

PUBLICATION  
OF  
AFRICAN NETWORK OF ADOLESCENTS AND  
YOUNG PEOPLE DEVELOPMENT (ANAYD)  
2022®



REPORT ON THE INTEGRATION OF ADOLESCENT  
AND YOUNG PEOPLE INTERVENTIONS INTO  
REGIONAL AND NATIONAL HIV AND HEALTH  
PROGRAMMING

An Assessment of The Nigerian RMNCHA+N Investment  
Case Strategy Implementation

# T a b l e o f C o n t e n t

## Table of Contents

-Table of Contents	1
-Acknowledgment (From ANAYD)	3
-Abbreviations	4
-Executive Summary	5
-Background	8
-Objectives	10
-Methodology	10
-Inclusion criteria	10
-Exclusion Criteria	10
-Evaluation Questions	10
-Data collection method	11
-Limitations	11
-Findings on Desk Review	12
-Situational Analysis	12
-RMNCAH GLOBAL	13
-RMNCH IN NIGERIA	13
-Adolescent and young people	14
-HIV/AIDS Among Adolescent and Young People in Nigeria	17
-Nigeria RMNCAH+N Investment case	18
-Findings on Key Informant Interview conducted in the course of the Assessment	19
-Knowledge of Nigeria RMNCAH + N investment case?	19
-Level of Implementation	19
-Relevance of Nigeria RMNCAH+N to AYP In Their Complexities	19
-The most significant change that has resulted from the implementation of the strategy	19
-Other strategic plans being adopted and implemented to reduce the prevalence of HIV among AYPs and improve their access to health services	19
-policies sufficiently cover the needs of young people as it relates to their health	19
-Partnership and Collaboration	20
-Funding	20
-Level of engagement of youth-led organizations either as partners or beneficiaries	20
-Community groups, forums, and platforms inaugurated and sustained where AYP issues were discussed and addressed	20

# T a b l e o f C o n t e n t s

## Table of Contents

-Next steps during and after the implementation of the Nigeria Investment case strategy document that will improve access to health of AYP and also reduce the prevalence of HIV among the AYP population	20
-Recommendations to government and partners for the improvement of AYP access to better health services	21
-Recommendations to partners for the improvement of AYP access to better health services	21
-Recommendation	21
-Conclusion	21
-Annex	22
-List of resources	22
-Evaluation Questions for Government stakeholders	23
-Evaluation questions for CSOs stakeholders	24
-Participant profile	25
-Reference	26

# **ACKNOWLEDGEMENT**

The African network of Adolescent and young people development (ANAYD) is extremely grateful to the West and Centra Africa Civil Society Institute for Health (CSIWCA) and Education as a Vaccine (EVA) for the support received which enable ANAYD to conduct an assessment of the Nigerian RMNCHA+N Investment Case Strategy Implementation with a focus on Adolescent and Young People in their diversity through the EndaSante Project.

This briefing paper is part of ANAYD's research and advocacy program on integrating Adolescent and young people interventions into regional and national HIV and health programming in Nigeria. We are grateful to Mr. Aaron Sunday Executive Director of ANAYD under whose leadership oversees the development of this assessment report and Ekanem Itoro Effiong, the lead consultant engaged who lead the process of this report. We would also like to thank Ayeni OluwaSeun, who offered technical assistance and co-led the report's processes.

We also recognized the active participation of adolescents and young people living with HIV and critical young populations who participated in the process as Key Government Stakeholders.

Their stories and engagement will help to improve AYP health interventions across Nigeria. And would also like to express gratitude to the following organizations for their contributions to the development and creation of this situation report:

- Federal Ministry of Health (FMOH)**
- Federal Ministry of Health-National AIDS and STI Program Control Unit (FMOH-NASCP)**
- National Agency for the Control of AIDS (NACA)**
- Joint United Nations Programs on HIV/AIDS (UNAIDS) Nigeria**
- Association of Positive Youth Living With HIV/AIDS (APYIN)**
- National Coalition for Advancement of Adolescent and Youth Health**
- Kosi Izundu, Outgoing GFF Youth Focal Point for Nigeria**
- The Network of People Living with HIV and AIDS in Nigeria (NEPWHAN)**
- Finally, we want to thank everyone on our team who participated in just about any manner in this process; you make us proud every time.**

A  
C  
K  
N  
I  
V  
E  
L  
C  
E  
N  
T

# Abbreviations

AIDs	Acquired Immune Deficiency Syndrome
AND	African Network of Adolescents and Young Person's Development
ASH	Adolescent Sexual Reproductive Health
AU	African Union
APP	Adolescent and Youn People
CSOs	Civil Society Organizations
CSIWCA	Civil Society Institute for Health in West and Central Africa
CTC	Core Technical Committee
DHS	District Health Survey
ECOWAS	Economic Organization of West African States
EVA	Education as a vaccine
FMOH	Federal Ministry of Health
Moj	Federal Ministry of Justice
FWA	Federal Ministry of Women Affairs
FMoYSD	Federal Ministry of Youths and Sports Development
GBV	Gender-Based Violence
GFF	Global Financing Facility
HIV	Human Immune Virus
IC	Investment Case
MDG	Millennium Development Goal
MICS	Mixed Indicator Cluster Survey
MMR	Maternal Mortality Ratio
MPDSR	Maternal and Perinatal Death Surveillance and Response
NACA	National Agency for the Control of AIDS
NPC	National Population Commission
PHIL	People Living with HIV
PSC	Police Service Commission
RMNCAH+N	the Reproductive, Maternal, Newborn, Child, Adolescent, and Elderly Health Plus Nutrition
SDG	Sustainable Development Goals
SEARCH	Sexual Reproductive Health
SEHR	Sexual and Reproductive Health Rights
STI	Sexual Transmitted Infection
TWG	Technical Working Groups
UN	United Nation
UNICEF	United Nations International Children's Emergency Fund
USAID	United States Agency for International Development
WCA	West Central Africa
WHO	World Health Organization

# EXECUTIVE SUMMARY

## Introduction

HIV responses in western and central Africa (WCA) continue to lag behind the rest of Sub-Saharan Africa. Despite some progress and successes, the HIV response in the region has not accelerated sufficiently and other priorities are pushing HIV off the agenda. The HIV epidemic, combined with humanitarian and socio-economic crises create vicious circles that destabilize the country efforts. Communities and minority groups such adolescents' girls and young women, young key populations, and young people living with disabilities are particularly at risk of being often left behind. UNAIDS estimates that around two-thirds of new HIV infections in West and Central Africa in 2017 occur in Nigeria, a country with an estimated population of about 200 million. The country's HIV prevalence rate stands at 1.5, with 1.9 million people living with HIV (NAIIS 2018).

In addition to the historically complex situation in Nigeria, where multifaceted vulnerabilities are in play, COVID-19 poses yet another threat to both individuals and to broader HIV responses. Community resilience is under renewed threat. As part of envisioning the country future response to the HIV epidemic, it is essential to examine how these new circumstances increase vulnerabilities to HIV transmission, and how HIV responses will need to change.

HIV continues to disproportionately impact adolescents and young people in all their diversity yet not enough is done to specifically address their needs; provide them with sexual reproductive health and rights (SRHR) information and access to SRH services. Criminalization remains a key concern for key population, this often involves human rights abuse and stigma towards marginalized communities. HIV testing among young people is below the 95% national target and although the Family Life and HIV Education curriculum guides the provision of sexuality education, it is still largely abstinence-based, and implementation differs widely between states. This is also to a large extent met with political and religious opposition. COVID-19 has also disrupted HIV prevention and treatment services and impacted economic and social drivers, giving room for increased risk of new HIV infections amongst adolescents and young people especially adolescents girls and young women.

