Scottish Government

Malawi Development Programme 2015-2018

End of Year Report – Part 1 of 3

This narrative report should be submitted together with your updated log frame and financial report.

PLEASE READ ATTACHED GUIDELINES BEFORE COMPLETING THE FORM

1. Basic Project Information Complete the information below for management purposes. Please indicate in the relevant section whether any changes to your basic project information (e.g. partners, geography, project dates or budget) have occurred during this reporting year. Explanations should be provided in section 3.		
1.1	**Project Reference Number**	M/15/H/002
1.2	**Reporting Year**	From 01/04/17 To: 31/3/18
1.3	**Project Year** (e.g. Year 1)	Year 3
1.4	**Name of Lead Organisation (Grant Holder)***	Professor REDACTED Edinburgh Napier University
1.5	**Name of Partner(s)***	Association of Malawian Midwives (AMAMI) White Ribbon Alliance Malawi (WRA) University of Aberdeen (UoA) Robert Gordon University (RGU)
1.6	**Name of Project***	Improving Respectful Midwifery Care in Rural Malawi: A Human Rights Approach

1. Basic Project Information		
Complete the information below for management purposes. Please indicate in the relevant section whether any changes to your basic project information (e.g. partners, geography, project dates or budget) have occurred during this reporting year. Explanations should be provided in section 3.		
1.7	**Project Description***	Improving access to maternity care is the most effective way of achieving MDG-5. Recent evidence suggests that the care women receive in health facilities is not always respectful of their human rights. If their treatment is not humane, they are unlikely to seek or return for care, so improvements in the number of women with skilled birth attendants are unlikely to be sustained. Respectful midwifery care will be achieved by the following: • Incorporating a human rights approach into pre-registration midwifery education curricula and continuous professional development programmes. • Capacity building for midwifery educators, and leaders using a human rights approach. • Delivery of clinical supervision for students and midwives, so they can apply a human rights approach in practice. • Improving clinical environments to promote the dignity and privacy of women during childbirth. • Systems developments that hold midwives to account for providing care that meets human rights standards. • Raising the profile of human rights within rural villages through community engagement.
1.8	**Project Country/ Region***	Malawi, Africa (Kasungu & Lilongwe)
1.9	**Project Start & End Date***	Start: 01/08/2015 End: 31/3/2018 plus extension 01/04/2018 - 30/09/2018
1.10	**Total Project Budget***	£432,196 (3 years)
1.11	**Total Funding from IDF***	£432,196
1.12	**IDF Development Priorities**	X Health Education X Civic Governance

1. Basic Project Information Complete the information below for management purposes. Please indicate in the relevant section whether any changes to your basic project information (e.g. partners, geography, project dates or budget) have occurred during this reporting year. Explanations should be provided in section 3.			
	Please tick the box next to the development priority/priorities that your block grant aims to address	Sustainable Economic Development	Renewable Energy
1.13	**Supporting Documentation** Check box to confirm key documents have been submitted with this report	**Up-to-Date Logical Framework (LF)** summarising progress against relevant milestones for project activities, outputs, outcomes and impact. Please indicate (check box) if you have proposed amendments to your LF since your last report. If so, please detail any changes in Q3.2 Please indicate (check box) if the LF submitted has been approved by the Scottish Government.	X X
		End of Year Financial Report	
		Proposed Revised Budget (if applicable)	
	Please list any further supporting documentation that has been submitted	Sample of photographs of activities	
1.14	**Response to Previous Progress Reviews**	**Scottish Government's comments on previous reports (state which):** Lack of log frame in last mid-year report	**Action taken since received:** Log frame included in this report
1.15	**Date report produced**	30th April 2018	
1.16	**Name and position of person(s) who compiled this report**	Professor REDACTED (Edinburgh Napier University) REDACTED (Edinburgh Napier University) REDACTED (University of Aberdeen) REDACTED (Malawian Project Lead)	

1. Basic Project Information		
Complete the information below for management purposes. Please indicate in the relevant section whether any changes to your basic project information (e.g. partners, geography, project dates or budget) have occurred during this reporting year. Explanations should be provided in section 3.		
1.17	**Main contact details for project, if changed**	REDACTED

Signed by_____REDACTED_____ Date___30/4/18_____

Designation on the Project__ Project Manager_

2.	Project Relevance
2.1	**Project Beneficiaries** Does the project remain relevant to the context and the beneficiaries with whom you are working? Please justify this in a short paragraph below.
	The project remains focused on the provision and promotion of respectful maternity care (RMC) within a maternity care setting. We are working closely with our Malawian partners (Association of Malawian Midwives (AMAMI) and the White Ribbon Alliance (WRA) to • instill the theme of RMC within pre and post-registration midwifery curricula and continual professional development • provide resources to maternity facilities to support RMC • raise awareness and empower women and communities about their rights to RMC • enhance employment and regulatory systems and processes of accoutability for midwives in relation to RMC.
2.2	**Gender and social inclusion** Please describe how your project has worked to ensure that women and girls, and other vulnerable groups (as appropriate) benefit from the project. Describe any challenges experienced in reaching vulnerable people and how these have been overcome.
	The project is working with the White Ribbon Alliance (WRA) who are experienced in the promotion of RMC both within Malawi and elsewhere. The WRA are working with communities, women's groups and health care advisory committees (HAC) to raise awareness and develop and imbed systems of reporting and addressing RMC. This project has targeted both urban and rural settings and been inclusive of all women (+girls) within communities, which includes those with disabilities and socio-economic deprivation. The WRA have extensive experience in promoting RMC and targeting vulnerable groups through community leaders, church groups, health advisory committees etc. Material used has been inclusive and accessible as communication has been verbal and pictorial. Initially, community engagement events targeted group leaders in villages to raise awareness and disseminate this. In 2017, we changed our methods and introduced Citizen Hearings to have broader reach and ensure that we were reaching women and girls directly, even the most vulnerable (photos included in powerpoint presentation.
2.3	**Accountability to stakeholders** How does the project ensure that beneficiaries and wider stakeholders are engaged with and can provide feedback to the project? What influence has this had on the project? What challenges have been experienced in collecting and acting on beneficiary feedback?

