CONSOLIDATED DISTRICT QUESTIONNAIRE REPORT

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

2020/2021

Compilation of District Level Questionnaires from Malawi, 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 district level questionnaires (DLQs) focused on sexual reproductive health (SRH) and HIV services administered in selected districts in the four countries of the Partnership for Social Accountability (PSA) Alliance[1] project, namely Malawi (Nsanje District), Tanzania (Mbozi District), Zambia (Chipata District) and Zimbabwe (Binga District).[2] The DLQs were administered during the period between September 2020 and March 2021.

2.0 Background

The DLQs are part of the regional monitoring tools (RMTs) developed in Phase Two of the PSA Alliance project, Strengthening Social Accountability and Oversight in Health and Agriculture in Southern Africa, supported by the Swiss Agency for Development and Cooperation (SDC). 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 youth, 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 DLQs on SRH and HIV are based upon indicators included in African Union (AU) and Southern African Development Community (SADC) regional level commitments on SRH and HIV services.[3] The DLQs provide a framework for tracking the management and performance of selected public services at the district/ward levels across the five target countries, specifically highlighting areas with good performance and those where service users are experiencing bottlenecks or service delivery that is below expected standards. Specifically, the DLQs seek to ascertain the extent to which quality, non-judgemental and inclusive SRH and HIV services are provided to young people[4] and adolescents[5] in the project's target districts. The evidence

[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] Note that the DLQs for Mozambique were still pending at the time of consolidation.

[3] The project focuses on the following SADC 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).

[4] The United Nations (UN) considers young people as those aged 10 to 24 years.

gathered informs social accountability monitoring (SAM) interventions and policy responses in the health sector, with a view to ensure comprehensive, quality, non-judgemental and inclusive SRH and HIV services that promote and protect sexual and reproductive health rights (SRHR) amongst adolescents and young people.

The evidence collected will also allow the PSA Alliance to assess how the performance of SRH and HIV public services impact the implementation of regional commitments, specifically the 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).

The same evidence is also key in identifying gaps that require prioritisation by decision/policymakers as well as unearthing service delivery issues for the development of evidence-based advocacy action plans in a participatory, inclusive and consultative manner. The PSA Alliance and its partners will use the DLQ findings to inform policy advocacy across the five project countries at local, national and regional levels, through engaging policymakers, SRH and HIV service users and other stakeholders at the district or ward level in order to influence the necessary action needed to enhance accountability and responsiveness of SRH service providers in the health sector. It is also the intention of the CSCs to facilitate comparative inquiry into HIV and SRH service delivery across the five project countries. The emergence of good practices through DLQs 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 service providers in the health sector.

3.0 Methodology

The DLQs were administered to various stakeholders, comprising local government officials (local health department staff and local council committee members); health service providers (health clinic staff and staff at adolescent and youth-friendly service (AYFS) centres); local

[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.

members of parliament; health facility committee members; members of community-based civil society organisations (CSOs) and the community media (local journalists); among others.

There was a total of 34 DLQs distributed and completed by the various stakeholders in the four districts covered across the four project countries (*see* **Table 1**, below). The minimum number of DLQs respondents that were targeted in the initial sample was 13 respondents per district. However, the total of 34 respondents across the four districts presents an average of 9 respondents per district, which is still within a reasonable range. The majority of the DLQs respondents (79%) were male, with females only accounting for 21% of total respondents.

The DLQs contained 15 questions in total (*see* **Annex 1**), which focused on different aspects of SRH service delivery at the district/ward level, as well as questions related to the participation of adolescents and young people in budgeting and planning consultations as well as decision-making processes. The DLQs also comprised questions that sought to establish the quality of SRH and HIV services in the different districts and measures being implemented to address challenges faced by adolescents and young people in accessing SRH services. Other questions sought to ascertain the impact of COVID-19 on the delivery of, and access to, SRH services whilst others were designed to determine the existence and efficacy of social accountability monitoring (SAM) mechanisms within the health sector at district/ward levels. SAM-related questions were framed using the Public Service Accountability Monitor (PSAM) five inter-dependent processes of SAM in public resources management: strategic planning and resource allocation, expenditure management, performance management, public integrity management (preventive and corrective action), and oversight.

Table 1: Number of DLQs administered across the four project countries

Country	District	Organizations of respondents	Gender of respondents		Total
			Male	Female	
Malawi	Nsanje	CSO official (1) District council (1) District council committee members (2) Ward councillors (3) Health service providers (3) Journalist (1)	8	3	**11**
Tanzania	Mbozi	CSO officials (2) Journalist (1)	2	1	**3**
Zambia	Chipata	Ministry of Health (7) Journalists (2) CSO (1) District council (2)	9	3	**12**
Zimbabwe	Binga	District council (4) CSO (1) Health facility staff (1)	8	-	**8**

		Journalists (2)			
Total			27	7	**34**

Source: DLQs data consolidation tables from Malawi, Tanzania, Zambia and Zimbabwe

4.0 Key Findings

The DLQ findings from the four districts revealed various trends and patterns across Malawi, Tanzania, Zambia and Zimbabwe, in terms of the management and performance of SRH services. Whilst given the limited nature and scope of the sample, broader generalisations on the state of affairs in SRH services in all districts in the respective countries cannot be made, the evidence drawn from the DLQs remains illustrative and useful in establishing the extent to which countries are making progress towards selected SADC and AU regional commitments.

In this report, the findings gathered from the DLQs are presented and discussed under seven thematic areas: (i) participation and engagement; (ii) SRH service delivery; (iii) adequacy and quality of SRH service delivery infrastructure and facilities; (iv) challenges in delivering and accessing SRH services; (v) conduct of SRH service providers; (vi) participation of adolescents and young people in SAM within the health sector and (vii) effects of COVID-19 on the delivery and access to SRH services.

5.0 Participation and Engagement

Pre-budget consultations and planning processes feed into the strategic planning and resource allocation component of the public resource management (PRM) process. Generally, the trend across the four project countries is that strategic plans are drawn up by government ministries, with each line ministry/department/agency using strategic plans as their roadmaps to plan activities needed to deliver specific public services for the financial year as well as setting timeframes, spending targets and performance targets. The process is preceded by a needs identification and needs analysis exercise (socio-economic needs to be addressed), a situational analysis of the challenges and resource constraints (internal resource and capacity constraints affecting the agency's ability to address these needs), and finally identification of activities required to address current needs and group these into clearly defined programmes of the ministry/department/agency. Budgets are then allocated to the ministry/department/agency by the ministry responsible for finance together with the human resources and infrastructural requirements for the programmes, which are debated and approved by the legislature, with performance indicators identified to measure the achievement of the specific programme outputs.

For the above process to be undertaken, the data gathered through the DLQs revealed that the four countries have structures and mechanisms at the district/ward level to facilitate the participation of young people, adolescents, men and women in the pre-budget consultation and planning processes of government-funded SRH and HIV services (*see* **Table 2**, below).

Table 2: Do structures and mechanisms exist to facilitate the participation of young people, adolescents, men and women in pre-budget consultation and planning processes at the district/ward level?

