Umoyo Network
Capacity Building for Quality HIV/AIDS Services Project

Final Report
May 15, 2003 – August 31, 2007

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Submitted to:
Aly Cameron
Cognizant Technical Officer, USAID
USAID Malawi

Submitted by:
Jeanne Russell
Deputy Director, Programs
Save the Children Federation, Inc.
Malawi Country Office
P.O. Box 30374, Lilongwe 3, Malawi

Contact details:

Jeanne Russell
Deputy Director, Programs
jrussell@llmw.savechildren.org

Paul Mecartney
Country Director
pmecartney@llmw.savechildren.org

Executive Summary

This is the Final Report for the "Capacity Building for Quality HIV Related Services" project, carried out by Save the Children in partnership with Adventist Development and Relief Agency (ADRA), Academy for Educational Development (AED), and JHPIEGO, with financial support from the United States Agency for International Development (USAID). The project was undertaken from May 15, 2003 to August 31, 2007.

The project provided technical assistance and sub-grants to 15 Malawian non-government organisations (NGOs) to build their capacity to scale up HIV related services. The main focus was on expanding counseling and testing (CT) and prevention of mother to child transmission services (PMTCT), and other HIV-related prevention services. Activities also focused on improving the quality of services and increasing demand.

This is a consolidated report covering the activities of the International Partners (ADRA, AED and JHPIEGO) and the 15 local NGO Partners (Malawi AIDS Counseling and Resource Centre (MACRO), Malawi Network of AIDS Service Organisations (MANASO), National Association of People Living with AIDS in Malawi (NAPHAM), Malawi Network of People Living with HIV (MANET+), Word Alive Ministries International (WAMI), Adventist Health Services (AHS), Development Aid from People to People (DAPP), Ekwendeni Hospital, Malamulo Hospital, Tovwirane AIDS Service Organisation, Nkhoma Hospital, Nkhotakota AIDS Service Organization (NASO), Partners in Hope (PIH), Salima AIDS Service Organization (SASO) and Mponela AIDS Information and Counseling Centre (MAICC). Each of the NGO Final Reports and Final Review Reports were submitted to USAID in September 2007.

A total of $13,544,914 was provided to Save the Children for the program period. In the latter years the funds came from the President's Fund for AIDS Relief (PEPFAR); country operational plans and reports (COP) were completed and submitted in 2006 and 2007.

This highly successful project has carried out the majority of its planned activities and achieved the outputs and outcomes targeted. The program achieved the Save the Children President's Award in 2006.

The capacity building activities carried out by the Umoyo staff were well appreciated by the NGOs. The Malawi National AIDS Commission has praised the activities of the project in assisting the NGOs in scaling up HIV-related services and improving quality. USAID has commended the quality of project data during a recent data audit.

The report recommends that the mix of funding with capacity building and institutional development be continued by USAID in the future.

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List of Acronyms and Abbreviations

AED	Academy for Education and Development
ADRA	Adventist Development and Relief Association
AHS	Adventist Health Services
AIDS	Acquired immune deficiency syndrome
ARV	Antiretroviral
ASO	AIDS Service Organization
AED	Academy for Education and Development
CACC	Community AIDS Coordinating Committee
CBU	Capacity Building Unit
CDQ	Community Defined Quality
CT	Counseling and Testing
DAPP	Development AID from People to People
DHMT	District Health Management Team
DHO	District Health Office
FGU	Finance and Grants Unit
FHI	Family Health International
IEC	Information, education and communication
HIV	Human immunodeficiency virus
INTRAC	International Training and Research
M&E	Monitoring and evaluation
MACRO	Malawi AIDS Counseling and Resource Organization
MAICC	Mponela AIDS Information and Counseling Centre
MANASO	Malawi Network of AIDS Service Organizations
MANET+	Malawi Network of People Living with AIDS
MIM	Malawi Institute of Management
MRA	Malawi Revenue Authority
NAC	National AIDS Commission
NAPHAM	National Association of People Living with HIV/AIDS in Malawi
NASO	Nkhotakota AIDS support Organization
NGO	Non-government organization
OD	Organizational Development
OIs	Opportunistic Infections
PIH	Partners in Hope
PMTCT	Prevention of mother to child transmission
PLWHA	People living with HIV and AIDS
PQI	Performance Quality Improvement
QA	Quality Assurance
RFP	Request for proposals
RH	Reproductive health
SAT	Southern Africa Training Network
SASO	Salima AIDS Service Organization
SC	Save the Children
SO	Strategic objective
STI	Sexually transmitted disease
USAID	United States Agency for International Development
VACC	Village AIDS Coordinating Committee
WAMI	Word Alive Ministries International

1.0 Introduction

1.1 Overview

Save the Children Federation, Inc., in partnership with Adventist Development and Relief Agency (ADRA), Academy for Education and Development (AED) and JHPIEGO, signed a cooperative agreement with the United States Agency for International Development (USAID) in May 2003 to implement a four-year program to support the Ministry of Health and the National AIDS Commission's plans to reduce new HIV infections in Malawi.

The **Capacity Building for Quality HIV/AIDS Services Project's** strategic objective was ***to increase use of preventive services and practices***. It was expected that the Project's approaches, strategies and interventions would lead to:

a) improved capacity of NGOs providing HIV-related support services,
b) improved use of those services, and
c) reinforcement of protective practices, ultimately reducing new HIV/AIDS infections.

NGO strength was measured by their governance and management systems, their human resources, relationship with communities, the quality and scope of the HIV-related services that they provide, and their ability to mobilize additional resources to sustain their project activities beyond the project funding.

The causal relationship between the project's results and key strategies are depicted in the project Results Framework and Figure 1. In October 2005 the USAID Mission revised its country strategy and Results Framework (Figure 2). The project has carried out activities under Strategic Objective12 ***Improved health and education status of Malawians***; and the program component 29 ***Reduced transmission and impact of HIV/AIDS***. The project Performance Monitoring Plan (PMP) was revised in October 2005 to incorporate the required USAID Mission and Global indicators and the latest PEPFAR required indicators. Final adjustments were made in a joint meeting with USAID in early 2007. Umoyo provided technical assistance to partner NGOs to effectively track both PEPFAR and USAID mission indicators through technical assistance in developing the NGO database.

The program was implemented by Save the Children's Umoyo Network, a program created as a field project of the USAID-funded NGO Networks for Health in 1999 to build the capacity of Malawian NGOs working in reproductive health and HIV/AIDS. The overall approach was to foster networking and partnerships for the provision of comprehensive support for HIV/AIDS along the continuum of care. The program ensured access to HIV-related services within a coordinated system of HIV prevention, management, treatment and care. Partnerships were forged at all levels from the community to the international levels to maximize use of resources and technical expertise. The project was guided by national health and HIV/AIDS policies and strategies, and provided constructive inputs into government policies and guidelines drawing from its own field experiences. The partnership addressed the three main avenues for transmission of HIV infection - sexual, mother to child, and parenteral routes.

This Final Report covers the period from May 15 2003 to August 31, 2007. It is a consolidated report covering the activities of the International Partners (Save the Children, ADRA, AED and JHPIEGO) and the fifteen local NGO Partners (Malawi AIDS Counseling and Resource Centre (MACRO), Malawi Network of AIDS Service Organizations (MANASO), National Association of People Living with AIDS in Malawi (NAPHAM), Malawi Network of People Living with

HIV (MANET+), Word Alive Ministries International (WAMI), Adventist Health Services (AHS), Development Aid from People to People (DAPP), Ekwendeni Hospital, Malamulo Hospital, Tovwirane AIDS Service Organisation, Nkhoma Hospital, Nkhotakota AIDS Service Organization (NASO), Partners in Hope (PIH), Salima AIDS Service Organization (SASO) and Mponela AIDS Information and Counseling Centre (MAICC).

1.2 Situation

The HIV and AIDS situation in Malawi continues to pose a severe health, economic and social problem. The most recent data indicates that 14% of adults of reproductive age are HIV positive, with rates higher in urban areas and in the south. Heterosexual and mother to child transmission are the main modes of transmission.

Policy and coordination is provided by the National AIDS Commission (NAC). The provision of HIV related services is spearheaded by the Ministry of Health. The NAC has been successful in raising resources from bilateral and multilateral donors and the Global Fund. The country is suffering from a severe shortage of staff at all levels of the health system.

The number of NGOs in Malawi has increased over the past fifteen years. Many are small, working in defined geographical areas. Some are larger and work at district or national level and have key input into policy making. An increasing number of NGOs are involved in HIV prevention and care and support activities. There are only a few that have had the opportunity for capacity building through donors such as Oxfam, Action Aid, Southern Africa Training Network (SAT) and Concern Universal. USAID has taken the lead in providing funding linked with technical assistance in building the capacity of the NGO sector to address HIV related issues.

Figure 1: Project Results Framework

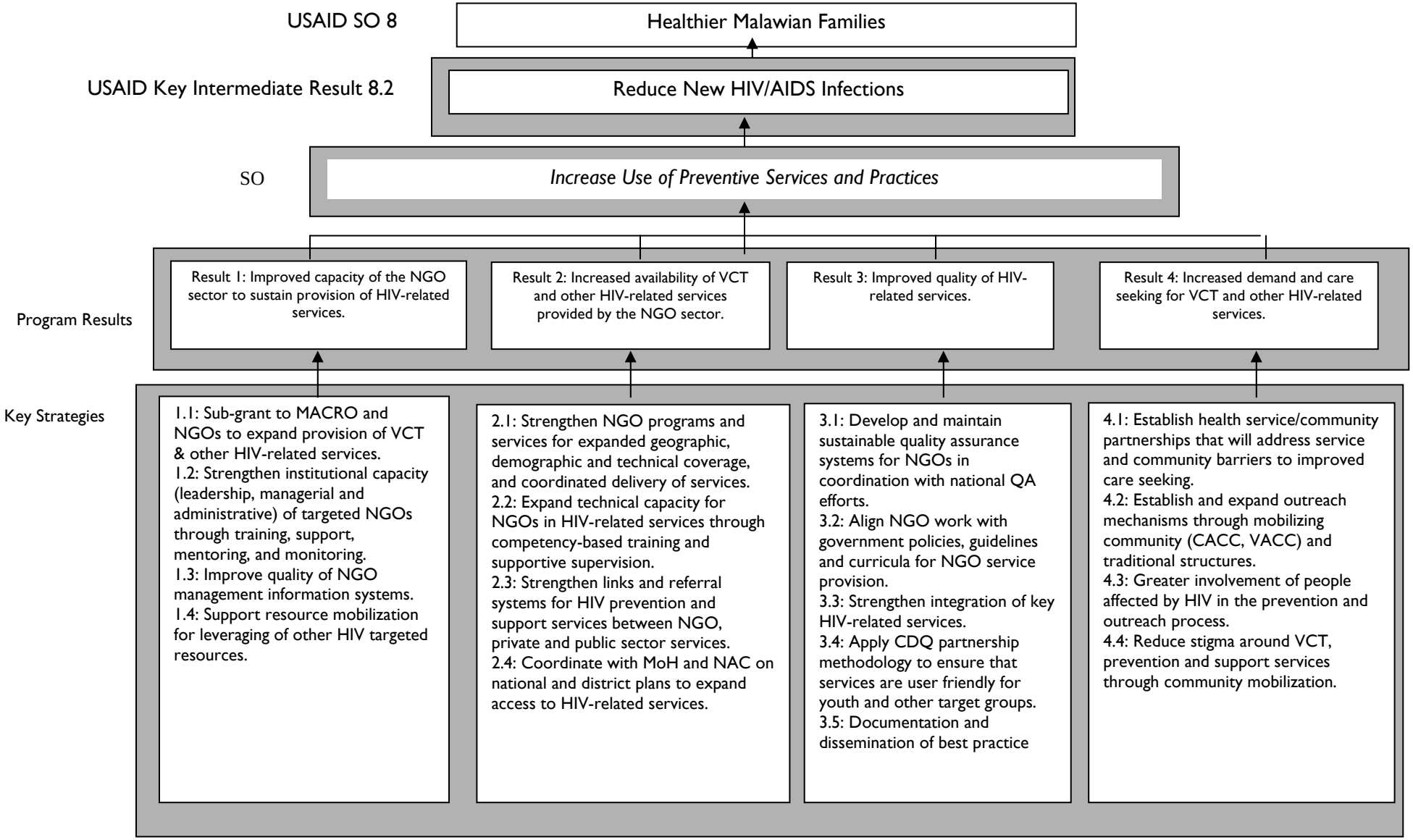
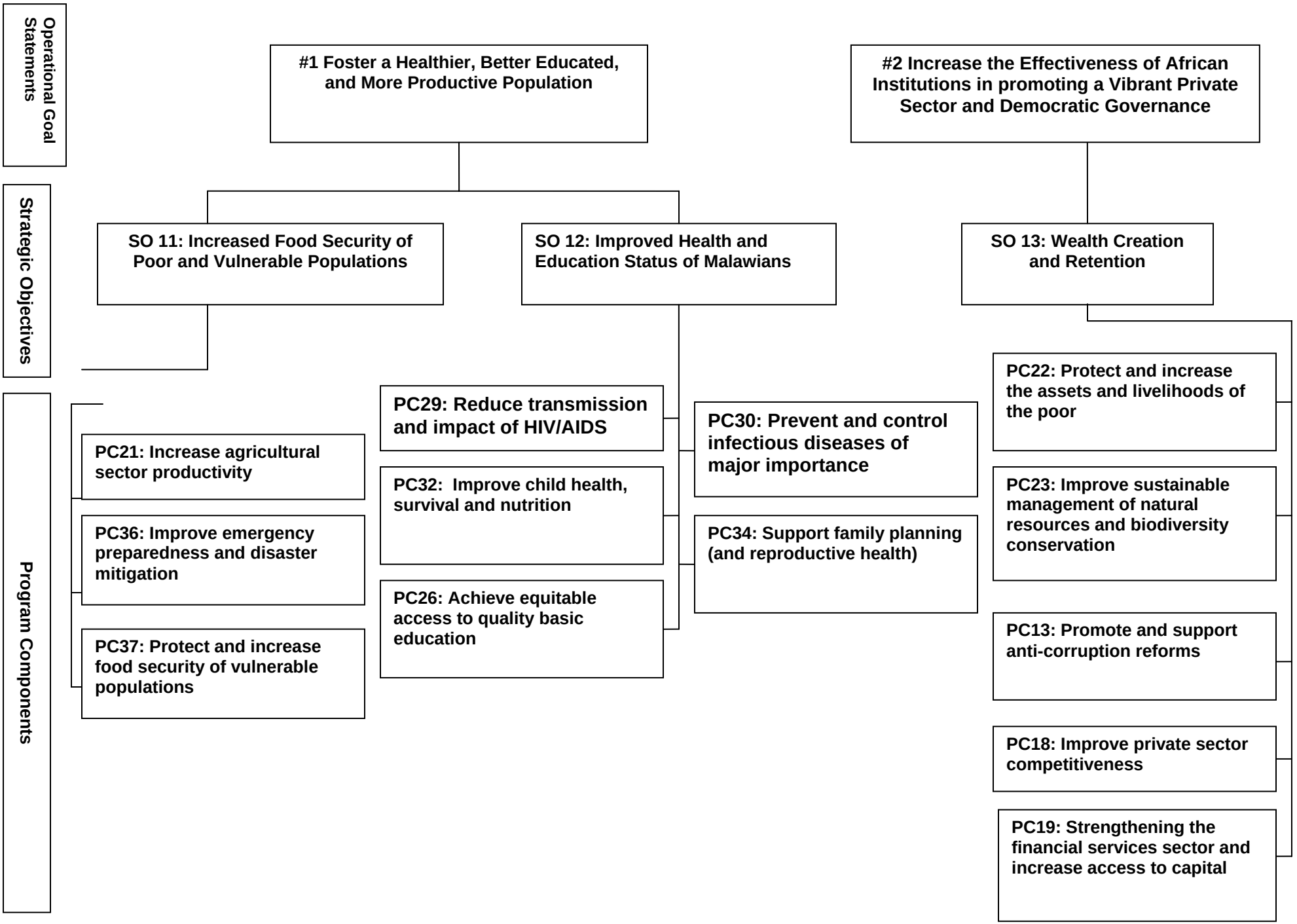


Figure 2: USAID/Malawi Results Framework 2005



2.0 Project Performance

2.1 Activities Against Plan

This section summarizes project activities in comparison to workplans, by Program Management, Results Areas and Strategies, for each year of funding, and each extension, with any deviations explained. Appendix 1 includes Expenditures vs. Budget, and Appendix 2 includes the Program Implementation Plan for Years 1 to 4, with outputs by activity. Final Reports from partners have been submitted to USAID previously and contain the detail of activities carried out during the project period.

Program Management

Yearly workplans and budgets were developed and agreed upon with USAID, and in Year 1 sub-agreements were signed with the international partners, and offices in Lilongwe and Blantyre were set up, staffed and equipped. Various staff development opportunities were provided at inception and throughout the program to ensure competent and up-to-date technical assistance was provided to the NGOs, as outlined in Attachment A. Staff leaving the program have reported that they have enjoyed the experience, learned a lot, *"like a university"*, and feel that they have undertaken and achieved a tremendous amount of work in a *"good family team with strong experts"*.

During the program, regular meetings were held to review, re-plan and manage the program: with international partners two to three times per year, with local partner NGOs quarterly, and monthly with Umoyo Network program management and units. The Chief of Party attended monthly Health, Population, and Nutrition (HPN) and bi-monthly Synergy meetings at USAID.

NGO managers commented on the benefit of networking: "*Umoyo Network quarterly meetings are the best forums where Umoyo funded NGOs come together and share their experience and best practices in HIV and AIDS work. They facilitate growth and provide a forum for learning and sharing; they help NGOs in effective project management." "The recent meeting tackled a lot of burning issues in the area of collaboration, networking, resource mobilization, and other important areas of project management"*.

Assets and supplies were procured by Save the Children and partners as per approved agreements with USAID. The disposition plan for the project was submitted to USAID in August 2007 and is included in Appendix 3.

Financial and program data was received from the sub-grantee NGOs on a quarterly basis; narrative and financial reports were prepared and submitted to USAID quarterly and annually. Internal audits were carried out; there were no significant findings and all issues were addressed. Written feedback was provided to the NGOs on their reports, and regular monitoring visits and quarterly desk reviews were implemented. Mid-term reviews were held with nine NGOs after one year of funding.

Various papers and posters on scaling up the delivery and quality of HIV related services were prepared and presented at national and international fora by Umoyo and NGO staff.

