GOVERNMENT OF THE REPUBLIC OF ZAMBIA

MINISTRY OF HEALTH

Adolescent Health Strategy 2017 to 2021

2017

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ACRONYMS AND ABBREVIATIONS

ADFHS	Adolescent Friendly Health Service
ADH	Adolescent Health
ADH-SP	Adolescent Health Strategic Plan
ADH-TWG	Adolescent Health Technical Working Group
AFS	Adolescent Friendly Services
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARH	Adolescent Reproductive Health
ART	Anti-Retroviral Therapy
ARVs	Anti-Retrovirals
ASRH	Adolescent Sexual and Reproductive Health
BCC	Behaviour change communication
CPs	Cooperating Partners
CSE	Comprehensive Sexuality Education
CSO	Central Statistical Office
CSO	Civil Society Organisations
DADH FP	District Adolescent Health Focal Point
DADH TWG	District Adolescent Health Technical Working Group
DHO	District Health Office
FP	Family Planning
GDP	Gross Domestic Product
GRZ	Government of the Republic of Zambia
HCADH FP	Health Centre Adolescent Health Focal Points
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICT	Information Communication Technology
IEC	Information, Education and Communication
LCMS	2015 Living Conditions Monitoring Survey
M & E	Monitoring & Evaluation
MDGi	Millennium Development Goal Initiative
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal and Child Health
MoCDSS	Ministry of Community Development and Social Services
MOF	Ministry of Finance
MOGE	Ministry of General Education
MOH	Ministry of Health
MOYSCD	Ministry of Youth, Sport and Child Development
NFNC	National Food and Nutrition Commission
NGO	Non Governmental Organisations
NHSP	National Health Strategic Plan
PAC	Post Abortion Care
PHO	Provincial Health Office
PMTCT	Prevention of Mother to Child Transmission of HIV
PPAZ	Planned Parenthood Association of Zambia
PPP	Public-Private Partnership
PTSS	Post Test Psychosocial Support

R&D	Research and Development
RH	Reproductive Health
SDGs	Sustainable Development Goals
SOWC	State of the World's Children 2010
STI	Sexually Transmitted Infection
SWOT	Strengths, Weaknesses, Opportunities and Threats
TWG	Technical Working Group
UN	United Nations
UN-ACRWC	African Charter on the Rights and Welfare of the Child
UN-CRC	United Nations Convention on the Rights of the Child
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
VCT	Voluntary Counselling and Testing
WHO	World Health Organization
YFC	Youth-Friendly Corner
ZDHS	Zambia Demographic and Health Survey
ZGSHS	Zambia Global School Health Survey
ZICTA	Zambia Information and Communication Technology Authority

KEY DEFINITIONS OF TERMS

Adolescent	Person aged between 10 to19 years
Early adolescent	Person aged between 10 to 14years
Late adolescent	Person aged between 15 to 19 years
Minimum Adolescent Health Services Platform	The platform requires a District Adolescent Health Technical Working Group (DADH TWG), a designated and trained District Adolescent Health Focal Point (DADH FP); designated Health Centre Adolescent Health Focal Points (HCADH FP); and designated Adolescent Friendly Space (AFS) at each Health Centre, manned by trained and sustained Peer Educators. Details are in Appendix 1.
Adolescent Responsive Health System	This is a move towards universal health access with a transition from "adolescent-friendly" project approach to a programme approach focused on mainstreaming capacity at primary and referral levels so that all providers and health services provided are responsive to the priority health and development needs of adolescents.
Adolescent Friendly Space Model	This is an adaption of the Adolescent/Youth Friendly Corner model. An 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 with designated and trained peer educators. It provides basic health information (ASRH&R and HIV, etc.), distributes IEC materials and condoms and provides guided referrals to health services in the health centres and to health workers who have been trained on the adolescent health standards. Details of this are found in Appendix 2.
Young people	Person aged between 10 to 24 years (UN definition)
Youth	Young person aged between 10 and 35 years (Zambia Youth Policy definition – UN definition: 15-24 years)

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FOREWORD

In Zambia, adolescents account for 25% of the total population with a significant influence on the health status of its Population. Adolescence represents a period of transformation from childhood to adulthood and if not well managed, could lead to significant vulnerability with huge health and socio-economic consequences.

In Zambia, adolescents bear a big brunt of the communicable, non – communicable diseases and morbidity and mortality from sexual reproductive health and nutrition conditions. Therefore, interventions targeting adolescents are key to our overall drive to reduce maternal mortality ratio from 398/100,000 to less than 100 per 100,000 livebirths, reduction of new annual HIV infections from 46,000 to less than 5,000 and elimination of malaria by 2021.

Zambia has prioritized adolescent health arising from the demographic dividend opportunity this presents in expediting our progress towards socio-economic development in line with vision 2030 and the 2030 sustainable development goals. The Adolescent Health Strategy 2017 – 2021 is in tandem with the NHSP 2017-2021 and has prioritized health systems strengthening as a pathway to attain universal health coverage using the primary health care approach. Our focus is on building a robust, resilient and responsive Adolescent Health System across the continuum of care, spanning in that order; promotive, preventive, curative, rehabilitative and palliative health services provided as close to the family settings as possible.

I wish to thank all our cooperating partners and stakeholders for their unwavering support in the development of this strategy. In partnership we should ensure that we now focus our collective energies to translate this strategy into action and significantly contribute to improved health status of our adolescents in our country.

I therefore urge everyone involved in the execution of this strategy to be fully committed to this important national responsibility.

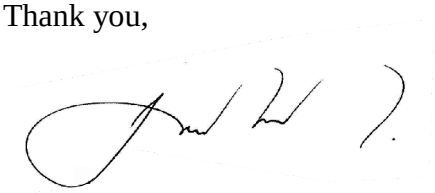
Hon. Dr. Chitalu Chilufya, MP
MINISTER OF HEALTH

ACKNOWLEDGEMENTS

On behalf of the Ministry of Health,I wish to thank all the institutions and individuals who contributedto this process and the successful development of this document, including our members of staff and the various partners. In this regard, I wish topay special tribute to all the members of the subcommittee of the National Adolescent Health Technical Working Group (NADH-TWG) which draws membership from line Ministries,Civil Society organizations and Cooperating Partners, who led the development of this document. I would also like to thank the adolescents and young people who reviewed the draft and provided timely inputs. In addition, I would like to expressly thank the United Nations Population Fund (UNFPA), the United Nations Children's Fund (UNICEF) and the World Health Organization (WHO) for theirtechnical and financial support to the development of this strategy document.

I therefore wish to commend the Department of Public Health of my Ministry, and all our partners and technical experts, who contributed to the process of developing this strategy.

Thank you,



Dr. Jabbin Mulwanda
Permanent Secretary – Health Systems
MINISTRY OF HEALTH

1 EXECUTIVE SUMMARY

1.1. Introduction

The Adolescent Health (ADH) Strategy 2017-2021 is built on the gains achieved and lessons learnt during the implementation of the ADH-Strategic Plan (ADH-SP) 2011-2015. It has three main components:(1) strengthening the capacity of the health sector for the deliveryof an adolescent responsive health service; (2)increasingadolescent health communication for the promotion of healthy behaviours and demand creation; (3) strengtheningleadership and governance issues that support the effective delivery of a comprehensive adolescent responsive health system and enablescommunities to promote healthy behaviours and the utilization of relevant health services by adolescents.

The development of this Strategy was led by the Ministry of Health (MOH) together with a core group of partners from the National Adolescent Health Technical Working Group (NADH-TWG) and in consultation with various stakeholders. It was presented to a group of adolescents and the main NADH-TWG for validation.

1.2. Situation Analysis

1.2.1. The health of Adolescents

Adolescence, a period of life between ages 10 to 19 years, is characterized by rapid changes physically, physiologically and in social function. Brain changes also occur, with changes within the limbic system[1] developing earlier than the pre-frontal cortex[2], and thisexplains, to some extent, the desire for exploration, experimentation, and risk-taking that often take place during this period of life.

While most adolescents are able to explore and experiment in ways that contribute positively to their health and development, some do take up behaviours that undermine their health, or behaviours that can lead to significant health problems later on in life. They often lack access to relevant health information and the skills to develop risk avoidance or risk reduction behaviours. They frequently have limited access to adolescent responsive health services, especially in regards to sexual and reproductive health (SRH). In addition, they often face challenges within their households and communities due to the lack of a protective and enabling environment that promotes positive behavioural development and access to and utilization of relevant health services.

About 32% of adolescents aged 15-17 and 60% of those aged 18-19 are sexually active in Zambia, and therefore face risks from HIV and other sexually transmitted infections (STIs), especially as only 40% of them report regular condom use. They also experience mental health issues, trauma and physical and sexual violence. Non communicable diseases, particularly those related to poor nutrition and physical inactivity, are also emerging areas of concern. In addition, there are significant gender differences related to risk and vulnerability among adolescents in Zambia: almost one in five adolescent girls are already married compared to only 1 in 100 adolescent boys aged 15-19;and one out of every four girls aged 17 and six out of every 10 girls aged 19 have already started child bearing! On the other

[1] the area responsible for pleasure seeking, reward processing, emotional response, and sleep regulation

[2] area responsible for decision-making, organization, impulse control, and planning for the future

hand, adolescent boys seem more predisposed to alcohol and substance use and abuse compared to girls.

Based on the more detailed Situation Analysis found in section 3 below, partners identified the following priority health areas to be addressed under the three components of the strategy. They are sexual and reproductive health; HIV and AIDS and other STIs; gender based violence; non communicable diseases - particularly nutrition related and mental health issues; alcohol and substance abuse; and health issues affecting adolescents with special needs.

1.2.2. *Lessons Learned on Adolescent Responsive Health Service Delivery*

During the implementation of the previous ADH-SP 2011-2015, Zambia made progress around implementing adolescent responsive health services. The country established national and district coordination mechanisms, produced guidelines, standards and training tools for the delivery of these services, tested out a number of implementation packages and scaled up a dedicated platform of services to over a quarter of the districts in the country. Many lessons have been learned around effective processes for convening and harmonizing partner's efforts. These include the need to achieve cultural and value shifts among opinion leaders and within communities; theimportance of working with adolescentsas partners in the design and delivery of interventions; and the necessity to apply efficiently the limited resources available from both government and cooperative partners through better targeting and tracking of partner's efforts and results.

STRATEGIC DIRECTION FOR THE ADH STRATEGY 2017-2021

The focus of the ADH Strategy for 2017-2021 is on strengthening the delivery of adolescent responsive health servicesto increase adolescents' access and utilization of quality health-careservices resulting in improved adolescent sexual, reproductive and general health; the reduction of HIV incidence; and the overall promotion and adoption of healthy living among adolescents.

VISION, MISSION AND OVERALL GOAL

Vision:	Healthy and productive adolescents for National Development
Mission:	To ensure equity of access to appropriate, quality and cost-effective adolescent-friendly health platforms and an adolescent responsive health system[3] as close to the people as possible
Overall Goal:	To improve the health status of adolescents in Zambia
Theme:	Knowledgeable and healthy adolescents, the future of Zambia

KEY PRINCIPLES

The implementation of this Strategy shall be guided by the WHO 'quality of care' framework and key elements in the context of respect for human rights and fundamental freedoms as well as the recognition of the critical role parents, guardians and communities play in the

[3]This is a move towards universal health access with a transition from an 'adolescent-friendly' projects focusing on SRH to programmes that strengthen mainstream capacity at primary and referral levels so as to respond to the priority health and development needs of adolescents.

provision of ADH services. The key elements are **Equitable, Accessible, Acceptable, Appropriate, and Effective**health care services(WHO, 2012).[4]

OBJECTIVES AND KEY STRATEGIES

	Objectives	*Key Strategies*
1.	To ensure availability of the minimum adolescent health service platform in all districts of Zambia by 2021	**Health Service Delivery Strengthening** • Refine and scale out the adolescent health services platform package. • Scale out ADH services to all districts and health facilities and strengthen integration of services. • Prioritize the delivery of comprehensive and integrated adolescent responsive packages of interventions within the key clinical services that are being utilized by adolescents. • Strengthen adolescents' participation in the delivery of adolescent responsive services, at national, provincial, district, health facility and community levels (including in planning, organization, implementation, and monitoring and evaluation). • Strengthen district level adolescent health coordination and harmonize efforts of partners in support of adolescent responsive health service delivery. • Mobilize and assist selected NGOs, CBOs and FBOs to support the delivery of adolescent responsive health services, including smart partnership service delivery relations with NGOs and community based partners. • Train and mentor adolescents to build their competencies in advocating for ASRH. • Promote effective integration of responsive health services for adolescents and at higher level facilities explore special clinic days and times for adolescent clients, especially in sensitive SRH and HIV services. • Develop a clear policy on transition of care from paediatrics to adult care. • Standardize the Adolescent Friendly Space minimum delivery package. • Operationalize the package of incentives for youth volunteers involved in the provision of ADH services in line with the MoCDSS guidance. • Scale up pre-service and in-service adolescent health training of health workers • Scale up training of peer educators and their deployment to adolescent friendly spaces at health facilities.
2.	Increase adolescents' awareness and utilization of available health services to promote healthy living.	**Health Promotion and Demand Creation** • Strengthen adolescent involvement and participation in health communication • Strengthen capacity of community based organizationsto promote and generate a protective and enabling community environment for adolescents. • Achieve cultural and value shifts through changes in social norms and behaviours, like GBV, child marriage, alcohol and substance abuse, etc. • Enhance adolescent's health literacy through behaviours and social change communication activities among adolescents (including activities designed for adolescents with special needs).

[4] WHO, 2012: Making Health Services Adolescent Friendly: Developing national quality standards for adolescent-friendly health services.

		• Design and implement targeted innovative BSCC campaigns with adolescents which promote healthy behavioural development and behaviour change; and promotes uses of preventative health services, including the scaling up of comprehensive sexuality education (CSE) for adolescents in and out of school. • Develop and implement mass media and interpersonal communication campaigns which promote the utilization of SRH/HIV and NCD services by adolescents. • Increase demand for and use of relevant health services through peer education outreach. • Strengthen community based preventive behaviours,developmentofactivities to help prevent the development of the risk behaviours and ultimately reduce the demand on health services. • Develop and adopt an adolescent sexual and reproductive health and rights package for community leaders, church leaders, school teachers and parents. • Strengthen use of innovative old and new media, including mobile technology and social media for effective partnership and engagement with adolescents.

3.	To strengthen the leadership and governance of an adolescent responsive health system and advocate for an enabling environment that ensures health for all adolescents, without discrimination	**Leadership and Governance** • Review/Strengthen the policy and regulatory framework for adolescent health including a clear policies and guidelines on age of consent and access to key SRH and HIV services, adolescents meaningful participation in service delivery (peer education); and the transition of care from paediatric to adult care. • Roll out an adaptive leadership approach targeting key stakeholders and strengthen organization and coordination for an efficient and effective harmonized response to delivering adolescent responsive health services. • Increase the dedicated adolescent health financing under the National Health Strategic Plan (NHSP) 2017-2021. • Ensure that efforts to strengthen management of key commodities, health infrastructure, and equipment and transport logistics prioritize the delivery of adolescents' responsive health services. • Strengthen accountability and budget tracking in respect to ADH funds allocated by the MOH and provided by cooperative partners. • Mobilize joint programming support by cooperative partners towards the delivery of an adolescent responsive health system. • Maintain, strengthen and implement the collection and analysis of age and sex disaggregated HMIS data. • Strengthen management, supervision, organization and coordination of the ADH services platform activities at all levels. • Strengthen multi-sectoral linkages and collaboration between key line ministries for effective referrals and follow-up, especial around issues of gender based physical and sexual violence, substance abuse and other key underlying determinants of adolescents risk and vulnerability (adolescent/youth development, education, employment, labour skills, and social welfare, etc.).

COSTING

The successful implementation of this strategy will require various resources, including human and financial resources. It will be imperative for all partners involved to adequately budget for the activities they will undertake in support of this strategy in their own budgets (and proposals to cooperative partners). MOH, in addition to providing core support, will also lead advocacy and resource mobilization work around the financing of this strategy to ensure sufficient resources to implement the proposed activities.

A number of strategies and activities have been proposed in this document. They are not all of the activities that will be required over the five year period. MOH and partners expect that actual annual costs will vary based on the prioritization of effective strategies and activities and the available of funds. The figures presented below are an indicative cost based on the setting up of the minimum adolescent health services platform in 62% of high burden health facilities catchment areas during the period of implementation.

Health facilities will be prioritized based on numbers of adolescents and the high burden of priority adolescent health issues. In addition, this budget includes resource for national level health promotion, including social and behavioural change communication, programme management, monitoring, supervision and logistics support costs. The minimum ADH services platform activities and costs are based on the MOH experiences with the implementation of adolescent health activities in 25 districts, over the 2015-2016 period.

The approximately estimated 5 years budget is **US$12,459,198[5].**

Budget of Setting up a Minimum ADH Services Platform in the targeted districts in 5 years:

Year	2016 (Baseline)	2017	2018	2019	2020	2021
Scale up of Minimum ADH Service Package	24%	30%	42%	50%	55%	62%
Cost of a Minimum ADH Service Package	-	$1,150,113	$5,524,654	$2,669,907	$1,779,936	$1,334,568
TOTAL						**$12,459,198**

[5] Indicative Budget Details can be viewed in Appendix 5

2 INTRODUCTION

Zambia has made strides in making Adolescent Health (ADH) an integral part of the nation's health agenda. The Ministry of Health (MOH) of Zambia has over the years championed the notion that "adolescents are neither older children, nor are they young adults" (WHO, 2015)[6], but that they represent a distinct group of individuals aged between 10 to 19 years (WHO, 2001)[7]. They are further divided into "early adolescents" (10 -14 years) and "late adolescents" (15 – 19 years).

This Strategywill be implemented within the framework of the National Health Strategic Plan (NHSP) 2017 to 2021. It is closely linked to relevant sector and national policies and strategic frameworks such as the 2012 National Health Policy, the 2010 National Population Policy, the 2015 National Youth Policy, the School Health and Nutrition Policy of 2006, the Revised Sixth National Development Plan (R-SNDP) 2014 – 2016,and the Vision 2030 Strategy for Zambia. It is also linked to relevant regional and global policies and strategic frameworks on ADH, like the Ministerial Commitment on Comprehensive Sexuality Education (CSE) and Sexual and Reproductive Health (SRH) Services for Adolescents and Young People in Eastern and Southern Africa (ESA, 2013), and the implementation of the Sustainable Development Goals (SDGs).

2.1 Review of past performance: ADH-SP 2011-15

The years 2011 marked an important milestone in ADH with the development of the first ever ADH Strategic Plan in Zambia. However, the Plan wasonly launched towards the end of the implementation period and this greatly affected its accomplishments. Nevertheless, a number of achievements were made, for example, the development of the Adolescent Friendly Health Services (ADFHS)standards, for different levels,were defined[8]and guidelines were developed and disseminated to a number of provinces. Progress was alsomade around thedesign and implementation of adolescent responsive health services in 24% of districts with support from different partners, such as UNFPA in facilities covering four provinces, the 11 EU and UN supported Millennium Development Goal Initiative (MDGi) districts, and the 14 Adolescents & HIV Social Cash Transfer Learning Initiative (ACTLi) districts supported by UNICEF.

[6]World Health organization 2015 policy Brief

[7]World Health organization 2001 Improving Adolescent Health and Development

[8] The definition of the Adolescent Health Platform is around the system for delivering ADH services at District level and Health Centre level. The National Standards and Guidelines for Adolescent Friendly Services describes the 'basic essential' clinical health services to be provided to the adolescents and a 'comprehensive health package'. The basic is focused on HIV, SRH services, and incudes the provision of information/BCC and Counselling on nine issues and services on four: Family planning (FP), antenatal care (ANC), Post-natal and Nutrition; and now HIV testing and counselling, with referral for all else. The comprehensive package indicates the availability of all the services at a health facility. In this Strategy, we are defining "minimum platform" not by the services at the facility, but based on availability of trained health workers, peer educators, adolescents' space and a management mechanism at district level (details in annex 1).

3 BACKGROUND

3.1 Rationale

Adolescents comprise about one-fifth of the world's population (UN Population Division, 2015). By the end of 2015, the proportion of adolescents in Zambia stood at 25% (CSO, 2014). They are a key population group where a triple return on investment can be obtained through improving health and survival during adolescence itself; through lasting impacts on their later adult health; and through the intergenerational transmission of health potential to their children. These health gains and emerging economic opportunities can be turned into a valuable demographic dividend that can boost a country's chances of attaining the development goals outlined in Vision 2030 and will break the intergenerational transmission of inequities (UNFPA 2015[9];WHO, 2016[10]).

At global level, the implementation period for the Millennium Development Goals (MDGs) expired and paved the way to the Sustainable Development Goals (SDGs) in 2015. A day after the launch of the SDGs, the Global Strategy for Women's, Children's and **Adolescent's** Health was launched by the United Nations (UN) Secretary General; with the health of adolescents as an important priority of this new strategy.

Locally, adolescents continue to face a number of health issues with access to sexual and reproductive health services (SRH)still a challenge for many adolescents. The ages of consent to various SRH services has been identified as an ongoing issue, while non communicable diseases, particularly those relating to nutrition and sedentary lifestyles, areemerging problems. Health risk misconceptions and limitedknowledge of available health services also affects adolescent utilization of services while some policies and legal frameworks also restrict access.

The ADH Strategy 2017 - 2021 has therefore been developed in response to these changes and emerging challenges. It is framed as a strategic framework with three main components, focused on service provision, demand creation and leadership for the delivery of a comprehensive and coordinated national response forZambia's adolescent population following the expiration of the ADH-SP 2011-2015.

3.2 Process

This plan has been developed by MOH and its key partners through a consultative process that provided for active participation and contributions from the key stakeholder groups. The strategic planning process included the following main stages:

Preliminary data collection and analysis: Literature reviewed included the ADH-SP 2011-2015 and other relevant national, regional and international policies, strategic frameworks and performance reviews relevant to ADH. Data from the MOH Health Management Information Systems (HMIS), the Zambia Demographic Health Survey (ZDHS) conducted overtime, and the Central Statistical Office (CSO) 2015 Living Conditions Monitoring Survey (LCMS), as well as other relevant sources such as UNAIDS, UNFPA, UNICEF and WHO were analysed for trends that formed the basis for the situation analysis. An outline of the strategic plan was then produced.

