Malawi

Operational Plan Report

FY 2010

Operating Unit Overview

OU Executive Summary

Budget Summary:

Technical Area	Budget Code	FY2009	FY2010
Prevention of Mother to Child Transmission	01 - MTCT	-	12,006,294
Sexual Prevention	02 - HVAB	1,287,447	5,240,472
	03 - HVOP	795,566	3,510,009
Biomedical Prevention	04 - HMBL	-	1,140,000
	05 - HMIN	-	-
	06 - IDUP	-	-
	07- CIRC	1,562,380	1,513,168
Adult Care and Treatment	08 - HBHC	769,230	2,556,604
	09 - HTXS	-	1,289,082
TB/HIV	10 - HVTB	1,240,000	912,997
Orphans and Vulnerable Children	11 - HKID	2,410,770	3,949,388
HIV Counseling and Testing	12 - HVCT	309,607	3,446,036
Pediatric Care and Treatment	13 - PDTX	-	591,957
	14 - PDCS	-	1,024,695
ARV Drugs	15 - HTXD	-	233,916
Laboratory Infrastructure	16 - HLAB	-	3,563,783
Strategic Information	17 - HVSI	200,000	3,838,252
Health Systems Strengthening	18 - OHSS	9,425,000	5,730,310
Management and Operations	19 - HVMO	-	4,453,037
TOTAL		**18,000,000**	**55,000,000**

HIV/AIDS Epidemic in Malawi:

- Adult HIV Prevalence: 11.9% (UNAIDS 2008)
- Estimated Number of HIV-infected People (adults and children): 930,000 (UNAIDS 2008)
- Estimated Number of Children Orphaned by AIDS: 560,000 (UNAIDS 2008)

Targets to Achieve 3-12-12 Goals:

Redacted

Program Description:

Approximately 12% of the Malawian adult population is infected with HIV, with more than 800,000 adults and more than 90,000 children currently living with HIV (UNAIDS 2008). An estimated 60,000 deaths in Malawi are attributed to HIV each year. The TB case detection rate in Malawi remains below 50% with 26,000 notified TB cases and an estimated burden of 48,000 TB cases in 2007. About 70% of TB patients are HIV positive.

Population growth has increased four-fold in the past two decades, and without more effective family planning programs, is on a trajectory to triple to an estimated 42,000,000 people by 2040. Unchecked population growth will result in unsustainable human and economic costs incurred by the Government of Malawi (GOM) including further strains on the already overburdened health care system.

Malawi continues to rank in the lowest 10% of indicators in the Human Development Index. The under five mortality rate is120/1000 live births; maternal mortality rate is1100/ 100,000 live births. Approximately 10% of antenatal women are HIV positive, and more than 50,000 HIV-exposed infants are born each year. The national PMTCT program has been rapidly scaled-up to more than 500 sites since 2008 and Malawi is on-track to counsel and test 500,000 pregnant women this year. However, the program continues to primarily utilize the less efficacious single dose NVP regimen and post-exposure prophylaxis and effective breastfeeding guidelines are not widely in place. Without increasing the quality of the national PMTCT program more than 15,000 infants will continue to be infected with HIV each year.

Between 2003 and June 2009, 234,395 people were started on ART and 169,965 people were still alive and on treatment, with about 9% of patients on ART, 15 years old and younger. Though there is approximately 60% coverage of those in need of treatment, unmet treatment needs will rise considerably upon adoption by the GOM of new WHO Treatment Guidelines.

Malawi's HIV epidemic is driven mainly by adult sexual behavior, with the vast majority of new sexually transmitted HIV infections occurring in adults, rather than in youth under the age of 18. Over 90% of new HIV infections among adults occur through individuals engaging in multiple and concurrent partnerships, and substantial transmission is driven by discordant couples.

Eighteen percent of all Malawian children (~1,000,000) are orphans and vulnerable children (OVC) with nearly 50% attributable to AIDS. Malawi's new HIV and AIDS legislation targets protection of OVC particularly because of their vulnerability to chronic poverty, food insecurity, child abuse, exploitation, violence, and disintegration of families affected by HIV and AIDS.

Under the newly signed Partnership Framework (PF) and the Partnership Framework Implementation Plan (PFIP), PEPFAR has prioritized Country Ownership and Sustainability under the new five year strategy. Responsibility for a Policy Framework to support the PFIP lies with the GOM to ensure the transition plan to country ownership is fulfilled.

PEPFAR funding will focus on the following programmatic areas to achieve the 3-12-12 targets. As Malawi currently has one doctor per 53,662, one nurse per 3,062, and one Health Surveillance Assistant (HSA) per 1,241 people, PEPFAR will also make it a priority to contribute to the goal of training and placing 140,000 new health care workers.

Prevention: $30,810,979

Under the PF and accompanying PFIP, PEPFAR will support the GOM to prioritize reducing new HIV infections over the next five years. Central to this broad goal is elimination of mother-to-child transmission (MTCT) of HIV by targeted interventions including an efficacious antiretroviral therapy (ART) regimen and family planning options for pregnant Malawian mothers. Prevention activities within the PFIP and in-line with the National Prevention Strategy include prevention of sexual transmission of HIV, prevention of mother-to-child transmission (PMTCT), and prevention of transmission through blood, blood products and invasive procedures.

PEPFAR will support the GOM with behavior change interventions directed at partner reduction, targeted condom social marketing in high-risk populations and for discordant couples, positive prevention and support for expansion of HIV Testing and Counseling (HCT), especially couples counseling, timely initiation of ART particularly for pregnant women, and increasing access to male circumcision. A strong component of the strategic support is to continue to build the capacity of indigenous organisations, both faith- and community-based, to take greater ownership of the HIV and AIDS response in Malawi.

Training, mentoring, and technical leadership will be supported to increase the quality and impact of

PMTCT services in the following ways: 1) scaling-up enrollment of HIV-positive pregnant women, children, and male partners in care and treatment, 2) optimize utilization of lay counselors, community health workers, PLHIV, and support groups to improve care, and 3) improving monitoring and evaluation of PMTCT programs. The technical priorities to be addressed in blood safety include national policy and guidelines, strengthening of youth groups to recruit and retain adult donors, appropriate screening of blood and blood products, and implementation of effective monitoring measures.

Principal Partners: Baylor College of Medicine Children's Foundation Malawi (BCM-CFM), Banja La Mtsogolo (BLM), Christian Health Association of Malawi (CHAM), Dignitas International, Elizabeth GLASER Pediatric AIDS Foundation (EGPAF), JHPIEGO, Malawi Blood Transfusion Service (MBTS), Johns Hopkins University Center for Communication Programs (JHUCOM), Lighthouse, Lilongwe Medical Relief Trust Fund, Malawi AIDS Counseling Resource Organization (MACRO), Malawi Defense Force (MDF), Management Science for Health, (MSH), Ministry of Health, Malawi, National AIDS Commission (NAC), Pact Malawi, Partners in Hope Trust, (PIH), Partnership for Child Healthcare (BASICS), Peace Corps, Population Services International (PSI), Project Concern International (PCI), University of Washington (ITECH)

Care: $14,744,722; Treatment: $3,797,699

Under the PFIP, PEPFAR will prioritize Care and Treatment support to Malawi through technical assistance to provide more efficacious, life-saving drug regimens including meeting the expected four-fold expansion of treatment need due to changing WHO guidelines on treatment eligibility. A signature Care and Treatment intervention in Malawi is strengthened continuum of care efforts through a new pre-ART program to embolden the entire referral network and significantly reduce loss-to-follow-up which is currently79% of mother-infant pairs. Public-Private Partnerships will also continue to be effectively utilized to scale-up the reach of limited PEPFAR and other public dollars in care activities. Care and treatment activities will include: 1) increasing the use and quality of pre-ART management for People Living with HIV (PLHIV), 2) strengthening laboratory support services for HIV diagnosis and management, 3) strengthening referrals and the continuum of care for PLHIV, 4) improving the capacity of the health care system to manage HIV and related diseases, 5) providing technical leadership within the Ministry of Health (MOH) and Ministry of Gender, Child Development and Community Development (MOGCCD), 6) enhancing zonal mentoring and capacity building, 7) scaling-up electronic health information systems, 8) supporting basic program evaluation, 9) providing directed support for pediatric HIV, 10) increasing support to military populations and families through the Malawi Defense Force, 11) expanding access to opioids, 12) strengthening sustainable food and nutrition programs, and 13) expanding TB/HIV interventions.

Under the PFIP, $6,360,158 of PEPFAR funds target OVC specifically. PEPFAR resources will support the GOM to increase OVC access to essential care, support and protection services, improve the quality of OVC services, strengthen the capacity of local institutions to provide OVC and PLHIV services, improve the policy and legal environment for the protection of OVC and PLHIV, and promote evidence-based strategic planning.

Principal Care Partners: Baylor College of Medicine Children's Foundation Malawi (BCM-CFM), Academy for Educational Development(AED), African Palliative Care Association (APCA), Catholic Relief Services (CRS), CHAM, Dignitas International, EGPAF, Feed the Children, Howard University, Johns Hopkins University Center for Communication Programs (JHCOM), KNCV TB Foundation, Lighthouse Trust, Malawi Defense Force (MDF), Ministry of Health, Malawi, PACT Malawi, Partners in Hope Trust, Partnership for Child Healthcare (BASICS), Peace Corps, Project Concern International, Save the Children (USA), University of Washington.

Principal Treatment Partners: Dignitas International, Howard University, Lighthouse Trust, Ministry of

Health, Malawi, Management Sciences for Health (MSH), Partners in Hope Trust, University of Malawi - College of Medicine/Lab.

Other: $23,646,599

As a non-focus country, PEPFAR Malawi has focused its limited resources on strengthening the Malawi health care delivery systems as an effective tool to promote country ownership and sustainability of the HIV and AIDS response. Primary health systems strengthening activities include the following: 1) supporting the GOM to increase the number of healthcare and social welfare workers through prioritizing Human Resources for Health, 2) strengthening Health Financing to program efficiently in a resource-constrained environment, 3) providing integrated support for Commodities and Procurement (PEPFAR, PMI, POP), 4) scaling-up Health Management Information Systems to provide real-time data for patient care, monitoring and evaluation and resource allocation, 5) enhancing Lab Services for the health care delivery system including HIV-related services, and 6), integrating HIV support with other health and development programs including Family Planning, Tuberculosis, Food and Nutrition, Education and Gender. Gender has been prioritized under the PFIP including the need to examine the gender imbalance at the level of local control of AIDS financing.

Principal Partners:
Academy for Educational Development (AED), Abt Associates, Baobab Health Partnership, CHAM, Dignitas International, EGPAF, Global AIDS Interfaith Alliance, Howard University, IntraHealth International Inc., Johns Hopkins University Center for Communication Programs, John Snow International (JSI), Lighthouse Trust, Macro International, Ministry of Health Malawi, MSH, National AIDS Commission (NAC), PACT Malawi, Partners in Hope Trust, Partnership for Child Healthcare (BASICS), Peace Corps, Project Concern International
Baylor College of Medicine Children's Foundation Malawi (BCM-CFM), Banja La Mtsogolo (BLM), Christian Health Association of Malawi (CHAM), Dignitas International, Elizabeth GLASER Pediatric AIDS Foundation (EGPAF), JHPIEGO, Malawi Blood Transfusion Service (MBTS), Johns Hopkins University Center for Communication Programs (JHUCOM), Lighthouse, Lilongwe Medical Relief Trust Fund, Malawi AIDS Counseling Resource Organization (MACRO), Malawi Defense Force (MDF), Management Science for Health, (MSH), Ministry of Health, Malawi, National AIDS Commission (NAC), Pact Malawi, Partners in Hope Trust, (PIH), Partnership for Child Healthcare (BASICS), Peace Corps, Population Services International (PSI), Project Concern International (PCI), University of Washington (ITECH) University of Malawi, College of Medicine.

Other Donors, Global Fund Activities, Coordination Mechanisms:

The United States is the largest bilateral donor to the Malawi's health sector, having provided a total of $284,475,966 in support for HIV/AIDS, TB and Malaria since 2003, 80% of which is for HIV/AIDS prevention, care and treatment. In addition to the Global Fund, other major donors include the United Kingdom, Norway, Germany, the European Union, and the World Bank. The Global Fund has approved four grants to Malawi, totaling $615 million over ten years for AIDS and TB programs. The primary HIV/AIDS coordinating body is the National AIDS Commission (NAC). In addition to working with NAC, USG meets regularly with key officials of individual Ministries (Health, Gender, Finance, Defense, Education and the Office of the President and Cabinet) to ensure that USG assistance complements and supports the Malawian Government's plans for prevention, care and treatment. A strategy for coordination for PEPFAR support was central to successfully developing a PF with the Government of Malawi under the Partnership Framework.

Program Contact: PEPFAR Country Coordinator, Mamadi Yilla

Time Frame: FY 2010 – FY 2011

Population and HIV Statistics

Population and HIV Statistics				Additional Sources		
	Value	Year	Source	Value	Year	Source
Adults 15+ living with HIV						
Adults 15-49 HIV Prevalence Rate						
Children 0-14 living with HIV						
Deaths due to HIV/AIDS						
Estimated new HIV infections among adults						
Estimated new HIV infections among adults and children						
Estimated number of pregnant women in the last 12 months						
Estimated number of pregnant women living with HIV needing ART for PMTCT						
Number of people living with HIV/AIDS						
Orphans 0-17 due to HIV/AIDS						
The estimated number of adults and children with advanced HIV infection (in need of ART)						

Women 15+ living with HIV						

Partnership Framework (PF)/Strategy - Goals and Objectives

(No data provided.)

Engagement with Global Fund, Multilateral Organizations, and Host Government Agencies

Redacted

Public-Private Partnership(s)

Partnership	Related Mechanism	Private-Sector Partner(s)	PEPFAR USD Planned Funds	Private-Sector USD Planned Funds	PPP Description
Building the nursing workforce and nurse training capacity in Malawi	12119:GAIA/HRH/GHAI	Global AIDS Interfaith Alliance	100,000	100,000	PEPFAR Malawi is in a process of developing a PPP agreement with the Global faith Interfaith Alliance (GAIA), an NGO providing scholarships for nurses to go through Kamuzu College of Nursing, a constituent college of the University of Malawi for a four year nursing degree program. Each funded scholar agrees to a four year bonding

					contract to work with the Ministry of Health in Malawi. GAIA will support 40 students over a period of 5 years. This activity will contribute significantly to the numbers of nurses that Malawi will produce and retain by the end of the five year Partnership Framework. The program will also support 4 Masters students in nursing and these will contribute to improving the faculty of the nursing college.
Capacity Building Initiative Pilot		Standard Bank	0	50,000	Standard Bank Group Limited, of which Standard Bank is a subsidiary, is currently the largest African Banking group in terms of assets, geographic spread and market capitalization. The group operates in 18 African countries

					and over 21 countries globally. The group is committed to making a real difference in Southern Africa by being relevant to the societies in which it operates. In this partnership with USAID/Malawi, Standard Bank Malawi has committed to support and strengthen the Local Assembly finance management systems through capacity building in finance management and reporting as one way of contributing to the development of Malawi. Large amounts of HIV/AIDS funds are channeled through Local Assemblies yearly and the capacity of these Local Assemblies to timely manage and absorb these funds is crucial for the

					progress of the HIV/AIDS response in Malawi. Standard Bank will place experienced finance management consultants in 4 pilot sites for a period of 6 months to transfer skills. USAID/Malawi through PEPFAR will not match funds in this initiative, but will utilize its experience in development work to provide technical support.
Capacity support for Early Childhood Development & Psychosocial Support (C-SEP)	12120:C-SEP				C-SEP is a three year co-ag implemented by Save the Children. Its goal is to help OVC realize their full potential by strengthening participation in quality early childhood development (ECD) and psychosocial support (PSS). C-SEP will accomplish this goal by increasing access to and quality of ECD

					and PSS programs; improving household and community capacity to promote ECD and PSS; and strengthening policies and capacities in ECD and PSS. These activities support the “Impact Mitigation” goal of the Malawi Partnership Framework. C-SEP is being implemented in 3 districts (Blantyre, Chiradzulu and Zomba), and works with the Ministries of Gender, Children and Community Development (MoGCCD), Health, and Education at the district level. In addition to the ministries, C-SEP works with the ECD network and community structures to ensure government-led collaboration and networking to identify

					opportunities for leveraging community resources to support the delivery of ECD and PSS.
Extending quality improvement for HIV/AIDS in Malawi	12107:EQUIP	Partners in Hope	2,263,000	2,263,000	The Project capitalizes on existing networks, infrastructure and acquired expertise and skills of partners and will achieve the goal through three complementary objectives: Strengthening the continuum of care between different health services and between facilities and communities. Working with CHAM and government clinics, the project will develop a model for care that involves integration of services within the same clinic or strong linkages among different clinics when integration is not possible; Developing Zonal

					mentoring teams- Individuals in CHAM hospitals will be trained in clinical and program management to ultimately serve as mentors at other sites in their regions; Creating a consortium of sites for operational research to inform the other 2 objectives and improve the quality of HIV care and training - This will involve operational research to address critical questions of priority to inform the national ART program.
Increased production capacity for ready-to-use foods in Malawi		Project Peanut Butter	152,858	2,424,545	USAID Malawi embarked on a new partnership with Project Peanut Butter in December 2008, a locally-based company that produces Ready to Use Therapeutic Food (RUTF) called plumpy nut. The GDA grant supports an alliance between

					Project Peanut Butter, Nutriset, Hickey Family Foundation and Arnow. The funding was used to purchase larger-scale machinery that will increase the rate of production from roughly 500 tons/year to 1200 tons/year, and to purchase a foil-seal sachet packaging machine with nitrogen. Plumpy-nut, locally known as chiponde, is used to treat severe acute malnutrition in children. It is a mixture of peanut butter, oil, sugar, milk powder and vitamins and minerals in a precooked paste. The GDA supports research into new and/or improved recipes for treating severe and moderate acute malnutrition in children and adults who are HIV-

					positive.
Integrated (HIV Effect) Mitigation and Positive Action for Community Transformation (IMPACT)	14249:Integrated (HIV effect) Mitigation and Positive Action for Community Transformation (IMPACT)	Clinton Health Access Initiative			The Integrated HIV Effect Mitigation and Positive Action for Community Transformation (IMPACT) project is expected to improve the wellbeing of 58,017 OVC and 41,505 people living with HIV (PLHIV) in nine districts in central and southern Malawi. Catholic Relief Services brings private sector, information technology and faith-based partners to the Title II-supported Wellness and Agriculture for Life Advancement (WALA) consortium. This alliance mobilizes expertise, cash and in-kind resources to expand access to care and treatment services OVC and PLHIV. IMPACT's implements through existing structures thus enhancing sustainability,

					country ownership, and active participation of beneficiaries. GOM's heavy involvement in the program at all levels has provided an optimal environment for implementation and coordination of services with various departments and other programs.
Malawi Tiwalere Orphans and Vulnerable Children (OVC) Project	12126:Feed/OVC/GHAI				Tiwalere is a five year project that takes a comprehensive approach to food security, nutrition education, income generation, and water and sanitation improvement. Tiwalere's goal is to ensure improved well-being of OVCs in 15 districts, targeting 73,051 children and 39,261 households. This goal will be achieved through three strategic objectives which support the impact impact mitigation

					goal of the PFIP. The first objective is to improve the health and nutrition status of children aged 0-59 months. This is done through activities for children attending community-based child care centers and through nutrition education to parents and caregivers. The second objective is sustainable improvements to food security by promoting new farming methods and improved crop varieties. The third objective is to enhance the capacity of households caring for OVC.
Male Circumcison	12118:BLM CIRC GHAI	Banja La Mtsogolo	1,200,000	1,200,000	Banja La Mtsogolo (BLM) is a national family planning (FP) and sexual and reproductive health (SRH) organization with static clinics in 22 of 28 districts in

					all three regions of Malawi. Under the Partnership Framework (PF) negotiated between PEPFAR and the Government of Malawi (GOM), BLM will target uncircumcised boys and HIV negative men between the ages of 10 and 29. BLM is committed to increased access to safe, voluntary male circumcision (MC) for 52,000 people; increased engagement of men in pursuing sexual and reproductive health for themselves and their partners, with an emphasis on HIV prevention and integration of MC service provision into ANC, PMTCT, and neonatal care programs in collaboration with MOH. BLM will train 100 private and MOH providers to provide a minimum

					package of MC in BLM and MOH facilities. BLM's experience implementing MC programs for HIV prevention in Malawi, and experience gained from similar programs across the MSI Global Partnership, will allow it to feed into policy dialogue and support the creation of the GOM MC policy.
NEPI - Building the nursing workforce and nurse training capacity in Malawi		Columbia University, Clinton Health Access Initiative , ELMA Foundation, IntraHealth/CapacityPlus			To support innovative strategies and promising practices that will inform curricula development, faculty preparation and strategies for faculty retention, and educational models that prepare new nurses to practice in the diversity of medical and community settings where health needs are greatest.
OVC (Education &	12129:TBD/LM	TBD	Redacted	Redacted	This proposed

Sustainable Economic Growth wrap arounds)	/GDA				project will be a new public-private partnership to strengthen care for orphans and vulnerable children in HIV-affected communities in Malawi. The project is expected to be innovative and pilot new strategies and/or scale up tested strategies that show promise in addressing strengthening family and community capacity to care, support and protect vulnerable children, as well as improve their access to essential services. One or multiple awards may be made depending on the applications that come in under the APS. Potential partnerships will be in line with the Malawi HIV and AIDS National Action Framework and the Malawi National Plan of

					Action for Orphans and Vulnerable Children and focused on expanding implementation of a comprehensive package of high quality interventions for orphans and vulnerable children
PEPFAR OVC Initiative		New Partner	5,586,000	5,586,000	67000 OVC and 33,000 PLHIV will receive support through a third application that seeks to wrap PEPFAR activities around Title II Food for Peace activities. Key activities will include improved infant feeding and young child feeding, integrated community management of childhood illnesses, improved child and legal protection services, education support and income generating activities including village savings and loans schemes. The application will also

					support the efforts of the GOM to develop and implement a national pre-ART program for PLHIV. This five year application will provide targeted supplemental nutrition and water purification commodities to OVC in CBCCs, as well as strengthen community and household food security through improved agricultural practices, farm inputs, and income generating activities. A total of 27644 OVC will be reached in nine districts.
Safeguard the Household	12106:LMRTF/ PMTCT/GHAI	Lilongwe Medical Relief Trust Fund	1,500,000	1,500,000	The “Safeguard the Household” (STH) project aims to improve the quality and impact of current PMTCT service delivery systems, increase linkages with ART and other maternal

					child health and family planning services, and explore new technologies and approaches make PMTCT services more effective and feasible. The project will target HIV-infected pregnant women, their partners, and HIV-exposed infants and children under five. In doing so, the project will safeguard the entire household.The overall goal is to empower and support the MOH in its efforts to implement a comprehensive HIV prevention, treatment and care program in Malawi in the areas identified by the Partnership Framework (of the GoM and USG) and the NAF. The STH project will be implemented by a partnership of 12

					organizations, all with substantial experience working in Malawi, and will be led by an indigenous organization, Lilongwe Medical Relief Trust Fund (aka Lilongwe Trust) and supported by their main technical partners UNC Project, the University of North Carolina and EGPAF.
Support for Health Systems Strengthening and HIV/AIDS service delivery in Malawi's South -East Zone	12105:Dignitas /QCT/GHAI	Dignitas International	2,151,773	2,151,773	The ultimate goal of the program is to achieve the highest attainable standard of health and wellbeing in Malawi. The program will build sustainable, locally owned capacity and increased local autonomy. In order to avoid dependency, the program is carried out with and through the South-East Zonal Health Office (ZHO) and the District Health

					Offices (DHOs) of the zone, and emphasizes targeted knowledge-exchange. The program comprises of three clusters of implementation activities: Management of the HIV/AIDS referral clinic at Zomba Central Hospital, which serves as a pilot site for several initiatives aimed at improving patient care and bolstering human resources for health; Training and mentorship of service providers (i.e., Clinical Officers, Medical Assistants, Nurses, midwives, and counselors), and health system managers and supervisors (i.e., ZHO, DHO, DHMT, EHOs, and District ART, HTC, PMTCT, and HBC Coordinators); and Design and implementation

					support of tools for patient management, clinic management, and health systems management.
Support to ten Malawi Bureau of Standards laboratory		Pfizer			USG Malawi continues to benefit from the global partnership with Pfizer, a U.S. drug company that provided technical expertise to USAID/Malawi in the development of business plans for several HPN and SEG partners in 2008. Although the TA ended his assignment in early May 2008, he has maintained a close relationship with the mission and in July 2008 managed to mobilize a high performance liquid chromatography machine to the Malawi Bureau of Standards (MBS) which was handed over to the MBS by the US Ambassador to Malawi by a

					representative of Pfizer in 2009. The MBS had been trying to source equipment for a long time. Through his continued efforts and interest in Malawi, the TA has managed to secure additional equipment for the MBS, from Pfizer. The significance of this donation is that it will help the MBS reach International Organization for Standardization (ISO) certification. Pfizer is also looking into the possibility of organizing a fellow to assist the MBS with the set-up, operation and maintenance of the new equipment. The estimated total value of the equipment and TA support is not yet available.
The Malawi Teacher Professional Development Support (MTPDS)		New Partner	175,000	175,000	The Malawi Teacher Professional Support activity will provide technical

activity,					assistance and support to Ministry of Education, Science and Technology (MOEST) in implementing teacher education support and systems management, with an emphasis on completing and reinforcing its introduction of the Primary Curriculum and Assessment Reform (PCAR). Targeting teachers, school administrators, young people and children nationwide, this Teacher Professional Development Support activity will support linkages and complement key MOEST and GOM priority initiatives and plans in teacher education and professional development, including the HIV/AIDS and

					Education Strategy and Plan.
Tingathe program	12130:Baylor/ QCT/GHAI	Baylor University, College of Medicine	500,227	500,227	The goal of this project is to expand the scope and reach of the Tingathe program resulting in a majority of mothers and infants at participating facilities receiving the full complement of PMTCT and early Infant Diagnosis (EID) services, and prompt entry of infected infants and mothers into care for optimal treatment outcomes. Despite extensive evidence on improved PMTCT regimens, post-exposure prophylaxis, and rapid clinical progression in HIV-infected infants, there has been scant progress made on how best to coordinate and ensure delivery of the multiple services that HIV-positive mothers and their

					infants require in the real-world setting. In the Lilongwe area, the BCM-CFM Tingathe outreach program has made strides in developing systems to improve the quality and utilization of PMTCT, EID, and pediatric HIV care services.
Together for Girls		New Partner			UNICEF Malawi with USG and CHAI will support the government of Malawi to undertake, for the first time, a nationally representative population based survey of sexual, physical and psychological violence against children and young women between the ages of 13 to 24, including those living with and affected by HIV and AIDS. The key purpose of the survey is to determine the

					prevalence of violence against children and young women and to develop a better understanding of protective and risk factors. This will contribute to informed policy decisions and sound programming, to effectively prevent and respond to violence against children and young women in Malawi. This project is in response to concerns regarding violence against children in Malawi and the need for quality data that is nationally representative. The implementation of the project will be guided by lessons learned during the successful implementation of similar surveys on violence against children conducted collaboratively by UNICEF and CDC

					in Swaziland in 2007 and in Tanzania in 2009. UNICEF will lead the survey process in collaboration with the Ministry of Gender, Children and Community Development (MOGCCD) with technical assistance from CDC and National Technical Working Group on Child Protection, which involves key government bodies including the Malawi National Police; Ministry of Health; the Judiciary; Ministry of Education; Ministry of Labour and key civil society organizations.

Surveillance and Survey Activities

Name	Type of Activity	Target Population	Stage
Behavioral and biological surveillance of high risk populations (sex workers, teachers, police, vendors, truck drivers, estate workers, fishermen, border traders)	Behavioral Surveillance among MARPS	Other	Development

Incidence surveillance (laboratory - based)	Recent HIV Infections	General Population	Planning
Prospective HIV drug resistance surveillance	HIV Drug Resistance	Other	Other
Transmitted drug resistance surveillance	HIV Drug Resistance	Pregnant Women	Other

Budget Summary Reports

Summary of Planned Funding by Agency and Funding Source

Agency	Funding Source				Total
	Central GHCS (State)	GAP	GHCS (State)	GHCS (USAID)	
DOD			310,000		**310,000**
HHS/CDC	75,000	3,052,000	16,923,000		**20,050,000**
HHS/HRSA			1,750,000		**1,750,000**
State			185,628		**185,628**
State/AF			90,000		**90,000**
USAID	200,000		17,189,372	15,500,000	**32,889,372**
Total	**275,000**	**3,052,000**	**36,448,000**	**15,500,000**	**55,275,000**

Summary of Planned Funding by Budget Code and Agency

Budget Code	Agency							Total
	State	DOD	HHS/CDC	HHS/HRSA	State/AF	USAID	AllOther	
CIRC			300,000			1,213,168		**1,513,168**
HBHC		100,000	985,000			1,228,481		**2,313,481**
HKID					90,000	3,690,850		**3,780,850**
HLAB			2,865,140			513,627		**3,378,767**
HMBL			1,140,000					**1,140,000**
HMIN			75,000			200,000		**275,000**
HTXD						138,000		**138,000**
HTXS			435,000	300,000		554,082		**1,289,082**
HVAB		105,000				4,748,700		**4,853,700**
HVCT			1,250,000	50,000		2,037,128		**3,337,128**
HVMS	185,628		3,790,000			2,750,000		**6,725,628**
HVOP		105,000	420,000			2,655,109		**3,180,109**
HVSI			914,560	650,000		1,654,310		**3,218,870**
HVTB			435,000	50,000		332,081		**817,081**

MTCT			4,375,000	50,000		7,581,294		**12,006,294**
OHSS			2,830,300	650,000		2,210,890		**5,691,190**
PDCS						591,957		**591,957**
PDTX			235,000			789,695		**1,024,695**
	185,628	**310,000**	**20,050,000**	**1,750,000**	**90,000**	**32,889,372**	**0**	**55,275,000**

Budgetary Requirements Worksheet

(No data provided.)

National Level Indicators

National Level Indicators and Targets

Redacted

Policy Tracking Table

(No data provided.)

Technical Areas

Technical Area Summary

Technical Area: Adult Care and Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
HBHC	2,313,481	
HTXS	1,289,082	
Total Technical Area Planned Funding:	**3,602,563**	**0**

Summary:
HBHC: $3,325,834 HTXS: $1,289,082 Context and Background Malawi's national ART has been extraordinarily successful in scaling up, with more than 220,000 people ever started on ART, and 169,000 still alive and on ART by September 2009. Success is a result of a highly streamlined, simplified approach with a fully loaded cost of ~$230 per patient per year. Currently, around 95% of the patients receive the same fixed-dose combination (d4T/3TC/Nevirapine); laboratory tests are not required either for initiation or monitoring of treatment and significant task-shifting is being utilized to compensate for the massive shortage in health workers. Cotrimoxazole prophylaxis (CTX) is readily available for those eligible in Malawi (i.e. WHO stage 2, 3, or 4, or CD4 count <500 cells/uL regardless of symptoms in HIV-infected adults, and all exposed infants and pregnant women,). Decentralization of ART services to lower level health facilities has created widespread access to ART for patients throughout the country, with 224 ART sites now operational. Over 65,000 new patients are projected to initiate ART each year over the next few years, to achieve Universal Access (UA) by 2012; however the quality of the care they will receive must be addressed now. Currently the proportion of patients remaining alive and on treatment at 12 months is 76%, and Malawi's NAF has set an ambitious target of improving this proportion to 85% by 2012. Support through the Sector Wide Approach for Health (SWAp) (GFATM, and GOM) covers the vast majority of the operational costs of the national ART program. Through the Partnership Framework (PF), PEPFAR will complement these efforts by specifically focusing support on improving the quality of services through 1) a new national pre-ART program; 2) increasing access to CD4 counts for determining eligibility for treatment initiation; 3) improving referrals and continuum of care between services; and 4) strengthening zonal supervisory capacity and supporting related quality improvement activities and basic program evaluation of importance to the national program. A key focus will be early identification, enrolment and retention in care of those who test positive to facilitate ART initiation at the point of eligibility, as this will improve patient outcomes, reduce HIV transmission, and reduce incidence of TB and other opportunistic infections (OIs). Accomplishments since the last COP USG funding has strategically supported facility-based adult care and treatment through human capacity development, training, laboratory services, supervision and program evaluation, while support for community-based services has been through Pact/Malawi's 13 indigenous partners. These partners provided clinical, prevention, social, psychological, spiritual, and mental services for people living with and affected by HIV and AIDS in facility, community and home-based care settings. Goals and Strategies for PFIP Years 1 and 2 1. Increase use and quality of pre-ART management for People Living with HIV Malawi is currently providing HIV counseling and testing (HTC) for more than 1.7 million people a year. However, many testing HIV-positive are lost to follow-up as no name or number referral system exists, and no formalized pre-ART program has been in place to provide initial ART eligibility screening, regular CD4 testing, CTX prophylaxis, and other prevention and care interventions which reduce disease transmission, progression

and OIs. A tremendous opportunity exists to fill the "gap" between HTC and ART services through a two-pronged approach of strengthening the referral system, and enrolling and retaining patients in pre-ART care. In September 2009 the MOH held a meeting to standardize and develop plans for an essential care package for facility- and community-based pre-ART care. The package will be implemented in both facility and community settings, and will include CD4 counts, Cotrimoxazole , TB screening and management, food and nutrition assessment, Prevention-with-Positives (PwP), psychosocial support, pain and symptom management, and targeted safe drinking water interventions. PEPFAR will provide support to the GOM in the following areas: 1) development and dissemination of pre-ART guidelines, mastercards, registers, and other M&E tools; 2) training of clinical workers, CHWs, and PLHIV in new pre-ART guidelines; 3) technical assistance and other logistics support to improve the national supply chain, including commodities needed for pre-ART program (i.e. CTX, condoms); 4) technical assistance to support district and zonal health offices to roll–out pre-ART services within health facilities; and 5) support to NGOs and CBOs to implement the community-based component of pre-ART. PLHIV support groups will play a key role in community-based efforts, supporting patient-tracking efforts and conducting interactive sessions on prevention, disclosure, nutrition, alcohol, safer sex, FP, and positive living. USG will support MOH to implement pre-ART services in facilities and in communities – with all implementers ensuring strengthened linkages between facility and community services. 2. Strengthen laboratory support services for HIV diagnosis and management In the last quarter, only 29% of patients initiating ART in Malawi did so based upon immunological criteria. To complement lab-based efforts described in the Lab and OHSS TANs, PEPFAR partners will work with zonal and district health offices to provide technical assistance to ART and PMTCT sites to increase infant diagnosis. CD4 testing will be prioritized for those HIV positive patients with the most need. Support for intensified TB-case finding is also a priority (national TB case-detection rate is less than 50%; WHO target is 70%). USG will support MOH and implementing partners to expand TB screening within HTC services and within the national HIV care and treatment program. 3. Early identification of HIV-infected persons, linkage and retention in care USG partners will assist the MOH to strengthen referral, feedback and patient tracking systems which will facilitate access to a continuum of HIV/AIDS prevention, care and treatment services in clinics and communities and reduce loss to follow-up. Follow up of persons who test positive will be greatly enhanced by the proposed MOH change in HTC policy from anonymous to confidential testing. Priority activities for support include: 1) mapping existing services (i.e. HCT, PMTCT, ART, food and nutrition, livelihoods, malaria, TB, FP services); 2) improving M&E systems for better tracking of referrals and care continuum (i.e. development of a name or ID-based referral system, standardization of indicators, development of referral directories and simple patient tracking tools); 3) testing and supporting phased national scale-up of innovative approaches to address barriers to retention in care such as: transport interventions; expert patients; cell-phones; and performance-based financing. The highest priority will be placed upon improving the following referrals between: 1) PMTCT and ART; 2) TB-treatment and HIV treatment for co-infected patients; and 3) HTC and pre-ART. 4. Improve the capacity of the health care system to manage HIV and related diseases Malawi's public health approach to ART has led to rapid scale-up of HTC and simplified clinical-based provision of treatment. Efforts to ensure high-quality ART services include a unique and beneficial system of standardized patient records and quarterly ART supervisory visits to all health facilities providing ART in the country. However, given the high number of sites and volume of patients, the amount of mentoring and skills transfer which occurs during supervisory visits is typically minimal. Implementing a specific quality improvement process could provide critical structure for both newly opening facilities and existing facilities that continue to grow rapidly in Malawi's l imited human resource context. Described below are USG's interrelated approaches to build Malawi's national program's capacity for strengthened quality improvement activities. A. Technical leadership within the MOH: The USG will continue to fund a clinical support team (CST) to assist the Department of HIV/AIDS in the MOH with the expansion of HIV/AIDS treatment services throughout Malawi and also provide support for MOH technical leadership activities on the national level through the CDC cooperative agreement with the MOH. These personnel will provide technical oversight for the expansion and improved quality of care and treatment services. B. Zonal mentoring and capacity building: Malawi has 5 zonal health offices (ZHOs) in the country which are responsible for providing supervision and mentoring

to the 28 district health offices (DHOs) within their respective zones. Zonal offices are to provide technical leadership and supportive supervision for the districts. USG will work to build the capacity of these ZHOs and DHO's to mentor, supervise, plan, develop and implement systems to manage patient and data flow. PEPFAR will work with existing partners to identify and develop best practices for sharing with the broader national program. Standardized supervision tools will be developed to ensure consistency of the supervision process. Once defined zonal and district-level goals have been achieved, systems will be consolidated, lessons learned will be compiled for dissemination, and validated processes and tools will be finalized by the MOH for scale-up. Areas of focus for quality improvement activities will be determined in consultation with the MOH and zonal and district health offices and may include: provision of a basic care package; strengthening ART-PMTCT linkages; HIV/TB; pediatric care; ART initiation, including the use of clinical guidelines, diagnostics, and the optimal approach to other aspects of HIV care; ARV substitution and how to operationalize switching regimens; treatment adherence, patient retention, and patient outcomes. An in-service clinical leadership training program will also be developed to help clinical leaders develop their clinical skills so that they can return to provide improved technical leadership in their respective zones and district. C. Electronic data systems: Zonal mentoring partners will provide technical assistance to sites to support phased implementation of electronic medical registers (EMRs) records for ART and, possibly pre-ART care, for patients at ART sites with large numbers of patients. The system of records and supervision has become stretched and vulnerable as facilities reach high patient numbers, and in many cases, data collection, supervision, and improvements in quality of patient care are no longer linked. Supportable and sustainable electronic systems with a minimum standard data collection and reporting capability will improve the quality of patient data and enhance its use in ongoing program improvement. D. Operational research (OR): Under MOH leadership, the zonal partners and USG technical staff will collaborate together as part of the national HIV Technical Working Group and an OR task force underneath it to identify and prioritize critical questions and develop and implement an agenda for operations research and programmatic evaluation of Malawi's national program. E. Support to the Christian Health Association of Malawi (CHAM): CHAM sites, which provide about 40% of all health care in Malawi, lag behind in the implementation of HIV services. Financial and technical support will therefore be provided to improve the quality and access to services at least 25 CHAM sites by the end of PFIP Year 2. 5. Improved Quality of Life for HIV infected persons Increasing opioid access: Access to opioids is a major challenge because of restrictions on prescription by nurses, poor clinical training in opioid pain management, weak supply chain, and a lack of pain management guidelines. USG will continue to support improved assessment and management of pain by improving advocacy and policy reform efforts to increase access to opioids, and other pain medication. While access to opioids is gradually improving in Malawi, USG efforts will continue to address major challenges to opioid availability through support to the Palliative Care Association of Malawi, and a broader OGAC-DFID collaborative initiative on opioids. Food and Nutrition: As part of the basic care package for the pre-ART program that MOH will develop, PLHIV support groups and volunteers will provide nutrition counseling and support PLHIV and their families to develop sustainable approaches to increase household food production and food security. TA will also be provided to facilities and community-based care programs to identify and refer malnourished patients to MOH "food by prescription (FBP)" type of program programs available at most ART sites. Additionally, support will be provided to help the GOM develop improved policy and practices around the FBP program. Because linkages are also weak between the FBP program, the community-therapeutic care (CTC) program and other community-based livelihood activities for PLHIV and OVC, policy efforts will attempt to improve integration of the management and monitoring of these programs, so that they run in a more harmonized manner rather than as parallel systems. New USG public private partnerships will also wrap around Title II Food for Peace programs that provide targeted food support to vulnerable households. 6. Support to the Malawi Defense Force (MDF) PEPFAR funding will be used to expand the reach of MDF's HBHC program. It will also enhance the clinical skills of military personnel using the training programs at the Infectious Disease Institute in Uganda, with a training of trainer's course being used to allow attendees to bring their knowledge back to share in Malawi with other personnel. Military facilities and staff will also be included in the quality improvement activities described above for the national care and treatment program. 7. Monitoring and Evaluation USG will

support limited proof of concept on models of delivery of care and support services, as well as mapping of care and support and treatment services for strengthened linkages between facility and community services, that ensure continuum of care and treatment services. Cost of services will also be assessed.

Technical Area: ARV Drugs

Budget Code	Budget Code Planned Amount	On Hold Amount
HTXD	138,000	
Total Technical Area Planned Funding:	**138,000**	**0**

Summary:
HTXD: $233,916 Context and Background Of the approximately 169,000 people currently alive and on ART in Malawi, greater than 95% are receiving the country's recommended first-line regimen of a fixed-dose combination of d4T/3TC/ NVP twice daily. With the exception of pediatric ARVs which are procured partially with UNITAID funding until 2010, ARVs for the national program are procured exclusively with Global Fund for AIDS, TB and Malaria (GFATM) resources through UNICEF, and supplied to sites through SDV, a private company funded by UNICEF with GFATM resources. SDV operates through a parallel system outside of the Malawi's highly dysfunctional national Central Medical Stores (CMS) system, which is responsible for supplying almost all other health commodities in Malawi, including HIV test kits and OI drugs. Unlike programs that depend on commodities through CMS, Malawi's ART program has not experienced any ARV stock-outs to date, but the increasing demand on the current supply chain for HIV/AIDS-related commodities requires streamlining certain pharmaceutical management and monitoring functions. This will be particularly true in the future as the numbers of patients on ART continue to increase and the fraction of patients requiring alternative and second-line regimens increases. The Government of Malawi (GOM) has expressed a strong desire to integrate ARVs into the CMS procurement and distribution system, but an assessment in 2008 by the USG-funded DELIVER project indicated that CMS currently did not have the capacity to take on the responsibility of procuring and distributing ARVs in the near future. The findings of this assessment, which were widely accepted by the GOM and other stakeholders, including the GFATM, led in 2009 to the decision by Malawi to competitively advertise for a third-party procurement agent to replace UNICEF in procuring ARVs and possibly other GFATM commodities However, to date, no competitive procurement has been issued. The goal of such an arrangement would be to see CMS able to take responsibility for ARVs within the next 3-5 years. While GF resources will continue to support procurement of ARVs, the USG is strategically positioned to support complementary technical assistance in the area of capacity building to help Malawi reach its longer-term goal of eventually integrating ARVs into its national supply chain system through CMS. In addition to the issues related to procurement and supply of ARV drugs, there are operational challenges that need to be addressed about how to optimize use of the specific drug regimens recommended by the current guidelines and ensure that patients receive alternative and second-line regimens when these are indicated due to toxicity or treatment failure. The Ministry of Health (MOH) adopted new treatment guidelines in April 2008 that built on the highly successful public health approach to the delivery of ART, and recommended continued use of d4t/3TC/NVP as the first-line regimen. However, widespread side-effects related to the use of the first-line regimen are leading Malawi to grapple with the difficult issue of whether to recommend a different, more expensive first-line regimen, such as one including AZT or TDF. Although the success of the program has been made possible by a highly streamlined approach using a single-fixed dose combination with no laboratory requirements, evidence is accumulating that use of the d4t containing regimen is associated with high loss-to-follow-up rates that occur in patients who have been on d4t regimens for 18 months or longer. Additionally, randomized trials have now shown clear health benefits to patients of starting treatment at a higher CD4 count of 350. Malawi was chosen as one of three countries in Africa to be part of a WHO feasibility

assessment to inform the discussions that will take place on new ART guidelines in late 2009. The preliminary results of this assessment are that while switching from a d4T-based regimen a nd starting treatment earlier are in the best interests of patients and likely to be recommended, within Malawi's highly streamlined approach the most feasible regimen for such a switch would be a once-daily fixed dose combination of EFZ/TDF/3TC, which is about three times as expensive as the current regimen and may not be economically feasible for that reason. Currently, Less than 1% of patients on ART have been switched to second-line regimens because of treatment failure. Although the public health approach in Malawi has appropriately concentrated efforts on expanding the use of first-line regimen, a growing number of patients are no longer benefiting from first-line therapy. Current guidelines for switching patients from first-line to second-line therapy can require multiple steps, followed by referrals to central facilities, which in turn may result in lower than ideal uptake of second-line ART. Accomplishments since the last COP Since developing the Partnership Framework in May, 2009, long-term capacity building efforts at CMS have continued toward Malawi's stated goal of fully integrating ARV drugs into it broader national supply chain system over the next five years. DELIVER provided technical assistance to Central Medical Stores and the Ministry of Health and was able to support the MOH to complete a quantification exercise, which was used to expose ongoing commodity gaps to the Health Donor Group and to senior leadership within the Government of Malawi. DELIVER was also particularly active and effective in working with districts and zonal offices to improve monthly reporting rates and data quality. Another USG partner, the Strengthening Pharmaceutical Systems (SPS) worked with the National AIDS Control Program to conduct supervisory visits to approximately 61 facilities. SPS has also strengthened its relationship with the Health Technical Support Services Unit and the Pharmaceutical Department in order to facilitate a mentorship program, which aims to assist pharmacy technicians to address pharmaceutical management challenges at facility level. Mentorship activities focus on adherence monitoring, recognizing suspected Adverse Drug reactions (ADRS) and how to report them, medication counseling, and pharmaceutical stock management Goals and Strategies for the PFIP Years 1 and 2 Under the PFIP USG will not procure any ARV drugs, but will rather continue to support activities to build the capacity of Malawi's Central Medical Stores and Health Technical Support Services (HTSS) which is responsible to coordinate and monitor pharmaceuticals and commodities in the public sector. PEPFAR will also continue to focus on supporting the area of improving the management of ARVs and other HIV-related pharmaceutical products at the health facility level. Additionally, through working with partners to more accurately quantify the extent to which patients are needing to switch regimens, either for toxicity or treatment failure, supply chain management efforts will help to support forecasting for ARVs, although this will remain primarily the responsibility of the MOH and the ARV procurement agent. Since the above activities do not involve procurement of any ARV drugs, the funding for the above activities is listed in the ARV drugs section is $0, with the OPSS and HIV care and treatments sections including the resources for these activities. However, in the interest of showing how these activities relate to the overall effort for improving ARV drug supply and management, they are briefly describe below. Building capacity of CMS and the MOH pharmaceutical services unit PFIP Year 1 funds will support the DELIVER project to build the capacity of CMS to manage procurement and supply of a wide range of pharmaceutical products, including HIV-test-kits and OI drugs in FY10. Beginning in the second-half of FY10, a new integrated supply chain management contract will be awarded that will continue and expand on the technical assistance activities begun under DELIV ER. While ARV drugs will remain in a parallel system outside of CMS in the near future, these capacity building efforts will potentially bear fruit over the long-term if ARV drugs can eventually be transitioned successfully into the CMS systems after 2010. support will also be provide to HTSS coordinate and national stakeholders to help develop of an ART inventory management system in the MOH pharmaceutical management services unit to track ART consumption at facility level and for installation of inventory management software that can accommodate the ART management information system. Technical assistance and on-site mentoring to help optimize implementation of new ART guidelines and strengthen pharmaceutical management at facilities As described under the HIV care and treatment section, technical assistance partners such as Dignitas, Lighthouse, and Partners in Hope will provide on-site mentoring support in concert with zonal and district health staff to improve the quality of care and treatment at select sites. As part of this zonal mentoring

approach, partners will work closely with the health center pharmacy staff at mentored sites, as well as other health care providers, to ensure that they are monitoring for d4T and NVP-related toxicities, reporting information about the prevalence of these toxicities and frequencies of drug regimen substitutions and switches, and operationalizing switches of patients to second-line ARVs in accordance with the national guidelines. These technical assistance partners will also help the MOH certify that given sites have appropriate SOPS in place and consistent availability of alternative and second-line ARVs so more sites can potentially be allowed to initiate second-line ART.

Technical Area: Biomedical Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
CIRC	1,513,168	
HMBL	1,140,000	
HMIN	275,000	
Total Technical Area Planned Funding:	**2,928,168**	**0**

Summary:
HMBL: $1,140,000 HMIN: $0 IDUP: $0 CIRC: $3,075,548 Technical Area Overview The new Partnership Framework in place between PEPFAR and the Government of Malawi identifies HIV prevention as the first of four goals to be addressed; thus emphasizing the importance of HIV prevention to both governments. In early 2009, Malawi finalized its first ever National Prevention Strategy, in an effort to both scale up and intensify HIV prevention efforts, and to encourage the implementation of evidence-based interventions. The Prevention Strategy places emphasis on both behavioral and biomedical interventions to reduce HIV transmission, and emphasizes the importance of prevention with HIV-positive individuals as well as those who are negative. HIV prevention addressed in the 2010 COP builds on previous partner approaches, and further scales up interventions which have proved successful. The areas included in this Biomedical Prevention narrative address blood safety, injection safety, and male circumcision; it does not include Intravenous Drug use as this has not been identified as a driver of the epidemic in Malawi and is not heavily emphasized in the National Prevention Strategy or the Partnership Framework which supports this strategy. Blood Safety Context and Background Blood safety is one of the major challenges in Malawi. The risk of transmitting HIV and other blood borne diseases through blood transfusion exists due to inadequate testing and poor quality controls. There is no current data on whether HIV transmission through unsafe blood transfusion has decreased, however, blood is not readily available in times of crisis, and it is common practice to identify relatives and friends with compatible blood types as potential blood donors for the person in need, conduct rapid HIV testing on the donors, and if negative do whole blood transfusions. In the area of blood safety, PEPFAR has three main contributions to the national system in Malawi: improvement of the physical infrastructure for blood collection; improving the knowledge and safety of health workers in blood collection; and ensuring the quality of blood screening and transfusion activities. Accomplishments since the last COP During FY09, PEPFAR supported the Malawi Blood Transfusion Services (MBTS) primarily for the refurbishment of hospitals and the provision of basic blood bank equipment, particularly for hospitals which serve rural and underserved populations. In-service training for lab techs, nurses, clinical officers, and medical doctors was expanded and pre-service training included blood safety. A final component of new FY09 activities was the scale-up of the National Quality Assurance Scheme, through which the competence of hospital blood banks is measured. Goals and Strategies for PFIP years 1 & 2 PEPFAR Malawi received significant funds to scale-up blood safety activities under the PF. These additional resources are being used to consolidate activities in the existing sites and expand to 10 new sites with PFIP year 1 funds and

have complete coverage of all 59 sites by the end of PFIP year 2. In addition, MBTS will support the expansion of blood collection through promotion of increased donor pools of voluntary, non-remunerated, low-risk blood donors and to support the development of blood safety policies and procedures and national guidelines for appropriate clinical use of blood and blood products. MBTS will train 165 Health Care Workers (20 laboratory technicians, 75 nurses, and 30 clinicians from the District-Level Hospitals whose blood banks will be rehabilitated and 40 undergraduate students of biomedical sciences) and tutors from training colleges in appropriate use of blood and modern blood transfusion medicine. In-service training for laboratory technicians, nurses, clinical officers and medical doctors from the 15 hospitals whose blood banks will be rehabilitated including tutors from training colleges will continue and another cohort of 40 undergraduate students of biomedical sciences will be trained. MBTS will also establish quality assurance systems in 15 hospitals whose blood banks will be rehabilitated and enroll them into the National Quality Assurance Program. Technical Priorities to be addressed The technical priorities to be addressed include national policy and guidelines, appropriate screening of blood and blood products, and implementation of effective monitoring measures. Injection Safety Context and Background The National HIV and AIDS Policy stipulates that the use of disposable sterilized infections can reduce the risk of HIV infection. The government has put in place systems to ensure that disposable materials and sterilizing equipment are used in all health facilities. Dissemination of appropriate and up-to-date information on the dangers associated with unsterilized material is a priority. Accomplishments since last COP Through PEPFAR, Pact Malawi has funded the Nurse and Midwives Council of Malawi (NMCM) to produce Post-Exposure Prophylaxis protocols, guidelines, and training materials for use by health workers in different cadres. Goals and Strategies for PFIP years 1 & 2 In PFIP year 2, NMCM will receive a fixed price contract to reproduce the training materials developed, including those for both facility and community-based health care providers. Materials focus on infection prevention, universal precautions, and post-exposure prophylaxis. Distribution of materials will be tailored to each implementing district. NMCM will also conduct health worker training in all districts through Master Trainers who are responsible for training District Trainers, who in turn train the health care providers in the district. Technical Priorities to be addressed Technical priorities addressed in COP 2010 are training of health care workers using new materials in injection safety and related procedures, appropriate health care waste management, and overall strengthening of the national injection safety program. Male Circumcision Context and background In Malawi, only 20.7% of the male population is circumcised, with the majority of circumcisions taking place among two Ethnic groups who live along the southern shore of Lake Malawi and further south. Male circumcision (MC) is done traditionally as part of an initiation ritual around the time of puberty. Mangochi District, where the majority of MC takes place, has actively encouraged people to bring their sons to health facilities for the medical male circumcision procedure, while maintaining the cultural customs and rituals of initiation. This has happened with varying levels of success, but is considered a best practice in the health sector, even before MC had been formally adopted as an HIV prevention intervention. In 2007, PEPFAR, through the National AIDS Commission (NAC), funded a two-day consultative workshop on MC and HIV prevention. Consensus was reached that MC should be included as part of the larger HIV prevention efforts, with the precaution however, that some critical issues need to be addressed before a national policy on MC is adopted. Accomplishments since the last COP Between 2007 and 2008, several significant political barriers slowed the adoption and implementation of MC in Malawi. Slow but steady traction was finally gained towards the end of 2008, when MC was identified as an evidence-based HIV prevention strategy for scale-up in the National Action Framework, the new National Prevention Strategy, and the National Strategic Application (NSA) to the Global Fund for AIDS, TB and Malaria (GFATM) submitted in August, 2009. Although no policy is formally in place yet, PEPFAR-funded research is underway using the WHO MC situation analysis toolkit. The results are expected before the end of the 2009 calendar year, and it is hoped that by early 2010, the Government of Malawi will formalize MC as an approved HIV prevention strate gy. Goals and Strategies for the coming year The National AIDS Commission will use old PEPFAR funds to finalize the situation analysis research, hold key stakeholder meetings, and develop a national MC policy, guidelines and scale-up plan. This will all be done through the MC sub-group of the National HIV Prevention Task Force, led by the Ministry of Health. Critical to the inclusion of MC as part of a national HIV prevention policy is

the need for an effective communication strategy. PEPFAR, through Population Services International (PSI) in partnership with Banja La Mtsogolo (BLM) and national partners, will explore how to motivate for, and support the uptake of, MC services as a health intervention to prevent various health risks for men and women including HIV transmission. The communication strategy for MC will still be developed in collaboration with national stakeholders to ensure that the packaging of MC addresses wider benefits of the practice so that stigma will be reduced. Pending the development of policy and guidance from the MOH on MC for HIV prevention, it is envisioned that this partnership will both capitalize on BLM's existing network of clinics and their clinical expertise in undertaking medical MC, and PSI's expertise in behavior change communications, technical assistance, quality assurance support, and social marketing for MC. By including MC services in Evidence-Based Targeted HIV Prevention (EBT-Prev) activities, PSI plans to promote and support uptake of MC services as part of a comprehensive prevention package. MC services will be promoted alongside EBT-Prev communication messages which aim to promote correct and consistent condom use, partner reduction, and uptake of HTC services. In addition, uptake of MC services will be promoted in conjunction with male and female condom social marketing and distribution activities and as part of a broader package of HIV/AIDS services which reflect the continuum of care. Technical Priorities to be addressed Technical priorities which will be addressed by PEPFAR partners in PFIP years 1 and 2 include the development of MC IEC materials and quality assurance tools. PEPFAR technical assistance from USG personnel in Malawi will be contributed through the HIV prevention task force as they participate in the advocacy of MC policy development, the development of MC guidelines, and a national scale-up plan for MC addressing most-at-risk adults, adolescents and infants.

Technical Area: Counseling and Testing

Budget Code	Budget Code Planned Amount	On Hold Amount
HVCT	3,337,128	
Total Technical Area Planned Funding:	**3,337,128**	**0**

Summary:
HVCT: $3,755,643 Context & Background As the entry point to both HIV Prevention counseling and all HIV-related care and treatment, the availability of high-quality HIV Testing and Counseling (HTC) is critical. Malawi has rapidly scaled up all HIV services in the last few years, with over 1,700,000 people tested between July 2008 and June 2009, approximately 30% of which were pregnant women. Scale-up has been particularly effective in Antenatal Clinics (ANC) where routine provider-initiated HIV Testing and Counseling (PITC) has been implemented and an estimated 80% of pregnant women received testing in 2008. The type of HTC available has shifted quite dramatically in the last two years, with increasingly diversified models implemented, including outreach, mobile, and door-to-door testing. In the second quarter of 2009, 27% of all sites reporting to the Ministry of Health (MOH) were outreach versus static sites, compared to 21% in the same period of 2008. This is reaching a large number of remote and underserved areas, and resulting in larger numbers of people than ever before, accessing testing, prevention counseling, and referrals to care and treatment. MACRO, a long-standing PEPFAR partner who provides nationwide access to HTC, reported that by the middle of 2008 approximately 80% of all tests done were at outreach and mobile sites, showing that a high demand for HTC access in remote and rural areas exists. PEPFAR provides support across all models of testing, and all levels of activity, from technical assistance at the central level to grassroots efforts. Accomplishments since the last COP Since the last COP, several accomplishments have been made at all levels. At the national level, implementation of PITC is starting to gain some traction, with large regional meetings held in November 2008 to sensitize District Health Offices (DHOs) and start the planning process. At the district level, DHO activities have been strengthened to monitor and supervise HTC counselors, coordinate the district planning for HTC campaigns, and to implement new HTC models. At the community level, PEPFAR

partners have scaled up mobile and outreach services, and one partner has demonstrated the effectiveness of offering HTC with Family Planning services in a mobile community-based approach. Goals and Strategies for PFIP years 1 & 2 Target Population and Promotional Activities PEPFAR will continue to support the national goals of increasing both access and quality in counseling and testing through provision of national level technical assistance, supporting the national HTC campaign week, continuing expansion of client-initiated testing and counseling (CITC) with a focus on couples and children, strengthening implementation and decentralization of provider-initiated testing and counseling (PITC) services, training of HTC counselors, improving of referral systems, and strengthening procurement and supply management. National Level Technical Assistance in HTC at Ministry of Health In the PFIP year 2 (FY11), the MOH will be in the second year of a cooperative agreement with USG; with the Department for and HIV and AIDS receiving HVCT funds and technical support from USG for all national-level activities. The MOH through the Department of HIV and AIDS coordinates HTC activities at the national level, with quarterly visits to sites across the nation. DHOs plan HTC activities at the district level with the supervision of the Zonal Health Officers (ZHOs), and report back to the central level HTC coordinator(s), and the HTC Technical Advisor (TA). The PEPFAR-supported position of TA has had a significant impact on the quality of HTC coordination nationally, as well as increased human capacity at the Ministry level. The TA has played a crucial role in increasing the HTC guidance documents available nationally; the geographic distribution of HTC services, planning and implementing three national “HTC week? ?? Campaigns, as well as assisting in an overall evaluation of the HTC Week Campaigns. The TA has also participated in the successful implementation of a revised HTC register which is used to record anonymous details of every person tested. With 2010 COP support, the TA will play a pivotal role in supporting a national shift from anonymous testing to confidential testing; a key issue which will strengthen linkages between HTC and the new pre-ART program. With the development and dissemination of the first National Prevention Strategy in 2009, the role of HTC in HIV prevention has stronger national focus. PEPFAR staff in Malawi will provide direct support to MOH to revise HTC materials to strengthen the prevention component of post-test counseling, thus increasing the impact of prevention counseling provided to those who test HIV-negative, as well as those who test HIV-positive. PEPFAR-supported CITC programs are well-situated to implement new models of post-test counseling with intensive prevention education, and to provide feedback to the national program on the new materials. The involvement of PEPFAR staff and funded technical advisors at the central level is critical, as all HTC guidelines and algorithms developed at the national level are required to be used by all HTC providers in both public and private sectors. HTC Promotion The highest profile HTC promotion activity in Malawi is the National HTC Week Campaign, held annually since 2006. In 2006, over 80,000 were tested; and in 2007 and 2008 over 180,000 tested. In 2009, it was determined that the campaign would be deferred and an overall evaluation of the 2006-2008 campaigns would be conducted in order to improve cost-effectiveness and maximize impact for future years. The planning and implementation of the HTC campaign is coordinated by the TA and the national HTC coordinator, with district level implementation and coordination managed by the District Health Office with support from implementing partners in the districts. HTC publicity in the weeks leading up to the campaign involved television, radio and poster advertisements, and additional advertising at both district and community levels. HTC publicity materials funded for this event are posted in clinics and hospitals nationwide, and serve to promote HTC well beyond the campaign time period. Client-Initiated Testing at Static Sites PEPFAR supports both the public and private sector in the area of client-initiated testing and counseling (CITC). MACRO, a local NGO has static (stand-alone) HTC sites in six cities in Malawi. Their outreach and mobile services are supported out of the static sites, with counselors rotating between provision of static and outreach HTC. In FY08 and FY09, PEPFAR supported a proof-of-concept program through BASICS which provides lay counselors hired by local NGO’s and seconded to MOH health facilities to provide HTC to in-patients. This successful approach demonstrated that NGO’s can effectively support and complement current human resource shortages in the health sector, through task-shifting of CITC in health facilities to lay personnel, releasing health care workers currently deployed for HTC to utilize their higher-level technical skills in the areas they trained in. This will be continued with FY2010 COP funds. Client-Initiated Testing through Outreach & Mobile Services A national shift is slowly taking place as HTC

counselors in both public and private sectors are taking services to more remote and harder-to-reach areas. A significant proportion of services provided by MACRO are now through mobile and outreach testing. This piloted approach by MACRO has had far higher demand than the number of testing vans or counselors can meet. Counselors report having up to 40 clients each per day while in the field. PEPFAR will provide support to continue and increase access to HTC through mobile testing, while ensuring that the ratio of clients to counselors does not create a situation wher e quality of counseling is decreased. PEPFAR partners are also implementing door-to-door testing in an integrated approach as part of comprehensive Reproductive Health counseling and services. This feasibility of expanding this model will be explored and scale-up planned. Provider-initiated Testing Provider-initiated testing (PITC) was officially endorsed by the MOH in late 2007, but has been slow to progress to implementation. A phased-in approach to PITC was planned for 2009, with primary funding sourced from the Global Fund for HIV/AIDS, TB and Malaria (GFATM). Delays in receipt of GFATM financing, and other challenges, have delayed national PITC implementation. Implementation of PITC will be done in part through for PEPFAR partner BASICS. BASICS has a low-cost, high impact program which provides a total of 16 counselors to 8 district hospitals, and contributed an estimated 50,000 tests in the 2008 calendar year. These counselors will play a critical role in implementing PITC in the facilities they are assigned to. PEPFAR will provide technical assistance for the implementation of PITC which will begin in 2009. The HTC TA, national HTC coordinators, and in-country PEPFAR staff will engage in an interactive approach with the DHO's to orient them to PITC, and develop PITC plans for their districts. PITC will first be implemented in those health services which self-select for higher HIV prevalence, including TB and STI clinics. PITC is already well implemented at the majority of ANC sites for mothers. The GOM Early Infant Diagnosis program receives PEPFAR funds to support PITC for HIV-exposed infants from 6 weeks of age, utilizing DNA-PCR testing. Full implementation into general clinics and wards will follow during the 2nd year of the PFIP. HTC in the Armed Forces The Malawi Defense Force (MDF) has eight HTC centers covering ten barracks, garrisons, and other facilities. Six of these centers were constructed by PEPFAR through DHAP and PEPFAR, and have been designated by MOH as ART distribution sites. The HTC centers are open to all military, their family members, and the surrounding community, and over 60% of those tested are civilians. During Malawi's annual HTC week campaign, the MDF expands the reach of its HTC services even further, supporting areas around the military bases and other government facilities. With FY10 COP funds, PEPFAR will continue to support HTC in the Armed Forces, with an additional focus: as the Armed Forces plan to implement male circumcision among recruits and experienced soldiers, HTC will be offered to all men prior to circumcision. Training for HTC Providers The three MOH partners who are implementing training for HTC counselors are PEPFAR funded. These partners have the mandate to train HTC counselors for all three regions of the country. Lighthouse and MACRO have both employed a model which allows for mentoring after the completion of training, ensuring that quality HTC services are provided. The decentralization of training from the central to the district level lends itself to increasing district-level coverage of highly trained counselors. However, decentralization can potentially reduce the quality of training provided, as training is no longer taking place only in specialty training centers, with well-trained trainers. In recognition of the changing needs of the MOH, there will be an adjustment of the GOM training model implemented by PEPFAR partners, to complement the new national decentralized approach to training. This will likely include more extensive mentoring of both the training process and subsequent HTC implementation by trainees, ensuring the maintenance of high-quality HTC services in Malawi. Linkages, Referrals, and Patient Follow-up The national HTC registers are very effective at anonymously capturing basic demographic data of individuals tested, and in documenting referrals to other services including PMTCT, TB, STI, and ART clinics. Each site offering HTC ha s a register and every site reports monthly to the DHO. This data is compiled at the district level and reported up to MOH. However, anonymous testing presents significant challenges in allowing providers to follow-up on successful linkages, or in identifying particular challenges in linkages. At present, there is simply no way to identify how quickly people attend referral services and what proportion attends a referral service. As MOH seeks to strengthen the linkage between HTC and pre-ART Family HIV Care Clinic (a new national program planned for implementation in 2010), a shift will need to take place from anonymous to confidential testing. Sensitization to all health care providers will need to take place, as confidentiality is

associated with anonymity, rather than with behaviors which protect the patient's privacy. The shift to confidential testing can be implemented concurrently with a strengthened name-based referral system, which allows for identification and follow-up of patients not presenting to the referred service. PEPFAR-funded programs such as MACRO, Lighthouse, and CHAM, who offer both HTC and ART services, are well-situated to pilot the new referral system and offer suggestions to MOH for improving it prior to national implementation.

Technical Area: Health Systems Strengthening

Budget Code	Budget Code Planned Amount	On Hold Amount
OHSS	5,691,190	
Total Technical Area Planned Funding:	**5,691,190**	**0**

Summary:
OHSS: $15,155,310 Context and Background Malawi has established that it is committed to being both the driving force and primary funder of its national HIV programs. Enormous strides have been made in implementing the national HIV treatment program, with 223, 437 persons ever started on treatment by the end of 2008, of which 147, 479 remained alive and on treatment. The PMTCT program has rapidly expanded to more than 500 ANC sites, Early Infant Diagnosis is scaling-up, and the CT program tested more than 1.5 million people in the past year. USG does not fund large service delivery programs in Malawi, but rather recognizes that the most strategic and cost-effective way to support the national response is to continue to emphasize government ownership and to provide technical inputs and resources to the existing health system. In addition, programs that support not only HIV-related services but also strengthen the broader health care system are given high priority. In order to sustain the current level of effort and enhance the quality, scope and accessibility of national programs, USG takes a comprehensive and multi-pronged approach to health systems strengthening in Malawi. At the macro-level, USG works with the Government of Malawi (GOM), National AIDS Commission (NAC), and other partners to ensure that evidence-based policies and strategies are in place to guide decision-making and resource allocation. In order to expand the pool of qualified staff to translate these policies into programs, the USG supports GOM human resource initiatives in both management and service delivery. A particular emphasis is placed on the following Human Resources for Health areas: 1) reforming recruitment and retention policies, 2) developing human resource information systems, 3) instituting pre-service and in-service training for clinicians, laboratory technologists and social workers that utilize strong curricula and high caliber teachers, 4) strengthening the planning, management, and monitoring and evaulation capacity of the Ministry of Health centrally and in the districts, and 5) placing Technical Assistants and Fellows in the Ministry of Health to train, mentor and support their counterparts in program development, monitoring and evaluation, and financial and grants management. At the implementation level, USG provides capacity building to central and district staff in organizational management, with a particular emphasis on supporting management of the Global Fund grants and decentralization of health services. In addition, services are strengthened across the entire health care system through USG support to reforming and streamlining procurement and logistics systems, scaling up laboratory services, and implementing standardized Health Management Information Systems. In working towards health systems strengthening goals, USG collaborates closely with other donors and partners, and in particular projects funding under the Sector Wide Approach (SWAp) and Global Fund for AIDS, TB and Malaria (GFATM) grants. Health Systems Strengthening Accomplishments, Goals and Strategies Human Resources for Health A GOM and USG priority has been to expand the cadre of qualified staff for health care provision and management positions. In FY10, USG will significantly expand its previous efforts and will support clinical, community services and managerial positions. Pre-service training for clinical officers, nurses, medical assistants, laboratory technicians, and social workers will also be of primary

importance. Through curriculum development, staff support, renovations, and accreditation, USG will train new clinical and community health workers in FY10. In addition, the College of Medicine will train public health students in health care management. A particular focus for all pre-service training activities will be in strengthening placement and retention systems in the health care system. To this end, USG w ill support the GOM Human Resource Information System to identify human resource capacity needs, develop and human resource database, streamline recruitment and deployment, and develop strategies to attract and retain qualified staff. In addition, laboratory trainees and staff will be provided with opportunities for rotations and skills development. The management capacity of the MOH will be strengthened bother centrally and in the districts. MOH staff will be provided with intensive capacity building in tracking health care expenditures, managing and monitoring and evaluating programs at the district assembly level, and analyzing and utilizing health financing information to inform decisions and health policy. District health managers will also be paired with qualified mentors to help improve their management and decision-making skills. USG has put into place a very successful program attaching Technical Advisors and Fellows with GOM counterparts in order to provide technical and managerial support and mentoring in implementing the national HIV program. In FY10, USG will support a Global Fund Coordinator to be deployed at the MOH under the supervision of the Principle Secretary for Health. Technical Advisors will be placed in the HIV Unit, Counseling and Testing Technical, Monitoring and Evaluation, Care and Treatment, Epidemiology and Laboratory, and Fellows in Monitoring and Evaluation, Information Technology, and Care and Treatment will work closely with the Technical Advisors. In addition, two Fellowships at the College of Medicine will train qualified candidates in public health management. Additional detail can be found in the Human Resources for Health Technical Area Narrative. Organizational Capacity Building In FY10, organizational capacity building will be provided to NAC and PEPFAR partners on financial and grants management, human resource management, strategic planning, monitoring and evaluation, and other important areas. These efforts will strengthen the decentralization process and district-level implementation and management structures. Procurement and Supply Chain Management Challenges and lack of capacity pervade the health supply chain in Malawi, and problems are cited at every level. Stockouts of essential drugs and commodities at districts and health centers are a common occurrence. Malawi is a small country with a relatively good road system. Although a Logistics Management Information System (LMIS) is in place, reporting of consumption and inventory data from the health centers and districts is non-existent in many cases and where data does exist, it is of extremely poor quality. Inaccurate and poor quality data is then the only basis for central quantification which causes an unfortunate cycle of inadequate forecasts. From the health facility level, through the district to the regional medical stores (RMS), consistent and timely reporting of drug consumption and stock on-hand remains a major barrier to ensuring adequate stocks at health facilities. The shared responsibility for reporting between Central Medical Stores (CMS), Health Technical Support Services (HTSS), and the District Health Officers requires that any systems strengthening effort must target multiple stakeholders within the MOH system. In addition, a recent MOH sponsored study identified many areas of leakage and pilferage, but the exact numbers and amount of medicine and commodities lost is unknown. USG has a long history of technical support for logistics and commodity management in Malawi including specific focuses on commodities for family planning, malaria and HIV/AIDS, and management of public health commodities will continue to be a key focus over the next five years. The commodity security and supply chain management activity is a collaborative effort and will cut across health accounts, receiving funds from three separate accounts: the President's Malaria Initiative (PMI), the President's Emergency Plan for AIDS Relief, and Populatio n Resources. USG supply chain management support will focus on organizational development, procurement, warehousing and inventory management, distribution, and data management. A clear plan for skills transfer and benchmarks to monitor progress of institutionalizing capacity of staff will be developed. USG will also work with the Logistics Unit to build leadership and technical capacity. Special efforts will be placed on transparent data management and providing HTSS with the tools to properly supervise the districts and ensure appropriate reporting to enable quantification and forecasting. While significant effort on the part of USG and other donors has been invested in improving Malawi's logistics system, stockouts of essential drugs and commodities negatively impact overall health outcomes. The USG will also

prioritize incorporating innovative approaches and bringing new ideas from private sector supply chain best practice that are appropriate for the Malawian public sector context. Gaps and challenges will be addressed at both district and health center levels which encompass the service delivery points where the supply chain begins and ends. USG will work with central level entities to address data management and flow from the health and district level and include capacity building in logistics management for all pharmaceuticals and commodities with a special focus on laboratory commodities and incorporating relevant lab personnel. USG will include strategies to enable the MOH to conduct regular supervision visits to district health officers and health facilities to monitor the supply chain. It is also imperative that work with the MOH include building capacity to ensure the rational use of pharmaceuticals and health commodities at all health facilities. Laboratory Services While USG has provided significant support and capacity building to laboratory services in Malawi, these investments have been strategic but too limited in scope to meet the increasing needs of the expanding HIV/AIDS services. Of high importance is ensuring that laboratory support for HIV/AIDS interventions also contribute to the overall improvement of laboratory services in the country. USG will continue to work with the government and other partners to provide strategic support to laboratory services with a focus on expanding access to these services while maintaining their quality. USG laboratory support to these efforts is directly aligned with a National Laboratory Strategy which has been developed with significant USG support, the National Action Framework (NAF) and is a focal area in the Malawi Partnership Framework (PF). These efforts focus on the following priority areas: 1) capacity building for laboratory technicians, 2) strengthening the National Reference Laboratory, 3) increasing access to laboratory services at point-of-care settings including support to pregnant mothers and babies, 4) supporting procurement and supply chain management systems, and 5) strengthening the Laboratory Management Information System (LMIS). Additional detail can be found in the Laboratory Services Technical Area Narrative. Health Management Information Systems USG has supported the MOH in moving forward the development and expansion of their Health Management Information System and this will continue to be a priority area in the following year. USG will support the MOH in providing leadership in implementing the national HMIS system, and a priority of next year's funding will be in capacity building in GIS analysis, providing on-the-job training for health care workers to implement the Electronic Data System (EDS) at facilities, implementation of National Data Standards, establishing the central data repository, and updating forecasting and quantification tools. With USG funding, the EDS will be expanded to 12 ART sites, two general health sites, three HTC sites, and private health facilities in FY10. USG will also continue to strengthen donor coordination, information s haring, development of data standards and intensive capacity building in medical informatics through our local partners. Additional detail can be found in the Strategic Information Technical Area Narrative.

Technical Area: Laboratory Infrastructure

Budget Code	Budget Code Planned Amount	On Hold Amount
HLAB	3,378,767	
Total Technical Area Planned Funding:	**3,378,767**	**0**

Summary:
HLAB: $3,563,783 Context and Background In order to address issues of equity and improved access to health care services in the public sector, Malawi developed a national health care strategy that focuses on the minimal essential services that could be efficiently delivered at a district level, the Essential Health Package (EHP). Complementary to the EHP is the Essential Medical Laboratory Services (EMLS) package. In 2009, with substantial USG support, the MOH developed a draft National Laboratory Strategic Plan to complement the EHP and better define the increasing laboratory needs of HIV/AIDS and other health services. This document is currently in its final draft and will provide guidance on providing tiered laboratory services at regional, district and primary health care unit levels, addressing issues such

as physical infrastructure, personnel, training, equipment, reagents and supplies, and monitoring and evaluation. With the scaling-up of ART, PMTCT, HCT, TB/HIV and malaria services, the need for laboratory capacity to support these interventions has expanded both in scope and complexity, and this strategy is the roadmap for implementing these services in a systematic and coordinated manner. While USG has provided significant support and capacity building to laboratory services in Malawi, these investments have been strategic but too limited in scope to meet the increasing needs of the expanding HIV/AIDS services. Of high importance is ensuring that laboratory support for HIV/AIDS interventions also contribute to the overall improvement of laboratory services in the country. USG will continue to work with the government and other partners to provide strategic support to laboratory services with a focus on expanding access to these services while maintaining their quality. USG laboratory support to these efforts is directly aligned with the National Laboratory Strategy, the National Action Framework (NAF) and is a focal area in the Malawi Partnership Framework (PF). These efforts focus on the following priority areas: 1) capacity building for laboratory technicians, 2) strengthening the National Reference Laboratory, 3) increasing access to laboratory services at point-of-care settings including support to pregnant mothers and babies, 4) supporting procurement and supply chain management systems, and 5) strengthening the Laboratory Management Information System (LMIS). Collaborating partners USG works with a broad range of collaborating partners to ensure that laboratory activities are providing integrated support to the national response. These partners include the Ministry of Health (Community Health Sciences Unit, Diagnostics Units, National TB Program), four central and twenty-eight district public hospitals, the Malawi Defense Forces, Howard University, Malawi College of Medicine, UNC, Johns Hopkins University, Loma Linda University, CHAM, Malawi College of Health Sciences, Malamulu College of Health Sciences, Malawi College of Biomedical Sciences, the Association of Public Health Laboratories, JSI/DELIVER, WHO (Malawi and AFRO), Roche, and the Clinton Foundation. Accomplishments since the last COP and Goals and Strategies for PFIP Year 1 and 2 Capacity building for laboratory technicians: USG has made it a priority to increase the number as well as skills of trained laboratory technicians by investing in pre-service training at two of the main laboratory training institutions in the country, Malawi College of Heath Sciences and Malamulo College of Health Sciences. Support includes continued funding for critical faculty, expansion of the curriculum to cover new technologies, renovation of physical space, and providing upgraded equipment and supplies for training purposes. In PFIP Year 2, USG will continue to support these efforts, expanding the program by strengthening and updating the pre-service curriculum, procuring the necessary equipment and supplies to execute the practical tr aining component, instituting an assessment plan, and coordinating clinical attachments. The standardized, comprehensive curriculum developed will be integrated into the degree, diploma and certificate programs at Malamulo College of Health Sciences, Malawi College of Health Sciences, and the Malawi College of Medicine. In addition, laboratory tutors will be retained at the Malawi and Malamulu Colleges of Health Sciences to assist with the implementation of the pre-service curriculum and to provide supervision and training of students at designated clinical training sites. In-service training will also be provided to eighty laboratory staff in HIV diagnosis and disease monitoring. Analyzer trainings will be conducted quarterly to cover topics such as HIV Rapid Testing, ELISA, Flow Cytometry and CD4 enumeration, PCR, and OI diagnosis. In an effort to attain high quality ART services at Queen Elizabeth Central Hospital, refresher and certification courses on ART and care for HIV infected children and infants will be conducted biannually and will target 100 clinicians, nurses and counselors. With USG funds, a advisory group for laboratory training is developing a five day intensive Good Clinical Laboratory Practice (GCLP) training tailored specifically to the types of assays and technical and management challenges met in clinical labs in Malawi, and Training of Trainers will be implemented. In the following year this activity will continue and an advanced training curriculum in National Reference Laboratory and Disease Surveillance activities will be developed for Senior Technicians and Technologists selected to do training rotations at CHSU. In an effort to retain medical laboratory science graduates placed at referral hospital laboratories, an internship program has been implemented for top graduates of the laboratory training programs. Graduates received advanced training at central hospitals in PCR, CD4, hematology and chemistry. This program has proven highly successful and will be expanded in the following year. Students will also be required to rotate in central hospital and reference laboratories as well as research

labs to gain advanced training in experience in research, molecular techniques, QA and management. A technician exchange and rotation programs will be also implemented for MOH and CHAM laboratory technicians to work with partner research institutions in order to learn advanced diagnostic techniques and quality practices in those laboratories. National Reference Laboratory and Diagnostics Unit: The National Reference Laboratory (NRL) within the Community Health Sciences Unit (CHSU) of the MOH has been a USG partner since 2001. The NRL has the national mandate to assure the quality of laboratory services throughout the country. USG support had focused on providing funding for critical laboratory and epidemiology staff and assisting with the implementation of the NRL mission. This support had allowed the NRL to develop national standards such as the national HIV rapid testing algorithm as well as to continue with in-service training of laboratory staff at national, regional and district levels. USG has supported the NRL to develop and implement a national Quality Assurance program for HIV rapid tests. They have also implemented programs that integrate HIV testing within routine laboratory services. With USG funding, the NRL has been instrumental in the initiation of the early infant diagnosis programs, expansion of CD4 capability, and development and implementation the first national surveillance system to detect emerging ART drug resistance. The NRL has also been an indispensable partner in supporting special studies such as the national ante-natal HIV survey and other epidemiological studies. In PFIP Year 2, USG will continue providing both direct MOH funding for NRL activities as well as intensive capacity building to NRL supporting partners. USG will support expansion of the national reference capability, training, national quality ass urance of important analytes including HIV, TB, malaria, OIs, chemistries, and hematology. The NRL will also expand their ability to support special studies such as new assay evaluations, expanded ART resistance monitoring, and epidemiological surveys including the Demographic and Health Survey and HIV incidence estimation. An epidemiologist and laboratory supervisor funded by USG will continued to be housed within the MOH to provide capacity building in these efforts. As part of the National Strategic Laboratory Plan, the MOH has developed strategic objectives addressing current needs in laboratory services delivery and quality management systems. USG will assist the MOH in developing and implementing a comprehensive quality service delivery program using internationally recognized Good Clinical Laboratory Practice standards including initiating a quality service delivery advisory group, developing a National Quality Manual and national Laboratory Standard Operating Procedures, and working towards a national laboratory certification scheme for the National Reference Laboratory. USG has also initiated a collaboration with MOH and partners to implement the WHO AFRO Laboratory Management Towards Accreditation (SLMTA) program to prepare laboratories for accreditation. By the end of next year, at least two laboratories in central and district hospitals will achieve accreditation based on WHO AFRO or international standards. Improved access to services at point-of-care settings: USG has previously supported two of the four regional laboratories, Kamuzu Central Hospital (KCH) in Lilongwe and Queen Elizabeth's Central Hospital (QECH) in Blantyre. In the following year, this support will be expanded to the additional two regional laboratories, Mzuzu and Zomba Central Hospitals, one central CHAM facility, and three regional Malawi Defense Force facilities. Support at these laboratories will involved improved diagnostics for HIV, TB, malaria, and opportunistic infections as well as CD4 capabilities, basic hematology, and basic chemistries. These central government, military and private laboratories will also provide mentoring, training, technical assistance, referral services, and supervision support through a tiered structure to other labs in their region. In addition, USG will support the refurbishment of four district hospitals in the Northern region. Four of these high through-put regional facilities will be designated as Mentoring Laboratories and each of which will have 12 district and CHAM lab facilities formally under their supervision. Baseline assessments will establish infrastructure and quality systems needs at the mentoring and 2nd tier laboratories using guidelines established in the national laboratory certification scheme, and corrective action plans will be developed. These laboratories will be capacitated to provide a minimum service package of HIV adult and infant diagnostics, CD4 counting, viral load monitoring, AFB microscopy and culture, OI and STI diagnostics, chemistry and hematology services at the Mentoring Laboratories, and a minimum service package of HIV adult diagnostics and infant referral services, CD4 counting, AFB microscopy, syphilis testing, basic chemistry and hematology services at 2nd tier laboratories. Service contract will also be supplied for selected critical equipment. Through this mentorship, quality standards, throughput, and

maintenance and reagent stock-out down time will be improved. Regional Outreach Supervisors and their MOH counterparts will visit each facility under their supervision monthly to monitor and supervise them in implementing the corrective action plans. MOH and partners are currently piloting several models for referral systems between laboratories providing HIV diagnosis and monitoring services and HIV treatment facilities. MOH will be supported to identify and develop an appropriate referral system addressing key issues of sample transport to testing laboratories and results turn-around times to care providers. Training on and implementation of the referral system between laboratories providing HIV diagnosis and monitoring services defined in FY09 will take place the following year. Improving turn-around-time for lab results will be prioritized so that by the end of FY10 80% of laboratory results in mentored facilities will be received by providers within the turn-around time specified by National SOPs. Procurement and supply chain management USG has supported the integration of laboratory commodities and procurement into the national supply chain management system. This activity will continue to take place next year including the completion of a laboratory supply chain management policy, formation of a logistics working group, and conducting standardization activities to lay the foundation for future quantification and systems design work. In addition, a national logistics system for laboratory supply will be designed in collaboration with Central and Regional Medical Stores the MOH. Laboratory Management Information Systems Monitoring and evaluation of laboratory services provides important feedback on program progress and inform national priorities. This year, the current data collection and reporting system will be assessed and strengthened under the direction of the MOH, and data sharing mechanisms will be developed. Discussions with HMIS, health service delivery and laboratory stakeholders on development of a national laboratory information management system (LIMS) will take place. LIMS systems specifications will be developed in collaboration with the MOH and the system will be piloted in several facilities.

Technical Area: Management and Operations

Budget Code	Budget Code Planned Amount	On Hold Amount
HVMS	6,725,621	
Total Technical Area Planned Funding:	**6,725,621**	**0**

Summary:
(No data provided.)

Technical Area: OVC

Budget Code	Budget Code Planned Amount	On Hold Amount
HKID	3,780,850	
Total Technical Area Planned Funding:	**3,780,850**	**0**

Summary:
OVC: $6,360,158 Context and Background The devastating effect of HIV/AIDS in Malawi is nowhere better captured than in the number of children orphaned or made vulnerable (OVC) as a result of the epidemic. In Malawi, 12 percent of all children are orphaned and nearly 7 percent of children are considered vulnerable (2006 MICS). Of the stunning 1,008,000 orphans in Malawi in 2005, nearly half were a direct result of AIDS. 101,939 of the 924,248 persons living with HIV/AIDS in Malawi are children

(0-14), and 9 percent of all persons ever started on antiretroviral therapy are children. While there are very few child-headed households in Malawi (two-thirds of one percent, DHS 2004), this issue warrants, and is receiving, attention. Currently, one third of all Malawian households and 50 percent of female-headed households are reported to care for at least one orphan. With DFID support, the Ministry of Gender Children and Community Development (MOGCCD) is revising the NPA to align it with the Malawi Development and Growth Strategy and extend it to 2010-2011. The revisions will address some key issues identified in the midterm review of the NPA, including: limited access of OVC to essential services; the poor quality of existing services; lack of basic data on OVC and mechanisms for collecting data; un-coordinated OVC reporting systems and limited OVC operational research to inform programming; limited capacity, leadership and coordination by the ministry; lack of collaboration and synergy among partners in implementing the NPA; and limited advocacy and enabling environment on OVC issues. Progress to date in the national OVC response include the development and inclusion of OVC action plans into district implementation plans in all 28 districts; registers of OVC in all districts; provision of school bursaries to about 15,543 children nationwide and social cash transfers to 24,051 ultra poor households (an increase from 7800 last year) and 60,203 children in seven districts. Despite these successes, support to OVC in Malawi is not sufficient. Only 6 percent of OVC households received medical support, 4% got psychosocial support, 9% material support and 6% education support (MICS 2006). Other challenges in implementing the NPA include the absence of a robust national M&E system to adequately capture OVC data to inform planning. To date, an OVC situation analysis has still not be done in Malawi to assess the impact of on-going efforts and identify the scope and priority areas that require additional focus in the national response. Limited MOGCCD capacity to utilize the GFATM resources also remains a major challenge due to challenges between MOGCCD (sub-recipient) and National AIDS Commission (NAC, principal-recipient). USG participates in the two coordinating bodies for OVC programs in Malawi: the National OVC Steering Committee (NSC) housed at the NAC and the National OVC Technical Working Group at the MOGCCD; and is therefore effectively involved in strategic leadership on OVC and supports national-level efforts such as development of materials, implementation of the NPA, and advocacy for OVC. Accomplishments since the last COP USG accomplishments since the last COP include the expansion of essential care, support, and protection services for OVC by partnering with a USAID education project – Education Decentralization Support Activities (EDSA) by Academy for Education Development (AED) – that is operating in six districts. These new activities complement services provided by the nine Pact partners in nine districts. By March 2009, Pact partners had reached a total of 39,860 OVC, out of a target of 39,020. Several public private partnership (PPP) initiatives are being developed to further expand OVC services in additional districts. PEPFAR funding increased age-appropriate and gender sensitive services for OVC such as food and nutrition, education and vocational training, shelter and care, health services, protection, ps ychosocial support, and economic strengthening and improved referrals for prevention, CT, PMTCT, ART and other HIV/AIDS related services to OVC identified by local communities. USG also supported community based child care centers where children under five (U5) participated in early childhood development activities, received food, growth monitoring and immunization. USG provided educational support in the form of facilitating enrolment into schools, scholastic materials, school fees and uniforms to help children stay in school, as well as strengthen access to health care and social support services for OVC. Meals were provided for children in food constrained homes through community feeding centers as well as food rations to child-headed households. Play, recreation and life skills were other key services provided to children. USG, in partnership with UNICEF, supported various human capacity development activities with MOGCCD in support of the on-going decentralization of government services to districts. Through the USG Southern Africa Human Capacity Development project (SAHCD), PEPFAR supported organizational strengthening retreats for key central and district level staff, senior leadership strategic planning training for senior MOGCCD staff, and supervisory skills enhancement training for senior and midlevel MOGCCD staff. Notable outcomes of these activities include improved inter and intradepartmental planning and communication, team work and planning, as well as improved staff morale, MOGCCD commitment and be more proactive. UNICEF also supported the assessment of Magomero institute (The Malawi institute that trains social welfare workers) in September 2009. Findings and recommendations from this key activity will inform future USG support to complement

these joint HCD efforts between MOGCCD, UNICEF and USG. USG, with co-funding from UNICEF, supported an MOGCCD led team of leading international and Malawian OVC NGOs to develop draft OVC quality improvement (QI) standards to ensure that OVC programs in Malawi make a measurable difference in the lives of OVC. Malawi is perhaps one of a few countries where the QI initiative is being led by government and championed by a broad collaborative of NGOs. This effort will facilitate greater country ownership and therefore sustainability of OVC programs. Goals and Strategies for PFIP Years 1 and 2 Goal III of the 5 year Malawi Partnership Framework is to mitigate the economic and psychosocial effects of HIV and AIDS and improve the quality of life for PLHIV, OVC and other affected individuals and households. This goal supports the Malawi Revised National HIV/AIDS Framework, and the Malawi NPA. The PEPFAR OVC program will complement the GFATM Round 5 HIV/AIDS grant for OVC. In FY10, USG will focus on addressing some key areas identified in the NPA midterm review. This includes expanding and strengthening integrated community-based platforms for direct OVC service delivery to children, especially in hard to reach communities; improving quality of OVC services through the QI initiative; continuing support for MOGCCD human capacity development; and upgrading of Magomero Institute, the school that trains social welfare workers, so it can commence a diploma and bachelors program rather than the current certificate only program. PEPFAR is also working with MOGCCD to request USG funded Technical Support to GFATM for MOGCCD on financial management. This will ensure USG maintains its strategic role in addressing the bottlenecks to accessing GFATM resources from NAC by beneficiaries. The PEPFAR Gender Initiative that aims to prevent HIV infection among 13-19 year old girls will also continue. i. Service delivery Nine OVC partners under Pact will continue to increase the scope of services and numbers of children and households affected by HIV/AIDS they reach. EDSA wraparound education support for OVC will facilitate the enrolment, retention and performance of OVC in primary and secondary schools in six districts by providi ng school bursaries and materials and psychosocial support to OVC, and improved community participation in primary school management. Other scale-up plans include integration of OVC activities in the follow on Food for Peace program to reach vulnerable OVC households with food and livelihoods support. Pact partners will also strengthen capacity at district assemblies to better coordinate the OVC response at district and community levels, and facilitate OVC access to GFATM school bursaries and social cash transfers. 2 - 4 public private partnerships are at various stages of completion to further increase coverage of OVC reached with support. ii. Improve quality of OVC programming The draft OVC quality standards that have been developed will be piloted in three districts in the three regions by a handful of CBOs that receive funding from USG, UNICEF and other donors. The standards promote a focus on child well being outcomes rather than outputs. Through communities of learning the standards will be revised based on lessons from the pilot, before being finalized, printed and launched, followed by a nationwide roll out for use by OVC programs in Malawi. Family Health International, with funding from The Funders Collaborative for Children (FCFC) – a consortium of four UK-based foundations - is currently piloting the use of the child status index, CSI, (a key component of the QI initiative) in Salima district. Boston University, with core funds from USG, is also piloting the CSI in Dowa district. Lessons from these pilots will continue to inform the USG/UNICEF efforts to scale-up the QI initiative. iii. Coordination of care at all levels A key focus for the PFIP Goal II is to strengthen the pre-ART program through strengthened referrals between community and facility-based HCT, PMTCT with care and treatment programs. USG supported JHU Bridge II project, through its partner International HIV/AIDS Alliance, has started preliminary mapping of HIV (including OVC) services in two traditional authorities in Chiradzulu district. These efforts will inform the national referral systems strengthening activities being planned by USG and MOH. iv. Address human resource needs USG, through the SAHCD project, and in partnership with UNICEF will continue its support to MOGCCD to address its HR needs in Malawi. SAHCD's goal is to strengthen MOGCCD's capacity to provide quality OVC programs by building the capacity of senior and middle level managers in the Ministry to effectively lead and manage programs by: Providing the Ministry with the HRIS tools and skills to be able to plan, manage and retain their current and future human resources; Strengthening the quality of pre-service training for social workers and align the content of the curricula with social welfare/OVC programs; Ensuring in-service training opportunities for existing social workers; and supporting MOGCCD to establish a regulatory council for social workers. The findings and

recommendations from the just concluded UNICEF-supported assessment of Magomero Institute will be key in fine tuning planned USG support on pre-service training of social workers. v. Address policy issues and strengthen national and local service systems MOGCCD with funding from the GFATM is working on several laws in Malawi. These include The Adoption Act; Child Care, Protection & Justice Bill; The Wills and Inheritance Act; Human Trafficking Act; Gender Equality Act; Domestic Violence Act; and, the HIV and AIDS Legislation. USG will collaborate with MOGCCD, UNICEF, NAC and other stakeholders in supporting the enactment of these laws. As already described elsewhere, USG will, in close partnership with UNICEF and MOGCCD, continue to support the restructuring and decentralization of the ministry functions, upgrading of Magomero Institute in order to strengthen the ministry's capacity at national and district level to provide, and supervise and coordinate support to OVC, their households and communities. The planned USG technical support to GFATM on financial management will also support MOGCCD to resolve its internal bottle-necks, which hopefully will assist in removing the barriers to the ministry's ability to draw on much needed GFATM for OVC programs. vi. Evidence based strategic planning Planning for OVC programs is greatly limited by the lack of basic data for programming. The situation analysis that was planned in the NPA has not happened. PEPFAR funds will support the collection of basic OVC data possibly through over-sampling the 2009 DHS to help programs understand the scope, dimensions and intensity of vulnerability in Malawi, and inform strategic decision-making for OVC programming. The planned OVC strategic information mapping will also support better targeting of USG services with needs on ground by identifying areas of high vulnerability and potential linkages with other programs. Formative research on the needs of HIV positive children in schools will provide important information for this critical group of OVC. Through continued partnership and information sharing of best practices and lessons learned with other agencies – UNICEF, FCFC, NGOs, MOGCCD - PEPFAR programs will ensure increased access to OVC data and information. Training and capacity building at all levels will also contribute to building knowledge. PEPFAR funds will also support USG partners to strengthen and harmonize data collection tools and ensure alignment with the national M&E tools. As a means to strengthening family centered approaches for OVC programs, a required Malawi mission level reported indicator will be the number of households that receive impact mitigation support. This household level indicator – required by both the Malawi NAF and USG PF - will ensure that USG supported OVC programs sufficiently support this approach to service delivery. USG will also explore costing of OVC services, as well as mapping of OVC services to further improve programming.

