Republic of Zambia

Ministry of Health

Adolescent Health Strategic Plan 2011 to 2015

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Abbreviations and Acronyms

Abbreviations/ Acronyms	Definition
ADFHS	Adolescent Friendly Health Services
ADH-SP	Adolescent Health Strategic Plan
ADH-TWG	Adolescent Health Technical Working Group
Adolescent	Person aged between 10 to19 years
AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ARH	Adolescent Reproductive Health
ART	Anti-Retroviral Therapy
ARVs	Anti-Retrovirals
BHCP	Basic Health Care Package
CDC	Centers for Disease Control and Prevention of the USA
CH	Child Health
CHAZ	Churches Health Association of Zambia
CPs	Cooperating Partners
CSO	Central Statistical Office
DHMBs	District Health Management Boards
DHMT	District Health Management Team
DHO	District Health Office
DOTS	Directly Observed Treatment Short Course
DPH&R	Directorate of Public Health and Research
DSBL	Drug Supply Budget Line
FAMS	Financial Administrative Management System
FP	Family Planning
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, TB, & Malaria
GRZ	Government of the Republic of Zambia
HIPC	Highly Indebted Poor Countries
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
ICT	Information Communication Technology
IEC	Information, Education and Communication
IMCI	Integrated Management of Childhood Illnesses
IMR	Infant Mortality Rate
IPTp	Intermittent Preventive Therapy in Pregnant Women
IRS	Indoor Residual Spraying
ITCP	Inter-Agency Technical Committee on Population

ITNs	Insecticide Treated Nets
LLINs	Long-Lasting Insecticide Treated Nets
KAP	Knowledge, Attitudes and Practices
M & E	Monitoring & Evaluation
MCDSS	Ministry of Community Development and Social Services
MDGs	Millennium Development Goals
MMR	Maternal Mortality Ratio
MNCH	Maternal, Neonatal and Child Health
MOE	Ministry of Education
MOFNP	Ministry of Finance and National Planning
MOH	Ministry of Health
MOYSCD	Ministry of Youth, Sport and Child Development
MTEF	Medium Term Expenditure Framework
NAC	National AIDS Council
NCDs	Non-Communicable Diseases
NDP	National Development Plan
NFNC	National Food and Nutrition Commission
NHSP	National Health Strategic Plan
NMCC	National Malaria Control Centre
OAU	Organization of African Unity
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
QA	Quality Assurance
R&D	Research and Development
RH	Reproductive Health
SHN	School Health and Nutrition
SNDP	Sixth National Development Plan
SNOs	Senior Nursing Officers
SOWC	State of the World's Children 2010
STI	Sexually Transmitted Infection
Stunting	Inadequate height for age
SWAp	Sector-wide Approach
TB	Tuberculosis
TI	Training Institution
TOTs	Training of Trainers
TWG	Technical Working Group
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
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
Wasting	Inadequate weight for height
WHO	World Health Organization
YFC	Youth-Friendly Corner
Youth	Young person aged between 10 and 35 years
ZDHS	Zambia Demographic and Health Survey
ZGSHS	Zambia Global School Health Survey
ZISSP	Zambia Integrated Systems Support Programme

Foreword

Globally, adolescents represent a significant demographic and socio-economic force, and are also a major factor in influencing public health trends. Adolescence is a special stage in any person's life, representing a period of transformation from childhood into adulthood. It is characterized by major biological, physical, psychological and behaviour changes, which if not properly managed, could lead to significant exposure to risky behaviours, with high consequences on the individual's immediate and long-term health and socio-economic life.

In Zambia, adolescents account for over a quarter (27%) of the total population, and have a significant influence on the health trends. They are highly affected by various health problems, including Communicable and Non-Communicable Diseases (NCDs), particularly: Sexually Transmitted Infections (STIs), including HIV and AIDS; and behaviour-related health problems, including early and unprotected sex, sexual abuse, early marriages and pregnancies, substance and alcohol abuse, accidents and violence, mental health, and unsafe cultural practices.

Several efforts have been made, at both national and sector levels, aimed at protecting children and adolescents, and improving their health status. However, there are still weaknesses and gaps which need to be addressed, in order to improve adolescent health in Zambia. These gaps are found at all levels, including policy, legislation, planning, financing, implementation, and monitoring and evaluation levels. It is for this reason that we have prioritised adolescent health in the National Health Strategic Plan 2011 to 2015 (NHSP 2011-2015) and have developed this strategic plan.

I therefore wish to commend the Directorate of Public Health and Research of the Ministry of Health (MOH), and all our partners and technical experts, who contributed to the process of developing this strategic plan. I also wish to call upon all the stakeholders, including the directorates within our ministry, other government line ministries and departments, the private sector, faith-based organizations under the Churches Health Association of Zambia (CHAZ), communities, and Cooperating Partners (CPs) to support the implementation of this plan. It is my sincere hope that this plan will provide the necessary strategic framework for implementation of Adolescent-Friendly Health Services (ADFHS), and will significantly contribute to the attainment of the national health objectives and Millennium Development Goals (MDGs).

Thank You

Dr. Peter Mwaba
Permanent Secretary
MINISTRY OF HEALTH

Acknowledgements

The development of this strategic plan has been successfully concluded. On behalf of the MOH, and indeed on my own behalf, I wish to thank all the institutions and individuals who contributed to this process, including our members of staff and the various partners. In this regard, I wish to pay special tribute to the following, for their participation and contribution to the process of developing this plan:

- Zambia Integrated Systems Support Programme (ZISSP)/USAID for the financial and technical support rendered towards the development of this plan;
- The World Health Organisation (WHO) for the financial and technical support to the Adolescent Health Situation Analysis, and technical support to the development of this plan;
- Ministry of Youth, Sport and Child Development (MYSCD);
- University of Zambia (UNZA), School of Medicine;
- National Population Council;
- The United Nations Population Fund (UNFPA);
- United Nations Children's Fund (Unicef);
- Churches Health Association of Zambia (CHAZ);
- Planned Parenthood Association of Zambia (PPAZ); and
- Civil society organizations: Africa Directions, Youth Vision Zambia (YVZ), Save the Children, ZRHEP, Young Women's Christian Association (YWCA), MWAZ, and Equality Now.

I also wish to extend my thanks and appreciations to the following individuals who played the role of facilitators: Dr. R Mbewe – Deputy Director Public Health and Research, Reproductive Health Department; Dr. Mary Nambao - Reproductive Health Specialist, MOH; Dr. Mutinta Nalubamba – Maternal Neonatal and Child Health (MNCH) Team Leader at ZISSP; Dr. Wezi Kaonga - HIV/AIDS, MOH; Mrs. Ruth Bweupe - Chief Family Planning and Adolescent Health (FP/ADH) Officer, MOH; Dr. Mary Katepa-Bwalya – WHO National Programme Officer for Child & Adolescent Health; Francis Kapapa - Adolescent Reproductive Health – ZISSP; Henry Kansembe – Principal Planner, Directorate of Policy and Planning, MOH; and Alex Nondo Chikwese - project consultant.

Last but not the least, I wish to call upon the relevant departments within MOH, and all our partners, including the government line ministries and departments, CHAZ, civil society and private sector organizations, involved in the implementation of the various aspects of ADH, to support the implementation of this strategic plan.

I thank you all.

Dr. Elizabeth Chizema
Director – Public Health and Research
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1 Executive Summary

1.1 Introduction

The national Adolescent Health Strategic Plan 2011 to 2015 (ADH-SP 2011- 2015) for Zambia, seeks to outline the strategic framework for promoting the planning, organization and delivery of appropriate, accessible, efficient and effective Adolescent Friendly Health Services (ADFHS) throughout the country, aimed at addressing adolescent health problems in a comprehensive and consistent manner.

The plan was developed through broad-based consultations with, and active participation of the key stakeholders. The plan is linked to, and will be implemented within the frameworks of the National Health Strategic Plan 2011 to 2015 (NHSP 2011-2015), the Sixth National Development Plan 2011 to 2015 (SNDP), the Vision 2030 strategy for Zambia (Vision 2030) and the Millennium Development Goals (MDGs).

1.2 Situation Analysis

1.2.1 Health Problems Facing Adolescents

The health of the adolescents is, to a large extent, determined by the environments and circumstances in which they live and operate. These include: the prevalence of diseases; the socio-economic environment; the physical environment; and the person's individual characteristics, behaviour and circumstances. The main health related problems facing the adolescents in Zambia, include both communicable and non-communicable diseases (NCDs), particularly: Sexually Transmitted Diseases (STIs), including HIV and AIDS; and behaviour related health problems, including early and unprotected sex, sexual abuse, early marriages and pregnancies, unsafe abortions, substance and alcohol abuse, accidents and violence, mental health, and unsafe cultural practices. If not detected and addressed early enough, these health problems often lead to severe short- and/or long-term consequences on the health and development of the adolescents.

1.2.2 Current Health Service Provision to Adolescents

Adolescents require holistic, appropriate and comprehensive packages of ADFHS, focused at addressing their special health needs and at reducing barriers to accessing health services. Currently, in Zambia, ADH services are not appropriately defined and structured. However, since 1996, a number of Youth Friendly Corners (YFCs) have been established, on pilot basis, which are intended to provide youth-friendly health services. However, the services offered by YFCs are targeted at youths[1], which are a much broader target group, representing different age groups, with varying health needs.

[1] Youths are defined as young people between the ages of 10 and 35 years

As such, it can be observed that, currently, there are no public health facilities offering specific healthcare packages targeting the adolescents and their special needs.

Under these circumstances, adolescents have two options available to them, in respect of accessing health services, namely: either accessing health services through the YFCs, where such services exist; or accessing the standard health services offered to the general public.

1.3 Vision, Mission, Goal and Principles

Vision:	Healthy and productive adolescents for national development.
Mission:	To ensure equity of access to appropriate, quality and cost-effective adolescent-friendly health services, as close to the family as possible.
Overall Goal:	To significantly improve the health status of adolescents in Zambia.
Key Principles:	Accessibility, Convenience, Privacy, Confidentiality, Appropriateness, Comprehensiveness, Decentralisation, and Partnerships.
Theme:	Healthy and informed adolescents, the future of Zambia.

1.4 Key Strategies

S/N	Objective	Key Strategies
1.	**Service Delivery**	
	To ensure availability of appropriate packages of basic and comprehensive, effective and affordable ADHS in all districts, health facilities and communities by 2015.	• Redefine and broaden the package of ADFHS. • Develop national guidelines and standards for ADFHS. • Improve the procedures for accessing ADFHS. • Develop and implement incentives for encouraging access to ADFHS. • Scale out ADFHS to all districts and facilities. • Strengthen community (especially youths) involvement and participation in the planning, organization, implementation, and monitoring and evaluation of ADFHS services. • Strengthen linkages and partnerships.
2.	**Health Workforce**	
	To ensure availability of appropriately qualified and experienced health workers and Community Health Workers (CHWs), with appropriate skills in ADFHS, with all health facilities having at least 50% of core health workers trained in ADFHS by 2015.	• Strengthen coordination and supervision of ADFHS. • Scale up training of health workers in the provision of ADFHS. • Review curriculum for pre-service training of health workers, teachers and social workers to emphasize the special needs for the adolescent cohort. • Introduce appropriate package of incentives for youth volunteers involved in the provision of ADFHS. • Strengthen community and family participation, by training CHWs in ADFHS (currently being trained in Ndola), and families, through community education.

3.	**Medical Products, Infrastructure, Equipment and Transport**	
	To provide appropriate and adequate logistical support, infrastructure, equipment, Information Communication Technologies (ICTs) and transport to at least 80% of the ADFH Units by 2015, in order to facilitate efficient and effective delivery of ADFHS across the country.	• **Strengthen the procurement and distribution of essential medical products:** ✓ Review the essential drugs list and incorporate any priority drugs and vaccines considered critical for the adolescents. • **Strengthen infrastructure, equipment and transport for ADFHS:** ✓ Allocate appropriate and convenient premises/offices to ADFH Units. ✓ Revise construction guidelines for health facilities, to include adolescent friendly facilities. ✓ Define a package of essential equipment, and ICTs for ADFHS. ✓ Improve the transport situation, by ensuring a dedicated vehicle at each District Health Office (DHO), for use by all ADFHS Units and services, to support outreach adolescent health services.
4.	**Health Information**	
	To ensure timely availability of appropriate, gender and age disaggregated data on adolescent health, for evidence-based decision making.	• Review the reporting needs and develop a comprehensive set of key ADH indicators. • Incorporate core ADH indicators into the HMIS reports, and advocate for greater disaggregation of HMIS data by age and gender, to make it possible to adequately analyse data on adolescents for each indicator contained in the HMIS. • Strengthen monitoring and evaluation of ADH activities across the country. • Carryout operational research on ADH subjects.
5.	**Healthcare Financing**	
	To prioritise financing to ADH in MOH planning and budgeting at all levels.	• Prioritise funding of ADH services by MOH. • Advocate for more donor funding and technical support to the ADH programme. • Strengthen budget tracking in respect of ADH funds, in order to ensure that the funds provided are utilized on the intended activities. • Promote private sector participation and support.
6.	**Leadership and Governance**	
	To strengthen leadership and governance of ADH and attain highest levels of transparency and accountability.	• Strengthen the policy and regulatory frameworks for ADH. • Strengthen organisation and coordination of the ADH programme. • Strengthen planning for ADH.

