NATIONAL HIV STRATEGY FOR ADOLESCENTS AND YOUNG PEOPLE

2016 - 2020

FOREWORD

The development of a National HIV Strategy for Adolescents and Young People is in alignment with ongoing efforts to reduce HIV infection rates in Nigeria. Efforts have been made to address issues of adolescents and young people in previous plans. These include: the HIV and AIDS National Strategic Framework 2010–2015, the HIV and AIDS National Strategic Plan 2010–2015, the National Youth Policy, National Policy on Health and Development of Adolescents and Young People in Nigeria (2007) and its Strategic Framework (2007–2011), as well as in the National Action Plan for Advancing the Health of Adolescents and Youth in Nigeria (2010-2012). However, these documents did not lay out the specific strategic actions that needed to be taken by different stakeholders and institutions in a synergistic manner to achieve the desired scaled-up HIV national response for adolescents and young people.

Over the past four years, the national response has made concerted efforts to gather evidence from all actors on the implementation of programmes focusing on adolescents and young people. Key amongst this was an analysis of the HIV epidemiology and response amongst AYP. The analysis highlighted gaps in the response, including poorly-targeted HCT and condom programming for AYP, weak linkages to treatment, care and support services for AYP living with HIV, weak participation of AYP in programme development and weak documentation, monitoring and reporting. It also highlighted the need for improved coordination of the AYP response, stronger guidance for implementers of HIV programmes for AYP andclearer definition of roles and responsibilities. Thus the need for a national strategy to address the gaps and provide clear guidance on what needs to be done in the HIV response for AYP.

This document is therefore the first Strategy that addresses the needs of AYPthrough clear, simple, and feasible guidelines, which will deliver a well-coordinated HIV response for all categories of AYP. This Strategy will not only be a guide to all stakeholders, it will also be a learning experience for the national response. We are confident that all components of this Strategywill be implemented in order for us to achieve our desired outcomes.

Professor John Idoko
Director General, NACA

ACKNOWLEDGEMENTS

The *National HIV Strategy for Adolescents and Young People 2016–2020* was developed by the National Agency for the Control of AIDS (NACA) through a series of wide consultative processes with various stakeholders working with adolescents and young people (AYP). NACA acknowledges every individual and organisation that participated in these consultations. In particular, we acknowledge technical support from United Nations Children's Fund (UNICEF), Population Council, and the AYP sub-group of the National Prevention Technical Working Group (NPTWG). Special appreciation also goes to UNICEF for financial support. Additional thanks goes to the core team in Programme Coordination Department, NACA; Dr Daniel Ndukwe, Mrs Uduak Daniel and Mrs Hafsatu Aboki, along with other colleagues for putting together all the information to produce this Strategy.

Being the first of its kind in Nigeria, this strategy will lay the foundation for subsequent development of detailed and standardized implementation plans at all levels, guide the implementation of HIV interventions for AYP, provide the outline for monitoring and evaluation, and performance assessment of the AYP programme, and ultimately provide direction for the expansion of our work with adolescents and young people.

Dr Akudo Ikpeazu
Director Programme Coordination Department, NACA

LIST OF ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARVs	Anti retroviral Drugs
AYP	Adolescents and Young People
BBFSW	Brothel -based Female Sex Workers
CBO	C ommunity -based O rganisations
CSOs	Civil Society Organisations
EID	Early Infant Diagnosis
FCT	Federal Capital Territory
FLHE	Family Life and HIV/AIDS Education
FMoH	Federal Ministry of Health
FMWASD	Federal Ministry of Women Affairs and Social Development
FP	Family Planning
FSW	Female Sex Worker
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HPDP 2	HIV/ AIDS Programme Development Project 2
IBBSS	Integrated Biological and Behavioural Sentinel Survey
ICT	Information and Communication Technology
IGA	Income Generating Activities
LACA	Local Government Area Action Committee on AIDS
LGA	Local Government Area
MARPs	Most At-Risk Populations
MDAs	Ministries, Departments, and Agencies
MDGs	Millennium Development Goals
MOE	Ministry of Education
MOH	Ministry of Health
MOJ	Ministry of Justice
MOT	Mode of Transmission
MOY	Ministry of Youth
MPPI	Minimum Prevention Package Intervention
MSM	Men who have Sex with Men
MWASD	Ministry of Women Affairs and Social Development
NACA	National Agency for the Control of AIDS
NARHS	National AIDS and Reproductive Health Survey
NASCP	National AIDS Control Programme
NBBFSWs	Non Brothel-based Female Sex Workers
NBTS	National Blood Transfusion Service

NDHS	National Demographic Health Survey
NGOs	Non-governmental Organisations
NHRC	National HIV/AIDS Resource Centre
NIBUCAA	Nigeria Business Coalition Against AIDS
NNRIMS	Nigeria National Response Information Management System
NPP	National Prevention Plan
NPTWG	National Prevention Technical Working Group
NSP	National Strategic Plan
NYNETHA	National Youth Network on HIV/AIDS in Nigeria
OI	Opportunistic Infection
OVC	Orphans and Vulnerable Children
PABA	Person Affected by AIDS
PCRP	Presidential Comprehensive Response Plan
PEP	Post-expo sure Prophylaxis
PET	Peer Educators Trainers/Training
PHC	Primary Health Care
PHDP	Positive Health, Dignity, and Prevention
PICT	Provider Initiated Counselling and Testing
PITT	Prevention Intervention Tracking Tool
PLHIV	People Living with HIV
PMTCT	Prevention of Mother-to-Child Transmission
PrEP	Pre-exposure Prophylaxis
PTA	Parent Teacher Association
PWID	Persons who Inject Drugs
SACA	State Agency for Control of AIDS/State Action Committee on AIDS
SBCC	Social and Behaviour Change Communication
SdNVP	Single Dose Nevirapine
SFH	Society for Family Health
SHC	Secondary Health Centres
SME	Small and Medium scale Enterprise
SMoH	State Ministry of Health
SMT	State Management Team
SPTWG	State Prevention Technical Working Group
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TasP	Treatment as Prevention
TB	Tuberculosis
TBA	Traditional Birth Attendants
TWG	Technical Working Group

UNAIDS	Joint United Nations Program on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Funds
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
WHO	World Health Organisation

DEFINITION OF TERMS

Below are definitions of terminologies used in this Strategy document

Adolescent: An adolescent is an individual between the ages of 10 and 19 years.

Young person: Young person is an individual between the ages 20 and 24 years.

Out-of-school youth: Out-of-school youth is any adolescent or young person that dropped out of primary or secondary school; never attended primary and/or secondary school; completed primary school but did not continue with secondary school.

Key populations at higher risk: Term used to refer to adolescents and young people whose sexual and other behaviours place them at high risk of HIV transmission and acquisition. These include adolescents and young people who inject drugs, adolescents and young females who sell sex, and adolescents and young men who have sex. [The terms “most at-risk adolescents (MARA)” or “most at-risk youth (MARY)” were formerly used to refer these populations. It is more appropriate and precise to describe the behaviour each population is engaged in that places individuals at risk of HIV exposure.]

Risky sexual behaviours: Risky sexual behaviours are a range of hazardous sexual practices that influence (increase the chances of) HIV transmission. They include early sexual debut, unprotected sex, and transactional sex.

Sexual intercourse: This involves vaginal and/or anal and/or oral penetration, between at least two individuals.

Sexual debut: Is an experience of sexual intercourse for the first time by a male or female.

Comprehensive knowledge of HIV: Comprehensive knowledge means knowing that consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting the AIDS virus, knowing that a healthy-looking person can have the AIDS virus, and rejecting the two most common local misconceptions about AIDS transmission or prevention.

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1 BACKGROUND

1.1 The Evidence

1.1.1 Socio-demographic profile of adolescents and young people

Globally, there are over 1.8 billion adolescents and young people (AYP). They constitute one-quarter of the world population with 90% living in developing countries where they tend to make up a large proportion of the population. Adolescents and young people in sub-Saharan Africa account for one-third of the population. Sub-Saharan Africa is the only region in the world where the population of AYP continues to grow substantially. It is projected that by 2025 the number of youth aged 10–24 in sub-Saharan Africa will increase to 436 million and by 2050 the population is further projected to increase to 605 million.[6,7]

Nigeria has a large population of over 173 million people. The largest proportion of the AYP population is those aged 10–14 (see figure 1). Disaggregating the data by five-year age groups, 10–14, 15–19, and 20–24 year olds constitute 12.3%, 8.8%, and 7.2% of Nigeria's population, respectively.[4]

Figure 1 Population pyramid, NDHS 2013

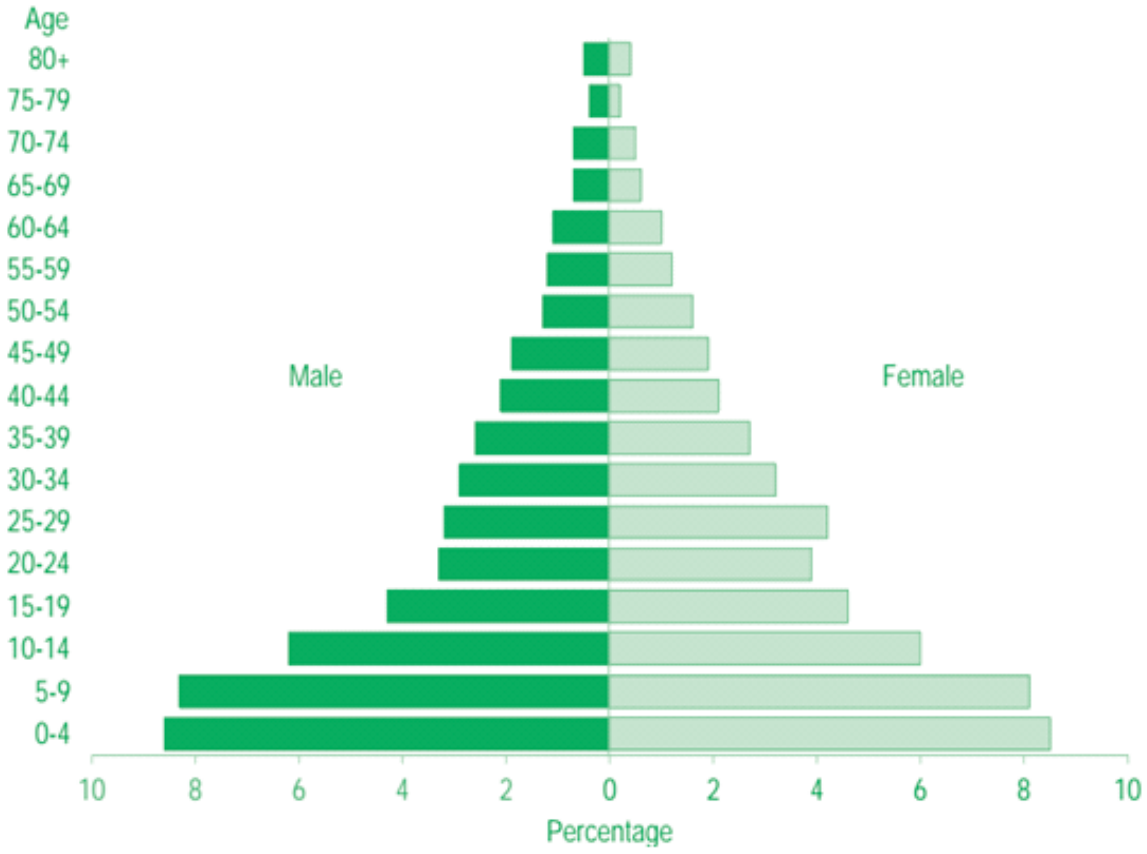


Table 1 Socio-demographic profile of AYP in Nigeria, NDHS 2013

Variable	Age group (years)	Value
Fertility rate	15–19	122/1,000 adolescent girls
	20–24	235/1,000 women
Married by age 15 (females)	15–19	11.6%
	20–24	17.3%
Married by age 18 (females) [4]	20–24	42.8%
No education (males)	15–19	16.6%
	20–24	16.6%
No education (females)	15-19	27.8%
	20-24	33.7%
Literacy rate (females)	15–24	57.1%
Literacy rate (males)	15–24	71.6%

The fertility rate is high among adolescent girls and women. Early child bearing is often a result of early marriage. A large proportion of young females (42.8%) are married by age 18. The education level is low among AYP and the literacy rate (among those aged 20–24) is lower among females compared to males.

