ADOLESCENT-FRIENDLY HEALTH SERVICES IN **ZAMBIA**

Healthcare Workers' Perspectives on Barriers and Services Offered

sharp
Solutions for Supporting Healthy Adolescents

ADOLESCENT-FRIENDLY HEALTH SERVICES IN **ZAMBIA**

HEALTHCARE WORKERS' PERSPECTIVES ON BARRIERS AND SERVICES OFFERED

Authors
Gaby Ooms, Research Manager, Health Action International
Janneke van Oirschot, Research Officer, Health Action International
Liyoka Liyoka, Executive Director, Medicines Research and Access Platform

Acknowledgments
Special thanks to the data collectors for the collection of research data, and the healthcare workers who participated in the research.

JUNE 2023

MedRAP
Medicines Research and Access Platform

HAI HEALTH ACTION INTERNATIONAL

Funded by the European Union

Publisher
Health Action International
Overtoom 60 (2) | 1054 HK Amsterdam
The Netherlands
+31 (0) 20 412 4523

HAIWEB.ORG

This publication has been produced with the financial support of the European Union. Its contents are the sole responsibility of Health Action International and do not necessarily reflect the views of the European Union.

TABLE OF CONTENTS

1. BACKGROUND

Access to sexual and reproductive health (SRH) services forms a crucial building block of health systems. Poor access to SRH services can result in early and unintended pregnancies, maternal mortality, HIV and sexually transmitted infections (STIs), as well as complications from untreated STIs, such as pelvic inflammation, specific types of cancer, and pregnancy and fertility issues. A health system is well equipped to provide SRH commodities and services when people are enabled to decide on pregnancy, to have a healthy pregnancy and safe childbirth, to protect themselves against STIs and HIV/AIDS, and are properly treated in a timely manner if transmission occurs. For a thriving society, it is also crucial that adolescents, a group often faced with additional challenges in accessing services, can access the SRH services they need to live healthy lives and protect themselves against key health risks.

Unfortunately, Zambia experiences many challenges with the adequate provision of adolescent-friendly SRH (AFSRH) services. This research was conducted to study the provision of AFSRH services and attitudes of healthcare workers in Luapula and Southern provinces in Zambia.

2. METHODOLOGY

This study was conducted by Medicines Research and Access Platform (MedRAP) and Health Action International (HAI) as part of the Solutions for Supporting Healthy Adolescents and Rights Protection (SHARP) programme, funded by the European Union. The research was approved by the National Health Research Authority (ref: NHRA0000007/19/10/2022) and was supported by the Zambia Ministry of Health.

This study used an adjusted version of the HAI/World Health Organization (WHO) Methodology[1] and, through a cross-sectional survey design, to gather insight into the provision of AFSRH services in Zambian health facilities. Teams of data collectors visited 182 health facilities from the public, private, faith-based and associative sectors to assess:

1. The type of SRH services being offered at the health facility.
2. To whom these services were offered, and whether parent/guardian consent was needed.
3. The measures in place at the health facility to improve access to SRH services for adolescents.
4. The attitudes and perspectives of the healthcare worker on AFSRH services.
5. Indicators on the general state of the health facility.

Health facilities that were included in the research ranged from health posts to teaching hospitals. One healthcare worker in every health facility was requested to provide the above information. In addition, eight questions were answered by the data collector based on their observations at the health facility. Healthcare workers were asked for their consent to participate in the study.

1. Measuring Medicine Prices, Availability, Affordability and Price Components. 2nd edition. World Health Organization, Health Action International. (2008). Geneva: Switzerland.

3. FINDINGS

Table 1 shows the distribution of surveyed healthcare workers across sectors and urban/rural locations. A total of 78 healthcare workers from the public sector, 11 from the private sector, and three from the faith-based sector were surveyed. Since only three healthcare workers were surveyed from the faith-based sector, this sector is not shown in the results as a separate sector. However, the data is included in the total percentages.

The specific findings from this report are presented in six different sections: Section 1 describes the provision of adolescent-friendly services; Section 2 goes into detail on the SRH services being offered as well as their costs; Section 3 highlights some of the processes for policies; management and oversight; Section 4 sets out the findings around training, education and outreach and Section 5 shows statistics on visible characteristics of the health facility, as filled in by the data collectors. Finally, Section 6 focusses on recommendations from healthcare workers to improve the provision of AFSRH services.

