WORKING PAPER

Adolescent-Friendly Health Services in Public Health Facilities in Lusaka, Zambia

April 2019

USAID
FROM THE AMERICAN PEOPLE

MEASURE Evaluation

WORKING PAPER

Adolescent-Friendly Health Services in Public Health Facilities in Lusaka, Zambia

Theresa Nkole, MBCHB, MMED
Mukatimui Kalima Munalula, MMED
Joseph Mumba Zulu, PhD

April 2019

MEASURE Evaluation
University of North Carolina at Chapel Hill
123 West Franklin Street, Suite 330
Chapel Hill, NC 27516 USA
Phone: +1 919-445-9350
measure@unc.edu
www.measureevaluation.org

This publication was produced with the support of the United States Agency for International Development (USAID) under the terms of MEASURE Evaluation cooperative agreement AID-OAA-L-14-00004. MEASURE Evaluation is implemented by the Carolina Population Center, University of North Carolina at Chapel Hill in partnership with ICF International; John Snow, Inc.; Management Sciences for Health; Palladium; and Tulane University. Views expressed are not necessarily those of USAID or the United States government. WP-19-230

USAID
FROM THE AMERICAN PEOPLE

MEASURE
Evaluation

ACKNOWLEDGMENTS

The research team would like to acknowledge the United States Agency for International Development (USAID)-funded MEASURE Evaluation, for its support of this study. We thank the Zambia Medical Association, which provided office space for the study team; the Zambia Association of Gynecologists and Obstetricians, for administering the funds for the project; research assistants; the administrative assistant; personnel who aided in analyzing the data; and study participants who took time to provide information.

The authors thank their sponsoring organizations for enabling their involvement in this research: Theresa Nkole thanks the Levy Mwanawasa Teaching Hospital, Department of Obstetrics and Gynaecology in Lusaka, Zambia; Mukatimui Kalima Munalula thanks the University Teaching Hospital, Women and Newborn Hospital, Department of Obstetrics and Gynaecology in Lusaka, Zambia; and Joseph Mumba Zulu thanks the University of Zambia School of Public Health.

We thank MEASURE Evaluation's Knowledge management team, for editorial, design and production services.

CONTENTS

TABLES

ABBREVIATIONS

AFHS	adolescent-friendly health services
FGD	focus group discussion
HCP	healthcare provider
ICPD	International Conference on Population and Development
IEC	information, education, and communication
MOH	Ministry of Health
NGO	nongovernmental organization
SRH	sexual reproductive health
STI	sexually transmitted infection
WHO	World Health Organization

EXECUTIVE SUMMARY

Background: Adolescents have healthcare needs that are distinct from adult needs, particularly in the area of sexual reproductive health (SRH) and rights. Adolescents need information, counselling, and other services to respond to the challenges they face as they transition to adulthood. Neglecting their specific needs can lead to negative outcomes such as drug abuse, unwanted pregnancy, unsafe abortion, dropping out of school, sexually transmitted infections (STI) including HIV, and sexual and gender-based violence.

In Zambia, adolescents and young people represent 40 percent of the population (Zambia Ministry of Health [MOH], 2011). To increase adolescents' access to and use of health services, the MOH developed National Standards and Guidelines for Provision of Adolescent-Friendly Health Services (AFHS) in 2009. Despite the recognition of the rights of young people to SRH information and services, adolescents still face challenges in accessing healthcare in public health institutions. Previous studies, particularly in Zambia, have focused on whether making facilities more youth-friendly will increase access and use. Because the government has already instituted AFHS, we sought to assess adherence to the standards and guidelines to identify the challenges, successes, and opportunities for strengthening adherence to the standards, thereby improving provision of AFHS and adolescent health outcomes.

Methods: This cross-sectional study was carried out in six public health facilities in Lusaka District, Zambia. Data collection entailed 11 focus group discussions (FGDs) with 70 adolescent girls and boys ages 10 to 19 years. The FGDs were intended to get information on adolescents' perceptions of how services are provided. Interviews were also conducted with health facility staff and community members. There were 123 total study participants.

Findings: Results of the study indicate an overall lack of adherence to the standards and guidelines for providing AFHS. Although most healthcare providers (HCPs) had heard of AFHS and were aware of the standards, most (77%) had not received training in providing services to adolescents. Young age was a barrier to providing health services to adolescents. Adolescents preferred providers of the same sex and a younger age, believing that older providers tended to be more judgmental. Although HCPs reported involving adolescents and community members in planning for AFHS, the adolescents indicated that they were not actively involved in planning of services and were involved only when it was a nongovernmental organization (NGO) initiative. The physical environment of the facilities was acceptable, and little concern was expressed about auditory or visual privacy, although adolescents did fear their visits would not be kept confidential. The adolescents reported that sometimes there were prolonged waiting times because of staff shortages and some HCPs did not respect clients' time. Adolescents felt that the information, education, and communication (IEC) materials in the health facilities were inadequate and nonexistent in the community. Half (50%) of the respondents reported shortages of drugs. The services are generally free and cost is not a hindrance to provision of services.

Recommendations: Provide in-service and preservice trainings on AFHS to all HCPs. Formulate context-specific policies and guidelines on providing AFHS that take into account the concerns of communities and adolescents and consider their cultural and religious inclinations. Engage adolescents and adult community members in planning and delivering AFHS to make them responsive to community needs. Develop more adolescent-specific IEC health materials for facilities and greater media use. Strengthen peer educator involvement and training in provision of services to adolescents because adolescents relate better to their peers.

INTRODUCTION

Adolescents have healthcare needs distinct from those of adults, especially in the area of SRH and rights (Jana, Mafa, Limwame, & Shabalala, 2012). Adolescence, defined by the World Health Organization (WHO) as ages 10 to 19, is becoming more of a specific developmental stage in many countries. Thus, there is concurrently a greater understanding of this age group's biological, psychosocial, and health needs (Jana, et al., 2012). Adolescents' transition from childhood into adulthood particularly affects their sexual development. Adolescents need information, counselling, and other services to respond to the challenges they face during this period. Neglecting their specific needs can lead to negative outcomes such as drug and alcohol abuse, unwanted pregnancy, unsafe abortion, school dropout, STIs including HIV, and sexual violence. This neglect negatively affects the health and socioeconomic development of adolescents (Zambia MOH, 2011).

Worldwide, complications related to pregnancy and childbirth are among the leading causes of death in adolescents ages 15 to 19 (WHO, 2014). Women who give birth before age 16 are three to four times more likely to suffer maternal death than those in their twenties (Conde-Agudelo, Belizán, & Lammers, 2005). Sexual abuse is also a problem among adolescents, with defilement, rape, and forced marriage being most common (MOH and Ministry of Community Development, 2011).

The global health community recognized at the International Conference on Population and Development (ICPD) in 1994 that adolescents' SRH issues (such as unwanted pregnancy, unsafe abortion, and STIs including HIV/AIDS) should be addressed by promoting healthy and responsible reproductive behavior, including abstinence and appropriate counselling and services suitable for the age group. Participants noted the need to provide services for adolescents and also to respect their cultural and religious beliefs as well as rights, duties, and responsibilities of parents (United Nations Department of Public Information, 1994). Recognizing the challenges associated with adolescence, the WHO developed guidelines on AFHS (WHO, 2012). This is a relatively new and sensitive area due to cultural and religious norms concerning the provision of SRH services to young people. Without guidelines, services for adolescents are fragmented, poorly coordinated, sometimes inaccessible, and of varying quality. Residents in urban centers have better access than those in rural and peri-urban areas (Kamau, 2006). This is particularly true in developing countries.

