YOUTH FRIENDLY SEXUAL AND REPRODUCTIVE HEALTH SERVICES IN NENO DISTRICT:

A Programmatic Analysis of Abwenzi Pa Za Umoyo

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EXECUTIVE SUMMARY

Access to youth friendly health services (YFHS) is vital for the youthful population of Neno District - one of Malawi's poorest and most hard-to-reach areas. Abwenzi Pa Za Umoyo (APZU) is a public health organization that supports the efforts of the Government of Malawi (GoM) in providing quality health care services to the poor and marginalized demographic of Neno. This paper presents findings from an assessment of the youth friendliness of sexual and reproductive health (SRH) services in the district. Using a social connectedness lens, the assessment aimed to assess the youth responsiveness of APZU services, programming, and operations, explore existing opportunities that promote youth-responsive programming and identify the best youth-inclusive practices that foster belonging for young clients.

To conduct this assessment, interviews were held with four facility managers, eight health service providers, four receptionists and 16 youth across four of the 14 health facilities in Neno that are supported by APZU. The assessment used the 'Provide' toolkit developed by the International Planned Parenthood Federation (IPPF). The findings indicate that Neno offers a wide range of YFHS and the presence of an APZU Youth Corner initiative was found to greatly foster a sense of belonging amongst the youth as it integrates SRH information and services with engaging recreational activities. However, the primary mode of SRH information dissemination was verbal, and as such disadvantageous to clients with hearing and learning disabilities. Similarly, accessibility challenges were noted as facilities reported a lack of trained staff to meet the needs of people with various disabilities.

The absence of hardcopy SRH informational materials across all facilities adds to the accessibility challenges. In response to these findings, it is recommended that youth be involved in the design, publication and dissemination of SRH informational materials. Moreover, the GoM, with support from APZU, is encouraged to provide adequate training and resources to empower service providers with the necessary skills to deliver inclusive services.

CHAPTER ONE: INTRODUCTION

1.1 Chapter Introduction

This chapter provides an overview of the assessment, starting with a description of youth friendly health services, then focusing on youth friendly sexual and reproductive health services. It then introduces Partners in Health Malawi and gives an understanding of both social connectedness and belonging. Finally, it outlines the purpose, guiding questions and objectives of the assessment.

1.2 Youth Friendly Health Services

There are more young people on Earth today than ever before, with a reported 1.8 billion youth making up nearly a quarter of the world's population (Masula, 2023). This diverse demographic is considered to be a powerhouse of potential development, but in order to realize their full potential, these youth must have access to health services that respond to and meet their broad range of health care needs.

However, mere access to health care is not enough for the youth as they require the provision of Youth Friendly Health Services (YFHS) which, according to (IPPF, 2017) are health services that are able to effectively attract young people, responsively meet their needs, and succeed in retaining these young clients for continuing care (IPPF, 2017, p. 9). Characteristics of YFHS include a private, youth-centred approach to service delivery, a convenient location and the display of educational material on issues related to adolescent and youth health (Forum for Dignity Initiatives, 2020).

YFHS therefore require a preliminary understanding of what diverse youth in a particular community need in order to ensure effective service provision. This tailored approach to youth health care is critical to their well-being as it provides a safe space

for youth to access tailored services, building a sense of trust and connection to their health care system and promoting better health outcomes.

1.2.1 Youth-Friendly Sexual and Reproductive Health Services

A critical aspect of YFHS lies in the providers' awareness of the special difficulties that young people face in accessing sexual and reproductive health (SRH) services (IPPF, 2008, p. 4). According to (Kim, 2024), SRH services as those that encompass the wide range of SRH issues, such as the service provision on the prevention and treatment of sexually transmitted infections (STIs) and information on gender based and intimate partner violence which, according to the (World Bank and the Sexual Violence Research Initiative, 2019), are forms of violence that are highly susceptible to young people and may lead to serious physical and mental health issues. As such, SRH services are vital for young people as they offer essential screening, counselling, and treatment.

1.3 Partners in Health, Malawi

Partners in Health (PIH) is a global health organisation that prioritises patient centred care and addresses the physical, emotional and mental health needs of patients by the use of a social justice lens. PIH understands that social determinants of health - such as historical, social and economic factors play a crucial role in individual and community health. The organisation thus seeks to go beyond clinical care and 'treat the whole patient' by working to address the various social determinants. This is done through the PIH program on social and economic rights (POSER), which supports the most vulnerable of patients with housing, food and transportation to health facilities, to name a few.

In collaboration with national governments, PIH operates in eleven countries worldwide to ensure the deliberate provision of high quality health care to the poor and disadvantaged. Malawi is amongst the five African countries in which PIH operates, and it is locally known as ‘Abwenzi Pa Za Umoyo’ (APZU), which is a direct local translation of ‘Partners in Health’. In 2007, APZU began its operations in the mountainous Neno District - a remote, rural area located in the South West of Malawi. Through its collaboration with the Ministry of Health (MoH), APZU caters to approximately 150,000 people, of which 51% are female, across 14 health facilities (Malawi National Statistics Office, 2019).

1.4 Understanding Social Connectedness and Belonging

Social connectedness is the quantity and quality of meaningful and supportive relationships between individuals and their peers, mentors, and community (Synergos, 2018). The strength of social connectedness in group settings has an impact on one's sense of belonging, which is the experience of feeling at home in the social, environmental, organisational, and cultural contexts of one's life (Forbes, 2022). Similarly, one’s sense of belonging can help to build stronger social connections within a community. The United States Centres for Disease Control and Prevention (CDC) acknowledges social connectedness as a crucial social determinant of health that has the ability to affect the health outcomes of communities (CDC, 2024).

1.5 The Purpose of the Assessment

Globally, youth experience a high unmet need for SRH information and services (Langat et al., 2024). According to (Abubakari et al., 2020), the ability of a young person to fully enjoy their sexual and reproductive health rights (SRHR) remains a significant

challenge, particularly for the youth of sub-Saharan Africa (SSA) who face various intersecting factors such as gender, disability and poverty. Further complicating this issue is the World Bank's projection that SSA will constitute nearly half of the global youth population by 2030, increasing the potential for a youth health crisis if SRH services are not scaled up to respond to the needs of this demographic (Afkar & Weber, 2024).

Majority of the Malawian population comprises the youth, with 51% being under the age of 18 (Malawi National Statistics Office, 2019). The Malawi National SRHR Policy (2017) states that, due to the nation's economic and socio-cultural conditions, young people face barriers to accessing family planning education and services, leading to SRH challenges caused by harmful cultural practices. For instance, early marriages in the country remain a critical issue as 42 percent of girls are married before they turn 18 (Malawi Broadcasting Cooperation 2024), and data from the *Malawi violence against children and young women in Malawi survey (2013)* shows that before the age of 18, one in five girls and one in seven boys experience at least one incident of sexual abuse. Consequently, youth account for a large proportion of the nation's new HIV infections, with girls and boys aged 10-29 accounting for 33% and 24% of new cases, respectively (National Aids Commission, 2024).

