Republic Of Malawi

Ministry of Health

National Youth Friendly Health Services Strategy

2015–2020

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Foreword

The Government of Malawi recognises that the health of young people is a component of public health, which is of concern in this country. However, lives of most young people continue to be threatened by a number of factors such as sexually transmitted infections including HIV and AIDS, teenage pregnancies, unsafe abortion complications, nutrition inadequacies, alcohol and drug abuse and mental health problems. This contributes significantly to the high mortality and morbidity rates in Malawi.

The youth are regarded as the window of hope for the development of this country. As such, they need proper care and guidance to ensure that they remain healthy and productive. As young people grow and develop, they have various needs and problems, which affect their growth and development. Most of the needs and problems are related to sexual and reproductive health. However, the young people are not aware of them; neither are they aware of the existence of reproductive health services. Those that are aware of these services have problems in accessing them.

The Ministry of Health through the Directorate of Reproductive Health and partners initiated the programme evaluation of youth-friendly health services to assess the extent to which young people access the health services they need at various levels of care. The findings and recommendations from the evaluation stressed the need to have a robust adolescent and youth sexual and reproductive health strategy.

The process of developing this adolescent and youth SRH strategy was through extensive consultations from international, national and individuals with various experiences in working with youth programs. The Sexual & Reproductive Health Policy and Strategy underpin Malawi's commitment to achieve universal access of services by young people regardless of sex, religion, race and marital status.

This strategy, therefore, aims at giving direction and guidance to the implementation of SRH services for all young people countrywide, so as to achieve the highest possible level of quality integrated services.

The Ministry of Health is fully committed towards the implementation of this strategy and hence welcomes collaboration with all stakeholders in mobilising the necessary resources and improving access to and utilisation of quality SRH services in Malawi in order to achieve the sustainable development goals for young people.

M.P. Magwira, PhD
Secretary for Health

Acknowledgements

The Ministry of Health Directorate of Reproductive Health is greatly indebted to a host of organisations, service providers and individuals who collectively contributed to the development of the Youth Friendly Health Services (YFHS) Strategy and are too numerous to be mentioned individually. The Ministry would like to specially acknowledge the U.S. Agency for International Development (USAID) in Malawi and the USAID-funded Health Policy Project (HPP) for the financial and technical support to the Directorate of Reproductive Health. The leadership and technical support from Veronica Chirwa (USAID), HPP staff Olive Mtema, Henry Sapuwa, and Barwani Msiska, and consultants Sandra Mapemba and Marjorie Macieira has been greatly appreciated.

Special mention should go to all stakeholders for the interest, commitment, and participation in all the high-level national and regional-level consultation meetings that provided the strategic direction for the nature of the final YFHS Strategy. Thanks should also be accorded to the YFHS Technical Working Group who, under the leadership of the Ministry of Health Directorate of Reproductive Health through Fannie Kachale and Hans Katengeza, provided oversight of the process.

In addition, special thanks is given to all line Ministries of Health, Education, Gender, and Youth, CSOs and young people who formed the writing group of the first draft of the Strategy and key individuals who provided oversight and review to the drafts of the Strategy. These individuals are Lonnie Ncozana (FPAM), Dominique Likongwe (NAC), Sewenthe Chipofya (YONECO), Jayne Mwalabu (YFHS – Salima DHO), Esnart Phiri (MoGCDSW), Julius Chingwalu (CHANCO – DPS), Lonjezo Sithole (NAC), Promise Matatiyo (NYCOM), Samuel Longwe (MoH – Northern Health Zone Office), Caroline Bakasa (PSI), Frank Mwafulirwa (SCF), Abiba Ngwira (AFIDEP), MacBain Mkandawire (YONECO), Wezzie Kamphale (YONECO), Dalisto Midiani (MoH – HIV Department), Taonga Mafuleka (MoH – Health Education Unit), Peter Katuma (MoEST), Deus Lupenga (MoYSD), Fred Simwaka (MoGCDSW), Jean Mwandira (UNFPA), Rose kamanga (UNFPA), Khama Patrick Ziyabu (MAGGA), Jane Chirwa (SSDI Services), Lucky Mbewe (CYECE), Faith Kalonga (NAYPLHIV), and Grace Mlava (UNICEF).

The YFHS Strategy is a living document that will be revised as new data emerges. The Directorate of Reproductive Health will also rely on the passion and dedication of partners in the youth, health, education, gender, and population and development sectors to make this data available, as we disseminate, implement, and revise our YFHS Strategy.

Acronyms

ADC	Area Development Committee
AFIDEP	African Institute for Development Policy
AIDS	Acquired Immune Deficiency Syndrome
ART	Anti-retroviral Treatment
ARV	Anti-retroviral
BCC	Behavioural Change Communications
BLM	Banja La Mstogolo (Marie Stopes affiliate)
CBO	Community-Based Organisation
CHAM	Christian Health Association of Malawi
CHANCO-DPS	Chancellor College, Department of Population Studies
CIP	Costed Implementation Plan
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive Sexuality Education
CSO	Civil Society Organisation
CVSU	Community Victim Support Unit
CYECE	Centre for Youth Employment and Civic Education
DAC	District AIDS Committee
DEC	District Executive Committee
DHIS II	District Health Information System II
DHMT	District Health Management Team
DHO	District Health Office (Officer)
DIP	District Implementation Plan
DYO	District Youth Office (Officer)
EFA	Education for All
EMIS	Education Management Information System
ESA	Economic and Social Affairs
FGD	Focus Group Discussion
FP	Family Planning
FPAM	Family Planning Association of Malawi (IPPF affiliate)
GEWE	Gender Equality and Women Empowerment
GBSV	Gender-based Sexual Violence
GBV	Gender-based Violence
GCYS	Gender, Children, Youth and Sport
GMIS	Gender Management Information System
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPP	Health Policy Project
HPV	Human Papilloma Virus
HSA	Health Surveillance Agent
HTC	Health Testing and Counselling
ICPD	International Conference on Population and Development
ICT	Information and Communications Technology
IEC	Information, Education, Communications
IGA	Income-generating Activity
IHS	Integrated Household Survey

LARC	Long-acting Reversible Contraceptive
M&E	Monitoring and Evaluation
MAGGA	Malawi Girl Guides Association
MANET	Malawi AIDS Network
MDG	Millennium Development Goal
MDHS	Malawi Demographic Health Survey
MGDS	Malawi Growth and Development Strategy
MICS	Multiple Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MoEST	Ministry of Education, Science and Technology
MoFEPD	Ministry of Finance, Economic Planning and Development
MoGCDSW	Ministry of Gender, Children, Disability and Social Welfare
MoH	Ministry of Health
MoLG	Ministry of Local Government
MoYSD	Ministry of Youth and Sports Development
NAC	National AIDS Commission
NAD	Norwegian Association of the Disabled
NAYPLHIV	National Association of Young People Living with HIV
NGO	Nongovernmental Organisation
NSO	National Statistical Office
NSP	National HIV and AIDS Strategic Plan
NYCOM	National Youth Council of Malawi
NYP	National Youth Policy
PMTCT	Prevention of Mother-to-Child Transmission of HIV
PPP	Public-Private Partnership
PSI	Population Services International
PTA	Parent-Teacher Association
RH	Reproductive Health
RHD	Reproductive Health Directorate
SADC	Southern Africa Development Communities
SAfAIDS	Southern Africa HIV and AIDS Information Dissemination Service
SBCC	Social and Behavioural Change Communications
SCF	Sports Connections Foundation
SDP	Service Delivery Point
SMC	School Management Committee
SMS	Short Message Service
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SSDI	Support for Service Delivery Integration
STI	Sexually Transmitted Infection
STWC	Sub-Technical Working Committee
TUM	Teachers Union of Malawi
TWG	Technical Working Group
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDESA	United Nations Department of Economic and Social Affairs
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
VACS	Violence against Children Survey

VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organisation
YCBDA	Youth Community-based Distribution Agent
YFHS	Youth-friendly Health Services
YONECO	Youth Net and Counselling
YoSMIS	Youth and Sports Management Information System
YPLHIV	Young People Living with HIV
YSRH	Youth Sexual and Reproductive Health
YSRHR	Youth Sexual and Reproductive Health and Rights
YTSC	Youth Technical Sub-Committee

Glossary

Adolescence: The period in human growth and development that occurs after childhood and before adulthood, from ages 10 to 19. It represents one of the critical transitions in the life span and is characterised by a tremendous pace in growth and change that is second only to that of infancy (WHO).

Advocacy: A set of strategic, targeted actions undertaken by a group of individuals or organisations directed at decision makers in support of a specific policy issue.

Categories of youth: Early adolescents: 10–14 years; Late adolescents: 15–19 years; Young people: 10–24 years (UN).

Contraceptive Prevalence: The percent of women of reproductive age 15–49 who are using (or whose partner is using) any form of contraception. "Modern" methods include pills, intrauterine contraceptive devices, injectables, implants, female and male condoms, emergency contraception, and female and male sterilisation. "Any" methods include modern and traditional methods such as rhythm/periodic abstinence, withdrawal, or other traditional methods (MoFEPD, 2013, Malawi Youth Data Sheet).

Demographic dividend: The accelerated economic growth that may result from a decline in a country's mortality and fertility, a change in the age structure of the population (increased number of working-age adults), and the increased ratio between a productive labour force and non-productive dependents.

Gender: Socially constructed roles, behaviours, activities, and attributes that a given society considers appropriate for men and women.

Gender-based violence: Violence targeted at girls, boys, women and men based on the gender roles assigned to them. It involves girls, boys, women and men, in which the female is usually the victim, and is derived from unequal power relationships between men and women (UN-Instraw, UNFPA 2010). Sexual abuse is any sort of non-consensual sexual contact.

Gender sensitivity: The act of being aware of the ways people think about gender, so that individuals rely less on assumptions about traditional and outdated views on the roles of men and women; being conscious of the need to understand the social relations between men and women and taking these into account before embarking on interventions (UN-Instraw, UNFPA 2010).

Gender-sensitive reproductive health (RH) programmes: RH programmes that are aware of and address the specific RH needs of women and men, boys and girls, and account for and respond to prevalent gender norms and roles in programming.

Health: A state of complete physical, mental and social well-being and not merely the absence of disease and infirmity (WHO 1948).

Meaningful youth involvement: "Involving youth in responsible, challenging action that meets genuine needs, with opportunity for planning and/or decision-making affecting others, in an activity whose impact or consequences extends to others – outside or beyond the youth participants themselves" (U.S. National Commission on Resources for Youth).

Sexual health: "Sexual health is a state of physical, mental and social well-being in relation to sexuality. It requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence" (WHO 1948).

Sexual and reproductive health rights (SRHR): Implies that people should have a satisfying and safe sexual life and that they shall be assisted to have the capacity to reproduce and the freedom to decide if, when and how often to do so. SRHR in this Strategy is inclusive of adolescent sexual and reproductive health; safe motherhood and newborn care; prevention and management of consequences of abortion; family planning; prevention of sexually transmitted infections including HIV; prevention and management of cancers; health and development; reduction of gender-based violence; interpersonal communication and counselling; and health education (SRHR Policy 2009 and Maputo Plan of Action 2007–2010).

Unmet need for family planning: Women and girls are considered to have an unmet need for family planning if they wish to delay, space, or limit their next pregnancy by two years or more and are not currently using any modern or traditional method of contraception (MoFEPD, 2013, Malawi Youth Data Sheet).

Vulnerable groups: Vulnerable populations are defined as those groups of people who are typically excluded, disadvantaged or marginalised based on their economic, environmental, social, or cultural characteristics, age, health status, or other characteristics. Members of vulnerable groups may not be well integrated into the health care system, may experience stigma or discrimination, and/or may not receive necessary medical care, which then increases their risk for adverse health outcomes.

Youth: Those aged between 10 to 24 years regardless of marital, social and economic status (YFHS Standards 2007). All persons from age 10 to 35 years regardless of their sex, race, gender identity, education, culture, religion, economic, marital, and physical status (Malawi National Youth Policy, 2014). This Strategy will refer to youth as those persons aged 10 to 24 years aligned to the Ministry of Health life cycle approach.

Youth-friendly health services: High-quality services that are relevant, accessible, attractive, affordable, appropriate and acceptable to the young people. The services are provided in line with the minimum health package and aims to increase acceptability and use of health services by young people (National Standards – YFHS, 2007).

Executive Summary

Malawi is one of the few countries in the region to have implemented youth-friendly health services (YFHS) from as early as 2007 through the Ministry of Health (MoH) Reproductive Health Directorate (RHD). These services are offered to young people between the ages of 10 and 24 years, recognising that this is a vulnerable time for adolescent transition to young adulthood. YFHS are high-quality services that respond to the general health, especially sexual and reproductive health and rights (SRHR), needs of young people. YFHS are meant to be relevant, accessible, attractive, affordable, appropriate, and acceptable to young people.[i]

This National Youth Friendly Health Service Strategy 2015–2020 has been developed in the context of the findings and recommendations of the YFHS Programme Evaluation study (2013–2014) carried out by the MoH-RHD with assistance from the U.S. Agency for International Development (USAID)–supported Evidence to Action Project and Centre for Social Research, University of Malawi. The report cites that only 31.7%[ii] of young people have heard of YFHS and 13% have ever used these services. Further findings point to negative provider attitudes, long distances to YFHS access points coupled with long waiting times, and lack of confidentiality as some of the reasons for discontinued use of health services by youth. Such results have called for an urgent need to revisit, revamp, and reinstitute a robust and successful YFHS programme in the country particularly as 66% of Malawi's population is under 25 years of age and the country presently registers a high number of adolescent pregnancies and high STI/HIV incidence among youth.

This large youthful population is an opportunity for Malawi to achieve great economic and political change (commonly referred to as a demographic dividend) if investments are made in youth health, education, and job opportunities. However, early sexual debut continues to persist with 20.3% boys and 5.3% girls having had sex by age 10 (YFHS Evaluation Study, 2014), adding to the high school drop-out rate among girls due to pregnancy and early and child marriages. The absence of quality YFHS that provide information and services for healthy youth development has resulted in:

- Low comprehensive knowledge in SRHR: Fewer than half (42%) of young women and (45%) of young men 15–24 years fully understand HIV and AIDS (MDHS, 2010).
- High adolescent birth rate: 143/1,000 live births; 45.7% of maternal deaths between 2008 and 2010 were in the ages of 14–23 years (MOH, 2014).[iii]
- High number of teenage pregnancies: 106,000 or 26% of all pregnancies annually (MDHS, 2010)
- High school drop-out rate among girls due to pregnancy: 2 in every 7 girls in primary school (EMIS, 2013)
- High HIV incidence: 3,200 annually among youth 14–19 years (NAC, 2013)
- High unmet need for contraceptives: 31% of females who had a child reported they did not want the pregnancy and another 9.3% would have wanted to wait until a later time (YFHS Evaluation, 2014); 26% among youth 15–24 years (MHDS, 2010); 19.8% women 15–49 years (MICS 2014).
- High rates of drug and alcohol use/abuse: 50% of the drug- and alcohol-related cases that come before the courts involve young people (NYP, 2013).

This National YFHS Strategy is framed to address these gaps in general health and particularly SRH knowledge and services by employing a multi-sectoral approach to fully deliver in the three areas of YFHS:

1) Access to information through health promotional activities, social and behavioural change communications (SBCC), and formal learning
2) Delivery of services mainly through static and outreach sites
3) Referrals dependent on the situation at hand (social services, district and central hospitals, community structures, and/or police)

The objectives of the Strategy seek to create an enabling environment for YFHS delivery, guarantee strict adherence to YFHS standards, strengthen synergies between and across sectors, increase youth and community participation, and identify opportunities for funding for creating a generation free of all chronic conditions.

The development of the YFHS Strategy was initiated through the MoH-RHD's comprehensive evaluation study of the YFHS programme based on the 2007 National Standards criteria over the years. An extensive mapping of youth SRHR programmes and literature review were conducted to inform the Strategy. A multi-disciplinary Steering Committee provided overall guidance in the revision process, in conjunction with a highly participatory, consultative and ongoing transparent approach with the relevant stakeholders, including line ministries, development partners/donors, district-level staff, youth organisations, youth, community radios, print media, nongovernmental organisations (NGOs), and technical working groups. The USAID-funded Health Policy Project closely worked with the RHD to facilitate the development process and consolidate the Strategy document.

Through prioritisation and investment thinking, the YFHS Strategy has capitalised on evidence-based interventions sought to increase quality of services, improve demand, increase access, and diligently monitor, document, and report on the YFHS programme. All YFHS are to be implemented in an integrated manner to reduce stigma and shyness among youth.

The primary strategies for the 2015–2020 YFHS Strategy are:

1) *Advocacy:* Youth are a diverse group; as such, institutions have chosen to categorise young people according to programme delivery and policy expectations. These categorisations have led to mixed messaging in the access to SRHR/HIV information and services among sectors. Similarly, several policy documents have not been widely disseminated and therefore the Strategy will advocate for harmonisation of policies relating to SRHR/HIV and gender, repackaging of information to ably reach communities and enhance understanding of policy makers and communities alike.

2) *Capacity building:* The delivery of the YFHS involves all key sectors such as health, education, youth, and gender for a comprehensive youth-responsive programme. On-the-job training, mentorship, supervision, and orientation are the foundation to ensuring that all sectors are knowledgeable about the YFHS approach and can provide relevant, age-appropriate SRHR/HIV information including in areas of drug and alcohol use and gender. Capacity building is expected to be conducted at national, district, and community levels and is not limited to the health sector but subjective to the service being delivered.

3) *Outreach and alternative spaces:* Whilst the onus of service delivery of YFHS will still be provided through static sites, outreach and alternative spaces will seek to extend the reach

of YFHS especially in the hard-to-reach areas. The majority of youth (85%) reside in rural areas in Malawi and rely on only health centres, classroom education, and community events for YFHS. Scaling up outreach services via mobile clinics and utilising youth clubs, teen clubs, youth organisations, development centres, and door-to-door approaches will provide alternative, more accessible opportunities for youth to access readily available YFHS information, services, and referral outside the static sites and institutional blocks. The intent is to bring services closer to youth in hard-to-reach areas and vulnerable populations[1] and provide services where youth congregate, as well as to reduce congestion in health facilities for non-clinical services.

4) *Comprehensive sexuality education (CSE):* Evidence strongly links delayed sexual debut, use of contraception, and healthy choices to CSE. Instituting CSE within the school curriculum and out-of-school SRH manuals therefore is of high priority in the Strategy.

5) *Youth participation:* YFHS is a youth-responsive programme designed to attract youth and maintain patronage. Involving youth to contribute towards the planning, implementation, and monitoring of the programme will ensure that YFHS is implementing suitable interventions in acceptable places and at appropriate times. Noting that young people rely mainly on their peers for information, this will also enhance the peer-to-peer approach and build youth champions in SRHR. Increasing youth participation will allow for more credible SRHR information being passed on to other youth and increase ownership of the programme.

6) *Social and behavioural change communications:* Demand creation of YFHS involves changing preconceived negative values and attitudes of parents, traditional leaders, teachers, and the youth themselves, which act as a barrier to uptake. Therefore, SBCC will allow for dialogue between technical experts and communities to frame a positive mind-set towards YFHS and the implementation of gender transformative interventions necessary for the programme to thrive. Subsequently, community systems strengthening will be of utmost priority as a means to furthering the success of the YFHS programme.

7) *Public, private partnerships:* Social marketing and partnerships with faith-based organisations, NGOs, and private clinics have shown to be effective in increasing demand creation and uptake for YFHS. It is therefore proposed to build on existing partnerships to expand catchment areas as well as form engage pharmacies and corporates and other new partnerships to invest in YFHS either through equipment, information conduits, or provision of services commensurate with their mandate.

8) *Use of emerging/appropriate health technologies:* Young people are technology savvy and therefore identification of specific technologies that can increase access to information is important. Phone/SMS technology, mHealth, eHealth, and hotlines will be used for the hub of information to the youth. The same technology will also be used by monitoring and evaluation (M&E) persons and providers where necessary and adaptable.

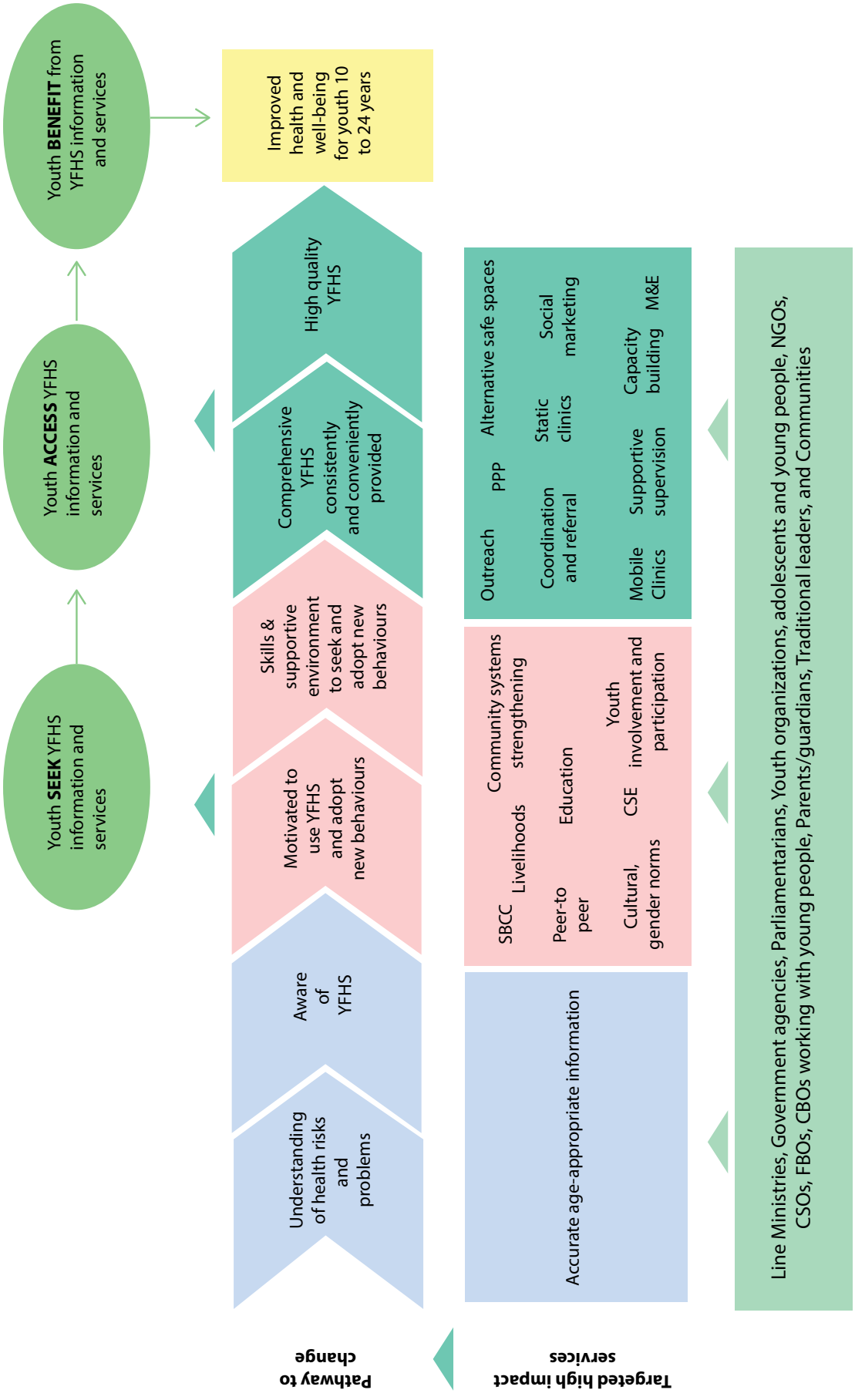
9) *Monitoring and evaluation:* YFHS has faced challenges in the past with documentation and data collection, resulting in limited evidence generated to support youth-specific interventions. Youth indicators are peppered in the different management information systems and sometimes offer conflicting results. The M&E matrix (Annex 4) is framed to capture progress of the YFHS programme supported by the harmonisation of management information systems and provision

[1] *Refer to Glossary*

of equipment for M&E focal points. Skills training and use of appropriate technologies are aimed at providing quality, real-time data for the YFHS programme.

