GET UP SPEAK OUT for youth rights

‘WE NOW KNOW MORE ABOUT THE QUALITY OF HEALTH SERVICES’ - YOUTH-LED SOCIAL ACCOUNTABILITY WITHIN THE GET UP SPEAK OUT PROGRAMME IN MALAWI

MALAWI SEXUAL REPRODUCTIVE HEALTH RIGHTS ALLIANCE

CAYWOC · COWLHA · FPAM · CHRR · YONECO Youth Net and Counselling · Centre for Youth Empowerment and Civic Education

aidsfonds · CHOICE FOR YOUTH & SEXUALITY · dance4life · IPPF · Rutgers · Simavi

Supported by: Ministry of Foreign Affairs

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LIST OF ACRONYMS

ADC	Area Development Committee
CBDA	Community-Based Distribution Agent
CBO	Community-Based Organisation
CHRR	Centre for Human Rights and Rehabilitation
CAVWOC	Centre for Alternatives and Victimised Women and Children
COWLHA	Coalition of Women Living With HIV and AIDS
CYECE	Centre for Youth Empowerment and Civic Education
DHO	District Health Officer
DHS	Demographic and Health Survey
DYO	District Youth Officer
FGD	Focus Group Discussion
FP	Family Planning
FPAM	Family Planning Association of Malawi
GoM	Government of Malawi
GUSO	Get Up Speak Out
HIV	Human Immunodeficiency Virus
HSA	Health Surveillance Assistant
MoH	Ministry of Health
MYP	Meaningful Youth Participation
NGO	Non-Governmental Organisation
OR	Operations Research
SHR	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
STI	Sexually-Transmitted Infection
T/A	Traditional Authority
VDC	Village Development Committee
YFHS	Youth-Friendly Health Services
YONECO	Youth Net and Counselling

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Author: Fednant Steven Chizimbi

INTRODUCTION AND BACKGROUND

INTRODUCTION

Social accountability approaches such as the community scorecard (CSC) have been receiving attention and growing in popularity in the health sector over the last decade. These approaches engage community members and service providers in processes that aim to improve services and public sector performance. These approaches hold actors accountable for delivering on their commitments. In Malawi, some studies of social accountability have already been done. A study by CARE in 2017 concluded that by facilitating the relationship between community members, health service providers and local government officials, the CSC contributed to important improvements in reproductive health-related outcomes. The study further noted that CSC builds on mutual accountability and ensures that solutions to problems are locally relevant, locally supported and feasible to implement. This operational research on Youth Led Social Accountability within the Get Up Speak Out (GUSO) programme in Malawi aims to contribute information on social accountability, particularly as it relates to youth.

BACKGROUND

Get Up Speak Out (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. The change that is envisioned is that all young people, especially girls and young women, are empowered to realise their SRHR in societies that take a positive stance towards young people’s sexuality.

There is unique added value in using a multi-component approach, as a multitude of factors and actors are addressed as influencing young people’s SRHR. Theory of change describes five interrelated outcomes that contribute towards the long-term objective. These interrelated outcomes are:

1. Strengthened in-country SRHR alliances.
2. Empower young people to voice their rights.
3. Increase access to and utilization of SRHR information/education.
4. Increase access to and utilization of sexual and reproductive health (SRH) services.
5. Create and nurture a supportive environment for SRHR.

The five outcomes, in combination with five core principles, are related to the strategies of the programme. The five core principles are: Meaningful Youth Participation, Gender Transformative Approaches, Rights-Based Approach, Inclusiveness and Sustainability.

Operational research has been identified as an integral activity in the GUSO programme. Its aim is to enhance the performance of the programme, improve outcomes, assess the feasibility of new strategies and/or assess and improve the programme Theory of Change (ToC).

This research track focuses on one of the three strategies under outcome area 4, namely: scaling up social accountability systems which actively involve young people and communities in quality monitoring of health services and (multi-stakeholder) dialogue for improvement.

SOCIAL ACCOUNTABILITY ACTIVITIES WITHIN GUSO

Globally, increasing attention to young people's involvement in quality of care and YSRHR standards is a key strategy to ensure services meet the needs of young people. 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 for empowering young people to hold duty bearers accountable. Two of the Northern consortium partners, IPPF and Simavi, developed Social Accountability manuals. In several GUSO countries, IPPF and Simavi have provided training and capacity-building to young people and community members to use the tools to voice their needs and rights. 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 young people to understand and demand their sexual, reproductive and health rights (SRHR).

RESEARCH OBJECTIVES

This operational research aims to understand how social accountability initiatives in Mangochi and Chikwawa in Malawi, implemented by YONECO, CYECE and FPAM, contribute to the empowerment of the young people involved and to the improvement of the quality and inclusiveness of Sexual Reproductive and Health (SRH) services for young people. 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 etc).

METHODOLOGY

RESEARCH PARTICIPANTS AND STUDY TOOLS

The operational research was done in two districts of Mangochi and Chikwawa. A total of 18 focus group discussions (FGDs) (137 participants, 65 male and 72 female) were conducted for this research, in nine villages surrounding health centres. Twenty-two key informant interviews were also conducted. The research team consisted of a consultant and six research assistants, half of whom were young. All received three days of training on key operational research concepts, conducting interviews and facilitating focus group discussions. A list with members of the research team is included as Annex 3.

Training including detailed discussions of research tools, ensuring that the objectives of the research were fully understood.

The research team collected data through participatory, qualitative research, conducting in-depth interviews in Mangochi and Chikwawa. Interview subjects included young people, YONECO, CYECE and FPAM's national and district-level project partners, government partners at district and health centre level and, at the community level, village headmen and village advisory committee members. FGDs with young people were also conducted. The research team also reviewed project documentation and other literature on social accountability. The number of people interviewed or participating in the focus group discussions and key informant interviews is included in Annex 1.

ETHICAL CONSIDERATIONS

During the research, oral consent was obtained from the respondents and then documented. The COVID-19 pandemic imposed certain precautions on the way the team conducted the study. The research team had to conduct the study in an ethical manner. Measures to mitigate the spread of COVID-19 were implemented during data collection in the field, ensuring that the research activities were compliant with national regulations and that both respondents and the research team were safe. Safety measures included both the provision and use of personal protective equipment and physical distancing and hygiene practices such as using sanitiser and frequently washing hands with soap. The research team made a deliberate effort to explain the necessity of these precautions to respondents. The young people felt comfortable with the research teams as they not only putting on personal protective equipment, but also sanitised respondents' hands.