The country also has its fair share of multiple challenges including climate change and environmental shocks, extreme poverty, rapid population growth, insecurity and conflict, forced displacement, malnutrition and governance gaps which drive high levels of vulnerability. This is compounded by the fragility of certain states in the region, inter-communal tensions and the increasing number of locations where government presence is weak. Millions of people face increasing protection risks and human rights violations, including gender-based and sexual violence (and conflict-related sexual violence).

# EXECUTIVE SUMMARY

## Findings

Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition have continued to gain attraction from multiple stakeholders across various levels. Globally 2.4 million children died in the first month of life in 2019. The 2016-17 Nigeria Multiple Indicator Cluster Survey (MICS) reported 44% of children under five as stunted, representing a 16% worsening from 2013. In March 2017, MCSP facilitated the formation and inauguration of ASRH TWGs in Ebonyi and Kogi as platforms to drive ASRH in the states. Additionally, MCSP set up four adolescent corners in four health facilities to offer Adolescent and youth-friendly services and demonstrate the need for the states' provision and scale-up of ASRH services. Data collection was completed for Phase 1 of formative research activity to inform plans and interventions for Adolescent and youth-friendly health services in Ebonyi and Kogi.<sup>1</sup>. In Nigeria, the HIV prevalence rate stands at 1.5, with 1.9 million people living with HIV. While Adolescent and young people constitute 48 percent of the country's population, the HIV prevalence amongst this group has risen from 0.2 percent for adolescents aged 15-19 years to 1.3; the most significant change is the lunch of the RMNCAH+N coordinating platform to ensure that coordination of RMNCAH +N action is galvanized and maximized. The groups within the AYP spectrum are not covered within the investment case. There is an opportunity where strategic plans developed by NACA and other stakeholders can be harmonized and aligned with the RMCAH+N using the investment case strategy as an entry point to ensure implementation.

The significant gap with MDAs implementing strategies is that MDAs do not fund the implementation themselves; they use funds from donor partners and other stakeholders to support implementation. However, donor partners fund programs according to their priorities, thereby calling the shots on how those funds will be used. The youth representatives need to understand the process; for example, the GFF process is a very technical process in which understanding is complex. During the implementation process of the MNCH strategy in 2007, Core Technical Committee (CTC) platform was inaugurated in 24 of the 36 states of the country; however, when the strategy was updated to RMNCAH+N and implementation began, five states have set up a coordinating platform as a step ahead of the CTC that was initially inaugurated.

## Recommendation

Government should collaborate with CSOs and NGOs to review the investment case and implement recent global strategies; new guidelines on developing the investment case have been created. A new component has been added worldwide following Nigeria's investment case development. They must also determine the implementation level, include new difficulties, and prioritize AYP inputs in every investment case's implementation step.

African network of Adolescents and young person's development (ANAYD) is a regional organization working for adolescents and young people in their diversities, which include (adolescents' girls and young women, adolescents and young people living with HIV, young key populations and young people living with special needs) both infected or affected with HIV, Tuberculosis, and Malaria. It was from 2015 in Nigeria but inaugurated adequately on 29th September 2017. It is established and saddled with the responsibility to facilitate the provision of "Educational Development," "Digital and Socio-Economic Development," "Treatment, Care and Support services to adolescents and young people to equip them with adequate capacity and skills and information on HIV, Tuberculosis, Malaria, sexual, reproductive health and rights (SRHR) to prevent further spread of HIV, Tuberculosis, STI and other related Health disease among adolescents and young people, and the general population. In addition, ANAYD strives to promote adolescents' and young people's access to services in a youth-friendly manner and of good quality. AND is still growing and involved significantly against all odds. Besides that, it has its officials, and today ANAYD is part of the success story in the fight against HIV/AIDS, SRHR, GBV, and other related health cases among Adolescents and young people in Nigeria and Africa.

# **BACKGROUND**

The Federal Republic of Nigeria is a country in West Africa. It is the most populous country in Africa. It is geographically located between the Sahel and the Gulf of Guinea to the North and the Gulf of Guinea to the South. It has a population of about 211 million people and an area of 923,769 square kilometers (356,669 square miles). Nigeria is bounded to the North by Niger, the northeast by Chad, the east by Cameroon, and the west by Benin. Nigeria is a federal republic comprising 36 states and the Federal Capital Territory, where Abuja's capital is. The largest city in Nigeria is Lagos, one of the largest metropolitan areas in the world and the second-largest in Africa.

Nigeria is a multinational state inhabited by more than 250 ethnic groups speaking 500 distinct languages, identifying with various cultures. The three largest ethnic groups are the Hausa in the North, Yoruba in the west, and Igbo in the east, comprising over 60% of the population. The official language is English, chosen to facilitate linguistic unity at the national level. Nigeria's constitution ensures freedom of religion, and it is home to some of the world's largest Muslim and Christian populations simultaneously. Nigeria is divided roughly in half between Muslims, who live primarily in the North, and Christians, who live mainly in the South; indigenous religions, such as those native to the Igbo and Yoruba ethnicities, are the minority.

Nigeria's mixed economy is the largest in Africa, the 26th-largest in the world by nominal GDP, and 25th-largest by PPP. It is a lower-middle-income economy with abundant natural resources, well-developed financial, legal, communications, transport sectors, and the Nigerian Stock Exchange.

As of 2010, about 30% of Nigerians are employed in agriculture. Agriculture used to be the principal foreign exchange earner of Nigeria. Major crops include beans, sesame, cashew nuts, cassava, cocoa beans, groundnuts, gum arabic, kolanut, maize (corn), melon, millet, palm kernels, palm oil, plantains, rice, rubber, sorghum, soybeans, and yams. Cocoa is the leading non-oil foreign exchange earner. Rubber is the second-largest non-oil foreign exchange earner.

Despite Nigeria's steady progress in economic prosperity, security, and other development areas, political fragility weak health institutions, amongst others, need urgent attention. Particularly in place of Adolescent and young people's wellbeing. In Nigeria, according to recent estimates, over 30 million Nigerians are between the ages of 10-19 years, and nearly one-third of Nigeria's total population is between the ages of 10-24 years.<sup>2</sup> The HIV situation among these groups paints a gloomy picture as recent estimates show that the HIV prevalence of AYP rose from 0.2% to 1.3% for ages 15-19 years. As of 2017, 247,293 adolescent and young persons were living with HIV, and the number continues to grow.

# **BACKGROUND**

As part of its efforts to deep dive and assess adolescents and young people prioritization on health and socio-economic interventions including investment of government towards mitigating sexual and reproductive health related issues of adolescents and young people the African Network of Adolescents and young person's development (ANAYD) sees it paramount to have this assessment study conducted and which is part of the effort driven through the Enda Santé project. The ultimate beneficiaries of this Assessment are adolescents and young people, who will help improved access to evidence-based preventive and curative services that reduce the risk of mortality and morbidity.

In addition, the conclusions and recommendations from this Assessment will be shared among Government and other stakeholders to amplify the voices of adolescents and young people on issues affecting their health and overall wellbeing. And also inform policymakers and other stakeholders on gaps to be addressed to improve AYP access to quality health services.