Table 1. Number of surveyed healthcare workers per sector and urban/rural location.

	Public	Private	Faith-based	Total
Urban	21	10	0	**31**
Rural	57	1	3	**61**
Total	**78**	**11**	**3**	**92**

3.1 Provision of Adolescent-friendly Services

Overall, 80% of healthcare workers indicated that their health facility was officially accredited as an adolescent-friendly health centre (see Table 2). Interestingly, these numbers differed considerably between the two sectors, with the public sector having more officially accredited adolescent-friendly facilities. A total of 89% of healthcare workers said that their health facility offered AFSRH services, irrespective of whether they were officially accredited as an adolescent-friendly health facility; many more private sector facilities did offer AFSRH services even though they were not officially accredited as an adolescent-friendly health facility.

Table 2. Health facilities accredited and offering AFSRH services.

	Public (%)	Private (%)	Overall (%)
Health facility is an accredited adolescent-friendly health facility	84	45	**80**
Health facility provides AFSRH services	91	73	**89**

Sixty-six health facilities responded to an open question on how services were made adolescent friendly. The most common responses were that the health facility had a youth-only space or waiting room (13 times), that it had a peer education programme (12 times) and that privacy was guaranteed (11 times).

If health facilities did not offer AFSRH services, the healthcare worker was asked for the reason why. In total, eight health facilities answered this question. A word cloud specifying the most often mentioned reasons can be found in Figure 1. Two health facilities mentioned that they planned to start an AFSRH programme soon, while two other mentioned that they lacked a space where adolescents could gather. Other reasons provided by single health facilities were that the person in charge left, that it fell outside of the health facilities' remit, and that adolescents are referred to the hospital.

Figure 1. Reasons given for health facilities not offering AFSRH services.

Figure 2 lists some common characteristics of adolescent-friendly health services. The study found that, overall, health facilities in Zambia scored well on these characteristics. For instance, at 90% of health facilities adolescents could see a healthcare worker without a formal appointment. In addition, in 89% of health facilities adolescents can request to be seen by a same-sex healthcare worker, and 84% of the facilities have a private examination room to discuss SRH issues with clients. Further, 80% of health facilities had dedicated staff offering AFSRH services, and 70% of the facilities were open during the evening or the weekend for SRH services.

When comparing findings across the sectors, the public sector scored the highest on all indicators except one (see Table 3). For example, 83% of public facilities have dedicated staff offering AFSRH services, compared to 55% of facilities in the private sector. Similarly, 87% of health facilities in the public sector have a private examination room where they can discuss SRH services and issues with clients, compared to 55% of health facilities in the private sector. In the private sector adolescents also had less chance to be able to request a same-sex healthcare worker (64% vs 93% in the public sector). However, 90% of health facilities had a staff member who was 25 years or younger who can offer SRH services to adolescents, compared to 71% in the public sector.

Figure 2. Adolescent-friendly organisation of care

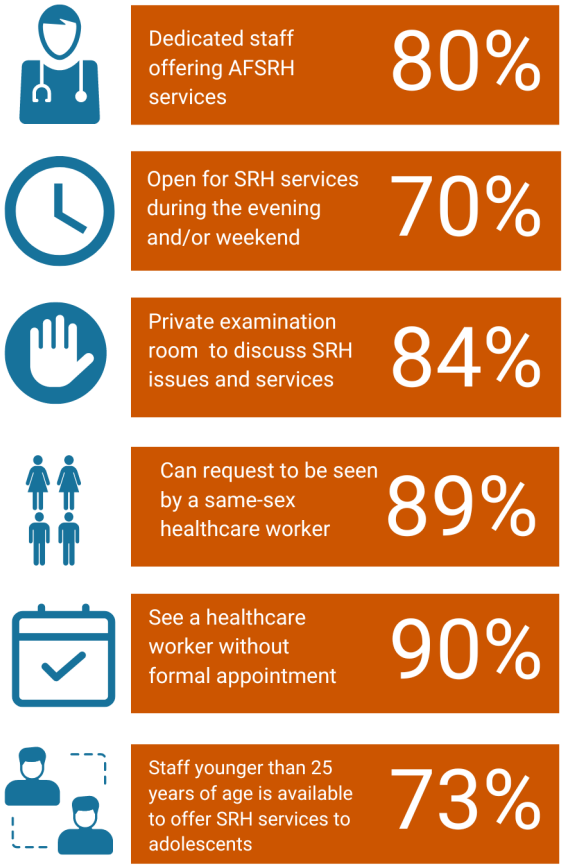


Table 3. Adolescent-friendly organisation of care, per sector.

