GET UP SPEAK OUT for youth rights

PILOTING THE COMMUNITY SCORECARD IN THE GUSO ALLIANCE IN ETHIOPIA

Effects of a Youth-Led Social Accountability Intervention Implemented in Addis Ababa

ETHIOPIA GUSO ALLIANCE

TALENT YOUTH ASSOCIATION

YNSD

DEC

aidsfonds CHOICE FOR YOUTH & SEXUALITY dance4life IPPF Rutgers Simavi

Supported by: Ministry of Foreign Affairs

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

This social accountability research report is developed within the context of the Get Up Speak Out for Youth (GUSO) programme. We have many people to thank for their efforts and commitment in producing this report. First and foremost, the volunteer young change agents, adult members of the local community, health facility staff and staff from member organisations of the Ethiopia GUSO alliance. They all have devoted their time and energy to being part of this study and we are very grateful for that. Atsede Gidey (former national programme coordinator for the Ethiopia GUSO Alliance) played a central role in the design phase of the study. We are most thankful for the excellent coordination of the research in Addis Ababa by Dagem Demerew (Youth Country Coordinator for the Ethiopia GUSO Alliance) and Eyasu Amante (senior programme officer at the Family Guidance Association of Ethiopia). Hawi Shemelis, Yabtsega Getachew and Rekik Ketema were the co-researchers in this study. They managed to collect the data while adapting their methods to the COVID-19 regulations in place. Their flexibility and commitment were very important to the success of the study. Finally, we are grateful for the financial support of the Ministry of Foreign Affairs, The Netherlands, through which we were able to carry out this study.

Research Team:
Dagem Demerew
Eyasu Amante
Rosalijn Both
Hawi Shemelis
Rekik Ketema
Yabtsega Getachew

ABBREVIATIONS

CSC	Community Scorecard
FGAE	Family Guidance Association of Ethiopia
GUSO	Get Up Speak Out
IEC	Information Education and Communication
IPPF	International Planned Parenthood Federation
SA	Social Accountability
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually Transmitted Infections
TaYA	Talent Youth Association
YNSD	Youth Network for Sustainable Development

INTRODUCTION

BACKGROUND

This report presents findings from an operational research that was conducted to assess the effects of piloting Community Scorecard (CSC) activities under the Get Up Speak Out (GUSO) programme in Ethiopia. In 2018, the Family Guidance Association of Ethiopia (FGAE) in Addis Ababa, more specifically in Akaki sub-city, piloted the Community Scorecard as a youth-led social accountability initiative under the GUSO programme. GUSO is a five-year programme (2016-2020) developed by a consortium consisting of Rutgers, Aidsfonds, CHOICE for Youth and Sexuality, Dance4life, International Planned Parenthood Federation (IPPF) and Simavi. The programme is financed by the Dutch Ministry of Foreign Affairs under the SRHR Partnership Fund. The GUSO programme addresses the following problem: "Young people do not claim their sexual rights and their right to participation because of restrictions at community, societal, institutional and political levels. This hinders both their access to comprehensive SRHR education and services that match their needs, and also their ability to make their own informed SRHR decisions." The GUSO consortium addresses this problem in seven countries: Ghana, Kenya, Uganda, Malawi, Indonesia, Ethiopia and Pakistan.

One of the five core outcome areas of the GUSO programme is to increase access to and utilisation of sexual and reproductive health (SRH) services. One of the strategies under this outcome area is scaling up social accountability systems which actively involve young people and communities in monitoring the quality of health services and multi-stakeholder dialogue with an eye towards areas for improvement. The community scorecard is one of the youth-led social accountability initiatives that has been implemented under this strategy.

SOCIAL ACCOUNTABILITY ACTIVITIES WITHIN GUSO

Globally, increasing attention to young people's involvement in quality of care and youth sexual and reproductive health (YSRHR) standards is a key strategy to ensure services meet their needs. Youth-led social accountability tools provide evidence with which young people can discuss needed improvements with service providers and other duty bearers. 2018 was the first year in which most GUSO countries started using social accountability as a key mechanism by which young people were empowered to hold duty bearers accountable. Two consortium partners, IPPF and Simavi, developed social accountability manuals. In several GUSO countries, IPPF and Simavi have provided training and capacity-building to partner organisations so that they may apply these tools. In the GUSO Alliances, several types of social accountability interventions are used. These include community scorecards, client feedback forms, and youth-led social accountability monitoring. What these different approaches have in common is that they aim to reach and effectively engage with young people in understanding and demanding their sexual, reproductive and health rights (SRHR).

The GUSO alliance in Ethiopia decided to pilot the community scorecard in two health facilities in Addis Ababa. The community scorecard was designed to be conducted according to the following guiding principles: a) The community scorecard (CSC) implementation should be led by young change agents. b) Indicators should be selected by the community and young change agents; healthcare providers should then review these indicators to establish that they are fit for the purpose. c) Participants in the CSC should be at least 50% young people; the rest should be residents/citizens from the local community, healthcare providers and beneficiaries. d) The CSC should be conducted according to the guiding principles of fair scoring and comprehensive knowledge of the facilities being evaluated. e) Results of the scorecard should be communicated in transparent manner during the interface meeting, when young people, community members and healthcare providers come together to discuss the results and agree on an action plan (FGAE, 2018).[1]

1. **Family Guidance Association of Ethiopia (FGAE). 2018. Community Scorecard Assessment. Addis Ababa, Ethiopia.**

METHODOLOGY

RESEARCH OBJECTIVES

This Operational Research aims to understand how social accountability initiatives in Ethiopia contribute to empowering the young people involved and improving the quality and inclusiveness of SRH services for young people in general. The objectives of the research are:

1. To understand the effects of involvement in social accountability processes on young people themselves.
    a. How are young people involved at each stage of the process?
    b. How does being involved in social accountability processes enable young people to better articulate, voice and express their concerns regarding service delivery?
    c. To what extent do young people have a better understanding of their SRHR rights through their participation in social accountability processes?
    d. What are the dynamics between young people and other groups in the community (e.g., healthcare providers and local officials)?
2. To understand the effects of Youth-Led social accountability (YLSA) on the quality of SRHR services for young people (e.g., changes in the behaviour of healthcare providers, youth friendly corners, inclusivity or changes in policies and guidelines).