Following submission of NGOs final reports, a review was held to assess the extent to which the NGOs achieved results based on their subagreements, carried out their activities according to

plan, and expended according to budget. In closing the projects various NGOs noted their satisfaction with the support provided: *"We would like to express sincere appreciation deep down in our hearts for the time we have been together, tangible achievements have been made, and we will live with the memories of Umoyo Network"*(Ekwendeni); *"You were very energetic and determined to see us succeed."* (Tovwirane); *"We wish to express our sincere heartfelt gratefulness for all the support and guidance you have provided to us during the entire period of working with you. We feel that we learned a lot from you and your team and we sincerely thank you for this"* (Malamulo); *"Let me thank you and your staff for the technical support you rendered to MAICC which has made MAICC to be successful"* (MAICC); *"Thank you very much for the assistance. Despite the challenges faced with our project there has been a good improvement in what the health department is offering in HIV"* (Nkhoma Hospital).

A USAID-led mid-term evaluation (MTE) of the program was carried out in May 2005[1]. A table showing progress against the recommendations of the mid-term evaluation is in Attachment B. The team visited many of the NGOs, undertook a questionnaire-based survey, and held various meetings with NGO partners. They received the following feedback from NGOs:

"Our monitoring and evaluation system was developed with great assistance from Umoyo. We never had one before their coming."
Respondent to NGO survey questionnaire

"We have accessed other funding as a result of the capacity building of Umoyo."
Director of an Umoyo Network NGO

"With Umoyo help, we now have the confidence of our clients."
NGO staff person

"What does the Umoyo Network do best? Build up capacity to perform better."
Respondent to questionnaire

"Even if we are weaned away from Umoyo, the support will still help us."
NGO official

In their debriefing and final report the MTE team commented:

"You have a wonderful program"; "Umoyo Network is terrific"; "It was a privilege to work with you all and to be out with the NGOs. We found them to be energized and devoted."

"The Umoyo Network has contributed significantly to the national effort to prevent HIV transmission by measurably expanding access, quality and coverage in the delivery of HIV/AIDS services, and realizing substantial improvement in USAID indicators for VCT, PMTCT and infection prevention."

"Over and over, respondents emphasized to the team the value of this personal support and mentoring to developing specific skills and confidence. All in all, in the view of the evaluation team, the Umoyo Network has demonstrated a pragmatic and flexible approach to training that is reaping significant positive dividends in the form of a larger, better-trained work force."

"Umoyo staff is consistently praised as responsive, supportive and available to work with member NGOs. Its technical advisors are well known and respected, and are called on frequently for expert advice at the national level."

[1] Mid-Term Evaluation Report Save the Children's Capacity Building for Quality HIV/AIDS services (Umoyo Network). Initiatives Inc., June 2005.

A USAID team undertook a pre-audit of data quality in early 2007. The Umoyo Network program was highlighted in their report: *"The Monitoring, Evaluation and Reporting (MER) Plan was viewed as one of the best MER plans among PEPFAR Malawi partners. Logical steps follow the whole DMS step by step to ensure that all aspects of the data quality process along with data quality criteria are interlinked with the DMS as a whole."*

PACT were asked to include all the Umoyo Network partners in their study of collaboration amongst Malawian NGOs – Umoyo partners were 8/10 "Most Active Networkers" and 7/10 of the "Most Favoured Collaborators"; Umoyo was assessed as top "Capacity Building Provider" and second "Resource Hub" (after NAC).

USAID decided not to undertake a final evaluation of the project because they have assessed from the regular reporting that the project has achieved its results.

Result 1 – Improved capacity of the NGO sector to sustain provision of HIV-related services

A total of fifteen local partner NGOs were supported between 2003 and 2007. A competitive process was used to solicit concept papers, which were shortlisted by a team of senior staff from the MOH and NAC. Technical assistance was provided to develop and improve proposals and budgets, and clarifications were provided on feedback from USAID. Pre-award assessments were carried out and the final NGOs agreed by USAID. Several NGOs required extensive capacity building activities to enable them to build the administrative systems needed to receive USAID funds; these NGOs were part of the network but did not receive grants until later. The NGOs were as follows:

NGO	Project	Expenditure $	From	To
MACRO	Prevention of HIV transmission through intensifying and improving IEC and anonymous counseling and HIV testing	1,664,326	July 2003	March 2007
MANET+	Capaicty building and institutional support for quality HIV/AIDS services to MANET+ and member support groups	402,333	October 2003	September 2006
NAPHAM	Improving care and support and reduction of stigma and discrimination for PLHIVs	517,456	October 2003	October 2006
MANASO	Building capacity of CBOs in HIV and AIDS networking and grant management	467,952	July 2003	September 2006
Ekwendeni	Intergrated VT/PMTCT/STI programme	441,585	February 2004	March 2007
AHS	Integrated clinic and community based HIV/AIDS STO prevention project	532,214	February 2004	March 2007
DAPP	Capacity building for a community response	490,033	February 2004	March 2007
WAMI	Capacity building for VCT and other HIV related services	311,585	March 2004	September 2006
Malamulo	Malamulo Hospital integrated HIV/AIDS prevention and family planning promotion project	334,471	February 2004	March 2007
Tovwirane	To mitigate the social impact of HIV/AIDS by reducing the rate of new HIV infections	149,193	September 2005	March 2007
NASO	Behaviour change interventions in beach places	236,937	September 2005	February 2007
Nkhoma	Nkhoma Hospital HIV/AIDS programmes	216,627	September 2005	March 2007
PIH	Bridging the gaps	51,890	September 2005	February 2007
SASO	Youth friendly health services in Salima	158,780	January 2006	March 2007
MAICC	VCT stand alone and other HIV/AIDS related services	108,552	February 2006	March 2007

Funds were disbursed on a monthly basis on receipt of reports and cash requests. Vouching visits were made as required to check on financial information and assist in improving financial management systems. MANASO was assisted to set up and run a small grants scheme, using USAID and other donor funds. Audits were undertaken with all NGOs at least once and annually with those receiving more than $300,000 per year.

An Organization Development Assessment (ODA) tool was developed with assistance from International Training and Research (INTRAC). Externally facilitated ODAs were undertaken with all NGOs at the start and end of funding to assess institutional capacity building requirements and achievements. At USAID's request a scoring system was developed, which is discussed in Section 2.2, Achievements Against Targets, Indicator 4.

Findings of the ODA were incorporated into the NGO capacity building plans and various training and on-site mentoring opportunities were provided. Key activities included corporate governance and leadership; strategic planning and/or review; financial management; project management; logistics; computer use; human resource management and development; HIV in the workplace policies and action plans; and financing strategies and resource mobilization. A complete list of trainings and workshops for NGO staff is included in Attachment C.

Several activities were carried out to improve the quality of the NGO's management information systems (MIS). An MIS review was undertaken with each NGO and the findings incorporated into capacity building plans. PMPs were harmonized with those of USAID and the National AIDS Commission, and training and supervision was provided in obtaining qualitative and quantitative information from community members, using Lot Quality Assurance Sampling (LQAS), focus group discussions and observations; on-site support in data collection, and in report writing and use of data for decision-making and disseminating findings to communities.

Final LQAS Reports were produced by Nkhoma; NASO; SASO; AHS; Ekwendeni; Partners in Hope; WAMI; MAICC; Malamulo; DAPP; Tovwirane, and NAPHAM (national networking NGOs without specific catchment areas did not carry out the survey). Findings are summarized in their final reports. All NGOs improved their understanding of the purpose of monitoring and evaluation and the quality of their reports. Unfortunately, a final consolidated report was not completed as planned due to key staff turnover near the conclusion of the program and inability to identify a consultant to carry out the work.

A series of modules on resource mobilization were provided during NGO quarterly meetings, and several NGOs developed written financing strategies. The majority received technical assistance to improve project proposals to other donors and most had replacement funding in place when Umoyo funding ceased, either from USAID through PACT or other donors.

Result 2 – Increased availability of VCT and other HIV-related services provided by the NGO sector

Serviced delivery assessments were carried out with all the NGOs providing services at community level. Findings were incorporated into capacity building plans and several activities took place to build the technical capacity of the NGOs, including various trainings and on-site mentoring and visits to improve advocacy; counseling and testing supervision and site management; couple counseling; management of STIs; community-based counseling; psychosocial support and positive living; treatment of opportunistic infections; PMTCT; and infant feeding. Appendix 2 and Attachment C include further detail in this area.

Key Umoyo and NGO staff participated in national level meetings of the National AIDS Commission and the Ministry of Health to assist in developing relevant policies, guidelines and training curricula.

A Resource Center was maintained and updated in Blantyre to provide information to Umoyo and NGO staff.

A study was carried out in March 2005 to document the referral systems in place in the NGOs. Many different forms were being used and minimal information was being captured in various different ways. Suggestions were made to the NGOs on how to improve the forms and the system, particularly for back referral. MACRO, NAPHAM, WAMI and AHS have set up relatively successful schemes.

Work was carried out with the NGOs to develop a strategy to advocate on key issues with national bodies, such as MOH and NAC; technical assistance was provided by the POLICY project. Three advocacy issues were taken up – nutrition for People Living with HIV and AIDS (PLHAs), beneficial disclosure of HIV status, and availability of antiretrovirals (ARVs).

The scaling up of prevention of mother to child transmission (PMTCT) services was also promoted at national level. The Reproductive Health Adviser from AED assisted various committees to develop the policy, guidelines and curricula, and Umoyo catalyzed and helped lead the planning and organization of a national PMTCT scale up meeting in 2007.

Result 3 – Improved quality of HIV prevention and support services

JHPIEGO took the lead on improving the quality of services with the NGOs. Performance Quality Improvement processes were used to address infection prevention in hospitals and clinics and quality of counseling and testing using performance standards. A Quality Improvement score was also developed. Training and extensive on-site mentoring was provided to staff from the NGOs and periodic assessments made. Achievements are detailed in Indicators 28-33 in Section 2.2. Performance standards included elements of community-defined quality and NGO staff were oriented to this process to ensure that the needs of community members were taken into account.

NGOs were assisted to align their institutional policies to those of the government, particularly the National HIV Policy and the National Reproductive Health Guidelines. NGOs were also provided with external technical assistance in developing their HIV and AIDS in the workplace policies and action plans as follows:

NGO	HIV Policy	Implementation Guide and Action Plan
MANASO	Existing policy reviewed	
MANET+	Policy developed	Action plan finalized
MACRO	Policy developed by MACRO	Developed draft plan
NAPHAM	Finalized policy	Finalized plan
DAPP	Developed own policy in Sept. 2003	Developed plan, though without budget
AHS	CHAM policy adapted	Developed draft plan
Ekwendeni	Using CHAM policy	Guide and Plan completed, no time frame
Nkhoma Hospital	Used CHAM policy	Plan, though short-term
Malamulo Hospital	Adapted CHAM policy	Plan finalized

NASO	Finalized	Drafted not finalized
Partners in Hope	Finalized internally	Did not submit plan
MAICC	Policy finalized	Plan finalized
SASO	Policy finalized	Plan finalized
Tovwirane	Policy drafted & submitted to Board	Plan drafted, though no timeframe
WAMI	Policy developed by WAMI	Plan finalized

Significant achievement was made by all NGOs to improve the provision of integrated services to enable clients to be better served. Youth friendly and PLHA friendly services were introduced and a check list to assess the quality was provided. On-site support and advice was provided and several opportunities were made to visit and share experiences with other NGOs.

The documentation and dissemination of best practices was encouraged through quarterly meetings, attendance and presentation at national and international fora and through exchange visits; many presentations were made by NGO staff. MANASO represented Malawi at two international AIDS conferences with a booth showing NGO and CBO achievements; these were well attended by people from the region wanting to know about Malawi's work in HIV. MANASO also attended ICASA meetings.

Presentations and posters made by Umoyo staff over the course of the project included:

- M. Ng'ambi and C. Osborne (2007) 'Channels for the Movement of Resources', National HIV and AIDS Monitoring, Evaluation, Research and Best Practices Conference.
- C. Osborne and R. Tolani (2007) 'Good Use of Data Helps Scale Up Quality Services'. National HIV and AIDS Monitoring, Evaluation, Research and Best Practices Conference.
- C. Osborne and M. Chintu (2007) 'Scaling Up PMTCT Services through Community Involvement'. National HIV and AIDS Monitoring, Evaluation, Research and Best Practices Conference.
- C. M. Osborne (2007) 'Increasing use of HIV-related services and practices'. Key note address, Umoyo Network Best Practices Conference
- T. Mwapasa and C. M. Osborne (2006) 'Identifying and addressing community barriers to HIV counseling and testing to improve utilization of the services', presentation at National Research Council of Malawi, Annual Conference
- G. Kamanga, S. Mwalebu and C. Osborne (2006) 'Involving families in HIV/AIDS workplace programmes – a key to success?'. Poster presentation, XVI International AIDS Conference, Toronto
- E. Gumbo and C. Osborne (2006) 'Building and maintaining quality HIV Counseling and testing and injection safety practices – what does it take in a resource poor setting?'. Poster presentation, XVI International AIDS Conference, Toronto
- E. Gumbo and C. Osborne (2006) 'Delivery of quality counseling and testing, improved infection prevention services and injection safety: A Umoyo Network experience'. Poster presentation, XVI International AIDS Conference, Toronto
- T. Mwapasa, C. Osborne, R. Ligowe, J. Wachepa (2006) 'Identifying and addressing community barriers to counseling and testing (CT) in the presence of quality CT services'. Poster presentation, XVI International AIDS Conference, Toronto
- H. Dzama and C. M. Osborne (2004) 'Condoms and Religion – a controversial mix'. Poster presentation, XV International AIDS Conference, Bangkok
- C. M. Osborne, I. Chipofya, J. Mbuna, P. F. Moses,(2004) 'Water the roots as well as the flowers: capacity building of NGOs in Malawi'. Poster presentation, XV International AIDS Conference, Bangkok
- G.A.C. Manda and C.M.Osborne (2004) 'The benefits of community level monitoring and evaluation'. Poster presentation, XV International AIDS Conference, Bangkok

- C.M. Osborne and A. Hruska (2004) 'Nicasalud and Umoyo Network: Lessons learned from establishing and managing health networks in Nicaragua and Malawi'. Poster presentation, XV International AIDS Conference, Bangkok

Two Best Practices Conferences were arranged for staff of the NGOs and other NGO and government institutions. These were attended by senior representatives of the Malawi government, the US Ambassador and the USAID Mission Director. Over two hundred participants enjoyed the opportunity to hear and discuss the presentations, listen to testimonies from PLHAs, view exhibitions of work and see youth groups perform.

Result 4 – Increasing demand and care seeking for VCT and other HIV-related services

Various activities were carried out by the NGOs to increase demand for and care seeking for VCT and other HIV-related services. Qualitative research was undertaken by four NGOs and the findings used to develop their and other NGOs' strategies to increase demand. Various NGOs also strengthened community structures to assist with demand creation, such as youth clubs, community AIDS committees, clinic committees, PLHA support groups, and mother support groups. Training was provided in community mobilization and hundreds of mobilizers were active in their communities. Training in interactive drama was provided to youth groups to enable them to use traditional methods to encourage and educate community members.

District mapping was not undertaken as planned as the National AIDS Commission indicated they intended to do this; unfortunately it has not been carried out to date. However, the NGOs worked closely with their District AIDS Coordinating Committees to scale up services to the neediest areas.

Gender issues were addressed in demand creation and are discussed in further detail under Gender in Section 2.4. PLHAs were involved at all levels of planning and implementation of the project – as member of clinic/ NGO management committees, as volunteers and staff members.

To reduce stigma and discrimination as a barrier to care seeking and demand creation, the project NGOs developed behavior change action plans, trained community mobilizers and worked with the USAID Malawi BRIDGE Project to develop and use the Journey of Hope IEC materials. Other IEC materials were developed and/or accessed and disseminated, and are listed in Attachment D. The Faith Based Coordinator from ADRA took the lead in much of this work to address faith based issues of stigma and discrimination. She attended the MANERELA and ANERELA meetings and advocated for greater understanding by faith leaders on use of condoms for people living with HIV and AIDS. ADRA also incorporated the various key messages in their regular radio and TV shows and invited staff and volunteers from the NGOs to participate.

2.2 Achievements against Targets

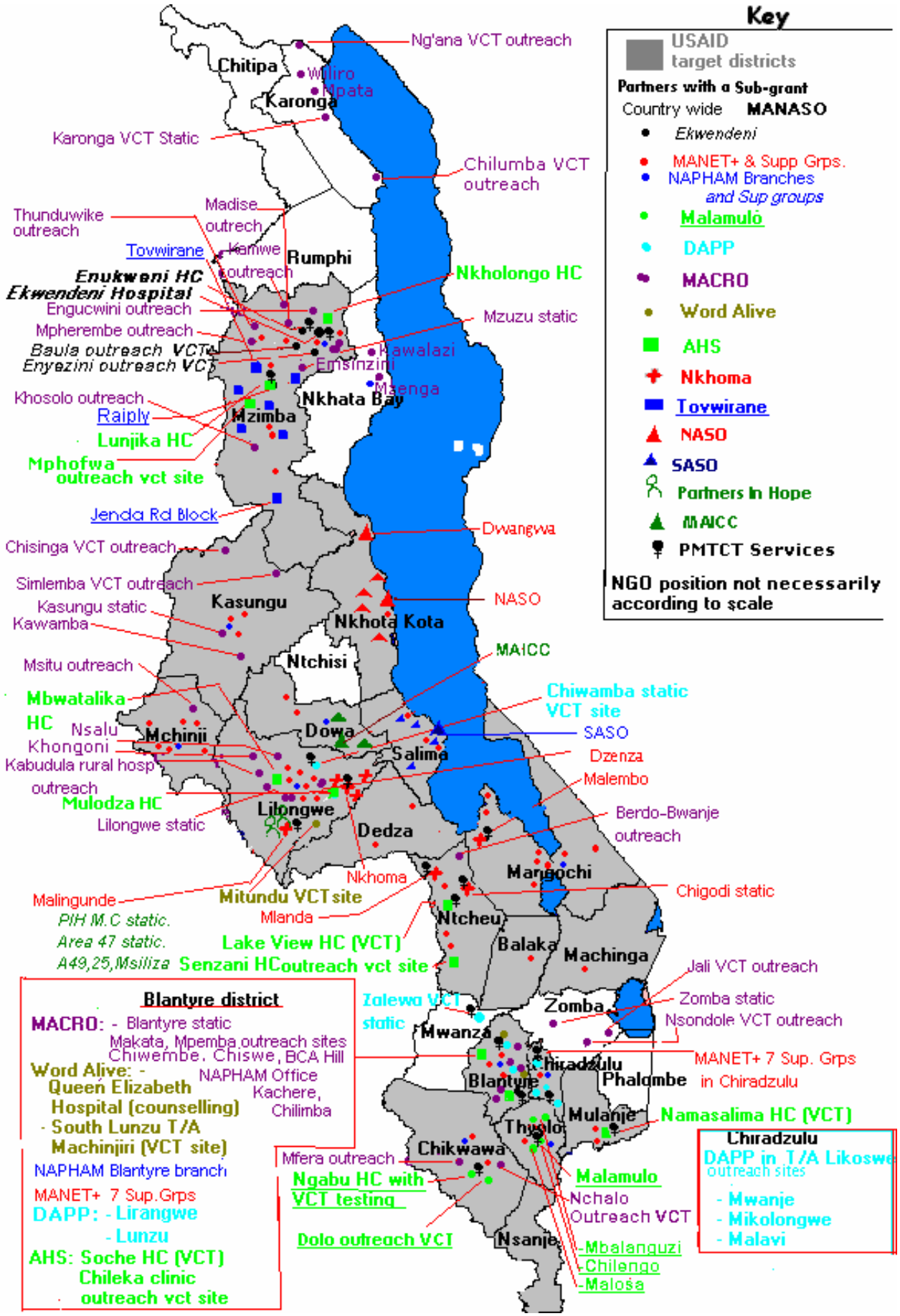
The draft PMP was submitted to USAID in Year One; revisions or changes to targets were made each year during the annual planning process. PEPFAR indicators were added in October 2005; NGOs and Umoyo set targets for FY 06 and FY07. The final PMP was reviewed and agreed with USAID in early 2007. Appendix 4 includes the PMP with indicators, definitions, targets, and achievements for the various reporting periods and requirements. This narrative describes the results against targets to the end of Year 4 of the project plan and for the FY07 COP, which is included as Appendix 5.