DATA PROCESSING

All FGDs and individual interviews were tape recorded and transcribed verbatim. Brief field notes were also taken. The recordings were translated into English, back to the local vernacular, and then into English again. Data was then processed using the thematic analysis method. The report was written based on the thematic analyses.

LIMITATIONS

As indicated above, the research was conducted during the COVID-19 pandemic. This may confound the findings as there was a period of about seven months when, in compliance with government guidelines, few or no social accountability activities took place.

FINDINGS

The following sections present the findings of the operational research on youth-led social accountability interventions.

In addition to community leaders, health services delivery personnel and partners, 137 young people participated in the research. Their ages are displayed in Figure 1. The majority of the youth in this study (76.6 percent), were no more than 24 years old. Of those interviewed, 47.4 percent were male and 52.6 percent were female (Figure 2). Young people with disabilities and those living with HIV who participate in social accountability activities were also mobilised to attend. Although many of those living with HIV attended, those with disabilities did not, as most would have had to travel a great distance and preferred to exercise caution with regard to COVID-19. Other demographic information about the young people is attached as Annex 2.

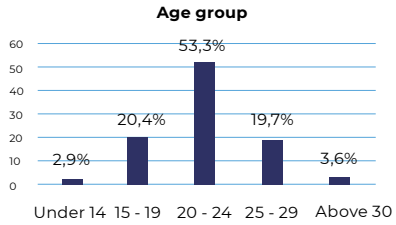

Figure 1: Age of Youth Interviewed

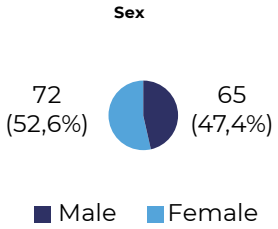

Figure 2: Sex Distribution of Youth

INVOLVEMENT OF YOUNG PEOPLE AT EACH STAGE OF THE PROCESS

CYECE and YONECO both use scorecards in social accountability, while FPAM uses client feedback forms. To launch the use of scorecards, both CYECE and YONECO organised training workshops in Chikwawa and Mangochi in May and June of 2019, to capacitate youth in youth-led social accountability. YONECO and CYECE host **youth clubs**, which are informal community youth organisations, for both GUSO and social accountability activities. When informed about the scorecard training workshops, the youth clubs requested that they be allowed to choose the participants. The partners advised them to select young people from 10-24 years old who could read and write.

The training sessions were facilitated by the Youth-Friendly Health Services (YFHS) coordinator from the District Health Office and the District Youth Officer (DYO). YONECO and CYCE also let these individuals take the lead in facilitating the workshops because, as staff of the district assemblies, they are the custodians of youth-friendly services in the district. All youth-friendly interventions implemented by different partners in the districts are coordinated by the YFHS coordinator and the DYO.

The training workshops for YONECO and CYCE lasted two days. The young people were informed of the range of services offered at health facilities and their rights when it comes to accessing these services. YONECO had an additional workshop for mystery clients. The training for mystery clients included the following topics:

- The meaning of **adolescents, very young people, young people and youth**, according to WHO
- The necessity of investing in the health and development of adolescents and young people
- The meaning of Youth-Friendly Services and the Malawi MOH's criteria for designating health services as youth-friendly
- Characteristics of a YFHS facility
- What young people want from a health services facility

– What young people want from health services
– Minimum package for delivery of YFHS
– National Youth-Friendly Health Services Standards
– Factors that prevent young people from accessing YFHS
– Cervical cancer signs and symptoms, risk factors and primary prevention
– Family planning
– Sexually-Transmitted Infections and important factors to consider when managing young people with STIs
– Factors that hinder young people's prompt access to STI treatment
– HIV and strategies for preventing its transmission
– Customer care and customer service in relation to YFHS
– Things to consider when working with adolescents

This list of topics is also included in Annex 6. Workshop participants were also taught to impart what they'd learned to other people interested in becoming trainers – that is, to train trainers. They agreed that after completing their training, they would return to their own communities and train other young people during their regular youth club meetings and activities. As a result, about sixty youth have been trained in Chikwawa and Mangochi. The majority of them were trained by their peers.

At the end of the workshop, the young people and district partners jointly planned the first scorecard session. This was to ensure that the young people understood the concept and were provided with technical support. Thereafter, partners also jointly planned the meetings with health services providers in which they responded to issues raised during scorecard sessions. After the first planned scorecard and dialogue sessions had been implemented, the young people did scorecards on their own and sent monthly reports about them to partners; at this stage, partners and the DYO were involved only in the dialogue sessions.

> **"YONECO helped us conduct the first scorecard exercise. The practical exercise really helped us understand how to do scorecards on our own".**
> — Youth at Monkey Bay Health Centre.

> **"The design of scorecard activities are done by youth with their leaders and put in plan of where and when the activity on scorecard should be done. The same process goes to other activities. But due to inadequate structures in some processes, like are not done".**
> — Medical Assistant, Chikwawa

> **"Before training on community scorecard and social accountability, we were generalizing in provision of services to young people. But after the training on scorecard, we realised that we lack certain relevant materials in the process of providing services to our youth and also that the procedures we use in providing these services were inadequate, as some young people are in hard-to-reach areas".**
> — Medical Assistant, Nankhumba Health Centre

After young people collect the information, they send it to YONECO and CYECE, Thereafter, CYECE and YONECO project officers take the lead, summarising the findings/concerns/issues regarding SRHR services. Generally, each summary deals with about five issues. Once the issues are summarised, a **dialogue** meeting is organised. Present at the dialogue meeting are health services delivery personnel, youth representatives, partner representatives, the YFHS District Coordinator and/or the DYO. The dialogue meetings are facilitated at venues where district-level personnel are present, as should the matters discussed need to be escalated to a higher level, they would be the ones to do so. Generally, the dialogue meetings are conducted at health centres.

> **"After we conduct the scorecard exercise, we send the forms to YONECO office. However, sometimes we run short of the forms".**
> — Young person, Nankhumba Heath Centre

> **"Since we are the ones who compile scorecard issues sent by the youth, we usually limit the scorecard issues for dialogues session to no more than five".**
> — YONECO Programme Officer, Mangochi

At the end of each dialogue session, the issues or matters that should be improved upon are agreed to and follow-up actions, where necessary, are arranged. On average, there is one dialogue meeting per quarter in Mangochi and one dialogue meeting per quarter in Chikwawa. According to the information available, YONECO has conducted five dialogue sessions at five different health centres since they launched the scorecard, while CYECE has conducted nine. CEYCE dialogue sessions include governance sessions.