	Public (%)	Private (%)
Dedicated staff offering AFSRH services	83	55
Facility open for SRH services during the evening and/or weekend	74	55
Adolescents can see a healthcare worker without formal appointment	90	82
Adolescents can request to be seen by a same-sex healthcare worker	93	64
Private examination room at the health facility where healthcare workers meet with clients to discuss SRH issues and services	87	55
Staff working at the health facility who are younger than 25 years and can offer SRH services to adolescents	71	90

When zooming in on the ways in which adolescents could make an appointment for SRH services, we found, again, that in most cases (89%) no appointment was needed (see Figure 3). This statistic was more or less similar across the two sectors (see Annex 1). In both sectors, in around 40% of health facilities appointments could be made at the reception. Other methods for making appointments, such as by phone, or via text messaging/WhatsApp, were generally less commonly used in the public sector, while in the private sector these methods to make an appointment were more often used (30%-60% of health facilities).

Figure 3. Ways in which adolescents and youth can make appointments for SRH services.*

*Multiple answers were possible

The survey further asked healthcare workers about their personal opinions on 11 different statements. Their perspectives on these statements can be seen in Table 4. Almost all (97%) healthcare workers indicated that adolescents feel welcome and safe at the health facility, and at ease to access SRH services. Further, 95% of healthcare workers indicated their health facility was easily and safely accessible for adolescents by foot or public transportation, and 92% stated they have enough time to sufficiently treat and answer questions of adolescents accessing SRH services. Waiting times at the health facility were seen as a barrier by 14% of surveyed healthcare workers, while cost was mentioned to be a barrier to adolescents by 80% of private sector healthcare workers and 6% of those working in the public sector.

Regarding attitudes of healthcare workers, 94% of healthcare workers (97% in the public sector, 82% in the private sector) said they are okay with providing contraceptives to unmarried women. Similar percentages feel comfortable talking about contraceptive and SRH matters with adolescents, even though slightly less healthcare workers feel comfortable providing contraceptives to adolescents (93% in the public sector, 73% in the private sector). Further 59% of healthcare workers in the public sector, and 64% of healthcare workers in the private sector advise adolescents to abstain from sex when they seek contraceptives at the health facility. Similarly, 49% and 73% of healthcare workers in the public and private sector, respectively, believe adolescents should not have sex. About 30% of the surveyed healthcare workers indicated contraceptive use goes against their religion and should therefore not be provided to adolescents.

Table 4. Perspectives of healthcare workers on AFSRH services.

	Public (%)	Private (%)	Overall (%)
Adolescents feel welcome and safe at this facility, and feel at ease to access SRH services	100	75	**97**
This facility is generally easily and safely accessible by foot or public transportation for adolescents	96	91	**95**
I am okay with providing contraceptives to women who are not married	97	82	**94**
I feel comfortable talking about contraceptives and sexual health matters with adolescents	97	82	**94**
When offering SRH services to adolescents, I have enough time to sufficiently treat and answer their questions	93	80	**92**
I am okay with providing contraceptives to adolescents younger than 18 years	93	73	**89**
I advise adolescents to abstain from sex when they seek contraceptives at the health facility	59	64	**59**
Adolescents should not have sex	49	73	**52**
Contraceptive use goes against my religion and should therefore not be provided to adolescents	27	36	**28**
Waiting times at this facility to receive SRH services are a barrier to adolescents	13	20	**14**
Costs of SRH services are a barrier to adolescents at this facility	6	80	**12**