Result 1: Improved capacity of the NGO sector to sustain provision of HIV-related services

1. The number of NGOs funded (Umoyo indicator)
A total of 15 NGOs, against the same target, were funded under this grant. Four (MACRO, MANASO, NAPHAM, and MANET+) were funded in May 2003 with bridge funding based on their workplans from the previous grant, and from September 2003 based on the new grant. DAPP, Malamulo, AHS, Ekwendeni and Word Alive Ministries were funded by March 2004; Tovwirane, Nkhoma, NASO, SASO, PIH were funded in 2005; and MAICC in January 2006. The NGOs whose funding started later were provided with significant capacity building to improve their finance and administrative systems to prepare them for managing a USAID grant.

2. Percentage of program-supported NGOs that have increased the number of people served (Umoyo indicator).
All the NGOs, against a target 100%, have increased the numbers of people served by expanding their geographical coverage, increasing the number of service delivery sites, or offering more services. Figure 3 on the next page depicts the coverage of the 15 NGOs at the conclusion of the program.

Figure 3: Umoyo Network NGOs in 18 USAID target districts



3. Number of districts with HIV related systems strengthened (Umoyo indicator)

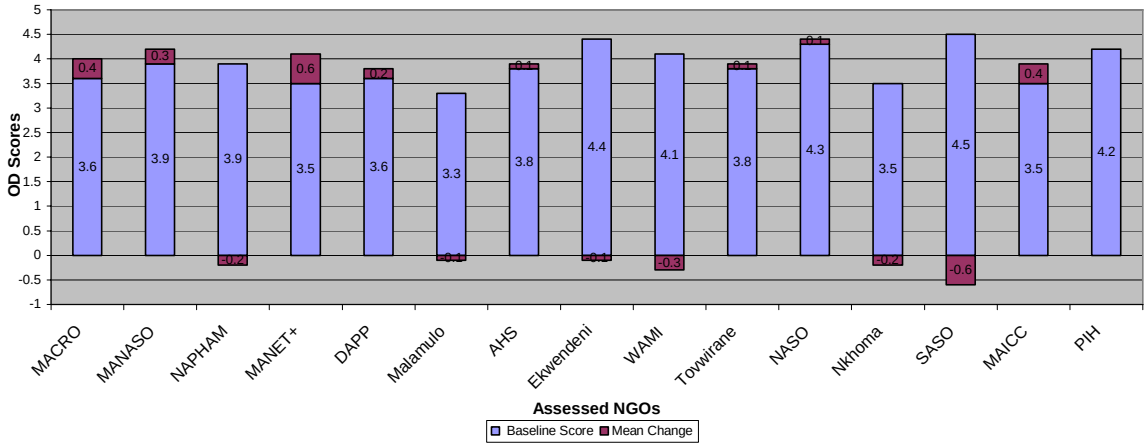
All 18 of the USAID targeted districts had their HIV related systems strengthened to provide improved HIV related services. In addition, many of the NGOs also strengthened services at sites in other districts where they worked. The two networks, MANASO and MANET+, expanded and strengthened their work in all 29 districts of Malawi.

4. Number of HIV related NGOs with capacity strengthened (USAID Malawi indicator)

The number of USAID assisted HIV related NGOs that attained a 10% increase in the organizational development assessment by 2007 was six against an Umoyo target of 15 and a USAID mission target of 10. The NGOs found the ODA process very useful to identify issues to address in their organization. It is clear, however, that having a scoring system for a qualitative assessment is open to various errors. NGO staff members carrying out the assessment were often different in the second assessment as compared to the first. In addition, many of the NGOs were harder upon themselves as they gained more experience in understanding organizational development issues. The following table summarizes baseline and follow-up results for each NGO.

NGO	Baseline Score	Range	Second ODA Score	Range	Mean Change	Mean % Change
MACRO	3.6	2.6 - 4.3	4	3.04 - 4.51	0.4	11.11%
MANASO	3.9	1.0 - 5.0	4.2	1.0 - 5.0	0.3	7.69%
NAPHAM[2]	3.9	N/A	3.7		-0.2	5.00%
MANET+	3.5	1.0 - 5.0	4.1	1.0 - 5.0	0.6	17.14%
DAPP	3.6	1.0 - 5.0	3.8	1.0 - 5.0	0.2	5.50%
Malamulo	3.3	N/A	3.2	1.0 - 5.0	-0.1	- 3.03%
AHS	3.8	2.0 - 5.0	3.9	1.0 - 5.0	0.1	- 2.63%
Ekwendeni	4.4	0.0 - 5.0	4.3	1.0 - 5.0	-0.1	- 2.30%
WAMI	4.1	1.0 - 5.0	3.8		-0.3	- 7.32%
Tovwirane	3.8	1.0 - 5.0	3.9	1.0 - 5.0	0.1	2.63%
NASO	4.3	0.0 - 5.0	4.4	2.6 - 5.0	0.1	2.33%
Nkhoma	3.5	1.0 - 5.0	3.3	1.0 - 5.0	-0.2	- 8.57%
SASO	4.5	1.0 - 5.0	3.9	1.6 - 5.0	-0.6	-13.30%
MAICC	3.5	1.3 - 5.0	3.9		0.4	11.43%
PIH	4.2	2.5 - 5.0	Not done			

The following graph depicts the change in OD scores over time, against the target of 10% above the mean at baseline



[2] Note that the OD score for NAPHAM excludes area 13 as this was omitted from the first assessment results

5. Number of local organizations provided with technical assistance for HIV related policy development (PEPFAR indicator 12.1)
A total of 15 Umoyo supported NGOs received technical assistance, from Umoyo staff and the POLICY Project, in support of policy development. This included training in advocacy skills and advocacy strategy development, involvement in national HIV related policy development, and arranging meetings between the NGOs and the MOH and NAC to ensure that NGO experience and needs are addressed in national HIV policy development.

6. Number of local organizations provided with technical assistance for HIV related institutional capacity building (PEPFAR indicator 12.2)
The targeted total of 15 NGOs received technical assistance in support of institutional capacity development. All 15 were assisted with developing or reviewing their strategic plans, strengthened their financial management systems, and improved their human resource management and systems for procuring key HIV related commodities, such as HIV test kits and Nevirapine. Four NGOs (Tovwirane, SASO, MAICC, NASO) were supported to finalize their registration with CONGOMA and the NGO board. Ten NGOs adapted or renovated their service delivery sites to better provide quality counseling and testing services. MANASO strengthened and expanded its network of AIDS service organizations from 300 to 637 during the project period; MANET+ increased the number of post test clubs within its network from 0 to 13, and PLWA groups from 32 to 187. The board members of seven NGOs received training in government and leadership, and several NGOs received training in team building and in time management.

7. Number of individuals trained in HIV related policy development (PEPFAR indicator 12.3)
In FY06, a total of 106 against a target of 53 individuals were trained by Umoyo and 8,035 against a target of 160 by MANASO and MANET+ in HIV related policy development. The project did not set an indicator for this in FY07 as the sub-grant to MANASO and MANET+ finished on September 30, 2006 but did train 22 individuals.

8. Number of individuals trained in HIV related institutional capacity building (PEPFAR indicator 12.4)
In FY06 a total of 402 against a target of 460 individuals were trained by Umoyo and a total of 4,871 against a target of 27 were trained by MANASO and MANET+ in HIV related institutional capacity building, in the subject areas described in Indicator 6 above. In FY07, a total of eight individuals were trained by Umoyo.

9. Number of individuals trained in HIV related stigma and discrimination reduction (PEPFAR indicator 12.5)
A total of 623 individuals, against a target of 80, were trained in stigma and discrimination reduction in FY07. The majority of these (451) were CT promoters and community leaders trained by Ekwendeni to overcome stigma related barriers to care seeking in their catchment area.

10. Number of individuals trained in HIV related community mobilization for prevention, care, and all treatment (PEPFAR indicator 12.6)
A total of 745 individuals against a target of 80 in FY07 were trained in supportive interventions to strengthen NGOs prevention, care and treatment programs. DAPP, Ekwendeni, Tovwirane and MAICC trained a total of 716 individuals.

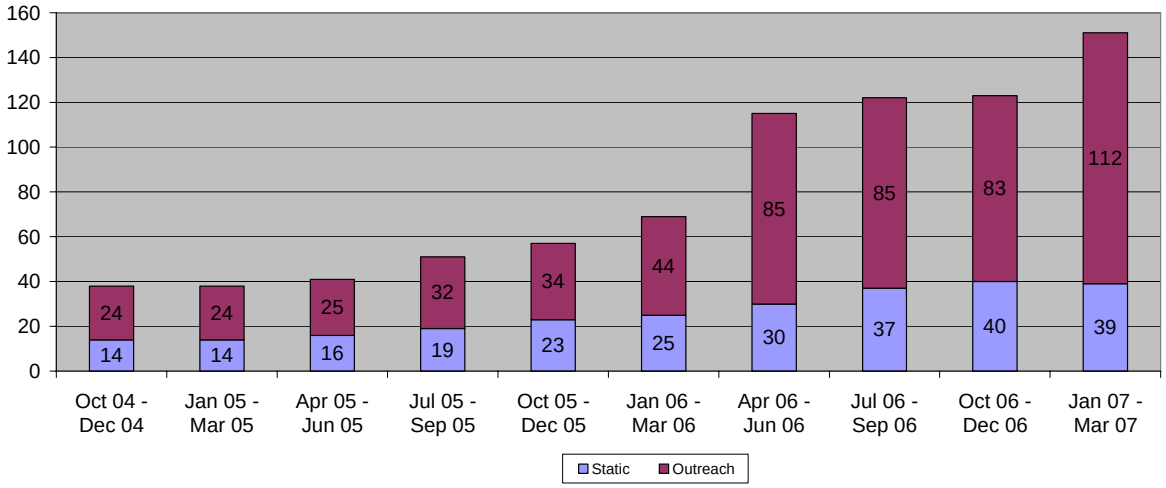
11. Number of local organizations provided with technical assistance for strategic information activities. (PEPFAR indicator 11.1)
All 15 of the partner NGOs received technical assistance to improve their strategic information activities, particularly on ensuring data quality and improving their report writing.

12. Number of individuals trained in strategic information (PEPFAR indicator 12.2)
A total of 25 individuals, against an FY07 COP target of 70, were trained in strategic information in the period from October 1, 2006 to June 30, 2007. In FY06, a total of 47 individuals, against a target of 30, were trained by Umoyo and 8,148, against a target of 80, were trained by other NGOs.

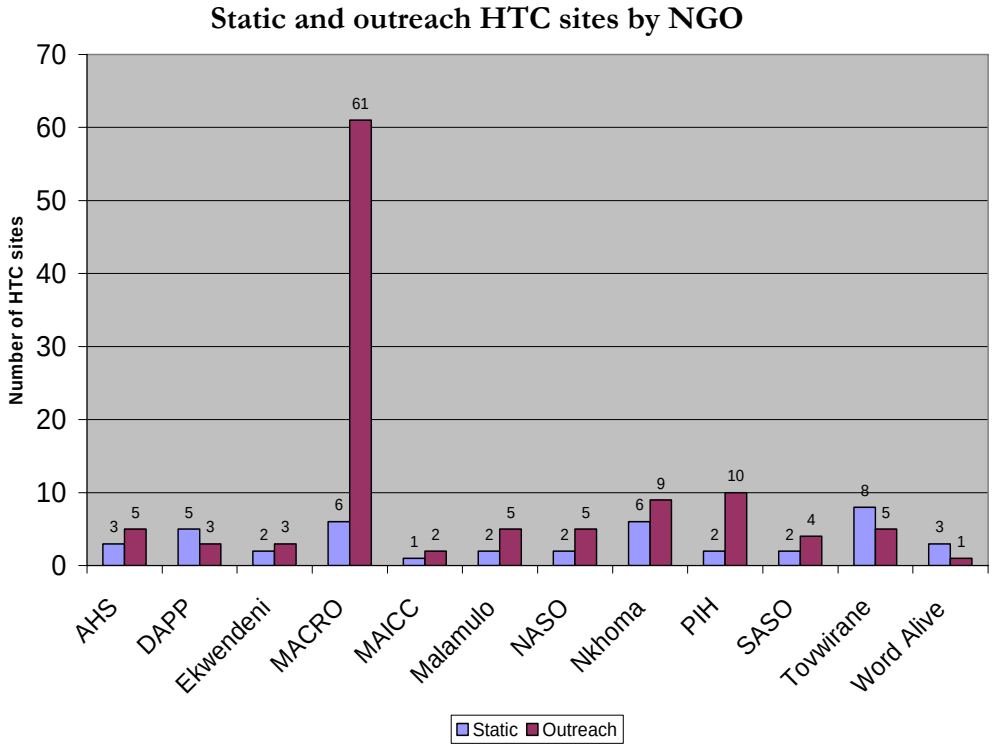
Result 2: Increased Availability of VCT and other HIV-related services

13. Total number of USAID assisted VCT sites (USAID Washington Indicator) / Number of service outlets providing counseling and testing (PEPFAR indicator 6.1)
The total number of USAID assisted CT sites supported by the end of the program was 151 against a Year 4 target of 54, and an FY07 target of 128. Of these, 39 were static sites (target 22) and 112 were outreach sites (target 32). These sites comprise 43% of the 350 CT sites in Malawi. The major increase in outreach sites is due to a conscious expansion of services to target women in rural areas. The following graph shows the growth in sites over the program period.

Number of USAID-assisted Counseling and Testing sites

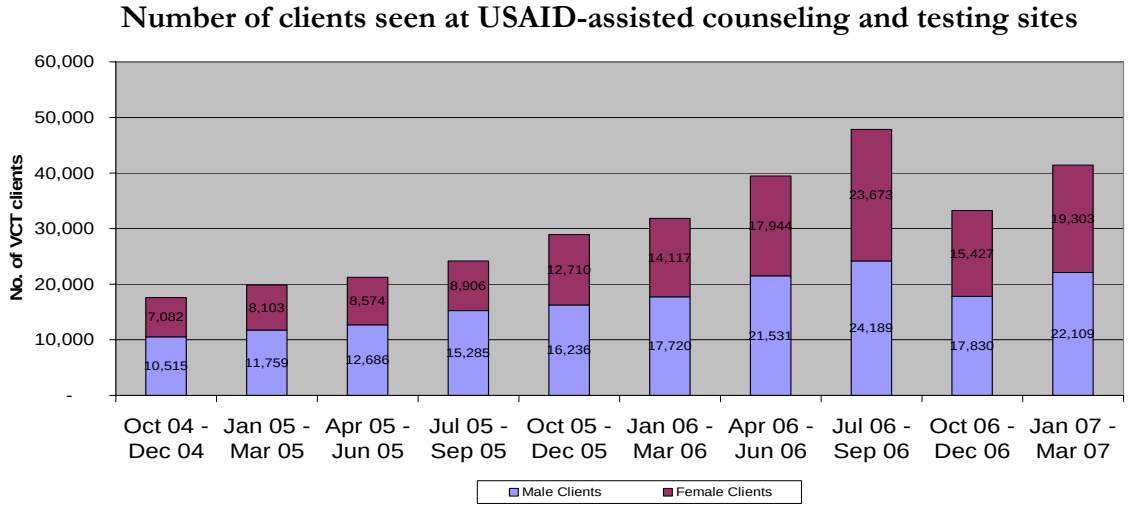


MACRO well exceeded its target of six outreach sites, with a total of 61. The graph below shows the number of static and outreach sites for each NGO by the end of their project funding.



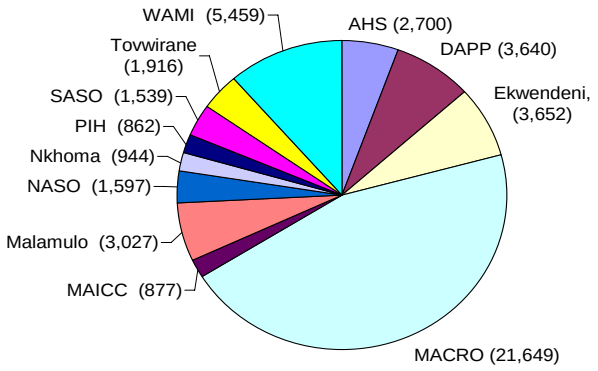
14. Total number of clients seen at USAID-assisted VCT centers (USAID Washington and Malawi indicator) / Number of individuals who received counseling and testing for HIV and received their test results

Overall, 374,080 clients were seen at USAID-assisted centers over the project period. In Year 4, 111,174 clients were tested and received their results (58,351 males and 52,823 females) compared to a target of 110,000. This exceeds the original USAID mission target of 85,000 by 2007. The COP FY 07 target of 70,000 was also exceeded, with a total of 74,669. This was due to an increased number of sites and effective community mobilization. NGOs contributed significantly to National Counseling and Testing Week in July 2006, which combined with the introduction of the opt-out strategy in June, dramatically increased testing in the third quarter. WAMI figures are not included after October 2006, as their subgrant concluded.