According to the Malawi Demographic and Health Survey, Neno is one of the poorest and hardest-to-reach districts in the country, with a poverty rate of 75% (Malawi National Statistics Office, 2016). However, 43% of the district's population is under the age of 15, with 23% falling under the 10-19 years category. Due to the district's severe poverty and challenging geographical conditions, such as poor road networks and

limited access to healthcare services (Kachimanga et al., 2017), these youth are confronted with significant social determinants of health which may negatively affect their overall well-being, with particular implications for their SRH.

1.6 Objectives and Guiding Questions

The purpose of this assessment is to assess the youth friendliness of SRH services in Neno district.

The objectives of the assessment were:

1. To assess the Youth responsiveness of APZU services, programming, and operations.
2. To explore existing opportunities that promote youth-responsive programming in Neno.
3. To identify best youth-inclusive practices that foster belonging for young clients.

The assessment had the following guiding questions:

1. To what extent and in what ways are APZU's services, programming, and operations youth-responsive?
2. Using a social connectedness lens, what opportunities exist for enhancing the extent to which APZU is youth-responsive?
3. How can APZU increase a sense of belonging for staff, patients and communities that is youth inclusive?

CHAPTER TWO: LITERATURE REVIEW

2.1 Chapter Introduction

This chapter provides literature on the crucial role of social connectedness and belonging in healthcare outcomes and explores the framework of rights based approaches to healthcare. It then explores the various national, regional and global YFHS policies and frameworks in place. Finally, an overview of various assessment tools used to measure the youth friendliness of health services is provided.

2.2 Social Connectedness and Belonging in Healthcare

The Samuel Centre for Social Connectedness (SCSC) views belonging as a connection to the 4 P's - people, place, power and purpose. It argues that belonging stems from our social connections with others and our surroundings, as well as our ability to influence decision making and find shared meaning or purpose in our lives (Samuel, 2022).

Literature shows that improved social connectedness and belonging play a more significant role than traditional risk factors such as Body Mass Index (BMI) in improving health outcomes (Cole, 2012), as a study by (Deitz et al., 2020) showed that organized community health groups greatly improved health outcomes by providing direct care and reducing the financial and social burdens associated with healthcare access. Similarly, (Oberle et al., 2023) found that physical and mental well-being amongst seventh grade adolescents was highest when the students felt highly connected within their families, friendships, communities and at school, whereas their well-being was reported to be lowest when they felt lower levels of connection. In addition, a study by (Miyawaki, 2015) to assess the association of social isolation and health across different

racial and ethnic groups of older Americans found that social isolation was associated with negative health outcomes that were similar across the three elder groups of white, black and hispanic elders in the United States.

Furthermore, the recently launched World Health Organization (WHO) Commission on Social Connections (2024-2026) acknowledges the importance of social connectedness on health outcomes, aiming to raise awareness and lobby for adequate policy and resource allocation that prioritises it as a public health priority (WHO, 2024). Similarly, a UN Special Rapporteur (human rights expert) in 2019 urged that states, in their effort to protect and promote their universal human right to health, should assess the factors that affect mental health, stating that the quality of social connection in homes, schools, workplaces and social settings at large play a crucial mental health role (Hannah & Sadiq, 2019).

Although belonging is not a universally acknowledged human right, the SCSC recognises its pivotal role in health outcomes and advocates for it to be prioritised in political discourse (Samuel, 2019). These efforts are in line with the UN Special Rapporteur's report which stresses the need for states to consider the human rights aspects of human relationships.

2.3 Rights Based Approaches to Healthcare

According to (Beracochea, 2011, p. 19), rights based approaches (RBA) to healthcare are frameworks that emphasise the broader social-determinants of health such as economic, political, and social systems, which often have a more significant impact on health outcomes than the mere availability of medical care. Similar to the universal human right to healthcare (United Nations, 1966), RBAs to healthcare are

based on principles of participation, accountability, transparency and equality, and non-discrimination (Bustreo & Doebbler, 2020). As such, throughout all stages of the health programming process, RBAs make deliberate efforts to meaningfully include people in all decisions that directly affect them, ensuring that policies and programmes are responsive to their needs (WHO,2010). Similarly, (IPPF, 2017, p. 6) describes rights-based programming in healthcare as a concept that aims to make the shift from the traditionally used needs-based programming, which is closely linked to charity and volunteer work.

2.4 YFHS in Policy and Frameworks

Various global, regional and national policies are rooted in the same principles that drive the RBA in healthcare. At global level, the International Covenant of Economic, Social and Cultural Rights (ICESCR) is a legally binding instrument ratified by over 170 state parties (including Malawi), recognizing everybody's right to the enjoyment of the highest attainable standard of physical and mental health (United Nations, 1966). Although the ICESCR did not make special reference to youth, it paved the way for broader discussions to be held on the rights of the various vulnerable groups, including young people. Similarly, the third sustainable development goal, good health and well-being (United Nations, 2015), upholds principles of universal access to healthcare and aims for increased health promotion but does not make special reference to the youth.

The importance of YFHS has also been consistently emphasised by various international bodies that have developed standards for youth health care, such as the *KEYS TO YOUTH FRIENDLY SERVICES* developed by the International Planned

Parenthood Federation (IPPF, 2012) and the WHO *GLOBAL STANDARDS FOR QUALITY HEALTH-CARE SERVICES FOR ADOLESCENTS (2015)*.

Regionally, the African Youth Charter explicitly mandates state parties to provide YFHS and conduct thorough needs assessments that will inform the deliberate design of youth-tailored SRH programmes, particularly the vulnerable and disadvantaged. The charter also employs states to provide rehabilitation for young people struggling with drugs and substance abuse and to institute programs that will effectively disseminate information on SRH (African Union, 2006).

In line with these commitments, the Malawi National Youth Policy (2023) advocates for improved provision of and access to quality, and integrated YFHS with a deliberate focus on rural populations in Malawi.

2.5 YFHS Assessment Tools

2.5.1 IPPF Keys to Youth-Friendly Services and Provide Toolkit

The International Planned Parenthood Federation (IPPF) is a global health care provider with an extensive history in providing quality health care to the youth and advocating for equal SRHR for all. The IPPF states that needs based approaches to healthcare may be reactionary, whereas RBA compel service providers to be proactive in providing information and access for young people in a manner that resonates with their unique realities (IPPF, 2012, p. 3). As such, the organization developed a series of topics to guide health professionals in applying a new lens to service delivery that ensures health services meet the needs, realities and rights of young people. This series consists of five topics, namely: understanding evolving capacity, ensuring confidentiality, obtaining informed consent, celebrating diversity and adopting a sex

positive approach. These topics are considered by IPPF to be ‘keys’ to unlocking access to SRH services for young people and are guided by the nine IPPF principles for the delivery of an integrated package of essential sexual and reproductive services (IPES). These include the facilitation of respect, protection and fulfilment of human rights such as sexual and reproductive rights, and the change from a provider-centred approach to a client-centred approach to healthcare, using the RBA perspective.

In collaboration with their youth team, IPPF has made great contributions to the assessments of youth friendliness of healthcare services, having developed their own self-assessment toolkit named ‘Provide,’ which was originally developed to self-assess their own service delivery, but may be adopted by other organisations. Provide was created with a mind that young people are sexual beings, yet health services often overlook that and thus do not reflect the lives of the youth nor meet their needs (IPPF, 2008). The tool was thus created with a highly focused RBA to young people’s SRH.