[9] UNFPA 2011 Strategy on Adolescents and Youth

[10] The World Health Organisation, 2016: Global Accelerated Action for the Health of Adolescents (AA-HA!): Implementation Guidance DRAFT

*Strategic Planning Workshop:*A five day strategic planning workshop was held in Chongwe comprising key stakeholders where the initial draft was consolidated.

*Validation Process:*The draft was presented to a representative group of adolescents from across Zambia for inputsand validation at a meeting held in Kabwe. The second last draft was presented to the Adolescent Health Technical Working Group before finally being presented to the Director Public Health for presentation to the MOH Permanent Secretary – Health Systems and Minister of Health for approval and endorsement.

4 SITUATION ANALYSIS

4.1 Social-economic Determinants of Adolescent Health

4.1.1 Population

In 2015 Zambia's population was estimated at 15.5million, with 58% of it rural and 42% urban (CSO, 2014[11]). Early adolescents (10-14 years) account for 15.5% of the total population (16% males and 15% females), while late adolescents (15-19 years) represent 9.5% (9.7%, males and 9.4%females). Overall, they represent approximately 25% of the total population (about 3.9 million).

Economic activity of population

Of the total population, 43% of the population aged 12 years and above are in paid employment and therefore adolescents contribute significantly to the country's economy. Between 2013 and 2014,19.4% of females and 36.5% males aged 15-19 were in formal employment (CSO, 2014).

4.1.2 Poverty

In the general population, 54.4% people live below the poverty line, more so in rural areas (76.6%) than in urban areas (23.4%). This is a reduction from 2010 statistics when it was 60.5%. Western Province has the highest number at 82.2%, followed by Luapula Province at 81.1%. Lusaka Province has the least at 20.2% (CSO, 2016).Data on actual poverty levels affecting adolescents is not available but it is assumed that they are similar to these.[12]

4.1.3 Adolescents Living Arrangementsand Orphanhood

Among early adolescents, aged 10–14, approximately 17% has lost one or both parents while among the 15–17 year olds, this was 24% (ZDHS - CSO, 2014). Orphanhood has a major impact on the general wellbeing including access to health, education, financial resources and increases vulnerability to risky behaviours as well as acquisition of HIV. For example, 53% orphaned adolescents aged between 10 and 14 years have never attended school (MOGE, 2015).[13]

[11] CSO, 2014: Central Statistical Office (CSO) [Zambia], Ministry of Health (MOH) [Zambia], and ICF International. 2014. *Zambia Demographic and Health Survey 2013-14.* Rockville, Maryland, USA

[12] Central Statistical Office, 2016: 2015 Living Conditions Monitoring Survey Key Findings

[13] Ministry of General Education (MOGE[9]) 2015 Educational Statistical Bulletin

4.1.4 School attendance and Literacy levels

Education and high literacy levels increase access to information and greatly influences ones choices and behaviour(CSO, 2014).

The *Living Conditions Monitoring Survey (LCMS)* [CSO, 2016] showed that school attendance rate for children aged 7-13 years (i.e. primary school attendance) increased from 78% in 2006 to 82.8% in 2010, and 83.1% in 2015. Similarly, the school attendance rate for secondary school-aged adolescents (14-18 years) increased from 74% in 2006 to 77.2% in 2010 and then dropped to 75.7% in 2015.

While there are no visible differences between the sexesup to the age of 12 years (around Grade 6), starting from the age of 13 (Grade 7) and coinciding with puberty, the proportion of girls dropping out of school is much higher than boys. Age 13-14 is also when the transition from Grade 7 to Grade 8 occurs marking the end of primary education (UNICEF, 2013[14]).

There is a tremendous drop in proportions for tertiary school attendance between both sexes, though there are still more males than females attending school. For example in 2015, among the 19 – 22 year olds, tertiary school attendance was 29.4% (34.0% urban and 25.4% rural), with statistics for females at 22.5% and males at 36.5% (CSO, 2014).

According to the 2013-2014 ZDHS (CSO, 2014), men are more likely to be literate than women. Literacy is highest among men aged 15-24 (85%), more so among urban men living in Lusaka (93%). Literacy levels among adolescent males aged 15 – 19 years is 82.3% and 78.8% among females in the same age group.

4.1.5 Exposure to MassMedia and Usage of Information and Communication Technologies

Overall, global access to information and communication technology (ICT) has improved for the general population, as witnessed even in the Zambian setting. However, data on adolescent access to and use of ICT are minimal, and standards and definitions that would aid data analysis and comparison across countries are lacking (UNICEF Zambia, 2013).

Exposure to mass media by 15-19 year old females is 11.7% and 15.3% in males (CSO, 2014) with the radio being the most common form of media that both groups utilize.

Table 1: Exposure to mass media

Category	Exposure to all media	Radio	Television	Newspaper
15-19 year old females	11.7%	49.1%	43.1%	25.8%.
15-19 year old males	15.3%	60.2%	46.3%	27.8%

(ZDHS 2013 – 2014)

In the general population, access to mobile phonesis around 64.5% of Zambian households determined by at least one member of the household owning a mobile phone. Further, about

[14] United Nations Children's Fund (UNICEF) 2013: A Report Card On Adolescents In Zambia

51% of people aged above 10 years in Zambia are active users of mobile phones. Only 13.5% of the individuals that own mobile phones have smartphones. About 71% individuals that own smartphones use the devices to access social media applications like WhatsApp, Viber, Facebook, Skype and Twitter for communication using instant messaging or voice calling (ZICTA, 2015[15]).A large proportion of internet users (63%)are members of at least one social media network similar to the proportion reported in 2013 of 64.3%. Of these, most are on Facebook (91%) followed by WhatsApp (60%) and Blackberry messenger (15%).

4.2 Adolescent Health Situation

4.2.1 Health status and health seeking behaviours

Adolescents' use of health services can be highly influenced by the social values and attitudes (perceived or real) of their peers, parents and other adult gatekeepers including clinicians (WHO, 2015[16]).In the general population, 17.9% rural population and 9.1% urban population reported having been unwell within two weeks of the LCMS survey, with 70.5% persons who reported an illness having consulted over their illness (medical, traditional, church, spiritual institution) while 19.7% resorted to self – administered medication. About a tenth of those who were unwell neither consulted nor used self-administered medicine. Of those who consulted medical institutions, 40.5% were seen by clinical officers, 35.0% by nurses/midwives and 17.1% by medical officers. This pattern was generally the same in both urban and rural areas(CSO, 2015).

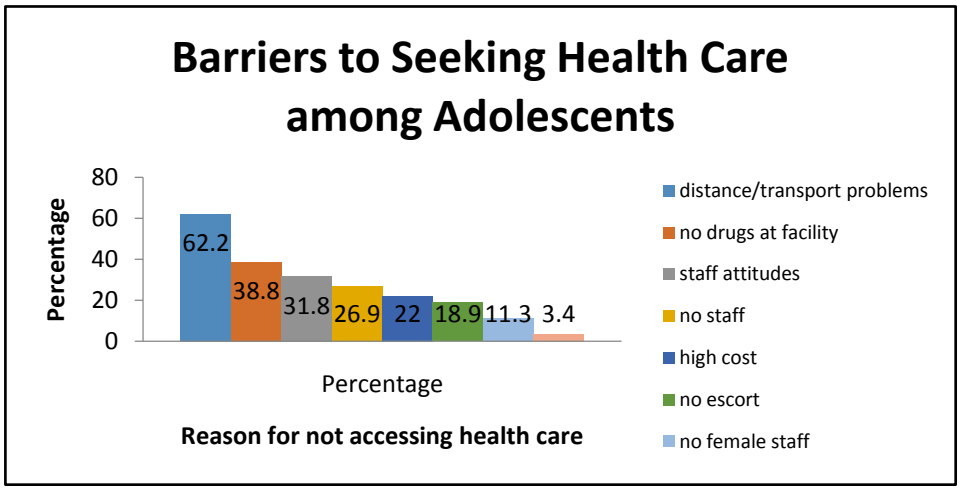
4.2.1.1 Barriers to accessing health care among female adolescents:

In the 2013-14 ZDHS, women were asked whether or not each of the following factors would be asignificant problem for them in seeking medical care: getting permission to go for treatment; gettingmoney for treatment; distance to a health facility; having to take transport, not wanting to go alone;concerns that there may not be a female health provider; concerns that there may not be any health provider; concerns that there may not be drugs available for treatment; and then concerns about rude attitudes among health providers. Among 15-19 year olds, the majority(65.2%) gave distance and transportation problemsas being major issues. Details of the barriers to accessing health care are as shown in the graph below (CSO, 2014):[17]

[15]Zambia Information and Communications Technology, Central Statistical office, Ministry of Transport and Communication, 2015: ICT Survey Report - Households and Individuals 2015.

[16]World Health Organisation 2015 Policy Brief.

[17]Apart from the "CSO, 2015" which is the 2015 Living Conditions Monitoring Survey Key Findings, the remaining "CSO" documents are the Zambia Demographic Health Survey documents with the latest being the ZDHS 2013-2014.



(ZDHS 2013 – 2014)

It is important to note that the healthcare providers' attitudes are among the major constraints and affect 32% of adolescents.

4.2.2 Sexual and Reproductive Health (SRH)

Adolescence is a period when many young people begin to explore their sexuality, hence access to sexual and reproductive health information and services is necessary for their well-being. Early unprotected sex, including sex with older men, can result in early child-bearing, and increases the risk of HIV infection (UNICEF, 2015).

In Zambia, approximately 7.2% of sexually active girls, aged 15-19, reported having had a sexual partner who was 10 or more years older than they were in 2013-2014 (CSO, 2014). The NHSP2017-2021 (MOH, 2017[18]) has highlighted the high adolescent birth rate (estimated at 141 crude birth rate (CBR) in 2013-14 (CSO, 2014) despite a downward trend from the 2007 ZDHS which was 146 (ZDHS-CSO, 2008[19]). In 2013-2014, approximately 18.5% of adolescent girls aged 15-19 were married, 28% had started childbearing, while 5% were actually pregnant during the survey. The MOGE recorded a five times increase in teenage pregnancies among girls in grades 1-12 between 2002 and 2015 (from 3,663 to 15,125) This data clearly points to the need to prioritize access to adolescent responsive health services for girls in Zambia.

Table 2: Exposure to Family Planning (FP) Messages:
Adolescents get exposed to FP messages mainly from the radio, followed by television and lastly through written/print media(CSO, 2014):

Table 2: Mode of Exposure to Contraceptive Messages

Category	Radio	television	Written/Print media
Female	22.4%	16.8%	8.6%
Male	22.4%	16.1%	9.5%

(ZDHS 2013 – 2014)

[18]Ministry of Health of Zambia, 2017 – 2021 Zambia National Health Strategic Plan.
[19]Central Statistical Office,Ministry of Health, Tropical Diseases Research Centre, University of Zambia, MEASURE DHS, Macro International Inc. Zambia Demographic and Health Survey 2007.

Table3: Use of Contraceptive Methods:
Among 15-19 year old females, the overall use of any FP method was 10.6% and was higher among women who were currently married (37.5%) than those who were unmarried and sexually active (18.6%). Overall condom use as a family planning method was very low at only 4.4% among married adolescents and at only 8.7% among unmarried sexually active females. Details of FP use among 15-19 year old women are as shown in the table below:

Table 3: Use of Contraceptives among Female 15 – 19 Year Olds

Category	Any method	Any modern method	The pill	Male condom
Overall (all 15-19 year olds)	10.6%	10.2%	1.7%	1.9%
Currently married	37.5%	35.8%	6.4%	4.4%
Unmarried but sexually active	18.6%	17.6%	3.1%	8.7%

(ZDHS 2013 – 2014)

Use of FP methods was higher among urban than rural women. This is probably due to wider availability and easier access in urban settings. Similarly, condom use was about twice the rate in urban areas compared to rural areas. In the general population, Lusaka Province had the highest FP usage (58%) while Western Province had the lowest (33%). Contraception use was noted to increase with increasing levels of education (CSO, 2014).

Unmet need for FP is highest among women 15-19 years at 25% (rural 24% and urban 17%). Luapula Province has the highest unmet need and Lusaka Province has the least (CSO, 2014). The disaggregated health information data on use of FP among adolescents from the MDGi supported districts shows that very few adolescents are accessing FP services to prevent their first pregnancy, but rather use FP as a means for planning their second pregnancy.

4.2.2.1 Child Marriages, Sexual Debut and Teenage Pregnancies

Child and early marriage is a significant issue in Zambia, with 17% of adolescent girls aged 15-19 being in-union in 2014. Among adolescent boys of the same age group, only 1% reported having been married. This data demonstrates a very high level of age disparately among adolescents' marriages, which has been shown to be a high risk context for HIV transmission. There was a decrease in the proportion of 20-24 year old females who reported having been married by age 18 from 42% in 2007 to 31% in 2013-2014. Overall, the median age at first marriage among females 25-49 years is18.4 years and 23.9 years among males in the same age group.

Zambian women generally initiate sexual intercourse a year before marriage, while men do so at least five years before first marriage. There were significant differences among provinces with Western Province showing a median age for girls at first sex of 16.5 years while Lusaka Province showed a median age of 18.2years. Girls who completed secondary school initiate sex later than those with little education (20.9 years vs 16.6 years).

The table below shows the proportion of 15-19 year olds who admitted to having first sex before 15 years:

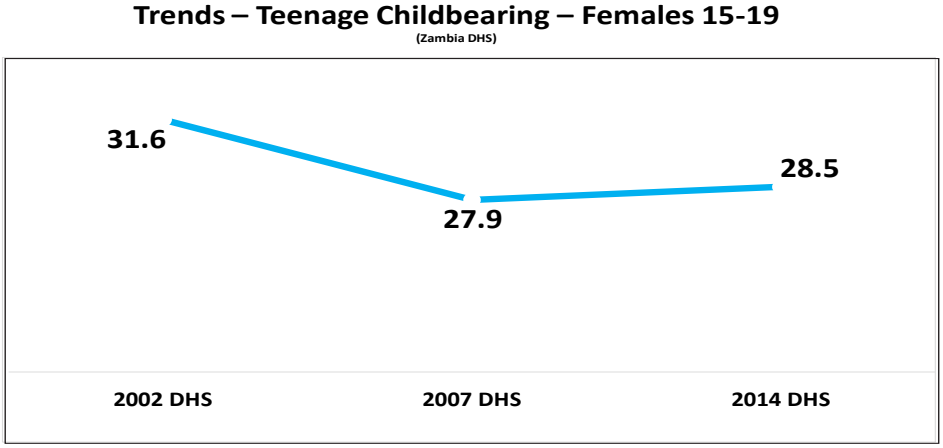
Table 4: Proportion of 15-19 year olds who had Sex before Age 15

Sex	Overall 15-19	15-17 years	18-19 years
Females	11.7%	12.4%	10.8%
Males	18.3%	18.9%	17.5%

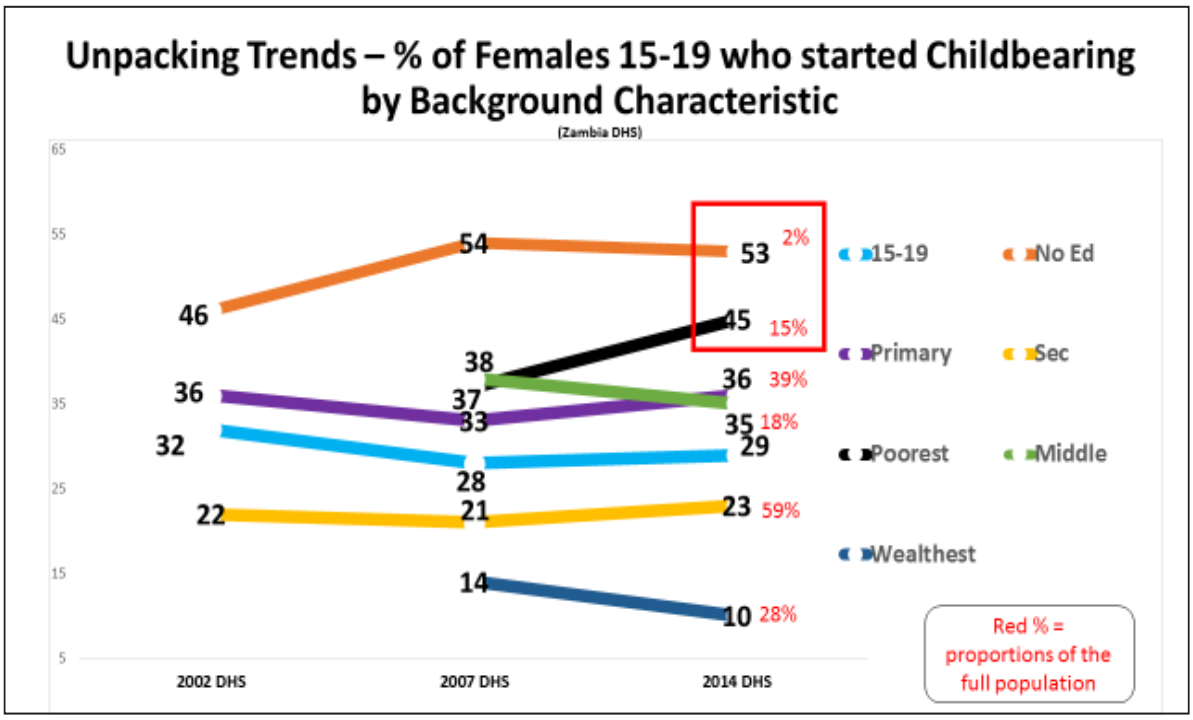
(ZDHS 2013 – 2014)

Overall, 38% of non-married adolescent girls and 32% of adolescent boys aged 15-19 reported that they had had sexual intercourse in 2014. This supports a two prong response – with prong one of the strategy to prioritize sexually active adolescents, to support them to increase their access and utilization of contraceptives, especially condoms, FP and HIV services. The second prong, which requires a multi-sectoral response, led by the Health, Education and Youth sectors, should focus on the 60% of adolescents who are not yet sexually active. The focus would be on developing the skills adolescents needed to continue to delay sexual debut and their capacities around risk reduction practices, for when they do become sexually active.

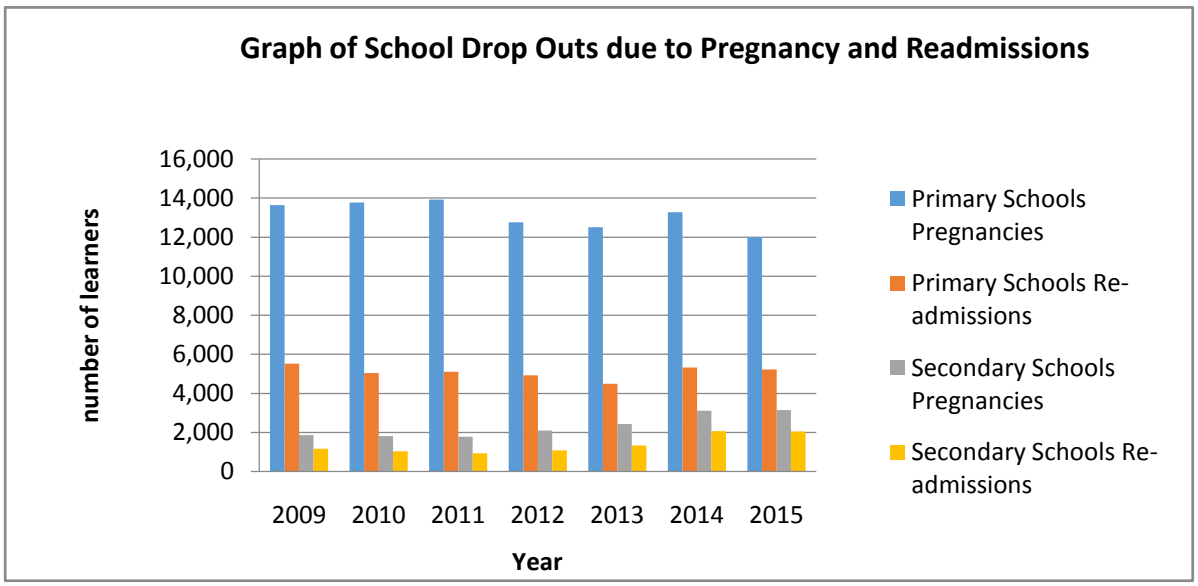
The NHSP2017-21 has highlighted the fact that Zambia has the fifth highest adolescent birth rate in sub-Saharan Africa, a region which has the highest rates in the world. As the graph below demonstrates, teenage child bearing remains very highat 28.5%. This is a slight increase from the 2007 ZDHS (CSO, 2008) of 27.9% and a decline from the 2002 ZDHS of 31.6%.



Further unpacking of the ZDHS 2013-14 teenage pregnancy data (see graph below) shows that teenage childbearing was highest among adolescent girls with no education (at 53%) and from the poorest families (45%). Childbearing was 36% among girls with primary education, 23% among those with secondary school education and only 10% of adolescent girls from the wealthiest households.In the graph below, of significance for the ADH Strategy, are the figures in red. These show, for example, that adolescent girls with secondary education accounted for 59% of all the girls who had started childbearing. In addition, although only 10% of girls from wealthy households started childbearing they account for 28% of all adolescents girls, while poorest girls only account for 15% of all girls. Thegirls from wealthy households have significantly higher levels of reproductive health knowledge compared to the others, but still account for a significant amount of the childbearing!This means it will be important to ensure that the programming under the strategy applies a differentiated response for both poor girls with only primary education and girls from more well-off households with some secondary education.