1.1.2 HIV epidemic among AYP

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, there were over 160,000 adolescents aged 10–19 living 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.

In Nigeria, HIV prevalence among adolescents aged 15–19 is estimated to be 2.9% and 3.2% among young people aged 20–24 (Table 2). HIV prevalence varies considerably by region and age, though. The HIV prevalence among females aged 15–19 ranged from 1.3% in the South East (SE) to 4.3% in the South 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 compared to 2.4% among their male counterparts.

Please note that estimates are not available for children aged 10—14 years.

Table2 Prevalence of HIV among AYP in Nigeria, National AIDS and Reproductive Health Survey (NARHS) 2012

	Male			Female			All		
	15–19 yrs.	20–24 yrs.	15–24 yrs.	15–19 yrs.	20–24 yrs.	15–24 yrs.	15–19 yrs.	20–24 yrs.	15–24 yrs.
North Central (NC)	2.5	1.3	1.9	2.4	2.8	2.6	2.5	2.1	2.3
North East (NE)	3.7	1.5	2.6	2.9	4.0	3.5	3.3	3.0	3.1
North West (NW)	5.6	5.0	5.3	1.6	2.1	1.9	3.3	3.2	3.3
South East (SE)	0.7	0.5	0.6	1.3	1.8	1.5	1.0	1.3	1.1
South South (SS)	3.9	3.5	3.7	4.3	7.5	5.9	4.1	5.8	4.9
South West (SW)	1.7	1.8	1.7	4.0	3.7	3.8	2.8	2.9	2.8
All	2.9	2.4	2.7	2.8	3.7	3.3	2.9	3.2	3.0

Nigeria is estimated to have about 160,000 adolescents aged 10–19 years living with HIV with 73,000 being males and 90,000 females. Number of AIDS-related deaths among adolescents in 2013 was 11,000 and the number of new infections among them was 17,000 in the same year.[17]

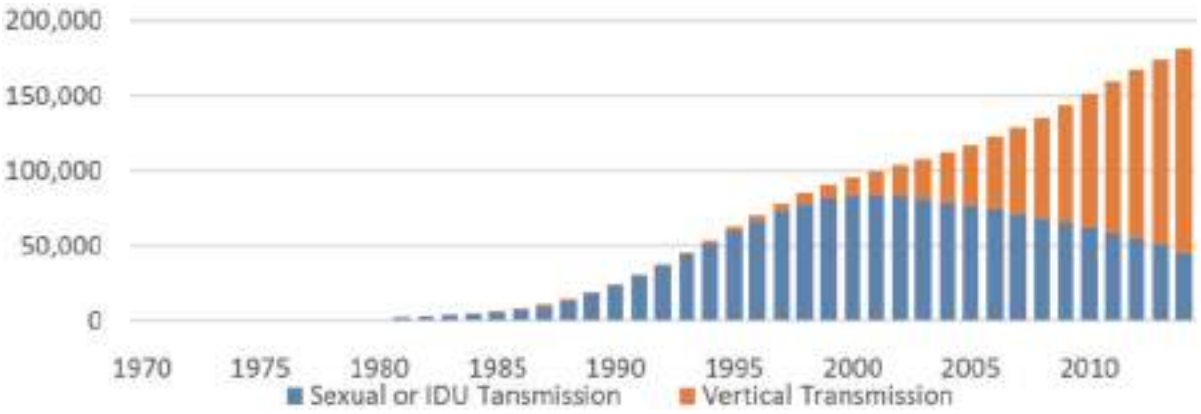
1.1.3 Drivers of the epidemic among AYP in Nigeria

There are social and contextual factors that make AYP vulnerable to HIV infection. Identification of prevailing 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 increased risk of HIV infections from their husbands.

Exacerbating high-risk behaviours 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 a number of 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[13] 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, among adolescents, factors other than high-risk sexual behaviours play a significant role. There is some evidence to suggest that vertical transmission may account for a fairly high proportion of the infections among adolescents. Figure 2 shows how vertical transmission has increasingly become a significant mode of HIV transmission for adolescents aged 10–19.

Figure 2 Adolescents aged 10–19 living with HIV in Nigeria by mode of transmission



Source: Stover et al. 2014.

Substance use is increasingly prevalent among people. Alcohol and cigarette are the most common substances used by young people, and constitute "gateways" to the use of other substances and illicit drugs. Marijuana is the most common illicit drug taken by adolescents (0.5%) and young people (1.0%) aged 15-24yrs.[14] The use of volatile organics solvents, such as petrol, and sniffing glue has also been reported. Substance use and abuse can be a result of peer pressure, youthful curiosity and the urge for experimentation. The adverse consequences of drug use by young people include dependence, overdose accidents, physical and psychological damage and sometimes, premature death. Drug use can also dampen inhibitions which may lead to reduced ability to negotiate for safe sex and increased sexual risk taking such as failure to use condoms. The use of intravenous drugs may lead to increased risk of HIV infection through sharing of contaminated needles, syringes and other equipment. While there is insufficient evidence to ascertain the extent to which substance use is a "driver" of the HIV epidemic among AYP, it is a factor that should be addressed in HIV programming for AYP.

1.2 Programming Landscape: Overview of the National AYP Response

There are several policy documents which 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 behaviour." The President's Comprehensive Response Plan for HIV and AIDS (PCRP) recognizes young people and has a specific priority area dedicated to addressing 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 recognise 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 School in Nigeria, the National Youth Service Corps peer education programme for in-school youth, and the formation of a national network—National Youth Network on HIV/AIDS in Nigeria (NYNETHA)—to coordinate a youth-led and youth-focused response.

Although these initiatives are in place, there are gaps. AYP have not been adequately involved in the development, implementation, and evaluation of the programmes and interventions targeting or affecting them. Also, data capturing the HIV response among the AYP has not been adequately disaggregated by age. Consequently, the national HIV response has not been comprehensive for AYP.

1.3 Developing the National HIV Strategy for AYP

1.3.1 Rationale for the Strategy

Adolescence is a time of physical and sexual maturation, independence, conceptual and functional identity, cognitive development, and sexual self-concept. All of these place new challenges on the young person as they transition from adolescence to adulthood and this can be further complicated by economic, cultural, and political environments. AYP are caught between tradition and changing cultures brought about by urbanisation, globalised economies, and a media-saturated environment. Traditional beliefs that guide AYP's sexuality, such as the traditional norm of chastity before marriage, are being eroded. Rates of unprotected sexual intercourse, unplanned pregnancy, unsafe abortions, sexual violence, STIs, and HIV and AIDS, are increasing. Studies show that among AYP there is low comprehensive knowledge of HIV, low HIV risk perception, low HIV counselling and testing (HCT) uptake, and increased risky sexual behaviour. In addition, there is a rise in mortality amongst AYP living with HIV.[15]

Factors that contribute to AYP's high-risk HIV profile include: negative provider attitudes towards AYP's sexual activities, concerns about confidentiality and bias, limited access to youth-friendly services with adequately sensitized health care workers, socio-cultural norms about sex, and poor sexual health-seeking behaviour among AYP.
Other factors that may contribute to the low uptake of services among AYP are relatively low awareness of HIV, HCT and places where HCT services are offered, low-risk perception, actual or perceived cost of HCT, and fear of being positive and stigmatized

In 2011 the National Prevention Technical Working Group (NPTWG) identified the following national concerns related to AYP: poor harmonization of partner funded projects for AYP; insufficient data disaggregation for AYP to capture age groups 10–14, 15–19 and 20–24; weak programming for out-of-school youth; weak coordination of interventions for AYP; minimal evidence base to guide the design, scale-up of delivery, and evaluation of a comprehensive package of interventions for the different categories of AYP. In a national consultation with AYP, it became evident that AYP perceive the national health system and the national response as not being AYP-sensitive or friendly, and not involving AYP in the planning, implementation, and evaluation of the HIV response.

There is, therefore, the need to have a national HIV strategy for AYP to provide:

- Direction for the HIV response for AYP for the next five years in terms of goal, targets, priority actions, and priority populations.

- A tool for mobilizing resources for the HIV response for AYP that is sensitive to their needs.

Key strengths of this Strategy are that it provides evidence-based guidance for programming across AYP age groups such as 10–14, 15–19, and 20–24 years, and guidance for in- and out-of-school AYP. The Strategy also provides guidance for applying a minimum prevention package intervention (MPPI) for AYP prevention programming and gender responsiveness.

1.3.2 Development process of the Strategy

An AYP sub-group of the NPTWG was formed in 2011 to drive the process of addressing the identified concerns. The committee agreed to commission a situation analysis—"An Analysis of HIV Epidemiology and Response amongst Adolescents and Young People in Nigeria"—as the first step towards addressing gaps within AYP programming.

The preliminary findings of the analysis led to the consensus that an HIV strategy for AYP in Nigeria needed to be developed to guide the HIV response for AYP. Following the development of a framework for the Strategy by the AYP sub-group and stakeholders, consultations were held with AYP via social media (Twitter, Facebook, and an online survey) and face-to-face interactions to ensure the participation and inclusion of AYP in the development process. After the consultations, this Strategy was drafted and reviewed through a series of meetings, and finalized by the AYP sub-group and other stakeholders. Subsequently, the finalized draft of the strategy was validated by the NPTWG.

1.4 Target audience for the National HIV Strategy for AYP

The Strategy is to be used by all stakeholders addressing HIV prevention, treatment, care, and support among AYP in Nigeria. These include:

- AYP living with HIV, people affected by AIDS (PABA), and their organizations and networks

- Vulnerable women and girls, such as orphans and vulnerable children (OVC), young people living with disabilities, survivors of gender-based violence, those who married early

- AYP out-of-school and AYP at higher risk, such as adolescent and young men who have sex

with men, adolescent and young female sex workers and AYP who use drugs with particular attention to those who inject drugs

- Family, Parent Teachers Associations (PTAs)
- International development partners, such as multilateral agencies, bilateral agencies, and international non-governmental organizations (NGOs)
- Civil society organizations (CSOs), community-based organisations (CBOs), NGOs, and faith-based organisations
- Advocacy organizations and patient-support groups that address HIV prevention, treatment, and care for AYP
- Uniformed services such as the armed forces, police force, and prison services
- Ministries, departments, and agencies (MDAs), such as Ministry of Education (MOE), Ministry of Health (MOH), Ministry of Youth (MOY), Ministry of Women Affairs and Social Development (MWASD), Ministry of Justice (MOJ)
- Schools, academic, and research institutions
- Profit-private establishments
- Media
- General populace

2 GOAL AND TARGETS

2.1 Goal

Reduce new HIV infections among adolescents and young people in Nigeria.

2.2 Objectives

1. Promote HCT, including client-initiated and provider-initiated, among AYP.

2. Promote safer sexual behaviors to decrease risk of acquiring HIV (delaying sexual debut, consistent and correct condom use, mutual faithfulness to an uninfected sex partner, accessing HCT, seeking STI testing and treatment) among AYP.

3. Promote early treatment and linkages to positive health, dignity, and prevention (PHDP) interventions for AYP living with HIV.

