SMP Health Forum Minutes

23rd October 2018
Edinburgh City Chambers

1. Welcome

Stuart welcomed attendees to the SMP Health Forum, and noted that the SMP wherever possible seeks to bring practitioners from both Malawi and Scotland together to discuss these links. Scotland-based Rachel Macleod and Dr Ibe Iwuh, visiting from Malawi, would be presenting and we would also be hearing from Scottish Government funded projects and receiving an update from the NHS Scotland Global Citizenship Programme. The aims of the forum are to help raise awareness of health funded projects in Malawi and their scale and scope across the nation, in order to facilitate connectivity and promote collaboration with practitioners, civil society stakeholders, and identify tangible actions which will enhance the work of those in the health sector. There will be a Q&A where attendees can discuss priorities in Scotland Malawi health matters. Rachel Macleod will show a short video and introduce Dr Ibe Iwuh, followed by a Q&A. This forum was filmed in order for this content to be made available to presenters and shared online so that anyone can view these tangible outputs.

Stuart invited attendees to introduce themselves in a roundtable introduction.

2. Rachel Macleod's Introduction

Rachel thanked everyone for the opportunity to speak and for attending. She played a short video which she had previously made for last year's SMP AGM 2017 as part of the Member Awards, which showcased her work as a midwife in Malawi. She explained that she had worked as a midwife for more than 30 years, and went to Malawi in 2007 to work in Lilongwe where she remained for eight years. Rachel introduced Dr Ibe Iwuh, whom she met while he was working on rotation during medical training doing obstetrics while she was in Malawi. They worked together for many years with little support, and Rachel helped Ibe find funding from a generous donor in Ireland who funded him throughout his training in Cape Town in gynaecology. He then went back to Malawi. Rachel also spoke about her personal experience in Malawi, and discussed sustainability as a major issue and how she had contributed to sustainability while there. She helped to set up a skills lab, and supplied materials. Her work of 8 years left a considerable impression upon her, and since returning, she has reflected upon this sustainability. Rachel believes that the sustainability she helped to embed is embodied in the women she cared for, the midwives she mentored, and the example she gave.

3. Dr Ibe Iwuh, Obstetrician & Gynaecologist

Ibe thanked everyone for the opportunity and privilege to address attendees. He thanked the Scotland Malawi Partnership for facilitating the visa process enabling him to be at the forum. He explained that he is one of ten children, and

his mother nearly died giving birth to the tenth sibling, inspiring him to study gynaecology. He noted that infant mortality is a significant issue in Malawi, as well as cervical cancer, where Malawi is leading on cervical cancer numbers throughout the world. Reasons can be attributed to delayed diagnoses, not early enough screening, few surgeons, and not enough preventative care. Ibe works with the Ministry of Health in Malawi in Area 25. There, he also aims to reduce neonatal complications, 90% of which he noted are avoidable. He sees 100-120 patients per day, and demand for access is high. His groups' vision is that mothers should be able to go home with a healthy baby.

4. **Q&A**

Stuart thanked Ibe and Rachel, and spoke of how their own passion and partnership reflects the essence of Scotland-Malawi links. He opened the floor to questions.

Q: 91% of ladies in Malawi have seen a midwife, so how does that translate to the percentage who will have an HIV test so that they can be treated during their pregnancy?

A: As part of the programme, every patient must receive a test. 2-4% who are negative are found dead within two weeks, so we retest them if they are found negative. 8-10% of women tested at the beginning are HIV+.

Q: Regarding the health facilities in Area 25, are all of those private that you have interacted with to make a composite area?

A: Before the College of Medicine, there had been organisations who were interested. There are a few who are coming in with small units, so the goal is to see if all the facilities can be integrated.

Q: Is what you're doing here to be used as a model to show what can be achieved?

A: It's a political question, but we intend to increase employment to bridge the gap, so it could be used to make a difference.

Q: To what extent will these new operating theatres be available to organisations outwith Area 25? And, what is the capacity of surgeons in a long-term training plan to take forward surgical training as well?

A: We need to create a system of sustainability, so we need to get everyone on board to get them trained, and train others as nobody is there forever. The facilities will be open to every patient.

Rachel: It's a public-private partnership, and it's not just about teaching emergency obstetric skills – it's about caring for women and women's needs, and that's what we hope to achieve working there.

Ibe: There is a great need for midwives as well and those who are experienced can train others in good midwifery care.