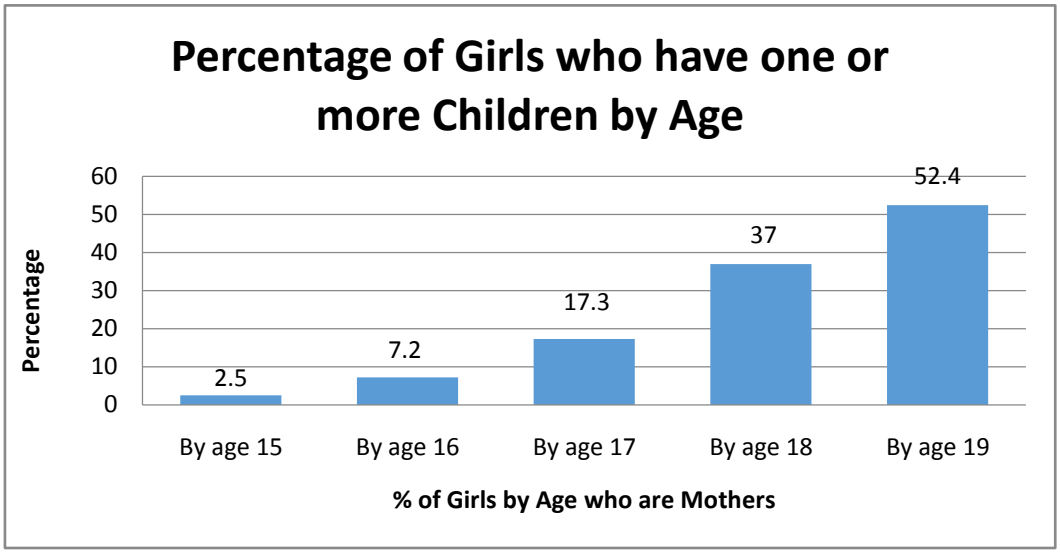


Among school going girls, adolescent pregnancies have been a matter of growing concern, with the numbers showing an upward trend from 13,654 among primary school going girls in 2009, reaching a peak of 13,929 in 2011, to 11,989 in 2015as can be seen in the graph below. Among secondary school girls, there has been an upward trend from 1,863 in 2009 to 2,096 in 2012, to 3,136 in 2015. This has resulted in a lot of school drop outs with very few seeking readmission, especially among girls in primary school (MOGE, 2016).



Source: Ministry of Education Statistics 2016

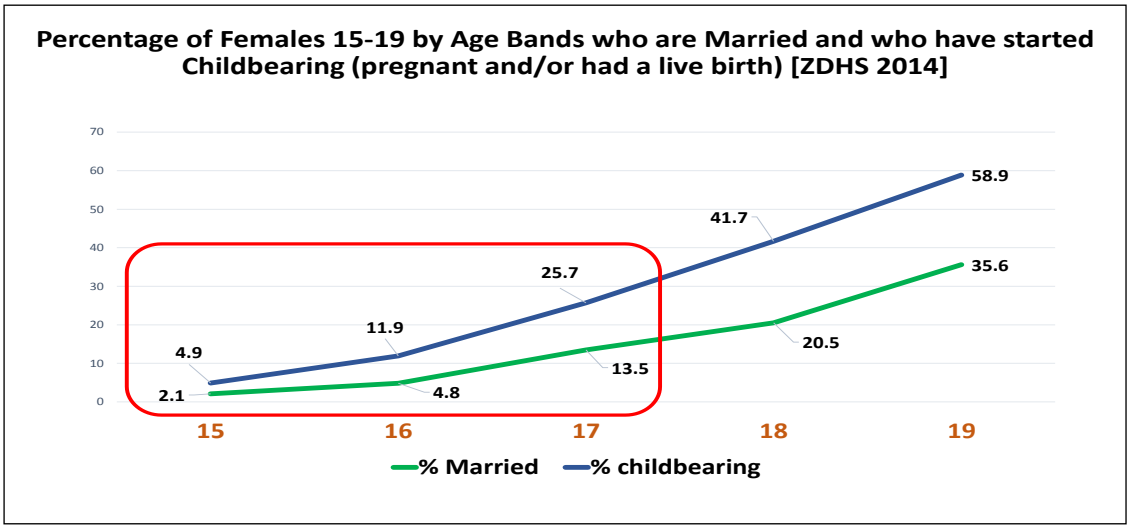
The proportion of adolescent girls reporting a live birth rises with increasing age, from less than 3% at age 15 to approximately one in 5 by age 17 to over 5 out of 10 girls by the age of 19 years. This high prevalence would seem to suggest to adolescent girls that it is quite 'normal' to become a young mother with half of adolescent girl's already mothers by age 19. Of note is the significant increase in live births between ages 15 and 17 among adolescents,from approximately one out of every 20 girls aged 15-year olds to one out of every four 17 year olds:



(ZDHS 2013 – 2014)

The strong association between early childbearing among adolescents and early marriage is demonstrated in the graph below. The data shows that there were 4.9% of 15 year olds who had started childbearing and 3.9%, who were also married. Among 17 year olds, 26% had started childbearing and 14% were married. Overall, in 2014, there were approximately 244,000 adolescent girls who had started motherhood and approximately 159,000 adolescent girls who were married. Around 69,000 of the girls who had started childbearing were below the age of 18 and approximately 33,000 of the married adolescent girls were below the age of 18.[20] The significant number of pregnant adolescent mothers needs to be prioritized within ANC services, including within the Prevention of Mother to Child Transmission of HIV (PMTCT) service (especial across prongs one and two - HIV prevention and family planning, as well as prongs 3 and 4 - HIV testing and treatment), as both the mother and unborn child are high-risk clients. This also applies to maternal, child health and nutrition services, as children of adolescent mothers are often underweight, face immunization and nutritional challenges, and both the adolescent mother and the child face significant morbidity and mortality risks.

[20] Estimated numbers generated by UNICEF Zambia through a calculation done with the ZDHS adolescent marriage and childbearing data, applied to the Zambia census projection numbers.



The 2014 ZDHS also found that 44.7% of women under the age of 20 had an unplanned pregnancy at the time of the survey. There is a strong link between unwanted pregnancies and unsafe abortions. Despite abortionsbeing legal on specific medical grounds, under The Termination of Pregnancy Act, enacted in 1972 (Chapter 304 of the Laws of Zambia) and amended in 1994 (GRZ, 2009[21]), studies have shown very limited knowledge of the provisions of the law by both the general public and health professionals alike. In one study, only 16% of the women interviewed showed comprehensive knowledge about the stipulations of the law (Owolabia et al, 2016[22]). This lack of knowledge is reflected in the limited number of medical abortions being undertaken by women generally with a large proportion estimated to be unsafe.Another study cited fear of parental disapproval especially among adolescents as another reason for them not seeking medical abortions (Cresswell et al, 2016[23]). This is also contrary to the National Youth Policy that aims at strengthening commitment to and support for the SRH and rights, and needs of adolescents and youth[24].The actual statistics of adolescents/women seeking unsafe means to abort are unknown.

4.2.2.2 Deliveries by Pregnant Women under 20 years of age

Women living in urban areas are more than twice as likely to give birth at a health facility, as compared to women in rural areas. While most deliveries in rural areas (66.5%) are at home, most deliveries in urban areas (79.0%) occur at a health facility. One reason for this is the significantly lower number of health personnel in rural areas compared to urban areas. According to the R-SNDP 2013-2016, the number of deliveries conducted by skilled personnel was 31.0% in rural areas compared to 83.0% in urban areas (MOF, 2014[25]).

In 2013-14, one in four pregnant females under the age of 20 delivered at home (CSO, 2014). Long distance from the nearest health facility was cited as the commonest reason (32.1%). Other reasons included high cost of services (3.4%); absence of a female provider at the health facility (1.2%) and facility not open (0.8%).

[21] Ministry Of Legal Affairs, Government Of The Republic Of Zambia The Termination Of Pregnancy Act Chapter 304 Of The LawsOf Zambia

[22] Owolabia, O. O., Cresswell, J. A., Vwalika, B., Osrinc, D. and Filippi, V. 2016:Incidence of abortion-related near-miss complications in Zambia: cross sectional study in Central, Copperbelt and Lusaka Provinces. Elsevier Inc.

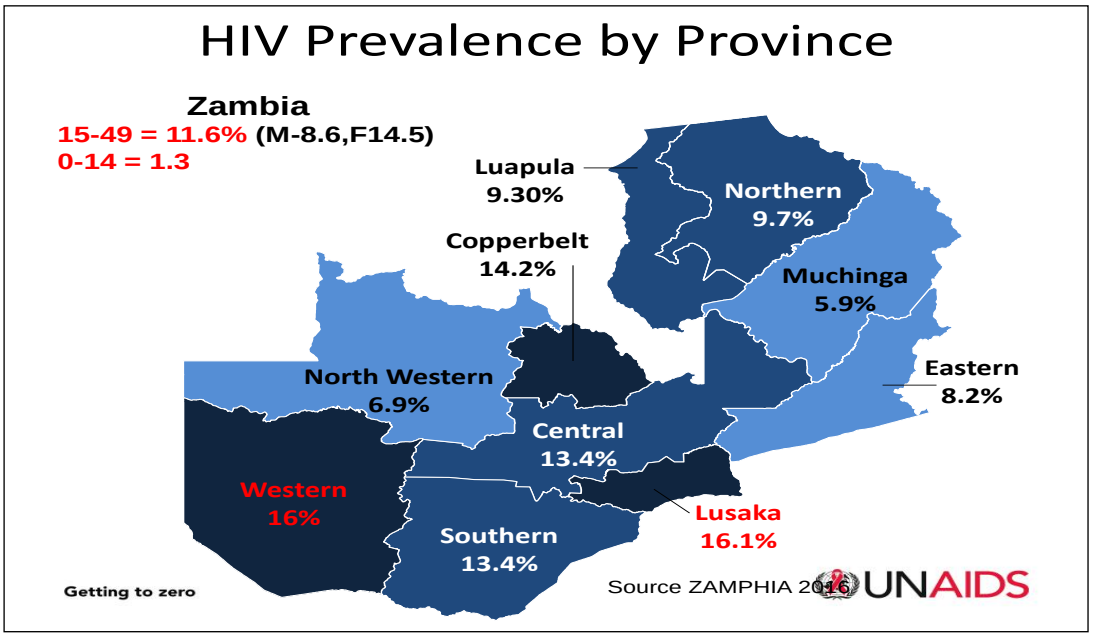
[23]Cresswell J. A, Schroeder R, Dennis M, et al. Women's knowledge and attitudes surrounding abortion in Zambia: a cross-sectional survey across three provinces. BMJ Open 2016;6: 010076. doi:10.1136/bmjopen-2015-010076

[24] The 2015 National Youth Policy of the Ministry of Youth and Sport

[25]Ministry of Finance, 2014: The Revised Sixth National Development Plan 2013-2016

Fistula, a condition that develops when there is damage to the tissues of the vagina, bladder, and/or rectum during prolonged obstructed labour, resulting in the formation of an opening between the bladder or rectum and the vagina through which urine and/or faeces pass uncontrollably, is a cause of worry in all women and particularly adolescents. The 2013-14 ZDHS reported knowledge about this condition by only 19.2% adolescents.

4.2.3 HIV/AIDS

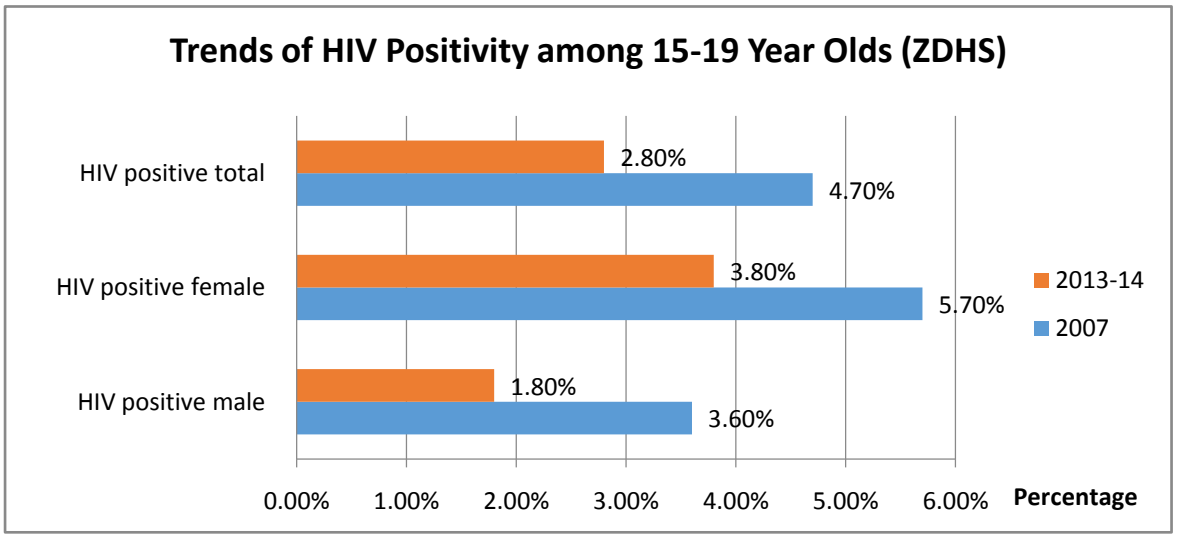


Globally, HIV/AIDS was the leading cause of death among both sexes in the age group 10 – 14 years. It was the third leading cause of death among females and fourth among males aged 15 – 19 years. Overall among all adolescents (10 – 19) AIDS as a cause of death is ranked second only to road injury (WHO,2016)! While deaths due to AIDS have decreased for all other age groups since 2010, among adolescents deaths have actually increased. The majority of these deaths are among maternally infected adolescents who were either long-term progressors who had not been diagnosed until they were very ill or were adolescents who, when transitioning from paediatric to adult ART care, had significant adherence challenges and then experienced treatment failure (UNICEF, 2016)[26].

Statistics from within Zambia on the actual current HIV prevalence among early adolescents is scarce. Among the 15 – 19 year olds there is disaggregated trend data available from the Zambia 2007 and 2014 DHS[27]. HIV prevalence among adolescents, like in the general population, has declined from 5.7% to 3.8% among females and from 3.6% in 2007 to 1.8% in 2014 among males (see footnote 24 below). However, the degree of viral suppression among adolescents has been noted to be very low due to poor adherence. Therefore an area of importance in the strategy will be responsive ADH servicesfor adolescents living with HIV.

[26] United Nations Children's Fund, 2016: For Every Child End Aids Seventh Stocktaking Report

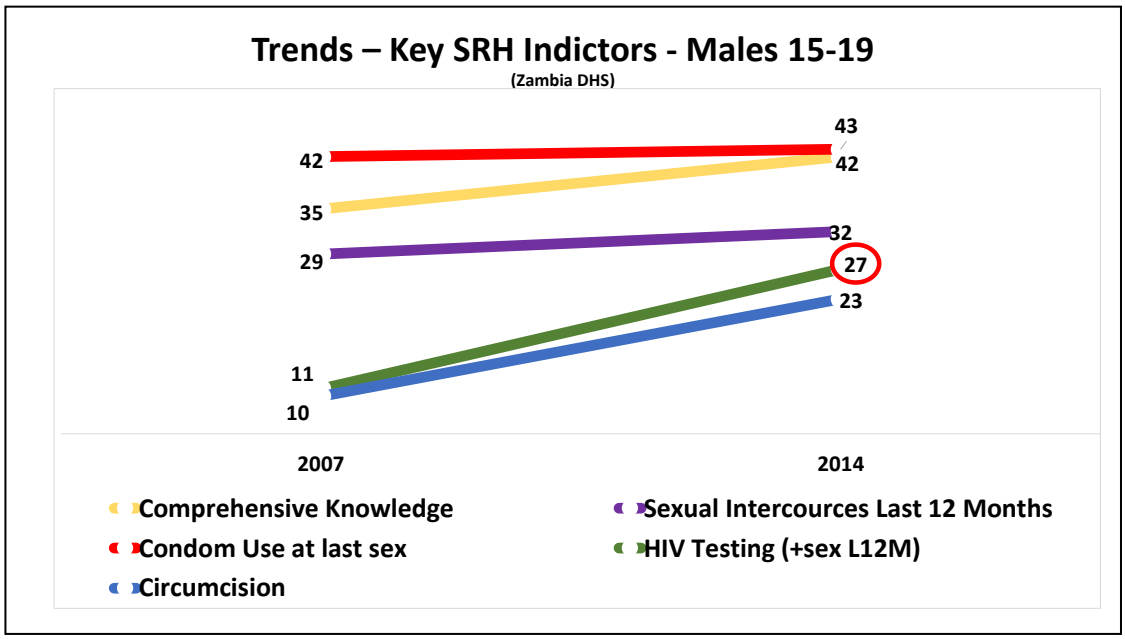
[27] The Zambia Central Statistical Office, based on the results of the 2016 ZAMPHIA study recently supported a reanalysis of the DHS data. This lead to a downward revision of the 2014 HIV prevalence data from 15.1% for females 15-49 to 13.6% and for men 15-49 from 11.3 to 8.5% (Confirmatory HIV Testing on Specimens from the 2013-14 Zambia DHS, CDC, UTC, CSO, UNAIDS Zambia March 2017).



The transition from late adolescence to early adulthood shows a significant increase inHIV infection risk, with HIV prevalence going from a low of 3.8% for females and 1.8% for males aged 15-19 to 9.6% for females and 3.5% for males aged 20-24. Condom use (see below) also remains low. Therefore progress will need to be made around increasing adolescents' (and young adults') use of condoms, a high impact HIV intervention, in order for Zambia to have a significant impact on reducing new HIV infections. In addition, with around 1 in 30 adolescents aged 15-19 living with HIV, it is very critical that the ADH Strategy has a significant focus on provider initiated HIV testing for at risk adolescents. Adolescents living with HIV also need prioritized support to ensure they are initiated into ART services and then supported with adolescent responsive adherence support, as well as sexual health and psycho-social support. Those who are pregnant need support on PMTCT, infant nutrition and care.Other vulnerable adolescents in need of special attention and support in terms of HIV prevention, care and treatment are young sex workers, adolescents with substance abuseissues and adolescents living with disabilities.

Awareness of some modes of HIV transmission and HIV misconceptions among adolescents, aged 15-19,is around 80%. About 30% of themstill think mosquitoes can transmit HIV! Comprehensive knowledge among adolescents, defined as correctly identifying in a survey the three modes of HIV transmission and the two common misconceptions, remains low in Zambia at 39% for females and 42% for males, which is significantly below the 90% target recommended by international standards. In addition, understanding of mother to child transmission of HIV (MTCT) among 15-19 year olds was only 62% among females and 44% among males in 2014.

Although adolescents' knowledge of condoms as an HIV prevention method is high, at 79%, this has not resulted in increased reported condom use at last sex, which was only 36% for females and 42% for males, aged 15-19, in 2014. These percentages did not increased between the 2007 and 2014 ZDHS. Of noteis that HIV testing among sexually active adolescents,aged 15-19, did increased by 150% between 2007 and 2014 for both females and males, from 20% to 50% for females and from 11% to 27% for males. In addition, male circumcision also increased by130% during the same period. The disparity between the increases in the use of some HIV services compared to others points to systems integration challenges and suggests that HIV testing and counselling (HTC) and voluntary male medical circumcision (VMMC) services are not effectively promoting condom use among adolescent clients

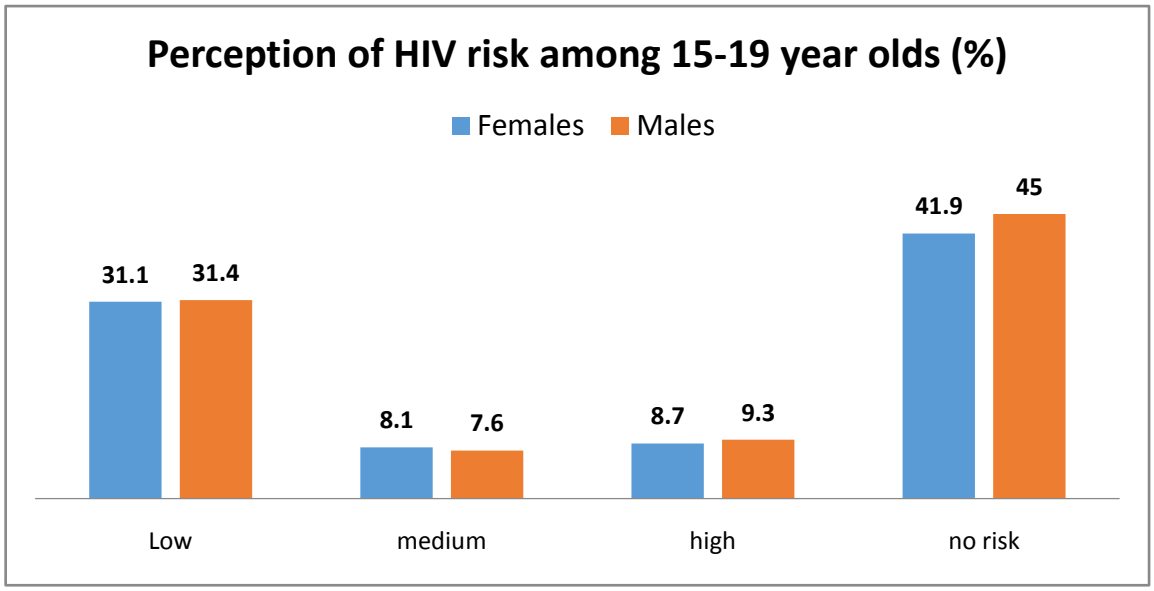


(Prepared by: UNICEF Zambia, 2016).

Other factors for low/ inconsistent condom use could be due to limited availability, as noted from the Baseline Health Facility Assessment data from the MDGi programme (2014) where 93% of facilities reported having had a stock out in the three months prior to the assessment.