2.5.2 MOMENTUM Participatory Tool for Analysis and Action Planning

MOMENTUM is a global organisation that forms partnerships with governments, civil society organisations (CSOs), local and international nongovernmental organisations (NGOs) and other various stakeholders in an effort to scale up health interventions and improve the overall health and well-being of mothers, children, families, and communities (MOMENTUM, 2022). In 2022, MOMENTUM developed an assessment tool for ministries of health (MOHs), NGOS, CSOs and adolescents to examine the youth friendliness of the health care system, assessing if it well acknowledges and responds to the various gender disparities and opportunities that influence adolescents’ access to quality health care. However, the tool is not a facility

assessment tool and cannot determine the quality of YFHS of individual health facilities. Rather, the tool primarily assists in identifying the strengths and weaknesses of the health care system at a sub-national/national level, focusing on the gender influences to health care accessibility (MOMENTUM, 2022).

2.5.3 WHO Tool to Conduct Quality and Coverage Measurement Surveys to Collect Data About Compliance with the Global Standards

Through an in-depth needs assessment, analysis of national standards, technical working groups and peer reviews, the WHO developed eight standards for quality health care services for adolescents: adolescents' health literacy, community support, appropriate package of services, providers' competencies, facility characteristics, equity and non-discrimination, data and quality improvement and adolescents' participation as the first of a four volume guide to implement a standards-driven approach to improve the quality of health-care services for adolescents (WHO, 2015). The third volume, *Tools to conduct quality and coverage measurement surveys to collect data about compliance with the global standards* is a toolkit to assess whether the standards have been successfully implemented and can be adapted for use in different cultural contexts. The toolkit consists of client exit interviews with adults and adolescents, interviews with health facility managers, health care providers and support staff, an observation tool and checklist for facility inventory and finally an observation of client-provider interactions.

CHAPTER THREE: METHODOLOGY

3.1 Chapter Introduction

This chapter presents the approach employed by this assessment. It does so by describing the study setting and target population, sample size determination and profile of respondents. Finally, an explanation of the data collection and analysis tool used by the assessment is provided.

3.2 Study Setting and Target Population

The assessment was conducted in four APZU health facilities in Neno district:

- Neno District Hospital
- Dambe Health Centre
- Zalewa Health Centre
- Matope Health Centre

The assessment targeted facility-based healthcare workers, receptionists, managerial staff, and youth beneficiaries of APZU services (aged 18-24) of all genders.

3.3 Sample Size Determination

The determination of this sample size was informed by the scope of study, as it was an evaluation. The principal investigator interviewed 32 respondents (4 facility managers, 16 youth, 8 health care providers and 4 receptionists). The assessment used purposive sampling with key informants and randomly selected youth within their clusters. Purposive sampling was used due to the information required on APZU programming. The youth were engaged through their Youth Corners while APZU staff through their respective health facilities.

3.4 Respondents' Profile

There was a 50% representation of male and female facility managers. The health care providers too had an equal representation of males and females, having representatives from nurses, clinicians and HIV Testing and Counselling (HTC) officers. The 16 Youth who responded to this assessment tool were between the ages of 18-24 years, with an equal representation of males and females. The receptionists had a 75% representation of males.

3.5 Data Collection and Analysis

The principal investigator used the 'Provide' self assessment toolkit by IPPF to collect and analyse data. Provide was selected due to its high focus on RBAs to healthcare which are similar to APZU values. Other identified assessment tools were not as focused on RBAs. Data was collected through one-on-one interviews with each of the study participants. The tool was slightly modified for the Malawian context. All research ethics were adhered to, including confidentiality and informed consent.

CHAPTER FOUR: RESULTS AND DISCUSSION

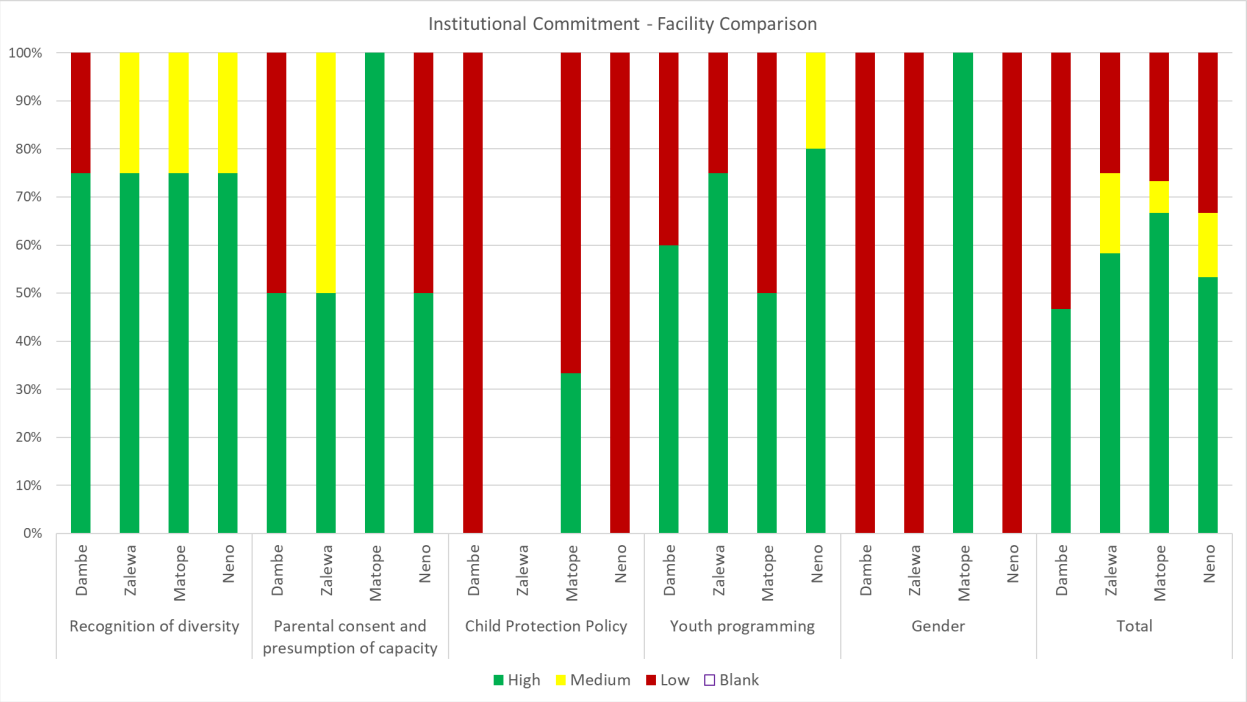
4.1 Chapter Introduction

The Provide self-assessment tool interrogates the youth responsiveness of SRH services across eight dimensions: institutional commitment, facilities, providers, service package, Information, Education and Communication (IEC), youth participation, rights and continuity of care. This section offers insights into the performance of four APZU clinics in Neno District against these dimensions.

4.2 Dimension One: Institutional Commitment

The institutional commitment standard by IPPF emphasises that organisations maintain strong commitment to youth friendliness in SRH service delivery, as evidenced by the existence and implementation of policies, systems and structures. The standard comprises sub-domains interrogating rights-based recognition of diversity, parental consent and the rights-based principle of presumptive capacity, child protection policies, youth programming and gender responsiveness. The figure below shows performance of various health facilities based on dimension one sub-standards.