Country & District	Existence of structures and mechanisms	Structures and mechanisms	Percentage of respondents aware of the structures & mechanisms	
			YES	NO/NOT SURE
Malawi (Nsanje)	Yes	Youth officer to the Council, youth clubs, youth networks, area development committees (ADCs), village development committees (VDCs), youth technical sub-committee (YTSC), Council, health advisory committee (HAC), village civil protection committee (VCPC), CSOs, such as the Tiphedzane Community Support Organization (TICOSO), youth committees	7	4
Tanzania (Mbozi)	Yes[6]	n/a	0	3
Zambia (Chipata)	Yes	Health centres, national assembly, NGOs dealing with adolescents such as Young, Happy, Healthy and Safe (YHHS), Department of Youth, youth focused projects such as the Youth Development Fund (YDF)	9	3
Zimbabwe (Binga)	Yes	District Council meetings, child protection committee (CPC), peer educators, hospitals, NGOs such as Red Cross Society, Basilwizi; district advisory council (DAC)	5	3

Source: DLQs data consolidation tables from Malawi, Tanzania, Zambia and Zimbabwe

As represented in Table 2, above, structures and mechanisms exist in all the districts to facilitate the participation of young people and adolescents, men and women in the pre-budget consultation and planning processes of government-funded SRH and HIV programmes and projects. Except in Tanzania, where the DLQs respondents expressed ignorance of the existence of district-level structures and mechanisms for participation; the majority of the respondents (that is, 64% in Malawi, 75% in Zambia, and 63% in Zimbabwe) were aware of these structures and mechanisms. However, the few respondents who are either unaware or not

[6] Whilst structures and mechanisms exist to facilitate the participation of young people, adolescents, men and women in the pre-budget consultation and planning processes, such as District Council, CSOs, etc; some DLQs respondents were unsure whether these exist. *See* https://iyfglobal.org/sites/default/files/event/resources/Behaviors_Attitudes_Tanzania%20paper_0.pdf

sure whether these structures and mechanisms for participation exist may signal a challenge amongst young people and adolescents, men and women that they are also unaware of these and henceforth are not fully utilising them.

Inferences can therefore be drawn from this reality that when a substantial number of young people and adolescents, men and women are not effectively participating in pre-budget consultation and planning processes, the likelihood is high that strategic planning and resource allocation patterns may not fully reflect their SRH services needs and priorities.

In terms of gender representation in the above structures and mechanisms for participation, only a majority of respondents in Zambia (58%) indicated that there is gender balance in these structures. In Malawi and Zimbabwe, gender imbalances were pointed out, with most respondents noting the inclusion of more men than women, and this is worsened by the exclusion of young people. The inclusion of youth in budgeting processes, resource planning, resource allocation and policymaking is fundamental, as their SRHR, health and wellbeing are directed affected by these services.

Some DLQs respondents offered explanations as to why there is an under-representation of women in these structures. In Malawi's Nsanje District, respondents indicated that low self-esteem was prevalent amongst women, and that men threaten women and hinder their participation, whilst limited education and reluctance of women to support each other were also identified as some of the major factors. This is worrying, as substantive gender balance ensures that the special needs of both men and women are reflected in policy and practice and resources are allocated to address these. Gender mainstreaming in strategic planning and resource allocation in the health sector also assists in fighting off gender-based stereotypes and prejudices in SRH services delivery whilst fostering inclusivity in the access to SRH services.

The data from DLQs respondents showed mixed patterns in terms of whether young people and adolescents meaningfully participate in the planning and pre-budget consultation processes, and the extent to which their SRH and HIV service needs and priorities are reflected in the SRH and HIV services delivered in the district. It is only in Zambia where the majority of respondents concurred that young people and adolescents meaningfully participate in the planning and pre-budget consultation processes. This was not the case in Malawi, Tanzania and Zimbabwe where young people appear not to be effectively participating in the processes. In Binga District (Zimbabwe), DLQ respondents hinted:

> *"Young people are not included in decision-making. Committees are just formed but most of the time young people do not know about these platforms [of participating in planning and pre-budget consultation processes]. There is a need for them to be consulted and be educated about the importance of such platforms and their involvement".*

Thus, the lack of participation, from the DLQs respondents, is motivated by several factors. In some instances, it is because young people and adolescents are not aware of the meetings. Often they lack information on the importance of their participation, so even in meetings they attend they do not take the opportunity to raise critical SRH service delivery issues that concern and affect them. For instance, in Tanzania's Mbozi District, DLQs respondents noted:

> *"They do participate in some of the meetings, but they participate in the meetings like observers since they do not actively contribute. There are meetings on budget consultations and young people representatives are not in attendance most of the time".*

In most cases, representatives of women and young people are the ones who are involved in participation. In Chipata District (Zambia), a respondent stated that "Adolescents are left out. The adolescent focal point decides for them what activities will suit the adolescents". Whilst having a representative contributes to participatory democracy, direct participation of young people and adolescents strengthens social accountability through direct engagement with policymakers in resource allocation. As expressed by respondents, most of the SRH services are not a true and adequate reflection of the needs and priorities of young people and adolescents in the districts. In the end, young people and adolescents in most of the districts face challenges in accessing quality and comprehensive SRH services in the form of maternal health services, antenatal care, family planning services and contraceptives, fertility services, perinatal and postpartum services and safe abortion services, among other SRH services.

When probed whether SRH service needs and priorities of young people and adolescents are reflected in the SRH services provided in the districts, most DLQs respondents in three project countries (83% in Zambia, 82% in Malawi and 100% in Tanzania) indicated that the SRH services are reflective of the needs and priorities of young people and adolescents. However, the other DLQs respondents were critical of the SRH services being delivered, stating that they were not reflective of the needs of young people and adolescents. In Nsanje District (Malawi), some DLQs respondents expressed their views:

> *"Limited consultation sometimes leads to misplaced priorities. Limited ART [antiretroviral therapy] services for youths, limited space, CDF not prioritising youth needs, ARVs not accessed by most girls. There are minimal standards, low condom supply and inconvenient space for youth services due to inadequate funding towards SRH services. The services of SRH and HIV are provided to the youth but mostly not accessible to the youth at the expected rate due to the various limiting factor like space, time and shortage of resources. Young people to some extent they do not get services in a friendly manner.*

Many youths do not access SRH information and not all centres have necessities and supplies such as condoms."

The state of SRH service delivery in some health facilities, clinics, as well as adolescent and youth friendly service (AYFS) centres, has not been in line with the regional commitments and aspirations, especially the Strategy for Sexual and Reproductive Health and Rights in the SADC Region (2019-2030) which provides policy and programming framework for SADC member states to improve SRH services. In Mbozi District (Tanzania), for instance, DLQ respondents stated that there are instances where SRH services are not reflective of the needs and priorities of young people and adolescents "because some the services provided are not friendly to adolescents, which makes young people not to enjoy them". SRH services need to be friendly and comprehensive, and there is scope to improve SRH delivery facilities to achieve this.

