families and local partner organizations to identify, assess, rehabilitate deaf blind and MSI children. The organisation has also worked with government through the Ministries of Education and Health which have scaled up some of its work. During the project for strengthening services for deaf blind people which was European Commission funded(2010- 2013), the organization reached over 300 deaf blind people and their families (Evaluation report enclosed in hyperlink under section 8.15).

8.11 **FUND MANAGEMENT:** Please provide a brief summary of this organisation's recent fund management history. Please include source of funds, purpose, amount and time period covered.

Name of Project	Year of Implementation	Funder	Amount
Kenya Vocational Project (Wezesha)	**2011-2014**	**Sunil Shah and Friends**	**Kes 30,465,982 (£237,701)**
Strengthening services for Deaf blind people and their families	**2010-2013**	**European Union**	**Kes 32,982,038 (£259,497)**
Community Based Education	**2014-2017**	**Big Lottery Fund**	**Kes 44,356,356 (£348,988)**

8.12 **CHILD PROTECTION (for projects working with children and youth (0-18 years) only) How does this organisation ensure that children and young people are kept safe? Please describe any plans to improve the organisation's child protection policies and procedures for the implementation of this project.**

SI Kenya has a child protection policy and a person in charge of enforcing the policy.

8.13 **FRAUD: Has there been any incidence** of any fraudulent activity in this organisation within the last 5 years? How was the fraud detected ? What action did your organisation take in response ?How will you minimise the risk of fraudulent activity occurring?

SI Kenya has an anti-fraud policy well spelt out and being implemented according to its human resource manual and other guidelines.

8.14 **DUE DILIGENCE: Please provide brief details of any due diligence assessments of the organisation conducted on behalf of DFID or other donors within the past 5 years. Please include date, organisation responsible for the assessment, brief comments, and a link to the assessment, if available.**

Annual Audits by Ashwin Brothers (2009 to date). All audits reports have been satisfactory.
The Kenya National Council of Non-Governmental Organization has given compliance certificates from 2009 to date.

8.15 **EVALUATION: Please provide details of any independent evaluations of the organisations work that are relevant to the project proposal. Are these published? If not, can they be shared with DFID?**

Evaluation for the project strengthening services for deaf blind people (2010 to 2013).

http://www.senseinternational.org.uk/sites/default/files/YOUNG-EC-REGIONAL-EVALUATION-(FINAL).pdf

SECTION 8: CAPACITY OF APPLICANT ORGANISATION AND ALL IMPLEMENTING PARTNER ORGANISATIONS (Max 3 pages each)
Please copy and fill in this section for your organisation **AND for each implementation partner**

8.1	**Name of Organisation**	Mbagathi District Hospital	
8.2	**Address**	20725-00202	
8.3	**Web Site**		
8.4	**Registration or charity number (if applicable)**	GOK- facility	
8.5	**Annual Income**	Income (original currency): 500 Million KES Income (£ equivalent): £3,933,910 Exchange rate: 127.1 ***Start/end date of accounts (dd/mm/yyyy***) From:1/07/2014 To: 30/06/2014	
8.6	**Number of existing staff**	400	
8.7	**Proposed project staffing staff to be employed under this project (specify the total full-time equivalents - FTE)**	Existing staff	41 Health professionals (nurse, doctors, clinical officers, therapists) trained
		New staff	Hospital data officer 1 FTE

8.8	**Organisation category** (Select a maximum of two categories)			
	Non-Government Org. (NGO)		Local Government	Yes
	Trade Union		National Government	
	Faith-based Organisation (FBO)		Ethnic Minority Group or Organisation	
	Disabled Peoples' Organisation (DPO)		Diaspora Group or Organisation	
	Orgs. Working with Disabled People		Academic Institution	
	Other... (please specify)			

8.9 **A) Summary of expected roles and responsibilities, AND**
B) Amount (and percentage) of project budget which this partner will directly manage.

A): We will be responsible for screening and identifying sensory impairments in newborn babies in maternity wards and infants aged 0-3 years at immunisation clinics, following the provision of specialist equipment and training for hearing and visual testing. We will establish a dedicated Early Intervention unit capable of coordinating the EI programme, with assessment areas and equipment, and an office. We will also equip each of the primary health care facilities with an assessment and office area and equipment to enable the OTs stationed there to coordinate the EI service in their locality. We will train 294 hospital and health centre staff and local administrators including - OTs, Nurses, Doctors, Clinical Officers, Counsellors and admin staff, on their involvement in the screening programme and Early Intervention service

B): Approximately 10% (£71,108).

