The Government of Malawi

Ministry of Health

NATIONAL SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS (SRHR) POLICY

(2017-2022)

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Foreword

This Policy document provides direction on the effective implementation of Comprehensive and Integrated Sexual and Reproductive Health and Rights (SRHR) Services, which the Malawi Government is committed to provide to its citizens.

The commitments are in line with International recommendations, treaties and Action Plans to which Malawi is signatory. Notable are the Cairo 1994 International Conference on Population and Development (ICPD) and the African Union Maputo Plan of Action, both of which advocate for integrated SRHR services. In Malawi, the Reproductive Health Department (RHD) of the Ministry of Health (MoH) has since 1997 coordinated the integration, implementation, monitoring and evaluation of SRHR services at all levels. The RHD manages SRHR services through a framework known as the Malawi National Reproductive Health Program. The goal of the program is to promote through informed choice, safer reproductive health practices by women, men and youth including use of quality and accessible reproductive health services.

The first SRHR Policy was formulated in 2002 and was revised in 2009. The implementation of the SRHR services in Malawi has therefore been hitherto guided by the 2009 SRHR Policy. The Policy has facilitated the coordination among all stakeholders, provided guidance to decision makers, protected clients and providers, and provided the basis for SRHR service resource allocation.

The 2009 SRHR Policy expired in 2016, hence the need to revise the Policy. The revision has aimed at noting the successes of the expired policy, updating and revising the targets that were set in 2009 and filling existing gaps in the implementation of the 2009 Policy. Recently emerging issues such as the adoption of the Sustainable Development Goals (SDGs) to replace the phased out Millennium Development Goals (MDGs) have also been incorporated in the revised Policy. These reviews are in line with both national and international recommendations on SRHR services as guided by the Malawi Government Development Strategy, the Malawi National Reproductive Health Strategy, the Roadmap for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Malawi, the Malawi Gender Policy, African Union SRHR Policy guidelines and the SDGs.

The revision of the SRHR Policy is based on the results of the analysis of the implementation process of the past policy, which has provided evidence to ensure that the revised policy is relevant and effective. The revision has also been done with the participation of all national stakeholders who have also international experience on SRHR issues. The Ministry urges all public and private institutions to use this policy as a guide in the implementation of SRHR services in the country.

Hon. Atupele Muluzi, MP.
Minister of Health

Acknowledgements

The Ministry of Health would like to extend sincere appreciation to the UNFPA for the technical and financial assistance rendered during the revision of this Policy.

The RHD and consultants are acknowledged for facilitating the revision exercise of the Policy. The Ministry also acknowledges all individuals who have participated in the revision of the SHRH Policy. A number of stakeholders were consulted at different stages of the policy development. During the inception phase of the SRHR Policy review, the following stakeholders were consulted;

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In addition, the following were consulted as key informants during data collection; Dr. Abigail Kazembe (KCN); Mrs. Immaculate Chamangwana (Director, Mental Health Services); Mrs. Tulipoka Soko (Director of Nursing and Midwifery Services); Mrs. Rose Nyirenda (Director, Mzuzu Central Hospital). The College of Medicine (CoM) is also acknowledged for providing vital information on the review of the policy.

The MoH is grateful to the following people who were consulted when the first draft was produced and made valuable comments, which were incorporated to come up with the final draft;

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The final consultations on the draft policy were made with experts that attended the wind up meeting on Research in Maternal, Neonatal and Child Health that was held at Mount Soche Hotel on the 30th of September, 2016. A final consultative meeting on SRHR indicators was done with members that attended a Safe Motherhood ad hoc meeting that was held at the RHD on the 3rd of November,

2016. The participants were;

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The Ministry of Health would like to extend its gratitude to all who have made valuable contribution during the revision of this policy.

Preface

The Programme of Action of the 1994 International Conference on Population and Development mandates countries to provide comprehensive SRHR services in an integrated manner. The adoption of a comprehensive and integrated approach to SRHR in Malawi is a necessary response to expanding needs that includes increased demand for family planning, increased maternal and neonatal morbidity and mortality, and a growing burden of reproductive ill health.

The Malawi Government is committed to implementing the comprehensive and integrated approaches to SRHR despite the financial and institutional challenges. The comprehensive approach to SRHR offers opportunities to improve not only the health of childbearing women, but also address the needs of youth, and involves men in all aspects of SRHR. The health of the new born is largely dependent on the mother's health status and of her previous access to health care. SRHR needs increase during youth but for women they particularly increase during the reproductive years. In old age, the general health of men and women reflect the earlier reproductive life events. Although individual SRHR needs differ at different stages of life, events at each phase have important implications for future wellbeing.

The rationale for integration is to increase effectiveness of the health care system to meet people's needs for accessible, acceptable, convenient client centred care. This includes prevention of ill health, provision of information and counselling, screening, diagnosis and curative care and referral of various SRHR problems. Integration of SRHR services needs to occur at the point of service delivery, at the health sector level, and within the national development planning processes. At the point of service, integration requires that health care providers have knowledge, skills, and attitudes to provide SRHR services and to refer patients for other necessary services not provided at the site. The type of SRHR services provided at any given level will be determined by the capacity of health care providers, available equipment and supplies, and feasibility of referral system. The social and cultural norms play important role and therefore need to be taken into account to provide acceptable SRHR services. SRHR raises issues of human rights, equity, and discrimination, which must be addressed through participatory and inclusive processes that involve communities, families and individuals. Therefore, community mobilization is an integral part of integration at the point of service delivery.

Integration at health sector level is achieved through collaboration with other health programmes such as nutrition, HIV and AIDS, tuberculosis, and Malaria. SRHR services require a strong functioning health system; therefore, there is need for developing mechanisms for supporting SRHR services. These include strengthening financing for the services, procurement and distribution of essential medicines and human resource availability. Integration between public and private sector is critical for improving access and availability of SRHR services. This is achieved through mechanisms of contracting the private sector for provision of health ser-

vices. Health sector level integration also requires intensive resource mobilization exercises.

At the national development planning, integration involves linkages between SRHR policy within the health sector and other sectors such as agriculture, education, youth and women and child development. Promotion of SRHR within the development framework is crucial because health and development are entwined and SRHR is of importance for economic and social development.

The SRHR Policy provides the framework for implementation of SRHR programmes in the country. The policy has been divided into five sections as follows: introduction, broad policy directions, policy themes, implementation arrangements, and monitoring and evaluation.

For some thematic areas such as reproductive cancers (especially prostate and breast cancers), infertility, obstetric fistula, domestic violence / harmful practices and male involvement in maternal health of their spouses, there is scanty data for the baseline and targets for the key indicators. For effective monitoring of the policy, there is a need to collect data that will be used to update these statistics during the implementation of this policy.

Dr. Dan Namarika
Secretary of Health

Acronyms

AFIDEP	African Institute for Development Policy
AIDS	Acquired Immunodeficiency syndrome
ART	Anti-Retroviral Therapy
AU	African Union
BCC	Behaviour Change Communication
BEmONC	Basic Emergency Obstetric and Neonatal Care
BLM	Banja La Mtsogolo
CBD	Community Based Distribution
CHAM	Christian Health Association of Malawi
CHAI	Clinton Health Access Initiative
CMERD	Central Monitoring, Evaluation and Research Division
CoM	College of Medicine
CRHO	Chief Reproductive Health Officer
DHMT	District Health Management Team
EC	Emergency Contraception
EHP	Essential Health Package
EN/M	Enrolled Nurse/Midwife
FPAM	Family Planning Association of Malawi
HIMU	Health Information Management Unit
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistant
HTC	HIV Testing and Counselling
HSSP	Health Sector Strategic Plan
ICPD	International Conference on Population and Development
IUCD	Intra-uterine contraceptive device
IEC	Information, Education and communication
ITN	Insecticide Treated Bed Nets
KCN	Kamuzu College of Nursing
MACRO	Malawi AIDS Counselling and Resource Organisation
MASAF	Malawi Social Action Fund
MDGs	Millennium Development Goals
MDHS	Malawi Demographic and Health Survey
MGDS	Malawi Growth and Development Strategy
MEAL	Monitoring and Evaluation Learning

MASAF	Malawi Social Action Fund
MHSP-TA	Maternal Health Strategic Plan – Technical Assistant
MMR	Maternal Mortality Ratio
MNH	Maternal and Neonatal Health
MNCH	Maternal Neonatal and Child Health
MoH	Ministry of Health
MoLG	Ministry of Local Government
MTCT	Mother to Child Transmission
NAC	National AIDS Commission
NAPHAM	National Association of People Living with HIV AND AIDS in Malawi
NGO	Non-Governmental Organisation
NMCM	Nurses and Midwives Council of Malawi
NPO / FHP	National Program Officer – Family Health Program
POA	Programme of Action
PMTCT	Prevention of Mother-to-Child Transmission
PSI	Population Services International
PoW	Programme of Work
RH	Reproductive Health
RHD	Reproductive Health Department
RHMIS	Reproductive Health Management Information System
RHO	Reproductive Health Officer
RMNCH	Reproductive, Maternal, Neonatal and Child Health
RNM	Registered Nurse/Midwife
SSDI	Support for Services Delivery Integration
SRH	Sexual and Reproductive
SRHR	Sexual and Reproductive Health and Rights
STA-MH	Senior Technical Assistant – Maternal Health
STI	Sexually Transmitted Infections
SWAp	Sector Wide Approach
TBA	Traditional Birth Attendant
UNFPA	United National Population Fund
WHO	World Health Organization

01

Introduction

The Malawi Government is providing comprehensive Sexual and Reproductive Health and Rights (SRHR) services in line with National and International policies, protocols and Agreements to which the country is committed to abide. The national frameworks include the National Health Policy and the National Reproductive Health Program. The international frameworks include the recommendations of the International Conference on Population and Development (ICPD) that was held in Cairo, Egypt in 1994 and the 2006 African Union Maputo Plan of Action.

SRHR implies that people should have a satisfying and safe sexual life and that capacity should be built amongst the people.

The National Health Policy of 2012 presents a framework that articulates issues that are central to the development of health delivery systems in Malawi. The Policy serves as a point of reference in the provision of sound foundation for the successful provision of a comprehensive range of health services which, includes the sexual and reproductive health services. The National Reproductive Health Program presents strategies for the implementation of some components of SRH services, which include; family planning, maternal and neonatal health (including the management of unsafe abortion), prevention and management of sexually transmitted infections (STI) and HIV and AIDS, prevention, early detection and management of cervical cancer, infertility, mitigation of harmful practices and obstetric fistula.