The global population of adolescents stands at 1.2 billion, representing 17 percent of the world population. Eighty-five percent of these are in low- and middle-income countries (WHO, 2014). In Zambia, adolescents and young people represent nearly half (40%) of the population (Central Statistical Office [CSO] Zambia, 2013–2014). The median age for sexual debut is 17 years for girls and 18 for boys (CSO, 2014). Seventeen percent of girls ages 15–19 are married, and among them, 25 percent have an unmet need for family planning. About 30 percent of all girls ages 15 to 19 have begun childbearing, 8 percent have experienced sexual violence, and the HIV prevalence among the youths ages 15 to 24 is 7 percent and rising (Zambia CSO, 2013–2014). In the last Zambia Demographic and Health Survey, despite universal knowledge of HIV, only 40 percent of young women and 49 percent of young men reported having used a condom at last sex, putting themselves at risk of not only HIV, but also unplanned pregnancy (CSO, 2013–2014). These factors increase the risks for adolescents.

AFHS Standards and Guidelines

In Zambia, adolescent health services were initially provided by NGOs in collaboration with the MOH; however, the services were not sustainable after the projects ended—because they were donor-driven, with no

national guidelines and policies for providing AFHS. Without national standards, AFHS efforts were scant and uncoordinated. Lack of clear policies and guidelines hamper adolescents' access to and use of AFHS (Godia et al., 2013). The realization of this deficiency led to the MOH developing the National Standards and Guidelines for provision of AFHS. The following is a summary of the key components of the standards:

- Planning: The facility has a service plan developed through a process that includes a needs assessment. The findings of the needs assessment are disseminated to the community and adolescents so the community is aware of the needs of adolescents.
- Policies and procedures: All policy guidelines and procedures for provision of services are in place for the facility.
- Service provision: The facility has adequate staff, including clinical personnel, counsellors, and peer educators. The facility is well-equipped with medicine, commodities, space, IEC material and equipment, and supplies for providing services. Adolescents should be aware of the services.
- Implementation and management: There are systems for engaging young people and community members in management and decision making during implementation of activities and services.
- Training: All healthcare providers, counsellors, and peer educators as well as drama groups are trained in AFHS, in line with the training needs report and skills training plan.
- Quality assurance, monitoring and evaluation: A system and tools are in place for data collection, data analysis, and use of data and information for monitoring and evaluation as well as quality assurance.

Despite the recognition of young people's right to SRH information and services and the development of national AFHS standards, adolescents still face challenges accessing information and services in public health institutions.

Previous studies, particularly in Zambia, have not focused on whether facilities are adhering to set standards; rather, they have focused on the premise of whether making facilities more adolescent-friendly will increase access and use. In other settings where standards have been set and implemented, such as in South Africa, service delivery to adolescents has improved (Dickson, Ashton, & Smith, 2007). In this study, an important factor that was noted to shape adherence to adolescent-friendly health standards was community acceptance of adolescent use of services. Adolescents' and young people's access to and use of SRH information and services is a sensitive issue among HCPs, parents, and teachers because there is fear that giving adolescents too much information and services may encourage promiscuity. This belief is also affected by religious and cultural factors, with some providers believing the service provision conflicts with their religious and cultural beliefs.

Research Objective

With the government of Zambia establishing standards for AFHS, assessing adherence to the standards and guidelines may help identify the challenges, possible successes, and opportunities for improving adherence to the standards in the provision of AFHS. The objective of this study was to assess adherence to AFHS standards and guidelines in public health facilities in Lusaka District, Zambia.

The findings of this study will inform policymakers, managers of facilities, and healthcare providers on what can be done to improve the quality of service provision to the adolescents.

METHODS

Study Design

This was a cross-sectional study involving both quantitative and qualitative methods. Using FGDs and interviews, we collected information on the perspectives of both HCPs and adolescents. Other health facility staff and community members also participated in the study, which was carried out in six public health facilities in Lusaka District in urban Zambia.

Qualitative Data Collection

The qualitative component of the study was conducted with only adolescents to get a better understanding of how they perceived AFHS regarding standards and guidelines. Over three months, we conducted 11 FGDs with 70 adolescents attending the six level-one hospitals in Lusaka District. We deliberately selected these health facilities based on the expectation that they should have functioning youth-friendly services. The selected facilities were recently upgraded to level-one hospitals. The participants in this study were also deliberately selected from the facilities, based on their willingness to participate in the study. The adolescents were drawn from every department in the facility where they were found on the day the research assistants visited the facility, including general outpatients, those coming for treatment in the antiretroviral treatment clinics, and those who were found in youth-friendly corners, which are places in the health center where youth find safe and respectful healthcare. The space is staffed by young volunteers, and youth come for counselling and referrals to other services, such as family planning. Some of the youth-friendly corners that are funded with donor support also provide youth with room to read.

We prepared a standard FGD guide that we used in each group to maintain consistency of questions. The guide was pretested in one of the facilities before the start of data collection. No problems were found and no amendments were made to it.

The focus groups were disaggregated by age group, 10 to 15 years and 16 to 19 years, to ease the discussion by having adolescents in the same age range grouped together. Each group had both boys and girls. We made an effort to ensure a gender balance and include six to eight participants in each group. The FGDs were conducted in community halls, church halls, and meeting rooms near the selected health facilities where the adolescents were found. The two research assistants had prior experience in conducting qualitative interviews in the community.

Table 1. Focus groups

Townships	Age group 10–15	Age group 16–19	Total
Chilenje	6	6	
Chipata	8	8	
Kanyama	6	6	
Matero	-	8	
TOTALS	**30**	**40**	**70**

The researchers requested an FGD for younger adolescents in Matero; however, the community was very suspicious and declined.

All the FGDs were conducted in English and audio-recorded. The research assistants took notes during the discussions. Given the potentially sensitive nature of the subject matter, careful attention was given to maintaining confidentiality of data by not including identifiers of the respondents in the results. After every FGD, we reviewed the notes and audio recording and debriefed on the discussion. This enabled us to reflect on the major issues that surfaced, identify complex issues that required further clarification, and pose additional questions during subsequent FGDs.

Quantitative Data Collection

This component of the study was also done in the same facilities mentioned above and was conducted by the same research assistants. We conducted 123 one-on-one interviews with adolescents, health facility staff (HCPs, facility managers, and receptionists) and community members. The adolescents were purposively selected as indicated in the qualitative data collection. The health facility staff were purposively selected based on being in one of the six study facilities and willingness to participate. The community members were purposively sampled from those attending the facility that day, providing they were not parents of the youth in the study.

We administered questionnaires that had been previously validated and were adapted for this study. For the interviews with adolescents, we used the WHO questionnaire, the YFHS-WHO Questionnaire (Boersema 2016), to assess a facility's youth friendliness. This questionnaire had been previously validated for South Africa. We used the South African version of the questionnaire, with a few changes after pretesting, because we felt the South African environment was similar to Zambia. For the participants other than the adolescents, we used the tool from the WHO's Quality Assessment Guidebook: A Guide to Assessing Health Services for Adolescent Clients (2009). The interviews were conducted at each of the six facilities. Auditory and visual privacy was ensured while carrying out each interview.

Data Analysis

The transcribed data were analyzed with a thematic approach by using a qualitative data analysis software program, N. vivo (version 10, QSR International), to organize, code, and analyze the data. The researchers first identified emerging themes from the transcripts. These were then used to come up with codes. Reliability was achieved by thoroughly reviewing and reading through the interviews, which included reviewing of data transcribed by the data collectors. The research team mangers took several turns reviewing the transcripts to ensure they reflected the audio recordings. After reviewing the transcripts, the team collectively identified emerging codes and compiled them in a codebook, which was reviewed by other authors. Data coding began after final agreement was reached on the codes. All authors took several turns reviewing the transcriptions to develop the final themes.

