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 logframe 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-003
1.2	**Reporting Year**	From: 01/04/2017 To: 31/03/2018
1.3	**Project Year** (e.g. Year 1)	Year 3
1.4	**Name of Lead Organisation (Grant Holder)***	Christian Aid Scotland
1.5	**Name of Partner(s)***	Foundation for Community Support Services (FOCUS) Malawi Health Equity Network (MHEN)
1.6	**Name of Project***	Increasing Citizen's Demand for Accountability and Transparency for maternal and child health (InCiDAnT)
1.7	**Project Description***	To increase community demand for and participation in accountable, responsive maternal and child health service delivery in Balaka district in Southern Malawi. The project seeks to strengthen health governance within Balaka through empowerment of citizens to hold duty bearers to account for their services they provide. It fosters accountability and transparency ensuring government funds are utilised effectively.
1.8	**Project Country/ Region***	Balaka, Malawi
1.9	**Project Start & End Date***	**Start:** 01/04/2015 **End:** 30/09/2018
1.10	**Total Project Budget***	**£646,148**
1.11	**Total Funding from IDF***	**£600,000**
1.12	**IDF Development Priorities** Please tick the box next to the development priority/priorities that your block grant aims to address	☒ Health ☐ Education ☒ Civic Governance ☐ Sustainable Economic Development ☐ Renewable Energy
1.13	**Supporting Documentation** Check box to confirm key	**Up-to-Date Logical Framework (LF)** ☒ summarising progress against relevant milestones for project activities, outputs, outcomes and

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.			
	documents have been submitted with this report	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.	
		End of Year Financial Report ☒	
		Proposed Revised Budget (if applicable) ☒	
	Please list any further supporting documentation that has been submitted	Other, please detail	
		Reports – submitted with mid-year 3 report District Budget analysis Report Interface report Situation analysis findings paper Policy brief Parliamentarians and MoH Interface meeting with Balaka DHMT, CSOs Report of community budget consultation meeting	
1.14	**Response to Previous Progress Reviews**	**Scottish Government's comments on previous reports (State which):**	**Action taken since received:** **No Cost extension and other planning to catch-up on activities agreed for Year 4**
1.15	**Date report produced**	**30th April 2018**	
1.16	**Name and position of person(s) who compiled this report**	**[REDACTED]** Programme Funding Officer **[REDACTED]**, Global Governance Advisor **[REDACTED]**, Senior Programme Officer, Community Health and HIV **[REDACTED]**, Programme Funding Officer **[REDACTED]**, Global Health Programme Advisor	
1.17	**Main contact details for project, if changed**	**[REDACTED]** is on maternity leave form April 2018. Main contact person between May – Aug 2018 is **[REDACTED]** After August 2018 main contact person is **[REDACTED]**	

Signed by_____[REDACTED] _____
Date____07/06/18_____

Designation on the Project_____

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 relevant to the beneficiaries considering that it builds the capacity of community structures (CAGs, HACs, VDCs, religious and traditional leaders; MAPs, youth, and women groups) in health governance. Community structures have been empowered and are capable of demanding their health rights, better services from service providers apart from fostering accountability and transparency among duty bearers. The project provides a forum to negotiate for national and district level budget increase among key actors (technocrats, Members of Parliament, development partners, CSOs, and community structures) to improve delivery of universal health coverage. This is expected to improve delivery of maternal and child health services to the vulnerable populations, as such no one will be left behind.
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 prioritises gender and social inclusion such that its primary target beneficiaries are women and children who are the most vulnerable. The project activities primarily target women to ensure equal opportunities and access to services, for example, specific groups targeting women (women corner groups). However, to address inequitable socio-cultural norms that are preventing women and other marginalised groups from accessing quality health services, men (through Men as Partners) have been incorporated into the project. The project also ensures that women, youth, people with disability, people living with HIV and the elderly are actively involved in activities in community interventions, as well as lobbying and interface meetings to enable representation of the vulnerable groups The project conducts gender sensitive budget analysis at national and district level to ensure district and national health sector budgets are gender responsive. It's important that women have access to maternal and child health services, however, due to current gender norms this is sometimes not achieved. One of the ways the project achieves this is that it targets men specifically to educate about the benefits to women and the whole family when women are able to access maternal health services. Men are often one of the key barriers to women accessing health care and this way we ensure that women are prioritised to access services.
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?
	The project works directly with community governance structures i.e. Area Development Committees (ADCs) and Village Development Committees (VDCs) Health Centre Advisory Committees (HACs), Community Action Groups (CAGs), DHMT from Balaka District Hospital, CSO's and other stakeholders. Consultative meetings, interface meetings, lobby and advocacy meetings, and review meetings with key players at national, district and community level conducted within the project provide fora for beneficiaries and stakeholders to participate and provide feedback on the project interventions. These fora have enhanced accountability and transparency among duty bearers and strengthened knowledge among citizens on their right to healthcare. Feedback from various stakeholder meetings has contributed to

	adjustment / modification of interventions to meet the needs of the beneficiaries. For example, initially the project didn't include monitoring activities by trained community groups and transportation of community volunteers. These were later included in the project in response to the feedback from community members and other stakeholders. One of the major challenges is unavailability of DHMT members to support some activities due to the policy that no per diems should be paid/ 'Full Board' policy. We have found this policy challenging as per diems are expected by some of the DHMT staff as they are paid by other agencies. This can be a disincentive for them to attend. Christian Aid has decided to implement a new policy that focuses on 'half-board' across all projects and it is hoped that this will overcome this barrier. We therefore plan to ensure that specific sums for lunch, transport and accommodation (where required) should be paid to participants who can then source food, travel and accommodation themselves. This will get over the barrier this policy has created and hopefully will encourage more DHMT officers to attend and participate in more accountability activities.

3. Progress and Results

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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.

The focus of the project has not changed however there has been approval for a no cost 6-month extension which changes the completion date to 30/09/2018. See grant variation letter attached to email which reflects this change.

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.

Result Area/ Indicator	**Proposed/ Approved Change** (please clarify and evidence below)	**Reason for Change**
No Cost Extension	Approved – additional targets and activities to utilise underspend and exchange gains. See grant variation letter dated 9/1/18	No cost extension into year 4
Output 1.4	Community-Based Health Financing (CBHF) or 'health insurance savings schemes': we proposed a change from ***"Number of households accessing health services using community based health financing / community based social insurance scheme"*** to **"Number of households participating in Village Savings and Loans in support of**	As explained in mid-Year 3 report the CBHF has not been rolled out therefore we have changed the budget towards VSLs activity that will support the outcome – SG agreed revised wording of Output Indicator 1.4 in July 2017.

3. Progress and Results			
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		ancillary health related expenses"	
	Output 3.4	"National level Meeting to share Annual Report and best practices with government" [delete "and showcase the Pilot report on Community Based Health Financing" (Note: this Pilot report is no longer relevant as the CBHF scheme did not roll out from Government]	To match with above change this target must also be adjusted as suggested here – there is no report as there was no pilot!
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: *Women and girls have increased awareness and opportunity with reduced socio-cultural barriers to incentivise women and children to access health services*		
	Output Indicator	**Progress against Planned Milestone/ Target**	
	1.1 *60% of women and men reached, demonstrate increased levels of knowledge, attitudes and improved practices related to MCH*	***Milestone Year 3:*** *1, 170 people reached (720 female + 450 male)* *Cumulative: 2,800 people reached (1,900F, 900M)* **Achievements: 8311 people reached (5185 women + 3127 men)** **Cumulative = 26, 571 (13,681F & 12,891M)** **89% of women and 72% of men demonstrate increased knowledge, attitudes and practices on MNCH** A total of 8311 people (5185 women + 3127 men) were reached with messages on MNCH, SRHR, right based approach, accountability and transparency, etc through various groups trained by the project (Training of Trainers, mother groups, Men As Partners, and youth). These were empowered with knowledge and skills to enable them to hold duty bearers to account for MNCH services. The project intensified community sensitization meetings especially on the feedback mechanism that the Ombudsman and District Health Office must use. This led to the high numbers of people reached as this was new and crucial information to disseminate to the communities.	