4. Promote integration of gender responsive HIV prevention programming for AYP with other health services.

2.3 Targets

Programs will focus on the following targets:

1. At least 50% of AYP access HCT services by 2020.

2. At least 80% of AYP key populations access HCT by 2020.

3. At least 90% of pregnant adolescent girls and young women have access to HCT by 2020.

4. At least 95% of all HIV-positive pregnant adolescent girls and young women access antiretroviral (ARV) prophylaxis by 2020.

5. At least 80% of sexually active AYP with STI symptoms have access to treatment services by 2020.

6. At least 80% of AYP have comprehensive knowledge on HIV and AIDS by 2020.

7. At least 80% of young people aged 15–24 adopt appropriate HIV-related behavior by 2020.

8. At least 90% of HIV-positive AYP who are eligible are receiving treatment by 2020.

9. At least 90% of AYP living with or affected by HIV provided with a minimum of one clinical care service by 2020.

3 PRIORITY AREAS FOR ACTION

The priority actions will concentrate on the following intervention areas: HCT, prevention of mother-to-child transmission (PMTCT), prevention of sexual transmission of HIV and other STIs, and treatment care and support. Priority intervention programmes should take into consideration geographical variations in prevalence, prevailing local socio cultural context, age, and gender of the targeted population and lessons learnt from field experiences.

3.1 Target Population Groups

The target populations for the strategy are divided into three major groups: in-school youth, out-of-school youth, and key populations at higher risk. These target populations are further sub-divided as shown in table 3 below and specific recommended interventions are outlined in table 6.

Table 3. Target population groups for the National HIV Strategy for AYP

In-school youth	Out-of–School youth	Key populations at higher risk
Upper primary	AYP in the street[a]	AYP who inject drugs
Lower secondary	AYP on the street[b]	Adolescent and young FSWs
Upper secondary Tertiary	AYP in closed settings (Prisons)	Adolescent and young men who have sex with men (MSM)

Cross-cutting considerations for targeting

Across these target groups, efforts should be made to target adolescent girls and young women who are especially vulnerable to HIV compared to their male counterparts.

3.2 HIV Counselling and Testing

HIV counselling and testing can be client-initiated (CIT) or provider-initiated (PICT). Irrespective of the type, HCT involves pre-test counselling, an HIV antibody test, post-test counselling, and follow-up counselling. In Nigeria, only 12.7% (12.4% male and 13% female) of 15–19 year olds and 24.5% (20.4% male and 27.5% female) of 20–24 year olds have ever tested for HIV while 7.0% of 15–19 year olds and 15.2% of 20–24 year olds have received their test results.[15]The percentage of those that have ever tested was highest in the SE (40%—35% male, 44% female) and least in the NW(13%—12% male, 14% female).[15]Only about 50% of young MSM and FSWs aged 15–24 had ever had an HIV test. The evidence shows that a majority of AYP (79.3%) are willing to test for HIV,[15] suggesting that increasing their access to HCT may lead to an increase in the uptake of HCT and if positive, subsequently treatment, care, and support services.

[a]AYP living in the street have no home to go back to. Their home is also in the street.

[b]AYP on the street during the day, but have homes to go back to at night.

Source: The AYP comprehensive analysis finalization meeting report.

3.2.1 Strategic focus

- PICT should be offered routinely to all AYP attending health facilities—including inpatient and outpatient clinics such as general outpatient, STI, family planning (FP), tuberculosis (TB), and surgical outpatient.

- Information, education, and communication (IEC) materials geared towards promoting HCT to AYP should be developed and displayed in schools, shopping malls, health facilities, and other locations where AYP congregate.

- Review the age of consent to increase access to HIV counselling and testing services.

- HCT data should be disaggregated according to sex and age (10–14, 15–19, and 20–24 years) for AYP at all service provision points.

- All state prevention and monitoring and evaluation (M&E) technical working groups should include AYP HCT data analysis and reporting on their agenda.

- Routine mobile HCT services should be targeted at AYP in hard-to-reach locations and hot spots (a geographical area or location with evidence of high prevalence of HIV, STIs, or behaviours that put people at risk for acquiring HIV infection).

- All stakeholders should work with AYP-related groups to provide platforms for AYP to serve as champions, advocates, and service providers of HCT in order to increase HCT uptake among their peers.

- Ensure strong linkages and referral pathways between HCT and AYP-friendly prevention, treatment, care, and support services.

- There should be intensive engagement and awareness building with gatekeepers, adults who are responsible for the daily needs of AYP and/or are involved in the planning and implementation of SRH-related services and/or influence community attitudes towards AYP sexuality (parents, guardians, community leaders, religious leaders, teachers, and principals), to create an enabling environment for the uptake of HCT. Gatekeepers' attitudes and perceptions influence the type of services accessible to AYP.

- Adult PLHIV in treatment centres and support groups should be actively engaged to encourage HCT uptake by AYP.

3.3 Prevention of Mother-to-child Transmission of HIV

The high rate of HIV infection and pregnancy among adolescent girls underscores the significance of PMTCT among AYP. A recent national survey shows that 23% of women aged 15–19 have begun childbearing, with a larger proportion in the rural areas (32%) than in urban areas (10%).[4] A comparison of the geopolitical zones shows that the NW has the largest proportion (36%) of teenagers who have started childbearing, while the SE (8%) and SW (8%) have the lowest proportions.[4]

Universally, PMTCT is a comprehensive four-pronged strategy:

Prong 1: Primary prevention of HIV infection in women of reproductive age group and their partners.

Prong 2: Prevention of unintended pregnancies among HIV-positive women.

Prong 3: Prevention of HIV transmission from HIV-positive mothers to their infants.

Prong 4: Care and support for HIV-positive mothers, their infants, and family members.

This Strategy emphasizes the need to prevent HIV among AYP and the prevention of unintended pregnancies among AYP living with HIV. It is critical that pregnant AYP living with HIV have timely access to ARVs to prevent transmission of HIV to their babies and for their own well-being. It also encourages better integration of HIV care, treatment, and support for AYP living with HIV, their infants, and families.

3.3.1 Strategic focus

- Integrate AYP-friendly health services into existing ART clinics in all states in the country.
- Identify and pay special attention to pregnant AYP receiving antenatal care (ANC), provide HCT, and provide high quality PMTCT services to those who test positive (including encouraging male involvement, family support, adherence counselling) taking into consideration the peculiarities of AYP.
- All pregnant adolescents attending ANC clinics and/or delivering in a hospital should receive adequate counselling and support on FP and prevention of HIV/STIs.
- Community engagement and AYP empowerment to ensure access to PMTCT services for pregnant AYP.
- All data collected at PMTCT sites should be disaggregated by age (10–14, 15–19, and 20–24years).
- Promote the implementation of all four PMTCT prongs with emphasis on the peculiarities of AYP.
- Integrate SRH and HIV programs for AYP, including promotion and provision of FP services, in the community, and when receiving ANC, postpartum care, and immunization services.
- In the planning and implementation of demand creation for PMTCT services, the unique needs of pregnant AYP should be taken into consideration.
- Promote operational research and evidence-informed PMTCT programming for AYP.

3.4 Prevention of Sexual Transmission of HIV Infection

Sexual transmission accounts for over 80% of HIV transmission in Nigeria. However, there is no specific information on sexual transmission among AYP. Reports show that only 24% of young men and women aged 15–24 have comprehensive knowledge of HIV.[24]Only slightly over half (55%) of young people aged 15–24 used a male condom during last sexual intercourse with a non-marital partner. The proportion was higher in males (63%) than in females (45%) and

higher in urban (63%) than rural areas (50%). The SW zone had the highest use of male condoms among young people (62%) while the NE had the lowest (51%).[15] Anecdotal evidence suggests that there are adolescents under 18 years who are sex workers, MSM, or PWID.

3.4.1 Strategic focus

- Build capacity of CSOs to program for vulnerable and most at-risk populations among AYP.
- Scale up male and female condom and lubricant programming.
- Increase community knowledge on HIV and SRH.
- Gather and use evidence-based information to develop programming around increasing HIV and SRH knowledge amongst AYP.
- Scale up STI treatment services and referrals, and integration of SRH/HIV service provision for AYP.
- Strengthen social behaviour change communication (SBCC) to facilitate positive behaviour change at individual, community, and structural levels especially for AYP.
- Educate AYP through social and mass media (e.g., documentaries on HIV/SRH, radio and television programs, develop a following on social media sites) about HIV and SRH.
- Establish designated centres close to hotspots frequented by young key populations to provide condoms and lubricants to AYP; needles and syringes for AYP who inject drugs.

3.5 Social and Behaviour Change Communication

Communication is an essential element of HIV prevention, treatment, care, and support. Historically such efforts have been limited by a focus on messages about how HIV is transmitted, with less attention paid to comprehensive knowledge of HIV, risk perception, correct and consistent use of a condom, stigma reduction, disclosure, and treatment adherence.

3.5.1 Comprehensive knowledge of HIV

The UN General Assembly Session on AIDS (UNGASS) knowledge indicator defines comprehensive HIV knowledge as correctly identifying ways of preventing the sexual transmission of HIV (correct and consistent condom use; having one HIV-negative, faithful partner); and rejecting major misconceptions about HIV transmission (HIV can be transmitted by mosquitoes or by supernatural means).A comprehensive analysis has shown that there is inadequate HIV knowledge among AYP in Nigeria. This low level of knowledge is linked to the social normative barriers that discourage them from seeking information from reliable sources. Studies have shown that only 21.8% of adolescents aged 15–19, and 27.4% of young people aged 20–24 have comprehensive HIV knowledge.[24] Rural AYP are worse off as they often

experience a degree of isolation from contemporary society. In the rural areas, only 22% of AYP have comprehensive HIV knowledge, which is relatively low compared to the 29.1% in the urban areas.[24]

There are geo-political differences in comprehensive HIV knowledge across the six geo-political zones among especially vulnerable adolescents and young people—engaged in high risk sex, did not use a condom at last high risk sex, and who lack comprehensive HIV knowledge—with the SS having the highest proportion (38.2%) while NW had the lowest (11.7%)[24] (Table 4).

Table 4 HIV knowledge, risks and prevention related outcomes among especially vulnerable adolescents and young people, by geo-political zone[24]

Indicators	NE	NW	NC	SE	SW	SS
Comprehensive knowledge of HIV	21.6	11.7	19.6	32.7	12.7	38.2
High-risk sex	9.6	4.3	16.1	19.4	20.2	24.8
Condom use at last high-risk sex	46.3	51.3	52.5	61.2	60.9	48.2
Average age at sexual debut	15.8	15.0	16.8	17.4	16.8	16.5
Low risk perception	37.6	20.8	38.4	40.1	40.2	44.5

3.5.2 Risk perception

A correct analysis of personal risk and being able to understand the link between behaviour and susceptibility to infection are important first steps in preventing disease. Low risk perception is one of the drivers of the epidemic for the general Nigerian population and is unfortunately a common problem among Nigerian youth. Findings from the NARHS 2012 reveal that only 1.2% and 2.1% of AYP aged 15–19 and 20–24 respectively, perceived themselves to have a high chance of contracting HIV while 55.1% and 44.8% of AYP aged 15–19 and 20–24 respectively, believe they are at no risk of HIV infection.

3.5.3 Strategic focus

- Promote intensive sexual health education—combining teacher-led activities with peer-led activities; use of media to relay messages.

- Implementation of programmes such as community youth forum for out-of-school youth maybe deserving of wider adoption and replication at the local government area (LGA) level with appropriate support from State Agency for Control of AIDS/State Action Committee on AIDS (SACAs). Such programmes are useful for reaching economically disadvantaged or out-of-school youths.

