GOVERNMENT OF THE REPUBLIC OF ZAMBIA
MINISTRY OF HEALTH

NATIONAL ADOLESCENT HEALTH STRATEGIC PLAN

2022 TO **2026**

NATIONAL ADOLESCENT HEALTH STRATEGIC PLAN

2022 TO **2026**

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FOREWORD

Zambia has an estimated population of 18, 383, 956 of which a quarter are adolescents. These adolescents face several challenges related to their development, including unemployment, gender-based violence, unintended and teenage pregnancies, HIV infections and sexually transmitted infections, among other challenges.

Zambia has prioritised adolescent health arising from the demographic dividend opportunity this presents in expediting its progress towards socioeconomic development in line with the Vision 2030 and the Sustainable Development Goals. The 2022–2026 Adolescent Health Strategic Plan is in tandem with the National Health Strategic Plan 2022–2026 and has prioritised health systems strengthening as a pathway to attain universal health coverage using the primary health care approach. The Ministry of Health is focused on building a robust, resilient and responsive Adolescent Health System across the continuum of care, spanning in the following order: promotive, preventive, curative, rehabilitative and palliative health services provided as close to the family settings as possible.

I am confident that the implementation of various strategic frameworks contained in this document will lead to fulfilment of the health care and development needs of our adolescents and young persons.

Hon. Sylvia T. Masebo, MP
MINISTER OF HEALTH

ACKNOWLEDGEMENTS

On behalf of the Ministry of Health, I wish to thank all the institutions and individuals who contributed to the successful development and revision of the Adolescent Health (ADH) Strategic Plan 2022–2026. We particularly thank the Adolescent Health Unit for overseeing the development process.

We wish to pay special acknowledgement to adolescent focal point persons at all levels (provincial and district levels) and members of the National Adolescent Health Technical Working Group, which draws membership from line ministries, civil society organisations, cooperating and implementing partners who took time to attend the programme review and validation meetings and provided their valuable inputs. I would also like to thank the adolescents and young people, including those with disabilities, who participated in the review of the previous strategy and development of the current strategic plan.

In addition, I would like to express my gratitude to the United Nations Children's Fund (UNICEF), World Health Organisation (WHO), Marie Stopes Zambia, HIVOs, SAfAIDS, SAT Zambia and other cooperating and implementing partners for their technical and financial support to the development of this document.

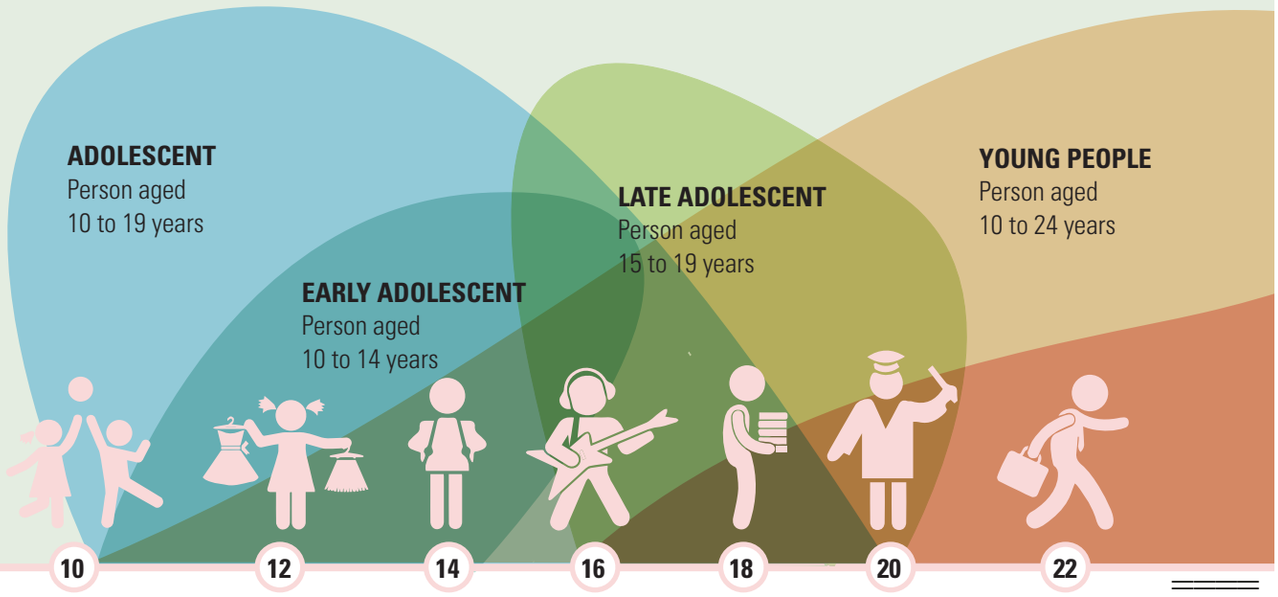
Thank you

Prof. Lackson Kasonka
Permanent Secretary
MINISTRY OF HEALTH

ACRONYMS AND ABBREVIATIONS

ADFHS	Adolescent Friendly Health Services
ADH	Adolescent Health
AFS	Adolescent Friendly Spaces
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Anti-retroviral Therapy
AYP	Adolescents and Young People
CSE	Comprehensive Sexuality Education
CSOs	Civil Society Organisations
FP	Family Planning
GRZ	Government of the Republic of Zambia
HFADH FPP	Health Facility Adolescent Health Focal Point Person
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
IEC	Information, Education and Communication
MoH	Ministry of Health
SBCC	Social Behavioural Change Communication
SADC	Southern Africa Development Community
SGBV	Sexual and Gender Based Violence
SRH	Sexual Reproductive Health
SRHR	Sexual Reproductive Health and Rights
STIs	Sexually Transmitted Infections
SWOT	Strengths, Weaknesses, Opportunities and Threats
TWG	Technical Working Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WHO	World Health Organization
ZDHS	Zambia Demographic and Health Survey

KEY DEFINITIONS OF TERMS



Adolescent: Any person between the ages of 10 and 19 years[1].

Adolescent friendly health services: These are a combination of high-quality services that are relevant, accessible, attractive, affordable, appropriate and acceptable to adolescents and young people. The services are provided in line with the minimum health care package and aim to increase acceptability and utilisation of health services by young people.

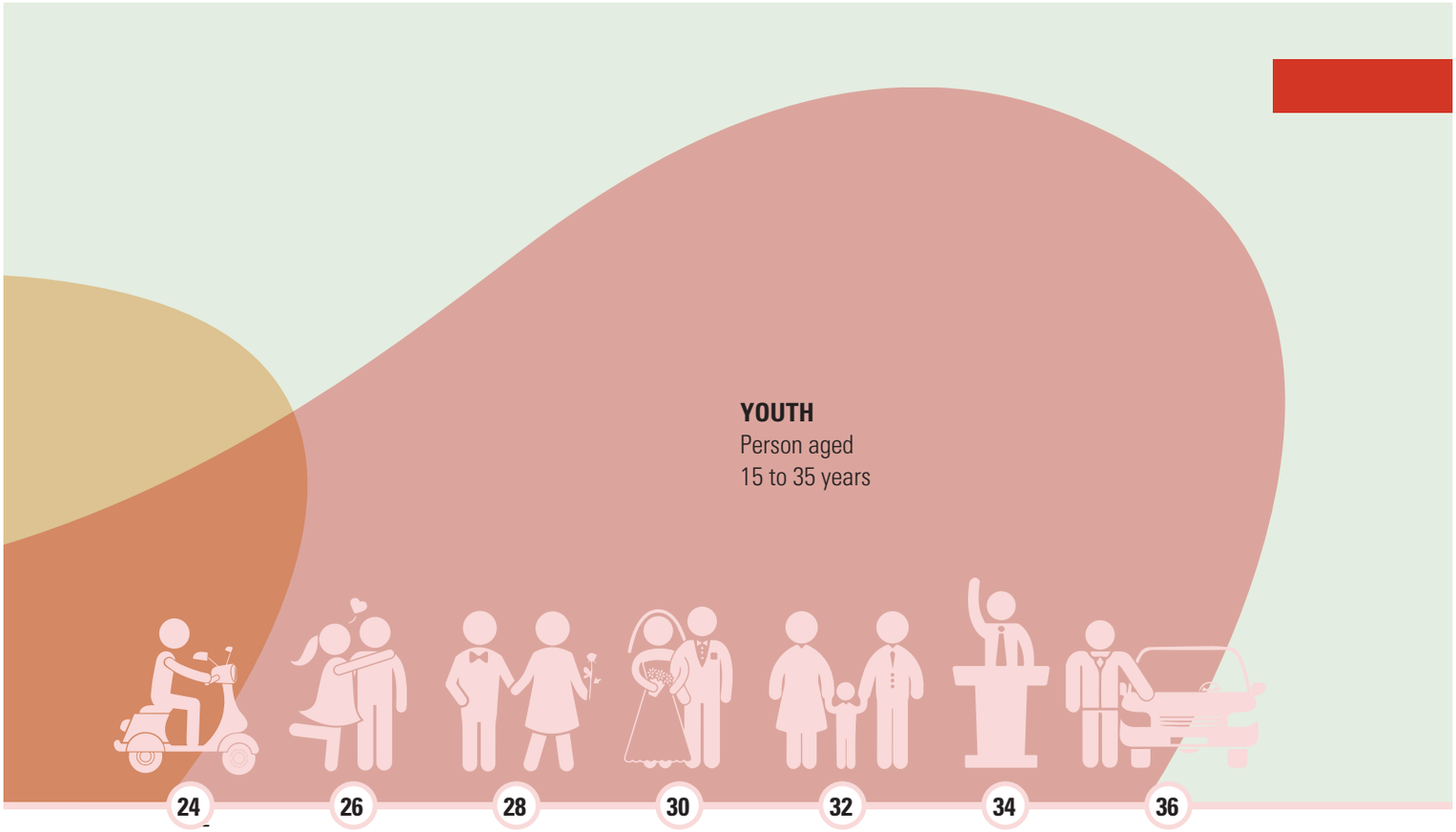
Adolescent responsive health system: This is a move towards Universal Health Access with a transition from an "adolescent friendly" project approach to an approach focused on addressing the building blocks of a health system. Each building block including service delivery, workforce capacity and financing responds to the adolescents' health needs

Adolescent friendly space model: This is an adaptation of the adolescent/youth friendly corner model. An adolescent friendly space (AFS) is defined as a well-advertised adolescent space, which serves as an entry point service for adolescents visiting a health centre. It is operated by designated health workers and trained peer educators. It provides basic health information, distributes information, education and communication materials and contraceptives and provides guided referrals to health services within the health centres and to health workers who have been trained in provision of adolescent friendly health services.

Comprehensive sexuality education: is a curriculum-based process of teaching and learning about the cognitive, emotional, physical and social aspects of sexuality. It aims to equip children and young people with knowledge, skills, attitudes and values that will empower them to: realise their health, well-being and dignity; develop respectful social and sexual relationships; consider how their choices affect their own well-being and that of others; and understand and ensure the protection of their rights throughout their lives[2].

1 WHO. 2022. Health Topics- Adolescent Health. https://www.who.int/health-topics/adolescent-health#tab=tab_1.

2 UNESCO. 2018. International Technical Guidance on Sexuality Education. International technical guidance on sexuality education (unfpa.org)



Minimum Adolescent Health Services Platform: The platform requires a District Adolescent Health Technical Working Group, a designated and trained District Adolescent Health Focal Point Person, a designated Health Facility Adolescent Health Focal Point Person and a designated AFS at each health centre, which is manned by trained peer educators.

Reproductive health and rights: Is a state of complete physical, mental, emotional and social well-being in all matters related to the reproductive system, its functions and processes. It implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so[3].

Reproductive rights: These are legal rights and freedoms relating to reproduction and reproductive health that rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children, to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health[4].

Service standard: A statement of a defined level of quality in the delivery of services that is required to meet the needs of adolescents. It defines performance expectations, structures or processes needed for an organisation to provide safe, equitable, acceptable, accessible, effective and appropriate services[5].

Taskforce: A governance structure constituting stakeholders grouped by technical expertise or area of work to provide technical support in a respective component of the adolescent health (ADH) strategic plan 2022–2026.

Young People: Any person aged between 10 and 24 years.

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3 UNFPA. 2022. Sexual and Reproductive Health. https://www.unfpa.org/sexual-reproductive-health

4 WHO. 2022. Sexual and Reproductive Health and Research (SRH). https://www.who.int/teams/sexual-and-reproductive-health-and-research/key-areas-of-work/sexual-health/defining-sexual-health

5 WHO. 2015. Global standards for quality health-care services for adolescents: standards and criteria. https://www.who.int/publications/i/item/9789241549332

01

INTRODUCTION

1.1 Background

Adolescence is defined as a period of transition between childhood and adulthood, covering ages between 10 and 19 years, is a unique stage of human development. It is characterised by physiological, emotional and sexual development, shaping a sense of identity and individual autonomy. As an individual grows and develops, the environment where they reside has a profound effect on how their genes are expressed. Therefore, their brain develops with the expression of the genes they have received from their parents, that is, nature, and the environment they are raised in, that is, nurture. Therefore, the health and health behaviour of adolescents are influenced by both their genetic makeup (nature) and their environment (nurture).

The adolescents' individual transformations, mainly the hormonal changes, the brain development and their personality traits, lead to new sets of behaviours and capacities that influence their social capital transitions in the family, among peers, among teachers and in health behaviours. The experiences that a young person has at this stage will affect brain development to a greater extent than other times of their life. Despite being viewed as a healthy stage of life, adolescents are affected by many health challenges, including illnesses and death, most of which are avoidable or treatable. Evidence is abound suggesting that adolescence provides a second window of opportunity to influence developmental trajectories (including growth and cognitive development) and counteract poor childhood vulnerabilities, hence an important time for laying the foundations of good health and well-being[6].

The population of adolescents continues to grow globally and even more so in Zambia making it an important population group to consider in socioeconomic development strategies. Globally, adolescents make up 16 per cent of the total population and one-fifth of the sub-Saharan African population. In Zambia, about one quarter (24 per cent) of the total population are adolescents. Investing in adolescent health has triple dividends—improving adolescents' health now, protecting the health of adolescents in adulthood and protecting the health of the future generation (their offspring). Improving general health outcomes for adolescents and young people (AYP) therefore remains a key priority area in Zambia as the majority of AYP continue to face health challenges. To respond to the health challenges faced by AYP, the Government of Zambia through the Ministry of Health (MoH) successfully implemented the second Adolescent Health (ADH) Strategy for the period 2017 to 2021.

The current strategic plan builds on the successes and lessons learned in implementing the preceding Adolescent Health Strategy 2017–2021, and will guide implementation of adolescent and young peoples' health services by employing evidence-based strategies. The 2022–2026 ADH Strategic plan is aligned with the Zambia National Health Strategic Plan 2022–2026 and other relevant national, sector policies and strategic frameworks, such as the Vision 2030 Strategy for Zambia, the Eighth National Development Plan (8NDP) 2022–2026 and the National Adolescent Health Minimum Package of Services and Standard Guidelines. This strategic plan is also linked to relevant global

[6] Young Lives. 2018. Adolescence provides a second crucial window of opportunity to address child poverty https://www.younglives.org.uk/sites/www.younglives.org.uk/files/YL-Adolescence-SnapShot-Jun18.pdf

and regional policies and strategic frameworks on adolescent health, such as the Sustainable Development Goals, specifically goal 3 (good health and well-being), goal 5 (gender equality) and goal 10 (reduced inequalities), the Global Standards for Quality Health Care Services for Adolescents, Global Accelerated Action for the Health of Adolescents, the Eastern and Southern Africa Ministerial Commitment on Sexuality Education, the Southern Africa Development Community (SADC) Sexual and Reproductive Health and Rights 2019–2030, and Sexual and Reproductive Health Services for AYP.

Informed by current epidemiological profile and health system context, the current strategic plan maintains and integrates priority areas including sexual and reproductive health (SRH), HIV and AIDS, STIs, sexual and gender based violence (SGBV), non-communicable diseases, drug and substance abuse, and a consideration of adolescents with special needs for more inclusive adolescent health programming in Zambia. The strategic plan is aimed at providing guidance to different governmental ministries, and non-governmental and civil society organisations (CSOs) in the provision of health services to AYP.

1.2 Socioeconomic determinants of adolescent health

Achieving good health for adolescents transcend the health sector hence the need to understand the situation in key determinants of health, advocate for and adopt a multisectoral approach in addressing the health and developmental needs of adolescents.

1.2.1 Population

In Zambia, adolescents make up almost a quarter (24 per cent) of the total population, with adolescents aged 10 to 14 years accounting for 13.3 per cent, while those aged between 15 and 19 years account for about 11 per cent. For different stages of adolescence [early adolescence (10–14 years) and late adolescence (15–19 years)], residence in either urban or rural settings as well as gender have an effect on adolescent health in various ways due to unique needs and opportunities of access to essential health and other services. The proportion in relation to sex is not significantly different and varies little between urban and rural areas, even though in 2018, nearly 49 per cent of all adolescents lived in the rural areas of Zambia[7, 8]. The number of young people in Zambia is projected to increase to 6.9 million by 2025 and to 14.8 million by 2050[9].

1.2.2 Poverty

Zambia is among the countries with the highest levels of poverty and inequality across the globe, with more than 54 per cent of its population living below the poverty line in 2020. Western Province has the highest poverty rate at 82.2 per cent, followed by Luapula Province at 81.1 per cent[10]. Zambia is also facing various forms of severe social inequalities, especially in rural areas. This situation has been exacerbated by the 2018/19 drought and the COVID-19 pandemic in 2020–2021. Socioeconomic indicators also dwindled in the wake of the pandemic, particularly affecting adolescents[11]. Poverty impacts adolescent health in many ways, mostly related to restricting access to

7 UNFPA. 2022. Adolescent and Youth Dashboard- Zambia. https://www.unfpa.org/data/adolescent-youth/ZM.

8 Zambia Statistics Agency, Ministry of Health (MOH) Zambia, and ICF. 2019. Zambia Demographic and Health Survey 2018. Lusaka, Zambia, and Rockville, Maryland, USA.

9 UNFPA. 2012. Status Report Adolescents and Young People in Sub-Saharan Africa. https://www.prb.org/wp-content/uploads/2014/01/status-report-youth-subsaharan-Africa.pdf.

10 Cheelo, C., Hinfelaar, M. and Ndulo, M. eds., 2022. Inequality in Zambia. Routledge.

11 UNICEF. 2022. https://www.unicef.org/social-policy/child-poverty/covid-19-socioeconomic-impacts.

quality health services and other determinants, such as good nutrition and quality housing. Evidence shows a higher risk of morbidity and mortality among poor households compared to rich households.

A noteworthy contributor to poverty among adolescents and their households is orphanhood[12]. In 2018, the population of children below 18 years including adolescents with one or both parents deceased stood at 36 per cent[8], which is a concern to household poverty and health outcomes for adolescents[13].

1.2.3 School attendance

Education is a protective factor against ill health, and schools offer an important delivery platform for adolescent health information and services. Evidence continues to highlight the reduction in chances of early and unintended pregnancy with more years of education. Unfortunately, there are gender differentials in access to education which is further restricted for young people with disabilities and for orphans, placing them at a high risk of a life of poverty[14.] In 2018, 79 per cent of primary school-age (7–13 years) children were attending school, while only 40 per cent of secondary school-age adolescents (14–18 years) were attending school [Zambia Demographic and Health Survey (ZDHS) 2018]. Disparities in school enrolment between boys and girls widen throughout adolescence. While boys and girls enrol in relatively equal numbers up to Grade 5, the ratio starts to slip in Grade 6, yielding a composition of 54 per cent boys and 46 per cent girls by Grade 12[15]. The Zambian education system has continued to record high dropout rates among adolescent girls in secondary school due to pregnancy, early marriage and economic hardship.

As a response, the school re-entry policy spearheaded by the Ministry of Education was launched in 1997. From 2010 to 2017, the education system managed to re-admit 44 per cent (53,814 out of 121,435) children at both primary and secondary levels; although girls who became pregnant at primary school level had a higher risk of dropping out of school forever[16].

1.2.4 Exposure to mass media and usage of information and communication technologies

Social media provides an opportunity to reach young people with appropriate health messages. The ZDHS reveals that the rate of exposure to newspaper, radio and television in the population aged 15–19 years dropped from about 12 per cent in 2014 to 5 per cent in 2018, and these were concentrated in Lusaka and the Copperbelt, while other locations had no access at all. In 2018, internet use was at 12 per cent for women aged 15–49 years in the month preceding the ZDHS survey, and the highest rate of use was in women aged 20–24 years at 18 per cent, and only 9 per cent among girls aged 15–19 years. Use among men was twice as high compared to women, and overall use was unsurprisingly concentrated in the urban areas[8.] Social media is increasingly becoming important among young people and is being used as a means of disseminating health information. A study conducted in Zambia showed that multi-media (especially video and animations) and other digital interventions may attract more interest among AYP[17]. However, social media can also be a source of "misinformation (false or misleading information) or disinformation (false information that is purposely spread to deceive people)" requiring special attention to the accuracy and quality of information shared.