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.		
		On average 89% of women and 72% of men demonstrated increased knowledge, attitudes and practices on MNCH. 94% and 84% of women; and 76% and 68% men were able to identify danger signs during pregnancy and among new born respectively. The survey also showed that 100% of women interviewed delivered at the health facility during their last pregnancy compared to 87% during the last reporting period. Proportion of men who escorted their spouses to ANC only increased by 1% from 85% to 86%. Through scorecards, dialogue and interface meetings with duty bearers, some change has been noted which will contribute to the improvement in MNCH services uptake, for example, improved attitudes of health care workers, improved working relationship between health advisory committees (HACs) and hospital staff specifically on issues of monitoring drugs, improvement in opening hours for health centres, reduction in drug pilferage at Nandumbo and Ulongwe health facilities.
	1.2 At least 70% of youth reached demonstrate increased levels of knowledge and improved attitude and practices related to sexual and reproductive health and rights (IDF 2.4)	***Milestone Year 3:*** *900 youths reached,* *Cumulative 1910 youths reached* **Achievements:** **1164 Youths (718 Males and 446 females)** ***Cumulative: 7078 (3428F, 3649M) youth reached.*** **76% of youths reached demonstrated an increased level of knowledge, attitudes and practices regarding SRHR.** During the reporting period, there has been a 26% increase in the level of knowledge, attitude, and practices on SRHR ie 49% to 76% among the youth reached. This is due to sensitization meetings that were done in communities facilitated by youth peer educators but also incorporation of sports within the project which enabled more youths to join the youth clubs. A total of 1164 Youths (718 Males and 446 females), 129% against annual target, have been reached with messages on Sexual Reproductive Health Rights, HIV Testing Counselling, Family Planning, maternal and child health and Rights-Based Approach. During this reporting period, 42 youths (20 females and 22 males) from 21 youth clubs, drawn from 3 Youth Networks were trained as peer educators in 3 refresher training sessions. Cumulatively 82 youth clubs consisting of 183 youths (96 female youths and 87 male youths) have been trained in peer education, and these have reached to 7078 (3428F, 3649M) fellow youths. The project embraced sports as a mobilisation tool for youths through "**Protect the Goal Campaign**" by the UNAIDS, which is a global advocacy initiative that harnesses the power of sports to attract people, to bring HIV into the public domain. During the campaign launch sports materials (55 footballs, 55 Netballs, 55 Pumps, 55 Chess boards and 55 Bao boards) were donated to the District Youth Office to assist in mobilising youths to participate in sports and other youth clubs' activities

3. Progress and Results

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	and enable them to access SRHR information. During this campaign, the teams through their captains pledged to spread HIV prevention messages including HTC among their fellow youths, during games. Key people in attendance during the campaign included: District council representatives, DHMT, Malawi Scotland Partnership (MASP) representatives, Christian Aid, partners, Chiefs from the area, youth groups, the media and community members. The youths gave SRHR and HIV prevention messages through drama, poems and traditional dances. The event was published in the weekend Nation Newspaper of 10th June, 2017 and broadcasted on MBC TV and Zodiak radio Station.
1.3 Proportion of men and community leaders (key interlocutors/ opinion leaders) actively involved in enabling women, girls and children to access quality health services (IDF 2.3)	***Milestone Year 3:*** *100 new leaders* *Cumulative:740 community leaders (480 traditional leaders and 50 religious and other leaders)* *50% of the leaders are actively involved in enabling access to quality health services* **Achievements:** **360 new leaders** **(216 Area/ Village Development Committee members (118M, 98F), 72 Traditional Leaders (45M, 27F), 72 religious leaders (52M, 20F)** **Cumulatively: 971 community leaders (576 traditional leaders, and 179 religious leaders)** **66% of men and community leaders were actively involved in enabling women, girls, and children to access quality health services.** There has been 25% increase in participation of men and community leaders in enabling women, girls, and children to access quality health services i.e. from 41% to 66%. The performance has surpassed the annual target by 16%. This has been due to targeted interventions to reach out to men (through Men As Partners) and influential traditional, religious and community leaders but also increased awareness and engagements through dialogue and interface meetings with community leaders and men. 360 community leaders - 216 ADC/VDC members, 72 traditional leaders, 72 religious leaders participated in consultative meetings between the Magistrate and community leaders to finalize the formulation of the bylaws and enact them into laws. 36 Youths (20M, 16F) also participated in these consultative meetings. The bylaws were enacted in March 2018 and all relevant parties signed to certify them as legal. Community leaders and their members are expected to abide the by-laws or else face punishment. The by-laws are providing an enabling environment for women, girls and children to access quality health services. Below are some by-laws pertaining to MNCH certified by the magistrate of Balaka District Council.

By-Law	**Fine**
Every woman to give birth at a health facility.	K5, 000 to be given to the Village Chief K10,000 to be given to the Village Chief

3. Progress and Results

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	<table><tr><td>Delivering at Traditional Birth Attendant</td><td></td></tr><tr><td>Pregnant women to start ANC the moment they realize that they are pregnant</td><td>**K5, 000** to be given to the chiefs committee</td></tr><tr><td>Men to escort their wives for ANC visits and to take care of the mother and the unborn child</td><td>**K10,000** to be given to the chief</td></tr><tr><td>Parents and chiefs should not allow a child who is under 18 to get married</td><td>**K10, 000** to be given to the village chief by parents from both sides.</td></tr><tr><td>Impregnating a child (<18 years) is not allowed. This bylaw is meant for everyone regardless of one's position in society.</td><td>The offender should be reported to the police by the local people under the leadership of the chief.</td></tr><tr><td></td><td></td></tr></table> **2034** men were reached with information on MNCH, Sexual and Reproductive Health and rights, Family Planning, male involvement, Rights based Approach and Male involvement in maternal and child health and also address social norms through Men As Partners. Some improvements have been noted as men are able to support their wives during pregnancy and child birth ie provide transport for ANC, buy items for birth preparedness, but also escort women to ANC. 94 Men as Partners were trained as peer educators in 2 refresher training sessions targeting Kalembo, Ulongwe, Balaka, Nandumbo, and Namanolo Health facilities during this reporting period.
1.4 Number of households participating in Village Savings and Loans in support of ancillary health related expenses	*Milestone year 3:* *10 VSLA providing support of ancillary health related expenses* **Achievements: 15 VSLA groups, 175 VSLA members (70% women)** A total of 175 VSLA members from 15 VSLA groups were trained on leadership, VSLA material, share calculations and share outs in communities surrounding 10 health facilities during this reporting period. The trained VSLAs members are engaged in small scale businesses which help them raise funds for their household utilization and to support their access to health services. Almost 100% of the women and men engaged in VSLAs utilised part of the resources / finances earned through VSLAs for medical support which is in the form of transport, payment of hospital bills (in CHAM / private hospitals), procurement of drugs from private pharmacies when out of stock in government health facilities but also to buy nutritious foods to support recovery.
Output 2: *Communities empowered to demand and actively holding duty bearers accountable for improved quality of services*	
Output Indicator	**Progress against Planned Milestone/ Target**
2.1 Number of local health structures (Village Health	*Milestone Year 3:*

3. Progress and Results		
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	Committees (VHCs), health facility advisory committees (HACs) and community action groups (CAGs) with increased awareness on their roles and supported to actively participate in holding the government transparent and accountable to quality MNCH service provision (voicing the concerns of the local community on MNCH issues) (IDF 2.3)	*Cumulative 270 VHCs. 14 HACs, 14 CAGs (no additional VHCs in target)* **Achievements: 100 VHCs, 2 HACs, 6 CAGs** **Cumulatively, 276 VHCs, 14 HACs and 14 CAGs** **100% have increased awareness knowledge and skills on their role and responsibilities and are holding duty bearers accountable** Cumulatively, the project has oriented 276 Village Health Committees on the use of scorecards consisting of 914 members (290M and 624F). Through the community scorecard sessions that were conducted by VHCs in collaboration with Training Of Trainers and CAGs, the trained VHCs have managed to conduct 20 Community Scorecards and reached out to 593 people (375M and 219 F). The trained VHCs, CAGs, and HACs have been able to hold duty bearers to account for their actions through evidence generated from Scorecards. 100 VHCs - 349 Village Health Committee members (105M and 244F) were oriented on scorecards and their roles and responsibilities, in 10 orientation sessions. VHC members were equipped with knowledge and skills in generating issues and evidence for advocacy and lobbying with the duty bearers but also health rights and governance. 6 CAGs - 75 Community Action Group members (35F and 40M) were trained on Maternal and Child Health, Sexual Reproductive Health and Rights, and demanding accountability through community scorecards in 2 training sessions. The trainings targeted 6 CAGs from the following health facilities, Phimbi, Utale 1 and Utale 2, Kankao, Phalula, and Balaka DHO. Cumulatively 14 CAG have been trained and are participating in community score cards. 68 Training Of Trainers (35 female and 33 male) were trained on use of community scorecard. The training focussed on: Rights-Based Approach to development, Scorecard-the process, how to demand accountability and transparency from duty bearers, and the decentralisation of government. Together with the previously trained TOTs they conducted 20 Community Scorecards and **593** people (375 males and 219 females) participated during the sessions **Challenges** ➢ Community participants are demotivated due to the policy of not paying per diems or daily allowances. They note that the opportunity costs of attending these meetings are high and the cost of providing food and refreshments can be prohibitive. Telephone credit needs to be used and the process of claiming against receipts for minor expenses puts people off (they would rather have the simple daily allowance for food, transport and accommodation that is commonly used in other projects – note this is not a per diem – see above under challenges) ➢ The trained TOTs do not have reliable transportation (bicycles) to enable them to travel and go around their community to support the other trained volunteers

