Scottish Government International Development Programme
Mid-Year Report

Notes for Completion:

- Please note, with the exception of the cover page, this report will be published.
- To ensure compliance with GDPR, refrain from using any personal or identifying information unless you have obtained consent from the data subject and are content for this to be made public.
- Answer all questions in the template provided, noting the word limits.
- Include all relevant information in the reporting template – hyperlinks and annexes will not be accepted as part of the report.
- Ensure answers are clear, concise and in plain English. Avoid using jargon and explain acronyms.

Supporting Documentation *Check box to confirm key documents have been submitted with this report*	**Logical Framework, which reflects any changes in this reporting period.**	☐X
	Budget	☐X
	Case study	☐X
	Risk register	☐X
As the project manager responsible for the completion of this report, I hereby confirm the information included is accurate and complies with the notes for completion.		
Scottish based Project Manager: [redacted]	**Signature:** [redacted]	

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1.	General Project Information	
1.1	**Project Reference Number:**	MAL/18/01 - StJS
1.2	**Name of organisation:**	St John Scotland
1.3	**Lead Partner(s) organisation:**	St John Malawi
1.4	**Project Title:**	Community Action and Service Access for Maternal, Newborn and Child health
1.5	**Reporting Period:**	**From:** 01/04/2019 **To:** 30/09/2019
1.6	**Reporting Year:**	2
1.7	**Project Start date**	01/10/2018
1.8	**Project End date**	31/03/2023
1.9	**Total Project Budget***	£465,421
1.10	**Total Funding from IDF***	£465,421 (includes grant variation additional funding for Bicycles of £7,830)
1.11	**Provide a brief description of the project's aims, highlighting which of the SDGs your project is working towards? (200 words)**	The project aims to support Sustainable Development Goal (SDG) 3's target to "achieve […] health coverage, […], access to quality essential health-care services and access to safe, effective, quality and affordable essential medicines and vaccines […]" (3.8), in Malawi through health education activities delivered in the household to pregnant women, new mothers, partners, and children under five. These activities directly contribute to "reduce the […] maternal mortality ratio" (3.1) and to "end preventable deaths of newborns and children under 5 years of age" (3.2) by focusing on safe motherhood. The project's mobile outreach clinics, and community-to-clinic referral system ensure women and men have "access to sexual and reproductive health-care services, including for family planning, information and education" (3.7), and also addresses the high pregnancy rate among adolescent girls. This further emphasizes the objective of Goal 5, which aims for gender equality and the empowerment of women and girls through "universal access to sexual and reproductive health and reproductive rights" (5.6). Lastly, the project aims to support SDG 6, to "achieve access to adequate and equitable sanitation and hygiene for all […], paying special attention to the needs of women and girls and those in vulnerable situations" (6.2), by providing practical sanitation

		advice delivered in the household; strengthening household knowledge and behaviour.

2. Project progress and results

Please use this section to give an update on the progress the project has made during this reporting period.

2.1	Provide an update on the progress your project has made during the reporting period. Use this space to update us on what has gone well and any challenges you have experienced, detailing how you have overcome these. (Max 350 words)
	Over the past six months, the project has continued to successfully deliver safe motherhood activities in Kauma, Chiuzira and Chimbalanga, Lilongwe District. Three new project initiatives have been introduced in Year 2; Water, Sanitation and Hygiene (WASH), referrals for malnutrition, and Volunteer Savings and Loans Associations (VSLA). WASH activities kicked off with training delivered to 136 volunteers and 31 Health Surveillance Assistants (HSAs). Volunteers had limited knowledge of WASH practices before the training, but are now successfully delivering WASH education to households. These messages are welcomed and households are starting to demonstrably change their behaviour, such as erecting hand washing facilities. Volunteer retention is high with only 2/136 volunteers replaced since project commencement. To sustain this engagement, VSLA training was provided to empower volunteers through financial stability. Training was based on a Ministry approved review of VSLA best practice. The groups are active and demonstrating healthy saving and loans practices. Refresher training was provided to 136 volunteers in 'Safe Motherhood' and 'Growth Monitoring and Nutrition training'. Training was tailored to strengthen knowledge gaps identified during field supervision visits, volunteer monthly meetings, and in consultation with health staff. A key area of focus was malnutrition referrals. This is expanded upon in section 2.3 and 5.1. Volunteer household support for safe motherhood continues to be successful; pregnant women are now actively seeking out volunteers to enrol in Safe Motherhood. Health clinics also report an increase in women attending ANC in the first trimester. Male enrolment for safe motherhood has been high, however, there are challenges in sustaining support to men. This is expanded upon in section 2.3 and 5.1. Community meetings were held with 70 Chiefs, across all three sites. The Chiefs outlined initiatives to address project challenges in sustaining male involvement; advising volunteers to report disengaged men so they can follow up with them. Outreach clinics and mini-clinics continue to be held every month across all three sites. These services have been strengthened through collaboration with the NGO Banja la Mtsogolo who provides family planning services.

