KADUNA STATE POLICY ON HEALTH AND DEVELOPMENT OF ADOLESCENT AND YOUNG PERSONS (AYP)
2021 – 2030

KADUNA STATE MINISTRY OF HEALTH
DEPARTMENT OF PUBLIC HEALTH
18 INDEPENDENCE WAY, KADUNA
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Table of Contents

Foreword

Worldwide, AYP are a major group for driving transformative changes in global health and development. Twenty-five years down the line from the 1994 International Conference on Population and Development (ICPD) giant strides have been made in advancing the health and wellbeing of this target group, who constitute a formidable force for National development. Optimizing the strengths and prospects of Kaduna youthful population through investments in their health and development, will bring about serious economic and social benefits, a safer and more prosperous nation, and are a necessary condition for the state to realize the Sustainable Development Goals (SDGs) 3 and 4.

Kaduna state understands the need for an effective Policy Framework as an instrument of collective aspirations and a guide for appropriate programmatic actions and interventions aimed at improving the health and well-being of its AYP. This policy has been developed through a rigorous, evidence-based process harnessing expert knowledge from multi-stakeholder engagement designed to scale up youth health and development interventions. The Policy objectives focus on AYP's health and wellbeing with emphasis on the biological, emotional, and psychosocial contexts of their growth and eventual transition to healthy and productive adults. Additionally, we have considered the peculiar needs of Adolescents and Young Persons (AYPs) as parents and added some components of Early Child Development, the modalities of which are to be expatiated at coordination and operational levels.

The policy also provides an institutional framework for coordination, monitoring and evaluation to ensure effective implementation of its broad goal and objectives with the understanding that accomplishing the objectives will require multi-sectoral collaboration with relevant Ministries, Departments and Agencies (MDAs); Development Partners, Civil Society Organizations, Youth Serving Organizations; the Private Sector; Communities and the Academia.

The State Government is committed to all efforts directed at the realization of the AYP's potentials in nation building.

Dr. Amina Mohammed Baloni
Honorable Commissioner for Health

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The review of the National Policy on the Health and Development of AYP was a collaboration of Stakeholders passionate about AYP and totally committed to their health and optimal wellbeing. Desk review was carried out, co creation workshop held, and training plan developed to take care of emerging Kaduna State, national and global issues, a situation analysis on adolescent health and development and an assessment of barriers to accessing health services for disadvantaged adolescents in Kaduna State.

Let me start by extending my appreciation to the Honorable Commissioner for Health and other Management Staff for their support and leadership role towards the development of this important policy.

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Dr. Hajara N. Kera
Director, Public Health

ACRONYMS

AA-HA	Global Accelerated Action for Health of Adolescents.
AYFHS	Adolescent and youth friendly health

AYPHD	Adolescent and AYP's health Development.
AYP	AYP
AYPLHIV	Adolescents and Young People Living with HIV
CEDAW	Convention on Elimination of All Forms of Discrimination against Women
CEFP	Community Engagement Focal Person
CHIPS	Community Health Influencers Promoters and services
CRPD	Convention on The Rights of Persons With Disability
CSOs	Civil Society Organizations
DALYS	Disability Adjusted Life Years
DHPRS	Department of Health Planning Research Statistics
ECCD	Early Childhood Care and Development
ECD	Early Childhood Development
E-FLHE	Expanded Family Life and HIV Education
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
HIV	Human Immunodeficiency Virus.
HPV	Human Papilloma Virus.
ICPD	International Conference on Population and Development.
LFH	Life, Family, Health.
LGA	Local Government Area
LGAs	Local Government Areas
LTNDP	Long Term National Development Plan
M&E	Monitoring and Evaluation.
MDAs	Ministries, Departments and Agencies
MHM	Menstrual Hygiene Management
MICS	Multiple Indicator Cluster Survey
MMA	Matasa Matan Arewa
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	Reproduction, Maternal , Newborn, Child, Adolescent Health and Nutrition
SAHDWG	State Adolescent Health and Development Technical Working Group
SAYPHIN	Society For Adolescent and AYP's Health in Nigeria.
SCH	State Council on Health
SDGs	Sustainable Development Goals
SEMA	State Emergency Management Agency
SMOH	State Ministry of Health
SPHCB	State Primary Health Care Board
SRH	Sexual and Reproductive Health
SRHR	Sexual and Reproductive Health and Right
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
WHO	World Health Organization

DEFINITION OF TERMS

Abortion: Abortion is the termination of pregnancy before the fetus is capable of living an independent life. It could be induced abortion, whereby the abortion is due to medical or surgical procedures, or it could be spontaneous, when it occurs on its own, which is referred to as miscarriage.

Adolescents: These are persons aged between 10 and 19 years.

Adolescent-Friendly Services: These are sexual and reproductive health services delivered in ways that are responsive to specific needs, vulnerabilities and desires of adolescents. These services should be offered in a non-judgmental and confidential way that fully respects human dignity.

Age-Appropriate Comprehensive Sexuality Education (AACSE): This is an age-appropriate, culturally relevant approach to teaching about sexuality and relationships by providing scientifically accurate, realistic and non-judgmental information. Sexuality education provides opportunities to explore one's own values and attitudes as well as build decision-making communication and risk reduction skills about many aspects of sexuality.

Child: This is an individual who has not attained the age of 18 years.

Child/early Marriage: This is a situation where marriage, cohabitation or any arrangement is made for such marriage or cohabitation with someone below the age of 18 years.

Early Childhood Care and Development (ECCD) is defined as the **period from conception up to primary school entry (0 – 6 years)**. It is a holistic concept that refers to the unique window of opportunity for children's cognitive, social, emotional, physical and linguistic development, which occurs as the result of the interaction between the environment and the child.

Early childhood experiences have a profound impact on brain development, affecting learning, health, behavior and ultimately, adult social relationships and their earnings. For healthy brain development in these early years, children need a safe, secure, and loving environment, with the right nutrition and stimulation from their parents and or caregivers.

Family Life and HIV Education: A planned process pf education that fosters the acquisition of factual information of positive attitudes, beliefs and values as well as development of skills to cope with the biological, psychological, socio-cultural and spiritual aspects of human living,

Female Genital Mutilation (FGM): Comprises all procedures involving partial or total removal of the female genitalia or any other injury to the female genital organs or any harmful procedure to the female genitalia, for nonmedical reasons and includes clitoridectomy, excision and infibulations but does not include a sexual reassignment or a medical procedure that has a genuine therapeutic purpose.

Gross Enrolment Ratio (GER): Total enrolment in a specific level of education, regardless of age, expressed as percentage of the eligible official school age population corresponding to the same level of education in a given school year.4

Health: A state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.

Marginalized and Vulnerable Adolescents: These are adolescents at high risk of lacking adequate care and protection. For the purpose of the Policy, the term includes orphans and street children as well as adolescents with disabilities; adolescents living with HIV and AIDS; adolescents living informal settlements; adolescents in the labour market; adolescents who are sexually exploited; adolescents living below poverty line and children affected by disaster, civil unrest or war as well as those living as refugees.

Non-State Actors: A non-state actor is as an entity that is not part of any state or a public institution. Non-state actors range from grassroots community organizations to non-governmental organizations, philanthropic foundations and academic institutions.

Sexual, Reproductive Health and Rights: The exercise of control over one's sexual and reproductive health linked to human rights and includes the right to: Reproductive health as a component of overall health, throughout life cycle, for both men and women. It includes reproductive health decisions-making, voluntary choice in marriage, family formation, determination of the number, timing and spacing of one's children, right to access to information and services.

AYP: individuals aged 10 – 24 years

Youths: individuals aged 15 – 24 years

1. INTRODUCTION

1.1 Background

Adolescence is a transitional phase of physical and psychological development between childhood and adulthood. It presents with changes in the body, behavior and experiences and worldview. The very rapid somatic growth, brain development, sexual maturation, and attainment of reproductive capacity that occurs during the period results in physical, sexual, cognitive, social, and emotional challenges that bring anxiety for both children and their families. It is therefore a period that offers opportunity for consolidation of the earlier health investments in the childhood years such as Early Childhood Care and Development (ECCD), and for laying the critical foundation for a healthy adulthood.

Investments in adolescent and young persons (AYP) health and wellbeing brings a triple dividend of benefits in terms of the life cycle impact – benefits to adolescents in their current phase of life, and their future adult life, as well as benefits for the next generation of children who the adolescents would be parents to[1]. At community and societal levels, investments in adolescent health are key to achieving population health and sustainable development. Furthermore, appropriate investments in AYP's health and development have the potential to transform national economies, facilitate the achievement of demographic dividends and engender development.

Critical to the attainment of the global development agenda including the Sustainable Development Goals (SDG) and Universal Health Coverage (UHC) is investment in the health of adolescents and young persons (AYP), as they are integrated in these agendas. Globally, AYP 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."[2]

Kaduna State has aligned with the Federal government in duly recognising the potentials and importance of investing in the health and development of AYP and has given considerable attention and increasing priority to this important population group. 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 AYP. In that regard, Nigeria developed her first National Policy on Adolescent Health in 1995. The National Policy on the Health and Development of AYP succeeded that Policy in 2007 with a complementary National Strategic Framework. In addition, Nigeria developed the National Action Plan on the Health

and Development of AYP 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 AYP 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 AYP in Nigeria as well as to reenergize the national commitment and stakeholders' engagement in this important agenda.

Kaduna State in her commitment to ensure improvement in the health and wellbeing of adolescents in the State, is domesticating the National Policy on Adolescent and AYP to provide a direction and guide in meeting the health needs of all categories of AYP. Notably, the state has recognized the need of integration of some components of its Early Child Development policy, given its increasing effort to promote integration, for optimization of results.

1.2 Rationale for domestication of the national Policy

While at the national level, the country has produced three adolescent sexual and reproductive health policies, this is the first time Kaduna State is domesticating a national adolescent health and development policy. This demonstrates the state's increasing appreciation of importance of promoting the health and wellbeing of adolescents and young persons.

The estimated population of AYPs aged 10 – 24 years is 3,780,945, 39.9% of the projected 9,476,053 population of the state. The sheer size of the population of AYP in the state has implications for the state's health and development agenda, especially in terms of needs and demands for health care and other services from other sectors. The prioritization of the needs of AYP is important for the actualization of the state's development agenda and SDG goals.

Adolescence is increasingly being recognized as a critical period in the life course. This period of transitioning from being a child to an adult, with the associated complex developmental changes of the body and behavior is association with certain challenges, as the adolescents have a propensity for experimentation, novelty seeking, and risk-taking behaviors with potentials for poor health outcomes. However, this period opens a window of opportunity for interventions that may affect their health throughout life. Actions and inactions relating to AYPs health and development, therefore, have direct consequences for the overall health status of the nation as well as its demographic and developmental trajectories. To navigate this stage successfully, AYPs 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 AYP requires specific interventions that take due cognizance of their developmental context, tasks, interests, and characteristics.

