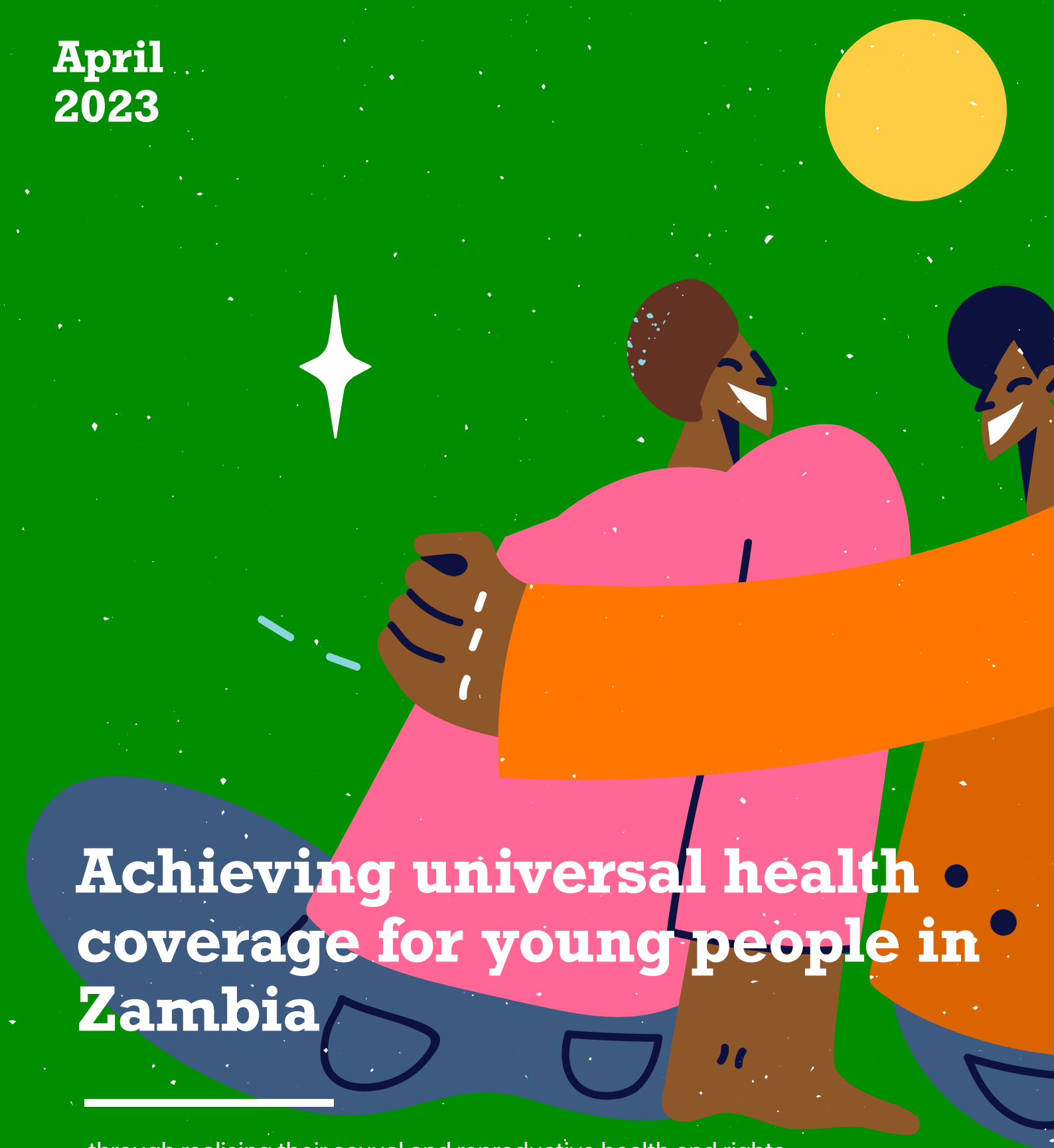
April 2023



Achieving universal health coverage for young people in Zambia

through realising their sexual and reproductive health and rights, and scaling up selfcare for health

You(th) Care
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Network for Adolescent and Youth of Africa NAYA

NYP+ Network of Young People Living With HIV and AIDS

PATA PATA

Global Network of Young People Living with HIV

Developed by African Alliance

Universal health coverage and self-care: Zambia

April 2023

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Introduction

In September 2023, governments will meet in New York during the second United Nations High-Level Meeting (HLM) on Universal Health Coverage (UHC) to agree on new commitments to realise UHC by 2030. In 2019, during the first-ever HLM on UHC, an ambitious Political Declaration was adopted to guide countries in their efforts to reform health systems, increase funding for health, and address barriers that prevent people from receiving the health services they need.

The world has fundamentally changed since 2019. The COVID-19 pandemic demonstrates the devastating impact of weak health systems, underinvestment, and harmful policies and laws that prevent vulnerable, marginalised, and stigmatised populations from taking care of their health.

This new HLM is critical to get world leaders back on track and agree on the need to invest in long-term, sustainable responses to ensure life-saving health services are guaranteed for everyone, particularly in the face of the ongoing effects of the COVID-19 pandemic – and the potential impacts of future pandemics. In addition, there needs to be a continued push for sociocultural and economic change; intersectional, human-rights based and gender-inclusive approaches to health; inclusive engagement of civil society in developing, implementing and monitoring health policies and funding. And empowering and equipping people to meet their health needs, including scaling up self-care interventions for realising sexual and reproductive health and rights (SRHR).

Self-care has never been more relevant than during the COVID-19 pandemic, where, globally, public health systems failed to meet the demands and needs of citizens. Governments increasingly stepped up self-care and digital health interventions to reduce the burden on public health systems and give people choices to access the services they need despite COVID-19-related service restrictions related to the emergency response measures, including movement restrictions, total lockdowns and social distancing – affecting people's ability to reach clinics, but also – with the demand on emergency health services – resulting in increasing shortages of healthcare workers.

Solutions such as HIV self-testing, self-sampling for sexually transmitted diseases (STIs) and digital health information offer new options for people who are unable or willing to access clinic-based services. This is not just due to COVID-19-related limitations but also poverty, gender-based violence (GBV), (dis) ability and other vulnerabilities, as well as a lack of privacy and the related fear of stigma and discrimination that prevent adolescents and young people (AYP) from accessing sexual and reproductive health (SRH) services in public clinics.

Thus, self-care provides a crucial contribution to realising UHC, where UHC is defined by the World Health Organization (WHO) as all people having access to the health services they need, when and where they need them, without falling into financial hardship.

The "***where and when they need them***" is the very essence of self-care where this approach means people are not dependent on the availability of doctors, nurses or the capacity or accessibility of health clinics for all of their health needs. It also increases people's autonomy, choice, and power in relation to their health.

