Scottish Government Malawi Development Programme

End of Year 1 Report

1.	General Project Information	
1.1	**Project Reference Number:**	MAL/18/03
1.2	**Name of Organisation:**	University of Edinburgh
1.3	**Lead Partner(s):**	Nkhoma Hospital
1.4	**Project Title:**	Moving towards sustainability: strengthening rural health facilities, upskilling providers and developing mentoring capacity to support roll-out of cervical cancer 'screen and treat' services across Malawi.
1.5	**Reporting Period:**	**From:** 01/10/2018 **To:** 31/03/2019
1.6	**Reporting Year:**	Year 1
1.7	**Project Start date**	01/10/2018
1.8	**Project End date**	31/03/2023
1.9	**Total Project Budget***	£1,459,178
1.10	**Total Funding from IDF***	£1,288,378
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
All	Entire Log Frame revised with guidance from Corra	Provide higher-level Impacts, and revise wording of Outcomes to strip back to actual numbers.	Revision submitted to Scottish Government on 06/11/18 following the approval of Corra.
Mulanje MH component	Mulanje MH component is being re-profiled – activities planned for four health centres/ post to be re-distributed to other partners	Mulanje MH have chosen not to accept a subcontract (see below)	Ongoing decision-making with in-country discussions, detailed plans to be shared and approval sought from Scottish Government

1.12		**Up to date Logical Framework, which reflects any changes detailed above.**	X

	Supporting Documentation Check box to confirm key documents have been submitted with this report	**Up to Date Budget Spreadsheet**	**X**
		Appendix 1: March 2019 VIATRAINING/ WORKSHOP REPORT	**X**
		Appendix 2: Reports from newly trained providers	**X**
		Appendix 3: December 2018 visit – report of Project meeting/ Mentoring workshop	**X**
		Appendix 4: March 2019 visit – reports of Database and Safeguarding meetings	**X**
		Appendix 5: Intellectual Property(explanatory statement submitted to partners with subcontract)	**X**
		Appendix 6: Case studies in the value of partnership	**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)

Establishing Teams and Roles:

i. We have had regular / monthly Skype meetings with our lead partner Nkhoma Hospital; and face-to-face meetings when in-country.
ii. Contract with Lead Partner has been signed; and partner Collaboration Agreements have been signed by five partner Hubs.
iii. Measures for financial management and reporting are in place (i.e. due diligence checks in process, invoicing and reporting templates).
iv. Lead persons in the 5 partner Hubs are being identified,
v. Lead and partner processes have been approved for database hosting and data collection (using REDCap)
vi. A project Safeguarding policy has been developed.

Year 1 Project meetings and Workshop:

i. The 1st project meeting /mentoring workshop was held in Mponela from 10th -12th December, with all partners represented.
   - Introduction: Bringing all relevant Hub staff together to get to know one another, Nkhoma shared experience of initial project
   - Project planning: discussions regarding contracts and collaborative agreements, finances and invoicing, current provision across partner areas, etc.
   - Agreement to set up data management and Safeguarding working groups
   - Development of first draft of the Mentoring toolkit – full day of small group work to develop and share best practice across essential

  - elements of service provision, used to draft a three-page Mentoring framework, for field-testing over following four – six months by partners
  - CPD session led by [Redacted] – VIA discrimination, staging, treatment

ii. A second visit was undertaken in late January / early February to progress the Database and Safeguarding Working Groups :
  - Data management system – following the exploration of options with in-country database experts, REDCap was selected, and a cervical screening-specific module developed with SOPs for data entry and data extraction/ reporting. The module is being hosted by University of Malawi Polytechnic.
  - Safeguarding policy – the working group developed a draft policy: this is now undergoing final review by the Ministry of Health, partners, and civil society organisations

Planning ahead:

i. Establishing a programme of mentoring and local 'screen and treat' educational programmes

ii. Identifying April visit requirements

Engaging with others:

i. We are represented on National Cervical Cancer Technical Working Group

ii. Discussions with service delivery and research partners in Malawi regarding complementary working

What has gone well:

i. The willingness to fully engage and add value partnership –including sharing of experiential training (see below)

Challenges:

i. Finding the best data management system: DHSII (mentioned in the application) is a reporting system that provides summary data; Baobab health data system used within some facilities in Malawi was judged inflexible (in terms of what our Project needs) and also expensive. REDCap has been chosen as it is a longitudinal dataset, used in Malawi for large-scale clinical projects, and with a free licence for LMIC contexts.

ii. Mulanje Mission Hospital communicated to the Project leads on 7th February 2019 that they had concerns about entering into a subcontract with Nkhoma Hospital for the project. Despite face-to-face meetings and email dialogue to find an acceptable solution they further indicated on 29th March 2019 that they would not sign the subcontract and are withdrawing from the project. See Section 5 below for more detail.

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)

The Baseline is nearing completion and all areas are included in the LogFrame.

Positive updates: Our starting point was the overall national coverage of 30% (as presented at the 2018 National Cervical Screening Programme meeting). Hub partners have been working hard to link their own numbers of women who have undertaken an initial screen in 2017 and 2018 to the number of eligible women in their catchment area. Drilling down to Hub level, our data shows great variability and we're in the process of finalising the data for each of our 5 Hub areas, but likely to be in region of 10 - 25% coverage.

	Challenging positions: We have been working with [Redacted] and his team to establish robust baselines for screening coverage. Despite data collection for the national cervical cancer screening meeting, baselines are not always clear at the DHO level. The recent census provide accurate and updated numbers of numbers of women eligible for screening but this has not yet fed into detailed planning. The UK looks at cumulative coverage over 5 years and it may be appropriate for Malawi to consider a similar time period. In addition, obtained signed subcontracts with each partner took time; therefore staff did not prioritise identifying locally relevant numbers. However, all subcontracts are now in place, and having spent time at the April Mponela project meeting discussing coverage there is now active engagement from the team, including a better understanding of the power of understanding local demographics.
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)
	We have worked hard during this foundational 6 months of the Project to ensure that both the Scottish and Malawian sides have come together in terms of: • Full engagement with our Lead partner • Finances and the main contract in place • Collaboration Agreements and working policies • Engaging across the 5 Hubs (in Northern, Central, Southern Regions) • Reviewing SOPs, undertaking CPD, and building a skills development programme. Within that context there are no delays. There is a small delay in refurbishment of an initial Hub and starting screening in 2 new health centres. This was mainly due to ensuring subcontracts and subsequent financial arrangements were in place. However, these are now in place across the five Hubs, 11 new providers have been trained (both MoH basic and experiential trainings), the tranche of new health centres across all Hubs identified, and we expect to have initial refurbishment and equipping carried out over next two – three months. Indeed, in the case of one health centre (Mpherembe, Mzimba North DHO) screening started 1st April so just outwith the reporting period.
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 1: Increased geographical coverage of 'screen and treat' services

Outcome Indicator	Milestone / Achievement	Progress
1.1 An additional 60-70,000 women will have been screened, and received	400 additional women screened	**Achieved**: 859 additional women screened during Year 1 (additional at

	treatment where necessary.		Nkhoma and at cross-Hub experiential training sessions).
	1.2 33 additional health centres will be providing screen and treat services	Screening at 2/33 additional health centres	Not yet achieved (see 2.3 above, first health centre started 1st April)
	Outcome 2: Increased national capacity to deliver VIA-based screening, and treatment with thermo-coagulation		
	Outcome Indicator	**Milestone / Achievement**	**Progress**
	2.1 80-90 additional VIA providers	10 new trained VIA providers	**Achieved.** 11 trained
	Outcome 3: Increased national capacity for mentoring and support of VIA providers		
	Outcome Indicator	**Milestone / Achievement**	**Progress**
	3.1 Mentoring toolkit for cervical screening developed and in use	A draft toolkit developed for field-testing	**Achieved:** draft toolkit has been developed, currently being field-tested**.**
	3.2 Number of in-country mentors trained and providing mentoring within their organisations	5-10 identified for training	**Achieved –** 7 mentors identified, initial training in early December (one from each partner Hub, and one from Partners in Hope)
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 1: New screening centres established in areas of strategic priority		
	Output Indicator	**Milestone / Target**	**Progress**
	1.1 Number of hubs refurbished / strengthened	1 hub refurbished	At needs assessment planning stage for all 5 partner Hubs.
	1.2 Number of health centres refurbished and with equipment	2 additional	At planning stage – as above active implementation
	1.3 Number of health centres providing screening and treatment	2 additional	Training for screen and treat of new providers for additional centres completed. One health centre started 01/04/19