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		which may affect sustainability **Learnings**: ➢ Intensify follow-up visits to the trained TOTs on the practical implementation of Community Score Card in their areas. ➢ Provide bicycles for transportation to volunteers to enhance their motivation. ➢ NOTE: the above recommendations/ learning are incorporated in the new proposal that builds on this work
	2.2 Number of interface meetings held by communities with duty bearers to discuss and prioritize health issues measured through level of community participation in engaging duty bearers (1. assisted to engage duty bearers by partner 2. actively engaging duty bearers without partner support or 3. taking constant initiative to engage duty bearers) (IDF2.5)	*Milestone year 3:* *37 interface meetings (23 at facility level and 14 at TA level)* *5 meetings initiated by partners and 3 meetings initiated by communities themselves* *Cumulative: 71 meetings, 9 meetings supported by partner and 5 community initiated* **Achievements: 27 interface meetings; 7 at TA (initiated by community) and 20 at facility level (initiated by partner)** **Cumulatively: 48 interface meetings (68%), 36 (400%) at facility and initiated by partner; 12 (240%) at T/A, initiated by community** 27 interface meetings were held in 14 health facilities and 7 TA's during the reporting period representing 73% achievement against the annual target. Some other interface meetings were supported by another project ONSE by USAID and so duplication was avoided. This led to 27 rather than 37. Of the 27, 20 were at facility level and initiated by the project, 7 were at community level and initiated by the community. A total of 593 people (375 males and 219 females) attended the interface meetings. These included youths, TOTs, ADCs, VDCs, traditional and religious leaders, women, men, HAC and health workers. Some key issues raised during scorecard sessions were discussed with the DHMT during these interface meetings using participatory approach to find solutions. The community scorecard sessions assessed 9 health standard indicators in all the 14 mentioned health facilities as follows: Availability of drugs and other maternal and child health services (materials) at this facility; Availability of Health Workers at this facility providing maternal and child health services and other general health services; Conduct or attitude of Health Service providers on maternal and child health; Conduct or attitude of Health Service users (community members) on the utilization of the maternal and child health services; Adherence to opening and closing time of the health facilities; Male involvement in ANC, PNC, PMTCT and other MNCH services; Availability of sanitary facilities for Infection prevention (toilets, washrooms and water; Involvement of traditional leaders on maternal and child related activities (ANC, PNC, PMTCT and others); Cultural, traditional and religious beliefs that hinder maternal and child health. Issues identified during scorecard sessions and action points made during interface meetings between health workers and community members are listed in the table below. Project team and community members shall continue following up the issues

3. Progress and Results

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with responsible individuals / offices to ensure they have been resolved.

ISSUE	ACTION POINT
Shortage of staffs	Insufficient funds hence unable to meet its facility requirement
Shortage of drugs	insufficient funds hence unable to meet its facility requirement
Lack of maternity i.e. Namanolo, Chienda, Usiku, kwitanda and Chimatiro	Communities have started fundraising and moulding of bricks. Waiting for Council to assist the construction of the maternity and provide the government standards
Lack of adequate toilets and bathrooms.	Lobby the council to use development funds through councillors
Shortage of staff houses and maintenance	Lobby the council for development funds through councillors.
Poor attitude of health staff	health centres management to take disciplinary action for the offenders of patients/clients
Hospital attendant assisting pregnant women in labour while the nurse is away for her/his personal business (Phimbi)	Hospital attendant warned to follow their job description period. Nurse warned, and advised to be available and refrain from doing personal issues during working hours
Male involvement on Maternal and Child Health (MCH)	Reinforce bylaws ie spouses to escort their wives to ANC, and continuous sensitization needed
No wheel chair to carry a patient to consultation rooms (this problem is in most health centres)	HAC and TOTs to source from NGOs who work within their catchment area
Most CHAM health centre do not have Medical Assistant, Nurses are the one who act as MAs (i.e Utale 1, Kankao)	DHO to follow up with CHAM secretariat to allocate Medical Assistants in health centres.
No access of other services on ART days (i.e. OPD) Health Centres like Namanolo and Chimatiro	The DHMT to look into the matter. Staffing issues are contributing to this; current staff cannot manage both OPD and ART services at the same time.

2.3 Number of commitments secured from state actors by citizens disaggregated by type/significance and as % against number of maternal health issues raised (% DIP commitments

Milestone year 3:
At least 50% of MNCH issues raised by communities, e.g. through ADCs, integrated in District Implementation Plans (DIPs). At least 50% of MCH commitments in Multi-plan successfully implemented
2 issues acted upon or citizen follow up made

Cumulative: 4 issues acted upon or citizen follow up made

Achievements: *80% of issues raised were incorporated in the DIP, and 50% of MNCH issues raised by communities that were incorporated in the DIP were acted upon/ implemented.*

3. Progress and Results

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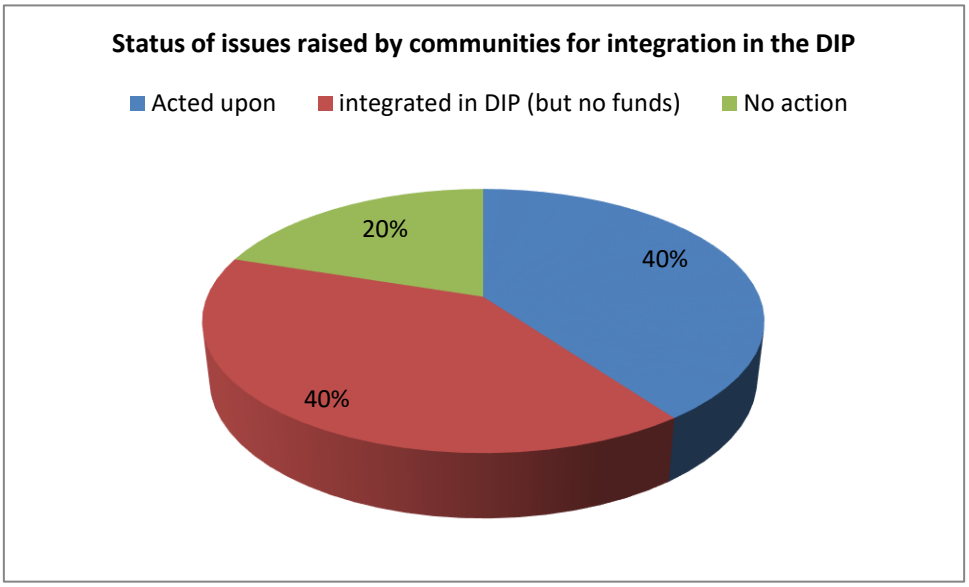
related to maternal health delivery successfully implemented across all the 6 TAs)

2 issues acted upon

Cumulative: 2 issues acted upon

During the reporting period, 80% (4 of the 5) of MNCH issues raised by the community were incorporated in the District Implementation Plan (see table below). Of the 80% of the issues that were incorporated in the DIP 50% (2 of 4) were acted upon. against a target of 50% representing 100% achievement. Below is a chart and table showing distribution of issues and status in more detail. We knew that incorporation in DIP for 2016/17 was no guarantee of implementation due to budget, capital or HR (or other) constraints and this has proved to be the case. Monitoring of the DIP for 2017/18 will be available and included in the final report by end of September 2018.



The issues incorporated in the DIP were generated through consultative meetings between DHMT and community members. Below are details of some major issues identified and their current status.

Issues	Status	Comments
Support towards construction of maternity wings to improve access and uptake of maternal health services	Included in the current DIP	Funds not available
Expansion of Under 5 services to increase coverage. Under 5 services are not offered in some areas	Included in the DIP	Expansions are currently rolling out
Construction of Under 5 shelters,	Not included in	DIP currently under

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services are mostly provided on an open space or under trees which is very difficult during rainy season or hot seasons.	the DIP	review
Shortage of staff and construction of staff houses to contribute to provision of quality health services.	Included in the DIP to lobby for more staff from central level	Government still not recruiting new staff
Unreliable transportation during emergencies: Some hard to reach health facilities need a resident ambulance to support emergency cases.	Included in the DIP to allocate 1 ambulance to either, Phimbi/ Kalembo	Ambulance allocated to Phimbi health facility in November 2017

The project team together with ADCs shall continue following up on issues that the DHMT committed in the DIP to ensure they have really been implemented.