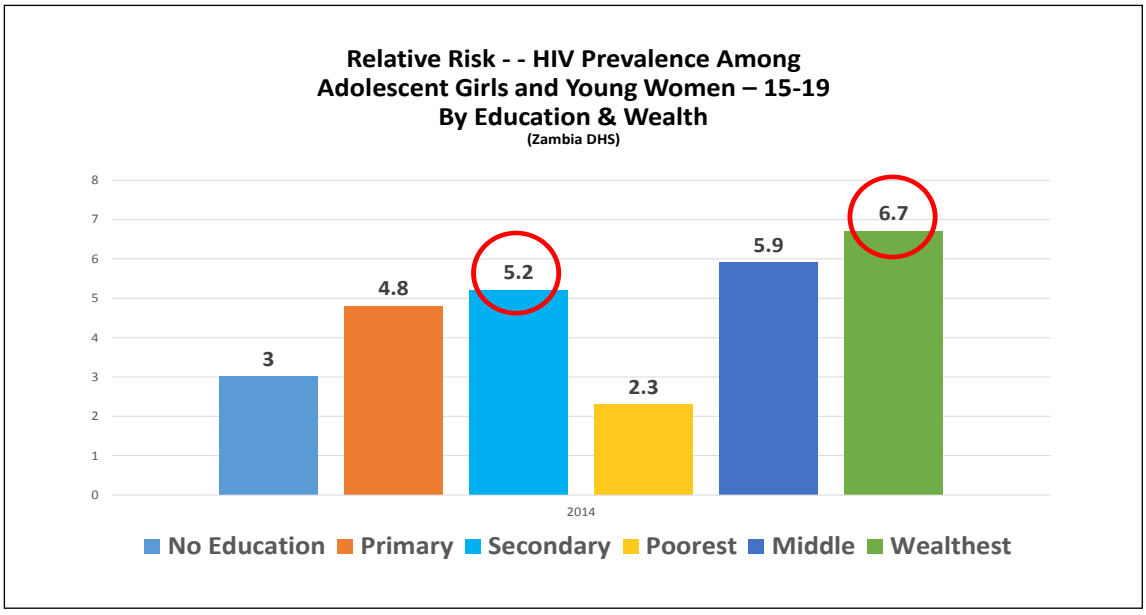
Young women's ability to negotiate condom use is often cited as another reason for low levels of use. However, according to the 2014 ZDHS, 74% of females, aged 15-19, believe that they could refuse sexual intercourse, or would at least ask their partners to use a condom, if they thought that they had been unfaithful or may have an STI, which suggests a high level of perceived ability to negotiate condom use.

With an 8% increase in adolescents having sex between 2007 and 2014, coupled with the low condom usage, there wereapproximately 151,000 non married adolescent boys and 118,000 non married adolescent girls who are sexually active and not using condoms in 2015 and therefore frequently putting themselves at risk of HIV infection (and teenage pregnancy). Despite this data, a significant proportion of them perceive themselves to be generally at low or norisk of contracting HIV, as shown in the graph below:



(Source: ZDHS 2013 – 2014)

HIV prevalence in Zambia is higher among adolescent girls with some secondary school education and among those who come from wealthier households (CSO, 2014).Girls from these households report higher levels of comprehensive HIV knowledge and report slightly higher rates of condom use (but this use is probably not consistent use). The fact that their HIV prevalence is higher is cause for concern. It could be that the common discourse around HIV risk and poverty has created the perception among urban, educated and wealthy adolescent girls that they and their partners are not at high risk of HIV infection[28].



The data in the graph above suggests the need for a differentiated HIV prevention response targeting the different categories of adolescent's girls, who also have varied levels of

[28]Note – this analysis was done with the original ZDHS 2013-2014 HIV data. This data also showed that among all women 15-49, the largest groups reporting themselves to be of low risk of HIV are those with secondary and post-secondary education and those from the wealthiest households – ZDHS 2013-14.

knowledge, skills and agency, to increase their risk perceptions, risk avoidance and risk reduction skills and behaviours[29].

4.2.4 Gender Based violence

Gender Based Violence (GBV), which includes, sexual, physical, psychological, economic, social/cultural violence, is a common problem throughout the world. It is defined as any harmful act that is perpetrated against a person's will and is based on socially ascribed (gender) differences between males and females" (IASC, 2005[30]). In addition, the Council of Europe includes the following as part of gender based violence: forced sterilization, forced abortion, coercive use of contraceptives, female infanticide and parental sex selection" (MOH, 2015[31]).

Ever experienced physical violence is reported by 29.3% of 15-19 year olds. It is also noted to be higher among females aged 15-49 who are married (48.4%) compared to 26.5% among those who have never been married (CSO, 2014). The frequency of physical violence is a mental and physical health indicator, with 13.2% of females 15-19 having reported experiencing physical violence 'often or sometimes'. Intimate partner violence is the predominant physical violence context, with current husbands/partners (63%) and former husband/partners (29%) the main perpetrators of physical violence. The third highest perpetrator are 'mothers', at 8.9%. Among never married females, 'mothers' account for 28% of the perpetrators of physical violence, hence the need to put more efforts intoprogrammes to contextualize the concept of 'gender roles' when designing interventions to address social norms around physical violence.

In 2014, 8.2% of adolescent girls aged 15-19 had 'ever' experienced sexual violence, defined as a forced sexual act under the DHS, with 4.2% of these females having experienced sexual violence within the last 12 months. Table 6 presents disaggregated data on females 15-17 and 18-19 and their experience of either physical, sexual violence or both, as most sexual violence includes physical violence. Married adolescents reported significant higher rates of sexual violence at 13.2%. Only 36% of females 15-19 who had experienced physical and sexual violence had ever sought help to stop the violence. Among all women, their own family and/or partners family were the main source of help for addressing physical or sexual violence (69% own family and 43% partners family). Among all women, only 1.5% sought help for physical or sexual violence from a health provider, according to the 2014 ZDHS. This data has significant implication for the design of interventions under the ADH strategy to address both physical and sexual violence.

Table 5: Percentage of Females aged 15-19 who have ever experienced any form of violence

Age	Physical violence only	Sexual violence only	Physical and sexual violence	Physical or sexual violence
15-19	24.0	2.9	5.3	32.2
15-17	22.2	2.7	3.7	28.6
18-19	26.7	3.1	7.9	37.8

(ZDHS 2013-2014)

[29]See Footnote 27 above - on the recent reanalysis of the 2013-2014 ZDHS, which reduced the HIV prevalence among adolescent girls from 4.8% to 3.8%. The data in this slide was based on the previous prevalence of 4.8% with the assumption that the associations presented are still relevant.

[30] Inter-Agency Standing Committee (IASC): 2005 Guidelines for Integrating Gender-Based Violence Interventions in Humanitarian Action: Reducing risk, promoting resilience and aiding recovery

[31]Ministry of Health, 2015: Health Sector Strategy on Health & GBV 2015

4.2.5 Alcohol and Substance Abuse:

Adolescents experience intense physical, psychological, emotional and economic changes as they make the transition from childhood to adulthood. Many people have their first experience with tobacco, alcohol and illicit drugs during adolescence, partly out of a need to explore boundaries as they begin to develop their individuality (UNICEF, 2013).

Alcohol and substance abuse are linked to risky sexual behaviours leading to risk of acquisition of HIV and other STIs. There is a general perception of high substance abuse by many in and out of school adolescents, particularly those found to be on the streets ("street kids").

There was a general decline in reported alcohol use among adolescents from 9.1% in 2000 to 2.4% in 2009 for boys and from 8.4% to 1.3% for girls. Among 15-19 year olds, 5% of girls had sexual intercourse when drunk or with a partner who was drunk as opposed to 1.6% of boys in 2013-14. This was a drop from the Zambia Sexual Behaviours Survey (ZSBS) 2009, which reported an increase from 9% in 2005 to nearly 11% in 2009 among adolescent girls having sex while they or their partner were drunk in the 12 months prior to the survey.

The amount of cannabis seized by the Zambia Drug and Enforcement Commission (DEC) increased steadily from 2008, reached a peak in 2010, and thereafter showed a downward trend. Miraa/khat is the second most common substance being used after cannabis in Zambia with trends between 2008 and 2012 showing an upward swing. Seizures of drugs like cocaine and heroin have also been reported in Zambia. In 2012, the DEC reported seizures of 21.30 kilogrammes of cocaine and 431.44 grams of heroin. This was a notable increase over 1.29 grams of heroin seized in 2011. (DEC, 2012[32]).

The abuses of some substances, like alcohol or opiates, have significant implication for adolescent health, both in the short-term and in the longer term, in terms of their overall health status. Sexual intercourse when one or both partners are under the influence of alcohol is more likely to be unplanned, and couples are therefore less likely to use condoms.

4.2.6 Non Communicable Diseases

The health-related behaviours and conditions that underlie the major non communicable diseases usually start or are reinforced during the second decade: tobacco and alcohol use, diet and exercise patterns, overweight and obesity. These behaviours and conditions have a serious impact on the health and development of adolescents today but devastating effects on their health as adults tomorrow (WHO, 2014[33]).

4.2.6.1 Nutrition

Adolescents and nutritionare serious issues in Zambia. In the 2004 Zambia Global School Health Survey[34],31% of the females and 27% of the males reported that they had gone hungry most of the time during the previous 30 days due to nothavingenough food at home (based on a sample of 2257 learners from grade 5 to 7). Twelve years later, another study conducted in Mongu and Mumbwa districtsamong 410 adolescent girls aged 14 to 19 found that only 42% had breakfast regularly, and only 41% reported easy access to food at any time (WFP, 2016)35.

[32] Drug Enforcement Commission Annual Report 2011 – 2012

[33] World Health Organisation, 2014: Health for the World's Adolescents: A second chance in the second decade

[34]WHO.CDC/MOH/MOE

Table 6: Adolescent changes according to stage of development

Period	Characteristics
Early adolescence: 10–13 years	The body experiences a spurt in growth and the beginnings of sexual maturation, while thinking is more abstract
Mid-adolescence: 14–15 years	The main physical changes are complete. The person develops a stronger sense of identity and relates more strongly to peers, although family usually remains important. Thinking becomes more reflective.
Late adolescence: 16–19 years	The body fills out and takes its adult form, while the person now has a distinct identity and more settled ideas and opinions

Source: World Health Organization

Studies indicate that during adolescence more than 20% body height, 50% of adult body weight and about 37% of bone mass is acquired. This stage is a nutritionally vulnerable period due to the increased demand for nutrients and calories for physical growth and changes in the body composition. Inadequate consumption of nutrients can slow or stop linear growth as well as delayed sexual maturation.

Good health and nutrition are not only essential inputs but also important outcomes of quality basic education. On one hand, learners must be healthy and well-nourished in order to fully participate in education and gain its maximum benefits. Thus, programmes which improve health and nutrition can enhance the learning and educational outcomes of learners (MOE, 2006)[36]. Among pregnant adolescent girls, poor nutrition could lead to increased rates of maternal mortality and a higher likelihood of giving birth to underweight and unhealthy babies, with reduced chances of child survival. Nutritional deficiencies such as anaemia are often exacerbated during pregnancy because of the additional nutrient demands associated with foetal growth.

Table 7: Barriers to Adequate Nutrition for Adolescents[37]

Nutrition	Structural and community level barriers	Lack of nutritional programs targeting adolescents
		Lack of community amenities and livelihood support systems
		High levels of poverty
	Household level barriers	Low proportion of households with adequate dietary diversity (HDDS≥7), (22%)
		Priority given to younger children
		Decision-making on what to eat done by mothers
		Food not easily accessed by adolescents in households (only 40.5%)
	Individual level barriers	Low proportion of adolescent girls with well diversified diet (ADDS≥5), (11%)
		Low proportion of adolescents able to prepare a simple meal on their own (47.6%)
		Very few have breakfast regularly (41.5%)

Source: World Food Programme, 2016[38]

[35] World Food Programme, 2016:the Barriers to HIV Prevention and Adequate Nutrition among Adolescent Girls

[36] Ministry of Education: The School Health and Nutrition Policy, 2006

[37] Zambia Civil Society Organization's Scaling up Nutrition Alliance.2016. Multi-level Barriers to HIV Prevention and Adequate Nutrition among Adolescent Girls.

The latest Zambia Demographic Health Survey also indicates that 16% of adolescent girls aged between 15 to 19 years are underweight, while about 9% of the girls in the same age group are obese. Adolescents from the rural areas are the most affected with regards to poor nutrition. The levels of education also have a direct bearing on nutrition, as poor nutrition is very high on the part of the population that has low levels of education.

4.2.6.2 Mental Health and Self Harm

Recent data on mental health issues, including self-harm, among adolescents is not readily available in Zambia. However, going by global trends, it is assumed to be a big problem here too. Unipolar depressive disorders and anxiety disorders are said to be among the major mental health problems affecting adolescents worldwide (WHO, 2016). Emotional disorders are also common in adolescents and these include excessive fear, anxiety, or avoidance of specific situations or objects; changes in sleeping and eating habits; diminished interest or participation in activities; and oppositional or attention-seeking behaviour (WHO 2016). Early adolescents (10-12 years) may also experience recurrent, unexplained physical symptoms (e.g. stomach ache, headache, nausea); reluctance or refusal to go to school; and extreme shyness or changes in functioning (e.g. new wetting or soiling behaviour or thumb sucking). Older adolescents (13 years and above) may experience problems with mood, anxiety, or worry; excessive distress; and changes in functioning.Self-harm, including suicide, was the third greatest cause of mortality among adolescents globally in 2012, and it was also was the fifth greatest cause of adolescent DALYs lost (WHO, 2016).

In the 2004 Zambia Global School Health Survey (WHO/CDC/MOH/MOE) mental health was identified as a significant issue, with 53% of learners feeling so sad or hopeless almostevery day for two weeks or more in a row that they stopped doing their usual activities. The study revealed unsettling findings on suicide, with 32% of learners having seriously considered attempting suicide during the past 12 months. What was more significant was that 41% of learners even made a plan about how they would attempt suicide. This data, which is 13 years old, is a probable indicator of the current mental health context for adolescents, as there are still very limited mental health and psycho-social support services being provided by either the education or health sectors.

4.2.6.3 OtherNon-Communicable diseases

New data presented in *Health for the world's adolescents* (WHO, 2014) show, for example, in countries with survey data that fewer than one in every four adolescents meets recommendedguidelines for physical activity; as many as one in every three is obese in some countries; and, in a majority of countries in every region, at least half of younger adolescent boys report serious injuries in the preceding year.

Linked to obesity is diabetes mellitus type 2 which is said to be on the increase among adolescents. There is also an increase in cases of hypertension among adolescents as a result of obesity and sedentary lifestyles. Other conditions that affect adolescents in Zambia are haematological conditions such as sickle cell anaemia, leukaemia, and others.

[38] World food programme 2016: https://www.wfp.org/operations/200891-zambia-country-programme-2016-2020

4.2.7 Adolescents with Special Needs

Using the International Classification of Functioning definition, WHO (2002[39]) defines disability as a generic term that includes impairments in body functions and structures, activity limitation and participation restrictions.
Zambia is estimated to have about 2 million women and men, or 15% of the population, with a disability (WHO and World Bank, 2011[40]). The actual number of adolescents with disabilities is unknown.Available data indicate that generally people with special needs, adolescents inclusive, are excluded from accessing various forms of services such as health, education, etc. In 2003 there were 256,690 persons with disabilities in Zambia not in school. Out of this number, 43.2% had no formal education, 39.7% had primary school education, 14.5% had secondary school education, 1.3% had attained A-levels and another 1.3% had attained tertiary education (CSO, 2003[41]). The more current ZDHS has no data on this special group.

Needs of Adolescents with special needs include the following:

- Occasional follow up by specialists such as neurologists, ophthalmologists, etc.
- Occupational therapy including placement in special schools
- Physiotherapy
- Speech & language therapy
- Cognitive/learning support
- Behaviour support including other services available to the rest of the population such as SRH services, HIV services, etc.
- Psychosocial counselling (UTH, 2016[42]).

4.2.8 Analysis of Current Gaps in ADH

While it is appreciated that a lot of effort has been made towards improving ADH in Zambia, substantial gaps still remain. In some cases scarcity of recent data, as well as existence of data that is not age and sex disaggregated,makes it difficult to appreciate the actual extent of the problem. Areas that emerged as priority were furthersubjected to a detailed "SWOT" analysis against the six health system building blocks[43](Details in section 4.3).

[39] World Health Organisation, 2002: Towards a Common Language for Functioning, Disability and Health

[40] World Health Organisation and World Bank, 2011: World Report on Disability 2011

[41]Central Statistical Office (CSO) [Zambia], Ministry of Health (MOH) [Zambia], and ICF International. 2004. *Zambia Demographic and Health Survey 2003*

[42]Source: University Teaching Hospital (UTH) Paediatric Centre of Excellence (PCOE) Report on Children with Special Needs, 2015-16

[43]Service delivery; Health workforce; Medical products, infrastructure, equipment and transport; Health information; Healthcare financing; and Leadership and governance

4.3 Adolescent Health System: Analysis of Strengths, Weaknesses, Opportunities and Threats (SWOT)

STRENGTHS	WEAKNESSES
• Inclusion of ADH management structure at National level. • Existence of the previous ADH-SP 2011-15 providing for the strengthening and establishment of the following: ▪ ADFHS in selected districts which provide basic SRH and in some cases targeted nutrition Services; ▪ Existence of ADH TWG which provides important lessons and experiences for strengthening the ADH programmes; ▪ It has also provided for lessons learnt in the developing of this new national ADH Strategy. • Political will to address issues of HIV: ▪ Existence of ART facilities throughout the country; ▪ Development of MOH acceleration plan for HIV prevention, care and treatment for women, children including early adolescents (10-14) after noted gaps in getting children into ART by some health centres providing HIV Testing service (HTS) and Adult ART services; ▪ Development of Adolescent specific ART guidelines following gaps in ADH and HIV (addressing late adolescents and transition to adult care) leading to a more coordinated approach to adolescent HIV services. • Existence of initiatives that encourage strong collaboration between health and key stakeholders (police, commission, community). • Existence of PaediatricCentre of Excellence (PCOE) in some places to provide multidisciplinary management of GBV among adolescents, as well as offer multidisciplinary management of adolescents with special needs. • Existence of National and provincial Rehabilitation centres for alcohol and	• Lack of MOH designated ADH staff at various levels (provincial and district) resulting in lack of coordination and harmonization mechanisms of ADH structures across all levels. • Under the current set up, although there is a national ADH TWG in which stakeholders participate, they are not legally accountable under the MOH strategy for ensuring effective multi-sectoral linkages on GBV, substance abuse, HIV, and SRH, etc. • The current approach to programming and implementation resulting in existence of a fragmented response to issues and therefore leading to duplication and inefficiency utilization of available resources. • Unavailability of adolescent responsive SRH health services in all health institutions, with access to existing services,without parental consent for HTC and family planning, limited to age 16 and above. • The components of ADFHS are not known or practiced at all levels. • Inadequate knowledge about the existing health services among adolescents. • Inadequate knowledge of key adolescent health issues among health care workers (HCWs). • Inadequate HIV/SRH outreach services for adolescents (HTS, ART, Contraceptives, and condoms), especially adolescents with special needs who have challenges accessing services from health institutions. • ADH focused on service delivery and addressing the proximate and intermediate determinates of adolescents risk and vulnerability. To address underlying causes, like unemployment and poverty, needs more focus on referrals to other sectors. • Absence of PaediatricCentres of Excellence

drug addictions. • Existence of CSOs in communities working on issues of ADH and HIV, and issues of people with special needs including adolescents.	(PCOE) services across the country to provide multidisciplinary management of services for all adolescents, including adolescents with special needs and key populations. • Weak referral systems to continued care, including to community support groups.

OPPORTUNITIES	**THREATS**
• The inclusion in the National Health Strategic Plan issues that affect ADH issues directly and indirectly, e.g. infrastructure, manpower, drug supply, etc. • Opportunities for the district ADH TWGs to ensure that the other key sectors are addressing issues of responsive service delivery and demand creation around sexual and physical violence being experienced by adolescents. • Existence of political will: Zambia is a signatory to a number of global and regional protocols on child and adolescent health, rights and development including the UN Convention on the Rights of the Childrenand the establishments of programmes, across government departments, which addressadolescent development issues. • There has been an increasing recognition and awareness in most sectors' plans of adolescents and their issues as a priority, e.g. inclusion of ADH in the National Health Policy, policies that address ADH through Alcohol policy, Nutrition policy, etc. • Global concern and goodwill for ADH generally, as well as specific areas, such as adolescent nutrition. The recent Zambian study: *Multilevel Barriers to HIV Prevention and Adequate Nutrition among Adolescent Girls*provides recommendations on HIV and nutrition linkages. Ongoing school health and nutrition programme which could strengthen referrals to health centres. • Prioritization and integration of services gives an opportunity to ADH to leverage the provision of a continuum of care in all areas, especially in HIV services (including HTS, eMTCT), TB, nutrition services and others.	• Very high prevalence of adolescentpregnancies that has an impact on the delivery of maternal, neonatal, child and adolescent (MNCAH) services. • High prevalence of HIV and AIDS, and other STIs among adolescents. • Fragmentation and lack of a sectoral approach to ADH arising from lack of funding (internal and external) with funding often focused on vertical activities. • Inadequacy in policy guidelines on age of consent for accessing ASRH and HTS, for sexually mature adolescents under the age of 16. • Low HTS and HIV treatment utilization of available HIV services by adolescents due to lack of adolescent responsiveness (both to high risk adolescents and to negative at risk adolescents (e.g. promotion of condoms and contraceptives use). • Myths, misconceptions and unsafe traditional practices. • Barriers to access of certain services due to a number of constraints e.g. communication barriers, physical barriers, lack of confidentiality issues due to a need for a third party for interpretation. • Lack of clear guidelines and policy on certain issues such as adolescent GBV issues. Lack of clear guidelines and policy relating to adolescents with special needs. • High unemployment levels among adolescents leading to high poverty levels and thereby increasing the risk and vulnerability to risky behaviours and their

With 1 out of four 17 year olds girls havingalready started childbearingand utilizing ANC services, it is critical that they receive an integrated package of services. • Existence of tools, guidelines and implementation experience which would assist expansionof rehabilitationcentres for alcohol and drug addictions to other high burden districts. • Availability of laws and regulations on a number of issues that affect adolescents: access to services; to substances; against of abuse by adolescents, ending child marriage, Anti-GBV Act, etc. • Presence of well-informed traditional leaders and gatekeepers.	consequences. • Societal norms (adolescents exposed to drunken elders) and reports of drug trafficking in and out of the country exposes adolescents and makes them more vulnerable for use, addiction and other consequences. • Inadequate financial support, lack of suitable infrastructure as well as transport in some cases.

4.4 Adolescent Health Priorities

Based on the situation analysis, there are many critical health issues facing adolescents. However, bearing in mind the resource constrains that Zambia faces, it has been recognized that adolescents are able to access many clinical services without many issues in terms of prejudice and discrimination. Forexample, many adolescent easily access treatment for conditions such as malaria. Challenges arise, however, when it comes to accessing services forsexual health and reproductive health related problems, or when in need of services which are currently in limited supply (e.g. mental health services, or services for those with special needs, etc.).

