



ENDLINE SURVEY

ACCESS TO CERVICAL CANCER AND RMNCAH+N SERVICES DURING THE COVID-19 PANDEMIC ENDLINE STUDY IN KASOBA AND MPATA CATCHMENT AREAS IN PARAMOUNT CHIEF KYUNGU IN KARONGA



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(REPORT)

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
CECAP	Cervical cancer control and prevention
Cidex	is a common designation for a variety of solutions used for antimicrobial or disinfection purposes
COVID-19	Coronavirus disease of 2019
EPI	Expanded Programme on Immunizations
FGD	Focus Group Discussions
FP	Family Planning
GVH	Group Village Head Man
HIV	Human Immunodeficiency Viruses
HPV	Human Papilloma Virus
ICT	Information, Communication and Technology
KDH	Karonga District Hospital
M & E	Monitoring and Evaluation
RMNCAH+N	Reproductive, Maternal, Newborn, Child and Adolescent Health and Nutrition
SRH	Sexual Reproductive Health
SRHR	Sexual Reproductive Health and Rights
TA	Traditional Authority
VIA	Visual inspection with acetic acid
WCAH	women's, children's and adolescents' health

WHO World Health Organization

WOCACA Women Coalition against Cancer

Acknowledgement

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Executive Summary

The Endline Survey was conducted in order to understand the current situation of the mobilization campaign and outreach clinics conducted in Mpata and Kasoba catchment areas under T/A Kyungu. The total catchment population for the two areas is 28,422.

Aim

The main objective of the survey was to build capacity for community awareness and mobilization in order to create demand for cervical cancer prevention and control services amidst Covid -19 Pandemic.

Methods

A quasi-experimental design was used to compare the state before and after project implementation in the two areas. There was no control catchment area for the study. Data was collected both, quantitatively and qualitatively. Qualitative data was collected through two focus

group discussions and four key informant interviews in order to help understand the quantitative findings.

Key findings

Overall, knowledge on general SRHR has risen from 33.3% to 40.1%. Health facility remains the main source of SRHR information on both covid-19 and SRHR followed by mobilization campaign. Access to cervical cancer screening in the past 3 months has increased more than 100% from 1053 in July to December 2020 to 3092 in the period spanning from July to December 2022. Health facility remains the main source information followed by Community mobilization. Traditional leaders remain a single most tool used to mobilize local people to access health services. Myths and misconceptions, lack of equipment, and unavailability of a conducive environment for screening are some barriers to accessing SRHR services. Long distances to health facilities, and the rainy season were other barriers to accessing health services.

Recommendations

The mobilization campaigns need to continue to create demand in the people to access health services. Mobile clinics must be established in hard to reach areas to ensure access to cervical cancer screening. Train more health care workers on cervical cancer screening and establish more clinics in remote areas. There has to be a continuous supply of consumables for use during screening.

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Recommendation

There is need to scale up the project to include other areas to ensure that universal health care coverage is achieved. Bottlenecks at Mpata such as unavailability of resident health care providers need urgent attention.

1.0 Introduction

This chapter presents the end line survey with background relating to the project, context of project implementation, study objectives and finally, the scope of the project.

1.1 Project Background

The project is derived from Women's Coalition against Cancer (WOCACA) vision to address issues surrounding awareness, stigma and access to cervical cancer services in Malawi. WOCACA is a women's led organization that was established with the vision of ensuring that women and adolescents girls have access essential health and nutrition services to their health outcomes and that of their families(women, children and adolescents) (WCAH) in Malawi with much focus on reproductive cancers.

WOCACA places emphasis on empowering women, young girls and their families through civic education, advocacy and networking to access health services as a right. This is done by involving the marginalized community through information sharing, networking, and community mobilization.

WOCACA also builds capacity through training of health care providers, provision of basic equipment to use during service delivery including cervical cancer screening, and logistical support on sample transportation to reference laboratories within Malawi.

Literature shows cervical cancer is the most malignant cancer among women in Malawi, accounting for more than 40% of the female cancers(Rudd et al., 2017). With an HIV prevalence rate of more than 10.6% ((Gerstl et al., 2022; Howitt et al., 2017)) Malawi has one of the highest HIVAIDS prevalence rates in the world. Cervical cancer is one of the HIV defining conditions and double morbidities with HIV reduces the chances of survival in infected individuals ((Maseko et al., 2014)Studies in sub-Sahara shows that women who have been diagnosed with both cervical cancer and HIV barely survives 5years from the time of diagnosis (Malawi Ministry of Health, 2019). Before covid-19 pandemic, cervical cancer services uptake was very low in Malawi, Karonga in particular. Poor health care systems, lack of proper screening methodologies, myths and misconceptions are some of the hindrances to accessing cervical cancer services. These bottlenecks were exacerbated by the Covid-19 pandemic, forcing health care systems to focus

much on epidemic control at the expense of SRHR services. The health care system in Malawi literally collapsed.

1.1 Context

In Malawi, Cervical cancer screening is not fully intergraded within the Maternal and Neonatal Health programs (MNH). For instance, 11 out of 22 health facilities have one health care provider who provides cervical cancer services in addition to other essential health services such as ANC,FP, EPI just to mention a few. As such cervical cancer screening is done on specific days of the week in all health facilities. This limits access to the services. The scope of the services is limited to screening using Acetic Acid, and basic treatment using Thermocoagulation.

In health facilities that do not have a trained provider, technical staff from Karonga district hospital conduct outreach clinics on scheduled days to provide the service. Due to limited resources, KDH is not able to provide outreach services to all health facilities that do not have trained personnel. At Mpata and Kasoba health Centre in T/A Kyungu, cervical cancer screening was conducted as an outreach from KDH. This was made possible with financial support from WOCACA, with funding from Management Sciences for Health (MSH). The outreach clinics were conducted from 29th March 2022 to 30th June 2022 covering Tuesdays and Fridays only.

Karonga has a significantly higher number of child bearing women, estimated at 89, 419 (NSO, 2021). Kasoba and Mpata in T/A Kyungu has an equally high proportion of childbearing women at 17,187 and 11, 235 respectively. The lack of cervical cancer services poses a high risk for the progression of cervical cancer as women report to health facilities when cancer is advanced (Gerstl et al., 2022). This is facilitated by lack of specific symptoms characteristic of cervical cancer, making the disease difficult to identify in its early stage.

Though Malawi government has reviewed its cervical cancer strategy and cervical cancer procedure manual, little effort has been seen on the implementation level to combat the disease (Malawi Ministry of Health, 2019). It is against this background that WOCACA put together a project in order to contribute towards eradication of the disease.

1.3 Overall Objective of the Project

The main objective was to build capacity for community awareness and mobilization in order to create demand for cervical cancer prevention and control services. Specifically, the project aimed to:

- Conduct advocacy, and communication campaigns, through media engagement, to help communities to access essential health services related to cervical cancer such as vaccinations and screening during the COVID-19 pandemic.
- Ensure provision of support to women, children and adolescents so that they demand and use essential SRH services during the COVID-19 pandemic.
- Monitor if services in health facilities are delivered according to standards by ensuring availability of and access to high-quality RMNCAH+N information, supplies and services in light of the pandemic.

The main focus was to ensure that despite the Covid-19 pandemic, marginalized populations are able to access essential health care services in an environment plagued with systems challenges pre-pandemic.

1.4 Objectives of the End line Survey

The objectives of the end line survey was to collect data (Quantitative and Qualitative) on community mobilization and cervical cancer outreach services conducted in Mpata and Kasoba catchment areas under Traditional Authority Kyungu. This data was analyzed, measured, and compared to the baseline survey in order to determine successes and weak areas in need of further support for the project. The data as collected in Kasoba and Mpata Catchment area before and after the project in order to evaluate the impact of the intervention (Mobilization campaign and service delivery). This was done through a thorough examination of project activities in the context of Covid-19. The constraints with respect to the short duration for implementation were carefully considered. Success stories were also documented in order to inform the public on best practices.

The Specific Objectives of the Endline Survey

Based on the project implementation, the specific objectives of the study were as follows:

- To assess the level of knowledge on Covid-19, SRHR and Cervical cancer among the local population in Kasoba and Mpata after community Mobilization
- To determine community awareness of their right to health, including right to access essential health services during pandemics (such as Covid-19 pandemic)
- To determine the level of civic engagement and its influence on access to SRHR
- To determine community leaders' support on access to Sexual, Reproductive and Rights
- To determine the commitment and support from stakeholders such as political leaders, health officials and traditional leaders ensuring availability of SRHR services during pandemics

Scope of The Endline Survey

The survey was conducted at Kasoba and Mpata catchment areas under T/A Kyungu. Kasoba covers 2 VDCs, 28 village headmen and 4213 households while Mpata covers 6 VDCs, 49 villages and 5103 households. (NSO, 2022).

2.0 Study Methodology

This chapter summarizes the end line methodology including study design, study methodology, tools and study procedures.

2.1 Endline study design

A Quasi-experimental Design was used in this study. Realizing the need to have scientific measurement of project impact, the end line survey attempts to adapt some principles of experimental designs. Since the project locations are purposively selected prior to the baseline, randomized control design was replaced by a Quasi-experimental design.

What is a quasi-experimental design?

It is an experimental design that does not need meet all the requirements necessary to be an experimental design which requires controlling influences of extraneous or confounding variables. It is an evaluation design where the interventions implemented are selected purposively (without any form of randomization). In the context of this project, where project areas were purposively selected accounting needs assessment and other criteria, quasi experimental designs allow measurement of project by calculating double differences. Moreover, since there were two areas of implementation, variables in these two areas in terms of human capacity and geography were not exactly the same, allowing comparisons to take place.

A chart below illustrates how a Quasi-experimental design works in evaluating a project

Quasi-Experimental Design (Double Differences)

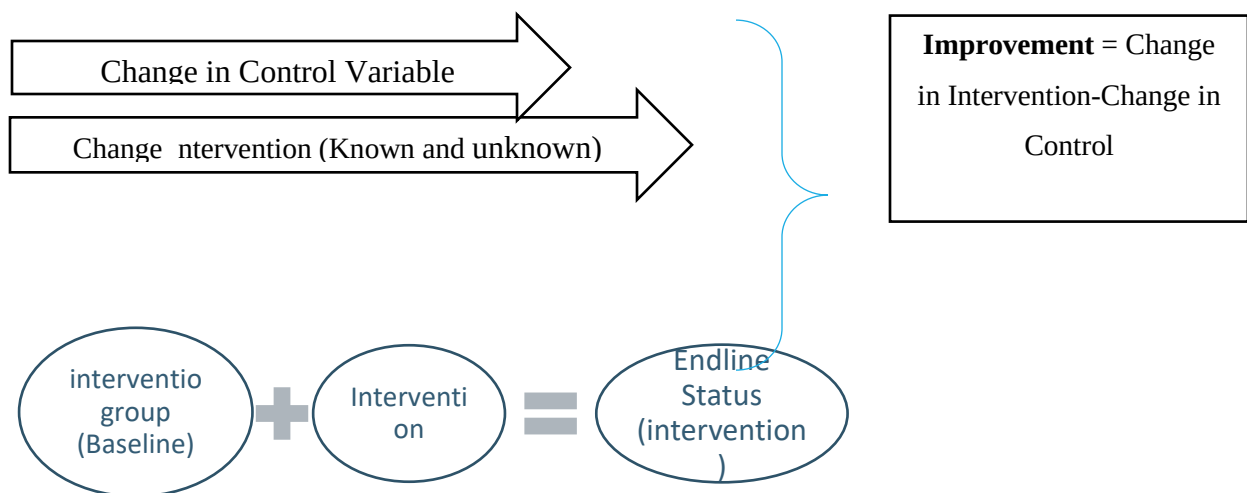


Figure 1: Study design

2.2 Study methods

The end line study collected both quantitative and qualitative data. The quantitative tools will be used to primarily to estimate the status of counterfactuals, and the qualitative tools are expected to contribute in explaining the quantitative findings. The charts below illustrates the key methods/tools by category.

2.2.1 Quantitative Methods

Method 1.

