CONSOLIDATED COMMUNITY SCORECARD REPORT

SEXUAL AND REPRODUCTIVE HEALTH (SRH) SERVICES FOR ADOLESCENTS AND YOUNG PEOPLE

2020/2021

Compilation of Community Scorecard Findings from Malawi, Mozambique, Tanzania, Zambia and Zimbabwe, as part of the PSA Alliance Regional Monitoring Tools (RMTs) Initiative

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1.0 Introduction

This report is a consolidation of findings from community scorecards (CSCs) administered in selected districts in the five Partnership for Social Accountability (PSA) Alliance[1] project countries, namely Malawi (Nsanje District), Mozambique (Chibuto District and Lugela District), Tanzania (Mbozi District), Zambia (Kasenengwa District and Chipata District) and Zimbabwe (Binga District). The CSCs were administered between September 2020 and March 2021.

2.0 Background

The CSCs are part of the regional monitoring tools developed in phase two of the PSA Alliance project. The PSA Alliance project seeks to improve accountability and gender-responsiveness in public resource management (PRM), particularly in the areas of HIV and sexual and reproductive health (SRH) services for adolescents and young people, and agricultural services for smallholder farmers. Delivery of these public services ultimately contributes to the realisation of selected Southern African Development Community (SADC) regional commitments across the project's five countries of focus.

The CSCs on health services are based upon indicators included in regional commitments[2] on HIV and sexual and reproductive health and rights (SRHR).[3] These CSCs provide a framework for tracking the management and performance of selected public services at the district/ward levels in the five target countries, specifically highlighting areas with good performance and those where service users are experiencing bottlenecks or below average service delivery. The evidence collected through CSCs by local implementing partners allows the PSA Alliance to make informed comments on selected public services and assess how they impact the implementation of regional commitments.

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[1] The Partnership for Social Accountability (PSA) Alliance is a consortium of organisations including ActionAid International (AAI), Public Service Accountability Monitor (PSAM) of Rhodes University, Eastern and Southern Africa Small Scale Farmers' Forum (ESAFF) and SAfAIDS.

[2] The project focuses on the following regional commitments in Health: Strategy for Sexual and Reproductive Health and Rights in the SADC Region (2019-2030); the SADC Maseru Declaration on the Fight Against HIV and AIDS (2003), the Maputo Plan of Action for the Operationalization of the Sexual and Reproductive Health and Rights Continental Policy Framework (2016-2030); Minimum Standards for the Integration of HIV and Sexual & Reproductive Health in the SADC Region (2016), the Abuja Call for Accelerated Action Towards Universal Access to STI/HIV and AIDS, TB and Malaria Services in Africa (2006); and the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001).

[3] SRHR incorporates the rights of all people, regardless of age, gender and other characteristics, to make choices regarding their own sexuality and reproduction. These promote reproductive decision-making; freedom from forced abortion; access to information and appropriate reproductive education; freedom from harmful traditional practices and gender based violence and freedom to express one's sexuality.

The same evidence is also key in identifying gaps that require prioritisation by decision/policymakers, as well as unearthing service delivery issues for evidence-based advocacy action plans in a participatory, inclusive and consultative manner. Thus, CSCs findings will serve as advocacy tools that feed into policy and advocacy processes for the PSA Alliance, its partners and stakeholders in the five project countries at local, national and regional levels. In the end, the CSCs are used to engage young people[4], adolescents[5] and women and other stakeholders at the district or ward level. It is also the intention of the CSCs to facilitate comparative inquiry into HIV and SRH service delivery in the five project countries. The emergence of good practices through CSCs will inspire better results for communities and by respective governments, and this allows for the exchange of lessons learnt and the promotion of social accountability in the region. The essence, therefore, is to increase the accountability and responsiveness of health service providers in the provision of SRH services.

3.0 Methodology

The CSCs were administered through community scorecard interface meetings/focus group discussions (FDGs), and other facilitated discussions in the district wards and villages (*see Table 1 below*). Participation in CSC interface meetings varied from one country to the other, as shown in Table 1 below. A total of 523 participants were recorded, with Mozambique having the highest number of participants (204), whilst attendance in other countries was distributed as follows: Malawi (120), Tanzania (71), Zambia (64) and Zimbabwe (64). Thus, there was an average of 105 participants per project country.

Participants in the CSC interface meetings were asked specific standard questions regarding the perceived quality of public services (related to the thematic areas of human resources, commodities and equipment, infrastructure and quality of services) as well as government accountability (participation and engagement) in delivering those services (*see Annex 1*). Questions relating to participation and engagement were framed using the five inter-dependent processes of social accountability monitoring (SAM) in public resources management, namely strategic planning and resource allocation, expenditure management, performance management, public integrity management (preventive and corrective action), and oversight in order to assess the effectiveness of SAM within the health services sector

[4] The United Nations (UN) considers young people as those aged 10 to 24 years.
[5] The World Health Organization (WHO) defines an adolescent as someone between the age of 10 and 19 years. During this period of life, there are specific health and developmental needs and rights as well as knowledge, skills, attributes and abilities that should be acquired given their importance for the enjoyment of adolescent years and assumption of adult roles.

(specifically in the delivery of HIV and SRH services) in the respective districts across the five project countries.

During each CSC interface meeting, the process and purpose of the CSC were explained, participants agreed on the indicators to be tracked and participants rated/scored the state and quality of HIV and SRH service delivery, service delivery facilities and other social accountability indicators in the district/ward. The average scores were justified by the existence of an agreed standard of service provision; perspectives and expectations of the community; perspectives of service providers; respective client service charters; and other relevant operational guides and policy guidelines. The ratings were captured on the CSC Excel templates by facilitators and the raw data was analysed using thematic analysis to produce district CSC reports. The CSC used is included as Annexure 1.

All participants were invited to freely attend CSC interface meetings without any form of coercion or enticement; there was informed consent. Some participants were reimbursed for transport expenses that they incurred in travelling to attend CSC interface meetings. In light of COVID-19, national health protocols and guidelines were strictly adhered to as precautionary measures were taken in an attempt to prevent and control COVID-19 transmission during CSC interface meetings. Specifically, the participants in CSC interface meetings were limited in numbers, whilst physical (social) distancing was observed. Other measures enforced included hand hygiene and respiratory etiquette, good ventilation, use of hand sanitisers, consistent wearing of face masks, and others.

