EXECUTIVE SUMMARY

Sexual and reproductive health (SRH) services for young people and adolescents - Community scorecard (CSC) findings

Compilation of Community Scorecards from Malawi, Mozambique, Tanzania, Zambia and Zimbabwe as part of the PSA Alliance Regional Monitoring Tools Initiative

2020/2021

A PSA Alliance community scorecard meeting at Sianzundu clinic in Binga District, Zimbabwe.
PHOTO: SAFAIDS ZIMBABWE

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1. INTRODUCTION

This is a summarised report of a consolidation of findings from community scorecards (CSCs) administered in selected districts of the five Partnership for Social Accountability (PSA) Alliance project countries; namely Malawi (Nsanje District), Mozambique (Chibuto District and Lugela District), Tanzania (Mbozi District), Zambia (Kasenengwa District and Chipata District) and Zimbabwe (Binga District). The CSCs were conducted during the period September 2020 to March 2021. The full report is available at http://copsam.com/wp-content/uploads/2016/03/PSA-Consolidated-CSC-Report-Health.pdf

2. BACKGROUND

The PSA Alliance project seeks to improve social accountability and gender-responsiveness in public resource management (PRM), particularly in the areas of HIV and sexual and reproductive health (SRH) services for adolescents and young people, and agricultural services for smallholder farmers. As part of the regional monitoring tools, CSCs provide a framework for tracking the management and performance of selected public services at the district/ward levels in the project's five target countries. They also serve to identify gaps that require prioritisation by policymakers, as well as unearth service delivery issues for evidence-based advocacy action plans in a participatory, inclusive, and consultative manner.

3. METHODOLOGY

A total of 17 CSCs were conducted through interface meetings and focus group discussions. Questions related to perceived quality of public services, government accountability in delivering those services, and social accountability monitoring (SAM) in public resource management.

Figure 1: Participants by country

A total of 523 participants were involved in the CSCs, with Mozambique having the highest number of participants (39%), whilst attendance in other countries was distributed as follows: Malawi (23%), Tanzania (14%), Zambia (12%) and Zimbabwe (12%) respectively.

4. KEY FINDINGS

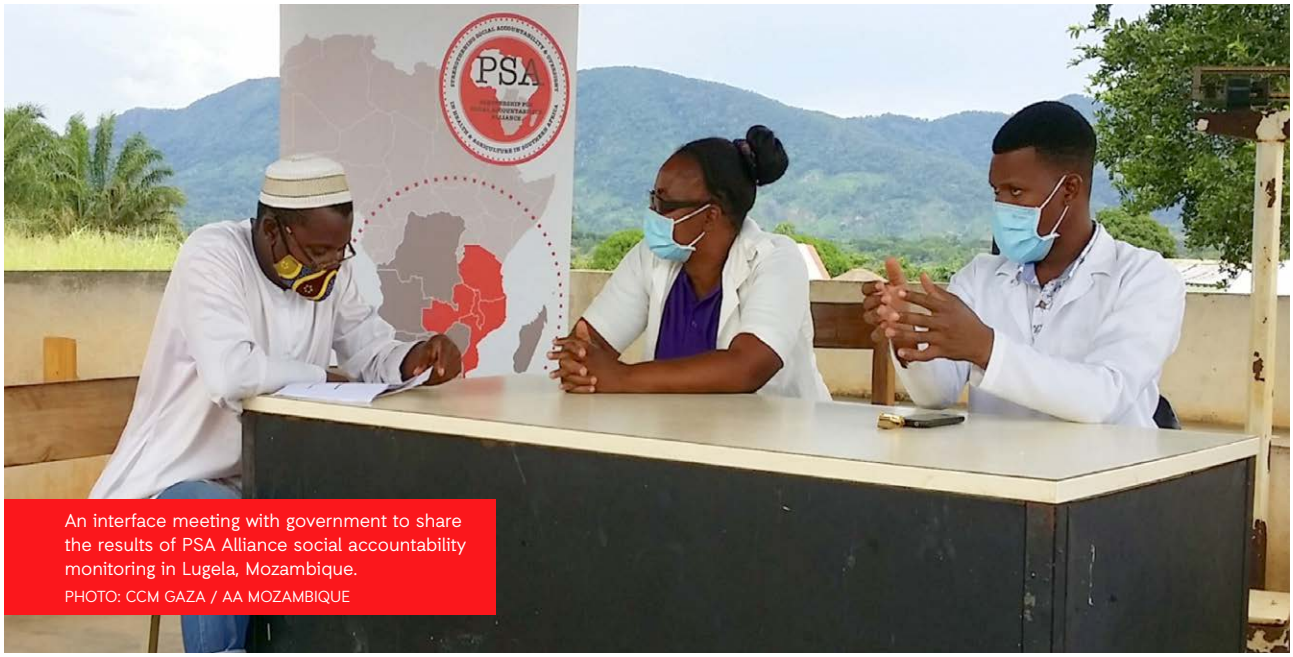
The key findings from the CSC interface meetings hosted in the five project countries were analysed, organised, and presented under the five thematic areas of human resources, commodities and equipment, infrastructure, quality of services, and participation and engagement. The findings show different trends and patterns across the five project countries with respect to the management and performance of HIV and SRH services at the district/ward levels.