		• Strengthen participation and partnerships in the planning, implementation, and monitoring and evaluation of ADH services. • Strengthen systems for ensuring high standards of transparency and accountability in the management and utilization of the resources available to the ADH programme at all the levels.

1.5 Results Framework/Planned Targets

The results framework, including planned targets, is provided at Appendix II.

1.6 Implementation Framework

This plan will be implemented within the existing policy, regulatory, institutional, coordination, and monitoring and evaluation frameworks, which are currently in place at MOH. Specific measures will also be pursued, aimed at reviewing and strengthening all these frameworks, in order to ensure efficient, effective and successful implementation of the plan.

1.7 Costing and Gap Analysis

The total cost of implementing this plan is estimated at US$7,659,423, based on activity-based costing. Below is the summarized analysis of the costing.

Costing and Financing Gaps - ADH Strategic Plan 2011-2015 **US$**

S/N	Service Delivery Area	2011	2012	2013	2014	2015	Total
A.	**Projected Financing Needs**						
1	Health Service Delivery	124,000	243,713	932,200	1,645,260	2,626,248	5,571,421
2	Health Workforce/ Human Resource for Health	12,480	91,621	89,281	89,281	89,281	371,943
3	Medical Products, Infrastructure and Equipment	0	5,938	403,025	400,000	400,000	1,208,963
4	Health Information	10,682	10,682	23,372	23,372	30,682	98,790
5	Health Financing	3,170	-	15,030	15,030	15,030	48,261
6	Leadership and Governance	72,009	72,009	72,009	72,009	72,009	360,045
	Total	**222,341**	**423,963**	**1,534,917**	**2,244,951**	**3,233,250**	**7,659,423**
B.	**Projected Financing**						

	Sources						
1.	Government/MOH	59,201	65,034	500,000	1,000,000	2,000,000	**3,624,234**
2.	Partners and others	-	-	-	-	-	**-**
	Total	**59,201**	**65,034**	**500,000**	**1,000,000**	**2,000,000**	**3,624,234**
C.	**Financing Surplus/(Gaps)**	**(163,141)**	**(358,930)**	**1,034,917)**	**(1,244,951)**	**(1,233,250)**	**(4,035,189)**

Detailed analyses of the costing and gaps are provided as Appendix III and IV.

2 Introduction

Adolescents are defined as young people between the ages of 10 and 19 years. Zambia recognizes the importance and significant impact that adolescents have on the overall health status of the country, including the attainment of the national health objectives and Millennium Development Goals (MDGs). In view of the foregoing, the Ministry of Health (MOH) has identified the need to strengthen Adolescent Health (ADH), by developing and implementing a national strategy, aimed at providing a comprehensive and coordinated response to ADH problems and needs in the country.

This document presents the Adolescent Health Strategic Plan 2011 to 2015 (ADH-SP 2011-2015) for Zambia. The plan seeks to provide the strategic framework for strengthening the governance, coordination, delivery, and monitoring and evaluation (M&E) of Adolescent-Friendly Health Services (ADFHS) in Zambia. The plan has been developed and will be implemented within the framework of the National Health Strategic Plan 2011 to 2015 (NHSP 2011- 2015), which presents the overall strategic framework for health sector governance and development in Zambia for the 5 years ending in 2015. The plan has been developed through broad-based consultations and involvement of the key stakeholders, including MOH, the relevant Government ministries and departments, the Churches Health Association of Zambia (CHAZ), private sector, Civil Society Organisations (CSOs), and international Cooperating Partners (CPs).

3 Background

3.1 Justification

Globally, adolescents represent a major demographic and socio-economic force, and are also a major factor in influencing public health trends. Currently, adolescents are estimated at one fifth (or 20%) of the world's population[2] and form a major proportion of the socially, economically and sexually active population. Eighty-eight percent (88%) of the world's adolescents live in developing countries, and Sub-Saharan Africa is home to 18% of these adolescents[3]. Due to the major biological and psychological transformations associated with this age group, adolescents are significantly exposed to risky behaviours, with high consequences on their immediate and long-term health and socio-economic lives.

In Zambia, adolescents account for over a quarter (approximately 27%) of the total population. Whilst the importance of this age group has been acknowledged in various national policy documents, including the National Population Policy 2007, National Reproductive Health Policy 2008, National Strategy for the Prevention of HIV and AIDS 2009, and the National Youth Policy, the health of this population group has not been given the special attention that it deserves. Further, a number of surveys[4] have provided evidence of continued high prevalence of health risk behaviours among the adolescents and young adults. This situation was also confirmed by the ADH Situation Analysis, conducted by MOH and its partners in 2009, which reviewed the status of ADH in Zambia.

In view of this background, MOH has identified the need to develop and implement the ADH-SP 2011-2015, in order to provide for an appropriate strategic framework for a comprehensive and coordinated national response to adolescent health needs.

3.2 Process

This plan has been developed by MOH and its key partners, through a broad-based consultative process, which 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:** This was largely based on the review of the ADH Situation Analysis 2010 Report, and other relevant national, regional and international policies, strategic frameworks and performance

[2] Broadening the Horizon: Balancing Protection and Risk for Adolescents, WHO, Department of Adolescent Health and Development, 2002
[3] State of the World's Children 2011 Report, Unicef.
[4] Zambia Demographic and Health Survey, 2007; Zambia Sexual Behaviour Survey, 2005; Global Student Health Survey, 2004

reviews relevant to ADH. Other literature that was consulted included leading books in corporate strategy management.

- The data collection tools used for the ADH Situation Analysis 2010 included questionnaires, focus group discussions, in-depth discussions with youth groups on what they considered to be the challenges and gaps in the delivery of adolescent health services, and how the same could be addressed in the ADH strategy.

- **Strategic Planning Workshop:** A 2 days strategic planning workshop was held in Lusaka. This workshop attracted a total of 28 participants from a broad spectrum of stakeholder groups, including MOH officials at district, provincial and national levels, representatives of other relevant government ministries and departments, CHAZ, Youth-Friendly Corners (YFCs), other youth organisations, CSOs and CPs.

- **Preparation and review of the Draft ADH-SP 2011-2015:** Based on the contributions made at the strategic planning workshop, a draft strategic plan was developed. The same was then subjected to 2 stakeholders' review meetings, attended by representatives of all the key stakeholders, including MOH, government line ministries, CSOs, Community-Based Organisations (CBOs), CHAZ, youth groups and CPs.

- **Finalisation and Approval**: Review comments were incorporated into the draft plan, which was then submitted to the Directorate of Policy and Planning at MOH, for final review and approval. The plan was then finalized and officially submitted to MOH.

3.3 Structure of the Plan

The structure of this plan includes the following major chapters: Executive summary, presenting a brief summary of the plan; Introduction, outlining the context of the plan; Background, presenting the justifications, process, structure and critical linkages; Situation analysis, reviewing the determinants of adolescent health, health problems facing the adolescents, and an analysis of the strengths, weaknesses, opportunities and threats; Vision, mission, objectives and key principles; Proposed strategic directions, outlining the proposed strategic framework and key strategies; Implementation framework, outlining the policy, institutional, and M&E frameworks that will facilitate the successful implementation of this plan; and appendices; and Costing of the strategic plan and analysis of financing gaps. The full outline of the structure of this plan is presented in the table of contents.

3.4 Critical Linkages

The ADH-SP 2011-2015 is closely linked to the NHSP 2011-2015, and other relevant sector and national policies and strategic frameworks, particularly the National Population Policy 2007, the National Reproductive Health Policy 2008, the National Strategy for the Prevention of HIV and AIDS 2009, the National Youth Policy 1994, and the School Health and Nutrition (SHN) Policy and strategic framework. Through the NHSP 2011-2015, this plan is also linked to the overall national development agenda, particularly the Sixth National Development Plan 2011-2015 (SNDP), and the Vision 2030 Strategy for Zambia. It is also linked to relevant regional and global policies and strategic frameworks on ADH, including the health related MDGs.

4 Situation Analysis

4.1 Determinants of Adolescent Health

The health of the adolescents is, to a large extent, determined by the environments and circumstances in which they live and operate. These include: the burden of disease; the socio-economic environment; the physical environment; and the person's individual characteristics, behaviour and circumstances.

4.1.1 Disease Burden

The burden of disease, including prevalence levels, patterns and trends of diseases, has a bearing on the health of the adolescents. Zambia has a high disease burden, which is largely influenced by the high impact of communicable diseases, particularly malaria, HIV and AIDS, Tuberculosis (TB), and Sexually Transmitted Infections (STIs). The country is also faced with a high burden of Maternal, Neonatal and Child Health (MNCH) problems, and a growing burden of Non-Communicable Diseases (NCDs)[5]. The influence of these specific health problems on the health of the adolescents is further discussed in Section 4.2.

4.1.2 Socio-economic Environment

The socio-economic environment is a major determinant of adolescent health. In Zambia, the main socio-economic factors affecting the health and development of the adolescents include education and literacy, poverty and nutrition, unemployment, socio-cultural beliefs and practices, and the family and community.

4.1.2.1 Education and Literacy

Education and literacy are important tools for understanding and interpreting information on adolescent health. They are also important tools for accessing better jobs and household wealth status by adolescents and their families. Zambia is making significant progress towards expansion of the education sector and enhancing literacy levels, across the country. According to the 2008 Economic Report, pupil enrolment at basic education level (Grade 1-9) increased by 5.4%, from 3,166,310 in 2007 to 3,336,009 in 2008. Progress is also being made towards improving literacy levels. It is currently estimated that more than 6 in 10 women (64%) and 8 in 10 men (82%) in

[5]NCDs that are most prevalent in Zambia include mental health, cancers, sickle cell anaemia, diabetes mellitus, hypertension and heart diseases, chronic respiratory disease, blindness and eye refractive defects, and oral health problems.

Zambia are literate. For females, literacy is highest among young women aged 15-19 years (73%), while for males it is highest among the 15-19 years and 40-44 years (84%)[6].

4.1.2.2 Poverty

Zambia has high poverty levels, estimated at 67% of the population. Poverty leads to failure to meet the basic needs and nutrition, and has significant implications on health, growth, morale and self-esteem of the adolescents. Poverty also impacts negatively on the ability of the families to support the educational needs of their children/adolescents, and contributes to creating environments for drug abuse, violence and sexual abuse, particularly among the adolescents.

4.1.2.3 Socio-Cultural Beliefs and Practices

Zambia is a multi-cultural society. Several socio-cultural practices, including social, cultural and religious practices, have significant potential to promote good health. However, there are also some beliefs and practices that adversely affect the health of adolescents. These include cultural practices, such as sexual cleansing of surviving spouses, unsafe traditional male circumcision, early marriages for the girl child, and gender discrimination, usually in favour of males.

4.1.2.4 Family, Community and Friends

Families, communities and friends have significant influence on the behaviour and health of the adolescents. The breakdown in family units due to various social factors, such as death, divorce and breakdown of traditional extended families, often force adolescents to head households and engage in risky behaviours for survival. Peer pressure also has potential to mislead adolescents into risky behaviours, such as alcohol and substance abuse, smoking, sexual abuse and violence, with consequences on health, including the risks of contracting HIV and other STIs, physical trauma, early pregnancies and abortions, and mental illnesses.