	To improve the reach of the RMC agenda to women and their communities we worked with the WRA and AMAMI to conduct Citizens' Hearings throughout the target areas. At these events women are invited to give feedback about the care they have received and the health workers and their managers have an opportunity to respond. This has given stakeholders a platform to share their experiences and become increasingly empowered. Through this forums we have heard about disrespectful care by others such as guardians and non-registered staff (i.e. maids). This has influenced our planned acitivities in the project extension which will now include focus during Citizen Hearings on guardians treatment of women during childbirth and broadening our training in RMC to non-registered staff. The Advisory Group continues to support the project by attending meetings and through lively debate on its WhatsApp group. They have supported the project by working behind the scenes identifying incidents that require investigation and following up with relevant organizations and individuals. We can then lobby for appropriate action to be taken. A recent example is the suspected abuse of female applicants and bribary of applicants to a nursing college by lecturers, which is now being investigated by CHAM. Challenge in responding to such reports are the sheer volume, lack of detail and informality. Encouraging and advising Malawians to use formal processes of complaints is at times all we can do and this doesn't always happen. Some of the challenges we reported in 2017 have improved. Midwives are now paid regularly. Our Malawian partners report that the delay in payment was caused by the change from a central to a local government payroll. The employment of newly qualified nurses and midwives is still delayed and many remain unemployed despite the number of vacancies. The Ministry of Health reports that this is partly explained by IMF and World Bank fiscal policies to reduce the national wage bill. It is also explained by the lengthy and cumbersome recruitment processes. As a result the employment of newly qualified staff may take more than a year.

3. Progress and Results This narrative report on project performance and results will be reviewed together with your revised and updated Logical Framework (or if not yet approved your original Logical Framework). See Guidelines (Annex 1) for details.	
3.1	**Changes to Project Status** Has the focus or delivery of your project changed significantly over the last financial year? If so, please explain how and why, and attach copies of all relevant correspondence with the Scottish Government.
	No.
3.2	**Changes to the Logical Framework** If changes have been made to the logframe since the previous financial year please describe these below. Please also provide evidence (e.g. copies of correspondence). that these changes have been agreed with the Scottish Government. If you would like to make changes to your logframe, but these have not yet been approved by the Scottish Government, please describe and justify in detail the requested changes below – and highlight the proposed changes in the revised logframe.

3. Progress and Results

This narrative report on project performance and results will be reviewed together with your revised and updated Logical Framework (or if not yet approved your original Logical Framework). See Guidelines (Annex 1) for details.

	Result Area/ Indicator	**Proposed/ Approved Change** (please clarify and evidence below)	**Reason for Change**
	N/A		

3.3 **Gaps in Monitoring Data**

If baseline or monitoring information is <u>not</u> available, please provide an explanation below. Where monitoring data has been delayed (since previous report), please provide an indication of when and how it will be made available to the Scottish Government.

N/A

3.4 **Project Outputs**

In the table below, please list each of your project outputs, and provide further detail on your progress and results over this reporting period. Describe any delays or other challenges that you have experienced and how these have been addressed, and provide information about any unexpected results. Progress should be supported with evidence (such as links to monitoring data in line with logical framework, case studies, web-based information, reports etc) where possible.

Output 1: *Improved capacity among pre-registration students in respectful practice for maternity care.*

Output Indicator	**Progress against Planned Milestone/ Target**
1.1 Number of midwifery educators oriented to reproductive health rights and RMC	This year we have trained/sensitised a further 30 lecturers bringing our total to 106. This exceeds milestone 3. This figure is likely to be higher as lecturers have sensitised colleagues and teaching staff within their institutions in order to teach Respectful Maternity Care within the curricula. It is challenging to quantify this additional peer training across Malawian institutions as they have not all recorded this activity or reported it. What this does indicate is that the 'train the trainer' method has been effective and that sustainability of the engagement and training of educators in RMC is will go beyond the duration of the project. Here are some quotes from those who attended our training.

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		"..BUT… most of the content that was there we were teaching it but not in a scenario form as we are taught by AMAMI" Lecturer, Holy Family College ***"The scenario based is good .. we modified it because we have to put them into groups because there are many ..but when they are in groups and there is a scenario they put themselves in the shoes of those mothers, so in the end you make them reflect "If I do this… if it were ME…how would I feel?"*** **Lecturer, MCHS Za**
	1.2 *Number of pre-registration students who have received education that includes RMC*	This year we have trained/sensitised a further 332 students, bringing our total to 637, exceeding the target of 270 (milestone 3). These numbers have been achieved through the work of the project team and the college lecturers. One particularly successful event was our visit to St Luke's Nursing College (Zomba) in November 2017, which resulted in the training of 231 students. Even with this large number, the students asked questions and discussed examples of Respectful Care during the session (see gallery of photos submitted with report).
	1.3 *Number of students who have the skills to deliver RMC*	Current figures of final year students orientated to RMC are still being gathered by the project team. Information from 3 colleges who have trained a total of 341 final year students bringing our running total to 578, far exceeding our target of 100. These numbers will continue to increase as more students graduate from the programmes as RMC is part of the pre-registration curricula.
	1.4 *Pre-registration prerequisites operational- syllabus/curricula*	Although the approval process for the amalgamated RMC module through the Reproductive Health Unit has been slower than we expected, this has not restricted its use within training institutions across Malawi. Lecturers report that the content is used in many teaching environments (e.g. skills labs and classroom activities). Respectful Care is also formally assessed within the skills lab - this is core assessment and students are not permitted to enter into the clinical areas until they achieve a pass.
	Output 2	***Improved capacity among practicing midwives to deliver respectful care.***

