



HIV, Sexual and Reproductive Health and Rights (SRHR), Nutrition and Gender: Capacity-building in partnership with Zambian and Malawian organizations

Call for Expressions of Interest from Non-Governmental and Community Based Organizations in Canada

Application Deadline: 1 September, 2017 at 11:59 pm ET

Please submit completed application by Survey Monkey at:
<https://www.surveymonkey.com/r/SANItwinningEOI>

Language of application: All applications must be submitted in English as this is the working language of the Selection Committee and funds are not available to translate applications.

In order to ensure that you receive any follow-up information, please register your intent to submit an Expression of Interest by emailing sanitwinning@icad-cisd.com by 11 August, 2017. You may still apply if you do not register.

For more information: ICAD’s website :<http://www.icad-cisd.com/our-work/projects/southern-african-nutrition-initiative-sani-project/> Email: sanitwinning@icad-cisd.com

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A. EXPRESSION OF INTEREST GUIDELINES

1. Introduction

As part of CARE Canada's Southern African Nutrition Initiative (SANI) funded by the Government of Canada, the Interagency Coalition on AIDS and Development (ICAD) is leading a capacity-building initiative to improve the health outcomes of women living with HIV and children living with and/or affected by HIV in targeted regions of Malawi and Zambia. The ultimate aim is to contribute to the reduction of maternal and child mortality in targeted regions.

This capacity-building initiative will be accomplished through twinning partnerships between organizations or groups in Canada and in selected districts in Malawi and Zambia (partnerships will include Zambia- Canada, Malawi-Canada, Zambia-Malawi, Zambia-Malawi-Canada). Following the selection process, ICAD will facilitate the development of partnerships as needed. Organizations or groups with existing partnerships in participating districts/countries are also eligible to apply if both partners fit the eligibility criteria (see Section 3). Small grants will be awarded to selected organizations to implement 18-month community projects that focus on gender, SRHR, HIV and nutrition/food security.

The **goal** of the SANI HIV/SRHR capacity building initiative is:

To reduce the impact of HIV, gender inequality and poor nutrition as confronted by women of reproductive age living with HIV and children under 5 living with and/or affected by HIV in selected districts in Malawi and Zambia.

The **objectives** of the initiative are:

1. To improve the health and nutrition outcomes of women of reproductive age living with HIV and children under 5 living with and/or affected by HIV;
2. To strengthen community/civil society capacity in Canada, Malawi and Zambia to address gender, SRHR, HIV and food and nutrition security;
3. To increase the knowledge of community/civil society in Canada, Malawi and Zambia to better understand and address linkages between gender, HIV and food and nutrition security through the exchange of good practices;
4. To identify and disseminate results and lessons learned about community twinning projects and the community/civil society response to gender, SRHR, HIV and nutrition/food security in Canada, Malawi and Zambia.

This initiative will use a twinning model to build the capacity of community-based organizations to address intersections between HIV and nutrition and improve information, education and services for women living with HIV and children living with and/or affected by HIV, working with a sexual and reproductive health (SRHR) framework.

2. Call

The Interagency Coalition on AIDS and Development (ICAD), on behalf of the Southern African Nutrition Initiative, invites Canadian organizations to submit Expressions of Interest to engage in twinning partnerships and implement community based projects that address issues related to HIV, gender, SRHR and nutrition in **Ntchisi and Dowa, Malawi** and in **Mpika and Shiwa Ng'andu, Zambia**. Collaborative projects will directly benefit women aged 15-49 and boys and girls under 5 who are living with and/or affected by HIV.

3. Eligibility

Eligible Canadian organizations will be those that are involved in (i) HIV, SRHR and/or nutrition work in Canada or (ii) international development work, focusing on HIV, SRHR and/or nutrition. Organizations that have not previously been involved in HIV, SRHR, nutrition or international development may apply but must clearly demonstrate a strong rationale and capacity to participate.

Academic institutions are eligible to apply.

Priority will be given to ICAD member organizations. For information on how to become a member, please visit: <http://pages.icad-cisd.com/apply>.

