Strengthening sexual and reproductive health public services delivery for young people in Malawi, Mozambique, Tanzania and Zambia:

Defining the accountability agenda

This policy brief[1] presents an analysis on the status of delivering sexual and reproductive health services for young people (10-24) in Malawi, Mozambique, Tanzania and Zambia. Analysis is done through the rights-based approach to social accountability lens, which posits that the state must obtain and use all resources available to ensure young people access quality Sexual and Reproductive Health (SRH) information and services. Furthermore,young people have a right to engage and monitor the state's delivery of such services, which is a fundamental right.

Policy Brief

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Introduction

Access to and utilisation of SRH services leads to a fulfilling and healthy life for young people. This recognition lies at the core of Sustainable Development Goals (SDG) 3 on health and wellbeing and SDG 5 on gender equality and empowerment of women and girls. The International Conference on Population and Development (ICPD) affirmed that sexual and reproductive health and rights (SRHR) are human rights.[2] Signatories to the global human rights treaties and commitments thus have an obligation to ensure that SRHR are realised, by ensuring access to SRH information and services is guaranteed for all. Today however states are yet to fulfil that obligation for a segment of their young people. More work is needed to demand accountability from the state to meet this obligation and commit more resources for improving and expanding SRH services.[3]

This policy brief has been developed by the Partnership for Social Accountability (PSA) Alliance to present findings from the analysis of SRH policy implementation in Malawi, Mozambique, Tanzania and Zambia. Policy recommendations are presented to national governments, civil society, and parliamentarians on how to strengthen accountability in delivery of SRH services.

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2 Population Council, UNFPA, Government of Zambia Human Rights Commission, WLSA, and United Nations in Zambia (2017)

3 SAfAIDS (2018)

Conceptual framework

To monitor and evaluate delivery of SRH services as part of the oversight and accountability agenda, the PSA Alliance uses a rights and evidence-based approach. Based on the model developed by PSAM, this looks at the five processes of public resource management to monitor and evaluate delivery of SRH services for young people. Figure 2 below, shows the five PRM processes.

Analysis presented in this brief is drawn from: i) A rapid assessment of SADC policies on SRHR to assess whether they have been translated into national policy and implementation; ii) Community scorecard analysis and budget analysis that was done between the years 2017–2018 by PSA Alliance project partners.[4] This is complemented by reference to secondary publications such as Demographic Health Survey reports and other research publications.

Partnership for Social Accountability Alliance

Partnership for Social Accountability (PSA) Alliance is currently implementing a social accountability project in Malawi, Mozambique, Tanzania and Zambia. The project seeks to improve public service delivery in health (HIV/AIDS, sexual and reproductive health and rights) for young people by strengthening the oversight and social accountability roles of five target groups in the SADC region, specifically: selected parliamentary committees, relevant government departments, issue-based civil society organisations (CSOs), smallholder farmer organisations, and the media. Using a rights and evidence-based approach to social accountability monitoring, the project focuses on the five inter-related processes of public resources management (PRM): planning and resource allocation; expenditure management; performance monitoring; public integrity and oversight.

PSA Alliance is a consortium of organisations of ActionAid International (AAI), SAfAIDS, the Public Service Accountability Monitor (PSAM) of Rhodes University, and Eastern and Southern Africa Small Scale Farmers' Forum (ESAFF).

Findings: Tracing commitments to improving SRH outcomes

SADC has made significant strides to promote its commitments on SRHR, HIV and cross-cutting issues on gender, tuberculosis and malaria, as well as sexual and gender-based violence prevention. Regional policy framework has the following key policies; SADC Health Protocol (1999), Maseru Declaration on the Fight against HIV/AIDS in the SADC Region (2003); Policy Framework for Population Mobility and Communicable Diseases in the SADC Region (2009); Minimum Package for HIV and SRH Integration in the SADC Region (2015) and the SADC 1998 Addendum on the Prevention and Eradication of Violence against Women and Children. Key to this is the SADC Integrated HIV, SRH, TB and Malaria Strategy and Business Plan, 2016-20, which is very clear on the importance of young people. The SADC Food and Nutrition Security Strategy 2015–2025 mainstreams both issues of HIV and those of adolescents, but not linked together as they remain two separate cross-cutting issues.[5]