5. Presentations from Scottish Government-funded health projects

a. Dr Christine Campbell, Prof Heather Cubie: 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

Christine re-iterated that Malawi has the greatest incidence of cervical cancer in the world, and explained that they are building on previous Scottish Government funding (2013 – 2016) which sought to provide same day 'screen and treat' programme of cervical screening using visual inspection with Acetic Acid (VIA). They work with the Malawi Ministry of Health which is influencing WHO policy. Their priorities are a 'hub and spokes' approach with approvals from local chiefs, building local capacity to provide 'screen and treat' services, and to develop mentoring capacity, ie. in-country leadership and skills to support the national programme. Christine also noted their respectful partnerships within Malawi, and with Scottish and international partners and of the importance of hearing the voices of women.

b. Dr John Ferguson-Smith, St John Scotland

John explained that St John Scotland is made up of volunteers worldwide and that one of their foci is Malawi, working with volunteers at St John Malawi. They provide resources from Scotland and Malawi and the feet on the ground. They've been engaged with primary care products and they've sought to address the basics of healthcare, and they focus on fundamental health education and hygiene in the communities themselves. These basics save lives and improve rates of infant mortality, etc. When they had the chance to expand their work with the Scottish Government, they seized the opportunity to extend the work into Lilongwe, Kingomo, and other cities. The extended project is based on tried and tested activities of newborn and neonatal projects. They are tied to parallel initiatives around water, sanitation and hygiene (WASH) projects. They believe they can significantly affect the lives of 99,000 beneficiaries, which will be measured.

c. Dr Barry Klaassen, NHS Tayside Scottish Emergency Medicine, Malawi Projects 2010 – 2015, 2018 – 2023

Barry introduced himself and his Scottish Project Team Lead Nurse, Gwen Gordon, also in attendance. He explained that the project has clear objectives: to reduce the mortality of adult emergency admissions to QECH; to enhance the standard of care of all adult emergency admissions to QECH; to introduce a fit for purpose teaching programme for clinicians and nurses to enhance the practice of emergency care; to encourage high quality collaborative emergency medicine research; to encourage a sustainable, coordinated, multi-specialty approach to emergency care in Blantyre within the project time-frame. Barry displayed a

slideshow of images which showcased their project across the stages, including the development of true mentoring, the opportunity to train/teach, and the impact of the AETC through improved treatments, earlier initiation of treatments, less emergency admissions, and anecdotal reports of lower death rate on the wards. The plan for 2018 – 2023 is to develop three ETC's and emergency medicine in Kamuzu Central Hospital Lilongwe, Mzuzu Central Hospital, and Zomba Central Hospital.

d. Professor Jeremy Bagg, the The Maldent Project

Jeremy explained that the call for this project came directly from Malawi. Dentistry might seem low on the priority list but this isn't true. There are 36 dentists in Malawi, and 30 are in private practice so there are the equivalent of six NHS dentists in Malawi. There hasn't been a high quality of epidemiology. In the outcomes of this project, Malawi doesn't have an oral health policy at all at the moment, but now there is one. They do, however, need a prevention policy, ie. Child Smile in Scotland, and Jeremy is working with WHO on this. The President of Malawi visited earlier this year and he specifically spoke about dental medicine. The planned outcomes are 1) establish a Bachelor of Dental Surgery Programme at the College of Medicine, University of Malawi, 2) Produce highly trained dentists, prepared for clinical practice in Malawi, who will graduate from the College of Medicine and register with the Medical Council of Malawi, 3) Establishment of a national Oral Health Policy, Oral Health Strategy and Implementation Plan. Jeremy currently updates all features of the project via his blog.

6. Q&A Discussion

This round of Q&A took on the format of a discussion, rather than a set Q&A. Discussion points are bulleted below.

- The main thing is collaboration, so don't be discouraged if you are a new grant holder. NHS Tayside offers collaboration and others do too. WE need to promote education and peer reviews. All of this can happen through the Scotland Malawi Partnership and the Malawi Scotland Partnership. MaSP is really important for our colleagues in Malawi to get to know each other.
- When you get on the ground, there are many people from different countries doing good work. If we don't work together and find out what everyone else is doing then there is competitive interest which can break things down.
- There are important things coming out of this and the way forward, ie. Upskilling and the emphasis on women.
- **Kerry Chalmers, Scottish Global Health Scotland:** We want to map baseline what the partnership is working on and what projects are going on. You can learn so much from other models as well. This will be published on the 2nd November on the website, so that we can start to link and network and share the work that's been happening.

- An MOU is helpful so that if someone from another country wants to help, then you can share what you can do. We welcome help from North America and they focused on one aspect of training. That way you're not duplicating.

