POLICY BRIEF

Strengthening Access to Youth Friendly Sexual and ReproductionHealth Services in Resources Constrained Settings:
Experiences and Lessons from Binga, Zimbabwe

BASILWIZI SAFAIDS actionaid

Executive Summary

This policy brief draws from the findings of a rapid assessment conducted by Southern Africa AIDS dissermination service (SAfAIDS) in partnership with Basilwizi Trust in the Binga District of Matebeleland North Province in Zimbabwe. The assessment among other things sought to develop a comprehensive, contextual, and evidence-based understanding of the current situation- availability, functionality, and accessibility of youth -friendly Sexual Reproductive Health (SRH) spaces and services in Binga district. At the same time, the study investigated young people's participation in monitoring these services at selected health centres. The policy brief acknowledges; though at distinct levels, and despite the evident constraints, the health centres are generally providing SRH services like safe motherhood, family planning, voluntary medical male circumcision, ante-natal care, post-natal care, mother-to-child transmission and counselling to everyone including young people as walk-in-clients. However, the extent to which the services are youth-friendly is something this policy brief will explore. Clearly, youth corners are no longer functional, though there are attempts to revive some of them. There are also concerns with staff availability and the competency to provide youth-friendly services. The policy brief is divided into three major sections: First is the introduction which places the policy brief into context and frames the socio-economic context of Binga, as well as access to health care including youth friendly SRH services. The second section establishes the policy context within which SRH services for young people are provided at a national level. It also discusses the availability and functionality of youth-friendly spaces and services at select health centres in Binga, and the challenges, and/or barriers young people are facing in accessing SRH services. The third and final section captures the recommendations on policy options for strengthening access to youth-friendly sexual and reproductive health services in resource-constrained settings like Binga District.

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Introduction

SAfAIDS and Basilwizi Trust with support from Action Aid Zimbabwe (AAZ) are implementing the Partnership for Social Accountability Alliance Project (PSA) funded by Swiss Agent for Development and Cooperation (SDC) in the Binga wards of Sianzyundu (Ward 9), and Simatelele (Ward 10). The project focuses on Strengthening Social Accountability and Oversight in Health and Agriculture in Southern Africa. SAfAIDS' work in the Alliance centres around improving social accountability and gender-responsiveness in public resource management, particularly in the areas of HIV/SRH services for adolescents and youth, contributing to the realization of selected national and Southern African Development Committee regional commitments. Project implementation makes use of Social Accountability Monitoring (SAM) tools and mechanisms to strengthen citizens-public authorities' engagement in public resource management and facilitate access to comprehensive gender-responsive Sexual Reproductive Health youth-friendly services.

Between June and July 2022, SAfAIDS commissioned a rapid assessment in Binga North District with specific objectives of developing a comprehensive, contextual, and evidence-based understanding of the status quo on the availability and provision of SRH youth-friendly spaces and services respectively. The study also investigated young people's involvement in the monitoring of service delivery at selected health centres in the district. The assessment was a qualitative cross-sectional mixed methods approach with Sianzyundu and Simatelele clinics purposely selected as the study sites. Data was collected through some desk reviews of project reports, and relevant national reports to determine the context and extent of challenges adolescents and youths face, as well as Key Informant Interviews and Focus Group Discussions with youths and community leaders within the Health Centre Committees.

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About Binga District

Binga is a rural district that lies in the agro-ecological natural farming region four and five of Zimbabwe. It is located in the Matebeleland North province, south of Lake Kariba, and across the same Lake from Zambia. It is over 850km from the capital city Harare by the serviceable road that goes through Bulawayo, and then along the Bulawayo to Victoria Falls. It is characterised by arid and semi-arid soils which are agriculturally unproductive and receives erratic rainfall with an annual average which is below 100mm.[1]

The main source of livelihoods is smallholder agriculture which includes small grains (i.e., rapoko and sorghum), informal fishing, weaving, wood sculpturing, vending, and livestock rearing for some supplementary income. The dry weather conditions experienced in Binga hinder vibrant agricultural productivity.[2] The majority of men (93.5%) are into informal fishing, whilst women constitute 87% of people involved in vending which includes selling wild fruits.[3] The ongoing socio-economic challenges facing the country at large have not spared Binga district with skyrocketing prices of basic commodities resulting in households struggling to sustain themselves.

