



**Increasing Adolescents’  
Access to Sexual and Reproductive Health  
Information and Services in Malawi:  
A Problem Driven Political Economy Analysis**





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## ABBREVIATIONS AND ACRONYMS

<b>AGYW</b>	Adolescent Girls and Young Women
<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>AOGM</b>	Association of Obstetricians and Gynecologists of Malawi
<b>APHRC</b>	African Population and Health Research Center
<b>AREP</b>	Emergency Radio Education Program
<b>BLM</b>	Banja La Mtsogolo
<b>CAMFED</b>	Campaign for Female Education
<b>CAVWOC</b>	Centre for Alternatives for Victimized Women and Children
<b>CHAM</b>	Christian Health Association of Malawi
<b>COMREC</b>	College of Medicine Research Ethics Committee
<b>CPD</b>	Continuing Professional Development
<b>CRECOM</b>	Creative Center for Community Mobilization
<b>CSE</b>	Comprehensive Sexuality Education
<b>CSO</b>	Civil Society Organization
<b>CYECE</b>	Centre for Youth Empowerment and Civic Education
<b>DFID</b>	Department for International Development
<b>ESA</b>	Eastern and Southern Africa
<b>FBO</b>	Faith-Based Organizations
<b>FPAM</b>	Family Planning Association of Malawi
<b>GBV</b>	Gender-based Violence
<b>HEARD</b>	Health Economics and HIV and AIDS Research Division
<b>HIV</b>	Human Immunodeficiency Virus
<b>ICPD</b>	International Conference on Population and Development
<b>ICT</b>	Information and Communication Technology
<b>INGO</b>	International Non-Governmental Organizations
<b>ITGSE</b>	International Technical Guidance on Sexuality Education
<b>KUHeS</b>	Kamuzu University of Health Sciences
<b>LGBT</b>	Lesbian, Gay, Bisexual, and Transgender
<b>LSE</b>	Life Skills Education
<b>MAGA</b>	Malawi Girl Guides Association
<b>MAM</b>	Muslim Association of Malawi
<b>MDAs</b>	Ministries, Departments and Agencies
<b>MoE</b>	Ministry of Education
<b>NAC</b>	National Aids Commission
<b>NER</b>	Net Enrollment Rate
<b>NESP</b>	National Education Sector Plan
<b>NGO</b>	Non - Governmental Organization
<b>NSO</b>	National Statistical Office



<b>NYCOM</b>	National Youth Council of Malawi
<b>ODI</b>	Overseas Development Institute
<b>PAC</b>	Public Affairs Committee
<b>PACHA</b>	Pediatric and Child Health Association of Malawi
<b>PB- PEA</b>	Problem-Based Political Economy Analysis
<b>PPE</b>	Personal Protective Equipment
<b>PSI</b>	Population Services International
<b>PTA</b>	Parents Teachers Association
<b>SRH</b>	Sexual and Reproductive Health
<b>SRHR</b>	Sexual and Reproductive Health and Rights
<b>SSA</b>	Sub-Saharan Africa
<b>TTC</b>	Teachers Training College
<b>UK</b>	United Kingdom
<b>UN</b>	United Nations
<b>UNAIDS</b>	United Nations Programme on HIV and AIDS
<b>UNESCO</b>	United Nations Educational, Scientific and Cultural Organization
<b>UNFPA</b>	United Nations Population Fund
<b>UNGASS</b>	United Nations General Assembly
<b>UNICEF</b>	United Nations Children's Fund
<b>USAID</b>	United States Agency for International Development
<b>WYCA</b>	Young Women Christian Association
<b>YFHS</b>	Youth Friendly Health Services
<b>YONECO</b>	Youth Network and Counselling





## BACKGROUND

In 2020, the African Population and Health Research Center (APHRC) in Kenya conducted a problem-based political economy analysis (PB-PEA) focused on the access of adolescents to sexual and reproductive health information and services in Malawi. This work was done in close collaboration with the Health Economics and HIV and AIDS Research Division (HEARD) Institute at the University of KwaZulu Natal in South Africa, and the Department of Community and Environmental Health at the Kamuzu University of Health Sciences (KUHeS) in Malawi. The overall goal of this PB-PEA was to understand the gaps between policy and regulatory commitments that relate to adolescent SRH on the one hand, and implementation on the other.

## METHODS

Qualitative interviews with key stakeholders and a desktop review of the literature were conducted to assess relevant policies and the prevalent socioeconomic conditions affecting the delivery of comprehensive sexuality education (CSE) and broader sexual and reproductive health (SRH) services to adolescents in the country. This study engaged key stakeholders in all three administrative regions of the country (South, Centre, and North) and those operating at the national level. Given that government ministries, departments, and agencies, as well as non-governmental organizations are headquartered in Lilongwe, this became the primary data collection site. The analysis was informed by the Overseas Development Institute (ODI) PB-PEA framework with a focus on how structural and institutional factors, such as Malawi's health system and prevalent school-related factors, affect the delivery of sexual and reproductive health. Primary data obtained through the qualitative interviews and stakeholder engagements were analyzed using thematic analysis and presented accordingly. Secondary data from relevant literature and demographic and health surveys were analyzed and presented. Key actors in the delivery of CSE and sexual and reproductive health services were mapped and scrutinized during a validation meeting, with a focus on their level of interest and influence. Also, at the validation meeting, stakeholders had the opportunity to engage, refine and propose additional recommendations. The provision of SRH services to adolescents is conceptualized and analyzed in four layers:

1. structural factors,
2. institutional factors,
3. actors' decision-making logic, and
4. room for maneuver.

## MAIN FINDINGS

### Structural and institutional factors

#### Malawi's health care system

Health care in Malawi is primarily provided by the government and is free of charge. However, donors are the highest contributors of the health budget. The Christian Health Association of Malawi (CHAM) is a key player in the delivery of SRH services, targeting populations in rural and remote areas. Several health system challenges hinder the delivery of quality health services. Currently, there is a significant shortage of health workers to deliver care. Inadequate in-service training and poor staff retention are key factors contributing to the poor delivery of SRH services. Quality of health care is also compromised by drug stockouts, weak supply chains, as well as inadequate basic equipment and infrastructure.

#### Malawi's adolescent sexual and reproductive health policy framework

Malawi is a signatory to the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa, better known as the Maputo Protocol. At the 2019 Nairobi Summit, Malawi renewed its commitment to Sexual and Reproductive Health and Rights (SRHR). In 2007, Malawi was among the first

countries in Africa to implement youth-friendly health services. Malawi committed to increasing the percentage of adolescents accessing these services to 100% by 2030. Relevant ministries have consultatively developed policies, strategies and guidelines in line with these commitments in an effort to guide the country's delivery of adolescent SRH services. The adolescent SRH policies have created an enabling environment for the greater involvement of NGOs and partners in delivering services to young people at the community level.

Several relevant policies are up for review, including the National Sexual and Reproductive Health and Rights (SRHR) Policy, 2017–2022; the National Girls Education Strategy 2018–2022, and the National Youth Friendly Health Services (YFHS) Strategy 2015–2020. This presents an opportunity to assess progress, identify gaps and address those gaps in new policies.

Despite the progress recorded, young people continue to face barriers in accessing SRH services. The cultural expectation of saving sex for marriage persists and hinders unmarried young people from seeking services. Misinformation about contraceptive effectiveness and side effects results in poor utilization, especially among unmarried young people and consequently, many adolescents are exposed to early, unintended pregnancies. Even with significant investment in youth-friendly services, judgmental attitudes of providers towards unmarried girls accessing contraceptives persists and negatively influences uptake. Health facilities are considered unfriendly for adolescents living with disabilities or who identify as sexual minorities. National laws remain nonaligned to international and regional human rights instruments and standards – regardless of whether signed or ratified. Malawi's law does not explicitly address the minimum age of consent for contraception, leaving it to interpretation by service providers. Malawi's domestic laws do not fully comply with the Maputo Protocol because abortion is restricted to circumstances under which the mother's life is endangered. A lack of financing provisions in policies and laws adversely affects the implementation of many SRH programs; reliance on fluctuating financial support from international agencies creates uncertainty and makes planning difficult. In addition, COVID-19 and the shifting of resources required to manage it divert attention and resources from SRH services.

The Ministry of Education's 100-meter rule, which states that there is no contraceptive distribution or availability within 100 meters of schools, is also at odds with the Ministry of Health's goal of making contraceptives accessible to young people. It is also against school policy for children to be carrying condoms, and schools are opposed to facilitating access to contraceptives on their premises. Out-of-school adolescents are further compromised as they are not exposed to comprehensive sexuality education (CSE); the majority of these adolescents reside in rural and underserved areas, making accessing health services more challenging.

## Comprehensive sexuality education

Sexuality education is primarily provided through the education system. The occurrence of HIV as a global crisis, and its high prevalence among young people in Malawi, resulted in the government acknowledging the value of promoting SRH among young people. This led to the emergence of HIV prevention education, which was the driving force for the development of CSE.

Malawi has a policy framework for CSE, developed following technical support from international agencies. The Ministry of Youth is developing an out-of-school CSE curriculum, and the Ministry of Education is reviewing the in-school CSE curriculum. Given the nature of curriculum development, opportunities for engagement and consultation exist which, if adequately cultivated, would make the curriculum more comprehensive.

Although the government is supportive of CSE, implementation has been hindered by several challenges. For example, there remains opposition from some religious and traditional authorities. Conservative opposition to CSE has slowed progress towards a more comprehensive approach to sexuality education in schools. The 'deafening silence' surrounding sexuality matters, as reported by key informants, coupled with the lack of a strongly organized and vocal civil society, may explain why public debate on CSE is limited. The slow adoption of a comprehensive approach has been compounded by the education sector's focus on a value-based and prevention-based education, with teachers lacking the skills and resources to deliver on the policy objectives.

Provision of sexuality education is entrenched within cultural practices. The Ministry for Gender is central to engaging with traditional authorities and to influencing the curriculum for initiation ceremonies. However, there is resistance amongst traditional authorities who are reluctant to adopt what they consider to be westernized. Development partners such as the United Nations Population Fund (UNFPA) and civil society organizations (CSOs) such as the Family Planning Association of Malawi (FPAM), work with government ministries for gender, children, disability and social welfare, and the Ministry of Health to collaboratively deliver CSE to out-of-school adolescents in youth-friendly health facilities, youth clubs and other community outreach programs.

## Decision-making logic

### Civil society engagement in adolescent sexual and reproductive health

A strong and experienced civil society that includes youth-led and women-led groups, can effectively promote CSE and better access to SRH services for adolescents, even in the face of opposition. Malawi has CSOs working on SRH-related issues that are experienced and engaged, and in many cases, have worked on this issue for decades, giving them needed authenticity and legitimacy for working at the community level.

## Room for maneuver

### An enabling policy environment

- There is growing recognition of adolescents' SRH challenges and the need to invest in their reproductive empowerment. This increasing recognition is demonstrated in the government's signing and ratifying of forward-looking international and regional frameworks and commitments. For example, Malawi is among the countries that recommitted to the East and Southern Africa (ESA) Ministerial commitments on sexuality education and reproductive services for adolescents and young people.
- Efforts to expand access to adolescent SRHR services are gathering momentum, and the provision of youth-friendly services and training of health workers is increasing.
- The government of Malawi has signed international commitments to provide SRH services to adolescents.
- Civil society therefore has a crucial role to play in continuing to lobby and advocate for SRH services and, in so doing, it holds the government accountable to these commitments.
- Traditional authorities are sometimes engaged on the issue and acknowledge the importance of sexuality education. They remain open to engaging stakeholders while there remains a willingness to play a substantive role in positively shaping adolescent sexual health behavior. Traditional leaders can be an engine of change. If traditional leaders lead on norms around adolescent sexuality, it may be of tremendous benefit in improving adolescents' access to sexual and reproductive health information and services.
- The engagement of young people and youth organizations in the policy development and implementation processes is key to ensuring their needs are accounted for. Malawi has active organizations representing youth but enhanced and more strategic coordination is needed.
- The involvement of experts outside government can help the Ministry of Education in the development of strategies aimed at improving CSE implementation; these experts can also work with the Ministry of Health in its efforts to expand access to SRH services to underserved areas. Malawi can rely on technical and financial support from various international agencies and, albeit more sporadically, from bilateral development agencies.
- It is important to build on existing CSO networks that are working on adolescent sexual and reproductive health to increase access to relevant information and services. Such organizations would include FPAM, the Centre for Youth Empowerment and Civic Education (CYECE), the Centre for Alternatives for Victimized Women and Children (CAVWOC) and the Youth Network and Counselling (YONECO) to name a few.
- In addition, community-based interventions that work with parents and guardians, health providers and community leaders need to be expanded. It is important to engage these gatekeepers because they play a critical role in facilitating the access of adolescents to SRH services.

- Academia needs to better leverage CSO networks to share easily understood findings from emerging research that can guide advocacy efforts; donor assistance can help facilitate this process. There is an appetite among civil society entities for a role in informing the research agenda and to be partnering the process.

### Areas requiring attention

- With the expansion of SRH services targeting adolescents, improved coordination and communication is essential. Donors and international organizations should make sure their approach is informed by appropriate NGOs and CSOs, as well as academia, and that a coordinated approach is adopted to ensure synergistic efforts. The Parliamentary committees on education and health could be effective channels for offering key stakeholders a legitimate opportunity and a stronger voice in driving the SRH agenda forward.
- The provision of SRH services for adolescents needs to be anchored in a system of rights and corresponding obligations established by international law, including all civil, cultural, economic, political, and social rights, as well as the right to development. Achieving this entails not only service availability but that the people seeking and those providing the services know and understand the implications of these framing laws and policies. This is important for adolescents because societal norms and values often conflict with the principles of autonomy and access to SRH services espoused in regional and national commitments.
- There are bottlenecks in effective implementation of SRH policies that reflect wider systemic problems in the education sector: insufficient teacher training and support, teacher shortages, overcrowded classrooms, and insufficient teaching materials (some of which remain at odds with cultural and community norms).
- Specifically, teacher training is required to shift the pedagogy and content from a values-based approach to a rights-based approach. The development of standardized scripted lesson plans and other teacher training materials may assist in ensuring that the delivery of CSE retains its 'comprehensiveness'.
- Evidence needs to be refined to the point where it can be effectively consumed by the community, traditional and religious authorities. Cultural practices and religious teachings will evolve where there is clear evidence that prevailing practices are proving harmful and leading to poor health outcomes.
- The respective goals of the Ministries for Education and Health on SRH knowledge advancement and service provision need to be bridged. The implementation of programs in silos between the two ministries is not an optimal approach; a common strategy could be more effective.