> **"We have helped the youth facilitate five dialogue sessions since we launched the scorecard".**
> — YONECO Project Officer, Mangochi

> **"We have facilitated many interface meetings in various health centres. Some of the interface meetings cover governance issues".**
> — Project Officer, Chikwawa

In Chikwawa, young people are provided with the tools or materials (e.g., stationery, flip charts, pencils, pens, printed forms and registers) necessary for them to conduct scorecard activities such as visits to health facilities, youth club meetings and activities at youth-friendly corners. However, in Mangochi, the young people reported that YONECO does not provide them with adequate materials to conduct their activities. Despite this, the young people said that they really appreciate the scorecard approach, as it has opened up new avenues for youth-led social accountability.

> **"We now know more about the quality of health services, as we are able to check these as mystery clients and later on engage the health staff on what can be done to improve services."**
> — Youth Club member at Nankhumba, Mangochi

MYSTERY CLIENTS

As part of the Scorecard approach, YONECO trained 20 young people as **mystery clients**. These mystery clients were then added to the scorecard, in order to provide a more independent perspective on SRHR issues in health facilities. The course content (i.e., topics) for training mystery clients is outlined in Annex 6. After they completed training, they proceeded to collect data for scorecards as follows:

A mystery client visits a health facility just as any other client would. However, because they have been trained, the mystery client already has information on the range of services that are offered, especially those related to SRHR. They also use indicators on the Youth-Friendly Health Services Form (Included here as **Annex 5**). The form was adopted from Ministry of Health YFHS indicators. At the health facility, the mystery client observes and silently documents the quality of services, including introductions, diagnosis, treatment and follow-up visits.

As can be seen from the assessment form in Annex 5, the shortcomings identified by the mystery client are based on the scoring weights in each of the indicators. The indicators that the health facility scores poorly on, when aggregated from several scorecards, are considered areas in which the facility is unfriendly to youth. These are later summarised and presented to the health services provider in a dialogue session, at which the District Youth-Friendly Health Coordinator is present. The health services provider does not know who may have reported their facility, and they usually acknowledges that the report is not wrong. At the dialogue meeting, action points to remedy the situation are agreed upon and commitments and assurances are made by the health services provider.

> **"The health personnel usually accept that the issues we bring out are true".**
> — Youth Club member, Nankhumba Health Centre

> **"Our elders don't attend the dialogue sessions that take place at heath centres because generally there are issues that concern parents not allowing us children to get family planning commodities".**
> — Youth Club member, Monkey Bay Health Centre.

> **"Misconceptions by our elders usually come up at our dialogue meetings. We discuss with health personnel how they can include this issue in health education talks".**
> — Female Youth Club member, Mkope Health Centre.

The mystery client continues visiting the health facility to check whether or not the health services provider is taking corrective measures based on the agreed-upon action points. Because health personnel never know who mystery clients are, they are forced to treat every client with care. This process is then repeated at other health facilities until the mystery clients have gathered enough information for the scorecard.

Mystery clients face challenges when they visit health facilities. For example, when they need to travel to facilities far from where they live, they sometimes don't have enough money to pay for transportation. Tackling the issues identified by mystery clients undoubtedly helps improve the quality of SRHR services however, some challenges are beyond the control of the health services providers. For example: youth-friendly consultation rooms are not available, and there is little the health services providers can do to change this; and health facilities are visited by adults, including the young people's parents and other relatives. This makes them young people uncomfortable, as they feel they will be reported.

> **"Our parents do not want us to be seen around health centres for sicknesses they are not aware of. Such appearances raise suspicions of promiscuity".**
> — Youth Club member, Mkope Health Centre

> **"Although health personnel are willing to offer us recreational facilities within the health facility, this is not possible because there is no such facility. That is why we meet at the ART clinic".**
> — Youth, Monkey Bay Health Centre.

Based on scorecard and mystery client reports, the following common issues have emerged and been discussed at dialogue meetings:

- Limited access to contraceptives
- Shortage or limited access to condoms.
- A need for youth recreational facilities. The youth corners are a short-term solution.
- A need for health staff to deal with cultural issues, myths and misconceptions, especially during the health talks.
- Attitudes of health service providers at health centres.
- YCBDA issues in communities.

HOW INVOLVEMENT IN SOCIAL ACCOUNTABILITY ENABLES YOUTH TO ARTICULATE CONCERNS ABOUT SERVICE DELIVERY

Many young people testified that their involvement in social accountability activities helped their peers and themselves in the following ways as follows:

Because an abortion bill is currently being discussed in Parliament, safe termination of pregnancy and related pregnancy issues are currently being widely discussed and debated in Malawi. Although the bill before Parliament cannot be directly attributed to social accountability activities in the two districts, partners and young people mentioned pregnancy-related issues in most discussions and interview sessions. The concern they raised most often was that not only are teenage pregnancies on the rise, but there is also no access to legal pregnancy termination services. As a result, there are many unsafe abortions being carried out.

> **"We have been discussing with the youth and encouraging them, during meetings and dialogue sessions, to talk to Members of Parliament [MPs] on the Pregnancy Bill, as a sort of advocacy, so that the MPs can support the bill when it is debated and voted in Parliament".**
> — CYECE partner, Chikwawa.

"We frequently talk about pregnancy and unsafe abortions in our meetings, especially among our teenage girls. This issue has become more urgent because we have seen more pregnancies among teenagers during this COVID-19 lockdown".
— Peer facilitator, Chikwawa.

The training helped the young people understand that health services providers are there to serve *them*, especially in the case of government health facilities and church-sponsored health centres, which are also subsidised by government. Before the scorecard activities, young people felt that they were at the mercy of health services delivery personnel and obligated to accept whatever services they were provided with. They were not aware that the services at health centres are government-provided and something that citizens – including young people – have a right to access..

"When we were trained in scorecard activities, including mystery clients, we understood that the reasons we are involved in these activities is because we understood that as citizens [nzika] we have a right to quality services. This gave us boldness."
— Young person, Nakhumba health centre

"Going through the [scorecard] as part of our training was really very helpful in understanding our role".
— Young person, Monkey Bay Health Centre

Dialogue meetings helped the young people understand some of the problems that already existed at health facilities. Prior to the scorecard activities, many found this difficult; it was not clear to them, for example, that shortages of certain contraceptive methods are sometimes due to them simply being out of stock. Condoms, for one, are in short supply because they are in great demand, by not only young people but also other groups – sex workers, for example. The young people also became more aware that staff shortages in health centres result in staff becoming overstretched and sometimes not able to attend to them adequately. As their understanding of the health delivery system's limitations increased, young people were better able to articulate their needs in relation to that system.

"When we go to collect condoms, sometimes they give us only nine condoms for one month – this is too few".
— Youth Club member, Namkumba.