Therefore,the following issues have been identified as areas needing special attention:

- Sexual and Reproductive Health;
- HIV and AIDS, other STIs;
- Gender Based Violence;
- Non Communicable Diseases – e.g. Nutrition and mental health issues;
- Substance Abuse Issues (alcohol, tobacco, drugs, etc.);
- Problems facing Adolescents with Special Needs.

4.5 Linkages between Adolescent Health Priorities and Strategic Components

To address the adolescent health priorities which were identified during the situation analysis and building on the analysis of the adolescent health system, the ADH Strategy has prioritized three main strategic components for effectively addressing the ADH priorities. The first is the need for a strategic focus on strengthening the capacity of the health sector to delivery adolescent responsive health services. The second strategic component will address the need to prioritize both health promotion and demand creation with and for adolescents. The third component focuses on the need for an enabling programme environment through strategies thatstrengthen leadership and governance issues to ensure the effective delivery of adolescent responsive health serviceand the mobilization of communities to promote healthy behaviours and the utilization of relevant health services by adolescents.

Health Priorities	Strategic Components
• Sexual and Reproductive Health • HIV and AIDS, other STIs • Gender Based Violence • Non Communicable Diseases – e.g. Nutrition and mental health issues • Substance Abuse Issues • Adolescents with Special Needs	▪ Adolescent responsive health services through system strengthening ▪ Health promotion and demand creation ▪ Leadership and governance

5 STRATEGIC DIRECTION FOR THE ADH STRATEGY 2017-2021

The focus of the ADH Strategy for 2017-2021 is on strengthening the delivery of adolescent responsive health services; to increase adolescents' access and utilization of qualityhealth-care leading to improved adolescent sexual and reproductive health; the reduction of HIV/AIDS, and the promotion and adoption of healthy living amongadolescents.

5.1 Vision, Mission and Overall Goal

Vision:	Healthy and productive adolescents for national development.
Mission:	To ensure equity of access to appropriate, quality and cost-effective adolescent-friendly health platforms and an adolescent responsive health system[44] as close to the people as possible.
Overall Goal:	To improve the health status of adolescents in Zambia
Theme:	Knowledgeable and healthy adolescents, the future of Zambia.

5.2 Key Principles

The implementation of this Strategy shall be guided by the key elements of the WHO 'quality of care'[45] framework, including the respect for human rights and fundamental freedoms as well as the recognition of the critical role parents, guardians and communities play in the provision of ADH services. The key elements are as follows:

[44] See text box below

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

Equitable:	All adolescents, not just certain groups, are able to obtain the health services they need.
Accessible:	Adolescents are able to obtain the services that are provided.
Acceptable:	Health services are provided in ways that meet the expectations of adolescent clients.
Appropriate:	The right health services that adolescents need are provided in ways that account for issues such as privacy, confidentiality, non-stigmatization, and gender-responsiveness.
Effective:	The right health services are provided in the right way, and make a positive contribution to the health of adolescents.
In order to address the six identified ADH priorities, the ADH Strategy aims to strengthen the following areas: Health Service Delivery, Health Promotion and Demand Creation, and Leadership and Governance responses.	

Steering the Transition from Adolescent-Friendly Projects to Adolescent-Responsive Health Systems

To make progress toward universal health coverage, ministries of health and the health sector more generally will need to transform how health systems respond to the health needs of adolescents. A number of transitions in service delivery, workforce capacity and financing will be needed.

Service delivery:*A transition is needed from "adolescent-friendly" projects to programmes that strengthen mainstream capacity at primary and referral levels to respond to the priority health and development needs of adolescents.* A number of actions would facilitate this transition:

- establishing and implementing a national package of adolescent health interventions at primary and referral levels and strengthening the capacity to deliver the package in an integrated manner;
- developing and implementing national quality standards and monitoring systems;
- raising awareness about the health needs of adolescents and generating community support for the delivery of the adolescent health care package and for its uptake.

Preventive care:*Transitions are required to create opportunities for all adolescents to make contact with primary care services for individual preventive services.* Countries' experiences[179 180] suggest that actions to facilitate this might include:

- strengthening school health services and exploring the potential of including periodic check-ups for adolescents in primary care;
- embracing e-health and m-health technologies;
- undertaking community-based initiatives for demand creation through peers, community health workers, lay counsellors and others.

Workforce capacity:*Transitions are required in the ways the workforce is trained, so that all providers have a basic knowledge of adolescent development and their implications for clinical practice.* Actions that may facilitate this shift include:

- making competency-based training in ADH care mandatory in pre-service curricula and post-graduate specialist training;
- designing competency-based training programmes that emphasize the developmental and contextual aspects of ADH;
- including policies and strategies that support the supervision of primary care providers and specialists providing services to adolescents.

Financing:*Transitions are required in the way that resources are allocated and purchasing of services is designed, so as to meet the need of adolescents.* The following actions may facilitate this transition:

- removing (or at least reducing) the need for adolescents to pay for services at the time of use by maximizing the number of adolescents covered by effective prepaid pooling arrangements, with adequate subsidization of vulnerable adolescents and their families;
- making the national package of ADH interventions an instrument to guide purchasing decisions and benefit packages, with attention to preventive services and to adolescent's right to confidentiality and the highest attainable standard of health;
- providing incentives that motivate health workers to provide specific interventions that are essential for adolescents' health and development and to comply with quality standards

Source: http://apps.who.int/adolescent/second-decade/section6/page8/sdolescent-

5.3 Health Service Delivery:

5.3.1 Overview:

This Strategy emphasizes the following as a means to provide appropriate ADH services:

- The minimum ADHservices platformwhere appropriate,
- An Adolescent Responsive Health System[46].

The adolescent health servicesplatformto be established in 60%[47]of districts in Zambia and approximately 200 high burden health centres-- as described in detail in Appendix One. The AHS Platform Package was consolidated based on the MOH experiences implementing ADH services in 24 districts over 2015-2016, under the previous ADH Strategic Plan (2011-2015).

The Platform has the following minimum components – which should be supported and funded by all partners working in the health sector on programmes with and for adolescents:

1) Multi-Sectoral District Adolescent Health Technical Working Group;
2) District Adolescent Health Focal Point (Two);
3) Trained Health Workers on the ADH Standards;
4) Health Centre Adolescent Health Focal Points (Two);
5) Adolescent Friendly Space (AFS) at Health Centres;
6) Trained ADH Peer Educators (4-8 per AFS);
7) Routine Supervision of ADH service provision and ASF;
8) Routine Health Facility to Community Outreach.

Once the minimum district platform is established within an MOH Health Centre – partners can implement additional activities within the Health Centre and health Centre catchment area.

An Adolescent Responsive Health System has been described in the previous section (see text box). Issues of workforce capacity and financing are to be addressed under the overall Health Sector Strategic Plan 2017-2021, and advocated for and supervised under the Leadership and Governance components of this strategy. The delivery of adolescent responsive health services, under this strategy, recognize that many adolescent are already using health services and will focus on ensuring that all health providers are assisted and encouraged to provide response quality services. In other words, when a health provider sees an adolescent client in their service they will aware of and knowledgeable of the adolescents health issues that they need to assess and then address. They will also need to leverage opportunities for better integration and linkages between the existing services that are being provided and utilized by adolescents at the various levels of the health system, for example, HTS, FP, ANC, MCH and OPD services. The following illustrates the provision of adolescent responsive HTC services:

- Current MOH service utilization data suggests that approximately 20% of all HTS clients are adolescents. With approximately 3 million HIV tests conducted in

[46] The details pertaining to an adolescent responsive health system is given in the text box above

[47] The platforms already exist in approximately 24% (25) of districts, and therefore to reach 60%, 40 more districts will have to be reached (making a total of about 65 districts)

Zambia in 2016, this suggests that around 600,000 adolescents may have undergone an HIV testing in 2016 (disregarding any repeat clients). With an HIV prevalence rate of approximately 2.5% among adolescents, this could mean that around 15,000 adolescents may have been diagnosed HIV positive. According the MOH HTC Implementation Plan 2014-2016, these positive clients should have been extensively counselled and then referred to ART service (with a responsive service having prioritize the special needs of any adolescent clients around disclosure, referral and adherence).

- According to the MOH HTC Implementation Plan (2011-16), adolescents and young adults in HTC should now receive Post-HIV Test Support Services (PTSS). These include the promotion of condoms, couple counselling and male circumcision and the provision IEC materials with key HIV and STI information. They were also to be provided with both male and female condoms and referredto additional SRH services (MC, FP, STI, etc.).

- What then was provided for the 585,000 negative adolescents in the HTC service? During the period 2007 and 2014, the use of HTC services in Zambia increased by 150% among adolescents (to 50% of females and 28% of males). During this same period, condom use at last sex among both female and male adolescents did not change. This would suggests that a significant opportunity was missed within HTC service topromote safer sex and demonstrated and distribute condoms.

The design of the PTSS model in the HTC Implementation Plan is a very good example of applying an integrated and adolescent responsive service.[48] The implementation and supervision of this adolescent responsive component of HTC still remains a challenge. Under the Adolescent Health Services Platform, for high burden health centres, both negative and positive adolescents would need to be prioritized and effectively linked to peer support groups within their community by Peer Educatorsoperating out of Health Centre based Adolescent Friendly Spaces (AFSs).

Applying a responsive approach is not limited to HTS. For example, using ZDHS data, MOHestimatesthat there are approximately 45,000 adolescent girls giving birth annually. Within ANC services, the eMTCT service is being provided. Providers in this service are very focused on 'test and treat' – ensuring mothers are tested and initiated on to HIV treatment. An adolescent responsive service should prioritized both Prongs One and Prongs Two of the eMTCT service for adolescent clients, with Prong One focused on HIV prevention, including condoms promotion and Prong Two focused on Family Planning promotion. There could also be provision of other services such as appropriate nutrition support to adolescent mothers, etc.

5.3.2 Objective:

To ensure availability of the minimum adolescent health services platform in all districts ofZambia by 2021.

[48]Please note that the HIV Testing and Counselling (HTC) Implementation Plan (2014-2016)under annex 8, calculates only 5 minutes for posttest counselling for negative clients compared to 30 minutes for positive clients.

5.3.3 Key strategies, Indicators and targets

Table 9: Key Strategies against Indicators/Targets under Service Delivery

KEY STRATEGIES: HEALTH SERVICE DELIVERY STRENGTHENING	INDICATORS	TARGETS
Standardize the Adolescent Friendly Space minimum delivery package.	The Adolescent Friendly Space minimum delivery package standardized.	Adolescent Friendly Space minimum deliverypackage standardized by June, 2017.
Refine and scale out the adolescent health services platform package • Operationalize the package of incentives for youth volunteers involved in the provision of ADFHS in line with the MoCDSS	• Minimum package harmonized and scaled out • Package of incentives for youth volunteers involved in the provision of ADH services harmonized in line with the MoCDSS	• Minimum package harmonized and scaled out by mid-2017. • Package of incentives for youth volunteers involved in the provision of ADH services harmonized in line with the MoCDSS by Dec, 2017.
Scale out ADH services to all districts and health facilities and strengthen integration of services • Prioritize the delivery of comprehensive and integrated adolescent response package of interventions within clinical services that are being utilized by adolescents. • Integrate health services in available recreation facilities (Condom distribution, IEC distribution, health talks, HTC, etc.) • Conduct mobile outreach ADH services in communities. • Promote effective integration of responsive health services for adolescents and at higher level, facilities explore	• Percentage of districts with functional minimum adolescent health services platforms by 2021. • Percentage of districts with at least 1 recreation facility with integrated health services being offered (Condom distribution, IEC distribution, health talks, HTC, etc.). • Percentage of ADH districts with mobile outreach services. • Integrated nutrition package being implemented within ANC/PMTCT for adolescent mothers. • HTSC Post Test Support Services package for adolescents designed and being implemented. • Number of HC per ADHS district with the minimum	• 60% of districts with functional minimum adolescent health services platforms by 2021. • 60% districts with at least 1 recreation facility with integrated health services • 60% of ADH districts with mobile outreach services. • Integrated nutrition package being implemented within ANC/PMTCT for adolescent mothers in all targeted districts by 2021. • HTSC Post Test Support Services package for adolescents designed and being implemented in all ADHS districts by 2021. • 5 HC per ADHS district with the minimum ADH service delivery platform operating routine facility to school and community outreach by 2021.

special clinic days and times for adolescent clients, especially in sensitive SRH and HIV services.	ADH service delivery platform operating routine facility to school and community outreach by 2021.	
Strengthen linkages and partnerships with relevant line ministries and Government agencies[49] in order to strengthen multi-sectoral approach to programme. implementation (e.g. School Health and Nutrition Programme (SHN), prevention of road traffic accidents (RTAs), other forms of violence including GBV, prevention of alcohol and substance abuse, etc.).	• Line Ministries and Government Agencies represented on the ADH-TWG. • Number of ADH related joint sensitization programmes/activities developed and implemented.	• Line Ministries and Government Agencies represented on the ADH-TWG, by December 2017. • At least 2 ADH related joint sensitization programmes/activities developed and implemented / district/year.
Strengthen partnerships with relevant CSOs and NGOs in order to strengthen linkages and unit of purpose in implementation of ADH. • Strengthen district level ADH coordination and harmonize efforts of partners in support of adolescent responsive health service delivery	• Percentage of districts with functional ADH-TWGs. • Number of provinces with technical support supervision visits included in the action plans and conducted on a consistent basis.	• 60% of districts with functional ADH-TWGs. • All provinces (10) with technical support supervision visits included in the action plans and conducted on a consistent basis.

[49]Examples of which are MOGE, Ministry of Youth, Sport and Child Development; Government Agencies such as the Road Traffic Safety Agency (RATSA), Zambia Police Victim Support Unit (ZP-VSU) and the Drug Enforcement Commission (DEC, Ministry of National Guidance and Religious Affairs

Strengthen adolescent participation in the delivery of adolescent responsive services, at national, provincial, district, health facility and community levels (including in planning, organization, implementation, and monitoring and evaluation) • Build mechanisms for adolescent participation at the local level, including taking advantage of technological platforms. • Establish structures and processes to institutionalize adolescent participation in the implementation, monitoring and evaluation of the ADH strategy. • Train and mentor adolescents to build their competencies in advocating for ASRH.	• Number of trainings/mentorship of adolescents held. • Number of adolescents with capacity to advocate for ASRH. • Structures and processes established. • Percentage of districts with clearly established structures and processes allowing for adolescent participation in the implementation, monitoring and evaluation of the ADH strategy.	• 20 trainings/mentorship of adolescents held by 2021. • 250 adolescents with capacity to advocate for ASRH (4/ADH district by 2021). • 60% districts with clearly established structures and processes allowing for adolescent participation in the implementation, monitoring and evaluation of the ADH strategy.
Increase condom availability and usage through innovative ways – vending machines, street vendors, peer educators, etc.	• Number of condom vending. machines purchased and distributed • Percentage of districts with condom vending machines. • Percentage of districts with street vendors selling condoms.	• 320condom vending machines purchased and distributed. • 60% of districts with condom vending machines. • 60% of districts with street vendors selling condoms. • Condom use increased to 90%.
Mobilize and assist selected NGOS, CBOs and FBOs to support the delivery of adolescent responsive health services, including smart partnerships service delivery relations with NGOs and community based partners.	• Number of NGOS, CBOs and FBOs mobilized and assisted to support the delivery of adolescent responsive health services, including smart partnerships service delivery relations with NGOs and community based partners.	• 5 NGOS CBOs and FBOs mobilized and assisted to support the delivery of adolescent responsive health services, including smart partnerships service delivery relations with NGOs and community based partners.
Scale up training in ADH • Of health care workers (HCWs). • Of peer educators and their deployment to adolescent friendly spaces at health facilities.	• Curriculum for pre-service training of Medical Doctors and Clinical officers reviewed and updated to emphasize ADH issues • Percentage of HCWs oriented in ADH • Percentage of districts with at least one HCW trained in ADH	• Curriculum for pre-service training of Medical Doctors and Clinical Officers reviewed and updated to by December, 2018 • 95% of HCWs oriented in ADH • 60% of districts with at least one HCW in their health institutions oriented in ADH by 2021

	• Number of Peer educators trained and deployed to adolescent friendly spaces • Percentage of districts with at least 5 health centres with 6-8 peer educators each.	• 1860 Peer educators trained and deployed to adolescent friendly spaces in 100% ADH districts • 60% of districts with at least 5 health centres with 6-8 peer educators each.
Strengthen M &E activities in relation to ADH	• Number of Operational Research conducted (2 by 2021). • Annual Progress Report made and presented at ADH annual retreat. • Mid – Term Review of Strategy Conducted. • End of Term Review of Strategy Conducted.	• 2 Operational Research conducted by 2021. • Annual Progress Report made and presented at ADH annual retreat. • Mid – Term Review of Strategy Conducted. • End of Term Review of Strategy Conducted.

5.4 Health Promotion and Demand Creation:

5.4.1 Overview

Many adolescents do not have adequate health literacy to enable them to gain access to, understand and effectively use information in ways that promote and maintain their good health (WHO, 2014[50]). Health promotions is the "process of enabling people to increase control over, and to improve, their health" and it goes "beyond a focus on individual behaviour towards a wide range of social and environmental interventions," (WHO, 2016).[51]It thereforeencompasses awareness creation on the available services in terms of the "where", "what", "who", "how" and "when" as well as knowledge creation foradolescentsin regards tothe laws and regulations that govern their health and rights.The approach also has a focus on behavioural development that aims at preventing adolescents from developing the risk behaviours, which will prevent the negative health consequences and also reduce the demands on health service.

Demand Creation: an effective health response needs to address both the supply and the demand sides of service delivery. The supply side has been highlighted in the section above, and aimsto ensuring a quality service which is focused on addressing the 5 A's[52] and by making the health services more adolescent responsive. The demand side focuses on increasing demand for and utilizationof the services by adolescent who have the relevant risk behaviours and/or health conditions. It is important that these two components be well integrated, as it is not an effective strategy to promote utilization of a non-responsive service, as it will be more difficult to get adolescents clients back into the service, if their experience has been a negative one.

[50] World Health Organisation, 2014: Health for the World's Adolescents: A second chance in the second decade

[51] http://www.who.int/topics/health_promotion/en/

[52] 5 A's – Affordability, availability, accessibility, accommodation, and acceptability

5.4.2 Objective

To increase adolescents' awareness and utilization of available health services and promote healthy living.

5.4.3 Key strategies, Indicators and targets

Table 10: Key Strategies against Indicators/Targets under Health Promotion and Demand Creation

Key Strategies: Strengthen Health Promotion and Demand Creation:	**Indicators**	**Targets**
Strengthen adolescent involvement and participation in health communication.	• Number of community based Adolescent led drama clubs formed. • Percentage of districts with at least 1 community based Adolescent led drama clubs.	• 62 community based Adolescent led drama clubs formed (1/ per ADH targeted district). • 60% of districts with community based Adolescent led drama clubs.
Enhance adolescent's health literacy through behaviours and social change communication activities among adolescents to enable them gain access to, understand and effectively use information in ways that promote and maintain their good health. ○ Produce and distribute IEC materials to inform adolescents on various topics of concern (with IEC materials designed for adolescents with special needs as well). ○ Conduct health promotion campaigns on adolescent health. ○ Scale up Comprehensive Sexuality Education (CSE) for in and out of school.	• Percentage of districts with ADH IEC materials. • Number of health promotion campaigns held. • Percentage of schools reached with CSE. • Percentage of districts with out of school adolescents reached with CSE. • Percentage of teachers trained and delivering CSE in schools. • Percentage of PTAs oriented and sensitized on CSE. • Percentage of learners (grade 5 to 12) reached with CSE annually.	• 60% of districts with IEC materials (nationally). • 1 per quarter health promotion campaigns held. • 100% of schools reached with CSE. • 60% of districts with out of school adolescents reached with CSE. • 100% of teachers trained and delivering CSE in schools • 60% of PTAs oriented and sensitized on CSE (5/ADH district). • 100% (grade 5 to 12) of learners reached with CSE annually.
• Design and implement targeted innovative BSSC campaigns with and for adolescents which promote health behaviours development and behaviours change and uses of preventative health services. • Develop and implement mass media and interpersonal communication campaigns which promote the utilization	• BSCC campaigns (mass media and interpersonal communication) designed and implemented at national and community levels which promotes the utilization of SRH/HIV and NCD services by adolescents.	• Mass media campaign designed and implemented through government, commercial and community media services. • Community Based Interpersonal Communication activities undertaken in

of SRH/HIV and NCD services by adolescents.		62 districts.
• Strengthen capacity of community based organization promote and generate a protective and enabling community environment for adolescents. • Challenge social norms and behaviours, like GBV, Child Marriage, alcohol and substance abuse, etc., which put adolescents health at risk. • Increase demand of relevant services through peer education outreach. • Strengthen community based preventive behaviours development activities to help prevent the development of the risk behaviours that will reduce the demand on health service. • Strengthen use of innovative old and new media, including mobile technology and social media for effective engagement with adolescents. • Strengthen community and family participation, by training CHWs and families in ADH: o Orient CHWs on ADH; o Involve religious leaders and families in ADH issues; o Identify and appoint community leaders/celebrities as ADH champions within communities; o Create a social media platform for adolescents and the community to participate in ADH issues.	• Number of orientation workshops held. • Number of CHWs oriented on ADH. • Percentage of districts with CHWs oriented on ADH Number of districts with ADH champions. • Percentage of districts with organized discussions/platforms with parents/guardians.	• 310 CHWs oriented on ADH (5 per target district). • 60% of districts with CHWs oriented on ADH and number of districts with ADH champions. • 60% of districts with organized discussions/platforms with parents/guardians.

5.5 Leadership and Governance:

5.5.1 Overview

Leadership and Governance, at various levels, remain key in ensuring the achievement of the desired status of ADH in Zambia. In understanding the leadership and governance issues pertaining to ADH, the "adaptive leadership model"[53]was adopted during the situation analysis, particularly in areas aimed at achieving a cultural and value shifts at different levels (personal, family, community and institutional) that move away from moral rigidity, silence or the avoidance of tough/uncomfortable conversations to helping people build the leadership capacity to engage as needed. This mainly applies to HIV prevention (see details in appendix 6).

