

**FEDERAL REPUBLIC OF NIGERIA**

**NATIONAL POLICY ON THE HEALTH AND DEVELOPMENT OF  
ADOLESCENTS AND YOUNG PEOPLE IN NIGERIA:  
2020-2024**

**(Revised Policy)**

**Federal Ministry of Health,  
Nigeria**

**November 2019**

## Foreword

## **Acronyms and Abbreviations**

AYFHS	Adolescent and Youth-Friendly Health Services
AYPHD	Adolescent and Young People's Health and Development
CEDAW	Convention on Elimination of All Forms of Discrimination against Women
CRPD	Convention on the Rights of Persons with Disabilities
CSOs	Civil Society Organisations
DALYs	Disability-Adjusted Life Years
DPRS	Department of Planning, Research and Statistics
ERGP	Economic Recovery and Growth Plan
FCT	Federal Capital Territory
FGM/C	Female Genital Mutilation/Cutting
FLHE	Family Life and HIV Education
FMoH	Federal Ministry of Health
GASHE	Gender, Adolescent, School Health and Elderly
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HPV	Human Papilloma Virus
ICPD	International Conference on Population and Development
LGA	Local Government Area
M&E	Monitoring and Evaluation
MHM	Menstrual Hygiene Management
MICS	Multiple Indicator Cluster Survey
NAHDWG	National Adolescent Health and Development Technical Working Group
NCDs	Non-Communicable Diseases
NDHS	Nigeria Demographic and Health survey
NEET	Not in Education, Employment or Training
NGOs	Non-governmental Organisations
NHMIS	National Health Management Information System
PHC	Primary Health Care
PHCUOR	Primary Health Care Under One Roof
PMA	Performance Monitoring and Accountability
RMNCAH+N	Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition
SAHDWG	State Adolescent Health and Development Technical Working Group
SAYPHIN	Society for Adolescent and Young People's Health in Nigeria
SDGs	Sustainable Development Goals
SMoH	State Ministry of Health
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Rights
SRR	Sexual and Reproductive Rights
STIs	Sexually Transmitted Infections
TB	Tuberculosis
UHC	Universal Health Coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
VAPP	Violence Against Persons (Prohibition) Act

## Table of Contents

1.	INTRODUCTION .....	1
1.1.	Background to Policy Development .....	1
1.2.	Rationale for Policy .....	2
1.3.	Target Population .....	3
1.4.	The Context for Policy Development .....	3
1.4.1.	The National Context .....	4
1.4.2.	The Regional Context for Policy Development .....	5
1.4.3.	The Global Context for Policy Development .....	5
1.5.	The Process of Policy Development .....	6
2.	SITUATION ANALYSIS .....	<del>7</del> 8
2.1.	Demographics of Adolescents and Young People in Nigeria .....	<del>7</del> 8
2.2.	Health Status and Risk Factors among Adolescents and Young People .....	<del>7</del> 8
2.2.1.	Sexual and Reproductive Health and Rights .....	<del>8</del> 9
2.2.2.	Mental Health, Substance Use, and Addictions .....	<del>10</del> 11
2.2.3.	Violence and Injuries .....	<del>12</del> 13
2.2.4.	Nutrition and Physical Activity .....	<del>12</del> 13
2.2.5.	Non-Communicable Diseases .....	<del>13</del> 14
2.2.6.	Disabilities .....	14
2.2.7.	Communicable diseases .....	<del>14</del> 15
2.2.8.	Oral Health .....	15
2.2.9.	Socially Marginalized and Most Vulnerable Adolescents and Young People .....	<del>15</del> 16
2.3.	Factors Associated with Health Status of Adolescents and Young People .....	<del>16</del> 17
2.4.	Responses and Interventions .....	<del>19</del> 20
3.	POLICY DECLARATIONS AND GUIDING PRINCIPLES .....	23
3.1.	Underlying Principles and Values .....	23
3.2.	Policy Declarations .....	24
4.	VISION, MISSION, GOAL, STRATEGIC OBJECTIVES, AND KEY STRATEGIES .....	26
4.1.	Vision .....	26
4.2.	Mission .....	26
4.3.	Goal .....	26
4.4.	Strategic Objectives .....	26
4.5.	Key Implementation Strategies .....	27
5.	PRIORITY PROGRAMMATIC AREAS AND TARGETS .....	29
5.1.	Priority Programmatic Areas .....	29
5.2.	Targets .....	29
5.2.1.	Sexual Reproductive Health and Rights .....	29
5.2.2.	Mental Health, Substance Use, Addiction. ....	30
5.2.3.	Violence and Injury .....	31
5.2.4.	Nutrition and Physical Activity .....	31
5.2.5.	Non-Communicable Diseases .....	31
5.2.6.	Disabilities .....	32
5.2.7.	Communicable Diseases .....	32
5.2.8.	Oral Health .....	32
5.2.9.	Health system and services .....	32
5.2.10.	School health system and services .....	33

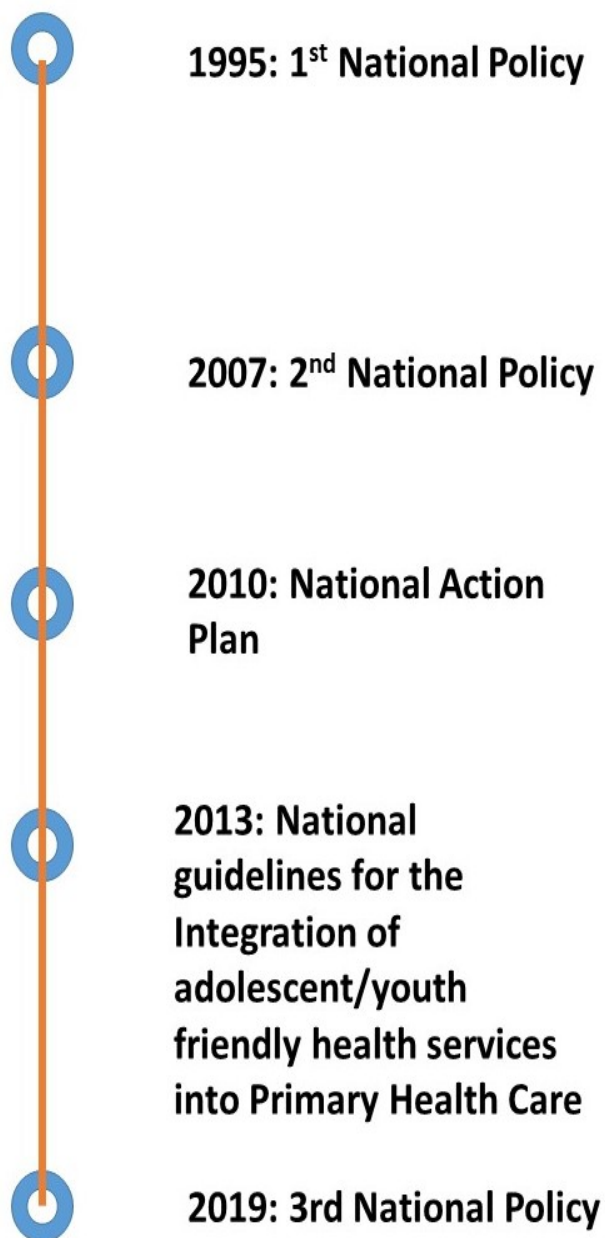
5.2.11.	Family and community systems .....	33
6.	POLICY IMPLEMENTATION.....	34
6.1.	Multisectoral agenda and principles in the policy implementation .....	34
6.2.	Role of the Health Sector .....	34
6.2.1.	Federal Ministry of Health .....	34
6.2.2.	State Ministries of Health .....	35
6.2.3.	Local Government Health & Related Social Development Departments.....	36
6.3.	Role of Other Government Ministries and Agencies .....	36
6.3.1.	The Legislature .....	36
6.3.2.	Ministry of Education.....	37
6.3.3.	Ministry of Women Affairs .....	37
6.3.4.	Ministry of Youth and Sport Development.....	38
6.3.5.	Ministry of Finance .....	38
6.3.6.	Ministry of Justice .....	39
6.3.7.	Ministry of Budget and National Planning.....	39
6.3.8.	Ministry of Information and National Orientation .....	39
6.3.9.	Ministry of Agriculture and Rural Development.....	39
6.3.10.	Ministry of Labour and Productivity .....	40
6.3.11.	Ministry of Works and Housing.....	40
6.3.12.	Ministry of Power .....	40
6.3.13.	Ministry of Interior .....	40
6.3.14.	Ministry of Humanitarian Affairs, Disaster Management and Social development.....	40
6.3.15.	National Population Commission.....	41
6.3.16.	National Bureau of Statistics .....	41
6.3.17.	National Commission for Persons with Disabilities .....	41
6.4.	The Armed Forces, Other Uniformed Services and Security Agencies .....	41
6.5.	Non-State Actors .....	42
6.5.1.	Faith-based Organisations .....	42
6.5.2.	Non-Governmental Organisations.....	42
6.5.3.	Professional and Learned Societies .....	42
6.5.4.	Academia, Tertiary Education Institutions, and Research Institutes .....	43
6.5.5.	Organized Private Sector .....	43
6.5.6.	Political Parties.....	43
6.5.7.	Media .....	43
6.6.	Young People.....	44
7.	MONITORING, EVALUATION, ACCOUNTABILITY, AND LEARNING .....	45
7.1.	Coordination and Oversight for Monitoring, Evaluation, Accountability, and Learning.....	45
7.1.1.	Oversight Function by the National Technical Working Group .....	45
7.1.2.	Coordination Function by the Adolescent Health-focused Division of FMOH ..	46
7.2.	Monitoring and Evaluation.....	46
7.2.1.	Monitoring Process .....	46
7.2.2.	Evaluation and Review Processes .....	47
7.3.	Research .....	47
7.4.	Development of evidence-related products and promotion of learning platforms.	48
7.5.	Accountability Mechanisms and Actions .....	48

7.6. Adolescent and youth engagement .....	49
MATERIALS CONSULTED .....	50

## 1. INTRODUCTION

### 1.1. Background to Policy Development

Adolescence is the pivotal period of transition from childhood to adulthood and offers the opportunity for consolidation of the earlier health investments in the childhood years and for laying the critical foundation for a healthy adulthood. Investments in adolescent health and wellbeing bring



a triple dividend of benefits in terms of the life cycle impact– benefits to adolescents in their current phase of life, benefits in terms of their future adult life, as well as benefits for the next generation of children who the adolescents would be parents to<sup>1</sup>. At the community and societal levels, investments in adolescent health are key to achieving population health and sustainable development. Furthermore, appropriate investments in adolescents and young people’s health and development have the potential to transform national economies, facilitate the achievement of demographic dividends and engender development. As the *African Union Roadmap on Harnessing the Demographic Dividend through Investments in Youth* notes, national development aspirations will be impossible to achieve without adequate investments in the lives, health, and development of young people.

Additionally, investments in adolescents and young people are integral to the global developmental agenda, including the sustainable development goals (SDG) and universal health coverage (UHC). Globally, young people have been acknowledged as a major group for driving transformative changes in global health and development. In the words of the United Nations Secretary-General, adolescents are “central to everything we want to achieve, and to the overall success of the 2030 Agenda.”<sup>2</sup>

Nigeria duly recognises the potentials and importance of investing in the health and development of adolescents and young people and has given considerable attention and increasing priority to this important population group in her national agenda over the years. Among others, the country acknowledges the need for an effective policy framework as an instrument of collective national aspirations and a guide for appropriate programmatic actions and interventions aimed at improving the health and well-being of adolescents and young people. In that regard, Nigeria developed her first National Policy on Adolescent Health in 1995. That Policy was succeeded by the National Policy on the Health and

Development of Adolescents and Young People in 2007 and with a complementary National Strategic Framework developed. In addition, Nigeria developed the National Action Plan on the Health and Development of Adolescents and Young People in 2010 to facilitate the improved implementation of the national policy. With a time lapse of about 10 years after the development of the last policy, the move to revise the policy to better respond to current and emerging issues in the field of adolescent and young people's health culminated in a national stakeholders' consultative forum and the formal onset of the policy revision exercise in 2018. Resulting from that national process, this new policy was developed in 2019 and designed to provide the strategic direction for improving the health and development of adolescents and young people in Nigeria as well as to reenergise the national commitment and stakeholders' engagement in this important agenda.

## **1.2. Rationale for Policy**

Adolescence is a critical stage of life and adolescents are a distinct population group with unique potentials as well as peculiar needs. Adolescents navigate through a complex set of developmental issues as significant biological, psychological, cognitive, spiritual and social changes take place during this crucial formative stage. Adolescents are energetic, still undergoing brain development, have expanding social networks and assume increasing responsibilities at household and community levels. They also have the propensity for experimentation, novelty-seeking, and risk-taking. These characteristics and developmental tasks may increase their engagements in some health-risky behaviours with potentials for poor health outcomes. Adolescents need appropriate support from parents, care providers, other stakeholders, as well as community and social systems, among others, to engage successfully with their new biological, emotional and psychosocial contexts and to eventually transit to healthy and productive adults. Addressing the health and related needs of adolescents and young people requires specific interventions that take due cognisance of their developmental context, tasks, interests, and characteristics.

In addition, adolescents and young people are a major demographic force as they constitute more than a fifth of the world's population and the current generation of adolescents is the largest cohort in history. In Nigeria and other African countries, the adolescent population is expected to increase progressively beyond 2050. Actions and inactions relating to adolescent and young people's health and development, therefore, have direct consequences for the overall health status of the nation as well as its demographic and developmental trajectories. Among others, achieving demographic dividends – the accelerated economic growth that may result from a rapid decline in a country's fertility and the subsequent change in the population age structure – will be impossible without adequate, strategic and multiple investments in the health and development of adolescents and young people. Investments in appropriate sexual and reproductive health and family planning services to achieve an economically favourable age structure is critical in this respect, along with the provision of quality education and opportunities for decent employment and recreation.

Ensuring quality health care for adolescents and other young people is also crucial to the universal health coverage agenda. As the World Health Organization (WHO) notes, universal coverage requires that appropriate and effective interventions for improving adolescent health and development are available and that adolescents and other stakeholders are well aware of these services.<sup>3</sup> There is, therefore, a clear need to develop and effectively implement a policy specifically targeted at improving the health and development of adolescents and young people. Developing such a policy that is fully supportive of young's people health and development as well as respects, protects and fulfils their rights to health is one of the key responsibilities of the health sector.<sup>4</sup>

Over the last decade, Nigeria has experienced significant changes in the health trends of her young people, alongside a remarkable transformation of the social and political contexts in which her adolescents and young people are growing and functioning. These changes are also evident in the



determinants of health and behavioural patterns relating to young people. Among others, Nigeria has experienced significant changes in her education, information and communication technology, legal, economy, gender-related and social norms, as well as political landscapes. The policy context and programme frameworks in the health and youth/adolescent domain have also significantly changed with time. In addition, the forces of globalisation and global youth culture also impact directly and indirectly on adolescents and young people in Nigeria, even as global development agenda exerts influences on national policy thrusts. These changes in the national and international context, some of which are highlighted in the development context of this new policy, have significant implications for efforts to improve the health and well-being of adolescents and young people in Nigeria.

Overall, the context, challenges and the programming landscape for adolescents in Nigeria in the current dispensation is strikingly different from that of the adolescents a decade back – when the last national adolescent health policy was developed. This reality provides a strong rationale and justification for the revision of the 2007 national policy. This new Policy, while building on the foundation of the previous policies, seeks to provide a framework that responds adequately to the health needs and situations of young people in the context of the present time and the immediate future, with the aim of informing programmes that would enable adolescents and young people to attain the highest possible level of health and well-being. As the Global Strategy on Women's, Children's and Adolescents' Health (2016-2021) emphasizes, *“By investing in the right policies and programmes for adolescents to realize their potential and their human rights to health, education and full participation in society, we can unleash the vast human potential of this ‘SDG Generation’ to transform our world.”*

### **1.3. Target Population**

The 2007 National Policy on the Health and Development of Adolescents and Young People adopted the United Nations' definition of 'adolescents' as individuals between the ages of 10 and 19 years, 'youth' as persons aged 15 to 24 years and 'young people' as those between the ages of 10 and 24 years. The Policy identified its core target group as age 10 to 24 years to cover all young people. This revised Policy builds on the platform of the 2007 Policy and retains the chronological definition of the primary target group. In essence, this Policy targets the entire age spectrum of young people, encompassing adolescents and youths, age 10 to 24 years, as its primary target population and the rights-holders.

In addition, based on the socio-ecological model, the policy also recognises the critical role of stakeholders who are duty bearers in fulfilling the national agenda and aspiration for adolescent and young people's health and development. Therefore, the Policy also secondarily targets the policy makers and relevant government ministries, departments and agencies (MDAs) as state actors and duty bearers with obligations and responsibilities for the protection, promotion, and improvement of the health of adolescents and young people. The policy also targets diverse non-state actor duty bearers, including parents, care givers, service providers in the health and other social development sectors, religious and community leaders, private sector actors, and civil society organisations engaged in the field of adolescent and young people's health and development as outlined in the policy implementation section of this document.

### **1.4. The Context for Policy Development**

Broadly, this Policy is situated within the context of Nigeria's overall development framework and the national agenda for ensuring the health and development of her young people. The Policy also takes cognisance of regional and global development frameworks that Nigeria is a signatory or party to and have significant implications for the health and development of her adolescents and young people. Overall, this Policy seeks to complement the various national efforts geared at implementing

actions to meet Nigeria's aspiration for improving the health and well-being of young people and ensuring their optimal development.

#### **1.4.1. The National Context**

The *constitution of the Federal Republic of Nigeria* assures the rights of every citizen to health and development and, in that context, this Policy affirms the rights of all adolescents and young people in Nigeria to the highest standard of health and well-being, irrespective of tribe and ethnicity, gender, religion, geographies, economic level, physical status, and mental capacities or any other personal or socio-demographic attributes. *Vision 20:2020* expresses Nigeria's aspiration to become one of the top twenty economies in the world by the year 2020 and provides an overarching framework for the country's developmental agenda. The *Economic Recovery and Growth Plan* (ERGP), which is Nigeria's medium term development plan for 2017-2020 has "investing in people" as one of its main pillars and emphasises investment in adolescents and young people as part of the national aspiration for achieving the demographic dividend. The National Roadmap to harnessing Demographic Dividends in Nigeria, launched in 2017, further emphasises investments in young people and sexual and reproductive health, among others, as strategic to realising demographic dividends. This Policy is framed within the context of these national development agenda, recognizing the central place of healthy and well-developed young people in transforming the national economy and ensuring the country's future and sustainable development.