Ethical Considerations

Ethical approval was obtained from the Eres Converge Research Ethics Committee. For both components of the study, participants provided written consent after the research assistants informed them on the study requirements and purpose. For the adolescents who were younger than age 18, their parents gave written consent and the children also gave assent.

RESULTS

Qualitative Results

We conducted the FGDs with adolescents to find out their understanding of SRH and their perception of how adolescent health services are being provided in the community and facilities. This was to help us assess, from the adolescents' perspective, whether they are being served according to national guidelines.

First, we asked questions to ascertain whether adolescents understood what SRH is and why SRH services are important. We then explored the various areas pertaining to standards for providing AFHS set out in the guidelines. The qualitative results are reported according to five themes that emerged from the FGDs:

1. Adolescent involvement in planning and implementation
2. Types of providers, with a preference for younger providers and a gender balance
3. Appropriate approach and respectful care
4. SRH information and IEC materials
5. Shortage of commodities

These five themes are grouped under the three guideline categories: understanding of SRH and related services, adolescent SRH planning and implementation, and service provision standards.

Understanding of SRH and Related Services

Reproductive System and Organs: Most of the adolescents explained that they thought SRH is the state of health of sexual organs and the reproductive system. They indicated that SRH is a way of ensuring that sexual organs, like the vagina and penis, are taken care of and kept clean. They also stated that SRH entails understanding how the sexual organs function and how to protect them from infections. The following quotes illustrate these ideas:

> *I think sexual reproductive health has to do with the health of the reproductive systems and how we take good care of them, how we* look *after our reproductive organs.* —FGD, Matero

> *When I just hear sexual reproductive health, what comes in my mind is what they will talk that has something to do with private parts like the vagina, the penis, what they talk about that's what comes on my mind.* —FGD, Kanyama

SRH Services: Some adolescents understood SRH as everything related to one's feelings and sex. Others, however, defined it is as everything related to the sexuality of individuals, including associated services that are provided at the health facility. For example, they mentioned that HIV counselling and testing, prenatal care, and family planning are all SRH services. When asked to define SRH, one adolescent from Kanyama had this to say:

> *I think sexual reproductive health are those are the things related to our sexuality. For example, we talk of puberty, it's on sexuality. We talk of services offered concerning sexuality because it is sexual reproductive health and HIV/AIDs to go for counselling and testing, pregnancies, and early pregnancies. Then we talk of maybe accessing family planning to avoid pregnancies and maybe condom use. All those are in one packet of sexual and reproductive health.* —FGD, Kanyama

The adolescents understood that SRH is an important topic and they need to be concerned about it because having good knowledge will help keep them protected from problems such as HIV, STIs, and unwanted

pregnancy. They also recognized that they are most vulnerable to these issues during adolescence, and that SRH information and access to SRH services is critical. Two adolescents from Chilenje and Chipata had this to say when asked about the importance of SRH:

> *I feel it is really right because as adolescents, this is the age where you are so vulnerable to a lot of things like teenage pregnancies, catching maybe HIV/AIDS. Because us teenagers, we want to experiment and see the reason why they are refusing you to do such things. So, it basically goes to the champions in the hospital I think for many people."* —FGD, Chilenje

> *I agree with my colleagues that we should be concerned about sexual reproductive health because sexually transmitted infections are deadly diseases. Yah, so in order to keep ourselves and not to die young.* —FGD, Chipata

From the discussion quotes, adolescents clearly have an understanding of SRH and its importance. They recognize the need for accessible SRH services to help them make the right decisions regarding their health.

Adolescent SRH Planning and Implementation

Adolescent Involvement in Planning and Service Provision: Most of the adolescents indicated that HCPs, not adolescents, are involved in planning and implementing SRH services at health facilities. As a result, the adolescents felt that even when the HCPs plan, they do not understand what this audience is going through. The majority stated that they had never been consulted about planning SRH services at the local health facilities. For the adolescents that were involved in planning, they indicated that it was mostly on occasions where it was an NGO initiative and not organized or requested by a health facility.

> *We are not part and parcel of the planning; they only make a plan for us [and] we start following it. They don't involve us. They don't.* —FGD, Chelstone

> *I think when they select among the adolescents they feel like, who can contribute to the same, but what they do is that they sit down as adults, then they plan, then they bring things for us. However, they are not going through the same things as we do as adolescents. So, they should include us as well—people that are experiencing the same thing—they include us so that we may contribute. If they come up with a plan, we are able to say okay, this came out from the adolescents, unlike just them sitting down as adults, then they bring they bring issues for us.* —FGD, Chelstone

The adolescents provided various reasons for the non-participation of adolescents in planning for SRH services. They complained about the lack of visibility of HCPs in the community, stating that on most occasions, HCPs showed up only when offering certain services to adolescents, for example, during blood donations. The male adolescents felt that most facility-based SRH services seemed to focus more on girls. In addition, a lack of feedback to the adolescents when they are invited to participate in planning (i.e., not receiving any follow up to their concerns or recommendations on the quality of services, facility conditions, types of services provided, and so forth) from the providers was very demotivating to the adolescents who wanted to be involved in improving service delivery. Some adolescents were occupied with other activities, such as school, which is why they did not participate in SRH planning and activities.

> *They only come when they are in need of something, like for example blood donation. For girls, they usually have some lessons, but for us boys, it is difficult. I don't know why, but maybe there is not much to talk about* [with] *us boys. With girls, I have seen many times they communicate with girls and have some stuff…that's what I can say.* —FGD, Matero

The level of involvement, I don't think it was enough because the feedback didn't come. Like, you just submit - okay they see these are the plans for the adolescents, of course, for the adolescent-friendly space. They do planning, so we don't really know how many activities they involve in their plans. So, it could be better we plan, we submit to them. After planning they show us the copies like 'Ok, this is what we have involved from your plan. These are some of the activities we have involved [in] our plan that one will be better. —FGD, Kanyama

Service Provision Standards

Young Providers: Most of the adolescents narrated that having young providers who understood the challenges they go through is important for services to be friendly. They indicated that because younger providers were closer in age to them, it made them easier to relate to and more approachable to talk to about SRH issues. On the other hand, they dislike being attended to by older adults because they feel they tend to judge adolescents, even going so far as to ask for their parents when providing services. Adolescents were afraid that some older providers would breach confidentiality and report to their parents that they were accessing SRH services.

When children go to the hospital and they find elderly people, when pregnant, she will have difficulties requesting a pregnancy or STI test because you may find that maybe they congregate together at church, or maybe they know your parents, or maybe they will think otherwise. Therefore, young people get scared, and they want young people like them. When they come in the community that's when they ask, like, 'I suffered from gonorrhea, so how can you help me?' The questions they find difficult to ask from elders when they go to the clinic. —FGD, Kanyama

I think young doctors might be of good help because we will be free, they are of our same status, we are both of the same age. However, if we find parents there, we will be like no, they're also parents, they have children. How can I explain? Meaning, by us explaining, maybe that may cause them not having trust in their children. So, I think having young doctors might help. —FGD, Matero

Gender Balance among HCPs: The adolescents asserted that for services to be youth-friendly, gender balance among service providers is needed. They indicated that it would be much easier to access SRH services from a provider who is the same sex as they are. For example, some of the female adolescents indicated that they were not comfortable with male providers, but attended services because they required medical assistance. Having someone of the same sex to provide SRH services would allow adolescents to freely express themselves and their concerns when they attend the health facilities.