An assessment conducted by the PSA Alliance in 2018 found that SADC member states targeted by the PSA project have integrated regional SRHR policies into their national policy frameworks. Figure 1 below shows relevant national policies that are aligned to the SADC SRHR policies promulgated by member states. However, the assessment identified major gaps in the implementation of national policies with regard to access and utilisation of SRH information and services for adolescents.

Malawi	Mozambique	Tanzania	Zambia
National Youth Policy (2013)	Health Sector Strategic Plan (2014-2019)	National Health Policy (2007)	Reproductive Health Policy (2000)
National SRHR Policy (2017-2022)	National Strategic Plan for HIV and AIDS Response (2014-2019)	National Policy on HIV/AIDS (2001)	National Health Policy (2012)
National HIV and AIDS Policy (2011)	National Strategy against premature marriage (2016- 2019)	National Five Year Development Plan 2016/17 - 2020/21	Adolescent Health Strategy 2017-2021
National Community Health Strategy (2017-2022)		National Guideline for HIV testing and Counselling	National Health Strategy 2017 - 2021
National Youth Friendly Health Services Strategy 2015-2020		Vision 2025	CSE curriculum for adolescents and young people

Figure 1: National SRHR policies adopted by Malawi, Mozambique, Tanzania and Zambia

Findings show that while significant progress has been made more work still needs to be done to ensure SRH policies translate into tangible action; there is increased domestic resourcing minimally for SRH services delivery; and increased knowledge and engagement of communities and civil society on SRHR policies and commitments. Increased linkages between sexual and reproductive health (SRH) and HIV services have been shown to increase access and uptake for both SRH and HIV services in the four countries, and they will need to assess how to allocate limited resources to SRH and HIV service integration.

The national budget allocation to health in the four countries has not reached 15% as per the Abuja Declaration, whereas the national allocation to SRH of the total national health budgets is barely below 2% in the last five years. Whilst there is general dependence on external donor funding among the countries, Zambia has reached a landmark in domestic resource mobilisation for health. The National Health Insurance Act (2018) is meant to achieve universal health coverage for all Zambians.

5 SAfAIDS (2018)

Findings: Tracing commitments to improving SRH outcomes

The findings are drawn from community scorecard meetings facilitated by the PSA Alliance to monitor and evaluate access to SRH services by young people in Malawi, Mozambique, Tanzania and Zambia. Data was collected from two districts in each country.[6] Analysis is also included from associated PSA Alliance studies on tracing implementation of SRH commitments by SADC member states, and media reports.

Strategic Planning and Resource Allocation

Governments across the four countries have made an effort to formalise consultative processes to ensure people participation in budget development and setting priorities. Mozambique has opened space for community consultations through their elected leaders in the local and district Consultative Councils.[7] The Councils are part of the participatory governance process in the country that recognises the districts as the primary unit for planning and budgeting,[8] which feeds into provincial and national plans and budgets. Furthermore, the Mozambique parliament has offices for youth and HIV/AIDS meant to facilitate young people's engagement and report on key challenges they face. Zambia has adopted district and provincial development coordinating committees as part of a decentralised planning process. Decentralised planning takes a bottom up approach and starts from ward development committee level, through to district, provincial and national level.[9]

In Malawi, there are village development and area committees as well as district and national level structures.[10] The structures are supposed to provide inputs to programme prioritisation and budget allocation to those programmes. Tanzania has made strides in promoting participatory governance, which recognises people's participation through local government structures i.e. ward development committees and village development committees. Through the PSA project, health committees in Kilosa and Mbozi district have been involved in planning the facility health budget and funds gathered from the Community Health Fund. The committees contribute to the purpose of the Community Health Fund Act being: "*...to provide for the mechanism of establishment of Community Health Fund and to provide for the constitution of the management organs, and the administration of the Fund and other related matters*."[11] Participants from the project, who are now committee members, expressed satisfaction being given the opportunity to participate in budgeting for health as citizens.[12]