## **Objectives**

The purpose of this evaluation is to assess investment progress made in the improvement of HIV and sexual and reproductive health services of adolescents and young people in Nigeria.

## **Methodology**

The evaluation combines process and outcome evaluation methods to conduct the Assessment. The desk review method was employed to meet the above research objective using peer and non-peer review articles. Websites of electronic databases were accessed using specific keywords. Websites of different organizations were searched, including WHO, UNICEF, UNAIDS, NACA, DHS, NAIIS, already published Government of Nigeria documents from the Federal Ministry of Health, and other academic reports accessed online. Also, a critical key informant interview (KII) was utilized as a follow-up to the desk review. KII interview questions were developed, drawn from the desk review process, and directed to the stakeholders. The key informant interviews were conducted with stakeholders from the public health sector at the National level and stakeholders from the civil society organization participating in the AYP space.<sup>3</sup>

A request for interview mail was sent to a total of 15 participants. However, only four stakeholders responded to the request, and then an interview was conducted with the available participants.

### ***Inclusion criteria***

This review includes adolescents and young people as defined by the WHO, UN, and other established definitions. According to the WHO, Adolescence is the phase of life between childhood and adulthood which ranges from ages 10 to 19.<sup>4</sup> This review, therefore, includes articles on Adolescents and young people, articles or reports from other groups, which provides information on youth, HIV, SRHR, CSOs working in the area of adolescents and young people. The KII has stakeholders working in the AYP space, including key officials of the FMoH

### ***Exclusion Criteria***

The review excludes resources, articles describing other interventions, articles or resources representing different countries, help in other languages. In addition, the KII excludes non-health stakeholders, stakeholders not working in the RMNCAH+N, AYP programs, and low-level stakeholders.

### ***Evaluation Questions***

The following questions were developed for the evaluation.

- Have you heard of the Nigeria RMNCAH + N investment case?
- To what extent have the investment case strategy document been implemented by the MDA you represent?
- From your point of view, do you think the document address the health needs of Adolescent and young people in their complexities?
- From your point of view, can you describe the most significant change that resulted from the implementation of this strategy?
- What other strategic plans are being adopted and implemented to reduce the prevalence of HIV among AYPs and improve their access to health services
- Do these policies sufficiently cover the needs of young people as it relates to their health.
- Are you currently working with youths or youth-led organizations in improving AYP's access to health services?
- What other stakeholder do you partner or collaborate with outside your MDA in implementing the please kindly name the organization
- Do you partner with community leaders in implementing the strategy
- In your opinion, what are the next steps during and after the implementation of the Nigeria Investment case strategy document that will improve access to the health of AYP and also reduce the prevalence of HIV among the AYP population

## **Data collection method**

An Internet search for the relevant document aligns with the objectives of this Assessment and paper shared alongside the TOR of the Assessment. The KII leverages technology as zoom meeting; an online meeting platform was used.

## **Limitations**

A significant limitation to this Assessment is the availability of critical stakeholders for the interview.  
Most of the stakeholders

## **Findings on Desk Review**

Each of the following sections includes findings according to its topic areas.

### **Situational Analysis**

Located in West Africa, the Federal Republic of Nigeria comprises 36 States, and the Federal Capital Territory of Abuja, Nigeria is the most populous black nation globally. According to the National Population Commission (NPC), the country's 2020 population is estimated at 214,392,163, according to the National Population Commission (NPC). Nigeria occupies approximately 923,768 square kilometers of land stretching from the Gulf of Guinea on the Atlantic Coast in the South to the fringes of the Sahara Desert in the North. The country is a multinational state inhabited by more than 250 ethnic groups speaking 500 distinct languages, identifying with various cultures. The three largest ethnic groups are the Hausa in the North, Yoruba in the west, and Igbo in the east, comprising over 60% of the population. The official language is English, chosen to facilitate linguistic unity at the national level. Nigeria's constitution ensures freedom of religion, and it is home to some of the world's largest Muslim and Christian populations simultaneously. Nigeria is divided roughly in half between Muslims, who live mainly in the North, and Christians, who live primarily in the South; indigenous religions, such as those native to the Igbo and Yoruba ethnicities, are the minority.

Nigeria operates a mixed economy which is the largest in Africa and the 26th largest in the world by nominal GDP. It is a lower-middle-income economy with abundant natural resources, well-developed financial, legal communications, transport sectors, and the Nigerian stock exchange. Although economic development has been hindered by years of military rule, corruption, and mismanagement, the restoration of democracy and subsequent economic reforms have successfully put Nigeria back on track towards achieving its full potential. Next to petroleum, the second-largest source of foreign exchange earnings for Nigeria are remittances sent by Nigerians living abroad.<sup>5</sup>

The Nigerian economy experienced relatively healthy economic growth rates over the past decade, but the oil shock has broken this trend. Oil accounts for more than two-thirds of the country's fiscal revenues and about 90 % of foreign exchange receipts. Since 2003, Nigeria has achieved substantial growth for a decade, averaging over 6 % a year. Growth was mainly driven by the non-oil-sector (agriculture and services), private consumption, and factor accumulation (capital mostly) with only a minor contribution from productivity gains. Since the onset of the oil price shock in mid-2014, growth declined from 6.3% in 2014 to 2.8% in 2015. Revenue accruing to the Federal budget fell to 7.2% of GDP in 2015 and was among the weakest revenue mobilization efforts in the world. In 2016, the economy registered negative growth in the first three quarters, with GDP contracting by -2.24% (year-on-year) in the third quarter, and by the end of the year, the economy was contracted by 1.5%. The economic deterioration triggered by the oil price shock became compounded by a drop in oil production attributable to militant activities in the Niger Delta. It is important to note that the following fiscal constraints have had severe consequences for much-needed investments, especially in the social sectors, including health.

## **RMNCAH GLOBAL**

Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition have continued to gain attraction from multiple stakeholders across various levels. Globally 2.4 million children died in the first month of life in 2019. There are approximately 6,700 newborn deaths every day, amounting to 47% of all child deaths under the age of 5-years, up from 40% in 1990.<sup>6</sup> While the world has made remarkable progress in child survival in the past decades, most regions in the world and 153 out of 195 countries have at least halved their under-five mortality rate since 1990.<sup>7</sup> Among all countries, 45 percent (88) cut their under-five mortality by at least two-thirds over this same period – 39 of them are low- or lower-middle-income countries, indicating that, while the burden of child mortality is unevenly distributed throughout the world, improving child survival is possible even in resource-constrained settings.<sup>8</sup>

The UN has adopted as part of its SDG 2030 target to reduce high mortality and morbidity rates for mothers, neonates, children, and adolescents, working with countries and other development partners to deliver on this reality by improving health service delivery and care continuum of care which spans from pre-pregnancy and birth to the immediate postnatal period for women and newborns through to childhood and adolescent age. In September 2015, the Global strategy for women's Children's and Adolescents' health (2016-2030) was launched to stimulate action and accountability. It includes a list of targets and a core of indicators to track progress towards achieving them.

## **RMNCH IN NIGERIA**

According to the latest projections, Nigeria has approximately 169 million (UN, 2012), 29 million are children under the age of five. It is estimated that more than 7 million babies are born in Nigeria every year. Nigeria is the largest economy in Africa, yet the country still ranks 152 of 187 in terms of the Human Development Index. According to the World Bank, "despite a strong economic track record, poverty in Nigeria is significant, and reducing it will require strong non-oil growth and a focus on human development. In addition, constraints to growth, such as the investment climate infrastructure, incentives and policies affecting agricultural productivity and quality, and relevance of tertiary education have been identified".