	Output Indicator	Milestone / Target	Progress
			(Mpherembe); second due to start within next several weeks (Enukweni)
	1.4 Uniform data-collection systems will be developed across all hubs.	Identify required data collection fields	**Achieved.** REDCap data system in place and data collection protocols developed.
	Output 2: Training in VIA 'screen and treat' delivered to providers in targeted centres		
	Output Indicator	**Milestone / Target**	**Progress**
	2.1 Number of individuals successfully completing VIA training course	8-10 additional VIA providers	**Achieved.** 11 trained. See Appendix 1 March 2019 TRAINING/ WORKSHOP REPORT
	2.2 Number of individuals successfully completing thermo-coagulation experiential learning courses	2 x thermo-coagulation courses; 8-10 providers trained	**Achieved.** 9 completed this further experiential training (see Appendix 2 for their reports). This was done in partnership with experienced trainers in partner Hubs
	2.3 Number of individuals attending CPD (continuous professional development) courses	3 x regional CPD courses	Achieved. [Redacted] provided CPD for 25-30 screening providers from all partner Hubs in December 2018 (representatives from all three regions)
	Output 3: Increased skills of in-country mentors		
	Output Indicator	**Milestone / Target**	**Progress**
	3.1 A cervical screening toolkit for use in Malawi	Workshop 1; A draft toolkit developed for field-testing	Achieved – the draft toolkit has been developed, and is currently being field tested across the 6 partners (5 Hubs, plus partners in Hope).
	3.2 Number of mentors trained	5-10 mentors have initial workshop training	Achieved. 7 mentors identified, initial training given

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)
	Staff in place: Lead Project Manager Nkhoma Hospital - [Redacted] VIA focal persons are in place for all partners:

	Nkhoma – [Redacted] Mlambe - [Redacted] Mitundu - [Redacted] Mzimba North DHO - [Redacted] Ekwendeni - [Redacted] DI - [Redacted] The regional coordinators have been identified. Hub data clerks have been identified, and attended training in use of the REDCap module in early April. The lead accountant is based at Nkhoma Hospital (Yowati Nthenga) and he has linked with the financial lead at partner sites, undertaking due diligence and setting up invoicing arrangements. [Redacted] has spent 2 days at Nkhoma advising [Redacted] on processes. Senior management have signed the subcontracts across partners. A project contact list is maintained, project WhatsApp groups are in place (for the Hub leads and VIA providers, and for the data clerks).
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)
	All project partnerships are in place (except Mulanje MH which has withdrawn). One of the highlights has been the way in which experiential training in thermal ablation has been delivered close to providers' facility. This is not only beneficial to individual providers but also lightens the training load and impact on screening delivery for Nkhoma Hospital. There have been no challenges associated with this shared workload. Another highlight has been the sharing of hospital resources when need arises through the partnership – see case study 1 in Appendix 6 **Wider national level partnerships**: • ***[Redacted]*** Ministry of Health Reproductive Health Directorate lead for cervical cancer control is fully engaged in the Project. • [Redacted] engaged with ***[Redacted]*** Deputy Director of Planning at the Ministry of Health and MaSP Health Strand Lead, at the MaSP Symposium in March 2019. CC, HAC and BK met him at his Ministry Office on Thursday 11th April. [Redacted] had a good grasp of the MALSCOT project. 'Screen and treat' screening is included in the Essential Health Package (EHP) but provision requires strengthening. He outlined the resource mapping database which the Ministry was developing to track all Scottish funding. **Establishing relationships with others active in cervical screening services** • USAID PEER award- provision of screening by HPV testing of self-collected samples within Family Planning Centres - possibility of Nkhoma being one centre mooted.

	• Global Fund cervical screening partners (including Baylor, Light-house, EGPAF). • CHAI/UNITAID supported HPV pilot programme within routine services for women with HIV, using GenXpert HPV test and extra capacity on platforms available for TB testing. Expertise of Nkhoma with GenXpert acknowledged • Achikondi Community Clinic – see case study 2 in Appendix 6		
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**
	December 2018	CC and [Redacted] (See Appendix 3 for details). Visits were made to partners in the Southern region (CC), clinical components of the project were reviewed (MD), the first project meeting and mentoring workshop was held (all)	1. Subcontracts with partners to be progressed 2. Safeguarding and Database Working Groups to be set up (February 2019 visit) 3. Draft mentoring toolkit to be field-tested by partners
	February 2019	CC convened meetings of the Safeguarding and Database Working Groups (see Appendix 4 for details). Both were important in bringing together relevant expertise and in preparation for project implementation	1. A draft Safeguarding policy to be reviewed and refined prior to approval by the Safe Motherhood Committee 2. A screening module to refined, SOPs finalised, REDCap licence obtained
	March 2019/ into April 2019	1.HAC spent week of 25-29th March in Blantyre and the South, including one full day with [Redacted] and his team in The Polytechnic, Blantyre. This was a very useful 2-way interaction and helped preparations for the 2nd Partners' meeting in Mponela on 9-10th April She also visited Zomba, met the D.I. providers involved in MALSCOT and saw their clinic set-up.	1. [Redacted] and staff to estimate screening coverage from published information for 2017 for each hub partner. 2. [Redacted]to visit The Polytechnic Innovation lab where an innovative training toolset for screening has been created 3. A request from [Redacted] was received to consider reaching vulnerable groups by supporting screening clinics in

		2. HAC and CC were based in Nkhoma Hospital from 1-12th April, covering financial issues, 2nd Partners meeting and visit to Ekwendeni and Mzimba North. As these fall in April, they will be fully detailed in the next report	Zomba Mental Hospital and Zomba prison

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)
	Although we have not spent the Year 1 Budget in full, we do not consider this to be True Underspend, rather Delayed, as it took longer than anticipated to set up the subcontracts. There have been some associated delays in spend for refurbishment and equipping of health centres but needs assessment is underway in April 2019 and we anticipate Hub strengthening in May and June, equipping of the first two health centres in April /May, and a rolling plan of additional health centres across Year 2. We envisage the need for detailed re-profiling discussion with SG as a consequence of Mulanje MH's withdrawal from the project (see Section 5 below). Coverage for the Southern region is our main concern and we are in contact with other providers of cervical cancer in Malawi to better understand the needs and gaps and inform our decisions.

5. Any other Information

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

During Year 1 we were disappointed to lose Mulanje Mission Hospital as a project partner.

i. Mulanje MH indicated an unwillingness to sign the subcontract on 7th February 2019. We discussed with Scottish Government on 22nd February. We met face-to-face with [Redacted] from Mulanje MH in Edinburgh on 14th March to try to resolve concerns.
ii. All our partners need to be working with Nkhoma Hospital, the Lead Partner, on the same basis otherwise the partnership will not deliver as set out in our Application for funding

iii. Mulanje MH management have chosen not to accept an in-country subcontract and withdrawn from the project (29th March 2019).

iv. We are reviewing two options to enable us to deliver our Outcomes: a) work with our existing 5 Hubs and redistribute the health centres according to need, or b) work with our partners to identify an additional Hub.

