FP2020 Commitment
2019 Update Questionnaire
MALAWI

The FP2020 Secretariat surveys FP2020 commitment makers annually to track progress made, activities undertaken, and challenges faced toward fulfilling commitments. We kindly ask you to complete the FP2020 Commitment 2019 Update Questionnaire for Malawi, by **5 July 2019**. Your responses support greater information and knowledge sharing, transparency, and accountability among the growing number of FP2020 commitment makers and the broader family planning community. As in previous years, we will share your responses on your country's dedicated country webpage (https://www.familyplanning2020.org/malawi) so in-country and global stakeholders alike can follow Malawi's progress in reaching the ambitious goals set on behalf of the women, girls, families, and communities in your country.

FP2020 commitments can be achieved with coordinated actions across multiple sectors and partners at various levels. We hope this will be an opportunity for you to engage with your country focal point team, including youth focal point, and family planning stakeholders in country to jointly review progress.

Please note that the self-reporting process complements the national family planning data consensus workshops that take place during the same time period. If the data consensus workshop for Malawi is scheduled after **5 July 2019**, please let us know so we can discuss how to align the commitment reporting deadline to ensure results from each process are compatible.

Please complete the attached Word document and submit to Martyn Smith msmith@familyplanning2020.org and Krista Newhouse knewhouse@familyplanning2020.org with a copy to Onyinye Edeh oedeh@familyplanning2020.org. Should you have any questions or concerns, please contact Onyinye on oedeh@familyplanning2020.org.

Additionally, the Core Conveners of FP2020 are currently gathering input to build a shared vision for family planning post-2020. We look forward to learning from your response and appreciate your partnership in delivering on the promise that is FP2020.

Thank you for your time and effort to fill out this questionnaire and provide useful information for the broader partnership.

The questionnaire includes 1) the 2017 revitalized commitment and elements of Malawi's original commitment that still stand, and 2) seven standard questions to all FP2020 commitment-making countries.

As you provide your updates below on each element of your commitment, kindly focus on:

- **Progress made** and **key challenges or barriers** you faced, during the **July 2018 - June 2019 period.**
- Please also include information on **any key upcoming commitment-related milestones**.
- Lastly, we invite you to reflect on progress per commitment through a **self-assessment**.

SECTION I: QUESTIONNAIRE FOR COMMITMENT UPDATE

COMMITMENT OVERVIEW

The Government of Malawi re-commits to ensure universal access and coverage of sexual reproductive health and rights information and services with specific focus to all adolescents and young people. By promoting wider method mix choice and long-acting and reversible contraceptives (LARCs), the goal is "no parenthood before adulthood," and in the spirit of the SGDs "leaving no-one behind." Malawi is further committed to reducing teenage age pregnancies by 5% per annum until 2030 in line with HSSP II set targets (2017 -2021) per annum until 2030. This will be done through ending child and early forced marriages and ensuring that girls complete their secondary education to safeguard young people in anticipating better youth participation necessary for harnessing the Demographic Dividend. Likewise, Malawi is committed to increasing the budgetary allocation for family planning commodities, FP and youth programming. In all these commitments, Malawi is expected to involve all key government sectors, CSOs, NGOs, parliamentarians, traditional leaders, parents and most importantly the youth themselves through a robust multi-sectoral approach and achieving declined fertility paramount for the development of Malawi.

The Government pledges to:

1. **COMMITMENT**: Slow the pace of population growth, lower fertility rates, and expand contraceptive method choice and availability of LARCs:

1.1. Implement the newly constituted WHO guidelines on youth contraceptives and align national policies/guidelines to allow increased access to Family planning commodities by 2030.

1.2. Design a task-shifting service delivery model that promotes method mix and reaches young people.

1.3. Advocate to mobilize resources for sexual and reproductive health and rights (SRHR) outreach services for hard-to-reach adolescents.

1.4. Execute fully the youth friendly health services (YFHS) strategy to ensure multi-sectoral participation and accountability of stakeholders for improved access to SRH including contraceptives amongst sexually active young people 10-24 years.

1.5. Increase the percentage of accredited YFHS facilities that meet at least the 5 minimum standards from 37% to 60% by 2020

a) Please provide an update below on achievements made in July 2018 - June 2019 in support of these elements of your commitment, including any key upcoming commitment-related milestones:

1.1. Implement the newly constituted WHO guidelines on youth contraceptives and align national policies/guidelines to allow increased access to Family planning commodities by 2030.

Malawi is currently working on revising FP pre-service and in-service reference manuals to incorporate emerging issues but also integrate into one comprehensive National FP Training Manual to be used for both pre and in-service training.