Overall, gaps in various other areas at different levels of implementation have been identified. Examples of these include the current shortages of human resources for health that are cross cutting in the health sector, fragmentation delivery of some health services, inadequacies in the supply chain of medical supplies with occasional stock outs, limited infrastructure and lack of desired designs in some settings, plus legal and policy issues, etc. While some are being addressed in the National Health Strategic Plan 2017-2021, there are others that are not yet addressed.One of the most important roles of this Strategy is therefore to advocate for changes to laws and policies that inhibit adolescents' access to services or the development of new policies to protect, promote and fulfil adolescents' right to health, as well as champion the cause for improved ADH. This will result in the creation of an enabling environment that will ensure that all services that adolescents need are available and accessible to them, without discrimination.

5.5.2 Objective

To strengthen the leadership and governance of an adolescent responsive health system that provides an enabling environment that ensures health for all adolescents, without discrimination.

[53]Technical vs Adaptive Challenges: This model highlights the importance of correctly diagnosing the type of challenge we are facing and want to take action on. Most day to-day challenges are Technical: They can be relatively easily understood and responses are known or knowable. This is the domain of traditional authority and hierarchies. It restores a system back to status quo and provides predictability and consistency. For example, a broken arm in a health system calls forth a straightforward diagnosis and a known response. Adaptive challenges are the ones where the problem definition is not clear and/or where the solutions cannot simply be generated from within existing knowledge and processes. These are challenges that may continue to continue even when we mistakenly apply technical solutions to them. They are characterized by being Social (where people have different beliefs & values), dynamic (cause & effect are far away in time and space) and generative (there is uncertainty about impacts). Adaptive challenges require a whole system to learn – including those in roles of authority. http://leadership.benevolent.org.au/programs/adaptive-leadership

5.5.3 Key strategies, Indicators and targets

Table 11: Key Strategies against Indicators/Targets under Leadership and Governance

Key Strategies: Leadership and Governance	**Indicators**	**Targets**
An effective adolescent responsive health system can be established through the implementation of following strategies by the leadership and management of the health sector: • Strengthen organization and coordination of the ADH programme at all levels. • Improve collaboration and break down silos across and sometimes within, government agencies, sectors and civil society organizations and so avoid duplication, increase efficiencies and better leverage resources. • Strengthen procurement and availability of essential drugs and medical products with a dedicated allocation to adolescent health issues. • Strengthen/develop infrastructure and equipment for the delivery of adolescent responsive health services bearing in mind. • Strengthen health infrastructure and equipment with a dedicated allocation for the delivery of ADH services. • Strengthen the health system transport situation, by providing dedicated means of appropriate transport for supporting the implementation and monitoring of adolescent responsivehealth services. • Maintain and implement the proposed disaggregated adolescent health indicators within the HMIS. • Increase the dedicated ADH financing under the	• Clear structure of ADH personnel at various levels adopted with dedicated position of District ADH Focal Point Person established. • Age of consent of uptake of SRH services reviewed from the current 16 to lower. • Number of partners with renovated spaces for ADH services. • Vehicles for ADH activities procured at national level and bicycles procured for ADH activities at community level • Health facilities design guidelines include space for ADH services. • ADH-Specific indicators included in MOH data capturing tools. • Number of months/year without stock outs of contraceptives and condoms in health centres. • Minimum package of ADH services platform adopted by MOH. • ADH incorporated in pre-service curriculum for MOs and COs. • ADH orientation workshops for HCWs in the MOH's Action Plans at various levels funded by MOH resources. • Mid –Term and End of Term Reviews of the	• Clear structure of ADH personnel at various levels adopted with dedicated position of District ADH Focal Point Person established. • Age of consent of uptake of SRH services reviewed downwards. • 2 vehicle for ADH activities procured at national level and 3905 bicycles procured for ADH activities at community level. • Guidelines and designs of health facilities include space for ADH services. • ADH-Specific indicators included in MOH data capturing tools. • 12 months/year without stock outs of contraceptives and condoms in health centres. • Minimum package of ADH services platform adopted by MOH • ADH incorporated in pre-service curriculum for MOs and COs. • ADH orientation workshops for HCWs in the MOH's Action Plans at various levels funded by MOH resources. • Mid –Term and End of Term Reviews of the Strategy fully funded. • A separate budget line for

National Health Strategic Plan. • Strengthen accountability and budget tracking in respect to ADH funds allocated by the MOH and provided by cooperative partners –regardless of funders there is need for accountability. • Review/strengthen/develop the policy and regulatory frameworks for ADH. • Advocate for more recreation facilities for adolescents with integrated health services.	Strategy fully funded. • A separate budget line for ADH at district levels created. • Percentage of districts with recreation facilities built/createdintegrated with health. • Policy Guidelines on age of consent and access to SRH and HIV services • Policy guidelines on transition of care from paediatric to adult health care developed.	ADH at district levels created. • 60% of districts with recreation facilities built/created with integrated health services (at least 1/ADH districts). • Policy guidelines on age of consent and access to SRH and HIV services. • Policy guidelines on transition of care from paediatric to adult health care developed by Mid-2018.

6 IMPLEMENTATION FRAMEWORK

Implementation of this strategy will be guided by the existing MOH policy, regulatory, institutional, coordination, and monitoring and evaluation frameworks. Efforts will also be made to review and strengthen these frameworks, in order to make them responsive to adolescents' health issues and to ensure smooth and successful implementation of the proposed strategies. As far as possible, the implementation of this strategy will depend on existing structures including existing infrastructure, supply chains for drugs and other medical supplies and human resources for health. **However, in some areas, specifically around the scale up of the minimum adolescent health servicesplatform and for health promotion, dedicated funds will be required to support the proposed strategies and activities.** Below is an overview of the implementation framework that will be put in place, in order to ensure efficient and effective implementation of this plan.

6.1 Policy and Regulatory Framework

The policy and regulatory framework under which will support the strategy will include all of the following, and any amendments thereof:

- National Population Policy, 2015;
- National Health Policy, 2012;
- National Child Policy, 2015;
- National Reproductive Health Policy, 2005;
- National Education Policy;
- National Food and Nutrition Policy, 2006;
- Mental Health Policy, 2005;
- National Youth Policy, 2015;
- National HIV/AIDS Policy, 2002;
- School Health and Nutrition Policy; and
- Other policies relevant to adolescent health.

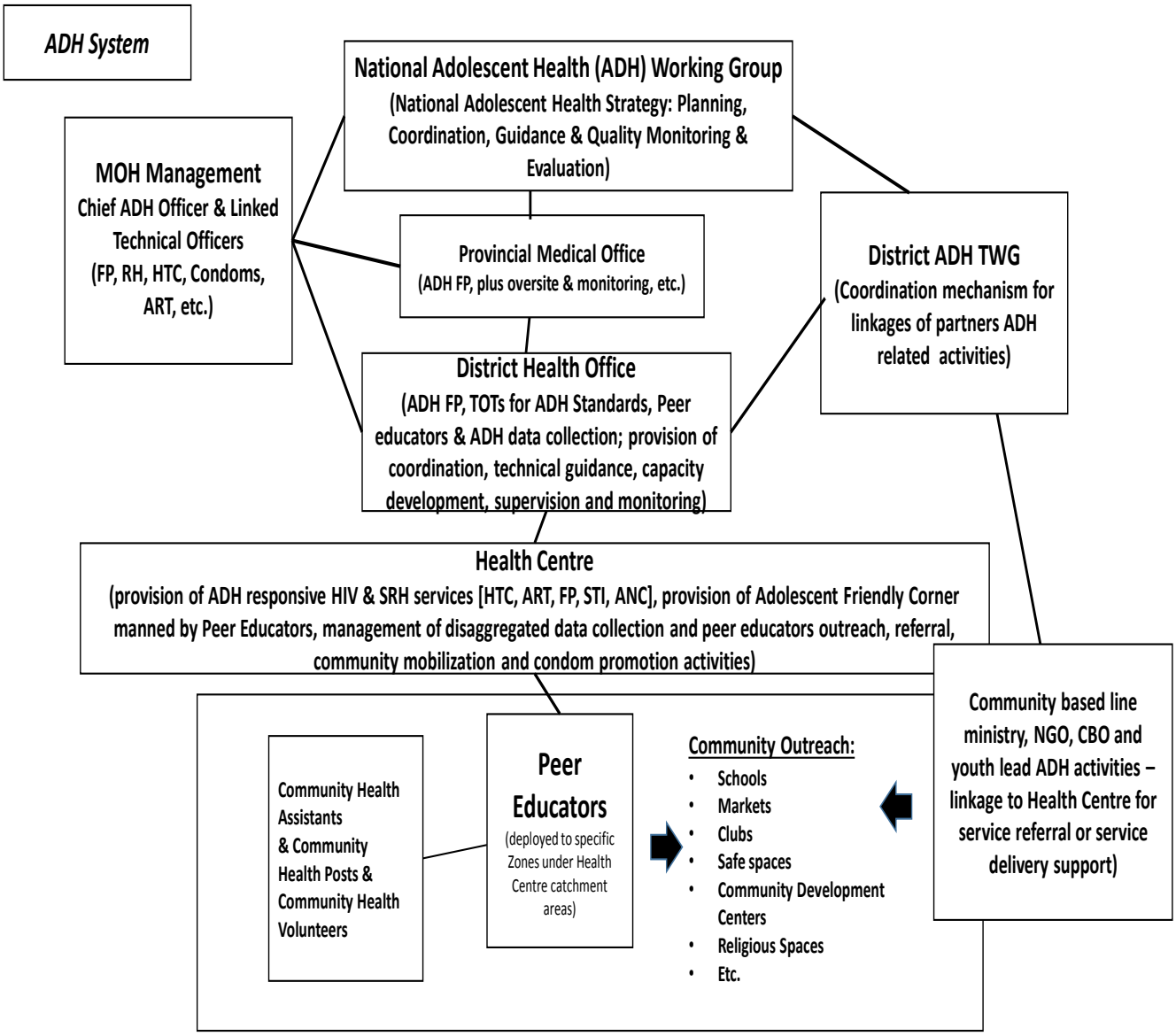
The legal and regulatory framework will include:

- The Constitution of Zambia, particularly the Bill of Rights;
- The Juvenile's Act;
- The Termination of Pregnancy Act of 1972; and
- Other relevant Laws, including those on tobacco use, alcohol and substance abuse, sexual violence, anti-gender- based violence act and other forms of violence.

6.2 Institutional and Coordination Frameworks

At national level, The Adolescent Health Program, working together with FP andSafe Motherhood under the Mother and Child Health Unit, in the Department of Public Health at MOH will be responsible for the overall coordination of the implementation of the plan. These will also chair the ADH TWG which serves as the main coordinating body of ADH in Zambia. In future, there might be need to revolve the chair among key stakeholders. The plan will follow the already established structures where possible, with some proposals made where necessary, for coordination of the strategy, such as:

- Maternal and Child Health (MCH) units within the Provincial Health Offices (PHOs)
- District Health Offices (DHOs) – The proposed ADH focal point persons will be housed within the DHOs and be responsible for coordinating the work of all activities pertaining to adolescent health as per proposed TOR (annex 3)
- The District ADH TWG will be established at district level and will also play a pivotal role in coordinating ADH activities.
- ADH focal point persons will be appointed at health facilities to coordinate the delivery of adolescent response health services, especially within the basic and comprehensive clinical services (ANC, Post-Natal; Reproductive Health/Family Planning; HIV [HTS, ART, VMMC, EMTCT]; Nutrition, etc.).
    - At higher levels of care facilities with distinct departments, more than one focal point person may be appointed in key departments
    - At primary and lower levels of care facilities where adolescent friendly spaces (AFS) will be established or strengthened, atleast two focal point persons will be appointed after the necessary training, to manage the peer educators and oversee the activities at facility level.
    - Links will be established, by the lower level health facilities focal points with key structures in the community, from schools to community development centres, faith based organization, CSOs and community volunteer structures, (specifically those mandated under the District Council Decentralization programme – NHC and NATF, etc.) under the supervision of the District ADH Focal Point Person, with the communities so that there is proper linkages developed for the coordination at District level as well.


ADH System
National Adolescent Health (ADH) Working Group
(National Adolescent Health Strategy: Planning, Coordination, Guidance & Quality Monitoring & Evaluation)
MOH Management
Chief ADH Officer & Linked Technical Officers
(FP, RH, HTC, Condoms, ART, etc.)
Provincial Medical Office
(ADH FP, plus oversite & monitoring, etc.)
District ADH TWG
(Coordination mechanism for linkages of partners ADH related activities)
District Health Office
(ADH FP, TOTs for ADH Standards, Peer educators & ADH data collection; provision of coordination, technical guidance, capacity development, supervision and monitoring)
Health Centre
(provision of ADH responsive HIV & SRH services [HTC, ART, FP, STI, ANC], provision of Adolescent Friendly Corner manned by Peer Educators, management of disaggregated data collection and peer educators outreach, referral, community mobilization and condom promotion activities)
Community Health Assistants & Community Health Posts & Community Health Volunteers
Peer Educators
(deployed to specific Zones under Health Centre catchment areas)
Community Outreach:
Schools
Markets
Clubs
Safe spaces
Community Development Centers
Religious Spaces
Etc.
Community based line ministry, NGO, CBO and youth lead ADH activities – linkage to Health Centre for service referral or service delivery support)

6.3 Monitoring and Evaluation (M&E)

Monitoring and evaluation of the ADH Strategy will require greater coordination of all players in ADH in order to allow for optimal utilization of available resources and sharing of experiences and best practices. From the outset, the ADH TWG will form a subcommittee to oversee M&E issues.

6.3.1 Monitoring

MOH will coordinate all activities for monitoring of the implementation of the Strategy and work closely with the ADH TWG M&E subcommittee. As the current baseline data for a number of the indicators are based on national population-based surveys conducted overtime, efforts will be made at the beginning of the implementation period of the strategy to strengthen the utilization of the HMIS, DHIS2 and other routine data collection tools for monitoring changes in output and outcome indicators and targets. In some cases, new tools and innovative approaches for data collection will be explored and piloted. The submission of quarterly reports by 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 on a regular basis to monitor the implementation process and also to inform programme management and adjustments of ADH services.The subcommittee will present annual progress reports 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 Strategy 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 operational research that will be conducted during the implementation period to track behaviour change as well as use of health services by adolescents under the Health Promotion component.

6.3.2 Evaluation

A mid-term review will be conducted with support from various cooperating partners to assess progress made in the implementation of the annual work plans developed by partners for the implementation of the strategy. An end of term review will also be conducted to focus on the relevance, effectiveness, efficiency and impact/outcome of the implementation of key health system strengthening, health promotion and leadership and governance strategies. Findings of the evaluation will assist in providing the contextual framework for the subsequent Strategic planning period, as well as inform policy for the coming years.

6.3.3 Learning

As stated the Strategy will rely on a number of data sources to monitor its implementation. Adolescent health data that will be collected through the HMIS/DHIS2 and ZDHS as well as through implementing partners will be core to learning. The Ministry of Health through the M&E TWG will analyse the data and the best practices in the implementation of the strategy and share with various stakeholders. The learning process will be documented and inform strategy adjustments as necessary.

7 COST OF KEY STRATEGIES / ACTIVITIES

The costing below is based on calculations of various activities making up a minimum ADH servicesactivities platform. The costing has been spread across the five years of implementation based on the proposed process of setting up these platforms across a minimum of 62% of all districts. The Districts will be prioritized based on large numbers of adolescents and high burdens of priority adolescent health issues.**In addition, this budget includes resource for national level health promotion, including social and behavioural change communication and programme logistics, management and supervision support costs.** The minimum ADH services platform activities and costs are based on MOH implementation of adolescent health activities in 25 districts, over 2015-2016[54]. For the purpose of this strategy, the following assumptions were made:

- Total number of districts in Zambia: 105
- Number of districts with MOH Health Centres providing full ADH Minimum Services Platform at baseline were 25, which is approximately 24%
- Target by 2021 is 62% coverage, approximately 40additional districts, **for a total of 65 districts**.
- Number of high burden Health Centres providing full ADH Minimum Services Platform per district: approximately 5.
- Total number of Health Centresacross the 40 new districtswith full minimum ADH services platform: 200. Combined with 125full platform Health Centres under the current ADH strategy: 325 Health Centres[55].

Table 12: Summary of Costs (Note: Appendix 5 provides the detailedindicative budget for the total estimated figure below):

Year	2016 (baseline)	2017	2018	2019	2020	2021
Scale up of Minimum ADH Service Platform	24%	30%	42%	50%	55%	62%
Cost of a ADH minimum platform of activities with nationalcoordination, SBCC and M&E of ADH		$1,150,113	$5,524,654	$2,669,907	$1,779,936	$1,334,568
TOTAL						**$12,459,198**

The total cost for setting up minimum ADH Services Platforms in 62%districts is therefore estimated at **US$$12,459,198.**

[54]Activities in 11 districts were under the Millennium Development Goals Initiative (MDGi), funded by the European Union through the United Nations and in 14 districts under the Adolescent Social Cash Transfer- HIV Linkages Initiative (ACTLi), funded by the Netherlands Government, through UNICEF.

[55] Please note that this is a minimal coverage figure. A recent review of the status of ADH services across 11 Districts by the MOH has shown a significant higher baseline coverage of some of the components of the ADH services. For example, a large number of facilities have a designated adolescent friendly space/corner and some active volunteer peer educators, but in most cases the spaces are under-resourced or not formalized and the majority of the peer educators, who are linked to the facility, are still not trained and under-resourced.

APPENDICES

APPENDIX 1: The Minimum Adolescent Health Services Platform

For districts to deliver either the basic or comprehensive adolescent health package, this requires them to have established the full minimum adolescent health services platform. The platform requires a District Adolescent Health Technical Working Group (DADH TWG), a designated and trained District Adolescent Health Focal Point (DADH FP); designated Health Centre Adolescent Health Focal Points (HCADH FP); and designated Adolescent Friendly Space (AFS) at each Health Centre, manned with a minimum of 8 trained volunteer Peer Educators (PE's).

District Adolescent Health Focal Point (DADH FP): At District level, at least one primary health care officer (ideally two) will be made accountable by the DHD for implementing the ADH activities according to the DADH FP TOR (See Appendix 3 below). This dedicated officer should have been trained on the Adolescent Health Standards. The officer should also be trained as a trainer on the in-service Adolescent Health Training materials, the Adolescent Health Standards, and the Adolescent Health Peer Education Package (HIV and SRH initial package). The officer would also preside over adolescent health issues within the DHO management team and facilitate the delivery of adolescent responsive clinical services as per the basic and comprehensive adolescent health package (family planning, antenatal, postnatal, HIV testing, treatment and male circumcision, nutrition services, etc.) depending on the level of the health facility, the staffing, equipment, and staff competencies, etc. The DADH FP officer would also be responsible for any designated reporting as well as routine adolescent health supervision of the work being undertaken by the health centres.

District Adolescent Health Technical Working Group (DADH TWG): Additionally, the DADH FP would be responsible for convening the DADH TWG (See Appendix 3 for the TOR). The function of the Adolescent Health Technical Working group (ADH – TWG) would be to coordinate and harmonize the efforts of health, education, youth, and local government, as well as key NGOs and CBOs working on adolescent health, to ensure effective linkages and referrals. The current draft TOR (which will be provided in the ADH Standards supplement) recommends bi-monthly meetings, with joint field monitoring to health centres and into the community, every other month, by the key line ministry and NGO partners.

At Health Centre level,[56] clinical health workers should receive in-service training on adolescent health, dependent on the number of staff, equipment and competencies. In large facilities, the providers of SRH, HIV and ANC services should be the priority staff to receive training on the adolescent health package and standards. Key support staff should be oriented on adolescent health issues, as they need to be responsive and welcoming to adolescent clients.

[56] This depends on the size of the facility. At lower level facilities, with say 4-6 clinical staff all HCW can be trained. In the larger facilities – the recommendation is to train the HCW providing the SRH, HIV and ANC services.

Health Centre Adolescent Health Focal Points: At least two clinical staff should be designated as the Health Centre Adolescent Health Focal Points (see Appendix 3 for the HC ADH FP TOR) for promoting AFHS within the Health Centre management team. The HCADH FP would also be responsible for the reporting and supervision of adolescent disaggregated HMIS data collection. They will also be responsible for the supervision of the Adolescent Friendly Space and Peer Educators, and will receive the same incentive package as the Peer Educators and will participate in the Peer Education Training.

Adolescent Friendly Space (AFS): Each Health Centre will need to (re)designate a space for the (re)establishment of an Adolescent Friendly Space (AFS), previously referred to as an adolescent and youth friendly corner (See Appendix 2 on AFS TOR). The AFS will be manned by trained volunteer peer educators and act as a first stop for adolescents to get information, counselling; and access to condoms and IEC materials. Guided referrals will be provided from the AFS to the SRH, HIV and other services within the health centre. The AFS will need to have a minimum of 8 trained peer educators, to ensure that at least one male and one female volunteer is on site daily, while two volunteers are engaged in health promotion and demand creation outreach activities. Two peer educators should be designated as Co-Team Leaders(Lead Peer Educators) who will support the HCADH FP with the supervision and management of the AFS and the peer educators' activities and reporting, as well as represent the volunteer peer educators within the Health Centre management team.

APPENDIX 2: Adolescent Friendly Space – Minimum Package Guide

Purpose: Adolescent Friendly Spaces (AFS) are to be (re)established at Health Facilities. Their main function is to act as an entry point for adolescent clients to the respective health facility. Basic services - information, condoms and IEC materials and guided referral to services should be offered by trained volunteer peer educators at this service delivery point.

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/meetingbench for peers. They should have one lockable cupboard to store reporting forms, IEC materials, condoms, and any sports equipment. The initial supply of sports equipment would be two soccer balls and two netball[57]. Their location will be determined based on the availability of space at the facility[58]. They should be easily accessible, as well as offering a measure of confidentiality. Signage – which directs the adolescent to the AFS and indicates its operating hours is a requirement.

Volunteer Staffing: The space is to be manned by trained community based volunteer peer educators. To ensure regular coverage, it is proposed that a minimum of 8 volunteer peer

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

[58] The desk, chairs and bench 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 & referrals.

educators[59] (equal females and males) to be trained for each space. This is to ensure full time coverage of at least 2 peer educators – one female and one male – during the H/C operating hours while 2 volunteers are engaged in health promotion and demand creation outreach activities[60]. For planning purposes, this is the number per H/C who would be eligible to attend a 5 day residential peer education training on SRH & HIV information and outreach activities and routine reporting. The incentives packages (T-shirts, Caps, Bags, Boots, Raincoats, torch, reflector vests, ID) budgeting is for 8 peer educators per AFS per H/C, under the 2017-2021 ADH Strategy. Six bicycles (4 for the AFS to be signed out for outreach use by the peer educators) and 2 for the ADH FP are also proposed under the 2017-2021 ADH Strategy. Two peer should be co-team leaders (Lead Peer Educators) to manage AFS staffing and schedules.