Personally, I feel I am not too comfortable with the male doctors myself. But looking at the situation, I have found myself in, I am ill or maybe I just want to inquire some information from there, and there is a male doctor, I will ask if there is a female doctor who can attend to me just to tell them what I feel about myself. If it is not possible, I will just swallow my pride and be attended to. —FGD, Chilenje

I would say the hospital must be gender balanced because like us guys, we are not free to girls. Ladies, even them girls they are not usually free when they find male doctors. Sometimes you will find that when you go there, then you find your attendant is a woman and you are a male, you want to start explaining things in detail, but you see that the person is a woman. So, you will find that, that drives us back, so I think it should be gender balanced. —FGD, Matero

Appropriate Approach: The style in which adolescents are approached and welcomed at the health facilities was considered important for SRH services to be youth-friendly. They spoke of the need for providers to show an interest in understanding more about why the client was visiting the health facility. Adolescents further indicated that it is important for the HCPs to be caring and consider them when they go to the facility,

and not pay attention to them only when they are with their parents. They also felt the need for providers to assure the adolescents of total confidentiality of SRH services.

> *Yes, they are trained and qualified, but for us young people nowadays, they don't consider us to be people who are matured enough. At least when you go with your parents and all that, they can concentrate on giving you information that you need.* —FGD, Chelstone

> *The welcoming, like what he has said, and also the confidentiality itself. Because maybe you find that we go to the health facility, they won't even assure us to say what we will discuss here, it will remain here. So, they will just go on and start screening. As a result, you won't be open to what you wanted to say because you are not sure whether to open up, so you won't open up. They haven't said anything about confidentiality. So maybe they will go on and tell someone else. You know adolescents, we are very sensitive, yes.* —FGD, Chipata

Respectful Care: The adolescents said they thought some providers were rude to them because they didn't think the adolescents were old enough to be accessing certain services. Because HCPs were said to be unkind and disrespectful to the adolescent patients, adolescents were discouraged from going to the health facility and attended only for illness, rather than to inquire or get information about something. In addition, because of the negative attitude on the part of providers, the adolescents stated it is very difficult for them to explain themselves properly when it is time to discuss an issue with the provider.

> *Coming to the issue of the attitude of the staff, I think it really matters because some staff at the facility are very rude to us. Because they feel that since we are young, they can tell us anything. Like that, we won't be comfortable, and we won't feel like going there. As a result, we will end up just staying home with our illness, which will lead to a lot of deaths to the society.* —FGD, Chilenje

> *You find that always just for you to tell them nicely you have to really struggle. You will find that just for a simple thing, the response that they will give you won't be nice. People don't usually go to the clinic unless the illness is really serious and needs medical attention. If someone has a headache, they will say ah it's just a headache, I will take medicine and I will be ok, because when you go to the clinic their attendance isn't good.* —FGD, Kanyama

The adolescents did not consider the clinic hours problematic; however, they complained of how the working hours were mismanaged by facility staff. They felt some staff spent a lot of time chatting at the expense of attending to clients.

> *I personally feel the government should do something because there are a lot of doctors that are being trained and they are not doing their jobs. I think like they have got bad job cultures because when you go to the mentioned health facility, they have got limited doctors and staff, but the way they attend to patients is very slow. You find that they are seated there chatting and there is a que outside pending, you know.* —FGD, Chilenje

> *I do receive the services that I want whenever I go to the health facility, but not most of the time. Because you find that the time I go there, maybe I just want to get information from the nurse or go to the clinical officer, you find that they are busy on the phone and just say no they don't have time. In the meantime, you can see that there are a lot of people there who need to be attended to while she is on the phone. So, I end up going, just going back home.* —FGD, Chipata

SRH Information: Some adolescents reported not having information on SRH. Although most of them had heard about it, they indicated that they did not really know much about the topic. One reason for this is that most of them did not know where to get information if they wanted to know more. In addition, they felt that even in some places with SRH information, the messages are not appropriate (e.g., not in the local language, too many technical and complex terms, or not geared toward youth). For example, if an adolescent

contracted an STI, got pregnant, tested positive for HIV, or was suffering from AIDS, he or she would not know exactly where to seek care and assistance.

> *I will agree, sexual reproductive health is a problem to many adolescents in the sense that many don't have the appropriate information on, let's say for instance, STIs, early pregnancies, and HIV. So, you will find that when a person has STIs, they wouldn't know how to be treated or where to go. Instead, they will try to, like, keep to themselves. And then at the end of the day, they experience the damage.* —FGD, Chipata

Although the adolescents mentioned not having enough information on SRH, they felt that their adolescent health lessons in school put too much emphasis on sex and conception. They believed the focus on sex makes adolescents curious, causing them to want to experiment. Thus, they end up in premature sexual relations and engage in sexual activities before they are ready.

Respondents felt that SRH information should be age-appropriate, taking into account the maturity of the recipient. Some respondents indicated that information should be given to only those who are 16 years and older because they are better positioned to know what is right and wrong.

> *Then again, I feel the more teenagers are being told about sex and sexual issues. They kind of like get too curious that they end up actually having these sexual relationships. So, I feel like, maybe, I don't know it is the way they are taught something.* —FGD, Chilenje

IEC Materials: Adolescents indicated that SRH posters and flyers can be found at the health facilities, in places like youth-friendly corners; however, the adolescents think the placement of posters and flyers is inadequate because the posters are absent in many departments in the facility. They also indicated that the content of the materials addresses only general SRH issues, without mentioning or targeting adolescents' needs specifically. In addition, adolescents expressed the need to have the language in these IEC materials be as simple as possible and translated into local languages.

> *Yes, you know, like flyers are there, but they don't make an effort to put them everywhere. They just put them around the clinic just there, but it's not a lot of people* [see them]. *We don't use the same routes, no we don't we use other routes, so I cannot say that they are everywhere, no they are not.* —FGD, Kanyama

> *Looking at the recent brochures that I came across, the English was quite simple, but like you said earlier, it is not everyone who can understand the technical language in terms of English. So, I think mixing languages like Nyanja, Bemba, and English on the messaging part should be more because health people, Ministry of Health, it is not only elderly people who come at the facility. They should also consider there might be young people who are not able to read in English. There may be young people who don't understand really what it means when somebody says, let's say for instance, treatment. So, the mixture of languages should be there.* —FGD, Chipata

They indicated that youth-friendly corners are a huge source of information for adolescents, although the corners are few. They noted, however, that at the health facility, information on SRH services tends to be provided only after an issue is found, for example, HIV or pregnancy.

> *I remember when I was going for male circumcision myself, first of all, before I went there, I was attended to by I think a healthcare worker. He explained everything on male circumcision. But after explaining, still he insisted that he gave me some paper to read and said, 'You should read this for more information'. I read that paper again and before I entered, I was told the same thing again the worker told me before I entered the room for circumcision. So, for me I think they are really there. —FGD,* Chilenje

> *From my own understanding, if we go to health facilities, you can only learn about it when maybe they found out, like, you are pregnant or, like, you have some diseases, you know, HIV/AIDS. That's when you can learn about it. If you*

are just healthy, they cannot really tell you that—they don't really. Ok, if you go there, they will just attend to you as in your state, the way you are, how you are feeling and all…these days we don't really learn about it. —FGD, Chelstone

Commodities: The adolescents cited a number of health system challenges that affect access to and use of SRH services. They mentioned a lack of medication and equipment as common challenges facing health facilities. They said that, due to frequent stockouts at the facility, sometimes they must get prescriptions from private pharmaceutical stores.

