MALAWI FINAL REPORT

October 1999–September 2007

USAID'S IMPLEMENTING AIDS PREVENTION AND CARE (IMPACT) PROJECT

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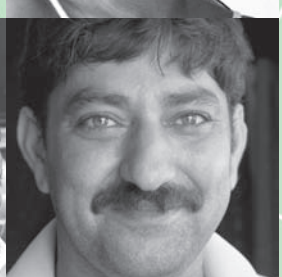
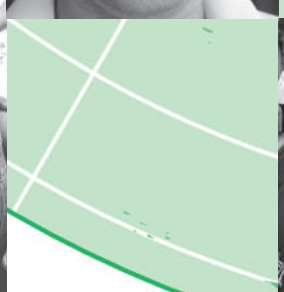
Impact Implementing AIDS Prevention and Care Project









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for
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Submitted to USAID
By Family Health International

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In partnership with

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For the enthusiasm with which the IMPACT project has been welcomed and supported in Malawi, Family Health International (FHI) would like to sincerely thank

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- members of FHI's **subgrantee implementing agencies**—Family Health Education Counseling and Care (FHECC), Friends of AIDS Trust (FAST), the Lighthouse Trust, Mponela AIDS Information and Counselling Centre (MAICC), Namwera AIDS Coordinating Committee (NACC), the Salvation Army (TSA), Save the Children, Story Workshop Educational Trust, Trinity Hospital, the Umoyo Network, and Word Alive Ministries International (WAMI)—who participated energetically to improve awareness and services in the field
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- the numerous **other collaborative partners**—Population Services International (PSI), the United Nations Children's Fund (UNICEF), the Joint United Nations Program on HIV/AIDS (UNAIDS), and others—with whom FHI is grateful to have had the opportunity to work in achieving the common goal of reducing the burden of HIV/AIDS in Malawi

The high level of commitment and collaboration of IMPACT's stakeholders played a major role in the accomplishments of this diverse and far-reaching program. We commend them for the significant impact that they helped us make on behavior change interventions, ART systems, HBC and OVC services, and food and nutrition security in homes and communities of Malawi.

CONTENTS

ACRONYMS

ACCOCAP	AIDS Care Counselling Campaign Project
ART	Antiretroviral therapy
ARVs	Antiretroviral drugs
BSS	Behavioral surveillance survey
CACC	Community AIDS coordinating committee
CBCCC	Community-based child care centers
CBO	Community-based organization
CD	Country director
CHBC	Community and home-based care
CO	Country office
DACC	District AIDS coordinating committee
FAST	Friends of AIDS Trust
FBO	Faith-based organization
FHECC	Family Health Education Counseling and Care
FHI	Family Health International
GOM	Government of Malawi
HAART	Highly active antiretroviral therapy
HBC	Home-based care
HIV	Human immunodeficiency virus
IA	Implementing agency
ICOCA	Intervention counseling and care
IMPACT	Implementing AIDS Prevention and Care Project
IR	Intermediate results
KSG	Key social groups
M&E	Monitoring and evaluation
MAICC	Mponela AIDS Information and Counselling Centre
MOA	Ministry of Agriculture and Food Security (current name)
MOGCS	Ministry of Gender and Community Services
MOH	Ministry of Health
NAC	National AIDS Commission (formerly National AIDS Control Program)
NACC	Namwera AIDS Coordinating Committee
NGO	Nongovernmental organization
NSO	National Statistics Office
OIs	Opportunistic infections
OVC	Orphans and other vulnerable children
PLHA	People living with HIV/AIDS
PSI	Population Services International
PSS	Psychosocial support
SO	Strategic objective
SRH	Sexual and reproductive health
STI	Sexually transmitted infection
TB	Tuberculosis
TCN	Third Country National

TSA	The Salvation Army
UNAIDS	Joint United Nations Program on HIV/AIDS
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VAC	Village AIDS committee
VACC	Village AIDS coordinating committee
VCT	Voluntary counseling and testing
VOCCS	Village orphan care committee
WAMI	Word Alive Ministries International
WFP	World Food Programme
WHO	World Health Organization

I. EXECUTIVE SUMMARY

In October 1999, Family Health International (FHI), under the USAID-funded Implementing AIDS Prevention and Care (IMPACT) project, initiated an HIV/AIDS prevention, care, and treatment program in Malawi. The project, which concluded in FY2007, featured components in the following areas: behavior change communication policy reform and workplace programming; community and home-based care; services for orphans and other vulnerable children (OVC); nutrition and food security; antiretroviral therapy (ART) systems strengthening; and a behavioral surveillance survey related to HIV and other sexually transmitted infections. Interventions were conducted at both the national and community level.

USAID committed a total of $7,070,523 for the implementation of the IMPACT project in Malawi. Of this amount, $5,728,740 was allocated for field support, $541,783 for agricultural interventions, $500,000 was from CDC/LIFE, and $300,000 was restricted to nutrition interventions.

At the national level, IMPACT worked with the Ministry of Health (MOH) to develop HIV/AIDS prevention, care, and treatment policies and guidelines, scale up care and treatment models, and strengthen monitoring systems, especially those related to home-based care, OVC, and ART. IMPACT also supported the Ministry of Agriculture and Food Security—formerly called the Ministry of Agriculture, Irrigation, and Food Security—to strengthen policy and strategies concerning HIV/AIDS in the agricultural sector. IMPACT offered technical assistance to the National AIDS Commission (NAC) BCC Unit and the MOH's Sexual and Reproductive Health Unit to increase knowledge and reduce risky sexual behavior, thus contributing to the national goal of risk reduction. Additionally, in collaboration with the National Statistics Office and NAC, IMPACT executed an HIV/STI behavioral surveillance survey.

At the community level, IMPACT subgranted with local NGOs and community-based organizations to deliver integrated home-based care services and support with a nutrition component to OVC. In collaboration with Umoyo Network and local brewery companies, IMPACT contributed significantly to HIV/AIDS workplace programming with a focus on prevention and care.

Between 1999 and 2002, the program was managed from FHI/Arlington. A full-fledged country office was established in September 2002 with its base in Malawi's capital, Lilongwe.

II. PROGRAM OBJECTIVES, STRATEGIES, IMPLEMENTATION, AND RESULTS

A. INTRODUCTION

In Malawi, AIDS remains the number one cause of death, and significant increases continue to occur in both the numbers of orphans and other vulnerable children and the number of chronically ill individuals due to HIV/AIDS and related complications, such as opportunistic infections, malnutrition, orphaning, and poverty. This poses a considerable challenge to the healthcare system and to communities in responding to and coping with the HIV/AIDS epidemic. Given the chronic nature of this infection, most patients are discharged from healthcare facilities to be cared for at home. The needs of chronically ill patients and OVC are numerous but related. This demands provision of quality care and support at community and household levels, as well as an emphasis on nutrition and food security. Because of the variety of needs, the involvement of various stakeholders within multiple sectors and at all levels is crucial for complementary provision of comprehensive services.

To meet Malawi's diverse needs, USAID committed $7,070,523 to FHI for the IMPACT project in Malawi, of which $5,728,740 was in field support, $541,783 was agriculture funding, $500,000 was from CDC/LIFE, and $300,000 was denoted for nutrition interventions. Between fiscal years 1999 and 2007, these financial commitments enabled FHI to address activities along the continuum of prevention to care and treatment to impact mitigation. Such interventions took place at the national policy level and with community-based service delivery, and the project featured multisectoral interventions in the following technical areas: behavior change communication (BCC); HIV/AIDS workplace programming; community and home-based care (CHBC); OVC services; nutrition and food security; antiretroviral therapy; and a behavioral surveillance survey (BSS) related to HIV and other STIs.

IMPACT programming in Malawi included the following over the life of the project:

- technical assistance to the MOH for the development of HIV/AIDS care and treatment policies and guidelines, scaling up of care and treatment models, and strengthening of monitoring systems, especially related to home-based care (HBC), OVC, and ART.
- support to the MOA to strengthen policy and strategies concerning HIV/AIDS in the agricultural sector
- technical assistance to the National AIDS Commission (NAC) BCC Unit and the MOH's Sexual and Reproductive Health (SRH) Unit to increase knowledge and reduce risky sexual behavior, thus contributing to the national goal of risk reduction
- HIV/STI behavioral surveillance in collaboration with the National Statistics Office (NSO) and NAC
- service delivery in integrated HBC and support to OVC with a nutrition component, through subagreements with local NGOs
- HIV/AIDS workplace programming focusing on prevention and care in collaboration with Umoyo Network and local brewery companies

To facilitate the aforementioned interventions, IMPACT seconded a BCC technical advisor to the BCC Unit of NAC and a care and treatment technical advisor to the Clinical HIV Unit of the

MOH. It also enabled FHI to hire a full-time nutrition advisor, the only person globally to serve in such a position within FHI.

The project was managed from FHI/Arlington between 1999 and 2002, after which the FHI/Malawi country office was formed. It continues to exist today with non-IMPACT funding.

B. COUNTRY CONTEXT

Malawi is a poor country with a population of 11 to 12 million people and a gross domestic product of less than US$200 per capita per year. HIV/AIDS is the leading cause of death among adults in Malawi. Almost 900,000 people are believed to be HIV-infected. Every year another 100,000 people are infected, and every year 90,000 people die of AIDS. According to the NAC, the national HIV seroprevalence is estimated at 14.4 percent among people 15 to 49 years old,[1] equal to approximately 1 million people infected with the virus.[2] Surveillance data from antenatal clinics shows a slow but steady increase in HIV infections, with the highest rate, 25.7 percent, continuing to occur among women ages 20 to 24 years.

The primary means of HIV transmission in Malawi is through unprotected heterosexual intercourse. Factors that contribute to the HIV/AIDS epidemic in Malawi include

- traditional cultural practices such as polygamy and widow/adolescent sexual cleansing
- increases in the amount of commercial and transactional sex
- high incidences of casual premarital and extramarital sex
- low literacy levels
- increases in STIs
- malpractices of traditional healers and birth attendants
- alcohol and drug abuse
- gender inequality, including women's limited power to negotiate safer sex
- inadequate resources for HIV/AIDS prevention and mitigation activities
- poverty

Home-Based Care: Overall life expectancy has declined in Malawi from 56 years to 40 years due to AIDS-related deaths. The country's healthcare system is overwhelmed by the growing number of patients requiring multiple and often long-term treatments because of the combination of acute and chronic patterns of the illness. As a result of shortcomings in the healthcare delivery system, communities continue to assume responsibility for caring for people living with HIV/AIDS (PLHA). Threatening to undermine the country's stability are overstretched household safety nets, the social distress of child-led households, and the spiral of poverty that accompanies continued health problems. Unfortunately, the HIV/AIDS response in Malawi has not been commensurate with the needs; the World Bank estimated that only 10 percent of patients needing HBC receive these services.[3] Key factors in the limited scale are inadequate numbers of NGOs, community-based organizations (CBOs), faith-based organizations (FBOs) and volunteers involved in CHBC. Local organizations supporting HBC activities are generally

[1] National AIDS Commission, *HIV and AIDS in Malawi: 2003 Estimates and Implications*, January 2004.
[2] National AIDS Commission HIV Surveillance Report, November 2003.
[3] World Bank, 1999.

small, with limited funding, reach, and capacity. As a result, HBC programs have not been able to make effective links with existing health structures and other partners at national, district, and community levels to encourage shared ownership and sustainability.

Orphans and Other Vulnerable Children: Extended families and communities face the heavy burden of meeting the needs of children who are often left behind when parents and caregivers die.[4] Malawi is home to more than 1 million orphaned children, 48 percent of whom are orphaned due to AIDS.[5] In addition to the large number of children who are already orphans, an estimated 30,000 more children are vulnerable to becoming orphans because one or both parents are HIV-positive. Both groups of children lack basic necessities at a critical period of their lives, and society is faced with the huge responsibility of accommodating their physical, medical, and developmental needs.

Nutrition and Food Security: One of the major challenges in Malawi to ensuring overall good health of households with OVC and chronically ill family members—and in fact many households in general—is food and nutrition security. The diet consumed in communities results in poor intake of the variety of nutrients necessary for good health, particularly when compromised by disease and infection. Poverty and lack of understanding of the importance of a balanced diet are major constraints for the adequate consumption of a varied diet, as are seasonality (only one growing season), small land holding, and soil infertility. For a chronically ill person, especially in a resource poor setting such as Malawi, consumption of an adequate diet to cope with the challenges of chronic infection, and possibly frequent acute infections, is very difficult to achieve. Studies indicate that on average, HIV-positive asymptomatic adults and children require 10 percent more energy than non-infected adults and children; when symptomatic, 20 to 30 percent more energy, provided there is no weight loss. Children with weight loss require 50 to 100 percent more energy. The rate of chronic malnutrition (stunting) among children under five years old in Malawi is 49 percent;[6] iron deficiency anemia in preschool children is 80 percent; and asymptomatic vitamin A deficiency is 59 percent.[7]

Antiretroviral Therapy: At any one time, it is estimated that 170,000 people in Malawi are in immediate need of ART. In January 2004, before national scale-up of ART, there were nine health facilities in the public sector delivering ART to about 3,000 patients. ART delivery was unstructured, very few health workers had been formally trained in the subject, and there were no national systems of monitoring or reporting.

The government's national response to HIV/AIDS is based on Malawi's HIV/AIDS strategic framework. Among other issues, the framework acknowledges that the increase in number of orphans due to AIDS-related deaths calls for special interventions to mitigate the impact of the epidemic. Therefore, the challenge is to develop adequate and effective strategies and mechanisms for care and support while integrating interventions for the chronically ill and OVC into programs. The framework further acknowledges that NGOs and CBOs should play a critical

[4] NAC, 2003.
[5] Children on the Brink, 2004.
[6] MDHS, 2000.
[7] MOH, 2003.

role in implementation. Finally, it emphasizes capacity building for individuals, families, and communities.

The aim of the national response to the HIV/AIDS pandemic is to bring a balanced approach among prevention, mitigation, care, support, and treatment of HIV/AIDS in Malawi. This approach is in line with the current position of leading agencies in HIV/AIDS, such as UNAIDS. More importantly, however, the national response is directed at preventing disruption of the country's socioeconomic and political stability by focusing efforts at the individual, family, community, and national levels. Among the strategies of the national response is the introduction of an integrated CHBC, prevention, and treatment system. Bringing quality services closer to clients will foster greater understanding of the need for services, empower individuals to act on health-related issues, improve access to services, and ultimately improve the quality of CHBC services and OVC support. When IMPACT began, there were very few national guidelines or policies to guide implementation of these and other HIV/AIDS-related services, contributing to uncoordinated efforts in the country.

CBO/NGO Capacity: Malawian CBOs, international NGOs with offices in Malawi, and local FBOs were the main providers of care for OVC and HBC in the districts covered by the project. On average, the larger organizations covered two to four traditional authorities, up to half a district, while the majority of local CBOs covered only parts of one traditional authority. Other than the large international NGOs, most agencies providing HBC and support to OVC had no consistent funding sources, compromising the reach and sustainability of their programs due to their reliance on the ability to access external funding. IMPACT's initial formative assessment identified major needs among these implementing agencies (IAs), including the need to broaden the definitions used for selecting beneficiaries of HBC and OVC services; support organizations to provide a broader range of services; strengthen weak linkages to healthcare; and improve the ability of the district AIDS coordinating committees (DACCs) to coordinate district programs and enhance their sustainability.

C. IMPLEMENTATION AND MANAGEMENT

1. Implementation

IMPACT/Malawi began in early FY1999 with a request from USAID/Malawi for FHI to conduct training and technical assistance aimed at capacity building for behavior change interventions (BCI) to ultimately contribute to Intermediate Result (IR) 4.1: "Reduction of Sexual Risk." In response to this request, IMPACT hired and placed a full-time resident BCC specialist at the NAC (formerly called the National AIDS Control Program [NACP]) office in Lilongwe starting in June 2000. The BCC advisor worked with the NAC BCC unit to strengthen governmental and nongovernmental sector capacity, build human resource capacity, and assist NAC in the development and implementation of a BCC strategy. This resident BCC specialist's first main activity was to convene a workshop to form a BCC Technical Working Group and, subsequently, to lead the group in drafting a national BCC strategy. She also collaborated with counterparts at the NAC to plan events and messages for World AIDS Day 2000. In addition to fielding a resident specialist and providing technical assistance in prevention, IMPACT helped upgrade the BCC Unit of the NAC with procurement of office equipment to improve efficiency.

IMPACT also received funding from the Centers for Disease Control (CDC)'s LIFE Initiative to initiate additional prevention activities in FY2000. This led to the creation of a partnership with Umoyo Networks for a comprehensive HIV/AIDS workplace prevention program for the Bowler Beverages Company, Ltd. (BBCL), a brewer of the national beer company, Napolo Brewery. BBCL's brewery workplace interventions in Lilongwe began with prevention activities and later expanded to include a care and support component. This activity drew on funds from the CDC/LIFE Initiative and represented a model case of private sector leveraging.

Preliminary discussions with the MOA and the USAID/Agriculture office occurred in 2001 and led to the execution of a subagreement between FHI and the MOA to help mainstream HIV/AIDS mitigation and workplace prevention in the agricultural sector. One of the main results of this collaboration was the development of the comprehensive *HIV/AIDS and Agriculture Sector Policy and Strategic Plan*, for which FHI staff and consultants provided extensive technical assistance.

In FY2002, USAID/Malawi began negotiations with FHI for the creation of an integrated nutrition care and support program targeting PLHA and OVC that would be supported with field support funds under the IMPACT mechanism. The initial scope of work proposed by USAID included

- developing a strategy to define and support a state-of-the-art program for providing comprehensive, household-based services for HBC and OVC
- documenting and disseminating lessons learned and project successes for replication by other stakeholders in Malawi

In July and August 2002, IMPACT conducted an initial rapid assessment of HBC for OVC in the central and southern regions of Malawi. The assessment was designed to provide an overview of current HBC and OVC activities; identify potential partners and opportunities for intervention; define a strategic vision for IMPACT's HBC/OVC response, including a set of strategic options for implementation and operations research issues; and identify next steps in the development and implementation process. Following the completion of an in-depth assessment of Malawi's HBC needs, FHI developed a broad strategy document and fact sheet that presented the IMPACT approach to HBC for HIV/AIDS in Malawi. The assessment report and strategy document were shared with USAID, the NAC, and the Ministry of Gender, Youth, and Community Services (the ministry responsible for OVC activities).

From the assessment results, FHI and USAID identified the districts for implementation of IMPACT's integrated care and support program based on the following selection criteria: their HIV prevalence rates; the number of potential beneficiaries in the district; the number of local organizations and the potential result of capacity-building efforts by IMPACT; and district-level political buy-in and support. FHI then selected IAs based on their prior performance, current and potential geographic coverage, relationships with local communities and government, and financial accountability. In August 2003, IMPACT began work with the first group of six IAs; work with the remaining three IAs commenced shortly thereafter in early 2004, with subagreements as the primary funding mechanisms. FHI's Rapid Response Fund was used for grants valued at less than $5,000 each awarded to six additional partners. At the time these new

grants were awarded, IMPACT had three other active subagreements in Malawi: one with Umoyo Network to support the prevention project with BBCL; one with the MOA for the development and implementation of the ministry's HIV/AIDS policy/strategy; and one with Story Workshop to finalize the development of educational HIV/AIDS materials for youth.

In 2004, the scope of the project was expanded to include national-level strengthening of the ART delivery system. By seconding a care and treatment technical assistant to the HIV/AIDS Unit of the MOH, IMPACT was able to provide direct technical assistance on policies and systems concerning ART nationwide. This component of the project was funded by IMPACT from February 2004 to September 2005, when it transitioned into the new USAID/Malawi bilateral project managed by FHI.

IMPACT's HIV/AIDS care and support program featured an integrated approach to assist partners, volunteers, households, and individuals to better care for the chronically ill and vulnerable children. Recognizing the critical effect that nutrition has on the rate of progression from HIV to AIDS and the wellbeing of individuals on ART, USAID committed funding specifically for an integrated nutrition component within the HBC/OVC program, beginning in May 2005. The nutrition component expanded the existing limited nutrition activities within the HBC package and provided a more holistic approach to food and nutrition security for HIV/AIDS-affected families. It incorporated knowledge about nutrition and HIV and advice on cooking, improved preparation of food to prevent loss of nutrients, and the establishment of household kitchen gardens to provide more diverse food crops. The use of medicinal plants and trees for the relief of symptoms and side effects of drugs was also encouraged.

