



**Analysis of Policy for Protection of HIV Positive Adolescent Girls Against  
Vulnerabilities faced in using Contraception in Malawi**

**By**

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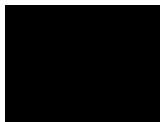
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## DECLARATION

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Signed:



Date: April 28<sup>th</sup> 2022

## DEDICATION

This thesis is dedicated to;

My Parents; the Late Rev. Canon and Mrs. Mubbala, for being the torch bearers for my academic ambitions, imparting in me the value of education, the strong foundation laid for me – principles which have enabled me to get this far in life, for believing in me and pushing my life and career ambitions regardless of their economic situation. Dad and mum, we did it!

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And lastly;

To the young girls and women of today and tomorrow, in Sub-Saharan Africa and world over, whether in or out of reach by conventional systems, and/but whose hands and voices raised are neither seen nor heard, and who are left out and left behind; the world knows about you!

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## ABSTRACT

There are challenges faced in accessing and using contraception by adolescent girls, but the reality is worse for adolescent girls living with HIV. Thus, it is important to investigate the extent to which current policies in Malawi put into account the vulnerabilities faced by this sub-population.

This study therefore sought to answer the following research questions:

1. What are the structural and socio-cultural issues affecting the use of contraception among AGLHIV in Malawi?
2. What policy provisions are in place in Malawi to address the issues/risks faced by AGLHIV during reach and use of contraception?
3. What implementation challenges affect the effectiveness of the available policy provisions?

This study was guided by the healthy policy triangle (HPT) framework and it was qualitative in nature, using both secondary and primary data collection methods. The findings include;

- Access to contraception by adolescent girls living with HIV is hampered by several structural and socio-cultural issues, mainly; the mode of service provision, supply chain and infrastructural challenges, age restrictions, conditioned access, as well as integration challenges. The socio-cultural issues include; the high momentum for children, male dominance, social labelling, non-disclosure of HIV serostatus to sexual partners, social sensitivity, perpetuation of harmful content, and a general lack of social support, and poor risk perception.
- The available provisions include those addressing gender-based violence, discrimination and stigma, community engagement, confidentiality, and emphasis on adolescent girls and young women. However, most of the provisions are broadly stated and gaps exist too.
- Effective implementation is affected largely by cascading challenges, lack of sufficient funding, limited political will, low comprehension of policy directives, limited participation of target population, coordination challenges, social resistance, effects of decentralization, low capacity of implementing partners and the slow pace of behaviour change among the targeted population and communities.

While the policy environment in Malawi is seemingly favourable, undertones exist around harmonization, and representation of interest groups, mainly PLHIV groups. Policy makers ought not to continue ignoring the importance of formulating HIV-sensitive policies which can give way to social protection programs for the most vulnerable within the society, given the benefits of a healthy youthful population.



## ACRONYMS AND ABBREVIATIONS

AA-HA!	Accelerated Action for the Health of Adolescents
ABYM	Adolescent Boys and Young Men
AGLHIV	Adolescent Girls Living with HIV
AGs	Adolescent Girls
AGYW	Adolescent Girls and Young Women
ALHIV	Adolescents Living with HIV
AMLHIV	Adolescent Mothers Living with HIV
ANC	Antenatal Care
ART	Anti-Retroviral Therapy
ASRH	Adolescent Sexual and Reproductive Health
AU	African Union
BLM	Banja La Mtsogolo
CBDAs	Community-based Distribution Agents
CBOs	Community-based Organizations
CCWPs	Community Child Protection and Case Management Workers
CEDAW	Convention on the Elimination of all forms of Discrimination Against Women
CHAM	Christian Health Association of Malawi
COMREC	College of Medicine Research and Ethical Committee
CPR	Contraceptive Prevalence Rate
CSE	Comprehensive Sexuality Education
CSOs	Civil Society Organizations
DHS	Demographic Health Survey
DPs	Development Partners
DREAMS	Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe
EC	Effective Contraception
ESA	Eastern and Southern Africa
FP	Family Planning
FP2020	Family Planning 2020
FPAM	Family Planning Association of Malawi
GBV	Gender-based Violence
GDP	Gross Domestic Product
GoM	Government of Malawi

HAART	Highly Active Anti-Retroviral Therapy
HC	Hormonal Contraception
HDI	Human Development Index
HIV	Human Immuno-deficiency Virus
HPT	Health Policy Triangle
HSAs	Health Surveillance Assistants
ICCPR	International Covenant on Civil and Political Rights
ICESCR	International Covenant on Economic, Social and Cultural Rights
ICPD	International Conference on Population and Development
IP	Implementing Partners
KPs	Key Populations
LMICs	Low and Middle-Income Countries
LSP	Local Service Provider
MDHS	Malawi Demographic Health Survey
MoEST	Ministry of Education, Sports and Technology
MoF	Ministry of Finance
MoGCDSW	Ministry of Gender, Children, Disability and Social Welfare
MoH	Ministry of Health
MoLG	Ministry of Local Government
MoLYSMD	Ministry of Labour, Youth, Sports and Manpower Development
MPoA	Maputo Plan of Action
MSM	Men who have Sex with Men
NAC	National AIDS Commission
NAF	National HIV and AIDS Action Plan
NSP	National Strategic Plan (for HIV and AIDS)
OVC	Orphans and Vulnerable Children
PHC	Primary Health Care
PI	Principal Investigator
PLHIV	People Living with HIV
PM	Policy Maker
PMTCT	Prevention of Mother-To-Child Transmission
PoA	Program of Action
RSSH	Resilient and Sustainable System for Health
SADC	Southern African Development Community

SBC	Social and Behaviour Change
SBCC	Social and Behaviour Change Communication
SCs	Simulated Clients
SDGs	Sustainable Development Goals
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SSA	Sub-Saharan Africa
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UCRC	Universal Convention for the Rights of the Child
UHC	Universal Health Coverage
UKZN	University of KwaZulu-Natal
UN	United Nations
UNCPD	United Nations Commission on Population and Development
UNGA	United Nations General Assembly
USAID	United States Agency for International Development
VAWG	Violence Against Women and Girls
WHO	World Health Organization
WLHIV	Women Living with HIV
YFHS	Youth-Friendly Health Services
YKPs	Young and Key Populations
YPLHIV	Young People Living with HIV

## TABLE OF CONTENTS

### Table of Contents

CHAPTER 1: INTRODUCTION .....	1
1.1    Introduction to the study .....	1
1.2    Background to the study .....	2
1.2.1    Fertility control among adolescent girls (AGs) in developing countries .....	4
1.2.2    Situation analysis .....	6
1.2.3    Malawian context: The SRH situation of adolescent girls and young women (AGYW) .....	8
1.3    Rationale of the study .....	12
1.4    Research aims and objectives .....	14
1.4.1    Research questions .....	14
1.4.2    Specific objectives .....	15
1.5    Theory and Theoretical framework .....	15
1.5.1    Theoretical Framework .....	15
1.6    Study contribution to literature/knowledge .....	16
1.7    Scope of the study .....	17
1.8    Research/study process .....	18
1.9    Definitions of key terms used in the study .....	19
1.10    Synopsis of the thesis .....	20
CHAPTER 2: LITERATURE REVIEW .....	22
2.1    Introduction .....	22
2.2    Sexual and Reproductive Health and Rights, of adolescent girls living with HIV .....	22
2.3    Needs and aspirations of AGLHIV .....	25
2.4    Dual burden of HIV and teenage pregnancy and motherhood .....	28
2.5    Perceptions on family planning and use of contraception in SSA .....	30
2.6    Contraception use among adolescent girls and young women in Malawi .....	31
2.7    The importance of contraception for AGLHIV .....	32
2.8    Formulation and implementation of a policy .....	35
2.9    Health policy, its formulation, and implementation .....	37
2.10    The role of policy in promoting SRH for AGLHIV .....	39
2.11    Malawi and the ICPD .....	40
2.11.1    The ICPD and Sexual and Reproductive Health and Rights .....	40
2.11.2    Understanding the sequence of political, and socio-economic context for SRH in Malawi post-ICPD 1994 .....	42
2.12    The SRHR policy framework and program environment in Malawi .....	46

2.13	Contraception, health and human rights for PLHIV .....	48
2.13.1	Guidelines for contraception for Women living with HIV .....	51
2.13.2	Rights-based family planning: .....	52
2.14	Conclusion .....	53
CHAPTER 3: SCOPING REVIEW; BARRIERS FACED BY ADOLESCENT GIRLS AND YOUNG WOMEN LIVING WITH HIV/AIDS IN THE UPTAKE OF CONTRACEPTION, IN SUB- SAHARAN AFRICA.....		54
3.1	Introduction:.....	54
3.2	Rationale .....	54
3.3	Conceptual argument .....	56
3.4	Objective of the scoping review.....	56
3.5	Methodology for scoping review .....	57
3.5.1	Identifying the research question .....	57
3.5.2	Identifying relevant studies and search strategy .....	57
3.5.3	Study Screening and selection .....	58
3.6	Charting of data.....	60
3.7	Collating, summarizing, and reporting of results.....	60
3.8	Summary of Results.....	66
3.9	Data synthesis .....	66
3.10	Conclusion .....	68
CHAPTER 4: METHODOLOGY .....		69
4.1	Introduction.....	69
4.2	Study/Research design .....	70
4.3	Study population .....	70
4.4	Sampling procedure .....	72
4.5	Sample size .....	78
4.6	Data collection approaches and process.....	79
4.6.1	Phase one: Documents Review: .....	79
4.6.2	Phase two: In-depth interview:.....	82
4.7	Approaches to Data analysis .....	87
4.8	Ethical considerations .....	88
4.9	Study limitations and challenges.....	89
4.10	Conclusion .....	91
CHAPTER 5: FINDINGS.....		92
5.1	Introduction:.....	92

5.2	Structural and socio-cultural issues affecting the use of contraception by AGLHIV in Malawi .....	92
5.2.1	Structural issues: .....	92
5.2.2	5.2.2 Socio-cultural issues .....	105
5.2.3	Discussion on structural and socio-cultural issues.....	134
5.2.4	Conclusion .....	156
5.3	Policy provisions in place in Malawi to address the issues and risks faced by AGLHIV during the reach and use of contraception .....	156
5.3.1	Introduction:.....	156
5.3.2	Discussion on policy provisions available in Malawi to address the identified risks and vulnerabilities.....	177
5.3.3	Conclusion .....	183
5.4	Implementation challenges affecting the effectiveness of the available policy provisions	184
5.4.1	Introduction.....	184
5.4.2	Discussion on implementation challenges affecting the effectiveness of the available policy provisions.....	211
5.4.3	Conclusion: .....	215
CHAPTER 6: SYNTHESIS OF STUDY FINDINGS AS PER HPT FRAMEWORK .....		216
6.1	Actors:.....	216
6.2	Context:.....	222
6.3	Process: .....	223
6.4	Content:.....	226
CHAPTER 7: CONCLUSIONS AND RECOMMENDATIONS .....		230
7.1	Conclusion .....	230
7.2	Recommendations (as per the Health Policy Triangle).....	235
7.3	Areas for further research .....	240
Annex 1: Data Collection Tools.....		261
Annex 1.1 Documents' Review Framework.....		261
Annex 1.2 PLHIV organizations' interview guide .....		263
Annex 1.3 Local service providers and implementing partners' interview guide.....		265
Annex 1.4 Policy makers' interview guide.....		267
Annex 1.5 Development partners' interview guide .....		269
Annex 2: Principal Investigator Request Letter to Targeted Participants .....		270
Annex 3: Informed consent forms (ICF).....		272
Annex 3.1 : Malawi National Health Sciences Research Committee (NHSRC) Consent form (English version).....		272

Annex 3.2: Malawi National Health Sciences Research Committee (NHSRC) Consent form (Chichewa version) .....	275
Annex 3.3 UKZN Humanities & Social Sciences Research Ethics Committee (HSSREC) ICF ...	278
Annex 4: Ethical Clearances/Approval Letters.....	280
Annex 4.1 Country ethical approval .....	280
Annex 4.2 Full Ethics Approval – University Ethics Committee .....	281

## LIST OF TABLES

<i>Table 1 Types of studies included</i> .....	59
<i>Table 2 Data charting table</i> .....	62
<i>Table 3 Study population details</i> .....	72
<i>Table 4 Summarized sampling procedure for the study</i> .....	73
<i>Table 5 Actual details of participating organizations, agencies and institutions</i> .....	77
<i>Table 6 Country policy and related documents reviewed</i> .....	80
<i>Table 7 Details of study participants interviewed</i> .....	83
<i>Table 8 Thematic analysis framework for the study</i> .....	88
<i>Table 9 Final analysis framework</i> .....	88



## LIST OF FIGURES

<i>Figure 1.1 Description of health systems interaction with environment for SRH.....</i>	<i>3</i>
<i>Figure 1.2 Map of Malawi.....</i>	<i>6</i>
<i>Figure 1.3 Walt and Gilson Policy triangle framework .....</i>	<i>16</i>
<i>Figure 1.4 Research process.....</i>	<i>18</i>
<i>Figure 2.1 Stages Heuristic policy process .....</i>	<i>36</i>
<i>Figure 3.1 Flow chart showing decision process .....</i>	<i>61</i>

## CHAPTER 1: INTRODUCTION

### 1.1 Introduction to the study

Today, there are 1.2 billion adolescents worldwide (UNICEF, 2019). This highlights the potential for enormous economic growth and social development in the countries with large youthful populations (UNFPA, 2014). In sub-Saharan Africa (SSA), 15 countries have half of their populations below the age of 18. Some of the SSA countries are yet to begin the demographic transition, and without a decrease in the rate of population growth, these countries will find it difficult to create sustainable development. In addition, ensuring good health for the population is key, if SSA is to harness the demographic transition and dividends in the near future.

Adolescence is a normal part of human development, comprising of emerging sexual desires, behaviours and relationships. If supported by information and access to required health services and proper decision-making, this process has the potential to result into life-long positive impact in terms of sexual health and overall well-being and development of a person. However, due to a host of biological, socio and economic factors that come alongside this stage of life, adolescents in general can be at a higher risk of adverse sexual and reproductive health (SRH) outcomes mainly HIV and other sexually transmitted infections (STIs), unintended pregnancies and abortions - usually clandestine and unsafe. There is equally an elevated risk for those who give birth at that early stage of development/life, exposing themselves and their newborns to various possible risks of poor health outcomes, including death (Woog; et al., 2015). Therefore, it is important to recognize that there are structural inequities and certain social environments that place certain groups of adolescents at increased risk and jeopardize healthy transitions to adulthood. Poor (SRH) outcomes can often be traced to adolescence, when most people become sexually active (WHO, 2011). This makes the SRH of the youth a fundamental issue to pay attention to.

For example; the sexual behaviour of HIV-positive youths, whether infected perinatally, through risky behaviour or other ways, is not substantially different from that of HIV-uninfected peers (Kancheva Landolt et al., 2011). They become sexually active and thus the need for targeted reproductive health services and policies to ensure uninterrupted access. Approximately a quarter of all HIV-positive people, infected in various ways, are below 24 years of age. Half of this population is female. Whereas their needs may not be very different

from those of HIV negative people, their increased susceptibility to certain medical conditions warrants that extra caution or attention be extended to put their SRH needs in consideration. In addition to their HIV regimen, effort is still required to guarantee easy access and use of other SRH services, while highlighting the rights of such vulnerable groups in SSA. Therefore, for the case of adolescent girls (AGs), and in the case of teenage pregnancy among adolescent girls living with HIV (AGLHIV) in SSA, effort is required to control the rampant teenage pregnancies among the group. It is therefore imperative to assess how the current policy environments promote or hinder the access and use of preventive services such as contraception, as a means of offering protection to the vulnerable against possible risks faced.

However, it is also important to recognize that while such policies may be intended to provide the desired good, they may also come off either as positive or negative, especially in terms of meeting or hindering the fulfilment of the needs of people living with HIV, specifically AGs. The constraints on access and use of SRH services mainly contraception exist not only in societal and cultural attitudes but law and policy too (UNFPA, 2017, Browne et al., 2018) and other factors related to structural hinderances equally exacerbate these limitations. Thus, in addition to ensuring that related legal and policy provisions are in place, and that ASRH services are friendly, there is also need to uncover the vulnerabilities faced in the process.

## 1.2 Background to the study

Teenage pregnancy is more common among poorer households. This trend may be attributed more to unmet need for contraception than to a desire to start having children earlier in life (UNFPA, 2018), and the challenges faced in accessing and seeking services. Girls from wealthier households have better information about sexual and reproductive health, and greater access to contraceptive services; they may even have access to safer, although illegal, abortion services (Vignoli and Cavenaghi, 2014). In some countries, minors, whether poor or rich, have limited access to emergency contraception and might need parental permission to access modern methods of contraception, such as the pill.

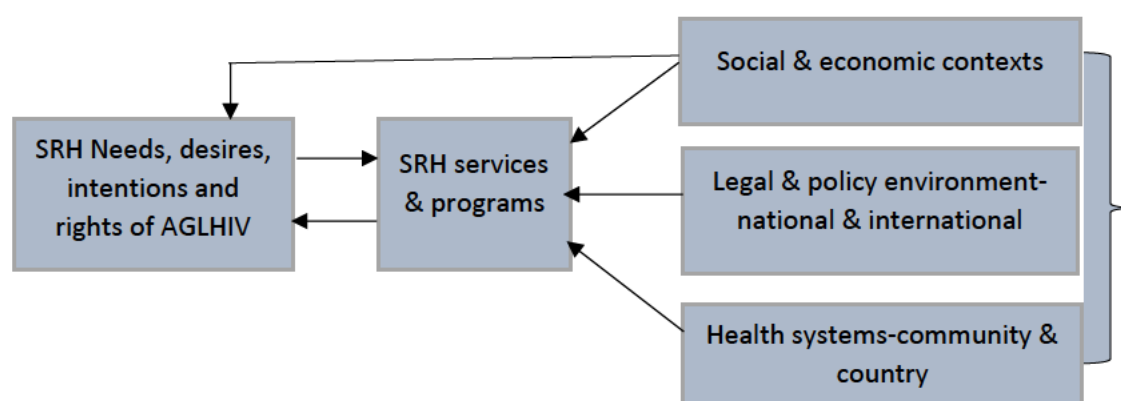
Family size is closely linked with reproductive rights, which, in turn, are tied to many other rights, including the right to adequate health, education, and jobs. Where people can exercise their rights, there is a tendency to thrive. Where these rights are stifled, people often fail to achieve their full potential, impeding economic, social and individual progress, and this is common for girls and women in general (UNFPA, 2018). Yet, there is evidence that when a

woman has the power and means to prevent or delay a pregnancy, she can have more control over her health and has increased possibility of realizing her full economic potential.

Since the 1994 International Conference on Population and Development (ICPD), reproductive health and rights have substantially improved around the world. People have more information about their reproductive rights and choices, and a greater capacity to claim their rights. However, in SSA today, there is no country that can claim that all of its citizens enjoy reproductive rights at all times. In many countries, most couples cannot have the number of children they want because they either lack the legal backing, economic and social support to achieve their preferred family size (Biseck; et al., 2015), or the means to control their fertility. With specific reference to women and girls, the unmet need for modern contraception prevents hundreds of millions from choosing smaller families and this can be attributed to a combination of factors including absence of supportive policies which can promote access to the needed services, as well as the general socio-economic and cultural environment.

In most countries in SSA, access to healthcare, notably SRH services is largely shaped by the health systems in place but largely guided by national and international legal and policy environments within which these systems operate coupled with the general social and economic contexts of peoples' access and use of desired healthcare services (Browne et al., 2018). Thus, there exists a dynamic relationship between the way services are provided, the contexts within which they are delivered, and how the target users access and use them (UNFPA, 2017), (Gruskin et al., 2007) which warrants policies to support this routine occurrence which is demonstrated below.

*Figure 1.1 Description of health systems interaction with environment for SRH*



Adapted from (Gruskin et al., 2007)

### 1.2.1 Fertility control among adolescent girls (AGs) in developing countries

In developing countries, there are 200m girls and young women who do not want to get pregnant but are unable to get contraception (Wulifan et al., 2017). Yet, the most important measure to give women and girls the possibility to make decisions about their own bodies and when to have children is to make family planning methods and contraceptives easily accessible (UN, 1995), (UNFPA, 2018). Some societies in developing countries still attach value to a high number of children. Thus, although there has been momentum in implementing such SRH services in most countries, the services typically remain under-utilized by adolescents despite their demonstrated need (Mazur et al., 2018). The sustainable development goals (SDGs) equally recognise how adolescents have been left behind previously and highlight the importance of addressing their SRH needs so as to achieve the set goals (Deitch and Stark, 2019). As a result, many young people in SSA report a mismatch for example between desire for contraceptive services and the actual uptake (McCurdy et al., 2014).

For example, many married adolescents desire to delay, space or limit their births but they are not using contraception. WHO's analysis indicates that contraceptive use is alarmingly low in LMIC (WHO, 2011), (Michaels-Igbokwe et al., 2015). Furthermore, unmet need for family planning remains high in many low and middle-income countries (LMICs) with about one in three women of reproductive age not using contraception in spite of their desire to delay or limit child birth (Wulifan et al., 2017). Thus, young women's desires for preventing, spacing pregnancy and child birth in most developing countries is affected and not fulfilled. In Tanzania, 60.3% of unmarried 15-19year old adolescent girls are not using contraceptives, while 85.1% of adolescents in union within the same age group are not using contraception (Parameshwar; and Chandra-Mouli;, 2018). This has resulted into the high un-met need which correlates with the high fertility rates in SSA. A study in Ethiopia found also that women who are living with a man were more likely to have unmet need compared to those who are not married (Abubeker et al., 2019).

Additionally, high rates of teenage pregnancies persist in the SSA region. Over the past 15 years, fertility rate among the poorest adolescents in many countries has increased and caused a crisis for the poor economies together with their already weak health systems and adolescent girls from the poorest communities are estimated to be four times more likely to become pregnant than those in the richest (WHO, 2011). It has also been established that maternal

health problems are a leading cause of death among young females, accounting for 15% deaths among 10-24-year old females globally. In SSA estimates show that adolescent mothers comprise about 20% of maternal deaths, most of which are due to complications of unsafe abortion. Furthermore, unsafe abortion rates are highest among young women aged 15-19 years, at 57% in SSA (Prata et al., 2013). The high maternal mortality ratio among youth may be related to a higher burden of unintended pregnancy, possibly due to lower access to family planning services (Prata et al., 2013). According to (Morris and Rushwan, 2015), the current contraceptive prevalent rate prevents 272000 maternal deaths per year, but if current family planning needs are met an additional 104000 women would be saved (Morris and Rushwan, 2015). Teenage pregnancies also have a negative effect on educational achievements for the girls who experience it, and this has contributed to the huge economic burden in some countries.

In SSA, macro level cultural beliefs and norms around gender regulate how the youthful population perceive and interact, and this shapes their reproductive health outcomes. A set of complex issues contribute to SRH problems among adolescents, especially the girls, and adolescent girls are known as a key population in relation to sexual and reproductive health (Starrs et al., 2018). Thus, enormous resources are required to address their reproductive health needs. Low and middle-income countries continue to suffer the burden of teenage pregnancies, 90% of these taking place within marriage among 15-19-year adolescent girls (Williamson, 2013) with a significant number not seeking contraceptive services.

In 2015 alone, 3.3 million births were registered among adolescent girls in East and Southern Africa (ESA), out of a total of 15.2 million births registered globally (UNFPA, 2016). On average, adolescents aged 15-19 years in SSA have a birth rate of 143 births per 1000 women (Prata et al., 2013). This further needs to be correlated with the increasing risk of unwanted pregnancies, and related mortalities and morbidities among the same age-group, and has resulted in 3.2 million AGs suffering unsafe abortions (Darroch et al., 2016). Among the 10-24 year olds, another 15% are suffering the effects of poor outcomes such as maternal morbidity, and mortality (Loaiza; and Liang, 2013). Adolescent sexual and reproductive health (ASRH) has therefore become one of the key public health issues to address due to the evidence of poor health and social outcomes for AGs (Michaels-Igbokwe et al., 2015). The transition to lower fertility can best be achieved through people claiming or being supported to enjoy their right to make choices about their reproductive lives, to have few, or as many children as they would want and afford, and when they would want (UNFPA, 2018).

Over the last few years, SRH programs have made tremendous impact in changing harmful cultural practices such as early child-birth and marriage, and girls have been enlightened about available services for birth control. However, in practical terms, even adolescents who are equipped with the right information may not access the health services they need to protect themselves (UNFPA, 2014). For those living with HIV/AIDS (AGLHIV), such interactions between them, the social pressures as well as the high possibility and occurrence of confrontations at facilities or actual points of care have the potential to inflict several forms of harm depending on the actual form of exposure. In general, there are limiting factors, which include fear, negative experiences during the process of seeking and using contraception and susceptibilities that limit the agency of adolescent girls, more so those living with HIV even in situations of awareness of services provided in their vicinity. Such limiting factors can be addressed by legal, institutional and procedural guidelines, such as policy. Given the challenges suffered, it is important to learn if there are vulnerability or risk reduction strategies put across in the form of policy and how current policy provisions can offer some form of protection against such occurrences.

### 1.2.2 Situation analysis

*Figure 1.2 Map of Malawi*





### *1.2.2.1 Geographical context*

Malawi is a relatively small (94,280 km<sup>2</sup> land area), densely populated (186 people/km<sup>2</sup>), and land-locked country in the Southern-Eastern Africa. It is bordered by Zambia to the West, Tanzania to the North and North-east and Mozambique to the South and South-west. As per the 2018 Population and Housing Census, Malawi has a population of 17.6 million (NSO, 2019). The total population increased by 35% between 2008 and 2018, representing an average annual growth rate of 2.9%. The country is divided into three regions (Northern, Central and Southern) and 28 administrative districts. Districts are further divided into a total of 433 Traditional Authorities (TAs) and then villages. Sixteen percent (16%) of the population resides in the four urban areas, among which is Lilongwe, Blantyre, and Zomba. 44% of the population live in the Southern Region, 43% in the Central Region and then 13% in the Northern Region (NSO, 2019).

### *1.2.2.2 Population and socio-economic characteristics*

The population is young, with 51% of the population being under 18 years, and about 64% projected to be under 25 years of age (Chipokosa et al., 2019). A significant proportion of this underaged population are orphans (11%), with 39% of them orphaned by HIV and AIDS epidemic (UNDP, 2018). This has increased their vulnerability to poverty, gender-based violence (GBV), and other forms of structural violence which leads to an elevated risk of HIV infection among the underaged population (UNDP, 2018).

Malawi is among the world's least developed countries, and is ranked 171 out of the 189 countries and territories on the 2019 Human Development Index (HDI) (UNDP, 2018). Malawi has a widespread poverty, with 52% of the population living below the poverty line in terms of daily consumption. The level of poverty is mainly concentrated in the rural areas, with 60% of people in rural areas experiencing poverty compared to 18% of people in urban areas (NSO and Bank, 2018). The economy is largely backed by agriculture with about a third of it contributing to the national gross domestic product (GDP) (UNDP, 2017). The large rural-based population also continues to grow at an alarming rate. The government depends largely on foreign aid to meet the development needs of the country, and the needs keep growing as well since 2000 (UNDP, 2018). Malawi faces the challenge of building and expanding its economy, improving education, health care, environmental protection and wide-spread unemployment. However, since 2007 the economy has been seen to improve due to



introduction of several programs to address the challenges, with a rise in healthcare and education achievement seen. Health services are free at the point of delivery in public facilities.

Malawi has a low life expectancy at 64 years, with a high prevalence of HIV/AIDS at 10.6% overall among the 15-64 age group, with 8.5% among males and 12.5% among females (MoH, 2018). HIV incidence is eight times higher among AGYW at 0.40% than among adolescent boys and young men (ABYM) at 0.05%, and the prevalence is almost five times higher among AGYW at 5% than in ABYM at 1% (MoH, 2018). There is a high girl drop-out from school/education, with less than 10% of the girls earning a high school diploma. Only 36% of girls who successfully complete primary school enter secondary school. 20% of school-age girls are prevented from continuing with education due to sexual and reproductive health issues such as menstrual hygiene and the lack of required hygiene-related products. In addition, girls hardly achieve their education aspirations due to high rate of child-marriage.

Malawi has one of the highest rates of child marriage in the world, and it was ranked at 8<sup>th</sup> position out of the 20 countries considered to have the highest rates (UNWOMEN, 2015). Approximately, 1 in 2 girls are married and raising children by the age of 18 (UNWOMEN, 2015). Today, it is estimated that 42% of girls are married by their 18<sup>th</sup> birthday, while 9% are by the age of 15 years (UNICEF and GoM, 2019). There have been efforts to discourage early marriage among young girls, with focus on orphans and disadvantaged children since 2007, and teenage pregnancies cost the economy approximately USD 57 million, which is posing serious challenges for poverty reduction and development (MoH, 2015). The government and its partners have spear-headed such programs across the country, with more efforts in rural communities and a gradual increase has been recorded so far.

### 1.2.3 Malawian context: The SRH situation of adolescent girls and young women (AGYW)

Context is a key aspect which bears a significant impact on health outcomes. Similarly, the context can either minimize or support the performance of legal and policy actions. In resource limited settings, characterised by stringent cultural practices, it becomes difficult for vulnerable populations to negotiate their way without clear policy provisions addressing their respective situations. Furthermore, the social norms which promote male dominance undermine the successful use of basic legal regulations.

Malawi's largest-ever population of adolescent girls (ages 10–19) and young women (ages 20–24) represents great potential. Over half of the 17.2 million population of Malawi are under the age of 20, and 950,000 are young women between the ages of (15 -19) years. Also, 64% of

women aged (25-49) years have already had sex by age 18 (Neason; et al., 2017). Malawi has a seemingly progressive policy environment which supports and encourages adolescents to utilize SRH services (UNFPA, 2017). However, these adolescent girls and young women are negatively affected by structural inequities, sociocultural norms, and harmful traditional practices, all of which impede their ability to thrive, realise their aspirations, and contribute to the future development of the country. Traditional attitudes and practices lay emphasis on preparing girls for marriage and sexual partnership more than their economic and development abilities. The traditional attitudes and practices therefore have led to the problem of low participation of girls in development activities. Even among the married/ those in a union, there remains a significant number of adolescent girls who would prefer to have pregnancies later but have failed-resulting into mistimed and unwanted pregnancies, because of failure to use contraception.

#### *1.2.3.1 Highlighting the aspect of early pregnancies among AGYW*

Pregnancies continue to feature as a key reason for school drop-out, with majority of the girls not continuing to secondary schools. Needless to say, the reproductive health harms and risks of early pregnancy when girls marry young, which include maternal death, obstetric fistula, premature delivery, and anaemia are rampant among adolescent girls in Malawi. The shortage of prenatal and postnatal health care services, especially in Malawi's rural areas, increases these risks (Watch, 2014). It is also important to calculate the costs of early pregnancy to the health care system of the country. Furthermore, whereas there are several initiatives addressing these challenges among AG, many remain parallel in the nature of their operations, meaning that the vulnerable among them, such as an HIV positive adolescent girl who desires contraception may not necessarily have a straight path to contraceptive services.

Malawi is signatory to all major international agreements and treaties that support adolescent access to family planning including the ICPD PoA and the Maputo Plan of Action (MPoA), through which it has focused on improving access to family planning services with the aim of increasing its uptake by the young people (Mugoni, 2018). In order to achieve the targets, several interventions were implemented, such as; peer education campaigns, mass media campaigns, and service provision through clinical and outreach settings. Malawi has a robust SRH programme that is supported by the Government of Malawi (GoM), development partners (DPs), NGOs and civil society organization (CSOs). SRH services are provided in all government and Christian Health Association of Malawi (CHAM) facilities as well as private

facilities. Some of these SRH services are provided through dedicated Youth Friendly Health services (YFHS) model. The SRH services provided include prevention of ill health, provision of information and counselling, screening, diagnosis and curative care and referrals.

However, despite the robust SRH programme, Malawi remains a generally high fertility context, with relatively poor SRH outcomes, with un-matched service utilization rates especially among the adolescent girls (Group, 2015) and worse among those living with HIV.

The Malawi Demographic and Health Survey (MDHS) 2015-2016 indicates that maternal mortality stands at 439/100,000 live births, perinatal mortality at 35/100,000 live births (NSO and ICF, 2017). The adolescent fertility rate for girls 15–19 years was 136 births per 1,000 women (NSO and ICF, 2017), and Malawi is recorded to have one of the highest fertility rates in the region (MoH, 2015). The proportion of pregnancies among the (15-19) year olds is 29%, and the unmet need for family planning among the married is 19% and among the unmarried is at 40% (NSO and ICF, 2017). Teenage pregnancy increased from 24% in 2010 to 29% in 2015 indicating challenges in uptake and access of modern contraceptives and other SRH services among this age group. The onset of sexual activity at an early age, coupled with low use of contraceptives is reported to contribute a large extent to the high fertility among adolescent girls (AGs) in Malawi (MoH, 2015). Unmet needs for family planning among unmarried sexually active women (15-19yrs) is 22% and overall is at 47% (NSO and ICF, 2017).

Teenage pregnancies is rampant with 1 in 2 adolescent girls (15-19) beginning childbearing and 46% of them give birth before 18 years old (UNICEF and GoM, 2019). 1 in 3 pregnancies among (15-19) adolescent girls and young women are not planned. In retrospect to the country demographic and health survey (MDHS) 2010, the percentage of women aged 20-24 who gave birth before the age of 18 in Malawi was 34.7% (NSO, 2010). The demand for contraception among the (15-19) year age group in general is very low at only 39%. Furthermore, it was reported that 59% of 19year-old girls had started child-bearing (Chipokosa et al., 2019). And contraceptive use among unmarried sexually active young women is even lower at 32% (Neason; et al., 2017). Therefore, whereas Malawi registered a reduction in total fertility rate from 5.7 children in 2010 to 4.4 children in 2015 (ICF, 2017), a slower progress was experienced among the youth (15–24) years old, and teenage pregnancies increased over that time period. Whereas 68% of health centre providers were trained in YFHS, little impact in terms of number of youth seeking services was made (E2A, 2014), (Feyisetan, 2014). Studies

in Malawi indicate that 20% of HIV positive mothers are conceiving every year, and the country still experiences a high birth rate contributed by young girls on ART (estimated at 9%), with around 300,000 deaths of children being related to HIV (Biseck; et al., 2015). However, UNAIDS/MOH spectrum 2019 estimates that 74% of AGYW living with HIV know their status while 92% are on ART and 87% are virally suppressed.

A 2016 study among adolescents in Malawi reported that regardless of the high levels of awareness (72%) of the availability of SRH services and modern contraceptives, the demand and utilization for the service was reported at only 38.4% among the 15-19 year age group (Munthali; and Kok, 2016 ). This raises questions about the bottlenecks experienced by adolescent girls and more so those living with HIV. In Malawi, teenage childbearing increases with age. The percentage of women aged 15-19 who have begun childbearing rises from 5% among women aged 15 years, to 59% among women aged 19 (ICF, 2017). Thus, there is adequate evidence that there are some underlying vulnerabilities that adolescent girls living with HIV (AGLHIV) face, factors that limit their ability and willingness to fully exercise their agency towards contraception service use.

Despite these successes, adolescent girls and young women especially young pregnant women, those living with HIV, and mothers continue to face several challenges towards sexual reproductive health, HIV prevention and testing services. However, there has not been a specific documentation/study done to determine the rate of pregnancies amongst AGLHIV in Malawi and contraceptive usage for that sub-population in Malawi, and statistical information is therefore not available for inclusion in this narrative.

Similar to all people living with HIV, the experience of such young girls in this regard comes with several vulnerabilities especially because many may not have a clear understanding of their rights. Young girls especially those living with HIV have not received adequate attention in relation to accessing and using contraception (Groves et al., 2018). There are key contextual factors that influence young women's access to services, but they are greatly influenced by cultural aspects. Thus, the vulnerability of AGLHIV is worsened by the social, cultural, economic and political realities at community, national and international levels. The magnitude of this phenomenon is wide spread and recognised. However, they remain insufficiently addressed in policies and programs (UNFPA, 2017).

Although some studies suggest that people who are at risk of poor health such as those living with HIV are also more likely to face health care and social disparities, they do not usually focus on studying those disparities and the possibility of harm that they expose such people to (Grabovschi; et al., 2013), and whether the policies in place address those disparities. The thematic focus of this study was on the disparity of vulnerabilities faced by HIV positive adolescent girls, and the policy provisions to address such risks, among this sub-population of adolescents which is dis-advantaged.

### 1.3 Rationale of the study

The debate surrounding the control of sexuality of young girls - especially early conception and child birth in many African societies has been going on for quite some time now. However, regardless of the actions taken at the international level and commitments made by countries towards ensuring the use of modern contraception, the attitudes towards it have not improved much amongst some communities, and this makes the use of contraception difficult for young girls. In Malawi, conception and child birth are celebrated, and remain an important aspect of life and culture in general, and young girls are prepared ahead of time when they reach adolescence to become mothers (Watch, 2014). In addition, adolescent girls in the reproductive age group in Malawi suffer a double burden of HIV and teenage pregnancy 12.9% (Biseck; et al., 2015), which is followed by numerous births after the first one, unsafe abortions or adverse maternal conditions (Groves et al., 2018). Furthermore, more than 90% of all newly infected children are born to women living with HIV (Biseck; et al., 2015). According to the National HIV and AIDS Strategic Plan (NSP) 2020-2025, whereas government of Malawi has made effort in curbing the spread of HIV through mother-to-child-transmission (MTCT), one of the challenges is the high proportion of unintended pregnancies among HIV-positive women.

Within all this context, contraception prevalence rates remain significantly low among this population, and worse in the rural areas. Proponents of family planning/modern contraception decry the low use of services by both married and unmarried adolescent girls, as the teenage pregnancy and birth rates keep rising in Malawi. In light of this, it is important to pay attention to the sensitivity and challenges attached to being HIV positive, the experience of pregnancy/motherhood at an early age, coupled with the possibility of being married or having a partner in a community that still upholds certain cultural practices and norms (Watch, 2014); as these have drastic effects for an AGLHIV who may desire to delay or space child birth. Previous studies show some of the causes of failure of access being family and violence by

spouses which makes it paramount to investigate if there are any policies sheltering against such extreme vulnerabilities (UNWOMEN, 2018). More still, the sensitivity around contraception use by young girls still remains in Malawian society and is largely restricted (Starrs et al., 2018) and warrants specific policies to address constraints faced by AGLHIV. Sexually active young women report knowledge of services but with unmatched utilization rates (Morris and Rushwan, 2015), pointing to experiences of hardships in the process. Therefore, the situation is presumably worse for an HIV positive girl due to stringent culture, and also the general inhibitions related to the nature of service provision. In biological terms people living with HIV are more vulnerable to certain SRH problems than those who are not especially when pregnancy and child birth is involved. This makes their ability to control pregnancy very paramount, because of the extended danger that the conditions cause and policies geared towards ensuring their unrestricted access are needed. Such may be in the form of protection against risks exposed to in the process of seeking SRH healthcare services or products.

In a poor community where an AGLHIV or adolescent mother living with HIV (AMLHIV) is highly dependent on the available social capital (family, neighbours, community), it becomes very difficult to break the boundaries or to do something differently even when appropriate information is shared. There is certainly a nervousness towards the negative sanctions that arise as a result of trying or using contraception, which an AGLHIV has to deal with. Basing on human rights norms, the main principles include among others ensuring that HIV positive people must be able to make non-coerced and autonomous decisions regarding their sexuality and fertility, and that young people must have access to relevant information, counselling and services tailored to their SRH needs (UNFPA, 2017). But up to recently, the SRH concerns of HIV positive young people, and specifically girls, are yet to be harnessed in the health policy research and literature. Since adolescent population does not necessarily belong to one category, the potential for exclusion is high.

Thus, in trying to understand the limitations faced by adolescent girls, the dynamics for an AGLHIV who may desire to limit or space child birth are different, and there are high chances that such aspects are omitted or not adequately catered for by on-going policy and programming efforts. While human rights are universal and most SRH needs and aspirations are common to people whether or not they live with HIV, there are nevertheless some principles related to the rights, needs and aspirations of AGLHIV which require specific attention. As evidence indicates, there is certainly a level of susceptibility in the process of securing and

using contraception in such a context (Thindwa et al., 2019), and identifying the actual issues and gaps related to policy provisions for protection against such risk or, harm they are exposed to, will provide good information to address the limitations to service uptake by this sub-group. The policy and legal frameworks play a critical role in transforming norms and protecting the rights of women and girls (UNWOMEN, 2018). Thus, national governments are required by international human rights frameworks to put in place such laws, policies and practices that enable HIV positive young women to fulfil their SRH needs and aspirations and identifying the policy gaps in Malawi is a good starting place. The relevance of appropriate policies is key given that the source of vulnerability is local, and contextualised. This demands for both local solutions but also the important role of the central government in directing solutions or ensuring the safety of such a vulnerable group. In addition, states have obligations to promote and protect human rights of all people with HIV, as well as protect the rights of adolescents with HIV, as children. Thus, formulating policies which address the vulnerabilities is also a way of ensuring the effectiveness of SRH interventions in the long-run and ensuring of human rights observance for the vulnerable people.

#### 1.4 Research aims and objectives

The aim of this study therefore was to assess the SRH policies in Malawi in relation to addressing the risks, and other contextual factors faced by AGLHIV in process of reaching and using contraception, and identify implementation challenges affecting the effectiveness of the policies. This is intended to assist in ensuring that key government policies are linked to the broader adolescent development processes and address the realities they are faced with and promote their health, while contributing to universal health coverage.

In this thesis, I demonstrate the importance of enacting policies which not only resonate with the setting, but also address particular vulnerabilities facing specific population groups as a key factor to promote contraception use among AGLHIV. I further argue that ensuring an inclusive process and successful implementation are critical aspects in promoting accessibility to contraception services and successful implementation can transform socio-cultural norms and address structural aspects while ensuring a form of social protection for such a vulnerable sub-group in the society.

##### 1.4.1 Research questions

1. What are the structural and socio-cultural issues affecting the use of contraception among AGLHIV in Malawi?



2. What policy provisions are in place in Malawi to address the issues/risks faced by AGLHIV during reach and use of contraception?
3. What implementation challenges affect the effectiveness of the available policy provisions?

#### 1.4.2 Specific objectives

- I. To explore the socio-cultural and structural issues affecting the use of contraception among AGLHIV in Malawi
- II. To examine the policy provisions in place in Malawi to address the issues/risks faced by AGLHIV during reach and use of contraception
- III. To identify the implementation challenges affecting the effectiveness of the available policy provisions

### 1.5 Theory and Theoretical framework

This study was guided by the healthy policy triangle (HPT) framework as advanced by Walt and Gilson (1994). The HPT highlights the complex interplay of social, economic, and political factors that influence, and are involved in the process of policy making. Specifically, it gives attentions to the context, content, process and actors involved in the process, as key issues in health governance which help to determine the emergence of a policy, which issues receive attention on the national agendas, how networks of interest groups can rally around or against a specific issue, as well as how they choose to implement it, which all contribute to the existing policy environment.

#### 1.5.1 Theoretical Framework

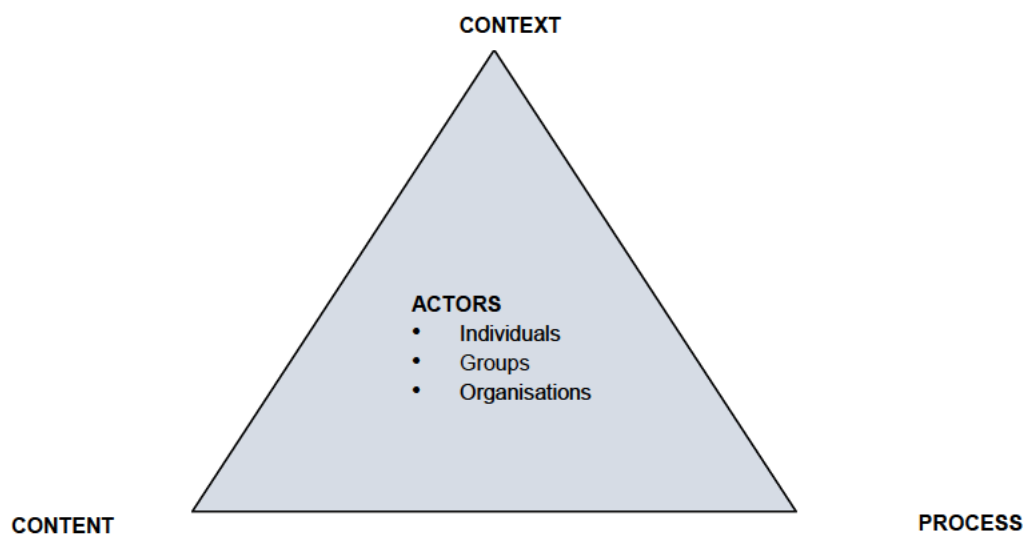
This study is guided by the Health Policy Triangle framework (HPT). The HPT framework was designed in 1994 by Walt and Gilson (1994). It was meant to provide guidance for the analysis of health sector policies, although its relevance extends beyond this sector today. At the time, there was concern that health policy research was focussing mainly on the content of the policy, while ignoring the actors who participate, context within which a policy is developed and implemented, and process (Walt; and Gilson;, 1994). Thus, the HPT presents four dimensions that ought to be considered during the making and implementation of a specific health policy. These are; the content, context, processes and actors.



- i. The context refers specifically to systemic factors such as political, economic, social or cultural, both national and international which may have an effect on health policy, and within which the policy processes interact
- ii. The content refers specifically to the substance of a particular health policy which details its constituent parts
- iii. The process refers specifically to the way in which policies are initiated, developed or formulated, negotiated, communicated, implemented and evaluated, and how power influences all those decisions
- iv. The actors, also referred to as players signifies involved individuals, organizations or even the state and their actions that affect policy, through their power structures and their own values and expectations

In line with the concept of vulnerability and the objectives of this study, the vulnerabilities that have ability to limit AGLHIV from easily accessing and using contraception can be addressed by recognizing the different factors as guided by the HPT and putting measures in place to address the susceptibility.

*Figure 1.3 Walt and Gilson Policy triangle framework*



(Walt and Gilson, 1994)

## 1.6 Study contribution to literature/knowledge

This study was tailored to a sub-population of the adolescent population, which is disadvantaged and less researched, and this research is a dedication to identifying the different

needs of different adolescent groups and exploring the existing challenges specific to a particular sub-population of AGLHIV.

In trying to find sustainable and effective solutions to teenage pregnancies, this study fills in the gaps of how policies are central to this phenomenon, as well as an important part of health systems development. The understanding of AGLHIV's realities ought to be reflected in policies and demonstrated through the implementation process as a way of providing social support and protection for the vulnerable, and as a practical way of creating a safe and enabling environment for AGLHIV to exercise their rights, and knowledge and skills gained in the course of their development.

In this thesis I argue that there is need to diversify the package of proven approaches for adolescents by recognizing their varying vulnerabilities, emerging capacities, and paying attention to policies is one way to do that. Therefore, this study communicates the SRHR realities of AGLHIV to decision makers and policy makers, the risks and barriers navigated in the process of access and uptake of contraception, and serve as evidence for advocacy while holding responsible authorities accountable to earlier commitments made to young people. While other studies have looked at young people in general, and have shown that young people face a number of barriers when trying to seek services, it is equally of crucial importance to broaden the evidence base with a focus specifically on AGLHIV and their pathway to health care utilization, and the impact of policies.

Therefore, among other things, it is anticipated that the findings of this study will provide an evidence base for reference by decision and policy makers to recognize the policy gaps, implementation challenges, and ensure the design and preparation of adequate programs that promote contraceptive use and improve health outcomes.

## 1.7 Scope of the study

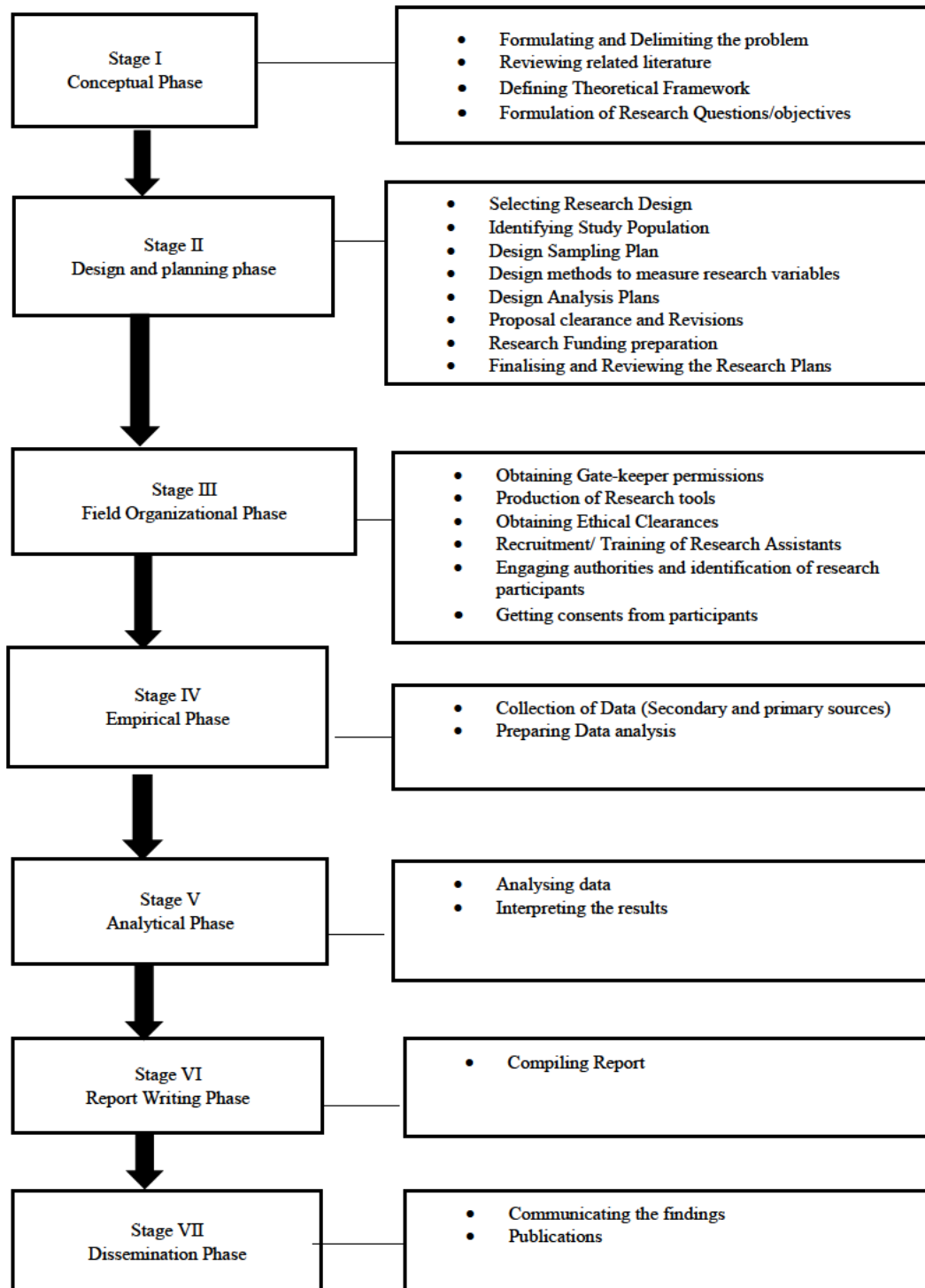
This study assesses the relevance of policy, and covers the process of policy formulation, enactment and use for the protection of vulnerable populations. Specifically, this study covers national SRHR policies in place currently in Malawi, and the related guiding documents, with specific reference to contraception or family planning use by HIV positive adolescent girls. The study focuses solely on adolescent girls living with HIV/AIDS, and living in Malawi.

## 1.8 Research/study process

The research process is defined as the series of steps which make up research from the development of an idea to the completion of the research project (Polit; and Beck, 2010). The research process in this study comprised seven distinct phases that were followed to formulate and execute this study. However, the process was also iterative as demonstrated in the figure below. The last phase of the process shall be conducted after clearance of this report, and as per guidance.

*Figure 1.4 Research process*

### *Details under each phase*



Adapted from (Polit; and Beck, 2010)

## 1.9 Definitions of key terms used in the study

- i. Adolescent girls: Girls aged between 10-19years

- ii. Adolescent mothers: The term adolescent mothers will be used to refer to all adolescent girls who have ever experienced a pregnancy
- iii. Family planning: The practice of controlling the number of children one has and the intervals between their births, particularly by means of contraception or voluntary sterilization
- iv. Contraception: The deliberate use of artificial methods or other techniques to prevent pregnancy as a consequence of sexual intercourse
- v. Health policy: Decisions, plans, and actions that are undertaken to achieve specific healthcare goals within a society. The term health policies in this study is used to refer to the sexual and reproductive health related directives, guidelines, statements and approved frameworks, which have been published/documented (available in writing)
- vi. Human rights policies: Policies that support our *human rights* value and commitments
- vii. Human rights: Moral principles or norms that describe certain standards of human behaviour and are regularly protected as natural and legal rights by national and international law.
- viii. Mitigation: The elimination or reduction of the frequency, magnitude, or severity of exposure to risks, or minimization of the potential impact of a threat or warning
- ix. Policy: Refers to decisions taken or not taken by those with responsibility for a particular area. Policies can be laws, documents, procedures, guiding principles, statements of intent, working frameworks to achieve certain objectives
- x. Resilience: The ability to cope and recover quickly from difficulties
- xi. Risks: A situation involving exposure to danger either physically or emotionally
- xii. Vulnerabilities: The quality or state of being exposed to the possibility of being attacked or harmed, either physically or emotionally
- xiii. Young women: Girls aged 15-24years

### 1.10 Synopsis of the thesis

This thesis comprises of seven chapters. They are systematically arranged as follows;

The first chapter sets the background for the study. Within this, detailed background information is provided to highlight the context in relation to the phenomenon under study and the country of study. The chapter also highlights the rationale of the study while highlighting gaps in literature which the study sought to fill, the aim of the study, the research questions and objectives of the study. The chapter also entails the theoretical framework upon which the study is hinged, the scope of the study, the research process followed, and provides a definition

of key terms used. It also highlights the study's contribution to the body of knowledge and literature.

The second chapter presents a comprehensive literature review on the study focus. The third chapter presents the details of a scoping review, including its rationale and objective, methodology followed, as well as results. The fourth chapter describes the details of the methodology employed, which includes the study design, study population and sample, sampling procedure, sample size, data collection approaches, approaches to data analysis, ethical considerations taken for the study, and the study limitations and challenges. The fifth chapter presents the findings for this study. These are presented in three different but connected sections, following after each other according to the order of the research questions/objectives of this study – i.e.; research question one, research question 2, and research question 3. Each section is also covered with a discussion section.

The sixth chapter presents, the synthesis, a jointed discussion based on the HPT framework. Finally, the seventh chapter of this study presents the conclusions, recommendations, and areas for further research.

## CHAPTER 2: LITERATURE REVIEW

### 2.1 Introduction

This chapter presents a review of available literature on the use of contraception among adolescent girls, PLHIV, and policy guidelines. It also looks at the SRH needs and aspirations of adolescent girls who are HIV positive, barriers faced in using contraception across the world and in SSA, and also provides an excerpt of the SRH policy environment in Malawi. The section also includes the process of policy formulation and the role of policy in SRH.

### 2.2 Sexual and Reproductive Health and Rights, of adolescent girls living with HIV

Globally, women and girls account for 50% of all new HIV infections (UNAIDS, 2021), with the potential to become a much larger proportion. Quite often young women are not aware of their HIV serostatus until when they fall pregnant and join antenatal care services where HIV testing and counseling is mandatory in most settings today. For most of the young girls, antenatal care and PMTCT programs are the main entry points to SRH services as HIV positive women, presenting them with awareness about the existence of SRH services even for future use, such as contraception. However, for AGLHIV, the possibility of fully utilizing these services is often curtailed by stigma and discrimination and results into denial of their rights to SRH services (Cowden et al., 2019).

The concepts of sexual and reproductive health and of reproductive rights (SRHR) were adopted for the first time by governments under the oversight and guidance of the United Nations at the 1994 International Conference on Population and Development (ICPD) in Cairo. The ICPD laid out a bold, clear, and comprehensive definition of reproductive health as “a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes”. The concepts have four major interrelated fields as follows;

- i. Sexual health is the physical, mental, and social well-being in terms of sexuality. It therefore means safety from sexual illness and violence. Therefore, it points to the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence
- ii. This brings in the aspect of sexual rights – the ability to decide on one’s own about sexuality mainly refers to one’s ability to express their sexuality by making their own decisions about partners, privacy and pleasure, and this includes women’s ability to

have control over and make decisions concerning their own sexuality, including managing their own sexual and reproductive health.

- iii. Reproductive health ensures a healthy reproductive system and health pregnancies through access to healthcare, medication and education. It mainly focuses on the reproduction processes, functions and system at all stages of life, and implies that people are able to have a responsible, satisfying and safer sex life and that they have the capability to decide if, when and how often to do so. Within this, it implies men and women's ability to information and access to safe, effective, affordable, and acceptable methods of birth control, and access to other health care services related to sexual and reproductive health.
- iv. Reproductive rights are legal rights and freedoms relating to reproduction and reproductive health. They are based on the basic human rights of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, as well as the highest standard of sexual and reproductive health. This argument leads to the advancement of the family planning agenda and the promotion of modern contraception including among adolescents. Reproductive rights also include the right to make decisions concerning reproduction free of discrimination, coercion and violence.

The concept of sexual and reproductive health and rights or SRHR therefore applies to human rights on sexuality and reproduction. It combines the four separate but interrelated fields namely; sexual health, sexual rights, reproductive health, and reproductive rights. Therefore, sexual and reproductive health was affirmed as a human right following the ICPD, 1994, and the subsequent others thereafter, with focus on specific themes- mainly free choice, empowerment of women, and physical and emotional well-being of women.

Yet, this is not always the case in some countries due to limitations faced in accessing contraception and family planning tools especially among certain population groups such as adolescents.

Therefore, sexual and reproductive rights include the right to bodily integrity, the right not to be abused or violated (physically, mentally and sexually), the right to have consensual sexual relations within or outside marriage, the right to be able to decide if, whom, and when to marry or to partner with, the right to decide if, when, how many children to have, the right not to be discriminated against because of one's gender identity, and sexual orientation, and the right to



access comprehensive sexuality education, services and interventions related to one's sexual and reproductive health regardless of diversity, age, gender, marital status or HIV status, among other issues.

Sexual and reproductive health and rights (SRHR) are largely influenced by contextual, cultural and social-norms, and existing laws and regulations, among other things. Thus, the social-structural environment has a large influence on access of SRH care and interventions. It is imperative to acknowledge that the application of consistent SRH interventions to address the rights, needs and aspirations of young people is equally hampered by several issues. These include lack of consensus on aspects surrounding age limits and health status. Thus, many young people are faced with the challenge of poor sexual and reproductive health.

For adolescent girls living with HIV, SRHR includes among others; access to information, healthcare services ranging from their ART medical regimen to other SRH care such as contraception and treatment for other STIs, as well as psychosocial support to ensure their continued well-being.

Overall, young women make up more than 60% of all people living with HIV, and 72% in SSA. Whereas everyone including adolescent girls living with HIV deserve the right to make their own sexual and reproductive health related decisions as afore-alluded to, in some instances it may not be achievable without policies, government and public support to enforce the rights, given that the recent developments have continued to overlook the tailoring of strategies for AGYW living with HIV. In 2017, in Eastern and Southern Africa (ESA), 79% of all new HIV infections among 10-19year olds were among females. However, services and interventions have not been effective in reaching most of the them and their uptake of services and participation in interventions remains low.

In many countries in sub-Saharan Africa, young people encounter significant obstacles to receiving sexual and reproductive health services and lack access to the services they need to protect themselves from HIV, other STIs and unwanted pregnancy. Given the increasing vulnerability of young people to HIV, it is of program and policy relevance to better highlight young people's vulnerabilities while accessing health services in order to help young people protect themselves or be protected, and have healthy reproductive lives. However, young girls especially those living with HIV have not received adequate attention in relation to accessing and using contraception (Groves et al., 2018).

There are key contextual factors that influence young women's access to services, but they are greatly influenced by cultural and structural aspects. Thus, the vulnerability of AGLHIV is worsened by the social, cultural, economic and political realities at community, national and international levels. The magnitude of this phenomenon is wide spread and recognised. However, they remain insufficiently addressed in policies and programs (UNFPA, 2017).

Although some studies suggest that people who are at risk of poor health such as those living with HIV are also more likely to face health care and social disparities, they have not focussed on studying those disparities and the possibility of harm that they expose such people to (Grabovschi; et al., 2013), and whether the policies in place address those disparities. Furthermore, although there is recognition that adolescents are a heterogeneous group, they are continuously categorized as one. Programs often use a one-size-fits all approach. This prompts further investigation for individual and sub-group dynamics, as convenient policies are also viewed strategically and programmatically as a way of social support and protection.

### 2.3 Needs and aspirations of AGLHIV

Adolescents living with HIV have particular SRH needs which are often not met. It is important to recognize that the challenges that adolescents have or face are different from those that adults face, which warrants attention to existing government mechanisms to safeguard the adolescents. And adolescents continue to be left behind in many health care related issues despite the on-going momentum on universal healthcare coverage. Beyond the HIV treatment of anti-retroviral therapy (ART), adolescent girls require more support to be able to live a fulfilled desired life on a daily basis within the communities where they live, which demands for extension of differentiated care and interventions beyond medicines to match their unique needs. In addition to the ART, more considerations are required to ensure a holistic response.