For this reason, the partner organisations implementing the YouthWise and You(th) Care projects in Malawi, Uganda, Kenya, Tanzania and Zambia are advocating for governments to commit to scaling up self-care in the 2023 UHC Political Declaration as a crucial component of health systems strengthening; self-care services and commodities must be included in national UHC plans and budgets.

Purpose of this Document:

To inform this advocacy, the African Alliance ('the Alliance'), funded by Aidsfonds, conducted a series of policy analyses for the five countries above to better understand why self-care is critical to improve the SRHR needs of AYP and achieve UHC. The analyses assessed the policy landscape; lived experiences around UHC, SRHR and Self-Care; and the current limitations AYP face in accessing the services they need – and used this process to develop a set of country-specific advocacy messages for partners in the five countries to take forward running up to the HLM.

Country snapshot: Zambia

ZIMENE HLM PA UHC AKUFUNA KUMVA - NDIPO MUCHITE!

Umphawi ukadali wodetsa patsamba lachitukuko cha Zambia, pomwe madera osasankhidwa akukhudzidwa kwambiri kuposa kale. Achinyamata sali otetezedwa ku zenizeni izi ndipo kusagwirizana kukupitilirabe kuchititsa anthu omwe adakumana nawo kale - nthawi zina zovuta zosagonjetseka kuti akwaniritse moyo waulemu, chilungamo ndi chitukuko - mpaka m'mphepete. Utsogoleri uyenera kufulumizitsa kukulitsa ndi kudzipereka kwazinthu kuti zitsimikizire kuti tsogolo lomwe achinyamata aku Zambia akukumana nalo ndi mwayi wopeza, wothandizira osati thandizo

WHAT THE HLM ON UHC NEEDS TO HEAR–AND DO!

Poverty remains a stain on Zambia's progress sheet, with marginalised communities hit harder than ever before. Young people are not spared from this reality, and inequality continues to drive populations that have historically faced - at times, odds to realising lives of dignity, justice, and prosperity - further to the margins. Leaders need to resource commitments to ensure that the future of young Zambians faces one of access, agency and not aid.

Zambia ranks among the countries with the highest levels of poverty and inequality globally. The incidence of poverty worsened with the onset of the COVID-19 pandemic, but is projected to slowly return to pre-pandemic levels by 2025, reflecting the sustained growth in the services and construction sectors that are expected to benefit the urban poor and reverse the recent increase in urban poverty. Progress with rural poverty, however, is more uncertain. While the agriculture sector is projected to grow, rates are just above population growth, and the sector is subject to high volatility. Structural barriers to agricultural productivity and limited ability to cushion external shocks among the rural poor mean that additional support may be needed to improve their lives. 54.7% of Zambians live below the international poverty line of earning less than $2.15 per day (compared to 41% across Sub-Saharan Africa), and three-quarters of the poor live in rural areas[1].

1 Ministry of Community Development and Social Services (2023)

HIV landscape

In terms of the HIV landscape, in 2022, 1,336,056 Zambians are estimated to be living with HIV. Of these, new infections among young women are consistently more than double (0.5%) compared to 0.2% for adolescent boys and young men in the same age group (15-24 years). Of those estimated to be living with HIV, 90% are on anti-retroviral (ARV) treatment, and 86% are estimated to be virally suppressed. ARV coverage among children living with HIV less than 15 years of age is 72%[1].

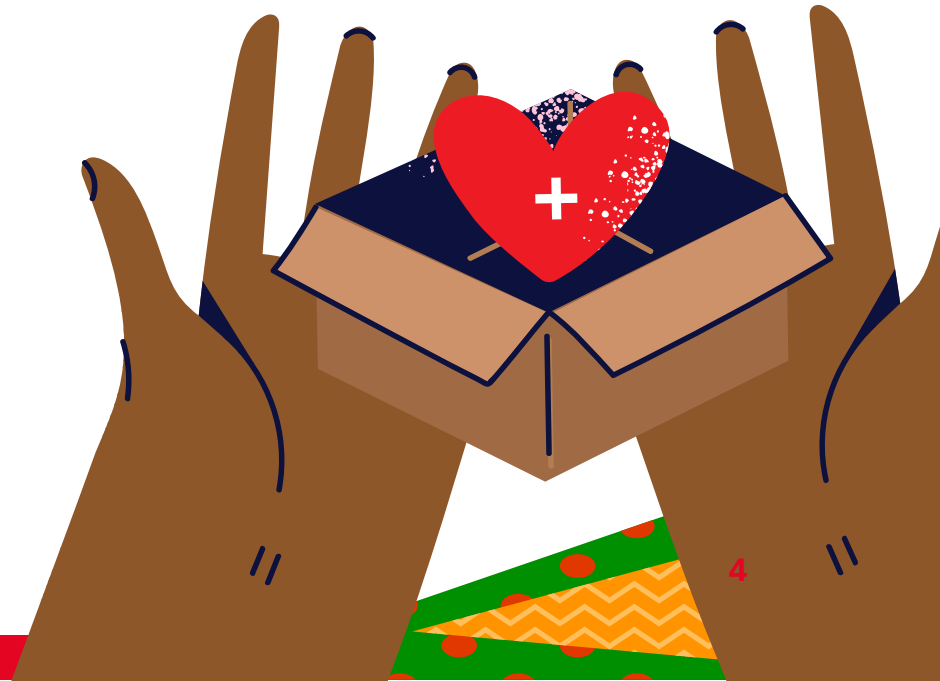
It is clear from this data that the HIV burden remains high and disproportionately affects young women. There is a need to amplify combination HIV preventive measures by increasing access to HIV testing services and improving linkage to various HIV preventive measures such as voluntary medical male circumcision (VMMC), condoms, Pre-exposure prophylaxis (PrEP) and treatment of STIs, with a particular focus on those most at-risk, such as adolescents and other priority or marginalised populations.

Large youth population

Zambia is one of the world's youngest countries by median age, with its population, much of it urban, estimated at 19.6 million (2021), with a rapid growth rate of 2.7% per year, reflecting the relatively high fertility rate. As the large youth population attains reproductive age, the population is anticipated to double in the next 25 years, resulting in additional pressure on the demand for jobs, health care, and other social services[2]. Gender inequal-ity, household poverty and the expansion of peri-urban populations are some of the systematic challenges for adolescents and young people (AYP) in particular. The situation is further compounded by the high population growth[3].

"When it comes to economic barriers, most of the young people that we work with or majority of young people in Zambia come from economically challenged backgrounds. They are not able to access certain services; as I mentioned earlier, if a young lady wants to go for screening, not because she has a pressing matter but because she feels some way in her reproductive organ and would like to get answers from a gynaecologist.Such services are only available to pregnant women or women suffering from certain medical conditions that are very serious".

(Youth organisation representative)



1 PEPFAR (2022) p 4.
2 Zambia Statistics Agency (2022)
3 Ministry of Health (2022).

ZIMENE HLM PA UHC AKUFUNA KUMVA - NDIPO MUCHITE!