Supervision: The spaces are to be supervised by the H/C ADH Focal Points who has been trained in Adolescent Health (ADH) and on the same Peer Education Training as the volunteers.

Core Tasks: As a service utilization entry point – adolescent clients should be initially attended to by the volunteer peer educator. The volunteer(s) are to welcome the adolescent client to the facility and then explain the mix of services[61] -- general and SRH health, HIV testing & counselling (HTC), family planning & contraceptives (FP), etc. They are to explain how the health facility services operate (e.g. OPD service, special clinic days, out-reach to health posts and communities). The peer educator(s) are to 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 (e.g. HTC, etc.). **The promotion of HIV testing and the demonstration and distribution of condoms should be provided to ALL adolescent clients on an 'opt out' basis.** The provision of IEC materials should be done in sufficient quantities, so that the adolescent client will be able to share additional copies with their friends. The AFS volunteers should be trained to record the IEC and condom distribution information[62]. This information should be included in the Health Facility monthly report. When not deployed to the AFS, the other peer educators/counsellors – should have a regular community outreach schedule, to their peers in the community, which should include the distribution of IEC materials and condoms and the promotion of the SRH services (HTC, FP, STI, etc.) available at the Health Centre and the Health Posts. They should undertake outreach to their local schools as well as organizing group discussions and health talks, combined with scheduled games and sports activities, in the community. Data on the outreach schedule, numbers of adolescents talked with and the distribution of IEC materials and condoms should be included in the AFS monthly report.

[59]Note – Peer educators should be between 16 and 24 years old. They should be drawn from their communities. They can includestudents 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. To reduce turn over and improvement, adolescent mothers, who may be familiar with the facility, and more anchored to the community, could be prioritized.

[62] 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 H/C, how these services operate. They also need to be aware of their peers concerns with utilizing different services, etc.

APPENDIX 3: Terms of References

Terms of Reference for: 1) the District Adolescent Health Technical Working Group; 2) the Districts Adolescent Health Focal Point; and 3) the Health Centre Adolescent Health Focal Points.

1) District Adolescent Health Technical Working Group (DADH TWG)

a) Proposed Membership (the TWG could operate as a Task team under the District AIDS Task Force or as a Stand Alone TWG). The Key is to have a small and focused membership, of partners who already undertake work with adolescents).

- Ministry of Health (Secretariat)
- Ministry of Community Development and Social Services
- Ministry of General Education
- Ministry of Youth, Sport and Child Development
- Ministry of Gender
- Ministry of Local Government and Housing
- Ministry of Chiefs & Traditional Affairs
- Civil Society Organizations which work with Adolescents and have district coverage
- Two representatives of adolescents peer educators

b) Operations: The initial plan was for quarterly meetings. This was transitioned to monthly meetings. The current proposal is for bi-monthly meetings, with the alternative month used for field monitoring, led by the MOH District Adolescent Health Focal Point, with key members of the TWG. These joint field visits to health facilities and to communities and different ministries institutions (schools, etc.) should be used to promote access to SRH services and to meet and discuss with adolescents and adults the progress being made and the challenges which need to be addressed. Minutes should be taken of the bimonthly meetings and Field Visit reports generated, using the standard Health Centre ADH Supervision Tools and the issues identified recorded in the following month's minutes.

c) Key Functions:

1) Forum for improving the coordinationand monitoring of adolescent health programmes in the district. (E.g. routinely capturing disaggregated data from implementing partners and report to National ADH TWG through provincial offices).
2) Mechanism for leveraging of human and financial resources among implementing partners to ensure coverage of entire district of adolescent health activities.
3) Platform for advocating for adolescent health issues at district level (based on feedback from field visits, the national strategy, and evidence and research data).
4) Platform for engaging and advising key stakeholders and leaders on key adolescent health bottlenecks which require key sectors to help address in the district– i.e. teenage pregnancies and child marriages.
5) Mechanism for collecting, assessing and then providing feedback on key adolescent health issues and bottlenecks to provincial and national levels.

2. District Adolescent Health Focal Point

Background: Under the current implementation model for the National Adolescent Health programme, one District Health Office staff member needs to be designated as the District Adolescent Health Focal Point. This staff member should be trained as trainers on the adolescent health standards and on the HIV & SRH peer education package and be responsible to manage the training of all health staff, key partners and adolescents in the District.

Key Tasks: The District Adolescent Health (ADH) Focal Pointwill also be responsible to act as the District Adolescent Health Technical Working Group Secretariat (or delegate the responsibility) and to ensure that the structure is operational (see: the District Adolescent Health Technical Working Group – DADH TWG Terms of Reference). The District Focal Point has a key responsibility in developing work plans and managing the utilization of MOH and cooperative partners adolescent health resources, like the adolescent HIV sensitive social cash transfer initiative (in partnership with District Social Welfare office). The Focal Point needs to work very closely with the MOH District Information Officer on the collection and assessment of service utilization data by adolescent clients**.**

Health Centre ADH Supervisions: The District ADH Focal Point needs to ensure that a minimum of 5 high burden Health Centres are identified for the implementation of the full minimum Adolescent Health Services Platform. Depending on the number of staff, either all (centres with 6 or less clinical staff) or all clinical staff providing sensitive HIV, SRH and ANC services are trained on the adolescent health standards, and at least two trained staff are designated as the Health Centre ADH Focal Points. The District ADH Focal Point supervises the Health Centre ADH Focal Points to ensure that their facilities provide adolescent responsive health services. This includes monitoring the routine collection of adolescent age and sex disaggregated data on key SRH and HIV indicators, the dissemination of IEC materials and contraceptives (condoms) and the supervision of the operation of an adolescent friendly space and the peer educators - including their monthly reporting. (See: the new 5 day HIV & SRH Peer Educators Training manual for information on the Peer Educators reporting tool).

The Adolescent Friendly Spaces (AFS) under a minimum of 5 high burden health centresshould be (re)established. These will be manned by 8 trained peer educators who will provide HIV and SRH information, condoms and guided referral to their peers. The peer educators are to undertake mobilization activities among their peers, to schools, and with community organizations and volunteers.

District ADH FP Key responsibilities:

1) Provide technical support in planning, coordination, management and monitoring of adolescent health programme in the district.
2) Act as, or designate, a secretariat to the District Adolescent Health TWGand attend District AIDS Task Force (DATF) monthly meetings.
3) Organize District Adolescent Health Technical Working Group bimonthly meetings and bimonthly field visits.
4) Plan, support and monitor the training of HCW and peer education in the district.
5) Monitor the deployment, retention, activities and reporting of the peer educators.
6) Ensure that all facilities in the district submit monthly disaggregated adolescent health data to the district office.
7) Support the MOH District Information Officers to aggregate disaggregated data from health facilities for reporting to the provincial and national levels and the District Adolescent Health TWG
8) Undertake routine supervision of Health Centres and their AFS and ensure distribution of HIV/SRH information materials including condoms to all clinics and AFS and monitor mobilization and outreach activities (especially between schools, health facility linkages)

and linkages between peer educators and community volunteers (health, social welfare, WASH, etc.).

3. Health Centre Adolescent Health Focal Points

Background: The current implementation model for the National Adolescent Health programme calls for at least two health staff from a health centre, who has been trained on the national Adolescent Health standards, to be designated at the Health Centre Adolescent Health Focal Points (HCADH FP). These staff members, once designated and active, will also be trained as trainers on the HIV and SRH peer education package, and provided with the same incentive package of materials, including a bicycle and community outreach allowances (dependant on funds). This will be linked to their joint accountability to supervise the peer educators attached to their health centre. By attending the training, they will also be able to do 'in-service basic training' for new Peer Educators, on site, based on the Trainers Manual version of the MOH Peer Education Manual, to routinely replenish volunteers who have dropped out.

The Adolescent Friendly Space (AFS) and Peer Educators: These are to be (re)established at Health Facilities. Their main function is to act as an entry point for adolescent clients to the respective health facility. Basic services - information, condoms, IEC materials and guided referrals, should be offered at this service delivery point. The H/C ADH FP key responsibility is to supervise and support the operations of Adolescent friendly spaces, and to work with and manages the eight AFS designated peer educators. Two Co-Lead Peer Educators (Lead Peer Educators) need to be designated to assist the Health Centre ADH FPs, especially around scheduling operation of the AFS and outreach activities and the consolidation of the individual Peer Educator's reports into a monthly Health Centre Peer Education Activity Report[63].

IEC Materials and Condoms: TheHCADH FPs also need to oversee that their facility has IEC materials on HIV and SRH in stock and being displayed and distributed. The management of condom supply is also critical, as they need to be easily accessible in a number of locations at the health centre – with no requirement for people to sign for them. Supply numbers from DMO or MSL should be based on 30 male condoms per year for each adult male over age 15 in the Health Centre Catchment area (e.g. for a population of 10,000 – 2500 would be adult males – so this would be 75,000 male condoms – a average monthly stock of 6250 (approximately 43 boxes per month of 144 male condoms per box). Distribution numbers should be generated based on the Health Centre stores/pharmacy stock – e.g. what was in stock, plus what arrived at the facility that month, and what was taken out of the stores/pharmacy for the different distribution sites. Distribution can be estimated by looking at the numbers taken out of the pharmacy for the different distribution sites in the facility and the numbers still at the different distribution sites, to estimate the numbers that have been taken up by clients. In addition, getting the condoms out of the facility into the community is very important. This is a key activity for the Peer Educators. They will need access to significant stocks of the Health Centres condoms for community based promotion, demonstration, and distribution to adolescent aged 16 and above.

Community Outreach: The ADH FPsshould undertake regular meetings with key community leaders, at least once per month, to ensure they are supportive of adolescents accessing HIV and SRH services. Use of the facility SRH data is useful for advocacy. They should also undertaketwice a month with the peer educators HIV and SRH health talks at

[63]Please see the Peer Educator training manual for the Peer Educators reporting tool. Also, see the Adolescent Friendly Space Minimum Package Guide, in Appendix 2 of this document. Additional information on peer education activities, including TORs and Reporting Tools are found in the ADH Peer Education Training manual.

schools, churches, markets, and sports grounds in their catchment area. They should develop a working relationship with the school(s) management and guidance and counselling focal points and promote to learners the availability ofadolescent responsive health services at their health facility. The Health Centre Focal Points should work with the Peer Educators and support them to undertake two formal mobilization activities per month among their peers, to schools, and with community organizations and community volunteers.

Data collection: They will also be responsible to ensure that their facility extracts adolescent data monthly from the different ledgers (FP, ANC, HTC, etc.). The MOH HIA data collection tool has now added age and sex disaggregated indicators on key HIV to monitor adolescent health issues and track service utilization. The Co-Lead Peer Educators can also be designated to assistance with the extraction of the adolescent data from the ledgers, in partnership with the key service providers – e.g. the HTC provider, etc. The U-report sms tool can now be used to report the service utilization and peer educator's monthly activity data to MOH and NAC.

Health Centre Adolescent Health Focal Points

Key responsibilities

1) Ensure that adolescent responsive HIV and SRH services are available at the centre.
2) Support establishment and functioning of the AFS at health facility and deployment of peer educators to zones within the facility catchment area and organize refresher training for peer educators.
3) Coordinate the facility adolescent friendly health activities by supervising the operations of the AFS and peer educators.
4) Support health facility providers with the delivery of HIV and SRH services – as directed by the Officer-in-Charge (OIC) of the facility (e.g. disaggregated data collection, condom distribution, etc.).
5) Manage and supervise the Peer Educators'community outreach activities, ensuring that Peer Educators are doing community outreach to key hotspots to hand out condoms and IEC materials and do SHR talks, games and one-on-one peer education. (Note – at least 2 Peer Educators need to always be available at the AFS every day the Health Centre is open).
6) Oversee that the Health Centre has a relevant stock of ADH IEC materials and significant numbers of condoms for peer educator distribution (Based on undertaking and monitoring stock against the 30 male condoms per year per adult male aged 15 in the catchment area forecasting and tracking formula).
7) Oversee the collection of the HIV and SRH service utilization by adolescents data using the MOH FLEA (Facility Ledger Extracted Adolescent) data form for consolidating disaggregated data on adults and young adults use of Family Planning, ANC, HTC and ART service, and ensure that this data is submit to District Information Officer monthly.
8) Supervise that the Peer Educators are completing their 'daily outreach' logs and consolidating this information monthly. Ensure that the Lead Peer Educators are producing a Consolidated Peer Educators/ASF Monthly Report. (Note: These Reports cover the number of adolescents who visited the AFS and the number of Peer Educator Outreach conducted. The reporting format requires information on the key issues discussed the number of condoms distributed, and number of referrals made, and for which issue, to the Health Centre -- see the Peer Educator manual). The Peer Educator Activities Report needs to be submitted on monthly basis to the District ADH Focal Point, for consolidation and review by the District ADH Technical Working Group. They will also supervise the availability of this data, when undertaking routine visits to the health Centre.)

APPENDIX 4: ADH Result Framework Performance Targets 2017 – 2021

Program Objectives and Indicators	
No.	**Objective**
Objective 1	To ensure availability of the minimum adolescent health package in 60% of districts by 2021.
Objective 2	To increase adolescents' awareness and utilization of available health services to promote healthy living.
Objective 3	To strengthen and advocate for an enabling environment that ensures health for all adolescents, without discrimination.

Table 13.

Obj. No.	Indicators	2016 Baseline	2017	2018	2019	2020	2021
1.1	Minimum package harmonized by December, 2017 {Source: ADH-TWG minutes}	Draft package available	Package harmonized end Dec.	-	-	-	-
1.2	Percentage of districts with functional minimumADH Services by 2021.{Source: PA reports}	24%	30%	40%	50%	55%	60%
1.3	No. of HC with minimum ADH delivery package are operating routine facility to school outreach by 2021{Source: PA reports}	60	112	164	216	268	320
1.4	All HC with minimum adolescent health service delivery platform are operating routine facility to community outreach by 2021{Source: PA reports}	24%	30%	40%	50%	55%	60%
1.5	Integrated nutrition package being implemented within ANC/PMTCT for adolescent mothers by December, 2019 {Source: PA reports}	-	-	-	Done		-
1.6	Line Ministries and Government Agencies represented on the ADH-TWG, by December 2017 {Source: ADH-TWG minutes}	-	100%	100%	100%	100%	100%
1.7	Number of ADH related joint sensitization programs/activities developed and implemented / Year {Source: ADH-TWG minutes}	-	1	2	2	2	2

Obj. No.	Indicators	2016 Baseline	2017	2018	2019	2020	2021
1.8	At least 60% of districts with at least one HCW in 50% of their health institutions trained in ADH {Source: PA reports}	24%	50%	60%	60%	60%	60%
1.9	Number of Full ADH Service Health centres with 25% of health workers trained on ADH standards	60	112	164	216	268	320
1.10	Curriculum for pre-service training of MOs/COs reviewed, updated and implemented to include ADH issues by December, 2018		Curriculum Reviewed	Curriculum Implemented	-	-	-
1.11	At least 60% of districts using age and disaggregated data tools (HIA2) in their health facilities {Source: PA reports}	24%	60%	-	100%	-	100%
1.12	Annual Progress Report made and presented at ADH annual retreat {Source: ADH-TWG minutes}	-	Progress report presented	Progress report presented	Progress report presented	Progress report presented	Progress report presented
1.13	HTS Post Test Support Services package (PTSS) for adolescents designed and being implemented in 100% of ADH Priority Health Centres {Source: ADH-TWG minutes/ PA reports}	0	120	164	216	268	320
1.14	Conduct a Mid -Term and End of year reviews{Source: ADH-TWG minutes}	-	-	-	Mid – Term Review of Strategy	-	End of Strategy review conducted
1.15	Percentage of districts with clearly established structures and processes allowing for adolescent participation in the implementation, monitoring and evaluation of the ADH strategy {Source: PA reports}	24%	30%	40%	50%	55%	60%

1.16	Number of Operational Research conducted {Source: ADH-TWG minutes}	-	-	1	-	1	-
1.17	Number of adolescent peer educators adolescents trained on new package {Source: ADH-TWG reports/ PA reports}	480 (TBC)	800	1120	1440	1760	2080
2.1	Number of districts with ADHS with active community based adolescent peer educator led drama clubs formed {Source: PA reports}	--	15%	30%	45%	55%	60%
2.2	Number of IEC materials produced and distributed {Source: ADH-TWG reports}	240,000	1,500,000	1,500,000	2,000,000	2,000,000	2,000,000
2.3	Percentage of schools reached with CSE in ADH Platform districts {Source: ADH-TWG reports}	TBD	40%	80%	100%	-	-
2.4	Percentage of communities reached with community OSY based CSE – 60 ADH Districts	TBD	10%	20%	30%	40%	50%
2.5	BSCC condom promotion intervention for sexually active adolescents designed and implemented {Source: ADH-TWG reports}	-	-	Done by end Dec.	-	-	-
2.6	National Integrated Mass and Community Media campaign designed and implemented on national, commercial and community radio which promotes the utilization of SRH/HIV and NCD services by adolescents / quarter {Source: ADH-TWG minute reports}	-	1	1	1	1	1
3.1	A separate budget line for ADH at provincial and district levels created by December, 2018{Source: ADH-TWG minutes}	-	-	Done	-	-	-
3.2	Revision to age of consent and access to SRH services conducted and new guidelines developed and implemented{Source: ADH-TWG minutes}	-	-	Done	-	-	-

APPENDIX 5: The Minimum Adolescent Health Services Platform Costing

Background: The Tentative Costing to the activities below are based on MOH costs submitted by DHDs during the implementation of the platform minimum activities by 25 Districts & 120 Health centresduring 2015-2016 which are already implementing the ADHS platform in 4 to 5 high burden health centres. **Additional national level and district costs are included in the budget to cover the health promotion and demand creation components and leadership and governance coordination and logistics and monitoring.**

Core Adolescent Friendly Services Platform Activities:

- National Planning, Lesson Learned & review meetings with National, Provincial & District Staff
- Provincial Supervision to Districts support
- District Teams – planning, budging & implementation management --MOH (MNCH, Planning & DIO) [**Institutionalization** – Adolescent HIV Technical Working Group (DATWG)– under DATF – core group membership – MOH, MOCDSW, MOY, MOGE, & district wide NGO/CSOs working with adolescents]
    - DADHTWG meetings
    - DADHTWG monitoring/supervision outreach (SW/MOH)
- Disaggregated data collection on adolescents utilization of HIV & SRH services (may now not be need with ADH indicators being integrated under national HMIS)
- One day Orientation on HIV and incentives for NHC volunteers to address adults attitudes to adolescents accessing HIV & SRH services
- Community Sensitization (Homage to the Traditional Leaders on need to address adolescent HIV/SRH issues) Training of all[64] health workers from 5 Health Centres per district (selection based on high numbers of adolescents, prevalence of HIV in catchment area and prevalence of teenage pregnancy and accessibility of health centre to Boma for management in 1st year)
    - Training Health workers
    - Refresher Training of Heath workers
    - Health Centre ADH Focal Point – community outreach support
- Establishment of adolescent friendly spaces (AFS) at health centres
    - Minimum renovation costs for an available space – based on minimum standards list of table, bench, chairs, etc.
- Training of adolescent peer educators (minimum of 8 per AFS plus 2 Health Centre Adolescent Health Focal Points (H/C ADH FP) who supervise the AFS, Peer Educators and H/C ADH activities)
    - Training of AFS peer educator (new)
    - Refresher training of peer educators (replacement & new activities) training
    - Refresher Orientations
    - Incentive supplies for Peer Educators and H/C ADH FP (minimum package new /refresher - replacement – T-shirt, cap, bag, boots, raincoat, shared bicycle for Peers)
- Support to Outreach for Peer Educators (K100 per month as transport allowance – dependent on availability of resources and performance driven – based on reporting).
- Support to Outreach by H/C ADH FP to schools, churches, community to promote availability of ADH services (dependent on availability of resources and performance driven).

[64]In small rural health Centres the aim is to train all HCWs. In large facilities with more than 10 HCWs – the focus should be on those who provide the sensitive SRH/HIV services. Each facility should have 2 dedicated ADH Focal Points for management of the AFS and Peer Educators and for advocacy and reporting.

Table 14 - Indicative Adolescent Health Strategy Budget				
Activity	**Costing Estimates per activity (US$)[65]**	**Estimated Cumulative Calculation[66]**	**Total Expansion Districts & H/C or by Frequency**	**Total over 5 years**
1. National ADH TWG Annual Planning and Annual Review Workshops	$150 per person x 35 people x 4 nights	US$ 5250 per workshop	X 10 workshops (2 per year)	$ 52,500
2. National level planning with new Districts on Adolescent health Services Platform	$150 per persons per district x 4 peoples X 4 nights = $2400	$2400 x 9 (8 districts & National Team of 4) = $ 21,600	$21,600 x 5 years (8 new districts only each year)	$108,000
3. Provincial Supervision	$ 450 x 4 day per province - district visited = $1800 (DSA & Fuel)	$1800 x 2 districts per province = $3600	X 10 provinces = US$ 36,000 per year	$180,000
4. District ADH TWG meetings (lunch allowances)	6 meetings per district – estimated cost @ $250 per meeting = $1500	$1500 x 25 districts = $37,500 x 5 years = $187,500	8 additional districts @ $12,000 x 5 years = $60,000; +8 @ 4 years = $48,000; + 8 @ 3 years = $36,000; + 8 @ 2 years = $24.000; + 8 @ 1 year = $12,000 = $180,000	$367,500
5. District ADH TWG field monitoring (lunch allowances & fuel)	6 sub-district ADH monitoring @ $100 per trip = 600	$600 x 24 districts = $15,000 x 5 years = $75,000	8 additional districts per year @ $4800	$147,000
6. Volunteers Orientations & Replenishment Orientations	20 per H/F X 4 per district @ $20 each volunteer (all costs) x 1 day =$1600	$ 1600 x 25 districts = 40,000 x 5 years	8 additional districts per year @ $12,800	$392,000
7. NHC Incentives	$10 T-shirt x 80 per district = $800	$800 x 25 districts = $20,000	40 additional districts @ $800 = $32,000	$52,000
8. Training of	5 H/C x 6 = 30	$14,440 x 25	40 additional districts in 5	$2,353,720

[65] Costing estimates incudes DSA, transport, stationary, and meeting refreshments, etc. and the accounting transitional costs.