This integrated HBC/OVC/nutrition program represented the large share of IMPACT's efforts in Malawi and continued to be implemented under IMPACT until USAID/Malawi awarded FHI a cooperative agreement focusing on HBC, OVC, and nutrition in September 2005. At this point, the subagreements transitioned into the Malawi OVC/HBC Bilateral Project, and IMPACT funds covered discrete activities that complemented the bilateral interventions and supported continuing national-level initiatives in the areas of OVC, HBC, and nutrition. IMPACT officially closed out in September 2007.

2. Management

Between mid-FY1999 and early FY2002, FHI managed activities from its headquarters with on-the-ground support from a full-time resident BCC technical advisor placed within the NAC's BCC Unit in Lilongwe. FHI/Arlington and FHI's regional office in Kenya provided significant assistance through technical support visits during this period.

In FY2002, FHI received official confirmation of its status as an NGO in Malawi. While still housed at the NAC, IMPACT was given additional space and began to expand its offices. An administrative officer and a behavior change training designer and workshop facilitator were hired. Headquarters support included assistance in the interview and hiring process of the administrative officer and the development of an employee handbook. The regional office provided financial orientation for the administrative officer and discussed the role of financial supervision with the behavior change advisor.

As IMPACT completed the behavior change interventions and the transition to the OVC program began, a full-fledged FH country office (CO) was established in September 2002 with its base in Lilongwe. The BCC technical advisor's contract ended at this time. From that point until the conclusion of IMPACT in Malawi, activities were initiated, managed, and coordinated locally with general oversight and ongoing support from FHI/Arlington as well as occasional technical assistance from regional FHI staff and local consultants. Overall program management and coordination and policy guidance was provided by the country director (CD). The initial office staffing structure included key full-time staff based in Lilongwe, but as the project grew, additional staff members were brought into the organization, including district coordinators and administrative secretaries who were placed in the following five districts: Nsanje, Chikwawa, Blantyre, Mangochi, and Dowa.

The local staff based in Lilongwe provided overall programmatic coordination and technical assistance for the program. These main office personnel were complemented by district coordinators who managed the groundwork in their respective districts with assistance from their administrative secretaries; they provided technical assistance to the IAs in addition to liaising and collaborating with district-level government departments and other stakeholders. The main office team conducted regular site visits, organized central program review meetings for staff and IAs, and contributed to technical assistance and training of IAs. The CO technical team also supported national-level collaborating partners such as the MOH, NAC, and MOA.

In addition to the Third Country National CD and the local-hire CO staff, IMPACT covered an expatriate care and treatment technical assistant who was seconded to the HIV/AIDS Unit of the MOH between February 2004 and September 2005; thereafter, he was funded by the USAID/Malawi bilateral cooperative agreement. Finally, between May 2005 and May 2007, an expatriate nutrition advisor was placed in the Lilongwe CO to support the community-based HBC/OVC program and provide technical assistance at the national level.

For continued quality program implementation and management, IMPACT also sought support from international experts for periodic technical assistance. This complementary, ongoing management and technical support was most often provided by FHI staff at headquarters in Arlington, with occasional assistance visits from staff in FHI regional offices.

3. Implementation Challenges

IMPACT encountered various obstacles to implementation and took the necessary measures to address issues in an appropriate and timely manner. Programmatic and management-related challenges included the following:

- The advancement of national strategies and policies as well as the multimedia package with Story Workshop were delayed by creative and technical differences among the various stakeholders (Story Workshop, IMPACT, and the BCI unit of the NAC).

- Linkages between IAs and other partner organizations improved but were limited, creating a tendency for inadequate delivery of care and support services. Efforts continued to be made to strengthen collaborations and to ensure comprehensive delivery of services. Such efforts

included networking meetings for sharing of experiences and development of joint plans, development of resource maps to enhance provision of comprehensive services, and minimizing duplication of effort.

- The capacity of some IAs to deliver and monitor HBC/OVC services effectively was limited, leading to insufficient provision and documentation of services. In response, IA capacity-building activities included refresher trainings (in technical areas, monitoring and evaluation, and financial management), mentorship, supportive supervisory visits, and study visits.

- Motivation of volunteers posed a challenge in continuation of HBC/OVC service provision. Incentives to sustain motivation included training, study visits, provision of bicycles to ease transport for home visits, provision of uniforms, and support of volunteer group income-generating activities. Also, there was inadequate support to volunteers from health facilities and the Department of Social Welfare. Efforts were made to elicit support for volunteers from these entities by encouraging their involvement in HBC/OVC trainings for volunteers, IA review meetings, and district meetings of stakeholders and networks.

- While IMPACT did not directly fund antiretroviral drugs (ARVs) or ART service delivery, insight was gained on the challenges to implementing ART national programs through the technical assistance that the project provided to the MOH. Due to the complicated nature of ART and national systems strengthening, there were several challenges to implementation of ART delivery, mainly:

  Children, pregnant women, and patients with tuberculosis. These three categories of patients were, and still are, relatively underserved. Until 2005, only 5 percent of patients in Malawi were children, and a small subanalysis showed that very few were under 1 year of age; an estimated 10 to 15 percent of patients on ART should be children. The small number reflects the difficulties faced by clinicians in diagnosing and managing HIV in infants, and in treating other children with split-tablet doses. To improve this situation, technical recommendations to simplify the diagnosis of HIV in infants have been developed, and specific pediatric drug formulations are being advocated for.

  Very few HIV-positive pregnant mothers are referred for consideration of ART. Many of these mothers are asymptomatic, and eligibility for ART depends on increased availability of CD4 testing. The proportion of TB patients placed on ART is also too small. With a national HIV seroprevalence rate of 70 percent among TB patients and 27,000 new TB patients being diagnosed and treated every year in Malawi, approximately 19,000 eligible TB patients annually should be receiving ART. However, placing TB patients on ART is difficult, due to problems with having these patients tested for HIV, concerns over drug-drug interactions between rifampicin and non-nucleoside reverse transcriptase inhibitors (particularly nevirapine), and the fact that in Malawi, ART is delivered largely from hospital clinics while anti-TB treatment in the continuation phase is largely decentralized to health centers.

High early death rates and losses to follow-up. There have been, and continue to be, two main problems with regard to treatment outcome. The first is the high early death rate in patients starting ART. High early mortality is not a feature confined to Malawi, but has been reported from most countries in sub-Saharan Africa. It appears to be related to patients presenting with advanced clinical stage HIV disease, wasting syndrome, TB, acute bacterial infections, malignancy, and immune reconstitution syndrome. An aggressive approach to the diagnosis of TB and early use of broad-spectrum antibiotic prophylaxis targeted at the common serious bacterial infections are two possible solutions to reducing early deaths. The second problem is that of loss to follow-up. There is no published information yet on this aspect. A study on patients lost to follow-up in the TB program in Malawi showed that about one-third had died, one-third had completed treatment, and the remainder had either transferred out of the district or stopped treatment.

- Other challenges included equitable access to general healthcare and prevention services of quality, specifically equitable access of patients to HIV/STI/OI treatment sites, particularly those living in rural and geographically remote areas where transport and poverty are significant barriers to access; the capacity of the health sector to absorb the extra demands of HIV/AIDS-related care and treatment delivery without compromising general healthcare; and the scaling up of prevention efforts alongside treatment.

D. PROGRAM OBJECTIVES, STRATEGIES, AND ACTIVITIES

1. Goal and Objectives

IMPACT's initial behavior change intervention (BCI) component aimed at capacity building and policy development for BCIs to ultimately contribute to USAID's IR 4.1: "Reduction of Sexual Risk."

The larger, longer-term HBC/OVC/nutrition component specifically addressed USAID/Malawi's Strategic Objective 8: "Healthier Malawian families" and IR 8.3: "Access to services increased" through improved quality of HIV/AIDS mitigation activities, including increased support and services for OVC and increased access to quality HBC and support. The goal was to support the development of an integrated HBC program for the chronically ill and provision of care and support to OVC to mitigate the impact of HIV/AIDS.

The objectives of IMPACT's integrated OVC/HBC program in Malawi were to

- strengthen capacity of partners, relevant stakeholders, and government departments to enable households and communities to provide HBC for the chronically ill and care and support for OVC
- strengthen referral mechanisms and other linkages between IAs and other service providers of HBC and OVC care and support activities
- strengthen capacity of coordinating and implementing structures to document and disseminate program information, lessons learned, and best practices about HBC/OVC and related activities
- support national level planning, design, and coordination of HBC and OVC programs

- help prevent nutritional deterioration in vulnerable households in communities affected by HIV and with food insecurity

The goal of the ART component implemented under IMPACT was to improve the capacity of the Government of Malawi to design, implement, and monitor a national ART service delivery and scale-up. In this regard, IMPACT's national-level technical assistance contributed to the MOH's efforts to reduce morbidity and mortality of HIV in adults and children through delivery of highly active antiretroviral therapy (HAART) to 80,000 eligible patients by the end of 2005. The government's objectives and targets of antiretroviral drug delivery were

- to provide long-term ARV therapy to eligible patients
- to monitor and report treatment outcomes on a quarterly basis
- to attain individual drug adherence rates of 95 percent for patients on ARV therapy
- to increase life span so that 50 percent of patients are alive and ambulatory after three years of ARV therapy
- to ensure that 50 percent of patients on ARV therapy are engaged in their previous employment or any other productive activity within six months of starting ARV therapy
- to reduce the number of new orphans registered each year

2. Strategy and Technical Approaches

IMPACT's main strategy in Malawi was to intervene in a large variety of technical areas and at diverse levels of implementation to have a broad-reaching and sustainable influence on HIV/AIDS-related prevention, care, and treatment services. The wide spectrum of technical areas addressed (BCC, OVC, HBC, nutrition, ART, and strategic information), the different sectors with which FHI collaborated (private, government, and NGO), and the various levels at which interventions were conducted (community, workplace, and district and national government) made this a uniquely multisectoral and comprehensive project. Recognizing that focusing on a single ministry or unique group of stakeholders limits the reach of the project, IMPACT maximized its results by working with a diverse group of partners, including NGOs/CBOs in five districts across all regions of the country; several units within the Ministries of Health, Agriculture and Irrigation, and Gender and Community Services; national structures such as NAC and NSO; and global IMPACT partners such as Population Services International (PSI).

IMPACT used a comprehensive approach to provide support to local partners for HBC/OVC activities through the following strategic areas:

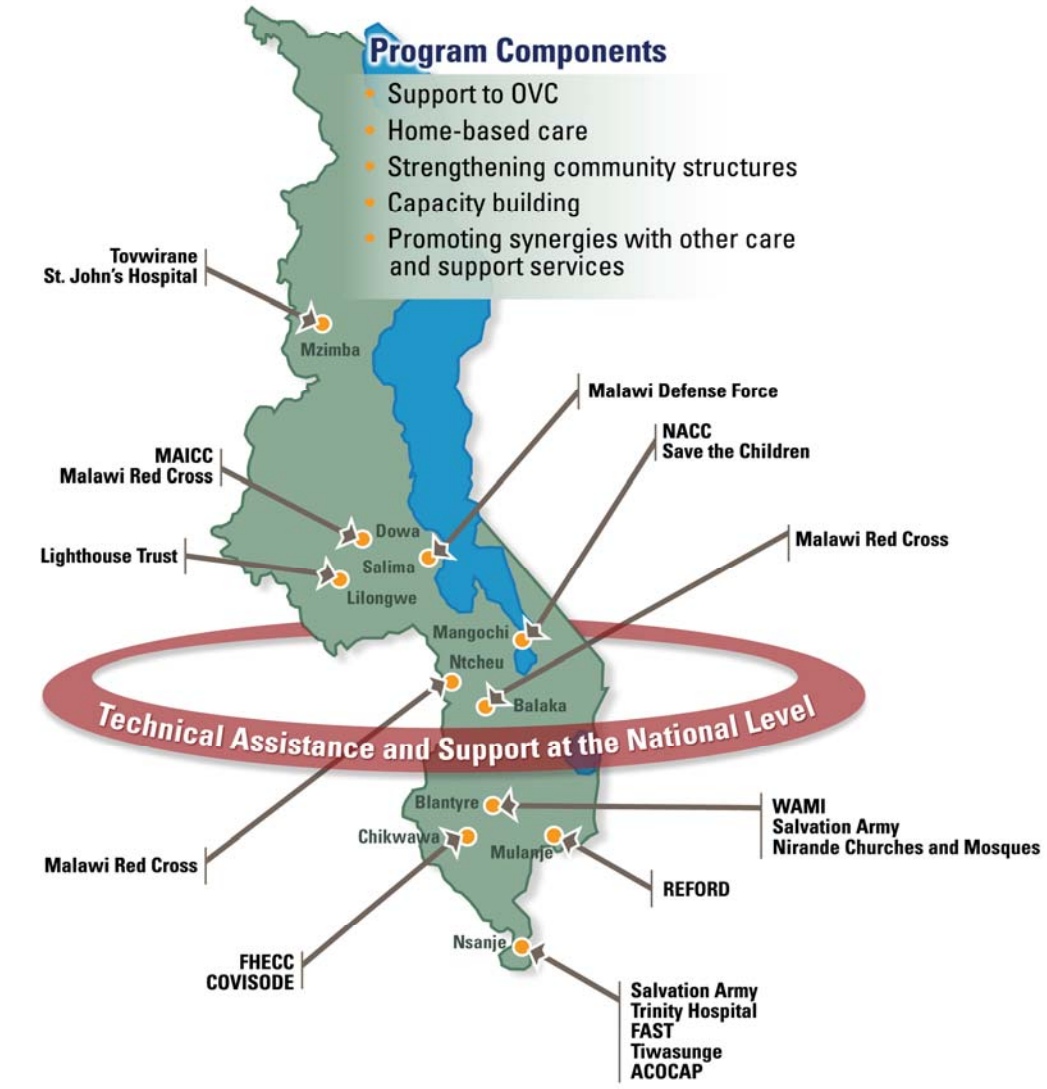
- conducting assessments of IA capacity and HBC/OVC service delivery
- training in HBC, OVC, nutrition, and monitoring and evaluation (M&E)
- developing monitoring tools for HBC/OVC
- facilitating collaboration between IAs and government agencies, as well as with other NGOs, CBOs, and FBOs
- providing technical assistance to NGOs, FBO, CBOs, and government departments

IMPACT developed an integrated program tailored to the Malawi context, designed to alleviate the impact of HIV/AIDS on families and communities. Acknowledging that the increase in the number of OVC due to AIDS called for special interventions, this integrated strategy linked HBC and OVC programs and directly supported Malawi's national HIV/AIDS framework and

other coordinated national HIV/AIDS responses in HBC, OVC, nutrition, and ART. The integrated program developed adequate and effective strategies and mechanisms to care for and support the chronically ill, the households in which these individuals live, and children who are orphaned or vulnerable. Nutrition activities were incorporated into the HBC/OVC program as part of the continuum of care and support to vulnerable households.

With the aim of building capacity for sustainability, IMPACT worked mainly with nascent CBOs. Very often, these local partners needed initial support not only in technical issues but also in financial and administrative systems. The IMPACT capacity-building strategy, therefore, comprised training in the many aspects of HBC/OVC care and support, including nutrition and M&E; it also involved face-to-face and virtual mentoring. The goal of providing comprehensive technical assistance is to make the organization more competent, efficient, and professional and help their progression to local NGO status. This assistance strengthens individuals as well as the organizations themselves.

Another important strategy was obtaining local buy-in and ensuring that interventions were locally relevant and culturally appropriate. Implementing agencies and IMPACT staff engaged in national-level advocacy and contributed to policy reform and guidelines development in collaboration with the government while orienting the communities and their leaders for program acceptance and support, involving community members in decision-making committees and as volunteers, and providing them with training and support for their household visits and activities.



3. Activities

IMPACT contributed to the reduction of new HIV infections in Malawi through support of HIV/AIDS prevention messages and provision of care and support to the chronically ill and OVC; this included a nutrition/food security component. This program facilitated linkages between HBC/OVC service providers that offered voluntary counseling and testing (VCT) and organizations conducting BCC activities as a prevention strategy. In addition to the integrated community-based HBC/OVC program, IMPACT provided technical support to government agencies and a commercial industry (Bowler Beverages) in strategic behavioral communication (SBC), HBC, OVC, nutrition, and ART.

i. National-Level Technical Assistance and Policy Strengthening

Support to the National AIDS Commission

Development of National BCC Strategy
Between FY1999 and FY2002, FHI provided technical assistance to the BCC Unit of the NAC through the seconding of a BCC resident advisor. After launching a 30-member BCC Technical Working Group (TWG), IMPACT led the process to develop a National HIV/AIDS BCC Strategy. After drafting a plan of action toward achievement of a comprehensive design through several TWG workshops, a decision was made to amalgamate the HIV/AIDS and sexual and reproductive health BCC strategies, which had a dramatic impact on the process and content of the strategy in that it created a closer working relationship between key people at the Ministry of Health Reproductive Health Unit (RHU) and the BCC unit. The development of the strategy included a literature review of behavioral research and BCC programs and the completion of a document titled "*Accomplishments update for the development of the HIV/AIDS/RHU BCC Strategy*." Consultants contributed to the finalization of the strategy by guiding inputs on the M&E portion and clarifying the roles and responsibilities of stakeholders in implementing the strategy. They worked closely with the BCI Unit of NAC and the RHU on these tasks.

Development of BCC Unit Annual Workplan
IMPACT's support also enabled the development of the annual BCC Unit Workplan, with main components on organizational development/structure of the BCC Unit; information resource and distribution center; World AIDS Campaign/National Youth Festival; targeted information, education, and communication (IEC) packages; leader communication campaign; mass media programs; and comprehensive design of the National HIV/AIDS/SRH BCC Strategy. A series of meetings were held to vet the strategy with key stakeholders across the country and to provide an update on the BCC strategy, present the new workplan, and identify gaps and challenges.

Additional Support to NAC BCC Unit
The BCC Unit conducted additional activities with support from the resident full-time BCC technical advisor, including

- working with the Canadian International Development Agency (CIDA) in developing HIV/AIDS messages for primary school subject books, which were included in 9 million books distributed over the following three years
- planning and implementation of Malawi's commemoration of World AIDS Day events
- conducting visits to the district AIDS coordinating committees, Women Against AIDS organization, and an orphan care community project in Mangochi District, and with the Umoyo Network, PSI, Story Workshop, and the Safe Motherhood project to discuss common issues and possible areas of collaboration
- collaborating with the Umoyo Network in the development and distribution of IEC materials aimed at the general public and at clients of health services
- supporting improvements in the physical site, procuring equipment and supplies for the unit, and providing funds for office facility upgrade, including security

HIV/AIDS/SRH Retreat
An HIV/AIDS/SRH values clarification retreat was organized for the entire National AIDS Commission staff in 2002. A total of 36 participants took part in this four-day retreat at the Kuchawe Inn in Zomba. The objectives were to clarify personal and professional values and attitudes on various HIV/AIDS/SRH issues through heightened self-awareness; enhance communication skills to promote healthy HIV/AIDS/SRH behaviors in various roles and environments; and engage in team-building exercises. Evaluations indicated that the workshop was successful, with a high level of openness among the participants regarding sexuality issues. The workshop resulted in a reported positive change in working relationships.

SRH and HIV/AIDS Situation Assessment
IMPACT provided technical assistance to NAC to conduct a situation assessment of the information needs of youth in Malawi (10 to 25 years old) on sexual and reproductive health and HIV/AIDS. This informed SRH programming for youth and resulted in an inventory of available resources and tools in Malawi to meet their needs.

Behavioral Surveillance Survey
Through IMPACT, technical assistance in strategic information was provided to NAC for ongoing second generation surveillance[8] and a behavioral surveillance survey. The BSS is an M&E tool that FHI has designed to track trends in HIV/AIDS- and STI-related knowledge, attitudes, and behaviors in subpopulations at particular risk of infection. It consists of repeated cross-sectional surveys conducted systematically to monitor changes in HIV/ STI risk behaviors based on HIV and STI surveillance methods.

Planning meetings were held with the MOH, the US Centers for Disease Control (CDC), the Centre for Social Research, and the NSO between January and March 2003, resulting in the formation of a technical working group to guide the survey and to provide long-term guidance for surveillance in the country. A behavioral surveillance coordinator was recruited by IMPACT to build national-level capacity and to lead implementation of the survey, which was conducted in 2004 by NSO through a subagreement with FHI.