The changing international, regional and national legislative and policy landscape and the emerging issues and concerns with regards to adolescents and young persons have come to the fore as a result of advances in information, communication and technology (ICT) and the resultant exposure to materials and practices that influence AYP's behavior. Other rising concerns include escalating poverty levels, declining age of initiation of sex, rising levels of substance abuse, internet addiction, violence, cultism, fraud, infodemics, etc.

Ensuring quality health care for AYP 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 AYP and other stakeholders are well aware of these services.[3] There is, therefore, a clear need to develop and effectively implement a policy specifically targeted at improving the health and development of AYP. 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 all relevant sector.[4]

The Policy will provide the needed guidance to MDAs, development partners, CSOs and other stakeholders working with the State Ministry of Health on how to respond to the sexual and reproductive health and other health needs of young persons in the state in an integrated, multispectral and coordinated manner that provides for a mitigation of the risk factors and puts in place safety nets for early detection and prevention of SRH challenges.

1.3 Target Population

In line with the national policy, Kaduna State policy targets the entire spectrum of young persons – adolescents and youths, and thus will cover the age group 10 – 24 years, as its primary target population and the rights-holders.

In addition, based on the socio-ecological model, the policy also recognizes the critical role of stakeholders who are duty bearers in fulfilling the national agenda and aspiration for AYP's health and development. Therefore, the Policy also secondarily targets the policy makers, programme managers and service providers from 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 AYP. It also targets diverse non-state actors as duty bearers, including parent, 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 AYP's health and development as outlined in the policy implementation section of this document

1.4 Policy Context

1.4.1 The State Context

The Kaduna State 2020 – 2025 Development Plan aims to transform Kaduna State into a knowledge-based economy through investment in human capital development, diversification of economic base and information technology.[5] This development plan provides the overarching framework for locating the health sectoral policies and strategic plans, including those that are AYP-focused. In recognition of the importance of the rights of every citizen to health and development and the goal of leaving no one behind, Kaduna State affirms the rights of all AYP in the state 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. It is in this context that the state aligns with all the constitution, agendas and policies guiding the development of the National Policy on the Health and Development of AYP.

1.4.2 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 AYP 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. Agenda 2050, Nigeria's 30-year Long Term National Development Pan (LTNDP)[6] and the Nigeria's Medium Term Development Plan (2021-2025)[7] which succeeded Vision 20:2020 and the Economic Recovery and Growth Plan, 2017 – 2020 respectively, that both ended in December 2020 provide the overarching framework for the country's developmental agenda. The Medium-Term Development Plan, has "enabling a vibrant, educated and healthy population' as one of its main objectives and it emphasizes investment in AYP as part of the national aspiration for sustainable development and achieving the demographic dividend. The National Roadmap to harnessing Demographic Dividends in Nigeria, launched in 2017, further emphasizes investments in AYP and sexual and reproductive health, among others, as strategic to realizing demographic dividends. This Policy is framed within the context of these national development agendas, recognizing the central place of healthy and well-developed AYP 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 guide and strategic directions for Nigeria. Together, these documents set an important context for the articulation of national policy directions for the health of AYP. 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 AYP in that agenda. The National Youth Policy emphasizes the provision of equal opportunities to people age 15-29 years to realize their dreams and aspirations and optimize their contributions to national development. The Youth Policy, among others, has "health services and healthy behavior" as one of its strategic thrust, with the Ministry of Health recognized 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, thus, the National Education Policy as well as the National School Health Policy set part of the context for this new policy and its agenda. Additionally, noting the HIV/AIDS is a major public health problem among adolescents, this Policy will also be informed by the National HIV Strategy for AYP (2016-2020)

Nigeria, through the Federal Ministry of Health (FMoH) and its parastatals, has developed several important health-related implementation strategies that are of key to improving the health and well-being of AYP. 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 AYP 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 AYP. Thus, the Policy aligns with the provisions of these documents as it relates to AYP's health and development.

From the Ministry of Education, the Policy derived draws from the provisions of the policy on Early Childhood development and the Family Life and Sexuality Curriculum.

1.4.3 The Regional Context for Policy Development

Nigeria is a signatory to several regional treaties, conventions, protocols, and charters that recognize adolescents' and AYP's rights to health and development opportunities. The African Youth Charter, The Protocol to the African Charter on Human and People's Rights, 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 recognizes 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 AYP'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 recognizes, reiterates, and relate intimately with Nigeria's commitment to these regional agenda.

1.4.4 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 AYP. 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 third goal of the SDGs is to ensure healthy lives and promote well-being for all at all ages. The goal of SDG 4 is "Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all" and that of SDG 5 "Achieve gender equality and empower all women and girls", among others. All these are 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 AYP. 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-HA!) 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 AYP and makes an important contribution to the global advocacy for adolescent health. This Policy recognizes 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/domestication

The adaptation and domestication of the already validated national policy was conducted through an evidence-based, consultative and collaborative process with the State Ministry of Health, relevant stakeholders and various partners in the state

The major stages in the process of developing and domesticating this policy include:

- Situation Analysis: A situation analysis on the status of adolescent sexual and reproductive health in Kaduna State was carried using secondary and primary data. The purpose was to provide information to help contextualization of the policy to align with the state's situation. A consultant conducted a desk review of extant policies, status of adolescent and young persons' sexual and reproductive health and key interventions being implemented in the state.

- Stakeholders' policy workshop: Following the situation analysis, a five days' workshop was held with stakeholders drawn from the state, development partners, and civil society organisations, The intent was to review the situation analysis, identify Kaduna State's priorities as a basis for aligning the national policy to the state's priorities and context and adapting the policy in the context of the state's context.
- M&E Workshop: A two-day workshop was convened with mainly the M&E personnel of the SMOH and SPHCB to review and align indicators and targets with the situation analysis statistics and priority interventions.
- Validation of the domesticated national policy: Following the adaptation of the national policy, a one day validation meeting was convened, involving wider stakeholders to validate and adopt the adapted national policy
- Finalization of the draft: Based on feedback from the validation meeting, the policy was revised and finalized.
- Final approval and adoption of the policy: The Kaduna State Policy on Health and Development of Adolescents and Young Persons was approved by the State Council??

2. SITUATION ANALYSIS

2.1 Social and demographic characteristics

AYP (10-24years) in Kaduna State constitute about 39.9% of the population, slightly higher than the population of AYP in Nigeria (32%). Adolescents in Kaduna State, like elsewhere, are diverse and heterogeneous in socio-demographics, vulnerability and health needs.

2.2 Sexual and Reproductive Health Status

2.2.1 Menstrual hygiene management

Menstrual Hygiene Management (MHM) refers to the practice of using clean materials to absorb menstrual blood that can be changed privately, safely, hygienically, and as often as needed for the duration of the menstrual cycle. Data on menstrual hygiene management (MHM) are scarce, especially at a large scale. However, a survey carried out by Performance Monitoring and Accountability 2020 (PMA2020)[8] that collected information across states in Nigeria found that only 37% of women aged 15 -49 years in Kaduna State have everything they need for proper MHM; there was little variation by age group. These needs for MHM include clean materials, sanitary facilities for changing and cleaning, pain medication, and places to dispose of used products. Rural women in the state were consistently less likely to have these provisions for MHM compared to urban women. Findings also include the types of environments women are using for MHM and highlighted disparities in facility characteristics among urban and rural women. The results reveal a widespread need for improved menstrual hygiene management.

2.2.2 Sexual debut and contraceptive use

Age at sexual debut is low and contraceptive use among the AYP is also very low. Results from the 2018 NDHS[9] showed that for females aged 20 -49 years in Kaduna State, the median age at sexual debut is 15.8 years, which is lower than the national value of 17.2 years. Prevalence of sexual activity among adolescent girls is also high as about 54.2% of adolescents between the ages of 15-19 years have had sexual intercourse while 42.1% of adolescents ages 15-19 are currently sexually active. Sexual activity among unmarried adolescents is mostly unprotected and reported more in the urban areas. Despite the high rate of sexual activity among adolescents, contraceptive use is low as only 3.2% and 2.3% of adolescent girls aged 15-19 years in the state are using any and modern contraceptive methods respectively. Higher rate of contraceptive was found among females aged 20 -24 years in the state with 10.9% using any method and 8.2% using a modern contraceptive method.

2.2.3 Harmful practices

a. Child marriages, childbearing and fertility

The prevalence of early marriage in Kaduna State, as in other parts of the north is high. The median age at first marriage for women aged 20 -49 years is 16.6 years, compared to the national value of 19.1years[8]. Available data shows that 44.8% of females 20-24years were married before 15years with 44.8% of 15–19-year-olds and 76.2% of 20-24 in urban Kaduna are married.

The prevalence of early childbearing in Kaduna State is higher than the national average. Almost a third (31.3%) of teenage women aged 15-19 have begun childbearing, a quarter had given birth, and 4% are pregnant with their first child[8]. Fertility levels among adolescents aged 15 -19 years is also high. The Kaduna State 2020 General Household Survey (KSGHS)[10] found the age specific fertility rate for girls aged 15 – 19 years to be 148/1000, with much higher rates among uneducated and rural girls. There were also wide variations across the LGAs and zones in the state, the Age Specific Fertility Rate ranged from 33/1000 in Chukun LGA to 263/1000 in Birnin Gwari LGA and higher rates in the Northern Senatorial Zone compared to Southern Senatorial Zone 3.

b. Female Genital Cutting

Kaduna State has the highest prevalence of female genital cutting in the zone. The 2018 NDHS reported a rate of 48.8% for the state, with almost all the girls circumcised within the first 5 years of birth.

2.2.5 Antenatal, Delivery Care and Post Natal Care Coverage

Utilization of maternal health care services by adolescents in much lower than among older females. While 61.6% of women aged less than 20 years who delivered within 2 years of the KSGHS had at least one ANC visit to a skilled provider, only 6.4% and 2.8% had at least 4 and the recommended 8 visits respectively. Delayed booking was common as only a mere 0.3% of these adolescents booked within the first 4 months of their pregnancy. A higher rate of home delivery was recorded among the adolescents; 83% delivered at home and only 23.5% of their deliveries was supervised by a skilled birth attendant. Use of postnatal care services was lower among the adolescent mothers with only 27.2% having a postnatal check by a health care provider.

2.2. 5 Risky Sexual Behavior, Knowledge of STI/HIV and Sexuality Education

The KSGHS showed rates of sexual activity among adolescents and youths to be high with very low condom use rate. Among the respondents, 62.7% and 43.7% reporting ever had sex within the last 12 months respectively. Higher rate no marital sex was reported in the southern zone. However, only 7% of adolescents reported non-marital sex, 0.6%, sex with more than one partner and 2.4% condom use.

From the 2020 KSGHS, the knowledge of STI and HIV is low among adolescents in the State. While information on level of comprehensive knowledge of HIV is not readily available, 84.6% of women aged 15 -24 have heard of HIV, only two-thirds know that mutual fidelity could reduce the transmission of HIV, while 64% do not know of any specific routes of mother-to-child transmission of HIV. Knowledge and practice of HIV testing among the female youths is poor as only 13.8 % know where HIV testing sites are, and while the same percentage reported ever being tested, only 6.4% knew their results and only 1% reported being testing in the past year. Of the young persons that were tested for HIV in 2021, 23.3% were reported to be positive.