As a result of the stretched livelihoods and limited economic opportunities the youths in Binga are highly mobile, and the majority cross the border into Zambia and urban areas such as Bulawayo and beyond in search of greener pastures. This impacts negatively programme work involving the participation of youths if interventions miss on related economic strengthening and/or resilience-building initiatives. The high attrition of the youths and other young people is resulting in an 'economic drain' for the district as the skilled and educated young people leave for better opportunities elsewhere. The same attrition is shared among the adult population with trained nurses and school teachers' leaving a reality citing accommodation, clean water, and phone network challenges.[4]

1. Binga, Matabeleland North, ZW Climate Zone, Monthly Averages, Historical Weather Data (tcktcktck.org)
2. The Independent. 17 April 2015. https://www.theindependent.co.zw/2015/04/17/quality-education-still-a-dream-for-binga-district/
3. Action Aid Zimbabwe. 2019. Stakeholder Mapping and Baseline Survey Report on Social Accountability and Oversight in Health and Agriculture in Zimbabwe
4. The Independent. 2015.

Binga District is made of 25 wards, and is serviced by one district hospital which is Binga District Hospital, one mission hospital which is Kariyangwe Hospital, and 16 operational health centres that are spread across the wards.[5] The mission hospital operates at the level of a rural health centre and has no resident doctor and the requisite equipment. Most people in Binga, therefore, endure long distances of between 5 to 25km to the nearest health centres. The situation is worsened by poor road infrastructure and limited public transport. There is also limited network coverage with some areas in the district completely out of network range thereby compromising communication for development and citizens' timely access to services brought by access to network coverage and connectivity.

The Tonga-speaking people are the majority in Binga, followed by the Ndebele, the Shona and Nambya-speaking communities. There are other minority groups of people from across Zambia. There are different religious groups that include the traditional churches such as the Roman Catholic, Methodist, and Anglican churches, and Pentecostals and the Apostolic sects. Some of the religious groups have been at the centre of preventing their congregants from accessing modern health care services, and the use of modern family planning methods thereby exposing adolescent girls and young women to unintended pregnancies and child marriage. Child marriage remains to be a daunting challenge across the district despite some active interventions from different stakeholders to combat the practice.[6]

5. The 16 health centres are in the following wards: 2, 4, 5, 6, 8, 9, 12, 15, 18, 19, 20, 21, 22 and 24. Five of these clinics are in Binga South constituency and the rest are in Binga North constituency where the PSA project is being implemented. It is clear that some wards have no health centre and communities have to travel to the nearest health centres across the wards.

6. The Standard. 19 June 2019. https://www.newsday.co.zw/2019/06/binga-records-spike-in-child-marriages

A synopsis of the policy context for SRH services for adolescents and youths in Zimbabwe

The first entry point for access to SRH services for adolescents and youths in Zimbabwe is the National Objectives of the Constitution of Zimbabwe. Section 20 of the National Objectives mandates that the State at every level takes measures among others to ensure that the youths have 'access to appropriate education and training, and are protected from harmful cultural practices, exploitation and all forms of abuse.'[7] Section 29 on Health Services further mandates the State to take 'all practical measures to ensure the provision of basic, accessible and adequate health services throughout Zimbabwe.'[8] These are established constitutional provisions which are further pronounced under Section 76 of the Constitution of Zimbabwe. Section 76 specifies that every citizen and permanent resident of Zimbabwe has the 'right to access basic health-care services, which include reproductive and health-care services.' It is clear that these constitutional provisions inform the understanding of what constitutes 'youth-friendly services,' [9] which, accordingly are services that are: 'equitable, accessible, acceptable, appropriate, and effective', to the extent they consider the unique needs and concerns of young people.[10]

The same Section 20 also provides for youths' participation, and the State is mandated to ensure that youths do have opportunities (including opportunities for recreation and access to recreational facilities) to associate, be represented, and participate in political, social, and economic activities, and other spheres of life.[11] This includes opportunities for employment and other avenues to economic empowerment.[12]

Health Centre Committee should have strong mechanisms to ensure that parents, guardians, and other community members recognize the value of providing SRH services to adolescents and young.

Indeed, access to youth-friendly SRH services can only be realised and be meaningful with the participation of the youths. This must be from an informed point of view where the youths are ready to make decisions and take on responsibility for matters of interest And have strong mechanisms to ensure that parents, guardians, and other community members recognise the value of providing health services to adolescents and support such provision and the utilisation of services by adolescents.