PPFP and DMPA guideline modules have been updated. The DMPA guidelines also include sub-cutaneous injection.

1.2. Design a task-shifting service delivery model that promotes method mix and reaches young people.

In 2018, Malawi introduced DMPA-SC into the country's method mix. A phased approach has been adopted with roll out starting in seven districts. A taskforce was formed to oversee the process and developed a roll out plan to aid effective scale up. DMPA-SC has also been included in the data tools and DHIS2.

300 Health Surveillance Assistants (HSAs) have been trained to provide DMPA-IM while additional Community Based Distribution Agents (CBDAs) including Youth CBDAs have been trained to provide information and services (for short-term contraceptives) to communities and youths.

Delivery of comprehensive SRHR through static and outreach clinics has been strengthened. Youth outreach clinics have been established in 11 districts of Chitipa, Karonga, Nkhotakota, Kasungu, Salima, Dowa, Lilongwe, Balaka, Machinga, Zomba and Mulanje to provide SRHR

services with designated youth clubs. Provision of YFHS has also been strengthened due to inclusion of customer care component during service delivery in their training.

A nested provider model has been adopted in 14 hospitals (Karonga, Nkhotakota, Kasungu, Salima, Dowa, Lilongwe, Balaka, Machinga, Zomba, Blantyre, Likoma, Ntchisi, Thyolo and Mulanje). Capacity building of service providers through coaching and mentorship to enhance provision of quality FP services, especially LARC, Permanent FP methods and organization of FP services through Integrated Family health outreach clinics.

MOH and its partners has strengthened publicity of SRHR services, with strong emphasis on long acting reversible contraceptives through open days and video shows to enhance access of FP services in hard to reach areas. Strengthened linkages between in-school adolescents and youth, and Youth Networks to improve IEC on SRHR. District Youth Officers (DYOs) and youth leaders have also been engaged to identify open spaces for youths to access SRH services.

1.3. Advocate to mobilize resources for sexual and reproductive health and rights (SRHR) outreach services for hard-to-reach adolescents.

DFID awarded Tsogolo Langa Project, a five-year project to be implemented in 17 districts with ten districts focusing on comprehensive SRHR services for young people. The project will be led by PSI, and BLM as an implementing partner. Funding also includes procurement of FP commodities for the country.

DFID also awarded WISH Project, a three-year project to be implemented in 2 districts focusing on comprehensive SRHR services for young people. The WISH consortium comprises of FPAM as the lead (service delivery), Options (national ownership) and DMI (demand creation).

A new project funded by the Norad Framework will provide adolescent SRHR outreach services in three districts (Mwanza, Neno and Mzimba) to reduce teenage pregnancies and child marriage.

A pilot project is using outreach teams to pilot service provision in the evenings targeting hard to reach adolescents including in-school youths in five districts. If successful, this will be scaled up to more teams so as to reach more young people with services especially those in institutions of higher learning.

Policy makers, policy holders and the private sector have been lobbied to increase resource allocation in health sector in particular SRHR.

Before the Presidential elections, presidential running mates were engaged to make commitment to increase resource allocation to SRHR especially youth programming.

1.4. Execute fully the youth friendly health services (YFHS) strategy to ensure multi-sectoral participation and accountability of stakeholders for improved access to SRH including contraceptives amongst sexually active young people 10-24 years.

The Ministry of Health continues to engage key stakeholders in YFHS through the quarterly YFHS TWG meetings. The TWGs act as an avenue for coordination and collaboration with other key players in YFHS.

SRHR interventions for young people and adolescents are aligned to the National Youth Friendly Health Services Strategy. These services include SRHR information and service provision by integrating YFHS into existing services to increase service delivery points.

CSE has been incorporated in the school curriculum and is now examinable.

25 Youth SRHR champions have been trained to engage fellow youth and policy makers around SRHR and accountability with emphasis on linking with the demographic dividend.

After school SRHR youth clubs are being implemented in schools by MoEST targetting in-school youth while the MoLYSMD implements youth clubs targetting out-of-school youth. These youth clubs including all girls clubs, are utilized by MoHP and partner outreach teams to provide information about contraceptives and benefits of LARC.

A grassroots activity is implemented in Mangochi District to enhance youth participation and accountability in YFHS service design and implementation.

District Youth Networks have been strengthened to address myths, and challenges on youth and modern contraception uptake.

Community scorecard sessions were conducted in youth friendly health facilities where youths had interface meetings with health workers, district health officers and community leadership to improve quality of YFHS. Some district level Community Scorecard were conducted on transparency and accountability initiatives i.e. making funding information available and accessible to key stakeholders, CSOs, youth and communities.