STUDY POPULATION AND SAMPLE SIZE

The Operational Research was conducted in Akaki, a sub-city of Addis Ababa, Ethiopia. The community scorecard was conducted in the second half of 2018 in one FGAE health facility (Akaki youth SRH Centre) and one government health facility (Akaki Health Centre). A total of 21 respondents participated in the research, 12 of whom were young people. Of those 12 young people, eight (six male and two female) were involved in the Community Scorecard intervention in 2018. The other four (one male, three female) were interviewed with an eye toward their perspectives as young people who were not involved. All the young people were sampled from change agents aged 10-24 who volunteer at FGAE facilities in the provision of peer education, dissemination of information, monitoring and evaluation and project implementation. They were selected from their respective local communities and work for the community and FGAE and include e.g., males, females, people living with a disability, in- and out-of-school youth and female sex workers. Change agents received several SRH-related capacity building trainings under the GUSO programme.

Adults who were part of the CSC activities in 2018 were also respondents, including two healthcare providers, three senior or management staff from the health facilities, two community members and two staff from Youth Network for Sustainable Development (YNSD) and Talent Youth Association (TaYA), partner organisations from the GUSO Alliance in Ethiopia.

Table 1: Overview of respondents

Respondents	Number of males	Number of females
Young people involved in social accountability (change agents)	6	2
Young people not involved in social accountability	1	3
Healthcare providers	1	1
Health facility senior staff or management	2	1
Community members	2	
Staff from partner organisations	2	
Total	**10**	**11**
Overall total	**21**	

DATA COLLECTION TOOLS

This research was originally planned for March 2020. However, due to the COVID-19 pandemic, it was postponed and data collection methods were adapted to be in line with COVID-19 prevention measures in place in Addis Ababa. The GUSO Operational Researcher from Rutgers provided a two-hour online orientation, dealing with the research topic and draft tools, to the Youth Country Coordinator (YCC) of the Ethiopia GUSO Alliance and three young researchers who are staff from alliance member organisations. After the online training, all researchers jointly worked on finalizing the data collection tools. A separate questionnaire was designed for each set of respondents. Due to COVID-19 regulations, it was decided that most respondents would be provided with paper copies of the questionnaire rather than interviewed in person. The research team would translate their responses from Amharic to English, review them and identify those respondents who should be asked to participate in follow-up phone interviews. In the few instances in which social distancing could be arranged for, face-to-face interviews with individuals were chosen over paper questionnaires.

DATA ANALYSIS

The study findings consist of qualitative data that was transcribed from Amharic to English. Using a thematic approach, the GUSO Operational Research Coordinator created a codebook by reading through all transcripts and creating codes based on the themes and sub-themes that emerged from the data.

ETHICS

Ethical approval for this research was obtained from the Addis Ababa Regional Health Bureau. All respondents verbally agreed to participate in the study. Young people participating in the study were between 18 and 24 years old. They were recruited with the support of a senior programme officer from FGAE who facilitated the CSC intervention in 2018 and who was actively involved in all stages of the research. All study participants were assured that no names or other personal identifiers would be used in the final report. The YCC and three young researchers had experience in doing research on sexual and reproductive health-related topics, and belonged to the same age group as the young respondents.

LIMITATIONS

This study had several limitations. First, due to the COVID-19 pandemic some data needed to be collected via paper questionnaires. This is less preferable than the face-to-face data collection originally planned. However, the research team managed to encourage respondents to write or speak freely about their experiences and there was quite some depth to the data collected. In addition, writing responses down on paper may have given some respondents a sense of privacy that actually encouraged them to share more. Second, the Community Scorecard intervention took place only once, in 2018, so respondents had to think back to what happened then and how it was followed up on. This could have had some influence on the findings.

YOUTH PARTICIPATION IN COMMUNITY SCORECARD ACTIVITIES

The Community Scorecard activities consisted of the following: site selection; the recruitment of participants; a five-day training on social accountability and the scorecard; a second meeting with young people and other stakeholders to review and finalise a set of measurable indicators for adolescent and youth health service standards as per the national guidelines; filling of the scorecard by all involved; an interface meeting and action plan development and follow-up. A simulation exercise was included in the five-day training; this helped young people, under the guidance of a trainer, to practice communication with facility coordinators or managers, healthcare providers and community members. This chapter discusses these components of the intervention as well as some additional topics that emerged from the data.

MECHANISMS OF PROVIDING FEEDBACK PRIOR TO THE CSC ACTIVITY

The Community Scorecard presented a new way for young people to provide feedback on the quality of SRH services. The only way to do this previously had been through oral feedback delivered during face-to-face sessions between young clients and providers. If young people felt comfortable enough to bring issues forward during such meetings, it was the healthcare provider's own decision whether or not to do something about them, for example by bringing the young people's feedback to monthly review meetings. Other avenues for feedback included a suggestion book, which was available in waiting areas and in which young people could write down their comments, and a suggestion box in which young people could leave their written suggestions. Although the box would be opened regularly, the suggestion box was also there for adults and young people would not be aware of whether and how their comments and suggestions would be discussed.

When young people were asked about how they would give feedback on services prior to CSC activities, most said that they would either not visit the facility anymore as a way of expressing dissatisfaction, discuss their complaints with friends, use a suggestion box or have a face-to-face discussion with a healthcare provider or someone in a higher position of authority in the facility. *"Mostly, we expressed it by not visiting the facility anymore"*, recalled one 19-year-old female. Another, aged 22, said, *"Predominantly, using the suggestion box was what we used"*. One person also mentioned that some gave positive feedback by expressing gratitude to providers who had given them high-quality care.

At first, the concept of the Community Scorecard was not clear to all. Some thought it was to be used to monitor healthcare providers and take administrative actions such as firing them. After the training and orientation, the concept became clearer to those involved.

