

MOMENTUM

Country and Global Leadership



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THE POWER OF YOUTH VOICES

How Youth Are Holding Their Health Systems Accountable for
Family Planning and Reproductive Health

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ABBREVIATIONS

AGYW	adolescent girls and young women
FP	family planning
FP/RH	family planning/reproductive health
GBV	gender-based violence
INGO	international nongovernmental organization
NGO	nongovernmental organization
PDQ-Y	Partnership Defined Quality for Youth
PYD	positive youth development
RH	reproductive health
SAfAIDS	Southern Africa HIV & AIDS Information Dissemination Service
SDGs	Sustainable Development Goals
USAID	United States Agency for International Development
YFS	youth-friendly services

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EXECUTIVE SUMMARY

Youth-led social accountability for health has the potential to advance positive youth development (PYD), improve the quality of family planning/reproductive health (FP/RH) care for youth, and strengthen the responsiveness of the health system to the needs and rights of youth. While youth have been increasingly engaged in social accountability for health, there has been relatively limited documentation and analysis of youth-led social accountability efforts. Little is known about the prevalence and scope of youth-led social accountability efforts, key challenges and promising practices in youth-led social accountability, and the pathways for increasing youth-led social accountability. To address these knowledge gaps and generate recommendations on the way forward, MOMENTUM Country and Global Leadership conducted this landscape analysis. The landscape analysis aims to answer the following questions:

1. How have youth been engaged in social accountability for FP/RH at facility, subnational, and national levels?
2. What outcomes have been achieved through youth-led and youth-inclusive social accountability for FP/RH?
3. What are the barriers and facilitators to youth participation and leadership in social accountability?
4. What are the barriers and facilitators of health systems' responsiveness to youth-led and youth-inclusive social accountability?
5. What lessons can be learned from broader social accountability initiatives for FP/RH?

To answer these questions, we conducted a desk review of peer-reviewed and grey literature as well as a series of in-depth interviews with youth, academics, and representatives of implementing organizations. Additionally, we held a virtual consultation with youth to corroborate the findings and enhance the recommendations.

Through this methodology, we identified 25 social accountability initiatives for FP/RH that were either youth-led or youth-inclusive (collectively referred to throughout this report as “youth social accountability”). We found very limited documentation of these social accountability initiatives making it difficult to discern the specific ways in which youth were involved, the extent to which it is meaningful, and the outcomes achieved.

The youth social accountability initiatives identified sought to change FP/RH outcomes in three categories: 1) improvements in the attitudes of providers toward youth; 2) improvement in the quality and equity of health services; and 3) changes in accountability relationships between youth and the health system. In addition, the youth and adult social accountability experts interviewed for this landscape agreed that youth social accountability also contributes to PYD and youth empowerment outcomes. However, there was no measurement of these outcomes in the social accountability initiatives identified.

We identified challenges to youth social accountability related to youth participation, health system responsiveness, and an over-emphasis on short-term project-based accountability compared with sustainable youth-led movement building. Promising practices for youth social accountability emerging from the landscape include capacity building for youth and adults, strengthening relationships between youth and health system actors, leveraging digital connectedness, and targeting accountability efforts at multiple levels of the health system.

Through this landscape analysis, we find that youth social accountability implementation is racing ahead of documentation, and that there are opportunities to improve youth social accountability practice in order to increase youth leadership and improve the responsiveness of health systems to the needs and rights of youth. Based on this we propose four recommendations to advance youth social accountability: 1) increase monitoring, evaluation, and learning of youth social accountability initiatives; 2) prioritize support for youth-led social accountability, rather than just youth-inclusive; 3) apply multi-level social accountability approaches; and 4) shift away from tools and toward relationship building as the focus of social accountability.

SECTION 1: INTRODUCTION

Youth social accountability for family planning/reproductive health (FP/RH)—whereby youth hold public officials and service providers to account for the provision of quality, equitable, and accessible FP/RH care—can contribute to youth-responsive health systems, improve quality FP/RH care and programming for youth, and foster positive youth development (PYD) and leadership. It is one of the ways in which youth can be meaningfully engaged in efforts that seek to advance their health and human rights.

Despite the potential of youth social accountability and increasing interest in both social accountability and meaningful youth engagement in FP/RH, there is not a clear understanding of what youth social accountability initiatives are being implemented, where they are, and what their impact and challenges have been. Understanding the state of youth social accountability is important to inform the way forward for youth, organizations, donors, and researchers interested in advancing the practice of youth social accountability. In order to fill this gap, MOMENTUM Country and Global Leadership conducted a landscape analysis to answer five questions:

1. How have youth been engaged in social accountability for FP/RH at facility, subnational, and national levels?
2. What outcomes have been achieved through youth-led and youth-inclusive social accountability for FP/RH?
3. What are the barriers and facilitators to youth participation and leadership in social accountability?
4. What are the barriers and facilitators of health systems' responsiveness to youth-led and youth-inclusive social accountability?
5. What lessons can be learned from broader social accountability initiatives for FP/RH?

The findings of the landscape analysis are contained in this report, which is divided into the following sections:

1) Introduction, 2) Methodology, 3) Characteristics of youth social accountability initiatives, 4) FP/RH and PYD outcomes of youth social accountability, 5) Challenges in youth social accountability, 6) Promising practices, and 7) Recommendations. In the annexes of this report, there are three case studies of youth social accountability for FP/RH and a table summarizing the 25 youth social accountability initiatives that we identified.

SECTION 2: METHODOLOGY

Social accountability is defined in a number of ways based on, for example, the actors between whom accountability relationships are established (e.g., duty-bearers and rights-holders), the instruments utilized (e.g., community engagement with scorecards), and the level at which initiatives are targeted (e.g., facility, national). Social accountability requires a socio-institutional relationship. In other words, it demands that a non-state actor interface with a representative of the state or other public actor; transforming that relationship is a core function of social accountability.

For the purposes of this landscape analysis, we used the following definition of social accountability: “Social accountability involves ongoing, collective action by civil society groups, which includes NGOs [nongovernmental organizations], to hold public officials and service providers to account for the provision of public goods” (Joshi and Gurza Lavalley, no date). Beyond mere provision, social accountability for health includes efforts to improve the quality, equity, and access of FP/RH care. A **youth-led** social accountability initiative is understood to adhere to this same definition, with the addition that the intervention is devised and implemented by youth. A **youth-inclusive** social accountability initiative differs in that youth are not leading but, rather, participating in a meaningful way. The term **youth social accountability** is used herein to refer to both youth-led and youth-inclusive social accountability. For the purposes of this landscape analysis, youth refers to those aged 15 to 24.

There were two primary data collection methods for this landscape analysis, a literature review and key informant interviews. Following the development of preliminary findings and a draft set of recommendations, we held a virtual consultation to seek youth input. Each of these methods is explained in more detail below along with limitations.

2.1 LITERATURE REVIEW

The literature review included both peer-reviewed and grey literature. We conducted online searches on Google, Google Scholar, PubMed, and the websites of selected organizations, United Nations agencies, and research institutions working in the areas of FP/RH and youth development. Box 1 sets out the search terms used. The literature search was conducted primarily in English with additional primary terms searched in Spanish, French, and Portuguese. In addition to the online searches, we used the bibliographies of recent reviews of social accountability by USAID's Maternal and Child Survival Program (MCSP 2017, 2019) and CORE Group (2014) to identify relevant resources.

Box 1: Literature review search terms

Youth-led social accountability; adolescents/youth/young people/10 - 24 + social accountability; social accountability + family planning; social accountability + reproductive health; monitoring and evaluation + social accountability; social accountability tools; social accountability processes

Further resources were sought through the dissemination of a brief Google Form aimed at identifying documentation not unearthed through the above-mentioned search strategy. The authors sent the survey to known global, regional, and national experts on social accountability as well as the Youth Health and Rights Coalition, ISRRRC, and FP2020 listservs in August 2020. The Google Form asked respondents to provide information on any youth-led social accountability initiatives they have been involved with. By September 15, 2020, eight responses to the survey were received. Additional documents were also identified by interviewees and later added to the review. A total of 59 publications were identified and assessed against the following inclusion criteria:

-
- ```
graph TD; A["• addresses youth social accountability for FP and/or RH; and/or
• addresses youth social accountability for health broadly; and/or
• addresses (adult-led) social accountability for FP and/or RH"] -- "< OR >" --> B["• addresses social accountability theory and practice broadly; and
• was recommended by an interviewee"]; A -- "v AND v" --> C["• published on or after January 1, 20101"]
```
- addresses youth social accountability for FP and/or RH; and/or
  - addresses youth social accountability for health broadly; and/or
  - addresses (adult-led) social accountability for FP and/or RH
- < OR >
- addresses social accountability theory and practice broadly; and
  - was recommended by an interviewee
- v AND v
- published on or after January 1, 2010<sup>1</sup>

Fifty-four publications met these inclusion criteria and were reviewed; 14 were peer-reviewed publications and 40 were categorized as grey literature. The grey literature was subdivided into guidelines and standards (9), evaluation reports (1), project reports (8), unpublished literature review (1), research reports (8), webinars (2), working papers (1), and other (10). An analysis sheet was developed around the questions for this landscape analysis to review the 54 publications in a standardized manner. It included domains related to youth participation and leadership, tools and processes, outcomes, and barriers/facilitators. Relevant information and quotations from the literature were drawn into the sheet and analyzed thematically to formulate the contents of this report.