6.0 Quality of SRH Service Delivery Infrastructure and Facilities

The Strategy for SRHR in the SADC Region (2019-2030) aspires to have a region where health services that are both responsive and acceptable to adolescents and youth and are provided in a non-judgmental, confidential and private environment, in convenient times and locations. In addition to this, the Abuja Call for Accelerated Action Towards Universal Access to STI/HIV and AIDS, TB and Malaria Services in Africa (2006) calls for African Union member states to individually and collectively strengthen health systems and build on existing structures (infrastructure, human resource, financing, supplies and other essentialities) for scaling up and accelerating universal access to prevention, treatment, care and support for HIV and AIDS.[7] All these milestones are only achievable if there are sufficient and quality enabling infrastructure and facilities. Even the Minimum Standards for the Integration of HIV and Sexual & Reproductive Health in the SADC Region (2016) call on SADC member states to put systems in place, including the necessary facility and community service provision modifications and infrastructure, to facilitate access to SRH and HIV services by key populations, especially adolescents, youth, LGBTI persons and people with disabilities[8].

Thus, health facilities, clinics, hospitals, SRH services centres and adolescent and youth-friendly service (AYFS) centres are enablers of quality SRH service provision. The majority of DLQ respondents in almost all four project countries (45% in Malawi's Nsanje District, 58% in

[7] See https://au.int/sites/default/files/pages/32894-file-2001-abuja-declaration.pdf, p.7
[8] See http://menengage.org/wp-content/uploads/2016/09/Minimum-Standards-for-Integration-of-HIV-and-SRH-in-SADC-Region.pdf

Zambia's Chipata District and 50% in Zimbabwe's Binga District), indicated 'to a lesser extent' that the provision of SRH services to adolescents and young people in the respective districts are adequate. However, there were some respondents (36% in Malawi's Nsanje District, 67% in Tanzania's Mbozi District, 25% in Zambia's Chipata District and 50% in Zimbabwe's Binga District) said the facilities for SRH services are inadequate in their districts. The view of these respondents may reflect challenges in the existing facilities to handle and allow for SRH service provision. Some of the respondents from Nsanje District (Malawi) averred:

> *"There are no standalone structures/rooms to provide SRH and HIV services to adolescents and young people. There are no specific facilities for young people. All health facilities have no special room for the provision of SRH & HIV services for young people. Most health facilities are not fully youth-friendly. There are no conducive spaces (adequate infrastructure for privacy). There is, therefore, need for more youth centres & youth-friendly SRH service providers to increase access to SRH services and HIV services".*

The same issues relating to limitations of facilities emerged from Zambia's Chipata District, where respondents mentioned that most young people and adolescents in Chipata have limited places to access SRH services; health care facilities only have "corners" dedicated to SRH services for young people and adolescents. Once SRH services are not provided in a confidential and private environment, and in locations that are convenient for adolescents and youths, it compromises access to these services as young people and adolescents may feel uncomfortable discussing confidential issues in open spaces. In Mbozi District (Tanzania), respondents felt that SRH service facilities are not equipped to provide quality services. In Binga District (Zimbabwe), a shortage of healthcare facilities was reported. Respondents from Binga affirmed:

> *"The clinics are very far from each other. As a result, the basics [SRH services] are not provided. Talking of youth friendly service centres; they are few in the district and at ward level. There is little budget dedicated for this".*

It is not only the absence or shortage of adequate facilities dedicated to SRH services that is a challenge in most districts. The general and broader infrastructure that supports and sustains the provision of SRH services to young people and adolescents emerged as a serious challenge too. Overall, in Binga District (Zimbabwe) and Nsanje District (Malawi), the majority of the DLQ respondents (62% and 55% respectively) were of the view that there was no quality and adequate SRH service delivery infrastructure in the respective districts whilst in Chipata District (Zambia), 60% of the DLQ respondents 'somewhat agreed' that there is adequate and quality SRH service delivery infrastructure (see **Table 3**, below).

Table 3: State of SRH service delivery infrastructure in the districts

Country	District	Percentage of respondents/stakeholders that AGREE that there is quality and adequate SRH service delivery infrastructure	Percentage of respondents/stakeholders that SOMEWHAT AGREE that there is quality and adequate SRH service delivery infrastructure	Percentage of respondents/stakeholders that DISAGREE that there is quality and adequate SRH service delivery infrastructure
Malawi	Nsanje	17%	23%	55%
Tanzania	Mbozi	33%	33%	33%
Zambia	Chipata	18%	60%	22%
Zimbabwe	Binga	11%	27%	62%

Source: DLQs data consolidation tables from Malawi, Tanzania, Zambia and Zimbabwe

Based on the data gathered through the DLQs, the level of satisfaction with the quality and adequacy of SRH service delivery infrastructure appears to be very low across the four project countries as shown in Table 3, above. Very few respondents (33% in Tanzania's Mbozi District, 18% in Zambia's Chipata District, 17% in Malawi's Nsanje District and 11% in Zimbabwe's Binga District) agreed that there is adequate and quality SRH service infrastructure in the districts.

7.0 Adequacy and Comprehensiveness of SRH Service Delivery

Comprehensive SRH services encompass the full range of SRH care components, including antenatal, perinatal, postpartum and newborn care, family planning services, fertility services, safe abortion services, STIs and HIV testing and treatment services, reproductive tract infections treatment, and all the services directed at promoting healthy sexuality and SRHR. These should be provided in a non-judgmental, confidential and private environment, during, and at, times and locations that are convenient for adolescents and youth. The non-existence of some of these aspects makes SRH services inadequate and non-comprehensive.

From the DLQs responses in the four project countries, there appears to be an adequate supply of male condoms, adequate contraceptive tablets and HIV/STI testing kits for young people and adolescents in SRH service centres. However, across four districts, namely Mbozi (Tanzania), Nsanje (Malawi), Chipata (Zambia) and Binga (Zimbabwe), DLQs respondents reported that there were inadequate supplies of female condoms, implants, injectables, pregnancy testing kits, post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP).

8.0 Conduct of SRH Service Providers

The conduct of SRH service providers is key in facilitating better access to SRH services. When SRH service providers are friendly, easily approachable, accommodative and respectful towards young people and adolescents, and they treat shared information with privacy and

confidentiality, it contributes to the realisation of the Strategy for SRHR in the SADC Region (2019-2030). Responses to the DLQs showed missed trends and patterns regarding the conduct of SRH service providers.

Table 4: Conduct of SRH service providers in the districts

Country	District	Percentage of respondents/stakeholders that AGREE that the conduct of SRH service providers is positive	Percentage of respondents/stakeholders that SOMEWHAT AGREE that the conduct of SRH service providers is positive	Percentage of respondents/stakeholders that DISAGREE that the conduct of SRH service providers is positive
Malawi	Nsanje	39%	45%	15%
Tanzania	Mbozi	6%	44%	50%
Zambia	Chipata	21%	57%	21%
Zimbabwe	Binga	47%	30%	23%

Source: DLQs data consolidation tables from Malawi, Tanzania, Zambia and Zimbabwe

Generally, most of the respondents in Zambia's Chipata District (57%) and Malawi's Nsanje District (45%) 'somewhat agreed' that SRH workers are positive in their conduct of duty. However, it is only in Zimbabwe's Binga District that most of the DLQ respondents (47%) reported that SRH service providers are friendly, easily approachable, polite, respectful, respect the privacy of young people and adolescents, are trusted to treat shared information with confidentiality, and young people and adolescents feel comfortable. Respondents who found the SRH service providers to be rude, unfriendly, unapproachable, disrespectful to the privacy and confidentiality of young people and adolescents, and make young people and adolescents feel uncomfortable were distributed as follows: 50% in Mbozi District (Tanzania), 23% in Binga District (Zimbabwe), 21% in Chipata District (Zambia) and 15% in Nsanje District (Malawi). Such levels of outright dissatisfaction signal the need for various interventions to be put in place to monitor, supervise and assess the conduct of SRH service providers at SRH facilities.

