Scottish Government Malawi Development Programme

End of Year 1 Report

1. General Project Information		
1.1	**Project Reference Number:**	MAL/18/01 - StJS
1.2	**Name of Organisation:**	St John Scotland
1.3	**Lead Partner(s):**	St John Malawi
1.4	**Project Title:**	Community Action and Service Access for Maternal, Newborn and Child health
1.5	**Reporting Period:**	**From:** 01/10/2018 **To:** 31/03/2019
1.6	**Reporting Year:**	1
1.7	**Project Start date**	01/10/2018
1.8	**Project End date**	31/03/2023
1.9	**Total Project Budget***	£457,590
1.10	**Total Funding from IDF***	£457,590
1.11	Have you made any changes to your logframe? If so please outline proposed changes in the table below. Please note all changes require Scottish Government approval. If changes have already been approved please indicate this in the table.	

Outcome/Output	**Proposed /Agreed Change**	**Reason for Change**	**Date Approved and by whom**
Outcome 1 Indicator 2 Output 3 Indicator 3.3 Output 4 Indicator 4.1 – 4.3	Reallocation of targets from Year 1, to Years 2, 3, 4 and 5. The total number of beneficiaries reached and the outcome targets for the programme will be achieved across 4 years of the project (Years 2-5) instead of 5 (Years 1-5).	There is a typo in our log-frame relating to the delivery of household outreach for common communicable diseases and WASH activities. The log-frame indicates targets in Year 1 for these activities, however common communicable diseases and WASH household outreach will not commence until Year 2.	Discussed during in-person meeting 18/10/2018. Submitted via email 31/10/2018.

1.12	**Supporting Documentation Check box to confirm key documents have been submitted with this report**	**Up to date Logical Framework, which reflects any changes detailed above.**	**x**
		Up to Date Budget Spreadsheet	**x**
		Case Study	**x**
Report Author: [redacted]		**Signature: [redacted]**	

2. Progress and Results	
2.1	Please give an update on the progress your project has made during the reporting period. Please use this space to update us on what has gone well and any challenges you have experienced, detailing how you have overcome these. (Max 500 words)
	The project has successfully kicked off in Kauma, Chiuzira, and Chimbalanga, Lilongwe District, over the first six months. The full support of the District Executive Committee (DEC), District Health Management Team (DHMT), and District Council was secured for project commencement. Initially, consultation meetings were held across project sites with 223 village leaders and 21 local Health Surveillance Assistants (HSAs). These meetings introduced the objectives of the project, sought community buy-in, and identified preferred sites for outreach clinics and mini-clinics. The village leaders saw the project as a great opportunity and enthusiastically mobilised the community. For example, in one site the community pooled resources to construct a latrine for the out-reach clinic to improve accessibility. Health Clinic staff and local leaders from all three sites collaborated to identify and recruit 136 community volunteers. They were trained together with 22 local HSAs in: ‘Safe Motherhood’ and ‘Growth Monitoring and Nutrition for mini-clinic support’ using Standard Operating Procedures validated by the District Health Office (DHO) and developed with the District Environmental Health Officer, Expanded Programme on Immunisation, Community Management of Acute Malnutrition, and Malaria Coordinators. Training in basic First Aid, Fraud, and Safe guarding were also delivered by St John Staff. Monthly meetings between HSAs and volunteers coordinated the work of the volunteers with the health aims of the HSAs, effectively presenting the St John volunteers as a resource to bring health advice into the home.