Family Life and HIV Education, which is Nigeria's form of Comprehensive Sexuality Education for use in secondary schools to improve knowledge and build the skills of students around reproductive health and STI/HIV has suffered from poor implementation in Kaduna State, as in many states of the country. Poor political commitment, resistance by religious leaders and other stakeholders has frustrated the implementation. There is an on-going attempt to revise the curriculum, which is been pilot tested in 10 schools in 10 LGAs

Most (96.2%) schoolteachers have poor knowledge of components of School Health services, while 72.7% of schools provide some form of school health service and only 9.6% had a designated sickbay

2.2.6 Abortion and maternal mortality

The prevalence of abortion in Kaduna is higher than the national average. It accounts for 18.9% of the state's maternal deaths, with the proportion of abortion related maternal deaths higher among adolescents, who also accounted for a higher proportion of post-abortion care patients. The state is reported as having one of the highest levels of unsafe abortions. Induced abortion rate among young persons has been reported to be as high as 22.2% in Kaduna State. In almost 40% of the cases of these abortions someone within the community or the adolescent herself induced the abortion. Early initiation and high rates of sexual activity in the face of low contraceptive use are contributory factors to the observed high induced abortion rates in this age group.

Although there is dearth of data on maternal mortality for Kaduna State, and available data is dated and not disaggregated by age, the MMR of 1,025/100,000 live births as at 1999 in the North-West zone, where Kaduna State is located, is almost six times the rate in the South-West (165/100,000). The 2018 NDHS did not provide zonal disaggregated MMR data, but a survey conducted in three communities in Kaduna State in 2010 shows an MMR of 1,400/100,000 live births,[11] which is high and consistent with the MMR of the North-West zone of the country. This rate is unacceptable by any standards. It is known that risk of maternal death is higher among adolescent women than other age groups, thus we expect MMR among adolescents in the state to be higher than these figures.

2.2.7 Gender-based violence (GBV)

Gender-based violence encompasses any harmful act (physical, sexual, psychological, or economic) that is perpetrated against a person's will and on the basis of socially ascribed gender roles. The prevalence of GBV among AYP is high. A national study conducted by UNICEF and National Population Commission in 2014 found that by the age of 18 years, 60% of the children had experienced some forms of violence, with a quarter of the girls and one in ten of the boys reporting sexual violence and half experiencing physical violence[12]. The study documented that girls were more likely to suffer from a combination of sexual and physical violence, and multiple experiences of a combination of physical, sexual and emotional violence were common and tended to start early in life. A study in Kaduna State found the rate of domestic violence among adolescents in secondary school to be 59.3%. Studies have documented higher rates of violence among out of-school adolescents. There is a general concern that COVID-19 has exacerbated the rates of violence.

2.3 Nutrition

Data on AYP is scanty, however, available information indicates that adolescents are a nutritionally vulnerable group due to their high energy and nutritional requirements for development; pregnancy during this period further increases this demand and increases the risk of intrauterine malnutrition and low birth weight. About 60.6% of adolescent girls 15-19years are anemic across Nigeria, while 44.0% of women in (15-49) have anemia in Kaduna State, Underweight is high among children, adolescents and women in Kaduna state

2.4 Substance Abuse and Mental health

Drug and substance abuse is increasingly becoming a major public health problem, especially among young persons. A national survey conducted by UNODC in 2018 showed the national prevalence of substance abuse to be 14.4%, that of the Northwest Zone 12% with Kaduna State having a rate of 10.0%[13]. Based on this, it is estimated that 462,000 individuals aged 15-64years are using drugs in the state. The Kaduna state-wide survey on the prevalence of substance abuse conducted by the State Bureau of Statistic in 2020 also show a prevalence of 10.9% among adolescents.[1] The commonest substances abused are cannabis and opiates. Other small-scale studies have found much higher rates of substance abuse among adolescents and university students where they abuse a wider range of substances. One study documented a lifetime prevalence and current drug use rates of 69.3% and 46% respectively among adolescents in the state.

The increasing prevalence of some mental disorders in the state has been attributed to the increasing use of psychoactive substances among AYP. The psychoactive substances commonly used among AYP include Tramadol, Marijuana, Cough Syrup, glue tranquilizer, alcohol – including fermented palm wine. Admission data from Neuro-Psychiatry Hospital Kaduna between 2018 and 2021 indicated a rising trend in substance abuse among AYPs, which was attributed to mostly use and misuse of substances among AYP. There is an association between substance abuse and risky sexual behavior and its attendant consequences.

Anecdotal evidence points to rising prevalence of addiction to pornography, betting games and internet, which are becoming causes for concern.
Despite the need for services for the prevention and control of substance abuse and other forms of addiction, there is a dearth of these services in the state and the few that are available are all privately- owned and urban-based. Additionally, mental health services are available in only specialist facilities and some

[1] Kaduna State Bureau of Statistics, Kaduna State wide survey o the prevalence of substance abuse 2020

secondary health facilities, which are yet to be cascaded to primary health care level in the state.

2.5 Violence and Injury

Violence among AYPs is defined as the intentional use of force or power to threaten or harm others by AYPs. Violence among AYP include fighting, bullying, threats with weapons, gang-related violence, yahoo-yahoo, cultism, etc. Reports are replete with exponential increase in interpersonal violence among AYP in Kaduna State, as in other parts of Nigeria, who are increasingly participating in cultism, 'yahoo- yahoo activities', bullying, banditry, kidnappings, and communal clashes, herders-farmer's clashes, school-based violence, drug-related violence and the attendant injuries and murder associated with these activities. In recent times, Kaduna State has become the hotbed of incessant banditry and kidnappings, including attacks and kidnapping of school children, resulting in closure of schools. Rising poverty levels, serious asymmetry in wealth distribution, high rates of youth unemployment, changing values and the increasing lack of opportunities for self-development and self-actualization have been identified as some of the factors responsible for the observed trend.

Road injuries are also major causes of morbidities and mortalities, especially among male AYP. While state-specific data, disaggregated by age is not available, the UNICEF dashboard for adolescents showed that in 2019 in Nigeria, road injuries accounted for 18-19% and 1-7% of disability adjusted life years among male and female adolescents respectively[2].

2.6 Non-Communicable Diseases

While literature is replete with information on ASRH, there is a dearth of data on NCDs among adolescents. Thus, while there are indications of increased prevalence of NCDs among adolescents, there is little data to corroborate this.

Where data is available, it is mainly on knowledge of NCDs and prevalence of behavioral risk factors such as tobacco use, alcohol consumption, unhealthy diet and physical inactivity, which show an increase among AYPs. Data at national level shows rising trend in the prevalence of risk factors for NCDs among adolescents, with prevalence of obesity and heavy drinking and physical inactivity increasing in the country, with higher rates among males.[3] The prevalence of risky behaviours for NCDs is high among AYPs in Kaduna State. Different studies have reported different prevalence of alcohol consumption among adolescents in secondary

[2] Adolescent health dashboards country profiles - UNICEF DATA
[3] Adolescent health dashboards country profiles - UNICEF DATA

schools in some parts of the state of between 14.4% and as high as 52.5% and that of smoking to range from 1.7% to 11%; this is one of the highest in the country[14, 15].

The UNICEF dashboard shows that in 2019, NCDs contributed 20 – 23 % to mortality among male adolescents and 17- 25% among female adolescents in Nigeria. The same showed a disproportionately large contribution of NCDs to the burden of disease among adolescents in the country: NCDs are responsible for 34% and 39% of DALYs among adolescents (10-14years) boys and girls respectively in 2019. Among male and female 15-19years old, non-communicable diseases were responsible for 42% and 46% of DALYs respectively. About 23% and 25% of deaths among male and female adolescents (10-14years old) in Nigeria respectively were due to NCDs while among males and females age 15 – 19 years, the figures are 42% and 46% for males and females respectively.[16]

Anecdotal evidence shows that the prevalence of NCDs such as diabetes, sickle cell disease (SCD), epilepsy, eye diseases (both communicable and noncommunicable) and cardiovascular diseases (CVD) are on the increase among AYP. Although there is an increase in reported cases of NCDs among AYP, poor availability of data makes it challenging to plan effective strategies to address them.

2.7 Communicable Diseases

Among adolescent, most communicable diseases have not received as much attention as sexually transmitted infections including HIV and tuberculosis. However, globally, malaria is one of the ten leading causes of mortality and morbidity among adolescents (Mokdad et al., 2016). At national level, the UNICEF dashboard showed that in 2019, among male and female adolescents' diarrhoeal diseases, HIV, malaria, tuberculosis and meningitis are the leading causes of communicable diseases mortality and morbidity. From the UNICEF dashboard, at national level, communicable diseases contributed 41% and 43% to DALYs among male and female 10-14years olds respectively in Nigeria, while among male and female adolescents age15-19years, the values were 37% and 29% DALYs respectively. For the young adolescents age 10 -14 years the contribution of communicable diseases to their overall mortality was high; 51% and 58% of deaths among male and female young adolescents (10-14years) respectively are due to communicable diseases. While among male and female 15-19year old adolescents, communicable diseases are responsible for 53% and 44% of deaths, respectively.

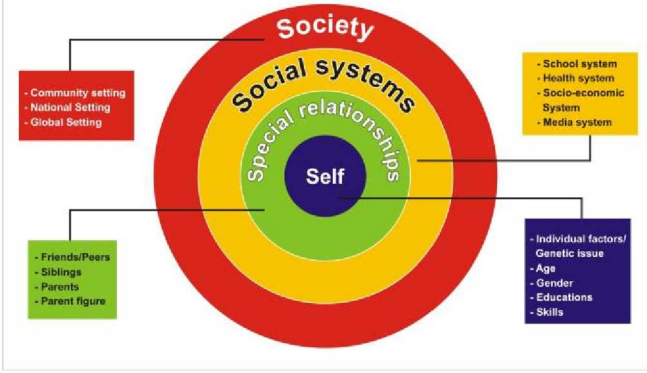
The Kaduna State AIDS Indicator Survey (KADAIS) conducted in 2017[17] showed

HIV/AIDS prevalence among adolescents aged 10-14, 15-19 and 20-24 years as 0.1%, 0.2% and 0.6% respectively . STI's/HIV among women age 15 - 24 years who had sex in the 12 months preceding the survey was 62.7% (KDS Annual Survey, 2020).

Malaria, diarrhoeal disease, respiratory tract infections, and tuberculosis are among the top 5 causes of deaths across among adolescents.

3. FACTORS ASSOCIATED WITH HEALTH STATUS OF AYP

Wide inequities in vulnerabilities, access to health information and services and health outcomes exist among adolescents. These health inequities are largely driven by social determinants of health, which are fundamental to the health and wellbeing of everyone, including 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 behaviors), special and interpersonal relationships (such as parents and peers), social and system, and the larger society. This Policy recognizes the imperative of addressing key social determinant issues, reducing risk factors, and enhancing protective factors for Kaduna State to realize her vision of improved health and development of AYP. Some of the key social determinants and risk and protective factors are highlighted in this respect.