Table 1: Number of SRHR CSC Interface Meetings per District Wards and Villages in the Five Project Countries

Country	District	Ward	Participants
Malawi	Nsanje	Malemia	32
		Mbenje	30
		Mlolo	15
		Ngabu	43
Mozambique	Chibuto	Chibuto	31
	Lugela	Lugela	173
Tanzania	Mbozi	Hasamba	14
		Idiwili	17
		Itaka	13
		Iyula	10
		Zelezeta	17
Zambia	Kasenengwa	Makungwa	15
	Chipata	Kapata	15
		Nsingo	17
		Kanjala	17

Zimbabwe	Binga	Simatelele	64
		Sianzundu	
			523

Source: CSC data sheets from the five project countries

3.0 Key Findings

The findings from the CSC interface meetings show different trends and patterns across the five project countries with respect to the management and performance of HIV and SRH services at the district/ward levels. Granted, findings from the identified districts in the five project countries may not be sufficient enough to allow for broader generalisation of the state of affairs in HIV and SRH services. However, the evidence drawn from CSC interface meetings are useful in facilitating an assessment of progress, challenges and opportunities faced by the respective governments in the provision of HIV and SRH services, and the extent to which the five project countries are progressing towards selected SADC regional commitments in HIV and SRH services: Strategy for Sexual and Reproductive Health and Rights in the SADC Region (2019-2030); SADC Maseru Declaration on the Fight Against HIV and AIDS (2003); Maputo Plan of Action for the Operationalization of the Sexual and Reproductive Health and Rights Continental Policy Framework (2016-2030); Abuja Call for Accelerated Action Towards Universal Access to STI/HIV and AIDS, TB and Malaria Services in Africa (2006); and Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001).

The key findings from the CSC interface meetings hosted in the five project countries are analysed, organised and presented under the five thematic areas of human resources, commodities and equipment, infrastructure, quality of services, and participation and engagement.

3.1 Human Resources

Healthcare providers are considered essential in determining the quality of SRH services since their competence, skills, abilities and attitudes are fundamental in addressing the needs of young people, adolescents and women both at health facilities and in communities. This is why the World Health Organization (WHO) includes the health workforce as part of the six core components or 'building blocks' of any health system.[6] At CSC interface meetings undertaken in the five project countries, community members presented their perceptions and assessment

[6] The WHO identifies the following as the six core components of a health system: (i) service delivery, (ii) health workforce, (iii) health information systems, (iv) access to essential medicines, (v) financing, and (vi) leadership/governance.

of the HIV and SRH service providers in terms of their adequacy, approachability and friendliness. Participants were also probed on whether HIV and SRH service providers adequately explain issues to clients and the extent to which they provide such services in a way that ensures confidentiality and respect. In addition to this, the representativeness of HIV and SRH service providers by gender and age was also assessed.

Adequacy of HIV and SRHR Service Providers

There is a common challenge of inadequate HIV and SRH service providers across the five project countries. In their feedback, most CSC interface meeting participants in the five project countries were of the view that the available HIV and SRH service providers are not sufficient to assist young people, adolescents and women at health facilities and in communities. This becomes an access barrier to service users which hinders the progress of most countries in their pursuit of regional and continental commitments, which all emphasise the need for member states to increase access to quality, integrated and comprehensive HIV and SRH services to ensure at least 90% of the population benefit from these services.

Community members in Ngabu Traditional Authority, Nsanje District (Malawi), complained about the inadequacy of qualified staff at SRH service centres in the area with several unfilled vacant posts. The community members and young people stated that instead of having a minimum of 20 service providers, the SRH service centre has seven. Thus it has a shortfall of 13 staff. In the end, unqualified and untrained grounds maintenance workers end up providing support services at the health centre. This also applies to health centres in Mbenje Traditional Authority where participants noted that the use of non-skilled labour is widespread due shortage of personnel. For instance, participants stated that Mbenje Health Centre has one specialist for SRH for youth and the same person is also assigned other responsibilities. The only SRH specialist is said to be always busy and so fails to attend to youth issues adequately. In the end, "gate attendants and cleaners are assigned nursing and clinical duties to assist the technical staff". On the other hand, at Snakhulani Health Centre (a public facility under Nsanje District Health Office) and Mlolo Health Post (which is a centre for health surveillance assistants and receives support from government under Masenjere Health Centre) in Mlolo Traditional Authority (Nsanje District), there are no permanent SRH staff and centres are run through untrained volunteers and some ground maintenance workers who provide clinical services. Banja La Mtsogolo (BLM)[7] assist to bridge this shortfall by offering SRH services one per week

[7] Banja La Mtsogolo is Malawi's largest non-profit provider of SRH and HIV services established in 1987 to provide SRH services to people most in need, primarily women and young people living in hard-to-reach rural and urban areas. It has a network of 30 clinics, 600 mobile outreach points and 50 social franchise partners in the country.

every month. The trend of inadequate numbers of HIV and SRH staff to meet the demand for HIV and SRH services is also a challenge reported in Lugela and Chibuto Districts (Mozambique) and Mbozi District (Tanzania).

Conduct of HIV and SRHR Service Providers

HIV and SRH service providers and community health workers play an important role in providing health education, information, resources, advice and services to young people, adolescents and women. Services offered include those related to HIV (including voluntary counselling, testing and access to anti-retroviral therapy), screening for sexual violence and cancers, sexual health education and counselling, contraceptives provision, services related to sexually transmitted and reproductive tract infections (STIs/RTIs), safe abortion services, among other support services. In providing these services at health care centres or youth centres, HIV and SRH service providers are expected to be easily accessible, approachable and respectful of the right to privacy and confidentiality. The services should be inclusive and people-centred, so that the sexual and reproductive health and rights of young people, adolescents and women are promoted and protected. This is in line with the commitment made by SADC member states in the Strategy for SRHR in the SADC Region (2019-2030),[8] wherein member states commit to ensuring that all adolescents are able to access people-centred integrated SRH services, including HIV services.