	Volunteer household support to both women and men has been well received and very successful, effecting demonstrable behaviour change. Specifically, we have identified that the people that our volunteers speak to are taking steps to improve maternal health by accessing the health service more, and preparing their home and finances for a coming baby. Outreach clinics providing ante-natal care and post-natal care were held every month. Local health clinic staff deliver clinical services, while St John volunteers help to mobilise the population, organise the clinic site, and deliver health messages to the attending population. Clinics are being delivered across four locations in Chimbalanga, three in Kauma and three in Chiuzira. Mini-clinics provided growth monitoring and immunisation for under-5's, and were co-hosted by volunteers and HSAs four times per month in Chimbalanga, and once per month in Kauma and Chuizira. Public attendance at these services has been phenomenal – particularly in Chimbalanga. Community leaders reported that services are reaching out to areas where access to health care was impossible before the programme. Area Development Committees (a total of 135 Village Headmen and Area Officers) in Chimbalanga, Kauma and Chuizira were guided to establish Health Advisory Committees (HACs) within their areas. Three HACs were established, each with 15 members, and trained in collaboration with the DHO Health Promotion Department. The HACs have started to identify areas where health services need to be improved; however stronger support will be required in Year 2 so that these needs can be communicated to the right institutions and enacted. Working with the HACs, the project provided practical training on methods to provide friendlier and more patient-centric health care to 25 health staff. Each health clinic has now developed an action plan with commitments to improve punctuality, patient welcoming and the triage process. The HAC will support the DHMT to monitor implementation – which is a first step to building a partnership between the health service and the local community.
2.2	Have you completed all baselines for the project? If not please explain why and describe what plans are in place to ensure these are completed. If you have please ensure these have been added into your logframe. (Max 200 words)
	All baselines have been completed and added to the log-frame. Several baseline results differed from the national demographic health survey (DHS) statistics and previous 2015 baseline data used in the log frame proposal. These include; • Impact Indicator 1: The District MMR is much lower than the national average due to maternal health interventions in Lilongwe District. How-ever these interventions do not directly support St John Malawi's project sites, which were recommended by the District Health Office as areas

	with particularly poor maternal health outcomes. It is not possible to obtain accurate site level MMR, as the intervention impact will be affected by those cases referred outside of the area of intervention. • Output Indicator 1.2: The baseline is higher than DHS statistics. Isolation and poverty levels in Chimbalanga make breastfeeding the most available option. • Output Indicator 1.3: The baseline is higher than DHS statistics due to presence of Family Planning Association Malawi. • Output Indicator 2.2: The baseline is significantly lower than 2015 baseline as new project areas of intervention include more rural communities. At this stage, we do not wish to propose any amendments to log-frame targets in reaction to variance in baseline data. We suggest that targets are reviewed alongside baseline and achievements at the end of Year 2, when clearer measures of project impact have been established.
2.3	Have you experienced any delays to planned activities? Please provide full details including what action is being taken to bring activities back on track. (Max 250 words)
	The printing of the WASH guidebook under Output 4, has been delayed as a consequence of the necessity for DHO validation of the guidebook. To bring this back on track, procurement processes for printing have already been put in place, so that the guidebook can be printed immediately once it is completed by April 18th. The curriculum and draft guidebook have already been developed and shared with the WASH trainers. The guidebook will be printed and available in time to allow delivery of the WASH training in Year 2. The Health Advisory Committees (HACs) were formed later than planned, delaying the HAC training in Year 1. The establishment of HACs involved significant consultation and coordination with Area Development Committees, District Health Departments, Health Clinic in-charge, and Traditional Authorities. It was fundamental that the selection process for HAC members be driven by these bodies. This took time – especially in Chimbalanga, where the existing defunct group had to be sensitively dissolved, and selection of new members undertaken against the new expectations of HAC responsibilities. There is a lesson about the importance of allowing the correct process to run its course, and the time that this can take, that has been learnt. As a consequence the HACs had less time to carry out their role in Year 1 after training. To bring activities back on track, monthly guidance will be provided to the HACs during their monthly meetings, to support the HAC to identify key stakeholders and institutions for which they can mobilise support to make changes to improve health services.

2.4 **Project Outcomes**

In the table below, please list each of your project Outcomes, 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 (for example where targets have been vastly exceeded). Progress should also be updated within the relevant fields of your logframe.

Outcome: **Increased healthy practices and demand for key maternal, new-born and child health services**

Outcome Indicator	**Milestone / Achievement**	**Progress**
1.1 % of pregnant women attending ante-natal care in the first trimester of their pregnancy	26%/38%	End of Year Survey results indicate that for the pregnant women enrolled in the project and surveyed, 38% attended ANC in their first trimester. This is a significant improvement from the baseline of 16% and exceeds the project target for Year 1. Attending ANC in the first trimester is a particular challenge for women - especially in Chimbalanga - due to strong cultural pressure against disclosing pregnancy in the first trimester. One of the reasons for the immediate improvements recognised in the project is the strong advocacy from Village Chiefs, who have the influence needed to directly challenge this misconception. In addition, St John volunteers continue to educate and engage women and other influential community members through household visits, community health education campaigns and quarterly community leaders meetings, on the dangers these cultural practices have on pregnant women, and how they can negatively affect the health and well-being of the unborn baby.
1.2 % of households reporting incidents of diarrhoeal disease for under 5's in the last 2 weeks	[Year 2]	[Year 2]