Ecological model for factors influencing adolescent health

Source: Fatusi, 2014

3.1 Socio-economic inequity and poverty*:* Socio-economic class is a major determinant of health for AYP in Kaduna State and Nigeria. Among others, AYP 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 AYP 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 Kaduna State and Nigeria, in general, have poorer health status and worse health outcomes compared to their urban mates, except with regards to affluent lifestyle-related behaviors and conditions such as obesity and physical inactivity. The rural-urban differentials largely reflect differences in socio-economic status, 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 AYP.

Available data from the KSGHS of 2020 showed that poorer, rural and uneducated adolescents are more vulnerable to reproductive health problems, they have less access to information and services, resulting in poor coverage with adolescent health care services, and they are more likely to suffer from poorer health outcomes.

3.2 Education and safe school environment:

Access to quality education, particularly secondary school education, positively impacts the health and development of AYP. Among others, it contributes to increased health knowledge and health literacy, equips AYP 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 behaviors.

Investment in the growth and development of children in their early years, especially has profound effect on not only their survival chances but on their health and educational capacities and job opportunities in later years, in addition to having a generational. The concept of 1000 days, which is from the time of conception to the when the child becomes two years is of paramount importance, as it offers a unique opportunity to build lifelong health and intelligence with impact on their health and survival chances, school performance, job opportunities and also generational effects. Early child education, which is pre-school education offered to children from birth to the age of 6 years builds a child's cognitive, physical, social and emotional proficiency which prepare them for life challenges. The 1000 days of the child and the early child education could be greatly enhanced by appropriate maternal health behaviors and care seeking and responsive and positive parenting. It is acknowledged that adolescent mothers are more likely to come from poor, rural communities, and have low levels of awareness of health and parenting

and thus are less likely to seek appropriate care during pregnancy, childbirth and for their children. They are also more likely to be uneducated or drop out of school. Early Child Education, which focuses on the health of the mother and child, enabling environment, nutrition, education and early learning and protection, safety security provides a unique opportunity to foster interpectoral collaboration between the education and health sector to address both the education and health needs of the mother and child in a synergistic manner as the components of AYP follows the lifecycle framework. The ECD thus encourages the AYP to seek maternal care and provide her support to continue with her education and other personal development in addition to the child's interventions.

In general, less educated AYP in Kaduna have poorer health status and a higher risk of health-risky behavior 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 AYP. 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 diarrhea and discourage school attendance for adolescent girls who are undergoing their menstrual period.

Access of adolescents and youths to education, school enrolment and completion in Kaduna State is lower in the northern part of the state compared to the south and lower for the rural-based AYP compared to their urban-based peers as well as lower among the poorer adolescents compared to the richer ones. Also, access to education is considerably lower for the female compared to the male in the northern part of the country. The gender, geographical and economic imbalance in access to education need to be addressed. Additionally, the quality of education and school environment should be improved, access to quality education and safe schools increased, and the secondary school completion rate boosted to improve the health and development of AYP in Kaduna State.

Gross school enrolment in Kaduna State has increased by 91% from 1.1million in 2017 to 2.1million in 2019 in the State. School enrolment, retention and completion is higher among males than females. It is estimated that 41.2% of females have no formal education. There are also educational disparities with rural, poor and people living in the northern part of the state having lower rates.

3.3 Gender and social norms:

Gender plays a significant role as a health determinant. Gender-inequitable norms underlie several of the disadvantages that female adolescents experience

compared to their male peers in Kaduna State. Gender and social norms negatively impact the access of females to health services, education and training as well as social development opportunities. Gender and social norms are also at the root of several pervasive harmful practices against females in Kaduna State including gender-based violence, female genital mutilation/cutting, and girl-child marriage; the prevalence of these are generally higher in the northern compared to the southern part of the state. 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 AYP, particularly the females.

3.4 Marginalized and vulnerable adolescents

Married adolescents, adolescents in the labour markets, AYP living with disabilities, orphans, street involved AYP, minority sexual groups, and AYP living with HIV/AIDS comprise marginalized groups, whose vulnerability to reproductive health pathologies may be higher than that of the general population, but usually remain invisible in planning ASRH services.

Rates of sexual activity, pregnancy and fertility is higher among married adolescents than girls that are not married. Adolescents tend to marry men that are much older than them. While risk of HIV is higher among adolescents, condom use is very limited, especially among married adolescents. Married adolescents also tend to have less access to SRH services; this may in part be due to their limited education and the practice of seclusion, which restricts their spatial mobility outside the home without the express permission of their husbands. The age gap between them and their husbands, reinforced by patriarchy creates power asymmetry and exposes them to risks of intimate partner violence. Use of ANC and delivery services is much lower among adolescents compared to older women. It is important to deliberately target services to married adolescents and to link them to early childhood development programmes which empowers them and enhances their health literacy and improves their access to maternal health services.

AYP living with disabilities represent a significant proportion of any population. It is estimated that globally, 10 -15% of the population comprise PLWD, and they have the same sexual and reproductive health needs as any other person, yet they often face barriers to information and services regarding sexual health. Lack of awareness of their bodies, and rights to define and determine what they want or do not want further exposes them to increased abuse and vulnerability. Lack of targeted information, physical lack of access, negative provider attitude are some barriers to accessing services by PLWD. Attention to the sexual and reproductive

health needs for persons with disabilities is important to ensure the protection of their human rights, to move forward in building a truly inclusive society, and ensuring that we are not leaving anyone behind. There is a dearth of literature on the reproductive health needs of AYP living with disabilities in the state, and they have remained a hidden population even in state development and health plans.

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.[18] The population of sexual minorities in the State 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.[19] Studies on the health of sexual minorities are rare, and very few ever focused on teenage and young sexual minorities. There is a need to ensure inclusivity in programming.

3.4 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 AYP. Positive parental practices including effective parent-AYP communication, high level of connectedness, supportive and trusting relationship, and adolescent monitoring are protective factors against mental health disorders, substance use, as well as engagement in risky sexual behavior. The family environment also plays an important role in adolescent and AYP'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 highly promotes the health and development of AYP in Kaduna State.

3.5 Health knowledge and literacy: Low health literacy is associated with higher levels of risky health behaviors and poorer health seeking practices. The level of health knowledge and literacy about specific adolescent health issues in Kaduna State is low not only among AYP but also among other stakeholders. Studies across the country, for example, has documented low mental health literacy among AYP, teachers and as well as parents. HIV prevention provides an example of the low level of knowledge of health conditions in Kaduna State. Nationally, in 2018, the NDHS reported that only 12% of adolescents (15-19 years), and only 14% of female youth (age 20-24) and 15% of male youth had comprehensive knowledge

of HIV transmission. Based on patterns of results in the NDHS, it is expected that the knowledge of STI and HIV is equally low among adolescents in the State, lower than the national average. Part of the underlying challenge in this regard is the poor implementation of the approved Kaduna State sexuality education curriculum, the Expanded Family Life and HIV Education (E-FLHE)

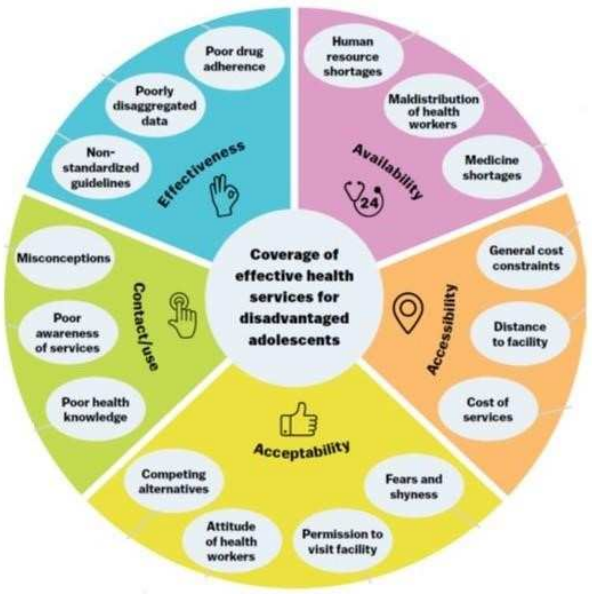
3.6 Media and digital technology:

Both traditional mass and digital media have significant implications for the health and development of AYP. 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. Alternatively, exposure to violent and sexual media, for example, has negative influence on AYP in several dimensions, including sexual behavior and mental health. The access of AYP in Kaduna State to cell phones, internet, social media and other forms of digital technology has significantly increased in the last decade. However, excessive and negative use of digital media has considerable negative implications for health and well-being.[20,21] 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 AYP.[22,23]

Infodemics explosion post-Covid has been on the rise especially among AYP affecting access to health services.

3.7 Access to and utilization of health services:

Access to relevant health services is important to ensuring the health and wellbeing of AYP, but the access of AYP to health services in Kaduna State still needs considerable improvement. In 2018, as the NDHS indicated, nationally, over a half of all female adolescents (52%) and youth aged 20-24 (51%) reported that they had serious problems in accessing health care for themselves when they were sick. Health providers' discriminatory and judgmental attitudes constitute one of the key barriers to accessing available health services by AYP. 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 AYP from poor households, AYP with low levels of education, AYP based in rural areas, married AYP, adolescents AYP with disabilities, AYP living with HIV, orphans, street-involved AYP, and AYP in conflict-afflicted areas and in humanitarian settings.



Barriers to adolescent health services in Nigeria
Source: FMOH & WHO, 2019

Some of the limitations to access and use of health services by adolescents and young persons in the state includes limited availability of youth friendly ASRH services in PHC facilities. Whereas UNICEF reported that there is at least one health worker in ASRH, the services are not there. Dearth of skilled health workers, poor motivation of the health workers, their negative and stigmatising attitudes towards adolescents seeking care and the infrastructural deficits that makes facilities inaccessible to adolescents with disabilities are added constraints[24].

Studies have shown, in general, that AYP in Kaduna State 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 AYPs to attain the highest level of health and wellbeing possible.

3.8 Access to School Health Services

School health programmes are designed to ensure healthy growth and development among school going children. The focus is to promote safe environments for school children. Components of a school health programme include: healthy school environment, monitoring the growth and development of the children, school health services, nutrition, physical education, counselling and psychological services. School health services, come under the purview of the Ministry of Education; unfortunately, it has suffered considerable neglect across the country, especially in government-owned schools.[25,26] Poor implementation of school health programmes has been documented in Kaduna State. Studies have found knowledge of school health programme among even teachers is abysmally poor: only 9.6% of the schools have a sickbay and 96.2% of teachers had poor knowledge of what school health services entail.[27] Whereas about 72.7% of the schools provided some form of school health service, only about 9.6% had a

sickbay for students to access health care services. In the study although most teachers were aware of the school health programme, knowledge was poor with 96.2% of teachers having poor knowledge.

