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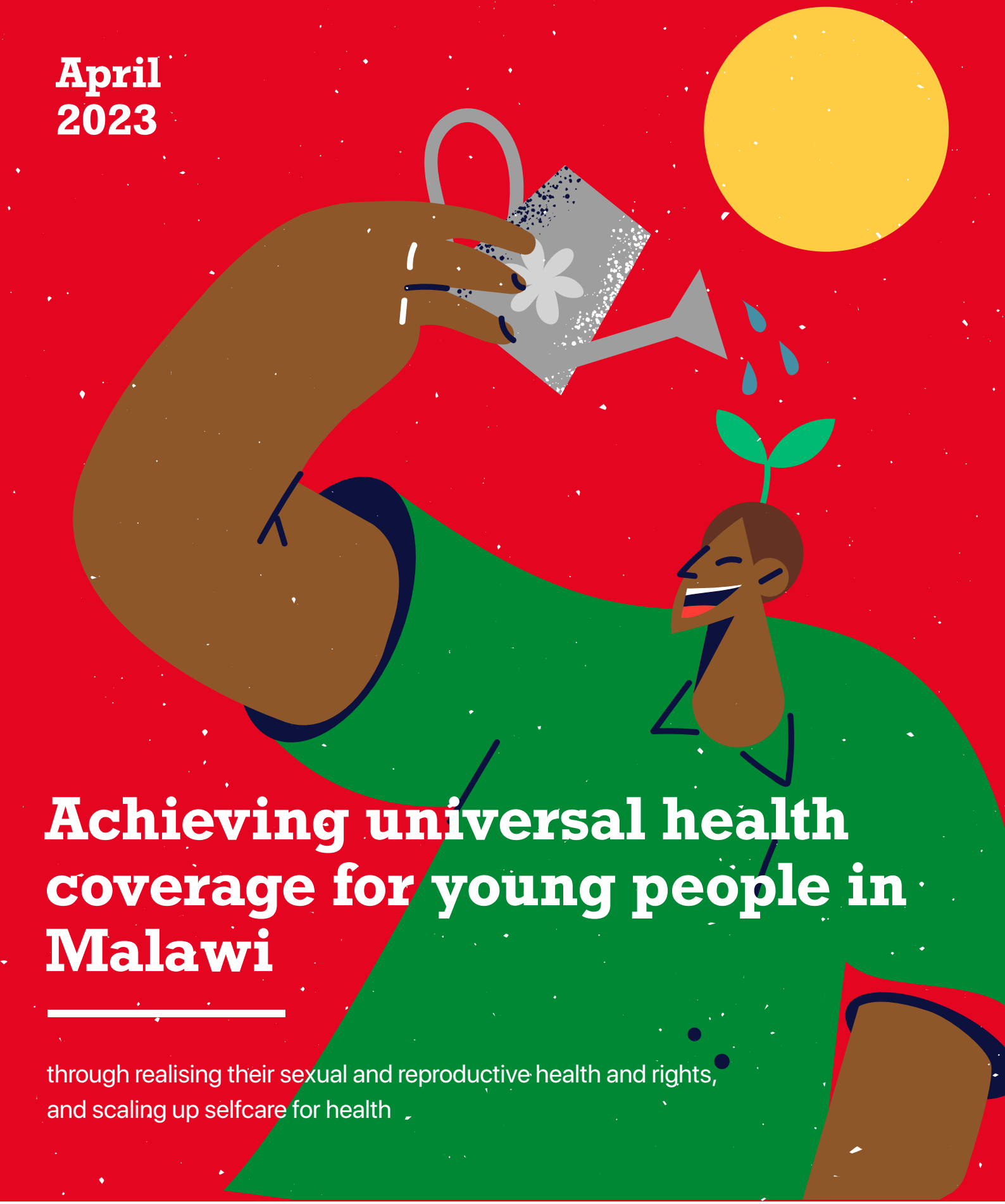

Achieving universal health coverage for young people in Malawi

through realising their sexual and reproductive health and rights, and scaling up selfcare for health

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Global Network of Young People Living with HIV

Developed by African Alliance

Universal health coverage and self-care: Malawi

April 2023

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Introduction

In September 2023, governments will meet in New York during the second United Nations High-Level Meeting (HLM) on Universal Health Coverage (UHC) to agree on new commitments to realise UHC by 2030. In 2019, during the first-ever HLM on UHC, an ambitious Political Declaration was adopted to guide countries in their efforts to reform health systems, increase funding for health, and address barriers that prevent people from receiving the health services they need.

The world has fundamentally changed since 2019, with the COVID-19 pandemic demonstrating the devastating impact of weak health systems, underinvestment, and harmful policies and laws that prevent vulnerable, marginalised and stigmatised populations from taking care of their health.

This new HLM is critical to get world leaders back on track and agree on the need to invest in long-term, sustainable responses to ensure lifesaving health services are guaranteed for everyone, particularly in the face of the ongoing effects of the COVID-19 pandemic – and the potential impacts of future pandemics. In addition, there needs to be a continued push for sociocultural and economic change; intersectional, human-rights based and gender-inclusive approaches to health; inclusive engagement of civil society in the development, implementation and monitoring of health policies and funding; and empowering and equipping people to meet their own health needs, including through scaling up self-care interventions for realising sexual and reproductive health and rights (SRHR).

Self-care has never been more relevant than during the COVID-19 pandemic, where, globally, public health systems failed to meet the demands and needs of citizens. Governments increasingly stepped up self-care and digital health interventions to reduce the burden on public health systems and give people choices to access the services they need despite COVID-19-related service restrictions related to the emergency response measures, including movement restrictions, total lockdowns and social distancing – affecting people's ability to reach clinics, but also – with the demand on emergency health services – resulting in increasing shortages of healthcare workers.

Solutions such as HIV self-testing, self-sampling for sexually transmitted diseases (STIs) and digital health information offer new options for people unable or willing to access clinic-based services. This is not just due to COVID-19-related limitations but also poverty, gender-based violence (GBV), (dis)ability and other vulnerabilities, as well as a lack of privacy and the related fear of stigma and discrimination that prevent adolescents and young people (AYP) in particular from accessing sexual and reproductive health (SRH) services in public clinics.