Every time we go to the mentioned health facility and I am with a problem, when they give me the medicine and the doctor prescribes, and I go to the pharmacy, I have never found the medicine. They always tell me you have to go and buy this at some other pharmacy. Then the last time I went there, and I went to the pharmacy at Chilenje market, I went to buy the medicine, they were like, 'What is this for'? I told them the problem and they were like, 'No, this is not the right medicine, you have to get this other thing.' I have never really gotten my services right. —FGD, Chilenje

Another challenge is staff shortages in the health facilities. Sometimes they find that one staff member is attending to a lot of people at once, increasing the wait time at the facility. They think that some of the providers do not have negative attitudes, but they are simply overwhelmed and overworked by the large number of patients.

Quantitative Results

During the quantitative analysis, we checked normality assumptions for continuous variables, such as age, and conducted a descriptive statistical analysis. We reported continuous variables for the mean and standard deviation and categorical variables, frequency, percentages, and totals. All analyses were performed using STATA software, version 14.0 SE (Stata Corporation, College Station, TX, USA).

Adolescents

We interviewed a total of 78 adolescents. More than half (55%) were female, the majority (85%) were above age 16 years, and only one was married. Most of the study participants were well educated and financially dependent on their parents.

Table 2. Demographic characteristics of the interviewed adolescents

Variable	Characteristic	N (%)
Sex	Male	34 (45)
	Female	42 (55)
Age	12–15	12 (15)
	16–19	66 (85)
Education Level	None	2 (3)
	Primary	12 (15)
	Secondary	59 (76)
	Tertiary	5 (6)
Marital Status	Single	77 (99)
	Married	1 (1)
Primary Source of Income	Parents	59 (76)
	Relatives	20 (26)
	Friends	6 (8)
	Others	1 (1)

Note: two respondents did not report sex, and some reported more than one primary source of income.

From the adolescent interviews we were able to assess four criteria for health facility services to be considered adolescent-friendly: (1) policies and procedures, (2) planning, (3) implementation, and (4) service provision standards.

The respondents thought that the most frequent reasons people visit health facilities are to seek immunization, condoms, and health education. They believed the most common reason adolescents visit health facilities is for sexual-related concerns, followed by injury and physical illness. On whether they would recommend attending a facility to others, they indicated they would for physical injury, physical illness, and sex-related concerns.

Service Provision Standards: The facility environment was said to be fairly welcoming. The majority (84%) of adolescents reported that the facilities had some educational material in the waiting area; however, over two-thirds (77%) of the participants felt the information provided in the posters and brochures is substandard.

We inquired about various waiting times in the facility: time at registration to get a file or clinic card, time to see an HCP, and time to collect medicine. The shortest wait time was at the registry, with most (79%) participants reporting they got their card within 30 minutes of arriving at the facility. The longest wait time was to see an HCP, with nearly half (47%) reporting that it took up to an hour to be attended to after receiving their file. Most (83%) of the participants reported getting their medication from the pharmacy within 30 minutes. Most (72%) reported that their experience of care was within their expectation, although three-quarters (75%) reported not being given a treatment option.

The adolescents expressed concern about confidentiality and the possibility of their parents (72%) or school authorities (36%) finding out they were attending the facility for SRH services; however very few had concerns about the police finding out about them accessing AFHS.

Table 3. Adolescent responses to service provision standards

Criteria	n (%)	n (%)	Total
Clinic Hours	**Yes**	**No**	
Completely unsuitable	0 (0)	72 (100)	72
Often unsuitable	29 (40)	43 (60)	
Occasionally unsuitable	44 (61)	28 (39)	
Wait Time	**Less Than 30 Minutes**	**More Than 30 Minutes**	
To get file at registry	60 (79)	16 (21)	76
To be seen by HCP	38 (53)	34 (47)	72
To obtain medication at the pharmacy	62 (83)	13 (17)	75
Experience of Care	**Yes**	**No**	
Treated as expected	55 (72)	21 (28)	76
Treatment explained	66 (80)	15 (20)	71
Tests explained	57 (75)	19 (25)	76
Results explained	69 (91)	7 (9)	76
Preferred treatment given	19 (25)	57 (75)	76
Enough time with HCP	52 (71)	21 (29)	73
Confidentiality	**Yes**	**No**	
Privacy ensured	35 (56)	27 (44)	62
Educational Materials	**Yes**	**No**	
Present	64 (84)	12 (16)	76
Poor quality	67 (94)	4 (6)	71

Fair quality	4 (6)	67 (94)	71
Waiting Area	**Yes**	**No**	
Appealing	32 (42)	44 (58)	76

Provision of Health Services to Adolescents: The adolescents recognized peer educators as being the ones who provided most (86%) health services to adolescents in the community, followed by community volunteers (75%) and other adolescents (69%). (Peer educators and HCPs in charge of adolescents may co-opt other adolescents who frequent the facility youth corners.) Half (50%) of the participants reported that HCPs were also seen providing services in the community. These services consisted mostly of condom distribution and health education.

Table 4. Providers of health services, as reported by adolescents

Criteria	Yes (%)	No (%)	Total
Peer educator	64 (86)	10 (14)	74
HCP	40 (53)	34 (46)	74
Community volunteer	54 (76)	17 (24)	71
Adolescent	54 (76)	17 (24)	71

Although over 80 percent of the adolescents did not feel that sex, religion, or marital status were barriers to accessing health services, 40 percent of the respondents indicated that young age could be a reason for HCPs to deny services. Most of the adolescents did not think they would be denied services on the grounds of their social problems. Seventy percent knew that they were not likely to be asked to pay; therefore, cost was not a barrier to accessing AFHS.

Table 5. Adolescents' reasons for not visiting a facility and receiving services

Criteria	Yes (%)	No (%)	Total
Reasons for not receiving AFHS			
Young	45 (59)	31(40)	76
Old	1 (1)	75 (99)	76
Boy	6 (8)	68 (92)	74
Girl	5 (7)	68 (93)	73
Marital status	13 (17)	63 (83)	76
Drug user	22 (29)	54 (71)	76
Religion	14 (18)	61 (81)	75
Reasons for not visiting a facility			
Fear of parents	56 (72)	22 (28)	78
Fear of police	9 (12)	69 (89)	78
Fear of school authorities	28 (36)	50 (88)	78
Fear of being asked to pay	23 (30)	54 (70)	77

Healthcare Providers

We interviewed 30 HCPs. These study participants included nurses, midwives, and clinical officers. Most (87%) held diplomas in nursing. Their ages ranged from 21 to 70 years, with a mean of 39 years.

Table 6. Demographics characteristics of the interviewed HCPs

Variable	Characteristic	N (%)
Sex	Male	7 (23)
	Female	23 (77)
Age	21–28	6 (20)
	29–36	11 (37)
	37–44	6 (20)
	45–52	3 (10)
	53–62	3 (10)
	63–70	1 (3)
Religion	Christian	30 (100)
	Muslim	0
	Other	0
Education	Certificate	3 (10)
	Diploma	27 (90)

Service Provision Standards: The HCPs indicated that they use protocols and guidelines to provide general reproductive health services, although seven did not respond to this question, possibly indicating a lack of awareness of the guidelines and protocols. Only slightly more than half (55%) of the HCPs interviewed said they knew about the standards and guidelines on provision of AFHS. They had become aware of them through meetings (83%), colleagues (11%), and youth-friendly corners (6%); however, only seven (23%) of the HCPs indicated they had the required competencies to serve adolescents, according to the standards. Most had competencies to provide SRH services, but not particularly to adolescents.

