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Country programme document for Malawi

Proposed indicative UNFPA assistance:	$75 million: $15 million from regular resources and $60 million through co-financing modalities or other resources
Programme period:	5 years (2024-2028)
Cycle of assistance:	Ninth
Category:	Tier II
Alignment with the UNSDCF Cycle	United Nations Sustainable Development Cooperation Framework, 2024-2028

I. Programme rationale

1. Malawi's first digital population and housing census in 2018 recorded a population of 17.5 million (PHC 2018),[1] a 35 per cent increase when compared to 13.0 million registered in the previous census in 2008. With a high annual population growth rate of 2.9 per cent, the population is expected to reach 33.6 million by 2050.[2] Malawi has a total fertility rate of 4.2 children per woman (MICS 2019-2020),[3] and a youthful population with more than half the population under the age of 18 (51.3 per cent), and 26 per cent comprising adolescents aged 10-19 years. Also, 561,696 persons aged 10-24 years are reported to live with disabilities, representing about 3.2 per cent of the total population.

2. Malawi remains one of the poorest countries in the world despite making significant economic and structural reforms to improve economic growth. An estimated 50.7 per cent of the population lives below the poverty line,[4] with 56.8 per cent females, compared to 48.5 per cent males, living in poverty (National Statistical Office, 2021). The majority of the population (84 per cent) lives in rural areas with implications for rural poor households (PHC 2018). Poverty in Malawi is driven by low productivity in the agriculture sector, limited opportunities in non-agricultural sectors, volatile economic growth, rapid population growth and limited coverage of safety net programmes. The high debt burden continues to constrain the fiscal space, with inadequate investments in human capital development. The country is recovering from the socio-economic impact of the COVID-19 pandemic, which resulted in disruptions to sexual and reproductive health and rights (SRHR) services, particularly for women and girls.

3. Malawi is extremely vulnerable to economic shocks, natural disasters and public health emergencies. In 2022, a tropical cyclone hit the southern and central regions of the country, leaving scores of dead and injured persons, and with more than 500,000 without access to basic goods and services. Disrupted access to SRHR life-saving interventions places adolescent girls and women at increased risk of gender-based violence (GBV), harmful practices, unintended pregnancies and preventable maternal deaths in the country, which is also coping with other public health challenges, such as cholera and polio outbreaks. Inflation, food insecurity and energy crises are rife with adverse implications for the health and livelihoods of the population. Disasters and health emergencies deepen pre-existing inequalities and underscores the need for resilience building at system, institutional, community and household levels, to ensure life-saving services are accessible before, during and after emergencies.

4. Malawi has an increasingly favourable legal and policy environment that promotes access and utilization of modern family planning methods among adolescents and young people, such as the Sexual and Reproductive Health Policy, 2017-2022; the National Sexual and Reproductive Health and Rights Strategy, 2021-2025; the National Youth-friendly Health Services Strategy, 2022-2030; the National Youth Policy, 2022-2027; and the National Youth Investment Plan, 2022-2063. This has contributed to a substantive increase in the modern contraceptive prevalence rate, from 42 per cent in 2010 (DHS 2010) to 58 per cent among married women in 2015-2016 (DHS 2015-16)[5] and nearly 65 per cent in 2019-2020 (MICS 2019-20.[6] The country has also registered remarkable progress in the fight against HIV and AIDS, with the HIV prevalence in the population over 15 years of age decreasing from 10.6 per cent in 2010 to 7.7 per cent in 2023 (NSP for HIV and AIDS 2020-2025).[7]

5. Despite advancements in SRHR, the adolescent birth rate remains extremely high, with an estimated 136 births per 1,000 girls aged 15-19 years for 2015-2016 (DHS 2015-16), ranking among the highest in Africa; this translates to three of ten girls aged 15-19 years giving birth. Early pregnancy in Malawi is a cause and consequence of child marriage, early union and sexual and gender-based violence. It is also linked to early sexual debut, with 19 per cent of women aged 25-49 years having first sex before age 15, and 64 per cent before age 18 (MICS 2019-20), resulting from multiple factors namely, initiation ceremonies and rape, among others. Adolescent pregnancy, caused by unprotected sexual intercourse, is also influenced by poverty and education levels, place of residence, and social and gender norms. It is a major contributor to maternal and child mortality and to intergenerational cycles of ill health and poverty.