<sup>1</sup> One exception to this criterion was made for documents relating to Save the Children's Partnership Defined Quality for Youth initiative in Nepal; the initiative is ongoing; available reports were written before 2010.

## 2.2 IN-DEPTH INTERVIEWS

Following the literature review, we developed an in-depth interview guide that focused on the primary landscape questions and addressed gaps emerging from the literature. The guide contained questions on youth-led or youth-inclusive social accountability for FP/RH specifically, (adult-led) social accountability for FP/RH generally, and on what is needed to better support youth participation and leadership in social accountability efforts. We conducted a total of eight interviews with 11 individuals. Interviewees included practitioners and academics from global, regional, and national organizations, including youth-led and youth-serving organizations. The authors assigned interviewees numerical codes to ensure their anonymity. The authors analyzed the interview data according to the landscape questions, extracted relevant evidence, and identified and discussed key themes.

## 2.3 VIRTUAL YOUTH CONSULTATION

To validate the findings of the literature review and in-depth interviews, MOMENTUM Country and Global Leadership held a virtual consultation with 14 youth on October 29, 2020. Following a presentation of preliminary findings and recommendations, three to five youth participants formed discussion groups with one facilitator and one note-taker. Facilitators asked the groups to respond to the following two questions:

- Do the findings resonate with your own experience? Why or why not? Is anything missing?
- Are there any key recommendations for advancing youth social accountability that have been missed? Are there recommendations you don't agree with? Recommendations that need more detail?

The authors used the discussion to refine and enhance the recommendations of this landscape analysis.

## 2.4 LIMITATIONS

This landscape analysis was exploratory. There was not a firm sense before it began of the amount of literature and experience available on youth social accountability for FP/RH. While there is a growing body of literature, this landscape analysis found significant gaps, including a dearth of peer-reviewed literature, few comprehensive evaluation reports, and a lack of documentation of the processes through which youth social accountability initiatives operate. In terms of experience and expertise, however, there is no shortage across the youth and FP/RH sectors globally. Interviews with experts helped to fill some of the gaps in the available literature. Interviewees noted that documentation and evaluation of youth social accountability has not kept up with practice, and as such there are likely many more youth social accountability initiatives that are not captured in this landscape analysis because they are not documented.

A further limitation is the blurring of lines between social accountability and several other areas of FP/RH programming, including advocacy, quality improvement initiatives, and meaningful youth engagement. This landscape analysis examines initiatives that self-identify as social accountability. There are likely to be more initiatives that would have characteristics of social accountability but were not identified using the search terms and parameters set for this landscape analysis.

Finally, this landscape analysis focused on youth social accountability for FP/RH; we did not review the full body of social accountability literature related to broader health, development, or political science. To provide context, however, on the advice of interviewees, the authors reviewed a small number of recent and/or widely-cited (mostly peer reviewed) studies.



## SECTION 3: CHARACTERISTICS OF YOUTH SOCIAL ACCOUNTABILITY INITIATIVES

### 3.1 GEOGRAPHIC DISTRIBUTION AND SCALE OF INITIATIVES

The landscape analysis identified 25 social accountability initiatives across 33 countries in five regions (see Figure 1 and Annex 4). Of the 25 initiatives, two were multi-regional, three were regional in Africa, and the remaining 20 took place in one country. Fifteen of the initiatives sought to engage on the subnational level, while 11 targeted the national level and five targeted the facility level; seven initiatives combined activities at multiple levels of the health system (mostly subnational and national), one of which engaged both regional and national levels.

**FIGURE 1: REGIONAL OVERVIEW OF YOUTH SOCIAL ACCOUNTABILITY INITIATIVES**



Documentation of the scale of youth social accountability initiatives, such as the number of youth participating in the initiatives and geographic coverage is incomplete. Four of the 25 initiatives provided information on the number of youth participating in the initiatives, which ranged from 10,000 youth in a movement for legal reform in Peru to 10 youth reporters in a Sustainable Development Goals (SDGs) accountability initiative in Tanzania. Information on geographic coverage is provided for at least nine of the 25 initiatives, most of which are operating at a subnational level in just one or two districts or regions of a country. Of the five initiatives working at the facility level, two provided information on the number of health facilities engaged in the social accountability effort; in Nepal, 67 health facilities engaged in the social accountability effort and in Panama three facilities participated (see Annex 3 Partnership Defined Quality for Youth Case Study and IPPF 2016).

In relation to sustainability, only the Partnership Defined Quality for Youth (PDQ-Y) initiative in Nepal provided detailed information. In Nepal, Save the Children trained several district health officials to carry forward PDQ-Y without further funding or involvement from Save the Children. However, given that the responsibility sat with individuals at the subnational level and was not institutionalized within the Ministry of Health, turnover of staff members and health management and operation committee members meant that the approach was not carried forward even in districts where it had already been used for some time (Interviewee 8).

Of the 25 initiatives, at least 10 were funded and led by international nongovernmental organizations (INGOs), while another 10 were led by national NGOs. For the remaining five, the lead organization is either unclear in the documentation, or they are led by a regional organization or global network of national organizations.

## 3.2 HOW YOUTH ARE ENGAGED IN SOCIAL ACCOUNTABILITY

There is scant description of exactly how youth were engaged in the 25 initiatives. The lack of documentation makes it challenging to understand the mechanics of youth engagement and to identify promising practices in various settings and for distinct communities.

Based on the limited descriptions, we identified five initiatives that appeared to be youth-led, including two implemented by the INGO Restless Development. The remaining 20 appear to be youth-inclusive. We found only one initiative that described how youth were engaged in the initial design stages of the social accountability initiative. The perspectives of several youth consultation participants reinforced the finding that youth are typically absent from the design and ultimate decision-making spaces within initiatives led by or jointly led by adults.

We found a wide range of social accountability methods used by youth for FP/RH. These include:

- Youth assess the friendliness of health services using pre-defined criteria/scorecards (sometimes called social audits).
- Youth report barriers to service access and poor quality of service provision using digital tools, such as apps and online platforms.
- Youth gather data on the extent to which governments are upholding national, regional, and international commitments to youth health and rights, and meet with government representatives to present findings and request accountability.
- Youth participate in facilitated dialogue processes whereby youth and service providers/health officials collectively define quality FP/RH care and create joint action plans to improve the quality (e.g., PDQ-Y).
- Youth participate and/or convene public hearings that bring together youth, community members, and health officials to jointly discuss issues of concern to youth.
- Youth work with legal institutions to pursue strategic litigation in the form of a constitutional challenge to existing law.
- Youth conduct public inquiries and data collection on rights violations.
- Youth participate in ministry of health budget allocation processes to ensure service quality improvement for youth and other youth health programs receive budget allocations, and then follow-up the budget process by tracking public expenditure.
- Youth participate in health facility management/co-management committees designed to ensure community oversight and input into health facility operations.

As part of many of these social accountability processes, youth receive support to use a variety of tools aimed at identifying gaps in the respect, protection, and fulfilment of their human rights. At the facility level, for example, health care standards, patient charters, nurse codes of ethics, and principles for youth-friendly service delivery have been used to understand the guidelines by which service providers are bound. At subnational and national levels, regional and international human rights conventions as well as national law serve to clarify governments' legal obligations to provide FP/RH care to youth. To translate this understanding of rights and entitlements into measures of duty-bearers' compliance, youth are using various tools, including digital applications to input data on the youth friendliness of providers and scorecards to measure compliance with quality health care standards. The outputs of these tools provide evidence that is then used to raise awareness among the general population of youth and to engage in dialogue with duty-bearers.

### 3.3 PROFILES OF YOUTH INVOLVED

With limited documentation, it is difficult to say anything conclusive about which youth were involved in the social accountability efforts, and how and if particularly marginalized youth were engaged. Information from the 25 youth social accountability initiatives indicates that most initiatives originate in youth-led or youth-serving organizations, including INGOs, based in urban contexts. As such, there are challenges in ensuring the participation of marginalized youth, particularly from rural settings, from the outset of social accountability initiatives (Interviewee 8, 3). The groups of youth engaged in the 25 initiatives included people living with HIV, young women, married young men, rural youth, and urban and peri-urban youth.