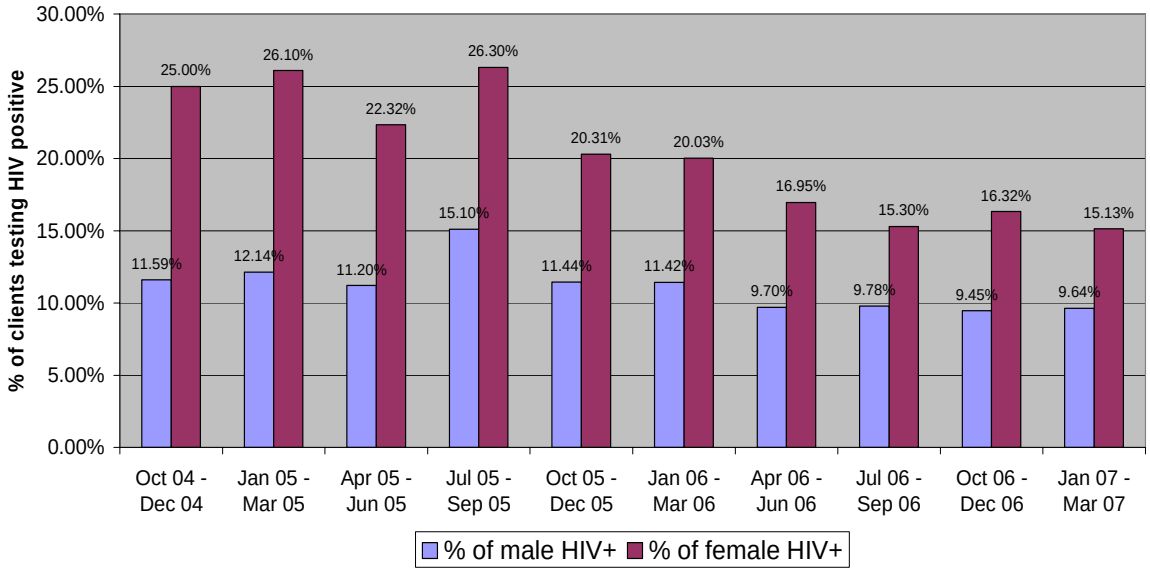
The pie chart below shows the percent of total clients tested by each NGO through the project period.

Proportion of total clients tested, by NGO



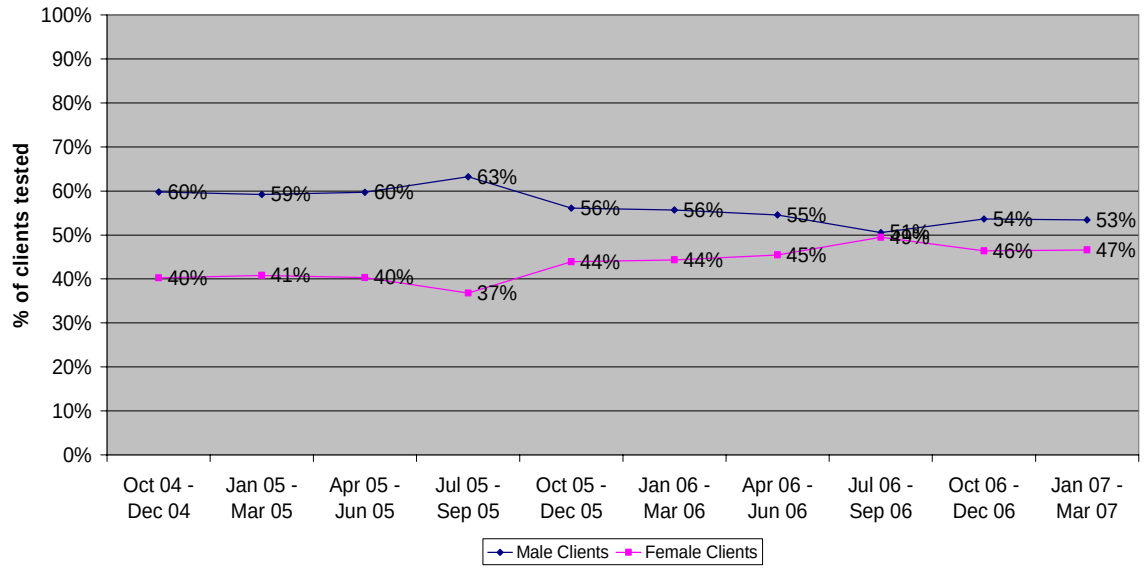
The graph below shows the percentage of clients who tested HIV positive at USAID-assisted counseling and testing sites, diaggregated by gender. Throughout the period, the percentage positivity for females exceeded that of males. It is likely that the higher percentage seen in females in the early months is due to more pregnant women being tested. As the project progressed, more outreach sites were opened in rural areas where both married and non-married women had access to testing services. The Malawi sentinel surveillance survey generally shows a higher rate of HIV in antenatal women than in the general population.

Percentage of clients who tested HIV+ at USAID-assisted CT sites, by gender



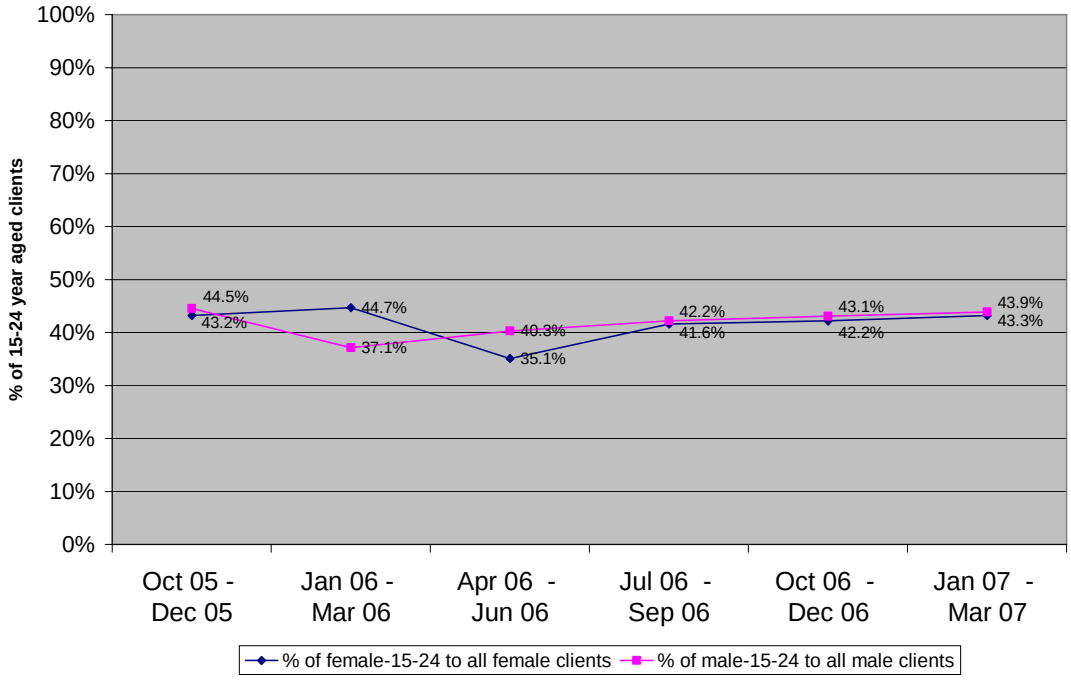
The introduction of outreach sites appears to have increased the proportion of women to men being tested. The graph below shows the percentage of men and women tested in each quarter. It should be noted that from mid-2005, there was a large increase in outreach sites.

Percentage of males and females accessing CT services at USAID supported sites



Early in the program, NGOs found it challenging to capture the age of clients consistently. This was resolved by late 2005. Age disaggregated data over time are shown below. Despite extensive activities to encourage youth (aged 15-24) to go for testing and the introduction of youth friendly services, there has unfortunately not been a significant increase in the proportion of young people being tested over time.

Percentage of male and female youth aged 15-24 years accessing CT services at USAID supported sites



15. Number of individuals trained in counseling and testing according to national or international standards (PEPFAR indicator 6.3)

The project trained 30 individuals in FY07 against the same target. A total of 233 individuals were trained throughout the project period using USAID resources. All of these individuals were trained using the national counseling and testing curriculum.

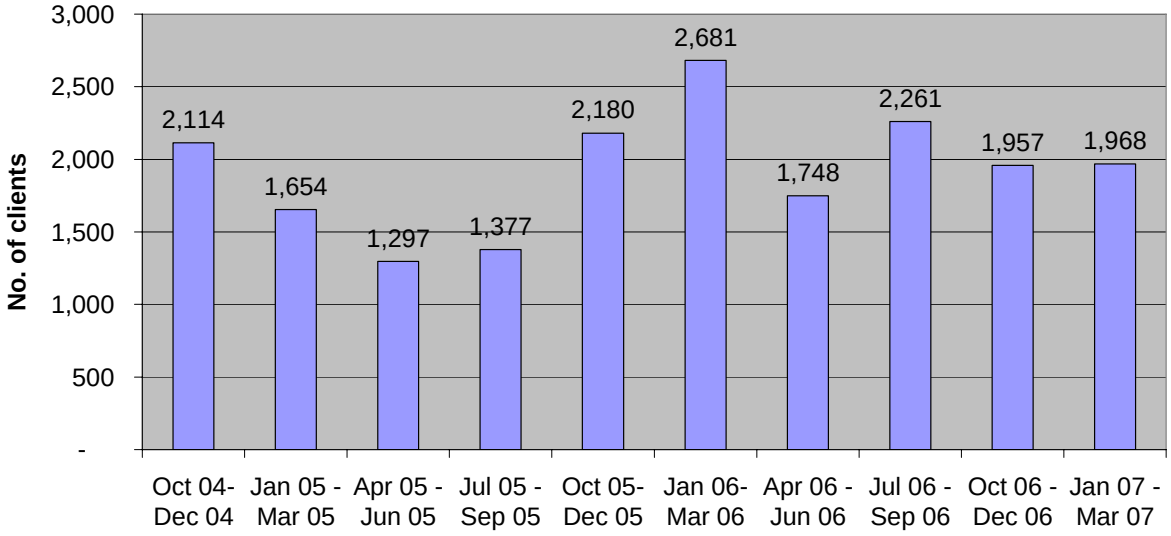
16. Total number of USAID-assisted STI clinics (USAID Washington and Malawi indicator)

A total of 29 STI clinics have been assisted. The baseline of 16 rose to 18 in the second half of 2005 and to 29 in the third quarter of the same year, where it remained through the end of the program.

17. Total number of clients seen at USAID-assisted STI clinics (USAID Washington and Malawi indicator)

The total number of clients diagnosed and treated for STIs at USAID assisted clinics in Year 4 was 7,173 against an annual target of 4,450. For the whole project period the number of clients diagnosed was 24,098 against a target of 19,450. The project over-achieved this indicator partly due to the fact that in sites where integrated services were offered, most pregnant women were also screened for STIs.

Number of clients diagnosed and treated at USAID assisted STI clinics



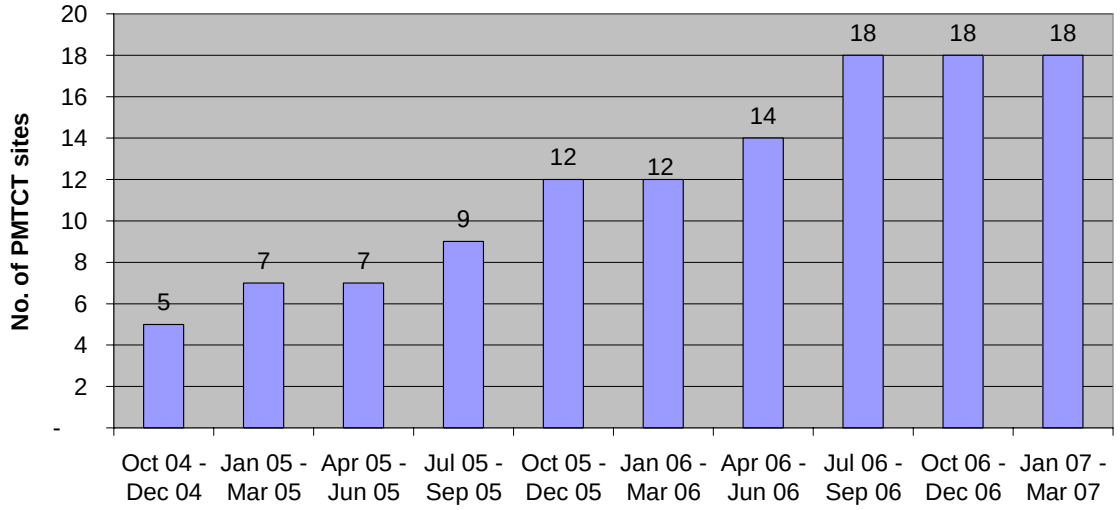
The NGOs have had difficulty in reporting STI service information disaggregated by sex and age; only five NGOs have achieved this consistently. Some of the NGOs, particularly DAPP, Ekwendeni and AHS have tried to encourage community members to come for treatment of STIs and have also managed STIs at antenatal clinics. It is apparent that there is still reluctance for individuals to seek STI treatment. The project had hoped to see an initial rise in clients attending for STI treatment and then a reduction over time as abstinence and condom use became more common; the national data does not yet show this is happening in Malawi.

18. Number of USAID supported PMTCT sites (USAID Washington)/ Number of service outlets providing the minimum package of PMTCT services (PEPFAR indicator 5.1)

The project has made great strides to increase the number of PMTCT sites, with additional

financial support from USAID provided for this in the last six months of the program. The total number of sites is now 18, as reflected in the graph below.

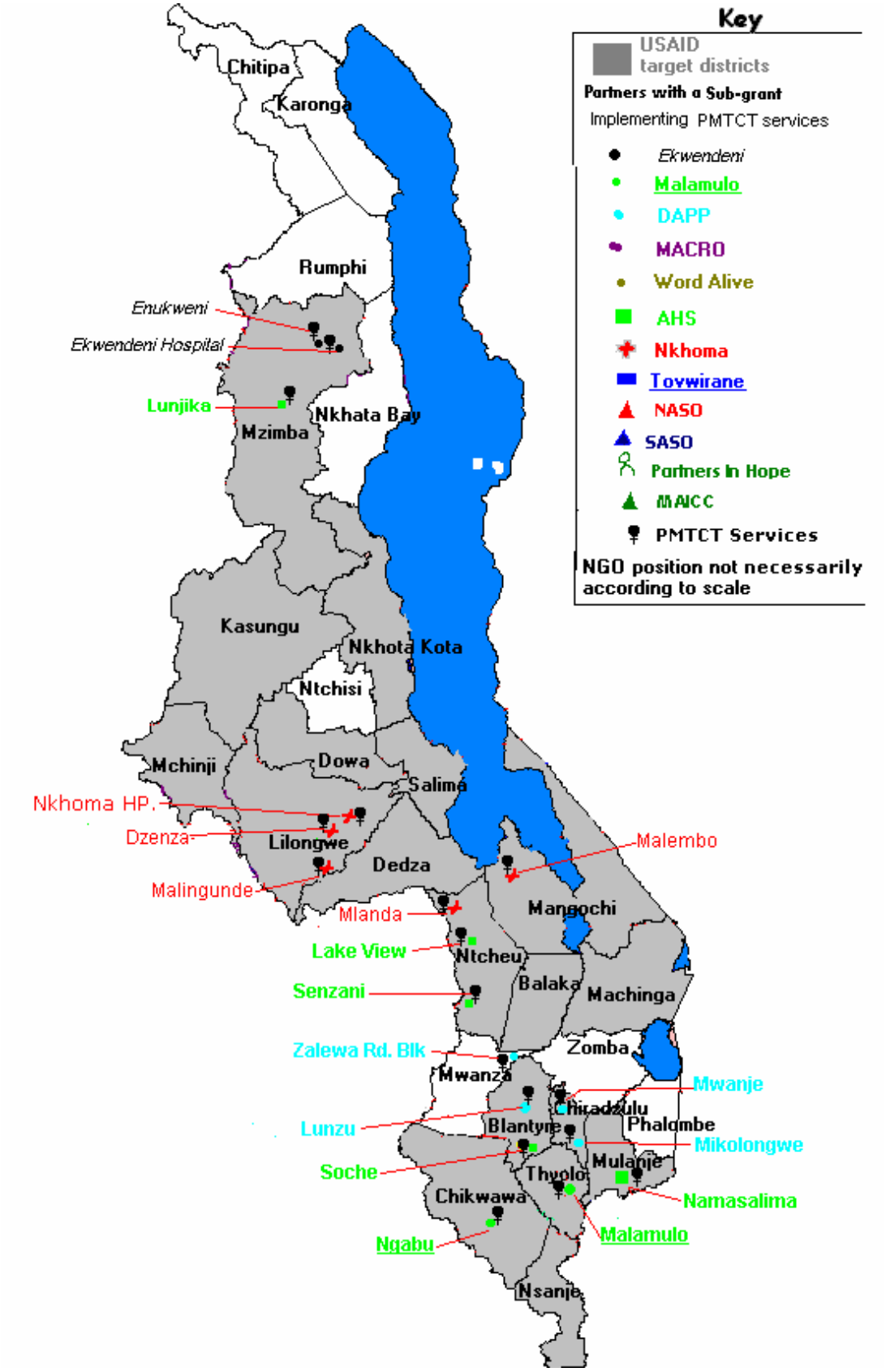
Number of sites offering minimum package of PMTCT services



The majority of these sites provide counseling and testing, ARV prophylaxis, support for safe infant feeding, and family planning counseling or referral. DAPP sites do not provide delivery services and hence mothers enrolled in the PMTCT program were referred to other institutions for assisted delivery.

The map on the following page shows the location of USAID-supported PMTCT sites.