Maonekedwe a chithandizo chaumoyo ku Zambia akhala akusintha nthawi zonse. Zomwe zachitika posachedwapa zomwe zawona kuti mawu a achinyamata akuyikidwa patsogolo pa nkhani ya dziko nthawi zonse sizinamasuliridwe muzinthu zowonongeka ndi zomwe zimachitidwa ndi omwe ali ndi udindo wa mtsogoleri. Kusokonekera kwa kusalingana kwa atsikana ndi atsikana kumakhalabe cholepheretsa kukwaniritsa ulemu ndi chilungamo kwa onse monga momwe zimakhalira gawo losinthika la thanzi, chilungamo ndi chitukuko cha anthu lomwe likufunika kuyenda mwachangu, liyenera kusintha malingaliro ake ndikuzindikira kuti pokhapokha ngati achinyamata aku Zambia. m'mitundu yathu yonse ndi zozindikirika, zomveka, zolemekezedwa ndi zosowa zathu zofunikira, chiyembekezo cha Universal Health Coverage chidzakhalabe patali ndipo sitingathe kuwapeza.

WHAT THE HLM ON UHC NEEDS TO HEAR –AND DO!

The landscape of access to health services has constantly been evolving. Recent developments that have seen young people's voices being prioritised in the national discourse have not always translated into resourced and implemented remedial actions being taken by those who hold the title of leader. The disproportionate impact of inequality on girls and young women remains a hurdle to the realisation of dignity and justice for all, as does a transformed health, justice and social development sector that needs to move faster, needs to reform its thinking and realise that unless young Zambians in all of their diversity are recognised, heard, respected and our basic needs resourced the prospect of Universal Health Coverage will remain distant and out of our reach

Some of the specific realities for AYP that impede their health service access are outlined below.

Age of consent to sex and marriage

The age of consent to sex is 16 for girls and not specified for boys. Sex with a girl below 16 is criminalised by the Penal Code. Regardless, Zambian adolescents (10-19 years) and youth (20-24 years) are sexually active, with girls especially exposed to the risks of unintended pregnancies, unsafe abortion, maternal mortality, sexual violence, STIs, HIV, and discrimination based on gender identity and early marriages. Childbearing begins early in Zambia, with more than one-third of women giving birth by age 18 and more than half giving birth by age 20; 29% of adolescent girls and women aged 15-19 years are already mothers or pregnant with their first child, of which most births occur within the context of marriage; thus, adolescent births, like early marriages, are highest in Zambia.

The recently signed ***Children's Code Bill*** brings into direct law prosecution of child marriage. Prior to this, the only law that could prosecute child marriages was indirect via the ***Education Act*** and only if the child in question was at school, which was often circumvented by perpetrators ensuring that a girl stopped school before they entered the arranged marriage.

Access to contraception

The 2017-2021 ***Adolescents Health Strategy*** reveals that not all Zambian adolescents had access to adolescent-responsive health services, especially regarding SRH. These disparities are partly due to limited protective and enabling environment, limited access, inequitable distribution of adequately trained health professionals, cost and poor youth-friendly health services[4] delivery and are particularly problematic in rural areas[5]. Service obstacles that adolescents face include limited contraceptive options, compounded by judgmental attitudes of providers, lack of confidentiality, and a lack of policies and guidelines for protecting adolescents' rights to information and services.

4 Ministry of Health Zambia (2017).
5 Ministry of Health Zambia (2017a).

Access to abortion

The ***Termination of Pregnancy Act*** (1972) legalises abortion in certain circumstances, namely when the pregnancy poses a risk to the life of the woman, or her physical or mental health or those of her existing children and where there is a substantial risk that the foetus would be 'seriously handicapped'. In addition, an amendment to the Penal Code in 2005 permits girls under 16 who have been raped to access legal abortion[6]. Despite the legislation, abortion is highly stigmatised in Zambia, with high numbers of unsafe abortions and maternal deaths attributable to complications from unsafe abortions. Women and girls in rural areas in particular experience increased barriers to accessing legal abortion, as not all Government facilities provide access, and there is a lack of information about where and how to access a legal abortion safely.[7]

Age of consent to health services:

While the Ministry of Health has placed adolescent health high on the agenda, AYP still experience challenges accessing health services. In Zambia, minors below 16 years of age require parental consent to access SRH services.

Comprehensive Sexuality Education (CSE)

A CSE framework was developed to enrich the provision of Reproductive Health and Sexuality Education, which is a cross-cutting theme in the Zambia Education Curriculum Framework, recognising that this is an issue that affects a large cross-section of society. CSE, when done well, can provide young people with age-appropriate, culturally relevant and scientifically accurate information. It includes structured opportunities for young people to gain knowledge, skills and positive attitudes and values, which will help them apply life skills in addressing challenges with regard to their sexuality. However, the topic of CSE is still highly contested, with significant opposition from the faith-based community, particularly the Evangelical Fellowship of Zambia, who issued a statement in October 2020 advising the Zambian Parliament to suspend CSE until enough consultation and a broad consensus are achieved on the matter, and the Paramount Chief Chitimukulu of the Bemba-speaking people and Chief Chipepo of the Tonga people, who urged the Zambian Government to halt the implementation of CSE in schools, with the then Minister of Religious Affairs stated, "CSE is harmful to adolescents and young people." [8]

Criminalisation

Same-sex, sexual conduct between men and women remains a criminal offence in Zambia. However, there are some positive signs of change, with two men sentenced in 2018 by the High Court to fifteen years imprisonment for engaging in same-sex sexual activity pardoned in May 2020 by President Edgar Lungu as part of 3,000 pardons in commemoration of Africa Freedom Day[9]. Sex work is fully criminalised in Zambia, and sex workers experience abuse at the hands of law enforcement officials, with 91% indicating they had a bad experience with police and were often not treated well during arrest and detention. 90% reported that they had experienced violence from police or other men during their time as sex workers, 87% reported that police harassed them because they engaged in sex work, and 61% said they would be unwilling to lay a complaint against the police because they fear further abuse, that the complaint will not change anything, that the police think they are "above the law" and/or because they were unfamiliar with the complaint options available to them. Sex workers reported high levels of stigma and discrimination in healthcare, including denial of services, discriminatory treatment, and abuse; similarly, they felt unwilling or unable to challenge the healthcare sector via healthcare.[10]

6 ARASA (2019).
7 UN Zambia (2017).
8 Chief Editor (28 September 2020).
9 SALC (2016)
10 SALC (2016)

What this means in practice

In practice, this means that young people are affected in their health-seeking behaviour by negative attitudes of healthcare providers towards young people due to cultural and religious reasons; a lack of youth-friendly health centres as the current set up has no privacy for young people, as well as limited SRH services in health facilities. There are also limitations around the age of consent for adolescents to access services, compounded by the reality that the majority of AYP come from economically challenged backgrounds which means they don't have the option of paying for health services unavailable at public health centres.