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12 Seshamani, V., 2018. Deprivation levels in Zambia, 2006–2015: an analytical profile. African Research Review, 12(1), pp.1-11.

13 UNCEF 2018. Child poverty. https://www.unicef.org/zambia/reports/child-poverty-zambia -report-2018.

14 CSO. 2012. Living Conditions Monitoring Survey Report (2006 and 2010). (Central Statistical Office. Lusaka.

15 McConnell, C. and Mupuwaliywa, M., 2015. Keeping girls in school: situation analysis for Zambia. World Bank.

16 MOE. 2017. Self-Diagnosis Report for Ministry of General Education. Ministry of General Education, Lusaka.

17 MOH. 2021. Knowledge and use of Sexual Reproductive Health and HIV services among Adolescent Girls and Young Women in Central and Western Provinces: A Qualitative Knowledge Attitudes and Practices Study.

1.2.5 Health seeking behaviours

The access and use of general health services remains poor among adolescents. Although the availability of adolescent friendly services, youth clubs and peer educators at health facilities and HIV clinics provide a safe space for AYP to openly discuss the issues they face, adolescent friendly services are not widespread and as such are not always used and accessed by the majority of AYP. With the COVID-19 pandemic, challenges in the use of adolescent health services are currently being experienced by most countries including Zambia[18.]

Utilisation of SRH services (including information) in particular is also affected by socio-cultural norms, myths and misconceptions, poor services, lack of knowledge and mistrust of health workers[19, 20]. Concerns regarding the appropriateness of reproductive health messages affect the delivery of sexual reproductive health and rights (SRHR) information to adolescents. For example, Comprehensive Sexuality Education (CSE), which was launched by the government with the view of improving knowledge about sexuality and reproduction, has been received with mixed reactions in both the school and community settings[21].

Access to sexual and gender-based violence services, such as counselling, treatment and support is also very low[22]. Self-stigmatisation among persons with disabilities, limited knowledge on SRH and inadequate availability of services affect access to health services including SRH services[23], and adolescents are no exception to this. For young refugees, limited access to quality healthcare, good sanitation and comprehensive public health information have been identified as significant barriers to the realisation of the highest quality of health. Limited health services in selected facilities, poor and judgemental health worker attitudes, and costs associated with accessing health care have also been identified as barriers to access and use of SRH services among AYP[24]. The non-existence of a policy on the age of consent for family planning allows the decision on the provision of care to the discretion of the health providers, based often on their religious beliefs and not on the right of adolescents.

1.2.6 Climate change

The climate change crisis continues to impact all aspects of health for AYP both male and female, with the already marginalised and most vulnerable adolescents, such as the AYP with special needs and disabilities at a higher risk[25.] Two of the most common impacts include school dropouts and migration in search of economic activities, which disrupt their connectedness to family, friends and community. On the contrary, adolescent girls are reported to be more vulnerable to child marriages, increased gender inequality and risk of sexual violence because of daily chores such as drawing water from long distances. Healthy, educated and empowered adolescents can participate more effectively in climate change planning and natural resource management.

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18 UNICEF. 2020. Country Office Annual Report 2020- Zambia. https://www.unicef.org/media/101256/file/Zambia-2020-COAR.pdf.

19 Munakampe M.N., Zulu J.M., Michelo C. Contraception and abortion knowledge, attitudes and practices among adolescents from low and middle-income countries: a systematic review. BMC health services research. 2018(18):909.

20 Mesic A., Halim N., MacLeod W., Haker C., Mwansa M. & Biemba G. Facilitators and Barriers to Adherence to Antiretroviral Therapy and Retention in Care Among Adolescents Living with HIV/AIDS in Zambia: A Mixed Methods Study. AIDS Behav. 2019(23):2618–2628. doi:10.1007/s10461-019-02533-5.

21 Chavula M.P., Svanemyr J., Zulu J.M. & Sandøy I.F. Experiences of teachers and community health workers implementing sexuality and life skills education in youth clubs in Zambia. Global Public Health, 2021:1–15.

22 Mathur S., Okal J., Musheke M., Pilgrim N., Kishor Patel S., Bhattacharya R., et al. 2018. High rates of sexual violence by both intimate and non-intimate partners experienced by adolescent girls and young women in Kenya and Zambia. PLoS One. (13): e0203929.

23 International Solutions Group. 2017. Sexual and reproductive health and rights of girls and young women with disabilities. Lusaka, Zambia.

24 UNHCR. 2016. Women Refugee Commission, AAH, World Vision. Zambia National Refugee Youth Consultation: Summary Report 19th–22nd April 2016.

25 Plan International. Adolescent Girls in the Climate Crisis: Voices from Zambia and Zimbabwe. https://plan international.org/publications/adolescent-girls-in-the-climate-crisis-voices-from-zambia-and-zimbabwe/

1.3 Overview of performance of the Adolescent Health Strategy 2017–2021

Zambia has made progress in making ADH an integral part of the nation's health agenda. Over the past five years, the MoH and its partners have implemented adolescent health services, guided by the ADH Strategy 2017–2021, to promote the delivery of quality health services and better health outcomes for AYP. Based on findings from consultative meetings and programmatic reports, important progress has been made in the implementation of the strategy including:

- Increased youth friendly service provision through adolescent friendly spaces (AFS) to 60 per cent of districts compared to 24 per cent of districts at the end of the 2011–2016 implementation period.
- Improved adolescents' awareness and utilisation of available adolescent health services.
- Improved coordination of ADH services through the establishment of technical working groups (TWGs) at all levels (national, provincial and district).
- Institutionalised adolescent health service quality assessments to improve quality of adolescent friendly health services (ADFHS).
- Increased participation of AYP in ADH decision making platforms, demand generation and service delivery.
- Expanded scope of adolescent friendly health service provision in critical sectors including education, such as the establishment of adolescent friendly services in tertiary institutions.
- Disaggregated age and sex indicators in the Health Management Information System (HMIS) to allow for ascertaining progress in utilisation of essential health interventions by AYP.

Although the 2017–2021 ADH Strategy and its operational plans were available, their dissemination was delayed in some districts and facilities partly due to insufficient funds to print copies of the strategy. With support from different partners such as United Nations Children's Fund (UNICEF), Clinton Health Access Initiative and United Nations Population Fund (UNFPA), guidelines on improvement of the quality of adolescent health service at district and facility levels were defined, communicated and implemented through periodic service quality assessments. Attrition of peer educators and limited infrastructure to designate AFS were among the main challenges to provision of ADFHS.

A number of lessons have been learned through the process and these include:

- Inter-sectoral coordination is integral to provide holistic and responsive services for adolescents. The need to work with other ministries, such as Ministries of Social Welfare & Community Development and Education, in a complementary manner to ensure that policies regarding adolescents are harmonised.
- High attrition of peer educators requires strategies to ensure retention and continued functionality of peer service delivery. Provision of incentives to peer educators to prevent high attrition rates has been proposed but policy direction is yet to be instituted.

- Community engagement is integral hence the need to engage community members as stakeholders, particularly traditional leaders, for programme support and the importance of imparting moral values in young people, which were perceived to be important particularly among communities with strong cultural and religious beliefs. Partner-dependency led to a disproportionate distribution of services in the country due to concentration of support in some geographical areas.
- Performance review brought to the fore the fact that resources including financial, commodities and human resources were not adequate for the implementation of ADH services at all levels, hence this led to non-achievement of set targets.

1.4 SWOT analysis of the Zambia health systems' preparedness to respond to the needs of adolescents and young people

The Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis framework was used to determine the strengths, weaknesses, opportunities and threats pertaining to health systems preparedness to deliver health services that are responsive to the needs of AYP.

Table 1.1: *Analysis of SWOT for implementation of the adolescent health services*

STRENGTHS	WEAKNESSES
• Adolescent health is a priority area in health policy and strategies • Availability of ADH services in all the districts and selected health facilities • Availability of AFS in selected health facilities • Availability of health promotion officers, trained health workers and peer educators in ADH • Existence of provincial and district TWGs and use of facility integrated meetings • Availability of guidelines, standards and information, education and communication (IEC) materials • Availability of focal programme point persons • Availability of commodities and supplies to provide ADH services • Availability of IEC materials, media and digital platforms for social behavioural change communication (SBCC) • Existence of relevant technical and coordination units at MoH (Adolescent Health, Health promotion and communication units) • Budget allocation from the Government of the Republic of Zambia (GRZ) for ADH programme • Availability of age disaggregated data e.g., in HMIS • Availability of partner supported-community-based ADH spaces and recreation activities • Development and guidance on terms of references for the operation of adolescent friendly services	• The non-existence of a policy on the age of consent for family planning allows the decision on the provision of care to the discretion of the health providers, based often on their religious beliefs and not on the right of adolescents. • Inadequate adolescent health spaces and one stop centres • Inadequate equipment for ADH service delivery • Inadequate programmes targeting adolescents with special needs and those with disabilities • Inadequate service providers trained/oriented in ADH and sign language • Inadequate privacy and confidentiality at health facilities in the community • Poor stakeholder coordination at subnational level • Limited funds and transport for adolescent health outreach programmes • Inadequate IEC materials translated in local languages • Lack of standardised reporting tools • Poor attitude of health care providers affecting service utilisation • Non flexible operating hours for adolescent health services • Inadequate roll-out and guidance on terms of references for TWGs at national and provincial levels • Inconsistent TWG meetings at the provincial and district levels • Non-availability of policy on the age of consent to health services • High attrition rate of peer educators • Lack of robust data (GBV cases, early pregnancies, fistula, etc).

OPPORTUNITIES	THREATS
• Existing programms in other line ministries-linked to promoting adolescent health and development (e.g., CSE, Youth resource centres , Social Cash transfer, Menstrual health and hygiene management (MHHM), ending child marriage and violence against children) • Availability of partner support to conduct ADH activities • Political will to support the ADH programme • Participation of community leaders in ADH programmes • Availability of multimedia platforms e.g., social, electronic and print media • Participation of community leaders in ADH programme • Partnerships with key influencers e.g., artists, religious youth organisations • Increase in allocation of Constituency Development Fund (potential investment in youth empowerment and adolescent health programmes) • Free education up to Grade 12 and availability of bursaries for under privileged learners	• Dependence on partner support affecting service coverage • Myths and misconception about ADH programme • Cultural and religious beliefs deter access to some adolescent health services e.g., SRH (contraceptive uptake) • High poverty levels affecting AYP • High unemployment among young people • Pandemics e.g., COVID-19, Monkey Pox • Effects of climate change • Harmful traditional messages transmitted within the households and by marital counsellors (Bana Chimbusa, alangizi) promoting unconditional obedience to male partners, secretiveness and none disclosure of GBV

1.5 Process of developing the Adolescent Health Strategic Plan 2022–2026

This strategic plan was developed through a participatory and consultative process that actively engaged all parties involved in adolescent health programmes from the MoH, multilateral organisations, such as the United Nations, bilateral organisations, non-governmental organisations, the civil society who constitute the National Adolescent Health Technical Working Group, and AYP themselves. The following steps were undertaken in the development of the strategic plan:

- **Synthesis of local evidence on adolescent health.** A study was conducted which led to a comprehensive synthesis of local evidence focusing on burden of disease and conditions, availability of cost-effective interventions and implementation modalities focusing on six priority areas of the ADH Strategy 2017–2021. The findings were key in contributing to evidence-based decisions on selecting priority areas and interventions that work.
- **Adolescent health research and best practices symposium** was conducted in December 2021 as an initial step to developing a situation analysis of the ADH strategic plany. The evidence presented and discussions that ensued were a critical part of prioritisation of diseases, conditions and interventions.
- **Rapid technical review of the Adolescent Health Strategy (2017–2021)** through virtual consultative meetings with the implementers of the adolescent health programme in Zambia was conducted to ascertain successes, challenges and lessons learned in the implementation, governance, and the adequacy of the scope of the strategy with regard to addressing priority health needs of AYP in Zambia.
- **Relevant literature and programme documents were reviewed in addition to the evidence synthesis report.** Further synthesis of existing peer reviewed literature and reports, local and international literature was undertaken to understand the programming landscape in Zambia and proven interventions to address health needs of AYP. The Global Accelerating Action for the Health of Adolescents Framework and the Global Standards for Adolescent Health were among the key documents used to inform design of interventions.
- **Validation process:** The various draft versions of the strategic plan were presented to key stakeholders for validation and approval.

1.6 Rationale for developing the Adolescent Health Strategic Plan 2022–2026

The 2022–2026 ADH Strategic plan is a follow-up to the 2017–2021 ADH Strategy. While the previous strategy had significant impact on the health outcomes and well-being of AYP, there is still a need to keep responding to the challenges that AYP face. The current strategic plan is therefore in tandem with new developments that occurred during the past five-year period and the dynamic environment that adolescent and young people live in. Evidence suggests a need to respond to the evolving challenges that AYP continue facing, especially in the context of COVID-19.

This strategic plan aims not only to achieve new targets but also to achieve those not attained during the 2017–2021 implementation period and address outstanding challenges.

02

STRATEGIC DIRECTION FOR THE ADOLESCENT HEALTH STRATEGIC PLAN 2022–2026

2.1 Introduction

This section outlines the vision, mission, strategies and approaches for service delivery of adolescent and youth friendly services. The focus of the ADH Strategic Plan 2022–2026 is premised on strengthening the delivery of adolescent and young people's responsive health services aimed at improving their health outcomes. The focus areas are adolescent SRH, HIV, STIs, alcohol and substance use, non-communicable diseases, and sexual and gender-based violence services to increase access and use of quality health services. The ADH strategic plan adopts an integrated approach to ensure that AYP with special needs including persons with disabilities are equally prioritised at all levels of intervention.

2.2 Vision, mission, overall goal and objectives

Vision: Healthy and productive adolescents for national development in Zambia.

Mission: To ensure equity of access to appropriate, quality and cost-effective services that are responsive to the health needs of adolescents through multisectoral approach.

Overall goal: To improve the health status of adolescents in Zambia.

Specific objectives:

1. To increase the number of facilities with functional adolescent friendly spaces from 964 to 1,550 in 2026.
2. To strengthen the health system to be responsive to the health needs of adolescents including those with special needs and disabilities.
3. To strengthen availability and use of strategic information to guide adolescent health programme design and implementation.
4. To strengthen multisectoral referral and linkages to respond to health needs of adolescents, those with special needs including those with disabilities.
5. To strengthen and sustain partnerships with related sectors to reduce health related risks for adolescents and optimise the achievement of adolescents' full potential.

2.2.1 Time frame

This is a five-year strategic plan from 2022 to 2026 and is in line with the Zambia National Health Strategic Plan and the Sustainable Development Goals. The strategic plan will be revisited periodically (mid-term) to review and assess its relevance in a rapidly changing context.

2.3 Guiding principles

The implementation of the ADH Strategic plan for 2022–2026 shall be guided by the World Health Organisation (WHO) quality-of-care framework, which provides a useful guide to improving health service provision and utilisation[26]. The quality-of-care framework provides a useful working definition of adolescent-friendly health services, which should be accessible, acceptable, equitable, appropriate and effective, as outlined in Table 2.1.

Table 2.1: *Key principles of the Adolescent Health Strategic plan*

ACCESSIBLE	*All adolescents are able to obtain the services that are provided.* Adolescents should be able to receive health services free of charge and/or be able to afford any charges that might be in place. All services should be available to all AYP during convenient hours, i.e., after school or work hours, during weekend and holidays where applicable. The location of the facility should be easily accessible and the physical infrastructure should be user-friendly to all adolescents including those with disabilities.
ACCEPTABLE	*Health services are provided in ways that meet the expectations of adolescent clients.* Guidelines and procedures that maintain AYP's rights, privacy and confidentiality should be in place at all times. Service providers should be non-judgmental, considerate, and easy to relate to adolescents. Services should be provided in ways that adolescents do not feel discriminated against or stigmatised.
APPROPRIATE	*The right health services that adolescents need are provided in ways that account for issues such as privacy, confidentiality, non-stigmatisation, and gender-responsiveness.* The health needs and issues of all adolescents will be addressed by the health service package provided at the point of health service delivery or through effective referral linkages and networks. The services provided should also meet the adolescents with special needs and other marginalised groups.
EQUITABLE	*All adolescents, not just certain groups, are able to obtain the health services they need.* All adolescents including those with disabilities, living with HIV, who are hard-to-reach, in humanitarian situations and in low-resourced settings will receive the full range of health services they require.
EFFECTIVE	*The right health services are provided in the right way, and make a positive contribution to the health of adolescents.* ADH service provision should be based on protocols and guidelines that are technically sound and of proven usefulness to address health challenges faced by adolescents. Health care providers should have the required competencies to work with adolescents and provide them with the required and appropriate health services.
MEANINGFUL ADOLESCENT PARTICIPATION	*All adolescent girls and boys, either individually or collectively, form and express their views and influence matters that concern their health.* All adolescents including those with disabilities, HIV, hard to reach, in humanitarian situations, in low resourced settings, of varying ages, family wealth levels, physical, emotional and cognitive abilities must be given participation opportunities and activities that are inclusive and given the chance to take part in decisions that affect their health.

[26] WHO. 2012. Making health services adolescent friendly: Developing national quality standards for adolescent-friendly health services.

2.4 Standards for quality adolescents and youth friendly services

The eight standards that will be pursued in implementing the ADH Strategic Plan 2022–2026 are outlined in Table 2.2. Each standard reflects an important form of quality services required to meet the needs of all AYP. Table 2.2 provides a measurable criterion of the standards.

Table 2.2: *Key standards of the Adolescent Health Strategic Plan*

STANDARD 1 Adolescents' and young people's health literacy	The service delivery point implements systems to ensure that AYP are knowledgeable about their own health, and know where and when to obtain health services.
STANDARD 2 Stakeholder support	The service delivery point implements systems to ensure that stakeholders recognise the value of providing health services to adolescents and support such provision and the utilisation of services by AYP.
STANDARD 3 Appropriate package of services	The service delivery point provides a package of information, counseling, diagnostic, treatment and care services that fulfil the needs of all AYP. Services are provided in the facility, through referral linkages, networks and outreach including in humanitarian settings.
STANDARD 4 Providers' competencies	Health care providers demonstrate the technical competence required to provide effective health services to AYP. Both health care providers and support staff respect, protect and fulfil adolescents' and young people's right to information, privacy, confidentiality, non-discrimination, and non-judgmental attitudes.
STANDARD 5 Facility characteristics	The service delivery point has convenient operating hours, a welcoming and clean environment and maintains privacy and confidentiality. It has the appropriate and relevant equipment, medicines, supplies and technology needed to ensure effective service provision to AYP.
STANDARD 6 Equity and non-discrimination	The health service providers and delivery point provide quality services to all AYP irrespective of their ability to pay, age, sex, marital status, education level, religion, ethnic origin, social status, cultural background, disabilities or other characteristics. The service providers and points of service shall ensure human rights of adolescent and young people are upheld.
STANDARD 7 Data and quality improvement	The service delivery points collect, analyse and use data on service utilisation and quality of care, disaggregated by age and sex, to support quality improvement. The service providers are supported to participate in continuous quality assessment and improvement. This data should be captured in the MoH Health information system/tools including uploading data into District Health Information System as is appropriate.
STANDARD 8 Adolescents' participation	AYP are involved in the planning, monitoring and evaluation of health services and in decision-making regarding their own care, as well as in certain appropriate aspects of service provision.

2.5 Adolescent health priorities

Based on the situation analysis (Chapter 3), health issues facing adolescents remain the same and indicate the need to continue strengthening adolescent responsive health systems with a focus on the following areas needing special attention:

Table 2.3: *Summary of health priorities*

FOCUS AREAS
• Sexual and reproductive health
• HIV and AIDS, and other sexually transmitted infections
• Sexual and gender based violence
• Non-communicable diseases, such as nutrition and mental health related conditions
• Alcohol, tobacco and drug use
• Adolescents with special needs including those with disabilities

To effectively address the ADH priorities identified through review of literature and a situation analysis, each of the priority areas will be individually addressed.