Over the past decades, Nigeria has achieved good progress in improving maternal and child health outcomes over the past decades, although insufficient to achieve its Millennium Development Goals. According to recent estimates, the under-five mortality rate has declined from 213 per 1,000 live births in 1990 to 128 per 1,000 live births in 2019.<sup>9</sup> the MDG 4 target of reducing under-five mortality to 71 per 1,000 live births by 2015 remains far from reach. Trends in neonatal mortality also show good progress. The neonatal mortality rate has reduced from 52 per 1,000 live births to 37 per 1,000 live births from 1990- to 2013. The country has also successfully reduced Nigeria's maternal mortality ratio (MMR); the MMR was estimated at 1,200 per 100,000 live births in 1990 and 576 per 100,000 live births in 2013. The MMR has more than halved during the period, although Demographic and Health Survey (DHS) data indicate that no progress has been achieved during the period 2008-2013, and further investments are still needed to achieve the MDG 5 target for MMR, set at 300 per 100,000 live births.<sup>10</sup>

The COVID-19 pandemic has further worsened the situation due to the disruption of essential Sexual and Reproductive Health (SRH), including Family Planning services at all levels of health care delivery. The World Health Organization estimated that nearly 20 percent of all global maternal deaths occurred in Nigeria, with over 600,000 maternal deaths and about 900,000 maternal near-miss cases between 2005 and 2015. Women in Nigeria have a 1 in 22-lifetime risk of dying during pregnancy, childbirth, or postpartum/post-abortion compared with the lifetime risk of 1 in 4900 in the most developed countries.<sup>11</sup>

Despite substantial reduction in global maternal and child mortality rates in the last two decades, Nigeria's maternal mortality rate remains significantly high. Nigeria's maternal mortality rate accounts for 14% of the global burden of maternal deaths--second only to India. In addition, the under-5 mortality rate is 120 per 1,000 live births, and Nigeria experiences over 800,000 deaths among under-five children annually, 30% of which is attributable to newborn deaths.<sup>12</sup> Mortality rates for children, infants, and neonates are higher than the latest average estimates for the Sub-Saharan Africa region: 120, 70, and 39 per 1,000 live births, respectively.<sup>13</sup>

Childhood malnutrition rates remain poor and have worsened in the last two decades. Nigeria is home to the highest number of stunted children in the continent and ranks second globally with more than 10 million little children. The 2016-17 Nigeria Multiple Indicator Cluster Survey (MICS) reported 44% of children under five as stunted, representing a 16% worsening from 2013. MICS 2016 presents the rate of wasting among under-five children to be 11% and 32% underweight, with malnutrition being the underlying cause of 53% of deaths.<sup>14</sup>

However, the health indicators in Nigeria have remained below country targets and internationally-set benchmarks, including the SDGs, which have recorded plodding progress over the years. Currently, the health sector is characterized by a lack of influential stewardship role of Government, fragmented health service delivery, inadequate and inefficient financing, weak health infrastructure, mal-distribution of the health workforce, and poor coordination amongst key players.

### **Adolescent and young people**

While there are no universally accepted definitions of adolescence and youth, the United Nations understands adolescents to include persons aged 10-19 years and youth as those between 15- 24 years for statistical purposes without prejudice to other definitions by the Member States. Together, adolescents and youth are referred to as young people, encompassing ages 10-24 years. However, these terms can refer to varying age groups that are separately defined as required due to data limitations. There are over 1.8 billion young people in the world today, 90 percent of whom live in developing countries, where they tend to make up a large proportion of the population.<sup>15</sup>

The number of adolescents and youth today is at an all-time high, but that number might not increase considerably in the coming decades if global fertility continues to decline. The proportion of young people is set to decrease from 17.6 percent in 2010 to 13.5 percent in 2050. While the proportion of young people between the ages of 12-24 years living in Africa is expected to rise from 18 percent in 2012 to 28 percent by 2040, the shares of all other regions will decline. The area comprising Asia and the Pacific is expected to experience the sharpest decline, from 61 percent in 2012 to 52 percent by 2040<sup>16</sup>.

Even though youth is, in general, the healthiest period of life, the international differences of mortality amongst youth are striking. In more developed regions, Northern Africa, Eastern Asia, and Western Asia, only 1 percent or less of 15-year-old do not survive until their 25th birthday. Concurrently, the odds of dying during youth are almost twice as high in South Asia and four times higher in sub-Saharan Africa. Despite some regional variations, there is a commonality in the causes of adolescent deaths worldwide. The causes of adolescent death include communicable diseases (HIV/AIDS, tuberculosis, and lower respiratory tract infection) and non-communicable diseases related to problem behaviors (motor vehicle fatalities, violence, self-harm, alcohol, tobacco, and other drugs, and risky sex leading to early or unintended pregnancy)

Data from Demographic and Health Surveys since 2005 for 53 countries, including 31 in Africa, indicate that the share of women beginning sexual activity before marriage is significant. Thus, the percentage of women aged 20-24 at the time of the interview who reported having started sexual activity before age 20 is generally higher than the percentage who married before age 20, except for a few countries in Asia. Because contraceptive use is low among adolescent women, early initiation of sexual activity, whether after marriage or before, is associated with higher levels of adolescent fertility.

The adolescent birth rate has declined in all regions since 1990, but it is still high in Africa at 101 births per 1,000 women aged 15-19 in 2008, in South Asia at 77 births per 1,000, and Latin America and the Caribbean at 73 births per 1,000. The adolescent birth rate in developing countries was 52.3 births per 1,000 women aged 15-19 in 2000 — more than double that of developed countries, which was 23.4 births per 1,000.<sup>9</sup>

Nigeria is the most populous country in sub-Saharan Africa. It also has a very young population. In Nigeria, according to recent estimates, over 30 million Nigerians are between the ages of 10-19 years, and nearly one-third of Nigeria's total population is between the ages of 10-24 years. Altogether, the adolescent and young people population in Nigeria constitutes about 50 million people. The majority of the population is below the age of 25 years, with 22 percent of the country's population between 10-19 years. Data on sexual and reproductive health (SRH) outcomes in Nigeria highlight the importance of focusing on adolescents. At 576 maternal deaths per 100,000 live births, Nigeria accounts for roughly 14 percent of the global burden of maternal mortality.<sup>17</sup> Global evidence shows that young girls bear a higher maternal mortality and morbidity burden. Data show that the average age at sexual debut is roughly 15 years of age among adolescent mothers in Nigeria (DHS 2003, 2008, 2013). Nigeria's national adolescent fertility rate is 122 births per 1,000 women aged 15–19 years. It is as high as 171 births per 1000 women aged 15-19 years in the northwestern states.

There has been a growing recognition of young people's health issues and addressing this challenge in Nigeria. However, as evidence from various local and national surveys have shown, young people in Nigeria face the challenges of early sexual initiation, early marriage, and unsafe sexual practices, among others, with the consequences of an increasing rate of unwanted pregnancies, unsafe abortions, and sexually transmitted infections (STIs), including HIV and AIDS.