	EXPERIENCE: Please outline this organisation's experience in relation to its roles and responsibilities on this project (including technical issues and relevant geographical coverage). Please include details of any external evaluations of this organisation's work (relevant to the proposed project) which have been completed and whether they are available.
This facility has been involved in research collaboration with Kenya Medical Research Institute, universities, CDC, Kenyatta National Hospital referral facility for sub-country facilities. Have relevant personnel mix for the study including paediatrician / gynaecologist / physician/ Occupational Therapist/ Nurses/ Clinical Officers. Have large catchment population, adequate diagnostic/ labour back up. Have space for creating an office space.	
8.11	**FUND MANAGEMENT:** Please provide a brief summary of this organisation's recent fund management history. Please include source of funds, purpose, amount and time period covered.
Uses public finance management systems. Exchequer and fees- Appropriation-In-Aid.	
8.12	**CHILD PROTECTION** (for projects working with children and youth (0-18 years) only) How does this organisation ensure that children and young people are kept safe? Please describe any plans to improve the organisation's child protection policies and procedures for the implementation of this project.
We use national guidelines on child protection / rights. All personnel are conversant with the professional ethics and are answerable to their respective registration boards.	
8.13	**FRAUD: Has there been any incidence** of any fraudulent activity in this organisation within the last 5 years? How was the fraud detected? What action did your organisation take in response? How will you minimise the risk of fraudulent activity occurring?
We do have minor incidences which are handled administratively through the disciplinary committees. Adherence to code of ethical conduct and addressing fraud using the laid down procedures. We have anti-corruption committees in the hospital.	
8.14	**DUE DILIGENCE: Please provide brief details of any due diligence assessments of the organisation conducted on behalf of DFID or other donors within the past 5 years. Please include date, organisation responsible for the assessment, brief comments, and a link to the assessment, if available.**
This was done by Ethics and Anti-Corruption Commission in 2011.	
8.15	**EVALUATION: Please provide details of any independent evaluations of the organisations work that are relevant to the project proposal. Are these published? If not, can they be shared with DFID? .**
Several evaluations especially use of reproductive health copies can be made available	

SECTION 8: CAPACITY OF APPLICANT ORGANISATION AND ALL IMPLEMENTING PARTNER ORGANISATIONS (Max 3 pages each)
Please copy and fill in this section for your organisation **AND for each implementation partner**

8.1	**Name of Organisation**	Kenya Medical Research Institute (KEMRI)	
8.2	**Address**	P.O. Box 54840-00200 Nairobi, KENYA	
8.3	**Web Site**	www.kemri.org	
8.4	**Registration or charity number (if applicable)**	N/A	
8.5	**Annual Income**	Income (original currency): Total income Kes. 8,431,715,000 Income (£ equivalent): £56,211,433 Exchange rate: 1£ equivalent to Kes 150 ***Start/end date of accounts (dd/mm/yyyy***) From: 1st July, 2013 To: 30th June, 2014	
8.6	**Number of existing staff**	994 (KEMRI main - employees) 2,911 (KEMRI Projects - employees)	
8.7	**Proposed project staffing staff to be employed under this project (specify the total full-time equivalents - FTE)**	Existing staff	3
		New staff	

8.8	**Organisation category** (Select a maximum of two categories)			
	Non-Government Org. (NGO)		Local Government	✓
	Trade Union		National Government	
	Faith-based Organisation (FBO)		Ethnic Minority Group or Organisation	
	Disabled Peoples' Organisation (DPO)		Diaspora Group or Organisation	
	Orgs. Working with Disabled People		Academic Institution	✓
	Other... (please specify)			

8.9	**A) Summary of expected roles and responsibilities, AND** **B) Amount (and percentage) of project budget which this partner will directly manage.**

A): Researchers at KEMRI will conduct research to determine the prevalence of congenital sensory malformations and CRS which will lead to building the case for the governments to obtain funding from the GAVI Alliance to immunise against Rubella.

B): Approximately 5% (£35,554).