Thus, self-care provides a crucial contribution to realising UHC, where UHC is defined by the World Health Organization (WHO) as all people having access to the health services they need, when and where they need them, without falling into financial hardship. The "where and when they need them" is the very essence of self-care, where this approach means people are not dependent on the availability of doctors, nurses or the capacity or accessibility of health clinics for all of their health needs. It also increases people's autonomy, choice, and power concerning their health.

For this reason, the partner organisations implementing the YouthWise and YouthCare projects in Malawi, Uganda, Kenya, Tanzania and Zambia are advocating for governments to commit to scaling up self-care in the 2023 UHC Political Declaration as a crucial component of health systems strengthening; self-care services and commodities must be included in national UHC plans and budgets.

Purpose of this document:

To inform this advocacy, the African Alliance ('the Alliance'), funded by Aidsfonds, conducted a series of policy analyses for the five countries above to better understand why self-care is critical to improve the SRHR needs of AYP and achieve UHC. The analyses assessed the policy landscape; lived experiences around UHC, SRHR and Self-Care; and the current limitations AYP face in accessing the services they need – and used this process to develop a set of country-specific advocacy messages for partners in the five countries to take forward in the run-up to the HLM.

Country snapshot: Malawi

ZIMENE HLM PA UHC AKUFUNA KUMVA - NDIPO MUCHITE!

Nkhanza za umphawi zikadali cholepheretsa chitukuko, ufulu ndi chituku-ko cha anthu a Malawi ndi achinyamata awo. Zomwe zimatchedwa "gawo la achinyamata" sizingakwaniritsidwe pokhapokha zolepheretsa chikha-lidwe ndi chikhalidwe cha ufulu wa umoyo ndi ulemu zikhalebe zozikika mokhazikika ndikuyankhidwa mochepa. Achinyamata - mosiyanasiyana - m'Malawi muno akuyenera ndi kufuna zenizeni zomwe sangangokhala ndi moyo komanso kuti zitukuke komanso omwe ali ndi mphamvu pazandale awonetsetse kuti achinyamata nthawi zonse amakhala gawo lofunika kwam-biri lachitukuko chomwe chilipo komanso chamtsogolo.

WHAT THE HLM ON UHC NEEDS TO HEAR–AND DO!

The violence of poverty remains a critical and persistent barrier to the development, freedom and prosperity of Malawi's people, and her youth will not be realised unless social and structural barriers to health rights and dignity remain firmly entrenched and marginally addressed.

Young people – in all of their diversity –deserve and demand a reality in which they can not only survive but thrive. Those with political power must ensure that young people are always a central part of the current and future development pathways.

Malawi remains one of the poorest countries in the world despite making significant economic and structural reforms to sustain economic growth[01]. With persistently high fertility (4.4 children per woman and more than half of its people under age 18, Malawi's population is expected to double by 2038 to almost 40 million from its current estimated population of 19.6 million life expectancy at birth is 57 for men and 60 for women. In 2019, 70% of Malawians lived below $2.15/day[02].

In terms of the **HIV landscape**, Malawi has an HIV prevalence of 5.1% overall and 8.2% among adults - among the highest in the world[03]. An estimated 982 470 Malawians are living with HIV, of which 62% are women, 38% are men, and 5% are children under 15 years old[04].

Despite these numbers, results from the Malawi Population-Based HIV Impact Assessment (MPHIA) 2020-2021 show that Malawi has almost achieved the 95-95-95 goals (88%-98%-97%). Results were similar for men and women except for the first 95, where men were slightly behind at about 85% awareness of their HIV infection. Despite progress, some critical disparities between geography and populations persist.

01 Osman, H (January 2023)
02 National Statistical Office of Malawi (2022)
03 PEPFAR (2022). p 7.
04 PEPFAR (2022). p 7.

Malawi has a youthful population, with the 2018 census indicating that 51% are under 18, 2.4 million young people, or 41% of school-aged children, do not have access to primary and secondary education,[05] while the youth unemployment rate was 7.74% in 2021. While this was a slight decline from 2020, the last two years recorded significantly higher youth unemployment rates than in preceding years[06].

Young people's experiences of SRHR services access:

ZIMENE HLM PA UHC AKUFUNA KUMVA - NDIPO MUCHITE!

Achinyamata a ku Malawi ali ndi ufulu wopeza maphunziro, chisamaliro chaumoyo, komanso kukhala opanda nkhanza zamtundu uliwonse - kuphatikizapo kugwiriridwa kwa ana (nthawi zambiri kumabisa ngati "ukwati"). Izi zikutanthauza kuwonetsetsa kuti maunduna akugwira ntchito limodzi pamaphunziro, zaumoyo, chilungamo ndi mafakitale. Atsogoleri ammudzi ndi azipembedzo ayenera kupitiriza kulankhula ndi mgwirizano ndi achinyamata ndi madera omwe sali nawo kuti awonetsetse kuti achinyamata onse a Malawi akukhala moyo wolemekezeka komanso wathanzi - kuphatikizapo uchembere - chilungamo. Ndondomeko ndi malamulo akuyenera kuwonetsa momwe achinyamata amavutikira ndipo akuyenera kuwonetsetsa kuti thanzi lisalowe nawo mosalekeza kukhalabe pa mndandanda wa zolepheretsa ufulu wa achinyamata a Malawi.

WHAT THE HLM ON UHC NEEDS TO HEAR –AND DO!

Young Malawians have the right to access education and quality health care and be free from violence in all its forms – including child rape (usually disguised as marriage). This means ensuring the Ministries work together across education, health, justice and industry. Community and faith leaders must continue speaking up and in solidarity with young people and marginalised communities to ensure that all young Malawians live lives of dignity and health – including reproductive – policies and laws must reflect the reality of young people's struggles and needs to ensure that health does not join persistently remain on the list of barriers to the freedom of young Malawians.

05 National Statistical Office of Malawi (2018)
06 O'Neill, A (2023).

Some of the specific realities for AYP that impede their health service access are outlined below.