From the generic provisions set in the Constitution of Zimbabwe, there are corresponding specific instruments regarding SRH services for youths. The National Adolescents and Youth Sexual Reproductive Health Strategy II [ASRH Strategy II (2016-2020)] focuses on the age groups of 10-24 years, and advocates for the provision of health services for adolescents in a youth-friendly context, with the services expected to be accessible, available, affordable, appropriate and safe.

7. Section 20, Constitution of Zimbabwe, Amendment No. 20. 2013.
8. Section 29, Constitution of Zimbabwe, Amendment No. 20. 2013
9. Section 76, Constitution of Zimbabwe, Amendment No. 20. 2013
10. Starter Guide: Youth-Friendly Services. 2017
11. Section 20, Constitution of Zimbabwe, Amendment No.20. 2013
12. Ibid

This is further complemented by the 2016 National Guidelines on the Provision of Clinical Sexual and Reproductive Health Services. The Guidelines are clear in terms of providing and defining a pathway on how youth-friendly services should be delivered. These strategic documents provide the key intervention strategies and a minimum SRH service package that is youth friendly, at the same time ensuring uniformity in the provision at a national level. The Guidelines are a tool for ensuring quality services and have been used to assess adolescent-friendly health services and identify gaps to improve the provision and utilisation of adolescent and youth-friendly health services.

Further, the Government of Zimbabwe through the Ministry of Health and Child Care (MoHCC), has made efforts to improve SRH education and services for young people by supporting SRH programming, articulating ethical and evidence-based policy options and providing norms, and standards, and promoting their implementation and monitoring. The World Health Organization (WHO) recommended the development and implementation of national quality standards and monitoring systems. The Government of Zimbabwe thus commissioned, through the MoHCC and the National Adolescent Sexual and Reproductive Health Coordination Forum, the process of developing national guidelines on the provision of youth-friendly clinical SRH services. This was in line with the 2015 WHO Global standards for quality health care services for adolescents.

Availability and functionality of youth-friendly spaces and services at select health centres in Binga North

The rapid assessment noted that youth-friendly spaces are limited with some of the corners that were previously used by young people no longer fully functional due to resource constraints. Health centres in Binga are still using the 'Youth Corner Model' where a room is set aside at the health centre to offer services to adolescents and young people. Whilst this remains to be acceptable within contexts of resource constraints, it deviates from the current Ministry of Health and Child Care three-pronged approach which focuses on the 'Youth Friendly Health Facility Approach; 'Community-based Youth Centres,' and the school-based approach.'

The local Council has however established social centres within communities which act as sports recreational parks for young people. The Ministry of Youth, Sports, Arts, and Recreation is coordinating this. The Council is also in the process of mobilising resources to construct a stadium at the Growth Point. This will increase young people's space and access to recreational activities. This will further provide a platform for all stakeholders in the health sector and the community to disseminate SRH information among young people at a central place.

The health centres visited were providing all primary SRH health care services to everyone including adolescents and young people with no discrimination based on age as walk-in-clients-only when they visit the health facility. The services ranged from safe motherhood, family planning, voluntary medical male circumcision (VMMC), ante-natal care, and post-natal care, to mother-to-child transmission. Referrals were in place for services not offered at the clinics. There were no

Social Accountability Monitoring for Sexual Reproductive Health and Rights (SAM4SRHR): A Model to Strengthen the Delivery of SRHR Services among Adolescents and Young People in Resource Constrained Settings

In both Sianzyundu and Simatelele wards, Basilwizi Trust works with SAM4SRHR Mentees to disseminate SRH information to adolescents and young people. Ten Mentees (6 females and 4 males) were trained and they work with 25 youth network members in each ward. The Mentees even reach out to young people in remoteareas where health centre staff are unable to conduct outreaches due to lack of resources which include lack of transport and inaccessible road network. The Mentees host dialogues on social accountability monitoring and public resource management issues related to SRHR within their communities and health centres. The work of the Mentees in the community raises awareness among young people on SRH services available at the local health centres. It also assists in identifying gaps in service provision. Where there are gaps, the Mentees commence the issues with the Health Centre Committees. The Committees in return submit the issues to the health centres for amendment, or take them to the district level for attention where necessary. The Mentees conduct debriefing meetings with Basilwizi Trust where they share information gathered during their community outreach. In return, Basilwizi Trust provides guidance and mentoring to the Mentees with additional support from the MoHCC health worker(s) responsible for youths.

user fees charged, therefore adolescents and young people were accessing the services free of charge. This is a key element for youth friendliness of services, which is of benefit for young people who each time are struggling with the socio-economic challenges defining the district, and thus may not have disposal income to pay for services.