	Intensive support has been provided to the three Health Advisory Committees established through the project, heralding positive results. These learnings are expanded upon in section 7.
2.2	Have you experienced any delays to planned activities? Provide full details including what action is being taken to bring activities back on track. (Max 350 words)
	The project experienced some delays to activities as a result of political tension in Lilongwe. WASH, VSL, and Growth Monitoring and Nutrition trainings were all delayed by two-three weeks in May 2019 due to tensions which arose before and after the presidential elections. These trainings were successfully re-scheduled, with limited negative impact to the project. Volunteer activities were also mildly affected; volunteers were encouraged to heed local advice and ensure they did not put themselves in danger, however this impacted on their ability to conduct household visits. Household visits by volunteers were rescheduled around local political conflict, and therefore had limited impact to the project overall. Mid-year stakeholder reviews have been delayed by 3 weeks due to key stakeholders from the DHO being engaged in training from another NGO. The stakeholder reviews have been re-scheduled to October, which will bring this activity back on track.
2.3	Are you on track to meet your year-end milestones? Give details of any areas that are behind, and how you plan to overcome this. (Max 350 words)
	We are on-track to meet our year-end milestones, however, there are two key areas of focus which we plan to build on in the next six months. Output Indicator 3.3: The percentage of beneficiaries completing their referral for malnutrition is high, however the number of referrals made by volunteers is much lower than we expected. A referral made by a volunteer for malnutrition has to be confirmed by an HSA, before the individual can be referred to a health clinic. In contrast referrals for antenatal care, safe delivery, or family planning, can be made directly by a volunteer, without HSA confirmation. We have consulted HSAs and volunteers, and established that this additional step in the process has created confusion about when a volunteer should refer. To address this, targeted training was delivered to volunteers during refresher training in 'Growth monitoring and nutrition'. Malnutrition referrals will be an on-going focus during Monthly Meetings with volunteers, to ensure referrals increase. We expect to see an improvement in the number of referrals made in the next 6 months of the project.

	Output Indicator 2.1: The enrolment of expectant and new fathers is much higher than predicted, however after men receive their first education session with their partner, it is difficult to engage them in further sessions with their partner. In the past 6 months we have involved community Chiefs to advocate for male involvement in safe motherhood. Household visits have also been scheduled at the weekend, to reach men back from work, with their partners. This has resulted in men being more willing to engage in the programme, however, meeting both partners together is a significant challenge. We plan to initiate a new strategy to address this, whereby volunteers engage men in safe motherhood sessions even if their partner is not present. As long as the man is learning more about the value of supporting his partner in accordance with Standard Operating Procedures, it is of benefit - even if he is not learning alongside his partner. This should therefore make it easier to engage men in further sessions.

3. Partnerships and collaboration

This section allows you to discuss how partnership working is progressing on the project, as well as wider collaboration and sharing of learning.