*Photo: Yagazie Emezi / Save the Children*

## SECTION 4: OUTCOMES OF YOUTH SOCIAL ACCOUNTABILITY

Social accountability practice is racing ahead of documentation, evaluation, and research (Interviewees 1,4; Boydell and Keesbury 2014). This is, at least in part, due to the complex nature of social accountability, which makes it difficult to evaluate using traditional methods (Interviewee 4; Steyn et al 2020). We found only one youth social accountability initiative that was rigorously evaluated. The other initiatives were largely documented in the form of project reports, short case studies, and anecdotes. Where data was included, it typically focused on the use of a particular commodity or health service or the number of youth reached. While the documentation doesn't include significant information on the outcomes that were *achieved*, we found that the youth social accountability initiatives *aimed to achieve* outcomes in two key areas: FP/RH and PYD. Each of these is explored below, followed by an analysis of gaps in measurement.

“Current social accountability practice has been racing ahead of clear evidence of impact. The paucity of studies of impact (although increasing rapidly), the fragmentation of the data points, the lack of comparative evidence, the need for studies using mixed methods all have contributed to a situation where there is a strong normative belief in citizen-led accountability without a clear understanding of the conditions under which it can have impact”

(Joshi 2013 quoted in Boydell and Keesbury 2014).

### 4.1 FAMILY PLANNING/REPRODUCTIVE HEALTH OUTCOMES

Looking across the youth social accountability initiatives identified, the FP/RH outcomes they sought to achieve fall into three broad categories: 1) improvements in the attitudes of providers toward adolescents and youth; 2) concrete actions to improve the quality and equity of service provision; and 3) changes in accountability relationships between youth and service providers. Specific outcomes reported in these three categories are detailed in Table 1.

TABLE 1: INTENDED OUTCOMES OF YOUTH SOCIAL ACCOUNTABILITY

| Category                                                                                 | Outcomes                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |
|------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Changes in attitudes of providers toward adolescents and youth                           | <ul style="list-style-type: none"> <li>• More respectful attitudes of service providers toward youth and adolescents</li> </ul>                                                                                                                                                                                                                                                                                                                                                                                                   |
| Actions to improve the quality and equity of service provision for adolescents and youth | <ul style="list-style-type: none"> <li>• Designation of youth-friendly clinics and areas</li> <li>• Lower cost of services for youth</li> <li>• Train staff on delivering youth-friendly services</li> <li>• Modification of communications materials to be more adolescent-friendly and to increase the visibility of adolescent-friendly activities</li> <li>• Timely restocking of essential commodities</li> <li>• Improvements in quality standards and the establishment of technical and programmatic protocols</li> </ul> |
| Changes in accountability relationships between youth and service providers              | <ul style="list-style-type: none"> <li>• Strengthened communication channels between providers and youth</li> <li>• Mechanisms for youth input into services (e.g., question boxes to welcome questions and feedback from clients)</li> <li>• Improvements in trust, confidentiality, privacy, and mutual respect</li> </ul>                                                                                                                                                                                                      |



It is worth noting that youth may be limited in their “asks” and the outcomes they seek through social accountability. Several youth participants in the virtual youth consultation suggested that this is due to a lack of human rights education and low levels of awareness among youth of their rights to health and quality health services, and the conditions necessary for their realization. As a result, youth tend to ask for tangible, visible changes such as the establishment of youth-friendly corners and clinics, rather than other, more systemic changes that may affect long-term sustainable change in service quality and equity.

## 4.2 POSITIVE YOUTH DEVELOPMENT OUTCOMES

While changes to improve health services are the most commonly observed outcomes of youth social accountability initiatives, several interviewees noted shifts in understanding among youth of the power of their own voices and leadership as well as greater weight placed on youth perspectives by communities.

“When it works, it massively shifts how young people are viewed in a community. There’s a catalytic effect and brings together others who may be inspired to join the movement. [Social accountability] increases young people’s authority. Young people are seen as experts and are able to pick up knowledge quickly and demonstrate their own capabilities. Young people have capacity and knowledge, and just need the tools” (Interviewee 6).

Across all initiatives reviewed, there was implicit focus on not only creating positive shifts in health outcomes but also on creating space for youth voices and leadership. As noted by several interviewees, an emphasis on building youth leadership is an investment that has the potential to outlive health facility level improvements and help foster cultures of accountability and movement building (Interviewee 1). Another interviewee observed that “leadership training needs to go hand in hand with a platform to apply that learning, to learn by doing. We’ve seen young women stand for council after social accountability initiatives because they have that increased confidence and efficacy and agency” (Interviewee 4). While some of the documentation and, in particular, interviewees highlight the PYD outcomes achieved through social accountability initiatives, the evidence available is anecdotal and we did not identify any empirical measures of PYD or empowerment used in the evaluation of youth social accountability initiatives.



Photo: Mauricio Botero / Save the Children

## 4.3 GAPS IN OUTCOME MEASUREMENTS

Measuring social accountability can be a challenging endeavor. This is a result of the myriad of contextual factors and relationships at both micro and macro levels that affect outcomes, and the fact that measuring outcomes of social accountability must take account of its long-term nature; in other words, it requires patience.

“Social accountability is a long game. Because there’s money on the table, people are playing it as a short game. As an emphasis, we have to show that it ‘works.’ The essence of social accountability is not to ‘work’—we have an indicator that’s bad, and we’re going to have it improved by year 2 or 3 or whatever year of the project. [That’s a] very intervention design model. Social accountability can help, but it is not meant to do that. It’s meant to work on an intermediary result—do you care about your clients [and] about what signals they are sending you?” (Interviewee 5)

In light of the above-mentioned challenges, measurement frameworks need to be grounded firmly in context-specific theories of change, and take into account the efforts of other actors using similar or complementary strategies to achieve change in the same context. Indicators should measure the intended short-, medium-, and long-term impacts at various levels. While most existing studies of impact “are looking for the immediate outcomes such as visible improvements in services,” there is a need to “systematically identify all the potential impacts one might be interested in to trace the extent they might have been achieved in specific cases” (Joshi 2014). These indicators may relate to changes in social actors, such as changes in rights awareness among youth or changes in norms related to youth participation; changes in state responses, such as the responsiveness of health systems to demands made by youth; and the opening up of spaces for collaborative dialogue between youth and the state (Joshi 2014).

Interviewees expressed a desire to move toward indicators of success that measure solidarity, collectivism, and the ability of citizens to coalesce around and act on commonly observed or experienced rights violations (Interviewee 3). This focus necessitates a shift away from measuring immediate change in health-seeking behavior as the only indicator of success and toward measuring the strength of socio-institutional relationships and PYD and empowerment among youth. As described by one interviewee, change should be measured in part by the way that “people [youth] see themselves as actors and build a sense [of] buy-in, sense of responsibility” (Interviewee 5). On the side of the state, interviewees suggested that health systems’ responsiveness be measured by the extent to which state actors take youth demands into consideration and make decisions commensurate with their rights.

“Social accountability is [when] a duty-bearer, who has a responsibility, is confronted with a choice every day about funding, [and] at some point that person thinks ‘people won’t be happy or that won’t be fair.’ That moment is what makes the system work” (Interviewee 5).



## SECTION 5: CHALLENGES IN YOUTH SOCIAL ACCOUNTABILITY

The landscape analysis identified several challenges to youth social accountability. Some of these are challenging for all social accountability efforts, while others are specific to youth. These challenges are categorized under 1) youth participation, 2) health system responsiveness, and 3) sustainability, each of which is explored in more detail below.

### 5.1 CHALLENGES FOR YOUTH PARTICIPATION

We found that the challenges youth encounter in their efforts to participate in social accountability processes fall into three main areas: 1) power, hierarchy, and social norms; 2) inclusion of diverse youth; and 3) practicalities.

#### POWER, HIERARCHIES, AND SOCIAL NORMS

In many contexts, social norms—unwritten rules of behavior shared by member of a given group or society—suggest that youth must be subordinate and deferential to their elders. These norms can stifle the willingness and ability of youth to participate in initiatives that require youth to speak up and share their perspectives with people who are older and in positions of leadership.

“A young person usually is at the bottom of the decision-making chain, so we need to give that capacity building to realize that there is a need to deliberately target the traditional norms.... A part of the barriers is the politics that surrounds older people being service providers because it becomes volatile when you speak to gaps. Young people have a major fear to raise issues.... You can’t really stand up and say it in your community.... When young people are going to advocate, they need to know how they are going to be protected when they speak out about the realities that are on the ground” (Interviewee 9).