Nonetheless, we are confident we have made good progress in other vital aspects of the project, as described in this Report. Most heartening has been the enthusiasm of the first tranche of newly-trained VIA providers – see Appendix 2 for summaries of their experiential training. A few quotes:

- "It was a very good learning experience as l have gained adequate practical skills as a new VIA provider. I feel confident and ready to provide the service to clients at Mlambe Hospital"
- "I thank MALSCOT for the funding that has enabled us to become new VIA providers"
- "May the Good Lord continue blessing our partners from Scotland as well as Nkhoma hospital staff who are working very hard to save our women from dying of the preventable cervical cancer"
- "After the training I find it very important to work towards prevention of cervical cancer to save our population from developing cancer from precancerous cells"

We are also pleased to have been successful in obtaining a small LMIC partnership travel award through the University of Edinburgh's International Development Research Hub which will fund a visit of [Redacted] in June to strengthen project links with SG colleagues, SMP, and clinical and academic partners.

Appendix 1 TRAINING/WORKSHOP REPORT

<table>
<tr><td colspan="3">REPORT ON CERVICAL CANCER PREVENTION TRAINING FOR NKHOMA MALAWI SCOTLAND CCSP PROGRAMME</td></tr>
<tr><td colspan="2">Training Topic: CERVICAL CANCER PREVENTION

Training Focus: - VIA AND COLD COAGULATION</td><td>Training 3RD to 8TH March 2019</td></tr>
<tr><td>Training Venue: - Dedza

Mountain View Lodge Conference Room</td><td colspan="2" rowspan="3">Facilitators: -
[Redacted]</td></tr>
<tr><td>PRACTICAL SESSIONS VENUE
Dedza District Hospital
Mtenthera H/C and
Diampwe H/C</td></tr>
<tr><td rowspan="3">Number of participants –11</td></tr>
<tr><td colspan="2">Reported by:- The Trainers</td></tr>
<tr><td colspan="2">Date report submitted: 11/03/19</td></tr>
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Purpose/ Aim of training/ workshop
Train nurses and clinicians from health facilities supported by Nkhoma under Malawi Scotland project in cervical cancer screening using visual inspection of the cervix with acetic acid (VIA) and treatment using thermo-coagulation.

INTRODUCTION

Teaching /learning methods

Illustrative lecture
Individual/group exercises
Group discussions
Role play
Demonstration
Clinical activities
On the job training
Brainstorming
Computer assisted learning

COURSE GOALS

> To influence in positive way the attitudes of the participant toward the benefit and appropriate use of VIA and cold coagulation.

>To provide the participant with counseling skills needed to talk with women about cervical cancer testing using VIA and outpatient treatment of precancerous cervical lesion with cold coagulation.

>To provide the participant with knowledge and skills needed to perform VIA and if indicated cold coagulation.

>To provide the participant with the knowledge needed to manage side effects or other problems related to the treatment of precancerous cervical lesion with cold coagulation.

LEARNING OBJECTIVES

The main objective of conducting this training was to train service providers in visual inspection of the cervix using acetic acid (VIA) as a screening method for identifying precancerous lesions on the cervix and cold coagulaion as treatment modality.
By the end of the training course, participants were expected to be able to perform the following specific tasks:-

- Talk to women about cervical cancer(counseling)
- Explain who should have cervical cancer screening and how VIA screens for precancerous lesions
- Explain how cryotherapy treats precancerous cervical lesions
- Use recommended infection prevention practices to protect clients, health care workers and providers themselves
- Perform a general and pelvic examination
- Perform cryotherapy if indicated
- Provide follow up instructions and counseling after VIA or cold coagulation
- Provide care and referral as needed.

The topics covered during the six days training were:-
> Chapter One –Introduction to cervical c.ancer and Human Papiloma Virus
> Chapter Two—Pathopysiology of cervical cancer
> Chapter Three—Talking to women about cervical cancer
> Chapter Four ---Visual Inspection on the cervix
>Chapter Five---Treatment and follow up.
>chapter six – Infection Prevention in health care setting

ASSESSMENT OF KNOWLEDGE
That was done through a pretest and results showed minimum knowledge level with scores ranging from 55-85% and the average mark was 66%.
On the 6th day of the training, the post test results ranged from 65- 95% and the average score was 80%.
The image assessment post test score ranged from 65-95% with average score of 82%.
Nobody had supplementary examination.

CLINICAL PRACTICE
On day two participants did some practice on anatomical models in class to prepare them before working with clients as humanistic learning approach.
Three days were dedicated to the clinic at Dedza District Hospital, Diampwe and Mtenthera Health Centres.
They were exposed to practical skills in counseling and VIA/Cold coagulation clinical skills with clients.
In total 213 clients were screened, 13 were found with positive lesions and all were treated with cold coagulation. 13 clients were identified with other gynaecological problems and were referred to other clinics for further assessment and management.
One client was suspected to have cancer of cervix and uterus and she was referred immediately for further assessment. She is only 19 years and married for 2 years without a child but currently divorced due to same problem.

TABLE SHOWING DATA COLLECTED DURING THE CLINICAL SESSIONS.

Day	Total VIA	Positive	Neg	Sus Ca.	TC done	Other gynae	Refer Out
1	52	4	48	0	4	5	5
2	78	3	75	0	3	5	5
3	83	6	76	1	6	5	6
Totals	213	13	199	1	13	15	16

SUCCESSES
There were successes as regards this training process. This training was successful in that all participants arrived in time the time we started the training and participated fully during all six day.
>There was good course organization.
>There was active participation both in class and practical area.
>The goals, expectations and objectives that were set were achieved.
>There was a significant knowledge and skills gain as witnessed from the pre and midcourse assessment results.
>The trainees were good, hard-working, dedicated and determined to learn.
>There was good demand generation as evidenced by total number screened.

CHALLENGES
There were no major challenges regarding this training. The only challenge was heavy rains on day and three of practical session training.

RECOMMENDATIONS
>Intensify support supervision and mentorship to these providers in the first six months of their service provision to facilitate skills proficiency.

General comments:
The participants valued the course and promised to utilize the content they learned in the service provision.

Next Steps:
All new providers are ready to start the service soon if supplies will be available.

From their action plans they will report to their authorities. They will sensitize the community and continue services.
Since in most of the facilities services are available the providers will work as a team on improving the running of their clinic.
But for the facilities that do not offer services these new providers will need to be assisted in establishing screening services by mentorship on site and improve services by close support supervision.

Eleven new VIA providers were trained, from project Hubs/ health centres across Malawi.

Additional comments from [Redacted]

The training started with a positive note that all participants arrived in time despite that the training started on Sunday morning, all participant were active throughout the training. This was the first training to have more male VIA providers since VIA is mainly dominated by female providers.

During the three days of clinical practical session it was raining heavily but women still were able to come for screening. This show that women really needs this service in various facility.

Incident during the training - case study
A woman came to the facility to visit her sick relative who was admitted, she was coming from far away from Dedza Hospital, a distance of more than 20 kilometers. Upon hearing the sensitization talk of VIA from female ward, she opted to be screened. She said she has been hearing about VIA but other women used to tell her that it is a painful procedure and she wouldn't be able to walk soon after the screening. Upon arrival where screening was being done and seeing other women walking without any problem from the screening room, she was so surprised. When her turn came, she was screed and she was VIA positive. She accepted treatment and TC was done same day. She was given a chance to ask if she had any question before leaving, this is when she narrated her story and she was really happy that she made the decision to be screened and promised to tell all her relatives and friends who are afraid to be screened because of what other people says. She went home with a bright face and happy, which was really shown on her face.

Lesson learnt: there are still many women who are afraid to access VIA because of what other people says, and common misunderstandings. They are just lacking someone to talk to them and also to hear from health works and be assured that VIA is just a simple procedure.

Appendix 2

Experiential training - Reports from newly-trained VIA providers

Following the initial training in VIA and thermal ablation, the MalScot project includes at least one week of experiential training in order to consolidate skills. This experiential training was spread out between Nkhoma Hospital and the partner Hubs (Zomba Central, Mzuzu Health Centre) and with MSF (who the MalScot project also work closely with (Limbe Health Centre)).