"One of the major barriers for young people when it comes to accessing SRHR services, something that we are also researching and concluding on as an organisation, is the values and attitudes, especially when it comes to health care providers. It makes it hard for the youths to access the services. Another issue is the 'friendliness" of a health centre. There are some sensitive services which the young people would like to access, but the manner in which they are provided makes it hard for them to access them".

(Staff, SRHR organisation)

"The social barriers mainly revolve around social and cultural norms that are in our societies that limit young people's access to services. For example, youth-friendly services are not provided at youth-friendly corners of these health facilities. There are certain social barriers and norms that make people so judgmental to the point where it will be hard for young people to access these services. The session we had yesterday with the adolescents mentioned that they fear visiting the health facilities because they women meet aunties that know them and their parents".

(Staff, youth-led SRHR organisation)

"One of the gaps that we as an organisation have noticed is the access to health provision. One of the things that we have learned about access is that, as much as we are advocating for more youth-friendly spaces, we have few clinics that do have them. Look at the western province, for example, you will discover that it has young people at the facilities, but they do not have the structure that enables them to have a youth-friendly space. They are just found everywhere in these health care facilities, for example, you will find one at the OPD Department today, and tomorrow you will find the person at the dental ward and so on".

(Staff, SRHR organisation)

Health Policies & Funding

ZIMENE HLM PA UHC AKUFUNA KUMVA - NDIPO MUCHITE!

"Tiyenera kufananiza zolankhula za achinyamata kukhala "tsogolo". Ngati ndife tsogolo ndi-ye tiyenera kufunsa chifukwa chake tsogolo limenelo likuthandizidwa makamaka ndi opereka ndalama zapadziko lonse osati tokha. Mgwirizano wapadziko lonse lapansi ndi chithandizo - komanso ngakhale ndalama zothandizira zaumoyo - ndizofunikira kwambiri ngati tikufuna kupitiliza kukonza zowonongeka zomwe zachitika chifukwa cha atsamunda - koma chisamaliro chaumoyo wa anthu onse ndi ntchito ziyenera kuthandizidwa kunyumba, ziyenera kukhala pat-sogolo kwa atsogoleri athu komanso kuti kuika patsogolo kuyenera kuwonetsedwa mu ndala-ma zathu zapakhomo. Sitingathe kupereka zathanzi ndi thanzi la achinyamata a ku Zambia kwa bwenzi lothandizira potsatira ndondomeko ya ndalama ndi kusintha kwa geo-politics. Sitingathe kulamulira tsogolo lathu ndi tsogolo la dziko lino lomwe timalitcha kwathu popanda kukhala ndi thanzi labwino komanso moyo wolemekezeka - ndipo zimafuna utsogoleri wamasomphenya ndi wolimba mtima."

WHAT THE HLM ON UHC NEEDS TO HEAR –AND DO!

"We need to match the rhetoric of young people being the "future". If we are the future, then we need to ask why that future is being resourced mainly by international donor partners and not by ourselves. Global solidarity and support - and even funding for some health interven-tions - is, of course, critical if we are to continue to undo the damage done by colonisation - but basic public health care and services must be sustained domestically, must be a priority to our leaders and that prioritisation needs to be reflected in our domestic health spending. We cannot outsource the health and wellness of young Zambians to a donor partner at the mercy of a funding cycle and evolving geopolitics. We cannot take control of our future, and the future of this country we call home without being healthy and living lives of dignity – and this requires visionary and courageous leadership."

Policy landscape

Efforts undertaken by the Government to demonstrate commitment to improving AYP access to health services are reflected in the formulation of the ***Adolescent Health Strategy***, delivered under the Health Promotion Department of the Ministry of Health from national to district levels. Various stakeholders are involved in the implementation of this work through Technical Working Groups (TWG) established at all levels (national, provincial and district), with members constituting all key stakeholders in adolescent health.

A set of ***National Standards and Guidelines for Youth Friendly Health Services*** describe the basic 'essential' clinical health services to be provided to AYP[11]. This basic package is focused on HIV and SRH services and includes the provision of Information/Social Behaviour Change Communication (SBCC) and Counselling on issues and services on family planning, antenatal care, post-natal and nutrition, and now HIV testing and Counselling.

The availability of some progressive policies, guidelines and laws in Zambia provides an opportunity to realise AYP's SRHR, but their successful implementation requires a multi-sectorial collaborative effort from Government, civil society, the private sector - and meaningful participation of AYP.

In terms of UHC, this is not mentioned explicitly in many of the current policies and strategies, though the language implies this is a priority. For example, the ***National Youth Policy (2015)*** aims to "promote equal rights and access to education, skills development training, legal and ***health services for both male and female youth***". Beyond this there is no mention of UHC in youth or SRHR and HIV and AIDS-related health policies.

Neither the Constitution of 1991 nor the 2006 Amendments contain any mention to UHC or even the right to health care. In the ***Zambia Vision 2030*** there is no use of the term UHC specifically, but there are some references to facilitating access to 'health care for all'. One of the Vision's socio-economic development objectives is to: "provide equitable access to quality health care to all by 2030". The Government also expresses its aspiration to provide "access for all to good quality basic human necessities such as shelter, titled land, ***health*** and education facilities and clothing". It states that it intends to increase annual health expenditure per capita to a period average of US$150, comparable to middle income economies like Botswana, Gabon, Panama and South Africa. There is no mention of the term UHC in the ***National Health Policy*** (2011) but the policy also uses the term 'health for all.

The Zambia ***National Health Strategic Plan 2017–2021***, does not mention UHC in its Vision, Mission, Overall Goal, Principles and Priorities page but there are references to UHC at other points in the document, for example, using a primary health care approach and a social health insurance scheme as a resource envelope for UHC.

11 Ministry of Health Zambia (2017).

Financing for health

In terms of funding, health financing is currently led by international donors and entities such as President's Emergency Plan for AIDS Relief (PEPFAR), United States Agency for International Development (USAID) and the World Health Organization (WHO), among others. Regarding health financing from Government, user fees were abolished in rural areas in April 2006, peri-urban areas in mid-2007, and the entire PHC level in January 2012. PHC facilities in Zambia include health posts, health centres, and district hospitals. All services provided under these facilities are provided free of charge. Further, patients referred from the PHC facilities to secondary and tertiary level hospitals are supposed to be treated free of charge in line with the user fee removal guidelines[12]. It was noted that the inability of the Zambian Government to provide healthcare services has resulted in a lack of public trust in the healthcare system.