4.1.2.5 Gender

Gender has an influence on the health of the adolescents, which manifests through discrimination of both male and female adolescents, leading to marginalisation. Zambia has made commitments towards promoting gender equality to attain MDG 4 and SADC targets, and progress is being recorded in a number of areas relevant to gender. One such area is the increase in Secondary School enrolments for girls. Even though the rate of enrolment into grade one has almost equalised for both boys and girls, only 21% of girls complete secondary school in Zambia[7]. There are also more female domestic workers than male domestic workers, and this is a particularly vulnerable group that may be overlooked when it comes to adolescent rights and protections. Further, girls

[6] Zambia Demographic and Health Survey, 2007
[7] Global Student Health Survey, 2004

experience higher rates of domestic violence than boys. Girls also have earlier sex debuts than boys, and are less likely to use condoms than boys. On the other hand, young males aged between 15 and 19 years (94%) are more likely to engage in high-risk sex than the girls (48%). More young females (22%) test for HIV than the males (10%)[8].

4.1.3 Physical Environments

Poor access to safe water and sanitation, poor housing and unsafe food are among the key drivers of diseases, such as diarrhea and cholera, which significantly affect the health of adolescents within the communities. In Zambia, only 41% of the households have access to improved sources of water[9]. Households in urban areas are more likely to have access to improved sources of water than those in rural areas (83% compared to 19%). Overall, 25% of households in Zambia do not have toilet facilities, which is more common in rural areas (37%) than in urban areas (2%). Climate change is also a major environmental problem, with major implications on health and human development in general.

4.1.4 Personal Health Practices and Coping Skills

Personal character and commitment to health seeking behaviours, including prevention of disease, health promotion and early seeking of appropriate treatment and care, are important factors for adolescent health. Adolescents are the healthiest age group, but it is also the stage at which the youth get exposed to risky behaviours, which have negative consequences on their health. These risky behaviours, include tobacco use, substance and drug abuse, unhealthy diets, inadequate physical activity, risky sexual behaviours, and violence. The impact of some of these risks may not only affect their health, but could also impact negatively on their off-springs.

4.1.5 Access to Health Services

Several factors hinder adolescents from accessing health services. These include: long distances and problems related to transport and communication; inadequate information on where and how to access health services, particularly for rural areas; inadequate facilities and skilled personnel to provide ADFHS; availability of essential health workers, drugs and medical supplies; and inequities in income levels at household level. The situation is even more difficult for adolescents living with disabilities and those suffering from chronic health conditions, secondary to NCDs.

4.2 Health Problems Facing Adolescents in Zambia

The main health-related problems facing the adolescents in Zambia, include: common health problems, including communicable and NCDs; and behaviour related health problems, including early and unprotected sex, sexual abuse, early marriages and

[8] Zambia Demographic and Health Survey of 2007
[9] Zambia Demographic and Health Survey 2007

pregnancies, unsafe abortions, drugs and alcohol abuse, trauma/accidents and violence, and unsafe cultural practices.

4.2.1 Common Health Problems

Zambia has a high disease burden. Whilst the various health problems are common to the general population, largely due to stigmatization, health problems such as HIV and AIDS, and STIs present special challenges to the adolescents, calling or special attention.

4.2.2 Nutrition

Nutrition is one of the major determinants of health for children and adolescents. Poor nutrition significantly impacts on the health and development of children and adolescents, leading to physical-stunting, poor mental development, delayed attainment of puberty, and susceptibility to infections. It has also been acknowledged by the WHO that, in pregnant adolescent women, poor nutrition could lead to high mortalities and a higher likelihood of giving birth to under-weight and unhealthy babies, with reduced chances of survival.

The Zambia Global School Health Survey of 2004 (ZGSHS-2004) reported low levels of nutrition status in the study population. It observed that 26.7% male and 30.6% female respondents indicated going hungry most of the time or always during the 30 days prior to the survey, because there was not enough food in their homes. Prevalence of obesity was also reported to be on the increase, which was attributed to unhealthy diets and inadequate physical activity.

4.2.3 HIV, AIDS, and STIs

Zambia is among the countries that are most affected by the HIV and AIDS epidemic in Sub-Saharan Africa. This is despite the fact that HIV prevalence among adults between the ages of 15 to 49 years, is reported to have dropped from 16.1% in 2002 to 14.3% in 2007[10]. STIs, HIV and AIDS present major health problems for the adolescents in Zambia. According to the ZDHS 2007, approximately 7% of young women (aged 15-19 years) and 4% of young men in the same age group are HIV positive. It is also estimated that about 700,000 children in Zambia, including adolescents, have been orphaned as a result of AIDS.

4.2.4 Early, Unprotected Sex and Sexual Abuse

Early and unprotected sex are among the major problems affecting the adolescents, and carry significant risks to their health, including the risk of contracting HIV and other STIs, and teenage pregnancies. The WHO has observed that teenage pregnancies present significant risks to the health of both the pregnant adolescent and the expected baby.

[10] ZDHS 2007

In Zambia, majority of young people begin sexual relationships during adolescence. The ZDHS 2007 reported that 56% of females and 51% of males, aged between 15 and 24 years, reported that they had sex before the age of 18 years. At the same time, only 24% of females and 22% of males of this age group reported to have used a condom at first sex, meaning that majority of them practiced unsafe sex. Sexual abuse involving adolescents is also a major problem in Zambia. The most common types of sexual abuse among adolescents include defilements, rape and forced marriages. According to available statistics, in 2003, 16.9% of girls aged 15-19 years reported that they had been forced to have sex[11].

The consequences of child sexual abuse are severe and wide-ranging, and include risks of early pregnancies, abortions, mental torture, trauma and the risk of contracting STIs, particularly HIV and syphilis. A study conducted by the WHO in 2003, estimated that 14% of all unsafe abortions that take place in developing countries involve adolescents under the age of 20 years (WHO, 2003).

4.2.5 Sexual and Reproductive Health

Sexual and reproductive health is an important area for adolescents. About 16 million women aged 15 to 19 years give birth each year, representing about 11% of all births worldwide[12]. In Zambia, by the age of 18 years, about 56% of girls and 51% of boys are reported to have had sex, and only about one quarter of adolescents aged between 15 and 19 years used condoms at first sex[13]. Further, 3 in 10 young women aged 15 to 19 years have either given birth or carrying a pregnancy. Adolescent pregnancy is dangerous for both the mother and the child, contributing to high maternal and neonatal mortalities. Worldwide, complications related to pregnancy and childbirth are among the leading causes of death for adolescent girls aged 15-19 years[14]. A study done in Latin America showed that girls who give birth before the age of 16 are three to four times more likely to suffer maternal death than women in their twenties.

In Zambia, adolescents also face other problems related to sexual and reproductive health, including the risks of contracting HIV and STIs, fistula problems among adolescent girls, especially in rural areas, and puberty related illnesses. Currently, the challenge is that there are no adolescent-tailored sexual and reproductive health services, and often adolescents find it difficult to attend sexual and reproductive health services together with adults.

4.2.6 Drugs and Alcohol Abuse – Substance Abuse

Abuse of alcohol, drugs and other psychotropic substances is also a major problem among the adolescents in Zambia. The most common mode of tobacco and substance

[11] Central Statistical Office et al, 2003
[12] WHO, Fact Sheet: WHO/MPS/08.14
[13] Zambia Demographic and Health Survey 2007 (ZDHS 2007)
[14] Conde-Agudelo et al, 2005

abuse is that of smoking tobacco and drugs, mostly cannabis. According to a study conducted in 1999, in the town of Kafue, overall 8.2% of the adolescents were active cigarette smokers (10.4% males and 6.2% females)[15].

4.2.7 Accidents and Violence

Accidents and various forms of violence are also prevalent among the adolescents in Zambia. These include road traffic accidents, industrial accidents, home-based violence, sexual violence, robberies, murder and other forms of violence involving adolescents, as either the perpetrators or victims. Large numbers of adolescents are reported to have suffered injuries, which sometimes lead to morbidities, permanent disabilities, death or imprisonment.

4.2.8 Unsafe Cultural Practices

Zambia is a multi-cultural society, which embraces and promotes cultural diversity. However, certain cultural and religious practices are detrimental to the health of those affected. In this respect, unsafe cultural practices affecting the adolescents include sexual cleansing, forced teenage marriages and unsafe traditional male circumcision practices. These practices are also driven by gender disparities and social norms.

4.2.9 Mental Health

Mental health refers to the state of being mentally sound, and to the ability of an individual to cope and adapt to the demands of life and the changing meaning of life itself. Adolescents in Zambia are vulnerable to various forms of mental health problems, with the most common form being depression. The Zambia Global Schools Health Survey 2004 (ZGSHS 2004) Report revealed that loneliness, being worried, hopelessness, suicidal ideas and loss of friendships where the main determinants of mental health among the youths. Low esteem is common in this age group. The survey also revealed unsettling findings on suicide, reporting that 31.9% of students (31.4% male and 31.5% female), were reported to have seriously considered attempting suicide during the 12 months prior to the survey, and 41.4% of the students (40.4% male and 41.7% female) actually made plans about how they would commit suicide.

4.2.10 Physical Disabilities

Adolescents with disabilities, including the blind, deaf and dumb, physically or mentally handicapped, face additional challenges. These are in most cases subjected to stigmatization and various forms of abuse, including sexual, physical, verbal and mental abuses. Even when it comes to accessing health services, they are disadvantaged by their disabilities, and in some cases discriminated against.

[15] Malawi Medical Journal; 19(2):75 - 78, June 2007

4.3 Government's Efforts in Improving Adolescent Health

The government has the overall responsibility of establishing appropriate environments for promoting adolescent health in Zambia. In this respect, efforts have been made, aimed at establishing appropriate policy, regulatory, institutional, and monitoring and evaluation frameworks that take into account the needs of the adolescents. However, these efforts are often isolated and inadequate.

4.3.1 Policy and Regulatory Frameworks

At international level, Zambia has signed and ratified the 1990 United Nations Convention on the Rights of the Child (UN-CRC), the Organisation of African Unity (OAU) African Charter on the Rights and Welfare of the Child (UN-ACRWC), the Reproductive Health Strategy for the African Region, as well as the optional protocols on the minimum standards of employment and on the worst forms of child labour.

At local level, the Zambian Constitution, through the Bill of Rights, guarantees specific political and civil rights and freedoms of the citizens, including for children and adolescents. These include the right of young persons to protection from physical or mental ill-treatment, all forms of neglect, cruelty or exploitation, or trafficking of any form. All the fundamental rights and freedoms in the Constitution are guaranteed and justiciable. In addition, the Constitution also provides for economic, social and cultural rights, which are however non-justiciable and therefore not legally enforceable. Apart from the national Constitution, there are also a number of policies, legislations and strategic frameworks, relevant to the promotion of child and adolescent health and development. These include:

Legislation	Policies	Strategic Frameworks
• The Juvenile's Act. • The Termination of Pregnancy Act of 1972.	• National Population Policy, 2007. • National Youth Policy. • National Child Policy, 2008. • National Reproductive Health Policy, 2008. • National Policy on Education. • National Food and Nutrition Policy, 2006. • Mental Health policy, 2005. • National HIV/AIDS Policy, 2005.	• National Health Strategic Plan 2011-15. • National Multi-sector Strategy on HIV and AIDS. • Sixth National Development Plan 2011-15. • The Vision 2030.

Even though the fundamental political and civil rights related to children and adolescents are guaranteed by the Constitution, there are still gaps in the existing legal framework, which make it difficult to enforce these provisions of the constitution to adequately protect children and adolescents.

4.3.2 Institutional Frameworks

The existing institutional and coordination arrangements for adolescent health in Zambia include: the MOH structures at national, provincial, district, facility and community levels; other relevant government line ministries and departments; faith-based health sector under the coordination of CHAZ; the private sector; civil society; and CPs.

MOH is responsible for the overall coordination of ADH programmes and activities across the sectors. The new MOH organizational and management structures include adolescent health under the Reproductive Health (RH) Unit in the Directorate of Public Health and Research (DPH&R). At provincial, district and facility levels, ADH activities are coordinated by senior nursing officers (SNOs) in the Maternal and Child Health (MCH) units.

At facility level, some facilities have established Youth-Friendly Corners (YFCs), which serve as entry points of access to health services for youths, including adolescents and young adults. These were however established on pilot basis, and have not been expanded to other facilities. YFCs fall under the MCH units. The organization, management and performance of YFCs are further discussed in Section 4.4.2.1.

Several government line ministries and departments are actively involved in implementing programmes and activities relevant to ADH. These include: the Ministry of Youth, Sport and Child Development (MOYSCD), which carries the overall responsibility of coordinating and spearheading the youth and child development agenda in the country; Ministry of Education (MOE), implementing the School Health and Nutrition (SHN) Programme; Ministry of Community Development and Social Security (MCDSS), involved in the provision of social welfare and support, particularly to the adolescents with disabilities and those who are homeless; National Food and Nutrition Commission (NFNC), involved in implementing nutrition programmes which target youths in schools; and the National AIDS Council (NAC), which has some programmes targeting the youths. However, policy guidance and technical supervision for all ADH related programmes are provided by MOH.