The ICPD approved a program of Action in 1994, which emphasizes the need to integrate SRHR. Hence the provision of SRHR services vertically was recommended for discontinuation. The meeting further defined Reproductive Health (RH) as a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity in all matters related to the reproductive system and its functions and processes. SRHR therefore, implies that people should have a satisfying and safe sexual life and that capacity should be built amongst the people to enable them reproduce and also offer them the freedom to make informed reproductive decision regarding frequency and appropriate time for having children.

Malawi is a signatory to the African Union Maputo Plan of Action, which was signed in September 2006. The Plan of Action delineates the nine components of an integrated RH plan and takes into account the human lifecycle approach.

The components of the plan are;

i. Integration of prevention and management of STI, HIV, AIDS and malaria service in primary health care;
ii. Strengthening of community-based STI, HIV, AIDS and other SRHR services;
iii. Repositioning of family planning as a key development strategy
iv. The positioning of adolescent sexual and reproductive health as a strategy for empowerment, development and social wellbeing;
v. Reduction of the incidence of unsafe abortion
vi. Universal access to quality safe motherhood and child survival services;
vii. Increasing resources for SRHR services
viii. Achievement of reproductive health strategy
ix. Establishment of effective coordination, monitoring and evaluation of implementation of the Maputo Plan of Action.

In Malawi, the coordination, planning, implementation, monitoring and evaluation of SRHR services in primary health care is the responsibility of the RHD in the MoH. The goal of the National SRHR service is to promote through informed choice, safer reproductive health practices by men, women, and young people including the use of quality and accessible reproductive health services.

The SRHR services in Malawi focus on;

i. Maternal and neonatal health (including prevention and management of unsafe abortion),
ii. Young people sexual and reproductive health
iii. Family planning
iv. Prevention and management of STI, HIV and AIDS
v. Early detection and management of cervical, prostate and breast cancers
vi. Elimination of harmful maternal practices, including domestic and sexual violence,
vii. Prevention and management of obstetric fistula
viii. Prevention and management of infertility
ix. Male involvement in the development, promotion and delivery of SRHR services
x. Development of human resources for SRHR services
xi. Strengthening of the support systems for delivery of SRHR services

The number of births per woman is high averaging 4.0 live children per woman of childbearing age, indicating that the population will continue to grow in the foreseeable future.

The goal of the national SRHR services cannot be realized with efforts of the Ministry of Health alone due to the multidimensional aspects of the services, hence there is a need for effective collaboration with other government and non-governmental organizations and institutions. There are cross cutting issues of SRHR services, which include issues of human rights, gender and equity, resource availability and distribution. These issues have been addressed through participatory processes with the stakeholders at individual, family, group, community and institutional levels. The revised SRHR policy provides guidance to the Ministry of Health and all stakeholders on the coordination and implementation of the RH program in response to the country's SRHR needs.

1.1 Background

Malawi is a densely populated landlocked country in the South-Eastern Africa. The country is divided into three administrative regions; South, Centre and North. The country has a total number of 28 districts, out of which 13 are in the Southern region, 9 in the Central Region and 6 in the Northern Region. Malawi's human population has been growing rapidly at 2.8% per annum. Over a 40-year period, the human population increased from 4 million people in 1966 to 13.1 million in 2008 (NSO, 2012). Males comprise 49% while 51% are females. The number of births per woman is high averaging 4.0 live children per woman of childbearing age, indicating that the population will continue to grow in the foreseeable future. The NSO (2012) estimates that even with a projected declined in fertility rate, the population will still reach 26 million in 2030. In 2014, the Index mundi estimated that the population of Malawi was 17.4 million, with about half (49%) of the population being under 15 years old (NSO, 2011). The youth (15-24 year olds) comprised about 17.6% and those aged between 25-54 years were 26%, only

3.7% were aged between 55-64 years and those aged 65 years and above were 2.8% (NSO, 2011). This population structure means that the total dependency ratio for Malawi is 93.3% with the youth dependency ratio being high at 87%.

The NSO (2012) estimates that even with a projected declined in fertility rate, **the population will still reach 26 million in 2030.**

Life expectancy at birth increased to 62.7 years in 2014 up from 61.5 in 2013 (countryeconomy.com, 2016). For males the life expectancy is lower at 61.8 years than that of females, which is at 63.7 years (Countryeconomy.com, 2016). About 82% of the women and 81% of the men live in rural areas (MDHS, 2015-16). Educational attainment is higher for men than women as 5.0% of the men have never been to school as compared to 12.0% of the women (MDHS, 2015-16).

1.2 Situation Analysis

The Ministry of Health (MoH) in Malawi provides the bulk of health care services (60%). The Christian Health Association of Malawi (CHAM) and other private-not-for profit NGOs provide about 37% of the health care services. The Ministry of Local Government (MoLG) provides 1% and the others provide the remaining 2%, such as the Private Practitioners, Commercial Companies, the Army and Police.

The Malawi healthcare system is at three levels. The primary level comprises; health centres, health posts, dispensaries, and rural or community hospitals, while the secondary is made up of district and CHAM hospitals. The tertiary level consists of the central hospitals and one private hospital with specialist services.

According to statistics in the Malawi Demographic and Health Survey (DHS 2015-2016) maternal mortality is still high at 439/100,000 live births, perinatal mortality at 35/100,000 live births, proportion of women initiating antenatal care during the first trimester is 24% and women who completed 4 or more antenatal care visits is 51%. Proportion of assisted deliveries is high at 91% suggesting that the quality of care may be substandard in view of the high maternal and neonatal mortalities. Proportion of women and new born babies receiving postnatal care during the first 48 hours is 42% and 60%, respectively. The proportion of pregnancies among the 15-19 year olds is 29%. The unmet needs for family planning among the married are 19% and among the unmarried is at 40%. The proportion of pregnant women that are abused by their husbands is at 5%. There is a need to improve these SRHR statistics to promote good health among Malawians.

1.3 Rationale of the SRHR Policy

The need to revise the SRHR Policy has arisen due to the expiry of the 2009 Policy in 2016. There is a need to incorporate emerging issues in the various components of SRHR. The Millennium Development Goals (MDGs) were phased out in 2015 and have been replaced with the Sustainable Development Goals (SDGs). Although health was a cross cutting issue in all the seven MDGs, three of them (MDG4, reduce child mortality; MDG5, improve maternal health and MDG6 combat HIV and AIDS, malaria and other diseases) were directly linked to the 2009 SRHR policy. Of the 17 SDGs in which health is cross cutting, SDG3 is specifically ensuring healthy lives and promoting well-being for all at all ages. Furthermore, the reviewed Policy has incorporated issues

that have not been completed in the 2009 Policy. An analysis has been done of the then emerging issues during the 2009 policy review, which include: Basic Emergency Obstetric and Neonatal Care (BEmONC); Community Based Neonatal Care; Cervical Cancer Screening; Youth Friendly Health Services; Anti Retroviral Therapy (ART); Voluntary Male Medical Circumcision (VMMC) and Prevention of Mother to Child Transmission of HIV (PMTCT).

The Policy has also been designed to address SRHR issues in line with the 1994 ICPD Programme of Action; ICPD + 10; SDGs; African Union SRHR policy guidelines; the African Union Health Strategy; the Southern Africa Development Community Health Strategy; the Maputo Plan of Action; the Malawi Reproductive Health Strategy 2006 -2010; the Malawi Reproductive Health Service Delivery Guidelines; the Road Map for Accelerating the Reduction of Maternal and Neonatal Mortality and Morbidity in Malawi; Malawi Accelerated Child Survival and Development Strategy; Malawi Health Policy, Malawi Gender Policy, National Policy on the Equalization of Opportunities for Persons with Disabilities and Malawi Population Policy. These issues are addressed in the national development guiding frameworks such as Vision 2020 and Malawi National Development Strategy.

The purpose of the SRHR Policy is to address SRHR problems (maternal and neonatal health, family planning, teen age pregnancies and domestic violence) that are prevalent in different age groups and diverse groups of Malawians. For the youths the policy addresses sexuality education that is provided in schools and youth clubs in the communities. To other groups such as the mentally disturbed and disabled persons, like every other person, the policy addresses SRHR issues of pregnancy, family planning, STIs and HIV and AIDS. Additionally, the policy also provides the framework and institutional arrangements for implementation, monitoring and evaluation of SRHR programmes in the country.

The unmet needs for family planning **among the married are 19% and among the unmarried is at 40%.**

1.4 Linkages between the SRHR Policy, Health Sector Strategic Plan and other Development Frameworks and Sectoral Policies

In Malawi the overarching Policy that guides government planning has been the Malawi Growth and Development Strategy I and II (MGDS I and II), which focused on poverty reduction through wealth creation, sustainable economic growth and infrastructure development to attain the Malawi Vision 2020. These areas of focus comprise the Malawi Development Strategy and define priorities within priorities in different sectors of the Malawi economy. The priority areas are interdependent, interrelated, and complimentary and are linked to the SRHR policy.
The Policy is also aligned to the Health Sector Strategic Plan (2017-2022) which prioritizes Reproductive and Adolescent Health and acknowledges that adolescent health indicators remain poor. In addition, the policy is aligned to the SADC Protocol on Health, which Malawi ratified in 2004 among others. The protocol has three articles which are key to SRHR (Article 16- Reproductive Health; Article 10 - HIV and AIDS and Sexually Transmitted Diseases; and Article 17 – (Childhood and Adolescent health).

The MoH launched and implemented the Programme of Work (PoW) and delivery of the Essential Health Package (EHP) in 2004. The EHP has gone through several phases since 2004 and comprises eleven key components, together with essential supporting structures and systems, which address the major causes of death and illness in Malawi. The critical issue was that the EHP is delivered free of charge to every individual in Malawi. Improved access to EHP and other related activities has contributed to the improvement of the health status of Malawians.

The SRHR policy is linked to the Malawi National Youth Policy and Youth Friendly Health Services National Standards. The young people in Malawi are faced with challenges such as early marriages, early and unwanted pregnancies, unsafe abortions, high new HIV infections, early child bearing, drug and alcohol abuse, high illiteracy rate, poverty, and HIV and AIDS pandemic.

The SRHR policy is linked to the HIV and AIDS policy, which provides guidelines for implementation of HIV and AIDS activities. The policy advocates for rapid scaling up of testing and counselling services as well as access to ARTs. The policy also focuses on scaling up of PMTCT services.

The SRHR policy is also linked to the Malawi Gender Policy as it addresses the issues of gender equality and equity. More efforts are required to attain gender equality and equity in Malawi. The gender policy focuses on women empowerment and gender mainstreaming in all development programmes.

The SRHR policy is also aligned to Family Planning 2020 Declaration where governments including Malawi are committed to provide FP services at health centre and village levels to increase accessibility and utilization of reproductive health information and services by all women of child bearing age especially eligible sexually active adolescents.