1.5. Increase the percentage of accredited YFHS facilities that meet at least the 5 minimum standards from 37% to 60% by 2020

District Health Officers (DHOs) are being engaged to increase capacity on facilities to meet accreditation standards in line with the National Youth Friendly Health Services Strategy 2015–2020 and the AGYW Strategy.

A pilot YFHS project is being implemented in Chiradzulu with an intention to provide a robust YFHS program, including certifying providers in Chiradzulu district in YFHS.

11 districts are being supported to conduct quarterly YFHS internal assessments as means towards accreditation of YFHS sites.

Trainings for YFHS providers continues in a number of districts

Check Points:

Anticipated Impact:

1. Fertility decline of 2.2 from 4.4
2. Reduction in teenage pregnancies from 29% to 24%
3. Promotion of Ten Rights Based FP programing

Proposed Actions:

1. Scale up delivery of integrated adolescent and YFHS in public, private health facilities from 33% to 70%, with adequate services for SRHR with emphasis to increased method mix to adolescents and young people including internally displaced persons during humanitarian crisis.
2. Ensure focal points in emergency cluster/teams for improved coordination
3. Procure and strategically pre-position RH kits through numbers utilized by the Women of childbearing age.
4. Generate in-country evidence on cause and effect of Depo-Provera for women living with HIV as this may affect future programming and fertility.
5. Implement the newly constituted WHO guidelines on youth contraceptives and align national policies/guidelines to allow increased access to Family planning commodities by 2030.
6. Design a task shifting service delivery model with all short acting methods (promoting method mix) to reach out to more young people.
7. Mobilize resources to support SRHR outreach services for hard to reach adolescents through advocacy.
8. Execute fully the YFHS strategy as a guiding document to ensure multi-sectoral participation and accountability of stakeholders for improved access to SRH including contraceptives amongst sexually active young people 10-24 years.
9. Increase the percentage of accredited YFHS facilities that meet at least the 5 minimum standards from 37% to 60% by 2020.
10. Fully disseminate key family planning and population and development policies and issues.

b) Please mark X below how you assess progress toward elements of your commitment:

Achieved OR On-Track ( ) / In-Progress OR Off-Track (X)

c) If you marked "In-Progress" OR "Off-Track" in the above question, what are the key challenges or barriers you face in achieving these elements of your commitment?

- *Revision of pre- and in-service FP reference manuals has been delayed for over a year due to funding*
- *Most district FP coordinators do not have the capacity and resources to implement interventions at district level.*
- *There is also high turnover of FP coordinators in the districts and hence undermining the capacity building efforts that might have been done.*
- *Low coverage for projects – i.e. projects conducted in few districts/areas within a Traditional Authority.*
- *Youth Drop-In Centre model is effective but expensive.*
- *Youth Community Based Distribution Agents (YCBDAs) is voluntary, has high turnover, and/or not being handed over to partner organizations once projects ends*
- *Outreach is expensive and not a sustainable model for public health institutions to replicate.*
- *Multi-sectoral investments in SRHR outreach services including SBCC, CSE, etc. has been slow due to lack of understanding of the interconnectedness amongst the different sectors*
- *SRH guidelines are not harmonized deterring some age groups from accessing services.*

- *Multi-sectoral investments in YFHS has been slow due to lack of understanding of the interconnectedness amongst the different sectors.*
- *No mid-term review of the YFHS strategy due to funding.*
- *Accreditation of YFHS focuses mainly on structures and systems and not necessarily how services are delivered which increases the likelihood that provider attitude will still be poor*
- *Some facilities accredited to provide YFHS are not maintaining the quality of services to meet the minimum standards*

2. **COMMITMENT**: End child marriage by 2030 and delay first pregnancy among girls:

2.1. Work closely with line ministries – e.g. Health and Population Services, Gender, Youth, Education; parliamentarians, religious leaders, civil society, private sector, and the media to reinforce implementation of the Marriage, Divorce and Family Relations Act. Efforts to bring value to girls in the family, highlight the importance of keeping girls in school through public dialogue with traditional leaders, discuss with parents and other stakeholders, finally, to address the root causes of early child and forced marriage and end this practice by 2030.

a) Please provide an update below on achievements made in July 2018 - June 2019 in support of these elements of your commitment, including any key upcoming commitment-related milestones:

MoHP partners working with DYO and DHO to increase awareness on the Marriage, Divorce and Family Relations Act.