Adolescents girls living with HIV are more prone to social evils and the negative effects of vices of society such as stigma and discrimination, as they face disclosure of their HIV status to parents, peers and partners, are faced with other SRH needs, adherence, making social protection a key issue. As they continue to grow, they tend to explore with their sexuality as well and develop relationships which require more SRH services such as contraception. Similar to all young people, adolescent girls living with HIV equally have dreams and ambitions which they look forward to achieving and through counseling, many express their needs and request for the appropriate and age-specific information and services to enable them make healthier choices and achieve their desired goals (Guttmacher, 2017). Thus, there is need to foster their

access to services they may require at any period of their growth and evolution, depending on what they are experiencing, and support their healthy development and SRHR. It is worthwhile for national governments to respond more appropriately to the needs of AGLHIV today, both perinatally and horizontally infected, given the gaps that have resulted into the increasing unmet need for contraception among this particular subgroup.

As young people, AGLHIV ought to be understood as a non-homogenous group with different needs and aspirations, and this should be translated and reflected in the laws and policies which govern and guide SRH services and interventions to ensure all categories are addressed. Given the dynamics of the dual burden of HIV and adolescence, special attention ought to be given to AGLHIV to cater for their needs and aspirations as a right.

Currently across several countries, adolescent girls in general continue to report unmet need for contraception. Young women living with HIV deserve to have easy access to a range of SRH services and interventions, including HIV treatment, and family planning, and should be provided with the opportunity to make informed decisions (UNAIDS, 2019b). This also means linking general SRH services and HIV at the policy, program and services levels to ensure the protection of rights and address the needs of girls living with HIV. However, this is yet to be achieved in most settings as programs still exist as separate from policies, and programs operate vertically. It is common that the contraceptive needs of PLHIV are often poorly addressed within policies and even HIV programs (Chandra-Mouli et al., 2015a). And similarly, family planning programs inadequately consider the needs of PLHIV, and the scenario is even worse if they are adolescent girls.

Precisely, all teens/adolescents, especially those with critical health conditions, those who are pregnant or parenting deserve quick access to resources that promote positive sexual and reproductive health, while upholding their rights to health care and service use. It is beneficial to ensure that the interventions addressing their SRH needs are holistic in nature, targeting all the key barriers in specific contexts. Thus, the need to ensure that policies and normative guidelines are centered on the actual needs of affected girls. Across developing countries, different regions may have varying age limits, and different laws and policies may have different definitions too. However, sexual and reproductive poor health and HIV have similar root causes which include poverty, gender inequality, gender-based violence, stigma and discrimination, and social marginalization as women living with HIV often represent a sub-set of the most vulnerable of populations in a particular society. To be specific, women living with

HIV continue to have sexual relationships and become pregnant either intentionally or not, and many decry the many obstacles they face in reaching and using contraception services even in circumstances where the services are provided. Despite of all this, there is scant progress in terms of policy support, and protection for such circumstances (Avert, 2018). While women continue to emphasize the importance of access to contraceptives described as the difference between life and death sometimes, it is imperative that attention is given to enable them meet their aspirations and create a better life for themselves and their families.

Contraception use among PLHIV, specifically women living with HIV has positive outcomes in terms of dual protection, promotion of SRHR, and a reduction in maternal, new-born and child mortality. However, AGLHIV fall under marginalized adolescents who are more likely to experience social and health disparities, with less possibilities of accessing and receiving preventive health services such as contraception. One way of solving this reality is by national governments enacting and implementing evidence-based policies to address the barriers.

Access to family planning methods/contraception has benefits and is critically important for both the individuals and public health, as it reduces the risks of unintended pregnancies for this population which has an already weakened immune system. When such girls can't uphold their human rights, specifically their sexual and reproductive health and rights, it undermines the success of efforts to get to zero exclusion, zero discrimination, zero violence and zero stigma experienced by PLHIV (UNAIDS, 2019b). Needless to say, it limits the levels of new infant/perinatal infections through mother-to-child-transmission (MTCT), and is a means of empowerment to young women and women at all ages to have more control of their reproductive health. PLHIV, and specifically AGLHIV ought to have easy and continuous access to SRH services which are of high quality and rights-based. Yet, up-to today scant attention is being given to their SRH and rights as most interventions focus mainly on prevention of mother to child transmission (PMTCT), antiretroviral therapy (ART), HIV testing services and linkage to treatment while ignoring other important aspects such as contraception and their daily experiences in reaching and using it (Roxo et al., 2019).

The vulnerability of AGLHIV is complicated further by absence of protective national and context-based mechanisms in the forms of laws and policies which can ensure the safety of AGLHIV. Therefore, putting in place policy provisions which directly address the socio-cultural aspects and clearly define structural issues to ease the reach and use of contraception by vulnerable and already marginalized groups such as AGLHIV remains a critical issue.

Across SSA, policies are sighted to be limiting the anticipated progress in relation to SRH and rights, which warrants investigating the contextual factors limiting AGLHIV and available policies, as well as the challenges faced in implementation.

## 2.4 Dual burden of HIV and teenage pregnancy and motherhood

In sub-Saharan Africa, 1.7 million adolescents aged 10–19 are living with HIV (Hagey et al., 2015). As common knowledge now, females are disproportionately affected. Today, large-scale changes such as the declining age of menarche, rising age of marriage and persisting norms around sexual behaviour have led to earlier and more frequent sexual activity among this age group. The period between first sexual encounter and marriage can leave an adolescent exposed to STIs including HIV, and the much younger age of sexual debut among adolescent females in developing. This is due to continuous sexual exploration or experimentation, potentially with different partner countries continuously increases their risk for not only acquiring HIV, but also having unintended pregnancies, and lack of consideration for uptake of health care services. Due to the physiological immaturity and increased vulnerability of adolescent girls, susceptibility to STIs and HIV transmission during this stage is increased, twice as likely as young men to be living with HIV (UNFPA, 2014). This is exacerbated by the engagement in sexual activity with older male partners who are previously sexually exposed to several other partners along their life course (Morris and Rushwan, 2015). Other adolescents have been perinatally infected and are able to live a normal life due to the use of highly active anti-retroviral therapy (HAART). Over one-third of perinatally infected children world-wide have reached adolescence and half are female (Abuogi, 2018). Thus, as perinatally HIV-infected children mature into adolescence and adulthood and new HIV infections among adolescents and young adults continue to occur, the need for reproductive health services becomes inevitable.

Sub-Saharan Africa, home to 70% of all new HIV infections in 2015, is at the epicentre of the HIV epidemic and continues to carry the full brunt of its health and socioeconomic impact (Wang et al., 2016). SSA still remains the most-affected continent of the world in terms of HIV infection and related effects (Biddlecom et al., 2007); (Abubeker et al., 2019) with adolescents accounting for two-thirds of the people living with HIV in the region (Hindin and O.Fatusi, 2009). An estimated 800,000 young people get infected annually, with 79% of these infections occurring in SSA (Denno et al., 2015). Young girls and women account for 1 in 4 (25%) of new HIV infections in SSA (Patton et al., 2016); (Abubeker et al., 2019) with adolescents girls

(15-19 years) accounting for 3 in 4 new HIV infections occurring among adolescents (Starrs et al., 2018).

Adolescent motherhood is equally common in sub-Saharan Africa than anywhere else in the world and occurs against a backdrop of the world's highest HIV rates. Despite this, young girls especially those living with HIV have not received adequate attention in relation to accessing and using contraception (Groves et al., 2018). For HIV-positive adolescent girls and young women (AGYW) who do not want to become pregnant, contraception has the added benefit of reducing HIV-positive births and, by extension, the number of children needing HIV-related services (Abubeker et al., 2019). The potential contribution of contraception to preventing HIV-positive births is well established. Despite its demonstrable contribution, far less attention has been given to prevention of risks faced in the process as a strategy to preventing early and unintended pregnancy and vertical transmission of HIV (Abubeker et al., 2019).

The proportion of recent births to mothers younger than age 20 that are unplanned is particularly high with more than 40% of such births being unplanned in African countries (Woog; et al., 2015).

Current levels of contraceptive use in all of sub-Saharan Africa are already preventing 173,000 HIV-positive births annually, even though contraception is not widely available in the region. An additional 160,000 HIV-positive births could be averted every year if all young women in the region who did not wish to get pregnant could get access to contraceptive services (Abubeker et al., 2019). The use of contraception to prevent early and unintended pregnancy is among the World Health Organization's (WHO) recommendations for prevention of maternal-to-child transmission (PMTCT) of HIV (WHO/CDS/HIV, 2019).

However, studies show that HIV-positive AGYW living in SSA have higher rates of unmet need for contraception, while others are simply reported to not be using contraception and are more likely to have unintended pregnancies-both unwanted and untimed, compared to HIV-negative women; and face unique obstacles in accessing family planning services (Hersey et al., 2019). There is also need to be aware and pay attention to the possible effects of the interactions between hormonal contraception and antiretrovirals, which might require a consultation with a health workers (Kancheva Landolt et al., 2011), thus necessitating a facility visit. Thus, significant barriers to family planning use among HIV-positive adolescent girls remain. There are challenges faced everyday by AGLHIV among which is the adjustment to adult responsibility when they fall pregnant. In one of the studies in Zambia, female participants revealed that they feared to get pregnant when they suspected or confirmed that

they were HIV positive, and the main reason was the realization that the advancement of the pregnancy would further worsen their health status (Biseck; et al., 2015).

Multiple demographic, psychological, sexual, medical, and relationship-based factors play a role in the reproductive decision-making of HIV-infected adolescents as young adults (Kourtis et al., 2016). Adolescents with chronic medical conditions are faced with many challenges as they transition from paediatric to adult care. Thus becoming a mother during adolescence in unfavourable cultural and legal environments further entrenches these young women's complex vulnerabilities (Abuogi, 2018). HIV-infected adolescents, in particular, may have difficulty expressing their medical needs, particularly those related to SRH (Kourtis et al., 2016). Furthermore, impairment in cognitive ability and reasoning may also present a major barrier to complicated discussions about reproductive health and contraceptive counselling.

Relatedly, research shows that a young person's relationship to HIV may shift and change depending on the extent of their "affectedness" (Toska; et al., 2019). Importantly, how HIV affects an adolescent girl may change throughout pregnancy and motherhood; for example, a significant proportion of new infections occur during late pregnancy, putting both mother and child at risk when ART initiation is delayed (Mofenson, 2018). The synergy of HIV and adolescent pregnancy and motherhood has resulted in this important population being overlooked in research, policy, funding and programming. Consequently, this highly vulnerable population remains largely invisible in the global and national contraception-focused policy response and maternal and child health work. This makes the enactment of policies to safeguard them against the risks and issues encountered paramount, with anticipation that they would cause an increase in the utilization of contraceptive services.

## 2.5 Perceptions on family planning and use of contraception in SSA

Family planning methods are intended to regulate fertility, as well as improve the health outcomes for mothers and children (Amran et al., 2019). Despite several interventions to reduce fertility in SSA, reports still indicate that fertility rate continues to rise. It is estimated that about 218 million women of reproductive age in developing countries still indicate a desire to avoid pregnancy but are not using modern family planning (Calhoun et al., 2022). The reasons for the growing rates of fertility are numerous, and they include the unmet need for contraception which is largely attributed to limited access to contraception, limited choice of methods, but also fear and experience of side-effects, and poor quality of available



contraception services. These are also a result of household, community-level factors embedded within perception.

Perceptions about family planning are built by socio-cultural norms and environment within which people live (Ahinkorah, 2020), the likely exposure they have had, which in turn influences their reproductive behaviour (Calhoun et al., 2022). It is therefore important to understand and address the role of social influences on the use of family planning methods/contraception especially. The fostering of better understanding through high-quality services such as counseling is vital to improve perception as well as encourage rational uptake. Also, it is important to note that the majority of these can be addressed if effective policy measures are in place. According to WHO, the gaps within family planning programming and services, including contraception contribute to a great extent to the high rates of teenage pregnancies (WHO, 2017), (Chandra-Mouli et al., 2015a) and it is also anticipated that national level policies should be in position to address such gaps.

## 2.6 Contraception use among adolescent girls and young women in Malawi

The right to decide on the number, spacing and timing of children is a critical element of women's reproductive autonomy at all ages, and is an important element of women's sexual and reproductive health and rights. Thus, it is important that adolescent girls and young women have access to contraceptive methods, especially modern ones, as well as information on the pros and cons of the different methods. The main consequence for low contraceptive use and prevalence is unplanned and unwanted pregnancies.

Unmet need for family planning is defined as “the number of women with unmet need for family planning who are fecund and sexually active but are not using any method of contraception and report not wanting any more children or wanting to delay the birth of their next child.” Unmet need is expressed as a percentage of women of reproductive age who are married, in a union, or are sexually active but are not using any method of contraception despite not wanting any children. This is usually a result of barriers experienced in the process of desiring and accessing or using contraception. The concept of unmet need is therefore important as it shifts the focus from the limits on family size set by the government to rightly focus “on the ‘need’ for contraception based on whether and when a woman wants a child.

The barriers have contributed to the growing unmet need for contraception among women of reproductive age group in general. According to WHO, 214 million women in the reproductive



age group in developing regions experienced unmet need for contraception in 2017, and 270 million in 2020. This is largely attributed to limited access to contraception, limited choice of methods, fear and experience of side-effects, poor quality of available contraception services and gender-based barriers. It is important to note that the majority of these can be addressed if effective policy measures are in place.

Among the adolescents, 23 million girls have an unmet need for contraception, further elevating their risk of unintended pregnancies. To prevent unintended pregnancy among adolescent females living with HIV, contraceptive services must reach a larger proportion of those with unmet need. According to UNFPA report on laws and policies (2017), in East and Southern Africa (ESA), there are an estimated 2.4 million sexually active adolescent girls (aged 15-19 years) who have an unmet need for family planning (UNFPA, 2017). This is expected to rise to 3.4 million by 2030 if access to family planning methods does not improve.

The majority of countries in the region do not have provisions that clearly set out the right of adolescents to access SRH services (UNFPA, 2017). However, regional and international commitments and treaties ratified by countries in the region outline and provide guidance for ensuring SRHR.

Malawi is recorded to have one of the highest fertility rates in the region (MoH, 2015). The proportion of pregnancies among the (15-19) year olds is 29%, and the unmet needs for family planning among the married is 19% and among the unmarried is at 40% (NSO and ICF, 2017). Teenage pregnancy increased from 24% in 2010 to 29% in 2015 indicating challenges in uptake and access of modern contraceptives and other SRH services among this age group. A 2016 study among adolescents in Malawi reported that regardless of the high levels of awareness (72%) of the availability of SRH services and modern contraceptives, the demand and utilization for the service was reported at only 38.4% among the 15-19 year age group (Munthali; and Kok, 2016 ). This raises questions about the bottlenecks experienced by adolescent girls and more so those living with HIV. In Malawi, teenage childbearing increases with age. The percentage of women aged 15-19 who have begun childbearing rises from 5% among women aged 15 years, to 59% among women aged 19 (ICF, 2017).

## 2.7 The importance of contraception for AGLHIV

Globally, it is estimated that one-third of perinatally HIV-infected children worldwide have reached adolescence, and half of them are female (Landolt et al., 2016). Additionally, young

women aged (15-24) years of age contribute about the same fraction to all new infections in sub-Saharan Africa, the region with the highest HIV prevalence in the world (Landolt et al., 2016). Antiretroviral therapy (ART) gives young people with HIV a chance to live, grow up and enjoy life, including a pleasurable sex life. Whereas many are infected behaviourally, and others perinatally infected, HIV-positive adolescents remain sexually active. Antiretroviral treatment significantly reduces mother-to-child transmission and restores health. It also restores fertility to people living with HIV both as a biological process and as an option. Thus, the majority of people on ART are able to resume socially productive and sexually active lives that involve both protected and unprotected sex with or without the desire for children.

As a result, they often experience unintended pregnancy (ies) due to engagement in unprotected sex.

From a general perspective, many adolescents living with or without HIV are sexually active and in need of continuous free access to a range of contraceptive methods, while the level of risk remains significantly great for those already living with HIV. While there are no population-based estimates of unintended pregnancies in women and girls living with HIV, studies suggest that levels of unintended pregnancies among HIV-positive women range from 51% to 90 (Njuguna et al., 2017). These estimates are based on anecdotal reports from Uganda, Rwanda, South Africa, and Côte d'Ivoire (Njuguna et al., 2017). It is prudent therefore to acknowledge that dual contraception offered by the use of effective methods of contraception (hormonal contraception [HC]) such as intrauterine device (IUD), and the barrier methods, usually condoms together seems to be the most effective option for female adolescents for protection from unintended pregnancy and sexually transmitted infections.

Contraception is vital for ensuring the health and well-being of sexually active adolescent girls, in addition to increasing their opportunities for learning/education and productive livelihoods (Fikree; et al., 2017). Contraception is important to help young girls to control the timing of their pregnancy and the effects it has on their lives. Thus the use of modern contraception such as pills, injectables, intra-uterine device, implants, spermicides, male and female condoms is an effective way of preventing unplanned pregnancies (Woog; et al., 2015).

Complications from pregnancy and childbirth are the leading cause of death for women (15–19) years, and births to girls under 15 years of age pose especially high health risks for mother and infants, and many end up dropping out of school. Regardless of this fact, adolescents have

an unacknowledged and frequently unmeasured need for contraception. The use of contraceptives in SSA is highly linked to the personal, economic, as well as a healthcare systems issues and remains low in comparison to other regions of the world (Ba et al., 2019). Women with a higher economic status, a higher level of education and living in the urban areas are more likely to use contraceptive than those without. The case for girls and young women living with HIV becomes even more difficult. However, with effective contraception (EC), the number of unintended pregnancies can significantly reduce, and thus improve the quality of life of AGLHIV, socially, physically and in many other ways.

Pregnancy in HIV-positive women is in general safe, but, adolescent pregnancy coupled with HIV infection is viewed as more-risky (Landolt et al., 2016). Logically, perinatally HIV-infected adolescents seem to be exposed to a higher risk of disease progression and death postpartum in comparison to those who are behaviourally infected as a result of the complex inter-relation of reproductive health, adherence and mental health issues. EC can therefore equally contribute to a reduction in the vertical transmission of HIV from mother to child, by reducing the number of pregnancies. Additionally, it also reduces horizontal transmission, given that HIV-negative pregnant women might have increased risk for HIV acquisition, while HIV-positive women may have increased ability to infect their sexual partners too. Similarly, ensuring access of contraception to AGLHIV in a way advances a number of human rights including the right to life and liberty, freedom of opinion and expression, as well as promotion of the rights of children, and of all persons living with HIV, in addition to the health benefits and other expanded benefits such as possibility of education and empowerment for girls.

Therefore, the prevention of unintended pregnancies among women living with HIV remains a paramount issue in SRH. And meeting the contraceptive needs of adolescents and those categorised as women in reproductive age, living with HIV is presumed to reduce illegal and unsafe abortions, reduce HIV incidence among infants, and child deaths (Tsui et al., 2010). In addition, it contributes to the lowering of rates of maternal and child morbidity and mortality. Whereas unintended pregnancies may not necessarily mean or result into unwanted pregnancies, there is a range of notable health risks that they may impose on the life of the mother and child such as malnutrition, illness, abuse and neglect and even death, more so among those with already weakened immune system like AGLHIV (S. Bellizzi et al., 2020). Furthermore, and as noted in several referenced literature, in SSA, it consequently results into cycles of high fertility, low levels of education and reduced employment potential, and deepened poverty on an individual level, but this can also span to generations. The use of

contraception is a recommended practice to tame such situations, prevent generational poverty, and promote proper utilization of people's potential which commonly goes un-tapped and un-utilized as a result of such preventable scenarios, which continue to be witnessed across SSA, and Malawi is no exception to the phenomenon.

## 2.8 Formulation and implementation of a policy

Policy making is a process of continuing interaction among institutions, interests, and ideas (Buse et al., 2005). The institutions specifically include structures and rules which shape how decisions are made; interests include players, actors, groups and individuals who stand to gain or lose from change; while ideas include arguments to support or disprove, and evidence (Buse et al., 2005). This also constitutes much of the policy analysis, which is a legitimate area of academic inquiry, with practical importance for health system development too.

A policy is a general high-level intent that guides and defines the boundaries within which decisions can be made. It is a broad guideline for decision making that links the formulation of a strategy with its implementation (Buse et al., 2012). A policy is a statement of intention that describes what needs to be done (responsibilities), by whom (roles), and the problems it will solve (objectives). It helps to determine the nature of programs and services to use, and answers the question “why?” by identifying goals and mission (Browne et al., 2018).

Policies provide general direction, and are often supported by other stipulations which foster its implementation and use. The additional supporting stipulations include standards, which establish specific criteria and measures of comparison.

Standards are measurable and describe the path to a desired outcome. Guidelines on the other side provide inputs and recommendations related to various aspects including interpretation of policy or procedures. All these are designed to streamline certain processes according to what the best practices are. They should be open to interpretation and not need to be followed to the letter. Guidelines include recommendations of best practices, a piece of advice on how to act in a given situation, and are recommended but non-mandatory control. Procedures too, are chronological steps involved in performing any action or taking any decisions (WHO, 2017). They are a sequence of activities that have to be performed to achieve any objective, a series of interrelated steps taken to help implement a given policy. Therefore, procedures can be series, or step-by-step instructions for performing a specific operation, in conformance with applicable standard. Procedures are operational documents that describe the processes and

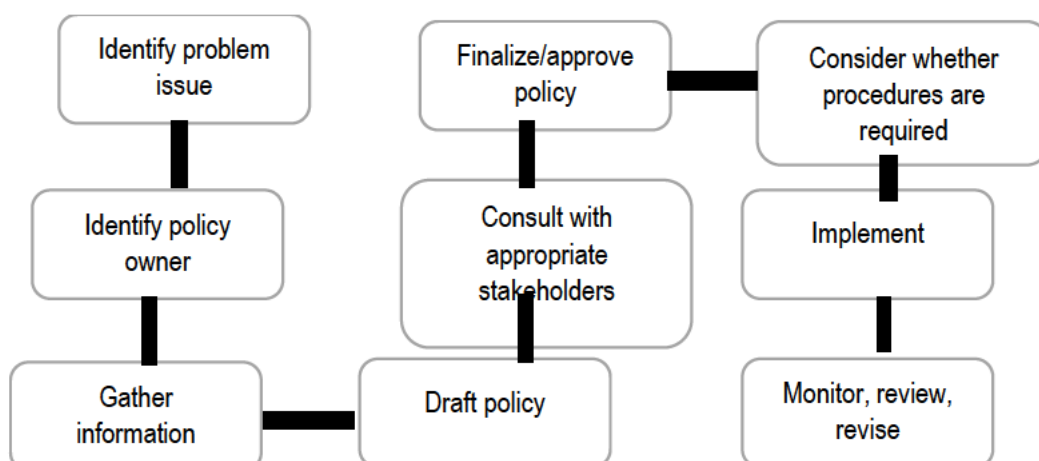
actions that are required to enable the implementation of a policy. Often, compliance with procedures is mandatory.

Therefore, a policy can only be put in effect where; responsibilities are clearly defined and assigned, methods of accountability are established, proper procedures and program activities are implemented, adequate provision of financial and other resources are provided, and responsibilities for carrying out the policy objectives are clearly communicated and understood within the workplace.

In writing a policy, it should contain all the major components and communicate easily what to do and why. Furthermore, through a policy statement – which is considered a formal document, an organization for instance would outline the ways in which it intends to conduct its affairs and act in specific ways in particular circumstances.

According to (Cairney, 2014) the general process of policy development may be as indicated in the figure below. However, this is a theoretical model to provide guidance, and it does not necessarily represent the exact process often in the real world, since the process is not always linear as demonstrated. Furthermore, the original Heuristic framework divided the policy process into four key stages: agenda setting, formulation, implementation, and evaluation; but subsequent frameworks have included additional stages – for example as demonstrated below, which helps to have a simple and useful way to think of a public policy.

*Figure 2.1 Stages Heuristic policy process*



Adapted from Zu-p, 2019

- i. Identify problem issue – characteristics of policy problems include solubility, complexity, monetization
- ii. Identify policy owner – the person who is identified as the legal owner under the terms of the policy
- iii. Gather information – do you have any legal responsibilities in this area, are there any existing templates or examples that you could draw on, when will you go for guidance?
- iv. Ensure that the wording and length or complexity of the policy are appropriate to those who will be expected to implement it
- v. Consult with appropriate stakeholders – Individuals or groups that make a difference or that can affect or be affected by the achievement of the policy
- vi. Finalize/approve policy – who will approve the policy, is this a strategic issue that should be approved by the management committee?
- vii. Consider whether procedures are required – consider whether there is need for clear guidance regarding how the policy will be implemented. Determine who will be responsible for developing these procedures and when this will be done
- viii. Monitor, review, revise – it is important to indicate clearly on what basis and when the policy will be reviewed and revised

It is also important to ensure that a given policy is well-written in a language that is understandable, named as a specific document, and aligned with relevant legislative and regulatory or organizational requirements such as strategic plan or goal.

## 2.9 Health policy, its formulation, and implementation

According to World Health Organization (WHO), health policy refers to the decisions, plans, actions (and inactions) undertaken to achieve specific health care goals within a society or undertaken by a set of institutions and organisations, at national, state and local level, to advance the public's health (WHO, 2020).

In many countries, the health sector is an important part of the economy. The health sector contributes a large extent through ensuring the health of the population for economic productivity. People's health can be affected by several other decisions which are not health-care related, such as poverty, and social issues, all of which affect people's behaviour. Thus, it is influenced by so many determinants beyond the health system, which makes it imperative to understand the relationship between health policy and health.

Health policy provides guidance and direction about technology, organization and financing of health services, as well as a country's provision of specific drugs and medical care for free. For purposes of this study, health policy will be looked at from the dimension of courses of action and inaction that affect the provision, delivery, uptake of contraception services by AGLHIV in Malawi, and the level of protection offered (if there is), in relation to the country context. This is by way of looking at formal statements and position of the government, or its departments which are mandated to provide national level support and leadership to the health sector.

According to Walt (Walt et al., 2008), health policy goes hand in hand with politics and deals explicitly with who influences policy making, how they exercise that influence and the conditions under which they do so. This implies that most activities and decisions within the health system are subject to the ebb and flow of politics. The process of enactment and review is largely political, dynamic, and highly complex. For the health sector, it is specifically challenging because of the technically complex nature of the health systems, with different parts inter-connected to each other, and with numerous actors and interest groups (Wuyts et al., 1992).

Therefore, governments often consult external groups to see what they think about issues of policy concern, to generate their views and obtain information on the issue. In reverse, interest groups may make attempt to influence governments' position and direction especially if it is a matter that they have great interest in. In most countries today, interest groups exist and they put enormous pressure to influence the thinking of governments on policies, and the provision of required services (Walt et al., 2008). In a way, this helps in stretching the governments to make the right decisions which address the actual health needs of the population. The interest groups make use of various tactics so as to be noticed and heard, including relationship building with government officials and people in power, expressions through the media, and setting up of formal discussion. Often, some interest groups have more influence over others. A range of interests are presented and considered during the formulation of a policy, from which the state mediates over the competing interests since no individual has absolute power. Thus, health policy is not only the set of decisions but includes the processes of interaction between different groups and forms of public action, which also includes the internal processes of the state (Wuyts et al., 1992). Health policy therefore relates to the creation of guidelines which are necessary for achieving specific health governance outcomes.



In 2015, the sustainable development agenda was unanimously adopted by the United Nations (UN). The sustainable development goals (SDGs) aimed to end poverty, fight inequality and create a better world by 2030 (UNDP, 2015). Given that children and adolescents under 15 years of age die mostly from preventable causes, and approximately 38 million people globally were living with HIV in 2019, SDG 3 aims to address such issues by ensuring healthy lives and promoting well-being for all (UNDP, 2015). This goal also has several benefits including reduction of maternal mortality, promotion of mental health, promoting universal health coverage, increasing access to SRH care, family planning and education, among others. It is of advantage that these health topics are regularly examined in the health policy literature and frequently analysed with policy frameworks, such as the health policy triangle (HPT) framework.

## 2.10 The role of policy in promoting SRH for AGLHIV

The creation of healthy societies through enactment of relevant policies has been a key function of public health for over thirty years (Browne et al., 2018), confirmed by the WHO in the Ottawa Charter for Health Promotion and Adelaide Recommendations (WHO, 1988). Withstanding all that, it is well documented that public health evidence which underpins the need for healthy policy environments is not often translated into policy (Browne et al., 2018) and this deficiency can be seen across SSA (UNFPA, 2017). Access to SRH services such as contraceptive services by HIV positive people can be largely shaped by the legal and policy environment if it resonates with their needs and aspirations. The laws and policies have the ability to influence the social and economic context through reinforcement of positive social determinants, and addressing the social norms and conditions that exacerbate health inequity and violation of human rights.

The effectiveness or need for a health policy can be reflected through routine decisions, activities and achievements or the lack of in a health issue or group, country or community. Thus, in relation to protecting of AGLHIV, having a policy in place to address issues they encounter and ensure their safety in the process of seeking and using contraception is paramount.

Some of the key national policies are always hinged to or guided by international standards, usually adopted by each country. Through healthy policy analysis, solutions to social problems and public health issues can be identified, analysed for consideration in relation to protecting



AGLHIV against vulnerabilities resulting into effectiveness of SRH programs and the co-current fulfilment of the human rights of AGLHIV. It is therefore a mandate of each respective country to ensure the enactment of such provisions and to monitor their successful implementation to ensure effectiveness and achievement of intended goal. Thus, in analyzing the current policy (ies), it is important to review the context, including the political economy and its drivers, the culture, the state and non-state actors involved in the process in terms of their influence either on demand or supply side (Fritz; et al., 2009); the steps involved – how the policy was proposed, debated and adopted, the actual inputs and details in relation to the study focus, and the policy implementation process in the country, putting in consideration the progress achieved so far.

Adolescents continuously find themselves in situations where they do not have either the economic or practical means of accessing health SRH services such as contraception (Chandra-Mouli et al., 2015b) given the sensitivity attached to it. However, their willingness and desire to utilize it should be adequate gesture of their need, regardless of the situations they may be in. This therefore calls for targeted policy provisions and their rightful implementation as key precipitation in promoting the health of AGLHIV.

## 2.11 Malawi and the ICPD

### 2.11.1 The ICPD and Sexual and Reproductive Health and Rights

The International Conference for Population and Development (ICPD) was a landmark meeting in Cairo where 179 governments adopted a revolutionary Program of Action (PoA), calling for women's reproductive health and rights to take center stage in national and global development efforts. This was organized principally by the United Nations Population Fund (UNFPA), and the Population Division of the UN Department for Economic and Social Information and Policy Analysis (UN, 1995).

In its Program of Action (PoA), the ICPD specifically called for all people to have access to comprehensive reproductive health care, including voluntary family planning, safe pregnancy and childbirth services, and the prevention and treatment of sexually transmitted infections. The program equally recognized that reproductive health and women's empowerment are intertwined, signaling that both are necessary for the advancement of society. The ICPD further calls for the full and equal participation of women in civil, cultural economic, political, and

social life, at the national, regional, and international levels. It also calls for the eradication of all forms of discrimination on grounds of sex.

*Thus, the ICPD is often referred to as a global consensus that reproductive health and rights are human rights, which are a pre-condition for women's empowerment.*

It is important to recognize that the inception of the ICPD was in the 1960s when mortality rates declined around the world and panic grew among policy makers and researchers that population growth would outstrip natural resources, and result into famine and societal collapse. Different governments responded differently, with some considering coercion as a means to lower fertility rates. Therefore, through its PoA, the ICPD brought the global community together and reflected a new consensus about response to population growth. Within this it firmly established that the rights and dignity of individuals, rather than numerical population targets were the best way for individuals to realize their own fertility goals. In addition, governments acknowledged that these rights are essential for global development too.

The ICDP through its PoA comprises of fifteen principles which encourage a balance between recognition of individual human rights and development of nations. Thus, the principles mainly focus on key issues such as gender equality, equity, and the empowerment of women, the integration of population into sustainable development policies and programs, access to reproductive health care and family planning, among other rights and needs of the population. There is reaffirmation that the advancement of gender equality and equity, and the empowerment of women, the elimination of all kinds of violence against women and ensuring that women's ability to control their own fertility are key in population and development programming (UN, 1995). States and governments are therefore obligated to ensure the universal access to healthcare services, including those related to reproductive health care, which largely include family planning and sexual health. This includes ensuring the basic right of all couples and individuals to decide freely and responsibly the number and spacing of their children and have the required information, education and means to do so. The PoA also stresses the importance of promoting mutually respectful and equitable gender relations, specifically in relation to meeting the needs of adolescents, as a way of promoting positive and responsible sexuality among them (UN, 1995).

It is therefore imperative to acknowledge that the ICPD represented a resounding endorsement that the securing of reproductive health, individual rights and women's empowerment is an obligation of every country and community. Through the annual commission on population

and development, the UN reviews the state of SRHR around the world and measures extent of progress made or ground lost in efforts to empower women, educate girls, and eliminate gender-based violence and harmful practices.

#### 2.11.2 Understanding the sequence of political, and socio-economic context for SRH in Malawi post-ICPD 1994

The 1994 ICPD coincides with Malawi's first democratically elected government, which assumed office in March 1994. Earlier that year, the new government had adopted a comprehensive National Population policy in March 1994 (Thompson, 1999). Malawi's new government therefore had the opportunity of participating in the ICPD which took place later in September of the same year. Therefore, when the ICPD passed its PoA, the GoM took an initiative to review the earlier adopted policy to ensure that it covered the PoA earmarked. It is documented that the policy was found to be consistent with the provisions of the PoA, and no further reviews or additions were required, except including ICPD initiatives in the action plan of the policy. Hence-forth, the policy and the subsequent implementation plan formed the pivot for Malawi's population program.

To affirm its commitment to the ICPD PoA and country's policy, in 1996, the GoM introduced an independent budget line to cater for coordination of population activities. In addition, the government was committed to making progress on recommended ICPD changes by promoting the integrated reproductive health culture, emphasizing gender concerns in development and enhancing efforts to ensure widespread support for the implementation of the National Population policy. Hence-forth, population factors received considerable emphasis in major policy and program documents, specifically the country poverty alleviation program. In the same year, the Family Planning policy and contraceptive guidelines were revised. The revision was aimed at liberalizing family planning services to accommodate all individuals within the reproductive age group, who need the services. Within the new guidelines, limitations to use of specific methods basing on age, parity, and marital status were removed. In addition, new approaches for accessing and expanding family planning services, such as community-based distribution agents (CBDAs) and social marketing were instituted. The integration of family planning with STDs and HIV/AIDS management was taught in all institutions as an additional measure too.

By 1996, the awareness of family planning methods was over 90% and within four years, the contraceptive prevalence rate (CPR) for modern methods had increased from 7% in 1992 to 14% in 1996.

In 1999, the GoM further affirmed its commitment to implementation of the PoA, and an additional establishment of a formal capacity for population program was formulated (UN, 1999). Furthermore, implementation of a Safe Motherhood plan of action was started. These actions can collectively be seen as commitment towards provision of an enabling environment for adhering to the ICPD program of action.

Furthermore, by 1999, a Reproductive Health policy was under preparation, and a youth and adolescent program for reproductive health had been put in place following the adoption of the National youth policy earlier in 1996.

The GoM recognized that gender was a prerequisite for proper reproductive decision making. Thus, to ensure gender sensitivity, legal reforms were introduced to amend laws that promoted gender discriminatory practices. These included the Affiliation Act, Marriage Act, and Inheritance Act. A new constitution had been enacted in 1995 which guaranteed human rights to all people, including women. It clearly stipulated that women had the right to full and equal protection of the law and the right not to be discriminated against on the basis of their gender or marital status. In an effort to institutionalize gender and development, Malawi instituted a National gender machinery, and drafted a National Gender policy, with the main aim of offering guidance for recognition and addressing of gender concerns, as well as for mainstreaming gender in all development programs.

The GoM also took initiatives to protect the girl child. Free primary education was introduced in 1994, pushing the enrollment levels to 50%. At secondary level, tuition fees for girls were waived, and a policy change was effected to allow girls who dropped out of school due to pregnancy to rejoin. Malawi had a country-wide awareness program, with education on population incorporated in the formal school curriculum.

However, the implementation of all the above policies and programs, especially in relation to gender and development programs were largely constrained by institutional and structural shortcomings, mainly, lack of trained personnel, weak institutional capacity, inadequate funds allocated to implementation institutions, and unavailability of structures for coordination at district and local levels, a weak resource base, lack of gender disaggregated data, cultural practices and beliefs, as well as traditions and social norms. Malawi was also faced with the

HIV/AIDS pandemic, although the government was committed to controlling it regardless of lack of financial and technical resources.

The civil society, specifically NGOs and private sector were of significant contribution to the formulation and implementation of policies and programs, through participation in the processes especially in relation to family planning provision and counselling, youth and adolescent reproductive health services and motivation training. However, despite of all their contributions, the GoM lacked a national strategy for harnessing the full potential of such players.

Thus, their presence, and that of an active private sector, as well as their participation was an assurance of a set of policy and program actors to help support the country to make the intended progress.

In 2007, a rise was seen in healthcare services and the economy had improved after introduction of programs which were aimed at addressing the development needs of the country.

After twenty years of the ICPD, in 2014, Malawi had achieved noticeable success in implementation of the ICPD program of action. The actions had been localized through the national development agenda as a way of ensuring ownership and effective monitoring (GoM, 2014b). The National Youth policy was revised to focus on six critical areas including health and nutrition. Priority was also given to family life education, and sexual and reproductive health.

Furthermore, the National gender policy was revised and implementation was steadfast, resulting into the establishment of a gender unit, development of a gender equality statute with affirmative action provisions (GoM, 2014b), and implementation of the National gender-based violence strategy which was put in place to provide support to victims of domestic violence. In addition, a Social Rehabilitation Center was established, a review of the “Prevention of Domestic Violence Act – 2006” was revised, and gender mainstreaming and gender budgeting guidelines were disseminated in all districts. This was a sign of commitment from the GoM towards the achievement of the ICPD PoA.

To reverse the trend of the high maternal mortality ratio at the time, GoM also rolled off the implementation of the Roadmap on Accelerated Reduction of Maternal and Neonatal death (2011-2016), and the National Sexual and Reproductive Health and Rights (SRHR) Strategy (2011-2016). Furthermore, the Malawi Integrated Clinical HIV Guidelines were adopted,

leading to the early ART initiation, PMTCT and an increase in HIV testing sites, thus improving access to information and services to the general population.

In order to sustain the momentum for integration of the ICPD PoA in national development plans, the GoM additionally pledged, in 2014, to continue implementation through a set of focus activities which included; the development, strengthening, effective implementation, and coordination of coherent national resources which target marginalized or disadvantaged groups such as women, to eradicate poverty and inequality; to adopt and implements legislation, policies and measures that prevent, punish and eradicate gender-based violence within and outside of the family; to eradicate all harmful practices which included child, early and forced marriage through integrated multisectoral strategies and the promulgation and enforcement of appropriate laws; to respect, protect, and promote the human rights of all people living with HIV, and enact protective laws facilitating access to health and social services to ensure that all persons living with and at risk of HIV can live free from stigma and discrimination.

In 2019 as the ICPD marked 25 years, the GoM made renewed commitment through a set of ambitious targets, aimed at “*accelerating the promise*” (Duckett, 2019). This was ahead of the 2019 ICPD summit in Nairobi. The targets which are set to be achieved by 2030 include; the provision of youth friendly services and reduction of the unmet need for contraception for unmarried young people to below 11% (from 52%) by 2030, to increase the budgetary allocations to reproductive, maternal, neonatal, child and adolescent health to 30% (from 10%) by 2030, to end early and unintended pregnancy, to eliminate child marriage by 2030, and to achieve 100% delivery of youth-friendly sexual and reproductive health and rights services at points of service.

However, there was still need for engagement of all stakeholders to ensure their systematic participation and contribution to this development process (GoM, 2014b).

Similarly, the country was still faced with a high HIV/AIDS prevalence, at 10.6% among the 15-49 age group, with women at higher risk at 13% as compared to 8% among the men.

It is also important to recognize Malawi’s commitment to the 2006 MAPUTO Plan of Action which aimed at addressing reproductive rights of young people (Commission, 2016); the 2012 London Summit on family planning to which it announced its “no child before adulthood” national campaign, with a focus to raise the country’s contraceptive rate to 60% by 2020 among the AGYW, passing the population policy, and raising the legal age of marriage to 18 by 2014,

committed to creating a budget line for family planning within the national drug budget, strengthen technical leadership on family planning within the directorates at the ministry of health, committed to delivering a comprehensive SRH program for the youth by 2013-2014 budget year and through public and private partnerships, increase access to family planning services through strengthening of community structures through the Presidential initiative on maternal and safe motherhood, and establishment of a Chiefs' delegation where traditional chiefs would be briefed by women about what is to be done, the secret mother registers for family planning care and monitoring at the community level, and the strengthening of data management for supply chain guidance; and its current involvement in the FP2020/2030 program which implements family planning. Malawi has often been faced with a funding shortage for family planning, to which partners are always solicited to bridge the gap.

## 2.12 The SRHR policy framework and program environment in Malawi

Malawi is a signatory to both international and regional treaties, conventions and protocols on SRHR as well as HIV and AIDS. Malawi is a member of the United Nations (UN) and the African Union (AU). It has ratified several UN human rights conventions and thus has made binding international commitments to adhere to the standards laid down in these universal human rights documents.

Malawi is signed on to the UN Human Rights Framework, the Convention on the rights of a child and is also very cognizant on gender-based violence issues, using the framework of the Sustainable Development Goals (SDGs) (UNDP, 2015). The country has also established several national plans and policies which have aspects of integration between SRHR and HIV and AIDS. National and international documents relevant to SRHR and HIV and AIDS that Malawi has ratified include the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), the International Covenant on Civil and Political Rights (ICCPR), the International Covenant on Economic, Social and Cultural Rights (ICESCR) and the Convention on the Rights of the Child, the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa, UNAIDS Policy Statement on HIV Testing," June 2004; HIV/AIDS and Human Rights International Guidelines, the Southern African Development Community (SADC) Protocol on Integration and Development, Africa Health Strategy for 2007 to 2015, the Maputo Plan of Action on Reproductive Health (both of which were endorsed by the AU Heads of States and Governments) and The SADC Protocol on Health of 2004. The SADC Strategy for instance calls for integration of different



reproductive health services to maximize the effectiveness of resource utilization. The provision of comprehensive reproductive health services through integration of STI, HIV and AIDS into other SRH services and Primary Health Care (PHC) is promoted.

With specific reference to HIV and AIDS, Malawi developed the first comprehensive National HIV and AIDS Strategic Framework for the period 2000-2004. Malawi followed this with the National HIV and AIDS Action Framework (NAF) 2005-2009, the Extended NAF 2010-2012, the NSP 2012-2016, and then the NSP 2015-2020 (NAC, 2020).

Malawi has used these strategic plans to guide the national response to the HIV and AIDS epidemic and mobilize resources for effective implementation of interventions. In pursuit of a healthy and prosperous nation free from HIV and AIDS, this new NSP provides the rationale and direction for key interventions that stakeholders and funding agencies should prioritize (NAC, 2020). The NSP 2020-2025 focuses on the following thematic areas: Combination Prevention, differentiated HIV Testing Services, treatment, Care and Support for HIV/AIDS and Related Diseases, TB/HIV, vulnerable Children, reducing Human Rights and Gender-Related Barriers, Social and Behaviour Change Communication (SBCC), Resilient and Sustainable Systems for Health (RSSH).

Over the years, Malawi has also increased focus on AGYW since 2016. This coincided with the launch of the DREAMS (Determined, Resilient, Empowered, AIDS-free, Mentored, and Safe) program in October 2016 and also the Global Fund support towards AGYW. In eight districts, PEPFAR and Global Fund support provision of a comprehensive package of services that go beyond the health sector to address the structural inequalities that impact both AGYW and ABYM vulnerability to HIV (GoM, 2018b). The comprehensive package of interventions are delivered in high burden districts consisting of information and delivery of HIV prevention interventions, reproductive health services, post-GBV care, violence prevention and perceived HIV risk determination, social asset building, back to school support, and village savings and loans programming. In medium and low burden districts, GoM plans to implement a referral system to ensure that AGYW have access to broad-based services across different sectors (GoM, 2018b). GoM has also committed to cross-sectoral coordination and collaboration among the Ministry of Education Science and Technology; Ministry of Health and Population; Ministry of Gender, Children Disability and Social Welfare; and Ministry of Youth, Sports and Culture. These core Ministries are collaboratively addressing the needs of AGYW and in 2018 they directed and launched the National AGYW Strategy (GoM, 2018b). It is reported that the



launch of this strategy and a functional secretariat have so far improved multi-sectoral coordination of GoM and partner activities.

In terms of contraception, the country has gone through three phases over the years to raise the contraceptive prevalence rate (CPR). From 1982 when the country had a restrictive program, the CPR was 7%, and up to date when the current CPR is 74% for married women. Currently, Malawi is now focusing on rights-based programming for youth and its importance.

Similar effort has been put on the SRH integration agenda, with National policies, plans and legislations related to SRHR and HIV and AIDS integration in place. These include the Malawi National Plan for the Elimination of Mother-to-Child Transmission of HIV, Malawi HIV and AIDS Policy, the National HIV and AIDS Strategic Plan 2011-2016, National HIV and AIDS Workplace Policy, National Sexual and Reproductive Health and Rights (SRHR) Policy, National Sexual and Reproductive Health strategy (2011-2015), National Youth Policy, National Standards Youth Friendly Health Services.

### 2.13 Contraception, health and human rights for PLHIV

Contraception has clear health benefits, since the prevention of unintended pregnancies results in a subsequent decrease in maternal and infant mortality and morbidity. Providing access to all women in developing countries who currently have an unmet need for modern methods of contraception would prevent millions of unintended pregnancies, abortions (both safe and unsafe) as well as maternal and infant deaths. This situation would particularly benefit adolescent girls, who are at increased risk for medical complications associated with pregnancy and who are often forced to make compromises in education that later leads to lower educational attainment and poverty. In addition, access to and use of contraception also contributes to individuals being able to take control over their sexuality, health and reproduction, thus helping them to achieve a satisfying sexual life.

Family planning and contraception use remain significant in the HIV prevention strategies, and the prevention of unwanted pregnancies is prong two among the approaches recommended for prevention, more so through the prevention of mother to child transmission of HIV (PMTCT) (Wanyenze et al., 2013).

The issue of human rights remains fragile. Human rights are guaranteed in international and regional treaties, as well as in national constitutions and laws. They include the right to non-

discrimination, the right to life, survival and development, the right to the highest attainable standard of health, and the right to education and to information. These rights have been applied by international, regional and national authoritative human rights bodies, such as UN treaty-monitoring bodies, international and regional courts, constitutional and supreme courts – to a wide range of sexual and reproductive health issues, including the accessibility of contraceptive information and services. All rights are interdependent and indivisible. The right to the highest attainable standard of health, for example, which includes access to health services and health-related information, cannot be fulfilled without promotion and protection of the rights to education and information, because people must know about health commodities and services to be able to use them. When governments ratify international human rights treaties, they are legally bound to ensure that their national laws, policies and practices do not conflict, and are consistent, with their obligations under international law. The main way governments do this is through respect, protection and fulfilment of rights. Respect of rights requires refraining from interfering with the enjoyment of rights, such as not criminalizing methods of preventing unwanted pregnancy.

Sexual and reproductive rights embrace certain human rights, most of which are recognized in international human rights instruments and other consensus documents. These include the rights of all persons to be free from coercion, discrimination, and violence; to achieve the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive healthcare services, such as contraception; to seek, receive, and impart information in relation to sexuality and comprehensive sexuality education; the respect for bodily integrity; the choice of a sexual partner; to decide whether to be sexually active or not; to have consensual sexual relations; to enjoy consensual marriage; to decide whether or not, when, and how many children to have; and to pursue a satisfying, safe, and pleasurable sexual life. Key among these instruments is the Universal Convention on the Rights of the Child (UCRC), to which most countries are signatory to. The convention mandates every child including adolescents to the right to access information on health and services needed to make their health better, to grow, and obtain their fullest potential (UN, 1989). Correspondingly, the right to SRH is an integral part of the right to health, enshrined in article 12 of the International Covenant on Economic, Social and Cultural Rights (UN, 1966). Protection of rights requires enacting laws that prevent violations of rights by state authorities or by non-state actors and ensuring that some form of redress mechanism is available; ensuring guarantees against forced sterilization would be an example of this. Fulfilment of rights requires taking active steps to

put in place institutions and procedures that enable people to enjoy their guaranteed rights through, for example, appropriate training for health-care providers, fostering the participation of people in the design, implementation and monitoring of services, or ensuring equitable geographic outreach to the population.

Contraception, basically safeguards women's and girls' health and rights, allowing them to make their own decisions from an informed perspective and not out of fear or coercion. Whenever a woman is denied the power to make her own decisions about whether, when or how often to become pregnant, her internationally recognized rights are violated. Access to family planning services such as modern contraception is a basic human right that increases gender equality and the empowerment of young vulnerable girls and women. Evidence shows, however, that in many countries, laws, policies and practices are not always consistent with human rights obligations (UNFPA, 2017) and this can present barriers to achieving targets and the highest attainable standard of sexual and reproductive health.

Therefore, every country is expected to remain committed to improving access to quality and rights-based family planning services. The human rights principle of non-discrimination obliges states to guarantee that human rights are exercised without discrimination of any kind based on race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status such as disability, age, marital and family status, sexual orientation and gender identity, health status, place of residence, economic and social situation (Williamson et al., 2014).

According to the Family Planning 2020 (FP2020), a global community of partners working together to advance rights-based family planning, each country is mandated to take the lead on their own framework on family planning, set their agenda for progress with formal commitments to develop, support, and strengthen their family planning programs (FP2020, 2020) – even when in collaboration with other partners. Thus, each country's commitment functions as a blueprint for collaboration, providing partners with a shared agenda and measurable goals to reach women and girls in some of the world's poorest countries to use voluntary modern contraception. FP2020 has since transitioned to FP2030, with similar goals of extending rights-based family planning choices and services.

With specific reference to PLHIV, the United Nations General Assembly (UNGA) in 2011 made a political declaration on HIV, requiring member states to “*create enabling legal, social*

*and policy frameworks in each national context in order to eliminate stigma, discrimination and violence related to HIV and promote access to HIV prevention, treatment, care and support an non-discriminatory access to ...health care...and social services, provide legal protections for people affected by HIV, including ...respect for privacy and confidentiality, and promote and protect all human rights and fundamental freedoms with particular attention to all people vulnerable and affected by HIV;” (Williamson et al., 2014), (Nations, 2011).*

This indicates the importance of protecting the human rights of PLHIV, including AGLHIV. However, these still experience denial and violation of their human rights (Williamson et al., 2014), including key health services. In Africa, a UNDP report on legal protections against HIV-related human rights (UNDP, 2013) indicates that several HIV-specific regulations fail to integrate the human rights principles, do not integrate accurate information and proven protective strategies for PLHIV, and most HIV-specific legislation fails to address protection and access to services for vulnerable groups such as AGLHIV (UNDP, 2013). Yet, policies can enable affected individuals to seek redress when they experience violation of their rights

#### 2.13.1 Guidelines for contraception for Women living with HIV

International commitments to meet the needs and demands of PLHIV and especially of their SRH and rights are yet to be met. However, enormous effort has been made by the World Health Organization (WHO) to provide guidance for key populations mainly PLHIV. Through its Global Reproductive Health Strategy, it highlights the provision of family planning services, promotion of sexual health, and elimination of gender-based violence against women and girls (WHO, 2006), among other guidelines.

Furthermore, the Consolidated guideline on SRHR of women living with HIV highlights the need for respectful and quality care for women living with HIV, and provides guidelines for countries to operationalize (WHO, 2017). The guidelines are centered around the needs and priorities of women living with HIV (WLHIV). WLHIV are often faced with social exclusion and marginalization, criminalization, stigma, gender-based violence, and gender inequality (WHO, 2017). There is need to improve accessibility, acceptability, uptake, equitable coverage, quality, effectiveness and efficiency.

It is therefore recommended that creation of enabling environment ought to be prioritized to enable WLHIV to enjoy healthy sexuality across their life course and provide for integration of SRHR and HIV services. The provision of enabling environment also includes protection from violence and creating safety, as well as engagement of communities for empowerment of

WLHIV in every society. It is also recommended that health interventions for WLHIV include sexual health counseling and support, the prevention of sexual violence against women, provision of family planning services (WHO, 2017). These are to be accompanied with comprehensive communication on sexuality, contraception, and prevention of perinatal transmission of HIV, and psychosocial support.

#### 2.13.2 Rights-based family planning:

Rights-based family planning is an approach to developing and implementing health programs that aims to fulfill the rights of all individuals to choose whether, when, and how many children to have; to act on those choices through high-quality sexual and reproductive health services, information, and education; and to access those services free from discrimination, coercion, and violence, working to ensure it is part of all sexual and reproductive health care programs (UNFPA, 2018). The rights-based framework can be traced back to the 1968 international conference which devised the principle that parents have the basic right to decide freely the number and spacing of their children (UN, 1995). The 1994 ICPD expanded this focus to reproductive health, with women as the focus/subjects rather than the objects of the programs, shifting the focus to reproductive rights and women's empowerment.

Initially the FP programs were slow to meet the ideals of reproductive health and rights, as focus was largely on contraceptive service delivery, and shifting to helping women and girls achieve their reproductive intentions was more under care which is clinical based (UN, 1995). Efforts were then invested to put women and girls at the fore-front and center of these programs while striving to make progress in similar health priorities such as HIV/AIDS pandemic. Thus, funding dwindled dramatically, and programs declined. However, in 2012 the ideals of reproductive health and rights were resurrected, re-affirming FP as a development priority. This revitalized FP with a shift in programming, to focus on the individual, resulting into the birth of the FP2020 – Family Planning 2020 agenda (FP2020, 2020). FP2020 is therefore an outcome of this summit where over 20 governments made commitments to address the policy, financing, socio-cultural, and delivery barriers hindering women from accessing contraceptive information, services, and supplies. Thus, it was founded on the principle that women wherever they are in the world should have access to lifesaving contraceptives.

Withstanding a lot of skepticisms, women and youths have since rallied behind this platform, working together with donors and stakeholders across the globe to center the aspect of rights in FP2020. Rights have prominently featured in FP programs hence-forth, with the principle

that women and girls' perspectives and rights will be observed and promoted across FP programs. A rights and empowerment principles-working group was established in 2012 to spear-head this and their relation to the ten dimensions of FP namely; agency and autonomy, availability, accessibility, acceptability, quality, equity and nondiscrimination, informed choice, transparency and accountability, and voice and participation. This is through facilitating and supporting thematic areas of rights-based family planning programming notably; demand creation; service delivery and access; contraceptive security; policy and enabling environment; financing; and stewardship, management, and accountability. At country level, focal points were identified to make them realize the commitments their country had made at the FP summit 2012, and to promote and hold themselves accountable of the FP programs. These comprised of numerous partners notably - government and two donor organizations usually UNFPA and USAID, as well as civil society and youth representatives who prepared country implementation plans which were critical to concretizing the ambitious country goals into programs and policies. The program has also been keen to integrate aspects of gender, HIV, male involvement over the years to provide a comprehensive service delivery program, and to debate approaches and best practices, but with the main motive of promoting rights-based programming.

Therefore, securing and upholding the rights of women and girls has been a cornerstone of the FP2020 agenda. Furthermore, the meaningful youth engagement has been a cornerstone of FP2020's efforts, and countries are encouraged to support the rights of young people to quality SRH and family planning information and services. FP2020's website has a page dedicated to adolescents and youth, noting that "the fundamental right of individuals (including young people) to decide, freely and for themselves, whether, when, and how many children to have is central to the vision and goals of this global movement.

## 2.14 Conclusion

From the literature reviewed, it is clear policies play a central role in advancing positive sexual and reproductive health outcomes, and rights for women and girls living with HIV. While efforts have been made to ensure easy access to contraception by such vulnerable groups, the glaring gaps point to the need to embrace the enactment and implementation of policy provisions which address the gaps and improve uptake of contraception for PLHIV.

## CHAPTER 3: SCOPING REVIEW; BARRIERS FACED BY ADOLESCENT GIRLS AND YOUNG WOMEN LIVING WITH HIV/AIDS IN THE UPTAKE OF CONTRACEPTION, IN SUB-SAHARAN AFRICA

### 3.1 Introduction:

A scoping review is a form of knowledge synthesis exploring a research question. In general, scoping studies aim to rapidly map the key concepts that underpin a certain research area, and the main sources and types of evidence available (Arksey and O'Malley, 2005). According to (Khalil; et al., 2016), scoping review is a preliminary assessment of the potential size and scope of available research literature on a specific subject or field under study, with the aim of identifying the nature and extent of the research evidence (Institute, 2015).

Scoping review is one of the different types of reviews that were advanced earlier by Arksey and O'Malley, in 2005. While scoping reviews are often confused with “mapping” reviews and systematic reviews, there is a slight difference in the methodologies. However, “scoping” is a technique to map relevant literature in a specific field of interest (Institute, 2015). Therefore, scoping reviews are important in assessing the extent of literature on a particular topic, to ensure that additional research in the area is beneficial (Khalil; et al., 2016). In addition, scoping reviews are important in synthesizing research evidence and the mapping of existing literature in terms of its nature, features, and volume (Arksey and O'Malley, 2005).

This is often conducted by following through a series of methodological steps as follows; identifying the research question, identifying the relevant studies, selection of the suitable studies, charting the data, and collating the results to identify implications of the study findings for policy, practice, and/or research. These steps make up the framework which was advanced by Arksey and O'Malley (Arksey and O'Malley, 2005), (Institute, 2015).

### 3.2 Rationale

Early motherhood is common in Sub-Saharan Africa (SSA) than anywhere else in the world. About 16 million adolescent girls and young women (AGYW) aged (15-19) give birth annually in low and middle-income countries, part of which is SSA (Ahinkorah et al., 2020). This also happens at the backdrop of the highest HIV prevalence in the world (Groves et al., 2018), and largely among the adolescent girls and young women in the region.



Adolescent girls and young women living with HIV are an important sub-population which is often under-looked in service provision and programing, research, and policy in Sub-Saharan Africa (SSA). Yet, the combination of motherhood while living with HIV has often been reported to attract dual stigma, exclusion and discrimination (Toska et al., 2020b). As a result, repeat pregnancies are rampant among this highly vulnerable group. However, it is important to continue to bring light the difficulties that an adolescent and young woman has to deal with while struggling to understand the demands of adolescence and womanhood, the changing demands for traditionally influenced care-giving to their husbands and families for those who are already married, in addition to personal health-care as a person living with a terminal condition which similarly requires a level of attention. All this coupled with pregnancy -often unplanned for and many times unwanted, and the high levels of poverty surrounding adolescent girls in most SSA settings is a pure remedy for a crippled life, especially if life-saving interventions are not easily reached.

Adolescents living with HIV continue to report resembling sexual activity as their uninfected peers. For the girls, this has also been matched with teenage pregnancies. The scenario is the same for young women, as many are initiated into romantic relationships and many are lured into marriage at that stage. Thus, it is important to acknowledge that AGYW living with HIV form relationships, become sexually active, and often fall pregnant. However, most of the pregnancies are reported to be unintended. In such cases, some have sought abortion services where they are available, while others still consider clandestine and unsafe measures to terminate such pregnancies. For instance, a facility-based study among HIV infected women who were within the reproductive age-group in Ethiopia revealed that 7% of the participants had ever experienced an abortion (Kebede et al., 2019). Consequently, this has put the lives of many adolescent girls and young women in more danger, resulting into maternal related morbidities, and mortality across SSA. While AGYW living with HIV poses an elevated health risk, they also have fertility desires but this which ought to be balanced with their health condition and treatment needs (Mokgatle; et al., 2017). In addition, many require support to easily access and use SRH services, mainly contraception to manage their fertility choices as well as promote their rights to choice and determination for child birth and establishment of family(ies). Also, there is evidence that young mothers are more likely to drop-off their lifelong ART regimens after child delivery (Toska et al., 2020b). Yet, the prevention of unplanned pregnancy among women who are infected with HIV is critical for preventing mother-to-child transmission of the same virus (Kebede et al., 2019). The deployment and use of modern



contraception is Principle One among the strategies for prevention of mother-to-child-transmission (MTCT) of HIV.

According to UNAIDS 2019 report, the uptake of modern contraception among AGYW in general remains low across SSA, and their unmet need equally remains high (UNAIDS, 2019a). It is therefore essential to enable AGYW living with HIV to plan whether and when to become pregnant. This is also a fundamental right, which promotes respect for women's reproductive choice, and is critical in the context of HIV/AIDS.

Thus, the use of contraception remains unacceptably low in SSA (Ahinkorah et al., 2020), regardless of the advanced awareness and knowledge among AGYW, including those infected and living with HIV.

Regardless of all the above, substantive omissions in programming for this group have been consistent across SSA, and the risk is high that they may continue to feature among the gaps within adolescent HIV prevention, and other adult-focused programs for PMTCT support. Thus, while AGYW may have a greater likelihood of using modern family planning methods, those infected with HIV have been found to have experienced an unintended pregnancy as opposed to those who are HIV-negative (Kimani et al., 2015). Yet, they continue to express limited desire to have more children as compared to those who are uninfected.

### 3.3 Conceptual argument

For purposes of this review, the population of focus was extended beyond adolescents to include young women too; that is to say (10-24) years for two main reasons. The HIV epidemic lies largely among the (15-24) year olds, and the factors affecting the adolescent girls extend to up to 24 years. Therefore, it was seen by the PI that extending the age and group band would generate more credible insights. Secondly, there is limited research focusing solely on the (10-19) age band which only makes it more rational to broaden the group. Furthermore, some of the studies include (10-19) as part of broader studies. While adolescence is defined largely as the life period between 10-19 years, this is not well-disaggregated within most of the literature. Therefore, it is somewhat difficult to segregate, yet they remain a largely vulnerable group.