In terms of approachability and attitudes, the experiences of young people, adolescents and women in seeking HIV and SRH services at health centres and youth centres in the five project countries are mixed. However, participants in the CSC interface meetings were satisfied with how HIV and SRH service providers delivered their services and interacted with them. In Nsanje District, most villagers consider SRH service providers to be largely 'friendly', 'passionate' and that they provide good feedback, although a few were reported to be unfriendly towards adolescents. According to CSC interface meeting participants, when healthcare providers exhibit unfriendly behaviour and attitudes it is often because they are overwhelmed by a high workload. In Mozambique's Chibuto District, and Tanzania's Zelezeta Ward (in Mbozi District) most health providers are also reported to be 'friendly and well-behaved'.

Challenges relating to elderly SRH service providers displaying condescending and patronising attitudes towards young people and adolescents were reported in some countries. In Mbenje Traditional Authority in Nsanje District (Malawi), community members reported:

[8] *See* Strategy for Sexual and Reproductive Health and Rights in the SADC Region (2019-2030), pp.28

> *"Generally (SRH service providers) are unfriendly sometimes, especially if it's an older person attending to a young person. The team fails to grasp the YFS (youth-friendly service) concept and are at times harsh with the youths."*

Being unfriendly compromises the approachability of SRH service providers, which becomes an access barrier. For instance, in Mlolo Traditional Authority in Nsanje District (Malawi), participants hinted that workers at Mlolo Health Post are less approachable than workers at Snakhulani Health Centre given their 'mood swings'. As a result, young people end up enquiring to know the health service provider on duty first before they decide to visit the health facility for assistance as they seek to avoid those known for being unwelcoming. This has the effect of discouraging young people from accessing HIV and SRH services.

Whilst participants in Itaka Ward in Mbozi District (Tanzania) indicated that SRHR service providers are considered friendly, in Iyula and Hashamba Wards (in the same district), it was noted that the HIV and SRH service providers were not consistent in their attitude towards young people, adolescents and women. Some HIV and SRH service providers were reported to be friendly and approachable whilst others were not. As for Itaka, Iyula, Hashamba and Idiwili Wards in Mbozi District, the friendliness of HIV and SRH service providers is thought to be dependent on whether they are in a rush on that particular day which makes them rude and impatient. It is because of this reality that 'some of the young people are no longer comfortable to visit the clinic'. Be that as it may, most of the five project countries, including Tanzania,[9] Zimbabwe,[10] have client service charters guiding the conduct of health workers which encourage health service providers to be friendly, responsive, empathetic and caring and treat service seekers with kindness, dignity, respect and compassion. Overall, the cultivation of good interpersonal relationships between SRH service providers and young people, adolescents and women facilitates the realisation of quality SRH services. Thus, as suggested by participants at CSC interface meetings in Binga District (Zimbabwe), there may be a need for all HIV and SRH service providers to be trained so that their conduct is youth-friendly.

In terms of confidentiality and respect for the privacy of young people, adolescents and women, most community members in the five project countries acknowledged that health service providers keep the information shared in confidence. This, as confirmed by most community members, is ensured by making sure that sensitive and confidential medical information, records and personal data of service seekers are kept securely, whilst related

[9] Tanzania has the National Client's Service Charter for Health Facilities (2018), *see* http://ciheb.org/media/SOM/Microsites/CIHEB/documents/CQI/Tanzania-Client-Charter.pdf

[10] http://www.mohcc.gov.zw/index.php?option=com_phocadownload&view=category&download=47:service-charter&id=6:acts-policies&Itemid=660

discussions are held away from the public. Young people, adolescents and women consider that personal information relating to HIV test results, reproductive health status, sexual matters, contraceptive choices, STIs/RTIs symptoms, abortion decisions, and other SRHR-related personal profiles to be very sensitive hence their right to confidentiality has to be consistently promoted and protected whenever they access these services. This builds trust between SRH service providers and the communities they serve. However, cases of HIV and SRH service providers breaching confidentiality and privacy rules emerged during CSC interface meetings across the five project countries. This is despite the fact that all the five project countries have legislative frameworks and regulations that provide for respect to privacy and confidentiality in the delivery of HIV and SRH services, as committed to under the Strategy for SRHR in the SADC Region (2019-2030).[11]

Participants at CSC interface meetings in the covered five wards (Idiwili, Iyula, Itaka, Hashamba and Zelezeta) in Mbozi District (Tanzania), confirmed that most HIV and SRH service providers observe confidentiality. This was the case in Lugela and Chibuto Districts (Mozambique), Mbozi District (Tanzania), Kasenengwa and Chipata Districts (Zambia) and Binga District (Zimbabwe).

Infrastructural constraints and limitations have also been identified as a barrier to confidentiality in the delivery of HIV and SRH services. The physical layout or structural design of some of the healthcare centres compromise the privacy and confidentiality of discussions between HIV and SRH service providers and young people or adolescents. Most of the healthcare centres or youth-friendly service centres do not have adequate rooms for SRHR consultations and most of the consulting rooms are not soundproof. Some centres have rooms with 'curtain' walls and/or cubicles that are divided by thin boards. In such circumstances, where the infrastructure is not conducive and sufficient enough to maintain privacy, young people, adolescents and women feel uncomfortable as their consultation conversations may be overheard by others in the next room, along the corridors or at the reception area. Participants in Chaimite, Maleice, Maniquinique and Mukhotwene villages in Chibuto District stated,

> *"The health providers are confidential, but the service spaces are small and you end up being overheard by other users. For example, in a single ward, they provide adult screening, counselling and testing…The spaces are small, young people don't feel comfortable because several services are provided in the same ward."*

[11] *See* Strategy for Sexual and Reproductive Health and Rights in the SADC Region (2019-2030), pp.29

Since confidentiality is also an ethical issue and legal obligation in health service provision, it is also positive to note that cases of HIV and SRH service providers who have breached confidentiality are managed and addressed at health service centres. An example was given in Mlolo Traditional Authority in Nsanje District (Malawi);

> "*In the past, one health worker used to spread out confidential information but he got transferred to another centre. There were also incidences of volunteers recording videos of clients during service provision. In the maternity, women were being filmed and clips spread to the public. All these people were transferred. Another person who got transferred was revealing people's blood status.*"

Gender Balance and Inclusivity of HIV and SRH Service Providers

In the delivery of HIV and SRH services, gender balance and the inclusion of young people as service providers is key in ensuring that there are varied perspectives and approaches in healthcare centres and at youth-friendly service centres. This may assist to strengthen decision-making, as diversity is key in improving the quality of service in dealing with gender-related aspects of HIV and SRH services.