## 1.0 The study's geopolitical context

Malawi has a population of approximately 18 million people, with about five million aged 15 to 24.<sup>1</sup> An estimated 85% of the population resides in rural areas, where access to healthcare services is limited.<sup>2</sup> The Malawi economy is based mainly on agriculture, and since 2000, economic growth has slowed due to reduced agricultural production. The country is susceptible to environmental disruptions due to climate change. After the 2018 drought, Cyclone Idai hit Malawi's central and southern regions in March 2019, resulting in higher levels of poverty and food insecurity.<sup>3</sup> The emergence of COVID-19 in 2020 had significant impacts on the economy, compromising the country's recovery from the 2018–2019 drought and subsequent floods.<sup>4</sup> A State of National Disaster was declared on March 20, 2020, and COVID-19 was declared a formidable disease.<sup>5 6</sup> Containment policies were implemented to reduce disease transmission by limiting human-to-human contact. Nationwide, schools were closed from March 23, 2020. Schools remained closed for five months and reopened on the September 7, 2020. Between May and July 2020, Malawi registered an 11% increase in teenage pregnancies and child marriages compared with the same period in 2019.<sup>7</sup>

Malawi has been politically stable since its 1964 independence from Britain. Elections have been held regularly, and the country re-introduced multiparty democracy in 1994 after 30 years of one-party state rule. Under the 1995 Constitution, the President is both the Head of State and the Head of Government. Executive power is vested in the presidency and its cabinet, with legislative power residing in the National Assembly. The Constitution provides for the independence of the Judiciary. The Constitutional Court nullified the 2019 elections, and in June 2020, Dr Lazarus Chakwera was elected as President. All three arms of government are interested in sexual and reproductive health (SRH) and have played a role in developing and interpreting legal and policy frameworks. A pointed example is the 2021 ruling by the High Court reaffirming the statutory protection for legal abortion under narrow circumstances.<sup>8</sup>

## 1.1 Malawi's health system

Malawi's health care system has three sectors: public, private-for-profit, and private not-for-profit. The public health sector is a three-tier system. Primary health care, the lowest tier, is tasked with meeting the general medical care needs of the population, including community and rural hospitals and maternity units. The second tier consists of district hospitals, which receive patients referred from primary health care facilities performing some primary care functions. The third tier is tertiary care, which provides specialized services as well as limited primary care. Approximately 61% of health care services are provided through public health facilities. The Christian Health Association of Malawi (CHAM) is the most notable non-public player, providing 37% of Malawi's health services and with a heavy presence in rural areas.<sup>9</sup> Only two percent of services are provided by private for-profit institutions.

Funding and poverty remain key challenges to Malawi's health system. The country's per capita expenditure on health was \$39.2 in 2014–2015, significantly below the average of \$98 for sub-Saharan Africa (excluding South Africa).<sup>10</sup> Malawi's total resource ceiling for the health sector has been limited (Government of Malawi, 2015), allocating only 9.4% of its fiscal year (FY) 2019/20 budget to health, far from the 15% recommended in Abuja Declarations.<sup>11</sup> Donor financing accounts for the bulk of Malawi's health sector budget, contributing an annual average of US\$27 per capita compared to the government's annual average contribution of US\$9 per capita from 2009–2010 to 2014–2015.<sup>10</sup> This implies that the contribution of Malawi's government to per capita expenditure on health is less than a quarter of the country's total per capita expenditure on health. Reliance on external development partners to finance Malawi's health programs is unsustainable and exposes the country to internal and external shocks.<sup>12</sup> Furthermore, about 62% of the external funding in Malawi is spent on HIV and AIDS, malaria and reproductive health, which leaves other health system components significantly underfunded.<sup>12</sup>

Limited funds allocated to health has negatively affected the sector's ability to fully deliver on key policy commitments on accessible and affordable healthcare.<sup>13</sup> Insufficient funding creates additional challenges, with the World Health Organization identifying Malawi as one of the countries with an acute shortage of health workers. For instance, it is estimated that there is a shortage of at least 7,000 Health Surveillance Assistants (HSAs), who deliver health services at the community level.<sup>13</sup> The health sector is further characterized by limited in-service training and poor staff retention. Malawi's health information system faces challenges due to the presence of parallel information systems and poor data collection and curation. Health care quality has been further compromised by frequent drug stock-outs, weak supply chains, inadequate basic equipment and infrastructure, and electricity problems compromising the cold chain storage capabilities.<sup>14</sup>

Most secondary and tertiary health facilities are located in urban areas. Irrespective of the mode of transportation, on average it takes an hour to travel to the nearest health center, 1.5 hours to a district hospital, and 2.5 hours to the nearest central hospital.<sup>15</sup> Over half of the population reported not having sufficient money to visit health facilities in 2019.<sup>15</sup>

## 1.2 Adolescent sexual and reproductive health in Malawi

In Malawi, adolescents and young people bear the highest burden of poor SRH outcomes.<sup>16,17</sup> For instance, about one in three new annual HIV infections (12,500 out of 36,000) occur among adolescents and young people aged 15–24 years, and close to three-quarters of these new infections are among girls.<sup>16</sup> About one in seven adolescent girls aged 15–19 years have already given birth or are pregnant, posing risks to their health and development.<sup>17</sup> The risk of maternal deaths is three times higher among adolescent girls compared to young women aged 20 years and older,<sup>18</sup> with adolescent girls accounting for close to 30% of all maternal deaths.<sup>17</sup> Moreover, adolescents have a higher risk of adverse perinatal outcomes, including low birth weight, preterm delivery, and cephalopelvic disproportion resulting in adverse consequences, including perinatal death.<sup>18</sup> Unsafe abortions are among the leading causes of maternal deaths among adolescent girls in Malawi, responsible for about 18% of all maternal mortality, making it the second leading cause of maternal mortality in the country.<sup>19</sup>

Age-appropriate CSE is an effective intervention to equip young people with knowledge, attitudes, values and skills that will empower them to realize their SRH and well-being.<sup>20</sup> This will also enable them to consider how their choices affect the well-being of others and allows them to understand and protect their rights.<sup>21</sup> Existing evidence shows that curriculum-based CSE programs can help to delay the initiation of sexual intercourse, decrease the frequency of sexual intercourse, reduce the number of sexual partners, and increase the use of condoms and contraceptives.<sup>20</sup>

Malawi's government has demonstrated a commitment to addressing the SRH needs of adolescents and young people by ratifying several international and regional human and reproductive rights frameworks, including the Maputo Protocol. Despite these commitments, however, as well as supportive policy and legal frameworks, the delivery of adolescent SRH services – including CSE, safe abortion and contraceptive use – continues to face implementation challenges.

## 1.3 Study aim and objectives

Recognizing that inadequate and inconsistent policy and legal frameworks can powerfully affect the health, rights and potential of adolescents and young people,<sup>22</sup> the African Population and Health Research Center (APHRC) in Kenya, along with the Health Economics and HIV and AIDS Research Division (HEARD) Institute at the University of KwaZulu Natal in South Africa, and the Department of Community and Environmental Health at the Kamuzu University of Health Sciences (KUHeS) in Malawi, undertook a problem-based political economy analysis (PB-PEA). The overall goal of this PB-PEA was to understand the gaps between policy and regulatory commitments that relate to adolescent SRH on the one hand, and implementation on the other. This involved assessing current policies and the prevalent socio-cultural conditions affecting delivery of CSE and broader SRH services to adolescents in Malawi.

The study had the following specific objectives:

1. Identify the structural and systemic drivers/barriers to the delivery of CSE and provision of SRH services to adolescents
2. Map institutional governance arrangements for the delivery of CSE and provision of SRH services to adolescents
3. Analyze a combination of perceived incentives, power, motivation, values, and beliefs of the agents/actors who influence the delivery of CSE and the provision of SRH services
4. Assess possible pathways to change and the entry points for better CSE and adolescent-friendly SRH services implementation
5. Identify proposed actions to support the above pathway of change in line with the identified constraints and opportunities.

## 1.4 Guiding framework

The Overseas Development Institute (ODI) PB-PEA framework guided this analysis.<sup>23</sup> ODI's framework prioritizes three analyses: problem identification; problem diagnosis; and identification of entry points or levers of change, policies and strategies that are likely to succeed in addressing difficult and persistent challenges, such as the lack of access by adolescents to sexual and reproductive health information and services. It facilitates better understanding of political, economic, and social processes enabling and stalling change. The PB-PEA approach facilitates an understanding of the political, structural and institutional dimensions of a difficult problem, as well as the level of interests and influence of key actors or change agents and how to engage them. Stakeholder analysis, a key component of PB-PEA, assesses the dynamics of power between and among actors, helping to understand the position of key actors regarding a challenge; where incentives or disincentives are distributed; and identifying strategic allies, neutral parties, opponents, actions and entry points.<sup>23</sup>

Political economy analysis involves looking at the dynamic interaction between structures, institutions, and actors (stakeholders), to understand how decisions are made:

- Structures are the more enduring specifics of the context that change slowly, such as global influences, natural resource endowment, demographic shifts, historical legacies, social-cultural factors and technological progress. Institutions are the rules of the game, the local laws, conventions and traditions that shape human behaviors
- Stakeholders can be individuals, organizations and coalitions from the public, private and civil society sectors. Their interests, motivations, networks and influence shift over time. Their behavior can be thought of as 'the games within the rules'
- We adopted the PB-PEA framework to assess the policies and the prevalent socioeconomic conditions affecting the delivery of CSE and the broader SRH services to adolescents and young people. The study was grounded in the understanding that the disjuncture between the 'technical and social aspects' of SRH is the interface sites among formal CSE and SRH policy and the broader political, social, and economic context of service provision. By focusing on access to services, the study extended the analytical lens to include diverse actors involved in influencing policy and implementation. In so doing, the analysis focused mainly on structural, institutional and stakeholder factors. The provision of SRH services to adolescents is conceptualized and analyzed in four layers: (1) structural factors, (2) institutional factors, (3) actors' decision-making logic and (4) 'room for maneuver'.<sup>24 25</sup>



## STUDY METHODS

### 2.1 Study design

The study utilized multiple data sources, triangulating qualitative interviews with a desk review of the relevant literature and engagement with key stakeholders at inception and validation workshops.

#### 2.1.1 Desk review

We conducted a macro-level analysis to explain the country's context within which CSE and SRH is provided. This was achieved through a comprehensive desk review to identify and assess key CSE- and SRH-related trends, events, processes and policies in Malawi. We systematically gathered the most recent national laws, policies, guidelines and plans from all sectors (including education, health and youth) directly related to sexuality education in schools and the provision of CSE and SRH services for young people and academic or grey literature from online sources. The relevance and completeness of the documents collected were validated with in-country partners to ensure accuracy. Only national and official documents (emanating from government ministries, departments and agencies) were retrieved, reviewed and referenced. We only included documents that have provisions for SRH education and services for adolescents and youth that were still in force.

#### **The desk review was used to answer the following questions:**

- What is the evidence on CSE and SRHR outcomes among adolescents in Malawi?
- What are the current laws and policies governing CSE and SRHR and the context in which they are implemented in Malawi?
- In what form are CSE and SRHR services available to adolescents, and who are the actors responsible?
- What are the principal challenges and barriers to implementing CSE and providing SRH services?
- What mechanisms exist to monitor and evaluate CSE and SRHR outcomes?

### 2.2 Participants' selection for the in-depth interviews and key informant interviews

This mixed methods study targeted key stakeholders identified at the national level in all three administrative regions of Malawi: South, Central, and North. Since key government ministries and NGOs are headquartered in Lilongwe, it became the primary data collection site, along with a few randomly sampled districts across the country. The study targeted multiple participants representing various government ministries, NGOs, civil society, and religious and traditional authorities at the policy level. Qualitative data was collected from a mix of respondents purposively selected based on their ability and knowledge of the subject of adolescent and youth SRHR in Malawi. Considering the nature of the study, key national decision-makers in the country who significantly influenced adolescent SRHR policy and legal frameworks were interviewed. These included representatives from the ministries responsible for Health, Education, Gender, Children, Disability and Social Welfare, and Members of Parliament. We also interviewed officers in the Ministry of Justice to seek further understanding of the legal implications of existing laws and areas that may undergo legal reform. Representatives from the following healthcare professional associations were also interviewed: The Pediatric and Child Health Association (PACHA) in Malawi and the Association of Obstetricians and Gynecologists of Malawi (AOGM).

The major religions in Malawi are Christianity and Islam; we therefore included study participants from both these groups. United Nations (UN) agencies, CSOs and traditional authorities play crucial roles in representing their constituents and influencing SRHR decision-makers, hence the study also targeted participants from such organizations or sections of society. Solid evidence has a critical role in decision making to improve adolescent health outcomes, so we also interviewed academics currently working in the field of adolescent SRHR.

**Table 1:** Overview of participants' affiliations

Categories of stakeholders	Number interviewed (n=42)	South	Central	North
National-level policymakers	8	1	7	
Education sector	11	6	2	3
Health providers	3	1	1	1
International development partners	3		3	
Civil society organizations	8	2	2	4
Town councils	2	1	1	
Religious Leaders	4	2	2	
Traditional authorities	3	1	1	1

\* Note that most policy makers were from the administrative capital in the central region and researchers from academic institutions were grouped under education sector

### 2.3 Stakeholder analysis

We conducted a participatory stakeholder mapping and analysis process with 24 participants at the study validation workshop held in Lilongwe on July 5, 2022. Attendees of the workshop included representatives from CSOs (11), government ministries (5), parliament (2), local government (1), traditional authorities/religious leaders (2), teachers (2), research institutions (1) and international development partners (1). During the workshop, these policy actors evaluated the level of interest and influence of adolescent sexual and reproductive health stakeholders in Malawi; they also worked together to refine the results and propose additional recommendations. We adopted the Mendelow Influence vs Interest Matrix to analyze stakeholder groups based on both their ability to influence the CSE/SRHR agenda and priorities and the strength of their interest.

### 2.4 Data management and analysis

Thematic analysis was used to analyze the data. The analysis involved an iterative process of data immersion, coding and categorization into themes. Three researchers who are experts in qualitative research separately developed the themes; after that, the whole team discussed and agreed on the themes. Using standardized data collection instruments for the desk and qualitative data collection tool facilitated thematic analyses across documents and interviews. Data from all sources were analyzed jointly using themes derived deductively and inductively from the study objectives.