Age of consent to sex and marriage:

The age of consent to sex was raised from 13 to 16 in 2011. Child marriage is a significant challenge endorsed by the *Constitution*, where Section 23 sets the legal marriage age at 18, with a proviso that persons between the ages of 15-18 years can contract legally valid marriages if they have the consent of their parents or guardians. While the review of marriage laws leading to the adoption of the *Marriage, Divorce and Family Relations Act* has provided for the legal age of marriage as 18, the effect of this provision continues to be challenged by the principle of constitutional supremacy. Subject to satisfying the applicable constitutional requirement under section 22 of the *Constitution*, persons of 15 -17 years can still enter valid marriages, despite the change in the *Marriage, Divorce and Family Relations Act*. The *Constitution* has been undergoing a protracted process of review where these challenges have been addressed[07].

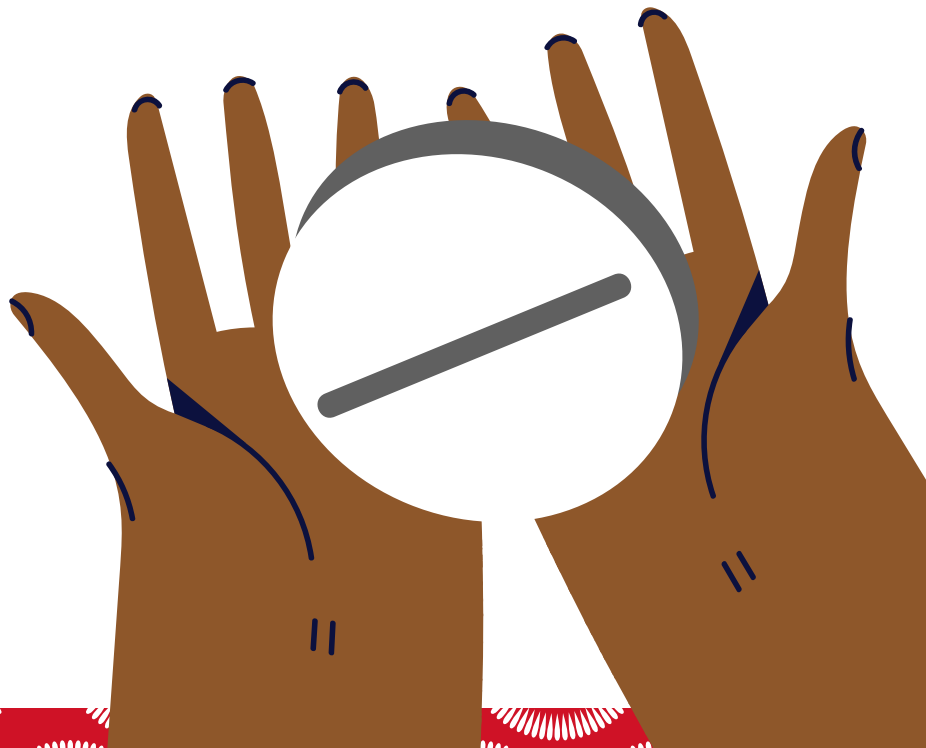
Access to contraception:

The high rates of child marriages and high fertility are compounded by a low modern contraceptive prevalence rate, which stands at 42% for married women only and 33% for all women of childbearing age, pointing to challenges in SRH interventions, including lack of availability of choice on contraceptives. The 42% reflects a remarkably rapid increase in family planning use even though it is still low. Despite this improvement, this rate does not capture unmarried women and girls who are sexually active, and shows a critical gap of 68% of married women not using modern contraceptives[08].

Access to abortion:

Malawi has a restrictive legal framework with respect to termination of pregnancy, where abortion is only available to serve the life of the mother, leaving several women, in particular poor women and young girls, with the option of unsafe abortion[09]. In June 2021, the Malawi High Court reaffirmed the statutory protections for legal abortion under narrow circumstances. In its ruling, the Court reiterated that despite the existing legal restrictions on access to safe and legal abortion under Sections 149, 150, and 151 of the Penal Code, Section 243 makes an exception when the life and health of a woman or girl are in danger. In the ruling, Justice Mzonde Mvula clarified that women and girls seeking to access abortion in Malawi must present themselves before a doctor and expressly request abortion services based on existing conditions. At that point, the doctor would then review the request and decide. According to the ruling, women and girls seeking an abortion should demonstrate to the doctor how a pregnancy would undermine their health and life in general. While the Penal Code only allows for abortion when the life of the woman or girl is in danger because of the pregnancy, the Court recognised in this ruling that preservation of life also entails safeguarding the mental and physical health of the woman or girl.[10]

07 UNFPA & UNHR (2016) p 11.
08 UNFPA & UNHR (2016) p23.
09 UNFPA & UNHR (2016) p 12.
10 Center for Reproductive Rights (2021)



Age of consent to health services:

Malawi's law does not explicitly address the age of consent for medical treatment and contraception, leaving it open to interpretation by service providers,[11] however, the *HIV and AIDS Prevention and Management Act* provides that a minor (13 years) can access HIV services without parental consent. Access to SRH services more broadly do not have a definite position however, which means young people are often denied access, despite their need.

Comprehensive Sexuality Education (CSE):

The Government's has committed to providing CSE but 'life skills' (as it is known) is not a compulsory subject and therefore is often not taught by schools, particularly faith-based schools. Where it is part of the curriculum, it often omits key content on issues such as sexual rights, or teachers are inadequately prepared and supported to teach the subject. In addition, the influence of culture and religion may mean some learners don't fully participate in the discussions due to confusion if it differs from what their parents or peers have shared, or because of the rigidity displayed by faith communities towards human sexuality issues. There is also no system between schools and SRH service providers for learners to easily access youth-focused referrals. As such, learners take their own initiatives when faced with SRH challenges which can put them at higher risk[12].

Criminalisation:

As discussed above, abortion is legal but highly restricted. Although sex work is legal, other laws are used to harass and arrest sex workers. Malawi's most recent HIV law no longer criminalises HIV transmission.[13] Consensual same-sex sexual activity among adults is criminalised, and there have been reports of cases of violence against lesbian, gay, bisexual, transgender and intersex (LGBTI) persons; due to the stigma, LGBTI persons do not enjoy effective access to health services[14].