The Maputo Plan of Action (2016-2030) on Universal Access to Comprehensive Sexual and Reproductive Health Services in Africa encourages increased domestic resources for SRH on the continent as one way of ensuring we realise commitments on SRHR. In all four countries, governments have allocated budgets to health with specific allocations to SRHR including HIV. However, looking at proxy data on health, there are varied levels of allocating resources for SRH.

6 Nsanje and Mchinji districts of Malawi; Chibuto and Marracuene districts of Mozambique; Kilosa and Mbozi districts of Tanzani; and Mongu and Chipata districts of Zambia.
7 UNDP Mozambique, n.d.
8 Massuanganhe (2005)
9 Lusaka Times (2017)
10 Action Aid Malawi (2018)
11 Republic of Tanzania (2001)
12 SAfAIDS (2019)

As a percentage of general government expenditure the countries have made the following allocations for health: Malawi (16.77%); Mozambique (8.81%); Tanzania (12.31%) and Zambia (11.31%).[13]

Regarding budget allocation, citizens who participated in the scorecard process felt the budgets allocated for adolescent and youth reproductive health services are insufficient, often a very small proportion of the total SRHR budget within the overall national health budget leading to insufficient funding for adolescent health.[14] Budget analysis findings show that in Tanzania there was a decline in national budget allocation for the Commission for AIDS (TACAIDS) and National AIDS Control Programme (NACP).[15] Allocations for SRH and HIV interventions averaged 1% of the total health sector budget for Kilosa district over the past three years.[16] In Zambia, only 9.3%[17] of the 2019 budget was allocated for health, implying a reduction in downstream funding of young people's SRH services delivery, in spite of the fact that over half of the population in Zambia is adolescent. (According to the 2014 census, adolescents and young people below the age of 24 constituted 65%[18] of Zambia's total population.)

Findings from the community scorecard show that generally respondents had concerns on the quality of participation in planning. In Malawi, findings suggest very low participation by youth and women in development structures.[19] Budget analysis and scorecard reports from Malawi and Mozambique also show a mismatch between budget consultations and final decisions. Pre-budget consultations in the countries are mainly done for national level stakeholders; in some instances the district plans are developed and submitted after the finance ministry has finalised the national plans and budget.[20] In Tanzania there is an Opportunity and Obstacles to Development Policy (O&OD) Policy that governs citizens' engagement in planning and priority at village level. However, youth do not have access to proper information on the planning process and in most cases the government does not have adequate resources to facilitate implementation of the policy.[21]

Citizens in all four countries felt that adolescents and youth are treated as recipients of programmes instead of active participants in the different levels of decision making on issues that affect them. Often consultations are among high level institutions who do not reflect the needs of adolescents resulting in policies that do not provide adolescents with adequate SRHR services. Even where youth are involved in local consultative councils or forums and meetings through civil society representation, for example in Mozambique, government does not provide feedback on how their priorities have been integrated in national plans and budgets. [22]

Feedback from focus group discussions (FGD) in Tanzania and Mozambique shows that the quality of participation of young people is also affected by their ability to read and interpret budgets.