The objectives of this first round of BSS were
- to provide baseline information that would assist in the development of a system for tracking behavioral pattern data for high risk and vulnerable target groups
- to provide information on behavioral patterns among key target groups in some of the catchment areas where intervention projects were planned or operating
- to provide information that would guide program planning
- to open and develop a dialogue on HIV/AIDS among the population from the policy to the community level
- to obtain data in a relatively standardized format that would enable comparison with BSS carried out in other countries

[8] The main objective of second generation surveillance is to monitor HIV and high risk behavior trends over time to provide data needed for the development of interventions and the evaluation of their impact.

A sample drawn from 13 target groups was interviewed for the survey. These groups were selected because they were believed to be those engaged in behaviors with the greatest risk for contracting or transmitting HIV, including male and female police officers, primary school teachers, secondary school teachers, and estate workers; male truck drivers, vendors, and fishermen; and female sex workers and trade workers.

The findings revealed that most male respondents had multiple partners; in particular, 73 percent of the male vendors had multiple partners. Reported abstinence levels were very low. For example, less than 10 percent of the respondents reported never having had sex, and less than 35 percent had not had sex in the past 12 months. Consistent condom use with regular partners was at 3 percent, and with non-regular partners less than 50 percent. The survey also found that male vendors and truck drivers did not consistently use condoms with female sex workers. A second round of BSS has been completed under a bilateral agreement with USAID.

Support to the MOA

Desk Review
IMPACT began supporting the MOA in 2001. Initial activities included a review of current literature on policy and strategic planning.

HIV/AIDS and Agriculture Sector Policy and Strategic Plan
Through collaboration with the MOA under a subagreement with FHI, IMPACT enabled the development of a national HIV/AIDS policy (2003–2008) for promoting political will to address HIV/AIDS, financial commitment to support HIV/AIDS programming, and gender mainstreaming at all levels of the agriculture sector's workplace and rural farming communities. A local consultant hired by FHI worked with the MOA to move the policy/strategy document forward. The final *HIV/AIDS and Agriculture Sector Policy and Strategic Plan* was closely linked with the Malawi National BCI Strategy that FHI helped to develop through IMPACT.

HIV/AIDS and Agriculture Working Group
Following a workshop led by Oxfam, the Agricultural Mainstreaming Task Force was established, of which FHI was a founding member. Through IMPACT, FHI participated actively in this working group, which featured membership of important players in the public health and agricultural arena, such as NAC, the Natural Resources Centre, the Agricultural Development and Marketing Cooperation (DMARC), and the Malawi Agricultural Sector Investment Program (MASIP).

MOA Training Materials in HIV/AIDS
IMPACT's collaboration with the MOA also included technical and financial assistance for training curricula, tools, and workshops for gender and AIDS desk officers.

Support to the Ministry of Health

National OVC Rapid Assessment, Analysis, and Action Planning (RAAP)
In response to findings from The Special Envoy of the Secretary General on Humanitarian Needs in Southern Africa (April 2003), a Global OVC Partners Forum was held in Geneva in October

2003. IMPACT/Malawi participated in a meeting of the National Task Force on OVC conducted as a follow-up to the initiatives set forth by the forum. The task force met to review Malawi's national action plan for OVC as part of the rapid assessment to assess the situation of OVC, with the aim of clearly defining and outlining urgent actions required to scale up responses to provide these children with support. The purpose of these rapid appraisals was to assess the current status of OVC responses, particularly in the most HIV/AIDS-affected countries of sub-Saharan Africa. It was undertaken jointly by UNICEF, USAID, UNAIDS, and the World Food Programme. UNICEF was the lead coordination agency, and IMPACT provided preliminary data from its IAs about the OVC situation.

National Home-Based Care Policy Guidelines
IMPACT's support of the MOH in developing national HBC policy guidelines included provision of technical assistance through participation in a series of meetings and workshops. The guidelines, intended to ensure that HBC is thoroughly integrated into existing health services, summarize the existing HIV policy supporting HBC and set forth Malawi's approach to this care modality. They define home-based care, present a rationale and guiding principles, delineate the required components of home-based programs, and outline programmatic standards and requirements for service delivery.

Integrated HBC/OVC Service Delivery Packages
HBC and OVC manuals and tools were developed to guide delivery and monitoring of care and support services at the household level during home visits to the chronically ill and/or OVC. The OVC service delivery package included food, clothing, shelter, healthcare/treatment, educational support (fees, uniform, and other scholastic materials), psychosocial support (parental love, counseling, memory work, emotional and spiritual guidance), vocational guidance, recreation, and child protection. The HBC package included nutrition support, maintenance of patient hygiene, psychosocial support, management of common medical conditions (such as cough, fever, and diarrhea), and provision of health education, including HIV/AIDS prevention messages.

Nutrition Care and Support Technical Assistance
IMPACT provided technical assistance on nutrition care and support for patients on ART as the MOH HIV/AIDS Unit commenced a pilot project to provide ART in six sites. The Ministry of Health and Ministry of Agriculture received technical assistance from IMPACT's nutrition advisor to strengthen national programs. The assistance included participation in working groups and contribution on national policy and guidelines concerning nutrition programs.

HIV/AIDS Care and Support Technical Assistance to MOH
In February 2004, FHI seconded a senior care and treatment technical assistant, Dr. Anthony Harries, to the Clinical HIV Unit of the MOH to help drive, coordinate, and facilitate the scale-up of ART in Malawi. In this role, Dr. Harries offered technical assistance in establishment and improvement of care and support services provision. Within the IMPACT timeframe, the national two-year plan for HAART scale-up (January 2004–September 2005) and the national counseling and HIV testing scale-up plan were developed and finalized.

National ART Scale-Up

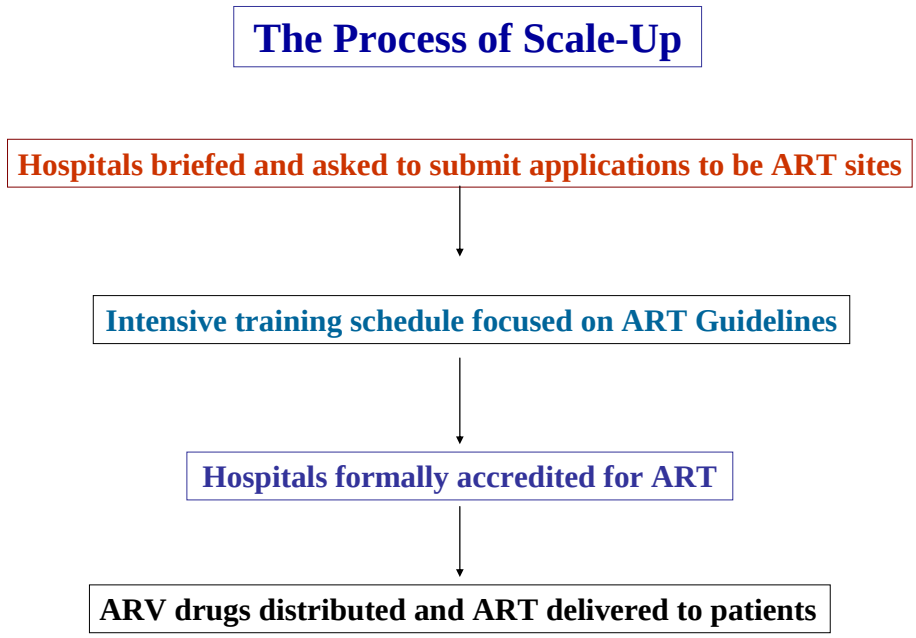
With technical assistance from FHI's care and treatment technical assistant under IMPACT/Malawi, the MOH implemented the national HAART scale-up plan in two phases between January 2004 and September 2005. The contributions from this seconded staff member included assistance in the development of policies and strategies on ART systems and service delivery, ongoing technical advice at the national level and within public health facilities, facilitation of training workshops for government officials and public health workers, active participation in supervisory visits to sites across the country, regular quality control, and monitoring and analysis of results.

In January 2004, Malawi started the process of delivering HAART to all eligible HIV-positive patients in the country. Between July and December 2004, 50 central, district, mission, and Defense Force hospitals in the public health sector delivered ARV therapy. An additional 28 hospitals in the public health sector and in the private sector began to deliver ARV therapy shortly following this period, which was called Phase 1 of the rapid scale-up of ARV therapy. Once hospitals satisfactorily demonstrated capacity to deliver Phase 1 therapy, they were encouraged to move to Phase 2 ARV scale-up (i.e., full adoption of Malawi ARV Treatment Guidelines using first line, alternative first line, and second line therapy). Although IMPACT did not fund ARV procurement or service delivery, the contributions made by the seconded care and treatment technical assistant significantly impacted the design and implementation of the phases described hereafter.

A) Phase I: Rapid scale-up of ARV therapy
The process for preparing staff and sites for ART delivery is outlined in **Figure 1**. Facilities were briefed about ART scale-up and asked to apply to be ART delivery sites. With the shortage of doctors in the country, it was recognized that paramedical officers (clinical officers and medical assistants) and nurses would make up the front-line force responsible for ART delivery at site level. These clinicians and nurses were required to undergo a formal ART training package based on the national ART guidelines, consisting of formal classroom training for five days, an end-of-course examination for competence, and a two-week attachment at an experienced ART site. The HIV Unit of the Ministry of Health then carried out a formal inspection of the ART facility for accreditation purposes. Once a site was accredited, ART drugs were distributed and ART delivery began.

Within six months of preparing for ART scale-up in the public sector, the private sector was brought on board as a willing participant agreeing to follow the national systems, undertake a modified weekend ART training course with an examination of competence, and prepare for accreditation in the same way as in the public sector. Private facilities would receive drugs free of charge, but would charge patients for the drugs at a subsidized fee (US$3.50 per course of treatment per month) and would be allowed to keep part of this money for dispensing costs.

Figure 1



There were three essential prerequisites for the Phase 1 rapid scale-up:

i) Simplification of the ARV delivery system: Use of first line regimen only. The level of excellence provided by ART services at Lighthouse, Thyolo, and Chiradzulu was not possible through the normal government and mission hospitals. It was therefore recommended that the first line regimen be used only in this first rapid scale-up of ARV therapy. This simplified the management of patients, recording and reporting, and drug procurement. Patients who developed side effects or failed the first line regimen were referred to centers of excellence for appropriate treatment; all of these centers were provided with drugs for alternative and second line treatment.

ii) Hospitals' readiness to start delivering ARV therapy assessed between July and December 2004. Readiness criteria included (a) commitment from Hospital Management Teams to go forward with ARV delivery, (b) a functioning VCT service, (c) a dedicated room for delivery of ARV therapy that was suitably equipped and had the appropriate monitoring forms and copies of the national ARV Treatment Guidelines, (d) a good supply of HIV test kits in stock and a system to ensure regular procurement of test kits from Central Medical Stores (CMS), and (e) allocation of the appropriate number of clinical and nursing staff, and other such staff as are needed, to work full-time in the ARV clinic, with team members having undergone a certified MOH training course.

iii) Adequate supplies of HIV test kits and ARV drugs. In the first instance, CMS ensured procurement and distribution of HIV test kits and UNICEF ensured procurement and distribution of ARV drugs. These were in sufficient quantities in the country by June, ready for start in July 2004. As estimates may have initially been inaccurate, it was important that the procurement

agencies specified as long a shelf life as possible to ensure HIV test kits and drugs did not exceed their expiry dates. Ultimately, Malawi developed its own rather unique system of drug procurement, with drugs delivered directly to ART sites by the procurement agent every six months.

The first-year Operational Plan was divided into three-month sections, the first of which (January to March 2004), involved

- a countrywide situational assessment in the public and private sector
- an estimate of the number of patients who would access HAART in the first year
- an assessment of the number of ARV drugs required, costs, and specification
- ARV monitoring tools in use in hospitals providing ARV therapy
- development of training modules, in-service training modalities, and preparedness criteria for delivery of ARV therapy
- a strengthened HIV/AIDS Unit in MOH
- improved HIV/AIDS care management and coordination
- meetings to inform the health sector and development agencies about ARV scale-up and preparedness for ARV delivery
- start of a campaign to inform the general public about ARV scale-up
- development and production of materials for patient education about ARV delivery
- a procurement, distribution, and security plan for ARV drugs
- development of a budget for the two-year plan and mechanisms for funding

The second three months (April to June 2004) involved

- training of staff in the 50 public hospitals in the country as well as a number of the 28 other non-profit and private sector hospitals
- implementation of preparedness for VCT and ARV in the 50 hospitals in the country with support and supervision from supervisory teams
- preparations made with the TB program to develop the systems and modalities for monitoring and evaluating ARV delivery. In addition, the health management information system (HMIS) included additional ARV indicators and the HIV/AIDS unit had worked out a method to collate, analyze, and disseminate the countrywide data.
- development of systems for managing operational research

During the next six months (July to December 2004), the following activities occurred:

- assessment of hospitals' readiness to implement ARV delivery
- hospital implementation of ARV therapy to eligible patients
- hospital visits from monitoring and supervisory teams
- regular monitoring and evaluation and reporting of ARV treatment

B) Phase II: Advanced scale-up of ARV therapy

Phase II was an extension of the ARV delivery plan started in Phase I. Once ARV treatment units were delivering first line ARV therapy, the hospitals and districts continued to work with their partners to deliver ARV treatment fully according to the ARV Guidelines (i.e., first line, alternative first line, and second line regimens). Other units attached to district hospitals, NGOs (e.g., Banja La Motsogolo), private companies, and private clinics also prepared and started to

deliver ARV therapy using first the simplified approach and then the more advanced approach. Activities for this phase were at both the national and local levels.

With input from IMPACT, the MOH's HIV/AIDS Unit coordinated the rollout and implementation of HAART countrywide and ensured continuation of activities begun in 2004. These national level activities included

- health promotion and advocacy
- procurement and distribution of stationery, HIV test kits, and ARV drugs
- recruiting additional ARV units to provide HAART in public and private sectors
- coordinating planning meetings
- coordinating quarterly supervision of ARV implementation
- coordinating quarterly monitoring and evaluation of ARV implementation
- updating treatment guidelines and training manuals
- coordinating training of staff from new ARV units and coordinating training of sites ready to use full ARV treatment guidelines
- scaling up training for all clinical staff in the country
- operational research
- annual surveillance for viral drug resistance (see ARV Treatment Guidelines)
- issuing six-month reports to all stakeholders
- annual review meetings, including a national meeting on lessons learned during the first six months of implementation

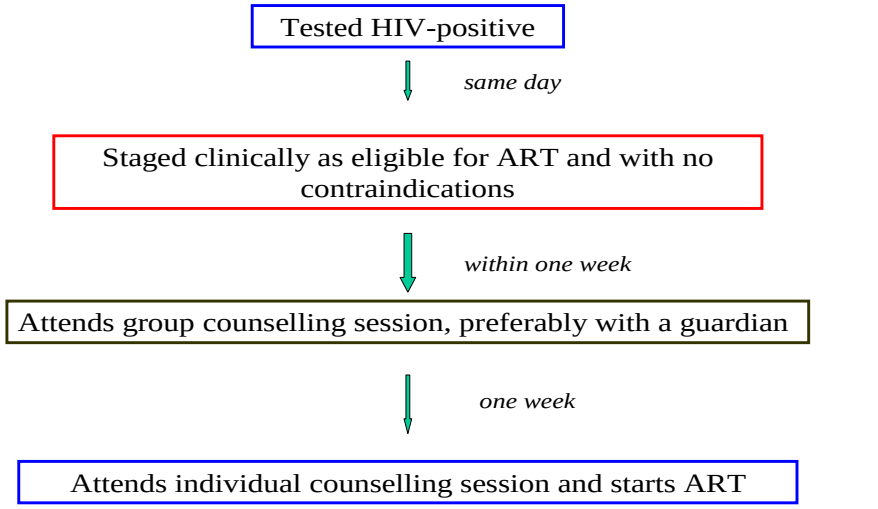
Meanwhile, each central, district, and mission hospital ensured the following:

- implementation of ARV therapy from the hospital ARV clinic
- regular systems of ordering supplies and drugs
- development of quarterly reports to supervising teams
- identification of other sites and personnel to provide ARV therapy in addition to the hospital ARV clinic (this includes sending personnel for training)
- consideration of scaling up from a simplified approach to providing ART in accordance with ART Guidelines

As part of the technical assistance provided to the MOH through IMPACT, the seconded care and treatment advisor contributed significantly to ensuring that the following important steps were taken in delivering and monitoring ART in public health facilities across the country:

Eligibility for ART. Adults and children were required to be HIV-seropositive, the patient or guardian had to understand the implications of ART, and patients were required to be assessed in World Health Organization (WHO) Clinical Stage 3 or 4 or be in WHO Clinical Stage 1 or 2 with a CD4-lymphocyte count below the threshold value for severe immunodeficiency (in the case of adults this was set at 250 cells/mm^3). Most ART clinics did not have a machine for measuring CD4-lymphocyte counts, and the emphasis was therefore on clinical staging. Once staged eligible for ART, patients went through a process of group and individual counseling, and then began treatment (see Figure 2).

Figure 2



Standardized ART. Malawi focused on the use of one generic, fixed dose combination treatment with stavudine, lamivudine, and nevirapine. Two alternative first line regimens (for serious side effects of ART drugs) and one second line regimen (for ART drug failure) were placed in central and major district hospitals over the first two years, and a referral system was set up so that any patient in need could access appropriate therapy. As sites became more experienced in the use of ART, more of them were given alternative first line therapy directly. Patients were started on treatment, seen two weeks later, and then followed up every four weeks for life. After six months, if the patient was stable and had been adherent to medication, the patient could be seen every two months. Monitoring for wellbeing, side effects, and drug adherence were all done clinically; in most sites there was little in the way of laboratory investigations.

Registration, recording, and reporting at ART sites. Similar to the process for TB programs, all patients were given a unique ART registration number that served as their key identification for the monitoring tools. At ART sites, the two important tools were the ART patient treatment master card and the ART patient register. Both of these included the case finding details of patients (ART number, name, address, age, sex, occupation, and reason for ART) and their monthly treatment outcomes. The treatment master card recorded the monthly visits and was in essence a chronological record of the patient's progress on ART. Any adverse outcome, such as death, default, stopped treatment, transfer out, or change in regimen, was recorded in the treatment master card, and this change was reflected in the ART patient register. The register therefore provided a record of the patient's status at a set point in time.

At the end of every quarter, the ART clinic team was expected to cross-check the records, in particular to check that treatment outcomes in the master card had been accurately recorded in the register, and to perform cohort analysis of cases and end-of-quarter outcomes with events censored at the end of that particular quarter. There were two types of cohort analysis: a

quarterly analysis of new patients started on ART in the latest three-month period and a cumulative analysis of all patients started on ART.

Supervision and monitoring. Every three months, the HIV Unit of the Ministry of Health and its partners conducted supervisory and monitoring visits to all ART sites in the country to ensure adherence to guidelines and standards, collect data for national reporting, provide encouragement and support (and sometimes admonishment if performance was poor), and obtain drug stock levels to help with drug procurement. At the time these visits were conducted, the supervising teams gave each ART site a copy of the latest national report and the schedule for the next quarterly visits—the latter activity nullified the need for posting letters to peripheral sites.

ii. Service Delivery

HIV/AIDS Prevention and Behavior Change Interventions

HIV/AIDS in the Workplace
In FY2002, IMPACT and Umoyo Networks completed a subagreement that provided funds for the Umoyo Network to work with Bowler Beverages Company, Ltd. (BBCL), a brewer of a local beer, Napolo. Through this partnership, Umoyo supported the implementation of a comprehensive prevention program at all stages of the beer industry of BBCL and Napolo, from production to consumption. The subproject began with a formative assessment consisting of qualitative and quantitative behavioral assessments among beneficiary groups in the project area (e.g., brewery staff, truck drivers, tavern owners and managers, and sex workers). Using the results of the behavioral assessments, IMPACT and Umoyo Network led a BCC strategy development workshop with representatives of NAC and staff, volunteer peer educators and beneficiaries, Umoyo, PSI, and BBCL. The results were used to guide project design by informing the peer educator curriculum and BCC materials.