3.2 Provision of SRH Services

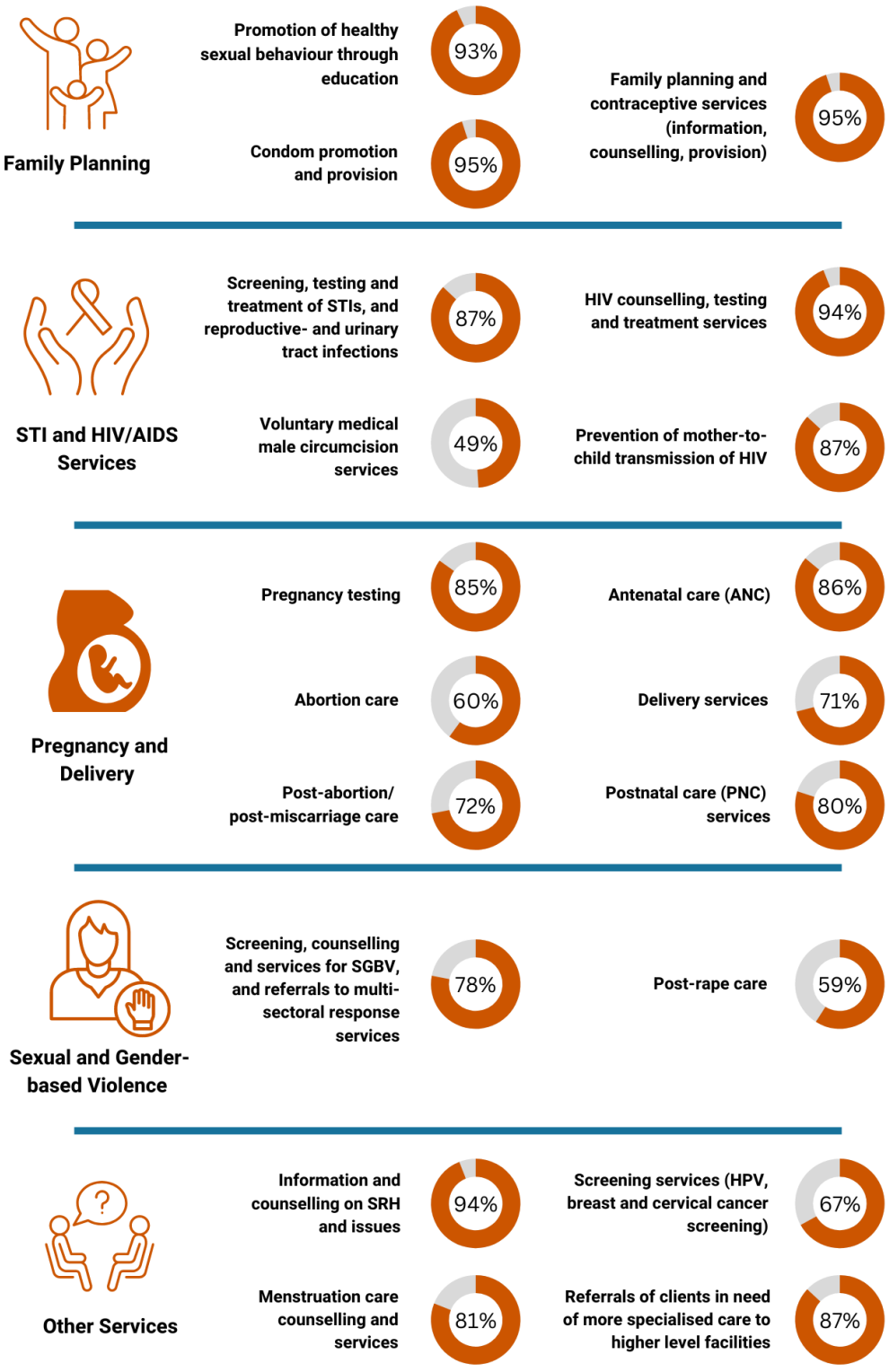
Figure 4 shows the provision of a broad spectrum of SRH services in all surveyed health facilities. Overall, 12 of 19 services were offered at 80% or more of health facilities. The most offered SRH services are family planning and contraceptive services, and condom promotion and provision (95% of health facilities each), followed by information and counselling on SRH and issues, and HIV counselling, testing and treatment services (94% of health facilities each). The least offered SRH services are voluntary male circumcision services (49% of health facilities) and post-rape care (59%).