Table 1: Knowledge, Attitude, and Perception (KAP) survey with target groups

Design	Implementation Zone
Sample size	300 (all in the implementation area). The sample size was calculated by considering a population of 28,422 and a confidence interval of 0.05. 187 were drawn from Kasoba (n=11235) and 117 were drawn from Mpata (n=17187).
Zone of influence	All VDCs in Kasoba and Mpata were considered as Zone of influence.
Sample distribution	The participants were considered equally distributed considering the nature of influence o interventions and were randomly selected by door to door
Sample frame	All women of reproductive age group 16-49 were considered for sampling
Sampling procedure	The sampling procedure was cluster based random sampling. The ward clusters were identified randomly. From within the clusters, stratified random sampling was done.



Figure 2: Pic 1. Administering a questionnaire to a participant in the field

2.2.2 Qualitative methods

Method 1. Focus Group Discussion

Focus group discussion (FGD) with homogenous groups-women, marginalized and who had been screened for cervical cancer in the last 6 months was used for qualitative data and in-depth interview. FGD data enables the research to delve into the meaning of information derived through quantitative tools. FGDs were conducted based on specific checklists supplemented by few participatory tools. FGDs was to be conducted with four groups: (i) women in Mpata (ii) Men in Mpata (iii) women in Kasoba (iv). Men in Kasoba



Figure 3: Pic 1. Men Focus group discussion at Kasoba

Method 2. Key informant Interview (KII) with stakeholders at district/health facility and VDC

The indirect target groups are duty bearers at district level and VDC level were administered key informant Interviews (KII). The key informants for this baseline survey include VDC, DHO, DNMO, CBO network group at district level. The number of KII conducted for this study were 1 DHO, 1 DNO, 4 community health nurses, 3 CSO representatives, 2 representative of CAC, and 2 representative from women's welfare groups.

Method 3. Review of registers in health facilities

Cervical cancer control program (CECAP) and Covid-19 registers were reviewed at Mpata and Kasoba health centers. These were done to take stock of service delivery before and after mobilization in the areas.

2.3 Study Procedures

The endline survey observed stringent standard research procedures.

1. Brainstorming and consultation-endline design process took off with rounds of brainstorming and consultation meetings with Karonga DHO, WOCACA and Karonga debate club. This helped refined the survey design proposed by the technical proposal

2. Review of literature-various available literature on endline study design, national and government reports, domestic and international publications, newspapers and other sources were reviewed for additional information to assist process
3. Finalization of research methods and tools-following the literature review, WOCACA finalized the design of the study. Suitable research method and design were identified based on the research design, coverage of the project and availability of resources.
4. Orientation and training of enumerators- following the finalization of the research design and development of methodologies, orientation workshop was held for enumerators. The training content included discussion on endline as part of monitoring and evaluation system, endline design, study methods, tools, and strategies for data collection (sampling, ethics and procedures)
5. Administration of tools and data collection- baseline questionnaire was adopted and modified into an online tool using Google files. This tool was pre-tested and customized. Pre-testing was done at Kasoba Karonga DHO before sharing the link with enumerators. The data was collected using smart phones applying the Google files.
6. Data analysis-Quantitative data was computed automatically using the Google files. Data officer analyzed the findings based on the field notes and transcripts.
7. Finalization of tools-based on the observations from pre-testing and feedback from training sessions, the tools were reviewed, revised, edited and finalized. The qualitative data was coded, compiled and sent to the principal investigator after data collection,
8. Data analysis-the data was entered into SPSS to analyzed quantitative data, qualitative data was analyzed based on filed notes and transcript. Both forms of Data were analyzed and triangulated.

2.4 Human Research Subject Research Ethics

WOCACA ensured strict adherence to human subject's research ethics related to anonymity, confidentiality and informed consent. The interview were conducted after seeking consent form from the participants, and arrangements were made to protect human rights. The field enumerators were thoroughly oriented on adhering to human subject's research ethics.

2.5 Limitations of the study

The end line study was conducted within a short period of time with limited resources as such some key informants like local Member of Parliament (MP) were not interviewed.

3.0 Key Study Findings

This chapter presents key baseline study findings starting with demographic and socio-economic profile followed by objective wise findings.

3.1 Overview of The Project

Key findings were based on the 5 thematic areas in the questionnaire in the study tool as follows: (i). Knowledge on Covid -19 (ii). Knowledge on SRHR (iii). Knowledge on cervical cancer (iv). Civic knowledge and (v). Access to SRHR and cervical cancer. The detailed findings on each thematic area have been presented below.

3.2 Demographic characteristics of respondents

Table 2: Demographic characteristics according to catchment area

	KASOBA		MPATA	
	BASELINE	ENDLINE	BASELINE	ENDLINE
Catchment population	33,052*	33,052*	23,693*	23,693*
Population (16yrs and above)	17,187	17,187	11,235	11,235
Proportion of sample	0.61	0.61	0.39	0.39
Sample Size	183	183	117	117
Respondents	134	169	120	115
% Respondents	73%	92%	102%	96%

*NSO Projections, 2021.

Table 1 shows an equal proportion of respondents from the two catchment areas. This is attributed to the mobilization activities that took place in these areas. Proportionate time was invested in sampling in both catchment areas in order to generate proportionate sample sizes for each catchment area.

3.2.1 Brief Description of respondents

The overall response rate for the end line survey was 90%. Kasoba had shown an increase on the number of respondents from 72% (n=135) to 91% (n=168) and Mpata had an equally high response rate of 81%. This is attributed to the strong mobilization campaign that took place at Kasoba. Secondly, data was collected in 3 days at Kasoba as opposed to 2 days at Mpata. Some areas in Mpata are hard to reach due to poor terrain. For a full description of the demographic attributes and their distribution, refer to annex 3.

3.3. To assess the level of knowledge on Covid-19 and Cervical cancer among the local

This chapter focuses on knowledge of COVID-19 in relation to sexual reproductive health and rights (SRHR).

Outcome Indicators.

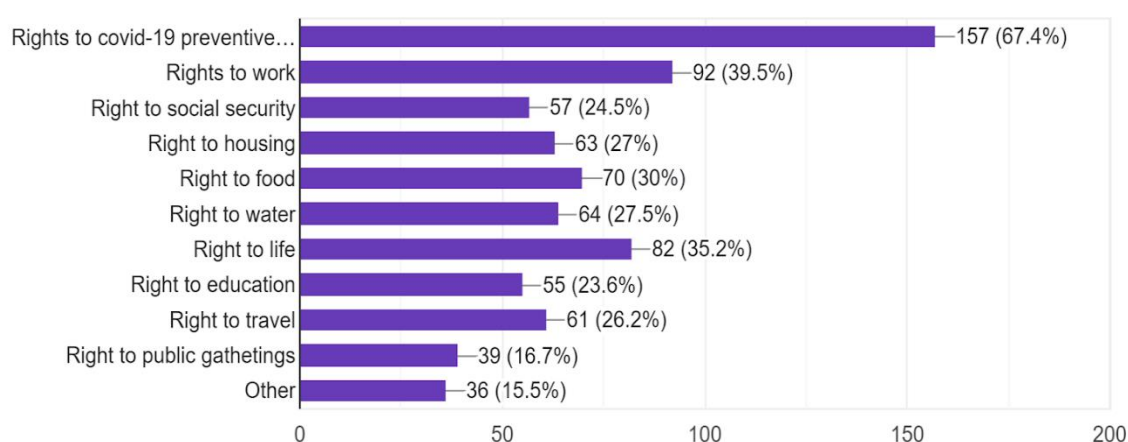
Four outcome indicators were assessed as follows:

- Percentage (%) of respondents (segregated by sex) aware of sexual and reproductive health rights and services.
- Percentage (%) % of respondents (segregated by sex) with comprehensive knowledge of SRH rights.
- Percentage (%) of respondents (segregated by sex) aware of COVID-19 rights and services.
- Percentage (%) of respondents (segregated by sex) with comprehensive knowledge of COVID-19 health rights.

Table 3: SRHR Outcome Indicators

Indicator	Baseline			End line		
	Overall	Male	female	Overall	Male	Female
% of respondents who are aware of sexual and reproductive rights and services	77.6%	78%	77.2%	86.5%	89.2%	83.7%
% of respondents with comprehensive knowledge of SRH rights	20.3%	17.7%	22.9%	41.5	44.3%	38.2%
% of respondents aware of COVID-19 rights and services	93.7%	94.6%	92.8%	98%	99%	97%
% of respondent with comprehensive COVID-19 health rights	29.3%	30.4%	28.6%	50%	62%	38%

The table above shows that people in Mpata and Kasoba have comprehensive knowledge on both SRHR as well as COVID-19 rights and services. There is no much difference before and after the project. The graph below depicts the knowledge on rights related to COVID-19.

**Figure 4: Source: Endline survey, 2022.**

3.3 Determine the most effective way of disseminating health related messages to the local population in a rural and semi-rural areas

According to participants, the major source of information is the health facility, followed by the media and mobilization campaigns as shown in the table below. Other respondents mentioned that door to door mobilization by health surveillance assistance helped them a lot.

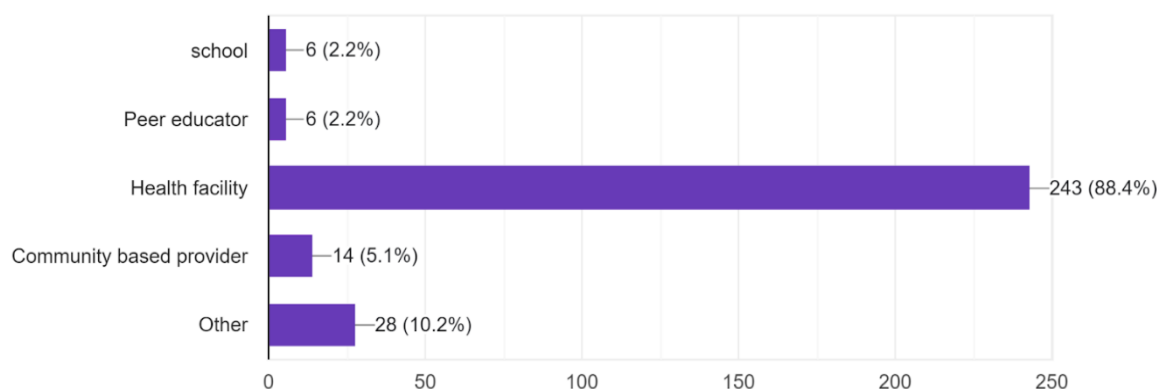


Figure 5: Chart 1. Source of knowledge on Covid 19

Source: End line Survey, 2022.

Key informants also mentioned that local leaders were a major driver in disseminating key COVID-19 messages to the local people. As noted by one key informant below:

‘TumbukaMafumu yithu wakutichsya chomene kuti tilutenge ku chirabu kukapulika za uthenga wa covid 19 [focus group discussion participant 003, Mpata]

‘English versionOur chiefs encourage us a lot that we go to our meeting points (Chirabu in local setting) to listen to information on Covid 19. FDG code 003, Mpata)’

Knowledge on SRHR, COVID-19 and rights

There is an increase in community awareness in terms of right to health, including right to access essential health services during pandemics (such as Covid-19 pandemic)

In terms of gender, 78% males as compared to 77.2% females indicated that they knew or heard about SRHR though their comprehensive knowledge on the same was very low. Radio was the main source of information before the project. The end line survey revealed similar findings (82%

males, 80% females) in that more men than women were aware of their sexual rights than women. This could be because of the following:

Survey behavior of respondents.

Limited access to information on the part of women.

Men do not share health related information with their spouses

This is further compounded by lack of access to ICT. According to NSO report based on PHC of 2018 at household level access to ICT is as follows:

51.7% have a mobile phone.

33.6% own a radio.

11.8% have a television.

16.4 % have an access to the Internet.

3.4 Knowledge on Cervical Cancer

This chapter discusses key findings on cervical cancer. It focuses on causes, prevention, treatment and attitudes.

3.4.1 Outcome Indicators

The study assessed two outcome indicators namely; % of respondents (segregated by Sex) aware of sexual and reproductive health rights and services and % of respondents (segregated by sex) with comprehensive knowledge of SRH rights.