Nigeria has increased awareness and knowledge surrounding SRH since the 1990s, but this is relatively low among adolescents and young people. For example, a study on SRH knowledge and attitudes carried out in Karu LGA in 2013 shows that less than 2 percent of boys and 6.6 percent of girls aged 15-19 were able to correctly identify when a female is most likely to get pregnant during the ovulatory cycle.<sup>18</sup> Another study carried out in southwest Nigeria concludes that unmarried sexually active adolescent girls have relatively low levels of information and knowledge of modern contraceptive use.<sup>19</sup>

Early sexual debut is a concern in Nigeria, especially among girls. While the median age at sexual debut for women in Nigeria is about 18 years, it is lower at 15 years among adolescent girls. For boys aged 15-19 years, the median age at first sexual intercourse is slightly higher at 16 years.<sup>20</sup> Study results from Karu LGA show that about 20 percent of adolescents in the sample were sexually active, with the median age at 14.8 years for girls and 15.3 years for boys.<sup>21</sup> Similar findings are found in the DHS data. Age at marriage for women has been increasing, but very slowly. Most women still get married in their teenage years. Under the Child Rights Act of 2003, the legal age for marriage in Nigeria is 18 years. However, marriage can occur at earlier ages under parallel systems – customary and Islamic – that also operate in the country. Due to this, there is limited enforcement of the law. As a result, there is a persistently high incidence of very early marriage, especially in rural and Muslim areas – nearly 1 in 4 girls are married by age 15 nationally.

One of the significant problems in addressing ASRH is that services remain low - partly due to social and cultural reasons and partly due to limited access to these services. Moreover, even when services are available, adolescents may not use them. For example, a study of sampled 836 adolescents in Owerri, Imo state shows that 73.4 percent confirmed availability of reproductive health center (s) within their neighborhoods, but only 21.5 percent were willing to purchase contraceptives through these centers. . DHS (2008) data show that adolescent women were less likely than older women to receive antenatal and postnatal care as well as skilled birth attendance.<sup>23</sup> Eighty-five percent of women under age 20 years in the North and 56 percent in the South delivered at home. Overall, about 25 percent of women under age 20 used skilled attendance at birth in the country, and about 32 percent received postnatal care within 42 days of birth.<sup>24</sup> In Karu LGA, data highlight limited access to SRH services, especially for unmarried girls. Only 10 percent had visited a health facility or doctor for SRH services, with the most significant proportion (15 percent) being girls aged 15-19 seeking contraception, abortions, pregnancy, or STI related services.<sup>25</sup> Embarrassment and fear of stigmatization are among adolescents' main concerns, discouraging them from using public health facilities and services. They, however, turn to private hospitals, traditional healers, patent medical vendors (PMVs), or chemists for reproductive health services, specifically contraception and in cases of unwanted pregnancies, for abortion.

The Family Life and HIV Education (FLHE) program is the central piece of the Government's efforts to improve ASRH outcomes in Nigeria. In 2003, the program targeted in-school adolescents, ages 10-17 years. Although being implemented country-wide, recent data suggests that it has reached only 13 percent of in-school adolescents.<sup>26</sup> there has been no large-scale impact evaluation as evidence of the FLHE's influence has been mixed. while several studies highlight improvements in knowledge and attitudes among students due to FLHE, those who are out of school do not have access to the same type of streamlined education.<sup>27</sup> A few ongoing efforts to reach these populations, including the Peer Education Plus (PEP) program, implemented by the Society for Family Health, a civil society organization, in partnership with the National Agency for Control of AIDS (NACA). PEP targets high-risk populations, ages 15-24 years, through training peer educators, focusing on HIV/AIDS and reproductive health. The Federal Ministry of Women's Affairs also runs a mentorship program for girls who drop out of school due to pregnancy or are single parents to teach them life skills. The program includes SRH education.

Association for Reproductive and Family Health, Action Health, and Life Vanguards have also led similar programs. However, these are smaller programs and are not connected to the FLHE (a different ministry or agency runs each), making it challenging to reach out-of-school adolescents systematically.

In March 2017, MCSP facilitated the formation and inauguration of ASRH TWGs in Ebonyi and Kogi as platforms to drive ASRH in the states.<sup>28</sup> Additionally, MCSP set up four adolescent corners in four health facilities to offer Adolescent and youth-friendly services and demonstrate the need for the states' provision and scale-up of ASRH services. Data collection was completed for Phase 1 of formative research activity to inform plans and interventions for Adolescent and youth-friendly health services in Ebonyi and Kogi.<sup>29</sup>

In October 2020, Nigeria Launched the Reproductive, Maternal, Newborn, Child, Adolescent, and Elderly Health Plus Nutrition Multistakeholder partnership.<sup>30</sup>

## HIV/AIDS Among Adolescent and Young People in Nigeria

In Nigeria, the HIV prevalence rate stands at 1.5, with 1.9 million people living with HIV. While Adolescent and young people constitute 48 percent of the country's population, the HIV prevalence amongst this group has risen from 0.2 percent for adolescents aged 15-19 years to 1.3.<sup>31</sup> HIV prevalence varies considerably by region and age, the HIV prevalence among females aged 15–19 ranged from 1.3% in the South East (SE) to 4.3% in the South (SS) and among 20–24-year-old females from 1.8% in the SE to 7.5% in the SS. Young women are more affected by HIV, with 3.7% of those aged 20–24 living with HIV than 2.4% among their male counterparts. In 2012, the global estimate of AYP living with HIV was 5.4 million, of which approximately 900,000 were adolescents (10–14 years old), most of them having acquired HIV through mother-to-child transmission. In 2013, over 160,000 adolescents aged 10–19 lived with HIV, 75% of whom are attributed to vertical transmission. In 2012, an estimated 780,000 youth aged 15–24 were newly infected with HIV. Females in this age group were 50% more likely to acquire HIV than their male peers, with 97% of the new infections occurring in low- and middle-income countries.

There are social and contextual factors that make AYP vulnerable to HIV infection. Identifying dominant socio-cultural factors in a particular community and designing interventions to address them is key to success. Reported drivers of the epidemic pertinent to Nigerian AYP include multiple and concurrent sexual partnerships, intergenerational sex, sexual coercion, low-risk perception, and transactional sex. Moreover, studies have shown that married adolescents and young women may also be exposed to an increased risk of HIV infections from their husbands. Exacerbating high-risk behaviors are socioeconomic conditions like pervasive gender inequalities and gender-based violence, poverty, unemployment or underemployment, and widespread HIV-related stigma and discrimination. There are also many traditional, religious, and cultural factors that increase the risk of HIV infection and other sexual and reproductive health (SRH) morbidities among young women and girls, such as child and forced marriage, female genital mutilation, and widow inheritance, in addition to ineffective sexually transmitted infection (STI) programming, poor integration of HIV and AIDS and SRH services. While the Modes of Transmission Study estimates that sexual transmission accounts for about 80% of HIV transmission in Nigeria's general population, factors other than high-risk sexual behaviors play a significant role among adolescents. There is some evidence to suggest that vertical transmission may account for a relatively high proportion of infections among adolescents. Figure 2 shows how vertical transmission has increasingly become a significant mode of HIV transmission for adolescents aged 10-19.