03

HEALTH SERVICE DELIVERY SYSTEM FOR ADOLESCENTS AND YOUNG PEOPLE

3.1 Sexual and reproductive health

3.1.1 Situation analysis

Early and unprotected sexual activities often lead to critical health problems among adolescents. According to the 2018 ZDHS, approximately 12.7 per cent of girls and 16.3 per cent of boys began sexual intercourse before they turned 15 years old. Further, approximately 40 per cent of girls and 45 per cent of boys had first sexual intercourse between the ages of 15 and 19 years[8]. The Violence Against Children survey (VAC 2015) reported that 28.3 per cent females and 6.8 per cent males declared that the first sexual intercourse before the age of 18 was unwanted. Teenage pregnancy has not significantly changed since 2007 when it was 27.9 per cent compared to 29.2 per cent in 2018 and the adolescent fertility rate, which reduced slightly from 141 in 2014 to 135 in 2018, remains among the highest globally. Although the percentage of adolescent girls reporting having ever had a live birth in the 2013/14 survey remained at around 24 per cent, similar to 2018. Provincial differences were apparent, with the greatest reductions in Lusaka, North-Western and Northern Provinces, compared to increases in Copperbelt, Eastern, and Southern Provinces. In 2018, teenage pregnancies were the highest in Southern Province (43 per cent) followed by Western Province (40 per cent). (see Figure 3.1).

The drivers of early pregnancies and childbearing include low uptake of contraceptives, gender based violence, poverty, limited economic opportunities for AYP, orphanhood, early marriage, and bride wealth and gender norms that favour childbearing for socioeconomic security[27,28]. Younger adolescent girls and those with lower levels of education are less likely to use contraception compared to older ones and those with higher levels of education[29], as suggested by the higher incidence of pregnancy in primary school than in secondary school.

Menstrual health and hygiene management (MHHM) remains a major concern for adolescent girls in Zambia. Adolescent girls in school miss class frequently because they often lack safe sanitary products, WASH facilities, and have inadequate experience and knowledge in MHHM[30].

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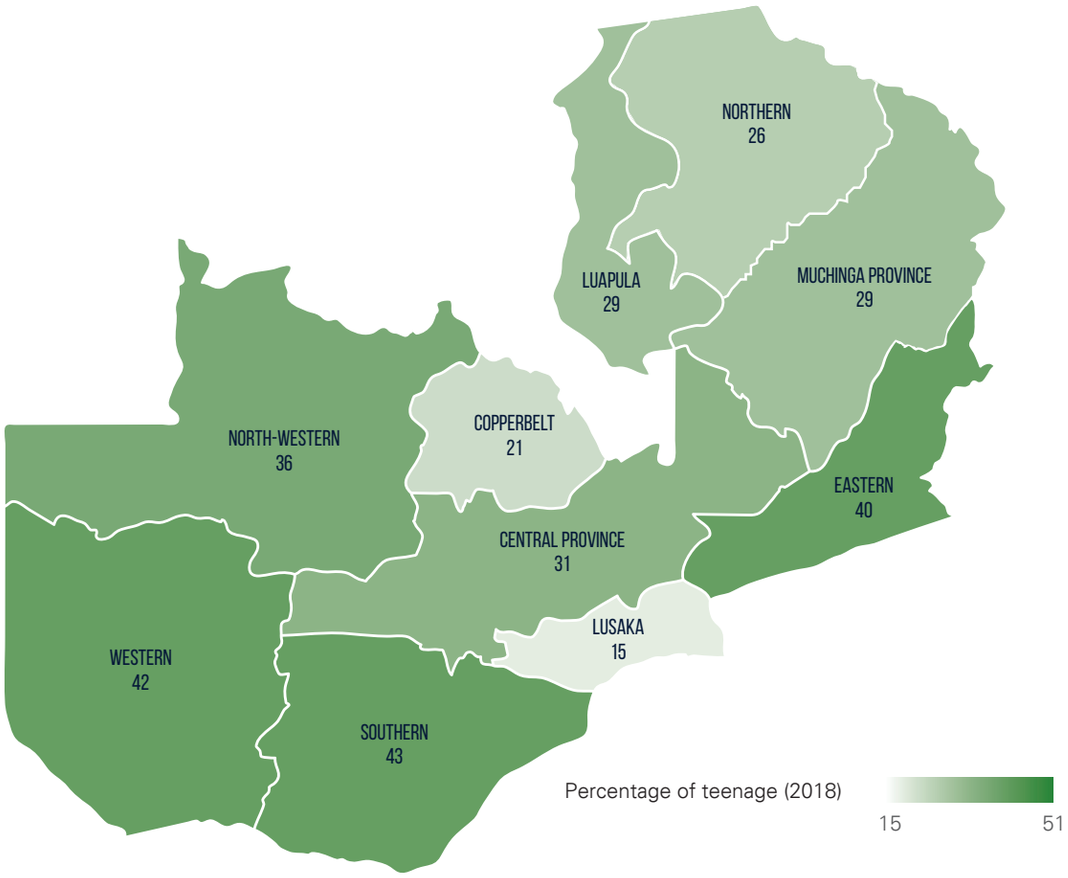
27 Girls Not Brides-Zambia Profile. https://www.girlsnotbrides.org/child-marriage/zambia/.

28 Petroni S, Steinhaus M, Fenn NS, Stoebenau K, Gregowski A. New findings on child marriage in Sub-Saharan Africa. Ann Glob Health. 2017; 83:781–790. doi: 10.1016/j.aogh.2017.09.001.

29 Chola M., Hlongwana K. & Ginindza T.G. Patterns, trends, and factors associated with contraceptive use among adolescent girls in Zambia (1996 to 2014): a multilevel analysis. *BMC Women's Health* 20, 185 (2020). https://doi.org/10.1186/s12905-020-01050-1.

30 UNFPA ESARO | Menstrual Health Management in East and Southern Africa: A Review Paper UNICEF-Guidance-menstrual-health-hygiene-2019.pdf.

Figure 3.1: *Proportion of adolescents who reported ever having a live birth by region, Zambia*



Source: ZDHS 2013/14 and 2018

Child marriages have hardly declined over the years and remain a challenge for Zambia with differentials at provincial and district levels. Girls with only primary education were four times more likely to marry before age 15 compared to girls with secondary education[10]. Early pregnancies and child marriages are associated with poor health outcomes for young people. The long-time effects on their health in adulthood and the physical and mental health of their offspring have been documented.

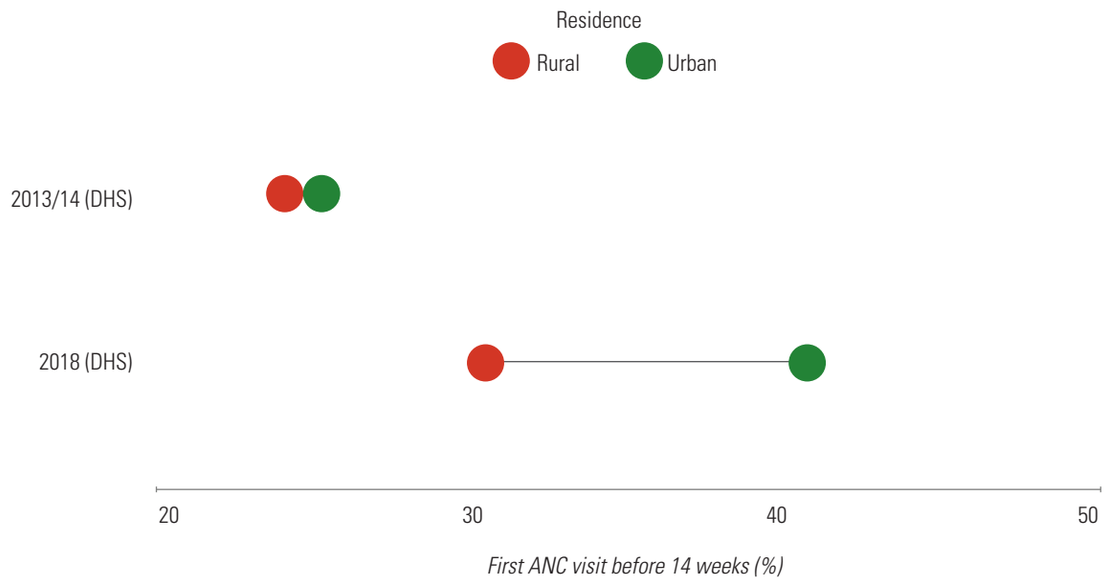
Zambia's maternal mortality ratio remains high, at 278 deaths per 100,000 in 2018[8]. Unsafe abortions and childbirth-related complications are some of the top causes of maternal mortality in Zambia. Approximately 30 per cent of maternal deaths are due to unsafe abortions. Induced abortions in girls younger than 18 years account for 25 per cent of maternal deaths[31]. With regards to deliveries by pregnant adolescent and young women, despite the percentage of deliveries assisted by skilled personnel increasing at the national level between 2013/14 and 2018, approximately one out of ten (11 per cent) of young mothers below 20 years gave birth home in 2018. Adolescent pregnancy often has complications associated with it. These include, pre-eclampsia/eclampsia, pre-term birth, maternal mortality, perinatal mortality and maternal morbidity including obstetric fistula[32].

[31] Moraes A.N., Likwa R.N. & Nzala S.H. 2018. A retrospective analysis of adverse obstetric and perinatal outcomes in adolescent pregnancy: The case of Luapula Province, Zambia. *Maternal Health, Neonatology and Perinatology*, 4:20. https://doi.org/10.1186/s40748-018-0088-y.

[32] Tebeu, P.M., Fomulu, J.N., Khaddaj, S., de Bernis, L., Delvaux, T. and Rochat, C.H., 2012. Risk factors for obstetric fistula: a clinical review. International urogynecology journal, 23(4), pp.387-394; Grønvik, T. and Fossgard Sandøy, I., 2018. Complications associated with adolescent childbearing in Sub-Saharan Africa: A systematic literature review and meta-analysis. PloS one, 13(9), p.e0204327.

Children born to adolescent mothers may experience a wide range of problems and a greater risk of stunting, infant mortality and a higher low birth-weight of 12 per cent compared to 9 per cent for the entire reproductive age-group[10,33]. Notably, the proportion of adolescents attending antenatal care (ANC) visits before 14 weeks increased from 25 per cent in 2014 to 38 per cent in 2018 and in rural and urban areas it increased from 20 per cent in 2014 to 27 per cent in 2018 respectively. The rural-urban gap in the proportion of ANC visits before 14 weeks was wider in 2018 (see Figure 3.2).

Figure 3.2: *Adolescents with first antenatal care visit before 14 weeks*



3.1.2 Overall objective

To enhance equitable access to high quality SRH services for AYP.

Specific objectives:

(i) To reduce teenage pregnancies from 29 per cent to 26.5 per cent by 2026.

(ii) To increase the percentage of adolescents accessing any type of modern contraceptive methods from 18.4 per cent to 25 per cent by 2026.

(iii) To reduce maternal complications (i.e., obstetric fistula, pre/eclampsia, antepartum haemorrhage) among pregnant adolescent girls and young women.

3.1.3 Strategic interventions

1. Increase the availability and utilisation of high-impact adolescent youth-friendly and inclusive SRH services (contraceptives, maternal health services, MHHM and cancer prevention services, such as human papillomaviruses vaccination).

[33] Population Council. 2017. Adolescent Pregnancy in Zambia. https://www.popcouncil.org/uploads/pdfs/2017RH_AdolPregnancyZambia_brief.pdf.

2. Enhance the capacity of health workers in the delivery of adolescent youth-friendly, inclusive, age and gender-sensitive SRH services, which include contraceptives, maternal health and cancer prevention services, such as human papillomaviruses vaccination.
3. Strengthen collaborations/linkages with line ministries and implementing partners on the age-appropriate CSE programmes at all levels including schools and training institutions.

Table 3.1: *Strategic interventions for sexual and reproductive health*

STRATEGIC INTERVENTIONS FOR SEXUAL AND REPRODUCTIVE HEALTH	
Strategic interventions	Activities
Increase the availability and utilisation of adolescent/youth-friendly high-impact SRH services (contraceptives, maternal health services, MHHM and reproductive cancers prevention services, such as human papillomaviruses vaccination).	• Provide static, and integrated outreach and community based sexual reproductive health services with particular focus on underserved areas (considering digital technologies where appropriate). • Forecasting essential medical commodities and supplies for effective adolescent/youth friendly sexual and reproductive (including maternal) health services. • Procure equipment for effective adolescent/youth friendly SRH service provision. • Establish and/or refurbish the adolescent and youth friendly spaces in facilities/communities. • Provide tailor-made and responsive prevention of mother to child transmission of HIV services for pregnant and breastfeeding adolescent and young women. • Conduct community engagements/sensitisations: ○ Social mobilisations ○ Debates ○ Drama groups ○ Dialogue meetings ○ Health education • Develop and distribute IEC materials approved by government (SRH, HIV, STIs, GBV, NCDs, mental health, nutrition, alcohol and substance use and adolescents with special needs) using multimedia platforms: ○ Print ○ Television and radio ○ Social media
Enhance capacity of health workers in the delivery of adolescent/youth-friendly age and gender-sensitive SRH services which includes contraceptives, maternal health services, MHHM and cancer prevention services such as human papillomaviruses vaccination.	• Train health care workers in adolescent health. • Train peer educators, including youth volunteers, in: ○ Adolescent health ○ Comprehensive sexuality education for out of school ○ Community based distribution of contraceptives ○ Safe motherhood ○ Sign language ○ Adherence counselling ○ Psychosocial counselling
Strengthen collaborations/linkages with line ministries and implementing partners on the age-appropriate CSE programmes at all levels including schools and training institutions.	• Integrate CSE programmes into existing programming, in schools, community programmes/organisations and in health care systems – especially at the primary health care level. • Conduct joint: ○ Meetings through TWGs ○ Supervisory visits ○ Annual review and planning meetings

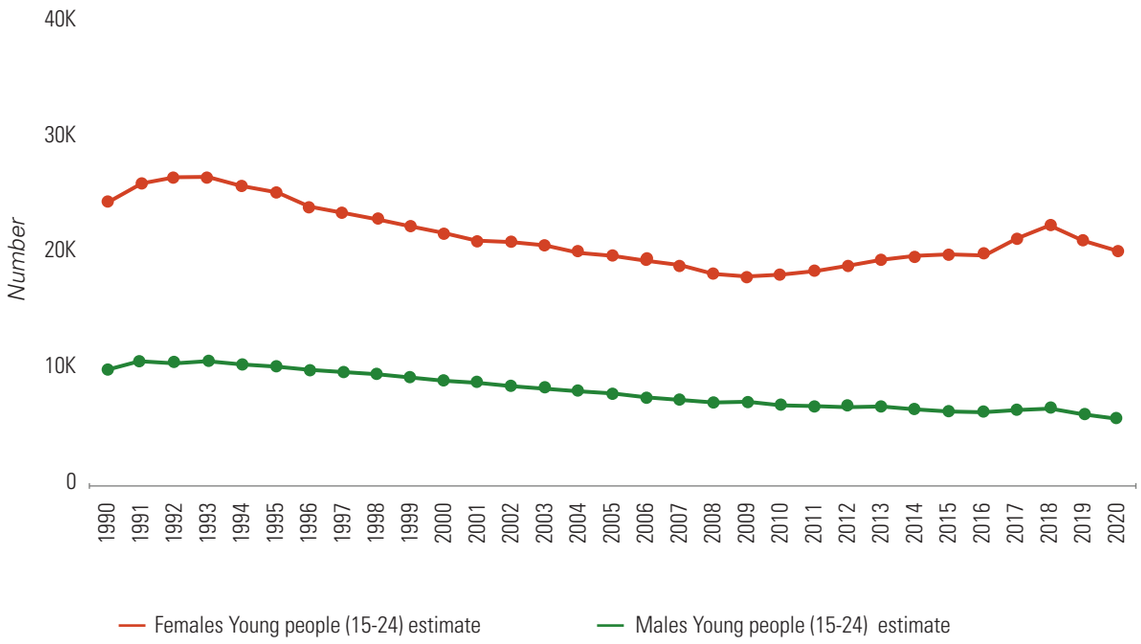
3.2 HIV, AIDS and STIs

3.2.1 Situation analysis

Zambia is among the priority countries for HIV epidemic control. Despite comprising about 20 per cent of the population, AYP aged 15–24 years account for 40 per cent of all new HIV infections annually. New HIV infections have declined at a lower rate among AYP. AYP represent a growing share of people living with HIV in Zambia.

Gender disparities are pronounced in the HIV burden among AYP (aged 10–24 years). As shown in Figure 3.3, in 2020 the estimated new HIV infections among adolescent girls were six times higher than boys, and HIV prevalence, although reflecting a declining trend over years, consistently shows a higher burden among adolescent girls and young women.

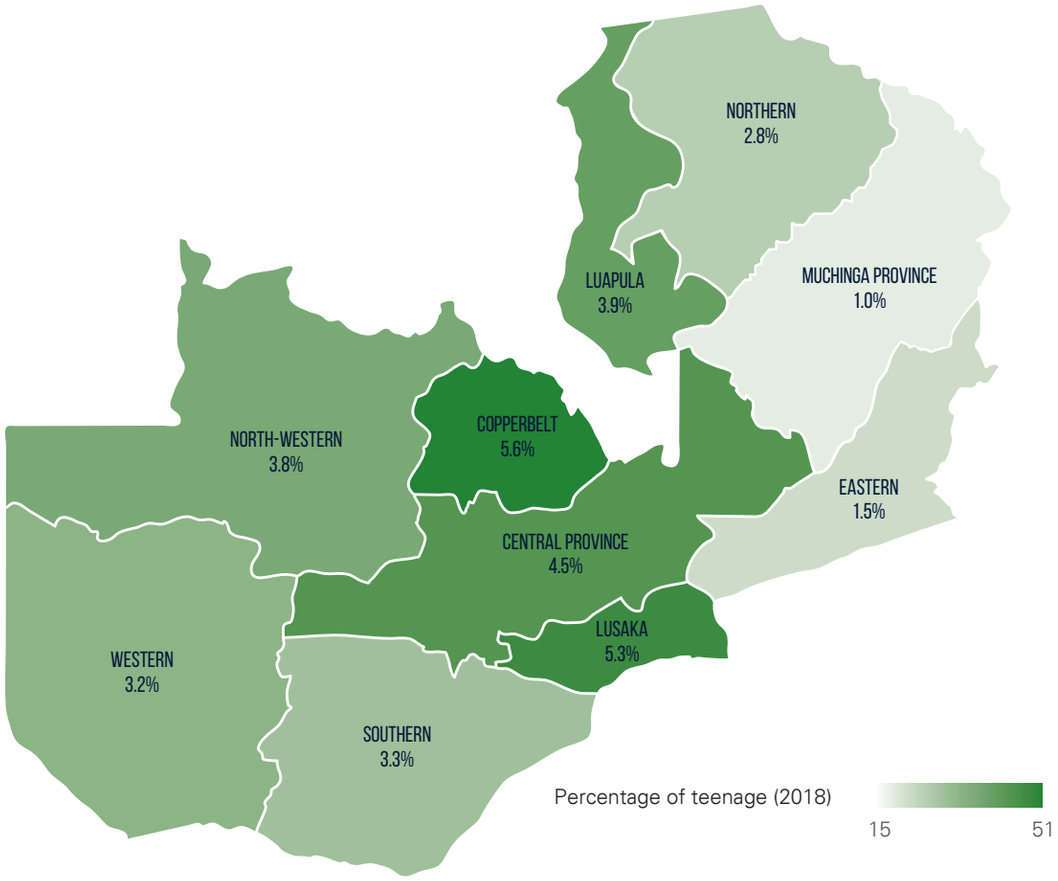
Figure 3.3: *New HIV infections among adolescents and young people (15–24 years) by sex*



Source: UNAIDS HIV Epidemic Atlas: aidsinfo.org

Comparisons across regions (Figure 3.4) show that, in the 2018 ZDHS, HIV prevalence rates were higher among AYP (15–24 years) living in the Copperbelt Province (5.6 per cent) followed by Lusaka Province (5.3 per cent) and lowest in Muchinga Province (1.0 per cent). This pattern where predominantly urban provinces have a higher burden reflects the established evidence where the urban adolescents are more affected compared to those in rural areas in both sexes[8].

Figure 3.4: *HIV prevalence by province among adolescents and young people ages 15–24 years*



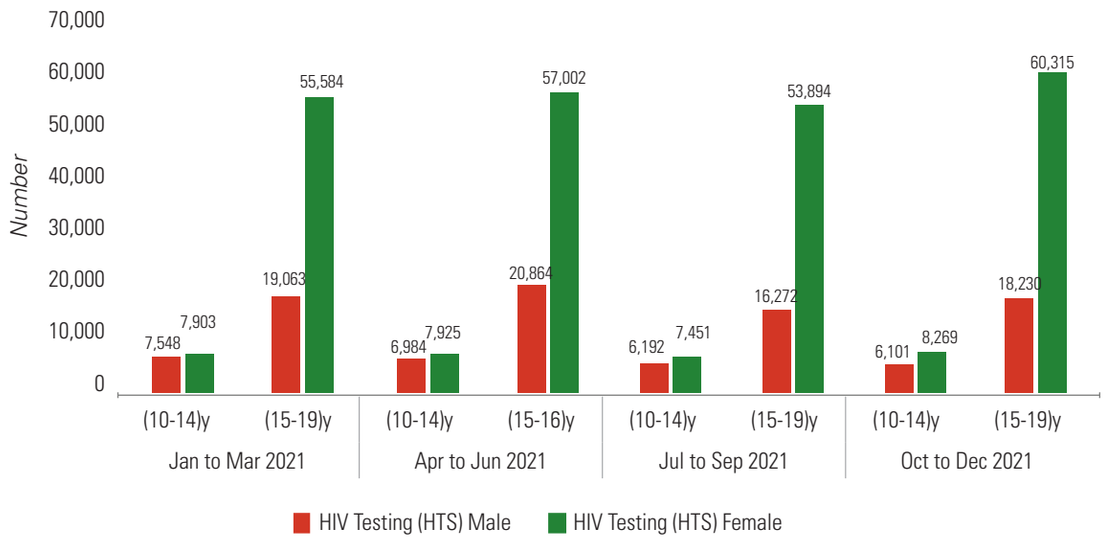
Source: ZDHS 2018

Notably HIV prevalence rates were also higher among adolescents and young women (15–24 years) who had two or more sexual partners (21.1 per cent) than those who had less than two sexual partners (19.2 per cent).