Table 4: Cervical Cancer Indicator Key Findings

Indicator	Baseline			Endline		
	Overall	Male	Female	Overall	Male	Female
% of respondents who are aware of cervical cancer	94%	95.2%	92.8%	98.5%	100%	97%
% of respondents with comprehensive knowledge of cervical cancer risk factors	19.9%	21.2%	18.6%	32%	35%	33%
% of respondents with comprehensive knowledge of cervical cancer prevention methods	8.4%	9.4%	7.4%	8.5%	10%	9%
% of respondents with comprehensive knowledge of cervical cancer treatment	5.9%	7%	4.8%	7.6%	7.2%	8%
% of female respondents ever gone for cervical cancer screening	33.3%	0%	33.3%	40.1%	0%	40.1%
% of female respondents who made own decision on cervical cancer screening	12.6%	0%	12.6%	17%	0%	17%

Proportion of respondents with negative attitudes towards cervical cancer and cervical cancer screening	39.4%	34.5%	44.3%	48%	44%	51%
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3.5 The following can be observed from the above results:

Generally, a large proportion of people are aware of cervical cancer irrespective of gender. (94% overall (95.2% male and 92.8%) knowledge on specific indicators has slightly increased after project implementation. For instance; cervical cancer risk factors (34% overall, 36% male and 32% female). However, knowledge on cervical cancer treatment modalities has remained the same. This is a cause for concern since most people are still not aware that treatment modalities for cervical cancer are available.

There was an increase in the number of women who had made decision to go for cervical cancer screening from 33.3% to 40.1%. This is attributed to the rise information sharing among families regarding SRHR.

3.6 Knowledge of Cervical Cancer.

Knowledge of respondents on cervical is important in the study because it gives a picture of the extent to which they know types of cancer in turn it shades light on whether they know the causes, symptoms, prevention and treatment services. This would assist relevant intervention planners and duty bearers to devise suitable strategies to combat the diseases. Below are finding on the respondents knowledge on types of cancer.

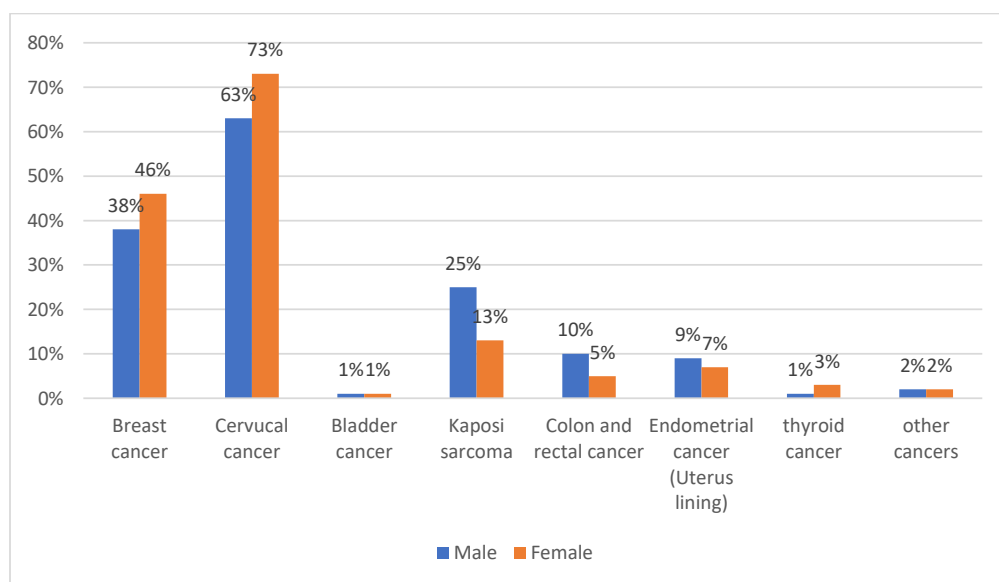


Figure 6: : Proportion of Respondents with knowledge of different types of cancers

Source: Baseline Survey: July, 2022.

Basing on the figure above, the baseline survey showed that cervical cancer was the most known type of cancer to both respondent's in males and females followed by breast cancer and Kaposi sarcoma. While the rest were least known. It is for this reason that it should be born in mind that while strategizing to come up with mechanisms to fight cervical cancer by various means, the same strategies should as well be blended with knowledge of other least known type's cancer such as breast cancer. An integrated approach must be adopted in screening for other reproductive cancers in Malawi. This would help communities to benefit from a number of services during a single clinic visit.

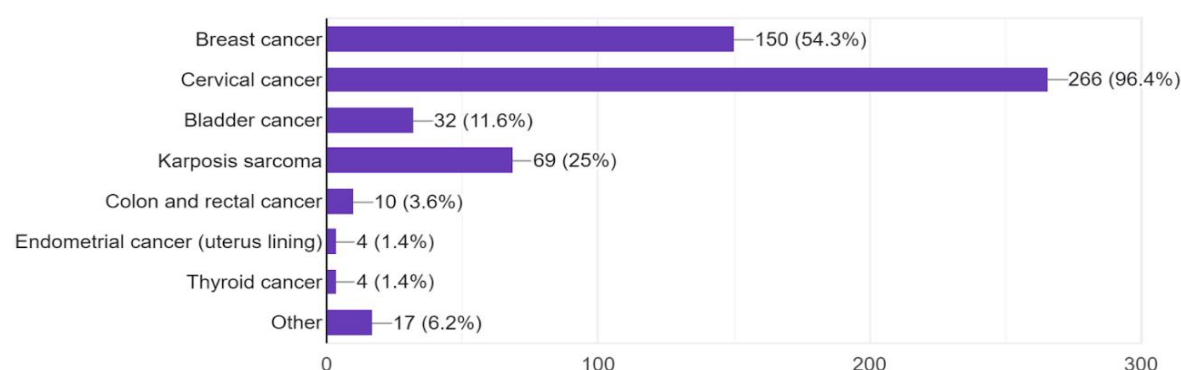


Figure 7: Source: Endline Survey (July, 2022).

Comparing with the baseline data, the endline survey shows that knowledge on cervical cancer has increased from 68% (63% males, 73% females) to 96.4% (94.8% males, 98% females) seconded by breast cancer which was on 42% and is now on 54%. Other cancers like Kaposi's (25%), Bladder Cancer (11.6%), Colon and rectal Cancer (3.6%), endometrial and thyroid cancer at 1.4%. this is a tremendous increase in both males and females and shows that men are engaged in female reproductive cancer issues.

The graph below shows the source of information on reproductive cancers (Endline survey)

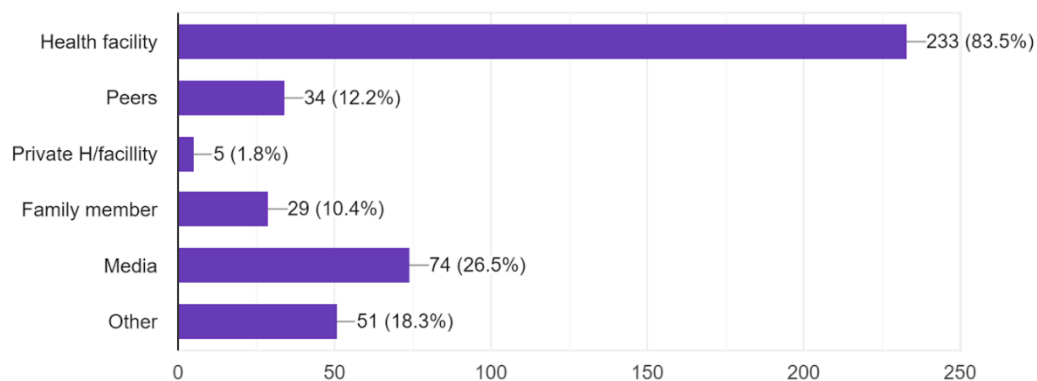


Figure 8: Endline survey

Basing on the graph above, health facility was the main source of information for both males and females in all sites (Mpata and Kasoba). This can be attributed to the routine campaign that was organized in these two sites. It is interesting to note that private facilities have also started offering reproductive cancer services. It is also interesting to note that family members (10.4%) are taking part in discussing reproductive health matters.

3.7 Risk Factors of Cervical Cancer

It is very important to measure the respondents level of knowledge associated with risk behaviors that would escalate contraction and spread of cervical cancer. Basing on their level of knowledge programs are designed to contextualize the intervention measures. When the root causes of the spread of the diseases are known then community members can be empowered to abandon their inappropriate conducts. Below is a graph depicting respondent's awareness on risk factors on cervical cancer.

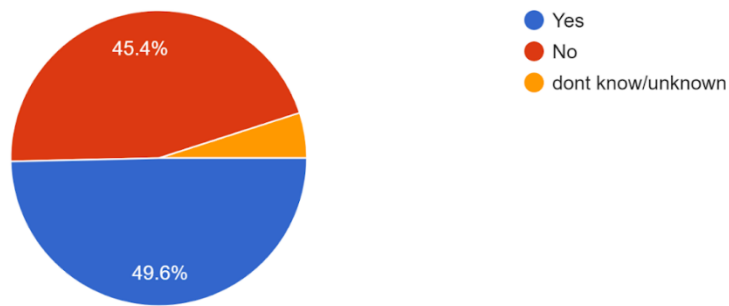


Figure 9: Knowledge on signs and symptoms of cervical cancer (endline survey, July, 2022)

The pie chart is a reminder that though people are aware of reproductive cancers, almost half the participants are not aware of the details including signs and symptoms of cervical cancer.

‘Kasi mwa WA WOCACA mungatiganizira yayi kuti nase tiwe na bubgwe la wachinyamata kuti tisambizyikenge vyakukhwasana na matenda yakupasana pakugonana, khansa, na matenda ayo yakutiwika ise pa chiofyo’ Peer educator Mpata’.

English: Can’t WOCACA consider establishing youth club here in Mpata so that we may be trained in SRH services including STI, reproductive cancer etc. Peer educator, Mpata’.

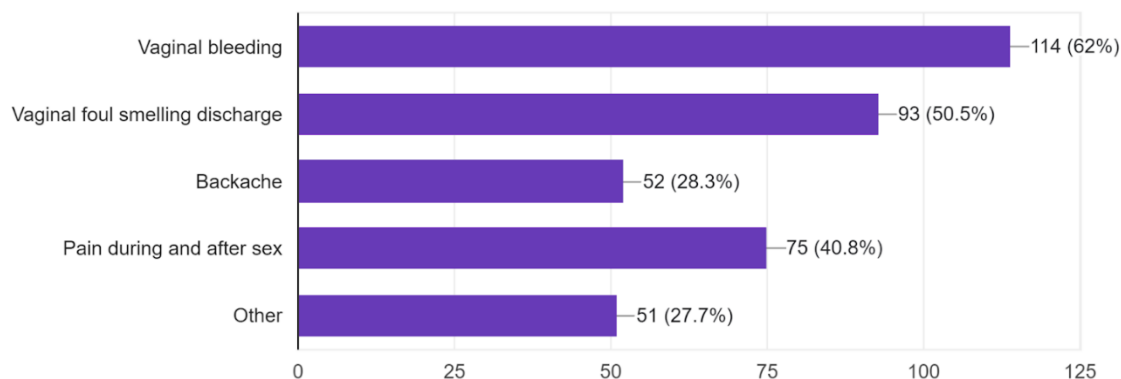


Figure 10: Signs and symptoms (source: Endline survey, July, 2022).

The endline survey shows that more people know vaginal bleeding as the main sign of cervical cancer followed by vaginal foul smelling discharge (50%).