Eligible organizations in Zambia and Malawi are community-based organizations (CBOs) who work in HIV, SRHR, women's rights, gender and/or nutrition and have existing programming that addresses linkages between these issues OR who are interested in developing new programming to address these linkages. Applicants must be non-governmental organizations and community-based and registered as such. Applicants must be based in or have existing partners in the targeted districts of Ntchisi and Dowa, Malawi and in Mpika and Shiwa Ng'andu, Zambia. Local arms of international organizations are not considered CBOs for the purposes of this initiative.

All participating organizations should have the capacity to administer a grant of 15,000 CAD to 60,000 CAD and to carry out an 18-month project.

The working language of the initiative is English.

This initiative will support existing partnerships and facilitate new partnerships. Partnerships can be: Canadian-Zambian, Canadian-Malawian, Zambian-Malawian, and Canadian-Zambian-Malawian. You do not need to have an existing partnership in order to apply. For existing partnerships, both partners must meet the other criteria in order to be eligible. The two partnership options are:

- a. If a partnership already exists between two or three eligible organizations (Zambia-Canada, Malawi-Canada, Zambia-Malawi, Zambia-Malawi-Canada), each partner should submit an application and describe the partnership in the application

- b. Organizations that do not have existing partnerships should apply and the selection committee will propose partnerships between successful organizations (Zambia-Canada, Malawi-Canada, Zambia-Malawi, Zambia-Malawi-Canada)

4. Selection of Organizations

Expressions of Interest (EOI) are being submitted by organizations in Canada, Malawi and Zambia. A Selection Committee will review and score all EOI according to a predetermined matrix. The top 6-8 scoring EOIs from Malawi and Zambia, along with the top 6-8 scoring EOIs from Canada, will be invited to move forward in the process. At this point, the Selection Committee will facilitate partnership development between the successful applicants as needed. Twinning partners will collaborate together to develop full project plans and budgets, according to a template to be provided. This second step will not be a competitive process.

Expressions of Interest will be assessed according to the following criteria:

- Eligibility of applications (see section 3)
- Capacities and programmatic experience are well aligned with the Zambian and Malawian EOI submissions
- Capacities and/or programmatic experience will be of benefit to twinning partners
- Identification of potential benefits of participating in twinning program
- Demonstration of capacity to work with international partners

The Selection Committee will also seek to support a balance of organizations, based on:

- Participating regions
- Focus of organizations (e.g. nutrition, HIV, women, SRHR)
- Target groups (e.g. children under 5, women etc.)
- Proposed project approaches

5. Timeline

1 September, 2017: Organizations in Malawi, Zambia and Canada will submit Expressions of Interest

September 2017: A Selection Committee will review and select 6-8 partners in Canada and 6-8 partners in Malawi and Zambia

End September 2017: The Selection Committee will propose partnerships to these organizations. The Selection Committee will let all organizations know whether or not their applications have been successful.

October 2017: Contracting and orientation (in country)

November 2017: All project partners will participate in a meeting in Canada to develop the projects with their partners and to participate in project-related site visits and capacity building workshops

November/December 2017: The twinning projects will begin and will last 18 months

6. Available funding

Small grants between 15,000 CAD and 60,000 CAD will be provided to twinning partnerships to administer projects over the course of 18 months.

Successful organizations will be supported to undertake the full proposal development process. This will include being supported to travel to a capacity building and project development workshop in Canada.

Full project budgets and project plans will be developed collaboratively between twinning partners after selection and matching takes place. In these project budgets, no more than 20 percent will be allocated to the Canadian partner organization (including travel) in each partnership.

Approximately 50 percent of resources will go towards partnerships involving Malawian organizations, and 50 percent to partnerships involving Zambian organizations.

7. About ICAD

The Interagency Coalition on AIDS and Development (ICAD) is a registered Canadian charity based in Ottawa, Ontario representing a large coalition of over 100 Canadian HIV and AIDS organizations, international development non-governmental organizations, academic institutions, labour unions, and individuals. ICAD was founded in 1989 as a working group of the Canadian Council for International Cooperation (CCIC) with the mandate to bring together AIDS service organizations and international development organizations to address the HIV crisis at home and abroad.