[1] Population and Housing Census (PHC), 2018.
[2] Malawi National Statistical Office Population Projection.
[3] Multiple Indicator Cluster Survey (MICS), 2019-2020.
[4] World Bank Poverty and Equity Brief, Malawi, 2020.
[5] Malawi Demographic Health Survey (DHS), 2010 and 2015-2016.
[6] The contraceptive prevalence rate for married women stands at 64.7% and the unmet need is 15.4% (MICS 2019-2020).
[7] Malawi National Strategic Plan (NSP) for HIV and AIDS, 2020-2025.

6. Modern contraceptive use by married women has increased in Malawi, from 42 per cent in 2010 (DHS 2010 to 58 per cent in 2015-2016 (DHS 2015-16), leading to a reduction of the total fertility rate from 6.7 to 4.4 children per female. However, only 43 per cent of sexually active unmarried women are using modern contraception; and this is especially low (32 per cent) among unmarried girls (DHS 2015-16). Malawi has made significant efforts in expanding the contraceptive method mix, with great gains made in the use of injectables, implants and female sterilization. Unmet need for family planning among currently married women was estimated at 18.7 per cent in 2015-2016, with disparities among age groups and geographical locations (DHS 2015-16). Adolescents aged 15-19 years and the northern region had the highest unmet need for family planning, with 22.2 per cent among the 15-19 year age group, compared to 19 per cent among the 35-39 year age group, and 22.5 per cent in the northern region, compared to 16 per cent in the central region. The provision of high-quality integrated SRHR services is affected by limited funding for commodities, weak supply chain management systems, an inadequate midwifery workforce, weak referral and health management information systems, the limited operability of a logistic management information system, and other health systems challenges. The national family planning programme is highly dependent on external funding, which accounts for 99.8 per cent of the reproductive, maternal, newborn and child health budget in the country. A reduction in external funding due to geopolitical tensions and economic downturns may limit or reverse gains made in universal access to SRHR.

7. The maternal mortality ratio declined from 675 per 100,000 live births in 2010 to 439 per 100,000 live births in 2015-2016,[8] with 25 per cent of deaths occurring to adolescent mothers under the age of 20. Also, 84 per cent of maternal deaths occur in health facilities due to postpartum haemorrhage (23 per cent); postpartum sepsis (19 per cent); severe pre-eclampsia (16 per cent); ruptured uterus (13 per cent); and complications from unsafe abortion (8 per cent).[9] While Malawi has a relatively high rate (90 per cent) of skilled attendance at birth (DHS 2015-16), weak referral systems and gaps in quality of care remain challenges, leading to maternal morbidity and mortality, including obstetric fistula, with a prevalence of 6 per 100,000 women of reproductive age (DHS 2015-16).

8. Gender-based violence (GBV), especially violence against women and girls, remains a serious challenge based on historically unequal power relations between males and females in Malawi. GBV, child marriage, domestic violence and other harmful practices persist at high rates, with 34 per cent of women experiencing physical violence since the age of 15, while 21 per cent of women have experienced sexual violence, and 42 per cent of ever-married women suffering from intimate partner violence, whether physical or sexual or emotional (DHS 2015-16). High rates of child marriage persist, with 9 per cent of girls married before the age of 15 and 42 per cent before the age of 18 (MICS 2019-20). Cultural biases, deeply rooted gender and social norms, including initiation ceremonies that reinforce gender stereotyped roles and perpetuate harmful traditional norms as a rite of passage, continue to disempower girls and women in the country. Additionally, some laws and policies still contain discriminatory provisions for specific issues, such as harmful practices, intimate partner violence, marital rape, sexual violence and child marriage. Women and girls aged 15 years and older spend 8.7 per cent of their time doing unpaid care and domestic work, compared to 1.3 per cent by male counterparts.[10] Efforts are ongoing to strengthening the capacities of institutions and stakeholders, at all levels from the national to the community level, towards promoting gender-equitable social norms that have the capacity to address harmful socio-cultural norms in a sustainable manner.

9. Malawi's HIV prevalence ranks among the 10 countries with the highest HIV burden in the world, with 7.7 per cent of the population living with HIV (9.3 per cent female and 6.0 per cent male) (NSP for HIV and AIDS 2020-2025). Young people are particularly at risk, with around 22 per cent of all new HIV infections in Malawi occurring among adolescent girls and young women aged 15-24 years and an estimated 1,600 new infections in infants aged less than 1 year (NSP for HIV and AIDS 2020-2025). Comprehensive knowledge of HIV is alarmingly low among adolescent girls and boys aged 15-17 years, especially among those living in rural areas and those with the lowest educational levels. Condom use is low, with only 52.2 per cent of men aged 15-24 years who had more than two partners in the past 12 months reporting condom use in the last sexual intercourse (DHS 2015-16). Vulnerability to HIV is shaped by sexual abuse in childhood, sexual and gender-based violence, harmful gender norms and socio-economic status.