Through this subproject, additional BBCL staff members were hired and key equipment was procured for the project office at the brewery. Zone coordinators then carried out trainings and BCC with workers selected from taverns, bars, and bottle stores in Salima, Lilongwe, Mchinji, and Kasungu districts. The workplace interventions initially focused on HIV/STI prevention at BBCL's brewery in Lilongwe, but later expanded to include a care and support component. This subproject not only provided services to the brewery employees but also conducted BCC activities with the truck drivers who delivered the beer, owners and managers of the bars that sold it, sex workers who worked at the bars, and the sex workers' clients.

This was an important workplace intervention because the owner of BBCL is very influential in Malawi, able to encourage the implementation of such programs within other breweries and workplaces.

BCI Materials Development
A subagreement with a local NGO called Story Workshop Educational Trust/Timasukirane was executed to develop a multimedia package in collaboration with NAC. The HIV/AIDS IEC materials they produced consisted of a facilitator kit with audio cassettes, drama sketches, songs, proverbs, and booklets. The content of these radio dramas and print materials was based on the

BCI literature review and BCC strategy spearheaded by the BCC technical advisor. The content was pretested and revised, then used in a Training of Trainers (TOT) and distributed to youth ages 14 to 25.

Key Social Groups Training
IMPACT and the BCI core team conducted five workshops in 2002, targeting organizations working on HIV/AIDS and sexual and reproductive health programs for some of the key social groups (KSG) identified in the strategy. The objectives of the training events were to analyze the BCI strategy, develop BCI implementation plans, and determine BCI support needs for implementation. A total of 186 managers and implementers of SRH/HIV/AIDS programs from around the country attended training events focused on several KSG areas: men and women engaging in high-risk behaviors; young people; service providers; women of childbearing age; and policymakers. For the purpose of capacity building and ownership, the IMPACT consultant worked in close collaboration with the BCI core team and Mzuzu University, Kamuzu College of Nursing, and the Malawi Institute of Management.

BCI Training Curriculum
During the KSG training events the facilitators from various fields of expertise carried out a process of continuous revision of the BCI curriculum. The BCI core team concentrated on technical content, and the partners from Mzuzu University, Kamuzu College of Nursing, and the Malawi Institute of Management focused on training techniques. Feedback from the participants was incorporated into the final document. The final product is a training manual with a facilitation guide composed of lesson plans for 15 sessions, a set of 108 presentation slides, a one-hour video titled “Lifecycles, a Story of AIDS in Malawi,” produced by Human Scale Productions, a set of materials (including a questionnaire BCI baseline, registration form, and evaluation form), and three diskettes containing all the above materials to assist in reproduction of the text and tools.

Integrated OVC/HBC/Nutrition Program

Beginning in August 2003, IMPACT initiated subagreements with nine IAs in six high-prevalence districts of Malawi (Nsanje, Chikwawa, Blantyre, Dowa, Mangochi, and Lilongwe) to reach children and households in greatest need. Of the nine IAs, the following six began work in 2003:

- Word Alive Ministries International (WAMI)
- The Salvation Army (TSA)
- Family Health Education Counselling and Care (FHECC)
- Trinity Hospital
- The Lighthouse Trust
- Namwera AIDS Coordinating Committee (NACC)

In April 2004, Friends of AIDS Support Trust and Mponela AIDS Information and Counselling Centre began implementing their activities; Save the Children (USA) initiated its work in September 2004.

Provision of OVC and HBC Services
Through FHI/IMPACT technical and programmatic support, the nine IAs listed above carried out the following activities in their OVC and HBC programs:

Training/capacity building
- recruitment and training of OVC volunteers and other caregivers to enhance their skills in providing support to OVC and offering HBC services
- workshops on life skills, child rights, and vocational skills training (including linkages with local artisans)
- development of vulnerability index
- exchange visits for FHI and partner staff and volunteers
- vocational skills training in tailoring, carpentry, and motor vehicle mechanics to OVC and HBC clients
- resilience training for OVC in responding to the impact of parental illness, death, and orphanhood

Mobilizing community support
- sensitization meetings for mobilizing community support of HBC/OVC programs
- identification and registration of OVC
- identification of community leaders and "champions" in support of OVC
- creation of public awareness about HBC and OVC, including discussions about child rights and types of child abuse related to OVC
- community capacity building and/or advocacy through collaborative meetings with stakeholders and partners to share experiences, lessons learned, and challenges in caring for HBC clients and OVC
- creation of community initiatives/structures to provide support to OVC
- support for community-based child care centers
- support for formation of youth clubs
- support for out-of-school and older OVC (ages 10 to 18)

Household-level interventions
- home visits to OVC households
- providing OVC with referrals for services and support including counseling and psychosocial support activities, food/nutritional counseling, medical care, and greater access to school fees, scholastic materials, and vocational skills training
- support to increase registration of children at birth

Promoting linkages and referrals
- linking adolescents to youth clubs
- strengthening linkages between multiple service providers and stakeholders
- development of a directory of service providers (e.g., resource map)

Increasing PLHA involvement in community activities and programs
- community mobilization and sensitization
- provision of care and support to OVC
- encouraging PLHA participation in project design and implementation

- group therapies and outreach activities focused on positive living, stigma, discrimination, and HIV/AIDS prevention. (When needed, clients were referred to the hospital for further medical management.)
- support to children living with HIV/AIDS, including nutritional, educational, health, and psychosocial support
- Memory project training of trainers

Educational support to increase OVC retention rates in schools

- advocacy among school officials for reduction of school fees/bursaries and increased support for OVC in schools
- orientation sessions for parent/teacher associations to advocate for OVC
- sessions with school committees and local leaders to discuss how OVC can be retained in school and how out-of-school OVC can be linked to vocational skills trainings to support their livelihood
- provision of food, clothes, and educational support
- promotion of early childhood development
- dissemination of OVC and early childhood development policies

Provision of Nutrition Support

Eight of the nine IAs incorporated the nutrition care and support component into their subagreement activities, with Lighthouse Trust opting out. Partners were trained within their respective districts and, in turn, they trained and provided ongoing guidance to the community-based volunteers and caregivers.

Most partners incorporated the following activities into their programs (with IMPACT conducting the first training of trainers and actively supporting each partner throughout by providing technical advice, resource and reference materials, and weighing scales):

- training of IAs and government district and extension staff in basic nutrition, malnutrition, the link between nutrition and chronic illness, nutrition counseling, and ways of addressing nutrition security using low input horticultural methods and better utilization of foods

- training/orientation of HBC/OVC households and community volunteers (HBC and CBCCC) by the partners in the importance of consuming a more balanced diet, obtaining a greater variety of foods, and more appropriate use of food commodities

- in interested households, establishment of kitchen gardens with a greater variety of vegetables and fruit, using low input horticulture, including mulching, compost making, and recycling of household water; linkages with organizations providing low cost drip-feed or other appropriate irrigation technology

- formation of monthly or twice-monthly cooking clubs for HBC households and members of the general community to demonstrate appropriate use of locally available foods; activities included demonstration of innovative, nourishing recipes and simple fuel/energy/timesaving technologies, as well as forums for discussion on such subjects as

caring for sick children, HIV/AIDS, weaning foods, and nutrition for pregnant and lactating women.

Food Aid
While IMPACT did not provide supplementary food aid, some individuals and households benefited from linkages with programs implemented by the World Food Programme or other NGOs operating in their communities.

Distribution of Weighing Scales
Gradual weight loss is almost always associated with chronic illness and especially with AIDS and tuberculosis. Detecting early gradual weight loss in adults or failure to thrive in infants and young children ensures that nutritional advice on suitable foods and provision of extra food supplements, if available, has a more profound effect. Mild weight loss is much easier to reverse than severe weight loss, and by preventing nutritional deterioration, early progression from HIV to AIDS can be slowed. With the provision of adult and children's weighing scales, the weight of HBC clients, OVC, PLHA, and children attending community-based child care centers (CBCCCs) can be monitored over time. Weighing scales were distributed in the last quarter of the project for continued use by the partners after the closeout of IMPACT.

Each of the partners received five adult stand-on bathroom scales and one hanging Salter scale for infants. It was agreed that the HBC clients should be weighed weekly if possible, or every two weeks, and children in CBCCCs should be weighed monthly with the assistance of health staff. Partners were trained in the correct use of the scales and recording of data, which in the case of HBC clients was in their household register/book. Weight was recorded against the date, and any client with declining weight for more than three weeks was required to be referred to the nearest health center for medical examination. Clients returning from the health center examination and/or ART were required to be followed up regularly, with nutrition advice and weight monitoring.

Sensitization of Community Leaders in HBC/OVC
Community leaders were sensitized and oriented in HBC/OVC, which led to the development of community initiatives to support HBC/OVC activities, such as establishment of communal gardens and CBCCCs. These community initiatives, which included HBC/OVC committees, facilitated mobilization of resources to support identification and provision of care and support to HBC patients and OVC. In addition, community leaders oversaw activities of community volunteers.

Household and Community Gardens
A phased approach was adopted for all implementing partners. The HBC/OVC program was established initially, with some nutrition education incorporated into the training sessions. When households had been identified and volunteers and partners were implementing the HBC/OVC activities successfully, the nutrition care and support activities began, including the establishment of household gardens and new community gardens.

Nutrition Package
The nutritionist held in-depth discussions during visits to all partners to assess their capacity, looking at nutrition care and support in detail and designing the approach and activity development. The IMPACT nutrition package was developed from these and other discussions.

iii. Capacity Building of IAs and Beneficiaries

FHI is committed to capacity building through skills and knowledge transfer, not only to our partners but also to government district staff. This extends to the national level with technical support in many aspects of nutrition to the Ministries of Health and Agriculture and Food Security, participation on technical committees developing protocols for treatment of acute malnutrition, food and nutrition security policy, monitoring and evaluation tools, nutrition surveillance, and counseling for PLHA, among other activities.

As part of the program, IMPACT's IAs and beneficiary communities participated in activities designed to build their capacity in areas such as staff/volunteer recruitment and training. These activities stimulated community involvement, while achieving their central aim of increasing the level and types of support available to OVC and the chronically ill.

Project Design/Proposal Development for Potential IAs
Every year that new subagreements were developed, and occasionally when amendments were executed, IMPACT facilitated a one-week participatory proposal development workshop for new IAs. In 2003, nine out of the 13 potential organizations who received training in project design and proposal development were funded by FHI through IMPACT (FHECC, WAMI, FAST, Trinity Hospital, TSA, MAICC, NACC, Lighthouse Trust, and Save the Children). The second such workshop, conducted in 2004, involved 11 additional potential IAs: Tovwirane from Mzimba, REFORD from Mulanje, St. John's from Mzuzu, Malawi Red Cross from Dowa, Balaka and Ntcheu, Ndirande Churches and Mosques from Blantyre, Malawi Defence Force from Salima, ACCOCARP and Tiwasunge from Nsanje, and COVISODE from Chikwawa.

Such proposals typically addressed the following issues: strengthening capacity of communities to provide care and support for chronically ill clients through HBC and care and support for OVC; strengthening/developing networks and linkages at the district level; involvement of PLHA in care and support activities; and psychosocial and memory approaches.

Most of these proposals resulted in subagreements between FHI and the IA. These new partnerships increased IMPACT's coverage, strengthening support for development of integrated HBC/OVC programs in Malawi's districts, and served as a mechanism for capacity building of the IAs. The projects also aimed to improve synergies with other USAID-supported organizations.

Training of Project Staff in HBC/OVC
IA project personnel were trained in HBC/OVC service delivery using national guidelines. This helped them guide, supervise, and monitor implementation of HBC/OVC activities in their catchment areas. As a result, IAs were able to deliver services such as sending children back to school through provision of school supplies; referral of patients to health facilities and VCT

services; and linking HBC clients and OVC to organizations that provide nutrition support (such as the World Food Programme). Furthermore, IAs were more prepared to document activities and share their experiences through reports and meetings.

Training of Trainers in HBC
A training of trainers (TOT) in HBC was conducted, involving 12 representatives from IAs and MOH-supported district hospitals. This training increased the number of HBC trainers in the country who, in turn, trained partner volunteers and other stakeholders.

Training of Volunteers in HBC/OVC Service Delivery
IAs trained volunteers in care and support service delivery and documentation of activities for HBC patients and OVC to equip them with the necessary knowledge, attitude, and skills to effectively deliver and document care and support services. The training content included identification of HBC clients and OVC, information about different types of care and support, linkages/collaboration, referral, and use of client registration forms. Volunteer training in HBC and OVC service delivery, conducted using national guidelines, contributed to delivery of improved services to HBC clients and OVC.

Training in Psychosocial Support
To enhance service delivery skills, two participants from IAs and two from IMPACT received psychosocial support training at Masiye Camp in Zimbabwe. The training built the capacity of participants to implement and integrate psychosocial support into existing OVC programs. It also equipped participants with knowledge and skills to monitor and evaluate issues during implementation of psychosocial support at organizational levels. The training facilitated the transfer of lessons learned within partner organizations and expanded psychosocial support networks within the region. After returning from the training, the participants acted as resource persons, sharing the knowledge they had gained with other IAs. Examples of training content include self-awareness; impact of HIV/AIDS on children; OVC programming principles, guidelines, and programming strategies; bereavement counseling; and introduction to memory approaches to build children's resilience.

Training in Nutrition
Nutrition training included participants from the IAs and government district and extension staff from the MOH, MOA, and District Social Welfare Office. Facilitators varied from session to session but generally included the FHI nutritionist, district coordinators, and secretaries (who facilitated the creative cooking and other practical session) and professionals from partners, government, and other NGOs experienced in the low input approach. Teaching material was taken from the "Low Input Food and Nutrition Security Manual—Growing and Eating More Using Less" produced for Malawi by the World Food Programme (December 2005). Other nutrition, HIV, and horticultural materials from a variety of sources were also used. All participants received a file of handouts by the end of the course, and all partners and FHI district offices received resource and reference materials in the form of books, leaflets, posters, and equipment.

Practical sessions included creative cooking using energy/time/fuel–saving methods for cooking and preserving nutrients in foods; making paper briquettes from waste paper and Tippy Taps

from plastic bottles for hand hygiene; designing and making more nutrient-dense foods for children and the chronically ill; identifying food crops in Malawi's six food groups that are available locally in all seasons; and using medicinal plants and herbs.

iv. Linkages, Collaboration, and Strengthening of Partnerships

Establishment/Strengthening of Informal Linkages
Linkages and collaboration between IAs and other service providers were established in some areas and strengthened in others. This facilitated meeting the diverse needs of HBC patients and OVC. Strong working partnerships were established between IAs and surrounding health facilities, which led to improved referral systems and reduced duplication of effort.

Development of Referral Systems
A functional referral system between HBC programs, health facilities, VCT, community support structures, home care teams, and other relevant stakeholders within the community is a key component of the continuum of care. Facilitating development of effective referral systems enabled patients to access appropriate levels of care according to stage of illness, thus avoiding overburdening the hospital with minor ailments and ensuring that more serious conditions were treated promptly. In addition, better referral systems assisted patients in accessing support for other diverse needs.

Creation of Resource Maps
IMPACT facilitated establishment of IA-based resource maps. These maps were used to assist new partners with identifying focus areas and to help demarcate catchment areas, thereby minimizing duplication of effort and encouraging resource sharing.

Establishment of HBC/OVC District Networks
IMPACT facilitated establishment of HBC/OVC networks at the district level. This allowed for sharing of experiences pertaining to project performance and lessons learned. It also reduced duplication of effort because catchment areas were clearly noted.

Collaboration Among USAID Partners to Enhance Comprehensive Care for PLHA
IMPACT organized a meeting with other USAID partners in Chikwawa District to enhance collaboration and achieve comprehensive care for PLHA. Participants included representatives from Management Sciences for Health, Monfort and Chikwawa district hospitals, and IMPACT. The meeting identified several advantages of this type of collaboration, including standardization of services; broadening of volunteers' skills base; increased number of clients accessing VCT; increased number of clients disclosing HIV serostatus; increased number of patients accessing and adhering to ART and TB treatment; and increased number of HBC patients accessing a wide range of services. Strategic points were identified that partners felt would enhance future collaborative efforts, and an action plan was developed.

v. Strategic Information: Monitoring and Evaluation, Operations Research, and Surveillance

Behavioral Surveillance Survey
In collaboration with the NSO, IMPACT conducted a BSS that provided baseline information to assist in development of a system for tracking behavioural trend data for high risk and vulnerable target groups; to provide information on behavioral trends among key target groups in some catchment areas where intervention projects were operating; and to strengthen ARV rollout and the second generation surveillance system in Malawi.

End-of-Project Nutrition Assessment
A survey adapted from a generic questionnaire suggested by the Low Input Food and Nutrition Security Manual was developed with input from partner representatives and IMPACT staff. It examined individual households at baseline and again at six-month intervals to demonstrate whether they had adopted and were using the nutrition knowledge (especially low input concepts for cooking and raising crops). As the nutrition component of the program was implemented for a short time, only eight IAs were able to collect the data required. All data were aggregated and analyzed together as the relatively small numbers of respondents per partner precluded more robust individual partner analysis. The analysis, indicating gaps where more effort is needed and areas of achievement, was provided to partners.

Data Collection Tools
Standard data collection tools were developed to assist documentation of HBC and OVC activities and to guide service delivery. These included client/OVC registration forms, register guides, monthly and quarterly report templates, volunteer supervisory checklists, and quarterly supervisory checklists. The Monthly Indicator Report Form (MIRF) was modified in mid-2006 by the nutritionist and the M&E officer, with approval from FHI headquarters, after discussion with all partners. The checklist for use on supervisory support visits was modified at the same time to accommodate the nutrition activities.

Supportive Supervisory Visits and Quarterly Review Meetings
IMPACT conducted ongoing monthly and quarterly supportive supervisory visits to supervise HBC/OVC service delivery and follow up on data collection and reporting. These visits provided an opportunity to monitor the progress in implementation of planned activities, to identify areas that needed strengthening, and to provide on-the-spot technical support to implementing partners. In addition, supervisory visits helped to motivate partner organizations and their volunteers. Results from these visits were structured to be supportive rather than punitive, as illustrated below by a few examples.

Findings from supervisory visits…What is going well

- excellent referral linkages for patient care
- excellent mobilization of community
- communities are finding answers to their own problems
- implementation of vocational training for OVC
- implementation of sustainable food security programs
- volunteers empowered to mobilize communities for assistance

- adherence to HBC/OVC packages in providing care and support
- older orphans involved in providing care and support as volunteers

Findings from supervisory visits…Room for improvement

- absence of managers during field visits and discussion
- planned activities not conducted, thus compromising program
- decrease in volunteer commitment
- lack of regular and thorough volunteer household visits, compromising patient care and support
- weak linkage/involvement of needed health facilities
- weak referral of patients
- with increasing availability of ARV therapy, need to strengthen patients' access by overcoming obstacles

All findings were addressed immediately during the visit, and again at the next visit to ensure that follow-up or corrective actions had been taken. IMPACT also conducted quarterly review meetings with implementing partners, government departments, and other collaborating partners. These meetings provided an opportunity to review progress made during the implementation of planned activities within the context of achieving program objectives and sharing experiences, lessons learned, and challenges. The meetings provided an opportunity for study visits to other organizations, which contributed to improved service delivery and monitoring of activities.