In terms of the national health development agenda, the National Health Act, the National Health Policy (2016), and the Second National Strategic Health Development Plan (2018-2022) provide the overall policy guides for Nigeria. Together, these documents set an important context for the articulation of national policy directions for the health of adolescents and young people. Other important policy documents that this Policy aligns with and rests on include the *National Policy on Population for Sustainable Development*, the *National Youth Policy*, and the *Child Rights Act*. The population policy aims at improving the quality of life of all people in Nigeria and affirms the importance and key role of young people in that agenda. The National Youth Policy emphasises the provision of equal opportunities to people age 15-29 years to realise their dreams and aspirations and optimise their contributions to national development. The Youth Policy, among others, has "health services and healthy behaviour" as one of its strategic thrust, with the Ministry of Health recognised as the lead agency for achieving the objective of "improving the access to, and quality of youth-related health services." The Child Rights Act covers all individuals aged 0-18 years and stipulates, among others, their rights to enjoy the best attainable state of physical, mental and spiritual health." Education is a major determinant of adolescent health and HIV is still a major health and development concern relating to young people in Nigeria: In that regard, the *National HIV Strategy for Adolescents and Young People* (2016-2020), the *National Education Policy* as well as the *National School Health Policy* set part of the context for this new policy and its agenda.

Nigeria, through the Federal Ministry of Health (FMoH) and its parastatals, has developed several important health-related implementation strategies that are of key importance to improving the health and well-being of adolescents and young people. These include the *National Reproductive, Maternal, Newborn, Child, Adolescent Health and Nutrition [RMNCAH+N] Strategy* (2018-2022), the *National Strategy for Reproductive, Maternal, Newborn, Child and Adolescent Health Quality of Care*, the *National Standards and Minimum Service Package for Adolescent and Youth-Friendly Health Services*, the *National Guidelines for the Integration of Adolescent and Youth-Friendly Health Services into Primary Health Care*, the *National Guidelines on Promoting Access of Young People to Adolescent and Youth Friendly Services in Primary Health Care Facilities*, the *Task-shifting and Task-sharing Policy for Maternal and Newborn Health Care*, and the *Primary Health Care Under One Roof* (PHCUOR) agenda. The provisions of these documents, in fundamental ways, resonate with and make a useful contribution to the agenda of improving the quality and coverage of health

services for adolescents and young people. Thus, the Policy aligns with the provisions of these documents as it relates to young people's health and development.

#### **1.4.2. The Regional Context for Policy Development**

Nigeria is a signatory to several regional Treaties, Conventions, Protocols, and Charters that recognize adolescents' and young people's rights to health and development opportunities. *The African Youth Charter, The Protocol to the African Charter on Human and People's Rights on the Rights of Women in Africa (Maputo Protocol), the Maputo Plan of Action 2016-2030, and the Continental Policy Framework for the Promotion of Sexual and Reproductive Health and Rights in Africa* are particularly important in this regard. The African Youth Charter recognises the right of every young person to enjoy the best attainable state of physical, mental and spiritual health as well as developmental opportunities like education. The Maputo Protocol, the Maputo Plan of Action, and Continental Policy Framework on Sexual and Reproductive Health and Rights identify young people's sexual and reproductive health and rights as an area of major focus in the context of achieving universal access to comprehensive sexual and reproductive health services in Africa. As part of the commitment towards improving the health of the citizens, Nigeria and the other Member States of the African Union committed to the *Abuja Declarations* with the provision of allocating at least 15% of their budget to health. This policy recognises, reiterates, and relate intimately with Nigeria's commitment to these regional agenda.

#### **1.4.3. The Global Context for Policy Development**

At the global level, Nigeria has made a commitment to several initiatives and agenda on health and development and fully supports and adopts policy thrusts that have the potentials to contribute to the health and development of her population, including adolescents and young people. These include the *Sustainable Development Goals (SDGs), The International Conference on Population and Development (ICPD) and the ICPD Beyond 2014 follow-up action, the Convention on Elimination of All Forms of Discrimination against Women (CEDAW), the Convention on the Rights of Persons with Disabilities (CRPD) and the Universal Health Coverage (UHC).*

The thrust of the third goal of the SDGs is to ensure healthy lives and promote well-being for all at all ages. SDG 4 ("Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all") and SDG 5 ("Achieve gender equality and empower all women and girls"), among others, are also important to the adolescent health agenda. The ICPD and the follow-up action advocates universal access to sexual and reproductive health services and have a strong focus on adolescents and young people. CEDAW upholds the reproductive rights of women of all ages. Article 12 of CEDAW focuses on health and calls on State Parties to eliminate discrimination against women that serves as barriers to health care access and to ensure the availability of appropriate maternal health services. CRPD reaffirms that all persons with all types of disabilities must enjoy all human rights and fundamental freedoms. Article 25 of the CRPD focuses on health and requires State Parties to "take all appropriate measures to ensure access for persons with disabilities to health services that are gender-sensitive, including health-related rehabilitation."

UHC aims to ensure that all people have access to needed health services of sufficient quality without financial difficulties. The *Global Strategy for Women's and Children's Health (2016-2030)*, which replaces the erstwhile *Global Strategy for Women's and Children's Health (2010-2015)*, is designed to serve as a roadmap to achieve the highest attainable standard of health for all women, children, and adolescents globally. In tandem with that, the recently developed *Global Accelerated Action for the Health of Adolescents (AA-HAI)* focuses on translating the Global Strategy into actions for specifically improving adolescent health. With its focal themes as "staying healthy", "comprehensive education", "families, youth-rights and well-being, including sexuality", "transition to decent work", and, "leadership and meaningful participation", the *Bali Global Youth Declaration*

calls for greater investment in the health and development of young people and makes an important contribution to the global advocacy for adolescent health. This Policy recognises the relevance of these documents to Nigeria's adolescent health agenda and they constitute important elements in the global context for this policy development.

### **1.5. The Process of Policy Development**

This Policy has been developed through an evidence-based, consultative and collaborative process with strong youth participation and cross-sectoral partnership. The National Adolescent Health and Development Technical Working Group (NAHDWG), which is the multi-stakeholder and cross-sectoral national technical advisory body to the Federal Ministry of Health, formally initiated the process of developing a revised National Policy on the Health and Development of Adolescents and Young People in 2018.

The major stages in the process of developing this revised policy include the following:

- *Review of progress on the implementation of the last policy and generation of evidence on the current status of adolescent and young people's health:* the key activities included (i) extensive multi-stakeholder dialogue on the adolescent health trends and needs in Nigeria on the platform of the NAHDWG; and, (ii) commissioning of two specific studies – a national landscape study and an assessment of barriers to accessing health services for disadvantaged adolescents. The findings of the studies were reviewed at a national forum, and their implications for a new policy extensively discussed;
- *National stakeholders policy workshop:* this one-week workshop enabled stakeholders drawn from various parts of the country and sectors, and with a strong representation of young people, to collaboratively determine the focus, key priorities, and objectives of the new policy as well as roles and responsibilities for implementing the policy;
- *Engagement of an experienced national consultant and production of an initial draft of the policy document:* this stage featured the engagement of a national consultant to work with, refine and further develop the product from the stakeholders' policy workshop. The consultant's role entailed: (i) Further review of the literature and scientific evidence on the status, trends and programming experiences on adolescent health and development in Nigeria, including the technical presentations made at the 1<sup>st</sup> Nigeria's National Conference on Adolescent Health held in April 2019; (ii) Review of key peer-reviewed and grey literature on global adolescent health statistics, trends, and interventions; (iii) review of relevant global and national policy documents regarding the health of adolescents and young people. The first draft of the policy was developed by the consultant, informed by the national stakeholders' consensus documents, the intensive review, and documented best practices in adolescent health policy-making and programming, and his extensive knowledge of the adolescent health field nationally and internationally;
- *Stakeholders' review of the initial draft of the policy and revision of the initial draft:* The draft document was widely shared with stakeholders, including young people and youth-led organisations, for their review and comments, which were duly considered in revising the draft document;
- *Finalisation and national adoption of the draft policy document:* A national meeting incorporating the NAHDWG and other stakeholders was organised for a final review and adoption of the policy; and,
- *Final approval processes:* The draft policy was processed for the approval of the leadership of the Federal Ministry of Health and the National Council on Health – the highest decision-making body on health in Nigeria.

## 2. SITUATION ANALYSIS

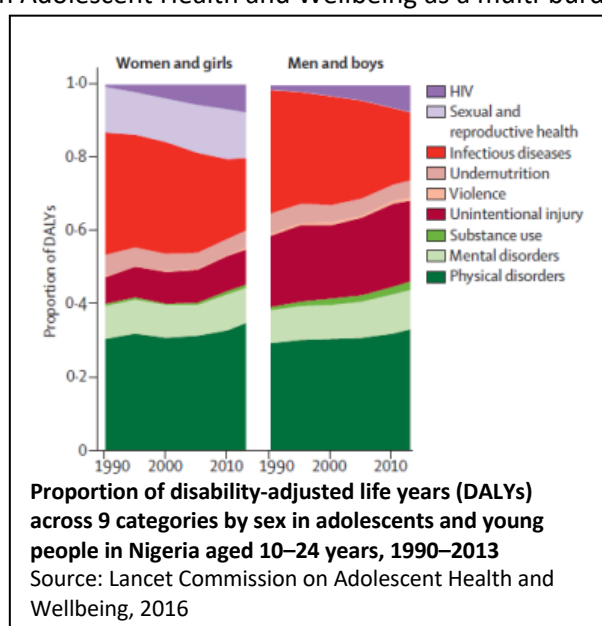
### 2.1. Demographics of Adolescents and Young People in Nigeria

According to the most recent national population and housing census (the 2006 Census), adolescents (10-19 years) constitute 22% of Nigeria's population while young people (age 10-24 years) as a whole constitute almost a third (32%). The 2019 population projection from the United Nations also estimates that 32% of Nigerians are aged 10-24 years<sup>5</sup>. The UN also projects Nigeria's population to be 200,964,000 (99,132,000 females and 101,832,000 males) by mid-year 2019<sup>6</sup>. Thus, Nigeria has about 64.3 million young people as of the time of developing this policy in 2019. Young people in Nigeria are diverse and heterogeneous in terms of socio-demographic characteristics, health needs, and social and health vulnerabilities.

Among others, adolescents and young people living with disabilities have a higher level of vulnerabilities, less access to health services, and specific health needs. Young people living in urban slums and in households with extreme poverty, those on the streets, those living in conflict areas and in humanitarian situations including those displaced from their home settings by conflicts, young people in remote and disadvantaged communities, young people who are not in education, employment or training (NEET), married adolescents and teenage parents also have higher vulnerabilities compared to their peers. The girl-child is also disadvantaged compared to her male peer due to gender-inequitable social norms that constrain her opportunities, choices, voice, and agency, as well as her sexual and reproductive rights and access to health services. Younger adolescents (age 10-14 years) are also disadvantaged based on inadequate programming focus. Adolescents living with HIV and sexual minorities may face discrimination and greater barriers to health services. With the vision that “no adolescent or young person is left behind”, in line with the SDGs and UHC, this policy recognises the need for specific actions to effectively respond to the needs of different categories of adolescents and young people with various levels of vulnerabilities and to remove barriers constraining the access of any subgroup to relevant services and opportunities for improved health, well-being, and development.

### 2.2. Health Status and Risk Factors among Adolescents and Young People

Nigeria is classified by the Lancet Commission on Adolescent Health and Wellbeing as a multi-burden country in terms of adolescent health based on a high burden of poverty-related diseases – infectious diseases, nutritional deficiency, and sexual and reproductive health. Nigeria is also simultaneously experiencing an increasing rate of non-communicable conditions and behavioural risk factors. Overall, the leading health challenges among adolescents and young people in Nigeria are issues of sexual and reproductive health and rights, mental health disorders, substance use, nutritional problems, violence, and injuries. Physical disorders and chronic conditions such as asthma, sickle cell disease disorders, and oral health problems also constitute a high burden among adolescents and young people. In addition, communicable diseases contribute significantly to the health burden among adolescents and young people in Nigeria.



### 2.2.1. Sexual and Reproductive Health and Rights

*Puberty-related concerns:* Knowledge about puberty and the accompanying changes is low among adolescents in Nigeria, as a result of which a high proportion responds to pubertal changes with shame, confusion, and anxiety.<sup>7</sup> Puberty-related concerns, including personal hygiene, early signs of sexual maturation, acne, body odour, menstrual issues, and psycho-social issues rank high among health-related concerns in early adolescence (10-14 years). These concerns are often left unaddressed by health workers while parents and teachers are poorly prepared to meaningfully engage adolescents in discussion of pubertal issues. Menstrual hygiene management (MHM) is a challenging issue for many adolescent girls and young females in Nigeria, particularly among rural-based and economically disadvantaged groups, as they have poor MHM-related knowledge and inadequate access to appropriate sanitary materials<sup>8</sup>. Findings from the Performance Monitoring and Accountability (PMA) 2020 indicated that only 37% of women aged 15–49 who were still menstruating had everything they need to manage their menstruation in 2015<sup>9</sup>: the situation is likely to be worse for adolescents and youths. The inadequacy of water and sanitation facilities in schools, homes, and work settings exacerbate the MHM challenge. According to participatory research undertaken in the public school setting in a South West Nigerian town, early adolescents (aged 10-14 years) identified both inadequate knowledge of menstrual issues and lack of sanitation facilities in schools as two of their leading challenges.<sup>10</sup> Menstruation-related issues can affect the quality of life of adolescent girls and negatively impact their psychological well-being, physical activities, school attendance, and academic performance. The use of unhygienic measures in the management of menstruation can lead to infections that may pose a threat to the future fertility of young girls.

*Sexual activity, contraception, unintended pregnancy, and abortion:* The level of unprotected sex is fairly high among adolescents (aged 15-19 years) and youths (aged 20-24) in Nigeria as reported by the 2018 Nigeria Demographic and Health survey (NDHS). Among adolescents, 35% of females and 10% of males are sexually experienced. Among youths, 86% of females and 47% of males are sexually experienced. Only 28% of unmarried sexually active female adolescents (15-19 years) use any method of contraceptives and 22% use modern contraceptive methods. Among unmarried female youths, 32% are current users of any method of contraceptives and 28% current users of modern contraceptive methods. Also, only 32% of female adolescents, 34% of male adolescents, 38% of female youths and 41% of male youths used a condom at the last sex with a non-marital, non-cohabiting partner within the last 12 months before the 2018 NDHS.

Nigeria has a high burden of unintended pregnancies and induced abortion. Nigeria was estimated to have an unintended pregnancy rate of 59 per 1,000 women aged 15–49 in 2012, with over a half (56%) of the unintended pregnancies ending up in induced abortion.<sup>11</sup> A total of 1.25 million induced abortions was estimated to have been carried out in Nigeria in 2012 with an abortion rate of 33 abortions per 1,000 women aged 15–49<sup>11,10</sup>. Unmarried adolescents and young people with unintended pregnancy have a high tendency to resort to abortion and constitute a significant proportion of the overall abortion figure. The law in Nigeria permits abortion only on the ground of saving a mother's life; as such, a high proportion of the abortion among young people is carried out clandestinely and likely to be performed by inappropriate personnel or/and using inappropriate methods. Consequently, the level of morbidity and mortality from such unsafe abortions is high. A prospective study published in 2019 indicates that adolescents constituted over a quarter (31%) of induced abortion complications recorded over a one-year period across nine secondary and tertiary healthcare facilities in South West Nigeria.<sup>12</sup> The use of medical abortion, particularly misoprostol, is also growing in Nigeria, particularly among young people.<sup>13,14</sup>

*Early marriage and childbearing:* In 2018, as the NDHS reports, almost a fifth (19%) of adolescent females (age 15-19 years) have begun childbearing, of which 14% already had a live birth while the remaining are pregnant with their first child. This figure represents a slight improvement over the situation in 2013 where 23% of adolescent females had begun childbearing. Adolescent girls in the North West are almost five times as likely to have begun childbearing as their peers in the South West (29% versus 6%). The 2018 NDHS reported the age specific fertility rate for adolescent girls (15-19 years) as 106/1,000 for 2015-2018 compared to a higher 122/1,000 for the 2010-2013 period. Early marriage contributes significantly to the high childbearing rate among adolescents in Nigeria, with 8% of adolescent girls married before age 15 and 23% in union (married or living together with partner). The rate of early marriage and childbearing is much higher in northern Nigerian than the south, and among the low educated compared to those with higher education as well as among the rural-based young people compared to their urban peers.

Pregnant adolescents in Nigeria have a lower level of utilisation of maternal health services compared to older women and experience a higher level of maternal morbidity and mortality. Obstetric fistula is a severe maternal condition that results from prolonged labour and its risk is higher among adolescents compared to older women. The typical profile of an obstetric fistula patient in Nigeria, as the National Strategic Framework on the Elimination of Obstetric Fistula (2019-2023) notes, is “a young, poor, illiterate rural girl who had been given out in marriage at a very early age, became pregnant soon after, had no benefit of antenatal care, laboured at home for days and ended up with a stillbirth and obstetric fistula.” Nigeria is reputed to have the highest burden of obstetric fistula in the world: the National Strategic Framework indicates that Nigeria contributes about 8% of the global obstetric fistula burden. Addressing maternal concerns of pregnant adolescents needs a comprehensive approach that covers access as well as utilisation of relevant services to reduce the risk of negative maternal and child health outcomes and provision of appropriate care to those who have experienced maternal morbidities, including obstetric fistula.