We looked at wait time before a client was seen at various points in the facilities, as reported by the HCPs, as well as how much time was available for the providers to attend to each client. Most (72%) said patients were seen within an hour of arrival at the facility. Among the 17 HCPs who responded to the question regarding adequacy of time to attend to adolescents, 76 percent said they did not have enough time to attend to the clients and needed to see them briefly.

Only 19 of the HCPs responded to the question on availability of commodities and equipment. Half (50%) said they had enough drugs, whereas the rest said they did not have enough or were unsure. Sixty percent of the providers reported not having to suspend services due to lack of equipment in the six months prior to the interview.

Provision of Health Services to Adolescents: Among the 17 HCPs who responded to the question about community support and provision of AFHS, 77 percent reported that community members supported AFHS and were involved in provision of community-based services, such as condom distribution and health talks.

According to the HCPs, adolescents could receive services without restrictions on age, sex, marital status, or any other social factor. The HCPs indicated they treat all adolescents the same; however, nine of the HCPs interviewed said if a client was, in their opinion, too young they could deny them services. Nearly all (96%) of the HCPs indicated that policies and procedures were in place that ensured confidentiality for the clients.

Table 7. Provider-reported standards

Standard	Criteria	Yes (%)	No (%)	Total
Health Provision Standard	Awareness of guidelines	17 (57)	13 (43)	30
	Source of information:			
	(a) Meetings, training	15 (83)	3 (17)	18
	(b) Colleagues	2 (11)	16 (89)	18
	(c) Youth-friendly corner	1 (6)	17 (94)	18
	Have required competency	7 (23)	23 (77)	30
	Commodities available	6 (32)	13 (68)	19
Implementation Standard	Community support of adolescent SRH	17 (77)	5 (23)	22

Facility Managers

Five health facility managers responded to the questionnaire; one facility manager was not available at the time of the study. They were nursing officers and medical officers, with an age range of 30 to 57 years.

Service Provision Standards: Four of the interviewed facility mangers said there was an established policy on provision of AFHS. In contrast to the adolescent responses, all five health facility managers said adolescents were actively involved in designing, providing, and assessing adolescent services, although only two reported that adolescents made recommendations or suggestions.

They all felt the facility hours and days were convenient for adolescents. All the facilities had posters and gave health talks; however, only one showed videos to provide information and education. Only one of the managers reported a stock-out of medicine in the previous six months.

The respondents reported that there is privacy when adolescents are being attended to, with only one manager indicating that people outside the consulting room may hear what is being said. The health facilities generally practice a policy of nondisclosure, as indicated by all the health facility managers. Two of the managers, however, indicated that when an adolescent presents with a life-threatening condition, parents or guardians need to be involved.

Provision of Health Services to Adolescents: When facility managers were asked about reasons a young person may be denied services in their facility, the responses varied. Some believed that age, sex, religion, and other social factors may influence an adolescent's access to AFHS, whereas others said these are not hindrances.

Only three facility managers responded to the question on the cost of services. One of the managers indicated that adolescents are charged for radiology services, that is, for x-ray and ultrasound scans; however, there is no charge for general medical care, contraceptives, and treatment of STIs including HIV/AIDS.

All the facility managers said that health talks and condoms are provided in the community. Services such as the pill and STI treatment are not provided in all communities but are available in facilities.

Adult Community Members

We interviewed 41 adults in the community. Nearly all (90%) had some formal education, with 49 percent having attained secondary education. The age range was 20 to 70 years.

Table 8. Demographic characteristics of the interviewed adult community members

Variable	Characteristic	N (%)
Age	20-30	13 (32)
	31-40	16 (39)
	41-50	8 (19)
	51-60	2 (5)
	61-70	2 (5)
Sex	Male	19 (46)
	Female	22 (54)
Education	No formal	2 (5)
	Primary	2 (5)
	Secondary	20 (49)
	College	12 (29)
	University	1 (1)
Religion	Christian	41 (100)
	Moslem	0 (0)
	Other	0 (0)

Twenty-seven (68%) adult community respondents knew what services are available for adolescents and said that efforts had been made to inform the community of their availability. Seventy-five percent of the community members responded that adolescents need AFHS and should be provided these services. The others felt that adolescents need parental control, especially those younger than age 16. Although only 10 respondents felt adolescents should not be provided with AFHS, when all participants were asked to list which services, if any, adolescents should not receive, 16 (40%) of the participants responded that adolescents should not be provided with any form of contraception and should not be engaged in condom distribution.

DISCUSSION

The aim of this study was to assess the adherence to standards and guidelines for providing AFHS in public health facilities in Lusaka District. We tried to do this by ascertaining the knowledge, attitudes and awareness of the standards as well as the practices as they relate to AFHS. We also attempted to understand the challenges to implementing the standards and adolescents' perceptions on how they were handled in facilities because we thought this could be an indication of the how the guidelines are being implemented. Adolescents have some knowledge of SRH issues and some access to SRH services, however .many of them classified the current services as not adolescent-friendly.

The HCPs interviewed showed an awareness of the guidelines and standards. More than half (55%) of those interviewed had heard about the guidelines through meetings and colleagues; however, despite the AFHS standards and guidelines being in place, interviewees had not been trained and lacked in depth understanding of AFHS. They used the knowledge from other services to help them serve adolescent areas such as treatment of STIs, contraception, and counselling. It is unsurprising that only 23 percent of HCPs felt competent providing services to adolescents.

Nearly half of the HCPs in this study were unaware of the AFHS standards and guidelines. A lack of knowledge of the AFHS standards and guidelines among HCPS is problematic because it affects the messages they disseminate to the wider population and erodes confidence in the facility-based care to this vulnerable adolescent population. Providers should be empowered with knowledge of adolescent health issues, because adolescents have distinct healthcare needs different from those of adults and thus require special attention from healthcare workers (Mngadi, Faxelid, Zwane, Höjer, & Ransjo-Arvidson, 2008). Poor knowledge resulting from lack of training and familiarity with standards is an obstacle to providing adequate services to adolescents, yet training alone has been inadequate in improving service delivery to adolescents. Coupled with other interventions, training has the potential to improve health service delivery to the adolescents (Donna, Hoopes, & Chandra-Mouli, 2015). Other research has shown that training can improve clinical skills and practices and build confidence as well as the perceived competence of HCPs in dealing with adolescents (AlBuhairan & Olsson, 2014). As a result of trainings, HCPs are likely to better understand adolescents' needs and rights.

In a study in Bangladesh, AFHS were assessed after HCPs were trained (Ainul, Ehson, Tanjeen, & Reichenbach, 2017). The study found that HCPs were more confident and felt more competent to handle adolescents after the training. The findings in our study that a lack of training hampers service provision agrees with the study by AlBuhairan and Olsson in in Saudi Arabia in which they also found the majority of HCPs were not specifically trained to provide services to adolescents, although they were aware of the guidelines (2014). The WHO has also recognized the importance of training HCPs to help provide services to adolescents (Godia et al., 2013).

Adolescents perceive HCPs as being the right people to give information and services and are therefore likely to see HCPs for their health concerns. For young people to feel confident attending facilities for AFHS, they need to be assured of confidentiality and privacy. Both in the FGDs and one-on-one interviews, the adolescents expressed concern that HCPs might disclose the adolescents' issues to their parents or to school authorities despite none of them experiencing such disclosure. This fear of being found out prevents some adolescents from seeking SRH services. Fear of disclosure has also been noted to affect adolescents' satisfaction with care (Sunil et al., 2013). This shows, as has been documented in other studies, that barriers to

accessing reproductive health services extends beyond health system factors to include families, communities, and cultural factors (Donna et al., 2015).