"The health centre staff are few. There are usually one medical assistant and one or two nurses. As a result, we wait long on queues and the staff don't have adequate time to attend to us. They are usually overstretched".
— Youth Club member, Nankhumba.

The scorecard approach has created an atmosphere in which youth interact with the health services delivery personnel more frequently.

"After people started to participate in community scorecard meetings, they are not only present at meetings, but also try to give consolidative solutions to the problems raised at the meetings".
— Village head, Mkhope, Mangochi

"When we do not have referral forms, we record referral cases in a notebook and use any type of blank paper from the notebook to write a referral and send them to the health facility so that they get assisted".
— Peer Educator, Chikwawa

UNDERSTANDING OF SRHR THROUGH PARTICIPATION IN SOCIAL ACCOUNTABILITY PROCESSES

As noted above, the two-day training workshops afforded young people opportunities to understand SRHR issues more deeply than before. They learned more about the stages of pregnancy, when a pregnancy can be terminated safely and when it is dangerous to do so. The issue of pregnancy has become a much-discussed topic among young people in general, so much so that it resulted in a bill in Parliament, as noted above. The young people also learned about the different types of STIs and can now recognise specific ones by their symptoms. They gained further STI knowledge during youth club meetings and interactions with health services personnel, the latter a knock-on effect of their monitoring of health services for young people.

Young people also became more aware of their boundaries. What they are and are not comfortable getting involved in. They came to know that certain issues – for example, malpractice by health personnel and abuse , – are handled by other regulatory bodies, such as the Medical Council of Malawi, the Nurses and Midwives Council and the Malawi Pharmacies and Poisons Board.

> **"We need more training and orientation. We are distributing health products in the community without adequate training" .**
> —YCBDA, Namwera

OTHER DYNAMICS BETWEEN YOUNG PEOPLE AND OTHER GROUPS IN THE COMMUNITY

Before the scorecard approach to social accountability was introduced, young people's interactions with health services personnel were limited to those occasions when they received services. The scorecard approach ushered in more frequent interactions between young people and health services delivery personnel; especially key to this were **interface meetings** between youth representatives and health personnel and partner representatives.

Once dialogue sessions began, health services delivery personnel's initial reactionwas that the young people, by checking on their work, were acting like the police. What right, they asked, did they have to do this? These initial reactions soon dissipated, as health personnel came to accept that youth activities are useful in enhancing the relationships between health personnel and the communities surrounding them.

> **"At the beginning of the scorecard, the health staff had negative attitude. Now we work well with them in addressing our issues".**
> —Youth, Nankhumba Health Centre

> **"Health services staff know that if they don't address concerns brought up through the scorecard system, they can be moved. One health staff was moved from Nakhumba Health Centre".**
> —Youth,Nakhumba Health Centre

> **"Through interface meetings with young people and us healthcare providers, we believe there is a reduction in the rate of early pregnancies and transmission of HIV, because youths have increased access to SRHR. Also, youth have managed to build structures and youth leaders so that issues are raised and discussed between both sides so that there are no negative feelings on the other party".**
> —Medical assistant, Chikwawa.

> **"Before the training in scorecard form by CYECE, there were complaints by young people regarding access to SRHR services. Some of the key issues were that we healthcare providers did not keep young people's privacy, that we had negative altitudes, especially when young girls and boys visit the facility to access SRHR services, and that young people were not free to express themselves. I believe these issues are becoming less pronounced because we are adjusting due to interface meetings we have been having with young people".**
> —Medical assistant, Chikwawa

Young people have come to realise that certain issues can only be dealt with if community leaders understand them and cooperate in their resolution. For example, the young people managed to remove several girls from early marriages that they did not wish to be a part of. However, only village headmen could enforce these withdrawals, as they were the appropriate, culturally-sanctioned authority. Similarly, cases of gender-based violence could only be dealt with by working with the local police, who have been trained in handling GBV.

> **"We withdrew some teenage girls from their marriages, but some went back because we did not have mechanisms of enforcing the withdrawal. Only the village headmen can enforce this. Unfortunately, some village heads do not take any action".**
> —Young people, Nankhumba

Now that they are aware that any abuse in the course of health services delivery will be noted and reported, health services personnel have developed a healthy respect for their clients, especially the young people.

> **"There is very good relationship amongst us and other groups within the community, we work together with all stakeholders in the community on any matter".**
> —Youth Club member, Mangochi

THE CLIENT FEEDBACK FORM USED BY FPAM

As mentioned in Section 3.1 above, FPAM uses the client feedback form for youth-led social accountability activities. In the following paragraphs, we will discuss the study team findings.

According to available FPAM documents, reports and discussions with FPAM staff and clients, some type of feedback form has been in use for many years as part of the FPAM feedback mechanism at FPAM facilities such as family planning clinics and youth life centres. The services delivery manager said that the guidelines for providing the client feedback form at FPAM facilities are as follows:

a. A suggestion box with a lock must be available and visible to all clients at each health services delivery facility.
b. If possible, there should be a notice displayed above or next to the box encouraging clients to provide their feedback on how services could be improved.
c. Client feedback forms, with guiding questions about the quality of services (both in local **vernacular** and English), must be available next to the box at all times.
d. A pen must be available next to the suggestion box at all times.
e. Health Services delivery personnel are encouraged to tell clients to give their suggestions, especially during health education talks and counselling sessions,.

The research team visited four FPAM sites and did not see any client feedback forms. When the district FPAM manager was asked why there were no client feedback forms, the team was shown blank client feedback forms (in English) that were kept in a folder (a copy is attached as Annex 4).

The research team did not find a suggestion box at the Mangochi district FPAM facility, nor did they find suggestion boxes at any of the three health centres where FPAM conducts SRHR outreach services. When the district outreach team manager was asked about the absence of a suggestion box at the district facility, he replied that the FPAM head office had taken the box, in order to access and compile the suggestions inside. The box, he said, had not been returned to the facility.

The manager explained the absence of suggestion boxes at the health centres with the fact there was only one outreach team and only one suggestion box. The team, he said, carried

the box with them wherever they went to perform outreach clinic services. They did not leave the box at health facilities.

When young people that regularly accessed services at FPAM clinics were asked if they had ever used the client feedback form, many did not seem to know anything about it. Some indicated that they had seen the box in the past but never used it.

The FPAM Service Delivery and Quality manager was later asked about this. She confirmed that the box had mistakenly been picked up from Mangochi sometime back, but said that they had assumed it had been returned. The research team also asked the Service Delivery and Quality Manager if past compilations of suggestions could be made available to them; with these, they hoped to ascertain whether any past suggestions had been made by young people, and how old they had been if so. No reports were available at the time, however.