Client summary VIA done during experiential training: VIA done 328, VIA positive 8, 6 TA done, 1 with large lesion, referred and one postponed. Ca suspect 6 and other gynae conditions16.

__Reports from providers (anonymized, as provided)__

1. provider from Mlambe Mission Hospital

I write to give a brief report on the one-week training as aforementioned at Limbe Health Centre. My clinical placement at Limbe Health Centre with MSF was from 18th - 22nd March, 2019. I was warmly welcomed by the nurse on duty and two other MSF support staff at Limbe Health Centre.

A Brief orientation was done. The VIA provider instructed me to observe her testing ten clients before l started testing the clients. After observation l was given an opportunity to test ten clients under close supervision. From 18th - 22nd March, 2019 l worked hand in hand with the MSF VIA provider Nurse and tested 83 clients in total.

Out of the 83, one client was VIA positive. She was counseled on the importance of treating the lesion the same day. However, Cold Coagulation was postponed because she wanted to seek consent from her husband. Nine women were diagnosed with AVD and 4 clients were also diagnosed with Candida. All these were treated right there.

SUCCESSES
. Good turn up of clients; Availability of STI medications at the VIA clinic; Availability of the supplies
CHALLENGES
. No opportunity to practice Cold Coagulation procedure; Most clients were returned almost everyday due to insufficient packs

In summary, it was a very good learning experience as l have gained adequate practical skills as a new VIA provider. I feel confident and ready to provide the service to clients at Mlambe Hospital.

2. Report of provider from Mpherembe health centre
I have reported at Mapale HC. Today being a first day on Experiential training. Everything was fine. Allice Nkhoma and other supporting staffs welcome me with a warmth attitude. We had ten clients. We started with a health talk, presented by I myself. The following is our data.

Number of Clients: 16; VIA Positive :0; VIA Negative: 16; Other Gynae: 1; Referred: 1

Second Day, Comment: It was a nice day, during health talk clients were feeling free to explain what they heard about cervical cancer and got the right information after the talk, promise to encourage their communities on the screening of cervical cancer.
On 28 March, we had one client who was complain lower abdomen pains for a long period of time and feel pains during coitus with bleeding after, she is married aged 37, HIV status

NR, after screening results was inflammation of cervix with some bleeding. After giving her the results, she looked not comfortable with the results. Then I did ask her to share her concern. She said, she was expecting VIA Positive and ready to be treated, she had a lot of questions about the bleeding and the causative. She said her husband is no more interest no her as a wife. I did refer her to CO for treatment and ask her to come back the next day with the husband. She did as we agreed. I explained to them the possible causes of the problem and the difference between Cervicitis and cervical cancer. A man also got the treatment. They went as a happy family and promise to report again after 4 weeks for review. And I did assure them that once the problem is over, then we will do VIA screening again to rule out positive or negative. I do thank Clinician for the support.

3. Provider from Mpherembe - experiential report

I had seen 25 client, 1 VIA positive, 24 negative , no cancer suspect. I did cryotherapy on one client who was VIA positive together with [Redacted] at Mzuzu h/c. It was well done and cover lesions that was <75%. I started it on April 1 to 5 2019. It was really experiential practice

4. Provider from Mitundu Community Hospital - Report on experiential via training at Nkhoma CCAP hospital

I am a senior nurse midwife technician and am currently working at Mitundu community hospital under Ministry of Health. I attended my initial VIA training from 17th of February to 23rd of February. The training was comprised of theory and practical's. I had a chance of viewing images of VIA negative, VIA positive and after treatment plus cancer suspect images. It seemed hard but upon completion of the training VIA is no longer a strange thing to me. During the training I did not have a chance to meet a VIA positive client or cancer suspect. I managed to screen 23 clients during the initial training. After the training I find it very important to work towards prevention of cervical cancer to save our population from developing cancer from precancerous cells.

On 25th March 2019 I reported at Nkhoma CCAP Hospital for my experiential training. The training was a success as I managed to screen 30 clients and found two cancer suspects and one VIA positive client and managed to use a C3 Thermo coagulation machine. I also managed to learn how to collect a sample using punch biopsy. Apart from practising my skill there are a lot of things I learned from the clinic, some of the things are documentation and arrangements of equipment in relation to infection prevention. The experienced nurses at Nkhoma Hospital manages the clinic very well that makes it easy to work and their support made me lack nothing.

I like the idea of having experiential trainings mainly in busy and referral clinics like Nkhoma CCAP Hospital. I had a nice experience with the help of whole staff working at Nkhoma VIA clinic and I felt like home. Thank you.

5. Report from provider from Kasina Health Centre - experiential training at Nkhoma Mission Hospital

I attended VIA training on 17th February to 23rd February 2019. The training was comprised theory and practical. This Experiential training has helped me a lot because I had enough time to practice with the help of experienced providers. I started experiential training on 20th February 2019 to 26 February 2019, and I managed to screen 20 clients. 2 clients had cervicitis, I treated them and I told them to come after 3 months for review. I didn't have a client which I found VIA positive and also suspect.

It was a nice experiential training. It has helped me equipped with knowledge and experience about VIA services.

6. Report from provider from St Joseph Health Centre

I did my experiential practical training at Nkhoma hospital from 1st April through 5th April 2019 following another training which I attended at Dedza mountain view lodge from 3rd March to 8th March 2019. During my experiential training at Nkhoma hospital I screened about 50 women under supervision of the well experienced VIA providers. Out the number of women screened 49 were VIA negative while one woman had advanced cancer who was linked to palliative care. The training has helped me to acquire the required knowledge in screening women for VIA.

Lastly I thank MALSCOT for the funding that has enabled us to become new VIA providers.

7. Report from provider from Matapila Health Centre

Placement at Nkhoma Mission Hospital from 18th March to 22 March 2019.

1.INTRODUCTION

I would like in the first place to thank the Scottish in coalition with the staff of Nkhoma hospital for funding both the training in VIA as well as the experiential training. We don't take it for granted. Women are very grateful for they can now come to the health center on weekly basis as compared to the past whereby they would only wait for Nkhoma hospital via providers on a monthly basis. If there be any opportunities of conducting more trainings in VIA in the near future, I will be very grateful, it will mean there will be more VIA providers in various health facilities hence preventing our women from dying of cervical cancer. If one provider is busy with other duties, the other can easily come in, leaving no gap in service provision.

2. EXPERIENTIAL TRAINING AT NKHOMA MISSION HOSPITAL

Many thanks again should go to our organizers for seeing it a necessity to further expose us in the clinical placement so as to sharpen our knowledge and skills. My experiential training has been a learning experience indeed. In fact, throughout the course of the experiential training at Nkhoma hospital, not even one client was found VIA positive. This already exposes the great work being done by Nkhoma hospital. Most of these women were already sensitized on the importance of via screening and utilized the opportunity. This was manifested in most clients coming for check-up, thus after the CC was already done. And the good news is that not even one who received treatment came out via positive again. Women were going out of the VIA screening room smiling. This shows how much important the program is to our women. Otherwise some of these would develop cervical cancer if it were not for the program. My not finding a positive via client I don't take it as a drawback really, because we would not want our women to actually develop into cancer. But for my learning purpose I was lucky that I managed to get three clients when I was at Dedza doing my clinical practice who were via positive and I managed to treat them.

I would like to thank the program for the provision of the necessary resources needed for the VIA screening to be possible in our facilities. I can assure you that we are now able to do the screening right here at our facility without any problem. The only challenge remaining is that we still have to refer our patients once found VIA positive since we don't have the thermocoagulation machine yet. It is therefore our plea to you again that if there be any chance of providing us with one machine, we would be very grateful. It will mean reducing the burden on our women to travel to Nkhoma for the treatment once found VIA positive. Again most of our women will be motivated to come for the screening because they know that once found positive, treatment will be there and then.