2.4 % increase in client satisfaction with maternal and child health services (family planning, Antenatal Care-ANC, labour and delivery, and postnatal care) received by women and/or children	*Milestone year 3:* *At least 80% of community members reporting satisfaction with MCH services* **Achievements: 95% of community members reporting satisfaction with maternal and child health services** The project has seen 6% increase in client satisfaction with maternal and child health services (family planning, antenatal care, labour and delivery and postnatal care) received by women and / or children i.e. from 89% to 95%. The achievement is 15% higher than the annual target. The increase is probably due to targeted interventions to improve uptake of services in health facilities such as: score cards, interface meetings between community representatives and health facility staff, feedback mechanisms in all health facilities. The frequent interactions between health workers and staff might have contributed to the increase. However, it should be recognized that there are also some other players (NGOs) in the district implementing MNCH interventions (supply side) which may have contributed as well.
2.5 Number of community based best practices and lessons learnt dissemination conferences aimed at sharing lessons and best practices with key MCH stakeholders and learning from the other key stakeholders	*Milestone year 3:* *1 meetings conducted* *Cumulative: 3 meetings conducted* **Achievements: *1 meeting conducted; 5 case studies documented*** **Cumulative: *2 meetings conducted*** 1 meeting conducted, and 5 case studies documented during the reporting period from the INCIDANT project. The case studies shared included: **HACs on drug security**, **Improved sanitation, Community united in the construction of under-five shelter and maternity wing, Male Champion Success story and VSLA as a key to better health.** These case studies were disseminated to the public through print (Nation Newspaper) and radio (Zodiak radio station). The media utilized in sharing these case studies are the most popular and it is believed that those in

3. Progress and Results

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	decision making positions were able to see the message ➢ During this stakeholder meeting ONSE project (USAID funded) working in Balaka also shared lessons learnt from their MNCH project, that mainly focuses on the supply side. The meeting was attended by 21 people (9F, 11 M) and targeted Balaka health stakeholder's forum and DHMT. Other issues discussed were on follow up of issues raised from the previous meetings for example, fundraising for the hospital corridor, solar backup project, water situation for Chiendausiku and Kwitanda, and development of the service Charter. Fundraising team reached out to 4 banks i.e. Standard / National / NBS and FDH, to follow up on feedback ➢ Solar backup quotations for 4 main areas [theatre/laboratory/children's ward] required 3.5 Million kwacha (3,800 pounds). There is need to lobby for more resources ➢ A water pump has been installed for Kwitanda, but one is yet to be installed for Chiendausiku The project team shall continue following up with relevant authorities on the above issues.
Output 3: *Citizens actively engaged in budgetary and accountability processes and influencing the government to increase health financing*	
Output Indicator	**Progress against Planned Milestone/ Target**
3.1 10 Civil Society Organizations trained & supported to improve citizens engagement with good health governance and budget tracking (IDF 2.1)	*Milestone year 3:* *10 CSOs actively engaged in budget tracking and sharing analysis reports regionally and nationally* **Achievements: 10 CSOs actively engaged in budget tracking and analysis at district and national level** Refresher training was conducted for 10 Balaka based CSOs on budget cycle, budget monitoring / tracking and analysis at district and national level. A total 13 people (3 Females, 10 males) participated. The training also included ability to hold authorities /duty bearers accountable and make sure that there is transparency in using public funds. The trained CSOs and CAGs presented the challenges they encountered at community and district level to national authorities. The trained CSOs exposed the inefficiencies within Balaka district council i.e. tracked the gate collections by Balaka district council. The council employees responsible for collecting cash from the bus deport were presenting inadequate cash / very little from the gate collections, about MK100, 000 / month was being deposited into the council account. As part of proving to the council the losses they were making on gate collections, the trained CSOs requested the council to do the collection for one week and they managed to collect over MK1 Million from the gate collections at the bus depot only. The CSOs gave feedback to the district council which was appreciated. However, instead of depositing the monies into the councils account, it was shared right away in the meeting. The CSOs who did the exercise were excluded i.e. did not get the share to do their activities which they usually get

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.		
		funding from the district council. This demoralized them and CSOs have been unwilling to track transparency among duty bearers. The project team will continue to strengthen the capacity of these CSOs to ensure they continue to hold duty bearers accountable CAGs participated in community budget consultative meetings to allow citizenry input to the 2018/19 health sector District Implementation Plan (DIP). The meeting was aimed at providing an opportunity to the trained Community Action Groups and Citizens to participate in community budget consultation. A total of 184 people participated. Main issues discussed during consultations included: ➢ Inability to provide feedback to community members following budget consultations by duty bearers. *"We would like to ask you to give feedback on issues that we have discussed here and ensure us that the issues will be taken into the budget for us as citizens to easily follow up on implementation" Said one Chief.* ➢ Inadequate health care workers, more staff needed but also some available HSAs do not reside within their catchment area. The DHO reassured community members that government will recruit new HSAs from 2018 to 2020 who shall reside in their catchment areas i.e. recruitment shall be community based. In order to reduce workload on health workers, the training for HSAs has been upgraded to enable them to provide some services in absence of the Medical Assistants (MA) ➢ Unavailability of Insecticides Treated Nets (ITNs). It was indicated that distribution is made every five years and processes have already been started however communities were warned on proper use of the ITNs when received. ➢ Construction of under-five clinics to improve access to services for children under the age of 5 years. Plans are under way to construct under-five clinics that will have solar refrigerator and a house for Health Surveillance Assistant. The project staff and some community representatives will be part of the 2018/19 Balaka district implementation plan to lobby for support to incorporate issues raised by the community members in the budget.
	3.2 National and district health budget analysis and tracking results published and disseminated; gender responsive budgeting and spending) (IDF= 2 per year)	*Target year 3:* *1 district specific budget analysis report for Balaka, 1 National budget analysis* *Cumulative: 3 district budget analysis reports, 3 national budget analysis reports* **Achievements:** **1 district specific budget analysis report for Balaka,** **1 national budget analysis report** **[and 1 situational analysis on power outages]** ***Cumulative:*** ***2 district budget analyses reports,***

3. Progress and Results		
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		3 national budget analysis reports The project conducted three budget analyses, namely National health sector budget analysis, Balaka District budget analysis and situational analysis of impact of power outages on National immunization cold rooms attached to emails in Case Studies files (internal CA link HERE) and will be shared on Project Facebook pages. Summary of results from the analyses are presented below: **Notable National level budget analysis identified issues** The Health Sector budget is the 3rd largest vote in terms of allocations, with nearly MK 129 billion, representing over 9.9% of the total budget, up from 8% over 2016/17, though still below 15% of the Abuja Declaration. The approved budget allocation for Balaka district Council was MK 4.82 billion in the 2017/18 FY, representing a 2.7% share of the total 2017/18 CGFT approved budget estimate.The district drug budget allocation from National Budget has remained unchanged at MK10.2 billion since 2016/17 budget. However, the spending rate has generally been good and so the drugs and other supplies have been running low or even running out completely, as compared to the central hospital. This threatens the welfare of poor women and children that mostly depend on free medication provided by public health facilities. **Balaka Health sector implementation Plan analysis** Of the devolved sectors within the district council, the health sector was allocated MK220.61 million (not inclusive of drug, PE and development budget) in the 2017/18 budget representing a 3% increase from the 2016/17 FY. This further represents just over 4% share of the total Balaka District Council allocation. In Balaka MNCH only accounts for 14% share (MK31 million) of the total 2017/18 FY Balaka DHO ORT Budget (MK220.61 million). MNCH services received 18% ceiling cut from treasury, this trickle down to the districts, as such MNCH is among the health areas that this under resourced area **Situational analysis on impact of power outages on immunisation** The project conducted a situational analysis on potency of immunisation in the national cold rooms to establish the effects these may cause among the under five children being immunized using the vaccines. Findings from the situational analysis were as listed below ▸ The country was at risk of losing approximately $13 million, equivalent to 9.5 billion Malawi Kwacha worth of vaccines due to prolonged blackouts. ▸ The cost of running EPI cold room national vaccine store was high as they were being run by a 50KVA generator which supplies power to both the central regional and National Vaccine stores. With the current trend of power outages, the generator utilises at least 2.7 litres per hour and operated for 12 hours per

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		day. Cumulatively, 230 litres are used in a week, costing MK187,611.00. The generators require at least 9 million Kwacha per year against MK 1 million allocated for 2017/18 Fiscal year. If the current trend of power outages persists, on average, 566,530 children are at risk of contracting various illnesses due to pending stock outs of vaccines including vaccine preventable diseases outbreaks such as measles and polio. The analyses reports highlight the potential threats that the poor Malawians, especially the vulnerable groups (women, girls, children, people living with HIV, people with disabilities) may face due to inadequate budget allocations to the health sector. The project used the evidence from these analyses report to lobby with Members of Parliament, minister of health, Minister of Finance and other key stakeholders for more resources allocation into the health sector; and improved electricity supply to the cold rooms i.e. connect to old statehouse in Lilongwe. The project shall continue to generate evidence and use it to advocate for more resource allocation to the health sector
	3.3 Number of lobbying and advocacy meetings (interface meetings) and other fora with duty bearers (including parliamentarians, Ministry of Health, Ministry of Finance and Office of the President and Cabinet officials) based on evidence from the budget analysis and tracking (using national forums for policy advocacy) conducted	*Target year 3:* *2 interface meetings, 1 Policy brief presented to influence priorities during budget process* *Cumulative: 6 interface meetings and 3 position papers* **Achievements:** ***2 interface meetings with MPs and Balaka DHO. 1 Policy brief presented to parliamentary committee on health*** ***Cumulative: 7 interface meetings and 2 position papers*** Following the national and district level evidence gathering the project conducted 2 interface meetings and follow up meetings on identified issues with Ministry of health technocrats, parliamentarians, Minister of health and Minister of finance. A total of 79 people (47M, 25F) attended the interface meetings i.e. 29 parliamentary Committee members (23M,6F), 4 MHEN network members (4M), 9 Journalists (6M, 3F), 5 Balaka DHO staff (2M, 3F), 8 CAGS (3M,5F), 18 Partners/Stakeholders (7M, 311). During these meetings, citizens and project team members requested those in authority to: ▸ Increase budget allocation for health to at least over MK190 billion to meet the recommended 15% as per the Abuja declaration. This will also increase the budget allocations to the districts and eventually improve allocations to MNCH services. ▸ Increase drug budget at national and district level to enable district health offices to maintain the stock of essential drugs throughout the year, for the benefit of the vulnerable groups, but also to cater for the ever-increasing population and increased MNCH needs ▸ Government through MoH should promptly increase the provisions for the Balaka district budgets at Midyear to facilitate an effective actualization of the district implementation plan which are heavily underfunded especially for interventions to do with MNCH services. ▸ Parliament to allocate resources amounting to 5,000,000 to Expanded