Technical Area: Pediatric Care and Treatment

Budget Code	Budget Code Planned Amount	On Hold Amount
PDCS	591,957	
PDTX	1,024,695	
Total Technical Area Planned Funding:	**1,616,652**	**0**

Summary:
PDTX: $591,957 PDCS: $1,024,695 Context and Background The number of children living with HIV in Malawi is estimated to be approximately 111,510. New guidelines state that all infected children under age 1 (35,000 children) are eligible for treatment. Currently, an estimated 14,700 children are alive and on ART, representing less than 50% coverage of the estimated need. Children account for about 9% of all patients presently on ART. Malawi has set a target of 15% of patients on ART being children by 2010, which would translate into a numerical target of 36,750 children and would more than double the current numbers of children enrolled. Such targets are ambitious given the fact that the proportion of all patients on ART has remained relatively static for a number of years, with children comprising approximately 9% of all persons initiated on ART during 2007/2008. The median age of children being initiated into

treatment is 7, with only about 12% of children ever started on ART being younger than 18 months. This is due in part to a lack of access at most health facilities to Early Infant Diagnosis (EID), and the fact that few providers have been appropriately trained and sensitized to initiate presumptive therapy according to national guidelines in settings where EID is not yet available. While 20,507 children were ever started on ART, it is estimated that about 36% of those initiated are no longer on treatment, indicating a need to improve the quality of the program, initiate children on treatment at an earlier stage of disease, and increase support systems to increase retention of children in care. While 95% of national ART sites report that they have ever started a child on treatment, the substantial majority of ART sites are still enrolling few children in proportion to the number of adults being initiated on treatment. Large numbers of children are being enrolled in care at only a select number of sites, mostly those which are supported by international partners. In order to more rapidly expand the number of children on treatment at ART sites in the country, it will be necessary to implement a more mainstreamed and decentralized approach to pediatric treatment. The national ART guidelines were updated in 2008 to recommend immediate treatment for all HIV-infected children less than one year of age, but little has been done to orient providers on this change or to develop plans of how to implement it nationally. Scale-up of the national EID program is planned in the coming year, but current resources under the GFATM are not sufficient to reach the national goal of testing 80% of exposed children by the end of 2010. Monitoring and evaluation for pediatric HIV in Malawi also needs more attention, as the standard child health passport has not yet been updated to include HIV-specific information, and there is no standard follow-up data-collection tool to use to track mother-infant pairs in the postnatal period. While plans have been in process to address the deficiencies for over a year, progress has been slow in standardizing such tools. Some implementers have developed their own versions due to the pressing need. Most HIV-positive children are on d4t/3tC/NVP. While there have been no reported stock-outs of ARVs, shortages of Cotrimoxazole (CTX) have been more frequent. This is due in part to the fact that CTX is supplied through the inconsistent Central Medical Stores (CMS) system. ARVs are supported through a parallel system operated by a private company. Both drugs are procured with Global fund for AIDS, TB and Malaria (GFATM) resources. Commodities for the pediatric cohort including ARVs, OI drugs, EID reagents, ready-to-use therapeutic foods (RUTF) (i.e. “plumpy-nut”), and other supplies are largely provided with resources from the GFATM, UNITAID, UNICEF, and Clinton Foundation (CHAI). CHAI and UNITAID have committed support until the end of 2010 at which time all pediatric ARVS will be purchased with GFATM resources, unless UNITAID funding is renewed, currently under discussion in the region. Accomplishments since the last COP In FY09, USG support for pediatric HIV activities in Malawi focused primarily on two priorities: 1) Expanding access to early infant diagnosis (EID); and 2) strengthening basic care for HIV-exposed and infected children. In expanding EID, USG and its partner Howard, along with other collaborators such as Baylor and CHAI, supported the Ministry of Health (MOH) in implementing a successful EID pilot in all three regions of the country. The country is in the process of developing a national EID scale-up plan based upon an evaluation of the program that was conducted in 2009 and the MOH has hired an EID advisor to sit within the HIV/AIDS Unit. With regard to the second priority of improving pediatric care, USG has been working to support the implementation of comprehensive child survival interventions through the Partnership for Child Health Care (BASICS) in eight priority districts which account for almost 30% of Malawi’s population. BASICS provides HIV-related support to district health management teams, health facilities, and communities to improve postpartum follow-up of HIV-exposed infants and increase access to pediatric HIV diagnosis, care, and treatment services for HIV-infected and exposed infants, including improving CTX utilization, management of OI’s, and nutrition and organizational aspects of pediatric care delivery. During FY09 BASICS supported the implementation of CTX in 112 (out of 180) facilities throughout the 8 BASICS supported districts. Input activities included training as well as the provision of patient cards and CTX registers. This activity has not only benefited children but pregnant women and other individuals requiring CTX. Goals and Strategies for the coming year With PFIP funding, USG will continue to deepen its support for the two priority areas of EID and improving the quality of pediatric care, while also expanding support to include activities that will increase provider initiated testing and counselling (PITC) of children, enable the rapid decentralization of pediatric ART to more sites, improve continuum of care between HIV and MCH services, and strengthen monitoring and evaluation of pediatric HIV activities. i. Laboratory and technical support for

scale-up of early infant diagnosis services With PFIP funding, Howard University and the Malawi College of Medicine will continue to support for the scale-up of EID, providing direct on-site technical assistance and commodities as needed to high-volume labs to ensure EID samples are processed and transported efficiently and accurately. These partners will also provide support for quality assured CD4 testing at zonal and district hospital labs, including CD4% which is needed for staging of children over 1 year of age. Clinical quality improvement partners will complement the technical assistance provided to laboratories by working in concert with zonal and district health officers to provide mentoring to health providers at PMTCT, care, and treatment sites to assist them to utilize CD4% and EID to initiate more children on treatment. See lab and care and treatment sections for more information. ii. Supporting expansion of PITC for children BASICS and Baylor will support counsellors and CHWs to provide HTC in pediatric wards and under-5 clinics at high-volume sites in the 8 districts where BASICS provides support as well as other high-volume facilities in the Central region of Malawi. The counsellors will focus on testing all new admissions to pediatric wards, prioritizing all children 17 months and below attending under-5 clinics at the district hospitals. The HTC counsellors will be assisted by Expert Patients who will help with on-site counselling of caregivers and will facilitate referral to the ART clinic for clinical assessment of all children who test HIV positive. Through its new cooperative agreement with the MOH, CDC will also support national roll-out of P ITC for both adults and children. BASICS will further contribute to PITC by ensuring that the community-based growth monitoring and therapeutic care nutrition activities it is supporting in 8 districts are actively linked with HIV testing and counselling services. iii. Training and mentoring to improve quality and access to pediatric treatment Under the leadership and with the support of the MOH, Baylor has developed and implemented successful approaches in the Malawi context to maximize PITC in high-volume facilities, link children and families into longitudinal care, strengthen community-based systems to improve retention of children in clinical care, and provide on-site mentoring and training of staff in pediatric treatment. Given its expertise in pediatric ART, Baylor is well-positioned to complement the technical assistance that BASICS is providing to facilities and communities and to help develop service outreach models which would allow pediatric ART to be decentralized to lower-level health centers. Baylor and BASICS will therefore work together to support on-site mentoring activities and district level technical assistance to help capacitate more ART sites to initiate large number of children on treatment. As part of this process, training will be provided to health workers in the basic pediatric ART curriculum for sites not currently providing pediatric ART. A major focus of activities will be increasing enrolment of children on ART, especially children <18 months. Toward this end, BASICS will support refresher training to ART providers on presumptive therapy for children < 18months, using a module recently completed by the MOH. BASICS supported Trainer of Trainer training at the request of the HIV Unit during September 2009, which will allow the national roll-out of the refresher trainings in 2010. Additionally, BASICS will train lower-level health workers who would not normally be able to access specialized HIV training. The orientation module emphasizes enquiring about a child's HIV exposure status at routine under-5 clinics; assessing HIV-exposed and infected children; enquiring about CPT; referring children for clinical assessment, testing, and treatment when needed; and practical issues such as appropriate patient flow pathways which prevent missed opportunities. In 2010, Baylor will work with BASICS and the MOH to further refine the manual to ensure that it is updated and reflects current HIV guidelines. Once ART prescribers at sites have received the refresher training on ART, BASICS will proceed with the training of non-prescribers at these sites. BASICS is also receiving non-PEPFAR USG Child Survival funding to provide technical assistance to support the MOH in rolling-out its Pediatric Hospital Initiative and Integrated Management of Childhood Illnesses (IMCI) interventions which are aimed at improving the quality of care provided to ill children at community and facility levels. BASICS will help ensure that HIV Positive children who present with common childhood illnesses (pneumonia, diarrhea, fever) are managed effectively, and conversely that children presenting with common illnesses are tested for HIV. These initiatives build on work done by the earlier BASICS bilateral project in incorporating key HIV components into IMCI materials. iv. Strengthening the continuum of care between MCH and HIV services To date, PMTCT programs have especially struggled with linking exposed and infected infants into care, and therefore the USG will therefore provide support to scale-up of successful models developed by partners to strengthen the continuum of care. This will include

approaches involving CHWs and PMTCT coordinators at health facilities that focus on improving coordination between PMTCT, EID, Pediatric HIV care and treatment, and other MCH services. The CHW and coordinators at facility level are responsible for tracking mother-infant pairs over time and helping to ensure that exposed infants will receive the correct ARV prophylaxis, PC R testing, CTX prophylaxis, and that mothers are appropriately counseled on exclusive breastfeeding. V. Improving nutritional care for HIV-exposed and infected infants While exclusive breastfeeding rates are high amongst women in Malawi, many children fall off of the growth curve after 6 months when complementary feeding begins, and HIV-exposed infants are at particularly high risk in this regard. USG support will therefore focus on improving growth monitoring, nutritional assessment and counselling, and linkages to services for HIV-exposed and infected children, as well as children more broadly. Selected MOH staff and community health workers will be trained and mentored to provide quality infant feeding counselling, as well as ongoing nutritional assessment using weight, length, MUAC, and assessment for edema. They will make referrals and ensure that their clients are receiving appropriate services. vi. Strengthening monitoring and evaluation of pediatric HIV USG staff and partners will continue to work within the national PMTCT/peds subgroup and HIV technical working group to strengthen M&E for pediatric HIV, with high priorities being: 1) development and dissemination of a standardized postnatal follow-up pre-ART register for mothers and children from PMTCT programs; and 2) supporting revision of the child health passport to include HIV-specific information. To accelerate progress on these items, partners such as Baylor and BASICs who have already developed and piloted standardized registers and patient mastercards to track identified pregnant women, exposed infants, and infected children, will work with the MOH so that these tools can be adapted as necessary and scale-up nationally.

Technical Area: PMTCT

Budget Code	Budget Code Planned Amount	On Hold Amount
MTCT	12,006,294	
Total Technical Area Planned Funding:	**12,006,294**	**0**

Summary:
MTCT: $12,006,294 Context and Background In the absence of PMTCT interventions in Malawi, over 15,000 infants will become infected with HIV each year. While only 54% of pregnant women deliver in health facilities, 92% of pregnant women have at least one antenatal care (ANC) visit, and all ANC clinics provide a minimum PMTCT package, allowing for identification of HIV-positive pregnant women and the provision of single-dose Nevirapine (sd-NVP). Malawi's PMTCT program is currently at a critical juncture: Although massive scale-up of basic PMTCT services including HIV Testing & Counseling (HTC) and provision of sd-NVP have occurred in the last two years, the need exists to improve the quality of and access to services including combination regimen, identification of ART-eligible pregnant women, and identification and care of HIV-exposed infants. Without these additional services, the potential impact of PMTCT will never be realized. All 544 antenatal clinics in Malawi provide at least a minimum package of PMTCT services with rapid testing, clinical staging, sd-NVP, and ART referrals. Despite the inability to identify double-counting of HTC in pregnant women, reporting indicates a very high coverage of HTC in pregnant women (>90%). Of those tested, 11,867 (9.6%) were positive, of whom 8,584 were reportedly given prophylaxis (72.3%) and 1,000 (8.3%) were initiated on full antiretroviral treatment. Accomplishments since the last COP Malawi, with PEPFAR Support, has approved a Second Edition of its PMTCT Guidelines, updated its 5-Year Scale-up Plan, and is in the process of rolling out new ANC and Labor & Delivery registers which will allow comprehensive HIV-related ANC and maternity data to be collected on all pregnant women. The new guidelines and 5-year plan emphasize support for infant feeding practices in keeping with recent WHO guidance, rapid roll-out of a more efficacious combination regimen with AZT and an AZT/3TC tail; improving follow-up of both mother and baby to access

comprehensive treatment and care, and improving integration of PMTCT within broader MCH, family planning (FP) and ART services. While Malawi is close to achieving 80% coverage of HIV-positive pregnant women with single-dose NVP, the acceleration of high-quality comprehensive PMTCT services spanning the continuum of care is needed. Although PMTCT accounts for about 30% of all testing in the country, relatively few pregnant women are being staged and referred for ART, most HIV-exposed infants and HIV-positive women are lost-to follow-up in the postnatal period, and very few male partners are being tested. In addition, less than 10% of sites are implementing the new more efficacious combination regimen. Further compounding the challenges in monitoring program quality, current data quality assurance is very poor, with inaccurate data being reported for a number of key indicators, as was evidenced above with >100% of pregnant women being reported as receiving HTC. Other systemic problems include an unreliable national supply chain, insufficient support for laboratory services, a shortage of staff at all levels and across all cadres, and weak linkages between MCH and ART services. Goals and Strategies for PFIP Year 1 and 2 The GFATM, other pool donors under the Sector-Wide approach to Health (SWAp), UNICEF, and Clinton Foundation support most of the human resources and commodities for PMTCT. The role of USG in PMTCT in Malawi is to strengthen critical areas which are inadequately funded, and to work closely with Ministry of Health providing technical assistance, advocating and planning for improved regimens, and improving the access to high quality PMTCT services nationally. I. Support for technical leadership for the national PMTCT program In 2007 USG funded an expatriate PMTCT/pediatric HIV technical advisor (TA) whose role has been adequately completed. The expatriate PMTCT TA will not be replaced; ongoing technic al support to the national PMTCT coordinator will be provided through Malawian fellows as part of the new USG-funded HIV Fellowship Program, as well as through the USG-funded expatriate HIV Development Assistant. Additionally, USG staff provide direct technical support in development of tools, policy, training, and plans, including the finalization and printing of adapted WHO/CDC counseling and testing tools and participate on the Technical Working Groups of the MOH. II. Training of HCWs in new guidelines, registers, early-infant diagnosis and infant feeding USG will support trainings related to combination therapy and early infant diagnosis as a component of the new Family HIV Care Clinics being developed by MOH, infant feeding counseling, and the new ANC and maternity registers. This will complement UNICEF funding for these trainings which is insufficient to ensure national coverage, to ensure that all PMTCT providers have access to current recommended practices. III. Mentoring of districts through zones to improve quality of PMTCT services Malawi has five zonal health offices (ZHOs) in the country which are responsible for the 28 district health offices (DHOs) that are within them. The MOH has encouraged the USG to assist in building the capacity of these ZHOs and DHO's to mentor, supervise, plan, develop and implement systems to manage patient and data flow. In FY09, the USG partners began supporting the MOH in developing zonal mentoring program specifically focused on PMTCT, conducting two rounds of mentoring meetings at zonal level which included all districts, through which priorities for quality improvement were identified. In FY10 the focus will be to implement the mentoring process at the site-level to address these priorities, many of which are highlighted below (i.e. improving PMTCT-ART linkages; strengthening mother-infant pair follow-up; improving PMTCT-related M&E; etc.). Several USG partners will be involved in supporting the comprehensive HIV services zonal mentoring process, with partners being assigned to specific zones and underserved districts to avoid duplication and provide adequate geographic coverage of support. Standardized supervision tools will be developed, used to ensure consistency of the supervision process, and the supervision process will be aligned with national HTC and ART supervision. Other components of HIV service delivery will be integrated into the mentoring program, so that it involves comprehensive zonal mentoring for HIV services, not just for PMTCT. (Please see HIV care and treatment and HIV/TB sections for more information). Leadership and oversight is provided by the MOH, with USG and other partners providing financial support for regular meetings at the national and zonal levels for improving infrastructure of the zonal health office level. Once defined zonal and district-level goals have been achieved, systems will be consolidated, lessons learned will be compiled for dissemination, validated processes and tools will be finalized by the MOH for scale-up, and basic program evaluation of national importance to the PMTCT and HIV care and treatment programs will be done. Additionally, to address the fact that Christian Health Association of Malawi (CHAM) sites,

which provide about 40% of all health care in Malawi, are lagging being in the implementation of PMTCT and other HIV services, a complementary interagency approach will be used to simultaneously increase the number of PMTCT sites nationally, and to ensure the high quality of services available in at least 5 CHAM clusters in FY 10 and 11 (consisting of ~25 CHAM sites). IV. Increasing enrollment of eligible HIV-positive pregnant women on ART Approximately 4,000 HIV-positive pregnant women are being initiated on ART each year in Malawi, which is less than 1/3 of all estimated eligible women. If the CD4 threshold for eligibility increases to 350 in the coming year, then as many as 25,000 HIV-positive pregnant women per year may be eligible to initi ate ART in Malawi,. With the majority of eligible women on ART, Malawi could potentially to avert over 75% of all excess maternal and child mortality attributable to HIV. Therefore the highest priority for zonal mentoring will be to provide technical assistance to ZHOs and DHOs, helping them support PMTCT and ART sites in their catchment areas to develop specific plans and interventions to increase the number of eligible HIV-positive pregnant women who are enrolled on treatment. A mosaic of approaches will be tested and utilized depending on site needs, and will likely include some of the following: development of referral tools; utilization of transport vouchers and strengthened transportation systems for patients and CD4 specimens; use of expert patients and Community Health Workers (CHWs) to provide active referral tracking; performance-based financing to increase the number of eligible pregnant women enrolled on ART; and targeted renovations at high-volume, high prevalence sites to promote ART-PMTCT integration. V. Optimizing PMTCT as an entry into longitudinal HIV care for mothers, infants, and partners In FY10, efforts will continue to further refine and expand proven models to at least two facilities per district which are receiving support, and then scale these approaches up nationally in FY11 as part of the larger national pre-ART program. Strengthening male involvement in PMTCT is also critical, particularly for identifying discordant couples and maximizing the primary prevention opportunities within PMTCT. Drawing on lessons from a successful male championship program in Mwanza district, USG partners will support DHOs to increase partner testing within PMTCT settings, using interventions such as HTC provision on Saturdays, and transport vouchers or other incentives. Prevention-with-positives (PwP) will be integrated within PMTCT interventions and efforts will be made to enable safe disclosure to partners and limit gender-based violence. VI. Utilizing lay counselors, community health workers, and expert patients to improve services USG will support a variety of approaches utilizing different cadres to improve continuum of care, including community counselors at high-volume, high-prevalence sites; facility-based peer-to-peer support and expert patient approaches; and community-based support groups and community workers, including HSAs, to reduce loss-to follow-up with mother-infant pairs. VII. Improving infant feeding and growth monitoring, especially among children aged 6-24 months While breastfeeding rates are high in Malawi, exclusive breastfeeding through six months is not as common, which significantly increases the risk of HIV transmission to these infants. Many children also fall off the growth curve after 6 months for a variety of reasons. Therefore, through the various approaches outlined above, USG support will improve growth monitoring, nutritional assessment and counseling, and linkages to services for malnourished children, including ready-to-use foods and HIV testing. (Please see OVC and pediatric care and support sections) VII. Strengthening PMTCT-related laboratory services Increasing CD4 monitoring capacity and supporting the scale-up of early infant diagnosis through the national Family HIV Care Clinic is a priority under the Partnership Framework (Please see lab narrative). VIII. Improving monitoring and evaluation of PMTCT programs In addition to supporting training for health workers in the new ANC register, PEPFAR will support the MOH to develop and disseminate a postnatal follow-up register linked to pre-ART registers, and finalize the child health passports with HIV-specific information. Data utilization will be improved through the zonal mentoring and capacity building activities, and surveillance will be done at immunization clinics to estimate population-based transmission rates. Improving monitoring of PMTCT commodities within the broader national logistic management information systems (LMIS) will also be supported. IX. Integration of PMTCT within MNCH and FP services and systems strengthening o Supply chain management: In FY10 a new integrated supply chain management contract will be awarded, with a focus on improvement of the reliable supply of commodities to the 544 MCH sites in the country. This will include PMTCT-related commodities (test kits, NVP, AZT, Cotrimoxazole, and DBS-supplies). These efforts will complement activities being funded through the same partners related to artemisinin-based

combination therapies for malaria and FP commodities. (See OHSS) o Strengthening supervision and M&E at MCH clinics: PEPFAR funding will be combined with other USG-funding through maternal and child health and PMI streams to help DHOs and ZHOs coordinate supervisory visits in a manner which maximizes resources while improving the technical linkages between maternal and child health interventions. o Performance-based financing (PBF): Norway and GTZ plan to support PBF approaches in Malawi, including patient vouchers as well as provider incentives. Following a feasibility assessment by these donors and further guidance from the MOH, PEPFAR will coordinate with GTZ and Norway and with other USG-funded child health activities and President's Malaria Initiative (PMI) to explore national support for PBF activities for a limited number (2-4) of high-impact maternal child health indicators. o Family planning (FP) integration within pre-ART programs: Given that approximately 50,000 HIV-positive pregnant women will be identified in Malawi's PMTCT program each year, the priority will be to enroll as many of these women as possible within the new national pre-ART program, and ensure that the national pre-ART program includes FP counseling and referrals as an essential component, to promote family planning in the postnatal period. Additionally, through a FP and HIV integration project in selected districts, community-based workers will follow-up with pregnant women in the postnatal period to help ensure they have access to FP counseling and referrals. X. PMTCT-related basic program evaluation PEPFAR will prioritize the following PMTCT-related evaluations: 1) Population-based PMTCT effectiveness evaluation; 2) Clean water and/or food supplements as incentives for care-seeking behavior among antenatal and postpartum HIV-positive and negative women; 3) Understanding the relationship between HIV and maternal mortality; and 4) Integrated postpartum facility-based care for HIV-positive and HIV-exposed infants. Please see the accelerated PMTCT scale-up plan for a more detailed description of these proposed evaluations.

Technical Area: Sexual Prevention

Budget Code	Budget Code Planned Amount	On Hold Amount
HVAB	4,853,700	
HVOP	3,180,109	
Total Technical Area Planned Funding:	**8,033,809**	**0**

Summary:
HVAB: $6,527,919 HVOP: $4,305,575 Context & Background Malawi's HIV prevalence is estimated at 12% nationally in adults aged 15-49, with estimated incidence at over 90,000 new infections per year; disproportionately affecting women. While access to ART has scaled up rapidly since 2004, with over 200,000 ever initiated on treatment, it cannot keep pace with the rate of new infections nor can it afford the growing costs associated with an expanding population on lifelong treatment, and the emerging need for a new ART regimen. Strengthening HIV prevention efforts has become the single most important area of focus which will have a significant and sustainable impact on HIV. A shifting epidemic reveals that over 90% of new HIV infections among adults in Malawi occur in two main groups: 1) a highly active "rapid" component where individuals engaging in multiple concurrent partnerships drive transmission through sexual networks; and 2) a chronic "slow" component with very substantial transmission, largely driven by existing discordant couples and people in permanent relationships entering latter stages of disease when they are potentially more infectious. This means that a large fraction of the general adult population in Malawi is at risk of HIV infection, while less new infections arise from sub-populations traditionally viewed as "high-risk groups". While there is a need to continue efforts to reach marginalized populations with very high HIV incidence, and youth, Malawi's emphasis has to be on the general population in order to significantly reduce incidence in the next five years. There is clear evidence that even among the youngest age groups, being in a long-term union or marriage is correlated with increased

HIV prevalence, with a greater than two-fold higher prevalence among married young women aged 18-25 than those in non-permanent, more sporadic relationships. HIV is not uniformly distributed throughout Malawi; approximately 2/3 of all estimated new infections occur in 11 districts in the Southern Region. A large proportion of transmission in the central and northern regions occurs in urban areas or specific "hot spots". Previous prevention efforts have overemphasized prevention among young people, and minimally targeted on the now recognized high risk behaviors of multiple concurrent partnerships among adults and increased risks within marriage. And while there has been a massive scale-up of HIV testing, care and treatment services over the last several years, there has been less effort devoted towards reaching HIV-positive individuals with highly effective PWP interventions, including promotion of couples testing, and condoms for discordant couples. The increased focus in HIV prevention needs to be balanced with efforts to streamline and make more efficient the process of moving funds from government to NGO's, including building technical, management and financial capacity. Accomplishments since the last COP Since the last COP, several key accomplishments have been made. In early 2009, Malawi finalized the first National Prevention Strategy. The new strategy shifts the emphasis of previous behavioral prevention efforts guided by the National BCI Strategy (2002), to prioritise a variety of evidence-based complementary behavioral and biomedical approaches to effectively reduce transmission in all possible areas, and to reach individuals in both clinical and community settings, with an emphasis on PwP interventions in clinical settings. It also provides opportunity for further redirection of programming among other key groups such as youth, to address increased vulnerability through stable relationships. NAC and MoH's leadership in steering the strategy's development signals a renewed commitment to prevention as the cornerstone of the national HIV/AIDS response. A National HIV Prevention TWG, under proposed NAC and MoH chairmanship, has recently been es tablished to guide its implementation and ensure synergy of efforts. The MOH, as a key implementing partner, has also shown greater involvement in prevention through its determination to develop a national Male Circumcision (MC) Policy and stronger linkages between HIV and Health Education Units. USG partners have addressed community norms and practices within the general population, targeting high risk settings and vulnerable groups, including young people. Among the general population, areas of concentration included strengthening self-efficacy around HIV prevention, challenging social and cultural norms around gender roles, encouraging male involvement, addressing stigma, and PwP using a variety of communication channels. Development of community transformative toolkits on gender and PLHIV, in particular, will be critical to scale up in FY10 under the Prevention Strategy. Continued support for social marketing of condoms in high risk areas, complemented with behavior change interventions will be further intensified in the next year. Goals and Strategies for PFIP years 1 & 2 Given the substantial support for HIV prevention activities directed at Malawian youth and also that the vast majority of new STI in Malawi are occurring in adults aged 18 and over, PF resources focus on high-impact evidence-based interventions to prevent adult infections among couples of all ages and in high risk populations. To address the "rapid" component of the epidemic, support will focus on behavior change communication directed at partner reduction among the general population and in high-risk settings; and condom social marketing targeted especially to populations with high-risk behaviors. Addressing the "slow" component of the epidemic requires a different approach involving active case-finding support. Therefore partners will focus on supporting access to HTC, particularly among couples, and providing assistance to help scale-up proven interventions to prevent transmission between couples. These include increasing awareness of the benefits of ART initiation immediately upon eligibility, and condoms for discordant couples closely linked with PwP interventions as part of the national pre-ART program. In order to more powerfully address both the "rapid" and "slow" components of the epidemic and thereby dramatically reduce incidence in the long term, PF resources will be used to support implementation of male circumcision once the policy is approved and national guidelines are developed, expected in 2010. Reduce multiple concurrent partnerships among adults USG partners will work closely with the National AIDS Commission and its partners through the Multiple Concurrent Taskforce, to strengthen the quality of BCC messages developed as part of a new national "one love" campaign scheduled to be launched in early 2010 with GFATM resources. More resources are needed for this campaign not only to expand mass media activities targeted at partner reduction for adults, but also to complement them with mutually reinforcing behavior change messages delivered in

interpersonal, community-based, and clinical arenas. PF funds will support Malawian partners such as BRIDGE Project to conduct formative research to help to better understand why people engage in multiple and concurrent partnerships in the Malawian context. Based upon this research, partners will work with NAC to design and test culturally appropriate, effective, and targeted messages and develop evidence-based BCC messages with a common “branding” that is complementary and harmonized with the “one love” campaign. USG partners, BRIDGE II and PACT, through supported CBOs, will equip communities and faith-based networks with resources and training to empower them to engage in self-directed efforts to determine how social and gender norms facilitate HIV transmission, with the goal of bringing about both individual behavior change and sustainable change in social norms, including reduction of mul tiple and concurrent partnerships (MCP), increased gender equity, and reduction of stigma of PLHIV. Transformative toolkits have already been developed to explore community social and gender norms and will be further scaled up through provision and training on use. Prevent HIV transmission in high risk settings (PPAs) It is estimated that approximately 7% of new infections occur either in clients of sex workers or partners of clients of sex workers, and another 13% of new infections occur in people who have multiple, non-regular sexual partners. Informal transactional sex is also very common. Therefore, partner reduction interventions need to be coupled with increasing consistent condom use. As a first step in improving condom targeting to populations at high risk, PF support will be directed to complementary and evidence-based approaches to map Priority Prevention areas (PPAs). Other sub-populations at risk who are often overlooked will be targeted, including agricultural workers, women engaging in informal transactional sex, men with multiple non-regular sexual partners, young women entering into a long-term marital union, and MSM. Population Services International (PSI) will identify and characterize PPAs and reach individuals engaging in MCP with integrated BCC interventions targeting partner reduction and increased condom use. These efforts will be complemented by other PF partners such as BRIDGE, MSH and PACT who will facilitate uptake of related HIV services such as STI screening and treatment, HTC, family planning, PMTCT, pre-ART and ART. Efforts will also be made to develop systems linking high-risk populations to HIV and other social services in and around the PPAs. Building partnerships between funded organizations, intensified interventions within PPAs will be linked, where possible, to wider partner interventions to address community norms around gender and workplace settings. Strengthen prevention among positives with particular emphasis on reaching discordant couples and initiating early access to ART Under Malawi’s current ART guidelines, many of those who test HIV-positive do not yet require ART. The best evidenced-based prevention option available to these individuals is condom use with all partners. Because evidence suggests that high rates of condom use in discordant and concordant couples is difficult to maintain over the long-term, pre-ART efforts will emphasize continual reinforcement of consistent condom use. This will be complemented with counseling on partner disclosure, partner and child testing, risk reduction counseling, family planning for HIV-positive women and discordant couples, and management and treatment of STI’s. PwP will be integrated into care and treatment clinics and delivered during routine visits. To set the stage for coordinated PwP activities and ensure links between prevention and care activities, national partners will take the lead in facilitating the development of a National Prevention with Positives Strategy for both clinical and community based settings. PF partners will promote the pre-ART program as it scales up, strengthen referrals and linkages among providers and services, develop and promote a new family planning condom for couples to increase acceptability, and strengthen PLHIV support group activities through dissemination and training of newly developed transformative tools focused on PWP issues. Build capacity of indigenous partners to implement prevention activities The USG partner PACT, in collaboration with BRIDGE II and PSI, will further work to strengthen collaboration and networking among CBOs to build synergy of efforts. Quality BCC tools and training will be offered to CBOs to increase their capacity for implementing interventions. Health care facilities will also be supported in effective screening of STIs, care of OI’s and ART. Integration with education sector USG will also support partners’ activities in reducing new HIV infections among Malawian teache rs through: Strengthening teachers’ HIV and AIDS knowledge, skills and positive attitudes towards prevention; reinforcing HIV/AIDS Life Skills education (LSE) curriculum development for teachers; integrating effective gender and HIV content into the national teacher training program, and building capacity of T’LIPO (a national organization of over

2,500 Teachers Living Positively) for advocacy, peer mentoring and teacher training support. Develop models of youth prevention programming for scale-up While a majority of PF funding will be targeted at adult prevention, prevention programs for youth will continue to be implemented in FY10 to reduce risks among young women in particular. PACT's 25 implementing partners will focus on delaying sexual debut and early marriage, protection from unwanted pregnancies and reduction of partners. A new focus will be promoting HIV testing for couple before marriage to protect both partners from infection. Partners will utilize a variety of complementary and targeted approaches to reach in-school and out-of-school youth including the following: Facilitating youth groups to improve interpersonal communication and training on specific life skills, training and supporting counselors, peer educators, youth patrons, parents and communities to serve as role models, share information, and provide emotional support, and providing other HIV prevention services for youth including condoms for sexually active youth age 15 and above, and HTC youth-friendly services. Youth prevention activities are linked to OVC programs by PACT's partners who work in both areas. Provide technical leadership to strengthen the national prevention response. USG partners and staff will continue to play an important role in providing technical support to NAC and the GOM to lead the national response, and to other USG partners to implement evidence-based prevention programs. USG has recruited a full-time international prevention expert and a local hire USG prevention program officer, who will both provide technical assistance and capacity development to the GOM, NAC, and other USG partners. Strengthen evidence base to inform prevention programming Both Sector I and Sector II programs will invest in improving strategic information for prevention to determine whether the current interventions are effective. They will continue to implement high quality monitoring methods and will consider population-based estimates of behavior change and coverage given adequate resources. All information on effective prevention programming will be shared with GOM and utilized to inform national prevention efforts. CHAM will develop an M&E system for CHAM facilities to support data collection and work with MOH to pilot new confidential referral systems linking HIV-positives to pre-ART.

Technical Area: Strategic Information

Budget Code	Budget Code Planned Amount	On Hold Amount
HVSI	3,218,870	
Total Technical Area Planned Funding:	**3,218,870**	**0**

Summary:
HVSI: $4,038,252 Context and Background Strategic Information in Malawi USG Malawi provides extensive support to the Government of Malawi (GOM) and partners in implementing Strategic Information (SI) activities within the Malawi National AIDS Framework (NAF). Under the Partnership Framework (PF), USG has committed to a unified reporting system to monitor and evaluate success in implementing the national response as well as measuring PEPFAR's contribution to reaching national goals. In order to achieve this objective, USG provides substantial technical and financial support to Health Management Information Systems (HMIS), surveys and surveillance, and monitoring and evaluation (M&E) activities at the national, sub-national and program levels. The data generated through these complementary systems serve as the cornerstone of evidence-based HIV/AIDS prevention, care and treatment programs throughout the country. Health Management Information Systems Health Management Information Systems are essential for effective monitoring and evaluation and require reliable, standardized data collection. In 2002, the MOH began to implement the national HMIS to support routine data collection, analysis and dissemination for health sector data, including indicators on HIV/AIDS, malaria, TB, reproductive health and other health programs. Facility-level HMIS indicators are aggregated on a quarterly basis at the district level and sent to the national level. However, the accuracy, completeness, and timeliness of data are limited. USG has provided a leadership role in institutionalizing

HMIS in Malawi and strengthening the scale and quality of the system. At selected locations, the MOH and local partners have introduced touch-screen clinical workstations at ART point of care that guide low-skilled healthcare workers through the diagnosis and treatment of patients according to national protocols, capture data that is used by healthcare workers during patient visits, and are easily aggregated for national-level analysis. This approach has required both hardware and software innovations, including alternative energy approaches, intuitive touch-screen-based user interfaces for users with no computing experience, and low-cost information appliances that are significantly more robust in harsh environments than traditional computers. This system is currently being rolled out in high through-put locations but will also be expanded to rural health facilities. A central data repository in the MOH is under development to house this Electronic Data Systems (EDS). USG has also supported developing well-documented EDS data standards and plans for integration of data systems collecting both HIV-related and other health data into a single repository. The MOH has taken full ownership of this system, and USG has placed crucial technical assistance within the MOH HIV/AIDS Unit to provide full-time capacity building to their counterparts in order to support the process. Surveys and Surveillance A National HIV Surveillance Strategy is under development with the leadership of the MOH and National AIDS Commission (NAC) and USG. This strategy will better document and codify surveillance activities to ensure they are well coordinated and provide timely, high quality data to evaluate the national program. The components of the national HIV surveillance system currently include the following: 1) Demographic and Health Survey (DHS) with HIV biomarkers every five years (next round in 2009/2010), 2) antenatal clinic surveillance every two years (next round 2010), 3) behavioral and biological surveillance of high risk populations every three to four years (next round 2010/2011), 4) routine HIV drug resistance surveillance among adults including prospective and threshold surveys and quarterly monitoring of early warning indicators, 5) situational analyses of health facilities annually or bi-annually, and 6) routine Estimates and Projections modeling. In addition, incidence surveillance, mother-to-child transmission evaluation and pediatric drug resistance monitoring are priority activities for inclusion in the national surveillance system in the coming years. A National Research Strategy is currently in place and will be revised by the National Research and Surveillance Technical Working Group to reflect operations research priorities defined in the NAF. Monitoring and Evaluation Under the guidance of the NAC, Malawi implements a single Monitoring and Evaluation Framework and regularly reports this data to stakeholders. While the M&E Framework has been successfully institutionalized at the national level, the rapid decentralization of activities to districts has required intensified local support to ensure that data is being collected and reported in a consistent and accurate manner. USG provides technical support in data analysis and synthesis to provide high quality data for the M&E system which is in turn used more localized planning and resource allocation. Strategic Information Challenges Malawi has taken a leadership role in advancing strategic information systems in Sub-Saharan Africa, particularly in its proactive use of evidence to guide national strategic planning and resource allocation. However, the country faces many challenges in this area including the need to increase staffing levels and technical capacity, institutionalize routine supervision of monitoring activities, and upgrade technology and infrastructure to support more advanced data management and communications systems. USG Strategic Information Team USG plays an integral role in providing the necessary information to effectively scale-up and decentralize services, evaluate the national response, and monitor changes in epidemic dynamics. The USG SI team is comprised of an SI Liaison, housed within USAID and serving the entire USG team, two M&E Officers, and an Epidemiologist. The SI Liaison ensures systems are in place at USG and amongst implementing partners to effectively plan and monitor programs per PEPFAR requirements. The Epidemiologist provides technical leadership to the implementation of the National HIV Research and Surveillance Strategies and coordinates Public Health Evaluations. The M&E Officers provide technical oversight and program management for M&E and Health Management Information System (HMIS) activities with the MOH, including strategic planning, routine monitoring and evaluation, capacity building, and data quality assessments as well as technical assistance and capacity building support to USG partners. A new SI Liaison has been recently filled and will be in place early in FY10. The position of M&E Officer overseeing HMIS is currently being recruited. Collaborating partners USG works with a broad range of collaborating partners to ensure that SI activities are providing integrated support to the national response. These partners include the Ministry of Health

(HIV/AIDS Unit, Community Health Sciences Unit, Central Monitoring and Evaluation Division), the Ministry of Economic Planning and Development, the National AIDS Commission, Kamuzu, Queen Elizabeth, and Mzuzu Central Hospitals, MSF Belgium, Baobab, CHAM, Lighthouse, MACRO, PACT, Malawi College of Medicine, UNC, the National Health Sciences Research Committee, the Center for Social Research, Kamuzu College of Nursing, Mzuzu University, the National Statistics Office, Family Health International, UNAIDS and WHO. Strategic Information Accomplishments, Goals and Strategies USG-supported strategic information was critical in the development of an evidence-based National Action Framework (NAF) in 2009. Because of the high quality of this document, the USG Partnership Framework is able to directly support implementation of the NAF and, in turn, will harmonize its monitoring and evaluation data with NAF goals and objectives. In addition to supporting national HMIS, Surveillance and M&E Strategies, the Partner ship Framework Implementation Plan (PFIP) will include a five year Monitoring and Evaluation Plan that encompasses key SI indicators. USG is working closely with MOH, NAC and other partners to ensure PF indicators and SI activities are in full alignment. Health Management Information Systems USG has supported the MOH in moving forward the development and expansion of their Health Management Information System and this will continue to be a priority area in the following year. USG will support the MOH in providing leadership in implementing the national HMIS system, and a priority of next year's funding will be in capacity building in GIS analysis, providing on-the-job training for health care workers to implement the Electronic Data System (EDS) at facilities, implementation of National Data Standards, establishing the central data repository, and updating forecasting and quantification tools. A key HMIS partner is Baobab who supports the MOH in improving strategic information by strengthening health information systems, in particular the technology required to obtain higher quality results. In collaboration with the MOH, Baobab is currently installing it system at 12 ART sites, two general health sites and three HTC sites. In the following year, the HMIS system will continue fine-tuning its software and reporting to reflect the changes in the dynamic M&E system including adding a supervision tool and automatic alerts for defaulter tracing, incorporating electronic mastercards, and providing timely aggregate data to facilities. In addition, the architecture will be developed for the central data depository. USG will continue to strengthen donor coordination, information sharing, development of data standards and intensive capacity building in medical informatics through our local partners. The EDS will be expanded to new sites including CHAM (private) facilities. Lighthouse Trust will incorporate child counseling and pediatric treatment modules into its existing EDS and it will continue to work with the MOH and Baobab to test algorithms for better integrating CD4 testing, tuberculosis monitoring, and referral between ANC, PMTCT and ART services into the system. Surveillance and Surveys USG will continue to play a pivotal role in driving the coordination and implementation of surveillance activities in Malawi. The very active HIV Research and Surveillance and Drug Resistance Surveillance Technical Working Groups will continue to meet to define surveillance policies, develop methodologies and oversee implementation of surveillance activities. Data use and dissemination activities including data triangulation, the third round of which will be completed this year, will also continue to play a pivotal role. The first round of prospective drug resistance surveillance was conducted this year at four sites and a threshold survey was conducted at two sites. The prospective cohort will be extended for another two years and an additional site will be added. Routine surveillance of drug resistance among infants will also be introduced using cross-sectional methodologies. As well as providing extensive technical assistance, USG is the primary funder to the Malawi DHS, including a behavioral component, HIV biomarkers, and oversampling for selected district-level estimates. The protocol was developed this year and is currently under review in country and with the CDC and DHS Macro. Data collection is expected to begin in late 2009 or early 2010. USG will continue to support regional and district-level data analysis, data use and dissemination activities in the following year. In the upcoming year back testing for HIV incidence on stored DBS from the general population (DHS surveys) and high risk populations (BSS surveys) will commence. This activity will be carried into the following year. In addition, the USG, MOH and partners will continue to provide intensive capacity-building in epidemiology through technical assistance and mentoring and the ex pansion of basic epidemiology training. Monitoring and Evaluation District-level monitoring and evaluation continues to be a priority. PACT has a trained cadre of monitoring, evaluation and reporting (MER) staff that will continue to support

PACT and NAC/Global Fund grantees in their activities. In addition, a standardized M&E system will be developed for CHAM (private) facilities to capture program-specific indicators as well as those to be reported to PEPFAR and the NAF. USG will also continue to support more localized data analysis and dissemination to feed into the District Implementation Plans.

Technical Area: TB/HIV

Budget Code	Budget Code Planned Amount	On Hold Amount
HVTB	817,081	
Total Technical Area Planned Funding:	**817,081**	**0**

Summary:
HVTB: 2,152,997 Context and Background As in other Sub-Saharan African countries, Malawi faces the challenge of a dual epidemic of HIV and TB. According to the 2007 HIV sero-survey, Malawi has an HIV prevalence of 12% in the general adult population (15-49 years) with an estimated 90,000 new HIV infections in 2009. The high HIV prevalence has also fueled the TB epidemic and has led to a fivefold increase in the reported TB cases from ~ 5,000 cases in 1985 to 27,000 cases in 2007. HIV prevalence among these TB patients is approximately 70%. HIV has also led to poor treatment outcomes among TB patients. Cure rate has decreased from 87% in 1985 to 78% in 2006, while the death rate has increased from 5% in 1985 to 13% in 2006. Despite these challenges, Malawi has been in the forefront in the global TB/HIV response, including being one of the first countries to pilot the WHO-coordinated Pro-test project. The goal of the project was to create an environment in which more people would choose to be tested for TB, by enhancing voluntary counseling and testing (VCT) linked to appropriate clinical and supportive services especially in TB settings. Lessons from the Pro-TEST project were applied to develop the country's first 3-year TB/HIV strategy in 2002. Activities successfully implemented were focused on reducing HIV among TB patients particularly through HIV testing among TB patients, and provision of Cotrimoxazole among HIV +ve TB patients. Though this strategy expired in 2005, TB/HIV activities continued to be implemented within the TB and HIV departments of the MOH, but in an uncoordinated manner. In addition, most of the activities remained in a pilot mode without a clear plan for national roll out of these activities. Several models of best practices for delivery of TB/HIV services have been developed by several PEPFAR and non-PEPFAR partners including Lighthouse, MSF, and TBCAP which can be easily adopted and rolled out nationally. TB services in Malawi are delivered through a network of 145 microscopy centers, 47 TB registration sites and over 600 DOT centers. However only nine have integrated routine HIV testing services as a standard package of care for TB patients and of the 30 TB officers in the country, only 18 focus on TB/HIV integration. With TB/HIV activities and the need for better coordination between the TB and HIV program driving the initiative, a new 5 year TB/HIV strategy was developed in 2008. Since then, great progress has been made in activities targeted towards reducing HIV among TB patients. According to the recent reports over 80% of TB patients are tested for HIV and 70% of these were found to be HIV-infected. Of these HIV-infected TB patients, over 90% were started on Cotrimoxazole. Although all the HIV-infected TB patients are eligible for ART according to the national ART guidelines, <30% of HIV-infected TB patients get started on ART. Progress in the activities targeted towards reducing TB among PLHIV has been limited. Although intensified TB case finding has been carried out at some of the ART centers, it is not consistently carried out at all the ART centers (over 200), and HIV testing and counseling centers (HTC) in the country. There is a need for a standard TB screening approach and diagnostic algorithms for diagnosis of TB among PLHIV. Currently Malawi does not have a policy regarding provision of Isoniazid Preventive Therapy among PLHIV. There is also a need to improve access to sputum smear microscopy and to improve the quality of services. The issue of infection control for TB in HIV service delivery settings is increasing becoming problematic as AIDS patients congregate in large numbers to receive services. Recently TB infection control guidelines were drafted and would be

incorporated into the general infection control guidelines. Implementation of TB infection control practices at all the health facilities especially at the HIV settings would be critical. Multi-drug re sistant (MDR)-TB prevalence in Malawi is currently unknown. There are presently 32 MDR-TB cases registered. 20 of these patients are on treatment while 12 are awaiting treatment. Malawi successfully applied for financing for TB through the Global Fund for AIDS, TB and Malaria (GFATM) for the first time in 2008. A grant for $18,000,000 (2008 – 2013) will provide funds to strengthen the National TB Program's (NTP) capacity to deliver TB treatment. This GFATM grant which is targeted towards strengthening Malawi's TB program also incorporates a few TB/HIV activities. Malawi also has a significant funding for implementation of HIV activities with GFATM financing. The district health management teams are expected to include TB and HIV program activities including TB/HIV activities in their district implementation plans so that adequate funding for TB and HIV activities is available through the MOH mechanism for funding, the Sector Wide Approach for Health (SWAP). Availability of these basket funds has been a challenge, adversely affecting implementation of the TB program activities. Accomplishments since the last COP USG support was focused on improving national-level coordination between TB and HIV programs, improving the quality of services, and expanding the geographic coverage of the program. This support for TB/HIV mainly wrapped around CSH funds for tuberculosis and supported the United States funded Tuberculosis Control Assistance Program (TBCAP) to support TB/HIV activities in two selected districts in the South Eastern zone and four districts in the Central Western zone. There has been remarkable improvement in uptake of ART in sites supported by TBCAP with up to 70% HIV-infected TB patients starting on ART, compared to the national average of <30%. TBCAP also supported decentralization of smear microscopy by creating sputum collection sites, and creating new microscopy centers in the supported sites. Support was also provided to develop and implement external quality assurance program and laboratory supervision. This has lead to significant increase in TB case finding overall including among PLHIV. TBCAP also supported renovations of the central reference lab to international standard category 3. TBCAP also supported MDR TB survey using PEPFAR funds. Goals and Strategies for PFIP Year 1 and 2 Support to the GOM through PEPFAR is provided through HHS/CDC to NTP, and USAID through TBCAP. PEPFAR will provide technical support to the NTP and HIV unit to develop the five year operational framework as well as the development of TB/HIV operational guidelines. TB infection and control guidelines would be developed and incorporated into the existing infection control guidelines using USG support. USG funds are also planned to be used to train TB and HIV staff which will assist in the national roll out of the/HIV activities. Joint supervision by TB and HIV unit staff at national and zonal level to monitor implementation of TB/HIV activities would also be supported. USG would also support a national level consultation to develop IPT policy and a plan for pilot implementation of IPT. USG would continue to support TB/HIV activities in accordance with the Partnership Framework goals. Although TBCAP support would end in October 2011, the activities would be continued through other partners. USG support would be focused on improving integration of TB/HIV services, increasing uptake of ART among HIV-infected TB patients as well as improving TB case finding among PLHIV through intensified TB case finding. USG has identified key areas in TB/HIV coordination which would be supported in PFIP Year 2. 1. Support coordination between TB and HIV programs at national, zonal and district level and national roll out of TB/HIV activities: Overall, TB/HIV activities in Malawi continue to be implemented in an environment where National TB and HIV programs are functioning reasonably well, but do so independently and with relatively weak interactions at the a dministrative as well as service delivery level. In coordination with the other key stakeholders, USG would continue to facilitate the dialogue between TB and HIV program and support TB/HIV sub-group planning and review meetings at the national and zonal level. USG would also support orientation of zonal and district level health management and program managers requested in the to ensure that TB/HIV planning at the zonal and district level and that sufficient resources would be requested in the zonal and district implementation plan. 2. Integration of TB/HIV services: USG would continue to support integration of TB and HIV services at TB and HIV service delivery sites to improve patient management. USG has identified low uptake of ART among HIV-infected patients as a priority. It would involve piloting and rolling out provision of ART at TB clinics to improve uptake of ART among HIV-infected TB patients to support the PF goal of increasing number of PLHIV on ART. USG would also support training of all the ART providers and HIV counselors on intensified TB case finding and TB

diagnostic evaluation. USG would also support decentralization of TB registration sites to ART sites. 3. TB infection control: USG would support development of training curriculum for zonal and district quality improvement teams on TB infection control. This would enable these teams to assess TB infection control practices during their visits and assist facilities to practice TB infection prevention and control procedures. 4. Monitoring and evaluation: USG would continue to support joint supervision by the TB and HIV units and zonal review meetings to monitor implementation of TB/HIV activities. USG would also support an evaluation of revised TB and HIV recording and reporting system to improve the quality of data. 5. Support laboratory capacity building to improve TB diagnosis among PLHIV: In accordance with the PF goals of improving TB case finding among PLHIV, USG would support NTP in establishing fluorescent microscopy in selected high-burden sites and also building the capacity of the CRL to diagnose sputum-negative TB cases especially among HIV-infected persons using liquid culture capacity by purchasing a MGIT 960 machine.

Technical Area Summary Indicators and Targets

Redacted

Partners and Implementing Mechanisms

Partner List

Mech ID	Partner Name	Organization Type	Agency	Funding Source	Planned Funding
7166	Howard University	University	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	3,950,000
9257	Ministry of Health/NTP	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention		
9259	University of North Carolina	University	U.S. Department of Defense		
9261	Baobab Health Trust	Implementing Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	1,325,000
9263	Elizabeth Glaser Pediatric AIDS Foundation	NGO	U.S. Agency for International Development		
9266	John Snow, Inc.	Private Contractor	U.S. Agency for International Development		
9268	Johns Hopkins	Implementing	U.S. Agency for		

	Bloomberg School of Public Health Center for Communication Programs	Agency	International Development		
9269	KNCV TB Foundation	NGO	U.S. Agency for International Development		
9270	Lighthouse	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	900,000
9271	Malawi AIDS Counseling Resource Organization	NGO	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	600,000
9273	Management Sciences for Health	NGO	U.S. Agency for International Development		
9274	Management Sciences for Health	NGO	U.S. Agency for International Development	GHCS (USAID)	500,000
9276	National AIDS Commission, Malawi	Parastatal	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	700,000
9277	Pact, Inc.	NGO	U.S. Agency for	GHCS (State),	2,850,000

			International Development	Central GHCS (State), GHCS (USAID)	
9280	Partnership for Child HealthCare Inc.	NGO	U.S. Agency for International Development	GHCS (State), GHCS (USAID)	2,429,913
9281	University of Washington	University	U.S. Department of Health and Human Services/Health Resources and Services Administration	GHCS (State)	1,750,000
9882	Johns Hopkins Bloomberg School of Public Health Center for Communication Programs	Implementing Agency	U.S. Agency for International Development	GHCS (State), GHCS (USAID)	4,600,000
9883	Population Services International	NGO	U.S. Agency for International Development	GHCS (State), GHCS (USAID)	2,914,372
10427	Malawi Blood Transfusion Service	Parastatal	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GAP, GHCS (State)	1,140,000
10764	Macro International	Private Contractor	U.S. Agency for International Development		
10781	University of Malawi College of Medicine	University	U.S. Department of Health and Human Services/Centers	GHCS (State)	600,000

			for Disease Control and Prevention		
10783	JHPIEGO	NGO	U.S. Agency for International Development	Central GHCS (State)	125,000
10785	IntraHealth International, Inc	NGO	U.S. Agency for International Development	GHCS (USAID)	400,000
10786	Academy for Educational Development	NGO	U.S. Agency for International Development	GHCS (USAID)	500,000
11453	U.S. Peace Corps	Implementing Agency	U.S. Peace Corps		
12105	Dignitas International	NGO	U.S. Agency for International Development	GHCS (State)	2,301,773
12106	Lilongwe Medical Relief Trust Fund	TBD	U.S. Agency for International Development	GHCS (State)	1,550,000
12107	Partners in Hope	FBO	U.S. Agency for International Development	GHCS (State)	2,438,000
12108	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
12109	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
12110	University of Malawi, College of Medicine/Lab	Implementing Agency	U.S. Department of Health and Human Services/Centers for Disease Control and	GHCS (State)	2,050,000

			Prevention		
12111	Ministry of Health, Malawi	Host Country Government Agency	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	GHCS (State)	2,900,000
12112	JHPIEGO	NGO	U.S. Agency for International Development	GHCS (State)	1,710,087
12113	Pathfinder Outreach Ministry	NGO	U.S. Agency for International Development	GHCS (State)	300,000
12114	TBD	TBD	U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Redacted	Redacted
12115	Project Concern International	NGO	U.S. Department of Defense		
12116	ASFG/State	Implementing Agency	U.S. Department of State/Bureau of African Affairs	GHCS (State)	90,000
12117	Abt Associates	Private Contractor	U.S. Agency for International Development	GHCS (State)	100,000
12118	Banja La Mtsogolo	TBD	U.S. Agency for International Development		
12119	Global AIDS Interfaith Alliance	TBD	U.S. Agency for International Development		

12120	Save the Children Republica Dominicano	NGO	U.S. Agency for International Development	GHCS (State)	100,000
12121	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
12122	Catholic Relief Services	FBO	U.S. Agency for International Development	GHCS (State)	1,250,000
12123	Ministry of Health/CHSU	Host Country Government Agency	U.S. Agency for International Development		
12124	Academy for Educational Development	NGO	U.S. Agency for International Development	GHCS (State)	50,000
12125	African Palliative Care Association	NGO	U.S. Agency for International Development	GHCS (State)	200,000
12126	Feed the Children	Implementing Agency	U.S. Agency for International Development	GHCS (State)	1,056,000
12127	TBD	TBD	U.S. Department of Defense	Redacted	Redacted
12128	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
12129	TBD	TBD	U.S. Agency for International Development	Redacted	Redacted
12130	Baylor College of Medicine Children's Foundation Malawi	Implementing Agency	U.S. Agency for International Development	GHCS (State)	1,125,227
12131	Christian Health	FBO	U.S. Department	GHCS (State),	1,195,000

	Association of Malawi		of Health and Human Services/Centers for Disease Control and Prevention	Central GHCS (State)	

Implementing Mechanism(s)

Implementing Mechanism Details

Mechanism ID: 7166	Mechanism Name: Howard University
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Howard University	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 3,950,000	
Funding Source	**Funding Amount**
GHCS (State)	3,950,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The primary objective of Howard University (HUTAP) activities in Malawi is to increase the Ministry of Health's (MOH) capacity to maintain and enhance its laboratory infrastructure in order to provide high quality HIV-specific as well as broader health services at the community, district and central health facilities levels. These programs will be guided by the experience and relationships HUTAP has built on the ground since 2003, and the training, human resource and infrastructure development, and quality assurance activities that are already in place.

Consistent with the purpose, principles and strategies outlined in the Partnership Framework, HUTAP's Year 2 (PFIP Year 2) activities will strengthen the national HIV care and treatment program in Malawi by providing technical assistance, procuring and placing laboratory commodities including equipment and consumables, building capability and capacity of laboratory service providers and institutions, and providing resources to support the scale-up and increased quality of the national HIV and AIDS response. In particular, HUTAP's activities to expand CD4 capacity in conjunction with adult and pediatric programs will improve the quality of treatment and care for Malawians affected by HIV (PF Goal II). In addition, continued, cross-cutting focus on training, quality assurance and infrastructural improvements will strengthen the diagnostic, treatment and surveillance capacity of the national laboratory system and

enhance provision of health services nationwide in ways that MOH can sustain over time (PF Goal IV).

The program's key contributions to health systems strengthening are inextricably linked priority areas for laboratory as defined by PEPFAR and the Government of Malawi, most notably the Malawi National Laboratory Strategic Plan (MNLSP) for 2009-2014, which HUTAP played a key role in developing.

HUTAP will implement these activities using a mechanism that aims to empower the MOH to take ownership of the process. HUTAP will also provide leadership to key stakeholders in aligning their activities and securing their commitment to work toward developing and sustaining a lab system with the high-quality diagnostic, treatment and surveillance capacity necessary to support a robust national response to HIV/AIDS in particular and national health care delivery in general.
Monitoring and evaluation of the implementation of Year 2 plans will be carried out to assure that set targets are met. The proposed family-centered ART Clinic at QECH will provide data on essential indicators for adult and pediatric HIV treatment. At the national level the M&E system will provide information to laboratories to better facilitate HIV testing for adults, pregnant women and infants. Data on pre-service and in-service training will form the basis for reports that we will be generating quarterly. Modifications to this database will allow for tracking of individual laboratory technicians and whether they are still actively utilizing the skills taught. Additionally, quarterly assessments of district hospital laboratories on their capabilities to provide essential quality laboratory services will be conducted, and quality assurance assessments will carried out bimonthly.

Under the Partnership Framework, we will undertake surveys, programmatic data review, and other forms of assessments to evaluate the effectiveness of the interventions to attained desired goals. HUTAP in collaboration with MOH and other partners will assess the effectiveness of the in service training and mentorship of laboratory technicians in improving, skills, competency and output. HUTAP will assess and determine the role of establishing and implementing a national laboratory quality assurance system in improving access and quality of care. We will also keep the nation of Malawi informed on monitoring the effectiveness of and threats to the ART program through the ongoing HIV drug resistance surveillance.

Completion and successful implementation of the National Laboratory Strategic Plan is crucial to the success of our goal and objectives, and HUTAP will support towards implementing of the plan in Year 2. Additionally, we will contribute to the overall HIV disease monitoring and strengthening Malawi's national response to HIV and AIDS through the HUTAP-supported epidemiologist and laboratory specialist placed in the national reference laboratory to provide on-site capacity building to their counterparts.

PFIP Year 1 Budget – $2,570,000
PFIP Year 2 Budget – $3,850,000

Cross-Cutting Budget Attribution(s)

Construction/Renovation	675,000
Human Resources for Health	350,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**7166**		
Mechanism Name:	**Howard University**		
Prime Partner Name:	**Howard University**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HTXS	235,000	

Narrative:

II. Budget Code – HTXS $235,000

More than 90,000 children in Malawi are living with HIV, and the vast majority was infected maternally. Without treatment, an estimated one in three infected newborns will die in their first year of life and one in two will die before the end of their second. According to UNAIDS, more than 90% of children acquire HIV during pregnancy, labor and delivery or through breastfeeding after birth. Increasing access to ART for pregnant women is thus one important element in fighting HIV/AIDS in children. However, very few women who are tested for HIV and are positive start ART.

The goal of HUTAP in PFIP Year 1 and 2 will be to develop the ART services at QECH and MCH into true family ART clinics. All health care workers will be trained in both adult and pediatric ART as well as aspects of ART for pregnant and post-partum women. This will make it possible for a single clinician to assist all family members on a single visit. The efficiency of ART services will improve when each staff member can provide ART care and treatment to patients of all ages and special groups.

In-Service Training-Addressed in OHSS-HRH budget code

Activity 1: Refurbishment
The current ART clinic at Queen Elizabeth Central Hospital (QECH) was opened in 2004 to accommodate 1,000 people. Currently, there are approximately 6,000 patients seen at the clinic and the number continues to rise steadily. Compounding the lack of space is the design of the building which obstructs patient flow, poor ventilation which increases the risk of transmission of infection such as tuberculosis,
and long lines and delays.

Year 1 funds will be used to expand the ART Clinic at QECH. This refurbishment project will create adequate space for patient registration and a waiting area, data management, and administration. Patient flow will be enhanced and the number of clinic rooms will be increased. Year 2 funds will be used to renovate and expand the existing ART clinic at Mzuzu Central Hospital (MCH) to provide family-centered ART and care.

Activity 2: Coordination of Diagnostic Testing and Referral Networks
In Year 2, this activity will focus on strengthening the laboratory infrastructure at EID sites as entry points for quality laboratory testing that would support all HIV/AIDS-related treatment and care. Currently, several of the sites are linked to PMTCT and ARV programs at district hospitals and rural health centers. Strengthen laboratory capacity at other service-delivery sites through expansion of quality-based CD4 and routine testing; improvement of transportation mechanisms to ensure timely and reliable reporting of test results; provision of reagents and supplies to close gaps in laboratory services; and acquisition of laboratory equipment.

Currently, the program is relying completely on a local courier service to transport specimens for PCR and CD4 due to the limited capacity for these referral sites to provide these services. Many of these sites still lack the capacity to provide routine, consistent testing services. In Year 2, HUTAP will assist the MOH to build and strengthen a CD4 network and to expand PCR testing to at least one more site.

Activity 3: Human Resources Support
Although ART services have been successfully scaled-up in Malawi, gaps still exist with respect to access to HIV care for children and pregnant women. One important reason for this is the shortage of skilled health care workers, particularly in government health facilities. In Year 1, HUTAP will address these shortages at the QECH ART clinic by hiring 4 Clinical Officers, 3 Nurses, 2 HIV Counselors, 1 Patient attendant, a Data Officer and Administrative Assistant. The additional staff will assist in improve the quality of services and increase access to ART particularly for infants, children and pregnant women at the clinic.

In Year 2-HUTAP will support the hiring an additional 8 staff (4 Nurses and 4 Clinical Officers to be placed at QECH and MCH as needed). HUTAP will retain the existing staff that was hired in Year 1 in Year 2.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	235,000	

Narrative:

I. Budget Code – PDTX $235,000.00

Until recently, the means to diagnosis HIV in infants <18 months old in Malawi was limited to research institutions. ART provision to HIV infected infants has therefore remained very limited, both country-wide and at Queen Elizabeth Central Hospital (QECH) in Blantyre and Mzuzu Central Hospital, the largest referral hospitals in the southern and northern regions, respectively and well-established HUTAP-supported sites. In PFIP Years 1 and 2, HUTAP will strengthen ART services at referral hospitals using a family centered approach to provide full-time coverage of pediatric ART and care. All current and new ART clinical officers and nurses will be trained in both adult and pediatric ART care as well as aspects of ART for pregnant and post-partum women. Similarly, activities will support the Essential Medical Laboratory Services (EMLS), for ARV and PMTC scale-up throughout Malawi. Labs supported by HUTAP will be linked directly to HIV service provision sites. This includes the central, district and health center level hospitals where testing and treatment are rendered. Effective sample transport mechanisms will be established to strengthen linkages for testing and treatment.

In PFIP Year 1 and 2, HUTAP will directly support these efforts at QECH and Mzuzu Central Hospital through the following activities:

In-Service Training-Addressed in OHSS-HRH budget code

Activity 1: Refurbishment

The current ART clinic at Queen Elizabeth Central Hospital (QECH) was opened in 2004 to accommodate 1,000 people. Currently, there are approximately 6,000 patients seen at the clinic and the number continues to rise steadily. Compounding the lack of space is the design of the building which obstructs patient flow, poor ventilation which increases the risk of transmission of infection such as tuberculosis,
and long lines and delays.

Year 1 funds will be used to expand the ART Clinic at QECH. This refurbishment project will create adequate space for patient registration and a waiting area, data management, and administration.

Patient flow will be enhanced and the number of clinic rooms will be increased. Year 2 funds will be used to renovate and expand the existing ART clinic at Mzuzu Central Hospital (MCH) to provide family-centered ART and care.

Activity 2: Strengthen Referral Networks
In PFIP Year 1 and 2, HUTAP will assist to improve access to ART for HIV positive infants and children. Many HIV exposed infants born at referral hospitals reside near health centers that provide Pediatric ART and Care. After receiving diagnosis, referral to their nearest health center for ART would be one of the most effective ways asure these children receive treatment. This would also reduce the waiting time for patients to be seen by a clinician at the referral hospitals and and ease the burden of staff who provide ART services at these sites. In order to assure access to ART at these centers, staff will require training in infant ART care. There will also need to be an effective system in place to assure patients who are diagnosed at the hospital are receiving treatment.

As HIV programs are increasingly decentralized, district and sub-district level diagnostic capacity will also need to be radically increased. HUTAP, in collaboration with other partners, will devise a transportation system to assure a reasonable turnaround time for CD4 and PCR results to enhance the linkages to care and treatment and to reduce the loss to follow up rate that is currently over 30% in PMTCT/Early Infant Diagnosis (EID) programs.

Activity 3: Human Resources Support
Although ART services have been successfully scaled-up in Malawi, gaps still exist with respect to access to HIV care for children and pregnant women. One important reason for this is the shortage of skilled health care workers, particularly in government health facilities. In Year 1, HUTAP will address these shortages at the QECH ART clinic by hiring 4 Clinical Officers, 3 Nurses, 2 HIV Counselors, 1 Patient attendant, a Data Officer and Administrative Assistant. The additional staff will assist in improve the quality of services and increase access to ART particularly for infants, children and pregnant women at the clinic.

In Year 2, HUTAP will support the hiring an additional 8 staff (4 Nurses and 4 Clinical Officers to be placed at QECH and MCH as needed). HUTAP will retain the existing staff that was hired in Year 1 in Year 2.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	1,000,000	

Narrative:

V. Budget Code - OHSS $1,000,000 (PF09 Funds)

Activity 1: Support the implementation of the laboratory pre-service curriculum
HUTAP along with a key laboratory partners including the Laboratory Consortium, laboratory tutors, technicians, and curriculum development experts, will review and update the laboratory pre-service curriculum. This activity will focus on HIV testing and molecular techniques as well as testing for HIV monitoring, treatment and identification of opportunistic infections (OIs) and supply chain management. The competency-based curriculum will be designed to address gaps that will be identified from a needs assessment, and a series of curriculum review meetings that will take place in Year 1.

All pre-service activities will be done in collaboration with other USG funded partners including the Laboratory Consortium and JSI. HUTAP will focus its efforts on the Malawi College of Health Sciences while the lab consortium will focus on Malamulo College of Health and the College of Medicine. Both partners will hire a mentor and a local counterpart that will be based at the teaching institutions to assure that the implementation and monitoring of activities are carried out successfully. Each partner will procure the necessary equipment and supplies to support the practical training component. Prior to the implementation of the updated curriculum a training of trainers and clinical instructors on the new curriculum content, educational methodology and curricular implementation including an assessment plan will be carried out by partners. HUTAP will provide training on curriculum implementation, and technical content and the lab consortium will provide training on Good Clinical Laboratory Practices including lab management, quality assurance, lab safety and ethics. JSI will assist in developing the curriculum content and training in Supply Chain Management.

Activity 2: Support Lab Assistant Pre-service Training Program
HUTAP will support the Lab Assistant program at Malawi College of Health Sciences. The Lab Assistant Program is an 18-month program designed to train a cadre of health practitioners to perform basic lab testing in rural health centers and other underserved facilities. During the program, students undergo a 6-month orientation at MCHS followed by 12 months alternating lectures and clinical attachments to district and central hospitals. During Year 1, HUTAP in collaboration with the MOH, CHAI, and other partners will review and update the curriculum that was developed in 2008, strengthen the infrastructure at the lab training schools including procurement of equipment, teaching and learning materials, and hiring additional tutors/staff to assure capacity to provide instruction to the students. In Year 1, HUTAP will begin the recruitment process which will involve advertising for prospective students to apply to the program, interviewing and selecting students. With Year 2 funding, HUTAP will support the enrolment of 25-30 students to the program. A 6-month orientation program which encompasses lectures and basic laboratory skill training will be provided to the students. The updated curriculum will be implemented and on-going program assessments will be conducted. Clinical attachments will be coordinated with high

through put labs in central and district hospitals to provide optimal hands on experience. Funding will support the recruitment, student orientation sessions, training, supervision, lab and teaching supplies, reagents, equipment, vehicle for transporting staff and students, allowances and accommodations for students while on clinical attachments, and staffing support to provide classroom and clinical instruction.

Activity 3: In-Service Training
In Year 1, HUTAP will build the capacity of laboratory staff in HIV diagnosis and disease monitoring. Analyzer trainings will be conducted quarterly to cover topics such as HIV Rapid Testing, ELISA, Flow Cytometry and CD4 enumeration, PCR, and OI diagnosis. This activity will target laboratory technicians who are working at PEPFAR supported laboratories and from other laboratories linked to HIV service delivery sites. Two PCR trainings will be conducted in Year 1 for laboratory staff providing EID. With Year 2 funding an additional two PCR in-service trainings (new and refresher) will be conducted for 20 lab technicians. Four CD4 trainings, and four analyzer trainings targeting hematology and chemistry will be conducted during Year 1, and eighty lab technicians will receive in-service training in Year 1.

In Year 2, increased funding will allow HUTAP to build on its achievements in Year 1 where an additional 80 lab technicians will receive knowledge and skills updates through in-service training. In an effort to attain high quality ART services at QECH, refresher and certification courses on ART and care for HIV infected children and infants will be conducted in Year 1 biannually and will target 50 nurses and clinicians from QECH and the surrounding Blantyre district in Year 1. In Year 2, this program will be expanded to train 100 staff (Clinicians, Nurses, and Counselors) from ART clinics in the southern and northern Regions.

Activity 4: Human resource support
During Year 1 and Year 2, HUTAP will retain two laboratory tutors at the Malawi College of Health Sciences to assist with the implementation of the updated pre-service curriculum and to provide supervision and training of students at designated clinical training sites.

Activity 5: Develop an Incentive Program for Clinical Staff
As an incentive and motivation strategy, HUTAP will support short-term training for ART staff at QECH in Year 1. QECH staff in collaboration with HUTAP will identify courses offered locally (in Malawi) for ART clinic employees to upgrade their knowledge and skills. In exceptional cases, in Year 2 HUTAP support will be provided for staff to pursue short courses, workshops or conferences offered in another country within the region.

Activity 6: Provide Internships for Medical Lab Science students
In an effort to retain medical laboratory science graduates placed at referral hospital laboratories, an

internship program was implemented in FY08 for top graduates of the laboratory training programs. Seven graduates, selected on the basis of performance, received advanced training at Kamuzu Central Hospital and Queen Elizabeth Central Hospital in PCR, CD4, hematology and chemistry. This program has proven highly successful and will be expanded In PFIP Year 1 and 2 to allow exceptional students to gain experience in all aspects of laboratory services. Students will also be required to rotate in central hospital and reference laboratories as well as research labs to gain advanced training in experience in research, molecular techniques, QA and management.

Activity 7: Provide Mentoring and Training for Laboratory Supervisors
In Year 1, HUTAP will collaborate with MOH and partners to implement the WHO AFRO Laboratory Management Towards Accreditation (SLMTA) program to prepare laboratories for accreditation. This program will focus on training and mentoring laboratory supervisors and managers from central and district hospitals in quality assurance, supply-chain management, preventive maintenance of equipment and documents and records management. Through this training and mentorship, supervisors will be able to manage the laboratory more efficiently and to assure accuracy and quality in testing results. Supervisors will be trained to oversee quality assurance programs instituted for HIV testing. By the end of Year 2, at least two laboratories in central and district hospitals will achieve accreditation.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	1,100,000	

Narrative:

1. PMTCT Budget Code Narrative ($1,100,000.00)

Activity 1: Lab Systems-Quality Assurance (QA) and Point of Care Technologies

Assuring accuracy and reliability of HIV related testing is of paramount importance in the diagnosis and treatment of pregnant women, children and the adult population. With additional funding, HUTAP in collaboration with the MOH National Reference Laboratory at CHSU, the Diagnostics Division in the MOH Community Health Sciences UNIT Central Reference Lab (CHSU) and other laboratory partners will strengthen and expand the existing QA programs for HIV Whole Blood Rapid Testing, CD4, PCR and routine laboratory services. Through existing funding, HUTAP supports an HIV Lab supervisor based and the National Reference Laboratory at CHSU whose major responsibility is to coordinate and supervise the scale-up of HIV WB rapid testing and CD4 QA nationally. With the additional funds, HUTAP will provide support to strengthen the infrastructure of the NHRL through refurbishment and procurement of equipment and supplies, hire additional staff, conduct refresher and new training courses, develop standard operating procedures and QA guidelines.

Quality CD4 testing, as opposed to WHO staging, of pregnant women allows for more HIV-infected women to be initiated on ART and therefore the need to improve access to CD4 testing in the district and rural areas. HUTAP will also support the training of the testers through refresher courses and the purchase of QC materials and proficiency testing (PT) samples for all CD4 platforms currently available in Malawi with an emphasis on the NHRL. Between 2007 and 2009, HUTAP enrolled a total of 25 Government and Christian Health Association of Malawi (CHAM) laboratories in either the UK National External Quality Assurance Scheme (UKNEQAS) from United Kingdom or African Regional External Quality Assessment Scheme (AFREQAS) from South Africa. One of the major barriers to assuring quality testing at these sites is due to the frequent breakdowns due to the age and use of the machines. With additional funding, HUTAP will upgrade 4 CD4 machines to percentage capabilities that are attached to the CD4 EQA program. Additionally, we will support the infrastructure at the NHRL at CHSU to become the hub for the CD4 QA program. HUTAP will procure additional fridges, freezers and equipment needed as to enhance CHSU's ability to prepare, store, distribute specimens and administer proficiency testing (PT) for CD4 testing nationally.

Infants of HIV-infected mothers identified through rapid testing at ANC sites are referred to Early Infant Diagnosis (EID) for DNA-PCR testing. HUTAP has been supporting the EID component of the PMTCT program in Malawi and with additional funding will expand the DNA-PCR testing to the referral hospital in the Northern Region of Malawi where it has just refurbished the laboratory. HUTAP will procure quality control (QC) materials to support implementation of the current DNA-PCR quality assurance protocol that requires retesting of all specimens that produced an initial positive result. Funds will also support the shipment of DBS samples and PT results through a major courier to CDC Atlanta. Additionally, HUTAP will build the capacity of the NHRL through refurbishment and procurement of equipment for PCR testing to establish CHSU as the QA focal point for DNA PCR and viral load testing for the country.

HUTAP will collaborate with the Malawi Laboratory Consortium in conducting feasibility studies on the use, cost benefit analysis, and efficiency of Point of Care Technology for CD4 and PCR testing for use in the rural health care setting. This technology will bring critical laboratory services directly to patient care without relying on the need for courier systems for sample transport and extensive training, equipment and service contracts. With this funding, HUTAP will focus its efforts in these studies to the Northern region which it will be supporting through existing funding to strengthen laboratory services and implement activities.

Activity 2: Sample Transportation and Referral Systems

Currently, the PMTCT program is relying on a local courier service and ambulances and other modes of transport to transport samples for EID (DNA PCR) and CD4 to the referral laboratories due to the lack of a cost-effective, consistent and reliable national sample transportation and referral mechanism. Many of these sites still lack the capacity to provide routine and reliable testing services. Moreover, several of the sites offering PMTCT and ART services have weak systems in place for referring patients for care and treatment due to weak follow-up programs and slow turnaround time for test results once the specimens

are sent to these laboratories.
HUTAP in collaboration with the MOH and other partners will implement a comprehensive sample transportation and referral system with scheduled pick-up and drop off of samples from all health facilities using a phased approach. Initially, the program will be established in one region. HUTAP will support the procurement of start-up equipment such as vehicles, motorcycles, uniforms, helmets, and specialized cooler boxes and devices to transport specimens as well as expand its office space to accommodate and manage program operations. HUTAP will also hire and train staff to manage the program and on the use of sample transportation and bio-safety. Funds will also be used for vehicle maintenance, fuel, and other logistics costs. The drivers and equipment will be absorbed into the MOH at the end of the funding period. Lessons learned from the initial scale-up of the program will be used to inform the MOH on the rollout of a nationwide sample transportation system that the MOH can sustain over time.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	1,380,000	

Narrative:

III. Budget Code – HLAB ($2,350,000)

With the scale-up of ART, EID, PMTCT, HIV counseling and testing (HCT), TB/HIV and malaria services, laboratory service to support these programs have increased in scope and complexity. Through PEPFAR Year 1 and Year 2 funding, HUTAP will provide assistance in strengthening lab services in Malawi through pre-service and in-service training, building human resource capacity through staffing and mentorship programs, Quality Assurance (QA), and creating an enhanced laboratory infrastructure to support CD4 and other tests for HIV diagnosis and disease monitoring.

Activity 1: Refurbish of Laboratories at Central and District Hospitals
In FY08, HUTAP in collaboration with CHAI, Roche and the MOH renovated the Mzuzu Central Hospital (MCH) laboratory to provide PCR/Viral load testing in support of EID and other HIV services. There is now an EID testing hub in each of Malawi's three health regions. Using a tiered approach, HUTAP will complete the refurbishment of Mzuzu Central Hospital Laboratory to expand the lab capacity to provide basic lab services including CD4, Chemistry, Hematology, TB Microscopy and Cultures in Year 1. In Year 2, HUTAP will complete the refurbishment of 4 district hospitals in the Northern region, thereby establishing distinct capacity for services, protocols and communication at the central, district and community levels. This will enable stronger provision of laboratory services, from building high-level leadership, management and supervision down to providing more accessible and high quality care for patients. HUTAP will particularly target EID sites that are entry points for quality laboratory testing that would support all HIV/AIDS-related treatment and care.

In Year 2, HUTAP will expand EID lab services to Zomba Central Hospital through renovations and expansion of the existing lab. These activities will be complementary to the renovation activities being conducted by the USG-funded Laboratory Consortium.

Activity 2: Implement and Monitor Quality Assurance (QA) programs for HIV-related Testing
Using Year 1 funds, HUTAP will increase the capacity at government, mission and Malawi Defense Force (MDF) hospital laboratories to carry out quality HIV diagnosis and disease monitoring by establishing national quality assurance programs for HIV, CD4, and PCR testing at 35 sites. During Year 2, this activity will be expanded to all ART sites (52) that provide HIV testing and disease monitoring. Funds will support enrollment of sites in External Quality Assurance (EQA) Programs, supervision, and logistics. This activity will be done in collaboration with the MOH National Reference Laboratory which has the mandate for implementing laboratory QA programs in Malawi.

Activity 3: Human Resource Support
With Year 1 funds, HUTAP will retain three lab technicians and one EID laboratory coordinator to assist with the scale-up of EID laboratory services. HUTAP will also support in building the capacity of their staff to assume these roles by Year 2 through mentorship and technical and leadership trainings in Year 1. HUTAP, in consultation with the, will determine the need to support these positions in Year 2 based on results from program assessments and staffing needs. An HIV epidemiologist and lab supervisor are placed in the MOH in an effort to strengthen the Malawi Community Health Sciences Unit which houses the National Reference Laboratory and disease surveillance units. These positions will continue to be funded In PFIP Year 1 and 2.

Activity 4: Procurement of Reagents and Supplies, and Provision of Service Contracts for Equipment
HUTAP, in collaboration with CDC, UNICEF, and the Clinton Foundation will continue to support the MOH in building the capacity of laboratories to provide testing services for HIV diagnosis and disease monitoring. Reagents and other consumables will be procured through HUTAP and the Clinton Foundation to supplement orders currently procured by the through the Global Fund and other pooled donors during Year 1. HUTAP will also work with the MOH in collaboration with JSI DELIVER to strengthen lab supply chain management and to assist with system design and training for a more effective program. In Year 2, HUTAP will provide support for additional resources only when gaps exist which will interrupt service deliver.

HUTAP has supported the over the past five years in maintaining equipment through the provision of service and maintenance contracts. As more equipment is procured it will be necessary for the MOH to maintain the current agreements and purchase new ones as needed. In Year 1, HUTAP will support the

MOH to provide contracts for 11 BD Facs count analyzers, four Chemistry analyzers, and two EPIC Flow cytometers. With Year 2 funding, HUTAP will provide funds for service contracts on additional equipment as required.

Activity 5: Support the development and implementation of the National Laboratory Strategic Plan
The development of greater laboratory capacity in resource poor countries is an urgent need, as clearly stated in the 2008 WHO Maputo Declaration on Strengthening of Laboratory Systems, developed by consensus at a large meeting of government and international partners. This Document appeals to national governments to prioritize support for laboratory systems through implementation of a National Strategic Laboratory Plan that integrates laboratory support for the major diseases of public health importance including HIV, tuberculosis, and malaria. HUTAP is committed to play an instrumental role in developing and implementing Malawi's National Lab Strategic Plan (NLSP) during Year 1 and Year 2 through hosting meetings in collaboration with MOH to review, update and disseminate the plan to stakeholders.

Activity 6: Strengthen the Malawi Defense Force laboratory service
The Malawi Defense Force (MDF) plays a pivotal role in providing health care services not only to its uniformed cadres and their families, but also to the large civilian communities in its catchment areas. The MDF has one central laboratory at the Kamuzu Barracks in Lilongwe and three regional laboratories in the southern, central and northern regions.

USG through the Department of Defense has worked with the MDF on strengthening their HIV-related laboratory through providing critical equipment to support HIV diagnosis, CD4 monitoring, and basic chemistry and hematology as well as TB and malaria diagnosis. In addition, USG has provided technical support to MDF in making its service provision more cost effective through standardization and integrating it into the national laboratory strategy.

In Year 2, USG will scale-up its support to the MDF at all four high through-put labs by providing physical infrastructure improvements, training relevant staff, and establishing a network between the MDF institutions and public and private institutions that would assure the quality and reliability of test results. The training efforts and the utilization of common Standard Operating Procedures (SOP) between the Ministry of Health and the MDF facilities will assist in integrating health service delivery as the MDF will be providing services to populations that are not reached by the MOH.

These objectives will be carried our by implementing the following activities:
Activity 1: Develop an appropriate assessment tool and conduct a rapid assessment of physical and programmatic laboratory needs of the four MDF institutions. Develop a plan for program implementation

Activity 2: Based on the assessment make relevant repairs and physical space improvements to support the laboratories Activity 3: Provide in-service training and mentorship for 16 medical laboratory technologists from the 4 institutions Activity 4: As a special focus area of training, develop a training and mentoring program for CD4 testing and QA at the 4 institutions Activity 5: Establish a laboratory quality assurance network between the 4 institutions and public and private laboratories that would include enrollment and integration in international and national EQA program for critical tests performed in these institutions

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9257	**Mechanism Name: NTP TB**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Ministry of Health/NTP	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This mechanism is zero funded in FY2010 but is contributing to FY10 APR Targets. For all activities please see the new MOH Template

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9259	**Mechanism Name: UNC MDF PMTCT**
Funding Agency: U.S. Department of Defense	Procurement Type: Grant
Prime Partner Name: University of North Carolina	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

DOD will complete PMTCT training for the MDF using previously approved PEPFAR funding. The Malawi Defense Force (MDF) is the only military force in the country. Under the authority of the Army Commander, the MDF is composed primarily of army units, but has a marine unit and an air wing. Currently smaller than the authorized strength of 10,000, the MDF is a highly professional and apolitical force and customarily earns praise for its performance, conduct, and contributions when participating in regional military exercises and training with U.S. troops. The annual military expenditure is $11.2 million, which is approximately 0.73% of GDP and 2% of the national budget.

The MDF operates in a unique HIV/AIDS environment when in Malawi and in diverse HIV/AIDS

environments during peacekeeping and humanitarian operations. Understanding such environments is of paramount importance when considering the risk exposure of soldiers and their dependants. Due to the fact that the MDF is largely located in the urban areas, its prevalence rate is estimated to be closer to that of the urban population. Available data shows that urban prevalence rate is 22.83% (NAC 2003) and 20.8% (GOM/MOH, 2003). Based on this data the MDF's Strategic Action Plan assumes the possible HIV prevalence rate for the MDF ranks between 20-25%.

Summary

Implementation of the USG plan in Malawi is a model of excellent partnership and collaboration, with sharing of tools and approaches at all levels. In this activity, DOD is expanding its role as a provider of prevention services to the Malawi Defense Force (MDF) by strengthening the PMTCT programs at 6 MDF bases, through partner University of North Carolina (UNC). PMTCT is a key linkage to DOD's AB and other prevention activities.

This is an initial PMTCT program area for the MDF
• The target populations for this activity are spouses of MDF servicemen in all units and civilians in surrounding villages that are usually serviced by MDF's medical facilities.
• University of North Carolina (UNC) will be the prime implementer the project
• PMTCT (MTCT) activities are aimed at preventing mother-to-child HIV transmission including counseling and testing for pregnant women, ARV prophylaxis for HIV-infected pregnant women and newborns, counseling and support for maternal nutrition and safe infant feeding practices.
Linkages

Implementation of PMTCT plan in MDF will be a model of collaboration, sharing tools and approaches to the extent that the MDF would use resources from already existing HIV programs like AB and C. For example, external local FBOs/CBOs are reproducing the kit messages and materials developed by partners which will continue to be used and scaled up by other groups. Another key linkage between AB and other prevention activities programs is the introduction of the PMTCT update pack in the community activities. The PMCTC pack by BRIDGE for example is designed to generate dialogue and positive support among communities for a spectrum of behaviors, including assessing information to understand the risk of contracting HIV, encouraging young women to know their HIV status and support towards HIV testing during pregnancy.

Background

According to statistics provided through UNC, 98% of Malawian women attending their first antenatal care

visit accept HIV testing. 15% are HIV-positive and all accept nevirapine prophylaxis (NVP). UNC provides services to over 20,000 women a year and is estimated to prevent transmission of HIV to over 2,500 babies per year. All exposed infants are given NVP prophylaxis and are followed up for 18 months. UNC's PMTCT program provides almost half of all PMTCT services offered in Malawi.

UNC's primary mission is to identify innovative, culturally acceptable and relatively inexpensive methods of reducing the risk of HIV and STD transmission through research, strengthen the local research capacity through training and technology transfers, and to improve patient care for people living with HIV and AIDS. In addition, PMTCT training will address issues of intergenerational and transactional sex as well as DOD's Other Prevention activities and Abstinence and Being Faithful activities.

The MDF has two sites providing antenatal and delivery services, Cobbe Barracks in Zomba and Kamuzu Barracks in Lilongwe. In addition, MDF provides antenatal services only at Chilumba garrison in Karonga, the Marine Unit in Mangochi, the Combat Support Battalion in Dowa, and the Malawi Armed Forces College (MAFCO) in Salima. MDF has plans to establish labor wards at the MAFCO and Combat Support Battalion clinics. All these sites are serving large civilian populations surrounding the facilities because government hospitals are not within reach. Since the MDF supports civilians in the surrounding communities, Ministry of Health (MoH) assigns at least one nurse or clinical officer in clinics that provide such services.

PFIP Year 1 Budget – $60,000
PFIP Year 2 Budget - $0

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Military Population

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9261	**Mechanism Name: Baobab**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Baobab Health Trust	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,325,000	
Funding Source	**Funding Amount**
GHCS (State)	1,325,000

Sub Partner Name(s)

Luke International Norway	Pfizer	

Overview Narrative

Background

Baobab Health is a local Non Governmental Organization (NGO) dedicated to improving the delivery and management of HIV/AIDS care in Malawi through continued development, enhancement and support of information systems used in real-time by clinicians at the point of care. Baobab has been working with the Ministry of Health (MOH) to design and deploy medical informatics to resource poor settings. In Malawi, paper-based registers have traditionally been used to record patient/client data. This data is commonly transcribed and subsequently manually aggregated by staff with little or no training in medicine or clinical terminology.

Baobab's strategy has been to improve data quality and to replace traditional paper-based data collection with point-of-care systems. The core of Baobab's approach is the installation of easy-to-use touch screen clinical workstations at the point of patient care. This system efficiently and accurately guides health care workers through the diagnosis and treatment of patients according to national protocols. The system also captures timely and accurate data that is used by health care workers during patient visits, which

supplements decision making. The data is aggregated and used at a national level for policy-making and analysis.

HIV-AIDS also has a major impact on the paper records in clinics. Some clinics have over 5000 patients and district hospitals often more than 1,500. This increases the workload and the possibility of data errors at clinics. Baobab's Electronic Point-of-Care Data System (EDS) facilitates data processing at patient, clinic and national level. Baobab trains health care workers to use the system and provides support for maintenance.
Baobab has done a proof of concept and deployed at 5 HIV sites, it can now be rolled out nationally on demand of the Ministry of Health (MOH) – HIV-AIDS unit.
Baobab system will be deployed mainly in the Southern region of Malawi due to the higher HIV incidence. Baobab partners with Luke International Norway in the Northern region, and continues to strengthen activities in the central region.

In the current Baobab system clinics, there is an opportunity to increase the system's breadth by adding software modules: e.g. TB, Malaria, Pharmacy, etc.
All Baobab activities are aligned with MOH objectives, and Baobab is working with the HIV unit and Central M&E Department (CMED). Baobab has proposed a framework to prioritize HIV sites for implementation over the next 5 years. Baobab will start scoping the central data repository for Malawi.

Overall Goals & Objectives are in line with the PEPFAR Partnership Framework and the National Action Framework:

1) Improve the quality of treatment and care for Malawians impacted by HIV - PEPFAR funds will support Baobab to roll-out the HIV-EDS system, so that more patients will be able to benefit from the follow-up and care support given through the EDS.

2) Cross Cutting Systems strengthening by improving Health Information Systems - The EDS provides better data for overall M&E for the national ART-program, to support ART drug-procurement, and to support reporting needs of the MOH HIV-AIDS unit. EDS supports the implementation of MOH protocol and contributes to a higher standard of care in each EDS-site. As more sites become active on EDS, Baobab will ensure patient data sharing between sites. The objective is to create a national central repository at the MOH, which would contain all patient data, collected on EDS.

Three primary activities will be supported:

1) To Improve HIV-AIDS Patient Care through EDS development Baobab will continue to:

i) roll-out of EDS installation; ii) collaborate with MOH/CMED; iii) develop an EDS for T&C (MACRO); iv) strengthen its software development team to improve current modules.

2) To build robust monitoring and evaluation capabilities:
The EDS supports delivery of cohort reports for the MOH, informing drug forecasting and procurement decisions and providing information to the MOH and District Health Officers.

3) To build indigenous capacity in medical informatics and a mentoring centre
Being a leader in the information technology, Baobab will continue building capacity within the MOH and support HIV clinics to move to an electronic data system. Baobab will share its know-how with stakeholders, nationally and internationally.

Overall Project Sustainability:
The long term goal of the MOH is to have ART EDS in all high-burden sites over a period of 5 years (2010 – 2014).

The installation of the ART EDS-system (software development and initial deployment at ART-site) and maintenance for year 1 is funded by CDC (and others). When deploying the system at a health-care site, a Memorandum of Understanding (MOU) will be drafted, in which the site commits to carrying part of the maintenance costs for ongoing years. Basic technical expertise will be taken on by MOH over time. However, it is mandatory that hardware and software are maintained at high quality level, to ensure that data are captured for each patient at every visit. When maintenance is handed over, it must be ensured that the MOH can really commit to maintaining the system, so that the initial investment made by donors can further be built on.

The protocols followed in the EDS are all provided by the MOH and there is a very close collaboration between Baobab and MOH. Baobab is a permanent member of the Data Standard Working Group and takes the lead to develop a 'concept-dictionary' – and will continue to work on a national unique patient identifier.

In partnership with other donors, Baobab is developing an in-patient diagnosis and outcome module and a diabetes and hypertension treatment and follow-up module. Baobab is working towards cooperating with other donors for peadiatrics and maternity healtcare. Other international donors interested to use the Baobab system are Dignitas in Zomba, MSF France and MSF Belgium. Baobab has further formed a public/private partnership with Pfizer.

Year 1 Budget – $1,000.000

Year 2 Budget - $2,000.000

Cross-Cutting Budget Attribution(s)

Human Resources for Health	430,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9261**		
Mechanism Name:	**Baobab**		
Prime Partner Name:	**Baobab Health Trust**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	HVSI	200,000	

Narrative:

Budget Code – HVSI

Year 1: $200,000

1. With PFIP Year 1 funding, the Baboab system will be installed in 7 ART sites, 2 general health sites and 3 HTC sites (+ a mobile HTC system). The quantity of data of these high burden sites is very high and an EDS will help facilitate the gathering of data, analysis and aggregation of data at patient level, Clinic level, district level and eventually nationally at the MOH-level.

To build robust monitoring and evaluation capabilities, Baobab will support the delivery of cohort reports, for the MOH, informing drug forecasting and procurement decisions.
? Provide and develop M&E capabilities within BART software tools
? In close cooperation with the MOH – HIV-AIDS unit the EDS will be adapted to the changing needs of the MOH. For example, the master card may require other fields of information, more detail, or other aggregated data. It is Baobab's aim to work closely with them to address the need of change in software.
? Develop a supervision tool to more easily and interactively supervise the EDS sites

? This is a software tool that will be deployed on the touch screens and used at supervision missions, to help understand and analyse the data captured (at traditional sites, supervision happens manually which is time consuming and is prone to errors).
? Start scoping the central repository framework
? The main task will be to canvas the needs of the stakeholders. MOH, CDC, CMED and look at realistic objectives and targets of this central repository. In cooperation with LIN, a first draft on the technical characteristics will be drawn up.
? Reports
? Baobab will continue to work closely together with those people receiving reports, e.g. hospital directors, District Health Officers (DHO's), MOH to ensure that the EDS-reports are addressing their information needs.

With Year 2 funding, Baobab system will be installed in 10 new sites and provide maintenance services in 12 sites supported by Year 1 funding.

Year 2: $400,000
To build robust monitoring and evaluation capabilities, Baobab will support the delivery of cohort reports, supporting the Ministry of Health with drug forecasting and procurement decisions. By using the EDS at burdened ART-clinics, we will help to collect qualitative and reliable data and can aggregate and analyse them in a short space of time. These figures help the clinic and the District Health Officers to deliver results to the MOH in a timely and qualitative way.