MOH has also established partnerships with some private sector organisations, CSOs and CPs. The private sector and civil society are involved in the implementation of ADH related programmes, while CPs are mainly involved in providing financial and technical support. Currently, the CSOs that are significantly involved in ADH include: the Planned Parenthood Association of Zambia (PPAZ); Child Fund (CF); CIDRZ; Marie Stopes; and Afya Mzuri. The PPAZ stands out strongly among those actively involved in providing ADH services to the youths and adolescents, and has established YFCs in Lusaka, Livingstone and Kitwe. CPs have played a very important role in supporting ADH services in Zambia, particularly the establishment of the pilot YFCs. In this respect, the main CPs include the WHO, UNFPA, UNICEF and CARE International.

In order to provide for multi-sector coordination, MOH has established the ADH Technical Working Group (ADH-TWG), which brings together representatives of the

key stakeholders. The ADH-TWG is responsible to the Reproductive Health (RH) Sub-Committee of the Inter-Agency Technical Committee on Population (ITCP) at the Ministry of Finance and National Planning (MOFNP). However, both the ITCP and the ADH-TWG need to be strengthened and reactivated.

4.4 Current Health Service Provision to Adolescents

4.4.1 Adolescents' Needs for Health Services

Adolescents need health services and support which aim at effectively addressing the various barriers to accessing health services, including: physical, psychological, social and economic barriers.

In this respect, such services should take into account the following key adolescent needs:

- Easy access to health facilities and services, with minimal physical barriers;
- Health services that are convenient, appropriate, comprehensive and integrated, providing for continuity of care;
- Assured privacy and confidentiality of services, with no or minimal requirement of parental consent; and
- Cost effectiveness, with either free or highly subsidized health services.

The packages of health services offered to the adolescents should therefore be *adolescent-friendly*. This concept was introduced by the WHO, to help define packages of health services targeted at providing the adolescents with appropriate and convenient health services, which take into account their special needs. ADFHS seeks to provide adolescents with access to essential health services in an adolescent-friendly environment, including appropriate location of health facilities, appropriate standards of care, privacy and confidentiality, affordable services, flexibility, availability of appropriate Information, Education and Communication (IEC) materials, effective partnerships, and involvement of the adolescents in policy formulation.

4.4.2 Health Services Offered to the Adolescents in Zambia

In Zambia, the concept of ADFHS is not clearly defined and practiced. Currently, there are no health facilities offering comprehensive packages of ADFHS. Since 1996, a number of YFCs have been established, which are intended to provide youth friendly health services. However, though the services offered by YFCs' are similar to ADFHS, they target youths, which is a much broader target group, representing different age groups with varying health needs.

In Zambia, youths are defined as young people between the ages of 10 years and 35 years (National Population Policy 2007), and all the young people meeting this criteria are eligible to join the YFCs and also to access services offered by YFCs. However, adolescents only represent youths between the ages of 10 to 19 years. Currently,

there are no facilities offering specific health packages targeting the adolescents, to respond to their special health needs. Under these circumstances, adolescents have two options available to them in respect of accessing health services, namely: either accessing health services through the YFCs; or going to health facilities offering standard health services to the general public.

4.4.2.1 Services offered by Facilities with YFCs

YFCs are organized as youth clubs within particular communities, with a common interest of providing fellow youths with youth-friendly health services. Members of the YFCs are youth volunteers, drawn from the communities. These include students, working class, unemployed, and the vulnerable. YFC services are offered by peers, either at the fixed centres located at the respective health facilities, or through outreach programmes conducted within the communities and schools.

The standard package of health services offered by YFCs includes:

- Peer counseling, education and referrals for common health problems;
- Screening and testing for STIs;
- Voluntary counseling and testing (VCT) for HIV;
- Family planning services;
- Counseling for other health conditions;
- Health promotion and education (Cholera , child health and Malaria);
- Health promotion through drama activities within schools and communities;
- Outreach activities: education through sports (edusport), education through entertainment (edutainment), peer counseling, referral services;
- School health and nutrition programmes;
- Distribution and dissemination of appropriate Information, Education and Communication (IEC) materials; and
- Facilitating private and convenient access to health service providers, within the health facilities.

YFCs serve as the entry points to the respective health facilities. Youths are initially attended to by youth peer counselors, who provide counseling, before referring them to the appropriate health workers. One major weakness is that the YFC package of services does not include specific services for the disabled adolescents and for those with chronic conditions, such as complications of NCDs.

4.4.2.2 Services Offered in Non-ADFHS Health Facilities

Apart from the health facilities offering YFCs, adolescents also have access to other health facilities which offer standard packages of health services to the general public. These facilities offer promotion, prevention, curative and rehabilitation health services. However, such facilities do not offer specially-tailored ADFHS services, and adolescents are treated just like any other client.

4.4.3 Availability and Adequacy of Resources

Availability and adequacy of resources, is an important factor in ensuring successful operations of ADFHS. However, under the current arrangement, major gaps have been identified in these areas, including:

- Inadequate funding for ADH programmes and activities;
- Shortages of youth peer counselors, and lack of training opportunities for them;
- Shortages of health workers, within the health sector;
- Inadequate training of health workers in the provision of ADFHS';
- Inadequate medical supplies, RH commodities and IEC materials, targeted at adolescents;
- Inadequate and inappropriate infrastructure for ADH services;
- Lack of transport for outreach ADH activities; and
- Inadequate community involvement and participation.

4.5 Strengths, Weaknesses, Opportunities and Threats

Table 1 below, presents a summarized analysis of the strengths, weaknesses, opportunities and threats (SWOT) in respect of ADH in Zambia.

Analysis of Strengths, Weaknesses, Opportunities and Threats

S/N	STRENGTHS	WEAKNESSES	OPPORTUNITIES	THREATS
1.	**Service Delivery**			
	• Establishment of YFCs in selected pilot districts, which provide important lessons and experiences for strengthening the ADH programme.	• In Zambia, the concept of ADFHS has not been clearly defined and practiced. • Whilst YFCs have been established in pilot districts, they are targeted at youths, which is a much broader age group than the adolescents. • Most of the facilities used for YFCs are not appropriate and convenient for ADFHS, and lack basic equipment for providing basic ADH services. • The concept of YFCs has remained at pilot stage and has not been extended to the other districts and health facilities.	• The growing global concern and goodwill for health and development of the adolescents[16]. • Policy and technical support from WHO on the establishment of ADFHS. • Political will from the Government. Zambia is a signatory to a number of global and regional protocols on child/ adolescent health and development. • Existence of institutional framework for implementing ADH programmes.	• High prevalence and impact of the key determinants of ADH, including the changing social-cultural environment and behaviour patterns among the adolescents. • High burden and impact of HIV and AIDS, Malaria, TB, STIs, adolescent pregnancies, maternal health problems and NCDs on the adolescents. • Fragmentation and lack of a holistic and coordinated multi-sector approach to ADH.
2.	**Health Workforce**			
	• On-going improvements in the numbers of health workers within the health sector. • The staff establishment for the ADH/FP Unit at MOH head office has been filled.	• Though the numbers of health workers are improving, there are still shortages and inequitable distribution of health workers, particularly those trained in ADFHS.	• Availability of expert advise/support from the international community, particularly WHO, UNFPA and Unicef.	• ADFHS has not been incorporated in the training curricular for training of health workers.

[16] The 2010 State of the World's Children (SOWC) Report focuses on the adolescent, as a vulnerable group and a window of hope for a number of preventive interventions [against HIV, Obesity & other NCDs, and promotion of healthy living].

	• Some health workers at national, provincial, district and facility levels have been trained in the provision of ADFHS • Availability of many youth volunteers, currently in YFCs, who are highly committed to the course of strengthening ADH.	• The numbers of health workers trained in the delivery of ADFHS are inadequate. • Limited training opportunities for youths/volunteers in peer counseling, education, and ADFHS. • Lack of incentives for youth volunteers involved in YFCs/ADFHS.	• Opportunities to engage the services of ADH retired professionals on concessional and volunteer basis from other countries. • Availability of training materials on ADFHS, developed by the WHO and other relevant bodies.	•
3.	**Medical Products, Infrastructure and Equipment**			
	• Most of the drugs and medical supplies required for supporting ADFHS are available. • Lack of prioritization of ADFHS infrastructure, equipment and transport needs by MOH.	• Erratic distribution of essential drugs and medical products. • Shortages of appropriate IEC materials for peer education and health promotion. • The infrastructure and equipment needed for ADFHS have not been defined and packaged. • The existing YFCs are not provided with appropriate infrastructure and equipment, particularly ICTs, for smooth functioning. • YFCs are not provided with appropriate transport to support outreach community activities.	• Opportunities for promotion of private sector and Public-Private Partnerships (PPPs) investments in ADFHS. • Government has scaled up construction of health infrastructure. Need to revise the standard construction plans for health facilities, to include ADFHS infrastructure. • Government currently strengthening mobile/outreach health services. Need to budget for ADFHS transport under this programme.	• Inadequate government support.

4.	**Health Information**			
	• Existence of a comprehensive and robust Health Management Information System (HMIS), which includes some indicators relevant to ADH. • Existence of data capturing and reporting frameworks at YFCs.	• ADH indicators are not adequately covered in the HMIS. • The data capturing and reporting tools at YFCs are not standardized and consistent.	• Strengthen coordination and sharing of ADH information among the various sectors.	• Fragmentation and weak coordination of reporting by the various stakeholders.
5.	**Healthcare Financing**			
	• YFCs are involved in the planning process at facility level and do submit their proposed activities for inclusion in the facility action plans, though these are not always included in the final plans. • ADH/FP have since been allocated separate budget lines within the RH budget and action plans.	• Lack of prioritization of ADH at planning, financing and implementation stages at all levels. • Budget allocations to ADH at all levels are grossly inadequate and not adequately tracked.	• ADH has now been prioritized in the NHSP 2011-2015. Existence of funded health programmes that are relevant to ADH, such as the HIV and AIDS programme. • Financial resources available with other sectors implementing some aspects relevant to ADH. • Existence of some international organizations, which are currently involved in ADH programmes, e.g. UNFPA, WHO, Unicef. • Private sector participation and support.	• Inadequate government funding to the health sector. • Lack of an aggressive international initiative to provide financial and technical support to ADH. • Impact of the global financial/economic crisis on the national economy and on the potential donors for adolescent health programmes.

6.	Leadership and Governance			
	• ADH is included in the draft National Health Policy. • ADH is prioritised in the NHSP 2011-2015. • Inclusion of ADH management structures in the new MOH organizational structures at national, provincial, district and facility levels. • Existence of YFCs in pilot districts. • Availability of youth volunteers/peers. • Existence of the ADH-TWG.	• No consolidated policy statement on ADH. • The ADH structures provided for in the new MOH organizational structures are still inadequate/still have weaknesses, e.g. placing of ADH under MCH limits its scope. • YFCs are only in pilot districts. • Weak coordination structures. ADH-TWG not active and coordination structures at provincial and district levels are weak. • Weak monitoring and evaluation framework for ADH programme and activities.	• Existence of international and regional policy frameworks aimed at strengthening ADH, including the UN-CRC and UN-ACRWC. • Availability of national policies relevant to ADH, including: the National Population Policy, National Youth and Child Development Policy, National Reproductive Health Policy, and Child Health Policy. • Availability of legislation relevant to ADH, including the National Constitution/Bill of Rights, the Juveniles Act, and the Termination of Pregnancy Act. • Partnerships. Involvement of other government ministries, private sector, civil society and CPs in ADH related programmes.	• Weak linkages among the policies dealing with various aspects of adolescent health, leading to fragmentation of approaches and weak coordination of efforts of various sectors. • Lack of clarity and commonality in the objectives and strategies contained in the policies and strategic frameworks relevant to ADH. • Weak dissemination and enforcement of relevant legislation. • Weak partnerships and inadequate private sector participation. • Inadequate support from CPs. Most of them are no longer providing support.