8.10	**EXPERIENCE:** Please outline this organisation's experience in relation to its roles and responsibilities on this project (including technical issues and relevant geographical coverage). Please include details of any external evaluations of this organisation's work (relevant to the proposed project) which have been completed and whether they are available.

KEMRI has conducted collaborative research for the last 30 years. Kemri has also undergone auditing for compliance with OMB circular A133 by DCAA under the arrangement of USAMRU in the year 2009 and 2010/11. The institute is also routinely audited by various stakeholders represented by the list of donors in sections 8:11 below.

8.11	**FUND MANAGEMENT:** Please provide a brief summary of this organisation's recent fund

	management history. Please include source of funds, purpose, amount and time period covered.
KEMRI manages large funds from the Kenya Government and from bilateral donors. Some of the donors are University of California, American Embassy, Case Western Reserve, University, Drugs for Neglected Diseases Initiative (DNDI), National Institutes of Health, NIH, EDCTP, Liverpool School of Tropical Medicine, bilateral donors amounting to approx. Keshs.7,308,000,000 equivalent to approx. USD84M in any financial year.	
8.12	**CHILD PROTECTION (for projects working with children and youth (0-18 years) only) How does this organisation ensure that children and young people are kept safe? Please describe any plans to improve the organisation's child protection policies and procedures for the implementation of this project.**
The institute has an Ethics review committee that evaluates all projects before implementation and has particular concern for vulnerable populations which includes children and those under the legal age of majority. All researchers undertaking human research take an exam on ethics every two years. They are answerable to ERB at KEMRI.	
8.13	**FRAUD: Has there been any incidence** of any fraudulent activity in this organisation within the last 5 years? How was the fraud detected? What action did your organisation take in response? How will you minimise the risk of fraudulent activity occurring?
No there has not been any fraud incidence that is under investigation or alleged in the last 5 years.	
8.14	**DUE DILIGENCE: Please provide brief details of any due diligence assessments of the organisation conducted on behalf of DFID or other donors within the past 5 years. Please include date, organisation responsible for the assessment, brief comments, and a link to the assessment, if available.**
This has not been done in the last 5 years.	
8.15	**EVALUATION: Please provide details of any independent evaluations of the organisations work that are relevant to the project proposal. Are these published? If not, can they be shared with DFID?**
KEMRI has also been audited by DCAA for compliance to OMB circular A-133. There has not been any independent evaluation of the institute. Regular institute audits both finance and systems have been conducted regularly. The last institute audit can be forwarded as a published document.	

UGANDA

SECTION 8: CAPACITY OF APPLICANT ORGANISATION AND ALL IMPLEMENTING PARTNER ORGANISATIONS (Max 3 pages each) Please copy and fill in this section for your organisation **AND for each implementation partner**		
8.1	**Name of Organisation**	Sense International (Uganda)
8.2	**Address**	*Physical:* Plot No. 99 Martyrs Way, Ntinda-Nakawa Road, *Postal:* P.O. Box 72611, Kampala, Uganda
8.3	**Web Site**	
8.4	**Registration or charity number (if applicable)**	Registered with the NGO Board – S 5914/6927 of 2007 AND Certificate of incorporation no. 91402 of 2007
8.5	**Annual Income**	Income (original currency): 696, 437,843 Uganda Shs Income (£ equivalent): £174,215

		Exchange rate: 3997.58 ***Start/end date of accounts (dd/mm/yyyy***) From:1st April 2013 To: 31st March 2014	
8.6	**Number of existing staff**	4	
8.7	**Proposed project staffing staff to be employed under this project (specify the total full-time equivalents - FTE)**	Existing staff	3 – Part time (1.2 FTE equivalent) Country Representative 0.4 FTE Finance & Admin Officer 0.4 FTE Driver 0.4 FTE
		New staff	Project Officer 1 FTE

8.8	**Organisation category** (Select a maximum of two categories)				
	Non-Government Org. (NGO)	✓	Local Government		
	Trade Union		National Government		
	Faith-based Organisation (FBO)		Ethnic Minority Group or Organisation		
	Disabled Peoples' Organisation (DPO)		Diaspora Group or Organisation		
	Orgs. Working with Disabled People	✓	Academic Institution		
	Other... (please specify)				

8.9	**A) Summary of expected roles and responsibilities, AND** **B) Amount (and percentage) of project budget which this partner will directly manage.**

A): SI Uganda will coordinate the implementation of the project in Uganda by: 1) Disbursing funds to other partners and managing finances, 2) Monitoring project activities, 3) Coordinating the steering committee and annual review and learning process.