### 2.5 Ethical considerations

The University of Malawi's College of Medicine Research and Ethics Committee (COMREC), and the University of KwaZulu Natal's Humanities and Social Sciences Research Ethics Committee (HSSREC) reviewed and approved the study protocol (Protocol number: P.11/20/3192 and HSSREC/0002190/2020). Participants underwent an information and consenting process that emphasized their participation was voluntary and that they had the freedom to decline any question or withdraw from the study at any point in time without penalty. The study fully respected the privacy of participants and maintained data confidentiality. Data were stored under password protection, and access was restricted to selected study personnel.

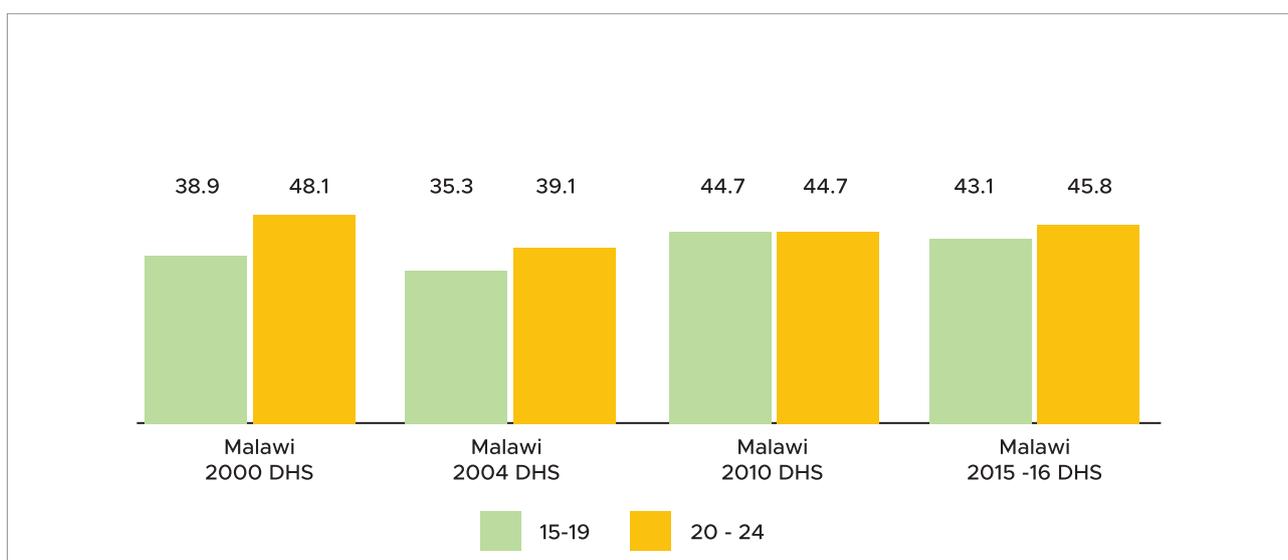


### 3.1 Overview of adolescent sexual and reproductive health in Malawi

While our findings show a conducive policy environment, significant gaps exist in the access of adolescents to sexual and reproductive health services, and that these gaps are the result of several factors. Consequently, the fertility rate among adolescents remains high, posing a risk to their health and socioeconomic wellbeing. Their limited knowledge and lack of access to sexual and reproductive health services not only put them at risk of early unintended pregnancy, but it also exposes them to risk of HIV infection. Approximately one in three new annual HIV infections (12,500 out of 36,000) occur among adolescents and young people aged 15-24 years<sup>16</sup>. We begin by presenting the trends in adolescent knowledge and their use of sexual and reproductive health services. We then present the findings of the review of policies, guidelines and strategic frameworks for the provision of adolescent SRH services.

#### 3.1.1 Trends in adolescents sexual and reproductive health knowledge and access to services

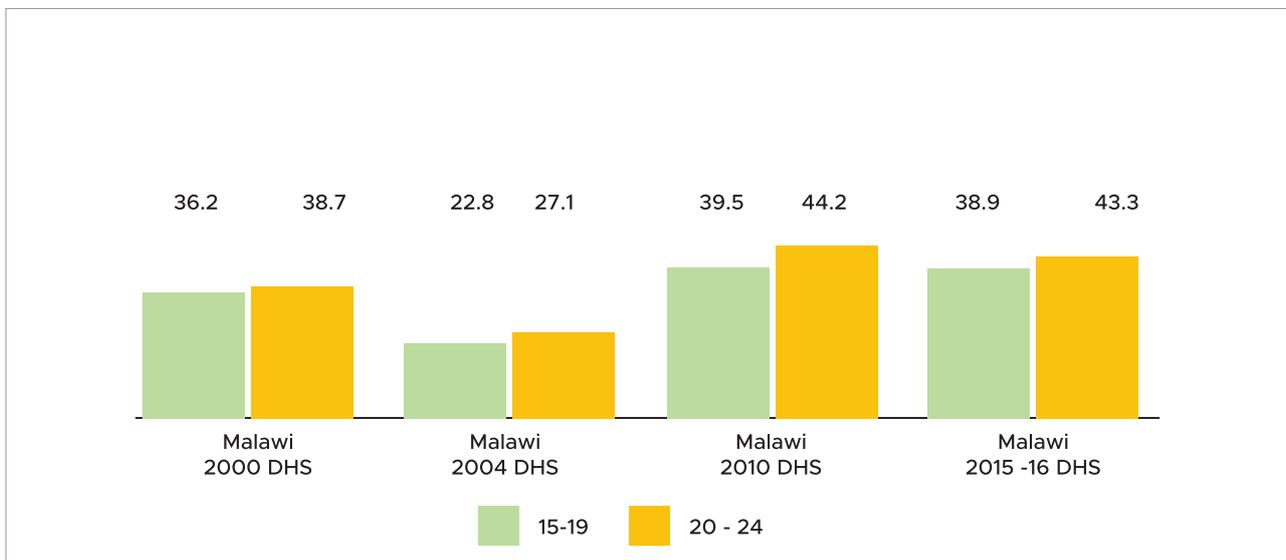
We analyzed the Malawi Demographic and Health Surveys (DHS) and Multiple Indicator Surveys from 1992 to 2016 to examine the changes in young people’s SRH knowledge and use of services. While there is evidence of a slight improvement in young people’s knowledge of sexual and reproductive issues, including HIV prevention and fertility awareness, substantial gaps exist. For example, the 2015-16 DHS shows that only 43.1% and 45.8% of young boys aged 15 to 19 and 20 to 24 years, respectively, were able to (1) correctly identify two major ways of preventing sexual transmission of HIV (using condoms and limiting sex to one faithful uninfected partner), (2) reject the two most common local misconceptions about HIV transmission, and (3) know that a healthy-looking person can still be HIV positive. This proportion increased by only 6% points among adolescent boys aged 15 to 19 since the year 2000, and declined by 2% among boys aged 20 to 24. Notably, a lower proportion of boys aged 15 to 19 had a comprehensive and correct knowledge about HIV transmission compared to those aged 20 to 24 years (see Figure 1). Most young people knew at least one contraceptive methods, with condoms being the most known method.<sup>26 27</sup> Knowledge of emergency contraception increased by over 25% among girls aged 20 to 24 in Malawi between 2000 (24%) and 2016 (49%); that knowledge increased by only 12% among girls aged 15 to 19 (from 13% in 2000 to 25% in 2016).<sup>28</sup>



**Figure 1: Trends in comprehensive correct knowledge about AIDS**

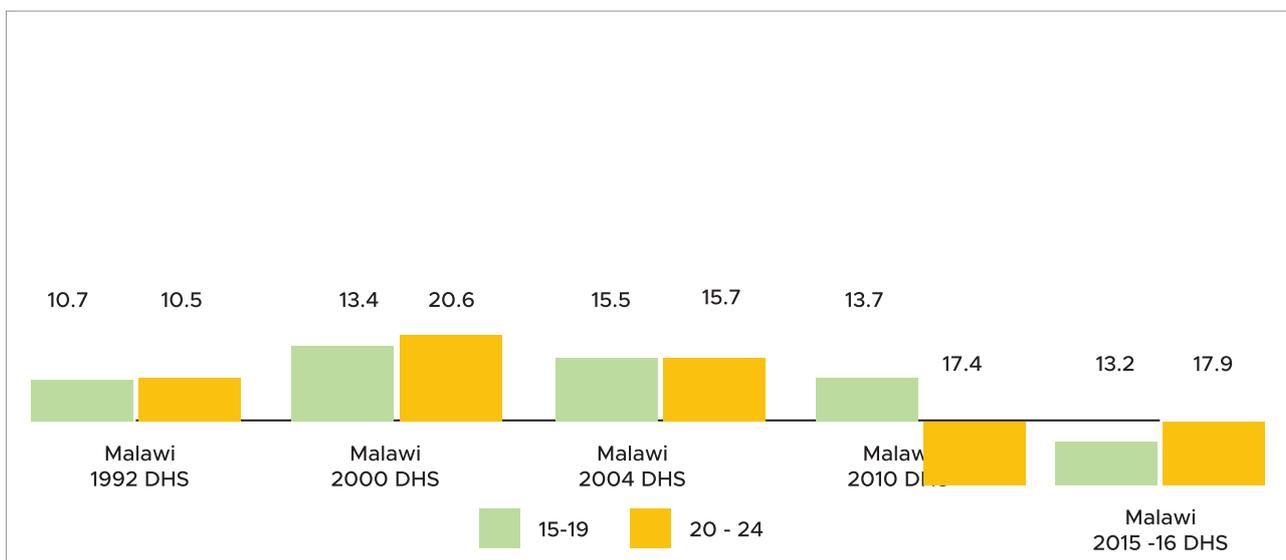


Similarly, only 38.9% and 43.3% of young girls aged 15 to 19 and 20 to 24 years, respectively, were able to correctly identify two major ways of preventing sexual transmission of HIV, reject the two most common local misconceptions about HIV transmission, and know that a healthy-looking person can still be HIV positive. The proportion of girls with a comprehensive and correct knowledge about AIDS has increased by about only 3%, and by about only 4% among boys aged 15 to 19 and 20 to 24 since 2000 (Figure 2).



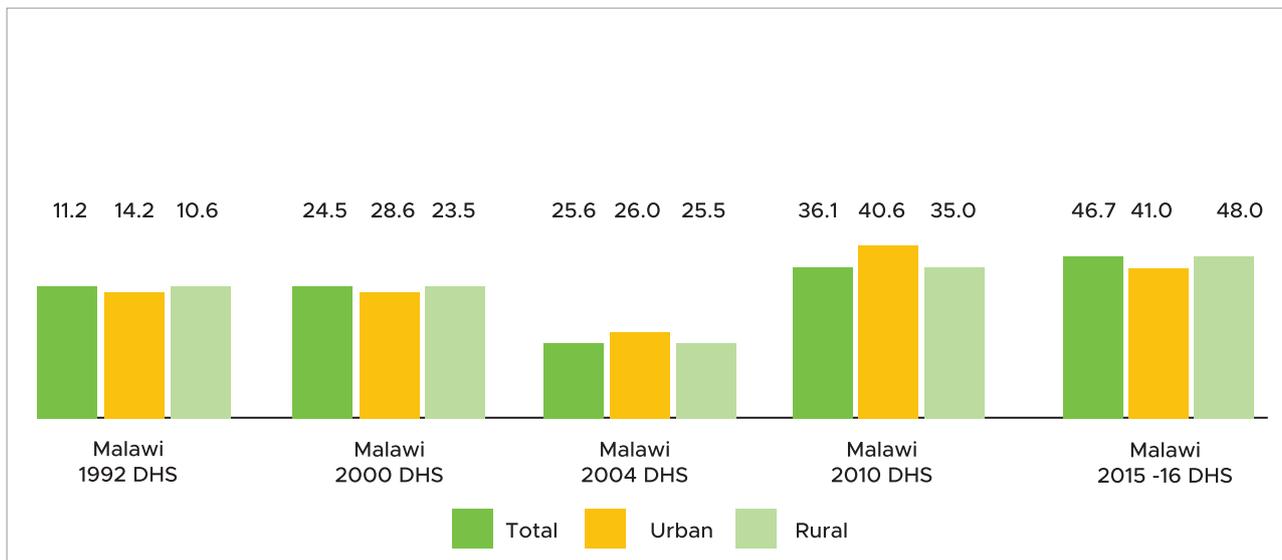
**Figure 2: Trends in comprehensive correct knowledge about AIDS**

Since 1992, correct knowledge of the fertile period has barely increased among young Malawians and especially among girls aged 15 to 19. As shown in Figure 3, by 2016 only 13.2% of adolescents (15 to 19 years) and 17.9% of young adults (20 to 24 years) had accurate knowledge of the fertile period. The proportion of girls with that knowledge has increased since 1992 by only 2.5% among those aged 15 to 19, and by only 7.4% among young women aged 20-24 years.



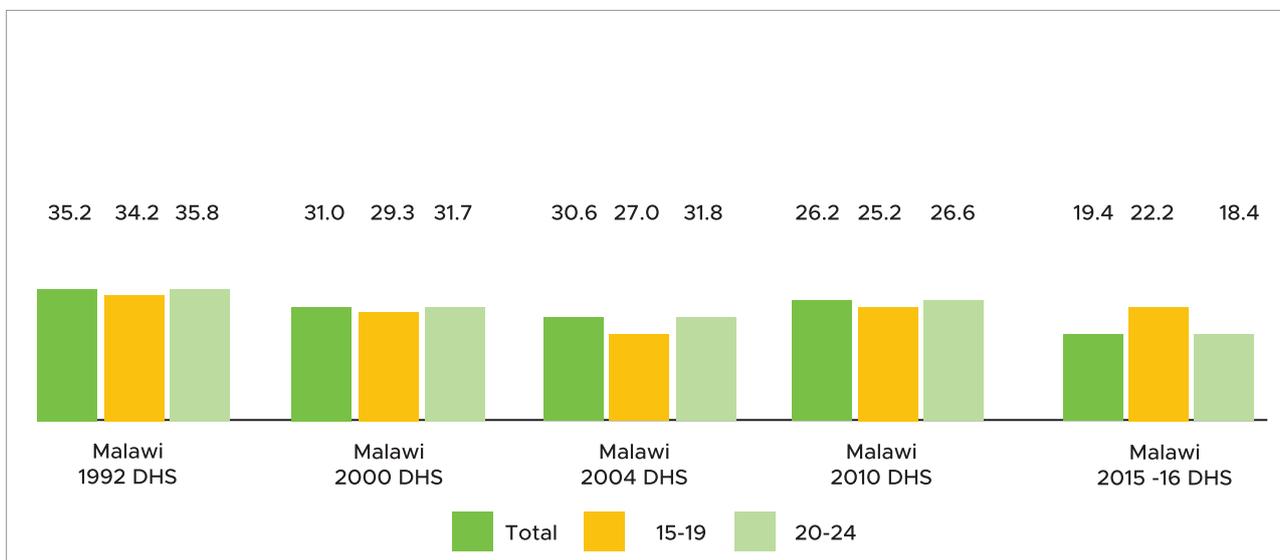
**Figure 3: Proportion of girls with correct knowledge of the fertile period**

As shown in Figure 4, the use of contraceptives among married young women aged 15 to 24 has increased by 35.5%, from only 11.2% in 1992 to 46.7% in 2016. The increase in contraceptive use was higher among those residing in rural areas than in urban areas. Despite the substantial increase in contraceptive uptake, the proportion of young women who are not using any method is huge, explaining why the adolescent childbearing rate has barely changed since 1992.