From the evidence gathered through CSC interface meetings, it is apparent that very few districts have achieved gender balance amongst the existing HIV and SRH service providers. Gender balance was reported at healthcare centres in Mbozi District (Tanzania) and Lugela District (Mozambique). At the same time, the majority of HIV and SRH services providers working at healthcare centres in Mbozi District (Tanzania), as well as in Chibuto and Lugela Districts (both in Mozambique) were also found to be young persons (below the 35 years of age). Young people and adolescents felt that they are more flexible and comfortable being assisted by a young person at healthcare Centres. In Zimbabwe, however, it was reported that no young people were working as HIV and SRH services providers at healthcare centres in Binga District.

There was also a trend of gender imbalances that favoured men over women amongst HIV and SRH service providers in most countries, except in Chibuto District (in Mozambique) where women were the majority of HIV and SRH service providers at the centres covered. For instance, in Nsanje District in Malawi, most of the HIV and SRH service providers are men, with very few women. Men constitute between 60 to 70% of the total SRHR staff complement at healthcare centres or youth-friendly service centres in the covered five wards in Nsanje District. These gender dynamics have their impact on young people, adolescents and women who seek services at the centres. For example, women expressed their discomfort at being served by male staff when seeking SRH services, although in some instances (as was gathered

in Traditional Authority Mbenje in Nsanje District), women asserted that they preferred male midwives to assist them ahead of their female counterparts. Although several reasons were provided for the underrepresentation of women – including issues of lack of requisite qualifications amongst women and corrupt practices, among other factors – the achievement of gender balance is essential in ensuring quality SRH service provision in the five countries.

3.2 Commodities and Equipment for HIV and SRH Services

Since member states have committed – under the Strategy for SRHR in the SADC Region (2019-2030) - to promote the provision of comprehensive SRH services that reaches those hardest to reach,[12] it is the consistent supply of commodities and equipment needed for the delivery of HIV services (testing and treatment), contraceptives, safe abortion, among other SRH services, that remains indispensable. In fact, one of the four core strategies formulated to drive progress to achieve the 10 outcomes identified in the Strategy for SRHR in the SADC Region (2019-2030) is that of ensuring that health facilities 'have the necessary equipment, commodities and supplies'.[13] Thus, healthcare centres and youth-friendly service centres are expected to have adequate supplies of male and female condoms, family planning pills, pregnancy testing kits, HIV/STI testing kits, pre-exposure prophylaxis (PrEP) pills, post-exposure prophylaxis (PEP) pills, among other supplies. Otherwise, SRHR cannot be promoted and protected if such commodities are not freely and conveniently available as and when they are needed.

Based on the CSC scores provided during the CSC interface meetings, four of the five project countries (except Mozambique) reflected an average score, denoting that most SRHR commodities and equipment are available but there are challenges associated with both their availability and access by young people, adolescents and women in communities. A number of the commodities and equipment are in short supply when measured against demand from the respective communities.

The common trend that emerged from the CSC interface meetings is that there are serious shortages of four main commodities in almost all the five countries, namely *female condoms*, *pregnancy test kits, PEP* and *PrEP*. Three of these commodities (female condoms, PEP and PrEP) are salient to the realisation of several commitments made to combat HIV and AIDS under the SADC Maseru Declaration on the Fight Against HIV and AIDS (2003), the Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases (2001) and the SADC

[12] *See* Strategy for Sexual and Reproductive Health and Rights in the SADC Region (2019-2030), pp.11
[13] *See* Strategy for Sexual and Reproductive Health and Rights in the SADC Region (2019-2030), pp.14

Regional Strategy for HIV and Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations (2008). These feed into the global goal, stated under United Nations (UN) Sustainable Development Goal (SDG 3) which targets to end HIV/AIDS by 2030 (Project 2030). As part of its Regional Scorecard for HIV Prevention, SADC member states targeted, among others, to improve condom access by ensuring that 90% of high-risk populations have access to condoms by 2020, and also ensuring that 10% of the populations at high risk have access to PrEP by 2020.[14] On the other hand, the provision of pregnancy test kits assists to facilitate safe abortions, itself a fundamental reproductive right. Shortages of these commodities will undermine investments in pursuit of regional and global commitments towards both fighting HIV/AIDS and the promotion of SRHR in the region.

Other than being inadequately supplied, commodities such as PrEP and PEP appear to be associated with challenges of lack of knowledge of their use by most young people, adolescents and women. In Traditional Authority Mbenje in Nsanje District (Malawi) it emerged that PEP was available but accessibility to young people remains poor as most young people do not know what PEP is, resulting in low uptake. This was the case in Traditional Authority Malemia in the same district where a significant number of community participants in the CSC interface meetings indicated that they were unaware of PEP.

The non-availability of some SRHR commodities and equipment further prevent the poor from accessing SRH services. This is the case with commodities such as pregnancy test kits in most healthcare centres, which forces young people, adolescents and women to purchase these in pharmacies, as was reported in Lugela District in Mozambique. Those who cannot afford to purchase test kits end up not accessing the service.