Figure 1: 'Institutional Commitment' Scores Per Facility:



In regard to recognition of diversity, the study established that all health facilities are accessible to individuals of all sexual orientations, cultures and gender identities. However, neither are accessible to people with disabilities (PwD), with greater accessibility challenges noted in the mountainous region of upper Neno (Dambe and

Neno District Hospital). One youth from Dambe expressed that, ‘‘There are wheelchair ramps here at the facility but getting to the facility is hard for PwD.’’ In agreement, the Dambe youth focal point stated that,

> ‘Because of our geographically hilly setting, especially during heavy rains, even a land cruiser can't drive here. At the facility, there are a few ramps but the road from the clients' home to get here is bad and motorcycles are expensive.’

According to (Malawi Public Roads Act, 2017, p.3) the Government of Malawi (GoM) is the mandated controller of roads responsible for the planning, designing, construction, care and maintenance of roads. The underprovision of this public good by the GoM has restricted health care access by clients in Neno. This calls for APZU’s involvement in advocating for road access with state and non-state actors at both district and national level in order to promote inclusive public infrastructure investment and equitable access to health services for the marginalised.

Additionally, staff from Neno District Hospital outlined communication barriers between clients with speech disabilities and service providers, noting that no staff member is specifically responsible for addressing this issue. The exclusion of diverse groups such as PwD impedes their right to meaningful participation in SRH and other socio-economic processes. Moreover, it was found that APZU does not have an explicit inclusion policy which clearly outlines its roles and responsibilities as they relate to ensuring that people from all walks of life can access and benefit from its services. This may lead to unintended consequences such as unconscious bias among staff members as they may unintentionally discriminate against PwD due to the lack of clear and formal guidelines. Unconscious bias refers to a bias that we are unaware of, usually happening outside of our control as we make quick judgements and assumptions of people or

situations based on our past experiences and background (Equality Challenge Unit UK, 2013).

The assessment also revealed a critical gap in APZU's policy framework, particularly in the areas of parental consent, child protection, and gender, as there appeared to be a lack of corresponding policies. Interviews with facility managers further highlighted inconsistencies in their awareness of these policies as half of the managers reported that no parental consent policy exists, while 25% confirmed its existence, and the remaining 25% were unsure. Similarly, only one manager claimed the organisation has a child protection policy in place while the others could not conclusively confirm its presence. Regarding a gender policy, 25% believed one was in place, 25% were uncertain and the rest acknowledged its absence. The lack of clarity about the organisational policy landscape speaks to an important communication challenge across the organisation.

However, the organisation has made significant efforts in safeguarding both beneficiaries and staff from sexual exploitation, abuse and harassment (SEAH) through its Prevention of Sexual Exploitation, Abuse and Harassment (PSEAH) Policy (2022). The PSEAH outlines the roles of various personnel (including executive directors, managers, supervisors and site HR) that are responsible for safeguarding rights of all including children. It also provides a list of prohibited behaviours from staff towards children such as sexual activity or attempts to engage in sexual activity, with anyone under the age of 18, regardless of the local age of consent (APZU PSEAH POLICY, 2022, p. 5). It was noted that the PSEAH policy is the only policy APZU employees sign separately as a stand alone document. Other policies, such as the transport and whistle

blowing policy, are included in a collective declaration form that employees sign to acknowledge having read the various other PIH/APZU policies. Albeit, there is no institutional mechanism to ensure an employee has duly read and understood the contents of the numerous policies in mention. One APZU senior manager stated that,

> ‘There is no quiz or test that employees take after reading the documents. When they sign the declaration form then it is assumed they have read it. Some practitioners may not even know what the policy contains.

According to (Kolovich & Newiak, 2024), a gender responsive budget is one that deliberately incorporates a gender lens into the budget design process to ensure governments and organisations are aware of the impact of their financial choices on gender outcomes. It was noted that inasmuch as APZU’s funds (both restricted and unrestricted) support gender responsive programming, the organisation does not have a gender responsive budget. This absence of a formal gender-responsive budget has implications on the equitable distribution of resources to fully reflect and meet the specific needs of men, women, boys, girls, and non-binary individuals. This may consequently disadvantage the youth, who have distinct health needs such as mental health support and protection from gender based violence.

Regarding youth programming, it was found that APZU, through the Global Affairs Canada (GAC) ‘No Woman or Girl Left Behind’ program, operates a Youth Corner initiative in nine facilities across Neno, where youth can gather and access SRH services such as family planning, information and counselling and services related to sexual and gender-based violence. Each of the four facilities sampled in this assessment has an operational Youth Corner.

In the 2023-2024 period, the Youth Corner groups reported 2,963 visits, with the most frequently accessed service being information and counselling, sought by 1,263 females and 1,249 males. It was noted that these weekly Youth Corner meetings provide more than SRH service delivery as they deliberately integrate various recreational activities such as local games, songs and dances, as well as the dissemination of SRH information by peer educators into their weekly events. Through this initiative, youth can connect with peers, participate in these activities, and access crucial SRH information and services. Furthermore, these Youth Corners serve as a platform for young people to engage in income-generating activities, such as farming, supported by the monthly Youth Corner membership fee. Profits from these activities are shared among the youth as cash or kind, for instance writing materials. Further analysis with both the youth and staff members showed that these Youth Corner meetings provide spaces where young people can freely discuss SRH issues with their peers and peer educators, while also receiving individualised SRH services. This is in line with the assessment's finding that 100% of the youth interviewed consider their facility as one that promotes a safe space for them to access SRH services.

It was noted that only Neno and Dambe facilities had ever conducted a needs assessment among the youth regarding YFHS, but this was over two years ago. Also, while all facility managers reported regular youth consultations to improve the quality of YFHS, the methods used – suggestion boxes, client exit interviews, and focus group discussions – are limited, as they provide feedback on a once off basis (Graban, 2012). Further assessments found that there are various government structures at district and community level thus District Youth Network (DYN) and Youth Clubs respectively which

empower youth to voice the SRH and other needs. It was also noted that, as of July 2024, the Neno District Youth Network had recently held its executive committee elections, where for the first time ever, a young woman was elected as Chairlady.

Lastly, one best practice revealed by the assessment was the use of youth-disaggregated data to inform decisions regarding YFHS, as 100% of the sampled facilities disaggregate clinic data quarterly by youth, with an age bracket of five years. This is in line with WHO recommendations to disaggregate health data by 5 years, except for those younger than 5 years, as they experience rapid biological and physiological changes, justifying a finer disaggregation (Diaz et al., 2021).

4.3 Dimension Two: Facilities

Under this section, the assessment examined aspects related to the accessibility/convenience of the location of the facilities, branding for YFHS and the confidentiality at the facilities.

According to the Health Belief Model (1966), perceived barriers to healthcare are obstacles that an individual believes stand in the way of them accessing health services. The observational assessment tool found that all sampled facilities have relatively little signage available. This can limit the facility's informational and directional communication and potentially dissuade youth from seeking health services as they may feel shy or hesitant to ask for directions or assistance, especially if they already fear stigma associated with seeking SRH services.