5 Mission, Vision, Goal, Priorities And Targets

Overall, the ADH-SP 2011-2015 emphasizes the following:

- Increasing access to adolescent friendly health services;
- Strengthening human resource capacity by improving the availability, and equitable distribution of qualified health workers, adolescent volunteers and community health partners;
- Ensuring the availability of adequate drugs and medical supplies for adolescent health services;
- Strengthening the capacity of the M&E systems for adolescent health;
- Increasing funding and financial management for adolescent health; and
- Strengthening leadership and governance of adolescent health services, including policy and legislation, organization and coordination, participation and transparency.

5.1 Vision, Vision, Goal and Objectives

Vision:	Healthy and productive adolescents for national development.
Mission:	To ensure equity of access to appropriate, quality and cost-effective adolescent-friendly health services, as close to the family as possible
Overall Goal:	To improve the health status of adolescents in Zambia.
Theme:	Healthy adolescents, the future of Zambia.

5.2 Key Principles

Accessibility:	Ensuring easy access to appropriate ADFHS facilities and services, with minimal physical barriers.
Convenience:	Conveniently located ADFHS facilities, with appropriate infrastructure, furniture, equipment and tools.
Privacy and Confidentiality:	Assured privacy and confidentiality, with no or minimal requirement of parental consent;
Appropriateness:	Appropriate packages of health services, taking into account the special health needs of the adolescents.
Comprehensiveness:	Comprehensive and integrated health services, providing for continuity of care.
Affordability:	Cost effectiveness and affordability of services, with either free or subsidized health services.

Decentralisation: Decentralised and strong coordination of ADFHS services.

Partnerships: Strong partnerships and collaborations, to ensure a unified approach and maximize benefits from synergies.

Involvement: Active involvement of adolescents in the governance, planning and implementation of ADH programmes.

5.3 Adolescent Health Priorities

ADH Core Priority Areas	Other Priorities
• Health promotion and behaviour change.	• Human resource capacities.
• Sexual reproductive health: family planning, early and unprotected sex, sexual abuse and unsafe abortions.	• Essential drugs and medical supplies, infrastructure, equipment and transport.
• Communicable diseases: HIV/AIDS, malaria, STIs and TB.	• Health information and operational research.
• NCDs: Nutrition and healthy living, mental health, drugs, alcohol and substance abuse, violence, and unsafe cultural practices.	• Financing, transparency and accountability.
• Adolescents with special needs.	• Leadership and governance: policy and regulation, advocacy, partnerships, and monitoring and evaluation.

5.4 Results Framework/Planned Targets

A summarized analysis of the results framework and planned targets is provided at Appendix II.

6 Strategic Directions

In order to provide for a holistic and comprehensive approach to ADH, the strategic directions proposed in this plan have been structured along the WHO "Six health system building blocks"[17]. This is also in line with the approach adopted for the NHSP 2011-2015. In this respect, the proposed objectives, strategies and targets have been analysed in accordance with the following six health systems building blocks, as they pertain to adolescent health:

- Service delivery;
- Health workforce;
- Medical products, infrastructure, equipment and transport;
- Health information;
- Healthcare financing; and
- Leadership and governance.

The proposed objectives and strategies are based on the existing situation, including trends, strengths, weaknesses, opportunities and threats in respect of adolescent health in Zambia. They are intended to appropriately respond to ADH challenges, in order to achieve the overall goal. These objectives and strategies are targeted at adolescents in the following age groups: Younger adolescents 10-14 years; Middle adolescents 15-19 years; and Late adolescents 20-24 years.

6.1 Service Delivery

6.1.1 Overview

In Zambia, the concept of ADFHS has not been clearly defined and practiced. Currently, none of the public health facilities are offering comprehensive packages of ADFHS. Whilst MOH has established some YFCs at selected health facilities in pilot districts, the packages of services offered by these YFCs and facilities are not comprehensive enough to fully address adolescent health needs. YFCs are also not adequately funded and supported. Further, the services offered by YFCs are not specifically targeted at the adolescents, but at all the youths[18]. In public health facilities where YFCs have not been established, there are no specific packages of health services targeting the adolescents, as adolescents are treated just like any other person seeking health services.

[17] This assumes that, for any health programme/system to be successful, it should ensure that all the six health system building blocks are properly managed.
[18] Youths are defined as young persons between the ages of 10 and 35 years, while adolescents are those between the ages of 10 and 19 years.

Apart from the public health facilities under MOH, there are also a number of other government ministries and departments, private sector institutions and civil society organizations that are running programmes relevant to ADH. The government ministries and departments include MOYSCD, MOE, MCDSS, NFNC and NAC, which have some programmes targeting youths.

Several civil society organizations are also offering programmes that are relevant to ADH, particularly PPAZ, which has established YFCs in Lusaka, Livingstone and Kitwe. Again, while the services offered by these players are relevant to adolescent health, they are not specifically targeted at the adolescents and are not comprehensive enough to address adolescent health needs.

In view of the foregoing, adolescents have two options, when it comes to seeking health services. They can either go to health facilities that have established YFCs, or to health facilities offering standard health packages to the general public. However, both options do not adequately address the special health needs of the adolescents. The main problems and gaps affecting the delivery of health services to the adolescents include:

- Lack of a clear definition and common understanding of adolescent health services among the key stakeholders;
- Lack of defined packages of ADFHS;
- Shortages of health workers, both in numbers and skills, to deliver quality ADFHS;
- Inadequate and, in most cases, inappropriate infrastructure and equipment for adolescent health services; and
- Inadequate funding and logistical support, including supply of IEC materials.

During the course of this plan, significant efforts will be directed at establishing, strengthening and scaling up ADFHS, based on a comprehensive and systematic approach. In this respect, a range of packages of ADFHS will be developed, which will include minimum, standard and comprehensive packages of ADFHS. These packages will include:

- Health promotion and education, with main emphasis on behaviour change;
- Disease prevention, for both communicable and non-communicable diseases;
- Early diagnosis, screening and detection of diseases; effective treatment;
- Care, especially for the disabled and chronically ill; and
- Psycho-social counseling services, in order to deal with depressions and other emotions.

Efforts will also be directed at strengthening the referral systems and the roles of the families, peers and communities in promoting and facilitating good health for the adolescents. Consideration will also be made to separate adolescent health from the Reproductive Health (RH) Unit, so as to establish a separate unit that would aim at holistically addressing adolescent health needs, and not only maternal related health needs.

6.1.2 Objective

To ensure availability of holistic, appropriate and cost-effective adolescent friendly health services in all the health facilities and communities in all the districts by 2015.

6.1.3 Key Strategies, Indicators and Targets

#	Key Strategies	Indicators/Targets
1.	Define the packages of ADFHS to be provided at different levels. Appendix I presents the key characteristics of ADFHS. The package should take into account the need to strengthen: • Health promotion and education, including regular exercises, recreation and healthy life styles, and access to appropriate IEC; • Nutrition; • Adolescent sexual and reproductive health; • HIV and AIDS, and STIs services; • Sensitization against drugs, alcohol, tobacco and sexual abuses, and violence; • Mental health; • Access to health services by adolescents with disabilities and those with chronic health problems/conditions; and • Appropriate incentives and support to adolescent volunteer peer educators.	• Comprehensive packages of ADFHS defined different levels of care, by December 2012. • ADFHS guidelines developed, disseminated and implemented, by December 2012.
2.	Scale out ADFHS to all districts and health facilities.	At least 80% of health facilities and communities in all districts, with functional ADFHS by 2015.
3.	Strengthen community (especially youths) involvement and participation in the delivery of ADFHS. • Strengthen Community involvement in ADHS. • Promote the establishment of community based youth centres. • Promote youth involvement in community health committees.	Neighborhood Health Committees and youth involved in the planning and delivery of ADFHS at community level, starting from January 2012.
4.	Strengthen linkages and partnerships with the School Health and Nutrition Programme (SHN) at the Ministry of Education (MOE).	• MOE/SHN represented on the ADH-TWG by December 2011. • Deliberate package for in-school youth developed by December 2012. (ADH incorporated into the SHN Programme).
5.	Strengthen sensitization and partnerships with relevant institutions, including Road Traffic Safety Agency (RATSA), Zambia Police Victim Support Unit (ZP-VSU) and the Drug Enforcement Commission (DEC), in order to	• RATSA, ZP-VSU and DEC represented on the ADH-TWG, by December 2011. • Joint sensitization programmes and activities developed and implemented, with RATSA, ZP-VSU, DEC and other

	fight against accidents, violence, and alcohol and substance abuse, among the adolescents.	relevant stakeholders, in communities and schools.
		• Recommendations on policy, and legislative changes needed to reduce accidents, violence, and alcohol and substance abuse, among the adolescents, developed by the ADH-TWG and submitted to the Government, by December 2013.

6.2 Health Workforce

6.2.1 Overview

The health sector in Zambia is experiencing critical shortages of health workers at all the levels of health service delivery. This problem is manifested in the shortages of qualified health workers, as well as inequitable distribution of the available health workers, and skills-mix challenges. However, for ADH, there is also an additional dimension of inadequate training of all the health workers in the provision of ADFHS, and the weak coordination structures for ADFHS at facility level. There is also inadequate involvement of the communities and families in the promotion and delivery of such services.

6.2.2 Objective

To ensure availability of adequate health workers and community health partners, with appropriate skills in ADFHS, with at least 50% of core health workers and community health partners trained in ADFHS by 2015.

6.2.3 Key Strategies, Indicators and Targets

S/No.	Key Strategies	Indicators/Targets
1.	Strengthen coordination and supervision of ADFHS at national, provincial, district, facility and community levels.	• Dedicated ADH Coordinators/focal point persons appointed at provincial, district and facility levels. • ADH-TWGs at provincial and district levels established. • TWG meetings held on quarterly basis. • Technical support supervision visits included in the action plans and conducted on a consistent basis.
2.	Scale up training of health workers in the provision of ADFHS. **Activities:** • Conduct training for health workers • Review and update the curriculum for pre-service training of health workers to emphasize the special needs for the	• In-service training plan developed and implementation commenced by January 2013. • ADFHS incorporated into the training curricular at all health, teachers and relevant training institutions by January

	adolescent cohort.	2013.
3.	Introduce appropriate package of incentives for youth volunteers involved in the provision of ADFHS, in similar lines as the other community health partners. **Activities:** • Stakeholders' consultation meeting on package of incentives for adolescent volunteers. • Produce/print and disseminate the package of incentives.	Package of incentives for youth volunteers developed and implemented by 2013.
5.	Strengthen community and family participation, by training CHWs and families in ADFHS. **Activities:** • Conduct training for CHWs and families in community and family participation strategies.	Programme for training CHWs and families developed and implemented by January 2013.

6.3 Medical Products, Infrastructure, Equipment and Transport

6.3.1 Overview

Currently, ADFHS services are adversely affected by: erratic supply of drugs and medical supplies; lack of appropriate adolescent-friendly infrastructure and equipment at health facilities, schools and communities; lack of essential ICTs for development and dissemination of IEC materials on ADH; and shortages of appropriate transport for delivery of ADFHS within the communities. The aim of this strategic plan is to improve the availability of essential drugs and medical supplies, infrastructure and equipment, ICTs, and transport, to facilitate the scaling up of ADFHS services throughout Zambia.

6.3.2 Objective

To provide appropriate and adequate logistical support, infrastructure, equipment, ICTs and transport to facilitate efficient and effective delivery of ADFHS across the country. At least 80% of health facilities across the country, to offer ADFHS by 2015.

Key Strategies, Indicators and Targets

S/No.	Key Strategies	Indicator/Targets
1.	**Strengthen procurement and availability of essential drugs and medical products:**	
1.1	Strengthen the supply and management of priority drugs and medical products that are considered critical for ADFHS, including: • Condoms; • Family Planning supplies; • Test kits for STIs; and • Other drugs and medical supplies for common adolescent health problems. **Activities:** • Develop and implement an appropriate drugs inventory management system for essential ADH drugs and supplies. • Strengthen coordination with the pharmaceuticals and procurement units, and Medical Stores Limited (MSL).	• Drugs inventory system that includes ADFHS, in place by December 2013.
2.	**Strengthen infrastructure, equipment and transport for the delivery of ADFHS**	
2.1.	Provide appropriate and convenient premises/offices to ADFHS units. **Activity:** • Revise construction guidelines and designs for public health facilities to include adolescent-friendly facilities. • Inter-departmental consultative meeting with Infrastructure Unit.	Construction guidelines and designs for public health facilities revised, by December 2013, to take into account ADFHS.
2.2.	Define a minimum package of essential equipment, and ICTs for ADFHS. **Activity:** Meeting to develop package of essential equipment for ADFHS services.	Minimum package of essential equipment and ICTs for ADFHS centres defined and implemented by December 2013.
2.3.	Improve the transport situation, by providing a dedicated vehicle at each DHO, to be shared by all ADFHS centres. **Activity:** procure vehicles, motor bikes and bicycles for ADH programmes.	• Appropriate vehicles procured for ADFHS at all districts, starting from 2012 to 2015. One vehicle per district. • Guidelines on the usage and control of the ADFHS vehicles developed and implemented by December 2012.