Since most SRH service providers are part of the public service, governments need to strengthen their enforcement mechanisms for the implementation of the relevant governing codes of conduct, public service regulations and client service charters. For instance, Zimbabwe already has a client service charter[9] administered by the Ministry of Health and Child Care,

[9] See https://zdhr.uz.ac.zw/xmlui/bitstream/handle/123456789/1418/CLIENTS%20SERVICE%20CHARTER.pdf?sequence=1&isAllowed=y

over and above the Public Services Commission Employee Regulations[10] which penalises public servants who undermine the integrity of the Public Service Commission. Tanzania has a standing National Client Service Charter[11] administered by the Ministry of Health, Community Development, Gender, Elderly and Children, and the Code of Ethics for Public Servants in Tanzania[12] which also applies to SRH service providers in all district SRH facilities. The Code of Ethics for the Public Service[13] guides the conduct of SRH service providers in Zambia. Malawi has a Code of Conduct and Ethics for Malawi Public Service[14] together with the Malawi Public Service Charter[15] to guide quality, professional and standard public service delivery whilst SRH service providers working in Council SRH facilities are also bound by local Council client service charters. For instance, SRH service providers engaged with SRH facilities in Blantyre City Council are bound by the Blantyre City Council Service Charter[16]. Thus, more improved compliance enforcement mechanisms are needed to allow SRH service providers to execute their duties with integrity, honesty, respect, accountability, selflessness and professionalism in a way that improves access to SRH services by young people and adolescents.

9.0 Barriers to Accessing SRH Services

In all of the AU and SADC regional commitments related to SRH services, member states commit to eliminating the barriers that affect young people and adolescents in accessing SRH services at the national level. Although member states continue to implement policy, legal and regulatory frameworks that assist in addressing these barriers, various challenges persist which limit access to SRH services at district/ward levels in the project countries.

From the data gathered through DLQs, it emerged that the adolescents and young people in the four project countries are confronted with legal, policy, structural, cultural, psycho-social, financial and geographical barriers in accessing SRH services within their respective districts. On whether there are any challenges that young people and adolescents are facing in accessing SRH Services in their respective districts, all but one respondent in Zambia's Chipata District were affirmative, as shown in Table 5, below.

Table 5: Existence of barriers to accessing SRH services by young people and adolescents

[10] See https://www.law.co.zw/download/1022/
[11] See http://ciheb.org/media/SOM/Microsites/CIHEB/documents/CQI/Tanzania-Client-Charter.pdf
[12] See https://www.policyforum-tz.org/sites/default/files/CodeEthics.pdf
[13] See https://www.cabinet.gov.zm/wp-content/uploads/2018/01/Code-of-Ethics-Booklet-1.pdf
[14] See https://uclgafrica-alga.org/wp-content/uploads/2019/06/code-of-ethics-and-conduct.pdf
[15] See https://uclgafrica-alga.org/wp-content/uploads/2019/06/UNPAN039481.pdf
[16] See http://bccmw.com/assets/uploads/2019/04/Service-Charter-Booklet_compressed.pdf

Country	District	Percentage of respondents/stakeholders that AGREE that there are access barriers	Percentage of respondents/stakeholders that DISAGREE that there are access barriers
Malawi	Nsanje	100%	0
Tanzania	Mbozi	100%	0
Zambia	Chipata	92%	8%
Zimbabwe	Binga	100%	0

Source: DLQs data consolidation tables from Malawi, Tanzania, Zambia and Zimbabwe

The main barriers to accessing SRH services identified in Malawi's Nsanje District related to insufficient infrastructure, geography, limited supplies of SRH materials and commodities, as well as psycho-social and socio-cultural barriers. Respondents in the district asserted:

> *"Young people and adolescents travel a long distance to access SRH services since some of them stay in hard to reach areas that are far from health facilities. There is inadequate access to YFRH services centres and infrastructure, and in the end, there are long queues and delays at the few SRH centres. The timing of service provision in most of the centres is inconvenient as most of the services are offered when the youths are busy at school. There is a lack of SRH information and IEC materials and supplies such as condoms and contraceptives."*

Respondents in Malawi indicated that these challenges resulted in limited uptake and utilisation of SRH services. Because of the long distances that young people and adolescents have to travel to access SRH services, access to emergency SRH and HIV services, such as PEP and PrEP, is made more complicated. Due to the geographical access barrier, which was also mentioned by respondents in Binga District (Zimbabwe), young people and adolescents must find transportation to access SRH service centres, and financial barriers may, in turn, confront these SRH service users as many may be unable to afford transport fares. The shortage of supplies and SRH commodities mentioned, such as condoms and contraceptives threaten SRHR among youths and adolescents and increase unplanned teenage pregnancy, STI and HIV infections. Additionally, even the few existing SRH facilities and infrastructure, in some instances, compromise the privacy and confidentiality of SRH service users.

Some of the SRH service staff are considered barriers to access for young people and adolescents as some DLQ respondents reported that some staff at SRH service centres exhibit non-professional behaviour and poor attitudes towards SRH service users by being judgemental, rude, unwelcoming, unfriendly and failing to be good listeners. This was reported in Nsanje District (Malawi) and Mbozi District (Tanzania). This is worsened by the fact that some SRH service workers are not trained, as was pointed out by respondents in Binga District (Zimbabwe). In some cases, there is understaffing at the SRH service centres. Respondents in Nsanje District, Malawi noted:

> *"There is poor attitude of some health workers in assisting the youth and some SRH service providers are untrained. There is a lack of youth-friendly health services. Youths and adolescents fear being labelled or being judged by SRH service providers".*

There are socio-cultural and religious barriers to accessing SRH services, as described by DLQ respondents in Nsanje District (Malawi) and Binga District (Zimbabwe). Respondents in Nsanje District mentioned that "most of the youths are barred by their parents due to cultural values". This is despite national policies not restricting adolescents and young people from accessing SRH services. For instance, the Malawi Youth-friendly Health Services (YFHS) Training Manual[17] allows adolescents and young people to access SRH services without any discrimination, as it does not stipulate any minimum age for accessing such services. However, Malawi's National Education Policy of 2016[18] does not support access to contraceptives and condoms to young people and adolescents in school, which affects sexually active young people in school, yet the country's National Sexual and Reproductive Health and Rights (SRHR) Policy (2017-2022)[19] seeks to promote universal access to comprehensive and quality SRH services in Malawi. This was also alluded to by respondents in Chipata District (Zambia) and Binga District (Zimbabwe). The same challenges were highlighted by respondents in Mbozi District (Tanzania):

> *"Cultural beliefs are a barrier whereby some of the family do not allow the adolescent to access SRH and HIV services. There is also stigmatisation from the community which believes that when you allow accessibility of SRH and HIV services to young people and adolescents you will speed up the rate of sexual activity among them. There is also a lack of enough information and education among the community keepers including parents, religious leaders on SRH and HIV".*