In practice, these realities contribute to the challenges of limited access to SRHR information and services. Where services are available, they are sometimes not friendly to AYP. This lack of a conducive environment within health facilities where young people can access information and SRHR services, i.e., youth-friendly health service corners, is compounded by the limited knowledge and expertise of healthcare workers to provide services, especially for the LGBTI community, who usually face stigma from healthcare workers in terms of judgmental questions or discrimination.

There are also policy and legal barriers, as mentioned above, where one piece of legislation, such as the *HIV and AIDS Prevention and Management Act* provides for HIV service access for minors without consent, but the interpretation of whether HIV prevention activities (using contraception and testing) could apply to other SRH needs is unclear in the absence of other legislation, creating indirect barriers where adolescents – including those above the age of majority – who seek care alone are often told to consult their parents to access SRH, including lifesaving care for abortion-related complications."[15]

11 Kangaude, G; Coast E; Fetters, T. (2020). p 6.

12 Alice, F (2021)

13 Be in the Know (2018).

14 UNFPA & UNHR (2016) p 17

15 Kangaude, G; Coast E; Fetters, T. (2020). p 8.

Health Policies & Funding

ZIMENE HLM PA UHC AKUFUNA KUMVA - NDIPO MUCHITE!

Masomphenya a dziko la Malawi pa tsogolo lawo ali pakati pa achinyamata ndipo ali okonzeka kuchita bwino ndi cholinga choti asasiye aliyense mmbuyo, mwachangu komanso momveka bwino pothana ndi mavuto omwe dziko lino likufuna kuthana ndi mavuto a chitukuko obwera chifukwa cha kusapeza bwino kwaumoyo komanso kupezeka kwa ntchito zomwe zimakhudza makamaka achinyamata. anthu - m'mitundu yawo yonse. Masomphenyawa atha kukhala ophatikizika, ndikupangitsa kusintha kuchoka ku 'kugula' kwa achinyamata kupita ku umwini wawo ndikuwonetsetsa kuti malonjezo olephera a Abuja sakhala cholowa chathu chonse cha ku Africa powonetsa momwe kubweza mawuwa kumalipiradi phindu!

WHAT THE HLM ON UHC NEEDS TO HEAR –AND DO!

Malawi's vision for the future centres young people and is well positioned to make strides in the goal of leaving no one behind, urgently and clearly addressing how the country intends to tack-le the development challenges of poor health access and service availability that particularly affects young people - in all of their diversity. This vision can truly be inclusive, driving a shift from young people's 'buy in' to their ownership and ensuring that the failed promises of Abuja are not our collective African legacy by demonstrating how resourcing the rhetoric does indeed pay dividends!

Policy landscape

The *Constitution (1994)* commits to providing adequate health care commensurate with the health needs of Malawian society and international standards of health care, with the state to provide for the realisation of the right to development, through equality of opportunity for all to access health services.

The goal of the *Vision 2063* document is to:

> *"attain universal health coverage with quality, equitable and affordable health care for all Malawians. This will be achieved by providing a comprehensive healthcare system through interventions that will address shortfalls in the recruitment, distribution and retention of health workers; strengthening reproductive, maternal, neonatal, child and adolescent health; improving the availability and quality of health infrastructure, medical equipment, medicines and medical supplies; and exploring innovative and sustainable financing for health while focusing on efficiency-enhancing measures such as strengthening governance, among other interventions. Every constituency in the country shall have well-equipped and staffed hospitals and health centres with commensurate investment in public health and medical health programmes, including E-health. Malawi shall have a health sector with advanced data capturing and management systems to support decision-making and policy formulation".*[16]

16 National Planning Commission (2020). p 37.

However, Malawi lacks a specific comprehensive law on SRH, resulting in the absence of a comprehensive framework for the protection and advancement of SRH rights and responsibilities; promotion of women's health and safe motherhood; achievement of rapid and substantial reduction in maternal morbidity and mortality; accessing quality and comprehensive provision of family planning services; addressing harmful cultural practices relating to sexual, reproductive, maternal, newborn and child health; and providing for adolescent reproductive health, which are some of the objectives of similar legislation in comparable jurisdictions[17].

In terms of UHC, the *Constitution of 1994 (2017 Amendments)* doesn't explicitly use the term but commits to providing adequate health care, commensurate with the health needs of Malawian society and international standards of health care. It also states that "the State shall take all necessary measures for the realization of the right to development. Such measures shall include, amongst other things, equality of opportunity for all in their access to [among other things] health services."[18] In the *Vision 2063* document, UHC is mentioned more explicitly, with the stated goals is to: "attain universal health coverage with quality, equitable and affordable health care for all Malawians."[19] The *National Health Policy (2017)* is more explicit, titled, "Towards Universal Health Coverage" and in the foreword, it states its intention to achieve UHC by 2030. The overall Policy goal is to "improve health status of all Malawians, and increase client satisfaction and financial risk protection towards attainment of Universal Health Coverage." The first of seven policy objectives is to "improve service delivery by ensuring Universal Health Coverage of essential health care services, paying particular attention to vulnerable populations." The most recent *Malawi Health Sector Strategic Plan II (2017-2022)* also mentions UHC but not in much detail: "The goal of the HSSP II is to achieve universal health coverage of quality, equitable and affordable health care with the aim of improving health status, financial risk protection and client satisfaction" and to ensure "affordable essential medicines and vaccines for all". It also mentions UHC in relation to the Essential Health Package: "while the EHP is supposed to guide free health care provision in an attempt to achieve universal health coverage (UHC), there have been a number of related problems since its inception which have hampered this objective."

In terms of linkages between SRHR and UHC, there is no mention of UHC in the *National SRHR Policy 2017-2022*, or how this policy might fit into the country's UHC plans, but it does state that it wants all SRH services to be 'accessible' and 'affordable' for all. The *National Youth Friendly Health Services Strategy 2015-2020* also doesn't mention UHC but similarly states that the Ministry wants youth friendly services to be 'accessible' and 'affordable.' The *National Strategic Plan for HIV and AIDS 2020-25* does mention UHC but in passing, acknowledging the Government's intention to achieve UHC and that the Strategic Plan is guided by that.