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.		
		Programme for Immunization (EPI) to cater for fuel to run the cold room generators for the remaining months of the fiscal year ▸ Government to instruct ESCOM to connect the national cold rooms to a reliable source i.e. Mtunthama state lodge as a long-term solution. **Outcomes and achievements out of the interface and engagement meetings** ▸ The national drug budget was increased by nearly 10% (9.8%) which is MK11.2 billion from the 2017/18 which also led to 9.8% increase in Balaka District Health Office's drug budget ▸ There has been improvement on power supply at the national cold rooms however the project team will continue lobbying for a long-term solution such as installation of solar panels ▸ Project team to follow up together with the trained groups on issues that action hasn't been done yet.
	3.4 MHEN and CA sharing outcomes and lessons learnt with other health stakeholders, CSOs and wider social media networks by end of Year 3 (Target: Annual learning and sharing meeting held; all key briefs/reports shared)	*Target year 3:* **National level Meeting to share Annual Report and best practices** *(this activity carried over from Year 2) and showcase the Pilot report on Community Based Health Financing (Note: this Pilot report is no longer relevant as the CBHF scheme did not roll out from Government]* **Achievements:** **National Level meeting delayed until May 2018** Christian Aid in collaboration with the Reproductive Health Directorate of the Ministry of Health will hold a best practice and lessons learnt dissemination conference for key stakeholders in the sector. The conference in scheduled to take place in May 2018. The meeting is expected to involve Ministry of Health (Reproductive Health Directorate) all district health offices in Malawi and all NGOs working within the MNCH thematic area. During this meeting MOH will share overall national performance on MNCH and MNCH priorities. DHOs will share their performance and how they have been working with partners, while NGOs will share some best practices and lessons learnt from MNCH project implementation in the countries. The meeting is expected to unearth some gaps in provision of quality MNCH services but also highlight issues of priorities within the MNCH. *Additional activities: Christian Aid attended Malawi-Scotland Partnership meeting to share the projects activities and lessons learnt; and is now getting invites from reproductive health unit to attend their stakeholder forums. Christian Aid also presented the health portfolio of which INCIDANT project is part to the Parliamentary committee for health (consist of Members of Parliament (MPs).*
	Output 4: *Government is transparent, responsive and accountable in health resource allocation, setting of*	

3. Progress and Results

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priorities, and service provision at country, district and health facility levels

Output Indicator	Progress against Planned Milestone/ Target
4.1 Number of staff in District Health Office (DHO) and health centres/facilities (HCs/HFs) and data clerks trained in data quality and audit and actively participating in collecting quality data and analysing the data	*Target Year 3:* *70% (25) providing accurate, complete, timely and comprehensive data.* **Achievements:** **60% (21) providing accurate, complete, timely and comprehensive data** 35 data clerks have now been trained on data quality and audit, 60% (21) were actively participating in collecting and analysing quality data. So while the project trained more clerks this year the number actively gathering data dipped to 21. Some key reasons for this and issues affecting data management included: changing roles and transfers of some trained personnel - some staffs trained as data clerks now have other responsibilities and as such they have prioritised those new responsibilities that they were recruited for other than data management; poor attitudes of some coordinators in supporting data management coupled with inadequate capacity; low motivation of some clerks as not supported; inadequate budget with partner and low budgets of DHMT to consistently monitor the data clerks, monthly review and planning meetings with data clerks and other key stakeholder. Data audit showed 51% accuracy and 90% timeliness and completeness Additionally: - the DHMT conducted supportive supervision and mentorship to trained staffs to enhance data quality in OPD, under five and maternity using an inbuilt mobile phone supervisory check list. - MHEN oriented 44 (31M, 13F) programme coordinators, supervisors and health center in-charges on performance and quality improvement (PQI) to ensure effective and continuous provider-initiated monitoring of data on quality MCH services in the district.
4.2 Number of data quality audits conducted at health facilities	*Target year 3:* *4 quarterly data audits conducted* *75% (11) health facilities with improved quality of reports.* **Achievements:** **3 quarterly data audits conducted in all the 14 health facilities** **60% (9) health facilities showed improved quality of reports** 3 data quality audits using the Routine Data Quality Assessment (RDQA) or Lot Quality assessment tool were conducted during the reporting period. The assessment focused on 15 indicators that were randomly selected focusing on Completeness and Accuracy in the Registers (source documents) and hard copies of submitted forms. Of the 14 health facilities in Balaka, 60% (9) showed improved

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.		
		quality of reports. Following the assessments, it was established that Balaka district has a high coverage of all the reporting requirements in regards to Timeliness and Completeness i.e. above 90%. However, accuracy is at 51% on average i.e. ranged from 33% to 69% across the facilities for the data in reporting forms compared to the source registers. The key issues noted were missing registers, incorrect interpretation of the indicators, and counting errors and use of poorly trained personnel. **Proposed Plan of Action to the District** ➢ The DHMT should strengthen the capacity of data clerks to ensure they provide HMIS Office with accurate data which is complete and timely ➢ Regular data review exercises at facility level using random indicators to ensure that the data being submitted is fairly accurate. Also training health facility staff on data utilization ➢ Supportive supervision assisting in identifying data source, indicator definitions and reviewing the data quality are critical towards improving the data submitted. *Although the DHMT committed to take action on issues presented above they have a challenge in financial resources to honour commitments i.e. mostly rely on partners. The project team shall however follow up in extension period to ensure the issues are resolved.*
	4.3 Number of cases addressed at the office as complaints through the complaint channel mechanisms namely, office of the Ombudsman, SMS and toll free mobile phone (IDF 2.2)	*Target year 3:* *56 cases reported and 80% acted upon* *Cumulative: 112 cases* **Achievements:** **46 cases reported using suggestion boxes; 43 (93%) cases resolved;** **Cumulative: 87 cases** [Note: 409 complaints received during sensitisation process for communities to use the complaints process! 2 were referred and 1 remains unresolved – see below]. In total 455 cases reported of which 46 cases were reported through suggestion boxes at facility with another 409 cases reported during sensitization meetings to encourage communities to use the Complaints/ Suggestion Boxes. - Of the 46 cases 29 cases from Health centres and 17 cases from District Hospital. - Of the 46 cases reported through health facilities, 43 (93%) cases were resolved, 2 were referred to the DHO and district council and 1 was unresolved. - The feedback from hospital ombudsman was done through phones or physical. - The project team is following up with the Ombudsman on the status of the 409 cases reported during sensitization meetings. Additionally: The project-oriented health facility in-charges and ombudsman officers on Health Service Charter, Patient charter of rights, rights and duties of Service Providers and supportive care (positive attitude). A total of 42 people (11F, 31M) participated. The training was aimed at building the capacity of Ombudsmen, HAC

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		chairs and DHMT on the feedback mechanism, rights and duties of the patients/ clients, rights and duties of service providers. Conducted supportive supervision and mentorship to 14 people (3F, 11M) to monitor implementation of Patient charter of rights, rights and duties of Service Providers and supportive care (positive attitude). Challenges: ➢ Lack of privacy and confidentiality for clients, since the Ombudsman was sharing an office with other officers ➢ Most of the community members were afraid to complain against Health workers for fear of not been treated well in future. This contributed to reduction in number of cases reported at facility level. Christian Aid is planning to strengthen this activity in the next proposal being submitted on health governance ➢ No data collection tools e.g. register to record case, use improvising of hardcovers. Project team working with DHMT and trained groups to rectify problems. More sensitization meetings on availability of feedback mechanism to be done at community and facility level to enhance knowledge and utilization.
	4.4 Number of health facilities supported to establish feedback/ complaint channel mechanisms including support to improve office of the ombudsman at district hospital (Target: 16 facilities installed with feedback channels (IDF 2.2)	*Milestone year 3:* *14 facilities and communities actively using feedback mechanisms* **Achievements:14 health facilities and its surrounding communities were utilizing feedback mechanism** Feedback mechanism has been established in all the 14 health facilities and surrounding communities in Balaka. The project donated 14 suggestion boxes to all the 14 health facilities in the district and a total of 177 people attended the handover ceremony. The project also distributed 14 phones to enhance reporting of cases to the Ombudsmen in all the targeted health facilities. Community sensitization meetings on the use of feedback mechanism were conducted in Balaka to strengthen reporting of cases following observations that community members were afraid to report cases. During these sensitization meetings community members reported 409 cases using suggestion boxes. **Challenges** ➢ Health workers were not sensitizing the community to present their complaints at their facility, because not all were oriented on the feedback mechanism. ➢ Inadequate knowledge on how to use the information gathered in form of complaints by the community.