6.4 Health Information

6.4.1 Overview

The situation analysis of this plan revealed that the existing information systems, including the HMIS and survey-based systems do not adequately report on ADH. Even though the existing HMIS is comprehensive and robust, it does not include adequate indicators that are considered critical to ADH.

This strategic plan therefore aims at strengthening health information, and monitoring and evaluation, to ensure that key indicators on adolescent health are included in both the routine and non-routine survey-based health information systems, in order to strengthen reporting on ADH and support management decision making. It also aims at strengthening monitoring and evaluation of the ADH programme and activities, in order to ensure efficient and effective feedback.

6.4.2 Objective

To ensure timely availability of relevant, gender and age disaggregated data on adolescent health, for evidence-based decision making, by incorporating critical indicators into the HMIS and M&E frameworks of MOH by December 2012.

6.4.3 Key Strategies, Indicators and Targets

S/No.	Key Strategies	Indicator/Targets
1.	Strengthen data capturing and management for the ADH programme and activities. **Activity:** • Hold consultative workshop. • Review the reporting needs and develop a comprehensive set of key ADH indicators. • Advocate for inclusion of core ADH indicators into the HMIS reports, and greater disaggregation of data by age and gender, to make it possible to isolate data on adolescents for each indicator.	• Comprehensive set of ADH indicators developed and consensus built, by December 2012. • ADH core indicators included in routine HMIS reports. • HMIS reporting on disaggregated data by age and gender.
2.	Strengthen Monitoring and Evaluation of ADH activities across the country. **Activity:** • Conduct bi-annual performance assessments. • Conduct technical support supervisions every quarter. • Feed into the review of Performance Assessment (PA) tools.	ADH indicators incorporated into the Performance Assessments (PA) tools, Joint Annual Reviews, Mid-Term and End-Term Reviews for the health sector by 2013.

3.	Strengthen and scale-up operational research on ADH. **Activities:** • Conduct Operational Research (OR) on relevant aspects of ADH. • Disseminate research and M&E findings/data. • Incorporate the OR findings/ recommendations in the annual/MTEF planning technical updates.	At least 1 operational research event on ADH related subject, every 2 years, starting 2012.

6.5 Health care Financing

6.5.1 Overview

MOH financing of adolescent health services is not adequate and appropriately structured. Funding of adolescent health activities is included under the budget for Reproductive Health (RH), but the levels of funding are grossly inadequate. This has led to severe operational difficulties for the ADH programme and YFCs, which have most of the time remained without any dedicated funding. The situation is further compounded by the fact that, currently there is very little or no donor support to ADH activities.

The focus for this area will be directed at prioritizing financing of the adolescent health programme activities within the MOH action plans and budgets, and ensuring transparency and accountability in the utilization of the allocated funds. Further efforts will be directed at promoting increased financial and technical support from the cooperating partners, private sector and civil society.

6.5.2 Objective

To prioritise and increase funding to the ADH programme activities, through the MOH plans and budgets, and cooperating partners, and ensure that at least 90% of budgeted activities are funded, throughout the duration of this plan.

6.5.3 Key Strategies, Indicators and Targets

S/No.	Key Strategies	Indicator/Targets
1.	Strengthen and scale up financing of the ADH programme activities. **Activities:** • Advocate for prioritization of funding of ADH services within the MOH plans and budgets.	• MOH funding to ADH progressively increased. • Percentage of donor funding to adolescent health increased to at least 40% by 2015.

	• Advocate for financial support to ADH, from CPs. Identify potential donors and develop financing and technical proposals. • Strengthen harmonization, and participation of CPs in planning, monitoring and evaluation of ADH programme.	
2.	Strengthen budget tracking in respect of ADH funds. **Activities:** • Meeting to develop appropriate indicators for use during PA visits, to track ADH funds. • Prepare quarterly budget performance reports for the ADH-TWG meetings.	• Appropriate indicators for ADH budget tracking included in the PA tools. • Quarterly reporting on ADH budget performance, to the ADH-TWG, introduced and institutionalized, from January 2012.
3.	Strengthen financial transparency and accountability for the resources available to ADH. **Activities:** • Comply with the financial management regulations established by GRZ/MOH. • Broaden participation of partners/stakeholders, in the budgeting and monitoring of implementation of ADH activities. • Comply with the terms and conditions of the financing and technical support agreements with the CPs.	• Reduction in audit queries in respect of utilization of ADH funds. • System for monitoring utilization of donor funds developed and implemented by 2013.

6.6 Leadership and Governance

6.6.1 Overview

The existing leadership and governance arrangements for adolescent health in Zambia need further strengthening, as they have a number of weaknesses. While there are several policies that have relevance to adolescent health, none of them provides a comprehensive policy framework for adolescent health. The institutional and coordination frameworks also have some weaknesses. Whilst the ADH-TWG has been established at national level, to strengthen coordination of partnerships, similar coordination structures have been established at provincial and district levels. Further, monitoring and evaluation of adolescent health is not adequately recognized and integrated into the existing M&E frameworks within the health sector.

During the duration of this strategic plan, MOH will focus at reviewing and strengthening leadership and governance of adolescent health, within the broader governance and coordination frameworks provided by the NHSP 2011-2015.

6.6.2 Objective

To strengthen leadership and governance of ADH, and attain highest levels of transparency and accountability at all levels of implementation of the ADH programme.

6.6.3 Key Strategies, Indicators and Targets

S/No.	Key Strategies	Indicators/Targets
1.	**Strengthen the policy and regulatory frameworks for ADH.**	
1.1	Strengthen the policy framework for ADH in Zambia. Review the existing policies related to ADH and develop key policy issues to be incorporated into the National Health Policy, currently under development. **Activities:** Meeting to review the draft National Health Policy for coverage of ADH.	ADH policy issues integrated into the draft national health policy, in 2011.
2.	Strengthen the legal framework for ADH in Zambia. **Activity:** • Review the existing legal and regulatory frameworks related to ADH, identify critical gaps.	• Consultancy report on the review of the legal framework relating to ADH submitted by June 2013. • Relevant legislation amended to incorporate the recommendations for strengthening provisions related to ADH effected, by December 2014.

	• Advocate for amendment and strengthening of enforcement of relevant legislation related to ADH. • Advocate for domestication of adolescent-friendly international policies and strategies in Zambia.	• Number and percentage of adolescent-friendly international policies, protocols and strategic frameworks domesticated.
2	**Strengthen organisation and coordination of the ADH programme at all levels**	
	Strengthen inter-sector coordination of ADH services. **Activities:** • Operationalise the ADH-TWG at national, provincial and district levels. Review and strengthen the terms of reference, composition and leadership. • Hold quarterly TWG meetings. • Advocate for the appointment of ADH focal point person at provincial and district levels. • ADH focal point person to participate in the District Integrated Meetings.	• ADH-TWG at national level fully operational by December 2011. • TWGs established and functional at provincial and district levels by 2012. • ADH focal-point persons appointed at provincial, district and facility levels by December 2012.
3	**Strengthen planning for ADH**	
	Strengthen visibility of ADH in NHSPs, Medium-Term Expenditure Framework Plans (MTEFs) and annual action plans/budgets. Ensure that there is visibility of ADH in these plans and a specific budget line is included in the MOH Budgets. **Activity:** • Participate in MOH planning activities at national, provincial, district and facility levels. • Advocate for increase in funding. • Broaden involvement of partners/ stakeholders in planning for ADH.	• MOH Annual Action Plans and budgets with clear ADH component and budget line, starting with the 2012 Action Plan.
4	**Strengthen monitoring and evaluation for ADH**	
	• Advocate for amendment and strengthening of enforcement of relevant legislation related to ADH.	Report on the review of M&E systems and recommendations on the inclusion of ADH developed and implemented by December 2012.

	Review the existing M&E systems, including the HMIS, PA, Zambia Demographic and Health Survey (ZDHS), Zambia Sexual Behaviour Survey (ZSBS), MOH Mid- and End of Term performance reviews, and the other routine and non-routine information systems, and ensure adequate inclusion of ADH. **Activity:** • M&E needs and gaps consultancy. • Participate in the review of PA tools at national, provincial and district levels.	

7 Implementation Framework

Implementation of this plan will be guided by the existing policy, regulatory, institutional, coordination, and monitoring and evaluation frameworks. Efforts will also be made to review and strengthen these frameworks, in order to ensure smooth and successful implementation of the proposed strategies. Implementation of the plan will also be significantly influenced by the availability of funding to support the proposed strategies and activities. Below is a discussion of the implementation framework that will be put in place, in order to ensure efficient and effective implementation of this plan.

7.1 Policy and Regulatory Framework

The policy and regulatory framework under which this plan will be implemented will include the Constitution of Zambia, the relevant local and global policies and strategic frameworks, and applicable legislation and regulations. During the course of this strategic plan, efforts will be directed at reviewing and strengthening the existing policy and regulatory frameworks, to improve their effectiveness. The policy framework will include the following, and any amendments thereof:

- National Population Policy, 2007;
- National Child Policy, 2008;
- National Reproductive Health Policy, 2005;
- National Education Policy;
- National Food and Nutrition Policy, 2006;
- Mental Health Policy, 2005;
- National Youth Policy;
- National HIV/AIDS Policy, 2005;
- 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, and other forms of violence.

However, a number of gaps have been identified in the existing policy and regulatory frameworks, and specific strategies have been included in this plan, aimed at reviewing and strengthening them.

7.2 Institutional and Coordination Frameworks

The strategic plan will be implemented within the existing sector and multi-sector institutional and coordination frameworks. The Reproductive Health (RH) Department, under the Directorate of Public Health and Research at MOH will be responsible for the overall coordination of the implementation of the plan. MOH has already established the following structures for coordination of the sector's performance, which will also facilitate coordination of the ADH services:

- The Sector Advisory Group (SAG) under the Sector wide Approaches (SWAp), which is the highest policy and coordination body for the sector, bringing together the MOH and its key stakeholders, including relevant line ministries and departments, CHAZ, private sector, CPs and civil society;
- MOH Headquarters, particularly the Adolescent Health and Family Planning (ADH/FP) Unit under the RH Department;
- Maternal and Child Health (MCH) units within the Provincial Health Offices (PHOs), District Health Offices (DHOs) and health facilities.

This plan has also proposed to establish ADFHS Units at facility level, which would be the entry points for adolescents seeking health services at facility level. Efforts will be made to ensure that these units are appropriately located within the respective health facilities, and that they are convenient, appropriately equipped and provided with appropriate technical, material, logistical and financial support by MOH and other partners. Coordination will be strengthened by the proposed appointment of ADH focal-point persons at provincial, district and facility levels. These centres would be operated by youth/adolescent volunteers from various backgrounds, under the coordination and supervision of focal-point persons that would be appointed, at health facility level.

It is recognised that several aspects of ADH are implemented by other sectors, and that efficient and effective delivery of ADH services requires strong and broad partnerships with families and communities, civil society, other sectors and CPs.

In view of the foregoing, MOH will seek to strengthen multi-sector coordination by reviewing and strengthening the existing national level ADH-TWG. In this respect, the membership of the ADH-TWG will be reviewed and broadened, to include all the key stakeholders, including representatives from relevant sectors and government departments, civil society, CPs and other stake holders at national level. Further, the terms of reference of the ADH-TWG will be reviewed and strengthened.

MOH will also strengthen coordination of partnerships at provincial and district levels, by either incorporating the ADH agenda into the existing TWGs, which are currently active, or establishing ADH-TWGs at these levels. The final decision on this matter will be made through the ADH-TWG. In this respect, the district ADH structures/TWGs would be feeding into the provincial structures/TWGs, and the provincial TWGs into the national level ADH-TWG. The specific terms of reference for these TWGs,

including the roles and responsibilities, composition, organisation and coordination would be developed by the national level ADH-TWG.

7.3 Monitoring and Evaluation

Monitoring and evaluation of the implementation of the plan will be conducted through appropriate existing and new systems, procedures and mechanisms. The Monitoring and Evaluation (M&E) Sub-Committee of the SAG at the national centre will be responsible for providing leadership on all matters concerning M&E. The following describe the M&E framework that will be applied.