Activities include:
? Provide and develop M&E capabilities within the BART software tools
? This will consist of more reporting modules, based on expressed needs from users. At a care level (nurses), clinic level and national level. The aim is to work on a national system that is similar in every site. No individual requests will be adhered to unless; it has the support at national level.
? Specific to the ART cohort reporting – Baobab will continue to improve the cohort-reporting and further improve on presenting relevant data in a better way.

? Strengthen the supervision tool for supervising EDS sites
? As more sites start using the EDS, the system supervision tools will be further developed and improved.

? After initial set-up of framework for the central repository, initiate the installation at MOH – HIV-AIDS unit.
? Malawi will continue to have more and more sites that use a system of electronic data-collection,

although the MOH encourages standardisation between the systems, there are differences but there is also a need to easily aggregate and analyse all this data. Baobab will take the lead, in close coordination with the MOH HIV-Aids unit, to explore the development of the architecture for a central data repository. Other relevant partners will be participating in this process.

? Start the process of transfer knowledge from Baobab to MOH, for strengthening internal M&E capabilities.
? For the sustainability of the project, the MOH will identify staff members who will become involved in the day-to-day management of the EDS-sites. The software development is deemed too specific, but overall maintenance and support will over time, become a responsibility of MOH

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	800,000	

Narrative:

OHSS – Health Systems Strengthening

Year I: $800.000

To Improve HIV-AIDS patient care, Baobab will continue to roll-out the installation of the EDS (Electronic Data System) to more sites, in line with the vision of the MOH HIV-AIDS unit.
The sites are chosen based on a number of criteria in coordination with MOH- HIV AIDS unit.
? Further development of BART software, in line with MOH requirements
? The MOH has institutionalized the mastercard as the main data-sheet on which all basic and necessary patient data are recorded to follow-up the evolution of a patient. Any changes in the mastercard, warrants changes in the EDS software.
? Support of current 5 BART sites (Lighthouse, Martin Preuss, Dedza, Salima District hospitals and Queen Elizabeth Central Hospital)
? Installation of BART in 2 high burden sites of more than 1500 patients, in line with requirements of HIV-AIDS unit. A module to select sites, based on a number of criteria will be deployed to objectively choose the most needing sites.
? Cooperate with LIN in the North (maintenance of 5 EDS-sites in the Northern Region: Mzuzu (2), Karonga, Nkhata Bay and Rumphi)
? Develop and install HIV Testing and Counseling(HTC) software module for clinic use at MACRO in Lilongwe, Blantyre and Mzuzu
? The system will allow for the testing records to be confidential rather than anonymous;
? This includes training of MACRO staff and upgrading the hardware systems.

? Develop a software module for a mobile-device that can be used to record routine patient data while testing in the field. Baobab will deliver a prototype application and hardware for testing by one MACRO field team (maximum 3-4 mobile devices).
? Maintain the outpatient diagnosis module installed at 2 sites (CMED) Ngoni and M'bangombe, which are sites off the electricity grid. Baobab is working with wind and solar energy to keep the EDS running. Baobab will now move into the second year on these sites.
? Initiate the use of electronic mastercard at all BART sites (replacing the current manual mastercard). The overall benefit of this is to reduce the workload of the overburdened nurses and health care workers)
? Work together with LIN to explore using HL7 messaging, to support interoperability between systems, to the benefit of national data-collection/data warehousing.

2) To build indigenous capacity in medical informatics and build a mentoring center
Baobab will build capability within the MOH and Baobab to support HIV clinics to move from a paper system to electronic.
? Hire and train 7 new Baobab staff. Baobab hires and trains its local staff to ensure sustainability and capacity of the system on the ground. This includes: data manager, software developer, trainer, network technician and a senior hardware supervisor.
? Train approximately 30 (new) health care staff on EDS and re-train 65 health care staff. The success of the system is completely reliant on the day-to-day use by the nurses/health care workers. Training is therefore a highly important element in the installation of the EDS at a site.
? Train staff at MACRO on static system
? Training in 3 locations, with the objective to hand-over some of the technical knowledge to IT-staff on site. Over time, MACRO will be responsible for its own day-to-day maintenance. Baobab will remain responsible for the development of software.
? Work closely with and train MOH HIV-AIDS unit supervision staff on EDS
? Every quarter a team of MOH-staff visits every ART site, as well as EDS ART sites, to counter-check the accuracy of the data reported. As EDS- reports are gathered on the system, training needs to be given to this team, so they feel comfortable analysing the accuracy of the EDS data
? Share knowledge nationally and internationally
? Attending relevant conferences in which we showcase the Baobab EDS system
? Brown-bag lunches at Baobab office – sharing of knowledge from different partners and stakeholders through informal presentations. Some of these are attended by external partners/ interested people or colleagues from the health-care sector who want to learn more about the EDS.

Year II: $1,600,000
To Improve HIV-AIDS patient care, Baobab will be working with the Ministry of Health HIV-AIDS unit to roll out the Baobab ART (BART) system from 2010 – 2014. Activities include:

? Further development of BART software, in line with MOH requirements, this entails upgrading the system to reflect changes in master-card, changes in what data to capture.
? Support of current 7 BART sites (and work with BART sites installed with other donor-monies)
? Installation of BART in 7 new high burden sites >1500 patients (sites indicated by MOH – HIV-AIDS unit)
? When installing a system, much time is dedicated to ensure that the ownership of the system lies with the sites and MOH. So, the selection of a site and the initial communication prior to the installation is crucial to the success of the EDS.
? Cooperate with LIN in the North (maintenance and upgrade of 5 EDS-sites in the North)
? Roll-out the Counseling and testing module to 3 more MACRO sites and maintain 3 current sites (Zomba, Kasungu and Karonga) train MACRO staff
? roll-out mobile device (50 sets) with technical and practical support from MACRO
? Macro has a large field team, which does testing and counseling. They are in need of a mobile system, in which they can collect the data at point-of-care, and can submit the data to the 'server' for aggregation of data.
? This includes training of MACRO staff + hand over of technical knowledge on the mobile devices.
? Maintain the outpatient diagnosis module installed at 2 sites (CMED)
? Upon agreement of needs – further develop features.
? continue and reinforce the use of electronic master card at all BART sites
? through refresher training courses, regular checks and quarterly cooperation on cohort reporting
? Continue to collaborate with other partners of MOH to roll-out BART (e.g. MSF, CHAM, MACRO)
? Develop a pharmacy management software module, which can better register not only ART-drugs, but also general drugs available at ART-clinics.
? Work together with CMED and the national data standards workgroup to develop a national unique patient identifier
? Integrate the current Baobab ARTsystem (BART) with Open Medical Records System MRS, to increase the interoperability between different systems.

2) To build indigenous capacity in medical informatics and build a center of excellence:
Baobab will build capability to support HIV clinics to move from a paper system to electronic.
Activities include:
? Hire and train 10 Baobab staff, in software development, software support, training, project coordination, technical networking, connectivity, data management, stock management, support staff and others.
? At times consultants are brought in to train on new areas of expertise. It is envisaged that there will always be a transfer of knowledge with each consultant.
? Train approximately 100 (new) health care staff on EDS and further train 100 current health care staff.

? Train MACRO staff on usage of static and mobile system
? Work closely with and train MOH HIV-AIDS unit supervision staff on EDS supervision tools
? Share knowledge nationally and internationally
? see above
? Attend national and international conferences on Information Technology.
? Baobab is planning to hold a high level workshop to showcase the baobab system to all relevant stakeholders, to increase the interest in the system.
? Promote the simple, robust and user-friendly EDS Baobab developed in cooperation with MOH and CDC, so that other countries might benefit from learnings gathered in Malawi.
? Work with CMED and co-chair the national standards Task Force (leading the policy making on patient identifiers, central repository and collaboration with HMIS-stakeholders)
? Continue to liaise with international organizations such as WHO, Partners in Health, who are interested in use-cases of information technology world-wide. As it leads to overall better data-quality, and in Malawi, support of better patient care.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	325,000	

Narrative:

PMTCT Budget Code Narrative $325,000

Activity 1: Provide and develop M& E capabilities for PMTCT within the current EDS software modules

In close cooperation with MOH and key partners including Lighthouse, the current BART module will be adapted to suit PMTCT-specific needs. This will include capturing medical data of pregnant women (HIV-positive) throughout pregnancy, delivery and post-natal period. Ensure that the PMTCT module can deliver reports in line with MOH requirements for those sites where EDS is available including tracking defaulters, loss to follow-up, linkages between child and mother, and linking patients to other services

Activity 2: Mobile solution for follow-up of pregnant women to reduce loss to follow-up

Develop an application for a mobile handset to be used by healthcare workers to help remind women about their next ART clinic visit. This service will also help identify PMTCT candidates and will support follow-up throughout the treatment by sending messages prior to expected visits. Women who were not registered would receive follow-up via mobile phone, and the mobile system will be developed to support EDS-sites (test-period) and at a later stage non-EDS sites as well.

Activity 3: Test and roll-out the PMTCT Electronic Data System module

The Martin Preuse Clinic (MPC) and the Bwaila maternity ward sites have longstanding experience with EDS and staff has a great deal of oversight and input in the system. There is already an existing working relationship with MPC and Bwaila in following-up PMTCT candidates. Deploying the EDS PMTCT module in this setting will be the best strategic testing ground, enabling Baobab to further strengthen and finalize it the system before deploying it to other sites.

After testing, the PMTCT module will be deployed to other sites rural health centers (Ngoni or Mbangombe), or where PMTCT is already being delivered in EDS-sites. After successful testing and optimization, the PMTCT module will also be tested in non-EDS sites in-line with the pilot for the unique national patient ID.

Thirty healthcare staff as well as Baobab staff will be trained to support the implementation and management of the EDS PMTCT project which will increase the pool of people trained in medical informatics in the country.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9263	**Mechanism Name: EGPAF**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Elizabeth Glaser Pediatric AIDS Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

Lilongwe Medical Relief Fund		

Trust/UNC		

Overview Narrative

With PEPFAR funding, the EGPAF program will continue supporting comprehensive PMTCT/ANC/MCH services and referrals, linking HIV-positive mothers, male partners, exposed infants and children to HIV care and treatment services, and will also continue to support the training of PMTCT service providers. Comprehensive services provided in clinics entail HIV/PMTCT education to communities; routine counseling and testing (CT) for all pregnant women and their partners; CD4 testing for all HIV-positive women; early infant diagnosis (EID) for HIV-exposed infants; infant feeding counseling; provision of comprehensive antenatal, obstetric, and postnatal care; provision of antiretroviral (ARV) prophylaxis to mother and infant pairs; Cotrimoxazole prophylaxis (CPT) for all HIV-exposed children and their mothers; and the provision of psychosocial support for HIV-infected and lactating mothers through clinic-based support groups.

Pregnant women, their children and male partners are the target populations for EGPAF and the Lilongwe Medical Relief Fund Trust/UNC, EGPAF's sub-grantee partner.

MTCT — Prevention

EGPAF, in partnership with MOH and other partners, intends to focus its support on improving the quality and impact of services by strengthening linkages and patient monitoring across PMTCT and care and treatment, increasing implementation of combination ARV regimen, and improving infant feeding practices.

EGPAF supports clinical training in PMTCT service delivery and provides TA at the district and site level to support the provision of comprehensive PMTCT services in ANC clinics and maternity. Currently EGPAF provides TA in Lilongwe District through our sub-grantee, the Lilongwe Medical Relief Fund Trust/UNC. EGPAF will expand technical support to Dedza and Ntcheu Districts in the coming months through direct provision of TA in close collaboration with District PMTCT Coordinators and District Health Officers. EGPAF will also continue providing TA to the MOH to support national PMTCT program implementation through active participation in the zonal mentorship program, technical working groups and the development of policy, guideline and training materials.

HBHC — Adult Care and Support

EGPAF will contribute to the implementation of a national pre-ART program in ANC by supporting the roll-out of a basic care package of prioritized essential interventions, including increased access to HTC for pregnant women and male partners, and improved linkages to family planning and staging for ART

eligibility, including CD4 testing, CPT and referrals.

In addition to PMTCT clinical capacity building at ANC facilities, EGPAF currently supports the provision of psychosocial support for HIV-affected women and families. Support groups are led by trained lay counselors and HIV-positive mothers trained as mother mentors. Areas of emphasis include lactation support, infant feeding options, nutrition counseling, and the importance of EPI vaccines and well-child visits.

PDCS — Pediatric Care and Support
EGPAF aims to increase access to CPT and EID among HIV-exposed children through several technical support mechanisms. EGPAF will participate in technical working groups and committees to support the roll-out of a national plan for EID. Additionally, EGPAF will support integration of EID into under-five/EPI vaccination programs through HSA community outreach and through active identification of HIV-exposed children using mother and child health passports. HSAs are MOH-employed non-clinicians currently working in the community and clinics providing HTC, EPI, FP, health education

All activities will be conducted in close collaboration with the MOH, District Coordinators and other partners in order to enable them to take over and own the program. EGPAF will also support the establishment of a transport mechanism for dried blood spot sampling (DBS) for EID to ensure families get results in a timely matter, reducing loss to follow-up.

Cross-cutting
Human Resources for Health
EGPAF will continue to support training of clinicians to provide quality PMTCT services. EGPAF and its sub-grantee, LMRFT/UNC, trains approximately 360 clinicians annually in PMTCT service delivery, which will continue in FY 10. Additionally, EGPAF will mentor PMTCT Coordinators for improved site supervision and mentorship. HSAs will also be oriented in PMTCT, EID and mother-baby follow-up through a pilot on-the-job training program.

Gender
Increasing the number of male partners of pregnant women being counseled and tested is a priority area for EGPAF. The Male Championship program encourages HIV-positive women to bring spouses/partners to be counseled and tested at PMTCT sites to enhance support for wives/partners, reduce stigma, and accord individuals/couples the opportunity to make informed decisions on accessing care and treatment services.

PFIP Year 1 Funds – $420,000
PFIP Year 2 Funds – $0

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9266	**Mechanism Name: JSI CSH**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: John Snow, Inc.	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Budget Summary
PFIP Year 1 Funding – $429,000
PFIP Year 2 Funding – $0

Summary
The activities proposed within this area are aimed at overall capacity-building and support for the Central Medical Stores (CMS) system to better procure, supply, and manage the distribution of HIV/AIDS-related commodities such as HIV test kits, drugs for Opportunistic Infections (OI's) and ultimately antiretrovirals (ARV's) to points of service. The DELIVER Project will second Regional Logistics Officers (RLO) to provide support to the District and Service Delivery Points (SDP) levels; and support targeted minor improvements to commodity facilities when needed. In addition to the activities focused on CMS, the project also proposes to develop a supply chain logistics Pre-Service Training Curriculum with local partners, including a component for handling of HIV/AIDS-related commodities.

Background

The role of CMS is the procurement, storage, and distribution of public medical supplies. Under the health Sector Wide Approach (SWAp), the Ministry of Health and its collaborating partners recognize the need for efficient reforms of the drug and supply system to improve access to drugs and are committed to, among other things, improving stock management controls and strengthening accountability mechanisms at CMS and RMS. The USG through the DELIVER Project has been supporting supply chain system strengthening since 2000 with special focus on the lower levels of the distribution system using reproductive health funding. This is a wrap-around project that combines EP funding with PMI and reproductive health resources to build an integrated supply chain management system within the MoH.

Under the DELIVER Project, USG funds were used to computerize processing of MoH logistics data from 400+ service delivery points at 26 district-level facilities using Supply Chain Manager, which was in turn used to order electronically contraceptives, sexually transmitted infection (STI) products, EHP drugs, and other products from the RMS's. Use of the computerized system resulted in improved availability of contraceptives and information for decision making for other essential drugs at the SDPs. In the first year of the DELIVER Project, the USG funds had been used to assist the MOH including CMS to use effectively the available information to guide their forecasting and quantification exercise for selected drugs and medical supplies.

With FY 2009 EP funding, the DELIVER Project will provide assistance at the national and regional levels to strengthen the capacity of CMS to manage and distribute HIV related commodities like HIV Test kits, OI's and eventually the system will have the capacity to support management of ARV's which until now

are managed through a parallel system. The activities will also contribute to ensuring continuous, uninterrupted and adequate supply of approved quality and affordable HIV/AIDS commodities. Finally, DELIVER will complete the rapid test kit pilot, evaluate it, and then roll it out as well as complete the ARV supply chain strengthening strategy and its implementation plan.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Malaria (PMI)

Family Planning

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9268	**Mechanism Name: TBD VG Country**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Johns Hopkins Bloomberg School of Public Health Center for Communication Programs	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Budget Summary
PFIP Year 1 Funding – $50,000
PFIP Year 2 Funding – $0

PFIP Year 1 only: Go Girls will receive a total budget of $50,000 in the first year of the partnership framework with which it will implement the following activities:

Summary
The PEPFAR Gender Initiative on Girls' Vulnerability to HIV has been developed as part of a set of PEPFAR special gender initiatives. The program aims to prevent HIV infection among 13-19 year old girls by developing innovative program interventions to 1) modify contextual factors associated with increased sexual risk behavior and rates of HIV infection; and 2) assess the feasibility and effectiveness of these interventions and their potential for sustainability, scale-up, and transferability to other settings. Botswana, Malawi and Mozambique are the three countries selected for this Initiative.

Background
Many PEPFAR programs reach adolescent girls through broad-reaching AB prevention activities that focus on HIV education in church and school settings. However, these programs often do not reach those at highest risk, who commonly are found outside of these settings. Those at highest risk need to be reached with a package of comprehensive services, including economic strengthening activities, to meet their unique needs. In addition, many OVC programs focus on younger children and overlook the needs of adolescent orphans, even though this latter group represents a significant proportion of all orphans. This Initiative seeks to address these programming gaps by implementing and evaluating promising integrated models to reach highly vulnerable adolescent girls with comprehensive services tailored to their particular needs.

The goal of the Malawi Go Girls! Initiaitve is to prevent HIV infection in the most vulnerable adolescent girls. The objectives are: 1) To identify and expand promising new and existing program approaches for addressing the contextual factors which place some adolescent girls at especially high risk of HIV; and 2) To evaluate the feasibility, sustainability, and effectiveness of these interventions and their potential for adaptation and scale-up to other settings. Initiative activities will be closely linked with other prevention and OVC activities, as well as relevant wrap-around programming.
JHU will fund a small sub contract with a local partner to enable the project to expand its depth within the project communities. Areas coverdinthe sub award will include enagaing district, faith and community

leaders in advocay andcollective action to reduce girls' vulnerability to HIV infection; promoting parent-child dialogue and access to youth friendly services, education services, micro credit/IGAs for girls and providing trainings in lifeskills.
Interventions will aim at discouraging early marriage for girls and mobilizing comunities to take action to adress vulnerability to HIV infection for young married girls who are within the target group's age arange. Underlying this theme will be interventions and messaging to dealy sexual debut, abstain from sex, promote condom use and promoting a conducive and supportive environment to positively enforce and reward positive behaviour.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9269	**Mechanism Name: KNCV/MSH TB-CAP**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: KNCV TB Foundation	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Summary

Previously USG had provided technical assistance (TA) and support for TB/HIV through the MSH-TB Control Assistance Program (TBCAP) with child health funding. The activities were focused on ensuring quality of TB and HIV diagnosis and treatment at the Central TB Reference Laboratory (CRL) and local laboratory sites in Zomba and Mangochi districts. The overall objective of the project was to strengthen management and technical systems for the delivery of TB/HIV services in Malawi. In recognition of the needs of the National TB Program (NTP) in Malawi, USG also provided direct support to NTP beginning in FY 2008. USG plans to re-compete an integrated award to include TB/HIV in 2009.

Background

The National TB Program (NTP) in Malawi has attempted, and failed, to conduct an MDR-survey since 2001. The central obstacle to successful completion of this survey was the non-functional Central TB Reference Laboratory (CRL), particularly the lack of competent leaders and managers within the laboratory. Additional difficulties in the health system around sample collection and case detection though important, are non functional in some local labs.

PEPFAR funds and other wrap around funding will be used to rebuild and strengthen the capacity of CRL and selected local labs to implement the MDR-TB survey. The proposed key activities to be funded with PEPFAR funds by TBCAP will include the complete refurbishment of CRL and selected local labs in Zomba and Mangochi districts, improving the management and technical capacity of CRL staff through international TA and sub-contracting of sample collection, data entry, and analysis aspects of the MDR survey by a dedicated Malawian research team to work with the NTP. In addition, a basic "TB/HIV package" will be implemented in selected health facilities that will help build capacity for joint TB/HIV planning, monitoring and evaluation (M and E), and surveillance of HIV prevalence in TB patients in Zomba and Mangochi districts. Malawi recently received a $35 million TB Grant through the Global Fund Round 7 call for proposals.

Key previous achievements using USG support have included

- Drafting the Terms of Reference (TOR's) defining the working relationship between TBCAP and the

National TB Program (NTP)

- Drafting the TOR's defining the working relationship between TBCAP, REACH Trust, and the Liverpool School of Tropical Medicine (LSTM)
- Conducting the baseline survey in Zomba and Mangochi from the 22nd to 27th May 2007
- Conducting orientation meetings of 400 Health Center health workers on the role and function of TBCAP

TBCAP started activities in April 2007. During the three months start-up period, the project team focused on organizing the administrative and logistics support as well as providing orientation to the MoH district teams. Now they are shifting focus to technical activities.

Budget Summary
PFIP Year 1 Funding – $400,000
PFIP Year 2 Funding – $0

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

TB

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9270	Mechanism Name: Lighthouse GHAI
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement

Prime Partner Name: Lighthouse	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 900,000	
Funding Source	**Funding Amount**
GHCS (State)	900,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Lighthouse Trust provides a range of services in HIV, which encompass all aspects of the Partnership Framework between the US Government (USG) and the Government of Malawi (GOM), and in providing services at two major hospitals and supporting services at several smaller health centers in the capital city Lilongwe, is also contributing to the strengthening of the broader health system. Lighthouse is in the process of expanding their focus on HIV prevention through a formalized Prevention with Positives program, scaling up HIV care and treatment, providing care and support to HIV-affected and infected children, and addressing Health systems strengthening through HIV in-service training and mentoring, and through increasing the laboratory services available to those in care and treatment.
Lighthouse started in 1997 as a voluntary group of staff working at Kamuzu Central Hospital (KCH) in Lilongwe, Malawi. Lighthouse Mission Statement is that it exists to fight against AIDS in Malawi by providing a continuum of quality care and support and by working to build capacity in the Health Sector.

This is achieved through three technical objectives:
1. To provide Integrated HIV and AIDS Treatment, Care and Support services, maintaining capacity and improving quality.
2. To develop a systematic approach to health care delivery at the Lighthouse through defined and documented protocols and procedures that would serve as a model that informs similar interventions elsewhere.
3. To establish the Lighthouse as a training institution that builds capacity to deliver care and support for HIV and AIDS in Malawi.

Lighthouse as a Malawian Trust functions as part of the public services at Kamuzu Central Hospital and Bwaila Hospital in Lilongwe. Lighthouse has become a major HIV service provider with operations in HIV-testing and counseling (HTC), antiretroviral treatment (ART) and other facility-based clinical care.

Lighthouse provides community home based care (CHBC) interventions through a network of community volunteers.

During the first five months in 2009, Lighthouse has: Tested 17,729 clients, and identified 4,117 people living with HIV (PLHIV); registered 2,527 new patients, of which 1,646 started ART bring to a total of almost 10,000 patients alive on ART; CHBC nurses looked after 210 patients in their houses; and our 450 community volunteers provided psychosocial support to 2,657 patients in the community. Lighthouse operations follow national guidelines and our policies are designed to be implemented at the district level. Combined with strong monitoring and evaluation, this gives us the opportunity to be leader among HIV providers in the public sector. Key policies rolled out by the Ministry of health were piloted and evaluated at Lighthouse. The Ministry of health (MOH) and the National AIDS commission are our largest donors. The US government contributes significantly through CDC and PACT to Lighthouse's success.

Malawi continues to scale-up ART, however patients are still presenting late, and new HIV infections have not significantly reduced nationally. PLHIV need to access HTC, ART and prevention messages earlier in the course of their disease.. With FY09 through to FY10 financial support we plan to mobilize our facilities and community to achieve earlier and timely initiation of ART through establishing comprehensive pre-ART services. From outreach points we will deliver messages on prevention with positives (PwP), including positive living, condom use, and other issues such as ART and CPT adherence. Patients will receive Cotrimoxazole preventive treatment, and link to the Lighthouse clinic for WHO staging and regular CD4 count testing. They will also receive food supplements and insecticide treated bed nets. Volunteers will regularly visit them in the community as we do for ART patients. By providing these services, patients will enter the continuum of care earlier and we will carefully monitor the outcomes of this pre-ART cohort. Longitudinal care of PLHIV is also strengthened by our focus on women referred for ART from antenatal care (ANC). We will actively trace women who do not show up to register at Lighthouse, as well as women who did not collect the positive HIV-PCR results of their infants. ANC-women will be entry points of family-centered care, especially at Bwaila Hospital.

Resources in the community are limited; mobilization of community members requires additional resources. With FY10 funding we want to facilitate the set up of PLHIV-support groups to achieve greater involvement and ownership of our patients. Support group members will be trained how to provide IEC messages for positive living and referral network.

Lighthouse will build on existing cadres: volunteers, Lighthouse HTC-, clinic- and CHBC- staff, and a strong monitoring and evaluation team with an established system for registering and following up patients. Our targets for PFIP years 1 and 2 are entered in the Indicator table.

Budget Summary
PFIP Year 1 Funding – $397,000
PFIP Year 2 Funding – $800,000

Cross-Cutting Budget Attribution(s)

Human Resources for Health	276,391
Water	5,600

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9270**		
Mechanism Name:	**Lighthouse GHAI**		
Prime Partner Name:	**Lighthouse**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	385,000	

Narrative:

Budget Code – HBHC ($385,000)
Lighthouse has an established system of managing patients on ART at its two clinics. However, proactive identification of patients before ART initiation from HTC services needs to be strengthened. We manage patients under primary care but the minimum package has not been prescribed yet by Ministry of Health. HBHC activities are closely interlinked with HVOP activities, and the two narratives will reflect that.

In Year 1 we would like to pilot management intervention for Pre-ART patients linking them from facility based HTC, community based HTC and the clinic for comprehensive care and support. This will involve treatment for opportunistic infections, screening for TB and STIs, as well as screening for pregnancy, and providing family planning services among patients at every visit. We will use Lighthouse services to define a model intervention for Pre-ART service delivery.

Lighthouse comprehensive care center houses one of the busiest ART clinics in Malawi registering over

8, 000 contacts with HIV positive patients on ART each month. This clinic presents an opportunity where HIV preventive interventions will be delivered routinely to ART patients at each visit. Lighthouse has an existing patient education and counseling program into which prevention messages for positives will be incorporated. The Training unit will work with HBC and clinic staff to develop focused messages targeting individuals with HIV. This will also be a model intervention for Prevention with Positives (PwP) which aims at reducing HIV transmission.

Some activities lined up for Year 2 as a scale up from the FY09 are described below. Lighthouse provides facility based HIV Care services at the Lighthouse center, Martin Preuss Center, Maula Prison, two Lilongwe rural health centers and community-based HIV services with Lilongwe city strategic areas. We use a family-centered approach for a continuum of care to HIV positive persons including adolescents. This care is aimed at improving quality of life and prevention for positives. Methods of program and monitoring and evaluation are described in technical budget area HVSI.

Activity 1: Lighthouse establishes a model for pre- ART service delivery in Malawi

Patients frequently come to our ART clinic or are referred from HTC in advanced stages of HIV-infection. Therefore, early mortality among patients starting on ART remains high and their prognosis is low. However, regular follow-up of patients including WHO-staging, immunological monitoring, and provision of Cotrimoxazole prophylaxis would add an additional workload to our already overstretched ART-clinic staff. With the view to universal access, and the goals of reduction of early mortality among patients on ART, durability of the 1st line regimen, and intensified Prevention-with-Positives (PwP), there is need to develop a model to deliver pre-ART services to patients not yet eligible for ART. In collaboration with MOH, we plan to develop a comprehensive service package for this underserved group, including provision of CPT, TB screening, STI screening, nutritional screening and counseling and provision of therapeutic feeding and food supplements if eligible, regular CD4 monitoring in order to improve their clinical condition, to delay their disease progression, and to identify ART eligibility. In addition, we will set up a robust M&E system for pre-ART services and link with the MOH, With MOH, we will explore options to develop, implement and evaluate these procedures to inform national policy on the feasibility of this new area.
At ANC in Bwaila hospital, the PMTCT program traces HIV infected pregnant women with CD4 count below 250/µl, which do not pick their results. However, those women, who picked their result but did not register at the ART clinic at MPC, are not yet actively followed-up. With funding available, we will close this gap and give these women a continuum of quality care at MPC and at the same time make PMTCT much more effective.

Activity 2: Prevention with Positives (PwP)

Lighthouse comprehensive care clinic houses one of the busiest ART clinics in Malawi registering over 8,000 contacts with HIV-positive patients on ART each month. This clinic presents an opportunity where HIV preventive interventions will be delivered routinely to ART patients at each visit. Lighthouse has an existing patient education and counseling program into which PwP messages will be incorporated. The Training unit will work with HBC and clinic staff to develop focused messages targeting individuals with HIV. The messages will be delivered through group education sessions, one-on-one counseling, and IEC materials. The primary focus will be on assisting HIV infected individuals to disclose their HIV status to partners, reduce their risk of transmitting HIV, and reduce the risk of primary STI infection or HIV re-infection. This package aims at reducing HIV transmission (prevention with positives) and will rely on support and involvement of the community through linkage with our existing Ndife Amodzi program.

Activity 3: Promotion of Water Guard Technology for safe water

Health interventions at community level to prevent opportunistic infections are very crucial especially for PLHIV. Lighthouse in collaboration with Population Services International (PSI) piloted Water Guard water purification technology in one CBO (Chimoka) in FY08, which reported high incidences of cholera previously. This targeted HBC patients' households to improve access to safe water thereby reduce incidences of diarrhea disease in immuno-compromised patients in home based care program. The initiative started with one day training of 40 volunteers from the pilot sites in water guard technology usage, which in turn transferred skills gained to primary care givers so as to effectively prevent water borne diseases in the households. Because of anticipated on-going exposure to cholera in some of the higher-density residential areas, Lighthouse plans to comprehensively continue providing Water Guard to HIV-infected individuals and their families. In FY10, Lighthouse will purchase and distribute 1,800 bottles of water guard which will benefit 150 patients.

Activity 4: Strengthen linkage between community and Lighthouse facilities

There is a need to further strengthen LH links and contributions to the community in order to enhance HIV prevention through behavioral change, improved knowledge of volunteers and community care supporters, and economic empowerment. Health interventions at community level to prevent opportunistic infections through use of clean water, insecticide bed-nets for malaria and nutritional support as well as distribution of prophylaxis for common opportunistic infections by CPT will reduce the disease burden and progression of HIV infection among our patients. Our linkages with the community and the active pool of the volunteers will assist in the establishment of outreach points for pre-ART clients which will be recruited through the NA-program.

Activity 5: Training and supporting Community Volunteers for the HBC Program

Lighthouse plays a significant role in the development of palliative care policies and services. In 2007, Lighthouse made significant inputs in the development of Malawi's National Curriculum for Palliative Care Training. With the current PEPFAR funding through Pact – Malawi Lighthouse has managed to train 473 volunteers and staff in community home based care and other in – service trainings which were conducted in response to the needs assessment done by the training department. In year 1 LH plans to train 450 volunteers, 7 community care supporters and 4 nurses. We also plan to train 40 expert patients in positive living. As a way of preventing malnutrition, Lighthouse plans to engage agriculture extension workers to train 90 volunteers on crop diversification, manure making and food preparation. Early detection of malnutrition is critical in caring for PLHIV. In view of this, Lighthouse in Year 2 will procure weighing scales for use by nurses and Community Care Supporters. This will assist them to do weekly and monthly weighing of all HBC patients and Ndife Amodzi clients respectively thereby closely monitoring nutrition status and provide nutritional support (RUTF) and Likuni Phala where necessary.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	200,000	

Narrative:

Budget Code – HTXS ($200,000)
Currently, Lighthouse has about 10,000 patients on ART between their two sites; both serving high-density population areas and the greater city. Lighthouse will continue to provide comprehensive quality care to PLHIV. With FY09 funding we expect to enroll 4,300 new patients in the program and retain in cumulative care 12, 794 adults and children by September 2010. Our initiatives of group adherence sessions will continue to enhance treatment adherence. Our Back to Care Program (B2C) will continue to actively trace patients who miss appointments for at least 21 days.

Activity 1: Lighthouse Clinics at KCH and Bwaila together manage 15,741 patients on HAART by the end of 2010

The work load at Lighthouse and MPC clinics continues to grow steadily, with over 8, 000 visits per month. The introduction of CD4 count testing for all new HIV-positive clients has made a significant contribution to the numbers starting ART, and between the two sites, Lighthouse now starts more than 300 patients on ART each month. Currently about 10,000 patients are alive on ART requiring one, two or three month's reviews. We ensure that 66% of the patient reviews are made by nurses, leaving the more complex cases for the few clinicians available. We plan to pilot pediatric ART review to be done by

nurses. At our Martin Preuss Centre (MPC), based at Bwalia Hospital, we will continue to provide TB/HIV integration for Malawi's largest TB Registry, and facilitate access for HIV infected women (and their families) identified through the country's largest PMTCT program.
The MPC now manages over 4,000 patients on ART. 95% of TB patients now know their HIV status as they start treatment, and 64% of HIV-positive TB patients enroll in ART at the MPC. Average new monthly ART registrations at MPC (234) are exceeding those at LH (134), showing the steady and rapid growth of the new site.

In collaboration with the University of North Carolina, we provide CD4 testing for all HIV-positive pregnant women identified through UNC's PMTCT program and will continue in Year 2. More than half of those women identified as eligible for ART (CD4 < 250) successfully start ART at the MPC whilst still pregnant, up from less than 10% in 2006.

Activity 2: Lighthouse clinic decentralizes ART follow-up working with HIV Unit to develop methodology
The current major theme for Lighthouse services is decentralization. This is aimed at decongesting our centralized services, allowing us to provide higher quality care to those who need it most. One key activity is to support ART delivery at two health centers in Lilongwe district. One such center (Chileka) has been approved by the MOH for the next round benefiting from our mentoring role. Although no additional staff are planned for these centers, Lighthouse through funding from Year 2 will provide minor refurbishment of rooms, furniture, and equipment; will support and train staff; and will provide on-site supervision. Ultimately, these sites will become satellite ART clinics of the Lighthouse.

Activity 3: Ndife Amodzi (Pact funded)

The Ndife Amodzi (NA) program is a USAID - PACT funded effort aiming at exploring effective ways to involve the community in the support of ART patients by using Community Volunteers to promote adherence, early referral, and positive living, and to support the monitoring of ART patients. Meaningful involvement of PLHIV is critical to any work in HIV and AIDS. Currently Lighthouse CBOs have expert clients working as volunteers. In FY10, we plan to work with them more vigorously in community sensitization activities including NA promotion in all health facilities that are running the program (including Lighthouse clinics). Two PLHIV will be placed at each facility twice per week. Their role will be to sensitize and refer ART patients into the program. This will enhance enrolment and ownership of the program amongst clients themselves. Specific activities will include: developing expert patient specific IEC materials including topic guides; Training expert patients and members of staff in the HBC program in positive living in addition to the current volunteers who promote Ndife Amodzi in the clinics; schedule formal support group meetings; Expert patients conducting the NA promotion and patient education; all these will require proper documentation and supervision by the CHBC leadership.

Lighthouse through NA will establish Community Based Distribution Points (CBDP) that will be managed by PLHIV support groups where integrated services like HTC, pre-ART (including Cotrimoxazole prophylaxis), PMTCT, condom distribution and RUTF will be provided. The existing Community Care Supporters will be responsible for community mobilization, sensitizing the general public on HIV prevention and services accessible at CBDP. Clients will also be referred from PLHIV support groups, Lighthouse clinics and other ART facilities to the CBDP. HTC Counselors, nurses, clinicians, and CCS will come to the sites every month to offer services at community level. This will therefore assist in reducing frequency of client visits to ART clinics thereby decongesting them. This will also promote open disclosure among patients which will impact on stigma and discrimination in the community.

Through HHS/CDC-supported senior staff and HHS/HRSA technical assistance staff, Lighthouse aims to establish Ndife Amodzi as an effective and appropriate 'minimum standard' of HBC and an effective reporting mechanism for HBC nationally, working in partnership with donors, other NGOs and the MOH.

Activity 4: Capacity building to maintain quality provision of HIV Treatment

Lighthouse acknowledges HIV treatment as a dynamic field. It keeps in-service training for its staff high on the agenda to keep them up to date. These trainings cover updates in internal medicine, ART refresher and monitoring methodologies for HIV management. In Year 2, these internal trainings, mentoring and supervision will continue.

Traditionally, Lighthouse also provided two-week clinical attachments for over 75% of all clinicians and nurses trained to provide ART services in Malawi primarily for the central and northern regions. As the next round of ART sites get going with trainings, we expect that newly trained staff will work with already trained staff in their districts for their attachment. However, as we continuously get requests from specific institutions to place people on at clinical attachment at the Lighthouse, we will continue to support this activity. The expertise of Lighthouse clinical staff will be complemented by the training team to ensure the maximum impact of the two-week attachments.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	30,000	

Narrative:

Budget Code – HVSI ($30,000)

We monitor our programs rigorously using our more established M&E unit which has a robust real time

Electronic Data System supported by another PEPFAR supported partner – Baobab Health Trust. With FY09 we plan to revise the current Lighthouse modules to be used among child counseling and pediatric treatment. This will also go further to incorporate the module into the TB clinic and the newly built Bwaila Maternity unit which is close to MPC. This will offer an opportunity to link up directly the PMTCT mothers into Care and method for follow up of those who have be lost to follow up. It is envisaged that new features for the national roll out will be tested and piloted at the Lighthouse before they are deployed. We plan to do an evaluation of the functionality of the EDS at the Lighthouse. This will be carried over into FY10.

Activity 1. Consolidate the Lighthouse Electronic Data System (EDS)

A rigorous monitoring and evaluation of the proposed activities will be done using our robust Electronic Data System (EDS) and reports will be submitted using the PEPFAR indicators. We are working with Baobab Health Trust to consolidate our EDS. There is a plan to revise the current Lighthouse modules to be used among child counseling and pediatric treatment. This will also go further to incorporate the module into the TB clinic and the newly built Bwaila Maternity unit which is close to MPC. This will offer an opportunity to link up directly the PMTCT mothers into Care and method for follow up of those who have be lost to follow up. It is envisaged that new features for the national roll out will be tested and piloted at the Lighthouse before they are deployed. We plan to do an evaluation of the functionality of the EDS at the Lighthouse. This will include its function as care delivery tool such as accuracy in setting appointments and prescriptions; and its functionality as an M&E tool such as conducting a cohort analysis which is still a challenge now. We plan to do this with year 2 funds.

Activity 2: Evaluation of Task-Shifting Project and other activities

PEPFAR funds a broad SI budget line which covers costs of recruiting external enumerators, data entry staff, and others to support many small program evaluations. This enables Lighthouse to be flexible and responsive to emerging issues. As an ongoing task shifting plan, Lighthouse would like examine whether nurses can monitor stable children and identify children with complications who need re-assessment and management by clinical officers

Lighthouse plan to conduct regular monitoring and evaluation of the roll-out of HIV testing and counseling (HTC) to health center ANCs, and revised Ndife Amodzi ART community program M&E tools. Currently, HIV/TB co-infected patients who are eligible for ART are managed within the TB clinic. Lighthouse also plans to evaluate the effectiveness of providing ART services within the TB clinic. If the program is successful, Lighthouse intends to rollout the program in other health centers.

The details of these investigations will be developed through Year 1, and timing will largely depend on the capacity and priorities of our M&E department.

Activity 3: Roll-out of the ART EDS

This activity directly supports treatment services and because of the ever growing burden of managing large number of patients at treatment sites, the paper-based system of registering and tracking patients is becoming inadequate to meet the program needs. The will support MOH the transition from a paper-based tracking system to an electronic system for high burden sites. With another PEPFAR supported partner, Baobab Health Trust, we will continue piloting and improve innovations in the software and hardware for the new electronic data system (EDS).

Lighthouse replaced the old touch screen system at Lighthouse with the EDS currently working at the Martin Preuss Center. Lighthouse will continue to help designing algorithms for the next level version of the EDS, including options for more pediatric functionality and more integration of CD4 testing. Lighthouse will offer their facilities as beta testing sites for Baobab as they develop new modules for TB treatment, and for referral between ANC, PMTCT, and ART services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	100,000	

Narrative:

Budget Code: HVOP ($100,000)
As mentioned in the HBHC narrative, HVOP activities at Lighthouse are closely interlinked with HVOP activities and so the narrative describes the broader activities within which these two budget codes are implemented.

In Year 1 we will pilot management interventions for Pre-ART patients, linking them from facility-based HTC, community-based HTC and the clinic for comprehensive care and support. This will involve treatment for opportunistic infections, screening for TB, screening for STIs, screening for pregnancy, family planning services among patients at every visit. We use Lighthouse services to define a model intervention for Pre-ART service delivery.

Lighthouse comprehensive care center houses one of the busiest ART clinics in Malawi registering over 8, 000 contacts with HIV positive patients on ART each month. This clinic presents an opportunity where HIV preventive interventions will be delivered routinely to ART patients at each visit. Lighthouse has an existing patient education and counseling program into which prevention messages for positives will be

incorporated. The Training unit will work with HBC and clinic staff to develop focused messages targeting individuals with HIV. This will also be a model intervention for Prevention with Positives (PwP) which aims at reducing HIV transmission.

Some activities lined up for Year 2 as a scale up from Year 1 are described below. Lighthouse provides facility based HIV Care services at the Lighthouse center, Martin Preuss Center, Maula Prison, two Lilongwe rural health centers and community-based HIV services with Lilongwe city strategic areas. We use a family-centered approach for a continuum of care to HIV positive persons including adolescents. This care is aimed at improving quality of life and prevention for positives. Methods of program and monitoring and evaluation are described in technical budget area HVSI.

Activity 1: Lighthouse establishes a model for pre- ART service delivery in Malawi

Patients frequently come to our ART clinic or are referred from HTC in advanced stages of HIV-infection. Therefore, early mortality among patients starting on ART remains high and their response to ART is less than if had started in less advanced immunological stages. However, regular follow-up of patients including WHO-staging, immunological monitoring, and provision of Cotrimoxazole prophylaxis would add an additional workload to our already overstretched ART-clinic staff. Current national guidelines focus on scaling-up ART-initiation of eligible patients through decentralization, task-shifting and extended supplies of ART up to 3 months, and there is no clear guidance on where and how pre-ART patients should be managed. These guidelines are currently under finalization at the Ministry of Health (MOH), and Lighthouse is playing a key role in working with MOH to conceptualize and demonstrate the new national pre-ART program.

With the view to universal access, and the goals of reduction of early mortality among patients on ART, durability of the 1st line regimen, and intensified Prevention-with-Positives (PwP), there is need to develop a model to deliver pre-ART services to patients not yet eligible for ART. Every month, Lighthouse registers HIV-infected patients, who are not yet eligible to start ART (pre-ART patients). They usually receive CPT and are asked to come back in regular intervals. The needs for this large group of pre-ART patients are not yet addressed. In collaboration with MOH, we plan to develop a comprehensive service package for this underserved group, including provision of CPT, TB screening, STI screening, nutritional screening and counseling and provision of therapeutic feeding and food supplements if eligible, regular CD4 monitoring in order to improve their clinical condition, to delay their disease progression, and to identify ART eligibility timely to reduce early mortality related to late ART initiation. In addition, we will set up a robust M&E system for pre-ART services and link with the MOH, which plans to recommend standard procedures and M&E tools for pre-ART services. With MOH, we will explore options to develop, implement and evaluate these procedures together in order to inform national policy on the feasibility of

this new area.

At ANC in Bwaila hospital, the PMTCT program traces HIV infected pregnant women with CD4 count below 250/µl, which do not pick their results. However, those women, who picked their result but did not register at the ART clinic at MPC, are not yet actively followed-up. With funding available, we will close this gap and give these women a continuum of quality care at MPC and at the same time make PMTCT much more effective.

The package will:
a. Link with the HIV and AIDS Department of the MOH and consult on possible plans and developments, e.g. introduction of specific M&E tools for the pre-ART clinic (e.g. pre-ART register), which can be piloted
b. Establish a cohort of HIV positive patients not yet on ART and monitor their outcomes for a period of three years.
c. Monitor regularly WHO stage and six-monthly CD4 counts in pre-ART patients and refer to ART if eligible
d. Examine knowledge, attitudes and perceptions of pre-ART patients
e. Develop and deliver IEC-messages focusing on CPT, nutrition, positive living and "positive prevention", taking results of the previous activity into account
f. Organize involvement of the community in the care of pre-ART patients: Encourage pre- ART patients to join support groups formed with the support of our community home based care program.
g. Give all pre-ART patients who attend support group meetings a monthly professional talk within their catchment's area focusing on disease progression
h. Document this process, evaluate and disseminate findings to inform MOH about feasibility and outcomes

Activity 2: Prevention with Positives (PwP)

Lighthouse comprehensive care clinic houses one of the busiest ART clinics in Malawi registering over 8,000 contacts with HIV-positive patients on ART each month. This clinic presents an opportunity where HIV preventive interventions will be delivered routinely to ART patients at each visit. Lighthouse has an existing patient education and counseling program into which PwP messages will be incorporated. The Training unit will work with HBC and clinic staff to develop focused messages targeting individuals with HIV. The messages will be delivered through group education sessions, one-on-one counseling, and IEC materials. The primary focus will be on assisting HIV infected individuals to disclose their HIV status to partners, reduce their risk of transmitting HIV, and reduce the risk of primary STI infection or HIV re-infection. This package aims at reducing HIV transmission (prevention with positives) and will rely on support and involvement of the community through linkage with our existing Ndife Amodzi program.

Activity 3: Promotion of Water Guard Technology for safe water

Health interventions at community level to prevent opportunistic infections are very crucial especially for PLHIV. Lighthouse in collaboration with Population Services International (PSI) piloted Water Guard water purification technology in one CBO (Chimoka) in FY08, which reported high incidences of cholera previously. This targeted HBC patients' households to improve access to safe water thereby reduce incidences of diarrhea disease in immuno-compromised patients in home based care program. The initiative started with one day training of 40 volunteers from the pilot sites in water guard technology usage, which in turn transferred skills gained to primary care givers so as to effectively prevent water borne diseases in the households. To ensure that the trained volunteers have really transferred the skills, a survey was done by Lighthouse staff, which proved that all households involved in the pilot accepted the concept and were adhering to the procedures. A follow up was done to establish incidence of water borne diseases in that community and proved that there was none. Further enquiries at Area 18 Health Center confirmed it, as there was no cholera case reported from the pilot during the FY 07 rain season period. However with limited funding this activity did not progress in FY 2008 and during the next rainy season a major cholera outbreak occurred. Because of this experience, and because of anticipated on-going exposure to cholera in some of the higher-density residential areas, Lighthouse plans to comprehensively continue providing Water Guard to HIV-infected individuals and their families. In Year 2, Lighthouse will purchase and distribute 1,800 bottles of water guard which will benefit 150 patients targeted for care at any particular time.

Activity 4: Strengthen linkage between community and Lighthouse facilities

There is a need to further strengthen LH links and contributions to the community in order to enhance HIV prevention through behavioral change, improved knowledge of volunteers and community care supporters, and economic empowerment. Health interventions at community level to prevent opportunistic infections through use of clean water, insecticide bed-nets for malaria and nutritional support as well as distribution of prophylaxis for common opportunistic infections by CPT will reduce the disease burden and progression of HIV infection among our patients, indirectly reducing transmission of the virus to HIV-negative individuals. Our linkages with the community and the active pool of the volunteers will assist in the establishment of outreach points for pre-ART clients which will be recruited through the Ndife Amodzi program.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	150,000	

Narrative:

Budget Code - PMTCT ($150,000.00)

Since 2007, Lighthouse with its partners at Bwaila hospital works to strengthen the linkage between ANC/pMTCT and ART services so that HIV-infected pregnant women, eligible for ART have more effective pMTCT and better quality of life. However, in 2007 and 2008, less than 40% of women referred from ANC started ART while pregnant. Despite improvement to 67% in 2009, the proportion is still low. However, of those who registered at MPC, 78% started on ART while pregnant.
In FY08 we developed protocols to facilitate documentation and referral of eligible pregnant mothers for ART initiation from PMTCT program to the Lighthouse ART. With Year 1 funding we are setting up and reinforcing strategies of referral of PMTCT mothers into ART at Bwaila Hospital. This will involve setting up linkage of our EDS and tracing mechanism using our Back-to-Care Program operations to trace the referred mothers who do not turn up at MPC ART Clinic.
In 2010, the new maternity at Bwaila hospital next to MPC is fully operational and the new maternity at KCH next to Lighthouse will open. Both facilities will offer PITC at ANC and HTC in the labor ward, as well as CD4 testing for HIV-infected pregnant women.
The electronic data system (EDS) will expand with several workstations at Bwaila maternity, including the registrations of newborns, which will allow us to better monitor effectiveness of referral at patient level.
PF year 2 funds will be used to strengthen the referral and follow-up systems for PMTCT mothers between ANC and ART. In 2010, additional funding will allow Lighthouse to manage effective services with the increased demand and this will give an opportunity to improve the situation:

Activity 1: Implement identification of exposed and infected infants and provide pre and ART Care at MPC -
Increasingly, HIV DNA PCR positive infants are identified or referred to MPC, with their HV-infected mothers, who choose MPC as their ART site. We are able to offer HIV-exposed infants with uncertain HIV status HIV DNA PCR and Cotrimoxazole preventive therapy (CPT) directly at MPC without further referral. If infants are presumed HIV infected with severe HIV disease or are PCR positive they start ART at MPC when ready.

Activity 2: Pilot a systematic continuum of pre and ART care model for mother-infant pairs -
The proposed additional funding will push the momentum provided by MoH's decision to place the continuum of care for mother-infant-pairs (MIPs) within the context of systematic pre-ART care- a model, which is already one focus of Lighthouse activities within this agreement. We will be able to pilot pre-ART tools and systems developed by the MoH, improve M&E of MIP-follow up, and inform future direction.

Activity 3: Implement active tracing for eligible pregnant mothers from PMTCT to ART - Gaps which will be addressed in Year 2 include identifying missing ANC attendees who are eligible for ART, and have

been referred from ANC but have not reached the ART clinic. We will reinforce our Back-to-Care Program team to follow up on all referred cases that do not reach the clinic and establish their outcomes. Consent for follow-up as part of routine care will be obtained at ANC during their initial visit. This funding will support one additional field tracer. We rely on all our diagnostics on Kamuzu Central Hospital including CD4 count for pregnant women. KCH as a tertiary care center for the central region and they are under pressure to deliver laboratory services to many providers. We will therefore continue to request backup CD4 services from the University of North Carolina (UNC) laboratory at KCH.

Activity 4: Restructure ART Clinic at Lighthouse to Ensure Prompt Initiation of HAART for Eligible HIV-Positive Antenatal Mothers -

The Lighthouse ART clinic is one of the largest ART sites in Malawi and already operates at full capacity. Lighthouse faces challenges in its service delivery capacity to address the urgent ART needs of eligible HIV-positive mothers identified at nearby PMTCT sites close to their homes. FY10 funds will be used to continue reorganizing operations at the ART clinic to ensure that all eligible antenatal mothers are initiated on HAART promptly, and followed up in a schedule that is synchronized with their PMTCT visits.

Activity 5: Integration of family planning services into the ART- and pre-ART clinic -
Lighthouse is a family centered clinic and recent plans include the integration of ANC and family planning activities into the ART clinic at both Lighthouse and MPC. With the opening of the new Bwaila Maternity Wing close to MPC has reduced the gap between ANC and MPC ART therefore we will now implement the family planning integration at Lighthouse. All patient receiving care at the Lighthouse will access counseling and provision of contraceptive methods.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	35,000	

Narrative:

Budget Code HVTB ($35,000)
With Year 1 funds, Lighthouse will continue to implement protocols for routine provider-initiated testing and counselling (PITC) of both the general population in all its sites and TB patients at Bwaila hospital. The scale-up of HIV Testing and Counselling (HTC) in Malawi will be informed by the Lighthouse experience at Bwaila Hospital, (TB and HIV integration) and we have already set in place clear mechanisms to transfer this knowledge through TB quarterly meetings in all the three regions of the country. We will maintain our HIV screening among TB patients at above 90%. We are also planning to extend this to TB suspects. We will also consolidate our initiative of starting and managing TB patients on ART in the TB unit at MPC instead of referring them to the ART clinic which we have observed to have a

risk of losing some. The pilot of early start of ART among TB patients will also be finalised in 2009 and lessons learnt will be taken into consideration for the FY10 implementation of this activity.

In Year 2, Lighthouse plans to additionally:

Activity 1: Support National roll out of New TB/HIV Collaborative activities

As a member of the National TB/HIV technical subgroup, Lighthouse was part of the task force developing a new 5-year National TB/HIV Operational Framework for Malawi that was completed at the end of 2007 covering 2008 to 2011. The plan emphasizes integrating HIV information in the National TB register and incorporating TB information in the ART register. With PEPFAR support, Lighthouse piloted a program which integrates HTC as a standard package of care for all TB patients and captures HIV information on each TB patient in one register. The National TB/HIV subgroup planned to work with Lighthouse to roll out this new register nationally. However, this plan was not achieved due to other factors beyond Lighthouse control. In the meanwhile all logistics to implement this are in place. Lighthouse will utilize National TB existing quarterly meetings in all the three regions of the country. TB officers will be reoriented on the use of new register and to monitor their ongoing recording and reporting practices. This would be supported by a comprehensive follow up system to the sites.

Activity 2: Support TB Officers on collaborative TB/HIV activities

Lighthouse will continue to provide input and support to the development process of TB/HIV Collaborative activities sharing experience from the MPC. As appropriate, support the implementation of the National Plan, specifically in terms of the development and planning of guidelines and training. As part of the process of implementing a model pilot program integrating TB and HIV activities, Lighthouse adapted the WHO/CDC generic DTC training guidelines to the Malawian context, and used it to provide a two-day training to TB officers. Collectively, the trained TB officers (TBOs) have done well in the field and increased HIV testing rate for TB patients to over 93% within their clinics. About 40% of people reaching the TB registry actually had tested positive prior to arrival at the Lighthouse, but that was not being systematically captured in the registers.

Working in collaboration with the National TB/HIV coordinating body, Lighthouse with 2010 funds plans to focus on supporting new Monitoring and Evaluation (M&E) system tools; integration of HTC, especially in Referral hospital (50% of registrations); and co-management of TB treatment and ART combined from 2 months.

Activity 3: Counseling and Testing for TB Patients and Suspects

With Year 2 funds, Lighthouse will continue to implement protocols for routine counselling and testing of both the general population in all its sites and TB patients at Bwaila hospital. The scale-up of HIV Testing and Counselling in Malawi will be informed by the Lighthouse experience at Bwaila Hospital, (TB and HIV integration) and we have already set in place clear mechanisms to transfer this knowledge through TB quarterly meetings in all the three regions of the country. We will maintain our HIV ascertainment among TB patients at above 90%. Studies in Malawi have shown that HIV prevalence in TB suspects submitting sputum for AFB microscopy is about 60% and compares closely with the rate in TB patients (70%). HIV screening of TB suspects therefore offers an opportunity for early identification of HIV as an underlying cause of symptoms in TB suspects. We plan to provide a similar routine HIV testing and counselling among TB suspects who come to MPC (chronic coughers). We will advocate that this HIV ascertainment among TB suspects and patients should be a routine service in TB clinics nationally.

The planned activities will result in improved TB/HIV services for hopefully over 4000 people. We are happy to report that Lighthouse persuaded the National TB program (NTP) to decentralize registration. And sputum microscopy is taking shape in most of the health within and outside Lilongwe. Only about 35% of the TB patients registered at the MPC are actually managed there. However if registration is decentralized, a significant proportion of MPC registrations will be lost and Lighthouse will have to consider how to support its health centers in Lilongwe and other referring sites and how to get TB patients onto ART.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9271	**Mechanism Name: Malawi AIDS Counseling Resource Organization**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Malawi AIDS Counseling Resource Organization	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 600,000	
Funding Source	**Funding Amount**

GHCS (State)	600,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

As a key partner to both governments in the first two pillars of the Partnership Framework between the US Government and Government of Malawi (GOM), HIV Prevention and HIV care and treatment, MACRO's ability to provide high-quality HIV Testing and Counseling (HTC) is critical. Malawi has rapidly scaled up all HIV services in the last few years, with over 1,700,000 people tested between July 2008 and June 2009, approximately 30% of whom were pregnant women.

MACRO is the largest non-government provider of HTC in Malawi, providing approximately 10% of all testing nationally; they operate 6 'static' sites in cities across the nation: Karonga, Mzuzu, Kasungu, Lilongwe, Zomba, and Blantyre. Each site provides outreach testing to market places and other public areas, and the three largest sites also operate large mobile testing vans, which serve the remotest areas of underserved districts to directly impact on universal access targets.

The type of HTC available has shifted quite dramatically in the last two years, with increasingly diversified models implemented, including outreach, mobile, and door-to-door testing; In the second quarter of 2009, 27% of all sites reporting to Ministry of Health (MOH) were outreach versus static sites, compared to 21% in the same quarter of 2008. MACRO, a long-standing USG partner who provides approximately 10% of all HIV tests done nationally, reported that by the middle of 2008 approximately 80% of all HIV tests they were conducting were occurring at outreach and mobile sites, showing that a high demand for HTC access in remote and rural areas exists.

MACRO maintains a robust database using Electronic Medical Record Systems (EDS) in collaboration with Baobab Health Trust (another CDC partner). With the dramatic shift in testing models from static to outreach and mobile, the need for portable data entry technology has become clear. MACRO and Baobab intend to work together to develop and pilot a new system which can be used in all settings and provide quality data for basic program evaluation.

MACRO also provides training in HTC, and has employed a model which allows for mentoring 3 months after the completion of training, ensuring that quality HTC services are provided. The recent decentralization of national HIV training to district level lends itself to increasing district-level coverage of highly trained counselors. However, decentralization can potentially reduce the quality of training provided, as training is no longer taking place only in specialty training centers, with well-trained trainers.

In recognition of the changing needs of the MOH, there will be an adjustment of the USG partners training model to complement the new national decentralized approach to training. This will likely include more extensive mentoring of both the training process and subsequent HTC implementation by trainees, ensuring the maintenance of high-quality HTC services in Malawi.

Budget Summary
PFIP Year 1 Funding – $350,000
PFIP Year 2 Funding – $600,000

Cross-Cutting Budget Attribution(s)

Human Resources for Health	142,642

Key Issues

Mobile Population

Budget Code Information

Mechanism ID:	**9271**		
Mechanism Name:	**Malawi AIDS Counseling Resource Organization**		
Prime Partner Name:	**Malawi AIDS Counseling Resource Organization**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HVCT	600,000	

Narrative:

Budget Code - HVCT ($600,000.00)

With year 1 funds we expect to implement the following activities, which will continue in year 2, (FY11):

Activity 1: Support for a National CT Training and Post-training Mentoring Center ($100,000)

MACRO's training centers trained 130 HTC counselors in FY08. With FY09 and FY10 funding, the

training center will continue its close linkage with the direct services outlets operated by MACRO and will provide training to 160 health care workers using the national HTC curriculum. Each course will be limited to a maximum of 20 participants and deliberate efforts will be made to ensure fair representation of males and females in each course. The training center will collaborate with district HTC supervisors to mentor newly qualified CT counselors and give feedback on their performance using standard tools developed for this purpose. In districts with no structures for decentralized mentoring, trainers from MACRO will visit each newly trained counselor at least once within the first 6 post-training months.

Activity 2: Improve HTC services and linkages ($100,000)

MACRO will continue training and mentoring new HTC counselors, and meet the staffing needs of their training center to maximize the quality of training provided. In support of the training decentralization of MOH, MACRO will work with District Health Officers to increase the training provided to the public health sector. In this way, the number of people receiving HTC as a direct and indirect result of MACRO's services will increase.

MACRO will also strengthen linkages between HTC and other facility and community services by working with MOH to develop improved referral and follow-up systems for individuals testing HIV positive, including the strengthening of pre-ART services.

Activity 3: Strengthen all M&E activities ($400,000)

MACRO's EDS hardware and software will all be updated in PFIP year 1, including the implementation of a portable data entry solution for the extensive mobile and outreach testing now being conducted. This will mprove the ability to counselors to quickly and accurately collect data and develop risk reduction plans with their clients. Training to support the implementation of this system will be implemented at all levels.

Year 2 funds in this activity will be used to procure hardware that includes the touch-screen systems and other hand-held devices to capture data at both the static sites and during mobile and outreach activities. Funds will also be used to support data entry clerks and statistical analysis of data. The secretariat staff will be recruited to strengthen communication, connectivity, and data storage for all sites and the secretariat. All Human Resource and Accounting systems will be computerized for greater efficiency and accountability.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9273	Mechanism Name: MSH-SPS
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

PFIP year 1 budget – $281,581

PFIP year 2 budget – $0

Summary

After prolonged negotiations with the HIV/AIDS Unit and the Ministry of Health, it has been decided that the SPS project will focus on building technical capacity related to PMTCT relative to the rational use of medicines and create tools that will assist clinical and management staff to better track and report on PMTCT commodities. The TA provided will not to be limited to PMTCT/ARV drugs only, but rather the focus is to provide technical assistance to create an integrated pharmaceutical supply and rational use/dispensing system. To the extent feasible, some support would be linked to on-going SPS work under malaria medicines supported by PMI. Finally, support to strengthen MOH pharmaceuticals department will be provided as they transition into a directorate, which is critical part of a long term system strengthening and institution capacity development that will have a broader impact on the pharmaceutical sector in Malawi. Both in a short and long term, this support would serve the interest of HIV/AIDS unit and other public health programs.

Background

With FY 2008 PEPFAR funding, MSH/SPS supported the MOH scale up plans for counseling and testing, ART, and PMTCT services by facilitating the integration of HIV/AIDS medicines into the general supply chain to improve overall pharmaceutical management for HIV/AIDS programs. Current support in pharmaceutical management addresses each HIV/AIDS area individually and there is need to consolidate

these efforts under the umbrella of the National Drug Policy in terms of drug selection, procurement, distribution, and rational use.
The procurement of all medicines and medical supplies in Malawi is done in accordance with the Malawi National Drug List and the Essential Health Package. The National Drug Committee is charged with the responsibility of selecting drugs and reviewing the Essential drug list and standard treatment guidelines (STG). MSH/SPS will work with the MOH to update the Malawi Essential Drug List as well as STG with HIV/AIDS medicines, to provide a facilitative policy environment for HIV/AIDS commodities integration into routine supply chain systems, and their rational use at facility levels.
MSH/SPS will continue to work closely with the DELIVER Project and the MOH (the new HIV/AIDS M and E unit) to ensure a seamless complementarity of assistance and training between the two projects. This activity focuses on pharmaceutical management and rational drug use while the JSI - Deliver project focus is on logistics and information systems.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Malaria (PMI)

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9274	**Mechanism Name: MSH TASC III**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Management Sciences for Health	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 500,000	
Funding Source	**Funding Amount**
GHCS (USAID)	500,000

Sub Partner Name(s)

District Health Offices - Malawi		

Overview Narrative

Management Sciences for Health (MSH) works closely with Ministry of Health (MOH) to strengthen family planning (FP) and HIV/AIDS services and is designed to achieve sustainable results. In 2008, Malawi's USAID Mission began funding activities through MSH Community-based Family Planning and HIV/AIDS Services (CFPHS) project to improve access and utilization of family planning and HIV services in rural underserved communities through establishment of fully functional integrated community based FP/HIV services in eight target districts. The population in the eight districts (Karonga, Nkhotakota, Kasungu, Salima, Balaka, Mangochi, Phalombe and Chikwawa) is 3.4 million served by 150 health facilities. USAID's Community-based Family Planning and HIV & AIDS Services (CFPHS) program, implemented by MSH along with its subcontractors, provides a unique opportunity for the GOM/MOH to reposition family planning and improve/increase HIV & AIDS services in communities in the eight target districts.

CFPHS also facilitates policies and guidelines development for social marketing and community distribution of injectable contraceptives. Following policy changes enabling Health Surveillance Assistants (HSAs) to provide injectable contraceptives at community levels, CFPHS has been piloting provision of injectable contraceptives in the target districts over the past year. Through CFPHS, USAID/Malawi also funds a RH Technical Advisor to the Ministry of Health. CFPHS is scheduled to end in September, 2011, and activities funded through this mechanism will play a pivotal role in enabling USAID Malawi to meet its objective of improving the health status of Malawians.

FP/RH and HIV/AIDS services have traditionally been provided at health facility level by professional staff. In order to increase access to community FP/RP and HIV&AIDS services in the context of a severe lack of human resources for health innovations, CFPHS project proposes to invest in training up to 450 CBDAs as volunteer health workers for FP/RP and HIV/AIDS by the end of the project. MSH CFPHS has already trained 75 CBDAs and 15 supervisors (HSAs) to provide door-to-door HIV Counseling and Testing (HTC), referral to FP/HIV services and communication activities to promote positive living,

treatment adherence and increase demand for community FP/RH and HIV/AIDS services. In Year 1 CFPHS trained 21 CBDAs in HTC. By June 2009, these counselors had counseled and tested about 29,000 people. A further 54 CBDAs and 15 HSAs had been trained in HTC by March 2009. Therefore, additional resources will enable the program to train and retain more community-based volunteers through enhanced door-to-door services.

The objective of the CFPHS is to deliver quality, integrated services for Family Planning/ Reproductive Health and HIV/AIDS in 4 of MSH's 8 operational districts namely: Salima, Mangochi, Phalombe, Kasungu. With a population of approximately 2 million people, including about 900,000 adults over age 18, each of the households in the 4 targeted districts could potentially be reached with HTC by an estimated 500 CBDAs if each CBDA visited on average 500 households per year. Given a national adult HIV prevalence of 12%, it is estimated that approximately 90,000 PLHIV live in the four districts, the majority of whom do not know they are infected. These statistics indicate that it would be feasible to scale-up door-to-door testing in these 4 districts and to provide other high yield preventive services (TB screening and nutritional surveillance) in the process of visiting these households.

CFPHS implementing mechanism's strategy relies on an integrated approach to deliver HIV and FP to simulate new activities and meet active demand for HIV Counseling and Testing (HTC) and FP needs by overcoming constraints to accessing services. The activities to be implemented are part of the initiative to be undertaken with Child Survival and Health Population funds and 2008 U.S. President's Emergency Plan for AIDS Relief (PEPFAR) funding.

The key contributions to health systems will be ascertained through the following results: Increased community knowledge and interest in FP and HIV/AIDS services, improved social norms for sexual reproductive health (SRH), FP and HIV/AIDS, increased access and utilization of FP and HIV/AIDS services in communities, improved linkages between point of services, the community and household levels with the existing MOH referral channels and a strengthened enabling social environment for FP, RH, and HIV/AIDS services and behaviors.

CFPHS will enhance collaboration and partnership with district health offices in the four districts. The Community Health Sciences Unit (CHSU), National AIDS Commission (NAC) and MOH's HIV & AIDS Unit have been extremely supportive of this cost-effective initiative and provided necessary guidance regarding Quality Assurance, and logistics management. CFPHS monitors its activities through routine data collection by focusing on 19 core indicators in a reporting system which is integrated in MOH's Health Management Information. M&E tools are being reviewed and adopted for community based recording and reporting.

Budget Summary
PFIP Year 1 Funding – $1,000,000
PFIP Year 2 Funding – $1,000,000

Cross-Cutting Budget Attribution(s)

Human Resources for Health	250,000

Key Issues

Family Planning

Budget Code Information

Mechanism ID:	**9274**		
Mechanism Name:	**MSH TASC III**		
Prime Partner Name:	**Management Sciences for Health**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HVCT	250,000	

Narrative:

II. Budget Code – HVCT

$250,000 – Year 1
$750,000 – Year 2

Activity 1: Community Based HTC

CFPHS will scale-up community-based HTC services in four targeted districts and scale up operations by expanding coverage, access, and consistent use of FP/RH and HTC services. CFPHS will train 450 CBDAs in HTC/TB screening in PHC Training centers at Mponela, Mwanza and Mzimba. Although MOH HTC guidelines call for all clients tested for HIV to be screened for TB at the same time, this is rarely carried out in practice. HTC training will also include a component on couples counseling per the MOH

approved curricula. CBDAs will also be educated about high-yield HIV prevention topics, especially the importance of discordant couples using condoms and the importance of PLHIV receiving regular CD4 testing per national guidelines and initiating treatment as soon as they become immunologically eligible. The DHMTs will support the program by ensuring quality through supervision of counselors in the provision of door to door HTC services.

In addition to HTC, CFPHS will also provide CBDAs with training to conduct quick nutrition assessment/surveillance, particularly of children under 5 while visiting households, using MUAC or similar easy and inexpensive methods. Malnourished children identified will be referred to appropriate levels of care, either at health facilities, village health clinics, or using community-based approaches to manage malnutrition. Household members will also be provided with focused nutritional education and counseling, including assessment of nutritional risks in young children and PLWA.

In addition to the QA in door-to-door supervision, HSAs will receive a four-day training in HTC and TB screening. The training, to be conducted at CHSU, provides a strong link between the program and the MOH in ensuring quality of services. These HSAs will also be trained in collecting dried blood spots for early infant diagnosis from HIV-exposed infants as per national guidelines (currently 4-6). CFPHS will facilitate referral of TB suspects to community sputum collection centers or health facilities nearest to the community level. HSA supervisors will also be trained in sputum collection, so that patients that are suspected of having TB and referred by the CBDAs can have their sputum collected by the HSAs and delivered to a lab for inspection.

To promote quality in provision of community-based HTC services, CFPHS will facilitate quarterly review meetings to share experiences and lessons, and to address emerging issues in implementation. Trained counselors will have an opportunity to discuss challenges with their supervisors and their respective DHMTs. These meetings will also serve as a forum for updating counselors on new developments in HTC.

In order to secure the investment of trained CBDAs, CFPHS will explore various options that would help retain this valuable human resource in the target districts. It is proposed to provide CBDAs with a monthly honorarium of up to MK3,000 as a form of incentive. Obtaining the full amount of incentive will be dependent on CBDAs attaining a target of HTC at least 85% of adults in their catchment area each year (most door-to-door programs in Malawi achieve >90%) and assuring a high-rate of PLHIV identified through HTC in their given area obtain CD4 testing at least once a year during the annual pre-ART days. Mechanisms will be put in place to ensure that such incentives are sustainable and do not act as a disincentive to other cadres of volunteers within same program. Such mechanisms will also require full commitment and buy-in by the GoM/MoH. There is also need to have mechanisms to ensure that quality

of counseling does not suffer.

As CBDAs provide community-based HIV testing, they will require some essential items to enable them to work. These include: bicycles, stop watches and barcode materials. Other essential requirements include sputum collection kits, lap tables, bags, golf shirts, scissors, aprons, umbrellas, raincoats and lamination of HTC protocols.

Activity 2: Synergy with other projects and services

CFPHS will link CBDA activities to other HIV prevention projects including PSI EBT-Prev, BRIDGE II and PACT, to provide the following:

• Family Planning condoms for PLHIV and discordant couples who are identified through the door-to-door HTC activities. The project will collaborate with PSI-EBT project to socially market the new family planning branded condom once it becomes available.
• Communication related to prevention-with-positives for discordant couples developed by the MOH, PSI, BRIDGE II, and/or other partners.
• Active linkages to PLHIV support groups in communities
• CBDAs will also provide referral information about male circumcision to couples once a scale up plan has been developed with national stakeholders.

CFPHS will also collaborate with TB/CAP and Project Hope to implement community-based TB interventions.

Activity 3: Annual pre-ART Saturdays

PLHIV and their partners will be invited to an annual pre-ART Saturday at a nearby health facility or other appropriate location shortly after a given village or set of villages associated with the health center has received door-to-door testing. During this event they will receive education about HIV-prevention, CD4 testing, condoms, cotrimoxazole, and other social support information and referrals. CD4 samples will be taken in the morning and transported to the nearest lab and processed quickly so that results can be phoned to the clinic by the afternoon if possible – if not CBDAs can assist in ensuring patients follow-up to receive their CD4 results at a later time point. This project will liaise with other prevention partners, including Targeted Outreach Communication (TOC) agents funded through the PSI-EBT project, who may be able to provide IEC, films, and other high quality materials to enhance the quality of the information given at the pre-ART Saturdays. The project will seek to link/collaborate with existing PLWH network organizations and other prevention partners to develop sustainable strategies to serve the PLWH and partners in the target districts.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	125,000	

Narrative:

III. Budget Code – OHSS

$125,000 – Year 1
$125,000 – Year 2

Activity 1: Support data collection activities at the district level

Because of the high volume of HIV tests anticipated to be done by the project, , it will be necessary to provide support to the districts to manage the patient data. This will be done in a manner that supports the district systems, rather than creating parallel systems, but will require at least additional staff to support the district M&E officers. These staff will also be responsible for supporting the CBDAs in managing the unique IDs surveillance activity.

CFPHS will strengthen District and Community Provision and management of FP/RH and HIV and AIDS services by supporting the district health management team (DHMT) so that they provide their mandated supervisory and support functions to the health centers. By directing efforts towards the district level, the program can create sustainable supervision and management capacity. CFPHS activities will also focus on strengthening the capacity of the DHMT members to support community based providers, as well as DHMTs capacity in performance monitoring and improvement as related to HIV.

Funding is budgeted for CFPHS to work in collaboration with the MOH and USAID to summarize the results of the door-to-door testing component and disseminate the results in at least one international conference or workshop.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	125,000	

Narrative:

I. Budget Code: HVOP
$125,000 – Year 1
$125,000 – Year 2

Activity 1: Dual Protection/condom distribution at household and community level

CFPHS will integrate HIV/AIDS, family planning and sexually transmitted infections (STI's) prevention through promotion of dual protection, encompassing condom promotion and distribution and other behavioral change efforts to reduce STI/HIV risk at household and community level. The program will focus on integrating all HIV community based activities into CBDAs' role. Trained CBDAs, will promote benefits of HIV testing, as well as promote and distribute condoms among the general population and discordant couples to prevent re-infection. HIV positive women, and couples, will be targeted with family planning interventions to reduce the occurrence of unintended pregnancies among them and PMTCT and ART services available.

Activity 2: Behavior Change Communication

Behavior change communication (BCC) will be incorporated into CFPHS activities and shall portray family planning and HIV testing and treatment as mainstream health interventions.
BCC messages will target women and men as individual clients or as couples as primary targets.

Secondary target groups will include health providers, village headmen, other community leaders, and opinion leaders whose counseling and supporting role is deeply rooted in Malawian culture as agents of change toward more positive social/cultural norms. BCC at community, family and individual level will be enhanced by the trained CBDAs who will conduct interactive, client-centered interpersonal communication activities with their community networks. The target groups will be engaged in discussions, and create a supportive atmosphere where FP and HIV&AIDS topics will be discussed openly.

Quality communication tools will also be made available for counseling clients, and these will also incorporate key actions around reduction of partners, discordance, and prevention with positives. With PFIP year 2 funds, the program will consolidate efforts started with PFIP year 1 resources and continue to increase coverage of the same activities.

Activity 3: Gender

CFPHS will incorporate a gender approach into HIV/AIDS services by training providers to address gender-related barriers/issues, including identifying signs of gender-based violence that should be addressed as part of HIV/AIDS counseling. Steps will be taken to ensure that protocols address legal and support services in the community to mitigate impact (e.g. partner testing and notification to support disclosure).

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9276	**Mechanism Name: NAC GHAI**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: National AIDS Commission, Malawi	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 700,000	
Funding Source	**Funding Amount**
GHCS (State)	700,000

Sub Partner Name(s)

Family Health International		

Overview Narrative

Established in July 2001 as a public trust under the Office of President and Cabinet (OPC), the National AIDS Commission (NAC) provides overall leadership and coordination of the national response to HIV and AIDS. Governed by a Board of Commissioners, NAC facilitates development of policies, frameworks and guidelines; provides technical assistance and financial support to implementing agencies; mobilizes resources to support HIV/AIDS interventions; and monitors and evaluates progress and impact of the various initiatives and programs of the national response.

Under the leadership of the NAC, the three year extended National Action Framework, a strategic document that guides the planning of HIV and AIDS programs, was developed in 2009. NAC, as the national coordinating body for HIV and AIDS, champions the implementation of the National Action Framework to guide various HIV and AIDS interventions by all stakeholders including the public and private sectors, non-governmental organizations, community-based and faith-based organizations and communities nationwide involved in the national response. The Integrated Annual Work Plan (IAWP) is

the principal tool that operationalizes the National HIV and AIDS Action Framework (NAF). As a planning and budgeting instrument, it ensures effective allocation and utilization of resources to achieve the short to medium-term objectives and programmatic targets of the NAF.

The NAC employs the National Monitoring and Evaluation Plan which was created to track and evaluate progress in the implementation of the National HIV and AIDS Action Framework. The NAF is aligned to the Malawi Growth Development Strategy (MGDS), and it aims at achieving priority goals and medium-term expected outcomes outlined under the social development theme of the MGDS. The National HIV and AIDS M&E plan therefore plays a critical role in tracking changes in the HIV epidemic and bringing about policy and programmatic improvements with the aim of effectively contributing towards the achievement of MGDS targets and goals.

The PEPFAR Partnership Framework was developed is collaboration with NAC, the Government of Malawi and other key partners and reflects the national priorities for mitigating the HIV epidemic in Malawi. The NAC will play a critical role in harmonizing and synthesizing the PEPFAR Partnership Framework reporting into the National M&E plan as well as coordinating the evaluation of the national response and providing data to guide policy, program and resource allocation decisions.

Since 2007, NAC has been funded through a cooperative agreement with CDC Malawi with the following primary objectives:

1. Coordination and implementation of national strategic information activities: NAC has the primary responsibility for coordinating and reporting on the national Monitoring and Evaluation plan. With PEPFAR funding, NAC takes a leading role in developing and surveillance strategies, implementing HIV surveillance activities in the general population and as well as high-risk groups, drug resistance monitoring, and carrying out important data dissemination and use activities including data triangulation, epidemic modeling, incorporating data into national policies, developing a research database, and national and sub-national data analysis.
2. Supporting policy development, implementation and capacity building for key national interventions: NAC has been instrumental in providing coordination and capacity building support for innovative new programs including National HIV Counseling and Testing Week. In addition, NAC is a focal partner in providing evidence and leadership to policy development and program implementation for the development and roll-out of male circumcision services.

NAC will implement PEPFAR activities under the National Action Framework and Partnership Framework with direct support to national-level capacity building in the Government of Malawi and other local partners and increasing program scope, scale and quality through the collection and use of strategic

information. NAC does not support any cross-cutting activities.

Budget Summary
PFIP Year 1 Funding – $800,000
PFIP Year 2 Funding – $900,000

Cross-Cutting Budget Attribution(s)

Human Resources for Health	183,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**9276**		
Mechanism Name:	**NAC GHAI**		
Prime Partner Name:	**National AIDS Commission, Malawi**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HVCT	100,000	

Narrative:

Budget Code – HVCT $100,000

Activity 1: Support for Full-time CT Technical Assistant at the MOH:
This is an ongoing activity from 2009. USG will continue to support the salary for a full-time CT Technical Assistant in 2010 at the HIV/AIDS Unit of the MOH. The Technical Assistant will work within the Government of Malawi (GoM) structure providing both technical and programmatic guidance for CT scale up while building local capacity for coordination of CT activities at National level.

Key responsibilities of the Technical Assistant will include:
• Provision of technical guidance to MOH on CT policy guidelines, CT sites development, and CT training; provision of support to MOH in planning, co-ordination and implementation of CT in a variety of

settings, including health care facilities, NGOs, CBOs and private sector; development of national system for CT standardized generic training, Training of Trainers (TOT), and training of CT Supervisors to ensure sustainability of CT service provision; provision of technical guidance in setting quality standards for CT; provision of assistance to MOH in developing and implementing a national system for CT supervision, M&E, and reporting; and conceptualization and implementation of innovative interventions for increasing uptake of CT by underserved communities.
Indicators:
Same as above

Activity 2: Support for Malawi's National HIV Testing Initiatives:

The HIV Testing and Counseling event has been a high profile national campaign involving accelerated community education on benefits of CT coupled with creation of opportunities for all Malawians to access HIV testing and counseling. The bulk of services during the weeklong campaign were provided in temporary sites as outreach to underserved communities. Resources for the exercise including HIV test Kits are provided largely through Global fund monies programmed for CT. The campaigns increased visibility of CT services and give every segment of the population an opportunity to be tested for HIV where they live.

With FY 2009 funding, NAC is supporting activities that strengthen the quality of the National Counseling and Testing Week, and with FY 2010 funding NAC will continue these activities.
Indicators:
P11.2.N

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	200,000	

Narrative:

Budget Code – HVSI $200,000.00

Activity 1: Support the Research and Surveillance Technical Working Group and implementation of the National HIV Surveillance Strategy

The Research and Surveillance Technical Working Group is tasked with the responsibility for developing and overseeing the implementation of the National HIV Research Strategy and the National HIV Surveillance Strategy. It is comprised of members from NAC, the Malawian government, local and international research institutions, NGOs and international donors.

In PF Year 1 and 2, NAC will support quarterly Research and Surveillance TWG meetings. A primary purpose of the TWG will be to develop and disseminate the National HIV Surveillance Strategy in 2010 and support key activities in its implementation in the following year.

Activity 2: Support the HIV Drug Resistance (HIVDR) Surveillance Task Force and implementation of the National HIVDR Surveillance Strategy

By March 2009, the Malawi Ministry of Health had initiated approximately 200,000 people on ART. The national ART program centers around one standardized first-line therapy, and there is very limited use of one standard second line treatment. It is critical, therefore, to monitor the emergence of HIV drug resistance (HIVDR) so that the MOH can respond accordingly. Malawi has adopted a three prong approach to monitoring HIVDR: Threshold Surveys to look at transmission of drug resistance, Monitoring Surveys to understand the development of drug resistance under treatment pressure, and Early Warning Indicators reporting to assess programmatic factors that contribute to the development of drug resistance.

With PF Year 1 funding, NAC is supporting quarterly HIVDR Task Force Meetings. The purpose of the Task Force is to ensure that drug resistance monitoring activities are being conducted on an timely basis and that the results are interpreted, disseminated, and when appropriate, that the MOH is responding by making necessary changes to the national ART program. The HIVDR task force includes more than 15 members from different divisions of the Ministry of Health, development partners, and representatives of the survey sites. In PFIP Year 2, NAC will continue to support the HIVDR Task Force to achieve the above objectives as well as to develop and implement the National HIV Drug Resistance Strategy.

Activity 3: Monitoring HIV among High Risk Populations

With FY 2009 funding, NAC organized regular meetings to review and revise the methodology for monitoring HIV prevalence and risk-taking behaviors in high risk populations. It has been agreed that the next BSS of high risk groups will not take place until after January 2010 so it does not overlap with DHS activities. With FY 2010 funding NAC will continue to support the coordination of BSS activities within the National HIV Surveillance Strategy. These will include revision of the methodology for the survey, data analysis and dissemination of the findings of the survey.

Activity 4: Monitoring HIV among the General Population

With Year 1 funds, NAC will support data collection and analysis for the Demographic and Health Survey

which includes HIV biomarkers. NAC has been highly active in the development and coordination of this activity and will continue to play a key technical and financial role in the implementation of the HIV biological component of this survey including the HIV counseling and testing component, laboratory supervision and quality assurance and analysis activities. With Year 2 funds NAC will support regional/district level data analysis and use of the DHS results.

Activity 5: HIV Incidence Estimation

NAC plays a focal role in using available HIV data to conduct mathematical modeling of the number of people estimated to be infected with HIV and projected to acquire HIV in the future. Incidence estimation currently relies on the UNAIDS/WHO EPP/Spectrum model to conduct these calculations. This information had proven to be invaluable to coordinating and financing the national response, however it has been recognized that additional laboratory estimation methods would provide necessary data for better understanding the incidence of HIV among the general population as well as high risk groups and geographic areas. NAC will continue supporting the process. NAC will also support the coordination and modeling and laboratory-based assay methodologies to estimate incidence, in particular data analysis, dissemination and use of findings as part of the National HIV Surveillance Strategy.

Activity 6: Data Triangulation

With previous funding, NAC supported the triangulation exercise including data collection, analysis and interpretation. With new funds NAC will support dissemination of the findings to all stakeholders for consideration in various HIV and AIDS programme developement.

Indicators:
H7.2.N
H7.5.N
H7.6.N
H7.7.N
H7.8.N
P11.1.D (DHS)

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	100,000	

Narrative:

Budget Code – OHSS $100,000

Activity 1: Support for Full-time CT Technical Assistant at the MOH:

This is an ongoing activity from 2009. USG will continue to support the salary for a full-time CT Technical Assistant in 2010 at the HIV/AIDS Unit of the MOH. The Technical Assistant will work within the Government of Malawi (GoM) structure providing both technical and programmatic guidance for CT scale up while building local capacity for coordination of CT activities at National level.

Key responsibilities of the Technical Assistant will include:
• Provision of technical guidance to MOH on CT policy guidelines, CT sites development, and CT training; provision of support to MOH in planning, co-ordination and implementation of CT in a variety of settings, including health care facilities, NGOs, CBOs and private sector; development of national system for CT standardized generic training, Training of Trainers (TOT), and training of CT Supervisors to ensure sustainability of CT service provision; provision of technical guidance in setting quality standards for CT; provision of assistance to MOH in developing and implementing a national system for CT supervision, M&E, and reporting; and conceptualization and implementation of innovative interventions for increasing uptake of CT by underserved communities.

Indicators:
H2.3.N
H6.1.D

Activity 2: Strengthening Capacity for District- Level Monitoring and Evaluation ($200,000 PF09 Funds)
Malawi has instituted a wide-scale decentralization of health services including responsibility for planning, implementation, financial management and monitoring and evaluation of HIV programs now resting at the district-level with Local Assemblies (LA). Districts require capacity building in order to implement and monitor quality programs and feed their results to the national level. Through a cooperative agreement between NAC and the Ministry of Local Government and Rural Development, USG will support the GOM to build the capacity of LA's to strengthen district-level monitoring and evaluation systems. Through this support at the central level, the Ministry of Local Government can create a sense of ownership and foster leadership in the district and community response. This is a new activity in FY11.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	300,000	

Narrative:

Budget Code – CIRC $300,000 - Year 1 funds

Activity 1: Dissemination of and sensitization on the male circumcision policy

With FY 2009 funding, NAC will provide national leadership in the development of the Male Circumcision Policy, in collaboration with other local and international partners. This policy will guide the implementation of interventions in the country, and wider dissemination of the policy as well as sensitization of communities and local leaders will take place in FY2010.

Activity 2: Critical Operations Research

In FY10, a rapid assessment of male circumcision is being undertaken in Malawi, and it is anticipated that this will raise some questions with regard to gaps in the current knowledge and practice of male circumcision in the country. PF Year 2 funds will be used in conjunction with other partners to support time-limited operations research that will help answer some of those questions. For example, efforts will be made to better understand confounding factors that may drive the high prevalence of HIV infections among communities with the highest proportion of male circumcision, the Yao, and the Lomwe ethnic groups.

Activity 3: Male Circumcision initiatives

NAC will work with the Male Circumcision sub-group of the National HIV Prevention Task Force, which is led by the Ministry of Health, to identify and fund priority male circumcision initiatives and campaigns to pilot and/or scale-up. This activity will begin in PF Year 1 and be expanded in FY 2010 Indicators:
P5.1.N
H6.1.D

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9277	**Mechanism Name: PACT CSH**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Pact, Inc.	
Agreement Start Date: Redacted	Agreement End Date: Redacted

TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 2,850,000	
Funding Source	**Funding Amount**
Central GHCS (State)	75,000
GHCS (State)	275,000
GHCS (USAID)	2,500,000

Sub Partner Name(s)

Baylor University, College of Medicine	Community Partnership for Relief & Development	Ekwendani Mission Hospital
Elizabeth Glaser Pediatric AIDS Foundation	FVM Matunkha Centre	Lusubilo Community Based Orphan Care
Malamulo Hospital	Mponela AIDS Information and Counseling Centre	Namwera AIDS Coordination Committee
National Association of People Living with AIDS in Malawi	Nkhoma Mission Hospital	Nkhotakota AIDS Support Organization
Partners in Hope	Toga Laboratories	UCLA Program in Global Health

Overview Narrative

Pact Malawi's mission is to help build strong communities that provide people with an opportunity to earn a dignified living, raise healthy families, and participate in democratic life. Pact achieves this by strengthening the capacity of grassroots organizations, coalitions, and networks, and by forging linkages among government, business, and the citizen sectors.

In 2007 Pact, Inc. was awarded a cooperative agreement from the USAID/Malawi to implement a HIV and AIDS grants management program in Malawi. This rapid response mechanism for HIV and AIDS in Malawi is part of Pact Malawi's global Community REACH (Rapid and Effective Action Combating HIV/AIDS) program, which offers competitive grant awards to local NGOs, CBOs, and FBOs to support best practices and innovative approaches to community-based HIV and AIDS prevention, care, and support activities. The Community REACH program is in its third year of implementation. To date, Pact Malawi has supported seven "roll-over" grantees from FHI and Save the Children, and twenty seven grantees have received awards through three competitive APS solicitations, including one request for proposals for a local organizational development partner.

Pact Malawi's strategic approach combines the efficient distribution of funds through the Community REACH grant mechanism with comprehensive technical assistance and capacity building for NGOs, supporting a coordinated, country-level US Government response to HIV and AIDS that is in line with the National AIDS Framework (NAF).

Pact Malawi Community REACH program complements and aligns itself to the goals of the NAF and USG-Malawi Partnership Framework by pursuing the following objectives:
• To implement an effective and transparent grant award and administration system to support responsive, fast-track assistance to organizations responding to the HIV and AIDS pandemic in Malawi.
• To provide implementers with access to financial resources and high-quality technical expertise they need to deliver effective programming and report results.
• To expand and strengthen the Malawian civil society response to HIV and AIDS by providing capacity building to increase their capacity to provide and sustain HIV and AIDS and related health services.

Pact Malawi partners implement activities across the following PEPFAR program areas: Prevention AB, Prevention Other, PMTCT, OVC, HTC, Care and support/HBC, Strategic Information, and Capacity Building/Systems Strengthening. Target groups depend on the individual grantees' program, but range from general population to high risk groups including fishermen and sex workers.

Pact Malawi's partners for FY10 and 11 (1 October 2010- 30 September 2011) include: Community Partnership for Relief and Development (COPRED), Ekwendeni Mission Hospital, FVM Matunkha, Lusubilo, Mponela AIDS Information and counseling centre (MAICC), Malamulo, Namwera AIDS Coordination Committee (NACC), National Association of people living with HIV/AIDS in Malawi (NAPHAM), Nkhotakota AIDS Support Organization (NASO), Nkhoma Mission Hospital, Partners in Hope (PIH), Southern African AIDS Trust (SAT), Society for women Against HIV/AIDS in Malawi (SWAM), and Tovwirane.

All of Pact Malawi's sub partners will close grants in either FY10 or FY11. Pact will conclude required close-out activities for these programs by the program end date, September 30, 2011. However as Pact prepares for the end of project close outs, Pact continues to establish strong linkages with local HIV/AIDS NGO networks and NAC to ensure sub partners transition into meaningful partnerships with these organizations for sustainability of Pact supported activities. However in doing so, Pact also recognizes the Organizational Development and grant management capacity gaps that are faced by these entities respectively and will continue to engage with them as necessary to provide and strengthen support. An end of project evaluation will be conducted in FY11 and depending on findings; Pact will recommend that the most improved sub partners also transition into partnerships with either USAID, (as Primes), NAC or

National NGO networks according to technical or organizational competence levels.

Budget Summary
PFIP Year 1 Funding – $4,371,100
PFIP Year 2 Funding – $2,850,000

Cross-Cutting Budget Attribution(s)

Education	289,832
Food and Nutrition: Policy, Tools, and Service Delivery	288,710

Key Issues

Increasing women's access to income and productive resources

Budget Code Information

Mechanism ID:	**9277**		
Mechanism Name:	**PACT CSH**		
Prime Partner Name:	**Pact, Inc.**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	327,331	
Narrative:			
V. Budget Code: HBHC $751,140 – Year 1 $327,331 – Year 2 In FY10 Pact Malawi will support thirteen indigenous organizations to provide HBHC. Pre-Art interventions			

As Pact Malawi responds to and aligns itself with technical direction in the Partnership Framework, In FY 10 and 11 Pact Malawi partners implementing HBC programs will be encouraged and supported to focus on Pre ART interventions beyond community based HBC. Pact partners will continue to provide the following services to support pre- ART interventions and strategies; provision of cotrimoxazole prophylaxis to all eligible adults, children and infants, CD4 count checks every six months where services are available (Nkhoma, Lighthouse, Ekwendeni, Malamulo), monitoring clients to access the services and promoting referrals by providing transportation incentives(NAPHAM, LIHASO), Conduct screening /assessment and treatment of opportunistic infections including TB and STIs, Some partners will provide nutrition support including assessment and malnutrition prevention activities. Pact will ensure technical capacity for Pre–ART support is built among partners. Partners will also continue with community HBC programs and will provide services that encourage positive living and early access to HTC and ART.

Support for Families and Care Providers

Partners implement activities to support family members and other care givers for PLHIV as part of a comprehensive care and support program. All partners providing care and support promote volunteer retention via training, provision of materials/incentives and self motivation. Self motivation for volunteers is one of the major motivating factors achieved by COPRED, Lighthouse and Nkhoma.

Nutrition Support

Partners implement nutrition support programs for PLHIV as part of comprehensive care and support. Nutrition assessments for PLHIV are conducted through HBC programs using national guidelines at the facility and community level. Partners also provide nutritional supplements including likuni phala, RUTF. Partners provide nutrition counseling to PLHIV and their care givers to promote adequate diet, weight maintenance/gain, and proper hygiene and sanitation. Livingstonia Synod, Lusubilo, FVM Matunkha and COPRED continue to utilize their internal referral systems to link PLHIV clients to food and economic programs provided by their organizations but supported by other donors. All service partners' interventions for patient care, including food security, will be reinforced through a multi-sectoral approach of linking PLHIV to support groups for gardening and livestock rearing to meet nutritional needs, as well as to provide an income generating source for other needs.

Ekwendeni hospital will from October this year implement a nutrition program known as Micronutrients and Health (MICAH) Project funded by USAID/Malawi which also complements the HIV/AIDS care efforts. The project is aimed at improving the health of women of child bearing age and children less than five years of age through micronutrient fortification of food..

Psychosocial Support

Pact Malawi's partners also provide psychosocial support for PLHIVs and their families. They will facilitate the strengthening of post-test clubs and support groups for PLHIVs for positive living through

activities such as counseling and group therapy, shared learning, and information on ways for coping with common concerns of PLHIV. Integration of adherence counseling for Pre ART and ART clients is a priority.