RECRUITMENT

Staff from partner organisations agreed that all the young people who participated in the CSC activities belong to and are representative of the community where the facilities are located. A 32-year-old female said, *"Yes, they are young people recruited from within the community and thus represent the community. Male and female, youth with disability, in and out of school are represented."* As this illustrates, it was also felt that the group of young people participating was a diverse one. One partner organisation (PO) staff member mentioned that *"young people with vision loss have participated while being partnered up with other young people that will lead them and describe the scenario and setting"*.

Young people involved in the CSC activities remembered being recruited because they were already active as change agents in the participating health facilities. They also recognized that a desire for gender diversity had been a factor, as had the fact that they all belonged to

a wide variety of groups of young people from the community that the facilities are located in. One 22-year-old female explained that "*I got the chance to participate in this activity after being evaluated for my previous participation in the facility. They have found me to be highly participating in FGAE and its different activities*". However, some also pointed out that the recruitment or selection procedure itself did not involve young people. According to a 19-year-old female, "*There wasn't a selection procedure. It wasn't a process that involved young people*". In addition, a 22-year old female said, "*The selection process was mainly carried out by higher officials in FGAE and youth committee*".

It is unclear whether some of the change agents involved as respondents in this study were themselves HIV positive or living with a disability as this was not specifically asked for on the questionnaire. When asked, a 19-year-old female shared "*We make sure [young people living with a disability] are involved in every step of our activities, from the planning to the implementation. We also make sure they are involved in the discussions platforms that we host so that they are able to share their ideas and comments and get answers for their questions*". This was echoed by most respondents, who said that the people living with a disability who had been involved gave constructive and useful input. Specifics about the inclusion of youth with disabilities were also discussed; one 22-year-old female explained, "*Young people have been working on facilitating easier steps to help young people with disabilities to have an easy working experience. We have also worked on making different materials and resources that are tailored for young people living with disabilities available*". Some participants felt that it was unclear whether young people living with HIV were also involved; one 21-year-old male said, "*On the contrary, known people living with HIV AIDS haven't been involved in the process, because we don't know who has HIV or not*".

Some young change agents who were not involved in CSC activities mentioned that they considered those who were involved well-suited to represent them, as they were from diverse backgrounds. They themselves, they said, had either not been around at the time of selection or hadn't have sufficient information about taking part. As one 21-year-old female summarised it, "*Yes, they were fairly selected from change agents. [...] I think they represent for young people because they come from all walks of life. [...] I couldn't participate because I was not there at the time*".

The participating community members felt that they had been recruited either because they were frequent visitors to the facility or because they were active in their community. A 37-year-old female explained, "*The clinic coordinator asked me to participate through telephone call and I said 'okay'. Because I have been using contraceptive from the clinic. I think they know me that I am consistently visiting the clinic on my appointment dates and I always tell them I am happy with their services*". The other community member, a 45-year-old female, added, "*I have been an FGAE, Akaki Health Centre project advisory committee member at the time of the assessment. And also, I am local community women's association chairperson. I think they approached me due to my visibility in the community*".

MOTIVATION

The main motivation for most young people who participated in the intervention was to be involved in enabling change for themselves and their peers, something that had also been their motivation when signing up as a volunteer. One 19-year-old female said, "*I figured, if I have questions then other young people who have no exposure to SRHR services will have their own questions too. For that reason, I wanted to be a part of a movement that could help me and others*". In addition, a 22-year-old female said, "*By becoming a volunteer, I was motivated to be among the people that were working to solve problems we have within our community. Unless we are part of the solution, we are part of the problem, and being able to bring about change in my community motivated me*". Other young people mentioned being motivated by the newness of the scorecard approach and their desire to learn about it; some also said they were specifically interested in reducing the gap between healthcare providers and young people as a way of improving the quality of SRH services.

Healthcare providers, for their part, reported being motivated to participate in the CSC intervention both by the fact that they were asked to do so and a desire to improve the

quality of SRH services by identifying 'weak spots' that could be improved upon. One female healthcare provider said, *"The thing that motivates me is that it is a new approach and it shows me our weak side"*. Community members were also motivated by the opportunity to see improvements in services: *"Yes, I guess the assessment should involve the community. Because sometimes when we go to clinic for some services, they say there is no supply and no service. But we have to know why they are not providing the service. Such activity is good to understand the situation"*.

INCENTIVES

Young people involved in the CSC intervention were asked whether they received incentives for their involvement. Most of them agreed that they were given sufficient compensation for transportation and other financial expenses. In their responses, young people pointed not only to material incentives but also non-material ones, saying they obtained information and knowledge as well as networking opportunities. A 22-year-old female said, *"First, I was able to get a lot of information and knowledge. […] And finally, I have been fortunate enough to increase my knowledge by networking with different people that helped me gain access to useful information"*.

Five young people mentioned that they would have liked to receive a certificate recognising their contributions to the process. A 22-year-old male explained: *"The young people working on this are volunteers and they need to work on their future. So it would be best if a certificate is prepared for these volunteers to help them get recognitions for what they worked on"*. It was also suggested that more opportunities, such as access to further education and training, could be created. This was explained by a 22-year-old female, who opined, "*Some of the young people involved have dreams of getting certain trainings, like language schools, driving license trainings and fashion designing or hair styling trainings. I suggest, if certain opportunities could be prepared for participating young people, it would be a great motivator for young people to work better"*.

SOCIAL ACCOUNTABILITY TRAINING

FGAE organised a five-day social accountability training for young change agents, programme officers, healthcare providers and representatives of the local community. From what young people remembered of the training, it covered many issues. First it dealt with general topics like what SRHR is, youth reproductive health, gender, contraception and sexually transmitted diseases. Relevant national polices, guidelines and health service standards for young people were reviewed to select appropriate indicators.

Next, issues related to communication were covered. Young people really appreciated this part of the training and remembered many of the details. A 21-year-old male described the focus of the training as *"How we can address issues in the community and how we can make people become more attentive to solving those issues? What way we can use to communicate formally with community members, like choosing our language and our attire?"*. A 22-year-old female also explained it very well, saying, *"We discussed topics about how we can be received when we go into the community to work on different activities and in relation to that, how we can listen to and understand comments and concerns raised by members of the community. We also discussed points about how we should be dressed and how we should address certain people, mainly about formal attires and formal ways of communicating with people. We have also discussed on how we can approach anyone with the issues we want to raise; it should be with kindness and openness"*.