4.1 Human resources

There is a common challenge of inadequate HIV and SRH service providers across the five project countries, thus posing an access barrier for service users. Of note was the shortage of qualified staff at the majority SRH service centres which, as a result, compromises the quality of the services offered. Nonetheless, participants were generally satisfied with the manner in which HIV and SRH service providers delivered their services and interacted with them. Cases of unfriendly behaviours and attitudes were, however, reported in some cases with participants linking that to service providers being overwhelmed by high workloads.

In relation to confidentiality and respect for privacy, participants confirmed that most HIV and SRH service providers observe confidentiality with information shared. However, breaches of confidentiality and privacy were reported across the five project countries. Infrastructure constraints and limitations were also identified as a barrier to confidentiality in the delivery of HIV and SRH services. For instance, most health centres do not have adequate rooms for SRH consultations, and the consulting rooms are not soundproof, thus posing a barrier to confidential access to services by young people.

In terms of gender balance, it is apparent that very few districts have achieved gender balance as reported for Tanzania and Mozambique. Gender balance was reported at healthcare centres in Mbozi District (Tanzania) and Lugela District (Mozambique). For example, in the five wards of Nsanje District in Malawi, most of the HIV and SRH service providers are men constituting between 60 to 70% of the total SRHR staff at healthcare centres. Although several reasons were provided for the under-representation of women – including issues of lack of requisite qualifications amongst women and corrupt practices, among other factors – the achievement of gender balance is essential in addressing gender-related aspects of SRH service provision in the five countries.



An interface meeting with government to share the results of PSA Alliance social accountability monitoring in Lugela, Mozambique.
PHOTO: CCM GAZA / AA MOZAMBIQUE

4.2 Commodities and equipment for HIV and SRH services

Based on the CSC scores from four of the five project countries (except Mozambique), respondents indicated that most SRH commodities and equipment are available but their availability and access by young people, adolescents, and women in communities remains a challenge. On the whole, many commodities and equipment are in short supply when measured against demand from the respective communities with particular shortages of *female condoms, pregnancy test kits, PEP* and *PrEP*. Despite the limited supplies, the low uptake for commodities such as PrEP and PEP appears to be associated with challenges of lack of knowledge on their use.

Cultural, technical and corruption-related knowledge barriers in accessing SRHR commodities also emerged from the CSC interface meetings. In Traditional Authority Malemia in Nsanje District, for instance, community members explained how access to pregnancy test kits and other SRHR commodities was being complicated by corrupt practices.

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

In Binga District (Zimbabwe), for example, cultural norms prohibit women from using female condoms. On the other hand, the lack of insertion services for implants was due to the unavailability of trained staff to perform the insertion despite the availability of the implants.

4.3 Infrastructure

Standalone SRH youth-friendly spaces, permanent SRH service centres and adequate transportation services to transport SRH commodities are non-existent in the target districts of the five project countries. Where these spaces are available, accessibility is a challenge as the spaces are unconducive for young people as they end up being mixed with elders. For instance, in Mlolo Traditional Authority (Nsanje District), the SRH space is integrated into the maternity ward. Accessibility constraints are worsened by an absence of transportation. In most of the target districts, there are no ambulances, and health centres rely on other departments for transport services. Inadequate information, education, and communication (IEC) materials also affect SRH service delivery, as they are in short supply in Malawi, Tanzania and Zimbabwe.

4.4 Quality of service

Generally, participants judged the quality of SRH service across the districts to be average. However, the quality of SRH services is compromised by varied factors, including lack of stand-alone spaces, inadequate knowledge among some SRH service providers and inadequate staffing. Time spent to receive SRH services by adolescents and young people was viewed to be inadequate. The operating hours of SRH centres were deemed inconvenient. The absence of consistency and adherence to official schedule working hours by SRH service providers is a key challenge. In fact, the unpredictable working schedules are an inconvenience to service seekers.

4.5 Participation and engagement

In the districts covered across the five project countries, it is apparent that there is very limited involvement of young people, adolescents and women in the monitoring of health services in their localities and they rarely participate in budget consultation processes. Lack of consultation, marginalisation of young people, information gaps, and cultural underlying issues are the contributing factors for non-participation in SAM processes. The advent of COVID-19 suppressed most of the platforms for public participation. There are existing channels and procedures to report concerns related to SRH services; nevertheless, securing feedback on reported issues was stated to be difficult.

Recommendations

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

- Governments should effectively enforce compliance with existing ethical codes of conduct and public service regulations to ensure services are provided with integrity, professionalism and accountability.
- Given the continuation of COVID-19 governments need to find innovative ways to ensure consistent supply of SRH commodities and services during a pandemic.
- Governments should carry out a thorough participatory audit of health centres in order to establish staffing and equipment gaps for adequate resource allocations.
- Collective advocacy should push for the addressing of policy and legal barriers to accessing SRH services through legal reviews and adjustments.
- Ministries of Health, human resources and disciplinary units should provide awareness and capacity building for AYP on PRM processes and procedures for reporting public resource mismanagement and misconduct.
- SRH stakeholders should strengthen the capacity of AYP to fully comprehend SAM and PRM systems for them to effectively participate in all SAM processes.

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. For more information on PSA Alliance: online **http://copsam.com/psa/**, Facebook and Twitter at **@psaalliance**; email **psaalliance@actionaid.org**.