E. MALAWI IMPACT PROGRAM TIMELINE

Activity	FY2002				FY2003				FY2004				FY2005				FY2006			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Development of National BCC Strategy and workplan	X	X																		
Development of BCI materials			X	X	X	X	X													
Supervisory support for BSS									X	X										
Initial assessment for HBC and OVC activities				X	X															
Selection of districts for HBC and OVC program focus				X	X															
Recruitment of IAs						X							X							
Proposal development workshop							X							X				X		
Training of IAs in HBC and M&E							X							X				X		
Training of IAs in OVC and M&E											X								X	
Refresher training in HBC/OVC and M&E								X	X	X										
Development and procurement of CHBC training materials								X	X	X	X	X	X	X	X	X				
District networking meetings on HBC/OVC						X	X	X												
Development of M&E workplan									X	X	X	X								
Consultative workshop to review M&E workplan										X		X		X						
Review of OVC training manual									X	X	X	X	X							

Activity	FY2002				FY2003				FY2004				FY2005				FY2006			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Development of training handbook and tools on M&E for HBC/OVC										X			X							
Training in and establishment of computerized database (IAs/DACCs)											X	X		X				X (new IAs)		
Baseline assessment of IAs										X										
Training of trainers (TOT) in HBC							X	X	X	X	X	X	X	X	X	X				
National level stakeholder meetings and workshops (HBC/OVC/M&E)							X				X		X		X					
Regional meetings/workshops (HBC/OVC/M&E)							X	X	X	X	X	X	X	X	X	X	X	X	X	X
Quarterly supervisory visits							X	X	X	X	X	X	X	X	X	X	X	X	X	X
Quarterly review meetings							X	X	X	X	X	X	X	X	X	X	X	X	X	X
Compilation of quarterly progress reports								X	X	X	X	X							X	X
Review of M&E workplan											X								X	
Review of IA data collection instruments											X	X								X
Pilot testing of revised forms													X	X						X
Training of IAs in use of forms													X							
Memory project (TOT)												X	X						X	X
Development of integrated training manual (HBC/OVC/M&E)												X	X	X	X	X		X	X	X

Activity	FY2002				FY2003				FY2004				FY2005				FY2006			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Establishment and training of PLHA support groups															X					X
Annual staff meetings (Country Office Capacity Assessment Tool [COCAT], Team Building)													X					X		
Financial/administrative training of IAs														X	X	X				
Training of IA coordinators in computer skills													X							
Psychosocial support training														X	X					
HBC/OVC mentorship (FHI exchange visit)—Kenya and Namibia						X				X				X						
Global management meetings																			X	X
Operations research													X	X	X	X				
Burden of care													X	X	X	X				
Role of HBC in ART														X	X					
Cost analysis														X						
Follow-up program assessments (quality of care and support services)													X							
Annual national stakeholder program review workshop																				
National ART scale-up activities										X	X	X	X	X	X	X				

Activity	FY2002				FY2003				FY2004				FY2005				FY2006			
	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4	Q1	Q2	Q3	Q4
Nutritionist's arrival														X						
Proposal development for eight existing partners (not Lighthouse Trust)															X					
Development of nutrition package, modified MIRF, and support checklist																			X	
Development of nutrition care and support training, IEC																X				
Memorandum of Understanding (one year) signed with COMPASS II																X				
COMPASS II activities started																X	X			
Training of eight existing partners (not Lighthouse Trust)																	X			
Support to partners and MOH, Dept. of HIV/AIDS and Nutrition (Office of the President and Cabinet, MOA)														X	X	X	X	X	X	X
Budget amendment for all partners																				X
Training of new partners																				X
Distribution of weighing scales																				X
Closeout and pre-audit visits to all partners																				X

F. PROGRAM RESULTS

The achievements of IMPACT and its partners in Malawi are summarized below.

1. Inputs/Outputs[9]

Training

OVC: 1,103 service providers were trained to provide OVC services using national guidelines.*

HBC: 1,445 service providers were trained to provide HBC services using national guidelines.*

**Note: The service providers for the IAs that provided both OVC and HBC services were trained in both programs and counted in each program area, per PEPFAR specifications.*

Nutrition
Five nutrition care and support training sessions were held for FHI district staff, more than 100 partner staff, and more than 100 government staff. Following this training, all 19 partners further trained community members consisting of volunteers, CBCCC and HBC/OVC caregivers, PLHA, and community leaders—2,815 in total, an average of 148 per partner.

Activity	Total	Average per partner
Community members trained	2,815	148
Households participating	2,133	112
Kitchen gardens established	809	43
New communal gardens	244	13
Cooking clubs formed	71	4
Cooking club members	1,196	63, average per club 17

ART [10]

- a total of 996 healthcare workers trained and certified in ART in the public sector, 241 healthcare workers trained and certified in ART in the private sector, and 40 pharmacy technicians trained and certified in ART in the public sector
- a total of 33 staff in 13 colleges of medical and nursing education trained as trainers of students

[9] The service delivery data presented is from IMPACT programs implemented from 1999–2005. From 2005–2007, IMPACT funds covered discrete activities that complemented the bilateral interventions, such as manuals for HBC/OVC, community orientation guide, and continued support to national-level initiatives in the areas of OVC, HBC, and nutrition.

[10] Note: IMPACT/Malawi did not cover the costs of the training workshops but rather these figures include the individuals who benefited from trainings facilitated by the care and treatment technical advisor seconded to the MOH by FHI using IMPACT funds.

Technical Assistance

The nature of technical assistance provided by various organizations in Malawi has been described in the narrative of each of the activities above. Below is a list of the organizations or government bodies who were provided with technical assistance from FHI through IMPACT:

1. Lighthouse Trust
2. Word Alive Ministries International (WAMI)
3. Namwera Aids Coordinating Committee (NACC)
4. Family Health Education and Counseling Centre (FHECC)
5. Mponela AIDS Information and Counselling Centre (MAICC)
6. National Statistical Office (NSO)
7. Program for Appropriate Technology in Health (PATH)
8. Friends of AIDS Support Trust (FAST)
9. The Salvation Army (TSA)
10. Trinity Hospital
11. Save the Children (USA)
12. Umoyo Network/Napolo Brewery
13. Storybook Educational Trust
14. Ministry of Health (MOH)
15. Ministry of Agriculture (MOA)
16. National AIDS Commission (NAC)

Guidelines Development and Policy Reform

IMPACT provided human resources and/or funding support for the following policies, guidelines, and manuals:

- Guidelines for Integrated HBC/OVC Services, 2007
- HIV/AIDS in the Agricultural Sector: Policy and Strategy, 2003–2008
- Republic of Malawi Behavioral Surveillance Survey, 2004
- IMPACT/Malawi Home-Based Care and Support to Orphans and Vulnerable Children
- Assessment and National Workplan, July-August 2002
- IMPACT/Malawi Home-Based Care and Support to Orphans and Vulnerable Children
- Workplan and In-Depth Assessment, November-December 2002
- Assessment of HIV/AIDS and Sexual and Reproductive Health Information and Communication Needs Among Young People in Malawi, February 2005
- National Policy on Orphans and Vulnerable Children, February 2003
- National Best Practices on Community-Based Care for Orphans
- Developing a Comprehensive Monitoring and Evaluation Workplan for HIV/AIDS and STIs, 2003
- Training Manual on Orphan Care, planned for 2008
- National ART training curriculum (with five-day, two-day, and one-day modules), May 2004

Study Tours

Four people (two IA staff and two FHI staff) participated in a study tour to Zimbabwe, where they trained in psychosocial support for PLHA and OVC.

Strategic Information

Two surveys—a baseline evaluation in 2002 and a behavioral surveillance survey in 2004—were conducted during IMPACT. A final evaluation specific to the IMPACT program was not conducted because the activities merged into a bilateral program. A final evaluation will be completed at the end of the bilateral program, pending availability of funding.

Service Delivery

Strategic Behavioral Communication
In its early days, IMPACT's efforts in Malawi in the area of BCI were significant: A document charting Malawi's future BCI efforts was produced, and the reproductive health unit of MOH bought into the strategy and worked with the NAC's BCI unit to develop the joint strategy. The final activities for this phase included the completion of the BCI strategy; facilitation of training for key social groups; completion of a training curriculum for BCI implementation; a values clarification retreat on HIV/AIDS and sexual and reproductive health; and continued work on a multimedia package with Story Workshop.

OVC/HBC:

Program	**Total Direct Services ****			**Total Indirect Served/Supported ****		
	Achieved	Target	% of Target Achieved	Achieved	Target	% of Target Achieved
OVC	64,131	10,000	641.3 (more than six times the target)	19,832	10,000	198.3 (close to twice the target)
HBC	N/A	N/A	N/A	4,482	5,000	89.6
Volunteers	N/A	N/A	N/A	8,819	N/A	-

**Note: the definitions of "direct services" versus "indirect served" are as follows:

Number of OVC indirectly served refers to the total number of OVC reached with one service (as defined by PEPFAR indicator).

Number of OVC directly served refers to OVC who received three or more services (as defined by PEPFAR indicator).

ART
During the period that the MOH benefited from technical assistance provided by the care and treatment technical advisor supported with IMPACT funds, the national ARV program attained the following results:

- 60 facilities delivering ART in the public sector, from a baseline of 9 in February 2004; all facilities accredited for ART and using national systems for monitoring
- 30,055 patients started on ART in the public sector, from a baseline of about 3,000 in February 2004
- procurement systems in place and no stockout of drugs for ART
- operational research activities undertaken and papers published
- six-month reports written and disseminated since start of ART scale-up in 2004 and 2005

Between January 2004 and September 2005, 60 facilities in Malawi in the public health sector were delivering ART free of charge to eligible HIV-positive patients. Although IMPACT did not fund the ARVs themselves or the ART service delivery, the technical assistance provided to the MOH during this period enabled a total of 30,055 patients to begin ART; in the third quarter of 2005 alone (July to September), 7,784 new patients started on ART. For the quarter and for the cumulative analysis, 39 percent of patients were male and 61 percent were female; 95 percent were adults (13 years and above); and 5 percent were children.[11]

2. Outcomes

Through technical assistance provided by FHI CO personnel and staff seconded to government structures, IMPACT significantly influenced national-level policies, norms, and guidelines. In addition, IMPACT left behind a large body of knowledge and best practices in the form of technical manuals, training tools, and service delivery packages. The project also strengthened the capacity of its subgrantees through training workshops, ongoing technical assistance, and mentoring financial management. And most importantly, it enabled the provision of vital services to the population to improve their quality of life.

Improved Quality of Service Delivery Through Client Registers
Implementing agencies set up client registers, which did not exist prior to implementation of the HBC/OVC program. In these registers, client and OVC needs, as well as service provision, were documented. The creation of client registers assisted with tracking of patients and their needs, program planning, and data analysis.

Improved Nutrition and Food Security at Household Level
The End-of-Project Nutrition Assessment in 2007 clearly showed the positive effect that nutrition care and support—even in limited amounts—can have in a very short time (see Attachment C). Many households adopted a low input approach and implemented recommended practices regarding preparation and consumption of a greater variety of foods (diversification of diet) and growing methods for successful food crop production. The main findings are as follows:

[11] Again, IMPACT funds did not cover ARV procurement or service delivery; rather, IMPACT contributed indirectly to the achievement of these outcomes by providing intense technical assistance to the MOH's HIV/AIDS Unit in the design, implementation, and monitoring of the national ART program.

- For all food groups, both the number of types available and the number of types eaten on the previous day increased between baseline and six months (though it is impossible to tell whether this was due to the gardens or to the difference in season).
- Improved methods of food preparation (diversification and reduced boiling), counseling on HIV and nutrition, the growing and use of medicinal plants, and the use of the Tippy Tap[12] all increased between surveys.
- Membership in cooking clubs and use of a fuel-efficient cooker both increased after six months.
- All of the low input soil conservation and fertility building measures were adopted by more households at six months than at baseline.
- For all of the food groups, a greater variety was grown at six months than at baseline.
- Water recycling (mainly involving the use of waste water on the garden) increased by six months.
- Synthetic pesticides were used by fewer households at six months than at baseline. More natural remedies were used at six months, especially local remedies.
- More households were using low input concepts after six months than at baseline.
- More households reported spread of the new food security and nutrition ideas at six months than at baseline.
- Median income from the gardens (theoretically including the value of produce eaten at home) was not much greater than expenditure at baseline but was better at six months. Fifty-two percent of households were in deficit at baseline, compared with 38 percent at six months.

Nutrition Training Results

Nutrition training enabled all partners to implement their activities effectively. Quarterly reports, anecdotal evidence, and site visits to the eight partners first trained show increasing numbers of community members trained in many aspects of nutrition, food preparation, and low input horticulture; gardens established; cooking clubs formed; and nutrition-related activities included in meetings of PLHA support groups and district World AIDS Day demonstrations. Even partners trained toward the end of their subagreement with FHI, with only the training of community members budgeted for, have demonstrated great commitment to the importance of nutrition in caring for children and the chronically ill. At St. John's in Mzuzu, the PLHA support group is using low input cooking methods to prepare communal meals based on the six food groups. AIDS Care Counselling Campaign Project **(**ACCOCAP) in Nsanje, just a week after their training, staged a nutrition-orientated food preparation demonstration for World AIDS Day in 2006, which captivated high ranking government officials and many others. (See table in section F.1 above.)

Effect of Weighing Scales

Each of the 19 partners received five adult stand-on bathroom scales and one hanging Salter scale for infants. Partners decided where to place the scales for easy access and maximum use.

[12] The Tippy Tap primarily consists of a can that releases a small amount of water—just enough to wash hands clean—each time it is tipped. When the "tap" is released, it swings back to its earlier upright position. More details on the Tippy Tap by the Centers for Disease Control can be found in "Tippy Tap Saves Water," in Dialogue on Diarrhoea online, nr. 54, 1993. http://rehydrate.org/dd/dd54.htm

Most scales have been located in the community, at the community AIDS committee chairperson's home or the equivalent for use in that area and monthly in the local CBCCC. Some partners have retained one at their office for use when PLHA support groups meet. All are being used appropriately. The scales were procured and distributed in January/February 2007, at which time the partners were trained in their use. Therefore, any measurable impact on the community program has not been documented.

Strengthening of NAC
IMPACT helped the NAC develop a national BCI strategy involving HIV/AIDS and sexual and reproductive health. As the sole external BCC technical advisor to the NAC, FHI's BCC resident specialist seconded to NAC's BCC Unit played a key role in donor coordination and acted as an intermediary on behalf of USAID and the Canadian International Development Agency (CIDA) with the NAC. The presence of a resident BCC advisor helped to ensure the technical soundness of the Malawi BCC strategy and to move the implementation along at a more rapid pace, thus contributing to the national goal of risk reduction.

Strengthening of MOH
With technical assistance from IMPACT, the Malawian government developed a five-year scale-up plan to place 250,000 patients on ART by the end of 2010 as the part of the national response to "Universal Access to HIV/AIDS Prevention, Care, and Treatment," the Malawian national strategy.

ART Access and Quality Provision
Between 2000 and 2004, key steps were taken with assistance from IMPACT that enabled the country to scale up ART nationally and increase access to ARVs for Malawian patients in need. FHI's seconded care and treatment technical advisor contributed to these accomplishments.

Given Malawi's poor medical infrastructure and lack of skilled human resources in healthcare, it was recognized that ART delivery using a "medicalized" model would not work. The key to rapid and massive scale-up was to keep the principles and practice of ART delivery as simple as possible. In this regard, many of the principles of directly observed treatment, short course (DOTS)—the system used to successfully deliver anti-TB treatment to millions of people in some of the poorest countries of the world—were borrowed and adapted to ART delivery. A standardized system was put in place, so that wherever one traveled in the country and wherever one accessed ART, from central hospital to health center, the same system of finding cases, initiating treatment, registering, recording, and reporting cases and outcomes were followed. The country also made an important policy decision that ART in the public sector was to be free for all patients.

The success of the approaches used and the systems established/strengthened with technical assistance from IMPACT can be seen in the data on the beneficiaries of the national HAART program, below.

For the 30,055 patients who started on free ART, outcomes by the end of September 2005 (when this component of the project began receiving funding through the Bilateral Project rather than IMPACT) were as follows:

- 77 percent were alive and on ART at the site of registration
- 9 percent had died
- 7 percent were lost to follow-up
- 6 percent had transferred out to another facility (and were presumably alive)
- 1 percent had stopped treatment

Of the 23,168 patients alive and on ART:

- 97 percent were ambulatory; 93 percent were fit to work; 6 percent had one or more major side effects; and 92 percent, based on pill counts, showed 95 percent or greater adherence to therapy
- A six-month survival analysis performed on 4,450 patients starting free ART from 32 sites between January and March 2005 showed that 84 percent were alive (77 percent alive and on ART and 7 percent transferred out).
- A 12-month survival analysis performed on 3,096 patients starting free ART from 15 sites between July and September 2004 showed that 83 percent were alive (71 percent alive and on ART and 12 percent transferred out).

3. Impact

Impact on the greater population cannot be seen in the short timeframe that the IMPACT project covered. In addition, several rounds of national-level surveillance and project-level evaluations are required to analyze data and make inferences about the results that can be attributed to IMPACT. Therefore, it is not feasible to measure or document the actual impact of this project on Malawian society at large; we can only note the contributions it has made to the combination of public health efforts in the country. The changes observed at the outcome indicator level discussed above serve as a fair indicator of the program's contribution, particularly given that there were few stakeholders working in the project's technical areas and geographic target zones. Inferences can also be made about its successes through anecdotal information provided by beneficiaries at the community, organization, and government levels.

III. LESSONS LEARNED AND RECOMMENDATIONS

Full support from the communities and their leaders is essential for acceptance, implementation, and sustainability of the program. As IMPACT supported its IAs, rather than implementing activities itself, community participation ensured that the partners were accepted and known within their target areas. During program design and startup, the project lead and the IAs must orient the leaders and community members on the goals and objectives of the project, and the benefits of the proposed activities on the community. Village committees may be formed to lead the activities. The appropriate government district and extension workers in the community should also be involved wherever possible.

The importance of data collection should be emphasized to IAs and communities. During the initial months of program implementation, data collection was vastly overlooked by IAs and communities. This resulted in inadequate documentation of services and untimely compilation and submission of progress reports. With IMPACT's guidance, this situation improved over time. The importance of regular internal data audits also became clear.

The capacity of volunteers and patients' family members in basic comprehensive service delivery should be built. Volunteers worked closely with the patients and their family members to provide the continuum of care that is essential for chronically ill individuals and vulnerable children. They encouraged and assisted in household activities, including food preparation and production. It was, therefore, necessary that the volunteers and caregivers received training in a holistic approach to HBC, including food and nutrition security for the family. This incorporated knowledge about nutrition and HIV with advice on improved preparation of food to prevent loss of nutrients; cooking; kitchen gardens to provide more diverse food crops; and education about the use of medicinal plants for the relief of symptoms and side effects of drugs.

Increased involvement of adolescent/teen OVC in decision making and service provision is recommended. Participation by OVC in the older age bracket (adolescents and late teens) will help to ensure that their needs and the needs of younger OVC are met. Perceptions about program beneficiaries' needs can sometimes differ markedly between adults (including program staff) and children. Participation by older OVC in program design, development, and implementation can serve to bridge differences between adults and children about what the needs are and which services should be offered. This also promotes uptake by older OVC of future leadership roles in providing care and support in their community.

HBC clients must have easier access to VCT services. VCT is an entry point to care and support, and provides opportunities to appropriately manage opportunistic infections and access to ARV therapy. Most HBC clients in this program did not know their serostatus because of the scarcity of VCT sites in communities.

Volunteers and programs must be further supported to provide HIV/AIDS prevention information within the context of HBC. Volunteers were provided with service and support delivery checklists for their visits to HBC clients and OVC; one item on the checklists was to discuss HIV/AIDS prevention. The lack of adequate HIV/AIDS prevention discussions could partly be a result of volunteers not having enough time in a given visit to address prevention

while also trying to provide other forms of care and support. However, HIV/AIDS prevention is an important component of service delivery for PLHA, their families, and the greater community, especially as ART becomes more available.

Supportive supervisory visits motivate program staff, community leaders, volunteers, and the community. Supervisory visits help to shape and guide HBC/OVC programs and enhance program delivery. In addition, regular contact between supervisors and supervisees reinforces the idea that support provision is an essential component of effective supervision. With better understanding of this central aspect of supervision, there may be greater acceptance that all involved are working toward the common goal of high-quality program and service delivery.

When planning for HBC/OVC service delivery, transportation to and from service delivery sites is an important factor to consider. If transportation means are inadequate, more time might be required for transport than for the actual care, support, supervision, and coordination provided. The procurement and use of push bicycles improved volunteers' ability to conduct home visits to client households and make client referrals. In addition, use of the bicycles facilitated timely collection of reports.

Comprehensive training for volunteers using participatory approaches is essential for initiating an integrated HBC/OVC program. All partner managers, coordinators, and their volunteers were trained for 10 days in HBC and seven days in OVC care and support. These trainings invited participants from health facilities and social welfare offices within the relevant catchment areas and districts. This was to ensure easy referral of HBC patients and OVC to and from these facilities and offices, as well as for the programs to receive professional supervision from them. Trainings were facilitated by IMPACT and co-facilitated by trainers from the MOH and Kamuzu College of Nursing.

Support from community leaders contributes to successful implementation of HBC/OVC programs. In IMPACT/Malawi's integrated HBC/OVC program, community leaders were sensitized and oriented in HBC/OVC care and support issues. This led to the development of community initiatives to support HBC/OVC activities, such as establishment of communal gardens, construction of houses, and CBCCCs. These initiatives, which included HBC/OVC committees, assisted with mobilization of resources to support the identification and provision of care and support to HBC patients and OVC. They also served to oversee activities of volunteers in communities.