7.3.1 Monitoring

MOH will be responsible for monitoring of the implementation of this plan. The M&E systems that will be applied will include the HMIS, established routine management reporting, PAs, and Joint Annual Reviews (JARs). JARs will be planned and conducted jointly with the sector partners, including relevant line ministries and government departments, private sector, civil society, and CPs. The information obtained, through the various monitoring instruments, will be used for policy and management decision making, particularly in the programming and management of ADH services.

7.3.2 Evaluation

Implementation of this plan will be evaluated as part of the NHSP 2011-2115 evaluation. This is considered necessary for purposes of harmonization of M&E activities, and reduction of evaluation costs. In this respect, the review of implementation of this plan will be appropriately included in the Terms of Reference for the Mid-Term and End of Term reviews of the implementation of the NHSP 2011-15. The mid-term review will focus on reviewing the progress made in the implementation of the plan, and assessment of the appropriateness of the overall strategic direction. The end of term review will focus on evaluating the impact/outcome of the implementation of the plan and will assist in providing the contextual framework for the subsequent planning period.

8 Costing and Financing Gaps Analysis

This strategic plan has been costed, based on activity-based costing approach. In this respect, the strategic plan was broken down into service delivery areas, and each of the proposed strategies was broken down into key activities, which were costed. On this basis, the total cost of implementing this plan is estimated at US$7,659,423.

Currently, though there are some partners who are playing various roles related to ADH, it is difficult to quantify this support. In this respect, the only funding available to the Adolescent Health Unit is the Government grant, provided through the annual budget for MOH. Based on this understanding, an analysis of financing gaps was carried out, which estimated the total financing gap for the 5 years at US$4,035,189. In view of the foregoing, for this plan to be successfully implemented, it will be critical for MOH to mobilize and strengthen partnerships with the other key stakeholders, such as CPs, CSOs and other relevant government departments. The summarized costing and gap analysis is provided in the table below.

Costing and Financing Gaps - ADH Strategic Plan 2011-2015 **US$**

S/N	Service Delivery Area	2011	2012	2013	2014	2015	Total
A.	**Projected Financing Needs**						
1	Health Service Delivery	124,000	243,713	932,200	1,645,260	2,626,248	5,571,421
2	Health Workforce/ Human Resource for Health	12,480	91,621	89,281	89,281	89,281	371,943
3	Medical Products, Infrastructure and Equipment	0	5,938	403,025	400,000	400,000	1,208,963
4	Health Information	10,682	10,682	23,372	23,372	30,682	98,790
5	Health Financing	3,170	-	15,030	15,030	15,030	48,261
6	Leadership and Governance	72,009	72,009	72,009	72,009	72,009	360,045
	Total	**222,341**	**423,963**	**1,534,917**	**2,244,951**	**3,233,250**	**7,659,423**
B.	**Projected Financing Sources**						
1.	Government/MOH	59,201	65,034	500,000	1,000,000	2,000,000	**3,624,234**
2.	Partners and others	-	-	-	-	-	**-**
	Total	**59,201**	**65,034**	**500,000**	**1,000,000**	**2,000,000**	**3,624,234**
C.	**Financing Surplus/(Gaps)**	**(163,141)**	**(358,930)**	**1,034,917)**	**(1,244,951)**	**(1,233,250)**	**(4,035,189)**

Detailed analyses of the costing and gaps are provided as Appendix III and IV.

9 Appendices

Appendix I:	Characteristics of Adolescent Friendly Health Services
Appendix II:	ADH Results Framework/Key Performance Targets 2011 - 2015
Appendix III:	Costing - ADH Strategic Plan 2011 - 2015
Appendix IV:	Projected Financing Gaps 2011 to 2015
Appendix V:	Health Sector Strategic Framework 2011 to 2015

APPENDIX I: Characteristics of Adolescent Friendly Health Services

Adolescent Friendly Health Services (ADFHS) need to be accessible, equitable, acceptable, appropriate, comprehensive, effective and efficient. These characteristics are based on the WHO Global Consultation in 2001 and discussions at a WHO expert advisory group in Geneva in 2002. They require:

1. **Adolescent friendly policies** that
   - fulfill the rights of adolescents as outlined in the UN Convention on the Rights of the Child and other instruments and declarations,
   - take into account the special needs of different sectors of the population, including vulnerable and under-served groups,
   - do not restrict the provision of health services on grounds of gender, disability, ethnic origin, religion or (unless strictly appropriate) age,
   - pay special attention to gender factors,
   - guarantee privacy and confidentiality and promote autonomy so that adolescents can consent to their own treatment and care,
   - ensure that services are either free or affordable by adolescents.

2. **Adolescent friendly procedures** to facilitate
   - easy and confidential registration of patients, and retrieval and storage of records,
   - short waiting times and (where necessary) swift referral,
   - consultation with or without an appointment.

3. **Adolescent friendly health care providers who;**
   - are technically competent in adolescent specific areas, and offer health promotion, prevention, treatment and care relevant to each client's maturation and social circumstances,
   - have interpersonal and communication skills,
   - are motivated and supported,
   - are non-judgmental and considerate, easy to relate to and trustworthy,
   - devote adequate time to clients or patients,
   - act in the best interests of their clients,
   - treat all clients with equal care and respect,
   - provide information and support to enable each adolescent to make the right free choices for his or her unique needs.

4. **Adolescent friendly support staff** who are:
   - understanding and considerate, treating each adolescent client with equal care and respect,
   - competent, motivated and well supported.

5. **Adolescent friendly health facilities** that
   - provide a safe environment at a convenient location with an appealing ambience,
   - have convenient working hours,
   - offer privacy and avoid stigma,
   - provide information and education material.

6. **Adolescent involvement**, so that they are
   - well informed about services and their rights,
   - encouraged to respect the rights of others,
   - involved in service assessment and provision.

7. **Community involvement and dialogue** to
   - promote the value of health services, and
   - encourage parental and community support.

8. **Community based outreach and peer-to-peer** services to increase coverage and accessibility.

9. **Appropriate and comprehensive services that**
   - address each adolescent's physical, social and psychological health and development needs,
   - provide a comprehensive package of health care and referral to other relevant services,
   - do not carry out unnecessary procedures.

10. **Effective health services for adolescents**
    - that are guided by evidence-based protocols and guidelines,
    - having equipment, supplies and basic services necessary to deliver the essential care package,
    - having a process of quality improvement to create and maintain a culture of staff support.

11. **Efficient services which have**
    - a management information system including information on the cost of resources,
    - a system to make use of this information.

Source: Adolescent Friendly Health Services: An Agenda for Change, WHO, 2003

APPENDIX II: ADH Results Framework/Key Performance Targets 2011 - 2015

Program Goals, impact and outcome indicators									
Goal Number	**Goals**								
1	To improve the health status of adolescents in Zambia.								

Impact Indicator Number	**Impact Indicator Formulation**	**Baseline**			**Targets**		
		Value	**Year**	**Source**	**2011**	**2013**	**2015**
2	Reduction in STIs prevalence among the adolescents (15 - 19 years of age)	10%	2007	ZDHS 2007	20%	30%	70%
3	Reduction in HIV prevalence among the adolescents (15 - 19 years of age)	W: 7% M: 4%	2007	ZDHS 2007	W: 6% M: 3%	W: 4% M: 2%	W: 2% M: 1%
4	Increase in prevalence of modern contraceptives use among adolescents (15 - 19 years)	22%	2007	ZDHS 2007	30%	50%	70%

N/B:
1. **The ADH programme will just contribute to the attainment of these indicators, as there are also other programmes that will contribute to these efforts.**
2. **"F" stands for Female, while "M" stands for Males.**

Outcome Indicator Number	**Outcome indicator formulation**	**Baseline**			**Targets**		
		Value	**Year**	**Source**	**2011**	**2013**	**2015**
1	Increase in condom use among the adolescents (15 - 19 year of age)	10%	2007	ZDHS 2007	15%	30%	70%
2	Increase in prevalence of modern contraceptives use among adolescents (15 - 19 years)	22%	2007	ZDHS 2007	30%	50%	70%

Program Objectives, Service Delivery Areas and Indicators	
Objective Number	**Objectives:**
1	To ensure availability of holistic, appropriate and cost-effective adolescent friendly health services in all the health facilities and communities in all the districts by 2015.
2	To ensure availability of adequate health workers and community health partners, with appropriate skills in ADFHS, with at least 50% of core health workers and community health partners trained in ADFHS by 2015.
3	To provide appropriate and adequate logistical support, including drugs and supplies, infrastructure, equipment, ICTs and transport, to facilitate efficient and effective delivery of ADFHS across the country. At least 80% of health facilities across the country, to offer ADFHS by 2015.
4	To ensure timely availability of relevant, gender and age disaggregated data on adolescent health, for evidence-based decision making, by incorporating critical indicators into the HMIS and M&E frameworks of MOH by December 2012.
5	To prioritise and increase funding to the ADH programme activities, through the MOH plans and budgets, and cooperating partners, and ensure that at least 90% of budgeted activities are funded, throughout the duration of this plan.
6	To strengthen leadership and governance of ADH, and attain highest levels of transparency and accountability at all levels of implemention of the ADH programme.

Indicator #	**Objective #**	**Service Delivery Area**	**Indicator formulation**	**Baseline (Where Available)**			**Targets**		
				Value	**Year**	**Source**	**2011**	**2013**	**2015**
1	1	Health Service Delivery	Percentage of health facilities in all the 74 districts, with functional ADHFS by 2015.	New	N/A	PA Reports	20%	40%	60%
2	1	Health Service Delivery	Percentage of health facilities that avails a defined package of ADHS services for adolescents.	New	N/A	PA Reports	10%	50%	100%
3	1	Health Service Delivery	Percentage of communities in all the 74 districts with functional ADHFS Centres by 2015.	New	N/A	PA Reports	10%	30%	50%

4	1	Health Service Delivery	Percentage of public high schools providing appropriate and standardized sexual reproductive health education, through the SHN Programme	New	N/A	PA Reports	10%	30%	50%
5	2	Health Workforce	Percentage of health workers trained in ADFHS.	10%	2010	PA Reports	20%	50%	80%
6	2	Health Workforce	Percentage of districts with an ADH Coordinator/focal point person.	New	N/A	PA Reports	10%	50%	100%
7	2	Health Workforce	Percentage of CHW trained in ADFHS.	New	N/A	PA Reports	0%	25%	50%
8	3	Medical Products, infrastructure and equipment	Percentage of health facilities with no stock-outs of the defined package of medicines, condoms, and supplies.	New	N/A	PA Reports	10%		
9	3	Health Service Delivery	Percentage of health facilities that have a defined package of essential equipment and ICTs for the ADH centre.	New	N/A	PA Reports	10%	50%	100%
10	3	Medical Products, infrastructure and equipment	Percentage of districts with a functioning motor vehicle dedicated to ADH.	0%	2010	PA Reports	0%	20%	50%
11	4	Health Information	HMIS reporting disaggregated data by adolescent health age group.	New	N/A	HMIS Report	20%	100%	100%
12	5	Healthcare Financing	Percentage funding of the ADH annual budget by GRZ/MOH (% of total budget/needs)	New	N/A	SAG Reports	60%	70%	80%
13	5	Healthcare Financing	Percentage funding of the ADH annual budget by CPs/Partners (% of total budget/needs)	New	N/A	SAG Reports	40%	30%	20%
14	6	Leadership and Governance	Percentage of districts with established ADH coordinating mechanisms/TWG.	New	N/A	SAG Reports	5%	50%	100%

APPENDIX III: Costing - ADH Strategic Plan 2011 – 2015 (US$)

S/N	Service Delivery Area	Strategy	2011	2012	2013	2014	2015	Total (5 Years)
1	Health Service Delivery	Redefine and broaden the package of Adolescent Friendly Health Services (ADFHS) to be provided at different levels.	-	38,514	-	-	22,248	**60,762**
		Scale out ADFHS to all districts and health facilities.	-	1,200	481,200	961,260	1,920,000	**3,363,659**
		Strengthen community (especially youths) involvement and participation in the delivery of ADFHS.	124,000	204,000	444,000	684,000	684,000	**2,140,000**
		Strengthen linkages and partnerships with the School Health and Nutrition Programme (SHN) at the Ministry of Education (MOE).	-	-	7,000	-	-	**7,000**
		Sub-Total	**124,000**	**243,713**	**932,200**	**1,645,260**	**2,626,248**	**5,571,421**
2	Health Workforce/ Human Resource for Health	Strengthen coordination and supervision of ADFHS at national, provincial, district, facility and community levels.	12,480	12,480	12,480	12,480	12,480	**62,400**
		Scale up training of health workers in the provision of ADFHS.	-	76,801	76,801	76,801	76,801	**307,203**
		Introduce appropriate package of incentives for youth volunteers involved in the provision of ADFHS, in similar lines as the other community health partners.	-	2,340	-	-	-	**2,340**
		Strengthen community and family participation, by training CHWs and families in ADFHS.	To be included in the MOH integrated training for CHWs.					**-**
		Sub-Total	**12,480**	**91,621**	**89,281**	**89,281**	**89,281**	**371,943**