Given that it is in the very nature of social accountability to question existing power structures, upend dominant norms, and challenge embedded hierarchies between and within groups—including between youth and adults, citizens and the state, and different groups of youth—it is not surprising that youth engagement can encounter opposition from adults, including health care providers and other health system actors. This opposition may be even more pronounced in relation to FP/RH, given its linkages to contested issues such as gender identity, sexuality, and religion (Boydell 2019), and the stigma associated with youth sexuality. Adults may be unaccustomed to youth voices being positioned as authoritative and, as a result, are unwilling to listen to their demands for change. This is particularly true in the context of the medical profession, which may have the assumption that it is not the place of youth—or any lay person—to provide oversight of health services and systems (Lodenstein 2016).

“There’s resistance to change, there’s resistance to the idea of ‘big brother’ watching me, from both hospitals and the youth. Who knows my info? Who knows about me? Who is watching to see how much work I am doing? Who is judging me based on my judgment of others.... There is a lot of stigma around the idea of social accountability monitoring because it is that sense of being watched, and that makes even ethical, truthful people nervous, the idea that someone is just watching you” (Interviewee 11).

Power dynamics between youth and adults and between INGOs and youth-led organizations also impact the design of youth social accountability initiatives. Some youth described their participation in social accountability being a “means to an end” for adult-led organizations and donors. Youth consultation participants noted that they were often brought in once the terms and processes for social accountability have been decided by adults, and they described feeling as though they were waiting for an invitation to speak up. Furthermore, interviewees highlighted that the outcomes that youth are interested in are often

different from adults' priorities. They noted that youth are generally interested in issues of quality, rights, and control over one's own decisions, and donors and governments are often interested in the number of services provided (Interviewee 3). As one virtual youth consultation participant put it, "the challenges young people have are not the same as the difficulties older people face. For reproductive health issues [young people face difficulty in access to services], older people do not face the same issues."

## INCLUSION OF DIVERSE YOUTH

Although age-related discrimination may be unique to youth, the exclusivity of accountability spaces is not. Space for civil society representation within accountability processes may be limited to one or two people, making it nearly impossible to include the voices of all affected communities (Health Policy Project 2015). This "elite-capture" is a well-documented challenge for social accountability initiatives in general (Joshi 2014). Thus, the potential for already-excluded groups, including youth, to be further excluded in the context of social accountability necessitates "critical thinking about power and privilege that underline community voice" (Boydell et al 2019).

One of the primary challenges highlighted by interviewees was the participation of diverse and, particularly, marginalized youth in social accountability for FP/RH. While all youth experience challenges to social accountability participation due to power, hierarchy, and norms, youth who experience systematic exclusion and discrimination based on class, caste, ethnicity, religion, educational level, economic status, sexuality, and gender identity face additional barriers. One interviewee pointed out that youth from indigenous communities in his country have a deep mistrust of state authorities, which prevents them from engaging in social accountability (Interviewee 8).

"It's also about the diversity of the voices that are a part of the conversation, ensuring all classes—grassroots, lesbian, gay, bisexual, transgender, queer, and different voices—because even in developing such frameworks, the voices of those who are more or less disadvantaged in getting to 'the table' are lacking. It can become an elitist youth-led scenario. So, we are thinking through how to balance it" (Interviewee 2).

## PRACTICAL PARTICIPATION BARRIERS

We identified four challenges relating to the practicalities of youth participation and leadership in social accountability processes.

- 1. MOBILIZING AND ORGANIZING:** Organizing groups of youth is central to any youth social accountability process. In some contexts, particularly where the use of coordinating mechanisms and digital applications such as WhatsApp and Facebook Messenger are not available to youth, mobilization is a challenge. Adding youth's lack of control over financial and other resources to this means that youth often rely on adults and their funding to be invited and funded to participate in social accountability.

"Adults have more convening power because they have bigger budgets. In Kenya, youth are scattered everywhere.... A key learning is the coordination aspect of how to bring people together. Another aspect is having joint objectives as young people because we work across different topics—SRHR [sexual and reproductive health and rights], employment, climate. But, you find that there are cross-cutting issues in their advocacy where they can rely on the power of their networks. Coordination is dependent on resources, though" (Interviewee 2).

- 2. LIMITED ACCESS TO DATA AND THE INTERNET:** Low penetration of mobile phone usage, lack of access to data, and clinics without free Wi-Fi were all noted as challenges to youth participation in digital social accountability initiatives. While creative solutions are being tested, such as training youth champions in health facilities to provide support and access for other youth to use digital social accountability tools, there is a need to carefully consider how the digital divide may be further widened through the use of such technology in social accountability. Further, at least one interviewee noted the concern among youth that their information would be shared if it was recorded using digital tools (Interviewee 7).

“There were big issues with access to data. Mobile data in sub-Saharan Africa is ridiculously expensive and that’s a major barrier for a number of the youth and for the health care facility staff, not just the youth who are struggling” (Interviewee 11).

- 3. TURNOVER AMONG YOUTH PARTICIPANTS:** The perennial challenge of high rates of turnover among youth participants and leaders is one that has been documented extensively in FP/RH programs generally (IPPF 2016). In Nepal, for example, after orienting and supporting various adolescents in the PDQ-Y process, participation waned as work and school examinations took priority (Interviewee 8).

“We managed to have reps from adolescent groups on the quality improvement team, but the problem we encountered was continued participation. They are in school or on their own way with their business. We noticed throughout the years that the continued meaningful participation was a challenge” (Interviewee 8).

- 4. LANGUAGE:** The language surrounding accountability causes confusion and, in some contexts, prevents youth from participating. One interviewee pointed out that “accountability” is not a word that is widely understood; thus, it needs to be explained to youth and to communities before it is used. Further, there are negative connotations attached to the word “accountability,” particularly in places where government oversight is a reality in all areas of life. In one African country, the use of the word is avoided altogether and youth are called “youth data reporters,” even though their role is related to accountability (Interviewee 10).

“Reframing accountability away from something that sounds really technical and alienating. Breaking it down and framing it around supporting young people to understand that what they’re already doing is already accountability” (Interviewee 6).

## 5.2 CHALLENGES FOR HEALTH SYSTEM RESPONSIVENESS

This section explores challenges the health systems may have in responding to the demands of youth social accountability processes. Through the landscape, we identified challenges related to 1) the multiple levels and actors in health systems and 2) the health system capacity to engage with youth.

### MULTIPLE LEVELS AND ACTORS IN A HEALTH SYSTEM

Health systems are complex and it can be difficult to know where to apply pressure to affect change. Social accountability processes must take account of the “webs of accountability relationships” and the different actors operating at varying levels of the health system who hold power over decisions that affect FP/RH for youth, including public providers, health ministries, finance ministries, parliamentary health committees, budget committees, insurance agencies and hospital boards (Boydell et al 2019). Added to this complexity is the existence of private FP/RH providers, which may remain outside of accountability mechanisms altogether and, in some contexts, are more acceptable and accessible to youth who can afford to pay (Interviewee 3; Boydell et al 2019).

The layered, decentralized nature of many health systems is such that pressure applied at one level of the system may not translate into the desired change. Evidence suggests that there is a tendency in social accountability initiatives to focus at one level of the system or another, leading to a “squeezing the balloon” effect, whereby the barriers to FP/RH service provision identified by communities are deflected further upstream. For example, the facility level youth social accountability initiative in Nepal found that demands for longer operating hours and renovation of clinics could not be addressed given the requirement of approval from higher-up the decision-making chain and more funding (Interviewee 8; see Annex 3).

“For example, municipal authorities may claim the problem lies with the provincial or district government. Those subnational authorities may in turn point the finger either back downwards to the local level, or upwards to the national level. National officials, in turn, may claim that the problem resides at the subnational level, or they blame international actors. International actors, in turn, are quite capable of side-stepping their co-responsibility by shifting blame to national or subnational governments” (Fox 2016).

Further, where initiatives focused at one level have affected the desired changes, scaling up often means replication of the same initiative in other locations. This does not, however, account for the contextual variations in causal pathways. One interviewee suggested that it is more effective to scale the issues rather than the initiatives themselves: “If you are doing [social accountability] at the facility level, you don’t scale across every facility. You look at scaling it on issues that arise in those facilities using multi-level vertical and horizontal strategies with players at the national and local level” (Interviewee 4).

“The idea is that you have to adopt strategies at different levels depending on context. For example, if you did not have a primary health center that was functioning at the level of the community, there is no point arguing with community health workers because the stuff is out of their control. They cannot ensure infrastructural change. You have to lever up. You have to build more dynamism within your movement” (Interviewee 3).

## HEALTH SYSTEM CAPACITY TO RESPOND TO THE NEEDS AND RIGHTS OF YOUTH

Health facilities and health systems may lack the skills and resources to sufficiently address the demands of youth in social accountability processes. For example, without appropriate training, mentorship, and supervision, providers may not have the capacity to engage with youth in social accountability processes and may also lack the clinical competencies to provide youth with quality services. Similarly, health systems may not collect age-disaggregated data that allows them to know how young people are accessing services, and refine strategies accordingly. Without capacity to engage meaningfully, health systems do the “bare minimum” to respond to demands and, thus, be seen as responsive without committing to a long-term, collaborative relationships with youth (Sen et al 2020).