Several policy documents address HIV and AYP. One target of the National Strategic Framework (NSF 2011–2015) is that "at least 80% of young people 15–24 years adopt appropriate HIV and AIDS-related behavior." The President's Comprehensive Response Plan for HIV and AIDS (PCRP) recognizes young people and has a specific priority area to address HIV prevention among young people. Some of the other national documents that address HIV among AYP are the National Strategic Framework on the Health and Development of Adolescents and Young People in Nigeria (2007–2011) and the National Prevention Plan (2014–2015). Although these policy documents recognize the problem of HIV among the AYP, none of them provide a comprehensive policy on HIV among the AYP or sufficient guidance for HIV programmers and service providers to design and implement evidence-based AYP-focused interventions. In the national programmatic response to HIV and AIDS, there are a few interventions designed and developed for AYP. Examples of National level interventions include Family life HIV/AIDS Education (FLHE)Curriculum for Junior Secondary Schools in Nigeria, the National Youth Service Corps peer education program for in-school youths, and the formation of a national network

## **Nigeria RMNCAH+N Investment case**

In recognition of the above, the Nigeria RMNCAH Investment case was developed as a sub-component of the NHSDP. It presents an opportunity for the GON to fast-track rapid improvements in RMNCAH + N indices: This investment case sets out to do the following (i) it lays out the background and context of the challenges of RMNCAH in Nigeria; (ii) it establishes the objectives of the investment case and how the progress will be tracked; (iii) lays out a prioritized and phased approach to addressing the challenge; and (iv) it proposes a financing strategy for the prioritized investments. The Nigeria RMNCAH+N IC presents how Development Partners; specialized agencies, and the private sector can align behind a common framework led by the Government of Nigeria to finance a prioritized set of interventions with the best chance of rapidly improving health outcomes and at the same driving economic growth; the financing plan for this IC is based on a realistic and pragmatic assessment of current and estimated resource flows.

The Global Financing Facility in Support of Every Woman Every Child is a key financing platform of the UN Secretary General's updated Global Strategy for Women's, Children's, and Adolescents' Health (2016-2030). It is a multi-stakeholder partnership that brings together, under national leadership and ownership, stakeholders in reproductive, maternal, newborn, child, and Adolescent health as well as nutrition (RMNCAH+N), to accelerate efforts to end preventable maternal, newborn, child, and adolescent deaths by 2030 and improve the health and wellbeing of women and children. It is underpinned by International Health Partnership (IHP+) principles<sup>1</sup> and harmonizes fragmented RMNCAH+N approaches, using existing structures and processes. The GFF supports country leadership by drawing on the comparative advantages of the broad set of stakeholders involved in the RMNCAH+N response, including the financing of the World Bank Group, Gavi, the Vaccine Initiative, the Global Fund to Fight AIDS, Tuberculosis, and Malaria, and bilateral donors; the technical expertise and normative mandates of UN agencies; the reach and community-connectedness of civil society organizations; and the capacity and speed of the private sector.

The GFF was announced in September 2014, followed by a 10-month business planning process involving national governments and 20 institutions, including the United Nations, the private sector, private foundations, civil society and other partners, and the four front-runner countries (the Democratic Republic of the Congo, Ethiopia, Kenya, and Tanzania). The UN Secretary-General officially launched it at the Financing for Development Conference in July 2015, and seven countries were added (Bangladesh, Cameroon, Liberia, Mozambique, Nigeria, Senegal, and Uganda). Since then, an additional five countries (Guatemala, Guinea, Myanmar, Sierra Leone, and Vietnam) were announced for funding.

### **Findings on Key Informant Interview conducted in the course of the Assessment Knowledge of Nigeria RMNCAH + N investment case?**

There are various levels of knowledge of the Investment case, with all stakeholders interviewed saying there have heard of the document. However, the paper's content is not known to all the stakeholders. A stakeholder who is a youth representative responded in affirmative, saying that she has heard of the Nigerian Investment case strategy document.

### **Level of Implementation**

The exact extent to which the strategy is being implemented could not be ascertained as the plan covers the full spectrum of the RMNCAH+N and is being implemented as a whole. However, the Government has focused chiefly on the nutrition component as the backbone, while other partners such as international organizations and donor countries have also focused on a different strategy component based on their priorities, sometimes reported under RAMCAH. She also noted that in 2020 Nigeria launched its coordinating platform to monitor the implementation of the RMNCHA+N investment case.

### **Relevance of Nigeria RMNCAH+N to AYP In Their Complexities**

According to the government stakeholders, the document addresses the health needs of young people as it seeks to improve universal health coverage, which includes AYP. However, there are gaps in the paper as it does not address the unique groups in the AYP spectrum, but from face value, the paper seeks to reduce maternal mortality noneternal mortality rates, which AYP is a contributing factor.

### **The most significant change that has resulted from the implementation of the strategy**

The most significant change is the lunch of the RMNCAH+N coordinating platform to ensure that coordination of RMNCAH +N action is galvanized and maximized.

### **Other strategic plans are being adopted and implemented to reduce the prevalence of HIV among AYPs and improve their access to health services.**

Nigeria developed an investment case that speaks directly to the importance of HIV prevention, treatment, and care to AYP. Also, there are other policies and plans by NACA and other stakeholders, but under RMNCHA+N, there have not been many efforts to reduce the prevalence of HIV among AYP. There is a n opportunity where strategic plans developed by NACA and other stakeholders can be harmonized and aligned with the RMCAH+N using the investment case strategy as an entry point to ensure implementation

### **Policies sufficiently cover the needs of young people as it relates to their health**

The document covers the needs of AYPs to an extent as it conforms to the country's laws; however, AYP is not a homogenous group. The groups within the AYP spectrum are not covered within the investment case. She also noted that during the planning stage and the lunch of the RMNCAH platform, there was a constant struggle between was going to be a youth seat VS where youth was going to be included and also the structure of the platform to include youth representation and participation. So the venue was not set up to encourage youth participation as there were various sub-groups populated with older aged groups, which made it challenging to prioritize AYP to be either a chair or co-chair or even a member within those sub-groups. The group has various restrictions, which was a limitation for AYP participation. There was a seat reserved for youths, but the role of the seat holder was never clear as all other seats were specific to a thematic theme, but that was not seen for the youth seat as youth issues cut across all of the thematic areas, became impossible to be represented that way. Therefore, there is no participation of youths on the coordinating platform and the investment case. There is a youth steering committee that has the leadership of young people which advocates AYP issues by working with each of the sub-committee of the RAMCAH platform to see that youth issues are addressed. However, the youth steering committee is not a part of the RMNCAH platform. It is an independent advocacy body.

## **Partnership and Collaboration**

Health-related MDAs partner with other non-related MDAs such as FMoJ, FMoWA, FMoYS, PSC, inter-ministry, the agency coordinating platforms, and other government agencies. MDAs in the health sector are also currently working with youth-led organizations to implement to implement the strategy, but more could be done. The significant gap with MDAs implementing procedures is that MDAs do not fund the implementation themselves; they use funds from donor partners and other stakeholders to support implementation. However, donor partners fund programs according to their own priorities, thereby calling the shots on how those funds will be used. Therefore, the youth-led organization has to prioritize the goals and objectives of the funders over that of MDAs. Health and health issues are on the concurrent list where the state government is responsible for their state's health sector activities. However, work is ongoing to partner with community leaders to implement the strategy. The FMoH stakeholders are planning an advocacy meeting to the Governors' forum and community and traditional leaders where AYP agender will be put forward to get the buy-in of the governors and traditional leaders.

## **Funding**

Youth-led organizations receive funding from donor partners, but the funds are usually small and not enough to drive significant change. However, there is advocacy at the global level by youth representatives for funds to go directly to youth organizations as whatever funds go to the Government, some percentage goes to the youth organization to drive the process, monitor and evaluate the implementation of programs and also hold Government accountable on issues affecting them.