The estimated total cost of this Strategy is US$ 19,342,364. Funds for the implementation of the YFHS programmes will be realised through resource mobilisation primarily through government and the integration of YFHS components in other donor-funded programming as outlined in the plan to be developed. YFHS will be delivered within the delivery of the Essential Health Package and existing programmes of other line ministries and based on the priorities set in the YFHS Strategy 2015–2020. Stakeholders are expected to align all YFHS interventions to the YFHS Strategy. The MoH-RHD will work with key departments within the Ministry and all stakeholders for the successful delivery of the programme. The MoH-RHD will coordinate the programme at all levels. The National YFHS Strategy therefore strongly advocates for investments in YFHS that will ultimately allow Malawi to realise a demographic transition for accelerated economic growth by ensuring young people complete their education, delay their sexual debut, reduce the number of children born, minimise HIV transmission, make informed choices on their sexuality, and transition into healthy young adults as represented in the matrix.

Figure 1: Summary of the YFHS Strategy

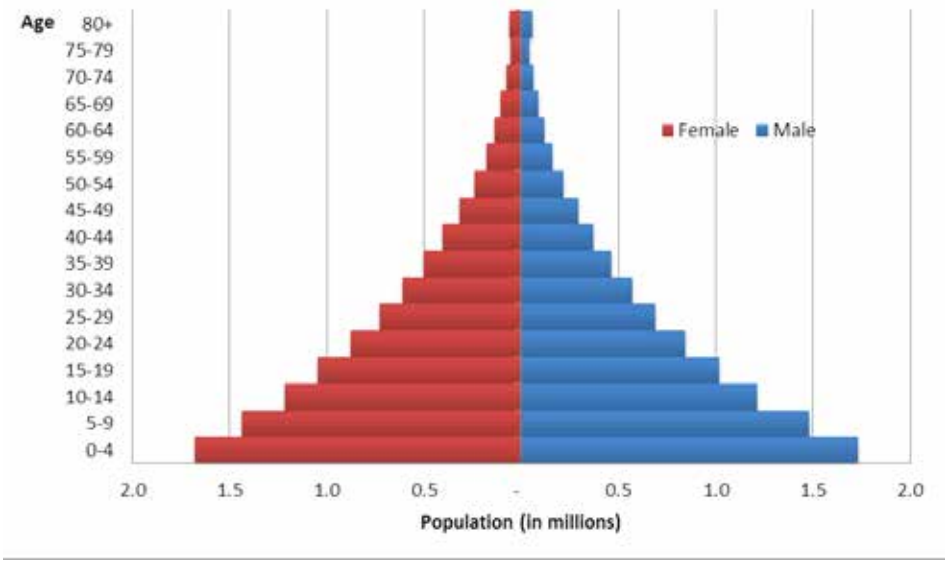


Chapter 1: Introduction

1.0 Background

Malawi has an overwhelmingly large sub-population of youth, with one out of three between the ages of 10 and 24 years. There are over 5 million young people in need of youth-friendly health services (YFHS),[iv] and this number is expected to continue to grow at least until 2020.[v] Malawi's current estimated population is 15.8 million people, having grown exponentially from only 13.1 million people in 2008 (Census Projection, 2008). Even as the average number of children per woman (total fertility rate) continues to lower slowly from 5.6 (MDHS 2010) to 5.0 (MICS/ MDG Endline Survey, 2014), the population is poised to continue to grow owing to the large generation of children and adolescents primed to mature and have children of their own.

Figure 2: Projected population pyramid in 2020



This large youthful population is an opportunity for Malawi to achieve great economic and political change (commonly referred to as a demographic dividend). The dividend refers to faster economic growth that is caused in part by changes in population age structure. It can contribute to both national development and improved well-being for families and communities. However, unchecked population growth can also strain the economic, education, health, and agricultural sectors of society, and it is imperative Malawi urgently intervene with young people to change direction now. Fertility rates have only marginally declined in the last decade, and without immediate and urgent change, Malawi will not be able to benefit from its currently large youthful population.

Because of this, investment in YFHS for a healthy transition for this very large population from childhood through adolescence to adulthood is vital to achieve the attainment of the Malawi Growth and Development Strategy (MGDS) II overarching goal of "continued wealth, poverty reduction, and sustainable economic growth and infrastructure development."[vi]

1.0.1 National, Regional, and Global Commitments

YFHS have been prioritised at global, regional, and national levels.[vii] This Strategy is informed by provisions that government has made for youth in national public sector policies and programs as well as other international standard setting instruments. Nationally, these include the MGDS II (2011–2016), Sexual and Reproductive Health and Rights Policy (2009), National Education Policy 2014, draft National Gender

Policy (2011), National Youth Policy (2013), National Alcohol Policy 2011, National Strategy for Sexual and Reproductive Health and Rights (2011–2016), the HIV and AIDS Prevention Strategy (2015–2020), and the National Population Policy Implementation Plan (2014). These are but a few policies that specifically segment youth as a special group that needs to be reached with youth-responsive sexual and reproductive health and rights (SRHR) programmes. Globally, the Government of Malawi is committed to achieving the Sustainable Development Goals and several regional and global commitments regarding YFHS, namely:

- *The ICPD (1994) Programme of Action:* Removal of barriers and increasing youth access to SRH information, education, and services.[viii]
- *2006 African Youth Charter: Article 16:* "Every young personshall have the right to enjoy the best attainable state of physical, mental and spiritual health [through comprehensive sex education and through contraceptive access, antenatal and post-natal services, youth participation and social protection."
- *African Youth Decade 2009–2018 Plan of Action:* Accelerating Youth Empowerment for Sustainable Development: A road map for multi-sectoral and -dimensional engagement of all stakeholders towards the achievement of the African Youth Charter, including setting standards and accountability measures.
- *African Union Agenda 2063 – The Africa We Want:* The 2014 document had seven aspirations: youth as drivers of change; achievement of gender parity; empowerment of women; an engaged and empowered youth with full implementation of the African Youth Charter; elimination of gender-based violence (GBV); quality health and education for women and girls; and full youth employment.
- *Malawi's FP2020 Commitments 2012:* FP2020 is an initiative set to enable an additional 120 million women in the world's poorest countries to use modern contraception by 2020. Malawi's goal is set at raising the contraceptive prevalence rate (CPR) to 60% with a focused increase in those aged 15 to 24 years.
- *Ministerial commitment on comprehensive sexuality education and sexual and reproductive health services for adolescents and young people in Eastern and Southern African 2013:* A pledge to educate and protect all children and youth from early and unintended pregnancy, unsafe abortion, sexually transmitted infections (STIs)/HIV, and substance misuse and to combat discrimination and rights violations including child marriage.
- *Global response of three-zeros (UNAIDS 2014):* Zero new infections, zero AIDS deaths, zero stigma and discrimination by addressing structural determinants, factors that undermine healthy living, and support of communities that prioritise engagement and communication.

Critical supporting factors include compliance with the national standards for YFHS provision and programme accountability, as well as domestication of the regional and global commitments, whilst aiming for sustainable, gender-equitable, multi-sectoral integration of the YFHS programme.

1.0.2 Youth-Friendly Health Services in Malawi

Youth are defined as "all persons from age 10 to 35 years regardless of their sex, race, education, culture, religion, economic, marital and physical status" (NYP 2013). Whilst the Strategy fully adopts the NYP 2013 definition of youth, the YFHS Strategy strives towards serving young people 10 to 24 years to closely

align with the Ministry of Health (MoH) life cycle approach. This sub-population group has specific and, very often, neglected health needs that are necessary for healthy growth and development. Unlike in the earlier childhood years where health is determined largely by mothers (parents/guardians), in adolescence young people become more dependent on their own judgment for health decision-making and ultimately health outcomes, thereby requiring more targeted health interventions.

LIFE CYCLE APPROACH (WHO 2002, UN 1998)

- Early adolescence 10–14 years;
- Middle adolescence 15–17 years;
- Late adolescence 18–21 years; and
- Early adulthood 22–24 years

In most national documents,[2] youth are acknowledged as a select group; however, all these documents prioritise and categorise youth differently according to the given institutional mandates (see Annex 1, "Categories of Youth in Malawi"). In the health sector, both the National Sexual and Reproductive Health and Rights Policy (2009) and the National Strategy on Sexual and Reproductive Health and Rights (2011–2016) insist on a comprehensive youth-responsive health promotion and health care delivery system delivered within the Essential Health Package arrangement, which has since become the basis of the YFHS programme in Malawi. YFHS were introduced by the MoH's then Reproductive Health Unit in 2007 with the aim of meeting all the services/components outlined in the national YFHS standards (2007) and as recommended by the Sexual and Reproductive Health and Rights Policy (2009) recommendations deeming that all youth health services be more relevant, attractive, acceptable, accessible, and affordable to young people between the ages of 10 and 24 years (see Annex 2, "YFHS Packages and Standards"). Implementation of the YFHS programme was, therefore, governed by the YFHS standards based on the World Health Organisation (WHO) international standards (see accompanying "National YFHS Standards 2007").

Youth Friendly Health Services are high-quality services that are relevant, accessible, attractive, affordable, appropriate and acceptable to the young people. (National Standards, YFHS, 2007)

National YFHS Standards 2007

Standard 1: Health services are provided to young people according to existing policies, procedures and guidelines at all service delivery points

Standard 2: Young people are able to obtain health services that include preventive, promotive, curative and rehabilitative health services appropriate to their needs

Standard 3: All young people are able to obtain health information (including SRH and HIV) relevant to their needs, circumstances and stage of development

Standard 4: Service providers in all delivery points have the required knowledge, skills and positive attitudes to effectively provide YFHS

Standard 5: Health information related to young people is collected, analysed and utilised in decision making at all levels

[2] *MGDS II – youth are crosscutting; NYP – Nutrition and SRHR are prioritised; Health – SRHR policy and strategy; HIV Prevention Strategy 2015–2020.*

YFHS are delivered using a three-pronged approach: 1) Health promotion as a means of providing SRHR information through social and behavioural change communications (SBBC); 2) Delivery of services mainly through static sites and outreach; and 3) Referrals and follow-up dependent on the situation at hand (i.e., referral to social services, district and central hospitals, community structures, and/or police).

The majority of YFHS are delivered through the three levels of the health system[ix] grounded within the normal MoH clinical standards and procedures and ideally are linked to appropriate outreach activities such as health promotion and counselling, treatment, and referral in line with minimum package requirements. However, the recent national evaluation of the YFHS programme (2014) reports that high proportions of young persons are not motivated to seek or access services and that health facilities' overall ratings in meeting these standards were medium to low, thereby adding to the low levels of uptake of services set out in the YFHS package.[x] Adherence to YFHS standards is a key area the Strategy hopes to strengthen through multi-sectoral collaborative approaches and with respect to prominent national, regional, and global instruments.

1.0.3 Youth Sexual and Reproductive Health and Demographic Data

One in three persons in Malawi is between the ages of 10 and 24 years.[xi] Addressing the general health needs – especially SRH needs – of these young people is complex because youth cannot be defined as a homogeneous group; they vary by age, sex, education, marital status, and residence. The National YFHS Strategy recognises the diversity of the socio-cultural and economic context of Malawian youth and calls for a wide range of strategies with a focus on integrated social investment[xii] for healthy youth development. Young people will drive development in Malawi for the next two decades and the developmental indicators provided in this section accentuate the urgency for investments in SRHR.

1.0.4 Prevalence and Incidence SRH/HIV

Youth continue to have limited access to targeted youth sexual and reproductive health and rights (YSRHR) care and services, which is contributing to and exacerbating many of the SRHR problems as outlined below. Despite YFHS being established in 2007, the recent evaluation of the programme states only 31.7%[xiii] of young people have heard of YFHS in Malawi and 13% have ever used these services. The main deterrents to sustained utilisation of these services include: low self-confidence among clients and "shyness," especially among girls; long distances to health facilities; long waiting times; and the condition that youth receive HIV testing and counselling before accessing other services in some health facilities.[xiv] Likewise, comprehensive knowledge on HIV also remains low amongst young people, i.e., less than half (42%) of young women and (45%) of young men ages 15 to 24 years fully understand HIV and AIDS.[xv] Young women are even less informed about condoms, with only 32% citing condom use as an effective prevention strategy as compared to over 42% of young men.[xvi] Congruently, young mothers are dying during childbirth. The recently published confidential maternal death audit report (2008–2010)[xvii] show that 45.7% of deaths were in the ages of 14 to 23 years and 31.2 % from the 24- to 33-year age group, calling for an urgent need to address the full range of maternal mortality causes amongst all young/teen mothers.

Table 1: SRH and HIV Status among Youth

Indicator	Status	Source
MMR	• 675/100,000 live births (15–49 years) 2010 • 574/100,000 live births (15–49 years) 2014 • 18% of MMR is contributed by young people below 25 years due to unsafe abortion complications 2011	MDHS 2010 MICS/MDG Endline Survey 2014 MoH Magnitude Study 2011
CPR	• 2% among 15–24 years in 2010 • 58.6% among 15–49 years in 2014	MDHS 2010 MICS/MDG Endline survey 2014
Unmet Need	• 26% among 15–24 years in 2010 • 19% among 15–24 years in 2014 • 31% would like to have access but are unable to • 9% would have liked to waited before having children but had no access to FP	MDHS 2010 MICS/MDG Endline survey 2014 YFHS Evaluation 2014
HIV Prevalence among Youth	• Declined from 6% to 3.6% amongst 15–24 year olds • HIV was more prevalent in urban communities (17.4%) compared to rural communities (9%)	NAC 2013
New HIV Infections	• 34,000 in 2013 with 7,400 new infections occurring amongst children aged less than 14 years • 3,200 new infections among adolescents 14–19 years annually • Amongst the new infections for those 15 years and above, over half of these are within youth 15–24 years	NAC, UNAIDS 2013
STI	• 12% of women and 7% of men (15–49 years) reported to have had an STI in the past 12 months. • 17.2% females and 14.2% males 15–24 years report having symptoms of STI including genital discharge and sores, and ulcers	MDHS 2010
Teenage Pregnancy	• 106,000 annually (26%) 15–24 years	MDHS 2010
Unsafe Abortion	• 24.4 abortions per 1,000 women of reproductive age (15–49 years) (70,000 per year) • 25% for those below 25 years • 7.4% abortions among adolescents aged 12–17 years	MoH 2010

The need for increased coverage of integrated client-centred SRH[3]/HIV YFHS, which take into account the special needs of youth (i.e., convenient hours, comprehensive knowledge of sex and sexuality, and access to emergency contraception (ECs) and STI and HIV care and treatment), has never been greater within a confidential environment. It is equally important to popularise all four prongs of prevention of mother-to-child transmission of HIV (PMTCT),[4] especially among young girls, to ensure young/teen mothers (married and unmarried) safely transition from primary HIV prevention through pregnancy, maternity, and ongoing HIV care, treatment, and social protection.

1.0.5 Adolescent SRH Behavioural Statistics

Early sexual debut coupled with extremely low use of contraceptives is contributing to the high fertility in Malawi and may derail the reality of achieving a demographic dividend.[xviii] Even though adolescent fertility is decreasing slowly, Malawi has one of the highest adolescent fertility rates in the region. Teenage pregnancies cost the economy an estimated $57 million,[xix] placing serious challenges for poverty reduction and development.[xx] Some determining factors are that adults in the community, including parents and health workers, feel uncomfortable discussing sex and reproductive health (RH) issues with young people. Young women lack adequate SRH/HIV information and/or the ability to communicate with peers, potential sex partners and adults on their needs and often do not realise they are at risk.

Table 2: Youth SRH Behaviours

Indicator	Status	Source
Early Sexual Debut	• 22% of boys and 14% of girls have had sex by age 15	MDHS 2010
	• 20.3% boys and 5.3% girls have had consensual sex by age 10	YFHS Evaluation 2014
	• 19.8% of females and 34.7% of males between 13 to 17 years old reported having sex.	VACS 2013
	• 87.2% of females and 75.9% of males 18 to 24 year olds have ever had sex, with 55.8% of females and 75.9% of males doing so before age 18	VACS 2013
Low Contraceptive Use	• Less than half (40%) of sexually active 15-19 year old boys are using condoms	MDHS 2010
	• Less than 30% of unmarried, and one-quarter (25%) of married girls 15 -19 years old girls use modern contraception.	
Condom Use	• 1 in 5 (20%) of sexually active 15 – 19 year old boys and girls use condoms consistently	MDHS 2010

Notably, one in three adolescent girls has begun childbearing, one in four already has a child, and 9% are currently pregnant.[xxi] Lowering fertility can be achieved through promotion of comprehensive sexuality education, delayed sexual debut, use of contraceptives, especially long-acting reversible contraceptives (LARCs) and birth spacing, and delayed first births.

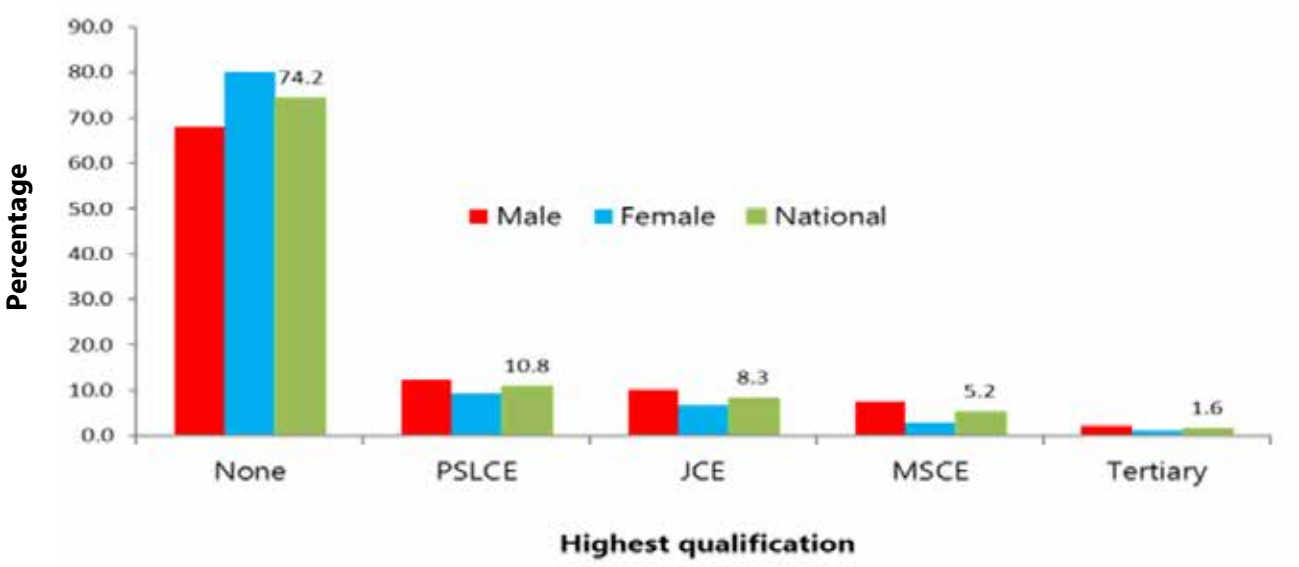
[3] *SRH services – refer to glossary for complete package.*

[4] *Prong 1: Prevent HIV among women of reproductive age; Prong 2: Prevent unwanted pregnancies among women living with HIV; Prong 3: Prevent HIV transmission from women living with HIV to their infants using ARV prophylaxis; and Prong 4: Provide appropriate treatment, care and support to mothers living with HIV, their children, partners, and families.*

1.0.6 Education

Fewer girls than boys attain formal educational qualifications in Malawi (see accompanying graph); half of the girls drop out of school at the primary school level and very few reach secondary education mainly due to child marriages and teen pregnancy (EMIS, 2014). Continuing on this path will not enable Malawi to realise a demographic dividend. Every year spent in primary school increases a girl's earnings by 10% to 15% and each year of secondary education by up to 25%. [xxii] The skills and experience gained in secondary school can position them to participate in the formal employment sector or increase the chances of securing funding for small businesses. Investing in quality education, with a focus on equal opportunity and completion of secondary schooling, especially for girls, is a protective determinant and strongly associated with healthy RH behaviours.