Volunteers play important roles in the integrated HBC/OVC care and support program. Volunteers are key to the provision of basic nursing and clinical care and social support. Because they are mobilized from the community in which they live, they are well placed to facilitate linkages between other community activities to ensure increased access to HBC/OVC services, healthcare, counseling and testing, and ART services. Volunteers play an important role in referring chronically ill clients and OVC to the HBC/OVC program. They assist HBC clients and OVC with food provision, maintaining patients' hygiene, management of common HIV/AIDS-related minor ailments, health education, and psychosocial support.

A standardized process should be developed for documenting the integrated HBC/OVC program's best practices, lessons learned, and case studies. Best practices, lessons learned, and case studies are important for disseminating program highlights and enable a process for identifying practices that can be scaled up and replicated. However, the quality and format of this documentation in required program reports by IAs in particular varied greatly. It is important to build the capacity of IAs to report this type of information adequately.

Nutrition support and care is essential to any HIV/AIDS care and support program. The diverse needs of chronically ill clients and OVC are a significant challenge. In particular, critical food shortages in households and lack of or inadequate basic necessities make HBC clients and children vulnerable. Therefore, nutritional support and food security initiatives must start as soon as a person is aware of their status, which means in the home and community. The maintenance of good nutritional status may delay progression of HIV to AIDS, assist in the management of opportunistic infections, and help clients cope with ART, given that ART and nutrition can interact to produce both positive and negative effects. The Ministry of Health recommends nutrition counseling as essential for understanding the part good nutrition can play in maintaining body weight and strength, relief of symptoms of infections and side effects of ART, and generally improving quality of life. Building the capacity of the community to create individual and communal gardens is another way to address these needs. Linkages with organizations providing food and nutrition should be established. In addition, it is necessary to promote income-generating activities for improving the socioeconomic status of households.

When teaching horticultural methods, site visits play a very important role. Initially FHI accompanied members of its IAs to established permaculture and low input gardens maintained by organizations outside of the IMPACT program; but for the subsequent horticultural training sessions in November/December 2006, FHI accompanied IAs to visit gardens established by other IAs who had been trained by FHI in the first sessions. This had a stronger impact on the IAs as they were able to observe gardens that had been achieved by people like themselves, under the same project, in similar communities with similar challenges and constraints.

FHI's experience providing technical assistance to the MOH on the national HAART program demonstrated that the following steps are important for delivering and monitoring ART:

- *Eligibility for ART:* Adults and children must be HIV-seropositive, the patient or guardian has to understand the implications of ART, and patients must be assessed in WHO Clinical Stage 3 or 4 or be in WHO Clinical Stage 1 or 2 with a CD4-lymphocyte count below the threshold value for severe immunodeficiency (in the case of adults this was set at 250 cells/mm^3). Most ART clinics do not have a machine for measuring CD4-lymphocyte counts, and the emphasis is therefore on clinical staging. Once staged eligible for ART, patients go through a process of group and individual counseling, and then start of treatment.

- *Standardized ART:* IMPACT focused on the use of one generic, fixed dose combination treatment with stavudine, lamivudine, and nevirapine. Two alternative first line regimens (for serious side effects of ART drugs) and one second line regimen (for ART drug failure) were placed in central and major district hospitals over the first two years, and a referral system

was set up so that any patient in need could access appropriate therapy. As sites have become more experienced in the use of ART, more of them have been directly provided with alternative first line therapy. Patients are started on treatment, seen two weeks later, and then followed up every four weeks for life. After six months, if the patient is stable and has been adherent to medication, the patient can be seen every two months. Monitoring for wellbeing, side effects, and drug adherence are all done clinically; in most sites there is little in the way of laboratory investigations.

- *Registration, recording, and reporting at ART sites:* In a similar way to TB programs, all patients are given a unique ART registration number, which is their key identification in the monitoring tools. At ART sites, the two important tools are the ART patient treatment master card and the ART patient register. Into both of these are written the case finding details of patients (ART number, name, address, age, sex, occupation, and reason for ART) and monthly treatment outcomes. The treatment master card records monthly visits and is in essence a chronological record of the patient's progress on ART. Any adverse outcome, such as death, default, stopped treatment, transfer out, or change in regimen is recorded in the treatment master card, and this change is reflected in the ART patient register. The register therefore provides a record of the patient's status at a set point in time. At the end of every quarter, the ART clinic team is expected to cross-check the records, in particular to check that treatment outcomes in the master card have been accurately recorded in the register, and perform cohort analysis of cases and end-of-quarter outcomes with events censored at the end of that particular quarter. There are two types of cohort analysis: quarterly analysis of new patients started on ART in the latest three-month period and cumulative analysis of all patients started on ART.

- *Supervision and monitoring:* Every three months, the HIV Unit of the Ministry of Health and its partners conduct supervisory and monitoring visits to all ART sites in the country to ensure guidelines and standards are being adhered to, collect data for national reporting, provide encouragement and support (and sometimes admonishment if performance is poor), and obtain drug stock levels to help with drug procurement. At the same time as these visits are conducted, the supervising teams give each ART site a copy of the latest national report and the schedule for the next quarterly visits—the latter activity removes the need for posting letters to peripheral sites.

Increasing access to ART and decreasing loss to follow-up is essential. Potential solutions to the low number of HIV-positive mothers being put on ART include more capacity in the country to measure CD4-lymphocyte counts, easier ways of performing the test, and an explicit priority for CD4 testing directed at HIV-positive pregnant women. Additional operational research should be conducted to determine reasons for patients being lost to follow-up, and systems should be strengthened to track the extent to which some of these losses can be attributed to health facility transfer rather than death.

The achievement of Malawi's Five-Year Scale-Up Plan is a daunting yet feasible challenge. This plan will succeed only if certain issues can be resolved. First, there is a need to tackle the dire shortage of skilled human resources that pervades not only Malawi but most of sub-Saharan Africa. Second, there is a need for ongoing financial support from either the old established

funding bodies such as the Global Fund to Fight AIDS, Tuberculosis, and Malaria or new institutions such as UNITAIDS. Third, there will probably be a need in the next few years to invest in and secure an alternative regimen to the one in current use, as HIV-drug resistance and long-term side effects, particularly of stavudine, become more of a problem. Fourth, undertaking regular supervision and reliable drug procurement for the increasing case burden will be essential if drug supplies are to remain uninterrupted and standards are to be maintained. Finally, HIV prevention methods must be similarly scaled up or caseloads will continue to increase indefinitely.

IV. IMPLEMENTING PARTNER ACTIVITY HIGHLIGHTS

A. IMPLEMENTING PARTNER MATRIX

No.	NAME	TYPE	GEOGRAPHIC LOCATION	TARGET GROUPS	EOP* BUDGET	DATES	INTERVENTIONS
COMMUNITY-BASED HBC/OVC/NUTRITION SERVICE DELIVERY							
1	Friends of AIDS Support Trust (FAST)	CBO	Nsanje District	Chronically ill and households affected by HIV/AIDS	$37,743	April 1, 2004 to August 31, 2005	Increased community capacity for care and support and improved quality of care provided by households to HBC patients and OVC through community mobilization meetings and trainings; OI service delivery; reduction of school dropouts among OVC and promotion of early childhood development; facilitation of access to VCT, ART, and nutritional support for HBC clients; improved collaboration, linkages, and networking with other partners; conducting HIV/AIDS prevention and nutrition discussions integrated within provision of care and support; nutrition support, including vegetable gardens, drip irrigation kits, and healthy recipe promotion
2	Family Health Education Counselling and Care (FHECC)	CBO	Chikwawa District	Chronically ill and OVC	$48,000	August 1, 2003 to January 31, 2005	
3	Lighthouse Trust	Private trust	Lilongwe	PLHA and people affected by HIV/AIDS	$104,823	August 1, 2003 to June 30, 2005	
4	Mponela AIDS Information and Counselling Centre (MAICC)	Local NGO	Dowa District	Chronically ill and households affected by HIV/AIDS	$56,720	April 1, 2004 to August 31, 2005	
5	Namwera AIDS Coordinating Committee (NACC)	Local NGO	Mangochi District	PLHA and people affected by HIV/AIDS	$85,417	August 1, 2003 to August 31, 2005	
6	Save the Children (USA)	International NGO	Mangochi District	Chronically ill and OVC	$132,061	September 1, 2004 to August 31, 2005	
7	Trinity Hospital	Hospital	Nsanje District	Chronically ill	$37,172	August 1, 2003 to August 31, 2005	
8	The Salvation Army (TSA)	FBO	Nsanje District and Blantyre	Chronically ill and OVC	$85,836	August 1, 2003 to August 31, 2005	
9	Word Alive Ministries International (WAMI)	FBO	Blantyre	Chronically ill and OVC	$75,576	August 1, 2003 to August 31, 2005	

No.	NAME	TYPE	GEOGRAPHIC LOCATION	TARGET GROUPS	EOP* BUDGET	DATES	INTERVENTIONS
BEHAVIOR CHANGE INTERVENTIONS							
10	Program for Appropriate Technology in Health (PATH)	NGO	National	Residents of Malawi	$44,801	April 1, 2001 to January 31, 2005	Visual and Communication Guide for BCI (special work order under Task Order #14)
11	Story Workshop Educational Trust	NGO	National	Residents of Malawi	$229,472	March 1, 2002 to June 30, 2003	Media toolkit and BCC training materials
12	Umoyo	NGO	Lilongwe	Brewery workers, bar staff, truck drivers	$25,092	December 1, 2001 to March 31, 2004	BCC and VCT/care in the workplace, in collaboration with national brewing companies
NATIONAL LEVEL POLICY AND SYSTEMS							
13	Ministry of Agriculture and Food Security (MOA)	Govern-ment	National	Residents of Malawi	$111,755	April 1, 2004 to January 31, 2005	HIV/AIDS policy development for Malawi's agricultural sector
14	MOA	Govern-ment	National	Residents of Malawi	$47,989	May 1, 2002 to March 31, 2003	Integration of HIV/AIDS programs into national agriculture strategy and action plan
15	National Statistics Office (NSO)	Govern-ment	National	Residents of Malawi	$229,472	October 1, 2003 to January 31, 2005	BSS Round One

**EOP = End of project (actual expenses over life of project)*

B. SUBPROJECT HIGHLIGHTS

The details of interventions conducted by each of FHI's IMPACT/Malawi subgrantees and their coverage zones are described in the paragraphs below.

1. Friends of AIDS Support Trust (FAST)

Organization Profile
FAST was created in 1996 in Nsanje District and registered with the government of Malawi in 1997. The organization was established with the belief that HIV/AIDS demands a special response because of its community-wide impact and high rate of claiming lives, which in turn renders large numbers of children vulnerable or makes them orphans.

FAST's initial activities were focused on HIV/AIDS awareness. As messages were increasingly disseminated, FAST expanded to surrounding areas. Communities saw the need for HBC and OVC programs as part of mitigating the impact of HIV/AIDS. They approached FAST with requests to implement HBC and OVC programs, which FAST did in response to its community's concerns. IMPACT/FHI supported FAST between April 1, 2004 and August 31, 2005.

Goals and Objectives
The goal of this subproject was to improve the quality of life of people living with HIV/AIDS and households affected by the pandemic by providing improved care and support services in two areas of Nsanje District.

The objectives were to
- establish and strengthen community structures to provide care and support services to HBC clients and OVC through groups of village headmen in traditional authorities.
- improve capacity of households and communities to care for and support those affected by HIV/AIDS
- work with households and secondary schools to develop innovative mechanisms for facilitating secondary education attainment by OVC
- increase managerial and technical capacity of FAST
- help prevent nutritional deterioration in vulnerable households in communities affected by HIV and with food insecurity

Accomplishments
To help improve community capacity of HBC/OVC service provision, FAST conducted weekly supervisory visits to HBC clients and OVC, who were provided with emotional support during the visits. This subproject also provided monthly supervisory visits with volunteer groups. To address the need for facilitating volunteer transport to and from service delivery sites, FAST procured bicycles and distributed most of them to volunteers. A small number of bicycles were distributed for use in FAST's catchment area as bicycle ambulances.

As one facet of collaborating with households to ensure OVC educational access, FAST distributed scholastic materials to OVC in secondary school. FAST also facilitated the establishment of CBCCC care committees. This assisted many older OVC, especially girls, who

typically do not go to secondary school because of caretaking responsibilities in the home of parents or siblings.

Quarterly collaborative meetings with stakeholders were held for partners to share experiences, lessons learned, and challenges. These meetings were a component of improving community capacity to care for HBC clients and OVC. The importance of referral and linkages, an essential part of a continuum of care, was also discussed at the meetings.

Challenges and Recommendations
HIV/AIDS prevalence in Nsanje District is one of the highest throughout Malawi. Yet, the district had only two VCT sites when this project began. Many of FAST's HBC patients received counseling services through HBC and therefore become convinced of the need to know their serostatus. However, the long distance between VCT sites and HBC patient residences and the difficulty of transportation hindered HBC patients' access to VCT services. A similar problem has occurred in connection with trainings addressing cultural practices in Malawi that facilitate HIV transmission. More support should be invested in this district so that adequate VCT services are available.

2. Family Health Education Counselling and Care (FHECC)

Organization Profile
FHECC was established in Chikwawa District in 1994 with HBC and OVC as its primary programmatic areas, along with HIV/AIDS awareness activities. Primary activities within FHECC's HBC/OVC services include basic nursing, provision of medication, and psychosocial support. In addition, nutritional support is provided to HBC clients and orphans. To facilitate its aim of holistic HBC and OVC service delivery, FHECC maintains and strengthens linkages with several local organizations. IMPACT/FHI supported FHECC from August 1, 2003 to January 31, 2005.

Goals and Objectives
The objectives of this subproject were to

- improve the capacity of communities to provide quality care and support for chronically ill people and OVC
- mobilize community leaders in Ngabu, Lundu, and Maseya to provide support to HBC/OVC programs
- strengthen the management capacity of FHECC to plan, implement, monitor, and supervise HBC/OVC activities
- strengthen referral and linkages between the HBC/OVC programs and other service-providing organizations
- strengthen the capacity of households to support HBC/OVC clients
- help prevent nutritional deterioration in vulnerable households in communities affected by HIV and with food insecurity

Accomplishments
FHECC conducted trainings for CBCCC caregivers and volunteers to enhance their skills in providing support to OVC. FHECC also held life skills trainings for service providers and

volunteers (with support from Action Aid) and involved PLHA in conducting sensitization meetings for mobilizing community support of the HBC/OVC program.

Strengthening referrals and linkages was an important component of this subproject. Through the Ministry of Education, the World Food Programme (WFP) had begun a school feeding program. Through FHECC's linkages with WFP, several schools from FHECC's catchment area benefited from the program. Children who consistently maintained school attendance for 18 days were given food once per month in the form of Likuni phala (10 kg), maize (10 kg), and beans (10 kg). One of the main aims of the program was to reduce absenteeism among girls in schools. It was observed that absenteeism was reduced in some schools due to introduction of school feeding programs. In addition, FHECC visited households to provide HBC clients and OVC with care and support.

3. Lighthouse Trust

Organization Profile
Lighthouse Trust was formed in September 1997 by a small group of local healthcare professionals in Lilongwe who provided care for the sick in their communities on their own initiative. Soon, however, Lighthouse began sharing its skills with other community members.

Lighthouse has grown over the years to provide palliative care, home-based care, and free ARV therapy, as well as offering counseling services on-site. It is linked to a local hospital and receives professional support from nurses and other clinicians. Lighthouse also trains HBC volunteers. By working with its volunteers in the community every day, Lighthouse HBC nurses provide ongoing training and support to active volunteers, build volunteers' skills and confidence, and help to maintain motivation. Lighthouse serves as a learning center for other organizations. IMPACT/FHI provided support to Lighthouse Trust from August 1, 2003 to June 30, 2005.

Goals and Objectives
The goal of this subproject was to improve the quality of care and support to people infected and affected by HIV/AIDS in Lilongwe City.

The objectives were to
- strengthen the Lighthouse HBC program to transform it into a learning model for other HBC programs
- strengthen community participation in providing care and support to people infected and affected by HIV/AIDS in Lilongwe City
- improve referral systems between Lighthouse and other support services in communities
- improve the quality of care and support that PLHA and their households receive from the HBC program

Accomplishments
Lighthouse made progress toward strengthening its program to enable it to become a learning model for other HBC programs. Steps taken included training and supporting community volunteers to provide regular supportive visits to HBC clients, referring clients from the clinic to

the HBC program, conducting biweekly clinical field support of HBC nurses, and facilitating training workshops for HBC nurses in clinical management of opportunistic infections. Lighthouse conducted weekly clinical review meetings with HBC nurses to support their care provision, and held care-of-carers meetings to support and motivate volunteers. These activities also improved Lighthouse's overall quality of care and support provision.

Other activities to enhance care and support of PLHA and families in Lighthouse's HBC program included training in ARV adherence counseling and palliation. Several HBC nurses attended a one-week certification course in ART. Lighthouse also increased awareness of HBC among community leaders in its target areas.

As part of improving its referral systems within communities, Lighthouse referred clients to a local organization, the Catholic Development Commission in Malawi, to receive orphan support and hosted coordination/networking meetings for Lilongwe HBC providers. Lighthouse also conducted refresher HBC trainings on referrals for health center staff.

Challenges
In connection with the much-needed introduction of free ARV therapy to the public by the GOM, Lighthouse provides free ARV therapy to its clients. There has been a large influx of ARV-seeking clients into Lighthouse, and as a result, staff workload has become overwhelming and waiting times for patients typically very long. In addition, it has been difficult to create priority of ARV distribution for HBC patients. Lighthouse continues to work on methods to meet these challenges.

Lessons Learned
Closer and more regular contact with communities provides opportunities for open discussions and support. It can also serve to ameliorate the perception that supervision is "policing." Support to supervisees is an essential role of supervisors. With an increased understanding of this supportive role, quality of care to HBC patients and their families can be further addressed, maintained, and improved.

4. Ministry of Agriculture and Food Security (MOA)—formerly called the Ministry of Agriculture, Irrigation, and Food Security

Organization Profile
The MOA is one of the largest employers in the public sector, with an employee establishment of 11,000 and 36 percent vacancy rate. The mandate of the ministry is to promote and accelerate broad-based sustainable agriculture and livestock development to achieve food security, economic growth, and poverty reduction. The ministry delivers its services through eight departments: Planning, Administration and Management, Irrigation, Animal Health and Industry, Land Resource Conservation and Management, Agriculture Extension Services, Crops and Human Resource Management and Development. IMPACT/FHI provided support to the MOA from April 1, 2004 to January 31, 2005.

Scope of Work/Accomplishments
Preliminary discussions with the MOA and the USAID/Agriculture office occurred in 2001 and led to the execution of a subagreement between FHI and the MOA to help mainstream HIV/AIDS mitigation and workplace prevention in the agricultural sector. This partnership resulted in the development of a national HIV/AIDS policy (2003–2008) for promoting political will to address HIV/AIDS, financial commitment to support HIV/AIDS programs, and gender mainstreaming at all levels of the agriculture sector's workplace and rural farming communities. A local consultant hired by FHI worked with the MOA to move the policy/strategy document forward. This final *HIV/AIDS and Agriculture Sector Policy and Strategic Plan* was closely linked with the Malawi National BCI Strategy that FHI helped to develop through IMPACT.

5. Mponela AIDS Information and Counselling Centre (MAICC)

Organization Profile
MAICC was established in February 1992 to mitigate the impact of HIV/AIDS on individuals, families, and the community through provision of VCT services, HBC, care for OVC, and support of youth and PLHA. MAICC operates in Dowa District through communities and volunteers to implement its activities. It has strong community initiatives, such as community-based child-care centers, village AIDS coordinating committees, and community AIDS coordinating committees. Community initiative groups' responsibilities include HBC and care of OVC, as well as facilitating HIV/AIDS prevention and mitigation through voluntary counseling services, information education and communication, and condom distribution. MAICC maintains strong linkages with a local hospital for nutritional support of OVC and with a Malawi-based organization that supports development of entrepreneurship. IMPACT/FHI provided support to MAICC from April 1, 2004 to August 31, 2005.