ICAD helps Canadians contribute to international HIV work and encourages Canadian organizations to use the lessons learned from the global response that ICAD makes available, to improve prevention, care, treatment, and support services across diverse settings in Canada. ICAD provides leadership in reducing the global and domestic impact of the HIV and AIDS epidemic through improving public policy, providing information and analysis, and sharing lessons learned.

8. About SANI

The *Southern African Nutrition Initiative* (SANI) is a 24 million CAD initiative to address undernutrition in women of reproductive age and children under five in Malawi, Mozambique and Zambia. Funded by the Government of Canada, SANI is led by CARE International and implemented in partnership with Cuso

International, the Interagency Coalition for AIDS and Development, and McGill University's Institute for Global Food Security in Canada, and with the Government and communities of Malawi, Mozambique and Zambia.

9. Twinning Brief

Twining is a formal, substantive collaboration between two organizations seeking to achieve a common goal. Twinning encourages civil society organizations to collaborate and to form partnerships with like-minded organizations in other countries or regions and provides a platform for the exchange of knowledge and strengthening of capacity.

Ideally, twinning should be two-way, as the name suggests. In other words, both organizations should benefit from the collaboration and learn from each other. This can include a mentorship exchange between peer organizations that work in similar or related fields, but who have different levels of experience.

Formal means that there is an agreement or contract, verbal or written.

Substantive means that the interaction is significant and that it lasts for a period of time (i.e., it is not just a one-time interaction, such as a telephone call asking for information).

Collaboration means that the two organizations work together on a specific project or to exchange information or skills.

Forms of Twinning

Twining can take many different forms. Activities within a twinning project generally fall into four main categories: training exchanges, information exchanges, technical exchanges and collaborations on specific initiatives. Each category is described below. Please note that twinning projects often involve more than one form of twinning.

Training exchanges. These involve one or more persons from one organization visiting the partner organization for a period of time to learn or impart information and skills. Training exchanges can involve internships, on-site training or study tours.

- Internships provide people with the opportunity to work in another organization to gain practical experience and exposure to the different ways in which that organization structures and carries out its work. Internships can be one-way (people from one organization visit the partner organization) or two-way (the two organizations exchange personnel, either at the same time or at different times). The training can be part of the host organization's regular training or it can be specifically tailored to the needs of the visiting persons. The internship can be short-term (e.g., 2-3 weeks) or longer-term (e.g., six months). In some internships, the visiting persons will temporarily fill positions in the host organization.
- On-site training occurs when a person from one organization who is experienced in a specific aspect of work (related to gender, nutrition, food security, SRHR or HIV) is invited to provide

training to the partner organization's staff, board members, or volunteers at the locale of the partner organization.

- Study tours involve the visiting person or persons touring several local organizations working in the fields of gender, nutrition, food security, sexual and reproductive health and rights (SRHR) or HIV (including the host organization) for the purpose of providing or receiving training.

Information exchanges. These are similar to training exchanges in that they involve people from one organization visiting the partner organization, but the visits are limited to an exchange of information and do not involve formal training. As with the training exchanges, information exchanges can be one-way or two-way and can involve study tours.

Technical exchanges. These involve people from one organization travelling to the partner organization to help implement a specific programme or activity. The visiting persons may temporarily fill positions in the host organization (similar to internships).

Collaboration on specific initiatives. This involves two organizations agreeing to work together to establish a particular programme or to address an issue that affects them both.

10. An Overview: Food Security, Nutrition, HIV, Gender and SRHR

In 2014, there are an estimated 805 million people globally who were defined as chronically undernourished (FAO, IFAD, WFP, 2014). Recent research underscores the critical intersection between HIV infection, nutrition, and food security (UNAIDS/WHO, 2011). Issues of gender inequality further compound this relationship.

In sub-Saharan Africa, high HIV burden is shouldered by low income regions already experiencing limited quantity and quality diets. In 2014, the sub-Saharan region of Africa had the highest prevalence of undernourishment. Approximately one in four people in the region remain undernourished (FAO, IFAD, WFP, 2014).