Highest Qualifications Attained by Girls and Boys in Malawi

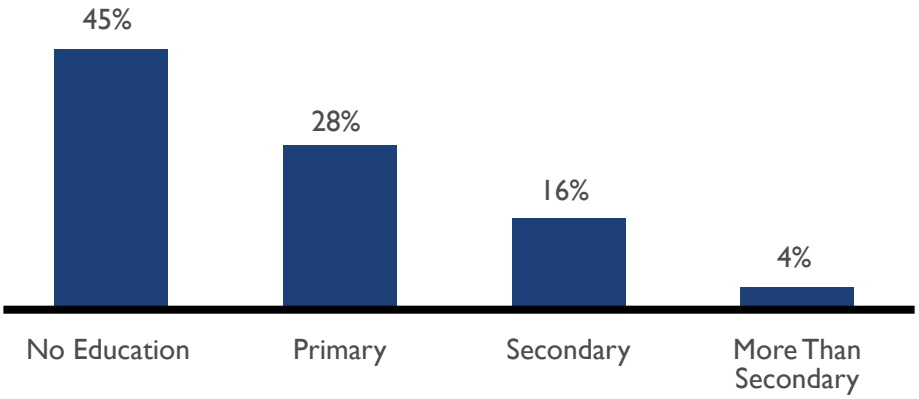


NSO, 2012. Malawi Integrated Household Survey 2011 - 2012

Evidence shows that the more educated a girl is, the more likely she is to use contraception; avoid unintended pregnancy (see accompanying graph); seek antenatal care, HIV counselling and testing and anti-retroviral treatment (ART); and thereby actively participate in productive livelihoods and/or community development activities. Access to comprehensive sexuality education (CSE), contraceptives and social protection initiatives such as cash transfers initiatives, availability of boarding facilities close to school, improving school sanitation, making schools gender-responsive, as well as community sensitisation on the benefits of female child education, can increase girls' chances of completing education. Hence this Strategy seeks to strengthen synergies and linkages with line ministries and other stakeholders for a robust and comprehensive YFHS programme.

Girls Ages 15 to 19 With No Education Are More Likely to Have Begun Childbearing

Percent of Girls 15 to 19 Who Have Begun Childbearing



Source: Malawi National Statistical Office and ICF Macro, 2010 Malawi Demographic and Health Survey (Calverton, MD: ICF Macro 2011) Table 4:8

Similarly, protecting those young girls and boys who proceed to tertiary education levels is equally important as youth of post-schooling age are likely to be experimenting and discovering themselves sexually and socially and may be prone to alcohol and drug use/abuse. Higher learning institutions have a role in developing professionals and citizens who are socially responsible and conscious of their contribution to the national development agenda of the country, including mitigating the impact of the HIV/AIDS pandemic[xxiii] and negative SRH outcomes. As such, SRH/HIV information and information on alcohol and drug use is imperative in tertiary institutions, as well as access to contraceptives, emergency contraception, STI services, HIV-related care, support, and treatment and gender literacy.

Table 3: Education Status of Youth

Indicator	Status	Source
Gross Enrolment Rate	• Primary School – 120% of children aged 6–13 years • Secondary School – 30% of children aged 14–17 years	IHS II 2010 – 2011
School Dropout Rate	• Overall 19% of girls due to teenage pregnancy. • 28% girls drop out of Standard 8 due to teenage pregnancies with less than 10% of young mothers being re-admitted into school. • 20% of girls drop out due to early marriages in primary and secondary school	EMIS 2013 MoFEPD 2013
Literacy rate	• 74% males aged 15 years and above • 57% female counterparts	IHS II 2010 – 2011

1.0.7 Social Protection

Women constitute about 52% of Malawi's population;[xxiv] however, girls continue to be susceptible to high levels of vulnerability, risk, and deprivation concerning SRHR/HIV-related issues. For example, in Malawi, more than three times as many females than males are HIV positive.[xxv] Gender-based sexual violence (GBSV) continues to mainly affect girls, with sexual abuse in Malawi often not reported due to gender disparities in homes.[xxvi] Social norms – including harmful cultural practices – and gender inequities result in males and females not participating equally in decisions about sex and sexuality or the use of contraception. This leads to unprotected sexual acts, unintended pregnancies, and STI and HIV infection. SRHR is an important issue that requires the input of both partners and can further aggravate gender disparities in health outcomes. High illiteracy and harmful cultural practices continue to put many girls in a disadvantaged position.

Intense gender-related attitudinal changes, especially among young boys (and the larger community), to initiate changes in perceptions are needed to break gender inequality and support girls' empowerment. Emulating and scaling up successful programmes such as the Gender Equality and Women Empowerment (GEWE)[5] project instituted by the Ministry of Gender, Children, Disability and Social Welfare (MoGCDSW) and stakeholders is an integral part of the YFHS programme. Likewise, access to community-based provision of SRH services including psychosocial counselling is necessary for the timely management of rape and associated traumatic experiences and support for those youth using alcohol and drugs. Inevitably, survivors of rape/abuse and young people living with HIV (YPLHIV) can be subjected to stigma and discrimination. Community approaches to deal with stigma and discrimination as well as gender equality are an important piece in health promotional talks and community systems strengthening interventions. With the projected growth in the proportion of youth in the population, there are major planning implications for integrated SRH/HIV and social services such as tailored support for the most vulnerable and at-risk youth, including orphans, youth with disabilities, key populations (e.g. married girls and sex workers) and those in hard-to-reach areas. Mental health services are essential for supporting social protection interventions to ensure healthy transitions to desired positive behaviours.

Table 4: Social Protection Issues Affecting Youth

Indicator	Status	Source
Child Marriage	• 19.5% girls and 1.9% boys 15– 19 years • Half of the women were married before their 19th birthday.	MDHS 2010
Abuse	• One in three children has been physical, mentally, or sexually abused. • 7.8% of girls and boys aged 18–24 have been sexually abused with 2.0% of this abuse being perpetrated prior to age 18 with less than a quarter of males and females aged 18 to 24 years knowing of a place to seek help about an experience of sexual violence.	VACS 2014 VACS 2013

[5] *GEWE aims to promote gender equality and women empowerment with support from state and non-state institutions to accelerate attainment of national development focusing on contribution towards efforts that advance gender equality and equity as a human right for the reduction of HIV and AIDS and poverty in line with the Malawi Growth and Development Strategy, the National Gender Policy and the future Gender Sector Wide Approach*

Indicator	Status	Source
Social Services	• 33.0% of girls 18–24 years reported getting pregnant as a result of unwanted completed sex.	VACS 2013
Drug and Alcohol Use	• 50% of the drug- and alcohol-related cases that come before the courts involve young people. • Hospital records at Zomba Mental Hospital show that of the 1,890 admissions received, 269 cases (14%) were a result of cannabis and alcohol and involved youth.	NYP 2013

1.0.8 Most Vulnerable Youth

Young people in Malawi meet many barriers in accessing YFHS including long distances to health facilities, long waiting and inconvenient opening times, poor attitudes of health workers towards youth, lack of privacy and confidentiality and lack of youth participation in the development of programs aimed at benefiting them. [xxvii] This challenge can no longer be ignored owing to the poor youth statistics cited, and, with the largest youth population of its time, the right investments must be made in SRHR for youth to transition into healthy and productive citizens.

All youth in Malawi should be able to access YFHS; however, youth-responsive programmes should recognise that some youth are more vulnerable than others (see box "Vulnerable Youth") and therefore deliberately modify services where necessary for inclusiveness.

Young girls: Malawi has one of the highest adolescent fertility rates in the sub-Saharan region: 143/1,000 live births with one in three adolescent girls having begun childbearing, one in four already having a child, and 9% currently pregnant. Likewise, unsafe abortion among young girls contributes 18%[xxvii] of maternal mortality, with the majority of sexually active adolescents having a high unmet need for modern contraception.[xxix] Whilst prevalence among youth is generally declining, females have a higher HIV prevalence than males (12.9% vs 8.1%), with the largest disparity being in the 15- to 19-year- old age group (3.7% in females and 0.4% males).[xxx] Increasing access to age-appropriate CSE, increasing awareness about YFHS, increasing access to contraception particularly LARCs, provision of safe youth spaces, and scaling up outreach YFHS are essential for reducing these statistics.

Married young girls: This sub-population is often forgotten with marriage being seen culturally as a protective factor from social stigma of unmarried teen mothers, STIs and HIV. However the vulnerability of this group is understated. They are in a position where many lack reproductive decision-making power, possess limited SRH/HIV information, lack access to any social network, and have limited mobility to visit services. The exposure to unprotected sex with older husbands, who may already have a history of multiple partners, places them at higher risk for STIs and HIV, and due to their age complications during pregnancy are numerous. All providers should be trained to understand the complexity of child marriage and how to work with married youth, acknowledging that most SRH decisions are made jointly by their spouse and/or their extended family. Messaging around delayed first births and spacing of births with emphasis on LARCs should be encouraged and post-partum family planning (FP) counselling should be enforced.

Teen mothers: Teen pregnancy gives rise to high rates of maternal morbidity and mortality, neonatal deaths, and post-natal complications for both mother and child and adds to school dropout rates. Social

stigma surrounding unmarried teen mothers is yet another barrier a young woman has to endure outside being able to access youth-friendly maternal health care. Provision of age-appropriate CSE from the primary school level and for out-of-school youth, increased school-linked and community FP services for access to contraception, especially LARCs, frequent outreach, and disbursement of bursaries are all necessary interventions to ensure that girls stay in school or return to school and complete their education and have a second chance to facilitate sustainable livelihoods.

YPLHIV: Advances in availability and effectiveness of ART mean that YPLHIV are growing into adulthood and have the potential to live long lives.[xxxi] YSRH is of particular importance during this time. Transition from paediatric to adult care, particularly for those young people born with HIV, demands that they are both well educated about HIV transmission and remain engaged with their health care regimen to guarantee adherence to medication and prevention of reinfection and transmitting HIV to sexual partners. Without this, YPLHIV can manifest in poor self-care. Living with a highly stigmatised chronic disease means they are concerned with disclosure of their HIV status to others, particularly romantic and sexual partners. Particularly at risk are young people living away from home (e.g., in boarding schools and tertiary institutions). Young females are at heightened risk for abusive reactions from male partners. Socio-behavioural change campaigns informing communities on HIV and AIDS, the importance of adherence to treatment, safer sex practices, provision of mental health care within communities to address YPLHIV needs, integrated SRH/HIV services, and school-linked or school-based SRH/HIV services are critical to ensure that YPLHIV are well integrated into everyday life. Promoting and including YPLHIV participation in the design and implementation of HIV prevention and treatment programmes is important for reduced risky behaviours and increased uptake and adherence to healthy choices.

Young boys 10–14 years: Gender-based violence (GBV) is an underlying thread of special importance to YFHS. Prescribed socio-cultural norms that encourage the demonstration of masculinity by expressing emotions through anger or violence can increase acts of GBV. This display of masculinity also has harmful effects on young boys. Violent sexual practices as well as limited or no condom use results in the higher risk of contracting STIs and HIV. These norms have profound negative health effects that disproportionately affect girls and young women, and as young women continue to have less power and status than young men, they are less able to access or advocate for what they need. Youth-responsive programmes need to be well equipped to integrate GBV screening, referrals, treatment and prevention. Investing in gender transformative programmes especially with young boys 10–14 years when they are at their most impressionable period can help reform harmful cultural norms and practices.

Key populations: Often young people with disabilities and young sex workers get lost in the wider programming of these key populations and do not receive adequate SRH care. However, it is important to recognise that these sub-groups need special programmes such as door-to-door services, inclusive education, and outreach, particularly for youth with disabilities, scheduling later hours for services, and promotion of alternative income-generating activities (IGAs) for sex workers outside the regular YFHS programming for general populations.

All the services mentioned are those provided under YFHS. Whilst it has been common place to identify HS as solely a health programme, the three-pronged approach, namely, health promotion, service delivery and referral, clearly cites collaborative efforts outside health. Issues such as education, social protection including gender, and youth participation rely heavily on other sectors to ensure that teen pregnancies, unsafe abortion, STI and HIV infection, and GBV are mitigated with health services available when preventive efforts fail. The YFHS Strategy seeks to encompass all these components governed through the national YFHS standards. This Strategy is focused on a providing a comprehensive youth-responsive YFHS programme for 10- to 24-year olds that offers:

- Strategic information geared towards adolescents;
- Supportive policies, such as the scale-up of outreach and creation of safe spaces for youth (see Annex 3, "Examples of Outreach Programs");
- Quality skill-based services such as referrals and provision of contraception. especially LARCs; and
- Strengthening other sectors in order to provide a multidisciplinary approach.

Adherence to standards through profiling extensive capacity building and monitoring of YFHS workers will enable scale-up of outreach with a high degree of efficiency, confidentiality, and accountability. This will allow for easing congestion of static facilities for more focused health care needs. It is vital that Malawian youth be provided with services that not only help them but teach them about what to avoid and to expect about risk behaviour. Investment in YFHS will protect the health and well-being of young people and equip them with the knowledge and skills needed to positively shape their families and communities and enable the start of an independent productive life necessary to positively engage in civil society and contribute to the social and economic development of Malawi.

1.0.9 Young People's Rights

Every young person is entitled to rights as enshrined in the Convention of the Rights of Children and the constitution of the Republic of Malawi, among others, as follows:

(a) Right to good health including sexual and reproductive health services;
(b) Right to quality education;
(c) Right to protection from sexual exploitation and gender-based violence, against child labour and neglect, etc.;
(d) Right to social and economic services;
(e) Right to participate in governance issues and in all decision-making processes relating to the welfare of the youth; and
(f) Right to gainful decent employment opportunities either in any sector on completion of formal or non-formal education and/or when entering the legal working age in the country.[xxxii]

Upholding these rights, this Strategy intends that youth will participate in the YFHS programme and have access to quality YFHS services that are safe, guard their right to privacy, ensure confidentiality, and provide respect and informed consent, while also respecting their cultural values and religious beliefs, to fully realise the potential of young people in Malawi. The Strategy describes the broad objectives and corresponding strategies that will ensure the realisation of healthy living and development of all young people – including YPLHIV and those with disability – aged 10 to 24 years in Malawi.

1.0.10 Critical Issues Facing Young People

- **Young women's vulnerability:** Lack of empowerment and decision-making power over their own sexuality and limited access to information and resources due to culture, coercion, socioeconomic status, etc., often result in early sexual debut, having sex against their will, and lack of self-confidence to seek out SRH information and services. This vulnerability contributes to high mortality and morbidity due to teenage pregnancy and unsafe abortion.

- **Limited knowledge and communication around sex including HIV among youth:** Youth have limited ability to communicate with peers, potential sex partners and adults on their SRH needs and often do not realise they are at risk. Adults in the community, health workers and teachers feel uncomfortable to discuss issues on sex, STIs and HIV with young people.

- **Poor educational status and GBSV:** These contribute significantly to school drop-out rates especially for girls leaving them vulnerable to child marriage, early childbearing, and STI/HIV infection and threaten mental health and development.

- **Reaching boys and young men to transform gender norms and ultimately society:** This is a cornerstone for prevention and essential interventions for healthy sexual behaviour, reduction of all forms of GBV, promotion of gender equality, and empowerment of young women to increase their contributions to Malawi's socio-economic advancement.

1.1 The Strategy Development Process

The development of the YFHS Strategy was initiated through the MoH Reproductive Health Directorate's (RHD's) comprehensive evaluation study of the YFHS programme based on the national standards criteria over the past six years. A multi-disciplinary Steering Committee provided overall guidance in the revision process, in conjunction with a highly participatory, consultative and ongoing transparent approach with the relevant stakeholders, including line ministries, development partners/donors, district-level staff, youth organisations, youth, community radios, print media, nongovernmental organisations (NGOs), and technical working groups (TWGs). The U.S. Agency for International Development (USAID)–funded Health Policy Project closely worked with the RHD to facilitate the development process and consolidate the Strategy document. Major components of the revision process included:

- Brainstorming of the Strategy priority areas and interventions during the national YFHS programme evaluation dissemination meeting.
- Mapping of youth SRHR programmes.
- Extensive literature review.
- Individual stakeholder meetings with key line ministries, developmental partners, donor agencies, and non-state actors for insight on future policy direction and clarification of existing programs.
- A national consensus building meeting to review a zero draft and prioritise areas for revision.
- A national consensus building writing workshop held with a cross-section of line ministries, academic institutions, NGOs, and youth to develop the first draft of the Strategy including a monitoring and evaluation (M&E) framework.
- Three regional stakeholders' consultation meetings in the Northern, Central, and Southern regions including district-level staff across sectors, youth organisations, NGOs, media, religious bodies, and parents to review the first draft.
- A final national consensus building meeting, including delegates of all coordinating institutions identified in the document, to ensure that all recommendations were ably covered and to suggest broad activities.
- Finalising process in which the Steering Committee enabled additional input from YFHS and FP sub-committee members and the MoH-RHD prior to a costing exercise, which was then presented to the SRHR TWG and MoH senior management team for final approval.

Youth and youth organisations were actively involved in the revision process from initiation to completion with young people attending the various meetings and workshops. Wider youth input was obtained through youth-led community radio stations (Ndzimwe, Nkhotakota, and YONECO) that engaged district-level youth through call-in programmes and interviews. Special weekly radio bulletins also encouraged further feedback, ensuring that a diverse range of youth voices was actively reflected in the Strategy revision.

1.2 Vision, Goal & Objectives

1.2.1 Vision

"Healthy, satisfied, and productive young people."

1.2.2 Mission

"To provide quality comprehensive integrated YFHS that are relevant, available, affordable, acceptable, accessible, and appropriate by all young people 10 to 24 years old."

1.2.3 Goal

The goal of the Strategy is to increase knowledge and improve awareness, access and utilisation of YFHS for all young people aged 10 to 24 years.

1.2.4 Strategic Objectives

The Strategic Objectives contribute towards achieving a reduction in the overall SRH indicators (see box "Overarching Indicators") poised to encourage healthy living and a generation free from chronic conditions. The five Strategic Objectives are to:

1. Enhance the enabling environment for planning, programming and delivery of YFHS information and services to young people.
2. Increase adherence to national standards on YFHS in service delivery, improve access to comprehensive age-appropriate sexual and reproductive health (YFHS) information and promote utilisation of quality services by young people through informed choice.
3. Strengthen ownership, coordination and collaboration among MOH-RHD, other line ministries, district structures, and key stakeholders at the national and district level, including community leaders and young people.
4. Mobilise parents, community leaders and young people to actively advocate and support YFHS uptake.
5. Mobilise resources to adequately support the effective management and implementation of the national YFHS programme

OVERARCHING INDICATORS

1. Contraceptive prevalence rate among 15–24-year-olds (Source: DHIS II, MDHS)
2. HIV prevalence rate 10–24-year-olds (Source: MDHS)
3. Percentage of teenage pregnancies (Source: DHIS II, MDHS)
4. Percentage of schools, teacher training institutions providing CSE (Source: ESA report)
5. Access to YFHS (Source: DHIS II)

1.2.5 Guiding Principles

The guiding principles, inspired by previous national standards and strategies, ensure quality, accessible services to all youth. These include:

- Recognising the diversity of youth: The socio-economic and cultural environment shapes adolescent SRH, thus requiring tailored youth interventions according to sex, age, gender identify, education, and marital and socio-economic status, with special attention required for vulnerable young adolescents ages 10 to 14 years, young married girls, YPLHIV, and youth with disabilities.

- Human rights and equity: All youth shall have access to health information and services without distinction of age, sex, ethnicity, disability, religion, political belief, economic, social condition or geographical location to the full extent of the laws of Malawi. The rights of health care users and their families, providers, and support staff are to be respected and protected.
- Gender sensitivity and cultural acceptability: Gender issues shall be mainstreamed in the planning and implementation of all YFHS programmes, which are an important determinant of access to social services and opportunities.
- Ethical considerations: Provision of YFHS by trained health worker and community volunteers with adherence to: confidentiality, safety, and efficacy.
- Active youth and community participation: Active participation of youth, community, and traditional leadership to be promoted during the planning, implementation and monitoring of YFHS, according to their level of capacity.
- An investment approach: Interventions shall be evidence-based, specific, measurable, and cost-effective. Scale-up of best practices shall be implemented after sufficient age-disaggregated documentation and analysis. All health care providers shall use health care technologies that are appropriate, relevant and cost effective.
- Decentralisation and accountability: Health services management and provision shall be in line with the Local Government Act of 1998 which entails devolving health service delivery to local assemblies. All stakeholders shall discharge their respective mandates in a manner that takes full responsibility for the decisions made in the course of providing health care.
- Multi-sectoral integrated approach: Public-private partnership (PPP) and multi-sectoral collaboration shall be encouraged and strengthened for the provision of integrated YSRHR services to address the determinants of health. All stakeholders shall use available YFHS resources efficiently to maximise gains.

Chapter 2: Implementation Strategies

2.0 Strategies for Specific YFHS Priority Areas

The strategies outlined in this section are supported by the M&E Framework (see Annex 4). The M&E Framework provides all related indicators for the strategies outlined.

2.1 Priority Area 1: Policy

Broad Objective: Enhance the enabling environment for planning, programming and delivery of YFHS information and services to young people.

Specific Objective 1: To ensure that policies, laws and strategies targeting youth are up to date, harmonised and enforced in line with relevant international and national frameworks

Strategy 1: Advocate with policy makers and traditional leaders and faith-based leaders for policy and legal reforms.

Implementation of policies that prioritise and promote YSRHR has been challenging because of: (a) conflicting messaging across policy documents and guidelines on who can access information and services and where, when, and how and (b) limited dissemination of information and services to the district and grassroots level. Harmonisation of all policy and strategic documents is needed.

Key Activities:

(i) Review policies and regulatory mechanisms to ensure they facilitate universal and equitable access to CSE, SRHR information, contraception and services for youth.

(ii) Advocate for harmonisation and enforcement of relevant laws for support of YSRHR across sectors, especially as they relate to underserved and hard-to-reach populations.

Specific Objective 2: To increase awareness of existing policies, laws and strategies among health workers, community leaders, parents and guardians, teachers, youth and other key stakeholders

Strategy 1: Disseminate existing policies, laws, and strategies.

All stakeholders shall be informed of existing polices for YFHS delivery as well as emerging trends and directives. Low literacy levels in Malawi, especially amongst youth and girls in particular, shall be accommodated.

Key Activities:

(i) Repackage policy and law information to suit various audiences.

(ii) Sensitise leaders at all levels, especially local ones, on all SRH policies, strategies, national YFHS standards, and guidelines.

(iii) Engage the media and innovative technology to inform all sub-population groups.

Strategy 2: Advocate and promote multi-sectoral linkages for integrated interventions

YFHS in Malawi is delivered in a three-pronged approach: provision of information, services, and referral, in which different sectors play important roles. All sectors need to identify cost-efficient and effective ways to deliver and monitor these services and work in harmony without conflicting policy barriers.