Financing for health[20]

In terms of health funding, excluding public debt charges, health remains the third spending priority for the Government (10% of the national budget) after education and agriculture, but allocations continue to fall short of national and international targets. The Health Sector Financing Strategy (HSFS), which is currently being finalised by the Ministry of Health (MoH), provides an opportunity for the Government to work towards promoting financial sustainability, efficiency, and resilience of the health system, in the face of the continued COVID-19 emergency.

Overall, the Malawi health sector continues to heavily rely on external financing, (channelled as off-budget

17 UNFPA & UNHR (2016) p 11-12.

18 See: Constitution, Section 30. P 3.

19 National Planning Commission (2020). P 37.

20 This section draws on UNICEF (2023).

support). Donors contributed an average of 75% to the funding of the health sector between 2018 and 2019, with the bulk of the funding coming from multilateral and bilateral partners. Households are also increasingly contributing to financing health activities, with their expenditures growing by 35% between 2014/15 and 2017/18[21]. The financing situation has generally not changed much over the past few years.

Funding for most programmatic interventions is also heavily donor dependent, with over 90% of funding for malaria, RMNCH, tuberculosis, HIV (including STIs), environmental health and diarrheal diseases, nutrition and vaccines coming from donors. The Government is the largest financier for mental health, non-communicable diseases (NCDs) and general health systems strengthening programmes. There are several factors undermining the efficiency of health sector spending, largely linked to weak public finance management systems. Given the high incidence of off-budget donor support, there has been an increase in agencies and NGOs managing financial resources on behalf of donors. These agencies mostly use their own planning, financing, procurement, and monitoring and evaluation (M&E) systems bypassing Government systems, contributing to fragmentation of the planning and budgeting, delivery, and M&E systems in the health sector.

"Increasing national health budget, we have seen this year they have increased allocation towards SRHR, but from January to now, we are facing stock out of SRHR commodities. There were only condoms. Central medical stores indicated that COVID and devaluation were affected. They say 97 SRHR commodities are donor funded; we will be in shambles if they pull out.

So they need to increase the budget towards SRHR commodities"

(Male, Youth organisation)

Inclusion of SRHR and self-care in policies and funding

The term 'self-care' doesn't come up at all in national health policies and strategies or in SRH and youth specific policies/strategic plans either. The term' youth-friendly services' is used in the SRH policies and strategies but these are often top-down and not focused on empowering youth and facilitating self-agency in relation to SRHR.

In the *National Health Policy (2017),* there is no mention of youth-friendly services and 'youth' are only mentioned twice while 'adolescent' appears only three times. The more recent *Health Sector Strategic Plan III* (2023-2030) only mentions youth-friendly services once, and youth three times as part of a 'special group' that includes key populations, among others. Adolescents are mentioned three times under a section on combined reproductive, maternal, newborn, child health services. The *National Community Health Strategy* (2017-2022) doesn't mention youth-friendly services, youth services, adolescent-friendly services or youth at all.

However, the most recent *National Youth Friendly Health Services Strategy (YFHS) 2015–2020* is focused on making health services more 'youth friendly'. While it doesn't use the language of 'self-care', a list of commodities and services to be provided, such as condoms and contraceptives is included, though services like self-testing or other testing options, and over-the-counter contraceptives are not mentioned. Overall, the term 'self-care' doesn't feature at all in any policy and strategy documents related to health, youth, SRHR or HIV, but there is an effort to integrate 'youth-friendly services'. In its *Vision 2063* document, under a section on Managing Population Growth, it says: "Malawians, especially the youth, will be empowered with the necessary sexual and reproductive health information and services."[22]

At the Nairobi Summit in 2019, Malawi committed to increasing the percentage of adolescents accessing youth-friendly health services to 100% by 2030[23].

21 World Bank (2020).

22 National Planning Commission (2020). p 38.

23 Kangaude, G; Coast E; Fetters, T. (2020). p 4.

Voices of Young Advocates

Some of the **key barriers and issues** shared by the young people engaged in this process included access to SRHR services and availability. Youth-friendly health centres sometimes do not have the services needed by young people, so they are referred to general population sections to access the service, which is mostly not a comfortable environment for young people, especially the LGBTI community. Further to this, there are times when SRH commodities are not available in facilities. This is also highlighted in the *National SRHR Strategy* (2021-2025), which states that many adolescents, especially those who are most marginalised or vulnerable, are not being reached by adolescent health programmes.

> *"... one of the key issues that is so pressing in Malawi, when you look at young people in this country, is the issues of access to services as well as also information; we have a point whereby young people can access this information and also the services.*
>
> *So due to this, I think they get misinformed of other services available for them and also on the knowledge which can inform their decisions so that they can make informed decisions. So, looking at the access to the services, it also leads to high teenage pregnancies among people of which when you look at the services that are available in the centres, that are they there not Youth-friendly"*
>
> ***(Female, SRHR organisation representative)***

> *"Most young people complain that when they go to access this, they find out that the services are not there. So, this is also a challenge, and also, it's an issue.*
>
> *So as much as there's a lot of work being done on raising awareness for young people to access the information and the services, the services are not there in the health centres. So that's also one key issue that we may consider looking at."*
>
> ***(Female, SRHR organisation representative)***

In addition, healthcare worker attitudes hinder AYP from accessing SHR services.
This also impacts the quality of SRHR services being provided. There is also a lack of sustainability in the SRHR programmes that do support young people. Unfortunately, most times, when the project ends, everything else ends.

Key Advocacy Messages

A clear set of recommendations emerged through this process:

YOUNG LEADERS ARE LEADERS!

Young people must be involved in making these linkages between SRHR, HIV and UHC – and how self-care can effectively strengthen health systems. This was resounded in the youth discussions where they advanced the clarion call of "nothing about us without us". Overall, young people just want to be engaged; they want knowledge and information and inclusion in key processes, and inclusion in decision-making on what services should be provided to them; they want to see young people serving and working on their issues, not older people and ensure that parents are actively engaged and supporting them.

"Meaningful participation of young people is still far away. In the past, we were fighting for the representation of young people, and now I have observed a tokenistic type of engagement where they want to make it look like a young person is participating, but the real views of young people are still not finding space".

(Youth representative.)

LEADERS MUST LEAD!