### 3.4 Objective of the scoping review

The objective of this scoping review was to assess and map any existing evidence relating to the barriers faced by HIV-positive adolescent girls in accessing and using contraception in

Malawi. This was specifically intended to provide more background evidence on the existence of barriers that AGLHIV in SSA are faced with in relation to uptake of contraception and family planning services. It was also important to help cover up any background data gaps, collating extent of evidence and research previously focused on AGLHIV in Sub-Saharan Africa at large.

Specifically, this scoping review contributes to the background and rationale sections of this thesis, by highlighting the barriers that AGYW living with HIV face in accessing SRH services, as well as the first research question; What are the structural and socio-cultural issues faced by adolescent girls living with HIV/AIDS in the use of contraception.

### 3.5 Methodology for scoping review

This scoping review was guided by the Arksey and O'Malley framework. Thus, the following steps were followed;

- i. Identifying the research question
- ii. Identifying the research studies
- iii. Study selection
- iv. Charting the data, and
- v. Collating, summarizing, and reporting the results

#### 3.5.1 Identifying the research question

What are the barriers faced by adolescent girls and young women (AGYW) living with HIV/AIDS in the uptake of contraception, in Sub-Saharan Africa? The term AGYW was used to refer to those aged (10-24) years.

#### 3.5.2 Identifying relevant studies and search strategy

This review focused on evidence published by primary studies and articles which showed results using clear methodological criteria in qualitative, quantitative or mixed methods. The studies were obtained from published peer-reviewed journals. In addition, notable organizational websites such as UNFPA, WORLD health Organization (WHO), and several government websites for reports on contraceptive behaviour and challenges among adolescent girls which could have been recorded over time across SSA. A targeted web-based search was undertaken to identify subject specific articles, starting with the titles. These were identified through Google scholar, Open Access, ResearchGate, and different reputable journals such as

PubMed, BMC, Science Direct/Elsevier, and published in English. The source was left open to allow for inclusion of all available evidence from credible sources. However, consideration was made for full text peer-reviewed articles and credible organizational reports such as those from WHO, UNFPA, UNAIDS, and other agencies. The types included general articles, surveys, program reports, scoping reviews, systematic reviews and meta-analysis papers all together.

For this study, searches were made for studies which focused on challenges, barriers and determinants of family planning use, factors determining access and utilization of SRH services, unmet need for contraception, as aforementioned. These were all electronically sought through the internet.

### 3.5.3 Study Screening and selection

Screening was conducted through reading of abstracts, with a focus on objectives, methodology and summary findings. Where clarification was required, the full text was rapidly reviewed before determining suitability of the article.

#### 3.5.3.1 *Inclusion criteria*

The search and selection of studies to review was guided by the PCC method, which basically focuses on three key issues; the Population, Concept, and Context (Institute, 2015). Thus, the population of focus was HIV-positive adolescent girls, the concept was barriers experienced or factors affecting use of contraception by the group, and context was limited to sub-Saharan Africa. While the period was not defined prior to the search, it can be reported that articles searched for ranged from the period 2005 to 2022. However, there was a deliberate emphasis on more recent publications to provide more updated information. The studies included as suitable for the final review were from 2012 to 2021. Furthermore, in order to facilitate easy identification of articles, key words such as adolescent girls, adolescent mothers, adolescent mothers living with HIV, teenage pregnancy, family planning for adolescents and young women, HIV-positive AGYW, HIV-positive women, contraception for teens/adolescents, teen mothers, contraception for AGYW living with HIV, PMTCT for adolescents, were used.

However, given the paucity of age and subject-specific articles, articles which focused on young people, young women, and women living with HIV/AIDS, factors affecting access to health services for youth, some studies covering both SSA and other countries outside of SSA, were additionally used to supplement the search.

For this scoping review, the word “barriers” was in some instances substituted with statements such as “unmet need for contraception and its determinants”, “factors associated with contraceptive use among adolescent girls and young women, to facilitate the identification of articles which were suitable for inclusion in the review.

### *3.5.3.2 Exclusion criteria*

This was based on age, specifically studies which focused on women in the reproductive age group but whose results were mainly focused on population above 24years, and studies conducted out of sub-Saharan Africa. Generalized studies on contraception for adolescents were in some instances excluded due to difficulty to attach findings to the focus of this review. Furthermore, studies with no clear evidence on barriers were excluded. This was partly conducted through a comprehensive screening of study titles.

### *3.5.3.3 Deviations*

A few studies were included which focused broadly on the needs, barriers and access of contraception by adolescent girls in low and middle-income countries. These were included on the basis of their importance for comparison in relation to the situation of HIV-positive adolescent girls and adolescent girls’ situation in general.

### *3.5.3.4 Types of studies included*

Several types of studies were sourced and screened. The types of studies that were included in the final results are as shown in the table below.

*Table 1 Types of studies included*

<i><b>Category</b></i>	<i><b>No. Included</b></i>
<i>Primary research studies</i>	7
<i>Intervention-based study</i>	2
<i>Systematic reviews</i>	6
<i>Meta-analyses</i>	1
<i><b>Total</b></i>	<b>16</b>

### 3.6 Charting of data

A data charting table was created to guide the extraction of all required information. This was updated continuously during the process of review of selected studies, capturing the relevant aspects as follows; Authorship, title of study, geographical setting, year of study, and the main findings which were specifically matched to the question as presented in Table 2 below. Nvivo was further used to identify emerging themes.

### 3.7 Collating, summarizing, and reporting of results

For analysis of the data from the selected articles, content analysis of extracted data was conducted. This was conducted through studying/reviewing the extent, nature, as well as focus and content of the results of the selected studies. In order to facilitating the understanding of the context, content and population of the selected studies, a table was designed to summarize the key characteristics of all selected studies in line with the focus of the review. Thus, the table included nature of study and methodology employed, population of focus, and geographical location, and the key barriers that were reported. This was helpful in guiding the PI to identify the key themes representing the barriers, and also the extent of research focus, on the use of contraception by adolescent girls, as well as the extent of evidence/knowledge available across SSA.

The Preferred Reporting Items for Systematic Reviews and Meta-Analysis (PRISMA) chart was followed in reporting the screening process for the obtaining of results, as indicated below.

The results of this scoping review are presented in the following flow diagram. According to the Joanna Briggs methodology for reporting on scoping reviews, a flow chart can be used to clearly detail the review decision process, and present the results.

Figure 3.1 Flow chart showing decision process

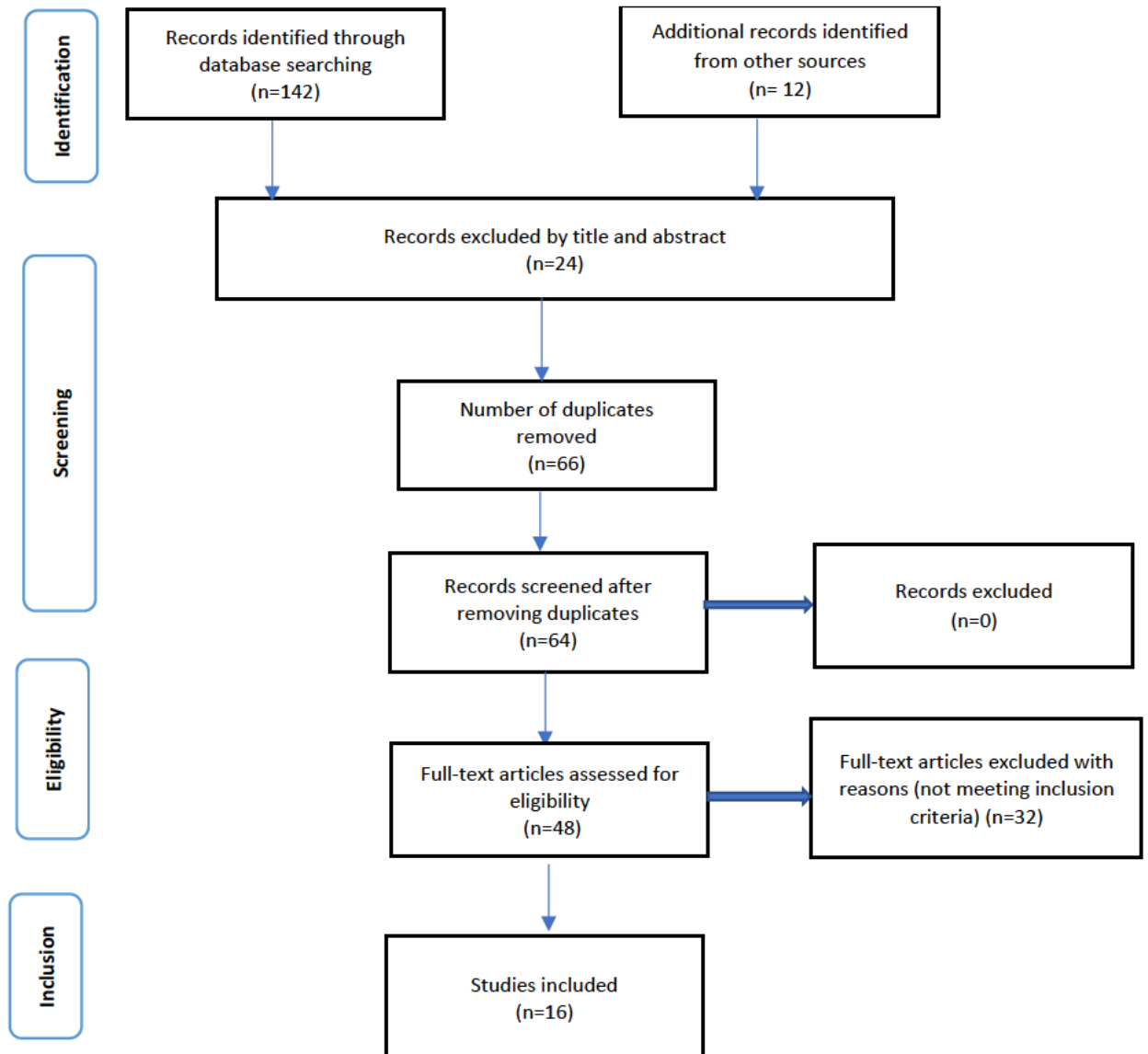


Table 2 Data charting table

Article Title	Author(s) and Date	Study Design/Methodology details	Study population and setting	Key Findings (Nature of associated barriers and emerging themes)
Barriers and facilitators adolescent females living with HIV face in accessing contraceptive services: a qualitative assessment of providers' perceptions in Western Kenya	(Hagey et al., 2015)	Qualitative study, with structured in-depth interviews	Service providers, Kenya	<ul style="list-style-type: none"> <li>The study found that interpersonal factors dominated the barriers adolescent females living with HIV face in accessing contraception. Providers felt that adolescent females fear disclosing their sexual activity to parents, peers and providers, mainly due to repercussions of perceived promiscuity.</li> <li>Also, adolescents find it challenging to seek contraceptive services without a male partner because some service providers view such adolescents as unserious, or have multiple concurrent relationships. Other barriers included stigma, concerns of negative parental attitude towards sexual activity, negative peer attitudes, and provider interaction bias.</li> </ul>
A scoping review of determinants of unmet need for family planning among women of reproductive age in low and middle-income countries	(Wulifan et al., 2016)	Mixed methods study	Low and middle-income countries (Sub-Saharan Africa, Latin America, Caribbean, Middle East and Asia)	<ul style="list-style-type: none"> <li>The study found that the determinants of unmet need in low and middle-income countries are at different levels notably; facility, household and community, couple, partner and individual levels. They include;</li> <li>Unavailability of long-acting methods</li> <li>Lack of access to FP information, and awareness</li> <li>Low socio-economic status</li> <li>Preference for male children, and more children by partner</li> <li>Poor communication/no discussion between couple</li> <li>Low levels of education</li> <li>Lack of decision-making authority</li> <li>Religious beliefs and prohibitions</li> <li>Lack of income</li> </ul>
Unmet need for contraception among HIV-positive women attending HIV care and treatment service at Saint Paul's hospital Millennium Medical College, Addis Ababa, Ethiopia	(Abubeker et al., 2019)	Facility-based cross sectional study, Quantitative	HIV-positive women of reproductive age (15-49) years, who are married or in a union and attending ART clinic. Ethiopia	<ul style="list-style-type: none"> <li>The overall unmet need for contraception was 25.1%. The most common reasons for non-use were related to perceived low risk of pregnancy, opposition to use of method due to religious and partners prohibition, and method related reasons such as side effects, and absence of preferred method.</li> <li>The unmet need was more common among unmarried women and those who did not have a discussion about contraception with HIV care provider.</li> </ul>



Article Title	Author(s) and Date	Study Design/Methodology details	Study population and setting	Key Findings (Nature of associated barriers and emerging themes)
Disrespectful care in family planning care among youth and adult simulated clients in public sector facilities in Malawi	(Hazel et al., 2021)	Mixed methods	Simulated clients (SCs) – adult and adolescent women. Malawi	<ul style="list-style-type: none"> <li>Some of the participants were denied care because they did not have an HIV test or vaccination for Tetanus, or because the clinic was closed during hours of operation.</li> <li>The study also found that over half (59%) of the visits did not have privacy, the SCs were not asked about their contraceptive method preference in 57% of the visits, and 28% reported that they were not greeted respectfully. 20 % of the SCs reported interruptions during the service provision, and 18% reported humiliation, including verbal abuse. Adult SCs received poorer counseling compared to the adolescent SCs.</li> </ul>
Demand for modern family planning among married women living with HIV in Western Ethiopia	(Feyissa and Melka, 2014)	Facility-based cross-sectional survey, Quantitative	Married/in a union women (15-49 years) living with HIV in Western Ethiopia	<ul style="list-style-type: none"> <li>The study found that the unmet need for family planning among women living with HIV was 15.4%. Lack of knowledge about mother to child transmission, and lack of discussion with partner were strongly associated with increased odds of unmet need for modern family planning.</li> </ul>
Pregnant adolescents living with HIV: what we know, what we need to know, where we need to go	(Callahan et al., 2017)	Secondary review	Adolescent girls living with HIV/AIDS, Sub-Saharan Africa	<ul style="list-style-type: none"> <li>The study found that uptake of PMTCT among expectant and postpartum adolescents was low, lessening the chance for family planning counseling and uptake among the group.</li> </ul>
Expanding contraceptive options for PMTCT clients: a mixed methods implementation study in Cape Town, South Africa	(Hoke; et al., 2014)	Mixed methods study based on an intervention	HIV-positive women, South Africa	<ul style="list-style-type: none"> <li>The study found that the intervention was poorly designed to yield expected results, service providers were unable to leave their work stations for training on administration of intrusive hormonal methods such as IUD which require specialized skill to insert and remove.</li> <li>The study also found that provider capacity in basic family planning service delivery was weak, with specific regard to HIV-positive women, high client loads for available staff on duty, lack of motivation among service providers to take on additional responsibilities such as delivering/dispensing contraceptives.</li> </ul>
Providing comprehensive health services for young key populations: needs, barriers, and gaps	(Delany-Moretlwe et al., 2015)	Document review	Young key populations (adolescents, youth, injecting drug use, MSM, sex workers), Sub-Saharan Africa	<p>The study found that Young and key populations (YKPs) including adolescents living with HIV, experience significant barriers to accessing care.</p> <ul style="list-style-type: none"> <li>Main findings included low coverage of services, stigma and discrimination experienced at both health system and policy levels, poor SRH services.</li> </ul>



Article Title	Author(s) and Date	Study Design/Methodology details	Study population and setting	Key Findings (Nature of associated barriers and emerging themes)
				<ul style="list-style-type: none"> <li>The reasons for poor access and barriers to care are also further categorized as individual level such as low levels of education and HIV knowledge, low risk perception, less sex education; health system level such as stigma, discrimination and victimization, and low levels of social support, with concerns about privacy and confidentiality, poor attitude of service providers, costs, and waiting time; or structural level barriers which are common to all YKPs</li> </ul>
Perceptions of contraception services among recipients of a combination HIV-prevention interventions for adolescent girls and young women in South Africa: a qualitative study	(Jonas et al., 2020)	Qualitative study	Adolescent girls and young women (AGYW), South Africa	<ul style="list-style-type: none"> <li>The study found that many AGYW especially those in the 15-19 age group experience difficulties in accessing contraception services, especially at the interpersonal and health service levels, lack of support for the use of contraceptives from parents and care-givers, as well as from sexual partners were the main barriers at the interpersonal level, while at the health service level, providers' attitude was identified as a key barrier.</li> <li>The majority of school-going AGYW felt that taking the contraceptive services and other SRHR services to the school premises would legitimize their use in the eyes of parents and help to overcome the barriers associated to parental support and acceptance, as well as overcome some of the health service and structural level barriers. However, views among school-going AGYW were mixed about the provision of contraception services at school, with concerns related to confidentiality</li> </ul>
Fertility intentions and interest in integrated family planning services among women living with HIV in Nyanza province, Kenya: A qualitative study	(Harrington et al., 2012)	Qualitative method	Women (18-45) living with HIV, Kenya	<ul style="list-style-type: none"> <li>The study found that participants expressed unmet need for contraception. Access-related obstacles included unreliable stock of contraceptive methods, privacy concerns, provider availability, inability of some providers to speak local language, and distance to the clinic.</li> <li>Partner resistance to family planning was reported as another barrier, with several using it secretly and some risking separation and abandonment by their partners as a result.</li> </ul>
Improving adolescents' access to contraception in Sub-	(Smith, 2020)	Documents' Review, mixed methods.	Sub-Saharan Africa	<ul style="list-style-type: none"> <li>The study found that persistent myths regarding side effects, and effectiveness of the contraceptives limit access to and demand for contraception among adolescents.</li> </ul>

Article Title	Author(s) and Date	Study Design/Methodology details	Study population and setting	Key Findings (Nature of associated barriers and emerging themes)
Saharan Africa: a review of the evidence				<ul style="list-style-type: none"> <li>Also, cultural and gender norms impede access and demand</li> </ul>
Associations of Reproductive coercion and intimate partner violence with overt and covert family planning use among married adolescent girls in Niger	(Silverman et al., 2020)	Quantitative study	Married adolescent girls, Niger	<ul style="list-style-type: none"> <li>The study found that one in four married adolescent girls using family planning reported doing so without husband's knowledge.</li> <li>The study models also indicated that physical intimate partner violence (IPV) and reproductive coercion (RC) were associated with covert family planning use. Thus, married adolescents experiencing physical IPV or RC were more likely than others to use without their husband's knowledge</li> </ul>
Barriers to accessing sexual and reproductive health services among adolescent girls and young women living with HIV in Nzega district, Tabora (Tanzania)	(Shimbi, 2019)	Qualitative study	AGYW (15-24 years), Tanzania	<ul style="list-style-type: none"> <li>The study indicates that HIV positive AGYW in Nzega, Tanzania have limited access to and utilization of SRH services including contraceptives. Key factors found individual level factors like fear, lack of confidence, and limited awareness on SRH services among AGYW negatively influenced their access to and utilization. Inter-personal level barriers included unfriendly language by the service providers and denial of permission to seek care by the male partner and parent(s). Additionally, organizational barriers included: unstable availability of SRH medications and contraceptive supplies, lack of comfort space at the clinic set up, and long waiting hours</li> </ul>
Contraception for adolescents in low and middle-income countries: needs, barriers, and access	(Chandra-Mouli; et al., 2014b)	Secondary data review/systematic review specifically for barriers adolescents face in accessing and using contraception	Adolescents, Low and middle-income countries	<ul style="list-style-type: none"> <li>The study found that all adolescents in LMIC especially the unmarried ones face a number of barriers in obtaining contraception and using them correctly and consistently; social pressure to conceive and bear children, stigma surrounding contraception use, and misconceptions about immediate and long-term side effects, low understanding of how contraception works.</li> <li>The study also found that laws and policies prevent the provision of contraception to unmarried adolescents and to those under a certain age.</li> </ul>
"It is challenging...oh, nobody likes it!": a qualitative study exploring Mozambican adolescents and young	(Capurchande et al., 2016)	Qualitative study	Adolescents and young adults, Mozambique	<ul style="list-style-type: none"> <li>The study found that adolescents experienced social and medical barriers such as restricted dialogue on sexuality among adolescents and their peers and parents. In addition, misconceptions about femininity and masculinity, and fear of side effects of</li> </ul>

Article Title	Author(s) and Date	Study Design/Methodology details	Study population and setting	Key Findings (Nature of associated barriers and emerging themes)
adults' experiences with contraception				<p>contraceptives create wary about modern birth control.</p> <ul style="list-style-type: none"> <li>Other barriers found include imposed contraceptive choice, overly technical medical language used at clinics, and absence of healthcare workers attuned to the needs of adolescents and young adults.</li> </ul>
Individual and community-level factors associated with modern contraceptive use among adolescent girls and young women in Mali: a mixed effects multilevel analysis of the 2018 Mali demographic and health survey	(Ahinkorah et al., 2020)	Secondary data Review	Adolescent girls and young women (15-24), Mali	<ul style="list-style-type: none"> <li>The individual-level factors included age, marital status, religion, educational level and employment status. Other individual level factors were wealth quintile, age at first sex (less than 20, 20–24 years), parity (zero birth, one birth, two births, three or more births), and ethnicity. In addition, exposure to mass media (newspaper/magazine, radio and television), desire for more children (have another, no more, undecided) and ideal number of children (0–3, 4–5 and 6+) were also chosen as individual-level factors.</li> <li>The community-level factors were residence (rural and urban), community literacy level (proportion of women who can read and write), and community socioeconomic status (proportion of women in the richest household quintile). Moreover, community knowledge level of modern contraceptives (proportion of women with knowledge on modern contraceptives) was also considered as a community level factor.</li> </ul>

### 3.8 Summary of Results

The key themes emerging from the review in terms of determinants and barriers identified are at different levels notably; facility level, household and community level, couple level, partner level, and the individual level of every AGYW.

### 3.9 Data synthesis

In almost all societies across SSA, deep social significance and cultural intimations have saturated the aspect of reproduction (UNFPA, 2019). Consequently, most of the activities and

stages of reproduction are regulated through cultural norms, thus reinforcing structural, social and economic systems. As they age into adulthood, HIV-positive adolescent girls and young women undergo critical biological and social transitions that influence their reproductive desires and choice of sexual partners. These typical transitions to adulthood are complicated (Yam et al., 2017), and therefore require a level of attention through routine access to quality care. However, factors such as relationship between clients and service providers continue to pose significant obstacles for such vulnerable service seekers.

The issue of disclosure of HIV sero-status to partners among AGYW living with HIV is of key concern too. Whether perinatally infected or horizontally, the internalized stigma and disclosure to partners is compounded with several other issues (Pantelic et al., 2017). A 2019 study conducted among women living with HIV similarly found that discussing contraceptive issues with sexual partners was positively associated with the use of modern contraception among the group (Kebede et al., 2019).

The fear of side-effects equally continues to feature among several groups of women as one of the key reasons for not using contraception. For instance, a study conducted in Uganda shows that of the 61% who did not use contraceptives, 24% cited the fear of side-effects as the main reason (Mbabazi et al., 2022).

While women continue to face these challenges, there is a consistent indication that AGYW living with HIV prefer to use short-term methods as opposed to long-term methods, known as the long-acting reversible contraception (LARC). The reason behind this is for the convenience of reversibility whenever they are ready to have children. However, given the challenges, it is important to encourage the use of LARC to prevent gaps in prevention of unwanted and unplanned pregnancy.

Furthermore, the lack of clear dis-aggregation of data of adolescent girls and young women living with HIV leaves a grey area in terms of identification, and recognizing, and planning for their unique SRH needs and challenges they are faced with from time to time, which also span their entire lifetime (Toska et al., 2020b).

AGYW living with HIV therefore continue to be at risk of repeat and poorly-spaced pregnancies which increase their danger (Toska et al., 2020b). This general low uptake of modern contraceptives contributes significantly to the high rates of adolescent pregnancies, unsafe abortion, maternal mortality and morbidity, as well as other life-long educational, social and economic impairments. Similarly, it highlights the gravity of limited access to quality and

youth-friendly SRH services and information relating to modern contraception (Ahinkorah et al., 2020). Furthermore, the regressive cultural environment in relation to implementation of modern life-saving health approaches only implies that SSA shall continue to register alarming incident rate of unplanned and unwanted pregnancies among teenagers and young mothers living with HIV, with all the related consequences and poor reproductive health outcomes.

It is also important to recognize how scant AGYW-specific data is, with majority of studies focusing on general population of AGYW, without specificity to health condition. However, it is equally important to acknowledge that HIV prevalence remains high among this age group in SSA, and some of the bottlenecks recorded in some of the studies apply to those living with HIV as well. This is mainly because in such studies, the population of focus does not exclude those who are living with HIV. Yet, across studies, they are described as sexually active females, in relationships, and/or young mothers (Ahinkorah, 2020). Thus, it can be over-ruled that those living with HIV are by default and saliently among the participants.

Throughout the review, it was additionally realized that AGYW with at least two or more children are more likely to use contraception than those with one child or none. This signifies the strong sentiments attached to child-bearing, which was also evidenced in the barriers around partner refusal and preference for children. While this may be an understandable scenario, AGYW in general and their partners ought to be taught about how modern contraception works, so that fears being held by partners are addressed. Ideal health promotional and educational activities should be prioritized, as well as the coverage of modern contraception services. This should be done with consideration of the unique needs, experiences of AGYW living with HIV and their pathways to accessing and using the services.

### 3.10 Conclusion

Regardless of the desire to use contraceptives by AGYW living with HIV, the majority still face challenges accessing and utilizing the services. This review revealed that AGYW living with HIV are exposed to a range of barriers to accessing and using contraception services as shown across the four levels; individual, interpersonal, community and organizational. The limited availability of preferred methods, experiences of denial of services, and poor attitude of health service providers, fear, and lack of confidence, as well as lack of privacy area were noted as key barriers. While services may be close to the AGYW, the same services could be denied to AGYW service seekers on several grounds which include legal issues and culturally biased attitudes.

## CHAPTER 4: METHODOLOGY

### 4.1 Introduction

This methodology for this study was guided by the Health Policy Triangle (HPT) framework. Thus, the context, content, process and actors involved in the health policy of Malawi were given attention to during review of current policies and strategic documents, in regards to their linkage, contribution or influence on vulnerability as experienced in relation to the focus of this study, as well as in the interview questions.

The study was qualitative in nature, and relied exclusively on qualitative approaches of data collection, and analysis. It was both descriptive and analytic, allowing for literature review and document review, also referred to as secondary data collection, as well as stakeholder mapping for interviews. All the data that was collected was pooled together to form the final analysis for the study findings which are presented in chapter four of this thesis. This approach allowed the investigator to freely explore the phenomenon under study by providing flexibility in review of the documents selected to the required depth to extort subject related information, and flexibility in posing questions from the in-depth interview guide which was used.

The choice and justification for qualitative research is that it allows for the in-depth exploration of topics, while providing valuable and rich insights generated through probing. It seeks to understand and explore, as well as providing opportunity to contextualize the phenomenon under study and permits interpretation of generated data into patterns (Sullivan and Sargeant, 2011), (Tiley, 2017). The qualitative techniques provide a unique depth of understanding due to the nature of open-ended questions, allowing respondents the ability to freely disclose their experiences, thoughts and feelings without constraint (Patton, 2002). Given the focus of this study which is on policies and SRHR, the main points of discussion for this study included contextual issues such as culture, gender norms, policy processes in the country, implementation arrangements, which all required an in-depth and iterative process of engaging with documents and participants. Qualitative methods offer a dynamic approach to research, where the researcher has an opportunity to follow up on answers given by respondents in real time, generating valuable conversation around a subject – something which isn't possible with a structured survey. Thus, the investigator can find answers for the 'why' that may arise during the guided discussion, because respondents have the opportunity to freely elaborate on their answers as was the case during this study. Qualitative method is equally concerned with the



point of view of individuals involved in the study, which is later collated and interpreted to form actual thematic points to explain a given scenario (Sullivan and Sargeant, 2011). Due to the interruptions of the Covid-19 pandemic, virtual/online qualitative methods of data collection were considered as appropriate in order to allow the study to go on during the period, without putting both the investigator and the participants at risk of possible infection.

## 4.2 Study/Research design

The study employed a descriptive research design, and cross-sectional in nature. Descriptive research design was adopted due to its ability to allow the investigator to study the phenomenon in its natural environment, without alteration or manipulation of the setting or context (Nassaji, 2015). The design equally allows the use of data collection methods which generate in-depth explanations which facilitate a deeper understanding of the phenomenon under study. The study used both secondary and primary data collection techniques.

## 4.3 Study population

A study population or sample is a subset of the entire population which is of interest to the researcher (Acharya et al., 2013), for purposes of achieving the study objectives. The general population of focus for this study was adolescent girls living with HIV, both married and unmarried, including those who were either mothers or pregnant. The age consideration ranged from 10-19years. Given the early sex debut, high prevalence of teenage pregnancies, and child and forced marriage in Malawi as earlier referenced, the age of focus ranged from 10-19years. The entire review of the documents was conducted in light of policies, strategies, guidelines and programs targeting this population or with components which relate to adolescent girls living with HIV, and family planning. However, it is important to state that for interviews, the investigator selected four main categories. The sample included four main categories as follows; policy makers, development partners, implementing partners and local service providers, and representatives from PLHIV organizations to complement the documents' review process. Thus, it is equally important to note that no AGLHIV were directly involved as study respondents or participants in any form. The different categories are here-by explained in detail;

- i. **Category 1 – PLHIV Organizations:** The representatives from PLHIV organizations were involved to seek their useful inputs on behalf of AGLHIV, since they were not involved directly as respondents. The participating organizations are included in Table 4.

- ii. **Category 2 – Local Service Providers and Implementing Partners:** Local service providers were included because of their frequent interaction with the target group since they are providers of sexual and reproductive health services, including contraception services and methods. Their experience was deemed relevant given that they interface directly with service seekers and the national policy and guidelines. As service providers, they also offer an important perspective, as they provide the contraceptive services adolescents need, and frequently influence community norms that dictate the acceptability of using contraception. Furthermore, service providers may be more aware of interpersonal, institutional and some societal factors influencing contraception uptake than adolescents themselves since they are linked to the government as duty bearers (Hagey et al., 2015). Similarly, implementing partners were included because of their level of knowledge in implementing programs that should largely be reflective of national policies and guidelines, requirements and demands based on the context. Furthermore, implementing partners are usually a representation of civil society which plays a critical role in policy advocacy and possibly implementation as aforementioned. Thus, this category was deemed relevant, necessary and very informative to highlight issues about the actual situation in the country in relation teenage pregnancies, HIV/AIDS, and Contraception service utilization in Malawi, and policies and guidelines in place. The Local service providers and Implementing partners who participated in this study include those indicated in Table 3.
- iii. **Category 3 – Development Partners:** The category of Development Partners (DPs) was considered for inclusion due to the unique role that development partners play in the health sector of most sub-Saharan African countries. In most countries, they are donors, providing funding to the health programs of the country and supplementing the national budgets for the health sector. Many Development Partner organizations also fund civil society activities, and provide technical support to both civil societies and government line ministries, and many are involved in health systems strengthening through various activities including capacity building. Thus, they play a visible and undeniable role in directing and influencing the health policy of a given country. For this study, the Development Partners who were involved included United Nations (UN) agencies, notably; UNICEF, UNFPA, UNWOMEN, bi-lateral and donor organizations notably USAID and PEPFAR.
- iv. **Category 4 – Policy Makers:** This category was deemed vital too due to their key role as custodians of the health policy and guidelines. Policy makers are duty bearers, with



the responsibility of enacting and executing national policies in response to the context. This process also includes interacting with the different interest people and institutions. The policy makers who participated in this study include; Ministry of Health Officials, Ministry of Gender officials, the National AIDS Commission, and Ministry of Youth and Sports, and the Ministry of Gender, children, disability and social welfare.

Table 2 below shows a summary of the study population and sample which was involved in this study.

*Table 3 Study population details*

Study Population	Actual Categories	Sample Description Details
General Population of focus	Adolescent girls (10-19) years	Living with HIV/AIDS Married and un-married Mother or expectant mothers
Interviewed Population	PLHIV organizations	Representatives of PLHIV organization
	Local service providers and Implementing partners	Contraception service providers and program implementing agencies/organizations
	Development partners	UN and donor agencies supporting programs related to AGLHIV and Family planning use
	Policy makers	Line ministries and government agencies responsible for AGLHIV, family planning and HIV/AIDS programming

#### 4.4 Sampling procedure

Sampling is the selection of specific data sources from which data are collected to address the research objectives (Gentles et al., 2015).

According to Merriam-Webster, it is the “act, process, or technique of selecting a representative part of the population for the purposes of determining parameters or characteristics of the whole population”, in relation to a specific phenomenon of study. Sampling procedure therefore is the method followed to select the required sub-set of the population. For this study, all categories of respondents were selected through purposive sampling.

Purposive sampling is one of the most commonly employed method (Acharya et al., 2013). In this case it was preferred as the most suitable because of the nature of the study which by default indicates the most suitable kind of respondents to include. In this study, the investigator identified and selected the required respondents determined by their connection to the topic under study either by the roles they play in relation to the study or how affected they can be. As stated by Patton 2016 (Patton et al., 2016), the logic and power of purposive sampling is in

enabling the investigator to identify and select information-rich sources, from which in-depth learning and generation of insights about the issue under investigation can easily be achieved. Therefore, through purposive sampling the afore-mentioned study sample of respondents was selected as most suitable and relevant to provide useful insights to the study.

Purposive sampling was equally employed in determining the most-suitable documents to review by selecting only those that have relevance to the study.

The following documents and participating organizations and departments were purposively selected for the document review/secondary data collection phase and the interviewing phase, respectively.

*Table 4 Summarized sampling procedure for the study*

<b>Research Aim:</b>	<b>Research question</b>	<b>Data collection approach</b>	<b>Description of Sample population and data sources</b>	<b>Inclusion criteria/Recruitment strategies</b>
To assess the SRH policies in Malawi in relation to addressing the risks faced by AGLHIV in process of reaching and using contraception, and identify implementation challenges affecting the effectiveness of the policies	<b>Question 1:</b> What are the structural and socio-cultural issues affecting the use of contraception among AGLHIV in Malawi?	Documents' review	Program documents/reports, publications, and other grey-literature	SRH Program documents/reports and other publications
		Interviews/Telephone/Virtual Survey	Policy makers, mainly representatives of line ministries	Ministry of health and population- Directorate of reproductive health <ul style="list-style-type: none"> <li>- Family planning programme</li> <li>- Adolescent/young sexual and reproductive health unit</li> </ul> Directorate of planning and policy development <ul style="list-style-type: none"> <li>- Policy and development unit/Zonal coordination unit</li> </ul>

			Ministry of gender, children, disability and social welfare -Gender unit -Planning and research unit
		Development partners; Selected donor agencies and international organizations supporting and implementing related programs	-UNICEF -UNFPA -USAID -PEPFAR -UN-WOMEN
		Local service providers and implementing partners, providing SRH/HIV/Family planning services or implementing related programs	-JPHIEGO -FHI360 -Banja La Mstogolo (Marie Stopes affiliate) -Family Planning Association of Malawi -Girls Empowerment Network (GENET)/Girls
		PLHIV organizations - organized networks or groups of people representing interests of PLHIV	-National Association of Young People Living with HIV (NAYPLHIV) -Malawi Network of People Living with HIV and In Malawi (MANET+) -Coalition of Women Living with HIV and AIDS in Malawi (COWLHA) -National Association for People Living with HIV and AIDS in Malawi (NAPHAM)
	<b>Question 2:</b> What policy provisions are in place in Malawi to address the issues/risks faced by AGLHIV during use of contraception?	Documents' review – following Health Policy Triangle/framework	Country SRH related policies, strategic plans, implementation frameworks Country Tangent policies International guidelines Other related/relevant publications  Focus was on the following categories; -Sexual and reproductive health and rights policy -Family planning/contraception policy Strategic plans -Implementation frameworks

				<ul style="list-style-type: none"> <li>-Adolescent related policies</li> <li>-Policies for PLHIV children/adolescents</li> <li>-National child marriage policies and related documents</li> <li>-Human rights policies</li> <li>-SRH services guidelines</li> <li>-WHO service delivery guidelines</li> </ul>
		Interviews/Telephone/Virtual survey	Policy makers, mainly representatives of line ministries	<ul style="list-style-type: none"> <li>Ministry of health and population- Directorate of reproductive health</li> <li>-Family planning programme</li> <li>-Adolescent/young sexual and reproductive health unit</li> <li>Directorate of planning and policy development</li> <li>-Policy and development unit/Zonal coordination unit</li> <li>Ministry of gender, children, disability and social welfare</li> <li>-Gender unit</li> <li>-Planning and research unit</li> </ul>
			Development partners; Selected donor agencies and international organizations supporting and implementing related programs	<ul style="list-style-type: none"> <li>-UNICEF</li> <li>-UNFPA</li> <li>-USAID</li> <li>-PEPFAR</li> <li>-UN-WOMEN</li> </ul>
			Local service providers and implementing partners, providing SRH/HIV/Family planning services or implementing related programs	<ul style="list-style-type: none"> <li>-JPHIEGO</li> <li>-FHI360</li> <li>-Banja La Mstogolo (Marie Stopes affiliate)</li> <li>-Family Planning Association of Malawi</li> <li>-Girls Empowerment Network (GENET)</li> </ul>

			PLHIV organizations - organized networks or groups of people representing interests of PLHIV	-National Association of Young People Living with HIV (NAYPLHIV) -Malawi Network of People Living with HIV and In Malawi (MANET+) -Coalition of Women Living with HIV and AIDS in Malawi (COWLHA) -National Association for People Living with HIV and AIDS in Malawi (NAPHAM)
	<b>Question 3:</b> What implementation challenges affect the effectiveness of the available policy provisions?	Documents' review – following Health Policy Triangle/framework	Program documents/reports, publications, and other grey-literature	SRH Program documents/reports and other publications
		Interviews/Telephone/Virtual survey	Policy makers, mainly representatives of line ministries	Ministry of health and population- Directorate of reproductive health -Family planning programme -Adolescent/young sexual and reproductive health unit Directorate of planning and policy development -Policy and development unit/Zonal coordination unit Ministry of gender, children, disability and social welfare -Gender unit -Planning and research unit
			Development partners; Selected donor agencies and international organizations supporting and implementing related programs	-UNICEF -UNFPA -USAID -PEPFAR -UN-WOMEN

			Local service providers and implementing partners, providing SRH/HIV/Family planning services or implementing related programs	-JPHIEGO -FHI360 -Banja La Mstogolo (Marie Stopes affiliate) -Family Planning Association of Malawi -Girls Empowerment Network (GENET)
			PLHIV organizations - organized networks or groups of people representing interests of PLHIV	-National Association of Young People Living with HIV (NAYPLHIV) -Malawi Network of People Living with HIV and In Malawi (MANET+) -Coalition of Women Living with HIV and AIDS in Malawi (COWLHA) -National Association for People Living with HIV and AIDS in Malawi (NAPHAM)

*Table 5 Actual details of participating organizations, agencies and institutions*

Study Population	Actual Categories/	Sample Description Details	Participating Organizations	Sample size Planned	Actual No. of Interviews	No. of Respondents
General Population of focus	Adolescent girls (10-19) years	Living with HIV/AIDS Married and un-married Mother or expectant mothers				
Interviewed Population	PLHIV organizations	Representatives of PLHIV organization	-National Association of Young People Living with HIV (NAYPLHIV) -Malawi Network of People Living with HIV and In Malawi (MANET+) -Coalition of Women Living with HIV and AIDS in Malawi (COWLHA) -National Association for People Living with HIV and AIDS in Malawi (NAPHAM)	5	4	4

	Local service providers and Implementing partners	Contraception service providers and program implementing agencies/organizations	-JPHIEGO -FHI360 -Banja La Mstogolo (Marie Stopes affiliate) -Family Planning Association of Malawi -Girls Empowerment Network (GENET)	5	5	7
	Development partners	UN and donor agencies supporting programs related to AGLHIV and Family planning use	- UNICEF - UNFPA - USAID - PEPFAR - UN-WOMEN	5	5	5
	Policy makers	Line ministries and government agencies responsible for AGLHIV, family planning and HIV/AIDS programming	Ministry of health and population- Directorate of reproductive health - Family planning programme - Adolescent/young sexual and reproductive health unit Directorate of planning and policy development - Policy and development unit/Zonal coordination unit Ministry of gender, children, disability and social welfare - Gender unit Planning and research unit	5	6	7
<b>Totals</b>				<b>20</b>	<b>20</b>	<b>23</b>

## 4.5 Sample size

Sample size is a numerical estimate of cases that are required to obtain information that is useful for understanding the complexity, depth, variation or context surrounding a phenomenon under study (Gentles et al., 2015).

This may form and represent the population of study (Acharya et al., 2013) or provide information for its analysis.

This study comprised of both secondary and primary data collection. Therefore, the sample population as described in afore-section included documents and human subjects. With the exclusion of the documents reviewed, the sample size for this study, in-terms of interview

respondents was twenty-three (23). Whereas the total number of interviews conducted was twenty (20), in three of the interviews, the organizations/institutions requested to be represented by two respondents who cross-checked facts between themselves, and others felt that it was better to have one joint interview in the place of two different interviews for the same institution. Such was the case with one of the ministries.

For the documents, a total of 12 policy, strategy and guiding documents were reviewed all together. This excludes the scientific publications and other literature reviewed to support the study.

This sample size was deemed as sufficient because interviews were a second source of data required for the study, and it was deemed adequate for cross-checking several issues that had been identified in the documents' review. Table 5 above further provides the details of the sample size for this study.

#### 4.6 Data collection approaches and process

This study employed both secondary and primary data collection methods, namely; document review and interviews. Therefore, it was two-phased as described below;

##### 4.6.1 Phase one: Documents Review:

This was conducted because policy documents are usually developed for a period of time and it would not be possible to extract all the required policy related information in an interview setting. Therefore, reviewing of documents was employed to allow the extraction of information from documents which cover periods before, during and after the period of the study, which is common for national policies and guiding documents. The review of documents provides an opportunity to retrieve comprehensive information from such national documents. In addition, review of documents was deemed most relevant and acceptable form of data collection to access the required information to answer the research questions during the COVID-19 pandemic, and to lessen the need for direct interaction between the investigating team and the targeted subjects.

During this phase, Secondary review of existing and relevant country policy documents, normative guidelines and global standards and programs reports, written SRH, contraception, and HIV related policy, and relevant program documents were gathered and reviewed. These included;

- Country SRH policy documents and normative guidelines



- Tangent policies which focus on human rights of girls, PLHIV and children
- International guiding documents/standards
- Published documents, program reports

During this phase an in-depth analysis was conducted to identify policy provisions and guidelines in relation to contraception access for AGLHIV, provisions stipulating protection of HIV vulnerability, and access to care and protection and measured the level of relevance and effectiveness in providing a required level of safety to AGLHIV to make use of the services.

This process was guided by the data collection framework in Annexure 1.1, which highlights the focus areas and information to extract while following the 4 principles of the theory supporting the study. Table 6 below provides the details of the documents accessed and reviewed.

*Table 6 Country policy and related documents reviewed*

Categorization of national policies, strategies and guidelines reviewed			Period of Coverage	Purpose
Adolescent health Specific policies, strategies and guidelines	National Strategy for Adolescent Girls and Young Women (AGYW)		2018-2020	“Ensure that Adolescent Girls and Young Women in Malawi are safe and protected and have equal opportunities to realize their rights and achieve their full potential through unlimited access to quality integrated education, health, employment and social protection services that are provided through a sustainable, coordinated governance framework and a comprehensive referral and linkage system.”
	National Youth-Friendly Health Services (YFHS) Strategy		2015-2020	“The goal of the Strategy is to increase knowledge and improve awareness, access and utilisation of YFHS for all young people aged 10 to 24 years.”
HIV and AIDS policies, strategies and guidelines reviewed	National HIV and AIDS Policy		July 2011-June 2016	Formulated to guide the implementation of the HIV and AIDS National Response  The purpose of the Policy is to facilitate: (i) Evidence-based programming and strengthening of the National HIV and AIDS Response while recognizing the emerging issues, gaps, challenges and lessons learnt during the implementation of the first Policy; (ii) Scaling up of evidence based innovative interventions; and

Categorization of national policies, strategies and guidelines reviewed		Period of Coverage	Purpose
			<p>(iii) Re-alignment of the National HIV and AIDS Response to the Government development agenda.</p> <p>The goal of the policy is to, prevent the further spread of HIV infection, promote access to treatment for PLHIV and mitigate the health, social-economic and psychosocial impact of HIV and AIDS on individuals, families, communities and the nation.</p>
	Malawi National Strategic Plan for HIV and AIDS	2020-2025	“To contribute towards ending AIDS as a public health threat in Malawi by 2030.”
	HIV and AIDS Prevention and Management Act	2018	To make provision for the prevention and management of HIV and AIDS; to provide for the rights and obligations of persons living with HIV or affected by HIV and AIDS; to provide for the establishment of the National AIDS Commission; to provide for matters incidental thereto or connected therewith
	National Clinical HIV Guidelines	2018 – (not indicated)	The guidelines standardise clinical management of HIV positive patients and HIV exposed children using an integrated approach, which incorporates protocols from other national guidelines such as those on family planning and reproductive health
	National Sexual and Reproductive Health and Rights and HIV and AIDS Integration Strategy for Malawi	2015-2020	“To increase the provision and uptake of integrated SRHR and HIV and AIDS services in Malawi.”
FP/SRH policies, strategies and guidelines reviewed	National Sexual and Reproductive Health and Rights (SRHR) Policy	2017-2022	“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 and enable them attain their reproductive rights and goals safely.”
General health related policies, strategies and guidelines	National gender policy	2015 – (not indicated)	“To strengthen gender mainstreaming and women empowerment at all levels in order to facilitate attainment of gender equality and equity in Malawi.”
	National Plan of Action to Combat Gender-based Violence in Malawi	2014-2020	“To create an enabling environment for the elimination of GBV in a holistic participatory and multi-sectoral manner.”

Categorization of national policies, strategies and guidelines reviewed		Period of Coverage	Purpose
	National Reproductive Health Service Delivery Guidelines	201-2019	“The purpose of RHSD guidelines is to assist service providers at all levels to deliver high-quality, comprehensive, and up-to-date RH services based on sound and acceptable principles of practice. ... intended to equip RH service providers with the tools required to maintain consistently high-quality care in a professional manner while keeping in mind clients’ needs and operating within the legal and RH policy framework of the country”

#### 4.6.2 Phase two: In-depth interview:

This phase comprised of a virtual survey conducted through different online and telephone platforms. The participants involved policy makers, selected development partners especially those with programs supporting contraceptive and HIV services for adolescents, local service providers and implementing partners, and a sample of PLHIV representatives/organizations. During this phase, participants were contacted with the aim of supplementing the document review and filling in any data gaps that had been identified in the process of document review and provide clarity where needed, to ensure a fair representation of the PLHIV in relation to specific policy issues, and for triangulation of data.

Participants were initially identified by contacting institutions directly through email, as well as through recommendations by the local research team which supported the survey processes in Malawi. The suggested names and officials were further verified by the Principal Investigator (PI) to confirm their eligibility before a request for appointment was sent out. They were all contacted through an initial email by the Principal investigator which included the sharing of necessary study approval documents, and requesting for an appointment. Identified participants were further followed up by a team of local research assistants, while others were followed-up directly by the Principal Investigator by telephone. Upon agreement, the Principal investigator would schedule the link through either Zoom or Microsoft Teams platform, while a few others preferred Whatsapp calls. The preference for Whatsapp call was due to internet connectivity issues, the easiness to use a telephone handset while out of office – especially because some of the participants were out of office due to the COVID-19 restrictions, or because they were not familiar with other methods.

Overall, participants were allowed the freedom to advise on the most suitable platform to use, following which the Principal Investigator would schedule the call. In an isolated incident, one of the key policy makers requested to be supplied with the questions so that they could be comfortably and satisfactorily responded to by all responsible officials within the institution. This was agreed to by the Principal Investigator because it was the only way possible to get the inputs of this key policy maker, and responses were satisfactorily provided in detail. As noted by (Tiley, 2017) the telephone/online qualitative research methods are a relatively new approach within the field but come with their own unique benefits. They are regarded to make qualitative research more accessible by taking away the constraints of traditional techniques as was the case in this study, which logistically made it slightly easier to manage certain key respondents.

The interviews were guided by the in-depth interview guides customized for each category as per Annexure 1.1 to 1.5. Each interview guide had between 10-15 questions which were asked to participating individuals, aimed at seeking their descriptions in words on a variety of issues surrounding the policy process, from policy agenda to formulation, implementation, as demanded by the research questions. Such direct engagements with policy makers and contributing actors as well as beneficiary representatives provide valuable information about the actual policy goals, processes and intended outcomes, which all provide useful background and understanding of the context to the investigator. This process lasted for 3 months between July 2021 and September 2021. It was concluded after interviews with all initial target participants and some additions had been achieved and information collected had reached the point of saturation.

The table below shows the details of the study participants who were interviewed.

*Table 7 Details of study participants interviewed*

Category	Description Details	Description of actual respondents
PLHIV organizations	Representatives of PLHIV organization	Executive Director District Coordinator
Local service providers and Implementing partners	Contraception service providers and program implementing agencies/organizations	Project Coordinator District coordinator Public Health Specialist/Chief of Party Monitoring and Evaluation Officer Community and outreach Officer
Development partners	UN and donor agencies supporting programs related to AGLHIV and Family planning use	Adolescent Health Focal Person, SRH SRHR Coordinator Adolescent Health and HIV Specialist

		Family Planning and Reproductive Health Specialist AGYW Technical Advisor GBV Specialists
Policy makers	Line ministries and government agencies responsible for AGLHIV, family planning and HIV/AIDS programming	Chief Executive Officer National Program Coordinator – Adolescent and Youth SRH Program (policy and strategic directions role) Director of Planning Coordinator AGYW & Networking Manager Chief Gender and Development Officer Chief Gender and Development Officer & GBV Coordinator Chief Reproductive Health Officer – National Family Planning Program, Directorate of Reproductive Health Services

### Description of participating agencies and organizations:

#### i. PLHIV organizations:

- Coalition of women living with HIV AIDS (COWLHA): Operates in all the districts of Malawi, where it has structures of women living with HIV/AIDS and also have committees at district level which goes down to the traditional authorities (TA)/committees. In the districts COWLHA has the Tas which overlook the activities which are done in the communities. It has a membership of 50,000 women who registered as members of COWLA (from a recent census). COWLHA focuses mainly on advocacy and awareness in the community, on SRHR, HIV, PTMTCT as well as TB and also other SRH issues such as cervical cancer especially to women who are living with HIV. Men have recently joined the support groups seeing that they benefit a lot to women as they discuss issues of psychosocial and other supporting issues as well as treatment and adherence to ART. COWHLA also recently started support groups of young people living with HIV – both girls and boys, operating in two districts so far.
- National Association for people with HIV AIDS in Malawi (NAPHAM): Is a non-government membership organization in Malawi whose members are people living with HIV AIDS. It operates nationally with presence in all the districts in Malawi. The members in all the districts are organized in support groups. NAPHAM promotes HIV services for people living with HIV and Aids, while also lobbying for appropriate HIV services, from the service providers. It also conducts capacity building.
- Malawi network of people living with HIV (MANET+): is a coordinating body of all PLHIV organizations in the country. As an umbrella which was formed in a 1997, it

brings together people living with HIV advocating for their issues, ensuring that there is proper coordination and collaboration. So, it's a membership organization. But at the same time, it also has a role within the National HIV response to act like an umbrella and a link to issues of people living with HIV. They therefore conduct advocacy for the rights of people living with HIV, conduct capacity building of organizations of people living with HIV. It is based in all districts of Malawi. Their membership includes women living with HIV, Young people living with HIV, and religious leaders living with HIV, Teachers living with HIV, Members of the UN living with HIV, healthcare workers living with HIV, journalists living with HIV. All these are part of the MANET Plus family although they operate independently, but our role is just to coordinate and provide that leadership.

- National association of young people living with HIV/AIDS (NAYPLHIV): Is an association which coordinates all young people living with HIV. It currently runs the Yplus project, and handles the affairs of young people living with HIV from 10 to 35 years.

ii. Local service providers and implementing partners:

- Girls Empowerment Network (GENET) is an empowerment network, with a holistic approach of handling adolescent girls and women below 25 years. SRHR, mental health and GBV, economic empowerment are some of the key activities offered.
- Family Planning Association of Malawi (FPAM): Basically, FPAM is a local non-government organization, it is an indigenous organization in Malawi. It is a non-profit making organization that strives to provide quality accessible, youth friendly, health service that's sexual and reproductive health service basically, to the youths, the young women, and even to the males. basically, the services that are provided are in three streams. The first one is the study clinic, where clients or patients walk in from their homes and the second stream of the service delivery point is the outreach clinic. And the third one is the CBDA – community-based distribution agents, which was developed as an adopted structure of the Ministry of health where community distribution agents assist with the service delivery, which includes information. The organization targets the youth from the age of 10 – 24 years. However, because it's a clinic, service to adults is not spared and older members of the community equally seek services. The clinic provides the whole package of sexual and reproductive health services. This includes family planning services, HIV testing services, ARV provision



cervical cancer screening, gender-based violence screening. The clinic reportedly has special interest with people living with HIV, in particular the adolescents, with a youth wing set aside, commonly referred to as youth action movement. This youth wing is for the general population of young people, but in particular, for the HIV infected youth, the clinic runs what they call “*zotheka*”, which can be translated to mean “*positive living*”. Mentorship is offered to some young people in this group in terms of sexual and reproductive health services, and they become peer educators, who propagate the information to their fellow young youth who are living with HIV.

- Banja La Mtsogolo (BLM): An organization/project focused on provision of post abortion care and reducing the unmet need of FP services. The organization provides choices on family planning services so that girls and women are able to make the correct choices in terms of their contraceptive needs. Where possible they also integrate other SRH services such as HIV counselling and testing, ART, cervical cancer screening, STI screening and treatment. The organization/project currently has 25 static clinics out of which 8 clinics are providing HIV counselling services and 4 clinics are providing ART services. These services are not targeted specifically to adolescents alone but rather to the general population.
- FHI360 implements a USAID-DREAMS project which targets adolescent girls, and well as offering other services including psychosocial, family planning, HIV testing and counselling through their DREAMS clubs.
- JPHIEGHO has a reproductive service focus targeting the general population as well as adolescents. Current programs do not differentiate between adolescents living with HIV and those without, but services are extended to all.

iii. National entities/ministries:

- National AGYW Secretariat provides coordination to the work of four ministries, and two agencies. Essentially, it includes Ministry of Youth and Sports, the Ministry of Gender, Child Department of Social Welfare, Ministry of Education, the Ministry of Health, all of which have got programs related to AGYW. The ministry of youth participation is aimed at enhancing adolescents, empowerment, and participation, while the Ministry of Gender is for gender equality and social cultural norms and the Ministry of Health is for SRH nutrition and HIV and AIDS and the Ministry of Education is to promote education in Malawi. The main focus for the secretariat is coordination role as

well as M&E, and coordination of data with National Health Commission to produce national HIV statistics

- Ministry of Health, as the custodian of public health
- Ministry of Gender, children, disability and social welfare

iv. Development partners:

- This category included UN agencies and donor agencies, whose mandate extends to children and adolescents, as well as family planning and gender related programs. These included UNICEF, UNFPA, UNWOMEN, and USAID and PEPFAR on the donors' side. USAID and PEPFAR are implementing the DREAMs project and supporting the national response to adolescent girls and young women programming within which is HIV and SRHR, including contraception as key.

#### 4.7 Approaches to Data analysis

Thematic analysis was followed, using the framework approach. Data was managed using Nvivo software. The different data collected using various approaches was entered into the Nvivo software for the final analysis which contributed to the final conclusions of the findings and helped to build a holistic picture through triangulation. The framework analysis provides flexibility during analysis of data, by offering an opportunity to either analyse co-currently during data collection or afterwards (Srivastava and Thomson, 2009). For this study, initial analysis was conducted during the document review process by identifying and extracting relevant information as possible pieces of evidence. These pieces were collated under each question and later re-analysed together with the data collected from interviews, as demonstrated in the Table 8 and 9 below.

This was followed by the analysis of individual cases through repeated reviewing of transcript to sort out key issues for reporting following the five-steps process of familiarization with data, identifying a thematic framework, indexing, charting and mapping and interpretation (Srivastava; and Thomson;, 2009), after which comparisons were made between cases. Following the steps of the framework analysis made it possible to identify any deviant cases during the cross-case comparisons, and associations were equally identified and established to build a comprehensive case outcome because it allows for full review of the entire data collected through all forms (Framework analysis).



Table 8 Thematic analysis framework for the study

Key question	Units of analysis	Generated data		
Question 1: What are the structural and socio-cultural issues affecting the use of contraception among AGLHIV in Malawi?		Documents' review-generated data	Interview-generated data	Themes identified
	Structural issues			
	Socio-cultural issues			
	Other issues to note			
Question 2: What policy provisions are in place in Malawi to address the issues/risks faced by AGLHIV during use of contraception?	Provisions on risks/vulnerabilities faced by AGLHIV			
	Other issues to note			
Question 3: What implementation challenges affect the effectiveness of the available policy provisions?	Implementation challenges			
	Other issues to note			

Table 9 Final analysis framework

		Parameters of analysis based on Health Policy Triangle				Other important issues to consider		
Issues to address	Policy in place	Context issues	Content (relevance to issues/risks faced)	Process of development & implementation	Actors/stakeholders involved	Implementation progress	Alignment with international guidelines/standards	Provisions on risks/vulnerabilities faced by AGLHIV

## 4.8 Ethical considerations

At country level, preliminary gate-keepers permission was sought from responsible representatives of targeted organizations to confirm their willingness to participate in the study. This was through direct contact by emails and physical follow-up by the local team that supported the study. Additionally, the proposal for this study was reviewed and approved by the National Health Sciences Research Committee (NHSRC) at the Ministry of Health, Malawi (Annexure 4.1). At University level, ethical review and approval was sought from the University of KwaZulu-Natal Humanities & Social Sciences Research Ethics Committee (HSSREC). The full study ethical approval was thus provided by the HSSREC as indicated in Annexure 4.2.

During data collection process, additional permission was sought from the relevant ministries to access the necessary national documents for review and the required interviews. For the interviews, copies of the informed consent form (ICF) were sent to respondents prior to the interview session to enable the respondent to read through and understand. During the interviews, oral consent was taken as well as permission to record each discussion. All respondents who participated in interviews consented to both the participation and recording. All participation was voluntary and no coercion was involved. In preparation, the informed consent form was translated to Chichewa and both versions were available to suit participants' preferences. Organizations and participants were contacted prior to the interview scheduling, with all necessary explanations to request for their participation. Special attention was taken to ensure that representatives of PLHIV organizations were not adolescents, and were mainly persons in relevant leadership position at the organization or specially seconded and suitable to participate in the study. There was no requirement for respondents to reveal their HIV status as was not required by the study, and questions asked were strictly kept within the scope of the study. Whereas the study was largely focused on adolescent girls (10-19) years living with HIV/AIDS, they were not directly involved or approached as study respondents. All information required was generated from networks of PLHIV organization through sharing of program-related information and interviews with identified officials who were not adolescents. The interviews were all virtual, online or telephone based in the preferred space of a specific respondent and using a platform of their choice. Special codes were allocated to each audio file recorded and maintained for the transcribed data report during data management to prevent identification. The copies of the informed consent forms used are attached in Annexure 3.1 - 3.3, and the ethical approval certificates are attached in Annexure 4.

#### 4.9 Study limitations and challenges

Several limitations were encountered in the process of conducting this study, mainly in relation to field coordination, ethical applications and approvals, and data collection challenges. The following limitations should be considered while using and interpreting the results and report of this study;

- The study methods which were determined to fit within the acceptable research means during the COVID-19 pandemic limited the direct involvement of AGLHIV as respondents. The sensitivity related to being HIV positive and possibility for respondents experiencing duress or psychological break-down made their inclusion

difficult. It would be extremely challenging to organize for psychosocial support services during the virtual engagements.

- Additionally, the travel restrictions due to the COVID19 pandemic affected the progression of the study since the Principal Investigator could not be on ground in Malawi to facilitate quick response and fast-tracking of necessary actions with authorities in Malawi. As a result, reliance on the local research assistants was employed.
- It was challenging to balance between university requirements, proposal formats and processes and the country ethics committee procedures. This resulted into a lot of back and forth review of documents to satisfactorily fulfill the different institutional demands for ethics application and approvals. Ultimately, this resulted into further delays. However, the Principal Investigator imperatively recognizes that such processes are significant and built more confidence in the study given the rigorous reviews. For example, the UKZN has a different format for informed consent while country ethics research committee required a different version. Translations were required for the different versions and at some point the investigator was confused about which one to administer during data collection. Nevertheless, all the versions were shared with intended respondents to allow them the opportunity to read through and provide their consent at the beginning of the interviews, and key issues were well-covered and addressed to prevent unethical practices during the data collection.
- The Principal Investigator relied on the services of local research assistants who delivered effectively. However, it was a challenge to identify an experienced research team to coordinate the study activities in Malawi, with the necessary skills and understanding of the study. This was solved by conducting training and de-brief sessions, providing close supervision daily, constant follow-up, and engaging third party authorities to support the study activities on ground. While the study commenced with one Research Assistant, the PI found it necessary to recruit an additional Research Assistant to fast-track the process.
- The challenge of not being on ground further delayed the confirmation of interview appointments, follow up and entire data collection process. The principal investigator had to rely on the services of a research assistant which also required constant follow up. In-depth interviews were initially planned for a period of two weeks but exceeded

to three months from July to September 2021. Consequently, the commencement of final data analysis and report writing was delayed.