10. Fragmented GBV, health and education data systems, with limited availability and use of gender-disaggregated data, within and across sectors, hinder the ability to identify, target and monitor the effectiveness of policies and programmes across the country. Efforts are ongoing to strengthen the capacities of stakeholders to

[8] This data is as per the Malawi Demographic Health Survey 2015-2016. More recently, the World Health Organization et al., "Trends in Maternal Mortality: 2000 to 2020" (2023), estimated the maternal mortality ratio in Malawi at 381 deaths per 100,000 live births.
[9] Emergency Obstetric and Newborn Care Survey, Ministry of Health, Malawi, 2020.
[10] UN-Women Malawi country profile (https://data.unwomen.org/country/malawi).

effectively engage in citizen-led decision-making and accountability mechanisms but with limited geographical focus.

11. The design of the new country programme was informed by key achievements from the evaluation of the previous country programme, including (a) improvements in emergency obstetric and newborn care services and skilled birth attendance in focus districts; (b) implementation of life skills programmes for the most marginalized adolescent girls; (c) progressive elimination of harmful practices through community-level interventions, namely safe spaces; (d) technical support to enable the first undertaking of the digital Population and Housing Census 2018; (e) UNFPA leadership in the United Nations data group to support the Government with the harmonization of sectoral management information systems; and (f) building on gains achieved from global and regional initiatives implemented in the country.

12. Lessons learned from the evaluation underscore the need to focus on: (a) strategically positioning UNFPA alongside other United Nations agencies to diversify partnerships and respond to the reduction of external funding for national development; (b) addressing underlying socio-cultural norms that deepen inequalities, poor SRHR outcomes, GBV and child marriages, including through gender-transformative programming and disability inclusion; (c) the importance of increasing sustainable financing for family planning, reproductive health commodities and programmes; (d) establishing a strengthened monitoring and evaluation system for the country to ensure data availability to guide programme planning, implementation, monitoring and learning; and (e) strengthening the financial management system and practices of the UNFPA country office and implementing partners to improve efficiency in programme implementation.

II. Programme priorities and partnerships

13. The new country programme responds to the Malawi 2063 Vision; the human capital development agenda of the medium-term implementation framework (MIP-1); the United Nations Sustainable Development Cooperation Framework (UNSDCF), 2024-2028; the African Union Agenda 2063; the National Population Policy; the voluntary national ICPD25 commitments made by Malawi; the government commitments on FP2030; the Generation Equality Forum (2021); and the Sendai Framework for Disaster Risk Reduction, 2015-2030.

14. In line with the existing gaps in adolescent girls and young women's SRHR status, the country programme will prioritize the health and well-being of adolescent girls, including by improving access to adolescent sexual and reproductive health and rights and increasing the agency and empowerment of adolescents to reduce gender-based violence and harmful practices, including child marriage, and strengthen HIV prevention, among others. The 'leaving no one behind' principle will be applied throughout the programme, targeting especially persons with disabilities, adolescent girls and young women, including those married, unmarried or pregnant, sex workers, and people living in emergency-prone districts and refugee camps or settlements. Given the large adolescent population, strategic investments in the health, education and empowerment of young people has the potential to facilitate the harnessing of the demographic dividend, thereby contributing to Malawi's economic development.

15. The programme will accelerate progress towards the three UNFPA strategic plan outcomes by 2025 – (a) the reduction in the unmet need for family planning; (b) the reduction of preventable maternal deaths; and (c) the reduction in gender-based violence and harmful practices – as well as the ESA region-specific result of ending sexual transmission of HIV.