The training also had a component on inclusiveness and disability. A 22-year-old female captured that part of the training as follows: *"Topics such as […] whether young people living with disabilities have convenient entrance and exit areas in and out of the service facility, how people with vision loss could get written materials in braille so that they can stay informed, whether healthcare providers with the ability to speak sign language are available in the facility, whether the service can be provided in a comfortable way for people that speak different languages"*.

Young people's sexual and reproductive health rights were also part of the training. In fact, young people felt this was the key issue throughout the training, as explained by this 21-year-old male: *"Young people's SRHR rights are important because it would mean young people would know and seek out the services in a youth-friendly way when they need to"*. Finally, practical issues were dealt with, such as how to register issues on the scorecards and how to categorise them.

Young people also mentioned they would like training on other topics, especially youth leadership skills. They also wanted more advanced communications training, on topics such as messaging and how to choose appropriate language when speaking to different people. Finally, they expressed an interest in further improving communication between youth and adults by learning more about planning, monitoring and evaluation and special needs.

PARTICIPATION IN EACH STAGE OF THE PROCESS

DESIGN OF THE SCORECARD

According to PO staff, youth were actively involved in designing the scorecard: *"Youth picked out, in review of documents on FP, STIs or HIV, questions for the community scorecard"*. Young people themselves had mixed views with some saying that there had been a low level of participation by young people or that not enough preparation work had been done. Others felt there was sufficient participation, noting that young people brought in the issues of making services more accessible to people living with a disability and availability of IEC materials as points that needed to be assessed. The two community members were equally involved in this process. They reviewed SRH-related documents, suggested indicators, came up with questions and shared their own experiences as clients at the clinic (e.g., how convenient it was for them and the sorts of interactions they had with healthcare providers).

FILLING OF THE SCORECARD

Regarding filling of the scorecard, a 21-year-old male participant explained that *"I was not alone in filling out the scorecards. Four young people, healthcare workers and community representatives were involved"*. Staff from PO's further elaborated that youth were assigned to be leaders of each group. Healthcare providers confirmed that they also filled in the scorecards. One female healthcare provider recalled supporting the assessment team by explaining the services that were available in the clinic and noting which of these were SRH services. The same healthcare provider remembered some of the issues that were discussed, saying, *"It was punctuality. Shortage of healthcare providers. I was the only healthcare provider at that time. The bathroom was not convenient for people with disability. These are what I remember from the finding"*.

THE INTERFACE MEETING

Participants in the interface meeting were similar to those who attended the five-day social accountability training. The interface meeting was set up not as a formal question-and-answer session but rather a discussion between young people and adults in which ideas and questions were shared back and forth. Young people appreciated this kind of discussion. In the words of one 19-year-old male, *"there was a common ground and equal opportunity for participation and communication of young peoples and adults"*. Young people felt that the training had prepared them with the knowledge they needed to speak confidently and freely during the interface meeting. A 19-year-old male said, *"Yes, I was fully able to express my ideas during the interface meetings with society and health providers. I wasn't afraid because I have knowledge and information on SRH"*. In general, young people felt that healthcare providers tried their best to respond to their questions and there was a free discussion on each topic. Some change agents remembered the questions they brought up during the interface meeting:

"Some of [my comments] were about making [sure] the services are comfortable for both genders and lastly, since there are people with different background seeking service, we need to make sure that the services provided are given to all of them in an appropriate and comfortable way." (female, 22)

"The questions that are raised by young peoples are to make the health centres and youth facilities easily accessible and to create an environment that make the youths comfortable. Also, they raised [the point] that the service providers should be persons that are easy to communicate to and honest. The questions that are raised in meetings are accepted and addressed by health providers and adults." (male, 20)

All young people agreed that the healthcare providers were open to hearing and responding to their questions. However, some of them did feel that they were not able to get a satisfying response to each question. They also noted that action was not taken on all the issues that they raised, saying, "*Us young people, we would like to get detailed answers to the concerns that we raise. We haven't been able to get that to some of the questions that have been raised"* and *"They were very open to receive the questions raised and they have tried to answer them as well but I believe there is some gap when it comes to putting their answers and what they said into action"*.

Healthcare providers involved themselves by providing information and responding to the opinions and concerns shared by young people and community members. According to one female healthcare provider, "*They have been asking questions from the community scorecard, filling the answers and questioning me about the services and how I provide the service. They are involved in the process and it was interesting to see them in the process. Working together with them as a team"*. She added that young people discussed their results with confidence and that they were active participants. PO staff agreed that healthcare providers were positive and supportive in the process. They did speculate, however, that the health facility staff might have been 'also a bit scared of' the young people, who were both highly honest and highly critical; they might also, PO staff observed, have found the process 'to be slightly intrusive' or thought that it 'undermines the work they have so far been doing'. In addition, one community member thought that healthcare providers' responses were sometimes a bit defensive. They replied that it was not their fault, for example, when questioned about the fact that HIV tests were not always available, and when it was pointed out that rooms were not wide enough to accommodate wheelchairs passing through. However, the overall impression was that healthcare providers supported the process.

COMPILATION OF ACTION PLANS

Most young people felt they were involved in the compilation of action plans, although they didn't provide many details about this. A female PO staff described it as *"They do action point monitoring of the action plans (…) they compile the data and summarise findings with actions points and schedules"*.

YOUTH-FRIENDLINESS OF THE CSC

Clarity of indicators
Nearly all young people found the indicators on the scorecard simple and clear. A 21-year-old male explained that *"They were very clear. We were all involved when the questions and indicators were identified, so the fact that young people had participation in the creation of the questions made it clear and simple"*. Indeed, the fact that young people and community members were involved in choosing the indicators made them easy to relate to. Only one young person found some of the indicators a bit confusing.