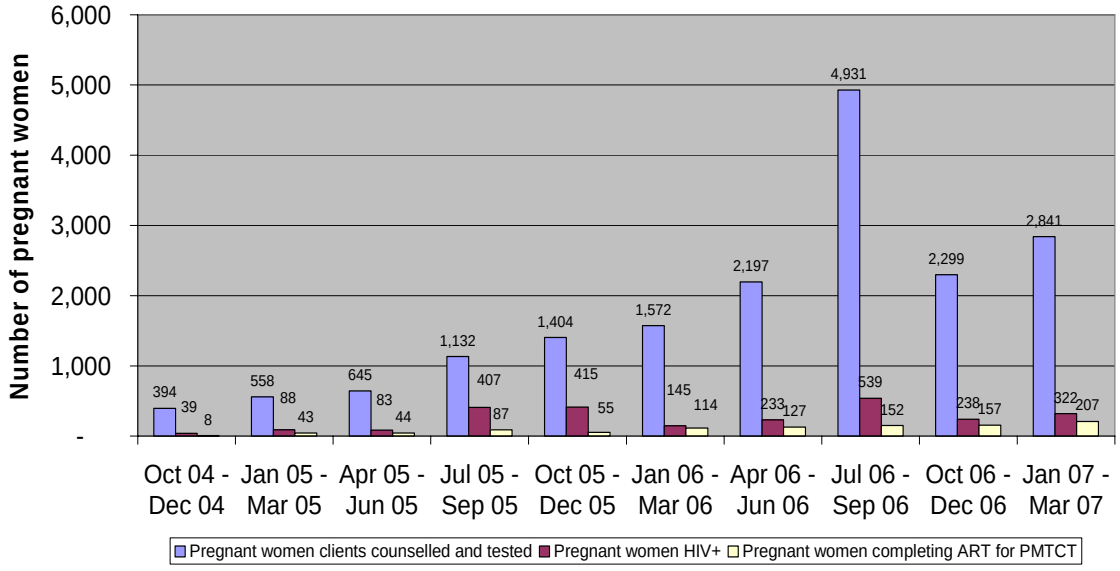
Umoyo Network NGOs scale-up of PMTCT services as at June 30, 2007



19. Total number of new antenatal clients registered (Umoyo indicator PMTCT 1)
The total number of new antenatal clients registered by the PMTCT sites was 24,467 throughout the project period.

20. Number of pregnant women who received HIV counseling and testing with PMTCT and received their test results (PEPFAR indicator 5.2)
Throughout the project period, a total of 20,242 pregnant women learned their HIV status, of whom 3,073 (15%) tested HIV positive. In Year 4, a total of 8,546 against a target of 6,660 pregnant women were tested; and a total of 5,140 against a COP 07 target of 5,800 pregnant women were tested. In the graph below, of note is the high number of pregnant women tested in July to September 2006, likely due to National Counseling and Testing Week and the introduction of the opt-out strategy.

Number of pregnant women who received minimum package of PMTCT services at USAID-supported PMTCT sites



21. Number of pregnant women provided with a complete course of antiretroviral prophylaxis for PMTCT (Umoyo and PEPFAR indicator 5.3)
A total of 1,157 pregnant women, and 603 of their babies were provided with a complete course of ARV prophylaxis in the project period. This included 399 women against a target of 200 in Year 4, and 364 against an FY 07 COP target of 331 pregnant women. ARV prophylaxis uptake by HIV infected pregnant women was approximately 50%. This low coverage is attributed to women opting for home deliveries because of traditional practices, long distance to health facilities, the requirement for fee payments for delivery services at non-governmental facilities, and lack of shared confidentiality of HIV status within the family. With that said, it is encouraging to note that the uptake of HIV prophylaxis greatly improved over the course of the program, reaching nearly 100% by the conclusion. Utilization of labor and delivery services also increased due to the provision in the national PMTCT scale up plan in which the government has agreed a memorandum of understanding with NGOs to pay for maternity services. Generally, this was single dose Nevirapine. At most sites, women were provided with the Nevirapine at their antenatal clinic after 32 weeks gestation in case they delivered at home, though all pregnant women were encouraged to return for a service provider-assisted delivery.

Of the 135 babies followed up at 18 months by four of the NGOs (excluding data from Nkhoma), 132 (97%) babies tested HIV negative and three tested HIV positive. All were exclusively breastfed, with early cessation at six months.

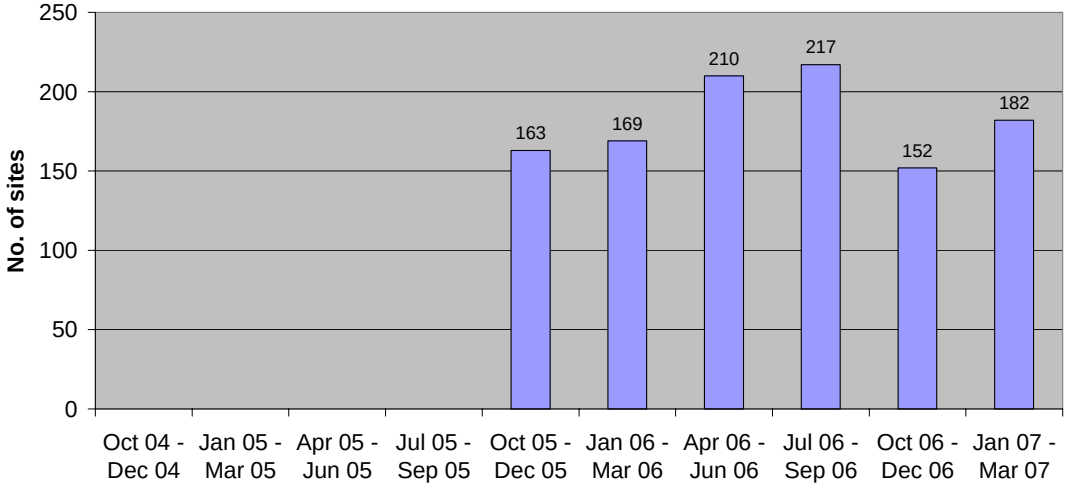
22. The number of health workers trained in the provision of PMTCT services (PEPFAR indicator 5.4)

Eighteen health workers against a COP target of 20 were trained in FY07. A total of 120 PMTCT providers were targeted to be trained for the project period and 107 was achieved, with the shortfall due to insufficient capacity of the NGOs to roll out the training immediately.

23. Number of targeted condom service outlets (PEPFAR indicator 2.1)

The total number of condom service outlets by the end of the program was 182 against a FY07 COP target of 156. From October 2005 to September 2006, the graph below captures the number of outlets for 15 NGOs; from October 2006 data is available for only 11 NGOs due to closure of subgrants.

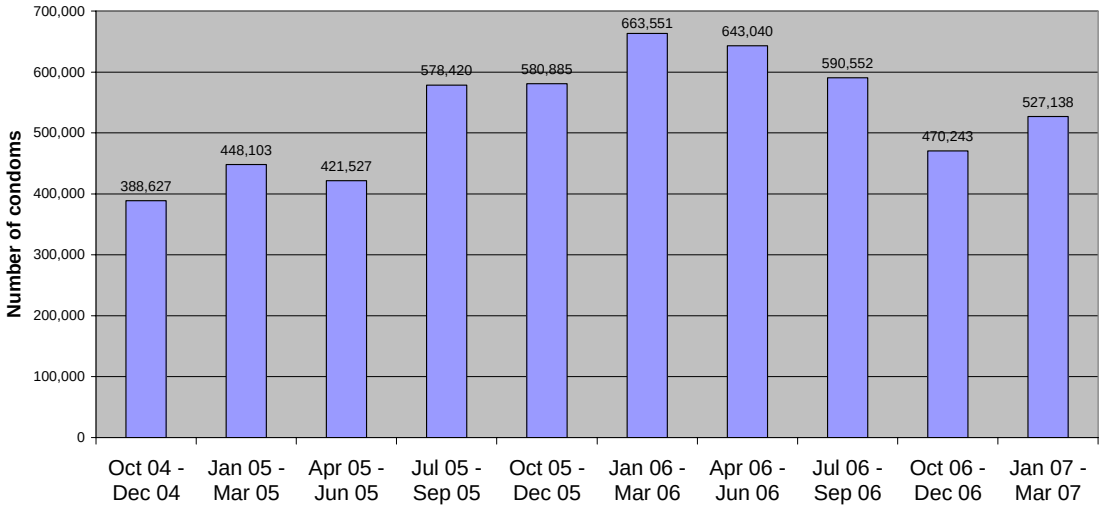
Number of targeted condom service outlets at partner NGO



24. Total number of condoms distributed by USAID assisted HIV related services to end users free of charge

A total of 5,577,025 condoms were distributed by the 182 condom service outlets throughout the project period. A total of 2,141,564 were distributed in Year 4 against a target of 3,000,000. Year 2 and 3 well exceeded the target as Umoyo provided PSI Chishango condoms for free distribution through funding from the previous program. This provision ceased in April 2006, and some of the NGOs found it difficult to obtain sufficient supplies from the district health offices. From October 2005 to September 2006, the graph that follows reflects distribution through 15 NGOs; from October 2006 the data is from 11 NGO due to completion of subgrants.

Number of condoms distributed by USAID assisted services



25. Number of service outlets providing HIV-related palliative care (PEPFAR indicator 8.1)

This indicator, introduced in October 2005, has been difficult to track as PEPFAR's definition of palliative care is different from that generally used in Malawi. Discussions were held with the USAID Malawi mission and with the NGOs to try to establish a common understanding of this definition. FY06 COP data may not be completely accurate as a result, although FY07 data appear complete. A total of 118 service outlets provided HIV related palliative care in FY07 against a COP target of 90.

26. Number of individuals provided with HIV-related palliative care (PEPFAR indicator 8.2)

Challenges in definition were similarly encountered with this indicator. A total of 11,271 individuals, against a COP target of 12,350 were provided with HIV-related palliative care by the Umoyo NGO partner service delivery sites in FY 07. The care included psychosocial support, spiritual counseling, management of opportunistic infections, and community and home based care of the dying. The target and achievement is significantly reduced from FY06 (63,508) as the majority of clients were attending NAPHAM and MANET+ PLWHA and post test clubs. The subgrants for these NGOs ended in September 2006.

27. The total number of individuals trained to provide HIV palliative care (PEPFAR indicator 8.3)

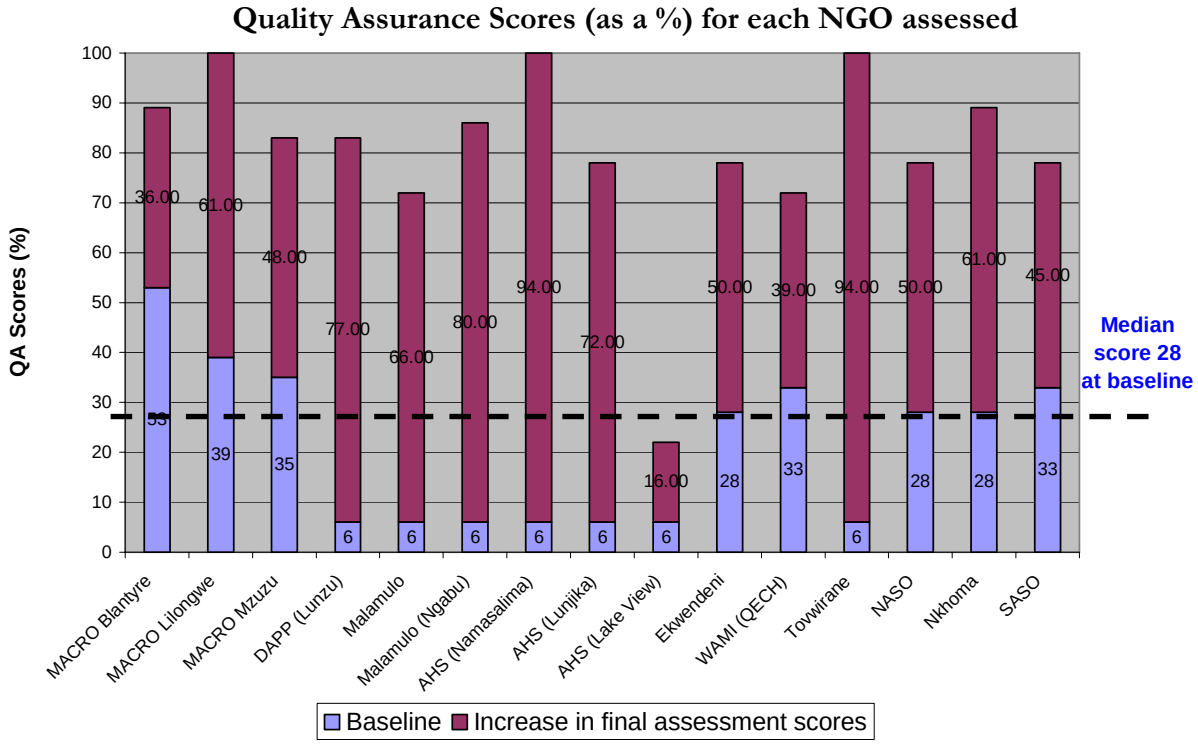
The total number of individuals trained to provide HIV palliative care in FY07 was 283 against a COP target of 150, the majority at Tovwirane, MAICC and Nkhoma.

Result 3: Improved Quality of HIV-related Services

28. Number (and percent) of USAID supported NGO sites with a quality improvement score above the median score at baseline. (USAID Malawi indicator)

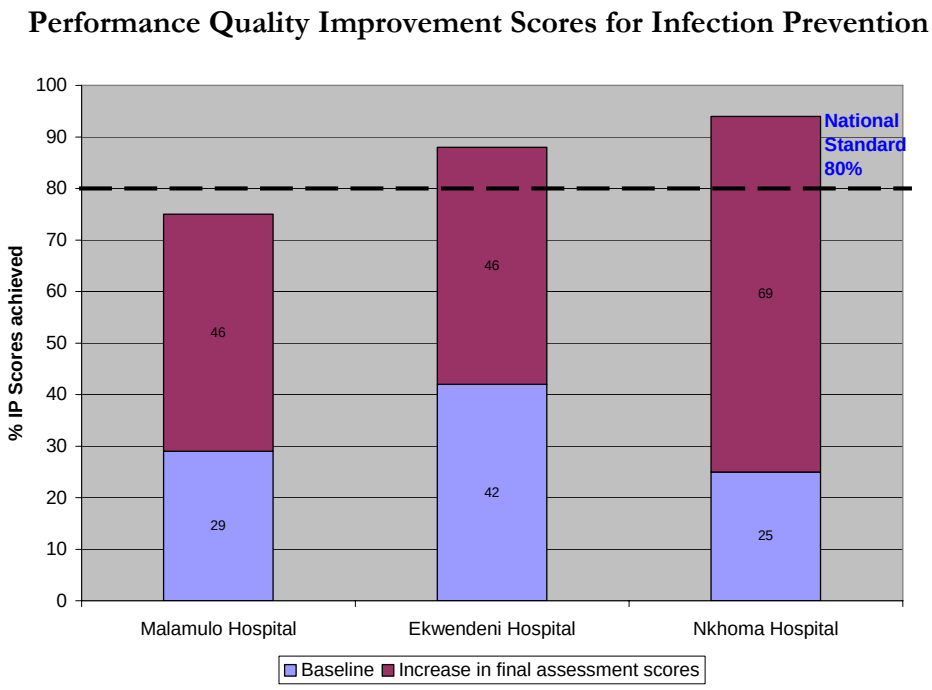
Umoyo partner JHPIEGO developed a set of indicators to measure the development of quality assurance processes at the NGOs. This was first assessed during the service delivery assessment and subsequently during the counseling and testing and infection prevention assessments. By the

end of the program, 14 (93%) of the 15 NGO sites assessed achieved a quality improvement score above the median score of 28% at baseline, as depicted in the following graph.



29. Number of health facilities that correctly apply 80% of national standards for infection prevention (USAID Malawi indicator)

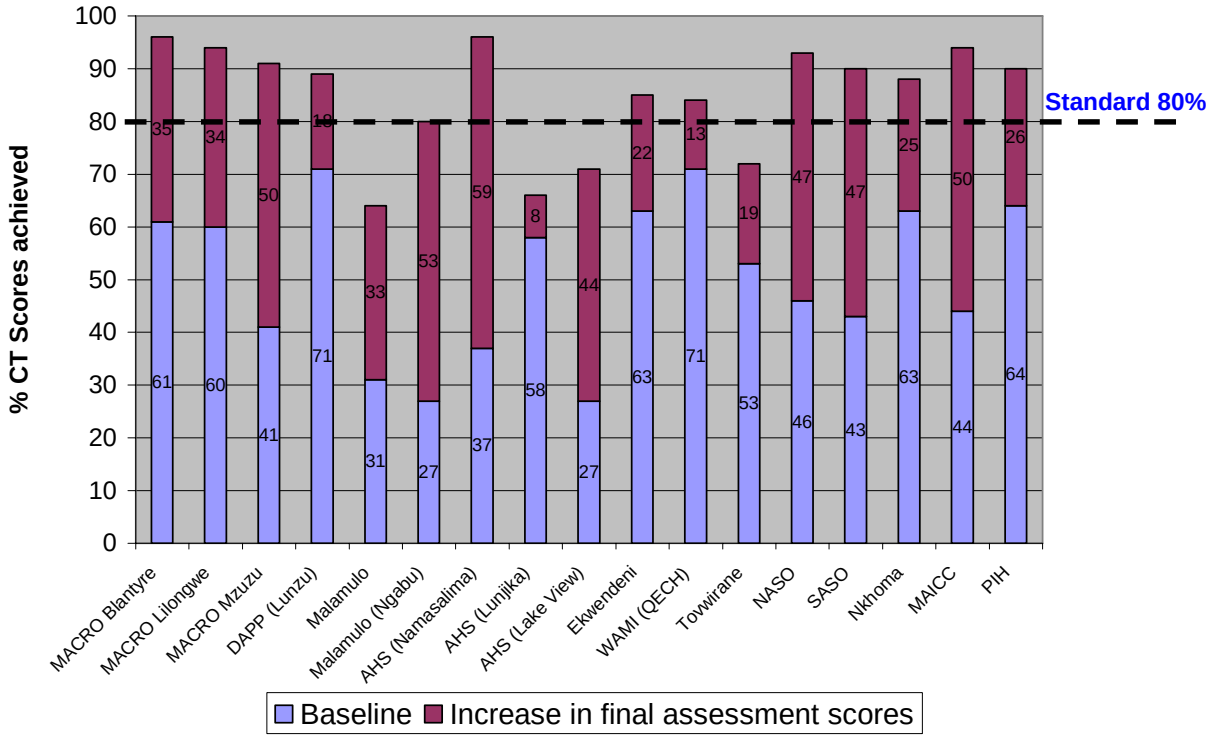
Three hospitals were assessed against the national standards for infection prevention. Of these, two achieved over 80% of the national standard in all areas assessed. All three made tremendous improvements and their commitment to improving infection prevention has been very impressive, as depicted in the following graph.



30. Number of facilities that achieve 80% of national standards for counseling and testing (Umoyo indicator)

A total of 12 (75%), against a Year 4 target of 9, of the 17 USAID-supported counseling and testing sites achieved the 80% standard. All 17 enthusiastically made tremendous strides to improve the quality of their counseling and testing services, as illustrated in the graph below.