[66] Costs are related usually for Districts, Health Centers or individuals and primarily the sustaining costs for the 25 districts and 120 Health centers that are currently implementing the AFHS platform. The following column includes the additional scale up costs.

Health Center (H/C) Health Care Workers (HCW) on ADH Standards - @ 6 per H/C (baseline 120 H/F)	persons + 3 trainers & support staff per district = @ $80 x 6 days = $14,440	districts x 3 years = $1,083,000 (Total: 2250)	year @ $14,440 x 3 years x 16 districts = $693,120; +$14,440x 16 districts x 2 years = $462,080; + $14,440 x 8 districts = $115,520: Total: $1,140,480 (Trained 2640)	(Total HCW trained= 4890)[67]
9. Refresher Training of Health Center (H/C) HCW on ADH Standards	2 per health centers per district @ 5 H/C per district @ 10 HCS + 1 trainer x $80 per person x 3 days = $2640	$2640 x 25 districts x 3 years = $198,000 (750 HCW)	8 additional districts per year @ $2640 x 2 years for 16 districts ($84,480), 1 years for 16 districts ($42,240) = $126,720 (480 HCW)	$324,720 (1230 HCW refreshed)
10. District ADH Focal Point Supervision	4 trips per year @ $ 150 per trip = $ 600	$ 600 x 25 districts x 5 years = $75,000	8 additional districts per year @ $600 x 3 years for 16 districts, 2 years for 16 districts x 1 year for 8 districts = $62,800	$ 137,800

Activity	**Costing Estimates per activity (US$)**	**Estimated Cumulative Calculation**	**Total Expansion Districts & H/C or by Frequency**	**Total over 5 years**
11.H/C ADH Focal Point outreach	Funds for H/C ADH FPs to conduct monthly outreach to schools and community leaders to promote ADH @ US$ 20 per month x 12 months = $240 per year	H/C 120 x $240 x 5 years = $144,000	40 additional H/C @ $240 x 4 years = $38,400; + 40 H/C @ $240 x 3 years = $28,800; + 40 H/C @ $240 x 2 years = $19,200; + 40 H/C @ $240 x 1 year = $9600: Total: $96,000	$240,000
12.Training of Peer Educators (Baseline 60 H/F)	8 peers per AFS and 2 ADH Focal Points = 10 per H/C = 50 plus 4 trainers per district = 54 per district. Est. cost per person is US$80 covering stationary, accountant & transport costs). Cost per district 54 x $80 x 6 days = US$ 25,920 per district	480 peer educator and 120 ADH FP trained in year one for completion of baseline districts = US$ 288,000 320 peers and 80 H/C ADH FP trained in year one from 8 expansion districts = US$ 192,000 Total = US$ 480,000	1280 peer educators and 320 H/C ADH FP trained over years 2 to 5 (320 peers and 80 H/C FP per year) = US$ 768,000	$1,248,000
13.Refresher Training for	24 per district @ $80 per day x 3 days =	24 districts x 3 round of trainings	8 additional districts x 3 years = x $5760 =	$783,360

[67]Note: if the 6 newly trained HCW were allocated to new health centers – this would cover 815 H/C

Peer Educators and H/C ADH FP	$5760	@ $5760 = $414,720 (over year 3-5)	$138,240; + 16 districts x 2 years x $5760 = $184,320; + 8 districts x 1 year x $5760 = $46,080 = Total $368,640	
14.ADH Materials	Training Materials (guides, job aids, etc.)	HCW & Peers training	Updated HCW & standards and Peer Education manual & tools	$65,000
15.Peer Educators Incentives (for 8 per H/C to manage Adolescent Friendly Space = 2 H/C HCW ADH FP)	$10 T-shirt; $5 Cap; $25 Bag; $2 Badge; $10 raincoat; $8 rubber boots; $6 torch; $6 reflector vest = $72 per peers	960 peers + 240 H/F ADH FP = 1200 x $72 = $86,400 (for 25 districts)	Plus 40 new districts = 1600 peer educators + 400 H/F ADH FP = 2000 X $72 = $144,000	$230,400
16.H/C Adolescent Friendly Space(AFS) Re-Establishment (purchase of locally made furniture and maintenance)	Basic US$ 500 for:1 table, 4 chairs, 1 bench, 1 book shelve, 4box files, and stationary, some paint& few bags of cement, local labour, locks, etc. plus 2 footballs per H/C	US$ 500 per H/c for AFS x 60 H/C = $30,000	Total H/C over 5 years = 200x $500 = $100,000	$130,000
17.H/C AFS Replenishment	$250 per Health Centre	$250	325 H/C X $250 = $81,250	$81,250
18.Bicycles for AFS	$80 x 4 per AFS + 2 per H/F ADH FPs	125 AFS x 6 = 750 bikes X $80 = $ 60,000	200ASF x 6 bicycles = 1200 x $80 = $ 96,000	$156,000
19.Peer educators Outreach, community mobilization and demand creation	$10 per month x 8 PE per H/C & 2 ADH FPs x 12 months = 10 X $10 x 12 = $1200 per year	60 H/C x $1200 x 5 years = $360,000 60 H/C x $1200 x 4 years = $288,000 Total = $648,000	40 H/C x $1200 x 4 years = $192,000; + 40 H/C x $1200 x 3 years = $144,000; + 40 H/C x $1200 x 2 years= $96,000; + 40 x $1200 x 1 year= $48,000 Total = $480,000	$1,128,000

Activity	Costing Estimates per activity (US$)	Estimated Cumulative Calculation	Total Expansion Districts & H/C or by Frequency	Total over 5 years
20. IEC materials	3.5 million leaflets for peer educators and	4.3 million leaflets @ $0.032 =	-	$233,448

	500,000 posters for H/C, schools and community	$138,448 and 500,000 posters @ $0.19 = $95,000		
21. CBO Capacity Development support and Mass Media Communication	Mass media – TV, radio, community radio and events; plus CBO interpersonal communication activities with community leaders	$240,000 each year for mass media x 5 years = $1,200,000 plus US$ 10,000 per district for CBO community mobilization	$80,000 x 4 years = $320,000 + $80,000 x 3 years = $240,000 + $80,000 x 2 years =$160,000 +$80,000 x 1 year = $80,000. Total $800,0000 (Including condom dispensers)	$2,000,000
22. Development and implementation of HTS Post-Test Support Services (PTSS) Package for condoms, VMMC and FP promotion	PTSS Package development targeting both positive and negative adolescents and integration into AFS guidance; and production of PTSS referral materials	$10,000 for Package development $5,000 for integration into AFS materials $100,000 PTSS packaged materials = $115,000 development	$ 240,000 for reprinting of materials over 4 years	$355,000
23. Adolescent sexual and reproductive health and rights (ASRH&R) community conversations package for community leaders, church leaders, school teachers and parents	Development and implementation of ASRH&R Community Conversations package with community leaders around adolescents, especially girls, access, to condoms and contraceptive services	$10,000 for package development $2000 per 25 baseline district per year @ 25 x 4 years = $200,000	$2000 x 8 districts x 4 years = $64,000 $2000 x 8 x 3 years = $48,000 $2000 x 8 x 2 years = $32,000 $2000 x 8 x 1 years = $16,000	$370,000
24. Support to Demand Creation through outreach between mobilization communities	Peer Educators and H/C ADH FP mobilization events with schools, community centres, youth centres and adolescent friendly spaces and health centres for promotion of linkages and referrals for SRH and	$2000 per 25 baseline district per year @ 25 x 4 years = $200,000	$2000 x 8 districts x 4 years = $64,000 $2000 x 8 x 3 years = $48,000 $2000 x 8 x 2 years = $32,000 $2000 x 8 x 1 years = $16,000	$360,000

	HIV services			
25. Application of comprehensive sexuality education promotion within communities and schools	Community outreach by CBOs to engage teachers and promoting CSE in communities	$1500 per 14 districts non MDGi per year @ x 4 years - $84,000	$1500 x 8 districts x 4 years = $48,000 $1500 x 8 x 3 years = $36,000 $1500 x 8 x 2 years = $24,000 $1500 x 8 x 1 years = $12,000 Total=$120,000	$204,000
26. Promotion of innovative new media, including mobile technology and social media for effective partnership and engagement with adolescents	Support integration of social media platforms targeting young people (e.g. u-report) and link to target campaigns (like condomize)	National level activities for linking social media and innovation campaigns $ 9,000 District mobilization funds: $1000 per 25 districts a year x 4 years - $100,000	$1000 x 8 districts x 4 years = $32,000 $1000 x 8 x 3 years = $24,000 $1000 x 8 x 2 years = $16,000 $1000 x 8 x 1 years = $8,000 Total= $80,000	$189,000

Activity	Costing Estimates per activity (US$)	Estimated Cumulative Calculation	Total Expansion Districts & H/C or by Frequency	Total over 5 years
27. 2017-2021 National ADH Strategy Printing and Distribution and dissemination & new strategic plan 2022-2027 development	$10,000 printing& distribution 2017-2021 Strategy $ 65,000 dissemination $ 13,000 2022-2027 plan development	$1000 per district	105,000 (105 districts)	$88,000
28. Pre-service ADH Curriculum development and implementation	$15,000 development $35,000 printing of materials $15,000 training of instructors	$65,000	-	$65,000
29. Policy and Guidelines development	Review of policy and development of guidelines	$20,000 for review and development and dissemination	$20,000 for review and revision of guidelines for care and support for	$40,000

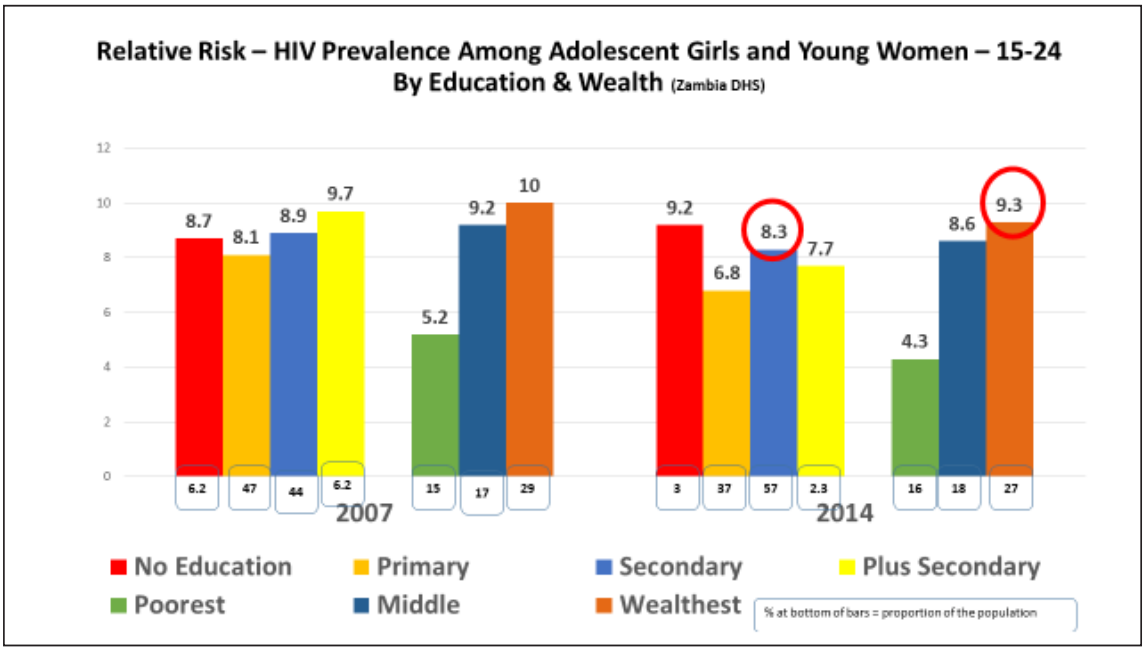
		of policy guidelines on age of consent and access to SRH services	adolescents to transition from paediatric to adult clinical care	
30. Monitoring and assessment of ADH strategy Implementation	Routine annual reviews of HMIS data on adolescents and mid-terms & end programme reviews	$20,000 for Mid-Terms Review $20,000 for End Term Review	$5,000 per year for HMIS data analysis ($25,000)	$65,000
31. Operational Research on adaptive leadership approaches for reducing teenage pregnancy and HIV prevalence	Operational research activities	2 studies funded at $40,000 each = US$ 80,000	-	$80,000
32. ADH Program Vehicles – National & District levels	4x4$35,000 for years 1-3 4x4 replacement $35,000 years 4-5 65 motor cycles	$70,000 4x4 vehicles (2) 65 x US$ 2500 = $162,500	- -	$ 232,500
			Total	**$12,459,198**

APPENDIX 6: Adaptive Leadership Strategies

Example of Innovative Adolescent Health Programme Planning --- the Development of a an Adaptive leadership Approach for HIV Prevention for Adolescent Girls (and Young Women)

Problem Analysis:

HIV prevalence in 2014[68] was highest among females aged 15-24 with no education (9.2%) although they account for only 3% of adolescent girls and young women in Zambia. The next highest groups were females with some secondary education at 8.3%, and they account for 57% of all adolescent girls and young women. Females aged 15-24 from the wealthiest households also had the highest rates of HIV prevalence at 9.3%. These females account for 27% of adolescent girls and young women, while the poorest adolescent girls and young women had HIV prevalence of only 4.3% and they account for 16% of females aged 15-24. This data points to the need for a differentiated response to HIV prevention for adolescents girls and young women. For adolescent girls, some are vulnerable due to limited household assets, and low levels of education, which will affected their levels of self-efficacy.



These girls need an adaptive leadership response that promotes a protective environment that enables these vulnerable girls to access support services. These need relevant sexual health information and context specific risk avoidance and risk reduction skills development. They need enabling community norms and values, which support their access to and utilization of HIV, sexual health and social protection services. For adolescent girls who have some secondary education and come from more wealthy households, they need targeted information and skills development interventions that focus on increasing their HIV risk perceptions and enhancing their self-efficacy and agency around risk avoidance and risk reduction behaviours. These girls have higher levels of comprehensive HIV knowledge and more agency around negotiating and practicing risk avoidance behaviours but their reported condom use is not significantlydifferentfrom poor females while 6 out of 10 of them believe they have low or no risk of HIV infection. (ZDHS Data).

In February 2017, the Ministry of Health held a consultative meeting with stakeholders, including, adolescent girls and young women (AGYW), to develop an adaptive leadership strategic approach to HIV prevention for AGYW.[69] This was a follow-up to the December 2016, MOH, Churches Health

[68]The ZDHS 2014 HIV prevalence data is currently under revision. Although the rates will be slightly reduced, the background characteristics rates data will still be applicable.
[69] The consultation took place from 15 -17 February 2017 at the 360 Convention Centre in Lusaka.

Association in Zambia (CHAZ), and Global Fund seminar in Livingstone, which brought together about ninety participants from various institutions ranging from government ministries, donor agencies, civil society organizations, and civic and traditional leaders.The purpose of the Livingstone seminar was to increase partners understanding of the urgent need for leadership at all levels and to promote the adaptive leadership approach as a tool for reducing HIV incidence amongst adolescent girls and young women in Zambia[70]. The Livingstone meeting conducted a diagnosis of societal and organizational factors and barriers that should be removed to effectively reduce new HIV infections among adolescent girls and young women in Zambia.

Objectives: The main objective of the consultation meeting was to apply the adaptive leadership framework[71]to address social norms with a focus on issues around community beliefs and values. The consultation came up with some new solutions around two of the four themes that were identified at the Livingstone meeting:

1) **Improve collaboration and break down silos** across and sometimes within, government agencies, sectors and civil society organizations to avoid duplication, increase efficiencies and better leverage resources;
2) **Achieve cultural and value shifts** at a personal, family, community and institutional level that move away from moral rigidity, silence or the avoidance of tough/uncomfortable conversations to helping people build the leadership capacity to engage as needed;
3) **Provide a nurturing emotional holding environment for adolescent youth;**
4) **Increase the levels of dialogue and involvement of adolescents in the design and delivery of peer education.**

The Lusaka meeting focused on themes 1 and 2 to develop the interventions. Theme 3 would be one of the outcome of Themes 1 and 2. Theme 4 was seen as on going, which is a key component of the current adolescent health programme being implemented by MOH, and partners. The two gaps identified align with two of the three components of the **MOH Adolescent Health Strategy**. The first is the Leadership and Governance component that is focused on generating an effective harmonized response across the key line ministries at both national and district level. The second is the Health Promotion & Demand Creation component, which aims to addresses social cultural norms that inhibit adolescent's access to relevant sexual information and SRH and HIV services. The proposed activities align with the national Adolescent Health strategy HIV priority and its strategic components and indicative activities. MOH and partners areto ensure a harmonized response that will effectively integrate the HIV AGYW priority activities under the ADH Strategy.

[70] The adaptive leadership model is designed to assist organizations and individuals in dealing with consequential changes in uncertain times, when no clear answers are forthcoming. Adaptive leaders identify and deal with systemic change, using techniques that confront the status quo and identify adaptive and technical challenges.

[71] Technical vs Adaptive Challenges: This model highlights the importance of correctly diagnosing the type of challenge we are facing and want to take action on. Most day to-day challenges are Technical, where the responses are known or knowable. This is thedomain of traditional authority and hierarchies. It restores a system back to status quo and provides predictability and consistency. For example, a broken arm in a health system calls forth a straightforward diagnosis and a known response. Adaptive challenges are the ones where the solutions cannot simply be generated from within existing knowledge and processes. These are challenges that may continue to continue even when we have applying technical solutions to them. They are characterized by being Social (where people have different beliefs & values), dynamic (cause & effect are far away in time and space) and generative (there is uncertainty about impacts). Adaptive challenges require a whole system to learn – including those in roles of authority. http://leadership.benevolent.org.au/programs/adaptive-leadership

ADAPTIVE LEADERSHIP STRATEGY FOR ACTION TO REDUCING HIV AMONG ADOLESCENT GIRLS AND YOUNG WOMEN IN ZAMBIA:

Identified Gap/s	***Proposed Intervention***	***Indicative Activities***
Inadequate coordination between different stakeholders	Strengthen coordination through Technical Working Groups with clear and agreed upon terms of reference (ToRs) which include a differentiated response	• Conduct a workshop to review and or revise already existing HIV TWGs ToRs to reflect the need to apply a differentiated and gendered response. • Develop and adopt a two way communication system both bottom-up and top down to generate local evidence on approaches • Ensure that joint annual review and planning meetings for key stakeholders prioritize applying a differentiated response to AGYW • Capture and increase adolescent girls and young women's representation in technical working groups at all levels(i.e. through quota allocation) • Develop and implement a disaggregated data monitoring, evaluation framework which include innovative surveys and tools to assess the quality of the delivery of interventions, like CSE and to monitor the ASRH attitudes of key gate keepers and AGYW • Strengthen the Adolescent HIV Advisory Committee, under NAC, and ensure applies a gendered response and incudes a focus on vulnerable young women
	Strengthening of CBOs to engage with parents, communities, religious leaders and school teachers on HIV an ASRH&R	• Mapping of CBOs relevant to Adolescent/ youth HIV and SRH&R Conduct capacity assessment for identified CBOs • Develop a mentorship kit for CBOs • Conduct mentorship of CBOs • Counsel on professional code of conduct and institute disciplinary procedures
	Strengthen and harmonize policies and guidelines	• Ensure that all reviewsand revisions ofHIV and SRH guidelines ensure the application of prioritized and differentiated responses for adolescents girls and young women • Ensure that the standardised training and service delivery package for ADH prioritizes AGYW with context specific differentiated approaches • Review, revise and disseminate policy on issues facing AGYW, like the age of consent for SRH and HIV services(including workplace policy)
	Roll out the Adaptive leadership approach targeting key stakeholders	• Undertake targeted advocacy activities on revised HIV and SRH&R policies and guidelines with key gatekeepers, like parliamentarians and traditional lenders • Hold regular high level meetings for bringing together society gate keepers, champions and key decision makers at policy level to look at leadership and programming challenges
Identified Gap/s	***Proposed Intervention***	***Indicative Activities***
Some cultural and religious values and norms prevent parents, communities and schools from addressing HIV education and SRH&R for adolescents and young adults (i.e. Cultural issues –	Development and deploy an advocacy strategy targeting parents, communities, church and traditional leaders, school teachers and the adolescents	• Develop and adopt an HIV/ASRH&R programme approach to reach parents, community leaders, church leaders and school teachers on risk and vulnerabilities of AGYW • Develop and implement an innovative advocacy strategy targeting key bottlenecks and stakeholders • Under the national ADH strategy mobilize communities, parents, teachers and adolescents on the availability of responsive health services • Undertake HIV and SRH awareness raising briefings for PTAs and faith based organizations on social norms which inhibit AGYW access to relevant HIV and SRH information and services

where parents do not talk to their children about sexuality and teachers are culturally constrained in teaching HIV and SRH) Religious values and norms preventing parents, communities and schools from addressing HIV and SRH & R (i.e. assumptions that the promotion of contraceptives is promoting sex before marriage, etc.).		• Review and revise training materials for health and school based counsellors and social workers to ensure AGYW issues are prioritized (Utilize existing structures) • Review the curricula for the alangizi (traditional teachers on SRH and HIV) to ensure AGYW issues are being addressed
	Development of communication campaigns with innovative approaches and tools to promote AGYW health seeking behaviours and increase their knowledge on sexual health and development opportunities	• Launch sustained national mass and interpersonal communication campaigns on what has changed, what we can do & how we can do it. • Information dissemination through sensitization workshops for traditional leaders (paramount chiefs, chiefs, sub chiefs, indunas, headmen • Identify of key champions (political, traditional, civil society, youths, church leaders) to use in the change campaigns • Develop, print and disseminate targeted HIV and SRH IEC materials (posters, brochures, leaflets, etc.) for opinion leaders, parents and different groups of AGYW (in local languages) • Review and revise and re-develop innovative and adaptive life skills, CSE and peer education modules for use by different cadre (teachers, CBO volunteers, health and youth workers, community volunteers, peer educators, etc.)

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