Cultural, technical and corruption-related barriers in accessing SRHR commodities and equipment also emerged from CSC interface meetings. In Binga District (Zimbabwe), for example, cultural hindrances were reported to prohibit women from using female condoms. Cultural barriers are highlighted in the Strategy for SRHR in the SADC Region (2019-2030[15] as one of the impediments to the realisation of SRHR in southern Africa that should be addressed. On the other hand, contraceptive implants at health facilities in the district were not being provided since there are no trained nurses trained in their insertion, despite the implants being available. The prevalence of corruption was also singled out as presenting a barrier to access SRHR commodities at health facilities. In Traditional Authority Malemia in

[14] SADC Scorecard for HIV Prevention (2018), pp.1, *see* https://www.sadc.int/files/2215/6343/6605/SADC-_2018_HIV_Prevention_Scorecard_Approved.pdf
[15] *See* Strategy for Sexual and Reproductive Health and Rights in the SADC Region (2019-2030), pp.27

Nsanje District, for instance, community members explained how access to pregnancy test kits and other SRHR commodities was being complicated by corrupt practices.

> *"There is corruption at the testing centre. Most service providers demand to be paid in order to help. This behaviour cuts across all services offered at the facility. Service providers require that one should enfold some money in the Health Passport Book in order to be considered for services."*

Therefore, addressing the identified gaps relating to the provision of SRHR commodities and equipment across the five project countries should be comprehensive enough to incorporate the provision of information and education, as well as bold enough to challenge cultural, technical and corruption-related barriers to access.

3.3 Infrastructure

The delivery of quality and comprehensive HIV and SRH services requires basic support infrastructure to facilitate unfettered access by all young people, adolescents and women. It is the existence of adequate infrastructure that promotes high-quality universal coverage for SRH services. The Strategy for SRHR in the SADC Region (2019-2030) mentions the essentiality of improved health infrastructure, adding that 'poor and unfriendly infrastructure limits access to quality SRHR services'.[16] In assessing the state infrastructure for SRH services, the CSC interface meetings sought to establish whether there are standalone healthcare centres, youth-friendly service centres, or permanent SRH centres in the respective districts of the five project countries. Whether the necessary infrastructure is in place to support the delivery of essential SRH services in communities can also be assessed based on the accessibility of such facilities to the public; the existence of information, education and communication (IEC) materials used to convey SRHR messages; and the availability of sufficient and reliable transportation facilities for SRHR commodities and related equipment.

Based on the above-stated indicators, only Zambia's two districts of Kasenengwa and Chipata (of all the five project countries) had a positive score on average. Tanzania's Mbozi District and Mozambique's two districts of Chibuto and Lugela all had an average score, an indication that most of the infrastructure facilities are in existence but there are associated challenges that compromise the delivery of SRH services and their accessibility to young people, adolescents and women in communities. Two traditional authorities in Malawi's Nsanje District (Malemia and Mbenje) have average scores, whilst the other two traditional authorities (Mlolo

[16] *See* Strategy for Sexual and Reproductive Health and Rights in the SADC Region (2019-2030), pp.22

and Ngabu) have negative scores, itself an indication of emergency/non-availability/bad SRH service infrastructure.

What is non-existent in most of the five project countries' covered districts are stand-alone SRH youth-friendly space/services, a permanent SRH service centre and adequate transportation services to transport SRH commodities. In all the covered five wards of Mbozi District (Idiwili, Iyula, Itaka, Zelezeta and Hasamba), there is no stand-alone SRH youth-friendly space/services, or a permanent SRH service centre. This is also the case in Mozambique's Districts of Lugela and Chibuto as well as Malawi's Nsanje District. In all these countries, there is dedicated space for SRH services are provided at local hospitals and healthcare centres. This poses its own challenges when it comes to the delivery of SRH services and accessibility to young people, adolescents and women. In Malemia Traditional Authority in Nsanje District (Malawi), it was noted;

> *"There is no stand-alone space (for SRHR services). The venue to access SRH services depends on where the person responsible for SRH is. If the person changes office, then centre for services change as well. The centre has no permanent SRH centre/office. Basically, there is shortage of rooms at Nsanje District Hospital. SRH services are Integrated within "Under-five Clinic".*

The same situation exists in Mbenje Traditional Authority in the same district where youth-friendly health services are dedicated space at a local hospital. Whilst these created spaces are accessible, one of the most serious challenges relates to their being non-conducive for young people as they end up being mixed with elders. In Mlolo Traditional Authority (Nsanje District), the SRH space is integrated into the maternity ward of Mlolo Health Post. There are inconveniences associated with such arrangements. A case in point is in Mbenje Traditional Authority (Nsanje District), where community members indicated,

> *"The rooms are specialised for SRH services but not youth-friendly health services separately. When accessing services (SRH), both older people and youths share the same spaces. The centre is accessible but not conducive for youth. It's easily accessed within the target community, but servicing other communities 10km away, outreach services have not yet been rolled out."*

Accessibility constraints are even more serious in some traditional authorities. In Ngabu Traditional Authority it was found out that young people would need to travel for 64 km to access the SRH service facilities. This is worsened by the absence of transportation services and facilities to service the SRH service centres as is the case in Mbozi District (Tanzania) where there are no transportation services for SRH commodities in all five covered wards. For most countries there are no ambulances, the SRH centres resultantly rely on other departments

for transport services. A related example is in Chibuto District where the SRH centre relies on vehicles from the District Services for Health, Women's Affairs and Social Action (SDSMAS). Similarly, officials at Sankhulani Health Centre in Traditional Authority Mlolo (Nsanje District) also indicated that since they have no vehicles, they borrow transport from Masenjere Health Centre and Fatima Clinic of Christian Health Association of Malawi (CHAM). CSC interface meeting participants in Ngabu Traditional Authority in Nsanje District reported that,

> *"The centre has no means of transport. But there is chance to request from the district hospital when need arises. There are serious transportation issues including absence of an ambulance. When they run out of stocks, they wait for a vehicle from DHO. Service providers use their own transport 50% of the time; there is no readily available transport"*

SRH service delivery is also being affected by inadequate information, education and communication (IEC) materials. Most SRH service centres do not have enough IEC materials. IEC materials, in their different forms such as flyers, brochures, posters, booklets and spots for media publicity (whether print or electronic) assist to promote awareness and education around SRHR programmes, activities and events. However, IEC materials are in short supply in a number of countries, except Mozambique and Zambia. This is despite the fact that knowledge, information and education are central to realisation of SRHR. In all Mbozi District's wards, for instance, there are insufficient IEC materials for young people, adolescents and women. This may be due to resource constraints. The following emerged from the CSC interface meeting at Traditional Authority Malemia in Nsanje District;

> *"There are no IEC materials. The only last time IEC materials were provided was in 2014 through GIZ/GTZ (Deutsche Gesellschaft für Internationale Zusammenarbeit/German Corporation for International Cooperation). There are no IEC materials targeting youths. There are no carry home. Posters posted within the facility are not youth-centred."*

On the contrary, there is a massive distribution of IEC materials with wider reach and coverage in some countries, including Mozambique and Tanzania. An example is in Chibuto District in Mozambique where young people, adolescents and women can get SRHR IEC materials in schools and communities.