Duty bearers (parents, traditional and religious leaders) in some districts are being engaged in withdrawing child brides and disseminating information on family planning.

In some districts, youth groups and Area Development Committees (ADCs) are being engaged on key cultural and structural factors that should be modified to reduce teenage pregnancy and child marriages

Check Points:

Anticipated Impact:

1. 50% of girls completing secondary education.
2. Reduction in CFEM by 5% per annum.
3. 80% of communities aware and enacting the law by 2030.

Proposed Actions:

1. Ministry of Health to work closely with line Ministries – e.g. Gender, Youth, Education; MPs, religious leaders, civil society, private sector, and the media to reinforce implementation of the Marriage, Divorce and Family Relations Act and the value of the girl child, the importance of keeping girls in school through public dialogue with traditional leaders, parents and other

stakeholders to address the root causes of child, early and forced marriage in the hopes of ENDING child and early forced marriages by 2030.

b) Please mark X below how you assess progress toward elements of your commitment:

Achieved OR On-Track ( ) / In-Progress OR Off-Track (X)

c) If you marked "In-Progress" OR "Off-Track" in the above question, what are the key challenges or barriers you face in achieving these elements of your commitment?

- *Limited coordination among line ministry due to varying mandates and poor communication. End child marriages is championed by Ministry of Gender with limited support from the other line ministries.*
- *Impacts and outcomes of efforts to keep girls in school, re-admit girls in school, redeem girls from marriages are minimal*
- *Lack of cohesive national campaigns that advocate on addressing key issues affecting girls. Limited engagement of boys*

3. COMMITMENT: Leverage resources for full implementation of its national costed implementation plan for FP (CIP):

3.1. Mobilize financial and technical resources to fully ensure that adolescents and young people have universal access to voluntary and informed contraception for all those sexually active who need it with demand satisfied (15-49 years) from 75% (MHDS, 2015), with focus on addressing the bottlenecks to contraceptive use among youth, and other underserved population sub-groups. This will be done through intensive; quality and balanced counselling by the trained Family planning health providers. This means the clients will be counselled according to target group.

3.2. Lobby with National Statistics Office for disaggregated DHS FP data by age (10-14, 15-19, 20-24 years) to track adolescent and youth, including young adolescents.

3.3. Continue to lobby for increased funding for FP budget and services according to the CIP funding gap analysis.

3.4. Promote public-private partnerships for provision of FP services and commodities.

a) Please provide an update below on achievements made in July 2018 - June 2019 in support of these elements of your commitment, including any key upcoming commitment-related milestones:

3.1. Mobilize financial and technical resources to fully ensure that adolescents and young people have universal access to voluntary and informed contraception for all those sexually active who need it with demand satisfied (15-49 years) from 75% (MHDS, 2015), with focus on addressing the bottlenecks to contraceptive use among youth, and other underserved population sub-groups. This will be done through intensive; quality and balanced counselling by the trained Family planning health providers. This means the clients will be counselled according to target group.

Family Planning Technical and FP2020 Engagement working group meeting were conducted quarterly to deliberate pertinent issues including resource mobilization.

In 2018, The Malawi Secretary for Health as 2012 and 2017 Signatory to the FP2020 Commitment hosted a discussion meeting with ALL Family Planning Stakeholders to discuss factors affecting increase in mCPR for ALL Women in Malawi. The stakeholders comprised of Government and Donor Focal Points and Family Planning stakeholders.

The Secretary for Health urged all Stakeholders to prioritize the CIP priority activities and the Seven Thematic Areas in their planning, funding and implementation of activities. These meeting will be scheduled regularly.

The Directorate of Reproductive Health supported four district councils to advocate, prioritize and leverage their multisectoral resources for Family Planning and Youth Friendly Services. These council have Task force teams and Terms of Reference developed in a multisectoral approach.

The Directorate of Reproductive Health held an annual FP CIP review meeting for key stakeholders and selected district family planning focal points to review progress on implementation of family planning, address gaps and map way forward.

The Directorate of Reproductive Health conducted a review of the Malawi CIP and came up with a CIP Addendum outlining prioritization of evidence based and high impact activities. The analysis enabled to identify low performing districts which resulted into categorizing these districts as Acceleration and Continuing districts with specific package of interventions to be implemented so as to achieve mCPR above the national. The Malawi Secretary for Health signed and endorsed the Family Planning CIP Addendum and stressed on need for a wider dissemination and execution.

Malawi monitored Stakeholders implementation status of the FP CIP priority activities using the 2018 Anglophone Malawi Plan and the CIP dashboard.