3.8 Risk factors for cervical cancer

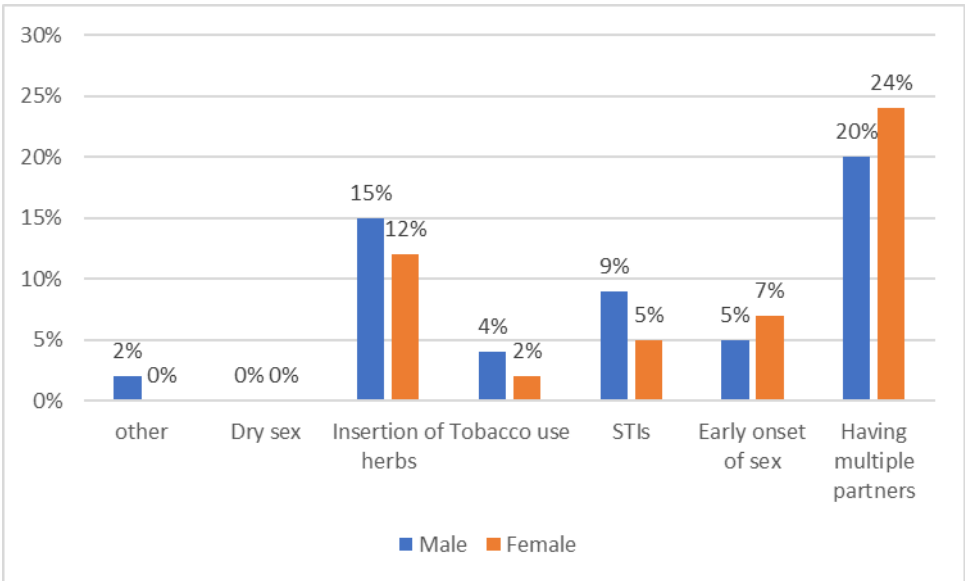


Figure 11: Proportion of respondents with knowledge of cervical cancer risk (baseline)

The baseline survey shows having multiple sexual partners is the major risk factor for cervical cancer at 22% (20% males and 24% females). The endline survey shows an increment in percentages to 69% (50% males, 88% females). This is followed by early onset of sex which was at 6% (5% males, 7% females) now at 37.9% then STIs which was at 7% (9% males, 5% females) now at 32,6% on endline survey .Therefore this shows an increase in awareness of the risk factors for cervical cancer as shown below.

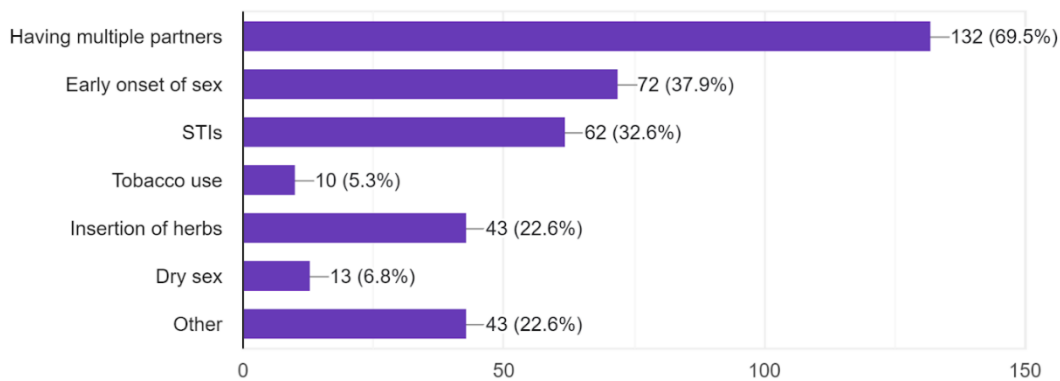


Figure 12: Risk factors

3.9 Prevention

Knowledge on prevention of cervical cancer was assessed in-order to determine if people are able to protect themselves against the disease. The graphs below shows the respondents level of knowledge appropriate to prevent the spread of cervical cancer before and after project implementation. The table below shows that people had comprehensive knowledge on the main prevention strategies after project implementation.

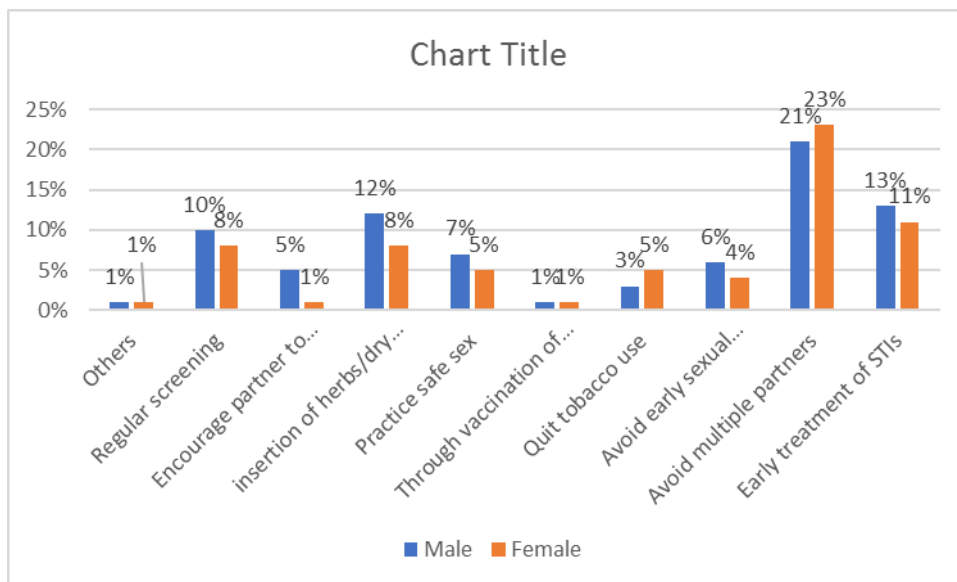


Figure 13: knowledge on the main prevention strategies after project implementation

From the graph it can be noted that a very large proportion of respondents are unaware of cervical cancer prevention methods before project implementation.

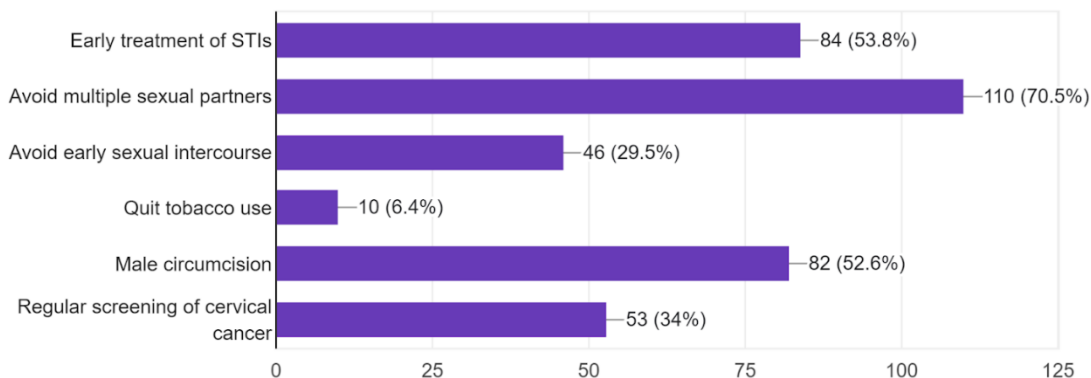


Figure 14: Treatment

3.11 Access to Cervical Cancer Screening

The graph below shows very low percentages of respondents who made decision to go for cervical cancer screening in both catchment areas. These low % outcomes are for those who made decisions by themselves, spouse or jointly themselves and spouse. This suggests that there is need to conduct massive campaigns in the two catchment areas targeting both males and females to jointly be making decisions for women to be going for screening.

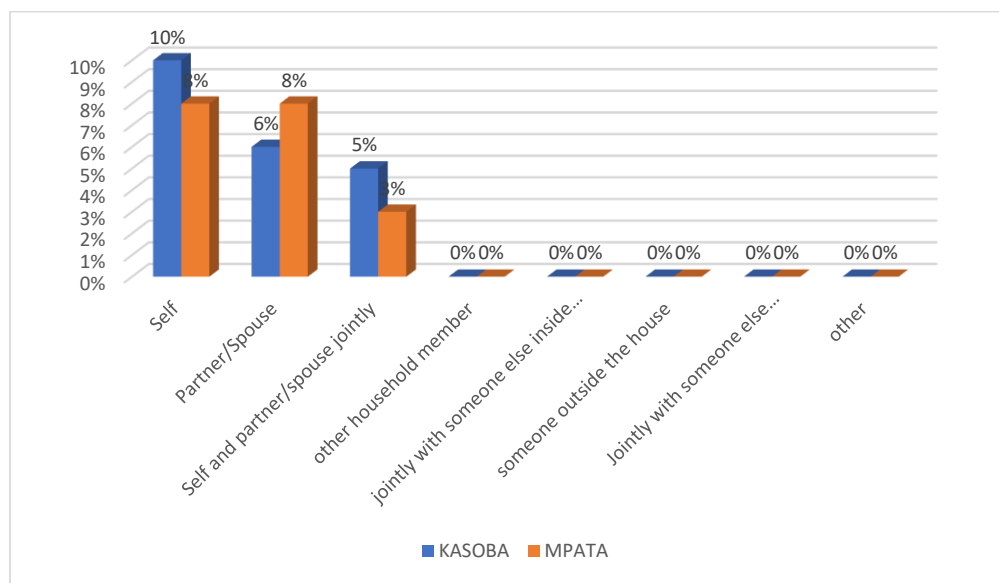


Figure 15: Proportion of Respondents who made decision to go for cervical cancer screening by type of decision segregated by catchment area

After project implementation, there was a significant shift in paradigm regarding decision making. For instance self-decision increased from 9.6% to 51%. Additionally, joint decision by spouse rose from 7% to 19.3%. The pie chart below shows this increment.

3.12 Decision making

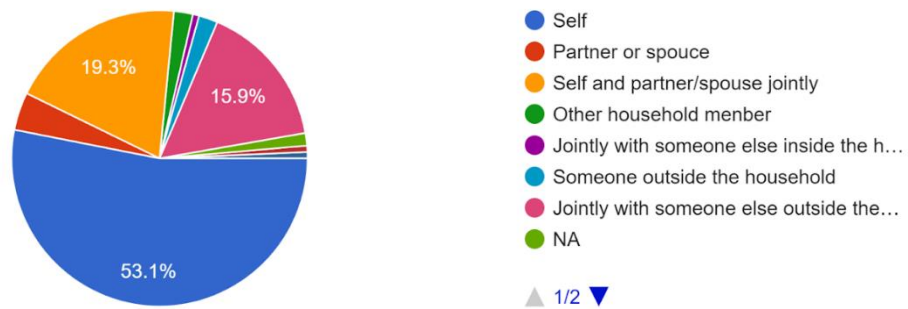


Figure 16: Decision making

3.13 Attitudes towards Cervical Cancer

Attitudes on health services influences client's behavior to seek the same. Therefore, it was important to undertint the attitudes of respondents regarding cervical cancer. As can be seen from the table below, the respondents hold strong negative beliefs and myths regarding access to cervical cancer. However, some key beliefs have changed. For instance, a large proportion of people are now aware that everyone is at risk of cervical cancer. Similarly, levels of embarrassment regarding discussing cervical cancer issues have decreased from 48% to 38.7% after program implementation.