As can be seen in Table 5 information and counselling on SRH and issues was provided at 94% of health facilities. Of the health facilities that offered this service, 95% also offered it to adolescents under the age of 18. This service was offered without permission from guardians/spouse to 97% of boys (10-17 years), 92% of married girls (10-17 years), and 94% of unmarried girls (10-17 years).

Promotion of healthy sexual behaviour through education was offered at 93% of health facilities and was offered to adolescents in 99% of those facilities. The health facilities which offered this service to adolescents were asked whether they provided other means or information to prevent pregnancy besides abstinence. In total, 96% of these

health facilities said that they did. Family planning and contraceptive services were offered at 95% of health facilities, and 95% of these facilities offered this service to adolescents as well. When the health facility offered contraceptives to adolescents, we asked whether adolescents can decide which type of contraceptive they want to use; in 97% of health facilities the adolescent had this choice (public sector 98%, private sector 89%). Condom promotion was offered in 95% of health facilities as well.

Figure 4. Overall percentage of health facilities offering specific SRH Services.



When comparing the provision of SRH services between sectors, some differences were found. For example, promotion of healthy sexual behaviour through education was offered at 97% of public health facilities, and 73% of private health facilities (see Table 5). Screening, testing and treatment of STIs, reproductive- and urinary tract infection was offered at 92% of public facilities, and 55% of private facilities. HIV/AIDS services, such as counselling, testing and treatment, but also prevention of mother-to-child transmission, were also offered less at private health facilities. Maternal health services, such as pregnancy testing, antenatal care, delivery services and postnatal care services were offered at 0% to 45% of private health facilities, while 78% to 92% of public health facilities offered this service.

Table 5. Percentage of health facilities offering specific SRH services per sector.

	Public (%)	Private (%)	Overall (%)
Promotion of healthy sexual behaviour through education	97	73	**93**
Family planning and contraceptive services (information, counselling, provision)	97	91	**95**
Condom promotion and provision	99	82	**95**
Screening, testing and treatment of STIs, and reproductive- and urinary tract infections	92	55	**87**
HIV counselling, testing and treatment services	97	73	**94**
Prevention of mother-to-child transmission of HIV	94	36	**87**
Voluntary medical male circumcision services	54	0	**49**
Pregnancy testing	90	45	**85**
Antenatal care (ANC)	92	45	**86**
Delivery services	78	18	**71**
Postnatal care (PNC) services	92	0	**80**
Abortion care	67	27	**60**
Post-abortion/post-miscarriage care	78	27	**72**
Screening, counselling and services for sexual and gender-based violence, and referrals to multi-sectoral response services (e.g., psycho-social and protection services)	90	0	**78**
Post-rape care	67	0	**59**
Information and counselling on SRH and issues	99	73	**94**
Menstruation care counselling and services	83	73	**81**
Screening services (HPV, breast and cervical cancer screening)	76	9	**67**
Referrals of clients in need of more specialised care to higher level facilities	97	18	**87**

The survey also asked how many strips of the birth control pill clients are given per visit; in the majority of health facilities, they are provided three strips per visit, good for three months of birth control. Some common long-acting contraceptives are intra-uterine contraceptive devices (IUDs) and implants. They require a trained healthcare worker to insert the product. In the public sector, 75% of the health facilities had a trained healthcare worker who could insert an IUD, and 89% had a trained healthcare worker who could insert a contraceptive implant (see Table 6). In the private sector, 45% of health facilities had a healthcare worker who could insert either product.

Table 6. Capability insertion and removal of intra-uterine contraceptive devices (IUD) and implants.

	Public (%)	Private (%)	Overall (%)
Someone at the health facility is trained, and can insert and take out an IUD	75	45	**71**
Someone at the health facility is trained, and can insert and take out contraceptive implants such as Jadelle or Implanon	89	45	**83**

Table 7 displays for which SRH services youth and adolescents have to pay. In almost all public health facilities SRH services are free. In the private sector, clients need to pay for SRH services in 40% to 60% of health facilities. When looking at the type of products that clients have to pay for, they pay for a range of things, including prescription and over-the-counter medications, disposable medical equipment, consultation fees, lab tests, and day charges for hospitalisation.