3. Progress and Results This narrative report on project performance and results will be reviewed together with your revised and updated Logical Framework (or if not yet approved your original Logical Framework). See Guidelines (Annex 1) for details.		
	2.1 *Number of practicing midwives who have received CPD that includes RMC*	Progress for this output has been impacted by the national situation around the lack of delivery of CPD in Malawi. This was reported verbally and in writing to the Scottish Government in 2017. We took a pragmatic approach and took the training to the nurse/midwives in situ (clinical areas) in 'briefing sessions'. The situation is gradually improving, and CPD is now in progress in the target districts. To date 306 midwives have been trained and we have reached our target. We believe that the situation is gradually improving and CPD is now in progress in our target districts. Although we can report on the numbers of midwives receiving CPD facilitated by the project, we are as yet unable to quantify the extent of delivery across our target areas. That said, Midwives are aware of RMC: "*To me, I also think the most vital thing about RMC is communication - Eh, you should be able to establish a good communication between you, your client, as well as the guardians."* Midwife 2,FGD Bwaila "*For me RMC is the care we provide to the woman that the woman at the end will feel good and will really appreciate .. and treat each and every woman as a unique individual…and the midwife at the end will feel good - that "Ive done something good"* Midwife 1, FDG Bwaila

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	2.2 *Number of DNOs trained in RMC and incorporating it into their regular clinical supervision*	All DNOs have been trained in RMC in our project areas and RMC has been incorporated into clinical supervision tools and they are using it in practice. So we achieved milestone 3. However, its use is impeded by the national situation regarding clinical supervision by DNOs who are prevented from providing regular clinical supervision due to: • lack of funds for fuel to travel to health facilities • the staffing shortfall, which has meant DNOs focused more on managing staff and services to meet demand. The DNO and his team in Kasungu has been very engaged in training and their input has been very helpful. Although there has been no formal clinical supervision this year, the DNO has started doing a walk-round the hospital reinforcing the importance of RMC and has initiated a mentoring programme for his staff. The Kasungu management team have also supported the project by attending training sessions. The DNO from Lilongwe has been less engaged and has now retired. We are awaiting the appointment of a new DNO and will train this person when they are in post. We are optomisic that things will improve with new leadership.
	2.3 *CPD educational prerequisites operational- syllabus/curricula*	The RMC training pack has been co-produced, approved and distributed to CPD facilitators in both areas, so it is now part of the CPD curricula. RMC CPD provision has had to be provided in clinical areas by the project team for reasons described in 2.1.
	2.4 *Health system pre requisites in place – (scope of practice/job description), supportive supervision*	The project has supported (with other agencies) the Nursing and Midwives Council of Malawi (NMCM) to review the NMCM Code of Ethics and Scope of Practice documents. RMC was incorporated into the new documents, published in 2016. The project has purchased these documents for the facilities within our project areas, and these were distributed while we were supporting clinical supervision. We are working in partnership with the White Ribbon Alliance and Ministry of Health to progress the development and implementation of midwifery-specific job descriptions (none exist at present). These products have been finalized and delivered to the Director of Nursing at MoH for implementation. Lack of funds in the Ministry of Health explains their lack of implementation during 2017/18 but the Director of

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		Nursing and Midwifery stated at the Advisory Group that this will be a priority in July when they receive their budget for 2018/19.
	2.5 *Number of role models for midwives in clinical areas*	A total of 30 role models have been identified by managers and were formally announced and awarded the honorary title of 'RMC Champion' at the International Day of The Midwife celebration in Lilongwe in May 2017. It is expected that 30 more role models will be formally recognised at the International Day of the Midwife celebrations in May 2018. Our partners, AMAMI and the White Ribbon Alliance have designed a "role model criteria" which has been distributed to the District Nursing Officers to ask them to identify role models. The nominations are from women and colleagues.
	Output 3	***Improved environments for respectful care in health facilities***
	3.1 *Number of institutions supplied with essential equipment and medical supplies to support provision of respectful care*	To date, 10 facilities have been supplied with plastic sheets, curtains, screens, blood pressure machines and stethoscopes to support the delivery of RMC. These have been distributed at the same time as the project team has been supporting managers in the introduction of RMC within clinical supervision. Photos have been included in powerpoint presentation.
	Output 4	***Women receive better quality care at health facilities***
	4.1 *Percentage of women who report that they receive respectful care from midwives*	Our initial baseline survey asked women if they received 'respectful care' during childbirth and a high number of women reported that they did (93.6%). However, when the same women were asked about specific aspects of their care and health care professionals behaviours, most reported disrespectful actions, such as physical abuse and harsh/rude language). A possible explanation for this is women's misunderstanding of the term 'respectful' and 'satisfaction'. This prompted us to seek and obtain further funding from Burdett Trust to explore this in more detail. Our initial analysis of the data would support our hypothesis. Our follow-up survey (post community sensitization) indicated a fall in the percentage of women reporting they had 'respectful care' (83.3%). However, when asked about specific behaviours they have reported a fall in these (i.e. physical abuse, harsh/rude language). We interpret this as showing that midwifery care has improved (fewer disrespectful actions) but women's expectations