In 2018, some districts got support for additional staff in facilities where there are critical shortages of personnel. For example, a total of 13 health workers in 12 health facilities across four districts (Mwanza, Ntchisi, Rumphi and Nkhatabay) were supported by CHAM with the aim of enhancing capacity of the facilities in the provision of SRHR services with special focus on Youth Friendly Health Services.

Quarterly integrated supervision, coaching and mentoring sessions were conducted to address gaps in quality of counselling.

3.2. Lobby with National Statistics Office for disaggregated DHS FP data by age (10-14, 15-19, 20-24 years) to track adolescent and youth, including young adolescents.

The National Family Planning Technical Working Group endorsed need for the Ministry of Health to write NSO to include into their ToRs the disaggregated DHS FP data by age (10-14, 15-19, 20-24 years) to track adolescent and youth, including young adolescents.

3.3 Continue to lobby for increased funding for FP budget and services according to the CIP funding gap analysis.

Through its partners, the Ministry of Health and Population rolled out RAPID an advocacy tool which is expected to improve prioritization of issues related to population growth, especially advocating for increased funding allocation to Family Planning interventions in district councils. Partners also supported budget analysis and advocacy for increased budget allocation through presidential debate (in the runup to the general elections) and local debate. MPs and councilors have been trained in SRHR government commitments and SRHR budget analysis. Parliamentary committees on Health and HIV/AIDS have also been engaged to increase support and funding for SRHR including family planning and HIV.

The reproductive health directorate has engaged district councils on integrating CIP in District Implementation Plans (DIP) in three districts. Council taskforces to advance prioritization of FP and population activities in the DIPs were set up in all these districts.

3.4 Promote public-private partnerships for provision of FP services and commodities.

FP Stakeholders are working in close collaboration with MOHP through the Reproductive Health Directorate (RHD). PPP interventions are being supported by partners to ensure their inclusion in the service delivery. A network of static private centers in urban and peri-urban areas draws contraceptive commodities from the government supply chain for distribution.

An assessment of all key private practitioners has been done and is waiting for analysis and dissemination. It is expected that MOHP will engage private practitioners to harmonize delivery of health services.

Check Points:

Anticipated Impact:

1. Adequate finances for full implementation to CIP
2. Disaggregated data available

Proposed Actions:

1. Mobilize financial and technical resources to fully ensure that adolescents and young people have universal access to voluntary and informed contraception for all those sexually active who need it with demand satisfied (15-49 years) from 75% (MHDS, 2015), with particular focus on addressing the bottlenecks to contraceptive use among youth, and other underserved population sub-groups.
2. Lobby with NSO for disaggregated FP/DHS data by age (10-14, 15-19, 20-24 years) to track adolescent FP and SRH indicators for 2020.
3. Continue to lobby for increased funding on FP budget and services guided by the CIP funding gap analysis. Support districts to implement fully the health and population priority areas in the Malawi Growth and Development Strategy III.

4. Promote FP public-private partnerships.

b) Please mark X below how you assess progress toward elements of your commitment:

Achieved OR On-Track ( ) / In-Progress OR Off-Track (X)

c) If you marked "In-Progress" OR "Off-Track" in the above question, what are the key challenges or barriers you face in achieving these elements of your commitment?

- *Funding channeled mainly through NGO who have limited mandates, restricted to small implementation areas. This limits coverage and sustainability*
- *Funding to NGOs not always linked to CIP and hence not linked to FP2020 commitments*
- *Districts not prioritizing CIP activities and leveraging resources from government and NGOs operating in the district.*
- *No funding for NSO to collect data for 10-14-year-old*
- *Competing priorities for government funding*
- *Pharmacies and private hospitals do not report because there is no mechanism for them to report to government.*
- *Social franchising is an expensive model for provision of FP services. With the closure of most projects that utilized this model, most people cannot access FP services at a subsidized cost from private facilities.*

4. **COMMITMENT**: Integrate information on FP modern methods into comprehensive sexual education and in public media:

4.1. Integrate information on modern contraceptive in CSE

4.2. Harmonize the in-and out-of-school CSE curricula

4.3. Promote standardized implementation of CSE curricula among all stakeholders in all sectors to ensure that standardized messages reach youth.

4.4. Lobby for use of CSE in both public and private primary, secondary school and all tertiary institutions

4.5. Use mass media and social media to destigmatize FP and to reach young people in workplaces and communities with FP information

a) Please provide an update below on achievements made in July 2018 - June 2019 in support of these elements of your commitment, including any key upcoming commitment-related milestones:

4.1. Integrate information on modern contraceptive in CSE

In school and out of school youths are being trained in CSE.