1.5 Key Challenges

Key challenges and barriers to implementation of the SRHR policy include: institutional, financial and accessibility of the SRHR services.

1.5.1 Institutional Challenges

In Malawi, many health facilities are not adequately equipped to provide comprehensive SRHR services. There is uneven distribution of essential drugs and equipment among the health facilities. Urban facilities are better equipped than the ones in rural areas. Communication and transport infrastructure is inadequately developed especially in the rural areas. In general, access to SRHR services is worse in rural areas where there is inequitable deployment of health personnel. The deployment of health personnel favours urban areas, the secondary and tertiary levels of care. This is aggravated by the critical shortage of health workers especially the midwives throughout the country. For example the average number of nurses in health centres in rural areas was 1.9 as opposed to 3 in urban areas (Manafa et al., 2009).

1.5.2 Financial Challenges

The Government of Malawi is making efforts to provide substantive financial resources to SRHR services, however, there is very high and overwhelming demand for SRHR services and therefore the allocated resources are not adequate. The policy needs to put into place strategies to promote cost-effective SRHR service delivery.

02

Broad policy directions

2.1 Vision

To attain highest level of sustained comprehensive and integrated SRHR services to improve quality of life for all.

2.2 Mission

Equitable delivery of comprehensive range of quality and integrated SRHR services that are accessible, acceptable, effective and safe to individuals, couples, and communities

2.3 Overall Policy Goal

To provide a framework for provision of accessible, acceptable and affordable, comprehensive SRHR services to all women, men, and young people of Malawi through informed choice to enable them attain their reproductive rights and goals safely.

2.4 Policy Objectives

i. Provide direction to decision makers and programme managers for effective implementation of SRHR services.
ii. Provide guidelines for capacity building for provision of quality SRHR services.
iii. Attain equivalence, harmonization, and standardization of guidelines for provision of SRHR services
iv. Inform and guide stakeholders and partners on SRHR issues

2.5 Guiding Principles

The guiding principles for SRHR policy are inspired by the Malawi Health Policy, which are;

2.5.1 Human Rights and Equity Based Approach

This principle ensures respect for human rights and fundamental freedoms including the right to life, human dignity, equality and freedom from any form of discrimination. Therefore, all the people of Malawi shall have access to health services without distinction of ethnicity, gender, age, disability, sexual orientation, mental and health status, religion, political belief, economic, socio-cultural condition or geographical location. The rights of health care users and their families, providers, and support staff shall be respected and protected.

2.5.2 Gender Sensitivity

Gender issues shall be mainstreamed in the planning and implementation of all health programmes.

2.5.3 Ethical Considerations

The ethical requirement of confidentiality, safety and efficacy in both the provision of health care and health care research shall be adhered to and respected for every Malawian citizen.

2.5.4 Efficiency

All stakeholders shall use available health care resources efficiently to maximise health gains.

2.5.5 Accountability

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.

2.5.6 Community Participation

Community participation shall be encouraged in the planning, management and delivery of health services. This principle also recognizes the critical role parents, guardians and community members play in the promotion of SRH services.

2.5.7 Evidence-based decision making

Interventions shall be based on proven and cost-effective national and international best practices.

2.5.8 Partnership and Multi-sectoral Collaboration

Public-Private Partnership (PPP) and multi-sectoral collaboration shall be encouraged and strengthened to address the determinants of health.

2.5.9 Decentralisation

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.

2.5.10 Appropriate Technology

All health care providers shall use health care technologies that are appropriate, relevant and cost effective.

2.5.11 Responsiveness

The SRHR services shall be responsive to the reproductive health needs of the people of Malawi, including the adolescents, youth, adults, the disabled, mentally disturbed and the elderly.

03

Policy themes

The SRHR policy shall be implemented within the framework of the Malawi Health Policy 2009, which calls for universal access to appropriate, affordable and quality health care services throughout the life cycles of every human being, on the basis of equality between women and men. In this respect, sexual and reproductive health services and HIV and AIDS services shall be fully integrated and provided as a package and all the stakeholders shall participate in the development, implementation, monitoring and evaluation of the national SRHR services.

The policy has set the following as priority areas that require attention and intervention to promote SRHR services:

3.1 Family Planning

The need for family planning services arises from the risk of maternal, infant, and child mortality and morbidity when pregnancies are too early, too many, too late, and too frequent. Despite efforts to make family planning services accessible to all Malawians, fertility rate remains high. According to the MDHS, 2015-16, total fertility rate is currently estimated at 4.4 per woman, down from 5.7 in MDHS of 2010. These figures range from 4.8 in rural areas and 3.0 in urban areas (MDHS, 2015-16). Although knowledge of family planning is high and almost universal at 99% (MDHS, 2015-16), the unmet need for family planning among married women is at 19 % and total demand for family planning for married people is at 78% which is satisfied, where as demand for family planning for sexually active unmarried people is at 84% with only 53% of the demand being satisfied (MDHS, 2015-16). In addition, there are 54.2% unintended pregnancies among women in Malawi (Guttmacher, 2013).

Family planning impacts the well being of individuals, families and nations and improves health of individual women and families to enable them accumulate wealth over time. Furthermore, FP improves the nutritional status of family members. When there are few children, there are also few mouths to feed. FP also lowers the risk of pregnancy related complications hence maternal, neonatal and infant mortalities are reduced at national level. Controlling the demographic pressure also supports sustainable use of natural resources, such as water and forests, therefore supporting the economic development of the country.

3.1.1 Family Planning Policy Goal

To reduce unmet need for family planning services through provision of voluntary comprehensive family planning services at all levels to all men, women and young people of reproductive age.

3.1.2 Policy Statements

3.1.2.1 Prevention of unplanned and unwanted pregnancy shall be given the highest priority in the development and implementation of the family planning services.

3.1.2.2 Public health facilities shall offer a full range of family planning services, including emergency contraception.

3.1.2.3 MoH shall facilitate expansion of FP service delivery through the private sector including social marketing

3.1.2.4 Individuals and couples shall be empowered to decide freely and responsibly the number, spacing and timing of children and shall be provided with the means to do so without coercion.

3.1.2.5 All public health facilities shall provide supportive supervision to community health workers in their catchment areas including Health Surveillance Assistants, and shall function as depots for CBDA commodities and supplies.

3.1.2.6 Injectable contraceptives shall be available through the community-based delivery system using appropriately trained service providers.

3.1.2.7 Availability of long acting and permanent methods of contraceptives shall be

expanded at all levels of health care service.
3.1.2.8 Post-exposure prophylaxis (PEP) ARVs shall be made available, free of charge after any high-risk exposure to HIV where medically indicated.

3.1.2.9 Dual protection shall be promoted among all sexually active persons.

3.1.2.10 Emergency contraception shall be made available to all women who have had unprotected sex.

3.1.2.11 Abortion shall be provided to the full extent of the existing national law and guidelines shall be formulated to properly interpret the law.

3.1.3 Family Planning Policy Strategies

3.1.3.1 Provide accurate and timely FP information to all groups of people

3.1.3.2 Strengthen the availability, access to, and utilization of family planning services at both facility and community level.

3.1.3.3 Increase coverage of family planning services among the young people

3.1.3.4 Strengthen the integration of family planning in community-based health care package.

3.1.3.5 Strengthen the integration of family planning services into the other EHP components.

3.1.3.6 Broaden the range of family planning methods offered at both health facility and community levels.

3.2 Maternal and Neonatal Health

Malawi's maternal mortality ratio is estimated at 439 per 100,000 live births, down from 675/100,000 in 2010 (MDHS, 2015-16), showing that the target for MDG 5 (155/100,000) was not reached in 2015-16 although there has been a steady decline in maternal mortality in Malawi from 2004. Neonatal mortality rate is estimated at 27/1,000 live births, down from 31/1,000 in 2010 (MDHS, 2015-16).

Maternal deaths in Malawi are related to early child bearing, high fertility, postpartum infection, post-partum haemorrhage, pregnancy induced hypertension, complications of abortion, obstructed labour, HIV and AIDS, Malaria and anaemia. Malaria and poor nutrition contribute to anaemia in pregnancy. Antenatal coverage is high and almost universal at 94.8% for mothers who make at least one visit, only 51% complete 4 or more visits as required. However 91% delivered in a health institution (MDHS, 2015-16) up from 73.2% in 2010 and those that delivered at home were 7%. These statistics imply that other women deliver either at home or at Traditional Birth Attendants (TBA). Furthermore, the high maternal mortality rates while more women seek facility delivery show that the quality of care may be poor in the health facilities. Therefore there is a need for quality maternal care to be provided to all women who deliver at a health facility under the assistance of skilled providers to reduce maternal and neonatal mortality and morbidity.

Malawi's maternal mortality ratio is estimated at **439 per 100,000 live births, down from 675/100,000 in 2010.**

In 2010, **about 50.4% of mothers received postnatal care** within 6 weeks of delivery whilst **43% received postnatal care** within 48 hours of delivery.

Most (67%) of the infant birth complications occur during the postnatal period, use of postnatal services in Malawi has stagnated between 2010 and 2016. In 2010, about 50.4% of mothers received postnatal care within 6 weeks of delivery whilst 43% received postnatal care within 48 hours of delivery (MDHS, 2010). However, in 2015-16, only a third (42%) of the mothers received postnatal care within 48 hours after delivery, while 60% of the new born babies received postnatal care within 48 hours.

To strengthen maternal and neonatal services, the MOH/RHD has integrated Focused Antenatal Care (FANC), EmONC, Respectful Maternity Care (mother friendly services), Community Based Neonatal Care and Kangaroo Mother Care (KMC), HIV prevention and treatment, and PMTCT, fistula treatment, family planning, post abortion care services into the SRHR programme.

3.2.1 Maternal and Neonatal Health Policy Goal

To accelerate the reduction of maternal and neonatal mortality and morbidity so as to contribute to the attainment of the SDG targets

3.2.2 Maternal and Neonatal Health Policy Statements

3.2.2.1 Focused antenatal care (8 contacts with skilled personnel) shall be available to all pregnant women.

3.2.2.2 Implementation of the roadmap for the reduction of maternal and neonatal morbidity and mortality, which is regularly updated, shall be given the highest priority.

3.2.2.3 All women shall have readily access to essential obstetric care, well-equipped and adequately staffed maternal health care services, skilled attendance at childbirth, emergency obstetric care, postpartum care and effective referral and transport to avail the optimum level of care available.

3.2.2.4 All women shall be encouraged to have "birth preparedness plans" for institutional delivery with skilled birth attendance. Traditional birth attendants shall not conduct deliveries but shall concentrate on their defined roles.

3.2.2.5 PMTCT services shall be packaged in obstetric care services and shall be routinely offered from the first contact with all pregnant women. All mothers with positive HIV tests shall have access to free ARV services for the prevention of vertical HIV transmission.