Goals and Objectives
The goal of this subproject was to improve the quality of care provided by households and communities to chronically ill people and to mitigate the impact of HIV/AIDS in the affected households.

The objectives were to
- improve the quality of services provided to chronically ill patients in households
- improve the care and support provided by the family members of the above-mentioned households to the children in those households
- promote positive living for PLHA
- strengthen MAICC's organizational capacity to implement the expanded, integrated HBC/OVC program
- help prevent nutritional deterioration in vulnerable households in communities affected by HIV and with food insecurity

Accomplishments
MAICC trained volunteers in integrated HBC/OVC care and support. To expand MAICC's work with PLHA, support to HIV-positive HBC clients also included conducting group therapies and outreach activities that focused on positive living, stigma, discrimination, and HIV/AIDS prevention. When needed, clients were referred to the hospital for further medical management.

MAICC supported OVC through psychosocial support, nutritional support, and provision of school fees. In addition, OVC under six years of age were accepted in CBCCCs. Sensitization meetings were held to address child rights and types of child abuse, focusing on the needs of OVC, and similar meetings were held for HBC. These meetings created awareness about the need for care and support to HBC clients and OVC.

To improve MAICC's own capacity to deliver services, HBC and OVC coordinators underwent a week-long capacity building workshop at Lighthouse Trust, which helped to identify gaps in MAICC's HBC delivery and facilitated identifying strategies to address those gaps. Other linkages included monthly meetings with Mponela Rural Hospital staff and other stakeholders to discuss the importance of feedback after clients are referred to and from the clinic.

Volunteer meetings were useful for sharing experiences and were also opportunities to discuss the HBC/OVC packages, the importance of skill transfer to untrained volunteers, and the importance of activating committees supporting CBCCCs.

Challenges and Lessons Learned
Drug availability for HBC kits was a challenge for MAICC at various times throughout the IMPACT project. Basic drugs such as aspirin and Panadol were sometimes difficult for MAICC to replenish, which affected quality of care. MAICC took the issue of replenishing drugs to a local hospital and the district health office with a plan that they would replenish the drugs for HBC kits, provided that MAICC would submit drug-related reporting to them. However, there was no concrete response from either the local hospital or the district health office. MAICC is working to find reliable sources of drugs to replenish the HBC kits in a timely manner so that HBC volunteers can consistently provide high quality care.

6. Namwera AIDS Coordinating Committee (NACC)

Organization Profile
NACC was established in 1996 as a collaborative effort between the Mangochi District AIDS Coordinating Committee and Save the Children through its Community-Based Options for Protection and Empowerment (COPE) program (now known as the STEPS program). NACC seeks to mitigate the impact of HIV/AIDS within its operating area by addressing the needs of PLHA and their families, especially OVC. NACC has a strong skills-training program for older OVC and has established links with local and international organizations. In addition, it has strong AIDS coordinating committees at the village and community levels. IMPACT/FHI provided support to NACC from August 1, 2003 to August 31, 2005.

Goals and Objectives
The objectives of this subproject were to

- strengthen community participation in providing care and support to people affected and infected by HIV/AIDS in villages of NACC's catchment area
- promote school participation for OVC in Namwera
- promote HIV/AIDS counseling and care services to reach additional chronically ill patients and their families

- strengthen referral and linkage systems between OVC and HBC programs, health centers, and other service providers in the catchment area
- improve the economic status of families infected and affected by HIV/AIDS within NACC's catchment area
- improve the basic child care services for OVC under five years of age by establishing community-based child care centers
- help prevent nutritional deterioration in vulnerable households in communities affected by HIV and with food insecurity
- improve NACC's institutional capacity

Accomplishments
NACC conducted public functions to mobilize communities to support and participate in HBC/OVC activities. Issues discussed included HIV/AIDS prevention, care, and support, children's rights, and the importance of knowing one's serostatus. A result of these meetings was formation of youth networks to promote participation of youth in providing care and support to the chronically ill and OVC. NACC was very involved in work with youth through forming youth clubs and increasing awareness at youth club meetings about HIV/AIDS and HBC/OVC programs.

NACC worked toward strengthening its referral systems. For promoting education of OVC, NACC referred several OVC to primary and secondary schools through village AIDS committees (VACs), as well as to CBCCCs. Most of these children had dropped out of school due to lack of scholastic materials, school fees, food, clothes, and encouragement from their guardians. NACC also provided counseling to both guardians and OVC on the importance of education. NACC referred clients to local health service providers when needed and followed up on the referral process of some patients to determine how patients were further assisted.

Volunteers were trained by NACC in HBC/OVC care and support skills. NACC held sensitization meetings to mobilize support of community leaders in establishment of a VCT center and HBC/OVC activities.

7. National Statistics Organization (NSO)

Organization Profile
The NSO is the main government department responsible for the collection and dissemination of official statistics. With headquarters based in Zomba, its 300 employees operate under the 1967 Statistics Act. The NSO has regional offices in the major urban centers of Lilongwe, Mzuzu, and Blantyre.

The mission of the NSO is to provide high quality, timely, and independent statistical information and promote its use for policy formulation, decision making, research, transparency, and general public awareness.

Scope of Work/Accomplishments
A subagreement was executed between FHI and NSO for the first round of a BSS in collaboration with CDC, the MOH (formerly called the Ministry of Health and Population

[MOSP]), NAC, the Centre for Social Research, and the NSO. Planning meetings were held with these partners between January and March 2003, resulting in the formation of a Technical Working Group to guide the survey and to provide long-term guidance for surveillance in the country. Support through IMPACT/FHI was provided from October 1, 2003 to January 31, 2005.

Objectives of the BSS:

- to provide baseline information that will assist in the development of a system for tracking behavioral trend data for high risk and vulnerable target groups, i.e. those groups that influence the epidemic in Malawi
- to provide information on behavioral trends among key target groups in some of the catchment areas where intervention projects are planned or operating
- to provide information that can guide program planning
- to open and develop a dialogue on HIV/AIDS among the population from the policy to the community level
- to provide evidence for the relative success of HIV prevention efforts taking place in selected sites in Malawi
- to obtain data in a relatively standardized format, which may enable comparison with other BSS carried out in other countries

NSO conducted the mapping activity, wrote the mapping report, finalized questionnaires and training guides, recruited and trained enumerators and supervisors, supervised data collection and data analysis, oversaw development of the final report, and participated in the dissemination of the results. Meanwhile, FHI oversaw the research and provided technical guidance in the design of the research protocol, questionnaire translation and adaptation, training of research staff, collection of data, analysis of data, report writing, and dissemination of research findings. The Ministry of Health provided general guidance and advice on policy and other technical issues regarding the BSS process and dissemination of research results, while NAC provided overall coordination of the BSS through summoning and chairing regular meetings of the Technical Working Group and other networking meetings, including the dissemination of results.

Round One of the Malawi BSS was completed in 2004. It provided behavioral data on key target groups such as in- and out-of-school youth, teachers, sex workers, women informal traders in border towns, estate workers, fishermen, police, and military. The survey provided additional data to support ongoing country surveillance that, over time, will help to measure achievements in HIV interventions nationwide and in selected district sites, including those supported by USAID.

8. Program for Appropriate Technology in Health (PATH)

Organization Profile

PATH is an international, nonprofit organization that creates sustainable, culturally relevant solutions, enabling communities worldwide to break longstanding cycles of poor health. By collaborating with diverse public- and private-sector partners, PATH helps provide appropriate health technologies and vital strategies that change the way people think and act. PATH's mission is to improve the health of people around the world by advancing technologies, strengthening systems, and encouraging healthy behaviors.

Scope of Work/Accomplishments
In 1989, PATH produced a manual titled "Developing Health and Family Planning Materials for a Low-Literate Audience, A Guide." The guide proved to be an excellent training resource for the process of materials development for a low-literate audience. Through PATH Task Order No. 13, PATH and FHI worked to adapt the guide for HIV/AIDS material development purposes.

In collaboration with FHI/IMPACT, PATH developed protocol for pretest of the low-literate guide for developing HIV/AIDS training material for a low-literate audience, conducted pretests in two countries, and developed the final product, "*Developing Materials on HIV/AIDS/STIs for Low-Literate Audiences,*" for printing.

PATH assumed the following responsibilities and activities:
- conducting pretest
- hiring a graphic designer and overseeing cover and layout design
- organizing and hosting two peer review meetings before and after pretesting, in collaboration with FHI/IMPACT, and one meeting for selection of key visuals for inclusion in the guide

9. The Salvation Army (TSA)

Organization Profile
TSA has been working in Malawi since 1978 and implementing HIV/AIDS programs for close to 10 years (as of the end of IMPACT). The organization operates in several districts, where it has trained and mobilized volunteers in community counseling, HBC, and OVC. Through its linkage with Masiye Camp in Zimbabwe, TSA's psychosocial support of OVC is strong; it also has an established partnership with the well-respected College of Medicine. Since 2002, TSA has assisted with emergency food rations. In one of its operating areas, TSA is involved in a supplemental feeding program targeting orphans and the chronically ill.

Goals and Objectives
The goal of this subproject was to improve the quality of life for the chronically ill and OVC in the East Bank, Nsanje District and Bangwe Township, and Blantyre District.

The objectives were to
- strengthen community capacity and increase local participation in providing care and support to households infected and affected by HIV/AIDS
- build capacity of community members in providing care and support to OVC
- build capacity of community members in providing home-based care services to the chronically ill
- improve the referral systems between the existing health system and HBC volunteers, as well as between the Social Welfare Office, locally based NGOs, and OVC volunteers
- strengthen capacity of the DACC in coordinating HIV/AIDS activities
- help prevent nutritional deterioration in vulnerable households in communities affected by HIV and with food insecurity

Accomplishments
Building community capacity to care for and support OVC was addressed by establishing CBCCCs and encouraging children to meet every Saturday. Activities included games, sharing of information on HIV/AIDS through drama, and advocating for care and support for OVC and chronically ill people. OVC associated with TSA participated in vocational skills training such as tailoring, carpentry, and motor vehicle mechanics. TSA conducted community mobilization meetings with key stakeholders; in one instance, this resulted in skilled businesspeople in the community volunteering to train OVC in vocational skills such as tailoring, carpentry, and knitting.

TSA also provided nutritional support to chronically ill patients and OVC. This support was provided from communal gardens, which contribute to improving the community's capacity to care for its chronically ill. Establishment of these communal gardens was facilitated by World Vision through provision of treadle pumps and 20 kg of maize seeds. Land for the communal gardens was provided by local chiefs.

To help build the psychosocial component of OVC service provision, TSA trained OVC as psychosocial support camp counselors. In addition, OVC were provided with resilience training for responding to the impact of parental illness, death, and orphanhood. TSA also trained OVC in life skills necessary for HIV risk reduction.

As part of delivering quality services, TSA conducted HBC/OVC refresher training for its volunteers.

Challenges and Recommendations
Certain cultural practices facilitate HIV transmission, such as sexual cleansing of widows/adolescents. To educate its community about methods of HIV transmission, TSA conducted information sessions that included reasons why sexual cleansing facilitates HIV transmission. After personal experiences with sexual cleansing were shared with the assembled group, participants felt that this cultural practice needed to be reconsidered. TSA recommended that cultural practices need to be explored further in forums other than overall HIV/AIDS information sessions so that these issues can receive the full attention they need.

10. Save the Children (USA)

Organization Background
Save the Children initiated operations in Malawi in 1983 and continues to scale up its program activities. Save the Children/Malawi implements a wide range of programs in education, health, HIV/AIDS prevention, and food security. Save the Children's community-focused HIV/AIDS prevention and impact mitigation program is STEPS, formerly known as the COPE program.

STEPS is a multisectoral approach for mobilizing community-based responses to the needs of OVC and others affected by HIV/AIDS. As STEPS evolved over the years, its scope broadened in building capacity of district and community structures to implement activities aimed at preventing the spread of HIV, caring for those affected by AIDS, and mobilizing resources to sustain individual and collective action.

Goals and Objectives
The objectives of this subproject were to

- strengthen capacity of community AIDS coordinating committees (CACCs), village AIDS committees (VACs), and other community-based structures to implement and scale up activities to care for OVC, chronically ill persons, and their families
- strengthen coordination and networking capacity of district AIDS coordinating committees (DACCs), CACCs, and VACs in supporting HIV/AIDS activities that address the needs of families, communities, and children affected by HIV/AIDS
- help prevent nutritional deterioration in vulnerable households in communities affected by HIV and with food insecurity

Accomplishments
Save the Children/Malawi facilitated formation of OVC care and support committees. In addition, it conducted orientations of CACC and VAC members in HBC and OVC care and support activities. Community HBC trainings were conducted for volunteers and several drug kits were distributed to two communities; some of the drug kits were made by VAC members themselves.

A series of five-day psychosocial support trainings was conducted for VAC members. Children and elders were trained in child rights. SAVE also held community open days at which public attendance was strong; these events addressed stigma and discrimination, HIV/AIDS and behavior change, and the need to provide care and support for OVC.

Challenges and Lessons Learned
Most volunteers are illiterate, and those who can read and write typically do both slowly. This was a challenge during integrated HBC/OVC training because of the amount of material that needed to be covered. Adjustments were made in the training to respond to participants' levels and relative speed of acquiring information.

11. Story Workshop Educational Trust

Organization Profile
Story Workshop Educational Trust, established in 1996, is the only educational media NGO in Malawi. Its mission is to bring together the communication strategies and methodologies from international development experience to train highly committed and talented young Malawians in the skills needed to blend culturally appropriate messages and educational objectives with authentic entertainment. In a country like Malawi where illiteracy is high and the population majority lives in rural poverty, radio- and performance-based social mobilization are the main channels of information for most people. Story Workshop's mission is to bridge the gap between decision makers in urban centers and rural communities with media formats that create dialogue. These media interventions help to bridge the gap between "what people know" and "what people do" with behavioral change motivation by popular story characters who are role models for new attitudes and social negotiation skills. The interventions link traditional cultural values in proverbs and stories to the values driving social change by fully utilizing the potential of various traditional and mass media to influence populations.

A subagreement with a local NGO, Story Workshop Educational Trust/Timasukirane, was executed between March 2002 and June 2003 to develop a multimedia package in collaboration with NAC. The HIV/AIDS IEC materials produced consisted of a facilitator kit with audio cassettes, drama sketches, songs, proverbs, and booklets. The content of these radio dramas and print materials was based on the BCI literature review and BCC strategy spearheaded by the BCC technical advisor. Content was pretested and revised, then used in a Training of Trainers (TOT) and distributed to youth 14 to 25 years old.

12. Trinity Hospital

Organization Profile
Trinity Hospital is part of the Christian Health Association of Malawi. It has a total bed occupancy of 200 and offers fee-based, in-patient and out-patient services. The majority of patients opt for shorter periods of admission to reduce hospital care expenses.

Trinity Hospital began offering home-based care services in 1992, with services restricted to psychosocial support for individuals, couples, families, and friends affected by HIV. The hospital later expanded its HBC services to provide nutritional support to HBC clients. Several community mobilization activities initiated by the hospital have generated strong commitment to HBC activities. VCT services are available at Trinity Hospital.

Goals/Objectives
The goal of this subproject was to improve the quality of care of chronically ill people in Trinity Hospital's catchment area.

The objectives were to
- increase awareness and knowledge among healthcare providers from health facilities and in catchment area communities about specialized care and support needs of chronically ill people
- strengthen capacity of communities to provide care and support services to chronically ill people from the Trinity Hospital catchment area
- increase capacity of households to provide basic quality care and support to clients affected by HIV/AIDS
- help prevent nutritional deterioration in vulnerable households in communities affected by HIV and with food insecurity

Accomplishments
Linkages were an important aspect of Trinity Hospital's work. A portion of its total client population was provided with food sourced from WFP and from the community through communal gardens and contributions. In another instance, treadle pumps and seeds were donated to volunteers, with support from World Vision. Making use of the donation, volunteers worked in already established communal gardens to supplement nutritional support of HBC clients and OVC.

Trinity experienced an increase in numbers of patients admitted to the HBC program, as well as an increase in numbers of volunteers accessing VCT and disclosing their serostatus. This may have been partly due to the community's increased trust in the program.

13. Umoyo Network

Organization Profile
The Umoyo Network, established in 1999, is a field project of NGO Networks for Health, a global health consortium of the following:

- Adventist Development and Relief Agency (ADRA)
- Co-operative Assistance and Relief Everywhere (CARE)
- Program for Appropriate Technology in Health (PATH)
- Plan International (PLAN)
- Save the Children (USA)

Save the Children (USA) is the lead agency in Malawi and manages the Umoyo Network, which addresses the HIV/AIDS epidemic and reproductive health needs of Malawians through partnering with public, nongovernmental and private sector organizations at the national and community level to foster networks that enhance the scale and quality of family planning, reproductive health, child survival, and HIV/AIDS programs.

The goal of Umoyo Network is to assist Malawian organizations, both governmental and nongovernmental, to reduce fertility, improve reproductive health and child survival, increase the use of HIV/AIDS prevention practices and services, and improve care for people infected with and/or affected by HIV/AIDS.

Scope of Work
Under a subagreement with FHI/IMPACT with CDC/LIFE fund in FY2002, a partnership was formed between Umoyo Networks and Bowler Beverages Company, Ltd. (BBCL), a brewer of the national beer company, Napolo Brewery, for an HIV/AIDS workplace program. Umoyo supported the implementation of a comprehensive prevention program at all stages of the beer industry, from production to consumption. The program began with a formative assessment consisting of qualitative and quantitative behavioral assessments among beneficiary groups in the project area (e.g., brewery staff, truck drivers, tavern owners and managers, and sex workers). Using the results of the behavioral assessments, FHI and Umoyo led a BCC strategy development workshop with representatives of NAC and staff, volunteer peer educators, and beneficiaries Umoyo, PSI, and BBCL. The results were used to guide project design by informing the peer educator curriculum and BCC materials for the project.

Through this subproject, additional BBCL staff members were hired and key equipment was procured for the project office at the brewery. Zone coordinators then carried out trainings and BCC with workers selected from taverns, bars, and bottle stores in Salima, Lilongwe, Mchinji, and Kasungu Districts. The workplace interventions initially focused on HIV/STI prevention at BBCL's brewery in Lilongwe but later expanded to include a care and support component. This subproject not only provided services to the brewery employees but also involved BCC activities

with the truck drivers who deliver the beer, owners and managers of the bars that sell it, sex workers who work at the bars, and the sex workers' clients.

14. Word Alive Ministries International (WAMI)

Organization Profile
WAMI formed the Intervention Counselling and Care (ICOCA) Program in 1992 as a response to the HIV/AIDS epidemic in Blantyre. The ICOCA Program's vision is to create an empowered, responsive, and healthy society, thereby mitigating the impact of HIV/AIDS. Its mission is to provide behavioral change interventions and access to quality health and social services to people infected and affected by HIV/AIDS in Malawi.

To meet its goals, the ICOCA Program reaches out to its community through several programs, including those for OVC and HBC, as well as efforts targeting youth and the police force. PLHA are actively involved with WAMI, which also has strong links with a local hospital that offers ARV therapy.

Goals and Objectives
The objectives of this subproject were to

- improve the quality of HBC provided to clients of the project
- strengthen community capacity to provide quality care and support to OVC in Blantyre
- promote school participation for school-age OVC and support out-of-school OVC to acquire vocational skills
- work with households to improve their nutritional status
- strengthen capacity of the ICOCA Program to implement quality OVC and HBC activities
- help prevent nutritional deterioration in vulnerable households in communities affected by HIV and with food insecurity

Accomplishments
WAMI trained HBC volunteers/care providers in HBC service delivery in accordance with national guidelines, trained OVC care committee members in OVC care and support, and conducted review meetings with volunteers to discuss progress of activities and share experiences.

Given the importance of education in OVC support work, WAMI met with school committees and local leaders to address how OVC can be retained in school, as well as how out-of-school OVC could be linked to vocational skills training and be supported to improve their livelihood. From within the program, support for OVC was initiated through visits to homes and CBCCCs. Children were provided with food, clothes, and educational support.

As a step toward working with households to improve their nutritional status, WAMI facilitated a study visit of volunteers to learn about the role of community mobilization in motivating participation in creating and maintaining communal gardens, as well as the role of communal gardens in providing nutritional support to HBC/OVC clients. Afterward, several communal gardens were established.