School health services has become more important with recent reports from media on the attendant problems of lack of health services within the schools. The Kaduna Contributory Health Management Authority (KADCHMA) plans to enrol secondary school students into its health insurance scheme[4]. This intervention will help in improving access to quality health care among AYP by establishing dispensaries in schools and expanding access to primary health care services. The education sector should accelerate effort to setup school health services and strengthen collaboration with the health sector.

4. RESPONSES AND INTERVENTIONS

Kaduna State has developed and began implementation of the Health Sector Strategic Implementation Plan – II and Essential Care Packages that includes RMNCAEH+N services. The plan highlights strategic objectives and interventions targeted at adolescents in the state.

While adolescent health services are available in Kaduna State, coverage is inadequate and not available in all the 23 LGAs. The State Primary Health Care Board (SPHCB) has responsibility for the provision of these services, but they are now available in only 9 LGAs and 18 communities. However, some partners working in the state provide some adolescent reproductive health services across 23 LGAs in the state.

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AYP project commenced in 2017 across 7 LGAs and plans are underway to scale it to 18 LGAs and include HIV – prevention, treatment, care and support services for AYPs. The Child Spacing Costed Implementation plan in Kaduna State targets adolescents as important for SBCC ensuring access to rights-based information and services with focus on AYFHS as part of its strategies.

As part of the Family Life Health Education, 700 teachers were trained across 350 primary schools in 7 LGAs and 23,628 primary school students have been reached as at 2018. Other programmes in response to AYP's health include AYPLHIV, Adolescent toolkit, FHIV Volunteers), Mentor Mothers, and LG CEFP

Kaduna State is one of the benefiting States for the Matasa Matan Arewa (MMA) mentorship program, Life, Family, Health (LFH) since 2018, which empowers girls

[4] https://punchng.com/kaduna-to-enrol-secondary-school-students-into-health-insurance-scheme-official/

to articulate goals, and gain practical knowledge and skills around health nutrition, and financial planning, that can help them achieve their future life goals.

There is increasing recognition of the importance of school health services with recent reports from media on the attendant problems of lack of health services within the schools. The Kaduna Contributory Health Management Authority (KADCHMA) has announced its plans to enrol secondary school students into its health insurance scheme in an effort to improve their access to quality care[28]. As part of the scheme, dispensaries will be opened/strengthened in schools. Further, students will have access to services at primary health care facilities closest to them while on holidays

A lot of progress has been made in terms of coverage of ECD services in Kaduna State, almost half of public primary schools have ECD facilities attached and there are established ECD officers in all LGAs

5. POLICY DECLARATIONS AND GUIDING PRINCIPLES 5. 1 Underlying Principles and Values

The principles and values underlying this policy are the following**:**

a. AYP as vital resources for sustainable future and State development: AYP are vital human resources for sustainable State development and not a mere target for development efforts. AYP 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 AYP, 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 programs that concern the health, development and overall well-being of AYP in their community, institutional settings and the country as a whole.

c. Diversity of adolescents' and AYP's needs and situation: AYP are not a homogeneous group, but a diverse group in terms of the health situation, needs, and vulnerabilities. As a matter of equity, disadvantaged AYP 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

almajiri and other groups of street-involved adolescents and youths; adolescents and youth in conflict-affected areas, humanitarian situations and fragile settings; AYP affected by extreme poverty; AYP not in education, employment and training (NEET); sexual violence survivors; sexual minorities; and, married and parenting adolescents.

d. Gender equity and responsiveness: all AYP – irrespective of status– 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 programs 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 culturally sensitive and responsive 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 AYP's health and development.

f. Participatory and consultative: Effective engagement of all relevant stakeholders, sectors, and groups including both the rights holders (adolescents and youths) 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 AYP 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 emphasizes 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 emphasizes a holistic approach throughout the life cycle to achieve the highest possible level of health and development for AYP as well as ensure the greatest possible gains for the state's investment in adolescent and AYP'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 programs will aim at defined outcomes that are in consonance with the policy objectives; programs and services will be implemented with firm commitment to high quality and cost-efficiencies, and be guided by set State standards as espoused in the State Standards and Minimum Service Package for Adolescent and Youth-Friendly Health Services.

5.2 Policy Declarations

The government (state and local government) and people of Kaduna State 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 AYP shall be prioritized in the State agenda, recognising that such investments are critical to our state's sustainable development and her potentials to achieve demographic dividends as well as yield benefits for today's AYP, tomorrow's adults, and the future generations.

2. This policy shall be complementary to other State's policy documents and laws relating to the health and development of AYP in Kaduna State. In addition to the State policy documents highlighted in the context for policy development section, the implementation of this policy also recognizes 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 State's Strategy to End Child Marriage, the State Policy for Obstetric Fistula, the State Oral Health Policy, the State Mental Policy, the State Strategic Plan for the Elimination of Malaria, the State's Strategic Plan for Tuberculosis Control, Standards and Guidelines for the Medical Management of Victims of Violence in Kaduna State, the Protocol on the Management of Female Genital Mutilation (FGM) Survivors, and the Expanded Family Life and HIV Education (FLHE) curriculum, among others.

3. AYP, 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 programs for AYP 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 agree to work together in partnership to promote the health and protect the rights of adolescents and other AYP and ensure their optimal health and development. To this end, development partners shall align their support to support the AYPHDP implementation plan.

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**.**

6. VISION, MISSION, GOAL, STRATEGIC OBJECTIVES, AND KEY STRATEGIES

6.1 Vision

A healthy life and optimal development for all AYP in Kaduna State and successful transition towards a healthy, active, productive, successful and fulfilled adulthood.

6.2 Mission

Kaduna State health system and other relevant sectors are adequately adolescent- and youth-responsive and deliver quality, gender-sensitive, equitable health and social development services that effectively meet the promotive, preventive, curative and rehabilitative health and other social needs of all AYP.

6.3 Goal

The goal is to reduce morbidity, disability, and preventable mortality rates as well as optimally contribute to the wellbeing and development of AYP.

6.4 Strategic Objectives

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 programs
    a. Improve the availability, accessibility, and utilization of quality and gender-responsive adolescent- and youth-friendly health services by

strengthening the implementation of the State 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 multi-disciplinary teams at facility and community levels, including oral and mental health care 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 programs 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 enactment or review of AYP responsive policies and legislation relating to the confidential access and utilization 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 ECD, health literacy, agency, and self-care competencies of school-attending AYP and facilitate access to relevant health and health-related services.
iv. Ensure safe and health-enhancing environment for adolescent parents and young people in all settings, including the schools, ECD centres and training facilities, work environment, and healthcare centres through appropriate policies, legislations and legal framework and processes
v. Strengthen the capacity of parents, households and the community system to provide the appropriate supportive environment and care to AYP as well as to engage with and support adolescent and youth-responsive policy and programme initiatives.
vi. 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
vii. Strengthen the partnership and collaborations within the health system and between the health sector and other sectors to enhance the

implementation of the AYP health and development agenda at various levels.

viii. Strengthen the social accountability systems regarding AYP-responsive policy, programmes and service delivery.

7. KEY IMPLEMENTATION STRATEGIES

a. *Advocacy and resource mobilisation*: Advocacy targeting relevant stakeholders to mobilise their support, political will, and adequate resources for the implementation of the state's 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 promotion interventions including health-related information and education communication (IEC), social and strategic behaviour change communication (SBCC), and counselling 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 AYP to a comprehensive range of quality, accessible and affordable AYP-friendly services in the health facility, school, and community settings;
d. *Safe and supportive environment*: Ensuring safe, rights-enhancing, healthpromoting and development-supportive environments for AYP 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 caregivers to provide appropriate care and nurture, supportive environment, enriching communication and connectedness, effective monitoring and supervision, and optimal opportunities for AYP to develop their character and capacities and achieve lifelong health and well-being;
f. *Competent and committed health and adolescent-focused workforce*: Build capacity of 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 programs to AYP;
g. *Meaningful AYP engagement and positive youth development*: Building the capacities and competencies of AYP, 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 successfully 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 AYP-focused health-related and programme outcomes;

i. *Social accountability strengthening*: Actively engage with and support AYP and non-state actors, including civil society organisations, community influencers, 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*: Strengthen linkages, effective partnership and active collaborations within the health sector and between the health sector and other sectors as well as enhance 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.

8. PRIORITY PROGRAMMATIC AREAS AND TARGETS

Priority Programmatic Areas

The priority programmatic areas are:

8.1 Sexual and Reproductive Health and Right: The policy will:

- Protect adolescents' Sexual Reproductive Health and Rights, through appropriate policy and legislation and ensure attainment of these rights
- Promote education on pubertal development and management of pubertal related concerns including menstrual hygiene management
- Strengthen implementation of comprehensive sexuality education (expanded Family Life and HIV Education -FLHE); risky sexual behavior, sexual activity, harmful sexual and reproductive practices relating to digital technology
- Improve access to quality maternal health services including contraception, prevention of unintended pregnancies, unsafe abortions and provision of post-abortion care for AYP,
- Increase access to girl-child education to reduce early marriage, childbearing, and maternal mortality
- Promote education to deepen awareness on gender-based violence and harmful practices such as female genital mutilation/cutting and other forms of harmful sexual and reproductive health rights violations
- Promote adolescent participation in key decision making around policy, advocacy, budgeting, planning, research and implementation processes;
- Promote education of parents and the community on Sexual and Reproductive Health and Rights of adolescents;

- Strengthen capacities of institutions, service providers and communities to provide appropriate information and services to adolescents who require them; and
- Support prioritization and allocation of resources to ASRH

Targets

1. Domesticate all relevant national policies and legislation related to sexual reproductive health and rights by 2030

Menstrual hygiene

1. 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 hygiene management by 2030
2. At least 75% of female adolescents have all they need to adequately manage their menstruation by 2030
3. At least 40% 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
4. At least 75% of students in upper primary and secondary schools (private and the public sector) are provided with school-based expanded family life and HIV/AIDS education by 2030

Sexual debut and contraceptive use

1. Increase the proportion of AYP (10-24 years) who have comprehensive knowledge of HIV transmission to at least 40% by 2030

By 2030, at least 50% of all adolescents receive comprehensive sexuality education

Female genital cutting

1. Eliminate female genital mutilation by 2030.
2. By 2030, reduce the proportion of male and female adolescent (age 10-19 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
3. Ensure implementation of the 2019 domesticated Child's Right Act and Kaduna State Child Protection Law 2018
4. Ensure implementation of the Violence Against Person Prohibition that commenced since 2018
5. Reduce incidence of GBV against AYP by 70% by 2030

Antenatal care, delivery and postnatal care coverage

1. At least 35% of pregnant young people (age 10-24 years) attend at least 8 ANC visits throughout the course of every pregnancy by 2030.
2. At least 35% of pregnant adolescents and young people have skilled attendants at birth by 2030
3. At least 25% of adolescents and young mothers receive postnatal care services within 48 hours of delivery by 2030
4. By 2030, 95% of pregnant adolescents and young women are tested for HIV, 95% of HIV-exposed infants are placed on co-trimozaxole prophylaxis at 2 months and 95% of HIV-exposed infants receive PCR test for their HIV status within 2 months and 9 months of birth.
5. Increase the proportion of sexually experienced AYP (10-24) who have their needs for modern contraceptives from 28% in 2018 to 50% in 2030
6. By 2030, increase the proportion of AYP (10-24 years) who used a condom at the last intercourse with a non-marital partner from 13% in 2020 to 50% for females, and from 13% to 50% for males
7. At least 75% of adolescents who experience abortion complications (either from induced or spontaneous abortion) receive appropriate post-abortion care by 2030.