3.2.2.6 All women tested for HIV shall be given their results and counselled accordingly.

3.2.2.7 The Partograph shall always be used in the management of labour.

3.2.2.8 Kangaroo mother care shall be routinely used in the management of premature newborns

3.2.2.9 All women who have complications of abortion shall have access to quality post abortion care services, including post-abortion counselling, and family planning to prevent repeat abortion.

3.2.2.10 Manual vacuum aspiration shall be the main method of management of incomplete abortion where gestational age permits.

3.2.2.11 within the confines of the existing law, service providers in public and private sector shall provide or refer for deemed to require or requesting the termination of their clients' pregnancies.

3.2.2.12 All maternal deaths shall be notified within 24 hours of its occurrence at facility level and 48hours at community level including zero reporting where no maternal death has occurred.

3.2.3 Maternal and Neonatal Health Strategies

3.2.3.1 Improve availability of, and access to maternal and neonatal care to increase utilization of services

3.2.3.2 Improve quality of skilled maternal and neonatal care at all levels of care to reduce case fatality rates.

3.2.3.3 Integrate new born care as a standard component of basic emergency obstetric care.

3.2.3.4 Empower all staff providing obstetric care to provide integrated new born care.

3.2.3.4 Encourage the use of Manual vacuum aspiration as a post abortion care method in all the health facilities.

3.2.3.5 Integrate comprehensive care of sick neonates through refurbishment of neonatal units, allocation of trained staff to the neonatal units and provision of new born equipment and supplies.

3.3 Sexually Transmitted Infections and HIV/AIDS

Sexually transmitted infections are a challenge in Malawi as they facilitate HIV acquisition, transmission, and progression. The prevalence of STIs in Malawi is still high. Regarding HIV, among the 15 to 49 age group, prevalence of HIV has fallen from 14% in 2004 to 10.6% in 2010 (MDHS, 2010) and to 8.8% in 2016 (MDHS, 2015-16). This reduction is due to efforts and investments that have been made to address the problems. HIV prevalence is higher among women (10.8%) than among men (6.4%). In addition, Malawi has high annual new HIV infections especially among young people. Mother to child transmission of HIV is the major cause of paediatric HIV infections. Prevention, care, treatment and support of STI's and HIV are keys to addressing the problem.

3.3.1 Sexually Transmitted Infections and HIV/AIDS Policy Goal

To reduce the incidence of new STI and HIV infections in Malawi

3.3.2 Sexually Transmitted Infections and HIV/AIDS Policy Statements

3.3.2.1 Management of STI shall be provided through the syndromic management approach at all levels, supported by diagnostic services as necessary.

3.3.2.2 HTC services and condom use shall be fully integrated in the management of STI and shall routinely be offered to all men, women and young people, who present for STI services to promote and protect their health.

Cervical cancer is increasing due to the HIV pandemic and constitutes **78.6% of all documented female cancers.**

3.3.2.3 Contact tracing and partner notification shall be strengthened at all service delivery outlets.

3.3.2.4 Young people shall not require parental consent for STI services, and confidentiality shall be maintained at all times.

3.3.2.5 Prevention of the transmission of sexually transmitted infections and HIV shall be given priority in the delivery of SRHR services by health workers.

3.3.3 Sexually Transmitted Infections and HIV/AIDS Policy Strategies

3.3.3.1 Strengthen behaviour change interventions to reduce risky behaviour among men, women and young people.

3.3.3.2 Strengthen integration of STI and HIV and AIDS services.

3.4 Reproductive Cancers

Cervical cancer is the commonest cancer in women in Malawi. The incidence of cervical cancer is increasing due to the HIV pandemic and constitutes 78.6% of all documented female cancers. Malawi leads other African countries on the incidence and mortality due to cervical cancer. The recorded Age Standardized Rate (ASR) incidence is 75.9/100,000 women and ASR mortality is 49.8/100,000 women (Globocan, 2012). Breast and prostate cancers are also on the increase but there is paucity of information regarding the prevalence in Malawi.

3.4.1 Reproductive Cancers Policy Goal

To reduce the incidence and complications of cancers of reproductive organs in all men and women.

3.4.2 Reproductive Cancers Policy Statements

3.4.2.1 Screening for cervical and breast cancers shall be integrated in primary health care and routinely offered to all women at all levels of health care.

3.4.2.2 Men of 40 years of age or older shall routinely be offered screening services for prostate cancer at all levels of health care.

3.4.2.3 All cancer patients shall be referred to the appropriate level of care for management.

3.4.2.4 All cancers shall be reported to the national cancer registry of the Ministry of Health.

3.4.3 Reproductive Cancers Policy Strategies

3.4.3.1 Strengthen awareness for the prevention and management of reproductive health cancers.

3.4.3.2 Strengthen the infrastructure for screening of cancers among men and women.

3.5 Infertility

Infertility affects some individuals and couples in Malawi. Infertility occurrences can be prevented

if the causes are detected early and reproductive tract infections are managed. The most prevalent is secondary infertility, which is preventable but is reported to affect about 17% of Malawian couples aged between 20 and 44 (Larsen, 2000).

3.5.1 Infertility Policy Goal

To reduce incidence of infertility among men and women

3.5.2 Infertility Policy Statements

3.5.2.1 Prevention of secondary infertility shall be fully integrated in Primary Health Care services at all levels.

3.5.2.2 Individuals and couples with infertility shall be screened and managed accordingly, including referral to appropriate level of care.

3.5.3 Infertility Policy Strategies

3.5.3.1 Strengthen awareness on the prevention and management of secondary infertility.

3.5.3.2 Strengthen research on infertility

3.6 Young people in Reproductive Health

Young people face a lot of challenges in Malawi due to the emerging economic situation, changing patterns in sexual behaviour, a social environment that encourages certain harmful cultural practices, premarital sex and lack of access to family planning education and services. These lead to early and unwanted pregnancies, induced abortions, STIs and HIV infections. Young people in Malawi also face alcohol and drug abuse and mental health problems. There are three main drugs of abuse in Malawi among the youth, which are; alcohol, Cannabis sativa (Chamba) and tobacco.

Most young people start having sex at the age of 15, on average (DHS 2015-16). High risk sexual behaviour is more common among young people aged between 15 and 24. In Malawi, young people get most information on SRHR issues from their peers, schools, and media (MDHS, 2015-16).

Young people are generally underserved in the current health care delivery system. Where SRHR services are available, often times; they are not convenient, acceptable nor accessible to young people. Young people therefore require not only basic information about their bodies, prevention of HIV, AIDS and pregnancy, but also age appropriate services that address gender equality, empowerment, rights and responsibilities, and sexual and reproductive negotiation and decision making. The MoH has developed the Youth Friendly Health Services Standards in an effort to address SRHR needs of young people.

3.6.1 Young people in Reproductive Health Policy Goal

To reduce the incidence of HIV and AIDS, STI's, unplanned and unwanted pregnancies, their complications, drug and alcohol use among young people.

High risk sexual behaviour is more common among **young people aged between 15 and 24.**

3.6.2 Young people in Reproductive Health Policy Statements

3.6.2.1 All young people shall have access to quality youth friendly health 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.

3.6.2.2 Youth friendly health services shall be provided at all levels of care.

3.6.3 Young people in Reproductive Health Policy Strategies

3.6.3.1 Improving availability of and access of youth friendly health services.

3.6.3.2 Strengthen behavioural change interventions in the YFHS.

3.6.3.3 Strengthen research on SRHR knowledge, and attitudes among young people.

3.7 Obstetric Fistula

Obstetric fistula is common among young child-bearing women in Malawi where some studies have revealed a prevalence of obstetric fistula of 1.6 per 1,000 women, with an estimated 20,000 women living with the condition (UNFPA, 2015). According to MDHS (2015-16), 43% of women aged 19 – 49 have heard about obstetric fistula, 1% have experienced it and 78% have sought treatment. Obstetric Fistula though preventable has remained a major public health problem in the country. Its persistence is a sign of poor quality of maternal care and indicates further that health systems are failing to meet the emergency obstetrics care needs of the pregnant women. Broader access to quality caesarean-section would help enormously in the prevention of fistula.

43% of women aged 19 – 49 have heard about obstetric fistula, 1% have experienced it and 78% have sought treatment.

3.7.1 Obstetric Fistula Policy Goal

To reduce incidence of obstetric fistula among women in Malawi

3.7.2 Obstetric Fistula Policy Statements

3.7.2.1 All community members shall be made aware of the prevention of obstetric fistula and availability of repair services.

3.7.2.2 All women shall be encouraged to deliver under the care of skilled birth attendants.

3.7.2.3 Partograph shall routinely be used to monitor labour and promote the taking of timely action.

3.7.2.4 The management of labour, including early post-partum care shall be geared towards the prevention of obstetric fistula.

3.7.2.5 Women who develop fistula shall have immediate access to comprehensive treatment and rehabilitation services.

3.7.3 Obstetric Fistula Strategies

3.7.3.1 Strengthen awareness of the magnitude and gravity of obstetric fistula and availability of services

3.7.3.2 Strengthen awareness of the prevention and management of obstetric fistula

3.8 Harmful Practices/ Domestic Violence

Domestic violence (DV) against women is prevalent in Malawi and covers all stages of the woman's life. According to MDHS, 2015-16, 34% of women are physically abused, 20% have experienced sexual violence and 5% have experienced violence while pregnant. DV is recognized as a major public health concern (Donohoe, 2003) and a violation of human rights. In addition, many Malawian women and children experience harmful practices, domestic and sexual violence. The proportion of girls who were forced during their first sexual debut in Malawi is as high as 38% (USAID, 2013). Other harmful practices include initiation, wife inheritance, fisi (hiring of a man for sex and conception), dry sex, death rituals, use of traditional herbs to induce labour, battery, rape, sexual harassment, psychological abuse, and genital mutilation.

3.8.1 Harmful Practices/Domestic Violence Policy Goal

To reduce the incidence of harmful practices and gender based violence among women, men, and young people.

34% of women are physically abused, 20% have experienced sexual violence and **5% have experienced violence while pregnant.**

3.8.2 Harmful Practices/Domestic Violence Policy Statements

3.8.2.1 Elimination of harmful SRHR practices shall be fully integrated in the delivery of sexual and reproductive health and rights services.