Key Activities:

(i) Enhance the capacity of YFHS programme managers to engage relevant departments, individuals, and institutions during national and district development planning, including implementing youth participation strategies.

(ii) Include relevant partners (MoH-related departments, line ministries, private sector, traditional leaders, etc.) to existing platforms, i.e., TWGs, sector working groups, Sub-Technical committees for increased YFHS partnerships among stakeholders.

(iii) Lobby SRHR donors for multi-sectoral funding of programmes.

2.2 Priority Area 2: Service Delivery

Broad Objective: Increase adherence to national standards on YFHS in service delivery and access to comprehensive age-appropriate sexual reproductive health (YFHS) information and utilization of quality services by young people through informed choice.

Specific Objective 1: To enhance capacity of service providers and implementing partners to deliver quality YFHS

Strategy 1: Strengthen the capacity of health facility youth-friendly service providers, youth community-based distribution agents (YCBDAs), health surveillance agents (HSAs), and peer educators in the provision of the minimum package of YFHS, including GBV.

Engagement of multiple sectors of society will enable stakeholders to leverage knowledge, expertise, reach and resources, allowing each entity to do what it does best in working towards the common shared goal of producing better health outcomes for the youth of Malawi. Inevitably, this will require taking stock of available resources and identifying the possible vacancies or strengthening skills sets expected for YFHS delivery. All YFHS providers need to be aware of the YFHS standards to ably implement the minimum package and deliver quality and efficient services. All providers outside the YFHS programme should be able to deliver services in a youth-friendly manner when interacting with young people.

Key Activities:

(i) Conduct a comprehensive capacity audit for the YFHS programme including M&E across sectors.

(ii) Provide on-the-job training to the different cadres including community health workers as a means of scaling up quality YFHS delivery, especially in hard-to-reach populations.

(iii) Regularly update YFHS training manuals.

(iv) Include YFHS standards as key competencies to be attained during pre-service trainings (practicums).

(v) Document and scale up in-service/on-the-job training approaches for service providers at all levels.

(vi) Develop the capacity of staff in referral centres including those in communities to receive and promptly manage the referrals including GBSV and LARCs.

(vii) Develop capacity of YFHS providers at all levels for delivery of prevention and treatment/counselling for alcohol-attributable conditions and HIV and AIDS.

(viii) Increase the number of YFHS Master Trainers at district level to provide decentralised YFHS training for providers within and outside the YFHS programme.

Strategy 2: Provide supportive supervision to health facilities and YFHS service providers to continually adhere to the YFHS standards in service provision and accreditation.

The YFHS Evaluation (2014) cites that health facilities are meeting varied criteria of the national standards. Supportive supervision and regular monitoring of YFHS sites and alternative spaces should be a priority with the aim of improved provider attitudes, standards of operation/quality, and invariably full accreditation of YFHS sites.

Key Activities:

(i) On-the-job mentorship.

(ii) MoH to provide timely supervision findings/feedback to YFHS service providers and managers at district and community levels for quality performance control/efficient quality improvement.

(iii) Partners to support MoH to annually accredit YFHS sites based on provision of YFHS standards (minimum package).

(iv) Disseminate YFHS SRH/HIV/FP clinical guidelines and procedures and ensure that these are posted publicly and visibly at all facilities.

(v) Conduct periodic facility assessment to identify the infrastructure and maintenance requirements and supply needs for the provision of YFHS at all levels.

(vi) Promote the use of innovative client/provider feedback appropriate technologies by YFHS providers at all levels for targeted client responsive interventions.

Specific Objective 2: To increase access and utilisation of age-appropriate YFHS among young people through informed choice

Strategy 1: Integrate YFHS into other outreach services and increase service delivery points.

YFHS comprises SRHR/HIV education and related services that have been largely limited to static sites and provided in an individualistic – almost blanket-like – manner, often times requiring repeat visits for specific services. The diversity of youth and different stages of adolescence requires that each sub-population receives information and services that are commensurate with their age and stages of development whilst meeting the goal of healthy choices by young people. Integrated YFHS represents a way of working with diverse partners and involves enhanced collaboration among organisations, authorities and sectors that meets all the unique pressing needs and tailored demands of the large growing numbers of youth and sub-populations. Integration also allows for multiple services in one sitting, cutting down on time spent visiting sites. With 85% of the population living in rural areas, meeting those in need of YFHS can be best catered to by bringing services nearer to the youth and providing YFHS in an integrated manner to ensure age-appropriate information and services across sectors. Outreach should ideally be done at the locations where young people congregate.

Outreach services will enable youth to receive information and services in the most appropriate setting possible, determined by their preference and services needed, as well as ease congestion in health institutions and avoid losing youth as they shift between rooms to attain varied services. Having integrated services closer in the community can increase utilisation of YFHS by youth, particularly those in hard-to-reach areas, key populations, and vulnerable and marginalised or otherwise "shy" youth, due to the

integrated service delivery of other programmes such as skills building and environment activities linked to the population, health and environment approach.

Key Activities:

(i) Clearly brand YFHS sites and outreach campsites/mobile clinics to enable youth to quickly identify where to obtain services.

(ii) Inform adolescents on how to access outreach services and find the information they need through community events, radio adverts and listener clubs, and mHealth platforms.

(iii) Increase role of social marketing organisations and private sector to expand service delivery points (SDPs) to hard-to-reach areas for the provision of information and SRH/HIV services.

(iv) Equip mobile outreach teams to deliver YFHS including drug and alcohol information and counselling within their normal routine visits to communities.

(v) Partner with pharmacies to provide YFHS-branded information on age-appropriate SRH/HIV and general health information.

(vi) Promote initiatives reaching out to out-of-school youths with YFHS information, education, communications (IEC) and integrated behavioural change communications (BCC) interventions.

(vii) Promote partnerships and coordination with other stakeholders (NGOs, faith-based organisations [FBOs], private sector) to provide YFHS outreach.

(i) Provide services in an integrated manner to ensure there is no stigma associated with accessing a specific service.

Strategy 2: Establish and strengthen safe spaces for young people for recreation, information, services and referral.

Health centres still remain a popular point of access of YFHS among young people despite the barriers cited previously. Providing health centres with discrete spaces (i.e., building a separate space or refurbishing an existing room), complete with skilled staff, equipment, and commodities, can ensure that YFHS are delivered in accordance to the YFHS standards. Such spaces do not have to be limited to health centres. Expanding YFHS through identifying alternative spaces such as strengthening capacity of existing youth clubs and development centres will increase the spaces where youth can meet safely and where tailored services are offered, particularly for vulnerable groups. These spaces should be equipped to provide YFHS with tailored services, i.e., information on SRHR and drug and alcohol abuse, livelihood skills development for IGAs, and sports-coupled non-clinical services (e.g., condom and oral contraception distribution disaggregated by age disaggregated by age and sex). This can be done alongside complementary programs such as mobile clinics, which can provide LARCS, counselling for drug and alcohol users, and referral particularly in locations where access to health centres is limited. These spaces will also serve as conduits for information on healthy living, nutrition, and common ailments affecting youth such as malaria. Utilising the standard outline for youth centres developed by the Ministry of Youth and Sports Development (MoYSD), National Youth Council of Malawi (NYCOM), and UNICEF, partners can ensure that these centres/spaces provide the necessary equipment and services to provide quality YFHS. With partners working together to provide various components of YFHS, the integrated care team will link youth to specialty services fitting their age in their area and enhance communication and coordination between medical and behavioural health care, which will lead to high-quality YFHS care.

Key Activities:

(i) Utilise the MoYSD, NYCOM, and UNICEF checklist/requirements necessary for the establishment and/or refurbishment youth drop-in centres to all youth organisations/clubs.

(ii) Utilise existing youth organisations/clubs to provide non-clinical services (information on SRH/HIV, drug and alcohol use and abuse, nutrition, general health, e.g., malaria prevention and provision of condoms), livelihood skills development, psychosocial support, and referral.

(iii) Conduct workshops with youth organisations and adolescent clubs to provide general and targeted information on SRHR/HIV and drugs and alcohol.

(iv) Utilise the peer-to-peer approach to provide youth with IGA skills at drop-in centres as one way of mitigating vulnerabilities to SRH/HIV.

(v) Utilise mass media and mHealth to popularise YFHS safe spaces.

(vi) Train peer educators in demand creation and SRH advocacy, including information on LARCS, and referral for services.

Strategy 3: Strengthen coverage and utilisation of HIV prevention, care, and treatment services among youth, especially young adolescents (10–14 years) and teen mothers.

SRH is of particular importance for YPLHIV, for not only are they living with HIV and trying to navigate life with HIV, but they are experiencing the same physical and emotional issues that other adolescents and young adults face. Stigma and discrimination towards YPLHIV is still rife in schools, health facilities, and communities in Malawi. The MANET+ 2014 reports states that YPLHIV encounter poor provision of services due to hostile attitudes from health staff, long queues when accessing ART (making them miss school), and breaches of confidentiality. At school, youth who disclose their serostatus become living examples among other learners. This underpins gross violations of the SRHR of young people. While both men and women experience stigma and discrimination, such attitudes are stronger towards women and girls who are often seen as 'vectors' of the disease. These perceptions present great barriers to young women living with HIV, especially disclosing their status to an intimate partner for fear of abandonment and violence. Overall, lack of disclosure can lead to low and inconsistent use of condoms during sex, delayed access to PMTCT, lack of adherence to ART, and eventually evidently further spread of the virus.

YPLHIV have unique health and psychosocial support needs that should be addressed. Actively engaging and supporting YPLHIV within the YFHS programme is key to ensuring reversal of the spread of the virus, realising human rights, and achieving universal access targets. Unless the needs of young positives are adequately addressed, the aim of achieving the three zeros will remain elusive. Prioritising the provision of ART to young positives, services that support their adherence to their life-saving treatment, and psychosocial support is imperative for the implementation of other HIV prevention and mitigation programmes aimed at youth.

Key Activities:

(i) Conduct youth-oriented social mobilisation campaigns to promote AIDS-related rights and eliminate HIV-associated stigma.

(ii) Increase the awareness and knowledge of vulnerable adolescents of SRH, abstinence, safe sex, sexuality and HIV/STI prevention in a wholesome environment.

(iii) Equip teen clubs[6] with SRH/HIV information to enable provision of preventive and psychosocial support services using the Teen Clubs model run by Baylor Clinics.

(iv) Engage the National Association of YPLHIV to advocate and champion comprehensive SRHR/HIV information and comprehensive condom programming and LARCs for YPHIV.

(v) Reduce stigma and discrimination against persons living with or affected by HIV and AIDS through advocacy and public education.

[6] *Teen clubs are specifically targeted to YPLHIV and are attached to the hospitals and differ from adolescent clubs, which are attached toschools or stand-alone targeting all youth.*

(vi) Re-invigorate AIDS Toto Clubs in schools to engage pupils in discussion and activities on HIV prevention, care, treatment (including adherence), stigma and discrimination, and general mental health (e.g., counselling).

(vii) Popularise PMTCT among young people and parents to reduce new infections for pregnant YPLHIV.

Strategy 4: Strengthen coverage and utilisation of contraceptives among 15–24 age group (young married couples and sexually active youth).

Adolescent birth rates are declining steadily from 193/1,000 births per women in 2010[xxxvii] to 143/1,000 live births per woman (2014);[xxxviii] however Malawi's still remain the highest in sub-Saharan Africa. Teenage pregnancy persistently leads to girls' failure to complete education, which is detrimental to both the development and economy of the country.[xxxix] More than one in five adolescent girls have begun bearing children by age 17.[xl] Early childbearing is a major health concern because of the increased risks of death and disability to both mother and child during pregnancy and childbirth. Use of contraception is low among sexually active 15- to-19-year-olds, especially among married girls. Fewer than one in three unmarried girls and two in five boys are using a modern method of contraception.[xli] Adolescent girls ages 15 to 19 prefer to have about two children fewer than their parents' generation. Providing women with the ability to plan their pregnancies leads to healthier outcomes for women, children, and families.[xlii] LARCs (IUDs and implants) are ideal for young women – married and unmarried – who wish to delay or space pregnancy. LARCs require little effort on the part of the user once inserted and are highly effective (less than 1% will experience unintended pregnancy), cost-effective, and safe for most women.[xliii]

Key Activities:

(i) Utilise all girls clubs to provide information on contraception, especially LARCs and referral.

(ii) Intensify messaging on the benefits of LARCs for young girls to dispel myths during community events, outreach promotion, and media.

(iii) Empower YFHS health workers at all levels, pharmacies, youth clubs/organisations, and NGOs to provide correct information on contraception and referral for LARCs.

(iv) Train providers in the insertion of LARCs in accordance with clinical guidelines.

(v) Provide monthly mobile outreach clinics to hard-to-reach areas for increased access to LARCs and other contraception methods.

Specific Objective 3: To increase access to comprehensive age-appropriate sexual and reproductive health information (CSE)

Strategy 1: Advocate for inclusion of age-appropriate CSE into the primary school curriculum.

Strategy 2: Harmonise CSE curriculum for out-of-school youth.

CSE is important for all youth – those in school, those out of school. Curricula developed for in-school youth should be age-appropriate and standardised for all these youth and supported by access to contraceptives through different service delivery models. Curricula developed for out-of-school youth must be aligned to that being used in schools and cognisant of the varying literacy levels of this sub-population. The current Education Policy (2014) allows CSE to be taught in the third year of secondary school (Form 3), roughly equivalent to pupils being 15 years of age. Life skills education is taught in the lower levels. However, high attrition rates between primary and secondary school result in fewer numbers of adolescents reaching the third year of secondary school.[xliv] Likewise, high repetition rates and late school starters result in

primary school pupils being much older than the recommended age. The Education Policy also prohibits the provision of contraceptives on school premises (except tertiary establishments), although access to these services is permitted 100 meters or further from the institutions. Evidence-based approaches to CSE show that the most effective programs cover a variety of SRH topics in an age-appropriate manner over several years. As such, introducing relevant and tailored CSE to primary and lower secondary school pupils and ensuring that the out-of-school curricula model those being taught in schools is essential. CSE in schools should also be complemented/coordinated with mobile and school-linked and outreach services. This will support the behaviour change messages delivered through CSE for youth that are in and out of school and guarantee a standardised equitable approach in the provision of information on SRHR and access to services.

Key Activities:

(i) Partners to lobby Ministry of Education, Science and Technology (MoEST) to include CSE from primary school level.

(ii) Partners to support Teachers Union of Malawi (TUM) and parents/communities to advocate for age-appropriate CSE to be introduced in primary schools.

(iii) Scale up "The World Starts with Me" programme in all teachers training colleges and technical colleges.

(iv) Establish routine school-linked YFHS for in-school SRH services at both primary and secondary school levels.

(v) Harmonise and implement comprehensive age-appropriate sexuality education for out-of-school youth, especially for 10 - to 14-year-olds.

(vi) Scale up orientation of teachers, parent-teacher associations (PTAs), and peer educators to deliver life skills and CSE.

Strategy 3: Strengthen the capacity, systems and structures of all tertiary clinics to provide integrated SHR/FP/HIV information and services

College students often reside away from their families and are likely to form intimate relationships. SRH information and services are critical to tertiary students to ensure that they have a safe sexual lifestyle; to reduce incidence of GBV; and for those who are YPLHIV to maintain their adherence to treatment.

Key Activities:

(i) Provide access to comprehensive SRH/HIV prevention programmes for students at all tertiary institutions through a well-designed SBCC programme addressing the main drivers of SRHR, HIV and AIDS, gender inequalities, alcohol and substance abuse, and elimination of HIV-related stigma and discrimination.

(ii) Equip all tertiary institution clinics in the delivery of YFHS including comprehensive SRHR and contraceptives counselling, psychosocial counselling, and commodity security.

(iii) Identify tertiary students per institution to train as interpersonal agents/YCBDAs to provide contraceptives where possible.

Strategy 4: Develop and implement gender-sensitive and age-appropriate YFHS SBCC campaigns at national, district and community levels

Communities, local leaders, parents, and family members are key influencers on cultural beliefs, practices, and values, particularly as they pertain to SRHR including HIV, stigma and discrimination, girl child education, and empowerment of women. Increasing the general community's knowledge at all levels and acceptance of youth access to SRH information and services is central to encouraging socio-cultural change and ultimately improved youth SRH outcomes. Comprehensive advocacy to these groups, particularly men,

is needed. Special attention should be placed on reaching young adolescents (10 to 14 years) with more positive socio-cultural norm messages, recognising that at this age boys and girls learn attitudes and behaviours that become more fixed in later years. The YFHS should include young married men and other male gatekeepers, owing to their decision-making power over daughters and young wives.

Key Activities:

(i) Promote community-driven research to inform creation of appropriate gender-sensitive messages.

(ii) Carry out SBCC activities to promote an understanding of positive gender relations and the obstacles to girls' active participation in SRH and use of available services at national, district, and community levels.

(iii) Conduct workshops with boys aged 10 to 14 years on informing and transforming gender norms and attitudes in urban, peri-urban, and community settings.

(iv) Conduct orientation meetings on SRH/HIV and gender equality with community providers, youth, parents, and guardians to build champions for YFHS.

(v) Utilise community-based participatory learning approaches to sensitise communities in urban, peri urban, and community settings on how modifying harmful gender norms can improve equity, SRH outcomes, and HIV prevention, care, and treatment, and reduce drug and alcohol abuse among young people.

(vi) Conduct workshops or camps to teach adolescents in urban, peri-urban, and community settings on how to protect themselves from exploitation and how not to exploit others.

2.3 Priority Area 3: Coordination and Collaboration

Specific Objective 1: To strengthen coordination structures at all levels

Strategy 1: Enhance the capacity of coordination structures at national, district, and community levels.

YFHS is delivered through a multi-sectoral approach to ably fulfil the YFHS national standards and provide the minimum package. Currently there is a fragmented approach and limited harmonisation among all partners which does not maximise the potential of meeting national health and development outcomes for youth. Increasing understanding of the YFHS programme at all levels and among all coordinating structures and existing related health programmes targeting youth, e.g., malaria, nutrition, human papilloma virus (HPV), and especially among youth-serving organisations/structures can serve to develop a supportive attitude about YSRHR. Improved coordination will garner the much needed commitment and contribute to a greater sense of service integration, cohesion, and solidarity for effective collaboration and a robust YFHS programme.

Key Activities:

(i) Promote joint planning, training, and resource mobilisation for integrated YFHS implementation and monitoring at all levels.

(ii) Support inter-departmental collaboration between the district health office (DHO), key line ministries, and district structures.

(iii) Identify platforms for coordination mechanisms for key line ministries at the national level to effectively execute the implementation of the YFHS regulatory instruments (policies, strategies, guidelines, and laws) for quality coordinated delivery and reporting.

(iv) Provide tools to support programming and collaboration between the YFHS coordinator, FP coordinator, and district youth officer (DYO) for implementation of SRHR activities.

Specific Objective 2: To strengthen the M&E system of the YFHS program

Strategy 1: Build capacity of staff to ensure implementation of M&E systems at all levels.

Strategy 2: Strengthen capacity of YFHS coordinators in M&E.

Strategy 3: Strengthen capacity for data utilisation at all levels.

Malawi's District Health Information System (DHIS) II, Health Management Information System (HMIS), Education Management Information System (EMIS), Youth and Sports Management Information System (YoSMIS), Gender Management Information System (GMIS) and other national M&E systems do not adequately disaggregate youth indicators by age, sex, school, marital, residence, education. YFHS-related data need to be instituted and integrated with these databases. Systematic review, harmonisation, and monitoring of YFHS is vital for this Strategy in order to meet the information needs of various stakeholders at all levels. Of importance is to ensure a feedback mechanism from all SDPs to the mainstream M&E databanks expected to promote evidence-based decision making at all levels involving several stakeholders. All relevant cadres responsible for data should be adequately trained and equipped to collect and input this data into the required databanks as well as be able to interpret and utilise this data in different formats.

Key Activities:

(i) Update and harmonise YFHS indicators in the DHIS II, YoSMIS, EMIS, and GMIS to ably track the impact of the YFHS programme.

(ii) Train YFHS coordinators, DYOs and other technical staff on accessing, appraising, analysing and utilising data.

(iii) Improve information and communications technology (ICT) access by YFHS coordinators and DYOs for real-time data capturing.

(iv) Implement and regularly update M&E plans at all levels.

(v) Support the implementation of quality assurance YFHS tools and other quality improvement tools at all levels.

(vi) Document the YFHS integrated approach.

(vii) Support repackaging of information from the different sources (research, routine health information, M&E systems, etc.) to various audiences.

(viii) Jointly monitor and review YFHS data across sectors.

Specific Objective 3: To ensure meaningful participation of young people in the coordination and implementation of the YFHS programme

Strategy 1: Strengthen capacity of SRH youth leaders from youth clubs and organisations to participate in planning, implementation and coordination of YFHS.

Strategy 2: Increase meaningful youth leadership in all coordination structures.

Strategy 3: Empower young people for peer advocacy on YFHS

The growing numbers of youth associations is an opportunity to increase active participation and leadership of youth in roles of designing SRHR policies, programmes, and interventions at all levels. Involving them in the YFHS coordination mechanism will ensure the voices of youth are included in the programming. Promoting youth participation in the different priority areas, trainings, and the design and implementation of YFHS interventions will strengthen youth leadership in the YFHS programme and ultimately improve YFHS so that it is more responsive to youth needs. Youth participation will amplify the peer-to-peer approach and ultimately strengthen youth clubs and reach the most marginalised and vulnerable groups such as YPLHIV, sex workers, and disabled youth.

Key Activities:

(i) Train district youth networks in youth leadership, project management, and advocacy to increase the number of youth leaders/advocates for YFHS.

(ii) Promote the incorporation of youth leadership into other development programs targeting young people.

(iii) Conduct periodic interface meetings/open days/business fairs between youth organisations and NGOs/FBOs to raise the profile of youth organisations for sustainable partnerships.

(iv) Implement a youth SRH leader's mentorship program.

(v) Orient youth leaders from youth clubs and organisations on the YFHS programme, standards, M&E tools and expected roles.

(vi) Convene annual best practice forums on YFHS.

(vii) Include YFHS as an agenda item in related SRHR best practice forums across sectors.

2.4 Priority Area 4: Mobilisation of Young People and Communities

Broad Objective: Mobilise parents, community leaders and young people to actively advocate for and support YFHS uptake.