Inclusion of SRHR and self-care in policies and funding

While significant policies are guiding AYP SRH services (see Annex 2), it is important to note that the term 'self-care' is in and of itself not commonly used; this is still a new concept in the SRHR and UHC space. Instead, language such as 'youth friendly' and 'adolescent friendly services' was prevalent and understood as, for example, the need to "reorient health staff on compassionate care, patient charter and rights of adolescents" by prioritising "school-age and adolescent health, education, child protection, equity, gender, and inclusiveness, WASH, nutrition, HIV and AIDS."[13] Additionally, the term' family planning' is extensively used in the policy documentation, which is problematic in that it often replaces terms such as 'reproductive health', 'reproductive rights', 'sexual and reproductive health and rights', and 'reproductive justice', and assumes the individual is using contraception to plan a family, as opposed to people who want to use contraception solely to exercise their right to choice; it also assumes a very heteronormative version of a nuclear family and procreative path. The term' family planning' also does not include access to safe and legal abortion, yet family planning is often used for all pregnancy prevention. The concept is best placed within a broader SRHR framework founded on the understanding of choice.

Self-care interventions such as self-testing for HIV, and accessing contraception, including emergency contraception and PREP, are part of the basic package of services at some health centres though in limited supply.

> ***"There is also a lack of political will in relation to enhancing service uptake and the utilisation of young people and spreading the services across the country, not only concentrating on Lusaka or Copperbelt people. They should also think about those coming from highly marginalised rural areas because that is where young people survive only on the things they know have worked for their parents for years. The only time rural girls get to access some of these services is when they are pregnant or sick. Screening for STIs and accessing contraceptives should be available to all regardless of location."***
>
> (Staff, youth-led SRHR organisation)

12 World Bank Group (2019).

13 Ministry of Health, Community Development, Gender, Elderly and Children Zambia (2021) P 13.

Voices of Young Advocates

Barriers to realising self-care

The following barriers to realising self-care were identified during the discussions with young people: lack of information on available SRHR services, such as modern contraceptives and HIV prevention, as well as limited access to comprehensive youth-focused services (non-compliance to ***National Standards and Guidelines for Youth Friendly Health Services*** was specifically mentioned); alcohol and drug abuse among young people; lack of adequate psychosocial support for young people living with HIV; lack of recreational facilities in local communities; and lack of skills training programmes to motivate and empower young people, including limited rights literacy around Zambia's legal Framework related to SRHR.

Specific examples included:

- *Legal Framework:* Lack of updated and harmonised policies and laws relating to SRHR and poor implementation of the existing policies due to limited resources in the health and education sectors. This is compounded by a lack of political will on SRHR issues, such as abortion, age of consent and criminalisation (of abortion, same-sex, sexual conduct and sex work).
- *Access to commodities:* Lack of commodities in health facilities negatively impacts access to services
- *Access to information:* HIV and SRHR information is limited, while the information available on HIV and pregnancy prevention, for example, is poorly packaged, leading to adolescents focusing more on pregnancy prevention at the expense of contracting and spreading HIV. Additionally, information targeting adolescents in rural areas are limited.
- *Health worker capacity:* Lack of capacity healthcare for healthcare providers.
- *Working with minors:* Lack of disclosure from caregivers who have children living with HIV and negative attitude of caregivers towards SRHR issues.
- *Cultural practices:* such as initiations for girls that include unsafe sex
- *Structural issues:* High poverty levels leading to transactional sex and a lack of recreational facilities/activities available, especially in schools.
- *Youth-led participation:* A shift is needed in terms of understanding AYP SRHR as something to be administered from a top-down perspective (as reflected in the framing in the legal documentation) to something that, with adequate support and resourcing, could be more youth-led and determined, based on young peoples' lived realities. For example, meaningful adolescent representation is lacking in key decision-making spaces like the Adolescent Health TWG meetings.

"One of the major concerns is how [the] approach to family planning and HIV prevention operate[s] in silos. That has been one of the challenges being faced... there's a way in which you need to unify these two approaches because sometimes when you're talking about family planning co-morbidities, some people neglect the aspect of HIV prevention. So you realise that young people would rather get HIV and not get pregnant. So there is a way in which we just need to do such kind of programming."

(Partner)

Key Advocacy Messages

A clear set of recommendations emerged through this process:

YOUNG LEADERS ARE LEADERS!

Young people must be involved in making these linkages between SRHR, HIV and UHC – and how self-care can effectively strengthen health systems. This was resounded in the youth discussions where they advanced the clarion call of "nothing about us without us".

And there are good practice examples of this already:

"One of the opportunities I have noticed is how the WHO is giving us as young people an opportunity to engage as young people under the youth council. Due to that, we now have a lot of young people that are volunteering under these Organisations. Instead of waiting for governments to do something, we young people under these organisations have an opportunity to voice out. Global Fund, UNAIDS and many others give us opportunities to be engaged as young people. Looking at what the Global Fund is doing through the Country Coordinating Mechanism (CCM), the money allocated for each country is making medication even cheaper".

(Staff, SRHR organisation)

"When it comes to opportunities, there is a pool of young people who want to participate in activities that will enable their fellow young people to access these services and commodities. We have several trained peer educators in these health facilities who would want to help us. They are willing to help in terms of creating demand for these services. The other opportunity we can explore is that most of these health facilities have existing adolescent health corners. However, it is just the services that need to be provided in those corners which are lacking".

(Staff, SRHR organisation)

LEADERS MUST LEAD!

Despite significant UHC policies and strategies, there is a clear gap in terms of implementation – as well as integration with HIV and SRHR policies - with the need for:

Regularly updated standards and guidelines to reflect current realities, linked to regular review and update cycles for SRHR-related policies.

Accessible standards and guidelines (at key levels of the health system) that translate the policy into tangible practice for service providers and users;

Processes to ensure that civil society (CSOs) and community-based organisations (CBOs) are adequately involved at the design and implementation stages;

Greater inclusion of AYP, their communities and service providers through human rights literacy training (with a specific focus on health rights and how these can be realised within the context of the SRHR and HIV response in each country), tailored to how AYP best receive information (online, via Apps, via peers, and so on).

> "With regards to Universal Health Coverage, the Zambian government is implementing the National Health Insurance Scheme (NHIS) through the National Health Insurance Management Authority NHIS is a social intervention program introduced by the government to provide financial access to quality health care for residents in Zambia."
>
> (Staff, SRHR organisation)

LEADERS MUST ACCOUNT!

There are many opportunities for communities to hold leaders accountable practically. However, the mechanisms to do this can be very opaque. Some examples of how to hold leaders to account at different levels include:

Leveraging the regional and international instruments Zambia has signed onto and their inbuilt accountability mechanisms. CSOs can check the status of these various treaties online[14] to identify meaningful advocacy opportunities, for example, submitting Shadow Reports to supplement periodic Government reporting on women's rights.

Similarly, understanding the national policy frameworks – and the gaps – provides a foundation for influencing through national bodies, such as national HIV and AIDS councils' review cycles for their National Strategic Plans or Technical Working Groups' reviews of key strategies and guidelines for AYP SRHR services.