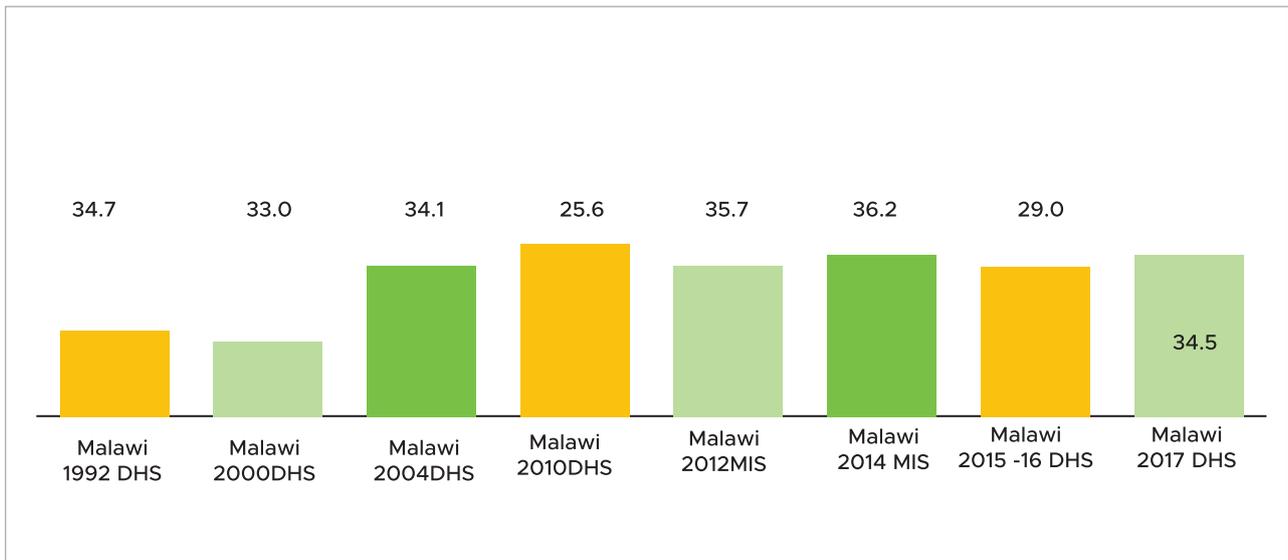
**Figure 4: Current contraceptive use among young women**

Similarly, Figure 5 shows that between 1992 and 2016 the unmet need for contraceptives declined by 45% among married young women (aged 15 to 24). The level of decline was steeper among girls aged 20 to 24 (48.6%) than those aged 15 to 19 (35.1%).



**Figure 5: Unmet need for family planning among married young women**

As illustrated in Figure 6, the proportion of girls aged 15 to 19 who had begun childbearing barely declined between 1992 (34.7%) and 2017 (31.5%). While the proportion of girls who had begun childbearing from the poorest households increased by 42.6%, there was a 35% decline in the proportion of girls from the highest wealth quintile. Between 1992 and 2016 there was 4.2% decline in teenage childbearing in rural areas compared to 29.7% decline in urban areas. The proportion of girls aged 15 to 19 who began childbearing was higher in southern region (35.4%) than the other two regions (27.3% in the central region and 30.2% in northern region). As of 2016, less than half of sexually active young men tested for HIV and only 53.3% of women did. While 53.7% of young men aged 20 to 24 were tested in the past year, only 31.0% of adolescent boys aged 15 to 19 were tested. The proportion of sexually active girls tested was over 50% for those aged 15 to 19 (50.6%) and 20 to 24 (54.8%). Overall, HIV testing uptake among young people increased by 2016 relative to previous surveys, up from 35.8% of young males in 2010 to 44.7%.



**Figure 6: Proportion of adolescents aged 15 to 19 who have begun childbearing**

### 3.1.2 Policies, guidelines, and strategic frameworks for the provision of adolescent SRH services

By signing and ratifying several international and regional frameworks, the Malawi government has demonstrated a commitment to addressing adolescent sexual and reproductive health issues. These frameworks include the International Conference on Population and Development (ICPD) program of action, the 2006 African Union Maputo Plan of Action, the Eastern and Southern Africa Ministerial Commitment 2013, and Family Planning 2020. Relevant ministries have subsequently developed policies in line with these commitments to guide the country's delivery of adolescent sexual and reproductive health services. The National Sexual and Reproductive Health and Rights (SRHR) Policy, 2017–2022, is the umbrella policy that guides the implementation of SRHR programs in Malawi. Other policies addressing adolescent SRH include the National Girls Education Strategy 2018–2022, Adolescent Girls and Young Women Strategy 2018–2022, Sexual and Reproductive Health Strategy 2021–2025, National Gender Policy 2015, National Education Act, National Girls Education Communication Strategy 2014–2019, National Education Standards 2015, Continuous Professional Development Framework 2018, Teacher Code of Conduct 2022, the National Youth Friendly Health Services (YFHS) Strategy 2015–2020, and the HIV and AIDS Act 201829-31. Given that several of these policies are up for review, there is an opportunity to assess progress, identify gaps, and address challenges in the strategies that follow.

Youth-friendly health services (YFHS) are meant to provide youth with equitable, effective, accessible, acceptable, and appropriate health services<sup>32</sup>. Offering youth-friendly family planning (FP) services is considered a key

element of YFHS with the expressed aim of increasing the uptake of contraceptives among youth.<sup>33</sup> Malawi started providing FP for the youth in 2000 and created its first YFHS program in 2007. Reviews of this program found that 68% of health facility staff had been trained in YFHS, but that only 63% of those trained were equipped to provide contraceptive counselling. The National YFHS Strategy 2015–2020 provided a framework for delivering quality SRH services to adolescents and young people. The Ministry of Health (MoH) developed a training manual on youth-friendly health services in 2016,<sup>34</sup> which was used to strengthen the capacity of health workers. Evaluation of Malawi’s YFHS 2015–2020 strategy found that implementation in Malawi varied by district, was implemented sporadically and relied heavily on donor support. A qualitative study conducted in Nsanje District shows that adolescents are accessing contraceptives through youth centers and youth clubs within communities.<sup>35</sup> A study in Lilongwe shows that girls were more likely to receive HIV testing, condoms, and hormonal contraception in the YFHS models than in the standard of care model.<sup>36</sup> As alluded to by a policymaker, the introduction of the youth-friendly services program in 2007 created opportunities for greater involvement of CSOs and partners in providing services to young people:

“As government, we just play a leadership role, creating a conducive environment and maybe a good policy environment, so the establishment of youth-friendly health service program in 2007 opened up opportunities for different partners to deliver services to young people. So, we have different organizations that are conducting outreach programs to deliver services to the members of the public, including young people; we have community structures like youth organizations and youth clubs; they are mobilizing the communities and young people to access services and information. Yes, so we also have clinics conducting outreach programs to deliver services. Those are some of the initiatives in the country, and we even have radio programs to deliver information to young people.

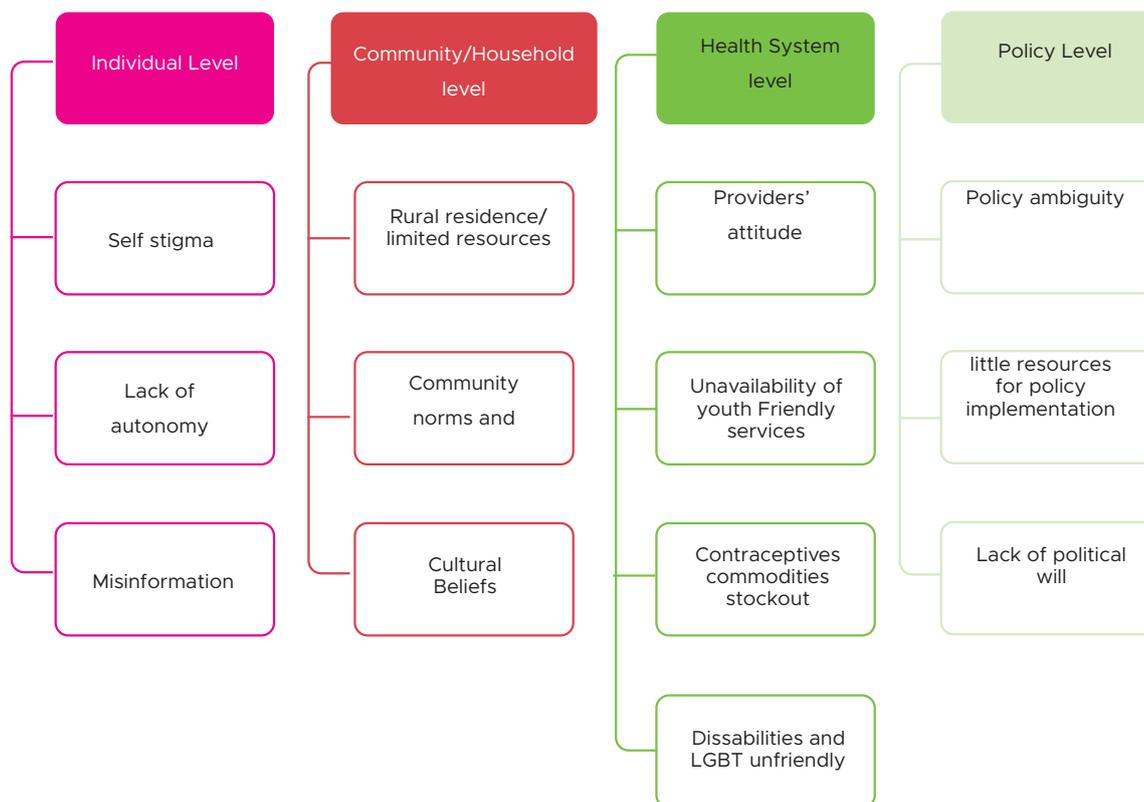
(Government Policymaker, KII 2, Lilongwe)

Malawi’s legal and policy environment for adolescent SRH is considered reasonably conducive and progressive. For example, Malawi recently passed a law forbidding child marriage<sup>37</sup> in compliance with Southern African Development Community Model Law of Eradicating Child Marriage and Protecting those Already in Marriage<sup>38</sup>. Adolescent SRH policies are aligned with previous and existing legal documents, with policy formulation procedures being consultative in nature. Almost always, policies and strategies developed over the past five years have included the participation of the National Youth Council (NYC) and Youth Net and Counselling (YONECO). NYC is a parastatal umbrella body of youth-focused and youth-led organizations, while YONECO is an NGO focused on implementing various adolescent and youth programs. The consultations allowed the government to obtain the views and contributions of relevant stakeholders regarding proposed policies. Study informants agreed that adolescent SRH policies were formulated following a consultative process and were aligned with national policies on health. Policies offered a broad framework and direction for CSOs and development partners, which created a conducive environment enabling CSOs and development partners to implement SRH service delivery programs for adolescents within communities. However, consultation was not undertaken with all interest groups or stakeholders, leading some to feel alienated.

In 2017, at the Family Planning Summit in the UK, the Government of Malawi committed to reducing teenage pregnancies by 5% per annum through 2030.<sup>29</sup> The government expected this reduction by raising the country’s contraceptive prevalence rate to 60% by 2020. Much of the increase in contraceptive uptake was expected among young people aged 15 to 24 years. The government also committed to increasing the budgetary allocation for family planning commodities, youth programming, and integrated access to sexual and reproductive health (SRH) services, including contraceptives and CSE services, in collaboration with CSOs, NGOs, parliamentarians, traditional leaders, parents, and, most importantly, the young people themselves.<sup>29</sup>

### 3.1.3 Barriers to implementation of adolescent SRH services in Malawi

Despite the significant progress in terms of policy and programs enabling adolescents’ access to SRH services, several challenges were identified from our desk review and interviews with key stakeholders. These challenges operate at four levels, as shown in Figure 7.



**Figure 7: Barriers hindering adolescents from accessing sexual and reproductive health services**

### 3.1.3.1 Individual level factors

Stakeholders affirmed that despite youth-friendly services and free contraceptives in some facilities, many adolescents, especially unmarried ones, do not seek services because of stigma. Adolescents were noted to have internalized cultural norms forbidding them from premarital sex, resulting in unmarried adolescents avoiding the use of health facilities for contraceptive services.<sup>39</sup> Stigma was also noted to be a barrier to seeking HIV/STI testing and antenatal care services. Even when adolescent girls become pregnant, they tend to hide the pregnancy and only present themselves for prenatal care late, as shown in a study conducted among pregnant and parenting adolescents in Blantyre in 2021.<sup>39</sup>

Organizations working with youth also indicated that adolescents lack the autonomy to seek SRH services. Instead of consulting nurses and other health professionals, they were noted to discuss their reproductive health needs and challenges with their peers, who often have inaccurate knowledge themselves.