Despite significant UHC policies and strategies, there is a clear gap in terms of implementation – as well as integration with HIV and SRHR policies - with the need for:

- Regularly updated standards and guidelines to reflect current realities, linked to regular review and update cycles for SRHR-related policies.
- Accessible standards and guidelines (at key levels of the health system) that translate the policy into tangible practice for service providers and users;
- Processes to ensure that civil society (CSOs) and community-based organisations (CBOs) are adequately involved at the design and implementation stages;
- Greater inclusion of AYP, their communities and service providers through human rights literacy training (with a specific focus on health rights and how these can be realised within the context of the SRHR and HIV response in each country), tailored to how AYP best receive information (online, via Apps, via peers, and so on).

LEADERS MUST ACCOUNT!

There are many opportunities for communities to hold leaders accountable practically; however, the mechanisms to do this can be very opaque. Some examples of how to hold leaders to account at different levels include:

- leveraging the regional and international instruments Malawi has signed onto and their inbuilt accountability mechanisms. CSOs can check the status of these various treaties online[24] to identify meaningful advocacy opportunities, for example, submitting Shadow Reports to supplement periodic government reporting on women's rights.
- Similarly, understanding the national policy frameworks – and the gaps – provides a foundation for influencing through national bodies, such as national HIV and AIDS councils' review cycles for their National Strategic Plans or Technical Working Groups' reviews of key strategies and guidelines for AYP SRHR services.
- Ensuring all SRHR-related policies and any associated strategies, plans and guidelines have regular review cycles and a schedule that can be accessed by civil society to influence policy updates by ensuring they reflect current realities on the ground.
- influencing through targeted information campaigns catering to key audiences' information preferences, e.g., hardcopy posters, dialogues, and activations in communities, or online (via Apps and social media) or via peers for AYP.

LEADERS MUST INVOLVE!

The meaningful participation of young people is still yet to be achieved:

- *"In the past, we were fighting for representation of young people on matters that affect us such as SRHR. However, young people are still not finding space to engage meaningfully"* **(Youth representative)**

Youth-led organisations also need to be better supported and involved in all change that affects them; **'nothing about us, without us':**

> *"The biggest challenge youth-led institutions face is requirements by donors for a youth-led organisation to be eligible for a grant, they will talk about systems, donors will put standard that youth led organisations cannot meet"*
>
> **(Youth representative)**
>
> *"Youth were getting Grants from the National Youth Council of Malawi (NYCOM). They would write a recommendation letter and would mentor the Youth-led organisation with no capacity. NYCOM used to do due diligence and capacity assessment, identify the gaps and build capacity. Maybe it's time to see what worked well in the past and how we can do it now"*
>
> **(Youth representative)**

24 See: https://www.ohchr.org/en/countries/malawi

LEADERS MUST UNITE!

Malawi has a strong network of stakeholders engaged in different ways in the SRHR and HIV landscape. There is, however, a clearly articulated need to meaningfully involve and – as part of that - better resource local CSO networks – particularly youth-focused and youth-led - to support a critical and representative mass of stakeholders who can support and drive the rights agenda.

This can include:

- catalysing around a shared issue to leverage different expertise and resources
- making available joint funding for shared action (campaigns, movement strengthening)
- making available unrestricted funding for non-traditional forms of advocacy that local groups can implement without 'sign off' from a donor.
- leveraging off the significant work already being done by CSOs in Malawi, for example, in 2021 the SRHR Alliance worked with young people to identify Government commitments towards regarding access to SRHR services and contribute to a country submission through the Universal Periodic Report (UPR) process.[25] In November 2022, they called on the Government to review the laws that protect minority populations to access quality health services in public facilities.[26]

LEADERS MUST EVOLVE!

While significant policies are guiding AYP SRH services in Kenya, the term 'self-care' is rarely used. Instead, language such as 'youth friendly' and 'adolescent friendly services' was prevalent and written from a top-down perspective. Similarly, the policy documentation extensively uses the term family planning. This is problematic where it often replaces terms such as 'reproductive health', 'reproductive rights', 'sexual and reproductive health and rights', and 'reproductive justice' and assumes the individual is using contraception to plan a family, as opposed to people who want to use contraception solely to exercise their right to choose and to be safe; it also assumes a very heteronormative version of a nuclear family and procreative path. The term' family planning' does not include access to safe and legal abortion, yet family planning is often used for all pregnancy prevention. The concept is best placed within a broader SRHR framework founded on the understanding of choice.

These language issues present significant opportunities for advocacy, where partners and communities can influence at different levels (policy influencing and community-based activism) around more inclusive, rights-based language that, in the You(th) Care project context, prioritises AYP's agency in accessing services and making decisions about their SRHR – and that also reflects that we do not live in a heteronormative paradigm of identities, orientations or choices.

"We need to start addressing the information around self-care; a lot of people are not aware of the term self-care even though they are already doing it; the information is there, and it's accessible, but for one to have the initiative to find the information, on their own it is hard"

(Male, youth representative)

25 Centre for Human Rights and Rehabilitation (October 2021).

26 Maravi Post (November 2022).

Organisations working in the SRHR sector see that it is possible to include self-care in the basic health services package. There is, however, a need to work on policies and guidelines to support self-care initiatives and innovation. There must be an enabling environment to achieve the inclusion of self-care interventions. For instance, it is challenging to attain safe abortion when the law is restrictive. A reference was made to an institution in South Africa, Mama Network, which shares evidence-based and stigma-free information about self-managed medical abortion and SRHR directly with women at the community level. This can only be achieved in Malawi if the legal environment is conducive and enabling:

"It is possible to achieve Self-care, but self-care itself must first be recognised as one of the health issues; whenever we are talking about health, SRHR, there must be a topic on self-care for it to get the same attention as any other health issue."