Upon entrance of the health facilities, only Dambe and Matope facilities had a mounted signage displaying the YFHS available at the clinic. It was however noted that both these signs are in the English language and the one at Dambe is weathered and

fading. This could be challenging for the local population to read and understand, as they are not fluent in English. The fading sign worsens this communication barrier as its diminished visibility limits the awareness of the YFHS offered. As such, the youth may not be fully aware of the YFHS available to them.

While Zalewa Clinic did not display information on what their YFHS offered, it was the only facility to have a poster with a brief description of its Youth Corner, including relevant contact details. However, this poster was simply an unlaminated A4 paper pasted on the entrance of the facility, hence vulnerable to damage due to weather or general wear and tear that can reduce the visibility of quality YFHS information to the youth. Additionally, the small size and placement of the poster could make it easily overlooked. As for Neno DHO, it had neither signage displaying the YFHS nor a poster promoting the Youth Corner events.

Under the sub-domain of location convenience, the assessment revealed that only Neno District Hospital and Zalewa facility are conveniently located less than a 10 minute walk from a public transport stage. In contrast, Matope and Dambe facilities are more than a 20-minute walk from the nearest public transport stage. This inconvenience has implications on patient accessibility and service delivery. Dambe facility manager confirmed that most patients opt to travel by foot to reach the facility, often enduring a four to five hour walk, as opposed to paying for a motorbike ride which would cost them MK30,000 ($17). Given that the average Malawian lives on $2.15/ day (World Bank, 2023), the motorbike cost would be excessively high for the people of Neno as the district has a poverty rate lower than that of the country. It was also noted that Dambe facility caters to Malawians living in neighbouring Mozambique, who also travel on foot

for about 12 hours. A Dambe facility service provider confirmed that this leads to a strain on the service providers as they often take extended and late working hours to serve these patients. In addition, it may be seen as a barrier to healthcare for young mothers as the long journey could be associated with additional financial costs and extended hours away from their family, leading to stress. It might also discourage them from seeking medical assistance on time, negatively affecting their health and the well-being of their children.

In regard to daily opening hours, all facilities operate on a 7:30am–4:30pm basis on weekdays. Notably, secondary school students finish at 3pm. Considering the geographical setting of Neno and the cost of motorcycles, the facility opening hours could interfere with young people's ability to access services. Youth may arrive at the facility right at closing time, leading to either rushed consultations or not receiving the services at all. On Saturdays, the clinics operate from 7:30 am–12:00 pm, which may be limiting for students who attend weekend classes or have domestic responsibilities, particularly girls who bear the brunt of the gendered division of labour, having a disproportionate amount of domestic roles (Action Aid UK, 2024).

With regard to opening hours, only Matope and Dambe facilities display their opening hours on the outside of the clinic and neither of the assessed clinics have specific opening hours for the youth. Regarding affordability, another key component of access, all sampled health facilities are financially supported by APZU and this goes a long way in addressing affordability concerns, as the majority of services are free for all.

It was observed that only Neno DHO has a signpost outlining the estimated time duration of several services offered at the facility, such as X-Ray services, surgeries and

vaccinations. However, this list is primarily descriptive of out-patient department (OPD) services and does not include services related to AYFHS. However, despite this limitation, providing the youth with advance knowledge on service durations may positively influence their health seeking behaviour of OPD services by helping them plan their already limited time.

Furthermore, with the exception of the Matope facility, youth from all four facilities stated that their facility is well lit during dark hours. However, the situation at Neno DHO may pose a risk to vulnerable populations as an interview with youth revealed that inasmuch as the facility corridors are well lit at night, the car park, gate and entrance area are not sufficiently lit. This lack of adequate lighting could trigger fear/discomfort in clients, particularly the vulnerable and marginalised groups such as AGYW and the LGBTQI+ community upon entrance to the facility in the early morning or late evenings. These feelings of discomfort may negatively impact their sense of belonging, as a welcoming environment requires individuals to feel safe, respected, and valued. Inadequate lighting can undermine these feelings.

Regarding consultation areas, 94% of youth across all facilities stated that the consultation rooms, which are in a closed-door setting and marked in a neutral manner, provide them with a sense of safety to freely discuss their needs with their provider.

However, concerns from 25% of youth from Matope and Zalewa were raised, as they said they do not fully consider the consultation rooms to be soundproof from the outside. Moreover, the high volumes of people around the vitals screening office was found to be a concern among some youth who stated that they may be overheard when speaking to the receptionists or nurses in waiting areas. Thirty-one percent feel

somewhat uncomfortable discussing their SRH needs with these receptionists/nurses, fearing judgement or gossip, and 6% say they have significant fear/discomfort in discussing these issues. A perceived lack of privacy and confidentiality could create a barrier to open communication between young people and healthcare providers, potentially compromising the effectiveness of SRH services.

Patient privacy protection varied across the sampled facilities, with Neno (80%) performing better than Matope and Zalewa (70%), and Dambe (60%). Overall, youth across all SDPs state they are given the opportunity to provide alternative contact information, such as cell or SMS number, as opposed to their home address, in an effort to protect their right to privacy. It was also found that clients' files are indeed stored securely, under the Health Management and Information Systems Office, with a lock and key system so that only relevant service providers can access them.

4.4 Dimension Three: Providers

The assessment also explored the capacity of the service providers to deliver AYFHS, through an examination of the capacity strengthening in SRHR, mental health, life skills, and other areas. It assessed whether APZU offered tailored training for various cadres of the health workforce, and considered workplace issues like confidentiality and non-discrimination for clients and providers. Additionally, the tool evaluated how well client needs were addressed, including providing adequate feedback in time and making available platforms for client expression.

Firstly, it was discovered that a wide range of YFHS trainings are provided to health service providers across the sampled facilities. Table 1 below shows a list of these trainings, as well those not included in the training package.

Table 1: List of Trainings Received/Not by Service Providers

TRAININGS RECEIVED	TRAININGS NOT RECEIVED (mutually across all SDPS sampled)
● Sexual and reproductive health issues of young people in Malawi ● Counseling on the mental health of young people ● SRHR of youth people ● Laws on parental consent, sexual consent and child protection ● Sexuality and relationships ● Addressing the needs of young PLHIV ● Addressing the needs of other key populations (e.g sex workers) ● Effective communication styles when discussing SRH with the youth ● Free and informed choice ● Life skills counselling ● STI counselling and treatment ● Confidentiality ● Referrals to support services ● Puberty and growing up ● Other issues that affect young people's lives, including drugs, alcohol, nutrition, smoking, bullying and abuse	● Clients rights ● Addressing the needs of LGBTQI+ young people ● The importance of promoting a sense of connection with the client ● Capacity of young people to consent ● Gender norms and how they impact SRH ● Creating a welcoming and supportive environment for young people that makes them feel like they fit in and are accepted at their SDP

Further assessments found that the majority of the youth-specific trainings are only offered to peer educators and youth mentors. That is, sexual and reproductive

health issues of young people in Malawi, sexual and reproductive rights of young people, effective communication styles when discussing SRH with the youth and puberty and growing up. Similarly, across all facilities, only selected staff (those in charge of youth programming) are provided with training on how to speak to young people with empathy and kindness. This can create an inconsistent quality of interaction amongst the youth and other service providers who have not had this training, and may affect the youth's sense of connection with these staff members.