Whilst Zambia has made significant progress towards the 90:90:90 targets, evidence from the 2016 Zambia population-based HIV impact assessment, HIV estimates and other sources show that adolescents are lagging in coverage for HIV testing, treatment and viral suppression. It is estimated that 90,000 adolescents (aged 10–19 years) are living with HIV, half of whom are on life-saving anti-retroviral therapy (ART). Adolescents living with HIV face unique challenges as they have to grapple with the physical and psychological changes of adolescence and the reality of a life-long state of living with HIV.

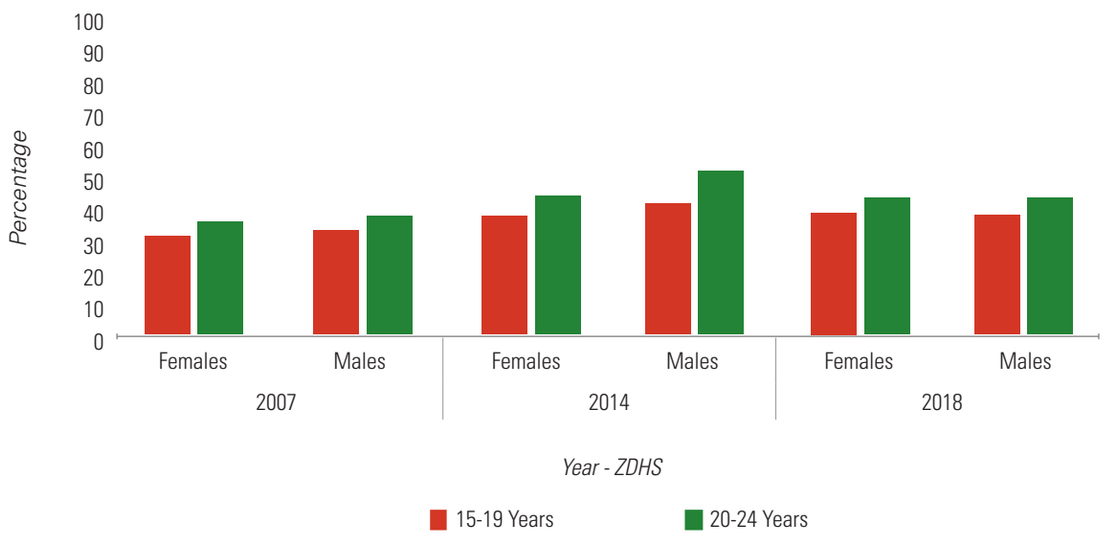
Figure 3.5 shows the numbers of adolescents testing for HIV between quarter 1 and quarter 4 of 2021 in the different age groups (10–14 years and 15–19 years) based on HMIS data. Testing for HIV remains lower among male adolescents with a wider gap between males and females in the age group 15–19 years.

Figure 3.5: *Number of HIV tests by age and sex among adolescents*



Adolescents are at higher risk of acquiring HIV due to various factors and this also affects their uptake of essential HIV prevention, care, treatment and support services. AYP still have low comprehensive knowledge-levels on HIV prevention methods with the proportions consistently below 50 per cent (for example 41 per cent and 39 per cent among adolescent girls and boys of ages 15–19 years respectively) (see Figure 3.6). Limited access to HIV prevention awareness campaigns and inappropriate packaging of HIV messages, including using platforms that may not be attractive to adolescents, contribute to low knowledge that also leads to perceptions of low risk among adolescent and young people.

Figure 3.6: *Knowledge of HIV prevention methods by sex and age*



High risk sexual practices are prevalent among young people, such as multiple sexual partners and low condom use at last sexual intercourse (39 per cent females and 41 per cent among males)33. Due to its protective effect on the acquisition of HIV, voluntary medical male circumcision has been promoted in Zambia. The 2018 ZDHS revealed that 35.9 per cent of young males aged 15–19 years were circumcised[8].

The 2018 ZDHS reported the prevalence of self-reported STIs to be 1.5 per cent and 4.7 per cent among 15–24-year-old women and men respectively. Another study found the prevalence of active syphilis among AYP of ages 15–24 years to be 2.4 per cent and co-infection with HIV at 0.5 per cent. A study conducted among school girls found 4 per cent of them had herpes simplex antibodies with an overall prevalence of herpes simplex being 5.5 per cent. The percentage of women aged 15–19 years who had sexual intercourse in the 12 months prior to the ZDHS had sex with a man 10 or more years older was at 2 per cent. This practice of age disparate sexual relationships is known to be a risk factor for HIV and STI acquisition largely because young girls may not have negotiating power for safer sex.

Evidence from Zambia and elsewhere show that factors, such as stigma and discrimination, including school settings, lack of sero-status disclosure among adolescents living with HIV, limited psychosocial support for adolescents living with HIV, long distances to health facilities affect uptake of essential services in Zambia. Additionally, best practices and lessons have been learnt through the implementation of the Adolescent HIV Surge. This strategic plan will promote these interventions and implementation modalities with a view to prevent incident infections among adolescents, identify adolescents living with HIV who are yet undiagnosed and link them to sustained care, treatment and support services.

3.2.2 Overall objective

To reduce the burden of HIV and STIs among AYP.

Specific objectives:

(i) To reduce new HIV infections among AYP from 15,000 to 8,858 by 2026.

(ii) To increase the coverage of HIV testing among AYP from 91.4 per cent to 96 per cent by 2026.

(iii) To increase the coverage of STI testing among AYP from 43.4 per cent to 52 per cent by 2026.

(iv) To increase HIV treatment coverage among adolescents living with HIV from 84.6 per cent to 95 per cent by 2026.

(v) To increase viral suppression among AYP from 83.4 per cent to 95 per cent.

(vi) To increase comprehensive knowledge of HIV, AIDS from 42 per cent to 45 per cent for AYP aged 15–24 by 2026.

3.2.3 Strategic interventions

1. Increase the availability and use of high-impact HIV, STIs prevention and treatment services.
2. Enhance the capacity of health workers in the delivery of quality adolescent friendly HIV and STI services.
3. Heighten community education and health promotion on HIV and STIs among AYP.

3.2.4 Strategic interventions

Table 3.2: *Strategic interventions for HIV, AIDS and STIs*

STRATEGIC INTERVENTIONS FOR STIS AND HIV/AIDS	
Strategic interventions	Activities
Increase the availability, utilisation of high-impact HIV/STIs prevention and treatment services.	• Provide static and outreach HIV and STI services to communities, schools and tertiary institutions. • Promote comprehensive HIV prevention interventions, such as abstinence, safer sex practices including condom usage using a total marketing approach (i.e., public service delivery, social marketing, promoting condoms that are popular among adolescents, utilising digital technologies), Pre-Exposure Prophylaxis (PrEP) and Post Exposure Prophylaxis (PEP). • Undertake index testing modalities (i.e., partner testing, children of parents living with HIV) to increase coverage. • Undertake targeted community-based HIV testing through outreach clinics and schools. • Trace defaulters and promote return to care for adolescents living with HIV using peer led models. • Establish and promote adolescent and youth-friendly HIV counselling and testing in AFS, including linkages to other services. • Review referral and linkages between HIV testing and treatment facilities for prompt HIV treatment. • Provide adolescent friendly ART care and treatment on efficacious regimens. • Implement differentiated service delivery models for HIV treatment e.g., multi-month refills, outreach models to support differential needs of adolescents living with HIV. • Introduce flexible working times (e.g., explore clinic days and times for adolescent clients, especially in sensitive SRHR, STI and HIV services). • Forecast and procure essential medical commodities and supplies for effective adolescent/youth friendly HIV and STI services (e.g., condoms, HIV and STI test kits, efficacious anti-retroviral drug regimens, STI medicines, viral load test kits). • Scale up peer support groups for AYP living with HIV (establish where support groups are none existent and maintain functionality through regular meetings and health care worker support). • Provide quality adolescent friendly services for STI screening and referral to care in clinics at high education settings and secondary schools. • Provide counselling and support for partner tracking and notification for adolescents who have undergone STI treatment.

Enhance capacity of health workers in the delivery of adolescent friendly HIV and STI services.	• Train health care workers in:
	  ○ HIV care using the Zambia Consolidated guidelines for treatment and prevention of HIV infection;
	  ○ Psychosocial counselling; and
	  ○ Syndromic management of STIs.
	• Train peer educators in basic STI, HIV and psychosocial counselling.
	• Provide mentorship and technical supportive supervision to service providers (health care workers and peer educators) in quality delivery of HIV and STI information and services.

Heighten community education and health promotion on HIV and STIs prevention, care and treatment among AYP.	• Develop SBCC materials approved by government targeting young people, parents and community gatekeepers) on HIV and STI prevention (co-create with AYP), care and treatment.
	• Disseminate/sensitise HIV and STI prevention and treatment messages using platforms that are popular among adolescents including social media, digital platforms, schools, recreation areas, community dialogue meetings including youth clubs (in and out of school), debates among AYP, drama groups, tailor-made TV and radio programmes.
	• Conduct I SBCC campaigns for HIV prevention among AYP, focusing on:
	  ○ delaying sexual debut;
	  ○ age-appropriate CSE;
	  ○ HIV testing (including IEC for HIV self-testing);
	  ○ appropriate and consistent condom use among sexually active adolescents;
	  ○ pre-exposure prophylaxis for eligible AYP and post exposure prophylaxis; and
	  ○ voluntary medical male circumcision for HIV and other benefits.
	• Conduct SBCC campaigns for HIV care, treatment and support, focusing on:
	  ○ HIV treatment to improve treatment literacy among AYP living with HIV (i.e., benefits of early treatment initiation, treatment adherence and retention in care);
	  ○ early treatment and partner notification for STI management.
	  ○ viral load testing and viral suppression;
	  ○ living positively with HIV (nutrition, exercise, positive mental health); and
	  ○ stigma and discrimination and implications on HIV response among AYP.
	• Translate developed SBCC materials into local, sign languages and braille.

3.3 Sexual and gender based violence

3.3.1 Situation analysis

Sexual and gender based violence as defined by the United Nations is an umbrella term for any harmful act that is perpetrated against a person's will and that is based on socially ascribed (i.e., gender) differences between males and females[34]. There are various forms of SGBV including physical, sexual and psychological violence. In Zambia, 43 per cent of women aged 15–49 years have experienced physical violence at least once. In 2018, 20.9 per cent of adolescents aged 15–19 years and 34.2 per cent of young women aged 20–24 years experienced physical violence as well as other forms of violence since the age of 15 as highlighted in Table 3.3. Factors contributing to SGBV include sexual cleansing rituals, initiation ceremonies, women's economic dependence on men, socialisation of boys and girls at home and in school, inadequate laws on SGBV and domestic violence, weak law enforcement and intimate partner violence[35].

Table 3.3: *Frequency and types of violence experienced by adolescent girls and young women (Source: ZDHS 2018)*

TYPE OF VIOLENCE EXPERIENCED	PERCENTAGE EXPERIENCED VIOLENCE	
	Adolescent girls (ages 15–19 years)	Young Women (ages 20–24 years)
Physical violence	20.9	34.2
Sexual violence	6.7	14.2
Different forms of violence (physical or sexual)	23.9	39.1
Violence during pregnancy	3.8	6.0
Emotional violence among married women	16.3	23.6

Studies have shown that perpetrators of sexual violence were current or previous partners. Sexual violence from non-intimate partners was associated with stress, anxiety, depression and suicidal ideations, and increased HIV risk perception warranting service integration in addressing SGBV. Among victims of different forms of violence, few seek help or report the matter, signifying poor help seeking behaviours among victims of SGBV. For instance, 58.3 per cent adolescent girls never sought help or told anyone, in comparison to 26.7 per cent who sought help to stop the violence; while among the 20 to 24 years old young women, only 30.1 per cent sought help and 56.5 per cent did not seek help or tell anyone[8]. Further, only 1.4 per cent girls and 7.2 per cent boys sought help for any experience of sexual violence prior to age 18 years and 0 per cent of girls and 7.2 per cent of boys obtained care[36]. This shows the magnitude of under-reporting of gender-based violence issues among young people in society and the need to tailor and strengthen adolescent health interventions to address the issues of SGBV. Fear of loss of income (where perpetrator is the bread winner), fear of stigma and discrimination, acceptance and justification, perception that perpetrators are not prosecuted and lack of knowledge are among the reasons cited for low reporting and SGBV service uptake among adolescents and young women in Zambia[17]. This strategic plan, will therefore use a multisectoral and integrated approach in strengthening efforts to reduce incidence of SGBV and provide holistic services that are responsive to the needs of survivors of SGBV when it occurs.

[34] GBV Guidelines. 2022. https://gbvguidelines.org/en/.

[35] MOH. 2017. National Health Strategic Plan 2017–2021.

[36] Ministry of Youth, Sport and Child Development, Ministry of Community Development and Social Services, University of Zambia, United Nations Children's Fund, Save the Children International, United States Centers for Disease Control and Prevention, Violence against Children in Zambia: Findings from a national survey, 2014, Ministry of Youth, Sport and Child Development, Lusaka, 2018.

3.3.2 Overall goal

To reduce the incidence of SGBV among AYP and provide responsive care and support services to AYP survivors of SGBV.

Specific objectives

(i) To reduce the burden of sexual abuse among AYP by 2026.

(ii) To increase access to essential services for the care of AYP who are survivors of SGBV (e.g. PrEP, PEP, emergency contraception, psychosocial support)

(iii) To strengthen integration and cross-sectoral interventions for the prevention and response to SGBV among AYP

3.3.3 Strategic interventions

1. Strengthen availability and delivery of comprehensive SGBV health services including referrals to one-stop centres (OSC) and providers of other social services.
2. Enhance the capacity of multi-disciplinary teams in the delivery of responsive SGBV services.
3. Community engagement through dialogues and sensitisation on the promotion of positive gender norms and utilisation of comprehensive gender-based violence services.

Table 3.4: Strategic interventions for sexual and gender-based violence

STRATEGIC INTERVENTIONS FOR SEXUAL AND GENDER-BASED VIOLENCE	
Strategic interventions	Activities

Strengthen availability and delivery of comprehensive SGBV health services including referrals to one stop centres and providers of other social services.	• Conduct static and mobile SGBV outreach services (integrated with other services) to communities, schools and tertiary institutions.
	• Conduct adolescent health days or weeks depending on what works in your locality.
	• Provide comprehensive gender-based violence services at health facilities including referrals to one stop centres and other social services.
	• Advocate for establishment of one stop centres where they do not exist and ensure functionality (to provide holistic services) where they exist.
	• Undertake mapping and design a referral and linkages framework for SGBV services.
	• Share information on SGBV prevention and OSC services.
	• Through the existing ABYM peer-education system, conduct integrated GBV and SRHR outreaches and service delivery in distant locations including GBV screening, topics on GBV causes, consequences and available services.
	• Conduct OSC service awareness outreach in schools to share information on SGBV prevention and available response services through the guidance and counselling programmes and clubs.
	• Collaborate with line ministries and partners to link conduct AYP to empowerment programmes for their well-being including:
	  ○ Life skills education for adolescents and young women
	  ○ Economic empowerment through access to loans and linkage to social cash transfers.

Enhance capacity of multi-disciplinary teams in the delivery of responsive gender-based violence services.	• Train health workers in provision of comprehensive SGBV services including referral and linkages for SGBV services. • Train health workers and social workers in child/adolescent counselling including psychosocial support for survivors. • Train peer educators in SGBV and available services including psychological first aid (GBV cases before referrals) and detection and referral of early pregnancies. • Train law enforcement officers (police, court staff) in SGBV, including referral and linkages services.

Increase community awareness and utilisation of comprehensive gender-based violence services.	• Conduct dialogue/sensitisation meetings with gate keepers (chiefs/traditional leaders, parents, guardians and communities at large) on instituting positive masculinity/gender norms, challenging sociocultural norms that propagate SGBV.
	• Conduct information sessions about SGBV response and prevention services available at the OSC.
	• Scale up coaching boys into men (CBIM) sessions to create awareness of SGBV against both adolescent boys and girls
	• Sensitise communities (using multimedia platforms) on:
	  ○ impact of SGBV on adolescents' well-being;
	  ○ identification and prevention of SGBV among AYP;
	  ○ need for survivors especially of SGBV to access health and social services immediately such as PrEP, emergency contraceptives, legal and social support.
	  ○ negative gender norms (e.g., child marriage, male dominance, girl child valued less etc.);
	  ○ male involvement in prevention of SGBV; and
	  ○ information and linkages to providers of other social services (e.g financial empowerment institutions).
	• Develop and distribute IEC materials and other knowledge products approved by government in braille, local and sign languages.

3.4 Alcohol, tobacco and drug use

3.4.1 Situation analysis

Use of and addiction to alcohol or other harmful substances affects an individual's health and psychosocial behaviours. Adolescents are at high risk of alcohol, tobacco and drug use as they begin to experiment with these substances posing a major public health risk. Evidence shows that early onset of substance use is associated with higher risks of developing dependence and other problems during adult life, and people of younger ages are disproportionately affected by substance use compared with people of older ages[37].

Zambia, like any other country in the region, records high numbers of alcohol and substance abuse among adolescents. The ZDHS 2018 reports that 2.9 per cent of adolescent boys smoke any type of tobacco. Adolescents use both cigarettes and smokeless tobacco (snuff). Among the male adolescents and young men, 2.9 per cent and 15.1 per cent respectively had smoked any type of tobacco compared to 0 per cent and 0.6 per cent of the adolescent girls and young women[8].

Some studies found that up to 42 per cent and 37 per cent of AYP reported ever consuming alcohol and cannabis respectively. Alcohol, tobacco and other drug use has significant implications on adolescent health, both in the short- and long-term overall health status. In addition, alcohol use has been reported to enhance risky sexual behavior and decrease participation in HIV testing services[38]. The main reasons provided for drugs or alcohol use were fun, curiosity, acceptance by their peers and to enhance their sexual pleasure. Smoking was 7 per cent prevalent among adolescents, 63.3 per cent of whom reported intentions to quit; indicating opportunities for behavioural change interventions[39]. Therefore, the prevention of tobacco, alcohol and drug use must remain a major priority for public health action, and may include population-based interventions, strategies and activities in schools and communities as well as at the family and individual level.

3.4.2 Overall objective

To reduce alcohol, tobacco and other substance use among AYP.

Specific objectives

(i) To reduce the incidence of substance (drug and alcohol) use among adolescents by 25 per cent by 2026.

(ii) To reduce percentage of clients with alcohol and substance induced mental health disorder who are AYP from 37.6 per cent to 28 per cent by 2026.

[37] WHO. 2021. Adolescent and young Adult Health. https://www.who.int/news-room/fact-sheets/detail/adolescents-health-risks-and-solutions.

[38] Bond V, Chiti B, Hoddinott G, Reynolds L, Schaap A, Simuyaba M, et al. "The difference that makes a difference": highlighting the role of variable contexts within an HIV Prevention Community Randomised Trial (HPTN 071/PopART) in 21 study communities in Zambia and South Africa. AIDS Care. 2016 Jun 2;28(sup3):99–107.

[39] Zulu M. J et al. 2021. Evidence Synthesis for adolescent health in Zambia. Unpublished.

3.4.3 Strategic interventions

1. Strengthen the provision and availability of health services aimed at promoting healthy lifestyles, prevention, treatment and rehabilitation of alcohol, tobacco and other substance abuse among AYP.
2. Enhance the capacity of service providers in delivery of services aimed at prevention of alcohol, tobacco and other substance use among AYP
3. Increase adolescent and young people's awareness on the harmful effects of alcohol, tobacco and other substance use.