- In relation to the above, targeted respondents were initially skeptical and uncomfortable about giving telephone/virtual interviews. Thus, their reception was largely poor to the idea/method. Numerous follow-ups had to be conducted, and after more detailed explanation regarding the country travel restrictions due to COVID 19 and the protection of human subjects' guidelines for research, appointments would be successfully secured. Other respondents were easily convinced after sharing about the participation of notable institutions.
- It was challenging to secure appointments for interviews due to fear among targeted respondents to discuss matters relating to policy. The PI had to conduct confidence-building and offer reassurances about confidentiality and significance of the study to generate interview appointments and actual interviews.
- This study was also affected by poor internet connectivity, especially in Malawi. This sometimes affected the quality of the interviews, the audibility and clarity of respondents. However, no interview was cancelled due to this challenge and effort was made during transcribing to ensure that all verbatim was well-captured.

#### 4.10 Conclusion

This study was qualitative and employed both descriptive and analytic approaches to produce the final results. This allowed for flexibility in exploring the topic, and contextualization of the phenomenon under study. Specific documents and participants were selected, purposively to meet the requirements of the study objectives. The processes of data collection and analysis was back and forth due to the need to cross-check facts and clarify several statements between what was documented and what was reported in interviews.

## CHAPTER 5: FINDINGS

### 5.1 Introduction:

This section presents the main findings of this study. The findings are a final synthesis of both secondary and primary data collected. The findings reveal interesting discoveries about the adolescent sexual and reproductive health policy situation in Malawi and the experiences of the AGLHIV. The findings are presented in the order of the research questions.

### 5.2 Structural and socio-cultural issues affecting the use of contraception by AGLHIV in Malawi

#### 5.2.1 Structural issues:

These are categorised under several themes and sub-themes as described below.

##### **1. Mode of service delivery vis a vis AGLHIV's preference**

Facility-based service delivery: According to the findings, the mode of contraceptive service delivery is mainly facility-based, requiring AGLHIV to go to the facility whenever they need contraceptives. AGLHIV are said to be constrained by the arrangement that family planning/contraception services are mainly facility-based. The facility (ies) are mainly government health facilities, usually situated at the community level and they are also utilized by other community members who may require health care services, including their relatives and guardians. It was expressed that AGLHIV are not comfortable with meeting other community members at the same service points. Whereas partners improvise with innovative approaches like delivery of services through peer clubs for AGLHIV, the main method of service delivery for family planning products/contraceptives is at the facility.

Communal model verses private service provision: The findings of this study further indicate that some AGLHIV who have sought contraception services at the public/government health facilities are not comfortable with sharing the same health facilities with other adult women from the community, and it exposes them to their relatives and guardians or other community members who know them. It was also found that many AGLHIV are uncomfortable with the arrangement of lining up in the same queue with adults who are members of the same village where they live. As a result, some enter and exit the health facility without receiving the service, with the claim that they have been denied the services or that they have been judged.

Location of contraception service delivery point within the facility: In addition, the positioning of the service within the health facilities was found to contribute to limitations in uptake and access of contraceptives by AGLHIV. It was reported that in most health facilities, one has to enter a special room with nurses (medical staff) to receive the contraceptives. This was reported to be inconveniencing for AGLHIV because it exposes them when they are seen going to a special room. Furthermore, it was revealed that it increases their chances of interface with their parents or guardians who may be seeking the same service. Therefore, this often limits them from getting the contraceptives even after they have travelled to the facility, for fear of being judged. Furthermore, this has instilled a sense of fear and many reportedly exit the facilities and return home without receiving the contraception service because of fear to request for it in the presence or close vicinity of other people who know them at the facility. Apparently, it is preferred that contraceptives are in easy reach once one approaches the facility. For example, at the reception, as opposed to going into the nurses' room so that it is easy to receive the service and exit swiftly to avoid being seen around the facility.

*“We don't give out contraceptives. Because many, many adolescents go to the government facility which is near to their community. But unfortunately, even though in some cases they go and get that type of assistance at the facility, unfortunately, most of them do complain a lot, they do have problems with that, because sometimes they are supposed to get the condoms or anything concerning SRH maybe at the reception or maybe I can say in the nurse's office and some of them they say in case they meet one of their guardian friends they do come out and say we didn't receive their assistance, they have turned us down and we should go back home, they have judged us.” (Int 1\_PLHIV)*

Consequently, there is a sense of preference for PLHIV organizations to be supply points for contraception for ease of access by AGLHIV.

Generalization of service approaches: This study also found that SRH services including family planning/contraception are offered through a universality approach that covers everyone but with no specification to special groups such as AGLHIV. In most of the health facilities, the target for contraceptive service delivery is general for women in the reproductive age group, which limits the chance to offer tailored support for AGLHIV in a better way to ensure they access and use the services they need, given their unique situation dealing with HIV/AIDS. Thus, the services are not targeted in most of the facilities, and other private key service

providers for contraception similarly do not have a targeted approach for AGLHIV which could cater for their interests and preferences.

*“Our interventions are focused on the general population and also adolescents in general. We do not have any targeted approach on AGLHIV.” (Int 6\_LSP)*

*“... the approach that we are having now is targeting just a general population, not only targeting young people living HIV...Because when we just approach as if everybody else is so, I think we are not doing fine.”*

*“when addressing these issues, it works better when you are talking to this selected group of individuals than approaching as a general population.” (Int 2\_PLHIV)*

Poor service flow and organization for AGLHIV: The study also found that the flow of services at the health facilities where AGLHIV receive regular HIV/AIDS-related services is not well-organized to allow those who may need contraceptives to easily be served. It was revealed that service delivery points for ALHIV do not have other ASRH services (are not well-integrated), are located far apart, which requires an AGLHIV to go through different service points with other different systems/procedures, and even distance to access. It was found that it is common practice at the health facilities at the community level to find different service points or rooms allocated for HIV/AIDS medication and family planning clinics, located far apart, either on different floors of the building or in completely different buildings. AGLHIV would have to go through two different queues and procedures to access the contraceptives.

*“Now, if we particularly drill down to adolescents who are living with HIV, we know that the... these adolescents access the services on a regular basis, but the structuring of the services is in such a way that the point of HIV service delivery does not have anything to do with SRH, you find that it becomes very difficult for an adolescent to navigate through the different points of service delivery to access all the services that the adolescent wants. So, I think that's a big issue.” (Int 9\_DP)*

*“Yes. Yes. So that's, that's what I'm referring to. So, you have a family planning clinic away from the HIV delivery service delivery points, Okay, for an adolescent to line up, to line up for service on the HIV line, then after finishing that should be sent to go and line up, usually, together with adults on the family planning line, that one becomes a problem.” (Int 9\_DP)*

## **2. Nature of service providers/cadres**



Age of service providers - elderly service providers as opposed to youthful cadres: This study found that AGLHIV constantly complain about engaging with elderly service providers who often manage the contraception service points. The elderly service providers are seen as a limitation to freedom of expression, and it would be easier for AGLHIV to express their contraception needs to a youthful medical staff, with the belief that youthful medical staff would be in a better position to understand what an AGLHIV needs when she explains what one is feeling in their body, and for it to be seen as justified or necessary even when they are young. In addition, it was also found that the youth in Malawi emphasize the “Nothing for us without us” slogan and would prefer to be served by fellow youths as opposed to service delivery points being managed by older people.

Sex of service provider – Male service providers as opposed to females: It was also expressed that some AGLHIV find it difficult to explain their method needs if they encounter a male service provider. They would feel more comfortable with a female at the service delivery point because they share similar experiences and would freely express their contraceptive needs.

Absence of HIV – positive peers at service points: In addition to the above, this study found that the absence of fellow HIV-positive youth at the contraception service points affects the AGLHIV’s perception about being understood. It was revealed that many do not feel understood if they have a unique request to match the situation and condition they are in, especially when they want to find what suits their ART regimen, or if they are experiencing any side-effects with a particular contraception method since they are also on ART.

*“Okay, when you go there to the facility, most of the time, the youth do complain that the ones who are found there, are adults. So, let’s say, in case of a young person living with HIV, they prefer that maybe there should be, someone who is also youth to be giving them the contraceptives so that they can be free to explain how they feel in their body or what is happening.” (Int 1\_PLHIV)*

*“Secondly, you might find that, although they (health workers) might be there, the people that are working there, of course, we say that, nothing for us without us, although the youth might be there, you find that maybe some of them are manned by older people, or maybe men, not necessarily young women themselves, because, for instance, I’m a girl, I’m HIV positive, I want to access the commodities at this youth center, and the youth are distributing, you know, a commodity like this, for me to actually go there and find a young man to talk to might be very challenging. I might be*



*more flexible if I find a young woman who I can talk to maybe to access those commodities.” (Int 20\_DP)*

Untrained and unfriendly adolescent service providers: In addition, the study also found that AGLHIV encounter service providers who have not been trained and lack the capacity and skills to deliver adolescent-friendly services. It was reported that whenever AGLHIV approach health facilities for contraception services, they are not given due attention as per guidelines of YFHS, which has discouraged many over time from visiting the facilities. The study also found that AGLHIV and adolescents in general are often poorly attended to or handled, and they often experience improper treatment from the health workers at the health facilities.

### **3. Unsupportive health care providers**

Inadequate medical support received: This study found that some service providers are not providing the necessary medical support or information to help the AGLHIV to choose the best type of contraception to use, as well as to address any side effects they may be experiencing. As a result, a number of AGLHIV have reportedly had negative experiences such as frequent unwanted conception and miscarriages right after. Consequently, many prefer not to return to the facilities as a way of preventing further reproductive complications such as the inability to deliver in the future. According to the data collected, this is attributed to the weak capacity of service providers and the inability to provide all the necessary guidance, and comprehensive information as AGLHIV may require given their HIV status and the likely bio-medical interactions between ART regimens and the contraceptives. It was also reported that in some facilities AGLHIV are denied contraceptive services. Furthermore, some health workers found at the facilities may not be skilled enough to offer long-term contraception methods of contraception that are sometimes preferred by the AGLHIV.

*“...Inadequate capacity in terms of human resources in most of the rural health centres. Okay, so even if the policy is there, there's one person at a rural health centre, who doesn't have even capacity in SRHR. But is expected to integrate SRHR, HIV, and SGBV. So that when an adolescent comes through, should be able to deliver all these services at one go under one roof in one, yeah, in one room. Yeah. But this person doesn't have the capacity to deliver SRHR because he's not well trained in that.” (Int 9\_DP)*

*“I think because it needs more qualified personnel to offer the longer-term methods”  
(Int 1\_PLHIV)*

Denial of HIV post-test counselling and information package: Further-more, this study found that some AGLHIV do not receive a comprehensive information package during post-test counselling, at the time when they test positive. It was revealed that most AGLHIV while sharing their experiences to PLHIV representatives often express that information relating to pregnancy and childbirth for people living with HIV was not shared with them when they first tested positive for HIV. The discussion and counselling session is most of the time limited to starting ART treatment, and many were only able to learn about contraception during antenatal care (ANC), which was late.

*“I also see that there is lack of counselling. When they are found to be positive, I think there isn’t enough counselling. because in the past, people would be told of the issues of pregnancy and HIV. What do you got to do when you want to get pregnant and so on and so forth? I think these days, I think because people just want to give results. You get a test and you’re given results. And the only thing that they are told is you will be on treatment. In the past counselling used to last, I think even an hour. Somebody would be counselled, they would really be told, what are the implications when you’re pregnant? And so on and so forth. But these days, it seems that that kind of counselling, I think is lacking in terms of content.” (Int 7\_PLHIV)*

#### **4. Provider negligence and omissions on counselling**

In addition, the findings revealed that AGLHIV have been affected by mistakes or omissions made by service providers when they seek contraception. Some of the revealed omissions include not being taught, or counselled about the different contraceptive methods, especially about how they may or may not interact/interfere with ART regimes being taken by the AGLHIV, and not offering them adequate attention. The study found that some AGLHIV have had negative experiences due to this, including back and forth pregnancies as a result of the failure of methods, and miscarriages while using specific types of contraception, which led them to abandon contraception even when they acknowledged the need for it. Thus, some resort to shunning the contraceptives because they are not getting the right guidance medically to address the possibility of side effects which sometimes occur when contraception interacts with ART, and to help them make the right choice on contraception method that is well-matched with their ART regimen.

*“...they don't explain properly about what are we supposed to do when ABCD happens to us? What about when we meet XYZ, what are we supposed to do? So that we should still stay safe, safe and self as young people living with HIV?” (Int 2\_LSP/IP)*

*“They will say...every time we go there, they just give us what we want not counselling us or tell us the impacts and the goodness of using that, or that type of contraceptive...” (Int 1\_PLHIV)*

## **5. Infrastructural issues/challenges, mainly limited space for operation**

Lack of privacy and confidentiality: In addition, the study also found that the current set-up at health centres, with rooms labelled for specific services, causes a level of stigma for AGLHIV, because other service users would know what service they are seeking. AGLHIV reportedly feel ashamed as a result. Furthermore, in this kind of arrangement, they are exposed to judgment by relatives, guardians, and community members who are known to AGLHIV.

In relation to the above, some of the health facilities lack physical structures, and special rooms especially at the community level to cater for YFHS as provided for in the policies. It was also reported that some of the facilities do not have a youth-friendly corner, or a space allocated specifically for the provision of services to adolescents or even YFHS, so they avoid going to such facilities.

*“The thing is our infrastructures are like demarcated. You already know that if am going this way, it is for service A, if I go this way it is for service B, so everybody knows that if this person goes there they are going for ART, if that person is going there she is going for STI or family planning...” (Int 3\_PLHIV)*

*“...the other issue Is that the government is supposed to have very good structures in healthy facilities for us girls living with HIV... and we want concentrated sessions actually. We need to have the best structures ...because for example, our youth policy provides for our youth-friendly health services, and stipulates that at each and every health facility, there must be structure specifically for young people to access such services, but when you go on the ground, you do not find such structures. So, by the end of the day, you know how it's, it's usually so hard for young people to go to a facility, let's say they have a certain problem” (Int 1\_PLHIV)*

*“...they complain much about the nature of the facilities that some facilities don't have a youth friendly health service corner because it's very important that they should have a*

*youth-friendly health service corner. So those facilities that don't have youth-friendly health service corner there are those facilities that most of the youth are complaining to say, we are not, we are not comfortable to go to such a clinic.” (Int 2\_IP)*

## **6. Regular stock-out of contraceptives, and of preferred methods**

The study found that when most preferred methods are out of stock, AGLHIV especially those who are already mothers stop using contraception. It was revealed that the most preferred methods are those that provide a level of discretion such as injection-Depo-Provera, jadelle, and also works well with the ART regimens. Other methods notably the pills are not preferred because of fear of likely exposure to husband or sexual partner. This leaves a window of risk for conception since the AGLHIV will not be using any form of contraception until the preferred method is available again. Once they do not find the methods of their choice, they are unable to continue using contraception because they are not in a position to seek it from elsewhere, especially if financial costs are involved.

*“Also, of recent we had some stock outs of aaarhh especially the injection method the depo-provera, so that is the most liked method by most young women but because of the stockouts most of these women stopped using because they did not want the pills...”*  
(Int 3\_PLHIV)

Similarly, the study found that PLHIV community-based agents who are engaged to reach adolescent peers often run out of supplies of contraception, including the very basic methods like condoms. This hampers the effectiveness of the community outreach programs regardless of the efforts made by some PLHIV organizations to take products closer to AGLHIV. Most times the stock is not available.

Rationing of contraceptive supplies (and discrimination against adolescents): Additionally, it was found that during times of scarcity/stock-out, contraceptives are restricted to special programs such as PMTCT, and community-based agents including those focusing solely on reaching AGLHIV are not supplied with stock or permitted to distribute part of the available stock.

*“...of course when you go to the facility they are told that there are not enough condoms, that they are reserved only for those women who are coming for PMTCT programs.” (Int 3\_PLHIV)*

## **7. Limited access (inaccessibility) to services**

According to the findings, AGLHIV are often faced with a challenge of access to contraception. Whereas contraception may be available, it was reported several times, especially by PLHIV

representatives that access remains a problem for the AGLHIV. According to the findings, access in terms of availability of services as well as type/method of contraception preferred, as earlier alluded to is difficult.

#### **8. Inconvenient hours of operation as described below**

Unfriendly youth services: Whereas the services are available in some of the facilities, they have been reported not to be as friendly for the youth as they are marked with numerous barriers which require an AG to have a lot of courage to access. In addition, most services provided under YFHS are based in hospitals and seen as inaccessible because young people mainly approach the health facilities/hospitals when they are sick.

Timing of service delivery: The services at health facilities are provided during the same hours when some of the AGLHIV are attending school, making it difficult and inconvenient for in-school AGLHIV to get the services. To bridge the gap, outreach activities are conducted in some provinces by partners but the coverage is still limited.

Long waiting hours: It was also found that AGLHIV complain frequently of spending a lot of time at the health facility, something which they detest and many prefer to return to their daily activities as opposed to waiting for the services.

*“...and then the ministry of health, they have yes what they call youth-friendly health services within hospitals but these are not very accessible because most of the time the young people are in school. so even if you have a youth-friendly health service at the clinic the adolescents will only access it when they're sick not when they're not sick.”*  
(R7\_PLHIV)

*“Young people in Malawi meet many barriers in accessing YFHS including long distances to health facilities, long waiting and inconvenient opening times...”* (DR)

#### **9. Fractional programming**

In relation to the above, most of the programs are reportedly inadequate in terms of looking at sexual and reproductive health for AGLHIV in a comprehensive manner. It was reported that AGLHIV often fail to find all services they need to meet their needs and many remain confused about the available services.

*“So, Ministry of Education, they have what they call life skills education. Where it introduces young people to a number of life skills, which include issues of reproductive health and so on and so forth but these are not adequate because it's like they don't go*

*beyond to look at sexual and reproductive health in a comprehensive manner. So, they will be taught about condom use and then the ministry of education will say any pupil who is in primary or secondary school should not access condoms within the school premises. So, they are taught this is what you should do and on the other hand, don't access. so, the adolescents are confused to say then why were you teaching us to do this when we cannot access” (R7\_PLHIV)*

#### **10. Age of access by-laws**

The study found that in Malawi, children less than 13 years are to be accompanied by a parent in order to access contraception. However, most parents are uncomfortable with the arrangement, because of the young age. Therefore, it is difficult for most of the AGLHIV to get contraception on their own. However, it was revealed by the ministry that a review of the adolescent and youth SRHR documents is currently underway to harmonize with the regional standards, and with the unique requirements of AGs, including those living with HIV so that they can easily access contraception.

*“There's still a requirement that they need, I think children less than 13 years. They are supposed to come with their parents. So yeah, so you cannot just go if you are 10, 11, 12, you still need to bring, to come along with your parents to access the services even with the contraceptives. So, in terms of policies, I think it's one of the gaps that has been seen. ... So, it's really challenging, because parents will not be comfortable to go with the 12-year-old girls to the health facilities, to receive contraceptives” (Int 5\_IP)*

*“Yes, I think the issue about age of consent, it has been one of the very great challenging elements, on the age of consent, but like, maybe I should just extend that this time around, we are in the process of revising the strategic, the adolescent and youth SRH strategic document. So ... we are trying to work out and harmonize what is happening at the regional level, in terms of age of consent in terms of access to services, especially SRH services.” (Int 12\_PM)*

#### **11. Poorly designed services, as described below**

This study also found that in some areas in Malawi some SRH services is not well-designed. This is because of the lack of flexibility within the system to consider the needs of vulnerable groups such as AGLHIV. Therefore, AGLHIV often find it difficult to get the SRH services they need. It was also found that because of this reason, many prefer to wait for the outreach

programs which are specific to the needs of the AGLHIV and can be extended to them in the communities where they live.

*“However, the current design and implementation of SRH interventions is conventional “one size fit all” approach. They may not adequately address the unique challenges of AGLHIV.” (Int 8\_PM)*

*“On the service delivery side, really, the challenge is, is where, you know, I feel like, in most countries, you'll find health facilities, don't really design services that are what you would call sensitive to the youth. Meaning that the youth cannot easily access health services because of certain structural issues. So, system design issues. So, you can't expect for example, a girl of 14 now going to a clinic next to an older woman, and she's asking for family planning, for example.” (Int 10\_LSP/IP)*

## **12. Frequent rotation of health care workers**

The study found that contraception service delivery to AGLHIV is also hampered by the frequent movement/rotation of health care workers, specifically after their capacity has been built for delivery of adolescent and youth SRH services. It was revealed that this is a common practice in areas where special ASRH programs are being implemented, which hinders the HIV/Family planning integration efforts and promotion of YFHS at the community levels, reflected through the low uptake of services, especially contraception.

*“Actually, the other key challenges we have had is that the staff retention and the staff motivation. We have most of the staff that are handling these cases, the dissemination of HIV/AIDS framework on common sense. They're moving from one ministry to another. And they start one program in one ministry but by the time people try to understand the program, they're in another ministry or they have been retired or they have been moved to another post altogether. So that creates a challenge of continuity and clarity.” (R16\_PM)*

*“...because some of the health facilities in the rural areas, they have only two or one Medical Assistant, looking after all the things...” (R9\_DP)*

## **13. Poor adaptation to YFHS, and failure of its absorption into government health system**

The study also found that the YFHS approach to ASRH has not been fully institutionalized within the ministry of health and government health system. As a result, it is viewed by health



care workers as an additional burden to the already heavy workload, and a luxury that is often under-looked. Therefore, it is not obvious that an AGLHIV will find all health facilities implementing YFHS, with allocated YFHS corners/spaces as per guidelines, or even human resources to serve them. This is mainly in the rural areas where health care workers concentrate mainly on the provision of primary health care services – minimum packages.

*“Yes. So basically, it has not been really institutionalized within the MOH system, that at any point, any facility would be able to deliver youth-friendly corners and the like, sometimes they say, maybe human resource constraint, because some of the health facilities in the rural areas, they have only two or one Medical Assistant, looking after all the things to may be come up with youth friendly corners, and the like...they feel like, oh, this would be an extra luxury that I (AGLHIV) want to have while I cannot manage.*

*“They just concentrate on providing the primary health care services...Yes, yes. Then they say, okay, come in one by one, everyone in the same line, which for adolescents, as we all know, it usually doesn't work.” (R9\_DP)*

#### **14. Long-distance to the facilities**

It was also found that some AGLHIV's use of contraception is affected by the long distance between their home and the facility. Whereas the government and partners try to provide contraception services, sometimes they are not within the catchment area of the user. And given the unique situation of AGLHIV, it may be extremely difficult to travel to other places to access the needed services because of the costs involved. This brings in the aspect of socio-economic situation whereby many AGLHIV are not in a position to either transport themselves to an alternative site/facility, or purchase contraceptives from a private facility close to them because services are paid for in private facilities. However, an effort to counteract this is ongoing with the support of partners such as BLM and the Family Planning Association of Malawi (FPAM) to take services closer to AGLHIV through community outreach programs.

*“...the issues of distance to access the facility, sometimes in the catchment area, in general in Malawi we offer free services, but sometimes it may not be readily available within a walkable distance. And probably the nearest service provider is a private and there is the paying issue.” (R17\_DP)*

*“The challenges range from long distance to facilities, ...”*



*“Distance to health facilities has also been a challenge though other partners such as BLM and FPAM are now addressing the issue of distance by bringing the services closer through community outreach services.” (R8\_PM)*

## **15. Integration challenges**

The study further found that the process of HIV/AIDS and SRHR integration is yet to be accomplished or activated at most of the health facilities across Malawi. And where it has been initiated, the integration is not adequate to cover HIV services, family planning, and GBV services. As a result, AGLHIV are unable to get all the services they need in one hospital visit. For example; during their ART refill days, but would be required to return on another day to get contraception services too. It was found that a lot of challenges still exist at institutional levels key among which is the ability of institutions to conduct the required mainstreaming of family planning into HIV/AIDS to ensure the intended integration and its benefits such as easy access.

*“...it's actually a need by the government. You know, we have been struggling, to include the service beneficiaries, the clients, they've been highlighting that as a challenge to say if you go to a clinic today you will just go for family planning, tomorrow you go for cervical cancer, the other day you go for HIV testing. The other day you go for TB screening something like that. So that's one of the elements to do with the integration approach to the services.” (R12\_PM)*

*“Currently, HIV services are inadequately integrated with SRH and GBV services.” (DR)*

*“At institutional level, there are also a lot of challenges and key among them is the limited gender mainstreaming capacities across all sectors” (DR)*

## **16. Conditioned access of contraception**

It was found that some AGLHIV are affected by the requirement that youth must carry out an HIV test before accessing contraception and other services at some of the health facilities.

*“The main deterrents to sustained utilization of these services include..., the condition that youth receive HIV testing and counselling before accessing other services in some health facilities” (DR)*

### 5.2.2 5.2.2 Socio-cultural issues

The socio-cultural issues identified by the study are categorised into several themes and sub-themes as presented in the text below.

#### 1. Social norms and practices

The study found that social norms, traditions and practices– including harmful cultural practices in Malawi, and gender inequities result in males and females not participating equally in decisions about sex and sexuality or the use of contraception. It was also found that harmful cultural practices are documented to have a significant contribution to putting young girls including those living with HIV/AIDS at a disadvantage in relation to access and uptake of SRH services, specifically family planning services.

*“...they have the information, but actually their key challenges are issues which surround the norms, the issues to do with the maybe norms about women and so on....”*

*(R14\_PM)*

*“Harmful cultural practices put many girls in a disadvantaged position” (DR)*

Conservative community: The study found that AGLHIV are faced with a regressive culture where the society does not support girls, in general, to freely express themselves or exercise their agency. Whereas there is acknowledgment of the early sex debut, the challenging poverty situation and limited education, access to contraceptive products is still not easily acceptable. In addition, community leaders are usually not supportive of programs that offer information to AGs in general about using contraception.

In other places, an extension of services and programs to AGLHIV in communities and schools is equally curtailed by local authorities and school leaders. It is seen as not right. Culturally, the norm is for girls to be quiet/silent and not be seen to take any action independently. For example, approaching a health facility to request condoms is not supported or expected as one is seen to be diverting from the acceptable behaviour in the society.

*“Where I stay, right now in Machinga, they prefer to say that a girl should be more-quiet. I can say some Malawian cultures. Like I have already said, a woman is supposed to be silent.” (Int 1\_PLHIV)*

*“Yeah, they're having sex earlier. And we also have those children that may be dropped out of school earlier, because of, you know, prevailing conditions. For instance, we're talking about poverty, long distance to school, among other things. So, if we say, okay, fine, they cannot access those products (contraceptives) too, what are we saying,*

*because they are still adolescent girls? So, this is the whole issue that has been happening and all these conversations that have been happening by partners, stakeholders on the ground, to see what do we do regarding the policies, ...” (R20\_DP)*

**Motherhood expectations and belief:** The study also found that in Malawi, girls and women are mainly focused on becoming wives and mothers. This cultural expectation acts as a push factor to start childbirth as early as possible, with the belief that that is their main role in life as women.

**High momentum for children:** In relation to the above, the study also found that one of the factors affecting the use of contraception among AGLHIV is the high drive among the youth to have children. It was reported that since most young people have had children at an early age, young girls, in general, have been made to believe that it is the right thing to do since their peers have done the same. Many reportedly do it to fit among the peers and society, regardless of their HIV serostatus, while others who are HIV positive prefer having children as a way of concealing their status to the public.

## **2. Male dominance and persistent resistance**

The study found that partners to AGLHIV are not always in support of their partners using contraception, and it is a common practice for them to resist its use by AGLHIV. In addition, girls are not expected to be approaching health facilities to request contraception, specifically condoms because it is believed to be a role of the male, which a young girl should not be seen to take over. Those who persist and do are perceived to be taking over as the man (lead) in the relationship, which is not appreciated socially.

*“Where I stay, right now in Machinga, they prefer to say that a girl should be more quiet, should not be the one to go and access a condom it's a job for a man to go and get that condom for her to use.” (Int 1\_PLHIV)*

*“Actually, in cultures, I can say some Malawian cultures...like I have already said that a woman is supposed to be silent, ...a woman is not supposed to ask for a condom.” (Int 1\_PLHIV)*

*“So, some men may decide to say no, I don't want that. So, here and there where we have men resisting, ...” (Int 4\_PLHIV)*

Restrictions on movement/restricted mobility: This study also found that in general the unaccompanied movement of girls is not permitted, which means that they would not be expected or allowed to easily leave the homestead unless they are in the company of a male. The situation is worse for those who are already mothers because as soon as the child immunization programs end, the girl is not expected to be going to the facility again. This makes it difficult for them to remain consistent with contraception use.

*“I don't know how easy it is for them to show up with the partners and how easy it is for the partners to release them to come to the health facilities. Because we also have evidence from other research, which shows that sometimes when they want to come to the facility, for example, the partner says you cannot go anywhere without me. So for a woman and taking the contraception, let's say it is the Depo Provera injection, they have to run off, go to the facility, take it and come back and the partner will not realize because you're not going to come back with pills or what, so that the partner sees it. There is also evidence that that's what some of the young girls do in order to prevent gender-based violence or those kinds of incidents with the partners.” (Int 5\_LSP/IP)*

### **3. Social labelling and stigma**

In relation to the above, the study found that names and labels are attached to AGLHIV who still wish to utilize contraception, with some of them being referred to as sex workers, prostitutes, a negative connotation that AGLHIV dislike and prefer to prevent by avoiding the use of contraceptives and going to health facilities.

*“I will refer back to our social-cultural environment, where if a woman, if a girl goes, a girl especially goes to a health facility, the first thing that a person thinks is she wants to access contraceptives, they are the first thing. So a girl is actually labeled to either being a prostitute, then that actually prevents a lot of girls to go to a facility to access different contraceptives.” (Int 5\_IP)*

### **4. Negative social perception**

Furthermore, the study found that girls especially those who are living with HIV who portray confidence and bravery are instead perceived negatively and described socially as rude. So most of them prefer to avoid such negativity by remaining reserved to the confines of what is socially acceptable which limits their ability and agency to seek contraception services if, and when needed.

*“...they portray that girl as if she is a sex worker, or She's rude, she's becoming rude, she wants to become a man in a relationship.” (Int 1\_PLHIV)*

## 5. Lack of decision-making power

Additional data also indicates that most AGLHIV have been made to believe that men are the custodians of power and decision making and that they must rely on the decision of the husband before they take any action, including seeking health services. AGLHIV also categorized as MARPs, who are constantly in a position with limited or no reproductive decision-making power, and lack the empowerment over their own sexuality, which is substantial barrier to their access to contraception.

The study therefore found that AGLHIV do not have the power to decide whether or not to take the contraception even when they are reached with the contraceptives through peers in PLHIV club meetings or programs. AGLHIV often do not feel comfortable receiving and taking contraceptives without consulting with their male partner. They still require to make a telephone call to make consultations with their male partner about whether they should take or not take the contraception – for example, condoms. However, this was specifically mentioned about condoms. It was also revealed that culturally, most of the women know that the husband is the decision-maker and prefer that he decides on their behalf to either take or not take the contraception. Some AGLHIV cannot, therefore, take the necessary action without the husband or sexual partner, and will rely on what they decide. It is important to note that as highlighted in other sections, the spouses and sexual partners are not always supportive of contraception use.

In addition, it was confirmed that many of the AGLHIV have the information and are aware of the actions to take but are not in control of the decision, which implies that they are unable to act in response to the information received.

*“They are in a position where many lack reproductive decision-making power, possess limited SRH/HIV information, lack access to any social network, and have limited mobility to visit services.” (DR)*

*“And sometimes it is even sometimes difficult for the woman to continue with the PMTCT program especially after the child has gotten the immunization programs. The woman will stop on the way, because she is afraid, when (she) the woman says am going to the facility the husband will say for what, since the child has already completed the vaccines.” (Int 3\_PLHIV)*

*“So, girls...mostly they are not allowed to go on their own” (Int 1\_PLHIV)*

## **6. Traditional rules and regulations**

The study further found that cultural leaders often set rules and regulations which govern the respective communities they lead, and in a way also target SRHR activities negatively. The rules reportedly limit the actions of girls and young people in general in the communities where they live and further curtail access to SRHR services and use. The information gathered further indicates that the rules and regulations are extended to institutions such as schools, and AGLHIV who attend boarding schools are affected too.

*“So those cultures, we need more work to do with the traditional leaders, because they are the ones who will come in with the rules and regulations about their cultures.” Int 1\_PLHIV)*

## **7. Non-assertiveness/low self-confidence and shyness**

The study also found that some AGLHIV are not assertive when they go to health facilities. As a result, they fail to communicate their need for contraception services or preferred methods of choice. In addition, it was found that some AGLHIV lack the ability to discuss and communicate with their fellow peers, other adults, and sexual partners about their needs.

*“Young women lack adequate SRH/HIV information and/or the ability to communicate with peers, potential sex partners and adults on their needs and often do not realize they are at risk (of pregnancy).” (DR)*

*“But also, because of the fact that HIV AIDS is open, people talk about it now. But I find that for young people, most of them, I think it is challenging for them to come out and talk about the issues, particularly the things that they're going through and also accessing, you know, the commodities so that these commodities can be used you know, for their own protection. So these young groups, these young networks, the youth networks, in HIV AIDS, most of them are not really empowered, and most of them are not really strong enough, or might not be able to really, you know, put these things together and have a voice on the issue that they are grappling with in terms of accessing commodities.” (Int 20\_DP)*

*“There is still a high prevalence of pregnancies among the adolescent mothers, and also those who are already mothers...aaarhhh I will give an example, recently we had a training with 60 adolescent mothers, and you find that someone is 17 and she is already pregnant maybe for the second or third time, and then also asking them about the information on family planning, they are aware of the family planning...but then, when they go to the*

*facility with their age, sometimes they are shy to ask for the services and then they end up getting pregnant.” (Int 3\_PLHIV)*

## **8. Transgenerational relationships and marriage**

According to the data gathered and analysed for this study, it was found that most of the AGLHIV are married to adult partners, or have casual sexual relationships with older men. In general, their sexual partners are often much older than them. This makes it difficult for them to negotiate for safe sex – whether use of condom or other hormonal methods. Where as many of the AGLHIV express willingness to use contraception when given the information and services, they are unable because of failure to negotiate.

Thus, this study also found that AGLHIV are faced with unequal power dynamics whereby they may know about contraception, and what to do, but are unable to act on it due to their inability to negotiate or discuss with their sexual partners or spouses. From the findings, it is evident that the partners have more power and rule over them. Therefore, it puts the AGLHIV in a weaker position as they are not able to negotiate for the sake of their health to use contraception.

*“Yeah, indeed, what XX stated is true, young women and adolescent girls are eight times actually, eight times (HIV prevalence) that of their boys or male counterparts. Why, because their sexual debut age is actually 16 years and that of the boys starts at 18 years. And which means that these adolescent girls mainly have got you know, sexual intercourse, with adults, you know, so intergenerational sexual issues” (Int 16\_PM)*

## **9. Preference for children by partners**

In addition, the study found that the partners/spouses of AGLHIV always prefer to have children with the AGs regardless of their HIV status. It was revealed that this causes fear among most of the AGLHIV to consider contraception and many end up conceiving because they are left without choice except to fulfill the desires and expectations of the partners. Therefore, contraception is not considered in such cases. Additionally, the AGLHIV are also unable to share information related to contraception use for PLHIV, and the required medical procedures to carry out before making the decision to have a child – such as CD4 checking to gauge the immunity levels of an AGLHIV.

*“What I learnt from the discussion is that most of these adolescents are married with older men who want to have children, and this adolescent girl doesn’t have the power*



*to negotiate with them and then also to bargain for her health as well as her child-bearing.” (Int 3\_PLHIV)*

*“You know, men would like to have more children. Yeah, so that’s the tendency casually. men would like to have more children.” (Int 4\_PLHIV)*

## **10. Fear**

The study found that fear is a major factor affecting the use of contraception among the AGLHIV. There is fear of angering the husband/partner once they find out that one is using contraception, there is fear of the repercussions, AGLHIV fear to say No or to negotiate, they fear not to conceive, fear of disclosure of HIV status, and generally live in fear while going through their day to day activities. The fear is incapacitating and curtails personal abilities to act, even in a risky sexual moment when they ought to use contraceptives.

*“Yeah, it is almost like these girls are getting pregnant out of fear and not out of their own choice.”*

*“...they are afraid to put these jadelles and implants because the husband will see. So that is the situation.”*

*“But those who have fear of their husbands, they will just keep it and not disclose to the husband and just continue with the antenatal clinic, where by the chiefs are advocating for the man to come with the wife during antenatal clinic, they even take the outside people, just hiring them and say I will give you this amount if you accompany me as my husband.” (Int 3\_PLHIV)*

## **11. Consent requirements**

The study found that the requirement for spousal consent at the point of service affects AGLHIV to access contraception. It was revealed that most AGLHIV are usually advised or required by service provider to turn up with their parent, spouse/husband or provide proof of permission to take contraception. In this study, the issue of consent is related to two main aspects – fear of disclosing HIV status, and lack of consent from the partners/spouses. Therefore, AGLHIV take it that without fulfilling that requirement, they would not be served since most of them are not always in agreement with their spouses about the use of contraception. The findings further indicate that some AGLHIV hire men to accompany them and pretend as the partners/husbands so that they can access the services, or convince the Traditional Authorities (TA) that the husband is not willing to accompany them. However, the



findings also indicate that some receive permission from the spouses/partners but this is reportedly a small percentage.

The study also found that AGLHIV are required to have the consent of their parents before participating in ASRH/HIV-related programs. However, there is still a level of resistance among most parents/guardians of AGLHIV who are not supportive of contraception. AGLHIV who are under the guardianship of such parents often do not receive permission to participate and therefore do not benefit from the programs/service delivery.

In addition, some of the SRH laws for access for contraception to AGLHIV require parental consent too. This is specific to those below the age of 16. Therefore, accessing and using contraception is still not at the discretion of the AGLHIV, and the situation is worse if the parent is not in agreement/supportive of their decision or desire.

*“The issue is that most women have to seek support from the husband and with our service providers the advice which we usually get is that family planning is to be discussed between spouses. So if the woman comes, she also has to get consent from the other part. So mostly, we have taken it that we need to get consent from the partner so that you can access the family planning methods” (Int 3\_PLHIV)*

*“they (AGLHIV) even take the outside people, just hiring them and say I will give you this amount if you accompany me as my husband. Or sometimes they just go to the chief and say my husband is refusing to accompany me to the clinic, and... some chiefs ... they give the letter that this woman doesn't have a husband, ...” (Int 3\_PLHIV)*

*“In addition, Laws require parental consent for adolescents to access sexual and reproductive health services if under the age of 16.” (Int 8\_PM)*

## **12. Non-disclosure of HIV serostatus**

The findings of this study indicate that the failure and unwillingness by either partner to disclose the HIV status is a key factor affecting the access and use of contraception among AGLHIV in Malawi. This occurs mostly to AGLHIV who seek ante-natal services without their partners and are subjected to an HIV test as required by the policy. Because of this, some AGLHIV do not disclose to their partners and will not want to involve them in their medical arrangements/plans for fear of their status being revealed during the discussions with the service provider. There is a level of discomfort and fear because they do not want to be considered as the source of HIV infection for their partner. Thus, after the antenatal and

childbirth, some drop out of the PMTCT programs where they can access contraception because they are unable to justify the continuous movement to the health facility if they have not revealed their status to the partners. In most cases, the AGLHIV have to seek the services secretly. This equally affects the willingness to seek consent from the partner for contraception services as required by service providers. (the “positive partner” when the other is not, yet, in reality, their partner has not revealed the truth to them)

*“But then the other issue we have come across in our discussions is that most men will still present themselves as if they are not positive. They will pretend to be negative and then they will take the drugs behind the woman’s back and when the woman knows that she is HIV positive, she, in turn, fears to disclose to the partners because the partner has pretended to be HIV negative. So it is like a challenge whereby the woman is not disclosing the status to the husband and the husband is also acting negative and not disclosing the status to the woman. So it is like the woman takes it herself.” (Int 3\_PLHIV)*

*“So just like XXX has mentioned, there are issues of disclosure which are really prevalent in the community to such an extent that some of the young women do have two health passports. One for family planning, and the other for more like general health curatives so that when they have a general issue the husband can look at it and escort them to the hospital. But when it comes to family planning they keep a separate health passport so that the spouse should not get to know necessarily or if at all, any method that they are using, or if at all they are using contraceptives.” (Int 6\_LSP/IP)*

*“...the challenge comes when the woman has gone alone, the HIV test had been done and she had gotten the positive results. Now to disclose that to the husband becomes the problem. So some say that I have heard about my HIV status, but I need to come back with my husband and you have to re-do it as if I do not know, in order to get the man on board. So for those who have managed to convince their husbands and they go together, that is what they have done, and they get all the information and the counseling together and they follow the processes. But those who have fear of their husbands, they will just keep it and not disclose to the husband and just continue with the antenatal clinic” (Int 3\_PLHIV)*

Within school settings: The non-disclosure is happening among both school – to the school leadership, and community-based AGLHIV. It was found that even in schools, AGLHIV are

not disclosing their HIV status to the male colleagues who approach them for relationships, although they go on to have intimate sexual relationships which often become known when one is reported to be pregnant and unable to continue school. The non-disclosure is apparently caused by fear of stigma, and lack of empowerment of the AGLHIV.

*“...you would note that most of the young girls that are living with HIV and AIDS, first of all, it's very hard for them to share. So, most of them are not well known to the authorities in the school. Because it's up to them to say that I'm HIV positive or not. But also to protect them from stigma, that kind of information is confidential among themselves, because sometimes they might be open about their situation, but you know they might not understand the impact of some of these things. So, you have a young girl in school, that might be sexually active, ...and but she might also want to access the commodities. So, you have this young girl, ... and we will assume she's protected because she's in an institution” (Int 20\_DP)*

By parents to AGs: The study also found that most AGs are not always aware of their HIV status until they get pregnant. As such, they are not mindful of seeking any specialized medical services since they are not aware of any special needs relating to their health situation and associated medical vulnerabilities. It was found that it is common to find that most AGs have not been told about their HIV status by their parents.

The study further found that AGLHIV are faced with the challenge of disclosing their need and uptake of contraception to their partners/spouses. Because of this, some AGLHIV maintain two different health passports; one for the general health requirements and another for contraception. This is done to hide the use of contraception from the partners/spouses such that they have no access to the health card which shows their contraception uptake, to prevent any likely confrontations and conflict with the partners/spouse. An example of places where the health passports are hidden in the kitchen, under the confidence that the partner/spouse would rarely check for something in the kitchen; and it was also revealed that some AGLHIV store their health cards at the health facilities.

*“But the issue is the others that are coming to them to say, Okay, I want to have a relationship with you, with these girls, and, oh, they're not empowered enough to tell them that that, um, you know, I'm HIV positive, ... But they will go ahead and have relationships and maybe even have sexual relations with these guys unprotected” (Int 20\_DP)*

*“So, there's a lot of things that we need to unpack in terms of the socio-cultural things that really impact adolescent girls, especially the ones that are HIV positive, because they have not been opening up, we've not equipped them enough, we've not really, you know, strengthened their voices.” (Int 20\_DP)*

### **13. Violence**

The study found that AGLHIV are faced with violence. This happens through different ways; Sexual and gender-based violence (SGBV): The study found that the frequent occurrence of gender-based violence experienced by AGLHIV, often conducted by their partners/spouses limits many from accessing the services. Given that the AGLHIV have no power in the relationship, they frequently experience abuse from their partners if perceived to be using contraceptives when not supported by the partner. Thus gender-based violence remains a critical barrier to access to contraception. SGBV continues to affect girls, with sexual abuse in Malawi often not reported due to gender disparities in homes.

*“Gender-based sexual violence (GBSV) continues to mainly affect girls, with sexual abuse in Malawi often not reported due to gender disparities in homes” (DR)*

*“...and also another factor that is also promoting these issues of lack of uptake to protective, to SRHR is GBV because whenever they're in a relationship with an older person, they completely have no power, and they are usually abused. So, because of that their rights are not respected as such it's difficult for them to prevent HIV, but also to prevent early pregnancies and to prevent STIs.” (Int 16\_PM)*

Emotional and psychological violence, mainly through blame game – It was found that this happens due to several circumstances such as when the girl is the first partner to disclose positive HIV serostatus. AGLHIV are always blamed by the male partners for being the source of the infection and infecting them with HIV if the partner also tests positive. Other practices which AGLHIV reportedly experience include being returned to their parents' home, or enduring the presence of other women within the same house to cater for the sexual needs of the husband who refuses to have sexual intercourse with her for fear of being infected. For others, the spouse marries another wife, while still maintaining her as a wife too, but without conjugal rights.

*“Aaaarhhh what has been reported is the violence which comes when the woman is the first one to say that I have been found with HIV/AIDS.” (Int 3\_PLHIV)*

Domestic conflicts/Intimate partner violence: The study found that adolescent girls experience domestic conflicts with their partners, stemming from hiding information among those who are married. This then results in gender-based violence, which affects adherence to both HIV treatment and contraception.

#### **14. Age and social sensitivity**

In general, the aspect of unmarried adolescent girls using contraception is not well-received by society at large, and there is enormous pressure from community members towards AGs to discourage them from using contraception, especially those who are not yet married. According to the findings, there is a high level of negative social sensitivity to the aspect of adolescents using contraceptives because they are considered to be still young to start using contraception. This includes those living with HIV. It was revealed that only those AGLHIV who go to the health facility with their child/children are qualified to get the contraception services because as mothers, they are considered to already be women/suitable to use. It was found that having a child is taken as the easiest “passport” for an AGLHIV to be granted access to contraception services. As a result, many AGLHIV who are not yet mothers and unmarried have become resigned and avoid going to the facilities regardless of being sexually active.

*“So the social-cultural environment literally, it has an effect, a direct effect on how people would give services to young people. But then I think it's not much of the big challenge, when, let's say a girl, has once been pregnant, and know she has decided to go for different way, to actually go for a choice of contraception. For a lot of girls who have once been pregnant, I think it's very easy for them to easily go to a health facility and easily be assisted than a girl who has never been pregnant or yeah, so yeah.” (Int 5\_LSP/IP)*

*“Aaarrh, I wouldn't say it is easy, because if you do not have a child you do not have a clear passport that you can go through freely. Unless you have a child, then no one questions you but if you do not have a child it is really a challenge to go through those services” (Int 3\_PLHI)*

For others, it was reported that they are frequently questioned about their need for contraception because of their young age. This often happens when they find elderly health workers who always required that AGLHIV explain and justify their need for contraception whenever they request contraception methods such as injectables. It was reported that AGLHIV dislike this

interface between them and the health workers and it has led to many avoiding the health facilities.

*“It's like most of the family planning services are meant for people that are in marriage, and not necessarily somebody who is not married. So, when they go there as a young person, and they say, Can I have an injection or pills even the service providers will ask one or two questions. And sometimes the girls just go back home without taking the contraceptives.” (Int 5\_LSP/IP)*

It was also found that the situation is worse for AGLHIV who live with their parents as they would be monitored closely not to use and the AGLHIV are aware that they do not permit them to access the contraception.

*“Okay, great. So sometimes it's issues with their parents or their guardians who actually would question them to say who, at your age, you're not married, you're still young, why go access the contraceptives? So, It means, that's something that is interpreted as a sign of promiscuity.” (Int 17\_DP)*

At home, they get into conflicts/domestic conflicts with their parents about their use of contraception. So regardless of the availability of contraceptive services in the country and at some of the community facilities, AGLHIV will not easily do it because they don't feel free with adult members of the community present.

*“When they're living with their parents is even much more difficult to access contraceptives, because parents would not accept them to access contraceptives” (Int 7\_LSP/IP)*

*“Like the general expectation that young people are not supposed to get contraceptives. So yeah, even if they have the facility in their area, they will still not access it, because the community and the adults in the community are around and the young people will not be free to access those services, even if they are there.” (Int 15\_PM)*

There is a general expectation that young people are not supposed to use contraceptives.

### **15. Indication of promiscuous behaviour and sexual debut**

In relation to the above, the study found that AGLHIV who are not yet mothers, and unmarried fear to ask for contraception when they go to the health facility or for the group programs because it exposes them as immoral because it means they have a boyfriend or sexual partner. It is also taken as a sign that one is sexually active before marriage, and promiscuous which

most of them are afraid of showing in a group setting or open area at the facility. Therefore, access and use of contraception remain slightly easier for AGLHIV who are mothers than those who do not have children yet.

*“So sometimes it's issues with their parents or their guardians who actually would question them to say who, at your age, you're not married, you're still young, why go access the contraceptives? So, It means, that's something that is interpreted as a sign of promiscuity.” (Int 17\_DP)*

*“So, it's really challenging, because parents will not be comfortable to go with the 12-year-old girls to the health facilities, to receive contraceptives, because, yeah. so, there's a lot of myths to say, A lot of parents still do not accept that Girls can be sexually active at that time. You know, yeah. So, it's like you are encouraging your child to misbehave things like that.” (Int 5\_LSP/IP)*

## **16. Social stigma, judgment, and shame**

The study found that the use of contraception by AGLHIV is also hampered by social stigma. This is largely caused by the lack of privacy at health facilities/contraception service points where AGLHIV reportedly encounter other community members who are known to them. It was reported that such encounters commonly include interrogation of AGLHIV about their needs for contraception given their age and HIV status.

Facility labels: In addition, the labelling of facilities and the different blocks or rooms for integrated services such as PMTCT which provide both HIV/AIDS and contraception for PLHIV was found to be a disservice to the AGLHIV as it contributes to stigma. It was revealed that many AGLHIV dislike the idea as it exposes them to all the people attending the facility on a given day when they go to seek SRH and HIV/AIDS related services including contraception. Therefore, some of them often fear to be seen approaching the service points demarcated rooms. However, it is important to note that integration of services at a facility is embraced but the demarcations are not well-received by PLHIV service users including adolescent girls.

*“At least if the services were integrated then we would have said it is free for everybody to access without fear, without even somebody questioning why, of course, everybody will be free to access services because it is not labelled. but in this case, whereby the services are labelled and the rooms are labelled, it becomes a challenge for someone to access the services.” (Int 3\_PLHIV)*



The stigma and discomfort are also felt/experienced by some of the parents to AGLHIV especially because of the legal requirement for AGs below the age of 13 to be accompanied by a parent before being granted contraception services of any form. For many parents, it is taken as encouraging their children to continue with sexual exploration. In addition, AGLHIV who have already experienced pregnancy are failing to return to school because of stigma and fear. As a result, they resort to having more children since they are unable to re-join school. Others suffer isolation and experience mental health challenges during the period, thus childbearing is taken as the only resort and purpose.

*“So, it's really challenging, because parents will not be comfortable to go with the 12-year-old girls to the health facilities, to receive contraceptives,...” (Int 5\_LSP/IP)*

AGLHIV also feel ashamed to be seen and known as users of contraception and also suffer double stigma at health facilities, for being known to use contraception and for their HIV status too. It was revealed that this stigma is usually demonstrated by the lower cadres at government facilities, who have been trained and allocated to provide short-term acting contraceptive methods to adolescent girls. This creates fear among AGLHIV and limits the freedom to seek the services being provided at health facilities.

*“So basically there is stigma for adolescents in general, and I think there might be a double stigma for adolescents living with HIV because of their status. If you go to the health centers you will see adolescents there and we have what we call the HSAs- Health surveillance assistants who are trained to provide Depo-Provera and pills, short term methods basically, they are government cadres trained to provide these methods but generally, it depends on their attitudes, the attitude of the HSAs, if it is good or if it is not good. So that limits adolescents’ access to long term methods like implants and all that.” (Int 6\_LSP/IP)*

The social stigma surrounding unmarried teen mothers is yet another barrier a young woman has to endure outside being able to access youth-friendly maternal health care

### **17. Low male involvement and interest**

The study also found that male partners are not keen on participating in the community support groups in Malawi. The groups are often attended by AGLHIV and WLHIV (women living with HIV) only. Therefore, only the females are reached with the health information shared, which includes advice on when to conceive, and available family planning methods to use. The females are then entrusted with the task of explaining to their partners/husbands, but it was also



reported that most of them experience difficulty in sharing such information with their partners/husbands.

*“... in support groups ... most of them are women who are in the support group. It means their husbands are not joining the support group. So, usually, the messages will go only to the woman or the young woman, their husband is at home. So, we always ask them to discuss with their husband and then they need to come to one point for them to go to choose which type of method they can use. But sometimes we may have those problems for them to tell the husband, some men will not allow that.” (Int 4\_PLHIV)*

### **18. Negative perception/cultural beliefs attached to contraception**

This study also found that in Malawi, husbands/partners to AGLHIV have negative beliefs about using contraception. They believe that it has negative effects on the body, and therefore, it is not suitable for their adolescent partners because they are still young to use contraception. In addition, some argue that culturally, girls who are already married do not need to use contraception.

*“And most of the adolescents, they are already married. Usually, they may be advised that once you take that (contraception), that means you may not have another child. You see, they say contraceptives are not taken by married people. Yeah, so somebody who's not married, why take the contraceptives?” (Int 4\_PLHIV)*

In the same way, some AGLHIV believe that contraception is meant for married couples, therefore, as unmarried girls, they do not use it even when they are sexually active or living actively.

*“And at the same time, most young people are looking at accessing contraceptives as something for the people that are already married couples that that is actually for them and not for the young people. so that also affects the way how young people look at issues of accessing contraceptives.” (Int 5\_LSP/IP)*

**Contraception considered taboo:** The findings also indicate that contraception use is considered taboo by most parents, and as such it is unacceptable and parents do not allow or encourage AGLHIV to use any of the methods. It was reported that this is worse among AGLHIV who are still living with their parents. It is also seen as taboo when a young girl suggests condom use to her partner.

*“When they’re living with their parents is even much more difficult to access contraceptives, because parents would not accept them to access contraceptives. So, it’s like, it’s a taboo. They wouldn’t encourage it.” (Int 7\_PLHIV)*

Furthermore, due to strong cultural beliefs, contraception has not been accepted among most communities in Malawi, especially for young girls. AGLHIV are shunning away from it to avoid being viewed as contrary to the rest of the community. In such communities, this is preventing its demand among AGLHIV.

*“When I look at the whole situation, I feel like I think there are a couple of issues that may drive this. But the one most important issue is the issue of cultural beliefs. Cultural beliefs I think will play a very important role there. Therefore, for a young adolescent to be seen accessing contraceptives, I think is something that the community has not yet accepted. So, most adolescents (AGLHIV) would shun away from accessing contraceptives. That’s number one from the demand side, ...” (Int 9\_DP)*

Local meaning of contraception: Furthermore, the study found that the local meaning of contraception and the common terminology which is family planning has affected the AGLHIV’s uptake. This is because of the local meaning of the term “family planning” which relates to women who have already started childbearing. This is used as a justification by some service providers who avoid distributing any methods of contraception to AGs in general, as well as AGLHIV who have not had children yet, who are convinced not to use any method.

*“So contraceptives are also referred to as family planning, which we translate in the local language as Kulela. So these are, from the local translation it can only mean that it’s a method for only those who have started childbearing, the translation means it is to be used by those who have already started childbearing. So this is what has affected the usage of contraceptives by the adolescents, or may be those who have not started childbearing”. (Int 6\_LSP/IP)*

However, it was also iterated that the introduction of YFHS in Malawi has slightly changed the atmosphere and made it possible for some service providers to issue contraceptives to AGs who express the need, including those living with HIV/AIDS.

*“But with the coming in of YFHS, at least now some of the adolescents or may be some of the providers are free to provide them to adolescents.” (Int 6\_LSP/IP)*

Dislike of condoms: Furthermore, there is a strong dislike for condoms by male partners to AGLHIV, considering it unfit/unenjoyable to engage in sexual activity with a condom. As a result, they either persuade or force the AGLHIV to leave out the condom or pay more money to those AGLHIV who are engaged in transactional sex.

### **19. Myths and misconceptions**

In relation to the above, the study also found that there are a lot of myths and misconceptions which are hindering AGLHIV from accessing and using contraception in Malawi. The myths and misconceptions deter many of the AGLHIV from taking the right actions regarding contraception. Among the most common is the belief that using contraception at an early age and before marriage signifies that a girl will not get married in the future, and that contraception before one's first-ever conception can lead to infertility. In addition, there are myths and misconceptions in the general community, attached to long term methods that could be more effective to control pregnancy among AGLHIV. Some of the myths include the belief that they will "travel to the heart" and that they can mistakenly go into the woman's womb, which can be very dangerous to one's health.

*"...for fear of maybe myths and misconception that maybe they will not have children in future. They say you cannot use the contraceptives when you have not started childbearing..." (Int 14\_PM)*

*"and also there are some beliefs naturally to say, once you take these, you may have some problems with your body Yeah, so culturally there's that belief." (Int 4\_PLHIV)*

*"And also, in the general population there are also myths pertaining to longer term methods like implants that they will travel to the heart, or that by mistake it will go into the womb of the woman, and things like that." (Int 6\_LSP/IP)*

*"... there are so many myths and misconceptions that are very crazy. You can wonder where these myths and misconceptions are coming from. These are indeed hindering the young people from accessing contraception. Like the crazy myths that we have heard is when a young person access or locates contraception before he or she gets married. That one will not conceive, in the near future. those are the misconceptions that are going around and there are so many crazy cultural beliefs that are available in different communities depending on the cultural aspect of that region. ...when you have got an interaction with a group of young people, they will really tell you that we cannot continue seeking for the service that we know for sure, it will harm our life*

*because of the myths and misconceptions that are going around. So, the problem that we have here we have is the myths and misconceptions.” (Int 2\_LSP/IP)*

## **20. Inconsistent use of contraceptives**

This study also found that some AGLHIV are inconsistent with using contraception. The inconsistency also relates to the methods of contraception. While some may say they use condoms, it was reported that it is common behaviour among AGLHIV to use it for only a short time after which they shift to unprotected sexual activity but without seeking an alternative method to replace the condoms.

*“It is there but probably access to contraception and then the use of the contraception and consistency in terms of the contraceptive methods that they use...after a short time they come back and say they dropped the condoms too” (Int 7\_PLHIV)*

## **21. Cultural rights and practice**

The study also found that the use of contraception among AGLHIV is affected by practices such as initiation ceremonies through which AGs are required/trained/prepared culturally to carry out activities, commonly of sexual nature as rights of passage into womanhood. Such cultural rites/ceremonies are organized for AGs aged 10-15 because by the age of 15 years one should have gone through it as a sign of adulthood because it is a preparation for womanhood.

*“Actually, it’s like from 12, sometimes even 10 to 15. Because by 15 They already should already have finished with the initiation.” (Int 7\_PLHIV)*

*“But then between let's say 15 to 19, that's when you'd find that most of them would be more sexually active. Although, of course, it's not unusual to find cases of between 10 and 15 being sexually active, and these are really enabled by cultural factors where we know young girls begin to go through some initiation processes, the initiation process is much more ... it is a preparation to womanhood. And in some cases, we hear that there is actually... (synonym for sexual intercourse) of the of these girls by unidentified males within the community.” (Int 10\_LSP/IP)*

As a practice those who fail to go through such initiation practices are not considered as adults henceforth, indirectly making it a mandatory exercise. However, during such ceremonies, AGs are prepared and initiated into sexual activity (sexually/sexually prepared/for sexual engagement) with older men, and encouraged to practice unprotected sex because they have attained the age of sex. Thus, the use of contraception of any nature is not promoted during such events. For many AGs, it has been the source of both HIV infection and pregnancy or

pregnancy alone for those who are already living with HIV/AIDS. This is reportedly common in the lakeshore areas and districts of Mangochi and Zomba, where “Kinamwali”- a passage of rights ceremony is often conducted.

*“Then there are issues of initiation, Whereby, if they don't go through cultural rights, people will say you are not an adult and so on and so forth. So, to prove that they're adults, and they have become of age they are pressurized into having unprotected sex regardless of their HIV status.” (Int 7\_PLHIV)*

*“... a specific name for instance, in areas where they live, the lakeshore areas of Mangochi and then Zomba area we have what we call “Kinamwali”. “Kinamwali” is like initiation rites whereby if they become of age, they take the adolescents to the river and they stay there for about three weeks. There they're given a lot of counseling, and once they come out of that place, is like they need to prove that they are really of age, and then they are also taught that the no man is ... (forbidden) for them. They can take on any man. So those are the things ...” (Int 7\_PLHIV)*

Another cultural practice found to be affecting AGLHIV's uptake of contraception and consequently exposing AGs to both HIV and unwanted pregnancy is the practice of providing AGs as helpers “blankets” to traditional leaders, in a practice code-named as the “Chiefs' blanket”. During the season of cultural ceremonies, all women are mandated to send their AGs to take care of the chiefs. Whereas the care is not necessarily defined to be sexual, the practice is said to involve close care such as preparing bath water for the elders/chiefs, practices which expose the AGs to sexual activity.

*“Yeah, the thing is the older men would like to take advantage because they take the girls as helpers during these kinds of ceremonies. So, for instance, say, I'll give you another cultural aspect...It's like the Chief's blanket. Yeah, chiefs' blanket. So, when there like some ceremonies, the women all the women will send young girls to take care of the elders. Not necessarily sexually, but maybe to bring them water and to bring them water for bathing and as caretakers. So, that also exposes the girls into sexual activity with the elders.” (Int 7\_PLHIV)*

Furthermore, it was also revealed that during such initiation events, girls who are also taken as “helpers” to adult men are sexually exploited and it is unlikely that contraceptives are considered since they are not part of the initiation counselling.