	Outcome: **Increased access to Malawi's Essential Health Package (EHP)**		
	Outcome Indicator	**Milestone / Achievement**	**Progress**
	2.1 % of beneficiaries in remote areas reporting increased use of health facilities in the past 12 months (disaggregated by gender)	60%/28% (14%M:32%F)	End of Year Survey results indicate that across the enrolled men, pregnant women and new mothers surveyed in the project, 28% reported using health facilities more in the last 6 months compared to before the project started. However, cross-correlating this figure with qualitative feedback and other quantitative performance data demonstrates a more positive result: • There has been a vast increase in accessibility of services through the introduction of mini-clinics and outreach clinic, with high utilisation of these services demonstrated through outcome 2.2. • Feedback from Chimbalanga Health Clinic staff indicates an increase in client attendance at the Health Clinic. • Feedback from stakeholder meetings indicates significant improvements in the number of men and women who seek health services after household visits from volunteers. It is our expectation that if 28% of beneficiaries report increased use of health facilities within 6 months, then this result will double over the course of 12 months to 56%, bringing it more in-line with logframe targets. We suggest that this indicator is reviewed at the end of Year 2, when clearer measures of project impact have been established.
	2.2 Number of people being reached by clinical outreach services in remote areas (disaggregated by gender	866/9412 (3318M:6094F)	The number of new beneficiaries attending outreach clinics and mini-clinics has far exceeded expectation. There are a number of reasons for this: • An additional outreach clinic was introduced in Chimbalanga, compared to the original proposal.

			• Volunteers were able to assess far more beneficiaries for growth monitoring during mini-clinics than expected. • The project counts the number of people being reached as any individual who is using the clinic for the first time. Thereafter they are logged as a repeat user. As the project progresses, we anticipate the number of new beneficiaries served by outreach clinics will fall more in-line with targets. This is because there's a limited population within the sites of intervention. For the initial outreach and mini-clinics, anyone who attends the clinic is a new beneficiary. As more people attend the clinic over time, there are fewer people left in the population who are attending the clinic as a new beneficiary. A saturation point is reached, where all members of the population have been counted as a new beneficiary, and there are no more new beneficiaries in the population to be served. So, even though our service delivery continues, our impact on this indicator will gradually reduce. We know this indicator cannot stand like this for 4 years, as the achievement will decrease as we succeed. We suggest that this indicator is reviewed at the end of Year 2, when clearer measures of project impact have been established.
	Outcome: **Stronger collaboration and accountability for better health outcomes and sustainability**		
	Outcome Indicator	**Milestone / Achievement**	**Progress**
	3.1 % of Health Advisory Committee members and Chiefs reporting increased	50%/66%	Prior to project commencement, the Health Advisory Committees were defunct and had no training. Their functionality was therefore incredibly low. The re-establishment of Health Advisory Committees to recommended Ministry of

	functionality of Health Advisory Committees		Health standards, and the provision of HAC training, has greatly increased understanding of responsibilities and expectations on HAC members. Community leaders were also oriented on the health responsibilities of the HAC. This served to enhance accountability of the HAC amongst their peers, thus improving functionality. Ministry of Health HAC self-assessments were conducted with each HAC member. The assessments enable the HAC to track their progress and performance over time, ensuring sustainable self-governance. The results for this indicator reflect self-assessments for Chimbalanga and Chuizira. Kauma HAC were unable to undertake the self-assessment as their Chairman became ill. As the HAC is self-run, we cannot dictate the terms of the meeting, therefore it has been re-scheduled.
2.5	**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 also be updated within the logframe		
	Output: **Pregnant women and new mothers are trained and educated on early and frequent ante-natal care, safe delivery, post-natal care for mother and baby, and family planning**		
	Output Indicator	**Milestone / Achievement**	**Progress**
	1.1 Number of pregnant women and new mothers enrolled in safe motherhood household outreach programme	646/1144	Volunteers worked in pairs to conduct household visits across all three sites. More women were enrolled than anticipated because community members in Chimbalanga were extremely responsive and demonstrated high demand for support from local volunteers. The project is perceived as a great opportunity by local leaders and the community.
	1.2 % of new mothers who exclusively	40%/N/A	The End of Year survey of new mothers enrolled onto the project identified that all infants were younger than 6 months old. It