Based on discussions with FPAM head office, the research team concluded that:

a) The client feedback form system was implemented for normal family planning services many years ago.
b) However, due to staffing changes at FPAM, the client feedback form was not operationalised in Mangochi with a specific focus on youth.
c) The staff at FPAM Mangochi Office have continued to use the client feedback form for normal family planning clients, which sometimes includes young people.

The COVID-19 pandemic seems to have further complicated the low functionality – or lack of functionality – of the client feedback form; that the box was mistakenly not returned to Mangochi for months is probably due to the shutdown.

The research team discussed these issues with FPAM, who indicated that they would reintroduce the client feedback form in a format specifically focused on youth. They also planned to institute a reporting mechanism allowing them to monitor and learn about young people's concerns with regard to the quality of SRHR services. The research team encouraged FPAM to consider updating the form based on the lessons FPAM has learned from operating two **youth life centres** in Ntcheu and Neno for over five years.

The research team therefore concludes that there is too little information available to be able to comment on or learn about how the client feedback form system – specifically the iteration aimed at young people – has worked in FPAM outreach clinics. The research team would like to add further comment as follows:

The findings on the use of the client feedback form in FPAM are not unique to that organisation. The consultant has evaluated two other well-known partners in Malawi, which offer similar family planning (SRHR) services; he found little evidence of success in the implementation of a client feedback form at either of them. In most cases, suggestion boxes are unavailable, they are improvised or clients are not aware of their existence. Forms are sometimes not available in local vernacular and a pen is usually not provided. Many clients are afraid of making suggestions because they are concerned about retaliation from health service providers if they are seen writing them down. However, client feedback form especially for youth has not been tried. As can be seen from the scorecard findings above, young people are enthusiastic about ensuring that youth-friendly SRHR services are available.

For this system to work, there must be clear lines of accountability. There is an added complication regarding non-governmental partners providing SRHR. Most SRHR providers are not accountable to the general public in the way that service providers at government facilities are. These service providers are accountable to development partners that provide funds for SRHR services.

EFFECTS OF YOUTH-LED ACCOUNTABILITY ON QUALITY OF SRHR SERVICES AND OTHER SERVICES FOR YOUNG PEOPLE

Before social accountability, health workers would often close health facilities or simply make themselves unavailable, especially on market days. They knew there were no systems for accountability at the community level. Since the scorecard activities were implemented, health workers have changed their attitude. They always keep health facilities open because they know that local communities expect a certain quality of services, which they must provide.

> **"On market days, the health centre staff would close the health centre early. Or not open at all. With the scorecard, they know they will be assessed. This time they always open and in good time".**
> —Youth Club member, Nankhumba

In the past, clients would sometimes receive the same medicine for different diseases because medicines were stolen and sold to private clinics. As the clients had little awareness of their rights, they would accept this without complaint. With the implementation of the scorecard, health services delivery personnel know that awareness levels are high when it comes to health issues, especially among the young people, who are the majority of the population. Young people reported that they are now receiving the correct drugs and contraceptives in a timely manner; they are rarely out of stock.

> **"It was common for health service provider give us the same antibiotic for infections. There was no proper explanation for this. This habit stopped after we implemented the scorecard".**
> —Youth Club member, Monkey Bay

In the past, due to low levels of awareness, health workers and youth club chairpersons could send their friends or relatives to training workshops without consultations. This has now changed because of increased awareness and accountability among youth club members.

Young people are now aware that the personnel at health centres provide youth-friendly services. Moreover, there are critical shortages of health staff at health centres (there are usually two nurses and one medical assistant at a centre). For these reasons, youth now appreciate health workers' limitations and are willing to work with them based on that understanding. This is one reason why the young people, in consultation with health centre staff and in order to better cater to youth SRH need in Magochi, have arranged for **youth corners to be set up in three health facilities**. These young people, along with health centre personnel, have also designated one day a week as a youth day. In some health centres the youth day is Saturday, in others it is Wednesday.

> **"We are afraid to access SRH services at Monkey Bay Health Centre, because the designated youth-friendly services corner is located in the same place where ART services are done. People may think we are getting ARVs, hence we cannot go there within the weekdays, except Saturday when only youths meet".**
> —Youth Club member, Monkey Bay, Mangochi.

> **"In most of the health facilities, we don't have multi skilled workers, so when a youth has been raped; we only help physically by providing medicine but not helping her psychologically".**
> —HSA, Mangochi

In the last 18 months, the experience gained through the engagement of young people in SRHR community discussions and activities and the scorecard processes in Chikwawa have enabled CYECE to also train youth in the governance component of the scorecard, capacitating them in governance issues that go beyond SRHR. Due to the active participation of youth in community activities, and as a result of their exposure to the scorecard, more of them are now being elected to community leadership positions at committee level. In Chikwawa, 15 young people have been elected to positions, in various localities, on the following committees:

1 Area Development Committees (ADC)
2 School Management Committee
3 Village Civil Protection Committee
4 Health Advisory Committees

The scorecard approach to community engagement has led young people and adults to work together. This has brought together Chiefs, village heads, teachers, religious leaders, councillors and male champions, to name a few. Because there are a number of activities taking place at the same time, the young people, in collaboration with partners, have created a **scorecard workplan** that is being implemented in three zones, necessitating three monitoring visits. This has also necessitated the development of a simple questionnaire to be used by young people checking on whether or not agreed-upon activities are being undertaken.

Government identification of a **constituency1** youth advocate has been a positive move towards social accountability in communities, in that it has created more constituency-level opportunities for youth-led social accountability. During this research, young people shared their own experiences of the challenges of being a 'youth representative"' They said that it is often unclear which constituency they are representing, who they are accountable to and what feedback mechanisms are available:

> **"As part of social accountability activities, it was noted that a certain health provider was not responding to agreed remedial actions on offering better quality services. The youth later informed the Health Advisory Committee (HAC), and the health worker was removed from Nakhumba health center".**
> —Youth Club members, Nankhumba, Mangochi

> **"Young people in this community were prone to early pregnancies and abortions. Today, with the introduction of interface meetings between the health facilities and the community, these cases have been greatly reducing. These days, if one is found with unplanned pregnancy, it may be out of choice or negligence, not because they lack protective measures or knowledge on precaution measures".**
> —Young person, Nankkumba

INVOLVED AND UNINVOLVED YOUTH

In this study, we arranged for a counter-example, by asking questions of both young people who are involved in youth-led social accountability and those who are not. About half of respondents are involved with youth-led social accountability, while half are not. The main areas of difference between involved and uninvolved youth are discussed in the following paragraphs.