Lack of food security has direct implications for HIV prevention and treatment efforts. Food availability constrains individual choice about work and education. This in turn can lead to increased migration and mobility, disruption in access to health services, and situations of heightened vulnerability to HIV infection such as transactional or commercial sex (for food, goods or money) or staying in abusive relationships due to economic dependency.

Nutrition and food insecurity have negative implications for treatment adherence, individual health outcomes and immediate and long-term downstream health system costs (e.g., through failures of first-line treatments and the need to move to a more costly second-line regimen) (UNAIDS/WHO, 2011). Poor nutrition exacerbates HIV and can hasten AIDS-related illnesses in people living with HIV. HIV infection affects the appetite and the ability to take in and absorb food yet the metabolic changes affiliated with HIV and treatment compliance increase a person's nutritional needs. Adults living with HIV have 10-30 percent higher energy requirements than an HIV-negative, healthy adult; children living with HIV have

50-100 percent higher needs than those who are HIV-negative (WFP, WHO, UNAIDS, 2008). Evidence shows that people living with HIV who are undernourished when they initiate into antiretroviral therapy are 2-6 times more likely to die in the first six months of treatment than those who have a normal body mass index (UNAIDS/WHO, 2011).

Similarly, **HIV infection erodes food security and nutrition** by reducing work capacity and jeopardizing household and community livelihoods (WFP, WHO, UNAIDS, 2005). In agrarian societies, productivity falls as labour is lost to sickness, death and care-taking responsibilities; increasing hectares of land lie fallow; livestock are sold in distress sales to pay for medical treatments or funerals; and agro-biodiversity, skills development and related intergenerational knowledge transfer are broken as parents die before they are able to pass on knowledge to their children (ICAD, 2005).

Gender inequality remains a key driver of the HIV epidemic and a leading factor contributing to food insecurity. Food insecurity occurs as a result of power imbalances and poverty as much as inadequate food supplies (Bezner Kerr et al., 2013; ICAD, 2005). Existing gender inequalities put women and girls at heightened risk for transmission. Women often have less social and economic power within relationships making protecting themselves extremely difficult. HIV and traditional gender roles have a disproportionate impact on the lives of women and girls. Women and girls traditionally bear an unequal responsibility for the work of caregiving for those who are sick and orphaned children due to AIDS effectively removing their labour from formal employment markets and the education sector (ICAD, 2004). Unequal intra-household decision making power (including income and food distribution), divisions of labour, resource and services access, and control (e.g., property/inheritance rights, access to water and land, credit, information and education) have deep implications for women's and girl's health, food, nutrition and livelihood security (ICAD, 2005; FAO, 2011).

The **linkages between HIV and sexual and reproductive health rights (SRHR)** are many. Most HIV infections are sexually transmitted or are associated with pregnancy, childbirth and breastfeeding. Sexually transmitted infections increase the risk of acquiring or transmitting HIV, and lack of sexual and reproductive wellbeing and HIV share root causes. Among women of childbearing age, HIV is the leading cause of death. When done correctly, linking of HIV and SRHR allows for the best use of limited health resources and can improve health service delivery (Stop AIDS Alliance, 2012).

11. Context, Strengths and Gaps

A. Malawi

Context: Malawi is a low-income developing country and is ranked 174 out of 186 countries surveyed in the UNDP's Human Development Index of 2014 and just over half the population (50.7 percent) continues to live in poverty. The agricultural sector employs 80 percent of Malawi's population, and 60 percent of the population relies on subsistence agriculture. A 2014 USAID assessment concluded that under-nutrition in women and children remains a persistent public health and development challenge in Malawi.

HIV prevalence in Malawi is approximately 9.1%, with rates of approximately 5.2% and 4.5 % in Dowa and Ntchisi respectively. Over the last decade, impressive efforts to reduce the HIV epidemic have been made at both national and local levels. New infections have dramatically declined from 98,000 new infections in 2005, to 28,000 new infections in 2015/2016 ([Ministry of Health, 2016](#)). Malawi has also witnessed a reduction in children acquiring HIV, with 4,800 new infections in 2015, a decline from 16,000 in 2010 ([UNAIDS, 2016](#)). A national assessment of the impact of HIV on the population, carried out by the Malawian Ministry of Health in 2015-2016, found HIV prevalence among adult women (aged 15-64) to be 12.8%, compared to 8.2% among Malawian adult men ([Ministry of Health, 2016](#)). This disparity is especially prominent among young people, with 3.7% of young women aged 15-17 living with HIV compared to 0.4% of their male counterparts ([Ministry of Health, 2014](#)).