	breastfeed their child for at least 6 months		is therefore not possible to report on this indicator until the infants are over 6 months. In year 2, the timeframe between enrolment and the End of Year survey will be over one year. Results for this indicator will therefore be recorded in Year 2.
	1.3 % of new mothers who are currently using a method of family planning	65%/80%	80% of new mothers surveyed, who were enrolled and educated on family planning chose to take up family planning services available to them in the area. This represents an increase compared to baseline data and exceeds the project target. Volunteers have strengthened the importance of modern family planning services during community sensitisation meetings. More women are comfortable accessing family planning methods. Combined with more accessible family planning through outreach clinics, this target has been greatly exceeded. The End of Year Survey, also indicated that the most popular methods of family planning were injectables and the pill. These methods require frequent renewal from health service providers, which is supported through the project's family planning services at outreach clinics.
	Output: **Expectant fathers and new fathers are trained and educated on their role in supporting maternal, newborn and child health for their partner and child**		
	Output Indicator	**Milestone / Achievement**	**Progress**
	2.1 Number of men enrolled in maternal, newborn and child health outreach education programme for men	72/75	It is more difficult to reach men in the project because the main income generating activity is farming, which draws men away from the household during the day. To address this, monthly plans are established with volunteers, to find mechanisms of engaging men, so that they take part in safe motherhood activities.

			Local leaders have also advocated strongly for men to enrol in the project, making announcements at every gathering and informing men whose wives are pregnant to meet with a volunteer for health education. Community leaders in Chimbalanga have agreed to hold quarterly meetings with men in their respective communities to look at new ways of bringing in more men and disseminating the messages of male involvement together with the HSAs so that all pregnant women and their spouses receive health education together in all ANC visits. So far strong progress has been made.
	2.2 % of enrolled men who can identify and explain (a) three key issues affecting health of mothers and children and (b) three actions they can do to support their wife/partner	70%/93%	Baseline data demonstrated that only 2% of men surveyed could identify 3 key issues for questions 'a' and 'b'. After receiving one on one support from volunteers, nearly all men knew what health issues may affect their wife or infant, and what actions they can do to support them. Health Centre staff have reported that more ANC visits are being attended by pregnant women and their spouses compared to before the project started. Those who attend report being encouraged to do so by male volunteers during household visits.
	Output: **Community-to-Health Centre referral systems are operationalised for pregnant women, new mothers with infants, and under 5's who are obviously ill or undernourished.**		
	Output Indicator	**Milestone / Achievement**	**Progress**
	3.1 % of pregnant women completing referrals for ante-natal care and safe delivery	70%/ 51% ANC referral uptake, 2% safe delivery referral uptake	We encountered three key challenges in reaching this output. Firstly our referral system incorporated referrals to health clinics, but did not include outreach clinics. Beneficiaries taking their referral forms to outreach clinics, were not counted. This issue has

			now been addressed by ensuring the referral system is also established at outreach clinics. Secondly, a large proportion of beneficiaries did not take the referral form with them to their consultation after being referred by a volunteer. We know this as volunteers have provided a referral, and followed-up with the beneficiary to ask whether they attended the appointment. It is possible to validate the beneficiaries response through their Health Passport, which shows they have been to the clinic. To address this, volunteers collaborated with community leaders to encourage and sensitize community members on why they are being given referral forms and the significance of taking the referrals with them when they visit the health clinic. Lastly, a number of safe delivery referrals haven't been taken up as Pregnant Women enrolled in the project who have been issued with a referral, have not yet delivered. Therefore, it is not that the referrals have been ignored, but the referrals have not yet needed to be used. Although progress towards achieving this indicator has been slow, we are confident that as the communities become accustomed to the referral process used by the volunteers, this will improve.
	3.2 % of new mothers completing referrals for family planning	70%/3%	Progress towards this indicator is based on the same referral system as above and can therefore be explained in the same way.
	3.3 % of under 5's completing referrals due to ill-health or malnourishment	[Year 2]	[Year 2]
	Output: **Households are educated and supported to prevent common communicable diseases and improve current water, sanitation and hygiene conditions and practices**		