Similarly, in Binga District (Zimbabwe), some DLQ respondents lamented parents' attitudes towards access to services", adding that "culture in some cases affect access to SRH services". Stigmatisation was mentioned, which makes young people and adolescents reluctant to seek SRH services even when they are in need. A respondent in Binga District alluded to this:

> *"There is a stigma associated with being known to be accessing services (SRH) of that nature in the community. Young people and adolescents end up being afraid to seek these services. Community leaders also need to be trained e.g. chiefs, village heads, child protection committees, village health workers, and nurses at local clinics".*

Whilst the stigmatisation against young people and adolescents' access to SRH services is being driven by socio-cultural and religious beliefs in communities, the restrictive laws,

[17] See http://www.healthpolicyplus.com/ns/pubs/2020-2029_YFHSTrainingManualParticipantsHandbookFINAL.pdf

[18] See http://www.reforms.gov.mw/psrmu/sites/default/files/National%20Education%20Policy.pdf

[19] See https://malawi.unfpa.org/sites/default/files/resource-pdf/Malawi_National_SRHR_Policy_2017-2022_16Nov17.pdf

regulations and policies in some of the countries also present legal and policy barriers. For instance, in Zimbabwe, whilst Section 76 (1) of the Constitution of Zimbabwe[20] states that: "every citizen and permanent resident of Zimbabwe has the right to have access to basic health-care services, including reproductive health-care services". Section 35 of the Public Health Act of 2018[21] provides that children (defined as persons under the age of 18) require parental or adult consent to access medical health services. Again, since people under the age of 16 years cannot legally consent to sexual intercourse by law, it is then presumed that they do not need contraceptives or other SRH services. This is also the case in Zambia where the minimum age of consent to sexual intercourse is 16; adolescents and young people below 16 years of age may be denied access to contraceptives and other related SRH services if they do not have parental consent. This may prejudice some young people and adolescents from accessing essential SRH services and can result in teenage pregnancy. For example, the Zimbabwe Ministry of Health and Child Care/Zimbabwe National Family Planning Council (ZNFPC)/United Nations Population Fund (UNFPA) report[22] revealed that 48% of adolescents have confirmed unplanned teenage pregnancies. Even in terms of accessing HIV services, the 2014 National HIV Testing Guidelines[23] of Zimbabwe states that young people under 16 years of age are unable to consent to HIV testing and counselling.

Some SRH services that are a priority to young people and adolescents are not available at SRH service centres. In Nsanje District (Malawi), it was reported by DLQs respondents that access to routine counselling and health education on HIV/SRH at outreach clinics was difficult to access in some hard-to-reach areas whilst cervical cancer screening services for young females/youths was unavailable. SRH services such as screening for HIV and syphilis for young people and adolescents was reportedly unavailable in some SRH centres in Chipata District (Zambia). Other SRH services such as PEP, PrEP and pregnancy testing were identified as scarce, together with information education and communication (IEC) materials centres at some SRH service centres. IEC was reportedly scarce in Mbozi District (Tanzania). This is despite the fact that access to SRH and HIV services is encouraged through the provision of adequate information.

[20] See Section 76 (1), https://www.parlzim.gov.zw/component/k2/download/1290_da9279a81557040d47c3a2c27012f6e1
[21] See http://www.veritaszim.net/sites/veritas_d/files/Public%20Health%20Act%20%5BCHAPTER%2015-17%5Dr.pdf
[22] See https://zimbabwe.unfpa.org/sites/default/files/pub-pdf/UNFPA%20NAFS%20Main%20Report%20%202016%20For%20Web.pdf
[23] See Page 19, https://depts.washington.edu/edgh/zw/hit/web/project-resources/HTC_guidelines_children2014.pdf

In a nutshell, the several challenges being faced in delivering SRH services are in themselves a barrier to the access of such services by young people and adolescents in Malawi, Tanzania, Zambia and Zimbabwe (*see* Table 6, below).

Table 6: Major challenges faced in delivering SRH services in the districts

Country	District	Major challenges faced in delivering SRH services
Malawi	Nsanje	• Inadequate funds to deliver SRH services and manage SRH service centres • Shortage of SRH services supplies/commodities • Lack of adequate standalone SRH facilities • Inadequate trained and qualified SRH staff at SRH service centres • Stigma and discrimination of young people and adolescents accessing SRH services (culture and fear of parents) • Conflicting policies that negatively affect and restrict access to SRH services • Abuse of funds meant for SRH services • Negative attitudes of SRH services providers/staff • Young people and adolescents travelling long distances to access SRH services and lack of reliable transport for such access • Lack of adequate IEC material on SRH services • Lack of integration of SRH and HIV services at health facilities • Lack of effective supervision of SRH service staff at SRH service centres • Service hours are not conducive and convenient to some SRH service users
Tanzania	Mbozi	• Some SRH service centres/health facilities are not friendly-oriented • Lack of full capacitated SRH service providers/staff at SRH service centres • Community cultural beliefs that are restricting access to SRH and HIV services by adolescents and young people
Zambia	Chipata	• Limited standard space and infrastructure for SRH service provision at health facilities • Limited NGOs offering adolescent health (ADH) services • Lack of proper coordination amongst SRH services stakeholders • Language barriers • Understaffing at SRH service delivery centres/facilities
Zimbabwe	Binga	• Few SRH service delivery centres/facilities; most are very remote • Negative attitudes of SRH service providers • Inadequate IEC materials • Lack of IEC materials translated to local vernacular (Tonga Language) • No communication channels to report dissatisfaction with SRH service provision • Lack of resources and incentives to provide SRH services • Limited knowledge concerning SRH services amongst young people and adolescents • No SRH-trained peer educators at ward and village level • Negative attitudes of parents towards access to SRH services • Culture in some cases affects access to SRH services

Source: DLQs data consolidation tables from Malawi, Tanzania, Zambia and Zimbabwe

10.0 Existence and utilisation of opportunities and appropriate channels to report cases of poor SRH service delivery

Public integrity management mechanisms are essential for social accountability monitoring. In the health sector, the delivery of SRH services to young people and adolescents is enhanced when young people and adolescents, women and other SRH service users and other relevant

stakeholders have the opportunity to report any cases of ineffective use and abuse of public resources (including cases of misconduct, inefficiency, maladministration, corruption and conflicts of interest). It is only through this that SRH service users are able to ensure that disciplinary and corrective mechanisms within ministries of health and departments of health in local authorities are utilised.

From the DLQ responses, there seems to be opportunities and appropriate channels for SRH service users to report cases of non-performance, poor service delivery, mismanagement and abuse of public resources in the provision of SRH services in the target districts. The common and most recurring challenge, however, is the limited use of such reporting channels by SRH service users and other stakeholders despite the prevalence of cases relating to the abuse of public resources, corruption, misconduct and maladministration at health facilities, SRH service centres and within government departments in charge of SRH service delivery. This has been due to a considerable number of factors presented by DLQ respondents.