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		of care and their understanding of RMC have improved due to sensitisation, leading them to report 'respectful care' less frequently.
	4.2 *Percentage of women reporting an intention to return for care on next pregnancy/or would recommend the facility to a friend*	Our follow-up survey indicated a slight (not statistically significant) fall in the percentage of women reporting 'an intention to return for maternity care during next pregnancy' (88.6% in 2018 from 91.2% at baseline data collection report). As indicated above, the same survey also recorded a fall in the numbers of disrespectful items reported (e.g. physical abuse, harsh/rude language). We interpret this as showing that midwifery care has improved (fewer disrespectful actions) but women's expectations of care and their understanding of RMC have improved (Citizen's hearings), leading them to report an intention to return for care with no statistically greater frequency.
	Output 5	***Strengthened systems for accountability – feedback, regulation and performance management***
	5.1 *Enhance the system for feedback by women*	The real time feedback (RTF) tool has been implemented in all participating health centres in our project areas. It is used by Healthcare Advisory Committee members who have been trained. The challenge of sustaining the RTF during exit interivews in health facilities is the lack of resources such as paper and pen. With the lack of electricity electronic tools are not feasible. We have supplied HAC members with laminated RTF and a batch of notebooks that can be used. Other examples of feedback systems agreed following community sensitistaion are in Wimbe. The community decided to open a WRA chapter and are feeding back to health centre staff. It has become so active that there are now 3 chapters in the area.
	5.2 *Enhance the referral system of midwives for disrespectful care*	An RMC component has been incorporated into the NMCM Monitoring and Evaluation (M&E) tool for undertaking audit/inspections of clinical areas. This component seeks evidence of RMC practice in these areas and raise awareness about referral systems. The tool was piloted in two areas in Kasungu and Lilongwe. Based on the findings from the pilot some small changes are being made to the tool.

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		Again, the main challenge is conducting regular NMCM M&E visits as not all nurses and midwives pay their registration fees regularly so funding for the organization is unreliable. As registration with the NMCM is essential for nurse and midwives to be employed and most are employed with the MoH, we plan, with-AMAMI to lobby employers to deduct the license fee from salaries and pass these directly to NMCM. We are also raising the profile of the NMC and mechnisms of referral through Citizen Hearings and Radio panels. The challenge is that the NMCM will only accept formal referrals in writing and many in Malawi are illiterate. HAC members can be advocates and support women and guardians, but we continue to lobby the NMCM to accept verbal complaints that they can record on behalf of the complainant. There have been 15 referrals to the NMCM that have included issues with respectful care.
	5.3 *Enhance the disciplinary process when initiated for disrespectful care*	As above, the same constraints affect the disciplinary process. On a positive note our focus group discussions have highlighted that where there is effectivce leadership and real time feedback is sought (Kasungu), many complaints are not being formalized as feedback is being more regularly and actively sought and negative feedback is handled locally in a timely way. Kasungu DNO has received no formal complaints in Year 3. He is working closely with the ombudsman to resolve issues before they develop into complaints. Lilongwe DNO has received 20 complaints, mainly due to poor quality of care, women being verbally abused and not assessed by the nurse/midwives. Various outcomes such as not upheld (no action), verbal or written warnings. With the appointment of a new DNO soon who will be orientated and trained in RMC we hope that this will improve.
	5.4 *RMC is incorporated into job descriptions, supervision and appraisal*	Completed project input in Year 2. Implementation is with MOH.

3. Progress and Results

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3.5 **Project Outcome**

In the table below, please list your project outcome, and provide further detail on your progress and results over this reporting period. Please describe any delays or other challenges that you have experienced and how these have been addressed, and provide information about any unexpected results. Progress should be supported with evidence (such as links to monitoring data, case studies, web-based information, reports etc) where possible.

Outcome 1 Midwives are supported and educated in respectful care	
Outcome Indicator	**Progress against Planned Milestone/ Target**
1. *Number of midwives in target areas trained and supported by the project to give respectful care*	We have successfully reached our target for Year 3, training 330 midwives. This has been done by project team and CPD facilitators through train the trainers.
2. Communities and women sensitised to reproductive health rights and respectful maternity care	***Outcome 2 Indicator 1. Number of communities sensitised to reproductive health rights and respectful maternity care (RMC)*** There have been 4 Citizens' Hearings in Year 3. The number of Group Village Headman (GVH) at these events totals 43 from Lilongwe and 42 from Kasungu. The GVH are each responsible for approximately 15 villages each, suggesting that the total number of villages exposed to the RMC concept in Year 3 is 645 in Lilongwe and 630 in Kasungu. In previous project years 62 GVH attended community sensitization events with a reach of a further 930 villages. This brings the totals for Lilongwe to 1,110 villages – 47% of the villages in the Project sites (2,354). The total for Kasungu is 1,095 – 84% of the villages in the Project sites (1,309). The overall coverage is thus 60.2% of villages sensitized to RMC.

		Outcome 2 Indicator 2: Number of women sensitised to reproductive health rights through attendance at community orientations /women's groups Our partner the White Ribbon Alliance has done some evaluation in the communities to assess the impact of the sensitization workshops. Five interviewers visited villages accompanied by the Health Surveillance Assistant from that village, and the Village Headman. Two specific interview guides were used- one for those community members who had attended the workshops and another for those who had not attended. The findings will be reported in out final report. The use of Citizens Hearings has increased our *direct* contact with women about RMC. Four hearings took place from September 2017 and we estimate that we have accessed a total of 3,241 women during these events. Women were provided with an opportunity to give direct feedback to the health facilities and the healthcare staff to respond. This has proved a useful strategy to begin open dialogue and reconciliation. In addition, we estimate that we have accessed 741 youths within a sexually active age group at these events. Radio panels have also reinforced our other strategies and extended our reach, even beyond the target areas. Two more are planned during our funded extension.