B): Approximately 47% (£334,206). Please note this includes the allocations for other partners also in Uganda as funds will be transferred from Sense International in the UK to SI Uganda. The amount attributable to SI Uganda specific activities is approximately 30% (£213,323) of the total.

8.10	**EXPERIENCE:** Please outline this organisation's experience in relation to its roles and responsibilities on this project (including technical issues and relevant geographical coverage). Please include details of any external evaluations of this organisation's work (relevant to the proposed project) which have been completed and whether they are available.

SI Uganda has worked with deafblind and MSI children for over seven years, with projects covering districts across northern, western, southern and eastern parts of the country. Similar to SI Kenya, the organization has provided technical and administrative support to deaf blind people, their families and local partner organizations to identify, assess, rehabilitate deaf blind and MSI children. The organisation has also worked with government through the Ministries of Education and Health which have scaled up some of its work. During the project for strengthening services for deaf blind people which was European Commission funded (2010- 2013).

8.11	**FUND MANAGEMENT:** Please provide a brief summary of this organisation's recent fund management history. Please include source of funds, purpose, amount and time period covered.

Source	Purpose	Amount	Period
Big Lottery fund	Education	£205,469	2014-2017

Porticus	Materials development	£42,912	2014-2015
Jersey Overseas Aid services	Education	£62,118	2014-2017
European Union	Community based rehabilitation	£232,202	2011-2013
CORDAID	Education	£50,508	2011-2013
PENSON Worldwide	Education	£66,169	2011-2013

8.12	**CHILD PROTECTION (for projects working with children and youth (0-18 years) only) How does this organisation ensure that children and young people are kept safe? Please describe any plans to improve the organisation's child protection policies and procedures for the implementation of this project.**

All staff are required and have signed up to the Sense International Child protection policy

8.13	**FRAUD: Has there been any incidence** of any fraudulent activity in this organisation within the last 5 years? How was the fraud detected ? What action did your organisation take in response? How will you minimise the risk of fraudulent activity occurring?

There was an incidence of fraud at the SI Uganda office during 2012. However, this was quickly identified during one of the regular monitoring visits. The problem was addressed, including action to identify how this occurred. The two staff members responsible subsequently left the organisation.

8.14	**DUE DILIGENCE: Please provide brief details of any due diligence assessments of the organisation conducted on behalf of DFID or other donors within the past 5 years. Please include date, organisation responsible for the assessment, brief comments, and a link to the assessment, if available.**

Not applicable

8.15	**EVALUATION: Please provide details of any independent evaluations of the organisations work that are relevant to the project proposal. Are these published? If not, can they be shared with DFID?**

SI Uganda participated as one of the co-ordinating partners in the EU supported regional project (2010-2013) covering Kenya, Tanzania and Uganda.
http://www.senseinternational.org.uk/sites/default/files/YOUNG-EC-REGIONAL-EVALUATION-(FINAL).pdf

SECTION 8: CAPACITY OF APPLICANT ORGANISATION AND ALL IMPLEMENTING PARTNER ORGANISATIONS (Max 3 pages each)
Please copy and fill in this section for your organisation **AND for each implementation partner**

8.1	**Name of Organisation**	Entebbe Hospital
8.2	**Address**	P.O.BOX 29 Entebbe Uganda.
8.3	**Web Site**	Ebb-hosp@hotmail.com
8.4	**Registration or charity number (if applicable)**	Not applicable
8.5	**Annual Income**	Income (original currency): 793,501,102shs Income (£ equivalent): £264,500 Exchange rate: 3000shs

		Start/end date of accounts (dd/mm/yyyy) From:1st July 2013 To: 30th June 2014.			
8.6	**Number of existing staff**	141 staff			
8.7	**Proposed project staffing staff to be employed under this project (specify the total full-time equivalents - FTE)**	Existing staff	50 Health professionals (nurse, doctors, clinical officers, therapists) trained + 2 records officers		
		New staff			
8.8	**Organisation category** (Select a maximum of two categories)				
	Non-Government Org. (NGO)		Local Government	x	
	Trade Union		National Government		
	Faith-based Organisation (FBO)		Ethnic Minority Group or Organisation		
	Disabled Peoples' Organisation (DPO)		Diaspora Group or Organisation		
	Orgs. Working with Disabled People		Academic Institution		
	Other... (please specify)				
8.9	**A) Summary of expected roles and responsibilities, AND B) Amount (and percentage) of project budget which this partner will directly manage.**				

A): The hospital will provide some staff, the infrastructure to house the project, plan, budget, coordinate the staff, implement the project, outreaches to the community, comply data, analyse and make reports. Collaborate with donors.