Specific Objective 1: To raise awareness of the YFHS programme among parents, community leaders and young people

Strategy 1: Strengthen demand creation and community mobilisation for YFHS.

Only 31.7% (one-third) of young people have heard of YFHS and 13% have ever accessed services, with communities and parents cited as barriers to access.[xlv] With the adolescent fertility rate at 143 per 1,000 live births, [xlvi] unmet need at 19%, and over half of new HIV infections occurring among young people annually, there is an urgent need to intensify awareness of and access to YFHS. Given low literacy levels and limited access to higher formal education, promotion of healthy SRHR behaviour needs to take place through an array of multi-media channels including the radio, TV, internet, mobile phones, and community members. There need to be clear tailored messages that should convey delaying sexual debut and abstinence; prevention of pregnancy and HIV/STIs including consistent condom use and hormonal contraception for dual protection; reduced numbers of sexual partners; addressing risk perception, myths and misconceptions; encouraging HIV testing and counselling; and nutrition, among other topics within the YFHS package. Engaging youth and youth-serving organisations at all levels to develop and disseminate appropriate IEC materials will ensure that messages are indeed youth-friendly, recognising that young people know best on how to communicate with each other.

Key Activities:

(i) Develop and implement a national communication strategy for the YFHS programme.

(ii) Implement YFHS SBCC campaigns at community level to rebrand and popularise the YFHS programme.

(iii) Develop a youth SRH website with key information and questions-and-answer section and support this with mobile technologies such as mHealth, eHealth, and SMS interventions as being used by Population Services International (PSI).

(iv) Utilise social media to popularise YFHS.

(v) Conduct youth mega-shows at regional and district levels on SRH/HIV to increase demand of YFHS.

(vi) Orient mass media, including youth and community radio stations to YFHS to demystify YFHS.

(vii) Support existing radio youth and community listener clubs to review/discuss SRHR issues.

(viii) Conduct community SBCC on YSRHR including HIV prevention and ART adherence including knowledge of rights and responsibilities by both youth and service providers.

(ix) Empower girls with information on SRHR/HIV to develop self-efficacy.

(x) Utilise champions to engage mother groups, traditional leaders, and community committees on YFHS.

Strategy 2: Strengthen capacity of child protection officers, health advisory committees, community village action groups and community victim support units (CVSUs) as key components/contributors to YFHS.

Social isolation and poverty have been associated with increased risks of sexual violence. Increasing protective factors in communities is essential for reducing social isolation of marginalised and vulnerable groups. Linking appropriately trained and efficient social safety nets and networks (e.g., community protection officers, CVSUs, social welfare officers, and health facilities) established by all stakeholders to the youth and the community will enhance visibility and maximum use of various referral systems available within each community.

Key Activities:

(i) Create safe and supportive environments that offer protection for youth.

(ii) Promote child protective services and provide spaces at health centres and within communities for psychosocial services.

(iii) Implement social cash transfers programmes to mitigate otherwise risky behaviours.

(iv) Orient and establish linkages between child protection officers, health advisory committees, community village action committees, and CVSUs on YFHS protocols and packages.

Strategy 3: Increase participation of community structures to participate in administering the YFHS package by partners.

Strategy 4: Develop a specific and relevant information package for cultural initiators.[7]

Social, cultural, and economic factors strongly influence young people's ability to access SRH/HIV information and services. Communities have been commonly cited by the youth as one of the barriers to accessing YFHS.[xlvii] To improve young people's SRH, therefore, this Strategy fully acknowledges that community and families significantly influence youth. Involving communities and cultural initiators in public discussions concerning YFHS will engender more thoughtfulness about the programme and its priorities for a more complete understanding of YFHS real interests and remove the myths and misconceptions surrounding the programme. This will provide an additional resource and conduit of SRHR information from within the community and accumulate acceptance of the YFHS programme.

Key Activities:

(i) Orient community-based organisations (CBOs) and YFHS community workers across sectors on YFHS standards, community organisation and information systems, behaviour change communication, youth participation, HIV prevention and adherence to ART, and YHFS for early recognition of SRH, GBV complications and early referral (transfer).

[7] *Cultural initiators are persons selected by the community to educate youth on their expected social roles during initiation ceremonies. Attendees of these cultural practices are young girls and boys who come of age usually on the onset of menarche or pre-adolescents. Initiates can be as young as 10 years of age.*

(ii) Train cultural initiators on specialised skills to effectively address SRHR and HIV.

(iii) Sensitise district health management teams (DHMTs) and other health advisory committees, on YSRHR.

(iv) Support mechanisms for civic action by communities relating to SRHR, i.e., formulating bylaws and monitoring enforcement.

(v) Expand linkages (interface) between health facilities and communities through effective decentralisation and partnership.

Strategy 5: Support PTAs, school management committees (SMCs), mother groups, and school clubs to support YFHS.

Strategy: 6: Advocate with young people, guardians, teachers and communities to develop positive attitude towards YFHS

Youth have repeatedly cited parents to be the best source of SRHR information; however, parents often shy away from this responsibility.[xlviii] Increasing YSHR knowledge (physiological and psychosocial) and age-appropriate communication skills with parents, PTAs, SMCs, and mother groups could provide the confidence to these key groups to provide credible SRH/HIV information to youth.

Key Activities:

(i) Sensitise communities on their roles in encouraging safer SRH practices among all youth sub-populations.

(ii) Increase "parent to child" dialogue platforms using the Youth Net and Counselling (YONECO) model.

(iii) Work with religious organisations to promote this inter-generational dialogue.

(iv) Orient chairpersons of PTAs and mother groups and school club patrons on SRH/HIV and YFHS.

(v) Support parenting conferences annually similar to those being held by YONECO.

(vi) Identify champions from within the PTAs, SMCs, and the community to encourage parent-to-parent dialogues on SRH/HIV to identify and share best practices on communicating with youth.

(vii) Reduce stigma and discrimination against persons living with or affected by HIV and AIDS through advocacy and public education.

(viii) Inform young people, guardians, teachers, and communities on YFHS programmes, procedures, and standards as a means to encourage positive attitudes towards YFHS.

2.5 Priority Area 5: Resource Mobilisation

Broad Objective: Mobilise resources to adequately support the effective management of the national YFHS programme.

Specific Objective 1: To ensure availability of human, financial, and material resources for the implementation of the YFHS programme

Strategy 1: Develop and implement a government-led resource mobilisation strategy for the YFHS programme.

Youth programmes have not, in the past, attracted large sums of funding for SRHR and have largely relied on the health budget and resource mobilisation as outlined in the Health Sector Strategic Plan

2011–2016. Mindful of the global and national economic constraints, there is a need for stakeholders to actively be involved in mobilising additional resources for the YFHS programme outside the normal realms of funding.

Key Activities:

(i) Explore and map funding partners for YFHS programming.

(ii) Implement mechanisms towards increasing the scope of YFHS financing such as the costed implementation plan (CIP) for FP2020.

(iii) Engage relevant parliamentary committees and other policy makers (e.g., local authority policy makers) for increased budgetary allocations for youth RH services.

Strategy 2: Advocate and lobby private sector through PPP for additional resources for integrated funding for contraception, HIV and YFHS programme

The success of private-public partnerships through institutions such as the Blue Star accredited/branded clinics and Youth Outreach under Banja La Mstogolo (BLM); Tunza accredited/branded clinics and Youth Alert! by PSI; and Youth Life clinics by the Family Planning Association of Malawi (FPAM) have successfully increased the reach of SRHR services, especially amongst youth, due to their alternative spaces and outreach services. Social marketing of contraceptives and condoms has also increased access. Pharmacies could, through partnerships, offer an opportunity for providing SRH information (leaflets) and services to youth, especially contraceptives and referrals to services. Expanding PPP can provide alternative spots for youth to obtain the necessary information and services.

Key Activities:

(i) Facilitate PPP to support the financing and delivery of YFHS commodities and services.

(ii) Lobby private sector in adopting YFHS as part of corporate responsibility.

Strategy 3: Engage parliamentary committee on health to support a youth SRHR programme for young people aged 15 to 24 years as per Malawi's FP2020 commitment

As part of its FP2020 commitment, Malawi promised to increase the country's CPR to 60% by 2020 with a focused increased in young people aged 15 to 24 years and increase service coverage with an emphasis on a comprehensive SRH programme for young people. This increased access to voluntary FP will support Malawi's overall CPR goal.

Key Activities:

(i) Support the implementation of the CIP for FP2020, which includes key areas on youth and contraception.

(ii) Work with the parliamentary committee to annually monitor the national SRHR programme.

(iii) Mobilise political will to support equitable provision of youth RH services.

Chapter 3: Implementation Mechanism

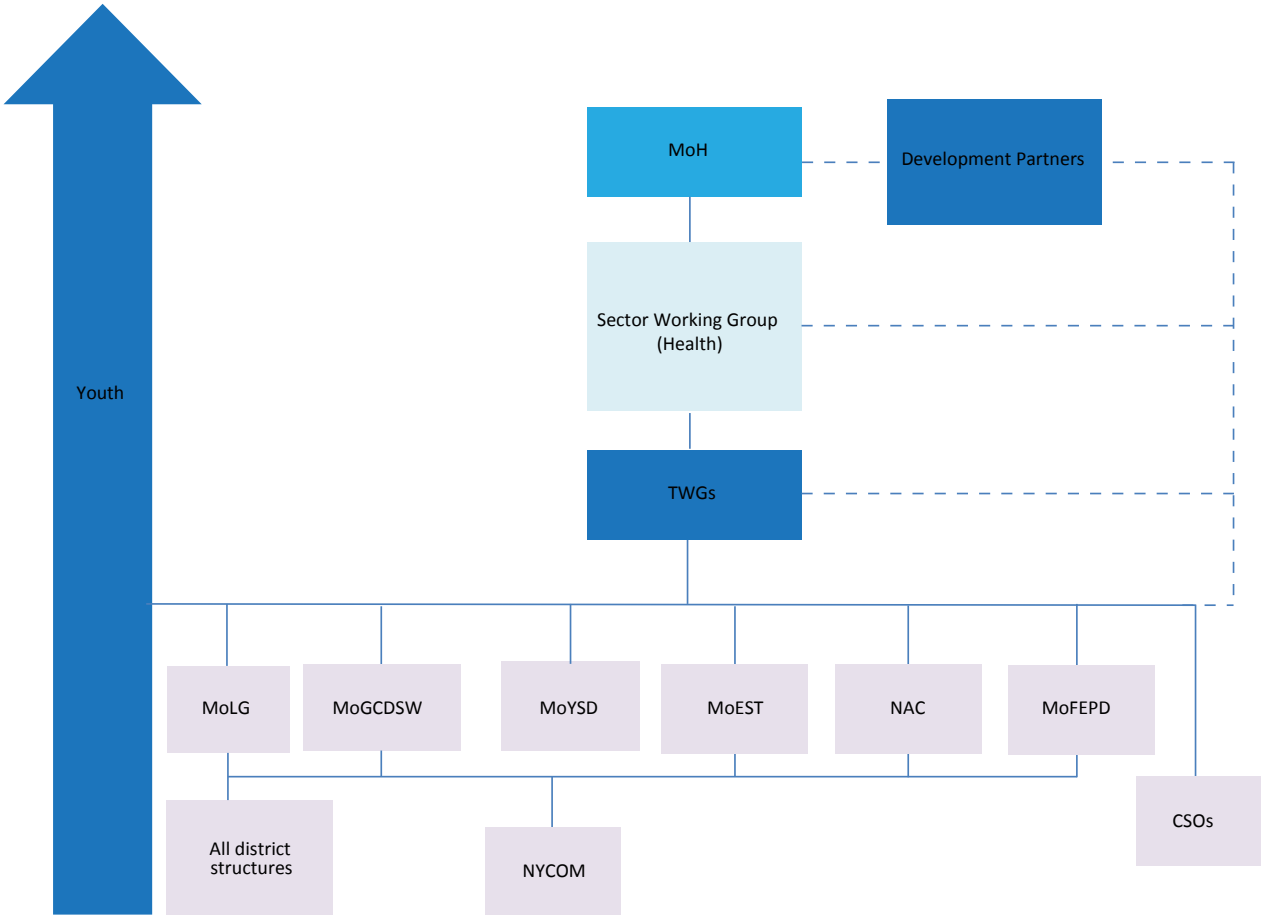
3.0 Implementation & Oversight

The adoption of the multi-sectoral and decentralised approach to achieve a comprehensive youth-responsive YFHS programme will require diligent coordination and management to create more opportunities for many and diverse stakeholders' involvement. With increased numbers of stakeholders, coordination will become increasingly complex, challenging, and dynamic. The process demands innovation, clarity of roles, and defined responsibilities linked to institutional mandates and comparative advantages.

3.1 Institutional Arrangements

The MoH working across departments and with other line ministries, youth, and all stakeholders will provide overall leadership in service delivery and oversight on the more structural and social behaviour change interventions. Central and other entities such as the Ministry of Finance, Economic Planning and Development, the Law Commission, and the Human Rights Commission can directly or indirectly support the YFHS programme.

Main coordinating bodies in the YFHS response



Line ministries will provide services up to the community level through existing structures. The RHD, as the overall coordinating body, will ensure an environment that is characterised by well-articulated mandates, roles and responsibilities for youth, communities, civil society, and the private sector; a functional joint programme review mechanism for planning and development that is evidence-based, gender-sensitive, and focused on specific results; and a strong M&E system that is anchored in a human rights framework. The RHD will also spearhead the coordination, development and implementation of strategies for sustainable financing of the YFHS programme, although all stakeholders will have a responsibility to mobilise resources/ finance towards the YFHS programme.

3.2 Roles and Responsibilities

- **Ministry of Health** – The MoH through the RHD will lead and coordinate the YFHS programme. MoH will provide leadership to guide the multi-sectoral approaches that will best achieve the five priority areas of the Strategy, thus providing overarching policy direction and oversight to ensure that YFHS standards are met within the Strategy framework. The MoH-Department of HIV and AIDS will be responsible for providing leadership and guidance on the HIV response for prevention, care, and treatment relating to young people. MoH-RHD will be responsible for district implementation of YFHS through supportive supervision and dissemination of any guidelines and overseeing information management. MoH will also be responsible for resource mobilisation for the YFHS Strategy. The specific roles of the MoH include (a) developing policies and guidelines on biomedical and non-biomedical SRH interventions; (b) planning and implementing biomedical and non-biomedical SRH interventions; (c) coordinating health sector–themed areas; (d) providing technical support for SRHR policy direction; (e) providing technical support in implementation of health-related YFHS interventions; and (f) supportive supervision for SRH/HIV.
- **Ministry of Gender, Children, Disability and Social Welfare** – MoGCDSW will provide policy guidance, capacity building, enforcement and gender mainstreaming within the YFHS programme through one-stop centres, community victim support units, safe spaces, and child protection mechanisms. Specific responsibilities include empowerment of girls for utilisation of services at various levels, advocacy on GBV, parent-child communication, enhanced community dialogue around gender-sensitive and mitigation of harmful cultural practices education as well as broader SRHR issues, and promotion of the participation of boys in attitude change of socio-cultural norms.
- **Ministry of Youth, Sport, and Development** – The MoYSD will assume responsibility for reaching out-of-school youth and collaborating with the MoEST and other line ministries and stakeholders for the harmonisation of CSE training manuals for out-of-school youth to achieve a standardised set of information and identify creative approaches. MoYSD will provide policy direction on out-of-school youth and work with NYCOM to provide policy direction and priorities in relation to the youth policy and the extent of involvement of youth clubs.
- **National Youth Council of Malawi** – NYCOM shall be responsible for providing technical expertise on SRHR to young people through youth organisations and will assume the leadership role of oversight and guidance of all partners working on youth SRHR. NYCOM will also assist in strengthening youth participation for YFHS at all levels, taking advantage of existing district networks in place. NYCOM will provide overall guidance to youth organisations and networks on YFHS. The organisation shall also assist in building the capacity of youth at the varying levels on youth participation and development. NYCOM shall also be responsible for linking out-of school youth to YFHS programme activities and facilitating partnerships between youth organisations and partners with focus on youth SRHR and strengthening linkages with the health facilities for efficient referrals.

- **Ministry of Education, Science and Technology** – The MoEST will be responsible for the inclusion and delivery of age-appropriate CSE information in school-based curricula at all levels in line with its policies. MoEST will work with MoGCDSW to provide oversight to all partners working to strengthen communication between parents and youth. The MoEST will also provide guidance for working with PTAs and SMCs at the community level as well as ensuring inclusive CSE for youth with disabilities in schools. MoEST will institute, enforce, and provide psycho-social counselling to youth in school and enforce the "keep girls in school" interventions, dissuading school dropout.
- **National AIDS Commission** – NAC will coordinate youth HIV stakeholders at national-, district-, and community-level organisations. NAC will also provide technical and financial capacity to youth SRHR/HIV stakeholders where necessary by providing resources for training and supervision as outlined in the new National HIV and AIDS Strategic Plan and National Prevention Strategy 2015–2020. All partners implementing HIV and AIDS-related interventions on YFHS will also be expected to provide quarterly and annual activity reports to NAC through the regular channel.
- **Ministry of Local Government** – In keeping with the spirit of decentralisation, the Ministry of Local Government will be responsible for overseeing all district-level implementation, reporting to MoH through relevant structures. Local authorities, through the Ministry, will coordinate the implementation of youth activities at district and community levels, specifically through the District Executive Committee (DEC), District Development Committees, and Area Development Committees (ADCs) complementing the work of local NGOs.
- **Ministry of Finance, Economic Planning and Development** – This Ministry will be required to promote YFHS in their current activities through the Population Unit and other relevant departments for technical support to MoH and district programme planners such, as advocacy on population and development. The Ministry shall also have the responsibility of ensuring adequate budget allocations for the YFHS programme.
- **Development Partners** – Donors and development partners supporting health initiatives in Malawi will provide technical and financial aid to interventions and collaborative mechanisms under the YFHS programme. Development partners support national priorities; facilitate implementation by funding capacity building; and assist the government's response in areas such as empowering leadership, mobilisation of public, private and civil society, strategic information, and facilitating access to technical and financial resources at the national level.
- **Health Sector Working Group** – The Health Sector Working Group Steering committee will provide policy guidance to other sectors working in YFHS, decision making for all issues arising from the TWGs and sub-committees, and endorsement of national documents ensuing from the YFHS programme.
- **Technical Working Groups** – TWGs are thematic groups established by the RHD and other related sectors, namely youth, SRH/HIV, gender, and education TWGs (see annex 5 for a list of TWGs). The SRH TWG will remain the umbrella TWG for all the sub-committees to report on YFHS TWGs under other ministries will provide their updates to the YFHS sub committee, which in turn will provide feedback to the SRH TWG. TWGs will provide technical guidance and make recommendations on various technical issues related to the YFHS national programme. The table in Annex 5 shows each TWG's function with regards to oversight of the YFHS programme.
- **NGOs and Civil Society Organisations (CSOs**) – NGOs and CSOs form the core of the implementing agencies, and, among others duties, they carry out advocacy, assist communities to mobilise resources locally, document best community practices, and support capacity building

programmes in collaboration with the RHD. Their role is to provide services, strengthen community and health systems, implement YFHS, and provide technical support to the varying structures, advocacy on SRHR issues, and resource mobilisation for district implementation plans (DIPs) and local levels complementing the national work. These organisations will report to RHD or indirectly through TWG meetings and other reporting mechanisms as identified by MoH and other coordinating line ministries.

- **Private Sector Providers** – These providers are to be encouraged and initiated by government to support service provision of health services at subsidised costs.
- **Academic and Research Institutions** – These institutions will provide the data and information for evidence-based planning and provide leadership for research on new areas of youth, SRHR, and YFHS and periodic updating of pre-service curricular relating to YFHS.
- **Youth** – Young people's active citizenship and participation in governance can provide significant value-added for the fulfilment of government commitments, ensuring that the goals, targets and indicators agreed through the post-2015 process are effectively implemented at national and local levels. They shall serve alongside technical experts, supported by mentorship relationships, and be provided with increased opportunities to contribute towards the design, implementation, and monitoring and evaluation of the YFHS programme.

3.3 District-Level Coordination

The district-level YFHS response will be coordinated by the DHO with oversight from the District Commissioner. The DHO will work closely with the Departments of Youth, Social Welfare, Education, and other relevant sectors where earmarked in the Strategy. The YFHS implementation reporting will be captured through the established district structures under the select departments, e.g., Youth Sub-technical Committee

The Health, Youth, Gender and Social Welfare, and Education departments will work together to:

- Mobilise and provide resources through the DIPS for YFHS,
- Implement YFHS programmes,
- Offer technical backup to communities,
- Coordinate youth programmes in their respective areas,
- Ensure young people's health polices, guidelines and strategies are adhered to, and
- Build capacity in young people regarding health issues and programmes.

Chapter 4: Systems Strengthening

Successful implementation of the YFHS programme relies upon strong and functional systems across sectors to achieve comprehensive youth-centred and equitable programmes.

4.0 Infrastructure

YFHS are mostly offered through integrated SDPs; however, YFHS offered in separate rooms/buildings connected to a health facility and other health services ably complement integrated SDPs and have higher repeated visits by youth. To increase such approaches in delivery of YFHS the Strategy recommends:

- Strengthening of integrated health services.
- Minimum equipment and supplies such as relevant medical equipment and supplies (basic set including examination beds); sporting equipment; ICT (computer, video); seating furniture for SDPs.
- Allocation of a separate room/building within the health centre, where possible.
- Appeal to private sector corporate responsibility to invest in YFHS infrastructure.

4.1 Information Management Systems

One of the key objectives of the YFHS programme is to provide comprehensive disaggregated data to highlight the status of youth SRHR. Disaggregated real-time data is important to track the performance and set priorities for adolescent and YSRHR. The Strategy recommends:

- Investment in the capacity building of data entry persons, programme manager and coordinators with the tools to be able to complete tasks for real-time YFHS data.
- Tracking performance programme and priority setting of the YFHS.
- Investments in mobile and eHealth technologies, the existing HMIS/DHIS II, and existing management information systems across ministries for real-time comprehensive disaggregated data.