*“...but that is done in in the context of giving respect to elders, but the elders take advantage and sometimes abuse the girls.” (Int 7\_PLHIV)*

It remains important to note that during such cultural events, the use of contraception is unaccepted or unthought of, and it is unlikely that AGs would be aware of any form of SRH related services. Thus, contributing to the high rates of HIV infection and teenage pregnancies which are often unplanned, unexpected, and in most cases unwanted.

## **22. Perpetuation of harmful cultural content**

The study found that AGLHIV are exposed to a lot of cultural content through initiation programs and events which promote sexual pleasure for men without consideration of protective measures against HIV or pregnancy. Similarly, men who participate in such activities are trained culturally and encouraged to have as many women as possible as proof of manhood, and consideration of protective sexual activity is not promoted.

*“...because we know that there are initiations that happen. and looking at the culture, different culture systems, when the girl is coming of age, she is trained, and she's been taught, yeah, she's been taught about how to take care of herself, how to please a man, but they don't really talk about issues around protection. You know, for instance, this girl is maybe HIV positive. And she's she knows she's HIV positive. But because maybe she's gone through this initial ceremony, they have not talked about it, then how does she, how have you given a skill so that, to equip her, so that, when she's in this situation, she can be able to demand for it?” (Int 20\_DP)*

*“The cultural issues, through the leadership structure, where you've got the traditional areas headed by traditional chiefs...up to the regional levels, it is really a big liability in terms of perpetuation of cultural content that is harmful... “ (Int 10\_LSP/IP)*

## **23. Social pressure relating to fertility**

For children/To bear children: The study found that many AGLHIV are pressured to have children as soon as they get into the adolescence stage. This pressure reportedly stems from the adult members of society who encourage to bear children as early as possible since it is the main role of the woman. As a result, many of them are made to focus only on conceiving, and using contraception is not a possible consideration. This also couples with the finding that most unmarried AGs are pressured into unprotected sex regardless of their HIV status, and discouraged from using contraception until a certain time when they have had at least one or two children.

For marriage: This study also found credible evidence that AGLHIV are pressured into marriage. It was reported that it is the pressure of her family or pressure of her soon to be family in law that an identified girl enters into the marriage, which is subsequently followed by expectations of bearing children as soon as one enters into the marriage. This leaves little room for family planning and the use of modern contraception methods to delay conception.

*“Because I think, again, with a lot of underage marriages, it's not necessarily that it's a girl's decision, you know that wouldn't have been her first choice for her life, right. But it's the pressure of her family or pressure of her soon-to-be family-in-law that she entered into the marriage. And she does and then she's, you know, in school one week and out of school the next week, it's just that drastic of a change.” (Int 18\_DP)*

Proving fertility: The study also found that AGLHIV always prefer to test and prove their fertility, the ability to bear children before they can use contraception. Therefore, many prefer to have at least their first child to fit within the community and among peers before considering contraception.

*“So yes, it's low (contraception uptake), but there are also issues, barriers that affect youth uptake towards contraception. Others... they will first want to prove their fertility... culturally, they think one shouldn't take contraceptives unless her fertility has been proven. At least she should have a child first that's when she should access contraceptives, so those are the cultural issues.” (Int 17\_DP)*

*“They're having these children out of wedlock, most of them. So, there are a lot of cultural factors surrounding, I mean, in the communities where these young people live, which pressurize them to having children at an early age, alright.” (Int 7\_PLHIV)*

About their status: Furthermore, some AGLHIV are pressured to have children because of the belief by family members that they would die soon. They are forcefully advised to consider childbirth as soon as possible.

*“Yeah, I think there's a whole array of issues affecting specifically adolescents who are living with HIV. I think you have put it well that sometimes, they're not well taken care of. One thing they're told is No, you are already going to die. Now, you just need to do this or you know, things like those.” (Int 9\_DP)*

## **24. Judgmental attitude**

The study found that some AGLHIV are discouraged to approach health facilities for contraception because of the poor and judgmental attitude displayed towards them by service



providers. This finding was mainly reported by implementing partner organizations that reported that the rate of complaints from AGLHIV about their experiences with service providers is high and mainly relates to being judged about their decision to seek and use family planning services/contraception. This is also attributed to the fact that most service providers are from the same community where the AGLHIV live and most times, they behave similarly as the rest of the community towards AGLHIV who wish to utilize contraception services. To the girls, the service providers are sometimes seen as an extension of the society/community and their regressive behaviours.

*“But then, most young people have also given their different views...that there is still need for a change of environment for young people, to be more inclusive in such a way that they don't have to be judged let's say if they go to a facility for any kind of a service. But you still find that the very same health workers who were trained to respond to the needs of the young people are sometimes judgmental.” (Int 5\_LSP/IP)*

*“You know ... because obviously, they are from the community and they have two faces, being a member of the community and being a health worker or provider, they sometimes put up their personal beliefs, even though they are supposed to respond to the needs of young people.” (Int 5\_LSP/IP)*

## **25. Lack of social support**

The study further found that AGLHIV do not have adequate social capital/support that is required to do exercise their agency, seek services, and provide legal support when needed. In most cases, their sex partners are unwilling to accompany them for services, or offer them consent as required by service providers. Furthermore, it was also found that some parents are uncomfortable accompanying their daughters to the facilities to get contraception services. This is common among those AGLHIV who are below the age of 13 years. By law and policy, these are required to be accompanied by their parent.

*“...we still have that kind of clause to say that at a particular age, you cannot go and access the services on your own, you still need to bring a parent. So, it's really challenging, because parents will not be comfortable to go with the 12-year-old girls to the health facilities, to receive contraceptives, because, ... there's a lot a lot of myths..., A lot of parents still do not accept that girls can be sexually active at that time” (Int 3\_PLHIV Rep)*



*“... we have had such situations where women are married, and their husbands do not want them to go and access the contraceptives. So, a lot of men unfortunately, in our society, they are not for contraceptives, they would want to make the women pregnant immediately after a pregnancy, ... so, a lot of them are not really in support of contraceptives. So, it would be really hard for like a boyfriend, or a young couple to say let's go to the health facility to access the services.” (Int 6\_LSP/IP)*

Discomfort about sexuality discussions: This study also found that in Malawi, adults in the community feel uncomfortable discussing sex and reproductive health issues with young people in general. This equally makes it difficult for AGLHIV to open up and freely seek support or information about contraception. Many lack a social network that they can rely on for any form of support or consultation regarding risky and violent situations they may find themselves in, as well as motivational discussions relating to the usage of contraception.

*“AGLHIV as part of MARPs (Most at-risk population), lack access to any social networks” (DR)*

## **26. Social economic situation**

This study also found that socio-economic factors such as; Persistent low levels of income and poverty affect AGLHIV's use of contraception. This is in such a way that the poor social economics perpetuates cultural issues which then become blind spots to the community, making it difficult for AGLHIV to behave any differently or seek specialized services. In addition, poverty has a causal link to all other key factors such as school dropout because of lack of school requirements, and as a result, many AGLHIV are forced to take gap years from school. This makes the uptake of family planning products difficult and also perpetuates allegations of the culture's negative influence.

*“...people have got not so much hope. And this now brings in the aspect of this social economics, the household income, poverty levels, you know, a cycle of poverty that keeps people really in a situation where they cannot leave the village. And then, people tend therefore to hide under culture.” (Int 10\_LSP/IP)*

Low levels of school enrolment among AGLHIV: This study found that the levels of school enrolment among AGLHIV are low. Consequently, many of the AGLHIV are out of school and illiterate. These remain uninformed, ignorant of ongoing national programs, and sometimes remain unreached if they are not within close distance to the intervention catchment areas.

Since they are not in school they may also be omitted from the CSE program if launched for school attending children.

**Perpetual School dropping:** In addition, those who have ever attended school dropped out during the adolescence stage and either did not complete the primary level of education or did not pursue higher levels after. This is attributed to both social and economic factors, including lack of tuition fees and school requirements, as well as education not being prioritized for girls. As a result, they get involved in several cultural practices which influence their way of thinking and become acceptable norms to them too. Such practices have been reported earlier on to be detrimental and contribute a fair extent to the AGs perceptions of contraception, and their ability to help themselves or act positively. Consequently, many have low literacy levels and their chances of succeeding in life are low because they are entangled within the cultural web. (however, school dropping is also caused by teenage pregnancy with girls dropping out of school when they get pregnant, and do not return to school after childbirth. Consequently, there is a link between early pregnancy and education, in terms of lower education attainment levels. This also creates a link between early pregnancy and lower socio-economic levels because of lower-earning rates throughout the life of an AG who was not able to complete education.

*“There's lots of data to show that, but I think that what's at the heart of it is poverty, because Malawi is, I believe, the sixth poorest nation in the world. And it's not just a matter of a girl. It's not just this, it's not just as easy as saying, a girl should stay in school, it costs a family money to keep a girl in school, primary school is free in Malawi. But there are still costs of books and sometimes still some random school fees, the cost of a uniform, and school supplies. And in secondary school, Malawi is moving toward that being a free service as well. But it's not there yet. And so, so many girls, don't. It's not just that we see girls dropping out because they get married or get pregnant young. But it's because their families can't keep affording to send them to school. Whether that's because they choose to keep their brothers in school over the daughters, whether it's because multiple children in the family are dropping out from one year to the next, because there was a bad tobacco crop, for example, that didn't give the family the income, we see a lot of girls who essentially are forced to take gap years, right. So, the family cannot afford to send them to school one year, and so they do end up sometimes coming back to school, but then they're a year or two behind, sometimes more. And so, I think that, from what I've seen, is that poverty is driving many of these issues because*

*poverty is also often driving the reason girls are forced into underage marriages” (Int 18\_DP)*

The practice of transactional sex among AGLHIV: The findings of this study indicate that AGLHIV engage in transactional sex, usually with older men for the benefit of materials like food for their families, shoes for school, or clothing. according to the study findings, this is pre-dominant in areas with sugarcane plantations/farms, and it is rampant because casual laborers hired to work on the farms usually have access to daily income which is used to seduce the girls. In such instances, using contraception is not considered because it is an on-and-off affair. Consequently, this has fuelled pregnancy among AGLHIV and other AGs living in those areas. Marriage is also seen as an incentive, because sending a daughter into marriage is equated to one less mouth to feed, and one less person to provide for or take care of. This is because the young girls are sent away to live with their spouses and future in-laws.

#### **27. Individual behaviour, inabilities and choices (Lack of individual empowerment)**

This study equally found that the use of contraception by AGLHIV is limited by individual behavioural inabilities, and the process of behaviour change which is not immediate. Whereas some of the AGLHIV have been exposed to information on SRHR and are constantly reached with services, the responsibility to make the right action remains with them as individuals since program and service providers cannot use force to ensure that they take or use contraception. It is also the choice they make as individuals at the moments when they need to use contraception. Thus, a slow response.

#### **28. Child marriage and its repetitive occurrence**

The study also found that child marriage which occurs repetitively to some of the AGLHIV, especially between the ages of 13-16 years is also contributing to low contraception use among the group. It was revealed that many of the AGLHIV are married off at early ages, but it is common that they leave the marriage after either one or two years, and re-marry elsewhere. During each marital occurrence, childbirth is expected, which makes consideration for contraception difficult or impossible. It was reported that it is common to find that by the fourth marriage, an AGLHIV has already four children from previous marriages.

It was reported that by the age of 18, half of the girls aged 10-24 are married in Malawi. Child marriage further continues the negative cycle for girls, keeping them out of school and limiting their future life opportunities. It may also increase their vulnerability to violence. A married

girl or woman, especially those from patrilineal communities, often leaves her maternal home to live with her husband and his family. Power and authority in the home is customarily held by men and older women, and this can place young married girls at greater risk of abuse and violence

### **29. Mistrust by partners**

According to the study findings, AGLHIV who use contraception are perceived by their partners to be having multiple relationships. In addition, they are perceived to be having covert activities and considered to be “street girls”, a term which is loosely used to refer to female sex workers or an untrusted partner. To counteract the mistrust, many end up abandoning contraception, and the effect is seen in frequent pregnancies among AGLHIV.

*“Usually, I’ve heard people, adolescents saying that no, I think when we’re seen by our spouses or boyfriends using the contraceptives, they think we are not straight in our dealings. Meaning that they are looked upon like a street girl.” (Int 9\_DP)*

### **30. Provider bias and ill-treatment of AGLHIV**

The study also found that AGLHIV are affected by the nature of treatment received from the service provider. As such, many are discouraged to visit the facilities to seek the contraceptives

*“The other issue could be probably the way they are treated by service providers. So, we are looking into issues of providers attitudes toward the way they treated these young girls... the youth.” (Int 17\_DP)*

### **31. Religious restrictions**

This study additionally found that in Malawi, some religions don't actually condone or promote or allow their faithful to be taking contraceptives. This is in general not just for the youth but for the adults too, they don't allow them and it's even worse when it's the youth.

*“So also, from the religious point of view, we know that some religions don't actually condone or promote or allow their faithful to be taking contraceptives. This is in general not just for the youth for the adults, they don't allow them and it's even worse when it's the youth.” (Int DP)*

### **32. Culture of silence**

The study also found that the culture of silence about issues relating to sex and sexuality affect the use of contraception among AGLHIV. In Malawi, it is culturally forbidden to openly discuss matters relating to sex and sexuality. This is limiting the level of discussion among young people living with HIV and in turn limiting their awareness levels about available

services, controlling childbirth using modern methods of contraception, dealing with compromising situations, addressing violence, and where to find the services for AGLHIV. Therefore, most AGLHIV especially those in schools are shy to discuss or seek information and any help about contraception.

*“... there's a lot of behavioural issues that are happening in universities, in colleges, but you don't have this conversation happening among young people in the universities, you know. this conversation is not happening, issues around the compromising, even pills, because these are commodities that they will need so they don't get pregnant out of wedlock, so they don't get pregnant when they're not ready for it either. These things are not really talked about. We are like watching them when I question all the young people, they're active nowadays, they're doing these things, but we're not running around for the people to put them together to discuss these things and discuss to have solutions. Because they have solutions as young people as well, but how we can come in to support...” (Int 20\_DP)*

*“But of course, it's very difficult to really be able to get access to women who've been abused. The silence is a critical barrier.” (Int 10\_LSP/IP)*

### **33. Side effects of contraception**

The fear of side effects was also found as a deterring factor to most AGLHIV. The study found that some AGLHIV fear the likely side-effects because they are of a young age and assume that taking contraception early in life would culminate into dangerous effects on their lives. This fear is coupled with the reality of their HIV status since many are already on ART, which is equally life-long.

### **34. Preference for short-term methods**

The study also found that there is a predominance of short-term methods of contraception and AGLHIV often tend to opt for them. These include condoms, injectables, and oral pills. However, the short-term methods were reported to be less effective among the group because of inconsistent and incorrect usage/uptake. The short-term methods are predominant among AGLHIV because they are the most preferred method of choice by women in general in Malawi, common among the population, and AGLHIV are more aware of them too.

*“... they tend to utilize the injectables which most women also tend to utilize in the community, and most of them get to utilize methods which they know of or which the*

*majority of them are aware of. So which tends to restrict the usage of long-acting and reversible methods of contraceptives.” (Int 6\_LSP/IP)*

*“Most of them do opt for short-term methods which are not necessarily 98 or 97 percent effective. So most of them might be utilizing mainly condoms which they do not necessarily know how to utilize them effectively.” (Int 6\_LSP/IP)*

The short-term methods, specifically the injectables are also preferred due to disclosure challenges that are attached to the long-term methods such as IUDs, and implants. Similarly, short-term methods are used as a coping strategy against partners who are not supportive of contraception, as AGLHIV are able to take them once for several months – such as Depo-Provera (injectables) in situations where movement is restricted.

*“And then the other is that there is less discomfort on disclosure if you take the shorter terms method-the injectables basically.” (Int 6\_LSP/IP)*

### 35. Limited prioritization for family planning by AGLHIV

The study found that family planning is not taken as an important aspect by AGLHIV in Malawi. Thus, while services may be available, AGLHIV are pre-occupied by other aspects of their homes and lives, and child birth but controlling it is not seen as necessary to some. It was reported that some shun activities which are targeted specifically for them to improve their perception and uptake of the contraceptives.

*“First I think is they do not see family planning as a concern to them. The word family planning itself...” (Int 6\_LSP/IP)*

However, it can be argued that this is due to many other issues as alluded to in earlier sections.

### **36. Low levels of comprehensive knowledge about HIV/AIDS and modern contraception among the population**

It was found that less than half (42%) of young women and (45%) of young men aged 15 to 24 years fully understand HIV and AIDS. Young women are even less informed about condoms, with only 32% citing condom use as an effective prevention strategy as compared to over 42% of young men. It was found that AGLHIV have limited access to SRHR information and resources in general, due to cultural restrictions and coercion.

*“They are in a position where many have limited access to information, ... and possess limited SRH/HIV information” (DR)*

### **37. Poor risk perception among AGLHIV**

The study further found that AGLHIV are in most cases unable to realize that they are at risk. This refers to the risk of pregnancy, as well as abuse and violations. Thus, many are unable to act in time to escape or mitigate the barriers they often face especially with their sexual partners. This is specifically in relation to pregnancy and experiences of intimate partner violence.

*“Young women lack adequate SRH/HIV information and/or the ability to communicate with peers, potential sex partners and adults on their needs and often do not realize they are at risk.” (DR)*

#### **5.2.3 Discussion on structural and socio-cultural issues**

Today, more than ever, the world has a large population of adolescents and this makes their sexual and reproductive health (SRH) needs such as contraception a great concern. Therefore, there is need to recognize how important it is to make access to needed health services easy and less cumbersome to facilitate the protection of adolescents as they go through the stage, given their added potential for the demographic dividends. Therefore, the necessity to invest in adolescent SRH and rights (SRHR) is warranted by the strong public health, human rights and economic reasons (Chandra-Mouli et al., 2015b) and the anticipated outcomes for adolescent girls, as compared to the effects of not doing so which may include a vicious cycle of ill health and socio-economic deprivation. The general lack of access to health services, youth-friendly service provision, and the lack of adequate information and knowledge on what is and what is not right or acceptable as modelled by the socio-cultural and structural aspects of the environments within which adolescent girls live makes the vulnerability of adolescent girls living with HIV/AIDS even more complex, if clear guidance is not provided to both the adolescent service seekers and the providers.

#### **Legal and social status of girls and women**

The constitution of Malawi recognizes women's rights to full and equal protection by the law and non-discrimination on the basis of their gender and marital status. The constitution equally calls for the elimination of harmful customs and practices that discriminate against women. However, the enjoyment of women's rights is largely restricted and this widens the gender inequality gap. In addition, there exists patriarchal beliefs and attitudes which perpetuate harm and shape and affect the lives of women and girls in general across all spheres of their existence, more so in the rural areas.



A study conducted in South Africa showed that male dominated societies accord to women a lower status than the men, coupled with high level of male control in the relationship (Biseck; et al., 2015). Thus, women occupy an unequal status, and this is further worsened by the interplay of general poverty and discriminatory treatment in family and social life. In general, girls and women occupy a low level in society in Malawi. This traditionally low status of girls and women is embedded within cultural beliefs and it undermines girls' ability to oppose the opinions of spouses, parents, care takers and community leaders. Women's inferior status allows them minimal or no power at all to initiate discussions relating to fertility control, with evidence across SSA that such discussion result into violence (UNWOMEN, 2018).

The study also found that AGLHIV have no power to exercise any form of agency. According to UNFPA, power, voice and choice shape the degree of agency that an individual can have in a relationship (UNFPA, 2019). This applies to interpersonal relationships and relationships with institutions such as health facilities. The three features are gender-dependent and have a large impact on the sexuality and reproductive decisions of women and girls. The power of an individual girl, their voice and choice are therefore key in aiding them to articulate their needs and advocate for preferred choices in relation to contraception and the HIV condition they may be dealing with. However, naturally as adolescents, they have little power, voice and choice, making it more challenging for them to manoeuvre the numerous challenges to access of care. With specific reference to Malawi, this is further worsened by the socio-cultural context.

Furthermore, other research from low and middle-income countries indicates that adolescent girls' low autonomy is a critical barrier to the use of modern family planning methods or contraception (Silverman et al., 2020). This is largely backed by social norms which place the power to make decisions to use contraception in the hands of male partners, including the choice of method. Due to this reality, it is also reported that male partners often act as active obstacles by intentionally blocking girls' access to family planning services and subverting reproductive autonomy (Silverman et al., 2020). It is therefore imperative to often recognize such significant barriers which exist at multiple levels in the life of an AGLHIV.

Traditional attitudes and practices lay emphasis on preparing girls for marriage and sexual partnership more than their economic and development abilities (Abuogi, 2018); (Biseck; et al., 2015). This study unearthed similar findings in Malawi. This emphasis of traditional roles limits the participation of girls in development activities and perpetuates practices such as forced marriage which lower the status of girls and women. While customary procedures are



in place to address criminal elements of certain gender-based crimes, they still discriminate largely against women (Watch, 2014) and this leaves women who fall victim without adequate remedy – meaning that they would need to think of personal capabilities to address any form of harm that they may be subjected to in the process of seeking health services such as contraception in the rural areas. Research also shows that in countries where the formal justice system seems inaccessible, victims are lured to the informal system where “justice” is quickly offered through pseudo procedures, and victims are awarded petty compensations (Watch, 2014). However, this leaves the issues unresolved, and limit the victims’ chances to accessing psychosocial support and related health services, leading to other poor health outcomes in the process. Governments are mandated to enact protective policies in relation to international human rights and health frameworks to ensure unrestricted reach to mainly SRH services for adolescents and people living with HIV.

In ensuring human rights within contraceptive programmes, evidence shows that the respect, protection and fulfilment of human rights contributes to positive SRH outcomes (UNFPA, 2018). The provision of contraceptive information and services that respect individual privacy, confidentiality and informed choice, along with a wide range of safe contraceptive methods, would increase AGLHIV’s satisfaction and continued use of contraception.

In relation to availability of contraception services and methods, and other structural matters, a core state obligation in connection with the right to health is to ensure the availability, accessibility, acceptability and quality of services, according to WHO (WHO, 2017). In order for this to be achieved, functioning public health and health-care facilities, goods and services, as well as programmes, have to be available in sufficient quantity within the country. The characteristics of the facilities, goods and services may vary depending on factors such as the country’s developmental level. However, governments have the role of addressing the underlying determinants and providing the basics, such as provision of rooms for privacy of patients, appropriate clinic hours, and other health-related buildings such as those dedicated as youth friendly corners, and appropriately trained medical and professional personnel (WHO, 2017).

As part of this core obligation, governments are also to ensure that the commodities listed in national formularies are based on the WHO model list of essential medicines, which guides the procurement and supply of medicines in the public sector (WHO, 2017). A wide range of

contraceptive methods is included in the core list of essential medicines. If such procedures are followed, issues related to stock-outs of preferred contraception methods would be solved.

However, similar to the findings of this study, in many low- and middle-income countries, contraceptives such as condoms (male and female), oral contraceptives, intrauterine devices (IUDs), hormonal injectable contraceptives, implants and emergency contraception, are often lacking or not available (Self et al., 2018), owing to inadequate laws and policies, inefficient systems of supply and logistics management, or low or absent funding. The lack of availability may also result from ideology-based policies regarding the range of medicines or services. Given the sensitivity in Malawi regarding the use of contraception by AGLHIV and AGs in general, it can be argued that this is the case. In addition, the structural challenges identified in this study also speak to ill preparation for implementation of AYPFHS.

Scientific evidence shows that there are barriers in using contraception by adolescent girls in SSA. Adolescents mainly face two different kinds of barriers in trying to access and use contraception. Similar to the study findings, the first set of barriers is in obtaining of contraceptives. In many poor communities of low and middle-income countries (LMICs), contraceptive methods are not easily available to adults or to adolescents. Furthermore, even when contraceptive methods are available, laws and policies prevent their provision to unmarried adolescents or to those under a certain age (Ba et al., 2019). Apart from South Africa, it does not appear that countries in the region have made provision at a policy level for the age at which adolescents can access contraception (UNFPA, 2017). This omission and lack of clarity provides the opportunity for adolescent SRHR to be denied further in some communities. Even where there are no legal restrictions, health workers in many places refuse to provide unmarried adolescents with contraceptive information and services because they do not approve of premarital sexual activity (Ba et al., 2019). Thus, various social, cultural and religious factors create inhibitive environment (Morris and Rushwan, 2015) especially for those who are out of marriage but yet sexually active. Adolescent girls are ignored in some contexts when they turn up at health facilities for contraception (Morris and Rushwan, 2015), revealing an overall deficiency in youth-friendly services provision. The same has been identified in Malawi.

The second set of barriers experienced is in using the contraception. While adolescents may access the contraception, social pressure such as the expectation to bear children prevents those who are married from using it (Abuogi, 2018); (Ba et al., 2019), (Chandra-Mouli; et al.,

2014b). As reported by several studies and reports, contraception is usually considered after the first pregnancy, and consistence is equally a challenge for most adolescents (Chandra-Mouli; et al., 2014a), which further points to the likelihood of bottlenecks which affect the continuous access of the contraceptives. Such barriers have the potential to limit young women's determination to use contraceptive services because women who are self-motivated to prevent pregnancy and are able to reach a service delivery point will most-likely encounter difficulty in the process. Thus, AGs' desire for contraception may not necessarily result into uptake due to potential failure to access desired method or any contraception at all (Deitch and Stark, 2019). Yet at a personal level, young girls' health care seeking behaviour is limited by fear, lack of information, stigma and shame (Morris and Rushwan, 2015), among other factors. The role played by social beliefs and values is key and central issue of focus (Chicoş et al., 2017) and can best be addressed through policy formulation by governments.

### **Equity in health care**

Inequalities in health are rooted in inequities in society. Closing the health gap between socially and educationally disadvantaged people and more advantaged people demands for policies that will improve access to health-enhancing goods and services, and create supportive environments. Such policies would offer high priority to underprivileged and vulnerable groups such as AGLHIV. Equal access to health services, particularly community health care, is a vital aspect of equity in health. A basic principle of social justice is to ensure that people have access to the essentials for a healthy and satisfying life.

The Discrimination poses a serious threat to SRH for many people. The legal and social restrictions on girls' access to contraceptive information and services affects study also highlighted experiences of discrimination at the point of service. their ability to take decisions regarding their sexual and reproductive health and lives, they are a manifestation of discrimination on the basis of sex or gender (UNFPA, 2017), and often contribute to poor physical and mental health. Discrimination on the grounds of age and marital status is also manifested through the fact that some AGLHIV are denied services at family planning clinics because of their age, while others are denied health services because they are HIV positive. Some individuals suffer discrimination on multiple grounds such as gender, race, socioeconomic status and health status, further affirming the findings of this study. Such practices reflect multiple forms of discrimination, have significant impacts on health, and are a violation of numerous human rights. As part of their human rights commitments, states must strive to eliminate all forms of discrimination and to promote equality by ensuring that

vulnerable groups such as AGLHIV have access to information and services. All individuals have the right to decide the number and spacing of children and the right to make a family on an equal basis. Government family planning policies and services should therefore not be discriminatory or compulsory for AGLHIV given their unique condition. Laws, regulations and policies, including those related to contraceptive information and services, should not be discriminatory and should aim at eliminating stereotypes and discriminatory attitudes that lead to intimidating practices as evidenced in the findings of this study.

### **Preference for children and high momentum for marriage**

Factors that influence and determine the desire of women living with HIV to have or not have children are multiple and complex. These include: age, marital, educational and socio-economic status, cultural and religious beliefs, sexual behaviour as well as family size and losses, access to family planning services, and beliefs and attitudes of providers. In resource-poor settings, notably in sub-Saharan Africa, these factors may be greatly influenced by the traditional role of women, the importance given to motherhood and the desire of the woman's partner for children. Although high levels of pregnancies have been observed in women and girls with HIV, a number of studies have now shown that these pregnancies are unintentional and unwelcome to the individuals who become pregnant. One analysis of a previous prospective cohort study over two years of women in rural Uganda showed that at any time over 93% of women repeatedly said they did not want more children, yet pregnancy incidence increased over the years (Wanyenze et al., 2015). Further analysis revealed that contraception use in general and condom use in particular was dependent upon the woman's partner's approval and cooperation, similar to the findings of this study.

### **Coercion and preference for children by partner**

The study also found that AGLHIV are coerced into pregnancy by their partners who often prefer to have more children. This is sometimes out of their own wish. Another ancient study in Nairobi revealed that women living with HIV who had already birthed 2-3 children were reportedly more likely to not want more children, as compared to HIV negative women (Hagey et al., 2015). And the reasons surrounded concern for their own health, difficulties caring for the children they already had, and uncertainties relating to vertical transmission if they became pregnant again.

Another study points out that often, men and women are faced with the pressure to prove their fertility because reproduction is seen as a fundamental part of the social ideals of both masculinity and femininity (UNFPA, 2019). Thus, both men and women may be pressured to prove their fertility within the early periods of their marital relationships. This is particularly common in contexts which attach a lot of preference and importance to sons. In a way, this also reveals the deeply held views about the value attached to males against females, and intrinsic values attached to such inequitable norms, which exert enormous pressure on women to bear more children in search for sons (UNFPA, 2019). It is important to highlight the limited voice, power and choice that women are stripped of in such circumstances. Thus, this implores the need of having accurate policies which can counteract social ideals which an individual AGLHIV or other young women may not be able to independently evade, given their vulnerable state.

### **Violence against women and girls**

Gender-based violence (GBV) and violence against women and girls (VAWG), is a global pandemic that affects 1 in 3 women in their lifetime (UNFPA, 2018). It ranges from physical, sexual, emotional, and other family violence such as child marriage and early child bearing. Whereas the numbers remain staggering, most women world-wide have at least experienced physical or sexual violence, and 37% of women will experience physical or sexual violence perpetuated by an intimate partner or non-partner in their lifetimes (Wood et al., 2020). GBV or VAWG has enormous consequences for women's physical health as well as their sexual and reproductive health. It is not only devastating for the survivors of violence and their families, but also entails significant social and economic costs for communities, economies, and it is a fundamental violation of women's human rights, and become a public health concern across countries (Silverman et al., 2020) -with all the adverse effects. Similar to the findings of this study, several studies on women's health across countries found that that younger women, particularly those aged 15-19 years, and those with lower levels of education faced a higher risk of physical or sexual violence at the hands of a partner in almost all the countries studied (UNFPA, 2018). It is also reported that one in every three women worldwide will experience physical or sexual violence during her lifetime (Silverman et al., 2020), a situation which leaves most women subdued in matters relating to SRH, and often resulting in increased risk of infections and unwanted pregnancies.

The East and Southern Africa (ESA) region has high rates of all forms of violence against women and girls, with 20% of girls in seven countries reporting to have experienced it. This is

maintained mainly by persistent harmful gender norms and poverty. In some communities, men have a sense of authority over women, feel entitled to their bodies and assign themselves the role of policing women's behaviour to ensure that they does not go against what is considered the norm, mainly in reference to conception and child birth (Wangamiti, 2019). This makes an important case for ensuring the safety of girls through policy provisions against such vulnerabilities.

In Malawi, records over the past 10years show that there is widespread violence against women in general. According to the 2015-2016 Demographic Health Survey (DHS), of all women and girls in the reproductive age group in Malawi, approximately 34% have experienced physical or sexual violence; 20% have experienced sexual violence and 5% of ever-pregnant women reported experiencing physical violence during a pregnancy (ICF, 2017). Many have experienced controlling behaviours from a husband or intimate partner, such as insisting on knowing where they are at all times-making it difficult for some to reach SRH services, including contraception. 42% of ever-married women have experienced spousal violence, mainly emotional (30%), followed by physical (26%) and sexual violence (19%). Younger women, and those with less education levels are reportedly susceptible to violence, mainly by intimate partners or close family members and much of it is not reported. Furthermore, less than half of women (40%) who have experienced any physical or sexual violence have sought help to stop the violence, and about half (49%) have never sought help and never told anyone about the violence, because they are either not aware of where to seek help or there is no formal/institutional support provided by the government. The findings of this study provide evidence that the same is the case for AGLHIV/AMLHIV who practice birth control given the sensitivity attached to the use of modern family planning methods as afore-mentioned in other sections. This underpins the importance of having targeted policies in place to help them address the continuous GBV and provide social protection and other mechanisms to cope – in a cultural environment that more or less condones abuse of women.

### **Child and forced marriage and related risks**

Globally, 15 million adolescents under the age of 18 years are married (UN, 2015). In SSA the average age for marriage among adolescents is 15 years. Regardless of numerous commitments made by nations to eliminate early marriage, the practice continues in several regions of the world, with high rates in SSA. Previously, entry into marriage was considered a safety net for young women to protect their pre-marital innocence (Starrs et al., 2018), reduce incidences of

pregnancy outside marriage, numerous sexual relationships and general maturity out of health risks. However today, entry into marriage is accompanied by increasing SRH risks such as HIV and other STIs, un-wanted pregnancies as well as experiences of gender-based violence (Patton et al., 2016) which further deteriorate health. The rate of young people experiencing this today is exacerbated by the high number of adolescents still transitioning into marriage at early age today in low wealth quintile communities, without power, due to the controlled situations they are in, and thus not able to engage in negotiation and proper communication with spouses. The early marriages are characterized by frequent violence (Loaiza; and Liang, 2013), fuelled by cultural and gender norms and poverty, and the historic benefits of early marriage have diminished.

Such practices are entrenched in harmful cultural and traditional practices, poor social security, low education levels for girls especially in rural communities; limited capacity of formal child protection services to prevent and stop child abuse, limited knowledge of the issues of child rights as well as limited law enforcement on child marriage and teenage pregnancy aspects. Thus, child marriage has been seen to perpetuate the exclusion of girls from decision making about who and when to marry, from health and education services, and has also created a pathway into early sexual activity, violence and economic and social limitations for young girls (Starrs et al., 2018). It significantly contributes to high rates of teenage school drop-out rates for girls. Regardless of the pressure for child-bearing in marriage, adolescents in unions/marriage sometimes want to delay pregnancy but the contraceptive prevalence rate among married adolescents is reportedly low (Morris and Rushwan, 2015). Yet, research shows that the desire to delay child bearing is growing, especially among married African youth (Prata et al., 2013).

Malawi has one of the highest rates of child marriage in the world. On average, one out of two girls in Malawi will be married by their eighteenth birthday according to the United Nations (Watch, 2014). In 2010, half of the women (50 percent) aged 20–24 years were married or in union before age 18; while 12 percent of women married before they were 15. It is also important to note that many girls in child marriages are also forced into those marriages, at much earlier ages such as 9 years, and in most cases immediately after one attains puberty, or appears physically mature. The reasons for the high prevalence of child marriage include poverty, prevention and occurrence of teenage pregnancy, culture and traditions that encourage violence against girls and women in general, and promote their subordination, and lack of education. Thus, it is an inter-play of factors, heightened by the weak laws and policies to



address the vice. At such an early age, many girls do not understand the implications of marriage and the events that follow as a result-such as child birth. The realisation of such responsibilities comes much later and it is anticipated that it is followed by a desire to try to control or space child birth in a bid to concentrate on personal development, such as returning to school or seeking remunerable petty employment. However, it is not always straight forward given that marriage puts them under control of their spouses and his close relations who act as “watchdogs” to limit the actions of young brides, as seen in the findings of this study. The key challenge to ending child marriage in the Southern African country is entrenched attitudes that accept the practice. Child marriage is also closely linked to poverty, as often in rural areas girls will be married off young to improve a family's financial status. In some parts of the country, *Kupimbira* (giving a young daughter in marriage as repayment for a debt) is still practiced.

### **SRHR as a right, and bodily autonomy**

The concept of bodily autonomy ought to be publicised further to both policy makers and beneficiaries. Women’s rights are human rights, and reproductive rights are human rights. Women and girls need to be in charge of when, and whom to have children with, and SRHR for girls, and adolescents, their needs and choices ought to be put at the core of certain policies. SRHR is relevant in order to put an end to the inequalities and gender-based discrimination that girls face, regardless of the health, economic situation they may find themselves in. AGLHIV need an opportunity to make decisions of their own destiny, whether to have or not have children, thus it is important to make young girls understand that their bodily worth is important, and this calls for intergenerational and inclusive strategies, multi-taskforces and supporting technical working groups to maintain a certain position by policy makers.

### **Poverty, teenage motherhood, and vulnerability**

A substantial proportion of young women (1 out of 20) are having children during their adolescence (UNFPA, 2016). Evidence has always shown how adolescent girls play a critical role in the global fertility rate (McQueston; et al., 2013) with more than 14 million children being born every year to adolescent girls aged 15-19 years. Pregnancy among adolescent girls less than 18 years of age is likely to show the greatest increase over the next 20 years in sub-Saharan Africa (UNFPA, 2016). There is a striking relationship between poverty, HIV and vulnerability in relation to accessing SRH services. In many ways, poverty contributes to poor reproductive health experiences and outcomes for young girls. Adolescent girls from poor families and in the rural areas are often viewed as financial burden as well as economic buffer.



In resource limited settings, access to contraception is usually limited and they are not often prioritised in policy work. Thus, families have an unlimited liberty of prompting their girl children into early relationships and marriage as soon as they can in several African societies, and evident in Malawi too. Similarly, the girls see relationships with the opposite sex as a way-out of economic burden, seek financial cover from their partners, resulting into transactional sex (UNFPA, 2018) which is relatively accepted in several societies, and eventually teenage pregnancy and HIV infection, matching with the findings of this study. However, as earlier mentioned, not all adolescent pregnancies are a result of conscious decision and thus, not all these births are wanted or intended. A significant percentage is unwanted or mistimed (Loaiza; and Liang, 2013).

It is important to understand the risk that young girls expose themselves to in such practices, given the limited knowledge about sexuality and contraception at that age, the negative effects thereafter, which further push them into impoverishment. There is evidence of income and gender inequality being key drivers of vulnerability among HIV positive women, and worse among AGLHIV (UNWOMEN, 2018). In such relationships, the girls always remain economically dependent on their spouses, exposing them to the likelihood of control and abuse due to unequal power relations, thus heightening the level of vulnerability for them, and the inability to defend one's self due to dependence on partner. Additionally, in most cases the freedom of adolescent girls in such relationships is limited, compounded by pressure from both spouse and her family to bear children-especially in situations where girls are taken as a source of economic gain for her family. Hence, barring them from appropriate health information and services such as contraception in the process. The scenario as indicated by the findings is worse for young women living with HIV as they suffer unique challenges, and this underpins the need for relevant policies to protect such girls and ensure the safe and continued use of contraception.

Early childbearing, high fertility rates and inadequate access to related health services are the main contributing factors in the high number of maternal deaths in SSA (15%) among the 10-24year olds. In Malawi, young girls aged 15-19 years are twice as likely to die during childbirth as women 20 years and above (Thindwa et al., 2019). Coupled with HIV, complications during pregnancy and childbirth are the leading cause of death for adolescent girls aged 15-19 years. In Malawi, adolescent fertility rates are high and estimated at 136 per 1000 births (NSO and ICF, 2017). Additionally, infants born to adolescent mothers are at risk of suffering poor health such as low birth weight and the possibility to be born premature (Yakubu and Salisu, 2018). The risk of perinatal infection also becomes high for infants born to HIV positive adolescent

mothers. Unsafe abortion because of unwanted pregnancy is also common among adolescents which is an indicator of girls' and women's unmet need for contraception-meaning there was desire to prevent conception but failed. Thus, in the situation of a pre-existing health condition such as HIV infection, it is paramount to enact rules and guidelines, and policies to ensure easy and safe reach to contraception to control child bearing which comes so soon and so often since early pregnancy is usually followed by subsequent childbearing (Santhya and Jejeebhoy, 2015). Poverty reduction programs are also expected to put in place measures that protect the vulnerability of young people living with HIV due to their routine health and social service needs. Regardless of the high risk at which they are, many of these pregnancies could be prevented to allow young girls an opportunity to explore their full potential and become productive citizens.

### **Effects of tradition and culture**

Within the last decade, efforts at global level have been directed towards improvement of policies and tailoring of programs to address the SRH needs of all categories of adolescents in form of information and services (Chandra-Mouli et al., 2017b). However, the progress registered as earlier alluded has been slow. The delivery of services has been hampered by structural and social barriers with little or no significant impact made on the lives of the vulnerable populations targeted. Different adolescents are growing up in different contexts, and the quality of these environments is impacting on their ability to act on thoughts, build intentions and beliefs (Patton et al., 2016) due to the influence of cultural practices and traditional norms. This has had negative effects on the uptake of specific health services such as modern contraception, creating an unfilled gap. This unmet need for SRH services is dominant among adolescent girls residing in rural areas, with limited education, and commonly from the low wealth quintile households in SSA (UNFPA, 2016). Whereas there has been effort to make options available, many of the AGs are still held back by socio-economic and cultural factors that make the fulfilment of their choices impossible (WHO, 2014) due to the risks involved, as indicated by the findings of this study too. In contexts without much legal protection such as Malawi, the agency to find the contraceptive services they desire is constrained.

Child bearing plays a significant role in most African societies, and barriers designed by culture are imminent. In Malawi, the obstruction role of culture and traditional beliefs and practices is seen to have effect of the agency of adolescent mothers, more so those in a deprived

environment and who are already marginalized-such as those living with HIV in rural areas. This manifests through opposition from community leaders and family members regarding use of family planning. In addition, given that conception and child birth are taken as part of women's sexual responsibility, desiring to use contraceptives may be seen as defiance to the natural roles of women (Toska; et al., 2019), without consideration of the adolescent mother's health condition at a given time, and their own desires or fertility intentions (Thindwa et al., 2019). This aligns very well with the findings of this study. Vulnerability in this case is anticipated to arise from such negative perceptions and the conflict on interests that may ensue, putting the life of the HIV positive mother at more risk.

Furthermore, many Malawian communities promote child marriage as being in the best interests of girls and their families. Some families see it as an important way to improve their economic status, sometimes through payment of dowry by the groom to the bride's family, or through continued support by their daughter's husband. For some girls, marriage suggests a route, often unfulfilled, to escape poverty. Child marriage is also deeply entrenched in Malawi's traditions and patriarchal cultures, which encourage early sexual initiation and marriage and women's subordination in society. Marriage is regarded as a means of protecting girls who get pregnant from undermining family honour. It is important to note the negative impact that child marriage has on girls' and women's realization of key human rights, including their rights to health information and services including contraception, education, and to freedom from physical, mental, and sexual violence. The younger the age of marriage the more serious these impacts are.

The interruption created by marriage makes the possibility of continuing with usual life difficult, given the cover of authority and power by spouse and in-laws, limiting girls' daily operations to household roles and child care. In such instances the possibility of lack of social support is high due to limited social network. In addition, it was reported that the return to school for such girls becomes difficult or impossible thereafter, the spouses become abusive, and young girls in such situations remain economically dependent on them since they lack the knowledge and skills needed to provide for themselves (Biseck; et al., 2015) and the freedom to seek work (Watch, 2014). Furthermore, domestic violence and other forms of emotional and psychological abuse occur, perpetuated by close family and social networks and this can be linked to increased experience of stressors and impoverishment.

In Malawi, most matters relating to family and marriage/domestic affairs are handled through customary measures which are many times hinged on harmful cultural beliefs and practices. This often happens at the expense of the safety and abilities of AGLHIV and AMLHIV, and it remains to be emphasised that appropriate policy measures can be employed to provide a form of cover from such harm and enhance the resilience of victims to withstand henceforth. In rural Malawi, there remains widespread and deep-seated discriminatory attitudes towards women (Watch, 2014), with limited programs for social protection for victims of social injustices especially against young women, making it relevant to conduct an analysis of current policy in relation to sheltering AMLHIV who desire and seek to use contraception.

The above set of findings are also similar to the assertions by (Smith, 2020) . In the study, it is noted that in different contexts of SSA, adolescents' positive perception of contraception as an essential element of their life is often challenged with negative perceptions hinged upon cultural beliefs and gender norms (Smith, 2020). The process of socialization in SSA often influences adolescents' attitudes towards gender and this affects the use of contraception, as well as considerations for family planning. The same study indicates that a previous assessment conducted by the World Bank reported that the use of contraception was low among adolescent girls, regardless of their reported knowledge of it, as a result of socio-cultural beliefs (Smith, 2020). Furthermore, in Tanzania and South Africa, norms around early marriage and cultural rites similarly prevented girls from using contraception.

### **Social inequalities affecting AGLHIV**

Women bear a huge burden in society from childhood to old age. From being teenage mothers and dropping out of school, they suffer high fertility which exposes them to severe maternal conditions and get into the vicious cycle of poverty. Poverty and social deprivation intensify most of the problems, especially in societies that are structurally not so resilient to deal with many social issues. The power to choose the number, timing and spacing of children can bolster economic and social development (UNFPA, 2018). However, in SSA today, few of the girls who have had children during their adolescence are happy. This is due to the poor conditions they are in both economically and health-wise with numerous pregnancies and children to take care of, as well as the possibility of HIV infection (Toska; et al., 2019). For the case of the HIV positive adolescent mothers, vulnerability can be a product of the of social inequalities embedded within the existing situation of unequal powers, discrimination, exposure to stigma which many people living with HIV suffer, economic dependence, lack of education, limited

and controlled access to health information and services. They suffer derogatory remarks which stem from social attitudes and experience hostile environments. Therefore, such inequalities have profound health and developmental consequences for young mothers, and such may impact them for a life-time. As young mothers, they are expected to take on all the household chores and care for children and entire family, while they are still children. And they often lack support when faced with child and family related problems, alongside the weakened health status they suffer while adjusting to living with the HIV infection (Biseck; et al., 2015). Such vulnerabilities ought to be factored into national health policies to ensure the safety of PLHIV.

It is important to note that many of the adolescent mothers in Malawi fall in various categories; they are either married/in a union, or still living with their parents as single mothers. Many girls are more likely to be withdrawn from school when families face financial constraints because of their low social status and the costs of educating them. This in turn limits their ability to fully exercise their potential given the limited knowledge and skills, resources, social support networks, mobility and autonomy (Watch, 2014). Early child birth equally limits their freedom and denies them the chance to develop their intellect and independent identities. They marry young and get overwhelmed with responsibilities at an early age, in a confined environment, characterised by lack. Power and authority in the homes is customarily held by men and older women, and this places young married girls at greater risk of abuse and violence if they seem to go beyond the beliefs and norms (Watch, 2014). This is similar to what is being experienced by AGLHIV as per the study findings.

Other research equally shows that spousal age disparity is a risk factor associated with the risk of violence, abuse for young women. Without contraception, young mothers living with HIV especially in the rural areas end up with unwanted pregnancies and adverse maternal conditions and many are likely to try to control such unlikely outcomes regardless of the continuous exposure to risks. Such on-going exposure to risk can be addressed by legal and institutional and procedural guidelines, such as policy. Given the challenges suffered it is important to include reduction, resilience building and social protection strategies within the policy frameworks.

AGLHIV are deterred from accessing services because of negative experiences they have had with health-care providers when seeking services. They indicated that in many cases, the health-care provider might be their neighbour or a friend of their parents, who may break confidentiality and tell their parents. In addition, some young people do not like the model that

allows youth-friendly services to be available only on particular days and hours as this limits their access. This can be avoided through policy provisions that respond to their unique needs for privacy as AGLHIV.

In relation to the long distance that AGLHIV have to trek to the health facilities, the fulfilment of human rights obligations requires that health commodities, including contraceptives, be physically accessible for all. The goal of universal health coverage is to ensure that all people can obtain the health services they need without suffering any hardship to access them. Services must be within safe physical reach for everyone, including for marginalized populations, something which policies can help to address.

The study also found that some AGLHIV are not provided with all the required health care information and counselling. Adolescents in many countries lack adequate access to contraceptive information and services that are necessary to protect their sexual and reproductive health. Human rights bodies have since immemorial called on governments to strictly respect adolescents' rights to privacy and confidentiality, including with respect to advice and counselling on health matters and to ensure youth-friendly, confidential reproductive health care, including contraceptive services, for adolescents from different socioeconomic backgrounds and with unique needs such as those living with HIV.

Similarly, adolescents' best interests and their evolving capacities need to be systematically considered, and appropriate SRH services should be available and accessible to them without necessarily requiring the authorization of a parent or guardian as required by the policy and as common practice at health facilities. Requirements for third-party authorization to receive contraceptive information and services are a significant barrier faced by women in many countries. Not only are such requirements a breach of confidentiality, but they also deny women autonomy in their decision-making. These requirements deter women from seeking the health services they need. International, regional and national human rights bodies have frequently emphasized that states should not restrict women's access to health services or to clinics that provide those services on the grounds that they do not have third-party authorization or because they are unmarried, or simply because they are female.

### **Denial of care and other discomforts**

The study also found that some AGLHIV are denied contraceptive services. Evidence shows that women's access to contraceptive information and services may be jeopardized by health-

care providers' refusal to provide services due to conscientious objection. In the context of contraceptive services, this is usually manifested in a provider's refusal to issue a prescription for contraceptives, or refusal to dispense or sell contraceptives. While the HPT stipulates that some policies may be affected by the social sensitivity, international human rights protects the right to freedom of thought, conscience and religion, it also stipulates that the freedom to manifest one's beliefs in the professional sphere is not absolute and might be subject to limitations that are necessary to protect the rights of others, including the right to access reproductive health care. Human rights bodies have consistently called on states to regulate the practice of conscientious objection in the context of health care, to ensure that patients' health and rights are not jeopardized. Therefore, health-care providers cannot give precedence to their cultural and religious beliefs and impose them on others as justification for their refusal to distribute such products. It is a role of policies to rectify such anomalies which create inequities in SRH care access, with specific reference to vulnerable and marginalized populations.

The findings also indicate that AGLHIV are frequently constrained by the demand for compulsory HIV counseling and testing (HCT) as a mandatory requirement before being offered contraception services. Furthermore, the findings indicate that AGLHIV feel disrespected and undermined whenever they turn up at health facilities for the services, due to their age and their health condition. These findings match with what (Hazel et al., 2021) in their study on disrespectful care where 12% of the adolescent clients were denied services due to unwillingness to take HCT, as well as due to facility closure at specific hours.

While recommended, it is noticeable that the conditioned access to contraceptives will continue to deter AGLHIV in Malawi from accessing contraception. It can be argued that service providers ought to exhibit a level of discernment, coupled with effective health counseling during the service provision to AGs and AGLHIV since evidence also shows that often, adolescent girls who are denied service will most-likely not return. Across SSA, this has resulted into registration of numerous missed opportunities and consequently un-met need for family planning, thus the increasing un-wanted pregnancies among the sub-group. Furthermore, the related health policies in Malawi do not require the HCT as a condition for accessing family planning services (MoH, 2009), implying that the requirement can be flexed through the discretion of the service provider to ensure uptake of contraceptives by an AGLHIV given the challenges they encounter to even reach the health facility, only to end up without receiving the service. However, the same study points out that a policy decree may be made at district level, though not nationally required. Structurally, this equally points to



considerations for effective integration of family planning and HIV/AIDS services to prevent experiences of fatigue (especially to clients who may already be aware of their serostatus) and subjection to unwanted services, although it contributes to a generally positive broader goal in HIV health care.

It is therefore imperative to recognize that laws and policies often disrupt SRH provision in SSA, and this is often a reflection of broader societal values relating to gender. In such instances, it is common that service providers could be prohibited from dispensing contraception to adolescent girls or specifically, those who are unmarried (UNFPA, 2019). This is a direct interference with the principle of autonomous decision making for SRH matters, including bodily autonomy.

This study further found that AGLHIV are reportedly not comfortable with older healthcare providers, and, correspondingly, had a preference for females, under the guise that they would understand them more. The principal investigator found this to be a unique and unexpected finding from this study, since most adolescent programs across SSA have focused largely on offering of “friendly services” with minimal issues around age and gender of the service provider, but with focus on skills-set. To contradict the findings further, a recent study in Malawi reportedly found that the proportion of female service providers to that of male service providers for family planning services was equal, and around 40% were below 30 years of age (Hazel et al., 2021). Another study carried out in Malawi in 2017 to assess the strength of family planning programs for adolescents and adult women indicates that the median age of health workers included in the study was between 35 – 38 years (Chipokosa et al., 2019), which is relatively young. Nevertheless, the finding holds weight given the implications it carries in relation to access of contraception services. It can instigate the need for further research around distribution of carders to actual service points, and the importance attached to the dispensing of contraceptives especially for young people.

This study also reported lack of privacy at the health centers, and in some instances leading to social stigma, judgement and shame for AGLHIV. This is similar to what (Hazel et al., 2021) found in their 2021 study, which reports that clients who were engaged in the simulated exercise reported having group counseling (59%), with no video or audio privacy, and some times there were more than one client in the dispensing room for family planning services (Hazel et al., 2021). The breach of privacy in such circumstances cannot warranty satisfaction and similarly does not guarantee motivation to return for the service, especially for AGLHIV



who may require additional privacy to discuss with the service provider prior to receiving the services. However, it can also be argued that the group counseling is an option considered due to limited human and financial resources to allocate specific time and attention to one client at a time. In other settings, it has also been reported that group counseling is often followed by individual counseling for clients who may require. However, given the vulnerable and timid nature of AGLHIV, some of whom may be unmarried and therefore fearful to assert their need for contraception in such a culturally restrictive environment, the onus remains to the service provider to ensure that this happens.

### **Judgemental attitude of service providers**

Numerous studies note that attitude of health workers often discourages and prevents adolescents from accessing contraception (Olakunde et al., 2019), (Wanyenze et al., 2013). This study also found that AGLHIV are constantly faced with the judgemental attitude displayed by the health workers who dispense contraceptives. This finding is similar to another study conducted in Nigeria which found that more than half of the health workers included in the study felt that adolescents who expressed need for contraception should instead be encouraged to abstain from sex (Smith, 2020), as opposed being given the services. Another study in Kenya reported that health workers were unwilling to offer contraception to adolescent girls due to their beliefs, and as such felt ill-prepared to offer pre-counseling sessions to adolescents seeking contraception, while in South Africa providers resorted to personal discretion basing on personal and cultural beliefs instead of following the implementation guidelines (Smith, 2020). All this points to the need for more consistent policies and supportive legislation to ease access to contraception for adolescent girls in general.

### **Low male involvement**

This study also found that there is a low level of involvement by the male partners of the AGLHIV. Specifically, this was in reference to their participation in health sessions often offered to couples, which is also anticipated to facilitate the decision-making process for use of contraception and planning for the family together. Although male involvement can have a positive impact, some studies have suggested that male opinions and desires can dictate reproductive health decisions (Abubeker et al., 2019). Thus, providers should give due emphasis to the needs of the woman and ensure that efforts to include male partners in family planning decision-making do not undermine women's reproductive health right and autonomy.

However, it is also of significance to acknowledge the nature of health programs which focus mainly on women and girls. While this is justifiable on the grounds that reproduction occurs within the bodies of women, the programs remain largely lacking in terms of appropriate approaches for integrating the men. Yet, men are equal contributors to the process of reproduction. Thus, men and boys ought to be better engaged to enlist their participation in advancing gender equality and rights, while meeting their unique needs. Across SSA, several interventions have supported the involvement of men as active agents in the reproductive processes with positive results in redefining harmful masculine norms, breaking down of patterns that contribute to GBV, fostering communication between couples and resolving conflicts, as well as promoting the involvement of men in childcare (Starrs et al., 2018).

### **Preference for children**

This study also found that there is significant level of preference for children, by both AGLHIV, as well as their sexual partners. This finding was slightly contradictory to the focus of the study which highlights the need for delaying and spacing child birth among the AGLHIV. However, it is important to acknowledge that today, with the increased access to HIV treatment and care (Wanyenze et al., 2013), and specifically the highly active anti-retroviral therapy (HAART), PLHIV can afford more comfortable lives which may include having children. This is a right which cannot be taken away from them despite the health condition caused by HIV/AIDS, and this further implies the need for comprehensive services to allow for choice about whether, when, and with whom to have a child, as this remains an important aspect given the vulnerability associated with the age of an adolescent girl. It should additionally be noted that this finding coincides with the societal norms as related to gender, the expectations that accompany them (Wanyenze et al., 2013), and it can be argued that the socio-cultural environment precipitates the desire equally among young women, including those living with HIV/AIDS. Arguably, a similar study conducted and published by the same team indicates that the results from a study conducted among HIV infected individuals on their fertility desires in one of the health facilities showed that 25.4% did not desire the last pregnancy at all, while 16.5% desired the pregnancy later (Wanyenze et al., 2015).

However, to contradict the above, a another study indicated that in Northern Uganda, quite often adolescent girls become reluctant to make use of contraception since it is seen to contradict their idealized role as future mothers (Smith, 2020), and many prefer to start using after their first child birth (Chandra-Mouli; et al., 2014b). However, as noted in earlier-sections, this often leads to frequent uncontrolled births.

## **Supply chain and other challenges**

Regarding stock-outs of preferred methods, this study found that AGLHIV's uptake is hampered by regular stock-outs, signifying supply chain challenges. The finding is supported by other studies that have reported stock-out or unavailability of certain family planning methods, among the community-based distribution agents (CBDA), the health surveillance assistants (HSAs), as well as by the health workers (Chipokosa et al., 2019), and implied difficulty to for health workers to provide all required commodities despite having the skills to offer almost all methods. This also signifies the need to extend and provide more contraceptive options to facilities to serve the needs of AGLHIV as a key population.

The findings of this study further indicate that Malawi is still grappling with challenges related to integration of family planning services and HIV/AIDS, something which has impacted negatively on the uptake of contraception by AGLHIV. According to (Wanyenze et al., 2015), it was stated that implementation challenges were still persistent across SSA, especially in regards to the operationalization of integration models (Wanyenze et al., 2015).

The role of service providers remains significant. The findings of this study indicated that some AGLHIV receive partial or no information and counseling during their facility visits to seek contraception services. This limits their access to comprehensive information which can hamper their decision-making process. While it is the role of service providers to have and offer this information, it remains to be learned if their service protocols have been updated to include information suitable for young women living with HIV/AIDS and their desires for contraception (MacCarthy et al., 2014), to complement their basic knowledge base.

This study also found that AGLHIV are affected by non-disclosure of their sero-status to their sexual partners, husbands, or community members which makes it difficult for them to justify need for contraception if they wished to delay pregnancy due to medical conditions, as well as other social support services. The non-disclosure is due to fear of unlikely outcomes such as social stigma and gender-based violence. The findings can be matched with an earlier study by (MacCarthy et al., 2014) which indicated that social stigma had the potential to complicate the decision of a woman, about whether to disclose or not to their family and community members.

In relation to unfriendly services, this study found that AGLHIV experienced unfair and disrespectful treatment at the health facilities, something which contravenes with the guidelines for YFHS. This finding matches with other studies which indicated that clients reported harsh

treatment during family planning service provision (Hazel et al., 2021). Another study indicates that whereas facilities report about provision of YFHS, especially for SRH services, few have gone ahead to allocate special days for the adolescents and youth (Chipokosa et al., 2019). The aim of YFHS is to ensure provision of equitable, effective, accessible, acceptable and appropriate health services in a manner that involves and resonates with the youth (WHO, 2015), (WHO, 2012). Offering youth-friendly family planning services is therefore a fulfillment of the expected friendly service for youth.

Similarly, regarding the infrastructural challenges such as lack of designated space for adolescent-specific services (adolescent corners) as found by the study, this is equally evidenced by other studies which have been published. For instance, a study by (Chipokosa et al., 2019) which was conducted country wide reported that only a third of the facilities confirmed to having special rooms for YFHS provision.

The findings equally indicate that non-disclosure is one of the factors hampering the ease of access to contraception for AGLHIV. The findings can be matched to another study which points out the use of community-based distribution agents who handle most of the youth-related SRH events. While these are very well-connected to the community and therefore the AGLHIV at grassroot, they are also reportedly the least educated (Chipokosa et al., 2019), something that rises the risk of disclosure for the AGLHIV.

The study equally found that the fear of myths and misconceptions relating to side-effects about use of contraception by adolescents in general is one of the factors affecting uptake by AGLHIV. Similarly, another study conducted recently in Malawi on drivers and barriers to contraception access among youth reported that misconceptions and perceived side-effects such as sterility, cancer, as well as other illness were found as one of the major barriers (Self et al., 2018).

The finding is also similar to another study that was earlier conducted in Kenya, which equally reported that the fear of side effects and other anticipated effects had significantly shaped young women's reproductive choices among the study participants, to either use or not use contraception (Harrington et al., 2012). Many of the side-effects are often misperceptions and often become the leading cause for contraceptive non-use across SSA countries (Chandra-Mouli; et al., 2014b).

The study also found that AGLHIV are faced with negative social attitude expressed towards them by community, service providers and parents for using contraception. This is in line with another study by (Hazel et al., 2021) which indicated that study participants had reported negative attitudes about youth using family planning as one of the main barriers to access. Societal attitudes towards family planning carry a huge bearing on the uptake of contraception by young people in general, and often coupled with misconceptions to deter them. Policies addressing such issues ought to be included as part of core package for the improvement of SRHR for AGLHIV.

#### 5.2.4 Conclusion

The findings are a clear indication of the issues that AGLHIV have to manoeuvre to reach and use contraception in Malawi. These are largely embedded in systems, and social constructs. Given the nature of risks faced by AGLHIV, it is imperative that government of Malawi pays attention to the plight of AGLHIV by ensuring availability of policies which match the identified issues.

### 5.3 Policy provisions in place in Malawi to address the issues and risks faced by AGLHIV during the reach and use of contraception

#### 5.3.1 Introduction:

Malawi has been keen to put in place so many strategies to protect AGLHIV from various harmful experiences that predispose women to vulnerabilities in the process of uptake of contraception. Internationally, Malawi is a signatory to the ICDP and therefore adopted the rights-based approach to family planning. Malawi is also a signatory to the Maputo Plan of Action, and a member of the FP2020. Currently, Malawi is implementing the FP2020 commitment national strategy within which uptake of family planning services for all categories such as married, adolescents has been incorporated. Below is the presentation on findings for research question two, categorized under different themes. The findings for this section were primarily gathered through review of county documents, but triangulated through clarifications during interviews and back and forth reviews of captured data. A discussion section follows immediately after the presentation of the findings.