	Outcome 3 *Midwives are accountable for the care they give*	***Outcome 3 Indicator 1 The number/reasons/outcomes of feedback/complaint by women and chiefs relation to RMC*** See output 5.3 ***Outcome 3 Indicator 2: the numbers/reasons of midwife referrals to NMCM related to RMC*** A total of 15 cases have been referred to the NMCM Disciplinary Committee that were related to respectful midwifery care. All of these featured elements of disrespectful care. Examples of cases include: • women being ignored • women not being clinically examined and deterioration in condition not detected or recognized • women being verbally abused • dismissal of requests for care or pain management. ***Outcome 3 Indicator 3: The numbers/ outcomes of disciplinaries involving midwives in relation to RMC*** Most cases have been fully investigated and presented to the panel and actions taken include: suspensions for three to 12 months, written warnings and dismissal. Untimely investigations and delays are explained by the lack fo resources available to the organization due to issues with nurse and midwives paying their registration fee (see Output 5.2).

3. Progress and Results

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3.6 **Project Impact**

In the table below, please list each of your project impact, and provide further detail on your progress and results over this reporting period. Please describe any delays or other challenges that you have experienced and how these have been addressed, and provide information about any unexpected results. Progress should be supported with evidence (such as links to monitoring data, case studies, web-based information, reports etc) where possible.

Project Impact: *An increased proportion of births in target areas*

Impact Indicator	**Progress against Planned Milestone/ Target**
1 *Percentage of births within target areas with professional care at delivery*	The most recent estimate of skilled delivery care in Malawi is 91% Malawi Demographic and Health Survey 2015-2016 (2017).

3.7	**Risk Management** If progress towards delivering activities and outcomes is slower than planned or there have been delays in the delivery of the project, please explain: a) What the issues have been and whether they were highlighted on your risk register? b) What actions have been taken in response to these issues?			
	Issue/ Risk	**On risk register?**	**Action Taken**	**Outcome**
	CPD SESSIONS Poor attendance at CPD sessions. We planned that following train the trainer sessions which would be followed by the CPD facilitators undertaking subsequent training. Members of the Advisory Group and during a Clinical Supervision workshop raised the lack of engagement in CPD. The lack of engagement was caused by the in country challenges of a staffing crisis. As a result many staff have not received any CPD on any topic. This is a particular challenge within Lilongwe District.	Yes - cited as LOW RISK and now changed to MEDIUM RISK	The Project Manager met with the NMCM CPD National Coordinator in February 2017. The full extent of the challenges facing various NMCM departments was clarified. Senior management from hospitals consistently report demotivated staff, exceptionally high levels of sickness and ever increasing workloads. Lack of staff within the NMCM itself has resulted in delays, overload and demotivation. As a result an SBAR (Situation, Background, Assessment, Recommendations) was developed by the Project manager and the problem discussed with the Principal Investigator. Action discussed and finalized with Scottish Government (2017).	Decision made for project team to provide CPD in the clinical areas with shorter sessions. Further discussion with Malawian partners has highlighted that plans are in place to alleviate the situation.

	STAFF MOBILITY The staffing crisis has increased staff mobility. They are being moved from one area to another, particularly from rural health centres to urban district hospital. The project has no ability to track midwives. The issue is that some of the midwives who have been trained in RMC may move out of the project areas which affects our ability to 'saturate' the staff in target areas as the need for training continues or increases.	Not on original Risk Assessment now seen as HIGH RISK	PI discussion with MM at Scottish Government – noted.	We have lists of those midwives in project areas who have/have not been trained. Training will continue targeting these original names. We also accept that the positive aspect of this is that those who are RMC trained and are mobilised out of target areas will have extend our reach – this is just not possible to record.
	Please add additional issues as required			

4.	Sustainability
4.1	**Partnerships** Provide a brief description of the roles and responsibilities of all partners, including in M&E. Have roles and responsibilities changed or evolved? Please provide a brief assessment of your partnership, including its strengths, areas for improvement and how this will be addressed. This section should be completed by lead partners based in Scotland and Malawi.

Edinburgh Napier University: Lead applicant, overall project management, implementation and dissemination. Development of training packages, facilitation of workshops, project and financial monitoring and lead for the development for reporting to Scottish Government.
Robert Gordon University: Involvement in the development of training packages and facilitation of workshops.
University of Aberdeen: Lead the process and outcome evaluation and be involved in any training/capacity building needed for Malawian project worker in data collection and analysis.
Association of Midwives Malawi: Project management in Malawi. Co-ordinate training and workshops for DNOs, midwives and lecturers. Maintain regular communication and effective relationships with key stakeholders in Malawi about progress of project, emerging priorities etc. Support monitoring and evaluation by participating in data collection and analysis. Exert political influence on policy makers, regulators and health service managers to ensure sustainability beyond lifespan of project.

White Ribbon Alliance: Technical support and advice with development of training materials and data collection tools. Maintain regular communication and effective relationships with key stakeholders in Malawi about progress of project, emerging priorities etc. Lead on community engagement.

All partners are involved in dissemination (includes papers, conferences and public engagement).

The White Ribbon Alliance role and responsibilities have expanded and they are now leading on community engagement. They have experience of doing this in Malawi and other countries and they have existing relationships within communities that will facilitate this.

The partnership between the Scottish Universities and AMAMI is well established and we are very familiar and respectful of each other, our unique contribution and preferred ways of working. Our partnership with WRA is now more established. It took some time for them and us to identify exactly where and how they could contribute to the project beyond an advisory and material development role. They are now taking the lead on community engagement and that has provided clarity and recognition.