With the exception of the Dambe facility, the presence of capacity building opportunities such as refreshers and on-the-job training was noted to be quite low across the facilities, with 75% of service providers stating that they rarely have such trainings, and when they do happen, only selected staff take part. Service providers from Zalewa and Neno District Hospital claimed refresher trainings do not occur frequently, and their last training was about a year ago. Similarly, a service provider from Matope facility stated that they had only attended one refresher training in the past three years. This gap in capacity building opportunities is not the reality with Dambe facility as they recently had mentors train selected staff in youth SRH, just three months prior to this assessment. This disparity in service providers' trainings could lead to knowledge and skill gaps amongst service providers, hence inconsistent service delivery across facilities.

Regarding staff's comfort working with the youth, 31% of youth respondents from Neno, Zalewa and Matope stated that some service providers may be uncomfortable working with them. This likely stems from the lack of comprehensive training on youth

topics to all service providers. A service provider from Zalewa facility corroborates this, saying,

> It’s not all staff that feel confident working with them. Some are reluctant because the Youth Corner work is volunteerism (free). Some just do not like interacting with youth. And also most staffs haven't been trained–as I said there is a lack of training on how to handle the youth.

The service provider also added that some staff may not be comfortable talking about SRHR due to the same lack of training, stating he is sure some may not even know anything about the rights of children. It was also noted that not all service providers had an extensive understanding of laws related to SRH, as across all facilities, only some staff knew the age of sexual consent in Malawi. This is in line with the lack of training to selected staff members, as well as the statement from a Zalewa representative on some staff not knowing the rights of children.

The assessment also found that facilities lacked sufficient job aids, including posters or flipcharts of clients’ rights that would support providers in their daily tasks. It was also noted that inasmuch as staff supervisors show appreciation and recognition for the efforts of service providers through verbal praise, they are much less likely to offer rewards or incentives. This can diminish staff motivation and morale, impacting the quality of their YFHS service delivery as motivated staff are more likely to create engaging and welcoming environments for young clients.

Furthermore, a difference was noted in how youth across the four facilities felt about being given a platform to ask questions during consultations. At Zalewa, Matope, and Dambe facilities, youth responses were fairly balanced, with 50% of respondents saying that they always had the opportunity to ask questions and the other half feeling

they sometimes did. In contrast, at Neno DHO, 50% of the youth respondents said they are never given this platform and the other half stated that they sometimes are.

Lastly, service providers from Dambe, Matope and Neno District Hospital all stated that they have adequate time during consultations to listen to and effectively answer client's needs and concerns. However, service providers from Zalewa felt they only sometimes have this opportunity as there is a disproportionate patient-provider ratio at the facility. They stated that when service providers leave the facility for a while (either at field visits or other duties) young people wait for the same provider to return, limiting the time for consultations.

4.5 Dimension Four: Service Package

All facilities were found to provide a wide range of SRH services to youth, including all the available long-acting contraceptive methods. Table 2 below displays the list of SRH services provided across the sampled clinics.

Table 2 : List of SRH Services Provided at APZU

CATEGORY	SERVICES PROVIDED
Contraception	● Condoms ● Injectables ● IUD ● Implant ● Emergency contraception (IUD or pill)
Screening and Testing	● Pap smear or other cervical cancer screening method

	● Screening for sexual and gender based violence ● HIV sero status laboratory test or HIV staging and monitoring laboratory test ● Atleast one RTI/STI laboratory test ● Pregnancy testing
Counselling	● Contraceptive counselling ● Sex and sexuality counselling ● SGBV counselling ● Relationship counselling ● Pre-/post HIV test counselling ● Life skills counselling
Clinical services	● Essential pre-natal care ● Essential post-natal care
Referrals	● Referal mechanisms for clinical, psychosocial and protection services

As per the Malawi Penal Code of 2014, induced abortion services are not permitted by law (except in the case to save the life of the mother) and as such, they are not provided in Neno District. Malawi has one of the highest maternal mortality rates globally, with unsafe abortions constituting 18% of those cases (Polis, 2017), and others argue that the country's laws are restrictive and potentially harm AGYW as they often undergo these unsafe abortions (Draganchuk, et al., 2024). It was also noted that AGYW are only provided with the continuation option of pregnancy, whereas termination (as per Malawi penal code) and adoption options were not provided to them.

In all facilities, with the exception of Dambe, there was reported to be a gap in the sensitization of the clients with regard to the potential side effects of the SRH services being provided. Half of the youth respondents stated they are only somewhat sensitised, with 13% saying they are not sensitised at all. ‘Somewhat sensitised’ referred to only receiving the information on the side effects after asking the service provider for information or only receiving partial/limited details.

Sexual well-being and sexual pleasure are core SRH values, as young people have the right to the highest level of health, including the possibility of pleasurable, satisfying and safe sexual experiences (IPPF, 2017). However, the observational assessment tool found that inasmuch as each facility provides counselling services on safe sexual relationships, counselling on pleasurable sex is not provided. This gap can limit youth’s understanding of and ability to have honest conversations with their partner on their desires and boundaries, having negative implications on informed consent and open communication within sexual relationships. Additionally, excluding sexual pleasure from counselling services limits open client-provider dialogue as discussing pleasure might encourage youth to seek further advice, ask questions, and ensure their needs are fully addressed.

4.6 Dimension Five: Information, Education and Communication (IEC)

This dimension of the tool focused on the SRH Information, Education and Communication (IEC) material distributed to youth at APZU clinics. It was found that the primary source of information dissemination to the youth were the weekly Youth Corner meetings at each facility. Other information dissemination avenues were found to be

school health outreaches, community focus groups and girls camps. SRH information and education in these avenues was available on the topics outlined in Table 3 below.

Table 3: Provision of IEC topics to the Youth

IEC topics provided to the youth	IEC topics NOT provided to the youth
● Emergency contraception ● Contraception ● Safer sex ● Peer pressure ● Stigma ● Sexual Rights ● Menstruation	● Consent to sex ● Sexual pleasure ● Sexual orientation and gender identity ● Relationships ● Genital Hygiene ● Adoption options

The absence of critical IEC topics on sexual consent to the youth poses significant risks such as the increased likelihood of sexual violence and the perpetuation of harmful gender norms. Without sexual consent education, young people have a limited understanding of the socio-emotional skills related to gendered sexual expectations and power dynamics, reducing their ability to assert and accept sexual consent and boundaries in a manner that respects both themselves and others, regardless of gender. It should be noted that dimension three - providers, showed a knowledge gap among providers as to the age of sexual consent in Malawi. This combination of problems has several implications, such as the increased risk of child abuse and missed opportunities in preventing sexual violence which leads to adverse health outcomes. Moreover, not providing the youth with IEC topics on gender identities

and sexual orientations is a missed opportunity to start dialogues that support the LGBTQI+ youth and create spaces for allies to learn more about promoting acceptance and inclusivity within their communities.

Furthermore, in as much as information regarding menstruation was confirmed to be distributed to the youth, further assessments found that this information is only distributed at Girls Camps (only to females). This has several implications, as male exclusion in the dissemination of critical menstruation information can perpetuate misconceptions and stigma surrounding menstruation, and contribute to shame and embarrassment amongst menstruating girls (George, 2019).