Performance Quality Improvement Scores for Counseling and Testing



31. Percentage of health facilities in targeted districts with no stock out of HIV test kits in the past 3 months (Umoyo/USAID Malawi indicator)

The percentage of health facilities with no stock outs was 85%, falling slightly short of the USAID target of 90% by 2007.

32. Percentage of USAID supported STI sites in targeted districts with no stock out of STI drugs in the past 3 months (Umoyo indicator)

The percentage of USAID supported STI sites in targeted districts with no stock out of STI drugs in Year 4 was 83%, falling short of the target of 100%.

33. Total number of individuals trained in injection safety (PEPFAR indicator 4.1)

A total of 100 people were trained in injection safety in FY07 against a COP target of 20. The majority of these were from Ekwendeni and PIH.

Result 4: Increased demand and care seeking for VCT and other HIV-related services

34. Total number of PLHA support groups (Umoyo indicator)
Among 10 of the NGOs there were a total of 60 PLHA support groups in Year 4. There were 305 PLHA support groups overall, the majority were in NAPHAM and MANET+, whose funding ceased in September 2006. These groups were still active at the conclusion of the program.

35. Number of existing members in PLWHA support groups (Umoyo indicator)
There were 2,913 members of the above PLHA support groups in Year 4. They benefited from various PLHA initiatives through strengthened psychosocial support and capacity building of the groups. Many attended group therapy and relevant trainings in nutrition and positive living.

36. Number of new PLWHA groups created this year (Umoyo indicator)
There were 25 new PLWHA groups created in Year 4.

37. Number of post test clubs (Umoyo indicator)
A total of 224 post test clubs were supported until the end of Year 4; 184 were supported to September 30, 2006 of which the majority were from MANET+.

38. Number of existing members in post test clubs (Umoyo indicator)
There were 4,754 regular signed up members registered with post test clubs by the end of Year 4.

39. Number of new post test clubs created (Umoyo indicator)
There were 40 post test clubs formed in Year 4.

40. Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful (PEPFAR indicator 1.1)
A total of 280,510 individuals, against an FY07 target of 144,000 were reached through community outreach activities focusing on abstinence and/or being faithful. The NGOs made great efforts to improve their data collection for this indicator over time; the USAID data auditors appeared satisfied that they had done so.

41. Number of individuals trained to promote HIV/AIDS prevention through abstinence and/or being faithful (PEPFAR indicator 1.2)
The number of individuals trained to promote abstinence and/or being faithful was 3,535 against a FY07 COP target of 3,058.

42. Number of individuals reached through community outreach that promotes HIV/AIDS prevention through other behavior change beyond abstinence and/or be faithful (PEPFAR indicator 2.2)
A total of 351,110 individuals were reached against an FY07 COP target of 354,500, which is substantially lower than FY06 due to the conclusion of funding of several NGOs.

43. Number of people enrolled in PLHA organizations (Umoyo indicator)
A total of 2,913 people are enrolled in PLHA organizations by the end of Year 4 against a Year 4 target of 2,720. This compares to 18,769 in Year 3, when the project was funding NAPHAM and MANET+.

44. Number of copies of HIV/AIDS IEC materials (brochures/booklets) distributed (Umoyo indicator)
A total of 326,623 IEC materials were distributed by the NGOs against a Year 4 target of 183,500.

Indicators 45-56 are for Umoyo tracking only. Eleven NGOs undertook community surveys using LQAS. Data is reported below by NGO, showing the baseline and follow-up data consolidated across supervision areas. As there are many other organizations working in HIV it is not possible to attribute causality to USAID funds. Each NGO used this data to formulate or re-formulate their workplans and focus of activities.

INDICATOR		AHS		DAPP		Ekwendeni		Malamulo		NAPHAM		Word Alive		Program	
		Base	Final	Base	Final	Base	Final	Base	Final	Base	Final	Base	Final	Base	Final
45. Percentage of adults in stable relationships who had sex in the past year with a non-marital cohabitating partner (USAID Washington indicator)	Fem.	3.8	2.3	12.1	9.0	2.2	3.9	3.5	1.4	10.4	8.7	12.0	9.2	7.7	6.0
	Male	11.1	6.8	13.1	14.4	19.5	11.9	12.3	11.3	10.5	9.3	8.6	18.8	12.7	12.2
46. Percentage of women and men aged 15-49 who had sex with more than one partner in the last 12 months (PEPFAR indicator)	Fem.	5.9	3.7	11.2	11.7	2.1	5.3	5.2	4.3	9.6	8.6	10.8	10.3	8.1	7.9
	Male	14.0	7.3	14.5	15.5	19.3	14.1	13.7	13.8	16.0	8.3	10.8	20.1	14.7	13.4
47. Percentage of people not in a stable relationship who had sex with more than one partner in the past year (Umoyo/USAID Washington indicator)	Fem.	13.5	8.3	9.3	16.4	**[3]	11.1	20.0	13.0	5.5	7.6	6.2	14.2	9.7	13.4
	Male	25.0	9.3	19.6	20.0	16.6	37.5	21.4	50.0	33.3	5.8	18.7	33.3	23.1	19.3
48. Percentage of respondents who report condom use at last risky sex (USAID Washington/USAID Malawi) *(used a condom with a non-marital, non-co-habiting partner in the last year)*	Fem.	37.0*	37.5*	80.0	33.3	0**	33.0**	**	25.0*[4]	**	44.4*	80.0*	40.0*	70.0	34.8
	Male	76.4	81.8	80.0	43.7	**	**	85.7*	99.0*	91.6	80.0*	75.0*	75.0*	81.5	65.3
49. Median age at first sex among young men and women (USAID Malawi)	Fem.	18.0	18.0	17.0	16.0	18.0	17.0	16.0	16.0	18.0	16.0	18.0	18.0	17.0	17.0
	Male	17.0	17.5	17.0	16.0	18.0	17.0	17.0	15.5	16.0	15.0	18.0	17.0	17.0	16.0
50. Percentage of young people aged 15-24 who both correctly identify ways of preventing the sexual transmission of HIV and reject major misconceptions about HIV transmission (PEPFAR indicator)															
51. Percent of never-married young men and women aged 15-24 who have never had sex (PEPFAR)	Fem.	69.0	61.9	57.9	55.7	80.7	78.2	56.2	52.9	65.0	80.0	57.1	73.0	63.9	64.1
	Male	58.6	53.7	40.4	27.9	47.3	49.0	22.2	32.0	32.0	39.2	60.0	58.3	42.8	43.1

[3] ** Number too small (between 0-5) not acceptable for statistical interpretation

[4] * Ssubjected to wide standard error margin of Confidence Interval CI. The difference is 'not significant' statistically. Numbers of respondents below 10

INDICATOR		AHS		DAPP		Ekwendeni		Malamulo		NAPHAM		Word Alive		Program	
		Base	Final	Base	Final	Base	Final	Base	Final	Base	Final	Base	Final	Base	Final
52. Percent of never-married women and men, aged 15-24, who had sex in the last month, of all never-married women and men, aged 15-24 surveyed (PEPFAR) *(sex in last 12 months)*	Fem.	61.5	56.2	44.8	37.0	40.0*	20.0*	42.8*	50.0*	57.1*	66.6*	30.0	28.5	46.4	42.4
	Male	41.6	56.0	42.8	55.1	36.8	33.3	60.7	64.7	38.2	26.4	60.0	46.6	45.0	48.6
53. Percent of women and men aged 15-49 who had sex with more than one partner in the last 12 months (PEPFAR)	Fem.	5.9	3.7	11.2	11.7	2.1	5.3	5.2	4.3	9.6	8.6	10.8	10.3	8.1	7.9
	Male	14.0	7.3	14.5	15.5	19.3	14.1	13.7	13.8	16.0	8.3	10.8	20.1	14.7	13.4
54. Percent of women and men aged 15-49, who say they used a condom last time they had sex with a non-marital, non-cohabiting partner, of those who have had sex with such a partner in the last 12 months (PEPFAR indicator)	Fem.	37.0	37.5	80.0	33.3	0	33.0**	**	25.0**	**	44.4**	80.0*	40.0	70.0	34.8
	Male	76.4	81.8	80.0	43.7	100.0 **	100.0 **	85.7*	100.0*	91.6	80.0	75.0	75.0	81.5	65.3
55. Percent of the general population with accepting attitudes toward PLWHA (PEPFAR indicator)															
56. Percent of people who fear disclosing HIV status because of negative reaction (USAID Malawi indicator)															

2.3 Capacity Building

During the program, staff development opportunities were provided to existing and newly recruited Umoyo staff to ensure that they had the skills to carry out their respective duties and to encourage and motivate them to provide state- of-the-art technical assistance to the NGOs. Several staff undertook formal training courses and/or attended national or international conferences. A full list of this staff development is in Attachment A. The purpose of this was to ensure good quality training and technical assistance to the NGOs and their community members. A list of the main trainings provided to the NGOs is in Attachment C.

The capacity building needs of each NGO was identified through various assessments. A prioritized capacity building plan was agreed and implemented. The main focus of much of the work by the Save the Children technical staff was to build the capacity of Malawian NGOs. Each NGO has provided detailed information on their capacity building in their final report, submitted to USAID separately. Considerable progress has been seen over the project period in governance, management, and quality service provision, as shown by the results of the various assessments as previously described in Section 2.2.

The focus on strengthening systems has led to increased provision of improved quality services and increased use.

2.4 Gender Issues

Gender concerns were considered at different stages of project implementation. They were addressed in the review of concept papers, proposals, curricula, training materials, and records in HIV-related services and during mentoring and supportive visits in health care and community services. In all levels of PMTCT training, sessions focused on male involvement in reproductive health services, MCH/FP, and infant and young child nutrition counseling and support services. Both male and female staff participated in PMTCT training, mentoring, and infant feeding training. AED advocated for fostering a conducive environment for male-friendly MCH services and introducing PMTCT in HIV pre- and post-testing counseling of male as well as female clients at stand-alone counseling and testing sites and in group therapy for people living with HIV. Other examples of efforts to involve men included:

- Encouraging males to support partners in early cessation of breastfeeding
- Helping PMTCT mothers with negotiation skills for male involvement
- Conducting focus group discussions for men and women as part of the PMTCT qualitative study
- Involving men in training of trainers for community mother support groups in Namasalima, Malamulo, and Lunjika health centers
- Providing technical assistance to the Nkhotakota AIDS Support Organization to initiate PMTCT services on Sunday afternoons to accommodate working male partners
- Mentoring both men and women on the opt-out strategy

The following examples show how some of the NGOs addressed gender issues.

MAICC. At program level MAICC made sure that the secretariat was gender balanced, having nearly equal numbers of male and female staff; there were 11 female and 12 male staff. A small

survey indicated that female clients access outreach services and MAICC management decided to introduce outreach services for female clients to access CT services.

AHS. At secretariat level, AHS achieved an equal ratio of male to female staff, a 1:1 ratio. On stigma and discrimination AHS carried out campaigns through TAs and religious leaders on gender roles and equalities as well as reproductive health rights. At the start of the program, men often blamed their partners for positive HIV test results. However, over the last two years, this attitude has changed because men and women better understand HIV related issues including modes of transmission.

AHS also developed male-friendly MCH services, which recognize men as service recipients. At the beginning of the program, men felt pregnancy-related issues were not their concern. Following community mobilization, there has been an increase in the number of couples coming together for reproductive health services.

Ekwendeni. Patterns of attendance indicate that more females than males are accessing services at both static and outreach sites within the Ekwendeni catchment area. This is most likely due to the fact that females often access integrated services for PMTCT, family planning, CT, STI management, and under 5 child health services.

Ekwendeni is continuing to address issues of gender in its programming using volunteers and community members to mobilize the community to utilize services. This includes specific targeting of male clients through male motivators and the planned introduction of HIV clinics for males.

NAPHAM. Men occupy the majority of executive positions. However, the majority of beneficiaries are females (89%). The management discussed with the groups about ways in which to include women in higher level positions. These suggestions were utilized effectively. More women are now engaged in community home based care and trainings were conducted in home-based care to include more male providers.

NASO. Beach village committees were active at the fishing points at the areas, exposing men to information regarding social issues. However, women were rarely included in these groups. Men were also the key decision makers in most of the issues including sexual reproductive health and family planning. Hence there continued to be great population growth in the beach communities. Additionally, it was found that many fishermen spent time with other women following their fishing trips, using the money they had made and putting themselves and their partners at risk for HIV.

The behavior change intervention project was designed to address some gender-related concerns and issues affecting beach areas in the NASO catchment area. Fishing communities have unique cultural beliefs and activities that put residents at risk for HIV infection. Women in fishing areas are often responsible for selling fish, often at night, putting them at particular risk for HIV.

2.5 Special Studies

ADRA Qualitative Study: Identifying and Addressing Community Barriers to HIV Counseling and Testing (HTC) to Improve Utilization of the Service. T. Mwapasa and CM Osborne, 2006.

With a national HIV/AIDS prevalence rate of approximately 14% in those aged 15-49 years, Malawi is among the countries hardest hit by the epidemic. HIV/AIDS counseling and testing (CT) is now internationally recognized as a key element in the provision of comprehensive HIV/AIDS services and as a key strategy for facilitating behavior change. In 2005, realizing a great need for the expansion of counseling and testing (CT), Malawi developed a 5-year (2006 – 2010) CT plan. Although there has been a steady increase in the number of cites offering CT services, coverage in many rural areas still remains low. Additionally, research has shown that increasing availability of CT services does not always result in increased service uptake.

To identify the community barriers that exist to CT, a qualitative study was conducted using study cites in Mzimba, Mulanje, Ntecheu, Lilongwe, Blantyre, Thyoto, Chiradzulu, and Chikwawa districts. The study included 63 focus group discussions (FGDs) with users and non-users of the service in the community. Twenty in-depth interviews were also completed with services providers at the CT sites as well as local and religious leaders in the community. A total of 535 people participated in the study through FGDs and in-depth interviews. The study was conducted at 12 CT sites of five NGOs being supported by Save the Children Umoyo Network: DAPP, MACRO, AHS, Ekwendeni Hospital, and Malamulo Hospital. Focus groups were also conducted with three NAPHAM support groups for PLWHA.

Results:

HIV/AIDS Knowledge and Access to Information. FGDs indicated that women had more access to HIV/AIDS education than men and out of school youth. Women demonstrated more knowledge of where to obtain services and the benefits of HIV testing compared to men. This differential in knowledge was likely due, in part, to women having more frequent contacts with health facilities as the primary caregivers of children and patrons of ANC services. Men also indicated that women have more access to information because most community outreach activities are conducted during weekdays, when they are at work, market, or engaged in other livelihood security activities.

In general, basic HIV/AIDS knowledge in the community was good. However, there was still a lack of specific accurate information in some areas. Almost all respondents knew the difference between HIV and AIDS, but were less sure about some modes of transmission. MTCT was not well known, especially to males and youth, which accordingly affected patronage of PMTCT and HCT services. Misconceptions also were identified regarding the HIV status of discordant couples. Most people did not know that both partners had to go for individual HIV tests and thought that the sero-status of one partner was automatically the same as the other partner. There was also a great deal of misinformation about STIs and their link to HIV. Most participants were unaware of the importance of STI testing and that these services were provided free. Instead, most opted for treatment from traditional healers. Knowledge about the availability of supportive services to help PLWHA was also lacking.

Fear of the implications of receiving positive HIV results. Information from FGDs and in-depth interviews revealed that stigma and discrimination remains a major barrier to accessing CT

and other HIV/AIDS related services. Many who had not been tested feared that they would be stigmatized for being tested and if the test was positive would be rejected by their community? Some participants, particularly men, revealed they would rather not know their HIV status. They felt that the anxiety of a positive result would make them die quicker than if they were positive and did not know their status.

Stigma is deep-rooted in some communities and comes in many different forms. One women's group in Chiradzulu stated that those who want to know their status are labeled in the community as 'prostitutes', while PLWHA are labeled as 'already dead'. According to women's groups, many women lack decision making power on issues regarding health, with their husbands having the final say about such matters. Because the men often do not have as much information and have their own fears about testing, they often prevent their partners from accessing services.

Many participants also expressed fears about ARV availability. Many feared an HIV positive diagnosis without having access to ARVs. If the drugs were made available, others feared the possible side effects that would accompany them and an inability to meet the nutritional requirements necessary to compliment medicine taking.

Post Study Interventions:

Based on knowledge gaps that were identified as barriers to care seeking, Umoyo Network NGOs intensified community sensitization activities on CT and other HIV/AIDS related services. The benefits of accessing such services were stressed. Community members that had gone for an HIV test were selected as volunteers who conducted different community sensitization activities. They were trained as community CT promoters and peer educators. NGOs have also been strengthening community structures by involving them in community mobilization.

To encourage PMTCT, Ekwendeni Hospital mobilized a group of grandmothers who also serve as promoters and provide care and support for infected mothers and their babies. Youth groups and drama clubs have also been trained in using interactive drama. Their purpose is to engage the community in discussions and dialogue about HIV/AIDS and to reinforce positive behavior change. Special efforts were also made to target men in order to increase HIV/AIDS knowledge, encourage them to be tested, and change their attitudes towards women's roles in health decision making.

Much of the reluctance to be tested for HIV was related to fears of community stigmatization and a lack of adequate support to cope with a positive HIV test result. To address this problem, NGOs established and strengthened post-test clubs (for both positive and negative people), mother to mother and infant feeding groups for PMTCT for mothers, and groups for PLWHA. Members of these groups get psychosocial and other forms of support as well as counselors. They also help promote CT in their communities and are involved in various outreach activities.

AED Qualitative Study: Rapid Assessment of Prevention of Mother-to-Child Transmission of HIV/AIDS (March/April 2006). Mwate Chintu, 2006

Mother-to-child-transmission of HIV and child malnutrition are major problems in Malawi. Although breastfeeding can protect against major childhood illnesses and provide optimal nutrition, it can also be a source of HIV transmission for mothers to their babies.

A Rapid Assessment of Qualitative Behavior Change on HIV/AIDS, PMTCT of HIV, and infant feeding was carried out in March/April 2006 in four PMTCT sites in four districts (Mulanje, Thyolo, Chiradzulu, and Mzimba). There were two hospital-based sites, one health center offering maternity services, and one health center providing a full range of maternal child health and family planning services. Forty-three focus group discussions (FGDs) were held with a total of 416 pregnant women, mothers of infants 0–11 months old, men and women in the community, and PLWHA. NGO health providers were also interviewed.