Child marriage and childbearing

1. Reduce adolescent childbearing rate from 32% in 2017 to 20% by 2030
2. Reduce the proportion of women aged 20-24 years who were married or in a union before age 18 from 56% to 36% by 2030
3. By 2030, reduce the maternal mortality ratio among adolescent girls by at least 40% compared to 2022.

Risky sexual behaviour, knowledge of STI/HIV and sexuality education

1. At least 50%of health facilities, schools and ECD centres provide AYP friendly services by 2030
2. Create budget line for ASRH in the state health sector annual budget
3. Achieve 75% of cash backing of ASRH allocation in the state budget
4. Support prioritization and allocation of resources to ASRH
5. Promote adolescent participation in key decision making around policy, advocacy, budgeting, planning, research and implementation processes
6. At least 50% of plans and strategy development are participated by adolescent by 2030

Education of parents and the community on Sexual and Reproductive Health and Rights of adolescents

1. At least 30% of parents have knowledge of sexual and reproductive health rights of adolescent by 2030

Prioritization and allocation of resources to ASRH

1. Create budget line for ASRH in the state health sector annual budget 2. Achieve 75% of cash backing of ASRH allocation in the state budget

8.2 Nutrition and Physical Activity:

The policy will:

1. Improve nutritional counselling, prevention and management of under and over nutrition among AYP including eating disorders
2. Increase access to micronutrients supplementation to prevent and manage micronutrient deficiencies among AYP
3. Promote physical activities among AYP through physical education and sports
4. Strengthen nutritional health component of the state school health programme
5. Strengthen community-based nutrition health programmes of AYP
6. Support state nutritional survey on AYP
   Increase public awareness on AYP nutrition

Targets

1. By 2030 at least 50% of health facilities have a trained nutritional counsellor
2. By 2030 at least 80% of AYP have access to affordable micronutrients supplements in public and private outlets
3. By 2030 at least 50% of schools have periods dedicated for physical health activities with trained teachers
4. By 2030 35% of schools have at least one teacher trained on nutritional health by 2030
5. By 2030 establish community-based nutrition programme in at least 30% of the 255 political wards
6. Integrate nutritional indicators into household survey and support the annual conduct by 2030
7. At least 30% of general public have knowledge of AYP nutrition by 2030

8.3 Substance and Drug abuse

1. Promote education and behaviour change communication on drugs and substance abuse
2. Create opportunities to help AYP participate in activities that reduce risk of substance and drug abuse or enhance protection

3. Scale up substance and drug abuse treatment and rehabilitation centres
4. Scale-up mental health counselling, screening and treatment services to primary health care facilities

Targets

1. By 2030, at least 25% of AYP, parents, teachers and caregivers have good knowledge of AYP mental health issues
2. Reduce the prevalence of substance abuse among AYP from 13.7% in 2020 to 6% in 2030
3. By 2030, provide screening for potential mental health conditions to at least 50% of AYP
4. At least 50% of AYP with mental disorders have access to skilled mental health services from the formal health system by 2025
5. At least 30% of AYP with substance use disorders, harmful use of digital technology-and addictions receives appropriate treatment interventions (pharmacological, psychosocial, rehabilitation and aftercare services) by 2030
6. By 2030, ensure that at least 75% of health and social care facilities managing people with mental health disorders are using the WHO Quality Rights tool kit[i], for quality improvement.

8.4 Violence and Injury:

Gender- based violence and harmful practices such as female genital mutilation/cutting and other forms of harmful sexual and reproductive health rights violations

- Unintentional injuries
- Intentional injuries; self-directed violence; interpersonal violence including bullying and cyber bullying; and collective violence

Interventions

1. Promote family environment that enhances healthy development
2. Provide early education in life through Early Childhood Education programmes
3. Strengthen youths' skills through universal access to education and other skills-based programming
4. Expand access to treatment services
5. Promote partnerships and collaboration in addressing violence among AYP

Target

1. At least 95% 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 2030

2. By 2030, at least 95% of motor parks are free of the sales of alcohol and illicit substances
3. By 2030, 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
4. By 2030, reduce the mortality rate due to road traffic injuries among AYP by 30%
5. By 2030, reduce the incidence of violence among AYP by 30%
6. By 2030, reduce the incidence of AYP violence-related mortality by 30%

8.5 Non-Communicable Diseases

The policy will:

1. Enact/review relevant policies and guidelines to promote early detection and management of NCDs among AYPs
2. Increase awareness on common non-communicable diseases
   (cardiovascular, reproductive health cancers, chronic respiratory disorders, diabetes, obesity, and sickle cell diseases) risk factors and prevention among AYP
3. Increase early screening, detection of preventable NCDs and strengthen referral system across healthcare delivery ladder.
4. Strengthening the capacity of health care workers on management of common NCDs and supply of basic equipment for effective management
5. Increase resource allocation to prevention and management of NCDs among AYP

Target

1. By 2030 100% of policies and guidelines on NCDs are domesticated/reviewed
2. 70% of AYP are aware of risk factors for NCDs and their prevention by 2030
3. At least 70% of health facilities provide early screening, detection and referral of common NCD
4. Strengthening the capacity of health care workers on management of common NCDs and supply of basic equipment for effective management
5. Increase resource allocation to prevention and management of NCDs among AYP

8.6 Communicable diseases

Reduce STI, including HIV and HPV The

Policy shall:

1. Support provision of accurate information on HIV and AIDS as well as other STIs to adolescents for risk reduction and ART adherence;
2. Promote screening and treatment of STIs;
3. Scale up adolescent-friendly HIV counseling and testing sites including linkage with other services;
4. Promote HIV testing and counseling among AYP including information on the potential benefits and risks of disclosure of their HIV status to others;
5. Promote implementation of HPV vaccine programmes among adolescents
6. Promote generation of adolescent-specific disaggregated data and its utilization for decision making;
7. Ensure adequate capacity of healthcare workers at all levels of healthcare for the provision of integrated, high quality SRH services in the context of STIs and HIV to adolescents;
8. Support meaningful participation of adolescents throughout HIV programming cycle.
9. Enhance integration of HIV and AIDS among other STIs information and services into SRH services at all levels of health care;
10. Support community-based approaches to improve HIV testing, STI screening, appropriate referrals and treatment adherence and retention in care of AYP living with HIV.

Targets

Sexually transmitted infection including HIV

Targets

1. Increase the proportion of AYP with comprehensive knowledge of HIV and STIs from 13% in 2018 to 50% in 2030
2. Increase the proportion of AYP tested for HIV to 95% by 2030
3. By 2030, at least 25% of female AYP receive HPV vaccine by age 15 years
4. By 2030, at least 90% of AYP (10 - 24 years) with symptoms suggestive of STIs access treatment

9. POLICY IMPLEMENTATION

9. 1 Multisectoral agenda and principles in the policy implementation

Ensuring the health and well-being of AYP 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, monitoring and evaluation and production of 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 all adolescents and other AYP, irrespective of gender, social and physical conditions 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 AYP 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 AYP, 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 state adolescent health agenda. Adolescents and youths are the rights holders and the prime actors in the health and development agenda for AYP in the state 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 Kaduna State government and her peoples the support and contributions of international development partners and other non-state actors are also important to achieve the policy objectives.

9. 2 Role of the Health Sector 9. 2. 1 Kaduna State Ministry 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:

- Foster partnership with other agencies and stakeholders to advance integrated AYPHD-related agenda in the state and ensure adolescent- and youth-responsive health and social development systems.
- Designate an Adolescent Health Focal Officer with specific terms of reference to promote the effective implementation and institutionalisation of AYPHD programmes in the State
- Provide appropriate infrastructure, staff, funding, capacity-development opportunities and logistics to support the Adolescent Health Focal Officer to function effectively.
- Effectively support the operations of a multi-disciplinary, multi-sectoral State Working Group on Adolescent and AYP's Health and Development with the SPHCB serving as the secretariat.
- Spearhead advocacy for increased government and stakeholders' commitments and support for AYPHD programmes and agenda in the state.
- Develop and implement a state AYPHD integrated action plan to facilitate improved services and programme to enhance adolescent and AYP's health and wellbeing in the state.
- Create a budget line for AYPHD activities and provide an adequate amount of fund annually to support the effective implementation of the policy at the state level.
- Provide technical assistance to Local Government Areas, Agencies and institutions in the state in the implementation of the policy.
- Strengthen the capacity of health workers, to provide quality and responsive integrated services to AYP
- Ensure the availability of integrated AYFHS at the primary health care level and the appropriate supportive back-up/referral services at secondary health care facilities.
- Track implementation of the Policy by regularly collecting, collating and disseminating of relevant data about adolescent and youth health services, uptake, coverage and other issues within the State in an age- and genderdisaggregated form and promote the appropriate use of the data for programming.
- Technically and financially support integrated AYPHD-related research endeavours to generate relevant data on AYPHD issues that will inform decision-making in the state.
- Monitor the implementation of the policy in the state and develop and share progress report regularly with GASHE and SAHDWG as well as stakeholders in the state and beyond

9. 2. 2 Local Government Health & Related Social Development Departments

- Promote and implement integrated 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.
- Establish relevant adolescent- and youth-related facilities at community levels and strengthen the community systems to support integrated AYPHD programmes and activities
- Strengthen the capacity of health workers, school teachers, social welfare officers, care givers and other relevant Local Government Area (LGA) staff to provide integrated quality and responsive services to AYP.
- Create a budget line and provide adequate and regular funding for integrated AYPHD services and judiciously manage all available funds for AYPHD services and programmes.
- Create a favourable environment for integrated 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 the policy.
- Regularly collect, collate and disseminate relevant data about adolescent and youth health services and issues within the LGA in an age- and genderdisaggregated form and promote the use of the data for programming
- Support operation and other types of research on integrated AYPHD issues within their LGAs.
- Monitor and document activities, services and programmes conducted in the LGA relating to AYPHD and share such reports regularly with SMoH and SAHDWG

10. Role of Other Government Ministries and Agencies 10. 1 The Legislature

- Make appropriate legislation regarding the health and development of AYP and support the implementation of this Policy at the relevant levels
- Support the implementation of relevant policy instruments that protect and promote the health, rights, and well-being of AYP, including international and regional treaties and conventions in the case of the State legislature, laws and policies in the case of LGA legislative councils
- Ensure timely and adequate budgetary approval and releases for integrated AYPHD activities, and provide effective oversight for the use of the funds and programme implementation
- Prioritise and champion issues relating to the health and development of AYP in various constituencies and in constituency projects

- Mobilise and educate members of focal constituencies to develop and support integrated AYPHD programmes, including AYFHS and school health initiatives.