Table 5: Attitudes towards cancer

Key Myths/Belief	Baseline				Endline			
	Response	Male	Female	Overall	Response	Male	Female	Overall
Any adult woman including me/your spouse/partner can develop cervical cancer.	Strongly agree	35%	47%	44%	Strongly agree	40.1%	62.3%	51.2%
	Agree	32%	31%	31%	Agree	30.5%	30.5%	30.5%
	Neutral	6%	2%	3%	Neutral	12%	4.4	8.25%
	Disagree	9%	7%	8%	Disagree	2%	2%	2%
	Strongly disagree	17%	13%	14%	Strongly disagree	3%	3.3	6.3%
Cervical cancer is a disease for prostitutes.	Strongly agree	5%	7%	7%	Strongly agree	1%	1%	1%
	Agree	8%	10%	10%	Agree	6.3%	6.3%	6.3%
	Neutral	3%	2%	2%	Neutral	15.1%	13.7%	14.4%

	Disagree	39%	36%	37%	Disagree	47	43.8	45.4%
	Strongly disagree	46%	44%	45%	Strongly disagree	34%	30%	32%
Cervical cancer is disease for the elderly women.	Strongly agree	2%	5%	4%	Strongly agree	2%	4%	3%
	Agree	5%	7%	3%	Agree	28%	18%	23%
	Neutral	5%	2%	3%	Neutral	13%	16.6%	14.8%
	Disagree	48%	45%	46%	Disagree	21%	27%	24%

	Strongly disagree	42%	41%	41%	Strongly disagree	31%	38.2%	34.6%
I would rather not know if I/my partner/spouse/female relative have cervical cancer.	Strongly agree	17%	16%	17%	Strongly agree	14%	10%	12%
	Agree	9%	3%	4%	Agree	7	3	5%
	Neutral	3%	3%	3%	Neutral	8.1	7.3	7.7%
	Disagree	42%	41%	41%	Disagree	32	39.2	35.6%
	Strongly disagree	29%	37%	35%	Strongly disagree	35.2%	45%	40.1%
Getting cervical cancer is a death sentence.	Strongly agree	8%	10%	9%	Strongly agree	7%	10.6%	8.8%
	Agree	19%	12%	14%	Agree	7.2%	16%	11.6%
	Neutral	14%	16%	16%	Neutral	14%	21.2%	17.6%
	Disagree	28%	24%	25%	Disagree	35%	46%	40.5%
	Strongly disagree	32%	38%	36%	Strongly disagree	20%	23%	21.5%

There is not much that can be done when someone has cervical cancer.	Strongly agree	9%	8%	8%	Strongly agree	4%	2	3%
	Agree	15%	14%	14%	Agree	11%	11.6%	11.3%
	Neutral	11%	11%	11%	Neutral	17%	26%	21.5%
	Disagree	29%	25%	26%	Disagree	42%	47.4%	44.7%
	Strongly disagree	35%	43%	41%	Strongly disagree	20%	18%	19%
Talking to members about cervical cancer is embarrassing.	Strongly agree	0%	0%	0%	Strongly agree	2%	2%	2%
	Agree	11%	10%	10%	Agree	6%	2%	4%
	Neutral	9%	2%	4%	Neutral	4%	6%	5%
	Disagree	37%	38%	37%	Disagree	44%	52.4%	48.2%
	Strongly disagree	43%	51%	49%	Strongly disagree	31%	46.4%	38.7%

3.14 Level of Civic Engagement by Gender

Overall, engagement, there is an engagement between couples regarding general cancer issues from 25% to 44.2%. This engagement has resulted in more women demanding cervical cancer services around Mpata and Kasoba. Other parameters such as discussing specific cervical cancer issues has also increased. This is a sign of positive drive within the catchment zone

Table 6: Level of Activism

Key Action Description	Response	Overall	Response	Overall
Ever discussed general cancer issues with a partner or spouse in the last three months.	Did	24%	Did	44.2%
	Can do	58%	Can do	38.7%
	Can never do	18%	Can never do	16.8%
Ever discussed cervical cancer issues with a partner or spouse in the last three months.	Did	24%	Did	43.1%
	Can do	55%	Can do	41.2%
	Can never do	21%	Can never do	15.7%
Ever discussed cervical cancer related issues other with family members	Did	22%	Did	29.3%
	Can do	63%	Can do	58.7%
	Can never do	15%	Can never do	12%
Ever discussed cervical cancer related issues with other community members.	Did	20%	Did	32%
	Can do	62%	Can do	56.3%
	Can never do	18%	Can never do	11.6%

3.15 Proportion of Respondents on social activism initiatives by sex

The table below shows engagement with stakeholders on issues relating to cervical cancer. Overall respondents had a negative drive to either engage the stakeholders, institutions or participate in social movement to effect positive change. However, end line data shows an improvement in key aspects. For instance, engaging duty bearer rose from 8% to 19.4% and followed by those who said ‘can do’ also rose from 51% to 71.4%. For those who said ‘can’t do’, the percentage has gone down from 41% to 9.2% which is attributed to mobilization campaign in the area.

Table 7: Proportion of Respondents on social activism initiatives by sex

Key Action Description	Response	Overall	Response	Overall
Engaging a duty bearer to take action on cervical cancer.	Did	8%	Did	19.4%
	Can do	51%	Can do	71.4%
	Can never do	41%	Can never do	9.2%
Making a phone call to a radio or Tv station to express my views on cervical cancer issues.	Did	0%	Did	0.3%
	Can do	70%	Can do	70%
	Can never do	30%	Can never do	29.7%
Expressing your views on cervical cancer issues on whatsapp, Facebook and other social media.	Did	0%	Did	0%
	Can do	75%	Can do	70.1%
	Can never do	25%	Can never do	29.9%
Signing to a petition on cervical cancer related issues.	Did	0%	Did	5.3%
	Can do	75%	Can do	69.3%
	Can never do	25%	Can never do	25.4%

Qualitative Findings

During endline survey, Qualitative information validated some of the data that has been collected quantitatively. The findings of qualitative data have been thematically presented into four themes: facilitators to cervical cancer uptake, source of information on reproductive cancers, barriers to access cervical cancer services, misconceptions about cervical cancer screening.

Theme 1: Facilitator's Cervical Cancer Services

Sub-theme 1: Social engagement

Several participants mentioned that there were mobilization campaign around Mpata and Kasoba health centre. 'Wa wocaca wakachemesya msonkhano uko wakaphalazganga nakusambizga za cancer yakhomo la chibabilo kwizira mu ma drama na bola'.

English... ' WOCACA organized meetings and awareness campaigns through drama and football matches [FGD 009, Kasoba]

Sub-theme 2: Chief's Engagement

'Mafumu yose ya mu mpata yakuchemesyanga misonkhano nakuwasambizyanga wamama nakuwasambizyanga za khansa yakhomo ya chibabilo kuti nyifwa zichepe. (KII GVH Mpata).

'All the village heads call for meetings to bring awareness on cervical cancer in order to reduce mortalities'.

Sub-theme 3: Awareness of cervical cancer signs and symptoms

'Kale wazimayi wakamanyanga yayi vyakukhwasana na khansa yakhomo la chibabilo. Para wakukhutuka ndopa wakatenge waka wanthu wamulowa. Kweni sono naumo watisambizgira za khansa, wanthu wakumannya kuti waka pimike mwaluwilo, nakuvwilika mwaluwilo. (FGD code 011, Kasoba).

'In the past, women were not knowledgeable about cervical cancer. Vaginal bleeding was interpreted as being bewitched. Now that they have learnt about cervical cancer, they for screening in good time.

Vikatichitikrapo mmuzi muno. Mama muyake wakaluwala. Wakathikanga waka ndopa. Kuluta nayokuchipatala, wakamutuma ku Mzuzu.wakamuphalira kuti wachedwa, paliye icho wangachita. Mbweni wakatileka. (KII, GVH, Mpata).

‘It happened in the past. One woman fell sick. She was bleeding from the Vagina. She was referred to mzuzu central hospital but I was too late. She passed on.

THEME 2: Barriers to accessing cervical cancer services

Sub-theme 1: Attitudes towards cervical cancer screening

.....‘Wazimayi wakuphalika kuti pakwiza kuzakapimika khansa ya mnyango wachibabilo wagezenge, nakujipwelelera ku malo yakubisika. FGD Code 003 (Mpata).

‘Some notable barriers revealed that some women are advised to bathe and observe perennial hygiene before coming for screening.

Sub-theme 2: Myths and misconception towards screening equipment

.....chisulo chakupimira khansa chikunyongotola matumbo lekani wakulutako yayi kupapimisya khansa yakhomo lachibabilo. FGD Code 007 (Kasoba).

English version’the instrument used to examine women goes into the women’s abdomen. Women are afraid, that’s why they shun away from screening for cervical cancer’

Sub-theme 2: Attitudes towards male providers

‘There is a male provider at our facility. We need a female nurse to screen us’. FGD Code 001 (001 Kasoba)’.

.....Wakupima khansa ni munthu mwanalume. Tikukana kutivula. Sono ise tikulhumba kupimika na munthu mwanakazi munyithu’

Sub-theme 3: Lack of transport

Transport njakusuzya. Tikufuma kutali. Kasi mungtiovwira yayi kuti mwizenge kuzakatipita kumizize uku? ‘Transport is a problem as we come from remote areas. Would you consider coming with outreach services? (FGD Code 002, Mpata).

3.16 Project Impact

Bi-annual service Delivery data showing service delivery before implementation (July -December, 2021) and during implantation phase (July-December 2021).

Table 8: Chart: Bi- Annual Indicator Trends

#	INDICATOR	Jul-Dec 2020	Jul-Dec 2021
1	# of women screened for cervical cancer	1453	3092
2	# of clients in the age group 25-49 years	1106	2356
3	# of women HIV POSITIVE screened for ca cx	836	2182
4	Total clients with a VIA positive	66 (HIV POSITIVE 28)	62 (HIV POSITIVE 44)
5	Percentage of women treated for ca cx	100% (21/21)	100 (27/27)
6	Percentage of women offered same day training	71% (15/21)	74% (20/27)
7	Number of clients Suspected of Cancer	24 (9 HIV positive)	50 (HIV POSITIVE 27)
8	Percentage of clients with feedback after referral	1/25	26/68

Source: Karonga DHO (2021).

Table 8 above shows that the number of women accessing cervical cancer screening services doubled from 1453 (July to December 2020) to 3092 (July to December 2021). The number of VIA positive was almost the same in both HIV positive and HIV negative women in 2020. However, this number was almost twice in 2021.

3.17 Implementing sites-Kasoba and Mpata health centers

Chart 11. Quarterly Cervical Cancer Screening indicators (April –June 2022)

#	INDICATOR	TARGET	ACTUAL
1	Number of outreach clinics conducted from march to June	30	40
2	# of women screened for cervical cancer	1000	916*
3	# of health facilities offering cervical cancer services	53	
4	% of VIA positive women receiving treatment in the 12-month period	100%	100%
5	% of curable cervical cancer patients receiving same day treatment	90%	72%
6	% of women receiving palliative care for advanced cervical cancer care	90%	50%
7	Decreased incidence of cervical cancer pre-cancerous lesions in both HIV infected HIV uninfected women	TBD	TBD
8	# of new cervical cancer cases diagnose	N/A	0
9	# of HIV negative clients	N/A	847*
10	# of HIV positive clients screened	N/A	69*
11	# of concurrent cases of cervical cancer and HIV	N/A	0
12	# of pre-cancerous cases among unvaccinated girls age group 16-46 years	TBD	4
13	% of women ages 16 to 25 years old who have been screened and treated of the 2000 women and girls mobilized	40%	100%

*TBD the total screened is the sum of HIV negative and positive.

Source: Outreach clinics at Mpata and Kasoba health centers (Karonga District hospital, 2022).

Chart 10 above shows that more women (916 against a target of 500) accessed cervical cancer screening in 3 months only. However,

(i). the case positivity rate is low in the catchment area or

(ii) few 8% (n= 916) were HIV positive

This means that there is need to conduct periodic mentorship so that providers are able to offer quality screening services. There is also need to screen more HIV positive women due to the increased risk of precancerous development in this group of women, this can be done by increase the number of days in which the services are offered in the two areas from two days a week to every working day. This will enable women to access the services with ease and is a necessary for attainment of universal health coverage. There is a possibility that some positive cases were given false negative results. There is need to start screening with HPV rapid test due to the high number of VIA negatives. Only those women that are positive will be done VIA. Studies have shown the high sensitivity, low cost and its acceptability of HPV rapid test in detecting HPV as opposed to VIA(Gravitt et al., 2010; Tang H et al., 2021)

3.18 Non-Implementing sites

Chart 12. Nyungwe and Lupembe Health centres as non-implementing sites

		JULY-DEC 2021		JAN-JUNE 2022	
#	INDICATOR	Nyungwe	Lupembe	Nyungwe	Lupembe
	Number of women of child bearing age	9997	1599	-	-
1	Number of outreach clinics conducted from march to June	0	0	0	0
2	# of women screened for cervical cancer	60	52	84	46
4	% of VIA positive women receiving treatment in the 12 month period	2 (1 HIV POS)	0	3 (3 HIV NEG)	4 (3 HIV Neg)
5	% of curable cervical cancer patients receiving same day treatment	0	0	0	66%*
6	% of women receiving palliative care for advanced cervical cancer care	0	0	0	0
7	Decreased incidence of cervical cancer pre- cancerous lesions in both HIV infected and HIV uninfected women	TBD	TBD	0	TBD
8	# of new cervical cancer cases diagnose	0	0	0 (2 suspect)	0
9	# of HIV negative clients	45	2	66	4
10	# of HIV positive clients screened	15	49	18	42
11	# of concurrent cases of cervical cancer and HIV	0	0	0	0

As can be seen from the chart above, despite the high number of women of child-bearing age estimated at 9997 and 1599 in Nyungwe and Lupembe respectively, the number of VIA conducted in the period under review was 242. In general terms, there is need to conduct mobilization campaign in these two areas and outreach clinics to increase the screening rates. There is need to intensify screening regardless of HIV status by fully integrating VIA within the MNH setting. This will reduce stigma and discrimination associated with ART clinic days.