16. Reducing the unmet need for family planning will contribute to a reduction in unintended pregnancies and maternal deaths in Malawi by 2028. The programme will prioritize improvements in the availability, accessibility, acceptability, quality and use of integrated SRHR information and services, with an emphasis on targeting adolescent girls and young people, improving gender equality and empowerment of women and girls. This will be achieved by (a) strengthening the policy environment and accountability for advancing SRHR, particularly for adolescent girls, including through evidence-based advocacy for sustainable financing; (b) improving the quality and integrated delivery of SRHR, GBV and HIV prevention services by strengthening people-centred delivery systems; (c) empowering women and young people to increase demand for SRHR and eliminate negative gender and social norms and harmful practices; (d) strengthening the capacity of institutions to generate, analyse, disseminate and utilize population data and evidence; (e) scaling-up innovative approaches to resilience building across the country, and disaster risk reduction in emergency-prone areas and humanitarian settings, including GBV prevention and response; and (f) scaling up tailored approaches on SRHR and GBV information and services to reach adolescents, youth, women and girls, including persons with disabilities.

17. The programme was developed in close consultation with the Government and civil society organizations, including disability-led, women-led and youth-led organizations. It will be implemented in collaboration with government line ministries and United Nations organizations, within the framework of 'delivering as one,' as well as with civil society, communities, the private sector, academia and other key partners, including women and youth groups.

18. The key programme interventions are integrated in national cross-sectoral implementation policies, strategies and frameworks and will use interconnected accelerators: (a) human rights-based and gender-transformative approaches to support delivery of rights-based integrated SRHR and services; (b) scale-up of innovative high-impact practices, including proven digital solutions; (c) enhanced public-private partnerships, partnerships with academia, South-South and triangular cooperation, cross-learning among districts, and exploring blended financing mechanisms with financing institutions and investors; (d) strengthened generation and use of evidence and data to guide tailored interventions; (e) addressing diversity, equality and inclusion to ensure non-discrimination, participation and accountability are anchored in the principles of 'leaving no one behind'; and (f) supporting national and subnational actors to enhance resilience and adaptation and ensure continuity of life-saving SRHR services through the implementation of the Minimum Initial Service Package and related interventions across the humanitarian, development and peace continuum.

19. The programme will apply five modes of engagement: (a) strategic advocacy and policy dialogue for positioning SRHR in national and district-level policies and programmes along the humanitarian, development and peace continuum; (b) knowledge management for evidence-based decision-making; (c) capacity development of key national and subnational institutions and stakeholders, including marginalized groups; (d) integrated people-centred delivery of SRHR information and services; and (e) strengthened coordination and partnerships to ensure programme linkages and learning across districts, as well as leveraging South-South and triangular cooperation to accelerate progress towards universal SRHR within the unifying framework of universal health coverage and the Sustainable Development Goals (SDGs).

20. Programme interventions will target the national-level actions, while focusing on target districts to support demonstration of impact of interventions and evidence-based scale-up. The districts will be selected by applying the following criteria: poor performance on adolescent SRHR, including HIV, maternal and neonatal health, family planning and gender-based violence; existence of other partners and ongoing SRHR interventions; political will of local governments; ongoing or planned United Nations joint programmes; and districts with emerging impact of climate change and humanitarian needs.

21. All country programme outputs will directly contribute to the UNSDCF strategic priority area 3 on human capital development while also contributing to the other three strategic priority areas.

A. Output 1. By 2028, sexual and reproductive health and rights, especially for adolescents, and gender-based violence prevention and response are integrated into national and district-level policies, plans and accountability mechanisms, taking into account population changes and other megatrends

22. This output aims to integrate SRHR, GBV, gender, youth and population issues into national policies, frameworks and accountability mechanisms and systems, and advocate for increased funding and financing for improving the sexual and reproductive health and rights of adolescents and youth by utilizing disaggregated data and evidence.

23. The country programme will support: (a) advocacy for sustainable and innovative financing (including for domestic financing); (b) advocacy for the integration of SRHR, HIV and GBV prevention and response, focusing on adolescents in UHC interventions and disaster risk reduction, emergency preparedness and response plans; (c) enhancement of stakeholder coordination for policy advocacy and programming ; (d) harmonization of sectoral management information systems; (e) strengthening data generation, analysis and reporting systems for SRHR, GBV and harmful practices, humanitarian programmes, including administrative sector-based data systems; (f) strengthening accountability mechanisms and capacities for resilient health, education and protection systems; (g) operationalization of the National Population Policy as an overarching policy framework; (h) rolling out innovative and digital solutions for evidence-based interventions targeting the populations left furthest behind; (i) technical assistance for the Population and Housing Census in 2028 and the Demographic Health Survey; and (j) strengthening the monitoring of national progress on implementation of the ICPD Programme of Action within

the context of the 20230 Agenda for Sustainable Development, the African Union Agenda 2063, and human rights obligations.