The involved youth were aware of the changes being brought about in the quality of health services and the reasons for these, as they themselves took part in assessing the quality of services, participated in dialogue meetings with health services providers and reached agreements about what would be changed. Those not involved may have been benefiting from improved services without knowing what brought about the changes. One uninvolved young person complained of issues that were already being addressed by those who were involved, as they were unaware of these efforts. For example:

> **"We have limited number of days in which to receive SRH services, which is every Saturday each week. This is not enough. Moreover, when visiting the health facility, health staff sometimes deny us services within weekdays until Saturday comes".**
> —Uninvolved young person, Nankhumba.

> **"We receive limited number condoms, so we end up visiting the facility several times".**
> —Uninvolved young person, Nankhumba

> **"Train more CBDA so that they can help in our respective communities, so that are able to assist more young people within the community. I was trained in 2013 as a CBDA and I have never received any refresher course or any training since then".**
> —Uninvolved CBDA, Namwera, Mangochi

> **"There is no confidentiality, such that when we do an HIV test or STI they reveal the results".**
> —Uninvolved young person, Kalulu community

The involved are taking up leadership positions in their communities, with the leadership lessons they have learned through social accountability factoring into their election to several developmental committees. As noted above, youth involved in scorecard activities in Chikwawa have been elected to various positions on development committees that were previously reserved for adults only.

Those involved know how to initiate change, follow up on agreed actions and see the results. The young people that were involved in social accountability learned negotiation skills as they had to negotiate with traditional leaders in order to gain concessions on certain issues and be allowed to become committee members, and, in some cases, chairpersons of committees.

The young people involved said that the scorecard tool was very different to other tools they had used in GUSO. The tool was undoubtedly effective in producing change; in just a short time there has been clear evidence of this in the attitudes of health personnel, the designation of separate days for youth-friendly services, the creation of designated youth corners and more. Therefore, uninvolved youth are missing out on the things those who are involved have discovered.

EFFECTS OF COVID-19

The COVID-19 Pandemic created unprecedented problems for communities, youth and SRHR services delivery. The effects were multifaceted. In the following paragraphs we discuss the effects that youth mentioned.

Many young people stopped visiting health facilities because the government **declared a state of national disaster** and immediately gave directives stopping all gatherings. At that time very little was known about the pandemic and there was fear of sickness and death. Therefore, young people stopped meeting and visiting health facilities not only in order to comply with government directives, but also out of fear of contracting COVID-19.

> **"Most youth were afraid to come to health facilities for SRHR services during the Covid19 period; hence, most of them were infected with STI diseases or got pregnant in the process".**
> —HAC Chair, Mangochi

At almost every FGD, young people mentioned that they believed health facilities were considered to be the riskiest places for infection because people infected with COVID-19 would come to clinics for testing and treatment. This was a reasonable belief, as the government soon issued guidelines establishing testing centres and isolation facilities in which those suspected to be infected could be tested and treated without risking exposure to the general public.

The young people said that youth meetings in communities became infrequent and poorly attended because their peers were afraid of COVID-19 and had to comply with government rules of social distancing. Moreover, young people could not afford to install handwashing facilities at their meeting sites, nor could they afford to buy sanitisers or masks. This further limited the number of youth meetings and activities.

> **"We were afraid to visit the health facilities because we believed that is where a person can contract the virus since sick people rash to the hospital/health centre when sick".**
> — Young person, Mkope Health Centre

Many community members involved with young people did not receive any orientation to or information about COVID-19 apart from what they would hear on the radio.

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1. **A geographical area equivalent to the area a Member of Parliament represents**

> **"No training sessions were conducted to orient us or any of the local committees on how to handle Covid-19 issues".**
> — HAC member, T/A Lundu Chikwawa

The government closed all learning institutions, including schools and colleges and universities. Although young people were prohibited from meeting formally, they were able to meet informally to socialise. This led to a rise in teenage pregnancies and early marriages.

> **"We have had many teenage pregnancies due to shutdown".**
> — Young person, Mkope Health Centre

In compliance with government guidelines, Youth Alliance partners cancelled or suspended many scorecard activities.

CHALLENGES

There were several challenges that were experienced in implementing this project. They are as follows:

1. A structure **to support** scorecard social accountability activities has not been developed. Currently, this is a project that depends on the support of development partners. For now, the initiative appears to be short-lived, even though the partners indicated that they are looking at options for continuing the activities with funding from other development partners.

2. Young people in Mangochi brought up the inadequacy of the systems that have been developed to support the monitoring and documentation of lessons and complaints. They said that they lack stationery such as flip-chart paper and, felt pens, with which they could conduct trainings and meetings, and the means to travel to far-away communities. These challenges could perhaps have been addressed by YONECO if the initial momentum of scorecard activities had been maintained. By the time of the COVID-19 lockdown, YONECO had only done three interface meetings and five dialogue sessions. The monitoring and documentation systems could have been further developed through more dialogues sessions and interface meetings if COVID-19 restrictions had not been imposed.

3. Health services delivery personnel are few and overstretched. They are involved in not only providing preventive and curative services at health centres, but also compiling outpatient data on service utilisation and maintaining pharmacy stock, maternity and other community health data compiled by the HSAs. This data is sent to the District Health Management team. These activities leave the few health centre staff with little time to adequately attend to social accountability activities such as those related to SRHR.

> **"We are very busy and overstretched to adequately attend to SRHR youth-friendly services. This is why we agreed to set aside Saturdays for these activities".**
> — Health personnel, Nankhumba Health Centre

In Mangochi, there are a limited number of young people trained in leading social accountability sessions. This is mainly due to continuous youth migration from rural areas to South Africa and various urban areas. This reduces the number of youth leaders trained in scorecard social accountability. Since this trend will continue, it is necessary to do regular training to make up for attrition.

Delays in supplying training materials to young people(in Mangochi) delayed the roll-out of scorecard social accountability activities.

> **"They trained us in scorecard and promised to send materials to facilitate our training of other youth and for meetings on scorecard. But until today, we have not received the promised materials".**
> —Youth Club member, Mkope Health Centre

FPAM's client feedback form was not promoted actively enough that young people began to use it in providing feedback towards improving the SRHR services provided at FPAM health centres and outreach facilities.

> **"The client feedback form is available, but we have never used it for youth. We use it here for any client who wants to give feedback, not necessarily the youth. Moreover, we have not used these forms for more than eight months because the suggestion box is in Lilongwe".**
> —FPAM CBDA District Manager, Mangochi.

LESSONS LEARNT

1. Teamwork in resolving problems has been enhanced, as community members, youth, health workers and others worked together to improve SRHR services delivery.