13 African Union (2014)
14 Refer to separate village level community scorecard reports from Kilosa and Mbozi districts of Tanzania, Nsanje and Mchinji districts of Malawi; Chibuto and Marracuene districts of Mozambique; and Mongu and Chipata districts of Zambia
15 TACOSODE (2018)
16 Ibid
17 Lusaka times(2018)
18 Zambia Central Statistical Office(2012)
19 ActionAid Malawi, and ActionAid Mozambique (2018)
20 Ibid
21 Key information interview(2018)
22 Action Aid Mozambique (2018)

Expenditure management

In terms of budget management, participants in the scorecard discussions raised concerns regarding differences between budgeted amounts and funds disbursed. In Mozambique there is a noticeable variance between initial health budget allocation, revised allocation and actual expenditure. In nominal terms, MT20.3 billion was spent on health in 2016 against an initial allocation of MT22.7 billion.[23]

In the districts of Kilosa and Mbozi in Tanzania there are gaps between cumulative spend and funds received from the Health Basket Fund. Due to perennial delays in the disbursement of funds from the central government, there is always unspent money that could be used to improve the quality of young people's SRH services.[24] Furthermore, health budget expenditure does always follow the plans in Malawi as funds can easily be re-directed to other Council expenses.[25]

Performance management

Findings from the community scorecards conducted across eight districts of Malawi, Mozambique, Tanzania and Zambia shows emerging challenges in the delivery of SRH services. Below are the concerns with SRH service delivery raised by the communities:

Mozambique:[26] The challenges are: staff capacity, structural and quality of service delivery. Staff at health facilities were reportedly using mobile phones when serving patients, and are insensitive to the suffering of people, especially pregnant women, children and the disabled. The facilities are also incapacitated by drug stock-outs and no ambulances to ferry critically ill patients. There are always long queues that mean sick people have to wait for a long time to be served.

Tanzania:[27] Challenges included shortage of staff at health facilities and inconsistent supply of medicines to meet demand. There were also inadequate SRH services infrastructure i.e. no set rooms for HIV testing services which undermines issues of confidentiality. It was also noted that there was no water and electricity in some health centres and dispensaries.

Malawi:[28] Overall the policies on HIV and SRH service delivery do reflect the needs of young people in Malawi, however performance management challenges still remain. There is limited availability of youth friendly corners for SRH services and this is compounded by young people not being knowledgeable on their right to access such services. People living with HIV who default on treatment are not followed up on, thereby increasing the risk of drug resistance. Service delivery of HIV services is also compromised by the use of non-skilled staff and by not upholding confidentiality when providing HTS. A unique gap compounding performance management in the country was the community role. Scorecard findings show that there is limited male involvement in HIV and SRH services utilisation, and negative attitudes by the community on SRH topics,which impacts on uptake and utilisation of services.

23 UNICEF (2017)
24 TACOSODE (2018)
25 ActionAid Malawi (2018)
26 Action Aid Mozambique (2018)
27 Action Aid Tanzania (2018)
28 Action Aid Malawi (2018)

Zambia:[29] There is recognition of government efforts to provide quality SRH services for young people. Scorecard findings show general satisfaction that adolescents and young people are provided services in a non-stigmatising manner. Consent was shown to be a major impediment in access to SRH services for young people. Notably, those under 16 years of age and not married require parental and guardian consent to access SRH service.[30] In Mongu district, FGD participants highlighted that young people are compelled by the service providers to produce letters authorising them to get family planning from either their husbands or parents/guardians.

Public integrity management

Results on issues of public integrity were mixed. People felt that although governments are making efforts to stamp out mismanagement of public finances by setting up anti-corruption institutions, there are still many cases of misappropriation of resources that are not fully investigated. Participants in the scorecard process perceived government accountability systems as ineffective and very slow. In some cases no action was taken against those found wanting, and in other cases government officials implicated in resource mismanagement were transferred from one department to another instead of being prosecuted or dismissed.

In Malawi, cases of misappropriation of funds have resulted in lack of medical equipment and supplies at a number of government hospitals. "*Malawi has funds to improve our health system, but the problem is that most of this money goes into some people's pockets...*," community member.[31] The extent of corruption in the public services delivery was exposed by the cash gate corruption scandal. The Malawi auditor general's report showed that during the scandal approximately MWK3.8 billion was paid for inflated procurement prices and MWK 1.9 billion was paid with no evidence of goods or services being provided.[32]

In spite of these limitations these governments have mechanisms for maintaining public integrity and taking action against abuse of resources. In Mozambique, between January and September 2018, a total of 107 complaints against health workers were received and investigated resulting in disciplinary proceedings against 155 of them.[33] In 2016, the Anti-Corruption Commission of Zambia arrested five Ministry of Health officers for theft involving K471, 275.[34]

These positive trends should be encouraged in order to ensure more effective management of public resources.