- Pilot the use of social media platforms and information and communication technologies (ICT) to promote AYP specific SBCC messages. Involve trained AYP to contribute and manage online SRH interactions.

- Develop and disseminate an interpersonal communication guide to help facilitate discussions between parents/guardians and AYP.

3.6 HIV Treatment, Care and Support

The estimated number of adolescents (aged 10–19) living with HIV as of 2013 was 160,000 (90,000 females and 73,000 males).[16]Among adolescents in 2013 there were an estimated 17,000 new HIV infections and 11,000 AIDS deaths.[16] Overall, the national treatment programme has reached 639,397 people; children make up 7.4% of this figure (47,313 children).[14]Specific data on AYP are not available.

There is loss to follow-up experienced during the transition from paediatric to adult clinical services. Treatment services are also not very youth friendly due to the limited capacity of service providers and/or negative provider attitudes towards service provision for AYP. Furthermore, the reluctance of parents/guardians to disclose their child's HIV status to their child/ward especially to very young adolescents (aged 10–14) and low treatment literacy among AYP living with HIV has negative implications for treatment adherence (e.g., the child thinks he/she is taking multivitamins and does not understand the importance fof adhering to his/her antiretroviral treatment).

Recently, PLHIV are required to pay for hospital/clinic administrative costs (i.e., costs of opening a hospital/clinic file), consultation fees, and drugs including ARVs. With high levels of poverty in Nigeria, this will likely cause increased financial strain on the families of AYP living with HIV and hinder access to and quality of treatment, care, and support services which may inevitably lead to increased AIDS-related deaths.

While studies have shown that support groups for PLHIV promote higher levels of social cohesion, psychosocial support, and treatment adherence, there are few support groups specifically for AYP and they are mostly tied to secondary and tertiary health care facilities. The existing comprehensive sexuality education curriculum targeted at adolescents does not address the specific SRH needs and vulnerabilities of AYP living with HIV.

Current laws and guidelines on the permitted age of consent for access to SRH services including HIV treatment, hinders the ability of adolescents below age 18 living with HIV to independently access essential HIV/SRH services. There has also been limited community engagement in terms of demand creation for treatment access. AYP living with HIV are also affected by HIV-related stigma and discrimination, drug stock outs, and inadequate numbers of health care personnel dedicated to HIV treatment, care, and support.

3.6.1 Strategic focus

- Implement the minimum package of interventions for AYP living with HIV at family, community, and facility levels (see appendix for interventions).
- Engage communities to create demand for access to treatment and empower AYP to advocate for access to services for AYP living with HIV.
- Build capacity of service providers to deliver care and treatment tailored for AYP to improve transition from paediatric to adult care.
- Activate AYP specific clinic days to encourage AYP to access ART appointments (offered separately from adult appointment days). Weekend/school holidays will be used to

allow the students to attend the clinic.

- Increase disclosure education and support for parents/guardians of HIV-positive adolescents.

- Involve family of AYP living with HIV in their treatment. Parents should receive 1) counselling to help their adolescent adhere to treatment; and 2) education on the nature of the treatment given to the AYP living with HIV.

- Scale up effective AYPsupport groups to address the unique needs of AYP related to psychosocial health, treatment retention, positive living, retention in school, and support of livelihood and vocational skills acquisition.

- Implement a community AYP treatment support model in which AYP living with HIV are trained and mentored to provide ART adherence support to their peers. They will identify AYP in need of ART, refer them for ART, support them through initiation, and continue to support them to ensure adherence to treatment. They will also track AYP living with HIV lost to follow-up or with complications to ART and suspected treatment failure linking such cases to treatment facilities. The AYP living with HIV will conduct home visits, clinic visits, and SMS support. They will work alongside clinic nurses, strengthening services for AYP living with HIV.

- Review the age of consent to increase early access to care and treatment.

- Review the age at which health care worker scan disclose an adolescent's or child's HIV status (16 years and below).

- Disaggregate treatment, care, and support data by age and sex to capture current service provision to AYP (10–14, 15–19, and 20–24 years) and be more responsive via programs and policies to the unique needs of each of these age groups.

- Support the initiative to reduce the cost implication of paediatric first line and second line.

3.7 Emerging Issues and Recommendations

3.7.1 Emerging issues

Social networking

Social networking among AYP in Nigeria is evolving to include ICT such as mobile phones, the Internet, instant messaging, and social media. The Pew Research Centre recently reported that in a study they conducted on cell phones in Africa, 89% of Nigerians surveyed owned a cell phone. About a quarter (27%) of Nigerians owned a smart phone (a phone that can access the Internet and applications) and 34% of Nigerian smartphone owners were aged 18–34 years.[27] A study by Education as a Vaccine (EVA) of 155 out-of-school young people aged 15–28 years residing in the Federal Capital Territory found that all respondents reported having a mobile phone and could access the Internet and mobile applications. Anecdotally, there are reports that ICT also provide opportunities for sexual networking among AYP.

Gender-based violence

While gender-based violence (GBV) has long been recognised, sufficient attention has not been paid to it. The dynamics of HIV transmission associated with GBV can be deduced from the larger society. There are increasing reports of sexual harassment and violence among and against AYP. Accurately estimating the prevalence of sexual abuse and violence in Nigeria is difficult because the societal stigma experienced by survivors often results in minimal reporting of incidents to both health care providers and law enforcement agents. In the last Nigeria Demographic and Health Survey (2013), 5.6% of Nigerian girls/women aged 15–19 and 8.5% of those aged 20-24 reported ever having experienced sexual violence. Boys/men were not asked about sexual violence and the definition of sexual violence was limited to forced/coerced sexual intercourse. Dr. Badejoko and fellow investigators in a study of sexual assault cases treated at Obafemi Awolowo University Teaching Hospital from 2007 to 2011 found that out of the 71 cases treated, an overwhelming majority (87.3%) were aged between 4 and 25 years old. In a survey of 1,366 students (50.4% females and 49.6% males) randomly selected from six public secondary schools in Ibadan, 34.9% had experienced sexual violence. A survey of 610 female undergraduates (mean age 21.0 years) revealed a date rape prevalence of 11.0%. Most (91.5%) survivors of date rape never sought any medical help, legal redress, or counselling services.

Internally displaced AYP

As of April 2015, Nigeria is estimated to have 1,538,982 internally displaced persons largely due to the violence occurring in the North Eastern Nigeria in the conflict between the Nigerian government and the armed group, Boko Haram, inter-communal conflicts, and natural disasters. AYP are especially vulnerable in situations of internal displacement and typically constitute the majority in displaced populations. In violent conflicts, AYP are often recruited into armed groups and are frequently the targets of sexual violence. They often lose the guidance of adults and clear social boundaries during their formative years and are often left to take care of themselves in settings unfamiliar to them. These vulnerabilities are heightened by the lack of access to sexual and reproductive health services that are typical of internally displaced person camps and other resettlement settings.

3.7.2 Recommendations

- Conduct research on how ICT influences the sexual behaviour of AYP.
- Develop HIV prevention, treatment, and care and support interventions which incorporate ICT.
- Adopt a multi-pronged approach (social, legal, and medical) to address gender-based violence among and against AYP.
- Partner with National Emergency Management Agency and State Emergency Management Agency to ensure that the concerns of AYP and HIV prevention, treatment, and care and support strategies are captured in emergency preparedness plans as well as programs/projects for displaced populations.

4 IMPLEMENTING THE STRATEGY

4.1 Guiding Principles of the National AYP Strategy

Youth responsive programming: AYP programmes should be responsive to the needs of AYP, and also take into consideration the sociocultural context of AYP.

Meaningful involvement of AYP: AYP should be involved in the development, implementation, and evaluation of the policies and interventions targeting or affecting them. This will ensure that policies and interventions are AYP-friendly.

Evidence-informed programming: Interventions should be informed by relevant information and data on the size, location, and characteristics (e.g., sex, age, education level, socioeconomic background, marital status, schooling status, sexual practices, drug use)of AYP.

Multi-sectoral collaboration: All relevant AYP stakeholders from all sectors should collaborate on the design, planning, implementation, and evaluation of AYP programmes.

Integrated service delivery: AYP services should be integrated and linked to SRH, maternal, newborn and child health, OVC, and TB services.

Gender-responsive programming: Based on gender analysis, AYP programmes should take into account gender equality concerns and address the needs of males and females in their design, implementation, and evaluation.

4.2 Adolescent and Young People-Friendly Service Delivery

Adolescent- and young people-friendly service delivery is about providing health services based on a comprehensive understanding of what AYP in any given society or community want and need. It is also based on an understanding of, and respect for, the realities of AYP's diversity and rights.

The World Health Organization (WHO) quality of care framework provides a useful working definition of adolescent-friendly health services. This should be adopted for AYP service

delivery. To be considered adolescent- and young people-friendly, health services should be accessible, acceptable, equitable, appropriate, and effective, as outlined below:

Accessible - Adolescents and young people *are able* to obtain the health services that are available.

Acceptable - Adolescents and young people *are willing* to obtain the health services that are available.

Equitable - *All adolescents and young people,* not just selected groups, are able to obtain the health services that are available.

Appropriate - *The right health services* (i.e., the ones they need) are provided to adolescents and young people.

Effective - The *right health services are provided in the right way,* and make a positive contribution to their health.

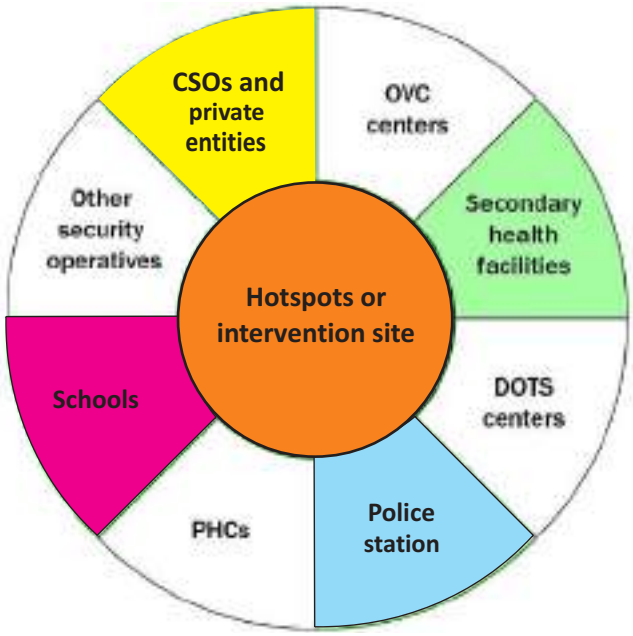
Identifying and meeting the needs and expectations of AYP and the communities in which they live is an important feature of any successful adolescent-/young people-friendly initiative. The involvement and participation of AYP is considered crucial to the successful implementation of this strategy. Services should be designed and implemented to meet the needs and aspirations of the intended AYP clients as the beneficiaries. To achieve this, service providers must understand the needs of the AYP being served and should empathize with them. Surveying AYP to determine their needs is one of the first criteria that should be met. Gender specific needs should also be analysed.

4.3 The Cluster Model of Implementation

The implementation of this Strategy should use the Cluster Model as the agreed mode of operational service delivery. The goal of a Cluster Model is to ensure effective management and improved efficiency of service delivery within the cluster. It guarantees that in every locality there is a "cluster" of comprehensive health and psycho-social services. The model is expected to ensure the expansion of the continuum of care from prevention and testing, to treatment care and support services across health care delivery levels for AYP living with HIV. The model also strengthens referral linkages between facility, school, and community-based services. It will also promote greater community involvement and the sustainability of programmes.

A cluster composition includes a hotspot or intervention site within the LGA that is linked to secondary and a number of primary health care (PHC) clinics offering HIV testing, STI management, PMTCT, and ART. A cluster also includes CBOs, community structures like support centres and groups, security operatives, police stations, schools, pharmacies, and other service providers. There can be several clusters within one LGA.