Discussions with young people themselves however identified barriers to accessing SRH services. These included staff competency issues- the district lacks trained service providers on ASRH to offer youth-friendly services at health facilities. The young people acknowledged that some SRH Information, Education and Communication materials had in the past been translated to Tonga, however, they wanted more materials.

The availability of a range of SRH commodities and services at the clinics was incomparable with the limited uptake of these services and commodities. The uptake of especially contraceptives (i.e., condoms) and VMMC remains a challenge due to a lack of appropriate information, and discouragement from parents, guardians, and the community as a result of general social myths, and misconceptions around contraceptives and VMMC. This also includes inadequate knowledge within communities on VMMC and some of the contraceptives.

In addition, young people are failing to reach out to the clinic staff because of a generation gap (i.e. most of the clinic staff are elderly), and this hinders young people from dialoguing freely on SRH matters. This is a clear compromise on the participation of youths in matters of interest. In place across the health centres are transparent, and confidential reporting mechanisms like Health Centre Committees, the local leadership, client exit interviews, and suggestion boxes for adolescents and young people to submit complaints, or feedback on service provision, nonetheless, these mechanisms are not fully utilised. In most cases, young people are not even aware of the existence of these platforms, nor the rationale for their establishment.

Summary of SRH services provision for young people in Binga

The summary is for the two health centres Sianzyundu and Simatelele Clinic covered during the rapid assessment. The table below presents the summary of service issues for each health centre against availability and the identified barriers. This is to allow for focused and context-specific responses to the services and barriers for each health centre.

SERVICE ISSUE	SIANZYUNDU CLINIC	SIMATELELE CLINIC
Availability of Comprehensive Sexuality Education (CSE)and general counselling HIV Testing Services(HTS), Anti Retroviral Therapy (ART), family planning, cancer, Sexual and Gender Based Violence (SGBV), life skills and safe motherhood)	The clinic does not offer any CSE except general counselling which is done for walk-in-youths	The clinic does not offer CSE because all clinic staff are not trained on CSE and youth friendly service provision. However, general counselling is done for walk-in- youths who come to the clinic.
Provision of contraceptives and condoms (i.e., reversible contraceptives) including emergency contraceptives and other service commodities	• The commodities and services are available; however, they are underutilised by young people due lack of awareness and societal restrictions, myths and misconceptions around family planning. At the time of the study there were not test kits (pregnancy and HIV), contraceptives (control depo), ARVs and Paracetamol	The commodities and services are available; however, they are underutilised by young people due lack of awareness and societal restrictions, myths and misconceptions around the use of contraceptives for family planning.
HIV and Sexually Transmitted Infections (STI) treatment and management and ART (pep, prep) and cervical cancer	• There were commodity stock outs for HIV test kits during the assessment, hence leading to prioritisation of special population groups such as pregnant women and those living with HIV. • Cervical cancer screening services are not available at the clinic, and referrals are made to the district hospital.	Services are available at the clinic and through referrals at the district hospital (e.g., testing and screening of cervical cancer is not done at the clinic).