B. Output 2. By 2028, the capacities of health and social sector institutions are strengthened to provide high-quality integrated SRHR and GBV information and services, especially for adolescent girls and young women

24. This output aims to contribute to health and social system strengthening to deliver high-quality SRHR and GBV care through integrated delivery of comprehensive SRHR services at national, district, facility and community levels. It will accelerate progress towards the three transformative results by especially focusing on the quality of care for adolescent sexual and reproductive health, survivor-centred GBV services, HIV prevention and reproductive health commodity security to 'the last mile.'

25. The country programme will be guided by evidence and data to support: (a) scaling up implementation of the standards of quality of care for integrated SRHR services and the GBV essential service package, including mental health and psychosocial support, with a special focus on adolescent girls, at all levels of care; (b) strengthening the capacity, distribution and retention of the midwifery workforce, in line with the International Confederation of Midwives standards; (c) improving reproductive health commodity security, focusing on supply chain management systems and 'last-mile' assurance; (d) scaling up the maternal and perinatal death surveillance system, at national and district levels, and setting up a digitized 'near-miss' maternal audit system, including verbal autopsy; (e) strengthening facility readiness to scale up emergency obstetric and newborn care and other essential SRHR services.

C. Output 3. By 2028, the capacities of communities and institutions are strengthened to address discriminatory gender and social norms to advance gender equality and adolescent girls' and women's decision-making

26. This output aims to address harmful gender and social norms and discrimination to promote gender equality and health-seeking behaviours, especially within communities. It will employ community-centred approaches to eliminating harmful practices by (a) building capacities at individual, community and national levels to address the root causes of structural inequalities; (b) promoting positive health-seeking behaviours and positive gender and social norms among the adolescents, youth and women left furthest behind; and (c) empowerment of adolescent girls and women as agents of transformative change in the country.

27. The country programme will support (a) the integration of gender and GBV prevention and response into justice, police and social sectors, with statutory functions for health, HIV prevention, education and protection interventions, particularly for girls and young women, across development and humanitarian locations; (b) strengthening evidence generation and data systems, including the GBV management information system; (c) strengthening the capacity of community structures for positive change by leveraging gatekeepers, chiefs, faith-based organizations, men, women-led and youth networks; (d) strengthening referral pathways and linkages for GBV services and other community initiatives in development and humanitarian programmes; and (e) rolling out the implementation of a male engagement strategy for improving SRHR.

D. Output 4. By 2028, humanitarian actors and institutions are enabled for agile preparedness and response in the provision of life-saving SRHR and GBV interventions and resilience building for vulnerable populations

28. This output aims to reduce the vulnerability of adolescents, youth and women while building resilience to climate change-induced disasters and shocks by applying the humanitarian-development-peace continuum approach. It will focus on disaster risk reduction and strengthening preparedness systems to ensure access to life-saving SRHR and GBV services in emergencies, including for people living with HIV/AIDS and disabilities. Informed by the lessons learned during the COVID-19 response, it will focus on anticipatory actions to ensure multisectoral and coordinated prevention, response and recovery.

29. The country programme will support: (a) strengthening the national and district readiness to provide the Minimum Initial Service Package (MISP) for sexual and reproductive health in emergencies; (b) pre-positioning and delivery of essential life-saving commodities and resources in the affected districts; (c) enhancing United Nations inter-agency coordination mechanisms and its functionality on SRHR, and GBV prevention, management

and response during emergencies; (d) monitoring the application of minimum standards for GBV in emergencies, including prevention of sexual exploitation and abuse; and (e) inclusion of adolescent girls, women, youth and persons with disabilities in emergency and crisis prevention, peacebuilding and recovery actions.

E. Output 5. By 2028, adolescents and youth, particularly girls, are empowered to make informed decisions about their sexual and reproductive health and rights to build their agency, health, well-being and socio-economic status

30. This output aims to empower adolescents and youth as agents of transformative change by enhancing their agency to make informed decisions about their lives, including those related to SRHR. It will also promote positive mindset change and bodily autonomy among young people to ensure that they are able to fulfil their potential and can contribute to productivity in the country, enabling Malawi to harness the demographic dividend.

31. The country programme will support: (a) expansion of empowerment interventions, such as safe spaces, mentorship programmes, SRHR self-care and inclusion of SRHR into adolescents livelihoods programmes; (b) scaling up demand, access and referral of adolescent girls to a comprehensive SRHR package of care, including HIV prevention and menstrual health interventions; (c) scaling innovation and digitalization solutions for in-school and out-of-school life skills and comprehensive sexuality education; (d) strengthening participatory community interventions and dialogues on adolescent SRHR pathways; and (e) strengthening youth-led accountability with organizations, networks, innovation hubs and youth participation mechanisms.