3.8.2.2 Service providers shall not perform pre-natal sex selection or female genital mutilation.

3.8.3 Harmful Practices/Domestic Violence Policy Strategies

3.8.3.1 Strengthen awareness of practices that have a negative impact on maternal and neonatal health among both men and women in the community

3.9 Male Involvement in Reproductive Health

Male involvement in maternal and new-born health care is a relatively new approach in Malawi, hence nation-wide statistics are scanty. However, there are reports that in 2013, in Balaka, 23% of antenatal women were accompanied by their husbands, while in Blantyre the percentage was only 5.2 (Nyondo et al., 2013). Traditionally, women have been viewed

as the custodians of maternal and neonatal health. Hence maternal and new-born health care services have focused on women, with very little male involvement. Male involvement in maternal and neonatal health care touches on sensitive gender roles related to culture, social norms, values and beliefs. Therefore male involvement should be viewed as a new health or social and behavioural change activity. Male unfriendly infrastructure at the health facilities, illiteracy, ignorance, poverty, increasing rural urban migration, and cultural beliefs contribute to lack of male involvement in SRHR issues.

3.9.1 Male Involvement in Reproductive Health Policy Goal

To promote male involvement in all SRHR issues and services

3.9.2 Male Involvement in Reproductive Health Policy Statements

3.9.2.1 Behavioural change and high impact SRHR services shall be delivered at community level to promote universal coverage.

3.9.2.2 Men's shared responsibility and active involvement in parenthood and sexual and reproductive behaviour shall be emphasized in the delivery of SRHR services.

3.9.2.3 Development of community SRHR services shall be participatory to ensure that such services meet the needs of men, women and young people as well as being culturally acceptable.

3.9.3 Male Involvement in Reproductive Health Strategies

3.9.3.1 Empower men to promote and patronize SRHR services.

3.9.3.2 Encourage couple initiatives, i.e., women to personally invite their husbands to patronize SRHR services.

3.9.3.3 Create conducive environment in health facilities to promote male involvement in SRHR services.

3.9.3.4 Mobilize communities and create awareness on the importance of male involvement through information, education and communication.

3.10 Resources and Supporting Systems

Human and material resources; and supporting systems influence the provision of comprehensive SRHR services. Currently, there are major challenges in the health delivery system in Malawi. These challenges include brain drain among health worker professionals, inadequate output in health training institutions, lack of supportive supervision, inadequate resources and materials, and poor communication.

3.10.1 Resources and Supporting Systems Policy Goal

To mobilize human and material resources; and supporting systems for provision of comprehensive SRHR services at all health care levels.

3.10.2 Resources and Supporting Systems Policy Statements

3.10.2.1 Pre-service and in-service training and supervision at all levels of care shall be provided to all relevant service providers to ensure that they maintain technical competence, adhere to standards and respect human rights of the people they serve.

3.10.2.2 There shall be increased fiscal investment designed to improve the quality and availability of sexual and reproductive health services to all people of Malawi.

3.10.2.3 Essential RH commodities as determined from time to time shall be included in the Essential Drug List of the Ministry of Health.

3.10.2.4 Programme managers shall ensure that all essential reproductive health commodities supplies and basic equipment are available at all service outlets.

3.10.3 Resources and Supporting Systems Policy Strategies

3.10.3.1 Advocate for increased commitment and resources for maternal and neonatal care among all partners.

3.10.3.2 Strengthen commodity supply and logistics management.

3.10.3.3 Strengthen the referral system.

Currently, there are major challenges in the health delivery system in Malawi. These challenges include brain drain among health worker professionals, inadequate output in health training institutions, lack of supportive supervision, inadequate resources and materials, and poor communication.

04

Institutional strategies for policy implementation

The Reproductive Health Department (RHD) of the Ministry of Health shall direct the implementation of the SRHR policy through Zone Health Officers, Directors of Central Hospitals and Chief Medical Officers in all the districts of Malawi.

4.1 Implementation Plan

The RHD is responsible for coordinating implementation of the SRHR programme. Therefore, the RHD is responsible for;

i. Policy guidelines formulation, dissemination and review.
ii. Coordinating all development partners and stakeholders involvement in SRHR activities
iii. Providing guidelines for SRHR research
iv. Guiding and monitoring implementation of the SRHR programme
v. Mobilizing resources to achieve the goals of SRHR programme

4.1.1 Programme Management

SRHR Policy will be implemented through the national RH Programme, which is coordinated by the RHD through various management structures. At the policy/ technical level the RHD will operate under the guidance of SRHR Technical Working Group, which addresses policy and programme issues and monitor progress in line with the comprehensive work plan. The head of RHD under the supervision of the Secretary for Health will manage all aspects of the RH programme and will provide overall policy and strategic direction to all SRHR activities. National budgets for SRHR will be reviewed and external resources will be mobilized through round table discussions, proposal development, and other fundraising activities.

4.1.2 Behaviour Change Communication

Under the SRHR programme a comprehensive BCC strategy for all aspects of SRHR, including HIV/AIDS has been developed. The BCC strategy will also address advocacy, gender issues, client/provider interaction, and incorporate elements of young people/men and friendly services. This strategy aims at coordinating the inputs of all stakeholders involved in behavioural change activities related to SRHR. This coordination will ensure the improvement of quality of SRHR services.

4.1.3 Community Participation

Community participation contributes to the achievement of the goal of the programme. Therefore, the RHD will collaborate with the District Health Management Team (DHMT) and Health Centre Staff to encourage community involvement in SRHR initiatives. The communities will be empowered with skills to take the lead in problem identification and solutions. Communities are diverse and complex, therefore, issues of culture and traditions will be taken into account.

The goal is to achieve community ownership of the health programme. The strategy is to empower communities to adopt and promote a continuum of care between household and health care facility.

4.1.4 Development of Human Resources

Implementation of the SRHR policy will require adequate numbers of well trained and highly motivated health workers. It will also entail provision of adequate material resources so that health workers provide efficient and effective services. The MoH has developed a Human Resource Development Policy for the Public Sector. It is anticipated that the implementation of this plan will result in a larger pool of human resources for the health sector, which will eventually lead to an increased number of skilled health workers providing integrated SRHR services efficiently.

The goal is to meet the minimum staffing levels at all services outlets, especially at health centres as per WHO criterion. The strategy is to advocate for increased training of skilled service providers and equitable deployment of the available staff. Service providers shall be expected to maintain their technical competence and standards.

4.1.5 SRHR Commodity Security

The MoH shall implement an RH Commodity Security Strategy to improve forecasting, quantification, procurement and distribution of SRHR commodities as well as logistical management systems. Districts shall ensure that essential SRHR commodities and supplies are always available in their respective service outlets.

4.2 Institutional Arrangements

Many institutions will be involved in implementation of SRHR programmes as follows:

4.2.1 Ministry of Health

i. Take overall responsibility and commitment for improving SRHR care
ii. Plan, develop and coordinate the provision of SRHR services
iii. Provide overall guidance for provision of SRHR care
iv. Advocate for the highest priority to be accorded to SRHR programmes as a necessary prerequisite for the attainment of SDGs
v. Mobilize and leverage human and material resources for the implementation of SRHR policy
vi. Promote and coordinate partnership with Development Partners, International Organizations, Non-governmental Organizations, Private and Public sectors for cooperation and collaboration to accelerate implementation of SRHR policy
vii. Ensure that the provision of SRHR services by all partners and stakeholders at all levels meets the required standards
viii. Disseminate relevant SRHR guidelines and standards
ix. Coordinate support and monitoring of progress towards implementation of SRHR policy

4.2.2 Ministry of Agriculture

i. Promote household food security and utilization of nutritious foods to ensure appropriate nutrition for girls and women before pregnancy, during pregnancy, and after delivery
ii. Promote creation of Farmers' clubs in communities to sensitize and mobilize farmers towards food security
iii. Collaborate with partners and other stakeholders to develop the concept and promote creation of model villages for holistic community development
iv. Organize periodic Agricultural shows/ fairs for raising awareness on good nutrition, food diversification, and food production at household level.

4.2.3 Ministry of Economic Planning and Development

i. Ensure the provision of adequate budgetary allocation to support implementation of SRHR policy
ii. Promote partnership with Development Partners, International Organizations, Non-governmental Organizations, Private and Public sectors for cooperation and collaboration to accelerate implementation of SRHR policy
iii. Utilise the Population Unit to promote awareness towards SRHR
iv. Monitor progress towards the achievement of all MDGs

4.2.4 Ministry of Education

i. Support services that address young people's SRHR issues
ii. Implement life skills curriculum in both primary and secondary schools
iii. Establish a counselling and referral system for boys and girls with SRHR needs
iv. Strengthen school clubs to address SRHR issues
v. Empower boys and girls to make informed decisions about their SRHR
vi. Provide age specific sexuality education to the youth

4.2.5 Ministry of Information

i. Raise community awareness on SRHR services including harmful practices/ domestic violence to promote women's and men's use of available services
ii. Facilitate public education through multimedia approach on issues of maternal, new born health and family planning
iii. Promote advocacy for the importance of SRHR services
iv. Facilitate debate and discussions on issues of SRHR
v. Facilitate implementation of Behaviour Change Interventions at community level on SRHR issues
vi. Coordinate publicity and media coverage among media stakeholders on SRHR issues

4.2.6 Ministry of Local Government

i. Support the promotion of community initiatives for SRHR at village level
ii. Support empowerment of men and women to make informed decisions on SRHR issues
iii. Assist communities dispel misconceptions and eliminate harmful practices that could prevent use of SRHR services
iv. Mobilize community leaders to participate in birth preparedness including organizing and supporting community transport for referral of women with obstetric complications
v. Support empowerment of community leaders to promote SRHR
vi. Support men involvement in SRHR issues

4.2.7 Ministry of Women and Child Development

i. Support empowerment of women to make informed choices on their sexual and reproductive health issues
ii. Mainstream SRHR issues of equity and empowerment
iii. Educate men to enhance their participation and involvement in the improvement of SRHR health of the community
iv. Support advocacy against harmful cultural practices that affect women's and girls' reproductive health.
v. Prevention of gender based violence

4.2.8 Ministry of Labour, Youth, Sports and Manpower Development

i. Promote sports among in and out of school youth as a medium for development of positive and healthy life style
ii. Raise awareness on cultural practices that expose youth, especially girls, to HIV infection and SRHR complications.
iii. Promote behavioural change among young people and communities; specifically looking at modifying negative cultural practices into safe practices
iv. Raise awareness on gender relationships that increase vulnerability to HIV infection and SRHR complications.
v. Equip youth with Life Skills
vi. Mobilise youth to participate in programmes that promote safe sexual behaviour

4.2.9 Department of Energy

The Department of energy is very important in SRHR issues, especially in rural areas where electricity is not available. The department should intensify its rural electrification program, which will provide power and light to rural areas for people to engage in economic activities and hence diverting attention from sexual activities.