Do the indicators on the Community Scorecard cover young people's needs?
Most young people felt that the indicators covered their needs, reporting that "*They have mostly been prepared in collaboration with young people so there has been focus that has been given to the questions and indicators revolving on topics of young people"*, and *"Yes, they do cover important areas. I am also a young person and I believe I related with the questions and indicators on the community scorecard. If I related to them and if I believe they are also my needs, they I can safely say that other young people would relate to them too"*. A few young people felt that not all issues important to young people were well-reflected by the indicators. One said, *"I don't believe all the important issues relating to the needs of*

young people have been included in the community scorecards but still, some have been mentioned to some extent".

Does the Community Scorecard look attractive to young people?
Regarding the look and design of the Scorecard, opinions were divided. Some felt that the aesthetic was attractive and appropriate for young people, a view supported by one 19-year-old-female, who said, "*They are attractive. This is because [young people] have been participating in the meetings leading up to the preparation of the Community Scorecards. Our ideas were taken into consideration so that it becomes more appealing and attractive for young people".* Several other participants, on the other hand, felt that improvements could be made. A 21-year-old male explained that *"It is good but it is not great. I think there is a potential to make it even more attractive and more appealing for the youth. I think it is best to work on that for the future".* A 22-year-old male added, *"It would be more interesting and attractive to young people if the young people design the community scorecard by themselves".*

DYNAMICS BETWEEN YOUNG PEOPLE, HEALTHCARE PROVIDERS AND ADULT COMMUNITY MEMBERS

COMMUNITY NORMS REGARDING YOUTH PARTICIPATION

Through the Community Scorecard (CSC) intervention, the Ethiopia GUSO Alliance aimed to give young people a platform for voicing and claiming their sexual and reproductive health (SRH) rights. Discussions with adult community members and healthcare facility staff about the quality of SRH services were key to this process. Young people involved in the CSC intervention expressed the view that, in their community, it is not very common or easy for young people to approach adults and have an open conversation with them. According to one 21-year-old male, *"It is difficult. This is because in our community, it is considered to be taboo to talk openly with adults. Parents and young people don't have a good relationship regarding having an open conversation in their households. Parents and guardians don't have the practise of raising their kids by allowing them to speak freely and ask what they want in the house"*. Another participant shared the thought that *"Young people are mostly scared when they speak with adults. They are shy and are not willing to open"*.

The young people involved in the CSC activities have long been active as GUSO change agents. As such, they have experience working on sensitive, SRH-related topics and they have dealt with negative feedback from adults before. Several young people shared that they often felt judged by adults when speaking out on such topics; some adults used to portray them as badly-raised deviants. This was sometimes demotivating for the young people and they shared the following:

"The most common beliefs and ideas in my community are: 1) The issue of sexual reproductive health are only for adults; 2) Discussion of reproductive health deviates from culture; 3) Discussing and talking about reproductive health is taken as being bold and immoral; 4) They connect sexual reproductive health with religious issues and they argue that it is not useful." (male, 19)

"They think that we are young people with obscene subjects to talk about so that they immediately think that we are there to teach their kids or other people bad behaviour. They also think that what we are there to talk about and what we are doing is completely out of the context of our culture. For this reason, they go off judging the way we grew up and the way our parents raised us." (male, 21)

However, many youth also reported that thanks to the CSC intervention, and perhaps also other GUSO interventions, they are witnessing positive changes This was well summarised by one 22-year-old female, who described community attitudes as increasingly friendly and detailed the strategies young people have been using to accomplish this:

"Yes, it was somehow difficult. This is because, while we were working on SRHR issues in the community, they have had raised plenty of questions related to the subject. If we were not able to answer those questions in a way they find acceptable or appropriate, they will immediately start judging us and deem us to be incapable of doing the job. At times, they are not open to listen to the ideas we raise or the opinions we share. They would consider us to be deviant and sometimes throw some insults at us. At other times, they try and make a connection with some religious views that has nothing to do with the topic and attack us through those views. But even through all these challenges, we try and connect with members of the society that have a high-standing position in the community, such as religious leaders, elderlies in the community and young people that are known to be accepted and listened to by the adults. We try and gather with these members of the community so that they understand what our views are and they are informed about the issues we are trying to educate others."

POSITIVE CHANGES IN RELATIONSHIPS BETWEEN YOUNG PEOPLE, HEALTHCARE PROVIDERS AND OTHER ADULTS

Adults seeing young people as competent enough to share their views about SRH service delivery
One female healthcare provider noted that FGAE provides different SRH-related trainings to the young people involved in the social accountability interventions. This, she felt, contributes to young people being knowledgeable and able to share competent views on SRHR issues and service delivery. This provider went on to say, *"I think they can make decisions on their health. For example, if a girl encountered unwanted pregnancy and want safe abortion, she can make her own decision. In addition, I think they can bring impact the decision makers and healthcare providers by their participation"*. Regarding the interface meeting, she said, *"I felt that young people can claim for provision of service and I understood that they are among the decision makers if the service not provided friendly"*. A Medical Director from one of the facilities added, *"Yes, but it is difficult to say they are 100% interested. Most of them may be interested, but it requires capacity-building and adequate training for young people to make an informed decision on reproductive health and service delivery"*.

Relationship between healthcare providers and young people
Most young people involved felt that the relationship between their peers and healthcare providers had improved because of the Community Scorecard process. This positive change was noted in several different aspects. First, the process created more friendliness between young people and healthcare providers, as a 19-year-old female explained: *"The Community Scorecard process has played a great role towards improving the relationship and interaction between healthcare providers and young people. The friendliness and understanding between the two is one of the changes that I can mention"*. One of the healthcare providers recognised this too, and shared the same feeling. She said, *"We discussed friendly and openly with young people just like as a friend. It allowed us to more closely discuss with young people during the assessment"*.

Secondly, the process made young people feel freer to openly share their thoughts with healthcare providers. A 22-year -old male explained that *"Previously, it was uncommon for the young people to share what they have experienced to the healthcare workers openly. But this has begun to change through time"*. Finally, it was felt that healthcare providers underwent a more intrinsic change in the way they personally felt or thought about young people and their SRH. As one 22-year-old female put it, *"It has also changed the way some healthcare providers used to think, like their views on SRHR issues or their views on young people in general"*. Still others felt more remains to be done; a 21-year-old male said, *"[Healthcare providers] have better relationship with young people. But there is still more work to be done. The relationship the health workers have with most of the young people is not as satisfactory as it should be"*.