III. Programme and risk management

32. The Malawi Ministry of Finance and Economic Affairs, through its Public Sector Investment Programme, Department of Economic Planning and Development, will oversee the execution of the country programme as the Government Coordinating Authority. UNFPA will utilize an optimal mix of execution modalities in implementing the programme, in collaboration with government partners, civil society and community-based organizations, the private sector and academia, to deliver the programme outputs. The programme will expand non-traditional partnerships, guided by value addition, to achieve the effective delivery of results for adolescents and young people, including the populations left furthest behind. The programme will strengthen South-South and triangular cooperation for knowledge exchange and learning, while also leveraging funding and sustainable financing mechanisms. The harmonized approach to cash transfers will continue to be applied, following a risk assessment of each implementing partner, and leveraging inter-agency cooperation for risk mitigation and cost efficiencies. UNFPA will strengthen collaboration with the United Nations country team, in line with the ‘delivering as one’ approach and as a contribution to the collective results of the UNSDCF.

33. Multidimensional risk analysis and mitigation plans have been undertaken as part of ‘One UN,’ with the proactive participation of UNFPA in the Common Country Analysis process. Potential risks to the programme include (a) the impact of long-standing unaddressed inequalities; (b) the spillover effects of geo-political dynamics impacting the country, with inflationary pressures on the import-dependent economy, leading to food insecurity and the disruption of power and electricity; (c) continuous fuel shortage, with impact on the economy and continuity of social service provision; and (d) rising youth unemployment, especially among the most vulnerable groups in Malawi, including adolescent girls, women, youth and people with disabilities. The proposed mitigation strategies include joint United Nations resilience-building interventions, including evidence-based targeting of vulnerable populations, women, young people and people with disabilities, to meet multidimensional needs, while scaling up the resilience of systems and institutions. UNFPA will apply risk-informed programming guided by risk thresholds.

34. Malawi is a disaster-prone country with tropical cyclones, floods, drought, and health emergencies with the recent COVID-19 pandemic and polio and cholera outbreaks. Coupled with a weak disaster management capacity, these disruptions have dire consequences on food security, energy supply, public health, including sexual and reproductive health, and the sustainable livelihoods of rural communities in Malawi. UNFPA, jointly with the United Nations country team, will support the Government to mainstream climate change adaptation, prevention of public health emergencies, resilience building and disaster risk reduction into national and local development plans, policies, financing, coordination and monitoring mechanisms. UNFPA will, in consultation with the Government, re-programme funds, as required, to respond to emerging issues within its mandate. Existing partnerships with the government and civil society humanitarian actors, especially women and youth-led organizations, will be leveraged for effective and sustainable humanitarian preparedness, response and recovery.

35. A human resource plan was developed for the programme through (a) a review of gaps and recommendations in the approved country programme staff realignment, along with other relevant assessment recommendations on staff competencies for effective programme delivery; (b) assessment of expertise and skills required to deliver the country programme; and (c) consideration of the inter-agency leadership role of UNFPA and priorities of the UNSDCF. The country office will coordinate technical assistance needs with the UNFPA Regional Office for East and Southern Africa and UNFPA Headquarters and will leverage, as needed, the capacities from other UNFPA country offices and the United Nations organizations in Malawi.

36. This country programme document outlines the contributions of UNFPA to national results and serves as the primary unit of accountability to the Executive Board for results alignment and resources assigned to the programme at the country level. Accountability of managers at the country, regional, and headquarter levels with respect to this country programme is prescribed in the UNFPA programme and operations policies and procedures, and the internal control framework.

IV. Monitoring and evaluation

37. UNFPA will implement results-based management systems and approaches to programming, building on a robust monitoring and evaluation plan with dedicated financial and human resources. UNFPA and partners will jointly develop and implement the monitoring and evaluation plan to track and report on country programme results, in line with UNFPA policies and guidelines.

38. The programme will support primary data collection, real-time monitoring, analysis and other innovative approaches to inform quarterly, annual and midterm reviews for course correction; it will undertake country programme evaluations to track and assess progress towards achievement of the transformative results. Depending on the evolving context, programme result monitoring will utilize multiple modalities, including in-person, remote and hybrid models.