Roll out of CSE in 300 schools in hard to reach areas has been supported. This includes provision of information on contraceptives.

4.2. Harmonize the in-and out-of-school CSE curricula

The curriculum for CSE will be reviewed and revised to align with UNESCO guidelines with support from a new Norad framework.

4.3. Promote standardized implementation of CSE curricula among all stakeholders in all sectors to ensure that standardized messages reach youth.

A working manual for conducting dialogue meetings for both in and out of school youths to be developed. Youth leaders and community facilitators will be trained on how to use the manual.

4.4. Lobby for use of CSE in both public and private primary, secondary school and all tertiary institutions

The ministry of Education Science and Technology incorporated CSE in the school curriculum and uses after school clubs for primary schools. Patrons and matrons managing these clubs.

4.5. Use mass media and social media to destigmatize FP and to reach young people in workplaces and communities with FP information

Utilizing the Community Scorecard, information on de-stigmatization of FP is being disseminated to young people in communities using Youth.

Through BCCI officers, YRHA, CCPF and local radios FP messages are disseminated to allay fears and misconceptions associated with FP methods.

Check Points:

Anticipated Impact:

1. Harmonized and standardized CSE messaging to all young people in-and out of school
2. Empowerment of young people on exercising their rights on SRHR decisions. This will be measured by reduction of teenage pregnancies by 5% annually and increased number of young people accessing SRHR services and increasing completion rates of secondary school.

Proposed Actions:

1. Integrate information on modern contraceptive in CSE and lobby for use in both public and private primary, secondary school and all tertiary institutions including Knowledge and attitude improvements, use of Mass media; social Media to reach-out more young people in workplaces and communities.
2. Harmonize the in-and out-of-school CSE curricula for standardized implementation by all

stakeholders and certainty of standardized messaging going out to youth in all sectors.

b) Please mark X below how you assess progress toward elements of your commitment:

Achieved OR On-Track ( ) / In-Progress OR Off-Track (X)

c) If you marked "In-Progress" OR "Off-Track" in the above question, what are the key challenges or barriers you face in achieving these elements of your commitment?

- *There are two MOEST curriculums – Life Skills Education (Std. 4 – Form 2) and Comprehensive Sexuality Education (CSE) – Form 3 onwards (year 11). Life Skills education does not have a module on modern contraception MOEST has now included modern contraception in the CSE curriculum but is taught too late.*
- *For the lower classes below form 3, CSE is taught via youth clubs but there is low patronage since it is provided after-school*
- *Every partner has their own CSE/Life Skills curriculum.*
- *Monitoring of the quality of delivery is a challenge. There is no uniformity in delivery between public and private schools.*
- *Difficult to regulate information coming through social media channels*

5. **COMMITMENT**: Promote meaningful engagement with young people in coordination and implementation of SRH/FP/YFHS:

5.1. Strengthen capacity of 100 to 200 SRH leaders at youth clubs and youth-led organizations to participate in planning and coordinating the implementation of YFHS services.

5.2. Advocate with young people, guardians, teachers, and communities to develop a positive attitude toward YFHS.

a) Please provide an update below on achievements made in July 2018 - June 2019 in support of these elements of your commitment, including any key upcoming commitment-related milestones:

5.1. Strengthen capacity of 100 to 200 SRH leaders at youth clubs and youth-led organizations to participate in planning and coordinating the implementation of YFHS services.

MoHP, Ministry of Youth and partners conducting trainings, coaching and mentorship for Youth Network members, youth leaders, youth champions and YRHAs in youth participation including planning and coordination of implementation of YFHS services. These initiatives are also strengthening the engagement of network members, youth leaders, youth champions and YRHAs at National, district, community and facility level.

Youth Community Based Distribution Agents (YCBDAs) have been involved in the provision of family planning services. These young people, who were selected from different youth clubs, are trained in provision of FP methods such as pills and condoms and they also provide health education.

5.2. Advocate with young people, guardians, teachers, and communities to develop a positive attitude toward YFHS.

MoHP and partners has provided gate-keepers with orientation and conducted dialogue workshop for youths in communities within YFHS service points catchment areas.

MOHP and partners also supporting community health action groups and champion communities to engage guardians and communities on health issues affecting their community which includes YFHS.