Further discussions with facility heads revealed that due to a lack of consistent and comprehensive training, peer educators may be restricted to provide information on the same topics. One facility head confirmed he noticed some topics were not being taught at the events, citing it could be an issue of lack of comprehensive training to all staff members. He stated that their current youth focal point only had a one day orientation and brief trainings.

In regard to the distribution of IEC material through hardcopy publications, 100% of the youth interviewed agree that they do not receive these. A youth respondent from Dambe facility cited,

> They do not give us hardcopy publications. They read to us the information from their devices and sometimes let us borrow their devices to read in their presence. But they do not leave us any hardcopies.

This is mostly due to the lack of IEC publications in the form of leaflets, posters or brochures which are neither available at the facilities, nor with the peer educators themselves. Therefore the main mode of this information dissemination is verbal, which

may create learning challenges for people with intellectual and developmental disabilities (IDD) as some may have challenges to quickly grasp the verbal information. Similarly, other individuals may prefer to read at their own pace or refer back to hardcopies for reference. It is also disadvantageous to the youth with auditory disabilities as the facilities lack specialised health service providers and peer educators to meet the various needs of marginalised groups. This is in line with results from dimension one, which showed that the facilities are inaccessible to people with disabilities. In addition, the lack of hardcopy IEC material in the facilities also limit the audience, as hardcopies would reach more youth in waiting rooms, outreaches and more.

Positive findings from discussions with the youth were that the information disseminated in these IEC dissemination channels is indeed presented with cultural sensitivity and in the languages that the youth speak (Chichewa) and all four facilities are currently in very vibrant and active partnerships with various local and international organizations that promote youth health and rights, such as providing protection to those experiencing violence. One service provider from Zalewa added that they have outreaches three times a month with a local NGO.

4.7 Dimension Six: Youth Participation

This dimension assessed the diversity and role of peer educators in disseminating SRH information to the youth, as well as youth participation in research and programming at PIH. Findings revealed that all four facilities work with peer educators who are grouped into three:

- YCBDAs (Youth Community Based Distribution Agents)

- Health Promoters
- Youth Corner Co-facilitators and Youth Focal Points

These peer educators have diverse representation from out-of-school young people, young people living in rural areas and married and unmarried young people, but there is no representation of sex workers, LGBTQI+ youth and those in school young people.

In addition, discussions with the youth showed that 38% of them think only some peer educators receive initial training, contrary to further assessments which showed that the peer educators do in fact receive initial training. However, only Dambe facility peer educators stated that they sometimes receive post-induction training, whereas at the other facilities, peer educators stated they rarely receive additional training. This inconsistency in and lack of continued training may cause skill gaps, inhibiting the efficiency of peer education programming, thus limiting the information access and uptake of SRH services.

It was also found that youth have few opportunities to give feedback on their level of satisfaction with the services they receive, as only Neno DHO purposefully solicits feedback from young people. They do this through the placement of a special youth suggestion box displayed during Youth Corner meetings for the youth to specifically drop in their feedback. Similar to the general suggestion boxes in all four facilities, this box is checked monthly by the hospital ombudsman whose role is to provide civic awareness for hospital users, receive and investigate alleged complaints in health service delivery and provide feedback to relevant authorities such as the Ministry of Health (MoH) (Malawi Office of the Ombudsman, 2022).

The assessment also revealed that young people are not meaningfully involved in SRH research within their communities. While on a limited number of occasions they have been included in focus groups to provide their insights and perspectives on how to improve the quality of YFHS (i.e. as research respondents), they have not been involved in the production or research at any point in the research cycle.

4.8 Dimension Seven: Rights

In addition to exploring the freedom of clients when it comes to personally choosing their service providers, the tool assessed the levels of which young clients' rights and confidentiality are honoured, as well as clients' sexual rights and the rights of clients with disabilities.

Across all facilities, clients are provided with the opportunity to include a supportive person in a decision making process and youth of all ages in all facilities are able to meet with the service provider alone–without a parent, guardian or partner. Additionally, Malawi's policy landscape does not explicitly address the minimum age of consent for contraception, so it is left to the interpretation of service providers (Muula et al., 2023).

It was found that neither facilities provide the youth with an opportunity to see the same provider/counsellor each time they visit the health facility and discussions with the youth revealed that the closest they usually get to a young provider is at the Youth Corner meetings as they are given the opportunity to engage with peer educators. One youth from Zalewa confirmed, ‘‘At Youth Corner we usually have young facilitators, but when we are at the clinic, we do not have a choice. We meet the available doctor for our treatments.’’ Moreover, only the Dambe facility sometimes ensures the presence of an

appropriate chaperone if the sex of the client and provider are different whereas the other three facilities never do so.

Regarding the visual display of rights, neither of the facilities have posters available to list/describe young people's sexual rights nor the rights of the client.

Lastly, across all facilities, the only attempts that have been made to meet the special needs of youth clients are wheelchair ramps. However, no special attempts have been made to meet the needs of clients with sight or hearing disabilities such as large print or braille documents.

4.9 Dimension Eight: Continuity of Care

This dimension evaluated the integration of the referral systems and follow-up procedures of SRH services within the assessed clinics. It was found that all 100% of facilities assessed have a referral system for services that cannot be provided, with clients from lower Neno (Matope and Zalewa) often being referred to a neighbouring APZU clinic in Lisungwi, whereas Dambe facility (Upper Neno) often refers clients to Neno DHO, which makes referrals to Queen Elizabeth Central Hospital (QECH) . It was also noted that peer educators are encouraged to make referrals to health facilities when they are presented with cases that need specific medical attention.

Additionally, APZU, in its effort to provide patients with both social support and medical care (Partners in Health, 2019), may provide free transportation when a patient needs to be transferred between facilities. It was also noted that APZU may at times provide cash to be used for public transportation for referrals to QECH. This helps to greatly reduce the cost of public transport and provides a much more comfortable

method of travelling to the referral facility, ensuring patients feel a sense of connection and care by APZU, thus fostering greater feelings of belonging.

The assessment found there is a tracking system in place to track patients that have missed appointments, either at their respective facility, or at a referral facility. This is the APZU Tracking and Retention of Client Enrollment (TRACE) system for patients with non-communicable diseases, tuberculosis, nutritional disorders, HIV, or those requiring palliative care.

However, for patients referred to another facility, there is a lack of a concrete, effective system in place to ensure follow-up of that patient. A service provider from Zalewa stated that:

> There is no system exactly. The patients are registered to have been referred, but there is no system to track how they are faring now. They are just usually told to come back and report on how they now feel. Community health workers used to be this (system) but they stopped operating now.

Community health workers (CHWs) were a household model adopted by APZU to visit community members right in their homes–whether ill or not. This model ensured extensive continuity of care, helping screen diseases earlier and enabling timely treatment (Phiri, 2022). However, this model is currently being phased out by APZU, as per previous quote.

Furthermore, addressing gender concerns throughout the referral process involves taking into account the diverse gender-related needs, preferences, and vulnerabilities of clients at every stage. This can include offering gender-sensitive provider options or creating safe spaces for confidential client-provider discussions during the referral process. It was discovered that none of the sampled facilities consider gender when making referrals. This could consequently reduce the comfort

and trust of vulnerable groups such as AGYW, young boys and LGBTQI+ youth when being referred for sensitive procedures, in turn affecting the critical social connection between the client and service provider.