Table 7. Costs of services

	Public (%)	Private (%)	Overall (%)
SRH services at the facility which clients need to pay for:			
Family planning	4	50	**11**
Maternal health services	4	50	**11**
STI treatment services	4	60	**13**
HIV/AIDS services	4	40	**9**
All of the services are for free	96	40	**86**
If any, type of products clients have to pay for:			
Prescription medications	100	71	**78**
Over the counter (non-prescription) medications	50	100	**89**
Disposable medical equipment (gloves, needles, personal protective equipment)	100	86	**89**
Consultation fee	100	71	**78**
Day charges for hospitalisation	100	43	**56**
Imaging diagnostics	50	71	**67**
Surgical procedures	0	43	**33**
Lab tests	50	71	**67**

3.3 Policies, Management and Oversight

Table 8 provides information on policies and monitoring of the health facility. In the public sector, most of the health facilities (90% or more) had guidelines available on HIV/AIDS testing and treatment, and on referrals for maternal and neonatal services. These guidelines were less available in private sector facilities (56%-78%). The guidelines on adolescent-friendly services and obstetrics and gynaecology were available in 77% and 73% of public facilities, respectively, and in 56% and 44% of private facilities, respectively. The WHO guideline on making health services adolescent friendly were available at around 50% of facilities.

The study further found that monitoring of the health facility's SRH services by government officials is low, with 20% of healthcare workers in the public sector stating that a government official visits their health facilities for this purpose zero times during year. In 40% of facilities, government officials visit four or more times during the year. Finally, adolescents are asked for input/feedback on the design and implementation of SRH services at 66% of public health facilities, and none of the private facilities. If they are involved, this is mostly through meetings on planning, implementation and feedback.

Table 8. Policies and monitoring.

	Public (%)	Private (%)	Overall (%)
The HF has soft or hard copies of the below guidelines/policies available for use:			
National Guidelines for HIV Testing and Counselling in Zambia	93	78	**91**
National HIV/AIDS/STI/TB Policy	91	67	**88**
Zambia National Referral Guidelines for Maternal and Neonatal Services (2018)	91	56	**86**
National Standards and Guidelines for Adolescent Friendly Services	77	56	**73**
Obstetrics and Gynaecology Protocols and Guidelines (2014)	73	44	**70**
Making health services adolescent friendly (WHO 2012)	54	44	**52**
Processes are in place at the HF to ensure that staff is updated and informed about changes when a new policy is developed	87	64	**85**
Frequency at which a government official visits to monitor how the health facility is performing with regards to SRH service provision:			
Zero times during the year	20	18	**20**
One time during the year	7	0	**7**
Two times during the year	9	0	**7**
Three times during the year	1	0	**1**
Four times during the year (quarterly)	29	0	**24**
Five or more times during the year	11	0	**10**
At irregular intervals	20	36	**21**
Don't know	3	45	**10**
The HF has a community committee that provides input into the HF's services and activities	44	9	**40**
Adolescents are asked for input into or feedback on the design, planning, implementation and evaluation of SRH services at the HF	66	0	**56**
If yes, ways in which adolescents are involved in these processes:			
Peer educators group	17	-	**16**
Meetings on planning, implementation and feedback	86	-	**84**
Included in the community health committee	11	-	**14**

3.4 Training, Education and Outreach

Continuous training of healthcare workers on AFSHR seemed not to occur very regularly, since in 54% of the public sector facilities and 9% of the private sector facilities, healthcare workers had received a refresher training in the last 24 months (see Table 9). Educational SRH materials for adolescents were available at 61% of public health facilities, and only 27% of private health facilities. Education materials for parents/guardians on adolescent SRH services to increase their support were available at fewer public facilities (41%), but more private facilities (36%). Regarding outreach and education on SRH, 72% of public health facilities provided this for adolescents within the community. This percentage was much lower for private facilities (17%). Similarly, 79% of public facilities organised group discussions on SRH, again much higher compared to private facilities (27%). The number of times these group discussions were organised ranged from less than once a month to twice per week. Peer educators were used by 75% of public health facilities, and only 9% of private health facilities.

Table 9. Training, education and outreach of the health facility.