*Sexually transmitted infections, including HIV:* The preliminary result of the 2019 Nigeria HIV/AIDS Indicator and Impact Survey indicates that HIV prevalence is less than 0.5% among both male and female adolescents (15-19 years). The HIV sero-prevalence rate among youths (20-24 years) is 1.3% for females and 0.4% for males. Even at that low sero-prevalence level, given the huge population of young people in Nigeria, over 300,000 young people were living with HIV in Nigeria in 2018. It is important to recognise that due to the nature of HIV, a significant proportion of cases in older people may actually have been contracted earlier in life – in adolescence or as a youth. Overall, young people have the lowest rate of HIV sero-prevalence across the age groups in Nigeria, but the gender disparity in HIV prevalence is greatest among youth age 20 compared to any other group, with almost a four-fold level among females compared to males. The gender-disparity in HIV prevalence among youths suggests a high level of age-disparate unprotected sexual relationship among female youths. Among sexually experienced young people (15-24 years), 16% of the females and 7% of the males reported having had sexually transmitted infections (STIs) in the last 12 months prior to the 2018 NHDS. A high proportion of adolescents and young people who self-reported STI-related symptoms self-medicated or sought treatment from inappropriate sources rather than use formal health services; this tendency was higher among males compared to females.<sup>15</sup> Sexual minorities (Lesbian, gay, bisexual, and transgender, questioning/gender queer) individuals and key populations (men who have sex with men, female sex workers, and people who inject drugs) have a higher risk of HIV and other STIs compared to other population groups in Nigeria because of higher prevalence of risky sexual behaviors and poorer access to appropriate and friendly sexual and reproductive health services as a result of health workers’ discriminatory behaviours and legal provisions that criminalise their sexual behavior.<sup>16</sup>

*Sexual violence:* Sexual violence is a major sexual and reproductive health issue as well as a form of intentional injury affecting adolescents and young people in Nigeria. It is also a gross violation of human rights as well as the sexual and reproductive rights of the survivors. Evidence indicates that the level of sexual violence in Nigeria is fairly high and also increasing. Adolescents and young people, particularly females, have a higher risk of being affected than other age groups but young people also constitute a significant proportion of the perpetrators. The Nigeria Demographic and Health Survey (NDHS) indicates that a higher proportion of young women had experienced sexual violence in 2018 compared to 2013. Among adolescent women aged 15-19, 8% had experienced sexual violence in 2018 compared to 6% in 2013. Also, 3% of adolescent women aged 15-19 had experienced sexual violence in the 12 months prior to the 2018 survey compared to 2% in 12 months prior to the 2013 survey. Among youths aged 20-24, 10% had experienced sexual violence compared to 9% in 2013, while 6% had experienced sexual violence in the 12 months prior to the survey in 2018 compared to 4% who experienced sexual violence prior to the 2013 survey. Almost a fifth of married adolescent girls (19%) reported experiencing at least three of the five controlling behaviours inquired about in the 2018 NDHS from their husbands and only a third did not report experiencing any of the five controlling behaviours. The proportion of married adolescents who reported experiencing controlling behaviour from their husbands is higher than that of older women.

A high proportion of sexual violence against females, particularly unmarried females, were current or former partners/boyfriends, although strangers were also involved in a significant proportion of cases. The Violence against Children Study<sup>17</sup>, in 2014, reported that a quarter (25%) of females aged 18-24 and about a tenth (11%) of the males had ever experienced sexual violence. Of these victims, only 4% of females and 2% of males ever received services in respect of their sexual violence experience. The study further indicated that among adolescents age 13-17 years, 16% of females and 8% of males reported experiencing sexual abuse in the immediate 12 months prior to the study. Of those that reported sexual abuse within this period, 47% of the females and 35% of the males had their first experience of sexual abuse at age 13 years or earlier. Also, 64% of the females and 76% of the males had experienced multiple incidents of sexual abuse over their lifetime. Sexual violence has also been reported to be very high in conflict-affected areas, and most of the victims were unable to seek services and several unintended pregnancies and childbirths had thereby occurred.<sup>18</sup>

*Female genital mutilation/ cutting* is another form of sexual violence and violation of human rights. Nigeria has a high burden of female genital mutilation/cutting (FGM/C) but the rate is gradually declining. The prevalence of FGM/C is much lower for young people compared to the older women: 14% for adolescents (15-19 years) and 16% for youth (20-24 years) compared to 31% for women aged 45-49 years. Also, compared to 25% of women aged 15-45 years reported by the 2013 NDHS to have experienced FGM/C, the 2018 NDHS reported a lower prevalence of 20%. The prevalence of FGM/C is highest in the South East (35%) and the South West (30%) and lowest in North East (6%). It is significant to note that a higher proportion of youths (26%) support the continuation of FGM/C compared to older women (21% among women 45-49 years, for example).

### **2.2.2. Mental Health, Substance Use, and Addictions**

Worldwide, 10-20% of adolescents experience mental disorders and neuropsychiatric conditions.<sup>19</sup> About half of all mental illness begins by age 14 and three-quarters by mid-20s.<sup>20,21</sup> Although Nigeria lacks current data, a high burden of mental health obtained in 2007 – 1,987 disability adjusted life years per 100,000 population<sup>22</sup>; one-third of the burden is attributable to young people. There are indications that the rate of mental disorders has increased further in recent years. Most mental disorders are treatable, mental health problems are highly stigmatised in Nigeria, mental health literacy low, and mental health services inadequate.<sup>23</sup> Multiple factors influence the mental health of adolescents and young people, including bio-behavioural factors (for example, substance use and genetic factors), inter-personal and family factors (such as the quality of relationships with peers and



family members and extreme household poverty), and community-level factors (such as communal violence and the media). The risk of a mental disorder increases with exposure to more risk factors.

Some adolescents are at greater risk of mental health conditions due to their living conditions, stigma, discrimination or exclusion, or lack of access to quality support and services. These include adolescents living in humanitarian and fragile settings; adolescents with chronic illness, autism spectrum disorder, intellectual disability or other neurological conditions; pregnant adolescents, adolescent parents, adolescents in early and/or forced marriages; orphans; and adolescents with a high level of discrimination experience such as those of sexual minorities. Adolescents with mental health conditions are vulnerable to social exclusion, discrimination, stigma (affecting readiness to seek help), educational difficulties, risk-taking behaviours, physical ill-health, and human rights violations. It is crucial to address the needs of adolescents with defined mental health conditions and it is important to avoid institutionalization and over-medicalization, prioritise non-pharmacological approaches, and respect the rights of the affected persons.

### *Depression and anxiety*

Depression is one of the most common mental health disorders in Nigeria. The burden is higher among females, survivors of sexual abuse, and those living in conditions of extreme poverty. Globally, depression is the ninth leading cause of illness and disability among all adolescents; while anxiety is the eighth leading cause.<sup>2045</sup> Emotional disorders can be profoundly disabling to an adolescent's functioning, affecting schoolwork and attendance. Withdrawal or avoidance of family, peers or the community can exacerbate isolation and loneliness. At its worst, depression can lead to thoughts of self harm or suicide. Depression and anxiety are treatable with appropriate therapies.

### *Psychosis*

Psychotic disorders include schizophrenia, bipolar disorder, and depression. Symptoms of psychosis most commonly emerge in late adolescence or early adulthood and include hallucinations (such as hearing or seeing things which are not there) and delusions (including fixed, non-accurate beliefs). Experiences of psychosis can severely impair an adolescent's ability to participate in daily life and education. Adolescents with psychosis are often stigmatised and at risk of human rights violations. Psychosis is treatable with appropriate pharmacological and psychological therapies.

### *Suicide*

Suicide is increasingly witnessed in Nigeria and a study carried out in the South West zone indicated that over 20% of adolescents reported suicidal ideation and 12% attempted suicide in the 12 months before the study.<sup>24</sup> Risk factors for suicide are multifaceted, including harmful use of alcohol, abuse in childhood, stigma against help-seeking and barriers to accessing mental health care. Other factors such as financial and economic difficulties as well as relationship issues may also be associated with suicide. Suicide is often preventable with the appropriate strategy and support services.

### *Substance use and abuse*

Substance use adversely affects young people's health, well-being and overall development, including educational progress. Substance use has assumed an alarming dimension among young people in Nigeria in recent years. Traditionally, marijuana had been the most commonly used substance,<sup>25</sup> but the range of substances has now widened considerably. Codeine-containing cough medications and tramadol are now among the most reported drugs abused. Volatile organic solvents (such as petrol), psychotropic substances (such as benzodiazepines), and illicit drugs (such as cocaine and heroin) are also used. The rate of harmful alcohol and tobacco use is also increasing. A high prevalence of illicit drug use is noted among specific groups, such as cult members and street gang members. One study reported a prevalence of 89% for the use of heroin and 87% for cocaine among street youths in Lagos undergoing rehabilitation<sup>26</sup>. A national study has identified the Federal Capital

Territory (FCT), Lagos, Kaduna, Akwa Ibom, Cross River, and Gombe State as high prevalence locations for substance use.<sup>27</sup> Urban slums are particularly high-risk locations for substance use.

#### *Compulsive Gambling and Gaming Disorders*

Gaming disorder, which refers to problematic, compulsive use of video and/or internet games that results in significant impairment in an individual's function in various life domains over a prolonged period of time, is a form of addiction and has now been classified by WHO as a mental health disorder.<sup>28,29</sup> While there is a paucity of research in this area in Nigeria at present, there are strong indications of a rising rate of gaming disorders as well as problematic use of the phone and internet. The rate of young people's engagement in offline and online gambling practices is increasing<sup>30</sup> with its potential for an increased risk of gambling addiction and compulsive gambling problems,<sup>31</sup> particularly as the gambling industry is growing very fast in Nigeria and is poorly regulated.<sup>32</sup>

### **2.2.3. Violence and Injuries**

Violence can be physical, sexual or psychological in form and is closely associated with injury<sup>a,33</sup>. Youth violence, defined as violence that occurs among individuals aged 10–29 years who are unrelated and who may or may not know each other<sup>34</sup>, is increasing in Nigeria.<sup>35</sup> Youth violence generally takes place outside of the home and ranges from bullying and physical fighting to more severe sexual and physical assault and homicide. Collective violence has increased tremendously in Nigeria over the last 10 years with the *Jama'atu Ahlis Sunna Lidda'awati wal-Jihad* group (the 'Boko Haram' group) insurgency, herdsman-farmers clashes, and inter-communal conflicts. Boko Haram members, for example, have abducted, intentionally injured and killed thousands of people, raped young girls and forced them into marriage. Boko Haram has also forced adolescents into their service as child soldiers and courier for explosives. The invasions of agrarian communities by armed herdsman are associated with injuries, disability, and death. School-related violence, including bullying and cyberbullying are increasingly reported among adolescents and young people and cult-related violence is a challenge in some educational institutions. Also, there is a nation-wide increase in the rate of kidnapping and other forms of Interpersonal violence such as assaults and homicides.

Together, the collective and interpersonal forms of violence ~~decrib~~<sup>described</sup> above have resulted in a high and increasing burden of intentional injuries in Nigeria. Intentional injury, from self-inflicted violence such as ingestion of poisonous materials for suicidal purposes is also gradually increasing among adolescents and young people<sup>b</sup>. Unintentional injuries, particularly traffic injuries, significantly and negatively impact the health of adolescents and young people in Nigeria. The increasing number of young people engaged in commercial motor-cycle riding in the face of a high rate of youth unemployment contributes significantly to the high burden of traffic injuries. Substance use, particularly among commercial drivers, also contributes to the high incidence of road traffic injuries. Sport-related injuries and accidental drowning from recreational activities also disproportionately affect adolescents and young people. Their high level of energy, adventurous nature and relatively low level of experience contribute to the high level of unintentional injuries among young people.

### **2.2.4. Nutrition and Physical Activity**

## **3. Addressing Adolescents' malnutrition is in line with the Global Strategy for Women's Children's and Adolescents' health (2016-2030) whose goal to survive, thrive and transform towards ending preventable deaths, ensuring health and**

<sup>a</sup> Sexual violence is a form of interpersonal and intentional injury as well as a sexual and reproductive health and rights issue. It is addressed under the latter category in this policy document.

<sup>b</sup> Suicide is a form of intentional and self-inflicted injury and also a mental health. It has been addressed in this policy under mental health problems.

wellbeing and expanding enabling environments is very significant. The 2018 National Nutrition and Health Survey indicates that 19% of adolescent girls (15-19 years) have acute malnutrition, out of which 11% of them had severe acute malnutrition in 2018. The rate of malnutrition in adolescent girls is almost five times that of women aged 20-49 years.<sup>36</sup> Similarly, the 2018 NDHS also reported that 25% Adolescents 15-19yrs are thin in weight when compared with 6% of older women 20-49yrs. In translation, 1 in 4 Adolescents girls and 1:16 older women are malnourished. The 2018 NDHS report on the micronutrient deficiencies of the adolescents show that 61% of adolescent girls aged 15-19 have anaemia while the 20-49yrs older women is 57.3%<sup>c</sup>. This prevalence of acute malnutrition reporting more than four times higher for adolescents 15 to 19 years than adult women (20 to 49 years) with the anaemia and myriads of disparity across the regions. This highlights the urgency of developing effective interventions to improve the nutrition of adolescent girls/boys for birth outcomes and subsequent nutrition throughout the lifecycle. Improving nutrition in adolescent girls and boys is critical to improving the nutrition status of the entire population.

Overnutrition with its attendants' effect on non-communicable diseases in later years is also spanning across the human life course- all physiologic age groups or continuum of life The National Nutrition and Health Survey indicates that 19% of adolescent girls (15-19 years) had acute malnutrition and 11% had severe acute malnutrition in 2018. The rate of malnutrition in adolescent girls is almost five times that of women aged 20-49 years.<sup>37</sup> The 2018 NDHS also reported that 61% of girls aged 15-19 have anaemia: 48% had mild anaemia, 12% had moderate anaemia, and 1% had severe anaemia. National figures are not available for male adolescents and young people. Alongside under-nutrition, Nigeria is also recording a growing problem of obesity among adolescents, particularly in urban areas and among upper socio-economic class families. WHO, in 2016, reported an obesity rate of 1% for male adolescents (age 10-19) and 2% for the females.<sup>38</sup> A growing culture of patronising fast food outlets, which are still poorly regulated in Nigeria, with the intake of high calorie diets is contributory to the slowly growing challenges of obesity. Physical inactivity also contributes to obesity. WHO reported the prevalence of physical inactivity among Nigerians aged 18 years and above as 25% in 2016 (22% for males vs. 27% for females). Nigeria's 2016 Report Card on Physical Activity for Children and Youth estimates that only 20-39% are engaging in health enhancing physical activity overall – and a lower level than that of 2013.

#### **2.2.5.3.1.1. Non-Communicable Diseases**

Cardiovascular diseases, ~~e~~Cancer, chronic obstructive pulmonary disease, and type 2 diabetes are the leading non-communicable diseases (NCDs) globally. The common behavioural risk factors for these NCDs are unhealthy diet, physical inactivity, tobacco use and harmful use of alcohol. Among young females in Nigeria, a smoking prevalence of 2% to 10% has been reported, and a range of 1% to 33% reported for males.<sup>39</sup> Tobacco use is higher among urban-based adolescents and youths. A systematic review and meta-analysis of studies on the harmful use of alcohol in Nigeria reported a prevalence of 33% for adolescents (15-19 years) and 33% for young people (20-24 years)<sup>40</sup>. Males engage in harmful alcohol use compared to females. Vaccination against human papilloma virus (HPV) in pre-adolescence and early adolescence is now a major approach for the control of cervical cancer but the availability and uptake of the vaccine in Nigeria are still quite low.

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<sup>c</sup> NDHS 2018: Page 267

Other important chronic physical conditions or NCDs with a high burden among adolescents and youth in Nigeria are sickle cell anaemia, asthma, and epilepsy<sup>41</sup>— all of which negatively impact the quality of life of the affected adolescents and young people. Nigeria has the highest burden of sickle cell anaemia globally: the carrier prevalence rate is 20-30% while about 2-3% of the population is affected by the disease.<sup>42,43</sup> The number of babies born yearly with the condition is expected to double by 2050 in the absence of effective and sustainable control strategies.<sup>44</sup> With the reduced death rate in the childhood period, the number of adolescents with sickle cell disease (SCD) is growing, and national response needs to be considerably stepped up.<sup>45</sup> Adolescents and young people with sickle trait and disease are crucial to the effective control of the condition as their careful choice of sexual and marriage partner is the key to the future. Studies on asthma among adolescents and young people in Nigeria have produced widely varying prevalence, partly due to methodological differences, but a metaanalysis of studies carried out between 1990 and 2013 reported a pooled prevalence of 10% for young people and adults aged 13 years and above with a slightly higher prevalence in males.<sup>46</sup> Epilepsy is a highly stigmatised condition in Nigeria. Epilepsy may be associated with behavioural problems and some mental health challenges as well as learning difficulties. A systematic and metaanalysis of studies conducted from 1960 to 2018 reported a pooled prevalence of 8 per 1000, with a higher prevalence in rural areas.<sup>47</sup>

### **2.2.6.3.1.2. Disabilities**

Adolescents and young people with disabilities include those who have long-term physical, mental, intellectual or sensory impairments.<sup>48</sup> As the CRPD notes, disability needs to be understood as a “complex and dynamic phenomenon arising from the interaction between the individual with a health condition and contextual factors that pose significant challenges to the enjoyment of one’s human rights and reaching one’s full potential.” Contextual factors negatively affecting the health and wellbeing of physically or mentally challenged young people in Nigeria include widespread discrimination, sexual abuse, stigma, social exclusion, lack of supportive facilities for physical movement, restricted access to health services, and limited opportunities for quality education and gainful employment. The 2018 NDHS, based on questions on six core functional domains—seeing, hearing, communication, cognition, walking, and self-care—indicated that 3% of adolescents and 3% of youths have some degree of difficulty in at least one of these domains.

The *Discrimination Against Persons with Disabilities (Prohibition) Act 2018*, signed into law on 23 January 2018, promotes the full integration of people with disabilities into the Nigerian society. The law prohibits discrimination on the basis of disability with due penalties for contravention and promotes the access of people to health and social services. Section 22 of the law stipulates that the “Government shall guarantee that persons with disabilities have unfettered access to adequate health care without discrimination on the basis of disability, and a person with mental disability shall be entitled to free medical and health service in all public institutions.” The law, among others, provides for a five-year transitional period for modifying public buildings, structures, and automobiles to make them accessible and usable for people with disabilities. The law also establishes the National Commission for Persons with Disabilities, with the responsibility to ensure that people with disabilities have access to housing, education, and healthcare.