The main challenge has been communication between partners out with the trips to Malawi. With little improvement in internet connectivity in Malawi over recent years, Skype and email have proved to be inconsistent. We have resorted to using WhatsApp. We are also now having Scottish working group meetings on a three monthly basis. Part of the day is dedicated to a project meeting (Malawi join by telephone) that allows us to share information and make plans. The remainder of the time we work together to develop training materials and analyse data etc.

4.2	**Exit Strategy** Describe the key components of your exit strategy and outline progress towards achieving it. Provide any other achievements or progress towards ensuring that your project remains sustainable in the longer term (including in relation to local ownership and capacity, and resourcing). Describe any challenges and how these will be addressed.
	Our exit strategy has underpinned and determined our entire approach to this project. The main approaches are: building capacity (train the trainer), system changes for feedback, performance management and regulation (accountability), embedding respectful care in pre and post-registration curricula. Progress towards these have already been described in the report. To summarise we have already trained lecturers, organisational midwifery leaders and district nursing officers in RMC. Systems have been mapped for feedback, appraisals and regulation and change has happened. RMC has been incorporated into pre and post–registration education curricula. This is across all providers of midwifery education, not just those in Kasungu and Lilongwe. Communities have been sensitized to RMC and our evalution evidence suggested that women are more aware of their rights, so expecatations are changing. Nurse/midwives behaviours are also improving with less reports of disrepecrful behviours experienced by women.. We have led some events/workshops/meetings at the beginning of this project, but now as we are building capacity we are taking more of a facilitative/supportive role as capacity is building in Malawi. Their confidence is growing and they are taking more ownership. The main challenge for midwives in Malawi is the continued lack of resource (human and material) which is impacting on their ability to provide and attend CPD.

5.	Learning and Dissemination
5.1	**Lessons Learned** Describe briefly any lessons learned during this reporting period, and how it will influence the project and your work moving forward.
	Learning in relation to the RMC project has been ongoing as the project progressed throughout Year 3. There have been three main points for learning: 1. Citizens' Hearings seem to be a very effective method of accessing many women directly, and preferable to our previous community sensitization events. We have been accessing greater numbers, women are empowered to question aspects of their care and receive immediate feedback from health care staff. In addition these events attract children, young people and men so have a wider reach in the community. 2. The need for flexibility in the RMC training package. Due to the staffing crisis and non-availability of staff to attend CPD we have had to adapt our training model to ensure that learning needs are met within the time constraints. We have implemented a pragmatic approach to RMC post-registration training, which is to use the project team to go into clinical areas to provide short taster sessions and raise awareness. Staff mobility means that we have potentially trained some nurse/midwives in RMC that are no longer working in our targeted regions, which will affect our impact and milestones. 3. Our follow up evaluation data found that women are less satisfied with their care but are also reporting fewer disrespectful behaviours by midwives. This suggests that both the midwifery training and the community sensitizations have had an impact – midwives seem to be behaving more respectfully and women are more aware of their rights and what acceptable treatment looks like.
5.2	**Innovation and Best Practice** Summarise briefly any examples of innovations/ innovative approaches or best practice demonstrated by your project during this reporting period. Please explain why these are innovative or best practice, and detail any plans to share these with others.

5.	Learning and Dissemination
	We have several examples of Innovation and Best Practice. **Innovation** **Commonwealth Fellowship Award** As a concurrent activity alongside the RMC project, we successfully applied and received funding to host 4 Malawian Professional Fellows who spent a month in Scotland in May 2017. The funding was secured from the Commonwealth Fellowship Commission. The Fellows undertook a leadership-focused programme; meeting members of the NMC from London, observing fitness to practice hearings, working with a variety of clinical champions and managers from the NHS and university settings. They also presented at International Week, an international conference hosted by Edinburgh Napier University. During their visit each Fellow started to develop a mentorship project and these are being implemented in Malawi. **Best Practice** **Kaluluma District Hospital** We visited Kaluluma District Hospital as part of following up leaning from the RMC training. The purpose of the follow up visits is to satisfy the team that the agreed Action Plans from the training sessions have been implemented. We were pleased to find welcoming, smiling staff who were obviously proud of their workplace. The staff had translated Women's Childbearing Rights into both the local languages, Chichewa and Tumbuka, and placed posters of these in public areas. They had oriented the staff and women and their partners to the RMC concept. There was evidence of a strong link between the Health Advisory Committee, the community and the staff at the hospital. We decided that on this evidence to design and award a "Certificate of Excellence" to the hospital, which was awarded at the time of the AMAMI Scientific Meeting for the International Day of the Midwife in May 2017. **Engagement of Community Leaders** Some communities have been very enthusiastic and committed to the RMC concept. In one area (Wimbe) the local community have developed their own White Ribbon Alliance group and have agreed to promote women's childbearing rights as a priority. In another area, women and men came together to the community engagement meetings, which is a significant result. There are now 3 WRA groups active in the area.
5.3	**Dissemination** Summarise briefly your efforts to communicate project lessons and approaches to others (e.g. local and national stakeholders in Scotland and Malawi, academic peers etc). Please provide links to any learning outputs.