39. The programme will support capacity building initiatives on results-based management for UNFPA staff and partners. It will also support the establishment of an innovative feedback mechanism to inform adaptive programme management, learning, resilient and agile programming that is responsive to changing contexts, including humanitarian and public health emergencies. As an integrated approach, UNFPA will continue to support national and subnational data and management information system strengthening with development partners.

40. UNFPA will strengthen joint monitoring and assurance mechanisms with implementing partners, including field visits and spot checks; periodic reviews and assessments; evaluations to generate evidence and inform programme scale-up within the complexity of the prevailing development and humanitarian contexts. To ensure risk-informed programming, analysis of major risks will be undertaken with risk-mitigation measures put in place, which may necessitate adjustment of joint workplans.

41. UNFPA will contribute to an integrated and multidimensional programming process through active participation in joint planning, programming, monitoring, reporting and evaluation of the UNSDCF. UNFPA will participate in the technical working groups related to the United Nations monitoring and evaluation, data for development, human development, gender and human rights, HIV and AIDS, and other relevant strategic result areas. In addition, the programme will contribute to joint activities, including periodic programme reviews, quality assurance and reporting through UNInfo. The monitoring and reporting of the country programme results framework will leverage the UNSDCF processes to the extent possible. A costed evaluation plan has been developed to inform programme evaluation, monitoring, learning and accountability.

42. The programme will collaborate with the Government, United Nations organizations and other partners to strengthen national and subnational monitoring and evaluation mechanisms to systematically obtain evidence to track results and enhance evidence-based decisions. As part of the evaluation plan, the programme will support innovative and participatory approaches for assessment and the preparation of voluntary national reports and universal periodic reviews, among others.

RESULTS AND RESOURCES FRAMEWORK FOR MALAWI (2024-2028)

NATIONAL PRIORITY: Malawi 2063 First 10-Year Implementation Plan (MIP-1) 2021-2030 Objectives: 1. Raise the country's status to lower-middle-income level by 2030. 2. Meet most of the Sustainable Development Goals (SDGs) whose end-line target is 2030.

UNSDCF OUTCOME: By 2028, more people, in particular women, children and youth, especially the most vulnerable and marginalized, are resilient with access to and utilization of quality, equitable, efficient, gender and shock-responsive education, health, nutrition, WASH, social and protection services. This outcome contributes to SDGs 1,3,5,10,13,16 and 17.

RELATED UNFPA STRATEGIC PLAN OUTCOME(S): 1. By 2025, reduction in unmet need for family planning has accelerated. 2. By 2025, reduction of preventable maternal deaths has accelerated. 3. By 2025, reduction in gender-based violence and harmful practices has accelerated.