In Zambia, which is a Christian nation, cultural and religious beliefs influence parents' fear that providing SRH education and services is immoral. Some community members specifically stated that adolescents should not be provided with any form of contraception and should not be engaged in condom distribution. Such views by community members raises some concern considering that the Zambia Demographic and Health Survey 2013–2014 shows the median age at first sex is 17.3 for girls and 18.3 for boys and the median age at first birth is 19.3. This scenario shows that there is a need for SRH education and services.

The HCPs in our study reported that there is a nondisclosure policy in the health facilities to ensure patient confidentiality. Only under certain life-threatening circumstances will an adolescent's parents or guardians be informed. Despite what the AFHS standards state, many adolescents did not trust that the HCPs will keep matters private, so it is important for HCPs to provide each adolescent client with an assurance of privacy, inform them about the confidentiality policy, and provide brochures or a posted placard explaining the policy.

Both the adolescent and HCPs believed that they are generally not discriminated against based on sex, religion, social standing in society, marital status, or physical or mental disability; however, age was recognized by all groups in the FGDs and interviews as a reason for denying services. Some providers, adolescents, and community members felt that information should be tailored according to age and that older adolescents are better able to discern right and wrong and are better placed to handle some information. There was fear of arousing curiosity about sex, especially because most of the information for the adolescents concerns sexual issues. This sentiment is in line with ICPD's recommendation that, for human-rights reasons, reproductive health services should be age-appropriate and consider cultural and religious norms (United Nations Department of Public Information, 1994). The role of sociocultural values in shaping access to and use of reproductive health services calls for promoting better integration of reproductive health interventions in both formal and community aspects of the health systems. The formal part includes health system delivery, human resources for health supply chain, and governance systems. On the community side, key factors to consider include the community capacity, making commitments and sustaining health actions, and developing effective partnerships among a complex array of actors involved in providing adolescent health services and information (Lunssford, Fatta, Storer, & Shrestha, 2015). Thus, effectively responding to the reproductive health needs of adolescents requires adopting alternative models that recognize that broader societal and cultural issues influence SRH outcomes (Hatcher et al., 2011).

Integrating adolescent-friendly health services into routine health services can be enhanced by involving adolescents in the planning and implementation of adolescent services, which are currently almost nonexistent in the Zambian health system. Despite what some HCPs reported, the adolescents in our study rarely reported being involved in planning for adolescent health services. Recognizing the limited knowledge the HCPs have of the SRH needs of adolescents, the involvement of adolescents in the planning process will create a worthwhile opportunity for them to be heard and ensure their concerns are taken into account in SRH programming. This engagement promotes a cultural shift towards openness to young people's needs, and it alters the information and power hierarchies—from being adult-centered to being young-people-centered—for the development and implementation of reproductive health education and service delivery (Allen, 2005; Hatcher et al., 2011). This approach suggests repositioning young people within reproductive health programs as "knowers" (as opposed to being treated as innocent in relation to sex) (Francis, 2010) and acknowledging "young people's sexual agency" (Allen, 2005). However, allowing young people to help develop the reproductive health agenda does not imply that they should be free to do anything or that their assumptions

should not be challenged. The goal is to create a collaborative process to develop SRH programs that are appropriate for young people (Rowland, 1997).

Most adolescents reported their experience of care was as expected, although the questionnaire did not ask if the expectation was good or bad. According to AFHS standards of providing services to adolescents free of charge in public facilities, cost was not seen as a barrier among most of the respondents. Wait time as well as time spent with the HCP was deemed acceptable by both adolescents and HCPs. The longest wait time was to see the HCPs. In the FGDs the adolescents confided that the prolonged wait time to see the HCPs was sometimes caused by the HCPs chatting with others, talking on the phone, or taking prolonged breaks. Excessive wait time can discourage clients from attending the facilities and cause them to avoid seeking care or information. A policy on the use of phones whilst on duty may reduce chatting at the expense of service provision.

Some of the adolescents realized, however, that long wait times and providers' negative attitudes were at times the result of the HCPs having too many clients. Some of the HCPs indicated that they had to rush through seeing their clients to accommodate everyone. This points to a shortage of human resources for providing quality services. Staffing shortages can result in adolescents being neglected because HCPs are forced to concentrate on ill clients rather than providing health education and counselling. Under these circumstances HCPs may not be able to spend enough time with adolescent clients to gain their trust. This is evidenced in other studies that note that an absence of dedicated staff to handle adolescents results in providers being overwhelmed, thus compromising services (Ainul et al., 2017).

In addition to a lack of human resources, nonavailability of commodities can be a hindrance to adolescent services, because adolescents would rather go without or go elsewhere to buy medicine or contraceptives than go to a facility and waste their time only to be told that what they need is unavailable. Our FGDs revealed that sometimes adolescents were told to go elsewhere to buy their medications. Only half of the HCPs responded to the question on commodities, and among those, half mentioned that a lack of some commodities hampered provision of services. The lack of response could indicate that HCPs were uncomfortable answering this question.

Community involvement and awareness in providing AFHS is important. It has been shown that community acceptance is a key factor in adolescents accessing health services (Mmari & Magnani, 2003). If the community is involved, the service will be tailored to its needs and sociocultural context, and the service will be more acceptable to the adolescents and wider community.

Limitations

This study was conducted in only six first-level peri-urban health facilities in Lusaka District, and thus the study findings may not be generalizable to other settings. The purposive sampling of the study participants also does not allow these study findings to be generalizable to the general population.

The study participants were selected from those present in the health facility on the day we visited. Although not all the youth were seeking reproductive health services, they represent youth who seek facility-based care rather than those in the community.

RECOMMENDATIONS

The study findings clearly indicate an awareness of AFHS by both HCPs and community members; however, service provision is hampered by both societal concerns and health system challenges. We have the following recommendations to improve adherence to the guidelines:

- Provide in-service training to HCPs in AFHS. The HCPs are conversant with SRH, but not with dealing with adolescents.
- Institute preservice training for HCPs on how to provide AFHS so that as new staff join, they have the knowledge and skills to effectively serve adolescents.
- Formulate context-specific policies and guidelines on providing AFHS that consider the concerns of community members and adolescents and take into account their cultural and religious values.
- Disseminate AFHS guidelines and standards to HCPs and create awareness of them. Address the guidelines during supportive supervision visits and quarterly meetings.
- Enhance active engagement of adolescents and adult community members in planning and delivering AFHS to make the services more responsive to community needs.
- Produce more adolescent-specific IEC materials that use fewer technical terms and more language that adolescents could understand; provide the materials in the local language and include images of happy, healthy adolescents; and make them available throughout the health facilities. Use media, such as television, to provide information to adolescents.
- Increase visibility of AFHS. Post a policy statement in the facility that includes the nondisclosure policy to encourage young people to access the services.
- Encourage HCPs to inform adolescents of the confidentiality and nondisclosure policy.

  Increase government investment in training peer educators and providers and train younger HCPs to take charge of AFHS because adolescents are more comfortable getting information and services from their peers and younger providers.

CONCLUSION

Study results indicate that although an effort has been made to make health services friendlier to adolescents, more needs to be done. The situational analysis of 2009 showed that Zambia had no standards and guidelines for providing reproductive health services and information to adolescents. It also identified the need for training HCPs to provide the services. Although AFHS standards and guidelines are in place, dissemination of them and training on them have been lacking. Many of the HCPs in this study reported not having been trained or oriented. Implementation of the standards and guidelines will translate into positive changes in how adolescents receive services.