Using every opportunity to mobilize women to come for cervical cancer services must continue.



Figure 17: A Midwife Health talk in a local church to mobilize women

4.0 Lesson learnt, Recommendations and Conclusion

4.1 Lessons Learnt

4.1.0 Engagement of traditional leaders and Chiefs

The project has shown that engagement of traditional leaders is key in project implementation. There is need to continuously engage those in positions of influence in order to yield meaningful results.

4.1.1 Team work and collaboration between DHO health staff and implementing Partners

There was strong collaboration between the two sides. This was a catalyst for successful implementation of the project.

4.1.2 Involvement of the media

The local radio stations played a pivotal role in relaying information on day to day basis to motivate local to go and access SRH services including cervical cancer. Covid-19 messaging was well integrated in the jingles in order to help prevent the spread of the same.

4.1.3 Continuous supply of consumables

Demand for services generated in the community must match the capacity of health care systems to provide the services. There was a continuous supply of consumables such as vinegar and cidex for use during the project implementation.

4.2 Recommendations

In view of the lessons learnt, the project recommends the following at different levels:

4.2.1 District Level

Continue engaging the District Executive committee (DEC) and getting an approval at inception of the project is crucial. For this project and its subsequent surveys, approval was sought from the DEC. on the implementation level, DHSS approval was sought as this was an already existing project and the district cervical cancer coordinator provided the necessary technical support.

4.2.2 At the community Level there should be continuous

- Engagement of traditional leaders and Chiefs through briefings for project ownership. Chiefs are important in mobilizing the community members through their local meetings where they preside. They also help to dispel rumors and misconceptions.
- Strengthening of health education to impact communities through the packaging of messages targeting the wider society using different delivery channels such as community campaigns, media engagement, sports events and health workers.
- Building of capacity of influential leaders for instance, traditional and faith leaders as well cultural practices so that they mobilize people using “institutions of trust” on cervical cancer and SRH information and also being in the forefront of organizing as well as attending the mobilization campaigns
- Involvement of women who have undergone cervical cancer screening from the same catchment area in cervical cancer awareness campaigns as motivation factor for other women to access cervical cancer services
- Working in collaboration with civil society which already have existing structures in the communities portrays that we are more people centered rather than project centered and not in competition with each other but focused on serving the underserved
- Offering screening service at health facilities and at the same establish mobile clinics with implementing partners to solve the problem of confining screening and treatment services to the health center which is a limitation to access services since women have to walk long distances from surrounding villages and through bad terrain due to the heavy rains
- Carrying out mobilization campaigns but they should be organized around the rainy and farming season ensuring that people are able to attend

4.3.4 At Programming Level continue

- Addressing issues of cervical cancer as an integrated approach that addresses the individual, relational, community and structural issues.

- At the individual level, the project has empowered the women, men, boys and girls with cervical cancer knowledge and skills through mobilization campaigns through theatre and sports
 - At the relations level, the project has aimed at building relationships that support and reinforce support towards cervical cancer at the household level. Using theatre during the mobilization campaigns targeting the whole family influences the gendered behaviors and experiences on cervical cancer.
 - At the community level, the project has involved schools through sports and social gatherings through churches and community meetings, community based organizations and the chiefs
 - At the structural level, initiatives should aim at addressing the formal and informal rules, policies and procedures that reinforce negative perception on cervical cancer in the communities.
- Looking for funding for a project that could support community mobile cervical cancer screening services by taking the service to the people to minimize infections in this time of COVID-19 or for future pandemics when travelling long distances. Conducting consistent community awareness and mobilization campaigns cervical cancer and on COVID-19 guidelines has encouraged women to access services at the health facilities.

4.3.5 Male Engagement Initiatives

Male engagement should be in three strands namely;

4.3.5.1 Men as equal partners should continue

Attending the community mobilization campaigns that will help men understand issues of cervical cancer and influence their women access to cervical cancer services Men have to support the decisions made by women relating to their own SRH, including issues surrounding contraceptives and abortion).

4.3.5.2 Men as clients should continue

Increasing men's utilization of relevant SRH services. The endline study has demonstrated a substantial increase in male involvement in SRH. Since men are also recipient of care they are decision makers in sexual health issues, Men will be targeted with cervical cancer related information so that they should influence decisions at household level. In this case, both men and females will benefit from cervical cancer screening. Men should also be motivated to consume HIV and cervical cancer preventive services such as male circumcision in order to reduce risk of acquiring HPV, HIV and transmitting the same to their spouses.

4.3.5.3 Men as agents of change should continue

Involving men in community forums, community radio talks, and sports especially football whereby they understand the critical importance of men taking responsibility on cervical cancer, and have an understanding of SRHR and cervical cancer. Involvement of men who have testimonies of spouses or relatives that survived cervical cancer, or clients that have undergone screening will help to influence other men to motivate their spouses or relatives to go for cervical cancer screening. This intervention has helped with increasing of access to cervical cancer services

4.3.5.4 Advocating for the effective implementation of SRHR related policies and increased budgetary allocation towards women's access to cervical cancer services should pursued continuously

4.4.0 Health Facility Level

4.4.1 More health personnel for service provision

Skilled workforce is one of the six pillars of health care system. In the short term, there is need to continue mentoring 'on-job' providers to offer cervical cancer services to address the shortage of qualified VIA service providers. This considers the long time it takes for 'Reproductive Health Directorate' to organize trainings. The mentees are selected on the basis of interest and Passion for the program. At present, only 3 have been mentored.

4.4.2 Constant routine mentorship of VIA service delivery

WHO has recommended routine mentorship in service delivery as part of quality improvement initiative (WHO, 2020). Karonga DHO needs mentorship in the health facilities offering cervical

cancer so that new providers must learn skills from the veteran, well experienced providers. This will ensure that quality services are provided to clients. Teams from facilities should be meeting on a routine basis to share experiences, best practices and how they navigate challenges experienced during implementation.

4.4.3 Mentorship of cervical cancer providers

Mentorship of providers at Karonga DHO and Kasoba health centers. This will enable providers to have adequate skills and knowledge with which to help clients seeking services

4.4.4 Mobile clinics

As noted in the endline study, women bemoaned the lack of SRH services in the remote areas of Mpata and kayelekera since the project concentrated VIA screening at health facilities in Mpata and Kasoba health centres. DHO does not routinely support cervical cancer screening during MNH outreach clinics due to logistical challenges. Ignoring this service places marginalized women at a very high risk of cervical cancer. Conducting VIA mobile clinics using movable tents can help bring cervical cancer services closer to them and reduce out of pocket expenditure for the common people in remote areas.

4.4.5 Urgently train at least a cervical cancer service provider at Mpata

Closing of the project on June 30, 2022 means that women from Mpata have to resume travelling to Karonga DHO for cervical cancer screening, a distance of more than 15km. Asymptomatic women would not do this travel that long distance because they are not sick. Training health care workers will reduce these barriers to accessing cervical cancer screening.

4.4.6 Constant supply of consumables

By the time of writing this report, KDH had no vinegar for screening cervical cancer. This leads to service interruption and women are sent back. These women are less likely to come again to the clinic for the same service.

Additionally, *thermo-coagulators* are urgently needed to promote “**Point of Care Treatment**” in health facilities reduce delay in treatment of precancerous lesions which can result to progressive cancer, congestions in referral hospitals, the burden of out-of-pocket expenses,

4.4.7 Integrate cervical cancer into daily clinic activities

Offering cervical cancer on specific ART clinic days brings stigma to the clients. As such, turn up reduces as clients do not want to be associated with ART services. Integrating cervical cancer into dairy routines would reduce this barrier.

Provision of proper infrastructure with enough space for women undergoing VIA screening and treatment as well as women undergoing further investigation or treatment it is required in the health facilities whereby privacy should be a priority.

The survey has shown that most people get information about SRHR, Covid 19 and reproductive cancers through the awareness campaigns organized by WOCACA. However, many people are still unaware of the details relating to cervical cancer. Hence the need to continue with mobilization activities.

4.5 HPV Rapid test for screening

Evidence has shown the feasibility of implementing HPV rapid test in Malawi. The low positive case detection seen in the end line study confirms the low sensitivity of visual inspection using vinegar to screen for cervical cancer. A large number of women are stripped off their privacy when this can be done to only those that turn positive on HPV rapid test. Therefore, the study recommends a paradigm shift in screening approach in which HPV rapid test should be an entry point for cervical cancer screening. Clients that are positive for HPV the rapid test should be done VIA in order to determine the presence of lesions or not. Moreover, HPV rapid tests are cheap, safe and easy to use.

4.6 Conclusion

The Endline survey was done in order to generate evidence on implementation of the project in Mpata and Kasoba catchment areas in T/A Kyungu. The overall performance of the project was a success considering the short duration of implementation. There is need to match the demand created in the community with capacity to offer services in the facilities. In order to achieve universal health care coverage, the services must reach people in their localities through outreach clinics. This will reduce out of pocket expenditure on health for the common people in the community.

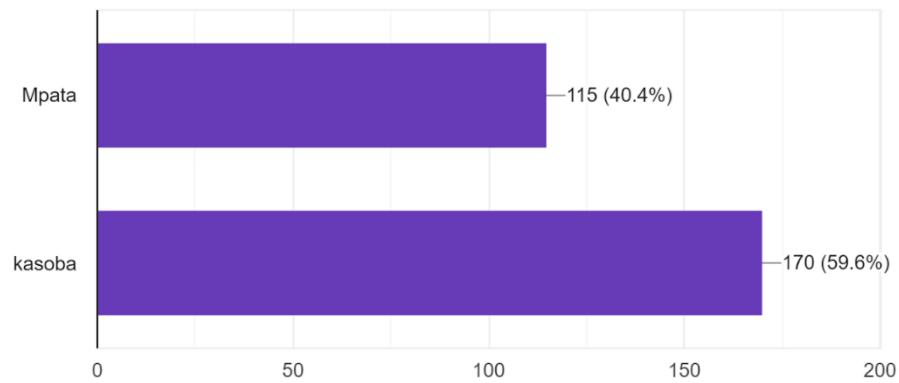
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Appendices

Appendices 1: Socio-demographic characteristics of participants

Distribution of Participants by location

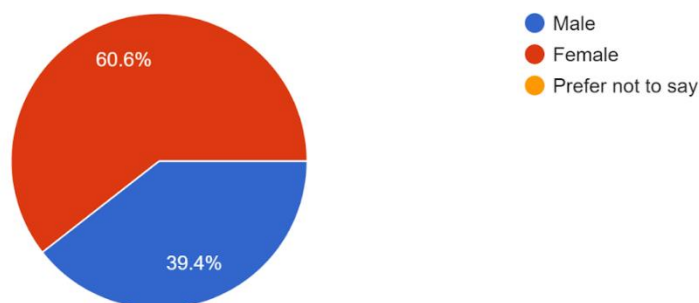


The chart shows the sample distribution according to their location. As expected more clients 60% (n=285) were sampled at Kasoba and 40% (n=115) were sampled from Mpata.