VMMC	The services are not available; people are referred to the district hospital. There is evident information and knowledge gap among community members and young people on VMMC.	The clinic only registers clients who want to access the service and then engages staff from the district hospital to conduct the procedure. There is a lot of social stigma and discrimination surrounding male circumcision.
Safe Motherhood including (i.e., ,Post Natal Care (PNC), Prevention of Mother to Child Transmission (PMTCT), post abortion care and pregnancy Tests,)	All the services were available at the clinic.	The services were available at the clinic.
Are all services offered in privacy and confidentiality?	Staff ensure that confidentiality is adhered to and there is both audio and visual privacy.	Staff ensure that confidentiality is adhered to and there is both audio and visual privacy.
There is a transparent, confidential mechanism for youth to submit complaints or feedback about SRH services.	Mechanisms are available but they are underutilised by young people. The mechanisms include; the suggestion box, the HCC, and the nurses-in-charge. -Young people do not use the suggestion box, and some are not even aware of the existence and purpose of the box.	• Existing reporting mechanisms are available and they include the HCC, local leadership and exit interviews which are done on a quarterly basis. However, they are not being utilised. • The clinic has a suggestion box for partner organisation, and this is solely used for reporting feedback on the partner's activity.
Staff attitude	Some of the nurses at the clinic are approachable yet some are not	Some of the nurses at the clinic are approachable yet some are not.
User fees and affordability	All services are offered free of charge	All services are offered free of charge.
Infrastructure friendly to diversity, gender responsive and disability inclusion.	The infrastructure is friendly, gender responsive and embraces disability inclusion, except for the toilets that have no ramps for clients on wheelchairs, and those on crutches struggle to use them because of the limited space inside the toilets.	The infrastructure is friendly, gender responsive and embraces disability inclusion, except for the toilets that have no ramps for clients on wheelchairs, and those on crutches struggle to use them because of the limited space inside the toilets.

Opening hours	Opening hours are convenient for young people	Opening hours are convenient for clients. However young people do not make use of the bonus hour they were offered to get SRH education from the health centre staff.
Are youth-specific and appropriate IEC materials on display for young people to take away?	The clinic has limited IEC materials. The distribution of existing IEC material is very minimal.	The clinic has limited IEC materials.
Client flow and signage	-Some of the young people are aware of (i.e., and some are not) the respective rooms where they can get respective services. -Abbreviations are often used to label rooms and some of the young people do not understand what these abbreviations stand for.	Some of the young people are aware of (i.e., and some are not) the respective rooms where they can get respective services. -Abbreviations are often used to label rooms and some of the young people do not understand what these abbreviations stand for.
Adolescents are involved in planning, monitoring and evaluation of health care services	A youth member is part of the HCC. The youth member has since proposed through the Committee for the setting up of a standalone youth friendly corner, and this has been included in the five-year development plan for the clinic.	The HCC seldom invites the youth representatives for meetings. Young people fail to reach out to the clinic staff because of the generation gap between youth and staff at the clinic (i.e., most of the clinic staff are elderly and this hinders engagement between the clinic staff and young people).

Recommendations on policy options for strengthening access to youth friendly SRH services in Binga

Binga district presents challenging socio-economic and climate-related contexts for access to SRH services for young people. Nonetheless, any policy options for strengthening access to youth-friendly SRH services for young people need first a clear understanding and categorisation of the existing barriers to SRH services for young people. From the rapid assessment, the barriers can be summed under the following broad categories:

a) Structural barriers: - These relate to policies and laws that do require parental, guardian, or partner consent to get the services, distance from health centres, costs of services and /or transport, long wait times for services, inconvenient hours, lack of necessary commodities at health facilities, and lack of privacy and confidentiality. [13] From the discussion above, distance to health facilities and linked transport costs remain key embedded factors deterring young people from accessing SRH services. The same with some commodity stock-outs as witnessed during the study. Once young people visit a particular health centre for a service, and it is not offered due to some commodity stock-outs they are more likely not to check back again. In addition, it was noted that no guidelines or policies on youth-friendly service provision were physically available at the health centres to act as reference documents by clinic staff when offering service. It is likely that service providers may end up not following proper procedures when administering services. The situation is worsened by the fact that the health centres were not offering youth-friendly services and Comprehensive Sexuality Education beyond general counselling because the staff are not trained. Hence the absence of skilled health care staff on providing youth-friendly SRH services is a concern in Binga. This explains the negative attitudes of some staff at the health centres as reported by the young people.

b) Cultural barriers: -These relate to harmful gender norms and practices, restrictive myths, misconceptions, and stigma around adolescent and youth sexuality including the use of some SRH services and commodities. [14] There were reported misconceptions around the uptake of oral contraceptives with some sections of the community arguing that they cause infertility or some illness. The same cultural beliefs and unfounded fears surround the uptake of VMMC among young people in Binga.