B): Approximately 10% (£71,108).

8.10	**EXPERIENCE:** Please outline this organisation's experience in relation to its roles and responsibilities on this project (including technical issues and relevant geographical coverage). Please include details of any external evaluations of this organisation's work (relevant to the proposed project) which have been completed and whether they are available.

The organisation has trained staff in management and planning ,technical one in disabilities .there are public health specialist for the community planning and outreaches. The community of Entebbe has urban and rural area especially the islands in lake Victoria(they are very poor communities with poor health care access , thus find their way to Entebbe Hospital. The main land too has poor communities which the project will benefit from the project. The base line data of hearing disability within our community will also be established from this project outcome for future intervention.

8.11	**FUND MANAGEMENT:** Please provide a brief summary of this organisation's recent fund management history. Please include source of funds, purpose, amount and time period covered.

Our major funding is central Government for recurrent expenditures, salaries, drug and supplies, utility bills. Some other funding is out of pocket of the community as user's fee on private wing of the hospital. Donors also employ some staff for their projects with run with them as well as some contribution to the drug budget of their project. The funds are annual for Government and for the donors; it depends on the period the project is with us.

8.12	**CHILD PROTECTION (for projects working with children and youth (0-18 years) only) How does this organisation ensure that children and young people are kept safe? Please describe any plans to improve the organisation's child protection policies and procedures for the implementation of this project.**
Child protection is one of the mandate our organization. We are supposed to take care of them, right from pregnancy: Maternal and child clinics, Antenatal clinic, maternity plus delivery then under 5years services, the above 5 years, adults. The plans are to have our staff re-trained in child focused services, strengthen the children clinics and outreaches. Have more analysis of data from these clinics for policy guidance on what works well. Budget and plan for these children services as well as incorporate in organization work plan.	
8.13	**FRAUD: Has there been any incidence** of any fraudulent activity in this organisation within the last 5 years? How was the fraud detected ? What action did your organisation take in response ? How will you minimise the risk of fraudulent activity occurring?
No	
8.14	**DUE DILIGENCE: Please provide brief details of any due diligence assessments of the organisation conducted on behalf of DFID or other donors within the past 5 years. Please include date, organisation responsible for the assessment, brief comments, and a link to the assessment, if available.**
Entebbe Hospital is a Government organization monitored, accredited, supervised by ministry of Health. We abide on their regulations.	
8.15	**EVALUATION: Please provide details of any independent evaluations of the organisations work that are relevant to the project proposal. Are these published? If not, can they be shared with DFID?**
Have no independent evaluation of the organization.	

SECTION 8: CAPACITY OF APPLICANT ORGANISATION AND ALL IMPLEMENTING PARTNER ORGANISATIONS (Max 3 pages each) Please copy and fill in this section for your organisation **AND for each implementation partner**			
8.1	**Name of Organisation**	Ministry of Health, Expanded Programme of Immunisation (EPI) Laboratory	
8.2	**Address**	C/O Uganda Virus Research Institute, Box 49 Entebbe, Nakiwogo Road Plot 51-59 Entebbe.	
8.3	**Web Site**		
8.4	**Registration or charity number (if applicable)**	Is a Government department	
8.5	**Annual Income**	Income (original currency): 275,103,164 UGX Income (£ equivalent): £91,701 Exchange rate: 3,000 ***Start/end date of accounts (dd/mm/yyyy***) From:1st July 2013 To: 30th June 2014	
8.6	**Number of existing staff**	10 Officers	
8.7	**Proposed project staffing staff to be employed under this**	Existing staff	3

	project (specify the total full-time equivalents - FTE)	New staff	

8.8	**Organisation category** (Select a maximum of two categories)			
	Non-Government Org. (NGO)		Local Government	
	Trade Union		National Government	√
	Faith-based Organisation (FBO)		Ethnic Minority Group or Organisation	
	Disabled Peoples' Organisation (DPO)		Diaspora Group or Organisation	
	Orgs. Working with Disabled People		Academic Institution	
	Other... (please specify)			