Sex of Respondents

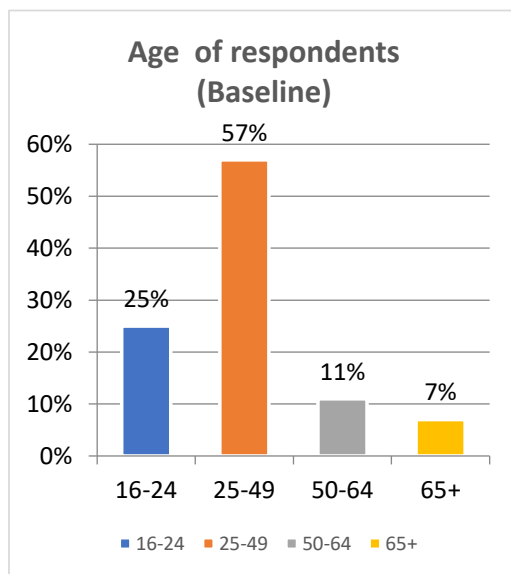
Chart below shows that the 40% of study respondents were males. Before the study, only 24% of the respondents were males. This illustration of male involvement in SRH issues including research is a good considering that males are decision makers in the households.

Sex of the respondents



Source: Endline Survey July, 2022.

3.1.5 Age of the respondents (Baseline)



Age of respondents after Project Implementation

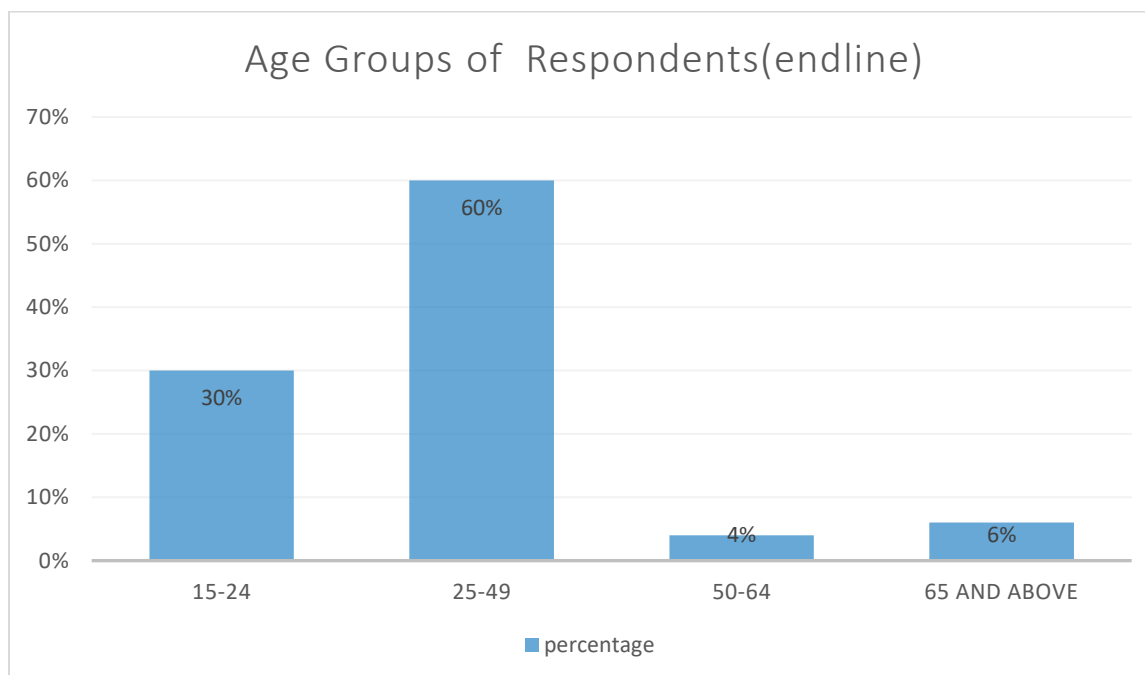
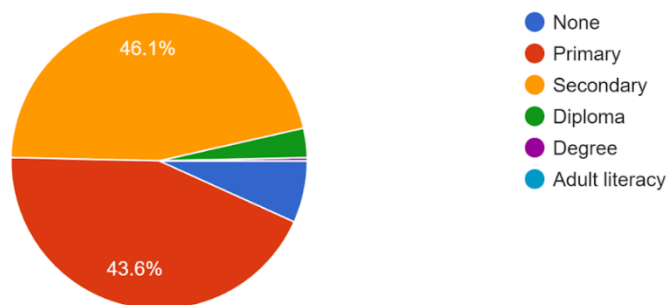


Chart 3.a Distribution of respondents by Age before and after project implementation

The graphs shows that the sexually active group from 16-49 participated in the survey. The dominance in participation from the young women is an indication of how active in health related issues the youths are in the two catchment areas. Notice must be made to the elderly population who are representative of senior citizens and took part in the survey. This shows how interested this group is in matters related to their sexual and reproductive health.

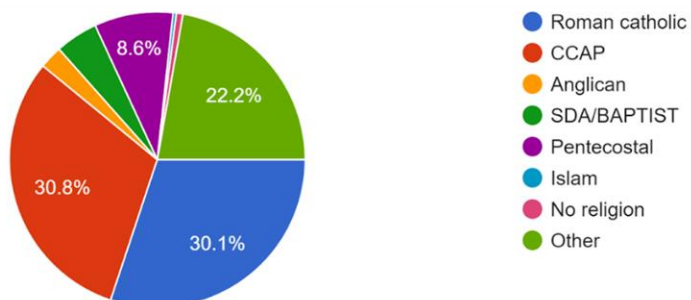
Level of Education



Source: Endline Survey, 2022.

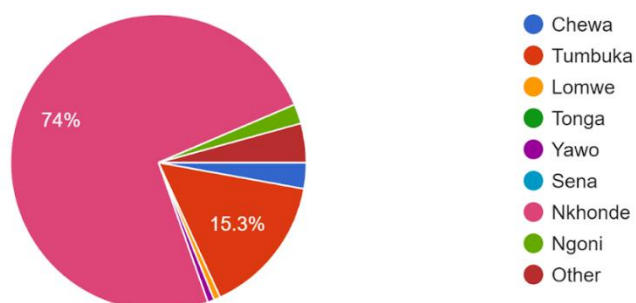
The endline survey shows more respondents (80%) had some basic education irrespective. This has a bearing on health seeking behavior in that educated people are more likely to understand the significance of seeking health services.

Religion of the respondents



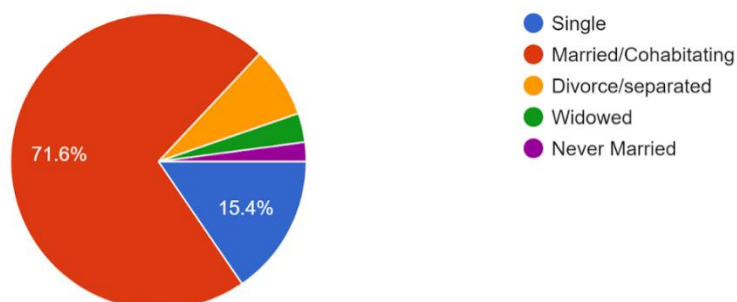
WOCACA employed all avenues available including religious gatherings to disseminate information on cervical cancer screening. This has contributed towards more reporting for cervical cancer screening within Kasoba and Mpata and surrounding areas.

Tribe of the respondents

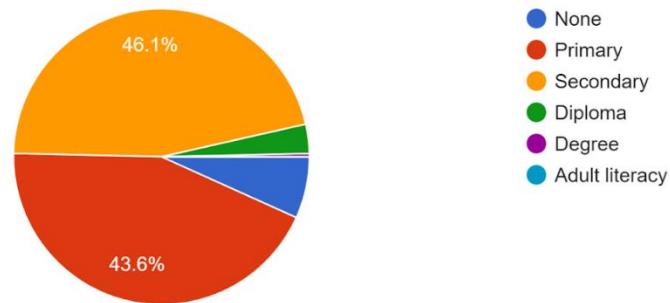


Source: Endline Survey, 2022.

The tribe of respondents is important for message dissemination. From the chart above, key messages were disseminated in Ngonde and Tumbuka as these are widely spoken in the catchment area. Posters on cervical cancer were also printed in Ngonde and Tumbuka for the same reason.



The pie chart above shows that many people (71%) are married followed by single people. Therefore. Key messages must target these categories of people for meaningful impact of the project.



The pie chart above shows that 90% of the respondents had attended some formal education. As such, it was easy for them to understand the mobilization messages. This contributed to the high turn up of the respondents during the screening as well as health education activities.

Appendix 2. Data Collection tools (questionnaire and Interview Guide)

INFORMED CONSENT

Hello. My name is and I am working with WOCACA. WOCACA is conducting a study on people's access to cancer services in your area. You have been randomly selected out of all the people in this area to be asked questions in the study. We would very much appreciate your participation in the study. I would like to ask you about your knowledge of reproductive cancer and access to cancer services in your area. The information you give us will help WOCACA and government to plan and improve access to cancer services. The study will not take much of your time. Whatever information you provide will be kept strictly confidential and will not be shown to other persons.

Your participation in this study is voluntary and you can choose not to answer any individual question or all of the questions or stop the interview. However, we hope that you will participate since your views are important.

Do you have any questions on what I have said?

May I begin the interview now? Agrees 1 Disagrees 2

SECTION ONE: RESPONDENTS BIO DATA

I would like to know more about you before I ask you about access to SRHR services

RB 1	Sex of Respondent	Male 1 Female 2
RB2	How old are you?	25-29 1. 30-34.....2 35-39..... 3. 40-44..... 4 45-49..... 5 50-54.....6 55-59.....7. 60-64.....8 65 and Above..... 9
RB3	Have you ever attended school	Yes1 No 2 Go to RB5
RB4	What is the highest level of school you attended	Primary 1 Secondary 2 Diploma3 Degree and above..... 4 Adult Literacy 5

RB5	What is the highest (class/form/year) completed at that level	Class/Year/Form1 UN/DK 98
RB6	What is your marital status	Single.....1 Married/cohabiting..... 2 Divorced/separated..... 3 Widowed.....4 Never married.....5
RB7	What is your religion?	Catholic1 CCAP2 Anglican3 Seventy Day Adventist/Baptist ...4 Pentecostal.....5 Islam6 No Religion.....7 Other (specify).....96
RB8	What is your tribe or ethnic group	Chewa 1 Tumbuka 2 Lomwe 3 Tonga 4 Yao 5 Sena 6 Nkhonde 7 Ngoni 8 Other 96 (specify)
SECTION II: KNOWLEDGE ON COVID-19		
<i>Now I would like to ask about your knowledge on COVID-19</i>		
KC191	Do you know anything about COVID-19	Yes 1 No2 Go to KC192 UN/DK 98
KC192	Where did you learn about COVID-19?	Friends/peers.....1

		School ... 2 Peer Educator 3 Health Facility..... 4 Parents5 Media 6 Other (specify)96
KC193	Do you know where you can get information about COVID-19?	Yes1 No2 Go to KC194 UN/DK 98
KC194	From where?	Friends/peers.....1 School ... 2 Peer Educator 3 Health Facility..... 4 Parents5 Media 6 Other (specify)96
KC195	What kind of information?	Vaccination 1 Wearing masks 2 Washing hands with soap 3 Alcohol hand sanitizing4 Social distancing 5 Highly contagious diseases6 Highly killer diseases.....7Limiting travel.....8 Banning public gatherings9 Force on people failing to self-isolate.....10 Other (specify)..... 96
KC196	Do you know where you can get services about COVID-19?	Yes1 No2Go to KC197 UN/DK 98
KC197	From where?	School ... 1 Peer Educator 2 Health Facility.....3

		Community based provider.....4 Other (specify)96
KC198	What kind of services?	COVID-19 Counselling services1 COVID-19 Prevention.....2 COVID-19 Sensitisation3 COVID -19 Education 4 COVID-19 Vaccination5 COVID screening6 COVID-19 Treatment.....7
KC199	Do you know any method of preventing COVID-19?	Yes1 No2 UN/DK 98
KC1910	What are the methods	Maintain a safe distance from others1 Wear a mask2 Choose open, well-ventilated spaces over ...3 Wash your hands with soap4 Sanitise your hands with an alcohol-based sanitiser5 Get vaccinated.....6 Cover your nose and mouth with your bent elbow or a tissue when you cough or sneeze.....7 Stay home if you feel unwell.....8 Other (specify)96
KC1911	Do you know your COVID-19 health rights?	Yes1 No2Go to RC1 UN/DK 98
KC1912	Which rights do you know? (Probe for multiple responses)	Right to COVID-19 preventive measures1 Right to work2 Right to social security.....3 Right to housing.....4 Right to food5