Relationship between young people and community members
Young people initially felt resistance from adult community members, with whom they reported finding it difficult to communicate about sexuality-related issues. However, they did notice changes in adults' attitudes, which motivated them to continue with their work.

"As I have mentioned previously, the way the society thinks about these issues made things difficult and sometimes having to work under these conditions was disappointing for me and it affected me. But nowadays, I have started to witness the changes that are currently underway and I am inclined to work more and bring about more change to the society." (male, 22)

"All in all, we have tried, to the best of our abilities, to change the minds of the community and change the views they have had on these issues. Although the change is small, we are very happy with the result." (male, 21)

Opinions from community members themselves reflected this positive change in mindset. A 45-year-old female said, *"Yes, because working with them is different from judging young people from a distance. The more I become closer to them, the more I become familiar with them and understood that they are knowledgeable about SRH and YFS"*.

EFFECTS

EFFECTS ON YOUNG PEOPLE

The young people involved in the CSC intervention unanimously felt that **their voice was being heard** throughout the activities. They regarded the atmosphere in which the discussions took place as one of mutual respect and listening between young people and adults. This was an important factor in the free and open exchange of ideas, opinions and concerns. Young people considered it a great experience. One 21-year-old male said, *"Yes, we were all speaking freely because we weren't scared. I personally have been asking questions and giving comments on a lot of issues freely"*, and a 22-year-old female observed that *"The young people involved were discussing freely. They were free to voice their opinions and concerns better than other times. Ideas were flowing back and forth easily and with full transparency"*.

The young people noticed adults accepting their opinions and concerns and taking notes occasionally; they also saw some real change occurring when it came to areas for improvement that they'd pointed out. This made them feel like their input was taken seriously. To this end, a 22-year-old male said, "*I feel like the comments and concerns I raised have been taken seriously because [...] I have been able to see changes to some extent and the comments and points of improvements I have raised are a part of the changes I have seen*". A 21-year-old male echoed this sentiment: *"My ideas were well received and taken seriously. I have shared my thoughts freely and they have accepted it and took notes from it"*.

Finally, young people felt **confident** about the ideas they brought up. This made them feel free to speak. A 20-year-old male explained, *"Yes, because I think the young man's ideas are good for the community and for the healthcare providers, so I was free to express myself"*. A female PO staff member said that *"those [young people] that we were able to reach showed significant confidence and ability to share what they have gained through the programme [...] it's actually quite rewarding to witness that"*. Healthcare providers also noticed the increase in young people's confidence levels. A female healthcare provider said: *"Yes, after the Community Scorecard they become more demanding and asking for some improvements they observe. For example, they request for Wi-Fi internet service to be available and the youth centre did according to their request. This is an indication for their involvement in addressing their demand and impacting the youth centre."*

EFFECTS OF THE TRAINING

Young people involved in the CSC intervention also talked about several positive effects of participating in the training. They felt that it taught them how to solve problems and how to communicate well with different groups of people, as well as a better understanding of young people with special needs. The thoughts that were shared included:

"I have managed to create a great relationship with the community that we work in and I have managed to communicate easily and have a common understanding. Besides that, I have managed to get closer with people with special needs." (male, 21)

"As an example, I can mention that with the training I received on communication it helps to have a good communication with adults. There was an adult who had a problem of understanding about reproductive health but I was able to change that attitude during open discussion." (male, 19)

"I have learnt how to approach different members of the community when we work on issues regarding SRHR and how to create a good relationship with them." (female, 19)

EFFECTS AT A PERSONAL LEVEL

At a personal level, two young people also shared:

"Yes, I used the information for myself and share it for other in different times and situations. As an example, from the information I got from the SRH training, I went to clinic and took a HIV test. In addition I got a chance to discuss with my sister about menstrual cycle." (male,19)

"I can mention that after the SRH training I took a test for HIV and advice my friends to take the HIV test." (male, 20)

EFFECTS ON HEALTHCARE PROVIDERS

Only two healthcare providers were involved in the CSC intervention and as respondents in this study. At a personal level, one 29-year-old, female healthcare provider experienced a positive transformation in the way she engaged with young people. She told her story as follows:

"Before [the intervention] I didn't even show any smile to young people. After the assessment I have been able to entertain and communicate in a friendly way and able to closely approach with young people. My communication with young people was improved. Most of the time, I have been arriving late to office. During the interface meeting they raised the issue of my punctuality and it was taken as an action point of the assessment finding. They claimed that clients are waiting for long time until she arrives, interrelating the issue with client satisfaction. Based on the discussions, I noticed that I am not only accountable for the clinic coordinator but also for the young people and community. I became punctual afterwards. My way of providing was changed to more friendly approach with good communication and interaction with clients."

"[...] The discussion with the team at that time was just like counselling for me. I decided to improve my weaknesses and gaps they told to me in public. I decided that my clients should get the service they want on time with quality. My punctuality was also good for clients to get the service on time. My communication was improved. When my face is not welcoming and if my communication is not good; people do not want to talk even about the reason for coming to the clinic based on my smile/facial expression. I understood that people look facial expression. When speaking to clients with smiling face, clients understood that the healthcare provider is listening and understanding the client need, so that they can discuss with me in good way."

She also mentioned how the CSC session made her reflect on her professional ethics and that she herself decided to make changes. The increased awareness of being accountable to young people was underscored by a senior member of FGAE programme staff. He believed that this change in mindset was felt by many of the health facility staff involved: *"In my opinion, all staff working in the respective healthcare facility will remember the social accountability afterwards. They had no idea that they are accountable to the community and beneficiaries"*.