Figure 3 Operational service delivery cluster model



A cluster is expected to be saturated with prevention interventions. Service providers working with AYP sub-populations in hotspots and intervention sites within a defined cluster are expected to ensure that monthly cluster meetings are held and reports are submitted to the Local Government Area Action Committee on AIDS (LACAs) for transmission to the SACAs or directly to the SACAs where the LACAs are not functional. Should more than one CSO operate in the cluster, a cluster coordinator and secretary are selected from amongst the available CSOs. Any issues affecting the implementation of interventions in a cluster can be discussed during a cluster coordination meeting. Such issues could include, but are not limited to: progress on implementation at the cluster level; service uptake on ART, PMTCT, HCT, support services; community mobilization efforts (including IEC materials at sites); and referral linkages and follow up of clients. Others include stock levels of drugs and other related products with respect to providing timely feedback to LACA/SACA; capacity building and on-site mentoring; security-related issues for providers and beneficiaries; monitoring and evaluation issues (e.g., timely reporting, quality of data); quality assurance issues; and timely reports to LACA/SACA on problems identified and steps taken to solve problems.

4.4 National Prevention Programme Overview: Minimum Prevention Package Intervention

The national response recognises that the global concept of combination prevention ensures greater impact in prevention programmes. This concept has been instituted in Nigeria and called the MPPI.

MPPI is defined as “the strategic, simultaneous use of different classes of prevention activities (biomedical, behavioural, structural) that operate on multiple levels (individual, community, and societal/structural), to respond to the specific needs of particular audiences and modes of HIV transmission, and to make efficient use of resources through prioritizing, partnership, and engagement of affected communities.”[3]

Table 5 shows the overview of the MPPI while recommended interventions for identified AYP sub-populations are detailed in Table 6. Further information on the MPPI can be obtained from the 'MPPI How to Guide'.

Table 5 MPPI: Level of operationalization and outcome

Programme component	Level targeted	Outcome
Behavioural interventions	Individual, Community	Reduced individual risk
Biomedical interventions	Individual	Reduced exposure, transmission and/or infection
Structural interventions	Community (norms, culture, practices, values, behaviours etc.) Structural levels (policy, legal etc.)	Reduced individual vulnerability

Table 6 Recommended interventions for identified AYP sub-populations

Target population		Behavioural interventions	Biomedical interventions	Structural interventions
In-school youth	Upper primary Lower secondary Upper secondary	1. Outreach 2. Peereducation co-curricular (HIV/ drama groups, etc.)	1. HCT 2. TB screening 3. STI prevention and treatment	1. Advocacy 2. Community mobilisation and dialogue. Engagement of parents, communities and PTAs
	Tertiary	1. Outreach 2. Peer education 3. Condom and lubricant programming	1. HCT 2. PMTCT 3. Condom and lubricant programming 4. STI control and treatment	1. Commmunity mobilisation and dialogue 2. Individual empowerment and income generating activities(IGAs) 3. Advocacy
Out-of-school youth	AYP in the street AYP on the street Migrants, *Almajiris*[c] Mobile populations AYP in closed setting (including detention centres)	1. Peer education 2. Outreach 3. Condom and lubricant programming (for non-detention centres)	1. HCT (mobile) 2. PMTCT 3. STI control and treatment 4. Condom and lubricant programming 5. Harm reduction interventions for PWID	1. Advocacy 2. Community mobilization and dialogue 3. Individual empowerment/IGAs

[c] Typically boys sent from their homes as young as 4 or 5 years old to Islamic boarding schools in Northern Nigeria. They often live under harsh conditions, including having to beg.

Target population		Behavioural interventions	Biomedical interventions	Structural interventions
Key populations at higher risk	Adolescent and young people who inject drugs Adolescent and young MSM Adolescent and young FSW	1. Outreach 2. Peer education 3. Condom and lubricant programming	1. HCT 2. PMTCT 3. Condom and lubricant programming 4. STI control and treatment 5. Harm reduction interventions for PWID	1. Advocacy 2. Community mobilization and dialogue 3. Individual empowerment/IGAs

4.5 Governance and Management of the National HIV Strategy for AYP

Governance and management are instrumental to ensuring the successful delivery of the AYP Strategy on HIV. To create an enabling environment for the successful implementation of the Strategy, there are three key requirements: coordination, sustainable funding, and monitoring and evaluation.

4.5.1 Coordination

Coordinated implementation of this Strategy is essential for achieving its goals and objectives. Coordination will result in:

- Increased efficiency, performance and results from all implementing partners through proper accountability.
- Optimised flow of strategic information by clarifying reporting hierarchies at national or sub-national levels.
- Synergies with existing structures managed by sectors at the national and sub-national levels, thereby enhancing cost-effectiveness.

The existing coordination structures of the national response would be utilised. NACA shall provide leadership at the national level while SACAs and LACAs will provide leadership at the state and local government levels respectively. These bodies shall ensure partnership with CSOs such as NYNETHA and Association of Positive Youth in Nigeria (APYIN), the public and private sectors, development partners, and communities.

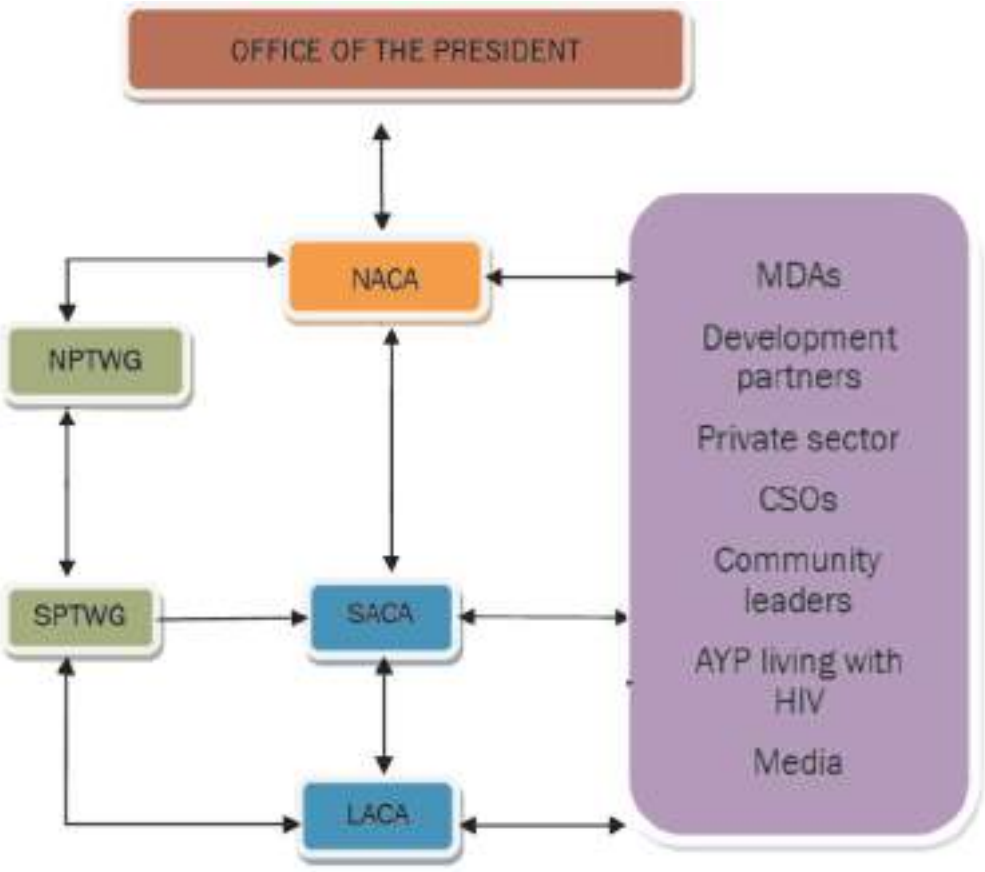
NACA, SACA, and LACA may establish task teams on an as-needed basis to undertake specific assignments to facilitate effective implementation of the AYP Strategy. NACA and SACA shall facilitate the formation, funding, and capacity building of CSOs and CSO networks to provide viable platforms for program implementation. Coordination mechanisms and platforms to facilitate CSO/public sector, CSO/development partners, and CSO/private sector interaction at national and state levels may be important to support the implementation of the AYP Strategy.

National/state technical working groups such as those for prevention, treatment, and care and support provide expert advice to inform the national HIV response. The groups comprise of

development partners, civil society, researchers, academics and affected communities. These platforms are also imperative for coordination of the AYP strategy as they can serve as a knowledge broker, sharing experiences to improve the quality of implementation as well as reduce the duplication of efforts among all parties.

Steps should be taken to strengthen coordination mechanisms especially those at sub-national levels to ensure effective coordination of the Strategy. Figure 4 illustrates the different interactions that should play a role in the coordination of the Strategy. A more detailed summary of the roles and responsibilities of key stakeholders that should be engaged in the implementation of the AYP Strategy is provided in appendix 5.4.

Figure 4 Illustration of the coordination structures' interactions for the AYP strategy



4.5.2 Funding and sustainability

The sustainable financing of this Strategy is imperative if the stated outcomes are to be achieved. The financial implications of an all-inclusive AYP Strategy for responding to HIV in the identified sub-populations can only be defined with some accuracy when operational plans have been defined and costed at all levels of implementation. It is expected that implementers will cost the full implementation of all the programme components, using recommended interventions (behavioural, biomedical and structural) and a priority setting processusing

available evidence and best practices. While aligning donor aid to support this AYP strategy, funds should also be sought from all levels of government through proper budget appropriation. Partnering with the private sector would also be key to financing this strategy.

For sustainability to be ensured, it is important that the programme is tailored to suit the different contexts. Planning for sustainability should be integral to all aspects of programming and effectively communicated. Capacity building, training, and support should be provided across functions (programme planning and management, implementation, monitoring, and financial management) and at all levels.

NACA will ensure an enabling environment for effective and efficient planning and implementation of the key priority interventions required to achieve the outcomes and objectives of this Strategy. For sustainability and effective implementation, capacity building should be built into plans at all levels and budgeted for.

4.5.3 Monitoring and evaluation

The monitoring and evaluation system of the national HIV response—the Nigerian National Response Information Management System (NNRIMS)—provides the framework for periodic monitoring of progress and implementation of the national strategic plan (NSP) and shall also serve as the monitoring and evaluation platform for the AYP strategy.

At the programme level, each organisation and programme implementer will generate result-based activities. All organisations implementing HIV prevention, treatment, and care and support programmes are expected to develop programme performance indicators with targets derived from the national targets outlined in this document. A monitoring and evaluation framework appears in Table 7. It contains 15 indicators which are linked to the NSP with targets to be achieved by the end of 2020.

Routine monitoring tools are available and should be used by implementers. Routine data generated will be complemented by results of national surveys, special studies, and other specific information generation activities. Qualitative and quantitative data on indicators will be collected and used to report progress. A review of progress will occur mid-term and a final evaluation of the strategy outcomes will be conducted late 2020.

NACA will be responsible for the compilation, management, and dissemination of all data collected through the national HIV and AIDS M&E system and sub-systems. NACA will serve as the clearing agency for all national multi-sectoral HIV and AIDS data and maintain functional reporting relationships with the National Bureau of Statistics, National Planning Commission, and global HIV and AIDS organisations. At the state level, SACAs will be responsible for management and dissemination of data and information on their respective state HIV and AIDS response. NACA and SACAs are expected to produce reports and disseminate them widely.