3. Progress and Results		
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		➢ There is need for community sensitization on how to use the suggestion boxes and reporting of cases but also introduce the District Ombudsman to communities in the district The project to organize trainings for community members and staffs on feedback mechanism
3.5	**Project Outcomes** 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: *Communities are holding duty bearers to account effectively and barriers to equitable and quality MCH are reduced leading to improved quality and uptake of maternal and child healthcare services.*	
	Outcome Indicator	**Progress against Planned Milestone/ Target**
	1. *Number of people in Balaka who have access to improved essential health services (IDF 4.5) measured through: (a) Proportion of births assisted by a skilled provider increased from 66.6% to 80% by 2018; (b)Proportion of under 1 children completing immunizations increased from 89% to 95% by 2018*	Target Year 3: 1. Skilled deliveries = 80% (16,891 women) 2. Under 1s fully immunized = 95% **Achievements:** 1. Skilled deliveries = 65% (13 731 women) 2. Under 1s fully immunized = 83% District Health records show a total of 13,731 pregnant women were delivered by skilled birth attendants representing a reduction to 65% from 68% in the previous year. The target (80%) set in 2015 in accordance with District Targets was based on a baseline level of 70% skilled birth attendant deliveries and initially the figures seemed promising in Year 1 but years 2 and 3 have seen declining numbers. Factors identified in the District Health Budget analysis, contributing to the low rate, include: inadequate budget allocation to support MNCH services (MNCH among least funded), poor facilities, harmful cultural practices, shortage of staff, and poor attitudes of health workers. It is these factors that are being addressed in this project continuing to September 2018. It is expected that some improvement will result from advocacy and social accountability as well as the by-laws that have been endorsed (see below) to promote MNCH service delivery which includes skilled birth attendance as well as antenatal care. The project shall continue utilising evidence generated through budget analysis and tracking to lobby for more resources to MNCH, but also strengthen feedback mechanism in all the health facilities to address issues of attitudes of health workers to enhance quality of services. The proportion of under 1 children completing immunizations is at 81%, a decrease by 7% from the year 2 and 8% from baseline. Factors that contributed to the decline included: lack of transport to collect vaccines from Blantyre (inadequate vehicles and lack of fuel due to inadequate budget), cancellation of clinics due to inadequate staffing and other logistics to support the activity; overwhelmed HSAs as many NGOs are targeting them sometimes without the knowledge of the DHO; lack of transport to support under-five outreach clinics etc. The project will continue lobbying with MOH and DHO to address the issues of inadequate resources (human and

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		financial). There is need to support the coordination of partners providing MNCH services within Balaka for a better impact.
	2. Number of people who are engaged on advocacy and holding the government to account for citizen's health rights and improved health services and financing (IDF 2.5 adapted)	Target Year 3: 14 communities, 8,400 people (1,080 women & 720 men) (3 new communities this year (1,800 people) **Achievements:** 14 communities, 10,327 people (4101M, 6226F) 71% of men, 45% women and 50% youths are engaged in advocacy for improving citizens health rights The indicator for this Outcome measures the number of communities and people participating in advocacy. These numbers increased during the reporting period from 10 to 14 communities (matching the 14 Health Facilities covered by the project) and a consequent increase in number of people from 5,295 to 10,327 suggesting new social accountability action by members of these community groups as well as more people in those communities already engaged. The rise was 47% among men, from 24% to 71%; 25% among women, from 20% to 45%; and among youth it was at 51%. The increase in various groups would be attributed to the various targeted capacity building interventions which enhanced their skills in holding duty bearers accountable but also demand for quality services. 10,327 people (4101M, 6226F) were engaged on advocacy and holding government to account for health rights and improved health services and finances in communities surrounding the targeted 14 health facilities. Of these, 8,311 (5184F, 3127M) were community members while 1347 people (538M, 819F) were from the trained groups i.e. 42 Ombudsmen, 68 TOTs, 75 CAGs, 349 VHCs, 183 youths, 94 MAPs, 366 women groups, and 180 community leaders. These participated in scorecards sessions, interface meetings, in health sector budget analysis and tracking to generate evidence to advocate for improved health financing but also presenting the issues to the authorities. Most community structures were engaged in scorecards and interface and dialogue meetings to identify gaps and probable solutions to MNCH issues but also ensuring that duty bearers are accountable. Some of the key outcomes from advocacy and lobby meetings included ▪ Increase in drug budget allocation at national and district level following lobby

3. Progress and Results		
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		and advocacy meetings with parliamentarians and MOH authorities. ▪ Trained groups from TA Amidu ➢ Demanded for the upgrade of Mwima dispensary to a health centre, renovations are underway, and the District Health Office committed to send a Medical Assistant and Nurse when completed. ➢ Advocated and sourced funding for construction of an under-five shelter at Namanolo health centre which is almost complete. ▪ Trained group under Phimbi Health Center are currently advocating for an increase in the number of Health Surveillance Assistants (HSAs) in their area. The communities are molding bricks to construct houses for the HSAs so that they can reside close to them. ▪ Chimatiro Health Advisory Committee (HAC) established a fund to address minor problems at the facility without external support, and each HAC member contributes monthly, e.g. batteries to be used for the security guards torch. ▪ Kwitanda Health Centre trained Trainer of Trainers (TOTs), HAC and Community Action Groups (CAGs) advocated and sourced funding for the building of new sanitary facilities. Currently the facilities are operational.
3.6	**Project Impact** In the table below, please list each of your project outcomes, 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: *To contribute towards the achievement of Malawi targets for MDGs 4 and 5 for MNCH outcomes [and Malawi Growth and Development Strategy Key Priority Area 5]*	
	Impact Indicator	**Progress against Planned Milestone/ Target**
	1. *MDG Indicator 5.1: Maternal mortality ratio (Target: 155 per 100,000 live births by 2018)* *Under-fives mortality ratio*	*Target Year 3:* *Maternal mortality ratio of 155 per 100,000 live births; (Target as per Malawi MDG progress report target)* **Achievements: 439 maternal deaths / 100,000 live births** Maternal mortality ratio remains very high though it decreased to 439MDs from 574 maternal deaths per 100,100 live births (2017). Contributing factors to high Maternal Deaths include inadequate budget allocation to the health sector (below 15%) which affected allocation to MNCH interventions, harmful cultural practices but also, improper coordination among partners and donors implementing MNCH services in the country as well as at district level. The project shall continue to advocate for more resources at district and national level, strengthen the reinforcement of by-laws. There is need to support district harmonization coordination committees to minimise duplication of efforts and enhance coordination among MNCH partners in the district. Although the immunization coverage decreased over the project period, under-five mortality ratio decreased from 78/1000 livebirths to 63/1000 live births. Factors contributing to this includes improved delivery of under-five health services with support from most of the donors.
3.7	**Risk Management**	

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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
Lack of per diems is an issue that is constantly being raised.	**No**	Explanation provided to participants however they have always requested for redress.	Stakeholders have been attending the meetings especially when the venue is good (usually expensive though). Though demotivated with the policy, they actively participate during meetings.
High staff turnover rate among partners (MHEN) which affect project implementation	**No**	Use of other staff to cover	Implementation of project activities continuing, and the partner can deliver project outcomes
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.
	Partnerships have remained strong through Year 3 with settled staffing and management arrangements. Roles of all partners have remained the same in the programme with FOCUS playing the key community mobilization role that facilitates social accountability activities plus the training on data quality and data audits, while MHEN manage the budget tracking and budget analysis activities at district and national levels. Christian Aid Malawi manage and coordinate the programme and have engaged in policy and budget advocacy along with MHEN at Parliamentary level. Strong working relationships continue. There is broad agreement between Christian Aid and MHEN that some of the policy and budget advocacy activities at national level should be developed in future. Another area for improvement is the need for coordinated activity with local government and the District Health authorities to ensure local sustainable ownership and capacity development. This has fed into future programme design proposals that will ensure a more coordinated and collaborative approach as well as a better-resourced policy and budget advocacy.
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.
	As intended in the exit strategy formulated in 2015, the project has empowered and mobilised community structures in Balaka and local CSOs in order that they have the capacity and skills on health rights, social accountability, scrutiny of local health facilities and budget advocacy skills. 1,347 people (538M, 819F) from the trained groups i.e. Ombudsmen, TOTs, CAGs, VHCs, youths, MAPs, women groups, and traditional and religious leaders are initiating advocacy initiatives at district level. This demonstrates that community groups are taking the initiatives for themselves in some cases. For some of these groups Year 3 represented the third year of activity while for others this year was the first time they had been active on maternal and child health issues. This variation suggests a need to share learning and disseminate good practice as planned for extension period into Year 4. While many local groups have found their voice and are established and self-reliant, they have some way to go to be able to advocate at national level and they will need to form district-wide groups or networks to support national level advocacy in the absence of FOCUS, MHEN and CA. [Christian Aid and its partners have therefore applied for the new Malawi Development Funding round to scale up and enhance the health governance work in Balaka based on the lessons learnt from this project.] The INCIDANT project has increased knowledge among citizens on health rights, accountability and transparency among service providers but also created a forum for lobbying and advocacy at national and district level. Despite these successes the INCIDANT project has unearthed a significant amount of learning from which to build on in the follow-on project. Observation from the project has shown that some of the trained groups eg CAGs, CSOs on budget analysis and tracking need further support as they are meeting some resistance from those in authorities which demotivates / silences them so that they become inactive. There is need for continued support to ensure they are fully empowered to enable them hold duty bearers accountable for services. Also, the feedback mechanism was mainly established in years 2 and 3 with the SMS based complaints process delayed due to technical issues so most communities are not very conversant with the system hence the need to embed the good practice and further strengthening.