EFFECTS ON HEALTH FACILITY MANAGEMENT AND LOCAL GOVERNMENT STAKEHOLDERS

Effects on health facility management mostly included an increased understanding of social accountability and familiarity with the idea of the Community Scorecard. They also became more aware of community concern and ownership when it comes to SRHR services. The Medical director of Akaki Youth Centre was even able to bring the discussion of social accountability to the board of the health facility. He recounted, *"Yes, we had a discussion with the board team members of the health centre. [...] We discussed that the institution is going to grow into a hospital and that the community scorecard is important for providing quality service. It is important in terms of accountability, ownership and developing trust"*. Two PO staff sounded a critical note, saying that while the healthcare providers were attentively participating in the CSC intervention, more work is needed to make it possible for them to report back to and request follow-up from the management of the facility when it comes to the gaps in service provision that have been reported to them.

According to the senior programme officer from FGAE, because the CSC intervention was a pilot programme, local government stakeholders were not involved. If this had been the intention, he felt, buy-in should have been sought from the early planning stage on. This explains why no local government stakeholder was interviewed for this study. One female PO staff member labelled the absence of local government officials 'a missed opportunity'. Another female PO staff member held the opposite view, stating, *"To my knowledge it is discussed with local officials or the different governmental bureaus as they are part of the team within the social accountability model. The identified gaps and what they can do to synergise the work of the health centre and all involved were discussed"*.

EFFECTS ON SERVICES

At the level of services, there was a general feeling that much has been improved since the CSC activities. Many changes were mentioned, and although some are perhaps more attributable to the GUSO programme as a whole, it does seem clear that despite being a pilot activity with limited budget, the CSC intervention has had many positive effects. In particular, it was felt that more young people are accessing the services. As a male healthcare provider put it, *"Young people used to be ashamed to access any kind of service but now they are accessing more"*. The medical director of Akaki Health Centre also noted that his centre has received an award and commented, *"There has been a lot of change and then we have a reward at sub-city level among other health centres. This is due to our quality service compared to others"*.

Table 2 dives deeper into the effects by summarizing changes in SRH services for young people at the two health facilities since the CSC activities.

Table 2: Summary of changes observed, as per Community Scorecard Indicator

Area identified in the Community Scorecard	Changes observed
1. Availability of services in the clinic	• Service providers felt that the number of services available to youth has increased: "No referral [anymore] for safe abortion and removal of implants and IUCD from public health facility to FGAE" & "There was no separate service for adult and youth. But as a result of discussion, we can give the service separately for youths and adults by creating a youth corner and youth friendly service". • Young people saw some positive changes, especially an increase in the number of young people accessing services: A 21-year-old male said, "By making people go to the recreational centres that are available in the facility, letting them know the available services and disseminating fact sheets that cover the available services in FGAE, we have managed to get as many people as possible to go to the facility so that they can see and experience for themselves", while a 19-year-old male observed, "There is an arrival of more service users".
2. Training of healthcare providers	• There was a shared belief that the training of healthcare providers has improved, as they were able to receive different training related to youth-friendly services under the GUSO programme.
3. Availability of IEC/BCC materials	• Opinions were mixed. Some said that the availability of IEC/BCC materials had not changed, while others felt that it had increased and that a wider variety of topics was available. According to one 22-year-

	old male, "We do have the materials but they don't take the comments that were given on them into consideration".
4. Accessibility of the facility for people living with a disability	• Plans are in place in both facilities to renovate bathrooms/toilets but these have not yet been executed as management decisions and financial support are pending. Currently, the feeling is that sufficient changes have not yet been made to make the facility fully accessible to people living with a disability. According to some, an access ramp was constructed to this end.
5. Convenience of services for young people	• Young people felt there were improvements, especially the fact that the service has become available on Saturdays (half day) was appreciated. However, according to one young person, "there have been good changes but it is still not enough and a lot should be done". • At Akaki Health Centre, more signposts have been placed in the yard in order to help people seeking services identify where to go. Some young people who were not involved in the CSC activities noticed this and said they appreciate it.
6. Meaningful participation of young people in the facility	• A gap was felt between the FGAE facility, where young people are more engaged (e.g., on the board of the facility and in a project advisory committee), and the public health facility, where this was less the case. • At Akaki Health Centre, there were plans to allow young people to become board members (as they do at the FGAE facility) and thus solicit their regular input. At the time of this study, these plans had not yet been realised.
7. Characteristics of healthcare providers	• Improvements were seen; healthcare providers' attitudes towards youth-friendly services are now more positive and their treatment of young people is kinder and more caring. "There has been a change because the healthcare providers have great relationships with the people coming in to get the service". • In one of the facilities, the number of service providers was not seen as sufficient. This was especially apparent when young people came to do the scorecard assessment and there were no staff in the room to provide services Following discussion with the Medical Director, there are now two service providers assigned to the facility; if one is absent, the other can cover them.
8. Availability of feedback mechanisms	• Responses were mixed. Some respondents saw no change while others noticed significant improvement. The latter group mentioned that more suggestion boxes are now available, as well as a customer feedback form.
9. Availability of national guideliness and policie in the facility	• Most responses suggested that the national guidelines and policies were made available in the FGAE clinics but that this was not yet the case in the public health clinic. A 32-year-old female said they

		were "Available within the FGAE clinics but needs improvement in the public health centres that FGAE is working with"; a 22-year-old female said, presumably about the FGAE clinic, "Yes they are available. When one enters the facility, it is available at the entrance in a visible way".
10.	Convenience of service rooms	• Staff from POs and healthcare providers said this has improved but that more work is needed, including the construction of a new service delivery room. However, this has budget implications that go beyond the scope of the social accountability pilot activities and therefore needs approval from management. • Young people involved agreed that it has improved somewhat but not enough. According to a 19-year-old female, "It has changed a bit but I suggest it would be better if a bigger space is provided; A 22-year-old female said, "They are becoming more convenient but there is still a lot to be done", while a 22-year-old male felt that "There needs to be much work done on them, they are not that much convenient". • Health facility staff mentioned that recreational facilities have been added, such as tennis courts and Wi-Fi. They believed this attracted young people to the facility. One 19-year-old female, who was not involved in the CSC activities, indeed appreciated the facility "adding a variety of entertainment items to make the compound more attractive, [plus] adequate internet service". • In addition, one healthcare provider added that they had provided more furnishings (e.g., tables and chairs) and equipment (e.g., physical examination tools) in the service rooms.