10. 2 Ministry of Education

- Intensify efforts to achieve universal basic education and address the educational needs of vulnerable adolescent and AYP including those in conflict-affected areas and street-involved adolescents and youths
- Improve the quality of educational services and the school environment to optimise learning and educational opportunities by AYP
- Adopt the policies and principles of health-promoting school and integrate best practices that guarantee the school as a safe, health-enhancing and health-promoting environment
- Adopt the reviewed and revised family life and HIV/AIDS education curriculum to ensure that it responds to the changing needs of AYP and conforms to the global best practices in comprehensive sexuality education curriculum design and delivery
- Scale-up the training of teachers in the expanded family life and HIV/AIDS education (E-FLHE) as well as expand the coverage and effectiveness of E-FLHE at all levels of formal education
- Integrate E-FLHE into mass literacy, adult and non-formal educational programmes to cater for the out-of-school adolescents and other AYP.
- Monitor the implementation of E-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
- Improve the quality and coverage of school-based health-related initiatives, including school health services, school feeding programme, and physical and health education
- Ensure that all schools – private and public – have adequate and genderresponsive 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
- 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 schoolrelated violence
- 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
- Ensure that all ECD concerns for adolescent mothers in school are adequately provided

- Adopt innovative approaches and programmes that promote the school as a platform for holistic adolescent and youth development and gendertransformative experiences for students and school population, the parents and other stakeholders
- Develop the capacity of AYP to serve as advocates for their health and development needs, and to champion accountability for quality service delivery.
- 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.
- Ensure the appropriate integration of E-FLHE into the teaching curriculum of institutions for AYP with disabilities and other forms of special needs. Conduct State-wide research activities on AYPHD issues

10.3 Ministry of Human Services and Social Development

- Promote awareness of adolescent and AYP's health, development and well-being issues among policymakers, community and religious leaders, and other stakeholders.
- Address gender-inequitable norms and harmful practices that negatively impact the health, well-being and development of the adolescents through advocacy, sensitisation and social behavioural change communication, legislative and policy changes, and legal actions.
- Promote the effective implementation of The Violence Against Persons (Prohibition) Law (VAPP) 2018 as well as the Discrimination Against Persons with Disabilities (Prohibition) Law 2020
- Engage in effective innovative gender-transformative programmes to remove the barrier limiting the access of adolescents and youths, including married ones, to health services, education and training opportunities, and other development prospects.
- Promote and ensure the implementation of measures and activities that will improve the status, health and well-being of AYP, particularly the females.
- Promote economic development and self-reliance among adolescents, other young females and other vulnerable groups through training and skill acquisition opportunities.
- Advocate for, and ensure the mainstreaming of gender concerns into all health development activities relating to AYP
- Organise capacity building activities to improve parents' ability to strengthen parent-adolescent communication, relationship, and connectedness
- Collect, analyse and disseminate gender-related statistics as well as support research activities to generate evidence to inform genderresponsive policies and programmes.

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  Establish and manage youth centres with integrated AYPHD programmes such as counselling to meet the needs of in- and out-of-school adolescents and other AYP.
- Sensitise and educate community influencers on the importance of adolescent and AYP's health and development (AYPHD) agenda.
- Undertake social and behavioural change communication programmes to improve the decision-making capacity and health behaviour of AYP.
- Build the capacity of AYP for gainful career/employment life and for engendering meaningful participation in national development activities
- 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 AYP.
- Encourage and supervise social welfare voluntary agencies to effectively implement appropriate areas of the policy.
- Ensure the establishment, maintenance and effective functioning of rehabilitation centres to cater adequately for AYP needing such services.
- Ensure the mainstreaming of the needs of AYP in vulnerable situations and special circumstances, including those with physical and mental challenges and AYP living with HIV and AIDS, into the sectoral activities.
- Collect, collate, analyse and disseminate sectoral data on adolescent and youth development initiatives and activities, and use the data generated to inform programmes
- Promote the implementation of the Discrimination Against Persons with Disabilities (Prohibition) law
- Introduce initiatives to support the development and integration of physically and mentally challenged adolescents and youths into the mainstream of society.
- Facilitate increased access of physically and mentally challenged adolescents and youths to relevant health and social services, and to education, development opportunities and jobs.
- Collect, analyse disaggregate, and disseminate data regarding AYP's health and development issues within the sector and use the collected data to inform actions

10.4 Ministry of Sport Development

- Develop recreational and other facilities to enhance the health and development of AYP and promote their access to such facilities through appropriate policies.

- Intensify the implementation of organised recreational and sporting activities to enhance physical activities and improve health outcomes.
  Collect, collate, analyse and disseminate sectoral data on youth talent hunt for sports development on adolescent and youth development initiatives and activities, and use the data generated to inform programmes.

10.5 Ministry of Finance

- Adopt adolescent-responsive budgeting for AYPHD issues and mandate sectoral ministries to justify investments with explicit attention to adolescents' health and development
- Support the establishment of specific budget lines for AYPHD activities for different line ministries and other government agencies
- Prioritize timely cash backing of funds for AYPHD activities.
- Collect, collate, analyse and disseminate sectoral data on adolescent and youth development initiatives and activities, and use the data generated to inform actions.

10.6 Ministry of Justice

- Review and reform, where necessary, laws pertaining to AYPHD, and provide legal guidance to facilitate legal frameworks that are supportive and promoting AYPHD agenda.
- Develop the appropriate legal framework that ensures and assures the reduction in the age of consent/access of AYP to sexual and reproductive health services as well as other interventions relevant to the health and wellbeing of AYP
- Undertake information, education and communication activities to increase public awareness on laws pertaining to AYPHD issues.
- Actively facilitate the prosecution of cases involving violation of AYP's rights and promote the enforcement of laws relevant to AYPHD
- Ensure the establishment of juvenile courts State-wide to address appropriate cases relating to young adolescents and enhance speedy handling and conclusion of all cases
- Collect, collate, analyse and disseminate sectoral data on adolescent and youth development initiatives and activities, and use the data generated to inform actions.

10.7 Planning and Budget Commission

- Ensure sufficient budgetary allocation for AYPHD activities and informed by appropriate evidence

- Ensure integration of AYPHD issues into development planning in all relevant sectors.
- Strengthen the coordination of International co-operation for AYPHD activities.

Integrate AYPHD data into the State data bank

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

10.8 Ministry of Agriculture

- Integrate FLHE activities into the training programmes of agricultural extension workers.
- Build the capacity of agricultural extension workers to promote the health and development issues of AYP among their target populations.
- Collect, collate, analyse and disseminate data regarding AYPHD issues within the sector.

10.9 Office of the Head of Service

- Strengthen training programmes on AYPHD issues, including family life and HIV/AIDS education, for workers.
- Monitor labour laws, policies, and practices to discourage workplace practices that could be detrimental to the health and development of AYP.
- Collect, collate, analyse and disseminate sectoral data on adolescent and youth development initiatives and activities, and use the data generated to inform actions.

10.10 Ministry of Business Innovation and Technology

- Promote policies and practices that will enhance the knowledge and skills of AYP to prepare them for gainful employment.
- Promote policies that will ensure equitable access to employment opportunities and reduce under-employment and unemployment among AYP (both males and females).
- Collect, collate, analyse and disseminate sectoral data on adolescent and youth development initiatives and activities, and use the data generated to inform actions.

10. 11 Ministry of Housing and Urban Development

- Provide and regularly maintain public infrastructure in their area of mandate in support of the creation of a healthy, safe and supportive environment for AYP.

- Collect, collate, analyse, disaggregate and disseminate data regarding AYP's health and development issues within the sector and use the collected data to inform actions.

10.12 Ministry of Public works and Infrastructure

Provide and regularly maintain public infrastructure in their area of mandate in support of the creation of a healthy, safe and supportive environment for AYP.

- Develop infrastructures in public spaces and facilities that will support the easy movement of AYP who are physically challenged.
- Collect, collate, analyse, disaggregate and disseminate data regarding AYP's health and development issues within the sector and use the collected data to inform actions.

10.13 Kaduna Power Supply Company

- Provide and regular power supply in support of the creation of a healthy, safe, supportive and productive environment for AYP.
- 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 AYP as well as their significant others.
- Collect, collate, analyse, disaggregate and disseminate data regarding AYP's health and development issues within the sector and use the collected data to inform actions.

10.14 Ministry of Internal Security and Home Affairs

- Ensure the establishment, maintenance and effective functioning of corrective centres to provide optimal services for AYP needing such facilities.
- Develop schemes and programmes that promote the access of AYP to social and economic development
- Collect, analyse disaggregate, and disseminate data regarding AYP's health and development issues within the sector and use the collected data to inform actions.

10.15 State Emergency Management Agency (SEMA)

- Ensure the safety of AYP in emergency situations and in fragile and humanitarian settings
- Ensure the provision of adequate facilities that will support the health and well-being of adolescents and young persons 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.

10.16 Kaduna State Resident Registration Agency

Collect, analyse, interpret and disseminate age- and gender-disaggregated demographic and other relevant data relating to AYP through census and sample surveys.

- Disseminate specific data regarding AYP through the development and distribution of monographs, fact sheets, and other print and electronic materials.
- Support and promote State research activities on AYPHD issues
- Collaborate with SMoH to generate data for the evaluation AYPHD programme across sectors.
- Advocate and promote the implementation of sexual and reproductive health programmes for AYP as part of population and development activities.
- 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.

10.17 State Bureau of Statistics

- Collect, analyse, interpret and disseminate gender-disaggregated socioeconomic data to facilitate monitoring and evaluation of AYPHD programmes.
- Disseminate adolescent- and youth-specific State and genderdisaggregated socio-economic data.
- Provide data on a regular basis to the State database and other relevant agencies and institutions regarding the health and development of AYP.

10.18 The Armed Forces, Other Uniformed Services and Security Agencies

- Enforce the protection of AYP's rights as enshrined in the constitution
- 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.
- Build the capacity of officers and staff to understand and effectively intervene in issues relating to AYP, their health and development.
- Ensure the enforcement of the existing code of conduct that protects AYP's rights.
- Collect, analyse disaggregate, and disseminate data regarding AYP's health and development issues within the sector and use the collected data to inform actions.

10. 19 Non-State Actors

10.19.1 Faith-based Organisations

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

10.19.2 Non-Governmental Organisations

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

10.19.3 Professional and Learned Societies

- Conduct regular and high-impact research, produce and disseminate research-related products on integrated AYPHD to address research gaps and generate new evidence that will inform decision-making

- Convene regular scientific forums on integrated AYPHD to improve understanding and learning about integrated AYPHD situations in Kaduna State and globally to replicate best practices in poly development and programming.
- 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 integrated AYPHD.
- Conduct training and undertake relevant capacity building to expand the adolescent health workforce, researchers and programme analysts
- Partner with one another and other non-state actors to initiate and/or implement effective social accountability mechanisms.