Check Points:

Anticipated Impact:

1. Empowerment of young people on exercising their rights on SRHR decisions
2. Increased quality participation of young people in local governance
3. Change of mind-set by communities towards youth and YFHS including contraceptive use

Proposed Actions:

1. Strengthen capacity of SRH leaders from youth clubs, and youth- led organizations to participate in planning implementation and coordination of YFHS services from 100 to 200 youth leaders.
2. Advocate with young people, guardians, teachers, and communities to develop positive attitude towards YFHS.

b) Please mark X below how you assess progress toward elements of your commitment:

Achieved OR On-Track (X) / In-Progress OR Off-Track ( )

c) If you marked "In-Progress" OR "Off-Track" in the above question, what are the key challenges or barriers you face in achieving these elements of your commitment?

- *There is no standardized curriculum for building capacity of SRH leaders at youth clubs and youth-led organizations.*
- *There are no strong youth networks for there to be meaningful youth engagement*
- *Limited coordination among stakeholders with little oversight from the ministries.*

- *Focus is more on contraceptives and SRHR and not YFHS. An opportunity missed to get communities to understand what YFHS is all about.*

6. **COMMITMENT**: Improve the accuracy of data on stocks at facility and central level:

6.1 Link service delivery stock status to main supply chain for last mile accountability.

6.2 Systems strengthening for supply chain management to respond to the service delivery needs.

6.3 Strengthen linkage of electronic LMIS system to DHIS II

6.4 Promote evidence-based FP product availability through SDP surveys, physical inventory and spot checks.

a) Please provide an update below on achievements made in July 2018 - June 2019 in support of these elements of your commitment, including any key upcoming commitment-related milestones:

6.1 Link service delivery stock status to main supply chain for last mile accountability.

MoHP and partners working to support supply chain to the last mile through monitoring and redistribution of FP commodities, supervision and mentoring of pharmacy personnel.

Partners also provide internet to support data entry into DHSI2 and LMIS.

6.2 Systems strengthening for supply chain management to respond to the service delivery needs

The Reproductive Health Commodity Security Technical Working Group (RHCS TWG) coordinates with key stakeholders on issues to do with commodity availability. It quantifies commodity needs, distribution, redistribution and reviews in order to ensure that the supply chain management responds to service delivery needs.

MoHP and partners conduct joint monitoring of SRHR related commodities and engages relevant stakeholders for re-allocation and re-distribution.

Malawi launched Open LMIS to monitor stocks and scaled up Supply Chain Maturity Model orientation for pharmacist and Assistants.

6.3 Strengthen linkage of electronic LMIS system to DHIS II

eLMIS datasets were customized in DHIS2 in the year 2017. Since that time, every month data on commodities consumed (including FP) is extracted from eLMIS into the DHIS2.

6.4 Promote evidence based FP product availability through SDP surveys, physical inventory and spot checks.

MoHP and partners conducts monitoring of commodities and supplies through regular quarterly supportive supervision. This include spot checks on availability of FP commodities and other SRHR related commodities and do physical check of facility inventory.

In 2018 Malawi conducted a Service Delivery Survey of availability of FP commodities.

Check Points:

Anticipated Impact:

1. Minimized over-stocks and stock-outs in a district.
2. Efficient supply chain.

Proposed Actions:

1. Link service delivery stock status to main supply chain for last mile accountability.
2. Systems strengthening for supply chain management to respond to the service delivery needs.
3. Strengthen linkage of electronic LMIS system to DHIS II
4. Promote evidence-based FP product availability through SDP surveys, physical inventory and spot checks.

b) Please mark X below how you assess progress toward elements of your commitment:

Achieved OR On-Track ( ) / In-Progress OR Off-Track (X)

c) If you marked "In-Progress" OR "Off-Track" in the above question, what are the key challenges or barriers you face in achieving these elements of your commitment?

- *From health center level to the lowest service delivery post, the system is paper based and hence affecting the accuracy and timeliness of data.*
- *SDP surveys are expensive to finance.*
- *Use of data by stakeholders is under-valued and limited.*
- *Roll out of global van is not clear.*

SECTION II: STANDARD QUESTIONNAIRE

Please respond to all parts of the following 7 questions:

1. **How has your country integrated adolescents and youth representatives, and/or representatives from marginalized groups** (e.g. lowest-income, people with disabilities, out of school, minority groups, remote or displaced populations, etc.) **into the FP2020 Focal**

Point team and/or country's FP technical working group or country engagement working group?

A Youth FP2020 Focal Point and a CSO Focal Point was appointed early in 2019 and has been part of FP2020 Focal Point team activities.