c) Socio-economic barriers: - These are the same as structural issues; social, or economic pressure that prevents people from the low social classes from moving over to access SRH services like those from more affluent classes. [15] This might be the cost of services or distances to health centres. There are cases where commodities and services might be available, and the health centres within reach, and everything in order around the 'youth friendliness' of services, but there is always this social restraint, especially among young people that makes them avoid the health centres. This is also compounded by individual perceptions; fear, and stigma at accessing SRH services as well as discrimination and judgment by communities, families, partners, and service providers. [16]

13. Ninsiima et al.2021. Factors influencing access to and utilisation of youth-friendly sexual and reproductive health services in sub-Saharan Africa: a systematic review, Reproductive Health, 18:135
14. Ibid
15. Ibid
15. Ibid

For example, the rapid assessment noted that SRH services were available in a majority of cases, and were offered free of charge, but there is significant underutilisation by young people. This is explained by a lack of knowledge and awareness of their use and rationale. It is the same case with the existence of reporting mechanisms on service provision. All these have remained underutilised by young people with young people noting that they were not even aware the suggestion boxes existed, and what purpose they were meant to serve.

Given the foregoing, below are some recommendations on policy options for strengthening access to SRH youth-friendly services in Binga and other communities elsewhere facing resource constraints. This is taken right from the health centre level, ward, district, and up to national level policy considerations. The options are informed by the current situation obtained in Binga regards young people accessing SRH services, and in acknowledgement of existing opportunities and the good work the MoHCC and Ministry of Youth and other development partners are doing to facilitate young people's engagement and participation in issues that affect them including the provision of SRH services:

Health centre level: The two health centres; Sianzyundu and Simatelele clinics do represent the MoHCC at the community level and provide an important intersect with communities for the fulfilment of the national health objectives and the right to health care as per the Constitution of Zimbabwe.

- Through the HCC, health centres should always be adequately stocked with SRH commodities. This is something that the HCC should advocate for through the Results Based Financing (RBF)mechanisms and the Zimbabwe Assisted Pull System (ZAPS). [17]
- HCC should be the interface between the community and the health centre. The former should include and accept young people within the structures where they are on equal terms in decision-making and responsibility on issues of concern. This includes meaningful representation and participation of young people within the HCC as opposed to just symbolic representation.
- Health centres should be community-focused with regular consultations with the wider community, young people, and the local leadership on matters of improving the quality of services. This strengthens feedback mechanisms which are key in public resource management.
- Through the HCC, health centres should allocate part of the money from the RBF to adjust. or renovate the physical infrastructure at health centres and make it accessible to people with disabilities. This includes the construction of ramps for wheelchair clients and adjustments to toilets to make them more spacious and user-friendly to clients for wheelchairs and those using crutches. Attach picture here
- The HCC and health centres should embrace the Social Accountability Monitoring for Sexual Reproductive Health and Rights (SAM4SRHR) Model as a best practice model for promoting uptake and strengthening access to youth-friendly services, especially in resource-constrained settings like Binga. This is an efficient, self-regulating working model which places young people at the centre (i.e., the Mentees) reaching out to fellow young people, generating demand for services, and linking them to the relevant SRH and other health care services.

17. This is a national medicine and commodities distribution system that is done by Government with support from the United Nations Development Programme (UNDP). Health facilities place their orders on quarterly basis depending on their stock levels and consumption. It needs very strong stock monitoring and projection to order enough, and not have stock-outs in between that will impact negatively on service provision. Rarely do they make emergency orders.

It is an open-ended, low-cost, but high-impact model that not only facilitates active young people's participation and decision-making on issues that affect them, but equally safeguards their welfare for them to realise their full potential in life. HCC should therefore advocate for the adoption of this model by the MoHCC at both district and national levels so that it becomes the official recognised entry point for a mass mobilisation of young people on SRH interventions.

- In a bid to curb the shortage of nurses in the district, HCC should engage the MoHCC at a district level in collaboration with Basilwizi Trust to identify young people with the requisite academic qualifications to enrol and train as nurses. This will ensure that the district has nurses drawn from the same community and are likely to stay in the district and serve the communities well.