	Public (%)	Private (%)	Overall (%)
Staff have received a refresher training on how to provide AFSRH services in the last 24 months	54	9	**48**
Educational materials on SRH and healthy sexual behaviour, such as posters, pamphlets, videos or booklets, targeted at adolescents are available at this facility	61	27	**58**
Educational materials with key messages on adolescent SRH targeted at parents/guardians to support adolescents to access services, are available at this facility	41	36	**40**
The facility provides outreach and/or education on SRH for adolescents within the community	72	17	**65**
If yes, frequency per year:			
Less than once a month	28	100	**30**
Once a month	48	0	**45**
Twice a month	4	0	**6**
Three times a month	4	0	**4**
Four times a month	8	0	**8**
Eight times a month (twice a week)	4	0	**4**
At irregular intervals	4	0	**4**
The facility organises group discussions or talks for adolescents on SRH	79	27	**71**
If yes, frequency per month:			
Less than once a month	20	67	**22**
Once a month	33	33	**33**
Twice a month	2	0	**2**
Three times a month	0	0	**0**
Four times a month	28	0	**28**
Eight times a month (twice a week)	13	0	**12**
At irregular intervals	4	0	**3**
The facility works with adolescent peer educators to provide outreach services to other adolescents	75	9	**65**

3.5 The State of the Health Facility

The information in Table 10 was collected based on observations made by the data collectors when they visited the health facilities. It shows that health facilities could in particular improve on having visible signage on services offered at the facility, as well as its operating hours, and on having visible SRH materials targeted at adolescents. In the private sector, the presence of private rooms where consultations can be held was low (55%).

Table 10. Information on the state of the health facility based on observations of data collectors.

	Public (%)	Private (%)	Overall (%)
Signage with services offered is available and visible at the health facility	51	45	**52**
Signage with operating hours is available and visible at the health facility	41	73	**46**
Materials targeted at adolescents on SRH are visible or provided at the facility (posters, leaflets, videos, etc.)	41	36	**41**
The health facility is clean	89	91	**90**
The health facility has private rooms where consults are held	82	55	**79**
The health facility has electricity	84	91	**85**
The health facility has soap and running water	81	82	**81**
The health facility has clean toilet facilities	84	73	**83**

3.6 Recommendations by Healthcare Workers

Forty-four healthcare workers gave suggestions on how to improve access to SRH services for adolescents. A Word-Cloud based on their responses can be found in Figure 5. From this WordCloud it becomes clear that the need for trained staff, as well as increasing commodities and services, along with the need for more outreach and sensitisation at schools. Below some specific quotes from healthcare workers who voiced what could be done are shared.

"Staffing could be improved, because when staff are busy opportunities are lost because the adolescents leave as they are often shy." HCW1

"Parents should be more involved. Schools should be more involved." HCW2

"Have more outreach programmes. More education and sensitisation on early marriages." HCW3

"I would like to see more healthcare workers trained, enough material, more refer courses to gain more knowledge as healthcare givers." HCW4

"More inclusion in decision making. Their voice is neglected for adolescents. Policies are looking more at girl child as opposed to boy child." HCW5

"The government should maximise on the supply of the SRH commodities." HCW6

Figure 5. WordCloud on what could be improved to enable better access to AFSRH services at the health facility.

4. DISCUSSION AND RECOMMENDATIONS

The Convention on the Rights of the Child (1989) (in Article 24) and the African Charter on the Welfare and Rights of the African Child (ACWRAC) (in Article 14) call on governments to 'recognise the right of the child to the enjoyment of the highest attainable standard of health'.[2,3] The ACWRAC (in Article 4) states, 'In all actions concerning the child (person below age 18) undertaken by any person or authority, the best interest of the child shall be the primary consideration.' The government thus has an obligation to consider the evolving capacities of the adolescents, and to provide services and empowerment programmes that ensure their sexual and reproductive health and rights are observed and respected.