Pediatric HIV/AIDS Care

Nkhoma and Livingstonia Synod will continue offering early pediatric HIV diagnosis and care at their facilities as this area of programming rolls out to other facilities nationally. All exposed infants of HIV+ mothers identified through PMTCT activities and all suspected HIV infants, including those with TB, severe malnutrition, failure to thrive, chronic fevers, and severe childhood conditions, and with unknown HIV status are included. Partners without such facilities will continue to test children for HIV at 18 months. Please refer to the PMTCT narrative for additional information. Care givers utilize the care and support field guide to provide support to affected children. MAICC, PIH, Lighthouse, Tovwirane and Matunkha will train volunteers in pediatric HIV/AIDS care to build their capacity as care givers.

Preventative care

During FY10, partners will work to strengthen positive prevention messages within care and support. Positive prevention covers a range of topics including prevention of re-infection which can lead to ART resistance, prevention of STIs, vertical transmission of HIV, and the importance of family planning.

Capacity Building of Service Providers and Partner Organization

Partners will provide training, supportive supervision, and mentoring for HBC providers and volunteers. The partners train providers using national training protocols and guidelines. Training topics include general care and support, data management and community HBC. PACAM will conduct training for staff and continue providing technical support in implementation of care and support services for Pact Malawi partners.

Advocacy/Policy, Quality, and Standards

Pact Malawi will continue supporting its partners to deliver services following the national guidelines and policies and minimum care package for care and support. Pact Malawi will continue using the quality assurance monitoring tool it developed in supporting partners. Pact Malawi will continue participating in national forums that work on development and monitoring of HIV care standards including the national HBC working group. Partners will utilize existing community mobilization strategies within their organizations to advocate for HBC in their communities and promote Care and support as part of integrated treatment, care, and support for both children and adults living with HIV/AIDS. PACAM will continue advocating to the government for access to pain management drugs such as Morphine as well the integration of the palliative care in the health workers training manuals. PACAM in collaboration with APCA will finalize and disseminate the OPIOD hand book and the volunteer's manual.

Grantee Closeout

Of Pact Malawi's partners implementing HBC/PC activities, only Lighthouse and PACAM will close in FY10. Malamulo, COPRED, NASO, Lusubilo, NAPHAM, MAICC, PIH and Ekwendeni were selected through the FY09 APS to extend their programs through May 2011.

With Year 2 funding Pact will implement the following activities:

In FY11 Pact Malawi partners will continue to provide the range of care and support services mentioned above to support families and care givers, treatment of opportunistic infections, provide nutrition support, pediatric HIV/AIDS care, psychosocial support, spiritual support, policy/advocacy, and quality and standards of care development. Pact Malawi will continue to provide up to date technical assistance, organization capacity building support and financial assistance to these grantees.
Pact Malawi's partners – COPRED, Malamulo, NASO , Tovwirane, Ekwendeni, MAICC , Malamulo , and PIH will continue implementing care and support including clinical care, preventative care, and psychosocial support. Pact Malawi's partners implementing HBC/PC activities will close in May 2011.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	599,619	

Narrative:

VI. Budget Code: HKID
$893,250 – Year 1
$599,619 – Year 2

The Malawi government and USG have committed themselves to uplifting the lives of OVC through innovative interventions.

Social Mobilization to Increase Community Awareness of OVC Issues
Pact Malawi's local partners target community leaders in their catchment areas with interventions to address the critical needs of OVC and the role they can play to encourage the community to support OVC programs. Interventions include sensitization on promotion of child protection, children's rights, prevention of harmful cultural practices, succession planning to reduce victimization of children in the case of a parent's death, as well as stigma and discrimination reduction. HIV prevention activities including referrals to HTC and PMTCT are integrated in to this process. Pact Malawi partners work closely with the Child Care Protection Workers (CCPW) who are under the DSWO to register and conduct community mobilization on child protection.

Age-Specific Interventions

Age-group-specific interventions (0-5years, 5-8 years, 9-12 years, and 13-17years) are implemented by all partners to ensure each child receives relevant support to promote growth, development, and protection.

Programs for younger OVCs address the need for early childhood development (ECD) OVC growth monitoring; prevention of childhood illnesses including immunizations with support from health staff in their districts; clean water, hygiene and sanitation. Severely sick children are referred to health centers for additional care. Expanded 'kid's clubs' for school going children aged 6-12 to provide sports, counseling, conducting memory book sessions, psychosocial support, life skills

Older OVC aged 13-17 participate in youth clubs. Peer educators are supported with training. Partners provide education support for OVC in the form of school fees, uniforms, and other school requisites, and by monitoring the children's school performance. Partners will provide school fees for secondary school going OVCs as well as vocational skills. COPRED will renovate one of the CBCCs for OVCs.

Partners provide continuous technical support to households, communities and volunteers to strengthen their capacity to provide care and support for OVC, to be more responsive to the needs of OVC, and to take ownership of interventions within their community to address OVC issues.

Nutrition Support

COPRED, NACC, MAICC and Tovwirane have communal gardens for their CBCC and they encourage the guardians to have a kitchen garden to meet the nutritional needs of OVC. MAICC has developed a partnership with Land'O' Lakes who provides 10% of their milk production weekly to the CBCCs. Under this program, 12 CBCCs are benefiting from the milk which is given to the children attending the CBCC. Communities are able to contribute food to the CBCCs including maize, groundnut, soya beans, and fruits. Pact partners are encouraged to link up with other organizations for nutritional support.

Technical Support to Partners

Pact Malawi has developed a minimum package of OVC service provision that forms the basis for partners' OVC programming and helps to improve the quality of OVC services. Pact Malawi will also adapt the Child status index (CSI) tool which will be used to assess the needs of the OVC and monitor the services provided. Pact Malawi will ensure that all partners have volunteers/ caregivers that are trained on how to use the CSI and minimum standards. Targeted technical support for individual grantees will continue to be conducted based on grantee needs and technical gaps.

Grantee Closeout

Of Pact Malawi's partners implementing OVC programs, only Zomba Catholic Health Commission will close in FY10. COPRED, NASO, Lusubilo, NAPHAM, MAICC, NACC and Mathunkha were selected through the FY09 APS to extend their programs through May 2011.

With Year 2 funding PACT will implement the following activities:

Pact Malawi's local partners will continue to implement OVC interventions as outlined above and Pact will continue to provide technical guidance to sub partners to align implementation with the PEPFAR partnership framework. All of Pact Malawi's OVC grants will close out in May 2011.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	279,214	

Narrative:

VII. Budget Code: HVCT
$558,650 – Year 1
$279,214 – Year 2

Pact Malawi's partners – Malamulo, MAICC, CCAP Nkhoma Synod, Ekwendeni, PIH, NACC, FVM Matunkha, Lighthouse, COPRED, NASO and MACRO are contributing to the national scale up of HTC in Malawi.

Community Mobilization
In FY10 Pact Malawi's local partners will continue sensitizing and mobilizing communities for HTC. Community gate keepers will be involved in HIV/AIDS awareness interventions to utilize available HTC services, as well as encouraging individuals to go for. Partners will also target high-risk groups such as migrant workers, youth, and pregnant women and their partners (Malamulo, Ekwendeni); fishermen and sugar plantation workers, (SAT, SWAM); youth (MAICC, PIH), and rural, inaccessible communities (NACC, FVM Matunkha).

HIV Counseling and Testing
In FY10 all Pact Malawi partners will continue working in collaboration with the District Health Offices to receive HIV test kits in order to provide HTC services to communities through static and outreach sites, as well as mobile services targeting men, women, youth, and HIV exposed and suspected infants aged 18 months and above. A family centered model will be implemented by Lighthouse where client (PLHIV) households will have HTC services provided right in their homes. Door to door initiatives will continue to

be implemented by MAICC, PIH and Nkhoma.

Establishing/Strengthening an Effective Referral System
All partners will maintain effective internal and external referral systems. Back referral mechanisms will also be strengthened. Partners will maintain inventory of necessary structures within their catchment areas to facilitate referral of clients such as TB and STI patients to HTC services and positive post-test clients to care and support services. HIV negative clients are referred to post-test clubs and other prevention programs in the community.

Capacity Building of Service Providers and Volunteers
Implementing partners support capacity building of volunteers and service providers through trainings, supportive supervision, mentoring and coaching to ensure the application of knowledge and skills. Capacity building is provided in HIV counseling, including integration of PMTCT, STI, nutrition, and TB information; HIV testing using the rapid test; couple and child counseling. Service providers are trained in psychosocial support to support PLHIV groups and post-test clubs or to encourage their establishment where they do not exist. Community volunteers are targeted for development of skills in their related areas of involvement, such as community mobilization and community motivation. Pact Malawi trains partner organizations in monitoring, evaluation, and reporting, as well as organizational development. See Pact Malawi's SI and Policy/Systems Strengthening submissions.

Grantee Closeout
Of Pact Malawi's partners implementing HTC programs, only Lighthouse and MACRO will close in FY10. Malamulo, MAICC, CCAP Nkhoma Synod, Ekwendeni, PIH, NACC, FVM Matunkha, COPRED, and NASO were selected through the FY09 APS to extend their programs through May 2011.

With Year 2 funding:
Pact Malawi's partners – Malamulo, MAICC, CCAP Nkhoma Synod, Ekwendeni, PIH, NACC, FVM Matunkha, COPRED, and NASO will continue to contribute to a national scale up of HTC in Malawi. Pact Malawi's HTC grants will close out in 2011.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	66,416	

Narrative:

VIII. Budget Code: HVSI
$125,190 – Year 1
$66,416 – Year 2

Pact provides M&E training to its partners to capture the impact and outcomes of their interventions in accordance with national and PEPFAR standards. At the district level, partners are encouraged to participate in the development of district implementation plans (DIP). Pact Malawi has global and local expertise in monitoring, evaluation, and reporting (MER), which it draws upon to provide technical assistance and capacity building for its local partners in Malawi. Pact Malawi conducts brief, introductory MER orientation in pre-award workshops followed by in-depth MER trainings as projects progress. Pact also provides focused, individualized MER technical assistance to partners during regular monitoring/supervision visits, and DQAs. Pact Malawi also provides its partners with MER tools, resources, and materials that can be used to strengthen their program implementation.

Trainings

In FY 10 and 11 in-depth detailed training on the Next Generation Indicators will be conducted for all Pact partners. This will enable partners to revisit their data collection tools to ensure that they are able to collect quality data for the new indicators. Improved MER skills acquired by participants facilitate sustained program quality beyond Pact's funding.

Data Quality Assessments and Quality Assurance
All Data Quality Management Plans will be consolidated in FY10 through on-site mentorship and support visits from Pact Malawi. Pact Malawi developed a quality assurance framework for the program which is employed to strengthen development of minimum standards for key technical areas. During FY10, Pact will continue to address quality assurance issues through mentorship and support visits to partners and provision of focused and individualized M&E support to partners.

Grantee Closeout
Pact Malawi's partners will close grants in either FY10 or FY11. Pact will conclude required close-out activities related to MER for these programs by the program end date, September 30, 2011.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	171,228	

Narrative:

XV. Budget Code: OHSS
$400,860 – Year 1
$171,228 – Year 2

Through this program area, Pact Malawi provides capacity building technical assistance in several areas to the Government of Malawi and HIV/AIDS service providers. Pact has global and local expertise in capacity building activities related to organizational development, financial management, monitoring and evaluation, and HIV/AIDS policy and technical areas, which will contribute to enhanced operational efficiency and increased sustainability of organizations participating in the national response to HIV/AIDS.

Support to the Global Fund Secretariat
In FY 10, Pact Malawi will recruit and train a program manager for a new, independent secretariat for the Malawi Global Fund Coordinating Committee. This manager, with support from Pact Malawi, will establish procedures and systems for the Secretariat and support the functioning of the MGFCC.

Organizational Development
In FY 10 and 11, Pact Malawi, in conjunction with its local OD provider CABUNGO, will conduct two in-depth organizational development workshops for its partners on common themes that emerge from partners ISPs. Themes might include human resource management, volunteer retention, strategic planning, etc.

Pact will continue to coordinate and oversee the OD activities. These will include conducting joint trainings and targeted interventions as identified through partner Institutional Strengthening Plans (ISP). A strategy for close follows up after the interventions and indicators will be developed.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	75,000	

Narrative:

$83,460 – Year 1
$75,000 – Year 2

The National HIV and AIDS policy stipulates that the use of disposable sterilized injections can reduce the risk of HIV infection. The government has put in place systems to ensure that disposable materials and sterilizing equipment are in all health centers. Dissemination of appropriate and up-to-date information on the dangers associated with unsterilized material is a priority. Through USG/Pact Malawi funding the Nurse and Midwives Council of Malawi (NMCM) has produced Post Exposure Prophylaxis protocols and guidelines for use by health care workers. NMCM will receive a fixed price contract to finalize the dissemination of the PEP training materials during this fiscal year.

Reproduction and Dissemination of Training Materials

NMCM will reproduce PEP training manuals and guidelines developed in FY09 to be used for trainings during this fiscal year. Materials were designed for different categories of health workers at the facility level and also community-based service providers involved in patient care in all districts of Malawi. The materials focus on infection prevention, universal precautions, and post exposure prophylaxis. Ministry on Health Technical experts and trainers were involved in developing the training materials. NMCM will develop a plan for materials distribution that will meet the needs of each district.

Health Worker Training

NMCM will conduct training in all districts of Malawi targeting different categories of health workers on infection prevention, universal precautions, and post exposure prophylaxis (PEP). Master trainers will train trainers at the district level, who in turn will roll out training to service providers at the institutional and community levels. A separate training specifically on PEP will also be conducted in all the districts in the country. The second training will target service providers who will be offering PEP, and will be conducted at the regional level.

NMCM's current grant was to end in FY10.

Additional one-time funding for HMIN:

Activity 1: Strengthening the current in-service PEP trainings being conducted by NMCM in FY11 to enable these trainings to incorporate a more substantial component to train providers in injection safety. As noted above the current trainings, while having some content on injection safety, are mainly focused on PEP. However, it would be e cost-effective to include more injection safety activities within these ongoing trainings

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	663,236	

Narrative:

II. Budget Code: HVAB
$834,600 – Year 1
$663,236 – Year 2

Partners implement a range of abstinence focused activities including mobilization of youth through existing and/or new structures (e.g., schools, church groups, and other community based forums);

facilitating youth clubs formation; provision of youth friendly services; and training of peer educators and youth patrons, including faith leaders.

With Year 1 Funds Pact will implement the following:

Community Sensitization and Youth Mobilization
Nine Pact Malawi implementing partners - SAT, Malamulo, MAICC, COPRED, FOCUS, Tovwirane, MBCA, MIAA and NASO – conduct community mobilization activities that include community sensitization meetings, drama, open days where social activities like football, netball are used to attract a large audience, learning exchange visits as well as targeted community meetings. In FY10, the partners will reshape these strategies to focus on smaller group activities that support interpersonal communication between PEs and the constituents they serve.

Facilitation of Youth Groups and Youth Friendly Services (YFS)
All partners will continue to strengthen these existing youth groups through various capacity building activities targeting both male and female youth that focus on in-depth information sharing, education, and communication on abstinence and faithfulness, including life skills development to maintain a healthy lifestyle. Malamulo, Ekwendeni, MAICC, AHS and Nkhoma are sensitizing service providers on youth-friendly reproductive health services, and are providing referrals to reproductive health services including STI management, HTC, and resource centers at district health offices.

Training of Peer Educators and Youth Patrons
All Pact Malawi's partners implementing AB activities will build the capacity of peer educators and youth patrons (older youth that serve as role models and provide emotional support for youth) through training, follow-up support, and mentoring. In FY10 Pact Malawi's AB partners will scale down mass outreach and other outreach activities and focus most of their attention on implementing small group youth discussions and other outreach activities as described above.
Technical Assistance and coordination
Pact Malawi will build the capacity of youth prevention organizations to access funds from the National AIDS Commission and the Global Fund. Specifically, Pact staff will work with these organizations to improve their documentation of best practices.
Staff Capacity Building
Pact Malawi's partners will continue training their staff in technical areas including BCC and interpersonal communication skills in order to strengthen their AB programs. Partners' staff member are also trained in strategic information and data management
Grantee Closeout
Of Pact Malawi's partners implementing AB activities, five will close at the end of FY10 (September 30,

2010): MIAA, CCC, MBCA, COVISODE, and FOCUS. The remaining partners were selected through the FY09 APS to extend their programs through May 2011.
With Year 2 funds Pact will implement the following:

The following Pact Malawi partners will support the implementation of above mentioned AB activities contributing to the prevention and behavior change component of the national HIV/AIDS program in FY11: Malamulo Hospital, Synod of Livingstonia at Ekwendeni, Southern Africa AIDS Trust (SAT), Mponela AIDS Information and Counseling Centre (MAICC),Nkhoma National Association of People Living with HIV and AIDS in Malawi (NAPHAM), Lusubilo, Community Partnership for Relief and Development (COPRED), Nkhotakota AIDS Service Organization (NASO), Namwera AIDS Coordinating Committee (NACC), Society for Women and AIDS in Malawi (SWAM), Nkhotakota AIDS Service Organisation (NASO), Tovwirane, Partners in Hope (PIH), FVM-Matunkha.
All Pact Malawi partners implementing AB will close in May 2011.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	293,379	

Narrative:

III. Budget Code: HVOP
$417,300 – Year 1
$293,379 – Year 2

In FY10 Pact Malawi's local partners- Ekwendeni, MAICC, SAT, MACRO, COPRED, NAPHAM, Malamulo, FOCUS, CCC, NACC, FVM- Matunkha and SWAM- will be implementing AB activities linked to the overall national HIV/AIDS prevention program for Malawi. The implementing partners will build on their previous experiences to expand their programs in FY10/11 to target men and women, especially high-risk groups such as sexually active youth, migrant workers, with HVOP messages through HTC services, PMTCT services, youth friendly services, and links to family planning services.

With Year 1 funding Pact will implement the following:

Training of Behavior Change Communication (BCC) Facilitators
Pact Malawi will continue to support SWAM, MAICC, Nkhoma, SAT, NACC, FOCUS, Malamulo, Ekwendeni, MBCA, and COPRED to train facilitators to use the Hope Kit HIV prevention training tool. This tool, developed through the Bridge program, uses experiential learning methods to assist people in moving from knowledge to action.

Comprehensive HIV Prevention Activities
Pact Malawi's partners support the implementation of comprehensive HIV prevention activities that include the promotion of safer-sex practices, condom distribution, promotion of consistent and correct condom use through static and outreach sites, sensitizing individuals and groups on HIV prevention, and HIV awareness campaigns. Gender equity and women's empowerment build self efficacy and decision making skills on HIV prevention issues, reduction of stigma and discrimination through active involvement of PLHIV and advocacy for leadership, secondary prevention activities (prevention for positives). Activities also strive to promote provision of clinical services, management of sexually transmitted infections (STI), advocacy for policy adjustments and provision of HTC. Malamulo, MBCA, SAT, NAPHAM, SWAM, FOCUS, and MACRO are supporting the printing and distribution of IEC materials that promote HTC.

Staff Capacity Building
Partners are supporting the capacity building of service providers through training, follow-up support, mentoring in technical skills, and supervision of volunteers to ensure effective implementation and scale up of HIV prevention programming. In addition, capacity building will also be provided through strategic information management (See Pact Malawi's SI and Policy/Systems Strengthening submissions).

Grantee Closeout

Of Pact Malawi's partners implementing HVOP activities, five will close at the end of FY10 (September 30, 2010): MIAA, CCC, MBCA, MACRO, and FOCUS. The remaining partners were selected through the FY09 APS to extend their programs through May 2011.
With Year 2 funding pact will implement the following:

In FY11 All partners will provide HIV/AIDS prevention interventions beyond those focused on abstinence and/or being faithful as above. Condoms are supplied by District Health Officers (DHOs), Banja La Mtsogolo (local NGO family planning centers), and Population Services International (PSI). The implementing partners will build on their previous experiences to expand their programs in FY11 to target men and women, especially high-risk groups such as sexually active youth, migrant workers, with HVOP messages through HTC services, PMTCT services, youth friendly services, and links to family planning services. Pact Malawi will work to ensure that the partners understand OGAC ABC guidance in implementing their HVOP activities.

All Pact Malawi partners implementing HVOP activities will close out in May 2011.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Prevention	MTCT	374,577	

Narrative:

I. Budget Code: MTCT ($374,577.00)

Pact Malawi has four FBO partners that are implementing PMTCT programs. These partners are proving PMTCT services in 20 health facilities Combined. The majority of their health facilities are in the rural areas, thereby improving accessibility to PMTCT services for rural populations. The PMTCT activities implemented through year 1 are summarized below.

Community Mobilization for PMTCT
Pact Malawi's PMTCT partners conduct community mobilization activities in their catchment areas, including sensitization on the importance and benefits of available PMTCT services. Women of reproductive age and their partners; community leaders and other gatekeepers such as traditional healers, community women counselors, and traditional birth attendants; and grandparents who are custodians of culture and have influence on maternal and child health practices will be targeted with messages to strengthen community support for PMTCT and encourage use of available services. Mainstreaming gender activities into PMTCT programs is also a key component.

HIV Counseling and Testing (HTC)
Pact Malawi partners provide HTC for PMTCT as part of integrated Maternal Child Health (MCH) services. In addition, exposed and suspected infants including, but not limited to, children with TB, severe malnutrition, failure to thrive, chronic malaria, and other severe illnesses at 18 months will be targeted for HIV testing and their parents counseled for HIV. A family centered approach is applied to identify other HIV-infected family members through an index case, which could be a mother or child identified in the MCH services, post-Delivery Follow-up of Mother/Infant pairs.
All four partners have already adopted provider-initiated HTC using the opt-out approach for PMTCT in MCH services

Follow-up Care and Support for HIV-Positive Mothers during Pregnancy, Labor, and Delivery
Pact Malawi's partners will continue to strengthen follow-up care and support services for HIV positive women through pregnancy, labor and delivery. During pregnancy mothers are monitored using WHO staging, HB tests, CD4 count test, and clinical care management including initiation or continuation of prophylaxis treatment of OIs and ART. Health status of the women is monitored during their antenatal visit, those with high CD4 count at initial visit and not eligible for ART, are monitored during the follow up visits for any signs and if need be another CD4 check is done. Counseling on risk reduction and positive living is given. Maternal nutrition is assessed through routine ANC weight motoring, provision of micronutrient supplements, and counseling on diet related issues and infant feeding options.

Post-Delivery Follow-up of Mother/Infant pairs
Pact Malawi's partners will continue to provide follow-up services for mother and infant pairs. All exposed infants, including those delivered at home if they reported to the health facility within 72 hours, will be provided ARV prophylaxis as per national guidelines. Mother's will be counseled on different infant feeding options, and on other essential newborn care including, but not limited to: Cotrimoxazole prophylaxis according to the national protocol, immunizations, monthly growth monitoring and assessment of presumptive signs for HIV. Monthly monitoring of mother and infant pair up to 18 months is conducted. Mechanisms to strengthen mother and infant follow up have also been developed by partners

Referrals and Links to Treatment, Care, and Support Services
All partners implementing PMTCT activities will continue to strengthen and/or establish new links for collaboration among partners and referral systems for mothers and exposed infants to access available services along the continuum of care for HIV/AIDS including, but not limited to: ART, nutrition support, psychosocial support through mother support groups, and other community support systems.

Staff Capacity Building
Partners will continue training their staff in PMTCT management to meet the increasing demand from the communities in which they work. Members of staff are trained in strategic information and data management to enable them to monitor program progress and make changes as necessary to effectively meet practice standards and program targets (See Pact Malawi's SI submission).

Grantee Closeout
Of Pact Malawi's four partners implementing PMTCT activities, only AHS will close at the end of FY10 (September 30, 2010). Malamulo, CCAP Nkhoma, and Ekwendeni were selected through the FY09 APS to extend their programs through May 2011. Prior to this date, Pact Malawi will submit an outline of the Final Program Report to the AOTRs for discussion and approval. This report will include a summary of the successes, challenges, and lessons learned regarding all programmatic areas.

With Year 2 funds Pact will implement the following activities:

Pact will have three FBO partners implementing PMTCT programs: Malamulo SDA Hospital, CCAP Nkhoma Hospita, and Livingstonia Synod Ekwendeni Hospital. These partners will be providing the above mentioned PMTCT activities in 12 health facilities; all the three are contributing to the scale-up of quality and comprehensive PMTCT services in Malawi. The majority of their health facilities are in the

rural areas, thereby improving accessibility to PMTCT services for rural populations.
Malamulo, CCAP Nkhoma, and Ekwendeni's grants will close in May 2011.

1. Supporting national scale-up of lay cadres and expert patients through PACT's existing community-based partners

The move to start pregnant women on ART at an earlier CD4 count will necessitate more intensive psychosocial support, as data from several settings seem to indicate that such clinically well patients are at a higher risk for default than other patients starting ART. The Tingathe program, which is implemented in Malawi by Baylor College of Medicine, is an example of a successful intervention with lay cadres that has shown dramatic results in the improvement in the PMTCT cascade In order to cost-effectively scale-up such lay cadre/PSS approaches, the USG strategy will be to support Baylor to a sub-set of high-volume sites (see Baylor COP entry), but at the same time provide complementary support through a network of community-based platforms that are already on the ground to expand standardized approaches with lay workers in a way that is sustainable and can be taken to national scale. PACT has a strong network of indigenous implementing partners that the USG will build upon to saturate the districts where these partners are operating with community-support for PMTCT. These partners include MAICC in Dedza; Namwera in Mangochi; Towvirane in Rumphi; COPRED in Mwanza and Blantyre; FVM Manthuka in Rumphi; and NASO in Nkhota-Khota, and Lusibilo in Karonga. These efforts will be solely coordinated with the lay cadres to be supported by MSH, Baylor, and IYCN that are described in their associated COP entries to ensure there is standardization of approaches and no duplication of coverage.
2. Primary prevention and male involvement in the context of PMTCT
Reported results of a male championship program in Mchingi and Mwanza districts have been very encouraging, with more than 75% of male partners reportedly attending ANC after an intensive community mobilization effort that engaged village headmen and traditional authorities. Through its cooperative agreement with the MOH, CDC will support an evaluation of the program in early 2010 to distill lessons learned which can be scaled-up to all districts. PACT's indigenous described above which have high population-based coverage and strong relationships with village leaders and traditional authorities in the district where they are operating will be used to scale-up community based activities to promote male involvement in PMTCT, couples counseling, and PwP within the PMTCT setting. Activities will especially emphasize increasing early and repeated antenatal care attendance and also delivery with a trained attendant; male attendance at ANC and partner testing; prevention with positives with the ANC setting, and also address broader male norms and issues such as prevention of domestic violence and stigma against PLHIV. This activity will be linked with the lay cadres and expert patients approach described above and operate in the same districts, using these cadres to implement the community mobilization activities.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9280	**Mechanism Name: BASICS Task Order II CSH**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Partnership for Child HealthCare Inc.	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 2,429,913	
Funding Source	**Funding Amount**
GHCS (State)	989,913
GHCS (USAID)	1,440,000

Sub Partner Name(s)

Baylor University International Pediatric AIDS Initiative	Chiradzulu	Dignitas International
Neno	Thylo	WALA Food for Peace Project

Overview Narrative

The implementing mechanism's comprehensive goals and objectives: The overall purpose of this task order is to significantly reduce childhood and morbidity and mortality rates, reduce malnutrition, and strengthen the health care system that will provide an enabling environment for effective implementation of these services. Achievement of these results will be carried out principally through partnerships with the MOH's health center and district health offices in Malawi. All activities implemented under this award will take place within the current government system; government structures will retain and exercise their normal authorities. BASICS objectives include:

Improved Prevention and Management of Childhood Illnesses – with an emphasis on strengthening both community level and facility level service provision (IMCI, community-case management of childhood illnesses, pediatric hospital initiative). Recently BASICS has commenced a program aimed at supporting the MOH to introduce zinc supplementation as a component of diarrhea management.

Improved Infant and Child Nutrition – including expansion of CMAM, strengthened quality of service provided through NRU's and the development of appropriate referral networks for malnourished children.

Support the efforts of the MOH in strengthening PMTCT and pediatric HIV. This objective includes aspects of expanding and strengthening PMTCT services, facilitating access to ARV's for HIV positive children, strengthening the implementation of CPT and nutrition practices of infants and young children

National level technical assistance to the HIV Unit- a continuation of the activities conducted by the TA for PMTCT and the TA for HIV Coordination
Strengthening of Community Malaria Interventions through Grants Program – the emphasis being to utilize NGO's to carry an IEC message at community level about the appropriate use of ITN's, ACT's and ensuring a rapid response by caretakers when a child presents with fever

Support to the National Malaria Control Program (NMCP) for the implementation of IPTp. BASICS is working with the NMCP to strengthen IPT implementation with a special focus on increasing uptake of the 2nd dose of SP during pregnancy.

Linkage with the Partnership Framework (PF) goals and benchmarks over the life of its agreement/award:
The following Partnership Goals are strengthened through the BASICS activities1) Reduction of new infections through strengthened PMTCT programs Benchmarks:
• High uptake of a quality PMTCT program has ensured that over 75percent of HIV+ pregnant women in the nation receive ARV prophylaxis or ART, and national mother-to-child transmission prevalence at 6 weeks postpartum is estimated to be less than 5percent for children born to HIV-infected pregnant women. Breastfeeding transmission has also dramatically declined due to optimization of infant feeding
• More than 75percent of adult Malawians report being counseled and tested within the past four years
• Improved quality of treatment and care for Malawian impacted by HIV
Benchmarks:
Malawi meets its national goal of having 334,000 people alive and on ART by 2013 Provision of discrete systems strengthening support in the area of human resources through support for in-service training of health workers

Geographic coverage and target population(s).
The BASICS program is active in 8 districts in Malawi – Balaka, Chikwawa, Kasungu, Mangochi, Nsanje, Phalombe, Salima, and Zomba. The districts are incorporated into 3 Zonal Office areas – Central East Zone, South West and South East Zones. The total population of the 8 districts is 3,714, 822 representing 28% of the Malawian population of 13.2 million people. Approximately 778,029 children

under 5 live in the 8 districts (175,098 below 12 months).

Cross-cutting programs and key issues: if a cross-cutting attribution will be entered or key issue selected (see COP guidance) it should be described in this narrative.

BASICS non-HIV activities support indirectly contribute to HIV related components in the following areas:
Nutrition assessment and counseling:
BASICS works in two nutrition areas which are beneficial to HIV–affected children.
Firstly, BASICS has been supporting Infant and Young Child Feeding activities in the districts of Zomba and Phalombe. HIV-affected children benefit from activities such as Growth Monitoring and Promotion (GMP), counseling on feeding practices such as exclusive breast feeding and the introduction of complementary feeds provided at community level through nutrition volunteers. During FY 2010 BASICS will be expanding GMP activities in Phalombe through a focus on strengthening the quality of GMP at outreach clinics at community level.

Strengthened GMP activities should lead to the increased identification of children with growth faltering or weight loss and contribute to earlier management of these children – a significant proportion who may be HIV –affected. The intention is to link nutrition counseling to the outreach clinics which will benefit all attendees including HIV affected children. HTC will be implemented at a selected number of outreach clinics with the purpose of integrating aspects of HIV service provision through the outreach clinics.
Secondly, BASICS has supported the implementation of Community Management of Acute Malnutrition in 6 of the 8 BASICS supported districts. CMAM activities emphasize HIV testing in children admitted to these programs and as a consequence these children are able to access RUTF and other appropriate care. During FY2010 to date, 3926 children have benefited from the CMAM program in 6 out of 8 BASICS districts.

Child survival activities:
BASICS is engaging in a range of child survival initiatives which benefit HIV affected children.
BASICS supports the implementation of the MOH's Accelerated Child Survival Strategy which benefits all children through an emphasis on aspects of nutrition, use of ITN's, management of life threatening conditions such as fever, diarrhea and pneumonia. During FY2010 BASICS facilitated the creation of approximately 320 village clinics from where community-case management is provided. Secondly, BASICS has worked with the MOH to strengthen hospital based pediatric care thereby contributing to improved quality of pediatric care of children admitted to pediatric wards. Additionally, BASICS has supported the ongoing strengthening of facility-based IMCI through support for training and supervision activities at district levels.

Malaria:
BASICS has implemented IEC/BCC programs at community level through a sub – grant mechanism. The activity has targeted increased use of ITN's, earlier uptake of IPTp and encouraging treatment of fever in children within 24 hours.

Strategy to become more cost efficient over time
BASICS will explore possible linkages with PMI to implement activities beneficial to both PEPFAR and PMI. Firstly, support for the implementation of the new ANC registers is beneficial to both PEPFAR and PMI – PEPFAR requires PMTCT related data whilst PMI requires data on the provision of SP for IPTp. Secondly, both PEPFAR and PMI will benefit from the implementation of the hygiene kit (PSI initiative) as it has value in terms of providing incentives women to return for repeat ANC visits (increased coverage of dose 2 of IPTp) and strengthens the implementation of Mother Infant Pair follow up.
BASICS will link PEPFAR funding with child survival funding by adding a component of HIV training and activities to the training of volunteers in GMP.
BASICS will continue to collaborate with UNICEF in terms of scaling up the proposed PMTCT training package on new M&E tools, EID and new combination regimen.

Linkage with Government of Malawi activities.
BASICS has a general strategic approach of implementing activities which are clearly aligned with MOH strategies and frameworks. Additionally, BASICS approaches the implementation of activities at district in close collaboration with DHMT's and the District Implementation Plans which are developed annually.

Summary monitoring and evaluation plans.
BASICS will work towards the expansion of service provision at a wide scale at district level. This will create an extensive challenge in terms of data collection from the almost 180 health facilities in the 8 districts. BASICS will carry out to hire two additional staff (assistant statistician level) to strengthen the data collection process and ensure consistent quality of data. The cost of the two additional M&E staff will be shared by other components of the BASICS program.

Budget Summary
PFIP Year 1 Funding – $1, 500,000
PFIP Year 2 Funding – $1, 440,000

Cross-Cutting Budget Attribution(s)

Construction/Renovation	500,000
Human Resources for Health	400,000

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection
Malaria (PMI)
Child Survival Activities
Safe Motherhood
TB
Family Planning

Budget Code Information

Mechanism ID:	**9280**		
Mechanism Name:	**BASICS Task Order II CSH**		
Prime Partner Name:	**Partnership for Child HealthCare Inc.**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HVCT	206,456	

Narrative:

II. Budget Code – 12 HVTC
$50,000 - Year 1
$206,456 - Year 2

BASICS has provided support for the provision of HCT services through the recruitment and secondment of 16 full-time counselors to district hospitals (two per district hospital). This activity, a relatively low cost, but high impact intervention, ensures the provision of regular HCT services in these facilities. It is expected that between October 2009 and September 2010 more than 70,000 persons will be tested by the 16 counselors.

Counselors provide support for all HCT activities which occur at district hospitals. This includes client-

and provider-initiated services, such as routine and diagnostic testing. Counselors will contribute to the provision of outreach services which take place at regularly scheduled times at community outreach points. The HCT activities provided by the counselors strengthen the provision of PMTCT services, the implementation of routine testing in pediatric wards, strengthen the implementation of active case-finding for TB through HCT sites as well as important initiatives such as couples counseling. The counselors have helped provide a solid testing platform to support the very successful ARV scale up in Malawi, and have helped identify the need for the MOH to deploy full-time counselors at health facilities in Malawi, rather than becoming reliant on Health Surveillance Assistants (HSA's).

Despite these inputs data collected through BASICS indicates that there is substantial room for improvement with regards to HIV testing in children. BASICS has tracked data on the number of children tested at BASICS supported district hospitals. National Pediatric HTC Guidelines recommend that all children admitted to pediatric wards as well as those attending Under 5 clinics should be tested for HIV. When the number of children tested between birth and 14 years are compared with the number of pediatric admissions at the district hospital there is great variability in terms of the proportion of children tested which ranges from 5.4% of pediatric admissions in Kasungu to 24.3% at Balaka District Hospital (data collected between January 2009 till June 2009 – this demonstrates the gap between policy and actual implementation. During FY09 BASICS worked with health workers and HTC Counselors from hospitals and health centers to reinforce the content of National HTC Guidelines and stimulate greater testing of children. A review of 6 months of data reviews no demonstrable impact based on data collected from district hospitals. This indicates that a additional efforts needs to be made to increase testing uptake amongst children. BASICS will carry out the following activities for PFIP Year 1:

• Ongoing provision of HTC. BASICS will continue this activity through the provision of general HTC services in district hospitals – this will include the testing of pregnant women and children.
• During FY2009 BASICS initiated a grants mechanism whereby two NGO's will be contracted to pilot the provision of HTC through the deployment of lay HTC counselors to MOH and CHAM facilities. This approach has been proposed in the recent Rolling Continuation Channel developed by the GoM but till now has not been implemented. The NGO led services are expected to become operational early during PFIP Year 1 when counselors are deployed to approximately 10 health centers each in Nsanje and Phalombe districts. The outputs and impact of these services will be carefully monitored to determine the feasibility for further expansion. Lessons learnt will be documented during the implementation process.
• Implementation of Provider initiated HTC (PiTC) in 7 district hospitals. BASICS will hire additional HTC counselors (1/district hospital) to provide HTC in pediatric wards and under 5 clinics. The counselors will focus on testing all new admissions to pediatric wards whilst prioritizing all children 17 months and below attending under 5 clinics at the district hospital. The HTC counselor will be assisted by Expert Patients who will help with on-site counseling of caregivers and will facilitate referral to the ART clinic for clinical

assessment of all children who test HIV positive. The model as described above has been successfully introduced by the Baylor Pediatric Initiative (BPI) at Kamuzu Central Hospital and will be introduced with technical assistance from BPI. During the first year of implementation BASICS expects that 30% of children admitted to pediatric wards will be tested, based upon experience that BPI has communicated in implementing similar programs, which usually do not optimize uptake until year 2. Testing uptake at Under 5 clinics is difficult to predict – the intention of BASICS is to target 10% of all children below 17months attending Under 5. Depending on the progress of implementation targets may be adjusted upwards after 6 months.

• BASICS will continue to support regular review meetings quarterly for HTC counselors at district level. The purpose of these meetings is to provide a platform for HTC counselors to meet and discuss issues related to HTC as well as receive regular updates and in service training as is necessary.

Expected results

• 7 District Hospitals prepared to provide PiTC in pediatric wards and under 5 clinics

BASICS will carry out the following activities for PFIP Year 2:

• Depending on the success of the implementation of the NGO Grant mechanism it may be appropriate to migrate counselors employed through BASICS into NGO organizations to continue ongoing provision of HTC.

• Depending on the success of implementation of the PiTC program BASICS will look towards expanding the model to additional sites. BASICS will track the implementation of the PiTC process carefully and will based on careful monitoring look towards increasing the uptake of children for HIV testing when admitted to or visiting health facilities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	80,140	

Narrative:

III. Budget Code – 14 PDCS

Activity 1: Cotrimoxazole Preventive Therapy (CPT)

In an attempt to redress service provision gaps for children exposed to HIV, the MOH is expanding rapidly activities such as strengthening the management of Opportunistic Infections (OI) and expanding access to ART's. Currently, the implementation of CPT forms the cornerstone for the management of OI's in Malawi but has limited availability. BASICS will support the implementation of CPT by working with

District Health Management Teams (DHMT) to strengthen the implementation of CPT service provision in health facilities. During FY2009 BASICS supported the implementation of CPT in 112 (out of 180) facilities throughout the 8 BASICS supported districts. Input activities included training as well as the provision of patient cards and CPT registers. This activity has not only benefited children but pregnant women and other individuals requiring CPT. During FY2010 BASICS will continue this activity to ensure that it is implemented in all health facilities in districts supported by BASICS.

Expected results

• Staff in an additional 60 – 70 sites oriented and equipped to implement CPT

During FY2011 BASICS will continue support for this activity in a scaled down fashion.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	372,433	

Narrative:

IV. Budget Code – 13 PDTX

The provision of ART to children in Malawi has remained relatively static for a number of years with children initiated on ART during 2007/2008 comprising approximately 9% of all persons initiated on ART (personal communication HIV/AIDS Unit). An important factor contributing to this situation has been the reliance on EID through DNA-PCR for treatment initiation. This reliance on EID has contributed to relatively low levels of rapid testing of children particularly in the age group between birth and 17 months. The proposal of the MOH is to implement presumptive ART for children below 18 months. Within this context BASICS is proposing the following activities:

Activity 1: Increasing the access to pediatric ART

This activity will build on and complement the introduction of PiTC at district hospitals. Children identified through the PiTC will be referred to ART clinics where based on the findings from the clinical assessment be placed on ART should criteria for treatment initiation be met. The proportion of children accessing ART in Malawi has remained at a constant 10% when compared with the total number of adults ever starting ART (personal communication – HIV Unit, MOH). BASICS intends to raise the number of children accessing ART through a three pronged approach

• A partnership will be initiated with Baylor Pediatric Initiative (BPI). BPI is expected to provide the technical support for strengthening the provision of pediatric ART services. Baylor has initiated the year long mentoring program in the districts of Balaka, Chikwawa and Salima and is due to complete the program by January 2010. BASICS will implement PiTC and will work with Baylor to ensure that fully functional Pediatric ART sites are provided in these districts. Baylor has committed to initiate the

technical mentorship program in Kasungu and Phalombe which will bring to 5 the number of districts supported by BPI. This partnership which will emphasize the implementation of PiTC and technical strengthening of providers should see an increase in the number of children accessing ART. Zomba is supported by Dignitas and BASICS will not support any pediatric ART activities there.
• Mangochi and Nsanje are districts where BPI will be unable to provide technical support. BASICS will arrange for the attachment of ART service providers from Mangochi and Nsanje to facilities which have supported through the BPI mentoring process to undergo in-service exposure to strengthening pediatric ART services. This will allow a small experiment to evolve to see whether a less resource intensive approach than is provided through BPI can approximate the results from the BPI initiative.
• Strengthening Pediatric ART at health centers and other service delivery points. The MOH in collaboration with DHMT's have been expanding service delivery points systematically during the last few years. Currently 39 fixed sites and 16 mobile sites are operational in the 8 districts supported by BASICS. The 8 districts plan to expand to a further 31 mobile sites. All sites providing ART require two levels of support:
• The first component is to provide refresher training to ART providers on presumptive therapy for children and new data collection materials. The module for this refresher training has been completed by the MOH and BASICS is supporting a Trainer of Trainer training at the request of the HIV Unit during September 2009. BASICS will carry out to conduct similar refresher trainings in the 8 BASICS supported districts to ensure that 80 ART providers are refresher trained.
• At a number of sites, staff have been trained to provide ART but implementation has not started as the practitioners have not been able to complete the practical learning sessions. BASICS will carry out to support 141 practitioners to complete the practical in-service sessions – this will allow more sites to be converted from mobile sites to permanent fixed sites in the 8 BASICS supported districts.

• During FY09 BASICS finalized a pediatric "orientation" module together with an orientation training in pediatric HIV care and treatment for "non-prescribers of ART" including MOH staff, OVC program staff, community health workers, and home based care workers. The content provides basic information about HIV in infants and children while addressing barriers to care seeking and HIV testing, including issues of stigma, counseling challenges with parents, etc. In PFIP Year 1, BPI will further refine the manual to ensure that it is updated and reflects current HIV guidelines. Once staff at ART sites have received the refresher training on ART, BASICS will proceed with the training of non-prescribers at these sites by using the orientation module described above. This will ensure that the "non-prescribers" are able to effectively support the pediatric aspects of ART service provision.
The expected results include the following:

• ART mentoring in collaboration with Baylor implemented in two high volume sites
• 80 ART providers participate in ART Refresher training

• 140 ART providers undergo practical attachment training

During PFIP Year 2 the emphasis will continue to support scale up of ART services where appropriate and a stronger focus on issues related to quality of care provided through the ART sites.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	400,000	

Narrative:

V. Budget Code – 18 OHSS

$400,000 – Year 1
$400,000 – Year 2

Activity 1: Support for a Long-term Technical Assistant to the MOH

The HIV Technical Assistant works in the HIV Unit and is the counterpart of the Head of the HIV Unit. While the Assistant plays a mentoring role, most significant is the wide array of services including policy development within the health sector in response to the HIV epidemic, and strengthening HIV services such as HIV Counseling and Testing (HCT), Care and Treatment (palliative care, ART services) and PMTCT.

Key activities include:
• Setting up and ensuring that important technical working groups meet regularly to discuss issues related to PMTCT, HIV Testing and Counseling and Care and Treatment. Technical working groups draw a wide variety of stakeholders and serve as an important platform to coordinate HIV activities implemented through the MOH, NAC, donors, bilateral organizations and NGO's.
• Ensuring that new developments in the health sector response to HIV are adequately addressed. This includes the development of new policies, guidelines and plans for the implementation of these activities. Examples are the development of the pre-ART program and further decentralization of the management of the HIV program.
• Playing an active liaison role with the National AIDS Commission (NAC) in areas such as: consolidating the MOH HIV Budget used to request funding from the NAC, facilitating the reporting process between the two organizations and the reporting from NAC to GFATM. Ensure good communication and coordination between the HIV and AIDS department and the National AIDS Commission.
• Contributing to developing and drafting of important funding initiatives such as Global Fund proposals.
• Support the supply management system for pharmaceuticals and medical supplies for the HIV and

AIDS program. This includes ensuring that improvements to the system are being made.
Additional activities for support during FY 2010 will include support to the 'grant negotiations' with GFATM in case the NSA is granted, a new mechanism set in place by the Global Fund to provide ongoing support (6 year period) for well performing country programs.
This project will strengthen capacity, policies, and guidelines in HIV and PMTCT at the Ministry level, including improved overall coordination of HIV/AIDS services and capacity development.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	1,370,884	

Narrative:

Budget Code: MTCT ($1,705,971.00)

In Year 1 (FY10), of the PFIP, the following PMTCT activities are being undertaken:

Activity 1: PMTCT TA Activities –

Activity 2: Capacity Building around PMTCT Services
BASICS proposes to support the following activities during FY2010:

a) Support the MOH with the implementation of refresher trainings related to combination therapy, EID training package and training on the new ANC and maternity registers.
b) Increase the number of eligible pregnant women enrolled on ART:

c) Introduction and strengthening of Mother Infant Pair (MIP) follow up strategies. BASICS has developed a model for the implementation of MIP follow up at three sites in Phalombe District. The model is built up based on the identification of a PMTCT coordinator at facility level who is responsible for tracking mother-infant pairs over time, the use of a register which facilitates tracking of MIP's, and the implementation of a screening process. This model, which had its origin through the OGAC initiated integration program, will link with the implementation of the Hygiene Package developed by PSI. The Hygiene Package provides important incentives (Waterguard, soap) for MIP's to return for follow up assessment and the intention is to determine the impact that the provision of incentives will have on maintaining continuity of care. Currently the package will be implemented in Phalombe in the first half of 2010 extended to additional districts in the second half of 2010 and 2011

d) Ongoing support for the PMTCT mentoring program initiated during FY2009.

e) Exploring use of routine testing at immunization clinics to monitor PMTCT transmission rates.

f) Strengthening community-support for PMTCT, with an emphasis on enhancing growth monitoring promotion (GMP), complementary feeding, and linkages to HIV counseling and testing

In Year 2, of the PFIP (FY11), the following PMTCT activities will be undertaken:

Activity 1: Capacity Building around PMTCT Services

• Ongoing support to increase the number of eligible pregnant women enrolled on ART, scaling-up successful approaches to all 8 districts supported by BASICS in 2011, and sharing results with the MOH and other partners so that lesson learned can be rapidly scale-up to other districts not supported by BASICS.
• Ongoing scale-up of Mother Infant Pair (MIP) follow up system to a total of X high-volume sites in the 8 districts supported by BASICS
• Ongoing support for the implementation of EID depending on the capacity of laboratories to deal with the increased demand. MIP follow up is a pre-cursor of pre-ART and options to expand MIP into a pre-ART mechanism will be explored during FY2011. Expanded support for PMTCT effectiveness surveillance
• Ongoing support for the PMTCT and broader HIV mentoring program initiated during FY2011. The focus will be to look at mechanisms to transition the mentoring program fully into the MOH system and to ensure a sustainable and integrated mentoring/supervisory support system which incorporates all aspects of HIV. BASICS will continue to provide focused technical assistance to the South Western Zonal Health Office as part of this initiative and the bi-annual review meetings on PMTCT for district level staff in BASICS districts whilst affecting a transition to routine implementation by the MOH.
• Based upon lessons-learned from the GMP program in Phalombe, BASICS will support scale-up of best practices for GMP to other districts supported by BASICS and share these results more broadly with other partners, including the WALA Food-for Peace Project in the South and other USG OVC partners implementing nutrition activities in the North and Central Regions of Malawi. This includes ongoing integration of HIV services into outreach clinic activities. The mother-father support groups in Zomba and Phalombe will be transitioned to other mechanisms of support that do not depend on the BASICS project by FY11, including possibly through linkages with other projects such as WALA.

Additional PMTCT funding will be used to implement the following priorities of the GOM.
Activity 2: Assist the MOH with coordination and organization of training of nurses and other providers at ANC sites in provision of ART
In order to initiate more pregnant women on ART, it will be vital to have more nurses at MCH sites trained

and certified as qualified ART providers. Therefore, with additional PMTCT FY10 funds, the USG will provide support directly to the MoH for a large-scale effort to train nurses at MCH sites in ART provision. As needed, BASICS will also provide focused on-site training to fill gaps that arise for training of lower level providers at MCH clinics related to ART and PMTCT linkages. For example, HSAs may be trained in phlebotomy and DBS testing so that they can draw reflex CD4 and other labs necessary for ART initiation, or nurses may be oriented will in postnatal course of NVP for non-ART eligible women as needed.

Activity 3. Expanding mentoring and quality improvement to specific districts in the South Western Zone and coordination of mentoring process with the MOH

Mwanza, Neno, Thyolo, and Chiradzulu are 4 high-prevalence districts that are in the South Western Zone and do not receive direct support from USG partners for PMTCT. Despite the fact that 3 of these districts receive non-USG partner support for PMTCT, significant gaps remain. BASICS will therefore utilize additional PMTCT funds to support the DHOs in these districts, and to fill gaps, particularly in Mwanza, a district that does not receive external partner support for PMTCT. Additionally, BASICS will collaborate with UNICEF and MSF-France in Chiradzulu as part of a PMTCT MNCH integration project, building on experiences from similar work in Phalombe. BASICS will also provide logistical support related to coordination of the other the USG-funded PMTCT implementing partners with the MoH, assuring that at least quarterly meetings are held with the MoH and USG, that the partners produce and submit joint work plans and progress reports to the MOH, and that they share best practices with one another.

Activity 4. National scale-up of MIP follow-up model utilizing HSAs
BASICS have worked with the MOH to develop a model for the implementation of MIP follow up at three sites in Phalombe District. This model, which had its origin through the PEPFAR HQ PMTCT/peds TWG initiated integration program, is based on the identification of a PMTCT coordinator at facility level, typically a Health Surveillance Assistant (HSA), who is responsible for tracking mother-infant pairs over time, the use of a register which facilitates tracking of MIP's, the implementation of a screening process to ensure that MIP's are assessed clinically during each visit, and the implementation of IYCF counseling every time a MIP visits the facility. With PMTCT-additional resources, BASICS will provide on-site training and mentoring to support scale-up this MIP model in the South Western and South Eastern Zones of Malawi. Assistants will also be trained and equipped to provide supervision for the lay workers described below, with assistance from NGO staff where necessary

Activity 5. Supporting national scale-up of lay cadres and expert patients through existing community-based platforms

The move to start pregnant women on ART at an earlier CD4 count will necessitate more intensive psychosocial support, as data from several settings seem to indicate that such clinically well patients are at a higher risk for default than other patients starting ART. The Tingathe program, which is implemented in Malawi by Baylor College of Medicine, is an example of a successful intervention with lay cadres that has shown dramatic results in the improvement in the PMTCT cascade In order to cost-effectively scale-up such lay cadre/PSS approaches, the USG strategy will be to support Baylor to a sub-set of high-volume sites (see Baylor COP entry), but at the same time provide complementary support through a network of community-based platforms that are already on the ground to expand standardized approaches with lay workers in a way that is sustainable and can be taken to national scale. Management Sciences for Health, the lead implementer for BASICS in Malawi, is also the lead implementer for the family planning and HIV integration project, through which 1,000 community-based distribution agents (CBDAs) in 8 districts have already been trained with USG support to provide family planning counseling and referrals as well as HIV prevention information and, in some cases HIV testing. BASICS will provide training and support to this existing cadre in PMTCT follow-up and DBS testing, and also possibly to some NGOs supported through its malaria small grants program support the national scale-up of lay cadre approaches that support PMTCT.

Lay cadres will only be utilized in cases where it is judged that HSAs are unable to provide adequate community-based coverage to ensure follow-up. MSH will provide technical assistance to assist the GoM and the other partners implementing community-based PMTCT activities to rationally plan for sustainable national scale-up of these approaches. MSH will also provide technical assistance to help the MoH ensure that lessons learned and best practices from various partners (e.g. the Baylor project, Mother-to-Mothers; the MSH FP/HIV integration project; the PATH IYCN project) will be applied to the trainings of the lay cadres/expert patients during the national roll-out.

Activity 6. Primary prevention and male involvement in the context of PMTCT

Reported results of a male championship program in Mchingi and Mwanza districts have been very encouraging, with more than 75% of male partners reportedly attending ANC after an intensive community mobilization effort that engaged village headmen and traditional authorities. Through its cooperative agreement with the MOH, CDC will support an evaluation of the program in early 2010 to distill lessons learned which can be scaled-up to all districts. BASICS will cost-effectively apply these best practices for male involvement within the existing community-based MSH FP-HIV platform as well as potentially other USG-supported platforms such as IMPACT which have high population-based coverage and strong relationships with village leaders and traditional authorities. Activities will especially emphasize increasing early and repeated antenatal care attendance and also delivery with a trained attendant; male attendance at ANC and partner testing; prevention with positives with the ANC setting,

and also address broader male norms and issues such as prevention of domestic violence and stigma against PLHIV. This activity will be linked with the lay cadres and expert patients approach described above and operates in the same districts using these cadres to implement the community mobilization activities.

Activity 7. Training and technical assistance to support national scale-up of Cotrimoxazole prophylaxis
Currently, less than 30% of identified HIV-exposed infants in the country are being initiated on Cotrimoxazole, which is a huge gap in pediatric care that urgently needs to be addressed. During FY09 the USG partner BASICS supported the roll-out widespread implementation of pediatric CTX in 8 districts, including training of staff, provision of patient cards, and distribution of CTX registers. Based upon this highly successful experience, BASICS will provide support for national scale-up of on-site training to assist all districts they work with to implement as similar approach and thereby achieve better national coverage of CTX for all HIV-exposed children. If possible, this activity will be integrated with on-site orientation providers on the new postnatal Nevirapine regimen for PMTCT as well to enable cost-savings and rapid scale-up. This will include monitoring and supervision of Maternity wards to ensure that the new infant health passports with HIV information (to be developed in FY09 by MOH with CDC support) are provided to the infant at birth, ensuring that infants entering under-5 clinics at 6 weeks of age are more easily identified as HIV-exposed so they can be provided with CPT and other care.
Activity 8. Renovations of high volume MCH sites in the Southern Malawi

Renovations will mainly focus on upgrading antenatal sites to meet the MOH criteria for qualification as ART sites, and also will improve the condition of labor and deliver wards at high-volume sites, provide additional space for storage of commodities, and enhance patient flow between services. The process to select sites for renovations will be done in close consultation with the MOH and other stakeholders and utilize evidence-based criteria, for example prioritizing those sites that could enroll many more women on ART if they had the proper physical infrastructure. Efforts will also be made to leverage already approved Global Fund resources for renovations at MCH sites that would enable the renovations to achieve more national coverage of MCH sites, and also to utilize USG non-HIV health funding to increase the scale of effort further. Renovations will be coordinated with those to be funded under other sources (i.e. Global Fund, SWAp) to ensure that there is no duplication.

Activity 9. Capacity building to improve data utilization and reporting
BASICS staff have work side by side with staff and district health staff to build their capacity to interpret and use data to improve programs and enable them to be will then report to PEPFAR how they its efforts have helped the SW zone. The focus of additional PMTCT resources will be specifically on supporting Mwanza, Chiradzulu, Thyolo, and Neno in this process. PMTCT Data will be reviewed on at least a quarterly basis with health officers; action plans will be developed and implemented to address data

quality issues identified; and feedback will be provided to PMTCT sites to enable them to improve their program in specific ways and monitor such improvements.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9281	**Mechanism Name: I-TECH**
Funding Agency: U.S. Department of Health and Human Services/Health Resources and Services Administration	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Washington	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,750,000	
Funding Source	**Funding Amount**
GHCS (State)	1,750,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Within Malawi's partnership framework, developing a skilled health care work force, and implementing and scaling up national systems for collection and use of strategic information are of high priority. As the number of patients served by national HIV programs increases, the challenge of providing sustainable and integrated services also increases.

The International Training and Education Center on HIV (I-TECH) was founded in 2002 by the Health Resources and Services Administration (HRSA) in collaboration with the Centers for Disease Control and Prevention to share lessons learned from the U.S. domestic AIDS Education and Training Centers. I-TECH works primarily on activities that contribute to the achievement of PEPFAR. Working at the invitation of Ministries of Health and USG, I-TECH supports the development of comprehensive training systems for health care workers in regions hardest hit by AIDS. Ongoing mentoring activities, pre-service education, infusion of multimedia into training and distance learning are high impact teaching

methodologies utilized by I-TECH.

I-TECH has been working with CDC in Malawi since 2003 to support capacity building activities. Since 2005, I-TECH has placed Technical Advisors (TAs) at the Lighthouse Trust (LH) to: 1) support the ongoing development of healthcare worker (HCW) training systems; and 2) establish a robust monitoring and evaluation (M&E) unit to ensure it has the means to effectively evaluate its work. In 2007-08, I-TECH was invited to build capacity of the MOH to lead the national response to the HIV epidemic through placement of high level TA's within key units of the MOH. Their focus is to: 1) facilitate the continuation of antiretroviral therapy (ART) scale-up and to develop and implement treatment and care models for HIV/AIDS; and 2) to strengthen the strategic information systems of the Central Monitoring and Evaluation Division (CMED) and the HIV and AIDS Department of the MOH; 3) to strengthened the MOH's capacity to collect, manage and use strategic information. With a focus on building and reinforcing Malawian capacity, I-TECH has recruited and placed the following positions in the MOH:

• One (1) senior HIV Care and Treatment TA
• Two Malawian (2) HIV Fellows
• One (1) senior M&E TA
• One Malawian (1) M&E Fellow
• One Malawian (1) Information Technology (IT) Fellows
• One (1) Global Fund Coordinator
• In 2010, I-TECH will continue to support the Lighthouse through the recruitment of a TA for M&E

In 2010, I-Tech will also work directly with the Christian Health Association of Malawi (CHAM), a CDC partner, to produce 500 new healthcare workers by 2015. This initiative is in response to the critical need to mitigate the human resources crisis, particularly in the health sector. A holistic approach, including fortification of the training infrastructure, strengthening of faculty skills, and addressing gaps in retention and successful preparation of students is key to success. I-TECH's framework for training reflects the importance of a comprehensive approach to clinical training and is designed to ensure that training programs result in the transfer of learning to the jobsite. Clinical mentoring is a critical component of I-TECH's comprehensive approach to training, as it provides a bridge between didactic training and independent clinical practice. I-TECH's recognition of the importance of clinical mentoring is in alignment with global efforts to decentralize the provision of ART, expand the number of sites providing HIV treatment, and empower local experts to provide the care and leadership necessary to combat HIV.

In 2008, I-TECH opened an office in Lilongwe, and initiated the process of registering as a local NGO. To continue to support the growing number of technical and clinical staff, and the new initiatives to deliberately build local capacity, I-TECH will continue to establish its operational infrastructure and

required personnel in Lilongwe, including a country director, operations manager, and fiscal lead. Equipment such as 2 vehicles, laptops, computing supplies, and other necessary technology will be provided to its in-country staff to ensure their ability to continue their work.

In collaboration with the Country Director (TBN), the Seattle-based I-TECH Country Project Manager (CPM) will continue to foster the professional growth of the technical and clinical staff through long distance consultation and support, in-country visits, and liaising with other technical and clinical staff at HQ and within the region.
The overarching goal of I-TECH is to provide technical assistance to strengthen national health systems, provide mentorship through expert technical advisors, and build capacity of Malawian healthcare workers. In order to attain our vision of a high quality, compassionate and equitable health care, in a sustainable manner, we will improve our mentoring model in a contextually appropriate manner, placing greater emphasis on the transfer of skills and leadership development to our Malawian fellows, new healthcare workers, and partners.

This program will have national level impact in Malawi, increasing access to HIV and TB services through increasing the capacity of health facilities and health workers. The quality of HIV and TB services will be improved through provision of regular supervisory visits and on-going training of new and current health workers in relevant skills and knowledge. This program will also strengthen supportive services including laboratory, expansion of electronic data systems, revision of other paper-based M&E tools, as well as infrastructure needs.

This is therefore in line with the goals and objectives of PEPFAR.
The monitoring of activities in each program will be done through quarterly reports documenting progress toward objectives, lessons learned, and best practices. Reporting on activities conducted will be through existing reporting mechanisms, and will be submitted to MOH supervisors and I-TECH HQ. Progress and other requested reports will be provided as needed to HHS/CDC.

Budget Summary
PFIP Year 1 Funding – $1,200,000
PFIP Year 2 Funding – $2,750,000

Cross-Cutting Budget Attribution(s)

Human Resources for Health	1,750,000

Key Issues

Workplace Programs

Budget Code Information

Mechanism ID:	**9281**		
Mechanism Name:	**I-TECH**		
Prime Partner Name:	**University of Washington**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HTXS	300,000	

Narrative:

II. Budget Code – HTXS
$300,000.00 – Year 1
$300,000.00 – Year 2

Activity 1: Human Capacity Development in antiretroviral (ART) Management and Distribution (Continuation Activity and Expansion).
In 2009, the national HIV guidelines were revised and updated. I-TECH supported the efforts of the MOH in the revision of the 5-day national ART curriculum to incorporate the new changes of the revised ART guidelines 3rd Edition and revised Opportunistic Infections (OI's), guidelines. A pilot training was conducted in Blantyre and I-TECH incorporated the revisions into the final training product, including the development of slides, facilitator guides and participant handbooks.

In FY 2010, the department of HIV & AIDS will continue its work to build the capacity of 100 healthcare workers (HCW), including, clinicians, nurses, medical assistants, and clerks in ART management and ARV distribution and data collection and collation. The I-TECH Care & Treatment Technical Advisor and HIV fellows, will assist in planning and support for the ART training & mentoring program for both old & newly recruited staff and staff sent on attachment to ART sites in the public and private sector as part of their training. Within the Partnership Framework's overall goal to support the GOM's NAF, the I-TECH Technical Advisor will:
• Support assessment of new sites that are intended to scale up the provision of HIV treatment services at the ART sites.

• Develop and implement effective national communication strategies for the dissemination of information and best practices to HCWs in the public and the private sector.
• Contribute in the design and implementation of Training of Trainers (TOT) to conduct ART refresher course in collaboration with the District Health Officers according to their District Implementation Plans (DIP's).

Activity 2: Assist the MOH with the expansion of ART Services
The responsibilities of the I-TECH Technical Assistant in Care & Treatment has been divided equally between oversight for the expansion of ART services and training, quarterly supervision, as well as mentoring the senior leadership team of the HIV Unit including the Malawian Staff Fellow counterparts. The Technical Advisor will contribute to the development of the ART scale up plan 2010-2013 which will replace the 2006-2010 scale up plan. The 2010-2013 scale up plan will be based on the extended National Action Framework (NAF) and will build on the successes and the lessons learnt from the previous plan. A main priority for 2010 will be the strengthening of drug forecasting and procurement systems and processes. The Technical Advisor will also contribute to the ART drug, OI drugs and HTC test kits quantification, costing, procurement and distribution exercise.

Activity 3: Design and implementation of national pre-ART program
In collaboration with partners & stake holders, as part of the scale up plan, the Technical advisor will contribute to the design and implementation of the pre-ART program covering a continuum of care from antenatal clinic (ANC) through Early Infant Diagnosis/ presumptive severe HIV disease in children under 18 months up to adolescence and adult HIV care that will be termed Family HIV care clinics. These will encourage a family model approach to HIV care. Guidelines will be produced that define the minimum package for pre-ART at any given site nationwide.

Activity 4: Resource and on-site Support Supervision
In 2009, I-TECH recruited and placed 6 technical and clinical fellows and TAs within the HIV and AIDS Department who have contributed their expertise to expand the capabilities of the HIV Unit. This team has provided critical support to all other ARV service providers through training and on-site support supervision. In 2010, they will continue their activities to oversee the collection and collation of valuable data on the expansion of ARV services and ensure the quality of the services as programs expand. The team will work with others in the HIV Unit to prepare long-term plans, annual work-plans, 6-monthly reports, and other ad hoc reports on the state of scaling up and performance of the ART support services and operations research. The Unit will ensure timely dissemination of reports and updated guidance.

PEPFAR funds through I-TECH will directly support salary and benefits of 1 care & treatment TA (90% FTE) and two HIV fellows (40% FTE), training materials, travel support to 1 international conference and

2 regional conferences, laptops, vehicle and fuel (limited to work-related travel only), and supplies.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	50,000	

Narrative:

IV. Budget Code – HVCT
$50,000 – Year 1
$50,000 – Year 2

Activity 1: System Strengthening and Quality Assurance for HIV Counseling and Testing (HTC)
Massive scale up of HTC services in Malawi has only been possible through a radical 'task-shifting' approach. Non-medical /non-lab health extension workers (Health Surveillance Assistants) and lay staff who have undergone a 3-6 week specialized training in HIV testing and counseling are thought to account for over 90% of HTC in Malawi. While this approach has been successful in making HTC widely available, it has been increasingly challenging to ensure adequate quality assurance (QA) and quality control (QC). To address this critical area, the national M&E TA has assisted the development of a comprehensive follow-up system for all HTC providers operating in the country. A central database will be established at MOH to register all HTC providers and assign unique IDs.

HTC provider log-books will be issued to all HTC providers (estimated 3,500 as of mid 2009) to allow tracking of individual providers, to document qualification and refresher trainings attended, and to record participation and outcomes of HIV proficiency testing results. The ID system and the provider log books will be piloted in 3 districts in 2009 and national roll-out is planned to start in 2010. The log books will be an important tool to ensure effective supervision of HTC services, to track outputs from HTC trainings and to ensure adequate quality of HIV testing.

PEPFAR funds through I-TECH will directly support salary and benefits of 1 M&E TA (10%) and one 1 M&E fellow (10%), training materials, complimentary travel support (separate from MOH-provided travel allowances), and supplies.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	650,000	

Narrative:

V. Budget Code – HVSI
$200,000 – Year 1
$650,000 – Year 2

Activity 1: National Monitoring and Evaluation of HIV Services
I-TECH is supporting the MOH through a senior Technical Assistant for M&E who took up his position in September 2008 and one locally recruited M&E Fellow who was appointed in January 2009. The rapid and massive expansion of HIV services in Malawi since 2002 has required establishment of new M&E systems for HTC, PMTCT, STI and ART. It has been a particular challenge to ensure that these M&E systems can satisfy the complex technical requirements for longitudinal patient monitoring while needing to keep pace with the rapid scale up. M&E tools developed during the first phase of scale-up had critical data gaps and were often not well integrated into the general Health Management Information System (HMIS), which has the overall mandate for monitoring of the SWAp (Health Sector Wide Approach) and Program of Work within MOH.

As HIV services are becoming more established in the general health services, there is a need for the Department for HIV and AIDS to consolidate and rationalize M&E systems and work towards a full integration into the HMIS. At this critical juncture, a high level of technical expertise is required to design adequate and sustainable tools and oversee the deployment of the appropriate IT systems. The new M&E Unit within the HIV Department is responsible for monitoring site and program performance, disseminating information relevant to policy development, quantification and forecasting of drug and commodity needs, and for directing operational research.

I-TECH is prepared to provide the necessary support, professional development opportunities, and IT-related operations and infrastructure for routine data collection. Resources will be offered including networking, database development, long-distance consultation, and other necessary resources such as computers, software, communication technologies, sponsorship of the senior Technical Advisor and his/her local counterparts at major conferences and meetings, and a vehicle for meetings and quarterly HIV services supervision. As part of I-TECH's global team of M and E Technical Advisors, the MOH M and E Advisor will have extensive tested resources to draw from in health services monitoring and quality improvement.

In year 2 of the PFIP, HVSI activities include:

Activity 1: Devise national standard system and M&E tools for integrated follow-up for HIV exposed infants and pre-ART services for children and adults 'Family HIV Care Clinics'
The lack of any standardized system to ensure effective identification and follow-up of HIV exposed infants and of pre-ART interventions for children and adults has been identified as a critical gap in the national HIV response. The I-TECH technical assistants for M&E and Care and Treatment, in collaboration with the HIV fellows and with the MOH HIV program officers have started to develop a

comprehensive strategy to integrate these interventions into the maternal and child health services and into the existing HIV services. A critical component in this process will be the development of standardized M&E tools for Under Five Clinics and for dedicated Family HIV Care Clinics that will integrate pediatric and adult pre-ART services. In the course of FY 2010, the following (paper) tools will be developed / revised, piloted and implemented: routine screening of infants at U5 clinics for HIV exposure (integrate HIV exposure info into U5 / U1 registers), Family HIV Care Clinic Cards for children and adults, Family HIV Care Clinic register and reporting forms, revised Child Health Passport. These M&E tools are expected to address a critical gap in monitoring of outcomes for the PMTCT program.

Activity 2: Establishment of a central M&E database for HIV Programs integrated into the Health Management Information System

As of 2009, the M&E systems for HIV programs (HTC, PMTCT, ART, STI) in Malawi are not well integrated into the general HMIS and there is no coherent system for the collection of HIV data, aggregation for reporting and for data management. Facility and district level M&E reports are typically entered using improvised spreadsheets on individual PCs, giving little control over accuracy and completeness of data and making strategic information (SI) difficult to access and utilize for staff at facilities, districts and at the central level. In FY 2010, the I-TECH M&E team at MOH will lay the foundations for a full integration of HIV program data into the District Health Information System (DHIS), while supporting CMED in the transition to a new web-based version of the DHIS. The I-TECH M&E TA will facilitate the development of a common strategy for this process. This will include establishment and maintenance of a central health facility inventory linked to a Geographic Information System (GIS). It is currently envisaged that the central DHIS server will be housed in the new offices of the Department for HIV and AIDS at CHSU, making national M&E data freely available to all stakeholders over the internet.

Activity 3: Roll-out of Point of Care Electronic Data Systems (EDS) at health facilities for ART and other HIV services. Exploration of strategies for a central data repository for storing patient level data from EDS sites.

The I-TECH M&E team will assist with coordination and supervision of the roll-out of EDS for ART which is planned to start in FY 2010. Technical assistance will also be provided to the EDS implementing partners (Baobab Health Partnership and Luke International Norway) in order to ensure adequate design of software and database architecture. The team will make an important contribution to the national data standards task force and assist with the development and implementation of standards related to information systems (e.g. confidentiality and security of electronic data). The I-TECH M&E TA and the IT fellows will further facilitate the exploration of strategies for establishment of a central data repository for patient level data from EDS facilities, considering the business case for different technical solutions and ensuring that aqdequate data security measures are guaranteed to protect patient data.

Activity 4: Mentoring of fellows in development of M&E tools, data management and operational research. Recruitment and training of 2 new data clerks for the HIV Department
The ability to design and implement M&E systems and to correctly manage and interpret strategic information is considered a core skill for the HIV fellows in the MOH. In FY 2010 the I-TECH M&E TA will continue to build the capacity of the fellows in this important area, focusing on M&E principles, data base design and data management and analytical methods. The fellows will be trained in using professional data base applications, applying appropriate data models, use of SQL, data transformation and statistical analysis using STATA. The fellows will complete their first set of operational research studies, the results of which are expected to directly inform a review of the choice of ART regimens for the national program in early 2010. To strengthen the capacity of the HIV Department and to ensure long term sustainability of M&E systems and for operational research, 2 data clerks will be recruited during FY 2010 (through the CoAg between CDC and MOH). These clerks will be trained in IT skills and M&E and data management principles.

Activity 5: Implement integrated M&E system for HIV and STI services
Until 2009, there was no effective integration of HIV testing, prevention and appropriate referral to HIV services and there were no HIV data from STI clinics in Malawi. The I-TECH M&E TA and the M&E fellow have provided critical input into the design and implementation of an integrated STI / HIV register. From the start, this new tool was designed to be integrated into the HMIS, complementing the total number of STI cases collected at OPD with an expanded data set from dedicated STI clinics (found at all larger hospitals). Implementation has started in 2009 and 3 regional TOTs have been conducted reaching 80 staff. The new tools are expected to be fully established with national data being available from 2010.

PEPFAR funds through I-TECH will directly support salary and benefits of 1 M&E TA (80%) and one 1 M&E fellow (80%), training materials, complimentary travel support, and supplies.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	650,000	

Narrative:

VI. Budget Code – OHSS
$650,000 – Year 1
$1,650,000 – Year 2

Activity 1: Fellowship Program
The national response to HIV/AIDS in Malawi over the past few years has been very impressive. However, management and coordination of this very complex national HIV response, including

prevention, treatment, and care has been challenging primarily because of the very limited number of staff with the requisite skills to oversee the programs. Assistance has been sought through expatriate Technical Assistant staff to temporarily fill the human resource gap while building local capacity through skills transfer.

This capacity strengthening is also being balanced by the addition of extra manpower in key MOH departments through the Malawi HIV Fellowship Program, where 4 Fellows, and one fellow in recruitment are placed under the I-Tech supported Malawi HIV Fellowship Program. The fellowship offers opportunities for mentoring, coaching, and applied training in leadership and management to exceptional physicians and other healthcare professionals in Malawi. As the program matures, this program has the potential to become a robust model for leadership development in public health managers in Malawi. The HIV Fellowship Program is a field-based, non-degree opportunity which consists of a full-time apprenticeship attachment in the Ministry of Health. I-TECH will support the Fellows' professional development goals through distance learning courses, attendance at national and international conferences, and targeted trainings.

I-TECH budget directly supports salaries and benefits of the fellows (see above sections for percent of FTE breakdown), 1 international travel, and 2 regional trips, some in-country transportation support and professional development opportunities (e.g. STATA course, workshop in operations research, leadership development workshops, mentoring in informatics, equipment (laptops) and supplies, communications support (mobile phones and internet) etc.)

Activity 2: Technical support in human capacity development to Christian Health Association of Malawi: CHAM (PF09 Funding – $1,000,000)
The human resource crisis in Malawi impacts all sectors of development but none so pronounced as the health sector. The effective diagnosis, care, and treatment of infectious diseases require a skilled and motivated workforce, and sustainable systems to educate and train those workers. I-TECH supports the development of a skilled health work force and well-organized national health delivery systems in order to provide effective prevention, care, and treatment of infectious disease in the developing world. I-TECH combines the intellectual talents of leading clinicians, educators, researchers, and instructional designers to form multidisciplinary project teams. This results in innovative, comprehensive, and targeted capacity development activities that are tailored to the needs of individual countries.

In 2010, I-TECH will directly with the Christian Health Association of Malawi (CHAM), a CDC partner, to produce 500 new healthcare workers by 2015. This initiative is in response to the critical need to mitigate the human resources crisis, particularly in the health sector. The I-TECH approach to training recognizes that classroom-based training alone is not sufficient to support the application of complex clinical skills

related to care and treatment of people with HIV and AIDS (PLWHA). A holistic approach, including fortification of the training infrastructure, strengthening of faculty skills, and addressing gaps in retention and successful preparation of students is key to success. I-TECH's framework for training reflects the importance of a comprehensive approach to clinical training and is designed to ensure that training programs result in the transfer of learning to the jobsite.

The framework outlines a model in which the trainee progresses from acquisition of new skills and knowledge in the classroom, to closely supervised clinical practice of new skills, to increasing independence and responsibility in care and treatment supported by onsite mentoring, to initiation of the provision of guidance and advice on an as-needed basis. Responsibility and decision-making are thus gradually shifted to the trainee throughout this process as the trainee acquires increased skill and confidence, and this framework supports I-TECH's efforts to build capacity in a sustainable manner and in a way that allows local experts to continue the provision of care. Clinical mentoring as a bridge between didactic training and independent clinical practice is recognized as critical and in alignment with global efforts to decentralize the provision of ART, expand the number of sites providing HIV treatment, and empower local experts to provide the care and leadership necessary to combat HIV. To this end, I-TECH will hire 2 clinical mentors, and one training coordinator/project manager to work directly with CHAM's and two of its selected training colleges, to build the skills of the faculty, increase student retention and passing rates, and support CHAM in their delivery of 500 new healthcare workers by 2015.

By partnering I-TECH and CHAM we have the greatest opportunity of launching a program that would produce 500 high quality professionals that would add to the workforce of Malawi.

Through the new partnership framework and in line with Malawi's National Action Framework, I-TECH will complement current investments in the national HRH plan by supporting CHAM to producing 500 mid-level health professionals such as nurses, clinical officers, medical assistants, pharmacy technicians, and laboratory technologists. The intent is for these professional staff to not only help fill the existing vacancies, they would also work to complement the more than 11,000 HASs recruited and deployed by the Government of Malawi.

? By January 2010, assess the quality of training services at the 5 identified CHAM training colleges for baseline information. The purpose of the assessment is to help provide a body of data on the selected colleges in order to assist CHAM determine the most effective strategy for increasing the number of health care workers trained while ensuring that a high quality education is delivered. The focus of the assessment will be primarily on nurse training.
? Write assessment report. Make recommendations and plans for strengthening 2 of the 5 training colleges.

• Identify critical gaps in training implementation and help develop strategy for strengthening the quality of training
• Assist with curricula and training guidelines upgrades to include AIDS care
• Identify nursing competencies and develop competency-based curricula
• Assist with product and tools development (learner tools and teacher tools) and deployment
• Assist with faculty development, including but not limited to: strengthening Tutor teaching skills (both within the classroom and clinical facilities for student practicum experiences), increasing/updating clinical skills, building skills in writing effective lesson plans, evaluating students' performance, mentoring and coaching.
• Assist with quality assurance of training programs, and improvement of student success rate
• Assist with evaluation of effectiveness of training

Activity 3: Human Capacity Development in Monitoring and Evaluation of Clinical Services at Lighthouse Trust
Lighthouse Trust, a center of excellence in HIV counseling, testing, care and treatment centered at Kamuzu Central Hospital in Lilongwe, partners with the Ministry of Health to develop, test, and disseminate proven strategies for health worker training and HIV services delivery in Malawi. Since 2005, I-TECH has supported M and E activities of Lighthouse clinical services through technical assistance, human capacity development, and systems strengthening. In 2009, I-TECH will provide additional reinforcements from its Headquarters' based Quality Improvement unit to the Lighthouse to ensure continued technical assistance as needed. Meanwhile, I-TECH will recruit a clinical epidemiologist to provide systems strengthening and capacity development to Lighthouse's growing M&E team.

The technical assistance will be focused over a 2-year period with a goal toward establishing sustainable systems within the LH. The newly recruited TA will work with the M&E officer and Lighthouse director on a transition plan toward self-sustaining M&E Systems. This TA will mentor Lighthouse M and E counterparts to develop and apply appropriate monitoring and evaluation systems covering Lighthouse's core services in: HIV testing and counseling, family-centered ART services, integrated TB/HIV management, integrated PMTCT services, home based care, community PLWHA support group programs, therapeutic feeding, and clinical training programs.

PEPFAR funds through I-TECH will directly support salary, benefits, relocation benefits, laptop, telephone, 1 international and 2 national/regional travel for presentation at conferences and training, and technical support for one clinical epidemiologist/M&E specialist.

Activity 4: Strengthening coordination in the implementation of GFATM Grant Activities (Centrally Funded

- $300,000)
Malawi's GFATM envelope for HIV/AIDS, TB, HSS and Malaria is currently $791,690,180 (2003 – 2013) including the recently extended HIV Round 1 Grant, through the RCC. The Malawi Global Fund Coordinating Committee (MGFCC) provides oversight for all disease grants and the HSS Round 5 Grant to the Ministry of Health (MOH). The MOH serves as the largest implementer of all GFATM resources received by the Government of Malawi (GOM). Performance has been challenged by Human Resources constraints in the MOH which have led to insufficient coordination between various directorates implementing GFATM –supported program. This gap contributes to weaknesses in the coordinated planning, critical forecasting of planning and implementation needs, and poor information dissemination between partners. Capacity is needed in the MOH for improving coordinated GFATM Grant performance. I-TECH will use its expertise in the recruitment, preparation and retention of skilled work force to support a key position who will directly report to the Principal Secretary (PS) at the MOH. The goal of this position is to strengthen coordination in the implementation of GFATM Grant activities for which the Ministry is either a Principal or a Sub Recipient, including; HIV/AIDS, Health Systems Strengthening, Tuberculosis and Malaria.

I-TECH budget will directly support the GF Coordinator's salary and benefits, transportation, in-country and 1 international travel, communications support (telephone/Internet).

Activity 5: Infrastructure support for the HIV and AIDS Department
In 2009, I-TECH procured one-time equipment items and supplies to the newly renovated HIV and AIDS Department. Equipment items totaling nearly $85,000 ranged from servers to computers to software to equipment racks. In 2010, I-TECH will contract with a local agency to provide a maintenance contract to maintain and service the equipment as needed. A memorandum of understanding (MOU), which delineates the roles and responsibilities of each party has been drafted and shared with the MOH and copy has been submitted to CDC.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	50,000	

Narrative:

I. Budget Code: MTCT
$50,000 – Year 1
$50,000 – Year 1

Activity 1: Training, implementation and supervision of new ANC and maternity registers and reporting forms with integrated PMTCT information

The I-TECH M&E TA has spearheaded the development of registers and reporting forms for antenatal care clinics (ANC) and labor & delivery (L&D) wards with an aim to fully integrate reproductive health and PMTCT indicators in one single set of tools. Through a consultative process involving multiple stakeholders, a revised ANC and L&D register along with reporting forms and a revised national patient-held document (woman health passport) have been finalized and these tools were printed in August 2009.

In FY 2010, over 3,500 providers around the country will be trained in the use of these revised registers and reporting forms. Implementation will be supported by the I-TECH team in the HIV Department through development of training materials, facilitation of TOTs and through follow-up supervision and mentoring at ANC and maternity sites as well as capacity building of HMIS staff at the District Health Offices. PEPFAR funds through I-TECH will directly support salary and benefits of 1 M&E TA (10%) and one 1 M&E fellow (10%), training materials, complimentary travel support (travel allowances and fuel when MOH vehicles/funds are not available or are in short supply), laptops, and supplies.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	50,000	

Narrative:

III. Budget Code – HVTB
$50,000.00 – Year 1
$50,000.00 – Year 2

Activity 1: National Capacity Development: HVTB (Continued and Expansion Activity)
In 2009, TB patients are being offered provider-initiated HIV Testing and Counseling (HTC) and referral for ARV services at TB facilities. Through these services, 80% of TB patients have the HIV status ascertained, and ART patients are being screened for TB at ART facilities. In 2010, emphasis will be placed on strengthening the integration of TB and HIV for co-infected clients in the ART and TB clinics. Activities will include: joint supervisions conducted with NTP and HIV of ART and TB registration sites; development of national TB/HIV integration guidelines, including WHO's 3 I's (infection control, Isoniazid, Intensified Case Findings); training of HCW in the provision of integrated HIV/TB services. The I-TECH Technical Advisor will work with Department of HIV & AIDS and National Tuberculosis program (NTP) staff to assist in integrating training strategies and appropriate tools, as they develop national TB/HIV implementing guidelines.

PEPFAR funds through I-TECH will directly support salary and benefits of 1 care & treatment TA (10%

FTE) and two HIV fellows (10% FTE), training materials, vehicle provision and fuel (limited to work-related travel only), and supplies.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9882	**Mechanism Name: JHCOM GHAI - 12159**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Johns Hopkins Bloomberg School of Public Health Center for Communication Programs	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 4,600,000	
Funding Source	**Funding Amount**
GHCS (State)	533,234
GHCS (USAID)	4,066,766

Sub Partner Name(s)

International HIV/AIDS Alliance	Malawi Interfaith AIDS Association	Malawi Teacher Professional Development Activity
National Association of People Living with HIV/AIDS in Malawi	Pact Malawi	Save the Children
Teachers Living Positively		

Overview Narrative

Goals and Objectives

The BRIDGE II Project will scale up and deepen behavioral change communication activities in Malawi by removing barriers to individual action and confronting specific drivers of HIV at the normative/societal level. The overall goal is to contribute toward reducing new HIV infections among Malawians. BRIDGE II's outcomes:

• Individual perception of HIV risk and self-efficacy to prevent HIV infection strengthened;

• Communities mobilized to adopt social norms, attitudes and values that reduce HIV vulnerability;
• HIV prevention interventions strategically linked to services; and
• Malawian institutions supported for effective leadership and coordination.

Linkages with Partnership Framework
The Government of Malawi has made HIV and AIDS a priority in the Malawi Growth and Development Strategy. The National Action Framework and the HIV Prevention Strategy provide guidance on which HIV drivers to focus on to combat HIV. Throughout the Malawi Partnership Framework, PEPFAR supports the implementation of the Malawi national HIV and AIDS response. With PEPFAR Funds, BRIDGE II will focus its contribution to that support on the NAF objective to "Reduce the sexual transmission of HIV", emphasizing interventions that address sexual prevention, human capacity development and gender as a cross cutting issue. BRIDGE II will also contribute towards strengthening linkages and referral to other HIV and AIDS services.

Geographic coverage and target population
BRIDGE II will in the first phase implement activities in 6 districts in southern Malawi: Phalombe, Mulanje, Thyolo, Chiradzulu, Chikwawa and Nsanje. In FY2011 BRIDGE will scale up activities in these six districts whiles initiating activities in second phase districts of Blantyre, Zomba, Machinga, Neno, and Mwanza,. Activities will target the adult population (18-49), including People Living with HIV (PLHIV). Activities targeting the education sector and specifically teachers will be implemented in 8 BRIDGE districts (TBD) by end of Year 2. In year 1 two districts are targeted.

Contribution toward cross cutting, gender and key issues
Human Resources for Health: BRIDGE II will contribute toward building the capacity of frontline health care workers and para-social workers (community members/volunteers) through comprehensive proven training programs on interpersonal communication for HIV and by strengthening/creating new effective community referral networks.
Gender: BRIDGE II will influence gender relations and decrease women's vulnerability to HIV by: applying a gender lens in programming; ensuring that a thorough gender analysis is undertaken; ensuring that research considers gender-specific barriers, facilitators, and media preferences; and examining gender-disaggregated data and outcomes.
Support to workplace interventions: BRIDGE II will collaborate with companies to complement programs that need strengthening, build programs where there is active interest, and advocate with those that are resistant, through the training of existing workplace peer educators to use BRIDGE transformative tools.
Building Behavior Change Communication (BCC) Skills: BRIDGE II will strengthen the BCC skills of professionals taking a lead role in HIV prevention communication. BRIDGE II will offer the course "Leadership in Strategic Health Communication", that includes leadership concepts, cutting-edge BCC

theory, and communication techniques. BRIDGE II will aid the University of Malawi in creating a gender and HIV course for health communication professionals, and explore linkages with AfriComNet in order to have the University of Malawi become part of Africa's network of universities offering courses in communication for health and development.

Cost Effectiveness
BRIDGE II will leverage and build on USAID's investment in the north and central regions through training Pact/Malawi partners on BRIDGE II tools and approaches and providing implementation support. In BRIDGE II districts, linkages among HIV/AIDS, gender, workplace, and income-generation programs will be established for maximum efficiency. BRIDGE II will work with District Assemblies to set up HIV prevention network meetings where additional CBOs/NGOs can learn to inform their district implementation plans.

Linking with Government of Malawi Activities
Regarding harmonization, at the national level, BRIDGE II works with the National AIDS Commission and the Ministry of Health. At the district level, key partners include the District Assembly. Working with partners at both levels ensures that activities are linked, ensuring coordination of the national response.

Research, Monitoring & Evaluation Plans
The Research, Monitoring and Evaluation (R, M&E) plan will track PEPFAR and project indicators in accordance with the Country Operational Plan, and will enhance management through project performance data. A single efficient data -quality management system related to PEPFAR indicators will be utilized. Process and outcome indicators will be captured at all levels. Standardized data collecting tools will be utilized and fed into the BRIDGE II database, capturing information from all partners. In regards to assessing program impact, a baseline survey and formative assessment will inform program activities, and surveys will be administered at midterm and end of project.

Budget Summary
PFIP Year 1 Funding – $4,002,761
PFIP Year 2 Funding – $5,500,000

Cross-Cutting Budget Attribution(s)

Human Resources for Health	424,000

Key Issues

Addressing male norms and behaviors

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID: **Mechanism Name:** **Prime Partner Name:**	**9882** **JHCOM GHAI - 12159** **Johns Hopkins Bloomberg School of Public Health Center for Communication Programs**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	450,103	

Narrative:

III. Budget Code: OHSS

$325,337 – Year 1

$540,000 – Year 2

This mechanism will contribute to the cross-cutting objective of building the capacity of indigenous NGO's.

Activity 1: Capacity building

BRIDGE II will engaged communities to identify and take actions to respond to the HIV/AIDS epidemic. The program will provide capacity building trainings around HIV prevention to districts structures (District AIDS Coordinating Committees, Community AIDS Committees, and Village AIDS Committees and CBOs). BRIDGE II will provide skills building to CACs, VACs, and community based organizations on mobilization around HIV prevention using the community action cycle framework, including local assessment, action planning, program implementation, monitoring and local evaluation.

Other trainings will include using the transformational tools, proposal development and writing skills, resource management and budgeting, community data for decision making, and strengthening local support networks; and referral system.

Products/Deliverables: 70 CBOs strengthened and 70 CBOs networked.

Activity 2: Strengthening Behavior Change Communication Competency

BRIDGE II will strengthen the BCC skills of professionals taking a lead role in HIV prevention

communication. BRIDGE II will offer the course "Leadership in Strategic Health Communication", that includes leadership concepts, cutting-edge BCC theory, and communication techniques.
Products/Deliverables: 30 Local NGOs strengthened.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	3,249,874	

Narrative:

I. Budget Code: HVAB
$2,796,424 – Year 1
$3,780,000 – Year 2

PEPFAR funds to JHCOM will support interventions that strengthen individual perceptions of HIV risk and self efficacy; mobilize communities to adopt norms and attitudes to reduce vulnerability to HIV; strategically link HIV prevention with other HIV and health services; and support Malawian institutions to lead the national HIV prevention response.

HIV drivers, target audience and geographical location
BRIDGE II will confront specific drivers of the epidemic such as Multiple and Concurrent Partnerships, alcohol and substance abuse, women's vulnerability and sero discordance in promoting collective efficacy and normative change in the eleven districts of southern Malawi. BRIDGE project will continue implementing the interventions in the six districts (Mulanje, Phalombe, Nsanje, Chikwawa, Thyolo and Chiradzulu) that it started with FY 09 funding, then scale up to the additional five districts (Blantyre, Zomba, Machinga, Neno and Mwanza) in FY 2011. Roughly, BRIDGE II intends to reach approximately 75% of male and females within the age groups of 18 to 49 years in the implementation districts.

Activity 1: Mass Media Campaign
The Nditha Campaign formed a solid foundation on which almost all BRIDGE I activities were built. BRIDGE II project will build on the successes of this campaign while realigning it with the BRIDGE II focus and the longer term vision of moving toward a community focused collective response- thus from I can towards we will. The project will work with a core group of partners from NAC, MOH and other NGOs to create overarching themes with broad appeal to target group and implementing partners. This theme will provide a focus to organize activities at community levels. These activities will reinforce and stimulate dialogue around key issues on partner reduction, positive living, and alcohol and stigma reduction. Through community dialogue, individuals and communities will make action plans to prevent HIV. The approach will also emphasize the urgency for action by focusing on specific do-able actions, while still supporting self and communal efficacy to act.

Products/Deliverables: Communication Strategy, Campaign launch, Posters, Flyers, Radio spots and Message Guide.

Activity 2: Reality programming- Community live events focusing on partner reduction
In partnership with local radio stations, NAPHAM, MANET+, and others NGOs, BRIDGE II will develop a new strategy and implement the Real Real program. The approach will use community events and personal stories of people from diverse circumstances, PLHIV, discordant couples, men who have stayed negative by remaining faithful, women who have turned away from transactional sex to share the challenges they face and strategies they used to overcome them. These stories will be shared via broadcast and community forums so others can learn from their experience and develop their own risk-avoidance strategies.
Products/Deliverable: Reality programming strategy, Real Real Radio Programs and Radio Diaries produced

Activity 3: Community mobilization
In partnership with Save the Children (SC), BRIDGE II will work to assure increased depth, breadth and replication of community engagement and mobilization across the districts that will translate into sustainable responses for prevention, stigma reduction, and normative change. SC will use the tested Community Action Cycle (CAC) that helps communities analyze their situation and discuss the implications; identify internal community resources and knowledge, skills and talents; identify priority needs; develop a strategy to address those needs; and plan activities needed to execute their strategy.

SC will engage communities in a number of activities including:
? Facilitate a leaders working group on BCI and HIV Prevention Advocacy
? Facilitate formation of new Chiefs Councils in districts and engage councils, using the community action cycle, to identify norms that facilitate the spread of HIV and develop action plans.
? Facilitate community dialogue sessions (discussion forums) focusing on drivers of HIV such as multiple and concurrent partnerships.
? Facilitate CBO networking through regular meetings at Traditional Authority or Sub Traditional Authority level in the districts.

Products/Deliverables: Community Action Cycle re-designed, Community Mobilization Manual Produced, Chiefs' councils formulated and 70 Community Based Organizations networked.

Activity 4: Engage Faith Based Community Networks
BRIDGE II will work with Malawi Interfaith AIDS Association (MIAA) to engage faith based communities in

Phalombe, Thyolo and Mulanje. MIAA will build the capacity of religious leaders and marriage counselors to focus on marriage counseling, an area that has proven to impart great changes in HIV risk reduction. Areas of focus during counseling will specifically include communication issues, sexual decision-making, gender norms, and HIV prevention.

MIAA will conduct couple counselling and marriage counselling seminars. This activity would be followed by a mass wedding event not funded by PEPFAR to renew their marriage vows. We hope that after the couples have gone through marriage counseling/seminars, the renewal of vows would be appropriate to finally cement and or stand as a symbol of their renewed commitment to remain faithful. MIAA will also conduct community dialogue sessions around mutual faithfulness.

MIAA will work with leaders of faith-based institutions and advocate for the development of HIV and AIDS policies for its network churches and mosques through their mother bodies. These policies will direct and standardize implementation of HIV and AIDS services in these institutions. MIAA will provide technical assistance throughout the development process. MIAA will also advocate for the empowerment of women in churches and mosques so that they take part in church and mosque activities such as women's Sundays. The organization will also advocate for the establishment of social services committees in churches and mosques in order to facilitate provision of counseling and testing services in the institutions and empower the existing hospitality committees with counseling and testing skills.
As one way of reducing stigma and discrimination, MIAA will advocate for the acceptance of people living with HIV and AIDS within religious institutions. It will work with religious leaders and facilitate the establishment of support groups for PLWHA in churches and mosques as an arm of the hospitality committees. MIAA will also advocate for institutionalization of referral systems of clients to relevant service providers by the responsible church or mosque committee.
Products/Deliverables: Marriage counseling guide, Marriage vows commitment booklet, 90 marriage counselors trained.