Table 3.5: *Strategic interventions for alcohol, tobacco and drugs*

STRATEGIC INTERVENTIONS FOR ALCOHOL, TOBACCO AND DRUG	
Strategic interventions	Activities
Strengthen the provision and availability of health services aimed at promoting healthy life style, prevention, treatment and rehabilitation of alcohol, tobacco and other substance use among AYP.	• Conduct integrated outreach services to AYP on the streets and in schools. • Advocate for enforcement of age limit legal provisions for alcohol and tobacco purchase and consumption. • Conduct screening, detection and referral of substance use problems at an early stage using appropriate screening tools during static and outreach mobile health services. • Provide medical and psychological services at all levels including rehabilitation for adolescents exposed to substance use in a conducive space.
Enhance the capacity of service providers in delivery of services aimed at prevention of alcohol, tobacco and other substance use among AYP.	• Train/orientate health workers in mental health psychosocial counselling and sign language and braille. • Train/orientate peer educators in mental health, psychosocial counselling and sign language and braille. • Provide mentorship/technical supportive supervision to service providers.
Increase adolescent and young people's awareness on the harmful effects of alcohol, tobacco and other substance use.	• Develop and distribute IEC materials approved by government targeting young people, parents and community gatekeepers on prevention of alcohol, tobacco and drug use. • Translate developed materials into local, sign languages and braille. • Collaborate with relevant stakeholders to conduct regular and effective mass-media campaigns to raise awareness of the dangers of alcohol, tobacco and drug use, e.g., the use of social media and mobile technology. • Integrate messages on alcohol, tobacco and drug use in school health outreach activities.

3.5 Non-communicable diseases

3.5.1 Situation analysis

Non-communicable diseases have emerged to be of public health concern in Zambia including among adolescents. Whilst there are many non-communicable diseases affecting young people, the strategic plan has prioritised two issues that is prevention and treatment of; (1) nutrition disorders and (2) mental health disorders due to their epidemiological importance relative to others.

3.5.2 Nutrition

The nutrition status of adolescents has a profound impact on their immediate and future health (WHO 2018). Evidence shows that 17 per cent of the girls aged 10–14 years were stunted[39]. Many boys and girls in developing countries including Zambia, enter adolescence, facing a triple burden of malnutrition as they are affected by undernutrition (thinness), micronutrient deficiencies (anaemia), overweight and obesity. These forms of malnutrition co-exist and make AYP vulnerable to diseases and early death and have negative implications on the next generation (their offspring). Adolescent undernutrition is negatively associated with school performance. Low maternal body mass index in early pregnancy increases the risk of offspring who are small for gestational age as well as stillbirth, infant mortality and cerebral palsy. Adolescent obesity is associated with the increased risk of diet related non-communicable diseases. Childhood and adolescent obesity are strongly associated with adult obesity, which is linked to higher risk of cardiovascular disease, diabetes and cancer. Developing healthy eating habits in adolescence is the foundation to good health in adult life.

In Zambia, about one third (33.4 per cent) of adolescent girls aged 15–19 years were anaemic with 1.3 per cent having severe anaemia, a situation which was not hugely different with young women aged 20–24 years with 1.2 per cent severe anaemia[8]. Iron deficiency anaemia was ranked as the leading cause of adolescent Disability-Adjusted Life Years. Poor dietary intake in adolescents, resulting in inadequate or excessive amounts and proportions of energy, protein, vitamins and minerals, is associated with micronutrient deficiencies, such as iron deficiency, anaemia and preconception nutrient deficiencies. In addition, two-thirds of premature deaths and one-third of the total disease burden in adulthood are associated with environments, conditions or behaviours experienced, initiated or consolidated during adolescence (WHO 2018) (Table 3.6).

Table 3.6: *Nutrition levels*

	15–19 YEARS	20–29 YEARS
BMI less than 18.5 (thinness) - undernutrition	16.5	8.5
BMI between 25–29.9 (overweight)	8.5	15.2
BMI ≥ 30 (obesity)	1.1	4.8
Mild anaemia	19	28.6
Moderate anaemia	13.1	15.6
Severe anaemia	1.3	11.7
Any anaemia	33.4	1.3

A preliminary situation and landscape analysis of the adolescent nutrition in Zambia has identified following gaps and barriers at different levels, as shown in Table 3.7.

Table 3.7: *Levels and barriers to adolescent nutrition in Zambia*

LEVEL	GAPS OR BARRIERS
Policy and programmatic level	• Significant data gap related to adolescent nutrition. • Lack or limited evidence on what influences and motivates adolescents to change behaviour in Zambia. • Gaps in policy direction addressing undernutrition, micronutrient deficiencies or all forms of malnutrition (increasing obesity and overweight) through multisectoral approach. • Scarce nutrition programmes targeting adolescents. • Limited consensus on defining the set/package of interventions for adolescent nutrition.
Service delivery level	• Approach to reaching out to adolescents using different service delivery platforms (school, health facility or community peer group) not identified. • Inadequate capacity of health service providers on adolescent nutrition.
Household or community level	• Limited integrated approach within health and non-health sector at community level. • Low dietary diversity among adolescent girls. • Intra household food distribution – priority given to younger children. • High prevalence of child marriage and teenage pregnancy has contributed significantly for high fertility.

3.5.2.1 Overall objective

To prevent nutrition disorders and provide responsive nutritional care, treatment and support services for AYP.

Specific Objectives

(i) To promote healthy eating habits among AYP

(ii) To promote provision of quality nutrition treatment care and support services for AYP with acute malnutrition

(iii) To increase micro-nutrient intake among adolescent girls and young women

3.5.2.2 Strategic interventions

1. Strengthen availability and accessibility of nutrition services for AYP.
2. Enhance the capacity of providers of adolescent health services to provide quality nutrition treatment care and support services for AYP.
3. Increase awareness of adolescents and communities on healthy eating habits and risks of nutrition disorders on health and development of AYP.

Table 3.8: *Strategic interventions for nutrition*

STRATEGIC INTERVENTIONS FOR NUTRITION	
Strategic interventions	Activities
Strengthen availability and accessibility of nutrition services for AYP.	• Integrate nutrition assessment in primary health care especially in ANC, AFS, community outreach for adolescents and school health. • Conduct nutritional screening for AYP in schools and community setting, paying special attention for pregnant adolescents, with higher nutrition needs. • Conduct high-intensity school-based interventions that focus on diets and include supportive school environment and policies and healthy food options available through school food services. • Establish Health Promoting Schools or the Nutrition-friendly Schools Initiative (NFSI) through school health and nutrition programmes. • Provide intermittent (weekly) iron and folic acid supplementation to adolescents and school-aged children. • Provide deworming services to adolescents and school aged children. • Undertake cooking demonstrations in community and other congregate settings to transfer knowledge and skills on appropriate food preparation. • Provide adolescent friendly therapeutic interventions to address nutrition related problems • Provide intermittent oral intake of iron and folic acid supplementation for pre-pregnancy and pregnant adolescents girls. • Provide nutritional support (food supplements) for at risk AYP including adolescents living with HIV in poor or emergency settings. • Collaborate with the relevant unit in forecasting of essential nutritional supplies for treatment of acute malnutrition among adolescents. • Advocate for inclusion of nutrition indicators in HMIS for AYP. • Advocate for food fortification for essential micronutrients including zinc, folic acid, iron to benefit AYP. • Advocate with relevant government institutions for strengthening of government regulatory policies to limit access to unhealthy meals, drinks or snacks during school-day.
Enhance capacity of providers of adolescent health services to provide quality nutrition, care and support services for AYP.	• Train health workers in maternal infant and young child nutrition to provide adolescent friendly nutrition care, treatment and support. • Provide mentorship to health workers and other nutrition service providers at community and facility levels • Collaborate with other programmes, sectors and organisations on issues related to enhancing the nutrition and health of AYP.

Increase awareness of adolescents and communities on risks and problems due to poor nutrition and available services.	• Develop SBCC materials (co-creating with AYP) on the entire spectrum of adolescent nutrition (prevention of nutritional disorders, treatment of acute malnutrition).
	• Undertake SBCC campaigns using platforms attractive to adolescents to sensitise AYP on:
	  ○ healthy eating (healthy and nutritious diets) for adolescents;
	  ○ malnutrition (undernutrition and overnutrition) and implications on adolescent health and development;
	  ○ dispel sociocultural myths around nutrition including consumption of some foods; and
	  ○ good practices for food preparation and preservation.
	• Provide nutrition education and counselling for pregnant and breastfeeding adolescent girls and young women including out-of-school adolescents in community setting.
	• Undertake social mobilisation and community engagement to promote dietary diversification.

3.5.3 Mental health and self-harm

Globally, about 10 to 20 per cent adolescents experience mental health conditions, most of which are underdiagnosed and undertreated. Half of all the mental health disorders that manifest in adulthood start by age 14, but most cases are undetected and untreated. Most of the mental health issues affecting AYP lead to injuries through self-harm (suicide) and road traffic accidents, which were the leading cause of death among adolescents globally and in the African region (WHO 2017). In the Zambia HMIS, data from June 2021 indicate that adolescents constituted 7 per cent and 35 per cent respectively to the total number of patients treated for depression. Many factors have an impact on the well-being and mental health of adolescents. Violence, alcohol and substance abuse, poverty, stigma, exclusion, and living in humanitarian and fragile settings can increase the risk of developing mental health problems. Some adolescent sub-population groups, such as those living with HIV, survivors of SGBV and those with disabilities have been identified to be at risk of poor mental health. The consequences of not addressing adolescent mental health conditions extend to adulthood, impairing both physical and mental health and limiting opportunities to lead fulfilling lives as adults (WHO 2017).

In Zambia, AYP access mental health services mainly from general hospitals as they are not readily available at community and other first level health care, owing to inadequate skilled personnel and other resources. Gaps in the implementation of mental health services targeting AYP include limited safe and friendly spaces, inadequate multisectoral and collaborative approach and advocacy, lack of community involvement and participation as well as lack of culturally and context sensitive interventions remain the norm, with funding cited as the overall challenge[40]. Development of strong socioemotional skills among AYP, and providing them with psychosocial support in schools and other community settings will help promote good mental health.

3.5.3.1 Overall objective

To prevent mental health and self-harm and provide support services for AYP.

Specific Objectives

(iv) To reduce percentage of AYP diagnosed with anxiety related disorders from 54.5 per cent to 45 per cent by 2026.

(v) iTo reduce percentage of AYP diagnosed with depression disorder from 40.5 per cent to 33 per cent by 2026.

3.5.3.2 Strategic interventions

1. Strengthen availability and accessibility of mental health services that are responsive to the needs of AYP.
2. Enhance the capacity of providers of adolescent health services to provide mental health services for AYP.
3. Increase awareness on mental health among adolescents and communities.

[40] Munakampe M.N. 2020. Strengthening mental health systems in Zambia. *International Journal of Mental Health Systems*, 14(1):1–9.

Table 3.9: *Strategic interventions for mental health services*

STRATEGIC INTERVENTIONS FOR MENTAL HEALTH SERVICES	
Strategic interventions	Activities
Strengthen availability and accessibility of mental health services that are responsive to the needs of AYP.	• Integrate mental health care promotion, prevention and treatment programmes into existing programming, in schools, community programmes/organisations and in health care systems - especially at the primary health care level. • Map stakeholders providing adolescent mental health services. • Advocate for investments in adolescent and young people's mental health. • Provide screening, management (e.g., counselling and psychosocial support services) and referral services for mental health disorders especially among at risk AYP, such as those living with HIV, disabilities, in humanitarian settings, survivors of SGBV. • Provide mental health rehabilitation services for AYP. • Forecast and procure essential supplies for treatment of mental health disorders including rehabilitation services.
Enhance capacity of providers of adolescent health services to provide mental health services for AYP.	• Train/orient health workers to undertake first level care for adolescents with mental health disorders. • Train/orient peer educators on risks and prevention of mental health problems and other non-communicable diseases. • Train and sensitise teachers, youth associations and community and religious leaders on mental health, including developmental and behavioural disorders.

Increase awareness on mental health among adolescents and communities	• Develop SBCC materials (co-creation with adolescents) on mental health for adolescents.
	• Conduct awareness campaigns using popular platforms to adolescents, focusing on:
	  ○ key mental health risk factors and disorders including anxiety and depression;
	  ○ implications of mental health including suicide ideation and suicide; and
	  ○ positive mental health habits that improve stress coping mechanisms.
	• Conduct mental health education including stress coping mechanisms and behaviours to reduce risk of mental health disorders.
	• Undertake social mobilisation and community engagement to tackle stigma and discrimination linked to mental health disorders.

3.6 Adolescents with special needs

3.6.1 Situation analysis

Adolescents have different needs according to who they are and what setting they have grown up in. Adolescents with special needs include those living with chronic diseases like heart diseases, sickle cell anaemia, HIV, incarcerated juveniles, street children, adolescents in refugee camps, with disabilities, migrant and mobile populations.

3.6.1.1 Adolescents with disabilities

The United Nations defines persons with disabilities as those who have long-term physical (including speech), mental, intellectual or sensory impairments (visual or auditory), which in interaction with various barriers may hinder their full and effective participation in society on an equal basis with others[41]. In a disability survey in Zambia, 4.4 per cent of children aged 2–17 years were found to have a disability with very minimal difference between urban and rural areas (4.4 per cent vs 4.2 per cent respectively) and between male and female children (4.5 per cent vs 4.2 per cent respectively). Adults 18 years and above accounted for 7.7 per cent in the prevalence of disability. The survey data was not disaggregated to capture the proportion of adolescents (Zambia National Disability Survey 2015).

Young persons with disabilities have the same health needs for quality health services, same concerns about relationships, identity, sexuality and are also sexually active and have the same rights as their peers without disabilities[42]. There is limited data on the burden of diseases among adolescents with disabilities, accessibility to essential health services and responsiveness of these services to their needs[39]. Implementation experiences by various organisations and expert opinions have cited various challenges including that adolescent with disabilities face exploitation (including sexual), have limited access (physical, economic) to health services and when available, most health services are not responsive to their specific needs.

The National Disability Policy of 2015 highlights the need for the provision of quality, standard, and affordable health care and programmes as provided for others, including SRH. There is a need therefore, to ensure appropriate infrastructure and enhanced capacity of health care workers to provide quality services by being able to communicate with AYP with hearing impairment using sign language as well as upholding the rights and privacy of AYP with different forms of disabilities[43],[44].

3.6.1.2 Adolescents in confined settings/vulnerable conditions

According to an evidence synthesis conducted in 2021, there was a paucity of studies focusing on AYP with special needs in Zambia. For young people in correctional facilities, diseases such as HIV/AIDS, tuberculosis and sexually transmitted infections were reported because of sexual abuse by adult prisoners or casual sex encounters with community members. These diseases were felt to be common due to the poor health status of the inmates because of HIV infection, poor diet and confinement in poorly ventilated households[39].

The 2011 Human Rights and Health among Juvenile Prisoners research in Zambia published in the International Journal of Prisoner Health indicate that in April 2010, Zambia's prison held 414 juvenile inmates aged 8–18 years

[41] Convention on the Rights of Persons with Disabilities (CRPD) - Article 2 – Definitions - https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with-disabilities/article-2-definitions.html.

[42] UNFPA, 2018. Young Persons with Disabilities: Global Study on Ending Gender-Based Violence, and Realising Sexual and Reproductive Health and Rights.

[43] National Disability Policy 2015.

[44] Mental Health Act, no.6 of 2019.

representing 2.5 per cent of all Zambian inmates while the 2006 Ministry of Community Development and Social Services report on the survey and analysis of the situation of street children in Zambia reveal that there are 13,200 children on the streets. It should be emphasised that there is a much larger population of children who are extremely vulnerable and who may end up on the streets due to several risk factors. Other categories of vulnerable adolescents who are likely to engage in risky health behaviours, such as transactional sex, drug and substance use, include those in humanitarian settings such as refugee camps, fragile settings, adolescents living on the streets, those heading households and adolescents in childcare facilities. Such adolescents are vulnerable to health issues, such as malnutrition, physical violence and SGBV especially among AGYW, mental health problems, HIV and other STIs and teenage pregnancies that lead to maternal health complications including unsafe abortions[24,37].

The available evidence suggests that health programmes have not been inclusive in their approaches to the provision of services to these populations from involvement in the planning and implementation cycles to a review of the differential health outcomes when compared to other groups of AYP[39].

3.6.2 Overall objective

To strengthen adolescent health services delivery responsive to the unique needs of adolescents with special needs and those with disabilities.

Specific Objectives

(iv) To deliver disability friendly health promotion messages on priority focus areas.

(v) To provide disability friendly health services in all priority health programmes for AYP.

(vi) To advocate for integration of disability programming in adolescent and young peoples programming in health and other sectors.

(vii) To strengthen multisectoral linkages for respectful and adolescent friendly services for AYP with disabilities.

3.6.3 Strategic interventions

1. Strengthen availability and accessibility of health services tailored to adolescents with special needs and with disabilities.
2. Enhance the capacity of service providers in the delivery of health services, including prevention from and response to SGBV, tailored to adolescents with special needs and with disabilities.
3. Raise awareness on health needs of adolescents with special needs including those with disabilities and available health services.

Table 3.10: *Strategic interventions for adolescents with special needs*

STRATEGIC INTERVENTIONS FOR ADOLESCENTS WITH SPECIAL NEEDS	
Strategic interventions	Activities
Strengthen availability and accessibility of health services tailored to adolescents with special needs including those with disabilities.	• Conduct targeted and inclusive integrated outreach services to provide responsive health services for adolescents: ○ In confined settings (e.g., correctional, refuge, orphanages) ○ On the streets ○ With disabilities ○ Migrant and mobile populations ○ In schools and tertiary institutions • Provide responsive/differentiated health services to adolescents with special needs and disabilities e.g., albinism, mental, physical, visual and hearing impairment, etc. • Advocate for disability friendly health, school and social infrastructure such as ramps, wheelchairs, lifts and spacious conveniences. • Integrate disability prevention and support programmes into existing programming, in schools, community programmes/organisations and in health care systems - especially at the primary health care level. • Invest in research on innovative disability friendly services. • Map stakeholders providing disability friendly services and facilitate referrals and linkages for disability friendly health services for AYP. • Advocate for the supply of appropriate assistive technology for adolescents with different disabilities in health, schools and other service delivery platforms. • Provide protective interventions and services especially for adolescent girls and young women with disabilities. • Incorporate organisations working with people with disabilities to ensure user-centred programming (at programme design, implementation and review stages).
Enhance the capacity of service providers in the delivery of health services, including prevention from and response to tailored SGBV, tailored to adolescents with special needs and with disabilities.	• Train/orient service providers (health workers, peer educators) in disability inclusion in health service delivery. • Incorporate adolescents with special needs including those with disabilities in peer education training.
Raise awareness on health needs of adolescents with special needs including those with disabilities and available health services.	• Conduct community mobilisation and engagement to tackle stigma and discrimination against adolescents with special needs. • Develop disability friendly IEC materials for common disabilities e.g., braille and sign language for the blind and deaf respectively. • Sensitise communities using multimedia platforms on: ○ adolescents with special needs including those with disabilities to solicit participation in interventions that target them; ○ health problems affecting adolescents with special needs including those with disabilities and available health and other social services; and ○ identification and support of adolescents with special needs including those with disabilities.

3.7 Main implementation modalities and programmatic approaches

To ensure effective and efficient implementation of strategic interventions in all the priority areas of this Adolescent Health Strategic plan various programmatic approaches will be used, the salient ones being: adaptive leadership, a multisectoral/intersectoral approach, adolescent engagement and participation.

3.7.1 Adaptive leadership

Adaptive leadership is a programmatic approach that is premised on the need to provide a comprehensive HIV prevention approach tailored to specific needs of adolescents to halt and reverse the trend of HIV infections. This includes critical health services, but it must also address the behavioural and structural factors such as socio-economic factors that puts girls at a higher risk of contracting HIV. Adaptive leadership essentially promotes a protective environment that enables vulnerable groups of adolescents to access support services.

The approach recognises the need for a differentiated, but comprehensive response to HIV prevention for adolescents. For example, AYP who have some secondary education and come from more wealthy households need targeted information and skills development interventions that focus on increasing their HIV risk perception and enhancing their self-efficacy around risk avoidance and risk reduction behaviours. This is based on evidence that they have higher levels of comprehensive HIV knowledge and more agency around negotiating and practising risk avoidance behaviours, but their reported condom use is not significantly different from poor females, as 6 out of 10 of them believe they have low or no risk of HIV infection. According to the ZDHS 2018, the comprehensive knowledge of HIV for the urban ABYM was at 47.1 per cent vs 35.4 per cent for rural ABYM. For no education for ABYM is 16 per cent and secondary or higher is 48.9 per cent.

Similarly, AYP from poor households and with little education are vulnerable due to limited household assets and low levels of literacy, which will affect their levels of self-efficacy. This group will need relevant sexual health information and context specific risk avoidance and risk reduction skills development, and enabling community norms and values, which support access to and utilisation of HIV, sexual health and social protection services.