In Malawi's Nsanje District, several channels exist for young people and adolescents as well as other SRH service users to report cases of abuse of public resources, corruption and misconduct. The ineffective utilisation of these channels is largely attributed to a lack of information and awareness amongst young people and adolescents. Young people and adolescents have also been discouraged from reporting such cases by perceived fear of reprisals. Respondents in the district explained:

> "*There are channels to report the abuse of public resources, corruption, misconduct and maladministration in SRH delivery. This is usually done through holding youth meetings at the health facility, awareness meetings, suggestion boxes, health advisory committee (HAC), group village headmen (GVH), ward councillors, chiefs, area development committees (ADCs) and the Office of the Ombudsman*".

The respondents in Nsanje District further explained that there is a need to expand the provision of suggestion boxes at all SRH service delivery facilities. This should be complemented by capacity building and training targeting young people and adolescents on grievance handling mechanisms relating to HIV/SRH service delivery, since there has not been any meaningful engagement with young people on how they can report issues and get feedback. Community meetings were identified as one of the channels for reporting cases of public resource mismanagement in Mbozi District (Tanzania). In Zimbabwe's Binga District, DLQs respondents revealed:

> "*Young people in the rural areas do not know anything about opportunities and channels to report cases of misconduct, inefficiency, maladministration, corruption, conflicts of*

interest, ineffective use and abuse of public resources. They believe that those who are managing public resources are the owners of those resources. They lack information. Suggestion boxes at SRH service centres or facilities in the district are not effectively used."

To address the low utilisation of reporting channels for public resource mismanagement in the delivery of SRH services, DLQ respondents in Binga District suggested that "there is need for greater awareness among young people and adolescents of the existence of such opportunities and reporting channels". This applies to all the other districts given that there has been reported underutilisation of the existing reporting mechanisms to facilitate public integrity management in the management of public resources in delivering SRH services.

11.0 Effects of COVID-19 on the Delivery and Access to SRH Services

The spread of COVID-19 pandemic in the project countries was followed by national lockdown restrictions and containment measures that aimed to prevent and manage the spread of COVID-19 in the respective countries, except in Tanzania where only unnecessary movements were discouraged. National lockdown measures, curfews and travel restrictions impacted SRH service delivery by government institutions, CSOs and private sector entities at national, district and local levels whilst restricting young people and adolescents and other SRH service users from accessing SRH services.

From the data gathered through the DLQs, access to SRH services in the four target districts across Malawi, Tanzania, Zambia and Zimbabwe was seriously affected by COVID-19. Due to the overwhelming health needs and requirements in the fight against COVID-19, most governments channelled and re-prioritised budgets towards funding the expansion of hospital facilities and hospital beds, ventilators, COVID-19 IEC materials, establishing isolation and quarantine centres, procuring personal protective equipment (PPEs), COVID-19 testing kits, vaccination procurement, among other requirements needed to fight the COVID-19 pandemic. This was even more serious for imported SRH commodities since international supply chains, logistics and trade were all disrupted by the pandemic, even though some borders remained open for essential medical supplies including SRH commodities. In the end, COVID-19 related health service delivery was prioritised at the expense of SRH service delivery. Again, there was a lack of political will to address the SRH service delivery challenges and barriers, instigated by COVID-19 restrictions, which disrupted the support for universal access to SRH services in the various districts.

In terms of access to SRH services, all districts reported challenges amongst women, young people and adolescents in accessing SRH services. In Zimbabwe, a Rapid Assessment of COVID-19 Response in the Context of Maternal and Sexual and Reproductive Health in Zimbabwe conducted by the UNFPA and the Ministry of Health and Child Care revealed that COVID-19 affected women and young people's access to SRH, including access to family planning.[24] Due to national lockdown restrictions, there was a shortage of contraceptive supplies and stock in SRH facilities and clinics, including condoms and birth control pills, especially in Zimbabwean rural areas which ended up increasing unintended pregnancies, unsafe abortions and also fuelling HIV and STI transmissions[25] especially considering that over 70% of sexually active young women and girls in Zimbabwe rely on oral contraceptives and condoms as opposed to longer-term measures such as intrauterine devices.[26] To address this, the Ministry of Health and Child Care partnered with the United Nations (UN) and the World Food Programme (WFP) to distribute male and female condoms and share SRH information throughout the country, including in Binga District. Again, due to restricted operating hours for public and private clinics, and restricted public transport, access to condoms, contraceptives and STI treatment was affected.[27] DLQs respondents from Binga District (Zimbabwe) added:

> "*Women, young people and adolescents and other SRH service users could not access some of the SRH services due to COVID-19 national lockdown regulations that restricted mobility. Those who were on ART [antiretroviral therapy] had difficulties getting drugs on time due to restricted travel and curfews. However, some ended up having to give drugs for 6 months in advance so that they take time without coming*".

In Malawi, SRH service delivery and access were also compromised by COVID-19 management and prevention measures. Between April and July 2020, the provision of HIV services (including medical, male circumcision (VMMC), community HIV testing services, and PrEP) was severely disrupted and suspended whilst social asset building for adolescent girls and young women was also stopped. The provision of youth-friendly SRH services in the first half of 2020 declined by around 30% across Malawi whilst the number of teenage pregnancies increased, which had a likelihood of increasing HIV infections among adolescent

[24] See https://zimbabwe.unfpa.org/en/news/midst-covid-19-pandemic-unfpa-and-partners-call-greater-efforts-ensure-access-contraceptives
[25] See https://www.dandc.eu/en/article/zimbabwe-faces-spike-unwanted-pregnancies-due-shortage-contraceptives
[26] Ibid
[27] https://www.ohchr.org/Documents/Issues/Health/sexual-reproductive-health-covid/CSOs/ngo.frontline.aids.docx

girls due to lack of access to contraceptives as a result of COVID-19 restrictions[28]. The DLQ respondents in Malawi's Nsanje District noted:

> *"Most funds were directed by government towards COVID-19, so SRH services were limited. SRH guidelines for COVID-19 were youth-unfriendly. Some COVID-19 preventive measures restricted young people and adolescents to access SRH services. Youths feared visiting health facilities for SRH services as they feared contracting COVID-19 at the crowded health facilities and clinics, which had patients suspected of COVID-19. There was an increase in cases of defilement, sexual abuse, teenage pregnancies, STIs and school-dropouts at community level following the closure of schools."*

Similar challenges were experienced in Tanzania and Zambia in light of COVID-19 national lockdown restrictions on travel. The lack of personal protective equipment also exposed young people and adolescents from safely accessing SRH services, whilst the temporary ban on transport meant that SRH service users could not easily travel to access SRH services centres/facilities. The suspension of SRH education and campaigns due to national lockdown measures impacted the flow of critical SRH information, although the use of the media, especially radios that reach rural areas, assisted to address this challenge. International organisations such as the UNAIDS managed to facilitate SRH education and training in some places in Zambia to address the SRH information gaps created by COVID-19 lockdowns.[29] In Nsanje District (Malawi), respondents highlighted:

> "*No awareness campaigns were conducted to sensitise youths on their SRH rights. There was limited participation in youth networks and groups. The lack of provision of information on SRH and HIV due to restrictions on gatherings, and lack of PPE to support youths as they accessed SRH were all access barriers caused by COVID-19".*