Our study reveals that HCPs and community members still have reservations about providing SRH services to adolescents owing to religious and societal norms. HCPs and society must recognize the challenges adolescents face and address their health needs within their norms and culture, recognizing that adolescents' SRH issues cannot be ignored. The study also indicates a need to provide adolescent services that take into consideration age-appropriate information and services. Engaging adolescents and community members in planning, implementing, and monitoring health services can result in services that address the perceived needs of the community. Investing in the health of adolescents is of utmost importance because they are the future.

REFERENCES

Ainul, S., Ehson, I., Tanjeen, T., & Reichenbach, L. (2017). *Adolescent friendly health corners (AFHCs) in selected government facilities in Bangladesh: An early qualitative assessment.* Bangladesh: Population Council, The Evidence Project. Retrieved from http://evidenceproject.popcouncil.org/wp-content/uploads/2017/05/Bangladesh-AFHC-Report_2017.pdf

AlBuhairan, F. S. & Olsson, T. M. (2014). Advancing adolescent health and health service in Saudi Arabia: Exploring health-care providers' training, interest, and perceptions of the health-care needs of young people. *Advances in Medical Education and Practice,* 281–287. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4159223/

Allen, L. (2005). Say everything: Exploring young people's suggestions for improving sexuality education. *Sex Education, 5*(4), 389–402. Retrieved from https://www.tandfonline.com/doi/abs/10.1080/14681810500278493

Boersema, G. (2016). Validation of a measure of youth friendliness in primary care in services in Tshwane District.

Central Statistical Office (CSO), Zambia (2013–2014). *Zambia 2010 Census of Population and Housing, Lusaka Province Analytic Report.*

Central Statistical Office (CSO), Zambia (2014). *Zambia Demographic and Health Survey 2013–2014.*

Conde-Agudelo, A., Belizán, J. M., & Lammers, C. (2005). Maternal-perinatal morbidity and mortality associated with adolescent pregnancy in Latin America: Cross-sectional study. *American Journal of Obstetrics & Gynecology, 192*(2), 342–349. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/15695970

Dickson, K. M., Ashton, J., & Smith, J. M. (2007). Does setting adolescent-friendly standards improve the quality of care in clinics? Evidence from South Africa. *International Journal for Quality in Health Care, 19*(2), 80–89. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/17277012

Donna, M. D., Hoopes, A. J., & Chandra-Mouli, V. (2015). Effective Strategies to provide adolescent sexual and reproductive health services and to increase community demand and support. *Journal of Adolescent Health, 56*(1 Supplement). Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/25528977

Francis, D. A. (2010). Sexuality education in South Africa: Three essential questions. *International Journal of Educational Development, 30*(3), 314–319. Retrieved from https://www.researchgate.net/publication/248169075_Sexuality_education_in_South_Africa_Three_essential_questions

Hatcher, A., de Wet, J., Bonell, C. P., Strange, V., Phetla, G., Pronyk, P. M., . . . Hargreaves, J. R. (2011). Promoting critical consciousness and social mobilization in HIV/AIDS programmes: Lessons and curricular tools from a South African intervention. *Health Education Research, 26*(3), 542–555. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/20965911

Godia, P. M., Olenja, J. M., Lavussa, J. A., Quinney, D., Hoffman, J. J., & van den Broek, N. (2013). Sexual reproductive health service provision to young people in Kenya: A health service providers' experience. *Health Services Research*. Retrieved from https://bmchealthservres.biomedcentral.com/articles/10.1186/1472-6963-13-476

Kamau, A. W. (2006). *Factors influencing access and utilization of preventive health services by adolescent in Kenya: A case study of Muranga.*

Lunssford, S. S., Fatta, K., Storer, K. E., & Shrestha, R. (2015). Supporting close community providers through a community health systems approach: Case examples from Tanzania and Ethiopia. *Human Resources for Health, 13*(1). Retrieved from https://human-resources-health.biomedcentral.com/articles/10.1186/s12960-015-0006-6

Jana, M., Mafa, I., Limwame, K., & Shabalala, A. (2012). Challenges to youths accessing sexual and reproductive health information and services in Southern Africa: A review of qualitative research in seven African countries. *Southern Africa HIV and AIDS Regional Exchange*. Retrieved from https://www.researchgate.net/publication/266559371_CHALLENGES_TO_YOUTHS_ACCESSING_SEXUAL_AND_REPRODUCTIVE_HEALTH_INFORMATION_AND_SERVICES_IN_SOUTHERN_AFRICA_A_REVIEW_OF_QUALITATIVE_RESEARCH_IN_SEVEN_COUNTRIES_Soul_City_Institute_for_Health_and_Develop

Ministry of Health (MOH), Zambia. (2011). Adolescent Health Strategic Plan 2011–2015.

Ministry of Health (MOH) and Ministry of Community Development, Zambia (2011). National Standards and Guidelines for provision of Adolescent Friendly Health Services.

Mmari, K. N. & Magnani, R. J. (2003). Does making clinic-based reproductive health services more youth-friendly increase service use by adolescents? Evidence from Lusaka, Zambia. *Journal of Adolescent Health, 33*(4), 259–270. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/14519567

Mngadi P. T., Faxelid, E., Zwane, I. T., Höjer, B., & Ransjo-Arvidson, A. B. (2008). Health providers' perception of adolescent sexual reproductive health care in Swaziland. *International Nursing Review*, 148–155. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/18477098

Rowlands, J. (1997). *Questioning empowerment: Working with women in Honduras*. Oxford, United Kingdom: Oxfam. Retrieved from https://policy-practice.oxfam.org.uk/publications/questioning-empowerment-working-with-women-in-honduras-121185

Sunil, M., Ruchi, S., Vandana, N., Mahasweta, S., Ramanand, T., & Kaushlendra, D. (2013). Determinants of youth friendly services influencing client satisfaction: A study of clients perspectives in in India. *Indian Journal of Public Health Research and Development, 4*(2), 221–226. Retrieved from https://www.semanticscholar.org/paper/Determinants-of-Youth-Friendly-Services-Influencing-Mehra-Sogarwal/c284188ce5273e8bb7f7a6780d33202337bd6b1a

United Nations Department of Public Information. (1994). ICPD 94: Summary of program of action [Paper presented at the International Conference on Population and Development].

World Health Organization (WHO). (2009) *Quality assessment guidebook: A guide to assessing health services for adolescent clients*. Geneva, Switzerland: WHO. Retrieved from https://www.who.int/maternal_child_adolescent/documents/fch_cah_9789241598859/en/

World Health Organization (WHO). (2012). *Making health services adolescent friendly*. Geneva, Switzerland: WHO. Retrieved from https://apps.who.int/iris/bitstream/handle/10665/75217/9789241503594_eng.pdf?sequence=1

World Health Organization (WHO). (2014). WHO Fact Sheet. Geneva, Switzerland: WHO.

WORKING PAPER

MEASURE Evaluation
University of North Carolina at Chapel Hill
123 West Franklin Street, Suite 330
Chapel Hill, NC 27516 USA
Phone: +1 919-445-9350
measure@unc.edu
www.measureevaluation.org

This publication was produced with the support of the United States Agency for International Development (USAID) under the terms of MEASURE Evaluation cooperative agreement AID-OAA-L-14-00004. MEASURE Evaluation is implemented by the Carolina Population Center, University of North Carolina at Chapel Hill in partnership with ICF International; John Snow, Inc.; Management Sciences for Health; Palladium; and Tulane University. Views expressed are not necessarily those of USAID or the United States government.
WP-19-230

USAID
FROM THE AMERICAN PEOPLE

MEASURE
Evaluation