### **2.2.7.3.1.3. Communicable diseases**

Communicable diseases, although reducing in rates, remain a major cause of morbidity, disability, and mortality among adolescents and young people in Nigeria. As the Lancet Commission on Adolescent Health and Wellbeing noted regarding Nigeria, “Infectious diseases other than HIV,

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<sup>d</sup> Disability can technically be regarded as a non-communicable condition but has been made a different sub-section so as to give it the desired visibility and attention. The terminology of ‘adolescents and young people with disabilities’ is used here in line with the United Nations’ CRPD as well as Nigeria’s Discrimination Against Persons with Disabilities (Prohibition) Act.

though diminishing, are still prominent contributors to the burden of disease among adolescents with malaria and neglected tropical diseases notable among these.”<sup>41</sup> The World Malaria Report 2018 indicates that Nigeria contributes a quarter of all malaria cases globally and has the highest burden in the world. The number of malaria cases in Nigeria increased progressively from 17.4 million in 2015 to 23 million in 2017.<sup>49</sup> The uptake of malaria prevention measures is poor among adolescents and young people: The 2015 Malaria Indicator Survey indicated that on the night before the survey, only 37% of young people slept inside a mosquito net (treated or untreated), an insecticide treated net, a long-lasting insecticidal net or in a dwelling in which the interior walls have been sprayed against mosquitoes in the previous 12 months.<sup>50</sup> Pregnant teenagers constitute one of the high vulnerable groups for severe malaria morbidity and mortality.

Nigeria also has a high incidence and an increasing burden of tuberculosis (TB). Although young people are not the group with the highest incidence, the burden of TB is high among them. Nigeria ranks in the sixth position globally in terms of the burden of TB and contributes an estimated 4% of the global cases.<sup>51</sup> In 2017, Nigeria had an estimated 417,000 cases and 155,000 TB-related deaths. Lower respiratory infections, diarrhoeal diseases, and meningitis contribute significantly to morbidity and mortality among early adolescents (age 10-14). The 2016 National Guidelines for the Prevention, Treatment and Care of Viral Hepatitis indicates that Nigeria has one of the highest burden of viral hepatitis in the world and a prevalence of 11% for Hepatitis B and 2% for Hepatitis C.<sup>52</sup> Hepatitis may co-occur with HIV as a transfusion transmissible disease: the risk is higher for those injecting drugs.

#### **2.2.8.3.1.4. Oral Health**

Oral health is one of the most common chronic conditions in the world and a major global public health challenge<sup>53,54</sup> but a fairly neglected health concern. Nigeria has a high burden of oral health problems, with adolescents contributing a significant proportion of the challenge. As the National Oral Health Policy notes, periodontal disease with deep pocketing occurs at an early age in Nigeria, and the prevalence is in the range of 15-58% in persons over 15 years of age. Adolescence is a time of heightened oral health problems and a key life period for acquiring behaviours that will impact their oral health later in life. Among others, adolescents have a higher prevalence of gingivitis than pre-pubertal children or adults, partly due to an increase in sex hormones during puberty. Research evidence also indicates that irreversible tissue damage from periodontal disease begins in late adolescence and early adulthood. Dental caries tends to increase in adolescence due to the habit of frequent snacking on refined carbohydrates and acid-containing beverages. The use of tobacco products and alcohol, which become more common in adolescence and young adulthood, increases the potential for oral cancer. Current evidence also suggests a strong link between oral health and many key health conditions.<sup>55</sup> Malocclusion, for example, may impact negatively on psychosocial health of the adolescent, while exposure to violence and physical activities may result in oral and maxillofacial injuries. Nutritional anaemia and STIs may present with oral manifestations. Low levels of oral health literacy and poor oral hygiene practices contribute significantly to the high oral health burden. Nigeria currently has one of the lowest density of oral health care workforce in Africa<sup>56</sup> and this affects access to oral health services. Overall, oral health is one of the most prevalent unmet health care need among adolescents and young people in Nigeria.

#### **2.2.9.3.1.5. Socially Marginalized and Most Vulnerable Adolescents and Young People**

The study that assessed barriers to adolescent health services in Nigeria identified street boys, including *almajiris*, and adolescents living in a humanitarian and fragile setting as two of the major groups of young people “being left behind on the path to universal health coverage”.<sup>57</sup>

*Adolescents and young people in humanitarian and fragile settings:* Adolescents and young people affected by armed conflicts and in humanitarian contexts face a myriad of physical, mental and social health challenges and low access to health services. They also face significant deprivation challenges and have limited access to quality education and development opportunities.

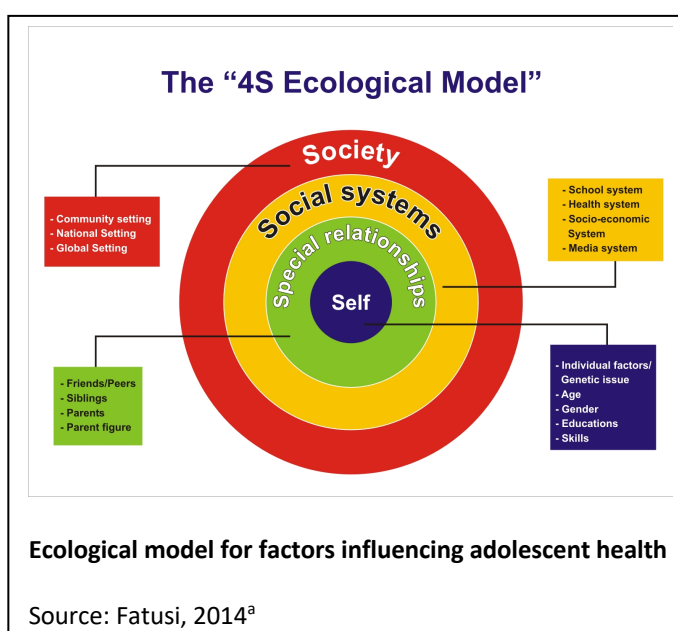
Unfortunately, the number of adolescents and young people in this category has been growing rapidly in Nigeria, particularly since 2009 when the Boko Haram challenge emerged strongly on the national scene. The significant increase in the severity and number of herdsman-farmers clashes, especially with the dimension of an armed conflict that it has recently assumed, has further aggravated the situation. New and renewed age-long community, religion- and ethnic-based clashes also increase the challenge further. Adolescents and young people constitute a significant proportion of the affected people, with a high level of injury, human rights violation (including abduction, rape and forced marriages) and deaths. With these armed conflicts, Nigeria is witnessing one of the worst humanitarian crises in her history. The Boko Haram crisis alone has affected over 17 million people, with 7.1 million people in need of humanitarian assistance in 2019, including 1.8 million displaced people, 1.6 million returnees, and 2.9 million people in the host communities. Even in the camp established for internally displaced persons on the account of the Boko Haram crisis, adolescents constitute one of the most vulnerable groups and some of the females are forced to engage in trading in sex to meet their basic needs, including personal hygiene and nutrition.<sup>58</sup>

*Street-involved adolescents and young people:* Street-involved adolescents and youth<sup>59</sup> covers varying degrees of homelessness and street-engagements, including those “of the street”, those “on the streets” and those who are not necessarily ‘homeless’ but are significantly engaged with the “street culture” and experiencing its associated physical, mental, emotional and social risks. Street-involved young people have a very high risk of several health problems, including risky sexual behaviours (unprotected, transactional, concurrent and multiple sexual partnerships), sexual violence, substance use, violence and injury, and poor nutrition. Despite their high levels of risks, street-involved adolescents and youths have highly limited or no access to health and related social welfare services: they are practically a neglected population in terms of health programming. These young people also lack a strong and positive social support system and very little access to development opportunities, with most of them not in education, employment, or training. With their social environment and developmental context, street-involved young people have a high tendency for deviant behaviours, substance use, sexual abuse, violent engagements, and criminality.

Fast-growing slum areas around major cities such as Lagos, Enugu and Port Harcourt particularly have a huge and growing population of adolescents and young people living on the streets. The *almajiris* in northern Nigeria constitute a special class of street-involved young people, with a huge population of about 10 million.<sup>60</sup> The system originally meant to be a traditional Islamic educational system, with young people living with and learning under old scholars has virtually become a system that fosters street culture as the young people turn to street begging as they are left to fend for themselves. High and increasing rates of unemployment, poverty, substance use among young people, and collective violence are contributing to the increased population of street-involved young people in Nigeria.

### **2.3.3.2. Factors Associated with Health Status of Adolescents and Young People**

There are significant variations in the health status of various groups of adolescents and young people in Nigeria, based on various socio-demographic and health-related factors. These health inequities are largely driven by social determinants of health— conditions in which people are born, grow, live, work and age. These determinants are



fundamental to the health and wellbeing of every young person. For example, socioeconomic position, a structural determinant, influences living conditions as well as the access to health care services and the interactions of the individual with the health system. In addition, several risk and protective factors influence adolescent health and operate at various levels in the domain of the adolescent life – self (such as genetic factors and health behaviours), special and interpersonal relationships (such as parents and peers), social and system, and the larger society. This Policy recognises the imperative of addressing key social determinant issues, reducing risk factors, and enhancing protective factors for Nigeria to realise her vision of improved health and development of adolescents and young people. Some of the key social determinants and risk and protective factors are highlighted in this respect.

*Socio-economic inequity and poverty:* Socio-economic class is a major determinant of health for adolescents and young people in Nigeria. Among others, young people from poorer families have higher rates of malnutrition, more likely to engage in risky sex and less likely to use contraceptives. Adolescents from poorer homes are also more likely to live in unhealthy and risky environments that expose them to a higher risk of violence, injury and substance use. These young people are also more likely to experience depression and other mental health problems and less likely to have access to quality health care and quality education. Rural-based adolescents in Nigeria, in general, have poorer health status and worse health outcomes compared to their urban mates, except with regards to affluent lifestyle-related behaviours and conditions such as obesity and physical inactivity. The rural-urban differentials largely reflect differences in socio-economic status, and, inequitable access to health, social services, and economic opportunities. Addressing extreme poverty, reducing socio-economic inequity, promoting social protection and pro-poor health and social policies, and improving the living and economic conditions in rural locations and urban slums will contribute to improved health and development of adolescents and young people.

*Education and safe school environment:* Access to quality education, particularly secondary school education, positively impacts the health and development of adolescents and young people. Among others, it contributes to increased health knowledge and health literacy, equips young people with life skills, increases their competency for self-care and empowers them for effective decision-making. Quality schooling increases the opportunities to have access to family life and HIV education, school-based feeding programme, physical education, and other forms of school health services. Increased access to education also reduces the rate of girl-child marriage. A high level of school connectedness also improves emotional well-being and is a protective factor against engagement in several health-risky behaviours. In general, less educated adolescents and young people in Nigeria have poorer health status and a higher risk of health-risky behaviour compared to their more educated peers. On the other hand, a poor and unsafe school environment can pose a considerable risk to the health of adolescents and young people. Among others, bullying and physical violence can increase in such contexts. Similarly, the overall negative social environment can increase the risk of sexual exploitation, gender-based violence, substance use, and emotional problems, among others. Inadequate water and sanitation facilities in a poor school environment can also increase the risk of communicable diseases like diarrhoea and discourage school attendance for adolescent girls who are undergoing their menstrual period.

Access of adolescents and youths to education is lower in the North compared to the South and lower for the rural-based young people compared to their urban-based peers<sup>61</sup>. Access to education is considerably lower for the female compared to the male in the northern part of the country, but the secondary school completion rate is higher for females compared to males in some parts of the South-east zone. The gender and geographical imbalance in access to education need to be addressed, the quality of education and school environment improved, access to quality education



and safe schools increased, and the secondary school completion rate boosted to improve the health and development of adolescents and young people in Nigeria.

**Gender and social norms:** Gender plays a significant role as a health determinant and gender-inequitable norms underlie several of the disadvantages that female adolescents experience compared to their male peers in Nigeria. Gender inequitable social norms negatively impact the access of females to health services, education and training as well as social development opportunities. Gender inequitable social norms are also at the root of several pervasive harmful practices against females in Nigeria including gender-based violence, female genital mutilation/cutting, and girl-child marriage. For example, the rate of female genital mutilation/cutting, as the 2018 NDHS shows, is highest among the *Yorubas* (38%) *Igbos* (30%), lower among the *Fulanis* (13%) and the *Hausas* (20%), and lowest among the *Tivs* (1%) and *Igalas* (1%). On the other hand, girl-child marriage is considerably higher in the north compared to the south. These ethnic and geographically-related statistics reflect significant differences in social norms and cultural beliefs and their considerable influences on health. Negative social norms need to be addressed and harmful practices eliminated and gender-transformative initiatives promoted as parts of the effort to improve the health and development of adolescents and young people, particularly the females. Sexual orientation can influence health and health care access differently and it is an important dimension of social inequality. Sexual minorities have higher risks of STIs, sexual violence, and some mental health issues such as suicidal ideation, suicidal attempts and depressive symptoms compared to heterosexual adolescents.<sup>62</sup> The population of sexual minorities in Nigeria remains largely hidden and access to relevant sexual and reproductive health services limited because of the state of the law, discriminatory attitudes of health workers and strong cultural oppositions.<sup>63</sup> Studies on the health of sexual minorities are rare, and very few ever focused on teenage and young sexual minorities.

**Parental responsibilities and family-related factors:** Parents and the family environment play key roles in the identity formation and health development of the adolescent. Commitment to the parental responsibilities of ensuring adequate provision for the health and development needs of the adolescent, impactful nurturing, guidance and support as well as positive role modelling have a significant impact on the health and development of adolescents and young people. Positive parental practices including authoritative parenting style, effective parent-adolescent communication and high level of connectedness, supportive and trusting relationship, and adolescent monitoring are protective factors against mental health disorders, substance use, and engagement in risky sexual behaviour. The family environment also plays an important role in adolescent and young people's health and development. Divorce and violence in family settings, for example, negatively impact the health and wellbeing of adolescents. Building the capacity of parents for effective parent-adolescent relationships and providing a health-enhancing family environment is highly promotive of the health and development outcomes among adolescents and young people in Nigeria.

**Health knowledge and literacy:** Low health literacy is associated with higher levels of risky health behaviours and poorer health seeking practices. The level of health knowledge and literacy in Nigeria about specific adolescent health issues in Nigeria is





low not only among adolescents and young people but also among other stakeholders. Studies across the country, for example, has documented low mental health literacy among adolescents, teachers and as well as parents. HIV prevention provides an example of the low level of knowledge of health conditions in Nigeria. In 2018, as the NDHS reports, only 12% of female adolescents (15-19 years) and 12% of their male peers, and only 14% of female youth (age 20-24) and 15% of male youth have comprehensive knowledge of HIV transmission. Overall, among young people (age 15-24), only 13% of females and 13% of the males had comprehensive HIV knowledge in Nigeria in 2018. Part of the underlying challenge in this regard is the poor implementation of the approved national sexuality education curriculum, the Family Life and HIV Education (FLHE), in schools. As of 2013 only four of Nigeria's 36 states have achieved a high level of FLHE implementation, while many states still had less than 20% of schools participating<sup>64</sup>. The out-of-school young people have even poorer access to sexuality education as very few programmes have so far focused on them.

*Media and digital technology:* Both traditional mass and digital media have significant implications for the health and development of adolescents and young people. The effect of media could be positive or negative, depending on the nature of the media as well as the intensity, constancy, and context of exposure. On the positive side, exposure to media can improve health knowledge and health literacy. On the other hand, exposure to violent and sexual media, for example, have negative influence on young people in several dimensions, including sexual behaviour and mental health. The access of young people in Nigeria to cell phones, internet, social media and other forms of digital technology has significantly increased in the last decade and the excessive and negative use of digital media has considerable negative implications for health and well-being.<sup>65,66</sup> With the increased access to digital technology, the phenomenon of sexting – the sharing of sexually explicit images, videos, or messages through electronic means – has increased among young people.<sup>67,68</sup> Studies in Nigeria have also documented the negative effects of digital media exposure on sexual behaviour<sup>69,70</sup> and sleep pattern<sup>71</sup>.

*Access to and utilisation of health services:* Access to relevant health services is important to ensuring the health and wellbeing of adolescents and young people, but the access of young people to health services in Nigeria still needs considerable improvement. In 2018, as the NDHS indicated, over a half of all female adolescents (52%) and youth age 20-24 (51%) reported that they had serious problems in accessing health care for themselves when they were sick. Health providers' discriminatory and judgemental attitudes constitute one of the key barriers to accessing available health services by young people. As the assessment of barriers to adolescent health services and other studies show, several groups of disadvantaged adolescents have poor access to relevant health services. These include adolescents from poor households, adolescents with low levels of education, adolescents based in rural areas, female adolescents in northern Nigeria (both married and unmarried), early adolescents, orphans, street-involved adolescents, and adolescents in conflict-afflicted areas and in humanitarian settings. Studies have also shown, in general, that adolescents and young people in Nigeria have poor healthcare seeking behaviour and do not utilise available services appropriately. Efforts to improve both the demand and the supply side of adolescent health services are crucial for adolescents and young people in Nigeria to attain the highest level of health and wellbeing possible.

### **2.4.3.3. Responses and Interventions**

Various forms of interventions have been mounted since 2007 as part of the national efforts to improve the health and well-being of adolescents and young people. The major ones are described below, with a particular focus on the health sector.

*Development of supportive policies:* The Nigerian government has developed several policy documents, including the following relating directly to adolescent health services: National Reproductive, Maternal, Newborn, Child, Adolescent Health + Nutrition (RMNCAH+N) Strategy; National Guidelines for the Integration of Adolescent and Youth Friendly Services (AYFHS) into Primary Health Care (PHC) Facilities; National Guidelines on Promoting the Access of Young people to AYFHS in PHC; and the National Standards and Minimum Service Package for AYFHS. These policies (along with others mentioned in the “context for this policy document”). However, the implementation of most of the policies has been considerably weak, and there is no effective accountability mechanism for tracking and holding duty bearers to the desired performance.