Activity 5: Engage PLHIV Support Groups
In partnership with NAPHAM, BRIDGE II will integrate the Radio Diaries Project into their already existing PLHIV support groups in Mulanje, Thyolo and Chiradzulu. NAPHAM will conduct training sessions for facilitators of the newly formed Radio Diaries Project listening clubs. These facilitators will assist in making the Radio Diaries listening clubs more dynamic and fruitful discussions exploring a variety of issues, such as stigma, discrimination, positive living practices, challenges faced by discordant couples, and gender norms and cultural practices that complicate the lives of those living with HIV/AIDS. NAPHAM will also train community facilitators in how to use the Hope Kit and Positive Prevention Toolkit. Using interactive drama, NAPHAM will engage communities into discussion on key issues such as condom use, multiple partners, positive living and couple HIV testing.

Activity 6: Use of transformative tools - Hope Kit
The Hope Kit is a package of interactive and participatory tools to guide individuals and community groups to develop personal and appropriate HIV prevention strategies. The Hope Kit assists community based organizations to conduct local outreach and mobilization by providing a package of ready to use activities and demonstrations that model prevention behaviors, challenge myths and assumptions about HIV transmission and provide an opportunity for frank and open discussion to address multiple partnerships and challenge norms that promote the spread of HIV among others. Communities use the toolkit in facilitating interactive activities to explore values, analyze options and assist people in making decisions and action plans as regards HIV prevention. The Hope Kit is a modular design, and thereby provides opportunities for participants to reflect on changes to their own behavior in new or emerging priority areas like concurrent partners, discordant couple communication, and male involvement. Another tool developed under BRIDGE 1, the Positive Prevention kit, will help address that issue within PLHIV support groups and care givers. BRIDGE II will, through its different partners (MIAA, NAPHAM, Pact), scale up use of the Hope Kit with the FY09 funding. Pact Malawi will take the Hope Kit to its 15 partners in the central and northern region.

Products/Deliverables: 750 Hope Kits disseminated

Activity 7: Supporting Behavior Change Intervention in work place
BRIDGE II will with FY 2009 support behavior change interventions within work place. BRIDGE II will work with six institutions to develop individualized action plans, as well as political advocacy. The project will advocate for the importance of HIV work place interventions in those estates where management is not yet convinced of such interventions. The work place support will include training peer educators who will in turn facilitate small group peer facilitated discussions during lunch hour using the Hope Kit.
Further more, the project will conduct open day functions within compounds so as to extend HIV work place interventions to employee families as well with HIV prevention messages.
Product/Deliverables: Strategy for behavior change interventions in workplace developed and 6 institutions engaged in behavior change interventions in workplace.

Activity 8: Linking HIV preventions with other HIV health services
Working with International HIV/AIDS Alliance, BRIDGE II will implement a pilot program that will link HIV prevention activities to other HIV and other health services. This linkage will enable continued and supportive care to those individuals who have been exposed to behavior change interventions. This exercise will start in one community in Chiradzulu district as a pilot and will then be scaled up to other districts in the subsequent years. The Alliance will train Community Network Agents (CNA) who, in partnership with a CBO and Save the Children, will facilitate the development and strengthening of the

referral system within the community. The CNAs will help provide linkages between formal clinical services (e.g. for HCT, STI services and ART) and other more informal services or contact points—health posts, support groups, mothers' clubs, etc. The CNAs will operate outside the formal health services, in order to reach the largest possible relevant population.
Product/Deliverables: Referral guide and Service maps developed.

Activity 9: Strengthen collaboration and networking among BRIDGE II CBOs
In partnership with Pact Malawi, BRIDGE II will use Pact's Organization Network Analysis (ONA) tool to building an understanding about patterns of collaboration and networking between individuals and organizations. This approach will be used to analyze networks in a number of ways: comparing networks and modeling best practices; identifying potential network coordinators; and comparing the reality of organizational interaction to network plans. Pact Malawi will conduct a participant survey of the community based organizations under BRIDGE II. Through the capacity building activities, network meetings and best practice symposia at the district level, we hope to build and strengthen the network system. This network will help to build a basis for scaling up an effective referral system after the pilot phase. The ONA will then be used periodically to track the development of the network over the life of the project.
Products/Deliverables: 70 CBOs networked, Compendium of best practices developed, and 6 district best practices conferences conducted.

Activity 10: Strengthening Behavior Change Communication Competency
BRIDGE II will strengthen the BCC skills of professionals taking a lead role in HIV prevention communication. BRIDGE II will offer the course "Leadership in Strategic Health Communication", that includes leadership concepts, cutting-edge BCC theory, and communication techniques. In addition to skills building, during this training individuals will be reached with HIV prevention messages.
Product/Deliverable: 30 people from local NGO's reached.

Activity 11: Research Monitoring and Evaluation
BRIDGE II will implement a Research, Monitoring and Evaluation (R,M&E) plan that will track PEPFAR and project indicators in accordance with the Country Operational Plan. A single efficient data -quality management system related to PEPFAR indicators will be utilized. Process and outcome indicators will be captured at all levels. Standardized data collecting tools will be utilized and fed into the BRIDGE II database, capturing information from all partners. In regards to assessing program impact, a baseline survey and formative assessment will inform program activities.
Products/Deliverables: Research reports, fact sheets, quarterly and annual reports and success stories.

With PFIP year 2 PEPFAR funds, BRIDGE II will continue with the same activities funded by PFIP year 1

funds in the first phase districts (Phalombe, Mulanje, Thyolo, Chiradzulu, Chikwawa and Nsanje). BRIDGE will scale up these activities to five new districts of Blantyre, Neno, Zomba, Machinga and Mwanza.

New activities will include:

Activity 1: Counseling training for lay and clinic-based counselors
BRIDGE II, in partnership with the International HIV Alliance, will offer a training on the GATHER technique - a compassionate approach for engaging and empowering clients that has been used successfully throughout Africa in both Family Planning and HIV; and reinforcing training through job aids and message guides on positive prevention for discordant couples, condom use, reducing alcohol intake, and other issues. Alliance will also train providers and counselors on the GATHER methodology. Counselors will be provided with the Referral Guide so they can channel "clients" to additional services as needed. BRIDGE II will also leverage the efforts of partners (MOH, MSF) providing clinic -based care and work with NAPHAM, and others offering community-based care.
Product/Deliverables: Counseling guide

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	900,023	

Narrative:

II. Budget Code: HVOP

$806,000 – Year 1
$1,080,000 – Year 2

PEPFAR funds to JHCOM will support interventions that strengthen individual perceptions of HIV risk and self efficacy; mobilize communities to adopt norms and attitudes to reduce vulnerability to HIV; strategically link HIV prevention with other HIV and health services; and support Malawian institutions to lead the national HIV prevention response.
Target audience and geographical location
BRIDGE II will confront specific drivers of the epidemic such as MCP, alcohol and substance abuse, women's vulnerability and sero discordance in promoting collective efficacy and normative change in the eleven districts of southern Malawi. BRIDGE project will continue implementing the interventions in the six districts (Mulanje, Phalombe, Nsanje, Chikwawa, Thyolo and Chiradzulu) that it started with FY 09 funding and then scale up to the other five districts (Blantyre, Zomba, Machinga, Neno and Mwanza) in FY2011. Roughly, BRIDGE project intends to reach approximately 75% of the adult population, both

males and females, within the age groups of 18 to 49 years in all the implementation districts.

Activity 1: Mass Media Campaign

The Nditha Campaign formed a solid foundation on which almost all BRIDGE I activities were built. BRIDGE II project will build on the successes of this campaign while realigning it with the BRIDGE II focus and the longer term vision of moving toward a community focused collective response- thus from I can towards We will. The project will work with a core group of partners from NAC, MOH and other NGOs to create overarching themes with broad appeal to target group and implementing partners. This theme will provide a focus to organize activities at community levels. These activities will reinforce and stimulate dialogue around key issues on partner reduction, positive living, alcohol use and stigma reduction. Through community dialogue, individuals and communities will make action plans to prevent HIV. The approach will also emphasize the urgency for action by focusing on specific do-able actions, while still supporting self and communal efficacy to act. Mass media dissemination will further be supported by community outreach events which provide a framework for local activities and decision making. BRIDGE II Team will use the results of the formative research and other relevant data to direct the redesigning of the campaign and consequently lead to its launch. BRIDGE II will develop the campaign with the input of HIV prevention implementing partners in Malawi. Additionally, BRIDGE Team will ensure that the messages are harmonized.

Activity 2: Reality programming- Radio Diary

In partnership with local radio stations, NAPHAM, MANET+, and others NGOs, BRIDGE II will develop a new strategy and implement the Real Real program. The approach will use personal stories of people of PLHIV to share the challenges they face and strategies they used to overcome them. These stories will be shared via broadcast so others can learn from their experience and develop their own risk-avoidance strategies. This approach will give voice to those who have undergone life-changing experiences to bring home, in personal terms, how such transformation is possible.

BRIDGE will train PLHIV to create their own personal weekly radio diaries which will then be broadcast. The diarists will be people who know their status and are willing and able to talk about their situation honestly, openly and with clarity, focus, and real emotion. The diarists will focus on one issue or key event in their lives each week. Over time they should cover a very broad gamut of everyday life: relationships with partners, family, friends and the community at large; medical issues and perceptions of response from the health services community (prejudice, support, etc); work and leisure; diminished capacity; emotional stress; and other key issues in the PFIP, such as coping as a couple/family incl. discordance, condom use, MCP, pre-ART and treatment.

Simultaneously, the program will train and support a team of local radio producers to assist to capture real stories and produce programs. BRIDGE will work with PLHIV support groups under NAPHAM to form listening clubs where they can discuss issues from the radio program. This will help individuals to

make personal decisions and take HIV risk reduction measures.

Activity 3: Community mobilization

In partnership with Save the Children (SC), BRIDGE II will work to assure increased depth, breadth and replication of community engagement and mobilization across the districts that will translate into sustainable responses for prevention, stigma reduction, and normative change. SC will use the tested Community Action Cycle (CAC) that helps communities analyze their situation and discuss the implications; identify internal community resources and knowledge, skills and talents; identify priority needs; develop a strategy to address those needs; and plan activities needed to execute their strategy. For BRIDGE II, the model will be adapted to include the use of behavior centered analysis to identify social and normative factors that need to be addressed for successful HIV prevention. SC will engage communities in a number of activities including:

• Facilitate formation of new Chiefs Councils in new districts and engage councils, using the community action cycle, to identify norms that facilitate the spread of HIV and develop action plans.

• Facilitate community dialogue sessions (discussion forums) focusing of drivers of HIV such as multiple and concurrent partners and risk reduction measures.

• Conduct stakeholders meetings and reviews for CBOs, Chiefs Councils, and DACCs.

Activity 4: Engage PLHIV Support Groups

In partnership with NAPHAM, BRIDGE II will integrate the Radio Diaries Project into their already existing support groups in the southern region. NAPHAM will conduct training sessions for facilitators of the newly formed Radio Diaries Project listening clubs. These facilitators will assist in making the Radio Diaries listening clubs more dynamic and fruitful discussions exploring a variety of issues, such as stigma, discrimination, positive living practices, challenges faced by discordant couples, gender norms and cultural practices. NAPHAM will also train community facilitators in how to use the Hope Kit and Positive Prevention Toolkit. Using interactive drama, NAPHAM will engage communities into discussion on key issues such as condom use, multiple partners, positive living and couple HIV testing.

Activity 5: Use of transformative tools – Positive prevention toolkit

The Positive Prevention tool kit is a set of practical and experiential learning activities designed to help people living with HIV, their partners and families address a range of HIV and AIDS related issues. The target population for positive prevention activities are support group members of people living with HIV (PLHIVs).

BRIDGE II project will train Trainers of the Trainers who will in turn train two support group members to conduct Positive Prevention small-group interventions of 15-20 support group members. The

participatory activities encourage and empower people with HIV to live positively by providing them with role models who have faced and overcome similar challenges. They adopt and maintain behaviors which support their own health as well as the health of their sexual partners, unborn babies and infants, families and wider community through identifying do-able actions to live healthy and productive lives.

The toolkit has two main components, a flip chart entitled 'Planting Our Tree of Hope' with five real personal stories of Malawian men, women and couples who have overcome barriers and in turn, lead healthy lives with HIV. The other component is a Facilitators' Guide, called 'Planting Our Tree of Hope' which is organised into different themes with participatory activities and questions to support discussion around the stories. BRIDGE II will support NAPHAM to scale up use of the Positive Prevention toolkit with the FY09 funding.
Products/Deliverables: 1000 Positive Prevention Toolkit produced and 250 Positive Prevention Toolkit disseminated

Activity 6: Supporting Behavior Change Intervention in work place
BRIDGE II project will, with FY 10 funding, continue supporting HIV work place activities. The project will train peer educators who will in turn facilitate small group peer facilitated discussions during lunch hour. The project will also advocate for the importance of HIV work place interventions in those estates where management is not yet convinced of such interventions. Further more, the project will conduct open day functions within compounds so as to extend HIV work place interventions to employee families as well with HIV prevention messages.

Activity 7: Linking HIV preventions with other HIV health services
Working with International HIV/AIDS Alliance, BRIDGE II will implement a pilot program that will link HIV prevention activities to other HIV and other health services. This linkage will enable continued and supportive care to those individuals who have been exposed to behavior change interventions. This exercise will start in one district as pilot and will then be scaled up to other districts in the subsequent years.

Activity 8: Strengthen collaboration and networking among BRIDGE II CBOs
In partnership with Pact Malawi, BRIDGE II will use Pact's Organization Network Analysis (ONA) tool to building an understanding about patterns of collaboration and networking between individuals and organizations. ONA will help identify the varying patterns of interaction amongst stakeholders and serve as a tool to monitor the development and strength of this network of organizations over time. This approach will be used to analyze networks in a number of ways: comparing networks and modeling best practices; identifying potential network coordinators; and comparing the reality of organizational interaction to network plans. Pact Malawi will conduct a participant survey of the community based

organizations under BRIDGE II. . Through the capacity building activities, network meetings and best practice symposia at the district level, we hope to build and strengthen the network system. This network will help to build a basis for scaling up an effective referral system after the pilot phase. The ONA will then be used periodically to track the development of the network over the life of the project.
In order to strengthen the network, BRIDGE II will conduct best practice symposia at the district level. This will promote best practice sharing and strengthen linkages and networking.

Activity 9: Research Monitoring and Evaluation
BRIDGE II will implement a Research, Monitoring and Evaluation (R,M&E) plan that track PEPFAR and project indicators in accordance with the Country Operational Plan. A single efficient data -quality management system related to PEPFAR indicators will be utilized. Process and outcome indicators will be captured at all levels. Standardized data collecting tools will be utilized and fed into the BRIDGE II database, capturing information from all partners. In regards to assessing program impact, a baseline survey and formative assessment will inform program activities BRIDGE II will disseminate its findings at national, district and community level.

Activity 10: Education Sector Teacher Adult Prevention
BRIDGE II will strengthen the response of the education sector to reduce incidence of adult infection among teachers through two key activities.

1) Building on the roll-out of the Prevention with Positives Toolkit (PwP), BRIDGE II will strengthen capacity of Teachers Living Positively (T'LIPO), a national organization with networks in all 34 educational districts, to provide advocacy, psychosocial support, prevention messages, and referral to HIV related services to more than 2500 members nationally. Six members of T'LIPO will be identified to become master trainers on the PwP toolkit within their support groups. BRIDGE will mentor trainers in subsequent trainings planned, and within their districts, offer ongoing support for its use.

2) Bridge II Project will provide technical expertise and capacity building to teacher trainers through support to the Malawi Teacher Professional Support activity, mandated to provide technical assistance and support to MOEST in implementing national teacher education support and systems management, 50% of a full-time BRIDGE program officer will be seconded to MTPDS to support the review, and revision of the national pre-service and in-service teacher training curriculum in order to integrate key gender and HIV prevention content and participatory methods based on BRIDGE II proven transformative tools. BRIDGE II will share existing tools developed, and possibly adapt content. This can include, for example, incorporation of powerful stories of real teachers, drawing on its work with T'LIPO members who have challenged social and gender norms, experienced intergenerational sex relationships, gender based violence, and taken positive preventive action.

Because of BRIDGE II work in communities address wider social and cultural norms; they can strengthen links between schools and communities to address key issues affecting teachers, children, and link with wider services available within selected districts. For example, teachers will be included in relevant BRIDGE district community mapping and networking analysis process. Stories of teachers can be included in regularly aired radio diaries, etc. Lesson learned, and testing of ideas will be fed back to MBTDS at the national level to further strengthen the education sector's roll-out of meaningful teacher training linked to broader support of teachers and school linkages within their communities.

BRIDGE II will also provide technical support to the MBTDS to develop a KAP survey for teachers to and could potentially support training and analysis. The proposed research will further investigate the effects and impact of HIV and AIDS on education personnel, teachers, students and pupils. This will include knowledge, behaviors and attitudes of these groups and explore issues leading to teacher absenteeism and attrition with respect to teacher management.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 9883	**Mechanism Name: PSI CSH**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Population Services International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 2,914,372	
Funding Source	**Funding Amount**
GHCS (State)	100,000
GHCS (USAID)	2,814,372

Sub Partner Name(s)

Banja La Mtsogolo	Pact Malawi	

Overview Narrative

This is a continuing mechanism which serves PF Goal I: Prevention - reduce new HIV infections in Malawi and PF Goal II: Treatment, Care and Support - improve the quality of and access to treatment and care for Malawians impacted by HIV. These contributions directly support National Action Framework (NAF) Objective 1.1 (reduce the sexual transmission of HIV), NAF Objective 2.2 (increase access to a continuum of HIV care and treatment services) and NAF Objective 2.1.3 (strengthen referral systems within and between health facilities and community).

The Evidence-Based Targeted HIV Prevention (EBT-Prev) Project focuses on implementation of HIV prevention activities in settings and populations with high-risk behaviors. The project will: conduct research to build a body of evidence that supports targeted adult prevention interventions; develop partnerships and interventions beyond PSI's mass communication strategies to address underlying issues for HIV prevention in high risk settings; develop linkages, networks and referral systems to support HIV prevention service provision in those settings; and use PSI's communications and condom social marketing (CSM) expertise to build new partnerships with local NGOs to address issues of concurrency, transactional sex, prevention with positives, discordance, improved CSM and appropriate support for male circumcision (MC) with selected MARPS.

PSI will ensure that these targeted activities dovetail with general population HIV prevention activities thereby building synergy. In partnership with Banja La Mtsogolo (BLM) and with collaboration from national stakeholders, PSI will work to package MC as a health intervention that targets the general population, as opposed to promoting MC as a stand alone HIV prevention intervention, thereby assisting PEPFAR lay the foundation to launch further MC interventions, at a later stage, once the policy environment is conducive.

EBT-Prev is designed to reach most at-risk populations (MARPs), populations that are identified as being at elevated risk of HIV infection because: (i) they are members of a group with high risk behaviors; (ii) they frequent known high risk settings; or (iii) a combination of these two factors. By implementing an extensive research agenda that utilizes an innovative combination of research methods (PLACE, GIS mapping and TRaC), EBT-Prev will identify populations and settings with high risk behaviors. In FY10, EBT-Prev will conduct an intensive baseline assessment to identify, segment and profile populations and settings (Priority Prevention Areas, or PPAs) with high risk behaviors. Specific target groups will be identified using research findings and may include CSW, migrant workers, truckers, MSM, men with money and women engaging in transactional sex.

In FY10, EBT-Prev will continue to deliver integrated behavior change communications (iBCC) interventions to populations with high-risk behaviors in existing 'hot spots' while research progresses in 5 pilot PPAs. In FY 11, these activities will be linked into HIV service provision networks, to be established under EBT-Prev, providing a 'point of entry' to the HIV continuum of care thereby fostering and expanding access to HIV prevention services and reducing HIV risk by targeting behavior change in these high risk

settings. In FY11, PSI will identify additional PPAs by utilizing the research findings, in conjunction with latest district-level HIV prevalence data, to give the project national coverage in a targeted manner.

EBT-Prev will sustain and refine PSI's general population marketing and distribution of male and female condoms to increase availability, including generic and branded communications. A family planning male condom will be introduced to the general population which will, additionally, provide an opportunity to develop a new CSM approach for discordant couples and PLHIV, including marketing and distributing male and female condoms in care and treatment settings and PLHIV groups in identified PPAs.

EBT-Prev will become more efficient overtime by partnering with Pact Malawi to build local NGO capacity to deliver project activities at PPA level. By utilizing a 'hub and spokes' model, PSI will form a research, communications and CSM 'hub of expertise' with Pact sub partners creating an extensive network of local NGOs acting as delivery 'spokes'. These NGOs will receive both technical and administrative capacity building from PSI and Pact throughout the project. This model will build project sustainability as knowledge and expertise is built at the local level and ensures integration with existing activities by partnering with local NGOs. Through Pact, PSI will also partner with MACRO, a renowned HTC local NGO in Malawi which has numerous testing sites that will be utilized as points of entry for linking into the continuum of care in identified PPAs.

EBT-Prev will address gender as a cross-cutting issue with iBCC interventions developed to address existing gender, sexuality and power constructs that increase both women's and men's vulnerability to HIV in different ways. The service provision network will be developed to be cognizant of the different needs of women and men and to include services to meet these needs accordingly.

Budget Summary
PFIP Year 1 Funding – $3,228,511
PFIP Year 2 Funding – $4,394,372

Cross-Cutting Budget Attribution(s)

Gender: Reducing Violence and Coercion	421,990

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Mobile Population

Budget Code Information

Mechanism ID:	**9883**		
Mechanism Name:	**PSI CSH**		
Prime Partner Name:	**Population Services International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HVCT	692,463	

Narrative:

IV. Budget Code: HVCT

$915,354 – Year 1
$1,054,843 – Year 2

With PF Year 1 funds PSI will implement the following activities:

In FY10, PSI will focus on completion of the research baseline assessment to identify PPAs and key behavioral determinants for target groups in support of HTC activities. PSI will also conduct pilot activities in Dwangwa sugar plantation to design and develop a HTC service provision network by local sub partners that will be replicated in additional PPAs in FY 11 to strengthen HTC uptake among the target groups. The promotion of HTC services among identified target populations will be achieved by utilizing a range of communication and interpersonal activities and by linking such activities to local healthcare services. The geographic coverage of HVCT activities will be determined by the identification and distribution of PPAs.

With PF Year 2 funds PSI will implement the following activities

A network of service providers will be established in 7 PPAs to support and promote increased access and uptake of services by populations with high risk behaviors. An integral activity in establishing these networks is to build effective referral networks in and around PPAs to ensure appropriate linkages to care, treatment and prevention services. To build robust referral networks, four specific activities will be undertaken in FY 11, as follows;

1. Identification and development of Strong Network Coordinators. These providers will have the credibility and infrastructure to support clients with chronic conditions and the capacity to provide some integrated services, conduct regular follow-up and refer clients to services outside their own scope, as required. Pact's partners that implement integrated HIV/AIDS programs will be critical to the development of this important role.

2. Build a HIV service provision network within and around PPAs. Using qualitative research to understand provider needs and barriers and how best to position the network to ensure provider participation in the network, tools, materials and training will be developed to recruit and motivate providers to network with one another, including development of a Service Directory.

3. Network Branding and Identification. A network brand will be explored and developed to unify communication materials, identify service points and build teamwork and commitment among providers.

4. Develop, disseminate and promote tools for effective referral and tracking. In collaboration with NGO partners and providers, PSI will develop mechanisms to facilitate referrals among providers and address the challenges of "back-referrals". Experience shows that vouchers, coupons and other referral documentation may aid clients to find recommended services and provide raw data to measure the breadth and depth of referral activity. EBT-Prev partners and providers will seek out sustainable, community-based solutions to address the issue of client transportation, a key barrier to successful referrals.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	CIRC	113,168	

Narrative:

III. Budget Code: CIRC

$140,000 – Year 1
$172,775 – Year 2

With PF Year 1 funds PSI will implement the following activities:

PSI in partnership with Banja La Mtsogolo (BLM) and in collaboration with national stakeholders will explore how to motivate for and support the uptake of MC services as a health intervention to prevent various health risks for men and women including HIV transmission. Pending the development of policy and guidance from the Malawi MOH on MC for HIV prevention, it is envisioned that this partnership will

capitalize on BLM's existing network of clinics and their clinical expertise in undertaking medical MC and benefit from PSI's expertise in behavior change communications, quality assurance support and social marketing for MC.

In FY10, PSI will focus on the development of PSI-BLM strategic partnership document to guide development of MC services as a health intervention in Malawi following which PSI, in partnership with BLM, will commence supporting MC services by providing training and designing quality assurance and social marketing tools for MC in Malawi. Further to this, PSI will establish a target and report on the number of locations providing safe MC surgery as part of the minimum package of MC services within the reporting period (P5.3.D). Geographic coverage of MC activities will be in line with distribution of PPAs.

PSI will undertake activities to promote the uptake of health services such as HTC, STI and FP as essential components of quality HIV programming; successful communication regarding these services will lead to increased demand for these services which will serve as 'points-of-entry' for MC services. PSI will develop a HIV Service Directory for each PPA which will also include locally available MC services.

PSI will support high quality MC services by visiting MC providers to assess capacity and service quality. PSI will draw upon existing protocols, Quality Assurance checklists and technical personnel from other PSI platforms with experience in social marketing of MC to ensure that MC services in PPAs follow established best practice.

With PF Year 2 funds PSI will implement the following activities:

PSI will continue to implement activities to promote the uptake of health services as essential components of quality HIV programming and the successful communication on, linkages to and referrals to these services will lead to increased demand for these services which will continue to serve as 'points-of-entry' for MC services in the absence of a supporting policy environment. PSI will continue to promote the use of the HIV Service Directory in each PPA including locally available MC services.

PSI will continue to support high quality MC services in and around PPAs through support and supervision visits to MC providers. PSI will use evidence generated from implementing MC activities to influence policy support for MC at national level.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	835,590	

Narrative:

I. Budget Code: HVAB

$963,799 – Year 1
$1,223,037 – Year 2

With the generalized AIDS epidemic in Malawi, multiple and concurrent partners (MCP) connects large numbers of people into a few, large sexual networks that put many individuals at risk of HIV. A person can be linked into a sexual network and at high risk of HIV infection even if that individual has only one partner, if that one partner is currently linked into sexual network or has been linked into one in the past. MCP with low condom use is a key driver in the HIV epidemic in Malawi. 27% of men and 8% of women reported having sex with a non marital, non cohabiting partner in the year prior to the survey and condom use was less than 50% (MDHS 2004). Therefore to effectively address the HIV epidemic it is critical to have a strong appreciation of why individuals engage in MCP and to address these realities in a consistent and appropriate manner.

PSI will deliver Abstinence/Being faithful (HVAB) activities, including training, aimed at preventing HIV transmission by delivering messages/programs to promote reduction of (MCP) and transactional sex and other related social and community norms that impact these behaviors. The geographic coverage of HVAB activities will be determined by the identification and distribution of PPAs. It is envisioned that over the life of the project approximately 25 PPAs will be established nationally.

With PF Year 1 funds PSI will implement the following activities:

Targeted Outreach Communication (TOC) – Existing PSI TOC teams will continue to conduct interpersonal communications (IPC) educational events and interactive audiovisual shows that focus on risk awareness and promote adoption of safer sexual behaviors, including partner reduction, in 'hot spots' by raising awareness of key risky behaviors and issues such as MCP, transactional sex and discordance respectively.

Interpersonal Communication (IPC) – IPC activities are divided into two components: IPC Outreach activities that engage less specific, less readily identifiable target groups (e.g. men with money, etc.) and Peer Education (PE) activities that work with more readily identifiable risk groups (e.g. FSW.) IPC Outreach activities will promote adoption of safer sexual behaviors, including partner reduction, by conducting individual and group level interventions through local NGO partners.

Mass Media – such campaigns will center on increasing risk perception and raise awareness of the risks of MCP, transactional sex and discordance while promoting strategies that will support adoption of safer

sex behaviors, including partner reduction. Campaign materials will be developed with broad stakeholder involvement and will be rigorously pre-tested to ensure that messages are appealing, appropriate and understood by target groups.

Links to local healthcare services - Activities to reduce MCP will include messaging on linkages to local health services, including public sector facilities, CHAM, BLM clinics and private health care providers to raise awareness and encourage utilization of support services such as STI and HTC.

Positive Prevention – EBT-Prev will contribute to HIV prevention with positives by communicating and implementing messages, through mass media and appropriate IPC channels, on PwP issues including: personal risk perception, discordance, safer sex, Family Planning (FP), PMTCT, linkages to PLHIV support groups and the benefits of HTC and pre-ART program activities.

MSM – Research shows that 67% of men who engage in MSM activities in Malawi are married. Given this fact and the very high risk associated with MSM activities, it will be very important to work with MSM on the risks associated with MCP - both within the MSM network and outside the MSM network into the heterosexual population. Working with CEDEP, a local partner NGO, PSI will develop and pretest appropriate messages and interventions for this target group to promote adoption of safer sexual behaviors, including partner reduction.

With PF Year 2 funds we expect to implement the following activities;

Using evidence generated from research in the five pilot PPAs, PSI will expand implementation of the above mentioned HVAB activities into 7 new PPAs to address key issues including MCP, transactional sex and discordance among identified target groups. In FY11, PSI will also develop and implement community-level interventions and referral systems between services, through Pact sub partners located in the PPAs, to deepen the scope and quality of PSI's communications and IPC activities.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	1,273,151	

Narrative:

II.Budget Code: HVOP

$1,665,009 – Year 1
$1,943,717 – Year 2

PSI will deliver Other Sexual Prevention (HVOP) activities aimed at preventing HIV transmission by implementing communication and interpersonal (individual and group level) activities to complement HVAB activities. HVOP activities will be designed in a manner that will address MCP, transactional sex and discordance among identified target groups.

With PF Year 1 funds we expect to implement the following activities:

Targeted Outreach Communication (TOC) – Existing TOC teams will continue to conduct IPC educational events, interactive audiovisual shows with emphasis on correct and consistent condom use in the targeted areas. Activities will include promotion of both male and female condoms and raising awareness of the risks of MCP, transactional sex and discordance.

Interpersonal Communication (IPC) – IPC Outreach activities will include individual and group level discussions and interventions that will address risk perception, promote efficacy to reduce risk at individual or group level and promote condom use. Interventions and messages will focus on promoting the uptake of HIV prevention services, including HTC and other health services, such as FP, STI, PMTCT, and risk reduction counseling.

Mass Media – such campaigns will center on increasing risk perception and addressing myths and misconceptions about condom use, benefits of knowing one's HIV status and seeking HTC as well as the benefits and availability of HIV prevention and care services for those who are HIV-positive. Campaign materials will be developed with broad stakeholder involvement and will be rigorously pre-tested for appeal, appropriateness and understandability.

Links to local healthcare services - All HVOP activities will raise awareness of linkages to local health services, including public sector facilities, CHAM, BLM clinics and private health care providers. TOC staff, IPC Outreach Workers and Peer Educators will receive training on existing services to encourage and promote service utilization for STI, HTC, MC, FP, PMTCT and GBV.

Positive Prevention – EBT-Prev will support prevention for HIV positive persons, their partners and their children by consistently communicating through mass media and appropriate IPC channels on key issues including: promotion of HTC for couples; condom promotion to discordant couples using the introduction of a FP male condom targeting established couples; and behavior change communication for positive prevention, including messaging on personal risk perception, self-efficacy, discordance, safer sex, FP, PMTCT and PLWHA support groups.

MSM - By working with CEDEP, the scope and extent of MSM communities in and around PPAs will be

identified. CEDEP will guide PSI and local NGO partners to appropriately engage with existing MSM networks and disseminate information on the risks faced by MSM and adoption of safer sexual behaviors, including condom use. Opportunities to introduce MSM peer education activities, incorporating use of condoms by MSM and development of MSM-specific HTC counseling modules, will be investigated.

Condom use and social marketing (CSM) - Activities aimed at sustaining and refining CSM to the general population will include: generic mass media communications to increase condom use; Chishango branded activities, including the re branding of the current Chishango packaging (with no change to the actual product) and the subsequent evidence-based development and launch of a Chishango scented variant targeting the more urban market with the original product repositioned to target the rural market. In addition, a FP male condom will be launched targeting couples and PLHIV. It is anticipated that this condom market segmentation will result in increased overall condom use. With UNFPA co-funding, EBT Prev will continue to sell CARE female condoms to pharmacies, drug stores, clinics and hair salons. PSI will expand the current CARE female condom program activities to target FSW and women engaging in transactional sex. Using a proven method from the region, PSI will identify, recruit and train FSW 'Queens' – older, less mobile and respected FSW – who will be trained to sell CARE female condoms to their colleagues and customers.

With PF Year 2 funds PSI will implement the following activities:

PSI will expand implementation of the above mentioned HVOP activities into 7 new PPAs to address key behavioral issues including MCP, transactional sex and discordance, among the identified target groups using the evidence generated from the research in the five pilot PPAs. In FY11, PSI will develop, implement and strengthen community level interventions and referral systems between services, through Pact sub partners located in the PPAs, to deepen the scope and quality of PSIs communications and interpersonal activities. Pact Malawi will put out an APS that will identify additional local partners to implement community level activities in the PPAs.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10427	**Mechanism Name: Malawi Blood Transfusion Service**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and	Procurement Type: Cooperative Agreement

Prevention	
Prime Partner Name: Malawi Blood Transfusion Service	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,140,000	
Funding Source	**Funding Amount**
GAP	546,622
GHCS (State)	593,378

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The objective of PEPFAR's support to the Malawi Blood Transfusion service (MBTS) is to reduce the incidence of HIV and other diseases transmissible by blood transfusion in the Malawi population. The MBTS will use year one funds to consolidate prior PEPFAR investments in the blood transfusion services of Malawi. We will use FY-10 funds to expand services that assure national coverage of safe blood interventions in the country.

MBTS is a nationally coordinated blood service and was established in 2004 with initial funding from the European Union. Currently, MBTS is funded by the Malawi Government and the Global Fund for AIDS Tuberculosis and Malaria (GFATM) through National AIDS Commission to collect, test, process, and store and distribute blood and blood products to hospitals in Malawi. However, the current funding level does not allow MBTS to fully meet the country need for blood and blood transfusion services.

MBTS accepts blood donations only from voluntary non-remunerated blood donors from low risk population groups. Donated blood is tested by using highly sensitive and specific reagents and techniques in a quality assured manner for: HIV, Hepatitis B and C, syphilis and malaria. MBTS prepares five blood products: whole blood, adult and pediatric red cell suspensions, platelet concentrates, fresh frozen plasma and cryoprecipitate.

Most hospital blood banks (HBBs) do not have the capacity and the infrastructure to order, store, cross match and issue safe blood to individual patients. Modern transfusion medicine was not adequately covered during the undergraduate training of practicing medical doctors, laboratory technicians, nurses and clinical officers, before the establishment of MBTS. There was no provision for the training of the

Health care Workers and for advocacy on appropriate clinical use of blood. The blood supply is also characterized by blood shortages during school holidays as 80% of blood donors are the youth in schools and colleges. There are no guidelines on the appropriate clinical use of blood and blood products among other challenges.

PEPFAR's funding seeks to improve the infrastructure and capacity of Central and District-Level Hospital Blood Banks and promote the appropriate Clinical Use of Blood and Blood Products to prevent the transmission of HIV and other infectious agents through blood transfusion. With increased PEPFAR funding in FY2010, MBTS will scale-up its activities. In addition, MBTS will coordinate the development of blood safety policies and procedures and national guidelines for appropriate clinical use of blood and blood products as well as the expansion of blood collection through promotion of increased donor pools of voluntary, non-remunerated, low-risk blood donors.

The specific objectives of PEPFAR'S funding are:
• Improve the infrastructure of Central and District-Level Hospital Blood Banks through rehabilitation of hospital blood banks and provision of basic blood bank equipment;
• Strengthen the national capacity in blood safety through in-service and pre-service training of Health Care Workers (Laboratory technicians, nursing and clinical staff) already enrolled in colleges and those working in Central and District-Level Hospitals;
• Promote quality assurance system through establishment and implementation of a National Quality Assessment Scheme (NQAS), development of Standard Operating Procedures (SOPs) and monitoring and evaluation of performance.
• Support the expansion of blood collection through promotion of increased donor pools of voluntary, non-remunerated, low-risk blood donors.
• Support the development of blood safety policies and procedures and national guidelines for appropriate clinical use of blood and blood products.

The program contributes to HIV prevention which is the priority area of the National Action Framework and the Malawi Growth and Development Strategy (MGDS). The strategy of the program improves the quality and access to services supported by the GFATM and Malawi Government and supports the PF goals of reducing new HIV infections and health system strengthening through support in laboratory services and training of human resources for health. The availability, appropriate use and adequate safe blood supplies also supports Millennium Development Goal (MDG) number 4 and 5, "Reducing Child mortality and improve maternal health respectively". Currently, over 67% of transfusions are carried out in children and mothers who are the most vulnerable and in need for HIV/AIDS prevention, treatment, and care services.

The program is contributing in building a sustainable, safe and adequate blood supply system for the country through improvement of the functionality of HBBs and training health care workers. The improved infrastructure, human capacity and the NQAS will support blood safety activities in the future with minimal maintenance. The trained undergraduate biomedical students will need minimal follow up after graduation. PEPFAR's support for expanded donor pool of voluntary, non-remunerated, low-risk blood donors will ensure continuity of supply of adequate and safe blood.

Budget Summary
PFIP Year 1 Funding – $250,000
PFIP Year 2 Funding – $1,140,000

Cross-Cutting Budget Attribution(s)

Construction/Renovation	500,000
Human Resources for Health	100,000

Key Issues

Workplace Programs

Budget Code Information

Mechanism ID:	**10427**		
Mechanism Name:	**Malawi Blood Transfusion Service**		
Prime Partner Name:	**Malawi Blood Transfusion Service**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HMBL	1,140,000	
Narrative:			
Budget Code: HMBL $250,000 – Year 1 $1,140,000 – Year 2 With PFIP year 1 funds we expect to implement the following activities:			

• Rehabilitate 10 hospital blood banks and provide them with basic but critical blood bank equipment
• Train 140 Health Care Workers (30 laboratory technicians, 50 nurses, and 20 clinicians from the District-Level Hospitals whose blood banks will be rehabilitated and 40 undergraduate students of biomedical sciences) and tutors from training colleges in appropriate use of blood and modern blood transfusion medicine.
• Establish quality assurance systems in 10 hospitals whose blood banks will be rehabilitated and enroll them into the National Quality Assurance Program.

These activities will be continued in PFIP year 2.
The National Quality Assessment Program (NQAP) is a program established using PEPFAR funds in 2006. It is a program through which MBTS assesses the competence of hospital blood banks in carrying out immuno-hematological testing. Currently 29 out of 54 hospitals are participating in the program. With the additional funds the program will be extended to all 54 hospitals in the next two years (10 in year 1 and 15 in year 2).

Activity 1: Rehabilitate 10 hospital blood banks and provide them with basic but critical blood bank equipment

With funding from GFATM through NAC and Malawi Government, the MBTS, collects blood, tests for transfusion-transmissible infections, prepares blood and blood products, stores and distributes or supplies blood and blood products to all hospitals in Malawi that include Central and major district and mission hospitals (district-level hospitals) in accordance with WHO standards. However, the quality and safety of processes for storage, cross-matching, issuing and clinical use does not meet the required standards in most of the hospitals that have not yet been reached by this program. Currently, only 29 out of 54 hospitals have functional HBB as a result of this program. There is need to improve the infrastructure and quality systems in the other hospitals.
With FY-10 funds from PEPFAR the MBTS will rehabilitate 10 hospital blood banks and provide them with basic blood bank equipment. Specific targets are government and Christian Health Association of Malawi (CHAM) or mission hospitals that serve the poor, rural and vulnerable populations including women and children who are the population groups receiving over two thirds of all transfusions in the country. The program will be extended to other hospitals in subsequent years.

Activity 2: Train tutors from training colleges and 100 Health Care Workers (30 laboratory technicians, 50 nurses, and 20 clinicians) from the District-Level Hospitals whose blood banks will be rehabilitated in appropriate use of blood and modern blood transfusion medicine

It is essential to equip the staff with the appropriate knowledge and skills in blood safety and modern transfusion medicine. In-service training for 30 laboratory technicians, 50 nurses, 20 clinical officers, medical doctors and tutors from training colleges will continue. These will essentially come from the 10 hospitals whose blood banks will be rehabilitated and a few others from the facilities that were rehabilitated in previous years. Training of 40 undergraduate students of biomedical sciences will continue as well. These students will come from training colleges in the country and those attached to the hospitals referred to in the above activities.

Activity 3: Establish quality assurance systems in 10 hospitals whose blood banks will be rehabilitated and enroll them into the National Quality Assurance Program -

Since the establishment of in the National Quality Assessment Program (NQAP) in 2006 with funding from PEPFAR, 29 hospitals whose blood banks were rehabilitated participate in the program. Through this program, MBTS assesses the competence of hospital blood banks in carrying out immuno-hematological testing. MBTS will establish the quality assurance systems in the 10 hospitals whose blood banks will be rehabilitated and enroll them in the NQAP. MBTS will also continue to monitor and provide support to the current 29 hospitals already enrolled in the NQAP in their quality assurance activities.

$1,140,000 – Year 2

MBTS will continue implementing year 1 activities. Increased funding in PFIP year 2 will enable MBTS to scale-up the activities. In addition, MBTS will support the expansion of blood collection through promotion of increased donor pools of voluntary, non-remunerated, low-risk blood donors and to support the development of blood safety policies and procedures and national guidelines for appropriate clinical use of blood and blood products.

Activity 1: Rehabilitate 15 additional hospital blood banks and provide them with basic but critical blood bank equipment

MBTS will scale up rehabilitation to cover the remaining 15 hospitals blood banks in order to reach all 54 hospitals that transfuse blood in the country.

Activity 2: • Train 165 Health Care Workers (20 laboratory technicians, 75 nurses, and 30 clinicians from the District-Level Hospitals whose blood banks will be rehabilitated and 40 undergraduate students of biomedical sciences) and tutors from training colleges in appropriate use of blood and modern blood transfusion medicine

In-service training for laboratory technicians, nurses, clinical officers and medical doctors from the 15 hospitals whose blood banks will be rehabilitated including tutors from training colleges will continue. Another cohort of 40 undergraduate students of biomedical sciences will be trained.

Activity 3: Establish quality assurance systems in 15 hospitals whose blood banks will be rehabilitated and enroll them into the National Quality Assurance Program

15 additional hospitals will participate in the National Quality Assessment Program bringing the total to 54 hospitals (100%).

Activity 4: Support the expansion of blood collection through promotion of increased donor pools of voluntary, non-remunerated, low-risk blood donors

The increased resources in FY2010 will allow MBTS to strengthen its blood donor associations, mainly the Blood Donor Association of Malawi (BDAM) and its youth wing, The Malawi Club 25, to recruit and retain more adult blood donors nationally and to retain more young blood donors particularly those out of school. The target is to recruit 50 new adult blood donors around each of the 41 district hospitals. This is important in addressing the blood scarcity that occurs during school holidays. 6,500 out of school youths will be retained in the 3 cities of Blantyre, Lilongwe and Mzuzu. Preliminary data suggests that 60% of the Malawi blood supply is voluntary and non-remunerated. With FY2010 funds, the percentage will increase to 70 as Malawi progresses to meet the WHO target of 80% voluntary and non remunerated blood by 2012. It is expected that Malawi will have established its baseline blood supply by the end of 2009 calendar year.

Activity 5: Support the development of blood safety policies and procedures and national guidelines for appropriate clinical use of blood and blood products

Hospital transfusion committees will be strengthened nationally starting with all central hospitals. Through these committees national guidelines on the appropriate clinical use of blood and blood products will be finalized and published. PEPFAR funds will be used to print and distribute copies of the guidelines to all institutions and officials involved in the blood transfusion services.

The establishment of transfusion committees will sustain the administration of transfusion services in hospitals beyond the funding period. The guidelines will be used for many years with revisions that may not be costly. MBTS will monitor the number of new adult blood donors recruited; the number of out of school youths retained, the number of blood units collected during school holidays and publication of guidelines on the clinical use of blood and blood products to determine the achievement of the activities

number 4 and 5.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10764	**Mechanism Name: Service Provision Assessment**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Macro International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Budget Summary

PFIP Year 1 Funding – $562,300

PFIP Year 2 Funding – $0

Summary

USG along with national counterparts will conduct the fourth Demographic and Health Survey (DHS) and the second DHS + survey which includes biomarkers for HIV. DHS surveys are conducted every four to five years, to allow comparisons over time. The next one will be scheduled for 2009 after the National Census is conducted in 2008.

Background

The DHS surveys are household surveys with a sample that represent the general population. DHS surveys provide data for a wide range of monitoring and impact evaluation indicators in the areas of population, health and nutrition. The basic approach is to collect and make available data that are

comparable across countries. In recent years, an HIV module with HIV testing was added to the survey in order to provide nationally representative HIV data including prevalence. The data are crucial for planning resources and in developing the national HIV prevalence estimate.

In Malawi, DHS has been conducted in 1992, 2000 and 2004. In addition, an interim Knowledge, Attitude and Practice Survey was conducted in 1996. The next DHS + is scheduled for 2009 and planning for it will commence in 2008. The DHS in 2004 had a sample size of 13,664 and included questions on HIV Behavior, HIV Knowledge as well as HIV testing. The findings from the latest survey were released in FY 2006 and will be compared to findings in 2010.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Impact/End-of-Program Evaluation

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10781	**Mechanism Name: GoM/HSS/GHAI**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Malawi College of Medicine	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 600,000	
Funding Source	**Funding Amount**
GHCS (State)	600,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goal of this program is to build leadership and management capacities among senior and middle-level public health managers in the country. This will be done through a Fellowship program for graduates of the University with a Masters degree and a coaching and mentoring program for existing managers at District level.

Malawi has major shortages of key human resources especially in leadership positions to manage an increasingly complex national HIV/AIDS program. Most of the program is managed by expatriate Technical Assistance (TA) staff with time-limited appointments. The TA system has not been successful in building the required local capacity and is expensive. Programs also tend to collapse when their tenure ends.

Malawi decentralized its health delivery system and transferred powers, functions and decision-making responsibilities to the district level in a sweeping manner with substantial independence of the central level. The aim of decentralization of the health sector is to improve efficiency in the use of resources and delivery of health services. However, the decentralized health sector faces challenges due to inadequate leadership and management skills among public health managers across all levels as identified in the MOH Plan of Work (2004 – 2010).

The Leadership and Management Development Program is intended to train the next generation of leaders and is implemented by the University of Malawi, College of Medicine (CoM) in collaboration with Ministry of Health (MOH). Having a well trained cadre of mid-level managers would not only support the efficient delivery of Health care services for HIV/AIDS prevention, treatment, and support services, it would help strengthen the health care delivery services in general as decentralization unfolds. The program supports the Malawi National Action Framework (NAF) Objective 2.1: To improve the capacity of the health care system to manage HIV and related disease diseases and Goal IV of the Partnership Framework on cross-cutting systems strengthening - "To provide targeted, discrete systems strengthening in 5 key areas (laboratory services, health information systems, human resources, procurement and supply chain management, and health finance) to support the Prevention, Treatment,

Care and Support goals". Ultimately, the program will strengthen the health system and ensure sustainability through local ownership and capacity to manage the national response to HIV and AIDS.

The program's initiative of coaching and mentoring of local Malawian public health managers will improve leadership and management capacity and therefore contribute to health systems strengthening. The local Malawian health managers will sustain and own the national response to HIV and AIDS and the general health system as desired by PEFAR (Partnership Framework, page 3, First Paragraph).

The Fellowship for leadership in HIV prevention, treatment, care and support Program
In September 2008, the COM, in collaboration with the MOH with support from CDC/PEPFAR, established the Fellowship Program for Leadership in HIV and AIDS Services. The program offers opportunities and provides financial and mentoring support to local Malawian individuals who have a Masters degree and have the potential to take up leadership positions in HIV and AIDS services in the public sector and NGOs. The health professionals are linked with the University system and field experience with US government (USG) partners and the MOH on HIV and AIDS for two years. After successful completion of the fellowship, fellows will be absorbed and retained within the public sector and in NGOs such as Christian Health Association of Malawi (CHAM). The first intake of four (4) fellows will be in January 2010.

The Management development for District-Level Public Health Managers
Along side the Fellowship Program for Leadership in HIV and AIDS services, the CoM is implementing management capacity building program for middle level public health managers who are already appointed and are serving in leadership and managerial positions in the District Health Management Teams (DHMTs), supervisory Health Support Zone offices and other senior managerial positions in the health sector. The Health Managers while in their workplaces participate in management and leadership classroom / workshop trainings and are mentored through support visits to ensure that they apply the skills they acquired in workshops. Even though the program focuses on MOH and NGOs working in HIV and AIDS others would benefit from this program.

With FY2008 funding from PEPFAR, the program established the National Steering Committee (NSC) to oversee and provide guidance to activities. The NSC guides the programs by identifying priority areas and reviews the performance of the administrative structure. The Committee is co-chaired by the MOH and COM, and comprises of members from key stakeholders in the national response to HIV and AIDS from the academic institutions, private sector and development partners. The NSC promotes linkages and collaboration among stakeholders and is strategic platform for building sustainability of the programs.

The quality of the operations of the programs will be achieved through use of independent external

examiners to review the courses and the standards of the program and outputs. The fellowship program will increase the number of new eligible local Malawian candidates for management and leadership positions in the national response to HIV and AIDS within a medium to a long term future. The Management capacity building program creates strategic local health officials/managers who are empowered with better management and decision-making skills, and creativity and innovation in problem-solving. These officials, in turn, optimize the functionality of the decentralized Malawi health system. This contributes immensely to Malawian ownership as well as ensures the long term sustainability of HIV and AIDS programs as well as the entire health service delivery system.

Budget Summary
PFIP Year 1 Funding – $253,205
PFIP Year 2 Funding – $800,000

Cross-Cutting Budget Attribution(s)

Human Resources for Health	600,000

Key Issues

Workplace Programs

Budget Code Information

Mechanism ID:	**10781**		
Mechanism Name:	**GoM/HSS/GHAI**		
Prime Partner Name:	**University of Malawi College of Medicine**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	600,000	
Narrative:			
PFIP Year 1 Funding – $253,205 PFIP Year 2 Funding – $800,000			

With PFIP year 1 funds we expect to implement the following activities:

• Promote linkage and collaboration among the stakeholders and HIV service organizations
• Strengthen the capacity of the College of Medicine
• Train DHMTs, and:
• Enhance sharing experiences in HIV and AIDS management, organizational leadership and service delivery management.

These activities will be continued in PFIP year 2.

Budget Code – OHSS
Management and Leadership Development for District Level Managers

$253,205 – Year 1

Activity 1: Promote linkage and collaboration among the stakeholders and HIV service organizations

The program will facilitate two meetings of the National Steering Committee; the first meeting will approve the first 10 DHMTS that will be enrolled in the training program. The second meeting will review the progress being achieved and the performance of the CoM. The meetings will also review policies and operating standards that guide the management of the mentorship schemes. The committee will also review the composition of its members to increase the number of stakeholders to be involved.

Activity 2: Train and mentor 10 District Health Management Teams
The goal of training for DHMTs is to improve the effectiveness of public health programs in Malawi by empowering District Health officials with better leadership, management and decision-making skills and stimulating creativity and innovation in problem-solving. The training will build the skills of local public health managers to prioritize, plan, organize, monitor, and evaluate the use of organizational resources (time, personnel and money) to prevent or control diseases, disabilities and premature mortality. To accomplish this activity, the program will collaborate with the Department of Planning and Policy Development in MOH to identify 2 out of 5 Health Support Zones from where 10 out of a total of 28 DHMTs (40 managers) will be enrolled in the training program.

The program will evaluate the management capacity building program that has been implemented by MOH with support from CDC from November 2007 to December 2008. The lessons learnt from this program will feed into the development of the College of Medicine coordinated program. Furthermore, the

program will assess specific training needs among the participating DHMTs in order to develop appropriate training modules. The program will receive technical assistance from CDC-Sustainable Management Development Program (SMDP) in evaluation of the previous program, conducting training needs assessment and developing training curriculum and modules.

Activity 3: Strengthen the capacity of the College of Medicine
The program will recruit a full time Training Facilitator to increase the capacity of the college's existing faculty on Heath Management. The program will also recruit four part-time trainers and mentors from a pool of active graduates of the Management for International Public Health (MIPH) course conducted by CDC-SMDP in collaboration with Emory University in Atlanta, USA.

The program will conduct a study tour to Botswana to learn from experiences of a similar program to help with improvements to the Malawi program. The program will sponsor one Malawian candidate to attend the MIPH course to be held in South Africa to increase the number of possible facilitators and mentors for district health managers.

Activity 4: Enhance sharing experiences in HIV and AIDS management, organizational leadership and service delivery management

The Program Director will present abstracts at the CDC-SMDP biennial conference and the HIV implementers' meetings to share experiences with others.

Budget Code – OHSS -
Management and Leadership Development for District Level Managers
$400,000 – Year 2

With PFIP year 2 funds, we expect to continue implementing the following activities:

• Promote linkage and collaboration among the stakeholders and HIV service organizations.
• Train and mentor District Health Management Teams and:
• Enhance sharing experiences in HIV and AIDS management, organizational leadership and service delivery management.

Activity 1: Continuing with governance of the scheme and promote linkage and collaboration among the stakeholders and HIV service organizations

The program will convene four meetings of the National Steering Committee to approve the second cohort of 10 DHMTS for enrollment in the training program and to review the progress achieved by the program. The meetings will also review policies and operating standards that guide the management of the mentorship schemes. The committee will also review the composition of its members to increase the number of stakeholders to be involved.

Activity 2: Train and mentor 18 District Health Management Teams

In collaboration with the Department of Planning and Policy Development in MOH, the program will scale-up and enroll the remaining 18 DHMTs (90 managers) from 3 Health Support Zones to cover the entire public health sector with the program. The program will use experiences and lessons learnt in year one of implementation to review the training modules.

Activity 3: Enhance sharing experiences in HIV and AIDS management, organizational leadership and service delivery management

The program sponsor one presenter to the HIV and AIDS implementers' meeting to share experiences with others

Budget Code – OHSS
Fellowship for Leadership in HIV and AIDS Prevention, Treatment, Care and Support Services
$400,000 – Year 2

Activity 4: Build fellows' competencies in managing HIV and AIDS services
The program will scale up and increase the intake of fellows from 4 in year 1 to 6 fellows in year 2. The program will review curriculum and training modules for the Fellowship program, conduct short courses and provide on-the-job coaching and mentoring.

Activity 5: Enhance sharing experiences in HIV and AIDS management, organizational leadership and service delivery management

The program will hold an annual dissemination and review meeting to share experiences of the Fellowship Program with key stakeholders in the national response to HIV and AIDS.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10783	**Mechanism Name: JHPIEGO CSH**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: JHPIEGO	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 125,000	
Funding Source	**Funding Amount**
Central GHCS (State)	125,000

Sub Partner Name(s)

Save the Children		

Overview Narrative

JHPIEGO will assist the Ministry of Health (MOH) to complete the roll out of the performance and quality improvement initiative in infection prevention to all districts in an effort to reduce HIV and possible Hepatitis B transmission among health providers in health facilities. This will be achieved through facilitating sensitization meetings, training quality improvement and assurance support teams in infection prevention (IP), conducting baseline assessments at the facilities, conducting monitoring and supervision at facilities, addressing identified IP gaps with available resources, and working with District Health Management Teams (DHMT's) to ensure they budget sufficient funds to guarantee the availability of adequate and consistent supply of IP commodities. Target population for the program is the general population. These activities wrap around performance and quality improvement work to be undertaken by JHPIEGO with family planning and maternal and child health funding.

Background

Since 2002, JHPIEGO Malawi has worked with MOH Nursing Division and the National Quality Assurance Steering Committee (NQASC) to improve IP practices in hospitals throughout Malawi. As the JHPIEGO bilateral agreement comes to an end in September 2007, the follow-on activities in this area will be undertaken through a central agreement with JHPIEGO. Among the critical activities to be completed is the roll out of the national IP guidelines and standards to all health facilities.

To date, the PQI/IP process has been introduced in 35 hospitals. Improvements have been documented in all hospitals and nine have achieved recognition by MoH. JHPIEGO will continue to roll out this initiative to other facilities and support the existing facilities to achieve recognition status.

Budget Summary
PFIP Year 1 Funding – $25,000
PFIP Year 2 Funding – $125,000

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	10783		
Mechanism Name:	JHPIEGO CSH		
Prime Partner Name:	JHPIEGO		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	HMIN	125,000	

Narrative:

$25,000 – Year 1
$125,000 – Year 2

Activity 1: Development of National Guidelines

JHPIEGO will build on the assistance provided through the previous JHPIEGO bilateral project to help the MoH in developing national guidelines and standards for IP. The infection prevention standards cover 14 departments of the hospital that includes the operating theater, labor/maternity wards, medical wards, surgical wards, casualty department, laboratory, dental, and family planning clinics; and these are being

implemented in 35 health facilities covering all central and district hospitals. Two thousand and twelve health workers in Malawi have been trained in injection safety with technical support from JHPIEGO and other USG partners MSH and Save the Children. With FY 2008 funding, JHPIEGO will provide support in increasing the capacity of health care institution workers to prevent occupational exposure to HIV, Hepatitis B and other infections including hospital-based nosocomial infections. The first activity is to provide supportive supervision to the existing 35 hospitals throughout Malawi that have already been introduced to the national IP standards so that a maximum number of sites receive certification as meeting MoH infection prevention standards and guidelines. These activities will be coordinated with activities carried out by USG partner Pact Malawi.

Activity 2: Technical Assistance
JHPIEGO will expand the provision of technical assistance to the MoH to adapt the standards to be applicable at the Health Center levels so that correct IP practices can be extended. As part of this process, JHPIEGO will also assist the Reproductive Health Unit (RHU) and the Nursing Directorate to create a method of recognition and certification for Health Centers which achieve IP standards.

Activity 3: IP Standards
JHPIEGO will work with stakeholders at the district level to roll out IP standards to the Health Center level. JHPIEGO will demonstrate this process in 15 Health Centers and encourage MoH, DHMTs, and other partners to take up this initiative.

Activity 4: Training in Injection Safety
JHPIEGO will train 180 health care workers in safe injection practices and universal precautions as well as introduce health care workers to procedures for using post exposure prophylaxis (PEP). Four training sessions will be held at these 15 sites, and three members at each facility will be trained. JHPIEGO will continue to work with the existing 35 hospitals to address multiple underlying factors affecting facilities' ability to meet their IP goals. Pact Malawi will extend this training and disseminate PEP information to greater numbers of health care workers (see Pact Injection safety narrative).
This funding will go specifically to support hospital staff training in providing injection safety and hospital supervisory staff training in ensuring a minimum quality standard for services.

With PFIP year 2 one-time funds, JHPIEGO will implement the following activities:
Activity 1: Implement quality improvement activities at high-volume sites to address injection safety, PEP, and other infection prevention priorities.
With USG funding, JHPIEGO has supported the MOH to implement a Performance Quality Improvement Initiative focused on infection prevention and reproductive health. To date this initiative has been

implemented in four focus districts, primarily at district hospitals and large volume sites. With additional PEPFAR funding, this approach will be scaled-up to more high-volume sites in other districts and also in these focus districts. JHPIEGO would also collaborate with DHOs and NMCM to help districts develop a supportive supervision plan to help ensure providers that have been trained by Nurse and Midwives Council of Malawi (NMCM) in PEP and injection safety are implementing proper procedures at the site level.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10785	**Mechanism Name: IntraHealth CapacityPlus**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: IntraHealth International, Inc	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 400,000	
Funding Source	**Funding Amount**
GHCS (USAID)	400,000

Sub Partner Name(s)

Council of Health Service Accreditation Community - Malawi	Foundation for Professional Development	Management Sciences for Health

Overview Narrative

The Southern Africa Human Capacity Development (SAHCD) Coalition is a four -year Associate Award issued by USAID that began on October 1, 2006. SAHCD is led by IntraHealth International, in partnership with Management Sciences for Health (MSH), the Foundation for Professional Development (FPD), the Council of Health Service Accreditation of Southern Africa (COHSASA), and the Eastern, Central and Southern African Health Community (ECSA). This project serves as a mechanism for implementing a regional human capacity building program to improve the quality of HIV/AIDS service delivery and client care.

SAHCD is designed to respond to the current human resource (HR) crisis in the region by implementing unified, locally-driven and well-coordinated human capacity development strategies addressing long-term workforce planning and policy issues as well as the immediate need for improving the skills and knowledge of the prevailing work force. SAHCD works by strengthening the capacity of health and social welfare workers, policy makers and planners, program managers, educational institutions and faculty members, that deliver the HIV/AIDS services.

In Malawi, SAHCD's goal is to strengthen the Ministry of Gender, Children and Community Development's (MOGCCD) capacity to coordinate the national OVC response, and ensure the provision of quality OVC programs. The objectives to reach this goal include:
Build the capacity of senior and middle level managers in the Ministry to effectively lead and manage programs.

• Provide the Ministry with the tools and skills to be able to plan, manage and retain their current and future human resources.
• Strengthen the quality of pre-service training for social workers and align the content of the curricula with social welfare/OVC programs.
• Ensure in-service training opportunities for existing social workers.
• Establish a regulatory council for social workers.

These objectives support Goals 3 and 4 of the Malawi Partnership Framework: To mitigate the economic and psychosocial effects of HIV and AIDS and improve the quality of life for PLHIV, OVC and other affected individuals and households; and To provide targeted, discrete systems strengthening support in human resources, respectively..

Activities completed to date by SAHCD in partnership with USG, UNICEF and Training Resources Group (TRG) that have contributed to the above objectives include; a Human Resource Gap Analyses for the Ministry of Gender, Children and Community Development; two team building retreats for senior and middle level ministry staff that focused on communication, team work and organizational strengthening; leadership training for MGCCD senior management staff; and supervisory skills and a performance management skills building workshop for the Ministry's senior leadership group and middle level managers.

These activities have produced positive results such as improved joint program planning and communication between and within departments in the ministry; improved staff morale and motivation; and promoted ministry staff to be more proactive. Over the next two years, SAHCD, in partnership with

USG, UNICEF, Training Resources Group (TRG) and the National Association of Social Workers (NASW), will support the ministry to implement the recommendations from the above activities.

UNICEF recently completed a pre-service training assessment of Magomero College, the school that trains social workers in Malawi, especially MGCCD frontline staff in the districts at certificate level. Currently, Magomero only runs social work and community development programs at certificate level. As a result of the decentralization process in Malawi, there is now a civil service requirement that district heads should have, at a minimum, a first degree.

For frontline/community level staff in other government departments and ministries, a diploma is now the norm. MGCCD's certificate qualifications are, therefore, lagging behind and limiting staff's ability to articulate issues at the district level. The bulk of work proposed by SAHCD on preservice training (PST) at Magomero to upgrade it to a diploma/degree awarding college will be based mostly on recommendations from this assessment and will address issues of curriculum development, staffing/faculty; infrastructure and governance Activity implementation will focus on the MGCCD head quarters, Magomero College and selected district offices and will target headquarters staff, frontline staff at district level, faculty and students at Magomero training college.

SAHCD plans to hire a dedicated project point person with a strong background in preservice training (PST) and social work to coordinate activities in-country and they will receive ongoing technical and management support from the regional SAHCD office based in Pretoria, South Africa. Periodically, SAHCD will hire consultants to conduct specialized activities that will support MOGCCD's efforts on human capacity development.

Sustainability: It is expected that the bulk of Magomero student intake will be fee-paying, so the college can generate resources for its running costs. There is currently a high unmet need for tertiary education in Malawi that current universities cannot met. Skills transfer for staff through planned activities will build sustained capacity for continuity of programs at Magomero running

SAHCD will work with MOGCCD to establish a plan for the ministry to absorb initial overhead costs as part of ministry's future recurrent costs. Also, MGCCD management capacity will be greatly enhanced through the provision of TA throughout the planned activities. Finally, the enhancements to be made in the capacity for both PST and IST will serve to significantly increase the Social Welfare staff.

Monitoring and Evaluation
The SAHCD Coalition has a comprehensive Performance Monitoring Plan (based on PEPFAR indicators but also has custom-designed indicators), which tracks and monitors all activities implemented by

SAHCD. For SAHCD's activities in Malawi, the country office will employ a full-time M&E Specialist (cost share with Intrahealth FP program in Malawi) who will handle all M&E related activities for both Family planning and HRH/OVC activities and will receive support from the Regional M&E Advisor based in Pretoria, South Africa. SAHCD also has a training database, a reporting and documentation mechanism and a dissemination strategy which is part of the broader coalition-wide strategic information system. SAHCD has also developed a Best Practice and Knowledge Management Strategy for sharing internal and external best practices as a means of improvements to approaches used. Success stories and best practices are periodically shared and/or adapted to be presented internally, externally at regional and international conferences and seminars, and on SAHCD's and partners' websites.

The following are proposed measurable outputs and indicators for the proposed for the activities,
• Pre-service education of social workers is strengthened and responsive to needs and priorities of the nation for care of OVC.
• Number of mentors trained based on student practicum standards.
• Number of practicum sites for social workers that are newly developed, strengthened and updated.
• Functional Structures, frameworks, committees are developed with defined mandate, policies and guidelines
• Number of lecturers and mentors of social workers (lecturers) who successfully complete an in-service training program and who engage in ongoing professional development activities.
• % of students that receive supervision and evaluation according to standards.

Budget Summary
PFIP Year 1 Funding – $500,000
PFIP Year 2 Funding – $900,000

Cross-Cutting Budget Attribution(s)

Human Resources for Health	200,000

Key Issues

Increasing women's legal rights and protection

Budget Code Information

Mechanism ID:	10785		
Mechanism Name:	IntraHealth CapacityPlus		
Prime Partner Name:	IntraHealth International, Inc		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	400,000	

Narrative:

I. Budget Code: OHSS

With Year 1 PEPFAR funds SAHCD plans to implement the following activities based on the UNICEF commissioned pre-service training (PST) assessment recommendations, the HR gap analysis and consultations with the Ministry's senior leadership:

Activity 1: Strengthen Pre-Service Training
UNICEF has just completed and disseminated findings of the PST assessment that contains a number of recommendations towards the upgrading of training of social workers at Magomero. The key recommendations relate to curriculum development; faculty/staffing; infrastructure and governance. SAHCD will provide technical assistance to the ministry to implement selected recommendations that will lay the necessary foundation for pre service training of professional social workers in Malawi. SAHCD and NASW will use their technical experts, local and regional consultants to implement activities aimed at ensuring adequate and appropriate teaching staff at Magomero; development of competency based curricula and training materials; development of teaching support systems and provision of teaching support materials and equipment.

SAHCD will work with the Principal Secretary MGCCD, the task force and its subcommittees (that will include USG and UNICEF) to be set up by MGCCD for upgrading Magomero, and other stakeholders to develop the road map for activities leading to the establishment of a (3 year) social work diploma and (4 year) degree program at Magomero College. During the crucial preparatory phase, the senior leadership group of the ministry will be provided with on site and virtual technical assistance to strategically lead the process, advocate for buy-in from key stakeholders such as DHRMD and for resource mobilization. As recommended in the assessment report, the following key activities will be supported:

Determine governance structure for Magomero: SAHCD, the Principal Secretary of MOGCCD, and the task force will agree the governance structure for Magomero, so it can become either autonomous, or semi autonomous and still be affiliated to the ministry. A certain level of autonomy for Magomero is inevitable, to facilitate prompt decision making, as well as ability to generate and utilize mobilized

resources. This will also serve as an initial step to begin the process of accreditation or affiliation with an external social worker training institution in Malawi or within the region.

Establish affiliation and accreditation with social work institutions in Malawi and the region: IntraHealth will assist in identifying a school of social work in the region with whom Magomero can establish an affiliation relationship, while at the same time working with MGCCD and the Malawi Ministry of Education to complete accreditation requirements for Magomero as part of the University of Malawi. The aim will be to have the first intake of 60 students for the diploma and degree program by September 2010.

Curricula development – SAHCD will work with the Magomero task force subcommittee on curriculum development to flesh out the curriculum outline in the assessment report, based on existing social work diploma and degree curricula in the region and globally. SAHCD and NASW will engage experienced academic and curriculum consultants from Malawi and the region to develop these competency based curriculum and teaching materials.

Strengthening teaching capacity - IntraHealth will apply its experience in other countries in the region to develop job descriptions for teaching staff at Magomero. The job descriptions and profiles will guide the recruitment of teaching staff. To enable a quick start up to recruitment of teaching staff for Magomero, SAHCD will work with the ministry to explore a number of options. These will include review of the current staff establishment to identify already funded vacant positions, budget for these and prepare a rationale for substituting these for teaching positions; assess open competition and development of proposals to mobilize scholarships for external or internal training of current Magomero faculty eligible and interested in teaching. SAHCD will also help the ministry to develop staffing needs for a human resource plan for Magomero and facilitate discussions with the Department of Human Resources Management and Development (DHRMD) to increase the number of senior and support staff positions on the ministry's establishment for Magomero, negotiate salaries and to add new cadre of staff to the ministry's establishment. These activities will be on going until Magomero is fully staffed with both teaching and support staff.

Establishing a database of teaching resource persons- During curricula review teaching resource persons will be identified from local and regional universities for short term or "sessional" teaching of selected modules to bridge the gap while recruitment and capacity building is ongoing. NASW will explore placement of volunteer teaching staff for periods of at least one year or more.

Developing training support systems- SAHCD will procure teaching and library equipment such as computers, projectors and reference materials and teaching aids in order to improve and update training standards for students and teaching staff. This will ensure that both students and teachers are updated

on current social work practices and standards. Other infrastructure support will include procurement of one school bus, provision of internet connectivity and land telephones, and a standby generator for Magomero.

Activity 2: Develop a Human Resource Information System (HRIS)
Develop an iHRIS Manage database to track staff movement and training – SAHCD will support MOGCCD to develop an HRIS database module tailored to the needs of MGCCD that will be linked to the national HR database at the national Department for Human resources management and development (DHRMD). The database will enable the ministry to track staff recruitment, deployment, retention and training. Related activities will include equipping the MOGCCD HR department with computers and software to run the database; training the HR department staff to maintain the database and generate reports needed by management for decision making. The HRIS will be used to review current recruitment and deployment procedures to improve timely staff recruitment and deployment based on workload volumes. This will ensure the equitable distribution of social welfare officers based on the number of children and OVC in a district, and other workload. Senior MOGCCD managers will also be trained on how to use reports generated by HRIS in planning and decision making.

Products/Deliverables (if applicable)

With Year 2 PEPFAR funds SAHCD will build on the initiatives started in 2008 and 2009 through the following activities:

Activity 1: Strengthen Pre-service training
Strengthening teaching capacity - SAHCD will build on activities of the previous year and conduct a capacity building assessment of the teaching that will include application of competency based teaching methods, IT skills and develop a continuing plan to provide this training. The plan will also guide the mentorship and identification of virtual training opportunities and other continuing education programs for the teaching staff.

Team building for the staff at Magomero- SAHCD will conduct a team building workshop for all staff at Magomero to build good working relationships, create a conducive teaching and learning environment. The workshop will include establishment of working norms, development of vision and mission, internal procedures that will include communication, reporting, supervision, conflict management and student relations.

Implementation of curriculum- Building on the achievements from the previous year, SAHCD will provide technical assistance to Magomero College to implement the curriculum and to provide continuous

professional development of lecturers. At the beginning SAHCD will also conduct a curriculum and transfer of learning orientation for teaching staff in preparation for curriculum implementation. We plan to utilize the short term/ "sessional" lecturers and NASW staff to provide mentorship and explore virtual learning opportunities during curriculum implementation.

Practicum training - SAHCD will assist Magomero College to develop standards and guidelines for students' practicum, identifying suitable sites to place students and training site mentors to supervise and evaluate students' performances.

Establishing regulatory framework- SAHCD will work with Magomero, the ministry and other stakeholders to establish a regulatory council for social workers in Malawi. A social work council will provide scopes of practice, professional identity, recognition and support, registration and re-registration etc. and ultimately professionalize the social worker cadre in Malawi. SAHCD will apply its experience of working with regulatory councils and share best practices in the region to establish a professional council for social workers and facilitate study tours and short term technical assistance from councils of social work.

Infrastructure support: SAHCD will continue to provide support for infrastructure to the extent feasible, and as needed.

Activity 2: Strengthen in-service training
IntraHealth is aware that there are some Ministry staff, Social Welfare Officers and Community Development Officers who might on the basis of experience and education level to be upgraded to diploma level in a shorter training period. IH and NASW will work with the ministry to identify these and develop a bridging curriculum for this update this refresher training. This will help the ministry to have a higher level of qualified social workers in a shorter period than the entry diploma course would take.
SAHCD will review the refresher training schedule and content for existing Social Welfare Officers and Assistants. We anticipate that the review will reveal the need for more regular trainings and updated and improved training materials. SAHCD, in collaboration with UNICEF, will assist in implementing these activities and SAHCD will fund the first round of refresher trainings. SAHCD also proposes a six month review of the diploma program, to be performed by the identified college that Magomero has the affiliate relationship with, IntraHealth and NASW.

Activity 3: HRIS
SAHCD will continue to provide technical assistance to MGCCD Senior Leadership Group to ensure that HRIS is maintained and used correctly and that the reports generated are being accurately used to inform HR decisions. Refresher trainings will be conducted as and when necessary.
SAHCD will also provide technical assistance to Magomero to develop training management information

system that is linked to the ministry's HRIS.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 10786	**Mechanism Name: AED/OVC**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Academy for Educational Development	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 500,000	
Funding Source	**Funding Amount**
GHCS (USAID)	500,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Academy for Educational Development through the Education Decentralization Support Activity works with the Ministry of Education, Science, and Technology (MoEST) to strengthen the decentralization process at the district and school level with clear policies and procedures. The program works in all districts (Blantyre City, Mulanje, Mangochi, Dowa, Dedza, Nkhata Bay), one district in each education division, to implement the MoEST decentralization policies, strategies and guidelines through three components.

? Component 1: Strengthened MoEST policy and strategy articulation, interpretation and implementation
? Component 2: Improved decentralization implementation, planning and data utilization for informed decision-making
? Component 3: Enhanced role and participation of communities in monitoring education service delivery

The AED districts were chosen using the criteria of low education efficiency (e.g. high pupil-teacher ratio, high dropout rate, and low girls enrollment) and social (limited literacy, high OVC burden and ultra-poverty

level) indicators. At the request of District Education Offices,

AED works in some of Malawi's most disadvantaged zones which in addition to poor education and social indicators, are often difficult to access and have few, if any, external interventions. Over the life of the activity, AED anticipates working in approximately 39 zones in the six districts. There are 352 education zones in the country.

AED is a longstanding partner of the Education Sector at USAID and provides integrated services and improves efficiencies for service delivery to OVC. This is a continuing mechanism to mitigate the economic and psychosocial effects of HIV and AIDS and improve the quality of life for PLHIV, OVC and other affected individuals and households (Partnership Framework (PF) Goal 3).

AED PEPFAR activities are integrated into the broader education support, which is part of the Education Sector Implementation Plan 2009-2013, to promote synergistic efforts and maximize primary and secondary school OVCs benefits from the larger Education activities. PEPFAR funding to AED will support interventions to improve the enrolment, retention and performance of OVCs in primary and secondary schools through a three-fold focus: 1) disbursement and monitoring of OVC grants for bursary, care, support and treatment grants, 2) building capacity of Teachers Living Positively (T'LIPO) to monitor grants and to form therapy groups for pre-ART management, and 3) operationalizing the national education HIV strategy and guidelines through school and district education planning processes.

PEPFAR OVC activities are implemented through existing government systems, where possible, and harmonized with existing processes and framework. The disbursement of OVC bursaries follows the Ministry of Gender, Children and Community Development (MOGCCD) guidelines. At the district level a committee comprising the District Education Manager, District Director of Finance, District Social Welfare Officer, District Education Network Representative and District T'LIPO Representative supports this process. Unlike the GFATM bursaries, EDSA OVC bursaries will be wired directly to school bank accounts and will benefit from the management and oversight processes and structures that support broader EDSA school improvement activities. Wiring bursaries will ensure swifter distribution (so children are not sent away from school for late payment of fees), and increased transparency in bursary management.

The OVC grant process follows the draft Government of Malawi Minimum Service Standards for Quality Improvement: Orphans and Vulnerable Children Programs. Strategies to ensure the OVC grants are implemented properly include:

? Advocacy and Awareness Creation: AED will properly inform the public about the education support

scheme through the Assemblies to create public awareness and understanding.
? Community Participation: The major aspect of AED education support scheme is to involve the community in the identification, screening and recommending for the provision of support to most vulnerable OVC.
? Multi-Sectoral Coordination and Collaboration: To reduce duplication of efforts and promote linkages among stakeholders, AED shall work with District social welfare officers, NGO partners and networks of stakeholders providing education support to needy children.

OVC identification and grant activities are integrated into MoEST school improvement plans and district education plans to align the mechanism with the Partnership Framework and government process and support development of cost-efficiencies and sustainability over time. The AED approach makes certain HIV issues in the learning environment are addressed and builds on efforts to increase district and school capacity to manage and report OVC bursary activities and recipients.

AED's broader system strengthening efforts, which are expected to improve education planning, management, monitoring and quality at the district and sub-district levels are expected to reduce management and transaction costs over the life of the project and could support expansion of OVC grant activities with low marginal costs. Lessons learned will be integrated into the national school improvement planning and district education planning processes. AED will reach 10,000 OVC over the life of the project in over 250 schools in the first year, and an anticipated 400 schools in the second year of project. AED uses the Government of Malawi OVC selection criteria, and the focus is on ensuring that the most vulnerable learners identified in year 1 and subsequently in year 2 are funded for the life of the activity.

In addition to school grant activities, AED also works with district officials (Social Welfare Officers, Community Development Officers, HIV focal points, etc.) to build the capacity of district Teachers Living Positively Organization (TLIPO) networks. This capacity-building focus aims to strengthen T'LIPO skills to register OVC in collaboration with community child protection workers, and assist in managing and monitoring of the disbursement of OVC grants. It will also assist in building the skills of teachers to help young HIV positive learners cope with their health condition.

As part of this focus area, AED will conduct formative research on the quality of life for OVCs, in particular HIV positive students, in the learning environment. A phenomenological strategy will be the underlying premise used to measure this qualitative indicator. This approach utilizes meaning questions to elicit the essence of individuals' experiences and will employ a personal experience/ biographical data collection method to understand the needs of HIV positive students and how the OVC bursaries and care, support and treatment vouchers that provide transport funds for HIV positive children to access ART are meeting or not meeting their needs. Information from the study will enable EDSA create a more enabling school

environment for HIV positive children

Indicators to monitor these activities will include indicator C1.1.D Number of eligible adults and children provided with a minimum of one care service; C5.4.D Number of eligible children provided with education/and or vocational training; and C5.9.N Quality of life for OVC, and number of households that receive impact mitigation support (Country level indicator).

Budget Summary
PFIP Year 1 Funding – $750,000
PFIP Year 2 Funding – $500,000

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**10786**		
Mechanism Name:	**AED/OVC**		
Prime Partner Name:	**Academy for Educational Development**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	500,000	
Narrative:			
$750,000 – Year 1 $500,000 – Year 2 Activity 1: Provide OVC bursaries, care, and support and treatment grants. Bursaries will cover school contributions, such as development fees, examination fees, and stationery. Based on the EDSA bursary package, 5,500 students will be targeted in primary and community day			

secondary schools (CDSS) in EDSA districts in Year 1, and 8700 students in Year 2. HIV+ students in the target group will also receive care, support and treatment support such as transport funds to enable them access ART in clinics. Lessons learned channeled into system refinement for country-wide spread. Indicators: C1.1.D; C5.1.D; C5.4.D; C5.9.N.

Activity 2: Build T'LIPO capacity to administer and monitor grants.
Teachers Living Positively (T'LIPO) is a civil society network of organizations of HIV+ teachers who implement programs supporting HIV+ teachers and students. The project will leverage and strengthen district-based T'LIPOs to work with school OVC committees to support the performance of HIV+/OVC children in school. Coverage: Six districts. One expected outcome of T'LIPO Capacity Strengthening activity is reducing stigma among HIV+ teachers and students. Integration of HIV content into the school improvement planning process and HIV Policy Support are expected to support Health Systems Strengthening. Indicators: custom indicator used.

Activity 3: Formative research

AED will conduct formative research to better understand the issues of HIV positive children, and well being of OVC in schools. Project will assess the impact of HIV on HIV+/OVC learners at school and in the home, including better understanding stigma and discrimination facing this population and other challenges that limit OVC/HIV+ students' opportunity to learn. Assessment will be implemented in six districts. Indicator: C5.9.N

Activity 4: Support the integration of the MoEST HIV Strategy and Guidelines into decentralization and community participation policies. Coverage: countrywide. Enhance data collection at the decentralized levels to ensure relevant HIV activities are incorporated into District Education Plans. Coverage: Six districts trial systems and policies; lessons learned channeled into system refinement for country-wide spread. Indicators: custom indicator used.
With PFIP year 2 funding, we expect to continuing implementing the activities 1, 2 and 4

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 11453	**Mechanism Name: Peace Corps Volunteers**
Funding Agency: U.S. Peace Corps	Procurement Type: USG Core
Prime Partner Name: U.S. Peace Corps	

Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Peace Corps Malawi (PCM) will work with the existing pipeline to implement the activities described below. PCM requires a moderate pipeline to ensure program continuation, however, this Plan will significantly reduce Post's existing pipeline to a reasonable level.

Overview

PCM has worked closely with the HIV/AIDS Country Team (HCT) in the development and presentation of this implementation plan. PCM's strategy over the PEPFAR Partnership Framework (PPF) period is fully in concert with the goals, objectives, and anticipated outputs of the GOM National Plan, the Malawi PPF and Implementation Plan (IP), OGAC's priorities and the Obama Administration's Global Health Policy. PCM's role in the PPF and all the elements in this section of the COP have the technical, programmatic, and fiscal endorsement of the HCT and the PEPFAR Coordinator. PCM plans to embark on a new paradigm for HIV/AIDS prevention and control in Malawi. The Peace Corps Response Volunteer (PCRV) program will no longer be the keystone of our endeavors; rather, PCM will pursue an integrated, holistic approach to HIV/AIDS prevention and control. Post will anchor this approach in broad and deep Volunteer participation, key ABC prevention efforts aimed at women, pregnant mothers and youth, PMTCT+ activities, and improved management of District AIDS Control Offices via standardized PCRV inputs and deliverables. PCM will pursue innovative, integrated programming with PCVs and ensure improved volunteer reporting through streamlined reporting systems and oversight from PCM staff and complementary USG experts on the HCT.

Goals and Objectives

• To promote safe behaviors and practices in >80% of communities served by PCVs including women, men and youth.
• To help empower communities to care for PLWHIV and those affected and assist them to be

economically, socially, and psychologically independent.
• To help strengthen local assemblies' systems in their response to HIV.
• To pursue and promote innovative practices and programming within Peace Corps Malawi (PCM) to effectively and efficiently deliver integrated HIV/AIDS prevention and control interventions by all PCVs and PCRVs
• To promote PMTCT at the community level throughout Malawi in all PCV sites.

In order to achieve the above-mentioned objectives, PCM will prioritize the following elements.

HIV Infection Prevention – PCM will focus on prevention of new HIV infections in PCV sites and contiguous communities. PCVs will focus on preventing transmission and mitigating the impacts of infection by working with individuals (including women of reproductive age and pregnant mothers), families, communities, village leadership, and community-based organizations (CBOs) within the Volunteers' purview.

Care – Peace Corps Malawi has 130 volunteers in-country and serve an estimated 650 communities countrywide and have unparalleled access to communities and families throughout Malawi. PCM will train all Volunteers in community-based care and prevention. All Volunteers will canvas their communities, within the realm of cultural appropriateness, to identify PLWAs and families/children affected by HIV/AIDS. Each will endeavor to provide levels of care, counseling, and referral commensurate with their roles and capabilities. PCVs will also provide training and materials to counterparts and community leaders for care and support at the community level. USG collaborating partner institutions and technical experts within the HCT will facilitate material identification and use.

System Strengthening/Capacity Building – PCM will enhance system strengthening and capacity building of the District response to HIV/AIDS through the GOM's decentralization program at District Assemblies. The keystone of this component is the PCRV District Assembly support activity. Over the PPF timeframe, we anticipate deploying appropriately skilled PCRVs in all 28 districts. However, the Program remains immature at present and Post will phase in approximately ten PCRVs per year in a January or June Training Input. PCRVs are not routine Volunteers, nor are they third-year Volunteers. Post perceives the PCRV effort as the deployment of junior-level consultants with specific systems-strengthening tasks. Their DA counterparts and the District Commissioner view them as skilled professionals and most serve as Deputy District AIDS Coordinators. A generic scope of work (SOW) is in place that requires substantial technical, analytic, administrative, and programmatic skills and experience. HQ will identify qualified PCRVs (and/or PCVs in the longer-term). However, Post will review the qualifications of all applicants recommended by HQ prior to a final decision. Given budget and implementation realities on the ground, Post will enhance the support for PCRVs to enable them to complete the deliverables

enunciated the SOW. Key elements of district-level system-strengthening/capacity building include, but are not limited to: stakeholder analysis and GIS mapping of stakeholder programs; strengthening the monitoring and evaluation of District Assembly efforts (including CBO activities); budget development and accounts analysis; co-management of special campaigns; resource mobilization (grant writing for external support); stakeholder coordination (meetings, priorities, problem-solving, etc.); project design and development; information/advocacy in urban, peri-urban, and rural communities; and, outreach/coordination of PCV HIV P&C efforts in the districts. Post highlights these deliverables in the OHSS narrative. As noted, to achieve these deliverables, Peace Corps Malawi will enhance technical support the PCRVs, PCVs, and their counterparts with technical training, orientations, mentoring and technical assistance.

Expanded Partnerships – The HIV/AIDS Country Team (HCT) is among the strongest and most unified PEPFAR Teams in Africa. Post will expand inter-Agency partnerships over the PPF period. USG technical experts from all US Agencies (notably CDC and USAID) will strengthen their support to Volunteers and PCRVs in all PEPFAR priority areas. Post will also expand partnerships to other Volunteer organizations such as VSO and JICA, and to key USG collaborating partners such as MSH, AED, CARE, SCF, PSI, Concern International, WALA, NGOs, CBOs, and other partners as appropriate. The horizon for integrated support for PCM and its Volunteers is vast. PCM will maximize this potential over the life of the PPF.

Linkages with the Partnership Framework

As noted above, PCM's HIV/AIDS P&C program is in full concert with the GOM Country Plan and the approved PEPFAR Partnership Framework. PCM will work in the areas of Sexual prevention, other prevention, HBHC, HKID and OHSS. Post will train all new and serving volunteers and their counterparts on HIV/AIDS global epidemiology, the HIV/AIDS epidemic in Malawi, state-of-the-art (SOTA) HIV P&C, and the practical application of monitoring, evaluation, and reporting (M&E). Furthermore, all trainees, PCVs, and PCRVs will receive training in, and updates on the GOM National Response to HIV/AIDS and HCT/PEPFAR priorities therein.

PCM will also develop a "buffet" of deliverables for the regular PCV program. These deliverables will ensure direction of PCV opportunities and efforts, and promote integration of HIV/AIDS activities into all volunteer primary assignment/duties. All HIV/AIDS related technical trainings will be incorporated into the Pre-Service Training (PST), In-Service Training (IST), Mid Service Training (MST), and other trainings arranged by post. Post will also exercise greater flexibility to integrate HIV/AIDS and other health/development challenges facing Malawi including gender inequality, girls' empowerment, and other social, cultural, and economic challenges.

Post will ensure prudent expansion of the program by continuing with placement of volunteers, i.e. an appropriate mixture of PCRVs in district Assemblies and PCVs in rural/peri-urban communities. PCM will expand our PCRV program to 20 Assemblies in PFIP Years 1 & 2 and expand as appropriate in PFIP Year 3. We anticipate deeper maturity and innovation will evolve in the program regarding PCRV skills/experience and tasks/deliverables. Post will also explore greater flexibility of the PCRV and PCV program and opportunities and find innovative ways to utilize PEPFAR funds given PEPFAR's reauthorization, new PEPFAR leadership and the Administrations Global Health priorities. The program will also explore options of PCRV placement in PEPFAR-funded partner NGOs in Malawi that are doing capacity building for local assemblies and/or community institutions. As implied, Post will also actively participate in reviewing PCRV qualifications to ensure a more efficient and effective recruitment process and reduce attrition. Post will strengthen PCV and PCRV training through inter-Agency collaboration and the use/provision of national training materials and those developed by USG and other collaborating partners (e.g. Life Skills training, safe water [water guard/PUR], Bridge Project materials, etc.).

Research, Monitoring and Evaluation

PC/M will strengthen and streamline monitoring and evaluation of the program technically regarding PCRV/PCV reporting. To guarantee uniform data collection among all volunteers, PC/M will ensure consistent and correct usage of the Volunteer Reporting Tool (VRT). PCM staff will assist in monitoring VRT submissions and endeavor to simplify reporting based on seminal indicators and an appreciation of limited connectivity and bandwidth in Malawi. APCDs will work with the M&E/Peer Coordinator and as necessary the PEPFAR Strategic Information Officer (SIO) to ensure that the tool is aligned to the PEPFAR indicators and requirements.

Volunteers and their counterparts will assume primary responsibility for data collection and indicator reporting.
The M&E/Peer Coordinator (and the SIO when appropriate) will provide on-site technical assistance, mentoring idea development to support to volunteers and counterparts on reporting. Post anticipates this will avoid double counting, and help promote quality assurance of records and data.

For quality assurance, PC/M, with assistance of inter-Agency experts, will conduct M&E sessions for volunteers during PST, IST, and MST. Post will consider additional special sessions at the regional level as the need demands. PCM will collaborate with the SIO to conduct an internal review of its M&E systems to identify options to streamline and improve reporting. HCT Inter-Agency experts will provide materials and technical training for all PCVs and PCRVs throughout the year and during the Partnership Framework period. PC/M will work with existing and new partners to standardized monitoring tools for all

partner projects. PCM will also develop a standardized M&E tool for staff to use during routine site visits. Post will identify a user-friendly data base program to promote accurate and timely data entry and analysis. PCM will analyze the data to track program outputs and identify best practices, lessons learned, and program efficiencies.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12105	**Mechanism Name: Dignitas/QCT/GHAI**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Dignitas International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 2,301,773	
Funding Source	**Funding Amount**
GHCS (State)	2,301,773

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Goals and Objectives: The ultimate goal of the program, Support for Health Systems Strengthening and HIV/AIDS Service Delivery in Malawi's South-East Zone, is to contribute to achieving the highest standard of health and well-being in Malawi. The program is designed to accomplish this by pursuing three objectives, which leverage Dignitas's core competencies and are closely aligned with the Malawi National Action Framework and the Partnership Framework, including:

a. Reducing new HIV infections;

b. Improving treatment, care and support for people living with HIV/AIDS; and,

c. Strengthening health systems.

The program will implement activities across eight Technical Areas, including PMTCT, Adult Care and Treatment, TB/HIV, Counseling and Testing, Pediatric Care and Treatment, Laboratory Infrastructure, Strategic Information, and Health Systems Strengthening.

Link to Partnership Framework: As captured above, the three objectives of: reducing new HIV infections; improving treatment, care and support for people living with HIV/AIDS; and, strengthening health systems are closely linked to the Partnership Framework.

Geographic Coverage and Target Populations: The program will be implemented in the South-East Health Zone – the districts of Balaka, Machinga, Mangochi, Mulanje, Phalombe and Zomba – with a combined population of greater than 3.1 million people.

The beneficiaries of the program fall into three categories:

a. Front-line healthcare workers: Approximately 2,000 individuals including Medical Doctors, Clinical Officers, Medical Assistants, Nurses, ART and PMTCT Providers, ART and HTC Counsellors, ART Clerks, Health Surveillance Assistants, and Patient Care Attendants who work in health facilities across the South-East Health Zone;

b. Health systems supervisors and managers: More than 100 individuals, including Zonal Health Office (ZHO) staff, District and Deputy District Health and Nursing Officers, HTC, TB, ART and PMTCT Supervisors and members of District Health Management Teams; and,

c. The population of the South-East Health Zone: More than 3 million people are considered as beneficiaries. As of December 2008, nearly 225,000 individuals had ever registered to receive ART in Malawi, including 41,000 people in the South-East Health Zone; during the implementation of the program, Dignitas will assist the MoH to enroll approximately 45,000 people on ART in the South-East Health Zone.

Key Contributions to Health Systems Strengthening: The program's key contributions to health systems strengthening include:

a. Strengthening Systems for Referral, Patient Tracking and Follow-Up
b. Systems and Processes (e.g., development of Standard Operating Procedures for decentralization, implementation of stakeholder meetings to ensure that the PEP and TB/ HIV programs are operating effectively)
c. Pharmacy Management (e.g., management of supplies, establishment of effective protocols)
d. Strengthening Coordination (e.g., mentoring and supporting ZHO and DHOs in the development of the HIV-related program components of the yearly District Implementation Plans)

Cross-Cutting Programs and Key Issues: The cross cutting programs include: HRH; and, Gender: Reducing Violence and Coercion. The key issues are: Health-Related Wraparounds; Gender, EOP Evaluation; and, Workplace Programs.

Cost Efficiency: The program is designed to build sustainable, locally owned capacity and increased local autonomy, during a finite time-span, thus becoming more cost efficient over time. In order to avoid dependency, Dignitas will plan with the ZHO and DHOs, establishing project goals together. Services are delivered through the existing system, strengthening it over time, rather than building a parallel system.

Link to the Government of Malawi: The program has been planned through consultation with MoH officials at all levels, including the Zonal Health Office. This has made it possible for partners to incorporate innovative programming that will have an impact on policy and practice, while remaining consistent with the goals and implementation plans developed under the Malawi National Action Framework.

M&E Plans: Dignitas will conduct routine, systematic and integrated M&E across all program areas and activity streams, to assess program impact on health outcomes and cost-effectiveness. Dignitas will also work to bolster the capacity of the ZHO, DHOs and health facilities to conduct appropriate data gathering and reporting, to reflect on this data, and to adjust their practices accordingly. In addition, Dignitas will perform targeted evaluations at key points in the intervention cycle: baseline assessment upon new program initiation including: a) geographic expansion and scale-up (to identify health-service gaps in each new district); b) training needs assessment of District Health Supervisors; mid-term audit of District Health Supervisor support program (including supervisory tools, curriculum, and training); annual audits of clinical programs (PMTCT, HTC, ART); and, an end-of-term evaluation compiling lessons learned and intervention outcomes (measured against targets).