Oversight

Governments in the four countries have put in place oversight processes. There are several oversight institutions such as the public accounts committees - a parliamentary committee that provides budget oversight of the executive branch of government; the auditor general's office whose mandate is to audit and report on government expenditure; and anti-corruption commissions mandated to investigate corruption and prosecute corrupt offenders. However these institutions are perceived to be weak and not fully utilised.

29 Action Aid Zambia (2018)
30 Population Council, UNFPA, Government of Zambia Human Rights Commission, WLSA, and United Nations in Zambia (2017)
31 Mweninguwe 2018
32 Smith (2015)
33 All Africa (2018)
34 Lusaka Times (2016)

Below is a brief analysis of oversight structures in each country:

Zambia:[35] Parliamentary Committees related to health include that on estimates, on public accounts, and on health, community development and social services. The oversight role is currently limited as there is little participation of parliamentarians in sector needs assessments, strategic planning and monitoring and evaluation. The parliamentary committees' decision on health is influenced by alignment to political parties and has not fully utilised collaboration with civil society and media. At the district level, the District Council Committee is the decentralised unit of government mandated to oversee and implement government programs at the district. However, the Council faces literacy challenges in reviewing public documents, limited understanding of the social accountability concept and being aligned to political parties' interests.

Tanzania:[36] An assessment conducted by MS TCDC shows the oversight role was limited by inadequate funding to conduct field visits and perform their duties as mandated; inadequate access to classified public documents and skills gap among members in budget monitoring and accountability.

Malawi:[37] District Council Committees hold great potential for improving accountability and service delivery. Local Members of Parliament are ex officio members of the councils. However, respondents of the MS TCDC assessment highlighted challenges including a high level of illiteracy among council members, poor facilitation (sitting allowance is small and not paid on time), and political alignment. A key gap was identified as communication between the Committee and government ministries.

Mozambique:[38]The District Council Committees face the challenges similar to the other countries in low literacy levels, highly politicised and low understanding on the rights-based approach to public resources management.

Overall citizens felt that the public accounts committees (PAC) are making significant efforts to hold government accountable.[39]They have been given wide ranging powers to scrutinise public expenditure and ensure accountability of national resources and have the power to summon government departments cited in the auditor general's report. PACs conduct public hearings and they make their reports public. In Zambia, for instance, their proceedings are broadcast on parliament radio for the public to follow. In spite of these positive trends there is a lot of room for improvement to strengthen PACs, as currently they do not have prosecutory or disciplinary powers.

Similarly while the auditor general's office conducts annual public funds audits, they have no prosecutorial powers and most of their findings are not investigated by law enforcement agencies. In all four countries anti-corruption commissions are perceived to be selective in the cases they investigate. Participants felt that political interference in anti-corruption commissions affects the capacity of those institutions to investigate corruption, particularly involving high ranking officials.

35 MS TCDC (2016)
36 MS TCDC (2016)
37 MSTCDC (2016)
38 MS TCDC (2016)
39 Action Aid Malawi, Action Aid Tanzania, Action Aid Mozambique and Action Aid Zambia summary SAM data reports, (2018)

In Zambia, this was identified by the Anti-Corruption Commission as one of the reasons for the drop in number of people reporting corruption.[40] Oversight institutions need to be strengthened, including ensuring that the executive responds regularly to the findings of these institutions. Oversight bodies should also be encouraged to produce reports with findings and recommendations timelines for providing progress reports on corrective actions.