#### **1. Provision of youth responsive and friendly services**

Under a broader framework of youth-friendly health services, the national SRHR policy as well as the guidelines, family planning services are designed to attract specifically young people.

Through the same policy the Minister of Health is mandated to improve access for young people to family planning facilities by coming up with specific clinics for young people, and specific clinic days. The Minister is equally mandated to design additional initiatives, like youth centres, one-stop centres, which can make it easier for the young people to access SRH services including contraception as a key service (MoH and UNFPA, 2017).

The policy also provides for establishment of youth friendly corners at the health facilities to provide adolescent and youth-friendly RH services, including contraceptives to adolescents and young people. These also act as drop-in centres where adolescents are free to walk through and get any type of contraceptive service that they desire or may be in need of (MoH and UNFPA, 2017).

With the introduction of the YFHS, the bias towards the provision of contraceptives to AGs is to be reduced to include all those who express a need, and not only the married or those who have started childbearing.

In addition, through the National AIDS Commission, the development of the National Strategic Plan for HIV and AIDS 2020-25 was coordinated to include game-changing strategies to ensure access and utilization of a comprehensive package of YFHS through community youth centres among other strategies (NAC, 2020).

A condom strategy was launched in 2020, highlighting the government's efforts for an enabling environment to promote access to basic contraceptive methods such as condoms to young people. This is intended to provide double protection from both STIs and teenage pregnancies (NAC, 2020).

Through the NSP 2020-2025, Malawi also has a provision to decentralize and increase the number of youth-friendly health services through community/youth centres, particularly in high burden districts and hard to reach areas (NAC, 2020).

## **2. Integration of HIV and Family planning in all health facilities and services**

Malawi has the Family planning and HIV integration guidelines in place, PMTCT guidelines and policies, as well as the national family planning strategy and guidelines which provide for integration of HIV and family planning. It was found that integration through service provision is ongoing by following the available guidelines. However, the Ministry of Health is currently reviewing the current guidelines to strengthen the integration of HIV and Family planning and contraception at points of service delivery.

*“So, for us, even when they are HIV positive, when they go to the facilities, we have integrated the provision of our services. So, once they go for ART, they can also access condoms. They can also actually we do provide the Depo Provera. Within the ART services, maybe let’s say, maybe they had like an abortion, we ensure that they also get the contraceptive methods Depo Provera, according to the WHO guidelines, or the medical eligibility...” (Int 14\_PM)*

*“And of recent, we have also seen the documents of the government and the WHO advocating for integration of services in all the facilities whereby women living with HIV should have access to all the services that are required for them regardless of the age and what have you. and the policies are also stipulating well that adolescent girls and women who need access to HIV and family planning as well as SRHR services should be given that opportunity.” (Int 14\_PM)*

Furthermore, the study found that Malawi has a family planning action plan, with a linkage to HIV and family planning as a combined package, making family planning services available to those who are living with HIV. The action plan also emphasises family planning and young people, with the intent of making services available to young people as well (GoM, 2015). The action plan is supported mainly by development partners such as USAID and UN agencies.

*“But all in all, Malawi government, Ministry of health, with the support of development partners like USAID we are advocating for increased uptake of contraceptives among the youth and adolescents.” (Int 17\_DP)*

At the time of the study, the Ministry of Gender was conducting a scoping mission for the development of the integrated services package for SRHR, GBV, and HIV/AIDS to be provided as part of YFHS.

*“Yes, the one that we are currently working on... the document that I'm referring to is the integration guidelines. It's not yet approved. But it's almost done, because we have just validated it, and it will be presented to the senior management under the Ministry of health, to get some inputs to that. And then once it is approved, then we'll be having a living document that will be used for dissemination and so forth.” (Int 16\_PM)*

Inclusion of Family planning in HIV prevention strategy: In prospect, the development of the new National HIV prevention strategy is ongoing. Unlike the previous strategy, it was reported that the strategy under development has provided an opportunity to include aspects of AGYW, HIV and Family planning integration of services, with a belief that moving forward Malawi



will have a well-streamlined program for AGYW and cater for the needs of all vulnerable sub-groups.

Immediate post-partum family planning: Integration is also provided through the ANC and PMTCT guidelines. It was found that there is a system of ensuring that AGLHIV are counselled to receive contraceptives immediately after childbirth (postpartum), before they are released from the health facility (GoM, 2015). Since some of the contraceptive methods require medical procedures, the post-partum family planning is being offered to most of the AGLHIV as part of the implementation of the guidelines.

Through the Global Fund support for the period 2021-2024, Malawi will invest in the design and implementation of tailored, evidence-based high impact policy interventions to address unique challenges, vulnerabilities, and needs of young pregnant women and mothers. The prioritized interventions are those that optimize SRH – HIV integration, focusing on the 1st and the 3rd 90. Malawi intends to improve uptake by implementing the robust peer-led comprehensive SRH and HIV integrated package at both community and health facility levels (GoM, 2018b).

### **3. Promotion of family planning for AGs**

The Malawi National Youth-friendly Health Services Strategy explicitly addresses the provision of family planning services, promoting SRH services including contraception as a human right, including their access by vulnerable populations such as AGLHIV (MoH, 2015). Policies such as the National Reproductive Health Service Delivery Guidelines lay out adolescent-specific clinical guidelines for health workers to follow while offering family planning/contraception services to AGs (GoM, 2014a).

In addition, the Guidelines for the Management of Sexual Assault and Rape encourage adolescent access to family planning post-sexual assault. The Health Sector Strategic Plan mentions the need to focus on adolescents seeking sexual and reproductive health and post-abortion care. Several policies link adolescent family planning to broader family planning and health policies. The National Population Policy and the National Youth Policy both link adolescent family planning services to broader adolescent development policies (GoM, 2013). The Malawi Growth and Development Strategy III addresses some adolescent-specific concerns. Malawi is a signatory to all major international agreements and treaties that support adolescent access to family planning. Malawi, therefore, accords high priority to the promotion

and use of contraception as one way of improving the quality of life and productivity of women and girls in general.

#### **4. Addressing harmful cultural practices**

The government of Malawi has been keen on including in the policies advocacy against harmful cultural practices. The elimination of harmful SRHR practices is fully integrated into the delivery of sexual and reproductive health and rights services as provided for by the National SRHR policy (MoH and UNFPA, 2017). The National HIV/AIDS policy implementation plan (GoM, 2011) equally indicates that the elimination of harmful SRHR practices shall be fully integrated into the delivery of sexual and reproductive health and rights services. Under institutional arrangements (Chapter 4), the policy clearly stipulates the roles of various government ministries, given the multisectoral nature of SRHR. Relevant to AGs and family planning are clauses 1 and 2 under institutional arrangements where the policy mandates the Ministry of Information to;

- 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 the multimedia approach on issues of maternal, new-born health, and family planning
- iii. Furthermore, it mandates the Ministry of Local Government in clauses 2 and 3 to support the empowerment of men and women to make informed decisions on SRHR issues, and assist communities to dispel misconceptions and eliminating harmful practices that could prevent the use of SRHR services
- iv. For the Ministry of Women and Child Development, it provides for it to support advocacy against harmful cultural practices that affect women's and girls' reproductive health, and the prevention of gender-based violence
- v. For the Ministry of Labour, Youth, Sports, and Manpower Development, to raise awareness on cultural practices that expose youth, especially girls, to HIV infection and SRHR complications, promote behavioural change among young people and communities; specifically looking at modifying negative cultural practices into safe practices, to raise awareness on gender relationships that increase vulnerability to HIV infection and SRHR complications, and to equip youth with life skills

- vi. For the parliamentary committee on health to support enactment of appropriate legislation with respect to SRHR including minimum age of marriage and legislation on violence against women
- vii. Legal and social protection is provided for under policy thematic area 8 which focuses on harmful practices, including domestic violence. This provides for access to legal entitlement course of law, counselling and other support services provided for victims of harmful practices, domestic and sexual violence. It also provides for strengthening of human resources to provide screening, treatment, and follow-up care for support of victims of harmful practices and domestic violence including post-exposure prophylaxis, and advocates for strengthening research on the magnitude of harmful practices and domestic violence

Similarly, the enactment of the Gender Equality Act of 2013 and the HIV and AIDS (Prevention and Management) Act, 2018 prohibits harmful practices (GoM, 2018a).

To address gender-based violence (GBV), the National Strategy for AGYW provides for gender equality and protection to facilitate the removal of cultural barriers and negative gender stereotypes for men and women that contribute to SGBV and discrimination against AGYW (GoM, 2018b).

The current National Gender Policy also puts emphasis on addressing persistent unequal power relations between men and women, boys and girls due to strong patriarchal attitudes, addressing the increasing cases of GBV, high HIV, and AIDS infection rates, especially among women and girls; limited male involvement in reproductive health. It also puts emphasis on HIV and AIDS programs, addressing the continued high dropout rates for girls from schools, high poverty levels particularly amongst women, limited participation and representation of women in decision-making processes at all levels, and the inadequate enforcement of related laws (MoGCDSW, 2015).

## **5. Addressing harmful gender norms**

To reduce harmful gender norms, stereotypes, and gender-based violence, the NSP 2020-2022 has included strategic interventions to support HIV and AIDS-related programs to address harmful gender norms and stereotypes, and support programs to reduce gender-based violence (NAC, 2020). In addition, there is a provision for a minimum services package for GBV, in the gender policy. The Ministry of Gender has developed a minimum services package for GBV, to be offered at health centres within the districts to handle the cases. The minimum package

is targeting out-of-school, in-school girls, out-of-school boys, in-school boys, young women, as well as young women and men. This is intended to provide a holistic approach to the GBV challenge (MoGCDSW, 2015).

Furthermore, the Ministry of Gender following the policy directive under gender policy has created the National Information Management System for Gender-based violence (GBVMIS). This was created to harmonize the data tracking, management of GBV cases, as well as reporting and follow-up of cases of violence across Malawi (MoGCDSW, 2015).

## **6. Provision of free contraceptive services**

The government of Malawi through the Family Planning policy, is ensuring the provision of free SRH services, including contraception to AGLHIV to address the financial constraints and dependence on partners for contraceptive needs (GoM, 2015). Through the Ministry of Health, public, notable faith-based health facilities, and non-profit organizations are mandated to offer free contraceptives to AGs. This is specific to the government health facilities, the Christian Health Association of Malawi (CHAM) – a selection of Christian institutions that receive support from the government, including the supplies of contraceptives. Therefore, young people get the services free of charge in those facilities, including some of the non-profit organizations. To gather more support, the government has also managed to advocate for support from the private sector such as (Banja La Mtsogolo) BLM – an affiliate of the internationally recognized reproductive health services provider – Marie Stopes, to ensure free access to contraceptives, by young people.

The promotion of couple counselling, is also stressed, encouraging AGLHIV to visit the health facilities with their sexual partners or husbands so that they are trained together about contraception. This is done to create awareness for the couple about available methods, facilitate informed decision making specifically about using contraception, preferred method choices and promote family planning among PLHIV.

## **7. Ombudsman services**

According to the MoH, there is provision for a hospital ombudsman where clients are encouraged to report if they experience ill-treatment during contraceptive health care delivery. This has been put in place to ensure the protection of the rights of patients and vulnerable populations such as AGLHIV. The ombudsman is an office within the health facilities and is currently an established department under the MoH. The ministry reported that this direction

is being taken and followed up to ensure that under all circumstances a client who experiences abuse should be able to appropriately report and seek redress.

## **8. Community engagement**

The government of Malawi is promoting and conducting community engagement programs to offer social support to AGLHIV who are identified as vulnerable to abuse and any other identified risks. In addition, the community engagements are also used as a means to support AGLHIV who are not empowered enough to defend themselves against risks faced.

The Ministry of Gender is implementing the Gender policy by conducting community engagement to address harmful cultural practices. This is through engagement with traditional leaders, whom they support to come up with community-based by-laws, to ensure that the communities themselves are involved in protecting the rights of AGLHIV. Through this forum, traditional leaders are being mandated to ensure the observance of AGLHIV's and other children's rights to education and supporting them to attend ANC if they are identified as pregnant so that they receive the required information and support, act as watchkeepers against child marriage in their respective communities and observe the constitutional amendment for the age of marriage to 18 years (MoGCDSW, 2015).

Engagement of cultural leaders: The ministry through the Gender policy provides for the elimination of harmful cultural practices, and encourages engagement with traditional chiefs to ensure that cultural practices which are harmful to children are not carried out in their respective areas. Such include the *Kutomera* practice which involves older men getting engaged to children as young as 7 years, exposing them to abuse and control for the rest of their life.

The use of community approaches to deal with stigma and discrimination as well as gender equality are also included in the YFHS 2015-2020, as an important piece in health promotional talks and community systems strengthening interventions (MoH, 2015).

Furthermore, the National strategic plan for HIV and AIDS provides for engagement and collaboration with influential leaders to transform and implement community and social norms change programming at the individual, community, and structural levels. This is reportedly intended to create an enabling environment to support the girl child; end child marriage, sexual

abuse, and stigma; promote HIV prevention; and recognize the rights of women and girls (NAC, 2020).

The National SRHR integration Strategy 2015-2020 includes activities such as conducting community awareness on integration, and training of stakeholders including community (MoH and UNFPA, 2017). This if implemented can support awareness of available support by the target population in a non-stigmatizing way. It can also serve as preparation for support for any vulnerabilities occurring or that may arise during the process of seeking care.

The NSP 2020-2022 further mandates the NAC and its partners to work with community leaders to address cultural and gender norms that fuel GBV in the communities and affects uptake of SRHR/ HIV prevention, treatment and support services (NAC, 2020).

To address some of the socio-cultural issues, the Ministry of Youth and Sports through the National AGYW strategy provides for community engagement through the involvement of religious and traditional leaders. This is being implemented through local councils and chiefs by conducting forums where community discussions are held to discuss matters relating to AGYW and SRHR (GoM, 2018b). It can be presumed that this would include addressing harmful cultural practices and the restrictive socio-cultural environment in terms of how it impacts access to SRH, and demystifying issues around SRHR access.

## **9. Revitalizing of community structures**

This is provided for under of the National Gender Policy (MoGCDSW, 2015) and implementation is on-going as follows;

Through the Ministry of Gender, there is the engagement of community gatekeepers, and area development committees which are responsible for planning the development of communities, to understand and incorporate aspects of SRHR, HIV, and GBV as development issues. Similarly, technical groups in 20 councils have been established, oriented on the same, and prepared to offer technical support, traditional authorities/chiefs have been engaged on the same, so that the area local plans include aspects of SRHR, HIV, and GBV.

Establishment of a referral system: Furthermore, at the time of the study the Ministry of Gender was establishing a referral pathway. The pathway is intended to link AGLHIV who need help, by connecting from the community, to victim support units, to the police to ensure that at every level, reports of abuse can be received and punishment and prosecution follow there-after.

Engagement of district Gender Officers: At the time of the study, it was reported that the Ministry of Gender was engaging with local government structures such as Gender Officers to ensure the provision of social services to AGLHIV who need support as a result of risks they are exposed to. This is also intended to link the structures from the traditional leaders to the national level so that there is a system of reporting in case of the occurrence of harmful practices such as child marriage and GBV cases.

Training of duty bearers: At the time of this study, the Ministry of Gender had recently concluded training of duty bearers who are part of the referral pathway system. This included health workers, police, and NGOs that deal with GBV. It also included gender officers, and child protection workers. During the same phase, they conducted activities to revive the community victim support units, which is a structure that registers the cases of GBV and child-based violence and abuse, all of which are linked and include AGLHIV.

Community leaders are also mandated to bring families together in case of GBV and other violations against AGLHIV in their communities. Under this arrangement, counselling is provided, and other support services are sought when community leaders contact the social support structures of a respective catchment area. The local leaders have been empowered to support AGLHIV.

## **10. Empowerment of AGLHIV**

Through the various policies under the youth and gender sectors, the government of Malawi has made provisions for the empowerment of young people. The programs are specific to young people to facilitate their decision-making abilities and boost their empowerment in general. The available National HIV/AIDS Policy 2011-2015 priority area 5 provides for the protection, participation, and empowerment of PLHIV and other vulnerable populations. This is indicated under policy statement 2 which states that the policy shall ensure that punitive laws are repealed and specific legislation are enacted to address inadequacies, in the context of HIV and AIDS, in respecting, protection and fulfillment of human rights and freedoms to enable effective HIV prevention, treatment, care and support services for all who need them, and statement 3 states that the legal and policy framework, consistent with human rights obligations, is strengthened in order to sustain the national response to HIV and AIDS. Furthermore, statement 4 states that; PLHIV, vulnerable and marginalized populations including women and girls are empowered and capacitated to ensure their effective participation in programs and policy developments



(GoM, 2011). From these provisions, AGLHIV are covered over multiple barriers that they are faced with as a result of lacking empowerment.

To ensure its implementation, the focus is further expounded in the policy implementation plan, priority area 5 which clearly covers protection, participation, and empowerment of PLHIV and other vulnerable populations with the goal of protecting human rights, fundamental freedoms, and human dignity for all HIV affected people. The objective is to provide a conducive environment so that the rights of PLHIV, key, and vulnerable populations are protected and can access all available services when needed. The strategies are clearly stipulated as follows;

- i. Reduce stigma and discrimination in all settings
- ii. Promote gender sensitivity in all program interventions
- iii. Promote a legal, economic, and policy environment that protects, upholds, and respects the human rights and dignity of PLHIV, key, and vulnerable populations
- iv. Facilitate effective participation of PLHIV, Key populations in all aspects of the national response
- v. Promote access to and delivery of HIV and AIDS services provided by the public and private sectors to PLHIV and key populations including those in closed settings
- vi. Advocate for the enforcement of legal and social rights of PLHIV, key and vulnerable populations.

It can be concluded that the HIV/AIDS implementation plan outlines strategies matching the policy directives.

## **11. Comprehensive Sexuality Education (CSE)**

Malawi is committed to ensuring universal access and coverage of sexual reproductive health and rights information with a specific focus on young people. Comprehensive sexuality education policy is being implemented as one of the guiding principles for engaging both in-school and out-of-school AGYW. The CSE provides directives being used for the HIV prevention strategy and YFHS provision. In this regard, the YFHS strategy 2015-2020, includes the provision of age-appropriate CSE from the primary school level and for out-of-school youth (MoH, 2015). In addition, the National Sexual and Reproductive Health and Rights Policy and the National Youth Policy support age-appropriate sexual and reproductive health education and information. Information sharing and awareness on contraception have been strengthened.

## **12. School curriculum review**

School curriculum for secondary education has been revised to incorporate issues of GBV, it reports, and understanding the difference between civil cases and criminal cases and the process of reporting such cases. The review was also aimed at incorporating sexuality education to create more awareness among young women to promote good sexual health. This includes modern contraception.

### **13. Promoting adherence to human rights**

The government of Malawi made a deliberate effort to include human rights provisions in most of the policies and related programming. In the AGYW strategy, human rights is one of the core guiding principles, with strong advocacy for a human rights approach to all programs. The AGYW strategy puts focus on AGYW who are living with HIV/AIDS as key populations, and emphasizes ensuring that all AGYW policies and programs are based on human rights while guaranteeing all adolescents equal rights to quality health, education and other economic and social services, which are all a necessary input towards the social protection of AGLHIV (GoM, 2018b). With more specific reference to HIV, human rights guiding principles are included in the National HIV Prevention Strategy too. There is a high level of inclusion of these subpopulations as a way of making sure that their human rights are safeguarded. Similarly, the YFHS strategy 2015-2020 emphasizes the rights of children and young people as enshrined in the Convention of the Rights of Children and the constitution of the Republic of Malawi, among others, with those clauses relevant to AGLHIV, contraception uptake, and protection as follows:

- i. Right to good health including sexual and reproductive health services
- ii. Right to quality education
- iii. Right to protection from sexual exploitation and gender-based violence
- iv. Right to social and economic services
- v. Right to participate in governance issues and all decision-making processes relating to the welfare of the youth

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

Similarly, the National strategy for AGYW 2018-2022 has a goal of ensuring that Adolescent Girls and Young Women (AGYW) in Malawi are safe and protected and have equal opportunities to realize their rights and achieve their full potential through unlimited access to quality integrated education, health, employment and social protection services that are provided through a sustainable, coordinated governance framework and a comprehensive referral and linkage system. By doing so, it aims to ensure that AGYW in Malawi are safe and protected from all forms of violence and discrimination (including child-marriage), demand their sexual and reproductive rights, and are educated and empowered to make their own informed life choices.

#### **14. Review of the Constitutional age of marriage**

Malawi has an incredibly strong policy protecting vulnerable groups like adolescent girls. The study also found that in 2017/2018, the government of Malawi revised the laws of the Constitution which relate to the legal age of marriage, so that girls under the age of 18 years, could not legally be married. Previously, the laws provided for marriage at 16 years, and 15 years was also permitted with parental consent. This was amended to 18 years in 2017, implying that marriage before the age of 18 years was illegal hence-forth. In addition, the clause which provided for parental consent was completely excluded from the Constitution. This was in a bid to stop child marriage and protect young girls who are always the victims. Similarly, there are strong laws around consensual sexual relationships, with very strong punishments for anyone who engages in a sexual relationship with minors, (girls under 18 years).

#### **15. Harmonization of laws**

It was also reported that at the time of this study, the government of Malawi was in the process of harmonizing laws relating to the protection of PLHIV, AGs, and SRHR service provision which include family planning products for AGs. This was in specific reference to the penal code, constitution, and policies of line ministries relating to health care provision. In addition, the YFHS strategy 2015-2020 includes activities for harmonization of policies relating to SRHR/HIV and gender, the mixed messaging from different policy implementers, repackaging of policy information to ably reach communities and enhance the understanding of policymakers and communities alike.

#### **16. Standard operating procedures for SRHR and police**

At the time of the study, the government of Malawi was in the process of developing guidelines and standard operating procedures for SRHR. This was being spearheaded by the Ministries of Gender and Ministry of Health. In addition, the development of standard operating procedures

for police, to guide the use of available legal frameworks while handling cases of AGLHIV, especially child marriage, GBV, and sexual violence, among others was under-way.

### **17. National level coordinating entities**

This study also found that at the national level, the government has established the adolescent girls and young women (AGYW) Secretariat, to which relevant ministries are members. These include the Ministry of Gender, Ministry of Health, Ministry of Education, Ministry of Youth and sports. The AGYW secretariat's role is mainly to provide technical leadership and guidance on issues of gender-based violence, ending child marriages, as well as developing guidelines, standard operating procedures, or dealing with these cases.

The National AGYW strategy 2018-2022 is a combination of activities relating to improving SRHR services for adolescents, young people, women, and youths in general in Malawi. Thus, it is mandated to strengthen multi-sectoral responses, and streamline referrals and linkages across service delivery platforms to improve their health, well-being, and economic potential. The comprehensive interventions are meant to empower AGYW and address cross-sectoral barriers faced by AGYW through maximizing investments to improve health, education, gender equality, and economic empowerment outcomes. To achieve these results, government, civil society, development partners, and other stakeholders are mandated to coordinate their efforts to ensure cohesive planning, targeting the most vulnerable girls in the most deprived geographic areas (GoM, 2018b).

Another coordinating structure is established under the National Health Commission, code-named HYWG with a focus on girls and women living with HIV/AIDS. It has procedures for service as well as a savings package for members, as a means to economic empowerment. All the documents developed have special references to AGLHIV, referred to as *YPlus* (*Y+*), a code-name for young girls and women living with HIV and services are streamlined for them.

### **18. Monitoring and Enabling environment**

The National AGYW results framework provides a common monitoring structure that ensures that the six key/line ministries (MoEST, MoH, MoGCDSW, MoLYSMD, MoF, MoLG), and other implementing partners work towards a common goal to provide an enabling environment for AGYW (GoM, 2018b).

### **19. Promoting equity in service provision**

The study found that the integrated National SRHR provides for equity in service provision. This is regardless of age, ethnicity, or health status of the person seeking contraceptive services. It is one of the measures to ensure that all people including AGLHIV have access to contraception services. The policy is linked to the HIV policy, and Family planning 2020 declaration for Malawi. One of the guiding principles is a human rights and equity-based approach under which it stipulates that ensuring respect for human rights and fundamental freedoms including the right to life, human dignity, equality, and freedom from any form of discrimination is vital (MoH and UNFPA, 2017). Therefore, it provides for all the people of Malawi to have access to health services without distinction of ethnicity, gender, age, mental and health status, economic, socio-cultural condition, or geographical location.

#### **20. Extension of SRHR services to key populations through outreach and alternative spaces**

The SRHR policy provides for the extension of services to key populations which includes AGLHIV. Through this provision, community-based distribution agents have been established. Under this structure also is the lowest cadre, the health assistants who support the service delivery through the community-based distribution agents. Community-based distribution agents are by policy mandated to maintain family planning products with them at the community level so that AGLHIV can easily access them when they need them. Furthermore, the ministry has ensured the establishment of several access points across the country, including in hard-to-reach areas too, through additional youth-friendly structures such as the youth community-based distribution agents (MoH and UNFPA, 2017). Thus, the provision for the promotion of outreach services is to ensure that AGLHIV who live far away from the health facilities are facilitated by taking services closer to them. This is done to reduce the vulnerabilities related to time away from home and travel costs that may be associated. The outreach services are also used to provide privacy and confidentiality and protect the AGLHIV from unlikely exposure at the health facilities.

The Ministry of Health is also currently revising the YFHS strategy, to include safety measures for PLHIV during the process of accessing services. Additionally, the Youth policy includes guidelines for engaging with adolescents living with HIV, and provides guidelines to the health care workers for dealing with such adolescents. In a way, this is intended to address those issues of GBV, and situations where service providers deny the service to an individual AGLHIV.

#### **21. Similarly, the YFHS strategy 2015-2020 provides for the establishment of outreach and alternative spaces**

Whilst the onus of service delivery of YFHS will still be provided through static sites, outreach and alternative spaces will seek to extend the reach of YFHS, especially in the hard-to-reach areas. The majority of youth (85%) reside in rural areas in Malawi and rely on only health centres, classroom education, and community events for YFHS. Scaling up outreach services via mobile clinics and utilizing youth clubs, teen clubs, youth organizations, development centres, and door-to-door approaches will provide an alternative, more accessible opportunities for youth to access readily available YFHS information, services, and referral outside the static sites and institutional blocks. The intent is to bring services closer to youth in hard-to-reach areas and vulnerable populations and provide services where youth congregate, as well as to reduce congestion in health facilities for non-clinical services. The strategy equally has a provision for extending services closer to teenage mothers through school-linked and community family planning services to improve access to contraception, especially LARCs.

## **22. Promotion of access and choice**

The SRHR policy provides for access to family planning services for all, including adolescents and those living with HIV/AIDS. Thus, there is a promotion of access and free choice of a preferred method of contraception in a user-friendly atmosphere (MoH and UNFPA, 2017). Furthermore, the National strategy for AGYW 2018-2022, through its key objective on health provides for a coordinating entity aimed at increasing access to and uptake of a core package of comprehensive, integrated health services (nutrition, sexual and reproductive health, and HIV) for adolescents and young people aged 10 to 24, including YPLHIV (GoM, 2018b). Similarly, the HIV and AIDS Prevention and Management Act states that a person shall not be denied access to health services or be charged a higher fee for any health services, at a health facility, on the grounds of the actual or perceived HIV status of the person. However, “health services as afore-mentioned are not defined beyond treatment for HIV/AIDS conditions which limits the consideration for related SRH services, mainly contraception. However, the Act further enforces personal conduct and responsibility for persons living with HIV. It clearly stipulates that a person diagnosed as having HIV infection shall be required to –

- undergo counseling by a health service provider; and
- comply with precautions and safety measures prescribed by a health service provider. From this, it can be interpreted to provide a lee-way for an AGLHIV to seek contraception upon the advice of the health worker, especially through the

ANC services. Thus, this takes responsibility away from policymakers to service providers and eventually to rights bearers to act on it.

### **23. Promotion of rights-based approach**

Malawi promotes the rights-based approach in all policies, where comprehensive information is provided to facilitate informed decisions among AGLHIV given their unique situation. In addition, the rights-based training is also promoted to ensure confidentiality of AGLHIV and to build their confidence to ask for methods that are suitable for them, and to have access to quality contraception services like all other SRH and HIV/AIDS services. This is provided for in the National SRHR policy/strategy, family planning implementation plan and YFHS strategy documents.

To address the risks faced, the policies have provisions for male involvement, and current programs are involving males in understanding and supporting family planning, changing the attitude of men towards family planning, and promoting their involvement in decisions regarding family planning for AGLHIV and all women who express the need for its uptake. At the time of this study, It was reported that a male engagement strategy had also been developed, targeting men to deter cases of GBV, HIV, and SRHR. The National SRHR policy/strategy equally provides for the incorporation of male involvement activities into the programming.

### **24. Addressing capacity building of service providers**

The low capacity of service providers was identified as a key barrier to AGLHIV in their uptake of contraception. The YFHS strategy provides for capacity building, to be conducted at national, district, and community levels and is not limited to the health sector but includes education, youth, and gender sectors too, and it is subjective to the service being delivered to ensure a comprehensive youth-responsive program (MoH, 2015). This provision is therefore intended to provide on-the-job training, mentorship, supervision, and orientation which are the foundation to ensuring that all sectors and implementing stakeholders are knowledgeable about the YFHS approach and can provide relevant, age-appropriate SRHR/HIV information including in areas of gender. Such capacity building is also intended to train all providers to understand the complexity of child marriage and how to work with married youth, acknowledging that most SRH decisions are sometimes made jointly with their spouse and/or their extended family.



## **25. Social and behavioural change communications**

To address the negative perceptions and attitudes of the community, leaders, parents, and the AGLHIV themselves, the YFHS strategy further includes the employment of social and behavioural change communication. This will allow for dialogue between technical experts and communities to frame a positive mindset towards YFHS and the implementation of gender-transformative interventions necessary for the program to thrive. Subsequently, AGLHIV will be supported, protected, and a reduction of some negative practices can result because preconceived negative values and attitudes of parents, traditional leaders, teachers, and the youth themselves, which act as a barrier to uptake will be challenged in due course. The SBCC related activities were also intended to provide intense gender-related attitudinal changes, especially among young boys (and the larger community), to initiate changes in perceptions, which is required to break gender inequality and support the empowerment of girls, including the most vulnerable such as the AGLHIV (MoH, 2015).

## **26. Scaling up of successful programs**

The YFHS strategy 2015-2020 considers the emulation and scaling up of programs such as the Gender Equality and Women Empowerment (GEWE) project instituted by the Ministry of Gender, Children, Disability and Social Welfare (MoGCDSW) and stakeholders as an integral part to the successful implementation of YFHS in Malawi. This implies extension of tailored services to AGLHIV as a means of empowering them and addressing some of the barriers experienced.

## **27. Social protection services**

To address psychosocial problems resulting from stigma and discrimination as a result of living with HIV/AIDS, the YFHS strategy also caters for social services such as tailored support for the most vulnerable and at-risk youth, including young people living with HIV/AIDS (YPLHIV), key populations (e.g. married girls and sex workers) and those in hard-to-reach areas. Furthermore, the National strategic plan for HIV and AIDS 2020-2025 provides for the building of social support and increasing the resilience of AGYW through the delivery of evidence-based social and economic assets interventions for vulnerable AGYW, notably through small group structures such as afterschool and community clubs. Malawi also provides for the establishment of peer clubs at the community level to extend psychosocial support in form of counselling and peer sharing.

The YFHS strategy further advocates for the provision of mental health services especially psychosocial counselling, alongside the SRH package for youth (MoH, 2015).

## **28. Coordination, oversight, and management of services for the protection of AGLHIV**

To improve cross-sector collaboration and to ensure integration of AGYW services, a coordination mechanism shall be formalized. The Government of Malawi (GOM), through the four line-ministries, MoEST, MoH, MoGCDSW, MoLYSMD, in addition to the two supporting ministries, MoF-EP&D, MoLG, the National Youth Council of Malawi (NYCOM), and the National AIDS Commission (NAC) are to collaboratively provide leadership to the implementation of the AGYW strategy. The Government of Malawi and various civil society and development partner stakeholders currently provide significant resources to implement sector-specific AGYW strategies.

## **29. Creation and strengthening of referral systems**

A referral and linkage system is provided for through the National strategy for AGYW 2018-2022 to enhance an integrated and case management approach to services and interventions for AGYW. As part of the AGYW Implementation Plan, a comprehensive network of referrals and linkages will be mapped across interventions to discern where existing referrals and linkages may need to be strengthened and where new referral and linkage systems across interventions may need to be created (GoM, 2018b). Ultimately, this referral and linkage system will help streamline access to and uptake of services for AGYW.

Within the National strategic plan for HIV and AIDS 2020-2022, there is a provision for health care facilities and staff to strengthen linkage to complementary and supportive services to improve treatment outcomes for mothers and their HIV-exposed children. This will include active tracing for mothers who miss appointments and the use of expert clients and/or mentor mothers to improve retention in care. Similarly, as communities are integral partners in e-MTCT and their engagement is necessary to provide quality services, community engagement will be done across the cascade of e-MTCT services (NAC, 2020).

Similarly, the National YFHS 2015-2020 provides for the strengthening of synergies and linkages with line ministries and other stakeholders for a robust and comprehensive YFHS program, which can enhance protection. The line ministries include education, youth, and

gender. In general, the higher the level of education the more the chances of using contraception/delaying pregnancy among the general adolescent population including those living with HIV/AIDS (MoH, 2015).

### **30. HIV sensitive child protection and protection for vulnerable children**

The GoM has a Child Protection Case Management Framework in place to scale up HIV sensitive child protection case management in high HIV burden districts. The framework details how children experiencing abuse, neglect, violence, exploitation and the impact of HIV and AIDS can best be taken care of. Within the NSP 2020-2022, it is reflected that throughout implementation of the 2020-2025 NSP, the case management approach is to be scaled up in HIV burden districts to protect all vulnerable children. According to the NSP 2020-2022, this includes household visitations from Community Child Protection and Case Management workers (CCWPs) to vulnerable children where they conduct monitoring of their well-being. Other interventions include improving sources of livelihood for orphans and their households, GBV prevention and care, strengthening local structures that help with addressing child protection issues, and improving coordination.

### **31. Reducing human rights and gender-related barriers**

This NSP 2020-2025 aims to eliminate human rights and related barriers to HIV and is stipulated to ensure the provision of other services through increasing legal and human rights literacy among health workers, teachers, law enforcers, key populations, and the general public – basically the cadres who AGs and AGLHIV frequently meet. Among other strategies, this will be achieved by the involvement of PLHIVs and key populations in creating awareness about the rights of PLHIV and key populations. Further, acknowledging the fact that gender inequality hinders social and economic development, the achievement of gender equality remains one of the critical components of the HIV agenda. Within targeted geographic settings, CSOs, CBOs, OVC committees, and communities are critical players in the delivery of comprehensive community packages which address gender barriers and a package of clinical and social services will be promoted and provided to survivors to mitigate the harms associated with GBV (NAC, 2020). In addition, the National YFHS strategy 2015-2020 equally advocates for gender literacy (MoH, 2015).

### **32. Addressing stigma**

To reduce stigma and discrimination against PLHIVs and other key populations (KPs) the NSP

2020-2022 includes strategic interventions such as; creating awareness/legal literacy about HIV related stigma and discrimination and legal services to women, girls, vulnerable populations, and key populations; it provides for improving access to health services for key populations; improving access to legal services for PLHIV and KPs for issues relating to discrimination, violence protection, and other human rights; and provides for strengthening of the legal environment for PLHIV, KPs, and other discriminated minorities, including redress mechanisms in cases of human rights violations in the provision of health care (NAC, 2020). The government of Malawi has also been keen on including in the policies advocacy for behavioural change towards AGLHIV among different sections of the population, including among health workers. This is included in the HIV and AIDS Prevention and Management Act, which highlights the prohibition of such practices for children under 18 years.

The Act further prohibits discrimination based on one's HIV status, and states penalties provided for by the act in part 6; part 7 highlights the rights and duties of persons living with HIV/AIDS, including dignity of his person, physical integrity, life and health. The study also found that the HIV Act and Management Bill which was enacted some time back in 2008 mainly focus on protecting all PLHIV including AGLHIV from discrimination and stigma (GoM, 2018a). The current policies on HIV/AIDS promote a test and treat approach where everyone who tests positive for HIV is started on ART. For AGLHIV, they are usually identified during ANC mandatory test, and those found to be HIV positive are followed up through the pregnancy and monitored until delivery in a hospital. This monitoring includes initiation to contraception during ANC post-partum care.

### **33. Additional critical measures**

There is also a range of other measures provided to reduce unwanted pregnancies and unintended pregnancies among HIV infected women include strategic interventions provided for in the National Strategy for HIV and AIDS 2020-2022, such as supporting counselling on a wide range of family planning methods to HIV positive women, supporting the provision of family planning commodities to HIV positive women, and ensuring the linkage of family planning with provision of other SRH services to increase coverage (GoM, 2018a). And the National AGYW strategy is currently being implemented. although it was in line for review by end of 2021.

### 5.3.2 Discussion on policy provisions available in Malawi to address the identified risks and vulnerabilities

A positive policy environment is crucial in expanding access to family planning, contraception and reproductive health services in general. Across the world, government policies have contributed, to a large extent to the shift in positive reproductive behaviour seen through increased use of contraception, and fertility transition in several countries, such as Indonesia in the mid-1990s, and Egypt following the 1994 International Conference on Population and Development (ICPD) (Hardee et al., 2004). This underscores the important role of policies in shaping fertility. Following the findings of this study, Malawi is certainly on the verge of desired progress as per the SDGs, but a lot more needs to be done around the policies which support the access and use of contraception for AGLHIV. A number of aspects were noted about the policy situation and they are discussed as follows;

#### **Nature of measures provided by policies to address the risks**

The study found that the policies are generally broad with minimal specificity to the phenomenon of AGLHIV and contraception use but rather to adolescents as a group of the population. Nevertheless, the available provisions can be interpreted to match the needs of AGLHIV and the vulnerabilities suffered in the process of uptake of contraception. As noted by one of the policy makers *“I'm not particularly aware about policies that are targeting youth who are HIV positive, but I think in the broader framework of vulnerable youth, HIV is also one of the risk factors that is considered when addressing the vulnerability of young people.”* (Int 15\_PM). This implies that there is no one policy that specifically addresses the issues of AGLHIV and the vulnerabilities experienced along the pathway to contraception uptake. But rather, they are categorized under the key groups and vulnerable populations within the policy environment. However, it should be also noted that the categorization in most policy and related documents is limited to PLHIV and women living with HIV which further excludes the nature of vulnerabilities suffered due to the dual burden of HIV and teenage life and pregnancy.

**Policy related challenges:** The constraints on access and use of SRH services mainly contraception exist not only in societal and cultural attitudes but law and policy too. Examples include requiring the consent of a parent or other adult for use of a service, and restricting of services to only adults (UNFPA, 2017, Browne et al., 2018). Factors related to gender and sexuality equally exacerbate these limitations. Adolescence and HIV is also one of the fields where most of the controversy about rights happens. Thus, in addition to ensuring that legal

and policy provisions are in place, constraints are less cumbersome, and that ASRH services are friendly, there is also need to cover the vulnerabilities faced in the process.

**Generalization issue:** According to the findings, most of the policies seen and reviewed are general to adolescents and young women, without considering the unique needs of sub-groups such as AGLHIV. This limits the extent of applicability of the policies to address the issues they are faced with. Furthermore, the issue of vulnerabilities is not explicitly addressed too. According to (Chandra-Mouli et al., 2015b), although there is recognition that adolescents are a heterogeneous group, they are continuously categorized as one and this remains one of the key challenges in adolescent SRHR today (Chandra-Mouli et al., 2015b). Programs often use a one-size-fits all approach, without consideration for individual and sub-group dynamics. This therefore limits the use of policies as convenient policies are also viewed strategically and programmatically as a way of social support and protection.

**Actions to promote adolescent girls' sexual and reproductive health and rights (SRHR):**

The reproductive health of adolescents is dependent on several complex and often independent factors including social-cultural influences (such as family, peers, cultural leaders and teachers), and policies that promote access to SRH services remain key (Landes et al., 2016); (Ronen et al., 2017). Across communities in SSA, access to recommended SRH services for adolescents such as modern contraception continues to be a difficult issue. To be specific, the SRH needs are hardly met and the gaps are glaring regardless of numerous on-going SRH initiatives. SRH services in SSA have not moved beyond biomedical efficacy to address the full range of adolescents' well-being and development needs (Atuyambe et al., 2015). In a way, access to services remains controlled and today's adolescents are limited (Cowden et al., 2019).

Whereas adolescence is a stage where children are expected to determine their own social networks and will continue to do so in their life-time, the scenario is different in some of the countries which have unfavourable cultural and legal environments. The lack of access to modern and effective contraceptive methods, the high discontinuation rate (Chandra-Mouli et al., 2017a), high unmet need among sexually active unmarried and married adolescents, limited access to safe abortion, post-abortion care as well as maternal health services for expectant adolescents, limited access to services for HIV/AIDS and other STIs as part of universal health coverage (UHC) access, worsens the scenario (Santhya and Jejeebhoy, 2015). Of even greater concern is that the trend in unmet need for family planning since the ICPD shows almost no change.

Additionally, the increasing rates of abortion are an indication of poor uptake of modern contraception (Starrs et al., 2018). Thus, over the years there has been incredible consideration for improvement and promotion of reproductive health policies and services to clearly cover the different categories of adolescents. According to WHO, the need for contraception among young women living with HIV (WLHIV) is high, with well-documented benefits of giving women the opportunity to decide if and when they want children, as well as how many they want (WHO/CDS/HIV, 2019). This choice promotes positive educational and economic outcomes for women, which is key for achieving gender equality, empowering women and reducing poverty. Child and maternal health outcomes are also improved. Equally, the Sustainable Development Goals (SDGs) put emphasis on leaving no one behind (UNDP, 2015), and the updated Global strategy equally puts adolescents' health at the centre of focus (UN, 2015), while highlighting the importance of harnessing the double prevention of both teenage pregnancy and new infant infections. In addition, the global "accelerated action for the health of adolescents (AA-HA!) calls for more attention to adolescents' health needs and development.

Malawi's government has made efforts to improve the availability of reproductive health care services. Among other steps taken, is the increasing of access to family planning services and promotion of delivery in health facilities. Through-out all the national guiding documents, there is deliberate attention to the improvement of the situation of adolescent girls and young women, by tackling the teenage pregnancies and high maternal mortality rates and their causes. However, the health indicators have remained poor (Watch, 2014) and often vary by residence, age, wealth and educational status – an indication of the existing social inequalities and vulnerabilities suffered in the process. The harmful obstacles encountered by AGLHIV in the process of accessing and using contraception continue to impend access.

The scenario is worse in rural areas due to unequal distribution of health and social support infrastructure across the communities with less than 25% of the population living adjacent to a health facility (MoH; and UNFPA;, 2017) at 25 kilometers, and other support centres remain either distant or unavailable. Such realities have caused unforeseen and unusual risk to the life of young girls and women living with HIV and yet wish to control child birth. The reality of living with HIV, carries with it levels of difficulties for AGLHIV who try to reach the distant facilities and receive the desired services. Having the information, the power and the means to freely decide the number, timing and spacing of pregnancies in a safe environment is a right (UNFPA, 2017) which ought to be enjoyed even by young people living with HIV, and they



ought not to be coerced into undesired actions relating to their sexuality and fertility (Groves et al., 2018). The extent to which this right is upheld affects decisions about family size and thus fertility rates (UNFPA, 2018), and it has been a keen focus of this study to examine the extent to which such provisions are covered within SRH related policies to extend protection against risks faced. Moreover, the constraints on access and use of SRH services mainly contraception exist not only in societal and cultural attitudes but law and policy too. For instance requirements for consent of a parent, or spouse for use of a certain contraception service, and the restriction of services only to specific groups (UNFPA, 2017) which make the process more cumbersome (Cowden et al., 2019). Thus, in addition to ensuring that legal and policy constraints are less cumbersome, and that adolescent SRH services are friendly, there is also need to cover the vulnerabilities faced in the process to its fullest.

The use of contraception advances the human rights of people to determine the number and spacing of their children. Sexual rights embrace human rights that may already be recognised in national laws, international human rights documents, and other consensus documents. These include the rights of all persons to be free from coercion, discrimination, and violence; to achieve the highest attainable standard of health in relation to sexuality, including access to sexual and reproductive healthcare services; to seek, receive, and impart information in relation to sexuality and comprehensive sexuality education; the respect for bodily integrity; the choice of partner; to decide to be sexually active or not; to have consensual sexual relations; to enjoy consensual marriage; to decide whether or not, when, and how many children to have; and to pursue a satisfying, safe, and pleasurable sexual life.

Therefore, providing measures that increase contraception use among all adolescent females has also been associated with greater female empowerment and enhanced educational and economic opportunities, and adolescent females living with HIV using contraception may garner similar benefits.

Contraceptive information and services are fundamental to the health and human rights of all individuals. Access to safe, quality, affordable contraceptive information and services, together with the provision of fertility care, allows people to decide whether and when to have children, and also the number of children they would like. Ensuring access to preferred contraceptive methods for women and couples is essential to securing their well-being and autonomy, while supporting the health and development of communities.

Like Malawi, many countries are working to prevent adolescent pregnancy. Unfortunately, these efforts often covertly burden girls and aim mainly to change their behaviours, rather than address the underlying drivers of early pregnancy. Such drivers include gender inequality, poverty, sexual violence and coercion, child marriage, social pressures, exclusion from educational and job opportunities, and negative attitudes about girls in all categories (Chandra-Mouli; et al., 2014b). Many efforts also neglect to account for the role of boys and men as the sexual partners to the girls, and as members of a given society.

More holistic approaches are therefore required to support girls' rights and to empower them to avoid early and unwanted pregnancy. More importantly for the case of AGLHIV in Malawi, such approaches could include the use of policy mandates to build gender-equitable societies by empowering girls, and putting practical measures to ensure AGs' access to sexual and reproductive health information as well as services that welcome them and facilitate their choices.

The considerations for establishment of community-based delivery of contraceptive information and services as seen in the policies is therefore seen as apposite action to wards extending services closer to the AGLHIV at the community level. Globally, family planning programs have previously made efforts to de-medicalize contraceptive delivery by shifting services from clinical settings (Tsui et al., 2017). This been witnessed in several SSA countries including Zimbabwe, Kenya, and Ghana since the mid-1980s to the 1990s, where local health volunteers were trained. Today, this community health approach has been piloted and being implemented successfully in Ethiopia, Ghana, Rwanda, Zimbabwe, and now Malawi. Similarly, other countries such as Tanzania and Sierra Leone have registered significant success with approaches such as household visits through which health workers deliver and discuss family planning with women in need (Tsui et al., 2017), which makes the inclusion of such a policy provision relevant.

The legal frameworks play a critical role in transforming norms and protecting the rights of women and girls. The study however cautions that the legal and policy frameworks are not sufficient drivers in themselves to realize the vision of increasing contraception uptake among AGLHIV, but must be paired with effective enforcement and comprehensive protection efforts. Policies are equally a form of support to empowerment of vulnerable girls. Gender based violence stems from inequalities, and makes the SRH situations worse. Thus, responsive policies would act as a disruption to the continuous occurrence and existence of causal

situations, and GoM ought to reach AGLHIV who are in distress and provide them with safe spaces and social safety nets, as well as think of policy measures which can stop the violence before it occurs.

Throughout the findings of this study, evidence on protection mechanisms through policy provisions addressing specific vulnerabilities at the country level remains scant—with little details known beyond the generalised policies which promote access to SHR services. This study went beyond the general policies of SRH to specifically explore the details in relation to addressing of specific vulnerabilities specific to AGLHIV in Malawi, given their unique reproductive health needs.

Therefore, a responsive adolescent SRH system should include well-tailored policies as part of creating the favourable environment. Paying attention to policies is also a means of accountability, holding governments responsible for commitments made to young people and addressing the challenges faced in universal health coverage (UHC). Examples from elsewhere indicate the central role of governments in taking necessary remedial actions proposed usually through organized set of solutions, by formulating desired goals and objectives which are then implemented (Hardee et al., 2004).

### **Gaps and discrepancies identified in legal and policy instruments and provisions relating to protection and mitigation against vulnerabilities faced by AGLHIV**

The following were identified as notable gaps relating to the available policies which Malawi has made tremendous effort to put in place.

- i. Limited “reproductive age” band: It was found that the definition of “women in the reproductive age group” is in most cases limited to the 15-49 years age group, leaving out the 10-14year olds who are very vulnerable with numerous unique needs. For the case of Malawi, contextualization of the policies ought to consider the younger adolescents too given the statistics of early sex debut and high rate of teenage pregnancy and child birth as alluded to in the introduction sections of this thesis.
- ii. Outdated policy documents and guidelines: At the time of data collection, several documents were found to be outdated or expired but still being followed, for example 2016, 2014, 2009 policies were still “active” since it is what was available for specific ministries. However, the research team was also reliably informed that several were under review at the time of the study.

- iii. Malawi has also recently developed a community health strategy. However, this is not linked to bio-medical departments, yet they work closely with the community teams to prepare service provision activities at the grassroots, which is where most AGLHIV would prefer to seek care.
- iv. No safe spaces: Regardless of the introduction of YFHS and SRHR, and gender programs since 2007, Malawi reportedly lacks safe spaces under the community structure plans. Safe spaces can act as places of shelter for women and girls who may need to escape violence. This limits the operation of protective clauses earmarked in the policies as victims of violence and other forms of abuse or AGLHIV facing risks remain without a place to shelter during such difficult situations.
- v. Limited understanding of the concept of policy: This study found that the level of understanding of the concept of policy is limited and not comprehensive. From the study findings, responses to policy questions and clauses received mixed arguments/responses which revealed a limited level of understanding of the role of policies, laws and regulations in relation to social protection of vulnerable peoples. In such a context, the role and influence of such actors becomes limited to few aspects.
- vi. Measures to mitigate risks are minimal and inexplicit, with limited specificity to AGLHIV, throughout most of the policies.
- vii. Within the National HIV and AIDS Policy, it imperative to note that the policy outcomes are specific to HIV/AIDS condition to a larger extent, and spaces for inclusion of related aspects such as contraception are abstract, vague, and not fully descriptive.
- viii. Absence of dissemination procedures: For most of the policies and guidelines reviewed, there are no dissemination plans to extend the policy to the common people who the policies ought to serve and benefit.

### 5.3.3 Conclusion

The study found that the policies are generally broad with only a few specific to AGLHIV and contraception but rather to adolescents as a group of the population. Nevertheless, the available provisions while not adequate to address the issues faced by AGLHIV, can be carefully interpreted and explored to match and include the needs of AGLHIV and the vulnerabilities suffered in the process of uptake of contraception. Overall, the existing policies and guiding instruments offer scant attention to the plight of protecting AGLHIV against risks and vulnerabilities faced in process of seeking and using contraception.

## 5.4 Implementation challenges affecting the effectiveness of the available policy provisions

### 5.4.1 Introduction

From the study findings, it is evident that effective implementation of the policies in Malawi is a challenge. The translation of policy into actions that respond to the needs of ALGHIV was found to be difficult, even though some policies are in place. Thus, there is a remarkable distinction between having the right policy in place and its implementation. Below is the presentation of findings from the study, categorized under various themes and sub-themes, as well as independent points as per the analysis conducted. The findings will be followed by a discussion for the section and brief conclusion.

#### **1. Cascading challenges**

The study found that for policies that are in place, the trickle-down process that would ensure the movement from the government to line ministries, to departments, to service providers, and eventually to communities, is poor or lacking. Similarly, cascading of policy from the national level to lower levels up to the grassroots, to ensure that the policy is implemented, active and helpful to all categories of people targeted is a challenge. Given that AGLHIV are usually found at the lower level of society, chances are high that any preliminary implementation does not often reach them. Consequently, most of the provisions provided for by the policies have not been realized, especially at the community level where the end-user is based. In addition, most policy provisions have no structures on ground to support the recommended implementation/activities, while others are not backed by strategies and action/implementation plans. It was also found that others do not have costed implementation plans, implying that there are no allocated resources to cover the implementation phase.

#### **2. Partial dissemination and low community awareness**

In relation to the above, this study found that the dissemination of policies, laws, and strategies is mainly limited among ministry departments, officials, and selected programs without reaching the intended populations and communities. There is limited dissemination of policy intent information and related services to the district and grassroots level. It was found that departments that are supposed to disseminate the information focus mainly on facility-based dissemination and do not go beyond that to reach the community and to facilitate the knowledge-imparting process for the most vulnerable members of the population. Similarly, several policy-related documents have not been widely disseminated and are therefore not

known to be existing, which makes their application difficult or impossible. This finding was mainly reported by PLHIV representatives. An example given was the HIV Prevention Management and Act.

### **3. Limited and Low community awareness of available policies**

The study additionally found that the low awareness among the targeted population, the communities, and the end-users is affecting the effectiveness of the available policies to protect AGLHIV. Therefore, the end-users have difficulty in responding positively to the directives once implemented, or observe them for a limited period and divert from it or consider it unavailable. As a result, it is common to find traditional leaders and religious leaders conducting marriages of underage girls yet there are laws that prevent that. Therefore, whereas some relevant policies are in place with clauses that potentially provide protection for AGLHIV against identified vulnerabilities, the awareness of such policies among the population is low. Without that awareness, the society and AGLHIV in particular equally remain unaware of any available provisions to safeguard their lives, remain excluded from implementation procedures, and are unaware of their role as rights holders. Similarly, they remain unaware of any legal measures provided to safeguard them, the legal procedures or services that they can seek in relation to vulnerabilities being experienced such as reporting of cases, or whether referral mechanisms are available, safe places to go to for safety and support, and consequently remain in their homes with the unresolved and frequently occurring abuse.

*“Because in the policy, you have the guidelines to be used, and then the community has to know those guidelines that whenever they go to the health facility, they need to know what is supposed to be done there. And, if they are given a chance to know, they will be able to refer to that they know what they are supposed to get at the health facilities. So, if they don't know, it means It will be difficult for them. Because they don't know what we're supposed to do and what they're supposed to get at the health facility. They don't know where to go.”*

*“You know, I think maybe the way they approach them, but the committee's in Malawi there are not developed they need to be involved, they need to understand, they need to understand and usually, it's important to involve the community whenever they are developing their policies, where there is involvement, it will be easier for them to understand that policy and the way we approach them, we need to approach in a manner that we should discuss, explain they need to understand what is in the policy*

*and the importance of using those guidelines. Yeah, so if the approach is done in the way for them to Understand the pitch, but I haven't heard that. Maybe there's a policy and maybe the community of adolescents has rejected the policy. I haven't heard of that.”*

#### **4. Limited involvement of AGs in the policymaking, program planning processes, and implementation**

The study found that while policy development and planning of related interventions and their implementation takes place at the national level, the targeted population does not often participate in these processes. As a result, their views are not necessarily captured, approaches suggested may not be the most accurate, and implementation procedures could be ineffective to yield the desired outcomes. Precisely, AGLHIV’s unique needs in relation to protection against identified vulnerabilities remain unaddressed as many remain unreached or uninvolved in the processes.

*“... we tend to discuss a lot about the young women (AGLHIV) but the young women themselves are not involved. Sometimes it's us at a higher level, we sit down and propose, but the levels to which these young women and these girls are involved are not that very good, not very desirable, to the extent that even the uptake of these contraceptives is not very good among young women as we would have desired. That's why we're experiencing a lot of these teenage pregnancies, ... among girls and young women.” (Int 16\_PM)*

#### **5. Low comprehension of policy directives**

In other instances, it was revealed that partial details of the policies are usually known to a segment of the population and not the entire population. For example, the health workers and the youth may be provided with the information but without informing the entire community about the intention of a particular policy and how it can help to protect the youth. Similarly, some youth may not have all the details to facilitate their comprehension about the extent of protection, available services, or referral pathway, to enable them to fully benefit from the directives provided by a specific policy. Policy is seen as an issue for government officials and technocrats, and there is limited understanding about how one would impact on an individual’s life.

#### **6. No contextualization**



The study also found that some international policies are not well-conceptualized, or contextualized at all to facilitate the understanding of different local players/stakeholders. Such as the province and regional leaders so that implementation is well-supported.

*“So if you are able to say you can have a national-level policy, for you to succeed, I think you have to really do contextualize that policy to the local district or province or whatever regional governance the country has.” (Int 10\_LSP/IP)*

## **7. Centralization of policy activities**

The study found that policy matters are highly centralized and activities relating to policies are managed and controlled by the government high-level offices. In this way, community-based organizations such as those supporting PLHIV are not always permitted to conduct policy-related activities at the community level. This in turn limits the trickle-down effect and affects effectiveness in the long run.

*“What I think... the biggest problem is that most of the government’s policies are essentially centralized. Yet the problems are not in the capital cities.” (Int 10\_LSP/IP)*

## **8. Poor design of interventions and approaches**

The study found that the current design of programs and implementation of SRHR interventions among which are programs for AGLHIV is conventional in nature, with a “one size fits all” approach. As such, they may not be able to adequately address the unique needs of AGLHIV even when implementation is carried out.

*“However, the current design and implementation of SRH interventions are conventional “one size fits all” approach. They may not adequately address the unique challenges of AGLHIV. (Int 8\_PM)*

**De-link between facilities and community:** This study found that one of the challenges affecting effective implementation is the disconnect between community and health facilities where most of the services and programs are situated. According to PLHIV representatives, the community department is not always involved in bio-medical discussions and the two departments are not linked. In addition, the study found that the recently developed community health strategy is not linked to the bio-medical department, yet it is vital to AGLHIV and contraception use.

*“...I see a de-link between facilities and the community. Aaaarh because most of the time when we think of and talk of medical or health the community department is not involved. And if we look at the community health strategy which has been developed recently, it is missing some link with the bio-medical departments.” (Int 3\_PLHIV)*

Discrepancy between policies and programming: The study further found that there is a disconnect between policies and programming. According to the findings, the discrepancy is between the programs implemented by the key line ministries in Malawi which are responsible for handling issues of AGs and PLHIV. Specifically, the Ministry of Health, Ministry of Youth, Ministry of Education, and Ministry of Gender, implement disjointed programs which are inconsistent with the policies. It was also found that the different line ministries run unrelated programs/interventions as opposed to supporting a specific policy directive. For example; the Ministry of Education implements a life-skills education program which includes reproductive health programs, but the same ministry sends a divergent message regarding pupils accessing condoms at school; messaging related to family planning which could be promoted by the Ministry of Health is sometimes not linked to delay of marriage which is a Ministry of Gender mandate, and delay of first childbirth, use of long-acting and reversible contraceptives (LARCs) is sometimes not linked to post-partum counseling under Ministry of Health. In addition, whereas programming may be prioritized, the allocation of resources does not always match with the prioritized programs intended for supporting AGLHIV.

*“The services are there but they are not enough because we have programs that are disjointed between the Ministry of Health and Ministry of Education. So, we have three ministries that are handling issues of girls, young people living with HIV, we have the Ministry of Health, Ministry of Gender, Ministry of Youth, and Ministry of Education, I think even 4 ministries. So, Ministry of Education, they have what they call life skills education.” (Int 7\_PLHIV)*

Furthermore, the strategies are not well-aligned with the policies. The study found that it is common for only a single item of the policy to be picked up for inclusion in strategies, an indication that the focus on the actual policy contents will remain very minimal for the period of the policy. (not in tandem) and most of the programs are designed independently by implementing partners, with limited reflection of the policy priorities.

*“... strategies are not developed in tandem with the policy policies, we will pick one aspect to the policy and plan on that and it will be implemented.” (Int 10\_LSP/IP)*

Unharmonized policies and laws: The study found that related policies are uncoordinated, and not connected to a triage. Also, related policies are not harmonized with the laws, and with other policies that contribute to addressing the same issue, such as the health policy and education policies, and the SRHR policy, to support AGLHIV to take necessary steps during difficult situations which expose them to a lot of vulnerabilities.

Adamancy within line ministries/conservative nature of society/rigidity within the government systems: In relation to the above, the study found that some of the reasons contributing to the disharmony is rigidity of processes and procedures which makes it difficult to make linkages between line ministries and any diverging policies. As a result, it is difficult to have implementation fully initiated and included in school, health facilities, and community plans and programs. A notable example is the Ministry of Education, in relation to the implementation and promotion of school-based, age-appropriate SRHR programs and provision of SRHR commodities such as non-hormonal contraceptives. It was expressed that the rigidity has continuously made it difficult to address some of the issues that expose AGLHIV to vulnerabilities, such as long-distance to the health facilities, restrictions to movement, consent issues, and timing of health service delivery. While partners and other line ministries may make effort to use the platform of schools to create awareness, build life skills, conduct sexuality education, and extend services closer to the AGLHIV, the school systems often do not permit such programs. Similarly, clearance for community engagement is equally difficult.

*“For those young girls, I know that education (ministry) is adamant that they don't want if it's a child going to school, they want that child to complete school. So, we should not bring these things into their face to say you can also access reproductive health materials for you to protect yourself, just in case so that you shouldn't get pregnant. So, the Ministry of education is really adamant about those kinds of things.” (Int 20)*

Inaccurate targeting: In relation to the above, the study also found that one of the critical challenges is that messaging and services that target AGLHIV is reaching mainly those who have had at least one child, and need social services, and are ready to space or delay additional births, but without reaching the AGLHIV who have not had children yet, and who have not had any negative experiences. As a result, those without children are contributing largely to the incidence of pregnancies, as well as suffering associated risks involved because they have not been reached previously with the messages and services and it becomes a new phenomenon to them. This means that services are mainly targeting AGLHIV who are either in peer groups, community clubs and are already aware of their HIV status, without extending it to the wider community for more awareness as a preventive measure.

