GAIA Mobile Health Clinics
Program Logic Model

**Program:** Mobile Health Clinics

**Situation:** Sub-Saharan Africa remains the epicenter of the global HIV and AIDS epidemic, with over 25 million people presently living with HIV. Malawi has an HIV prevalence of 7.7% among those aged 15-49 years, with nearly 1 million people living with HIV from the population of 19 million. Approximately 13,000 Malawian adults and children died of AIDS-related illnesses in 2021 and 20,000 were newly infected. Many rural Malawians have poor access to health care due to distance to health centers and a lack of transportation for those who are ill. Health centers are under-resourced in materials and staff, especially nurses. Malawi's public sector has a nurse vacancy rate of 55%. GAIA currently co-operates 7 mobile clinics in partnership will local district health officers across southern Malawi in high need areas to fill the gaps in government services.

**Inputs**

1. Funding: ETAF + individual and foundation donors
2. GAIA Staff in the US and Malawi
3. 4 wheel drive vehicles
4. Government supplied medications and supplies
5. Partners: MoH, DHO, ETAF

**Activities**

- A1: Establish an MOU with the MOH and local DHOs to determine service gaps
- A2: Secure free medications and supplies, from Gov't and purchase others from local suppliers
- A3: Train and staff vehicles with CO, nurse, nurse aide, driver
- A4: Track medications/tests/supplies inventory
- A5: Provide services to test and/or treat patients for acute and chronic conditions and make referrals to higher levels of care as required
- A6: Train and hire a community outreach nurse for community level follow-up
- A7: Provide health talks and preventive health care
- A8: Assist government in provision of ART at nearby government/CHAM health facilities and tea estates
- P1: DHO and MOH admin, Central Stores/local suppliers
- P2: GAIA Staff
- P3: Malawian living in clinic catchment areas
- P4: Health Surveillance Assistants
- P5: Government and CHAM facilities and employees

**Outputs**

1. Increased community awareness on disease prevention and treatment
2. Patients treated for acute and chronic conditions and referred to higher level of care as necessary
3. Patients tested using Rapid Diagnostic Tests for HIV, Malaria, other STIs
4. Disease outbreaks reported to MOH promptly
5. Increased community awareness on importance of prescription drug adherence
6. Patients recognize signs of common diseases and promptly seek testing/treatment/care
7. Patients make informed decisions to protect and improve their health
8. Patients encourage community members to attend clinics
9. HIV positive and critically ill individuals are linked to government health system for ART initiation and further management
10. Reduction in stigma and discrimination among community members

**Outcomes**

1. Access to basic health care expanded to reach rural Malawians
2. Increased health care utilization
3. Strong referral network established for seriously or chronically ill individuals
4. Improved ART and other drug/treatment adherence
5. Gaps in the HIV treatment cascade, moving patients successfully from diagnosis to viral suppression, are narrowed

**Impact**

1. Expand access healthcare
2. Stem the spread of HIV, TB, malaria and other infectious diseases
3. Decrease morbidity and mortality due to preventable and treatable conditions

**Acronyms:**

- ETAF - Elizabeth Taylor AIDS Foundation
- MOH - Ministry of Health
- CHAM - Christian Health Association of Malawi
- MOU - Memorandum of understanding
- DHO - District Health Office
- CO - Clinical officer
- F/C - Follow up coordinator
- HTS - HIV testing services

**Assumptions (Program Focused):**

1. Funding for clinics is maintained.
2. Clinics vehicles operate with no need for significant repairs or upgrades for 5+ years.
3. Need continues for rural mobile outreach facilities.

**External Factors (Environment Focused):**

1. International donors continue to provide funding for/donations of medications.
2. Price/availability volatility of fuel is not insurmountable.
4. There is a continued need for outreach facilities, government is not providing a comparable service or filling the gaps GAIA targets.
### Program Logic Model

**GAIA Mobile Health Clinics**

**Inputs**

1. MOUs
2. Meetings between program partners
3. Medications supplied by GAIA
4. Frequency of stock outs
5. Accuracy in inventory tracking
6. Patient treatment by diagnosis
7. Clinic operating days
8. Number of clients with MOUs

**Activities**

1. CQIs conducted to maximize service provision
2. Clinics staff members’ job satisfaction
3. Frequency of stock outs
4. Accuracy in inventory tracking
5. Patient treatment by diagnosis
6. Clinic operating days
7. Number of clients with MOUs

**Outputs**

1. MOUs
2. Meetings between program partners
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**Participation**

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**Medium Long**

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**Impact**

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3. Medications supplied by GAIA
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### Key Evaluation Questions

<table>
<thead>
<tr>
<th>Level</th>
<th>Questions</th>
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</thead>
<tbody>
<tr>
<td>L1</td>
<td>- Are the clinics meeting unmet needs? Do clients walk less than 5km/1 hour for care?</td>
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<td>- Are additional services demanded that should be offered through the clinics?</td>
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<td>- Is demand constant or consistent with seasons?</td>
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<td>- How widespread was our reach?</td>
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<td>- Where can the clinics go next?</td>
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<tr>
<td>I1</td>
<td>- Has Malawi Achieve universal health coverage?</td>
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<td></td>
<td>- Have the number of deaths due to HIV, TB, and Malaria decreased?</td>
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<td></td>
<td>- Are the number of AIDS orphans remaining constant or decreasing?</td>
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<td></td>
<td>- How has the local economy of the clinic catchment areas changed?</td>
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### Indicators

<table>
<thead>
<tr>
<th>Input</th>
<th>Indicators</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1.1</td>
<td>MOUs</td>
</tr>
<tr>
<td>A1.2</td>
<td># of meetings between program partners</td>
</tr>
<tr>
<td>A1.3</td>
<td># of needed service areas identified by DHO/GAIA</td>
</tr>
<tr>
<td>A1.4</td>
<td>% of medications supplied by GAIA vs. MOH</td>
</tr>
<tr>
<td>A1.5</td>
<td>Frequency of stock outs</td>
</tr>
<tr>
<td>A1.6</td>
<td>Frequency of errors identified in inventory tracking</td>
</tr>
<tr>
<td>A2.1</td>
<td># of clients treated by diagnosis</td>
</tr>
<tr>
<td>A2.2</td>
<td># of clinic operating days</td>
</tr>
<tr>
<td>A2.3</td>
<td># of clients with MOUs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Output</th>
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</tr>
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<tbody>
<tr>
<td>P1.1</td>
<td>CQIs conducted to maximize service provision</td>
</tr>
<tr>
<td>P2.1</td>
<td># of clients satisfied with clinic services</td>
</tr>
<tr>
<td>P2.2</td>
<td># of patients reporting waiting for clinic day to seek treatment</td>
</tr>
<tr>
<td>P3.1</td>
<td># of patients referred to higher level of care or services not offered</td>
</tr>
<tr>
<td>P3.2</td>
<td># of clients transported by clinics</td>
</tr>
<tr>
<td>P3.3</td>
<td>Level of satisfaction with clinics, staff, and care</td>
</tr>
<tr>
<td>P3.4</td>
<td>Level of satisfaction with clinics, staff, and care</td>
</tr>
<tr>
<td>P4.1</td>
<td># of health talks attended by topic</td>
</tr>
<tr>
<td>P4.2</td>
<td>Level of reception and comprehension of information</td>
</tr>
<tr>
<td>P5.1</td>
<td># patients reported</td>
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