The MoH and partners have been implementing the Adaptive Leadership initiative since 2020. The initiative helps individuals and organisations adapt and thrive in the face of challenges and prepare them to take on a process of change. This will represent one of the main approaches, especially in addressing the burden of SRH, HIV,AIDS and other STIs, SGBV, alcohol and drug abuse, and mental health as priority areas of the strategic plan.

3.7.2 Objectives of the Adaptive Leadership initiative are:

(i) To improve collaboration and break down silos across and sometimes within, government agencies, sectors, CSOs and communities to avoid duplication, increase efficiencies and better leverage of resources.

(ii) To achieve cultural and value shifts at a personal, family, community and institutional level that move away from moral rigidity, silence, covering of GBV cases and protection of perpetrators or the avoidance of tough/ uncomfortable conversations to helping people, build the leadership capacity to engage as needed.

(iii) Increase the levels of dialogue between adolescents, parents/guardians and communities as well as involvement in the design and delivery of adolescent health interventions.

3.7.3 Key interventions for the Adaptive Leadership initiative

Build capacity of health care workers and communities in the adaptive leadership methodology to implement the following interventions and initiatives:

1. Strengthening community based organisations to engage with parents, communities, religious leaders and school teachers on HIV, STIs, mental health, alcohol and drug abuse, SGBV and SRHR.
2. Strengthening coordination through TWGs with clear and agreed upon terms of reference, which include a differentiated response.
3. Strengthening and harmonising policies and guidelines.
4. Developing and deploying an advocacy strategy targeting parents, communities, religious and traditional leaders, school teachers and the adolescents.
5. Developing communication campaigns with innovative approaches and tools to promote adolescent health seeking behaviours and increase their knowledge on sexual health and development opportunities.
6. Facilitating improved financing of adolescent health programmes.
7. Strengthening data management of the adolescent's health focus areas to guide programming and policy formulation.

3.7.4 Adolescent engagement and participation

Adolescent participation entails that adolescents form and express their views and influence issues/matters that concern and affect them directly and indirectly. Meaningful adolescent engagement and participation is integral to designing and implementing programmes that are responsive to their health and developmental needs. Throughout implementation of this strategic plan, various strategies will be employed to ensure meaningful engagement and participation, including:

- Advocating for the establishment and institutionalisation of laws, policies, practices and budgets that create an enabling environment that guarantee meaningful engagement and participation.
- Enhancing positive social norms and attitudes that respect and promote meaningful adolescent engagement and participation in health. This may entail engaging influential actors, enabling intergenerational dialogue and supporting media interventions that showcase and promote the importance of adolescent views and contribution in peer service delivery.
- Building the awareness, skills, capacities of adults to interact with adolescents in a respectful, participatory and inclusive way and to partner with adolescents as change agents. This will require capacity building of adults and professionals such as teachers, health workers and other service providers, engaging with parents and opinion leaders who are in frequent interaction with adolescents.
- Building the awareness, skills and capacities of AYP to meaningfully engage in health programmes throughout the project cycle from design to implementation. This will entail increasing access to adolescent friendly information; building capacity through training and mentorship in various areas and principles of engagement; partnering with youth organisations and specialised agencies; and supporting peer education, participatory research and action initiatives.
- Creating and sustaining platforms for adolescent participation through representation in governance structures, peer service delivery and structures to review and monitor programmes targeting them. Involvement in TWGs at all levels, peer service delivery through peer educators are among the existing platforms which will be strengthened.
- Enhance the adolescent research capacity by identifying and upskilling a cadre of adolescent researchers who would be able to gather and use information and data that deepens the understanding of key SRHR issues for adolescents from an adolescent perspective. This will contribute to increased adolescent and youth capacity, participation and leadership within the adolescent SRHR field and broader SRHR discourse.

3.7.4.1 Intersectoral action for adolescent health and development

Addressing health needs of AYP transcends the health sector thus requiring the strengthening of intersectoral collaboration to improve programming across all priority areas of this strategic plan. To ensure intersectoral collaboration, this strategic plan will pursue various strategic approaches including:

- Ensure sustained representation and participation of stakeholders from other sectors relevant to adolescent health and development in governance structures for the adolescent health strategic plan including TWGs. Some of these sectors include education, youth, child welfare and social services, nutrition and the private sector.
- Strengthen sectoral collaboration in the delivery of health information and services, including school-based outreach for SBCC in priority areas of adolescent health; ensuring that health workers support delivery of CSE in schools by creating demand for services in schools.
- Conduct stakeholder mapping at subnational (provincial, district and community levels) to understand the context of service delivery targeting AYP and creating relevant contact among stakeholders to facilitate referrals.
- Strengthen referral and linkages for services across sectors including appropriate follow up to ensure that adolescents receive required services. This may include referrals, such as vulnerable adolescents to social protection services, pregnant adolescents to maternal and child health services including nutritional support and back to school upon delivery, adolescents living with HIV to nutrition and psychosocial support services, adolescents with disabilities to health, protection and support services rendered by organisations working with people with disabilities.
- Strengthen data management of the adolescent health programmes.

04

IMPLEMENTATION FRAMEWORKS

4.1. Leadership, governance and coordination

Implementation of the 2022–2026 Adolescent Health Strategic plan is guided by three key frameworks namely: the MoH policy and regulatory frameworks, the institutional and coordination frameworks, and the monitoring and evaluation frameworks. In addition, existing health system structures, such as infrastructure, commodities/ supply chains and medical supplies, human resources for health and health financing will be needed to support the implementation of the ADH strategic plan.

4.2 Policy and regulatory framework

The following policy and regulatory frameworks that includes existing documents, any amendments thereof, and new policies and documents that may be developed in the course of implementing the strategic plan will be needed in guiding effective implementation of this strategic plan. Key legal and regulatory frameworks, policies and guidelines that inform this strategic plan, include:

- The Constitution of Zambia, particularly the Bill of Rights
- The Juveniles Act
- The Termination of Pregnancy Act of 1972
- National Education Act 2011
- Mental Health Act 2019
- Gender Equity and Equality Act
- Other relevant laws, including those on tobacco use, alcohol and substance use, sexual violence, anti gender-based violence act and other forms of violence.

Policies and frameworks include:

- Vision 2030
- Eighth National Development Plan 2022–2026
- National Youth Policy 2015
- National Alcohol Policy 2018
- National School Health and Nutrition Policy 2006
- National Gender Policy 2014
- National Education Policy 1996

- National Education Policy 2011
- Education Re-entry Policy 1997
- National Population Policy 2019
- National Health Policy 2012
- National Reproductive Health Policy 2005
- National HIV/AIDS Policy 2005
- Child Policy 2015
- Mental Health Policy 2005
- Migration Policy 2022
- Ministry of General Education CSE Framework 2013
- National Health Strategic Plan 2022–2026
- Zambia Integrated Family Planning Costed Implementation Plan and Business Care 2021–2026
- Standards and Guidelines for Comprehensive Abortion Care in Zambia 2017
- National AIDS Strategic Framework 2022–2026
- National Population Policy Implementation Plan 2019–2030
- Migration in Zambia: A country profile, 2019
- Other policies relevant to adolescent health

4.3 Institutional and coordination mechanisms

The coordination mechanism will be inclusive with both government actors and non-government stakeholders on board at all levels. Specifically, key line ministries and government agencies, such as Ministries of Health; Community Development and Social Services; Education; Youth, Sport and Art; Local Government and Rural Development; Finance and National Planning; Infrastructure, Housing and Urban Development; and the Gender Division at the Cabinet Office will be involved in the coordination of the implementation of the ADH strategic plan. Implementing partners, such as CSOs that work with adolescents, including representatives of adolescents, peer educators, youth CSOs and non-governmental organisations will also be involved in the implementation of the ADH strategic plan.

The MoH will assume the stewardship role in the implementation of this strategic plan. At national level, already established structures, such as the Adolescent Health Unit in the Department of Public Health at the MoH, will be responsible for the overall coordination in the implementation of the strategic plan, in collaboration with other relevant MoH and government departments.

4.3.1 Adolescent health technical working groups

To ensure greater engagement of various stakeholders in the implementation of the ADH Strategic Plan, the existing TWG will be strengthened at national, provincial and district levels with membership constituting all key stakeholders in ADH. In districts where TWGs do not exist, TWGs will be established.

AYP will also be included as members of TWGs at all levels to reinforce the principle of adolescent participation. Notably, the Adolescent Health TWG, irrespective of the level of operation, has the mandate to provide technical direction in the design and implementation of adolescent health services. The terms of reference for the TWGs

are provided in Appendix B. However, different levels of the TWGs will have different compositions in terms of membership and functions, as articulated below:

(i) **National Adolescent Health Technical Working Group** will comprise key national level stakeholders in adolescent health and other sectors that address determinants of adolescent health, such as Youth and Sports, Education, Social Welfare, Economic Empowerment and Labour Sectors. The TWG will be chaired by the MoH given that the overall stewardship role remains with MoH, whilst task forces will be co-chaired by the MoH and one stakeholder. It will continue to work closely with the Adolescent Health Unit of the MoH and set the national agenda (both policy and practice) for the adolescent programme. The National ADH TWG will provide technical support to the provincial level ADH TWG. To facilitate optimal functioning, the TWG will have technical task force teams, which will be responsible for providing specific guidance on respective strategic components of the ADH Strategic Plan.

(ii) **Provincial Adolescent Health Technical Working Group** will comprise provincial level stakeholders in adolescent health and other relevant sectors. Its role will be to coordinate provincial level stakeholders in adolescent health and provide technical oversight in the implementation and monitoring of adolescent health services. The Provincial ADH TWG will provide a technical link between national and district levels, effectively ensuring adherence to policy and standards at the level of implementation. The Provincial ADH TWG will be the platform for organising provincial review meetings and reporting to the central level. The Provincial Health Office will be the secretariat whilst chairpersonship will be agreed upon by stakeholders at provincial level.

(iii) **District Adolescent Health Technical Working Group** will comprise district level stakeholders in adolescent health and other relevant sectors and will play a pivotal role in coordinating and harmonising the efforts of all stakeholders in adolescent health and other relevant sectors contributing to adolescent health including: nutrition, education, social welfare, youth and local government. Given that this is the implementation level, community level stakeholders will be key, hence community-based organisations, youth led organisations, and non-governmental organisations working at district and community level on adolescent health will constitute members.

(iv) Notably, AYP will be included as members of the TWGs at all levels to strengthen the principle of adolescent participation as articulated in this strategic plan.

Detailed description of the operations of the TWGs at all levels (national, provincial and district) are provided in Appendix B.

4.3.2 Adolescent health focal point persons

Proper coordination of adolescent health services will require designating focal point persons at all levels of the health system, especially at district and health facility levels. The ADH focal point person will be responsible for the coordination and implementation of the adolescent health services. Traditionally, the ADH focal point person has been designated from the Maternal and Child Health Departments, but the designated focal person can be nominated from other departments as long as they are health workers who meet the basic criteria as outlined in Appendix B:

- This ADH Strategic Plan is designed to use multisectoral and integrated service delivery approaches. Hence, the expectation is that these focal point persons at different levels will promote effective collaboration with other departments within health and other sectors.

(i) District adolescent health focal point person

At district level, at least one primary health care officer will be designated by the District Health Director to coordinate the work of all activities pertaining to adolescent health in the district. Specific roles of the district ADH focal point person are articulated in the terms of references (see Appendix B).

(ii) Health facility adolescent health focal point person

At least two clinical staff should be designated as ADH focal point persons at a health facility although at higher levels of care, more than two focal point persons may be designated. For example, at a health facility with distinct departments, a focal point person may be appointed to coordinate adolescent health in each relevant department. The majority of AFSes (the main delivery platform for adolescent health services) will be at the health centre level.

The health facility adolescent health focal point person (HFADH FPP) will facilitate the delivery of adolescent responsive clinical services as per standards and adolescent health package according to the level of the health centre in terms of service delivery capacity. The ADH focal point person at health centre level will specifically be responsible to ensure functionality of the AFS including supervision and mentorship of peer educators in their roles at the health facility and community. (See Appendix B for the HFADH FPP terms of reference).

4.4 Structural arrangements for health service delivery for adolescents

4.4.1 Adolescent friendly space

The AFS will remain the central part for adolescent health service delivery at facility level as the base for community health activities. If not yet available, each health facility will need to designate a space for the (re)establishment of an AFS. The AFS will be the first stop for adolescents to get information, counselling and access to SRHR and other health services. Peer educators will assist in guided referrals from the AFS to the relevant services within the health facility.

Peer educators will provide services at the AFS with the support of ADH focal point persons at the health facility. The AFS will need to have a minimum of eight trained peer educators with a fair representation by gender to ensure that at least one male and one female peer educator is on site daily, while other peer educators are engaged in health promotion and demand creation outreach activities. More details on the mode of implementation for service delivery at the AFS are provided in Appendix C in the AFS terms of reference.

4.4.2 Peer educators

Peer educators are the backbone of delivering ADFHS. As guided by evidence, peer service delivery is critical and effective when peer service providers, such as peer educators, are adequately trained, supervised and mentored. Trained peer educators will be responsible for operationalising the AFS and will use the AFS as a platform to conduct links with community and schools through outreach sessions.

Peer educators will also be responsible for providing information on all priority areas of the adolescent health strategic plan using different participatory methods including games, group discussions and interactive education programmes. Two peer educators should be designated as co-team leaders who will support the HFADH FPP with the supervision and management of the AFS and the peer educators' activities and reporting. The lead peer educators will also represent other peer educators and advocate for adolescent friendly services in engagement with the health facility as well as the district health management from time to time.

4.4.3 Trained health workers

To make the entire healthcare system adolescent friendly, all clinical health workers should receive in-service training in adolescent health and all key support staff should be oriented on adolescent health issues. In large health facilities, the providers of SRHR, SGBV, HIV, STIs, mental health and ANC services should be the priority staff to receive training on the adolescent health package and standards.

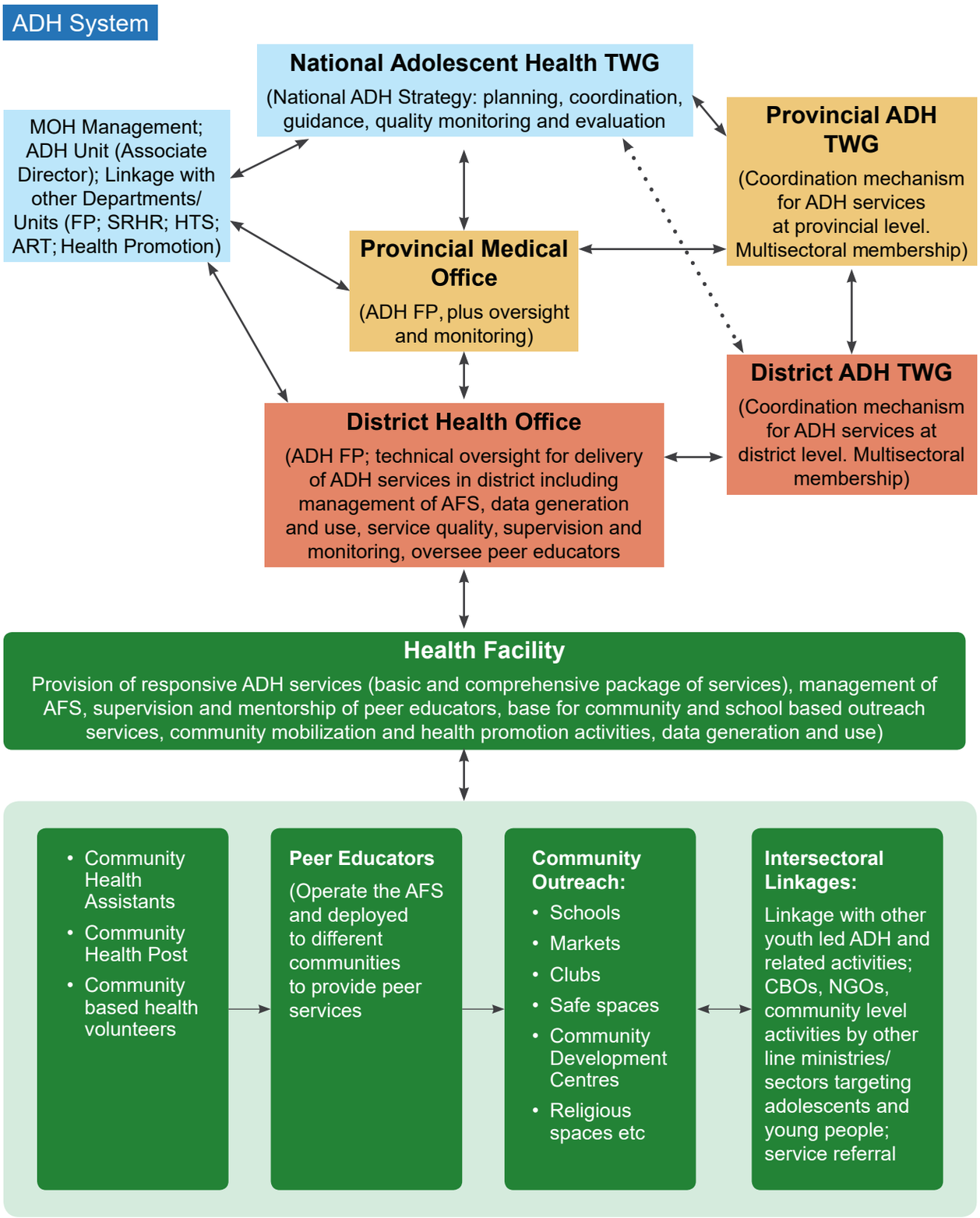
4.5 Linkage and coordination of structures

For effective implementation of adolescent health services, linkages should be implemented at all levels through established structures, coordination mechanisms and designated focal point persons. At various levels, adolescent health focal point persons should have the overarching responsibility of ensuring that coordination and governance structures are functional by organising meetings and seeking management support.

Each structure or focal point person should provide technical and administrative support to a lower-level structure. This will entail that the provincial ADH TWG should provide technical and management support to the district ADH TWG, who in turn should provide technical and management support to health facilities and health facility focal point persons. Links should be established among various stakeholders, such as health facilities focal points, key structures in the communities, schools and community development centres, faith-based organisations, CSOs and community volunteer structures, specifically those mandated under the District Council Decentralisation Programme, under the supervision of the district ADH focal point person.

The coordination and governance structures will therefore interact at the same level and the higher level as depicted on Figure 4.1.

Figure 4.1: *Interaction of governance and coordination structures*



05

MONITORING, EVALUATION AND LEARNING

Monitoring, evaluation and learning will require coordination of all sectors implementing adolescent health services. Monitoring and evaluation will also be achieved through social accountability activities championed by adolescents, community stakeholders and CSOs to improve adolescent health programming.

5.1 Monitoring and evaluation

Monitoring and evaluation of the ADH Strategic Plan will be coordinated by MoH, with the participation of all players in ADH programming to help identify the most valuable and efficient use of available resources and sharing of experiences and best practices. Monitoring and evaluation will also guide strategic planning, allocation and re-allocation of resources. Designated data focal point persons at all levels will oversee the collection of data. An existing monitoring and evaluation taskforce will oversee monitoring and evaluation issues.

5.1.1 Monitoring

The MoH will coordinate all activities for monitoring the implementation of the strategic plan and work closely with the adolescent health technical working group monitoring and evaluation taskforce. To monitor progress, HMIS, (including DHIS2), programme assessments/reports and data collection tools will be used. In some cases, new tools and innovative approaches for data collection will be explored and piloted. Quarterly reports to various stakeholders involved in delivering adolescent health will be strengthened as they too form an important source of data in areas they support. The data collected will be analysed regularly, mostly on a quarterly basis, to monitor the implementation process and inform programme management and adjustments of ADH services. Annual progress reports will be submitted by the sub-committee to the ADH TWG during the annual planning and review meetings.

The reports will provide a basis for an annual assessment of the overall implementation of the strategic plan and evaluation of the strategic direction as well as for programming and management decision making for the coming year. Other tools that will be used for monitoring purposes will include data audits and operational research that will be conducted during the implementation period to track behavioural change as well as the use of health services by adolescents.

5.1.2 Evaluation

A mid-term review will be conducted to assess progress made in the implementation of the strategic plan. In addition, an end-of-term review will be conducted to focus on the relevance, effectiveness, efficiency, equity, coherence, sustainability and impact/outcome of the strategic plan. Findings of the evaluation will inform implementation of the strategic plan (in the case of the mid-term review) and development of subsequent strategies (in the case of the endline evaluation).

5.2 Implementation research

Implementation research is a "powerful tool for capturing and analysing information in real time allowing for the assessment of performance and is particularly important in supporting the scale up of effective interventions and their integration into health systems"[45].