## 5.3 CHALLENGES FOR SUSTAINABLE CHANGE

This landscape analysis found that a focus on short-term projects in social accountability initiatives comes at the cost of the longer-term, sustainable impact sought by social accountability. The project-based approach to FP/RH common among INGOs has instrumentalized social accountability in support of behavior change, such as higher FP uptake—an approach that “is reductive of the potential of [social accountability] in driving deeper institutional changes” (Grandvoinnet 2015).

Part of the project-based approach to social accountability is a misplaced focus on tools and the related measurements of success focused on the effective use of scorecards or digital applications. Practitioners and researchers argue that this focus has a “depoliticizing effect” on social accountability processes, which are inherently political (Interviewees 1, 3, 5; Joshi 2012).

“Current conceptualizations of social accountability suffer from what we call the ‘widget’ problem. Even if one narrows down the set of mechanisms currently conceived as social accountability to those that involve an element of monitoring, the range is quite large—from public expenditure tracking surveys, to community monitoring, to citizen report cards. Much of the (very limited) empirical evidence and analysis comes from social accountability initiatives that have a structured, institutional form—often driven by external actors. Assuming that the ‘widget’ is what leads to success ignores the range of contextual and process factors that support the widget (and the processes that comprise the widget) in the successful cases and enables it to work” (Joshi 2012).

While there is an understandable need from donors’ and programmers’ perspectives to demonstrate that social accountability “works” and short-term projects with strong evaluation frameworks allow for this, it may come at the expense of more meaningful consideration of the socio-institutional relationships that sit at the heart of social accountability, particularly for youth-led social accountability.

## SECTION 6: PROMISING PRACTICES IN YOUTH SOCIAL ACCOUNTABILITY

It is important to situate social accountability processes within their unique contexts; “what works” in one context does not translate wholesale into another. As such, the promising practices unearthed are not necessarily universally applicable but, rather, give an indication of considerations that have facilitated

implementation of youth social accountability in varying contexts. These promising practices relate to the following: 1) capacity building and support for youth, 2) capacity building of health system actors, 3) relationship building between youth and health system actors, 4) norm change, 5) digital connectedness, and 6) engagement with the health system at multiple levels.



Photo: Mauricio Botero / Save the Children

### 6.1 CAPACITY BUILDING AND SUPPORT FOR YOUTH

Youth often lack information not only on their rights to health and quality services but, also, on the processes available for holding duty-bearers to account. Youth virtual consultation participants expressed frustration that, while many youth know that they are rights-holders, many do not know that accountability is a right; further, there was a sense that youth do not have a full grasp of the health and human rights commitments made by their governments. Beyond rights education, several youth pointed to the need for capacity building related to specific accountability processes—in other words, the very specific details of how it works and who is involved. One virtual consultation participant explained that building capacity may be as granular as introducing a young person to the relevant duty-bearer.

### 6.2 CAPACITY BUILDING FOR HEALTH SYSTEM ACTORS

There is a need to support and capacitate health system actors, including service providers, health managers, and administrators, to engage with and respond to youth in a manner that challenges prevailing hierarchies and norms (Health Policy Project 2015). In its 2019 publication *Youth Leadership, Participation and Accountability 2.0*, UNFPA highlights building “capacity of social accountability stakeholders on meaningful youth engagement” as one of 10 key facilitators for social accountability (UNFPA 2019). Given turn over within state systems, including the health system, capacity building on how to engage meaningfully and be responsive to youth has to become an institutional commitment.

### 6.3 RELATIONSHIP BUILDING BETWEEN YOUTH AND HEALTH SYSTEM ACTORS

In response to challenges in health system responsiveness, a promising practice is building non-adversarial, collaborative relationships between youth and health system actors. A key feature, which pushes back against the tool- and project-heavy approaches used to date, is to reposition social accountability actions as “one part of a broader and longer process of engagement between collective actors and the state” (Joshi and Houtzager 2012). This necessitates buy-in from actors within the health system and their inclusion from the outset of any new social accountability process—an important requirement for scale-up as well (Interviewee 11).



Despite challenges in health system responsiveness to youth at the facility level, there are also opportunities to build two-way relationships given their more direct linkages with communities. Evidence indicates that where service providers have collaborated with youth and seen the mutual benefits, they are keen to sustain the relationship going forward (Interviewee 7, 8, 11).

“Service providers are directly accountable—they face communities every day. For them, that’s an important relationship. No matter how disrespectful, they have to work there! The community knows that they are depending on them, too. The relationship is more symbiotic there than higher up” (Interviewee 3).

## 6.4 CHANGES IN HIERARCHIES AND NORMS

There was recognition among several interviewees and in the literature that youth can contribute to challenging hierarchies and the norms that underpin them through their involvement in social accountability. While youth engagement in accountability can be perceived as a threat by health system actors, it can also be a driver of change. Hearing youth speak up and use their voices to catalyze change can be powerful for adults, particularly in contexts where that is unexpected. In one instance, an interviewee spoke of how during meetings with service providers in Indonesia, young women spoke out confidently about maternal health issues although their mothers would not (Interviewee 2).

“Young people are disruptive, and when they know there is a gap that can be avoided they have such a powerful and strong voice to voice it out! ... Young people are at the core. We cannot discuss issues of sexual and reproductive health and rights or employment without young people being a core aspect” (Interviewee 2).

## 6.5 DIGITAL CONNECTEDNESS

While the challenge of the digital divide is well documented, there are many places around the world where youth are already collectivized through social media platforms. Where this is the case, digital tools can have an organizing function for youth that allows the articulation of a collective identity and objectives. One initiative in the Southern Africa region researched where youth are accessing information about services, which led to the development of digital social accountability tools that incorporated forums for chat and exchange between youth (see case study in Annex 1). Harnessing digital tools that are already familiar to youth can help to demystify social accountability (Interviewee 6); at the same time, these tools act as an engine of social organization by putting the power directly in the hands of youth to collectivize and share information. Despite these benefits, caution should be exercised in ensuring that digital tools are not seen as social accountability in and of themselves but, rather, that there are human and social processes behind them to instigate change (Interviewee 5).

## 6.6 MULTI-LEVEL ACCOUNTABILITY

Many promising youth social accountability initiatives engaged at multiple levels of the health system to create change. In Uganda, for example, youth champions worked with district level health system actors, who then charted pathways for youth demands and voices to be elevated to subnational and national government budgeting and planning processes (IPPF 2019). In the case of several other initiatives, buy-in at the national, ministerial level was often a requisite first step to create an incentive for local health facility administrators and staff to engage with youth. In these cases, some degree of pressure from further up in the hierarchy and being able to report higher numbers of youth seeking services were motivating factors for hesitant providers.



Photo: Save the Children Partner

## SECTION 7: RECOMMENDATIONS

Through this landscape we find that youth social accountability efforts are being implemented and have significant potential to cultivate youth leadership, improve health system responsiveness to the needs and rights of youth, and improve FP/RH outcomes. To improve youth social accountability practice, scale, and impact, we have identified four key areas for investment and focus.

### 1. Increase monitoring, evaluation, learning, and documentation of youth social accountability efforts in FP/RH and other health areas.

The vast majority of youth social accountability for FP/RH initiatives are not documented or evaluated, meaning we have limited evidence and learning to build on to improve youth social accountability practices. Further, existing measurement frameworks often prioritize immediate improvement in service provision and rarely capture PYD outcomes, the complexity of social accountability relationships, and longer-term changes in the health system. Monitoring, evaluation, learning, and documentation of youth social accountability initiatives should:

- Monitor short-, medium-, and long-term impacts on PYD, service delivery, and health systems.
- Assess youth social accountability's impact on PYD and FP/RH outcomes as defined by communities of youth themselves.
- Use collaboration, learning, and adaptation methodologies to document the complexity of implementation processes and iteratively improve key aspects of youth social accountability, including exploring different models of youth-adult partnerships and the processes by which youth-led accountability initiatives form and change relationships with other civil society actors and the institutions they seek to influence.
- Document which youth are involved (or not) in social accountability initiatives, and the contextual and political factors that facilitate and/or obstruct youth participation and leadership in social accountability efforts.