Ensuring all SRHR-related policies and any associated strategies, plans and guidelines have regular review cycles and a schedule that can be accessed by civil society to influence policy updates by ensuring they reflect current realities on the ground.

Influencing through targeted information campaigns catering to key audiences' information preferences, e.g., hardcopy posters, dialogues, and activations in communities, or online (via Apps and social media) or via peers for AYP.

14 See: https://www.ohchr.org/en/countries/zambia

LEADERS MUST INVOLVE!

Young people who are working with Copper Rose and Nyali Zambia (among others) are leading youth advocacy in Zambia. They use social media and community mobilisation mechanisms to raise awareness and advocate for access to quality services

.“One of the opportunities I have noticed is how the WHO is giving us as young people an opportunity to engage as young people under the youth council. Due to that, we now have a lot of young people that are volunteering under these organisations. Instead of waiting for governments to do something, us young people have an opportunity to voice out [through] Global Fund, UNAIDS and many others that give us opportunities to be engaged in as young people”.

(SRHR youth led organisation representative)

“When it comes to opportunities, there is a pool of young people who would want to participate in activities that will enable their fellow young people to access these services and commodities. We have a number of trained peer educators in these health facilities who would want to help us. They are willing to help in terms of creating demand for these services.”

(SRHR organisation representative)

LEADERS MUST UNITE!

Zambia has a strong network of stakeholders engaged in different ways in the SRHR and HIV landscape. There is, however, a clearly articulated need to meaningfully involve and – as part of that - better resource local CSO networks – particularly youth-focused and youth-led - to support a critical and representative mass of stakeholders who can support and drive the rights agenda.

This can include:

- catalysing around a shared issue to leverage different expertise and resources
- making available joint funding for shared action (campaigns, movement strengthening)
- making available unrestricted funding for non-traditional forms of advocacy that local groups can implement without ‘sign off’ from a donor.

leveraging off the significant work already being done by CSOs in Zambia, for example Nyali Zambia is part of NGO networks advocating for the implementation of progressive national policies focusing on SRHR for adolescents and young people while the Foundation for Adolescent Girls and Young Women is raising awareness on key SRHR issues affecting adolescents and young people in rural areas of Zambia. Organisations such as Copper Rose Zambia, Zambia Youth Platform, Africa Directions and SAT Zambia are among those leading youth-led advocacy by providing technical support to the Ministry of Health and building capacity in AYP to take a leading role in youth-led health advocacy towards policy change.

LEADERS MUST EVOLVE!

The language issues related to phrasing such as 'youth friendly' and 'adolescent friendly services' presents significant opportunities for change at different levels and particularly at Government level to reframe who SRHR is seen.

At community level, it is a key focus for advocacy, where partners and communities can influence at different levels (policy influencing and community-based activism) around more inclusive, rights-based language that, in the You(th) Care project context, prioritises AYP's agency in accessing services and making decisions about their SRHR – and that also reflects that we do not live in a heteronormative paradigm of identities, orientations or choices.

"Currently, there is the 'WHO consolidated guidelines on self-care interventions for health'[15]. And further, we have the Ministry of Health at the local level working with partners like Copper Rose to put up guidelines that can be used. These guidelines are adapted from WHO guidelines. The guidelines are also shared with health providers and community health workers who work closely with us to implement other projects, including the You(th) care project. The guidelines were further adapted and implemented, updated in 2019, and the second update in 2021. These are the guidelines that speak to the current self-care interventions".

(Staff, SRHR organisation)

"At the moment, we have WHO-approved guidelines and further, we have the Ministry of Health at the local level that is working with partners like us as Copper Rose to put up guidelines that can be used. These guidelines are adopted from WHO guidelines. We are also using them to build capacity in health providers and community health workers who are closely working with us in the implementation of other projects, including the youth care project. The guidelines are there and are being adapted to local settings through training health workers and community health workers".

(Staff, SRHR organisation)

15 WHO (2019).

YOUNG PEOPLE ARE DIVERSE!

A strong theme in the discussions was that young people are not a homogenous group, and the pre-existing policy frameworks are restrictive in catering to their lived experience and current realities:

"[SRHR organisations in Zambia are] involving young people to be in charge of their health. By being involved, the young people are motivated to be in charge of taking care of themselves, instead of waiting to be told or reminded".

(Female, young person)

TAKE SRHR INFORMATION ONLINE!

There is a need to use technology in innovative ways given the many examples of the use and access of the internet through mobile phones (or other online channels) by young people in the region to access health information/self-care as a potential mechanism to enact different advocacy and influencing initiatives, alongside the provision of comprehensive, accessible SRHR information and referral information for key health services.

"I usually use Google as my first source of information. Sometimes I also ask friends that I know are in the medical field. I will explain to them how I am feeling, and then they will advise whether it is something treatable at home or I need to go to the clinic".

(Female, young person)

"For me, it depends because there [are] some questions I can easily get on Google while I can only get some from a health provider. This is because some information does not require much attention while some questions require much attention".

(Female, young person)

"Getting correct information these days is somehow easy and somehow hard, especially on the internet because we have a lot of bloggers trying to earn money, and they do not even care whether they are spreading wrong or correct information. You can google something today and feed your mind on it when it is wrong information based on someone's opinion. It should be easy getting the correct information on the internet but not anymore unless you go directly to the clinic or the hospital."

(Female, young person)

"With the introduction of the internet, it is easy to get the correct information because the information is readily available even on our mobile devices. It is just sad that young people do not want to do research or go to health facilities to ask. In short, the information is already there, and it is up to us to go and get it".

(Female, young person)

ANNEX 1: Research Methodology

In August 2022, following reflections from You(th)Care consortium partners about gaps in knowledge of the policy landscape for SRHR and HIV in each programme country, Aidsfonds commissioned the African Alliance ('the Alliance') to undertake an initial country-specific (Kenya, Tanzania and Zambia) policy analysis to provide the consortium with insights into each country's policy environment to support partners to better promote and realise AYP's SRHR and HIV self-care needs, including AYP access to self-care services and commodities.

This first phase of work focused on mapping policies, strategies and guidelines related to AYP aged 10–25, as well as identifying key stakeholders and the specific barriers or enablers to progress in improving SRHR and the practice of self-care. To that end, the Alliance engaged stakeholders from the You(th) Care consortium cohort (partners and young people) alongside a small sample of thought leaders working regionally, continentally, and globally on SRHR and self-care to understand better the policy landscape and what opportunities may exist for You(th) Care to inform its adaptation and future implementation. The policy analysis process sought to understand the state of the national Adolescent and young peoples' SRHR and HIV response in each country and the possibilities to practice self-care; key policies and guidelines that influence adolescent and young people's SRHR and HIV vulnerability and access to self-care; barriers and opportunities for improving Adolescent and young people's SRHR, the practice of self-care; the main stakeholders; recommendations to impact on adolescent and young people's SRHR, the practice of self-care and HIV/AIDS in the country.