The objectives of the FGDs were to determine community perceptions and understanding of HIV/AIDS, PMTCT, PLWHA, and the use of MCH services in the context of PMTCT. The FGDs also explored infant feeding practices in the context of HIV, and the perceptions of PLWHA regarding available care and support services. Findings of the qualitative assessment are presented in a separate report on *Rapid Assessment of Prevention of Mother-to-Child Transmission of HIV/AIDS: Qualitative Data Summar*y. Key findings of the FGDs are summarized below.

Results:

MCH services and infant feeding. Most pregnant women did not access antenatal care in the first trimester in order to reduce the number of visits, hide their pregnancy or wait for physical signs of pregnancy. Other deterrents included long distances to care sites, transport costs, negative health provider attitudes, and illness. Most women sought care alone, as men were commonly unwilling to leave work or thought the services were only for pregnant women. Pregnant women were aware of the services available at health facilities and expressed satisfaction. Even so, home births by traditional birth attendants remained the norm.

Many mothers with infants less than six months old knew about the dangers associated with early introduction of other foods, but felt unable to practice exclusive breastfeeding for six months. Some introduced liquids and foods as early as two to three days after birth, particularly in Mzimba and Thyolo districts. Most mothers waited two to four months before discontinuing exclusive breastfeeding, most fearing they lacked adequate amounts of breast milk. Mothers of 6-11 month olds indicated that diarrhea was the first major sign for early introduction of fluids.

HIV/AIDS and MTCT. The majority of respondents mentioned sexual intercourse as the first mode of HIV transmission, while abstinence and condom use were identified most frequently as ways to prevent HIV. Respondents were knowledgeable on the signs of AIDS, and where to go for HIV testing. However, fear of positive results, stigma and discrimination from family and the community, poor pre-test counseling, and death hinder respondents from collecting results. The majority of pregnant women and mothers with infants 0–5 months old knew several ways to prevent mother-to-child transmission of HIV, but few mentioned exclusive breastfeeding. Most mothers perceived a low risk for MTCT during pregnancy and a higher risk during delivery because of blood and secretions. Almost all mothers, men, and community members stated that HIV-infected mothers give birth to HIV-infected infants. Frequent responses for why HIV-infected mothers should breastfeed include nutritional and psychosocial benefits. Additionally,

respondents feared stigma, discrimination, and discovery by husbands and relatives of their HIV status if they did not breastfeed. Alternatives, such as replacement milk and heat treatment of breast milk expression are unavailable, foreign or taboo.

Experience and perceptions of people living with HIV/AIDS. In the focus groups for PLWHA, all respondents were aware of the care and treatment that HIV-infected people need, and knew it was available from their hospitals. They reported that HIV-infected persons are stigmatized both in family and community settings. Over half said that their parents were disappointed, laughed at them, isolated them, and discriminated against them by not eating together or sharing a room at night. Almost all men wanted their wives to continue having children despite HIV-positive test results, but women did not want to have children because of the risk of MTCT. In addition, women felt that their health would deteriorate with each birth and they would have difficulty caring for their children.

Recommendations:

Several recommendations are based on the results of the focus group discussions. Maternal and child health services are the entry points for integrating PMTCT strategies, treatment, and support services. Women showed high knowledge of services provided during antenatal care and benefits. Increasing knowledge about the risks of MTCT during pregnancy could motivate women to go to the ANC clinic during the first trimester. Strategies should also seek to involve males in antenatal care and increase deliveries in health facilities.

Continued efforts are also urgently needed to reduce stigma in the community. If strong social stigma against HIV persists, women will not utilize PMTCT services or if positive, implement proper feeding options. Women should be counseled and encouraged to identify a supportive family member throughout the PMTCT process. Attention to the process of infant feeding must be given at the community level so that the mother can implement exclusive breastfeeding and complementary feeding effectively. Women who opt to stop breastfeeding at six months need to be provided with an infant food supplement.

3.0 Problems or Issues

Significant problems or issues encountered during the project	Responses to those problems or issues Recommendations about the future
Staff attrition in the NGOs affecting the use of capacity building efforts.	The project provided additional training courses and technical assistance to replacement staff. The NGOs need to continue to work on factors to motivate and retain staff.
Shortage, and occasional stock-out of HIV testing reagents, IP supplies, Nevirapine and condoms.	NGOs obtained MOUs with the DHOs and insured that their requirements are in district implementation plans. Some have budgeted for 5% handling fee charged by central medical stores to obtain supplies directly. All NGOs have included IP supplies in their budgets.
Some NGO counselors found it difficult to determine clients' risk perceptions.	Follow-up mentoring and supportive supervision of counselors is important to help develop counselors confidence in working with clients on risk reduction.
The mission hospitals need to charge for labor and delivery services; this was often out of reach for many pregnant women.	The project successfully advocated for the NGO management to have an agreement with the district health office to provide free maternity services as a part of the Essential Health Package (EHP).
Stigma and discrimination against people living with HIV continued to be a barrier to care seeking.	The project trained community mobilizers in stigma and discrimination issues, helped NGOs create networks of religious leaders, and trained youth groups in interactive drama. NGOs need to continue discussing this issue at the community and leader level.
A widespread shortage of suitable food for infants after six months makes early succession of breastfeeding difficult.	NGOs were linked to other organizations that could provide nutritional supplements and health workers were trained to advise women on the diet meeting the AFASS requirements.
High fertility rate among women in the PMTCT program; many women were pregnant before their infants had reached 18 mos.	The project advocated for closer integration of family planning services with post-natal and under 5 clinics and encouraged increased involvement of men.
Few couples have been noted to attend ANC Services together.	Communities have been sensitized to the inclusion of men in services. ANC clinics provide VCT, STI and other services to men as well. Some NGOs have used notification slips to invite men.
Short supply of STI drugs, basic drugs for ANC, gloves, syphilis testing materials	Action plans that estimate needs in advance are helpful for planning and procuring supplies. Additionally, linking with other projects, DHOs and the MOH can ensure more regular procurement.
Inadequate food supplement for the PMTCT mothers as well as PLWHA	Poor nutrition can increase vulnerability and severity of opportunistic infections, and accelerate the disease process. NGOs were linked with other organizations who provided vita-meal for HIV-infected mothers. Many NGOs added provision of nutritious food to services for PLWHA.
Few male clients responded to notifications for STI treatment	Motivational talk and community education sessions were used to sensitize men to the need for treatment. TBAs, traditional healers, and community leaders were also trained on the issue.
Long way for ART availability of PLWHA	The widespread understanding that ART is provided at no cost increased demand and leads to long waiting times to receive therapy. Links were made with other partners providing ART. Emphasis was also placed on positive living.
Shortage of funds to hire additional needed staff	Volunteers can be utilized to perform a number of important community activities and fulfill gaps in program staffing needs. Volunteers can be retained through small incentives such as bicycles and umbrellas.
Increased demand for CT services in rural areas that are inaccessible to static clinics	Outreach CT services can be provided to these communities through periodic visits from CT counselors who can provide services on a regular basis at a designated location.

4.0 Key Lessons Learned

Save the Children and the NGOs learned the following lessons through the four years of the program:

Capacity Building

- The involvement and participation of beneficiaries in issues of identification, planning, implementation, monitoring and evaluation promotes a sense of ownership and support for the program. This will make the program more sustainable in the long term.

- Networking and collaboration amongst organizations within communities is key for success/sustainability. Networking provides a sharing of strategies and best practices, and allows service providers to acquire and enhance their service delivery skills, use appropriate and relevant techniques, and avoid duplication of interventions.

- Coordination and collaboration of networking organizations at the national level enhances credibility from development partners. This minimizes the risk of duplicating efforts on the ground. It was also observed that collaboration and coordination can help strengthen individual organizations' capacity and enable them to focus on their mandates.

- Involving local religious leaders in HIV services is particularly effective. These leaders garner a great deal of respect from communities and have enormous influence. The church is well positioned in society and is respected for its role as an educator and counselor. Faith-based Organizations (FBOs) should be encouraged to take part in advocating for gender equality, mainstreaming HIV/AIDS in all sectors and reducing the stigma associated with infection.

- The use of local human resources, utilizing community members as staff, promotes ownership of the program and increases likelihood of sustainability.

- Transparency and accountability are key to instilling trust between partners including management and staff.

- The ability to adapt to changing environments should not be underestimated as a strength: communities are constantly changing as are the issues that are important to them. Service providers need to change and adapt to the needs of the communities they serve.

- Good communication within an organization (and amongst its branches) is essential. It allows for better planning, implementation, and follow-up. Written communication is particularly useful as it gives documentation and something to refer to when acting. Communication should be multi-directional and should include all levels.

- Establishment of a monitoring and evaluation department or section enables an organization to keep better track of program data. It also allows for this data to be more easily accessed and used. It is essential that monitoring data be used to inform program decision-making.

- Development of a strategic plan creates organizational focus and allows staff to understand the activities that are planned and the reasons they are necessary. It keeps everyone on track and can be used as a tool to mobilize resources.

- Capacity building through mentorship was the most effective way of transferring knowledge and skills to care providers and was an excellent supplement to formal training courses.

- A local NGO with sound and transparent financial management will build confidence in the community it is serving as well as attracting local and international donors to fund it.

- Close collaboration with the Ministry of Health helps to ensure that the program adheres to the MOH policies and standards.

- Using comprehensive short training modules in times of crisis prevent interruptions in services while maintaining quality provision of services.

- Capacity building of local communities is essential for project sustainability, ownership and service uptake.

- It is particularly cost effective to build the technical capacity/competencies of staff within the organization because it cuts down on the need for sub-contracting.

- It is difficult to retain technical staff that have special expertise (ie. doctors, nurse, HIV specialists) because they are in great demand throughout the country.

- Regular staff appraisals provide a forum to assess staff performance and keep everyone focused on appropriate tasks.

- Service delivery assessments should be done prior to any capacity building. Gaps in service provision and required resources must be developed. Then a Capacity Building plan should be developed that is designed to meet the gaps in skills and knowledge that are specific to an organization.

- For the capacity building of service providers, a trainer of trainer technique is most effective to meet the growing service demand. This training should be done using MOH standardized guidelines and training materials.

- It is more effective to utilize already existing structures and systems than to attempt to create new ones. Support should be provided to NGOs to strengthen the systems that are already in place, and creating new ones when already existing systems are not possible.

CT and HIV Service Delivery

- Outreach CT promoted the uptake of CT services by the clients. Moving the CT services to the localities of the clients overcomes some of the usual barriers to access.

- Ongoing HIV/AIDS awareness campaigns enable communities to increase knowledge about HIV/AIDS, testing and treatment. NGOs have found that greater numbers of clients go for testing in areas undertaking campaigns.

- Integrating food security into programs for people living with AIDS appears to improve adherence to ARV regimens. PLWHAs on ARVs quickly decline if they have a lack of accessible food; this can lead to an inability to follow proper regimens.

- PLWHAs are more engaged in meetings and show greater adherence to ARV regimens when other aspects of their health and lives are addressed. Availability of materials such as drugs, food supplements, and services/education on pertinent issues such as soft loans, makes service delivery easier and engages more people.

- Theater arts – a combination of drama, songs, traditional dances and audience interaction, is an effective way of engaging communities. It is inclusive of people of all ages and backgrounds. Theater arts engage community members in a fun way and also provide a good opportunity to disseminate information.

- Integrating CT services is effective from a cost effectiveness and access/provision standpoint. Placing CT services in already existing health institutions lowers the operating costs, which are shared with the health institution. Integrating the services also reduces stigma, as clients are not identified as attending CT services by their entry into the facility. Further, clients accessing other types of health services have increased access and a greater likelihood to be tested.

- Community volunteers, including youth, are an invaluable resource in mobilizing communities and spreading information among communities. Using volunteers strengthens the linkage and referral systems between the community and health facilities. Because these volunteers are seen as members of the communities they are serving, the information they dispense is trusted.

- Participation of PLWHAs in program planning and implementation is effective because community members identify themselves with PLWHAs. These individuals are also useful in changing social norms through reduction of stigma and HIV risk behaviors.

- There is an urgent need for service providers to be well informed about myths and misconceptions that are circulating in their communities. Dispelling these myths should be of high priority for service providers. Information can be disseminated during CT visits and through volunteers in the community. This is vitally important in protecting vulnerable populations from contracting HIV/AIDS (eg. The myth that HIV+ men who have sex with virgins will be cured).

- Services need to be tailored to the target population. They must take into account the target population's age, gender, and needs. (For example, an adult group therapy approach will probably not yield the same results when used with a group of young children.)

- Youth are eager to be informed and will utilize reproductive health information and services if they are provided in a youth friendly manner. Involving youth in programming and using them to reach their peers is a particularly effective way to make services known to youth.

- Infection prevention practices can improve even with limited additional resources; Nkhoma hospital started registering improvement in infection prevention practices following technical assistance, well before they started receiving funds through Umoyo Network.

- Outreach CT services provide access for people in areas where static services are not available. Additionally, the make it possible for more women to access CT services.

- Gender issues should be taken into account when planning HIV-activities. Strategies need to include provisions to mobilize people of both genders.

- A peer to peer approach for community mobilization and HIV information transfer is particularly effective in reaching underserved communities where financial resources are constrained.

- There are a number of societal and cultural barriers that sometimes prevent women from carrying through with activities that could prevent MTCT. Community education can create the support women need to implement activities that will reduce MTCT.

- PMTCT should be implemented in health centers or health posts that do not have labor and delivery suits. This will allow for HIV-testing access for pregnant women even if other services are not available.

- The integration of different youth activities at a CT site creates openness for youth and makes they feel comfortable accessing HIV related services, including family planning and CT.

- Mobilization for partner support for STI and PMTCT clients should start from the grassroots level with the community leader as a target group helping to advocate for such support from male partners.

- Notification slips given to the male partners of women accessing PMTCT and ANC services can an effective tool for informing men about the services available to them.

- Outreach services provide a method of delivering services to communities who otherwise have limited access to services.

- Collaboration with other organization providing HIV/AIDS related services allows for a sharing of information and more effective service delivery, as services are not duplicated in the same communities.

- An integrated services approach allows for clients to access different types of services at one venue. This makes it more convenient for them and also diminishes some of the stigma that could be attached to seek some services (i.e. CT and STI treatment).

- It is important that linkages and referral systems be established within communities to facilitate a continuum of care. Clients are more likely to continue with care regimens if they know where care in available to them.

- Post-test clubs and support groups for PLWHA provide much needed camaraderie and support. These clubs/groups provide a forum for clients to discuss concerns and triumphs and share ideas with their peers.

- Issues of gender need to be mainstreamed into all activities to ensure that both genders have equal access to information and services.

5.0 Best Practices

Program Best Practices:

5.1 Integrating HIV testing and counseling in MCH/FP services as an entry point to PMTCT and pediatric HIV care. This includes CT in ANC, labor and delivery, post natal care service, under five clinics, integrated management of child hood illness, and outpatient departments. The entry points will include CT for parents and identification of HIV children. All facilities with MCH/FP regardless of whether they have maternity facilities should integrate PMTCT services.

5.2 Fostering PMTCT mother support groups. Health care and community support systems should set up PMTCT and other reproductive health support groups and encourage all women enrolled in the PMTCT program along with their spouses and family members to attend support group sessions. The support groups enable women to implement interventions that reduce the risk of MTCT and improve their psychosocial quality of life. AHS Nanasalima is an example of PMTCT mother support group as best practice.

5.3 Involving males in MCH/FP services. PMTCT requires male involvement to support a woman in implementation of prescribed PMTCT interventions. Involvement of men in MCH/FP means that together males with their spouses go through the ANC and other maternity related process including HIV testing and counseling. In the event that one is found to be HIV infected, the couple can support each other in the implementation of interventions for PMTCT. Nkhoma Mission Hospital is an example of male involvement in MCH/FP services as a best practice.

5.4 Creating agogo (grandmother) support groups in RH services. This is a group of grandmothers in the community, the custodians of culture who have been involved in RH and PMTCT. They actively play a role to reduce stigma associated with utilization of HIV-related services and support HIV-infected women to implement recommended PMTCT interventions. Ekwendeni Hospital is an example of agogo support groups as a best practice.

5.5 Following mother–infant pairs for exclusive breastfeeding process and early cessation of breastfeeding. One of the most challenging care and support components in the PMTCT program is mother-infant pair follow up to six months for exclusive breastfeeding and continued follow up to 18 months when the infant's HIV status is established. The follow up allows mother and baby to access HIV-related services such as ongoing counseling on infant feeding and provision of cotrimoxazole for baby and mother (and father if also infected) and access to ART when indicated. Malamulo hospital championed this best practice

5.6 Recognizing parents whose infants get tested at 18 months. Through mother- infant pair follow up, parents of infants who get tested at 18 months are awarded a certificate of appreciation for complying to prescribed PMTCT interventions from the date they were diagnosed with HIV till the infant's HIV status was established at 18 months. The ceremony is witnessed by relatives, fellow women in the program, and health workers. This ceremony provides a forum to encourage defaulters, reduces stigma, and gives hope that parents can have HIV-free children if they comply with the prescribed interventions. Three PMTCT sites held the award ceremonies. One outcome was the selection of HIV-infected parents who had HIV-free children for training as mother support group counselors and advocates in the communities.

NGO Best Practices:

NAPHAM: Encouraging positive living in people living with HIV/AIDS

Background. NAPHAM is an NGO, formed in 1993 when a small group of HIV-positive people observed and experienced that the needs of people living with HIV and AIDS were not being met. Over a decade now membership has increased to 6,288 in 10 districts with 130 support groups affiliated to NAPHAM. The organization is committed to improving the quality of life of people infected and directly affected by HIV/AIDS.

Objective/Scope. The Lighthouse Clinic provides ART in Malawi and sees 150 patients per day. Because of its high degree of utilization by PLWHA, it provides a good point of intervention for positive living information and services. NAPHAM sought to provide healthy food, information on positive living, and health educational talks to clients waiting for services.

Methodology. NAPHAM volunteers provided weekly educational talks on positive living, nutrition, stigma and discrimination, disclosure, and recipes for local remedies and indigenous plants. NAPHAM operated a non-profit kiosk that sold a variety of subsidized items including healthy foods, traditional plants, mosquito nets, and condoms and also distributed information packets.

Results. The kiosk was well utilized and appreciated by clients of the Lighthouse Clinic. The kiosk also distributed 2,000 Pakachere booklets, 120 posters, and 45 NAPHAM nutritional guides. Clients reported that the use of indigenous plants recipes has been helpful in enhancing their health.

Conclusions and Recommendations. PLWHA can benefit greatly from services in addition to medical treatment. Their lives can be greatly improved with increased information and access to necessary items such as nutritional food and bed nets. Educational sessions also provide a venue for them to socialize and share information with each other, gaining support from other PLWHA. Services such as those described here can easily be integrated into other clinics and hospital settings. They can provide comprehensive support to PLWHA that will allow them to live happier, more productive lives.