4.2.10 Parliamentary Committee on Health

i. Support enactment of appropriate legislation with respect to SRHR including minimum age of marriage and legislation on violence against women
ii. Lobby with MPs to use constituency development funds to support SRHR initiatives in their various constituencies
iii. Promote and support adequate national budgetary allocation for SRHR
iv. Lobby for MPs to designate a focal person in their constituencies responsible for monitoring SRHR services.
v. Declare SRHR as a national priority and ensure allocation of resources to ring fence family planning commodities and life-saving drugs and commodities.

4.2.11 Development Partners

i. Advocate for the mobilization of resources and political will necessary to implement the SRHR policy
ii. Foster the relationship and collaboration among all development partners to support Government in the implementation of policies and strategies to bring about necessary changes and improve health and quality of life
iii. Support provision of technical and financial assistance to the MOH in thematic areas relevant to implementation of SRHR

iv. Strengthen and support monitoring and evaluation of SRHR services
v. Support operational research related to SRHR
vi. Promote advocacy for SRHR
vii. Provide technical and financial support to review and develop policies, standards, and guidelines in SRHR

4.2.12 Nurses' and Midwives' and Medical Councils of Malawi

i. Provide guidance for certification to attain minimum standards, competence, and skills required for the provision of SRHR care
ii. Support and promote inclusion of relevant components of SRHR into pre-service curricula of training institutions
iii. Monitor and evaluate nursing midwifery/medical services to ensure adherence to acceptable standards of practice
iv. Support development of SRHR standards
v. Reinforce professional conduct for health care providers to ensure provision of quality SRHR care

4.2.13 Training Institutions

i. Incorporate emerging issues in SRHR into pre-service training
ii. Conduct research for improvement of SRHR services
iii. Increase out-put of professional health workers
iv. Institute in-service education training in SRHR services

4.2.14 Professional Associations

i. Support advocacy for prioritizing implementation of SRHR programme
ii. Promote community awareness and empowerment on issues of SRHR
iii. Support human resource development for SRHR care provision through advocacy

4.2.15 Christian Health Association of Malawi (CHAM)

i. Collaborate with MoH to implement Service Level Agreements to enable beneficiaries access maternal and newborn care services in CHAM institutions free of charge
ii. Provide technical and financial support for provision of SRHR services
iii. Support MoH in training health workers to provide SRHR services

4.2.16 Civil Society Organisations

i. Provision of sexual and reproductive health and rights services
ii. Support community initiatives related to sexual and reproductive health and rights
iii. Create awareness of sexual and reproductive health and rights issues in the community.
iv. Advocate for the strengthening of sexual and reproductive health and rights services

05

Monitoring and evaluation

5.1 Monitoring and Evaluation

The National Reproductive Health Strategy has set monitoring and evaluation approach with RH core impact, outcome, indicators, and targets. These will be utilized in monitoring and evaluation of the SRHR policy.

The strategy is to strengthen the monitoring and evaluation mechanisms of the SRHR services for better decision-making and service delivery, and to strengthen the supervision of SRHR services at all levels.

5.2 Policy Review

The SRHR policy has been developed within the broader framework of development strategies such as Malawi Development Strategy and SDGs. In this regard, the lifetime of the policy has been set to five years (2022), when it will be reviewed to assess its performance and its targets. However, the policy may be reviewed earlier if there are new emerging SRHR issues that may need urgent inclusion in the SRHR policy.

Appendices

Appendix 1: Implementation plan

Overall Policy Goal: To provide a framework and guideline for accessible, acceptable and affordable, comprehensive SRHR services to all women, men, and youth of Malawi that enable them to attain their reproductive rights and goals

Appendix 1

Specific Goal	Outcome	Strategy	Responsibility for Implementation	Time frame
Policy Thematic Area 1: Family Planning				
Fertility rate among Malawians reduced through provision of voluntary comprehensive family planning services at all levels to all men, women and youth of the reproductive health age.	Contraceptive prevalence rate increased from 59% to 70%	Strengthen the availability, access to, and utilization of family planning services at both facility and community levels	Ministries responsible for (Health, Economic Planning and Development, Local Government and Rural Development), NGO's, CHAM, United Nation Agencies, Development partners and Communities.	2017-2022
		Strengthen male and youth friendly family planning services	Ministries responsible for (Health, Youth Development, Economic Planning and Development, Local Government and Rural Development), NGO's, CHAM, United Nations Agencies, Development partners and Communities.	2017-2022
		Strengthen behaviour change interventions and outreach services	Ministries responsible for (Health, Information, Youth Development, Economic Planning and Development, Local Government and Rural Development), NGO's, CHAM, United Nations Agencies and Development partners.	2017-2022
		Strengthen the integration of family planning services into other EHP components	MoH, NGO's, CHAM, United Nations Agencies Development partners and Communities.	2017-2022
		Strengthen monitoring and evaluation of family planning services.	MoH, NGO's, CHAM, Development, United Nations Agencies and Development partners.	2017-2022
		Create awareness amongst individuals and families so that they delay the first pregnancy until the age of 20	Ministries responsible for (Health, Youth Development, Economic Planning and Development, Local Government and Rural Development, Education, Gender and Child Development), NGO's, CHAM, Communities.	2017-2022
		Create awareness among individual women, men, and couples to space their births for a minimum period of three years.	Ministries responsible for (Health, Economic Planning and Development, Local Government and Rural Development), NGO's, CHAM, United Nations Agencies, Development partners and Communities.	2017-2022
		Raise awareness amongst individuals and families to avoid pregnancy after the age of 35	Ministries responsible for (Health, Local Government and Rural Development), NGO's, CHAM, United Nations Agencies, Development partners and Communities.	2017-2022

Appendix 1

Specific Goal	Outcome	Strategy	Responsibility for Implementation	Time frame
		Create awareness amongst women, men and couples not to have more than 4 children	Ministries responsible for (Health, Rural Development, Local Government and Rural Development), NGO's, CHAM, United Nations Agencies, Development partners and Communities.	2017-2022
		Strengthen accessibility to emergency contraception and post exposure prophylaxis (PEP) among all clients including youth.	Ministries responsible for (Health, Local Government and Rural Development), NGO's, CHAM, United Nations Agencies, Development partners and Communities.	2017-2022
		Strengthen research in family planning	MoH, NGO's, United Nations Agencies, Development partners and Training Institutions	2017-2022
	Community Based Distribution of family planning at community level adopted as the main channel of delivery of family services.	Strengthen human resources to provide quality family planning services including community based distribution agents	Ministries responsible for (Health, Youth Development, Economic Planning and Development, Local Government and Rural Development), NGO's, CHAM, United Nation Agencies, Development partners, and Training Institutions.	2017-2022
Policy Thematic Area 2: Maternal and Neonatal Health				
Maternal mortality rate reduced to 350/100,000	100% mothers have accessed comprehensive antenatal care and quality intrapartum and postpartum care by skilled attendants.	Improve the availability of, access to, and utilization of quality MNH care.	Ministries responsible for (Health, Youth Development, Economic Planning and Development, Local Government and Rural Development), NGO's, CHAM, United Nation Agencies and Development partners, Professional associations.	2017-2022
		Strengthen national and district health planning and management on provision of quality MNH care Continuously advocate for and strengthen male involvement in MNH care Advocate for internships during pre-service of nurse-midwives to strengthen quality MNH care	Ministries responsible for (Health, Youth Development, Economic Planning and Development, Local Government and Rural Development), NGO's, CHAM, United Nation Agencies and Development partners, Professional associations. Ministries responsible for (Health, Youth Development, Economic Planning and Development, Local Government and Rural Development), NGO's, CHAM, United Nation Agencies and Development partners and Professional associations. Ministries responsible for (Health, Youth Development, Economic Planning and Development, Local Government and Rural Development, Women and Child Development), NGO's, CHAM, United Nation Agencies and Development partners, Professional associations, Parliamentary Committee on Health.	2017-2022 2017-2022 2017-2022

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Specific Goal	Outcome	Strategy	Responsibility for Implementation	Time frame
		Advocate for increased commitment of government, development partners, and other stakeholders and partners for MNH care	Ministries responsible for (Health, Youth Development, Economic Planning and Development, Local Government and Rural Development, Women and Child Development, Information and Agriculture), NGO's, CHAM, United Nation Agencies and Development partners, Professional associations, Parliamentary Committee on Health.	2017-2022
		Strengthen monitoring and evaluation mechanisms for better decision-making and service delivery of MNH services.	MoH, NGO's, United Nations Agencies and Development partners, CHAM,	2017-2022
Neonatal mortality rate reduced to 22/1,000 live births and under-five mortality rate reduced to 48/1,000 live births.	100% of pregnant women have access to basic emergency obstetric and neonatal care services. 100% of all neonates receive quality essential care for every baby services (sick, small and healthy)	Strengthen research in MNH	MoH, NGO's, United Nations Agencies and Development partners, Training Institutions, Professional associations.	2017-2022
		Strengthen human resources to provide quality MNH skilled care	MoH, NGO's, CHAM, United Nations Agencies and Development partners, Training Institutions, Nurses and Midwives Council/Medical Council	2017-2022 2017-2022
		Empower communities to ensure participation and demand for MNH services.	Ministries responsible for (Health, Local Government and Rural Development, Information), NGO's, CHAM, and Parliamentary Committee on Health.	2017-2022 2017-2022 2017-2022 2017-2022
		Strengthen provision of quality neonatal services at all levels	MoH, NGOs, United Nations Agencies, development partners, training institutions, professional bodies.	2017-2022
		Increase availability of neonatal services at all levels	MoH, NGOs, United Nations Agencies, Development Partners, Training Institutions, Professional Bodies.	
		Strengthen integration of care for small and sick babies	MoH headquarters, CHAM, Division Offices, District Offices, Health facilities.	
		Remove barriers that affect care seeking behaviours for new-borns at community and facility levels	MoH, NGO's, CHAM, United Nations Agencies and Development Partners, Training Institutions, Nurses and Midwives Council/Medical Council. MoH, NGOs, United Nations Agencies, Development Partners, Training Institutions, Professional Bodies.	
		Strengthen neonatal unit management skills of health care providers		