## **2. Prioritize investment in youth-led organizations and movements to design, implement, and sustain youth-led social accountability.**

True youth leadership of social accountability initiatives remains limited. To increase youth leadership of social accountability, we recommend supporting youth-led organizations and youth-led movements to design and lead social accountability initiatives. Additional considerations for increasing youth leadership of social accountability initiatives include:

- Youth need practical information on their rights, including the right to accountability, and the details of their government's commitments to health and human rights, including in local languages. Youth also need to understand the way in which health system decisions are made and which levels of the health system are important to engage; they may need introductions to the right duty-bearers.
- Funders and partners should support cross-sectoral accountability whenever possible. Youth often want to address a range of issues, such as FP/RH, education, employment, and gender, in their social accountability efforts.
- Adults need capacity strengthening to partner meaningfully with youth in social accountability and respond effectively to youth social accountability demands.
- Social accountability initiatives and supportive partners must also seek to address the social norms that limit the value and power of young people to facilitate sustainable and effective youth-led social accountability initiatives. This includes understanding the specific social norms and power dynamics at play in each context using social norms diagnostic tools.

## **3. Invest in youth social accountability initiatives that target multiple levels of the health system.**

Many youth social accountability efforts focus on one level of the health system (e.g., only the national level or the facility level), thus limiting the effectiveness of accountability initiatives. Youth social accountability initiatives should be supported to develop strategies that target multiple levels of the health system and to coordinate with other organizations and movements to catalyze broader change.

## **4. Shift from a tool-focused approach toward supporting youth movements for accountability, and emphasize transforming relationships between youth and the health system.**

Tools, such as score cards and digital applications, have been a major focus of youth social accountability initiatives to date. There has been comparatively less emphasis on longer-term social accountability processes that require relationship building between rights-holders and duty-bearers. Investing in youth-led organizations and movements to lead social accountability initiatives, rather than direct implementation of social accountability tools through short-term projects, can contribute to transforming the relationship between youth and the health system.

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## ANNEX 1: TRANSFORMING LIVES CASE STUDY

**Project name:** Transforming the Policy Environment for Accelerating Access to Sexual and Reproductive Health and Rights (SRHR) by Adolescents and Young People, within an SDGs Framework, in Southern Africa (Transforming Lives)

**Funder:** Swedish International Development Agency

**Timeline:** January–2018 ongoing

**Objectives:** Strengthen the capacity of regional youth organizations and networks in social accountability monitoring of the delivery of youth-friendly gender-based violence (GBV) and HIV information and services and FP/RH care in Southern Africa, by 2021.

**Social accountability approach:** Youth use the MobiSAfAIDS Application to register concerns about the quality of health services. Health facilities respond and provide feedback on the response via the application. [Click here](#) to visit the MobiSAfAIDS website.

### BACKGROUND

Social accountability is a core part of the work of Harare-based SAfAIDS, a center of excellence that promotes effective and ethical development responses to reproductive health and HIV (including prevention of mother to child transmission and tuberculosis) through advocacy, communication, and social mobilization. While SAfAIDS is not a youth-led organization, young people are core to the organization's work.

The Social Accountability Monitoring for SRHR (SAM4SRHR) project implements a three-pronged approach: 1) capacity strengthening and community mobilization, 2) generation of social accountability and monitoring data on health services through the MobiSAfAIDS app and other methods, and 3) design of collaborative policy advocacy actions to address health challenges faced by young people.

### SOCIAL ACCOUNTABILITY APPROACH

The MobiSAfAIDS pilot was rolled out in six countries: Eswatini, Lesotho, Malawi, South Africa, Zambia, and Zimbabwe. Across these countries, the project involves a total of seven municipalities, eight public health facilities, 14 public health service providers, and seven civil society organizations. Most sites involve one to two civil society organizations and one to two facility administrators; in some contexts, local authorities are also involved.

The MobiSAfAIDS web and mobile application is being used by young people to monitor and report on quality issues they experience at local health facilities. Services being monitored by young people include gender-based violence (GBV), FP counseling and provision, and HIV testing, information, and counseling. The MobiSAfAIDS app can be downloaded for free by anyone in one of the eight pilot sites. It is promoted locally by young people who have been trained as social accountability and monitoring youth champions. [Click here](#) to view the MobiSAfAIDS tutorial video on YouTube.

When a young person identifies or experiences a service barrier or quality issue, they can report this by initiating a ticket through the app. The ticket is put in the queue for that particular health facility and the administrator is notified that there is a new report waiting. The facility administrator reviews the ticket and assigns it to a staff member to resolve the issue. Through the app, the responsible staff member is able to respond to the anonymous youth to communicate how the issue has been resolved. The final decision to close the ticket rests with the youth, who may not agree to close the ticket should they not be satisfied that

the issue is sufficiently resolved. If this is the case, the facility administrator is notified and it is assigned again. In the context of COVID-19, tickets entered into the app have reflected emerging issues regarding access to services, while also capturing the surge in GBV among young people under lockdown.

Young people have been involved throughout the project, from pitching the idea and seeking buy-in from the government, to training other young people in the pilot sites. Young people shaped the application's features, and SFAIDS continues to receive feedback and to refine and change the system based on their inputs. Each participating clinic used in-person support from the pilot's young volunteers, who would support young people seeking services with logging service issues, particularly when accessing a smartphone or data was a barrier, and also to provide a link between the young person seeking services, the facility, the implementing partners, and SFAIDS. Young people were also supported to participate in advocacy activities, such as meetings with local health authorities.

## **IMPACT**

While the initiative is still being evaluated, impacts to date have included a marked increase in the number of young people accessing health facilities. There has also been increased awareness among government decision-makers and facility administrators of the barriers that exist for youth to access quality services. A number of facilities have developed youth-friendly corners or zones where young people can feel confident and comfortable asking for help. Staff have also reported integrating information from the app into their staff meetings, where issues can be discussed as a team, and used for planning and decision-making.

Some governments, including Eswatini, South Africa, and Zambia have started budgeting to help support the continuous operation of the project. However, this also raises questions around ownership and decision-making around the project, the technology, and the implementation, which could threaten the longer-term sustainability of this project.

## ANNEX 2: PARTNERSHIP DEFINED QUALITY FOR YOUTH CASE STUDY

**Project name:** Partnership Defined Quality for Youth (PDQ-Y), Integrated into Adolescent Reproductive Health Programme in Nepal

**Funder:** Save the Children

**Timeline:** 2007–ongoing

**Objectives:** PDQ-Y in Nepal aims to actively engage adolescents from a diversity of backgrounds in the process of improving the quality of FP/RH care.

**Social accountability approach:** A four step process involving dialogues among adolescents, adolescents and health providers, and action planning for quality improvement. The guide for this process is available in *Partnership Defined Quality for Youth: A Process Manual for Improving Reproductive Health Services Through Youth-Provider Collaboration*. [Click here](#) to view this publication online.

### BACKGROUND

Partnership Defined Quality (PDQ) has been used within Save the Children as an approach for quality improvement and social accountability since the early 2000s. In 2007, the Nepal team adapted the PDQ methodology for adolescents (ages 10–19) and piloted it in Kanchanpur District. Thereafter, the approach was integrated into a program in the Siraha District in the Terai of Nepal, where coverage of preventive health services was low and where vulnerable groups rarely used facilities. PDQ-Y later expanded to the Districts of Kapilvastu and Pyuthan (Save the Children 2008).

### SOCIAL ACCOUNTABILITY APPROACH

The PDQ-Y approach is premised on the assumption that the use of services by adolescents should increase as the perceived quality, accessibility, and acceptability of those services increases. Without partnership with adolescents, their perspectives are often overlooked and services fail to meet their real and perceived needs. PDQ-Y promotes partnership with adolescents not only to yield increases in the utilization and quality of health services but also to contribute to their development and empowerment.

The PDQ-Y approach follows a four phase process: 1) building support, 2) exploring quality, 3) bridging the gap, and 4) working in partnership (Save the Children 2008). To build support (phase one), a quality improvement facilitator held orientations with adolescents, service providers, and local health operation and management committees to explain the PDQ-Y process. This phase also included cultivating the confidence of adolescents in decision-making spaces, such as in local health committees. For the second phase, the facilitator held focus group discussions separately with adolescents and service providers to understand their ideas about quality and youth-adult partnership in an open and safe environment. During the bridging the gap phase (phase 3), the ideas generated during phase two were discussed in dialogues between adolescents, service providers, and local health operation and management committee members, and joint action plans developed for quality improvement. Quality improvement teams including youth, service providers, and health operation and management committee members, were established to oversee the plans during this implementation in phase four. They meet regularly to monitor progress and the facilitator supported youth participation in these forums.

## IMPACT

In the two districts where PDQ-Y was first implemented, program staff from Save the Children as well as local health authorities recognized the value of the approach soon after commencing. Within several years, PDQ-Y had been implemented in 62 health facilities, the majority of community health facilities within the two districts. In these facilities, structural changes were made to ensure privacy and confidentiality for adolescents. This included, for example, the establishment of youth corners, private rooms for youth counseling, and provision of informational materials in a confidential manner. In addition, practical changes such as extended opening hours were made to ensure accessibility; training on youth-friendly services was provided for health professionals. Health facilities reported increases in the number of young clients as well as satisfaction levels during exit interviews.