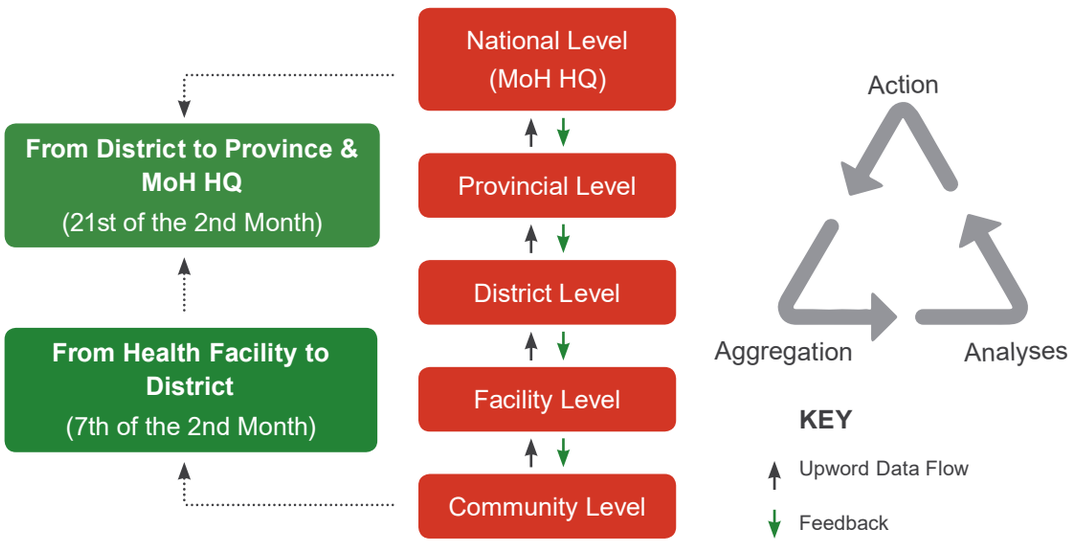
Implementation research will be conducted during the period of this strategic plan to build knowledge on interventions/ strategies or tools that can enhance the quality, effectiveness or efficiency of adolescent health programmes covering all six priority areas (to understand what is working or not working, how and why). Therefore, implementation research will be critical in implementing this strategic plan.

Implementation research shall be coordinated by the MoH in collaboration with research and academic institutions. The ADH TWGs will also contribute to developing implementation research needs.

5.3 Adolescent health data management

In this strategic plan, data will be critical in the implementation of services that are responsive to the needs of adolescents. The HMIS will be used to monitor data for decision-making. Given that some health indicators in the priority areas of the ADH strategic plan are not disaggregated, the ADH system will continue with advocacy efforts to achieve age and sex disaggregation to ascertain progress in adolescent health and achieve evidence-based programming in all priority areas of this strategic plan. Given that programming for adolescents with disabilities has been prioritised, advocacy efforts and technical assistance will be provided to partners to ensure that key indicators include disaggregation by disability. To ensure evidence-based programming for adolescents, at each level, data will be aggregated (from different units disaggregated by age and sex), analysed and action will be taken as informed by the data. Figure 5.1 illustrates the data flow and actions at different levels.

Figure 5.1: *Health Management Information System data flow*



[45] David H. Peters, Nhan T. Tran, Taghreed Adam. Implementation research in health: a practical guide. Alliance for Health Policy and Systems Research, World Health Organization, 2013.

5.4 Service quality assessments

Service quality assessments will be undertaken to ascertain the compliance of health facility and district health systems to existing standards of delivering adolescent health services. Ideally, service quality assessments will be undertaken on a quarterly interval and will focus on all important areas for quality ADH service delivery including: health infrastructure, human resource composition and competency, health information management and use, availability of standard operating procedures, policy documents, essential supplies and equipment. The assessment results will be disseminated through learning platforms and will guide decisions including onsite mentorship, supervision, training and advocacy. A service quality assessment tool will be used and is attached as Appendix C.

5.4.1 Learning

Learning is a process through which information generated from monitoring, evaluation and research is reflected upon and intentionally used to continuously improve a programme's ability to achieve results. Learning will be an important component of this strategic plan. To facilitate learning, the following strategic activities will be conducted at national and subnational levels, as appropriate:

- Capacity building through training, mentorship, and supervision of health workers and health information officers in the use of existing data for decision-making.
- Conduct quarterly HMIS data review meetings at district, provincial and national levels and draw implications for ADH service delivery (including demand creation).
- Undertake documentation of lessons learned and best practices in implementation of adolescent health.
- Disseminate evidence emerging from monitoring, evaluation and research through existing platforms, such as a national health research dissemination conference, Extension of Community Health Outcomes (ECHO) and TWGs.
- Institutionalise adolescent health research and best practices symposium at national level as a biennial event.

5.5 Adolescent health indicator matrix

The adolescent health indicator matrix below constitutes key indicators in the respective priority areas of this strategic plan. Mainly, collected through the HMIS platform, supervision, service quality assessments, ZDHS and research studies will be used to provide data for respective indicators at various levels.

Table 5.1: *Indicator matrix for the Adolescent Health Strategic Plan*

ADH PRIORITY AREA	INDICATOR	DESCRIPTION/CALCULATION OF INDICATOR	BASELINE	TARGET					MEANS OF VERIFICATION
				2022	2023	2024	2025	2026	
Adolescent health service delivery	Number of health facilities with functional AFS	Health facilities with a designated room or space for adolescents to get information, counselling services on SRHR and other health issues coordinated by ADH focal point persons at the health facility.	964	1,060	1,166	1,282	1,410	1,550	Programme Reports: SQA reports
	Number of districts that have at least 50 percent of health facilities with facility- or community-based AFS	Districts that have at least 50 percent of health facilities catchment areas with AFS at facility level or within the community	36	40	44	48	53	58	Programme Reports: SQA reports
	Number of health workers trained/ oriented in ADFHS	Health Workers in the country trained/ oriented in ADH package	2,328	2,560	2,816	3,097	3,406	3,746	Programme Reports: SQA reports
	Number of peer educators trained in peer education / ADFHS	Peer educators trained in peer education / ADFHS in the country	2,895	3,184	3,502	3,852	4,237	4,660	Programme Reports: SQA reports
	Percentage of districts with functional adolescent health technical working group	Districts in the country with an adolescent health technical working group that is functioning	84%(98/116)	88%	92%	96%	100%	100%	Programme Reports: SQA reports
	Percentage of districts that have incorporated adolescent health indicators in data review meetings	Districts reviewing ADH data during Quarterly integrated meetings	81%(94 /116)	88%	92%	96%	100%	100%	Programme Reports: SQA reports

Sexual Reproductive Health	Teenage pregnancy rate	The proportion of adolescents who get pregnant before the age of 20	29%	28.5%	28%	27.5%	27%	26.5%	ZDHS
	Percentage of adolescents aged 15–19 years using condoms at the last sexual encounter	The proportion of adolescents that used condoms at the last sexual encounter	35.2%	36.9%	38.7%	40.6%	42.6%	44.7%	ZDHS
	Percentage of clients accessing modern contraceptive methods (all contraceptive methods as per HMIS register) who are adolescents	Adolescents who received any type of modern contraceptive methods	18.4%	19.9%	21%	22.9%	24.5%	25%	HMIS
	Proportion of clients diagnosed with induced abortions who are adolescents (10–14 yrs)	Adolescents who are diagnosed with induced abortions	2.5%	2%	1.5%	1.5%	1%	0.5%	HMIS
	Proportion of clients diagnosed with induced abortions who are adolescents (15–24 yrs)	Adolescents who are diagnosed with induced abortions	41.4%	39%	36%	33%	31%	29%	HMIS
	Percentage of clients accessing first ANC who are adolescents	Adolescents accessing ANC services	24%	23.5%	23%	22.5%	22%	21.5%	HMIS

HIV, AIDS and Sexually Transmitted Infections	Number of new HIV infections among AYP	New counts of HIV infections among AYP (15-24)	15,000	13,500	12,150	10,935	9,842	8,858	HIV Spectrum Estimates
	Percentage of young people 15-24 years living with HIV who know their HIV status	AYP 15-24 years living with HIV who know their HIV status	91.4%	92.4%	93 %	94%	95%	96%	HIV Spectrum Estimates
	Percentage of AYP diagnosed with HIV who are on anti-retroviral treatment (ART coverage)	AYP diagnosed with HIV who are on anti-retroviral treatment (ART coverage) out of the total number of adolescents diagnosed with HIV	84.6%	86%	88%	90%	92%	94%	HIV Spectrum Estimates
	Percentage of AYP on HIV treatment that are virally suppressed	Number of AYP suppressed out of number of adolescents and young with viral load test done	83.4%	86%	88%	90%	92%	94%	Lab Information System (LIS)
	Proportion of clients diagnosed and treated with an STI who are AYP (10-24)	AYP diagnosed and treated for STIs	43.4%	42%	41%	40%	39.%	38%	HMIS
Sexual and Gender Based Violence	Percentage of clients diagnosed with sexual abuse who are adolescents	Adolescents who were diagnosed as sexually abused	61.4%	58%	56%	54%	52%	50%	HMIS
	Percentage of AYP who were sexually abused that received Post Exposure Prophylaxis for HIV	AYP who were sexually abused that received Post Exposure Prophylaxis for HIV	47.9%	45%	45%	42%	40%	38%	HMIS
	Percentage of clients reporting physical abuse who are adolescents	Number of adolescents reporting physical abuse out of total number of physical abuse reports	32.4%	31%	30%	29%	27%	25%	HMIS

	Percentage of clients provided with psychological Counselling for assault who are AYP	Number of adolescents and young peope who were assaulted and received psychological Counselling	37.3%	39%	41%	43%	45%	47%	HMIS
Nutrition	Proportion of AYP with iron deficiency anemia	AYP with iron deficiency anemia	TBA						Programme Reports
	Number of adolescents with malnutrition receiving nutritional care and support services	AYP with malnutrition provided with nutrition care and support services	TBA						Programme Reports
Mental Health	Percentage of patients diagnosed and treated with anxiety related disorders who are adolescents	Adolescents diagnosed and treated for anxiety disorder	54.5%	52%	50%	48%	46%	45%	HMIS
	Percentage of Patients diagnosed and treated with Mania who are adolescents	Adolescents diagnosed and treated for Mania	4.1%	3.8%	3.4%	3.2%	3%	2.8%	HMIS
	Proportion of patients diagnosed with depression disorder who are adolescents	Adolescents diagnosed with depression disorder	40.5%	39%	37%	35%	33%	31%	HMIS
Alcohol and substance use	Percentage of clients with alcohol and substance induced mental health disorder who are adolescents	Adolescents with alcohol and substance induced mental health disorder	37.6%	35%	33%	31%	29%	28%	HMIS

06

RESOURCE MOBILISATION

6.1 Cost of the Adolescent Health Implementation Plan

Costing of the key strategies responding to the ADH priority areas has been spread across the five years of implementation in all the districts. This budget includes resources for national-level health promotion, including social and behavioural change communication, programme logistics, management and supervision support costs. Prioritisation of the strategies during implementation as well as resource allocation will rely on the population size and the health needs of the targeted adolescents in each district.

Costing of the strategies and activities in this budget is based on the following assumptions:

- The total number of districts in Zambia are 116.
- The total number of health centres across the 116 districts with full minimum ADH services platforms are 964.

Table 6.1: *Summary of estimated budget (USD)*

YEAR	2022	2023	2024	2025	2026	TOTAL
Sexual and reproductive health	2,038,617.79	2,492,031.99	2,801,504.14	3,245,664.05	3,609,868.34	**14,187,686.32**
HIV/AIDS and other STIs	1,058,625.77	1,193,125.31	1,308,601.84	1,429,411.20	1,555,553.37	**6,545,317.48**
Gender based violence	602,169.33	668,862.24	731,466.60	796,866.75	865,062.70	**3,664,427.61**
Non-communicable diseases - Nutrition and mental health issues	813,842.45	876,468.50	941,669.51	1,009,003.65	1,078,470.92	**4,718,755.52**
Substance abuse issues	2,101,030.67	2,286,749.91	2,466,016.78	2,651,681.29	2,843,743.44	**12,349,222.09**
Programming for adolescents with special needs	869,830.18	932,846.54	1,000,732.22	1,065,665.14	1,142,902.97	**5,011,977.06**
Monitoring and Evaluation	118,800.00	132,800.00	138,266.67	132,800.00	140,133.33	**662,800.00**
Total	7,602,916.19	8,582,884.49	9,388,257.76	10,331,092.08	11,235,735.07	47,140,885.59

6.2 Resource mobilisation strategies

Resource mobilisation will be undertaken at various levels to facilitate the implementation of activities in this plan. Domestic financing through the MoH and other relevant line ministries and financing by various development partners will remain key sources of finances. The ADH Strategic Plan 2022–2026 will be used as a resource mobilisation tool from different sources. Non-monetary resources, such as donation of supplies, equipment or human resource and technical assistance will also be sought through the building of partnerships with other stakeholders that may not be traditional donors. Given that ADH is a relatively new priority area, continued advocacy for an increase in resource allocation will be undertaken.

The following are some of the proposed avenues for resource mobilisation:

The Government of the Republic of Zambia through its line ministries will continue to provide human resources for health, infrastructure and financial resources required to implement the strategic plan. However, the GRZ will continue to rely on cooperating partners' aid to finance health.

President's Emergency Plan for AIDS Relief has partnered with the Government of Zambia to accelerate progress toward achieving HIV, AIDS epidemic control. Whilst the focus is primarily HIV epidemic control, many interventions benefit overall adolescent health and development.

The Global Fund continues to fund the Government of Zambia through the MoH and the Churches Health Association of Zambia (CHAZ) as principal recipients of the Global Funds to support malaria, TB and HIV with a specific percentage going towards the implementation of the ADH programme.

United Nations Agencies have continued to support adolescent health programming at various levels including adolescent health service delivery in Zambia. The government will continue leveraging on mandates of the United Nations, such as coordination, technical support, advocacy for human rights and resource mobilisation to ensure that this plan is optimally implemented to achieve the goals.

Bilateral organisations have recently invested in adolescent health programmes in Zambia. Notably, among these are: the Swedish International Development Cooperation Agency (SIDA), United States Agency for International Development(USAID) and Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ) have supported the government and CSOs to implement programmes aimed at improving adolescent health and well-being.

Civil society organisations including faith-based and community-based organisations remain key partners to the MoH in the provision of ADH services. Whilst typically funded by donors, CSOs will be integral in advocacy efforts for increased resource allocation to adolescent health and also use efficient implementation modalities at community level.

Public-private partnerships These are contractual arrangements where the private sector performs government functions of service delivery on behalf of the government. Private sector engagement will be intensified (through the central MoH) to benefit from various forms of public-private partnerships including advocacy for corporate social responsibility projects.

APPENDIX A
ADOLESCENT FRIENDLY SPACE – MINIMUM PACKAGE GUIDE

Purpose: Adolescent friendly spaces (AFS) are to be (re)established at health facilities or at community level. Their main function is to act as an entry point for adolescents, including special needs clients to the respective health facilities. Basic services and information on: SRHR, SGBV, mental health, substance and drug abuse services and distribution of IEC materials and guided referral to services are offered at AFS. In addition, the AFS offers basic life skills such as CSE.

Design: The minimum model is for an AFS to have at least one desk and one table, four chairs (for peer educators and clients) and two waiting/meeting benches for peers. They should have one lockable cupboard to store reporting forms, IEC materials, contraceptives, condoms, HIV test kits and any sports equipment. The initial supply of sports equipment would be two soccer balls and two netballs[46]. Their location will be determined by the availability of space at the facility[58, 47]. They should be easily accessible and must offer a measure of confidentiality. Signage which directs the adolescent to the AFS and indicates its operating hours is mandatory.

Volunteer staffing: The space is to be manned by trained community-based volunteer peer educators and supported by trained health care providers. To ensure regular coverage, it is proposed that a minimum of eight volunteer peer educators[48] to be trained for each space (gender-balanced and where possible those with special needs). This is to ensure full time coverage of at least two peer educators – at least one female and one male – during the health facility operating hours while two volunteers are engaged in health promotion and demand creation outreach activities[49]. For planning purposes, this is the number per health facility who would be eligible to attend a 5-day residential peer education training on SRH and HIV information and outreach activities and routine reporting. The incentives packages (t-shirts, caps, bags, boots, raincoats, torch, stationary, reflector vests, ID) budgeting is for eight peer educators per AFS per health facility. Six bicycles (four for the AFS to be signed out for outreach use by the peer educators) and two for the ADH family planning (FP) are also proposed. Two peers should be co-team leaders (lead peer educators) to manage AFS staffing and schedules.

Supervision: The health facility and community based spaces are to be supervised by the health facility ADH Focal Point Persons who have been trained in Adolescent Health (ADH) and on the same Peer Education Training as the volunteers.

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46 Note – a much more costly model is being piloted in select districts in Copperbelt and Lusaka provinces, which includes a TV screen, DVD players, sports equipment packages, and so forth. This is currently not designated as a minimum package that can be easily scaled up with GRZ resources.

47 The desk, chairs and benches could be mobile – for example, the desk and chairs could be stored in the health facility and then placed outside in the health facility compound close to the entrance in an urban site or under a tree, near the facility in a rural site. The aim is to create an easily accessible "space" at the health facility for adolescents to access confidential SRH information and referrals.

48 Note – Peer educators should be between 16 and 24 years old. They should be drawn from their communities. They can Include students or young people out of school and be semi or unemployed. Functional literacy is a minimum requirement, as well as an acceptable reputation among their peers in the community.

49 The peer educators/counsellors will be trained on the operation of an AFS and the reporting forms during the peer educator training. As part of the training of the peer educators, they will need to know what services are provided at their designated health facility, and how these services operate.

Core tasks: As a service utilisation entry point, adolescent clients should be attended to by the volunteer peer educator first. The volunteer(s) are to welcome the adolescent client to the facility and then explain the mix of services: SRHR, SGBV, mental health, substance and drug abuse services and so forth. They should explain how the health facility services operate (for example, out-patient department, special clinic days, out-reach to health posts and communities). The peer educator(s) should assist the clients to determine their health needs and then provide initial information and peer education on the health issue(s). If required, they should then provide guided referral to the appropriate services and ideally, the adolescent health trained health staff in this service (for example, HIV testing and counselling).

The provision of IEC materials should be done in sufficient quantities, so that the adolescent clients will be able to share additional copies with their friends. The AFS volunteers should be trained to record information on all services provided. This information should be included in the health facility monthly report. When not deployed to the AFS, peer educators/counsellors should have a regular community outreach schedule, which should include the distribution of IEC materials and other health promotion services available at the health facility and community. They should reach out to local schools as well as organising group discussions and health talks, combined with scheduled games and sports activities, in the community.

APPENDIX B
TERMS OF REFERENCES FOR THE ADOLESCENT HEALTH TECHNICAL WORKING GROUPS

Terms of reference for the National, Provincial and District Adolescent Health Technical Working Groups, the Provincial, District and the Health Facility Adolescent Health Focal Point Persons are outlined below.

1. National Adolescent Health Technical Working Group

a. Proposed membership – the TWG will operate as a structure under the MoH. The key is to have a focused membership of partners who already undertake work in the area of adolescent health. Membership will be represented by the following:

- National HIV/AIDS/STI/TB Council;
- Provincial ADH focal point person;
- Provincial AIDS Coordination Advisors;
- Ministry of Health (Secretariat);
- Ministry of Community Development and Social Services;
- Ministry of Education;
- Ministry of Youth, Sport and Arts;
- Ministry of Home Affairs and Internal Security;
- Gender Division - Cabinet office;
- Ministry of Local Government and Rural Development including the Department of Chiefs and Traditional Affairs and any other relevant line ministry;
- Cooperating partners (e.g. UN, USG, GIZ)
- Chief executive officers or technocrats from implementing partners and youth led/focused Civil Society Organisations working in adolescent health; and
- Two representatives of adolescents' peer educators;
- Research and Academia institutions

b. Key functions:

(i) Forum for improving the coordination and monitoring of adolescent health programmes at National ADH TWG through provincial and district health offices.

(ii) Mechanism for leveraging human and financial resources among implementing partners to ensure coverage of the entire country regarding adolescent health activities.

(iii) Platform for advocating for adolescent health issues at national level (based on feedback from field visits, the national strategic plan, evidence and research data).

(iv) Platform for engaging and advising key stakeholders and leaders on adolescent health bottlenecks which require key implementing partners in various sectors to help address health issues affecting the adolescents.

(v) Mechanism for collecting, assessing and providing feedback on key adolescent health issues and bottlenecks at national levels.

NOTE: The national TWG will constitute sub committees/task forces to execute duties as and when the need arises.