4.2 Service Delivery

Factors related to the achievement of service quality based on the YFHS standards, related MoH communication strategies, and service delivery guidelines emphasis include the performance of health workers on the supply side and public awareness of client rights on the demand side. Strategies identified to improve health worker performance and multi-sectoral workers at all levels for delivery of quality service include supportive supervision and mentorship programmes and advocacy for practicums on adolescent health during pre-service. In addition, supervision will provide a channel for dissemination of new/updated policies and guidelines, improving the knowledge and skills of service providers; assessment of institutional needs including training; and infrastructural maintenance needs. Raising public awareness of client rights will be achieved through community campaigns and educational curricula.

4.3 Human Resources

Human resources for health are strained in Malawi, impacting the effective delivery and management of programmes. However, due to the diversity of youth and their needs, YFHS are heavily reliant on skilled providers. As such, the YFHS programme hopes to minimise training costs and provider absenteeism through on-the-job training. Recruitment may be required when highly specialised skills are needed. The Strategy recommends:

- A capacity audit of all available YFHS cadres across key line ministries.
- Training, orientation, and sensitisation of YFHS delivery model.
- Inclusion of young persons as YCBDAs and interns in YFHS SDPs where possible.
- An additional officer at the RHD to assist the YFHS officer.

4.4 Community Systems

Investments in YFHS will not be effective and successful if the community does not play its role in impact mitigation of negative SRHR outcomes, especially in the areas of gender equality and human rights challenges, youth involvement, and developing capacities and competences of key populations and vulnerable groups. This Strategy has identified community systems strengthening as a critical area for YFHS to strive outside the operational systems. Community support and involvement is essential to safeguard YFHS and adolescents' uptake of SRHR/HIV information and services. Given that the majority of our population/youth are based in rural areas, the community systems should be empowered to be positive reinforcers of healthy sexual practices and provide community-level YFHS complementing national- and district-level YFHS efficient service delivery. The major stakeholders in this sphere include civil society, faith-based and community organisations and community leaders. The community systems strengthening in the YFHS Strategy will mainly focus on the components described below.

4.4.1 Meaningful Youth Leadership

Young people have the capacity to make positive and wide-ranging contributions to the YFHS programme. The quality and type of the partnership between youth, adults and decision makers is therefore critical and begins with a change in attitudes, power dynamics, and decision-making structures to allow for young leaders' capacity building, mentorship, and participation. The Strategy recommends:

- Young people must have a good level of empowerment, responsibility, and decision-making power and participate meaningfully in the YFHS programme.
- Youth and adults work together in YSRHR programming, i.e., conducting a needs assessment, writing strategies, policies or proposals, raising funds, designing programs, training staff, delivering services, implementing interventions and projects, overseeing programs, collecting data, evaluating a programme's effectiveness, and creating policy recommendations.

4.4.2 Advocacy

Advocacy for YFHS has the potential to increase dialogue among policy makers as well as between policy makers and communities. YFHS stakeholders, with sensitivity to the number of socio-cultural norms surrounding youth and SRH, will focus their advocacy efforts on:

- Strengthening implementation and/or advocacy for policies that support the provision of SRHR services addressing the needs of young people.
- Changing community perceptions of YFHS.
- Increasing parents-child conversations on SRHR.

- Increasing allocation of national resources for YSRHR programmes.
- Prioritisation of YSRHR in national development plans across sectors.
- Policy change to support the longer-term vision for CSE in primary schools.

4.4.3 Gender Equality and Human Rights

Gender equity and human rights are a prerequisite/building blocks for YFHS. It is against this background that the Strategy embraces experiences, ideas, concerns, needs and challenges of both adolescent girls and boys as integral dimensions in the design, implementation, and M&E of the YFHS programme. These dimensions should be mainly addressed through:

- Promoting gender equality and empowerment of young girls.
- Implementing gender transformative education among very young adolescent boys and girls (under age 14).
- Creating positive learning environments in which boys and men can change and challenge gender and cultural norms.
- Increasing use of health services by young girls, married and unmarried, including sex workers.
- Promoting socio-cultural change to empower young women to use contraception that best suit their needs and ensuring that they have access to methods that give them control of their reproductive health, including injectable contraceptives and female condoms.
- Teaching young women/adolescent girls to understand their social and biological vulnerability to STI/HIV.
- Ensuring accountability regarding the needs and interests of young women.

4.4.4 Targeting Groups with Special Needs

Hard-to-reach groups such as young persons with disabilities, YPHIV, sex workers, street children, orphans, teen mothers, and married adolescents are generally underserved by health services. This is mainly because of difficulties in accessing static health institutions, e.g., distances, operating hours, and infrastructure, and because of their reliance on others, e.g. spouse or parents. Such considerations have not been adequately addressed in the planning of health services. The Strategy will address these concerns (mindful of shortfalls) through:

- Targeted SBCC mHealth, and media.
- Outreach and door-to-door services.
- Inclusive CSE.
- Peer-to-peer approach for both youth and parents/guardians for promoting YFHS.
- Alternative spaces and operating hours for YFHS services.

Chapter 5: YFHS Monitoring and Evaluation

5.0 Quality Monitoring and Evaluation

M&E systems at all levels of service delivery and management will need strengthening to measure evidence-based and cost-effective ways to deliver services amid limited resources. Overall tracking of progress of the YFHS Strategy will be conducted by the existing Health M&E TWG, supported by the YFHS sub-committee, through quarterly meetings including overseeing the mid-term and final review national meetings. This will include the collection, processing, analysis and utilisation of disaggregated data at the facility and district levels. Ensuring that the DHIS II captures YFHS indicators is critical alongside the provision of real-time data for programme management. To ensure YFHS data are adequately captured at the national level, YFHS coordinators need to be equipped with the appropriate technology and oriented on the YFHS standard reporting requirements for each level of care, including indicators. Supportive supervision, monitoring, accreditation and evaluation of programme activities at regular intervals at all levels are considered to be a part of the M&E activities. Community members, especially youth, will be co-opted to actively participate in YFHS M&E through overseeing programs, collecting data, and evaluating a programme's effectiveness through their various serving capacities within the YFHS mechanism.

The RHD is responsible for coordinating the monitoring of the national YFHS programme, analysing this information, and disseminating it to policy makers and programme planners. The M&E of health facilities is coordinated and managed by the MoH in collaboration with private sector institutions and CSOs that manage health facilities. Data are reported through the HMIS/DHIS II. The monitoring of non-health-related interventions is through the different partnerships, i.e., with other line ministries, donors, CSOs, youth organisations, and local government and feedback to the RHD. These stakeholders will oversee capacity development, data quality assurance, resource mobilisation for M&E and data archiving.

Accountability: The M&E Framework (see Annex 4) provided is, therefore, expected to meet the information needs of stakeholders at all levels and guide the implementation and progress of the Strategy. This information will allow stakeholders to hold RHD accountable for the implementation of the YFHS Strategy. Traditional and innovative approaches should be considered for accountability systems including:

- YFHS sub-committee will lead in rolling out and monitoring the implementation of the Strategy.
- Reviewing membership of existing YFHS sub-TWG will be inclusive of youth members.
- NYCOM's accountability skills set will be strengthened.
- An outside agent will be contracted to conduct an evaluation of the YFHS programme periodically.
- An informal coalition of YFHS champions will be established to enable individuals to provide institutional memory and accountability over the long run even if individuals move from agency to agency or as youth members age up.
- A youth voice will be built to monitor and track implementation of the Strategy.

5.1 M&E Matrix

Overall, the YFHS Strategy is working towards the improvement of the national indicators below:

1. CPR among 15–24 years *(Source: DHIS II, MDHS)*
2. HIV prevalence rate 10–24 years *(Source: MDHS)*

3. Percentage of teenage pregnancies *(Source: DHIS II, MDHS)*
4. Percentage of schools, teacher training institutions providing CSE *(Source: ESA report)*
5. Access to YFHS *(Source: DHIS II)*

The Strategy M&E Framework (see Annex 4) clearly defines indicators for M&E programme progress, prescribes the frequency of the different monitoring activities at each level of intervention, and identifies the responsible actors for each respective activity. The M&E Framework also includes, where necessary, commissioned studies, special surveys, and reviews. The country will continue to monitor key YFHS indicators/YFHS national standards in general by conducting regular surveys, including where possible impact assessments, and evaluation studies. National surveys such as the Malawi Demographic and Health Survey (MDHS) will provide valuable insight into progress made in SRH.

Data collection and management: Strategies for disaggregated data collection, analysis and management will be developed and included in the M&E plans in consultation with stakeholders on how data should be disaggregated to best serve YFHS interests regionally, nationally and even globally. All implementing partners will be expected to collect information on process indicators relevant to the activities they implement. It is expected that this information will be reported as per the time schedule and in the M&E Framework and in relation to the national YFHS standards. Levels of programme performance will determine responsibility for disaggregated data collection, in which case methods of data collection may vary according to the type of indicators and data needs.

Implementing partners may undertake studies on particular themes for purposes of establishing benchmarks and targets to be achieved. Such studies are important in determining the different information needs, reviewing policies and programmes and also for determining best practices and lessons learnt. However, there are circumstances where there will be need for ad hoc information that may not have been planned for.

5.2 Research

The Strategy has placed emphasis on evidence-based practices and application of appropriate and cost-effective technologies. Research will therefore provide evidence-based information for strengthening the YSRHR programming relevant to YFHS. The Strategy suggests:

- Operationalisation of the MoH national SRH research priorities pertaining to YSRHR.
- Prioritisation of YSRHR research by the SRHR TWG and disseminated to all stakeholders, including donors, so that research priorities can be aligned with potential researchers/research funding and interest.
- Support relevant research themes such as SRHR, STIs, HIV, drug and alcohol abuse, and gender as it relates to YSRHR.

Chapter 6: Financing

Substantial financial and non-financial resources are required to support the implementation of the YFHS Strategy. A comprehensive prioritisation exercise through various consultation meetings guided the streamlining of YFHS activities to adequately fit in the resource-constrained environment. The five- year total cost of the activities reported in the YFHS Strategy amounts to approximately **US$ 19,342,364.00** (see Annex 6, "Detailed YFHS Programme Budget").

6.0 Financial Resources

A resource mapping exercise is conducted by the MoH annually and provides a detailed consolidated look at the health sector budget. This provides an opportunity to compare the projected costs of the YFHS Strategy to the projected funding envelope for Reproductive Health Malawi, as currently budgeted by the Government of Malawi, development partners, NGOs, and the Christian Health Association of Malawi (CHAM). Resource mapping inputs detailed activity-level data thereby showing how much funding is budgeted across districts, disease programmes, interventions, and cost categories. Comparing the funding needs from the YFHS Strategy to resource mapping data will ultimately lead to improved resource allocation, increased coordination with the various stakeholders and harmonised YFHS response priorities.

The National YFHS Strategy 2015–2020 will rely heavily on funds budgeted by government and integrated donor programmes. The MoH has adopted the approach of identifying alternative sources of funding to the health budget such as levying taxes and therefore it is important to ensure that RH – and specifically YFHS – is prioritised in the allocations of the collections from these pools. In the interim, the YFHS Strategy will be guided by the resource mobilisation plan as well as leaning on:

- Private public partnerships.
- Investments by the private sector to YFHS clinics based on social corporate responsibility reasoning.
- Integration of SRH/HIV services.
- Donor investments in the numerous global and regional commitments related to youth including FP2020.

This evidence- and results-based approach to budgeting should, inherently, lead to adequate funding to strengthen the YFHS programme.

6.1 Costing Methodologies

The costing of this Strategy was developed using the item-based budget template supported by the price list produced by the Office of Directorate of Public Procurement and Central Medical Stores Trust. The template breaks down the cost of the activity into minute sub-item payable components such as fuel, subsistence allowances, salaries, rent, stationary, drugs, etc. Sub-items are progressively aggregated and itemised into components, such as office supplies or internal travel, to provide the cost of each activity. The five-year total cost of the activities reported in the YFHS Strategy is approximately **US$ 19,342,364.00**, as detailed in the following table.

Summary By Priority Area

		Projection				Total 5 Years	
PRIORITY AREA	Costs 2016	Costs 2017	Costs 2018	Costs 2019	Costs 2020	Kwacha	US$
TOTAL ESTIMATED COST	**1,641,050,737**	**2,072,735,388**	**2,061,965,242**	**1,848,938,437**	**2,046,492,236**	**9,671,182,040**	**19,342,364**
Priority Area 1: Policy	217,454,333	238,571,867	221,390,066	216,376,266	204,355,377	**1,098,147,908**	**2,196,296**
Priority Area 2: Service Delivery	644,682,739	1,209,692,262	1,253,843,072	1,093,938,512	898,656,387	**5,100,812,971**	**10,201,626**
Priority Area 3: Coordination and Collaboration	437,133,456	135,507,676	87,644,075	49,660,075	447,260,075	**1,157,205,357**	**2,314,411**
Priority Area 4: Mobilisation of Young People and Communities	213,028,229	369,703,416	376,960,229	369,703,416	376,960,229	**1,706,355,520**	**3,412,711**
Priority Area 5: Resource Mobilisation	128,751,981	119,260,168	122,127,800	119,260,168	119,260,168	**608,660,284**	**1,217,321**

Exchange Rate ($1=MK500)

References

1. African Union. 2006. *African Youth Charter.* Addis Ababa, Ethiopia: African Union.

2. African Union. 2014. *Agenda 2063 – The Africa We Want.* Addis Ababa, Ethiopia: African Union.

3. African Union. 2009. *African Youth Decade 2009–2018 Plan of Action: Accelerating Youth Empowerment for Sustainable Development.* Addis Ababa, Ethiopia: African Union.

4. Family Planning 2020. 2012. *Malawi's FP2020 Commitments. Available at* http://www.familyplanning2020.org/commitments.

5. Clarfelt, C. 2014. *Youth-Friendly HIV Prevention and SRHR Programmes and Services at Post Schooling Institutions: A Review of the Literature. Final Report.* East London, South Africa: Students Partnerships Worldwide and UNFPA.

6. Government of Malawi. 2012. *Growth and Development Strategy II 2011–2016.* Lilongwe, Malawi: Government of Malawi.

7. UNESCO. 2013. *Ministerial Commitment on comprehensive Sexuality Education and Sexual and Reproductive Health Services for Adolescents and Young People in Eastern and Southern Africa.* Paris: UNESCO. Available at http://www.unesco.org/new/en/hiv-and-aids/our-priorities-in-hiv/sexuality-education/east-and-southern-africa-commitment/.

8. Ministry of Health and Ipas. 2012. *The Cost of Unsafe Abortion in Malawi* (Fact Sheet). Lilongwe, Malawi: Ministry of Health.

9. Malawi AIDS Network (MANET+) and UNAIDS. 2014. R*eport on National Mobilisation for the Formation of National Association for Young People Living With HIV and AIDS in Malawi*. Lilongwe, Malawi: MANET+.

10. Ministry of Economic Planning and Development. 2012. *Malawi Report on the Implementation of the International Conference on Population and Development (ICPD) Programme of Action (POA): ICPD Beyond 2015.* Lilongwe, Malawi: Ministry of Economic Planning and Development.

11. Ministry of Finance and Economic Planning and Development. 2014. *A Vision for the Health and Well-Being of Malawi's Young People* (Policy Brief). Lilongwe, Malawi: Ministry of Finance and Economic Planning and Development.

12. Ministry of Finance and Economic Planning and Development. 2014. "Carrying Malawi Forward: Investing in Sexual and Reproductive Health for Young People." ENGAGE Presentation Briefer. Lilongwe, Malawi: Ministry of Finance and Economic Planning and Development.

13. Ministry of Finance and Economic Planning and Development. 2014. *Malawi Youth Data Sheet.* Lilongwe, Malawi: Ministry of Finance and Economic Planning and Development.

14. Ministry of Economic Planning and Development. 2013. *Malawi's Pathway to a Demographic Dividend.* Lilongwe, Malawi: Ministry of Economic Planning and Development.

15. Ministry of Economic Planning and Development. 2012. *National Data Sheet*. Lilongwe, Malawi: Ministry of Economic Planning and Development.

16. Ministry of Health and Evidence to Action Project (E2A). 2014. *Evaluation of Youth-Friendly Health Services in Malawi.* Washington, DC: E2A.

17. Ministry of Health – National AIDS Commission (NAC). 2013. *HIV New Infection Estimates*. Lilongwe, Malawi: Ministry of Health.

18. Ministry of Education, Science and Technology. 2011. *EMIS Reports.* Lilongwe, Malawi: Ministry of Education, Science and Technology.

19. Ministry of Education, Science and Technology. 2014. *EMIS Reports*. Lilongwe, Malawi: Ministry of Education, Science and Technology.

20. Ministry of Education. 2008. National Education Sector Plan 2008–2017. Lilongwe, Malawi: Ministry of Education.

21. Ministry of Gender, Children, Disability and Social Welfare. 2014. *Violence Against Children Survey.* Lilongwe, Malawi: Ministry of Gender, Children, Disability and Social Welfare.

22. Ministry of Health, Ipas, and UNFPA. 2010. *Magnitude Study on Abortion* – National Estimates. Lilongwe, Malawi: Ministry of Health.

23. Ministry of Health. 2009. *Sexual and Reproductive Health and Rights Policy*. Lilongwe, Malawi: Ministry of Health.

24. Ministry of Health. 2011. *National Sexual and Reproductive Health and Rights Strategy 2011-2016*. Lilongwe, Malawi: Ministry of Health.

25. Ministry of Health. 2007. *Youth Friendly Health Services - National Standards. March 2007.* Lilongwe, Malawi: Ministry of Health.

26. Ministry of Health – National AIDS Commission (NAC) and UNAIDS. 2013. *Modes of Transmission Study – Know your Epidemic*. Lilongwe, Malawi: Ministry of Health.

27. Ministry of Health – National AIDS Commission (NAC). 2014. *National Strategic Plan for HIV and AIDS 2015 – 2020.*

28. Ministry of Youth, Sports and Development. 2013. *National Youth Policy*. Lilongwe, Malawi: Ministry of Youth, Sports and Development.

29. Munthali, A. 2011. *Situational Analysis of Persons with Disabilities in Malawi.* Zomba, Malawi: Centre for Social Research and NAD.

30. National Statistical Office. 2008. *Census Report.* Zomba, Malawi: NSO.

31. National Statistical Office, 2008. *Census Report on Children and Youth*. Zomba, Malawi: NSO.

32. National Statistical Office and ICF Macro. 2011. *2010 Malawi Demographic and Health Survey Fact Sheet.* Calverton, MD: NSO and ICF Macro. 32. National Statistical Office and ICF Macro. 2011. *Malawi Demographic and Health Survey 2010.* Zomba, Malawi, and Calverton, Maryland, USA: NSO and ICF Macro.

33. National Statistical Office. 2014. *Malawi MICS/MDG Endline Survey 2014, Key Findings*. Zomba, Malawi: NSO.

34. National Statistical Office. 2012. *Integrated Household Survey III 2010 - 2011*. Zomba, Malawi: NSO.

35. National Statistical Office. 2013. *Welfare Monitoring Survey 2011*. Zomba, Malawi: NSO.

36. "Oxford Policy Management paper on sustainability of HIV financing for Malawi."

37. Southern African Development Community (SADC). 2014. *Minimum Standards for SRH and HIV Integration for SADC Region* (post stakeholders' validation and consensus meeting draft 1). Gaborone, Botswana: SADC.

38. UNESCO. 2000. *The EFA 2000 Assessment: Country Reports – Malawi.* Available at http://www.unesco.org/education/wef/countryreports/malawi/rapport_1_1.html.

39. UNAIDS. 2014. Action on Social Drivers to End AIDS and Extreme Poverty. *An Expert Consultation on HIV/AIDS and the Global Health and Development Agendas.* New York: UNAIDS.

40. UNAIDS. 2014. Getting to Zero 2011-2015 Strategy. New York: UNAIDS

41. United Nations Department of Economic and Social Affairs (UNDESA). *UN Definition of Youth (Fact Sheet)*. New York: United Nations Inter-Agency Network on Youth Development and UNDESA Focial Point on Youth. Available at http://www.un.org/esa/socdev/documents/youth/fact-sheets/youth-definition.pdf.

42. UNFPA. 1994. *Programme of Action.* International Conference on Population and Development. Cairo, UNFPA.

43. UNICEF. 2002. YFHS *Needs Assessment: How Friendly Are They to Young People?* New York: UNICEF.

44. Villa-Torres, L. and J. Svanemyr 2014. "Ensuring Youth's Right to Participation and Promotion of Youth Leadership in the Development of Sexual and Reproductive Health Policies and Programs" *Journal of Adolescent Health* 56 (2015): S51eS57.

45. WHO, Department of Reproductive Health and Research. 2006. Promoting and safeguarding the sexual and reproductive health of adolescents. Policy Brief 4. Geneva: WHO

46. WHO. 2007. *Everybody's Business: Strengthening Health Systems to improve Health Outcomes; WHO's Framework for Action.* Geneva: WHO.

47. WHO. 2014. *Adolescent responsive health systems*. Available at http://www.who.int/maternal_child_adolescent/topics/adolescence/health_services/en/.