From the results of this study, it can be said that in general, the government of the Republic of Zambia, through the Ministry of Health, has made progress in meeting government obligations to respect, protect, and fulfil the ASRHR of all people, including adolescents, in Zambia. In most thematic areas assessed during the survey, statistics show commitment to improving ASRH services in the public health sector. For example, 91% of the surveyed facilities provide AFSRH services. These services were offered without permission from guardians in 97% of the surveyed facilities. This study also found that 96% of the facilities were easily and safely accessible by foot or public transport (according to the HCWs), while 97% of the healthcare workers also indicated that they were comfortable with providing contraceptives to both married and unmarried women, and discussing sexual health matters with adolescents. Availability of dedicated staff offering AFSRH services was recorded in 83% of the surveyed facilities.

However, there are also a number of thematic areas where performance of public health facilities was below the acceptable levels. For example, the survey observed that in 20% of the health facilities monitoring of health facilities' SRH services by government officials was not done at all during the year. Other results indicated that presence of signage with services offered and operating hours was rarely available (only at 41% of facilities), while SRH materials targeted at adolescents, parents or guardians were also poorly available. Continuous training of healthcare workers on AFSRH seemed not to occur very regularly: in only 54% of the public sector facilities and 9% of the private sector facilities had healthcare workers received a refresher training in the last 24 months.

Conversely, the private sector performed worse in most of the thematic areas cited above. For example, only 73% of the surveyed private facilities provide AFSRH services and only 55% of them have dedicated staff offering AFSRH services. Cost was mentioned as the main barrier to access to AFSRH services. Availability of policies and guidelines ranged from 44% to 78%, while materials targeted at adolescents, guardians or parents were also poorly available.

These findings clearly indicate a broad availability of adolescent-friendly health services, especially in the public health facilities in Luapula and Southern provinces. However, the findings of this study also show that AFSRH service provision across the public and private sectors is hampered by both societal concerns and health system challenges. Therefore, the following recommendations are made to improve service provision:

1. Government officials should conduct regular visits to the facilities and monitor to see whether facilities meet minimum standards in the provision of AFSRH services. The visits should monitor indicators that ensure facilities have adequate budgets; have adequate availability of ASRH commodities; have essential infrastructure; provide adolescent-friendly services; treat adolescents, especially girls, with respect; guarantee privacy and confidentiality of adolescents seeking SRH service; uphold the dignity of healthcare workers; do not charge fees; and address barriers related to harmful cultural practices.

2. UN General Assembly, Convention on the Rights of the Child, 20 November 1989, United Nations, Treaty Series, vol. 1577, p. 3..

3. Organization of African Unity (OAU), African Charter on the Rights and Welfare of the Child, 11 July 1990, CAB/LEG/24.9/49 (1990).

2. Increase transparency and active participation of citizens, CSOs and communities, and especially adolescents, in decision-making processes related to delivery and monitoring of SRH services.

3. Provision of regular in-service training to HCWs in AFSRH services and ensure that HCWs are conversant with SRH when dealing with adolescents.

4. Since adolescents are more comfortable getting information and services from their peers and younger providers, the government should increase investment in training peer educators and providers, and training younger HCWs to take charge of AFSRH services.

5. Incorporate AFSRH in the training curriculum of nurses and other HCWs so that as new staff join the health workforce, they have the knowledge and skills to effectively serve adolescents.

6. Design Zambian guidelines, policies and Standard Operation Procedures (SOPs) that will standardise the provision of AFSRH services in both public and private facilities. These documents should take into consideration socio-cultural and religious values of community members and adolescents.

7. Dissemination of Zambian guidelines, policies and SOPs to public and private facilities, and to HCWs through various channels, including the media and social media platforms, in order to standardise the provision of AFSRH services.

8. Publish more adolescent-specific information, education, and communication (IEC) materials in both English and local languages targeted at adolescents, parents and guardians on SRH.

9. Health facilities should ensure adequate signage is visible at their facility stipulating services offered and operating hours.

10. Increase visibility of AFSRH services. Post a policy statement in the facility that includes the nondisclosure policy to encourage young people to access the services.

ANNEX 1

Table 1. Ways in which adolescents and youth can make appointments for SRH services*.

	Public (%)	Private (%)
At the reception	38	40
Over the phone	15	60
Via text messaging/WhatsApp	7	40
Online	4	30
No appointment needed/walk in	90	80

*Multiple answers were possible.

Funded by
the European Union

sharp
Solutions for Supporting Healthy Adolescents