The respondents in Mbozi District (Tanzania) stated that SRH services were provided, but the fear of contracting COVID-19 resulted in young people and adolescents and other SRH service users being over-cautious to the extent that their access to SRH services was affected. In the end, the rate of young people and adolescents accessing the SRH and HIV was reduced in Mbozi District. COVID-19 also brought another dimension to SRH services access as manifested in the increase in cases of intimate partner violence (IPV), sexual violence and gender-based violence (GBV) as victims struggled to utilise channels to report such cases and seek counselling during the pandemic as generally the capacity of law enforcement agents was been weakened by COVID-19. In Zimbabwe, a total of 764 cases of GBV were recorded in the first 11 days of the national lockdown, but these had increased to 2 768 by

[28] Ibid

[29] See https://www.unaids.org/en/resources/presscentre/featurestories/2020/july/20200723_zambia

13 June 2020.[30] Zambia recorded a 10% increase in GBV cases in the first quarter of 2020 during COVID-19 as compared to the previous year[31] whilst recorded cases of GBV and sexual violence in Malawi between January 2020 to December 2020 were 35% higher than during the same period the previous year.[32] COVID-19 therefore changed and affected access to SRH services by young people, adolescents and other service users in different ways.

12.0 Recommendations and Key Issues for SAM Engagement

The evidence gathered using the DLQs administered in the four project countries, namely Malawi (Nsanje District), Tanzania (Mbozi District), Zambia (Chipata District) and Zimbabwe (Binga District), reveals different trends and patterns in the delivery of SRH services. SRH service delivery gaps in the districts emerged, whilst best practices in the delivery of the same services were also reported. Also identified were areas in need of intervention to strengthen social accountability mechanisms in the management of public resources in delivering SRH services. Based on the strength of these findings, the following six recommendations are made to enhance the delivery of quality, non-judgemental and inclusive SRH and HIV services to young people, adolescents and other SRH service:

1) All SRHR stakeholders should **strengthen community mobilisation, capacity building and training targeted at SRH service users, young people, adolescents and young girls,** so that they fully appreciate and comprehend the social accountability system and public resource management processes in order to effectively engage and participate in all SAM processes, budget planning and budget preparation consultations. This will enhance more effective and efficient public resource management for the improvement of SRH service delivery and universal access to SRH services in the district.

2) Governments should **carry out a thorough participatory audit of SRH service delivery facilities and centres,** hospitals and clinics that deliver SRH services to establish the staffing, material, equipment and material gaps, needs and requirements so that sufficient resources are allocated towards this for the promotion and protection of SRHR rights in pursuit of the various regional commitments that seek to strengthen the delivery of quality, non-judgemental and inclusive SRH and HIV services to young

[30] See https://www.amnesty.org/en/latest/news/2021/02/southern-africa-homes-become-dangerous-place-for-women-and-girls-during-covid19-lockdown/
[31] Ibid
[32] See https://www.voanews.com/africa/malawi-president-announces-strict-measures-against-perpetrators-gender-based-violence

people, adolescents and other SRH service users in the region. A participatory audit would also allow for better prioritisation of limited SRH budgets and resources such that access barriers to SRH services and challenges that are facing young people, adolescents and other community members in accessing SRH services are collectively addressed.

3) The ministries of health, departments of health of local authorities as well as senior managers at hospitals, clinics and other SRH service facilities/centres (together with human resource management directorates, and disciplinary units in the respective institutions) should provide **awareness and capacity building targeted at young people, adolescents, other SRH service users and other SRH stakeholders.** The capacity building should focus on the different forms of public resource mismanagement and abuse of resources, as well as the key provisions of the guiding procedural and regulatory framework that govern the conduct and performance standards of SRH service providers (such as, client service charters, codes of conduct and public service regulations, etc.) together with the appropriate channels and procedures for reporting cases of public resource mismanagement, corruption and misconduct.

4) Governments should **effectively enforce compliance with existing ethical codes of conduct, client service charters and public service regulations** so that staff deployed to serve at SRH service facilities, hospitals and clinics execute their duties with integrity, honesty, respect, accountability, selflessness and professionalism so that SRH services users freely and comfortably access such services.

5) Given the continuation of COVID-19, governments (working with relevant international and national non-governmental organisations) should seriously **consider innovative and pragmatic means and ways of allowing for consistent supply of SRH service supplies and commodities during the pandemic** in a way that is convenient and safe to SRH service users at local levels. Mechanisms should be put in place to allow for effective reporting of, and rapid response to, the increased cases of GBV and sexual violence.

6) Collective advocacy should ensure that all the **legal and policy barriers that impede access to SRH services by young people and adolescents are addressed** through legal reviews and adjustments. The process, however, must take into consideration

national and local socio-cultural contexts whilst also ensuring that existing socio-cultural barriers to SRH service access are progressively eliminated for the benefit of promoting and protecting the SRH rights of citizens.

Annexure 1 – District Level Questionnaire

DISTRICT LEVEL QUESTIONNAIRE
(Health – SRH and HIV Services)
2020-2021

INSTRUCTIONS

This questionnaire should be administered on an annual basis by the district/ward-level project implementation partners in each of the targeted project districts, in collaboration with national project team.

In the 2020-2021 project year, all interviews should be conducted between September and October 2020. The database of questionnaires should be submitted to the National Project Manager by 31 October 2020.

Each district partner is requested to follow 4 key steps:

1. **Select the respondents**

At least 13 questionnaires should be completed, by the following individuals. Where possible, at least 50% of those interviewed should be women:

Stakeholders to interview / complete questionnaires	Number of interviews / questionnaires to be completed
Local government officials (ie. local health department staff)	At least 2
Health service providers (ie. health clinic staff)	At least 2
Local district council (ie. local council committee members)	At least 2
Local member of parliament	1
Health facility committee (ie. members of the health facility committee) *[if applicable]*	At least 2
Community-based civil society organisations (ie. CSO volunteer/staff)	At least 2
Community media (ie. local journalists – staff/volunteer)	At least 2

2. **Prepare for the interviews**

- Translate the questions, adapting the language so that it is clear for the respondents.
- If possible, arrange to record the conversation – on your phone or using a recording device. This will assist as a backup for your written notes.

3. **Hold the interviews** (Sept – Oct 2020)

The interviews can be conducted through one-on-one interviews or shared as part of an interface / community consultation meeting.

One-on-one interviews:

- Decide whether the interview will be conducted in-person, or over the phone.
- Start by asking for consent to conduct the interview (request for consent included in questionnaire).
- Start the recording (if recording).
- Ask the questions, ensure that the respondents focus on the question you asked, if not, ask some probing questions.
- Include 'references' for each of the responses, if applicable. References could include all government documents and independent research, as well as PSA Alliance data.
- Conclude the interview explaining the next steps and thank the participant for his/her time.

Interface / consultation meeting:

- Start by explaining the purpose of the questionnaire.
- Review all the questions in plenary, and provide clarifications as necessary.
- Distribute questionnaires to all participants. Allow participants sufficient time to complete the questionnaires.
- Collect the questionnaires.
- [Optional] Debrief the participants' experience in completing questionnaire and discuss any issues they would like to raise.
- Conclude meeting by explaining the next steps (including timeframe for sharing report and/or potential dates for next information sharing or advocacy meeting). Thank participants for their time.