Nigeria has also developed some legal frameworks and guidelines that provide useful input into the policy response for the health of adolescents and young people. The Violence Against Persons (Prohibition) Act (VAPP), signed into law in May 2015, addresses the issues of rape, and female genital mutilation, among others. The Act prohibits all forms of violence, including physical, sexual, psychological, domestic, harmful traditional practices as well as provides protection and remedies for survivors and punishment for offenders. The Discrimination Against Persons with Disabilities (Prohibition) Act 2018, signed into law in January 2018, is a landmark development for enhancing the health and development of young people with disabilities as it promotes the full integration of people with disabilities into the Nigerian society and the national developmental agenda. On the other hand, there are legal-related issues that are yet to be addressed. The Child Rights Act of 2003, for one, is yet to be domesticated by 12 states, all of which are in the northern part of the country: Adamawa, Bauchi, Borno, Gombe, Kaduna, Kano, Katsina, Kebbi, Sokoto, Yobe and Zamfara. Also, while the age of consent for young people living with HIV to access HIV-related services has been reduced to 14 years in May 2019 by the National Council on AIDS, the issue of reducing the age of consent of adolescents to sexual and reproductive health services as a whole from the present age of 18 years is yet to be addressed nationally.

*Strategic information:* Recent development has positioned the National Health Management Information System (NHMIS) to be able to generate adolescent-responsive statistics from the routine health information process, with disaggregation into sex as well as into the ages of 10-14, 15-19 and 20-24. Moving forward, there is the need to ensure that the information generated from the NHMIS is better used for strategic decision-making and to drive policy implementation and programming. There are also significant gaps in the knowledge of the trends and state of adolescent and young people’s health in Nigeria. To date, there is no strategic and institutionalised approach in place for monitoring and evaluating the implementation of the previous policy and to annually document and disseminate information on the overall progress in the adolescent and young people’s health sector in Nigeria. There is also a lack of monitoring and evaluation plan to provide the overall framework and guide for a robust monitoring and evaluation engagements. The country has also not developed national research priorities to address the substantial gaps that currently exist as well as improve the available evidence regarding the health and development of adolescents and young people. However, the National Conference on Adolescent Health, the first edition of which was held in Ibadan in April 2019, provides a strong platform for addressing this challenge. The Conference, spearheaded by the Society for Adolescent and Young People’s Health in Nigeria (SAYPHIN) with the strong partnership of the Federal Ministry of Health and active participation of several stakeholders, has opened up a new vista and opportunity for the generation, aggregation, dissemination of evidence for adolescent and young people’s health and development in Nigeria. The conference also has the potential to enhance data producers-users interaction and promote the use of evidence for policymaking and programming. There is the need to sustain the momentum created by the Conference and ensure that the Conference holds every two years.

*Provision and scaling up of services:* Some critical steps have been taken towards improving service coverage for adolescents in Nigeria, but these efforts have so far fallen short of the goal of making the health system adolescent-responsive and to significantly improve the access of young people to AYFHS. While the national guidelines for the integration of AYFHS into PHC facilities and for promoting the access of young people to AYFHS in PHC have been developed, their implementation has been quite poor. Consequently, most public sector facilities are still not providing any significant adolescent-focused services or have an adequate capacity to provide AYFHS. There is an urgent need to strengthen the provision of quality adolescent and youth health services through primary health care and as part of the PHCUOR, using the national guidelines and ensuring that the services meet set national standards. This effort would require paying significant attention to every aspect of the service delivery system, including human resources, the structural element and related infrastructure, the financing system, and service operation policies. While the number of civil society organisations involved in the provision of services and undertaking interventions relating to adolescent and young people's health has been increasing, very little is known about the quality of services they provide. To address these and related issues, across both the public and private sectors, Nigeria has developed the National Standards and Minimum Service Package for AYFHS to guide service providers and facility managers in providing quality AYFHS for different levels of service facilities. However, the approved document is yet to be publicly released and disseminated to stakeholders by the Federal Ministry of Health. An implementation plan that would clearly specify the procedure and process of facility assessment to determine whether stated standards are met and guide the classification of facilities also needs to be developed. On the service demand generation side, the National Guidelines on Promoting Access of young people to Adolescent and Youth Friendly Services in PHCs facilities have been developed but implementation has been weak. Also, a national adolescent friendly health logo has been developed with the active participation of young people to promote services and catalyse service demands and an advocacy kit for demand generation and utilization of AYFHS but there has been no significant traction in their roll out and use on a national basis. Overall, the demand generation efforts have been weak, patchy and very limited in scope, scale and reach.

*Production of sustainable resources for ensuring adolescent-responsive health system:* Health workers are at the center of effective service delivery. Nigeria, currently, has a very low number of health workers who are trained and skilled in delivering AYFHS. While the country has developed a training manual for health workers and job aide for adolescent health services, most health profession training institutions lack the training manual and do not have an adequate number of skilled teachers and trainers to deliver quality and competency-based training to their trainees and students. Also, most facilities (public as well as private) lack the job aide. Thus, there is a huge gap in both the in-service and pre-service dimensions of developing health workers who are competent in adolescent health service delivery. This strategic gap needs to be systematically, effectively and cost-efficiently addressed over this new policy period.

*Strengthening other sectors in adolescent- and youth- related policy and programme efforts:* The health sector has been spearheading the activities relating to adolescent and young people's health nationally and at the state level in line with her mandate and the provisions of the 2007 policy. Among others, the Federal Ministry of Health provided critical input on the aspect of youth health in the new National Youth Policy. However, the same is not true with respect to the development of the National HIV Strategy for Adolescents and Young People. Efforts need to be strengthened by the Ministry to engage all other sectors in their adolescent- and young people-focused initiatives relating to health and development. The National Adolescent Health and Development Working Group (NAHDWG) has been a useful mechanism for intra-sectoral coordination and inter-sectoral collaboration and for fostering cross-sectoral dialogue and interactions. However, there is a need to further strengthen the collaboration between various sectors as well as harmonise and coordinate

the efforts of development partners working in the health sector and across sectors relating to adolescent and young people's health. The membership, activities, and processes of the NAHDWG itself need to be reviewed and amendments made where necessary for more cost-efficient and optimal performance. Adequate provisions also need to be made to ensure that the NAHDWG meets regularly as designed. At the state level, the State Adolescent Health and Development Technical Working Group (SAHDWG) is weak and poorly supported or even non-existent. Each state needs to establish its SAHDWG and ensure its effectiveness as well as build stronger linkages between the sectors at the state level to enhance the adolescent and young people's health agenda. The Federal Ministry of Health has been working on a draft guide that would help the states and the SAHDWG in terms of formation and function. The draft guide needs to be finalised expeditiously and disseminated to support the states. Relationships and partnerships between the Working Groups at the national and the state levels also need to be considerably strengthened.

### **3.4. POLICY DECLARATIONS AND GUIDING PRINCIPLES**

#### **3.4.1. Underlying Principles and Values**

The principles and values underlying this policy are the following:

- a. **Young people as vital resources for sustainable future and national development:** Adolescents and young people are vital human resources for sustainable national development and not a mere target for development efforts. Young people have competencies for appropriate self-care, and capacities as well as obligations to contribute to their own health and development as well as a sustainable and successful future for the entire Nigerian society.
- b. **Rights-based approach:** All young people, without any exception whatsoever, have inalienable rights to protection, information, quality health services, education and development opportunities – all of which contribute to their optimal health and development. They also have the right to participate in the development/review, implementation, monitoring and evaluation of this policy and relevant programmes that concern the health, development and overall well-being of adolescents and young people in their community, institutional settings and the country as a whole.
- c. **Diversity of adolescents' and young people's needs and situation:** Young people are not a homogeneous group, but a diverse group in terms of the health situation, needs, and vulnerabilities. As a matter of equity, disadvantaged young people have higher degrees of vulnerabilities and must be accorded specific attention that responds effectively to their situation and challenges. This group includes, but not limited to, those with physical and mental challenges; orphans and vulnerable early adolescents; the *almajiris* and other groups of street-involved adolescents and youths; adolescents and youth in conflict-affected areas, humanitarian situations and fragile settings; young people affected by extreme poverty; adolescent and young people not in education, employment and training (NEET); sexual violence survivors; sexual minorities; and, married and parenting adolescents.
- d. **Gender equity and responsiveness:** all young people – males and females – have equal rights to health and development and to participate in their own and the society's development in the spirit of justice, equity, and fair play. The implementation of this policy and the associated programmes shall be undertaken with the full consciousness of the differential gender needs, engage gender-responsive approaches, address existing gender-inequitable norms, and will foster relevant gender-transformative initiatives.
- e. **Cultural sensitivity:** Interventions under this policy will be culture-sensitive and respond effectively to the cultural setting and local values while at the same time striving uncompromisingly but respectfully towards fostering practices and an environment that is safe, supportive, and protective of adolescent and young people's health and development.
- f. **Participatory and consultative:** Effective engagement of all relevant stakeholders, sectors, and groups including both the right holders (adolescents and young people) as well as the duty bearers (parents, guardians, service providers, government agencies, civil society organisations, faith communities, the academia, professional groups, the private sector, and community gatekeepers) shall be vigorously pursued for their optimal participation in every aspect of policy implementation and programming at all levels.

- g. **Integration of services:** Appropriate integration and constellation of services at the community and primary care levels, backed with effective referrals, is critical to improving the access of adolescents and young people to quality services and to the achievement of this Policy's vision and goals; in recognition of the primary health care system as the platform for achieving universal health coverage, this policy emphasises the full and effective integration of AYFHS into the primary health system and operations.
- h. **Life course approach:** Recognising that the health of the adolescent reflects the past childhood experiences and is a determinant of future adult health, this policy emphasises a holistic approach throughout the life cycle to achieve the highest possible level of health and development for adolescents and young people as well as ensure the greatest possible gains for the country's investment in adolescent and young people's health.
- i. **Evidence-based and innovation-driven:** Research, evidence and innovations are critical for effective policy implementation and programme development, including addressing various barriers to AYFHS, strategic expansion of services towards achieving universal coverage, and cultivating best practices in programme design, implementation, evaluation, and learning.
- j. **Quality-focused and result-oriented:** The implementation of this policy and the associated programmes will aim at defined outcomes that are in consonance with the policy objectives; programmes and services will be implemented with firm commitment to high quality and cost-efficiencies, and be guided by set national standards as espoused in the National Standards and Minimum Service Package for Adolescent and Youth-Friendly Health Services.

#### **3.2.4.2. Policy Declarations**

The government (federal, state and local government) and people of Nigeria hereby commit themselves to the attainment of the objectives of this policy, and in that respect, make the following declarations and commitments:

1. Investment in the health and development of adolescents and other young people shall be prioritised in the national agenda, recognising that such investments are critical to our country's sustainable development and her potentials to achieve demographic dividends as well as yield benefits for the today's young people, tomorrow's adults, and the future generations;
2. This policy shall be complementary to other national policy documents and laws relating to the health and development of young people in Nigeria. In addition to the national policy documents highlighted in the context for policy development section, the implementation of this policy also recognises and will be in tandem with other key implementation documents relating to each of the priority programmatic areas of the policy and/or relate to its strategic objectives, including the School Health Policy, the National Strategy to End Child Marriage, the National Policy for Obstetric Fistula, the National Oral Health Policy, the National Mental Policy, the National Strategic Plan for the Elimination of Malaria, the National Strategic Plan for Tuberculosis Control, Standards and Guidelines for the Medical Management of Victims of Violence in Nigeria, the Protocol on the Management of FGM Survivors, and the Family Life and HIV Education (FLHE) curriculum, among others.

3. Young people, themselves, have the right and duty to lead as well as participate individually and collectively in the planning, implementation and evaluation of health and development programmes for young people and this policy.
4. All stakeholders and development partners, including the government and her institutions, civil society organisations and the private sector as well as international development organisations agreed to work together in partnership to promote the health and protect the rights of adolescents and other young people and ensure their optimal health and development.
5. An enabling environment will be created and relevant implementation frameworks, including a strategic framework, an action plan, and a costed monitoring and evaluation plan, will be developed and appropriate mechanisms established to facilitate the effective implementation of this policy and ensure the attainment of its goal, objectives, and targets.

## **4.5. VISION, MISSION, GOAL, STRATEGIC OBJECTIVES, AND KEY STRATEGIES**

### **4.1.5.1. Vision**

A healthy life and optimal development for all adolescents and young people in Nigeria and successful transition towards a healthy, active, productive, successful and fulfilled adulthood.

### **4.2.5.2. Mission**

To provide stakeholders in the health and other relevant sectors with a comprehensive framework for effective harnessing of resources and programming for the optimal health, well-being, and development of all adolescents and young people in Nigeria.

### **4.3.5.3. Goal**

The overall goal is to ensure that the Nigerian health system is adequately adolescent- and youth-responsive and delivers quality, gender-sensitive, equitable health services that effectively meet the preventive, curative and rehabilitative health needs of all young people, thereby reducing morbidity, disability, and preventable mortality rates as well as optimally contributing to their wellbeing and development.

### **4.4.5.4. Strategic Objectives**

The strategic objectives of this policy are to:

- i. Reduce morbidity, disability, and preventable mortality rates among adolescents and young people.
- ii. Strengthen the capacity of the health system to deliver adolescent-and youth-friendly services and innovative adolescent- and youth-responsive programmes
  - a. Improve the availability, accessibility, and utilisation of quality and gender-responsive adolescent- and youth-friendly health services by strengthening the implementation of the National Standards and Minimum Service Package for Adolescent and Youth-Friendly Health Services;
  - b. Increase the availability and equitable distribution of competent and committed adolescent health workforce at all levels, including health service providers, Community Health Influencers, Promoters and Services (CHIPS) personnel, social workers, and counsellors;
  - c. Strengthen the health systems management, leadership and governance, and financing capacity and mechanisms for sustainable development of an adolescent and youth-responsive health system; and,
  - d. Enhance the generation and use of data and innovative processes and technologies to improve the quality, effectiveness, and cost-efficiencies of adolescent and youth health programmes and services.
  - e. Promote the design and implementation of interventions to address the drivers of service providers' biases, unfriendly attitudes, and service-related norms that limit young people's access to services
  - f. Advocate for removal of all social, legal, policy and service-related barriers relating to the confidential access and utilisation of sexual and reproductive care as well as other relevant healthcare services by adolescents and other young people.
- iii. Strengthen the capacity of the school health system and its linkage with the health sector to improve the health knowledge, health literacy, and self-care competencies of school-attending adolescents and youths and facilitate their access to relevant health and health-related services.



- iv. Ensure safe and health-enhancing environment for adolescents and young people in all settings, including the home, community, schools and training facilities, work environment, and healthcare centres through appropriate policies, legislations and legal framework and processes.
- v. Improve the level and intensity of adolescents' and young people's meaningful engagement, participation, and involvement in the development and implementation of all policies and programmes relating to their health and development at all levels.
- vi. Strengthen the capacity of parents and households and the community system to provide the appropriate supportive environment and care to adolescents and young people as well as to engage with and support adolescent and youth-responsive policy and programme initiatives.
- vii. Strengthen adolescent leadership and engagement in the family and community using transformative interventions that address the power imbalance between adolescent girls and boys as well as gender-inequitable norms and practices, including gender-based violence.
- viii. Strengthen the partnership and collaborations within the health system and between the health sector and other sectors to enhance the implementation of the adolescent health and development agenda at various levels and nationally.
- ix. Strengthen the social accountability systems regarding adolescent- and youth-responsive service delivery and programmes nationally as well as for demand for the duty bearers to deliver on the policy promises to adolescents and young people.

#### **4.5.5.5. Key Implementation Strategies**

The key strategies for the implementation of this Policy and achieving its goal are:

- a. *Advocacy and resource mobilisation*: Advocacy targeting relevant stakeholders to mobilise their support, political will, and adequate resources for the implementation of the national adolescent and young people's health and development policy, related agenda and associated programme within and across sectors;
- b. *Health promotion, communication, and counselling interventions*: Promotion of access of adolescents and young people to quality, age- and gender-appropriate comprehensive health-related information and education, social and behaviour change communication, counselling, and health promotion interventions that foster high-level health literacy, healthy behaviours, and self-care health-related competencies;
- c. *Access to quality health services*: Provision of improved and equitable access of adolescents and young people to a comprehensive range of adolescent- and youth-friendly services in the health facility, school, and community setting;
- d. *Safe and supportive environment*: Ensuring a safe, rights-enhancing, health-promoting and development-supportive environments for adolescents and young people through appropriate policies, legislative frameworks, and laws;
- e. *Parenting for life-long health and well-being*: Improving the knowledge, skills, and competencies of parents and parent-figures to provide appropriate care and nurture, supportive environment, enriching communication and connectedness, effective monitoring and supervision, and optimal opportunities for adolescents and young people to develop their character and capacities and achieve lifelong health and well-being;
- f. *Competent and committed health and adolescent-focused workforce*: Capacity building for healthcare workers, teachers, counsellors, youth development officers, social welfare officers, and other professionals and personnel engaged in providing health care, health-related services, and development-oriented programmes to adolescents and young people;
- g. *Adolescent and young people's engagement and positive youth development*: Building the capacities and competencies of adolescents and young people, empowering them with life skills and livelihood skills, and providing them with the support, relationships, experiences,

resources, and opportunities they need to achieve optimal health and development and to successful transit to healthy, productive, prosocial, competent, and successful adults;

- h. *Research, innovation, and learning*: Promote research engagements and evaluations to generate relevant evidence and learning to inform innovations as well as effective policy implementation and programming, and promote the application of innovative processes and technologies to improve adolescent- and youth-focused health-related and programme outcomes;
- i. *Social accountability strengthening*: Actively engage with and support young people and non-state actors, including civil society organisations, community influentials, and religious leaders, to initiate and promote actions that foster the accountability of all duty bearers for the delivery of good-quality services and high-impact programmes that will lead to the attainment of this Policy's goals and objectives; and,
- j. *Collaborations and coordination*: development of strong linkages, effective partnership and active collaborations within the health sector and between the health sector and other sectors as well as enhancing coordination to improve programme synergies and effectiveness and ensure optimal returns on the investment of all stakeholders, including government agencies, civil society organisations, adolescent- and youth-led initiatives, academic and research institutions, and international development.