Annex 1: Categories of Youth in Malawi

Ministry/Institution	Youth Categories	Source
• Ministry of Youth, Sports and Development; • National Youth Council of Malawi (NYCOM); and • Ministry of Gender, Children, Disabilities, and Social Welfare	1. Urban and rural poor youths; 2. Street youths; 3. Out-of-school youths (drop-outs); 4. Youth with disabilities; 5. Semiliterate and illiterate youths; 6. Deviant youths; 7. Young women; 8. Unemployed youths; and 9. Orphaned youths	The Malawi National Youth Development Plan of Action (1995)[8]
Ministry of Health	1. Early adolescence 10–14 years; 2. Middle adolescence 15–17 years; 3. Late adolescence 18–21 years; and 4. Early adulthood 22–24 years	Life cycle approach, WHO 2002, UN 1998
Ministry of Education Science and Technology	Classification according to education structure: Malawi follows an eight-four-four formal education system. The first eight years are for primary education while secondary lasts for four years and tertiary also lasts another four years. 1. Primary Education: 6–13 years 2. Secondary Education: 14–17 years 3. Higher learning: 18–21 years Education systems: 1. Basic Education (early childhood development, out-of-school youth, complementary basic education and adult literacy as non-formal education and primary education); 2. Secondary Education (open and distance education and formal); 3. Teacher Education Development for Basic and Secondary Education; 4. Technical Education and Vocational Training (formal, village polytechnics and distant learning); and 5. Higher Education (private, public and open universities).	IHS II 2010–2011 NESP 2008–2017

[8] *The EFA 2000 Assessment: Country Reports – Malawi.* http://www.unesco.org/education/wef/countryreports/malawi/rapport_1_1.html

Annex 2: YFHS Packages and Standards

Health Promotion (and Counselling)

- Sexually transmitted infections (STIs)
- HIV and AIDS
- Contraceptives (FP) to prevent unwanted pregnancies
- Nutrition
- Sexual abuse
- Maternal and neonatal health care
- Adolescent growth and development
- Psychosocial support
- HPV
- Malaria

Clinical Service Delivery and Referral

Community level

- Contraceptive services including condoms
- HIV testing and counselling
- Referral to health facility or other service delivery points

Health centre level

- Contraceptive services including condoms
- Prevention, diagnosis and management of sexually transmitted infections
- Ante-natal, delivery and post-natal care services
- Prevention of mother-to-child transmission of HIV (PMTCT)
- HIV testing and counselling
- Treatment of sexual abuse victims
- Referral to hospitals or other service delivery points

Hospital level

- Post-abortion care
- Contraceptive services including condoms
- Prevention, diagnosis and management of sexually transmitted infections
- Ante-natal, delivery and post-natal care services
- Prevention of mother-to-child transmission of HIV (PMTCT)
- HIV testing and counselling
- Provision of ARVs
- Treatment of sexual abuse victims (including PEP)
- Voluntary medical male circumcision (VMMC)
- HPV referral to other service delivery points

Annex 3: Examples of Outreach Programs

Profile	Description
Facility-based YFHS separate spaces	Services will be provided in a separate room within or adjacent to the health facility. Services need to be provided in an integrated manner within the national YFHS standards and refurbished to meet the criteria determined by the checklist developed by MoYSD, NYCOM, and UNICEF.
Mobile clinics/camp sites	Services will be provided as school-linked or standalone camps in hard-to reach areas or areas agreed upon with the community and young people. Services need to be provided in an integrated manner within the national YFHS standards and include recreational and/or skills building.
One-stop centres	Separate rooms where young people can receive all the necessary counselling, information, health services and referral. These can be set up within health facilities, or communities.
Alternative spaces	Youth clubs e.g. anti-HIV/AIDS clubs, YPLHIV clubs, environment clubs, sporting and recreational venues, youth centres, or non-formal education settings where youth meet on a regular basis. Health care providers can be invited to go to where these young people are meeting to provide information, services, and skills building.
Social weekends, youth fairs, open days	A fun event tailored to provide SRH/HIV information and services for a targeted set of youth. The information and services should include skills building activities.
Hotlines, mobile technology, social media, radio	Forums set up specifically for youth to retrieve information, question, or air their views on SRH/HIV and related topics.
Social marketing	Products specifically targeting youth and set up in places where young people can easily access without stigma. YCBDA and interpersonal agents can provide information, products, and support.

Priority Area 1: Policy						
BROAD OBJECTIVE: Enhance the enabling environment for planning, programming and delivery of YFHS information and services to young people.						
Specific Objective: To ensure that policies, laws and strategies targeting the youth are up-to-date, harmonised and enforced in line with relevant international frameworks						
Strategies	**Responsible Institutions**	**Indicators**	**Baseline 2014**	**Target 2017**	**Target 2020**	**Source**
Advocate with policymakers and traditional leaders, faith based leaders for YFHS related policy and legal reforms	**Lead: MoH** - DRH with CSO, Law Commission. Partners: Ministry of Local Govt., FBOs, Media, Donors, UNFPA, MoEST, UNICEF, Traditional mother bodies, religious leaders, CSOs, Govt - MOH, Council of churches, NAC, UNFPA, NYCOM, CBO's, NGOs/CSO, Ministry of Justice, Traditional leaders	Number of policies reviewed	0	2	2	Annual YFHS report, YFHS Strategy Progress Report
		Number of laws reviewed	0	2	2	Law Commission; Annual YFHS report, YFHS Strategy Progress Report
Specific Objective: To increase awareness of existing policies, laws and strategies among health workers, community leaders, parents and guardians, teachers, youth and other key stakeholders						
Disseminate existing YFHS related policies and strategies (SRHP & S, YP, CIP, YFHS Strategy, Pop.P, HIVPrevS, NSP, Re-admission policy and Girls education strategy, Gender Policy	**Lead: MOH, MoYSD, MoEST, MoGCDSW.** Partners: Media, Development partners, NYCOM, Religious groupings, Youth clubs, Traditional leaders, District YFHS Coordinators, Local Government, Council of churches, NAC, CBO's, NGOs/CSO, Ministry of Information, Technology Hubs.	Number of policies and strategies disseminated	2	6	8	Annual YFHS report, YFHS Strategy progress Report.
		Number of policy briefs produced and disseminated	0	12	24	Annual YFHS report, YFHS Strategy progress Report
Advocate and promote multi-sectoral linkages for integrated intervention	**Lead: MoH, MoYSD, MoGCDSW.** MoEST. Partners: BLM, MBCA, PSI, FPAM, FBOs, Development Partners	Number of national multi-sectoral programs on YSRHR	1	3	5	Annual YFHS report, YFHS Strategy progress Report

Priority Area 2: Service Delivery						
BROAD OBJECTIVE: 2. 2. Increase adherence to national standards on YFHS in service delivery and access to comprehensive age appropriate sexual reproductive health (YFHS) information and utilization of quality services by young people through informed choice.						
Specific Objective: To enhance capacity of service providers and implementing partners to deliver quality YFHS						
Strengthen the capacity of health facility youth service providers, YCBDAs, HSAs, and peer educators in the provision of the minimum package of YFHS, including GBV	**Lead: MOH-RHD, MoYSD, MoEST, MoGCDSW.** Partners: Development partners (UNFPA, UNICEF, USAID), NGOs (PSI, YONECO, Save the Children, FPAM, BLM), Private Sector, Health training instutions - Baylor College of Medicine, Researchers, NYCOM, Youth Organisations, District YFHS Coordinators, Faith Community (CHAM), University Colleges, Police (VSU), Media	A comprehensive capacity audit is conducted and findings disseminated	0	1	1	Annual YFHS report, YFHS Strategy progress Report
		Percentage of YCBDAs and peer educators trained, oriented and refreshed in the provision of the minimum package of YFHS	52% YCBDA, 64% Peer Educators,	60% YCBDA, 75% Peer Educators	75% YCBDA, 90% Peer Educators	YFHS evaluation, routine program monitoring, Integrated RH supervision
		Percentage of trained youth friendly health services providers at health facility providing the minimum package of YFHS, including GBSV	73% (in hospitals), 68% (in health centres)	85% (in hospitals, 80% in health centres)	95% (in hospitals), 95% (in health centres)	YFHS evaluation, routine program monitoring, Integrated RH supervision
		Percentage of health facilities accredited to provide YFHS	37%	45%	60%	Routine program monitoring and accreditation report
		Percentage of health facilities providing Youth Friendly Health Services	75%	85%	90%	Routine program monitoring, Integrated RH supervision/DSHI2, Quarterly YFHS reports
Provide supportive supervision to health facilities and YFHS service providers to continually adhere to the YFHS standards in service provision and accreditation	**Lead: MOH.** Partners: MoYSD, MoGCDSW, M&E at central level, NYCOM, Youth Organisations, District YFHS Coordinators, Faith Community (CHAM), Development Partners (UNFPA, UNICEF, USAID), NGOs (Save the Children, BLM)	Percentage of YCBDA's and peer educators supervised	52% YCBDA, 64% Peer Educators	60% YCBDA, 75% Peer Educators	75% YCBDA, 90% Peer Educators,	YFHS mid and end term evaluation, YFHS Monitoring, Integrated RH supervision
		Percentage of youth accessing YFHS satisfied with YFHS	93%	95%	95%	YFHS midterm and end term evaluation

Specific Objective: To increase access and utilization of age-appropriate YFHS among young people through informed choice						
Integrate YFHS into other outreach services and increase service delivery points	**Lead: MoH.** Partners: MoYSD, MoGCDSW, NGOs, CHAM, Private Sector clinics, CSOs, DHOs, Youth Organisations, FPAM, PSI, BLM, Traditional leaders, CBOs, YFHS Coordinators, Youth clubs	Percentage of youth accessing YFHS	33%	45%	70%	YFHS Monitoring, Integrated RH supervision/DHIS II, Quarterly YFHS reports
		Number of YFHS service delivery points disaggregated by private and public facilities	Govt facilities = 519 Private facilities = 54* (BLM, FPAM, and Tunza sites)	Govt facilities =TBD Private facilities = TBD	Govt facilities = TBD Private facilities = TBD	YFHS Monitoring, Integrated RH supervision/DHIS II Annual YFHS report
Strengthen coverage and utilisation of contraception among youth married and sexually active youth 15 – 24 years	**Lead: MOH-RHD, HIV Department, NAC, Dept. of Nutrition.** Partners: MoYSD, MoEST, MoGCDSW, Development partners (UNFPA, UNICEF, USAID, GIZ), NGOs (PSI, YONECO, Save the Children, FPAM, BLM), Private Sector clinics and pharmacies, Baylor, NYCOM, Youth Organisations, District YFHS Coordinators, Faith Community (CHAM, FBOs), Media	Percentage of youth (15-24) using modern methods of contraception	67% F; 59%M MDHS	75% F; 65% M	75% F; 65% M	MDHS/ DHIS II
Establish and strengthen safe spaces for young people for recreation, information, services and referrals	**Lead: MoYSD, NYCOM.** Partners: MoH, Ministry of Local Government, Youth Organisations, MoGCDSW, MoEST, CSOs/NGOs, Private Sector, DHO, Traditional leaders, Ministry of Information, Min of Home Affairs, NAC	Number of safe spaces established/refurbished and maintained	40	80	120	Quarterly YFHS reports
Strengthen coverage and utilisation of HIV prevention, care, and treatment services among youth, especially young adolescents (10 – 14 years) and teen mothers	**Lead: MOH-RHD, HIV Department, NAC, Dpt. of Nutrition.** Partners: MoYSD, MoEST, MoGCDSW, Development partners (UNFPA, UNICEF, USAID, GIZ), NGOs (PSI, YONECO, Save the Children, FPAM, BLM), Private Sector clinics and pharmacies, Baylor, NYCOM, Youth Organisations, District YFHS Coordinators, Faith Community (CHAM, FBOs), Media	Percentage of young people (15-24) who have ever been tested for HIV and received the results	81.3% - F; 52.9% M	85% - F; 60% M	90% - F; 85% M	MDHS/ Global Aids Response Progress Report 2014/NAC Reports
		Prevalence of HIV among young people (15 -24)	5.2% F; 1.9% M	4% F; 1.5% M	3.5% F; 1.2% M	MDHS/ Global Aids Response Progress Report 2015/NAC Reports

Specific Objective: To increase access to comprehensive age appropriate sexual and reproductive health information (CSE)						
Advocate for inclusion of age appropriate CSE into the primary school curriculum	**Lead: MoH and TUM.** Partners: MoGCDSW, MoIT, NGOs (Save the Children, Action AID, FAWEMA), MoYSD, Development partners (UNESCO, UNFPA, UNICEF, GIZ, USAID), Traditional Leaders, Religious Mother Bodies (EAM, QMAM, Blantyre Synod, Livingstonia Synod, Catholic Health Commission), Youth Organisations, NYCOM, TUM, MIE, Eduaids network.	Age appropriate CSE integrated into the primary school curriculum	0	1	1	MoEST, YFHS annual reports
		Proportion of teachers oriented on CSE	221	TBD	TBD	UNESCO, MIE
		Number of teachers oriented on CSE through the World Starts with Me Programme	250	10000	25000	TUM "World Starts with Us" report
Harmonize CSE curriculum for out of school youth	**Lead: MoYSD, MoEST, MoGCDSW, MIE, MoH.** Partners: NGOs, Traditional Leaders, Youth Organisations, Religious Mother Bodies (EAM, QMAM, Blantyre Synod, Livingstonia Synod, Catholic Health Commission), MIAA, CBOs, NYCOM, NAC.	CSE curriculum for out of school youth harmonized	0	1	1	MoYSD, NYCOM
		Percentage of out of school youth accessing comprehensive sexuality information	Not available	TBD	TBD	YOMIS
Strengthen the capacity, systems and structures of all tertiary clinics to provide integrated SHR/FP/HIV information and services	Lead: MoH, Higher Learning Committee. Partners: Development partners (UNFPA, GIZ), NGOs (SAAT, PSI, BLM), NYCOM, NAC.	Number of tertiary institutions clinics providing integrated services	Not available	TBD	TBD	Quarterly YFHS reports, EMIS
Develop and implement gender sensitive and age appropriate YFHS SBCC campaigns at national, district and community levels	Lead: MoH, MoYSD, MoGCDSW. Partners: HEU, NGOs (PSI, BLM, FPAM, Save the Children, SAAT, YONECO, TfaC), Traditional Leaders, Youth Organisations, Religious Mother Bodies (EAM, QMAM, Blantyre Synod, Livingstonia Synod, Catholic Health Commission), FBO (DCA, NCA, MIAA, Act Alliance), CBOs, NYCOM, NAC, MoEST, HIV Department, Nat. Association for YPLHIV, Development partners (UNFPA, USAID, UNICEF).	Number of SBCC campaigns for YFHS developed at national level	0	2	4	Quarterly YFHS reports
		Number of SBCC campaigns for YFHS conducted	1	2	4	Quarterly YFHS reports, YOMIS

Priority Area 3: Coordination and Collaboration						
BROAD OBJECTIVE: Strengthen ownership, coordination and collaboration of the different program stakeholders: young people, MOH-RHD and line-ministries, parents, community leaders, and key stakeholders at national and district level						
Specific Objective: Strengthen coordination structures at all levels						
Enhance the capacity of coordination structures at national, district level, and community	**Lead: MoH.** Partners: MoYSD, NYCOM, MoGCDSW, MoEST, MoLG, CSOs, MIAA, MBCA, NAC, DHO, DEM, DPDs, DYOs, DACs, ADC Chairpersons, VAC Chairpersons	Number of functional district YFHS coordination committees; and Youth technical sub committees	Not available	29; 32	29;32	Quarterly YFHS report, Quarterly Youth Technical subcommittee report, YOMIS
		Number of meetings of the YFHS Sub-committee	4	10	20	YFHS sub-committee meeting minutes, Quarterly YFHS report
Specific Objective: To strengthen the M&E system of the YFHS program						
Build capacity of staff to ensure implementation of M&E systems at all levels	**Lead: M&E at central level - MoH, MoYSD, MoGCDSW, MoEST.** Partners: Police (VSU), MBCA, JSI, Development partners (USAID, UNFPA, DFID, UNICEF, GIZ), National and District Coordinators, HTSS, YFHS Coordinators, DHMT, M&E district focal points, NSO, Implementing Partners.	Number of functional related YFHS M&E systems in place	1	3	3	DHIS II, Quarterly YFHS report
Strengthen capacity of YFHS coordinators in M&E	Lead: MoH. Partners: CHAM, NYCOM, NGOs, Development partners (UNFPA, UNICEF, GIZ, USAID), HTSS, DHMT	Number of YFHS coordinators trained in HMIS & DHIS2	0	29	29	Quarterly YFHS report
		Number of biannual supervision visits	0	140	280	MOH reports
		Percentage of districts reporting YFHS using DHIS2	0%	50%	100%	DHIS II, Quarterly YFHS reports

Strengthen capacity for data utilization at all levels	**Lead: MoH.** Partners: Development partners (USAID, UNFPA, USAID, GIZ, UNICEF), NGOs (Save the Children, PSI, BLM, FPAM, MIAA, AFIDEP), MoGCDSW, MoYSD, Youth organizations, HTSS, YFHS Coordinators, DHMT, MoFEPD - Population Unit, DPDs, Tertiary Institutions.	Number of YFHS coordinators trained in data utilization	0	32	32	Quarterly YFHS reports
		Percentage of service providers reporting use of data to inform decision making	33%	40%	50%	YFHS monitoring report
Specific Objective: To ensure meaningful participation of young people in the coordination and implementation of the YFHS programme						
Strengthen capacity of SRH youth leaders from youth clubs and organizations to participate in planning, implementation and coordination of YFHS	**Lead: MoYSD, NYCOM, MoGCDSW.** Partners: MoH, MoEST, Faith community (DAC, NCA, Act Alliance), Private sector clinics; CHAM; NGOs working with the youth; CBOs; Development partners (UNICEF, UNFPA, USAID, Save the Children).	Number of SRH youth leaders from youth clubs and organizations mentored in SRH	Not available	100	200	YOMIS, Quarterly YFHS reports
Increase meaningful participation of the youth in all coordination structures	**Lead: MoYSD, NYCOM.** Partners: MoGCDSW, MoH, CHAM, Implementing Partners, NGOs working with the youth, MoEST, CBOs, Traditional and Religious leaders, FBOs, Development partners (UNICEF, UNFPA, USAID, GIZ, DFID), DYOs, DACs.	Number of young people participating in coordination structures (District YFHS coordination committees; national YFHS technical subcommittee)	Not available	14; 1	29; 1	YOMIS, Quarterly YFHS reports
Empower young people for peer advocacy	**Lead: MoH, MoYSD, NYCOM.** Partners: MoGCDSW, MoEST, NGOS (SAAT, PSI, BLM, FPAM, YONECO, Action AID, IPAS), Religious and Traditional leaders, FBOs (DCA, NCA, Act Aliance), CBOs, Youth organisations, NAC, Development partners (UNFPA, UNICEF, USAID, DFID, GIZ).	Number of young people trained in peer advocacy	9	20	32	Quarterly YFHS report

Priority Area 4: Mobilisation of Young People and Communities						
BROAD OBJECTIVE: Mobilize parents, community leaders and young people to actively advocate for and support YFHS uptake						
Specific Objective: To raise awareness of the YFHS program among parents, community leaders and young people						
Strengthen demand creation and community mobilization for YFHS	**Lead: MoH, MoYSD.** Partners: MoGCDSW, MoIT, NYCOM, CHAM, NGOs (BLM, FPAM, PSI, YONECO, Save the Children, SAAT), HEU, MoEST, Faith Community (Act Alliance, DCA, NCA), NAC, Development partners (UNICEF, UNFPA, USAID), Baylor, Lighthouse.	A communication strategy for the YFHS developed	0	1	1	Quarterly YFHS reports
Increase participation of community structures administering a minimum package of YFHS	**Lead: MoGCDSW, MoH.** Partners: MoYSD, MoIT, NYCOM, CHAM, NGOs (YONECO, Save the Children, SAAT), Faith Community (Act Alliance, DCA, NCA), NAC, Development partners (UNICEF, UNFPA, USAID), Department of Nutrition and HIV.	Percentage of functional youth organizations administering a package of YFHS	8%	16%	36%	NYCOM
Specific and relevant package to be developed for cultural initiators	**Lead: MoGCDSW.** Partners: MoH, MoEST, MoYSD, Development partners, Traditional leaders, MoLG	A package for custodians of cultural initiation ceremonies developed and implemented	0	1	1	Annual YFHS report
Support PTA, SMC, mother groups, and school clubs to support YFHS	**Lead: MoGCDSW, MoYSD, MoEST.** Partners: MoH, NGOs (Save the Children, Action AID, YONECO, PSI, SAAT), Youth Organisations, Traditional and Religious leaders, NYCOM, Faith Community (DCA, NCA, Act Alliance), CBOs, Youth Networks.	Percentage of PTA and school clubs oriented on SRH/FP/HIV	Not available	TBD	TBD	Annual YFHS report
Advocate with young people, guardians, teachers, and communities to develop positive attitude towards YFHS	**Lead: MoGCDSW, MoYSD, MoEST, MoH.** Partners: NGOs (Save the Children, Action AID, YONECO, PSI, SAAT), Youth Organisations, Traditional and Religious leaders, NYCOM, Faith Community (DCA, NCA, Act Alliance), CBOs, Youth Networks, Media.	Number of YFHS champions	0	6	12	Quarterly YFHS reports

Priority Area 5: Resource Mobilization						
BROAD OBJECTIVE: Mobilize resources to adequately support the effective management of the national YFHS programme						
Specific Objective: To ensure availability of human, financial, and material resources for the implementation of the YFHS programme						
Develop and implement a government led resource mobilization strategy for the YFHS programme	**Lead: MoH.** Partners: MoYSD, MoGCDSW, MoEST, MoLG, MoIT, Development partners, MoFEPD (Population Unit), NAC, CSO, NYCOM, Youth Organisations, FBOs.	A resource mobilization plan developed	0	1	1	Quarterly YFHS report
		Percentage of health sector budget allocated to YFHS	1%	2%	3%	National Budget
Advocate and lobby private sector through public private partnerships for additional resources for integrated funding for contraception, HIV and YFHS programme	**Lead: MOH, MoYSD.** Partners: Development partners, CHAM, MoFEPD (Population Unit), MoGCDSW, MoEST, MoLG, MoIT, NYCOM, CSO, NGOs, FBOs	Percentage change in resources for YFHS programme	0	3%	5%	Quarterly YFHS report
Engage parliamentary committee on health to support a youth SRHR programme for young people aged 15-24 as per Malawi's FP2020 commitment	**Lead: MOH.** Partners: MoYSD, MoFEPD (Population Unit), Development Partners, MoGCDSW, MoEST, MoLG, MoIT, NYCOM, NGOs, FBOs.	Percentage change in the allocation to youth SRHR	0	2	5	Quarterly1 YFHS report

Annex 5: Technical Working Groups (TWGs)

TECHNICAL WORKING GROUP	FUNCTION
The Health M&E (CMed) TWG	Monitor progress of the Strategy through the already established quarterly meeting calendar.
Gender, Children, Youth Development and Sports Sector Working Group	Responsible for mainstreaming all child, youth and gender issues in all sectors.
M&E TWG	Oversee the coordination of the mid- and end-term review of the Strategy.
YFHS Sub-Committee	Guidance to and coordination of the programme through quarterly meetings and assist the M&E TWG where required; it includes representative focal persons from each of the line ministries.
Other TWG such as: SRH TWG (RHD) and HIV TWG (HIV Dept./NAC);	Provide direct monitoring and guidance of the YFHS programme
Sub TWGS: ART/PMTCT sub-group; HTC sub-group, VMMC sub-group; YFHS sub-TWG (RHD); FP Sub-committee TWG (RHD); HIV Prevention TWG (NAC); GBV TWG (GCYS); and Population and Development Advocacy TWG	Provide direct monitoring and guidance of the YFHS programme
Youth Technical Sub-committee (district level) – MoYSD	Include representative focal persons from the line ministries and provide direct monitoring and guidance of the YFHS programme.