To alleviate some of the transportation problems associated with service provision by volunteers, WAMI procured bicycles for volunteer use and bush ambulances for communities in need**.**

WAMI hosted monthly meetings for PLHA in which positive living was discussed. Other activities during the meetings included physical exercises and visits to fellow PLHA who were sick in hospitals or in their homes.

Challenges and Lessons Learned
Supporting community initiatives in caring for HBC and OVC clients is an important element of WAMI's work for its communities. Communal gardens are a community initiative that provides nutritional support to HBC and OVC clients, and most communities welcomed the idea of communal gardens and have, in turn, cultivated several gardens of their own. Through mobilizing themselves, communities were able to procure seeds (primarily maize) but have encountered difficulties with fertilizer procurement. An inadequate supply of fertilizer will have an impact on the harvest communal gardens will be able to produce.

HBC/OVC committee job performance was sometimes not optimal due to lack of clarity about roles, so WAMI worked closely with the committees to increase understanding of roles. Another issue was occasional discord between HBC/OVC committees and HBC/OVC volunteers because volunteers received incentives, whereas committees did not. WAMI worked to the extent possible toward resolving problems that developed between the two groups.

V. ATTACHMENTS

ATTACHMENT A: COUNTRY PROGRAM FINANCIAL SUMMARY

Type of Funds	LOP Obligation
Malawi (MAARD/FS)/PEPFAR	$5,728,740
Malawi (Agriculture)	$541,783
Malawi (CDC/LIFE)	$500,000
Malawi Nutrition Advisor	$300,000

ATTACHMENT B: IMPLEMENTING PARTNER CONTACT INFORMATION

Lighthouse Trust P.O. Box 106 Lilongwe, Malawi Phone: 265 1 758 705	**Friends of AIDS Support Trust (FAST)** P.O. Box 190 Nsanje, Malawi Phone: 265 1 456 442
Word Alive Ministries International (WAMI) P.O. Box 2502 Blantyre, Malawi Phone: 265 1 674 451	**The Salvation Army** P.O. Box 51140 Limbe, Malawi Phone: 265 1 645 709
Namwera AIDS Coordinating Committee (NACC) P/Bag 52 Namwera, Malawi Phone: 265 1 586 006	**Trinity Hospital** P.O. Box 51937 Limbe, Malawi Phone: 265 1 459 203
Family Health Education and Counseling Centre (FHECC) P.O. Box 68 Nchalo, Malawi Phone: 265 1 424 336	**Save the Children (USA)** P.O. Box 30374 Lilongwe 3, Malawi Phone: 265 1 753 888
Mponela AIDS Information and Counselling Centre (MAICC) P/Bag 7 Mponela, Malawi Phone: 265 1 286 401	**Ministry of Agriculture and Food Security (MOA)** P.O. Box 30134 Lilongwe 3, Malawi Phone: 265 1 789 033
National Statistical Office (NSO) P.O. Box 333 Zomba, Malawi Phone 265 1 524 377	**Umoyo Network/Napolo Brewery** Private Bag 254 Blantyre, Malawi
PATH 4 Nickerson Street Seattle, WA 98109 Phone: 1 206 285 3500	**Story Workshop Educational Trust** Private Bag 266 Blantyre, Malawi

ATTACHMENT C: COUNTRY OFFICE REFERENCES

FHI/Malawi supported the development and publication of these reference documents and/or tools under the IMPACT Project.

IMPACT/Malawi Baseline Assessment, August 2002. Upon start-up of the HBC/OVC integrated program an initial rapid assessment was conducted in the central and southern regions of Malawi. It was designed to provide an overview of current HBC and OVC activities in the country—including nutrition, identification of potential partners and opportunities for intervention—and to inform the project strategy and workplans. This report was shared with USAID and Malawi government officials responsible for OVC.

End-of-Project Nutrition Assessment Malawi 2007. A survey adapted from a generic questionnaire suggested by the Low Input Food and Nutrition Security Manual was developed with input from some partners and FHI staff. It examined individual households at baseline and again at six-month intervals to demonstrate whether they had adopted and were using the nutrition knowledge (especially low input concepts for cooking and raising crops). As the nutrition component of the program was implemented for a short time, only eight IAs were able to collect the data required. All data was aggregated and analyzed together as the relatively small numbers of respondents per partner precluded more robust individual partner analysis. It is hoped that partners will find the analysis interesting and encouraging, indicating areas of achievement as well as gaps where more effort is needed.

Guidelines for Integrated HBC/OVC Services. IMPACT developed this document to guide CBOs and NGOs with integrating HBC/OVC care and support services. The guide draws from IMPACT's rich experience in providing integrated HBC/OVC care and support services in six districts of Malawi with nine partner organizations. It advocates for HBC/OVC integration of services, provides practical guidance, and considers the challenges and benefits of integrating HBC/OVC services. (Contact: FHI/Malawi, Arwa House, Box 30455, Lilongwe 3, Malawi)

HIV/AIDS in the Agricultural Sector: Policy and Strategy, 2003–2008. The development of this policy was a collaborative effort between IMPACT and Malawi's Ministry of Agriculture, Irrigation, and Food Security. The strategies and activities in this document are intended to inform HIV/AIDS mitigation efforts through providing guidance about reducing the HIV infection rate, reducing poverty, increasing agricultural output and productivity, and improving food security. (Contact: FHI/Malawi, Arwa House, Box 30455, Lilongwe 3, Malawi)

Republic of Malawi Behavioral Surveillance Survey, 2004. This BSS report provides a detailed analysis of trends in HIV/AIDS-related knowledge, attitudes, and behaviors of 13 subpopulations at particular risk of HIV infection in Malawi. The findings are very useful for informing HIV/AIDS-related programming and policy in Malawi, and also provide baseline information that can assist in developing a tracking system for behavioral pattern data of high risk and vulnerable target groups. The BSS was a collaborative effort among Malawi's National AIDS Commission, IMPACT, and CDC. (Contact: FHI/Malawi, Arwa House, Box 30455, Lilongwe 3, Malawi)

IMPACT/Malawi Home-Based Care and Support to Orphans and Vulnerable Children Assessment and Proposed Workplan, July-August 2002. This report is the product of an initial rapid assessment designed to provide an overview of current HBC and OVC activities in Malawi; identify potential partners and opportunities for intervening; define a strategic vision for FHI's HBC/OVC response, including a set of strategic options for implementation (and operations research issues); and identify next steps in the development and implementation process. (Contact: FHI/Malawi, Arwa House, Box 30455, Lilongwe 3, Malawi)

IMPACT/Malawi Home-Based Care and Support to Orphans and Vulnerable Children Workplan and In-Depth Assessment, November-December 2002. This is the follow-up assessment to the rapid assessment conducted in July-August 2002. The purpose of this report was to collect additional information required to develop FHI's HBC/OVC program. Major needs identified included broadening the definitions used for selecting beneficiaries of HBC and OVC services; supporting organizations in providing a broader range of services; strengthening weak linkages to healthcare; and improving the ability of district AIDS coordinating committees to coordinate programs and enhance their sustainability. (Contact: FHI/Malawi, Arwa House, Box 30455, Lilongwe 3, Malawi)

Assessment of HIV/AIDS and Sexual and Reproductive Health Information and Communication Needs Among Young People in Malawi, February 2005. IMPACT conducted this situation analysis about Malawian youth to inform planning and implementation of youth-related programs. Focus group discussions were the primary source of qualitative data, and a questionnaire was the main quantitative method used. The target population was young people 10 to 25 years of age, including both in-school and out-of-school youth. Major challenges reported in the community were poverty, alcoholism, substance and drug abuse, unemployment, early marriage for girls, and unplanned teenage pregnancies. (Contact: FHI/Malawi, Arwa House, Box 30455, Lilongwe 3, Malawi)

National Policy on Orphans and Vulnerable Children, February 2003. This policy document provides guidance for OVC service provision in Malawi. It aims to ensure that care and support services to OVC are in accordance with internationally recognized children's rights. (Contact: Ministry of Gender and Community Services, Private Bag 330, Lilongwe, Malawi)

Best Practices on Community-Based Care for Orphans, 1999. This collection of best practices was produced to facilitate more effective coordination and performance of OVC programs in Malawi, as well as to add to the existing body of knowledge of practices that can benefit OVC in the country. (Contact: Ministry of Gender and Community Services, Private Bag 330, Lilongwe, Malawi)

Developing a Comprehensive Monitoring and Evaluation Workplan for HIV/AIDS and STIs, 2003. IMPACT provided technical assistance to NAC in the design of this guidebook on developing comprehensive M&E plans for HIV/AIDS and STIs at the national level. (Contact: National AIDS Commission of Malawi, Box 30362, Lilongwe 3, Malawi; email: nac@aidsmalawi.org.mw)

Training Manual on Orphan Care, planned for 2008. With support from IMPACT, the Ministry of Women and Child Development reviewed the national training manual on orphan care that was originally developed in 1999. Revisions were made so that the manual would more effectively attain its purpose of improving the attitudes and performance of OVC care providers by equipping them with knowledge and skills to better address the needs of individual OVC. Issues of psychosocial support, child protection, and monitoring and evaluation were not addressed in the original training manual, but the new manual adopted an innovative strategy and introduced new modules to address emerging issues in OVC care and support as part of the continuing effort to promote the survival, growth, well-being and development, and protection of OVC. This updated manual draws on the insights and experiences gained from the various national and international OVC responses. It features the following modules: (1) basic information on HIV and AIDS; (2) concepts and issues related to OVC; (3) growth and development; (4) introduction to child protection; (5) OVC care and support services; (6) introduction to psychosocial support; (7) referral, networking, and collaboration; (8) resource mobilization, utilization, and accountability; and (9) monitoring and evaluation. The modules feature highly interactive sessions that emphasize participatory learning and provide practical steps for integrating OVC activities into existing programs. (Contact: National AIDS Commission of Malawi, Box 30362, Lilongwe 3, Malawi; email: nac@aidsmalawi.org.mw)

ATTACHMENT D: CASE STUDIES

CASE 1: From Beggar to Businessman: The Impact of Vocational Training on Amini Afika

"Poverty, and only poverty, made me come to the market begging. When I say poverty I mean I had no clothes and sometimes I could sleep without any meal. I asked myself, Why should I starve like this? So I started going to the market to beg."

Amini Afika doesn't remember exactly how old he was but believes he was 9 when he stopped going to school due to poverty; he began begging before that. He started begging along the road near his home, where he might get 5 Malawi Kwacha, the equivalent of 6 cents. There were not many people along the road, so he started going to the market. He would bring the money home and give it to his parents, who had seasonal employment as estate workers. Sometimes he would buy food himself and bring it home for his family.

Disabled since birth, Amini painfully recalls how people used to mock him. "First of all I was disregarded even by my relatives. I thought that my relatives would help me overcome my problems but they would not attend to my needs." He recalled a man he tried to beg from who could not just say "No" to the request for money but went on to ask, "Why are you begging from me? Is it me who bewitched you to become disabled?"

"It's very painful even right now when I remember this. Sometimes I would think if I was bewitched, I could find that person that bewitched me and sue him or her."

Prior to becoming involved with the Namwera AIDS Coordinating Committee (NACC), Amini recalls having no friends and living alone, physically and emotionally. He spent a great deal of time observing life in his community from the outskirts of existence, never being invited to community meetings or functions. It was only by chance that he overheard that there was a meeting with the village headman to talk about vocational schools and that the NACC was interested in identifying individuals to attend vocational training. Amini approached the NACC to express his interest in learning tinsmithing.

"I felt that this could be an alternative to begging. I was begging because of poverty but I was not happy begging. I saw this as the only chance to be self-reliant; I felt that if I lost this chance I would be begging forever." At age 27, after being accepted into the six-month training program, Amini recalls passionately, "The moment they said I am most welcome, I felt as if they had given me a large sum of money and I felt really happy. I started training right away. Even after I knocked off and went home I felt crazy—me, getting those skills and being self-reliant."

Tinsmithing is one of the many programs of the NACC Vocational School. With funds from donors such as FHI, it cost NACC approximately 8,000 Malawi Kwacha (US$64) to train a tinsmith. In addition to artisan skills, NACC's vocational curriculum includes training in advertising and business skills.

Today, as a result of the vocational training he received, Amini comfortably supports his wife, mother, and five children, and has generated employment opportunities for other people in his community. With the skills and confidence he gained through the NACC program, he is now a successful businessman working a farm as well as running a tinsmithing business. Three years after he started his own business, NACC hired Amini to teach at its vocational school. With a bank account—a significant accomplishment given the extreme poverty in rural Malawi—Amini now has enough money to invest in the future rather than live day to day. He employs many workers on his farm and has gained respect from his community as an active member of his village AIDS committee, of which he is now the chairman.

"Being a teacher and being an artisan who trains others, I feel very proud. If you have skills and do not teach others, when you die your skills die with you. I impart my skills to others such as orphans and vulnerable children so that when I die they will keep on going.

"From being a beggar to a service provider—I'm a very happy man indeed," says Amini Afika.

CASE 2: HBC Kits in Masanje Community

Masanje is one of the community AIDS committees (CACs) that the STEPs Program has mobilized in Mangochi. It is a splinter of Malombe CAC and is unique in the way it was mobilized: The normal mobilization process regarded Masanje as part of Malombe, but it was difficult for people in the Masanje community to cross the 7-km-radius national park that was between the two communities, and they realized that they could form a CAC on their own. They negotiated to stand alone and use the national park as a boundary. When this initiative was accepted by the district AIDS coordinating committee (DACC) and Malombe CAC, Masanje began mobilizing village AIDS committees and briefing them on the need to support people infected and affected by HIV/AIDS.

Among many other activities taking place in the area is home-based care for chronically ill persons. Masanje CAC is now one of the strongest CACs working independently of the DACC. This is a result of the community and its leaders identifying problems and seeking solutions as a community.

CASE 3: Volunteer Retention and Bicycles

Mobilization of volunteers within communities for the delivery of home-based healthcare services and services to orphans and vulnerable children has been a critical focus of FHI and its implementing partners. Volunteers are now starting to understand the importance of their role in

delivering these services and are identifying and meeting the challenges they face that may limit their effectiveness.

World Alive Ministries International (WAMI) is a centralized faith-based organization operating with outreach to communities throughout a large geographical area. One of the greatest challenges of delivering home-based healthcare services and services to orphans and vulnerable children is transportation for the volunteers, who are critical to the success of such programs. Most WAMI volunteers are not part of the communities within which they work—many of the villages are far apart from each other, and most volunteers work in several villages. Volunteers complained that the challenge of mobility was keeping them from reaching the number of clients they are expected to see and from seeing these clients as frequently as expected. WAMI realized that the physical location of volunteers, and the fact that the organization would not be able to motivate them by capitalizing on the concept of "contributing to the needs of your own community," required building a team spirit external to the community and providing a means of transportation.

WAMI decided to provide bicycles to volunteers. Not only would bicycles help to overcome transportation issues but also they are considered a symbol of status in communities, which would help to motivate the volunteers. With good intentions, WAMI distributed bicycles to many of its volunteers. However, over time, the good intentions began to be overshadowed by issues of ownership and appropriate use. For example, one volunteer died just a few months after receiving a bicycle. Since there was no clear agreement as to who then owned the bicycle, the family held it as an inherited asset of their late family member. The issue was taken to the village chief, who involved the police. After a great deal of negotiation and consumption of time and resources, the bike was retrieved from the family and given to another volunteer.

As a result of this incident, WAMI reassessed its decision and considered the possibility that volunteers would view the bicycles as their own property and that the bicycles would not be properly used and maintained to benefit the program. In addition, concern grew that the quality of volunteers would decline as the knowledge that bicycles are provided to volunteers would motivate many people to volunteer, but would not guarantee their commitment to the work.

To address these concerns, WAMI developed a document outlining the conditions of using the bicycles. In addition, all volunteers were required to sign a written agreement/memorandum of understanding: After three years, if a volunteer has remained dedicated to the work and has properly maintained the bicycle, it becomes the volunteer's property. WAMI views this condition as win-win, since the HBC and OVC services will benefit for three years as the volunteer remains motivated in the program and motivated to keep up with bicycle maintenance.

CASE 4: Malawi's Ministry of Health to Scale Up HIV/AIDS Services

By Anthony Harries

In January 2004, despite having one of the world's highest HIV prevalence rates, the majority of Malawians needing antiretroviral drugs had little access to them. The quality of HIV counseling

and testing services and clinical care and resources to treat opportunistic infections were also inadequate. Just nine health facilities in the public sector were delivering ART to about 3,000 patients. ART delivery was unstructured, very few health workers had been formally trained, and there were no national monitoring or reporting systems.

ART scale-up: A national endeavor

To help Malawi scale up HIV/AIDS care and support, in early 2004 FHI seconded senior technical assistant Dr. Anthony Harries to the Clinical HIV Unit of Malawi's Ministry of Health (MOH). Harries' job was to help the MOH drive, coordinate, and facilitate the scale-up of ART. Harries came to this position after having worked on HIV/AIDS and tuberculosis in Malawi for many years. Now, thanks to the Ministry of Health, the National AIDS Commission, and many other stakeholders and donors, Malawi has a national scale-up plan through 2010, a nationally accredited training curriculum in ARV treatment and management of HIV-related diseases, an accreditation system for institutes administering ART, and a system for registering and tracking patients on ARVs. By June 2007, 109 public sector facilities were delivering ART to more than 110,000 patients in all of the country's districts, and 37 private sector facilities, following similar protocols, had started 4,300 patients on ART.

Before moving to the ministry, Harries was a key writer of Malawi's 2003 National ARV Treatment Guidelines, which were developed in collaboration with the National AIDS Commission (NAC) and the MOH. This experience working with the government and his new location in the MOH placed him in a unique position to effect change. "If you want to influence national policy and practice, this is the place to do it," Harries says.

Harries worked with the MOH to call stakeholders together in 2004 to develop the ART national training module in just two months. The MOH asked contributing institutes to develop certain lectures and seminars and provided them with draft lectures based on the 2003 ARV guidelines. Each institute further developed the lectures and seminars, and the MOH ensured that timelines and deliverables were met. The training materials were subsequently adapted for the private sector.

Comprehensive care and treatment supported

While the focus of FHI's technical assistance is ART, the technical assistant supports other components of HIV/AIDS treatment and care as well. For example, Harries helped coordinate stakeholder discussions and led writing of the *Guidelines for the Management of HIV-Related Diseases*, which was incorporated into the ARV training module.

To ensure comprehensive care and treatment, the technical assistant works across disciplines and with other MOH units. For example, work is under way to integrate nutritional interventions into ARV delivery. The HIV/AIDS Unit is also working to scale up routine and diagnostic counseling and testing services, which is expected to identify more patients eligible for ART. Given the magnitude of the work needed to scale up counseling and testing services, in June 2005 a second FHI technical assistant was seconded to the MOH. The HIV/AIDS Unit is also working with nursing services to build formal and practical links between ARV delivery and home-based care.

National policy for cotrimoxazole preventive therapy

Finally, Harries provided technical assistance to the HIV/AIDS Unit to develop a national policy for cotrimoxazole preventive therapy (CPT). CPT is promoted by WHO and UNAIDS for the prevention of several secondary bacterial and parasitic infections in eligible HIV-positive adults and children in Africa. By June 2007, nearly 51,000 ART patients had received this therapy from 73 sites across Malawi. Staff in all public and private sector ART sites have been trained in the policy and equipped with monitoring tools. "We hope that by next year, all patients—whether on ART or not—will have access to cotrimoxazole," says Harries.

Challenges ahead

Malawi is in the midst of a five-year scale-up plan to place 250,000 patients on ART by the end of 2010. To meet this daunting challenge, urgent action will be required to

- address the shortage of skilled health personnel
- acquire and maintain financial support from a variety of traditional and new funders
- secure a second-line ART regimen as first-line regimens fail due to resistance
- strengthen supervision and drug procurement systems to ensure standards are maintained and drug supplies remain uninterrupted
- scale up HIV prevention services to slow the growth of ART caseloads

Malawi has had demonstrable success in initiating ART scale-up, but much work remains to build capacity for sustainable, comprehensive HIV/AIDS care and support services. FHI will continue to assist the HIV/AIDS Unit to meet Malawi's growing care and treatment needs, supervise and monitor services, increase access to pediatric ART, and undertake operational research to support policy development and implementation. (Note: This ART intervention was funded by the IMPACT Project until September 2005, at which point it was merged into the USAID-funded FHI HBC/OVC Bilateral Project.)