*“...the challenge is that those whom we target mostly with messages are people who have already had children and maybe they would like to stop having children. But for those new*

*entrants, who we may wish to target with the messages maybe to delay having children, those new entrants, we are not reaching out to them properly.” (Int 15\_PM)*

## **9. Limited community engagement and beneficiary participation**

In relation to the above, the limited involvement of the community renders the implementation at the community level where the greatest need is, ineffective. The study further found that AGLHIV and the communities where they live are disconnected from the policymakers, the policy directives, and therefore their views and those of community gatekeepers, faith leaders, traditional authorities, and their needs are either not known, not understood, and sometimes not reflected in the policy documents. As a result, the programming sometimes does not sync well in terms of responding to the unique needs of the AGLHIV. It was found that only a few stakeholders are invited to participate in the processes. Thus, policymakers have a limited interface with limited end-user during implementation but rather maintain engagement with high-level officers.

Top-down approach: The study equally found that most policy creation processes follow the top-down approach where officials from central government prefer to conduct the entire process and contact the local government and communities for minimal consultations.

*“More often than not we will come and make our presentation at the district level for endorsement (of the programs), and people go home with per diem that they expected. But where is the making of a policy supposed to come from? It’s from people that a policy affects, the people down (at the grassroots). So for example schools should go down and people give them exactly what they wish to have in the package. And then we practice it.” (Int 10\_LSP/IP)*

It was reported that most of the programs do not engage with the community and as a result, the community support and cooperation during implementation is limited, making achievements sub-optimal.

## **10. Insufficient preparation**

The study also found that the execution of the relevant policies is not well-prepared for. The government is not ready to provide the services related to the policies, and any community-based actions by civil society and community-based programs are most of the time not permitted. This is because of fear of creating demand for related health and social services which are usually not yet available at the health facilities or other government centres. In

addition, it is common that the guidelines for facility and community implementation may not be in place or costed yet.

### **11. No dedicated infrastructure/Infrastructural challenges**

The study further found that there is no infrastructure dedicated to social protection, such as safe homes for girls. It was revealed that it is common practice for traditional leaders – commonly referred to as Traditional Authorities (TAs)” to improvise some form of shelter for a limited period to AGLHIV who experience any form of violence or abuse, but this is usually within their homesteads. The homesteads are also known to the culprits and, commonly, victims can still be accessed and intimidated further.

### **12. Lack of political will**

This study also found that in Malawi, there is limited political will towards policies and this affects the effective implementation of available policies to protect AGLHIV. According to the findings, the government’s contribution to implementation is very minimal, as implementation is not always monitored or followed up, with much of it left to partners. This has had a major effect on hard-to-reach areas, and outreach activities to bridge the gap are independently executed by partners with limited coverage. Thus, there is laxity within the government.

**Lack of ownership over policies:** This study also found that in Malawi, most of the policy agendas are not initiated by the government but rather by Development Partners. As such, there is little focus on implementation after the policy has been enacted or revised. It was revealed that there would be no follow-up activities to ensure its proper implementation because it is not a government-owned agenda originally. Thus, it is common that when the initial and intense national level engagements between Development partners and government are concluded, there will most likely be limited or no further activities relating to that particular policy.

**Minimal appreciation of policy:** This study also found that in Malawi, policies are not prioritized as key instruments of development. As a result, policies are not viewed as required which makes it easy to omit their implementation/monitoring. In addition, the government has not prioritized soliciting support for the policies in any form.

These findings were attributed to the non-binding nature of international treaties, which permits countries to relax on implementation. It was revealed that international treaties are generally non-binding although they are signed off as a sign of commitment to address specific issues. For example, Malawi is a signatory to the convention on the rights of the child, SDGs with priority areas that cover GBV, the MAPUTO Declaration, which are all relevant to the situation

in Malawi. Thus, regardless of demonstrating commitment at international level, and ensuring the development of some policies which are in place, their effect is not felt among the community and AGLHIV who need them because minimal effort has been put in from the central government.

It was also found that there is laxity and complacency among government officials as they make very little effort towards implementation. It was revealed that after finalizing agreements on policy, the responsible officials often go back to what was termed as “default mode” after the signing of international agreements. This means that there is limited attention paid to some of the policies at the national level, after the signing stage.

Lack of accountability: It was also found that there is no credible system for accountability, and communities are not aware of measures to take to register queries relating to policy implementation/programs.

*“Accountability comes in, for example, in this case, who does one hold accountable? Because there is an issue of for example of the rights bearers and rights holders, ...that is the problem we have...” (Int 10\_LSP/IP)*

### **13. Financial constraints**

The study found that challenges relating to finances – inadequate, unavailable, shortages are affecting the implementation of the policies.

This is partially attributed to the lack of funding support from the government as the study further found that there are no budget allocations from central government to local government and community-based/PLHIV organizations for purposes of executing policy related activities and programs. In addition, some policies have been enacted, and their strategies developed, but with no budget allocation or costed plans for implementation. Therefore, relevant policies are in place, but it is not matched with financial commitment to ensure the provision of recommended services and commodities for contraception for AGLHIV as needed.

The study also found that policy activities in Malawi largely depends on donor support, which is often short-term funding support. The development of most policies and guidelines in Malawi are fully funded by donors and once the funding ends, it is common that activities relating to the policy such as strategy development will end too, or not be conducted at all until more funding is sourced and allocated by donors. Sometimes, this is after a long period which

implies that there will be no or minimal implementation of the specific policy during the period of lack of resources. This also includes activities such as calling for a meeting of stakeholders.

*“Usually, the government will say we don’t have money. So, we know. We know the problem of our government, we know what is there and, in their budget, mostly they’re salaries for the health workers with very few development projects. And most of the development projects are funded by the international donors and the like. So, we know our challenges. So if you go to government and say, can we have money, they will say you need to source money from the donors, and then you assist us?” (Int 4\_PLHIV)*

*“So yes, there are policies that are in place, but usually, they are supported (financially) by partners.” (Int 17\_DP)*

*“...Because those youth-focused outreach clinics that I mentioned earlier are usually done and implemented by partners. So that's the main challenge to say, most of these interventions are actually being supported by partners.” (Int 17\_DP)*

Minimal and catalytic funding for interventions: Similarly, policy-related interventions which offer needed support to the youth are project-based, and project life depends on the funding allocated. In most cases the allocations are catalytical and therefore short-term in nature. Therefore, implementation ends when the project life and allocated funding runs out. Thus, there would be no funds for continuous activities such as the capacity building of health care providers to offer YFHS which are most suitable for AGLHIV, and which demand continuous engagement to promote the needed behavioural change among community and target sub-groups.

#### **14. Limited scale of operation (coverage)**

the study found that most policy activities are conducted on a small-scale, limited to specific sites. As a result, hard to reach, and rural areas are neglected and AGLHIV in such areas remain without access to contraception services and other support programs implemented by the various stakeholders/partners. As a result, the country has failed to reach the intended targets in terms of coverage and results/impact.

*“I know that there are youth-friendly health services and facilities, but I think government is not doing enough in terms of reaching out to those in hard-to-reach areas. And government usually has challenges with the transportation to go and reach out to the youth, they say this and that blah, blah. So that's where I see the problem, ...if only government could do this extensively. I think we would say we have made good progress.” (Int 17\_DP)*



### **15. Failure to harness available community structures such as PLHIV community-based organizations and other support groups is affecting implementation effectiveness**

It was found that the government is omitting the utilization of the available structures whose presence and role at the community level is crucial for policy implementation towards the protection of AGLHIV in relation to vulnerabilities experienced in the process of accessing and using contraception can be channelled. Specifically, PLHIV organizations emphasized the level of engagement they have with the community in conducting several programs but also expressed concern that the government is not implementing through the structures that they as PLHIV organizations at the community level have.

*“So, its implementation. We have very good documents and the like. But now for us to implement its where we're having now being left out... Yet so far the way we work with the community, they know that we are there trying to make sure that the PLHIV are not discriminated against at the community level...” (Int 4\_PLHIV Rep)*

### **16. Social resistance**

The study also found that implementation is affected by subtle social resistance by the public or community members and leaders. This includes the community gatekeepers such as traditional authorities, faith/religious leaders, and other influential community members. This is usually when the policy has sensitive content which the public/community may view as divergent from their culture, or perceived to erode specific aspects of the culture and their identity. Therefore, it may be difficult to address certain cultural practices which define what a certain group of people identify with. In addition, the study also found that consent for AGLHIV to participate in programs implemented at the community level is denied, by their parents/guardians. Many also face resistance from sexual partners/husbands, according to the findings, thus affecting the success of any policy implementation efforts.

### **17. Poor coordination/coordination challenges**

The study found that there is poor coordination between government and stakeholders, as well as among the different implementing partners. For example, staff carrying out activities may not coordinate activities with other implementing organizations at any of the levels, with the exception of attending meetings. Thus, the implementation is poorly coordinated to allow for measuring the holistic outcome at the national level.

This study further found that implementation of policy is affected by weak coordination on the government side. This specifically refers to the government's role of coordination of donors and partners who are present and contributing to the national policy framework, especially relating to AGYW. It was revealed that the government has been reluctant in its coordination role, especially in ensuring that all resources available in the country, including financial resources are well-mobilized, well-allocated for implementation of key programs which address AGLHIV's situation, and duplication of roles by different partners is prevented.

It was found that currently, the Gender Machinery in Malawi is fragmented and poorly coordinated. Although the Ministry responsible for gender has been acting as the lead coordination institution for government, National Assembly, development partners, civil society, and the media on gender equality and empowerment of women; the coordination has not been effective.

There is weakness in coordinating the different partners and stakeholders to provide continuous support to the AGLHIV policy debates and ensuring that policies developed remain functional and impactful. For policies relating to the protection of AGLHIV several national institutions such as the police, judiciary, ministries of gender, health, youth, and education, have leading roles to play, but are reportedly inactive regarding such policy issues. The inactivity is related to a lack of involvement/coordination from the central government as a coordinator.

It was also found that while an AGYW coordination strategy was developed, the implementation has largely been fragmented across ministries. The strategy which was due for review in 2021 when this study was conducted had only been disseminated in 20 of the 30 councils in 2020 between March and November, and implementation had not fully commenced.

However, it was also found that the Ministry of Gender and Ministry of Health are collaborating to strengthen coordination, through the Department of Nutrition, and the National AIDS Commission.

Side-lining, shelving of critical partners and poor relationship between government and critical partners: In relation to the above, the study also found that some development partners who are critical to advocacy for girls and women, their protection and the monitoring of a country's observance of girls' and women's rights have not been involved in the policy processes. As a result, such partners are resigned about necessary advocacy and offering minimal support to

the government because they have been continuously left out of the policy processes and related programming. They are not consulted and not given a platform to participate, even as they implement relevant programs. This is having a detrimental effect on the effectiveness of implementation, given the comparative advantage that some partners have which could benefit not only the government to make the required progress in terms of protecting the AGLHIV, but also in saving, empowering, building the capacity of targeted population and communities within which they live, which could have a ripple effect over time. Specifically, one of the Development Partners was eager to share how deep their attempts as a mandated organization have been. When asked if they are engaged during the policy processes, the response recorded was as below;

*“To be honest, no, as XXX we have not been involved. We are never, we have not been even consulted, what we see is the end product. And then we have questions because we see that there's room for us to come in, we would provide our input while we're in the process, even as you're doing a review of a policy or even a strategy, bring us in. I think we have a comparative advantage because we, our work is around advocacy, our work is about also convening these young people, for the spaces that we're working with them. So, we have some kind of understanding where some of the issues are, but also because as XXX, we're saying, okay, fine, our target is about ensuring that every woman, every girl, child, their rights, their rights are protected. They have a voice in these issues. But at the same time to make sure that where they are issues and challenges to bring them to you know, to the to the institutions or the people that are manning that policy or that particular strategy or that law. But most of the time when they these things start it's usually, they leave us on the side. So, they don't, I want to give you just an example. With the Global Fund, they were developing what you call a COVID-19 response, I think the proposal to address a number of issues that were emerging, particularly looking at HIV as an issue. We pushed from our end to say, you know, I think we have comparative advantage, please bring us in so that we are on the table to give you some of the issues that we are seeing emerging from the women's constituency.” (Int 20\_DP)*

This study further found that implementation of relevant policies for the protection of AGLHIV is affected by parallel programming by the different partners in the country. As a result, programs with potential impact are covering few catchment areas/districts where they are allocated to work. Within the Government of Malawi and across the development sector, there

is currently a fragmented approach towards service delivery and limited harmonization of policies and programs. This has resulted in government sectors and other partners such as donors and civil society organizations (CSOs) implementing programs in silos, with limited coordination, minimal strategic planning, uncollaborated monitoring of interventions, and minus data sharing. As a result, current programming tends to be siloed by sector, designed at the national level without adequate district/community context, disconnected from existing policies and strategic frameworks, and lacking a holistic and integrated AGYW focus. Current policies and strategic frameworks targeting AGYW remain sector-specific with limited linkages and referrals across program areas, leading to poor coordination and accountability of activities and lack of services designed specifically for and accessible to AGYW populations. This implies that the benefit of the ongoing implementation is limited to a few AGLHIV who are within specific catchment areas which are targeted by each partner. In addition, scaling up is curtailed as partners limit their operations to specific areas. It was also revealed that different players have the tendency of each assuming the champion role, without clear collaborations or coordination with other partners. Thus, limited support for individual interventions.

#### **18. Nature of social support/Short term support**

The study also found that effective implementation is affected by the temporal nature of social support and protection interventions. According to the findings of this study, interventions from the government such as the provision of safe spaces or houses for victims of abuse are available for a short period and also seen to create a gap and cause division between the victim and the family. Where-as this is appreciated, its benefits are viewed as short-term too and an approach that provides longer-term support would yield better results. Additionally, interventions that build relationships are preferred.

#### **19. Government sensitivity to health-related indicators**

The study also found that reporting and monitoring of donor-supported programs, which contributes to policies relating to AGYW including the AGLHIV is sometimes hindered by sensitivity. The sensitivity is mainly related to data privacy, accountability, and reporting and sometimes program. Consequently, partners get constrained as they do not get a clear picture of implementation progress, especially when they have to use the same indicators as the government to record and report their progress. For other program details, partners find alternative ways of reporting their contribution without reports from the government, through third-party implementing partners. For instance, if a UN agency wants to register its progress on actual program details it would rely on a civil society organization or CBO because the

government would not provide it. Thus, it becomes difficult to track actual implementation progress and provide remedial action where it is required.

*“... the indicators will tell you a story, what indicators are we recording as a country? So usually, for the health sector, we use the demographic health survey, which can show like the one that we did in 2018, showed this acceptance of family planning among adolescents even fertility rate among adolescents versus urban and rural. So even for us, if we're doing our annual reporting, we make sure that we use national indicators for fear of being quoted to use one that government doesn't like. And you know, governments are sensitive to too many mundane things, and data is one of them. So, ... we can report our service delivery support using IPs. But for indicators, we use the same one for government because we're all contributors to the very same indicator.” (Int 20\_DP)*

## **20. Slow pace of behaviour change**

The study also found that the process of behaviour change among AGLHIV and the community is slow. Whereas services and information are provided to them, the rate of response to interventions in terms of outcomes such as behaviour change at individual level, household levels, and community levels is slow. This affects people's confidence in the policy-related programs and services. Similarly, given the age range of adolescents, most AGLHIV are naïve, not exposed, experienced enough, or empowered to have the confidence to take decisive action most of the time.

*“...you know, in all our support we believe in the principle of inclusiveness and making sure that we leave nobody behind. And even when it comes to services, we make sure that we provide services up to the last mile. So, you see that even in what we believe in as an agency that the young, even those with disabilities, those in rural areas are target beneficiaries lest they'll be left behind. So that's the area that we're always looking to. ...our role is to make sure that we provide the information and we provide the services, on assumption that the person takes it. ... I can't force them ...” (Int 11\_DP)*

It was also found that the majority of YFHS are delivered through the three levels of the health system grounded within the normal MoH clinical standards and procedures and ideally are linked to appropriate outreach activities such as health promotion and counselling, treatment, and referral in line with minimum package requirements. However, the recent national evaluations of the YFHS program report that high proportions of young persons are not motivated to seek or access services and that health facilities' overall ratings in meeting these

standards were medium to low, thereby adding to the low levels of uptake of services set out in the YFHS package.

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## **21. Weakness in law enforcement**

The study also found that enforcement of the laws related to protection of AGLHIV is weak, and poses a challenge. Acts of criminality/against the law continue to take place and some are embraced as preferred options. Such as child marriage, which may occur repetitively to an individual AGLHIV.

## **22. Inadequate monitoring of implementation**

The study also found that whereas there may be policies, there is minimal or close to no monitoring of the implementation to oversee the execution of activities up to the people at the grassroots. Consequently, other important issues such as the utilization of funds, and improving the capacity of teams are not well-addressed. From the findings, it was revealed that some health facilities may not have the supportive infrastructure, services, or manpower to execute the recommended medical or social support services, while in others, the tools required may not be available. Furthermore, it was found that the monitoring and evaluation system is fragmented. As a result, it has been difficult to track resources allocated for the promotion of provisions relating to gender.

## **23. Limited capacity of policy implementing agencies and ministries**

The study also found that government agencies that have the mandate to implement certain policy directives, or those that have the responsibility to do so have limited or no capacity to do so. The capacity is in terms of human resource, financial, and structural. As a result, the implementation is not conducted in a full-fledged manner to yield the necessary effect/results. Such agencies include the national line ministries and supporting institutions such as the police.

**Inadequate technical capacities:** It was found that the technical ability relating to AGYW, AGLHIV, is limited among some of the technocrats because programming for AGYW is new in Malawi. Therefore, a lot of interventions and approaches are still being piloted to identify the best practices to scale up. In the process, the technical ability of national staff and local

partners is being enhanced too for better performance in the years ahead. It was revealed that AGYW programming was introduced about four years ago and the government is still borrowing best practices from the HIV prevention initiatives that have been in place for a longer period. However, it was also reported that a number of strategies and new initiatives are being conducted, which provides an opportunity for effective inclusion of matters relating to AGYW, integrating family planning into HIV/AIDS ongoing programming, and to include and amplify the situation of AGLHIV and AGYW issues and address the challenges they are facing currently, as well as cover capacity development for programmer in AGYW.

*“...because, for instance, in this policy, the police might have a role to play or the Ministry of Gender might have a role to play in this policy. But are they having that role? Do they know their roles? Because I believe that all the partners that have a role to play to ensure this document becomes a living document need to also be well capacitated so that we can also provide the needed services to those young people, young women? ”(Int 20\_DP)*

Additionally, there are few staff supporting the AGYW ground-level implementation in the different districts/councils/provinces, making it difficult to address the vastly spread harmful cultural practices which are entrenched within the districts/provinces. It was reported that some districts have only two officers to handle the implementation.

*“The other challenge that also is a big hitch is that even those who are coordinating this strategy, Ministry of Youth and Sports, you find that at council level, there are very few people that are there. in some districts you have only 2 officers, some have only one officer. So that becomes a challenge for the district where you are trying to deal with harmful cultural practices which are widespread and entrenched in a council...”*  
*(Int 16\_PM)*

The study found that there is inadequate capacity to support the integration of SRHR, HIV, and SGBV, especially in the rural areas. There is lack of trained personnel to provide the longer-term acting contraceptive methods (LARCs) and reversible methods. This is mainly because the LARCs methods such as IUDs and implants require a level of specialized care to conduct the invasive medical procedure, which most health facilities do not have currently. It was reported that this has contributed to the selection of mostly short-term methods by AGLHIV, which are not very effective with them because AGLHIV fails to manage the consistency required. For example; pills and condoms. As a result, many end up with unplanned pregnancies.



*“For example, there's a policy about integration of the SRH, HIV, and SGBV, but there is inadequate capacity in terms of human resource in most of rural health centers. So even if the policy is there, there's one person at a rural health center, who doesn't have even capacity in SRHR. But is expected to integrate SRHR, HIV, and SGBV. So that when an adolescent comes through, should be able to deliver all these services at one go under one roof in one room. Yeah. But this person doesn't have the capacity to deliver SRHR, because he's not well trained in that.” (Int 9\_DP)*

High staff turnover: The study also found that implementation is affected by the high turnover of staff, especially in line ministries. It was revealed that staff who have been trained to support the planning, coordination, and implementation of policy-related programs and interventions frequently leave after they have been oriented and trained. The staff move from one ministry to another, move from one role to another (some are moved internally), and some retire. This creates a knowledge gap and a challenge of continuity and clarity of the policy, its role, and subsequently its performance.

*“Actually, the other key challenges we have had is that of staff retention and the staff motivation. We have most of the staff that are handling these cases, the dissemination of HIV/AIDS framework... They're moving from one ministry to another. And they start one program in one ministry but by the time people try to understand the program, they're in another ministry or they have been retired or they have been moved to another post altogether. So that creates a challenge of continuity and clarity.” (Int 16\_PM)*

## **24. Gaps in advocacy**

The study also found that advocacy during formulation of the policies is not adequate. It was revealed that stakeholders involved in the process are not keen to influence the direction of policies, to ensure the inclusion of relevant clauses which support vulnerable groups such as AGLHIV. Even among the PLHIV organizations, it was found that they have limited lobbying and advocacy abilities. Thus, despite their participation in policy roll-out processes, they are not articulate about the role of the policies rolled out. As a result, policies mainly reflect the general/broader population and are not targeted to specific children's, adolescents' and girls' needs. Consequently, implementation is curtailed as the nature of activities/programs by CSOs, CBOs, remains unsuitable to respond to the needs of vulnerable groups such as AGLHIV.

In addition to the above, the policies are generalized and partners find it difficult to effectively design programs that reflect both the policies and the needs of the target groups, matching the mandates of implementing partners, and using them as a reference to support the desired health

outcomes of vulnerable groups, and for protecting vulnerable groups such as AGLHIV. Partners expressed that during periods of reporting, they experience frustration especially when there is little to report about the AGLHIV.

*“I think that this issue of CSOs is becoming very important when formulating policies. HIV-related civil society organizations, I think should be able to come in and specifically say that this is what is supposed to be done for this vulnerable population. But in most cases, some of the policies reviews I have attended as an advocate for children, you find people and the other colleagues there, they say No, no, no, no, no, we're not choosing a person (referring to specific group). We're not choosing by age, but we're treating all people the same. While for me, I'll be advocating for children and the women, particularly those who are pregnant and HIV positive. So yes, even more advocacy is needed...”*

*“Sometimes you're even frustrated that the time for reporting has come now. But what have we done for this girl (AGLHIV)?” (Int 9\_DP)*

## **25. Un-updated/outdated policies**

This study also found that some of the policies are not updated. Therefore, the content does not match the current situation. Similarly, continuing to implement outdated policies does not yield positive results. A concern raised by one of the key development partners and donor to the adolescent program was that Malawi might not be able to achieve certain Sustainable Development Goals (SDG) related health targets if policies are not improved to address the actual social, cultural, and economic issues the AGLHIV encounter.

*“... if you dig deeper into different age groups you'll find that for adolescents, they're still lagging way behind...Because if we don't deal with the HIV-positive adolescents, then we're still keeping that pocket of HIV where the transmission can still be escalated from. The policies that it took us from 20% prevalence to around 10% prevalence will not take us from 10% prevalence to 2% prevalence. We need different policies, way better than what we had. Otherwise, there are a lot of things, social issues, cultural issues, economic issues surrounding the same HIV-positive adolescent. ...Once the health outcomes of this adolescent are improved, it will be very easy to achieve the HIV target, as well as the overall health target for SDG....” (Int 9\_DP)*

## **26. Functionality and leadership of responsible government offices**

The study also found that the offices responsible to guide and oversee policies relating to SRHR, HIV, FP, Adolescent health are sometimes without leadership, out of service, or disbanded/inexistent. This sends signals of a collapsing/weak system which affects the confidence of partners, both donors, and CSOs.

*“There are some challenges sometimes with the leadership. Leadership by Ministry of Health and reproductive health directorate is sometimes... I shouldn't say it's not there. But it sometimes looks like it's weak. So that's another challenge that affects the policy implementation.” (Int 17\_DP)*

## **27. Effects of decentralization**

This study also found that Malawi recently made amendments and adapted decentralization where districts become more powerful than the central government. Specifically, the Ministry of health (MoH). This is seen to be detrimental to implementation efforts for policy because policies are centralized, and implementation of national laws, policies, and programs is affected due to disagreements about why and whether they should be implemented.

*“..., they've (Malawi) gone through big decentralization efforts in the last few years. So as the district governments get stronger, I think the question posed is how do you see to the implementation of national laws? Because a district government gets more power, and there's great arguments for why they should. It doesn't mean that they don't have to adhere to national or central laws anymore. So, I think that's kind of the in-between space that Malawi is still navigating between government and the different parts of their government.” (Int 18\_DP)*

## **28. Chained nature of the problem and its magnitude verses narrow reach**

The study found that Malawi is challenged by the nature of the challenges facing AGLHIV, the vulnerabilities, and obstacles of insurmountable measure that they face. And yet, programs being implemented focus on a few specific aspects and catchment areas, with a narrow reach, and not nationwide. As a result, it is difficult to record the desired results because more effort is still required to extend family planning services to all AGs as a way of empowering them to have more bodily autonomy and control over their lives.

*“I think what's at the centre of it, and that makes it so difficult to address kind of, it's not just one issue, it's kind of a chain reaction of issues that are set off or just the amount of, I guess, obstacles that a girl in Malawi faces is insurmountable, and it's something that I can't ever understand ... All I know is the data and the evidence that we have to try to make the best programming and advocate for policies that would give these girls*

*greater autonomy and control over their lives. And family planning is a big part of that.” (Int 18\_DP)*

Similarly, the chronic nature of the disease/condition contributes to the stigma and fear among AGLHIV, requiring continuous support.

## **29. Difficult operating environment**

This study also found that implementation is largely affected by the Malawian context, given the environment with several cultural limitations relating to use of contraception by adolescent girls in general, within which the policies are to be implemented. The culture in Malawi is generally restrictive, especially in relation to the discussion of sexuality matters with children. Thus, it limits the development of favourable policies, inclusion of certain clauses, and affects the implementation thereafter. The strong culture further restricts the participation of AGLHIV in scheduled community-level initiatives which are organized specifically for them as a vulnerable sub-group. This makes it difficult for government officials and program implementers to reach them. In addition, culturally most girls and young women are cautioned not to discuss/expose marital challenges such as domestic conflicts and abuse, making it more difficult for AGLHIV to seek help from available support services or reach out for information regarding the same. Therefore, this culture of silence is detrimental to programs intended to reach the vulnerable AGLHIV who may need support. For many of them, issues relating to GBV and domestic conflicts are not discussed outside the home setting, and should not be reported anywhere.

*“You know, this Malawi is one of those countries with strong cultural values and traditional norms. So, one, generally, when you are targeting these young women, it's not that very easy for them to come out.” (Int 16\_PM)*

*“...the other one is the culture where we believe that the issues of sex cannot be discussed with children, so culture also plays a role.” (Int 3\_PLHIV Rep)*

Thus, the study found that whereas policies relating to contraceptive services may be available, there exists a number of contextual and social barriers that limit the AGLHIV from going to the facilities where the services are, resulting in low success.

*“For now I don't think they're easily accessible. Okay...they are available but there is inaccessibility in terms of, not physical barriers, but the social barriers, they are there. The services are available, but not easily accessible because of social barriers.*

*Although we have the buildings. Although we have the structures with the commodities inside, but the access is still limited because of social issues.” (Int 15\_PM)*

This study found that the implementation of available clauses related to protection of AGLHIV against vulnerabilities faced in using contraception is greatly affected by the poor socio-economic situation in the country, and most of the communities. It was revealed that some of the practices which fuel vulnerabilities are persistent because parents and communities are sometimes more focused on economic gain. For example, transactional sex. Implementing partners expressed difficulty in conducting advocacy about aspects like gender-based violence, education, and family planning when the focus of communities and families is on finding the ability to survive daily.

*“It is difficult, it's not just going in and addressing or talking about gender-based violence and the importance of education and why girls should get married older, but how are you going to fix these families' economic fortunes, so that they'll have an ear that is more receptive to hearing about different ways of doing things? ... it's very difficult when what's at the centre of most families day to day is just surviving.” (Int 18\_DP)*

Other contextual factors such as low literacy levels were also found to affect the accessibility and use of contraception by AGLHIV as it was found to contribute to many AGLHIV's disadvantaged position. Many of them are not able to fully comprehend the need and importance of contraception as PLHIVs. The low literacy levels similarly affect their decision-making capacity, and confidence levels to seek services for personal protection.

*“High illiteracy continues to put many girls in a disadvantaged position.” (DR)*

*“Other contextual factors such as low literacy levels also affect uptake to information and contraception services.” (Int 8\_PM)*

Additional contextual factors identified include early and child marriage, and persistent occurrences of gender-based violence which negatively affect the AGLHIV's way of life.

The study also found that to some extent, the perception of some of the policymakers is not matched to the issue being handled. It was revealed through this study that some policymakers are not entirely convinced with some of the policies being enacted, or provisions being included during policy revision, or during the introduction of new guidelines. As such, they agree to the policies and provisions but do not feel confident or convinced enough that whatever is being proposed can be implemented successfully in Malawi. It was revealed that regardless of

national officials' participation in international forums, and the country's agreement through the signing of international commitments, there is a sense of disbelief within the policymakers themselves and that limits them from following up with the implementation of certain policies or provisions at the country level, but instead carry on with their duties as usual (default setting and business as usual). Therefore, there is a sense of disbelief about some of the policies and their provision, and some are viewed as not national priorities especially when they are geared towards addressing culturally entrenched issues – which is the case for most of the vulnerabilities AGLHIV are exposed to.

*“... so we do a lot of initial outreach with those people in the communities to be able to go in and do the program because every girl who's under-age, their parent has to consent to them being in the program. We don't just put girls in a program and their parents don't know where they are, what they're doing, but they (parents) are still a little resistant because of the conservative nature and conservative leanings of Malawi and society at large.” (Int 18\_DP)*

The study also found that implementation of developed policies through different interventions is hampered by social stigma and fear which limit the AGLHIV's participation in activities targeting them. It was revealed that in most communities, AGLHIV do not turn up because they are not comfortable with opening up about their situation/condition and therefore fear to be known to be living with HIV/AIDS, or experiencing any form of abuse and the exclusion and discrimination that may ensue after that. Some of the reasons for the fear are social labelling/naming and shaming which were reported to be common. As a result, many hide during community engagement activities.

Furthermore, it was revealed that the stigma and fear are also caused by the fact that most people involved in the implementation activities are not HIV positive themselves, which makes AGLHIV feel that they cannot be understood because of the pain and experience of whatever vulnerability/violations they may be facing is not shared and cannot, therefore, be understood. Therefore, they do not have confidence in program implementers who are not “HIV peers” (living with HIV too) to provide them with the appropriate care and support.

*“Social stigma surrounding unmarried teen mothers is yet another barrier a young woman has to endure outside being able to access youth-friendly maternal health care” (DR)*

### **30. Competition among partners**

Similarly, the study found that there is a significant level of competition existing among key partners at the national level. This leads to others being left out of the national agenda while others whose mandates may not be the strongest to support a specific policy agenda are allocated or permitted to lead the programming. The study found that this is affecting the effectiveness of implementation in such a way that different partners have slightly different mandates and failing to involve all the necessary partners leaves a gap in actual activity/program design and implementation for a policy targeting the protection of AGLHIV.

*“We went all the way to even talk to the director of HIV services in the Ministry of Health. But to tell you the truth, we were disregarded, completely disregarded. not even invited to any of those meetings. And I said, I even took an effort even write to XXXX our fellow XX organization. I took an effort to also go and talk to Ministry of gender to say, you know what, maybe at your level as ministries, as government, speak to your colleagues so that we can work together, we can work for you as Ministry of gender, and you can be able to raise some of these issues.” (Int 20-DP)*

### **31. Supply chain challenges**

It was also found that implementation is affected by the supply chain of family planning commodities, with regular stock-outs of SRH medical products, specifically contraceptives. This is in such a way that some of the clauses provide for equitable access by AGLHIV as a means of addressing challenges related to the restrictions on movement. However, prescribed services become unavailable, thus creating more vulnerability, a gap during the period, making un-planned and unwanted pregnancy potentially possible. As reported in the aforementioned sections, the facilities frequently experience regular stockouts and, commonly, AGLHIV may not be able to have a specific/desired method of contraception on a given visit, but would have to travel to the health facility for more than one time, leading to other related challenges.

*“But in Malawi, in many health issues, it's difficult to just talk about the issue and not address the supply chain commodities and resources available in country because I know from meetings that I've been sitting in for the last two-plus years, that the demand in Malawi, for family planning is much higher than the actual resources and supply in country. There has been a continual gap the whole time that I've been working in Lilongwe and that affects what girls have access to. Plus all those other issues that we've talked about... they can't actually if the demand is always greater than the supply of what is available, and the hurdles that make getting supplies and resources in-country..., it's just not possible to.” (Int 18\_DP)*



### **32. Non-disclosure in schools**

The study also found that most AGLHIV do not reveal their HIV status to the school authorities. As such, it is difficult to ensure their protection from any forms of abuse from peers, and stigma, especially for those who are already known by community members/pupils attending the same school. So while the parents may assume that such children are protected, the reality is most times different and they continue to face challenges as they remain unreached by any support programs. For this reason, it was forecasted that such abuses will most likely continue to prevail.

*“...why I'm saying they're still prevailing is that you would note that most of the young girls that are living with HIV and AIDS, first of all, it's very hard for them to ... Okay, most of them are not well known to the authorities in the school. Because it's up to them to say that I'm HIV positive or not.” 20\_DP)*

### **33. (Hindrane of) Parental consent**

The study also found that parental consent is a hindrance to the activation of some of the laws that are stipulated for the protection of the AGLHIV. This is specific to all AGs below the age of 16. It was revealed that the common practice is for parents to settle matters relating to SGBV and domestic abuse/conflicts, among themselves, which usually leaves the culprits free for most cases when the parents are lured with large sums of money as compensation. Thus, the effectiveness of some protective mechanisms provided for by the laws and policies is obstructed, rendering the law/provision ineffective.

### **34. Limited scientific evidence and data specific to AGLHIV**

This study also found that implementation of policies related to AGLIV and violations encountered during uptake of contraception is hampered by a lack of adequate data showing the magnitude of the problem. Information about AGLHIV is not differentiated and they are mainly covered under several other sub-groups, such as key populations, as AGYW, but with little specificity to AGLHIV statistics alone. Similarly, some of the policies are broad and generalized which makes it difficult for implementation. Withstanding the above, the government has made effort to ensure initial relevant processes take place, such as the available policy provisions through which AGLHIV can refer to. In addition, it was revealed that several national-level studies are ongoing to provide the required specific information in relation to AGLHIV, including an assessment of gender and HIV in Malawi, and another focusing on the extent of HIV/AIDS sensitivity to gender issues.

*“But for all women, actually we are at 49%. And this is according to the FP 2020, the 2020 indicators. So, I cannot actually have much on how many are HIV positive but we just monitor the uptake of, they call it monitoring contraceptive prevalence rate, for married and also for all the others including the adolescents mostly the 15year olds.”*  
(Int 14\_PM)

However, it was revealed that some studies focusing specifically on AGs and HIV/AIDS, as well as gender aspects, are currently in preparation, with some finalized, aimed at bridging the data gap on AGLHIV.

*“Right now, we're validating a certain document. Somebody is doing a study just to evaluate to do an assessment of gender and HIV in Malawi, we just finished another study which was supported by XX, we have a report, a very robust report on to what extent is HIV AIDS responses sensitivity to gender issues. So, we had that report it was supported by XX. And now we are doing another study with the National AIDS Commission. And ... the first study revealed a lot of things, we were looking at the HIV response and its sensitivity to gender issues.”* (Int 14\_PM)

### **35. Attitude of service providers**

The study also found that the implementation of policy provisions is hampered by the poor attitude of health providers towards the AGLHIV. As a result, many reportedly suffer double stigma specifically from the appointed health surveillance assistants (HSA) at the health facilities. The HSAs are a lower cadre of health care providers which has been assigned by the government to deliver short-term acting methods of family planning, mainly the injectable (Depo-Provera) and the distribution of pills and condoms. These, are specifically assigned to deliver this service to adolescent girls in general at every health facility as part of YFHS. However, it was found that their attitude limits access instead, and AGLHIV who would prefer longer-term methods such as IUDs and implants are often constrained to request because of their poor attitude towards the AGLHIV. Since the uptake of contraception among AGLHIV is consistently low, it is presumed that the poor attitude exhibited by various service providers largely contributes to that.

*“If you go to the health centres you will see adolescents there and we have what we call the HSAs- Health surveillance assistants who are trained to provide Depo-Provera (injectables) and pills, the short-term methods basically. They are government cadres trained to provide these methods but generally it depends on their attitudes, the attitude of*

*the HSAs if it is good or not good. So that limits adolescents' access to long-term methods like implants and all that.” (Int 6\_LSP/IP)*

### **36. Mixed messaging from different policy implementers**

The implementation of policies that prioritize and promote YSRHR has been challenging because of conflicting messaging across policy documents and guidelines on who can access information and services and where, when, and how. It was found that because youth are a diverse group, institutions in Malawi have chosen to categorize young people according to program delivery and policy expectations. These categorizations have led to mixed messaging in the access to SRHR/HIV information and services among sectors.

### **37. Unfacilitated community health structures/systems**

The study found that community health structures in Malawi are unfacilitated and inadequately equipped. The MoH developed the National Community Health Strategy (NCHS) 2017-2022 which outlines the various community structures that are key to delivery and accountability of health services. These structures include HSAs, Village Health Committees (VHCs), Community Health Action Groups (CHAGS), Health Centre Management Committees (HCMCs) and Hospital Advisory Committees (HACs). Traditional and religious leaders also constitute part of the community system. The challenge however is that most of the community structures remain untrained; hence, they do not effectively deliver their functions. There is also a gross shortage of HSAs and limited participation of communities in the delivery of health services including HIV and AIDS services.

In addition, the community HIV prevention, treatment and care package which is intended to extend targeted interventions to PLHIV in the communities is sparsely implemented at the community level.

An additional implementation challenge for policies related to protection of AGLHIV is the limited gender capacities. It was found that at institutional level, there is limited gender mainstreaming capacities across all sectors, with misconceptions and misunderstanding of the meaning of gender in the communities.

### **38. Weak coordination and linkage among CSOs**

Whereas some CSOs are aware of services and structures available within the community and the country at large, some reported being unaware. For example; some are aware and run community victim support groups, while others are not aware of such services – however these

could be operating in different districts and not known to each other. This also limits the scale of operations and access to any protection services, including information.

### **39. Impact of COVID19**

In relation to the above, this study also found that the COVID19 pandemic has impacted the implementation of some programs which support the policies relating to protection of AGLHIV. Key community-based programs, such as the DREAMS program which support AGLHIV were affected. In most of the areas of operation, the numbers of AGLHIV beneficiaries reduced significantly because of fear of parents and guardians and partners, while in other areas, programs were paused following guidance from the ministry of health. Since medical service delivery for HIV and contraception/family planning is mainly situated within health facilities, AGLHIV were equally unable to freely access the facilities during the season of national lockdown. For family planning and HIV/AIDS services, there was extra challenge because service delivery implementing partners who are supporting partners were equally unable to conduct community outreach activities. It was reported that during the same season, cases of SGBV were on the rise but peer leaders were unable to render needed support in most cases. In the absence of systems such as a tollfree hotline, AGLHIV who faced danger had to find other means of coping, thus a missed opportunity to avert negative or undesired SRH and GBV outcomes.

#### **5.4.2 Discussion on implementation challenges affecting the effectiveness of the available policy provisions**

##### **Government's role and the importance of political will**

When there is adequate evidence of social vices, such as abuse and violations, the government has a mandate and obligation to show that there is a pressing and substantial problem affecting society that requires legislation, with which current legislation may not be in position to address. This then would open the way for targeted revision of necessary laws, frameworks guiding the nation and society at large, strengthen specific clauses with clarity, in a bid to protect the most vulnerable and under-privileged groups and members of society.

At the same time, a large amount of evidence also notes the strategic importance for national governments to invest in AGYW to ensure that they become powerful agents for economic and social empowerment within their communities and nations (GoM, 2018b). As AGYW face many diverse challenges, addressing their needs requires a multisectoral response and

collective action of national stakeholders, guided by a common coordinating mechanism, an agreed-upon strategy and common monitoring and evaluation framework.

According to (Hardee et al., 2004), the effectiveness of a given policy relied heavily on the implementation process. Thus, the mere existence of a policy is viewed as a step forward, but not adequate to cause the intended impact unless realistic plans for implementation are developed and executed (Hardee et al., 2004). Improving access to contraception for AGLHIV in Malawi requires a multi-sectoral approach. While policies exist, the public and non-governmental sector responses have faced challenges in breaking down discriminatory cultural ideals and improving women's rights. Harmful practices toward women continue unchanged in Malawi due to the persistence of negative and regressive cultural attitudes. There is need to maintain the involvement of all key stakeholders at both community and facility levels.

**Parallel programming:** Improving development outcomes for adolescent girls and young women requires high-level government support for a cross-sectoral approach that integrates education, health, children, gender, and social and economic empowerment. An essential first step to improve this is to engage high-level government leadership for a coordination body mandated to respond to the unique needs of AGYW across multiple sectors.

Evidence also shows that health policies and programs have a more positive effect on health outcomes when affected populations take part in their development. Also, the legal environment has an important role to play but it effectively contributes to SRH when it is in line with human rights standards. For example, the elimination of third-party authorization requirements for girls and women respects women's rights to autonomy and privacy, and is likely to lead to increased access to SRH services such as contraception. Thus, explicitly grounding contraceptive policies and programmes in a human rights framework improves people's access to information and services. It also guarantees the active participation of people in the processes that affect them, and calls for the elimination of any existing policy or programmatic barriers and for the establishment of clear accountability mechanisms at national, district and community levels.

**Legislation:** In order to address discriminatory behaviour that PLHIV are faced with today, it is important to enshrine rights-based approaches within the policy and legal provisions (Williamson et al., 2014). This must be accompanied equally with legal services that are

appropriately tailored and easily accessible for the different categories of PLHIV such as AGLHIV.

**Partial dissemination:** The process of policy formulation and making of laws provides that after a draft document has been gazetted, a public hearing is conducted where people are availed the opportunity to share their views on the proposed policy in question to ensure sufficiency for broader consumption.

According to (UNFPA, 2017), the issues that can serve as impediments to effective SRH service access and uptake include laws and policies that are either discriminatory, unclear, or inexistent for specific categories of the population. Additionally, poor or failure of implementation of available laws and policies also adds to the concerns. It is important to note that the enactment of for instance anti-discriminatory laws and policies does not alone ensure that PLHIV are not discriminated against and does not guarantee the receipt of best care and services matching their SRH needs. HIV-positive patients often have limited access to SRH services and are often deprived of quality services. Such systemic inequalities can best be addressed by policies which are non-discriminatory and rights-based.

Policies if implemented effectively can provide a safe environment within which young and vulnerable people such as AGLHIV can freely make life choices, and have their health protected concurrently. This can result into the enjoyment of health, dignity, and psycho-social well-being of the lives of AGLHIV.

**Funding challenges:** States and the international donor community may not have invested adequate resources to put in place good quality family planning and contraceptive services, which should include appropriately trained staff offering a full range of methods within easy reach of the entire population. States have an obligation to review and revise any related laws, policies and practices to ensure that they support all human rights obligations and development goals related to sexual and reproductive health. Systematic integration of human rights into law, policy and programme development to facilitate timely provision of good quality services requires addressing the underlying determinants of health, such as gender inequality, and the establishment of participatory, transparent and responsive processes (Lavis et al., 2009).

According to (Hardee et al., 2004), policies which have no resources allocated for implementation may not go beyond the formulation stage, and many stay kept at the shelves of ministry and departmental offices. This is also sighted as a common occurrence, for example,

in the United States these are referred to as “unfunded mandates” (Hardee et al., 2004), and many policies relating to reproductive health in Malawi can be labelled the same because they receive little or no funding from the national budgets. There is need to plan for the financial, physical and human resources that are required to implement every policy and for purpose of this study and the target group, the specific clauses for SRH, since donor funding may vary each year and affect the stability of essential programs (UNFPA, 2019). For the case of Malawi, it is evident that implementation is mainly conducted by partners who have budgets for programs that resonate with certain parts of the policy. However, effectiveness remains a challenge since some critical parts are handled and financed by the government. According to the UNFPA 2019 report, many developing country governments have been keen on aligning their domestic objectives and budgets with the ICPD PoA goals, but dwindling finances continuously affect the momentum (UNFPA, 2019). This implies the importance of assessing the financial implications and price tag of each policy mandate, and ensuring the availability of required resources, their source or means of mobilization to be assured of effective implementation.

**Gaps in advocacy:** The study found that there is a gap in the role of advocacy played by CSOs, and PLHIV organizations. It can therefore be argued that PLHIV/AGLHIV representatives are either disempowered or have limited lobbying and advocacy capacity to ensure inclusion of specific clauses to support the most vulnerable among them, specifically, the AGLHIV. In addition, PLHIV lobbying efforts are weakened by the constant negative response from government, about funding unavailability. Advocacy is a CSO role as players in the policy formulation process.

**Mixed messaging:** This study found that the mixed messaging about policies and programs YFHS in Malawi is delivered in a three-pronged approach: provision of information, services, and referral, in which different sectors play important roles (MoH, 2015). All sectors need to identify cost-efficient and effective ways to deliver and monitor these services and work in harmony without conflicting policy barriers. Homogeneity needs to be limited to primary health care services while other population-specific policies ought to be targeted and spelled out as so, without generalization and mix-up. Experience in a variety of different settings has shown that integrating contraceptive information and services into other SRH services has the potential for increasing accessibility of such services. For example, integrating HIV services and comprehensive contraceptive information, counselling and services is cost-effective and contributes to improving overall family health.



**Coordination:** The adoption of multisectoral and holistic approaches to achieving comprehensive and high-impact programming on AGYW demands strengthened coordination and strategic partnerships with clear and explicit roles and responsibilities for all sectors and stakeholders to work together towards successful implementation of the strategy.

#### 5.4.3 Conclusion:

The findings of this study as presented above continue to underscore the importance of taking the necessary policy actions, and integrating appropriate health policies into programs to improve health and socio-economic outcomes the of AGLHIV.

## CHAPTER 6: SYNTHESIS OF STUDY FINDINGS AS PER HPT FRAMEWORK

This study was guided by the HPT framework. The framework covers the four key dimensions that may influence policy, providing a summative way of looking at how policy is developed or adopted and why all or part of it was implemented and why it was or was not successful. The dimensions are; actors, content, context, and process.

The health policy triangle (HPT) framework points to the context within which policy is formulated and executed, the players involved in the policy making, and the processes associated with developing and implementing policy, and the interaction between them all. Thus, it is through the interrelation of context, process and actors that a health policy is made. Often, there is an ongoing interaction among interests, ideas and institutions (Buse et al., 2012).

The policy process is highly complex, but power and process are two major themes which remain integral to policy. The makers and implementers of policy decisions are often those with the power, and the process through which policy decisions are made largely determines the content of health policy (Buse et al., 2012), and ultimately people's health.

### 6.1 Actors:

According to the HPT, actors are stakeholders as individuals, groups, and organizations, who have power and influence at the local, regional, national or international levels. Actors can work individually or form collaborations and network influence – geographically, professionally, and through partnerships across organizations and groups, inter-departmental or inter-agency. Stakeholders include those individuals and groups with an interest in an issue or policy, those who might be affected by a policy, and those who may play a role in relation to making or implementing the policy – in other words, actors in the policy process. In Malawi, this includes the civil society and other key players in the community like traditional leaders, the chiefs or the religious leaders, to ensure that policies are all encompassing in terms of consultation. AGLHIV are also involved as members of the National Prevention Adolescent Working Group, members of the National AGYW Advisory Committee, which is the highest leadership level in terms of programming for adolescents and young women in Malawi. Overall, there is an indication that a number of stakeholders are consulted at different stages of the policy development (MoH and UNFPA, 2017).

In analysing the actors, three distinct aspects were considered. These include; identifying the policy actors, assessing their political resources, and understanding their position and interests with respect to any given policy (Hunter and Dahl, 1962).

(1) Identifying the policy actors:

Malawi has a range of policy actors in relation to SRHR, HIV, contraception and adolescent girls. Majorly, they are from the government while others are from the civil society/interest groups, as well as international donor and implementing organizations. Thus, the policy players related to the well-being of AGLHIV and contraception use were identified as follows;

- Government players in Malawi are mainly officials from line ministries, departments, and other institutions, mainly; ministry of health as the national custodian for health, other ministries especially ministry of gender, children, disability and social welfare, Ministry of Youth and Sports, Ministry of Education, Ministry of education, all of which have got programs related to SRHR, AGYW and PLHIV. Other national institutions include the National AIDS Commission, the AGYW Secretariat.
- Civil society organizations mainly include several non-governmental organizations (NGOs) implementing programs on family planning, HIV/AIDS and for adolescents in general.
- Interest groups mainly include organizations of PLHIV, such as women living with HIV, religious leaders living with HIV/AIDS, young people living with HIV/AIDS, and organizations implementing girls' empowerment programs.
- International and development partners mainly donor agencies such as PEPFAR and USAID, and UN agencies whose mandates are close AGYW, family planning and HIV/AIDS related programs.

These groups are affected by the policy, they play different roles in the process of policy making and implementation, and will have a level of influence in policy processes in Malawi. Furthermore, they are likely to be affected by the policy either positively or negatively. According to the HPT, the actors are of particular importance as individuals or organizations which can either block the adoption of a policy or support its implementation, depending on the amount of power a given group may have.

(2) Assessing their political resources:

In assessing the power of the sample of the actors above, it is important to note that power is demonstrated in form of different resources, dictated primarily by their different mandates and

by form of funding and expertise to execute roles related to the policy process, including implementation. The different players have either budget which they dedicate to support the government of Malawi in policy development and implementation, as well as programming around AGYW which has been adopted in the last 3-5 years when focus on it was heightened. The different levels of power are leveraged on to influence the policy agendas in Malawi, as seen in the findings of this study. Similarly, (Buse et al., 2012) highlight that political resources may take different forms, either tangible such as votes, finance, infrastructure, and members, and intangible such as expertise and legitimacy in the policy issue. The government's access to such resources increases the stakeholder's influence in the process of policy making and implementation. In Malawi, evidence clearly shows that those (partners and players) with mandates closer to AGYW, and players with more financial muscle to facilitate the policy process are more influential in directing the content of the policy and its implementation thereafter, given the country's dependence on donor funding for SRHR. In addition, some of the key players already have programs designed to suit the policies, which are also in line with their mandates as government partners. This implies that certain parts of the policy may be ignored, as seen in the results of this study too.

The reconciliation of different views and the resulting policy depends on the power of various players/actors within the policy arena and process, including how widely consultation is conducted and groups deemed as relevant to a specific policy are included (Buse et al., 2012). Thus, for purposes of this study, whether or not structural and socio-cultural issues were paid attention to largely depended on the people who were involved at the time, and its impacts on the trajectory of AGLHIV's utilization of contraception in Malawi.

The key to understanding actors, how they influence policies and how policies are implemented is power and how it is used in the policy process, especially formulation and implementation. Power is also the interplay, interactions and interconnections between agency and economic, political, and social structures in the society, often demonstrated through politics.

As noted in the findings of this study, there seems to be a great level of politics towards what is considered unfavourable policies or their provisions. This is mainly around statements relating to cultural aspects, and human rights of AGLHIV, as well as gender. The politics involved in the policy processes goes beyond enactment of a policy, to funding, and to implementation as policies or specific clauses which are deemed unfavourable stand a chance to be ignored, blocked or overlooked during the process of enactment, review and

implementation. This can apply to Malawi due to the limited level of support for contraception use among adolescents which is a highly sensitive and culturally contested issue today. It should be noted also that the Malawian culture is so regressive and stringent towards aspects of marriage at a young age, which is promoted often as soon as a girl reaches puberty. Similarly, other cultural practices as noted by the finding of this study are upheld and viewed as a promotion of their culture, and some authorities are in place to guard such cultural practices and ensure their continuity. Thus, the culture is still alive today and policy makers, as well as many of the actors live within the same society. It should therefore not be startling if they acted indifferent regarding the plight of AGLHIV in relation to risks they encounter to access and use contraception, since they have the power and authority to decide and determine what a policy can be and how it plays out.

Given that politics plays a key role and it is largely omnipresent, it can be argued that providing technical statements as per international consensus documents remains insufficient to facilitate the desired change in the real world in Malawi, if a level of understanding of the policy process among policy makers and key players is not reached. It can also be interpreted that some of the policy makers and players are supporters of the stringent culture, and therefore cannot promote a policy that promotes a divergent view, regardless of the current era of human rights that has been embraced.

However, as advanced by (Hunter and Dahl, 1962) in an ancient study on governance depending on who had power, he highlighted that the resources which give power to groups and individuals are diverse, although unequally distributed (Hunter and Dahl, 1962). This implies that different players or actors can derive power to influence policy outcomes differently. For example; the findings also indicate that other key players such as the National AIDS Commission which enjoy a more cordial and long-standing relationship with the government colleagues have more engagement and influence. Reportedly, the Commission ensures that strategic documents and guidelines that are developed for the national response to HIV in Malawi are aligned to the international human rights treaties and the constitutional provisions. The Commission also strengthens multi-sectoral coordination, collaboration and linkages between ministries and partners in the implementation of the HIV and AIDS (Prevention and Management) Act which prohibits discrimination, the national HIV and AIDS Policy and the National HIV and AIDS Strategic Plan which provides for strategic interventions to reduce human rights and gender barriers to accessing HIV and SRHR services.

With regard to policy related activities, the Commission works with diversity forums that champion issues of access and human rights related to SRH for adolescent girls living with HIV. The Commission regularly monitors implementation to ensure adherence to the provisions set in the policies. Therefore, whereas the Commission may be largely dependent of donor funds, it is leveraging on its power of association with government and line ministries, as a national coordinating entity to ensure the achievement of specific provisions.

Similarly, in order to get the issue of AGLHIV on the agenda, a section of actors ought to generate more recent statistics that show the extent of the problem, and highlight it through social and media outlets showcasing the suffering of AGLHIV, to cause more attention to the issue. interest groups such as the PLHIV groups that participated in this study and are active on ground ought to engage more strongly with other actors within SRHR programming, including gender, human rights, and education sectors to generate more support. In addition, since different interest groups and individuals have different forms of power (Hunter and Dahl, 1962), and can exert their influence differently and indirectly on different policy issues, PLHIV can rally themselves as rights bearers and end-users of the policies, to penetrate the political system in Malawi and exercise power over policy and decision makers regarding the needs and preferences of AGLHIV.

(3) In understanding their position and interests with respect to the issue:

According to (Buse et al., 2012), (Buse et al., 2005), the actors will direct their resources towards areas of interest. This largely determines where their resources – whether in the form of expertise or financial, are allocated. From the findings of this study, it is evident that the key players such as UN agencies and donor agencies such as PEPFAR and USAID have allocated their resources majorly to supporting the development of the policy (ies), providing technical guidance for writing, on supporting development of strategies and on programs which resonate with the policy guidelines. It can be argued that the key players are mainly interested in ensuring that Malawi as a country has documented guidance which also acts as a piece of commitment to global and regional guidelines, as a starting point. However, this has left some aspects of the policies un-catered for, such as dissemination, and the full-scale implementation. Moreover, given the resources and power some actors have over others, many have been left on the periphery of the policy process, making the national policy processes in relation to protection of AGLHIV and contraception use to seem incomplete.

This study also found that lack of political will is affecting the effective implementation of available policies for the protection of AGLHIV. According to (Buse et al., 2012), the position of one of the actors on a policy issue can be determined by the impact of the issue proposed for policy, on their interests. Thus, they may become neutral, supportive or opposed to a specific policy issue. Moreover, it was highlighted by (Reich, 1994) that policy reform is a profoundly political process, and this affects its origins, the formulation and implementation of health policy. He further argued that policy-makers, whether politicians or bureaucrats, are aware of the potential of a policy creating social instability because quite often the suggested reforms are unpopular among the different segments of society. Thus, they may be reluctant to push through the reforms (Walt and Gilson, 1994). Given the strong cultural sensitivity to the use of contraception by adolescent girls, it can be argued that the government of Malawi has remained less-committal to supporting implementation because of fear of conflicting with the conservative sections of the communities, and the traditional authorities who are the custodians of their culture, and society within which they also live, hail from and remain part of. Similarly, the society could hold certain expectations for those within public offices to reject what may be seen as a disruption of their heritage.

In addition, the policy contents are generalized and support for AGLHIV is scant. Also, actors may not be certain of their own position on an issue, for fear of how it may affect their interests, resulting into leaving the contents of the policy vague. It can be argued that the vagueness, limited specificity to the use of contraception by AGLHIV and the vulnerabilities they face – most of which are a result of social vices such as GBV, as found in the policies, was intentional to allow for different interpretation by the different users and targeted beneficiaries. This would ensure that the impact on societal and cultural beliefs varies and is not directly exposed to sudden attack as a result of the implementation of policies related to those issues. This resonates well with (Walt and Gilson, 1994)’s argument that *“A context in which market values dominate leaves little room for morality, values and feelings, and may undermine and destroy previously accepted, socially constructed concepts of public purpose, public morality and public accountability”* (Wuyts et al., 1992).

Therefore, as earlier alluded to, Malawi has a range of actors, evidenced by the numerous programs being implemented on SRHR. From the findings, it is evident that actors have made effort in trying to influence the policy process at the local and national levels. Many organizations represented in the study have been part of the policy processes during formulation, as well as implementation, while bridging the delicate position they occupy



between the state, individual, and households, as well as among interest groups. Many testified to have been consulted during the policy formulation and review processes.

However, it can be argued that their power and influence as interest groups, civil society and development partners, on the policy makers in regards to the focus of this study is viewed to be suboptimal. A further argument is that the power is unbalanced between the different actors, with others being considered as priority by the government while others are sidelined and excluded from certain policy processes. Thus, it is evident that different actors have different levels of power and influence, which leads the GoM to limiting the policy discussions among a specific category or agency which may demonstrate the financial ability to fund the policy processes, given that the country largely relies on international funding agencies. This leaves out those with slightly similar mandates, for fears of competition for governance of the process at the national level.

The effects this has on the policies, is omission on specific issues which may best be handled by an actor who was eliminated or excluded from the process, and further affects the final outcome. The subject of vulnerabilities faced by AGLHIV in the process of seeking and using contraception seems to have been overlooked by all the players without much hesitation from interest groups about certain clauses included in the policy documents. For PLHIV organizations that have participated, their voice and power equally seems to be less effective to cause the desired influence to direct certain policies or clauses to this cause. In addition, it can be argued that the phenomenon of SRH and rights (SRHR) is fairly new, with limited data and discussions focussed solely to AGLHIV in the recent past, which may limit actors' ability to technically contribute. Lastly, having content covering PLHIV may have been considered as an adequate initial step to guarantee the rights of all PLHIV and AGs who wish to use contraception. It is therefore imperative to highlight the dangers of generalizing policies, and taking adolescents as a homogeneous group. Furthermore, with the evidence gathered under this study, the GoM has an ethical and principle obligation to keenly ensure social and legal measures for AGLHIV, to ensure their full enjoyment of sexual and reproductive health and rights. This may also mean effectively galvanising all the actors into a productive policy outcome.

## 6.2 Context:

Context in relation to policy is mainly in four broad types; political, economic, social and cultural, covering local, regional, national and international factors that affect or influence the

whole policy spectrum. The context is largely determined by situational factors such as epidemics or war, structural factors such as political systems and economy, cultural factors mainly norms and customs of a particular society and related traditional hierarchies and patriarchy systems and the position of minority groups or people with specific health problems such as HIV; as well as international factors.

Culturally, in societies where formal hierarchies are instituted and operational, it may be problematic to challenge their authority. The HPT also states that the position of some minority groups may lead them into failure to access health services without the company of their husbands/partners or due to stigma. Some may also not receive information about their rights.

According to the findings of this study, for Malawi, the contextual factors have had and still hold a great bearing on the policies reviewed in relation to this study. From the secondary data collection which included review of selected national documents, most of the policy documents were developed or revised about 5 years ago and less. It is important to note that the context has not changed much, and national SRH statistics have only been slightly altered. This warrants enough rationale for the formulation of the policies. However, given the current situation, it can be argued that there is need to update all the policies with more information and guidelines as well as reflect on aspects of human rights and social protection, as a way of making the policies HIV, adolescent and gender-sensitive.

### 6.3 Process:

According to the HPT framework, the process, focuses specifically on the way in which policies are initiated, developed or formulated, negotiated, communicated, implemented and evaluated. Policy process therefore includes the assessment of population health needs in order for an issue to get onto the agenda of politicians. It also involves an assessment of possible intervention options using scientific and other sources of evidence, and the development of detailed policy choices with focus on the most cost-effective option. Furthermore, policy process includes implementation of the policy, and its evaluation to measure successful achievement of vision, aims, and objectives of the policy. According to the Kingdom's policy stream model, It is only when the problem, policy and politics come together that action to design and implement a policy is initiated. This highlights the important role of politics and power in the policy process.

In Malawi, the consultations have included the civil society and other key players in the community like traditional leaders, the Chiefs or the religious leaders, so that the policies are encompassing in terms of the consultation.