3. CONCLUSION

Lastly, may the Good Lord continue blessing our partners from Scotland as well as Nkhoma hospital staff who are working very hard to save our women from dying of the preventable cervical cancer. Thank you.

8. Report from provider from Likangala, based at Zomba central hospital for experiential training

NUMBER OF CLIENTS SCREENED 23; VIA POSITIVE & TREATED 1; VIA WITH LARGE LESSION 1; OTHER GYNAE. 2; VIA NEGATIVE 18; SUSPECT CASE 1

INTERESTING CASE

This is an old women aged +60 years who has been going to Machinjiri health center with Hx of per vaginal bleeding for so long, unfortunately she has been diagnosed & treated as hormonal imbalance. One day she also went to her usual facility, on this day she was referred to DOMASI RURAL HOSPITAL but she was referred to Zomba Central Hospital for further assessment & management. Upon arrival I noted that she was having foul smell, I opted to do speculum examination I found that she was also having watery discharges which was very offensive and also bleeding, the cervix was destroyed. I called the senior to confirm the case.

PLAN We counselled the old woman on palliative care then we referred her to palliative care unit.

LESSON This progression of disease could have been prevented if the woman was assessed properly earlier.

WAY FORWARD There is a need to train more VIA Providers to sensitize people on the importance of early VIA. We need to screen good number of those who are at child bearing age as much as possible for early detection of precancer lesion so that they could be free from cervical cancer.

9. Provider from DI City Clinic trained at Zomba Central Hospital

From 25 to 29 March my experiential training was at ZCH. I screened 32 women VIA positive two one Thermocoagulation done the other one was postponed because she refused, she said she will come after she get prepared. I was also privileged to observe cancer suspect though she was an old client she came for biopsy, was also able to see other gynae like endometrial cancer.

A case study: I screened a certain woman in her late 40's who was referred. During health education when I was explaining about the results like negative, positive and cancer this woman begin to cry, I can say shedding tears. After finishing the education I called her and took history that's when I realized that she has been referred for biopsy (cancer suspect) so I repeat the process but to my surprise she was VIA negative so I called for my senior & repeat vinegar application still it was negative but had some Nabothian cyst which is a Normal cervix. I explained the results & advised the woman, she was very happy the tears turned into joy. The whole scenario I learned that the results that we give to the women if we are not careful can have an impact on their life even making women to commit suicide.

Appendix 3

Visit of [Redacted] to Malawi in December 2019

[Redacted] were in Malawi from 3rd – 14th December 2018, initially covering project implementation and clinical aspect of the project, then leading the 1st project meeting and Mentoring Workshop.

Project implementation CC spent the week beginning 3rd December visiting partners to discuss project implementation issues.

The Polytechnic, in Blantyre: CC met with [Redacted] on a couple of occasions. We had detailed discussions about an appropriate database for use in the project, and met with a REDCap expert [Redacted] (College of Medicine) to work through the project requirements in order for [Redacted] to develop a bespoke module. REDCap is a centralised database but suitable for use at facility level on laptops, is suitable for longitudinal patient data, and patient data can be anonymised and customised for need. We also reviewed M&E components of the project, and planned for the project meeting the following week.

Dignitas International in Zomba: CC met with Heather Macey (Country Director), Joe Theu (Malawi Medical Programme Manager), and [Redacted] (Medical and Research Director). The discussion covered funding structures within DI (including the challenge of recent funding cuts from USAID), and their recent emphases on climate change impact on health. We reviewed the project plans, including DI's expertise in mentoring through long experience with working with people living with HIV, and ensuring complementarity with other organisations providing cervical screening within the planned catchment areas (including EGPAF, Lighthouse and Baylor).

Mulanje Mission Hospital: [Redacted]met with [Redacted] (deputy Medical Director), and senior personnel including [Redacted] (Deputy matron), and [Redacted] (Maternal and Child Health). Mulanje MH provides comprehensive care for the local population, and has a newly-agreed Service Level Agreement with the Ministry of Health for provision of diabetes and hypertension care, maternity services, under 5 care, palliative care for cancer (pain management), and funds for VIA. We discussed the current cervical screening provision at Mulanje: in addition to the SLA agreement, they receive some additional training support from Baylor, and currently there are approximately 14 or 15 trained providers. With respect to our project, the aim is to reach women attending health posts where there is currently limited / sporadic screening provision. Prevalence of HIV is 22% in the catchment area so there is ongoing need.

In addition, CC met with *Medicin San Frontiers* staff in Blantyre: MSF provide cervical screening at five centres in the Blantyre region, with plans to introduce screening in two more health centres in 2019. Nkhoma Hospital staff have been involved in training MSF screening providers. We had a useful discussion of different models of screening provision including campaigns for rural areas, quality assessment, and MSF's plans to build a surgical theatre (funding permitting) close to Queen's Hospital within the next 12-24 months.

Clinical aspects

[Redacted] was based in Nkhoma Hospital the week beginning Monday 3rd December. Her time was spend on reviewing and updating SOPs, CPD sessions with Nkhoma clinic staff, a session in theatre with Beatrice Kabota to provide support in use of LEEP for larger lesions, and visiting Kasina and Mthenthera health centres for clinical competency review with VIA

providers. In addition, she met with an HIV mentor visiting Nkhoma Hospital to better understand one model of how mentoring in HIV care is provided in Malawi.

Miriam also worked with the Nkhoma team on developing an updated 'consent for images' protocol for images taken on the clinic colposcope. Although consent for taking and use of images as always been sought from women, this had been for use within the Nkhoma Hospital and associated health centres. With the new project now involving additional partners and wider geographical reach, a consent form was developed explicitly seeking permission for any (anonymised) clinical images to be used for wider educational and training purposes. Interestingly, even within the first few days of use, one woman refused to give consent for a clinical image to be used for this purpose: the team were pleased with this, as it indicates the woman felt empowered to refuse.

1st Project meeting and Mentoring Workshop

Held in Mponela, Central Malawi, from Monday 10th – Wednesday 12th December 2018.

Attendees: 30 attendees were present. All project partners were represented, including Nkhoma Hospital, Dignitas International, Ekwendeni Hospital, Mitundu Hospital, Mlambe Hospital, Mulanje Hospital, Partners in Hope, Reproductive Health Directorate, and The Polytechnic University of Malawi, and with consultant input from Baylor.

Project management issues: this was the first time all partners had been together, so some time was spent on introductions of people, roles within their Hubs / organisations, and current set-up (if any) of cervical screening within their areas. We then reviewed the project background, overview and objectives. Beatrice Kabota (Project National Coordinator) led a discussion of current Hub provision and activities. We reviewed the status of contracts and collaborative agreements and Memorandum of Understanding (the contract with Nkhoma Hospital was ready for approval). [Redacted] (Principal Hospital Administrator, Nkhoma Hospital) led a discussion of the financial arrangements, CC spoke on Scottish Government reporting requirements, Safeguarding and vulnerability issues, and Partnership principles.

Mentoring Workshop: Tuesday was spent on development of the mentoring component of the MalScot project. [Redacted] (Nkhoma Hospital) described her experience of being mentored within the first SG-funded project, as well as her subsequent experience of training and supporting other VIA providers. [Redacted] gave a talk 'Introduction to mentoring' drawing on new Malawian guidelines and broader principles from the literature and her own professional experience. The rest of the day was spent in small group work, developing item lists relating to the domains of Physical environment, Performing VIA, Treating VIA positive and routes to other referral, Dignity and privacy, Infection prevention, Sensitisation and barriers to VIA, Including other health needs (HIV, fistula), Data collection and data utilisation, and CPD and support of providers. We considered a combination of checklist and free text assessments to be made by the mentee and shared with the mentor during the mentorship process. Input and feedback from groups was collated and developed into a draft Mentoring toolkit. This is now being field-tested in practice by partners as they support VIA providers.