Conclusion

Across Malawi, Mozambique, Tanzania and Zambia there have been notable commitments and efforts to improve access to SRH for young people, through formal commitments and policies, resource allocations for health and participatory governance. Regional commitments such as the SADC SRHR Strategy (2019-2030), ESA Ministerial Commitment on Comprehensive Sexual Education and Sexual and Reproductive Health and Rights and Maputo Plan of Action (2016-2030), provide regional frameworks for member states to refer to in promoting access to SRH services. Domestic policies and programmes truly reflect the commitment by national governments to improve SRHR outcomes for young people.

The PSA Alliance has facilitated conversations with representatives from the community. These conversations identify areas that must be strengthened to ensure that all young people have access to quality, affordable, accessible and available SRH services in the four countries. The recommendations below are drawn up for consideration by different stakeholder groups.

Recommendations

The SADC Secretariat must:

- Provide technical support and mentoring of SADC member states to implement the Regional SRHR Strategy (2019-2030).
- Continue to undertake the regional coordination and monitoring role of the Regional SRHR Strategy (2019-2030).
- Raise awareness on the relationship between good governance principles i.e. addressing corruption and its linkages with commitments in SRHR. Poor governance practices have a negative bearing on delivery of health services and this is rarely acknowledged in national plans and commitments on health.
- Establish a regional youth advisory committee to inform the implementation and operationalization of the SADC SRHR Strategy and Scorecard. It is further recommended that the committee be representative of young people from all SADC Member States and mirror national level structures that will co-monitor national progress.

SADC Parliamentary Forum must:

- Bring social accountability on the agenda to raise the discourse at the regional level and national parliaments.

40 Diggers News (2019)

National Governments / Policymakers must:

- Mainstream gender in design and facilitation of participatory community governance and budget planning, based on the design of indicators that track equal representation and quality participation of men, women, boys and girls. No one size fits all approach can be subscribed for all the countries, but a clear gender mainstreaming framework should be adopted that respects gender equity and equality in participatory community governance systems.
- Adopt appropriate fiscal discipline measures through parliamentary oversight and ministry functions to reduce variances between budget initial health budget allocation, revised allocation and actual expenditure.
- Simplify budget statements so they can be understood by communities, and make these available through other channels as well, as not all communities are computer literate.
- Enhance efficiencies in public resources management. This should reduce the burden of delayed disbursements, which has led to underspends in countries such as Tanzania.
- Incorporate consultative platforms for adolescents within national health planning mechanisms such as technical working groups or youth advisory groups.
- Deepen oversight and monitoring role of line ministries involved in SRH services delivery through functions of parliamentary committees on health, social development and finance. This should be complemented by investing in capacity building of parliamentary committees and district level oversight structures on topics such as policy literacy, public resource management and social accountability.
- Commit 5% of their national health budget for implementation of the SADC SRHR Strategy (2019-2030). Additionally, local government authorities, where relevant, should at least commit 10% of their own sources for the facilitation of the implementation by local health departments.
- Undertake innovative and sustainable domestic resource mobilisation and ensure adequate budgetary allocations to SRH services for adolescents and young people. Tailored SRH services for adolescent girls and young women, in particular, should be prioritized.

Civic society must:

- Design and roll out awareness and capacity building of marginalised communities on social accountability and SRHR. When more community members understand that access to SRH services is a right, then we will see more active participation in social accountability platforms. Civic mindedness is the key to strengthened engagement of communities in oversight and accountability roles.
- Design programmes that help to build sustainable capacity of community oversight structures i.e. health committees to undertake their oversight roles effectively.
- Participate in and support national government programmes whose objective is to meet national commitments on SRHR.
- Strengthen the capacity of media to write and disseminate information demanding for transparency and accountability by the state in public resources management.

Academia / researchers must:

- Conduct research on how states can measure and track 'quality' of participation by communities in public resource planning and allocation processes. It is imperative for 'quality' measurements of participation to focus on more than just numbers of people.

Communities and young people must:

- Demand for provision of youth friendly SRH services as a right.
- Encourage and support adolescent and young people to participate in public resources management processes.

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