4. Submit the completed interviews / completed questionnaires

- Submit all the completed questionnaires to the national project manager **by 31 October 2020.**
- National project manager enters all the completed questionnaires in the national database.
- National project manager submits the national database to PSA Alliance PRM Technical Officer (Clayton Vhumbunu).

[QUESTIONNAIRE BELOW – Do not share these instructions with respondents. Share/print only the questionnaire, beginning on the next page.]

DISTRICT LEVEL QUESTIONNAIRE
(Health – SRH and HIV Services)
2020-2021

1. CONSENT STATEMENT:

[NAME OF DISTRICT PARTNER] is doing social accountability monitoring to better understand how sexual and reproductive health services are provided to young people and adolescents in [DISTRICT NAME]. We would like to understand whether the services are of good quality, and if the services meet the needs of young people and adolescents. Additionally, we would like to hear your opinion on whether young people and adolescents are involved in the planning for these services. Your responses will help us to identify good practices as well as challenges in the provision of these services. The information will be used by [NAME OF DISTRICT PARTNER] to advocate for improvements in these services in [DISTRICT NAME]. The information will also be used by [NAME OF NATIONAL PARTNER] to develop a report and advocate for improvements at national level. Additionally, the Partnership for Social Accountability (PSA) Alliance, led by ActionAid International, will consolidate this information in a report to share at regional level in Southern Africa.

(a) Do you agree to participate in this interview?

Yes	No

(b) Do you agree for this interview to be recorded? [if recording]

Yes	No

2. Which stakeholder group are you a member of?

Local government officials (ie. local health department staff)	
Health service providers (ie. health clinic staff)	
Local district council (ie. local council committee members)	
Local member of parliament	
Health facility committee (ie. members of the health facility committee)	
Community-based civil society organisations (ie. CSO volunteer/staff)	
Community media (ie. local journalists – staff/volunteer)	

3. District Name, Ward Name, Village Name

District	

Ward	
Village	

4. Gender (tick appropriately)

Male	
Female	
Other	

5. Age (tick appropriately)

0-15	
16-35	
36-49	
Over 50	

6. Designation or position *[if willing to share – optional]*

7. Date Questionnaire Completed

8. (a) Are there structures and mechanisms that exist in the District/Ward to facilitate the participation of young people and adolescents, men and women in the pre-budget consultation and planning processes of Government-funded SRH and HIV programmes and projects in the District? (**tick appropriately**)

Yes	**No**	**Not Sure**

(b) If YES, state them

Reference:	

9. (a) Do these structures reflect gender balance and also allow for inclusion of young people and adolescents in decision-making processes? (**tick appropriately**)

Yes	**No**	**Not Sure**

(b) Explain your response above;

Reference:	

10. (a) Do young people and adolescents meaningfully participate in the planning and pre-budget consultation processes? (**tick appropriately**)

Yes, to a larger extent	Yes, to a lesser extent	No	Not Sure

(b) Please explain the basis of the above response:

Reference:	

11. (a) Are the SRH and HIV Services needs and priorities of young people and adolescents reflected in the SRH and HIV Services provided in the District/Ward? (**tick appropriately**)

Yes, to a larger extent	Yes, to a lesser extent	No	Not Sure

(b) Please explain the basis of the above response:

Reference:	

12. (a) Are there adequate facilities to provide SRH and HIV Services to adolescents and young people in the District/Ward? (**tick appropriately**)

Yes, to a larger extent	Yes, to a lesser extent	No	Not Sure

(b) Please explain the basis of the above response:

Reference:	

13. (a) Are there any challenges that young people and adolescents face in accessing SRH and HIV Services in the District/Ward? (**tick appropriately**)

Yes	**No**

(b) Please explain the basis of the above response:

Reference:	

14. How best can SRH and HIV Services workers be described in their conduct of work in the District/Ward? (**tick appropriately**)

	Agree	Somewhat Agree	Disagree
SRH and HIV Services workers are friendly			
SRH and HIV Services workers are easily approachable			
SRH and HIV Services workers are rude			
SRH and HIV Services workers respect the privacy of young people and adolescents			
SRH and HIV Services workers are trusted to treat shared information with confidentiality			
SRH and HIV Services workers make young people and adolescents feel comfortable			

Reference:	

15. How best can SRH and HIV Services centres be described in terms of provision of adequate services in the District/Ward? (**tick appropriately**)

	Agree	Somewhat Agree	Disagree
SRH and HIV Services centres have enough male condoms			
SRH and HIV Services centres have enough female condoms			
SRH and HIV Services centres have adequate implants for young people and adolescents			
SRH and HIV Services centres have adequate injectables for young people and adolescents			
SRH and HIV Services centres have adequate contraceptive tablets for young people and adolescents			
SRH and HIV Services centres have adequate pregnancy testing kits			
SRH and HIV Services centres have adequate HIV/STI testing kits			
SRH and HIV Services centres offers PEP for pregnancy prevention			
SRH and HIV Services centres offers PEP for HIV			
SRH and HIV Services centres offers PREP for HIV			

Reference:	

16. (a) Are there any other SRH and HIV Services that are not being provided at SRH and HIV Services centres in the District/Ward yet they are essential and of high priority to young people and adolescents?

Yes	No

(b) Please explain the basis of the above response:

Reference:	

17. How best can SRH and HIV Services centres in the District/Ward be described in terms of infrastructure (**tick appropriately**)

	Agree	Somewhat Agree	Disagree
SRH and HIV Services centres can be easily accessed by young people and adolescents			
SRH and HIV Services centres have convenient opening hours for young people and adolescents			
SRH and HIV Services centres has adequate information education materials for young people and adolescents			
SRH and HIV Services centres has adequate transportation for commodities and supplies			
SRH and HIV Services centres provides high quality services			

Reference:	

18. (a) Are you satisfied with the manner in which SRH and HIV services are being delivered in the District/Ward?

Yes	No	Somewhat

(b) Please explain the basis of the above response:

Reference:	

19. (a) Are there any SRH and HIV services that young people and adolescents are prohibited from accessing but would have wanted to?

Yes	No	Somewhat

(b) If YES, please state these:

Reference:	

20. (a) Do adolescents and young people have opportunities and appropriate channels to freely report cases of non-performance, poor service delivery, mismanagement and abuse of public resources in the provision of HIV and SRH services in the District/Ward?

Yes, to a larger extent	Yes, to a lesser extent	No	Not Sure

(b) Please explain the basis of the above response:

Reference:	

21. (a) Are there any cases of abuse of public resources reported in programmes that facilitate the provision of SRH and HIV services to adolescents and young people in the District/Ward?

Yes	No	Not Sure

(b) If YES, are follow-up actions or appropriate interventions always made to address the reported issues reported?

Reference:	

22. What are the major challenges that are being faced in the provision of, and access to, SRH and HIV services to (and by) adolescents and young people in the District/Ward?

Reference:	

23. Has COVID-19 changed and affected the delivery of, and access to, SRH and HIV services to (and by) adolescents and young people in the District/Ward?

Yes, to a larger extent	Yes, to a lesser extent	No	Not Sure

(b) If YES, please explain,

Reference:	

Thank you for your help!