Continuous Professional Development: [Redacted] led a well-received CPD session on Wednesday morning. This included tutorials on VIA positive lesions, and on staging on cervical cancer lesions.

Group 5
When giving results combine

Appendix 4

Visit of Christine Campbell to Malawi, February 2019 – Reports of 1) Safeguarding and 2) Database Working Groups

1) Safeguarding Working Group

Date: Monday 4th February 2019
Location: MaSP offices, Lilongwe
Attendees: [Redacted] (University of Edinburgh, Project co-Lead), [Redacted] (Nkhoma Hospital, project national coordinator), [Redacted] (Reproductive Health Directorate, Ministry of Health), [Redacted] (Nkhoma Hospital Administrator, also CHAM), [Redacted] (Country Director, Dignitas international), [Redacted] (Medical Program Manager, Dignitas international), [Redacted] (Medical Care Coordinator, Partners in Hope), [Redacted] (Director of Operations, Partners in Hope)

Purpose of the Safeguarding Working Group (SWG)
CC briefly outlined the background to the SWG. The Scottish Government (SG) is clear in its commitment to human rights and protection against sexual exploitation. It expects partners to monitor their work closely, and to be open, honest and transparent if there are any suggestions of abuse or malpractice, and it is a requirement of funding that all SG projects have Safeguarding policies (Award Letter). At the project meeting in Mponela in December 2018 it was agreed that a Safeguarding Working Group would be set up to develop Safeguarding policies for this project. Given the intimate nature of cervical cancer screening, there is a need for context-specific policies, training and promoting a safeguarding culture among project partners.

Discussion of Ministry of Health and partners' current policies/ approach
We reviewed current policies / approaches among partners.
TP advised that patient protection policies are already embedded within the MoH overall policy, and within the Code of Conduct for nursing and midwifery. These should be being used pre-service, i.e. at nursing school. Unfortunately, action is not always taken and scandals are heard in the media – most commonly sexual abuse, and patient neglect.

All DGHs have an Ombudsman for patient complaints, but most people are unaware of this. There is a Patients' Charter, with rights and responsibilities but again this is not always displayed or known. All complaints within a facility should normally go through the Ombudsman, where details are recorded and the Ombudsman is responsible for follow up. An official complaints process is there but not always clear. Examples of complaints are when patient are exploited financially and made to pay for services (in Government hospitals) or in non-government facilities charged for services covered by SLAs. Other complaints include patient privacy, including sharing of photos of patients (an example given of a nurse recently dismissed after sharing a selfie on social media, with a naked patient in the background).

AN advised that CHAM Human Resources Manual includes patient protection policies, and that these are adapted and adopted for the local working environment (i.e. CHAM partners will / should have their own policies, such as the Nkhoma Synod Child and Vulnerable Adult Protection Policy). It is the responsibility of the Medical Director, check by a lawyer.

[Redacted] and [Redacted] advised that DI have a Code of Conduct, Gender policy, Whistleblowing policy and Anti-corruption policy, all of which have some element of safeguarding within then. In addition, approx. 2 years ago they developed a Safeguarding policy, still going through an approval process as some differences with Canadian law. All DI staff work

through MoH facilities and bound by MoH Code of Conduct. There is a Whistleblower policy, and a complaints hotline: all complaints go directly to the CEO, and they do have experience of HSAs complaining directly to the CEO. Gave an example of a newspaper article with a photograph of a patient living with HIV, consent was challenged for use in this media, now have a stricter consent policy for images where a witness is required.

We discussed the short video on our MalScot WhatsApp group of the girl speaking about her HPV vaccine. Although the girl did give her name and the video was taken by a member of the HPV vaccination supervision team, the girl and her parents did not know what would happen with the video and it should not have been widely shared on social media. A learning point for our project to ensure adequate consent for all photos/ videos, and to be shared for defined purposes.

[Redacted]and [Redacted] advised that PiH have policies and provide training during staff orientation, although more orientated to staff issues c.f. client perspective. Their whistle-blowing policy includes guidance on reporting issues, how to handle reported issues, and protection of whistle blowers. There are different levels of reporting depending on the nature of the complaint. Each employee signs the Code of Conduct embedded in HR. there is also health protection training (online, via USAID). The employment policy also includes aspects of protection, including gender. There is a gap in policies with respect to rights and responsibilities and protection of clients. Acknowledged that in some facilities privacy of clients during screening is not always well-managed due to space constraints, leaving women vulnerable. [Redacted] also mentioned a case where an expert client had given consent for her image to be used in an MBC programme, but husband was not aware/ angered when the programme was broadcast and work colleagues discussed the next day.

We discussed a woman having a chaperone (where a male provider, but also at any screening).

We discussed adding Safeguarding training to the Ministry of Health VIA training course materials – TP advised that although supportive this required agreement at a higher level including WHO as it was their training materials / policies that were followed. (CC addition 18/02/19 – can we discuss with [Redacted] please?)

Scotland's international Development Alliance guidance
Scotland's International Development Alliance (SIDA) issued 'Developing a Safeguarding Policy - Process Template' in December 2018. This document provides guidance and a framework suitable for our needs. The process has the support of the SG.

We spent some time discussing the vulnerable groups we need to consider within our project, followed by the domains / areas of focus to ensure we cover.

Vulnerable groups in the context of cervical screening provision
Vulnerable groups:

- female clients (stigma, abuse, harassment, neglect)
- intersex clients (stigma, abuse, harassment, neglect)
- LGBTQI clients (stigma, abuse, harassment, neglect)
- People with disabilities; mental, physical, invisible, etc. (access, discrimination, neglect)
- People with albinism
- Illiterate / poorly educated

- Women LHIV
- Minors (abuse, underage initiation rites)
- survivors of abuse (sexual/violence)
- Survivors of FGM
- Female Sex Workers (FSWs)
- Prisoners (CC note – I added later as we will be screening prisoners in years 4 & 5)

Domains/ topic areas to cover:

- clients' rights
- sexual abuse
- privacy/ use of images/consent/ confidentiality
- accountability to clients/ responsibility
- empowerment
- communication; screening, rights, complaints process
- reporting/ responding to complaints

Risk Assessment template
We then used the SIDA risk assessment template to map out identified issues against the following four questions:
What are the risks? How will you mitigate them? Who is responsible? and When will it be addressed?
The completed table (see separate document Risk Assessment and notes from CC SWG 040219HM) will act as the basis for building the draft Safeguarding policy specific for the project.

Tasks and Timelines
We agreed tasks and timelines against a deadline of 8th April in order to share with the MalScot project team.

Task	Timeline / deadline
[Redacted]to send photos of flip chart notes to HM	Done 040219; HM has transcribed
[Redacted]to circulate summary notes	Sent on 18th February
[Redacted] and [Redacted] to write draft Cervical Screening Safeguarding policy (version 1.1)	18th - 25th February
[Redacted]is going to seek to obtain a copy of the Ministry of Health HIV/ AIDS Safeguarding policy	By 25th Ferbruary
[Redacted] to compare v1.1 with generic policies for gaps (becomes v1.2)	25th Feb - 4th March
TP to review version v1.2 from RHD perspective (becomes v1.3)	4th - 11th March
[Redacted] to share v1.3 with other partners inviting comment	11th – 25th March
[Redacted] to invite input /comment on v1.3 from civil society (e.g. HIV, albinism or disability groups	11th – 25th March
[Redacted] any final revisions; Implementation plans (training, monitoring, review)	25th March – 4th April
Share with MalScot project team at 2nd project meeting	week beginning 8th April (dates to be confirmed)
Revised version to be submitted to Safe Motherhood Committee for approval	late April or May? TP to advise

Examples of Safeguarding policies as additional resources
Nkhoma Synod Child and Vulnerable Adult Protection Policy
Dignitas International Child Protection Policy DRAFT (please treat as confidential as awaiting sign-off)
EMMS Child and Vulnerable Adult Protection Policy
CARE PSEA Handbook, implementation and monitoring policies and example of an Action Plan (documents and email)

Additional information from MaSP Symposium re Safeguarding
The Malawi Scoltand Partnership annual Symposium was held on Tuesday 5th February. [Redacted] from the Ministry of Gender gave a helpful presentation on Safeguarding (see pdf of his slides). He emphasised that the normative legal environment including the national constitution provides for safeguarding in Malawi (for women and children, and for employees), and described the currents efforts in relation to child protection. He also mentioned gaps/ challenges in current policies: relevant to our SWG discussion was the need for contextualized safeguarding guidelines, the need for reporting mechanisms and raising awareness on the part of potential beneficiaries.

