EXECUTIVE SUMMARY

Sexual and reproductive health (SRH) services for young people and adolescents - District-level questionnaire findings

Compilation of District Level Questionnaires from Malawi, Tanzania, Zambia and Zimbabwe as part of the PSA Alliance Regional Monitoring Tools Initiative

2020/2021

A staff member of ActionAid Malawi speaking during a community scorecard validation meeting in Mchinji District, Malawi.
PHOTO: ACTIONAID MALAWI

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1. 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 four of the five countries of the Partnership for Social Accountability (PSA) Alliance project, namely Malawi (Nsanje District), Tanzania (Mbozi District), Zambia (Chipata District) and Zimbabwe (Binga District). Data from Mozambique was unavailable at the time this summary was prepared. The DLQs were administered during the period September 2020 to March 2021. The full report is available at http://copsam.com/wp-content/uploads/2016/03/PSA-Consolidated-DLQ-Report-SRHR.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 SRH services for adolescents and young people, and agricultural services for smallholder farmers. As part of the regional monitoring tools, DLQs 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. Evidence gathered informs the PSA Alliance's social accountability monitoring (SAM) interventions and policy responses in the health sector.

3. METHODOLOGY

Figure 1: District level questionnaire participants by country

The health sector DLQs were administered to different SAM stakeholders comprising CSO officials, ward councillors, Ministry of Health officials, district council members and journalists. A total of 34 DLQs were administered in the implementing wards of the four countries. The majority of respondents were male, contributing 79%, with females accounting for 21% of the total respondents.

4. KEY FINDINGS

DLQs findings are presented under the following thematic areas:

- **Participation and engagement**
- **Commodities and equipment for HIV and SRH services**
- **Adequacy and comprehensiveness of SRH service delivery**
- **Conduct of SRH service providers**
- **Barriers in accessing SRH services**
- **Existence and utilisation of opportunities and appropriate channels to report cases of poor SRH service delivery**
- **Effects of Covid-19 on the delivery of and access to SRH services**

4.1 Participation and engagement

DLQs revealed that the four countries have different structures to facilitate the participation of young people in the pre-budget consultation and planning processes. The majority of respondents (that is, 64% in Malawi, 75% in Zambia, and 63% in Zimbabwe) were aware of these structures, except in Tanzania where respondents were unaware of the existence of such mechanisms. However, even those who are aware of these participation structures may not fully utilise them.

4.2 Commodities and equipment for HIV and SRH services

The majority of respondents across the countries indicated that, to a lesser extent, the SRH services facilities are adequate to allow for the provision of SRH services to adolescents and young people in the respective districts. However, some respondents maintained the view that the facilities are inadequate to provide for SRH services in the districts. Overall, in Binga District (Zimbabwe) and Nsanje District (Malawi), the majority of the DLQ respondents (62% and 55%, respectively) were of the view that SRH service delivery infrastructure in the respective districts were of poor quality and inadequate. Whilst in Chipata District (Zambia), 60% of the DLQ respondents 'somewhat agreed' that there is adequate and quality SRH services.

Figure 2: State of SRH service delivery infrastructure in the target districts

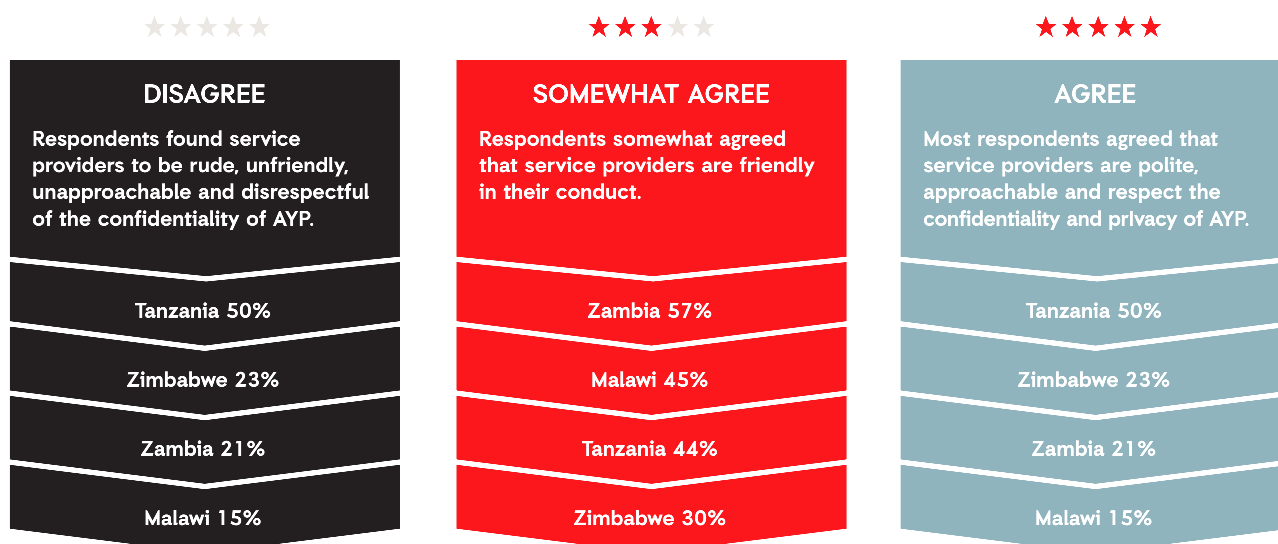
Country	District	Percentage of respondents/ stakeholders that **AGREE** that there is quality and adequate SRH service delivery infrastructure	Percentage of respondents/ stakeholders that **SOMEWHAT AGREE** that there is quality and adequate SRH service delivery infrastructure	Percentage of respondents/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