Our review of the literature shows that adolescents lack accurate knowledge of contraceptives and many of them were misinformed,<sup>40</sup> which prevents them from seeking contraceptive services.<sup>41</sup> Modern contraceptives are believed to cause infertility and therefore are not suitable for unmarried adolescents. Misinformation about more effective contraceptives makes sexually active adolescents rely on less effective contraceptives<sup>42</sup> and in some instances, none at all. They also lack knowledge about the timing of ovulation<sup>43</sup> even though they tend to use fertility awareness methods.<sup>44</sup> The reality, therefore, is that most adolescents lack the self-efficacy to access contraceptives. Consequently, many are exposed to early and unintended pregnancy.<sup>45</sup>

### 3.1.3.2 Community, cultural and household level factors

Adolescent girls and young unmarried women face significant barriers to accessing contraceptive information and services at the community and household level.<sup>41,44</sup> A previous study showed that most parents are unsupportive of adolescents using contraceptives and encourage their children to abstain from sex until marriage and focus on their education.<sup>44</sup> A study in urban Lilongwe revealed that parents are unprepared or uncomfortable about communicating sexual and reproductive health information to their children.<sup>44</sup> Limited parent/child communication regarding contraceptives contributes to the poor utilization of contraceptive services among adolescents.

In Malawi, women aged 15 to 24 were less likely to use contraceptives if they live in rural areas compared to those in urban areas.<sup>46</sup> Adolescents' access to SRH services is limited in rural areas compared to urban sites due to poor infrastructure, poor coverage/availability of health services, long distances to health care facilities, limited/expensive public transport, and shortage of skilled health workers.<sup>41 47</sup> A previous study shows that accessing SRH services is more costly for rural residents.<sup>48</sup> The availability of youth-friendly services is particularly limited in rural areas and hard-to-reach geographical settings.

*“Categorically no, it's not the same because of the methodologies employed, the systems adopted differ delivery in the cities is a lot easier because usually in the city you have everything close by and since roads, facilities these make information available readily and easily available to their inhabitants with city areas. Now, if you come to the rural areas you can travel five, six, ten kilometers and not any health center at all and that is a limitation, so it can never be the same unless somebody makes a huge effort.*

(Blantyre, Traditional leader, KII2)

Additionally, as documented in previous studies, some Malawian cultural practices, such as kusasa fumbi – sexual cleansing – increase the risk for poor SRH outcomes for adolescents and young people.<sup>49 50</sup> However, it is community norms and beliefs around virginity and contraceptive use for unmarried girls that constitute the biggest hindrance to adolescents accessing SRH services. There are cultural beliefs that ‘good girls are virgins’ and sexually active unmarried girls are wayward and not desirable for marriage.<sup>51</sup> Consequently, sexually active girls conceal it from their parents or health providers and do not seek contraceptives. Providing condoms for adolescents is also seen as encouraging sexual activity.

*“In most tribes, I think the culture says no to that because they take it as encouraging them unless maybe it comes with some sensitization so that the adolescents understand why they are given condoms. Unlike if we just distribute, they just think, okay, have these. What is the use of this? Ooh, it means we are now safe. We can now be doing these things, forgetting that sometimes, when they get used? This means one day they can immediately just say no, now we are now free. It means we are free from diseases. We have been playing with these using condoms. So now we are free from diseases. That's the problem.*

(Machiga Education KII6)

Contraceptives are also believed in the community to interfere with sexual performance, reduce sexual pleasure, and cause infertility, illness and even cancer. Fear that using contraceptives attracts negative perceptions and stigma from the community, health workers and parents also limit their use.<sup>41</sup>

“The cultural belief is that a girl child is not supposed to be using the contraceptives to prevent infertile later in life. So, all those things have a negative influence when we are delivering our services.” (Dedza health provider KII )

### 3.1.3.3 Health system factors

Health system factors hinder adolescents from seeking SRH services. It is well documented that the attitude of providers toward unmarried adolescents engaging in sex and seeking contraceptives is mainly negative.<sup>41</sup> Health facilities staffed by unfriendly providers are not conducive to meeting the needs of unmarried, sexually active adolescents seeking contraceptive services. Key stakeholders interviewed believed that the religion and cultural beliefs of providers, coupled with a lack of training in the provision of youth-friendly services, are reasons for providers' judgmental attitudes. Health workers were viewed as having difficulties setting aside their personal cultural and religious beliefs when dealing with unmarried, sexually active adolescents. One policymaker alluded to this by stating:

<sup>1</sup> kusasa fumbi – A practice where child and adolescent initiates are encouraged to have sex

“ ...some of the health workers that have been trained to provide the services to the young people they tend to ignore all the elements that they have been taught or what they have been trained instead they resort to using their own personality; that is to say, if a young person walks into a health facility they will ask him/her a lot of harassing questions, for example, if the adolescent is looking for condoms they will tell her you are too young to go for sex and something like that, yet the young person who has come to the health facility knows him/herself that he/she is sexually active is indulging, and sexual practices and hence is looking for the protection, and you will find a health service provider who is trained in that field resorts to chase away or harass young people whenever they are at the clinic.  
(Lilongwe Government Policy, KII5)

Due to inadequate resources, the provision of youth-friendly services is limited. Inadequate resource allocation has resulted in significant gaps in service coverage and poor quality of SRH services. The lack of resources was further highlighted as a major factor affecting the provision of SRH services outlined in policies and strategic documents. For instance, some participants indicated that while there are great policy and strategy documents, there remains a lack of resources to deliver the services, including providing an adequate number of health workers.

“ ... because of lack of resources, we have managed only to train 2,000 health care workers instead of 5,000.  
(Policymaker-Government)

Other obstacles include inadequate health facilities and health workers to perform post-abortion care (PAC), delays in the provision of care, and prohibitively high costs.<sup>52</sup>

Stakeholders also stated there were contraceptive stock outs in health facilities and youth-friendly services corners:

“ ...so you find that when you go to the youth-friendly health center, you will find that there are no... there are no services. Yes, the people are there to help you, but then they will say you want pills, but the district has run out of PEP as such, you cannot access this service, yeah, so... Or maybe we can always refer you to another facility...  
(Mchinji CSO Implementing org, KII3)

Lastly, stakeholders from CSOs and NGOs believed that health facilities were unfriendly to adolescents living with disabilities and to those who identify as lesbian, gay, bisexual and transgender (LGBT). While health workers maintained that they do not discriminate based on migrant status, gender identity, and disability status, many believed that the health facilities lack the infrastructure and resources to provide services for adolescents with disabilities.

“ ...Yeah, like most of our service providers like our nurses and uh, most people in the medical sector who are supposed to be there and allow different sexual and reproductive issues and education, stuff like that, do not have the capacity to help or interact well with an adolescent who has a disability.  
(Blantyre CSO, KII1)

The lack of SRH services provided for adolescents living with disabilities is blamed on the false perception that they do not need such services. Due to fear of discrimination and the unfriendly nature of health facilities, a few stakeholders believed that LGBT adolescents might not present for services or feel comfortable talking openly to the service providers:

“

...there was a certain guy people thought was gay, and people isolated themselves from him. It would be hard for him to get these services because it is their job [health providers] not to exclude anyone. Still, I don't think their approach would be friendly unless the person is open-minded, and in Malawi, it's somewhat hard to find a person who is open-minded [I: mmm] towards people of the LGBTQ community. The violence that these people meet as they are exposed or come out and everything. So, of course, there are people around who say, 'this person is gay, this person is gay, but the treatment in health services is not that different.

### 3.1.4 Legal and policy level barriers

The desk review and analysis of the interviews revealed several factors at the policy level that hinder adolescents' access to SRH services. Table 2 summarizes these factors and illustrates their implications for adolescent access to SRH services.

Key Findings	Implications
<ul style="list-style-type: none"> <li>■ Tensions between international commitments and state-level instruments</li> <li>■ Policy and legal ambiguity on access to SRH services</li> <li>■ Tension between the MoE and MoH</li> <li>■ Lack of stakeholder collaboration on policy development and limited dissemination of policy documents</li> <li>■ Limited funding to implement policies and overreliance on donor funds</li> </ul>	<ul style="list-style-type: none"> <li>■ When laws and policy provisions are ambiguous, adolescents' access to SRH services will depend on providers' discretion. This could result in conflicting policy implementation, leading to inefficient service provision</li> <li>■ No sustained and well-coordinated policy development, advocacy, implementation and monitoring.</li> <li>■ Partial adoption of policies and the implementation of some policies and several interventions</li> <li>■ Low uptake of SHR services by adolescents</li> </ul>

#### 3.1.4.1 Tension between international commitments and state-level instruments

Our review of relevant policies and laws illustrates tensions between international commitments and state-level instruments. It also demonstrates Malawi's willingness to sign up to regional and international frameworks but failure to domesticate them fully. For instance, in 2015, Malawi Ratified the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (commonly known as the Maputo Protocol), which was adopted in 2003 by the African Union. Malawi's ratification, however, is at odds with the country's current legal framework for safe abortion. Malawi's laws do not comply with the Protocol because Malawian law only allows abortion when there is a danger to the woman's life. The Protocol, however, deviates from Malawi Law in that it permits medical abortion under the following circumstances: rape or incest, grave fetal defects that are incompatible with life, and where the continued pregnancy endangers the mental and physical health of the mother or the life of the mother or the fetus. Clandestine abortion continues to put the lives of women and girls at risk and account for up to 18 % of maternal deaths in Malawi.<sup>53</sup> A study by the Guttmacher institute showed that young people aged 24 years and younger account for 55% of individuals treated for post abortion complications and morbidities.<sup>54</sup> Malawi's National Assembly has put off debating the Termination of Pregnancy Bill since 2015,<sup>55</sup> and in March 2021 unanimously voted to defeat a motion to debate the bill. The Episcopal Conference of Malawi, the Evangelical Association of Malawi, Malawi Council of Churches, and the Muslim Association of Malawi have been the main opposition to the bill.

The Malawi Law Commission reviewed the current law of colonial origin and proposed a revised Termination of Pregnancy Bill (2015). In its ruling on June 24, 2021, the Malawi High Court reiterated that despite the existing legal restrictions on access to safe and legal abortion under sections 149, 150, and 151 of the Penal Code, section 243 makes an exception when the life and health of the mother is in danger. The ruling clarified that women and girls seeking abortions in Malawi must first meet with a doctor and explicitly request for abortion services based on existing conditions.

Adoption or ratification of international and regional protocols and conventions are limited actions if they are not reflected in domestic law. One of the reasons for such dissonance is that, unlike in other countries, the Malawi National Assembly is not required to adopt the signed protocol. Although the Maputo Protocol is legally binding, the extent to which it can be applied within African Union member countries is limited. Malawi accedes to various international protocols and conventions, but unlike in other countries where such agreements and protocols are subjected to parliamentary approval, the same does not happen in Malawi. And where there is a conflict between Malawi laws and international agreements and protocols, the Malawi Constitution and Laws are pre-eminent.

#### 3.1.4.2 Policy and legal ambiguity on age of consent to accessing to SRH services

The law and policies are unclear concerning the age of consent for contraceptives, abortion, post-abortion care, and pre- and post-exposure prophylaxis.<sup>56</sup> No minimum age for accessing contraceptives was specified in the YFHS Training Manual. While the current policies generally permit adolescents and youth to access the contraceptives of their choice,<sup>57</sup> Malawian law does not explicitly address the age of consent for contraceptives; it is thus open to interpretation and the discretion of service providers. In practice, however, anyone 13 years and older can access HIV testing without parental consent. Still, those younger than 18 and those who are unmarried may be requested to come with their parents and provide their parents' consent.

*“ Uhm, guidelines like those, for example, family planning services, I would say no. However, it just depends on your judgment to say the adolescent who has come for the service is a 15-year-old girl, and she wants Norplant, so you just make a judgment call to say, I think I should give her counseling that this family planning method is not proper for you. But not that there are provisions in the policy to say if an underage comes to access a particular family planning service, we should not provide it to her. (Dedza Health Provider, KI11)*

Since parental consent is often hard to obtain, many unmarried, sexually active adolescents are not accessing contraceptives.

#### 3.1.4.3 Tension between the Ministry of Education and Ministry of Health

Respondents reported that the MoE's stance on no provision of contraceptives within a 100-meter radius of school property is at odds with the MoH's objective of making contraceptives and condoms accessible to sexually active adolescents. The MoE argues that the provision of contraceptives is at odds with its vision of ensuring students remain in school, concentrate on their studies, and abstain from sexual activity. The MoE (or at least certain stakeholders within the Ministry) believe that the provision of contraceptives will encourage indiscriminate sex, and that this will compromise the achievement of educational goals. Currently, adolescents may be expelled from school if found with contraceptives on school premises. While the MoE accepts that some adolescents may need to access contraceptives, a concentrated effort is needed by the MoH to create modalities for adolescents accessing health facilities:

*“ Yes, there is a hiccup in secondary school, and now there is a debate on how we will handle it. But the Ministry of Education came in and advised that the young people would be required to go to the nearest health facilities to access the services but providing the services within the educational institutions would not be allowed. According to the Ministry of Education, they said that these are adolescents, so the best we can do to help them is to work with the Ministry of Health so that the adolescents can visit the health facilities with issues to do with sex and sexuality, not necessarily providing with the services within our institutions. However, if we allow the provision of the actual services [SRH services] in schools, it will appear as if we are encouraging sex and other practices because whatever learners learn at school, they take it as the right thing to do so if we [Ministry of Education] put it in schools learners will consider it as something that is allowed. (Zomba Government Implementer, KI13)*

#### 3.1.4.4 Limited funding to implement policies

Most financial resources used for adolescent SRH policy formulation are obtained from partners and donors as the national purse is severely constrained. Not only are funds limited, but SRH also receives limited attention within the national health budget. Some policymakers and duty bearers noted that in part, the limited government funding may be informed by the significant funding for SRH program delivery, research, and policy formulation from several external agencies: the UNFPA, the UK Department for International Development (DFID) and its successor, the Foreign, Commonwealth & Development Office (FCDO), the United States Agency for International Development (USAID), and the Bill & Melinda Gates Foundation.