2. Provincial Adolescent Health Technical Working Group

a. Proposed membership – the TWG could operate as a structure under the provincial health multisectoral health committees or as a stand-alone TWG. The key is to have a focused membership of partners who already undertake work with adolescents. Membership will be represented by the following:

- Ministry of Health- Provincial health office (Secretariat);
- Ministry of Community Development and Social Services;
- Ministry of Education;
- Ministry of Home Affairs and Internal Security (Victim support unit, Drug enforcement commission)
- Ministry of Youth, Sport and Arts;
- District adolescent health focal point persons;
- Provincial and District AIDS coordination advisor;
- Gender focal point person-Provincial administration;
- Ministry of Local Government and Rural Development including the Department of Chiefs and Traditional Affairs and any other relevant line ministries;
- Implementing partners and civil society organisations that work in adolescent health and have provincial coverage; and
- Two representatives of adolescents' peer educators.

b. Key functions:

(i) Forum for improving the coordination and monitoring of adolescent health programmes in the province (for example, routinely capturing disaggregated data from implementing partners and reporting to the National ADH TWG).

(ii) Mechanism for leveraging human and financial resources among implementing partners to ensure coverage of the entire province on adolescent health activities.

(iii) Platform for advocating for adolescent health issues at provincial level (based on feedback from field visits, the national strategic plan, evidence and research data).

(iv) Platform for engaging and advising key stakeholders and leaders on adolescent health bottlenecks which require key implementing partners in various sectors to help address health issues affecting the adolescents.

(v) Mechanism for collecting, assessing and providing feedback on key adolescent health issues and bottlenecks to the national level.

NOTE: Provincial ADH TWGs will assume responsibility and galvanisation of resources so that they are rolled out to the district level and ultimately to the facilities through the following:

- **Service delivery** – coordinate and strengthen service delivery to adolescents in all focus areas by various implementing partners in the province.
- **Demand creation and health promotion** – coordinate and strengthen efforts aimed at mobilising young people to access health services and to increase health literacy levels among adolescents.
- **Monitoring and evaluation** – strengthen capacity to monitor programme adherence to set objectives and standards to monitor programme performance to improve programming.

3. District Adolescent Health Technical Working Group

a. Proposed membership – the TWG could operate as a structure under the district HIV and AIDS committee or as a stand-alone TWG. The key is to have a small and focused membership of partners who already undertake work with adolescents. Membership will be represented by the following:

- Health facility ADH focal point persons;
- Ministry of Health - District Health office (Secretariat);
- Ministry of Community Development and Social Services;
- Ministry of Education;
- Ministry of Youth, Sport and Arts;
- Ministry of Home Affairs and Internal security (Victim support unit, Drug enforcement commission)
- District AIDS Coordination Advisor
- Gender focal point person - District Administration office;
- Ministry of Local Government and Rural Development including Department of Chiefs and Traditional Affairs and any other relevant line ministries;
- Civil society organisations which work with adolescents and have district coverage; and
- Two representatives of adolescents' peer educators.

b. Key functions:

(i) Forum for improving the coordination and monitoring of adolescent health programmes in the district. (for example, routinely capturing disaggregated data from implementing partners and report to provincial health offices).

(ii) Mechanism for the leveraging of human and financial resources among implementing partners to ensure coverage of the entire district regarding adolescent health activities.

(iii) Platform for advocating for adolescent health issues at district level (based on feedback from field visits, the national strategy, evidence and research data).

(iv) Platform for engaging and advising key stakeholders and leaders on adolescent health bottlenecks which require key implementing partners in various sectors to help address health issues affecting the adolescents.

(v) Mechanism for collecting, assessing and then providing feedback on key adolescent health issues and bottlenecks to provincial levels.

Operations of TWGs

The ADH TWGs shall meet at least on a quarterly basis, coordinated by the MoH National, Provincial and District Adolescent Health Focal Point Persons.Members of the TWGs shall present their reports to the TWGs during meetings..

Provincial, District and Health Facility Adolescent focal point persons

The ADH focal point person has been traditionally designated from the Maternal and Child Health Departments, but the designated focal person can be nominated from other departments as long as they are health workers who meet the basic criteria as follows:

1. Should be trained in all relevant components of adolescent health programming, especially the following: trainer of trainers on the adolescent health friendly services for health care providers, comprehensive service package and standards and peer education package.
2. Have demonstrated a passion for adolescent health.
3. Express willingness to undertake the functions of the ADH focal point person upon being nominated.

1. Provincial Adolescent Health Focal Point

a. Background: One Provincial Health Office staff member will be designated as the provincial ADH focal point person. This staff member should be trained as a trainer of trainers in adolescent health and on the peer education package and be responsible to manage the training of all health staff, key partners and adolescents in the district.

b. Key tasks: The Provincial ADH focal point person will be responsible to act as the Provincial ADH TWG Secretariat (or delegate the responsibility) and to ensure that the structure is operational.

c. Supervisions: The Provincial ADH focal point person supervises the District

ADH focal point persons to ensure that their districts provide adolescent responsive health services. This includes monitoring the routine collection of adolescent age and sex disaggregated data on key ADH indicators, the dissemination of IEC materials and contraceptives such as condoms and the supervision of the operation of an AFS and the peer educators including their monthly reporting.

d. Provincial ADH focal point key responsibilities:

(i) Provide technical support in planning, coordination, management and monitoring of the adolescent health programme in the province.

(ii) Act as, or designate, a secretariat to the Provincial Adolescent Health TWG and attend the district HIV/AIDS committee meetings as scheduled.

(iii) Organise Provincial Adolescent Health TWG quarterly or bimonthly meetings and bimonthly field visits.

(iv) Plan, support and monitor the training of health centre workers and peer education in the district.

(v) Ensure that all districts submit monthly disaggregated adolescent health data to the district health office.

(vi) Support the MoH district information officers to aggregate disaggregated data from health facilities for reporting to the national levels and the Provincial Adolescent Health TWG.

(vii) Undertake routine supervision of districts and their AFS and ensure distribution of comprehensive Adolescent health information materials to all facilities and AFS and monitor the mobilisation and outreach activities.

(viii) Manage utilisation of the MoH and cooperative partners adolescent health resources.

2. District Adolescent Health Focal Point

a. **Key tasks:** The district ADH focal point person will be responsible to act as the district ADH TWG Secretariat (or delegate the responsibility) and to ensure that the structure is operational (see: the District Adolescent Health Technical Working Group terms of reference). The focal point person needs to work very closely with the MoH District Health Information Officer on the collection and assessment of service utilisation data by adolescent clients.

b. **Supervisions:** The district ADH focal point person needs to ensure that health facilities are identified for the implementation of the full minimum Adolescent Health Services Platform. Depending on the number of staff, either all (facilities with six or less clinical staff) or all clinical staff in out-patient,HIV, SRH, mental health and MCH departments e.t.c are trained on the adolescent health comprehensive service and package standards, and at least two trained staff are designated as the health facility ADH focal point persons. The district ADH focal point person supervises the health facility ADH focal point persons to ensure that their facilities provide adolescent responsive health services. This includes monitoring the routine collection of adolescent age and sex disaggregated data on adolescent health indicators, the dissemination of IEC materialsand the supervision of the operation of an AFS and the peer educators including their monthly reporting.

c. **The adolescent friendly spaces:** It is the responsibility of the Adolescent focal person to ensure that AFS are (re)established at every health facility.

d. **District ADH focal point person key responsibilities:**

(i) Provide technical support in planning, coordination, management and monitoring of the adolescent health programme in the district.

(ii) Act as secretariat to the District Adolescent Health TWG and attend the district HIV andAIDS committee meetings.

(iii) Organise District Adolescent Health TWG meetings.

(iv) Plan, support and monitor the training of health care workers and peer educators in the district.

(v) Monitor the deployment, retention, activities and reporting of the peer educators.

(vi) Ensure that all facilities in the district submit monthly disaggregated adolescent health data to the MoH District Health Information Officers.

(vii) Undertake routine supervision of health facilities and their AFS and ensure distribution of comprehensive ADH information materials to all facilities and monitor the mobilisation and outreach activities.

(viii) The district focal point person has a key responsibility in developing work plans and managing the utilisation of the MoH and cooperative partners adolescent health resources

3. Health facility Adolescent Health Focal Point Persons

a. **Key tasks:** The current implementation model for the National Adolescent Health Programme calls for at least two health staff from a health facility, who have been trained on the national adolescent health services, to be designated as the HFADH FPPs. These are responsible for the delivery of ADHFS at the facility (or community) and supervision of peer educators attached to their health facility and AFS. At least one of the HFADH FPP should be based at the AFS regularly to ensure consistent provision of services.

b. **The adolescent friendly space and peer educators:** The AFS are to be (re)established at health facilities or communities. Their main function is to act as an entry point for adolescent clients to the respective health services/facilities. Basic information and services on Adolescent health and guided referral, should be offered at all service delivery points.

The AFS will be manned by a minimum of eight trained peer educators who will provide comprehensive ADH services and guided referrals. The peer educators should undertake mobilisation activities among their peers, in schools and communities. Two co-lead peer educators need to be designated to assist the HFADH FPPs, especially around scheduling operation of the AFS, outreach activities and the consolidation of the individual peer educator's reports into a monthly Health Facility Education Activity Report [50.]

c. **Community and School outreach:** The ADH focal point persons should undertake regular meetings with key community leaders, at least once per month, to ensure they are supportive of adolescents accessing health services. Use of the facility ADH data is useful for advocacy and decision making during these community engagements. They should also undertake comprehensive ADH talks with the peer educators in schools, churches, markets, and sports grounds in their catchment area at least twice a month. They should develop a working relationship with the school(s) management and guidance and counselling teachers and promote the availability of adolescent responsive health services at their health facility to learners.

d. **Data collection:** The HFADH FPPs will also be responsible to ensure that their facility extracts adolescent data monthly from the different registers (FP, ANC, Delivery, STI, OPD, Mental health, ART (PrEP, PEP, Viral load, GBV, Obs & Gyn , and HIV Testing Services (HTS) from all testing points including index testing e.t.c). The MoH Health Information Assessment data collection tool has now added age and sex disaggregated indicators on keyadolescent health issues and track service utilisation. The co-lead peer educators can also be designated to assist with the extraction of the adolescent data from the registers, in partnership with the key service providers (for example, the HTS provider).

e. **Key responsibilities:**

(i) Ensure that adolescent responsive health services are available at the facility and Support the establishment and functioning of the AFS at health facilities.

(ii) Coordinate the facility adolescent friendly health activities by supervising the operations of the AFS and peer educators.

(iii) Support health facility providers with the delivery of ADH services

(iv) Manage and supervise the peer educators community outreach activities, ensuring that peer educators are doing community outreach to key hotspots to provide comprehensive adolescent health services and distribute IEC materials.

(v) Oversee that the health facility has relevant stock of ADH IEC materials and commodities.

(vi) Supervise the peer educators to ensure that they are completing their daily outreach logs and consolidating this information monthly. Ensure that the lead peer educators are producing a Consolidated Peer Educators/ AFS Monthly Report. (Note: these reports cover the number of adolescents who visited the AFS and the number of peer educator outreaches conducted and numbers of AYP reached. The reporting format requires information on the key issues discussed, such as the number of condoms distributed, and number of referrals made, and for which issues, to the health facility. The facilityActivities Report must be submitted on a monthly basis to the district ADH focal point person, for review and consolidation..

(vii) The HFADH FPPs will be responsible for conducting on site in-service basic training for new peer educators, to routinely replenish volunteers who have dropped out.

[50] Please see the Peer Educator Training Manual for the Peer Educators reporting tool. Adolescent Friendly Space Minimum Package Guide, in Appendix B of this document. Additional information on peer education activities, including terms of references and reporting tools are found in the ADH Peer Education Training manual.

APPENDIX C
SERVICE QUALITY ASSESSMENT TOOL

DOMAIN	CAPACITY	RESPONSE	SCORE
Infrastructure	1. Does the health facility provide Adolescent Friendly Health Services with room for counselling?	if No Score 1; if Yes go to Q2	
	2. Does the health facility provide Adolescent Friendly Health Services with room for counselling? (of adequate size, well-lit and ventilated; provides privacy and dignity; should have potable/running water)	if No Score 1; if Yes go to Q3	
	3. Does the health facility provide Adolescent Friendly Health Services with room for counselling and examination? (of adequate size, table and chairs, well-lit and ventilated; provides privacy and dignity; should have potable/running water) and has signage and designated area for adolescent care (youth friendly health facility	if No Score 2. if Yes go to Q4	
	4. Does the Health facility provide Adolescent Friendly Health Services with reception, room for counselling, examination, Pharmacy and laboratory (of adequate size, table and chairs, well-lit and ventilated; provides privacy and dignity; should have potable/running water and toilet within 30 meters, fire safety) and has signage and designated area for adolescent care (adolescent friendly health facility)	if No Score 3; if Yes Score 4	

Equipment	1. Does the Facility have any equipment in either category A or B	if No Score 1; if Yes go to Q2	
	2. Does the facility have some equipment in category (A)	if No Score 1; if Yes go to Q3	
	3. Does the facility have all the category (A) equipment	if No Score 2; if Yes go to Q4	
	4. Does the facility have all the category (A)and (B) equipment	if No Score 3; if Yes Score 4	
	Mandatory - Category A		
	BP Machine	Yes/No	
	Benches	Yes/No	
	Chairs	Yes/No	
	Cupboard (Lockable)	Yes/No	
	Length/Height board	Yes/No	
	Thermometer-clinical	Yes/No	
	Timer/clock	Yes/No	
	Weighing scale-Adult	Yes/No	
	Desirable-Category B		
	Computer	Yes/No	
	Drums	Yes/No	
	Entertainment unit	Yes/No	
	Examination couch	Yes/No	
	Football jersey	Yes/No	
	Footballs	Yes/No	
	Megaphones	Yes/No	
	Netballs	Yes/No	
	Pool table	Yes/No	
	Refrigerator	Yes/No	
	Stretcher	Yes/No	
	TV set	Yes/No	
	Wheelchair	Yes/No	
	Infection prevention equipment (wastes buckets etc)	Yes/No	

Human Resources	1. The health facility has trained or oriented Adolescent clinical and support team (Clinicians, Nurse, pharmacy, EHT, Lab tech, Counsellor(s), peer educators and support staff)	if No Score 1; if Yes go to Q2	
	2. At least one clinical staff and 2 peer educators trained or oriented in AFHS as per adolescent health strategic plan focus areas (HIV, SRH, GBV, Mental health, Alcohol, drug abuse, NCDs, Nutrition, adolescents with chronic diseases)	if No Score 1; if Yes go to Q3	
	3. Has at least one clinical staff, a focal point person and 8 peer educators trained or oriented in AFHS as per adolescent health strategic plan focus areas (HIV, SRH, GBV, Mental health, Alcohol, drug abuse, NCDs, Nutrition, adolescents with chronic diseases)	if No Score 2; if Yes go to Q4	
	4. Has at least one clinical staff, a focal point person, more than 8 peer Educators, at least one trained staff in sign language and all members of staff trained or oriented in AFHS as per the adolescent health strategic plan focus areas (HIV, SRH, GBV, Mental health, Alcohol, drug abuse, NCDs, Nutrition, adolescents with chronic diseases)	if No Score 3; if Yes Score 4	
Guidelines and Protocols	1. Does the health facility Have any documents in either category A or B	if No Score 1; if Yes go-to Q2	
	2. Does the facility have some documents in category (A)	if No Score 1 if Yes go-to Q3	
	3. Does the health facility have all the category (A) documents	if No Score 2; if Yes go-to Q4	
	4. Does the health facility have all the category (A)and (B) documents	if No Score 3; if Yes Score 4	
	Mandatory - Category A		
	Latest Adolescent Health Strategic Plan	Yes/No	
	Latest National Standards and Guidelines for Adolescent Friendly Health Services and Adolescent health service minimum package	Yes/No	
	Adolescent Friendly Health Services Training Manual for Health Workers	Yes/No	
	Training Manual for Peer Educators	Yes/No	
	Desirable - Category B		
	Adolescent HIV training manual	Yes/No	
	National Alcohol Policy		
	Latest Reproductive, Maternal, Neonatal, child and adolescent health/nutrition (RMNCAH-N) communication strategy		

Commodities and Supplies: comprehensiveness of commodities (IEC materials on various health issues and commodities for service provision)	1. Does the health facility have any commodities in either category A or B	if No Score 1. if Yes go to Q2	
	2. Does the health facility have some commodities in category (A)	if No Score 1; if Yes go to Q3	
	3. Does the health facility have all the category (A) commodities	if No Score 2; if Yes go to Q4	
	4. Does the health facility have all the category (A) and (B) commodities	if No Score 3; if Yes Score 4	
	Mandatory - Category A		
	Condoms – Female	Yes/No	
	Condoms – Male	Yes/No	
	IEC materials on Gender Based Violence (including sexual GBV)	Yes/No	
	IEC materials on HIV/VMMC	Yes/No	
	IEC materials on nutrition	Yes/No	
	IEC in sign language or braille	Yes/No	
	IEC materials on Sexual and Reproductive Health	Yes/No	
	IEC materials on substance abuse/mental health	Yes/No	
	Emergency Contraceptives	Yes/No	
	Desirable - Category B		
	IEC on chronic diseases (Diabetes, Heart diseases, sickle cell any chronic diseases etc.)	Yes/No	
	Nutritional supplements (ferrous and other supplements)	Yes/No	
	HIV test kits	Yes/No	
	All family planning methods	Yes/No	

Practices			
Comprehensive service provision and counselling in adolescent health priority areas. Sample 10 reports or pages of YFHS registers to assess delivery of or referral to prevention messages 1. HIV Risk reduction and counseling. 2. HIV testing, or ART Adherence counseling/ART support group 3. STI risk reduction and counselling /screening / treatment/referral. 4. Male circumcision counselling/ service/referral; 5. Sexual and reproductive health services and counselling (contraception, Condom provision and counselling, inquiry on LMP, ANC and abortion services etc.) 6. Effects of substance and alcohol abuse/counselling/ referral. 7. GBV counselling/ referral. 8. Over- and under Nutrition counselling/referral)	ONE of the listed services provided within the past 3 months	if No Score 1; if Yes go to Q2	
	2-4 of the listed services provided within the past 3 months	if No Score 1; if Yes go to Q3	
	5-8 of the listed services provided within the past 3 months	if No Score 2; if Yes go to Q4	
	ALL of the listed services provided within the past 3 months	if No Score 3; if Yes Score 4	
Comprehensive service Provision. Sample 10 books/patients files to ascertain whether health workers inquire about or provide information or services in the following: 1. HIV Risk reduction and counseling. 2. HIV testing, or ART Adherence counseling/ART support group 3. STI risk reduction and counselling /screening / treatment/referral. 4. Male circumcision counselling/ service/referral; 5. Sexual and reproductive health services and counselling (contraception, Condom provision and counselling, inquiry on LMP, ANC and abortion services etc.) 6. Effects of substance and alcohol abuse/counselling/ referral. 7. GBV counselling/ referral. 8. Over- and under Nutrition counselling/referral) 9. Patients assessed using the HEADSS Approach	All sampled books have no evidence or ONE of the listed services provided within the past 3 months.	if Yes Score 1; if No go to Q2	
	6-10 sampled books have evidence of 2-4 of the listed services provided within the past 3 months	if No Score 1; if Yes go to Q3	
	6-10 sampled books have evidence of 5-8 of the listed services provided within the past 3 months	if No Score 2; if Yes go to Q4	
	6-10 sampled books have evidence of more than 8 listed services within the past 3 months	if No Score 3; if Yes Score 4	

Practice: Facility referral (within and to the community care and support services	1. Is a system in place with tools to track referrals of adolescent with HIV or TB or mental health problems or NCDs or GBV etc.	If No Score 1. if Yes go to Q2	
	2. Is a system in place with standard tools to track referrals of adolescent with HIV or TB or mental health problems or NCDs or GBV etc. and their caregivers to ensure they receive a comprehensive assessment of needs provided by a clinic or community-based services.	if No Score 1; if Yes go to Q3	
	3. Is a system in place with standard tools to track referrals of adolescent with HIV or TB or mental health problems or NCDs or GBV etc. and their caregivers to ensure they receive a comprehensive assessment of needs provided by a clinic or community-based services. Is guided referral being done?	if No Score 2; if Yes go to Q4	
	4. Is a system in place with standard tools to track referrals of adolescent with HIV or TB or mental health problems or NCDs or GBV etc and their caregivers to ensure they receive a comprehensive assessment of needs provided by a clinic or a community-based service. Guided referral being done and means to confirm whether the beneficiary received those services available.	if No Score 3; if Yes Score 4	
Records/ data management	1. The Health facility has standardized registers and monthly reporting tools	if No Score 1; if Yes go to Q2	
	2. he Health facility has standardized registers, monthly reporting tools and monthly reports stored in an orderly manner.	if No Score 1; if Yes go to Q3	
	The Health facility has standardized registers, monthly reporting tools and monthly reports stored in an orderly and secure manner	if No Score 2; if Yes go to Q4	
	The Health facility has standardized registers, monthly reporting tools and monthly reports stored in an orderly and secure manner. Availability of minutes/reports/QI plans to confirm data utilization for decision making and continuous quality improvement	if No Score 3; if Yes Score 4	

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