3.4 Quality of Service

The Strategy for SRHR in the SADC Region (2019-2030) underscores the need for improved realisation of quality, comprehensive, integrated SRH, gender-based violence (GBV) and HIV/AIDS package that meets the needs of all women, men, adolescents, young people and key populations in SADC.

All the districts and wards across the project's five countries scored average on the consideration of whether the SRH services provided in the area are of high quality, the adequacy of time spent to receive the service by young people and adolescents, and whether the operating hours of the SRH centres are conducive. The interpretation is that the quality of SRH services in these districts is average; there are several factors compromising optimum quality services. Only Chibuto District has a positive score given the quality of SRH services that are reportedly being delivered. In Chibuto District, all indicators for quality service delivery were positive except the time spent to receive SRH services, which was considered inadequate.

Generally, the quality of SRH service was judged by participants across the districts to be of average quality, whilst the time spent to receive SRH services by adolescents and young people was viewed to be inadequate. Likewise, the operating hours of SRH centres were deemed non-conducive for the delivery of SRH services and commodities, as reported across all five wards in Mbozi District in Tanzania. The quality of SRH services is being compromised by varied factors, including lack of stand-alone space, inadequate knowledge among some SRH service providers (especially volunteers), limited time for consultations, long waiting times, lack of confidentiality at some centres, non-availability of SRHR commodities, infrastructure deficiencies and corruption, among other factors. The following was expressed in Traditional Authority Mlolo in Nsanje District (Malawi), by community members;

> "*The services are not of high quality due to staff knowledge/skills gap and facility infrastructure limitations. Some services are not available. Due to inadequate resources, the centres fail to attain good quality of services.*"

Related views were also submitted in Traditional Authority Mbenje;

> "*Due to inadequate staff, services are rushed through with little attention during consultations. The volunteers are non-skilled and offer services of low quality. (The) quality (of SRH services) is affected by competence and availability of commodities, understaffing, late opening and early closing of the facility, no confidentiality, and no privacy.*"

Concerning time spent to receive SRH by young people and adolescents, the common challenge reported in most districts was that SRH service providers are overwhelmed and, therefore, rush consultations. Similar to Lugela District in Mozambique and the other three wards in Nsanje District (Malawi), participants in Traditional Authority Ngabu mentioned;

> "*They (SRH service providers) open and close at will, only one day per week allocated to support young people. They are always in hurry and do not spend adequate time with the young people. The time for consultation and assistance is rushed through since the service*

providers are always busy. There is need to extend days and time spent with the youths, but the challenge is human resources and facilities."

Another trend related to the operating hours of SRH service centres was the lack of consistency and adherence to officially scheduled working hours by SRH service providers, which inconvenienced young people, adolescents and women. Participants in Traditional Authorities of Nsanje District chronicled how operating hours at the SRH service centre was unpredictable. Because some SRH service seekers are of school-going age, CSC interface meeting participants suggested the need for SRH facilities to open earlier and close later to accommodate young people.

3.5 Participation and Engagement

Participation and engagement are essential in facilitating social accountability monitoring (SAM) in public resource management (PRM). The actions, tools and mechanisms employed by citizens, communities, civil society organisations (CSOs) and other players to hold public officials and service providers to account for their actions, decisions and performance all assist to improve public service delivery and facilitate community empowerment. Young people, adolescents and women ought to be fully and actively engaged in the five PRM processes: strategic planning and resource allocation, expenditure management, performance management, public integrity management (preventive and corrective action), and oversight of HIV and SRH services. Effective social accountability monitoring of resources and decisions meant for HIV and SRH services (through participation in citizen monitoring, social audits, budget consultations, public expenditure tracking, etc.) should include young people, adolescents and women at village, ward and district levels to facilitate efficient planning, allocation, and expenditure of SRHR resources towards the improvement health service delivery.

In the districts covered in all the five project countries, it is apparent that there is very limited involvement of young people, adolescents and women in the monitoring of health services in their localities. Further, young people, adolescents and women hardly participate in budget consultation processes. The active and meaningful involvement, engagement and participation of young people in SAM processes that influence the allocation, expenditure and delivery of SRH services would ideally allow them to contribute towards decisions that shape their SRHR. By not participating, young people are likely to have their concerns, needs and priorities addressed. Ultimately, unless HIV and SRHR packages consider the special challenges and needs of young people, they become irrelevant, inaccessible, unattractive, unaffordable,

inappropriate and unacceptable. Moreover, the efficiency of resource allocations and expenditure in SRH service components (including human resources, supporting infrastructure and facilities, commodities and equipment, etc.) may be weakened by a lack of robust SAM.