Respondents also reported challenges with priority setting for SRH in Malawi. Just like several other resource-limited contexts, the process is affected by political priorities, which are usually conflicting. Lack of political will when budgeting for key SRH areas affects the delivery of SRH services. Those in power have a greater influence on budget lines and the flow of funds. However, there is little or no support for budget allocations to SRH issues in Malawi. What usually happens amounts to political symbolism, with political leaders calling for budgetary support but inevitably not prioritizing SRH, and instead leaving the funding of these programs to donors:

“

*There is no political will as far as budgeting agreements are concerned when implementing the youth-friendly health strategies and even maybe the policy itself. I think it's because they always think the support should come from NGOs.*

(Blantyre CSO, KII10)

#### 3.1.4.5 Lack of involvement of all stakeholders in policymaking and limited dissemination of policy documents

While things were different previously, at the national level it is now almost impossible to create policies, guidelines and regulations affecting or potentially affecting adolescents and young people without their involvement. However, given the large number of stakeholders across the country, consultations cannot be considered fully inclusive. CSOs and NGOs such as YouthWave, the Malawi Girls Guide Association (MAGA), and YONECO are often consulted and take active roles in policy formulation, implementation, and monitoring and evaluation. However, at the sub-national level, such involvement is not always assured for multiple reasons, such as limited funding, the constrained reach of the NGOs, and a lack of appreciation of the value of adolescent and youth engagement by sub-national entities. Some study participants observed the lack of youth involvement in the policy formulation process. This lack of involvement in decision-making processes is based on the perception that young people are not mature enough to make decisions, and as such, leaders are best placed to make determinations for them<sup>58</sup>. Further, no effort is made to publicize the contents of international conventions over and above the limited information presented through media briefings. Participants suggested that the lack of thorough consultations with young people amounts to imposing policies on them:

“

*So, the first factor that I would refer to would be that of non-involvement. Because, you know, these policies are meant to be for the youth or the adolescents. But you'll find that they're not involved in the design itself...it is like we are imposing the policies on the youth.*

(Zomba CSO, KII10)

### 3.2 Overview of sexuality education in Malawi

The MoE introduced Life Skills Education (LSE) in primary and secondary schools in 2002 and 2003, respectively.<sup>14</sup> Throughout this report, we use LSE and CSE interchangeably since they are synonymous in the study context. The LSE was introduced to equip learners with the knowledge and skills needed to tackle health and social challenges such as HIV and AIDS, teenage pregnancy and sexual abuse.<sup>14</sup> The goal of introducing LSE was to empower young people with appropriate information and skills to promote sustained HIV risk-reduction behavior through the promotion of abstinence, delayed sexual activity and safe sex.<sup>59</sup> LSE became compulsory in primary schools in 2004 and by 2006, became a core subject and examinable.

The subject is taught from standard two (approximately age 7) to the end of the secondary school year. It is taught as a standalone subject with material also integrated into biology, home economics, geography, and social studies curricula. In 2004, it also formed part of the curriculum for the first and second years in teacher training colleges (TTCs) and became examinable in 2010 through a continuous assessment organized by the Malawi National Examination Board<sup>14</sup>. UNESCO and other key stakeholders have supported the development of the LSE curriculum for in-school adolescents.

With the growing recognition that many children and adolescents are not in school and are thus missing out on the benefits of sexuality education, the Malawi has sought to encourage the implementation out-of-school CSE programs. Development partners and CSOs, together with various government ministries – Gender, Children, Disability and Social Welfare, Youth Sports and Culture, and the MoH – have long collaborated to deliver sexuality education to out-of-school adolescents through youth-friendly health facilities, youth clubs and other community outreach programs. These programs include community-based training and education and target such groups as married adolescent girls and youth engaged in sex work. The Ministry for Youth and Sports is currently developing an out-of-school LSE curriculum and has consulted with relevant stakeholders to ensure a standardized curriculum. Development partners provide programmatic and financial support to sexuality education delivered out of school.

One policymaker highlighted progress in creating an enabling environment and developing a curriculum for LSE:

*“The number one thing is the conducive environment; conducive in the sense that, you know, previously we had no curriculum that was highly reflecting issues to do with sexual and reproductive health, but now we have the curriculum because the political environment adopted that to be part and parcel of the curriculum, so that's number one.”*  
(Lilongwe Government Policymaker, KI12)

### 3.2.1 Policies, guidelines, and strategic frameworks for sexuality education

The Malawi government has several policies and strategy documents on education and SRHR, gender-based violence (GBV), and HIV and AIDS, all of which mention sexuality education. According to the Gender Equality Act 2013, Article 18, the government shall take active measures to ensure the provision of CSE in primary and secondary schools that integrates gender equality and human rights issues. The HIV and AIDS Act 2018 further states that the MoH, MoE, and other relevant parties should ensure the integration of HIV and AIDS materials into school curricula and has provisions for individuals out of school. However, no guidance is provided on resource mobilization, implementation, monitoring and evaluation. Indicators for tracking implementation of the provisions and the effectiveness of interventions is also lacking.

### 3.2.2 Life skills education content

UNESCO's 2019 Situational Analysis of LSE in Malawi revealed that content for primary school encompasses health promotion, social development, moral development, personal development, physical development, entrepreneurship and the world of work<sup>14</sup>. The content broadly targets three age brackets: 5 to 8 years, 9 to 12 years and 13 to 15 years. Older adolescents and young adults are not particularly targeted. Generally, LSE content conveys insights on interpersonal relationships, sexuality and sexual behavior, communication, negotiation, and decision making; human development and SRH; and youth empowerment. It is delivered using lecture-based, interactive, and participatory approaches, including role playing and poetry.

Even though there was consensus among teachers that age, culture and gender were deliberated during development of the curriculum, some parents and teachers felt that the content was inappropriate for the very young student attending junior primary school. UNESCO's study reveals that LSE in Malawi does not have clear public health objectives. The content emphasizes abstinence and fails to provide pupils with the knowledge and skills needed to tackle gender-related issues, avoid concurrent and multiple sexual partnerships, and obtain and use different methods of contraception, including condoms. The content is not inclusive of abortion, male circumcision, or sexual orientation issues, nor does it inform students about the increasing incidence of HIV among adolescents and young people, teenage pregnancies, child marriage, GBV, and school dropout. In some schools, LSE content is not taught consistently; in others it is not taught at all, and in many cases, only as an extracurricular activity<sup>14</sup>.

Table 3 presents an evaluation of LSE content in Malawi using UNESCO’s guiding principles. LSE in Malawi is age and developmentally appropriate, culturally sensitive, incremental, curriculum-based, and scientifically accurate. Still, it is not considered comprehensive and may not fully support the development of skills needed to make healthy choices.

**Table 3: Evaluation of LSE content in Malawi using UNESCO’s guiding principles.**

Characteristics of LSE	Evaluation of LSE content in Malawi
Scientifically accurate	Strong
Incremental	Strong
Age- and developmentally appropriate	Strong
Curriculum-based	Strong
Comprehensive	Weak
Based on a human rights approach	Partly
Based on gender equality	Partly
Culturally relevant and context-appropriate	Strong
Transformative	Weak
Able to develop life skills needed to support health choices	Partly

Study respondents drew particular attention to what was considered age-appropriate LSE content for adolescents. It is often the case that curriculum content assumes students are of a certain age within specific grades. In practice, older adolescents often find themselves in lower grades because they are repeating them or beginning school at an older age. Exposure to age-appropriate LSE curricula is then delayed for these adolescents. This dilemma is articulated by the one participant:

“ *And of critical interest now is the age diversity in some classes; if you see the curriculum of standard 4 in primary schools, it’s very light, and it avoids critical issues that enable them to make informed decisions about sexuality, but these days you will find someone who is at puberty or is a grown-up yet the information you are giving him/her cannot help him to make informed decisions because the content of the curriculum for standard 4 was designed as if the learners in that class would only be six years old ...* (CSO Lilongwe)

### 3.2.3 Sexuality education within cultural practices

Sexuality education is not a new phenomenon in Malawi. There is a historical practice of offering young boys and girls sexuality education through traditional initiation rites across communities in the country. It is estimated that over 30% of adolescents undergo initiation rituals, although the practice is more prevalent in Malawi’s rural and southern regions.<sup>49 60 61</sup> Older women, known as ‘anankungwi’, facilitate sexuality education, which covers gender norms, good behaviors, household skills, hygiene, health, reproduction, sexual instruction and sexual practice, and decision making. The initiation rite marks the transition into adulthood, and it is through it that community attitudes and beliefs about sexuality and adulthood are passed on to the next generations.<sup>61 62</sup> Prepubescent girls are required to attend the initiation camps for two weeks. Often shrouded in secrecy, critics have argued that the initial rites encourage girls to engage in sex and teach them how to please men through a *cultural dance known as the ‘Chisamba’*.<sup>63</sup> A policymaker alluded to this in an interview:

“ *There are some cultural dances that are still being practiced, and most of them happen during the evening, which in one way or the other they are promoting malpractices regarding unprotected sex, they are happening, so those are some of them.* (Nkhatabay Government Policymaker, KII4)

Critics also maintained that these initiation ceremonies are unregulated and offer unstandardized information<sup>64</sup>. Information and knowledge are largely transferred orally, and there is no standardized content or delivery methods. While some participants consider traditional sexuality education reasonably comprehensive, in the absence of content documentation it is difficult to assess this how comprehensive it really is. Because of the limited coverage of out-of-school LSE programs, many out-of-school adolescents, especially those residing in rural areas, depend on traditional sexuality education offered during initiation ceremonies, as alluded to by a key informant from the MoE:

“ *Mostly those who are out of school in the villages access sexuality education through ... amapita ku Simba kukalangizidwa (they receive sexuality education through initiation ceremonies)*  
(Mangochi Education Department, KII10).

It must be noted, however, that these initiation rites vary by ethnic grouping. The Chewa and Sena convey similar messages to girls during initiation. The nankungwis (a female facilitating the initiation ceremony for girls) advises the girls to respect their parents and elders, adopt good behavior and avoid sex before marriage; she also teaches them how to manage menses. It was also believed that if they engaged in premarital sex they would bring tsempho to their parents (a disease thought to result in wasting and eventual death – not medically described), which could result in illness or death.<sup>61 62</sup> For the Yaos, however, the emphasis is placed on sex and premarital sex is tolerated. Initiates attending chiputu and ndakula (initiations for girls just after menarche, preceding nsondo) are advised to pull their labia minora to prepare for sex, and they are taught about the sexual parts of a man and a woman and how to behave when having sex using fruits and dance to illustrate these lessons.<sup>61 62</sup> Furthermore, after the Nsondo (initiation ceremonies for Yao girls), the girls are asked to ‘shake the dust’ by having sex with male counterparts at least once.

Boys are also counselled in groups in one initiation ceremony. The counselling covers sex education, hard work, respect for elders, keeping away from youngsters, and proper dressing. However, there is more emphasis on sex than the other messages.<sup>61 62</sup> The nakanga advises boys to ‘spill oil’, kutaya mafuta (to ejaculate), and are encouraged to have unprotected sex with a girl who has just finished the nsondo initiation process so that they can “release sperms directly into the girl’s vagina”, called Ntalo.<sup>61 62</sup>

While participants in this study considered information provided during initiation ceremonies as a form of sexuality education, it is important to note that these are gendered ceremonies where girls are taught to please their husbands and boys taught how to be men; this contradicts UNESCO’s International Technical Guidance on Sexuality Education as to what CSE should entail.<sup>65</sup> Acknowledging the limitation of what is taught at initiation ceremonies, stakeholders attending the validation workshop emphasized the need to work with traditional authorities to more closely align sexuality education taught during these cultural ceremonies with the curriculum delivered to in- and out-of-school adolescents.

### 3.2.4 Barriers to implementation of CSE in Malawi

Key stakeholders agreed that substantial progress has been made in terms of policies, programs and impacts, considering the sociocultural context of the country. There is greater awareness of adolescents’ SRH needs. Despite the incremental progress recorded in CSE implementation in Malawi, stakeholders that took part in this study alluded to the challenges limiting the effectiveness and reach of CSE in the country. Table 4 summarizes these challenges.

**Table 4: Key barriers to CSE implementation in Malawi**

<b>Inequalities in CSE implementation</b>	<ul style="list-style-type: none"> <li>■ CSE does not reach vulnerable adolescents, including those in rural areas, living with disabilities, and those who are out of school.</li> <li>■ Adolescents in rural areas are disadvantaged because access to education is more limited than in urban areas. Adolescents in rural areas are also more likely to drop out of school and to have limited access to televisions or radio, which are mediums for information exchange.</li> </ul>
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<b>Resistance to CSE</b>	<ul style="list-style-type: none"> <li>Restrictive sociocultural and religious norms and differences in interests among policy actors limit the delivery of CSE in Malawi</li> <li>Perception that promoting CSE is equivalent to endorsing sexual immorality and that CSE is against traditional and religious beliefs and values in so far as it may touch on contraceptive use, and yet tradition and religion prefer adolescents to be sexually abstinent</li> <li>Parents and the community are resistant to CSE/LSE delivery approaches and prefer informal institutions (initiation ceremonies) for delivery of CSE</li> </ul>
<b>CSE is not a mandatory subject and not prioritized</b>	<ul style="list-style-type: none"> <li>Some religious-owned schools opt out of teaching CSE due to concerns that it conflicts with their religious beliefs</li> </ul>
<b>Teachers' dilemma</b>	<ul style="list-style-type: none"> <li>Teachers adopt values -based CSE Teachers lack good understanding of CSE CSE delivery is challenging to teachers as content is traditionally considered taboo</li> </ul>
<b>Lack of monitoring and evaluation mechanisms</b>	<ul style="list-style-type: none"> <li>Monitoring is limited to schools' visits No standardized indicators to evaluate performance and effects of CSE here is limited capacity to monitor and evaluate CSE programs</li> </ul>

### 3.2.4.1 Inequalities in CSE delivery in Malawi

Vulnerable adolescents bear a disproportionate burden of poor SRH outcomes; This group includes those living in rural areas, or those coping with disabilities, or are out of school, and/or are from the poorest households.<sup>66</sup> <sup>67</sup> Therefore, it is crucial to assess the extent to which existing sexuality education reaches these adolescents. While we have previously noted that the content of LSE is not comprehensive, the delivery of sexuality education in Malawi is further characterized by inequality. For example, there is little evidence suggesting LSE is reaching most out-of-school adolescents in Malawi. However, NGOs have implemented small-scale programs that target out-of-school adolescents and are delivered through existing or newly established youth clubs. The reach of these programs is limited, and inadequate funding hinders their coverage and sustainability.<sup>68</sup> The provision of CSE to out-of-school adolescents faces several additional challenges, especially in districts where there is limited penetration of NGOs. For instance, districts such as Mangochi have a plethora of NGOs, CSOs and UN partners, while districts such as Chitipa and Neno have fewer partners that serve adolescents. While assessing the coverage of CSE in Malawi, a policymaker noted:

*I think as a country we are still at a baby level in a sense. For example, some districts are not doing much as other districts are doing maybe because of the resources. For example, in Nkhata Bay most of these programs are being supported by the UNFPA. So, for example, we talk of Mzuzu city or Nkhotakota you will find that they are challenged because UNFPA is not there and they are challenged because of scaling up. So, there are those variations due to resources.*  
(Nkhatabay Government Policymaker, KII4)