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.
	➢ CSOs and CAGs that have been trained in budget analysis and tracking have begun the process of holding duty bearers accountable. On specific projects the communities have used the social accountability approach to produce tangible gains for their community health facilities. The monitoring and scrutiny process also has raised new concerns and communities are now actively monitoring as per their action plans. ➢ However, there remains a significant divide between knowledge, power and capacity of the community groups and the District Health Authorities. This rebalancing of power will require a further step-up in empowerment and resources (knowledge, position) to happen. ➢ Feedback mechanism to be more effective requires vigorous community mobilization to reduce fears in reporting among community members. There is need for continued efforts to strengthen the feedback mechanism to realize better impact, hence this has also been incorporated in the new proposal. ➢ Although the project provided phones there is need to strengthen the reporting system. This shall be strengthened during the no cost extension period. ➢ Budget analysis continues to underline the lack of accountability or ability to

5.	Learning and Dissemination
	influence national level budgets. This project's learning points to the need to vertically influence and advocate for change from local to national with a more concerted and deliberate strategy.
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.
	Budget tracking and monitoring training of local Community Action Groups by MHEN led to the trained CSOs and CAGs deciding to track revenue collection by the local council, with a view to increasing financial resources for the council to spend on their health needs. They investigated the gate collections at the bus depot in Balaka and noted some inefficiency that was presented to the council authorities as a potential under-collection of monies that could be used to develop the district. After 1 week of the exercise they showed that they could collect over MK1 Million compared to the MK100,000 / month collected by the council staff responsible. A feedback meeting was organized where they proved to the council the loss they were making in gate collections. To their disappointment, the responsible person at council thanked them for the collections and distributed the additional revenues to others at the meeting, rather than considering the health needs presented by the community groups. This behaviour by local council officials demoralised them and some no longer have interest to participate further in the activity. This innovative and positive activity has shown the kind of good practice that the community groups are capable of, along with the kind of mismanagement of revenue collection and unjust behaviour of council officials. The CSOs and CAGs had the knowledge and skills to do budget analysis and tracking, yet they are not yet fully empowered to hold duty bearers accountable. The project plans to highlight these initiatives and the increased level of knowledge on their needs in best practice dissemination in the near future. At these same events the project will highlight the need for sensitization on public accountability for those in local authorities (if meaningful impact is to be realised apart from empowering CSOs and other structures).
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.
	The project shares best practices and lessons learnt through stakeholder's coordination meetings, mass media (radio and print). Also results from the budget analysis are disseminated to members of parliament at national level apart from conducting side meetings with Minister of Finance and Minister of Health. Below are some articles from the project i. https://malawi24.com/2018/03/23/mhen-wants-health-budget-hiked/ ii. https://malawi24.com/2017/11/08/blackouts-killing-malawians-mhen/ iii. https://malawi24.com/2017/08/11/understaffing-rural-hospitals-worries-mhen/ iv. https://malawi24.com/2017/12/31/government-told-address-electricity-problems-hospitals/ v. http://mwnation.com/mhen-demands-extra-k61bn-for-health/ vi. http://www.maravipost.com/mhen-says-blackouts-affecting-health-service-malawi-calls-increased-budgetary-support/ vii. https://www.nyasatimes.com/mhen-bemoans-accountability-gaps-councils-wants-internal-auditors/

5.	Learning and Dissemination
	viii. https://www.malawistar.com/2017/06/02/mhen-suggests-a-budget-increase/ ix. https://www.times.mw/mhen-for-tough-measures-in-cholera-hotspots/ x. https://www.nyasatimes.com/electricity-crisis-underfunding-crippling-malawi-health-sector-mhen/ The project is organizing a national dissemination conference during which the lessons learnt, and best practices are to be shared with various stakeholders, and the forum shall enable other partners including MOH share their lessons and priorities as well. In Scotland the CA team have met with other health-concerned agencies that are currently active in Malawi and discussions on co-learning and sharing best practice have been taken forward.
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.
	The project has a wider influence, for example, the results from budget analysis and lobby meetings conducted with Minister of Finance, Minister of Health, and parliamentary committee for health influenced deliberations in the parliament where national decisions are made. The results influenced an increase in the drug budget although there has been no increase in district drug budget. Local learning and influence with other local projects has taken place. The above-noted ONSE USAID programme shares some of the same aims as INCIDANT and we are learning together Globally this programme helps to provide evidence for advocacy for Universal Health Care and Accountable Governance as per SDGs.

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.
	The project is underspent in 2017/18 by £78,228

Output/ Activity	Reason	£
Implementation all	See below	-61804
Implementation – Output 1	Mixture of overspend on some activities and delayed/ underspend on others - reasons below	£5649

Implementation – Output 2	Some small overspends but a number of big activities delayed	£17834
Implementation – Output 3	A number of big activities delayed	£16412
Implementation – Output 4	A number of small underspends due to activities that could not happen, and a big delayed spend on SMS data gathering system	£1595
MEL	The big delayed activities in MEL are the database-related activities and the EOP evaluation	£20313
In country travel/ subsistence	The delayed end evaluation and visits is the main reason for this underspend/ delayed spend	£3407
International Travel etc	As above	£8063
Running Costs		-£3250
Staff	Slight overspend due to higher salaries than in original budget but still overall within budget	+4472

Delayed Spend:
Some of the underspend was due to delays in implementation of activities. Please note that we expected these activities to take place before March and we did not flag them as expected delayed spend in January.
It should be noted that implementation of some of the activities has already been started in April but too late to be charged against the budget for 2017-18.

The following activities are delayed, and we seek your permission to carry them over into Year 4/ No Cost Extension period:

Output/ Activity	Reason for delay	£
International Travel	International travel was lower than budgeted due to the expected final monitoring/ evaluation trips being delayed into NCE period. This was to coincide with final reporting and due to pregnancy of Scottish Project Manager unable to travel. Clear plans are in place for the final programme visits now taking place between April and September 2018. Request balance be carried over into extension	7899

	period	
Output 1		
Output 1 Activity 1.7	dissemination meeting and development of IEC materials – planning has been done but delays with MoH – due in July	6218
Output 2		
Output 2 Activity 2.8	Service delivery satisfaction survey – done in April 2018	6300
Activity 2.9	Orient 15 journalists from community radios, national print and electronic media - Media event delayed until June to suit better timing,	6672
Output 2	Men as Partners (MAPs) exchange visits – there has been a delay in arranging these - scheduled now to take place before September	3000
Output 3		
Output 3	Cost-effectiveness Study – due to take place ponce budget announced in April and accounts resolved for previous year. This activity has had to be delayed to make it practical over past two years	6702
Output 3 Activity 3.5	Best Practice Dissemination still to take place – will require meetings with Government and that has been delayed see above	6320
Output 4 Activity 4.3	Orient 16 health facility in-charges and ombudsman officer in patient's charter of rights, rights and duties – delays in getting the in-charges together for training – about half-spent – recommend carry-over of balance to allow completion	979
Output 4 Activity 4.4	Complaints mechanism – SMS systems – technical delays in setting up this system has meant some sensitisation could not take place-delayed	2315
Activity 4.2	Quarterly monitoring visits (CA) – delays in expenditure being charged and in organising – recommend we carry over this deficit	707
Activity 4.4	Training of 15 DHMT Members in leadership and supportive supervision (request balance carried over into extension period)	2224
Output 4	End of project evaluation (CA) – delay until near end of extension – requested	9500
Output 4	Monthly follow-up and data collection with trained volunteers – delayed due to delays	3120

	in database finalisation	
Output 4	Quarterly data review meetings with trained volunteers – as above	1676
Output 4	Quarterly case studies' documentation	720
Output 4	Develop project database – delayed	5556
Total	=	69908

Note: we have added these delayed underspends into the Financial Spreadsheet for Year 4 marked in red

Overspend:
Staffing costs were overspent this year due to uplifts in salaries and higher grade of Christian Aid PO for 2017-18 but due to large underspend in Year 1 the overall salary costs are within budget for the three years to March 2018.
Minor overspends on some other activities due to unforeseen costs related to travel and accommodations costs etc

Underspend: there is a balance underspend (minor overspends, minor underspends where activities cannot be carried over and will not now occur) less delayed underspend: 78,228 (Total) – 69,908 (delayed) = £8,320.