PFIP Year 1 Funds – USD 642,182
PFIP Year 2 Funds – USD 2,151,773

Cross-Cutting Budget Attribution(s)

Human Resources for Health	841,000

Key Issues

Impact/End-of-Program Evaluation

Workplace Programs

Budget Code Information

Mechanism ID:	**12105**		
Mechanism Name:	**Dignitas/QCT/GHAI**		
Prime Partner Name:	**Dignitas International**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	29,713	

Narrative:

II. BUDGET CODE: 08-HBHC:

PFIP Year 1 - $8,867

PFIP Year 2 - $29,713

Activity One: Adult Care and Treatment at Tisungane Clinic & HRH: Dignitas will continue to manage Tisungane ART Clinic at ZCH, a high-burden site with over 36,000 clinician visits per year. The focus from 2010-2011 will be on building and supplementing the capacity of the MoH to provide high-quality, integrated care for HIV+ patients in the context of rapid decentralization of ART across Zomba District and the zone. Activities include the management of a Healthcare Worker Clinic, and the training and management of Expert Patients. These activities are facility-based. Outreach for new clients is done by training hospital and health centre staff to conduct access-related information, education and communication sensitizations.

Client retention is supported by defaulter tracing and referrals between sites are managed through supporting the development of a district wide referral system (see Budget Code 18-OHSS), which also

supports linkages with other HIV and non-HIV services. Program M&E includes quality improvement initiatives identified through operational audits in addition to collection and analysis of routine programmatic data. As well, these activities support research studies that will help to answer important clinical and programmatic knowledge gaps, such as optimal timing of ART in TB-HIV co-infection, the incidence of ART toxicity and side effects and the prevalence of occult opportunistic infections in patients on ART.

Products/ Deliverables
• Provision of clinical care for HIV+ patients not yet qualifying for ART (target: 7,200 by end of FY 2011).
• Provision of clinical care and support for ART patients in the Tisungane cohort and at decentralized or independent ART sites (target: 27,000 by end of FY 2011).
• Provision of specialist HIV consultation services for inpatients at ZCH and for tertiary care referrals from other health facilities in the zone.
• Management and staffing of a specialist Healthcare Worker Clinic (target: about 200 consultations/ month).
• Training and Management of a team of Expert Patients (in-service training and mentorship) (target: 10 by end of FY 2011).

Activity Two: Building Healthcare Worker Capacity Through Innovative Clinical Tools and Training: Scaling-Up of STAT-PALM+ to the Zone – In Zomba District, with support from the Canadian International Development Agency (CIDA), Dignitas is presently undertaking a 2-year knowledge translation project that will facilitate the integration of HIV/AIDS and TB care with primary care through activities that build sustainable capacity in the district health system. The project is focused on a set of integrated symptom- and sign-based primary care guidelines, and an innovative in-service training curriculum for healthcare workers.

In South Africa, this combination has been shown to promote higher-quality evidence-based practice, expanded access to care, reduced misdiagnoses and inappropriate treatments, and, just as important, enhanced staff satisfaction and confidence. This intervention package, STAT-PALM+ (Simplified Tools and Training – Practical Approach to Lung health plus HIV/AIDS in Malawi), is a Malawian adaptation of PALSA+ (Practical Approach to Lung Health and HIV/AIDS in South Africa), and takes the form of a guideline and clinical toolkit that consists of the following:
• HIV/AIDS (pre-diagnosis, testing, treatment and management, including ART);
• TB diagnosis in the context of a high HIV burden;
• PMTCT of HIV;
• Communicating and promoting adherence to HIV and TB therapy;
• Sexual assault referral and post-exposure HIV prophylaxis (PEP);

• Sexually transmitted infections (STIs);
• Female reproductive health;
• Chronic respiratory disease;
• Malaria management;
• Skin rashes and lesions (including shingles, scabies, etc.); and,
• Malnutrition.

Activities include coordination meetings.

Products/ Deliverables & Targets: The scale-up of STAT-PALM+ is not anticipated to commence until the final quarter of FY 2011. Therefore, the principal product/ deliverable during the period FY 2010 and FY 2011 is coordination meetings with DHOs and DHMTs (target: 3 by end of FY 2011).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	426,970	

Narrative:

III. BUDGET CODE: 09-HXTS:

PFIP Year 1 - $127,426
PFIP Year 2 - $426,970

Activity One: Adult Care and Treatment at Tisungane Clinic: Refer to Budget Code 08-HBHC: Adult Care and Support for an overview of the activity. Activities include PEP, registration, counseling and initiation of patients and the procurement of non-medical supplies. Clinical outcomes are tracked and evaluated monthly through an electronic database. Adherence to ART is monitored through self report at each clinic visit, and adherence counseling is a component of each clinical interaction.

Products/ Deliverables
• Provision of post-exposure prophylaxis (PEP) in cases of occupational exposure and sexual assault (target: 150 by end of FY 2011).
• Registration, counseling and initiation of patients beginning ART (target: 7,200 by end of FY 2011).
• Procurement of non-medical supplies (e.g., stationery, ink, pens, furniture, flipcharts, teaching aids), provision of routine maintenance of equipment at Tisungane, and purchase of buffer stocks of medicines and laboratory supplies to ensure continued operation in the face of supply interruptions.

Activity Two: Support for ART Decentralization: To expand equitable access to care, it is vital to enable

local health centres to provide basic ART-related services that are, at present, mostly available only through district hospitals and private facilities. Through training, community sensitization and supportive supervision, Dignitas will support the DHOs to provide these services. In accordance with the model developed with the Zomba DHO, and with the cooperation of the ZHO and relevant DHOs, decentralization will proceed through three phases (i.e., Phase 1 – new ART sites are permitted only to manage follow-up care of stable ART patients; Phase 2 – new ART sites are permitted to initiate patients on ART and manage the follow-up care of stable patients from the district hospital; Phase 3 – the ART site is independent).

Products/ Deliverables

• Initial training of ART providers (target: 70 by end of FY 2011), refresher trainings for ART providers (target: 180 by end of FY 2011), patient registration clerks (target: 70 by end of FY 2011), and ART initiation counselors (target: 60 by end of FY 2011). All ART provider trainings have an in-service component with follow-up through mentorship.

• Community sensitizations are intended to ensure awareness of HIV transmission, prevention and treatment, and to increase awareness of where, when, and how to access HIV-related services and will be conducted as ART services are rolled-out to new sites (target: 20 by end of FY 2011).

• Supportive Supervision:

o Mentoring will be provided to DHMT and health centre management to ensure that health centres receive appropriate support to progress through the phased introduction of ART – mentorship conducted on a weekly basis for "late Phase 1" facilities and on a quarterly basis at all Phase 2 sites.

o Quarterly meetings of ART providers in Zomba District will provide a forum for information exchange.

o Implementation of integrated supervision at Health Centres means that all Health Centres will receive supportive supervision for all HIV-related services during the same supervisory visit, including ART/OI clinical management, PMTCT, HTC, data management (including use of the pre-ART register), management of drug stocks and supplies, and TB/HIV integration.

Activity Three: Increased Access to Early Maternal HAART – Women testing HIV+ can radically reduce the chances of passing on HIV to their babies before, during, and after childbirth by taking full-scale HAART, or the AZT combination regimen from 28 weeks gestation onward. Activities will ensure access to CD4 testing, the coordination of decentralized CD4 services and supportive supervision.

Products/ Deliverables

• Ensuring access to twice-yearly CD4 testing for all pre-ART patients, with priority given to pregnant women in Zomba; in the rest of the Zone, access to CD4 testing will be decentralized along with ART services (target: 20 sites by end of FY 2011).

• Assisting DHOs in coordinating decentralized CD4 services.

• Supportive Supervision:
o Mentoring district laboratory staff to manage time and resources more efficiently and at the health centre level to improve ordering of CD4 testing and timely follow-up of results
o Working with designated lab supervisors from the DHO to ensure the quality of CD4 testing through semi-annual supervision visits to test sites.

Activity Four: Building Healthcare Worker Capacity Through Innovative Clinical Tools and Training: Scaling-Up of STAT-PALM+ to the Zone: Refer to Budget Code 01-MTCT Prevention: PMTCT for an overview of the activity and products/ deliverables.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	398,795	

Narrative:

V. BUDGET CODE: 12-HVCT

PFIP Year 1 - $119,018
PFIP Year 2 - $398,795

Activity One: Counseling and Testing – Basic HTC services are well developed in Zomba District. In the five other districts in the Zone, Dignitas will assist DHOs in completing the scale-up of basic HTC services (includes national quality assurance program). Additional activities include training, assessment, provision of non-medical supplies, sensitization to reach target population and the establishment of protocols. HTC services use the national algorithms and include client-initiated and provider-initiated testing, as well as couples testing, pediatric testing, and involvement in local and national "Know Your Status" campaigns. Regular M&E is conducted to national standards, and annual operational audits are planned. Linkages to care, treatment and prevention services will be supported through development of a referral system (see Budget Code 10-OHSS).

Products/ Deliverables
• Scaling-up of HTC services to the zone (target: 20 sites by end of FY 2011).
• Initial training of HTC counselors (target: 50 by end of FY 2011) and refresher training of counselors (target: 70 by end of FY 2011), the latter of whom will receive training in paediatric HTC and/ or couples counseling; additionally, HTC counselors (target: 140 by end of FY 2011) will be trained and mentored in paediatric HTC procedures.
• Assessment to determine the need for additional mentorship and/or supportive supervision in

coordination and clinical practice.
• Provision of non-medical supplies.
• Sensitizing care providers to the need for PITC, and providing them with the knowledge necessary to implement it and to make appropriate referrals.
• Establishment of protocols to identify and track infants in need of HIV testing.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	44,857	

Narrative:

VII. BUDGET CODE: 14-PDCS Care:

PFIP Year 1 - $13,390
PFIP Year 2 - $44,857

Activity One: Early Diagnosis and Treatment of Pediatric HIV Infection: Pediatric ART and Supporting HIV+ Adolescents – Relative to adolescent or adult HIV infection, paediatric HIV infection is characterized by rapid progression. It is therefore imperative to follow-up on HIV exposed infants, promptly diagnose HIV infection, and quickly initiate appropriate treatment. A core component of Dignitas's program is to support the MoHs Early Infant Diagnosis (EID) and Pediatric ART programs through supportive supervision and mentorship activities. The EID program's main focus is to strengthen laboratory support/diagnostics for pediatric clients. Additional activities include the establishment of a Teen Club for HIV+ adolescents, empowering them to build positive relationships, improve their self-esteem and acquire life skills through peer mentorship, adult role-modeling and structured activities.

Products/ Deliverables
• Support for the national scale-up of EID through the development of logistics plans to transport DBS samples for DNA PCR testing, assessment of HC and hospital needs, and the development and implementation support of a proposal for the zonal scale-up of PCR testing.
• Establishment of a Teen Club for HIV+ adolescents (target: 170 by end of FY 2011).
• Supportive Supervision/ Quality Assurance:
o Provision of ongoing mentorship in paediatric ART at decentralized ART sites in the zone (target: 20 by end of FY 2011).

Activity Two: Child Care and Treatment at Tisungane Clinic & HRH – Refer to Budget Code 08-HBHC: Adult Care and Support and Budget Code 09-HTXS Treatment: Adult Treatment for an overview of the

activity and products/ deliverables. Products/ deliverables that are specific to children are mentioned below. Procurement of pediatric drugs and nutritional support are provided through national mechanisms.

Products/ Deliverables
• Provision of clinical care for HIV+ child patients not yet qualifying for ART (target: 720 by end of FY 2011).
• Provision of clinical care and support for paediatric ART patients in the Tisungane cohort and at decentralized or independent ART sites (target: 2,700 by end of FY 2011).
• Registration, counseling and initiation of patients beginning ART (target: 720 by end of FY 2011).

Activity Three: Support for ART Decentralization – Refer to Budget Code 09-HTXS Treatment: Adult Treatment for an overview of the activity and products/ deliverables, which focus on training, supervision, improving quality of care and strengthening health services. Decentralization of ART services promotes integration with routine pediatric care and maternal health services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	62,717	

Narrative:

VI. BUDGET CODE: 13-PDTX

PFIP Year 1 - $18,717
PFIP Year 2 - $62,717

Activity One: Child Care and Treatment at Tisungane Clinic – Refer to Budget Code 08-HBHC: Adult Care and Support and Budget Code 09-HTXS Treatment: Adult Treatment for an overview of the activity and products/ deliverables, which focus on the provision of PEP, and the procurement of non-medical supplies. Procurement of pediatric drugs and nutritional support are provided through national mechanisms.

Activity Two: Support for ART Decentralization – Refer to Budget Code 09-HTXS Treatment: Adult Treatment for an overview of the activity and products/ deliverables, which focus on training, supervision, improving quality of care and strengthening health services. Decentralization of ART services promotes integration with routine pediatric care and maternal health services.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Other	HVSI	734,788	

Narrative:

IX. BUDGET CODE: 17-HVSI

PFIP Year 1 - $219,292
PFIP Year 2 - $734,788

Activity One: Strengthening Supervision and M&E Capacity – Health systems M&E in the South-East Zone is rudimentary and hampered by gaps and overlaps in reporting. This is an urgent action area, given the rapid decentralization of ART care to rural health centres, and the need to monitor clinical outcomes to facilitate continuous quality improvement. Key activities include development of district and zonal supervisory structures, assessments, training of HSA supervisors and supportive supervision. This will support national capacity building to collect, manage, analyze and use data, and support broader M&E initiatives.

Products/ Deliverables
• Collaborative development of functional district and zonal supervisory structures and processes with regard to supervision of service delivery, the referral system, and M&E.
• Assessments to determine the needs of: a. supervisors, and a subsequent assessment and revision of supervisory tools, curriculum and training; and, b. HSA supervisor training.
• Training of HSA supervisors through outreach training mechanisms and the development of appropriate structures and tools.
• Supportive Supervision/ Quality Assurance:
o On-the-job training for Supervisors.
o Monthly and quarterly reviews of ART, TB/HIV, HTC, and PMTCT data collected at health centres.
o Quarterly mentorship of District ART, TB, HTC, PMTCT, and HBC Supervisors to promote appropriate supervision of service delivery, and collection of M&E data.
o Routine supervisors' meetings to exchange lessons learned, best practices, and challenges, and to share and collaboratively interpret data and suggest ways forward.
o Collaborative knowledge translation mentorship project that will conduct program quality control audits, discuss results at dissemination meetings and incorporate lessons learned into district and zonal implementation planning process.

Activity Two: Health Management Information Systems (HMIS) – Specific activities include the adoption of unique patient identifiers, the incorporation of patient-level TB, HTC and PMTCT data in the Tisungane

database, and to implement an electronic medical records system, facilitating integration of non-ART and ART data (i.e. Activity One above).

Products/ Deliverables
• Adoption of unique patient identifiers and the incorporation of patient-level TB, HTC and PMTCT data in the Tisungane database.
• Implementation of the Baobab electronic medical records system at Tisungane Clinic and one additional site in Zomba, and roll-out to district hospitals across the zone (target: 2 sites by end of FY 2011).

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	212,447	

Narrative:

X. BUDGET CODE: 18-OHSS

PFIP Year 1 - $63,403
PFIP Year 2 - $212,447

Activity One: Strengthening Systems for Referral, Patient tracking, and Follow-up – In 2008, Dignitas initiated the development, with a task force of stakeholders, of a referral system for Zomba District. The task force is developing a series of tools and processes to strengthen links between communities and health facilities, to empower healthcare providers to make appropriate referrals and to close incomplete referral feedback loops, and to rapidly identify and trace ART defaulters and pre-ART patients and HIV-exposed infants lost to follow-up, with the assistance of HSAs. Key activities include meetings, the roll-out of the referral system in Zomba district, an analysis of patient tracking in Zomba, the development of a system to track patients in Zomba, engagement with Community Health Centre Committees, and quality assurance.

Products/ Deliverables
• Facilitation of quarterly task force meetings to complete development work of referral system and to lead annual referral guideline reviews and revisions.
• Roll-out of referral system across Zomba District (the introduction of the referral system at the zonal level will occur in FY 2012), including unique patient identification system, generic referral forms and feedback systems and orientation of health providers to use tools and processes.
• Conducting an analysis of patient tracking in urban Zomba, to better understand the particular challenges associated with retaining this cohort in care.
• Development and implementation of a system to track patients in Zomba District.

• Engagement with Community Health Centre Committees including conducting audits to assess community needs in relation to Health Centres and to measure the responsiveness of Health Centres to those needs.
• Quality Assurance: Completion of an audit to quantify and qualify the performance of the system.

Activity Two: Systems and Processes – A number of systems and consultative processes will be developed and implemented at ZCH which will be refined, and then disseminated to other district hospitals in the zone through decentralization support initiatives. Key activities include the development of Standard Operating Procedures and the holding of stakeholder meetings.

Products/ Deliverables
• Development of Standard Operating Procedures for decentralization, drug stock management, patient flow procedures for pre-ART patients, defaulter tracing, quarterly supervision, data cleaning, and clinical tools (e.g., clinical protocols and checklists).
• Implementation of stakeholder meetings to ensure that the PEP and TB/HIV programs are operating in an effective and responsive manner.

Activity Three: Improved Pharmacy Management – Dignitas will employ a Pharmacy Technician to provide mentorship to district and health centre pharmacies. The key activity is supportive supervision.

Products/ Deliverables
• Supportive Supervision:
o Management of supplies of ARVs, drugs for the treatment of opportunistic infections, and HIV test kits.
o Establishment of effective protocols and tools to facilitate timely communication between district and health centre pharmacies.
o Assisting new ART sites to project stock needs accurately, order supplies (including ARVs and other essential drugs) in a timely manner, and to follow MoH protocols to safeguard drugs and manage stock (e.g., stock rotation).

Activity Four: Strengthening Coordination – In all districts, Dignitas will seek to improve coordination among stakeholders in the short-term, and build the capacity of health systems managers to accomplish this goal in the future. The key activity is supportive supervision.

Products/ Deliverables
• Supportive Supervision:
o Provision of mentorship and support to ZHO and DHOs in the development of the HIV-related program components for the yearly District Implementation Plans (DIPs)

o Semi-annual meetings with ZHO and DHOs review implementation progress and support planning for the coming months
o Review of progress and challenges with ZHO and DHMT staff on a quarterly basis.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	350,000	

Narrative:

I. BUDGET CODE: 01-MTCT ($425,000.00)

Activity One: Improved Early Uptake of ANC and HTC Services – In order to provide the most effective PMTCT care, women need to be tested for HIV prior to 28 weeks gestation. This requires availability and awareness of, and access to, services.

Products/ Deliverables
• Scaling-Up HTC services in the Zone (target: 20 sites by end of FY 2011).
• Mobilization of HTC, PMTCT and ART providers to promote HTC/ Early ANC to their clients and to test them directly (target: 580 by end of FY 2011).
• Conduct community sensitization sessions (target: 25 by end of FY 2011).
• Production and dissemination of service maps and directories (target: 6 by end of FY 2011).
• Quality Assurance: Processes established and promoted to track whether ANC attendees have been tested for HIV, and to follow-up with those not tested.

Activity Two: Improved Access to PMTCT-Specific Drug Regimens & Perinatal HTC – Dignitas will assist by training and supporting PMTCT providers to prescribe and manage the new AZT combination regimen, and to perform the hemoglobin test that is necessary to monitor women receiving combination therapy.

Products/ Deliverables
• Training for PMTCT providers (target: 240 by end of FY 2011) in initial trainings (target: 90 by end of FY 2011) and refresher trainings (target: 150 by end of FY 2011) at sites (target: 20 by end of FY 2011).
• CD4 and Hemoglobin Testing available at PMTCT sites in the zone or through transport (target: 20 by end of FY 2011).
• Mobilization of PMTCT providers to practice PITC in the perinatal period (target: 240 by end of FY 2011).
• Supportive Supervision/ Quality Assurance:
o Provision of targeted support, and integrated supervision and mentorship visits to PMTCT providers

(target: 240 by end of FY 2011) as they roll-out the new drug regimen.
o Implementation of semi-annual meetings of PMTCT providers (target: 3 by end of FY 2011).
o Provision of ongoing quarterly mentorship and support.

Activity Three: Training, mentoring, and quality improvement for comprehensive PMTCT in the the Mulange District

Although Dignitas received $200,000 of FY2010 base funds for PMTCT, this support is inadequate to support scale-up of comprehensive PMTCT in the South Eastern Zone where approximately 1/3 of all MTCT occurs in Malawi. While BASICS and CHAI are operating in several of the districts in this zone, additional PMTCT initiative funding will be utized for on-site mentoring and quality improvement activities in Mulange District, which is a high prevalence, high burden district that currently lacks facility-based support from other partners for PMTCT. This will enable high quality PMTCT services to be scaled up more rapidly to sites throughout Mulange.

Activity Four: Capacity building to improve data utilization and reporting
While there is support SI capacity building with the Dignitas FY10 base, this applies broadly to ART, HIV care, and PMTCT activities. Given the need to focus on PMTCT data quality and use in the coming year, Dignitas will receive a small amount of additional PMTCT funding to enable its staff to work side by side with South Eastern zonal staff and district health staff to build their capacity to interpret and use data to improve PMNTCT programs and enable them to be able to better report to the MOH on the national level what they have accomplished. PMTCT Data will be reviewed on at least a quarterly basis with health officers; action plans will be developed and implemented to address data quality issues identified; and feedback will be provided to PMTCT sites to enable them to improve their program in specific ways and monitor such improvements.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	2,386	

Narrative:

VIII. BUDGET CODE: 16-HLAB

PFIP Year 1 - $712.00
PFIP Year 2 - $2,386

Activity One: Lab Capacity – At ZCH, Dignitas will employ a Lab Technician who will continue to provide

lab services as well as mentorship for quality assurance, and training in CD4 testing. A senior Dignitas Lab Technician will serve as Lab Services Coordinator, and will provide mentorship and training to lab staff in other facilities across the zone. Other laboratory management activities include workflows, stock management and the establishment of protocols.

Products/ Deliverables
• Establishing efficient and effective workflows governing daily and weekly laboratory procedures, managing incoming orders, managing incoming and outgoing data.
• Managing stock, including record-keeping, and forecasting and procurement of supplies, timely communication with colleagues regarding stock-outs.
• Establishing and following protocols for on-site and decentralized testing, especially CD4, DNA PCR, and hemoglobin.

Activity Two: Access To and Uptake of Lab Services – In addition to PMTCT clients, increased availability and uptake of CD4 testing will facilitate monitoring of the pre-ART cohort to ensure timely initiation of ART, and may enable earlier diagnosis of treatment failure among the ART cohort. In order to ensure sustainable, accredited laboratory services, the program prioritizes technical assistance to optimize the quality and throughput of service in existing MoH facilities. In addition to the products/ deliverables mentioned in Budget Code 01-MTCT Prevention: PMTCT, another activity includes the management of stock.
Products/ Deliverables
• Provision of a limited stock of medical and non-medical supplies, as needed.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	39,100	

Narrative:

IV. BUDGET CODE: 10-HVTB

PFIP Year 1 - $11,669
PFIP Year 2 - $39,100

Activity One: Integration of TB/HIV –Dignitas will facilitate the integration of TB/HIV screening and care at each district hospital, and will continue to staff and manage an integrated TB/HIV clinic at Zomba Central Hospital. TB/HIV integration will also be incorporated into other trainings and meetings. These activities support the MoH and partner organizations in achieving the goals of the national TB strategy, and the integration focus supports sustainability of the program over time. TB/HIV clinical outcomes will be

integrated in the electronic database to facilitate high quality data for review, reporting and tracking progress. The electronic database allows flexibility of reporting to adjust to new indictors. Products/ Deliverables • Management of an integrated TB/HIV Clinic. • Incorporation of TB/HIV integration into all trainings and routine meetings. • Integration of TB/HIV at each district hospital in the zone, including a contribution to site refurbishment (target: 2 by end of FY 2011).

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12106	**Mechanism Name: LMRTF/PMTCT/GHAI**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Lilongwe Medical Relief Trust Fund	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,550,000	
Funding Source	**Funding Amount**
GHCS (State)	1,550,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In order to reduce the vertical transmission of HIV to infants and increase survival rates of mothers and infants, current PMTCT programs in Malawi offer single dose NVP to most HIV-positive pregnant women and exposed infants, follow-up HIV antibody testing of exposed infants, and dietary counseling based on HIV infant feeding guidelines. The "Safeguard the Household" (STH) project aims to improve the quality and impact of current PMTCT service delivery systems, increase linkages with ART and other maternal child health and family planning services, and explore new technologies and approaches make PMTCT services more effective and feasible. The project will target HIV-infected pregnant women, their partners,

and HIV-exposed infants and children under five. In doing so, the project will safeguard the entire household.

The STH project will be implemented by a partnership of 12 organizations, all with substantial experience working in Malawi, and will be led by an indigenous organization, Lilongwe Medical Relief Trust Fund (aka Lilongwe Trust) and supported by their main technical partners UNC Project, the University of North Carolina and EGPAF. These institutions are well-established in provision of PMTCT and STI services as well as in providing technical assistance for building human resource and laboratory capacities. They have a team of committed scientists engaged in operations and clinical research in Lilongwe which has led to innovations in PMTCT interventions and services including the rapid HIV test, opt out testing, CD4 testing of mothers, partner involvement programs, infant NVP to prevent transmission through breast milk, early infant diagnoses, and incorporation of traditional birth attendants into the PMTCT team. Additional partners contributing to this project will be: Feed The Children (Nutrition), Proctor & Gamble (Clean Water), Abbott Labs/Northwestern University (Rapid Viral load/Early Infant Diagnosis), McFarlane Burnet (Rapid CD4), Emory University (Family Planning), CDC Reproductive Health Branch (infant NVP through breastfeeding), Baylor Pediatric Center of Excellence (Pediatric ART), and the NIH Fogarty International Center (training in M&E).

Building on an 8 year history of Lilongwe Trust's success with PMTCT services in Lilongwe city, the STH project will support the Ministry of Health to facilitate the expansion of comprehensive PMTCT services into all 107 health centers in the Central West Zone over a 3 year period. The overall goal is to empower and support the MOH in its efforts to implement a comprehensive HIV prevention, treatment and care program in Malawi in the areas identified by the Partnership Framework (of the GoM and USG) and the NAF. Specifically, the STH project will contribute to Partnership Framework goals by: 1) reducing new infections in HIV-exposed infants through increased early infant diagnosis, more effective prophylaxis regimes, promotion of safe delivery, and reinforcement of safer infant feeding practices; 2) improving the quality of treatment and care for HIV-infected mothers and children through more rapid CD4 & DNA testing and immediate referral to ART; and 3) improving the quality of life for HIV-infected mothers, their partners and children through increasing clinical follow-up rates and decreasing chronic illness. The project will also provide broader support for systems strengthening in laboratory services by validation of point of care testing, in M&E by supporting the roll-out of electronic data systems, in human resources by training and mentoring indigenous health workers in the implementation and supervision of quality PMTCT services, and in supply chain by strengthening management of medications and supplies at MCH sites.

To achieve these goals, the STH project will train and mentor MoH staff at the district and health center levels in the implementation, supervision, and quality assurance of these more comprehensive PMTCT

services to increase local ownership and ensure sustainability for the long-term. By using more effective and less expensive emerging technologies to identify, treat and retain patients, and by working in close collaboration with the MOH, other government agencies and NGOs to avoid duplications and increase economies of scale, the project will become more cost efficient over time. Improving monitoring and evaluation of PMTCT services will also be a priority, and as electronic data systems are more widely rolled-out nationally with support from Baobab and other USG partners, the project will collaborate with these efforts to assist high-volume sites to enter data directly entered into the EDS, which will allow for monitoring of goals to be achieved in aggregate as well as for individual patients and for better tracking between PMTCT and ART services. Data sharing mechanisms will be established with the MOH and other stakeholders, so that information can be utilized to continuously improve programs.

In addition to standard HIV testing of pregnant women and infants, the standard daily NVP intervention, and referral to treatment and care for those who are diagnosed as HIV positive, the STH project will focus on incorporating additional emerging technologies to increase patient retention rates and reduce infant diarrheal rates, decrease the MTCT transmission rate during delivery and breastfeeding, and reduce the time between eligibility for ART and initiation of treatment for mothers and their infants. Technologies will include adoption of the daily combined AZT regimen and potentially extended postnatal NVP prophylaxis (pending possible guideline changes in 2010), exploring rapid point of care testing technologies for CD4 for pregnant women and DNA for infants (using complementary private sector funding); utilization of donated water purification and food supplements to improve outcomes and increase follow-up; and expansion of partner T&C, active TB case finding, malaria prevention, clean water program, and reproductive health. Furthermore, linkages across the PMTCT care and treatment system will be strengthened through referrals of pregnant women to L&D centers, increased TB case referral, and utilizing a universal health ID linked to the EDS to monitor the patient's usage of various services and to link that patient to their family members and to track them between clinics.

Once the project is fully operational in FY11, it is expected that in 100% of the sites in the Central West Zone, health workers will receive high quality training and on-site mentoring and technical assistance in comprehensive PMTCT service delivery. Through this more comprehensive approach to PMTCT services, it is expected that 133,000 pregnant women annually will receive HIV and syphilis tests, HIV and reproductive health counseling, and TB screening. Of those women, more than 9,000 will receive CD4 count results each year; their children will have clean water, be sleeping under ITNs and will be fully vaccinated; and at least 20% of their partners will be recruited for HIV counseling and testing. In all, the project is expected to prevent more than 4,000 pediatric infections over three years, and will support the enrollment of over 3,500 mothers and 400 infants on ART annually.

The COP entry below briefly describes only those activities planned for the project from April 1, 2010-

September 30, 2010, after which the project will be funded through PMTCT resources to be described in the PMTCT scale-up plan to be submitted in draft to OGAC November 1st. The project overlaps with the EGPAF Call to Action (CTA) activity which is also operating in the Central West Zone and ends in September 2010. Since EGPAF is also a sub partner in the STH project, it will be possible to ensure a smooth transition in project support, as the CTA activity ceases implementation at project sites in the final quarter of FY10, while the STH begins full implementation.

PFIP Year 1 Budget – TBD
PFIP Year 2 Budget – TBD

Cross-Cutting Budget Attribution(s)

Construction/Renovation	300,000
Food and Nutrition: Commodities	100,000

Key Issues

Increasing gender equity in HIV/AIDS activities and services
Malaria (PMI)
Safe Motherhood

Budget Code Information

Mechanism ID:	**12106**		
Mechanism Name:	**LMRTF/PMTCT/GHAI**		
Prime Partner Name:	**Lilongwe Medical Relief Trust Fund**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	MTCT	1,550,000	
Narrative:			
BUDGET CODE: PMTCT ($1,550,000) Activity 1: Training, mentoring, and quality improvement for comprehensive PMTCT in the Central West Zone and the Dowa District			

Districts to be directly supported by STH in the CW Zone include Lilongwe, Ntcheu, Dedza, and Mchingi. As the Dowa district is a high-burden HIV district in the Central East zone that is next to Lilongwe, the STH project will also provide technical assistance to the Dowa DHO, although since this district is also heavily supported by the DREAM project, the STH support in anticipated to be mostly indirect and related to filling gaps.

STH project staff work with MOH staff to visit PMTCT sites in the CW Zone on a regular basis, at least quarterly and in preferably more often. MOH staff will provide supportive supervision, with LMRTF and EGPAF staff providing mentoring to build their capacity and help quality improvement activities be initiated at sites. At the quarterly site visits the MOH staff and UNC Project staff will work side by side to review the results obtained from the previous month's visit and show comparative data for the 10 nearest clinics, audit existing supplies and ensure that an order has been placed for next month's supplies, listen to staff comments on what went well the previous months and discuss needs of the clinic, develop quality improvement plans to strengthen PMTCT services as well as the overall MCH systems. During the quarterly visit, the project staff member will also observe an antenatal clinic to look at procedures and to ensure that staff our implementing all of the SOPs. Given that LMRTF has 22 experienced nurses under employment with extensive experience in PMTCT

Mentoring and quality improvement will focus on the following priorities

1) Improve the quality of HTC, including linkages with family planning and TB screening
As part of ongoing national efforts to strengthen the system of preventing mother-to-child transmission, HIV testing is currently being be routinely offered to >95% of pregnant women at most pre-natal clinics at the initial visit. However the quality of counseling is not routinely monitored, and there are missed opportunities for health workers to counsel both HIV-infected and uninfected mothers on HIV transmission and prevention methods as well as to link patients to family planning services, encourage exclusive breastfeeding, distribute condoms, promote partner testing, and perform TB screening. HIV positive mothers will be counseled on preventing transmission to their child, staged and referred to treatment, OI prophylaxis and to positive living support services. ITN's can be distributed at this point as well. The project will also support active TB case finding in MCH settings, and help ensure access of HIV-positive pregnant and lactating women have access to family planning counseling and a wide variety of contraceptive methods for those that want to use them, including depo-provera, IUDs, OCPs, and long-term methods where available.

2) Increase the enrollment of eligible HIV positive pregnant women on ART:
DHC staff (nurses, clinical officers, medical assistants) will be trained and supported to increase referral of eligible women and their partners to the nearest ART Clinic. Referral systems will be strengthened

and tracked at high-volume sites through the use of a patient ID system and linked to the national electronic data system being rolled-out by Baobab and other partners. Although referral is ongoing in urban Lilongwe where antenatal CD4 counts are available, the lack of an electronic mechanism for tracking leads to less than 60 to 70% starting therapy. This and the other activities proposed including supporting the availability of CD4 testing (see below) will enable the identification of those clients in need of immediate ART.

3) Increase implementation of more effective PMTCT regimens:
In addition to sdNVP, the project will work to support sites to rapidly scale-up the provision of AZT antenatally from 28 weeks to HIV-infected pregnant mothers with CD4 > 350 cells/ul and ZDV/3TC 7 day tail annually to mothers and HIV-exposed infants. The project will explore the possibility of supporting provision of daily NVP syrup to uninfected HIV-exposed children (5,560 annually) born to HIV infected mothers with CD4 > 350 throughout the breastfeeding period.

4) Improving postnatal follow-up among HIV positive pregnant women and their children Increasing patient retention is critical to prevention of vertical HIV transmission through breastfeeding and to the provision of medical care to HIV-infected mothers and infants. Furthermore, HIV-exposed infants are more susceptible to gastrointestinal illnesses, in part due to contaminated water supplies, and this can lead to malnutrition and increased infant mortality. Although, the MOH and LMRTF are not recommending early weaning to breastfeeding mothers, since mixed feeding occurs starting as early as 4 months post-partum and since malnutrition is a significant problem for all Malawian infants whether they wean or not, LMRTF shall continue to provide VitaMeal and PuR monthly from 6 months through 18-24 months depending on weaning. These commodities will be donated through private resources.

5) Improving access to CD4 testing and early infant diagnosis within PMTCT settings
Currently, CD4 testing is conducted only on HIV-infected pregnant women prenatally at 4 Lilongwe DHCs supervised by UNC Project. Post-natal testing is not yet standard practice. In order to increase the number of HIV-infected pregnant women who know their eligibility for ARTs and to decrease the time between their eligibility for ART and their initiation of treatment, CD4 testing will be conducted at time of diagnosis prenatally and for those with a CD4>350 who are not yet eligible for ART, CD4 testing will continue postnatally every 6 months for at least 18 to 24 months. This will be done by MoH staff at each health center. HIV positive breastfeeding women will return to the DHCs monthly to pick up Vitameal and PuR packets from 6-24 months. The project also support sites to roll-out of Early Infant Diagnosis (EID) using DNA PCR tests for all HIV-exposed infants at 6 weeks, 6 months, and 12 months, and rapid HIV antibody tests for all infants. EID is being implemented in Malawi currently but is not available at all of the centers and is only available through dried blood spots leading to a significant delay in diagnosis.

Nurses, clinical officers, medical assistants, medical officers and lab technicians will be trained and mentored by LMRTF staff to support the implementation of these activities.

6) Immediate referral of HIV- infected infants and child to HIV treatment and care
The project will provide mentoring and technical assistance to sites to strengthen referral systems between PMTCT and ART for children, and help increase the number of HIV-exposed children who are not only tested, but the proportion that receive their results (which is currently less than 50% at many sites), and reduce the number who are eligible for ART that are lost-to-follow-up before enrollment. The project will collaborate with Lighthouse, Baylor, and other partners in the Central region that support ART service provision to help foster better linkages.

Activity 2 National scale-up of MIP follow-up utilizing HSAs

USG partners have worked with the MOH to develop a model for the implementation of MIP follow up at three sites in Phalombe District. This model, which had its origin through the PEPFAR HQ PMTCT/peds TWG initiated integration program, is based on the identification of a PMTCT coordinator at facility level, typically a Health Surveillance Assistant (HSA), who is responsible for tracking mother-infant pairs over time, the use of a register which facilitates tracking of MIP's, the implementation of a screening process to ensure that MIP's are assessed clinically during each visit, and the implementation of IYCF counseling every time a MIP visits the facility. STH will provide training and the in-service orientation of HSAs and other staff to this model at PMTCT sites in the Central West Zone and Dowa district. The emphasis will be on on-site training to reduce costs.

Activity 3: Integration of PMTCT and HIV care with family planning

As part of the STH project, health centers throughout the Central West Zone will be supported to develop strong models of how to best integrate family planning services into the care of HIV-infected women throughout the postnatal period.) Private funding and USAID family planning (non-HIV resources) will be used to train providers to counsel women about family planning methods including use of Depo-Provera, OCPs, barrier methods, IUDs, and natural methods, and also in IUD insertion. STH will share the best practices related to FP/PMTCT integration that it develops with the other 4 zonal mentoring partners. M-CHIP will also collaborate with the Safeguard the Household in these efforts..

Activity 4: Refining best practices for involvement of TBAs in PMTCT

Recently the Ministry of Health issued a circular ordering all Traditional Birth Attendants (TBAs) to immediately cease deliveries and refer all patients to facilities. In Dowa district a program in which TBAs receive a small incentive for referring patients has been highly successful in increasing facility-based deliveries. The STH will therefore train TBAs will to refer all pregnant women in their catchment areas to deliver in facilities and also provided with PMTCT-specific training, building on a successful model of LMRTF's prior work with TBAs in Lilongwe. LMRTF and EGPAF staff will conduct each training session in cooperation with the DHOs and ZHOs. This approach may be scaled-up further in future years depending on the experience in the CW Zone

Activity 5: Logistical Support for Vitameal distribution in the Central West Zone
As part of the STH project, Feed the Children will be donating Vitameal as a nutritional supplement to HIV+ mothers and children (not as a weaning food). USG-funding will complement the private resources by supporting the logistics and storage of the commodity throughout the sites in the Central West Zone.
Activity 6 : Procurement of PMTCT-related commodities to fill gaps that arise

A small amount of USG resources is currently budgeted for the STH to procure commodities to fill gaps for PMTCT commodities as they may arise for the national program. (e.g. postnatal nevirapine, test kits, and hemacue reagents). While every effort will be made to ensure that adequate resources to procure commodities are provided through the MOH, GFATM, UNICEF, and other donors, experience has shown that there are often gaps that occur and it is necessary to plan according and have an alternative option for procurement available as insurance to enable program to be implemented effectively.

Activity 7: Renovations of high volume MCH sites in the Central West Zone and Dowa district
Renovations will mainly focus on upgrading antenatal sites to meet the MOH criteria for qualification as ART sites, and also will improve the condition of labor and deliver wards at high-volume sites, provide additional space for storage of commodities, and enhance patient flow between services. The process to select sites for renovations will be done in close consultation with the MOH and other stakeholders and utilize evidence-based criteria, for example prioritizing those sites that could enroll many more women on ART if they had the proper physical infrastructure. Efforts will also be made to leverage already approved Global Fund resources for renovations at MCH sites that would enable the renovations to achieve more national coverage of MCH sites, and also to utilize USG non-HIV health funding to increase the scale of effort further. Renovations will be coordinated with those to be funded under other sources (i.e. Global Fund, SWAp) to ensure that there is no duplication.

Activity 8: Link PMTCT data to the EDS and improve ART-PMTCT referrals
The project will work to assign a universal health ID number to each PMTCT client and link these clients into the electronic data system being rolled out by Baobab and other partners, initially focusing on high-volume sites. This will enhance the ability of the MoH to track the health progress, service usage and effect of the services, and movement of clients from center to center, clinic to clinic, and linkage of mother to each child and partner and health center. As the project progresses in FY11 and beyond, approaches will be explored in which data officers at the DHCs will be trained to collect data from lower-level sites that themselves cannot utilize the EDS and enter this data into the EDS at higher-volume sites, such as district hospitals. This may allow the EDS to be used to track patients at a larger proportion of sites than would be feasible otherwise.

ACTIVITY 9: CAPACITY BUILDING TO IMPROVE DATA UTILIZATION AND REPORTING
STH staff will work side by side with Central West zonal staff and district health staff to build their capacity to interpret and use data to improve programs and enable them to be able to better report to the MOH on the national level what they have accomplished. M-CHIP will then report to PEPFAR how they its efforts have helped the CW zone PMTCT Data from Central West Zone and Dowa district reviewed on at least a quarterly basis with health officers; action plans will be developed and implemented to address data quality issues identified; and feedback will be provided to PMTCT sites to enable them to improve their program in specific ways and monitor such improvements.

ACTIVITY 10: OPERATIONS RESEARCH
Programs supported by UNC Project in Lilongwe have found that provision of free clean water materials is associated with increased antenatal attendance and postnatal follow-up and also that sites which provide targeted food supplementation to HIV-positive lactating women in the postnatal period have much higher rates of follow-up. Support is also to be provided through other partners in Malawi for approaches utilizing HSAs and/or lay cadres to reduce loss-to-follow-up. The UNC Project will therefore collaborate with Baylor and other partners to conduct operational research around this important area to help inform national policy on how these various approaches should be used appropriately. The research will attempt to evaluate the cost-effectiveness and sustainability of different approaches. This will broadly address the PEPFAR priority PMTCT/peds OR question: "What are the interventions at the program, facility, community, and household level that have the greatest impact on retention in care, especially in the first 12 months of life?"

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12107	**Mechanism Name: EQUIP**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Partners in Hope	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 2,438,000	
Funding Source	**Funding Amount**
GHCS (State)	2,438,000

Sub Partner Name(s)

Baylor University, College of Medicine	Elizabeth Glaser Pediatric AIDS Foundation	Toga Laboratories
UCLA Program in Global Health	University of California at Los Angeles	

Overview Narrative

Goals and Objectives

Partners in Hope (PIH) Medical Center and our partners propose to improve the quality of HIV care in Malawi by increasing the capacity of Christian Health Association of Malawi (CHAM) facilities to deliver care, sustained by integrating and strengthening linkages within the continuum of care, innovative mentored training, and through the performance of operational research to inform the future of the Malawi National programs and policies.

Linkage to Partnership Frameworks Between USAID And Government of Malawi

EQUIP addresses all four goals of the Partnership Framework as follows:

To reduce new HIV Infections in Malawi and Support the above listed goals in Prevention, Treatment and Care by providing discrete systems strengthening support in human resources

With CHAM hospitals as the key partners, we propose integrating and strengthening the linkages among different HIV-related health services in the region to develop a 'continuum of care' including: HIV testing and counseling, pre-ART care, antenatal care and prevention of mother-to-child transmission, family planning, maternal child health, early infant diagnosis, and pediatric ART.

To improve the quality of treatment and care for Malawians impacted by HIV

We intend to train individuals from CHAM to serve as mentors at other sites in their regions (forming

CHAM clusters). A train-the-trainer program will provide the clinicians, public health personnel, and administrators the necessary tools and skills to teach in their respective areas of expertise that include clinical training, administration, monitoring and evaluation, and operational research.
To mitigate the economic and psychosocial effects of HIV and AIDS and improve the quality of life for PLHIV
Our project will include capacity building to establish and/or strengthen PLWA and prevention-for-positives support programs within the CHAM clusters.

Geographic Coverage
The EQUIP team will request CHAM and MOH zonal offices to identify and select geographic locations using pre-determined CHAM selection criteria. PIH and its partners will perform an initial assessment of possible sites for feasibility and overall needs. The project will support 6 CHAM clusters comprised of one CHAM hospital and at least 3 health care satellites per hospital. Initially we will focus on the two central zones and expand into the northern zone.

Health System Strengthening and Linkage with Government Activities
Our application includes a letter from the MOH supporting our proposal to establish strong ties between CHAM participants and District and Zonal health structures. We will conduct an initial assessment of each district and zonal health office in each CHAM site region. Based on this review, EQUIP personnel will tailor a program whereby district and zonal health officers and employees can be supported and trained in areas of need. These activities may be carried out by our partners (such as Baylor for pediatrics, EGPAF for PMTCT, or TOGA for laboratory infrastructure).

Cross-Cutting Attributions and Key Issues
a. Human Resources for Health (HRH): We will create a train-the-trainer program whereby clinicians, public health personnel, and administrators are given skills to teach in their respective areas of expertise including clinical training, administration, or monitoring and evaluation.
b. Food and Nutrition, Policy, Tools, and Service Delivery: PIH's current activities include an extensive Nutrition Education Program that will be integrated into the EQUIP curriculum.
c. Gender, reducing Violence and coercion: In the execution of our prevention, treatment and care program such efforts will include screening and counseling for gender based violence (GBV); strengthening referrals from HIV/AIDS services for GBV services and vice-versa; strengthening rape care services including the provision of PEP; and interventions aimed at preventing GBV including interpersonal communication.

Cost Efficiency
The EQUIP proposal begins with one site and expands, over time, to six. The intent is to develop best

practices and refine our activities and tools as we accelerate the program. By doing so, we can identify and integrate cost efficiencies into the program as we proceed.

Monitoring and Evaluation
At the end of year one, PIH will have performed detailed baseline assessment of two CHAM site/clusters. The baseline information will include documentation of personnel, resources, supplies, facilities, health care linkages (if they exist), services in different domains of the continuum, and policies for different domains of patient care. By the end of the first year the mentoring program will also be implemented. We will measure job satisfaction, perceived and actual level of clinical skills, and perceived job responsibility through a series of interviews and questionnaires. These will be measured serially such that at the end of five years we will be have a compendium of information about knowledge and skills that result from this program.
Budget Summary
PFIP Year 1 Funding – $1,365,662
PFIP Year 2 Funding – $2,263,000

Cross-Cutting Budget Attribution(s)

Construction/Renovation	150,000
Human Resources for Health	200,000

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID:	**12107**		
Mechanism Name:	**EQUIP**		
Prime Partner Name:	**Partners in Hope**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	190,668	
Narrative:			

Activity 3: Improving Adult HIV and AIDS Care, Support and Treatment at CHAM Sites (HBHC, HTXS) EQUIP will train personnel involved in HIV and AIDS care including clinicians, administrators/data managers, and laboratory technicians and staff. Individuals from designated CHAM sites who are selected to participate in EQUIP's train-the-trainer program will initially spend six weeks of intensive training at PiH Medical Center to be followed by regular interactions on-site with program staff. EQUIP will work alongside hospital leadership and Zonal Directors to improve linkages among the continuum of HIV services, and pilot incentives for connecting HIV+ patients in HCT centers with other services (especially pre-ART and ART). Eventually all sites will receive advanced training in HIV/AIDS management including management of OI, clinical staging, ART initiation, managing ART side effects, assessment and management of ART treatment failure.

The EQUIP consortium will create active pre-ART programs ensuring access and adherence to cotrimoxazole prophylaxis. CHAM staff will be trained and will implement programs to identify and manage malnutrition in HIV infection patients and train clients in safe water systems and hygiene. EQUIP-trained PLWA and HCT counselors will offer psychosocial and spiritual counseling at CHAM hospitals and affiliated sites. Interventions at CHAM Hospitals will reduce transmission of HIV infection through establishing prevention for positives programs (see Activity 2).

This activity includes the Cross-Cutting Attribution Human Resources for Health since it includes training health care workers in the areas of management and leadership development and performance assessment/quality improvement. This activity also addresses Food and Nutrition: Policy, Tools, and Service Delivery by developing protocols and policies for the inclusion of nutrition programs as part of HIV/AIDS care programs at each CHAM cluster. This component will include the training health care workers and counselors in performing nutritional assessments, counseling, and implementation of nutrition programs.

Products/Deliverables:
• 11,000 HIV+ persons receiving cotrimoxazole prophylaxis
• 600 HIV+ clinically malnourished clients receiving therapeutic or supplementary food
• 4 health care facilities that have the capacity and conditions to provide advanced-level HIV testing and HIV/AIDS clinical management
• 8 health care facilities that have the capacity and conditions to provide basic-level HIV testing and HIV/AIDS clinical management

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HTXS	127,112	

Narrative:

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• 4 health care facilities that have the capacity and conditions to provide advanced-level HIV testing and HIV/AIDS clinical management
• 8 health care facilities that have the capacity and conditions to provide basic-level HIV testing and HIV/AIDS clinical management

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	127,112	

Narrative:

Activity 5: Expanding Testing and Counseling Facilities at CHAM Hospitals (HVCT)
The EQUIP Malawi program will train HCT counselors for six weeks at PIH Medical Center in an intensive program that will focus not only on HIV testing but also on comprehensive HIV prevention delivery (see Activity 2). Counselors trained at PIH will follow-up at the site per the EQUIP training schedule to mentor and supervise the HCT program. Training will focus on boosting provider-initiated HCT at the base CHAM hospital and satellite clinics. EQUIP personnel will work within each CHAM cluster to increase the number of centers providing HCT services and pilot semi-quantitative CD4 measurement at these sites. HCT sites will be integrated with STI and family planning programs such that HIV prevention messages can be combined with screening for STIs and family planning for the prevention of unwanted pregnancy.
Products/Deliverables:
• 16 sites providing HIV Counseling and Testing services
• 3500 HIV+ individuals trained in correct and consistent condom use
• 16 HCT counselors trained

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	323,711	

Narrative:

Activity 6: Capacity Building for Pediatric Care and Support and Treatment at CHAM Hospitals (PDCS)
EQUIP Malawi's partner, Baylor will incorporate early infant diagnosis (including dried blood spot testing) linked to PMTCT and community-based follow up of infants born to HIV+ mothers training as a key component of the EQUIP program. They will then work alongside CHAM clinicians and staff to improve capacity for services within the CHAM hospital and implement existing and pilot new mechanisms to improve referral and retention of HIV-exposed infants in care within CHAM clusters. For example, expanding pediatric programs will include expanding provision of ART to HIV-infected infants and eligible children and regular clinical and CD4 monitoring of all HIV+ children. Alongside PIH PLWA-support staff, CHAM facilities will increase capacity to monitor growth and nutritional status of HIV infected children. Another emphasis of EQUIP/Baylor activities will be to improve integration of pediatric HIV services with MCH, under five, Tb and nutrition programs.
This activity is related to the Key Issue: Health Related Wraparounds: Child Survival Activities. A major focus in this activity will be ensuring that children benefit from linked services such as linking PMTCT, EID, community-based follow-up of infants born to HIV+ mothers, providing ART and regular CD4 monitoring to children, nutritional programs, MCH, Under-5, and Tuberculosis treatment .

Products/Deliverables:
• 5 service outlets providing linked care pediatric care and support programs

• 432 infants of HIV-positive women receiving EID
• 388 mothers of HIV-positive infants receiving results of EID
• 40 HIV-positive infants receiving ART according to national and international standards

• 40 HIV-positive infants receiving CD4 testing (at least 6 monthly)
• 40 mothers of HIV-positive infants receiving results of CD4 testing
• 388 HIV-positive infants receiving nutritional/growth assessments and supplementation

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	258,178	

Narrative:

Activity 7: Strengthening Pediatric HIV/AIDS Treatment at CHAM Hospitals (PDTX)
EQUIP-Malawi will train CHAM personnel and oversee the implementation and integration of Early Infant Diagnosis and pediatric ART programs at all CHAM clusters. Clinical training will include basic pediatric ART curriculum for sites not currently providing pediatric ART. All sites will eventually have personnel who receive advanced training in HIV/AIDS management including pediatric clinical staging, management of OI, ART initiation, managing ART side effects, assessment and management of ART treatment failure in children.

Products/Deliverables:
• Number of service outlets providing basic pediatric ART according to national and international standards
• Individuals trained in providing basic pediatric ART according to national and international standards
• Individuals trained in advanced HIV/AIDS management defined as pediatric clinical staging, management of OI, ART initiation, managing ART side effects, assessment and management of ART treatment failure in children.

Activity 8: Improving Laboratory Infrastructure at CHAM Sites (HLAB)
Through its partnership with TOGA Laboratories, EQUIP Malawi will purchase and supervise installation of laboratory equipment for on-site measurements of CD4, monitoring of ART side effects (especially Hb, lactate and creatinine) and OI testing at each CHAM facility. The program provides for training and technical support for CHAM Cluster laboratory staff through the laboratory at Partners in Hope Medical Center. Training includes accurate diagnosis of OIs, CD4 testing, laboratory monitoring of ART side effects, lab management and quality assurance.

Products/Deliverables:

• Purchase and supervise installation of laboratory equipment at three sites
• Provide training and technical support for laboratory staff at PIH and three sites
• PIH and three CHAM facilities performing on-site laboratory measurements of CD4, monitoring of ART side effects (especially Hb, Lactate and Creatinine) and OI testing
• PIH and three CHAM facilities performing quality assurance of on-site laboratory measurements of CD4, monitoring of ART side effects (especially Hb, Lactate and Creatinine) and OI testing

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	133,106	

Narrative:

Activity 9: Installing and Integrating Strategic Information Systems in CHAM Facilities (HVSI)
EQUIP Malawi, through a sub-contract in collaboration with TOGA Laboratories, will place site-level health information systems in targeted CHAM clusters. Services will include training of staff in use of health information system for HIV/AIDS monitoring and for operational research.
Products/Deliverables:
• PIH and three CHAM sites in the program with health-information systems
• 24 personnel in CHAM facilities trained in using health information systems

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	127,112	

Narrative:

Activity 10: Health Systems Strengthening (OHSS)
PIH will work with each CHAM facility to improve the diagnostic laboratory services to perform the laboratory testing required for diagnosis and monitoring of HIV and ART patients according to the national guidelines. This will include CD4 testing, hemoglobin, creatinine and AFB smear for microscopy. In partnership with TOGA, PIH will also implement an external quality assurance/proficiency testing (EQA/PT) program for CD4 and TB sputum microscopy.

Products/Deliverables:
• Four CHAM facilities will be able to perform laboratory testing required for diagnosis and monitoring of HIV and ART patients according to the national guidelines.
• Four CHAM facilities will pass annual quality assurance/proficiency testing (EQA/PT) for CD4 and TB sputum microscopy

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	63,556	

Narrative:

Activity 2: Building Comprehensive and Integrated HIV Prevention Programs at CHAM Sites (HVOP)
EQUIP will build prevention programs at CHAM hospitals and affiliated clinics by training counselors and establishing community outreach programs. We will build capacity such that every CHAM hospital and satellite clinic in the program offers HCT as part of a multi-faceted HIV prevention program. Activities will promote a comprehensive approach to HIV prevention, including a component on prevention with positives (PwP) and sero-discordant couples. We will develop and field test messages, literature, and videos that address issues relevant to PwP and relating to primary as well as secondary partnerships, with special emphasis on sero-discordant partners and multiple and concurrent partnerships (MCP). We will develop training materials to prepare clinicians to deliver general prevention messages as well as PwP messages in clinical encounters, and expect that the issue of PwP be addressed in every clinical encounter with HIV infected patients. The EQUIP team will draw upon our experience with the use of Community Health Workers (CHW) empowering them to follow up HCT clients. Our prevention program will include training and implementation of screening and counseling for gender based violence (GBV); strengthening referrals from HIV/AIDS services for GBV services; and interventions aimed at preventing GBV including interpersonal communication.

This activity includes the Cross-Cutting Attribution Human Resources for Health since it involves training health care workers in HCT and the delivery of HIV prevention programs, as well as Gender: Reducing Violence and Coercion, as it incorporates programs for the prevention and management of GBV.

Products/Deliverables:
• 12,600 PLHIV reached with a minimum package of Prevention with PLHIV (PwP)
• Establishment of community outreach prevention programs in each of the CHAM clusters
• 1200 HIV negative partners in sero-discordant couples counseled in HIV prevention

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	723,223	

Narrative:

PMTCT Budget ($723,223.00)

Activity 1: Capacity Building of PMTCT Services at CHAM Sites (MTCT)
Prior to initiation of activities, a detailed assessment of each CHAM site will be performed to understand the availability (if any) of ANC and PMTCT services. These activities as well as the training and implementation of ANC/PMTCT services will be performed in collaboration with EGPAF.

We will ensure that each CHAM hospital as well as every satellite health center included in the program has the capacity to deliver services including HCT for pregnant women, expedited initiation of ART for those women who qualify by CD4 cell count and/or WHO clinical staging, and PMTCT interventions for women who do not meet current criteria for ART. To achieve these goals EQUIP and EGPAF will perform training of individuals to perform clinical services (in ANC/PMTCT) and administrative services (to ensure referrals for ART are systematically performed). We also propose to expand capacity at each CHAM hospital for these ANC/PMTCT services by facilitating on-site CD4 testing. EQUIP and EGPAF will promote greater involvement of male partners of HIV+ women by developing outreach programs with specific focus on engaging male partners in HCT.

This activity incorporates the Cross-Cutting Attribution Human Resources for Health since it includes training clinicians, administrators, and laboratory technicians to deliver a comprehensive program for HIV-infected pregnant women. Key issues include gender, and building capacity for care of HIV-infected pregnant women will increase gender equity in HIV/AIDS activities and services.

Activity 2:
The EQUIP consortium will receive additional FY10 PMTCT funds in the amount of $175,000 to support operations research activities designed to identify and refine best practices for improving access of eligible HIV+ pregnant women to ART in the Malawian context and for implementing postnatal prophylaxis of infants under the new Malawian and WHO guidelines. This topic would fall under the top PMTCT/peds PEPFAR HQ OR priority: "What are the effective strategies for provision and monitoring of CD4 testing and antiretroviral treatment, if eligible for pregnant women" and "For postpartum prophylaxis during breast feeding: What are effective strategies for implementation, and what is the comparative effectiveness of infant vs. maternal prophylaxis?". This operations research will also be supported with private resources donated through UCLA and others, thus making it more feasible to generate. The specific design of the operations research study will be developed in the first half of Fy10 and shared with the HQ PMTCT/peds TWG for their input.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	271,241	

Narrative:

Activity 8: Improving Laboratory Infrastructure at CHAM Sites (HLAB)
Through its partnership with TOGA Laboratories, EQUIP Malawi will purchase and supervise installation of laboratory equipment for on-site measurements of CD4, monitoring of ART side effects (especially Hb, lactate and creatinine) and OI testing at each CHAM facility. The program provides for training and technical support for CHAM Cluster laboratory staff through the laboratory at Partners in Hope Medical

Center. Training includes accurate diagnosis of OIs, CD4 testing, laboratory monitoring of ART side effects, lab management and quality assurance.

Products/Deliverables:
• Purchase and supervise installation of laboratory equipment at three sites
• Provide training and technical support for laboratory staff at PIH and three sites
• PIH and three CHAM facilities performing on-site laboratory measurements of CD4, monitoring of ART side effects (especially Hb, Lactate and Creatinine) and OI testing
• PIH and three CHAM facilities performing quality assurance of on-site laboratory measurements of CD4, monitoring of ART side effects (especially Hb, Lactate and Creatinine) and OI testing

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	92,981	

Narrative:

Activity 4: Improving TB/HIV Care at CHAM Sites (HVTB)
The EQUIP Malawi program will emphasize development of clinical protocols for improved diagnosis of TB in HIV patients. This will be accomplished by training of health providers in TB diagnosis and treatment. Each CHAM site will also be equipped with improved screening tools such as standardized questions and laboratory services to support TB diagnosis and monitoring during treatment. Laboratory personnel will be trained by technical experts from Partners in Hope Medical Center.

This activity covers the key issue of TB and includes the Cross-Cutting Attribution Human Resources for Health since it includes training health care workers in TB diagnosis and treatment, as well as training laboratory technicians in TB diagnostics.
Products/Deliverables:
• 80 % of HIV+ patients screened for TB in HIV care or treatment settings
• 20% of HIV+ patients in HIV care or treatment (pre-ART or ART) initiated TB treatment
• 75% of HIV test results recorded in the TB register in patients being treated for TB

Activity 5: Expanding Testing and Counseling Facilities at CHAM Hospitals (HVCT)
The EQUIP Malawi program will train HCT counselors for six weeks at PIH Medical Center in an intensive program that will focus not only on HIV testing but also on comprehensive HIV prevention delivery (see Activity 2). Counselors trained at PIH will follow-up at the site per the EQUIP training schedule to mentor and supervise the HCT program. Training will focus on boosting provider-initiated HCT at the base CHAM hospital and satellite clinics. EQUIP personnel will work within each CHAM cluster to increase the number of centers providing HCT services and pilot semi-quantitative CD4

measurement at these sites. HCT sites will be integrated with STI and family planning programs such that HIV prevention messages can be combined with screening for STIs and family planning for the prevention of unwanted pregnancy. Products/Deliverables: • 16 sites providing HIV Counseling and Testing services • 3500 HIV+ individuals trained in correct and consistent condom use • 16 HCT counselors trained

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12108	**Mechanism Name: TBD/PSM**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Central Medical Stores (CMS) is responsible for the procurement, warehousing and distribution of all public sector health commodities, which includes over 1,500 items. CMS works through three Regional Medical Stores (RMS) in the north, center, and south of the country and is responsible for direct distribution to district hospitals and health centers on a monthly basis. CMS pushes stock out to RMS and in theory districts pull stock from RMS for district hospitals and health centers in their district. Current plans are to transform CMS into an independent trust with the objectives of increasing efficiency, enabling more flexibility around human resources, as they will no longer be a part of the GOM civil service,

improving staff retention and professional development, and ensuring more efficient, cost effective and responsive procurement processes.

All the aforementioned areas present current challenges to CMS and because of budget constraints, procurement issues and management problems, CMS is currently only able to supply 60% of the national requirement for drugs. As a result of this, programs such as the HIV/AIDS program and the immunization program have chosen to outsource the procurement and distribution of anti-retrovirals and vaccines through UNICEF. The expectation is also that CMS as a trust would become an economically viable entity. The GOM has recently taken steps to legally approve the establishment of the trust and the trust is in the process of being registered. Current CMS warehouse storage capacity is considered to be inadequate and the GOM is working on costed designs for a new facility, which the USG will facilitate.

A safe, secure and consistent supply of commodities represents an essential component of public health. Malawi's supply chain for pharmaceuticals and other essential health commodities faces many challenges. The overall goal of this project is to ensure that the people of Malawi have access to adequate quantities of affordable essential medicines and health supplies of high quality by strengthening the national supply chain for essential health commodities.

There are four principal objectives that the project is expected to achieve. First, central national supply chain entities will improve their technical capacity and performance through the institutionalization of best practices. One level down the chain, districts and facilities will boast improved capacity and performance in logistics and pharmaceutical management. Third, one national supply chain system will be created through the integration of current vertical supply chains. Lastly, an improved policy and regulatory framework will be created to provide for longer-term stability and sustainability of public sector health commodities.

The new contract will benefit from a well thought out and widely consulted tri-fecta of themes. The USG has provided the GOM assistance in the supply chain arena for the last ten years. Notable improvements have been achieved; however, the scale of successes has not matched the USG commitment to the area. Therefore, before signature, the USG will cultivate a high-level commitment from the GOM; it is expected that the GOM will buy in, sign a Memorandum of Understanding, and accede the supply chain mandate to the successful bidder. Second, key management issues, especially data management, will be addressed at all levels through transparent and open procedures. Finally, this contract will build on innovative and strategic approaches, which the private sector is so widely recognized for.

The TBD partner will receive funds from PEPFAR, the President's Malaria Initiative (PMI), and Population funds (POP). By combining PEPFAR, PMI, and POP funding streams, it will allow the partner and the Government of Malawi to be strengthen the entire supply chain, contributing towards a strengthened, integrated and GOM-controlled and managed system of procurement, disbursement, and quality control. Given the high visibility of this issue, the USG will pursue a Memorandum of Understanding that will outline both GOM and USG responsibilities as well as benchmarks for success. Further, the USG is exploring whether other donors, such as the Global Fund, can, essentially, "buy into" the USAID

mechanism and a joint program of work can be developed across partners to facilitate coordinated and comprehensive action.

PFIP Year 1 Budget – Redacted
PFIP Year 2 Budget – Redacted

Cross-Cutting Budget Attribution(s)

Human Resources for Health	Redacted

Key Issues

Malaria (PMI)
Child Survival Activities
Safe Motherhood
Family Planning

Budget Code Information

Mechanism ID:	**12108**		
Mechanism Name:	**TBD/PSM**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	HVSI	Redacted	Redacted

Narrative:

The Central Medical Stores (CMS) is responsible for the procurement, warehousing and distribution of all public sector health commodities, which includes over 1,500 items. CMS works through three Regional Medical Stores (RMS) in the north, center, and south of the country and is responsible for direct distribution to district hospitals and health centers on a monthly basis. CMS pushes stock out to RMS and in theory districts pull stock from RMS for district hospitals and health centers in their district. Current plans are to transform CMS into an independent trust with the objectives of increasing efficiency, enabling more flexibility around human resources, as they will no longer be a part of the GOM civil service, improving staff retention and professional development, and ensuring more efficient, cost effective and responsive procurement processes.

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comprehensive action.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	Redacted	Redacted

Narrative:

2010 PMTCT Funds - Redacted

1. PMTCT Budget Code Narrative (add here). Please cost your individual activities

This activity is funded mainly by HIV OHSS FY-10 base funds, malaria funding, MCH, and family planning resources, but some funding from the PMTCT additional resources is also provided given the critical importance of this activity to PMTCT. PMTCT-funding will be used to support the broader project and specifically ensure that PMTCT-related commodities are used as one of the key tracer commodities (test kits, NVP, AZT, cotrimoxazole, and DBS-supplies) that are followed. The TBD partner will report regularly to the MoH, USG, and implementing partners on the status of the supply chain for the PMTCT commodities is and provide specific support to remedy gaps as they may arise. These efforts will complement activities being funded through the same partner related to artemisin-based combination therapies for malaria and family planning commodities, which will be two other sets of tracer commodities that are closely monitored and also being provided to MCH sites.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	Redacted	Redacted

Narrative:

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through UNICEF. The expectation is also that CMS as a trust would become an economically viable entity. The GOM has recently taken steps to legally approve the establishment of the trust and the trust is in the process of being registered. Current CMS warehouse storage capacity is considered to be inadequate and the GOM is working on costed designs for a new facility, which the USG will facilitate.
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Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HTXD	Redacted	Redacted

Narrative:

The Central Medical Stores (CMS) is responsible for the procurement, warehousing and distribution of all public sector health commodities, which includes over 1,500 items. CMS works through three Regional Medical Stores (RMS) in the north, center, and south of the country and is responsible for direct distribution to district hospitals and health centers on a monthly basis. CMS pushes stock out to RMS and in theory districts pull stock from RMS for district hospitals and health centers in their district. Current plans are to transform CMS into an independent trust with the objectives of increasing efficiency, enabling more flexibility around human resources, as they will no longer be a part of the GOM civil service, improving staff retention and professional development, and ensuring more efficient, cost effective and responsive procurement processes.

All the aforementioned areas present current challenges to CMS and because of budget constraints, procurement issues and management problems, CMS is currently only able to supply 60% of the national requirement for drugs. As a result of this, programs such as the HIV/AIDS program and the immunization program have chosen to outsource the procurement and distribution of anti-retrovirals and vaccines through UNICEF. The expectation is also that CMS as a trust would become an economically viable entity. The GOM has recently taken steps to legally approve the establishment of the trust and the trust is in the process of being registered. Current CMS warehouse storage capacity is considered to be inadequate and the GOM is working on costed designs for a new facility, which the USG will facilitate.

A safe, secure and consistent supply of commodities represents an essential component of public health. Malawi's supply chain for pharmaceuticals and other essential health commodities faces many challenges. The overall goal of this project is to ensure that the people of Malawi have access to adequate quantities of affordable essential medicines and health supplies of high quality by strengthening the national supply chain for essential health commodities.

There are four principal objectives that the project is expected to achieve. First, central national supply chain entities will improve their technical capacity and performance through the institutionalization of best practices. One level down the chain, districts and facilities will boast improved capacity and performance in logistics and pharmaceutical management. Third, one national supply chain system will be created through the integration of current vertical supply chains. Lastly, an improved policy and regulatory framework will be created to provide for longer-term stability and sustainability of public sector health commodities.

The new contract will benefit from a well thought out and widely consulted tri-fecta of themes. The USG has provided the GOM assistance in the supply chain arena for the last ten years. Notable improvements have been achieved; however, the scale of successes has not matched the USG commitment to the area. Therefore, before signature, the USG will cultivate a high-level commitment from the GOM; it is expected that the GOM will buy in, sign a Memorandum of Understanding, and accede the supply chain mandate to the successful bidder. Second, key management issues, especially data management, will be addressed at all levels through transparent and open procedures. Finally, this

contract will build on innovative and strategic approaches, which the private sector is so widely recognized for. The TBD partner will receive funds from PEPFAR, the President's Malaria Initiative (PMI), and Population funds (POP). By combining PEPFAR, PMI, and POP funding streams, it will allow the partner and the Government of Malawi to be strengthen the entire supply chain, contributing towards a strengthened, integrated and GOM-controlled and managed system of procurement, disbursement, and quality control. Given the high visibility of this issue, the USG will pursue a Memorandum of Understanding that will outline both GOM and USG responsibilities as well as benchmarks for success. Further, the USG is exploring whether other donors, such as the Global Fund, can, essentially, "buy into" the USAID mechanism and a joint program of work can be developed across partners to facilitate coordinated and comprehensive action.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12109	**Mechanism Name: USAID Tuberculosis CARE Project**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

TBD NARRATIVE

The TB-CAP Program will end in September 2010, but there remains a great need to provide technical

assistance and focused support to the national TB program (NTP), including strengthening of TB/HIV activities. In 2010 a new bilateral cooperative agreement will be competed that will be funded mainly with USAID child survival resources earmarked for TB, but also complemented with HIV resources to help address specific TB/HIV priorities. During technical assistance visits in 2009 from TB technical experts from both HHS/CDC and USAID HQ, it was recommended that the USG continue to provide support for TB/HIV activities through a broader TB agreement.

The input and active involvement of these experts who are familiar with NTP and the country context will be utilized to support the country team in writing the RFA. Efforts will be made to ensure there is no duplication between the proposed TB/HIV activities and the GFATM grant and HHS/CDC funding to NTP through its cooperative agreement with the MOH. TB/HIV activities implemented through this new bilateral agreement will be highly complementary. This will draw on progress made during a recent TA visit from HQ, in which the contributions of donors particularly activities financed through the GFATM, in TB were systematically charted in a way that should enable gaps and areas for complementary support to be readily identified.

The technical areas of focus for TB/HIV activities will be: 1) increasing the number of co-infected patients who start HIV treatment (currently less than 40%) by strengthening referrals between TB treatment and ART clinics and 2) intensifying TB case-finding among PLHIV. The project will also link to the zonal mentoring partners implementing PMTCT, and HIV care and treatment, to help facilitate the roll-out of best practices and tools for TB/HIV. Specific interventions and targets will be entered into COPRIIs and can be reviewed by HQ as necessary, once the RFA is drafted.

PFIP Year 1 Budget - Redacted
PFIP Year 2 Budget - Redacted

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	12109		
Mechanism Name:	USAID Tuberculosis CARE Project		
Prime Partner Name:	TBD		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Treatment	HVTB	Redacted	Redacted

Narrative:

TBD NARRATIVE

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PFIP Year 1 Budget - Redacted
PFIP Year 2 Budget - Redacted

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12110	**Mechanism Name: University of Malawi College of Medicine**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: University of Malawi, College of Medicine/Lab	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 2,050,000	
Funding Source	**Funding Amount**
GHCS (State)	2,050,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Malawi HIV/AIDS Laboratory Capacity Consortium is made up of four institutions with a long-standing history of work in Malawi: the College of Medicine, University of North Carolina (UNC) Project, Loma Linda University-Malawi Adventist Health Services, and Johns Hopkins University-College of Medicine Research Project. These are well established institutions experienced in capacity building in areas of laboratory services, with a long-standing history of collaboration with the Malawi Ministry of Health (MOH) and other partners. They have a large team of committed and experienced scientists with the ability to lead large laboratory initiatives.

Our overall goal is to empower and support the Ministry of Health in its efforts to implement a comprehensive plan to strengthen the national HIV care and treatment program in Malawi in the areas identified in the Partnership Framework and the National Strategic Laboratory Plan. Specifically, this entails supporting human resource development by training medical laboratory technology students and currently deployed laboratory professionals; supporting the Malawi Ministry of Health (MOH), Christian Hospital Association of Malawi (CHAM) and other partners to deliver high quality HIV diagnostic and disease monitoring services; improving the referral linkages from HIV testing to treatment and treatment

monitoring sites; and assisting in collecting and using data to improve HIV prevention and treatment outcomes in Malawi.

To accomplish these goals training institutions at Malawi College of Health Sciences, Malamulo College of Health Sciences and College of Medicine will be supported in curriculum development and pre-service training. We will support upgrading of the current curriculum so that it is relevant to the needs of Malawi health care services. We will strengthen preservice training through staff support, and instructors will be sponsored for specialist training at internationally recognized institutions.

The National Reference and Diagnostics Laboratory at the Community Health Science Unit (CHSU) will be strengthened through infrastructure improvements. Support will be provided to CHSU to develop a national laboratory certification scheme and for CHSU to achieve accreditation from an internationally recognized laboratory accrediting body.

Four Mentoring Laboratories will be strengthened; QECH in the Southern Region, Malamulo Hospital in the Southern Region, KCH in the Central Region, and Mzuzu Central Hospital in the Northern Region to provide high quality laboratory services and act as training facilities for students. Support will be provided to the institutions to expand capacity and improve quality of CD4 counting, pediatric and adult HIV and OI diagnostics, TB fluorescence microscopy and TB culture, STI diagnosis, chemistry and hematology.

From the Mentoring Laboratories, District hospital and CHAM hospital laboratories will be supervised and mentored to achieve high quality diagnostic services and an expansion of HIV testing and CD4 count capacity, TB diagnostics, STI diagnosis, chemistry and hematology services. Staff in all Mentoring Laboratories and mentored district and CHAM hospitals will receive in-service training in Good Clinical Laboratory Practice and quality management systems. This programs targets urban and rural laboratories in all regions of Malawi, maximizing geographic impact and outreach to underserved populations.

Data collection and surveillance will provide feedback on program progress and inform national priorities. The current data collection and reporting system will be assessed and strengthened. Data sharing mechanisms with MOH and other stakeholders will be developed, so that routine lab, quality control and surveillance data can be collected at every laboratory in the entire national network. The Consortium will use its significant in-country experience and success with Laboratory Information Systems to support the MOH in its goal of implementing LIS technology.

In order to become cost efficient over time, we will centralize procurement of laboratory reagents and equipment, standardize equipment types across facilities, and strengthen preventative maintenance and

stock control mechanisms. Facilities which have already attained an acceptable standard of laboratory services will be supported and their services expanded with minimal expense.

This program will contribute significantly to the Partnership Framework goals of strengthening HIV treatment and support, providing systems strengthening in laboratory services, health information systems, and human resource development. It will be integrally involved in Partnership Framework goals of (1) scaling up quality assured CD4 testing, early infant diagnosis, TB microscopy, and cost effective methods for screening for virological treatment failure, (2) building MOH capacity to train, mentor, and supervise, laboratory staff, (3) improving referrals and linkages to strengthen the continuum of care, and (4) strengthening health information management systems. Close working relationships will be maintained with CDC, Howard University, CHAM, Malawi Defense Forces, and John Snow International to maximize our outreach and impact.

Budget Summary
PFIP Year 1 Funding – $1,738,000
PFIP Year 2 Funding – $1,700,000

Cross-Cutting Budget Attribution(s)

Human Resources for Health	360,300

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12110**		
Mechanism Name:	**University of Malawi College of Medicine**		
Prime Partner Name:	**University of Malawi, College of Medicine/Lab**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	HVSI	34,560	
Narrative:			
Budget Code – HVSI			

Activity 1: Support to MOH and partners in collection of laboratory service delivery data collection and analysis. Monitoring and evaluation of laboratory services provides important feedback on program progress and inform national priorities. During FY10, the current data collection and reporting system will be assessed and strengthened under the direction of the MOH and in partnership with other USG partners including Baobab and CHAM. Standardized reporting forms and data sharing mechanisms with MOH, CDC, CHAM and other stakeholders will be developed. Discussions with stakeholders on development of a national laboratory information management system (LIMS) will take place. LIMS systems specifications will be developed and a funding mechanism identified. This contributes towards percentage of health facilities with record-keeping systems for monitoring HIV/AIDS care and support.

In FY11, strengthening the laboratory national data collection and reporting system will continue under the direction of the MOH and in collaboration with partners. Identification and procurement of a national laboratory information management system fitting the specifications developed in FY09 will take place. The system will be piloted and validated at KCH, Bwaila Hospital, and Dowa District Hospital. This contributes towards percentage of health facilities with record-keeping systems for monitoring HIV/AIDS care and support.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	OHSS	330,300	

Narrative:

Budget Code – OHSS

Activity 1: Support to pre-service training institutions

In FY10, the laboratory pre-service training curriculum will be reviewed and revised. An advisory group for training incorporating members from relevant stakeholders will conduct a baseline assessment of the medical laboratory training curricula in Malawi, and update it where necessary to address technical and laboratory management skills development. Current district attachments for trainees are highly unstructured. The curriculum development process will specify activities and competencies that will be achieved in each training rotation and provide laboratory staff in the districts with training guidelines to more effectively mentor trainees, contributing to the number of new health care workers graduating from a pre-service training institution. In FY10, this standardized, comprehensive curriculum developed will be integrated into the degree, diploma and certificate programs at Malamulo College of Health Sciences, Malawi College of Health Sciences, and College of Medicine, contributing to the number of new health care workers graduating from a pre-service training institution.

In addition in FY10, full salary support will be provided for one expatriate at Malamulo College of Health

Sciences and one local clinical laboratory tutor at Malawi College of Health Sciences. These tutors will provide training and supervision of students, contributing to the number of new health care workers graduating from a pre-service training institution. This activity will continue in FY11.

In FY10, masters degree level specialty training in the US or South Africa will be provided to one qualified laboratory professional through the NIH Fogarty International Center (UNC AITRP), contributing to the number of new health care workers graduating from a pre-service training institution.

In both FY10 and FY11 we will be working in collaboration with HUTAP to support pre-service training in Malawi. Meetings are scheduled for mid-October 2009 to design with our HUTAP partners a complementary and comprehensive support program.

Activity 2: In service training support. Laboratory management and technical skills of currently deployed laboratory staff will be strengthened through in-service training in FY09. The advisory group for training will develop a 5 day intensive Good Clinical Laboratory Practice (GCLP) training tailored specifically to the types of assays and technical and management challenges met in clinical labs in Malawi. Training of Trainers will take place. The first round of GCLP in-service trainings involving 40 currently serving laboratory staff will take place, 10 from each Mentoring Laboratory catchment area, to provide national coverage. This will contribute to the number of health care workers who have successfully completed an in-service training program.

In FY11, this activity will continue, and in collaboration with other stakeholders, an advanced training curriculum in National Reference Laboratory and Disease Surveillance activities will be developed for Senior Technicians and Technologists selected to do training rotations at CHSU. The Good Clinical Laboratory Practice Training program developed in FY09 will be implemented in the Mentoring Laboratories, with each centre training 20 point of care lab staff in a series of small group trainings (a total of 80 technicians trained). This will contribute to the number of health care workers who have successfully completed an in-service training program.

In FY10, technician exchange & rotation programs will be implemented. Technicians in the Mentoring Laboratories will exchange benches for two weeks four times per year with technicians working at UNC Project and JHU/COM Research Project, giving MOH and CHAM lab staff the opportunity to experience first hand the quality culture and advanced diagnostic techniques offered at two of the country's premier clinical research labs while the JHU/COM and UNC Project exchange technicians share skills with their colleagues in the Mentoring Laboratories. Serving point of care lab technicians in District and CHAM laboratories will spend one week rotations in the Mentoring Laboratories to learn advanced diagnostic techniques and quality practices in those laboratories. This will contribute to the number of health care

workers who have successfully completed an in-service training program.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	350,000	

Narrative:

Budget Code – PMTCT ($350,000.00)
In Malawi, HIV counseling and testing numbers are very high for the PMTCT program, but there is currently great concern about the quality of the testing itself, the counseling that is given, and the way that data are recorded. One example is that the prevalence from the program data was less than 60% of the prevalence from ANC surveillance at the same sites in 2007, seeming to indicate that about 40% of the HIV positive women who were tested were incorrectly told that they were negative. The availability of high quality ANC data will be useful in determining what the true ANC prevalence is in different areas and following the changes in ANC prevalence in first attendees over time as a proxy for incidence.
Activity 1: Support to MOH to develop, implement, and monitor a comprehensive HIV rapid testing quality assurance program:
The following steps will be taken in FY10: Our organization will support MOH through the National Reference Laboratory at CHSU to provide quality assurance for HTC occurring in the ANC settings and to improve HTC supervision at PMTCT sites nationally. Specifically, we will assist MOH to develop a PMTCT program assessment tool which will identify the current quality challenges in rapid testing and data collection and analysis, assist CHSU to strengthen its national HIV Rapid Testing Proficiency Testing Program, assist CHSU to strengthen and fully implement its national HIV Rapid Testing sample retesting program, and provide support for training for PMTCT program supervisors in enhanced documentation, reporting, and quality assurance measures at ANC level. We will also support HUTAP in monitoring the CHSU-based CD4 external quality assurance program.

Activity 2: Support to MOH for feasibility assessments for emerging POC technology
Insufficient support for laboratory services means that only a small minority of HIV-positive pregnant women are able to access critical diagnostic tests including CD4 testing and HIV DNA PCR for early infant diagnosis. Use of point of care technology has the potential to increase access to the testing and to decrease costs to the national health system. Our organization will assist MOH to conduct a feasibility assessment and cost effectiveness analysis for use of point of care CD4 and EID testing and provide support for field testing of devices.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	1,335,140	

Narrative:

Budget Code – HLAB

Activity 1: Development and implementation of national laboratory quality assurance standards and national laboratory standard operating procedures

As part of the National Strategic Laboratory Plan, the MOH has developed strategic objectives addressing current needs in laboratory services delivery and quality management systems. In collaboration with CDC/Malawi, HUTAP and other partners, we will assist the MOH in developing and implementing a comprehensive quality service delivery program using internationally recognized Good Clinical Laboratory Practice standards.
To achieve these goals the following steps will be taken in FY09: A quality service delivery advisory group incorporating members from relevant stakeholders will conduct a baseline needs assessment and develop a comprehensive plan for implementation of this activity.

The outputs of this group will be a National Quality Manual and national Laboratory Standard Operating Procedures which will include laboratory policies, laboratory safety, quality management program, specimen management, turn-around-time compliance, results reporting, reference ranges, and handling of abnormal values, equipment operation and testing procedures, equipment maintenance, and procurement/stock control systems. A national laboratory certification scheme will be developed to be used until a national laboratory accreditation scheme is in place. This will contribute to Health Systems Governance, Laboratory Accreditation.

Activity 2: Laboratory supervision and mentoring for quality service delivery: Four Mentoring Laboratories will be supported at high through-put hospitals, each of which will have 12 district and CHAM lab facilities under their supervision. Regional Coordinators and Outreach Supervisors will work hand-in-hand with MOH Laboratory Supervisors to perform baseline assessments of infrastructure and quality systems at their Mentoring Laboratory and the 2nd tier laboratories under their supervision using guidelines established in the national laboratory certification scheme. The Regional Coordinators and Outreach Supervisors in cooperation with their MOH counterparts will prepare a corrective action plan for each facility with a target timeline for implementation with the goal of achieving and maintaining certification.

Through this mentorship, quality standards, throughput, and maintenance and reagent stock-out down time will be improved and MOH Laboratory Supervisors will be trained and empowered. A vehicle for each of the four Mentoring Laboratories will be key to this activity, providing project and MOH staff with the mobility necessary to effectively mentor laboratories in underserved and remote areas. This activity will contribute to the number of testing facilities accredited according to national standards, and the percent of testing facilities with satisfactory performance on EQA for CD4, HIV Rapid testing, and TB

diagnostics, and the percent of designated laboratories with the capacity to monitor ART according to national and international guidelines.

Beginning in FY11 the Regional Outreach Supervisors and their MOH counterparts will visit each facility under their supervision (including the Mentoring Laboratory to which s/he is assigned) every month to monitor and mentor them in implementing the corrective action plans developed in FY10, guiding them toward certification. Monthly monitoring of professional competencies, operational performance measures, and stock control will be provided. The regional M&E Officer will perform data collection, analysis, and provide feedback to all facilities and to the National Coordinator to inform program management. This activity will contribute to the number of testing facilities accredited according to national standards, and the percent of testing facilities with satisfactory performance on External Quality Assurance (EQA) for CD4, HIV Rapid testing, and TB diagnostics, and the percent of designated laboratories with the capacity to monitor ART according to national and international guidelines.

Activity 3: Support to the National Reference Laboratory
Development of national accreditation standards, accreditation of the National Reference Laboratory CHSU will be supported in FY10, beginning the process of developing national accreditation standards for laboratories. A suitable accreditation scheme will be identified/adapted. CHSU itself will be supported to achieve accreditation. In consultation with the selected accrediting agency, a plan will be developed for preparing CHSU for accreditation on selected testing systems by FY11. This will contribute to the number of testing facilities accredited according to national standards. This will contribute to Health Systems Governance, Laboratory Accreditation.

In FY11, we will continue to support CHSU in developing national accreditation standards for laboratories. CHSU's quality manual will be submitted to the external accreditation body selected in FY09 for evaluation. Action items from this evaluation will be addressed. The pre-accreditation inspection of CHSU by the external accreditation body will take place. This will contribute to the number of testing facilities accredited according to national standards. This will contribute to Health Systems Governance, Laboratory Accreditation.

Activity 4: Laboratory infrastructure development. Baseline infrastructure (laboratory equipment, furnishings, power, water and climate control systems) needs assessments will be conducted in FY09 for Mentoring Laboratories and the 2nd tier laboratories they support, with the target of a minimum service package of HIV adult and infant diagnostics, CD4 counting, viral load monitoring, AFB microscopy and culture, OI and STI diagnostics, chemistry and hematology services at the Mentoring Laboratories, and a minimum service package of HIV adult diagnostics and infant referral services, CD4 counting, AFB microscopy, syphilis testing, basic chemistry and hematology services at 2nd tier laboratories.

Service contract payments will be supplied for selected critical equipment. Laboratory equipment procurement will begin in FY10 for installation in FY11. This activity will contribute to the number of testing facilities accredited according to national standards, and the percent of testing facilities with satisfactory performance on EQA for CD4, HIV Rapid testing, and TB diagnostics, and the percent of designated laboratories with the capacity to monitor ART according to national and international guidelines.
Infrastructure and selected instrumentation upgrades will be completed in the Mentoring Laboratories in FY10. Regional Coordinators in each Mentoring Laboratory will coordinate infrastructure upgrades to two District/CHAM laboratories (a total of 8 in FY10). Service contract support will be supplied for selected instrumentation. Fluorescence microscopy capacity will be revitalized in the Mentoring Laboratories and TB culture capability introduced. TB fluorescence microscopy capability will be revitalized in the district hospitals where it is currently available, and extended to strategic district and CHAM hospitals where it is not.

Given the synergistic relationship between STIs and HIV transmission and acquisition, correctly treating STIs is an essential component of a comprehensive HIV prevention program. All labs will be equipped and supported to perform syphilis serology testing. Discussions will be held with partners to identify an additional 5 institutions in strategic locations with space that has the potential to be converted to a laboratory with HIV rapid testing and CD4 count capacity to be brought on-line in subsequent grant years. Selected laboratory equipment for this activity was already costed in FY09. This activity will contribute to the number of testing facilities accredited according to national standards, and the percent of testing facilities with satisfactory performance on EQA for CD4, HIV Rapid testing, and TB diagnostics, and the percent of designated laboratories with the capacity to monitor ART according to national and international guidelines.

Activity 5: Strengthening of referral systems. MOH and partners are currently piloting several models for referral systems between laboratories providing HIV diagnosis and monitoring services and HIV treatment facilities. MOH will be supported to identify and develop an appropriate referral system addressing key issues of sample transport to testing laboratories and results turn around times to care providers.
Training on and implementation of the referral system between laboratories providing HIV diagnosis and monitoring services defined in FY09 will take place in FY10. The regional M&E Officer will perform data collection, analysis, and provide feedback to all facilities and to the National Coordinator to inform program management. Improving turn-around-time for lab results will be prioritized so that by the end of FY10 80% of laboratory results in mentored facilities will be received by providers within the turn-around time specified by National SOPs.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12111	**Mechanism Name: Supporting implementation of National AIDS Framework through improving coverage and quality of HIV and AIDS Services**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Ministry of Health, Malawi	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 2,900,000	
Funding Source	**Funding Amount**
GHCS (State)	2,900,000

Sub Partner Name(s)

Central Monitoring and Evaluation Department (CMED)	Community Health Sciences Unit - Reference Lab	Department for HIV and AIDS
Department of Diagnostics	Department of Finance	Department of Nursing
National TB Program		

Overview Narrative

The Ministry of Health (MOH) plays the primary implementing role in the national HIV response. They complement the National AIDS Commission (NAC) and the Office of the President and Cabinet (OPC) policy development role through collaborative development of guidelines and scale-up plans to implement programs in the health sector, and to guide the private sector in their activities. MOH was a new Implementing Mechanism in FY09, and several departments are supported in under-funded areas which are critical to ensure effective and complete implementation of national programs supported by the Global Fund.

Within MOH, this implementing mechanism supports several departments: The HIV and AIDS Department, the Central Monitoring and Evaluation Department (CMED), the Community Health Sciences Unit (CHSU), the National TB Program (NTP), the Nursing Department, the Department of Finance and the Department of Diagnostics. The role of this implementing mechanism is to have national level impact on increasing access, quality, and sustainability in the following areas: Comprehensive HIV services including HIV Counseling and Testing (HTC), pre-ART care for those not yet eligible for ART, Prevention with Positives (PwP) interventions in pre-ART and ART settings, adult and pediatric antiretroviral therapy (ART), prevention of mother-to-child transmission of HIV (PMTCT); referrals between all HIV services; coordination, implementation and monitoring of TB/HIV activities; scale-up of HIV-related lab services; health management and information systems (HMIS) and monitoring and evaluation (M&E) systems.

In the second year of the program the Malawi Ministry of Health will continue implementing activities started in FY09. USG funding will be used to support the implementation of the National Action Framework (NAF) through expanding both the scope and quality of HIV and AIDS prevention, treatment, and care and support services, and to address cross-cutting issues such as training, capacity building, policy development and staffing and management.

The MOH implementing mechanism has several specific objectives:
1) To strengthen comprehensive HIV services across the continuum of care from prevention to treatment, with an emphasis on improved referrals and linkages
2) To increase access to adult and pediatric HIV care and treatment
3) To expand the range and quality of PMTCT services, including the strengthening of infant follow-up, care and treatment
4) To strengthen coordination, implementation and monitoring of integrated TB and HIV services
5) To scale-up the provision of HIV-related laboratory services
6) To support critical surveillance activities around HIV incidence, and emerging adult and pediatric drug resistance
7) To strengthen health management and information systems (HMIS) and monitoring and evaluation (M&E) systems
8) To increase the capacity of policy makers and program managers in the Malawi MOH to design, implement and evaluate HIV and TB services.

MOH will coordinate the use of the funds, which will be in a discrete account, separate from other donor and Ministry funds. The monitoring of activities in each department will be done through quarterly meetings a steering committee comprised of the Directors of those departments implementing the Cooperative Agreement. Reporting on activities conducted will be through existing reporting mechanisms in MOH, from health centers to district level, and district level directly to zonal health offices (ZHO) and

the relevant Department in MOH. Progress and financial reports will be provided as needed to CDC.

Budget Summary
PFIP Year 1 Funding – $1,720,000 (includes 50,000 CHSU; 200,000 NTP)
PFIP Year 2 Funding – $4,200,000

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Addressing male norms and behaviors
Impact/End-of-Program Evaluation
Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID:	**12111**		
Mechanism Name:	**Supporting implementation of National AIDS Framework through improving coverage and quality of HIV and AIDS Services**		
Prime Partner Name:	**Ministry of Health, Malawi**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	430,000	

Narrative:

HBHC - $430,000 (Department for HIV and AIDS & Nursing Dept)
(Department for HIV and AIDS $250,000, activities 1-3; Nursing Dept $180,000, activities 4-6)

Malawi is making progress towards achieving its target of enrolling 250,000 individuals on antiretroviral therapy (ART) by 2010. By March 2009 there were 223 public and private health facilities delivering ART in all districts, with 158,137 patients alive on ART. The National ART program is working to decentralize ART to lower level health facilities as well as to develop a pre-ART program as part of its scale up plan (2010-2013), and will need extensive support to succeed. The Nursing Department will work to ensure

linkages between facility and community are strengthened, and care and prevention activities are implemented at community level.

A formalized pre-ART program is being planned which will improve the management of PLWA from diagnosis until the initiation of ART through:
• Minimizing patients 'lost-to-follow-up' between HTC and ART clinics
• Following HIV-positive individuals closely enough to ensure timely initiation of ART and minimize early mortality
• Reaching the population most at risk of transmitting HIV to those who are negative with effective HIV prevention messages

The Department for HIV and AIDS will start program development and implementation activities in Year 1 and continued in Year 2, including:
1. Conceptualization and development of pre-ART program
a. Conduct 2 one-day meetings with stakeholders and implementers to determine the minimum pre-ART package, which will include facility based Pre-ART (Adult & pediatric) and community based Pre-ART which will include issues to do with community support, counseling, prevention issues including BCC and prevention with Positives activities (Year 1)
b. Conduct 2 two-day workshops to develop and produce guidelines and training manuals for Pre-ART to be incorporated into existing guidelines and manuals (Year 1)
2. Implementation of pre-ART program
a. Conduct 5 (in each zone) TOT training on the guidelines and modules for Pre-ART
b. Conduct training and in-service training for new and current providers on Pre-ART
c. Roll out Pre-ART to all sites which can implement the minimum package according to guidelines
d. Conduct onsite mentoring for sites implementating pre-ART to ensure smooth programme implementation and improve scale-up through an iterative learning process
3. The development and roll-out of M&E tools for monitoring Pre-ART programme and client outcomes (outcomes will be divided into died, defaulted, transferred out, started on ART or discharged for exposed infants found HIV negative at 18 months /after weaning)
a. Conduct a 2 day workshop for stake holders & implementors to develop M & E tools for Pre-ART (Year 1)
b. Produce and distribute Pre-ART registers, Master cards and patient ID's for Adult/PMTCT Pre-ART, Infant & pediatric Pre-ART
c. Conduct 5 (in each zone) TOT trainings on M & E tools for Pre-ART
d. Conduct training & in-service training for new and current providers on the M & E Tools
e. Conduct quarterly supervision of the Pre-ART package implementation by integrating with the quarterly TB/ART supervision

The Nursing Department will emphasize the complementary community activities through:
1. Review and update the National Community Home based Care Policy and Guidelines (NAF Objective 2.3.1) to incorporate community-based pre-ART
a. Conduct one 5 day meeting to revise CHBC policy and guidelines
b. Print revised CHBC policy and guidelines
c. Conduct 3 regional 2 day meetings to disseminate revised policy and guidelines at zonal level
2. Build capacity of community health nurses, medical assistants and HSAs to provide community-based pre-ART services.
a. Incorporate pre-ART into existing CHBC training manuals
b. Develop job aids for providers on community based pre-ART package
c. Print and distribute community-based pre-ART job aid and training manuals
d. Train community health nurses, HSAs and community volunteers in community based pre-ART in districts
3. Strengthen capacity of PLHIV support groups on pre-ART
a. Map out existing PLHIV support groups in collaboration with PLHIV support groups e.g. NAPHAM, MANET, etc
b. Support community health nurses and HSAs, in collabortion with NAPHAM, MANET, to establish community-based PLHIV support groups
c. Develop handbook on formation and managing PLHIV support groups and strengthening capacity of PLHIV support groups to provide pre-ART services (counselling on need for CD4 testing/staging and OI management, and referral for such services; status disclosure, stigma reduction, treatment literacy, adherence, positive prevention, defaulter tracing, psychosocial and spiritual support, nutrition counselling, and referral of pre-ART and ART patients to other social support services (nutrition, income generating activities, legal services, etc)),
4. Strengthen supervision and oversight of implementation of community-based pre-ART in districts
a. Provide transport support to community health nurses and HSAs to monitor and supervise implementation of community-based pre-ART services
b. Conduct quarterly mentoring visits to districts

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	350,000	

Narrative:

HVCT - $350,000 (Department for HIV and AIDS)
HIV Testing and Counseling (HTC) has scaled up rapidly in the last few years, and Malawi is now preparing to roll out Provider-Initiated Testing and Counseling (PITC) in mid-2009 while continuing to

strengthen other areas such as couples and pediatric testing. Support is needed to strengthen provision of comprehensive HTC services including PITC, increase the quality of HTC services nationally, print and disseminate HTC tools and materials, and conduct basic program evaluation.