Ekwendeni Mission Hospital: Increasing demand for CT through community mobilization and the use of influential community leaders

Background. In 2003, Ekwendeni conducted a community survey to identify gaps and needs for services. The results of the survey highlighted limited access and low turn up for CT services.

Objective/Scope. Given the results of the 2003 community survey, Ekwendeni wanted to advocate for CT in communities and increase CT utilization among sexually active 15-49 year olds in its catchment area.

Methodology. In preparation for scaling up CT service delivery, providers were trained in counseling and testing using the rapid whole blood parallel testing method. Providers were also trained in quality improvement processes in an attempt to improve the quality of counseling and testing services. In addition to the static CT site at the hospital, three outreach testing sites were opened in 2004. At the community level, influential leaders, including chiefs, and providers were

trained in community mobilization and were then dispersed into the communities to advocate for CT utilization. The training involved 300 chiefs and 520 CT promoters.

Results. Great community mobilization by traditional leaders and CT promoters has resulted in an increase in the utilization of CT services. From January 2004 to December 2006, 16,496 clients and 2,000 pregnant women were tested in the Ekwendeni and Enukweni catchment areas. Twenty-five post-test clubs and two parent support groups were established. Thirty youth clubs were also formed, which perform HIV-related dramas and raise awareness for CT services.

Conclusions and Recommendations. Community mobilization is a very effective way to increase the demand for services that can be replicated in a variety of settings. It is important to involve influential community leaders, training them on issues related to HIV and CT. These people are well known and trusted members of society. If they are given accurate information, they are a great resource for spreading HIV-related messages and should be utilized as such.

DAPP: Involving men in PMTCT through promoting couples centered services and notification slips for men

Background. Development Aid from People to People (DAPP) works to promote social and economic development through programs and projects in health, education and training, fundraising and environmental issues. DAPP was established in 1995 and is currently implementing eight development programs/projects in three districts of Malawi.

Through funding from Save the Children Umoyo Network, DAPP has expanded various HIV related services to its catchment areas. DAPP provides PMTCT services in Mwanje, Mikolongwe, and Lunzu. A strong culture of male dominance in decision making relate to PMTCT and ANC exists in Malawi. Currently men regard reproductive health programmes as only for women and are, therefore, reluctant and unwilling to participate. Additionally, women do not feel empowered or able to communicate and negotiate with their partners concerning these issues.

Objective/Scope. DAPP sought to increase the utilization of PMTCT through the increasing access to services, empowerment of women and the involvement of men in service delivery.

Methodology. DAPP took a multi-faceted approach to increasing utilization of VCT, STI, and PMTCT services among both women and men. Influential community leaders were utilized for community outreach. Community awareness on male participation was increased through community leaders, volunteers, and peer advocates. DAPP promoted couple counseling for ANC including PMTCT, CT and STI services for couples. Finally, notification slips were used to invite male partners to utilize services.

Results. As a result of these efforts, DAPP saw an increase in service utilization. More men came for services and became aware of the importance of their involvement in ANC services. The number of couples seeking services together also increased.

Conclusions and Recommendations. Men are play a vital role in a women's decision to seek ANC services including CT, STI and PMTCT. It is therefore important that men are educated about the importance of these services and are included in service delivery. When these services are promoted for couples, women become empowered to discuss issues related to ANC and

HIV/AIDS with their partners. Higher utilization of services in men often translate into higher utilization among women and greater exchange of information within couples.

Adventist Health Services Volunteering to Battle HIV/AID: Utilizing Community Volunteers in HIV/AIDS Programming

Background. Adventist Health Services (AHS) is a health institution belonging to the Seventh Day Adventist Church. The primary mission in Malawi is to promote good health by providing integrated health services to the people surrounding its 19 health clinics. Clinics provide curative and preventative health services aimed at improving the reproductive and child health, reducing fertility and preventing the transmission of HIV infection.

Objective/Scope. AHS is rapidly expanding services to respond to community needs. Through funding from Save the Children Umoyo Network, AHS has scaled up services in CT, HIV/AIDS, and STI. However, difficulties arose because there were not enough staff to fulfill all of the programming needs. AHS, therefore recruited volunteers to fill the gaps in staffing.

Methodology. An assessment to identify community needs was conducted, including community members and service providers. The community was involved in trying to solve the problem of staff deficits. It was determined that community volunteers could fills these gaps. A process for selecting volunteers was developed – a recruiting exercise followed by interviews. Community members were used to identify potential volunteers. Health service providers and community volunteers conducted interviews to identify the best candidates. Selected volunteers were then given extensive and ongoing training in matters related to HIV/AIDS, home based care, CT, reproductive health, and child health. Incentives are given periodically to volunteers including bicycles, umbrellas and bags. Strong volunteer monitoring, supportive supervision, and evaluation systems were established to make sure that volunteers were functioning to their fullest potential.

Results. The selection method and training of volunteers lead to well-informed, dedicated volunteers who were trusted by their communities. Because volunteers were nominated by their communities, they felt a sense of duty and loyalty to serve those communities to the best of their ability. Incentives were helpful in maintaining moral and rewarding the community involvement of volunteers. Because they were involved from the beginning of the program and played an integral role in volunteer selection, in community members had a sense of ownership for the program. All of these factors combined to create a low turn over rate of volunteer. Intensive supervision and continuous development motivates volunteers to contribute more to their calling.

Conclusions and Recommendations. Programs should utilize community volunteers to compliment staff and provide services to their communities. Selection of volunteers should to be the responsibility of the communities where the volunteers will serve. Community members know the needs of their localities and can select individuals who best suit these needs. Monitoring and supportive supervision should be used along with incentives and recognition of work to motivate volunteers and keep morale and commitment high.

Word Alive Ministries International: Involving 'faith' in the fight against HIV/AIDS

Background. World Alive Ministries International (WAMI) has been involved in the implementation of various HIV/AIDS interventions in local communities of Blantyre District for the last twelve years. During this time, interventions have covered a wide range of areas including care for orphans and vulnerable children (OVC), home based care (HBC), CT, and youth activities.

WAMI, recognizes the enormous influence of religious leaders and the faith community to help in the fight against HIV/AIDS. A great deal of trust and authority is afforded to religious leaders by their communities and this provides them with a very powerful and position from which to fight stigma and discrimination related to HIV/AIDS.

Objective/Scope. With funding from Save the Children Umoyo Network and other partners, WAMI has sought to involve the faith community in its community programming. As part of this involvement, churches were mobilized and church leaders were trained in HIV/AIDS.

Methodology. Trainings were held with church leaders and community volunteers to sensitize them to the issues related to HIV/AIDS that are impacting their communities. Religious leaders were encouraged to incorporate issues of HIV/AIDS into sermons in order to raise awareness and reduce stigma and discrimination. To promote acceptance within the community, WAMI hosted monthly meetings on church premises for PLWHAs This provides PLWHAs a forum to discuss survival skills and build fellowship, while dispelling the notion that HIV/AIDS is related to sin.

Results. Strong ownership of the program is shared by the community, allowing for greater ease is service delivery. As a result of programming activities and community sensitization, a quarterly-meeting faith-based network and a strong referral systems managed by the community were established. Quarterly interdenominational HIV/AIDS youth and ladies seminars are held by WAMI to provide accurate information and create a forum for discussion. Sixty-five church members were trained in HBC, which helped WAMI to serve 617 clients and distribute 3,000 care kits in the community. HBC volunteers have made 500 visits within their communities.

Church leaders are providing supportive supervision to the program's many activities. HIV/AIDS issues are now regularly incorporated into the sermons of the Clergy and they are encouraging their parishioners to have pre-marital HIV testing. They have also made 3,000 home visits within the communities to visit people infected and affected by HIV/AIDS.

6.0 Sustainability

6.1 Describe how the project has ensured the sustainability of the project activities by the local partner NGOs after this funding ends

- To ensure sustainability of quality services, JHPIEGO worked with each NGO to establish PQI teams that incorporated PDQ principles by including members of the community. NGO service providers were trained in PQI and infection prevention and to conduct assessments of infection prevention and counseling and testing practices. This will enable them to continue to measure their progress. NGO management teams incorporated infection prevention supplies into their hospital budgets to ensure sustained availability.

- To move toward self-sufficiency and sustainability, the NGOs were encouraged to incorporate income generating activities into the activity plans. A good example of this can be seen from DAPP. A Clothes and Shoes Sales Project was started by DAPP in Blantyre, which has now expanded to 16 shops across the three regions of Malawi. The shops employ a total of 141 people, bringing employment opportunities to the communities where they exist. The surplus income generated from this project is used to sustain other DAPP activities.

- Umoyo Nework encouraged partners to develop a fundraising strategy that will ensure the continuation of activities. Partner NGOs were trained in grant writing and were informed of potential sources of funding.

6.2 Describe links and referral systems set up

- Each NGO has established a directory of services available within their catchment areas to which they can refer clients. A system of referral and back-referral has been set up by many NGOs.

- NGOs were encouraged to partner and collaborate with DHOs. DHOs have been actively involved in the supervision of VCT sites, supply of testing kits and condoms and the provision of office space. DHOs are also instrumental in conducting Quality Controls and the supply of IP materials. A number of NGOs have partnered with the DHOs in their catchment areas to open CT sites within already established DHO health centers.

6.3 Describe membership of any supportive networks

- To understand about good quality services, NGOs were encouraged to visit NGO sites that were doing better than themselves. Nkhoma has visited Ekwendeni, Ekwendeni has visited Malamulo, MAICC visited MACRO, all visited PIH, SASO, NASO, DAPP, AHS and Malamulo.

- The project supported the setting up of regional counselor networks, which meet monthly to enable counselors to exchange experience and gain support. The northern and southern counselor networks are still functioning; the central network has lost its chairperson and is currently dormant.

7.0 Conclusions and Recommendations

- The Umoyo Network project has carried out the majority of the activities planned. Several additional activities were carried out in agreement with USAID as the need was identified through assessments, reviews, and yearly planning cycles.

- The project has achieved the majority of targets for the indicators in the performance monitoring plan and has exceeded a good number of them.

- The supported NGOs have significantly increased the availability of services, improved the quality of those services and increased use. USAID's support should continue to emphasize capacity building, ensuring that sufficient time is provided for institutional development.

- There have been many additional achievements in building the confidence of the NGOs to scale up their services and to address issues identified by them during community surveys and reviews. The NGOs have also gained better communication and advocacy skills.

- Data quality has improved through persistent mentoring of the NGOs and frequent discussions on use of data for decision making; this should be continued.

- The three hospitals have made tremendous strides to improve their infection prevention practices. The project recommends that they link up with the National Quality Assurance Committee for external verification visits and recognition. The project will encourage the Ministry of Health to carry out national assessments of CT sites; it is recommended that the NGOs continue to carry out internal assessments or to provide external assessment of each other.

- The capacity of support groups to offer quality services to PLWHA cannot be underestimated in importance in promotion of positive living. These groups provide a great deal of psychosocial support to PLWHA and should be recognized as an effective mechanism for dispersing information to PLWHA. They have helped more PLWHA become open about their status and have been essential in helping to combat stigma and discrimination. These groups should be incorporated into CT and PMTCT programs.

- Future USAID support to NGOs should ensure regular networking meetings as these have been greatly appreciated by NGOs.

8.0 Success Stories

Recognizing the impact of capacity building: MACRO makes huge strides against HIV/AIDS

[Story adapted from a speech made by Wellington Limbe, Executive Director, MACRO, made at the Umoyo Network Best Practices Conference Closing Ceremony.]

MACRO was established in 1992 with the goal of providing quality HIV voluntary counseling and testing services other HIV related support services. The project includes six static stand alone sites in Lilongwe Karonga, Blantyre, Zomba, Mzuzu(Mzimba), and Kasungu. There are also 61 outreach and mobile sites.

Capacity building can allow an organization to dramatically increase its ability to reach its objectives and better serve its clients. However, capacity building at the organization level is not enough to produce the dramatic strides that have been seen with MACRO over the past seven years.

Save the Children Umoyo Network did not focus solely on building the organization capacity of its NGO partners. Instead, it sought to increase capacity on four levels: the system level, organization level, human resource level, and individual/community level. The first three levels are related to supply of services, while the fourth level relates to service demand. This four-pronged approach has helped MACRO to grow into a national leader in CT and HIV support service provision.

At the system level, Umoyo Network engaged in capacity building activities with the Ministry of Health and other stakeholders to improve preventative, promotive, and curative services, particularly those related to HIV/AIDS. Umoyo played an advocacy role, aiding in the development of various instruments, policies, and guidelines at the National level. Through this involvement, Umoyo helped to place HIV/AIDS at the forefront of national importance, increasing interest and funding for services provided by MACRO.

At the organizational level, Umoyo Network helped MACRO to develop appropriate and efficient organizational structure, process, and management systems. A constitution and strategic plan were developed, which helped to guide the activities and goals of the organization. Financial management skills were expanded, which provided for greater financial transparency and donor trust. A resource mobilization strategy helped the organization plan for the dispersion of funds and other resources that were procured. Improvements in the organizational structure of MACRO allowed it to for effectively plan and implement program activities.

At the human resource level, MACRO staff and board members participated in a variety of trainings provided by Umoyo Network, such as counseling and testing, CT site management, CT supervision, couple counseling, financial management, governance and leadership, program management, human resource management. Building the capacity of staff allowed them to better execute their designated tasks. They also became more aware of how their individual responsibilities contributed to the bigger goals of MACRO and the ultimate goal of delivering high quality HIV testing services. MACRO staff had the chance to network with staff from other Umoyo NGO partners, sharing best practices and lessons learned and ultimately increasing their technical knowledge.

Capacity building at the individual/community level is related to service uptake, and is central to program/project ownership and sustainability. The needs of communities are very different in terms of capacity building. Therefore, it is essential to identify the gaps and needs prior to providing services for community development. To mobilize communities to utilize services provided by MACRO, it was necessary to sensitize communities to issues related to HIV and attempt to dispel stigma and discrimination related to HIV/AIDS and CT.

Through system, organization, human resource and individual level capacity building, MACRO was able to make service delivery more efficient, raise the quality of services, improve its reputation, and raise service utilization statistics. Improved proposal writing skills lead to increased ability to mobilize external financial resources. Financial transparency and accountability allowed for an increase in the number of donors and a nineteen fold increase in MACRO's budget from 1999 to 2006. With increased funds and organizational development, MACRO was able to increase its number of staff from 22 in 1999 to 193 in 2006. Improved work conditions lead to reduced staff attrition, meaning increased capacity remains within the organization. MACRO also intends to continue building the capacity of Malawian CT counselors by establishing the National Training Centre for Counselors.

Access to CT services in Malawi has been dramatically increase by MACRO. The number of MACRO HIV counseling and testing sites has increased from 2 in 1999 to 43 in 2006. Three of the sites have introduced ART and STI treatment, therefore increasing the impact of the HIV counseling and testing services. Capacity building at every level contributed to a dramatic increase in the number of clients tested from 7,979 in 1999 to 364,435 in 2006.

Capacity Building of Local NGOs prompts Capacity Building and Self Sufficiency of Local Communities

Development Aid from People to People (DAPP) was established in Malawi in 1995 to promote social and economic development. Through programs focusing on health, education, and livelihood training, DAPP empowers communities and gives individuals the skills they need to gain control over their health, environment, and future.

In 2003, DAPP entered into a partnership with Save the Children Umoyo Network. Through this partnership, funded by USAID, DAPP received a variety of capacity building services. Staff attended workshops and trainings which increased their skill sets and made them more effective in their positions. The management, planning and financial accountability of DAPP were improved. This allowed the organization and its programs to function more efficiently and reach more clients and communities.

Cedreck Village, a small village outside of Lunzu, is one of the communities that benefited from the increased capacity of DAPP. When DAPP first visited the village in 1998, it existed under dire circumstances. The village was experiencing great hardships including HIV infection, increased death rates, high rates of child malnutrition and growing numbers of orphans. HIV testing opportunities were limited and most villagers did not know their HIV status. Due to stigma and discrimination, those who tested HIV positive were unable to disclose their status to the communities or families.

Through support from Umoyo Network, DAPP staff were trained in identifying community needs and community mobilization. DAPP was able to identify priorities within the Cedreck Village and assemble community members to determine solutions. Suggestions from the

community were taken and DAPP and was able to assist the community in developing a plan of action, much the way Umoyo aided DAPP by developing a prioritized capacity building plan. Community groups were created to focus various community issues and problems. The groups elected a director, Mr. Chimphamba, to organize and mobilize them to address community needs.

DAPP has provided HIV/AIDS education sessions and provided testing services to the community. This has been essential in dispelling stigma and discrimination against those who test positive. The community headwomen recounted a change in the community that has now made PLWHA more comfortable disclosing their status:

"One time, people had problems disclosing status, but what impresses me is that all people who went to test for HIV disclose their status to the entire community or relatives. So as a community, we know what to do for them at a community level." Cedreck Headswoman.

Capacity building of the Cedreck Village community proved to be essential to identifying and mediating community problems. Community groups are well organized and are able to oversee activities in the community. They have enhanced skills and are now empowered to find creative and appropriate solutions to the issues facing the community. By working together to find solutions to their problems, the community has been strengthened and become more close-knit. The community no longer waits for outside help when a problem arises. With help from DAPP, community groups wrote proposals for funds to the National AIDS Commission and Network for Orphans and Vulnerable Children, which were accepted and dispersed. These funds have been used to make a number of community improvements. A school and multipurpose center were built and a bore hole was drilled in the community. These are essential advances that will increase the quality of life in the community, by providing education for children, a place for community gatherings, and clean water. The school also provides a meal to children who attend.

Funds were also designated to a number of income generating activities that will aid in community sustainability. A maize mill was built, which will provide the community with jobs, food, and a marketable product. Goats and chicken were purchased and are used as a source of income to run a pre-school and provide care to orphans and critically ill patients.

Capacity building provided by Umoyo Network enabled DAPP to effectively address specific needs of Cedreck Village. Instead of providing solutions for community problems, DAPP helped the community develop skills, organize itself, and produce an action plan to address both present and future needs. Gaps in services and infrastructure of Cederick Village were identified and the community worked together to find effective solutions. The village was introduced to the funding mechanisms of NAC and NOVOC and used funds in ways that will generate income and lead to future sustainability. The villagers now enjoy a better quality of life and are empowered to continue improving their community. The village director, Mr. Chimphamba spoke to the major improvements that have taken place in Cederick Village:

"It's very encouraging as we do not have major problems here regarding the community. Of course we cannot rule out the existence of a problem, but we are free from the major ones."