The process was phased, consisting of an initial briefing with You(th)Care colleagues from Aidsfonds, a desk review, and country-based semi-structured discussions with consortium partners and the young people (aged 18-25) they work with. A second phase was commissioned in September 2022 to add an analysis of Malawi and Uganda and build on the initial process with an adjusted focus to consider what commitments or policies on UHC each country has in place and how they are being implemented.

In Zambia, the following stakeholders were engaged in this process:

- Copper Rose Zambia ***(staff and young people)***
- Zambia Network for Young People Living with HIV ***(staff and young people)***
- Nyali Zambia ***(staff and young people)***
- Foundation for Adolescent Girls and Young Women in Zambia ***(staff)***

Through this approach, the Alliance sought to draw from the base set of findings from the desk review and build on these through the in-country processes, ensuring that the data collected is meaningful and nuanced rather than repetitive to draw a clearer picture of what is happening in each country from multiple perspectives. The Alliance used thematic analysis to compare the findings in each country and draw out country-specific advocacy recommendations. Where possible, useful examples of good practice are identified in the narrative. Findings are presented as individual country snapshots, with a summary' global brief' that also considers the profile of self-care in regional and global debates. Illustrative quotes are used throughout this document, extracted from the in-country conversations with partners and AYP.

Limitations

Any instance of participants not feeling comfortable using English was largely mitigated by conducting face-to-face conversations in local languages (Nyanja and Bemba in Zambia with young people). The recordings were transcribed and translated into English and used to generate synthesis reports of the conversations.

The sample of young people (aged 18-24) who participated in the conversations was limited due to

i) insufficient time to organise discussions with adolescents (age 10-17) due to the lead-in time required to coordinate informed consent processes with their parents and guardians; and

ii) the time of year the second phase conversations took place (November-December) where stakeholders had competing deadlines before the end of year break; iii) consultations were held in urban centres (Lusaka in Zambia) which meant that only those young people who could reasonably travel to the meeting locations (i.e. those living in proximal urban or peri-urban areas) participated.

ANNEX 2: Key Policies and Guidelines

National policy landscape

In addition to the Constitution, a sample of the most recent or currently available key policies, strategies and guidelines relevant to adolescents, youth, and HIV/SRHR in Zambia include, but are not limited to:

Policies:

- Marriage Act (1918)
- Public Health Act (1930)
- Juveniles Act (1956)
- Termination of Pregnancy Act (1972)
- Reproductive Health Policy (2000)
- Education Act (2011)
- Anti-Gender-based Violence Act (2011)
- National Health Policy (2011)
- National Gender Policy (2014)
- National Youth Policy (2015)
- Gender Equity and Equality Act (2015)
- Children's Code Bill (2022)

Strategies and guidelines:

- National Standards and Guidelines for Adolescent-Friendly Health Services (2011)
- CSE Framework (2013)
- National Operational Plan for the Adolescent Health Strategy (2017–21)
- eHealth Strategy (2017-21)
- National Health Strategic Plan (2017-21)
- National HIV and AIDS Strategic Framework (2017-21)
- National Strategy on Ending Child Marriage (2016-21)
- Zambia Consolidated Guidelines for Treatment and Prevention of HIV Infection (2020)
- Eighth National Development Plan (2022–26)

The availability of some progressive policies, guidelines and laws in Zambia provides an opportunity to realise AYP's SRHR, but their successful implementation requires more regular updates of the strategies and guidelines, as well as a multi-sectorial collaborative effort from the Government, civil society, the pri-vate sector - and meaningful participation of AYP.

The regional and international policy landscape

Significant international and regional law, through treaties, conventions, protocols, covenants and declarations, exists to interpret human rights within the Framework of Health and specifically to apply those rights to respect, protect and defend human sexuality and human reproduction. These resound with the rights to freedom, equality, non-discrimination, privacy, and human dignity and confer on states that are party to each treaty the obligation to provide, domestically, for the highest attainable standard of health. Zambia is obligated under several international and regional treaties to provide healthcare, including to promote and protect SRHR, and this is reflected to varying extents in the suite of policies, strategies and guidelines developed to realise these promises.

A snapshot of some of these international and regional treaties is provided below:

International treaties and guidance

Universal Declaration of Human Rights (1948)

International Covenant on Civil and Political Rights (1976)

Convention on the Elimination of All Forms of Discrimination against Women (CEDAW, 1979)

Joint General Recommendation No 31 of the CEDAW

International Covenant on Economic, Social and Cultural Rights (ICESCR)

Convention of the Rights of the Child (1989)

General Comment No 4 on Adolescent health and development in the context of the Convention on the Rights of the Child (2003); General Comment No 18 of the Committee on the Rights of the Child on harmful practices (2014); and General Comment No 20 on the Implementation of the Rights of the Child during Adolescence (2016)

Fast Track Commitments to End AIDS by 2030

International Conference on Population and Development Programme of Action (1994)

The Framework of Actions for the Follow-up to the Programme of Action of the International Conference on Population and Development Beyond 2014

The 2030 Agenda for Sustainable Development

Political Declaration on HIV and AIDS: On the Fast Track to Accelerating the Fight against HIV and to Ending the AIDS Epidemic by 2030

UNAIDS Agenda for Zero DiscrHealthcaren Healthcare Settings

Regional treaties and guidance:

African Charter on Human and People's Rights (1981)

African Charter on the Rights and Welfare of the Child (1990)

African Women's Protocol to the African Charter on Human and People's Rights (2003)

General Comments on Article 14 (1) (d) and (e)of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (2012); and General Comment No 2 on Article 14.1 (a), (b), (c) and (f) and Article 14. 2 (a) and (c) of the Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (2014)

African Youth Charter (2006)

Continental Policy Framework for Sexual and Reproductive Health and Rights (2005)

Maputo Plan of Action on Sexual and Reproductive Health and Rights (2006)

Model Law on HIV in Southern Africa (2008)

The ESA commitment made by ministers of health and education in 21 ESA countries to scale up comprehensive sexuality education (CSE and SRH services for AYP (2013)

Model Law on Eradicating Child Marriage and Protecting Children Already in Marriage (2016)

Southern African Development Community (SADC) Gender Protocol

AAU2063 Agenda

SADC Minimum Standards for the Integration of HIV and Sexual and Reproductive Health in the SADC Region

SADC Regional Strategy for HIV Prevention, Treatment and Care and Sexual and Reproductive Health and Rights among Key Populations (2018)

AU Catalytic Framework to End AIDS, TB and Malaria in Africa by 2030

The organisation of African Unity, Abuja Declaration on HIV/AIDS, TB and Other Related Infectious Diseases (2001)

AU Addis Ababa Declaration on Population and Development in Africa Beyond 2014 (2013)

SADC SRHR Strategy and Scorecard (2019-2030) (2018)

This is not a comprehensive list, but the examples shared give some sense of the extensive international and regional relationships between states and the shared values of the international and regional communities. This provides a basis for engagement of civil society at the national level, as well as within and between states, for shared international and regional accountability, recognising that, while it can be difficult to 'enforce' the implementation of the content of these documents, they are important to be aware of as each comes with its own set of review mechanisms that can provide a point of advocacy and influencing for civil society engagement. For example, the African Union (AAU Summits (for the Maputo Protocol) and the CEDAW country reviews, among others.