The country's FP TWG is diverse, various groups including youth, CSO, religious groupings are also included.

a. If yes, how has this engagement influenced achieving your FP2020 commitment? Please also share successes and/or lessons learned from these engagements.
The FP2020 Focal Point team has been meeting regularly. The inclusion of the two has added value to the discussions that the team has been having. Also, the inclusion of CARE as a CSO Focal Point has also opened new doors for advocacy and funding of some of the team's activities.

b. If not, what challenges have you faced in working with these groups? (Please give examples)

2. **How is your Government integrating family planning into universal health coverage (UHC)-oriented schemes and what is/are the mechanism(s) being used or considered? What specific actions were taken in the past year surrounding integration?**

FP services are provided through integrated and standalone static services and also through outreach services. Community health workers (HSAs, CBDAs, YCBDAs) also provide FP services in their communities.

FP services are also integrated with other services such as HIV/STI, Nutrition, Cervical Cancer, ANC, labor and delivery and EPI.

3. **Has your Government organized the 2019 data consensus workshop?**

Yes

a. If yes, did the FP2020 Focal Points participate in your country's 2019 data consensus workshop? If so, what insights were gained?

The FP2020 Focal Points participated in the 2019 data consensus workshop.

Malawi noted increased investment and efforts in FP service delivery reaching target groups through several models used.

Malawi yielded huge service statistics which prompted followed up. mCPR moved from 46.6% in 2018 to 48.3% in 2019.

There is more that need to be done to ensure that data captured in DHIS2 is accurate. There is need for more collaboration between public facilities, private facilities and CSOs/NGOs to ensure that static and outreach service data are properly recorded in DHIS2.

b. Were domestic expenditure data reviewed as part of the data consensus meeting? If so, please share insights and challenges you had in reviewing and validating these data.
Domestic expenditure data for 2017 were reviewed at a TWG meeting that took place prior to the consensus meeting. This data was then presented at the consensus building meeting. The estimated expenditure for the year 2017 was K4,801,286,394.72.

It was noted that the expenditure report was not aligned to the CIP thematic areas and hence making it difficult to note which areas were being underfunded.
It was also noted that collection of data from partners was problematic and hence delayed the process.
It was also noted that there was potential to capture this through the National Health Accounts and a recommendation was made on the same.

4. In the past year, were any efforts made to improve resilience and/or emergency preparedness of family planning systems in country?

Structures set in place to prepare and respond to emergencies and include Department for Disaster Management at National level and RH Disaster working groups for reproductive Health and Gender Based Violence using a multisectoral approach.

Malawi implements the MISP- RH to respond to emergencies and disasters affecting all with special focus on women and girls in emergencies. Malawi procures RH KITS and provides a method mix of contraceptives during emergencies.

Cyclone Idai affected FP systems especially in the Southern Region. MOHP together with partners put in place efforts to attenuate the impact of the cyclone on people in this region. In addition, the cyclone affected delivery of FP commodities (especially DMPA-IM) that were stuck at Beira port. Efforts were put in place to ensure that alternative solutions are available without greatly affecting users.

MoHP also approved that Triclofem can also be procured and provided to women as an alternative to Depo Provera.

5. **Has your country allocated GFF resources to your FP program? If so, how has this benefitted your work?**

Yes. **We have a draft GFF investment case (IC) which is not yet finalized where family planning has been reflected as a priority. The GFF IC will be tracking all the resources from partners and through this will be able to invest in priority areas based on need and also taking into account the interventions with high impacts to reach out special population.**

6. **Have you worked to improve quality of care/rights-based family planning in your programs?**
Yes. Programming ensures the realization of the Ten Rights Based FP programming to all target groups.

a. Do your family planning programs provide a broad range of contraceptive methods (long-term, permanent, or short acting)? Do you provide comprehensive information and counseling on all available methods, including information on any risks or side effects?
Yes. Family planning programs provide a broad range of contraceptive methods. This includes the introduction of new technologies i.e. DMPA SC and Levoplant.
Counseling *is done with some gaps which Malawi is currently addressing.*

b. To ensure a user-centered approach, do clients get a chance to provide feedback after clinic visits either through questionnaires, surveys, or suggestion boxes?
Yes.
Between 2018 and 2019, a quality of care study on FP services in Malawi was conducted. It included exit interviews for clients and use of mystery clients.
MoHP advocates for use of suggestion boxes at service delivery points for feedback on services accessed.

c. Are your clinics open to improve accessibility and availability of services?
Yes. Clinics provides integrated SRHR/FP/HIV services

7. **FP2020 and partners are currently gathering input to build a shared vision for family planning post-2020, in consultation with stakeholders at the country and global level. Have you had an opportunity to participate in any way in this consultation process** (e.g. online survey, consultative calls, etc.)**?**
No.

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