While adolescents living with disabilities (such as visual or hearing impairments, physical disabilities, mild intellectual incapacities, and even albinism) who attend school may benefit from sexuality education while there, challenges exist that hinder them from gaining full value from these lessons. There is a lack of disability-friendly infrastructure in most schools, both in rural and urban areas, limiting access for adolescents with disabilities. A study by UNESCO revealed that teachers lack the skills to deliver sexuality education in an inclusive manner.<sup>69</sup> In addition, a shortage of interpreters or sign language experts, limited teaching and learning resources, and an inadequate use of information technology comprise significant barriers to delivering sexuality education to pupils affected by

disabilities, especially those coping with hearing and visual impairments. While the policy context was considered favorable for LSE provision for adolescents living with disabilities, there was no mention of the specific support required by this group in education and health policies. In addition, disability policies and frameworks make limited reference to the provision of LSE.<sup>70</sup>

Access to life skill education is further limited for adolescents living in rural areas. Rural schools have fewer specialty trained teachers. Rural schools also have limited teaching and learning resources especially with respect to LSE. Rural/urban differences exist with respect to school enrolment, retention and completion, and therefore hinder access of rural adolescents to LSE.<sup>71</sup> Limited access to information technology in rural areas presents an additional barrier to adolescent access to SRH information. A policymaker alluded to the rural and urban disparity in LSE delivery by stating:

“ *...you don't even have adequate number of teachers in the rural areas that is a constraint...*  
(Lilongwe Government Policymaker, KI12)

The MoE has provided in-service training for CSE teachers since 2001. However, they mainly target public schools, leaving out teachers in private schools who may not have attended government TTCs that included CSE in their teachers' training curriculum. The in-service training of teachers lacks adequate funding, which hinders coverage. A policy implementer summed up the challenges with in-school CSE delivery by exclaiming:

“ *Financial and material and human resources are an issue.*  
(Zomba Government Implementer, KI13)

#### 3.2.4.2 Resistance to sexuality education in Malawi

Since its introduction, CSE has remained a controversial topic among conservative sectors and stakeholders in Malawi. Their resistance to CSE is based on culture and religion, and they argue that CSE conflicts with culture and religious teachings on morality, purity and chastity. Many tribes in Malawi place a premium on virginity until marriage. Engaging on sexual topics is, therefore, sensitive and considered to be appropriately reserved for adults. Others note that Chichewa words used to describe private parts and sex are considered vulgar and would make most people feel uncomfortable speaking about sex. Talks about sex are perceived to promote sexual activity among young people and are considered taboo, as a policymaker described during an interview:

“ *Yes, culture and religion affect the delivery of comprehensive sexuality education because it [CSE] conflicts with some cultural beliefs as well as religions. In our culture, mentioning things like sexual intercourse and private parts is considered a taboo, telling primary school learners about contraceptives is considered a taboo, so it [CSE] is somehow in conflict with our culture as well as religion.*  
(Lilongwe Government Policymaker, KI12)

Further, parents and broader communities resist CSE based on their concern that teaching young people about sexuality will only encourage them to have sex indiscriminately. A study by UNESCO 14 found that there were prevailing misconceptions about CSE among some parents and the community. Parents oppose school-based CSE and contend that certain myths and traditional values will be scrutinized and, therefore, rejected by their children.<sup>72 73</sup> Parents, especially those in rural areas, prefer their children to get information on sexuality from initiation ceremonies, faith leaders, community counsellors and family elders.

“ *... so actually, the parents were against the idea of introducing such sex issues in schools and at the same time there was that misconception about the curriculum to say this will promote promiscuity and a lot of sexual activities in schools.*  
(Mangochi Education, KI10)

Parents and community leaders were unwilling to discuss sexuality, GBV, and SRHR with their children or wards. The general understanding is that CSE solely focuses on sexual content, thereby going against traditional and religious teachings promoting abstinence. This point is supported by the views of a policymaker based on resistance to CSE in Malawi:

“ I know there have been conflicts, people saying that the CSE is leading young people to be promiscuous because they get information that is not fit for them. They say they get information that is fit for married people. Uhh... so those conflicts are there.

(Lilongwe Government Policymaker, KII2)

Combating CSE misconceptions is often difficult, even for proponents of CSE who are ambushed with emotionally charged questions. Sometimes advocates of CSE cannot respond satisfactorily and often concede to the detractors of CSE. A representative of a CSO made this point:

“ I've had conversations with peers and colleagues where we're talking about sexuality education, and a question will be asked, so would you tell your nine-year-old daughter, take your nine-year-old daughter, or enroll your child in that class? And most of them will say no, even though they're promoting it. They are promoting comprehensive sexuality education, but they're not fully convinced.

(Blantyre CSO, KII7)

Religious and private schools that are partially funded by the state are not required to meet the same standards as fully state-funded schools and are subject to a significantly less rigorous inspection regime. As such, religious and private schools can influence various aspects of the delivery of LSE content. Due to the influence and pressure from conservative groups, Malawi's LSE curriculum does not cover such issues as understanding LGBT problems, the inclusion of which is recommended in the International Technical Guidance on Sexuality Education (ITGSE).<sup>74</sup> Despite the exclusion of such topics, religious schools continue to resist LSE arguing that it is at odds with their religious and moral teachings (Kishindo, 2011). CSE is believed to include topics like homosexuality, which many stakeholders argue is foreign and against culture and religion. A key informant noted:

“ ... because mostly CSE tackles topics like sexual intimacy, gays, homosexuality, bisexuality, and emotional and physical changes when growing up. It includes mentioning some of the private body parts. In our culture, mentioning private body parts to younger adolescents is not good because that is considered explicit content. Yeah, so it is in conflict with our culture because there are no things like homosexuals or bisexuals in our culture. Teaching learners about that is like you are giving them things that are not there in our society. Yeah, so that's why I said it conflicts with our culture as well as religion.

(Machinga Education Department, KII5)

### 3.2.4.3 Lack of LSE monitoring and evaluation mechanism

LSE monitoring focuses mainly on routine supervision and the production of school census reports. Supervision of LSE in teacher training colleges (TTCs) is led by teams from MoE, and in the case of private and faith-based TTCs teams are led by implementing NGOs or faith-based organizations (FBOs).<sup>14</sup> However, MoE and officers at the District Education Management Office monitor LSE in primary and secondary schools, focusing on content accuracy, the appropriateness of teaching methodologies, the engagement of learners and the classroom environment.<sup>14</sup> No indicators have been agreed upon to track and monitor CSE implementation in Malawi. Thus, information on the coverage, cost, outcomes and impact of LSE in the country is lacking. Also, a lack of resources and capacity to analyze relevant data constitute barriers to LSE monitoring and evaluation.

#### 3.2.4.4 CSE is not a prioritized subject

LSE in secondary schools is an elective subject, and many students do not select it. Secondary school students believe that LSE subjects do not offer direct career opportunities as compared to science studies. This preference

for science is compounded by the MoE, which actively promotes science subjects; the result is an undervaluation of social sciences and humanities:

“ *The Ministry of Education is very much in promoting science subjects unlike the humanities subjects so comprehensive sexuality education is being looked down upon. Most students in the secondary schools are not taking it.*

(Zomba Government Implementer, KII3)

### 3.2.4.5 Teachers’ adopting a values-based approach

Teachers, especially older ones, are uncomfortable teaching sexuality topics and often skip them altogether. Several participants reported that schools and/or teachers do deliver the CSE curriculum in its entirety. Schools remained skeptical that content (e.g., condom use) would conform to prevailing social, cultural and religious sensibilities, while certain subjects remained at odds with the personal beliefs of individual teachers. Some instructors were not well prepared to teach CSE and were unable to handle the students questions and behavior.<sup>14 75</sup>

In general, there was an overemphasis on abstinence or total avoidance of such culturally sensitive topics as abortion, contraceptives, homosexuality and masturbation. Some teachers adopted a values-based approach to teaching, which can contradict the central tenets of CSE, especially concerning gender norms and SRHR.<sup>76 77</sup> An example of how some instructors teach only what they are personally comfortable with because of their religious beliefs:

“ *You find that some teachers may undergo training on life skills’ subject, but they may not deliver the way we want them to for many reasons. Other reasons could be like their faith, their self-esteem, so they start acting funny like with that subject you find they teach something else, which is not fair to our children.*

(Lilongwe Government Policymaker-Education, KII1)

Some policymakers believe teachers’ attitudes are driven by their lack of understanding of CSE. They appear to believe that CSE is all about sex. One policymaker from the MoE believed that addressing teachers’ misconceptions around CSE would help improve school based CSE delivery.

“ *...teachers are a great barrier to the provision of comprehensive sexuality education because a number of us teachers don’t understand what comprehensive sexuality education is all about. Whenever we hear about sexuality education, we think about sexual intercourse. Whenever we see boys and girls in pairs, we think it’s all about sex. So, most teachers have little knowledge about comprehensive sexuality education, and there are many of them. Let me just give an example for myself. At first, I had little knowledge of comprehensive sexual education until 2015, when I attended a certain orientation and now, I fully understand this topic. So, I think if the teachers in secondary or primary schools are oriented on comprehensive sexuality education, that will help them fully understand it.*

(Machinga Education Department, KII5)

## Decision making logic

### 3.3 Key stakeholders in the provision of SRH services and delivery of CSE

The provision of SRH services and delivery of CSE in Malawi involves several key stakeholders that play different roles based on their mandates, motivation for involvement, beliefs, values and power (Table 5). These include various ministries within government, funding partners, international NGOs, UN agencies, CSOs, FBOs and traditional authorities. In addition, community leaders, community gatekeepers and parents or guardians are often involved.

**Table 5: Key Stakeholders**

Stakeholder	Role in delivery of CSE and SRH provision
Government	<ul style="list-style-type: none"> <li>◦ The MoE provides policy guidance as well as resources for the delivery of CSE, including the development of curriculum and supervision for CSE provided in schools</li> <li>◦ The Ministry for Youth and Sports, through the National Youth Council of Malawi, provides policy direction and leadership in the delivery of CSE to out-of-school youths</li> <li>◦ The MoH provides policy direction and the implementation of youth-friendly health services</li> <li>◦ The National AIDS Commission (NAC) leads in coordinating, guiding, planning, implementing and monitoring HIV and AIDS</li> </ul>
Funding partners, international NGOs and UN agencies	<ul style="list-style-type: none"> <li>◦ Providing technical and financial support to ministries and local NGOs on advocacy and institutionalization</li> </ul>
Traditional leaders, families, and parents/guardians	<ul style="list-style-type: none"> <li>◦ Traditional leaders establish and maintain norms as well as decision making around communities</li> <li>◦ Parents teach and communicate with their children about relationships, sexuality and wellbeing. They also act as role models for their young</li> </ul>
CSOs and FBOs	<ul style="list-style-type: none"> <li>◦ Advocacy and delivery of CSE and SRH services both to in-school and out-of-school adolescents and young people</li> </ul>

### 3.3.1 Government Ministries

The government, through its ministries, provides overall leadership and resources for implementing adolescent SRH policies and programs. Specifically, the MoE takes a leading role in providing policy guidance and resources for the delivery of CSE, including the development of curriculum and supervision for CSE provided in schools.<sup>14</sup> In line with the same, the Ministry for Youth and Sports, through the National Youth Council of Malawi, provides policy direction and leadership in delivering CSE to out-of-school youths. The MoH provides policy direction for the provision of SRH services and implements YFHS. The MoH works hand-in-hand with the National AIDS Commission (NAC), which is leading in coordinating, guiding, planning, implementing and monitoring HIV and AIDS.

### 3.3.2 Funding partners, international NGOs and UN agencies

The delivery of CSE and the provision of SRH services in Malawi relies on financial and technical support from various funding partners, international NGOs, and UN agencies. These partners have supported the advocacy, development and institutionalization of CSE in Malawi.<sup>14</sup> Due to their financial aid, these partners have managed to influence the government in redefining its priorities.<sup>78</sup> Mainly at the policy level, respondents in this study argue that access to financial support from donors is part of what motivates local NGOs to be involved in delivering CSE and SRH services. While other actors have their own reasons for participating – reasons that are reflected in their efforts – the efforts of most NGOs are influenced by the policies and strategic plans of their funders. Most respondents argue that the donor agenda dictates intervention identification or length of funding:

“ *Sexual and reproductive health becomes an issue only when we are kind of getting external pressure like when the agenda is brought on the table by the external actors not really from within the system.* (KII2: INGO)

Among NGOs, respondents mentioned UNFPA, Banja La Mtsogolo—a Marie Stopes affiliate, and Population Services International (PSI) as international NGOs leading in SRHR agenda setting. UNFPA was frequently mentioned as a policy-level partner. At the same time, the other three were recognized for implementing SRHR policies and offering interventions for youths through clinics and community outreach activities. The respondents pointed out that these international NGOs have the power to push through their agenda due to their financial muscles. One of the respondents stated:

“ Yes, ... we also have some development partners like UN agencies, for example, UNFPA they have direct access or may be influential to decision-makers; the policymakers in government and they also have financial muscle; they can fund some interventions or even policy reviews we are talking about.

(Lilongwe Government official, K11)

Other major players in the realm of CSE include UNESCO, UNICEF, UN Women, Creative Centre for Community Mobilization (CRECCOM) and Campaign for Female Education (CAMFED). Depending on the point of entry, whether at the policy or implementation level, each has its own key players. UN agencies like UNICEF, UNESCO, and UN Women were identified as key actors in influencing and lobbying for policy review, change or development. At the implementation level, local NGOs were frequently mentioned as being key actors.

UNESCO and Rutgers International are critical partners to the Malawian government in designing and implementing CSE. In 2013, UNESCO supported the Malawian government in reviewing the secondary school curriculum, including the CSE curriculum, through a broad consultative forum involving parents and guardians.<sup>79</sup> Based on this curriculum review, in 2015 the MoE added sex and sexuality as a new core subject to make LSE more comprehensive and address gender issues, health and the SRHR of young people. As of 2018, UNESCO had supported the training of 1500 in-school secondary school teachers, 280 parent-teacher associations, 80 mother groups, 30 trainer-of-trainers, and 20 primary school inspectors on CSE14. Since 2012, Rutgers has supported, in partnership with Teacher's Union Malawi, the training of tutors and TTC students to facilitate 'The World Starts With Me' curriculum.<sup>80</sup> During their interviews, several key informants emphasized the contributions of UNESCO to CSE curriculum development. An example:

“ UNESCO works hand in hand with the Ministry of Education in curriculum development and training of teachers. It has also been writing supplementary books on CSE with MIE [Malawi Institute of Education] ... they said CSE information was not enough, so UNESCO facilitates the writing of supplementary books on CSE.