Annex 3: Key UHC Stakeholders

In addition to the work of the various Government Ministries (Health, Youth and Sports) that shape and hold policies and facilitate different kinds of Technical Working Groups (TTWG to engage civil society on key issues, there are also specific CSOs working on these issues. These include the Family Health Organisation, Plan International, Family Hill, and PACT.

Some youth-led, and youth-focused organisations working on UHC issues in the country include:

SRHR Africa Trust

Zoe Janice Health Foundation

Copper Rose Zambia

Africa Directions

Marie Stopes Zambia

Zambian Youth Platform (ZZYP

Treatment Advocacy and Literacy Campaign

Foundation for Adolescent Girls and Young Women in Zambia

At the national level, the National Youth Development Council mobilises financial resources to support and promote youth-led programmes.

In terms of key civil society stakeholders, partners who participated in this process include:

- Copper Rose Zambia ***(staff and young people)***
- Zambia Network for Young People Living with HIV ***(staff and young people)***
- Nyali Zambia ***(staff and young people)***
- Foundation for Adolescent Girls and Young Women in Zambia **(staff)**

Opposition actors include the Evangelical Fellowship of Zambia, which issued a statement in October 2020 advising the Zambian Parliament to suspend CSE until enough consultation and a broad consensus are achieved on the matter. Later that month, Paramount Chief Chitimukulu of the Bemba-speaking people and Chief Chipepo of the Tonga people urged the Zambian Government to halt the implementation of CSE in schools, with the then Minister of Religious Affairs stated, "CSE is harmful to adolescents and young people."[16]

New data from the International Planned Parenthood Federation (IPPF) reveals how opponents of SRHR worldwide are attempting to use the COVID-19 pandemic as cover to push back against progressive reforms. The latest IPPF survey of its worldwide membership on COVID-19 reveals that opponents are employing various tactics to undermine sexual and reproductive rights.[17]

16 Chief Editor (28 September 2020).

17 IPPF (8 June 2020).

Finally, Zambian members of the Civil Society Engagement Mechanism (CSEM) for UHC 2030 include:

- Alzheimer's Disease and Related Dementias in Zambia
- Centre for Reproductive Health and Education
- Mercy and Care Foundation
- Resilient Youth for Change – YOCA
- Tobacco Free Association of Zambia
- Volunteers Welfare for Community-Based Care of Zambia
- Zambia Heart and Stroke Foundation

ANNEX 4: Advocacy Roadmap

Timeline - UHC Negotiation Schedule

The UN Language Compendium is a useful tool for high-level United Nations negotiations and can be used for community advocacy to advance human rights commitments — particularly regarding access to healthcare and sexual and reproductive health and rights: https://hivlanguagecompendium.org

References:

1. ARASA (2019). Sexual and reproductive health, HIV, TB and Human Rights in Southern and East Africa.
2. Chief Editor (20 September 2020) 'EFZ Calls for the suspension of Sexuality Education Until Consensus is Reached' in Lusaka Times. https://www.lusakatimes.com/2020/09/28/efz-calls-for-the-suspension-of-sexuality-education-until-consensus-is-reached/
3. IPPF (2020) Opponents of sexual and reproductive health and rights step up pressure during COVID-19 https://www.ippf.org/news/ippf-members-see-opponents-sexual-and-reproductive-health-and-rights-step-pressure-during
4. Ministry of Health Zambia (2017) The National Aids Strategic Framework (NASF) 2017-2021.
5. Ministry of Health Zambia (2017a) The National Standards and Guidelines for Youth Friendly Health Services
6. Ministry of Health (2022) National Health Strategic Plan (2022-2026). https://www.moh.gov.zm/wp-content/uploads/2023/02/National-Health-Stratergic-Plan-for-Zambia-2022-to-2026-revised-February-2023-lower-resolution.pdf
7. Ministry of Health, Community Development, Gender, Elderly and Children Tanzania (2021) Health Sector Strategic Plan V (2021-2026) "Leaving No One Behind." Accessed from: https://mitu.or.tz/wp-content/uploads/2021/07/Tanzania-Health-Sector-Strategic-Plan-V-17-06-2021-Final-signed.pdf
8. PEPFAR (2022) Zambia Country Operational Plan (COP) 2022 Strategic Direction Summary (SDS). Accessed from: https://www.state.gov/wp-content/uploads/2022/09/COP22-Zambia-SDS.pdf
9. Southern African Litigation Center (2016) "They should protect us because that is their job": A preliminary assessment of sex workers' experiences of police abuse in Lusaka, Zambia. https://www.southernafricalitigationcentre.org/wp-content/uploads/2016/09/They-should-protect-us-pblctn.pdf
10. Tshindaye, N (December 2022) 'Government scale up fight against poverty' in Ministry of Community Development and Social Services News. https://www.mcdss.gov.zm/?p=6271
11. UNFPA (2020) Harmonization of Minimum Ages and Adolescent Sexual and Reproductive Health Rights. Technical Brief. https://esaro.unfpa.org/sites/default/files/pub-pdf/lates_technical_brief_harmonization_2.pdf
12. UN Zambia (2017) Status of Sexual and Reproductive Health and Rights in Zambia. Accessed from: http://zambia.unfpa.org/sites/default/files/pub-pdf/SRH%26R%20in%20Zambia%20-%20Part%201.pdf
13. WHO (2019) Consolidated Guideline on Self-Care Interventions for Health: Sexual and Reproductive Health and Rights. https://apps.who.int/iris/bitstream/handle/10665/325480/9789241550550-eng.pdf
14. World Bank Group (2019) Health Financing in Zambia. https://openknowledge.worldbank.org/server/api/core/bitstreams/1f82dc31-b21f-5008-b980-fb526b6aa81b/content
15. Zambia Statistics Agency (nd) Population data. https://nso-zambia.opendataforafrica.org/gqfzbzc/population

You(th) Care
My health.
My responsibility.

aidsfonds

ARASA AIDS & Rights Alliance for Southern Africa

AYAREP

CHILDREN'S DIGNITY FORUM
CDF
UTU WA MTOTO

COPPER ROSE ZAMBIA
Beautiful | Valuable | Empowered

Network for Adolescent and Youth of Africa
NAYA

NYP+
Network of Young People Living With HIV and AIDS

PATA

GLOBAL NETWORK OF YOUNG PEOPLE LIVING WITH HIV

Developed by
African Alliance