Table 7 National HIV Strategy for Adolescents and Young People—M&E Framework

S/ No	Indicator currently available	Definition	Indicator proposed for AYP	Baseline	Data source	Reporting frequency	Comments
Impact indicators							
1.	New HIV infections (15–24)	Estimated number of persons newly infected with HIV during one year	New HIV infections (10–24)	15–24: Male— 19,957 Female— 34,809 All ages: Male— 103,917 Female— 123,601 (GARPR, NACA 2015)	Modelling (Estimation and Projection Package (EPP)/ Spectrum)	Yearly	Advocate for generating EPP data covering the AYP age groups 10–14, 15–19, and 20–24
Outcome indicators							
2.	Percentage of young people aged 15–24 who are HIV - positive	ANC *Numerator*: Number of antenatal clinic attendees (aged 15–24) tested whose HIV test results are positive *Denominator:* Number of antenatalclinic attendees (aged 15–24) tested fortheir HIV infection status	Percentage of AYP aged 10–24 who are HIV - positive (disaggregated by sex and age: 10–14, 15–19, and 20–24).	15–19: M—2.9%, F—2.9%, T—2.9% 20–24: M—2.5%, F—3.7%, T—3.2% 15–24: M—3.3%, F—3.5%, T—3.4% (NARHS, FMOH 2012)	ANC Routine data	ANC: Once every 3–5 years Routine data: Annual	ANC: advocate to and engage survey technical committee to update the survey protocol to include adolescents aged 10–14 Routine data: Advocate for the inclusion of the analysis of AYP age groups in the annual routine data report
		Routine data *Numerator:* Number of young persons aged 15–24 tested whose HIV test results are positive in the year *Denominator:* Number of young people aged 15–24 tested in the year		0–14: F—4.33%, M—4.34% 15–19: F—13.77%, M—2.16% 20–24: F—3.85%, M—2.97% (Routine data, FMOH 2014)			

S/ No	Indicator currently available	Definition	Indicator proposed for AYP	Baseline	Data source	Reporting frequency	Comments
3.	Percentage of persons who received HCT in the last 12 months and who know the results (disaggregated by sex and age: 0–14, 15 and above).	*Numerator:* Number of individuals who received an HIV counselling and testing in the last 12 months and who know their results *Denominator:* Number of individuals	Percentage of AYP aged 10–24 who received HCT in the last 12 months and who know the results (disaggregated by sex and age: 10–14, 15–19, and 20–24).	15–49: 17.1% (NARHS, FMOH 2012)	Routine data	Annual	Routine data: Advocate for the inclusion of the analysis of the AYP age groups in the annual routine data report
4.	Percentage of persons reached with the MPPI	*Numerator:* Number of persons reached with individual and/or small group level minimum prevention package (MPP) interventions Denominator: Number of persons	Percentage of AYP reached with the MPPI (disaggregated by sex and age: 10 –14, 15–19 and 20–24)	Not available	Routine data	Annual	Routine data : Advocate for the inclusion of age disaggregation in the prevention aggregation tool (national summary form)
5.	Percentage of HIV -positive persons aged 0–14, 15 and above-24 who are eligible and currently receiving ART (disaggregated by first -line, second- line and third-line) (Routine)	*Numerator:* Number of HIV infected persons 0 –14, 15 and above who are currently receiving antiretroviral therapy in accordance with the nationally approved treatment protocol (or WHO/UNAIDS standards) at the end of the reporting period	Percentage of HIV -positive AYP aged 10–24 who are eligible and currently receiv ing ART (disaggregated by sex and age: 10 –14, 15–19, and 20–24, first -line, second -line and third -line)	44.9% (GARPR, NACA 2015)	Routine data	Annual	Routine data: Advocate for the inclusion of the analysis of the AYP age groups in the annual routine data report

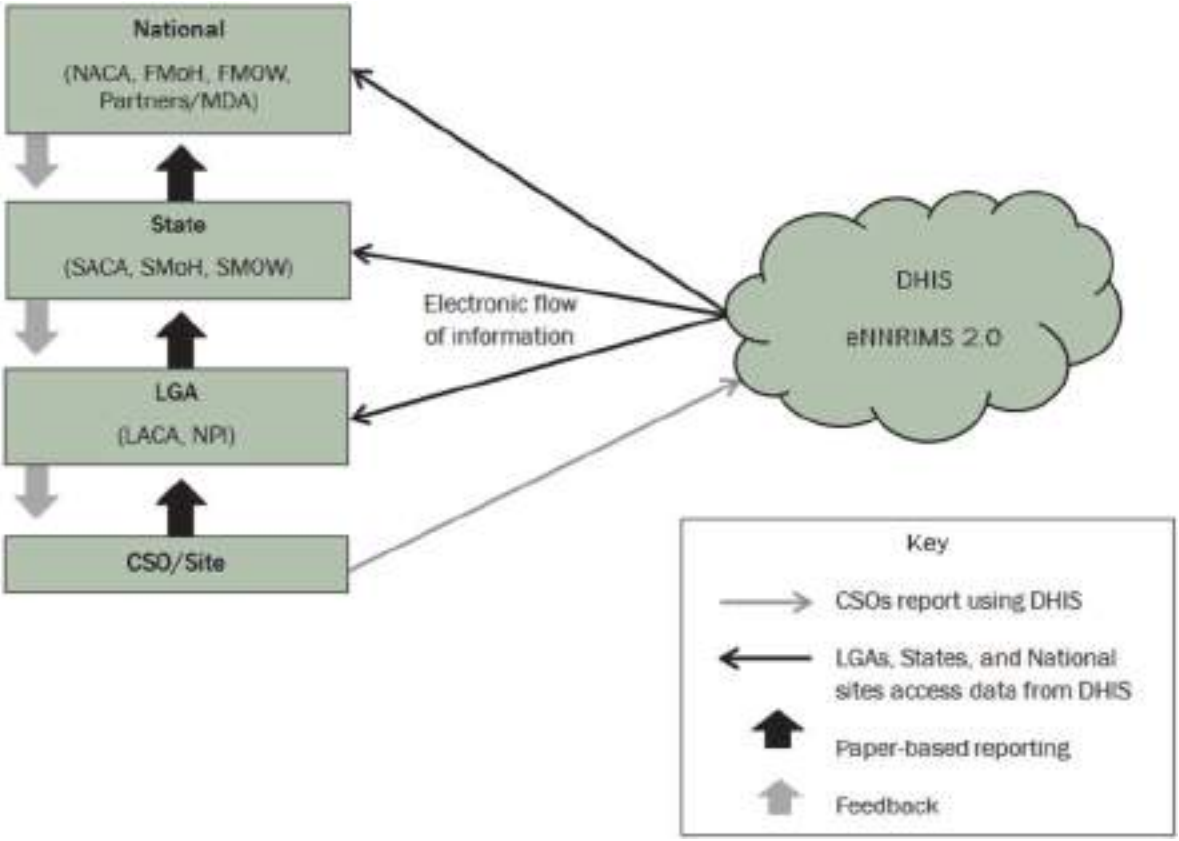
S/ No	Indicator currently available	Definition	Indicator proposed for AYP	Baseline	Data source	Reporting frequency	Comments
		Denominator: Estimated number of adults and children with HIV infection who are eligible for ART					
6.	Percentage of young people aged 15 –24 who both correctly identify ways of preventing the sexual transmission of HIV infection and reject a major misconception about HIV transmission	*Numerator:* Number of respondents aged 15 –24 years who responded correctly to all five questions *Denominator:* Total number of all respondents aged 15 –24	Percentage of AYP aged 10–24 who correctly identify ways to prevent the sexual transmission of HIV infection AND reject a major misconception about HIV transmission (disaggregated by sex and age: 10 –14, 15–19, and 20–24)	60.0%	NARHS	Once every 3–5 years	NARHS: advocate to and engage survey technical committee to update the survey protocol to include adolescents aged 10 –14
7.	Percentage of young people aged 15 –24 who have had sexual intercourse with more than one partner in the last 12 months	*Numerator:* Number of respondents aged 15 –24 years who have had sexual intercourse with more than one partner in the last 12 months *Denominator:* Number of respondents aged 15 –24 years	Percentage of AYP aged 10–24 who have had sexual intercourse with more than one partner in the last 12 months (disaggregated by sex and age: 10 –14, 15–19, and 20–24)	15–19: M—29.9%, F—6.9% 20–24: M—33.6%, F—8.0% 15–24: M—26.9% F—5.7% (NARHS, FMOH 2012)	NARHS	Once every 3-5 years	NARHS: Advocate to and engage survey technical committee to update the survey protocol to include adolescents aged 10 –14

S/ No	Indicator currently available	Definition	Indicator proposed for AYP	Baseline	Data source	Reporting frequency	Comments
8.	Percentage of young people aged 15–24 who have had more than one sexual partner in the last 12 months and report the use of a condom during their last sexual intercourse	*Numerator:* Number of respondents (aged 15–24) who reported having had more than one sexual partner in the last 12 months who also reported that a condom was used the last time they had sex *Denominator:* Total number of respondents (15–24) who reported having had more than one sexual partner in the last 12 months	Percentage of AYP aged 10–24 who have had more than one sexual partner in the last 12 months and report the use of a condom during their last sexual intercourse (disaggregated by sex and age: 10–14, 15–19, and 20–24).	15–19: M—56.4%, F—39.4% 20–24: M—64.8%, F—48.5% (NARHS, FMOH 2012)	NARHS	Once every 3-5 years	NARHS: A dvocate to and engage survey technical committee to update the survey protocol to include adolescents aged 10 –14
9.	Median age at first sex among youths 15–24	Median age at first sex	Median age at first sex among AYP aged 10–24 (disaggregated by sex and age: 10–14, 15–19, and 20–24).	Rural: 15–19: 16 years, 20–24: 18 years Urban: 15–19: 15 years; 20–24: 17 years (NARHS, FMOH 2012)	NARHS	Once every 3–5 years	NARHS: A dvocate to and engage survey technical committee to update the survey protocol to include adolescents aged 10–14 years

S/ No	Indicator currently available	Definition	Indicator proposed for AYP	Baseline	Data source	Reporting frequency	Comments
10.	Percentage of AYP aged 15–24 who have had sex with non - marital, non-cohabiting sexual partner in the last 12 months	*Numerator:* Number of AYP aged 15–24 who reported sexual activity with non-marital, non-cohabiting partners in the last 12 months *Denomenator:* Total number of AYP aged 15–24 surveyed	Percentage of AYP aged 10–24 who have had sex with non - marital, non - cohabiting sexual partner in the last 12 months (disaggregated by sex and age: 10 –14, 15–19, and 20–24)	15–19: F—33.7%, M—77.8% 20–24: F—21.8%, M—63.8% (NARHS, FMOH 2012)	NARHS	Once every 3-5 years	NARHS: Advocate to and engage survey technical committee to update the survey protocol
11.	Among persons age 15–49 who have heard of AIDS, percentage expressing specific accepting attitudes towards PLHIV	*Numerator:* Number expressing acceptance attitudes on all four indicators *Denominator:* Number of respondents who have heard of AIDS	Number of AYP living with HIV reporting discriminatory attitudes towards PLHIV (disaggregated by sex and age: 10 –14, 15–19, and 20–24)	Women: 11.5% Men: 13.3% (NDHS, NPC 2013)	NDHS	Once every 3-5 years	NDHS: Advocate to and engage survey technical committee to update the survey protocol
12.	Percentage of schools that provided life skills -based HIV education within the last academic year	*Numerator:* Number of schools that provided lifeskills-based HIV education within the last academic year *Denominator:* Number of schools surveyed		Number of schools that provide lifeskills - based HIV education in the last three months (Jan–June 2014 current data): 6,408 (Routine data, NACA 2014)	Routine data	Annual	Source: Routine data