Activity 1: Strengthen provision of comprehensive HIV Testing and Counseling (HTC) services

1. Institutionalize and roll out Provider-Initiated Testing and Counseling

The focus will be on rolling out provider initiated HIV testing and counseling services to government health care institutions, especially the district hospitals and CHAM facilities.

PITC will continue being introduced throughout the health care system, and especially in paediatric wards, female and male medical wards, OPDs, ANC, STI clinics, Under 5 clinics and family planning clinics. Training and orientation of health care workers including TOT will continue to ensure that health care worker comply with guides and protocols for PITC.

While institutiionalizing PITC;

• the linkages between linkages between HTC, PMTCT, ART, TB, and other related service will further be strengthened, and,

• the supply chain management systems for HIV test kits and other HIV commodities will be consolidated.

2. Intensify Couple HIV and Child HIV Counseling

Training and orientation of HTC trainers in Couple and Child Counselling will continue to ensure that all HTC trainers are proficient in training counsellors in couple and child HIV Counselling. This will cascade to refreshing and strenthening skills for all HTC counsellors in health care facilities and NGOs/CBOs in counselling couples and discordant couples.

3. Improve the quality of post test counseling

Revising the post-test counseling curriculum will strengthen prevention messages, and improve completion of referrals, enrollment and retention in care.

Activity 2: Strengthen Quality of HTC services

Intensified supervision through training in HTC supervision

Strengthen quality of HTC services through:

• intensified training in HTC supervision,

• intensified monitoring of HTC supervisors at district level

• support to national supervision of HTC week campaign events

• improvement of transport capacity for HTC supervision; and

• review and update all HTC superivision tools.

• Quality Assurance for Whole Blood Rapid Testing:
• Quality of HTC will further be improved through the sustained provision of Quality Asssurance for Whole Blood Rapid Testing (WBRT) and profiency testing.

Activity 3: Procurement, printing and production of HTC resource Materials
This will include additional procurement of stop watches, additional printing of Couple HIV Counselling Training Guide and Participant Manual, Child Counselling Training Guide and Participant Manual, additional printing of the generic HTC Training Participant Manual; additional procument of HTC training aids, e.g. DVDs.

Activity 4: Basic Program Evaluation
Develop and review innovative models aiming to strengthen referrals between HTC, PMTCT, TB, Pediatric and adult ART, and community-based programs with the aim of ensuring continuum of care and minimizing loss to follow up. A specific focus will be to evaluate effectiveness of referrals of HIV positives from HTC into the new pre-ART clinics 'Family HIV Care Clinics'.

Development and implementation of models and guidelines/recommendations based on the above evaluations and current international best practices.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Other	HVSI	400,000	

Narrative:

HVSI - $400,000
(CHSU Epi $300,000; CMED $100,000)

Community Health Sciences Unit
The Epidemiology section at Community Health Sciences Unit (CHSU) of the Ministry of Health is mandated to coordinate disease surveillance activities including HIV surveillance. For HIV surveillance: the activities have included conducting surveys for HIV prevalence, HIV drug resistance and sexually transmitted infections (STI).

In the financial year 2009-2010, the Epidemiology Unit will implement with USG support, HIV Incidence surveillance among high risk populations and general population, providing training in basic epidemiology, and prospective monitoring of HIV drug resistance strains among adult patients taking ART. In the financial year 2010 we shall continue with the prospective monitoring of drug resistance in adult patients, incidence surveillance, and training in basic epidemiology. In addition there will be

monitoring of HIV drug resistance among pediatric patients.

Activity 1: Prospective monitoring of HIV Drug Resistance Strains
Prospective monitoring of drug resistance started in February 2008 and will continue until 2010. Samples are collected every 12 months and next sample collection is due February 2009 and thereafter February 2010. Sample collection will be in March 2010, activities will include supervision, data abstraction, procurement of reagents and supplies.

Activity 2: Monitoring of pediatric of HIV Drug resistance in pediatric patients
Transmitted drug resistance from mother to child will be assessed using residual samples from the early infant diagnosis program. This program keeps samples collected from six weeks after delivery. Activities shall include protocol development, and data abstraction from medical records.

Activity 3: Incidence surveillance
Incidence surveillance using laboratory Assays in Malawi starts in 2009 in Malawi and is using samples collected as part of Demographic and Health Surveys in 2004, and in Behavioral and biological surveys conducted in 2006 among high risk populations. DHS will be repeated in 2009 and next BSS is scheduled for 2010. These samples will be tested for incidence monitoring in 2010.

Activity 4: Internet and network connections
Epidemiology unit collects surveillance data from health facilities on selected priority diseases including HIV/AIDS. For the unit to provide timely information and response there is need to have up to date communication facilities and equipments. Currently the unit is not connected to internet or any network that facilitates transfer of data between offices. In this proposal we plan to connect internet and network facilities within Epidemiology unit.

Activity 5: Basic Epidemiology Training
In the 2009 financial year we are introducing basic training in Epidemiology in order to strengthen surveillance skills. This program will continue in the year 2010 to send MOH staff members for short courses.

Central Monitoring and Evaluation Division ($100,000)
The Central Monitoring and Evaluation Division which falls under Department of Planning and Policy Development is responsible for coordinating the overall Health Management Information System (HMIS) in MOH. This HMIS is guided by the principles of integration of all routine information systems, decentralization in information generation and use, and provision of information for action which is simple to establish and maintain.

The integrated HMIS is designed to provide program managers and staff with reports on how well each program is functioning and to alert the service providers and program managers to take timely necessary corrective actions. In the FY10, CMED will collect and analyze GIS data, support the roll out of electronic data systems for ART clinics, engage with stakeholders on security, data exchange and interoperability of health information and install the data repository server.

Activity 1: Capacity Building in GIS data analysis
In Year 1 CMED will collect GIS data for health facilities including ART clinics in order to update the existing information that was last collected in 2003. The GIS Training workshop for district HMIS officers will serve as a capacity building platform for local use and information gathering for the zone and national level. Subsequent GIS data analyses will use GOM ORT funding.

Activity 2: Support Electronic Data System of the HMIS
CMED will continue to provide policy leadership on data collection including the functioning of EDS operated by Baobab Health, Luke International Norway, and MSF among others so that they are in line with the HIS Policy and Strategy. This will be achieved through:
• Supervision of installation and functioning of the EDS
• Supervision of on job training for Health Care Workers in implementation of the EDS at facility level

Activity 3: Implementation of National Data Standards
• Support to CMED for the implementation of National Data Standards involves:
• Consensus building on issues of National Data Standards Technical Working Group;
• Disseminate knowledge and experience sharing at International Data Standards forums;
• Annual review meeting to review changing technical knowledge.

Activity 4: Establishment and maintenance of the Central Data Repository Server
The support for EDS and roll out of the web-based DHIS will require the procurement of data warehousing facility at the national level. This will benefit from the continuous process of instituting a platform for the national data standards and will in FY0 involve:
• Reviewing technical specifications for the DRS
• On-the-job training (OJT) in Central Data Repository Server for CMED staff and zone M&E officers

With Year 2 PEPFAR funds the previous activities will be continued, and the following activities will be implemented:

Activity 5: Update tools for forecasting and quantification of commodities and other supplies

Activity 6: Train health workers, statistical clerks and M&E officers on the newly developed/updated data collection tools

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	70,000	

Narrative:

HVOP - $70,000 (Department for HIV and AIDS)

With the renewed emphasis on increasing sustainability of national ART programs, it is imperative that all HIV services have integrated HIV prevention activities which are practical and feasible for the country context, and which more completely address the issue of reducing multiple concurrent partnerships among other risky behaviors. Prevention is also important for those on ART, to minimize the likelihood of contracting or transmitting potentially resistant strains of HIV to partners.

A reduction in incidence of new HIV infections will be achieved through combination prevention encompassing prevention counseling, ART as prevention, PMTCT, BCC, condom promotion, distribution and use, male circumcision and prevention with positives. This will be done through developing a Prevention-with-Positives (PwP) strategy applicable to both clinical and community settings, and identifying health facilities and communities for implementation in a phased-in approach.

Activities will include:
• Identify feasible and practical Prevention-with-Positives (PwP) activities to be integrated with clinical HIV services including the new pre-ART program
• Produce IEC materials for all prevention strategies
• Conduct zonal awareness raising workshops with stakeholders including NGO's and PLWHA support groups
• Develop and implement guidelines for prevention activities in collaboration with the National AIDS Commission and the Office of the President and Cabinet

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	1,100,000	

Narrative:

1. PMTCT Budget Code ($1,100,000.00)

PMTCT services have scaled-up very rapidly since 2007, from less than 25% of Maternal and Child

Health (MCH) sites offering PMTCT services at the start of 2007, to 77% of MCH sites offering PMTCT by September 2008. The scale-up will continue with an increasing focus on improving the quality of PMTCT services, improving coverage and the choice of prophylaxis regimens used nationally, strengthening systems for the identification and follow-up of HIV-exposed infants and their mothers, and increasing access to infant diagnosis and referral for ART.

Activities for FY09 which will be continued in FY2010 include:

Activity 1: Strengthen district capacity to provide PMTCT services, and to sensitize communites on PMTCT

• Organize national co-ordination meetings
• Support districts to develop male friendly services in order to increase couple counseling, disclosure of HIV positive results and support for these women when they receive results together with their spouses
• Develop and implement a community PMTCT strategy to increase access to HIV prevention, care and treatment by HIV positive women, men and children through developing community support structures such as support groups

Activity 2: Increase the capacity of health workers to provide PMTCT services

• Finalize, print and implement ANC, Labour and Delivery and Postnatal Care Pre- and Post Counseling and Testing Tools and improve the skills of health workers in providing this service
• Conduct PMTCT training to increase the number of health facilities offering PMTCT services
• Orient Health Surveillance Assistants (HSAs) who provide HTC for pregnant women and who work in under-five clinics on PMTCT to improve the quality or pre-test group education, individual pre and post-test testing and counseling and identification of HIV exposed infants respectively
• Train health care workers in early infant diagnosis to increase access for universal ART for HIV infected infants

Activity 3: Improve the access to and quality of PMTCT services provided

• Provide job aids to help health care workers to improve the quality PMTCT service provision inclusive of giving appointments to pregnant women for return visits to health facilities
• Consolidate and sustain quality of PMTCT services in public, CHAM and private health facilities providing at least one MCH services through building the capacity of zones and PMTCT Coordinators to manage and provide regular supportive supervision of staff providing PMTCT services
• Develop, print and disseminate Psychosocial Support Guidelines to encourage women to appreciate the importance of the knowing their HIV status for early access to CPT and ART as needed
• Increase the number of pregnant women receiving a complete course of ARV prophylaxis
• Train PMTCT service providers to roll out combination regimen

• Revise and print the PMTCT Training Package to make it up-to-date
• Orient health care workers on the use of newly developed ANC and Maternity Registers to improve the quality of data recording and reporting

Activity 4: Improve the linkages, referrals and follow-up for all HIV-positive pregnant women
• Develop sustainable referral system for HIV positive pregnant women between PMTCT, HCT, ART, STI and TB services, including linking the mother's status to baby
• Support development of Postnatal Care and Follow Up to improve management of HIV positive mothers and their infants/children

Activity 5: Strengthen infant follow-up and care
• Roll out 'Family HIV Care Clinics': Integrate follow-up clinics for HIV exposed infants with the new national pre-ART program
• Increase the proportion of HIV-exposed infants starting on CPT from six weeks of age
• Increase the proportion of HIV-exposed infants accessing PCR testing from 6 weeks of age
• Support the diagnostic department to increase laboratory capacity in DBS processing
• Develop the a sustainable CD4 and DBS sample transportation
• Procure hemacule machines and cuvettes
• Support the central medical stores to to develop a sustainable storage mechanism for early infant diagnosis supplies
• Support development and printing of Under-five and Follow Up registers, patient cards and revision of the child health passport to include HIV information
• Conduct basic program evaluation to inform best practices and decision-making in mother-baby follow-up

Activity 6: Supporting rapid dissemination of new guidelines to PMTCT Providers ($50,000)
• Finalize on the new PMTCT guidelines
• Print the guidelines
• Disseminate the guidelines through successive trainings of PMTCT ToT's at zonal level

Activity 7: Training of nurses and other providers at ANC sites in provision of ART ($400,000)
• Train nurses in ANC to provide ART in a continued effort to decentralize ART and to minimize loss-to-follow up of pregnant women eligible for ART

Activity 8: Decentralization of pediatric treatment and scale-up of pediatric Cotrimoxazole ($100,000)
• Train PMTCT and under-5 clinic providers in early infant follow up for exposed infants, including DNA-PCR testing, provision of CPT from six weeks of age, and strengthened referrals for children presumed

positive in sites where DNA-PCR diagnosis is not available

Activity 9: Monitoring national Indicators ($150,000)
• Printing of revised PMTCT registers
• Finalization of the under-5 register to include a component on screening for HIV-exposed infants
• Printing of the under-5 register
• Development of a register to follow HIV-exposed infants if not adequately included in the pre-ART tools
• Printing of HIV-exposed infant register
• Training of providers in revised registers

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HLAB	150,000	

Narrative:

HLAB - $150,000
(CHSU lab $50,000; Diagnostics $100,000)

In 2010 the National Reference Laboratory and the Diagnostics Unit will continue the activities initiated with FY09 funding. The emphasis in on improving the quality of services provided by the labs nationally, increasing the lab capacity at sites, including the equipment available and the technicians trained to utilize the lab.

1. Provide national quality assurance for all surveillance and laboratory-based activities in support of the diagnosis, treatment, and care of HIV/AIDS

2. Conduct training for Central Reference Lab Technologist on EQA management

3. Procure essential supplies and equipments

4. Enhance program for quality assurance of CD4, viral load, biochemical and hematological tests for monitoring HIV and AIDS patients on treatment

5. Undertake orientation of supervisors on EQA activities

6. Provide corrective actions to underperforming sites

7. Support regular maintenance of equipment at CHSU

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Treatment	HVTB	400,000	

Narrative:

HVTB - $400,000 (Department for HIV and AIDS & NTP)
(Department for HIV and AIDS $200,000; NTP $200,000)

As in other Sub-Saharan African countries, Malawi faces the challenge of dual epidemic of HIV and TB. The high HIV prevalence in Malawi (12% among adults) has also fueled the TB epidemic and has lead to a five-fold increase in the reported TB cases from around 5,000 cases in 1885 to 27,000 cases in 2007. HIV prevalence among TB patients is 70%. Because of the high TB/HIV co-morbidity, it is crucial that the integration of TB/HIV activities be strengthened at all levels and across all services in the health care system.

Malawi has been in the forefront in the global TB/HIV response. Several models of integrated TB/HIV activities have been piloted by lighthouse, MSF, and TBCAP, however these activities have not been rolled out nationally. NTP in collaboration with the Department for HIV and AIDS will address these critical gaps in the implementation of integrated TB/HIV activities, with the goal of reducing the dual burden of TB and HIV through provision of universal access to integrated TB/HIV prevention, treatment care and support services.

With the support of previous PEPFAR funding, NTP and department of HIV/AIDS had planned to nationally roll out the integrated package of TB/HIV services. This roll out would be coordinated with other partners like TBCAP, Dignitas, MSF or Lighthouse supporting TB/HIV activities and other funding sources like the Global Fund. Routine provider initiated HIV testing and counseling and referral to ART services will be a standard package of care for all TB patients. Within the same comprehensive care approach, patients on ART are screened for TB using a standard checklist at every visit and referred to TB clinic if TB is evident or suspected. Similarly all HIV positive clients identified at a co-located HTC center are screened for TB using a standard checklist and referred for TB services if responses meet a set of predetermined criteria. These interventions are expected to reduce the burden of TB in HIV patients and the burden of HIV in patients. USG funding would also support monitor the implementation of TB/HIV activities through quarterly supervision and regular review meetings.

The PFIP Year 2 funds would continue to support to expand the geographic coverage of TB/HIV activities with a focus on the following activities. The activities would be coordinated with activities supported by the other funding resources to avoid duplication and to ensure that it compliments the existing resources and support.

1. Support national roll out of TB/HIV activities

National TB/HIV sub-group would continue to be supported to coordinate TB/HIV activities at the national level. Zonal and district health management teams would be sensitized on TB/HIV integration to ensure that these activities are incorporated into the district implementation plans. The FY10 funds would also be used to train of all ART and HTC staff in TB screening, diagnostic evaluation and TB infection control.

2. Integrate provision of ART in TB registration sites

Though there has been a great progress made with HIV testing among TB patients, uptake of ART among HIV-infected TB patients is very low. Improving uptake of ART among HIV-infected TB patients would be one of the priority areas. In addition to improving referral and linkages between TB registration sites and ART clinics, provision of ART at selected TB registration sites will be piloted at selected sites and rolled out to additional clinics.

3. TB infection control

Zonal and district level quality improvements teams would be trained in TB infection control. These quality improvement teams are expected to assist the facilities to implement TB infection practices through resources available under Global Fund round 7. TB infection control job aids like cough posters and triage poster would also be developed and made available at all the TB and HIV clinics.

4. Strengthen monitoring and supervision of TB/HIV activities:

Quarterly joint supervision by the national and zonal TB and HIV staff as well quarterly review meetings to monitor implementation of TB/HIV activities would be supported. An evaluation of the revised TB recording and reporting system would also be supported to assess quality of data.

5. Build capacity in pediatric TB/HIV integrated activities:

NTP would partner with Baylor Pediatric Center to build capacity to address TB/HIV issues in the pediatric population.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12112	**Mechanism Name: MCHIP (Maternal and Child Health Integrated Project)**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: JHPIEGO	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,710,087	
Funding Source	**Funding Amount**
GHCS (State)	1,710,087

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Maternal and Child Health Integrated Project (M-CHIP) is a global program whose vision is to accelerate the reduction of maternal, newborn, and child mortality in 20 priority countries by increasing the use of a focused set of high impact maternal, newborn and child health (MNCH) interventions that address the major causes of death among mothers, newborns and children under five. Delivery strategies will address barriers to access and use of these interventions along a MNCH continuum of care that links households, communities, first-level facilities, and hospitals. One of the overarching goals of the MCHIP Program is to contribute to the reduction of both the under 5 mortality rate and maternal mortality ratio (MMR) by 25 percent in the 20 high mortality-burden countries.

In Malawi, MCHIP is implementing a household to hospital continuum of care model in maternal and newborn health in four focus districts: Rumphi, Nkhotakota, Machinga and Phalombe. The HHCC comprises of a set of proven, evidence-based interventions focused on facility and community activities and include improving providers' skills to deliver Basic Emergency Obstetric and Newborn Care (BEmONC), improving the quality of care in facilities, and establishing Kangaroo Mother-Care (KMC), community maternal and newborn health (CMNH) and community mobilization (CM). Nationally, MCHIP is scaling up the quality improvement initiative in reproductive health to cover all district and central hospitals.

Traditionally, in Malawi PMTCT has been implemented using a vertical approach to current reproductive

health (RH) initiatives resulting in a missed opportunity to strengthen the continuum of care for women and children. Being one of the main RH partners in Malawi, and through PEPFAR support, MCHIP's goal will be to strengthen and improve the quality of PMTCT integration into reproductive health (RH) and family planning with a key focus on improving HIV care and treatment, and mother-infant pair follow-up. M-CHIP will focus on the 8 interrelated activities which are described in more detail under the PMTCT budget code narrative below.

• Supportive mentorship in the Central East Zone and selected districts
• Introduce the Standards Based Management and Recognition approach for performance and quality improvement (PQI) throughout the PMTCT continuum of care.
• Results-based financing for PMTCT and maternal and neonatal health
• Training of HSAs in Central East and Northern Zones in PMTCT-follow-up
• Strengthen integration of PMTCT and Family Planning
• Procurement of the Hygiene Package for HIV+ pregnant and lactating women
• Conduct retrospective analysis of maternal deaths linked to HIV.
• Capacity building of the central eastern zonal health office and select district health offices to improve data utilization and reporting for PMTCT.

Cross-Cutting Budget Attribution(s)

Water	250,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12112**		
Mechanism Name:	**MCHIP (Maternal and Child Health Integrated Project)**		
Prime Partner Name:	**JHPIEGO**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	MTCT	1,710,087	
Narrative:			

PMTCT Budget 1,710,087.00)
Activity 1: Supportive mentorship in the Central East Zone and selected districts

MCHIP mentorship activities will focus on supporting the Central East Zonal Health Office. M-CHIP will mentor and support ZHOs and DHOs to build their capacity to supervise, plan, and to help PMTCT sites develop and implement systems for better managing patient care and data flow. Sites will be supported to provide a comprehensive package of PMTCT services for mothers and children, including strengthening linkages and referrals between HIV care and treatment services and PMTCT. These efforts are part of a broader zonal quality improvement initiative, in which, under MOH leadership, M-CHIP will collaborate with 4 other USG partners who are supporting the other 4 zones and share best practices to improve the quality of PMTCT services with one another. MCHIP will also provide more intensive support to specific districts of Nkhota-Khota and Rumphi where MCHIP is already working on reproductive health and child survival activities, as well as to two new districts, Ntchisi and Likoma Island, which currently lack partner support for PMTCT.

Activity 2: Introduce the Standards Based Management and Recognition approach for performance and quality improvement (PQI) throughout the PMTCT continuum of care.

MCHIP will build on existing MoH-adopted standards on RH that include areas of PMTCT to support the MoH to develop specific PMTCT standards covering the continuum of care from antenatal, delivery and through to the postpartum period. The SBM-R methodology utilizes operational, observable performance standards that are linked to a scoring system which will enable partners and the Ministry of Health to numerically measure quality of care at every PMTCT site. At Nkhotakota and Rumphi where the program is already working, MCHIP will introduce and refine SBM-R through on-site training and coaching of the PMTCT providers in the spring of FY10. M-CHIP will then share the refined SBM-R approach for PMTCT with the other zonal mentoring partners and provide them with TA so that they can support the MOH to implement a standardized PQI process nationally.

Activity 3: Results-based financing for PMTCT and maternal and neonatal health

MCHIP will work closely with the MoH and German and Norwegian government currently developing a holistic system for implementing results based financing (RBF) in the health sector of Malawi. RBF consultants recently identified the PQI interventions used by Jhpiego/MCHIP as a platform for introducing RBF at the facility level. With PEPFAR funding, MCHIP will leverage this new partnership to also develop a system for recognizing and awarding PMTCT sites that reach accreditation and meet pre-determined targets for increasing the number of eligible pregnant women initiated on ART and the

number of skilled birth attended deliveries. Support may also be provided to incentivize staff such as nurses who work on weekends to initiate more pregnant and lactating women on ART. This support complements other USG MCH funding being provided to MCHIP for RBF. M-CHIP's subpartner Broad Branch with expertise in RBF will be engaged in this activity. Specific approaches will be worked out in the spring of 2010 in consultation with the MOH and other donors.

Activity 4: Training of HSAs in Central East and Northern Zones in PMTCT-follow-up

USG partners have worked with the MOH to develop a model for the implementation of MIP follow up at three sites in Phalombe District. This model, which had its origin through the PEPFAR HQ PMTCT/peds TWG initiated integration program, is based on the identification of a PMTCT coordinator at facility level, typically a Health Surveillance Assistant (HSA), who is responsible for tracking mother-infant pairs over time, the use of a register which facilitates tracking of MIP's, the implementation of a screening process to ensure that MIP's are assessed clinically during each visit, and the implementation of IYCF counseling every time a MIP visits the facility. M-CHIP will provide training and the in-service orientation of HSAs and other staff to this model at PMTCT sites in Rumphi, Nkhotakota, Ntchisi and Likoma Island. The emphasis will be on on-site training to reduce costs.

Activity 5: Strengthen integration of PMTCT and Family Planning

In order to build on the theme of increasing capacity for quality PMTCT services in reproductive health, MCHIP proposes to strengthen the family planning (FP) component of all PMTCT and HIV Testing and Counselling (HTC) service delivery points. As per Activity 1, FP will be a strong component of the PMTCT standards that will be developed and therefore FP will need to be well integrated into PMTCT clinical practice in order for a site to receive PMTCT accreditation. As part of the Malawi integration strategy, MCHIP will review and update the STI and Cervical Cancer Prevention (CECAP) components of the current Reproductive Health Standards to integrate HTC and FP into STI and CECAP service provision. Inclusive in the trainings will be an emphasis on HTC for couples and FP counselling which will provide increased prevention benefit for the couple rather than just the individual client. MCHIP will provide follow-up support in the form of supervision and quality assurance assessments using the integrated reproductive health standards assessment tool. MCHIP will share these tools and best practices with the other 4 zonal mentoring partners, and provide technical assistance to help them support their respective ZHOs and DHOs to include family planning integration as part of the PMTCT PQI process. M-CHIP will also collaborate with the Safeguard the Household in these efforts, the other USG-funded partner with strong expertise in family planning and HIV integration.

Activity 6: Procurement of the Hygiene Package for HIV+ pregnant and lactating women
USG-supported program evaluation in Malawi has shown that the free provision of water purification materials (PuR) and a bucket, along with IEC materials, significantly increases health service utilization by women attending maternal health clinics, and also decreases incidence of diarrheal disease. M-CHIP's partner PSI will procure the hygiene package and work with the USG partners in each district and zone to ensure that it is provided to sites and utilized correctly. The intent is to scale up this hygiene package nationally serving all HIV+ women identified in ANC settings. At a cost of ~$5 per household, M-CHIP will procure adequate supplies for one year for the households of all HIV+ women identified in PMTCT settings in Malawi outside of the Central West Zone. (Note that because Proctor and Gamble is donating these packages for the Central West Zone as part of the Safeguard the Household Project, M-CHIP will only provide these hygiene packages for sites in the other four zones.) This will also promote male involvement, increase antenatal attendance beyond the first visit and promote couple counseling and testing. Refills of soap, ORS and Zinc will be given to the couple for every subsequent ANC visit, delivery at the health facility, and postnatal visit.

Activity 7: Conduct retrospective analysis of maternal deaths linked to HIV.

Although maternal death audits are supposed to occur at the community level as well as the facility level, no standardized community-based maternal death audit form exists. MCHIP will lead in the development of a community maternal death audit form and orient HSAs to conduct the death audits using the developed tool. MCHIP, in cooperation with other partners, will then conduct a retrospective review of all maternal deaths in at least 3 districts from 2010-2011 at both the facility and community levels highlighting the proportion of maternal deaths occurring for HIV-positive women and HIV-negative women, and the causes of maternal death in each subgroup. These finding will be utilized to better inform programming aimed at reducing maternal mortality in Malawi.

ACTIVITY 8: CAPACITY BUILDING TO IMPROVE DATA UTILIZATION AND REPORTING
M-CHIP staff will work side by side with central east zonal staff and district health staff to build their capacity to interpret and use data to improve programs and enable them to be able to better report to the MOH on the national level what they have accomplished. M-CHIP will then report to PEPFAR how its efforts have helped the CE zone and the districts of Rumphi, Nkhota-Khota, Ntchisi, and Likoma Island to contribute to national PMTCT targets. A select number of high volume sites in these districts will receive intensive support from M-CHIP and in these cases their targets will be categorized as directly supported by PEPFAR.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12113	**Mechanism Name: Path**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Pathfinder Outreach Ministry	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 300,000	
Funding Source	**Funding Amount**
GHCS (State)	300,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The goal of this activity is to improve child growth, health and nutritional status, HIV-free survival of infants and young children, and maternal nutrition, PATH/IYCN will provide technical assistance to the OPC and the Ministry of Health to harness and strengthen the capacity of community agents and local government structures at the community level to plan and implement integrated nutrition and HIV activities. IYCN will provide technical assistance to condense lessons learned from the I-LIFE/WALA, BASICS and CHAM programs, the IYCN/Bunda College IYCF study, and IYCN's similar experiences in other countries, like Zambia and Côte d'Ivoire, to develop a comprehensive community nutrition package implemented by Community Motivators in Malawi. IYCN will also provide assistance for the training of community motivators and supervisors in one focus district (tentatively Mulanje), monitoring and evaluation of the pilot implementation, and implementation planning for national scale up. Additionally, PEPFAR partners will be supported to design and implement activities on infant feeding within the context of HIV. Initial activities will include support to the OPC to facilitate a stakeholders' workshop to develop an IYCF operational strategy which will identify national priorities over a specified time period and technical approaches for addressing each of the priorities. This activity is joint-funded by MCH nutrition resources and PEPFAR resources at a ration of 1:1.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	300,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12113**		
Mechanism Name:	**Path**		
Prime Partner Name:	**Pathfinder Outreach Ministry**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	MTCT	300,000	

Narrative:

1. PMTCT Budget Code ($300,000.00)

Project Objective 1
Activity 1: Improve enabling environment for IYCF programs
Support the OPC and MoH to develop IYCF operational strategy: IYCN will conduct a series of consultative meetings with the OPC, Nutrition Department, the MoH, and key members of the IYCF Technical Working Group (TWG) to draft a national IYCF operational strategy for the implementation of the National IYCF Policy. To inform these consultations, IYCN will compile information from the recent Demographic Health Survey (DHS), the UNICEF Multiple Indicator Cluster Survey (MICS) and the Micronutrient Survey, results of studies on nutrition and IYCF, and lessons learned from the ILIFE, BASICS, and other projects and programs in Malawi and other countries in the region. These consultations will culminate in a two-day stakeholders' workshop, facilitated by IYCN, to finalize the strategy. The strategy will identify, in accordance with the national policy, priority areas and targets to support infant and young child growth and to improve nutritional status, HIV-free survival, and maternal nutrition.
Activity 2: Develop operational guidelines, training curricula, job aids and IEC materials for community–based IYCF and HIV services: Guided by the priority areas and targets of the IYCF operational strategy, IYCN will work with the OPC to produce the technical supports required for operating a community-based nutrition and HIV support program. Operational guidelines and a detailed implementation plan will be developed to standardize activities at all levels of the program and guide management. Training curricula,

based on similar curricula IYCN has created for other country programs, will be produced for community motivator, supervisor, and local authority trainings. The training curricula used for lay cadres within PMTCT settings will also be reviewed and updated to reflect best practices, and if possible, combined with the training curricula being used for lay cadres within PMTC T settings so as to prevent duplication. Job aids and IEC materials will be developed in a two-stage process. First, IYCN will conduct an inventory and assessment of existing educational and counseling materials related to IYCF and HIV services. To the extent possible, IYCN will use these materials to develop standardized messages and counseling materials to support the new program, producing new materials only to fill gaps identified from the assessment of existing materials. Findings from the recently completed IYCN/Bunda College IYCF Study will inform the BCC/IEC material creation process. All materials will be context and target specific and pre-tested to ensure their suitability for communities.
Activity 3: Develop and Implement a Monitoring and Evaluation Strategy: Working from and with the OPC, IYCN will oversee the monitoring of field activities. A detailed M&E plan will be developed describing indicators and targets, and emphasizing management responses based on monitoring data. Key monitoring indicators will include: coverage (contacts with caregivers and services provided); infant and young child growth and nutritional status; pregnancies and known HIV status; ARV adherence; and referrals to health, HIV and food security services. Monitoring activities will incorporate a new initiative utilizing mobile telephone text messages for timely reporting of monitoring data and quicker response time for management response. Through quarterly joint review and planning meetings IYCN will coordinate stakeholders, including the Ministry of Health, local authorities, WALA, BASICS and USAID partners to assess progress and plan activities for the next period.
Activity 4: Support OPC to develop a national scale-up plan for supporting improved community-based : During the final months of the funding period, IYCN and OPC will develop a detailed implementation plan for national scale-up of the Community Motivator program, including through utilizing already existing community The plan will address human resources and training (including infrastructure for training, refresher training, and training for turnover vacancies), management, materials development, budget at national and local levels, and monitoring and evaluation.

Project Objective 2: Improve Provider Performance
Activity 1: Build capacity of community nutrition and HIV motivators: IYCN will provide technical assistance to the OPC and the Ministry of Local Government to train up to 10 trainers, 300 community nutrition motivators and 30 supervisors within the first project year. [OPC will be responsible to recruit trainers, agents and supervisors.] Trainers, who will be trained first, will in turn train community motivators and supervisors with technical assistance and support from IYCN. Working in OPC-designated but peripheral training sites, IYCN will provide training materials and communications tools. OPC will manage transport, per diem, sitting fees, etc. for trainees. All training activities will rely on best practices for adult learning, with extensive practicum to build experience with IYCN developed tools for

managing program logistics (e.g., participant registers), nutritional assessment and counseling, and monitoring and supervision. Close partnership will be sought with BASICS, WALA and CHAM in a bid to increase coverage of trained community motivators—for example by including current community agents from these projects in the training. To ensure sustainability of community training programs IYCN will coordinate activities closely with institutions such as Bunda Agricultural College, Natural Resources Centre and Magomero Training College.

Activity 2: Build capacity of local authority representatives: IYCN will work with the OPC to assist local government teams to develop a follow up plan which will include integration of community nutrition and HIV activities into local government plans and budget. Experience from IYCN's on going work with local government authorities in South Africa will inform this process.

Activity 3: Provide support to PEPFAR partners to design and implement infant feeding within the context of HIV

In addition IYCN will provide technical assistance to PEPFAR partners to design and implement activities on infant feeding within the context of HIV/PMTCT. This includes both partners implementing community-based support activities for PMTCT, such as Baylor, PACT, CHAM, and MSH, as well as partners providing facility-based support for PMTCT as part of the zonal mentoring and quality improvement initiative. Standardized approaches to supervision of IYCF activities on the facility-level will be also be developed and shared with these partners and the zonal and district health offices that they support, so that IYCN will be mainstreamed within the broader QI activities at facility level.

Activity 4: Mentoring of Supervisors:

Effective supportive supervision is an important factor in the success of community-based programs. In addition to producing guidance for supervision in the operational guidelines, and monitoring formats to highlight the key aspects of a supervision visit, IYCN staff will routinely accompany supervisors to mentor them in supervision techniques. To the degree that time permits, IYCN will also mentor supervisors of other lay cadres being employed in PMTCT (i.e. Baylor, M2M, MSH, PACT partners) to build their capacity to ensure that the community-based workers employed under these platforms are providing high quality support for infant and young child feeding in the context of HIV. Staff from the OPC will perform this function in later years as the project expands beyond the pilot phase.

Project Objective 3: Increase community and household support

Activity 1: Provide technical support for a pilot household and family centered program for nutrition and HIV support: Trained CM will be equipped to implement a package of IYCF activities which will focus on behavior change prior to the development of malnutrition rather than its detection and treatment after the fact, and on preventing HIV infection through breastfeeding. In collaboration with USAID and the OPC, IYCN will select one project district for the first year of implementation, determine coverage, and establish targets. The package will include the following:

- CMs will conduct nutritional assessments of women and children and counsel women on maternal nutrition and recommended infant and young child feeding and caring practices applying interpersonal

communication, negotiation, and participatory skills using job aids.
- CMs will conduct activities to enhance early identification of growth faltering (prior to the development of malnutrition). Activities will include: discussion with caregivers of growth faltering infants/children to determine current feeding practices; tailored counseling and negotiated behavior change for improved maternal diet, infant and young child feeding and caring practices; activities to reduce identified barriers to optimal nutrition practices; and home-based follow-up for mothers and children at risk. CMs also will involve traditional healers to ensure that they are providing correct messages and referring caregivers to services.
- CMs will implement activities to improve complementary feeding, such as identifying local complementary foods, assessing their nutritional value, and developing recipes that can be taught to mothers through participatory food preparation sessions in the community.
- CMs will guide pregnant women and caregivers to utilize HIV-related activities ensuring a standardized continuum of care for mothers, even as they move from one service type to another during pregnancy, delivery and lactation, emphasizing self-care, ARV adherence, and social support.
- The package additionally will target influential community groups (males, grandmothers) to build support for program activities, and strengthen linkages with food security, sanitation, livelihood, and health programs. Local government programs such as local authority planning, agricultural extension, women and development, and education will be consulted to harness their strengths in the program.
The implementation design will ensure adequate coverage for households, with no more than 20 eligible households served by a community motivator. Since effective supportive supervision is an essential element in the success of community-based programs, one supervisor will be responsible for no more than ten community motivators. Existing community local government structures will be supported to integrate the planning and implementation of these activities. Involving the local government structures will ensure that nutrition programs are managed in a more sustainable manner. The package will include: standardized behavioral change communications materials; training curricula and manuals; roles and responsibilities of local government, health and agricultural authorities; and implementation plans.
GENDER
PATH/IYCN will draw upon its experience working with men's groups and grandmothers' projects in other countries to develop and strengthen approaches that galvanize communities to address harmful gender norms and stigmatizing attitudes that can affect infant feeding choices and maternal nutrition. IYCN will ensure that gender concerns, including HIV-related stigma and discrimination against women and male participation, are integrated into facility and community-based activities. The aim will be to promote healthy practices and to highlight innovative approaches for engaging families and communities in transforming harmful stereotypes and stigmatizing attitudes, all of which increase vulnerability to illness and violence. IYCN will specifically ensure that training addresses the specific cultural and social barriers that female caregivers face in accessing community and government services and support for themselves and their children.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12114	**Mechanism Name: TBD/CDC/PHE**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Grant
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

In FY11, PEPFAR Malawi will explore monitoring early population-based PMTCT effectiveness through an approach similar to what has been used in South Africa and elsewhere in which routine rapid testing of infants at the 4-6 weeks immunization visit is linked to EID for those with positive rapid tests. As the new longitudinal PMTCT and postnatal follow-up registers and pre-ART tools are widely implemented, these will also be used to evaluate the PMTCT program using a cohort approach as well. However, to comprehensively attempt to measure the effectiveness of the national PMTCT program, PEPFAR Malawi proposes to support an evaluation along the lines of the PEARL study which incorporates both the population-based and longitudinal components. A baseline would be done in September 2010, once the new registers have been implemented nationally, and then one year later the evaluation would be done to look at the effectiveness after a full year of implementation. PEPFAR Malawi would like to discuss further with HQ, but has tentatively budgeted funding for this activity. The evaluation would not attempt to directly estimate HIV-free survival by surveys however, as this would be too costly, but rather only model it based upon the number of women on ART, reported infant feeding practices, etc.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12114**		
Mechanism Name:	**TBD/CDC/PHE**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	MTCT	Redacted	Redacted

Narrative:

BUDGET – Redacted

EVALUATION OF PMTCT EFFECTIVENESS

In FY11, PEPFAR Malawi will explore monitoring early population-based PMTCT effectiveness through an approach similar to what has been used in South Africa and elsewhere in which routine rapid testing of infants at the 4-6 weeks immunization visit is linked to EID for those with positive rapid tests. As the new longitudinal PMTCT and postnatal follow-up registers and pre-ART tools are widely implemented, these will also be used to evaluate the PMTCT program using a cohort approach as well. However, to comprehensively attempt to measure the effectiveness of the national PMTCT program, PEPFAR Malawi proposes to support an evaluation along the lines of the PEARL study which incorporates both the population-based and longitudinal components. A baseline would be done in September 2010, once the new registers have been implemented nationally, and then one year later the evaluation would be done to look at the effectiveness after a full year of implementation. PEPFAR Malawi would like to discuss further with HQ, but has tentatively budgeted funding for this activity. The evaluation would not attempt to directly estimate HIV-free survival by surveys however, as this would be too costly, but rather only model it based upon the number of women on ART, reported infant feeding practices, etc.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12115	Mechanism Name: DOD/GHAI
Funding Agency: U.S. Department of Defense	Procurement Type: Grant
Prime Partner Name: Project Concern International	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Introduction. Project Concern International (PCI) is a non-profit health and development organization committed to preventing disease, improving community health, and promoting sustainable development. In its 48th year, PCI is presently serving over 4.5 million people annually through programs in 15 countries in the Americas, Asia and Africa.

PCI's global work in HIV/AIDS spans the range of prevention, care and support in countries representing every stage of the pandemic, from emerging to advanced epidemics. PCI's HIV/AIDS work emphasizes building lasting local capacity to design, deliver and scale-up high quality HIV/AIDS programs.

Comprehensive Goals and Objectives. The overarching goal of PCI's partnership with the Malawi Defense Force (MDF) is to engage leadership in strengthening MDF's existing approaches to reducing HIV prevalence among armed forces personnel and their partners. In FY 2010, PCI will support this goal through technical assistance for holistic, integrated initiatives along the continuum of care, with a specific focus on systems strengthening by fostering MDF ownership of an effective response.

Integration with Partnership Framework. PCI and the Malawi Defense Force collaborate to implement evidence-based strategies in support of the Five Year Benchmarks of Malawi's Partnership Framework, the goals of the global PEPFAR program and the initiatives of Malawi's National Action Framework. In FY 2010, linkages to these benchmarks will include: fostering institutional capacity building through leadership development among senior commanders, endorsing an MDF-driven comprehensive HIV/AIDS response; developing and implementing military-specific behavior change initiatives that contribute to sustained risk reduction and prevention of HIV among soldiers, their partners and young people; strengthening of health and social welfare systems that provide care and support for affected individuals, families and communities; and, expansion of programs that mitigate the health, economic and

psychosocial impacts of HIV/AIDS with emphasis on orphans and vulnerable children.
Geographic Coverage and Target Population. The described collaboration targets the three geographic regions of Malawi, the sixteen military units therein, their respective uniformed populations with their families and, in many cases, the contiguous communities of civilians that interface with soldiers on a daily basis. The estimated size of the primary target population is 30,000 youth and adults, representing 15,000-20,000 soldiers and their dependents. A significant number of this primary target population is comprised of young people, both youthful soldiers themselves and dependent children of military families. Additional direct beneficiaries live in communities contiguous to the 16 military units, accounting for another 30,000 or more direct beneficiaries.
Strategy for Improved Efficiency. PCI sees an enormous opportunity to leverage the human and financial resources of the MDF with those of other stakeholders, including those of local government district assemblies which serve communities contiguous with military units. Sharing of limited resources and promises practices for prevention and care will enhance efficiency and effectiveness. PCI will support the MDF as they strengthen a multi-sectoral response that greatly impacts both military and civilian populations.
Cross-Cutting Attributions. In FY 2010, PCI will allocate funding to Human Resources for Health through ongoing leadership development among senior commanders ($19,200). Additionally, skills building in-service trainings will address the following: peer education for behavior change that promotes risk reduction ($7680); Prevention with Positives programs targeting sero-discordant couples ($5280); community care for OVC ($8800); increased uptake of counseling and testing through its integration with home-based care programs ($5280); and, promoting human capacity for expanded M&E programs at the field level for improved data management ($5280). PCI will additionally promote economic strengthening among youth in Edzi Toto Clubs ($4500) and among caregivers who provide support for orphaned children ($7,500). It is through these venues that PCI will provide technical assistance for the development of communal gardens to improve food and nutrition security for vulnerable populations.
Key Issues. Throughout all project activities, PCI will address gender equity and other behavioral norms among soldiers that contribute to gender-based violence (GBV) and coercive sex. Within PCI's Defense Force Leadership Program, commanders will confront issues of gender inequity and collective behaviors that contribute to heightened risk for HIV infection. As a result of strengthened institutional capacity, referral systems will evolve to effectively link soldiers and their spouses/partners to primary health services including family planning, maternal child health care and nutrition counseling and support.
Summary Monitoring and Evaluation Plans. The proposed program will have an impact both on military personnel and their family members, as well as the organizational capacity of the MDF to implement, monitor and evaluate HIV prevention programs. PCI will continue to use the Performance Monitoring Plan to track the project's expected results, illustrative indicators and targets. In addition to the core PEPFAR indicators for each technical area, PCI will report on process indicators for each activity, which will be included in reporting cycles as appropriate.

PFIP Year 1 Funding – $395,091
PFIP Year 2 Funding – $0

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12116	**Mechanism Name: ASGF/State for Ambassadors Small Grant for HIV/AIDS**
Funding Agency: U.S. Department of State/Bureau of African Affairs	Procurement Type: Cooperative Agreement
Prime Partner Name: ASFG/State	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 90,000	
Funding Source	**Funding Amount**
GHCS (State)	90,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Summary

Malawi launched the Ambassadors Small Grants Fund for HIV/AIDS (ASGF) through USAID with FY 2006 PEPFAR funds in August of 2007. The initiative is now run from State with a mandate to obtain greater USG complementarity with other DOS support. This initiative serves as an opportunity to engage small indigenous organizations the Malawi PEPFAR program may miss through its prime partners. The ASGF serves to address pressing interventions particularly for care and support to orphans and vulnerable children (OVC), and be active in hard to reach areas of the country such as Chitipa in the far North and Nsanje in the South.

Background

In FY 2006, ASGF PEPFAR funds were part of the USAID heath team budget, obligated under the FY 2006 SOAG but not implemented until FY 2007. All support and overhead costs were included in the $50,000, and in FY 2006, this was costed at approximately $7,000 for travel by applicants to Lilongwe for both financial and SI training, and for reimbursement of program funds. Forward funding of small CBOs and FBOs has proved to be disastrous in Malawi so grantees must first source funds for their activities, have mission verification, and then be reimbursed for implemented activities. This best practice though painful for
grantees, allows USG Malawi to minimize a high risk but potentially powerful method of saving lives.

In FY 2008, the HCT agreed that the burden on USAID was significant and the capability existed at State to move management of the program fully to the Department of State. The Public Affairs Officer is warranted to serve as the contracting officer for the small grants and agreed to assume fiscal oversight of the program. To provide ongoing oversight and support to grantees, where possible, we linked successful applicants to our larger prevention initiatives led by PACT, PSI, and Bridge as well as to future funding through the Global
Fund grants to NAC. The PEPFAR office at State monitors progress quarterly when reimbursement requests are satisfied. The management of this program requires additional support through a program assistant to the PEPFAR Coordinator, a request USG Malawi filled in August 2009.

In FY 2007, a call for proposals was announced and over 400 applications were received. More than 85% of applicants ignored the parameters of "HIV/AIDS Prevention" with over 50% of applicants seeking support to care for OVC. In FY 2008, we encouraged more proactively the types of interventions outlined here, by seeking out strong CBOs and FBOs through an expression of interest who are being mentored already by a larger NGO.

PFIP Year 1 Budget – $90,000
PFIP Year 2 Budget - $190,000

Cross-Cutting Budget Attribution(s)

Economic Strengthening	20,000

Key Issues

Increasing gender equity in HIV/AIDS activities and services
Family Planning

Budget Code Information

Mechanism ID:	**12116**		
Mechanism Name:	**ASGF/State for Ambassadors Small Grant for HIV/AIDS**		
Prime Partner Name:	**ASFG/State**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	90,000	

Narrative:

Activity 1: Call for Proposals:

This activity is a TBD and will be reprogrammed into the relevant program areas once the grants are awarded. Proposals to be funded in FY10 include
? Kasungu Teacher Training Colleges and network of teacher educators responding to HIV
? Promotion and advancement of the rights of adolescent mothers
? Palliative care support for pain management
? Water and sanitation support at the grass-roots level
? Micro-economic support through economic empowerment to PLHIV women
? Training for female condom use by NAPAM to increase access and use
? Support for vulnerable girls

? Using artistic Expression to curb the spread of AIDS

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12117	**Mechanism Name: HS20/20/GHAI**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Abt Associates	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 100,000	
Funding Source	**Funding Amount**
GHCS (State)	100,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Health Systems 20/20 project (HS 20/20) is a Leader with Associates Cooperative Agreement awarded by the U.S. Agency for International Development's (USAID) Global Health Bureau (GBH) for the period September 30, 2006 to September 29, 2011. The goal of HS 20/20 is to increase the use of priority population, health, and nutrition (PHN) services, especially by the disadvantaged. Towards this goal, it implements activities to improve health system performance in four key areas (1) health financing, (2) governance, (3) operations, and (4) local capacity. The project team brings together an exceptional pool of professionals with depth and experience in the project's results areas plus significant field presence and experience to link health system improvements to increased service access and use. Health system strengthening related to HIV/AIDS is a key element of the Partnership Framework (PF). HS20/20's has a commitment to country ownership and the development of local capacity in order to ensure sustainability of activities initiated under the agreement. Furthermore, HS 20/20 is dedicated to improving governance and financial management of HIV/AIDS related activities, two important components of the (PF).

The HS 20/20 vision for both strengthening health systems and making them more efficient over time

relies on the project's success in its core intervention areas, which include strengthening of financial systems, operations, and governance and building capacity. The project's results framework calls for improvements in these areas.

At its onset, HS 20/20 drafted a set of program indicators to benchmark its performance. These will be applied to each of the activities proposed for Malawi in order to both monitor and evaluate performance and create opportunities for learning. In addition, HS 20/20 will partner with MOH to collect information on the 2010 PFIP core indicator activities and report on targets that have been met. The data quality for program monitoring will be ensured through data validation exercises undertaken in conjunction with our implementing partners in MOH and USG staff. HS20/20 will also strengthen data feedback loops and dissemination mechanisms by working with our implementing partners in MOH to share infrastructure strengthening policies and health finance information widely among stakeholders as well as district, regional, and national level health system administrators and managers.

In FY10, HS 20/20 will support the Government of Malawi to conduct a National Health Accounts exercise, building on the results of a NASA exercise in 2009 supported by UNAIDS and a district health expenditure patterns study supported by UNICEF. It is anticipated that the full NHA will be financially supported not only by the USG through the HS 20/20 mechanism, but also by other donors is Malawi. The NHA will include sub-accounts for HIV, malaria, child health, and reproductive health. HS 20/20 will receive USG funding to support these activities from PEPFAR as well as from other non-PEPFAR sources (e.g. PMI, reproductive health, and child survival resources)

In FY11, the focus of activities will be to provide technical assistance to help Malawi build upon the NHA, institutionalize the process, and utilize the findings to improve national policies and systems. HS 20/20 will also provide technical assistance to Malawi to help develop an expenditure module for national health management information system, conduct a benefit Incidence Analysis (BIA) and Private Sector Assessment to complement the NHA, and build the capacity of Civil Society to meaningful participate in planning and oversight of health resources within the health sector.

FY09 Budget – $121,000
FY10 Budget – $500,000

Cross-Cutting Budget Attribution(s)

Human Resources for Health	100,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	12117		
Mechanism Name:	HS20/20/GHAI		
Prime Partner Name:	Abt Associates		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	100,000	

Narrative:

Activity 1: National Health Accounts Estimation)
In FY10, HS 20/20 is providing assistance for Malawi's 2009 NHA estimation, including subaccounts for Malaria, Child Health, Reproductive Health, and HIV/AIDS. The Malawi Health Financing component of this health system strengthening activity will work to improve the NHA production process and to increase the use of NHA findings.
Malawi has completed 4 rounds of NHA for the years FY1995/6, FY1998/9, FY2002/3, FY2004/5 and, most recently, FY2005/6. The 1995/6 round, which included only a general NHA estimation, was undertaken by a Ministry of Health employee and was widely used for informing the 5-year National Health Strategic Plan (1999-2004). The 1999 round also included only a general NHA estimation. The 2002/3-2004/5 round included subaccounts for Child Health, Reproductive Health, and HIV/AIDS. The 2005/6 round, conducted with Global Fund support, included the HIV/AIDS, Tuberculosis, and Malaria subaccounts.

Malawi is now ideally placed to begin to institutionalize NHA, the goals of which are to strengthen and streamline NHA production as well as increase the use of NHA data by stakeholders. On the supply-side, this includes actions such as integrating NHA data sources into routine health information systems; building in-country capacity for data collection, analysis, and reporting; and designing and implementing tools that simplify the NHA production process. On the demand-side, we need actions geared towards disseminating NHA results to a wider array of stakeholders and building their capacity to use NHA to guide policy and planning, make decisions about resource allocation, and undertake routine monitoring and evaluation of health system functions.

Following on the completion of the NHA exercise in FY10, PEPFAR resources will support the following activities listed below in FY11. (Note, these activities will also be supported by other USG non-PEPFAR health funds, but only the planned PEPFAR contributions are noted below)

Activity 2: NHA Institutionalization

Institutionalization of NHA in middle and low-income countries means that the activities related to collecting, analyzing and reporting health care spending are systemized as an integral function of a government department with the purpose of increasing the availability and use of timely and accurate information on health expenditure. Institutionalizing NHA should be looked at as a government responsibility (not necessarily implying sole financing) that ought to be enveloped into routine processes with the objective of forming a core dataset for health policy development, monitoring and evaluation. This implies that for NHA to become an institutionalized activity it should meet two principles:

i. Become a core activity within the entity responsible for producing it; and
ii. Be closely linked to policy requirements in order to be useful.

Simply having the capacity to carry out the technical aspects of national health accounts activities does not ensure that NHA is institutionalized. An environment that enables the initiation, growth, and sustainability of the NHA activities must also incorporate supportive policies, standardized methods for data reporting, effective leadership and adequate resource allocation which emphasizes the importance of NHA as a policy planning tool. Resources and structure that support the performance of the NHA technical team are also needed.

These essential elements provide the "staying power" for NHA; their presence or absence determines whether NHA remains a set of isolated, limited activities or becomes a core activity within the system. Building on previous experience of implementing NHA in middle and low-income countries, HS 2020 will provide technical assistance to help the GOM and other stakeholders put in place standardized procedures which will enable the GOM to institutionalize the NHA process.

Activity 3: Increasing key stakeholder involvement in NHA policy use:

a) To date, the full potential of NHA results to influence policy has not yet been fully realized. In the past, technical assistance has been largely for implementation and not for supporting policy penetration and implementation -- due to budget limitations. While efforts are made to involve NHA stakeholders on the technical (and steering committee) team, these representatives do not necessarily participate fully on the team limiting their ability to understand and use expenditure data for advocacy without further assistance. Consequently, once the estimations are completed, there has been limited use of the findings for policy purposes. Thus, there is need for continued assistance following the production of estimates such that their implications and value can be realized by local stakeholders.

Activity4: Develop an expenditure module for national health management information system:

This activity would incorporate an expenditure module into the national electronic health management information system (HMIS) at the district level. This innovation leverages a government's national HMIS to ensure provider expenditure data are collected routinely as part of facilities' routine information system. This entails training of providers on how to collect, enter, and tabulate expenditure data, preferably as part of broader HMIS trainings led by the government. The Health Metrics Network has been involved in supporting an open-source District Health Information System (DHIS) that is being rolled out to a number of countries in sub-Saharan Africa. The incorporation of an expenditure module into Malawi's health management information system could then be integrated into Health Metrics Network's broader efforts to promote the implementation of harmonized, feasible, and comprehensive DHIS in Africa.

Activity 5: Develop a donor/NGO database to regularly track health expenditure data

HS 20/20 will support the development of a national annual database of donor and NGO annual spending for health. The database would feature an online data collection tool to be annually emailed to donors and NGOs. In the spirit of the Paris Declaration, many country governments have expressed interest in making data collection of financing patterns routine. If an annual database were available, it would significantly reduce the cost and time to produce health accounts thus facilitating expenditure estimation on a routine basis.

Activity 6: Benefit Incidence Analysis (BIA) ($50,000)
Policy makers are interested in measuring health system performance in terms of equity – do all citizens have access to basic health care? Benefit Incidence Analysis (BIA) is a method of computing the distribution of public and donor expenditures across different demographic groups, such as income groups, or women and men. BIA is an analytical tool to examine who (which segment of a population) benefits from health care expenditures.
Here the benefit is defined as the public subsidy.

The public subsidy is equal to the total cost of a service less the amount (if any) that the individual paid for the service (i.e. out-of-pocket expenses for user fees). BIA can reveal how effectively governments/donors are able to target their limited resources towards meeting the needs of specific target groups, such as the poor (although this analysis can also break down the population by region,

age, or gender).

Health Systems 20/20 will work with the Government of Malawi to:
1. Specify the policy question(s) that the BIA is expected to inform. Typically, BIA answers the policy question "Are government and donor health expenditures benefitting intended target populations?" "Which income group is benefiting most from government and public health expenditures?" "Do women benefit equally as men?"

2. Decide how to group/categorize the beneficiaries based on policy objectives and interests. Options include: Income, sex, residence, tribe, etc.

3. Estimate the quantity of services used by individual for each beneficiary group for each type of care, for example, outpatient visits and hospital (inpatient) admissions.

4. Estimate the unit cost for the services by type of service using facility cost data.

5. Estimate the out-of pocket fees for services by types using household survey data.

6. Estimate the benefit (public subsidy) by defined population group

7. Finally, the findings need to be carefully interpreted and explained, and linked with currently health policy development in Malawi. The results can be presented in table and graphic format, as well as indices of progressivity such as the concentration index and the Kakwani index.

Activity 7: Private Sector Assessment:
In order to better understand the current private sector activities in health in the country, a private sector assessment will be done, integrating findings from the NHA household survey and benefit incidence analysis so as to provide policy recommendations to the MOH and USAID/Malawi on programming needs in the private sector.

Activity 8: Governance:
The active participation of Civil Society is essential to improve utilization of resources within the health system. HS 2020 will work closely with other USG partners, including PACT, which currently has over 20 indigenous sub partners, to support the following activities:
• Technical assistance to build the capacity of Civil Society organizations in resource tracking tools, quality of services assessment, and ability to participate in the district budget process and health center

oversight. • Training journalists and other media operatives on how to report on health sector issues to ensure adequate coverage of health sector problems and innovations. Results of the NHA exercise or reports on budget execution and benefit incidence analysis for instance, would be a key area to link finance and governance. Assistance will also be provided to link civil society to journalistic media, thereby enabling them to have an outlet to express their views on the health sector.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12118	**Mechanism Name: BLM CIRC GHAI**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Banja La Mtsogolo	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Banja La Mtsogolo (BLM) is a national family planning (FP) and sexual and reproductive health organization with static clinics in 22 of 28 districts in all three regions of the country. Under the Partnership Framework (PF) negotiated between PEPFAR and the Government of Malawi (GOM), BLM will target uncircumcised boys and HIV negative men between the ages of 10 and 29. National guidelines on informed and parental consent will apply and be strictly adhered to. This program will also provide referrals to organizations that support people living with HIV and AIDS (PWHIVs) and include strategies to increase access to FP services, financed by non-PEPFAR resources, among these and other underserved groups.

In the first two financial years, the comprehensive goals of this program are:

o Increase access to safe, voluntary male circumcision in Malawi
o Increased engagement of men in pursuing sexual and reproductive health for themselves and their partners, with an emphasis on HIV prevention
o Increase the access of men and their female partners to comprehensive SRH services including family planning with particular emphasis on increasing access among disadvantaged groups, including people living with HIV and AIDS.

The objectives of this one and a half-year period (April 2010-September 2011) include:
o In-service training of 60 private providers operating under the BlueStar social franchise and 40 providers at Ministry of Health (MOH) and NGO facilities to provide a minimum package of male circumcision services
o Provision of 52,500 voluntary male circumcisions in Malawi
o Integration of male circumcision service provision into ANC, PMTCT, and neonatal care programs in collaboration with MOH

This program specifically addresses PF Goal I, the reduction of new HIV cases, by providing male circumcision services for the prevention of HIV. This program will address Goal I over the life of the award (four years). Furthermore, technical information generated during the implementation of this program and previous experience of MC service delivery in Malawi will aid the MOH in the development of a national MC policy, planned under key policy reforms.

In addition to Goal I, this program will assist Goal IV of the PF by providing training to MOH clinicians. In the first 18 months of implementation this program expects to provide in-service training in a minimum package of MC services to 100 clinicians nationally, including at least 40 working in MOH and other NGO facilities (e.g. Christian Health Association of Malawi (CHAM)). This training activity will include infection prevention, STI screening and treatment, minor surgical and suture techniques, client counseling (including HIV prevention methods such as condom use and partner reduction), and post-operative review. In addition, this program expects to make strategic facilities improvements (e.g. autoclaves, instrument sets) that will strengthen the capacity of clinics beyond MC service provision.

This program expects to achieve national coverage of MC services.
Costs per procedure will be highest in the first 18 months as many costs (such as training and capital investments) largely appear in the first years and service delivery sites will begin offering services only after they have been trained and outfitted and therefore will not be providing services for the entire year. Cost per procedure will thus dramatically decrease as the program enters its subsequent years of activity, eventually dropping to under $25 per safe male circumcision over the four and a half years of funding.
The cross cutting program to which this program is related is human resources strengthening and the

wrap around issue is family planning.

Both public and private providers will be integral to the implementation of this program. Providers will be trained in line with World Health organization (WHO) minimum package guidelines for MC using in-service training methods. Vouchers combined with onward referrals for MC services will be available from mobile and static HIV testing and counseling (HTC) sites thus ensuring that adult clients have been recently tested in the event that the MC service provider doesn't offer HTC. Vouchers will be sold at a subsidized rate in urban areas ensuring partial cost recovery and distributed for free in geographic areas where service uptake is depressed by poverty. BLM's experience implementing MC programs for HIV prevention in Malawi, and experience gained from similar programs across the MSI Global Partnership, will allow it to feed into policy dialogue and support the creation of the GOM MC policy.

Monitoring and evaluation will take place throughout the implementation period. Through the voucher reimbursments system, BLM will closely track the number of services delivered to clients through private, public and NGO providers. To prevent fraud, regular auditing and spot checking of providers will be undertaken to assure that all client numbers are genuine.

Partnership Framework Year 1 Budget - $611,965
Partnership Framework Year 2 Budget – $1,200,000

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Addressing male norms and behaviors
Family Planning

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12119	**Mechanism Name: GAIA/HRH/GHAI**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Global AIDS Interfaith Alliance	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Malawi's health care is delivered through three levels of the government system: Central referral hospitals (located in major cities), district hospitals, and rural health clinics. Though free, the facilities are extremely under-resourced. There is a grave shortage of health care personnel, and one nurse commonly cares for 50 or more hospitalized patients. Many district hospitals have only one, or sometimes no physician, with medical care provided by clinical officers (with training similar to physician's assistants in the US).

The Malawi health care system has been presented in the US press (Dugger, 2004) as an example of the "brain drain" of professionally trained health care personnel. Attractive pay and notably better workplace conditions have drawn some of the best African health professionals, including nurses, to northern hemisphere countries. Great Britain's Department for International Development (DFID) has recently begun ameliorating the brain drain by "topping off" nurses' salaries. Even so, the internal brain drain from the public hospital and clinic system remains a problem as Malawi nurses seek more lucrative work in non-governmental organizations (Gorman, 2009).

Exacerbating the problem is the loss of nurses to the HIV and AIDS epidemic, and the lack of upward mobility and of continuing education in the public system (Manafa, et al, 2009). At the same time, replenishing the work force is challenging. Though the cost of nursing education is modest by U.S. standards, it is far beyond the reach of many qualified Malawi people. All these factors make Malawi's health care worker shortage particularly acute, even when compared with the rest of sub-Saharan Africa. The country has only 29 nurses for every 100,000 people, contrasted with 85 in Tanzania, 472 in South

Africa, and 836 in the U.S (WHO, 2005; Kaiser Family Foundation, 2008).

The purpose of this project is to partner with the Government of Malawi, Kamuzu College of Nursing, and the University of California, San Francisco, to: 1) increase the Malawi nursing workforce, and 2) build long-term sustainability of HIV and AIDS programs and delivery of primary health care to women.

This program will build on Global AIDS Interfaith Alliance's (GAIA's) already successful Nursing Scholarship Program, and at the end of five years will result in approximately 130 new Malawi registered nurses, who have been trained in Malawi and are committed to a service obligation of at least three years (four for those receiving a bachelors degree) in Malawi government and Christian Health Association of Malawi (CHAM) hospitals.

Further, the project will build HIV and AIDS and women's health programs through addressing and strengthening three key areas: 1) antiretroviral therapy (ART), 2) basic emergency obstetrical care (BEmOC), and 3) triage. The capacity of schools of nursing to deliver these skills to students and to practicing nurses in the field will be enhanced.

The purpose of the proposed project is thus consonant with Goal IV, Cross Cutting Systems Strengthening, as outlined in the President's Emergency Plan for AIDS Relief (PEPFAR) Partnership Framework Document to Support Implementation of the Malawi National HIV and AIDS Response between the Government of the United States of America and the Government of the Republic of Malawi (May 2009)

The proposed project is a Systems Strengthening strategy that improves health services. Systems Strengthening means increasing the number and boosting the skills of health and social welfare workers graduating from pre-service training institutions and, importantly, the number being retained in the Malawi health and social welfare workforce. In particular, the program would contribute approximately 130 newly graduated health workers towards the human resources target indicator of 1000 defined in the Malawi PEPFAR Partnership Framework document under Goal IV. Moreover, extrapolating from a recent Malawi Health Sector Employee Census data (GOM, 2007), we estimate that the 130 graduates would fill approximately 8% of the nursing vacancies in the health workforce and would therefore make a substantive contribution toward the desired Malawi PEPFAR Framework Document goal of filling 50% of the vacancies in the health and social welfare workforce.

While Goal IV of the Framework represents the primary fit with the proposed project, two other goals will also be supported, because increasing the number of nursing workforce while strengthening their skills will contribute to reduced HIV infections in Malawi (Goal I), and improve the quality of treatment and care

for Malawians living with HIV (Goal II).

The project will improve access to BEmOC through a train-the-trainer model that will build workforce BEmOC capability (see budget code narrative, below).

Budget Summary

PFIP Year 1 Funding – $213,002
PFIP Year 2 Funding – $100,000

Cross-Cutting Budget Attribution(s)

Human Resources for Health	100,000

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12120	**Mechanism Name: C-SEP**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Save the Children Republica Dominicano	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 100,000

Funding Source	Funding Amount
GHCS (State)	100,000

Sub Partner Name(s)

Education Development Center		

Overview Narrative

Malawi struggles with some of the poorest economic, health and education indicators in the world. High levels of dropout and repetition plague the education system, child mortality rates remain unacceptably high, and HIV/AIDS continues to undermine family and community safety nets. Children lack adequate parental care due to livelihoods demands, cultural factors and the effects of HIV/AIDS. Girls in particular are more likely to drop out of school.

Dropout exposes children to significant risks, including child labor and early marriage, robbing them of a healthy childhood. Thus, staying in school is an important strategy for child protection. A coordinated approach to early childhood development (ECD) that promotes children's psychosocial, physical and cognitive development – and reaches orphans and vulnerable children in a non-stigmatizing fashion – is even more critical in environments of high poverty, disease and marginalization. In addition, ECD can offer governments and communities a significant return on their investment, as children who participate typically achieve greater success in primary school and later in life than those who do not. Despite the clear benefits of ECD, fewer than 30 percent of Malawi's children have access to ECD services, and the quality of those services is generally poor. Several factors underpin these shortcomings, including a lack of awareness of the importance of ECD; weak capacity among duty bearers at the national, district and local levels; and limited linkages with vital services in health and nutrition. Although some hopeful signs have emerged in recent years, a catalyst is required to move ECD in Malawi beyond its nascent stage to reach national scale.

Capacity Support for ECD and PSS (C-SEP) Project is a three-year project by Save the Children that is jointly funded by PEPFAR and USAID Basic Education (ratio 1:3). It is a public private partnership that leverages additional resources from Save the Children private sponsorship, UNICEF and other private sector partners such as Fondazione Cariplo, an Italian banking foundation, and ELMA Foundation. The project aims to help children, including OVC, learn and develop to their full potential. Increasing children's participation in quality ECD programs and psychosocial (PSS) will be achieved by improving availability and access to ECD and PSS services; improving the quality of those services; improving household and community capacity to support young children's development; and strengthening ECD policies and resource allocation.

In Malawi, Community based child care centers (CBCC) and children's clubs (CC) provide that platform

where these services can be effectively delivered, with a focus on specific age group whole also ensuring a continuum of care and comprehensive service package. To increase children's access to ECD services, Save the Children will develop low-cost construction solutions, ensure that each CBCC has an essential package of teaching and learning materials, and support children's transition into the first year of primary school. C-SEP we will strengthen the quality of ECD by building capacity of service providers, improving parenting practices and linkages between the home and CBCC environments, and strengthening psychosocial support and access to health and nutrition services for young children. A key innovation will include the use of interactive audio instruction to improve teaching practices and enrich the CBCC learning environment. These direct investments in CBCCs will also be complemented by capacity building for communities to strengthen their ability to manage ECD services. Finally, advocacy to promote improved ECD policies and coordination will be achieved through a scale-up strategy that includes capacity-building at the district level and for local and national partners, tapping into national-level working groups as a platform for advocacy, and strengthening documentation and dissemination of best practices in ECD.

Over three years, the project will reach 39,450 children, including an estimated 8, 955 OVC. Beneficiaries in the C-SEP project will include children aged 3 – 12, including ages 3-5 through CBCCs; 6-8 through formal schooling; and 6 – 12 through children's clubs. To reach these, we will work with parents; primary school teachers; community based extension agents; community volunteers who will include CBCC caregivers, CBCC mentor caregivers, parents/center management committees, and children's corner patrons; and community leaders through Village Development Committees (VDC) and Area Development Committees (ADC). OVC are a significant target group, as CBCCs are designed to promote participation of the neediest children.

C-SEP will be implemented in three districts where Save the Children already has a presence: Blantyre, Zomba and Chiradzulu to allow us to realize management efficiencies while also benefiting from coordinated ECD programming and linkages to services such as nutrition and HIV prevention.

C-SEP directly supports the attainment Goal 3 of the Partnership Framework which seeks to mitigate the economic and psychosocial effects of HIV and AIDS and improve the quality of life for PLHIV, OVC and other affected individuals and households."

The C-SEP M&E plan includes standard results indicators in ECD, (indicators of access, quality, capacity and policy) and relevant PEPFAR indicators. C-SEP's evaluation plan will measure results of specific innovations where the evidence base has not yet been established, such as tracking children into early primary school; investigating changes in parenting practices; and evaluating improvements in CBCC caregiver practices as a result of IRI. There will be joint quarterly supervisory visits at district level, and joint biannual national level. CBCCs will be encouraged to conduct regular self-assessments using a quality monitoring checklist derived from the CBCC profile.

ECD interventions can be particularly effective because they promote gender parity; encourage the

participation of women; and promote inclusive services for the most vulnerable children in society. All Save the Children-supported CBCCs in Malawi promote equal enrollment of boys and girls and provide a welcoming environment that counters harmful gender stereotypes. CBCCs also promote skills development and self esteem for volunteer caregivers, most of whom are women. Gender parity is also encouraged in our CBCC management committees, which must be made up of at least 50 percent women, allowing women's voices to be heard in decision-making and management.
Budget Summary
PFIP Year 1 Funding – $140,000
PFIP Year 2 Funding – $280,000

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	25,000

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID:	**12120**		
Mechanism Name:	**C-SEP**		
Prime Partner Name:	**Save the Children Republica Dominicano**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	100,000	
Narrative:			
I. Budget Code: HKID $140,000– Year 1 $280,000– Year 2 PEPFAR funds will support interventions that increase availability and access; improved quality of services; improved household and community capacity; and strengthened ECD and psychosocial policies at the local, national and regional level.			

Activity 1: Develop low cost solutions that increase access to ECD:
C-Sep will work with the National ECD TWG to develop and disseminate cost-effective construction guidelines for CBCC construction and renovation that meet national specifications. The guidelines will promote community participation in construction, and the use of local materials. C-SEP will also assist communities to implement the construction standards, and encourage community resource mobilization for construction or improvement of structures.
Products/Deliverables: Low cost construction guidelines for CBCCs
Activity 2: Support transition to primary schools:
Anecdotal information from primary schools shows that children who have participated in CBCCs have stronger cognitive, socio-emotional and physical development than other children who did not have the opportunity to attend a CBCC. Children who participate in CBCCs thus perform well in school, and tend to enjoy school more, which can reduce truancy, absenteeism and eventual drop out.
C-SEP will support children's transition from CBCC to primary schools by strengthening linkages between CBCCs and primary schools through joint orientation sessions for CBCC caregivers and primary teachers to raise awareness and support for children's transition from CBCC to primary school; and organizing visits of CBCC children to primary schools. Graduation ceremonies will also be organized for CBCC children. Each graduating child will receive a start up pack consisting of assorted writing materials, and a graduation certificate. Parents will be encouraged to make contributions so that every child receives a gift during the ceremony. This will also ensure that vulnerable children whose guardians are unable to contribute will be treated like every other child.
Activity 3: Ensure an essential package of materials for ECD:
To ensure quality and safety in CBCCs, C-SEP will support communities in creating their own teaching, learning and other materials. However, some essential materials that are beyond the means of communities, such as cooking and eating utensils, water storage containers, chalk boards and chalk, will be supplied by C-SEP. Children's clubs will also receive board games, footballs and netballs, coloring supplies, skipping ropes and bawo games. All materials provided by C-SEP will be sourced locally to be more cost-effective and to support local suppliers.
Activity 4: Improve the quality of ECD and PSS programs
ECD is a nascent sector in Malawi, and there is a continued need for quality improvement in services. The bulk of C-SEP support will therefore focus on strengthening human resource capacity, increased involvement of parents, stronger psychosocial support; more deliberate health and nutrition linkages; and use of low-cost technology to achieve quality delivery of ECD services that meet all of the children's developmental needs. C-Sep will train 10 ECD caregivers per center (to allow caregivers to work on a rotational basis and have sufficient time to dedicate to their personal economic activities). C-SEP will also facilitate community-managed mentoring for caregivers; and provide incentives to caregivers and their mentors in the form of T-shirts, and transport support for mentors. Incentives will be distributed at events

such as community Open Days to provide additional recognition for caregivers and mentors. C-SEP will also strengthen linkages between the home environment and CBCCs

Activity 5: Conduct national stakeholder consultation on parenting formative research and curriculum adaptation.

Save the Children has collaborated with researchers from the University of Malawi Chancellor College to conduct ground-breaking formative research into parenting practices in Malawi. The analysis included a literature review on parenting practices in Malawi and globally; the status of parenting education in Malawi; parent's involvement in their children's development; and discussion of the program and policy implications of the findings. C-SEP will facilitate stakeholder discussions on these findings with Save the Children Sponsorship funding. Save the children will also revise the existing parenting curriculum to include early stimulation to promote children's physical, psychosocial and cognitive development, and print manuals. The manual will emphasize building parent's understanding of common developmental milestones and what they can do to promote their children's health and development at each "age and stage."

Products/Deliverables: Revised parenting manual

Activity 6: Strengthen psychosocial support for children, particularly those affected by HIV/AIDS. The C-SEP PSS strategy is linked to strengthening parenting practices, a more deliberate focus on the psychosocial needs of orphans and strengthening home to center linkages. It also includes community sensitization and skills development for caregivers and other community members through the Journey of Life manual. Experience suggests that children are often abused by people closest to them, and that some forms of abuse are seen as culturally acceptable. Therefore further to the community PSS awareness and skill building sessions, special sessions will also be organized for parents or primary care providers of OVC with a view to raising awareness and equipping them with improved skills, with a primary focus on positive parent-child communication.
Activity 7: Establish children's clubs
Children's clubs aim to create a safe space for children by providing a forum for expressing their feelings and receiving support from peers. In children's clubs, structured recreation activities enable children to open up to each other, a process that creates opportunities for children to act in solidarity with each other. In turn this enables children to master the strength to engage with adults on issues that need attention through open days. Save the Children has used the Journey of Life approach to raise awareness and build capacity of adults in PSS. In C-SEP, new children's clubs will be formed, in addition to supporting existing ones. This intervention targets children 6-12-year-olds through children's clubs. Play materials will be distributed to children's clubs.

Activity 8: Most Significant Change approach to outcome monitoring and documentation.
C-SEP proposes to improve capacities to measure outcomes of PSS activities through the "most significant change" (MSC) methodology, a participatory approach to working with communities to identify the most important outcomes of a given activity. This approach is particularly suited to PSS interventions because it secures testimonials from project participants in a way that provides deeper insights into the qualitative impacts of activities. MSC training will be held to orient community-level volunteers to help them form an MSC team, learn how to implement the MSC approach and develop work plans for their activities. Meetings will then be held at the community level so that the MSC teams can implement MSC activities and gather results for monitoring and documentation.
Activity 9: Strengthen links between CBCCs and child health and nutrition services and education.
CBCCs are recognized as a platform for providing integrated services to children. Simple but high impact interventions such as educating parents, CBCC caregivers and children about food hygiene, personal hygiene and sanitation are taking root with support from health surveillance assistants. C-SEP will strengthen this through consensus building with district health offices, social welfare offices and agriculture development offices and mobilize them to provide sufficient infrastructure for waste management, and strengthen hygiene and nutrition education for parents, children and CBCC caregivers and promote use of locally produced food products, and facilitate stronger linkages with health services.
Activity 10: Promote greater scale and quality through interactive radio instruction in ECD. Interactive Radio Instruction (IRI) offers a low-cost, large-scale way to improve the quality of teaching and learning and enrich the emotional environment of the pre-school classroom. Save the Children partnered with the Education Development Center (EDC) and the MGCCD to conduct a feasibility study on IRI called Tiyende! ("Let's Walk!") in two CBCCs in Blantyre District. During the feasibility test, it was found that IRI can help create an active play and learning environment in the CBCCs. Save the Children now plans to continue partnering with EDC and the MGCCD to implement a pilot in 20 centers (10 intervention centers that will receive basic ECD training and IAI, and 10 comparison centers that will receive only the basic training) in Zomba District.
Activity 11: Increase community participation and support for ECD activities
Save the Children will employ its experience using the Community Action Cycle to mobilize community organization to link into the central planning processes at the District Assembly (DA) secretariat. This will focus on facilitating coordination among community based organizations to minimize duplication of effort and enhance accountability at the community level.
Activity 12: Strengthen local, regional, national policies, capacities and resources for ECD and PSS
Save the Children's experience will capitalize on our existing partnerships with key stakeholders in Malawi to implement a three-step scale-up strategy: First, we will continue testing innovations so that we can strengthen the growing evidence base about what works best. Second, we will collaborate with other ECD partners by involving them in capacity-building opportunities. Third, we will work closely with government at the district and national levels to build their capacity and advocate for uptake of good

policies at a wider scale. We will utilize our involvement in the ECD and OVC TWGs as a platform for advocacy to emphasize integrating ECD within larger government structures to promote sustainability.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12121	**Mechanism Name: TBD/MTPDS/GHAI**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

Johns Hopkins Center for Communication Programs Malawi Bridge Project II	Ministry of Education and Sports, Guidance & Counseling Department, Uganda	T'LIPO (Teachers Living Positively)

Overview Narrative

The HIV/AIDS pandemic has dramatically affected the development of the education sector. It is believed that HIV has contributed to increased teachers' absenteeism and mortality. With 60% of the workforce under the Ministry of Education, Science and Technology (MoEST), this translates into high numbers of educational staff infected or affected by HIV. Despite increasing availability of HIV/AIDS services in Malawi, anecdotal evidence suggests that teachers remain reluctant to learn and take action on their serostatus, perpetuating AIDS-related morbidity and mortality among their ranks.

Furthermore, there is evidence that schools can be places of increased risky sexual behavior among teachers and between teachers and pupils. Gender based violence, intergenerational sex and sexual abuse have been cited as critical issues to be addressed that further undermine the role of schools and

positive learning. Effectively mitigating the needs is pivotal for a sustained reduction of HIV incidence among teachers and students (NESP, 2008).

Teachers are one of the primary means to reach children with key knowledge and skills around HIV prevention. And yet, teachers themselves are at great risk for both becoming infected, and infecting others with HIV (Action Aid, 2006). While the new primary curriculum formally integrates Life Skills Education, anecdotal evidence suggests few teachers are comfortable teaching it and because it is not tested, there is little motivation to address teacher weakness in effectively teaching it. Many teachers express low comfort around their own sexuality and ability to discuss these issues openly. With the demands of trying to implement a newly introduced curriculum within large classrooms (as many as 200 in the lower Standards), the teaching of necessary life skills education is not clearly understood and may not be taught in ways that equip pupils with or enhance needed skills.

Nonetheless, examples of positive action exist. Through the efforts of different development partner supported activities, district education managers and more than 7,600 teachers have been trained in HIV/AIDS prevention. The GoM has formed a national organization called T'LIPO (Teachers Living Positively), with a membership of more than 2,500 teachers. Five T'LIPO networks have also started work on home-based care through USAID Education funding. Trainers have been trained in most of the districts and in some districts have conducted district wide training sessions.

Teachers' potential as change agents has been exemplified by positive deviant teachers - particularly women - who have established PLWHA support groups. Some support group participants disclosed their HIV status in public, provided support to other teachers, visited schools to reduce the stigma associated with HIV/AIDS, and encouraged others to be tested and access treatment. However, challenges still remain. Male teachers living with HIV and AIDS are less willing to disclose, organize and advocate for change and need to be targeted for greater involvement. Networks and linkages to HIV related services need to be strengthened. There is also persistent stigma and discrimination at the school and community level.

The Malawi Teacher Professional Development Support (MTPDS) activity, drawing on its partnerships with T'LIPO, the Bridge II Project and other organizations addressing HIV, is well positioned to help address teacher adult prevention through its broader teacher development program.

The Malawi Teacher Professional Support activity provides technical assistance and support to MOEST in implementing teacher education support and systems management, with an emphasis on completing and reinforcing its introduction of the Primary Curriculum and Assessment Reform (PCAR). Targeting teachers, school administrators, young people and children nationwide, this Teacher Professional

Development Support activity will support linkages and complement key MOEST and GOM priority initiatives and plans in teacher education and professional development, including the HIV/AIDS and Education Strategy and Plan. Relevant components of the effort will focus on:

• strengthening teacher management and support systems,
• enhancing teacher performance, and
• improving primary education-related monitoring and evaluation systems and quality.

On the ground, HIV/AIDS-related and policy-level efforts will target schools and education personnel at all levels of the education system, primarily through revision of the national curriculum for teacher training, adaptation of key content to include gender and HIV related themes and provision of education tools, and finally, through its integration into national pre-service and in-service teacher training, teacher support and mentoring activities.

An MTPDS activity HIV focal person will facilitate the development and inclusion of gender and HIV content responsive to the needs and realities of teachers in collaboration with partners like BRIDGE II who can offer technical expertise. Using transformative tools, BRIDGE II can help enhance training and mentoring of teachers and provide technical assistance to efforts reviewing and integrating HIV/AIDS prevention into the pre and in service teacher curriculum. This can include, for example, supporting new materials development to incorporate powerful stories of real teachers and pupils who have challenged social and gender norms, experienced intergenerational sex relationships, gender based violence, and positive prevention, among other key themes. Their community presence within 11 Southern region districts will provide MTPDS activity with a testing area for new ideas for curriculum adaptation and training, as well as explore ways to strengthen links between schools, communities to address key issues affecting teachers, children, as well as wider services available.

With T'LIPO groups in all 34 education districts, the potential for their reach to other teachers is high. They provide MTPDS activity with expertise as both teachers and as individuals affected by HIV. Their involvement will be invaluable to supporting meaningful curriculum development for life skills for teachers and pupils, and can further strengthen responsive teacher training through possible utilization of their networks as part of training team. The existence of networks within all districts will also support new teachers living with HIV to access psychosocial support and health related services.

MTPDS activity will include a research component to further investigate the effects and impact of HIV and AIDS on education personnel, teachers, students and pupils. This will include knowledge, behaviors and attitudes of these groups and explore issues leading to teacher absenteeism and attrition with respect to teacher management. MTPDS partners will also contribute to the development of the research by providing technical input.

Goals and Objectives

The MTPDS activity, with the technical support of Malawi Bridge Project II and other key HIV communication partners, will facilitate integration of effective gender and HIV content into the national teacher training program. The overall goal is to contribute toward reducing new HIV infections among Malawian teachers. MTPDS activity efforts will:

• Strengthen teachers' HIV and AIDS knowledge, skills and positive attitudes towards prevention.
• Reinforce HIV/AIDS Life Skills education (LSE) curriculum development for teachers (TTCs)
• Build capacity of T'LIPO for advocacy, peer mentoring and teacher training support
• Improve education sector specific information on the impact of HIV and AIDS among teachers and pupils to inform and test efficacy of education based interventions.

Expected Outcomes

• Improved teacher knowledge of HIV and AIDS prevention information and resources
• Increased teacher access to prevention, treatment, care and support services
• Increase teacher awareness of and access to HIV and AIDS care and treatment options and services
• Established self-efficacy of teachers as adults at risk
• Improved teacher support networks (e.g. through T'LIPO)

Linkages with Partnership Framework

The National Action Framework and the HIV Prevention Strategy has prioritized reduction of adult infection. With PEPFAR Funds, MTPDS will focus its contribution to that support on the NAF objective to "Reduce the sexual transmission of HIV", emphasizing interventions that address sexual prevention among teachers, human capacity development and gender as a cross cutting issue. MBTDS will also contribute towards strengthening linkages and referral to other HIV and AIDS services by integrating key messages into curriculum content and training activities.

Geographic coverage and target population

MTPDS targets its efforts at the national level, through its collaboration with the Ministry of Education, to reach a minimum of 10% of Teacher Training College lecturers and student teachers, in-service teachers, and primary education advisors (PEAs) during the first year. In the second year, 40% of lecturers and student teachers will be reached and 30% of teachers, PEAs and Head teachers through the proposed interventions.

Contribution toward cross cutting, gender and key issues

Human Resources for Health and Education: MTPDS will contribute toward building the capacity of teachers through integration of responsive training program content on interpersonal communication to explore personal risk practices, damaging gender norms and develop self-efficacy to protect their health, Indirectly, the skills they will learn will support their role as teachers to deliver LSE for pupils effectively.
Gender: MTPDS will influence gender relations and decrease women's vulnerability to HIV by directly addressing gender in training content and interventions.
Support to workplace interventions: MTPDS will collaborate closely with the Ministry of Education to integrate effective educational training, and links to HIV related services for teachers and other educational personnel.
Building Behavior Change Communication (BCC) Skills: Through proposed pre-service and in-service training planned, MTPDS will strengthen the BCC skills of teachers reached for their own health but indirectly, will improve LSE for pupils. Efforts will be sustained through integration of key content within the national teacher training curriculums for both primary and secondary levels. With the support of partners like Bridge II, capacity of trainers for training HIV related content will also be enhanced through sharing of effective communication methodologies and tools, and strategizing on meaningful integration into training activities, possible links with T'LIPO trainers in training delivery, and feedback through testing of ideas, related interventions with teachers in select districts.

Cost Effectiveness
MTPDS will work directly with the Ministry of Education's teacher development system to ensure that efforts made will be feasible and are integrated into existing reform, training and materials development activities planned.

Budget Summary
PFIP Year 1 Funding – Redacted
PFIP Year 2 Funding – Redacted

Cross-Cutting Budget Attribution(s)

Human Resources for Health	Redacted

Key Issues

Child Survival Activities

Budget Code Information

Mechanism ID:	**12121**		
Mechanism Name:	**TBD/MTPDS/GHAI**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	Redacted	Redacted

Narrative:

I. Budget Code: OHSS

PFIP Year 1 Funding – Redacted
PFIP Year 2 Funding – Redacted

Activities

With PFIP Year 1 funding, MTPDS expects to implement the following activities:

Activity 1: Teacher focused Pre- and In-Service Curriculum HIV/AIDS review and integration
Through collaboration between the Education-led MTPDS activity and BRIDGE II, HIV and AIDS tools and materials will be shared and reviewed as part of review of Pre-service Teacher Training College Curriculum and the Continuous Professional Development (CPD) Modules for In-service teachers. The emphasis will be on supporting the MoEST and the Teacher Training Colleges (TTCs) to improve HIV/AIDS content and resources. A review of teacher-oriented curriculum will also assess other existing efforts with the intent to inform or improve pre-service and in-service teacher training. An outcome of the review will be the identification of appropriate BRIDGE II tools and materials that can be adapted and, as agreed with MoEST, can strengthen the curriculum or be incorporated as part of curriculum revision efforts. 50% of a MTPDS staff person's time will be devoted to facilitation of the review and materials adaptation.

Activity 2: Pre-Service Education Personnel Training
The MTPDS will provide technical assistance to the Department of Teacher Education and the TTCs to ensure lecturers at the six TTCs and a core group of Field Supervisors are oriented and trained in the revised materials for both the Initial Primary Teacher Education (IPTE) and Open and Distance Learning (ODL) programs, with technical input from BRIDGE II and T'LIPO. Efforts will be made to include HIV/AIDS teacher training as part IPTE and ODL student teacher training efforts under the MTPDS, where possible and optimal, to include or in collaboration with other organizations that may provide

similar training. Resource and other materials development for use at the trainings are included under this activity.

Activity 3: In-Service Education Personnel Training
An integral part of the mandate of the MTPDS partner is to operationalize and institutionalize the MoEST approved Continuous Professional Development (CPD) system of cluster training. MTPDS will incorporate HIV/AIDS training into CPD/in-service teacher training efforts through the use of the 6 Divisional hubs and/or the 352 Teacher Development Centers located at the zonal level. This intervention targets all of the approximately 35,000 teachers and additional District, zonal and school level personnel (e.g. Primary Education Advisors, Head-teachers, etc.) MTPDS will ensure a collaborative effort that tries to maximize any HIV/AIDS technical input available through BRIDGE II, as well as other organizations working in this area. Resource and other materials development for use at the trainings, as resources for an HIV/AIDS focal person are included under this activity.

Activity 4: Networking and Capacity Development Support to T'LIPO (under BRIDGE II partner activity)
Links will be promoted and fostered between T'LIPO, BRIDGE II, PACT, MTPDS and other education partners to strengthen the resource availability for and capacity of T'LIPO to more competently carry out its role of providing teacher psychosocial, mentoring and related support to positive teachers and students, as well as organizing activities that improve awareness of prevention information and strategies to teachers and other education personnel. Within this, a strategy can be developed to harness T'LIPO resources to adapt and include more teacher oriented stories within BRIDGE existing toolkits for pre- and in-service training delivery based on T'LIPO experience. An area of exploration is how T'LIPO at district level can further support teacher mentoring processes and perhaps use teacher meeting venues for training (e.g. Teacher Development Centers and cluster groupings) to strengthen teacher coping and peer to peer mechanisms and issues around HIV/AIDS life skills education. Targets at the end of a three-year period will be coverage of all T'LIPO members in all 34 Districts, with an initial focus on the six Districts covered by BRIDGE II.

Activity 5: Education sector HIV and AIDS KAP Study
Information on the negative impact of HIV/AIDS on primary and secondary education is available from two studies conducted by UNESCO in 2001 and 2004 respectively, but sampling limitations reduce the utility of these studies, which now are also outdated. Data from a recent HIV/AIDS needs assessment are limited to teacher trainees in the TTCs. As a result, significant gaps exist in the MoEST understanding of the ways in which HIV/AIDS is challenging the education system. Under the MTPDS, EMIS and TEMIS data, and any other data collection or information gathering conducted will be reviewed to will help determine what data already exist that can contribute to an assessment of the impact of HIV/AIDS on the teaching force and other MoEST staff. A KAP study focusing on the education sector

and HIV and AIDS will help address gaps in the existing knowledge concerning the impact of HIV/AIDS on the sector, especially through the planned interventions under the MTPDS (and other means) and the likely ways to mitigate those impacts while helping slow the spread of the disease.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12122	**Mechanism Name: CRS/OVC/GHAI**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Catholic Relief Services	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,250,000	
Funding Source	**Funding Amount**
GHCS (State)	1,250,000

Sub Partner Name(s)

Africare	Dedza Catholic Health Commission	D-Tree International
Emmanuel International	Lilongwe Catholic Health Commission	Opportunity International
Project Concern International	Save the Children	Telecommunication Network of Malawi
World Vision	Zomba Catholic Health Commission	

Overview Narrative

Malawi is among the hardest hit countries in the world in terms of the HIV pandemic and its effects on families. The Southern Region has the highest HIV prevalence rate at 16.5%, followed by the Central Region at 8.6%, and the Northern Region with 6.5% (OPC, 2007). Recent publications indicate 78% of people living with HIV (PLHIV) reside in rural areas out of which 69% are in the Southern Region (OPC,

2009). Such a high level HIV prevalence has contributed to the high number of orphans and vulnerable children (OVC) currently requiring support. There are approximately 1.1 million orphans in Malawi, 560,000 of whom are estimated to have been orphaned as a result of AIDS-related deaths (UNAIDS 2008). The prevalence of OVC in the southern region is highest at 23% of the children below 18 years of age.

Integrated (HIV Effect) Mitigation and Positive Action for Community Transformation (IMPACT) project is a five year Global Development Alliance of international NGOs and private for profit partners in Malawi, led by Catholic Relief Services. The goal of IMPACT is to improve the quality of life and mitigate the impact of HIV on orphans and vulnerable children and persons living with HIV (PLHIV) in Malawi. Over the life of the project, IMPACT will improve the well being of 67,000 OVC and increase access of 33,000 PLHIV to treatment and care in nine districts in Southern and Central regions of Malawi.

IMPACT will use the CRS led Title II Food for Peace program (WALA), as a platform for wrapping around services for OVC and PLHIV. Building on the substantial infrastructure of the Food for Peace (FFP) supported Wellness and Agriculture for Life Advancement (WALA) Program, and leveraging considerable resources from the public and private sectors, IMPACT will bring together six WALA partners (Africare, CRS, Chikwawa Diocese, Emmanuel International, Project Concern International, Save the Children and World Vision), and three additional partners (Opportunity International Bank of Malawi (OIBM) and Telecommunications Network of Malawi (TNM), and an information technology provider, D-Tree) to provide wrap-around services for OVC and PLHIV in targeted areas. Several faith-based partners will participate in the project: Catholic Health Commissions for Lilongwe, Dedza and Zomba to provide services in nine selected districts in Southern and Central regions of Malawi.

The IMPACT consortium brings a 1.4:1 match of private resources to the project in addition to the economies of scale generated by cost-effective integration with the USG-funded funded Food for Peace Project. Implementing partners will work across nine districts and 39 traditional authorities (TAs) and sub-chiefdoms (SCs). Program catchment areas will be predominantly rural, with one small peri-urban area included in Lilongwe District.