Throughout the entire PDQ-Y process, adolescents had opportunities to share their experiences and opinions on how services should be improved and they were also provided with opportunities to increase communication and leadership skills. Adolescents trained through the program were involved subsequently in budget advocacy for funds to implement the quality improvement action plans and acted as representatives during health management and operation committee meetings.

“Because of adolescents’ engagement, many facilities turned into adolescent-friendly services. It wasn’t possible to move in that direction without their participation. ... Adolescents were the change agents!”  
(Interviewee 8)

Based on more than a decade of experience implementing the approach, the Save the Children team noted the following lessons:

- The PDQ-Y approach has meaningful, positive effects on the quality of services for adolescents at the facility level. However, for those improvements that require systemic changes to the health system, the approach has not led to the desired changes sought by adolescents.
- Supporting the participation and leadership of adolescents over a long period of time is challenging for a number of reasons, including adolescents’ competing priorities and interests, education timetables, and migration. Working with existing youth clubs is a more sustainable option.
- Distrust of authorities among adolescents who experience poverty is a barrier to participation: *“...the problem among them [was] that those people from the poor societies or economically deprived—those people hardly raise their voices. That’s what we observed. For that reason, we engaged them indirectly. We chose a few adolescents who were vocal in the committees.”*
- The PDQ-Y process is time and resource intensive.

## ANNEX 3: YOUTH ENGAGE CASE STUDY

**Project name:** Simba Utano (Health is Power) in Zimbabwe. [Click here](#) for more information online.

**Funder:** Global Affairs Canada with contributions from the Canadian public

**Timeline:** Ongoing

**Objectives:**

1. Increased utilization of equitable FP/RH care, GBV, and HIV services by vulnerable adolescent girls and young women (AGYW) in four districts of Zimbabwe.
2. Improved delivery of quality, gender-responsive, inclusive care and support to address priority needs of adolescents and young people, particularly AGYW.
3. Improved effectiveness of young people, particularly AGYW, and community organizations to advocate for evidence-based, equitable, accountable, and quality services and policies.

**Social accountability approach:** Youth data reporters use scorecards to gather data and advocate for changes based on the scorecard findings.

### BACKGROUND

As part of the Simba Utano project, Youth Engage is a grassroots youth-led network in Zimbabwe that works toward data-driven accountability to measure and advance the impact of Zimbabwe's targets, policies, and interventions relating to young people's health. After being introduced to the concept of social accountability in 2015, Youth Engage started to drive its own social accountability work around the SDGs, with a specific focus on addressing barriers to young people's access to FP/RH care at the facility level.

Simba Utano is a four-year project to strengthen young people's access to FP/RH care and HIV treatment and care in four districts. The project is jointly implemented by the International Coalition on HIV/AIDS and Development (ICAD) and the International Council of AIDS Service Organizations in Canada, Katswe Sistahood, and Youth Engage. It aims to reach over 31,000 adolescent girls and young women and 12,000 adolescent boys and young men. Moreover, it works with parents, youth volunteers, health workers, and religious and community leaders to improve FP/RH and HIV health indicators for adolescent girls and young women. It also seeks to influence policies at the district and national level.

### SOCIAL ACCOUNTABILITY APPROACH

Youth Engage's youth data reporters use scorecards to collect and analyze quantitative and qualitative data from the district health facility level. Youth reporters are chosen from an applicant pool of young people who are already working in the community on issues of FP/RH and receive a year-long training. Data generated by youth reporters is used for a variety of purposes, including informing policy dialogues at a district level, budgeting for services, and advocating for changes in cultural, religious, and traditional practices that hinder youth access. The ultimate vision is for young people to lead change at the community level and hold health facility administrators and decision-makers accountable using the data they gather.

### LEARNING

Simba Utano has provided an opportunity for Youth Engage to participate in social accountability at the district level in a context where many funders are interested in national youth-led advocacy. Staff at Youth Engage highlighted the need for holistic approaches that ensure youth can engage from the grassroots to the national level, including in budget development processes. Youth Engage emphasized the need to develop youth-led social accountability processes that continue to exist even after the civil society organization and their social accountability projects have left.

## ANNEX 4: YOUTH SOCIAL ACCOUNTABILITY INITIATIVES

| Organization                           | Country                                                                                                                                        | Objective                                                                                                      | Level                    | Description                                                                                                                                                                                                                                                                                                                                                                                                  |
|----------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>MULTI-REGION</b>                    |                                                                                                                                                |                                                                                                                |                          |                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>Population Action International</b> | <b>Malawi, Zambia, Tanzania, Kenya, Ethiopia, Uganda, Democratic Republic of the Congo, Côte d'Ivoire, Nepal, India, Indonesia, Bangladesh</b> | To advocate for increased funding and improved policies on adolescent and youth, RH, HIV, and related topics   | Subnational and national | YOUAccess is specifically designed to provide youth-led organizations with funding and technical assistance. Social accountability initiatives have included budget-tracking at the subnational level and hosting roundtable discussions and forums with young people, key decision-makers from the ministry of health, the county assembly, religious leaders, and police (YOUAccess 2019).                 |
| <b>The Youth Coalition/ The PACT</b>   | <b>Cambodia, Egypt, Fiji, Ghana, Laos, Indonesia, Mali, Mexico, Myanmar, Nigeria, Russia, Panama, Philippines, Sri Lanka, Ukraine, Zambia</b>  | To improve the quality of FP/RH care and HIV services and to hold governments accountable to their commitments | Subnational, national    | #UPROOT is a global, youth-led agenda aimed at ending AIDS by 2030 and advancing health and rights. With the participation of more than 400 young people, #UPROOT scorecards were finalized and validated through national consultations conducted in 16 countries resulting in advocacy roadmaps in nine countries as a mechanism to hold governments accountable for their commitments (The PACT no date). |
| <b>AFRICA</b>                          |                                                                                                                                                |                                                                                                                |                          |                                                                                                                                                                                                                                                                                                                                                                                                              |
| <b>N/A</b>                             | <b>Eastern and Southern Africa region</b>                                                                                                      | To give voice to young people's FP/RH demands                                                                  | National and regional    | A group of 23 youth activists from 17 countries in the Eastern and Southern Africa region developed recommendations on FP/RH, which they used to advocate during key moments such as the International Conference on Family Planning and Nairobi Summit and to interface with duty-bearers at the national level (Interviewee 2).                                                                            |
| <b>SAfAIDS</b>                         | <b>Zambia, Lesotho, South Africa, Eswatini, Malawi</b>                                                                                         | To improve the delivery of FP/RH care and HIV services provided in their context                               | Facility                 | Young people trained to use the MobiSAfAIDS application on their phones report on the quality and delivery of FP/RH care, which then is then fed back to the facilities and SAfAids in real-time to inform quality improvement and advocacy (see MobiSAfAIDS case study in Annex 1).                                                                                                                         |



|                                                                                                                                     |                                                                   |                                                                                                                   |             |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|-------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------|-------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Restless Development</b>                                                                                                         | <b>Ghana, Kenya, Malawi, Tanzania, Uganda, the UK, and Zambia</b> | To improve service provision for young people and to institute citizen participation in accountability mechanisms | National    | Accountability Advocates is a network of 20 young leaders who, with the support of Restless Development and their partners, are leading the process of developing national accountability frameworks. The network's work includes monitoring and reviewing service delivery, producing citizen-friendly resources, generating data, convening stakeholders and lobbying for greater youth participation (CORE Group 2017).                                                                                                 |
| <b>N/A</b>                                                                                                                          | <b>Democratic Republic of the Congo</b>                           | To address GBV in South Kivu province                                                                             | Subnational | Grassroots youth clubs for adolescents have set up committees to monitor GBV in educational settings and to hold duty-bearers to account. Advocates from legal clinics work with the adolescents to report violations, thereby enabling them to better understand their rights and the law, and to encourage and refer their peers to various services (IAP 2017).                                                                                                                                                         |
| <b>Plan International</b>                                                                                                           | <b>Ghana</b>                                                      | To reduce maternal mortality and ensure access to health services including FP/RH care and maternal health care   | Subnational | The Young Voices Project built the capacity of young advocates to use social accountability tools to ensure standards of FP/RH care in the Patients' Charter and Nurses' Code of Ethics were implemented. The project entailed the development of joint youth-service provider action plans (Plan no date).                                                                                                                                                                                                                |
| <b>The Kenya National Commission on Human Rights, the Federation of Women Lawyers–Kenya, and the Center for Reproductive Rights</b> | <b>Kenya</b>                                                      | To conduct a public inquiry into violations of health rights                                                      | National    | In 2012, the Kenya National Commission on Human Rights partnered with the Federation of Women Lawyers–Kenya and the Center for Reproductive Rights to conduct a public inquiry into violations of rights. The inquiry used interviews, desk reviews, and public hearings to gather data and develop recommendations, including for young women. The inquiry's report aimed to document the extent of violations within the public health sector, and to suggest appropriate redress and remedies (TCI University no date). |
| <b>CARE</b>                                                                                                                         | <b>Malawi</b>                                                     | To identify barriers to young people accessing services                                                           | Subnational | Through application of a health facility scorecard assessment process in Ntcheu, youth identified that they needed safe spaces to talk about their health issues and needs. In response, the Maternal Health Alliance Project worked with a district government official to establish youth clubs in half of the intervention sites. The clubs provided a forum for adolescents to develop and implement solutions to overcome their unique barriers (CARE 2020).                                                          |
| <b>Youth Net and Counselling (YONECO)</b>                                                                                           | <b>Malawi</b>                                                     | To improve the quality of reproductive, maternal, newborn, child, and adolescent health services                  | Subnational | YONECO used the outcomes of <i>bwalo</i> forums, a traditional method of dialogue being used as part of UNICEF's Social Accountability for Every Women Every Child project, as content in its radio broadcasts to young listeners. This provided young people with an opportunity to engage with the outcomes and use them in their own advocacy (Butler et al 2020).                                                                                                                                                      |
| <b>N/A</b>                                                                                                                          | <b>Tanzania</b>                                                   | To hold governments accountable for commitments under SDGs and FP2020                                             | National    | Youth accountability advocates were trained and worked with an additional 10 young people to conduct research or gather data that allowed them to engage with local duty-bearers. Each young person picked their topic (GBV, FP, etc.), and focused on that, then they engaged at different advocacy moments (Interviewee 2).                                                                                                                                                                                              |