S/ No	Indicator currently available	Definition	Indicator proposed for AYP	Baseline	Data source	Reporting frequency	Comments
Output Indicators							
13.	Number of PLHIV receiving adherence support	Number of PLHIV receiving adherence support	Number of AYP living with HIV receiving adherence support (disaggregated by setting, sex and age)	Number of PLHIV receiving adherence support: 123,041 (Routine data, NACA 2014)	Routine data	Annual	Routine data: Advocate for the inclusion of the analysis of the AYP age groups in the annual routine data report
14.	Number of clients provided a with minimum of one care service	Number of clients provided with a minimum of one care service	Number of eligible AY P living with HIV and PABAs provided with minimum of one care service (disaggregated by setting, sex and age: 10–14, 15–19, and 20–24)	N ot available	Routine data	Annual	Routine data : Advocate for the inclusion of the analysis of the AYP age groups in the annual routine data report
15.	Number of vulnerable children provided at least one service	Number of vulnerable children provided at least one service		Not available	Routine data	Annual	Routine data : Advocate for the inclusion of the analysis of the AYP age groups in the annual routine data report

Figure 4 Data flow and reporting



5. APPENDIX

5.1 Factors that Affect HIV Transmission among AYP in Nigeria

Local practises, behaviour or condition	Context (regional variations, locations)
Age of first sexual intercourse among youth 15—24 years *NDHS 2013*	
Before age 15: Females—17%; males — 3.4 %	Not available
Median age at first sex among youth 15—24 years NARHS *2012 plus*	
Nationally:Females—17yrs; males—17yrs	Females: lowest in North West (15yrs) ;highest in South West and South East (both 18yrs) Males: lowest in North Central, South South, and South West (17yrs); highest in North West (19yrs)
Multiple sexual partnership *NARHS* 2012 plus	
Males: 29.9% (aged 15–19); 33.6% (aged 20–24)	Lowest in South East (21%); highest in North Central (35%)
Females: 6.9% (aged 15–19); 8.0% (aged 20–24)	Lowest in North West (2%); highest in North Central (10%)
Multiple non-marital/non-cohabiting partner *NARHS* 2012 plus	
Males: 22.7% (aged 15–19); 23.8% (aged 20–24)	Lowest North West (3.3%); highest South-South (12.4%)
Female: 3.0% (aged 15–19); 3.5% (aged 20–24)	Lowest in North west (0.8%); highest in South East (3.7%)
Non-marital/Non-cohabiting (Boyfriend/Girlfriend relationship *NARHS* 2012 plus	
Males: 12.4% (aged15–19); 33.4% (aged 20–24)	6% among males in North West, 28% in South
Females: 11.0% (aged 15–19); 16.4% (aged 20–24)	2% among females in North West, 17% in South
Condom use during last sexual acts with non-marital partner in the last 12 months *NARHS* 2012 *plus*	
Males: 56.4% (aged 15–19); 64.8% (aged 20–24)	54.0% and 70.0% in South South and South West respectively
Females: 39.4% (aged 15–19); 48.5% (aged 20–24)	38.6% and 52.9% in South South and South East respectively

5.2 Minimum Package of Interventions for AYP Living with HIV

The principles of PHDP are central to any interventions developed for AYP living with HIV. This encourages a human rights based approach to HIV treatment, and care and support programming and service provision. The WHO advocates 13 evidence-based interventions for PLHIV—psychosocial counseling and support; disclosure, partner notification, HCT; co-trimoxazole prophylaxis; tuberculosis counseling, screening and prevention; fungal infection prevention; sexually transmitted and other reproductive tract infection prevention; malaria prevention; selected vaccine preventable diseases (hepatitis B, pneumococcal infections, influenza and yellow fever); nutrition; FP; PMTCT; needle-syringe programmes and opioid substitution therapy; and provision of water, sanitation, and hygiene interventions. The national response recognizes the minimum package of interventions for AYP living with HIV at family, community, and facility levels as represented in the tables below.

Minimum package of interventions for AYP living with HIV: Family level

Partner or actor	Minimum components	Key activities	Monitoring indicator (s)
Primary caregiver	• Home-based management of AYP living with HIV • Provision of supportive environment for AYP living with HIV to reach full potential	• Build the capacity of families to understand HIV through training and discussion about HIV • Formation and promotion of peer support groups for AYP living with HIV • Support families to improve communication with AYP living with HIV • Strengthen life skills of AYP living with HIV in decision-making, dealing with conflicts, etc. • Primary caregiver peer support group to share experiences	• Primary caregivers and family members have improved knowledge of how to support adherence and disclosure • AYP living with HIV received information of SRH from primary caregivers • Primary caregivers' awareness of services • Number of training courses run for primary caregivers • Number of primary caregivers trained
AYP living with HIV-headed households	• Support of AYP living with HIV providing care and support for his or her siblings	• Recruit and train community volunteers to mentor AYP living with HIV • Conduct weekly home support visits • Identifyand refer AYP living with HIVtoproper CBOs • Establish and/or identify AYP living with HIV support groups and refer AYP living with HIV to support groups • Trace families/relative s to investigate whether they might be able to provide support to the family • Provide economic empowerment programs to AYP living with HIV	• Number of AYP living with HIV heads of households receiving support

Minimum package of interventions for AYP living with HIV: Community level			
Partner or actor	**Minimum components**	**Key activities**	**Monitoring indicator (s)**
Community health workers	• Community-based HCT • Treatment, care, and support of AYP living with HIV	• Provide HCT and referAYP living with HIV to health facilities • Provide treatment,and care and support for AYP living with HIV including a focus on adherence and disclosure • Support for families and caregivers	• Number of AYP tested • Monitoring activities of community health workers
Traditional, cultural and community leaders	• Enabling environment (challenging stigma and fostering change) • Implementation of services in line with national laws and policies	• Promote uptake of HCT services • Mobilize support for AYP living with HIV • Educate the community on HIV, correct misconceptions about HIV, and promote understanding instead of judgement to reduce stigma • Strengthen local government councils to protect AYP living with HIV • Monitor programme implementation	• Utilization of services • By-laws protecting AYP living with HIV • Community involvement
Schools	• HIV status awareness • Voluntary HCT in schools • Supportive environment for AYP living with HIV in schools • Elimination of stigma and discrimination • Comprehensive sexuality education and facilitating access to services • Links with health facilities	• Provide universal access to quality education • Disseminateaccurate information about HIV and AIDS • Develop an education curriculum that addresses the SRH needs of AYP • Provide teacher sensitization training • Provide outreach programs to AYP living with HIV • Support adherence among AYP living with HIV • Encourage and provide space and the appropriate staff to provide HCT in schools • Establish support peer groups • Provide referral mechanisms for mental, legal, and social support • Sensitize students on rights of AYP living with HIV	• Schools integrateAYP living with HIV needs into school health policy • States revise curriculum to include comprehensive sexuality education • Voluntary HCT in schools
CBOs	• Quality community AYP living with HIV services • Facilitation of community support for all AYP living with HIV • Capacity building activities to create a self-sustaining community	• Promote HIV status awareness • Provide adherence support • Provide support for AYP living with HIV to disclose their status • Sensitize community on needs of AYP living with HIV • Facilitate integration of AYP living with HIV services at community level • Hold community discussions • Facilitate referrals to health units • Support youth IGAs • Collect and share disaggregated data	• Stigma index • Level of community participation • AYP living with HIV in leadership positions

Minimum package of interventions for AYP living with HIV: Community level			
Partner or actor	**Minimum components**	**Key activities**	**Monitoring indicator (s)**
Judicial and law enforcement system	• Development of laws that promote and protect rights of AYP living with HIV • Policies and legislation that protect the rights of AYP living with HIV	• Sensitize communities on the rights of AYP living with HIV • Conduct community level activities that develop legal literacy on property rights, sexual abuse, gender-based violence, etc. • Promote AYP rights to health, food, education, identity, etc.	• Availability and enforcement of laws that promote rights of AYP living with HIV • Harmful laws and policies repealed or empowering laws and policies enacted and implemented • Number of reported cases contravening laws • Number of cases prosecuted • Human rights country reports
Youth leaders	• Meaningful involvement of AYP living with HIV in leadership positions • Respectful involvement of AYP living with HIV in planning and implementing interventions	• Conduct mentorship/leadership/advocacy trainings for AYP living with HIV • Advocate/mobilize for leadership positions for AYP • Engage in promoting the rights of AYP living with HIV, including their right to participate	• Active involvement of AYP, including AYP living with HIV, in designing, planning and implementing interventions

Minimum package of interventions for AYP living with HIV: Family level

Intervention	Components	Key activities	Monitoring indicators
HIV diagnosis	▪ Active identification of AYP living with HIV ▪ Linkage to care, treatment and support ▪ Elimination of stigma and discrimination surrounding testing	▪ Provide PICT in health facilities ▪ Provide HIV testing through PMTCT programs ▪ Make HCT available through VCT services	▪ Number of AYP who have been tested ▪ Number of AYP found to be HIV positive and in treatment/care ▪ Age disaggregation of WHO/UNAIDS indicators
Treatment, care and support	• HIV status disclosure to AYP • H IV status disclosure to parents/caregivers, friends etc.	• Develop protocols and guidance on disclosure among AYP • Train staff on disclosure (to AYP about their HIV status and to supportive adult/peers)	• Knowledge about HIV status • Disclosure to other support network
	• Prevention, early diagnosis, treatment and referral for mental ill health and psycho-social problems	• Distribute mental health IEC materials • Sensitise staff on mental illness symptoms (e.g., depression) • Screen for mental health problems • Treat mental health problems • Deliver counselling support for those diagnosed with a mental illness as well as their caregivers • Provide referrals for mental health services	• School attendance and making academic progress • Clinical mental health parameters • Adherence • High risk behaviours (e.g., alcohol and substance abuse)

Intervention	Components	Key activities	Monitoring indicators
	▪ Improve access to comprehensive SRH services	▪ Provide a broad range of AYP SRH and HIV prevention IEC materials ▪ Provide STI screening and management ▪ Conduct counselling on reproductive choices and and contraception, and provide FP commodities ▪ Promote condoms and provide supplies (dual protection): condoms, gels etc. ▪ Provide pregnancy testing and referrals for pregnancy care	• AYP SRH knowledge and reported behaviours • Age at sexual debut • Contraception rates • Use of condom at • last sex Availability of PEP, • condoms, contraception • Quality of service indicators Linkages between services (ANC, AYP living with HIV, FP, AYPSRH, PMTCT) • Age disaggregation of core indicators
• Prevention, screening and treatment of opportunistic infections (Ois)		• Provide OI screenings for all AYP living with HIV • Treat and provide prophylaxis for OI • Ensure availability of drugs (e.g., co-trimoxazole, anti-malarials) • Create linkages with TB services	• Proportion of AYP living with HIV screened for OIs
• HIV clinical care • Monitor AYP living with HIV		• Clinical HIV staging and monitoring at each visit • Monitor growth (weight, height) • Assess physical development using Tanner's staging • Provide nutritional counselling • Provide psycho-social support	• Retention of AYP living with HIV in program • Mortality rate
• Laboratory tests		• Provide: o Rapid HIV testing o CD4, viral load testing o Sputum smear o Biochemistry (LFT, RFT) o Haemoglobin concentration o Other; syphilis, pregnancy etc.	• Timely availability of test results • Quality control at national and state level
• Initiation to ART • Adherence to ART		• Ensure reliable access to first-and-second line ARVs • Initiate ART	• CD4/HIV staging when treatment started • Number of AYP living