10.19.4 Academia, Tertiary Education Institutions, and Research Institutes

- Provide training on integrated AYPHD issues.
- Conduct research that will advance knowledge in ARSH, address implementation challenges and provide innovative strategies for addressing adolescent and young persons' health problems.
- Develop and implement policies that will ensure a safe and supportive environment for AYP and enhance their health and development, including policies to protect them from sexual and gender-based violence
- Develop and implement programmes that will effectively support the health and development of the population of AYP, including health promotion activities, BCC programmes, and counselling services.
- Establish adolescent and youth responsive health services in their institutions.
- Develop and activate mechanisms to regularly monitor the health and development of AYP within their institutions.
- Provide advisory services on integrated AYPHD issues to development partners.
- Assist in the evaluation of programmes related to this policy.
- Undertake basic, operational and applied research activities to generate new ideas, monitor policy implementation, and improve integrated AYPHD programmes.
- Organise and disseminate findings from research on integrated AYPHD widely to the public and policy makers.

10.19.5 Organized Private Sector

- Actively participate in policy advocacy, programme development and implementation of activities relevant to the health and development of AYP

and complement the efforts of the Government and other sectors of the society.

- Endeavour to make the work environment friendly to AYP, including the vulnerable and disadvantaged ones such as the physically challenged adolescents, in terms of structure and infrastructure, policies, and processes.
- Collaborate in implementing activities with other partners including the state actors and non-state actors to synergise effort and increase impact in the integrated AYPHD field.

10.19.6 Political Parties

- Integrate AYPHD concerns into party manifestos, agendas, plans and programmes.
- Support the implementation of integrated AYPHD programmes
- Provide information and education on the importance of integrated AYPHD issues to State development to their members.
- Promote and advocate the appropriate policy changes in the area of AYP's health and development.

10.19.7 Media

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

10.19.8 AYP

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 AYP must have adequate and appropriate representation of various categories of AYP. Particular attention must be paid to gender and geographical balance, among others. AYP 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.

AYP shall have the following roles and responsibilities:

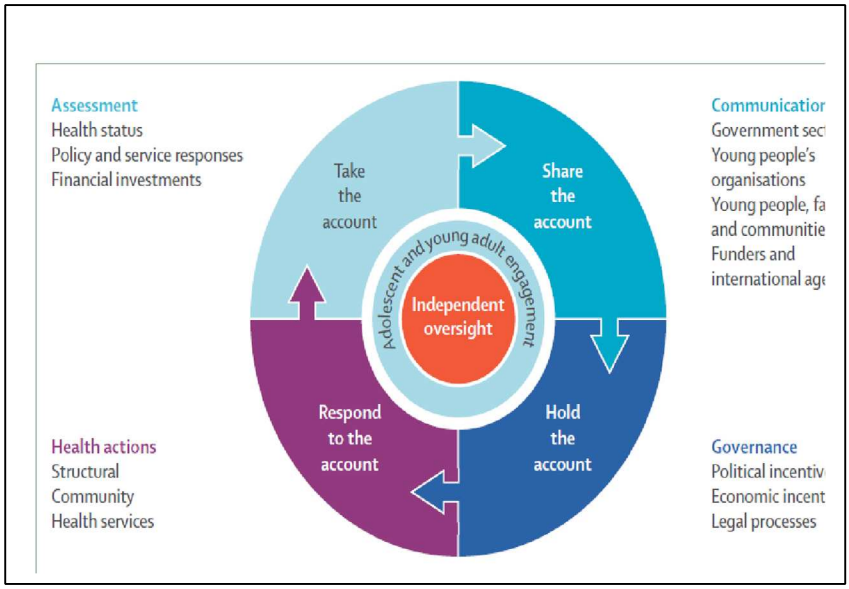
- Participate actively in policy development, advocacy and resource mobilisation in support of integrated AYPHD programmes;
- Undertake health advocacy and sensitisation programmes to promote youth participation in state and national development agenda
- Engage with communities to address customs and practices that discriminate and/ or impact negatively on the rights as well as the health and development of AYP
- Engage with peers to educate and build life skills for healthy and responsible living including health-seeking behaviours
- Encourage the formation of youth organizations i.e Civil Society Organisations (CSOs), Community-based Organisations and Faith-based

organisations to enhance youth participation and integrated AYPHD programmes

- Create linkages with government agencies, CSOs including youth-serving Non-governmental Organisations (NGOs) and other development partners to enhance integrated AYPHD programmes;
- Utilize digital platforms and other innovative approaches to disseminate social and behavioural change information and policy dissemination
- Monitor the implementation of the policy and establish suitable mechanisms for social accountability

11. 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 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 fo r the goal of improving the 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 State and stakeholders to take an appropriate stock of the



course of the policy implementation regarding the progress being made and provide the foundation health and wellbeing of AYP in Kaduna State 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' Healt*h and aligns with its perspective that,

"Accountability comprises three interconnected processes – monitor, review, and act – that are aimed at learning and continuous improvement".[29] 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* [30] and the recommendations of the Independent Accountability Panel's *Transformative accountability for adolescents* Report.[31]

11. 1 Coordination and Oversight for Monitoring, Evaluation, Accountability, and Learning 11. 1.1 Oversight Function by Reproductive Maternal, New born, Child, Adolescent, Elderly Health + Nutrition (RMNCAEH+N) TWG

The State RMNCAEH+N TWG through the Sub-committee of the AYPHD will have the lead oversight role for monitoring and evaluating the policy implementation and the attainment of its objectives. The committee will meet monthly. Among others, the committee will rigorously review the status of the implementation of the policy and note progress regarding the health and well-being of AYP in Kaduna State. The progress report that would regularly be prepared by Gender, Adolescent, School Health and Elderly (GASHE) Division of the Kaduna State Ministry of Health will be reviewed by the AYPHD Committee at every of its meetings. The committee will advise the SMoH on further steps to take in advancing the health and development of AYP following the review of the available evidence and progress reports.

11.2 Coordination Function by the Adolescent Health-focused Division of SMOH

The Gender, Adolescent, School Health and Elderly **(**GASHE) division of the Department of Family and Community Health Services of the State Primary Health

Care Board as the secretariat of the State AYPHD committee will develop and widely disseminate a uniform reporting format to be used by various organisations and institutions involved in integrated AYPHD programme at all levels in the State. 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 and Community Health Services of the State Primary Health Care Board as the secretariat of the State AYPHD Committee.

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. This officer will actively follow up with the LGAs, relevant MDAs, federal agencies, development actors and other stakeholders about the timely submission of progress reports. The officer will also have the responsibility of carefully organising and archiving the various reports in an electronic format. The officer would also ensure appropriate analysis of data and reports submitted, and summarise them to provide a State picture quarterly.

11.3 Monitoring and Evaluation

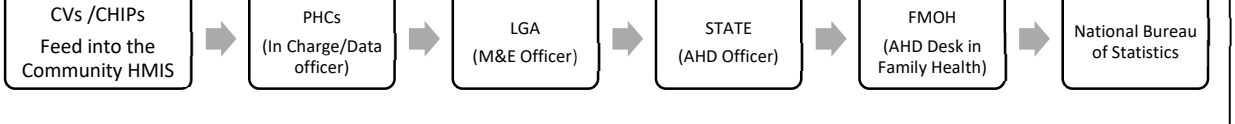
A State M&E Plan for the health and development of AYP will be developed to serve as one of the Policy's key implementation instruments. The Plan shall be guided by the goal, objectives, and targets of this Policy and will articulate, among others, the processes for systematically collecting, aggregating, 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 SMoH institutional M&E framework, and connected with the State Integrated Monitoring and Evaluation System.

11.3 1 Monitoring Process

The monitoring process will involve the following:

- *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 and Community Health Services of the State Primary Health Care Board as the secretariat of the State AYPHD Committee.

b. The NHMIS will provide a summary of service-related data with appropriate sex- and age-disaggregation (age 10-14, 15-19, and 2024) from its routine health information system on a quarterly basis to GASHE. All relevant Departments and Units of the SMoH 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 the state 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 Board and the LGA Health Units) 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 LGAs and other actors on a quarterly basis as part of the policy implementation process. The LGA adolescent health office will also conduct regular quarterly monitoring and supportive supervision visits within the state.



Data flow system for adolescent health programmes in Nigeria

11.3.2 Evaluation and Review Processes

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

- 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 RMNCAEH+N through its AYPHD Subcommittee for thorough discussion and review with appropriate recommendations made to the SMoH 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.
- 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 RMNCAEH+N through its AYPHD Sub-committee 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 State Health Strategies that will be taking place as part of the State Strategic Health Development Implementation to examine progress and issues relating to adolescent and AYP's health status. The Monitoring, Evaluation, Accountability, and Learning will also take advantage of the various research activities across the State regarding the health and development of AYP's health in Kaduna, as well as various databases and information systems, including the surveillance systems.

11. 4 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 state wide 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, mixedmethod approach and also include systematic reviews, review of reviews, client exit interviews, and meta-analysis. The research spectrum will cover both primary and secondary data analysis.

11. 5 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-todate AYPHD reports and information. The products that will be produced on a regular basis include the following:

- *Progress Report on Adolescent and AYP's Health Policy Implementatio*n: This will be produced annually by AYPHD Committee 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 the AYPHD Committee and desk reviews.
- *State of Kaduna's Adolescent and AYP'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 AYP in Kaduna State. The report will be produced in partnership with relevant stakeholders' groups such as 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.

The National Conference on Adolescent and AYP's Health: This is a unique national platform for promoting cross-sectoral learning, disseminating relevant reports and evidence-related products, engendering the interrogation and crossfertilisation of ideas, and advancing innovation relating to the health and development of AYP 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 AYP 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 AYP's health and actions in Nigeria.

11. 6 Accountability Mechanisms and Actions

The accountability mechanisms centre on the following:

- Annual reports – The SMoH should publish an annual report on integrated AYPHD policy implementation and disseminate the report to all stakeholders at the RMNCAEH+N
- The non-state actors should track budget release, allocation, and implementation on adolescent and AYP's health issues in SMoH and a report developed and disseminated.
- Scorecards will be developed as a simple user-friendly accountabilitypromoting 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 State evidence-related products.
- AYP, adolescent- and youth-led organisation and adolescent/youth-focused organisations, including the Youth Parliament, should also hold the SMoH accountable for the implementation of adolescent and AYP's health activities in Kaduna State and the coordination of the policy implementation as a multi-sectoral development effort. A Feedback mechanism from AYP on the implementation of AYPHD programmes in Kaduna should be put in place and monitored by SMOH and selected non-state actors.
- The State Council on Health (SCH) will also play a critical role in the accountability process – annual report on the implementation of the policy should be submitted to the SCH secretariat by RMNCAEH+N and presented according to the approved schedule of the SCH.

11.7 Adolescent and youth engagement

AYP 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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