David Hope-Jones, SMP, took the opportunity to ask what the SMP can do over this period to support collaboration both between these projects and amongst the wider civic effort between Scotland and Malawi on health. These are bigger projects than before with 4.5 years of funding, so this is a time for us as a network to think about how to support and inspire Scotland with stories of human impact, collaboration and inspiring and raising awareness of this work.

Responses bulleted below:

- Conscious that support is needed from different angles, ie consumables like equipment. The SMP already publicizes that well, but other needs can be identified.
- Suggest dividing meetings of different sectors so we can see who is working in what sector. There are the same difficulties in academia. Scotland and Malawi are not big countries but we struggle to share knowledge and information about projects.
- One of the biggest questions is the local Malawian staff resource to help sustainability. I'd like to see the SMP and MaSP help lobby engagement of public healthcare, perhaps commercially.
- Concern is fragmentation when those projects develop – there should be collaboration with the Ministry of Health on things like performance indicators so that everyone who is working on a particular field in diverse locations are feeding in together
- There is talk about sustainability but it is dependent on ownership.

Q: Does MaSP have similar health meetings?

A: Yes, it is part of the cooperation agreement. Vera, Chief Executive of MaSP, is similarly keen to have cross fertilisation across the two groups. If your partner is not a partner of MaSP, please do encourage them to join so they can take part. The model between these countries really only works if they have strong collective voices as we do here.

One attendee raised an area of collaboration addressing a Malawi-wide breast service with 3 programme pillars: 1) infrastructure and service provision, 2) roll out education to district hospitals, 3) raise awareness amongst the general provision. Cervical cancer is the single highest cause of death in women and breast cancer is the second highest. The main concern is lack of awareness and if breast cancer surgeons can work with cervical screening and gynaecological colleagues then that is one way to raise awareness. Some screening programmes incorporate breast examinations but that isn't approached in a focused way. This is an area for potential collaboration.

Dr Christine Campbell added that this also speaks to surgical capacity. There needs to be treatment pathways. It is one thing to identify it, but another to treat it otherwise it's an unethical situation. It's part of a broader discussion, awareness raising, capacity and training and treatment.

7. Kerry Chalmers, NHS Scotland Senior Policy Manager

In order to contribute to the wider international development strategy and commitment to support capacity strengthening and how we encourage NHS staff to participate in global health work here and abroad, we want to understand what the NHS's role is, what the global health landscape looks like. We've been mapping health partnership work at a more formal level. We've looked at who is doing what, where they're doing it, key challenges, how to better support them, and how to measure benefits from this work. We'll be publishing the health partnership database next week and this will be the start of pulling together this landscape. We've set up our Global Citizenship Champions Network, a network of NHS staff, actively involved in global health work of around 170 staff members across different staff groups, ie, nurses, doctors, retired colleagues, procurement specialists, etc. Those numbers will increase once the programme embeds. There are new pieces of work going forward, including a global health coordination unit. One other thing we're looking at is how we capture the organisational benefit and mutual learning from this work. We're doing some work with NHS Education Scotland so that we can start measuring the impact on individuals and on our healthcare system. It was mentioned earlier about approaches to equipment, like redundant or surplus equipment, and we're looking with colleagues in procurement about what a start to end NSH plan would look like. We will be identifying these elements across 22 different NHS boards. We have our next meeting on 29th October to discuss shipping, installation, and the capability to receive that equipment.

8. Closing remarks

Stuart thanked everyone for attending, and highlighted the afternoon's discussions on common themes of respectful partnership, where we are all learning as much as we are giving. Priorities are ensuring sustainability through Malawian mentorship as key for the future. There was tremendous openness and willingness to share knowledge during the course of the afternoon, as well as open volunteering of networking between the disciplines. From the SMP, there is potentially more scope to share specific needs of individuals, and for SMP and MaSP to look at lobbying and connecting with the private sector and the likes of the World Bank with a view to open things up to funding and backing which would compliment Scottish Government support. Main outcomes from this afternoon are that 1) these meetings are useful, 2) we will find ways of making meetings more interactive and engaging, with specific connections and collaborations, 3) listen to the needs of those projects and amplify them, 4) use our influence and leverage to bring in other funding from the private sector, both here and in Malawi. Final comments are that in two-three weeks, there will be an official Conference statement which was unanimously agreed on at the recent Malawi Scotland Conference. There will be three sections of the agreement, and

the last section is strand specific so there will be four main points for the health group.