In July 2011 Malawi became the first country to implement the Option B+ approach, which means all pregnant women living with HIV are offered antiretroviral treatment (ART) for life – irrespective of CD4 count. The percentage of mothers receiving ART to prevent mother-to-child transmission (MTCT) has dramatically increased from 17% in 2009 to 80% in 2015 ([UNAIDS, 2016](#)).

In 2015/2016 the Ministry of Health reported that, of the 900,000 adults (aged 15-64) living with HIV, 72.7% were aware of their status. Of these, 88.6% were on ART and 67.6% were virally suppressed ([Ministry of Health, 2016](#)).

For more information: [HIV and AIDS in Malawi](#) (AVERT, 2016)

Based on discussions with key stakeholders, the following strengths and challenges with respect to HIV, nutrition, SRHR and gender programming have been identified:

Strengths:

- Malawi has three national HIV organizations that are active in many districts across the country
- Successes in HIV treatment mean that many Malawians living with HIV are living longer and healthier lives
- Option B+ has led to dramatic increases in pregnant women living with HIV who are on treatment

Key identified challenges/gaps with respect to HIV, nutrition and gender:

- There is little data on the nutritional status of people living with HIV (PLHIV)/women living with HIV (WLHIV).
- Nutrition support programs do not explicitly identify PLHIV as a vulnerable group, or address the unique nutritional needs of PLHIV, making access to nutritional support program programs for PLHIV challenging.
- Inadequate food supply is a threat to treatment adherence. Guidance given to food insecure households to reduce the number of meals per day is not suitable for PLHIV.
- Women living with HIV who are new mothers have received unclear and sometimes conflicting information about infant feeding recommendations.

- Support groups and/or national umbrella organizations require training about the links between HIV, nutrition and HIV, as well as support and training for sustainable household food production (e.g. home gardens, small livestock) , preservation and preparation.
- There is a perception among nutrition-focused organizations that HIV is no longer a significant issue. This leaves nutrition/HIV links to be addressed within the HIV sector.
- There are challenges with linking women to care when they are not pregnant and do not have children under 5.
- National HIV umbrella organizations lack knowledge and capacity related to nutrition to be able to train support groups.

B. Zambia

Context: Zambia is among the countries with the highest levels of under-nutrition in the world and these levels have remained high—around 40%—even when the country has achieved significant growth in agricultural production. About 60% of Zambia’s population lives in rural areas where poverty levels are estimated to be as high as 75%.

HIV prevalence in Zambia has declined, falling by 19% between 2003 and 2015 ([PEPFAR, 2016](#)). However, it is still relatively high, with official figures estimating it at 12.9% in 2015 ([UNAIDS, 2016](#)) and a PEPFAR study estimating it at 11.9% in 2016 ([PEPFAR, 2016](#)). In 2015, 640,000 of the 1.1 million adults (aged 15 and over) living with HIV in Zambia were women ([UNAIDS, 2015](#)). Prevalence is much higher among younger women than younger men, standing at 11.2% for women and 7.3% for men aged 20-24 ([Zambia National AIDS Council, 2015](#)).

At the end of 2015, over 63% of people in need of antiretroviral treatment (ART) were receiving it. This equates to 67% of women and 56% of men living with HIV receiving ART ([UNAIDS, 2016](#)). Zambia has adopted 2013 WHO treatment guidelines that recommends anyone who tests positive for HIV should be started on treatment, regardless of their CD4 count. In 2014, around 85% of Zambians were still on treatment after one year ([PEPFAR, 2016](#)). Efforts need to be stepped up to ensure people who start treatment continue to take it as interrupted or stopped treatment causes illness, drug resistance and further transmission ([Zambia National AIDS Council, 2014](#)).