	Output Indicator	Milestone / Achievement	Progress
	4.1 Number of household members receiving education on the prevention of common communicable disease and water, sanitation and hygiene (disaggregated by gender)	[Year 2]	[Year 2]
	4.2 Number of household water, sanitation and hygiene action reports produced by volunteers in collaboration with households	[Year 2]	[Year 2]
	4.3 % of household water, sanitation and hygiene action report recommendations fulfilled by households	[Year 2]	[Year 2]
	Output: **Service users are reached with health services in zones far from health facilities**		
	Output Indicator	**Milestone / Achievement**	**Progress**
	5.1 Number of pregnant women attending mobile outreach clinics for ante-natal care	335/282	Ante-natal care forms part of service delivery during comprehensive and ANC-specific outreach clinics. Overall, outreach clinics are extremely well attended. However, ANC attendance was lower than expected. One of the reasons for this is that there were challenges using the monitoring system for the first time. We immediately learned from this and were able to address the challenges before subsequent clinics. However, as a result we were not able to include data from the first clinics into our results. Given the existing performance, had this data been

			incorporated, the milestone would have been met.
	5.2 Number of women attending mobile outreach clinics for family planning	296/864	The high uptake of family planning can be explained by the increased availability of family planning methods at outreach clinics in conjunction with the education on options for family planning delivered to new mothers at the household.
	5.3 Number of under 5's attending mini-clinics providing vaccination and growth monitoring services (disaggregated by gender)	315/3179 (1552M:1627F)	The project counts mini-clinic beneficiaries in the same way that it counts outreach clinic beneficiaries. Therefore an individual using the clinic for the first time is counted as a beneficiary. Thereafter they are logged as a repeat user. In the same way that new beneficiary attendance at outreach clinics is high at the beginning and will slow until a saturation point is reached, so too is new beneficiary attendance at mini-clinics.
	Output: **Strengthened capacity of Health Advisory Committees to represent community health concerns/priorities to Health Centres and the District Health Office and advocate for change**		
	Output Indicator	**Milestone / Achievement**	**Progress**
	6.1 Number of occasions that local Health Advisory Committees raise community health needs and priorities with relevant health authorities and service providers	6/0	Health Advisory Committees took longer to form than anticipated. As a result, there was a shorter period of time in which to raise community health needs. HAC support meetings have demonstrated that a number of issues have already been identified by the HACs to address, such as poor infrastructure at the health centre. Progress has therefore been made towards achieving this indicator. The next step is to take these issues to the relevant institutions and ensure that they are addressed. Support to HACs in Year 2 has been increased, so that they are better able to take action. Stakeholder review meetings also created an opportunity for committee roles and responsibilities to be shared. Community members were informed that they can

			approach the HAC with issues that concern the health centre.
	6.2 Number of Health Centre staff trained in patient-centred services (disaggregated by gender)	12/25 (7M:18F)	The number of people trained has doubled because advice from the district nursing officer stated that if less than 20% of members of staff were trained per each facility, it would be difficult to bring about meaningful change. Each trained staff member will mentor colleagues to improve services. After the training, each health centre developed an action plan to introduce a register to improve punctuality, improve patient's reception and triaging. The HAC will support the DHMT to ensure that the action plans are followed.
3. Operational plans and partnerships			
3.1	Are all staff required to deliver the project now in place? If not, please explain what action you are taking to ensure all essential roles as outlined in your application, are in place as you move into year two of the project. If plans for staffing has changed, please tell us about this. (Max 200 words)		
	All staff required to deliver the project are now in place. Two staff were recruited; Chimbalanga Field Officer and an Accounts Assistant. A driver was also recruited to support the project, funded by St John International.		
3.2	Are all partnerships on the project now in place? Please update on how these partnerships are progressing, letting us know about any highlights, challenges or changes to roles and responsibilities. (Max 300 words)		
	Clear lines of reporting and accountability have been established between St John Scotland and St John Malawi, and the partnership is progressing well. St John Scotland has been able to support better communication and strengthen project management in St John Malawi through the development of project management tools with RAG-ratings to clearly articulate project progress i.e. Work-plan, Budget Follow-up and MEL tools. Monthly project meetings and weekly activity updates enabled progress to be reviewed and operational challenges to be addressed. St John Malawi has strengthened its relationship with the District Health Management Team (DHMT) and District Health Office (DHO) through collaboration in the delivery of project activities. The DHMT have provided technical support to develop and review volunteer training curriculums, sourced Ministry of Health trainers for volunteer training, and loaned a		