Other points mentioned were the need for prevention to seek to stop abuse happening in the first place and processes that are clear to everyone (and an analogy with fire drills to work through scenarios, and 'don't dismiss a near miss'). He also mentioned the need to recognize power imbalances (I was unsure if he meant within a project team especially when externally funded, or between project members/ staff and beneficiaries (e.g. screening clients).

Vera from MaSP shared the slides and copies of the following documents:

- Child care, Protection and Justice Act 2010
- Deceased Estates (Wills, Inheritance and Protection Act 2011
- Gender Equality Act 2013
- Malawi Prevention Of Domestic Violence Act 2006
- Marriage, Divorce and Family Relations Act 2015
- National Plan of Action to Combat Gender-Based Violence in Malawi 2014 – 2020
- #NDIULULA#I WON'T BE SILENT CAMPAIGN
- Trafficking in Persons Bill 2015

2) Database Working Group

Date: Thursday 7th February 2019
Location: Audio-visual Centre, University of Malawi – the Polytechnic, Blantyre

Attendees: [Redacted] (University of Edinburgh, Project co-Lead), [Redacted] (University of Malawi – the Polytechnic, project data advisor), [Redacted] (Data Manager, Malaria Alert Centre), [Redacted] (Nkhoma Hospital, project national coordinator), [Redacted] (IT specialists at the Polytechnic IT department), [Redacted] (Dignitas international, data specialist)

Welcome and introduction to the project

[Redacted] welcomed everyone to the meeting and we all introduced ourselves. CC outlined the background to the database meeting, describing the MalScot Cervical Cancer Screening and Mentoring project and the need to ensure data capture and use in a more sustainable and robust manner than previously. Multiple health facilities will be involved across Malawi, and we seek to record a client's screening history over time, including screening outcomes and any results from investigations and subsequent clinic visits. When she met with [Redacted]and [Redacted] in December 2018, REDCap was looked at and it was agreed to use this database that is widely used for longitudinal clinical data for the project.

REDCap licensing and installation

[Redacted] advised that RECap is free software, but requires a license to the hosting institution (i.e. the Polytechnic). The IT department has to contact RECap via the online form, they will then be given permission and access, etc. This is critical, and BN to work with IT colleagues to complete the form and apply asap.

Server requirements to house REDCap within the Polytechnic

[Redacted] described to [Redacted]and PK the requirements for the central server to house the database within the Polytechnic, also allowing for multiple users to upload data from across Malawi, as well as remote access from Scotland. [Redacted] has also provided this information by email. [Redacted] and [Redacted]indicated that the Polytechnic has the infrastructure to accommodate the database, via a web domain. They have experience with similar databases.

Laptops requirements

[Redacted] advised [Redacted]about laptop requirements (sorry, I didn't make a note), estimated to cost up to 700,000 MK each. [Redacted] will get quotes and liaise with [Redacted] over purchase and shipping to the Polytechnic.

REDCap cervical screening module

[Redacted] had built a MalScot cervical screening module within REDCap based on the variables provided (fron the Ministry of Health screening register, plus additional variables provided by [Redacted]). [Redacted]guided us through this for each page and variable: we provided feedback on where it was unclear or where there was ambiguity in the drop-down options. Examples are adding in TC wherever cryo is mentioned, recognition that the Register column for Age gives options 1,2 and 3 (for , 25 years, 25-49 years, >49 years), how to document client address (need to ensure training is also given to VIA providers in our project on this), and working out the flow of fields for biopsy reporting. [Redacted]made a note of required changes and will update the module.
[Redacted]will also develop Dashboards for data extraction at different facility level, for review by the [Redacted].

SOPs for data clerks

MK had developed version1 of the SOP for the MalScot REDCap module. Together we worked through the first half of this (data entry), providing detailed field-by-field instructions for data clerks – see 'MalScot Cervical Cancer Screening Project Data Capture SOP v02 070219 changes accepted'. We recognise that many data clerks are familiar with data entry, but they may be unfamiliar with REDCap, hence the detailed guidance.
MK had also provided draft SOP for data extraction and reports, but we did not have time to review this. the DWG will review these steps over coming weeks.

Training

We discussed training needs for data clerks as they start using the REDCap database in each Hub. LL advised that based on experience in DI that training be given by someone involved in development of the database, as well as working through the detailed SOPs. Agreed we will seek to have a training session for data clerks at the April meeting running parallel to the main meeting session.

Detailed mapping of Hubs / health centres /authorisation levels

We discussed Data exports and Reports for the Project. Needed at different levels, with client anonymity protected beyond the Hub level (i.e. patient names are not available to anyone outside the relevant Hub). PB and PG requested a detailed mapping of Hubs, Health centres (number, even if names not yet known), and who will be entering / accessing data at each Hub, as well as at the regional and national level (again, if names not known, the position).

Tasks and Timelines

We agreed tasks and timelines all to proceed in parallel over the next few weeks to allow REDCap MalScot database module to be installed in laptops in time for the week beginning 8th April, when training will be given to data clerks at the next Project Team meeting.

Task	Timeline / deadline	Responsible
REDCap Licensing - https://projectredcap.org/partners/join/ https://redcap.vanderbilt.edu/surveys/?s=XWhFBvcc6q	ASAP, might take a few weeks	[Redacted]to complete the form, with advice from [Redacted] any Qs. Does this need senior IT authorisation, i.e. Halima?
Laptop purchase – quotes obtained, laptops purchased with shipping to Bagrey at the Polytechnic	End of February	[Redacted]
REDCap MalScot module refined based on discussions Dashboards developed	End of February	[Redacted]
Circulate current version (version 2) of SOP , but screenshots to be updated after step above	Circulated 18/02/19	[Redacted]MK to update screenshots
Review and update SOP for data entry	By mid-March	All
Draft and circulate SOP for data extraction	By end of March	[Redacted] others
Provide PB and PG in IT with detailed mapping of Hubs/ HCs/ levels of authorisation	End of February	[Redacted]
Finalise dates of 2nd Project meeting (sometime in week commencing 8th April)	ASAP, by end February	[Redacted]
Work with Hubs to identify data clerks for training sessions	By mid-March	[Redacted]
Provide training for data clerks at parallel sessions at the Project meeting		[Redacted]

Appendix 5
Intellectual Property

The Project: Moving Towards Sustainability: Strengthening Rural Health Facilities, Upskilling Providers and Developing Mentoring Capacity to Support Roll-Out of Cervical Cancer 'Screen and Treat' Services Across Malawi'

Nkhoma Hospital and the University of Edinburgh recognise there are questions in respect of transferring any intellectual property ("IP") created during the project to Nkhoma and we wanted to clarify the reason for this. We can confirm that the reason for this is not to prohibit the use of any such intellectual property but rather to enable such intellectual property to be used widely and freely by organisations and the public to the benefit of society.

Background

The University of Edinburgh has been funded by the Scottish Government to carry out the above collaborative project with partner organisations in Malawi. A condition of Edinburgh's funding was that all IP rights obtained as a result of the collaborative project would be transferred to the Crown (i.e. the government/the state) but any such information containing such IP would be available for continual use under what is referred to as an Open Government License (explained further below). As a result of this condition, Edinburgh must arrange for all partner organisations do the same. As the initial partner organisation, Nkhoma Hospital has transferred any intellectual property rights created during the Project to Edinburgh, it requires its partner organisations to transfer any such intellectual property rights to Nkhoma Hospital too.