Some of the reasons brought forward by young people, adolescents and women to explain their non-participation in SAM processes include, among others, lack of consultation and coordination, marginalisation of young people, information gaps, secretive tendencies of officials in high raking policy/decision-making officials, and non-consideration of young people's views. In some instances, the non-participation of young people in budget consultation processes, as explained by participants in Zimbabwe's Binga District, is because of 'cultural underlying issues'. The marginalisation of young people in SAM processes and budget consultations was echoed in Traditional Authority Malemia in Nsanje District (Malawi);

> *"There are no budget preparation consultations with young people. Actually, young people are not consulted at all on all decisions made at the facility. Youths are invited but do not provide feedback to their colleagues in youth clubs. The youth coordinator is the one who participates but not youths in general. Committees have youth representatives; however, there is lack of coordination between in the HCMCs (Health Care Management Committees)[17] and youth clubs."*

The non-consultation of young people in programming was also noted in Mbenje Traditional Authority in Nsanje District. Participants indicated that young people are 'never engaged' whenever budgets are formulated by the council. Notwithstanding the existence of HCMCs which comprise community members, the leadership rarely consult with communities when making its decisions. This was also confirmed in Mlolo Traditional Authority,

> *"The people are able to point out what needs to be done and participate in activities that happen at the centre. However, they do not really get involved in decision making and only get involved in implementing other people's ideas. Through health management committees (HACs), community members get involved in monitoring. Communities have health promoters who work closely with HSAs and act as community voices. Involvement of community members at CHAM facilities is limited due to nature of the institutions."*

The trend observed in Malawi, Mozambique, and Tanzania was also observed in Zimbabwe, where young people and adolescents are not involved in the monitoring of health services and do not participate in budget preparation consultations processes in their communities. Participants in Zimbabwe's Binga District (Sianzundu and Simatelele Wards) were of the view

[17] Every health centre has a Health Care Management Committees (HCMC) which is responsible for overseeing the planning and implementation of health services in line with district and national strategies.

that young people are not monitoring the health facilities since they are not among the health committee chairpersons (HCC) which monitors the service delivery and use. As a result, the needs and priorities of young people and adolescents in the five project countries are not sufficiently reflected in the SRH service programmes.

In assessing the extent to which members of the community are free to report concerns on the quality or availability of SRH services, and whether community members are provided with feedback on the concerns raised about the delivery of SRH services, what emerged is that the young people, adolescents and women in most of the covered districts in the five project countries are free to report any concerns about the quality or availability of SRH services. However, difficulties arise when it comes to the provision of feedback on particular issues or concerns raised. In the five wards of Tanzania's Mbozi District (Hasamba, Idiwili, Itaka, Iyula and Zelezeta), participants at CSC interface meetings acknowledged the existence of channels and procedures to report concerns related to SRH services. Nevertheless, securing feedback on reported issues always proves to be difficult. This is the same practice in Malemia Traditional Authority in Nsanje District (Malawi), where community members stated,

> '*There is an office of the Hospital Ombudsman for receiving concerns. However, most people do not utilise the channel and complain outside these structures. Youth clubs present their issues to youth networks but do not know where to report to at health facilities. There is no feedback on concerns that are raised. Although there are suggestion boxes at the facility, what comes out of them is not shared with the service uses.*'

One of the principal reasons why social accountability appears to be impeded in terms of feedback to complaints is the lack of independence and impartiality on the part of offices that are supposed to interface with the community. In Traditional Authority Mbenje (Nsanje District), participants were clear that people are free to report concerns through the health management committees (HMCs) and the Hospital Ombudsman at Phokera and Sorgin Health Centres within the ward. However, there are conflicts of interest that often arise since the Ombudsman at Phokera Health Centre is also the Officer-In-Charge for the facility. Such arrangements are highly likely to compromise the partiality of the Ombudsman, which ultimately undermines the efficacy of SAM processes in SRH service delivery.

Unlike the above cases, there are districts such as Chibuto District in Mozambique where young people, adolescents and women consistently receive feedback after reporting their concerns about SRH service quality or availability. However, in Lugela District in Mozambique, comments made through complaint or suggestion boxes are reportedly never attended to.

Without regular and consistent feedback between office bearers or SRH service providers, the promotion of citizen engagement and monitoring to improve the performance of SRHR systems are ineffective, and the services remain unresponsive to public needs.

The advent of COVID-19 has also affected the participation and engagement of young people and adolescents in SRHR planning and programming in all project countries except Tanzania.[18] Whilst public participation and engagement are the cornerstone of more sound decision-making, increased responsiveness and more efficient public resource management (PRM), COVID-19 suppressed most of the platforms, avenues and vehicles of public participation as a result of the national lockdown restrictions and other measures instituted to prevent and limit the movement and gathering of people. As hinted by participants in Ngabu Traditional Authority in Nsanje District,

> *'COVID-19 has interfered with provision of services at the facility. Restrictions on gathering make it hard for youth to meet and access information on SRHR services. There are many cases of pregnancies among girls and young women. Health centres failed to carry out community sensitisation activities; health workers did not visit youth clubs during COVID-19. They [community members] failed to buy masks and hence failed to access SRH services, as health centred had by-laws of not letting people with no masks enter their premises.'*

Related to participation and engagement in SRHR planning and programming, COVID-19 also imposed access barriers to many young people, adolescents and women who could not access healthcare centres and youth-friendly service centres to secure male and female condoms, family planning pills, pregnancy testing kits, HIV/STI testing kits, PrEP pills, PEP pills and other SRHR provisions. With inter-provincial travel banned in most countries, many healthcare centres and youth-friendly service centres ran out of SRH supplies as they could not receive supplies. This had consequences on young people, adolescents and women in most countries as they were denied passage at COVID-19 security checkpoints whenever they wanted to access SRH facilities, thereby risking unwanted pregnancies.[19] The following emerged from a CSC interface meeting in Mbenje Traditional Authority in Nsanje District,

> *"The restrictions on gatherings (due to COVID-19) affected young people from receiving adequate and correct information on SRH. People without masks were barred from treatment at the health centres, which affected the reception of services. Most people have not been going to the facilities in fear of contracting the Coronavirus. Activities in the YFHS centres stopped and youth had no access to information. Most girls have been*

[18] Tanzania did not implement national lockdown measures as of April 2021

[19] Even at global level, the UNFPA projected in April 2020 that some 47 million women may be unable to use modern contraceptives if lockdown carried on for six months. This would result in 7 million unintended pregnancies. *See* https://www.unfpa.org/sites/default/files/resource-pdf/COVID-19_impact_brief_for_UNFPA_24_April_2020_1.pdf

impregnated during the movement restrictions and closure of school. This brings pressure on the facilities and other social services."