(Zomba Government Implementer, K113)

The Family Planning Association of Malawi (FPAM), YONECO, Centre for Youth Empowerment and Civil Education (CYECE), and Centre for Victimized Women and Children (CAVWOC) were the main CSOs involved in the delivery of CSE to out-of-school adolescents.

### 3.3.3 Traditional leaders, families and parents or guardians

Traditional leaders, families, and parents or guardians are vital to the delivery of CSE and SRH services. Traditional leaders are the custodians of culture and are well respected within their communities. Traditional leaders play the principal role in establishing and maintaining norms as well as decision making around communities<sup>81</sup>. Similarly, parents play a critical role in teaching and communicating with their children on issues relating to sex and sexuality. Many respondents in the current study report that while formal institutions held power to shape policy and laws, as well as guide implementation and monitoring, informal institutions such as the family, traditional authorities, faith leaders and other community leaders – many of whom are neglected in the consultation process – also hold power in the adoption of interventions. Malawian communities, especially in rural areas, are organized by villages (each with a village headman), and at the next level groups of villages are formed under a Group Village Headman or Headwoman; these respected citizens consequently coalesce into traditional leaders (headed by a Traditional Authority).

Culture is often mentioned as a reason for the lack of adoption of policies and interventions. Respondents argue that cultural norms heavily influence some key actors (gatekeepers and traditional leaders) in Malawi. Culture was also mentioned as a barrier to the adoption of some SRHR and CSE interventions as various cultural groups have established systems for dealing with these issues. As such, any intervention or policy that would be deemed contrary to prevailing beliefs is likely to be ignored or fought against. Since cultures are considered part of an identity, most individuals are likely to conform to what traditional leaders (the custodians of local culture) believe.

The curators of SRHR and CSE – government ministries – are often influenced by such culture/cultural actors. Traditional leaders are often part of the national dialogue in policy formulation, program implementation and opinion formation. Program implementation within communities must be endorsed by the traditional leadership structures, irrespective of what is agreed to at the national level. Policy development is highly dependent on prevailing thought and influenced by gatekeepers in communities where implementation will happen:

*“ You know, traditional leaders are people of influence; you cannot talk of mobilization in the communities outside of the community leaders, so anyone, be it NGOs, be it Ministry of Health, that would want to do things on the ground then mobilization of people cannot be done without the community leaders. So, when the community leaders understand what is happening, mobilization of people becomes very easy.*

(Lilongwe Faith-based Organization, IDI2)

Participants report that community and religious leaders also play a major role in policy review and formulation. According to them, these leaders have a major influence on whether a policy can be adopted and implemented in their area or among followers of their congregation:

*“ Before drawing a policy, there is always a consultative meeting with different stakeholders. They hold meetings with the local communities, specifically the chiefs and religious leaders, informing them that “we want to come up with a law or policy. So, with our culture, the chiefs and religious leaders choose what should be put in the policy or laws*

(Zomba Government Implementer, KII3)

### 3.3.4 Civil Society Organizations and Faith-Based Organizations

CSOs and FBOs also play a critical role in CSE delivery and adoption of SRH services. This is because values related to the importance of the family, life-affirming approaches and solidarity form the basis for faith-based learning for young people. Faith-based institutions have for some time promoted sexuality education to protect and advance human dignity. For example, in 2003, the World Young Women’s Christian Association (YWCA) Council accepted a resolution on Reproductive Health and Sexuality that encouraged its members to support the work aimed at advancing the reproductive rights of young people.<sup>82</sup> Faith was the motivator most cited for choices and decisions made by religious leaders who are crucial to the adoption of policies and interventions in Malawi. Interviews with faith leaders confirmed the opinion of other respondents that faith was at the center of all decisions concerning CSE and SRHR. In general, traditional leaders and faith leaders operate in synergistic ways to promote abstinence-only sex education and resist CSE:

*“ What assurance do we have that in advancing this, we are not pushing an agenda contrary to our culture as Malawians and our beliefs in a predominantly faith-based nation?*

(Lilongwe Faith-based Organization, IDI2)

Of note is the contribution of the Christian Health Association of Malawi (CHAM) to SRHR service delivery and health workers’ capacity strengthening in Malawi. CHAM is by far the largest non-governmental healthcare provider and trainer of healthcare practitioners in Malawi. A 2017 study by the HEARD Institute and the University of Malawi shows that CHAM provide approximately 37% of the services through a network of 190 health facilities, 12 training colleges and 600 outreach clinics.<sup>83</sup> Funded mainly by international donors, including the Center for Disease Control and Prevention, USAID, the Norwegian Embassy, the UK government, and the German Agency for International Cooperation (GIZ), CHAM’s colleges train about 80% of the mid-level healthcare workers in Malawi, 95% of them on scholarships. CHAM offers comprehensive SRH health and GBV services in DREAMS Clubs in Zomba and Machinga, mostly in rural areas and hard to reach settings. Family

Health International 360 and World Relief Malawi as their main implementing partners. However, CHAM's health facilities do not provide the full range of essential health package services, mainly due to their inadequate human, financial and material resources.

### 3.4 Stakeholder analysis

As shown in Figure 8, stakeholders are categorized as follows: The first category includes those with high interest and that wield high influence. These are important players in adolescent SRHR and should be fully engaged and closely managed. Included here are government ministries like MoE, MoH, Ministry for Youth and Sports, and Ministry for Women and Child Development. National reproductive health networks are in this category as well, such as the Nurses and Midwives Council of Malawi, the Family Planning Association of Malawi, the Malawi Network of Religious Leaders living with HIV and the National Youth Council of Malawi. International NGOs and development partners such as the World Bank, UNFPA, UNICEF, WHO, UNESCO, HIVOS, Plan International, International Planned Parenthood Federation (IPPF) and Save the Children are also vital players to closely engage with in order to realize better access to SRH services for young people.

The second category of stakeholders are those with low interest and high influence. These stakeholders need to be kept informed and, to the extent possible, satisfied even though they are not particularly interested in SRHR issues; they command considerable influence and can use it to oppose access to adolescent SRHR. Efforts need to be made to draw them into supporting the adolescent SRHR agenda. Included here are the Ministry of Finance, Parliament, CHAM, the Chiefs' Council, Malawi Episcopal Conference, Malawi Interfaith Association, Public Affairs Committee (PAC), Malawi Council of Churches (MCC), Association of Religious Institutes in Malawi (ARIMA), Zodiak Radio and Television, Evangelical Association of Malawi, and the Islamic Information Bureau. All are important to helping fast-track progress towards better access to SRH information and services for young people in the country.

The third category of stakeholders includes those people with low influence, but high interest. This category of stakeholders should be adequately informed and engaged, as they can help point out areas that could be improved or that have been overlooked from their vantage point as SRH service consumers. The following stakeholders fall in this category: the Muslim Association of Malawi, Theatre for a Change (TFAC), Youth Research Academy, APHRC, African Institute for Development Policy (AFIDEP), Girls Empowerment Network (GENET), YONECO, Mothers Group, Teachers, Adolescents, SAT Malawi, Parents, GIZ, University of Malawi's Center for Social Research (CSR), HEARD Institute, Forum for African Women Educationalists in Malawi (FAWEMA), AGYW Network, Her Liberty and the Girls Not Brides Network.

The fourth category are stakeholders with low influence but also limited interest in CSE and ASHR. Minimal effort and attention should be paid to this group of stakeholders. It is, however, important to monitor whether their levels of interest or influence change. Only organizations or institutions in the private sector belong to this category.



While our findings show a conducive policy environment, significant gaps exist in the access of adolescents to Entry points and opportunities for advocacy and policy implementation on adolescents' access to sexual and reproductive health information and services

The findings of the PB-PEA presented in this report support the following conclusions:

#### 4.1 A case for investment in Malawi

- There is growing recognition of the sexual and reproductive health challenges faced by adolescents and the need to invest in their SRH empowerment. This increasing recognition is demonstrated in the government's signing and ratifying of forward-looking international and regional frameworks and commitments. For example, Malawi is among those countries that have recommitted to ESA commitments to improve the education, health and well-being of adolescents and young people first made in 2013.
- Efforts to expand access to adolescent SRHR services are gathering momentum; the provision of youth-friendly services and the training of health workers is increasing. Community structures such as mother groups, traditional leaders, and CSOs are active and supportive in delivering sexual and reproductive health services to young people.
- Evidence indicates that Malawi can significantly reduce adolescent pregnancy and new HIV infections by scaling up CSE for out-of-school adolescents and expanding the reach of youth-friendly health services in rural areas.

#### 4.2 Key points of leverage to expand adolescents' access to sexual and reproductive health information and services

- Civil society should continue to lobby and hold the government accountable to its international commitments for the provision of SRH services to adolescents.
- Strong and experienced CSOs, including youth-led and women-led groups, are capable of promoting CSE and access to SRH services for adolescents, even in the face of opposition. Malawi has experienced and engaged CSOs working on SRH-related issues; in many cases, they have worked on these issues for decades, giving them needed authenticity and legitimacy for working at the community level.
- Traditional leaders are engaged and acknowledge the importance of sexuality education. They remain open to engaging stakeholders and they remain willing to play a substantive role in positively shaping adolescent sexual health behavior. If they lead on norms change around adolescent sexuality, it may be of tremendous benefit to normalizing youth-friendly contraceptive access. Specifically, traditional authority figures generally concede that initiation ceremonies are inadequate in various ways; if these inadequacies were to be addressed, this could become an effective way of promoting healthy sexual behavior among adolescents.
- The engagement of young people and youth organizations in the policy development and implementation process is vital to ensuring that their needs are accounted for. Malawi has a number of active youth organizations, but coordination efforts need to intensify and become more strategic.
- The involvement of experts outside government can help the MoE in the development of strategies aimed at improving CSE implementation while also working with the MoH in efforts to expand access to SRH services to underserved areas. Malawi can rely on technical and financial support from international agencies and more sporadically from bilateral development agencies.
- A tradition of addressing sexuality within the Malawian education system can contribute, over time, to building openness, understanding, legitimacy and technical competence for not only including CSE in the school curriculum but also its effective delivery.

- Several relevant policies are due for review, including the National Sexual and Reproductive Health and Rights (SRHR) Policy, 2017–2022; the National Girls Education Strategy 2018–2022 and the National Youth Friendly Health Services (YFHS) Strategy 2015–2020. This presents an opportunity to assess progress, and to identify and address gaps in new policies.
- The Ministry of Youth is developing an out-of-school CSE curriculum, and the Ministry of Education is reviewing the CSE curriculum. Given the nature of curriculum development, opportunities for engagement and consultation exist and would make the curriculum more comprehensive if adequately cultivated.
- There is a need to increase the access of existing CSO networks to SRH information and services for adolescents; networks could include FPAM, CYECE, the Center for Alternatives for Victimized Women and Children (CAVWOC) and YONECO, to name a few.
- Similarly, there is a need to build on the growing influence of traditional leaders for implementing out-of-school CSE and facilitating adolescent access to SRH services. Community-based interventions that work with parents and guardians, health providers, and community leaders should be expanded. It is important to engage these gatekeepers because they play a critical role in the access of youths to SRH services.
- Academia needs to better leverage civil society networks to share easily understood findings from emerging research that can guide advocacy efforts; donor assistance can help facilitate this process
- There is an appetite among CSOs for playing a role in informing the research agenda and for being a partner throughout the process.
- There is a need to work with parliament to bridge the gaps between the MoH and MoE regarding the provision of SRH services in schools.
- Conflicting understanding of the meaning of CSE and its content requires targeted, fact-based public education/awareness programs to ensure that the fears and concerns of stakeholders, particularly parents, are allayed.
- Resistance remains to particular proponents of CSE, and key stakeholders require further engagement and, possibly, values clarification and attitude transformation training.
- The Episcopal Conference of Malawi, the Evangelical Association of Malawi, Malawi Council of Churches, and the Muslim Association of Malawi have been the main opponents to the proposed Termination of Pregnancy Bill. If Malawi is going to realize the rights of women to safe abortions, advocates need to engage with these religious associations.

### 4.3 Areas requiring attention

- Improved coordination and communication is essential for expanding SRH services targeting adolescents. Donors and international organizations should make sure their approaches are informed by NGOs and civil society, including academia, and that a coordinated approach is taken to ensure synergistic efforts
- The Parliamentary Commission on Education and Health may be the key channel through which major stakeholders can drive the SRH agenda forward.
- The provision of SRH services for adolescents needs to be anchored in a system of rights and corresponding obligations established by international law, including all civil, cultural, economic, political, and social rights, as well as the right to development. Achieving this entails not only service availability but that people seeking and providing those services know and understand the implications of these framing laws and policies. This is important for adolescents because societal norms and values often conflict with the principles of autonomy and access espoused in regional and national commitments.
- There remain bottlenecks to the effective implementation of SRH policies that reflect wider systemic problems in the education sector: insufficient teacher training and support, teacher shortages, overcrowded curricula, and inadequate teaching materials that are culturally acceptable. A lack of financing provisions in policies and laws affects the implementation of many programs, not only CSE, and relying on fluctuating financial support from international agencies is an unsustainable approach. COVID-19 and the shifting of

- resources to manage it has taken attention away from SRH services.

Teacher training is required to shift the pedagogy and content from a values-based approach to a rights-based approach. The development of standardized scripted lesson plans and other teacher training

- materials may help ensure the delivery of CSE that actually retains its 'comprehensiveness'.

Understanding and provision of sexuality education by traditional leaders is not aligned with that which is delivered in schools under the auspices of comprehensive sexuality education; the same is true for

- NGOs and other partners who target out-of-school youth with CSE.

Evidence needs to be distilled at a level where it is consumed by community, traditional and religious leaders. Cultural practices and religious teachings will evolve where there is clear evidence that these

- practices are proving harmful and leading to poor health outcomes.

The gaps between the respective goals of the MoE and MoH for advancing SRH knowledge and services need to be bridged. The siloed manner in which programs are implemented between the two ministries

- is not an optimal approach and a common strategy required.

There is a need for NGOs implementing sexual and reproductive health programs that target young people to better coordinate in scaling up coverage of services and ensure that adolescents in rural areas

- are not left behind.

There is currently a lack of political will when budgeting for major SRH services that is affecting delivery. This is partially due to the low prioritization of these services and the reliance on donors to fund them.

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