IMPACT will improve the wellbeing of children 0 – 17 years by providing appropriate nutrition, education, economic empowerment and protection support. Four of the proposed activities are incorporated under the WALA program and will be expanded through the non-WALA partners in IMPACT: the Care Group Model, Community-Led Complementary Feeding and Learning Sessions (CLCFLS), supporting GoM's expansion of the community integrated management of childhood illness (C-IMCI), and village savings and loans (VS&L). In addition, IMPACT partners will empower communities to protect OVC from abuse and exploitation through birth registration, interactive education on child rights, preventing child abuse,

and providing additional HIV education tools for children. Communities will also be supported to improve education retention through targeted secondary school support and school savings opportunities, as well as to improve financial assets of households hosting OVC through access to lines of credit and formal savings opportunities through OIBM. IMPACT will introduce simple targeting tools to identify truly vulnerable children and ensure that they are prioritized for services. Collectively, the services provided under SO1 will improve the emotional, physical, and social environment surrounding OVC.

IMPACT will also provide a continuum of care that increases access to HIV counseling and testing for adults and children; supports community-based pre-ART services; and reinforces the importance of adherence and follow up of individuals who test positive, ART and PMTCT patients on ART. IMPACT pre-ART activities will also support MOH to revise existing guidelines and policies.

IMPACT will pilot two M&E innovations with strong potential to benefit other organizations implementing HIV programs in Malawi. The first will be coordinated by D-Tree and involves the use of mobile-phone based applications for service delivery, including the child status index, C/IMCI protocol, and HIV client support. The second will be the use of Station Days, a child-friendly, participatory M&E strategy that monitors service provision for children.

CRS/Malawi is the grant-holder for the WALA Program, a five year Food for Peace (FFP) funded program that began implementation in southern Malawi in July 2009. Over the life of the program, WALA will reach more than 215,000 in food insecure communities in areas heavily affected by HIV. Based on clear analysis of the population density, poverty level and high prevalence of HIV, CRS/Malawi and alliance partners will leverage WALA for broad support to provide food and livelihood assistance to vulnerable households. In this way IMPACT will maximize synergy between FFP and PEPFAR resources as recommended in the Title II and PEPFAR conceptual framework, enabling PEPFAR resources to be directed to provide care and support for OVC and PLHIV, while not modifying the food security focus of main WALA activities. The table below illustrates the PEPFAR and Title II linkages, showing the breakdown of the target groups and intervention areas supported under IMPACT and WALA respectively.

The synergy created by the overlap of PEPFAR with Title II program provides a unique opportunity to effectively reach to the most vulnerable households with OVC and PLHIV. For this program, CRS proposes to add private sector, information technology and faith-based partners to the WALA consortium.

This alliance will mobilize additional expertise, cash and in-kind resources from other Government ministries, faith based institutions as well as non-traditional private sector partners. The alliance will consider partnership with a local food processing plant to fortify corn soya blend with essential vitamins. Food resources from WALA will support this program and consortium partners will prioritize the nutritional

needs of HIV-positive pregnant and lactating women, OVC, infants exposed to HIV, and HIV patients in care and treatment programs, especially those who are severely malnourished at entry.
IMPACT will work together with other USG implementing partners to increase synergies. IMPACT and Dignitas will work together on issues including defaulter tracing, adherence issues, follow up of HIV exposed infants and PMTCT. In terms of Bridge II, there will be overlap in six out of the nine districts targeted by IMPACT. Hence, the primary collaboration with Bridge II will focus on coordination and identification of geographic and demographic targets, sharing technical expertise as well as tools to maximize on coverage and standardize practices to the extent possible. The district assemblies will guide the geographic targeting by directing services where critical gaps exist. Finally, with AED, geographic overlap with the education grant is limited to only one district. IMPACT will work with AED to guide programming to under-served areas in the common district.
These interventions support the Partnership Framework and the Malawi National HIV and AIDS Response. In addition, IMPACT will directly contribute towards the achievement of the Malawi National Plan of Action for Orphans and other Vulnerable Children (2005-2009) as well as the Draft Malawi HIV and AIDS Extended National Action Framework (2010 – 2012).

Budget Summary
PFIP Year 1 Funding – $2,000,000
PFIP Year 2 Funding – $3,250,000

Cross-Cutting Budget Attribution(s)

Economic Strengthening	250,000

Key Issues

Addressing male norms and behaviors
Increasing gender equity in HIV/AIDS activities and services
Increasing women's access to income and productive resources
Increasing women's legal rights and protection

Budget Code Information

Mechanism ID:	12122		
Mechanism Name:	CRS/OVC/GHAI		
Prime Partner Name:	Catholic Relief Services		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	480,769	

Narrative:

$666,0000 – Year 1
$1,250,000 – Year 2

PEPFAR funds to the CRS led consortium will support interventions that (i)) ensure PLHIV are retained in care and initiate treatment in a timely fashion; and (iii) reduce loss to follow up of PLHIV (pre-ART and ART) and PMTCT

Activity 1: Ensure PLHIV are retained in care and initiate treatment in a timely fashion
Consistent with Goal II of the Partnership Framework IMPACT will support MOH to roll out community-based components of the national pre-ART program. PLHIV support groups and other pre-existing community structures will be the primary vehicle for all pre-ART activities. CRS/Malawi supported the HIV Unit of the MoH to conduct a preliminary workshop in August 2009 to develop a common understanding of the critical elements of pre-ART, from both the health facility as well as the community perspective. IMPACT will continue to support MoH to implement pre-ART activities at community and district levels, and support the reproduction of IEC materials, guidelines, training materials, launching events, sensitization sessions, etc. IMPACT will also train existing home-based care (HBC) volunteers in pre-ART concepts and ART adherence. These trained HBC volunteers will be responsible for working with support groups for PLHIV to raise awareness and facilitate access to key pre-ART services. They will also facilitate community-based tuberculosis screening, promote Cotrimoxazole prophylaxis for adults and children living with HIV and HIV-exposed infants; Community-based nutrition assessment and referral, including BMI calculation and individual nutrition planning; and prevention with positives. IMPACT will also conduct quarterly stakeholder meetings between volunteer representatives, health facility staff, and district health workers, and implementing partners to assess the referral and counter-referral system, discuss areas for improvement, and address any challenges This will be a critical mechanism to ensure that clients are monitored throughout the pre-ART period and initiate treatment at the appropriate time

Activity 2: Reduce loss to follow up of PLHIV on ART and PMTCT
IMPACT will establish additional PLHIV support groups in areas with poor access, as well as strengthen

existing groups as a strategy for reducing loss to follow up of pre-ART and ART patients. The National Association of People Living with HIV and AIDS of Malawi (NAPHAM) will be engaged to conduct positive living training for PLHIV support groups in targeted areas. In another effort to improve adherence, IMPACT will employ a mobile-phone based automated system to issue reminders to ART patients with phones, who desire such service. Patients may enroll in this service after receiving positive HTC results and may withdraw at any time. Messages will not contain any personal identification information, however the issue of consent will be emphasized to avoid unintentional disclosure. Also, to address the specific challenge of treatment adherence during the initial months of ART (when side effects are often most difficult) IMPACT will explore the possibility of establishing an ART-pre-ART buddy system, where clients already on ART partner with pre-ART clients to share experiences of treatment initiation and disclosure. This informal psychosocial support may help facilitate the transition to ART and improve adherence.

To reduce long-term adherence challenges, parents will be encouraged to bring children living with HIV to support groups as well. This innovation has been piloted by several CRS church partners and has proven to be a very powerful tool for helping children raise issues of stigma, the challenges of taking medication on a long-term basis, and stresses they may face in every day life. To provide effective psychosocial support, children's groups will be encouraged to self-select by age group (generally 6 to 12 year olds meet separately from 13 to 17 year olds) depending on the issue to be discussed. To facilitate children's discussion, IMPACT will adapt "Chipo's Heroes," a child-friendly ART adherence comic. For PMTCT, the Care Group Model provides an ideal platform for reducing loss to follow-up with individual counseling at the household level. Care Group Volunteers will encourage pregnant women and their spouses to attend antenatal clinics together and undergo HCT as a couple. IMPACT HIV Promoters will also work with PLHIV support groups to emphasize the importance of PMTCT, particularly delivering in facility to have full access to pre and post natal medical support. Partner disclosure remains a fundamental challenge in many Malawian communities. IMPACT will conduct awareness raising activities in target communities about the importance of male involvement in the prevention of parent to child transmission of HIV. Where individuals request assistance for disclosure, trained HCT counselors and clergy will be called on to assist.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HKID	769,231	

Narrative:

I. Budget Code: HKID

$1,333,0000 – Year 1
$2,000,000– Year 2

PEPFAR funds to CRS-led consortium will support interventions that ensure (i) OVC caregivers practise improved infant and young child feeding and caring techniques; (ii) OVC are protected from abuse and exploitation; (iii) OVC education retention rates in schools are improved; and (iv) OVC households have increased financial assets.

Activity 1: OVC caregivers practice improved infant and young child feeding and caring techniques
IMPACT will promote improved infant and young child feeding and caring techniques in project communities through the implementation of the care group model, community led complementary feeding and learning sessions, and community integrated management of childhood illnesses (C-IMCI). Using the care group model developed by CRS – an internationally recognized behavior change strategy that uses peer education (mother to mother) approach - caregivers will be encouraged to practice essential nutrition actions and key health behaviors. Men will also be encouraged to participate in care group activities. The community complementary feeding and learning sessions will be held twice every year in every catchment area and will focus on feeding young children and pregnant women using locally available foods and nutrient rich recipes in order to prevent malnutrition. C-IMCI activities will involve training community members to recognize and refer children exhibiting danger signs of serious illness to health facilities, while treating basic morbidities at community level. In this way, communities and caregivers are empowered, while health facilities are less burdened.

Activity 2: Protect OVC from abuse and exploitation
Assisting OVC to obtain legal identification will help assure their legal rights and reduce their risk to exploitation and abuse. Legal identification will also facilitate access to education, health, social, and financial services, as well as allow participation in civic activities later in life. To encourage birth registration, IMPACT will work with community child protection workers to raise awareness among local leaders and community members on the importance of birth registration and the mechanisms by which a child may be registered. IMPACT HIV promoters will also verify that OVC have been registered in the village headman registration system. Third, during periodic registration campaigns, IMPACT will assist the National Registration Bureau, Ministry of Gender Children and Community Development (MGCCD) and Registrar General Offices with logistics support in targeted traditional authorities to expand coverage. At national level, IMPACT will join the ongoing advocacy efforts of MGCCD, UNICEF, Plan International, and Human Rights Consultative Committee (HRCC). IMPACT will also strengthen the capacity of community OVC committees to identify and deal with child protection issues.

Activity 3: Improve OVC education retention rates
To improve education access and retention, IMPACT will provide targeted support for secondary education costs. In order to identify the neediest households, IMPACT will adapt the OVC Enrollment

Tool, a simple targeting form developed by CRS partners in Kenya. This single-page worksheet analyses household livelihood factors and other considerations, including disability, chronic illness, age of caregivers, number of dependents, etc., to classify the level of support needed. Empowering OVC Committees with the tools and resources to objectively identify households with the greatest need helps develop community capacity and ownership. Based on discussions with the MOGCCD, implementing partners will liaise with District Assembly to check for common names in the district database of pupils awaiting educational assistance. To ensure that school support is well used, the OVC Village Committee members and OVC guardians will visit the schools to follow up on the OVC performance on a quarterly basis. The OVC Village Committee will then conduct home visits to discuss about the child's performance with the guardian and agree on an attendance and performance improvement plan. This will provide a form of psychosocial support for OVC. Use of the Child Status Index (CSI) will also assist in measuring performance. Where children receiving support are not performing well, OVC Committees will assess the situation to determine the main causes and develop an action plan to address the challenges.

Opportunity International Bank of Malawi (OIBM) will also offer Tsogolo Langa™ account (My Future) – a savings account that will allow parents, guardians or older OVC to save for school-related costs on a monthly basis for three months, and then instruct the bank to pay a school account directly. This facilitates guardians' payment of school fees and helps guardians develop financial discipline, budgeting and savings skills. Similarly, OIBM will offer "Micro school™" loans to private schools serving school-going children aged 2-13 in both early childhood and primary education. Such loans will ensure that the schools have the necessary infrastructure such as sanitation and water.

Activity 4: Increase financial assets of OVC households

In Malawi, the informal sector supports the livelihoods of more than 80% of the population. Selected OVC aged 15 to 17 not qualifying to formal education will be offered the opportunity to enroll in informal vocational training. The Technical, Entrepreneurial and Vocational Education and Training Authority- the national regulatory body for vocational skills training - will implement this activity. TEVETA will facilitate community-based training using local artisans, and an attachment period to allow trainees to practice their newly learned skills. Trainees will receive supplies either at the start of the training to make them familiar with the tools of their trade, or at the end of their training as a graduation package. OVC Village Committees will use the OVC Enrollment Tool (OET) to identify and prioritize OVC to benefit from informal vocational training.

IMPACT will also expand the WALA experience with village savings and loans schemes to OVC and PLHIV households through sensitization. In this way, older OVC as well as relatives, parents, extended family caregivers, particularly aunts and grandmothers assuming caring responsibilities for orphans would have the option to participate. As VS&L groups increase their savings, they may graduate to access loans for income-generating activities from OIBM. Such opportunities for formal savings and

business expansion help ensure that caregivers can sustain caring for the OVC in the future. Finally, OIBM will offer agriculture micro-credit to smallholder farmers. Where farmers are participating in the production of a cash crop under an out-grower scheme for an estate, OIBM will use its Good Agricultural Practices (GAP) service to finance them with farm inputs. In this way, livelihoods are sustained through the proceeds from the sales and improved food security. Weather Index Insurance, another OIBM product, mitigates the effects of drought or excessive rainfall on yields, provided that farmers are within 30kms radius of a weather station. As access to such services grows, this insurance will be offered to additional vulnerable households.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12123	**Mechanism Name: CHSU GHAI**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Ministry of Health/CHSU	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 0	
Funding Source	**Funding Amount**

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This mechanism is zero funded in FY2010 but is contributing to FY10 APR Targets. For all activities please see the new MOH Template.

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

(No data provided.)

Budget Code Information

(No data provided.)

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12124	**Mechanism Name: FANTAII/GHAI**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Academy for Educational Development	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 50,000	
Funding Source	**Funding Amount**
GHCS (State)	50,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Goals and Objectives

In 2004, the MOH and partners developed nutrition care and support package for people living with HIV (PLWHAs), including OVCs, implemented in public ART sites. The package includes nutrition counseling for positive living, since the maintenance of good nutritional status can delay progression of HIV to AIDS, assist in the management of opportunistic infections and help cope with ART when instigated. Some technical gaps have been noted in nutrition care, treatment and support program (NCTS) that need to be addressed. According to hospital records, 25% of ART/TB clients are admitted into the NCTS program. Of these, 22% are moderately malnourished, and only 3% are severely malnourished. Yet, the program uses RUTF for all cases, making the program very expensive. It is also argued the amount of RUTF given --

about 5-6 sachets per day-- is more than necessary – FANTA estimates that about 300g would be sufficient. It has been noted that there are no links between the NCTS program and other community-based program livelihood, including those targeting OVCs. Furthermore, the NTCS and CTC programs are run as two separate and parallel programs, yet it makes logistical sense to manage them together.
Linkages with Partnership Framework
The Government of Malawi has made Nutrition, HIV and AIDS a priority within the Health pillar in the Malawi Growth and Development Strategy. The National Action Framework also prioritizes food and nutrition for PLHIV.
Geographic coverage and target population
The activities will be implemented at the national level.
Contribution toward cross cutting, gender and key issues
Human Resources for Health: FANTA II will contribute toward building the capacity of frontline health care workers by training a team of national-level staff as trainers in NCTS, who will in turn train other front line staff from the Ministry of Health and other health-service providers, such as CHAM.
Gender: N/A
Support to workplace interventions: N/A
Building Behavior Change Communication (BCC) Skills: N/A
Cost Effectiveness
Linking with Government of Malawi Activities
The NCTS program is already being implemented by the Ministry of Health in all public health facilities. This activity will improve the quality of services offered to clients.
Research, Monitoring & Evaluation Plans
None
Budget Summary
PFIP Year 1 Funding – $0
PFIP Year 2 Funding – $50,000

Cross-Cutting Budget Attribution(s)

Human Resources for Health	50,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	12124		
Mechanism Name:	FANTAII/GHAI		
Prime Partner Name:	Academy for Educational Development		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Other	OHSS	50,000	

Narrative:

Activities
FANTA will conduct two stakeholders' workshop aimed at addressing the challenges in the NCTS program. The primary objective of the workshop will be to figure out how to link the NCTS and CTC programs. The specific objectives will be to harmonize the implementation and M&E systems for the two programs. This activity will be linked to a planned evaluation of the NCTS program that will be done by AIDSTAR using core funds. The training is aimed at addressing bottlenecks and recommendations that of the AIDSTAR evaluation report. Participants to the workshop will be drawn from the Ministry of Health, The Department of Nutrition and HIV and AIDS, CHAM, and NGOs. The planned number of participants is 30.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12125	**Mechanism Name: Scaling Up Palliative Care Services in Malawi**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: African Palliative Care Association	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 200,000	
Funding Source	**Funding Amount**
GHCS (State)	200,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

Malawi has over 1 million people infected with HIV, and an estimated 25,000 living with cancer. For many of these people, curative treatment is unavailable, rendering them in need of palliative care, as a vital intervention to improve their quality of life. To this end, Malawi established the Palliative Care Association of Malawi (PACAM) in 2005 to work with health policy makers and service providers to scale-up palliative care in Malawi.

This project is a buy-in to a regional award to the African Palliative Care Association (APCA) with the Regional HIV/AIDS Program (RHAP) of the United States Agency for International Development (USAID), through the President's Emergency Plan for AIDS Relief (PEPFAR), for the scale-up of palliative care provision across several countries in Southern, Central and East Africa. In this project, APCA will continue to provide technical support to PACAM to strengthen local capacity in the provision of comprehensive palliative care services to people living with HIV/AIDS and their families.

The overall objective is to scale up palliative care services in Malawi through a partnership between APCA and PACAM by: 1) Strengthening the human and institutional capacity of PACAM to effectively coordinate palliative care development in Malawi; 2) Promoting linkages and sharing of knowledge between and among palliative care providers within Malawi; 3) Promoting, through advocacy, the availability of the essential drugs required for provision of palliative care in Malawi; and Coordinating and facilitating palliative care training and mentorship for NGOs, FBOs and government facilities to enhance the integration and provision of comprehensive palliative care within existing services.

The project will continue to build on the work that began in January 2008 with PEPFAR funding through PACT Malawi to PACAM/APCA. In the past two years with technical support from APCA, PACAM has strengthened its capacity to deliver comprehensive and holistic palliative care services, and provided technical support for palliative care in Malawi. Key health professionals at the Ministry of Health, NGOs, and CHAM have been trained to provide palliative care services; a strong working relationship has been established with the MOH; and a 5-day introductory palliative care course for health professionals accredited by the Ministry of Health has been developed.

To date twelve health professionals in Malawi (4 nurses, 2 doctors and 6 clinical officers) have received postgraduate qualifications in palliative care. 578 health professionals from district and CHAM hospitals have received an introduction to palliative care through a 5-day training. The 5-day training was delivered by those with postgraduate qualifications. As this project moves forward a mapping exercise will be carried out to establish the exact number of trained health professionals across the country to establish

which districts and facilities are adequately covered by trained palliative care staff and how they are using the knowledge they have acquired to support the ongoing development of palliative care in Malawi. Once this is established then it will be evident where the need for new trainings will be and can be planned accordingly.

Despite these successes, several challenges remain around legislation and policy; availability of opioids for pain relief; integration of palliative care into home based care services; and continued organizational development and technical support for PACAM to strengthen its role as a national coordinating and facilitating body. In July 2009 key MOH policy makers from Malawi visited Uganda to study the practice of scaling up morphine availability nationwide. The expected outcome of this visit was to support the development of opioid roll out in Malawi. With a national advocacy strategy in place this project will continue to advocate for improved drug availability and promote palliative care across Malawi.

The project will support Goals 3 and 4 of the Partnership Framework which seek to mitigate the economic and psychosocial effects of HIV and AIDS and improve the quality of life for PLHIV, OVC and other affected individuals and households; and to provide targeted, discrete systems strengthening in human resources, and procurement and supply chain management, respectively.

Budget Summary
PFIP Year 1 Funding – $0
PFIP Year 2 Funding – $200,000

Cross-Cutting Budget Attribution(s)

Human Resources for Health	200,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12125**
Mechanism Name:	**Scaling Up Palliative Care Services in Malawi**

Prime Partner Name:	African Palliative Care Association		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	200,000	

Narrative:

200,000 – Year 2

PEPFAR funds to APCA will support interventions that strengthen the human and institutional capacity of PACAM to effectively coordinate palliative care development in Malawi; promote linkages and sharing of knowledge between and among palliative care providers; promote the availability of essential drugs required for palliative care; and facilitate palliative care training.

Activity 1: Strengthen the human and institutional capacity of PACAM to effectively coordinate palliative care development in Malawi.

APCA supported PACAM to develop a clear strategic plan for 2009-2011. Through the implementation of the strategic plan and continued support to finalize and implement its fundraising strategy, APCA will assist PACAM to assess their sustainability and explore avenues through which this can be achieved. APCA will also support PACAM to assess and strengthen the organizational development needs of its member organizations, such as hospices; as well as work with PACAM to strengthen the monitoring and evaluation (M&E) of services. This will allow high quality data to be collected, analyzed and used for information and reporting on every PACAM activities by the PACAM secretariat and the wider stakeholders where relevant as well as forming a national palliative care a dataset for Malawi. As the M&E work develops and grows an M&E officer will be recruited to manage the dataset.

Activity 2: Promote linkages and sharing of knowledge between and among palliative care providers within Malawi.

PACAM will be supported to continue to promote linkages and sharing of knowledge between and among palliative care providers within Malawi through sharing of information and knowledge between and among palliative care providers within the country. Key activities will include collaboration with MOH to introduce palliative care into home-based care networks. APCA/PACAM will train all district home based care coordinators in palliative care. This training will be accredited by MoH so home based care coordinators will be certified as home-based palliative care trainers. Using the palliative care manual for volunteers APCA and PACAM will support MOH to train community volunteers in all 3 regions in Malawi. It is important to train community volunteers in palliative care to equip them with skills to deliver quality

palliative care. APCA will also establish a national taskforce team. A national taskforce team is essential to build links between the association, Government, MOH and other key players in palliative care.

Activity 3: Promote, through advocacy, the availability of the essential drugs required for provision of palliative care in Malawi.

APCA/PACAM will support ongoing advocacy training for in-country policy change that will facilitate the greater availability of pain relief drugs and the integration of palliative care services within the national HIV/AIDS framework. APCA/PACAM will also provide opioid guidelines orientation to prescribers using the opioid guidelines book currently being developed by APCA and PACAM. The handbook will act as a guide for morphine use to ensure morphine becomes widely used and phobias surrounding its use are eased amongst health professionals. APCA in collaboration with PACAM and MOH will develop a curricula and a training manual for prescribers and we will support MOH to provide prescribers' training. The training will help prescribers to understand the importance of morphine use for patients with severe pain and will focus on morphine storage, records keeping and reporting systems. It is expected that after the training prescribers will have reduced their fears regarding prescribing morphine to patients. APCA will also conduct district consultations to advocate for the inclusion of palliative care in district implementation plans; as well as strengthen referral networks for services.

Activity 4: Coordinate and facilitate palliative care education, training, standards and mentorship

In collaboration with MoH and with support from APCA, PACAM has finalized the development of a 5-day introductory palliative care course for health professionals and the training manual for this course has been finalized and piloted with great success. The course is recognized and accredited by the Ministry of Health. In view of this APCA, PACAM and the Ministry of Health will train trainers to deliver this course. PACAM has also been accredited by Medical Council of Malawi to provide Continuous Professional Development (CPD) for clinicians as a result of the impact of its work. APCA will train 10 master trainers. On completion of the 2-week training the participants will be accredited as MoH palliative care trainers. These Trainers of trainers will then train 30 Home based care workers and volunteers, including training of men as care givers using manuals developed by APCA. APCA has also developed palliative care standards for enhancing quality of care of patients with life-threatening illnesses and their families. The standards will be piloted in 3 sites that are involved in care provision. The results will allow the standards to be incorporated into the national palliative care standards and guidelines for Malawi.

Activity 5: Policy review to allow nurses prescribe opioids
At present only doctors are able to prescribe opioids in Malawi. APCA and PACAM will enter into discussions with MOH and key stakeholders to advocate for policy change to allow nurses to prescribe

opioids.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12126	**Mechanism Name: Feed/OVC/GHAI**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Feed the Children	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,056,000	
Funding Source	**Funding Amount**
GHCS (State)	1,056,000

Sub Partner Name(s)

Family Health International	NuSkin Inc/Local	Orphan Support Africa
Total Land Care	World Relief	

Overview Narrative

Malawi suffers from chronic poverty and repeated food insecurity. Nearly half of Malawi's population of 14 million people struggle to live on less than US $1 a day. More than 90 percent of those most affected by extreme poverty live in rural areas and depend on subsistence farming for their daily livelihoods. Malawi is predominantly an agriculture-based economy and has only one growing season, which limits the overall annual crop yields. Farming remains strongly attached to, and heavily reliant on, maize-crop production.

Further, Malawi has one of the highest levels of malnutrition in sub-Saharan Africa, with 22 percent of children under weight for age, and 53 percent of children under height for age.
HIV/AIDS in the community increases food insecurity by taking the lives of the young adults and leaving behind an imbalance of orphans and the elderly. Food insecurity also increases the level of risk behavior among women and children who may trade sex for food or enter into early marriage as a means to improved food security. As the traditional coping mechanisms of communities reach the breaking point,

the impact on children is manifest in multiple, overlapping ways including loses in economic productivity, less access to education and nutrition, and potential long-term psychological effects.

The Feed The Children Alliance, a public-private partnership, will implement Nutrition NOW, a five year project providing targeted, supplemental nutritional commodities and water purification packets, supported by technical training, mentorship, and assistance to HIV affected communities in nine districts (Salima, Chitipa, Dowa, Lilongwe, Mzimba, Nkhata Bay, Ntcheu, Rumphi, and Nkhotakota) in northern and central regions of Malawi. The project seeks to improve the nutritional status and psychosocial well being of OVC attending community based child care centers (CBCCs); strengthen the capacity of CBCCs to provide services to children; and support household economic strengthening and improved agricultural practices for households with OVC.

The Alliance consists of leading NGOs with extensive experience in Malawi, including Feed The Children (FTC), Family Health International (FHI), World Relief (WR), Orphans Support Africa (OSA) and Total Landcare (TLC). Nutrition NOW will be implemented in close collaboration with the Ministry of Gender, Child Welfare and Community Development, Ministry of Health, and Department of Nutrition, HIV and AIDS, with the National AIDS Council, district and local authorities, communities, PLHIV, and national and international private sector institutions. The Alliance provides a greater than 1:1 match of resources for the project.

NuSkin, Inc., a private sector company based in the United States, will provide 1,323 tons of VitaMeal, made with locally produced and purchased corn and soy, and fortified to specifications with added vitamins and minerals to 27,644 OVC in 315 CBCCs in the project communities. This will supplement the nutritional intake of vulnerable children. VitaMeal is important because it is made with locally produced and purchased corn and soy, and is fortified to ensure that beneficiaries receive not only calories, but important nutrients and vitamins. Proctor and Gamble will provide 5.5 million PUR (point of use) water purification packets to be distributed to targeted communities with unsanitary water sources to provide immediate protection for OVC and their families. The Alliance partners will also support long term and sustainable clean water sources through well-rehabilitation and upgrading.
These private donations will be complemented by complementary technical assistance in training, community mobilization, psychosocial services, income generation, gardening, agricultural system strengthening and other areas to assure high quality interventions in CBCCs and surrounding communities, and reduce dependency on donated food. Project inputs will also include construction materials, cooking kits, seeds, fertilizers, wells, and irrigation systems. This combination of interventions and inputs will result in small scale garden/food production, construction and/or renovation of CBCCs, including toilet and kitchen facilities, and improved nutrition status and well-being of target populations. Nutrition NOW supports Goal 3 of the Partnership Framework, which is to mitigate the economic and

psychosocial effects of HIV and AIDS and improve the quality of life for PLWHA, OVC, and other affected individuals and households. It also supports Malawian leadership and ownership of the national response to HIV/AIDS.

Nutrition NOW will measure progress against defined project indicators that include key PEPFAR Next Generation indicators. The project will also collaborate with activities of the GOM, USAID/M, Global Fund, UNICEF, the Funders Collaborative and other funders in data collection and analysis. M&E data will be reviewed quarterly by Nutrition NOW partners and program decisions made based on findings. Baseline studies, midterm and final evaluation results, lessons learned and best practices will be shared in workshops held with this wide range of stakeholders.

Budget Summary
PFIP Year 1 Funding – $1,000,000
PFIP Year 2 Funding – $2,056,000

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	50,000

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12126**		
Mechanism Name:	**Feed/OVC/GHAI**		
Prime Partner Name:	**Feed the Children**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	1,056,000	
Narrative:			
I. Budget Code: HKID			

$1,000,000 – Year 1
$2,056,000 – Year 2

PEPFAR funds to Feed the Children will support interventions that improve the nutritional status of children attending CBCC, strenghten the capacity of CBCCs to provide services to children; and support household economic strenghtening for OVC households.

Activity 1: VitaMeal distribution, management and use at CBCCs
FTC will work with its Alliance partners, other NGOs and other implementing agencies to develop the overall Nutrition NOW plan for VitaMeal supplementation that will best meet the needs of the CBCCs. This planning will involve in-depth discussions with producers and suppliers, relevant local and national government officials, CBCC and community committees, and all project stakeholders. FTC will draw upon its extensive experience and strong ties with the private sector members of the Alliance to manage and oversee the VitaMeal input. Nutrition NOW will distribute VitaMeal to 315 CBCCs in the nine project districts. The provision of VitaMeal will be made to the CBCC based on the high prevalence of OVC enrolled and the ability of the CBO networks to adequately manage this resource. All CBCCs receiving VitaMeal will be trained in the development and use of supply inventories and distribution lists.

Activity 2: Distribution and Education with PUR
In cooperation with the U.S. CDC, Proctor &Gamble developed PUR Purifier of Water, a powdered household water disinfectant that comes in small, affordable, and easy-to-use packets. Like safe water solution and other chlorine disinfectants, PUR inactivates viruses, bacteria, and protozoa, removes arsenic and turbidity (dirt) from water, leaving the water clear and safe to drink. PUR educes the incidence of diarrhea in young children by around 50%, and meets WHO standards for potable water. PUR will be distributed alongside the VitaMeal, and through the initial assessment, will be provided to those communities that lack reliable access to clean and safe water. Nutrition NOW will also distribute powdered PUR water purification packets to 5,100 households in addition to CBCCs.

Activity 3: CBO orientation
All local CBO partners and other community development structures will be provided an orientation to the proposed program, and will be provided information about the project, expectations about community participation, and the need to develop a sustainability plan jointly from project outset. Community obligation requirements are important to mitigate institutional dependency on outside food provision. This will enable CBOs to more effectively support implementation of Nutrition NOW, as well as the CBCCs themselves. The program start up meetings will be followed up by regular visits from the Nutrition NOW field staff.

Activity 4: Training and Support for CBCC Care Givers
Nutrition NOW will train caregivers initially and in refresher courses in 315 CBCCs on growth monitoring and psychosocial services for children in CBCCs using the curriculum approved by the Ministry of Gender, Child Welfare and Community Services. Training will also be provided to groups of CBCC caregivers and CBCC committees on psychosocial support services and on management of CBCCs. Nutrition NOW will organize a one day training-of-trainers (ToT) for groups of 20 caregivers (minimum of seven trainings) on growth monitoring and recording, preparation and use of VitaMeal. These trainers will then be able to provide on-going training for their CBCCs. Each CBO with a ToT can then provide new volunteer training in smaller segments. Other key topics for trainings to CBCC staff include:

MOGCCD Minimum quality standard for OVC programming; OVC care and support, using nationally approved curricula and OVC advocacy and care manual Let Your Light Shine; Child care and protection services; Communicating age-appropriate messages on proper health and nutrition; Recognizing the signs and symptoms of severe malnutrition and other illnesses and ensuring proper referrals to medical services; and general care giving skills. A cascade approach will be used to train CBO staff and CBCC leadership first, who can in turn provide training (formally and informally) to other CBCC caregivers. Trainings will be refreshed throughout the life of the project and assessed to determine if caregivers felt there were any gaps in their training.

Activity 5: Equip Health Surveillance Assistants to provide nutritional assessments
Health Surveillance Assistants (HSAs) periodically visit CBCCs to monitor the health of the children and perform routine primary health services. The Nutrition NOW project will assess whether HSAs require any training to improve the quality of their services and, if required, provide such a training to also include training on nutritional assessments.

Activity 6: Extending nutrition knowledge and support
Nutrition NOW will work with its local CBO partner organizations to mobilize communities to support CBCCs. This will include establishing/strengthening CBCC parents' committees, CBCC volunteer care givers, and community members to ensure they are trained in the storage and preparation of VitaMeal and other foods, proper feeding for young children, able to provide basic psychosocial support, and able to use other commodities (i.e. PUR). Nutrition NOW's mobilization model encourages community participation, empowerment and ownership of these supportive interventions. Nutrition NOW will also train Home Care Providers (HCPs) i.e. CBO community volunteers to provide nutrition and health education to families in their homes during their biweekly follow up visits. Wherever possible, the messages being delivered at CBCCs will be extended into homes and families where OVC spend the majority of their time.

Activity 7: Income generating activities in support of CBCC communities
Nutrition NOW will support several income generating activities (IGA) at the community level. FTC will provide rabbits to 10 CBCC groups of ten female- or child-headed households as an income generating project. As the rabbits multiply, the initial recipients will be required to distribute a male female pair of rabbits to other CBCC households in the same CBCCs or in other CBCCs. FTC will work with community CBCC committees to help select households. FTC discussed this activity with the Ministry of Agriculture and received a commitment of support for the training and technical guidance, especially for those committees and households first to initiate the rabbit activities. Income from the sale of rabbits can be used to purchase other food stuffs in vulnerable households and will serve as a high protein food to improve food availability in these vulnerable households. Other low-cost income generating prospects include petty trade, and procurement and distribution of hand-cranked peanut shellers; livestock rearing with appropriate technical guidance and support; agricultural development and small-scale farming projects. Orphan Support Africa will provide farm inputs (fertilizer and seed) to CBCC communities to enable them to produce maize and groundnuts and increase food availability. Small grants will also be provided to communities to plan and manage their own IGA projects. TLC will provide training in agriculture at demonstration plots to community volunteers; and training in business management. These activities will be targeted to caregivers or female/child headed families and will be linked with Malawian microfinance and savings institutions in order to gain access to micro-credit.

Activity 8: Strengthen CBCCs' capacity to effectively provide services to children in their catchment areas
To effectively serve children, CBCCs must be equipped with basic management techniques that will improve the efficiency and range of the services they offer. To ensure project sustainability and improve the capacity of CBCCs, Nutrition NOW proposes to train and mentor CBCCs Management Committees to improve the operational and financial management of the centers, including, but not limited to: Volunteer management; data collection; Infrastructure support and maintenance; and Community garden management (How to make use of agricultural extension offices). Nutrition NOW partner World Relief will also ensure effective management of CBCCs through their network of Church based volunteers. OSA will also use its unique participatory to train CBO committees in financial and organizational management income generating activities and food production, OVC psychosocial services, training support for CBCCs and provides grants for income generation defined by the community.

Activity 9: Construction and renovation of CBCCs
Nutrition NOW will work with its network of CBOs for community mobilization for the construction or renovation of CBCCs. Communities will provide labor, bricks, sand, gravel and some local materials, and Alliance partners will fund the purchase of corrugated sheets, iron bar and cement needed for the construction/renovation. The Alliance Partners will follow the GOM technical specifications & national standards for CBCC construction, and bricks will be made in an environmentally friendly way which does

not require the destruction of trees. FTC can commit to 10 construction/renovation projects each year. World Relief can commit to 10 construction/renovation projects, and in 50 CBCCs, WR will also mobilize communities to construct an extra 10 CBCCs, 50 toilets and 50 kitchens using their own resources (100% community contribution). OSA will also supply cooking and eating utensils, play and educational supplies to 27 CBCCs. The educational supplies will support the CBCC committees, volunteers and others to support and strengthen early childhood development activities and other psychosocial activities for children attending the CBCCs. These kits also enhance CBCCs' ability to prepare VitaMeal and other food served at the CBCC.

Activity 10: Construction of shallow wells
FTC unique contributions will also include the mobilization for the rehabilitation of 10 shallow wells near CBCCs in Lilongwe, Ntcheu and Dowa, and introduce low-tech, low-lift pumps to improve the quality of the water available at CBCC and their gardens. FTC will provide the pumps and the community will contribute the local labor and materials needed. Where repairable boreholes exist, FTC will work with technicians from the GOM water department to provide the technical guidance and support the communities' rehabilitation of these wells and train committees on the pumps maintenance.

Activity 11: Agricultural Technical Assistance and Improved Irrigation systems
Total Landcare's unique inputs will include agricultural technical assistance that are well suited to the agriculture environment: irrigated dry season high value crop production and conservation agriculture (CA) for maize and other crops. Irrigated agriculture provides both a more diversified diet as well as increased production during the long dry season. CA is labor saving, as annual hilling and much of the weeding is eliminated by the use of mulches to inhibit weed germinations. In HIV affected areas, labor is significantly reduced due to adult mortality, thus CA returns allow either more land to be cultivated or permits the adult population to carry on other duties. Also, CA has shown improved maize yields, directly benefiting food security. Finally, CA reduces soil erosion, and important benefit to sustaining agricultural productivity. Other low-cost irrigation systems will also be promoted to increase food security, nutrition and incomes during the winter or dry season. This activity will be implemented in the districts of Dowa in year 1 and expanded to Salima, Ntichisi, Nkhotakota or Nkhata Bay in the second year of the project. The aim of irrigated agriculture is to build the capacity of target communities to become more self sufficient and to take better care of their children. Systems promoted will include: Treadle pumps for pumping water manually to farms; river or stream diversion; or conservation agriculture. TLC will target a total of 500 with these systems.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12127	**Mechanism Name: DOD/TBD/MDF**
Funding Agency: U.S. Department of Defense	Procurement Type: Grant
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

TBD narrative – Continuing Activities

PEPFAR has provided funding to support HIV and AIDS interventions in the Malawi Defense Force (MDF) since the 2006 COP. Current activities are funded through Project Concern International (PCI) – see accompanying narratives. Pending an in-country visit by DHAPP to determine the follow-up plans for PCI (PCI is fully funded 2009 – 2012), DOD will program these resources for the PCI follow-up. Lab support to the MDF through the Partnership Framework to refurbish the three regional MDF labs is being undertaken by the lab partner HUTAP – see Howard narrative.
The Malawi Defense Force (MDF) is the only military force in the country. Under the authority of the Army Commander, the MDF is composed primarily of army units, but has a marine unit and an air wing. Currently smaller than the authorized strength of 10,000, the MDF is a highly professional and apolitical force and customarily earns praise for its performance, conduct, and contributions when participating in regional military exercises and training with U.S. troops. The annual military expenditure is $11.2 million, which is approximately 0.73% of GDP and 2% of the national budget.

The MDF operates in a unique HIV/AIDS environment when in Malawi and in diverse HIV/AIDS environments during peacekeeping and humanitarian operations. Understanding such environments is of paramount importance when considering the risk exposure of soldiers and their dependants. Due to the fact that the MDF is largely located in the urban areas, its prevalence rate is estimated to be closer to that of the urban population. Available data shows that urban prevalence rate is 22.83% (NAC 2003) and 20.8% (GOM/MOH, 2003). Based on this data the MDF's Strategic Action Plan assumes the possible

HIV prevalence rate for the MDF ranks between 20-25%.

The MDF has two sites providing antenatal and delivery services, Cobbe Barracks in Zomba and Kamuzu Barracks in Lilongwe. In addition, MDF provides antenatal services only at Chilumba garrison in Karonga, the Marine Unit in Mangochi, the Combat Support Battalion in Dowa, and the Malawi Armed Forces College (MAFCO) in Salima. MDF has plans to establish labor wards at the MAFCO and Combat Support Battalion clinics. All these sites are serving large civilian populations surrounding the facilities because government hospitals are not within reach. Since the MDF supports civilians in the surrounding communities, Ministry of Health (MoH) assigns at least one nurse or clinical officer in clinics that provide such services.

Linkages to the PMTCT program implemented by UNC for the MDF

? Implementation of PMTCT will be a first time activity for the MDF.
? Initially PMTCT will be executed at Kamuzu barracks as a pilot and then depending on successes, will be replicated in other units, starting with major units of Cobbe barracks in Zomba, Moyale in Mzuzu and Malawi Armed Forces College in Salima.
? This program will increase gender equity by involving and encouraging men (spouses) to participate and be available by accompanying their spouses to maternal visits and HIV/AIDS education on PMTCT sessions.
? Civic education that will encourage men to be supportive to their spouses will be highly encouraged to promote understanding as a couple with an aim of protecting the unborn child.
? It is widely recognized that gender norms-societal expectations of men's and women's roles and behaviors-fuel the global HIV epidemic. Equally, working with men to relieve their traditional male gender norms that encourage men to equate a range of risky behaviors-the use of violence, substance abuse, the pursuit of multiple sexual partners, the domination of women-with being manly would also help reduce the problem of HIV transition. Rigid constructs of masculinity also lead men to view health-seeking behaviors as a sign of weakness. Addressing these gender dynamics would play a critical role in reducing both men and women's vulnerability to HIV.
? Women will be trained on their legal right so that they are able to seek legal assistance incase of abuse.
? Involving women in income generating activities will make them more independent and self sufficient and less venerable to further risk of HIV infection. Reversing women's low status in many societies that contribute to limiting the social, educational and economic opportunities would help protect them from infection.

Budget Summary

PFIP Year 1 Funding – Redacted
PFIP Year 2 Funding – Redacted

Cross-Cutting Budget Attribution(s)

(No data provided.)

Key Issues

Military Population

Budget Code Information

Mechanism ID:	12127		
Mechanism Name:	DOD/TBD/MDF		
Prime Partner Name:	TBD		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	Redacted	Redacted

Narrative:

TBD narrative – Continuing Activities

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Linkages to the PMTCT program implemented by UNC for the MDF

? Implementation of PMTCT will be a first time activity for the MDF.
? Initially PMTCT will be executed at Kamuzu barracks as a pilot and then depending on successes, will be replicated in other units, starting with major units of Cobbe barracks in Zomba, Moyale in Mzuzu and Malawi Armed Forces College in Salima.
? This program will increase gender equity by involving and encouraging men (spouses) to participate and be available by accompanying their spouses to maternal visits and HIV/AIDS education on PMTCT sessions.
? Civic education that will encourage men to be supportive to their spouses will be highly encouraged to promote understanding as a couple with an aim of protecting the unborn child.
? It is widely recognized that gender norms-societal expectations of men's and women's roles and behaviors-fuel the global HIV epidemic. Equally, working with men to relieve their traditional male gender norms that encourage men to equate a range of risky behaviors-the use of violence, substance abuse, the pursuit of multiple sexual partners, the domination of women-with being manly would also help reduce the problem of HIV transition. Rigid constructs of masculinity also lead men to view health-seeking behaviors as a sign of weakness. Addressing these gender dynamics would play a critical role in reducing both men and women's vulnerability to HIV.
? Women will be trained on their legal right so that they are able to seek legal assistance incase of abuse.

? Involving women in income generating activities will make them more independent and self sufficient and less venerable to further risk of HIV infection. Reversing women's low status in many societies that contribute to limiting the social, educational and economic opportunities would help protect them from infection.

Budget Summary
PFIP Year 1 Funding – Redacted
PFIP Year 2 Funding – Redacted

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVAB	Redacted	Redacted

Narrative:

TBD narrative – Continuing Activities

PEPFAR has provided funding to support HIV and AIDS interventions in the Malawi Defense Force (MDF) since the 2006 COP. Current activities are funded through Project Concern International (PCI) – see accompanying narratives. Pending an in-country visit by DHAPP to determine the follow-up plans for PCI (PCI is fully funded 2009 – 2012), DOD will program these resources for the PCI follow-up. Lab support to the MDF through the Partnership Framework to refurbish the three regional MDF labs is being undertaken by the lab partner HUTAP – see Howard narrative.
The Malawi Defense Force (MDF) is the only military force in the country. Under the authority of the Army Commander, the MDF is composed primarily of army units, but has a marine unit and an air wing. Currently smaller than the authorized strength of 10,000, the MDF is a highly professional and apolitical force and customarily earns praise for its performance, conduct, and contributions when participating in regional military exercises and training with U.S. troops. The annual military expenditure is $11.2 million, which is approximately 0.73% of GDP and 2% of the national budget.

The MDF operates in a unique HIV/AIDS environment when in Malawi and in diverse HIV/AIDS environments during peacekeeping and humanitarian operations. Understanding such environments is of paramount importance when considering the risk exposure of soldiers and their dependants. Due to the fact that the MDF is largely located in the urban areas, its prevalence rate is estimated to be closer to that of the urban population. Available data shows that urban prevalence rate is 22.83% (NAC 2003) and 20.8% (GOM/MOH, 2003). Based on this data the MDF's Strategic Action Plan assumes the possible HIV prevalence rate for the MDF ranks between 20-25%.

The MDF has two sites providing antenatal and delivery services, Cobbe Barracks in Zomba and Kamuzu Barracks in Lilongwe. In addition, MDF provides antenatal services only at Chilumba garrison in Karonga, the Marine Unit in Mangochi, the Combat Support Battalion in Dowa, and the Malawi Armed Forces College (MAFCO) in Salima. MDF has plans to establish labor wards at the MAFCO and Combat Support Battalion clinics. All these sites are serving large civilian populations surrounding the facilities because government hospitals are not within reach. Since the MDF supports civilians in the surrounding communities, Ministry of Health (MoH) assigns at least one nurse or clinical officer in clinics that provide such services.

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Budget Summary
PFIP Year 1 Funding – Redacted

PFIP Year 2 Funding – Redacted

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	Redacted	Redacted

Narrative:

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Budget Summary
PFIP Year 1 Funding – Redacted
PFIP Year 2 Funding – Redacted

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12128	**Mechanism Name: TBD/CIRC**

Funding Agency: U.S. Agency for International Development	Procurement Type: Contract
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

This new activity will support the implementation of male circumcision services in Malawi over the final four years of the Partnership Framework. The RFP will be written in 2010 after Malawi has drafted more definitive male circumcision policy, and will be sent to PEPFAR HQ for input and review.

Given that the BLM circumcision activity (see BLM narrative) will emphasize support for circumcision in the private sector (although some clinicians in the public sector will also be trained and supported through this agreement), the TBD circumcision activity will have more of an emphasis on the public sector, supporting the MOH providers and facilities to roll-out circumcision nationally. Since $9 million is currently budgeted in the GFATM NSA for circumcision, the contract will be designed in a specific way to complement these resources.

Innovative approaches being used by BLM such as the use of vouchers to reimburse providers will also be scaled-up within the TBD project if they are proved to be successful.
For the purposes for target setting for this TBD COP entry, a fully-loaded cost based upon UNIADS estimates of $35 per circumcision has been utilized and targets are applied for only 9 months, allowing 3 months for project start-up. However, it is anticipated that once the project is up and running, economies of scale will enable the cost to be substantially lower than this in years 2-4. The COP entry will be revised and submitted in more detail to HQ.

PFIP Year 1 budget - Redacted
PFIP Year 2 budget - Redacted

Cross-Cutting Budget Attribution(s)

Human Resources for Health	Redacted

Key Issues

(No data provided.)

Budget Code Information

Mechanism ID:	**12128**		
Mechanism Name:	**TBD/CIRC**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Prevention	CIRC	Redacted	Redacted

Narrative:

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PFIP Year 1 budget - Redacted PFIP Year 2 budget - Redacted

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12129	**Mechanism Name: TBD/LM/GDA**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: TBD	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: Yes	Global Fund / Multilateral Engagement: No

Total Funding: Redacted	
Funding Source	**Funding Amount**
Redacted	Redacted

Sub Partner Name(s)

(No data provided.)

Overview Narrative

TBD NARRATIVE

This proposed project will be a new public-private partnership to strengthen care for orphans and vulnerable children in HIV-affected communities in Malawi. The project is expected to be innovative and pilot new strategies and/or scale up tested strategies that show promise in addressing strengthening family and community capacity to care, support and protect vulnerable children, as well as improve their access to essential services. One or multiple awards may be made depending on the applications that come in under the APS.

Potential partnerships will be in line with the Malawi HIV and AIDS National Action Framework and the Malawi National Plan of Action for Orphans and Vulnerable Children and focused on expanding implementation of a comprehensive package of high quality interventions for orphans and vulnerable

children (which may include care and shelter, food and nutrition, education and vocational skills training, health care – including care for children living with HIV, protection, psychosocial support and household economic strengthening). All activities will be linked to the HIV/AIDS Program Element and Orphans and Vulnerable Children Sub-Element in the Foreign Assistance Framework.

It is expected that the project will also include elements that address USAID/Malawi Economic Growth and USAID/Malawi Education Team priorities. While PEPFAR resources awarded under this project must specifically target children affected or made vulnerable by HIV, private resources used for leverage under this project may not necessarily be exclusively focused on OVC and could involve a wide range of activities targeting other groups than OVC and their families in different sectors including education, agricultural development, food and nutrition, primary health care, microfinance, women's empowerment.

Budget Summary
PFIP Year 1 Funding – Redacted
PFIP Year 2 Funding – Redacted

I. Budget Code: HKID
Redacted - Year 1
Redacted – Year 2
PEPFAR funds to this TBD partner or partners will support interventions that strengthen family and community capacity to care, support and protect vulnerable children, as well as improve their access to essential services.

Cross-Cutting Budget Attribution(s)

Economic Strengthening	Redacted
Food and Nutrition: Policy, Tools, and Service Delivery	Redacted

Key Issues

Increasing gender equity in HIV/AIDS activities and services

Budget Code Information

Mechanism ID:	**12129**		
Mechanism Name:	**TBD/LM/GDA**		
Prime Partner Name:	**TBD**		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HKID	Redacted	Redacted

Narrative:

TBD NARRATIVE

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Budget Summary
PFIP Year 1 Funding – Redacted

PFIP Year 2 Funding – Redacted I. Budget Code: HKID Redacted - Year 1 Redacted – Year 2 PEPFAR funds to this TBD partner or partners will support interventions that strengthen family and community capacity to care, support and protect vulnerable children, as well as improve their access to essential services.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12130	**Mechanism Name: Baylor/QCT/GHAI**
Funding Agency: U.S. Agency for International Development	Procurement Type: Cooperative Agreement
Prime Partner Name: Baylor College of Medicine Children's Foundation Malawi	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,125,227	
Funding Source	**Funding Amount**
GHCS (State)	1,125,227

Sub Partner Name(s)

Feed the Children		

Overview Narrative

1. Comprehensive Goals and Objectives

Despite an extensive literature on improved PMTCT regimens, post-exposure prophylaxis, and rapid clinical progression in HIV-infected infants, there has been scant progress made on how best to coordinate and ensure delivery of the multiple services that HIV-positive mothers and their infants require in the real-world setting. In the Lilongwe area, the BCM-CFM Tingathe outreach program has made

strides in developing systems to improve the quality and utilization of PMTCT, EID, and pediatric HIV care services. The main goal of this project is to expand the scope and reach of the Tingathe program resulting in a majority of mothers and infants at participating facilities receiving the full complement of PMTCT and EID services and prompt entry of infected infants and mothers into care for optimal treatment outcomes. This goal will be achieved through the following objectives:

a. Conduct operations research to identify barriers to mothers and infants accessing of services and strategies to overcome these barriers and improve service delivery.
b. Sensitize the community to reduce stigma and increase utilization of services.
c. Strengthen coordination and linkages between services to help ensure provision of comprehensive medical care.
d. Improve the quality of existing services and their capacity to absorb increased patient load via training, mentorship, and supervision of MOH staff, with a focus on the Northern Zone and Blantyre District for clinical HIV services more broadly, as well as capacitating other partners to provide enhanced support to improve pediatric HIV on a national level.
e. Provide a continuum of care for infected women and their infants starting at ANC and continuing until a definitive positive or negative diagnosis of exposed infant.
f. Improve identification of HIV-infected women and children and early referral to care through both health facility based and community home based testing and active case finding.
g. Improve adherence supervision and defaulter tracking activities.
h. Engage and coordinate services provided by local NGOs, CBOs, FBOs and other stakeholders to HIV-infected mothers and their infants.

2. Linkage to Partnership Framework (PF) between PEPFAR and the Government of Malawi (GOM)
The Tingathe program addresses all four goals of the Partnership Framework as follows:

a. To reduce new HIV Infections in Malawi. Through improved utilization of PMTCT and EID services there will be a dramatic decrease in the number of children infected through MTCT, which currently accounts for up to one quarter of all new infections.

b. To improve the quality of treatment and care for Malawians impacted by HIV. The main goal of this project is to use Community Healthcare workers (CHWs) to improve quality and linkages between PMTCT, EID, and pediatric HIV Care and Treatment services.

c. To mitigate the economic and psychosocial effects of HIV and AIDS and improve the quality of life for PLHIV. Through this program, patients and their families will be followed by CHWs who will advocate for them and ensure that they are receiving all available services.

d. To support the above listed goals in Prevention, Treatment and Care by providing discrete systems strengthening support in human resources. Our CHWs will serve to improve quality of services and the continuum of care at participating health care facilities and will serve as an example of how task-shifting can result in overall strengthening of the care system.

3. Geographic Coverage
Service delivery will be focused on ten high burden sites in the Central Region. Based on successful implementation at these sites, we have plans to expand coverage to high burden sites in both the North and South. Site assessments in the North and South will begin during year one of the program, with initial implementation activities starting during the second year.

4. Health System Strengthening
Through demonstration of improved service delivery, this project aims to inform policy on optimal and efficient use of task shifting and community health workers to improve PMTCT, EID and Pediatric HIV Care and Treatment Services.

5. Cross-Cutting Attributions
a. Human Resources for Health (HRH)
b. Food and Nutrition- Policy, Tools, and Service Delivery
c. Food and Nutrition - Commodities

6. Key Issues
a. Health-Related Wraparounds: Child Survival Activities; Safe Motherhood
b. Gender: Increasing Gender Equity in HIV AIDS Activities and Services; Addressing Male Norms and Behaviors

7. Cost Efficiency
We expect that cost efficiency of the programs will improve as we develop best practices and refine our training, mentorship, and supervision tools. We anticipate long-term cost savings for the health care system as successful PMTCT should reduce the number of patients needing chronic HIV care.

8. Linkage with GOM Activities
Our letters of support from MOH affirm that this program is fully in line with the MOH emphasis being placed on PMTCT. Our program addresses many of the activities outlined under Strategic Objectives 1 and 2 from the Malawi National HIV Prevention Strategy (2009-2013), specifically: 5.1.1 Reduce multiple and concurrent sexual among adults; 5.1.5 Reduce HIV transmission among HIV-discordant partners.

5.2.1 To provide universal HIV testing and counseling for women and their partners, adolescents in child-bearing age. 5.2.3 Strengthen linkages between PMTCT, ART, prevention, reproductive health, maternal and child health, and primary health care services. 5.2.5 Provide comprehensive PMTCT, care, treatment and support to HIV positive pregnant and lactating women and their families. 5.2.6 Provide care and support to all HIV exposed infants at facility and community levels.

9. Summary of Monitoring and Evaluation
We have developed standardized registers and patient mastercards to track identified pregnant women, exposed infants, and infected children. Site coordinators will collect and input data into a Microsoft Access database. They will also be required to randomly supervise at least 15% of visits for quality assurance purposes. Clinicians will also conduct site visits and review data regularly. Data will be crosschecked with national registers.

Cross-Cutting Budget Attribution(s)

Food and Nutrition: Policy, Tools, and Service Delivery	13,750
Human Resources for Health	142,000

Key Issues

Increasing gender equity in HIV/AIDS activities and services
Child Survival Activities
Safe Motherhood
Workplace Programs

Budget Code Information

Mechanism ID:	**12130**
Mechanism Name:	**Baylor/QCT/GHAI**
Prime Partner Name:	**Baylor College of Medicine Children's Foundation Malawi**

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	83,088	

Narrative:

4. BUDGET CODE: HVCT ($53,375 for Year 1; $99,688 for Year 2)

One of the primary goals of Tingathe is to increase the capacity to identify and provide services to patients with HIV. A significant limitation to identifying patients has been that VCT is facility-based and conducted passively at health centers with a limited number of trained VCT counselors. To overcome this obstacle, all members of the outreach team will be trained in HTC. CHWs will be involved in both facility based and door-to-door home-based testing. They will also be used to ensure that all family members of known infected patients are offered testing. When infected patients are identified, the CHW continues to follow them to ensure that they enter clinical care and are receiving all required, available services. In addition, CHWs are trained to do active case ?nding in the community and health centers to aid early identi?cation.

Activity 1: Training of CHWs in HIV Counseling and Testing
All CHWs will be trained in HTC and EID. CHWs will get extended supervision by more senior counselors and CHWs. Once this training is complete they will start to conduct testing at the health center and within the community.

This activity includes the Cross-Cutting Attribution: Human Resources for Health (HRH) as our CHWs will greatly augment the capacity to conduct counselling and testing.

Products/Deliverables:
• 75 CHWs trained in HTC and EID

Activity 2: Health Facility Based HCT and Active Case Finding
Our CHWs will augment the human resource capacity at the health center to conduct HIV Counseling and Testing. CHWs will be involved not only with passive testing, but will also engage patients at other key access points include ANC, TB clinic, adult ART clinic, STI, OTP and supplemental feeding nutrition clinics. The goal will be to make sure patients and their families at these high burden sites have been offered and counseled on the importance of HIV testing. Often patients are unable to bring their whole families to the health center for testing. Home-based testing will be offered for those clients who have family members at home who require testing. This is described further in activity three below. CHWs will also attempt to link patients who already know their status into care and treatment.

Products/Deliverables:
• 3,500 adults and children receiving HTC within the health facility

• >95% of exposed infants receiving PCR test at <18months
• 400 new or known but not in care HIV infected adults and children identified and enrolled into care
• 250 new exposed infants identified

Activity 3: Community Based HCT and Active Case Finding
During the first year of the Tingathe program, CHWs conducted over 7500 HIV tests in the community in a door-to-door fashion. This activity was a great success and well received by the community. A number of patients who otherwise might not have accessed counseling and testing were able to receive the service. We plan to expand the reach and scope of this activity with the proposed expansion of the program. CHWs will also attempt to link patients who already know their status into care and treatment.

Products/Deliverables:
• 8,500 adults and children receiving HTC
• 600 new or known but not in care HIV infected adults and children identified and enrolled into care
• 100 number of new exposed infants identified

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDCS	143,249	

Narrative:

3. BUDGET CODE: PDCS (Cost: $68,750 for Year 1; $171,875 for Year 2)

BCM-CFM has a strong history of developing innovative pediatric HIV care and treatment programs. With our proposed program we aim to apply these lessons to improve important aspects of pediatric care including adherence supervision, nutritional support, defaulter tracking, and routine childhood health maintenance activities. CHWs will follow all newly identified and treatment non-adherent patients monthly and provide adherence counseling, as well as, infant feeding counseling, nutritional screening, and prompt referral for support. In addition, they will make sure that their patients receive all available health related services. As part of this effort, they will engage local partners and stakeholders on an ongoing basis to help coordinate more comprehensive care for their patients.

Activity 1: Improved coordination between pre-HAART, ART, and Under-5 clinics
As described under MTCT Activity 5, our CHWs will be working to improved coordination between PMTCT, EID, and Pediatric HIV Care And Treatment programs. To date, programs have especially struggled with linking exposed and infected infants into care. With this program, our CHWs will provide the necessary link to ensure these infants enter care. CHWs will ensure that exposed infants will receive

the correct ARV prophylaxis, PCR testing, cotrimaxazole prophylaxis, that mothers are appropriately counseled on safe breastfeeding, and that newly positive infants are enrolled into care.

This activity is related to the Key Issue: Health Related Wrap Around: Child Survival.

Products/Deliverables:
• 1500 infants enrolled into Tingathe program
• 1500 infants having PCR test
• 1450 infants receiving ARV prophylaxis
• 1500 infants receiving cotrimaxazole prophylaxis
• 125 infants started on HAART

Activity 2: Nutritional Support
This activity relates to Cross-Cutting Attribution: Food and Nutrition: Policy, Tools, and Service Delivery. BCM-CFM is developing a training package on nutrition and infant feeding in the context of HIV. All CHWs and selected MOH staff working at target health centers will be trained in the curriculum. Topics such as breastfeeding, replacement feeding, complementary feeding, safe infant and young child feeding, nutritional assessment, and nutritional support (OTP, supplementary feeding) will be covered.

The Cross-Cutting Attribution Food and Nutrition: Commodities is also covered within this activity. As part of their regular monthly patient visits, CHWs will counsel patients on infant and young child feeding antenatally, perinatally and postnatally. They will support HIV-positive mothers concerning infant feeding options, as well as provide ongoing complete nutritional assessment using weight, length, MUAC, and assessment for edema. They will make referrals and ensure that their clients are receiving appropriate services. In addition, currently in partnership with Feed the Children, HIV-infected pregnant women and exposed infants followed in the Tingathe program, are given nutritional supplementation with Vitameal.

Products/Deliverables:
• Nutrition and Infant feeding in the context of HIV training curriculum
• 50 MOH staff trained in infant feeding in the context of HIV
• 3500 HIV infected children and adults screened for malnutrition using MUAC
• 50 HIV infected children and adults referred for treatment for malnutrition (OTP)
• 1500 pregnant/lactating women and exposed infants supported with supplementary feeding.
• 1500 number of pregnant/lactating women receiving on-going nutritional assessment
• 1000 number of exposed infants receiving on-going nutritional assessment
• >95% infants exclusively breast feeding

• 1500 number of HIV infected women receiving antenatal, peri- and postpartum counseling on infant and young child feeding

Activity 3: Adherence Supervision
Adherence is critical to the success of ARV treatment. Good adherence prevents the development of resistant forms of HIV virus, and resulting treatment failure. Studies on adherence show that adherence rates must be 95% or higher for long-term treatment success. Patients judged to be at risk for poor adherence and all newly diagnosed patients will be assigned a CHW. CHWs will follow these patients at least monthly to monitor adherence to treatment.

Products/Deliverables:
• 1000 infected adults and children started on Cotrimoxazole prophylaxis
• 1000 patients followed monthly for adherence supervision
• 250 number of infected children started on HAART

Activity 4: Defaulter Tracing
As mentioned above, adherence is critical to the success of ARV treatment. Hence, bringing defaulters back into care and conducting home visits to address the issues that place patients at high risk for poor adherence is essential to preventing treatment failure once patients are in care. We have developed a mapping and locator protocol to facilitate tracking of defaulters. Defaulters will be actively traced by CHWs. As with new patients and patients with documented poor adherence, defaulters will be followed at least monthly to monitor adherence to treatment.

Products/Deliverables:
• 100 defaulters tracked
• Percent defaulter rate for patients on HAART <5 percent

Activity 5: Engage and coordinate services provided by local NGOs, CBOs, FBOs and other stakeholders
Prior to Tingathe, there had been minimal coordination between our clinical care providers and the grass-roots groups and organizations providing services within communities. Several community-based organization (CBO) leaders voiced desires to improve contacts between groups providing services. Tingathe hosted a number of meetings for local community leaders, religious leaders and staff from NGO/CBO/FBOs. CHWs also conducted basic assessments of many of the NGO/CBO/FBOs in our catchment areas. These summaries were used to develop a NGO/CBO/FBO directory. This referral directory is meant to improve coordination among organizations and more comprehensive patient care. We plan to improve and expand these activities as we engage new facilities and catchment areas.

Products/Deliverables:
• Regular meetings of organization providing services to women and children
• Compilation of list of organizations providing services to women and children
• Detailed assessments of organizations providing services to women and children
• Compilation of Community Resource Directory
• Regular Updating of Community Resource Directory

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	PDTX	96,367	

Narrative:

BUDGET CODE #2: PDTX
In partnership with MoH, BCM-CFM has endeavored to scale up provision of comprehensive pediatric HIV care at ART clinics nationally through our Pediatric HIV Outreach and Training program. BCM-CFM has developed a systematic approach, called Mphatso, to on-site training and clinical mentorship in pediatric HIV care and has contributed to the improved capacity of ART clinics and providers to provide quality care and increase the enrollment of HIV infected and exposed children into care. This program proposes to use lessons learnt from the Mphatso experience to develop a comprehensive package of training in PMTCT, EID, and Pediatric HIV Care and Treatment. MOH providers will be trained and supervised so all sites participating in the program will be able to offer this minimum package of services.

Activity 1: Site Assessments
Thorough site assessments will be carried out before the roll out of interventions. Information to be gathered will assess PMTCT, EID, and ART service delivery. BCM-CFM will develop a minimum package for excellence in service delivery of PMTCT, EID, HIV care and treatment. The information gathered through site assessments will be used to create detailed and specific plans for each center to achieve the minimum package for excellence. This activity includes the Cross-Cutting Attribution Human Resources for Health (HRH) as it involves planning for the necessary workforce to accomplish the proposed improvements to PMTCT, EID, and Pediatric HIV Care and Treatment Services. Site assessments for the North and South will also begin in the first year of the program. All site assessments and action plans will be done in collaboration with the district and zonal health offices.

Activity 2: Training, Mentorship, and Supervision of MOH Providers
Our proposed program will result in an increase in the number of HIV-positive pregnant women, exposed infants and infected children accessing services at participating sites. MOH staff will need to be well

prepared and trained for this increase in demand. BCM-CFM has a developed systematic program, called MPHATSO (Malawi Pediatric HIV/AIDS Treatment Support Outreach), to conduct on-site training and clinical mentorship in pediatric HIV care and has contributed to the improved capacity of ART clinics and providers to provide quality care for HIV exposed and infected infants and children. The MPHATSO approach relies on mentorship teams consisting of doctors, nurses, clinical officers, data clerks, and CHWs to mentor MOH staff and improve services. This program proposes to use lessons learnt from the MPHATSO experience to develop a comprehensive package of training in PMTCT, EID, and Pediatric HIV Care and Treatment. Clinical officer and nurse mentors will be recruited to work with Baylor Pediatricians to instruct and supervise MOH staff in this comprehensive package. Support will be provided by the UNC project and the KCH/Bwaila Department of Obstetrics and Gynecology for mentorship on PMTCT and antenatal care. This activity includes the Cross-Cutting Attribution Human Resources for Health (HRH) as it involves pre-service and in-service training of health care providers.

Activity 3: Support for decentralization of pediatric treatment on a national level

With the support of the MOH, Baylor College of Medicine has played an important national leadership role in developing high quality service delivery models for pediatric care and treatment including approaches to expand PITC in high-volume facilities, linking children and families into longitudinal care, strengthening community-based systems to improve retention of children in clinical care, and providing on-site mentoring and training to build staff skills in pediatric treatment. Given their expertise in pediatric care and treatment as well as in training and mentoring of MOH ART clinics, Baylor is well-positioned to complement the technical assistance other partners are providing to facilities, and to develop service outreach models which would allow pediatric ART to be decentralized to lower-level health centers, so that all ART providers throughout the country are equipped to also treat children through a family-centered approach. A small proportion of FY10 PMTCT additional funds will be utilized to further expand these efforts to decentralize pediatric ART to high-burden districts which are not currently benefitting from the program. Baylor physicians, nurses, and clinical officers will accompany the other 4 zonal mentoring partners is some instances to provide district level technical assistance to help capacitate more lower-level ART sites to initiate a large number of children on treatment, especially children <18 months, using both DNA-PCR testing as well as presumptive therapy

Activity 4: Maternal and neonatal health: Piloting rapid EID turnaround and immediate treatment initiation in the peripartum period

Given that extended postnatal NVP is now being recommended for PMTCT, it will be even more

important to attempt to rule-out infection of neonates with EID before starting this. It also may be strategic to link EID to the time surrounding delivery rather than waiting to perform the test at 4-6 weeks as is currently practiced, so that infants in need of ART can be initiated on treatment as soon as possible. Therefore, at a small number of high volume urban sites with capacity support, Baylor will pilot and evaluate an approach in which HIV-positive postpartum women and their infants remain at the hospital or maternal waiting facilities until they receive EID and CD4 results with a rapid turn around. This could enable HIV-infected children to start ART immediately and non-infected to children to start postnatal NVP prophylaxis, while at the same time ensuring HIV-positive pregnant women receive quality postpartum care and ART initiation if eligible. A brief report documenting implementation experience of piloting and evaluating immediate postnatal EID and ART initiation for eligible children will be produced.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	802,523	

Narrative:

1. BUDGET CODE #1: MTCT ($802,523.00)

Activity 1. Supportive mentorship and quality improvement in the Northern Zone and Blantyre District: Baylor mentorship activities will focus on supporting the Northern Zonal Health Office and the Blantyre district. Team of Baylor physicians, clinical officers, and nurses will mentor and support ZHOs and DHOs to build their capacity to supervise, plan, and to help PMTCT sites develop and implement systems for better managing patient care and data flow. Sites will be supported to provide a comprehensive package of PMTCT services for mothers and children, with an emphasis strengthening linkages and referrals between HIV care and treatment services and PMTCT. These efforts are part of a broader zonal quality improvement initiative, in which, under MOH leadership, Baylor will collaborate with 4 other USG partners who are supporting the other 4 zones and share best practices to improve the quality of PMTCT services with one another. Baylor will especially focus its mentorship activities on the Karonga district and high volume sites within the Mzimba district, as these have much higher prevalence than the other districts in the North, as well as at high volume and high prevalence sites in Blantyre district where Baylor will also be providing support for service delivery through its Tingathe community health worker program.

Activity 2. Scaling up Tingathe program to additional high-volume sites
The move to start pregnant women on ART at an earlier CD4 count will necessitate more intensive psychosocial support, as data from several settings seem to indicate that such clinically well patients are at a higher risk for default than other patients starting ART. The Tingathe program, which is implemented

in Malawi by Baylor College of Medicine, is an example of a successful intervention with lay cadres that has shown dramatic results in the improvement in the PMTCT cascade. Using additional PMTCT funding, Baylor will scale-up the Tingathe program to at least double the number, focusing on high prevalence sites in Lilongwe's central region, Blantyre, and Karonga. Complementary support will be provided through the USG for similar approaches implemented through a network of community-based platforms that are already on the ground to expand these lay workers in a way that is sustainable and can be taken to national scale. Please see PACT, CHAM, and MSH entries for more details.

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prophylaxis, while at the same time ensuring HIV-positive pregnant women receive quality postpartum care and ART initiation if eligible. A brief report documenting implementation experience of piloting and evaluating immediate postnatal EID and ART initiation for eligible children will be produced.

Activity 5. Renovations of high volume MCH sites in the Central East and Northern Zone and Blantyre district

Renovations will mainly focus on upgrading antenatal sites to meet the MOH criteria for qualification as ART sites, and also will improve the condition of labor and deliver wards at high-volume sites, provide additional space for storage of commodities, and enhance patient flow between services. The process to select sites for renovations will be done in close consultation with the MOH and other stakeholders and utilize evidence-based criteria, for example prioritizing those sites that could enroll many more women on ART if they had the proper physical infrastructure. Efforts will also be made to leverage already approved Global Fund resources for renovations at MCH sites that would enable the renovations to achieve more national coverage of MCH sites, and also to utilize USG non-HIV health funding to increase the scale of effort further. Renovations will be coordinated with those to be funded under other sources (i.e. Global Fund, SWAp) to ensure that there is no duplication.

Activity 6. Capacity building to improve data utilization and reporting in the Northern Zone and Blantyre

Baylor staff will work side by side with Northern Zonal staff and district health staff of Chitipa, Mzimba, Karonga, and Blantyre to build their capacity to use data to improve programs and to better report to the MOH on the national level what they have accomplished. Baylor will then report to PEPFAR how they its efforts have helped the Northern zone and districts receiving support. PMTCT Data will be reviewed on at least a quarterly basis with health officers; action plans will be developed and implemented to address data quality issues identified; and feedback will be provided to PMTCT sites to enable them to improve their program in specific ways and monitor such improvements.

Activity 7. Operations Research

Programs supported by UNC Project in Lilongwe have found that provision of free clean water materials is associated with increased antenatal attendance and postnatal follow-up and also that sites which provide targeted food supplementation to HIV-positive lactating women in the postnatal period have much higher rates of follow-up. Support is also to be provided through other partners in Malawi through the Baylor Tingathe program and other platforms to use lay cadres to reduce loss-to-follow-up. The UNC Project will therefore collaborate with Baylor and other partners to conduct operational research around this important area to help inform national policy on how these various approaches should be used appropriately. The research will attempt to evaluate the cost-effectiveness and sustainability of different approaches. This will broadly address the PEPFAR priority PMTCT/peds OR question: "What are the interventions at the program, facility, community, and household level that have the greatest impact on

retention in care, especially in the first 12 months of life?" The program design for the Tingathe Program is fairly simple. Pregnant women who are diagnosed with HIV in community health centers are assigned a CHW and enrolled into the program via opening of a patient mastercard. Detailed location information is gathered at this point to allow proper follow-up. CHWs are responsible for ensuring that mother-baby pairs receive all appropriate services including obtaining CD4 counts, following up CD4 results, enrollment into ARV clinic if appropriate, provision of ARV prophylaxis for mother and child, testing/diagnosis of exposed infants, provision of CPT to exposed infants, counseling on infant feeding, and enrollment of newly positive infants into care. They follow their clients at their homes and at the health centers, from initial diagnosis up until cessation of breastfeeding and negative diagnosis or successful enrollment of positive infants into care (activities and services provided to infants to be described in PDCS and PDTX budget codes). Mothers of infants who test negative will be enrolled in the new adult pre-HAART clinics as they are formed. Listed below are the main activities involved under budget code MTCT. Many of these activities have considerable overlap with activities under budget codes PDTX, PDCS, and HVCT and this is noted in the description.

Implementing Mechanism Indicator Information

(No data provided.)

Implementing Mechanism Details

Mechanism ID: 12131	**Mechanism Name: Christian Health Association of Malawi**
Funding Agency: U.S. Department of Health and Human Services/Centers for Disease Control and Prevention	Procurement Type: Cooperative Agreement
Prime Partner Name: Christian Health Association of Malawi	
Agreement Start Date: Redacted	Agreement End Date: Redacted
TBD: No	Global Fund / Multilateral Engagement: No

Total Funding: 1,195,000	
Funding Source	**Funding Amount**
Central GHCS (State)	75,000
GHCS (State)	1,120,000

Sub Partner Name(s)

(No data provided.)

Overview Narrative

The Christian Health Association of Malawi (CHAM) is an ecumenical, not for profit non-governmental umbrella organization of Christian owned health facilities which provide health care to approximately 40% of the population in Malawi. CHAM will play a key role in the implementation of the Partnership Framework between the United States Government (USG) and the Government of Malawi (GOM) in Malawi, and the PEPFAR-supported CHAM activities will serve to further strengthen the broader health sector.

CHAM was established in 1966 by Malawi Council of Churches (MCC) and the Episcopal Conference of Malawi (ECM) to facilitate and coordinate the provision of health services by church based health facilities registered under ECM and MCC. As at the end of 2008, CHAM had 173 member health units across the country. Out of these health facilities 20 are main hospitals, 19 community hospitals, 1 mental hospital and 132 health centers. 90% of these health facilities are located in the rural hard-to-reach settings of the country. CHAM also has 10 training colleges, a college of health sciences and a mental health college, all of which are attached to CHAM hospitals. CHAM produces about 77% of the nursing personnel in Malawi.

CHAM has been very instrumental in the health sector by participating in all reforms being implemented by Ministry of Health (MOH). The reforms include Essential Health Package (EHP). CHAM is also a signatory to the Sector Wide Approach (SWAp), an overarching strategy that is used in implementation of the EHP. The Ministry of Health (MOH) outsource the provision of EHP to CHAM through signing of Service Level Agreements (SLAs), as they are unable to meet the national healthcare needs of the country especially in hard-to-reach areas where most CHAM facilities are located.

While the number of church-based health facilities operating under CHAM has increased, provision of health care in such health facilities has been greatly affected by lack of adequate staffing. In addition, CHAM Secretariat (headquarters), has also suffered from poor funding to effectively coordinate implementation of health care policies including the national response to HIV and AIDS. While attempts have been made to mobilize resources for HIV and AIDS interventions for church-based health facilities, very little has been allocated to strengthen the capacity of the secretariat to effectively monitor, supervise, train and document good practices that can be replicated in other CHAM health facilities (particularly in the areas of ART provision and scale up, adherence, Prevention of Mother-To-Child Transmission of HIV (PMTCT), Monitoring and Evaluation). To date only 35 health facilities provide comprehensive HIV Counseling and Testing (HCT), Antiretroviral Therapy (ART), and PMTCT services, 84 provide PMTCT only and 9 Pediatric ART. The Secretariat has only one employee dedicated to implementing of HIV programs for all member units. Therefore, through this project, CHAM envisages that CDC will work with its member units to increase access to high quality HIV services, strengthen linkages between HIV

services, and improve laboratory services and training programs for all health workers.

Monitoring of HIV services at member health facilities is not standardized at the site level, although standardized checklists are used during routine supervision visits by the secretariat. Monitoring and Evaluation, including surveillance and health information systems, are high priorities in the revised Malawi National Action Framework (NAF) and equally high priorities in CDC supported programs. This partnership will have a focus on strengthening the M & E activities at CHAM's member health facilities and their secretariat.
CHAM also oversees 10 training colleges which provide health care workers for both public and private health facilities in Malawi. These training colleges graduate about 450 health care workers from all cadres each year; approximately 60% are deployed to work for MOH, and 40% for CHAM. In 2008, the MOH asked CHAM to rapidly scale up their training programs, and to double their intake of new students within one year. The effort to scale up training so rapidly has put additional strain on the limited capacity of the secretariat, and the U.S Government (USG) will work with CHAM to creatively solve the challenges in this area.

To ensure effective coordination and implementation of the program, CHAM has the Director of Health Programs who oversees implementation of programs activities. She is supported by the HIV Manager who is responsible for managing all HIV and AIDS Activities in CHAM. The Executive Director, Director of Finance, Internal Audit Manager and Finance Manager and the Training Manager will all play a role to ensure that that all proposed activities are effectively implemented. Given that these members of staff are already involved in a number of activities, CHAM will further recruit additional staff who will be working fulltime to facilitate program implementation. These will include: the HIV Manager, Project Coordinator; Grants Management Officer, Laboratory Services Program Officer and M & E Officer. The Executive Director will provide overall leadership of the project implementation.

Budget Summary
PFIP Year 1 Funding – $770,000.00
PFIP Year 2 Funding – $770,000.00

Cross-Cutting Budget Attribution(s)

Human Resources for Health	122,122

Key Issues

Addressing male norms and behaviors

Budget Code Information

Mechanism ID:	12131		
Mechanism Name:	Christian Health Association of Malawi		
Prime Partner Name:	Christian Health Association of Malawi		
Strategic Area	**Budget Code**	**Planned Amount**	**On Hold Amount**
Care	HBHC	170,000	

Narrative:

III. Budget Code: HBHC ($170,000)
CHAM will work with MOH in developing and implementing the new national Pre-ART program. This will include the following activities:

With PFIP Year 1 funds:

Activity 1: The National ART program is working to decentralize ART to lower level health facilities as well as to develop a pre-ART program, and will need extensive support to succeed. A formalized pre-ART program is needed in order to minimize patients 'lost-to-follow-up' between HCT and ART clinics, and to follow HIV-positive individuals closely enough to ensure timely initiation of ART and minimize early mortality.

CHAM will use part of PFIP Year 1 funds to support the national ART program efforts by working with the Ministry of Health in developing and piloting the pre-ART program at selected health facilities. Activities include but are not limited to:

Implementing a pre-ART package which includes Prevention with Positives (PwP) strategies in collaboration with Ministry of Health is a core activity during FY10. It is critical to actively involve HIV-positive individuals in prevention activities in order to avert further infections. CHAM will participate in trainings on the guidelines and modules for the pre-ART package. The pre-ART model/package will also be pilot tested in selected CHAM health sites that have CD4 facilities along with Ministry of Health facilities. Trainings will be conducted at the pilot sites for health care workers on the minimum package and M & E tools. CHAM will implement PwP interventions to reduce the spread of HIV infections by

focusing prevention efforts on HIV-positive individuals who receive care services in its health facilities. A roll-out of treatment programs will provide an important opportunity to cater to the prevention requirements of the HIV-positive people.

PwP participants will receive risk reduction counseling and case management services, and learn skills to help them adopt safer behaviors to both help them stem the spread of HIV and prevent secondary infections. The interventions will include activities but not limited to: encouraging and counseling HIV-positive persons to prevent. Through PwP, CHAM will ensure that participating health facilities have the tools and training they need to maintain comprehensive and holistic client participation in the interventions. CHAM realize that a prevention response that does not recognize the needs and desires of people living with HIV cannot succeed hence community involvement strategies will be employed since it has been shown that it boosts the health care system, helps to tackle stigma and discrimination in the clinic set up and improves adherence in those that are on treatment.

PFIP Year 2 Funds ($170,000)

CHAM will continue the same activities described in year 1.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Care	HVCT	200,000	

Narrative:

IV. Budget Code- HVCT –($200,000)
With PFIP Year 1 Funds CHAM will:

Activity 1: Expand confidential HIV counseling and testing programs to reduce sexual transmission of HIV, and strengthen linkages between HTC and other services.
Activities include but are not limited to:
In a bid to expand HCT services, CHAM will embark on training HCT service providers who will undergo three weeks of the national certified training curricula. Efforts will be made to expanding confidential counseling and testing capacity to respond to demand and identify HIV positive individuals who require care, as well as to improve prevention services to those attending HCT services. Couple counseling will be emphasized to cater for PMTCT clients. CHAM intends to put more effort on expanding HCT services to cover TB, STI and ANC clients to avoid missing out on eligible clients. Strong referral systems will be worked out within the health facilities to maximize opportunities that arise when one consults to seek medical help for other related conditions.

CHAM will be working with Ministry of Health in designing a pre-ART package which will be strongly linked to HCT as part of strengthening linkages between HIV services. CHAM envisage that by working with Ministry of Health to pilot a new confidential referral system for HCT service, access to counseling and testing services for the general population will be improved. Counseling and Testing will be linked to other HIV services thereby establishing a functional referral system that will ably link potential clients to prevention, care and treatment services. The linkage will facilitate implementation of PwP interventions in the health facilities.

With PFIP Year 2 Funds, CHAM will:

Activity 1: CHAM will expand confidential counseling and testing capacity to respond to demand and identify HIV positive individuals who require services

CHAM will continue to assess capacity needs of HTC services in new and old implementing health facilities and trainings for service providers shall be organized based on the need. In addition, CHAM will facilitate renovation of user-friendly HTC infrastructures including equipping and furnishing where there are infrastructure gaps.

CHAM will facilitate training of health care workers and lay counselors in HCT following the approved national curricula. In addition, quarterly supervision of trained HTC counselors will be conducted to ensure that quality control is adhered to in service delivery.
CHAM will roll out and institutionalize Provider Initiative Counseling and testing (PITC) in-patient settings, ANC, STI and TB clinics to ensure integration of services and leverage of available resources. Linkage of different interventions will be established and promoted between HCT, PMTCT, ART, TB, and community support groups to ensure that no client is lost in the process.

CHAM will also facilitate establishment/improvement of HCT sites and train adequate personnel to cope with the expected increased uptake of HCT clients. Patients presenting with TB, STI or other common Opportunistic Infections will need a diagnostic HIV test to determine the medical care need. These patients do not need full VCT with a risk assessment and risk reduction plan. Given the current structure of services, it is not feasible for the TB clinician or the outpatient clinician to provide this lengthy intervention. The current procedure requiring full VCT for sick patients overloads the VCT service and reduces the availability of VCT to self referred clients. As a result, many TB, STI and other OI patients are not tested for HIV. CHAM endeavors to structure its services to allow implementation of PITC in its implementing sites.

Strategic Area	Budget Code	Planned Amount	On Hold Amount

Other	HVSI	50,000	

Narrative:

V. Budget Code- HVSI – ($50,000)

With PFIP Year 1 Funds CHAM will:
Activity 1: Strengthen its capacity in collection of HIV prevention data to use for informing national level programming and for informing decision-making for HIV/AIDS care and treatment programs. Activities will include but are not limited to:
CHAM will use part of the PFIP Year 1 funds to review its existing monitoring and evaluation tools and checklists to ensure that they capture all the project and PEFPAR indicators. This will strengthen the capacity of the CHAM secretariat to develop and implement a standardized M & E system for the health facilities.

A standardized monitoring system for member health units will be created and strengthened to ensure accurate data collection, analyses and utilization for information driven decision making. An electronic information management system will be established and implemented across the participating facilities and an office will be designated for this exercise.
All program staff will be trained in data recording, analysis and utilization and also to provide maintenance and trouble shooting at facility level.
Quarterly, bi-annual and annual reviews will be conducted in order to assess progress, draw lessons, identify challenges and refine or adjust the implementation plan as and when need arises.

With PFIP Year 2 Funds, CHAM will

Activity 1: Expand capacity in collection of HIV prevention data to use for informing national level programming and for informing decision-making for HIV/AIDS care and treatment programs ($50,000)

Through PEPFAR Year 2 funds, CHAM will continue to enhance its capacity in routine data collection, usage and management of HIV and AIDS programs. This will be done by expanding HIV/STI/TB surveillance programs and strengthening laboratory surveillance, diagnosis, treatment, disease monitoring and HIV screening for blood safety.
The capacity of CHAM secretariat and health facilities to collect, analyze and use data generated will be strengthened to ensure that the data is essential for planning and evaluating prevention and care activities and for assessing impact of the interventions that will be initiated.

CHAM will continue to improve its established monitoring and evaluation systems to ensure that they reliably capture all the project and PEFPAR indicators. A standardized monitoring system for member

health units will be sustained and strengthened to ensure accurate data collection, analyses and utilization for information driven decision making. An electronic information management system will be implemented across the participating facilities. All program staff will undergo refresher training in data recording, analysis and utilization.
Quarterly, bi-annual and annual reviews will be conducted in order to assess progress, draw lessons, identify challenges and refine or adjust the implementation plan as and when need arises.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HMIN	75,000	

Narrative:

CHAM will receive 1-time injection safety funds to strengthen pre-service training curricula and activities for nurses and other health providers to incorporate a stronger component on injection safety and PEP in all training facilities participating in the HRH initiative. (see OHSS narrative)

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	HVOP	250,000	

Narrative:

II. Budget Code: HVOP ($250,000)

With PFIP Year 1 Funds CHAM will conduct the following activities:

Activity 1: CHAM will improve the ability to collect standardized data on HIV prevention in their partner health facilities, including:
CHAM will also scale up the prevention activities conducted in non-HIV services including Tuberculosis (TB), Sexually Transmitted Infections (STI) and Antenatal Clinic (ANC). The interventions will include but not limited to HIV screening to which these service areas should make certain its clients have access, as well as services that the HIV program offer.

In order to decrease the burden of HIV in TB patients, the following activities will be undertaken; provision of HIV counseling and testing, Cotrimoxazole preventive therapy (CPT), ensure accessibility and availability of comprehensive HIV/AIDS care and support services. The HIV/ TB or STI or ANC collaborative approach will reduce number of eligible clients who get lost within service areas.
-Developing a standardized monitoring and evaluation system for CHAM facilities to support data collection
-Implementing the new M & E system, including the collection, analysis and reporting of HIV data to sites and relevant partners

-Working with Ministry of Health to pilot a new confidential referral system for those who test positive to ensure they are linked into care early, thus ensuring their exposure to Prevention messaging and timely initiation of ART, reducing the likelihood of transmission of HIV.

With PFIP Year 2 Funds, CHAM will:

Activity 1: Improve care and treatment of HIV/AIDS, opportunistic infection, sexually transmitted infections (STIs) and related opportunistic infections by improving STI management; enhancing the care and treatment of opportunistic infections, including tuberculosis (TB); and initiating programs to provide anti-retroviral therapy

CHAM will assess the laboratory capacity of all the Health facilities participating in the project, develop and implement standard operating procedures aligned with national standards. CHAM will work with district health offices and Ministry of Health, to ensure that laboratories are adequately staffed and equipped to carry out their activities effectively. More laboratory personnel will be trained and diagnostic equipment procured and distributed in order to strengthen laboratory services.

Training of health workers will be provided to improve technical skills and ensure that quality services are expanded and improved in the areas of PMTCT, HCT, ART (adult and pediatric), TB, STI laboratory and early infant diagnosis.

Strategic Area	Budget Code	Planned Amount	On Hold Amount
Prevention	MTCT	450,000	

Narrative:

I. Budget Code: PMTCT ($450,000)

With PFIP Year 1 funds, CHAM will conduct the following activities:

Activity 1: CHAM will increase access to PMTCT services ($100,000):
CHAM will work with the Ministry of Health to roll-out and scale up PMTCT services in order to improve availability and accessibility of the service to eligible pregnant women. CHAM is considering strengthening integration of PMTCT in MCH settings with a goal to alleviate overall maternal and infant morbidity and mortality. CHAM will implement activities including training of counseling and testing service providers so that they are able to address all aspects of HIV counseling and testing, including the reduction of the risks of sexual and postnatal transmission of HIV, contraception options and prevention of HIV sexual transmission appropriate to HIV status. Availability of counseling and testing services for

pregnant women will facilitate early presentation of HIV-positive pregnant women to benefit from a complete course of antiretroviral prophylaxis and early infant diagnosis interventions.

Under this component, CHAM will also undertake renovations of PMTCT service sites to make them male-friendly and ideal for services that are offered in PMTCT programs. CHAM will also increase and strengthen linkages between PMTCT interventions with ART and other health programs and creating a better system for monitoring and reporting. With these services, CHAM will implement interventions that will include identifying the HIV status of women and infants, providing ART to HIV-positive pregnant women within MCH, follow-up treatment for all babies exposed to HIV and follow-up for all mother enrolled in PMTCT programs to minimize loss to follow-up issues.

With PFIP Year 2 Funds, CHAM will continue increasing access to PMTCT nationally, and will also engage in the following additional activities:

Activity 1: CHAM will strengthen quality of PMTCT services its health facilities to reduce Mother to Child Transmission of HIV

CHAM will work with the Ministry of Health to roll-out and scale up PMTCT services in order to improve availability and accessibility of the service to eligible pregnant women. CHAM is considering strengthening integration of PMTCT in MCH settings with a goal to alleviate overall maternal and infant morbidity and mortality. CHAM will implement activities including training of counseling and testing service providers so that they are able to address all aspects of HIV counseling and testing, including the reduction of the risks of sexual and postnatal transmission of HIV, contraception options and prevention of HIV sexual transmission appropriate to HIV status. Availability of counseling and testing services for pregnant women will facilitate early presentation of HIV-positive pregnant women to benefit from a complete course of ART and early infant diagnosis interventions.

CHAM will also undertake renovations of MTCT service sites to make them male-friendly and ideal for services that are offered in PMTCT programs. CHAM will also increase and strengthen linkages between MTCT interventions with ART and other health programs and creating a better system for monitoring and reporting. With these services, CHAM will implement interventions that will include identifying the HIV status of women and infants, providing ART to HIV-positive pregnant women within MCH, follow-up treatment for all babies exposed to HIV and follow-up for all mother enrolled in PMTCT programs to minimize loss to follow-up issues.

Activity 2: CHAM will scale up lay cadres and/or expert patient approaches

CHAM would strengthen Mothers-to-Mothers (M2M) approaches where they exist and initiate where they do not exist. HIV-positive mothers and HIV exposed infants that are confirmed positive will be followed up in order to identify those eligible for ART as early as possible as well as for care and support services. Eligible HIV positive pregnant women and infants will be enrolled for ART initiation under the project.

Activity 3: Prevention of sexual transmission with a focus on discordant couples
CHAM will continue the provision of integrated, comprehensive PMTCT services in an effort to scale up male involvement in PMTCT, particularly in the area of men accessing HTC with their wives at the first Antenatal visit. CHAM shall endeavor to provide a male friendly environment in the Antenatal clinics by facilitating renovation of some Antenatal Clinic infrastructures in selected health facilities where this need arise. CHAM will endeavor to scale up evidence-based prevention efforts. This will entail strengthening support services for discordant couples, provision of quality Prevention-with-Positives counseling, improve support structures for the intervention therefore and community mobilization for male involvement initiatives. CHAM envisages that these interventions will facilitate HIV prevention for HIV-infected individuals during pre-ART and post-ART initiation.

Implementing Mechanism Indicator Information

(No data provided.)

USG Management and Operations

1.

Redacted

2.

Redacted

3.

Redacted

4.

Redacted

5.

Redacted

Agency Information - Costs of Doing Business
U.S. Agency for International Development

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Computers/IT Services					89,880	89,880
ICASS					69,306	69,306
Management Meetings/Professional Developement					60,680	60,680
Non-ICASS Administrative Costs				385,214		385,214
Staff Program Travel				45,924	94,346	140,270
USG Staff Salaries and Benefits					2,004,650	2,004,650
Total	**0**	**0**	**0**	**431,138**	**2,318,862**	**2,750,000**

U.S. Agency for International Development Other Costs Details

Category	Item	Funding Source	Description	Amount
Computers/IT Services		GHCS (USAID)		89,880
ICASS		GHCS (USAID)		69,306
Management Meetings/Professional Developement		GHCS (USAID)		60,680
Non-ICASS Administrative Costs		GHCS (State)		385,214

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Capital Security Cost Sharing				364,622		364,622
Computers/IT Services			204,000			204,000
ICASS				730,000		730,000
Management Meetings/Professional Developement			128,500			128,500
Non-ICASS Administrative Costs			352,083			352,083
Staff Program Travel			49,500			49,500
USG Staff Salaries and			1,771,295	190,000		1,961,295

Benefits						
Total	**0**	**0**	**2,505,378**	**1,284,622**	**0**	**3,790,000**

U.S. Department of Health and Human Services/Centers for Disease Control and Prevention Other Costs Details

Category	Item	Funding Source	Description	Amount
Capital Security Cost Sharing		GHCS (State)		364,622
Computers/IT Services		GAP		204,000
ICASS		GHCS (State)		730,000
Management Meetings/Professional Developement		GAP		128,500
Non-ICASS Administrative Costs		GAP		352,083

U.S. Department of State

Agency Cost of Doing Business	Central GHCS (State)	DHAPP	GAP	GHCS (State)	GHCS (USAID)	Cost of Doing Business Category Total
Management Meetings/Professional Developement				45,000		45,000
Staff Program Travel				80,628		80,628
USG Staff Salaries and Benefits				60,000		60,000
Total	**0**	**0**	**0**	**185,628**	**0**	**185,628**

U.S. Department of State Other Costs Details

Category	Item	Funding Source	Description	Amount
Management Meetings/Professional Developement		GHCS (State)		45,000