The same effect was felt in other wards in Nsanje District as reiterated in Mlolo and Malemia Wards in Malawi, Kasenengwa and Chipata Districts in Zambia and Binga District in Zimbabwe. However, other young people and adolescents maintained that they were never affected by COVID-19. For example, young people and adolescents in Chibuto District in Mozambique stated that the pandemic has not affected them as they still carry out meetings in communities. Similarly, the young people and adolescents of Lugela District in Mozambique were of the view that COVID-19 has not affected their participation and engagement in SRHR planning and programming because even before the pandemic they were not involved. This seems to be plausible considering the very minimal engagement of young people and adolescents in SRHR planning and programming. The digital participation that came with COVID-19 is not inclusive given the reality of the digital divide, especially between rural and urban areas. Rather, COVID-19 only exacerbated pre-existing structural barriers to accessing SRH services and SAM processes.

4.0 Recommendations and Key Issues for SAM Engagement

From the evidence gathered through the CSC interface meetings in the seven districts across the five project countries, there are best practices, challenges and opportunities that can be utilised to initiate interventions to improve and strengthen the delivery of HIV and SRH services as well as enhance SAM processes in Malawi, Mozambique, Tanzania, Zambia and Zimbabwe. In this regard, the following recommendations are made:

1) **Governments should be encouraged to undertake systematic staff audits to identify staffing gaps** at SRH facilities and take action to fill all open vacancies to address understaffing. This should be complemented by continuous capacity building and training to allow for the delivery of quality HIV and SRH services in communities.
2) **Governments should allocate more resources towards the establishment of stand-alone HIV and SRH service Centres or youth-friendly service centres (YFSCs).** The structural design and layout of the facilities should allow for dignity, privacy and confidentiality whilst ensuring convenient access by all SRH service seekers including people living with disabilities (PLWDs).
3) **National governments need to strengthen supervision of HIV and SRH service providers and healthcare staff in charge of HIV and SRH** so that they adhere to ethical principles and treat young people, adolescents and women service seekers with respect, confidentiality and dignity. The strict enforcement of *ethical codes of conduct*

and adherence to *client service charters* should be emphasised to overcome HIV and SRH service access barriers for young people, adolescents and women in the region.

4) Departments responsible for heath and SRHR issues should be encouraged to **revisit their recruitment policies and strategies such that they thrive for gender balance amongst HIV and SRH service staff.**
5) **Communities should be capacitated to actively and meaningfully participate in SAM, budget planning and budget consultation processes** so that their HIV and SRHR needs, priorities and requirements are considered to improve the availability of commodities and equipment at SRH facilities. It is only through consistent SAM advocacy on resource planning and budget allocation that the necessary, appropriate and requisite physical infrastructure needed to facilitate the delivery of SRH services will be considered. **Young people, adolescents and women should be targeted by capacity building. Specifically, their capacities should be built to engage in SAM processes, budget planning and budget preparation consultations** so that they influence efficient strategic planning and resource allocation, expenditure management, performance management, public integrity management and oversight.
6) **As COVID-19 persists, governments are encouraged to consider innovative and pragmatic means and ways of allowing for consistent supply of HIV and SRH commodities during COVID-19** induced national lockdown measures whilst also making plans to assist those young people, adolescents and women who refrain from visiting SRH facilities due to fear of COVID-19 exposure.

Annexure 1 – PSA Alliance Community Scorecard for HIV and SRH Services

		Score				
	Date conducted:					
	District Name:					
	Ward Name:					
	Village Name:					
	Number of men involved:					
	Number of women involved:					
	Variable	**Young People**	**Service Providers**	**Community Member**	**Overal Score**	**Reason for the provided score**
	Human Resource					
	Number of Service Providers providing SRH Services are adequate					
	The facility has young person as service providers					
	Service providers are confidential					
	Are the number of Service Providers Gender balanced					
	Service Providers are friendly					
	Service Provider make adolescents and young people feel comfortable					
	Service provider are approachable					
	Service provider want to see children parents when they go for services					
	We trust that the service provider will keep information shared in confidence					
	Service providers respect privacy of young people					
	Servive providers adequately explain issues relating to contraceptives and other SRH and HIV					
	Human Resources/staff is adequate at the service centres					

	Service providers provide adequate information for SRH information and services					
	Average					
	The center has enough Male condoms					
	The Center has enough Female condoms					
	The center has consistent adequate implants for adolescents and young people					
	The Center has consistent adequate Injectables for adolescents and young people					
	The Center has consistent adequate contraceptive tablets for adolescents and young people					
	The Center has adequate teenage pregnancy testing kits					
	The Center has adequate HIV/STI testing kits					
	The center offers PEP for Pregnancy prevention					
	The Center offers PEP for HIV					
	The center offers PREP for HIV					
	Average					
	The Center has a stand-alone health friendly space/services					
	The Center has a permanent SRH center					
	The location of the center is easily accessed by adolescents and young people					
	The center has Information, Education Communication (IEC are available					

	The center has adequate transportation for commodities					
	Average					
	Services provided are of high quality					
	Time spent to receive the service by a adolescents and young people is adequate					
	The operating hours of the center is conducive for service delivery of SRH services and commodities to adolescents and young people					
	Average					
	Participation & Engagement					
	We are involved in monitoring of health services					
	Youths and adolescents participate in the budget preparation consultations processes					
	The needs and priorities of youths and adolescents are reflected in the SRH services programmes					
	Everyone is free to report concerns on the quality or availability of SRH services					
	The staff give us feedback on the concerns we raise about services					
	COVID-19 has affected the participation and engagement of youths and adolescents SRH planning & programming					
	Average					
	Instruction					
1	The indicators are rated by the FGD participants on a scale of 1 (Totally unavailable) -5 (Well available). The indicators must be drawn up with the agreement of					

	participants and the above serve as a guide.
2	Type in the scores provided during the FGDs only, the template auto-calculates the average score for each indicator.
3	Green means a positive score; yellow means services are available but have some challenges; and red is an emergency indicating non availability
4	Priority actions must start from the red traffic light
5	Reasons for the average scores must have clear justification merging community perspective, servivce provider perspective and reference to operational guidelines, policy and service charters.