5.	Learning and Dissemination
	1. Within Malawi our partner AMAMI hosted their AGM in December 2017. At this meeting, the RMC project was presented to delegates and progress discussed. Areas of Best Practice were formally recognized along with midwives recognized as Role Models. 2. Edinburgh Napier University hosted an "International Week" Conference in May 2017. Our main Malawian partner spoke about our project with the Principal Investigator. The Malawian Commonwealth Fellows also attended and engaged in events and workshops. 3. Our Principal Investigator presented some preliminary findings from the project at the International Confederation of Midwives Conference held in Toronto, Canada in June 2017. 4. The four Commonwealth Fellows are each implementing projects around the leadership theme in their current workplaces. 5. A radio panel discussion on RMC was held in March 2018 involving Malawian partners, disseminating information about the project and raising awareness. 6. In May 2018 AMAMI will host an International Day of the Midwife event where more Role Models will be recognized and the project will receive further exposure. 7. A paper on the initial RMC pilot funded by Burdett was published in November 2017. 8. Initial findings of the M&E have been presented to the Advisory Group early in 2018. 9. A paper describing the study and its main findings is being prepared by the team. 10. A further paper on the research into RMC conducted with partners and additional Burdett funding is also in preparation.
5.4	**Wider Influence** Briefly describe any intended or unintended influence on development outcomes beyond your project. For example influence on local and national policy, contribution to debate on key development issues, uptake by other projects etc.
	▪ As we have detailed above, the Nurses and Midwives Council of Malawi have utilized aspects of the Respectful Care and Human Rights module and shared with the Ministry of Health and the Reproductive Health Unit as areas of Best Practice with a view to replicating the concept in other clinical areas. ▪ The Reproductive Health Unit has suggested amalgamating our module with WRA material to develop a country-wide document. ▪ Citizens' hearings are raising the profile of women's reproductive rights, particularly among rural women who have had no voice until now. ▪ In Wimbe (Kasungu) the impact of the concept of respectful care has been demonstrable in the formation of a White Ribbon Alliance chapter. It was also noticeable to the Scottish team when visiting the area that husbands were attending for antenatal care with their wives and were taking an active role in discussion.

6. Financial Report The narrative report below should be provided in conjunction with the Budget Spreadsheet report (see Annex 2). Please fill in the Budget Spreadsheet to: (a) confirm actual spend for the year and justify any significant disparities between programmed expenditure and actual expenditure within the financial year, (b) detail programmed spend for next year. Please note that any carry-over of funds to the next financial year should have been agreed with the Scottish Government by January 31st of the current financial year.	
6.1	**Project Underspend** Please note whether the project has reported a significant underspend, and whether the Scottish Government has agreed to this being carried forward. If this has been agreed, please provide copies of or links to relevant correspondence. Please indicate whether the underspend is the result of currency fluctuations or other issues with project delivery.
	There is no significant underspend in Year 3, but we have yet to spent the dissemination budget. We formally request now to carry this into the extension period so dissemination can be funded. This includes paying for an open access journal to publish the project, conference presentations in Europe and sub-suharan Africa and a dissemination workshop for stakeholders in Malawi. We commit to spending and disseminating this work during the month extension period.
6.2	**Cost Effectiveness and Efficiency** Please detail any efforts by the project to reduce project costs, whilst maintaining the quality of the project – for example through managing projects costs, efficient resourcing, working with and learning from others etc.
	We have managed to supplement the funding available for monitoring and evaluation through additional funding from the Burdett Trust to conduct an in depth qualitative study of women's expectations and experiences of maternity care. Whilst data collecting for this study, we have simultaneously collected monitoring and evaluation data. This reduced spend in this area has compensated for the overspend in other areas.
6.2	**Co-finance and Leverage** Please provide details of any co-finance or leverage that has been obtained for the project during the reporting period, including how the funds/ resources will contribute to delivering more and/or better development outcomes.

External funding has been obtained from the Burdett Trust (£7.5K) to fund some qualitative research that will inform the project activities in Year 3 and our monitoring and evaluation. The data collection has been completed and we are currently analysing the data.

The Gloag Foundation has funded travel, accommodation and salary costs of a Scottish Lecturer to be based in Malalwi for 12 months (Feb 2017 to Feb 2018) to facilitate the progress of the project – in particular strengthening midwifery regulatory systems of accountability.

Funding has also been obtained from the Commonwealth Fund for four midwifery leaders from Malawi to come to Scotland for one month to undertake a be-spoke leadership programme. They returned to Malawi with ongoing support from the project team to implement what they have learnt and will each have objectives related to supporting the RMC project.

7. IDF Programme Monitoring

The list of IDF programme indicators are listed below. With reference to Q46 on your application form, please report on progress for the IDF programme indicators that you have committed to tracking in your original proposal, including the 'Poverty and Vulnerability Indicators', which are obligatory for all Scottish Government funded projects.

1. IDF Programme – Poverty and Vulnerability (compulsory)

1.1 Indicator 1.1 Total number of people directly benefitting from the project

Milestone 2	Female	Male	Total	Brief description (e.g. small-holders)
	3241	947	4188	Men and women sensitised via Community Sensitisations/attending Citizen Hearings

State the evidence that supports the progress described

WRA initial report and feedback

1.2 Indicator 1.2 Total number of people indirectly benefitting from the project

Milestone 2	Female	Male	Total	Brief description (e.g. small-holders)
	3,807	12,744	16,551	Total population of the 14 Health Service Areas

State the evidence that supports the progress described

WRA report and feedback after community follow up.

2. IDF Programme – Civic Governance and Society (optional)

2.1	Indicator 2.1 Number of formal legal institutions supported to improve citizens' access to justice and human rights					
	Milestone 2		Total		Brief description (e.g. paralegal service)	
	4		4		CHAM Ministry of Health Nursing & Midwifery Council Malawi Association of Midwives Malawi	
	State the evidence that supports the progress described					
	Progress reports, meeting notes					
2.2	Indicator 2.2 Number of people who have directly benefitted from improved access to judicial and paralegal services					
	Baseline	Adult Female	Adult Male	Child Female (< 18 yrs)	Child Male (< 18 yrs)	Total	Brief description (e.g. widows)
	State the evidence that supports the progress described					
2.3	Indicator 2.3 Number of organisations with increased awareness of good governance and human rights					
	Baseline		Total		Brief description (e.g. paralegal service)	
	0		10		University college lecturers Clinical managers CPD trainers Nursing and Midwifery Council of Malawi Malawian Human Rights Commission Human Rights Education Programme (Malawi) Local Community Groups Village Headmen Religious Leaders Women's Groups	
	State the evidence that supports the progress described					
	Registration documents from training sessions/advisory groups.					