2. Due to implementation of scorecard activities, young people know their rights better than before; they are more able to stand up for their rights, mobilise and voice their opinions. The scorecard training sessions, the indicators used in the assessment process and the dialogue meetings and follow-up activities in which agreed-upon solutions were implemented all expanded their outlook on social accountability.

3. Social accountability has helped youth to build on what they have rather than following partner or donor solutions. Young people have been able to assess existing services, note the challenges and problems and then engage the appropriate stakeholders to agree on solutions that improve SRHR services.

4. Youths noted that some activities that are initiated using social accountability approaches are sustainable. The assessments of SRHR services, which youth carry out in health centres near where they live, do not require any financial resources. Posing as a mystery client does not require any resources. However, it is the partners who facilitate dialogue meetings and agreements about which actions are to be undertaken. Although the DYO and the District Youth-Friendly Coordinator get involved in trainings and dialogue meetings, the process is in the hands of partners. What is lacking is the integration of these processes into the local government structure. The encouraging development here is that young people are the drivers of the activities. Some investment is required.

5. Young people have come to the realization that they can exercise their rights as SRHR clients rather than passively accepting whatever services they receive, as they did in the past. Now they are able to access channels for voicing their dissatisfaction, knowing that they will be heard.

CONCLUSION AND RECOMMENDATIONS

Youth-led social accountability activities implemented in Chikwawa and Mangochi using the scorecard tool showed promising results. The results have been documented in this study. However, there was no data from the FPAM's client feedback forms, as they were never implemented with a focus on young people.

It was clear from discussions with young people that social accountability processes initiated through the scorecard tool have changed their perspective on their involvement in social accountability. There is a need to continue with these initiatives and processes. The following are the recommendations for action:

1. It is important for young people in the community to be at the forefront of community-based scorecard initiatives. To this end, continuous engagement is vital; if the community takes any kind of prolonged break from these processes, any gains made can be erased. The prolonged break due to COVID-19 negatively affected the momentum of scorecard activities. There is a need for partners to work with local government structures so that these processes can be facilitated by staff of local authorities.

2. All stakeholders need to be included in the scorecard and social accountability training activities. This should include **community leaders** such as youth, village heads, village committee members, health services delivery personnel, and police. It was noted that the involvement of community leaders in training was minimal or absent, and at times minor differences on certain issues emerged due to a limited understanding of the social accountability objectives on the part of traditional leaders. Traditional leaders are gatekeepers; they must be fully briefed and their buy-in obtained.

3. Training in scorecard activities should be done on a regular basis. The research team found that training had happened only once for each group of young people.

4. In scorecard activities, young people are trained to train others. However, training others requires them to travel great distances. Partners should consider providing transportation to enable youth facilitators/leaders to travel farther.

5. Provide stationary, forms and registers to young people so that they can begin to use them soon after they complete training. This will enable them to begin fulfilling their roles by training others and conducting assessments as soon as possible.

6. Produce and provide IEC materials for use during scorecard training activities. The research team did not find or see any IEC materials.

7. Youth should be monitored and visited frequently in order to show appreciation for their work and provide guidance and support where necessary.

8. The scorecard tools should be translated into local languages, printed and made available for distribution to community partners, especially young people. The scorecard assessment form with indictors, attached as Annex 6, is in English. The team did not see a local vernacular version.

9. FPAM should review what happened with the client feedback form system after they committed to implementing it with a focus on young people. They should then reintroduce the form and orient health service delivery personnel to putting it into practise.

10. FPAM should consider sharing lessons gained in using the **client feedback** form with other alliance partners as they are in the unique position of being the sole alliance

partners to own family planning (SRHR) clinics and to operate outreach via youth-friendly recreational centres. As such, they deal with young people on the demand side and service providers on the supply side. They can therefore provide information about the difficulties and challenges service providers experience and how those challenges have been resolved. Such lessons could also be shared with other partners outside Malawi.

11. The partners indicated that current funding for social accountability is coming to an end. Although they are looking at options for continuing with scorecard activities, the COVID-19 Pandemic reduced the period of implementation. It is therefore recommended that if possible, some funding should be provided by Rutgers, to enable partners to continue the activities for a period of time. During that period, partners would work with local authorities to integrate these processes into their structures. For example, each year, the DYO plans activities for which he is given a budget by the District Assembly. These activities could become a regular instance of the DYO working with the District Youth-Friendly Coordinator.

ANNEXES

ANNEX 1: LIST OF PEOPLE CONSULTED

No	Names	Organisation	Designation	District
1	Hastings Saka	Malawi Sexual Reproductive Health Rights Alliance	SRHR Alliance Coordinator	Lilongwe
2	Jimmy Kachale	FPAM	Project Officer	Lilongwe
3	Modesta Kasawala	FPAM	Service Delivery Manager	Lilongwe
4	Mphaso Mulenga	FPAM	CBDA Manager	Mangochi
5	Kumbukani Phiri	Chikwawa Hospital	Deputy YFSRHR Coordinator	Chikwawa
6	Lemani Makina	YONECO	Project Coordinator	Mangochi
7	Fanny Chilembo	YONECO	District Manager	Mangochi
8	Prisca Chakoloma	CYECE	Project Officer	HQ
9	Catherine Mbukwa	CYECE	Project Staff	Chikhwawa
10	Rangerson Ngirazi	Lundu youth Network	Public Relational Officer (PLO)	Chikhwawa
11	Wayison Ketinala	Lomasi Village	Village Headman	Chikhwawa
12	Pilirani Peter		Austin Village Head	Chikhwawa
13	Lonjezo Mchinji	Monkey Bay Youth network	Public Relational Officer (PRO)	Mangochi
14	Mavuto Alifayi	Hunger Health center	HAC Member	Chikhwawa
15	Kondwani Kathumba	Nakhumba health Center	HAC Chair	Mangochi
16	Frank Mleso	Mankey Bay Rural hosiptal	Nurse (YHFS)	Mangochi
17	Beatrice Chilombo	Matron	Nkope Health Centre	Mangochi
18	Tobias tauzeni	Mkungwi village	Village head	Mangochi
19	Sdney Labeka	Hunger Health Centre	Healthcare provider	Chikwawa
20	Blessings Simbi	Hunger Health Centre	Medical Assistant	Chikwawa
21	Chisomo Luwembe	Jalasi Health Centre	Medical Assistant	
22	Isaac Salimu	CYECE	District Coordinator	Mangochi
23	Lanjabu Abuduah	Mtimabi Health Centre	HAC Chairperson	Mangochi
24	Emmanuel Saka	Mtimabi Health Centre	Health Surveillance Assistant	Mangochi
25	Mike Matewere	Namwera R. Hospital	Health Surveillance Assistant	Mangochi
26	Steve Zimtambira	Ndakwera Health Centre	Facility Manager	Chikwawa
27	Amina Kaisale	Mkope Health Centre	Medical Assistant	Mangochi
28	Chisomo Matupa	Nakhumba Health Centre	Deputy MA	Mangochi