Zambia's prevention of vertical transmission programme has been successful. All pregnant women attending antenatal clinics received an HIV test in 2014, the most recent data available ([Zambia National AIDS Council, 2015](#)). Despite this, less than 60% of women attended four antenatal appointments, and 53% of women delivered their babies at home, where medical staff are not present to help with the birth and make important decisions regarding HIV risk for the child ([IATT,2012](#)).

For more information: [HIV and AIDS in Zambia](#) (AVERT, 2016)

Based on discussions with key stakeholders, the following strengths and challenges with respect to HIV, nutrition, SRHR and gender programming have been identified:

Strengths:

- Nutritional support is offered to PLHIV through support groups; Home Based Care groups provide health education awareness.
- PLHIV in Shiwa Ndangu received monthly weighing and nutritional counseling. Previously, the health centre provided some food stuffs but this is no longer done.
- Volunteers with knowledge on malnutrition give talks to mothers with children under 5.

Key identified challenges/gaps with respect to HIV, nutrition and gender:

- Misinformation/misconceptions around recommended infant feeding practices. Traditional beliefs discourage breastfeeding in public and poor nutritional status of mothers makes exclusive breastfeeding challenging.
- Stigma is preventing mothers living with HIV from taking their children for Growth Monitoring and Promotion.
- Need for the promotion of labour saving technologies such as conservation agriculture.
- Need for collaboration with other stakeholders to increase access of PLHIV to production resources.
- Inadequate food supply is a threat to treatment adherence.
- Higher protein requirement of PLHIV mean that small animals meant for reproduction (e.g. chickens) may be eaten.
- Time spent caring for sick family members reduces the amount of time to be devoted to food production.
- Vulnerability of people who are food insecure to HIV infection, and associated risk of HIV infection.
- Lack of nutrition interventions targeted directly towards women.
- Civil society capacity related to HIV is limited in Shiwa Ngandu.

B. EXPRESSION OF INTEREST APPLICATION TEMPLATE

Application Deadline: 1 September, 2017 at 11:59 pm ET

Please complete the online application at: <https://www.surveymonkey.com/r/SANitwinningEOI>

1. Name of Organization

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2. Type of organization (please check all that apply)

- AIDS service organization
- International development organization
- Youth organization
- Women's organization
- Nutrition organization
- Faith-based organization
- Coalition
- Advocacy organization
- Research organization
- Academic institution
- Other _____

3. Contact Information

Name	
Title	
Email address	
Phone number	

Address	
Website	
Skype name (if available)	

4. Please describe the work that your organization does and the populations you work with (Max 150 words)

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5. Please describe your organization's experience working internationally and/or with international partners. (Max 150 words)

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6. What is your organization's experience working with the following (Max. 150 words each) :

HIV	
Nutrition	

Gender and sexual and reproductive health and rights	

7. What program experience do you expect to contribute to this twinning partnership?
(Max 250 words)

8. What do you hope to gain from this twinning partnership? (Max 150 words)

9. Do you have an existing partnership in the participating districts that you would hope to build on?

- Yes (please answer questions 10 and 11)
- No (please answer questions 12 and 13)

10. If yes to Question 9, please provide summary details of the proposed partner, including primary contact, mailing and email address, website (if available). Your partner(s) should also submit an application.

11. If yes to Question 9, please share your partnership history and experience with this organization including project results attained and reasons this partnership responds to the objectives of this ICAD/SANI initiative (Max. 250 words)

12. If no to Question 9, do you have a preferred country of partnership?

- Malawi
- Zambia
- No preference

13. If no to Question 9, is there a specific type of organization you would hope to twin with (e.g. national umbrella organization, local AIDS service organization, women's organization, nutrition organization, HIV support group etc.)? (Max. 100 words)

14. Please describe any project concept that you would like to build upon with an identified partner, and how it would address intersections between HIV, nutrition, gender and/or SRHR. Please note that project development will happen based on needs of Zambian and Malawian organizations, and through a collaborative process. (Max. 350 words)

15. Is there anything else you would like to add? (Max. 250 words)