4.3 Adequacy and comprehensiveness of SRH service delivery

Based on DLQ responses in the four districts, across the four countries, there appears to be adequate supplies of male condoms, adequate contraceptive tablets and adequate HIV/STI testing kits for young people and adolescents in SRH service centres. However, respondents reported that there were inadequate supplies of female condoms, implants, injectable, pregnancy testing kits, post-exposure prophylaxis (PEP) and pre-exposure prophylaxis (PrEP).

4.4 Conduct of SRH service providers

Responses showed mixed trends and patterns of services providers' conduct. These are highlighted below:



Generally, most of respondents in Zambia and Malawi 'agreed' or 'somewhat agreed' that SRH workers are positive in their conduct of duty, while the greatest number respondents from Zimbabwe reported that SRH service providers are friendly, easily approachable and respectful of privacy. However, respondents from Tanzania and Zimbabwe contributed the highest percentages of those who found service providers to rude, unfriendly, and unapproachable.

4.5 Barriers in accessing SRH services

From the data gathered through DLQs, it emerged that all adolescents and young people respondents in the four project countries are confronted with barriers in accessing SRH services within their respective districts. Respondents from all countries agreed that there are existing barriers in accessing services as highlighted below:

Malawi	Tanzania	Zambia	Zimbabwe
Inadequate funds to deliver services and manage centres	Available SRH health centres are not youth friendly	Limited standard space and infrastructure for SRH service provision at health facitities	Few SRH service delivery centres/facilities, most are very remotely located
Shortage of SRH commodities	Lack of fully capacitated SRH service providers/ staff at SRH service centres	Understaffing at SRH service delivery centres/ facilities	Lack of IEC materials translated to local veracular
Conflicting policies that negatively affect and restrict access to SRH services	Community cultural beliefs that restrict access to SRH and HIV services by adolescents and young people	Lack of proper coordination amongst SRH services stakeholders	Lack of resources and incentives to provide SRH services
Lack of stand alone SRH facilities and inadequate trained SRH staff			Negative atitudes of SRH service providers

The other highlighted barriers to access of SRH services related to insufficient infrastructure and limited supplies of SRH materials and commodities. In addition, geographical challenges in terms of long distances makes access to emergency services, such as PEP and PrEP more complicated; in particular, involving a high transportation cost to access services.

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

From the DLQ responses, there is evidence that indeed there are 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 all the target districts in Malawi, Tanzania, Zambia and Zimbabwe. The common challenge, however, is the limited use of such reporting channels by SRH service users and other stakeholders in the respective districts, despite the prevalence of cases relating to the abuse of public resources, corruption, misconduct, and maladministration at health facilities.

4.7 Effects of Covid-19 on the delivery of and access to SRH services

From the data gathered through the DLQs, access to SRH services in the target districts of the four project countries was seriously affected by COVID-19. Due to the overwhelming health needs in the fight against COVID-19, most governments re-prioritised budgets towards funding COVID-19 response.

In Zimbabwe, a *Rapid Assessment of COVID-19 Response in the context of Maternal and SRH in Zimbabwe conducted 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. In Malawi, SRH service delivery and access was also compromised by COVID-19 prevention measures; between April and July 2020, the provision of HIV services (including medical, male circumcision (VMMC) and PrEP was severely disrupted. 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.

In Zimbabwe, a total of 764 cases of gender-based violence (GBV) were recorded in the first 11 days of the national lockdown, but these had increased to 2,768 by the 13th of June 2020. Zambia recorded a 10% increase in GBV cases in the first quarter of 2020 during COVID-19 as compared to the previous year, 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.

A young women in Binga district, Zimbabwe, speaking about her participation in budget consultations.
PHOTO: SAFAIDS ZIMBABWE

Recommendations

Evidence gathered from the DLQ has informed the following recommendations in order to enhance the delivery of quality, non-judgemental and inclusive SRH and HIV services to adolescents and young people in Malawi, Tanzania, Zambia, and Zimbabwe.

- 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 should develop 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**.