S/N	Service Delivery Area	Strategy	2011	2012	2013	2014	2015	Total (5 Years)
3	Medical Products, Infrastructure and Equipment	Strengthen procurement and availability of essential drugs and medical products	0	4,200	3,025	-	-	**7,225**
		Strengthen infrastructure, equipment and transport for the delivery of ADFHS.	0	1,738	400,000	400,000	400,000	**1,201,738**
		Sub-Total	**0**	**5,938**	**403,025**	**400,000**	**400,000**	**1,208,963**
4	Health Information	Strengthen data capturing and management for the ADH programme and activities.	7,310	7,310	-	-	7,310	**21,930**
		Strengthen Monitoring and Evaluation of ADH activities across the country.	3,372	3,372	3,372	3,372	3,372	**16,860**
		Strengthen and scale-up operational research on ADH.	-	-	20,000	20,000	20,000	**60,000**
		Sub-Total	**10,682**	**10,682**	**23,372**	**23,372**	**30,682**	**98,790**
5	Health Financing	Strengthen budget tracking in respect of ADH funds.	3,170	-	-	-	-	**3,170**
		Strengthen financial transparency and accountability for the resources available to ADH.	-	-	15,030	15,030	15,030	**45,091**
		Sub-Total	**3,170**	**-**	**15,030**	**15,030**	**15,030**	**48,261**
6	Leadership and Governance	Strengthen the policy and regulatory frameworks for ADH.	-	7,460	-	-	-	**7,460**
		Strengthen organisation and coordination of the ADH programme at all levels	72,009	72,009	72,009	72,009	72,009	**360,045**
		Strengthen planning for ADH	Advocacy. Participation. No additional costs.					**-**
		Sub-Total	**72,009**	**72,009**	**72,009**	**72,009**	**72,009**	**360,045**
TOTAL			**222,341**	**423,963**	**1,534,917**	**2,244,951**	**3,233,250**	**7,659,423**

APPENDIX IV: Projected Financing Gaps 2011-2015

		US$					
S/N	SERVICE DELIVERY AREA	2011	2012	2013	2014	2015	Total (5 Years)
A.	**FINANCING NEEDS**						
1	Health Service Delivery	124,000	243,713	932,200	1,645,260	2,626,248	**5,571,421**
2	Health Workforce/ Human Resource for Health	12,480	91,621	89,281	89,281	89,281	**371,943**
3	Medical Products, Infrastructure and Equipment	-	5,938	403,025	400,000	400,000	**1,208,963**
4	Health Information	10,682	10,682	23,372	23,372	30,682	**98,790**
5	Health Financing	3,170	-	15,030	15,030	15,030	**48,261**
6	Leadership and Governance	72,009	72,009	72,009	72,009	72,009	**360,045**
	TOTAL	**222,341**	**423,963**	**1,534,917**	**2,244,951**	**3,233,250**	**7,659,423**
B.	**EXPECTED SOURCES OF FINANCING**						
1	Government/MOH Grants (Target)	59,201	65,034	500,000	1,000,000	2,000,000	**3,624,234**
2	Cooperating Partners and other Sources	-	-	-	-	-	**-**
	TOTAL	**59,201**	**65,034**	**500,000**	**1,000,000**	**2,000,000**	**3,624,234**
C.	**FINANCING GAPS**	**(163,141)**	**(358,930)**	**(1,034,917)**	**(1,244,951)**	**(1,233,250)**	**(4,035,189)**
	Projected rate of increase in Government Funding	1.00	1.10	8.45	16.89	33.78	
	%GRZ/MOH Funding	27%	15%	33%	45%	62%	47%

Appendix V: Health Sector Strategic Framework 2011 to 2015

The current health sector strategy is articulated in the NHSP 2011-15, which also forms an integral part of the SNDP. The same is summarized below:

1. Mission, Vision, Goal and Key Principles

Mission Statement:	To provide equitable access to cost effective, quality health services as close to the family as possible
Vision:	Equitable access to cost-effective and quality health care by 2030
Overall Goal:	To improve the health status of people in Zambia in order to contribute to socio-economic development
Key Principles:	Primary Health Care (PHC) approach; Equity of access; Affordability; Cost-effectiveness; Accountability; Partnerships; Decentralisation and Leadership

2. National Health Priorities

Public Health Priorities	Other Health Priorities
• Primary health care services. • Maternal, neonatal and child health. • Communicable diseases, especially malaria, HIV and AIDS, STIs and TB. • Non-Communicable Diseases (NCDs). • Epidemics control and public health surveillance. • Environmental health and food safety. • Health service referral systems. • Health promotion and education.	• Human Resources for Health (HRH). • Essential drugs and medical supplies. • Infrastructure and Equipment. • Health information. • Health care financing. • Health Systems Governance.

3. Main Objectives/Targets

- Reduce the under-five mortality rate from the current 119 deaths per 1000 live births to 63 deaths per 1000 live births by 2015;
- Reduce the maternal mortality ratio from the current 591 deaths per 100,000 live births to 159 deaths per 100,000 live births by 2015;
- Increase the proportion of rural households living within 5km of the nearest health facility from 54.0 percent in 2004 to 70.0 percent by 2015;
- Reduce the population/Doctor ratio from the current 17,589 to 10,000 by 2015;
- Reduce the population/Nurse ratio from the current 1,864 to 700 by 2015;

- Reduce the incidence of malaria from 252 cases per 1,000 in 2008 to 75 in 2015;
- Increase the percentage of deliveries assisted by skilled health personnel from 45 percent in 2008 to 65 percent by 2015; and
- Reduce the prevalence of non-communicable diseases associated with identifiable behaviours.

4. Strategic Directions and Key Strategies

No.	Program	Objectives	Key Strategies
I	**Service Delivery**		
	Primary Care services	To provide cost-effective, quality and gender sensitive primary health care services to all as defined in the Basic Health Care Package	a) Implementation of the comprehensive roadmap and plan for Maternal, Newborn and Child Health services. b) Scale up and sustain high impact nutrition interventions including vitamin A supplementation, iron-folate supplements, iodations of salt, infant and young child feeding and management of malnutrition. c) Promote integration of nutrition component of various public health and clinical care interventions and strengthen coordination for multi-sectoral response. d) Strengthen training and capacity building for nutritionist and dieticians. e) Implementation of the malaria prevention and control interventions including IRS, ITN distribution, Intermittent Preventive Therapy in Pregnancy (IPTp,) and prompt and effective treatment. f) Implementation of High Quality Direct Observation Treatment Strategy and control of Multi-drug resistant with focus on high risk groups. g) Rehabilitation of people affected by leprosy. h) Expanded access to HIV/AIDS prevention services including Male Circumcision services; condom distribution, STI, Control, PMTCT and provision of safe blood. i) Continued expansion of ART services for both adults and children and in both rural and urban areas.

No.	Program	Objectives	Key Strategies
			j) Strengthen key interventions to address Neglected Tropical Diseases such as school health and nutrition programmes, SAFE strategy, community Mass Drug Administration etc. k) Promote a multi-sectoral approach to environmental health within the framework of the decentralization process. l) Implement comprehensive Health Promotion/BCC strategies to strengthen Health Promotion and disease prevention and address the social determinants of health in the country. m) Strengthen the preventive and promotive interventions to control the emerging and existing NCDs. n) Create a desk for clinical care specialist for non communicable diseases. o) Strengthen laboratory Capacity to support care and treatment programs by ensuring availability of adequate and appropriate infrastructure, equipment and supplies and qualified staff to run and manage the laboratories in facilities.
	Hospital and Referral services	To increase access to and quality of advanced referral medical care services.	a) Strengthen the clinical management and other services in non-communicable diseases. b) Continue the development of ophthalmologic services to move towards the vision 2020: The right to sight. c) Hospital Reforms Programme encompassing strengthened referral structures, outreach programmes from tertiary to regional referral hospitals, mobile referral services and improved quality of clinical services in hospitals. d) Building capacity in Hospital Management in financial management and mobilisation through cost sharing. e) Promote private sector participation in the provision of specialized care.
2	**Human Resource for Health**	To improve the availability of and distribution of qualified health workers in the country	a) Increasing the number of trained Health workers available to the sector improving the remuneration package and expanding training output. b) Improve efficiency in utilization of existing staff by improving HR management and better training coordination. c) Provide appropriate training and incentives to community health workers to mitigate HR shortages.

No.	Program	Objectives	Key Strategies
3.	**Medical Products, Vaccines, Infrastructure, Equipment and Transport**		
	Medical Commodities & Logistical Systems	To ensure availability and access to essential health commodities for clients and service providers.	a) Ensure availability of skilled Human Resource logistics management at all levels. b) Ensure availability of adequate finances for procurement of identified medical commodities, transport and training in logistics management. c) Strengthen Logistics management systems for Essential commodities. d) Ensure rational use of commodities and services through the provision of guidelines.
	Infrastructure	To provide sustainable infrastructure, conducive for the delivery of quality health services at all levels of the health care system	a) Update the existing infrastructure database and review of the HCIP to assess health facility requirements and expedite its implementation. b) Review and gradually rehabilitate existing facilities and building communication and transport systems. c) Develop maintenance and rehabilitation guidelines for all levels. d) Construction of National Drug Quality Control Laboratory, Laboratories and Drug storage facilities. e) Revision of the design of Health facilities through a consensus building process with key stakeholders.
	Equipment, Transport and ICTs	To ensure the availability of adequate, appropriate and well-maintained medical equipment and accessories in accordance with service delivery needs at all levels	a) Finalise policy to support acquisition, management and maintenance of medical equipment. b) Develop capacity program for management and maintenance of medical equipment. c) Development of Standard Equipment Lists at 2nd and 3rd Level Hospital Facilities. d) Strengthen capacity for transport management. e) Strengthen the vehicle service centres at provincial centres. f) Establish & upgrade LAN connectivity in all major health facilities. g) Build ICT capacity in innovative developments and progression of ICT services and infrastructure.
	Specialised Support Services	To strengthen and scale up other medical support services, to ensure efficient and effective support.	a) Strengthen and scale up blood transfusion services and universal precautions. b) Strengthen and scale up laboratory support services. c) Strengthen and scale up medical imaging and radiotheraupy services. d) Strengthen and scale up medical rehabilitative services.

No.	Program	Objectives	Key Strategies
5	**Health Management Information System (HMIS)**	To ensure availability of relevant, accurate, timely and accessible health care data to support the planning, coordination, monitoring and evaluation of health care services	a) Strengthening and capacity building of health information cadre at all levels in order to improve the efficiency, quality and timely availability. b) Strengthen data capturing capacity of HMIS to include other important conditions e.g. NCDs and eye diseases. c) Rollout and strengthening the HMIS to all public and private hospitals and at community level. d) Strengthening the harmonization and co-ordination of different health information systems among programmes.
5	**Health Care Financing**	To mobilise resources through sustainable means and to ensure efficient use of those resources to facilitate provision of quality health services	a) Promote adoption of Health Financing Policy as a long-term guide for financial reform. b) Resource Mobilization: explore alternative ways of raising health finances including PPP, private and social health insurance and ear-marked taxes. c) Resource Allocation: Refine RSF for Districts to account for input costs and develop RAF for other levels and inputs such as HR. d) Resource Tracking: Institutionalize NHA and PETS and strengthen routine resource tracking systems to link inputs to outputs (SAG Reports).
6	**Leadership & Governance**	To implement accountable, efficient and transparent management systems at all levels of the Health Sector	a) Introducing a management development programme. b) Reviewing and strengthen the existing fiduciary systems. c) Strengthen the Sector collaboration mechanisms. d) Introducing Performance based financing. e) Reviewing the overall legal and policy framework. f) Supporting the implementation of the National Decentralization Implementation Plan.

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