UNSDCF outcome indicators, baselines, targets	Country programme outputs	Output indicators, baselines and targets	Partner contributions	Indicative resources
UNSDCF Outcome indicator(s): *UNSDCF alignment will be determined further after the formulation process is completed.*) Health Sector Strategic Plan outcome indicator(s): ● Maternal mortality ratio *Baseline: 349 per 100,000 live births (2017); Target: 213 per 100,000 live births (2028)* ● Adolescent birth rate *Baseline: 136 per 1,000* aged 15-19 years *(2019); Target: 69 per 1,000* aged 15-19 years *(2028)* Related UNFPA Strategic Plan Outcome indicator(s): ● Proportion of women (aged 15-49 years; disaggregated by aged 15-19 years) who have their need for family planning satisfied with modern methods. *Baseline: 15-49 years: 79.9%; 15-19 years: 58%; (2015-16); Target: 15-49 years: 83.3%; 15-19 years: 70% (2028)* ● Percentage of young women and young men aged 15-24 years with comprehensive knowledge of HIV *Baseline: 41.4% (f) 44.3% (m); Target: 48.0% (f); 49.3% (m)*	Output 1. By 2028, sexual and reproductive health and rights and prevention and response to gender-based violence, especially for adolescents, are integrated into national and district-level policies, plans and accountability mechanisms, taking into account population changes and other megatrends.	Number of districts that have integrated sexual and reproductive health and rights and prevention and response of gender-based violence and harmful practices into district implementation plans *Baseline: 0 (2023); Target: 4 (2028)* Annual increase in the government commitment in the UNFPA Supplies compact agreement for family planning *Baseline: Annually 1%; Target: At least cumulative 5%.* Number of institutions supported to increase capacity to generate, analyse, disseminate and utilize administrative data, including civil registration and vital statistics *Baseline: 1 (2023); Target: 4 (2028)*	Ministries of: Health; Gender; Economic Planning and Development; National Statistical Office of Malawi; Registration Bureau; United Nations agencies; midwifery colleges; civil society organizations; academia; media; and development partners	$3 million ($1 million from regular resources and $2 million from other resources)
	Output 2. By 2028, capacities of health and social sectors are strengthened to provide high-quality SRHR and GBV information and services, especially for adolescent girls and young women.	Number of adolescents and youth (10-24) who access integrated sexual and reproductive health services in UNFPA-supported districts *Baseline: 1,460,600(2022); Target: 1,825,000 (2028)* Percentage of health facilities in UNFPA focus districts providing high-quality basic emergency obstetric and newborn care services *Baseline: 68 (2022); Target: 80 (2028)* Couple years of protection *Baseline: 1,542,891 (2022); Target: 2,142,891 (2028)* Number of women and girls, including persons living with disabilities and in humanitarian settings, subjected to violence who received essential services in focus districts *Baseline: 68,960 (2022); Target: 100,000 (2028)*	Ministries of: Health; Youth; Gender; Education; Local Government; civil society organizations; United Nations agencies	$26 million ($6 million from regular resources and $20 million from other resources)
	Output 3. By 2028, the capacity of communities and institutions are strengthened to address discriminatory gender and social norms to advance gender equality and	Number of men and boys who have benefitted from programmes promoting positive masculinities, healthy relationships and gender equality to end child marriage and other harmful practices in UNFPA target districts *Baseline: 32,504 (2022); Target: 150,000(2028)*	Ministries of: Gender; Health; Population; Malawi Police; United Nations agencies; national human rights institutions; media; civil society	$14 million (3 million from regular resources and $11 million

● Percentage of births attended by skilled health personnel *Baseline: 96% (2019); Target: 99% (2028)* ● Proportion of ever-partnered girls and women (aged 15 years and above, disaggregated by age groups) subjected to physical or sexual violence by a current or former intimate partner, in the last 12 months by age and place of occurrence *Baseline: 15-19 years: 29.4%; 20-24 years: 41.3%; 25-49 years: 45.9%; Target: 15-19 years: 20%; 20-24 years: 30%; 25-49 years: 35%* ● Existence of population and housing census every 10 years. *Baseline: 2018 Census; Target: 2028 Census*	adolescent girls' and women's decision-making.	Number of districts with functional gender technical working groups addressing gender-based violence and child marriage, including in emergencies *Baseline: 3 (2022); Target: 6 (2028)* Number of districts with at least two traditional authorities with sustained functional community platforms in reflective dialogue to address discriminatory gender and social norms to advance gender equality and adolescent girls' and women's decision-making *Baseline: (2023): 8; Target: 10 (2028)*	organizations, women-led organizations.	from other resources)
	Output 4. By 2028, humanitarian actors and institutions are enabled for agile preparedness and response in the provision of life-saving SRHR and GBV interventions and resilience building for vulnerable populations.	Number of districts with disaster risk reduction plans that integrate sexual and reproductive health and gender-based violence interventions, including MISP *Baseline: 0 (2024); Target: 6 (2028)* Number of women, adolescents and youth, especially girls, who benefitted from life-saving SRH and GBV interventions in humanitarian settings *Baseline: 20,000 (2022); Target: 132,000 (2028)*	Ministries of: Health; Gender; Education; Local Government; Department of Disaster Management; civil society organizations; United Nations agencies; and development partners.	$13.5 million ($1.5 million from regular resources and $12 million from other resources)
	Output 5. By 2028, adolescents and youth, particularly girls, are empowered to make informed decisions about their sexual and reproductive health and rights to build their agency, health, well-being and socio-economic status.	Number of marginalized girls, including girls with disabilities, reached by girl-centred programmes that build their life skills, health, social and economic assets *Baseline: 72,000(2022); Target: 250,000 (2028)* Number of youth networks that promote youth-led innovative initiatives, including digital solutions for accelerating the achievement of transformative results, with UNFPA support *Baseline: 3 (2022); Target: 12 (2028)*	Ministries of: Health; Youth; Gender; Education; Local Government; civil society organizations; youth-led organizations; United Nations agencies; and development partners	$17.5 million ($2.5 million from regular resources and $15 million from other resources)
Programme coordination and assistance				$1.0 million from regular resources