## **Level of engagement of youth-led organizations either as partners or beneficiaries**

Youth-led organizations are engaged as both beneficiaries and also as partners. The relationship between youths, Government, and donor partners is scored 60%. In most instances, Government engages children as mere tokenism where only symbolic effort is made to give the appearance of youth inclusion come to represent themselves and leave immediately after the meeting whereby there is follow up on issues discussed. Also, the youth representatives need the capacity to understand what the process is about. For example, the GFF process is a technical process in which understanding is complex. The ability of young people to represent these processes needs to be improved because it goes beyond the regular program implementation strategies, and so young people's capacity should be built to engage with the Government meaningfully. Young people should also be able to engage with Government leaving out personal gains and opportunities.

## **Community groups, forums, and platforms were inaugurated and sustained where AYP issues were discussed and addressed.**

Implementation is at the state level as what is being done at the National level galvanizes the partners. During the implementation process of the MNCH strategy in 2007, Core Technical Committee (CTC) platform was inaugurated in 24 of the 36 states of the country. However, when the strategy was updated to RMNCAH+N and implementation began, five states set up a coordinating platform as a step ahead of the initial inaugurated CTC.

## **Next steps during and after the implementation of the Nigeria Investment case strategy document that will improve access to the health of AYP and also reduce the prevalence of HIV among the AYP population**

The following steps are to ensure that UHC is achieved where anyone who needs to access health care services should be able to access it. Also, work is ongoing to achieve the policy of primary health care under one roof, and work is also ongoing to accomplish the refurbishment of 10,000 PHCs. The launch of the national emergency response system, which was recently launched, is part of the initiative of the current Government to improve access to emergency services to anyone who needs it at zero cost.

## **Recommendations to the Government and partners for the improvement of AYP access to better health services**

Government should collaborate with CSOs and NGOs to review the investment case and implement recent global strategies; new guidelines on how to develop the investment case have been developed, and a new component has been added at the worldwide level following Nigeria's development of her investment case. They must also determine the implementation level, include new difficulties, and prioritize AYP inputs in every step of the investment case's implementation.

## **Recommendations to partners for the improvement of AYP access to better health services**

Partners have a huge responsibility in ensuring that youths and young people are built to engage with other stakeholders correctly on issues affecting them and not as mere tokenism. They should be given opportunities to take responsibility and lead the change directly, not as spectators. Partners should get young people into their organization to develop and implement those strategies alongside them.

## **Recommendation**

- More needs to be done to improve partnership levels, and more partnerships are encouraged to increase connection levels.
- Government must ensure Ethical and Meaningful Youth Engagement and Youth-Led Accountability in the National and Sub-National RMNCAH Response.
- Update guidelines, SOPs, and training manuals on Adolescent and young people's health and development in Nigeria following COVID-19 and other developing health challenges.
- Recognize Young People in All Their Diversity; Intersectionality in the National and Sub-National RMNCAH Response is critical.
- Governments and donors must commit to long-term and appropriate funding for Adolescent and youth health programs, free of restrictive and time-consuming application and reporting processes, and without the requirement that youth-led groups be registered.
- Update the P2PYHE Training manuals to accommodate the issue of emergency response for AYP in their diversities
- Increase health workforce/capacity-building specifically for adolescent and youth health requirements
- Increase funding for Adolescent and youth-friendly health services and prompt release of funds.

## **Conclusion**

The investment case aims to improve access to care for the most vulnerable by deploying services in rural and hard-to-reach areas; AYPs are vulnerable due to their distinctive nature and environment. AYP are multifaceted individuals with multifaceted needs, and thus Adolescent component in the RMNCAH strategy cannot be siloed; they must be part of a broader agenda for ensuring a sustainable and healthy future for AYP in all our diversity.

## **Annex**

### **List of resources**

- Adolescent and Youth Demographics: A brief overview <https://www.unfpa.org/sites/default/files/resource-pdf/One%20pager%20on%20youth%20demographics%20GF.pdf>
- UN joint program on Reproductive, Maternal, Newborn, Child and Adolescent Health: <https://www.unfpa.org/publications/un-joint-programme-reproductive-maternal-newborn-child-and-adolescent-health>
- Adolescent sexual and reproductive health in Nigeria: Knowledge brief, Health, Nutrition, and Population Global Practice, World Bank Group March 2015 <https://openknowledge.worldbank.org/bitstream/handle/10986/21626/950290BRI00PUB0geria0VC0ADD0SERIES0.pdf?sequence=1&isAllowed=true>
- Modern contraceptive use among unmarried girls aged 15-19 years in South-Western Nigeria: results from a cross-sectional baseline survey for the Adolescent 360 (A360) impact evaluation <https://reproductive-health-journal.biomedcentral.com/articles/10.1186/s12978-020-01056-w>
- The National strategic health development plan framework 2009-2015 [https://www.uhc2030.org/fileadmin/uploads/ihp/Documents/Country\\_Pages/Nigeria/Nigeria%20National%20Strategic%20Health%20Development%20Plan%20Framework%202009-2015.pdf](https://www.uhc2030.org/fileadmin/uploads/ihp/Documents/Country_Pages/Nigeria/Nigeria%20National%20Strategic%20Health%20Development%20Plan%20Framework%202009-2015.pdf)
- Global Financing Facility: Frequently asked questions [https://www.globalfinancingfacility.org/sites/gff\\_new/files/documents/GFF%20FAQs.pdf](https://www.globalfinancingfacility.org/sites/gff_new/files/documents/GFF%20FAQs.pdf)
- UNICEF Data: Under-five mortality <https://data.unicef.org/topic/child-survival/under-five-mortality/#:~:text=The%20global%20under%2Dfive%20mortality%20rate%20declined%20by%2061%20per,a%20matter%20of%20urgent%20concern>
- WHO, Newborns: Improving survival and well being <https://www.who.int/news-room/fact-sheets/detail/newborns-reducing-mortality>
- Adolescent Sexual and Reproductive Health in Nigeria <https://www.wilsoncenter.org/sites/default/files/media/documents/event/Esiet%20Presentation.pdf>
- DHS Program, [https://dhsprogram.com/Countries/Country-Main.cfm?ctry\\_id=30](https://dhsprogram.com/Countries/Country-Main.cfm?ctry_id=30)
- UNAIDS press release 14 March 2019 [https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2019/march/20190314\\_nigeria#:~:text=The%20South%2DSouth%20zone%20of, North%20West%20zone%20\(0.6%25\)](https://www.unaids.org/en/resources/presscentre/pressreleaseandstatementarchive/2019/march/20190314_nigeria#:~:text=The%20South%2DSouth%20zone%20of, North%20West%20zone%20(0.6%25)).
- RMNCAH-N Services During COVID-19 Pandemic
- Nigeria Investment Case
- Nigeria MNCH Country Summary, March 2017
- Press briefing by the HON. Minister of Health Dr. Osagie Ehanire October 2020

## **Evaluation Questions for Government stakeholders**

### **Consent Statement**

My name is ..... I am an independent evaluator contracted by ANAYD. We are conducting an assessment of the progress made on current RMNCAH investment cases in Nigeria, emphasizing Adolescent and young people's health with a focus on access to HIV services and programs. The goal of this evaluation is to gain a better understanding of progress made in the provision of HIV treatment services to AYPs in public health faculties, progress made in scaling up testing, progress made in encouraging preventive measures against the spread of HIV, knowledge management, and the overall access to quality health services by Adolescent and young people.

To gain a better understanding of the project processes and outcomes. We want to ask you some questions about your opinions and experience implementing the strategy document.