The Open Government License ("OGL")
Under the terms of the OGL, parties are encouraged to use such information and are permitted to copy, publish, distribute and communicate such information. Parties are also free to adapt such information and exploit the information commercially and non-commercially. The main condition of the OGL being that when such information is used, the party using the information acknowledges the source of the information in any product or application by way of the following statement: '*Contains public sector information licensed under the Open Government License v3.0*'. Further information can be obtained at: http://www.nationalarchives.gov.uk/doc/open-government-licence/version/3/

Please note that the OGL is a perpetual (permanent) license which enables parties to use such information for an indefinite period of time as long as the terms noted above are complied with.

I hope this provides you with the necessary reassurance that the purpose of transferring any intellectual property created during the course of the Project to Nkhoma Hospital, and the associated rights, is to support the wider dissemination and access to such information. As such all partner organisations will benefit from this license which permits free, unlimited use of such intellectual property.

Alan Shanks
University of Edinburgh Contracts

Appendix 6

International Development Case Studies " Above and Beyond….2 Case studies in the Value of Partnership "

Project title: Moving towards sustainability: strengthening rural health facilities, upskilling providers and developing mentoring capacity to support roll-out of cervical cancer 'screen and treat' services across Malawi [MALSCOT CCSP}

Programme: Malawi Development Programme

Organisation: Edinburgh University

1. **Project partnership:**
   [Redacted], Principal Hospital Administrator, Nkhoma Hospital in discussion with [Redacted]

Interview Date: 2nd April 2019; Interview type: One-to-one

Project Summary

[Redacted], recounted an interesting event which could not have been foreseen.

The hospital had an elderly anaesthetic machine which suddenly stopped when there was emergency surgery to be done during the night. The patient was raced by ambulance to Kamuzu Central Hospital in Lilongwe but a strike of hospital workers meant they could not admit her. What to do? In the meantime, Nkhoma contacted Mitundu Hospital which had just agreed to sign the sub-contract relating to MALSCOT and they agreed to carry out the surgery. Indeed, they saw the great value of partnership through this event, carried out several operations for Nkhoma until funding was quickly secured for a new anaesthetic machine at Nkhoma, after which Nkhoma could reciprocate when Mitundu had a need.

Sometimes projects have unexpected (and beneficial) spin-offs.

Case Study Background

Nkhoma CCAP Hospital is the lead partner in Malawi for the MALSCOT programme and has had to have considerable interaction with hub partners across Malawi during the first 6 months of the project while sub-contracts were being prepared and signed.

Mitundu Rural Hospital is another CHAM facility on the other side of Lilongwe from Nkhoma, but through the new partnership a closer bond has developed, resulting in shared resources for surgical operations.

Quote

[Redacted] said “The first 6 months have gone well…… There have been benefits of sharing challenges and achievements and planning the way ahead together.”

Photo

2. Establishing relationships with other players in women's health

Players involved: George Watson's College Malawi PArtenrship; The Freedom from Fistula Centre in Lilongwe and Nkhoma CCAP Hospital through Scottish government funded Project MW01.
Beneficiary: Charity Salima, Founder and Director of Achikondi Community Clinic in Lilongwe
Date: 1st April 2019

Project Summary

[Redacted] approached Nkhoma Hospital for help in setting up a cervical screening service within the Achikondi Community Clinic in 2015. Following a visit there, it was discovered that both GWC and the Gloag Foundation had provided help in establishing and running the clinic. During 2018, the Fistula Centre in Lilongwe provided the Clinic with trained providers for a weekly VIA clinic and [Redacted]received experiential training in thermal ablation at Nkhoma Hospital.

Local Edinburgh links with GWC and through SMP led to the Watson's Malawi Partnership considering supporting Achikondi further by raising the funds to purchase a handheld thermo-coagulator for their clinic.

The opportunity was taken on Monday 1st April for members of WMP, the Fistula Centre, Nkhoma Hospital and Scottish MALSCOT partner, Heather Cubie to celebrate the handover of the thermo-coagulator together at Achikondi. The local community and Trustees of the Clinic organised dancing and speeches and made everyone most welcome at what was a happy occasion.

Case Study Background

[Redacted]chikondi's local community has benefitted by the relationship between at least three Scottish organisations which have financially and in kind supported their local women's health clinic. Indeed MUM's charity and Simpson Memorial Maternity Pavilion were original supporters in the construction of the facility.
Charity Salima has benefitted by being able to act as a trained provider of screen and treat services, thus redcuing her dependence on providers from the Fistula Centre

This event was reported in the Edinburgh Evening News on 23/04/19

Quotes

[insert quote 1]
[insert quote 2]

Photos

Edinburgh evening News 23rd April 2019

City school gives gift of hope to stop cancer developing

CENTRE OF EXCELLENCE: Professor Heather Cubie and her team join nurses at Nkhoma Mission Hospital in Malawi

George Watson's funds cervical treatment in Malawi

DIANE KING

WOMEN in a region of Malawi are set to benefit from new life-saving equipment for the preventative treatment of cervical cancer.

Funding for the project comes from pupils at George Watson's College as part of the Watson's Malawi Partnership.

The Watson's Malawi Partnership was launched in June 2017. It aims to facilitate work between George Watson's College's pupils, staff, parents, former parents and other friends of the school and members of the wider community to build sustainable and mutually beneficial partnerships with organisations and individuals in Malawi.

Globally cervical cancer is the fourth most common cancer in women.

According to the World Health Organisation over 1,600 women in Malawi die every year from cervical cancer, representing almost 70% of all diagnoses.

Malawi also has the highest incidence of the cancer in Africa

The new rechargeable battery-operated thermal ablation device is used to treat cervical pre-cancers and prevent the development of advanced cancer. It has been gifted to a community clinic in Achikondi.

The device also allows women who have been examined and found to have an abnormality to be treated immediately, rather than having to return at a later date.

> "More women can access cervical screening and, if needed, treatment in their own locality"
>
> MELVYN ROFE

Nkhoma Hospital operates a "hub and spokes" model whereby it acts as the main centre with other peripheral clinics in outlying areas using staff who have been trained and supervised by the Nkhoma Hospital team. Achikondi Community is one such clinic where the George Watson's College funded thermal ablation device will be used.

Nkhoma Mission Hospital has become a centre of excellence in cervical screening and treatment, including developing new screening tests with the guidance of Professor Heather Cubie and her team, funded by the Scottish Government.

This includes testing of a cervical sample for HPV which is the cause of most cervical cancers. The new test can be performed in the on-site hospital laboratory and takes 1-2 hours to carry out and return the result to the clinic. The hospital has daily screening clinics where all of these things are carried out, by trained nurses and midwives.

George Watson's College principal Melvyn Roffe said: "Our school has a long-standing, emotional connection with this clinic. An annual trip takes place each October offering pupils an opportunity to see first-hand how their fundraising efforts are helping to change, and save, lives.

"The clinic on the outskirts of Lilongwe offers a range of services for women and families, and many babies are delivered by Charity Salima and her team of midwives.

"With the thermal ablation device and trained staff, many more women can now access cervical screening and, if needed, treatment in their own locality rather than travelling to a hospital many miles away. This is a great step forward for the health of Malawi women."

The charity visited Edinburgh in 2014 as part of an educational visit organised by Edinburgh based midwifery charity MUMS to learn more about pre and post-natal care.

newsen@edinburghnews.com

Videos

Policy Contact Details

Name:
Contact Number:
Address:
Email:

Comms Contact Details

Name:
Contact Number:
Address:
Email:

Social Media Details

Twitter Handle: **Hashtags:**
Facebook:
Instagram:

Media List

Agreed to media work: Y/N

Case Study signed off: Y/N
Pictures attached: Y/N
Group photos: Y/N

Used for media: [insert date and media]