06.2	**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.
	The project is cost-effective considering that most interventions are conducted right in communities hence minimal resources required while reaching the targeted beneficiaries. Some activities are integrated just to maximise resources e.g. community sensitization meetings and use of suggestion boxes by community members.
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.
	Christian Aid Scotland has raised Community/ Church Partnerships funds alongside this project. Separate reporting on the benefits of this leverage will be submitted at end of project. The churches have indicated a willingness to support improved mother and baby facilities in health centres in Balaka.

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				
	Baseline	Female	Male	Total	Brief description (e.g. small-holders)

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.

	Data not available	2199	1078	3,267	*These are 42 Ombudsmen, 68 TOTs, 75 CAGs, 349 VHCs, 183 youths, 94 MAPs, 366 women groups, and 180 community leaders, 1,920 VSLA members.*
	State the evidence that supports the progress described				
	These are people directly involved in the project				
1.2	Indicator 1.2 Total number of people indirectly benefitting from the project				
	Baseline	Female	Male	Total	Brief description (e.g. small-holders)
	0	9469	12147	21796	Community benefiting from training by ToT and participating in awareness on feedbacks
	State the evidence that supports the progress described				
	Project data from training events				

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						
	Baseline		Total		Brief description (e.g. paralegal service)		
	Data not available		10 CSO,		The project trained 10 CSOs in advocacy who are actively involved in holding duty bearers accountable in service delivery		
	State the evidence that supports the progress described						
	These have been able to track the budget of Balaka district and use evidence in holding duty bearers accountable.						
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)
	0	0	0		N/A		
	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)		
	Data not available		10 CSOs		These have been trained on health rights, accountability and transparency issues; and score cards		
	State the evidence that supports the progress described						
	They have been able to conduct scorecards, budget tracking and monitoring, and have been able to hold duty bearers accountable for the services they deliver						
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)		
		6226	4101	10,327	These were reached by the trained groups in the project		
	State the evidence that supports the progress described						

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.

	They have shown an increase in knowledge, attitudes and uptake of MNCH services and SRHR					
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)	
	0	*819*	*538*	*1,347*	*These include trained groups i.e. 42 Ombudsmen, 68 TOTs, 75 CAGs, 349 VHCs, 183 youths, 94 MAPs, 366 women groups, and 180 community leaders*	
	State the evidence that supports the progress described					
	The groups are ensuring accountability and transparency is exercised by duty bearers					
	3. 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)	
					Not able to access data Engaging the DHMT to access the data	
	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				Not able to access data, only managed skilled deliveries reported below	
	State the evidence that supports the progress described					
4.3	Indicator 4.3 % births assisted by a skilled provider					
	Baseline		Total		Brief description	
			13,731 (65%)		These are women who delivered in health facilities with assistance from clinicians and nurses	
	State the evidence that supports the progress described					
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)
		13,731		13,531	27262		
	State the evidence that supports the progress described						
	These accessed skilled deliveries and immunizations						
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)
					Not able to access data; following up with		

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.							
					HIMS office		
	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)		
			14 health facilities		13 health centres and 1 district hospital. All health facilities were targeted, and interventions were being conducted in all the facilities		
	State the evidence that supports the progress described						
	Client satisfaction in service delivery has increased i.e. from 80% to 95%						
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)
	Data not available	5185	3127			8311	These were reached by the trained groups (women corner groups, MAPs and youths on MNCH and SRHR
	State the evidence that supports the progress described						

Annex 1: Guidance Notes: End of Year Report

- This report is to be completed by all project managers/leaders at the end of the financial year.
- Please complete this form electronically.
- Once complete please send this reporting form, by email to your Scottish Government project manager.
- The report should be submitted by the end of April following the financial year to which the report relates.

Question	Guidance
Basic Project Information	
1.1	The project reference number was given to you by the Scottish Government in your grant offer letter – please refer to it in all correspondence. This is a number unique to your project and helps the Scottish Government track information relating to your project within the system.
1.2	Insert the financial year for which you are reporting
1.3	Insert the year of your project (i.e. Year 1, 2 or 3)
1.4	Insert the name of your lead organisation responsible for managing the grant (based in Scotland). Please make a note if this has changed during this financial year. Reasons for changes should be reported in section 3.
1.5	Insert the names of your partner organisations in Scotland and Partner countries. Please make a note if this has changed during this financial

	year. Reasons for changes should be reported in section 3.
1.6	Insert the name of your project in the space provided. This should correspond with the name given in your grant offer letter. Please make a note if this has changed during this financial year. Reasons for changes should be reported in section 3.
1.7	Provide a brief project description as per your grant offer letter.
1.8	Insert the geographical area in which your project is being implemented. Please make a note if this has changed during this financial year. Reasons for changes should be reported in section 3.
1.9	Insert start and end dates. The start date is the date you received your first tranche of funding.
1.10	Insert the total project budget (including funding from other sources). Please make a note if this has changed during this financial year. Reasons for changes should be reported in section 3.
1.11	Insert the total amount of funding received through the IDF for this project.
1.12	Indicate the theme that your project addresses (tick as many boxes that apply.)
1.13	Confirm that supporting documentation has been included with your report. Please tick those boxes that apply. Confirm whether any changes have been made to the logical framework, and whether the LF submitted has been approved by the Scottish Government (or is pending approval). **Reports that do not include all required documentation will not be considered complete**.
1.14	Please reference previous (actionable) feedback that you have received in your last MY and EY report and describe any action that has been taken in response/ since then.
1.15	Insert the date that your report was produced.
1.16	Insert the names and positions of the key person(s) involved in preparing your report.
1.17	It is essential that you let us know if any of your contact details have changed, either in Scotland or in Malawi.
Project Relevance	
2.1	Provide a brief update on the context in which your project is working, and describe briefly how your project remains relevant to your project beneficiaries.
2.2	Working towards gender equity and social inclusion is considered essential to any projects funded through the IDF. Please describe briefly how your project is delivering this.
2.3	Please describe briefly how beneficiaries are engaging with the project (if at all) and what effect that is having, as well as any challenges in engaging with them.
Progress and Results	
3.1	If your Project has changed significantly in the focus of its delivery since your last report, please explain how and why, attaching copies of all relevant correspondence you have had with the Scottish Government about this. Please also describe and explain any changes to basic project information here.
3.2	If your Logical Framework has changed over the last Financial Year please detail and explain these here. This enables us to more quickly understand the changes and your progress, based on the most up-to-date information.
3.3	An update on any delays or challenges in monitoring will help us to understand the information presented in the report and logframe.
3.4	**For this question you will need to refer back to your most up-to-date APPROVED logical framework**. Looking again at the *output indicators*

	outlined, please comment on the progress made towards achieving these during the reporting period, including any challenges and how these were overcome. This should include a narrative (where relevant) as well as quantitative data – indicating clearly the milestones (including dates) and progress to date using the same measurement unit (e.g. number/ percentage) provided for the baseline etc. should be outlined using a percentage or number. E.g. By end March 2016, 5 wells have been dug in the last year against a milestone target of 4.
3.5	**For this question you will need to refer back to your most up-to-date APPROVED logical framework**. Looking again at the *outcome indicators* outlined in your original application, please comment on the progress made towards achieving these during the reporting period, including any challenges and how these were overcome.
3.6	**For this question you will need to refer back to your most up-to-date APPROVED logical framework**. Please comment on the overall impact of the project to date, including any challenges and how these were overcome.
3.7	If progress towards delivering activity and outcomes has been slower than planned, please use this space to indicate the reasons why and whether any of the risks outlined in your application have impacted on the project.
Sustainability	
4.1	Provide a brief update on how your partnership is working and evolving.
4.2	Detail briefly your progress towards ensuring that your project will be sustainable in the longer term. We would like you to refer back to your exit strategy in your application form) as well as reflect on other elements of sustainability.
Learning and Dissemination	
5.1	The Scottish Government is very interested to hear of lessons you may have learnt during any aspect of the project and may use your experience in future policy consideration.
5.2	The Scottish Government is very interested to hear of any innovations or examples of best practice, and how projects are sharing good practice more widely.
5.3	The Scottish Government would like to know how the work of the project is being communicated more widely to a range of stakeholders in Scotland and beyond.
5.4	The Scottish Government would like to know if your project (whether intended or unintended) is likely to have an influence on policy.
Financial Reporting	
6	**For this question, you will also need to complete the summary page of the budget spreadsheet**. Please use the budget headings on the spreadsheet to provide a detailed breakdown of actual expenditure incurred during the financial year to which this report relates, against expenditure planned as well as expected expenditure for the next financial year. Please outline any reasons for any discrepancy in the budget spend. *N.B If the budget spend is more than 10% different from the original estimate please use the additional tabs on the budget spreadsheet to provide more detail.*
6.1	It is important for us to understand and learn from how projects budget, including reasons for underspend.
6.2	The Scottish Government is interested in how projects are working efficiently and effectively.
6.3	Please detail if the project has succeeded in sourcing additional funds to enable it to extend its work.

IDF Programme Monitoring	
7	The Scottish Government needs to understand who is being reached by the IDF and how therefore it is essential that projects contribute to programme monitoring.

Annex 2: Budget Spreadsheet Report