INFLUENCE OF COVID-19

The CSC intervention was conducted in 2018, long before the COVID-19 pandemic. Most respondents mentioned this but also noted that 'because all efforts from health centres have been shifted towards the COVID-19 response', the virus may potentially have impacted follow-up on the action plans that resulted from the intervention. COVID-19 brought further restrictions on hosting and arranging meetings and discussion platforms, and new restrictions on public transportation stopped many young people from coming to the clinic.

SUSTAINABILITY

There was a feeling among the respondents that much had been achieved with one round of CSC activities on a modest budget:

"With minimum cost, the action plans have been good with positive effects. More could be done if there was budget for implementing/ supporting of set action plans for follow up." (female, 26, PO staff)

It remains to be seen how sustainable the achievements are. It seems auspicious that although time has passed since the intervention, certain positive outcomes seem to persist; the increase in healthcare providers' capacities and the positive changes that many of them have experienced personally, for example, as well as infrastructure improvements such as those made to youth recreational facilities. However, no official regulations or penalties were established with regard to the action points identified by the scorecard; following up on them, therefore, remains the personal responsibility of the individuals involved. Healthcare providers

and health facility management did mention that they were highly aware that not improving on the identified gaps would make them and their health facility look bad.

"I am aware of that if things are going on wrong directions in terms of service, it will not be good for me and our facility [...] Yes, any institution is liable if it does not meet the plan or if it is done below standard of the government." (Medical Director, Akaki youth centre)

EMBEDDING SOCIAL ACCOUNTABILITY IN HEALTH FACILITY POLICIES AND STRATEGIES

At the time of the study, social accountability activities had not been embedded in the policies or strategies of the two health facilities involved. This was because it was seen as a new concept that was not yet recognised or understood by a majority of the staff.

"Only few staff knows social accountability and community scorecard. To be included in the facility/organisation policy, it needs senior management buy-in and then there should be some additional assessment in other facilities and needs management and staff engagement during the overall process. May be in this way, it may be considered to be included as major activity." (male, Senior Programme Officer, FGAE)

"Right now we are planning and working on to include it on our 2021 action plan." (Healthcare provider, Akaki Youth Centre).

SCALING UP TO OTHER HEALTH FACILITIES

The CSC intervention was only carried out once, but respondents felt that it was an innovative approach with promising effects. Several strategies are therefore being put in place to allow for scaling up the activity in the future. The Youth Health Coordinator from Akaki Health Centre stated that they intend to expand CSC activities to other schools and health centres:

"We have already signed the agreement with twelve schools and two health centres to expand this same practise. Regarding this plan we have been working on awareness creation in the schools and the health centres." (male, Akaki Health Centre, Youth Health Coordinator)

According to a senior programme officer, approaches to scaling up CSC interventions at FGAE included incorporating them into new project proposals and creating buy-in from senior management.

CONCLUSIONS AND RECOMMENDATIONS

The piloting of the Community Scorecard by the Family Guidance Association in Ethiopia, as part of the GUSO programme in Ethiopia, has shown very promising effects. Though the CSC activities have only been implemented once, they clearly led to improvements in participation and a sense of ownership on the part of the community (particularly young people); improved communication between young people and different groups of adults (I.e., healthcare providers and community members); accountability on the part of healthcare providers and improvements at the level of the healthcare system. Despite the limited scale at which the intervention was implemented, study findings indicate the potential of CSC interventions to improve the quality of SRH services for young people in Addis Ababa.

The following sections provide recommendations for FGAE and the wider GUSO Alliance in Ethiopia with regard to the continuation of youth-led social accountability interventions.

General recommendations

1. Local governmental stakeholders need to be more engaged in future activities. Their involvement will increase the chances of successfully addressing young people's concerns.
2. The five-day social accountability training was key to the success of the CSC intervention. Future social accountability initiatives should preserve the length and richness of the training.
3. The level of youth participation in some steps of the CSS should be increased by, for example, letting them nominate young people to participate in the activities.
4. Healthcare providers should be empowered in such a way that they feel confident following up on issues raised during interface meetings with health facility management.

Recommendations from PO staff

5. Future youth-led social accountability interventions need to involve all alliance member organisations equally.
6. It should be ensured that recommendations and action plans that evolve from the CSC activities are practical and that the programme and/or the local government are able to follow up on them.
7. The social accountability model should be adapted in such a way that it can be applied more broadly (e.g., also outside of the health services).
8. Regular follow-up on and proper execution of action plans should be given emphasis in any similar activities in the future.
9. Social accountability initiatives need to be scaled up and become the culture of communities and organisations alike.

Recommendations from healthcare staff

10. Awareness of social accountability interventions should continue to be raised while scaling it up, as many people don't have information about it.

Recommendations from young people

11. Young people should design the community scorecard to make it more attractive to them.
12. Set indicators for youth participation in social accountability and monitor them regularly; involve more young people in the activities and increase their participation.
13. Answer scorecard questions with explanations rather than ranking, so that the information is useful for not just evaluation but also review.
14. Continue building the capacity of young people by offering them a variety of courses.
15. Set up social media accounts for the facilities to increase their visibility in the community.
16. Offer social accountability training to newcomers and refresher trainings for young

people who have already been involved.

17. Recognize young people who participate in social accountability trainings and activities by awarding them certificates.
18. Increase the participation of young people in future social accountability activities.
19. Collect as many concerns, opinions and new ideas from members of the community as possible, then deliver these to decision-makers and people in higher-up positions – in short, those in a position to bring about change.
20. Scale up by increasing the area of implementation and enrolling different health facilities and sub-cities in social accountability activities.
21. Focus more on people with special needs and work on issues related to their needs.
22. Ensure follow-up by having a monthly report that summarises what has been improved based on designed action plans.

Recommendations from community members

23. Scale up the social accountability activities and have interface discussions with healthcare providers on a regular basis.
24. Increase the number of community representatives participating in the CSC activities. The numbers of community representatives, young people and healthcare providers should be equal.
25. Increase awareness of the Community Scorecard, making sure that everybody understands what it is and why it is implemented.
26. Translate the Community Scorecard to local languages, as currently it is only available in English.