Annex 6: Detailed YFHS Programme Budget

		Projection				
Activity	Costs 2016	Costs 2017	Costs 2018	Costs 2019	Costs 2020	Kwacha
TOTAL ESTIMATED COST	**1,641,050,737**	**2,072,735,388**	**2,061,965,242**	**1,848,938,437**	**2,046,492,236**	**9,671,182,040**
Priority Area 1: Policy	217,454,333	238,571,867	221,390,066	216,376,266	204,355,377	**1,098,147,908**
BROAD OBJECTIVE: Enhance the enabling environment for planning, programming and delivery ofYFHS information and services to young people	217,454,333	238,571,867	221,390,066	216,376,266	204,355,377	**1,098,147,908**
Specific Objective: To ensure that policies, laws and strategies targeting the youth are up-to-date, harmonised and enforced in line with relevant international frameworks	**7,520,889**	**24,138,423**	**6,956,622**	**7,520,889**	**0**	**46,136,823**
Strategy-: Advocate with policymakers and traditional leaders, and faith-based leaders, for policy and legal reforms	**7,520,889**	**24,138,423**	**6,956,622**	**7,520,889**	**0**	**46,136,823**
Conduct 8 review national level meetings (2 per policy/law)	5,221,964	5,221,964	5,221,964	5,221,964	0	**20,887,857**
Conduct 1 meeting with Parliamentary committee for health	2,298,925	2,298,925		2,298,925		**6,896,774**
Conduct 3 regional-based meeting with traditional leaders		13,417,514				**13,417,514**
Conduct 1 national level meeting with faith-based leaders		3,200,021				**3,200,021**
1 meeting with Legal Parliamentary committee			1,734,658			**1,734,658**
Specific Objective:To increase awareness of existing policies, laws and strategies among community leaders, parents and guardians, teachers, youth and other key stakeholders	**209,933,444**	**214,433,444**	**214,433,444**	**208,855,377**	**204,355,377**	**1,052,011,085**
Disseminate existing policies and strategies (SRHP & S,YP, FP CIP, YFHS Strategy, NPP, HIVPrevS, HIV NSP, Readmission Policy, Girls Education Strategy, Gender policy)	**209,933,444**	**214,433,444**	**214,433,444**	**208,855,377**	**204,355,377**	**1,052,011,085**

Conduct 10 DEC meetings	147,600,000	147,600,000	147,600,000	147,600,000	147,600,000	**738,000,000**
Develop 3 Policy Briefs per policy		4,500,000	4,500,000	4,500,000		**13,500,000**
Conduct sensitisation meeting with traditional leaders;	9,375,377	9,375,377	9,375,377	9,375,377	9,375,377	**46,876,884**
Conduct sensitisations through Mass media spots; Web and mobile -based technologies	47,380,000	47,380,000	47,380,000	47,380,000	47,380,000	
Conduct an advocacy training for YFHS programme managers; Repackage information; Meetings with key stakeholders	5,578,067	5,578,067	5,578,067			**16,734,201**
Priority Area 2: Service Delivery	**644,682,739**	**1,209,692,262**	**1,253,843,072**	**1,093,938,512**	**898,656,387**	**5,100,812,971**
BROAD OBJECTIVE: Increase adherence to national standards on YFHS in service delivery. and access to comprehensive age appropriate sexual reproductive health (YFHS) information and utilization of quality services by young people through informed choice.	**644,682,739**	**1,209,692,262**	**1,253,843,072**	**1,093,938,512**	**898,656,387**	**5,100,812,971**
Specific Objective: To enhance capacity of service providers and implementing partners in YFHS	**321,916,207**	**629,943,880**	**336,671,748**	**513,687,407**	**321,916,207**	**2,124,135,448**
Strengthen the capacity of health facility youth service providers in the provision of the minimum package of YFHS, including GBV	**297,021,867**	**312,963,615**	**297,021,867**	**297,021,867**	**297,021,867**	**1,501,051,082**
Advertise and recruit a consultant		5,000,000				**5,000,000**
Conduct orientation meetings to build the capacity of YCBDAs, HSAs and peer educators in the provision of the minimum package of YFHS	148,510,933.33	148,510,933	148,510,933.33	148,510,933.33	148,510,933.33	**742,554,667**
Conduct orientation meetings to build the capacity of health facility youth service providers in the provision of the minimum package of YFHS, including GBV	148,510,933.33	148,510,933.33	148,510,933.33	148,510,933.33	148,510,933.33	**742,554,667**
Conduct Training of Master Trainers to build the capacity of health facility youth service providers in the provision of the minimum package of YFHS, including GBV		10,941,748				**10,941,748**

Provide supportive supervision and mentoring to health facilities and YFHS service providers to continually adhere to the YFHS standards in service provision and accreditation	**4,894,340.00**	**316,980,265.00**	**9,649,881.11**	**216,665,540.00**	**24,894,340.00**	**623,084,366**
Conduct orientation meetings to provide supportive supervision and mentoring to health facilities and YFHS service providers to continually adhere to the YFHS standards in service provision and accreditation		88,462,400.00				**88,462,400**
Conduct monthly supervision visits	24,894,340	24,894,340	24,894,340	24,894,340	24,894,340	**124,471,700**
Conduct On-the-job training in GBV and LARCs	0	0	0	0	0	**0**
Document in-training and on-the job training approaches		11,852,325				**11,852,325**
Scale-up in-training and on-the job training approaches			9,753,216			
Develop feedback tool			5,002,325			
Train YFHS providers on feedback tool		0	0	0	0	**0**
Conduct orientation meetings to strengthen the capacity of health facilities to continually meet the YFHS accreditation standards		191,771,200		191,771,200		**383,542,400**
Specific Objective: To increase access and utilization of age appropriate YFHS among young people through informed choice	**156,907,527**	**155,910,279**	**152,280,751**	**155,910,279**	**145,142,540**	**766,151,375**
Integrate YFHS into other outreach services and increase service delivery points	**36,386,417.71**	**30,647,126.67**	**30,647,126.67**	**30,647,126.67**	**30,647,126.67**	**158,974,924**
Train YFHS focal points to Roll-out of eHealth technologies to integrate YFHS into other outreach services and increase service delivery points	5,739,291.04					**5,739,291**
Refurbish YFHS centres	-	-	-	-	-	**0**
Conduct biannual data collection	30,647,127	30,647,127	30,647,127	30,647,127	30,647,127	**153,235,633**
Establish and strengthen safe spaces for young people for recreation, information, services and referrals	**63,979,149**	**65,091,664**	**65,091,664**	**65,091,664**	**57,953,453**	**317,207,595**
Training for focal points in all districts with YFHS spaces		7,138,211	7,138,210.67	7,138,210.67		**21,414,632**
Refurbish safe space	19,801,229	13,775,533	13,775,533.33	13,775,533.33	13,775,533.33	**74,903,363**
Training peer educators in demand creation, IGS, etc.	44,177,920	44,177,920	44,177,920	44,177,920	44,177,920	**220,889,600**

Engage the media to popularise YFHS	-	0	0	0	0	**0**
Strengthen coverage and utilisation of HIV prevention, care, and treatment services among youth especially adolescents (10-14 years) and teen mothers.	**56,541,960**	**60,171,488**	**56,541,960**	**60,171,488**	**56,541,960**	**289,968,856**
Conduct regional dissemination meetings to strengthen coverage and utilisation of contraceptive among 15 - 24 years (young married couples and sexually active youth)	8,326,832	8,326,832	8,326,832	8,326,832	8,326,832	**41,634,158**
Conduct SBCC campaign to strengthen coverage and utilisation of contraceptive among 15 - 24 years (young married couples and sexually active youth)	45,145,600	45,145,600	45,145,600	45,145,600	45,145,600	**225,728,000**
Champions Training	0	3,629,528		3,629,528		**7,259,057**
Conduct 1 themed open day to Strengthen coverage and utilisation of HIV prevention, care, and treatment services among youth especially young adolescents (10 – 14 years) and teen mothers	0	0	0	0	0	**0**
Conduct training of Network leaders on Advocacy	3,069,528	3,069,528	3,069,528	3,069,528	3,069,528	**15,347,642**
Specific Objective: To increase access to comprehensive age appropriate sexual and reproductive health information	**165,859,005**	**423,838,103**	**764,890,573**	**424,340,827**	**431,597,640**	**2,210,526,148**
Advocate for inclusion of age appropriate CSE into the primary school curriculum	**0**	**7,807,941**	**341,603,598**	**8,310,665**	**8,310,665**	**366,032,869**
Train TUM representatives in advocacy for CSE		6,123,091				**6,123,091**
Hold lobbying meetings to advocate for inclusion of age appropriate CSE into the primary school curriculum. (National and regional levels)		1,684,850	8,310,665	8,310,665	8,310,665	**26,616,845**
Scale-up teacher orientation in The World Starts with Me SRHR e-learning package			333,292,933			**333,292,933**
Harmonize CSE curriculum for out of school youth	32,204,102	31,180,000	31,180,000	31,180,000	31,180,000	**156,924,102**
Review of materials; consultation meetings at region with district level staff; finalise and print	32,204,102					**32,204,102**
Disseminate; Mass media spots; Innovative technologies		31,180,000	31,180,000	31,180,000	31,180,000	**124,720,000**

Strengthen the capacity, systems and structures of all tertiary institutions clinics to provide integrated SRH/HIV/FP information and services	124,184,972	104,370,450	104,370,450	104,370,450	104,370,450	**541,666,772**
Develop comprehensive SRH/FP and HIV prevention curriculum for tertiary level to strengthen the capacity, systems and structures of all tertiary institutions clinics to provide integrated SRH/HIV/FP information and services	14,348,522					**14,348,522**
Conduct 1 SBCC campaign per year over five years in all tertiary colleges	78,697,000	78,697,000	78,697,000	78,697,000	78,697,000	**393,485,000**
Provide supplies and information for clinics	31,139,450	25,673,450	25,673,450	25,673,450	25,673,450	**133,833,250**
Develop and implement gender sensitive and age appropriate SBCC campaign at national, district and community levels	**9,469,932**	**163,932,000**	**163,932,000**	**163,932,000**	**163,932,000**	**665,197,932**
Advertise and recruit a consultant to develop materials	7,750,000					**7,750,000**
Conducting the SBCC campaign		163,932,000	163,932,000	163,932,000	163,932,000	**655,728,000**
Meeting to validate the campaign materials	1,719,932					**1,719,932**
Conduct Open days, video vans, road shows, radio spots, radio programmes, drama training, drama performances (Once every quarter)	0	0	0	0	0	**0**
Conduct SBCC campaigns	0	0	0	0	0	
Priority Area 3: Coordination and Collaboration	**437,133,456**	**135,507,676**	**87,644,075**	**49,660,075**	**447,260,075**	**1,157,205,357**
BROAD OBJECTIVE: Strengthen ownership, coordination and collaboration of the different programme stakeholders: MOH-RHD and line-ministries, parents, community leaders, key stakeholders at national and district level and young people	**437,133,456**	**135,507,676**	**87,644,075**	**49,660,075**	**447,260,075**	**1,157,205,357**
Specific Objective: Strengthen coordination structures at all levels	**0**	**51,638,510**	**37,984,000**	**0**	**0**	**89,622,510**
Enhance the capacity of coordination structures at national, district levels, and community level	**0**	**51,638,510**	**37,984,000**	**0**	**0**	**89,622,510**

Conduct an orientation meeting with M&E officers at district level		5,325,658				**5,325,658**
Hold orientation meeting with DHMTs		8,328,852				
Conduct an orientation meeting with YFHS community officers from all sectors at district level		37,984,000	37,984,000			**75,968,000**
Specific Objective: To strengthen the M&E system of the YFHS programme	**416,023,336**	**58,545,700**	**28,549,955**	**28,549,955**	**426,149,955**	**957,818,903**
Build capacity of staff to ensure implementation of M&E systems at all levels	**4,213,346**	**44,335,710**	**8,563,408**	**8,563,408**	**8,563,408**	**74,239,280**
Review meeting - data collection tools;	4,213,346.11					**4,213,346**
Train YFHS coordinators on M&E tools		39,384,848	8,563,408	8,563,408	8,563,408	**65,075,071**
Conduct a meeting with focal points of line Ministries to update Management information systems		737,517				**737,517**
Develop YFHS M&E plan		4,213,346.11				**4,213,346**
Strengthen capacity of YFHS coordinators in M&E	**411,809,990**	**14,209,990**	**19,986,548**	**19,986,548**	**417,586,548**	**883,579,623**
Training of 32 YFHS coordinators (M&E, repackaging data, etc.)			5,776,557.71	5,776,557.71	5,776,557.71	**17,329,673**
Joint supportive M&E supervision	411,809,990.00	14,209,990.00	14,209,990.00	14,209,990.00	411,809,990.00	**866,249,950**
Specific Objective: To ensure active participation of young people in the implementation of the YFHS programme	**21,110,120**	**25,323,466**	**21,110,120**	**21,110,120**	**21,110,120**	**109,763,945**
Strengthen capacity for SRH youth leaders from youth clubs and organizations to participate in planning, implementation and coordination of YFHS	5,513,508	5,513,508	5,513,508	5,513,508	5,513,508	**27,567,539**
Train 35 SRHR Chairpersons in all districts	5,513,507.71	5,513,507.71	5,513,507.71	5,513,507.71	5,513,507.71	**27,567,539**
Increase meaningful participation of the youth in all coordination structures	15,596,612.08	19,809,958.19	15,596,612.08	15,596,612.08	15,596,612.08	**82,196,407**
Conduct orientation meetings	10,958,926.71	10,958,926.71	10,958,926.71	10,958,926.71	10,958,926.71	**54,794,634**
Conduct Interface meetings with NGOs	1,049,616.67	1,049,616.67	1,049,616.67	1,049,616.67	1,049,616.67	**5,248,083**
Develop mentorship programme and Mentor youth organisations		4,213,346.11				**4,213,346**
Best Practice conferences	3,588,068.71	3,588,068.71	3,588,068.71	3,588,068.71	3,588,068.71	**17,940,344**

Priority Area 4: Mobilisation of Young People and Communities	213,028,229	369,703,416	376,960,229	369,703,416	376,960,229	**1,706,355,520**
BROAD OBJECTIVE: Mobilize parents, community leaders and young people to actively advocate and support YFHS uptake	213,028,229	369,703,416	376,960,229	369,703,416	376,960,229	**1,706,355,520**
Specific Objective: To raise awareness of the YFHS program among parents, community leaders and young people	213,028,229	369,703,416	376,960,229	369,703,416	376,960,229	**1,706,355,520**
Strengthen demand creation and community mobilization for YFHS	4,339,858	168,271,858	168,271,858	168,271,858	168,271,858	**677,427,289**
Conduct Briefing meetings with DHMTs	-	0	0	0	-	**0**
Conduct briefing meetings with YFHS Coordinators	4,339,857.71	4,339,857.71	4,339,857.71	4,339,857.71	4,339,857.71	**21,699,289**
Conduct Open days, video vans, road shows, radio spots, radio programmes, drama training, drama performances	-	163,932,000	163,932,000	163,932,000	163,932,000	
Increase participation of community structures administering a minimum package of YFHS	**46,094,557**	**46,094,557**	**46,094,557**	**46,094,557**	**46,094,557**	**230,472,783**
Conduct orientation meetings on YFHS standards and monitoring of community structures	12,234,557	12,234,557	12,234,557	12,234,557	12,234,557	**61,172,783**
Conduct SBCC campaigns running once a year to cover all 32 districts eventually	0	0	0	0	0	**0**
Conduct extended Briefing meetings for community structures	33,860,000	33,860,000	33,860,000	33,860,000	33,860,000	**169,300,000**
Develop specific and relevant package for cultural initiators	**16,164,757**	**16,164,757**	**16,164,757**	**16,164,757**	**16,164,757**	**80,823,783**
Conduct training of cultural initiators	16,164,757	16,164,757	16,164,757	16,164,757	16,164,757	**80,823,783**
Support PTA, SMC, mother groups and school clubs at secondary school to support SRHR/FP/HIV	**22,624,533**	**22,624,533**	**22,624,533**	**22,624,533**	**22,624,533**	**113,122,667**
Conduct community-based workshops	22,624,533	22,624,533	22,624,533.33	22,624,533.33	22,624,533.33	**113,122,667**
Advocate with young people, guardians, teachers and communities to develop positive attitude towards YFHS	**123,804,525**	**116,547,712**	**123,804,525**	**116,547,712**	**123,804,525**	**604,508,998**
Conduct orientation meetings for Religious and Traditional leaders, CSOs	7,256,813		7,256,813		7,256,813	**21,770,440**

Conduct community-based workshops	114,003,200	114,003,200	114,003,200	114,003,200	114,003,200	**570,016,000**
Conduct an advocacy training for young peers	2,544,512	2,544,512	2,544,512	2,544,512	2,544,512	**12,722,558**
Priority Area 5: Resource Mobilisation	**128,751,981**	**119,260,168**	**122,127,800**	**119,260,168**	**119,260,168**	**608,660,284**
BROAD OBJECTIVE: Mobilize resources to adequately support the effective implementation and management of the national YFHS programme	**128,751,981**	**119,260,168**	**122,127,800**	**119,260,168**	**119,260,168**	**608,660,284**
Specific Objective: To ensure availability of human, financial and material resources for the implementation of the YFHS programme	**128,751,981**	**119,260,168**	**122,127,800**	**119,260,168**	**119,260,168**	**608,660,284**
Develop and implement a government led resource mobilization plan for the YFHS program	9,491,813	-	-	-	-	**9,491,813**
Develop a resource mobilization plan for the YFHS program	8,702,879					**8,702,879**
Meeting to disseminate the plan	788,933					**788,933**
Advocate and lobby private sector through public private partnerships for additional resources for integrated funding for contraception, HIV and YFHS programme	**115,200,000**	**115,200,000**	**118,067,632**	**115,200,000**	**115,200,000**	**578,867,632**
Conduct 3 regional breakfast lobbying meetings with the private sector			2,867,631.81			**2,867,632**
M&E visits	0	0	0	0	0	
Conduct routine maintenance services of YFHS facilities	115,200,000	115,200,000	115,200,000	115,200,000	115,200,000	**576,000,000**
Engage parliamentary committee on health to support a youth SRHR programme for young people aged 15-24 as per Malawi's FP2020 commitment	**4,060,168**	**4,060,168**	**4,060,168**	**4,060,168**	**4,060,168**	**20,300,839**
Conduct meetings with MPs and policy makers on FP2020 budget allocation for youth;	1,869,051	1,869,051.20	1,869,051.20	1,869,051.20	1,869,051.20	**9,345,256**
Conduct M&E visits with MPs and policy makers on						
FP2020 budget allocation for youth;	2,191,117	2,191,116.67	2,191,116.67	2,191,116.67	2,191,117	10,955,583

Endnotes

i WHO. 2006. Adolescent Health.

ii MoH and E2A. 2014. YFHS Evaluation.

iii MOH. 2008–2012. Report on the Confidential Enquiry into Maternal Deaths in Malawi.

iv MoFEPD. 2014., Youth ENGAGE.

v MoFEPD. 2012., National Data Sheet.

vi MGDS II, 2011–2016.

vii 2013 Youth Health and Nutrition of the National Youth Policy, 2011–2016 National Strategy for SRHR, and the 2015–2020 National HIV and AIDS Prevention Strategy.

viii UNFPA. 2011.

ix The three levels of health care include: **Hospital:** public, CHAM, private; **Health Centre:** public, CHAM, private, local government; **Dispensary:** public, CHAM, private, local government; including the **Community:** youth centres/clubs, HTC sites, peer educators, CBDAs, HSAs, pharmacy and shops.

x YFHS Evaluation 2014; UNICEF 2002

xi MoFEPD, Youth Engage, 2014.

xii (e.g. health, gender, education; comprehensive sexuality education and life-skills)

xiii MoH and E2A. 2014. YFHS Evaluation.

xiv MoH and E2A. 2014. YFHS Evaluation.

xv MDHS 2010.

xvi MDHS 2010.

xvii MOH. 2008–2012. Report on the Confidential Enquiry into Maternal Deaths in Malawi.

xviii Strategic investments supporting an educated, employed population which accelerates economic growth.

xix IPAS, 2012.

xx MoFEPD. 2014. – Youth ENGAGE.

xxi MDHS 2010.

xxii MoFEPD, 2014.

xxiii Clarfelt. 2014.

xxiv NSO. 2008. Census Projections.

xxv MDHS 2010.

xxvi MOGCDSW. 2014. Violence Against Children Survey.

xxvii MoH and E2A. 2014. YFHS Evaluation.

xxviii MoH, Ipas and UNFPA,. 2010. Magnitude Study on Abortion in Malawi.

xxix MoH and E2A. 2014. YFHS Evaluation; MDHS 2010.

xxx MoH-NAC. 2013. Know Your Epidemic Report.

xxxi Population Services International (PSI). 2014. Making your Services Youth Friendly – A Guide to Planners and Implementers.

xxxii MoYSDS. 2013. National Youth Policy.

xxxiii MoH and E2A. 2014. YFHS Evaluation.

xxxiv MANET+ and UNAIDS,. 2014.

xxxv MANET+ and. UNAIDS, 2014.

xxxvi SAfAIDS. 2011. Adolescent sexuality for young people living with HIV

xxxvii WHO Statistics. 2010.

xxxviii NSO. 2014. Malawi MICS/MDG Endline Survey.

xxxix MoH and IpasIPAS, 2012.

xl MDHS 2010.

xli MoFEPD. 2014. Malawi Youth Data Sheet.

xlii MoFEPD. 2014. Malawi Youth Data Sheet.

xliii Advocates for Youth. 2012. Providing LARCs to young Girls.

xliv MoEST. 2014. EMIS.

xlv MoH and E2A. 2014. YFHS Evaluation.

xlvi NSO. 2014. Malawi MDG Endline Survey.

xlvii MoH and E2A. 2014. YFHS Evaluation.

xlviii MoH and E2A. 2014. YFHS Evaluation; MANET+ and UNAIDS, 2014.; MoH-NAC,. 2014. National Strategic Plan for HIV and AIDS.

xlix MoH-NAC. 2014. National Strategic Plan for HIV and AIDS; Oxford Policy Management paper on sustainability of HIV financing for Malawi