## **5.6. PRIORITY PROGRAMMATIC AREAS AND TARGETS**

### **5.1.6.1. Priority Programmatic Areas**

The priority programmatic areas are<sup>e</sup>:

- a. *Sexual and Reproductive Health and Rights*: Pubertal development and management of pubertal-related concerns and processes, including menstrual hygiene management; comprehensive sexuality education; risky sexual behaviour, including sexting and other forms of harmful sexual and reproductive practices relating to digital technology; contraceptive use, unintended pregnancies, unsafe abortions and post-abortion care; safe motherhood, respectful maternal health services for pregnant adolescents and young people, and maternal morbidities; sexual violence, female genital mutilation/cutting and other forms of harmful practices and sexual and reproductive health rights violations;
- b. *Mental Health, Substance Use, and Addictions*: Mental health promotion and disorders, including suicidality and eating disorders; substance use, misuse and abuse; and, gaming addictions and other forms of problematic use of digital technology;
- c. *Violence and Injury*: unintentional injuries; intentional injuries; self-directed violence; interpersonal violence including bullying and cyberbullying; and, collective violence;
- d. *Nutrition and Physical Activity*: undernutrition, overnutrition, micronutrient deficiencies; and, physical activity.
- e. *Non-Communicable Diseases*: Common non-communicable diseases (prevention of cardiovascular diseases, cancer, chronic respiratory diseases, diabetes), and other high-burden chronic physical conditions (sickle cell anaemia; and epilepsy).
- f. *Disabilities*: long-term physical, mental, intellectual or sensory impairments.
- g. *Communicable Diseases*: Lower respiratory infections; diarrhoeal diseases; meningitis; malaria; HIV; tuberculosis; and viral hepatitis;
- h. *Oral Health*: dental hygiene; dental caries; periodontal diseases; oral and maxillofacial injuries; and, malocclusion.

### **5.2.6.2. Targets**

#### **5.2.1.6.2.1. Sexual Reproductive Health and Rights**

*Pubertal development and health literacy*

- i. At least 75% of students in upper primary and secondary school students (private and the public sector) are provided with school-based family life and HIV/AIDS education by 2024
- ii. Increase the proportion of adolescents and young people (15-24 years) who have comprehensive knowledge of HIV transmission to at least 80% by 2024
- iii. At least 80% of early adolescent girls (10-14 years) and 67% of early adolescent boys (age 10-14 years) have adequate knowledge regarding menstruation and ~~menstrual~~menstrual hygiene management by 2024

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<sup>e</sup>In each programmatic area, a gender-responsive and human rights approach is required and appropriate attention given to the socially marginalized and most vulnerable groups.

- iv. At least 75% of female adolescents have all they need to adequately manage their menstruation by 2024
- v. At least 75% of schools have separate and clean toilets for females and males in adequate number and with appropriate menstrual hygiene management (MHM) facilities in the female toilets

*Sexual activity, contraception, and sexually transmitted infection*

- vi. Increase the from 28% in 2018 to 75% in 2024
- vii. By 2024, increase the proportion of adolescents (15-19 years) who used a condom at the last intercourse with a non-marital partner from 36% in 2018 to 70% for females, and from 57% to 80% for males
- viii. By 2024, at least 90% of adolescents and young people (15-24 years) with symptoms suggestive of STIs seek treatment from formal health services

*Early marriage, childbearing, and maternal mortality*

- ix. Reduce adolescent childbearing rate from 19% in 2017 to 12% by 2024
- x. Reduce the proportion of women aged 20-24 years who were married or in a union before age 18 from 50% to 25% by 2024
- xi. At least 75% of adolescents who experience abortion complications (either from induced or spontaneous abortion) receive appropriate post-abortion care by 2024.
- xii. By 2024, reduce the maternal mortality ratio among adolescent girls by at least 40% compared to 2018.

*Maternal care for pregnant adolescents*

- xiii. At least 80% ~~percent~~ of pregnant young people (age 10-24 years) attend at least 8 ANC visits throughout the course of every pregnancy by 2024.
- xiv. At least 75% of pregnant adolescents and young people have skilled attendants at birth by 2024
- xv. At least 80% ~~percent~~ of adolescents and young mothers receive postnatal care services within 48 hours of delivery by 2024

*Sexual violence and harmful practices*

- xvi. Eliminate female genital mutilation by 2024.
- xvii. By 2024, reduce the proportion of male and female adolescent (age 15-19 years) and youths (age 20-24 years) who experience sexual violence or any other form of gender-based violence by at least 60% compared to 2018
- xviii. All the 36 states of Nigeria and the Federal Capital Territory adopt and domesticate the Child Act Rights by 2024
- xix. At least two-thirds of the States in Nigeria and the Federal Capital Territory adopt and implement the Violence Against Persons Prohibition law by 2024

**5.2.2.6.2.2. Mental Health, Substance Use, Addiction.**

- i. By 2024, at least two-thirds of adolescents and young people, parents, and teachers have good knowledge of adolescent mental health issues
- ii. By 2024, reduce the incidence of substance abuse among adolescents and Young People by 50% compared to 2018
- iii. By 2024, provide screening for potential mental health conditions in at least 50% of school-attending adolescents and young people (10-14 years; 15-19 years; and 20-24 years) and adequate support for those diagnosed with mental health conditions through the screening process

- iv. At least two-thirds of adolescents and young people with mental disorders have access to skilled mental health services from the formal health system by 2024
- v. At least 50% of adolescents and young people with substance use disorders, harmful use of digital technology and addictions receives appropriate ~~treatment~~ interventions (pharmacological, psychosocial, rehabilitation and aftercare services) by 2024
- vi. By 2024, ensure that the National Lottery Act of 2005 is revised to ensure and enforce responsible gambling policies that will mandate sports betting companies to commit to prevention of underage gambling and gambling addictions and assume the responsibility of rehabilitating young people who have otherwise become addicted to the use of their services.
- vii. By 2024, ensure that at least 75% of health and social care facilities managing people with mental health disorders are assessed using the WHO Quality Rights tool kit<sup>72</sup> and develop as well as implement quality improvement plans based on the results of the assessment.

#### ~~5.2.3~~ 6.2.3. **Violence and Injury**

- i. At least 90% of drivers age 18-24 years are knowledgeable of the highway code and duly licensed and approved by the relevant government agencies engaging in driving by 2024
- ii. By 2024, at least 90% of motor parks are free of the sales of alcohol and illicit substances
- iii. By 2024, at least 90% of all drivers, riders and passengers use appropriate safety measures, including seat belts in cars and crash helmets on bicycles and motorcycles
- iv. By 2024, reduce the mortality rate due to road traffic injuries among adolescents and youths by one-third compared to 2018
- v. By 2024, reduce the incidence of physical violence among male and female adolescents and youths by two-thirds of the rate for 2018.
- vi. By 2024, reduce the incidence of violence- and conflict-related deaths among male and female adolescents and youths by two-thirds compared to 2018.

#### ~~5.2.4~~ 6.2.4. **Nutrition and Physical Activity**

- i. By 2024, reduce the prevalence of acute ~~undernutrition-malnutrition~~ among adolescents and young people (age 10-14 years, 15-19 years, and 20-24 years) of both sexes by half compared to 2018 { from 25% in 2018 to 13% in 2024 }
- ii. Reduce the proportion of non-pregnant adolescent girls (age 15-19 years) with anaemia from 61% in 2018 to 30% in 2024.
- iii. By 2024, reduce the prevalence of overnutrition (overweight and obesity) among adolescents and young people (age 10-14 years, 15-19 years, and 20-24 years) of both sexes by half compared to 2018
- iv. By 2024, achieve a 5% relative reduction in the prevalence of insufficient physical activity among adolescents compared to 2018

#### ~~5.2.5~~ 6.2.5. **Non-Communicable Diseases**

##### *Non-communicable diseases*

- i. By 2024, at least 80% of young people have knowledge about behavioural risk factors for non-communicable diseases
- ii. By 2024, reduce the percentage of adolescents (age 10-14 years, and age 15-19 years) who had at least one alcoholic drink before age 15 and before age 18 by half compared to 2018.
- iii. By 2024, reduce the percentage of adolescents and young people (age 10-14 years, 15-19 years, and 20-24) who use tobacco by half compared to 2018.
- iv. By 2024, at least 90% of schools have no advertising and/or sales of cigarettes or any tobacco within 300 metres of its premises
- v. By 2024, reduce the percentage of physically inactive adolescents and young people (age 10-14 years, 15-19 years, and 20-24) of both sexes by half compared to 2018.

- vi. By 2024, Increase the proportion of early adolescents (age 10-14 years) who are immunized against HPV from 2% in 2015 to 50%
- vii. By 2024, eliminate stigma against epilepsy among young people, and increase treatment coverage for young people with epilepsy by 50% compared to 2018
- viii. By 2024, at least 80% of adolescents and young people (age 15-24 years) are knowledgeable about sickle cell disorder and how to prevent it By 2024, at least 80% of adolescents and young people with sickle cell disorder have received counselling about their condition and are on appropriate management

#### **5.2.6.6.2.6. Disabilities**

- i. By 2024, at least 75% of adolescents and young people with disability have access to relevant health services
- ii. By 2024, at least 50% of adolescents and young people have appropriate assistive technologies to enhance their mobility and self-care
- iii. By 2024, ensure that the National Commission for Persons with Disabilities is fully established and have operations in at least 50% of all the states and the FCT

#### **5.2.7.6.2.7. Communicable Diseases**

- i. End the incidence of HIV among adolescents and young people by 2024
- ii. By 2024, reduce the incidence of tuberculosis among adolescents and young people by two-thirds compared to 2018
- iii. Increase the percentage of adolescents (15-19 years) who sleep inside an insecticide-treated net or in a room sprayed with internal residual spray within a 12-month period from 37% in 2015 to 80% in 2024.
- iv. By 2024, reduce malaria incidence by 40% compared to 2015 and malaria mortality rates by 60% compared to 2015 among adolescents and young people (15-24 years)
- v. By 2024, at least 60% hepatitis B vaccination rate among adolescents and young people

#### **5.2.8.6.2.8. Oral Health**

- i. By 2024, at least 70% of adolescents and young people have good knowledge of oral health and ~~its the~~ importance to healthy lifestyle and wellbeing
- ii. By 2024, at least 50% of PHC facilities provide the basic package of oral health care
- iii. By 2024, at least 50% of adolescents and young people have access to oral health care

#### **5.2.9.6.2.9. Health system and services**

- i. Ensure that all adolescents age 14 years have the rights to receive ambulatory and non-surgical reproductive health services appropriate for their age and health situation – including contraceptive information, counselling and services, prevention and treatment of sexually transmitted infections, management of sexual abuse and post-abortion care – without any discrimination from health worker or request for adult/parental consent that may pose a barrier to prompt and quality services
- ii. At least 50% of all public sector primary health care facilities have at least one service providers trained in the provision of adolescent health services by 2024
- iii. At least 50% of public sector primary health care facilities offer the full complement of the nationally-specified minimum package of adolescent- and youth-friendly health services by 2024
- iv. At least 50% of adolescent and young people have access to public sector PHC facilities that offer the full complement of the nationally-specified minimum package of adolescent- and youth-friendly health services by 2024
- v. By 2024, at least three-quarters of all the states and FCT have an Adolescent Health Officer formally designated

- vi. By 2024 at least two-thirds of all the states and FCT have a functional State Adolescent Health and Development Technical Working Group
- vii. An annual progress report on the policy implementation is produced and publicly available electronically every year between 2020 and 2024

#### **5.2.10-6.2.10. School health system and services**

- i. By 2024, at least two-thirds of all public and private sector primary and secondary schools have a school health service or are linked to such a service
- ii. By 2024, at least two-thirds of all public and private sector primary and secondary schools have adequate water and sanitation facilities for males and females, including separate female-friendly toilets with appropriate provisions for menstrual hygiene management safe drinking water facilities; clean and separate female and male students
- iii. By 2024, ensure that at least 90% of all private and public schools incorporate and implement physical activities as part of their school curriculum and have adequate facilities for physical activities for the school population
- iv. By 2024, at least half of all public and private sector primary and secondary schools attain the status of health-promoting schools

#### **5.2.11-6.2.11. Family and community systems**

##### *Parental care and family environment*

- i. By 2024, at least 75% of adolescents report that their parents or guardians understand their problems or worries most of the time
- ii. By 2024, at least 75% of adolescents report that their parents or guardians really know what they are doing in their free time

##### *Community system*

- iii. By 2024, at least half of community and religious leaders are supportive of adolescent health services and programmes
- iv. By 2024, at least 25% of Community Health Influencers, Promoters and Services (CHIPS) personnel are knowledgeable and supportive of the provision of adolescent health services and programmes in their communities
- v. Ensure that not more than 25% of adolescents and young people (females and males) report a serious problem in accessing health care for themselves when they have a need for such.

## **6.7. POLICY IMPLEMENTATION**

### **6.1.7.1. Multisectoral agenda and principles in the policy implementation**

Ensuring the health and well-being of young people is a multi-sectoral endeavour. In addition to the health sector, several other sectors play key and complementary roles in that agenda nationally. These include the educational, youth development, information, legal and economic sectors. Thus, all government ministries alongside their agencies and parastatal have important roles to play in the implementation of this policy. Thus, the implementation of the Policy demands all sectors and their associated government institutions to reflect and implement relevant aspects of the policy in their sectoral plans as it relates to their mandates. As the constitution stipulates, health is a concurrent legislative item with all the levels of government having a role to play, and the National Health Act has articulated the responsibilities to each level of government in that respect. Thus, the three levels of governance – federal, state and local government level – have roles and responsibilities in the implementation of this policy and the attainment of its goals and objectives.

The health sector has the lead role in the implementation of this Policy and is responsible for the central coordination of the multisectoral actors and produce national reports on the state of implementation of the Policy. Other responsibilities of the health sector include the provision of quality health services and programmes for adolescents and other young people and the production and management of the human resources required to handle the services and programmes. The health sector also has the responsibility to provide accurate information to young people and adults working with them to improve their health knowledge, literacy, self-care competencies, and behaviour. Furthermore, the health sector has the responsibility to generate evidence and strategic information to guide her programming as well as that of the other sectors. In addition, the health sector has a responsibility to provide guidance and technical support to other sectors in developing programmes relating to the health of adolescents and young people, and a duty to collaborate with all the other sectors and stakeholders in every endeavours relating to the actualisation of this Policy.

All other duty bearers and stakeholders in the society, including the civil society, the academia/training and research institutions, the private sector (formal and informal) and families/households also have very significant, strategic and complementary roles to play regarding the national adolescent health agenda. Adolescents and youths are the right holders and the prime actors in the health and development agenda for young people in Nigeria and their meaningful engagement in all aspects of the policy implementation, monitoring, and evaluation is key to the success of the Policy. While the primary responsibility for the implementation of the policy is that of the Nigerian government and her peoples the support and contributions of international development partners are also important to achieve the policy objectives.

### **6.2.7.2. Role of the Health Sector**

#### **6.2.1.7.2.1. Federal Ministry of Health**

The Federal Ministry of Health (FMOH) shall provide overall strategic direction and technical guide for the implementation of this policy. In particular, the Ministry shall:

1. Prioritise adolescent and young people's health and development in her agenda and plans of work as well as integrate young people's health issues into all her policies as well as that of her parastatals, including the National Primary Health Care Development Agency and the National Health Insurance Scheme.
2. Foster effective partnerships for the advancement of adolescent and young people's health and development (AYPHD) agenda by creating and strengthening linkages with other



sectors, bilateral and multilateral international development organisations, national and international civil society organisations, as well as the academia and professional groups.

3. Support the effective functioning and optimal performance of the Gender, Adolescent, School Health and Elderly (GASHE) Division and the Adolescent Health ~~Unit~~ Branch through adequate resourcing, including human resources, financial resources, material resources (such as office space and equipment) and optimal provision of capacity strengthening opportunities.
4. Establish and effectively support the regular convening and operations of a multi-disciplinary, multi-sectoral National Adolescent Health and Development Working Group (NAHDWG). The Adolescent Health ~~Unit~~ Branch of GASHE Division, FMoH will serve as the secretariat for the NAHDWG.
5. Create, ~~maintain~~ maintain, and adequately fund a budget line for supporting AYPHD activities and policy implementation.
6. Develop, distribute and deploy complementary policy implementation tools and frameworks, including a Strategic Framework, Action Plan, and Monitoring and Evaluation (M&E) Plan.
7. Develop the required human resources development framework, service guidelines, training plans and manuals required for the effective implementation of the AYPHD agenda.
8. Develop, widely disseminate and periodically review national standards, minimum health packages, tools, instruments and materials in support of adolescent/youth-friendly health services in Nigeria, including clinical, counselling and health communication services.
9. Encourage, promote and facilitate the establishment of adolescent/youth-friendly health services in federal health institutions and the orientation of all services to be adolescent/youth-responsive.
10. Provide technical assistance to States, Local Government Areas, and other agencies and sectors in the implementation of relevant areas of the policy.
11. Mobilise the private sector and other development partners to support programmes for AYPHD including educational, vocational, life skills and livelihood skills activities.
12. Spearhead advocacy efforts to generate increased stakeholders' support and commitments for AYPHD programmes in terms of budget and resource provision, enactment of supportive legislations, and creation of an environment conducive for effective programming.
13. Develop national research priorities and promote/support research activities on AYPHD.
14. Regularly collect, collate and disseminate relevant age- and gender-disaggregated national-level data about the state of adolescent and young people's health and services
15. Review, monitor and evaluate the policy implementation processes and the associated programmes nationally to ensure the success of the policy agenda

#### **6.2.2.7.2.2. State Ministries of Health**

The State Ministry of Health (SMoH) shall provide leadership for the implementation of this policy within the state. In particular, the Ministry shall:

1. Foster partnership with other agencies and stakeholders to advance AYPHD-related agenda in the state and ensure adolescent- and youth-responsive health and social development systems.
2. Designate an Adolescent Health Focal Officer with specific terms of reference to promote the effective implementation and institutionalisation of AYPHD programmes in the State
3. Provide appropriate infrastructure, staff, funding, capacity-development opportunities and logistics to support the Adolescent Health Focal Officer to function effectively.
4. Establish and effectively support the operations of a multi-disciplinary, multi-sectoral State Working Group on Adolescent and Young People's Health and Development (SAHDWG), with the SMoH serving as the secretariat.