(Female, youth representative)

"There has been minimal integration of self-care itself, for example, the way primary school curriculum and secondary there is an element of CSE, but scholars only consider this for exam purposes. There should be mindset change and how we embrace this in our daily lives"

(Female youth representative)

"For me, I think I've just come across it and during the review of Youth friendly health services, but you may agree that most of these words or strategies become popular when government domesticate them into the policies and strategy. So, I think maybe we'll hear more because the new Youth friendly healthy service strategy has a component on self-care, so to be honest, I do not know it comprehensively"

(Male SRHR organisation representative)

"We also use the I CAN slogan. We usually just say "NDITHA" after every activity, so we usually just encourage them to say even they can do it. So, I think the way we use the terms in SRHR where I am working is all the information that we give them everything, every activity that we're doing with them, we want that day for them to make safe and informed choices so I think it's also linked to self-care. If you are managing, if you are taking medication, right? Yeah, exercising. It's making informed decisions about your body, so it's that slogan we use my body, my choice, it's all about taking care of yourself" (

Male SRHR organisation representative)

TAKE SRHR INFORMATION ONLINE!

There is a need to use technology in innovative ways given the many examples of the use and access of the internet through mobile phones (or other online channels) by young people in the country to access health information/ self-care as a potential mechanism to enact different advocacy and influencing initiatives, alongside the provision of comprehensive, accessible SRHR information and referral information for key health services.

Annex 1: Research Methodology

In August 2022, following reflections from You(th)Care consortium partners about gaps in knowledge of the policy landscape for SRHR and HIV in each programme country, Aidsfonds commissioned the African Alliance ('the Alliance') to undertake an initial country-specific (Kenya, Tanzania and Zambia) policy analysis to provide the consortium with insights into each country's policy environment to support partners to promote better and realise AYP's SRHR and HIV self-care needs, including AYP access to self-care services and commodities.

This first phase of work focused on mapping policies, strategies and guidelines related to AYP aged 10–25, identifying key stakeholders, and the specific barriers or enablers to progress in improving SRHR and the practice of self-care. To that end, the Alliance engaged stakeholders from the You(th) Care consortium cohort (partners and young people) alongside a small sample of thought leaders working regionally, continentally and globally on SRHR and self-care to understand better the policy landscape and what opportunities may exist for You(th) Care to inform its adaptation and future implementation. The policy analysis process sought to understand the State of the national adolescent and young people's SRHR and HIV response in each country and the possibilities to practice self-care; key policies and guidelines that influence adolescent and young people's SRHR and HIV vulnerability and access to self-care; barriers and opportunities for improving adolescent and young people's SRHR, the practice of self-care; the main stakeholders; recommendations to impact on adolescent and young people's SRHR, the practice of self-care and HIV/AIDS in the country.

The process was phased, consisting of an initial briefing with You(th)Care colleagues from Aidsfonds, a desk review, and country-based semi-structured discussions with consortium partners and the young people (aged 18-25) they work with. A second phase was commissioned in September 2022 to add an analysis of Malawi and Uganda and build on the initial process with an adjusted focus to consider what commitments or policies on UHC each country has in place and how they are being implemented.

In Malawi, the following stakeholders were engaged in this process:

- Malawi SRHR Alliance (staff)
- All for Youth (staff and young people)
- Child Rights Information and Documentation Centre (staff and young people)
- Purple Innovation for Women and Girls (staff)
- Centre for Youth Empowerment and Civic Education (staff)
- Youth Act Alliance (young people)
- Lilongwe Youth Organisation (young people)
- Youth Wave Malawi (young people)
- SRHR Africa Trust (young people)
- SRHR Africa Trust Youth Hub (young people)

Through this approach, the Alliance sought to draw from the base set of findings from the desk review and build on these through the in-country processes, ensuring that the data collected is meaningful and nuanced rather than repetitive to draw a clearer picture of what is happening in each country from multiple perspectives. The Alliance used thematic analysis to group and compare the findings in each country and draw out country-specific advocacy recommendations. Where possible, useful examples of good practice are identified in the narrative. Findings are presented as individual country snapshots, with a summary' global brief' that also considers the profile of self-care in regional and global debates. Illustrative quotes are used throughout this document, extracted from the in-country conversations with partners and AYP.

Limitations

- Any instance of participants not feeling comfortable using English was largely mitigated by conducting face-to-face conversations in local languages. The recordings were transcribed and translated into English and used to generate synthesis reports of the conversations.
- The sample of young people (aged 18-24) who participated in the conversations was limited due to i) insufficient time to organise discussions with adolescents (age 10-17) due to the lead-in time required to coordinate informed consent processes with their parents and guardians; and ii) the time of year the second phase conversations took place (November-December) where stakeholders had competing deadlines before the end of year break; iii) consultations were held in urban centres (Lilongwe in Malawi) which meant that only those young people who could reasonably travel to the meeting locations (i.e. those living in proximal urban or peri-urban areas) participated.

Annex 2: Key Policies and Guidelines

National policy landscape

In addition to the Constitution, a sample of the most recent or current available key policies, strategies, and guidelines include, but are not limited to:

Policies

- National Sexual and Reproductive Health Policy (2009)
- National Population Policy (2012)
- Malawi National Youth Policy (2013)
- Malawi National Health Policy (2018-2030)
- Malawi National SRHR Policy (2017-2022)
- National Social Welfare Policy (2018)
- HIV and AIDS Prevention and Management Act (2018)

Strategies and guidelines

- Malawi Vision (2063)
- Malawi Constitution of 1994 (2017 Amendments)
- Malawi Health Sector Strategic Plan III – Reforming for Universal Health Coverage (2023- 2030)
- Malawi National Community Health Strategy (2017- 2022)
- Malawi National Youth Friendly Health Services Strategy (2015 – 2020)
- National Strategic Plan for HIV and AIDS (2020-2025)

Regional and international policy landscape

Significant international and regional law, through treaties, conventions, protocols, covenants and declarations, exists to interpret human rights within the framework of health and specifically to apply those rights to respect, protect and defend human sexuality and human reproduction. These resound with the rights to freedom, equality, non-discrimination, privacy, and human dignity and confer on states that are party to each treaty the obligation to provide, domestically, for the highest attainable standard of health. Malawi is obligated under several international and regional treaties to provide access to healthcare, including to promote and protect SRHR, and this is reflected varying extents in the suite of policies, strategies and guidelines developed to realise these promises. A snapshot of some of these international and regional treaties is provided below.