8.9	**A) Summary of expected roles and responsibilities, AND** **B) Amount (and percentage) of project budget which this partner will directly manage.**

A):
Perform laboratory investigations to confirm Congenital Rubella Syndrome among the screened Children.
Provide data of the prevalence of congenital malformations and Congenital Rubella Syndrome for the purpose of building the case for governments to immunise against Rubella.
B): Approximately 5% (£35,554).

8.10	**EXPERIENCE:** Please outline this organisation's experience in relation to its roles and responsibilities on this project (including technical issues and relevant geographical coverage). Please include details of any external evaluations of this organisation's work (relevant to the proposed project) which have been completed and whether they are available.

The laboratory routinely performs research and surveillance on vaccine preventable diseases since 2000. It has well trained and experienced scientists and technicians with diverse academic backgrounds from Bachelor's to postgraduate qualifications in the field of basic sciences.
The laboratory runs World Health Organisation Accredited laboratories.
The laboratory provides technical services to the disease surveillance laboratories for the countries of Kenya, Rwanda, Burundi, Tanzania, Eritrea, Republic of Southern Sudan and Ethiopia.

8.11	**FUND MANAGEMENT:** Please provide a brief summary of this organisation's recent fund management history. Please include source of funds, purpose, amount and time period covered.

The laboratory receives funding from World Health Organisation to perform surveillance and research on Vaccine Preventable Disease that include measles, rubella, hepatitis, rota virus. The resources are managed by a Finance and Grants Department within the Uganda Virus Research Institute. The department receives annual external auditors and previous performance with respect to grants management has been un-remarkable.

8.12	**CHILD PROTECTION (for projects working with children and youth (0-18 years) only) How does this organisation ensure that children and young people are kept safe? Please describe any plans to improve the organisation's child protection policies and procedures for the implementation of this project.**

Through provision of data on the prevalence of rubella disease, the Organisations 'data generated is the pillar to the on-going advocacy to Government on the introduction of rubella containing vaccines to protect infants form being born with congenital malformations.

8.13	**FRAUD: Has there been any incidence** of any fraudulent activity in this organisation within the last 5 years? How was the fraud detected ? What action did your organisation take in response ? How will you minimise the risk of fraudulent activity occurring?

None	
8.14	**DUE DILIGENCE: Please provide brief details of any due diligence assessments of the organisation conducted on behalf of DFID or other donors within the past 5 years. Please include date, organisation responsible for the assessment, brief comments, and a link to the assessment, if available.**
8.15	**EVALUATION: Please provide details of any independent evaluations of the organisations work that are relevant to the project proposal. Are these published? If not, can they be shared with DFID?**
The laboratory receives external annual program evaluations by the World Health Organisation. Previous evaluation reports maintain high level performance and the laboratory is accredited by World Health Organisation.	

SECTION 9: CHECKLIST OF PROPOSAL DOCUMENTATION		
9.1	Please check boxes for each of the documents you are submitting with this form. All documents must be submitted **by e-mail to: ukaidmatch@dfid.gov.uk**	
	Mandatory Items	**Check Y/N**
	Proposal form (sections 1-7)	Y
	Proposal form (section 8 - for applicant organisation **and** each partner or consortium member)	Y
	Project Logframe	Y
	Project Budget (with detailed budget notes)	Y
	Risk register/matrix	Y
	Project organisational chart / organogram	Y
	Project bar or Gantt chart to show scheduling of activities	Y
	Communications Plan - 2 documents: C1 (communication plan form) and C2 (communications activity timetable)	Y
	Written evidence of **confirmed** appeal communications partnership(s), e.g. an email or letter	Y
9.2	**Please provide comments on the documentation provided (if relevant)**	
In addition to these documents we have included hyperlinks with reference to letters of support from the Ministry of Health in Kenya and Uganda, as well as links to relevant external evaluations. For ease of reference we have attached a scanned copy of the letters of support also to the e-mail.		