vehicle when St John Malawi's vehicle had broken down. The DHMT receive monthly updates and are very engaged in project activities.

St John Malawi has a strong relationship with the health centres it partners with. The provision of material support to the clinic and delivery of Patient Friendly Services training has greatly motivated staff. Health clinics have fulfilled their commitments to support outreach clinics and adopted the project's referral system. HSAs liaise with Health Clinic staff and meet monthly with volunteers to organise household outreach and support. To maintain this relationship, quarterly meetings will be held with health staff and HSAs to provide a forum for feedback and learning.

The support from local leaders has been invaluable to the acceptance of volunteer household outreach within their communities. Local leaders have recognised the potential benefits of the project and have used their influence as chiefs to engage the community. They have also created by-laws which advocate for greater male involvement in safe motherhood and are working towards improving site locations for outreach clinics.

3.3 Have any visits to the project taken place in this period? Please give details including key activities and outputs of these visits.

Date of Visit	Key achievements / outputs of visit	Follow up actions
02/02/19 – 09/02/19	• St John Scotland better understand the operational context for St John Malawi, progress, constraints and contextual risks in the delivery of the Scottish Government funded project. • Detailed review of progress in "Community action and access for maternal, newborn and child health" against updated workplan, budget and logframe achievements. • Review of Monitoring, Evaluation and Learning processes for project monitoring and project management. • Development of strategies for strengthening project implementation. • Chimbalanga field visit accompanying volunteers in their work, visit to health	Meeting with WaterAid to discuss WASH approach and potential collaboration for WASH Guidebook. Develop funding request for bicycles for volunteers to reduce burden of walking long distances. Year 2 work plan and budget forecast finalisation. Implement MEL health-review actions into project.

		centre, meeting local chiefs and HAC. • Hosting of Scottish Government International Development team field visit to Kauma. • MaSP partner meeting: partners well aware of St John Malawi's work, and see St John Malawi as an important partner. • Review Year 2 work plan and budget forecast.	Integrate MEL tool improvements into Year 2 roll out.

4. Financial Information

This section will be reviewed alongside your end of year financial report, which must be included with this report. Please ensure an explanation for any variance to planned expenditure is provided against each budget line in the space provided in the budget spreadsheet.

4.1	If your spending is not on track as expected, please outline the reasons why, and detail what plans are in place to bring spending back on track. If you are requesting changes to your budget at this stage, please outline them below. (Max 350 words)
	Our spending is on track. The variance in expenditure was anticipated in the budget forecast. Direct project costs for implementation have been fully spent; the exception is the delayed spend for the printing of the WASH Guidebook. Subsistence costs for National staff were included as part of Direct Implementation Costs in our proposal, but are now reported under subsistence for national staff. We request the delayed spend of £2062.64 for the WASH Guidebook printing, under Output 4, to be carried forward into Year 2. Once this is carried forward, the grant for Year 1 will be fully expended.

5. Any other Information

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

St John Malawi project volunteers are incredibly dedicated to their work. As such, they walk up to 7km a day, three times a week, on rugged off-road terrain to identify pregnant women and new mothers, and support them to achieve safe motherhood. When discussing their role during an in-country visit by the Malawi Development Officer in February 2019, the volunteers suggested that they be facilitated in their roles through the provision of bicycles. This would greatly benefit the programme and the volunteers in several ways.

A proposal for support has been submitted to the International Development team. We understand that any available funds are focused on supporting relief efforts to address the recent and devastating flooding in South East Africa,

including Malawi. However, if any unallocated funding does becomes available, we are still pursuing this avenue of support.