Under the National AIDS Commission, Malawi maintains a well-coordinated multi-sectoral team, which includes several other coordinating bodies of PLHIV, and a coordination structure for Young People living with HIV was established in 2017. All these bodies are represented at all level of decision making including the Malawi Partnership Forum (MPF) in order to ensure meaningful participation of PLHIV and AGLHIV. The coordinating bodies for PLHIV were key in the adoption of several policies such as the rapid scale-up of ART through the universal test and treat in 2016, scale up of Option B+ for PMTCT, the transition to Dolutegravir-based regimens in 2019 and primary prevention and structural interventions for AGYW with support from PEPFAR, Global Fund, Malawi government and other partners. The Teen club model has also been expanded to all districts in the country.

However, according to the findings of this study, there has been limited youth involvement during the making and implementation processes, with their participation limited mainly to attending meetings/workshops, but without speaking. This means that their views are not expressed and their presence does not necessarily translate into meaningful participation. Similarly, CSO involved as implementing partners are not satisfied with the level of representation of their views. It was found that not all suggested components are incorporated into the final product of the policies and strategic documents, although participation and consultation in the process is done (Walt; and Gilson;, 1994).

This study further found that in Malawi, PLHIV community-based support groups offer a lot of support to AGLHIV at the community level but they are not aware of the available laws/policies to refer to during challenging experiences. It was revealed that they continue to offer counselling and guidance to adolescent peers, and advocacy to health facilities if one of the AGLHIV is ill-treated or discriminated against while seeking contraceptive services. However, the findings indicate that they are not fully engaged or involved to address the challenges. It would be more beneficial if the government capitalized on their presence, as available community-based structures to consolidate support for AGLHIV.

Similarly, this study found that there is a limited level of understanding of the concept of policy among the different players, especially the interest groups which would benefit more. The level of understanding the concept of policy is limited and not comprehensive. From the study

findings, responses to policy questions and clauses received mixed arguments/responses which revealed a limited level of understanding of the role of policies, laws and regulations in relation to social protection of vulnerable peoples. This may imply short-comings in the processes in creating awareness prior to passing the policies. In such a context, the role and influence of such actors becomes limited to few aspects.

According to (Buse et al., 2012) the implementation part of the process is one that is often neglected. As a result, a policy or group of policies will either be poorly implemented or not implemented at all. This is similar to what this study findings revealed, where implementation has not been prioritised.

Whereas the HPT framework may present the policy process as more linear, it is iterative in the actual sense, and demands for back and forth interactions between the processes to achieve desired outcome, something which has not been well-done in Malawi.

In reiterating the role of power in policy decision making, it can be argued that Malawi has taken the approach of "stick and carrot" which signifies coercion and persuasion to the actors and public during the policy processes (Buse et al., 2012). From the findings, key players continuously decry the limited level of engagement of the community and AGLHIV in the policy processes, a situation which leaves many unaware of certain key activities relating to the policies.

According to (Buse et al., 2012), such approaches may result in less popular and legitimate policies, which are also not easily acceptable and certainly difficult to implement. This could be the case of AGLHIV if they do not feel well represented in the policies.

The findings also indicate that the consultation and dissemination of policies is not always conducted or only conducted partially, often restricted to the officials at the national level. According to (Walt; and Gilson;, 1994), policy process is sometimes dominated by technocrats and can be limited to a tight circle at the top, often small and made up of the elite.

In relation to funding limitations and the role of the MoH in allocating funds, it is imperative to note that spending on health is often seen as consumption, and governments would often try to limit funding to MoH causes. However, it is increasingly being recognized that wisely targeted spending on health improvement (such as HIV prevention and prevention of teenage pregnancies in high prevalence countries) can be a worthwhile investment, especially in countries with low life expectancy, and should be seen as part of economic policy since a

healthier workforce is highly likely to be more productive. For Malawi, the MoH still has a role to play as a custodian of public health, and creating a budget line is a good step to start.

The study found that decentralization is one of the issues affecting effective implementation. However, (Buse; et al., 2005) argues that whereas such a reform shifts the powers from the central to the lower levels, the state should retain a degree of functions that allow it to continue providing the role of a steward. This often includes protecting and safeguarding the health of its population, mainly through developing appropriate policies, resource allocation rationing, and setting up of regulatory frameworks, as well as monitoring of service providers .. This, would directly provide continuous oversight for their implementation. Given the numerous capacity challenges that Malawi faces, with specific reference to the health sector, it is paramount that the state continues to play the oversight role and provide clear guidance for policy implementation.

#### 6.4 Content:

Policy content is what the policy is made up of. The vision, aspirations, ambitions, aim, objectives, of the policy, and the details of how they will be made real. It may also present a framework or set of principles for how the actions fit together, and may sometimes include outputs, outcomes, deliverables, milestones, often out of the main policy document but in separate action plans.

According to the findings of the study, the policy content in Malawi in relation to protection of AGLHIV against the vulnerabilities faced in using contraception is largely in place. Key issues such as SRHR and HIV integration, protection of human rights of vulnerable girls and PLHIV, and clauses addressing issue slike gender-based violence are in place. However, as mentioned in earlier chapters highlight the gaps, the some of the policies are broad, and some clauses can be referred to as vague, inconsequential or redundant. For most of the clauses, smart approaches are required to implement in order to have visible impact. The implementation of protective policies can be supported by promotion of such policy clauses through community education and sensitization targeting key community members (UNDP, 2013), traditional authorities, peer representatives, health care workers, social workers and notable institutions whose mandate extends towards provision of protective services in one way or another, and building resilience of AGLHIV.

This study also supports the claim by (Buse; et al., 2005) that in using the HPT framework in analysing how specific policies are functioning, it is imperative to go beyond the content, and consider other aspects married to it such as the who and how questions, to find answers to decision makers, implementers involved and the circumstances under which specific policy may be introduced and executed. From the findings of this study, there is evidence of content within different policies and related national documents, but looking at implementation raises so many questions about what the initial intentions of the contents were as implementation remains poor or not done at all for most of the key contents of the policies.

Furthermore, since policy refers to the decisions taken or not taken by those with responsibility for a particular area, and health policy covers the course of action and inaction that affect the set of institutions, organizations, services, and funding arrangements of the health system, it can be argued that GoM has taken a more relaxed and less confrontational approach towards contraception use for AGs, and the plight of AGLHIV. Given the gravity of barriers, challenges and risks faced in the process, it is difficult to denote or attach meaning and reason to the inaction in the area of social support, a supportive legal environment, and on-going harmful cultural practices and the impact of the inaction on the well-being of the population.

When designing and implementing laws and policies for contraception use, it is important to consider young girls who are HIV positive, the vulnerabilities they are faced with and to consider them in all related policies consistently to remove all inhibitions to uptake of contraception services while ensuring their safety within the home, community and at the point of health care service provision.

Although Malawi has adopted some important laws and policies to protect women's and girls' rights, and promote access to health services, existing laws provide only partial protection or guidance and many are not synchronized with the actual situations young women are facing, making them less effective. In such cases, the marginalized groups such as AGLHIV within the society may find it difficult to seek the help of authorities or find where to seek assistance, leaving many at the discretion of family and traditional authorities who often fail them.

The findings of this study can also be used as a call to the authorities, as a moral imperative to reassess and recognize the status and contexts in which policies are made as marginalized populations still remain deprived of their rights. During SRHR policy formulation and review, some critical context issues should be maintained as standards from which not to deviate. These

should then be reflected clearly through provisions in the content of the policy once identified. For example, the value of life and health.

Health is both a fundamental human right and a sound social investment. GoM needs to invest resources in health promotion in order to raise the health status of adolescents given their anticipated overall contribution to societal productivity in both social and economic terms if well-being is assured. A basic principle of social justice is to ensure that people have access to the essentials for a healthy and satisfying life, and contraception services is a key essential for the AGLHIV. A healthy adolescent population would lead to long-term economic benefits. Additionally, efforts must be made to link economic, social, and health policies into integrated action at the country level.

In addition, the domestication of policies should put in consideration the use of innovative strategies and address root-causes to problems such as child and forced marriage, through poverty reduction programs.

Therefore, to ensure sensitive and quality policies, the GoM should consider a synchrony of issues, including the biomedical, economic, political and societal forces that HIV-positive children and young women have to deal with frequently (Chipokosa et al., 2019), and the participation of PLHIV specifically women ought to be maintained from inception to implementation regardless of the diverging powers involved in the processes.

Consider AGLHIV's evolving capacities and ability to defend themselves if policies provide for the right to do so. As growing adults in a culturally and socially challenging context as Malawi, an AGLHIV who is in a desperate situation needs to be legally permitted to seek and access contraception services that she requires to safeguard herself from an unwanted pregnancy and all the likely negative health consequences that may arise.

SRH programs such as CSE are essential for all AGYW living with HIV and it is recommended that such programs should be provided to young people way before they become sexually active (Yam et al., 2017), in a gender-specific and age-appropriate manner. This is aimed at arming young girls with the necessary information ahead of time, since their experiences of the biological and social transitions that they undergo influence their reproductive choices as they age into adulthood.

For issues which have policies that are hinged to global frameworks and agreements, interdependent with other nations worldwide, such as HIV, contraception, human rights, it is imperative to facilitate and monitor the policy domestication process at the independent



national levels. This will support the convergence of national and stakeholder interests by crafting local solutions to local problems, depending on the manifestation of the problem and socio-cultural/sensitivity around it, while maintaining internationally agreed on principles. For example, the case of fertility control visa vis societal perspectives and how to appropriately incorporate them in the policy making processes. This could address the cultural sensitivity around contraception use for AGLHIV and AGs in general.

## CHAPTER 7: CONCLUSIONS AND RECOMMENDATIONS

### 7.1 Conclusion

Basing on the research process and the findings of this study, the HPT framework provides seamless understanding of the various factors which have a bearing of the formulation and successful implementation of health policies. With specific reference to this study, the Principal Investigator found that focussing on each dimension aided the unearthing of important details which would otherwise be left out during the research process. However, the process is not necessarily linear as all the dimensions are interrelated, with a lot of back and forth re-analysis to produce an understandable comprehensive image of the phenomenon of protection for AGLHIV. The framework is adaptable to support focus on a specific population and issue as demonstrated through this study, with the ability to show who is likely to favour, support or resist specific policies. It can therefore be argued that the HPT framework is an adequate theory given its ability to encompass all key aspects surrounding health policy and its implementation. Through assessment of the actors, the HPT framework additionally permits for the examination of the role of the state and the roles of external players, often the donors and international organizations and their separate but intricate roles during the policy process and the harmonization of ideas through consensus.

As argued by Walt and Gilson, that health policy research needed to go beyond the content of a policy (Walt and Gilson, 1994), the role of actors, the context, and the process cannot be underscored in Malawi, and specifically for AGLHIV in relation to uptake of contraception. Health policies are largely made through the complex inter-relationship of context, process and actors. Given that the HPT is deeply grounded in a political economy perspective (Walt et al., 2008), it provides a more meaningful process of assessing the relationship between the institutions in Malawi, the different players, interest and ideas, given the multi-dimensional nature of the phenomenon under investigations. SRHR, the health and well-being of adolescent girls, and the reality of living with HIV all gather an array of stakeholders who are largely interconnected, and whose roles cannot be ignored in how they influence the policies around AGLHIV and contraceptive use. Yet, the political economy is equally paramount as seen through the findings of this study.

However, whereas it was envisaged by Gill and Walt that the framework can guide policy maker and researchers to better understand the process of health policy reform and plan for effective implementation (Walt and Gilson, 1994), the scenario is different for Malawi.

Therefore, it is clear that the formulation and effectiveness of policy for protection of AGLHIV from vulnerabilities faced in using contraception in Malawi is largely dependent on the values and culture (both national and international), accountability, morale of actors and the state, and improved communication and coordination. However, the continuing framework does not address the issue of unequal power relations which exists between the different players. For instance; it is clear from the findings that political will is not guaranteed, and that actors with more power will have a better chance to influence the direction of a policy. For the sake of the vulnerable population at the centre of the debate, the harmonization of ideas through a form of consensus ought to be made practical to prevent redundant policy clauses, which are not checked or implemented until the end of the policy period.

Since the 1994 ICPD and the socio-political process that followed, it can be argued that there has been a level of commitment from the government to matters of population and family planning. Malawi had initially affirmed its political commitment to pursuing all noble objectives which were aimed at addressing the population and development concerns. Malawi had affirmed to moving together with the international community towards ensuring improved access to family planning services for adolescents and young women.

According to the ICPD PoA, reproductive health programs should be designed to serve the needs of women, including adolescents and ought to involve them in the leadership, planning, decision-making, and implementation. Similarly, it is stipulated that government and the international community ought to use fully all means available at their disposal to support the principle of voluntary choice in family planning (UN, 1995). To address the unmet need for family planning, a special request was extended to all countries to identify and remove any remaining barriers to the use of family planning services, by providing a conducive climate, that favours access to and use of good-quality public and private family planning and reproductive health information and services, through all possible avenues. However, after twenty-five years, a lot of effort is still required (Chandra-Mouli et al., 2015b).

While the policy environment in Malawi is seemingly favourable, undertones exist around harmonization of legal age of access, as well as debates around representation of interest groups, such as PLHIV groups, and specifically AGLHIV. While decisions over policy content

may not be merely technical, policy makers ought not to continue ignoring the importance of formulating HIV-sensitive policies which can give way to development and implementation of social protection programs for the most vulnerable within the society, given the benefits of a healthy youthful population.

The SRHR policy environment in Malawi is quite complex, charged with political undertones and entangled with various interests, shifting positions, of the different organizations, groups, communities, and the state, as regards policy provisions for protections of AGLHIV and their uptake of contraception. To achieve the objectives of universal health coverage, practitioners still need to understand the context and become more aware of the existing obstacles and opportunities for effectively and clearly getting the issue of contraception use by AGLHIV on the policy agenda, and similarly ensure effective implementation of available policy provisions.

The findings of this study can also act as a call to targeted inclusion so that all categories of key populations or people who are to be served or represented in the policy document are involved in the process, as opposed to limiting participation to a limited few such as urban AGs whose experiences might not match those of rural areas, for instance. It is important to be able to segment for all the different categories of girls.

Malawi should accord high priority to the promotion and use of contraception as one way of improving the quality of life and productivity of women and girls. Women and girls need to have adequate information and access to contraception for them to make informed decisions to delay motherhood and plan their family size and in turn fulfill their rights to education, health, and employment. These human rights issues are intrinsic to a life of dignity and well-being, thus meriting the government's protection. Similarly, the non-fulfillment of these rights impedes the country's economic and social development for current and future generations.

The GoM ought to pay more attention to implementation of policy provisions which promote the aspect of integrating services, given its potential to alleviate some of the main challenges to AGLHIV's ability to exercise their sexual and reproductive health and rights. A context-specific model should be developed or adopted, without ignoring the effects of illiteracy and gender norms that elicit significant challenges for AGLHIV's agency and decision making. Therefore, efforts for service integration can be increased, and even go beyond HIV and family planning alone (MacCarthy et al., 2014) to include services for gender-based violence survivors within one centre or through extension.

While a range of policies related to AGLHIV and contraception use have been formulated, Malawi still needs to invest in the implementation so that policy content is matched with practice up to the lowest service centres where AGLHIV seek and receive the service, and improve the quality of service provision (Dasgupta et al., 2016).

Government of Malawi ought to go beyond formulation of policies to mobilization and allocation of funds specifically to cater for the social protection of AGLHIV as they seek and use contraception. For an adolescent girl who is unmarried and living with a terminal condition, the disclosure of sexual activity to health care providers and beyond yields a level of vulnerability and exploitation, and it is the role of the state to ensure that such young and vulnerable members of the society are protected.

The process of policy formulation should consider going beyond inclusion to strengthening and monitoring the implementation of general principles such as human rights and gender equality.

According to WHO, an integrated approach to health and human rights lies at the heart of ensuring the dignity and well-being of women living with HIV (WHO, 2017). This includes, but is not limited to, the right to the highest attainable standard of health; the right to life and physical integrity, including freedom from violence; the right to equality and non-discrimination on the basis of sex; and the right to freedom from torture or cruel, inhuman or degrading treatment. The right to SRH is an integral part of the right to health, enshrined in article 12 of the International Covenant on Economic, Social and Cultural Rights (ICESCR).

Similarly, the promotion of gender equality is central to the achievement of SRHR of all women, including women living with HIV in all their diversity. This means recognizing and taking into account how unequal power in women's intimate relationships, harmful gender norms and women's lack of access to and control over resources affect their access to and experiences with health services.

The integration of family planning and HIV services ensures that women who may require both services receive comprehensive health care. It is equally envisioned to reduce the logistical barriers and uphold women's privacy. Following the findings of this study, such programs would support the smooth access of contraceptives for AGLHIV and help to reduce the eventualities they are dealing with currently. However, it is a policy issue, to ensure mandate is given to the programmers.

The promotion of resilience mechanisms which target AGLHIV in Malawi is of paramount importance to enhance the life-skills and survival mechanisms in the context within which they live. Since the SRHR of AGLHIV is a complex phenomenon which requires different issues to work well together each time an AGLHIV is seeking contraceptive care, building individual resilience can serve as a means of self-defense and assertiveness during the process of care seeking. Some of the resilience mechanisms would include arming the AGLHIV with information about the available provisions and how it relates to their situation, where to seek assistance if violation is experienced, and available means of legal redress.

It is also necessary for the GoM to commit to strengthen the national social and child protection systems, and care and support programmes for children. In particular for the girl child, and adolescents affected by and vulnerable to HIV, as well as their families and caregivers, including through the provision of equal opportunities to support the development to full potential of orphans and other children affected by and living with HIV. This can be achieved, especially through equal access to education, the creation of safe and non-discriminatory learning environments, supportive legal systems and protections, and provision of comprehensive information, especially age-appropriate HIV information to assist children living with HIV as they transition through adolescence, consistent with their evolving capacities.

In thinking of alternative policy frameworks, a response to the entire needs of adolescents living with HIV (ALHIV) ought to be considered within the framework of positive health, dignity, and prevention which ensures a supportive and protective legal and policy environment. With a focus on holistic health and wellness, and not only the prevention of onward transmission of HIV, it would address the psychosocial, economic, education and socio-cultural vulnerabilities, as well as gender and sexuality. Furthermore, response should be tailored to specific contexts, spell out all key populations, consider individual dynamics, and with the full involvement of PLHIV as rights holders and service users. Such an approach places a person living with HIV at the centre of managing their own health and well-being since it links HIV treatment, prevention, support and care issues within a human rights framework. For instance, tailored services would be beneficial to young women living with HIV to plan their pregnancies while maintaining their health and interrupting the cycle (possibility) of HIV transmission (Toska et al., 2020a) to both sexual partners and infant.

For policies to be effective for SRHR, there is need to come up with more strategic programs and support on changing the behaviour, attitudes and mind set of policy makers, society and family which are important in shaping most of the day to day lives of AGs. This is important as a progressive measure towards achieving the transformative changes anticipated in the issues of SRHR, GBV and violence against women and girls in general.

Lastly, the preventing and addressing of the socio-cultural and structural challenges faced requires the same level of efforts as with other policy priority areas as the findings indicate a reluctance in critically addressing the socio-cultural issues. It is imperative to acknowledge the enormous impact these have on the day to day life of a vulnerable individual and their detrimental life-long impacts on human growth and development. Whereas the road to achievement of universal health coverage (UHC) is still long ahead of us, reproductive choice remains foundational in the drive for gender equality and to a future where young women and girls take their rightful place in all aspects of society.

This study therefore confirms the synergistic roles of SRH rights, needs and aspirations, the socio-cultural and economic context, the health systems, and the laws and policies in promoting the development and delivery of appropriate programs and services for HIV positive adolescent girls (Gruskin et al., 2007), as earlier alluded to in the introduction section of this thesis.

## 7.2 Recommendations (as per the Health Policy Triangle)

Basing on the findings of this study, it is clear that the main challenge is implementation, while gaps in specificity also prevail. The implementation progress is slow and curtailed by several factors which all resonate with prioritizing of the rights of specific individuals regardless of their vulnerability, as well as a lack of prioritizing of sexual and reproductive health and rights of young people. Therefore, the recommendations for this study are as follows;

- There is need to turn the available policy clauses into reality that can make meaningful change into the common AGLHIV's life. For this to be, there is need for careful investment into actions which can generate the desired behavioural and structural changes among concerned parties. Some of the policy implementation can be channeled through available community-based structures which can be incentivized to continuously deliver the services to the AGLHIV, and which can be easily accessed by AGLHIV at the community levels where they live. The implementation of the policies, in a manner that makes sense to AGLHIV remains a key aspect as it helps to translate



the narratives into actions which can be experienced by the people most affected. It is the role of the state to facilitate the process.

- The responsible players, stakeholders and actors should strengthen accountability, particularly social accountability where citizens are able to hold the government of Malawi responsible as a duty holder. This can be done by actively calling out the government responsible agencies and hold them accountable periodically. A citizens' score card, a measure of performance of commitments can be considered to solicit actual progress and societal sentiments.
- Specific indicators should be set to capture and measure the progress of set policies and associated programs, and national monitoring and evaluation systems for SRHR ought to be strengthened (Hardee et al., 2004).
- Processes of development of family planning policies should be both intersectional and inclusive, to work towards target groups such as AGLHIV and commit to reaching them adequately to address specific challenges such as the vulnerabilities they face.
- The findings of this study also call for rights literacy / rights-based literacy from government to the individual beneficiaries and make it a norm through policies and advocacy. This will promote social and behaviour change (SBC) and prevent crisis-communication by ensuring that information is available through-out, is culturally-sensitive and targeted to address the cultural short-comings towards AGLHIV as an immensely vulnerable group.
- Within the framework of human rights, rights-based FP and SRHR should be infused within the usual programming and policies, and other social and economic rights such as jobs, education rights, so that rights for FP are not seen in a vacuum. In other words, this implies a deliberate effort of linking FP/contraception/SRHR/ GBV to other rights, possibly by the GoM as the duty bearer.
- Furthermore, policy makers should link policies and rights to budgets as a means of ensuring commitment, as well as link them to sustainable development goals (SDGs) programs as a way of ensuring a holistic response to the barriers encircling an AGLHIV in Malawi.
- On a broader angle, UHC programs should be infused with rights, articulated for their promotion and implementation. This is as a means of main-streaming of rights, since the process is gradual.

- For promotion of community health and social welfare, there is need to empower the community with information on FP, contraception use and its importance, and also to emphasize why they need to change some socio-cultural practices that are barriers to access. This ought to be a constant social and behavioural change communication drive, which can be adopted as part of the main national SRHR programming.
- Given the sensitivity to FP and its local interpretations, flexibility with terminology of “rights” ought to be considered as the society does not perceive it well. Alternative words can be used, such as choice and information, access, essential service in order to operationalize a rights-based approach without much resistance.
- Civil society ought to engage with national human-rights institutions, to bring attention to the gravity of abuse of human rights and seek legal support for victims. CSOs focused on human rights could also form partnership with regional partners and find a common platform for forwarding such violations to expose the problem and stir discussion and solution seeking. Regional partnerships can also serve to remind a country of its commitments, which in-turn could lead to some form of positive action within Malawi.
- Persuade governments to make rights-based policies
- There is need for broadening of the knowledge about rights issues, specifically, among the decision makers, policy makers, politicians, and implementers, to guide their language and pronouncements on FP especially publicly to prevent going backwards on progress already attained. And also, to ensure that rights issues relating to HIV and FP access and use are indicated, covered, monitored with indicators, tracking to ensure the safety of adolescent girls in relation to rights-based approaches.
- Bring in the voice of AGLHIV in the policy making process and policies, and not only civil society and advocacy teams. The voices of affected young girls and their true sentiments on the issues of fertility, and the impact on their well-being, their life choices and ambitions, about having numerous births, and the effects of a woman being perceived by partner and society as a tool for reproduction and nothing else beyond that. There is need to hear the actual effects of child birth on girls’ health and their general well-being and have policy makers prioritize issues around SRHR since they are at the center of every adolescent girl’s life.

Additionally, key players should consider using a different discourse, counting the costs of inaction, economically, socially, and on family front so that it is not centered only around women, bringing men on board as family partners, and tracing lives of

successful women who have been able to contribute nationally and at family fronts as examples of results of FP and contraception use.

- Policy makers should consider the evolution of FP and its strong and intricate link to rights. The new era of measuring rights by tracking reproductive autonomy ought to be harnessed. It is anticipated that having such policies in place helps to influence the overall health outcomes. With anything being remotely done in family planning, the focus ought to always go back to women's rights and bodily autonomy. That counts for the vision of key players both regionally, internationally and sometimes home-based. Thus, the focus on rights has to remain at the forefront and remain core.
- In addressing the socio-cultural vulnerabilities, especially sexual and GBV, women need to be encircled with the full range of knowledge which they need, from risk mitigation at community level to national level policies, and any available social protection services. Within this, there should be language mindfulness as "rights" terminology seem not to be well-received among the Malawian society. If GoM is keen on protecting the AGLHIV, they additionally ought to work well with civil society so that they extend civic education to the people to understand what their duties are, and how to work closely with duty bearers.
- Adherence to standards through providing extensive capacity building and monitoring of YFHS workers will enable scale-up of outreach with a high degree of efficiency, confidentiality, and accountability. This will allow for easing congestion of static facilities for more focused health care needs. It is vital that Malawian youth be provided with services that not only help them but teach them about what to avoid and to expect about risk behaviour. Investment in YFHS will protect the health and well-being of young people and equip them with the knowledge and skills needed to positively shape their families and communities and enable the start of an independent productive life necessary to positively engage in civil society and contribute to the social and economic development of Malawi.
- Therefore, laws and policies should be aimed at supporting programmes to ensure that comprehensive contraceptive information and services are provided to all segments of the population, with special attention given to disadvantaged and marginalized populations such as AGLHIV in their access to these services.
- Policies should provide for the strengthening of integration of contraceptive commodities, supplies and equipment, covering a range of methods, within the essential

medicine supply chain to increase availability. Invest in strengthening the supply chain where necessary in order to help ensure availability.

- Special considerations ought to be given to cross-cutting issues. Given that some of the challenges and barriers identified by the study as limiting AGLHIV's access to contraception are cross-cutting, such as gender aspects and human rights violations, the equal consideration for them as cross-cutting issues across related national policies becomes paramount so that young and vulnerable girls such as AGLHIV are protected and their SRH needs easily met.
- The findings of the study equally found that some of the policies are outdated and as such not relevant to the current context. Policy makers, as duty bearers ought to maintain an intentional connection with the policy beneficiaries, and remain aware of the socioecological context of Malawi and create space for reviewing of provisions that are dormant and less helpful or impactful in relation to the challenges faced by beneficiaries. This can result into the enactment of responsive and tailor-made provisions which address the socio-cultural and structural issues identified.
- Re-enforce the importance of integration of SRH services into HIV care such that AGLHIV who are already enrolled in HIV care can be reached with contraception during their routine clinic visits. There is adequate evidence that this form of integration has increased promotion of contraception and its access by the most vulnerable populations such as AGLHIV. However, this will also call for addressing of key structural barriers such as attitude of nurses and care givers to make optimal use of the available modern family planning services for young women with HIV. Thus, synergies in policies, programs and service delivery ought to be promoted to comprehensively uphold the SRH and rights of AGs living with HIV. This can also be done within the framework of gender-equality and human rights as earlier alluded to.
- Promote SRH policies that improve access to family planning services as preventive action.
- Make clear, and known, the provisions for AGLHIV along with other adolescents and young people to report or obtain assistance if their SRHR are violated at an institution.
- Policies should include strategies that educate and raise awareness among parents and communities to prevent stigmatization, prejudice and denial of health services to adolescents who are HIV-positive, among other vulnerable groups

- Government technocrats should include the dissemination of policies among the key plans, budget for it and oversee its implementation.
- Furthermore, there is need for appropriate and frequent support supervision, guidance and mentorship for human resources involved in the implementation processes, as well as reporting on service delivery for policy related activities. Without this, Malawi just like other SSA countries will continue to struggle with addressing the special SRH rights and needs of AGLHIV, and young people in general.
- Refresh the FP and SRHR policy guidelines at major service points where AGLHIV receive care to act as constant reminders and reference points for service providers during service provision (Chipokosa et al., 2019).

### 7.3 Areas for further research

- Conduct more rights-based research related to sexual and reproductive health
- To support public policy, more research should be conducted to generate additional forms of evidence which can guide laws and policy makers to develop laws and policies that empower women and girls.

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## ANNEXURE

### Annex 1: Data Collection Tools

#### Annex 1.1 Documents' Review Framework

HPT (Health Policy Triangle) parameters	Key guiding questions	Sources of Information/data	Points of focus
-CONTEXT  -ACTORS	1. What is the existing social, political, economic, cultural and health system context?  2. What was the social, political, economic, cultural and health system context of the policy / strategy?  3. How relevant is it to the issues identified by the study?  4. Were there any key groups / actors influencing policy / strategy formulation?	Documents' review:  -Healthy policy plus program  National AIDS Commission  PSI program  Human rights reports  UN annual program-related reports  Scientific publications  Any other notable program reports   - Country SRH related policies, strategic plans, implementation frameworks  Country  Tangent policies  International guidelines	-Structural issues  -Socio-cultural issues faced by AGLHIV in using contraception
		Interviews conducted with; policy makers, development partners, Local service providers and implementing partners, and PLHIV organizations	
-CONTENT  -ACTORS	5. How did key groups/actors influence the policy/strategy formulation?  6. What was the process of policy formulation?  7. What were the objectives of the policy / strategy?	Documents' reviewed: Country SRH related policies, strategic plans, implementation frameworks  Country  Tangent policies  International guidelines  Other related/relevant publications	Policy provisions to address issues/risks faced by AGLHIV in using contraception

HPT (Health Policy Triangle) parameters	Key guiding questions	Sources of Information/data	Points of focus
	8. Which key thematic areas were addressed? Are there any/What are the gaps in the content?	Interviews conducted with; policy makers, development partners, Local service providers and implementing partners, and PLHIV organizations	
-PROCESS  -ACTORS	9. What was the implementation plan?  10. What progress has been attained to-date?  11. What were the challenges in implementation (such as cost, technical feasibility, acceptability among target populations/community, interferences by culture/traditions)?  12. Was the policy / strategy evaluated or reviewed? If yes, then what was the achievement in terms of coverage, effectiveness and inclusion of issues relating to AGLHIV? equity, among other factors?	Documents' review:  -Healthy policy plus program National AIDS Commission  PSI program  Human rights reports  UN annual program-related reports  Scientific publications  Any other notable program reports  - Country SRH related policies, strategic plans, implementation frameworks  Country  Tangent policies  International guidelines	Implementation challenges affecting effectiveness of policy(ies)
		Interviews conducted with; policy makers, development partners, Local service providers and implementing partners, and PLHIV organizations	

## Annex 1.2 PLHIV organizations' interview guide

**Institution:** \_\_\_\_\_ **Position:** \_\_\_\_\_

**Date of interview:** \_\_\_\_\_ **Duration:** \_\_\_\_\_

### Interview Questions

1. What services do you offer for PLHIV and specifically AGLHIV?
2. What can you say about the issue of pregnancies among AGLHIV and their need for and use of contraception in Malawi?
3. What can you say about the structural aspects of the sexual and reproductive health services for adolescents and its impact on contraception use by AGLHIV?
4. What is your perspective about the socio-cultural environment and how it affects the use of contraception by AGLHIV?
5. Would you say it is easy for adolescent girls living with HIV to access contraception in Malawi?
6. Would you say Malawi had made effort to protect AGLHIV to easily access contraception? Please give details
7. In your view, what has the government done to help young girls living with HIV to access contraception?
8. What guidelines are in place to facilitate easy access of contraception by adolescent girls living with HIV?
9. What policy or guidelines are provided by government to protect adolescent girls living with HIV against the risks encountered in the process of using contraception/contraceptive services as PLHIV?
10. Would you say the policies address the issues/risks faced by AGLHIV, and provide adequate protection for vulnerable people such as AGLHIV? Please clarify on the available provisions that you are aware of in this regard
11. From your experience working with and representing PLHIV, how easy/possible is it for an AGLHIV to access and use a specific method of contraception that she may desire?
12. What challenges do you face while seeking protection for your rights to accessing the contraceptive care you need?
13. Do you feel adequate attempts are being made to address the issues faced by AGLHIV to reach and use contraception in general? What gaps can you point out?



14. Do you feel that the policy directives in place have had any positive contribution towards addressing the issues faced by AGLHIV and protecting them, or facilitating their access and use of contraception?
15. In your view, what difficulties or bottlenecks is the country experiencing in implementing such policy directives/ service delivery guidelines?
16. What would you say is the cause of those difficulties/bottlenecks?
17. In your view, what challenges affect the effectiveness of the policy directives/implementation of guidelines?
18. How do the challenges affect service uptake by the AGLHIV in the community?

***19. INCLUDE QUESTIONS ON GAPS IDENTIFIED OR CLARIFICATIONS  
NEEDED FOLLOWING THE DOCUMENT REVIEWS***

### Annex 1.3 Local service providers and implementing partners' interview guide

**Institution:** \_\_\_\_\_ **Position:** \_\_\_\_\_

**Date of interview:** \_\_\_\_\_ **Duration:** \_\_\_\_\_

#### Interview Questions

1. What services do you offer for PLHIV and specifically adolescent girls?
2. What can you say about the issue of pregnancies among AGLHIV and their need for and use of contraception by in Malawi?
3. What can you say about the structural aspects of the sexual and reproductive health services for adolescents and its impact on contraception use by AGLHIV?
4. What is your perspective about the socio-cultural environment and how it affects the use of contraception by AGLHIV?
5. Would you say Malawi had made effort to protect AGLHIV to easily access contraception? Please give details
6. In your view, what has the government done to help young girls living with HIV to access contraception?
7. What guidelines are in place to facilitate easy access of contraception by adolescent girls living with HIV?
8. What policies are in place to ensure that AGLHIV can easily reach and use contraception?
9. Would you say the policies address the issues/risks faced by AGLHIV, and provide adequate protection for vulnerable people such as AGLHIV? Please clarify on the available provisions that you are aware of in this regard
10. From your experience working with and representing PLHIV, how easy/possible is it for an AGLHIV to access and use a specific method of contraception that she may desire?
11. In your view, what difficulties or bottlenecks is the country experiencing in implementing such policy directives/ service delivery guidelines?
12. What would you say is the cause of those difficulties/bottlenecks?
13. In your view, what challenges affect the effectiveness of the policy directives/implementation of guidelines?
14. How do the challenges affect service uptake by the AGLHIV in the community?

***15. INCLUDE ANY OTHER QUESTIONS ON GAPS IDENTIFIED OR  
CLARIFICATIONS NEEDED FOLLOWING THE DOCUMENT REVIEWS***

#### Annex 1.4 Policy makers' interview guide

**Institution:** \_\_\_\_\_ **Position:** \_\_\_\_\_

**Date of interview:** \_\_\_\_\_ **Duration:** \_\_\_\_\_

##### **Interview Questions**

1. Could you briefly describe your position and your key roles in relation to policy.
2. How familiar are you with the sexual and reproductive health or teenage pregnancy situation in the country?
3. What can you say about the issue of pregnancies among AGLHIV and their need for and use of contraception in Malawi?
4. What sort of work is being done by the government to ensure that adolescent girls use contraceptives?
5. What sort of effort is the government putting forward to ensure that AGLHIV access contraception without being exposed to risks?
6. What are some of the risks that AGLHIV face in accessing the contraception services? Please explain briefly
7. To what extent do you consider PLHIV especially adolescent girls when setting up or reviewing a health policy, directive or guideline in the country?
8. How familiar are you with the international consensus documents, such as international human rights treaties relevant to the sexual and reproductive health of PLHIV? Please explain briefly.
9. What HIV and family planning related policies are being implemented in the country currently?
10. What were the factors that contributed to action on this issue?
11. Do you think family planning /contraception services are easily accessible for AGLHIV in this country?
12. Given the risks that AGLHIV face in the process of reaching and using the services, what adjustments have you made to ease the process for them and ensure that they are protected or supported effectively?
13. What have been some of the challenges in translating policy to practice in relation to AGLHIV and contraception use? What are the bottlenecks?
14. What has been done to address the socio-cultural issues given the strong cultural environment/factors in the country and how they affect the efforts of AGLHIV and also put them at risk?

15. How does the ministry include attention to access and human rights related to sexual and reproductive health of PLHIV in this regard? What policy related activities is the ministry engaged in that relate to promotion of access and human rights related to sexual and reproductive health of adolescent girls living with HIV?

***16. INCLUDE ANY OTHER QUESTIONS ON GAPS IDENTIFIED OR CLARIFICATIONS NEEDED FOLLOWING THE DOCUMENT REVIEWS***

### Annex 1.5 Development partners' interview guide

**Institution:** \_\_\_\_\_ **Position:** \_\_\_\_\_

**Date of interview:** \_\_\_\_\_ **Duration:** \_\_\_\_\_

#### Interview Questions

1. What can you say about the issue of pregnancies among AGLHIV and their need for and use of contraception by in Malawi?
2. What can you say about the structural aspects of the sexual and reproductive health services for adolescents, and its impact on contraception use by AGLHIV?
3. What is your perspective about the socio-cultural environment and how it affects/limits the use of contraception by AGLHIV?
4. Are you familiar with the policies in the country that relate directly or indirectly to vulnerable groups? If so, would you say they have a negative or positive impact on the sexual and reproductive health of these groups? Please give specific examples.
5. In your view, what has the government done to help young girls living with HIV to access contraception?
6. Do you know of any laws, policies, regulations or other governance mechanisms in place to explicitly address human rights issues related to access of sexual and reproductive health services, specifically contraception pertaining to vulnerable groups (e.g. ensuring non-discrimination and access to services, and/or their participation in policy-making activities that impact on their lives, health and well-being)?
7. What guidelines are in place to ease access of contraception by adolescent girls living with HIV?
8. What processes are in place to ensure that AGLHIV can reach and use contraception?
9. Would you say the policies address the issues/risks faced by AGLHIV, and provide adequate protection for vulnerable people such as AGLHIV? Please clarify on the available provisions that you are aware of in this regard
10. In your view, what difficulties or bottlenecks is the country experiencing in implementing such policy directives/ service delivery guidelines?
11. In your view, what challenges affect the effectiveness of the policy directives/implementation of guidelines?

**12. INCLUDE QUESTIONS ON GAPS IDENTIFIED OR CLARIFICATIONS  
NEEDED FOLLOWING THE DOCUMENT REVIEWS**

## Annex 2: Principal Investigator Request Letter to Targeted Participants

May 25, 2021

Dr. \_\_\_\_\_

Chief Executive Officer

\_\_\_\_\_

Lilongwe – Malawi

### **Re: Self-Introduction and Request for your participation in a Research Study on Policy on Contraception for Adolescent Girls Living with HIV in Malawi.**

I am writing to request for your/your organization's participation in an up-coming research study focusing on adolescent girls living with HIV, in Malawi.

I am a PhD student from the University of KwaZulu-Natal in South Africa, registered under student number 218086806, School of Applied Human Sciences. I am planning to conduct a research study titled *“Analysis of Policy for Protection of HIV Positive Adolescent Girls against Vulnerabilities faced in using Contraception in Malawi”*.

I am currently in the process of ethics clearance and in generation of permission from potential organizations and individuals who are being targeted to participate in the research. You/your organization has been selected after an extensive review of your programs, duties and focus relating to the population and issue under study, and deemed as relevant. I believe that having a discussion with you will be beneficial to the data collection process that will inform the final report of the planned research. The discussion will be conducted through a series of questions (not more than 15), in form of a structured interview through a telephone method due to the current COVID19 situation. This may last between 30 – 45 minutes.

A full set of accompanying documents including all clearances will be shared when scheduling the actual interview appointment, but the full list of other organizations is here by attached.

I humbly request for your permission to engage with you or an appointed official (s) as part of the data collection process for my research. It is planned that after compiling the report, a copy will be shared with you/your organization as part of dissemination.

Whereas I will be directly involved in the interviewing process, **Mr. Noel Kafera** based in Malawi has been trusted to support the coordination of the research activities during this time, and he may follow-up with you as necessary. Kindly accord him your cordial assistance.



For more information please use the following contacts:

**Principal investigator/Researcher:** Patience Bulage, PhD Candidate, **Tel:** +256782305993; +27761639113, **e-mail:** [patiencebul@gmail.com](mailto:patiencebul@gmail.com), and [218086806@stu.ukzn.ac.za](mailto:218086806@stu.ukzn.ac.za),

**Institution:** University of KwaZulu-Natal, South Africa;

**And**

**Supervisor Name:** Professor Kaymarlin Govender, **Institution:** Health Economics and AIDS Research Division-University of KwaZulu-Natal, South Africa, **Tel:** +27312603096 – **e-mail:** [Govenderk2@ukzn.ac.za](mailto:Govenderk2@ukzn.ac.za)

This research is currently under review by the National Health Sciences Research Committee (NHSRC) at the Ministry of Health in Malawi; and the University of KwaZulu-Natal research and ethics committee (REC).

I will be pleased to receive your acceptance or appointment of relevant staff and permission in writing, and look forward to engaging with you during the next phase of this research.

Kind regards



Patience Bulage

PhD Student and Principal Investigator

**Status:**

Accepted	
Not accepted	

## Annex 3: Informed consent forms (ICF)

### Annex 3.1 : Malawi National Health Sciences Research Committee (NHSRC) Consent form (English version)



#### MINISTRY OF HEALTH NATIONAL HEALTH SCIENCES RESEARCH COMMITTEE

##### IMPORTANT ELEMENTS IN AN INFORMED CONSENT FORM

###### Study title

Analysis of policy for protection of HIV positive adolescent girls against vulnerabilities faced in using contraception in Malawi

###### Name and Contacts of Principal Investigator

Principal Investigator: Patience Bulage

Institution: University of KwaZulu-Natal, South Africa

Contact details: Tel: +256782305993; +27761639113 – e-mail: [218086806@stu.ukzn.ac.za](mailto:218086806@stu.ukzn.ac.za)

###### NHSRC Contacts

NHSRC Representative: Dr. Collins Mitambo

Institution: National Health Sciences Research Committee, Malawi

Contact details: +265999397913

**Introduction:** My name is Patience Bulage and I am a student at the University of KwaZulu-Natal in South Africa. I am conducting a research on the use of contraception among HIV positive adolescent girls in Malawi. I would like to invite you to participate in the study, by responding to a series of questions about the subject. This consent form may contain words that you do not understand. Please ask me to stop as we go through the information and I will take time to explain. If you have questions later, you can ask them of me.

**Voluntary participation:** Your participation in this research is entirely voluntary. It is your choice whether to participate or not, although we would emphasize how important your participation is. The interview may last between 15 – 30mins by telephone.

You have been selected to take part in this research because we feel that your experience as a (*policy maker, development partner, local service provider, or PLHIV organization leader*) can contribute much to our understanding and knowledge of the situation. Therefore, your input is very important in helping to get all the information required to come up with a good research report.

**Purpose:** The purpose of this research is to understand the government policies in relation to protecting young girls living with HIV in Malawi to reach and use contraception, and the implementation challenges affecting the effectiveness of such policies. We believe that you are in best position to share with us some information relating to this, and the situation in Malawi. This will be through an interview on telephone, due to the difficulties in mobility currently due to the COVID-19 pandemic.

**Procedure - Explain how the data collection process will be conducted:**

###### Methods and approaches of data collection

This study will be qualitative in nature, using both secondary and primary data collection methods. It will be two-phased, comprising mainly of documents' review which will be supplemented by a telephone survey;

###### Phase one: Documents' review

During this phase, relevant country documents, and programs reports, written SRH, contraception, and HIV related policy, and program documents will be gathered and reviewed as follows;

- Country SRH policy documents and normative guidelines
- Tangent policies which focus on human rights of girls, PLHIV and children
- International guiding documents/standards
- Published documents, program reports

During this phase an in-depth analysis will be carried out to identify policy provisions and guidelines in relation to contraception access for AGLHIV, provisions stipulating protection of HIV vulnerability, and access to care and protection and measure the level of relevance and effectiveness in providing a level of safety to AGLHIV to make use of the services.

3

Executive Committee: Dr. M. Joshua (Chairperson), Dr E. Chitsa-Banda (Vice-Chairperson)  
Registered with the USA Office for Human Research Protections (OHRP) as an International IRB  
IRB Number IRB00003905 FWA00005976  
Email: [mohdocentre@gmail.com](mailto:mohdocentre@gmail.com)

#### Phase two: Telephone interviews

This phase will comprise of a telephone survey which is proposed to compliment the documents' review. This will involve policy makers, selected development partners especially those with programs supporting contraceptive and HIV services for adolescents, local service providers, and a sample of PLHIV representatives/organizations. These will be contacted for telephone interviews with the aim of filling in any data gaps that may arise in the process of document review and provide clarity where needed, to ensure a fair representation of the PLHIV in relation to specific policy issues, and for triangulation of data.

**Benefits:** There will be no direct benefit to you, but your participation is likely to help us find out more about ensuring the safety of adolescent girls living with HIV.

**Risks:** There is a risk that you may share some confidential information. You do not have to answer any question which you do not want to although it is important that we generate responses to all questions asked. We are asking you to share with us program and policy related information, and we also understand that some of the questions that will be asked may be sensitive due to the nature of the research topic. You do not have to answer any question or take part in the interview if you don't wish to do so, but we still reiterate the importance of your responses in helping us to gather all the information required for this study. Please take your time to answer, and feel free to withdraw from the interview at any time if you feel the need to.

**Privacy and Confidentiality:** We will not be sharing information about you to anyone outside of the research team. The information that we collect from this research project will be kept private and used only for purposes of this research. Personal information about you such as name and place of work will have a number or code on it instead of your actual details. Only the researchers will know what your number is and we will ensure confidentiality.

**Study Approval** (Provide names and contact details of institutions of study review bodies that have approved the study)

This proposal has been reviewed and approved by the University of KwaZulu-Natal research and ethics committee (REC). It has also been reviewed and approved by the National Health Sciences Research Committee (NHSRC) at the Ministry of Health in Malawi for the same purpose. For more information, please see the attached REC letters of approval.

#### Malawi Review Body

National Health Sciences Research Committee (NHSRC)

Ministry of Health

Malawi – Lilongwe

Email: [mohdocentre@gmail.com](mailto:mohdocentre@gmail.com)

NHSRC Representative: Dr. Collins Mitambo

Institution: National Health Sciences Research Committee, Malawi

Contact details: +265999397913

#### South Africa Review Body

University of KwaZulu-Natal (UKZN) Humanities & Social Sciences Research Ethics Committee

Humanities & Social Sciences Research Ethics Administration

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557- Fax: 27 31 2604609

Email: [HSSREC@ukzn.ac.za](mailto:HSSREC@ukzn.ac.za)

OR

Supervisor name: Professor Kaymarlin Govender

Institution: Health Economics and AIDS Research Division-University of KwaZulu-Natal, South Africa

Contact Details: Tel: +27312603096 – e-mail: [Govenderk2@ukzn.ac.za](mailto:Govenderk2@ukzn.ac.za)

**Consent and Signature** Indicate where the participant, data collector and witness should sign

Executive Committee: Dr. M. Joshua (Chairperson), Dr E. Chitsa-Banda (Vice-Chairperson)  
Registered with the USA Office for Human Research Protections (OHRP) as an International IRB  
IRB Number IRB00003905 FWA00005976  
Email: [mohdocentre@gmail.com](mailto:mohdocentre@gmail.com)

4

Do you now confirm to participate in this research?

Record/tick appropriate response: YES: \_\_\_\_\_ or NO: \_\_\_\_\_

Name/code of participant: \_\_\_\_\_

Date: \_\_\_\_\_

Study site

Malawi, Lilongwe

Executive Committee: *Dr. M. Joshua (Chairperson), Dr E. Chitsa-Banda (Vice-Chairperson)*  
Registered with the USA Office for Human Research Protections (OHRP) as an International IRB  
IRB Number IRB00003905 FWA00005976  
Email: *mohdocentre@gmail.com*

5

Annex 3.2: Malawi National Health Sciences Research Committee (NHSRC) Consent form  
(Chichewa version)

**Informed Consent Form (ICF) - Chichewa**

**Mutu wa Kafukufuku:** Kafuku wa ndondomeko zotetezera atsikana omwe ali ndi HIV ku mavuto omwe amakuna nawo pogwiritsa ntchito zinthu zozitetezera ku matendewa

**Lamulo:** Ichi chidzaperekedwa kapena kuwerengedwa kumayambiriro asanayambe ma cheza kudzera pa phone

Macheza onse adzakhala muChizungu/English

**Chiyambi:** Dzina langa ndine Patience wophunzira wa ku University of KwaZulu-Natal in South Africa. Ndikupanga kafuku wa kagwiritsidwe ka njiri zozitetezera ku HIV pakati pa astikana omwe ali ndi ka cilomboka ku Malawi. Ndikukumphani kuti mukhale nawo pa kafukufuku wangayu potenganawo ngawo loyankha mafunso okhudza zimenezi. Pomwe simukumvetsetsa mutha kundifunsa mafunso.

**Cholinga cha kafukufuku:** Kafukufuke akufuna kumvetsa za momwe ndondomeko la boma la Malawi zotetezera atsikana omwe ali HIV pa kagwiritsidwe ntchito zinthu zozitetezera ku matendewa. Tikukhulupirira kuti inu muli ndikuthekera kotiyayankha mafunso amenewa ndi mmene ndiziliri ku Malawi. Kafukufuku tichita podzera pa foni potsata ndondomeko za mlirir wa COVID-19.

**Kusankhidwa mu Kafukufuku:** Mwasankhidwa mukafukufuku potengera kuti inuyo mukudziwako kanthu pa zokhudza kagwiritse ntchito ka njira zozitetezera ku ka chilombo ka HIV (*Opanga ndondomeko, otenga nawo gawo pa zimenezi, Opereka zinthu kapena upangari, kapena ma Otsogolera oterewo*). Chonco zomwe munganenepo zitithandiza kwambiri pa kafukufuku ameneyu

**Kutenga nawo gawo ndi ufulu wanu:** Kutenga nawo gawo mu kafukufuku ndi ufulu wanu. Mwayenera kusankha kupanaga nawo kapena ayi komabe ndikofunika kwambiri mutatenga nawo gawo. Kuchezaku kutha kutenga mphindi 15-30 mins.

**Chiopsezo:** Pali chiopsezo chakuti mutha kufotokoza uthenga wosayenera kufotokoza , pomwe mwawaona kuti ndipovuta kuyankha mutha kusiya komabe ndikofunika kufotokoza Iziz zili choncho popeza kuti kafukufuku wathuyi akukhudza za zinthu zomwe zimayenera

kukhala za chinsisi. Pomwe mukufunika kuganizira muli ndi ufulu kuterero. Ngati mwamangika kwambiri muli ndi ufulu kusiya kuyankha

**Phindu:** Palibe chomwe mupezepo ngati malipiro potenga nawo gawo komabe zomwe mungatifotokozere zitithandiza kuteteza atsika omwe ali ndi HIV

**Kusunga chisinsi chanu:** Tidzasunga zomwe takambirana ndipo sitidzagawana ndi wina aliyense. Izi zidzagwiritsidwa ntchito pa kafukufuku yekhayu basi. Mayina ndi zina zonse zokhudza inu zidzatetezedwa pogwiritsa ntchito nambala ya chinsisi. Ndipo namabala imeneyi adzayidziwa ndi a kafukufuku okha.

**Zotsatira za kafukufuku ndi kugawana:** Zotsatira za kafukufuku zidzaperekedwa ku UKZN komaso zidzaperekedwa ku boma Malawi ndi kwai nu podzera pa email kuti mudzathe kugwiritsa zotsatirazi pa zinthu zina, Zotsatirazi zidasindikizidwa.

**Anthu omwe angakuthandizeni :** Ngati muli ndi mafunso kapena zina zofuna kudziwa mutha kupeza anthu awa:

**NHSRC Representative:** Dr. Collins Mitambo

**Institution:** National Health Sciences Research Committee, Malawi

**Contact details:** +265999397913

**Principal Investigator:** Patience Bulage

**Institution:** University of KwaZulu-Natal, South Africa

**Contact details:** Tel: +27761639113 – **e-mail:** [218086806@stu.ukzn.ac.za](mailto:218086806@stu.ukzn.ac.za)

**OR**

**Supervisor name:** Professor Kaymarlin Govender

**Institution:** Health Economics and AIDS Research Division-University of KwaZulu-Natal, South Africa

**Contact Details:** Tel: +27312603096 – **e-mail:** [Govenderk2@ukzn.ac.za](mailto:Govenderk2@ukzn.ac.za)

Kafukufuku wawunikiridwa ndi kuvomerezedwa ndi the UKZN research and ethics committee (REC) komaso ndi a National Health Sciences Research Committee (NHSRC) ku Unduna wa za Umoyo Ministry of Health in Malawi. Mutha kuwona zikalata zovomereza mmusimu

**Ndinu ovomereza kutenga nawo gawo?**

Record/tick appropriate response: Eya: \_\_\_\_\_ kapena ayi \_\_\_\_\_

Dzina/Nambala ya chinsisi: \_\_\_\_\_



Tsiku: \_\_\_\_\_

**Wofufuza:** Ndawerenga bwino ndimoyenerakwa munthu amene tikufuna kucheza naye. Ndipo iye wamvetsa bwino lomwe.

Signed: \_\_\_\_\_

Tsiku: \_\_\_\_\_

**UKZN HUMANITIES AND SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE (HSSREC)**

**APPLICATION FOR ETHICS APPROVAL  
For research with human participants**

**INFORMED CONSENT RESOURCE TEMPLATE**

Note to researchers: Notwithstanding the need for scientific and legal accuracy, every effort should be made to produce a consent document that is as linguistically clear and simple as possible, without omitting important details as outlined below. Certified translated versions will be required once the original version is approved.

There are specific circumstances where witnessed verbal consent might be acceptable, and circumstances where individual informed consent may be waived by HSSREC.

**Information Sheet and Consent to Participate in Research**

Date: \_\_\_\_\_

Greetings Sir/Madam,

My name is Patience Bulage from the University of KwaZulu-Natal in South Africa, under the School of Applied Human Sciences, Student Number 218086806; Email: [218086806@stu.ukzn.ac.za](mailto:218086806@stu.ukzn.ac.za) and [patiencebul@gmail.com](mailto:patiencebul@gmail.com)

You are being invited to consider participating in a study that involves research on the use of contraception among HIV positive adolescent girls in Malawi. The aim and purpose of this research is to understand the government policies in relation to protecting young girls living with HIV in Malawi to reach and use contraception, and the implementation challenges affecting the effectiveness of such policies. The study is expected to enroll twenty (20) participants in total, in the categories of Policy makers, Local service providers, Implementing partners and Organizations of People Living with HIV (PLHIV). Each category will be represented by five (5) participants, in Malawi - mainly Lilongwe and other locations depending on the location of the organization selected to participate in the research. It will involve the following procedures; an interview on telephone, due to the difficulties in mobility currently due to the COVID-19 pandemic. The duration of your participation if you choose to enroll and remain in the study is expected to be 15 - 45 minutes. The researcher may also request for relevant documents to enrich the data collection process. The study is funded privately by the student.

The study may involve the following risks and/or discomforts; Sharing of confidential information; You do not have to answer any question which you do not want to although it is important that we generate responses to all questions asked. We are asking you to share with us program and policy related information, and we also understand that some of the questions that will be asked may be sensitive due to the nature of the research topic. You do not have to answer any question or take part in the interview if you don't wish to do so, but we still re-iterate the importance of your responses in helping us to gather all the information required for this study. Please take your time to answer, and feel free to withdraw from the interview at any time if you feel the need to. We hope that the study will be helpful in finding out more about ensuring the safety of adolescent girls living with HIV as they access contraception, but no direct benefits to participants will be offered.



This study has been ethically reviewed and approved by the UKZN Humanities and Social Sciences Research Ethics Committee (approval number \_\_\_\_\_).

In the event of any problems or concerns/questions you may contact the researcher at;

Principal Investigator: Patience Bulage

Institution: University of KwaZulu-Natal, South Africa

Contact details: Tel: +256782305993; +27761639113 - e-mail: [218086806@stu.ukzn.ac.za](mailto:218086806@stu.ukzn.ac.za)

And

Supervisor name: Professor Kaymartin Govender

Institution: Health Economics and AIDS Research Division-University of KwaZulu-Natal, South Africa

Contact Details: Tel: +27312603096 - e-mail: [Govenderk2@ukzn.ac.za](mailto:Govenderk2@ukzn.ac.za)

National Health Sciences Research Committee (NHSRC) Representative: Dr. Collins

Mitambo

Institution: National Health Sciences Research Committee, Malawi

Contact details: +265999397913

Or the UKZN Humanities & Social Sciences Research Ethics Committee, contact details as follows:

**HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS ADMINISTRATION**

Research Office, Westville Campus

Govan Mbeki Building

Private Bag X 54001

Durban

4000

KwaZulu-Natal, SOUTH AFRICA

Tel: 27 31 2604557- Fax: 27 31 2604609

Email: [HSSREC@ukzn.ac.za](mailto:HSSREC@ukzn.ac.za)

Participation in this research is voluntary and participants may withdraw participation at any point, and in the event of refusal/withdrawal of participation the participants will not incur penalty or loss. The researcher may terminate your participation in-case you are unable to provide responses to the questions asked.

There will be no incentives or reimbursements for participation in the study.

For confidentiality, we will not be sharing information about you to anyone outside of the research team. The information that we collect from this research project will be kept private and used only for purposes of this research. Personal information about you such as name and place of work will have a number or code on it instead of your actual details. Only the researchers will know what your number is and we will ensure confidentiality. The information that we get from this research will be compiled into a final report which will be submitted to UKZN. It will also be shared with you through email, with the government of Malawi to be used as a point of reference for any actions in the near future to improve the current situation, the University of Malawi, and the local service organizations we have interacted with. In the event of relevant conferences and workshops, the researchers may ensure their participation if invited, and we will publish the results so that other interested people may learn from the research-as a way of knowledge sharing.

## Annex 4: Ethical Clearances/Approval Letters

### Annex 4.1 Country ethical approval

Telephone: a + 265 789 400  
Facsimile: + 265 789 431

All Communications should be  
addressed to:

The Secretary for Health and Population



In reply please quote No. ....

MINISTRY OF HEALTH AND POPULATION

P.O. BOX 30377  
LILONGWE 3  
MALAWI

18<sup>th</sup> June, 2021

Patience Bulage  
University of Kwazulu Natal

RE: Protocol # 21/04/2701: Analysis of Policy for Protection of HIV Positive Adolescent Girls Against Vulnerabilities Faced in Using Contraception in Malawi

Thank you for the above titled proposal that you submitted to the National Health Sciences Research Committee (NHSRC) for review. Please be advised that the NHSRC has **reviewed** and **approved** the above titled study.

- **APPROVAL NUMBER** : 2701
- The above details should be used on all correspondences, consent forms and documents as appropriate.
- **APPROVAL DATE** : 18/06/2021
- **EXPIRATION DATE** : 17/06/2022  
This approval expires on 17/06/2022. After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the NHSRC Secretariat should be submitted one month before the expiration date for continuing review.
- **SERIOUS ADVERSE EVENT REPORTING:** All serious problems having to do with subject safety must be reported to the NHSRC within 10 working days using standard forms obtainable from the NHSRC Secretariat.
- **MODIFICATIONS:** Prior NHSRC approval using forms obtainable from the NHSRC Secretariat is required before implementing any changes in the protocol (including changes in the consent documents). You may not use any other consent documents besides those approved by the NHSRC.
- **TERMINATION OF STUDY:** On termination of a study, a report has to be submitted to the NHSRC using standard forms obtainable from the NHSRC Secretariat.
- **QUESTIONS:** Please contact the NHSRC on phone number +265 999397913 or by email on [mohdocentre@gmail.com](mailto:mohdocentre@gmail.com).
- **OTHER:** Please be reminded to send in copies of your final research results for our records (Health Research Database).

Kind regards from the NHSRC Secretariat.

  
.....  
CHAIRPERSON, NATIONAL HEALTH SCIENCES RESEARCH COMMITTEE  
Promoting Ethical Conduct of Research<sup>1</sup>



Executive Committee: Dr. M. Joshua (Chairperson), Dr. E. Chitsa Banda (Vice-Chairperson)  
Registered with the USA Office for Human Research Protections (OHRP) as an International IRBIRB Number  
IRB00003905 FWA00005976



02 July 2021

Ms Patience Bulage (218086806)  
School Of Applied Human Sc  
Howard College

Dear Ms Bulage,

Protocol reference number: HSSREC/00002253/2020

Project title: Analysis of policy for protection of HIV positive adolescent girls against vulnerabilities faced in using contraception in Malawi

Degree: PhD

### Approval Notification – Expedited Application

This letter serves to notify you that your application received on 20 November 2020 in connection with the above, was reviewed by the Humanities and Social Sciences Research Ethics Committee (HSSREC) and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number. **PLEASE NOTE:** Research data should be securely stored in the discipline/department for a period of 5 years.

This approval is valid until 02 July 2022.

To ensure uninterrupted approval of this study beyond the approval expiry date, a progress report must be submitted to the Research Office on the appropriate form 2 - 3 months before the expiry date. A close-out report to be submitted when study is finished.

**All research conducted during the COVID-19 period must adhere to the national and UKZN guidelines.**

HSSREC is registered with the South African National Research Ethics Council (REC-040414-040).

Yours sincerely,

Professor Dipane Hlalele (Chair)

/dd

### Humanities and Social Sciences Research Ethics Committee

Postal Address: Private Bag X54001, Durban, 4000, South Africa

Telephone: +27 (0)31 260 8350/4557/3587 Email: [hssrec@ukzn.ac.za](mailto:hssrec@ukzn.ac.za) Websites: <http://research.ukzn.ac.za/Research-Ethics>

Founding Campuses: Edgewood Howard College Medical School Pietermaritzburg Westville

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