5. Spearhead the advocacy for increased government and stakeholders' commitments and support for AYPHD programmes and agenda in the state.
6. Develop and implement a state AYPHD action plan to facilitate improved services and programme to enhance adolescent and young people's health and wellbeing in the state.
7. Create a budget line for AYPHD activities and provide an adequate amount of funds annually to support the effective implementation of the policy at the state level.
8. Provide technical assistance to Local Government Areas and agencies and institutions in the state in the implementation of relevant areas of the policy.
9. Strengthen the capacity of health workers, to provide quality and friendly services to young people
10. Ensure the availability of AYFHS at the primary health care level and the appropriate supportive back-up/referral services at secondary health care facilities.
11. Regularly collect, collate and disseminate relevant data about adolescent and youth health services and issues within the State in an age- and gender-disaggregated form and promote the appropriate use of the data for programming.
12. Technically and financial support AYPHD-related research endeavours to generate relevant data on AYPHD issues in the state.
13. Monitor the implementation of the policy in the state and develop and share progress report regularly with GASHE and NAHDWG as well as stakeholders in the state and beyond

#### **6.2.3.7.2.3. Local Government Health & Related Social Development Departments**

1. Promote and implement adolescent- and youth-responsive agenda in the health and social development system, including primary health care, primary schools, social welfare, and other related activities under the authority of the Local Government Area authority.
2. Establish relevant adolescent- and youth-related facilities at community levels and strengthen the community systems to support AYPHD programmes and activities
3. Strengthen the capacity of health workers, school teachers, social welfare officers, and other relevant Local Government Area (LGA) staff to provide quality and friendly services to young people.
4. Create a budget line and provide adequate and regular funding for AYPHD services and judiciously manage all available funds for AYPHD services and programmes.
5. Create a favourable environment for AYPHD programming at the LGA and community levels, and provide technical assistance and support to civil society organisations and institutions in the LGA in the implementation of relevant areas of the policy.
6. Regularly collect, collate and disseminate relevant data about adolescent and youth health services and issues within the LGA in an age- and gender-disaggregated form and promote the use of the data for programming
7. Support operation and other types of research on AYPHD issues within their LGAs.
8. Monitor and document activities, services and programmes conducted in the LGA relating to AYPHD and share such reports regularly with SMoH and SAHDWG

#### **6.3.7.3. Role of Other Government Ministries and Agencies**

##### **6.3.1.7.3.1. The Legislature**

1. Make appropriate legislation regarding the health and development of adolescents and young people and support the implementation of this Policy at the relevant levels
2. Support the domestication and implementation of relevant policy instruments that protect and promote the health, rights, and well-being of adolescents and young people, including

international and regional treaties and conventions in the case of the federal legislature and national laws and policies in the case of state legislatures

3. Ensure timely and adequate budgetary approval and budgetary release for AYPHD activities, and provide effective oversight for the use of the funds and programme implementation
4. Prioritise and champion issues relating to the health and development of adolescents and young people in various constituencies and in constituency projects
5. Mobilise and educate members of focal constituencies to develop and support AYPHD programmes, including AYFHS and school health initiatives.

#### **6.3.2.7.3.2. Ministry of Education**

1. Intensify efforts to achieve universal basic education and address the educational needs of vulnerable adolescent and young people including those in conflict-affected areas and street-involved adolescents and youths
2. Improve the quality of educational services and the school environment to optimise learning and educational opportunities by adolescents and young people
3. Adopt the policies and principles of health-promoting school and integrate best practices that guarantee the school as a safe, health-enhancing and health-promotive environment
4. Review and revise the family life and HIV/AIDS education curriculum to ensure that it responds to the changing needs of adolescents and young people and conforms to the global best practices in comprehensive sexuality education curriculum design and delivery
5. Scale-up the training of teachers in family life and HIV/AIDS education (FLHE) as well as expand the coverage and effectiveness of FLHE at all levels of formal education
6. Integrate FLHE into mass literacy, adult and non-formal educational programmes to cater for the out-of-school adolescents and other young people.
7. Monitor the implementation of FLHE at all levels and ensure its effective implementation through curricular, co-curricular, and extracurricular approaches as well as the adoption of innovative processes, approaches, and technologies
8. Improve the quality and coverage of school-based health-related initiatives, including school health services, school feeding programme, and, physical and health education
9. Ensure that all schools – private and public – have adequate and gender-responsive water and sanitation facilities that meet the basic needs of all adolescents and youth learners, including the specific needs of the females for appropriate menstrual hygiene management
10. Ensure that all schools have and enforce policies that enhance school connectedness and protect the health and freedom of adolescent and youth from physical, psychological, and sexual violence and all forms of school-related violence
11. Ensure that all schools meet the basic safety and legal requirements in terms of locations and the quality of infrastructure as well as the classroom facilities
12. Adopt innovative approaches and programmes that promote the school as a platform for holistic adolescent and youth development and gender-transformative experiences for students and school population, the parents and other stakeholders
13. Develop the capacity of adolescents and young people to serve as advocates for their health and development needs, and to champion accountability for quality service delivery.
14. Collect, analyse, and disseminate age- and gender-disaggregated education service statistics and promote the use of the data to improve school-based health-related programmes.

#### **6.3.3.7.3.3. Ministry of Women Affairs**

1. Promote awareness of adolescent and young people's health, development and well-being issues among policymakers, community and religious leaders, and other stakeholders.

2. Address gender-inequitable norms and harmful practices that negatively impact the health, well-being and development of the female adolescent through advocacy, sensitisation and social behavioural change communication, legislative and policy changes, and legal actions.
3. Promote the effective implementation of The Violence Against Persons (Prohibition) Act (VAPP) as well as the Discrimination Against Persons with Disabilities (Prohibition) Act 2018
4. Engage in effective innovative gender-transformative programmes to remove the barrier limiting the access of female adolescents and youths, including married ones, to health services, education and training opportunities, and other development prospects.
5. Promote and ensure the implementation of measures and activities that will improve the status, health and well-being of adolescents and young people, particularly the females.
6. Promote economic development and self-reliance among adolescents and other young females and other vulnerable groups through training and skill acquisition opportunities.
7. Advocate for, and ensure the mainstreaming of gender concerns into all health development activities relating to adolescents and young people
8. Organise capacity building activities to improve parents' ability to strengthen parent-adolescent communication, relationship, and connectedness
9. Collect, analyse and disseminate gender-related statistics as well as support research activities to generate evidence to inform gender-responsive policies and programmes.

#### **6.3.4.7.3.4. Ministry of Youth and Sport Development**

1. Establish and manage youth centres with relevant AYPHD programmes such as counselling to meet the needs of in- and out-of-school adolescents and other young people.
2. Sensitise and educate community influencers on the importance of adolescent and young people's health and development (AYPHD) agenda.
3. Undertake social and behavioural change communication programmes to improve the decision-making capacity and health behaviour of young people.
4. Build the capacity of young people for gainful career/employment life and for engendering meaningful participation in national development activities
5. Develop recreational and other facilities to enhance the health and development of young people and promote their access to such facilities through appropriate policies.
6. Intensify the implementation of organised recreational and sporting activities to enhance physical activities and improve health outcomes.
7. Ensure the availability of relevant gender-responsive social welfare services at various levels, including community-based adolescent-friendly counselling services that will contribute to a healthy, safe and supportive environment for young people.
8. Ensure the appropriate integration of FLHE into the teaching curriculum of institutions for adolescents and young people with disabilities and other forms of special needs.
9. Encourage and supervise social welfare voluntary agencies to effectively implement appropriate areas of the policy.
10. Ensure the establishment, maintenance and effective functioning of rehabilitation centres to cater adequately for young people needing such services.
11. Collect, collate, analyse and disseminate sectoral data on adolescent and youth development initiatives and activities, and use the data generated to inform programmes.

#### **6.3.5.7.3.5. Ministry of Finance**

1. Adopt adolescent-responsive budgeting for AYPHD issues and mandate sectoral ministries to justify investments with explicit attention to adolescents' health and development
2. Support the establishment of specific budget lines for AYPHD activities for different line ministries and other government agencies

3. Collect, collate, analyse and disseminate sectoral data on adolescent and youth development initiatives and activities, and use the data generated to inform actions.

#### **6.3.6.7.3.6. Ministry of Justice**

1. Review and reform, where necessary, laws pertaining to AYPHD, and provide legal guidance to facilitate legal frameworks that are supportive and promotive of AYPHD agenda.
2. Develop the appropriate legal framework that ensures and assures the reduction in the age of consent/access of adolescents and young people to sexual and reproductive health services as well as other interventions relevant to the health and well-being of adolescents and young people
3. Promote the integration of relevant international and regional charters and conventions relevant to AYPHD that Nigeria has signed into domestic laws, including the Maputo Protocol.
4. Undertake information, education and communication activities to increase public awareness on laws pertaining to AYPHD issues.
5. Actively facilitate the prosecution of cases involving violation of young people's rights and promote the enforcement of laws relevant to AYPHD
6. Ensure the establishment of juvenile courts nationwide to address appropriate cases relating to young adolescents and enhance speedy handling and conclusion of all cases
7. Collect, collate, analyse and disseminate sectoral data on adolescent and youth development initiatives and activities, and use the data generated to inform actions.

#### **6.3.7.7.3.7. Ministry of Budget and National Planning**

1. Ensure sufficient budgetary allocation for AYPHD activities and informed by appropriate evidence
2. Ensure integration of AYPHD issues into development and humanitarian planning in all relevant sectors.
3. Strengthen the coordination of International co-operation for AYPHD activities.
4. Integrate AYPHD data into the national data bank
5. Collect, collate, analyse and disseminate sectoral data on adolescent and youth development initiatives and activities, and use the data generated to inform actions.

#### **6.3.8.7.3.8. Ministry of Information and National Orientation**

1. Support the dissemination of AYPHD information through the national orientation strategies at all levels.
2. Mobilise available organisational structures and institutions to support the implementation of AYPHD policy and programmes.
3. Ensure integration of AYPHD issues into the curriculum for journalists' training.
4. Build the capacity of journalists and mass media practitioners in reporting and broadcasting on the health and development issues of young people.
5. Enforce the existing laws on information dissemination and mass media activities that have relevance to young people's health and development
6. Collect, collate, analyse and disseminate sectoral data on adolescent and youth development initiatives and activities, and use the data generated to inform actions.

#### **6.3.9.7.3.9. Ministry of Agriculture and Rural Development**

1. Integrate FLHE activities into the training programmes of agricultural extension workers.
2. Build the capacity of agricultural extension workers to promote the health and development issues of young people among their target populations.

3. Collect, collate, analyse and disseminate data regarding AYPHD issues within the sector.

**6.3.10.7.3.10. Ministry of Labour and Productivity**

1. Strengthen training programmes on AYPHD issues, including family life and HIV/AIDS education, for workers.
2. Promote policies and practices that will enhance the knowledge and skills of young people to prepare them for gainful employment.
3. Promote policies that will ensure equitable access to employment opportunities and reduce under-employment and unemployment among young people (both males and females).
4. Monitor labour laws, policies, and practices to discourage workplace practices that could be detrimental to the health and development of young people.
5. Ensure the mainstreaming of the needs of young people in vulnerable situations and special circumstances, including those with physical and mental challenges and young people living with HIV and AIDS, into the sectoral activities.
6. Collect, collate, analyse and disseminate sectoral data on adolescent and youth development initiatives and activities, and use the data generated to inform actions.

**6.3.11.7.3.11. Ministry of Works and Housing**

1. Provide and regularly maintain public infrastructure in their area of mandate in support of the creation of a healthy, safe and supportive environment for adolescents and young people.
2. Develop infrastructures in public spaces and facilities that will support the easy movement of adolescents and young people who are physically challenged.
3. Collect, collate, analyse, disaggregate and disseminate data regarding young people's health and development issues within the sector and use the collected data to inform actions.

**6.3.12.7.3.12. Ministry of Power**

1. Provide and regular power supply in support support of the creation of a healthy, safe, supportive and productive environment for adolescents and young people.
2. Ensure the safety of all electrical installation and other power-related infrastructure such that they do not constitute any hazard to the health and well-being of adolescents and young people as well as their significant others.
3. Collect, collate, analyse, disaggregate and disseminate data regarding young people's health and development issues within the sector and use the collected data to inform actions.

**6.3.13.7.3.13. Ministry of Interior**

1. Ensure the establishment, maintenance and effective functioning of corrective centres to provide optimal services for young people needing such facilities.
2. Ensure the safety of adolescents and young people in emergency situations and in fragile and humanitarian settings
3. Develop schemes and programmes that promote the access of adolescents and young people to social and economic development
4. Collect, analyse disaggregate, and disseminate data regarding young people's health and development issues within the sector and use the collected data to inform actions.

**6.3.14.7.3.14. Ministry of Humanitarian Affairs, Disaster Management and Social development**

1. Ensure the establishment, maintenance and effective functioning of rehabilitation centres to provide optimal services for young people needing such facilities.
2. Ensure the safety of adolescents and young people in emergency situations and in fragile and humanitarian settings

3. Ensure the provision of adequate facilities that will support the health and well-being of adolescents in humanitarian settings, including nutritional support services, sexual and reproductive health services, menstrual hygiene management materials, prevention of sexual violence interventions, and water and sanitation facilities, as well as access to health literacy and education.
4. Develop schemes and programmes that promote the access of adolescents and young people to social and economic development

**6.3.15.7.3.15. National Population Commission**

1. Collect, analyse, interpret and disseminate age- and gender-disaggregated demographic and other relevant data relating to young people through census and sample surveys.
2. Disseminate specific data regarding adolescents and young people through the development and distribution of monographs, fact sheets, and other print and electronic materials.
3. Support and promote national research activities on AYPHD issues
4. Collaborate with FMOH to generate data for the evaluation AYPHD programme across sectors.
5. Advocate and promote the implementation of sexual and reproductive health programmes for adolescents and young people as part of population and development activities.
6. Provide relevant and up-to-date data on AYPHD on a timely basis to the National Planning Commission for inclusion in the nation data bank.

**6.3.16.7.3.16. National Bureau of Statistics**

1. Collect, analyse, interpret and disseminate gender-disaggregated socio-economic data to facilitate monitoring and evaluation of AYPHD programmes.
2. Disseminate adolescent- and youth-specific regional and gender-disaggregated socio-economic data.
3. Provide data on a regular basis to the national data bank and other relevant agencies and institutions regarding the health and development of young people.

**6.3.17.7.3.17. National Commission for Persons with Disabilities**

1. Promote the implementation of the Discrimination Against Persons with Disabilities (Prohibition) Act 2018 nationally
2. Introduce initiatives to support the development and integration of physically and mentally challenged adolescents and youths into the mainstream of society.
3. Facilitate increased access of physically and mentally challenged adolescents and youths to relevant health and social services, and to education, development opportunities and meaningful jobs.
4. Collect, analyse disaggregate, and disseminate data regarding young people's health and development issues within the sector and use the collected data to inform actions.

**6.4.7.4. The Armed Forces, Other Uniformed Services and Security Agencies**

1. Enforce the protection of young people's rights as enshrined in the constitution
2. Establish an adolescent and youth-friendly desk within each of the focal organisations and designate an adolescent/youth focal person, and support the focal person to be fully effective through the provision of staffing, funding, and other resources needed.
3. Build the capacity of officers and staff to understand and effectively intervene in issues relating to young people, their health and development.
4. Ensure the enforcement of the existing code of conduct that protects young people's rights.
5. Collect, analyse disaggregate, and disseminate data regarding young people's health and development issues within the sector and use the collected data to inform actions.

#### **6.5.7.5. Non-State Actors**

##### **6.5.1.7.5.1. Faith-based Organisations**

1. Provide moral instructions and spiritual guidance that will promote positive development and health of adolescents and other young people, and undertake relevant AYPHD activities.
2. Sensitise members and communities on the health and development issues of young people and mobilise in support of the AYPHD agenda.
3. Advocate for appropriate AYPHD policy and programme development and changes.
4. Promote reproductive health services and other development activities for young people consistent with their religious beliefs.
6. Collect, analyse disaggregate, and disseminate data regarding young people's health and development issues within the sector and use the collected data to inform actions.

##### **6.5.2.7.5.2. Non-Governmental Organisations**

1. Complement government efforts in the formulation, financing, implementation, and monitoring and evaluation of AYPHD programmes.
2. Promote and support networks for AYPHD issues.
3. Mobilise, organise and build the capacity of the informal sector to support young people's health and development
4. Advocate for relevant policy changes and programme implementation relating to young people's health and development activities.
5. Sensitise and train religious leaders to speak publicly in support of adolescent and young people's health and development issues
6. Expand the delivery of AYFHS and related development services to the community, especially to hard-to-reach areas, using innovative approaches.
7. Undertake operation and other forms of research activities to improve AYPHD evidence.
8. Collaborate with relevant line ministries and government agencies in the implementation of AYPHD programmes.
9. Collect and submit service statistics to relevant government agencies on a regular basis.
10. Monitor the implementation of this national policy.

##### **6.5.3.7.5.3. Professional and Learned Societies**

1. The Society for Adolescent and Young People's Health in Nigeria (SAYPHIN), as Nigeria's national organisation of adolescent health professionals, will convene the National Conference on Adolescent Health every two years in partnership with FMOH and others.
2. Conduct and regularly and high-impact research and produce and disseminate research-related products on AYPHD to address research gaps and generate new evidence
3. Convene regular scientific forums on AYPHD to improve understanding and learning about AYPHD situations in Nigeria and globally and the best practices in policy development and programming.
4. Partner effectively with the FMOH in programme development as well as in the review of progress in policy implementation and in evidence-based advocacy on AYPHD.
5. Conduct training and undertake relevant capacity building to expand the adolescent health workforce, researchers and programme analysts
6. Partner with one another and other non-state actors to initiate and/or implement effective social accountability mechanisms.