Appendix 1

Specific Goal	Outcome	Strategy	Responsibility for Implementation	Time frame
Policy Thematic Area 3: Sexually Transmitted Infections and HIV and AIDS				
Incidence and prevalence of STI and HIV and AIDS in Malawi halved	All people in Malawi (100%) have access to STI and HIV prevention, care, treatment and support services	Strengthen human resources to provide STI/ HIV services.	MoH, NGO's, CHAM, United Nations Agencies and Development partners, Training Institutions, Nurses and Midwives Council/Medical Council.	2017-2022
		Strengthen provision of PMTCT services at all health care levels.	MoH, NGO's, CHAM, United Nations Agencies and Development partners, Training Institutions, Nurses and Midwives Council/Medical Council.	2017-2022
		Expand availability of STI/HIV prevention information, education and counselling (IEC) services to all men, women, and youth	Ministries responsible for (Health, Gender and Child Development, Education and Information), NGO's, CHAM, United Nations Agencies and Development partners.	2017-2022
		Strengthen provision of STI and HIV health promotion materials to all men, women and youth	Ministries responsible for (Health, Information and Agriculture), MoH, NGO's, CHAM, United Nations Agencies and Development partners.	2017-2022
		Strengthen STI/HIV commodity security	MoH, NGO's, CHAM, United Nations Agencies and Development partners	2017-2022
		Routinely offer HCT to all pregnant women, STI clients, and partners	MoH, NGO's, CHAM, United Nations Agencies and Development partners	2017-2022
		Comprehensively manage STI clients using the Syndromic Management Approach	MoH, NGO's, CHAM, United Nations Agencies and Development partners	2017-2022
		Strengthen STI/HIV activities within SRHR services	MoH, NGO's, CHAM, United Nations Agencies and Development partners	2017-2022
		Strengthen behaviour change interventions	Ministries responsible for (Health, Local Government and Rural Development, Gender and Child Development), NGO's, CHAM, United Nations Agencies and Development partners.	2017-2022
		Strengthen provision of ART to all eligible HIV positive pregnant women, youth, their partners and family members	MoH, NGO's, CHAM, United Nations Agencies and Development partners	2017-2022
		Strengthen research in STI/HIV.	MoH, NGO's, CHAM, United Nations Agencies and Development partners, NAC, Training Institutions	2017-2022

Specific Goal	Outcome	Strategy	Responsibility for Implementation	Time frame
		Strengthen availability of both male and female condoms at all levels of the health care system	MoH, NGO's, CHAM, United Nations Agencies and Development partners	2017-2022
		Registered Nurses and Nurse-Midwife Technicians to prescribe STI drugs following training in the Syndromic Management Approach. Strengthen Male Medical circumcision (MMC)	Ministries responsible for (Health, Local Government and Rural Development), MoH, NGO's, CHAM, United Nations Agencies and Development partners, Training Institutions, Nurses and Midwives Council MoH, NGOs, Development partners, Training Institutions, Community Leaders.	2017-2022
		Registered Nurses and Nurse-Midwife Technicians to prescribe STI drugs following training in the Syndromic Management Approach. Strengthen Male Medical circumcision (MMC)	Ministries responsible for (Health, Local Government and Rural Development), MoH, NGO's, CHAM, United Nations Agencies and Development partners, Training Institutions, Nurses and Midwives Council MoH, NGOs, Development partners, Training Institutions, Community Leaders.	2017-2022
Policy Thematic Area 4: Reproductive Cancers				
Incidence and complications of cancers of reproductive organs reduced in all men and women	Health promotion services on cancer of the cervix, prostate and breast provided to all people who need the services	Strengthen awareness on reproductive cancers and services available	Ministries responsible for (Health, and Information), NGO's, United Nations Agencies and Development partners.	2017-2022
		Strengthen awareness on reproductive cancers and services available.	Ministries responsible for (Health and information), NGO's, United Nations Agencies and Development partners.	2017-2022
		Strengthen human resources to provide reproductive cancer services	MoH, NGO's, United Nations Agencies and Development partners, Training Institutions, Nurses and Midwives Council, Medical Council	2017-2022
		Strengthen monitoring, evaluation and research in reproductive cancer.	MoH, NGO's, United Nations Agencies and Development partners, Training Institutions	2017-2022
Policy Thematic Area 5: Infertility				
Incidence of infertility reduced among men and women	Health promotion services on prevention of infertility provided to all clients who need the services	Strengthen awareness on causes of infertility and services available	MoH, NGO's, United Nations Agencies and Development partners, Training Institutions, Nurses and Midwives Council, Medical Council	2017-2022

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Specific Goal	Outcome	Strategy	Responsibility for Implementation	Time frame
		Strengthen human resources to provide infertility services	MoH, NGO's, United Nations Agencies and Development partners, Training Institutions, Nurses and Midwives Council/ Medical Council.	2017-2022
		Strengthen research in infertility	MoH, NGO's, United Nations Agencies and Development partners, Training Institutions.	2017-2022
Policy Thematic Area 6: Youth in Reproductive Health				
Incidence of HIV and AIDS, STI's, unplanned pregnancies and complications and drug use reduced among youth	Comprehensive and acceptable SRHR services provided to youth at health care delivery points, community level and in and out of school	Increase availability, access and utilization of quality youth friendly health services that meet needs of youth	Ministries responsible for (Health, Youth Development, Local Government and Rural Development, Gender and Child Development), NGO's, CHAM, United Nations Agencies and Development partners.	2017-2022
		Strengthen provision of information on SRHR rights to the youth	Ministries responsible for (Health, Education, Local Government and Rural Development, Youth, Gender and Child Development), NGO's, CHAM, United Nations Agencies and Development partners.	2017-2022
		Strengthen the training of service providers at all delivery points, communities and institutions to acquire knowledge, skills and positive attitudes to effectively provide youth friendly health services	MoH, NGO's, CHAM, United Nations Agencies and Development partners	2017-2022
		Strengthen behaviour change interventions	Ministries responsible for (Health, Youth Development, Education, Gender and Child Development and Information), NGO's, CHAM, United Nations Agencies and Development partners,	2017-2022
		Strengthen services on prevention and treatment of substance abuse	MoH, NGO's, CHAM, United Nations Agencies and Development partners	2017-2022
		Strengthen research in SRHR knowledge, practices, and attitudes among youth	Ministries responsible for (Health and Education), NGO's United Nations Agencies and Development partners.	2017-2022

Specific Goal	Outcome	Strategy	Responsibility for Implementation	Time frame
		Strengthen provision of health information including SRHR and HIV which is relevant to youth's needs, circumstances and stage of development	Ministries responsible for (Health, Youth Development, Education and Agriculture), NGO's, CHAM, United Nations Agencies and Development partners.	2017-2022
	SRHR services that are youth friendly provided by all service providers at all levels of care	Develop a supportive environment for the delivery of youth SRHR services	Ministries responsible for (Health and Education), NGO's, CHAM, United Nations Agencies and Development partners.	2017-2022
		Strengthen linkages between service delivery points, communities and Stakeholders for provision of information, counselling and advice	Ministries responsible for (Health and Education), NGO's, CHAM, United Nations Agencies and Development partners.	2017-2022
Policy Thematic Area 7: Obstetric Fistula				
Incidence of obstetric fistula reduced among women in Malawi	Health promotion services provided to all women, and men, and communities on causes and prevention of obstetric fistula	Strengthen awareness on the magnitude and gravity of obstetric fistula and the availability of obstetric fistula repair services	MoH, NGO's, CHAM, United Nations Agencies and Development partners	2017-2022
	Treatment and follow-up care provide to all women with obstetric fistula	Strengthen human resource for management of obstetric fistula	MoH, NGO's, CHAM, United Nations Agencies, Development partners, Training Institutions, Nurses and Midwives Council/ Medical Council.	2017-2022
		Strengthen research on operational challenges in case management and long term follow up of patents	MoH, NGO's, United Nations Agencies and Development partners, Training Institutions,	2017-2022
	Treatment and follow-up care provide to all women with obstetric fistula	Strengthen human resource for management of obstetric fistula	MoH, NGO's, CHAM, United Nations Agencies, Development partners, Training Institutions, Nurses and Midwives Council/ Medical Council.	2017-2022
		Strengthen research on operational challenges in case management and long term follow up of patents	MoH, NGO's, United Nations Agencies and Development partners, Training Institutions,	2017-2022

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Specific Goal	Outcome	Strategy	Responsibility for Implementation	Time frame
Policy Thematic Area 8: Harmful practices / Domestic violence				
Incidence of harmful practices and domestic violence reduced among women, men, and youth	Health promotion services on harmful practices/ domestic violence and their effects provided to all men, women and youth	Strengthen awareness on harmful practices/domestic violence that have a negative effect on reproductive health	Ministries responsible for (Health, Youth Development, and Information), NGO's, CHAM, United Nations Agencies and Development partners, Training Institutions, Parliamentary Committee on Health.	2017-2022
	Access to legal entitlement course of law, counselling and other support services provided for victims of harmful practices, domestic and sexual violence	Strengthen human resources to provide screening, treatment and follow-up care for support of victims of harmful practices and domestic violence including post exposure prophylaxis	MoH, NGO's, CHAM, United Nations Agencies and Development partners, Training Institutions, Nurses and Midwives Council/Medical Council	2017-2022
		Strengthen research on magnitude of harmful practices and domestic violence	MoH, NGO's, United Nations Agencies and Development partners and Training Institutions	2017-2022
Policy Thematic Area 9: Male Involvement in Reproductive Health				
Male involvement in all SRHR issues and services achieved	Information on importance of male involvement in SRHR issues and services provided to all men and women	Advocate for male involvement in SRHR issues and services.	Ministries responsible for (Health, Information, Gender and Child Development), NGO's, CHAM, United Nations Agencies and Development partners, Training Institutions, Parliamentary Committee on Health, Professional Associations, Nurses and Midwives Associations.	2017-2022
		Strengthen community awareness on the importance of male involvement in SRHR issues and services	Ministries responsible for (Health, Gender and Child Development and Information), NGO's, CHAM, United Nations Agencies and Development partners, Training Institutions, Parliamentary Committee on Health, Professional Associations, Nurses and Midwives Associations.	2017-2022
	Men are integrated into SRHR services of their spouses	Strengthen infrastructure and human resource capacity for promoting male in involvement in SRHR issues and services	MoH, NGO's, CHAM, United Nations Agencies and Development partners, Training Institutions, Nurses and Midwives Council/Medical Council	2017-2022

Appendix 1

Specific Goal	Outcome	Strategy	Responsibility for Implementation	Time frame
Policy Thematic Area 10: Supporting Systems				
Human and material resources; and supporting systems for provision of comprehensive SRHR services at all health care levels mobilised	Adequate human and material resources, and support systems for SRHR services provided to all health institutions	Strengthen commodity security and logistics management system of SRHR medicines and supplies	Ministries responsible for (Health, Local Government and Rural Development), NGO's, CHAM, United Nations Agencies and Development partners.	2017-2022
		Strengthen the referral and communication system	Ministries responsible for (Health and Economic Planning and Development and Local Government and Rural Development), NGO's, CHAM, United Nation Agencies and Development partners, Professional associations.	2017-2022
		Strengthen pre-service and in -service education for delivery of SRHR services	MoH, NGO's, CHAM, United Nations Agencies and Development partners, Training Institutions, Nurses and Midwives Council/Medical Council	2017-2022
		Strengthen monitoring and evaluation of SRHR services	Ministries responsible for (Health, Local Government and Rural Development), NGO's, CHAM, United Nations Agencies and Development partners.	2017-2022
		Strengthen behaviour change interventions	Ministries responsible for (Health, Local Government and Rural Development, Gender and Child Development), NGO's, CHAM, United Nations Agencies and Development partners.	2017-2022
		Strengthen research in reproductive health issues	MoH, NGO's, CHAM, United Nations Agencies and Development partners, Training Institutions	2017-2022

Appendices

Appendix 2: Policy impact monitoring and evaluation

Overall Policy Goal: To provide a framework and guideline for accessible, acceptable and affordable, comprehensive SRHR services to all women, men, and youth of Malawi to enable them attain their reproductive rights and goals.