3.1	Provide an update on how partnership working has gone during this reporting period, letting us know about any highlights, challenges or changes to roles and responsibilities. (Max 350 words)
	Clear lines of reporting and accountability have been maintained between St John Scotland and St John Malawi, and the partnership is progressing well. Monthly project meetings and weekly activity updates enable progress to be reviewed and operational challenges to be addressed. St John Malawi has strengthened its relationship with the District Health Management Team (DHMT) and District Health Office (DHO) through attendance at three District Executive Committee meetings, where activities were reviewed and progress shared. The involvement of the DHMT and DHO has increased; they have engaged in discussions with volunteers to understand how their office can assist them in delivering their work; Safe Motherhood Coordinators have outlined that they would like to be fully involved in supporting volunteer supervision; and the DHO have assisted in allocating an additional health staff member to Chimbalanga Health Clinic, in order to allow for enough staff to deliver the out-reach clinics. St John Malawi is a member of the Malawi-Scotland Partnership (MaSP). During the reporting period, members of the Ministry of Finance and Economic Planning undertook a supervision visit to our project site in Kauma through MaSP. It was a positive visit where beneficiaries were able to discuss how the programme is helping them, and the role volunteers play in their communities. St John Malawi has a strong relationship with the health centres it partners with. Health clinics have fulfilled their commitments to support outreach clinics

	and utilise the project's referral system. HSAs are supporting volunteers and providing mentorship as they deliver WASH education to households, for example, by delivering demonstrations on how to erect handwashing facilities. Community leaders have engaged in meetings which were held in all the three project sites. During the meetings 70 community Chiefs attended and actively participated. They have been pro-active in advocating on behalf of the project, which was confirmed during monitoring visits. Leaders have also proposed that any issues regarding male involvement be directly reported to them, so that they can also support and encourage men to engage in the project. Lastly, St John Malawi has further strengthened outreach clinic services through collaboration with the NGO Banja la Mtsogolo, which provides family planning services.
3.2	Have any international visits to the project taken place in this period? Give details including key activities and outputs of these visits.
	No international visits have taken place during this period.

Date of visit	**Key achievements / outputs of visit**	**Follow up actions**
N/A	N/A	N/A

4. Safeguarding and Fraud

Please ensure you complete questions 4.1 and 4.2 even if you have no incidents to report.

4.1	Have there been any incidents, relating to the Grant or the Project, in the last reporting period which contravene your safeguarding policy?
	There have been no incidents.
4.2	Have there been any incidents in the last reporting period of financial mismanagement or fraud, relating to the Grant or the Project?
	There have been no incidents.
4.3	Have these incidents been reported to relevant authorities, and if so, to whom?
	N/A

4.4	Describe what action has been taken, and highlight any lessons learned.
	N/A
5. Risk Assessment	
5.1	Have any issues materialised during this reporting period? If so, how will were these addressed?

Assumption	**Risk**	**Action Taken**	**Was this included in your original Risk Assessment Table?**
Men are willing to address and challenge negative gender stereotypes	Medium	1. Held stakeholder discussions to establish reasons. 2. Instigated household visits at the weekend, so that both parents could be taught together at a time when the man was likely to be home. 3. Engaged community Chiefs where the benefits of male involvement were detailed. 4. Instigated a new strategy whereby if volunteers are unable to meet parents at the same time, volunteers will engage the man separately. 5. Agenda point on Monthly Meetings to discuss how to approach men being uncomfortable discussing topics with female volunteers.	Yes
HACs and Chiefs are willing to commit time to training and to improve capacity to sustain functional groups.	Medium	Intensified performance monitoring of the weakest HAC in Kauma; 1. Meetings with individual members. 2. Discussions with the Chairman of the HAC. 3. Reviewing of meeting minutes. 4. Attending HAC meetings. 5. Mediation meeting with the HAC to discuss progress to date, and outline the value of collaboration.	Yes
HACs and Chiefs are able to organise and mobilise resources in an effective and concerted manner	Medium	1. Direct support from St John Malawi with each HAC to shift understanding and attitudes around ‘there is no point in reporting’ by justifying reasons why it is important and to make the most of the platform the project allows.	Yes

for joint decision making with HCs.		2. Intend to discuss these perceptions during project stakeholder review, where HACs and DHO will be in attendance. 3. Integrate this attitudinal change making into refresher training.	
Health clinic staff remain at health clinic for at least one year.	Medium	1. Refresher trainings with health staff on the referral system. 2. Frequent meetings with health clinics by St John Malawi staff to maintain relationship with senior staff, who notify St John Malawi of staff changes and provide an explanation and introduction to the project.	Yes
Referral System	Medium	1. Refresher training with volunteers which included malnutrition referral. 2. Discussion with volunteers during Monthly Supervision. 3. Discussion with HSAs to ensure understanding.	Yes
Political Stability	Medium	1. Project activities were re-scheduled outside of key political time periods. 2. Staff remained aware of political context and planned activities around known rallies.	Yes
Political stability – volunteer safety	Medium	1. Volunteers were advised to heed to local authority advice regarding political unrest. 2. Volunteers were advised to not wear their volunteer uniforms if they were undertaking volunteer work during political unrest, so that they do not stand out from the crowd.	No: focus was on risks to programme as opposed to volunteer risks