Intervention	Components	Key activities	Monitoring indicators
		• Monitor treatment failure and side effects • Provide adherence monitoring and counselling	with HIV on ARVs • Number of AYP living with HIV eligible for ART initiated within a month • Percentage of AYP living with HIV on second-line treatment
	• Integration of PMTCT services with ART and other services for AYP living with HIV	• Provide: o PMTCT services o HAART prophylaxis o Laboratory monitoring o FP and nutrition counselling • Follow up with pregnant AYP living with HIV • Followup with HIV-exposed AYP and families	• Rate of women attending PMTCT • AYP HIV infection rates • AYP living with HIV attending PMTCT services
	• Strengthening referral systems within and between facilities	• Create linkages and provide referrals to: o Secondary care for a range of services (e.g., ART complications, mental health) o Nutrition o Legal services o AYP friendly health services o NGOs working with/for AYP o Family and community levels	• Follow-up on referrals • Routine reviews

5.3 Target Populations and Minimum Prevention Package Intervention

Target Population	Component	Interventions	Activities
Upper Primary including AYP with disabilities and AYP living with HIV	**Behavioural**	Outreach	Small group discussions
		Peer education (co curricular)	• Peer sessions • Promotion of abstinence • HCT information
	Biomedical	HCT	HCT with parental consent
	Structural	Advocacy	Advocacy meetings, marches, press releases, position paper, communiqués, petitioning, letter-writing campaigns, debating to: • support the implementation of SRH and FLHE • protect the rights of the child
		Curriculum -based intervention	• FLHE
		Dialogue	• PTA • Parent child communication • Gender sensitization (Teachers, parents, communities and children)
		Youth -frien dly services	Provision/integration/creation of gender sensitive youth-friendly services/centres
		Individual empowerment	Decision making, values and values clarification, communication etc.
Junior secondary including AYP with disabilities and AYP living with HIV	**Behavioural**	Outreach	Small group discussions
		Peer education (co - curricular)	• Peer sessions • Promotion of abstinence • HCT information
	Biomedical	HCT	HCT with parental consent
	Structural	Advocacy	Advocacy meetings, marches, press releases, position paper, communiqués, petitioning, letter -writing campaigns, debating to: • support the implementation of SRH and FLHE • protect the rights of the child
		Curriculum - based intervention	• FLHE
		Dialogue	• PTA • Parent -child communication
		Youth- friendly services	Provision/Integration/creation of gender-sensitive youth-friendly services/centres

Target population	Component	Interventions	Activities
Senior secondary including AYP with disabilities and AYP living with HIV	**Behavioural**	Outreach	Small group discussions
		Peer education (co-curricular)	• Peer sessions • Promotion of abstinence • HCT information • Reinforce life skills
	Biomedical	HCT	• HCT with parental consent • Referrals
		TB screening	• TB screening with parental consent • Referrals
	Structural	Advocacy	Advocacy meetings, marches, press releases, position paper, communiqués, petitioning, letter-writing campaigns, debating to: • support the implementation of SRH and FLHE • protect the rights of the child
		Curriculum based intervention	FLHE
		Dialogue	PTA Parent child communication
		Income generating activities	Vocational skills building
		Youth-friendly services	Provision/Integration/creation of gender sensitive youth-friendly services/centres
Tertiary including AYP with disabilities and AYP living with HIV	**Behavioural**	Outreach	Small group discussions, interpersonal communications, community meetings
		Peer education	Making contact, referrals, distributing IEC materials, demonstrating and distributing condoms, running education and training sessions, mobilizing community members
		Condom and lubricant programming	Promotion and demonstration, of male and female condoms and water-based lubricants
	Biomedical	HCT (Mobile HCT, facility-based HCT including PITC, community-based HCT)	Pre-test counselling, post-test counselling, follow-up counselling, referrals
		STI control and management	Screening and treatment of STIs; Training on STI syndromic management for providers
		Condom and lubricant programming	Condom and lubricant forecasting and quantification; Condom and lubricant procurement and distribution systems

Target population	Component	Interventions	Activities
		PMTCT	Reproductive and allied health services including FP, ANC, postpartum/natal care; HIV treatment, care, and support for PMTCT
	Structural	Advocacy	Advocacy meetings, marches, press releases, position paper, communiqués, petitioning, letter-writing campaigns, debating to: • support the implementation of SRH and FLHE • protect the rights of the child
		Curriculum based intervention	FLHE
		Dialogue	PTA Parent -child communication
		Income generating activities	Vocational skills building
		Youth-friendly services	Provision/Integration/creation of gender sensitive youth -friendly services/centres
Out -of-school Including Married adolescents **Key populations at higher risk** **AYP with disabilities** **AYP living with HIV**	**Behavioural**	Outreach	Small group discussions, interpersonal communications, community meetings
		Peer education	Making contact, referrals, distributing IEC materials, demonstrating and distributing condoms, running education and training sessions, mobilizing community members
		Condom and lubricant programming	Promotion, and demonstration, of male and female condoms and water-based lubricants; Age appropriate condom information
	Biomedical	HCT (Mobile HCT, facility -based HCT including PITC, community -based HCT)	Pre -test counselling, post-test counselling, follow -up counselling, referrals
		STI control and management	Screening and treatment of STIs, training on STI syndromic management,
		Condom and lubricant programming	Condom and lubricant forecasting and quantification, Condom and lubricant procurement and distribution systems
		PMTCT	Reproductive and allied health services including FP, ANC, postpartum/natal care; HIV treatment, care and support for PMTCT

Target population	Component	Interventions	Activities
	Structural	Advocacy	Advocacy meetings, marches, press releases, position paper, communiqués, petitioning, letter -writing campaigns, debating to: • support the implementation of SRH and FLHE • protect the rights of the child[d]
		Curriculum based intervention	FLHE
		Dialogue	PTA Parent child communication
		Income generating activities	Partnerships with relevant public and private sector organization and entities, formation of cooperatives, provision of vocational skills training, provision of seed capital to beneficiaries, financial management
		Youth-friendly services	Provision/integration/creation of gender sensitive youth-friendly services/centres Creation of safe spaces

[d]For further guidance please refer to the National Response Plan for preventing and responding to violence against children (VAC) in Nigeria (Federal Ministry of Women Affairs 2015).

5.4 Summary of the Roles and Responsibilities of Key Stakeholders that Should Be Engaged in the Implementation of the AYP Strategy

S/No	Stakeholders	Coordination roles and responsibilities
1.	NACA	• Provide guidance for implementation of the National HIV and AIDS Strategy for AYP • Coordinate the implementation of the AYP Strategy • Establish, support, and facilitate the functioning of a multidisciplinary implementation committee • Mobilise sustainable resources for the implementation of the AYP Strategy • Establish and maintain an up-to-date database on AYP programmes, institutions, personnel, data, and reports • Facilitate collaboration between key stakeholders engaged with AYP-focused HIV programming • Facilitate dissemination and access to information on outcomes of the AYP HIV programmes nationally, regionally, and internationally • Facilitate the timely and periodic review of the AYP Strategy to ensure responsiveness to the dynamics of the HIV epidemic among AYP
2.	State Management Team (SMT)	• Supporting SACA's role as the coordination authority for the state • Strengthen advocacy and ownership amongst strategic stakeholders in the state HIV and AIDS response especially with the State Chief Executive Governor, Legislature etc. • Ensure state driven and state led HIV response and ownership of programme activities • Advocate for stronger linkages of the state HIV response with other development sectors in policies, and medium- and long-term plans • Ensure the constitution and functionality of the required prevention technical working group (TWG)/sub-committee
3.	SACAs	• SACAs perform similar functions to NACA at the state level. • Establish and maintain an up-to-date database on AYP programmes, institutions, personnel, data, and reports. • Actively partner with stakeholders and provide linkages in the design, implementation, and monitoring and evaluation of the MDA's HIV prevention-related activities. • Establish, encourage, and promote training programs for the human resources required to operationalize the AYP Strategy. • Mobilise resources.

S/No	Stakeholders	Coordination roles and responsibilities
4.	LACAs	• LACA performs similar functions to SACA at the local government level. • Establish and maintain and up-to-date database on AYP programmes, institutions, personnel, data, and reports . • Advocate mainstreaming AYP into the activities of all federal, state, and local government departments . • M obilis e resources. • Monitor and evaluate all activities at the local government level . • Develop and strengthen human resource capacity for effective management of the federal, state, and local government department responses.
5.	NPTWG	• Provide technical assistance and mentoring to the State Prevention TWG and relevant stakeholders involved in implementation of the HIV response. • Provide technical leadership for the imple mentation, monitoring, review, and evaluation AYP HIV programmes • Identify, develop, and undertake periodic review of AYP - related HIV priority research issues, needs, and agenda for the country in collaboration with relevant stakeholders • Facilitate the tec hnical review of AYP HIV programme proposals to be sponsored or endorsed by NACA and ensure they are in line with nationally -defined needs, priorities, and agenda. • Facilitate the implementation of the AYP Strategy. • Identify possible resource base s (human, material, infrastructure, and financial) necessary for the implementation of the AYP Strategy. • Evaluate and make recommendations on the implementation of the AYP Strategy to NACA, and to other stakeholders as may be required.
6.	State Prevention Technical Working Group	• Perform similar functions to the NPWTG at the state level. • Support LACA in implementing AYP HIV/AIDS programmes and coordinating the response at the community levels .
7.	MDAs	• Coordinate sectoral response in respective ministries (MOE, MOH, MWASD, MOY) at federal and state levels . • Ensure that provisions are made to support workplace HIV programmes for AYP. • Ensure provision of adequate human, material, and financial resources for the implementation of HIV prevention programmes that are related to their area of mandate. • Implement the areas of the AYP Strategy as relevant to their mandates. • Mobilise resources for implementation of programmes for AYP. • Partner with private sector for implementation of initiatives for AYP

S/No	Stakeholders	Coordination roles and responsibilities
8.	CSOs	• Play frontline role in advocating for adequate and timely funding to support implementation of AYP HIV programmes . • Work closely with established networks to ensure prompt implementation and programmatic oversight of the AYP Strategy at national, state, and community levels . • Responsible for AYP HIV programme data collection and transmission accordingly. • Sensitise and mobilize communities to participate in AYP HIV programme activities.
9.	Implementing/ Development partners	• Provide technical support to the national response at national and sub -national levels. • Participate on all platforms for the implementation of the AYP Strateg y. • Share the results and data of AYP HIV interventions with the Government of Nigeria and other relevant stakeholders.
10.	Organized private sector (i.e. , Nigerian Business Coalition Against AIDS – NIBUCAA)	• Ensure proper coordination and implementation of workplace HIV programmes for AYP. • Actively partner with stakeholders to implement the AYP Strategy. • Support human capacity development for the implementation of the AYP Strategy.
11.	Community leaders	• Serve as gatekeepers to ensure a conducive environment for the implementation of the AYP HIV programmes at the community level. • Ensure that the rights of the community and community members are protected • Facilitate community mobilization for effective implementation of the AYP Strategy
12.	AYP HIV/AIDS programme beneficiaries	• Provide feedback on services received, i.e , quality, acceptability, accessibility. • Participate in design, planning, implementation, and monitoring and evaluation of activities.
13.	AYP living with HIV	• Take responsibility for the coordination and implementation of the Greater Involvement of Adolescent and Young People Living with HIV/AIDS (GIPA)/Meaningful Involvement of Adolescent and Young People Living with HIV/AIDS (MIPA) initiative. • Provide feedback on services received, i.e ., quality, acceptability, accessibility. • Participate in design, planning, implementation, and monitoring and evaluation activities. • Sensitise and mobilize peers, support groups within the communities to participate in AYP HIV programme activities. • Partner with service providers and other stakeholders implementing AYP HIV programmes.

S/No	Stakeholders	Coordination roles and responsibilities
14.	Media	• Provide support through their various platforms to the national response for effective coordination and implementation of the AYP Strategy. • Provide holistic and frequent reportage on AYP - related HIV/AIDS HIV/AIDS issues. • Document successes and gaps in the national and sub - national AYP HIV/AIDS response.

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