This interview is voluntary; you can stop the discussion at any time or choose not to answer any question. Your responses to the questions are confidential as they will be analyzed with other responses from other persons and groups to arrive at general findings.

We would like to list you as an interviewee in an annex to our report, along with the names of other interviewees consulted for this evaluation. Is it okay if we include your name in that list?

Do you agree to continue with the interview?

### **Introduction**

- What is the name of the MDA you represent?
- What is your position in this organization?
- What is your role in this organization?
- How long have you been in this position?

### **Evaluation Questions**

- Have you heard of the Nigeria RMNCAH + N investment case?
- To what extent have the investment case strategy document been implemented by the MDA you represent
- From your point of view, do you think the document address the health needs of Adolescent and young people in their complexities?
- From your point of view, can you describe the most significant change that resulted from the implementation of this strategy?
- What other strategic plans are being adopted and implemented to reduce the prevalence of HIV among AYPs and improve their access to health services
- Do these policies sufficiently cover the needs of young people as it relates to their health.
- Are you currently working with youths or youth-led organizations in improving AYP's access to health services?
- What other stakeholder do you partner or collaborate with outside your MDA in implementing the please kindly name the organization
- Do you partner with community leaders in implementing the strategy?
- In your opinion, what are the next steps during and after implementing the Nigeria Investment case strategy document that will improve access to the health of AYP and reduce the prevalence of HIV among the AYP population?

## Evaluation questions for CSOs stakeholders

### Consent Statement

My name is ..... I am an independent evaluator contracted by ANAYD. We assess progress made on the Nigerian RMNCAH investment case, emphasizing Adolescent and young people's health and focusing on access to HIV services and programs.

The goal of this evaluation is to gain a better understanding of progress made in the provision of HIV treatments and services to AYPs in public health faculties, progress made in scaling up testing, progress made in encouraging preventive measures against the spread of HIV, knowledge management and the overall access to quality health services by Adolescent and young people in their diverse groups.

To gain a better understanding of the program processes and outcomes. We want to ask you some questions about your opinions and experience implementing the strategy document.

This interview is voluntary; you can stop the discussion at any time or choose not to answer any question. Your responses to the questions are confidential as they will be analyzed with other responses from other persons and groups to arrive at general findings.

We would like to list you as an interviewee in an annex to our report, along with the names of other interviewees consulted for this evaluation. Is it okay if we include your name in that list?

Do you agree to continue with the interview?

### Introduction

- What is the name of your organization
- What is your position in this organization?
- What is your role in this organization?
- How long have you been in this position?
- Is your organization a member of ANAYD

### Evaluation Questions

- Have you heard of the Nigeria RMNCAH + N investment case?
- To what extent have the investment case strategy document been implemented by the MDA you represent
- From your point of view, do you think the document address the health needs of Adolescent and young people in their complexities?
- From your point of view, can you describe the most significant change that resulted from the implementation of this strategy?
- What other strategic plans are being adopted and implemented to reduce the prevalence of HIV among AYPs and improve their access to health services
- Do these policies sufficiently cover the needs of young people as it relates to their health.
- Are you currently working with youths or youth-led organizations in improving AYP's access to health services?
- What other stakeholders do you partner or collaborate with outside your MDA? Please kindly name the organization.
- What and how many evidence-based activities have you carried out to amplify the voice of AYPs
- Do you receive funding from the Government other donor partners to implement those activities?
- If yes to the question above, what donor agencies have you received funding for and for what activity.
- Are there community-level groups, forums, or platforms inaugurated and sustained where AYP issues are discussed and addressed
- If yes to the question above, how many such platforms exist and in what state.
- In your opinion, what are the next steps during and after implementing the Nigeria Investment case strategy document that will improve access to the health of AYP and reduce the prevalence of HIV among the AYP population?

## PARTICIPANT PROFILE

S/N	Name of contributor	Stakeholder Type	Name of organization	Designation
1.	Dr. Femi	Government	Fedram Ministry of Health, Department of Family Health	Assistant director and focal person for RMNCAH coordination, also a staff of the Child Health division
2.	Dr. John Oluraya	Government	Federal Ministry of Health, Department of Family Health	Head of Gender, Adolescent, School Health and Elderly (GASHE) Department
3.	Dr. Niyi	Government	Federal Ministry of Health	Head of Safe Motherhood, Head of planning, Monitoring and Evaluation, Secretary of Accountability, Data and Knowledge, National focal person for MPDSR
4.	Kosi	CSO	GFF	Outgoing youth representative
5	Aaron Sunday	CSO	African Network of Adolescents and Young Persons Development (ANAYD)	Executive Director

## REFERENCE

- 1 Nigeria MNCH Country summary, March 2017
- 2 NPOC
- 3 See participant profile in an annex.
- 4 Adolescent health, which
- 5 Wikipedia
- 6 <https://www.who.int/news-room/fact-sheets/detail/newborns-reducing-mortality>
- 7 <https://data.unicef.org/topic/child-survival/under-five-mortality/#:~:text=The%20global%20under%2Dfive%20mortality%20rate%20declined%20by%2061%20per,a%20matter%20of%20urgent%20concern.>
- 8 <https://data.unicef.org/topic/child-survival/under-five-mortality/#:~:text=The%20global%20under%2Dfive%20mortality%20rate%20declined%20by%2061%20per,a%20matter%20of%20urgent%20concern.>
- 9 <https://www.who.int/news-room/fact-sheets/detail/newborns-reducing-mortality>
- 10 Nigeria-investment-case
- 11 RMNAEH AOP (2022\_02\_12 05\_56\_49 UTC)
- 12 Nigeria Investment Case
- 13 Nigeria Investment Case
- 14 Nigeria Investment Case
- 15 Adolescent and Youth Demographics: A brief overview
- 16 Adolescent and Youth Demographics: A brief overview
- 17 DHS 2013/WHO 2014
- 18 Adolescent sexual and reproductive health in Nigeria: Knowledge brief, Health, Nutrition, and Population Global Practice, World Bank Group March 2015
- 19 Modern contraceptive use among unmarried girls aged 15-19 years in South-Western Nigeria: results from a cross-sectional baseline survey for the Adolescent 360 (A360) impact evaluation
- 20 DHS 2003, 2008, 2013
- 21 Adolescent sexual and reproductive health in Nigeria: Knowledge brief, Health, Nutrition, and Population Global Practice, World Bank Group March 2015z
- 22 Assessing the Prevalence and Determinants of Adolescents' Unintended Pregnancy and Induced Abortion in Owerri, Nigeria.
- 23 Utilization of Maternal Health Care Services in Nigeria: An Analysis of Regional Differences in the Patterns and Determinants of Maternal Health Care Use.
- 24 Maternal Health Care Services Utilization Among Married Adolescent Women: Insights from the Nigeria Demographic and Health Survey, 2008.
- 25 Adolescent sexual and reproductive health in Nigeria: Knowledge brief, Health, Nutrition, and Population Global Practice, World Bank Group March 2015
- 26 National Agency for Control of AIDS 2014 Report
- 27 "Evaluation of School-and Community-based HIV Prevention Interventions with Junior Secondary School students in Edo State, Nigeria.
- 28 Nigeria MNCH Country summary, March 2017
- 29 Nigeria MNCH Country summary, March 2017
- 30 Press briefing by the HON. Minister of Health Dr. Osagie Ehanire October 2020
- 31 Nigeria HIV/AIDS Indicator and Impact survey 2018