6. Financial Information

This section will be reviewed alongside your mid-year budget spreadsheet, which must be included with this report.

6.1	Explain any variances to planned expenditure in this period. (Max 350 words)
	At this stage, all expenditure is as planned according to the Year 2 budget forecast with minimal adjustments outlined below. Mid-year stakeholder review meetings have been delayed to October 2019, therefore this expenditure has been delayed. The purchase of replacement shirts for Volunteer uniforms has also been moved from July to December 2019, to act as a Christmas reward for their hard-work. Expenditure for this activity has therefore also been delayed. Our Year 2 forecast submission, and Year 2 Mid-Term submission are consistent, and variance against the original proposal budget is within reasonable limits and fully justified within the context of project delivery.

6.2	At this stage, does your projected expenditure look to be on track? If not, outline the reasons why, and what plans are in place to bring spending back on track. If you are requesting changes to your budget at this stage, outline them below. (Max 350 words)
	Our spending is on track. The variance in expenditure was anticipated in the Year 2 forecast submission. All project costs for implementation have been spent in line with forecast. Subsistence costs for National staff were included as part of Direct Implementation Costs in our proposal, but are now reported under Subsistence costs for National Staff. We request that the true underspend for Staff Costs, National Salaries of £715.06, and £1.25 from Running Costs In-country, be allocated to support Output 5 to maximise the use of the grant funds provided. There are three reasons we propose this; 1. The costs associated with vehicle use for delivering the Outreach Clinics was higher due to a vehicle breakdown - we had to hire a vehicle. 2. The fuel costs are more than expected because we needed to support Health Staff to get to the outreach clinics from further away, due to staff shortages. 3. The mini-clinics and outreach clinics that we support require a number of small equipment purchases such as weighing scales, which in their absence makes it challenging for the Staff to run fully operational clinics without this.
6.3	Do you have a proposal for how you would like to utilise any of your ring-fenced underspend, excluding any currency gains? (Max 350 words) Our ring-fenced underspend from Y1 is still being utilised towards its intended and agreed purpose, which is the printing of the WASH guidebooks and monitoring tools.

7. Any other Information

Use this section to tell us any other relevant information regarding your project. (Max 350 words)

A fundamental objective of Health Advisory Committees (HACs) is to identify and report issues with health service provision to the relevant authorities, such as the Health Clinic, or to the District Health Office. We found that HACs were successfully identifying these issues, but were not reporting them to the relevant authorities because they felt their voices would not be heard. In some cases, HACs were taking on board the challenge of addressing the issues directly themselves. For example, raising funds locally to fix health clinic buildings.

The proactive nature of the HACs is positive, but advocating for their community and raising issues with the relevant authorities is also an important part of their role. It has taken a lot of direct support from St John Malawi with each HAC to shift understanding and attitudes around reporting of issues, so that their voices can be heard. We have made progress, with HACs reporting issues directly to the health clinic. This is demonstrated through successful achievement of output indicator 6.1.

Reporting issues at higher levels, such as to the DHO is more of a challenge. Acceptance of the contextual situation means HACs anticipate reasons why nothing will be done. For example, drug stock-outs at the clinic reflect broader district, regional and national level stock-outs, therefore HACs feel there is no point in reporting this. However, progress is being made; one HAC has agreed to set up a plan of action outlining who will represent them and visit the DHO's office, where they intend to request the support that their Health Centre needs, but which it currently does not get.

We will seek to make further progress with both HACs and the DHO during stakeholder meetings, where all parties will be in attendance. Here, it will be possible to discuss how issues are managed once raised at the DHO level.