Community level: The community with its institutions which range from political, traditional, cultural, and religious is home to a majority of the barriers to accessing youth-friendly SRH services. It is where harmful cultural norms, myths, misconceptions, and practices that deter young people from accessing SRH exist inherent. Below, are some proposed recommendations for community leadership, and these can be escalated, or replicated at the district and national levels:

- The community, and/or traditional leaders across the villages and wards in Binga should work together with Basilwizi Trust and HCCs as allies to the health centres. This will strengthen the relationship between the health centres and the communities with the latter appreciating more the different SRH services available at health centres for young people.
- The community leadership should also serve as community SAM4SRHR champions within their context so that when the young Mentees are going about their outreach, the champions are there to support them to enable reaching out to all their peer leadership and young people across the wards.
- Community leaders should be at the centre of addressing, and/or challenging some harmful traditional and religious norms, belief systems, and practices entrenching sexual violence, and child marriages, and deterring young people from accessing SRH services. The notion that traditions and culture do not change no longer holds. Traditions and indeed harmful social and cultural practices are undergoing transformation with community-social agency challenging the harmful gender norms and cultural practices. This journey and agency for gender norms transformation should be championed by the community leadership be it political, traditional, or religious.

Rural District Council level: The Rural District Council represents the government at a local level. Therefore, its work for young people should among other priorities be to advance the interests of young people who represent the demographic dividend of any community and the country at large. The following are some of the key recommendations for policy consideration at that local level:

- The Binga Rural District Council should strengthen partnerships with line Ministries like the MoHCC, Ministry of Youth, and other development non-state partners like Basilwizi Trust on interventions focused on strengthening SRH information dissemination and services within spaces meant for recreation and sporting for young people.
- The Council should continue to mobilise more resources to construct more spaces for recreation and sporting activities for the youths. The same partnerships should see the refurbishment of youth-friendly centres at health centres and the setting up of others where they are needed. The proposed idea of constructing a stadium is a welcome development and Council is advised to reach out to the private sector around Binga and Lake Kariba, and even engage eminent people in business, politics, and sports who trace their origins from Binga and surrounding areas to fund such initiatives. Once these recreation and sporting spaces are established, they also serve as centres where young people can receive SRH information and services.
- In that regard, Council should through its Social Services Department, or Social Services Committee reach out to Basilwizi Trust so that the Department can also appreciate the activities of the SAM4SRHR Mentees whom they can partner with and support during their Committee visits in wards. This will allow for the Mentees to reach out to a wider constituency of young people in the district. Through the partnership with Basilwizi Trust, more Mentees should be trained to increase their reach across the wards.

Parliament of Zimbabwe: Parliamentarians in their representative, budgetary, oversight and legislative roles have key roles in strengthening the availability and access to youth-friendly services in Binga. Parliamentarians do command a huge constituency that stretches from the village to the national level. These are spaces where they do not only influence policy making, but implementation and the resources that should be allocated. For Binga district, Members of Parliament should in collaboration with their constituencies and development partners consider the following:

- Ensure that part of the Constituency Development Fund is allocated towards the refurbishment of youth-friendly corners/spaces, and replenishment of SRH service supplies.
- Partner with HCC in strengthening the relationship between the health centres and the wider community, and ensuring that young people's health issues get addressed.
- Advocate for the allocation of at least 15% of the national budget to the health sector during the national budget consultations and in Parliament, and monitor to confirm the eventual allocation fulfils submissions by communities and young people during the public consultations.
- Partner with the Ministry of Youth and Health and mobilise for more resources to

strengthen edutainment activities, and ensure that SRH messaging for young people is always integrated with the various activities that happen within and around the recreation and sporting spaces.

- Serve as SRH allies and champions supporting the work of SAM4SRHR Mentees. This should include creating platforms for the Mentees to showcase and document their experiences of working with other young people to strengthen access to youth-friendly SRH service.
- Mobilise young people to take up social voluntarism within communities and let them embrace this as a positive norm for strengthening the socio-economic entrepreneurship and resilience of young people.

Ministry of Health and Child Care: This is the parent Ministry for all health interventions across Zimbabwe, and its purpose includes achieving equity in health by directing resources and interventions to the most vulnerable in society. This includes services that must be offered within all constitutional provisions which anchor on equality and non-discrimination:

- The Ministry should ensure that all existing guidelines, policies, and standards for SRH youth-friendly service provision are available at all health facilities.
- In cases where these Guidelines are yet to be available at a national level, the Ministry has a responsibility to ensure that international best practices as per WHO Global Standards for Quality Health-Care Services for Adolescents are referred to for use across the country. [18]
- Such documents should be made available at all health centres as full printed documents, or abridged versions. This includes the National Adolescent and Youth Sexual and Reproductive Health Strategy II (2016 – 2020) and the 2016 National Guidelines on Provision of Clinical Sexual and Reproductive Health Services. These two documents were reported not available at the health centres in Binga at the time of the rapid assessment, yet these are strategic documents that provide guidance and continuous learning for healthcare staff at all locations in the provision of especially youth-friendly SRH services.
- The Ministry should further ensure that where abridged versions of such documents are made available, they should be in the local Tonga language. This includes all other IEC materials that have to be in the appropriate local language, and in relevant acceptable formats for comprehensive access by all including young people across health centres and other spaces that young people in their diversity frequent for recreation or sporting activities.
- The Ministry should in addition to the IEC materials ensure that all signage at health centres is captured in the local language. This strengthens entry-point access to the health centres and avoids situations where some young people are deterred from checking in because they are not able to read and comprehend the language of instruction, and/or service provision.
- All healthcare staff should be trained in CSE and the provision of youth-friendly SRH services. In fact, the provision of youth-friendly SRH services should be included in

18. The MoHCC developed the National Standards for the provision of Youth Friendly Services in line with requirements of the WHO Global Standards. The Implementation of the standards were piloted across the country in twenty (20) high burden Districts covering a total of 356 facilities out of a total of 1800 facilities in the country in the following provinces: Mashonaland East, Mashonaland West, Mashonaland Central, Matabeleland North and Matabeleland South. Note that the MoHCC reports that were the basis for the desk review for the rapid assessment are based on field reports that have not yet been published and partly through telephone conversations with the Officers from MoHCC during the assessment.

especially the nurse training curricula so that it is embraced at inception as the core within the functions of nursing.

- In-service training of nurses on the provision of youth-friendly SRH services should also be done through partnerships with the Zimbabwe National Family Planning Council (ZNFPC) and other development partners.
- The Ministry should also ensure that upon deployment health centres do have young female and male nurses who will facilitate engagement with young people and the provision of related SRH services. This is good for balancing the generational and experience gap with young clinic staff that the youths can easily interact with.
- There is a need for the intertwining of roles of the Village Health Workers (VHW) under MoHCC and the Community Based Distributors under the ZNFPC to ensure that all health centres, and/or wards are equipped with people responsible for distributing family planning services to those who require them.
- The Ministry should prioritise the establishment of stand-alone Youth Friendly Centres to promote information sharing, access to SRH, and other essential services for adolescents as guided by the MoHCC Guidelines. This also means the need for a budget to cater to the infrastructure and supply of the different SRH commodities and services. Whilst, there is a transition to the health facility, school, or community-based approaches to youth-friendly services, the standalone approach to youth-friendly centres, or even corners remain relevant under resource-constrained settings. These centres should be used as youth hubs; platforms where young people can meet and discuss issues of concern.

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Page 4 Picture – Youths from Simatelele Ward discussing SRH issues supported by Basilwizi Trust

Page 5 Right Picture - Danisa Mudimba programmes manager for Basilizwi Trust conducting SRH session with youths

Page 5 Right - Caaba Muzamba from Sianzyundu Ward conducting an SRH session with youths from her community supported by Basilwizi Trust

Page 7 Left Picture – Mamanino Simonzyo from Simatelele Ward in Binga District conducting an SRH discussion with adolescents in her community supported by Basilwizi Trust

Page 7 Right Picture – Yegan Mudhenda standing at Simatelele Clinic youth-friendly room allocated by the clinic to be used by youths. The youth-friendly room was yet to be equipped by end of 2021

Page 9 Left Picture - Youths from Simatelele Ward and Sianzyundu Ward soon after attending an SRH session in Binga District supported by Basilwizi Trust

Page 9 Right Picture - Young mothers being assisted at Simatelele clinic in Binga District

Page 12 Left Picture - Soneni from Simatelele Ward conducting an SRH session with adolescents from her community supported by Basilwizi Trust

Page 12 Right Picture - Adolescents from Simatelele ward in Binga soon after attending an SRH session supported by Basilwizi Trust

Page 18 Left Picture - Adolescents from Simatelele Ward soon after an SRH session supported by Basilwizi Trust

Page 18 Right Picture – Youths from Simatelele Ward holding an SRH booklet provided by Basilwizi Trust

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