The assessment also found that all sampled facilities partner with local schools and conduct regular school outreaches. One service provider from Neno DHO stated they they have conducted school health outreaches in every school in the area and one youth from Dambe proudly stated that, ‘‘The facility usually visits our local secondary schools to conduct health talks and even screening.’’ Another youth from Dambe added, ‘‘There are field clinics to secondary and primary schools where they then refer the students to the facility.’’

Regarding mental health, APZU has mental healthcare providers available throughout the week at Neno DHO, and according to one health care provider from Zalewa facility, they receive a mental health practitioner from neighbouring Lisungwi facility on Tuesdays. However, these services appear to not be well publicised at Neno DHO as youth respondents stated that they are not even aware they have mental health practitioners available for them and another respondent stated they only recently became aware of this.

Lastly, in terms of social support integration into the referral systems, no clinics appear to integrate/promote social care into their referral systems by connecting the youth with relevant mental health counsellors or youth groups during the referral process.

CHAPTER FIVE: RECOMMENDATIONS

5.1 Chapter Introduction

Based on the understanding that the effective provision of YFHS requires both meaningful input from the youth and active support from staff and institutions, this chapter presents recommendations to various key stakeholders: the youth (primary beneficiaries), APZU, and the GoM. The recommendations are organised according to the eight dimensions of the assessment tool.

5.2 Recommendations

5.2.1 Institutional Commitment

- APZU and the GoM should continue to nurture youth researchers and prioritise youth focused research in its programming to timely unveil and intervene on youth needs. Beyond knowledge management and learning, this will create a sustainable platform for youth-driven research.

- GoM should strengthen the implementation of formal mechanisms that ensure youth voices are heard such as operationalizing a youth SRH action agenda through the District Youth Network (DYN) that interacts with GoM and implements relevant youth driven initiatives across Neno District. This will ensure the meaningful participation of youth in the co-designing of solutions that enhance the service provision of YFHS.

- APZU secretariat should prioritise issues of safeguarding, child protection, parental consent and gender equality by working towards the formulation and

implementation of respective inclusion policies that clearly define the organization's commitment to ensuring equitable access to healthcare services for all, including PwD.

- In an effort to build the social connection between the youth and APZU, the latter should introduce platforms for interaction, knowledge transfer and intergenerational dialogues. These platforms could, for instance, be in the form of an annual APZU youth-day that is deliberately inclusive of other members of staff (not restricted to those who work with the youth).

- In order to ensure staff comprehension on inclusion and safeguarding policies and consolidate knowledge and practice across APZU secretariat and health facilities, APZU should enhance accountability measures by conducting mandatory policy quizzes following orientation/induction. It should also provide refresher trainings to all staff on these critical policies.

- In order to achieve client accessibility to health services and gender equity, APZU should explore taking up an advocacy role targeted towards the GoM in improving road infrastructure.

5.2.2 Facilities

- In order to enhance youth SRH services uptake, GoM should ensure all health facilities in Neno district display clear and visible signs that are translated in both English and Chichewa, outlining the YFHS available. These signages should be highly durable and weather resistant.

- Similarly, APZU should place readable and durable posters/flyers describing the

Youth Corner initiative in visible areas of each health facility.

5.2.3 Service Providers

- The GoM should prioritise the recruitment of qualified health service providers and peer educators with expertise in youth-friendly approaches who can meaningfully and comfortably engage with marginalised populations, including LGBTQI+ youth.

- The GoM, in liaison with APZU, should provide comprehensive training programs and resources to equip health service providers and peer educators with the knowledge, skills, and attitudes necessary to deliver inclusive services that meet the needs of marginalised groups, particularly PwD.

- In an effort to ensure consistent and effective communication between the youth and all health facility staff, training programs focused on creating a supportive and non-judgmental environment for young people should be offered across every health department to equip all staff members with the necessary skills.

- Health service providers and peer educators who consistently demonstrate exceptional care and commitment to providing high quality YFHS should be publicly recognised by GoM to boost morale amongst staff members and encourage a high standard of service.

5.2.4 Service Package

- GoM should include information and counselling on pleasurable sex as part of the SRH information and service delivery. Specialised training for counsellors and peer educators on how to discuss sexual pleasure in a culturally sensitive,

informative, and non-judgmental manner with the youth should be provided.

- Similarly, APZU should continue promoting open dialogue amongst the Youth Corner initiatives as this supportive environment will enable the youth to feel comfortable and open enough to discuss issues to do with their sexual pleasure and boundaries.

5.2.5 IEC

- The youth should participate in the design and dissemination of IEC materials that describe their SRHR and the various YFHS accessible to them at their respective health facilities. This can help ensure the information is engaging and relates to the targeted audience.

- In an effort to drive demand to YFHS through messaging and communication, the GoM should intensify awareness of SRH information through use of hard copy IEC publications as they cannot demand what they do not know of. This IEC material should be youth and child friendly, printed in large fonts, in easy-to-read language and utilizing pictorial formats. Likewise, these materials should be available in Braille format to ensure accessibility to people with visual disabilities.

5.2.6 Youth Participation

- GoM and APZU should conduct regular consultation with the youth to inform the design, quality and accessibility of SRH services and research in Neno. This process should move beyond one-time feedback and foster continuous meaningful engagement that places youth at the centre of the identification and

implementation of youth related SRH research and programming.

5.2.7 Rights

- GoM should prioritise the dissemination of the rights of both the client and service provider through nationwide radio broadcasts and the display of posters describing these rights across health facilities. This dual display of client and provider rights helps balance the view on rights and responsibilities as the rights of the client demand certain duties from the service provider, and vice versa.

5.2.8 Continuity of Care

- GoM should introduce gender sensitive practices that ensure the referral system is catering to the needs of the youth, including LGBTQI+ youth and PwD. This could involve the integration of social care into the referral process by creating safe spaces for confidential client-provider discussions throughout the entire referral process where various gender groups can feel comfortable and supported enough to provide feedback based on their experiences and needs.

CHAPTER SIX: CONCLUSION

The assessment sought to achieve three objectives namely; to assess the Youth responsiveness of APZU services, programming, and operations, to explore existing opportunities that promote youth-responsive programming and to identify best youth-inclusive practices that foster belonging for young clients.

Overall, it established that APZU has various interventions in place that speak to the needs of the youth. Particularly, youth corners remain a major avenue that foster youth belonging. Peer educators were also seen to be relatable to the youth, allowing

openness and effective communication with young people. However, the lack of policies and guidelines that explicitly promote and safeguard youth beneficiaries of APZU services presents a challenge in effectively meeting the needs of young people.

For YFHS to be delivered with a social connectedness lens, youth have to meaningfully participate in planning, implementation, monitoring and research of all youth related interventions to address targeted group issues. To support this, APZU, in partnership with the GoM, can leverage on the formal youth structures that prioritise youth agency in programming such as the District Youth Networks and Youth Clubs. This will empower the youth and allow them to potentially benefit from a dynamic health care system in a way that best suits their needs.

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