#### **6.5.4.7.5.4. Academia, Tertiary Education Institutions, and Research Institutes**

1. Provide training on AYPHD issues.
2. Develop and implement policies that will ensure a safe and supportive environment for young people and enhance their health and development, including policies to protect them from sexual harassment and other forms of sexual rights abuses
3. Develop and implement programmes that will effectively support the health and development of the population of young people, including health promotion activities, BCC programmes, and counselling services.
4. Establish youth-friendly health services in their institutions.
5. Develop and activate mechanisms to regularly monitor the health and development of young people within their institutions.
6. Provide advisory services on AYPHD issues to other development partners.
7. Assist in the evaluation of programmes related to this national policy.
8. Undertake basic, operational and applied research activities to generate new ideas, monitor policy implementation, and improve AYPHD programmes.
9. Organise and disseminate findings from research on AYPHD widely to the public and policy makers.

#### **6.5.5.7.5.5. Organized Private Sector**

1. Actively participate in policy advocacy, programme development and implementation of activities relevant to the health and development of young people, and complement the efforts of the Government and other sectors of the society.
2. Endeavour to make the work environment-friendly to young people, including the vulnerable and disadvantaged ones such as the physically challenged adolescents, in terms of structure and infrastructure, policies, and processes.
3. Collaborate activities with other partners including the state actors and non-state actors to synergise effort and increase impact in the AYPHD field.

#### **6.5.6.7.5.6. Political Parties**

1. Integrate AYPHD concerns into party manifestos, agendas, plans and programmes.
2. Support the implementation of AYPHD programmes
3. Provide information and education on the importance of AYPHD issues to national development to their members.
4. Promote and advocate the appropriate policy changes in the area of young people's health and development.

#### **6.5.7.7.5.7. Media**

1. Produce programmes and disseminate accurate, culturally-appropriate and gender-sensitive information on young people's health and development
2. Collaborate with other development partners and sectors in undertaking educational campaigns on young people's health and development
3. Advocate relevant policy changes and programme implementation relating to the health and development issues of young people.
4. Assist relevant agencies in the dissemination of young people's health and development data and other relevant information.

#### **6.6.7.6. Young People**

As part of their rights to actively and meaningfully participate in all aspects of the implementation of this policy, programmes, and activities primarily focussing on the health and development of young people must have adequate and appropriate representation of various categories of young people. Particular attention must be paid to gender and geographical balance, among others. Young people have the right to participate in national development processes and also a duty to demand their rights in relation to health and development provisions of this policy. Furthermore, they have the right to participate in all forms of AYPHD.

Young people shall have the following roles and responsibilities:

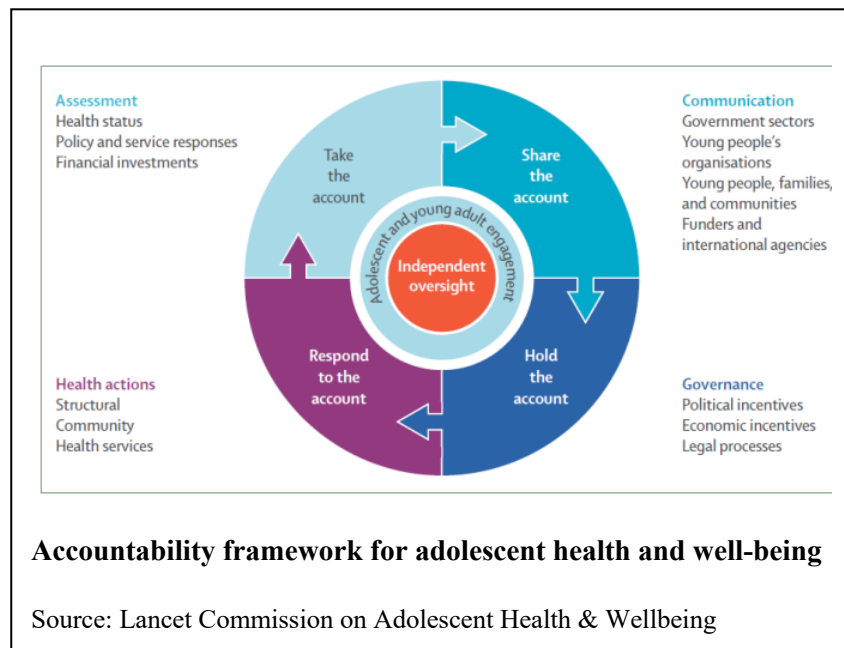
1. Participate actively in policy development, advocacy and resource mobilisation in support of AYPHD programmes;
2. Undertake health advocacy and sensitisation programmes to promote youth participation in state and national development agenda
3. Engage with communities to address customs and practices that discriminate and/ or impact negatively on the rights as well as the health and development of adolescents and young people ;
4. Engage with peers to educate and build life skills for healthy and responsible living including health-seeking behaviours
5. Encourage the formation of youth -ed Civil Society Organisations (CSOs), Community-based Organisations and Faith-based organisations to enhance youth participation and AYPHD programmes
6. Create linkages with government agencies, CSOs including youth-serving Non-governmental Organisations (NGOs), and other development partners to enhance AYPHD programmes;
7. Utilize digital platforms and other innovative approaches to disseminate social and behavioural change information and policy dissemination
8. Monitor the implementation of the policy and establish suitable mechanisms for social accountability

## **7.8. MONITORING, EVALUATION, ACCOUNTABILITY, AND LEARNING**

Monitoring, Evaluation, Accountability, and Learning are critical to ensuring the delivery of the goals of this policy and are designed as a set of deliberately planned and inter-related efforts that are integral to the policy implementation right from the onset. Monitoring and evaluation will be geared towards generating information that will enable the country and stakeholders to take an appropriate stock of the course of the policy implementation regarding the progress being made and provide the foundation for accountability. The monitoring, evaluation and accountability processes shall collectively provide an opportunity to document and draw useful lessons regarding our policy implementation and to apply those lessons in refining programmes and services for the goal of improving the health and wellbeing of adolescents and young people in Nigeria in line with the vision of this Policy.

This Policy's Monitoring, Evaluation, Accountability, and Learning approach leans on *The Unified Accountability Framework for the Global Strategy for Women's Children's and Adolescents' Health* and aligns with its perspective

that, "Accountability comprises three interconnected processes – monitor, review, and act – that are aimed at learning and continuous improvement".<sup>73</sup> In addition, the four-step accountability framework for adolescent health and well-being developed by the Lancet Commission provides a further guide for framing of the monitoring, evaluation, accountability and learning processes regarding this Policy. The framing also benefits from the UNAIDS' *Organizing Framework for a Functional National HIV M&E System*<sup>74</sup> and the recommendations of the Independent Accountability Panel's *Transformative accountability for adolescents* Report.<sup>75</sup>



### **7.1.8.1. Coordination and Oversight for Monitoring, Evaluation, Accountability, and Learning**

#### **7.1.1.8.1.1. Oversight Function by the National Technical Working Group**

The National Adolescent Health and Development Technical Working Group (NAHDWG) will have the lead oversight role for monitoring and evaluating the policy implementation and the attainment of its objectives. The Group will meet thrice a year on a regular basis. Among others, the Group will rigorously review the status of the implementation of the policy and note progress regarding the health and well-being of adolescents and young people in Nigeria. The progress report that would regularly be prepared by Gender, Adolescent, School Health and Gender (GASHE) Division of the Federal Ministry of Health will be reviewed by the NAHDWG at every one of its meetings. The NAHDWG will advise the FMOH on further steps to take in advancing the health and development of adolescents and young people following the review of the available evidence and progress reports.

#### **7.1.2.8.1.2. Coordination Function by the Adolescent Health-focused Division of FMOH**

The Gender, Adolescent, School Health and Elderly (GASHE) division of the Department of Family Health of the Federal Ministry of Health as the secretariat of the National Adolescent Health and Development Working Group (NAHDWG) will develop and widely disseminate a uniform reporting format to be used by various organisations and institutions involved in AYPHD programme at all levels in the country. The M&E unit of each government agency with roles and responsibility in the implementation of the Policy shall monitor the agency's activities and develop a summary report. The report shall be shared with the GASHE division of the Department of Family Health of the Federal Ministry of Health as the secretariat of the National Adolescent Health and Development Working Group (NAHDWG).

GASHE will have specific officers designated to specifically anchor its M&E-related responsibilities, including collating progress reports on the policy implementation from various groups of stakeholders and act as liaison with the Department of Planning, Research and Statistics (DPRS) on the NHMIS. These officers will actively follow up with the states, federal agencies, development actors and other stakeholders about the timely submission of their progress report. The officer will also have the responsibility of carefully organising and archiving the various reports in an electronic format. The officers would also ensure appropriate analysis of data and reports submitted, and summarise them to provide a national picture quarterly.

#### **7.2.8.2. Monitoring and Evaluation**

A National M&E Plan for the health and development of adolescents and young people will be developed to serve as one of the Policy's key implementation instruments. The Plan shall be guided by the goal, objectives, and targets of this Policy and will articulate, among others, the processes for systematically collecting, aggregating, analysing and interpreting information and data collected as part of the M&E process. The M&E plan will be framed to align with the National Health Management Information System (NHMIS) policy, plans and processes, linked to FMOH institutional M&E framework, and connected with the National Integrated Monitoring and Evaluation System.

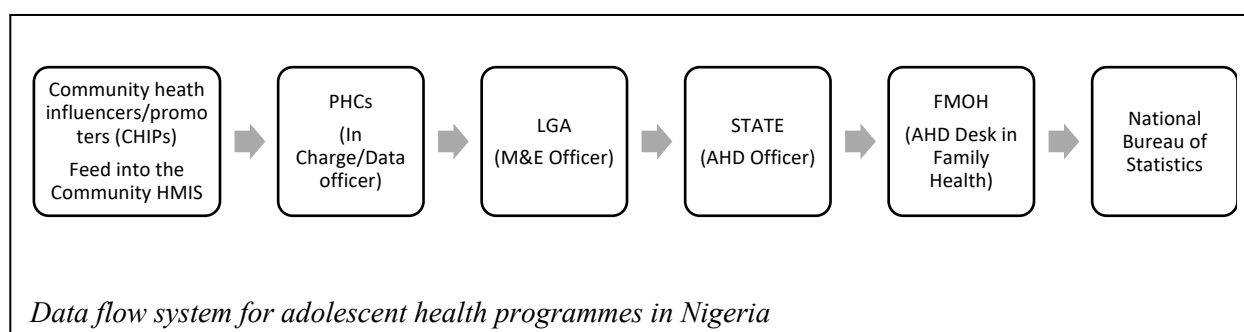
##### **7.2.1.8.2.1. Monitoring Process**

The monitoring process will involve the following:

- i. *Monitoring at the organisational level:* Reporting and monitoring of policy implementation by key state actors and non-state actors through service data and programme products:
  - a. The M& E unit of each government agency with roles and responsibility in the implementation of the Policy shall monitor the agency's activities and generate relevant reports. The report shall be shared with the GASHE division of the Department of Family Health of the Federal Ministry of Health as the secretariat of the National Adolescent Health and Development Working Group (NAHDWG).
  - b. The NHMIS will provide a summary of service-related data with appropriate sex- and age-disaggregation (age 10-14, 15-19, and 20-24) from its routine health information system on a quarterly basis to GASHE. All relevant units and parastatals of the FMOH will also provide quarterly reports with relevant age- and sex-disaggregated data. All government agencies and other stakeholders shall submit service-related data and other data as may be required by the NHMIS through the approved channels and using specified tools. Among others, data and activity reports from the communities shall go to the health facilities and LGAs shall send to the state monthly. The State Ministry of Health and the counterpart at the Federal Capital Territory as the Secretariat of the FCT/State Adolescent Health and Development Working Group shall compile quarterly progress reports and share the report with GASHE. All non-state actors working within any state of Nigeria will submit its report to the State Ministry of Health on a quarterly basis and share a copy with other relevant agencies

(for example, the State Primary Health Care Development Board and the LGA Health Unit) as may be required by the state structures and operational guidelines. International development partners, including bilateral organisations, multilateral organisations, and international NGOs, will also provide a copy of their relevant activities to GASHE.

- c. GASHE shall conduct regular monitoring and supportive supervision visits to states and other actors on a quarterly basis as part of the policy implementation process. The state adolescent health office will also conduct regular quarterly monitoring and supportive supervision visits within the state.



#### **7.2.2.8.2.2. Evaluation and Review Processes**

The Evaluation of the implementation of the policy will take place periodically as follows:

- a. Mid-Term Evaluation: A mid-term evaluation will take place mid-way into the five-year duration of the policy implementation period. The report of the evaluation will be presented to the NAHDWG through its secretariat, GASHE, for thorough discussion and review with appropriate recommendations made to the FMOH and other stakeholders. The mid-term evaluation will seek to examine the trajectory in the policy implementation, draw key lessons about progress and challenges, and make recommendations about the direction for further actions.
- b. End-of-Term Evaluation: An end-of-Term evaluation will take place towards the end of the five-year duration of the policy implementation period. The evaluation will be comprehensive in nature and undertaken by experienced professionals with the required technical knowledge and skills in M&E and Adolescent Health. The report of the evaluation will be presented to the NAHDWG through its secretariat, GASHE, for a thorough discussion. The report of the end-of-term evaluation will provide key learning points and an overview of progress made and the associated factors. The evaluation report will inform the development of a new policy.

The Monitoring, Evaluation, Accountability and Learning processes will take the advantage of the Joint Assessment of National Health Strategies that will be taking place as part of the National Strategic Health Development Implementation to examine progress and issues relating to adolescent and young people's health status. The Monitoring, Evaluation, Accountability, and Learning will also take advantage of the various research activities across the country regarding the health and development of adolescents and young people's health in Nigeria, as well as various databases and information systems, including the surveillance systems.

#### **7.3.8.3. Research**

Research activities are an important part of the policy implementation as a whole, and complementary to the monitoring and evaluation activities for the generation of evidence to

better inform programmes and interventions. Research priorities will be developed and released nationally every two years to guide researchers and research groups and institutions. The research will cover the whole spectrum of research activities, including qualitative research, quantitative research, mixed-method approach and also include systematic reviews, review of reviews, and metaanalysis. The research spectrum will cover both primary and secondary data analysis.

#### **7.4.8.4. Development of evidence-related products and promotion of learning platforms**

Evidence generated through the monitoring, research and evaluation processes will be processed and produced in user-friendly and user-responsive formats to cater to the needs of policymakers, advocates, and other stakeholders for up-to-date AYPHD reports and information. The products that will be produced on a regular basis include the following:

- i. *Progress Report on Adolescent and Young People's Health Policy Implementation*: This will be produced annually by GASHE and made available to stakeholders primarily as an electronic-based product. This report will essentially aggregate the programme implementation report submitted by stakeholders along with the M&E exercises conducted by GASHE and desk reviews.
- ii. *State of Nigeria's Adolescent and Young People's Health*: This will be produced every two years and will provide a systematic evidence-driven review of the state and trends in the health and development of adolescents and young people in Nigeria. The report will be produced in partnership with relevant national stakeholders' groups such as the Society for Adolescent and Young People's Health in Nigeria (SAYPHIN), research-focused organisations (state actors and non-state actors) and relevant development partners. The report will be produced in both electronic and print formats. Other relevant user-friendly products will be developed as occasion demands, for example, Policy Briefs and Fact Sheets for evidence-driven advocacy activities.
- iii. *The National Conference on Adolescent and Young People's Health*: This is a unique national platform for promoting cross-sectoral learning, disseminating relevant reports and evidence-related products, engendering the interrogation and cross-fertilisation of ideas, and advancing innovation relating to the health and development of adolescents and young people in Nigeria. The conference is also a veritable mechanism for reaching relevant stakeholders with information on the state of the implementation of the national policy and trends in the health of adolescents and young people in Nigeria. The Monitoring, Evaluation, Accountability and Learning processes will take the full advantage of the conference in collecting as well as disseminating relevant information and evidence. This policy advocate that the GASHE Division should have a booth at every edition of the conference to serve as a rallying point for distributing electronic and print national documents, interacting with the Nigerian populace, as well as meeting and connecting with other partners, among others. GASHE should similarly take advantage of other relevant national conferences and forums, as well as the World Congress on Adolescent Health and its regional counterparts to disseminate relevant information and evidence to an international audience. GASHE, the FMOH, and NAHDWG will also use such forums to cultivate relationships that will be supportive of Nigeria's national adolescent health agenda and gather information and lessons on good practices that can be applied to further improve adolescent and young people's health and actions in Nigeria.

#### **7.5.8.5. Accountability Mechanisms and Actions**

The accountability mechanisms center on the following:

- Annual reports – The FMOH should publish an annual report on AHD policy implementation and disseminate the report to all stakeholders at the NAHDWG

- The non-state actors should track budget release, allocation, and implementation on adolescent and young people's health issues in FMOH and a report developed and disseminated.
- Scorecards will be developed as a simple user-friendly accountability-promoting product, focusing on the performance of key stakeholders' groups, such as the federal agencies, state government and its agencies, and international development partners. A scorecard will be produced annually either-as a stand-alone product or integrated into other national evidence-related products.
- Young people, adolescent- and youth-led organisation and adolescent/youth-focused organisations, including the Youth Parliament, should also hold the FMOH accountable for the implementation of adolescent and young people's health activities in Nigeria and the coordination of the policy implementation as a multi-sectoral development effort. A Feedback mechanism from adolescents and young people on the implementation of AYPHD programmes in Nigeria should be put in place and monitored by FMOH and selected non-state actors.
- The National Council on Health (NCH) will also play a critical role in the accountability process – annual report on the implementation of the policy should be submitted to the NCH secretariat by GASHE and presented according to the approved schedule of the NCH.

#### **7.6.8.6. Adolescent and youth engagement**

Adolescents and young people will be at the heart of the monitoring, evaluation, accountability, and learning and participate actively in all the involved processes. Youth-led organisations, as well as adolescent-and-youth-serving organisations, will be involved in the processes based on this operational principle.

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