ANNEX 2: DEMOGRAPHIC CHARACTERISTICS OF YOUTH

Age Group	Frequency	Percent
Under 14	4	2.9
15 - 19	28	20.4
20 - 24	73	53.3
25 - 29	27	19.7
30 and over	5	3.6
Total	137	100

Sex	Frequency	Percent
Male	65	47.4
Female	72	52.6
Total	137	100

Highest Education Level	Frequency	Percent
No schooling	1	0.7
Some primary school	14	10.2
Completed primary school	17	12.4
Some secondary school	63	46
Completed secondary school	33	24.1
Some college or university	8	5.8
Completed college or university	1	0.7
Total	137	100

Occupation	Frequency	Percent
Business	20	14.6
Employed	9	6.6
Farmer	35	25.5
Mechanic	1	0.7
Peace worker	4	2.9
Student	37	27
Volunteer	2	1.5
N/A29	21.2	
Total	137	100

DISABILITY

Any Disability	Frequency	Percent
No	137	100

CONSENT GIVEN

Concent	Frequency	Percent
Yes	137	100

YOUTH INTEVIEWED BY PARTNER ORGANISATION

Organisation	Frequency	Percent
CYECE	44	32.1
FPAM	47	34.3
YONECO	46	33.6
Total	137	100

YOUTH INTERVIEWED BY LOCATION

Place	Number	Percent
Hunger	15	10.9
Jalasi	17	12.4
Kalulu	16	11.7
Monkebay	14	10.2
Mtimabi	15	10.9
Nakhumba	15	10.9
Namwera	15	10.9
Ndakwera	13	9.5
Nkope	17	12.4
Total	137	100

ANNEX 3: NAMES OF THE RESEARCH TEAM

Name	Designation
Fednant Steven Chizimbi	Consultant
Francisco Kalyalya	Research assistant
Charles Maganga	Research assistant
Elsie Nathalo	Research assistant
Chimwemwe Chizimbi	Research assistant
Andrew Kachisuzi	Research assistant
Hanna Mhone	Research assistant

ANNEX 4: FPAM CLIENT FEEDBACK FORM

CLIENT FEEDBACK FORM Date: .....
Site Name: ..... Location: .....
Site Type: ▫ Health facility ▫ Outreach ▫ Community (CHWs)
Gender: ▫ Male ▫ Female Age (in Yrs): ▫ 10-14 ▫ 15-19 ▫ 20-24 ▫ 25+
What services did you come for today? ▫ FP ▫ VCT ▫ VIA ▫ YFHS ▫Other.....

Name of indicator	Rate		
	Excellent	Satisfactory	Not satisfactory
How well were you treated when you arrived?			
How you find the SRHR information given to you?			
How do find the availability of method mix?			
How do you find the time you waited to be served?			
How do you find the privacy and confidentiality during service provision?			
How do you find the decision making about FP method to use?			
How do you find the overall time to the completion of your need?			
How do you find the cleanliness of the site?			
How do you find the time of starting services?			
How do you find the cleanliness of the service providers?			
How do you rate the attitude of the service providers?			
How do you rate the respect of your rights?			
How do you find the range of services provided at this site?			
How do you rate the youth activities being implemented?			
How do you rate the time of youth activities/ services?			
How do you rate the information on where to report in case your rights have been violated?			

1. What impressed you about this site/service provision.....
.....
2. What didn't you like about this site/service provision .....
.....
3. Any suggestions/changes you are recommending.....
.....
4. Would you recommend BLM/PSI services to others? ▫ Yes ..... ▫ No .....

ANNEX 5: YONECO ASSESSMENT OF YOUTH-FRIENDLY SERVICES

	QUESTION	SCORES					Comments or Remarks
		1	2	3	4	5	
1	Awareness of available SRH policy and guidelines for provision of YFHS						
2	Availability of referral system to other Service Delivery Points						
3	Availability of adequate infrastructure to provide YFHS (Check for availability of room/space for YFHS)						
4	Is a sign displayed that clearly shows schedule, time and location of YFHS?						
5	Are outreach services being provided according to schedule?						
6	Availability of equipment, supplies and medicines necessary to provide the YFHS						
7	Availability of recreational materials / Are they being utilised by young people at the facility?						
8	Do you have IEC materials targeting young people and containing health information at your Service Delivery Point?						
10	Established any links with other organisations/institutions in this area that provide information and education on health, including sexual and reproductive health, to young people?					X	
11	Ability to hold meetings or discussions withyoung people about YFHS in the past six months.		X				
12	Have the service providers in the SDP been trained in YFHS? How many (Minimum of 2 SPs per SDP)						
13	Conduct or attitude of service providers (providing privacy to young people? Respect?)						
14	Availability of disaggregated data for young people in their catchments area						
15	Distance travelled for the young people to access YFHS						
16	Access to family planning methods (check availability of contraceptives, including condoms, in the area)						

ANNEX 6: COURSE CONTENT FOR SCORECARD AND MYSTERY CLIENTS

Topics Covered During Mystery Client training

- Orientation on the meaning of adolescents, very young people, young people and youth according to WHO,
- Reasons why we need to invest in the health and development of adolescent and young people
- Meaning of Youth-Friendly Services and the criteria for health services to be outh friendly according to Malawi's MOH
- Characteristics of a YFHS facility
- What young people want from a health services facility
- What young people want from health services
- Minimum package for delivery of YFHS
- National Youth-friendly Health Services Standards
- Factors that young people from accessing YFHS
- Cervical cancer signs and symptoms, risk factors and primary prevention
- Family Planning
- Sexual Transmitted Infections and the important factors to consider when managing young people with STI
- Factors that hinder young people's prompt access to STI treatment
- HIV and its prevention strategies
- Customer care and customer service in relation to YFHS
- Things to consider when working with adolescents

Topics Covered during Scorecard Training

- The meaning of Youth-Friendly Health Services and the criteria for health services to be youth-friendly, according to Malawi Ministry of Health.
- National Youth-Friendly Health Services Standards.
- Factors that hinder young people's prompt access to STI treatment.
- HIV and its prevention strategies.
- Customer care and customer services in relation to STI.
- Things to consider when working with adolescents.
- What young people want from health services.
- Minimum package for delivery of YFHS.