		Right to water.....6 Right to life7 Right to education8 Right to travel.....9 Right to public gatherings10 Other (specify).....96
SECTION III: KNOWLEDGE ON SEXUAL REPRODUCTIVE HEALTH AND RIGHTS (SRHR) <i>Now I would like to ask about your knowledge on SRHR</i>		
KS1	Do you know anything about sexual and reproductive health rights?	Yes1 No2 Go to KS3 UN/DK 98
KS2	Where did you learn about SRHR?	Friends/peers.....1 School ... 2 Peer Educator 3 Health Facility..... 4 Parents5 Media 6 Other (specify)96
KS3	Do you know where you can get information about SRHR?	Yes1 No2 Go to KS6 UN/DK 98
KS4	From where?	Friends/peers.....1 School ... 2 Peer Educator 3 Health Facility..... 4 Parents5 Media 6 Other (specify)96
KS5	What kind of information?	Abstinence 1 STI/HIV prevention..... 2

		Menstruation and puberty education..... 3 Contraceptives.....4 Abortion and Post-abortal..... 5 Under-five clinic.....6 HPV Vaccine 7 Other (specify)..... 96
KS6	Do you know where you can get services about SRHR?	Yes1 No2 Go to KS9 UN/DK 98
KS7	From where?	School ... 1 Peer Educator 2 Health Facility.....3 Community based provider.....4 Other (specify)96
KS8	What kind of services?	Counselling services1 Contraceptives.....2 Antenatal care.....3 Postnatal care.....4 Under five clinic.....5 Abortion6 Post-abortal..... 7 STI Management8 HIV Testing9 HPV Vaccination.....10 Cancer screening11 ART.....12 Pregnancy Testing.....13 Safe Delivery.....14 Other (specify)..... 96
KS9	Do you know your SRH rights?	Yes1

		No2 Go to KS10 UN/DK 98
KS10	Which rights do you know? (Probe for multiple responses)	Right to control one's fertility.....1 Right to decide whether to have children, the number of children and spacing of the children.....2 Right to choose any method of contraceptives.....3 Right to self-protection and to be protected against sexually transmitted infections, including HIV/AIDS.....4 Right to be informed on one's health status and on the health status of one's partner, particularly if affected with sexually transmitted infections, including HIV/AIDS.....5 Right to have family planning education.....6 Right not to be discriminated against when accessing reproductive health services 7 <u>Right to legal and safe abortion.....8</u> Freedom from harmful practise such as early marriages and negative sexual practices.....9 Other (specify).....96
SECTION IV: ACCESS TO REPRODUCTIVE CANCER SERVICES <i>Now I would like to ask you accessing Reproductive Cancer Services</i>		
RC1	Have you heard of any Cancers	Yes 1 No 2 UN/DK 98
RC2	Where did you learn about Reproductive Cancers	Health Facility 1 Peers 2 Private H/Facility 3 Family member 4 Media..... 5 Other (specify) 96
RC3	What type of cancer do you know?	Breast Cancer.....1 Cervical Cancer 2 Bladder Cancer.....3 Kaposi sarcoma4

		Colon and Rectal Cancer5 Endometrial Cancer (Uterus lining)6 Thyroid Cancer7 Other.....
RC4	Do you know symptoms of cervical cancer	Yes1 No2 UN/DK 98
RC5	What symptoms do you know	Vaginal bleeding.....1 Vaginal foul-smelling discharges2 Back ache.....3 Pain during and after sex.....4 Other.....96
RC6	Do you know risk factors of cervical cancer	Yes1 No2 UN/DK 98
RC7	What are the risk factors?	Having multiple partners.....1 Early onset of sex2 STIs.....3 Tobacco use.....4 Insertion of herbs.....5 Dry sex.....6 Other.....96
RC8	Do you know any method of preventing cervical cancer	Yes1 No2 UN/DK 98
RC9	What are the methods	Early treatment of STIs.....1

		Avoid multiple sexual partners.....2 Avoid early sexual intercourse.....3 Quit Tobacco use.....4 Through vaccination of HPV vaccine.....5 Practice safe sex.....6 Avoid insertion of herbs/dry sex.....7 Encourage partner to go for male circumcision.....8 Regular screening.....9 Other.....96
RC10	Where do people go for cervical cancer in your areas?	Health Facility 1 City health facility2 Traditional Healer3 TBA4 Private H/Facility5 Other (specify)96
RC11	Have you/your spouse/your female partner or your relative ever gone for cervical cancer screening?	Yes1 No2 UN/DK 98
RC12	Where did you go or they go?	Health Facility 1 City health facility2 Traditional Healer 3 TBA 4 Private H/Facility 5 Other (specify)96
RC 13	When did you go or they go ?	Last week.....1

		Last Month.....2 Last 3 months.....3 Last 6 Months.....4 Last 12 Months.....5 Last 2 years.....6 More than 3 years ago.....7
RC14	Who made a decision for them to go for cervical cancer screening?	Self.....1 Partner/spouse.....2 Self and partner /spouse jointly3 Other household member.....4 Jointly with someone else inside the household.....5 Someone outside the house 6 Jointly with someone else outside the household.....7 Other (specify).....96
RC15	Why didn't you or they not go for a cervical cancer screening	Spouse refused.....1 Not interested.....2 Don't know about cervical cancer.....3 Religious restrictions.....4 Other96
ATTITUDES AND PERCEPTIONS ON REPRODUCTIVE CANCERS Now I would like to ask you about more about reproductive cancers		
AP 1	Now I would like to ask you if you agree or disagree with the following statements	

	Any adult woman including me/your spouse/partner can develop cervical	Strong agree1 Agree.....2 Neutral 3..... Disagree.....4 Strongly disagree....5
	Cervical cancer is a disease for prostitutes	Strong agree1 Agree.....2 Neutral 3..... Disagree.....4 Strongly disagree....5
	Cervical cancer are diseases for the elderly women	Strong agree1 Agree.....2 Neutral 3..... Disagree.....4 Strongly disagree....5
	I would rather not know if I/my partner/spouse/female relative have cervical cancer	Strong agree1 Agree.....2 Neutral 3..... Disagree.....4 Strongly disagree....5
	Getting cervical cancer is a death sentence	Strong agree1 Agree.....2 Neutral 3..... Disagree.....4 Strongly disagree....5
	There is not much that can be done when someone has cervical cancer	Strong agree1 Agree.....2 Neutral 3..... Disagree.....4 Strongly disagree....5
	Talking to members about cervical cancers is embarrassing	Strong agree1 Agree.....2 Neutral 3..... Disagree.....4 Strongly disagree....5
AP2	I want to know if you have ever done, can do or will never do the following;	
	Ever discussed general cancer issues with a partner or spouse in the last three months	Did.....1 Can do...2 Cant do.....3
	Ever discussed cervical cancer issues with a partner or spouse in the last three months	Did.....1 Can do...2 Cant do.....3

	Ever discussed cervical cancer related issues other with family members	Did.....1 Can do...2 Cant do.....3
	Ever discussed cervical cancer related issues with other community members	Did.....1 Can do...2 Cant do.....3
	Engaging a duty bearer to take action on cervical cancer	Did.....1 Can do...2 Cant do.....3
	Making a phone call to a radio or Tv station to express my views on cervical cancer issues	Did.....1 Can do...2 Cant do.....3
	Expressing your views on cervical cancer issues on WhatsApp, Facebook and other social media	Did.....1 Can do...2 Cant do.....3
	Signing to a petition on cervical cancer related issues	Did.....1 Can do...2 Cant do.....3

SECTION V: ACCESS TO SRH SUPPLIES & SERVICES, CERVICAL CANCER SERVICES DURING THE COVID-19 PANDEMIC

Now I would like to ask you accessing Reproductive Cancer Services

AC1	Were you able to access SRH and cervical services during the COVID-19 pandemic	Yes 1 No2 Go to AC UN/DK 98
AC2	Which of the services were you able to access despite the Covid-19 pandemic?	Counselling services1 Contraceptives.....2 Antenatal care.....3 Postnatal care.....4 Under five clinic.....5 Abortion6

		Post-abortion..... 7 STI Management8 HIV Testing9 HPV Vaccination.....10 Cancer screening11 ART.....12 Pregnancy Testing.....13 Safe Delivery.....14 Other (specify)..... 96
AC3	With the knowledge you now have on methods of preventing COVID-19 are you or will you be able to access RMNCAH+N information, supplies and services	Yes 1 No2 Go to AC4 UN/DK 98
AC4	Which of the services would you like to access during the Covid-19 pandemic?	Counselling services1 Contraceptives.....2 Antenatal care.....3 Postnatal care.....4 Under five clinic.....5 Abortion6 Post-abortion..... 7 STI Management8 HIV Testing9 HPV Vaccination.....10 Cancer screening11 ART.....12 Pregnancy Testing.....13 Safe Delivery.....14 COVID-19 Vaccination.....15 Other (specify)..... 96

Appendix 3: Qualitative Research Tools

FGD TOOL FOR WOMEN -

STEP 1: INTRODUCTION

Conduct formal introductory activities.

Explain that in this exercise, we are going to talk about all the key cervical cancer related resources and services which women access.

STEP 2: DRAWING THE SOCIAL MAP

Ask participants about the key cervical related services, resources and service providers which they can find in the community. Remember to probe on;

- *Sources of Cervical cancer information*
- *Cervical cancer service providers*

After they have listed, ask them to draw a map of the village with key features like roads, community meeting places, and the key resources and services they have identified above. As they are labelling the map, ask participants;

- *why the service or resource is important;*
- *what function do they play/what services do they provide*

STEP 3: ACCESSIBILITY OF THE INSTITUTIONS

Using a marker of any kind, ask participants on how easy it is for women to access this service, service provider and resources.

- The ones she access most easily/frequently should be marked differently from the ones she accesses least frequently/with greater difficulty would go farther away on the page

STEP 4: KEY DISCUSSION POINTS.

- What kind of cervical cancer services do women access?
- What challenges do they face to access the services? ***Probe on household, community and facility level challenges?***
- Are there any negative perceptions or attitudes associated with women with cervical cancer? What do people say about them?

STEP 5: CHANGES

- What changes would you like to see, that would enable women to access cervical cancer services
- What could make these changes happen?

Key Informants Interview Guide for stakeholders

Section A: Cervical Cancer information and services in the community

1. What are the main sources of information on cervical cancer in this area?

- What strategies are used to create awareness?
- Who are the major players in information dissemination?

2. What cervical cancer services exist in the district/community (government, NGO, community)

(Probe: since when, where/how work, target group, what services provide, etc.)

- How effective do you think these services have been?
- Are these services mostly responsive-Probe on prevention and treatment

3. What are the key challenges for women to access cervical cancer information and services-

Probe on household, community and facility related challenges.

Appendix 4: Budget for the endline survey

Budget for the endline survey				
ITEM	QNTY	RATE	DAYS	TOTAL
1 FACILITATORS (PREPARATION, DATA COLLECTION AND REPORT WRITING)	2	45000	4	360,000
3 PARTICIPANTS (DATA COLLECTORS)	6	15000	4	360,000
3 DRIVER	1	10000	4	40,000
4 REFRESHMENTS	6	1000	1	6,000
4 BUNDLE	1	5000	1	5,000
5 NOTEPAD	6	500	1	3,000
6 REAM OF PAPER FOR CONSENT FORMS	1	9000	1	9,000
6 SUB-TOTAL				783,000

Appendix 5: Timetable of data Collection Exercise

Week 1					Week 2		
Date	Friday	Monday	Tuesday	Wednesday	Saturday	Monday	Tuesday
	2 nd July 2022	4 th July 2022	7 th July 2022	8 th July 2022	9 th July 2022	11 th July 2022	12 th July 2022
Development of tools							
Planning Meetings							
Orientation of Enumerators Pre-testing tools							
Data Collection							
Data Analysis							
Report Writing							
Submission of Report							

Pictorial focus



Pic 1. VIA TEAM before departure to Outreach Clinic



Pic 2. Mobilization at church



Picture 4. Drama in progress at a Mobilization rally