Appendix 2

Specific Objectives	Indicator	Source of Data	Current situation (Baseline data)	Desired Target (2022)	Key Milestone (2020)	Responsibility for Implementation	Time Frame
Policy Thematic Area 1: Family Planning							
To provide access and convenient family planning services to all men, women and youth of reproductive age	Reduction in total rural fertility rate Reduction in percentage of married women with unmet needs for contraception	HSSP, MDHS, CIP HSSP, MDHS, CIP	4.4 19%	4.0 12%	4.1 by 2020 16% by 2020	Ministries responsible for (Health, Youth Development, Economic Planning and Development, Local Government and Rural Development), NGO's, CHAM, United Nation Agencies, Development partners and Communities	2017-2022
To provide and expand Community Based Distribution Agents (CBDA) of family planning at community level	% increase in modern contraceptive prevalence rate among married women in rural areas	HSSP, MDHS, CIP	58	70%	60% by 2020	Ministries responsible for (Health, Youth Development, Economic Planning and Development, Local Government and Rural Development), NGO's, CHAM, United Nation Agencies, Development partners NGO's, Training Institutions.	2017-2022
Policy Thematic Area 2: Maternal and Neonatal Health							
To reduce maternal mortality in Malawi	Reduction in maternal mortality Reduction in Adolescent Birth rate (15-19 years)	MoH, NSO, HMIS, RHD, MICS, HSSP,UN MoH, NSO, HMIS, RHD, MICS, HSSP,UN	439/100,000 live births 136/1000 live births	350/100,000 live births 100/1000 live births	400/100,000 live births in 2020. 115/1000 livebirths	NGO's, CHAM, Ministries responsible for (Health, Economic Planning and Development, Local government and Rural development), United Nation Agencies and Development partners Professional Associations, Nurses and Midwives Council/ Medical Council.	2017-2022
To reduce neonatal mortality	Reduction in neonatal mortality Reduction in under-five mortality ART Coverage among known HIV-Infected Pregnant Women	MoH, NSO, HMIS, RHD, MICS, HSSP,UN MoH, NSO, HMIS, RHD, MICS, HSSP,UN MoH, NSO, NAC, HMIS, RHD, MICS, HSSP	27 /1,000 live births 63/1,000 live births 83%	22/1,000 Live births 48/1,000 live births 85%	24/1,000 live births in 2020 55/1,000 live births in 2020 85%	NGO's, CHAM, Ministries responsible for (Health, Economic Planning and Development, Local Government and Rural Development), United Nation Agencies, Development partners, Professional associations, Nurses and Midwives Council/ Medical Council.	2017-2022

Appendix 2

Specific Objectives	Indicator	Source of Data	Current situation (Baseline data)	Desired Target (2022)	Key Milestone (2020)	Responsibility for Implementation	Time Frame
Policy Thematic Area 3: Sexually Transmitted Infections and HIV and AIDS							
To increase access to HIV prevention, care, treatment and support services for all individuals and families	Reduction in number of new HIV infections among 15-49 age group	MOH, NSO, HSSP, MDHS, HIV AIDS unit	8.8%	4.4%	6.0 in 2020	MoH, NGO's, CHAM, United Nations Agencies and Development partners, Training Institutions, Nurses and Midwives Council/ Medical Council	2017-2022
	Increased (%) of HIV –infected women on PMTCT during pregnancy and delivery the past 12 months	MOH, NSO, HSSP, MDHS, HIV AIDS unit MOH, NSO, HSSP, HIV AIDS Unit	83% 69% 78%	85% 81% 83%	84% in 2020 78% in 2020 81% in 2020	MoH, NGO's, CHAM, United Nations Agencies and Development partners, Training Institutions, Nurses and Midwives Council/ Medical Council	2017-2022 2017-2022 2017-2022
	Increased (%) of ART coverage among adults and children with advanced HIV infection	MOH, NAC, HIV AIDS Unit, HSSP	3.6% (males) 4.9% (females)	0.5% (Males) 0.5% (Females)	1.5% in 2020 1.5% in 2020	MoH, NGO's, CHAM, United Nations Agencies and Development partners, Training Institutions, Nurses and Midwives Council/ Medical Council	2017-2022
To increase access to STI prevention, care, treatment and support services for all individuals and families	Increased (%) of ART retention rate	MOH, HMIS				MoH, NGO's, CHAM, United Nations Agencies and Development partners, Training Institutions, Nurses and Midwives Council/ Medical Council	
	Reduction (%) in STI incidences					MoH, NGO's, CHAM, United Nations Agencies and Development partners, Training Institutions, Nurses and Midwives Council/ Medical Council	

Appendix 2

Specific Objectives	Indicator	Source of Data	Current situation (Baseline data)	Desired Target (2022)	Key Milestone (2020)	Responsibility for Implementation	Time Frame
Policy Thematic Area 4: Reproductive Cancers							
To provide screening, referral, and treatment services for cervical, and breast cancers to women and prostate cancer to men	Proportion of women aged 30-50 years screened every 3 years for cervical cancer	MoH, MNCR, WHS, NCD Department	Cervical Cancer 2.6%	40%	20% in 2020	MoH, NGO's, United Nations Agencies and Development partners, Training Institutions, Nurses and Midwives Council, Medical Council	2017-2022
	Proportion of men aged 30-50 years screened every 3 years for prostate cancer	MoH, MNCR, HSSP, NCD Department	Prostate cancer (unknown)	30%	15% in 2020	MoH, Development partners, National Cancer Registry	2017-2022
	Proportion of women aged 30-50 years screened every 3 years for breast cancer	MNCR, HSSP, NCD Department	Breast cancer 7.6%	40%	20% in 2020	MoH, Development partners, National Cancer Registry.	2017-2022
Policy Thematic Area 5: Infertility							
To provide health promotion services on secondary infertility at all health facilities	Reduction (%) in STI incidences in males and females which cause secondary infertility	MoH HMIS Health facility surveys	4.3%	0.5%	1.5% in 2020	MoH, NGO's, United Nations Agencies and Development partners	2017-2022
To provide management services for primary infertility to men and women at all appropriate levels of care	% of clients receiving services for primary infertility	MoH HMIS Health facility surveys	Not known	100%	50% in 2020	MoH, NGO's, United Nations Agencies and Development partners Training Institutions, Nurses and Midwives Council/Medical Council	2017-2022
Policy Thematic Area 6: Youth in Reproductive Health							
To provide comprehensive and acceptable SRHR services to youth at health care delivery points, community level and in and out of school	% of youths seeking SRH services in facilities and distribution points	MoH HMIS Health facility surveys	74.8%	100%	90% by 2020	MoH, NGO's, CHAM, United Nations Agencies and Development partners, Ministry of Local Government and Rural Development, Ministry of Women and Child Development	2017-2022

Appendix 2

Specific Objectives	Indicator	Source of Data	Current situation (Baseline data)	Desired Target (2022)	Key Milestone (2020)	Responsibility for Implementation	Time Frame
To provide services that are youth friendly by all service providers at all levels of care	% of youths accessing preferred contraceptive methods in health facilities and distribution points	MoH HMIS Health facility surveys	Injectable (81.9%) Male condoms (61.7%) Female condoms (48.4%)	100% 100% 100%	90% by 2020 90% by 2020 90% by 2020	MoH, NGO's, CHAM, United Nations Agencies and Development partners, Ministry of Ministry of Education	2017-2022
Policy Thematic Area 7: Obstetric Fistula							
To provide health promotion services to all women, and men, and communities on causes and prevention of obstetric fistula To provide treatment and follow-up care to all women with obstetric fistula	% of pregnant women accessing emergency obstetric care	MoH HMIS Health facility surveys, Maternal child health journal	20.7%	70%	50% by 2020	MoH, NGO's, CHAM, United Nations Agencies and Development partners	2017-2022
	No. of women provided with follow up treatment for obstetric fistula	MoH HMIS Health facility surveys, UNFPA	0.002/1,000	1.6/1,000	1.2/1,000 by 2020	MoH, NGO's, CHAM, United Nations Agencies and Development partners, Training Institutions, Nurses and Midwives Council/ Medical Council	2017-2022
Policy Thematic Area 8: Harmful Practices / Domestic Violence							
To provide health promotion services on harmful practices/ domestic violence and their effects to all men, women and youth	No. of people reporting and seeking care after abuse	MoH, NSO District Assemblies, Police	40%	100%	70% by 2020	Ministries responsible for (Health, Information and Youth Development) NGO's, CHAM, United Nations Agencies and Development partners, Training Institutions, Parliamentary Committee on Health.	2017-2022
To provide access to legal entitlement course of law, counselling and other support services for victims of harmful practices, domestic and sexual violence	% of people who access legal and counselling services after abuse	MoH NSO Ministry of Women and Child Development, Police, Courts	40%	100%	80% by 2020	MoH, NGO's, CHAM, United Nations Agencies and Development partners, Training Institutions, Nurses and Midwives Council/ Medical Council	2017-2022

Appendix 2

Specific Objectives	Indicator	Source of Data	Current situation (Baseline data)	Desired Target (2022)	Key Milestone (2020)	Responsibility for Implementation	Time Frame
Policy Thematic Area 9: Male Involvement in Reproductive Health							
To promote male involvement in all SRHR issues and services	% of women accompanied by their husbands when procuring facility antenatal, labour and birth services	MoH, NSO, Facility based surveys	10%	70%	50% in 2020	Ministries responsible for (Health, Information, Gender and Child Development), NGO's, CHAM, United Nations Agencies and Development partners, Training Institutions, Parliamentary Committee on Health, Professional Associations / Nurses and Midwives Associations.	2017-2022
Policy Thematic Area 10: Supporting Systems							
To provide adequate human and material resources, and support systems for SRHR services to all health institutions	% of facilities able to deliver EHP services	MoH, HSSP	90%	99%	95% in 2020	Ministries responsible for (Health and Local Government and Rural Development), NGO's, CHAM, United Nations Agencies and Development partners.	2017-2022

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