2.4	Indicator 2.4 Number of people with increased awareness of good governance and human rights				
	Baseline	Female	Male	Total	Brief description (e.g. small-holders)
	State the evidence that supports the progress described				
2.5	Indicator 2.5 Number of people who are engaged in advocacy for improving citizens' rights				
	Baseline	Female	Male	Total	Brief description (e.g. small-holders)
	State the evidence that supports the progress described				
	3. IDF Programme – Education (optional)				
3.1	Indicator 3.1 Number of schools with improved management and resourcing for provision of quality education				
	Baseline		Total		Brief description (e.g. primary school)
	State the evidence that supports the progress described				
3.2	Indicator 3.2 Number of children/ learners benefitting from improved management and resourcing of schools				
	Baseline	Female	Male	Total	Brief description (e.g. girls, visually-impaired)
	State the evidence that supports the progress described				

3.3	Indicator 3.3 Number of people trained in improved school inspection and/ or improvement services						
	Baseline	Female	Male	Total	Brief description (e.g. government staff)		
	State the evidence that supports the progress described						
3.4	Indicator 3.4 Number of new teachers qualified to provide quality education that is safe, equitable and accessible to all children						
	Baseline	Female	Male	Total	Brief description (e.g. primary)		
	State the evidence that supports the progress described						
3.5	Indicator 3.5 Number of people entering into higher education						
	Baseline	Adult Female	Adult Male	Child Female (< 18 yrs)	Child Male (< 18 yrs)	Total	Brief description (e.g. secondary, vocational)
	State the evidence that supports the progress described						
	4. IDF Programme – Health (optional)						
4.1	Indicator 4.1 Number of health professionals with up-to-date skills, knowledge and qualifications in essential healthcare						
	Baseline	Female	Male	Total	Brief description (e.g. nurses)		
	0						
	State the evidence that supports the progress described						

4.2	Indicator 4.2 Number of women who have access to improved maternal and neonatal healthcare services					
	Baseline	Total	Brief description			
	0					
	State the evidence that supports the progress described					
4.3	Indicator 4.3 % births assisted by a skilled provider					
	Baseline	Total	Brief description			
	73.2%	91%	Malawi Demographic and Health Survey 2015-2016			
	State the evidence that supports the progress described					
	Malawi Demographic and Health Survey 2015-2016					
4.4	Indicator 4.4 Number of people directly reached by improved essential health services					
	Baseline	Adult Female	Adult Male	Child Female (< 18 yrs)	Child Male (< 18 yrs)	Total	Brief description (e.g. malaria)
	State the evidence that supports the progress described						
4.5	Indicator 4.5 Number of people who have access to improved essential health services						
	Baseline	Adult Female	Adult Male	Child Female (< 18 yrs)	Child Male (< 18 yrs)	Total	Brief description (e.g. maternal health)
	State the evidence that supports the progress described						

4.6	Indicator 4.6 Number of institutions with improved essential health services						
	Baseline		Total		Brief description (e.g. district clinic)		
	State the evidence that supports the progress described						
4.7	Indicator 4.7 Number of people with increased awareness of determinants of health						
	Baseline	Adult Female	Adult Male	Child Female (< 18 yrs)	Child Male (< 18 yrs)	Total	Brief description (e.g. malaria prevention)
	State the evidence that supports the progress described						
	5. IDF Programme – Sustainable Economic Development (optional)						
5.1	Indicator 5.1 Number of people supported to establish or improve business/ economic activities						
	Baseline	Female	Male	Total	Brief description (e.g. agriculture marketing)		
	State the evidence that supports the progress described						
5.2	Indicator 5.2 Number of people accessing credit						
	Baseline	Female	Male	Total	Brief description (e.g. widows)		
	State the evidence that supports the progress described						

5.3	Indicator 5.3 % increase in household income				
	Baseline	Female	Male	Total	Brief description (e.g. vegetable farming)
	State the evidence that supports the progress described				
5.4	Indicator 5.4 Number of small holder farmers supported to adopt environmentally sustainable agricultural practices				
	Baseline	Female	Male	Total	Brief description (e.g. vegetable farming)
	State the evidence that supports the progress described				
5.5	Indicator 5.5 % increase in agricultural yield				
	Baseline	Female	Male	Total	Brief description (e.g. maize)
	State the evidence that supports the progress described				
	6. IDF Programme – Renewable Energy (optional)				
6.1	Indicator 6.1 Number of public institutions e.g. clinics, schools accessing renewable energy				
	Baseline		Total		Brief description (e.g. district clinics, schools)
	State the evidence that supports the progress described				

6.2	Indicator 6.2 Number of households accessing renewable energy				
	Baseline	Female	Male	Total	Brief description (e.g. solar)
	State the evidence that supports the progress described				
6.3	Indicator 6.3 Number of individual lamps/ lanterns sold				
	Baseline		Total		Brief description (e.g. lantern)
	State the evidence that supports the progress described				
6.4	Indicator 6.4 Number of community based ‘mini-grids’ that have been established				
	Baseline		Total		Brief description
	State the evidence that supports the progress described				