|                                        |                 |                                                                                                                      |                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |
|----------------------------------------|-----------------|----------------------------------------------------------------------------------------------------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Restless Development and UNICEF</b> | <b>Uganda</b>   | To hold decision-makers accountable for their commitments on health, child marriage, and employment                  | Subnational and national | Restless Development and UNICEF supported youth to hold decision-makers accountable for their commitments on health, child marriage, and employment. The project worked with 40 young leaders and generated community-level data across four districts in Uganda using a text message-based feedback platform. The data and analyses were shared and discussed at community consultations and with district and subnational-level decision-makers (PMNCH no date).                                                                                                                                                                                                         |
| <b>UNFPA</b>                           | <b>Uganda</b>   | To hold district health officers to account for improving the quality of youth-friendly services (YFS)               | Subnational              | ASHWA, a youth-led organization operating in Busia, Uganda, partnered with a local radio station to hold district health officers to account on access to HIV treatment. The radio station recorded meetings between young people and local leaders and later aired the sessions for the community to hear and join in the discussion. Community members use this platform to draw attention to problems they experience, such as accessing HIV drugs on time, and are able to call on the local leader to ensure that stock is replenished by the national drug authority in a timely manner (UNFPA 2019).                                                                |
| <b>Reproductive Health Uganda</b>      | <b>Uganda</b>   | To improve the quality of YFS and to ensure youth participation in local government planning and budgeting processes | Subnational and national | In Uganda's Gulu district, Reproductive Health Uganda identified a number of champions among district duty-bearers before the design of the youth-led social accountability pilot. These duty-bearers were trained together with peer educators in social accountability to strengthen the rights of young people. The champions became instrumental in linking young people to the most important decision-makers in the district and raising voices on issues of YFS in the local media. They also became key allies during meetings and reinforced the voices of young people calling for YFS during the local government planning and budgeting processes (IPPF 2019). |
| <b>Reach A Hand Uganda</b>             | <b>Uganda</b>   | To improve the quality of FP/RH care and HIV services in Uganda                                                      | Facility                 | Reach A Hand Uganda created a youth-led social accountability system to improve the quality of adolescent and youth health services by assessing and monitoring the quality of services using an e-referral card system (SAUTIPlus) and results-based bonuses for high-performing health centers. The SAUTIPlus e-referral card taps into locally-developed technology to confidentially refer adolescents and young people to health centers for YFS. The SAUTIPlus app operated on phones used by peer educators and computers and tablets used by health centers to collect and monitor data on quality of service provision (U-Decide 2.0 no date).                    |
| <b>Youth Engage</b>                    | <b>Zimbabwe</b> | To strengthen access to FP/RH care and HIV services and to realize rights                                            | Subnational and national | Simba Utano is a four-year project to strengthen access to health and rights in four districts by working with youth reporters to collect data and hold health system to account (see Youth Engage Case Study, Annex 3).                                                                                                                                                                                                                                                                                                                                                                                                                                                   |

| ASIA                                     |                       |                                                                              |             |                                                                                                                                                                                                                                                                                                                                                                     |
|------------------------------------------|-----------------------|------------------------------------------------------------------------------|-------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <b>Copasah</b>                           | <b>India</b>          | To improve maternal health for young, married women                          | Subnational | Groups of married young men engaged in community discussion groups about maternal health and gendered roles in households and societies. They were supported to develop village charters for holding each other accountable and health charters for holding the state accountable for high quality maternal health services (Interviewee 3).                        |
| <b>Save the Children</b>                 | <b>Nepal</b>          | To improve the quality of FP/RH care for young people                        | Facility    | A series of group discussions with young people, providers, and community health committees provided insights into their perspectives on the quality of service provision for youth. Quality improvement plans and quality improvement teams were developed and carried out actions to improve the quality based on youth inputs (see PDQ-Y case study in Annex 2). |
| <b>World Vision</b>                      | <b>Indonesia</b>      | To raise issues of concern to young women around maternal health             | Subnational | Young women were invited to community meetings to raise issues regarding resistance, including from their mothers, of bringing midwives provided by the government into their community (Interviewee 4).                                                                                                                                                            |
| EUROPE                                   |                       |                                                                              |             |                                                                                                                                                                                                                                                                                                                                                                     |
| <b>Czech Family Planning Association</b> | <b>Czech Republic</b> | To provide young women with assurance of the youth friendliness of providers | Facility    | Health care providers who committed themselves to youth-friendly service provision and are assessed by youth to determine if they adhere to the standards set by young people. If they do, they receive a certificate to display in their clinic (IPPF 2016).                                                                                                       |

| LATIN AMERICA     |           |                                                                                          |                          |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                |
|-------------------|-----------|------------------------------------------------------------------------------------------|--------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| N/A               | Argentina | Ensuring adequate budget allocation for youth services                                   | Subnational              | The Municipality of Rosario conducted annual participatory youth budgeting exercise, engaging young people across six districts to decide on budget allocations for youth services. Young people identified the priorities within their communities and elected a youth representative to speak on these issues. The delegates from youth councils, which meet regularly for several months, developed youth-oriented projects based on these same community priorities. This exercise allows the identification of gaps in services and proposals for actions to address them (PMNCH no date).                |
| CIES              | Bolivia   | To ensure the inclusion of young people's demands in the development of a new FP/RH bill | Subnational and national | <i>Centro de Investigación, Educación y Servicios</i> (CIES) in Bolivia involved youth networks in the Voices project, which focused on securing passage of a bill at the local government level to provide YFS. Young people participated in ensuring the rights of young people, including the right to access FP/RH care, were incorporated into the autonomous bylaws of three regions (IPPF 2016).                                                                                                                                                                                                        |
| Save the Children | Bolivia   | To improve the quality of FP/RH care for young people                                    | Subnational              | The Making Decisions project aimed to increase the quality and availability of information and reproductive health services for youth using the Partnership Defined Quality for Youth model. This model engaged youth in identifying improvements needed in 35 health facilities across 15 municipalities. Health providers also conducted self-assessments. Jointly, youth and health providers developed action plans to address the identified shortcomings (Save the Children 2009).                                                                                                                       |
| APLAFA            | Panama    | To conduct a social audit of the youth friendliness of public health clinics             | Facility                 | <i>Asociación Panameña Para el Planeamiento de la Familia</i> (APLAFA) trained young social auditors to conduct interviews with directors and young users of public clinics. The audit, which focused on service provision, infrastructure, and supplies, was officially recognized by the Minister of Health and, after use, three clinics signed agreements consenting to implement recommendations from young people. The initiative was later replicated in the Dominican Republic (IPPF 2016).                                                                                                            |
| N/A               | Peru      | To change the law in relation to consensual sex among teenagers                          | National                 | A landmark constitutional case was won when more than 10 thousand youth successfully challenged the criminalization of consensual sex—a law that acted as a barrier to their access to services. In 2013, the courts ruled in their favor, declaring that young people aged 14–18 years had a right to personal autonomy and self-determination with regard to their sexuality. In 2016, building on this landmark case, the new Ministry of Health FP guidelines removed a major barrier to adolescents' access, enabling 15–18-year-olds to seek FP/RH care without their parents' accompaniment (IAP 2017). |

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