International treaties and guidance

- Universal Declaration of Human Rights (1948)
- International Covenant on Civil and Political Rights (1976)
- Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979)
- Joint General Recommendation No 31 of the CEDAW
- International Covenant on Economic, Social and Cultural Rights (ICESCR)
- Convention of the Rights of the Child (1989)
- General Comment No 4 on Adolescent health and development in the context of the Convention on the Rights of the Child (2003); General Comment No 18 of the Committee on the Rights of the Child on harmful practices (2014); and General Comment No 20 on the Implementation of the Rights of the Child during Adolescence (2016)
- Fast Track Commitments to End AIDS by 2030
- International Conference on Population and Development Programme of Action (1994)
- Framework of Actions for the Follow-up to the Programme of Action of the International Conference on Population and Development Beyond 2014
- The 2030 Agenda for Sustainable Development
- Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030
- UNAIDS Agenda for Zero Discrimination in Healthcare Settings

Regional treaties and guidance

- African Charter on Human and People's Rights (1981)
- African Charter on the Rights and Welfare of the Child (1990)
- African Women's Protocol to the African Charter on Human and People's Rights (2003)
- General Comments on Article 14 (1) (d) and (e)of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (2012); and General Comment No 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (2014)
- African Youth Charter (2006)
- Continental Policy Framework for Sexual and Reproductive Health and Rights (2005)
- Maputo Plan of Action on Sexual and Reproductive Health and Rights (2006)
- Model Law on HIV in Southern Africa (2008)
- The ESA commitment made by ministers of health and education in 21 ESA countries to scale up comprehensive sexuality education (CSE) and SRH services for AYP (2013)
- Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage (2016)
- Southern African Development Community (SADC) Gender Protocol
- AU 2063 Agenda
- SADC Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC Region
- SADC Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations (2018)
- AU Catalytic Framework to End AIDS, TB and Malaria in Africa by 2030
- Organisation of African Unity, Abuja Declaration on HIV/AIDS, TB and Other Related Infectious Diseases (2001)
- AU Addis Ababa Declaration on Population and Development in Africa Beyond 2014 (2013)

SADC SRHR Strategy and Scorecard (2019-2030) (2018)

This is not a comprehensive list, but the examples shared give some sense of the extensive international and regional relationships between states and the shared values of the international and regional communities. This provides a basis for engagement of civil society at the national level, as well as within and between states, for shared international and regional accountability, recognising that, while it can be difficult to 'enforce' the implementation of the content of these documents, they are important to be aware of as each comes with its own set of review mechanisms that can provide a point of advocacy and influencing for civil society engagement. For example, the African Union (AU) Summits (for the Maputo Protocol) and the CEDAW country reviews, among others.

Annex 3: Key UHC Stakeholders

Key state actors include the Ministry of Health and the Ministry of Gender. In addition to the various state actors responsible for developing policies that affect young people, key civil society stakeholders working specifically on SRHR issues – and at the intersection of SRHR and HIV for adolescents and young people, partners who participated in this process include:

1. Malawi SRHR Alliance (staff)
2. All for Youth (staff and young people)
3. Child Rights Information and Documentation Centre (staff and young people)
4. Purple Innovation for Women and Girls (staff)
5. Centre for Youth Empowerment and Civic Education (staff)
6. Youth Act Alliance (young people)
7. Lilongwe Youth Organisation (young people)
8. Youth Wave Malawi (young people)
9. SRHR Africa Trust (young people)
10. SRHR Africa Trust Youth Hub (young people)

There are also a range of civil society organisations working directly on UHC, like the coalition of partners led by the Malawi Health Equity Network (MEHN) – a member of the Civil Society Engagement Mechanism (CSEM) for UHC (see below). Coalition members include:

11. Centre for the Development of People (CEDEP)
12. MANERELA+ (membership network of religious leaders living with or personally affected by HIV and AIDS)
13. Journalist Association against AIDs (JAA)
14. Network of Journalists Living with HIV (JONEHA)
15. Coalition of Women Living with HIV and AIDS in Malawi (COWLHA)
16. MANASO
17. Partners in Health (PIH)
18. Médecins Sans Frontières (MSF)
19. Global Hope Mobilisation (GLOHOMO)
20. Amref Health Africa
21. Save the Children Malawi
22. ActionAid Malawi

JAA, in particular, acts as the Deputy Chair for the UHC Coalition in Malawi. They are also a member of the National Non-Communicable Diseases (NCDs) Alliance. They have engaged in policy advocacy around the Health Sector Plan (2022 -2030) and the National Vision 2063. In the lead up to the UN High-Level Meeting on UHC, they have been engaged in consultative meetings with the international corps and the Government. They have also been active as a member of the Health Financing Technical Working Group (TWG) under the Ministry of Health on health insurance reforms.

The full list of Malawian members of the CSEM for UHC 2030 includes the following:

- Centre for Girls and Interaction (CEGI)
- Christian Aid
- Collective Action for Sustainable Community Development
- Community Initiative for Social Empowerment (CISE Malawi)
- Country Minders for People's Development
- Facilitators of Community Transformation (FACT)
- Foundation for Rural Development
- Health and Rights Education Programme Program
- NECCOSS
- OSSEDI Malawi
- Outreach Scout Foundation (OSF)
- Pakachere IHDC
- Patient and Community Welfare Foundation of Malawi
- Malawi Health Equity Network

ANNEX 4: Advocacy Roadmap

Timeline - UHC Negotiation Schedule

The UN Language Compendium is a useful tool for high-level United Nations negotiations and can be used for community advocacy to advance human rights commitments — particularly regarding access to healthcare and sexual and reproductive health and rights: https://hivlanguagecompendium.org

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You(th) Care
My health.
My responsibility.

aidsfonds

ARASA
AIDS & Rights
Alliance
for Southern Africa

AYARHEP
Ambassador for Youth & Adolescent Reproductive Health Programs

CHILDREN'S DIGNITY FORUM
CDF
UTU WA MTOTO

COPPER ROSE ZAMBIA
Beautiful | Valuable | Empowered

Network for Adolescents and Youths of Africa
NAYA

NYP+
Network of Young People Living With HIV and AIDS

PATA
PATA
PATA

GLOBAL NETWORK OF YOUNG PEOPLE LIVING WITH HIV

Developed by
African Alliance